DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

February 4, 2020

Ms. Michelle L. Farr
Executive Director
Social Services Administration
Maryland Department of Human Services
311 W. Saratoga Street
Baltimore, Maryland 21201

Dear Ms. Farr:

Thank you for submitting Maryland's title IV-E prevention program five-year plan for fiscal years (FYs) 2020-2024. The title IV-E prevention program is authorized under the Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115-123, which amended titles IV-B and IV-E of the Social Security Act (the Act). The FFPSA is an important tool that, if utilized effectively, will help move child welfare in the United States to a more preventative system that works to strengthen families and reduce unnecessary family disruption.

Plan Approval

Maryland (MD) submitted a title IV-E prevention program five-year plan to the Children's Bureau (CB) Regional Office on October 1, 2019. We completed a review of this submission and identified areas requiring further documentation to support compliance with state plan requirements. On December 18, 2019, MD provided a revised plan that addressed the identified provisions.

We are pleased to notify you that we reviewed MD's title IV-E prevention program five-year plan submitted December 18, 2019 and find it to be in compliance with applicable federal statutory and regulatory requirements. MD's title IV-E prevention program five-year plan for FYs 2020-2024 is approved as outlined below. An amendment must be submitted any time there is a substantial change to information in the approved plan.

The effective date of MD's plan is October 1, 2019. Please maintain this approval letter as a part of the final, approved plan.

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in an approved public assistance cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval

granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative costs in accordance with applicable regulations at §95.509(a)(3).

Approval of Services under the Title IV-E Prevention Program

Pursuant to Sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, only services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse or a state's designation based on an independent systematic review approved by the U.S. Department of Health and Human Services (HHS) for transitional payments as part of the title IV-E prevention program five-year plan are permitted. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse). The title IV-E agency must also provide an assurance each program or service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and that the state will use information gleaned from the continuous monitoring efforts to refine and improve practices. CB has approved the following allowable programs and services under this program:

Functional Family Therapy (Well-Supported)
Healthy Families America (Well-Supported)
Multisystemic Therapy (Well-Supported)
Nurse Family Partnership (Well-Supported)
Parent-Child Interaction Therapy (Well-Supported)

Approval of Request for Waiver of Evaluation Requirements

Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of Section 471(e)(5)(B)(iii)(II) are met. CB approves MD's request for waiver of the evaluation requirement for the following approved services:

Functional Family Therapy (Well-Supported)
Healthy Families America (Well-Supported)
Multisystemic Therapy (Well-Supported)
Nurse Family Partnership (Well-Supported)
Parent-Child Interaction Therapy (Well-Supported)

Data Collection and Reporting Requirements

Pursuant to Section 471(e)(4)(E) of the Act, states electing the title IV-E prevention program are required to collect and report on child-specific data to HHS for each child who receives title IV-E prevention services. MD has provided an assurance that the state will collect and submit information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures. CB will provide additional information on how to report this information in future guidance.

Payer of Last Resort
In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

The title IV-E prevention program is part of the Children's Bureau's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please contact Tina Naugler, Director of Regional Programs, at (202) 205-6733 or by e-mail at tina.naugler@acf.hhs.gov. You also may contact Stephanie McAllister, Children and Families Program Specialist, at (215) 861-4612 or by email at stephanie.mcallister@acf.hhs.gov.

We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,

Jerry Milner
Associate Commissioner
Children's Bureau

Enclosures

cc: Lourdes Padilla, Secretary; Maryland DHS; Baltimore, MD
Peggy Hughes, Deputy Director; Office of Budget and Finance; Maryland DHS; Baltimore, MD
Tina Naugler, Director of Regional Programs; Children's Bureau; Washington, DC
Gail Collins, Director; Program Implementation, Children's Bureau; Washington, DC
Stephanie McAllister, Children and Families Program Specialist; Children's Bureau, Region 3; Philadelphia, PA
Janice Davis Caldwell, Director of Family Protection & Resilience Portfolio; ACF Office of Grants Management; Dallas, TX
Janice Realeza, Grants Management Officer; Central Division, Family Protection & Resilience Portfolio; ACF Office of Grants Management; Philadelphia, PA

Maryland Department of Human Services, Social Services Administration

Family First Prevention Services Act

TITLE IV-E PREVENTION PLAN

Revision 12/12/2019

Contents

Title IV-E Plan Adherence Statement

As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (title IV-E), the Maryland Department of Human Services, Social Security Administration (DHS/SSA) submits this plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act. DHS/SSA hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act, and all applicable Federal regulations and other official issuances of the U.S. Department of Health and Human Services. DHS/SSA understands that if and when title IV-E is amended or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

Section 1: Introduction

The Maryland Department of Human Services/Social Services Administration (DHS/SSA) envisions a Maryland where *Families Blossom* by strengthening families so that children are safe, healthy, resilient and are able to grow and thrive. Submitting this Title IV-E Prevention Plan is Maryland's opportunity to continue to leverage all available resources to realize and sustain this vision.

Seizing an Opportunity to Advance Maryland's Strategic Vision

Maryland began a journey to reform our approach to child welfare in 2007 with the launch of the Place Matters initiative. Place Matters led to the provision of family-centered, child-focused, community-based services that promote safety, family strengthening, and permanence for children and families in the child welfare system. The primary success of Place Matters is evidenced by shorter lengths of stay in out-of-home placements, reduced entries into out-of-home placement and the increased number of children and youth exiting from foster care to permanent placement.

Building on Maryland's previous successful improvement efforts, Maryland implemented the Title IV-E Waiver Demonstration Project (Waiver) in 2014, known as *Families Blossom|Place Matters.* Maryland used the flexibility afforded by the Waiver to focus on preventing new entries and reentries into foster care through the two key strategies: the meaningful use of assessments of families; and installing and testing a range of evidence-based and promising practices selected by local jurisdictions to meet the needs of their population. These strategies are mirrored in several provisions of the Family First Prevention Services Act (Families First), which makes Maryland well-positioned to implement them.

DHS/SSA's vision is to transform the social service system in partnership with public agencies, private agencies, courts, and community partners, so that the children, youth, families, and vulnerable adults we serve and support are:

- Safe and free from maltreatment;
- Living in safe, supportive, and stable families where they can grow and thrive;
- Healthy and resilient with lasting family connections;
- Able to access a full array of high-quality services and supports that are designed to meet their needs; and
- Partnered with safe, engaged, and well-prepared professionals that effectively collaborate with individuals and families to achieve positive and lasting results.

DHS/SSA's ongoing strategies for accomplishing these goals are to:

1. Promote safe, reliable, and effective practice through a strength-based, trauma-responsive practice model for child welfare and adult services.
2. Engage in a collaborative assessment process that is trauma-informed, culturally-responsive, and inclusive of formal and informal family and community partners.
3. Expand and align the array of services, resources, and evidence-based interventions available across child welfare and adult services based upon the assessed needs of

children, families, and vulnerable adults, to include additional resources aimed at preventing maltreatment and unnecessary out-of-home placements.
4. Invest in a safe, engaged and well-prepared professional workforce through training and other professional development including strong supervision and coaching.
5. Modernize DHS/SSA's information technology to ensure timely access to data and greater focus on agency, individual, and family outcomes.
6. Strengthen the State and local continuous quality improvement processes by creating useful data resources to monitor performance, using evidence to develop performance improvement strategies, and meaningfully engaging internal and external stakeholders.

The title IV-E Prevention Services option authorized in Family First, provides an unprecedented opportunity for jurisdictions to be reimbursed for a portion of their investment into certain evidence-based parenting skills, substance use disorder prevention and treatment and mental health services when targeted to preventing children from entering foster care.[1] Maryland taking advantage of the prevention option provides an opportunity to connect the end of the Waiver and our experiences in implementing evidence-based programs to prevent foster care, with a comprehensive prevention strategy for Maryland.

Stakeholder and Partner Involvement in the Development of the Title IV-E Prevention Plan
DHS/SSA welcomed a collaborative effort in the development of the title IV-E Prevention Plan. Various stakeholders and partners directly contributed to the creation of this plan, learning along with DHS/SSA about the law's provisions beginning in 2018 and engaging in a thorough exploration and assessment of the opportunities in taking advantage of this option. To engage stakeholders in this effort, Maryland built on its existing DHS/SSA's Implementation Structure, which brings together system partners with a charge to advance key priorities to achieve the agency's strategic direction.

DHS/SSA launched two key Family First-specific working groups beginning in the spring of 2019 that included a cross-section of local department of social service staff, community partners, providers, and stakeholders. The focus of these groups was to develop a strategy to strengthen and stabilize families preventing the need for foster care and decreasing the entry and re-entry of children and youth into foster care.

These included a *Family First Core Team*, comprised of headquarters staff and technical assistance (TA) partners to engage in overall assessment and readiness, as well as track steady progress towards planning and implementation of Family First. The core team spanned practice/program, policy, federal compliance, outcomes, and administrative roles to ensure that all adaptive, functional, and technical considerations could be a part of the planning for Family First implementation. A *Family First Local Leaders Group* was also convened to engage DHS local department Directors and Assistant Directors in planning and readying for implementation of Family First from a field perspective. DHS/SSA worked in partnership with

[1] For a full summary of the Family First Prevention Services Act, including the prevention provisions, see the Children's Bureau's Information Memorandum, ACYF-CB-IM-18-02 available on https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf.

Casey Family Programs to convene a series of Family First dialogues with service providers. These sessions were to share information, highlight the opportunities for transformation and identify challenges in Maryland's early implementation of the Prevention Plan and ensure that DHS/SSA and providers could have a shared understanding of provider capacity-building needs.

As DHS/SSA began to explore the specific changes needed to achieve our desired outcomes for the Prevention Plan, DHS/SSA turned to its existing implementation teams or subgroups of these teams to review data analysis and existing business processes and develop recommendations for policy, practice and service changes or alignment. Specifically, the *Protective Services and Family Preservation Implementation Team,* which includes DHS/SSA and local staff, providers, community providers, and other stakeholders, assessed data analysis provided through SSA's partnership with Chapin Hall at the University of Chicago and identified populations most at risk of entering foster care. Subgroups of this team built on an understanding of the data to formulate recommended candidacy definitions and risk criteria. The *Service Array Implementation Team,* comprised of DHS/SSA and local leadership, technical assistance partners, parents with lived experience, and community partners, focused on identifying the evidence-based programs that could be leveraged and scaled, taking into consideration demonstrated success via the Waiver and other strategies. This team and a subgroup of the team took data and information on the potential population on candidates, scanned available evidence-based programs in operation in the state, examined apparent gaps in the array of evidence-based programs that could meet the needs of candidates and developed criteria for recommending the services in this plan.

Consultation and Coordination on the Continuum of Prevention Services

In addition to the specific Family First focused convenings and workgroups, DHS/SSA has used the Implementation Teams to identify opportunities and mechanisms to ensure that services are coordinated on behalf of children at risk of entering foster care or pregnant and parenting youth. The Service Array Implementation Team has standing membership that brings together SSA program staff and medical director, sister agencies, local department leadership and staff, health providers and managed care representatives and family and community members. Specifically, the following agencies are represented within SSA's Service Array Implementation Team and have partnered with SSA: Local Departments of Social Services, Maryland Coalition for Families, Maryland Department of Health, the Behavioral Health Administration, CASA, Behavioral Health System Baltimore, Institute for Innovation (The Institute) at the University of Maryland Baltimore School of Social Work (UMB/SSW), WIN Family Services, Chapin Hall at the University of Chicago, Baltimore City DSS-Adult Services, Advocates for Youth, Kids Peace, University of Maryland School of Pharmacy, Local Behavioral Health Authorities, St. Mary's County Health Department and the Maryland Department of Juvenile Services (DJS).

The Service Array Implementation Team's charge is, in part, to evaluate and enhance local partnerships with community-based services and use evidence to develop and improve the service array. The Implementation Team has had a key role in the process of conducting an EBP model environmental scan and EBP model selection as well as an ongoing role in service oversight and coordination. The Implementation Team is solution focused; looking to facilitate coordinated services and explore and address systemic barriers that impact service delivery.

Additionally, Maryland is facilitating local and regional town halls across the state, in the Summer and Fall of 2019. These town halls are intended to generate a shared understanding of the vision and opportunity in Maryland for improved family support services. The town halls will also engage partners in articulating how they can collectively contribute to the vision, leveraging tools such as Family First, the State's five-year Child and Family Services Plan, and Maryland's Child and Family Services Program Improvement Plan. Emerging from these town halls will be a *Call to Action*; a document outlining a locally-driven pathway for collective contributions to strengthening families and improving community-based services and systems support children and families.

Section 2: Prevention Services Eligibility and Candidacy Identification

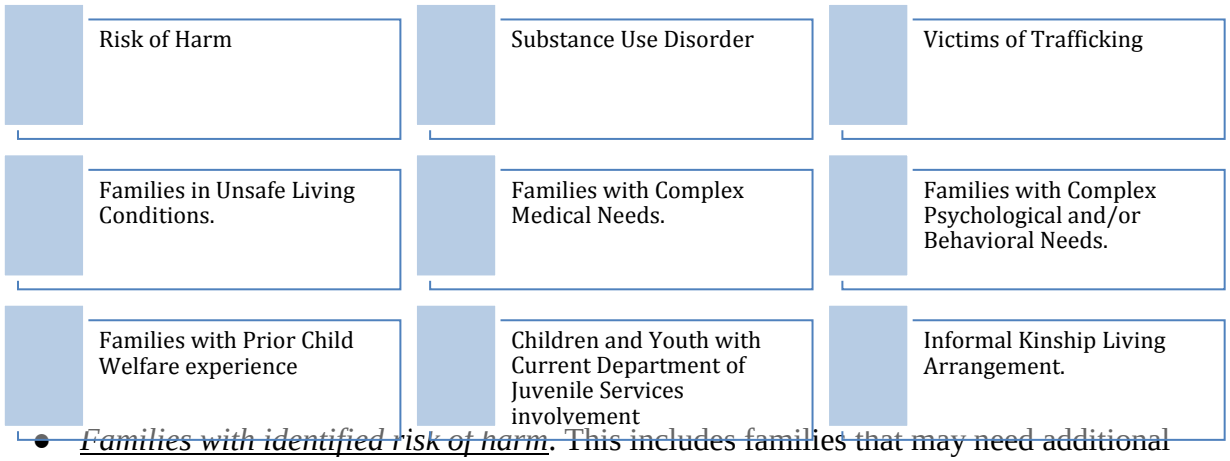
There are two child populations eligible for Family First preventive services: 1) children who are determined to be candidates for foster care; and, 2) pregnant and parenting youth who are in foster care. When a child is determined eligible, the child, parent, and/or kin caregiver of the child may receive prevention services. DHS/SSA reviewed recent data in determining the population who could receive Title IV-E prevention services. Based on a thorough understanding of key populations afforded by a review of data, as described in the next sections, DHS/SSA and its partners reached a decision as to which children and families could be eligible for and ultimately receive services under the prevention plan.

Identifying Candidates

Children at imminent risk of entering foster care will be defined as *children who receive in-home services and who meet specific imminent risk criteria*. Maryland chose not to include children who may have contact with the agency but do not receive in-home services at this time, regardless of their risk level. To provide a sense of volume, the total children served in-home in SFY 2018 was 12,640, versus a total screened out population of 135,883. Some percentage of the population served by in-home services would be defined as foster care candidates, depending on whether the child meets the imminent risk criteria. Maryland will continue to analyze data and may expand the candidacy description to include children who do not receive in-home services or refine the imminent risk criteria in later iterations of this plan. There is commitment by DHS/SSA to serve as many families as possible and appropriate through Title IV-E preventive services.

DHS/SSA will identify children at imminent risk if they meet any of the following criteria represented in Figure 1. The criteria are not mutually exclusive.

Figure 1. Imminent Risk Criteria for Candidates



- *Families with identified risk of harm*. This includes families that may need additional support because they have characteristics that have been found to elevate the risk of harm to the child and thus the potential for entering foster care. Specifically, this includes families who come to the attention of the local department because of a health provider notification of a substance-exposed newborn; domestic violence situations involving a minor; cases where there is an identified substantial risk of child sexual abuse due to a known sexual offender living with the child; and caregivers who have impairments that are likely to cause harm to a child. Other risk of harm situations include a family who has experienced a prior child fatality or serious child injury; situations in which there is previous report to child protective services (CPS) and there is currently a child age 5 or younger living in the home; and "Birth Match" cases in which a parent has previously had their parental rights terminated due to abuse or neglect and a subsequent child is born to the parent. Approximately 20% of families served with in-home cases exclusively are cases involving risk of harm.
- *Families experiencing substance use disorder*. Parental substance use disorders have been a leading circumstance associated with children entering foster care in Maryland, impacting approximately one quarter of entries in recent years and about 4 percent related to caregiver alcohol abuse. Child substance and alcohol use disorders are a factor in approximately 7% of removals. Due to the potential to lead to behavior which significantly disrupts the home environment and caregiver protective capacities, we identified substance use disorders of the parent, child/youth, and or other household member as one of the imminent risk criteria.
- *Victims of trafficking*. DHS/SSA is considering all forms of trafficking, human or labor trafficking, or sex-trafficking in this category. Research suggests that there is a significant intersection between youth who are or have been involved in the child welfare system and trafficking victimization (Child Welfare Information Gateway, 2017). Maryland's data indicates that 877 children came into contact with our local departments due to sex trafficking in particular, but just less than 10% received an in-home service. By identifying trafficked young people as a risk criteria, DHS/SSA seeks to expand access to prevention services that may keep children connected to their families when appropriate or address vulnerable youth exiting foster care.

- *Families in unsafe living conditions*. Approximately 9% of children enter foster care in Maryland with inadequate housing as a factor in their placement. DHS/SSA understands that unsafe housing, including homelessness, creates significant family instability, elevating parental stressors which can lead to maltreatment and safety concerns for children (Cunningham, Gillepsie & Batko, 2019).
- *Families with complex medical needs.* Families experiencing complex medical needs involve a myriad of situations, such as parents with medical challenges, medically fragile children, children with significant disabilities who need specialized care to ensure their health and safety, and children who are reported by health care practitioners to local departments as experiencing failure to thrive. It is difficult to specifically identify all of these situations in the data, but DHS/SSA believes that these families may need additional support to build their caregiving capacity and prevent entry into foster care when children are particularly vulnerable or parental health is challenged.
- *Families with complex psychological and/or behavioral needs*. Similar to the above, parents, caregivers and children who have complex psychological and/or behavioral needs are particularly vulnerable, often factoring into a child's placement into care. Data indicate that children's behavior is a factor in approximately 15% of entries into foster care and voluntary placements.
- *Families with prior child welfare experience*. Once a family has had some experience with the child welfare system, they are at higher risk of having additional involvement. For this reason, DHS/SSA identified families with a prior history of maltreatment, children/families involved in family preservation cases, children who have exited to some form of permanency, minors who leave care before turning age 21, and siblings of children in foster care who reside at home, as all at elevated risk for entering foster care. In particular, reentries into foster care within 12 months from reunification are at 16.2%, persistently above Maryland's target of 12% and trending in the wrong direction, indicating a need to continue to focus on supporting families who have come to the agency's attention or have experienced out of home placement.
- *Children and youth with current Department of Juvenile Services involvement*. DHS/SSA identified youth who are involved with juvenile services as at risk of entering or reentering an out of home placement. This population is a focus as we understand the intersection between those who have experienced maltreatment and engage in delinquent behaviors and could benefit from prevention services to avoid placement.
- *Informal kinship living arrangement*. Kinship families who are not formally involved with the child welfare system may need additional support to ensure that children can thrive and remain with their families. Maryland served at least 1,000 families through its Kinship Navigator programs in SFY2018; providing them with referrals to community services and access to concrete assistance. DHS/SSA believes that this is an undercount due to inconsistencies in how these services are recorded within MD CHESSIE.

Identifying Pregnant and Parenting Foster Youth

Since Family First identifies pregnant and parenting foster youth as a uniquely eligible population for prevention services, workers will assess each pregnant and parenting youth in foster care to see if they need a prevention plan to support their healthy parenting and avoid their

children being placed away from them. In exploring the data, we identified 83 young people in foster care on June 30, 2018, who are parenting and receiving in-home services on behalf of 49 children. DHS/SSA believes this number does not account for all youth in foster care who are pregnant or parenting as there is some inconsistency across local departments in reporting this circumstance and how such young people receive parenting support.

Determining and Documenting Eligibility

DHS/SSA carefully explored considerations, including pros and cons, for implementing a process to identify candidates and pregnant and parenting youth for prevention services. As Maryland is in the midst of a transition from our current case management system, Maryland's Children Electronic Social Services Information Exchange (MD CHESSIE) to an improved system known as Maryland Child, Juvenile and Adult Management System (MD CJAMS), DHS/SSA's ability to make significant changes within the current system is limited. As such, the process for identifying eligible families and documenting eligibility is semi-structured consistent with the capabilities of the current system.

A family's acceptance of in-home services and applicability of one of the imminent risk criteria is recorded in existing intake, assessment tools and data fields in MD CHESSIE. Workers will be directed by policy to review MD CHESSIE to identify potential candidates because there is imminent risk. Similarly out-of-home workers identify a young person's pregnant or parenting status within MD CHESSIE based on intake, assessment tools and other interactions with the young person. Even though imminent risk exists for a child or a young parent is identified, there is still a clinical determination to be made as to whether the family needs prevention services and a prevention plan to avoid foster care or build parenting capacity.

The caseworker, in conjunction with a supervisor, will make this clinical decision as to whether Family First prevention services are the appropriate course of action for this child/family and that they are within the target population for a specific evidence-based service in this Plan. The worker and supervisor will arrive at this decision using findings from the risk assessment, safety assessment and Child and Adolescent Needs and Strengths-Family version functional assessment tool (CANS-F), where appropriate. These tools along with authentic partnership and engagement of the family or young person will inform the identification of family strengths and needs, support co-creation of the prevention plan and selection of the most appropriate and effective evidence-based program. The final decision that a child is determined a candidate or pregnant/parenting youth eligible for prevention services will be recorded and dated within the Service Plan in MD CHESSIE. Any worker redeterminations of eligibility will also be captured in MD CHESSIE.

DHS/SSA will revisit the ability to initially identify imminent risk and pregnant/parenting youth (prior to worker/supervisor decision-making) as a more structured and automated effort as we roll out CJAMS. Similarly, we will continue to explore how future data fields can record the date and other aspects of the eligibility determination.

Section 3: Title IV-E Prevention Services Description and Implementation Plan

Maryland has selected an array of prevention programs for this plan that meet the evidence levels required by Family First and best align with the needs of children identified as at imminent risk of entering foster care, pregnant/parenting young people and their families. These services were identified through robust analysis of data on the needs and characteristics of potential candidates for foster care, the circumstances that are associated with children's placement into foster care, and a thorough scan of existing evidence-based programs implemented across the state.

Proposed Evidence-Based Preventive Services

Table 1 represents the programs that Maryland is requesting in its Prevention Plan that align with the needs of Maryland's target population and are currently rated by the Title IV-E Prevention Services Clearinghouse (Clearinghouse) as having achieved an approvable evidence rating. For each program, Maryland plans to implement the same EBP model version as reviewed and approved by the Clearinghouse. Maryland does not plan to implement any of these models with adaptations or alterations to the model.

Table 1: Maryland proposed preventive programs with a Title IV-E Prevention Services Clearinghouse rating

Program Type	Evidenced Based Program	Clearinghouse Rating	Version in Use/Documentation
Parenting	Healthy Families America	Well-Supported	Consistent with current required model training and manuals for Healthy Families America per https://www.healthyfamiliesamerica.org/
	Nurse Family Partnership	Well-Supported	Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamilypartnership.org/
Mental Health	Functional Family Therapy	Well-Supported	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for Adolescent Behavioral Problems.* Washington, D.C.: American Psychological Association
	Parent Child Interaction Therapy	Well-Supported	Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy*

			Protocol: 2011. PCIT International, Inc.
	Multisystemic Therapy	Well-Supported	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (2nd ed.)*. New York: The Guilford Press.

- *Healthy Families America (HFA).* HFA is home visiting program with a goal of preventing abuse or neglect or intervening with families at high risk of abuse and neglect. Families are eligible to receive HFA services beginning prenatally or within three months of birth. When referred from child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experience. HFA is currently implemented in 20 jurisdictions, many with support from the Maryland Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA), in partnership with the Administration for Children and Families (ACF). The goal under this Prevention Plan is to ensure facilitation of these services for child welfare system-involved families.
- *Nurse Family Partnership (NFP)* NFP is a home-visiting program where nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. It targets young, first-time low-income mothers from early pregnancy through the child's first two years. Given this program's target population, it may be most suited to pregnant and parenting youth in foster care or families with low risk who are referred to SSA due to their newborn's substance exposure. NFP is implemented in 8 jurisdictions in Maryland, many with support via MIECHV. The goal under this Prevention Plan is to ensure facilitation of these services for child welfare system-involved families.
- *Functional Family Therapy (FFT).* FFT a short-term, high-quality intervention program for youth demonstrating behavioral health problems. The target population is pre-teens to teens with serious concerns such as conduct disorder, violent acting-out and substance abuse. Approximately 15% of children entering foster care in Maryland have the child's behavior as a factor in the placement, indicating a significant need for programs such as FFT. FFT is currently available in 21 jurisdictions across Maryland via two providers, who both receive FFT clinical consultation from FFT, LLC. In 2007, Maryland's Children's Cabinet, DJS, and local Departments of Social Services began to work collaboratively to substantially increase the availability of FFT to youth and families in

Maryland. Maryland's stakeholders selected FFT with the goals of improving outcomes for youth and families and reducing the use of out-of-home placements.

- *Parent Child Interaction Therapy (PCIT).* PCIT is a behavioral parent training program with coaching by a trained therapist in behavior-management and relationship skills. It targets 2-7 year olds with emotional/behavioral issues and their parents/caregivers. PCIT is currently available in at least 6 jurisdictions in Maryland. One program was established via the Title IV-E Waiver demonstration; the rest have been installed via other grant and implementation efforts, with some operating for many years. Under the Title IV-E Waiver demonstration, DHS/SSA provided funding for training and other implementation support costs. The Institute has partnered with PCIT International to coordinate the training and certification of new PCIT-trained clinicians, and had also established a contract with a PCIT Master Trainer to provide on-going implementation consultation for the jurisdiction involved with the Waiver. Maryland is fortunate to have several certified PCIT trainers in the State to assist with clinician development and expansion.
- *Multisystemic Therapy (MST).* MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. It targets youth, ages 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors. MST is currently available in 5 jurisdictions in Maryland through three providers and implementation is supported by The Institute. Like FFT, stakeholders from Maryland's child-serving agencies selected MST with the goals of improving outcomes for youth and families and serving youth in their homes, thereby reducing out-of-home placements. The current providers have been implementing MST for well over 10 years.

The next set of interventions, represented in Table 2, are not rated by the Clearinghouse as of the submission of this plan. However, DHS/SSA research indicates that these programs have demonstrable evidence that will make them approvable by the Children's Bureau in the near future. Until they are determined to be allowable by the Children's Bureau, we are not claiming title IV-E reimbursement for the programs in Table 2 at this time.

Table 2: Maryland proposed preventive programs not yet rated

Program Type	Evidenced Based Program	Evidence Source and Rating
Parenting	Nurturing Parenting Program	Pending Clearinghouse review CEBC - Promising
Mental Health	Family Centered Treatment	Anticipated systematic review CEBC – Promising
Substance Use Disorder	Sobriety Treatment and Recovery Teams	Anticipated systematic review CEBC – Promising

These programs represent important elements of Maryland's service array that are already implemented and would be beneficial to continue or expand.

- *Nurturing Parenting Program (NPP).* NPP for Parents and their Infants, Toddlers and Preschoolers is a family-centered program designed for the prevention and treatment of child abuse and neglect. Both parents and their children birth to five years participate in home-based, group-based, or combination group-based and home-based program models. Lessons are competency-based ensuring parental learning and mastery of skills. The program lessons focus on remediating five parenting patterns known to form the basis of maltreatment. The Nurturing Parenting Program for Parents and their School Age Children 5 to 12 Years is a 15-session program that is group-based and family-centered. As home visiting programs for parents of children from pregnancy to age 2 are the most prevalent type of evidence-based parenting skills programs in Maryland, the Nurturing Parenting Program represents a program that targets parents of children up to the middle years and can thus reach an essential part of our target population.
- *Sobriety Treatment and Recovery Teams (START).* START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. The program targets families with at least one child 5 or younger in the child welfare system and have a parent where substance use is a primary child safety risk factor. Maryland used its Waiver to invest in a needs assessment as well as fit and readiness activities prior to selecting and beginning installation of START in over half of Maryland's jurisdictions. START is uniquely situated to address the needs of families with young children affected by substance use disorders, which is a significant group within our target population. Data shows that there were 2,568 substance exposed newborn notifications to local departments in SFY2018, 1,534 of them receiving in-home services. As mentioned early, approximately one quarter of entries into foster care are associated with parental substance use – many of whom have young children. Approval of START via the Prevention Plan offers Maryland the opportunity to continue and potentially expand DHS/SSA initial investment in START.
- *Family Centered Treatment (FCT),* is a well-established and evaluated intervention available in all jurisdictions in Maryland with a focus on youth involved in the juvenile justice system. FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. It is targeted towards family members at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. Since FCT has been used particularly effectively with crossover youth, Family First provides Maryland the ability to expand its use to child welfare populations and potential crossover youth who are at imminent risk of foster care.

All of the programs in Table 2 have been rated by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare as highly relevant to child welfare and as promising interventions. One of these programs, NPP, is pending review by the Clearinghouse review as of December 2019 and Maryland anticipates that it will meet one of the required evidence levels in the near

future. Maryland is considering the remaining two programs, FCT and START, for a systematic review. SSA has become aware of other states that are similarly interested in pursuing, or have already submitted to CB, a systematic review for these two programs based on the strength of evidence. SSA respectfully requests that the Children's Bureau and the Administration for Children and Families prioritize these programs for review in the Clearinghouse.

Finally, Maryland has identified additional services that would meet the needs of our families that are not included here for a variety of reasons. Maryland intends to submit additional iterations of this plan as more programs are approved by the federal government, DHS/SSA engages in additional planning around the implementation, training and evaluation of those programs, and Maryland works with the provider community to further expand effective services. Further, Maryland remains committed to using all available resources and funding sources to ensure that there is a quality array of services to strengthen families and prevent foster care.

Please see Appendix C for a summary of all proposed evidence-based interventions, including a brief description of the program and target population, evidence ratings, intended outcomes and current scope of the program across Maryland.

Trauma Informed Framework

A key criteria for selecting the evidence-based services included in this plan was that the service itself had a trauma-informed approach. DHS/SSA identified whether a service has a trauma-informed approach by several methods:

- Identification as a trauma-informed intervention on the National Child Traumatic Stress Network website;
- Listed as a trauma treatment on the California Evidence-Based Clearinghouse (CEBC); and/or;
- Otherwise described as including trauma-informed approaches via the CEBC, another federal clearinghouse such as the Home Visiting Evidence of Effectiveness (HOMVEE) review project, or the purveyor's websites or other literature.

One of Maryland's core strategies for implementing its vision is to promote safe, reliable and effective practice through a strength-based, trauma-responsive practice model for child welfare and adult services. As described in Maryland's 2020 - 2024 Child and Family Services Plan, DHS/SSA will integrate the practice model into our standard contract language for providers. This includes ensuring that providers are using a trauma-informed framework and co-creating with providers the standard reporting methods and metrics to assess their delivery of trauma informed care.

DHS/SSA anticipates at least annual monitoring of the trauma-informed framework, consistent with our contracts review and continuous quality improvement strategy. In particular, DHS/SSA currently requires placement providers to complete a Program Questionnaire to gather comprehensive information about the services offered and youth served by programs that are utilized by the Department of Juvenile Services and local departments of social services. This information is used to describe the service array, to identify gaps in services, and to improve

service matching based on youth characteristics, including identified risks, needs, and strengths. Included in the Program Questionnaire is the following set of questions related to the provision of trauma informed care.

- Written policies and procedures are established based on an understanding of the impact of trauma on children, youth and families.
- Staff members have regular team meetings and/or supervision where topics related to trauma and self-care are addressed.
- Every child has a written crisis-prevention plan that includes: list of triggers; list of ways child shows they are stressed/overwhelmed; specific strategies that are helpful/not helpful when a child is feeling upset/overwhelmed; list of people the child feels safe around/can go to for support.
- Based on trauma screening and the intake assessment, children are referred for further assessment and trauma-specific services by providers with expertise in trauma.
- The program educates children, youth and families about traumatic stress and triggers.
- Staff at all levels of the program receive training and education that includes what traumatic stress is, how traumatic stress affects the body and brain, and the relationship between mental health and trauma.

Providers implementing an evidence-based program under DHS/SSA prevention plan will be required, through a contractual obligation, to answer a similar set of questions to ensure that their services are delivered within a trauma informed framework.

See Appendix D for Maryland's assurance that each service and program in this plan is delivered under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach.

Implementation Approach

Maryland selected its services for this plan with a focus on the feasibility of implementation. In particular, consistent with the National Implementation Research Network's Hexagon exploration tool (Metz and Louison, 2019), DHS/SSA explored and considered whether programs demonstrate evidence, whether there are implementation supports, and usability. Maryland's experience with Waiver also provided us with valuable lessons which influenced our selection of services and informs our approach to ongoing examination of implementation and sustainability. SSA selected programs for this plan that have been installed and have an existing provider base in at least five jurisdictions, ensuring that there is both reach and efficiencies of scale. SSA also selected programs that had some level of established fidelity and/or outcomes monitoring consistent with purveyor criteria.

As the programs have already been installed, Maryland will implement Family First initially utilizing existing DHS/SSA contracts and/or expanding contracts and memoranda of understanding with sister agencies for those programs that have been primarily supported through another public agency.

Primary responsibility for the development and implementation of the Title IV-E Prevention Plan rests with the Implementation Teams. These teams are further informed and guided by the

Outcomes Improvement Steering Committee within Maryland's existing Implementation structure. These teams include representatives from the stakeholder and provider community, including families and youth, advisory and advocacy groups, community providers, university partners, the court system, and the Families Blossom evaluation team. The Implementation Structure allows for:

- Real-time refinements and enhancements during development and implementation;
- Identification and allocation of needed resources;
- Promotion of timely policy and programmatic decisions;
- Continual tracking and monitoring of progress towards identified outcomes; and
- Managing and sustaining the desired change.

The Implementation Teams will take information synthesized through continuous quality improvement and evaluation activities to ensure that the Prevention Plan is meeting agency goals and to address and resolve any organizational or systemic challenges or barriers. Please see the continuous quality improvement strategy section below for additional information on how Maryland will engage in ongoing activities to inform and enhance successful implementation.

Section 4: Child-Specific Prevention Plan

Developing Child-Specific Prevention Plans and Connecting Families to Services

Family Service plans will be developed in collaboration with the child, if age and developmentally appropriate, and the child's caregiver(s). Child-specific prevention plans will be subsets to each Family Service Plan within MD CHESSIE. For pregnant and parenting foster youth, these services should be documented in the foster youth's service plan, specifying those services that will ensure the youth is prepared and able to parent successfully. Child Welfare staff will engage individual family members in understanding the needs and strengths of each person in the family and will capture the information using CANS-F assessment for candidates or the CANS for pregnant/parenting youth. The family and/or child in consultation with the applicable caseworker will identify what service needs the family and/or child are willing and able to focus on at any given time to help ensure the child's safety, mitigate risk of future maltreatment and prevent foster care or strengthen parenting capacity. Child welfare staff will offer information about available services to address identified needs that are available taking into account and resolving any barriers that might exist for the family or child to receive an appropriate service.

Ongoing Monitoring and Coordination of the Child-Specific Prevention Plan

Staff will maintain frequent and regular contact with service providers and the family to support service provision, assess progress made and/or help identify any adjustments needed to services. While in many local departments families and pregnant/parenting youth receiving prevention services will be assigned a specialized family preservation worker, there may be times when child protective services are serving in this role, out of home care workers are involved with serving pregnant or parenting youth, or case associates are assigned in addition to ongoing workers to address families who have a higher level of needs. Multiple workers for a family will function as a team. When case transfers need to occur, the agency will ensure a "warm" hand off of the family to the new worker to ensure continuity of relationships, engagement and services.

For more information about staff practices and workforce development see section 7.

Section 5: Monitoring Child Safety and Assessing Risk

Initial and ongoing assessments of safety and risk are an integral part of the work of Maryland's child welfare staff. As candidates for foster care will be receiving in-home services or be pregnant and parenting youth in foster care, DHS/SSA will use existing practices to ensure child safety and assess risk. Caseworkers (both In-Home and Out-of-Home Placement Services staff) conduct their assessments face-to-face with all children and families while considering information from other sources, such as school and medical staff, therapists, etc. Each assessment requires supervisory approval following at least monthly case consultation between the worker and supervisor.

Caseworkers are required to make, at a minimum, monthly face-to-face visits with a family, including meeting privately with the child. The frequency of visitation and contact is determined by the assessed safety and risk levels. Table 3 outlines the frequency of staff face-to-face contact with families receiving in-home services.

Table 3. Guidelines for determining frequency of face-to-face contact

Safety Determination	Risk Rating	Service Intensity Level	Worker Contact with Parents and All Children in Household
Unsafe	High	Level 1	*Level I* cases will maintain a minimum of three hours of face-to-face contact per week
Conditionally Safe	High		
Conditionally Safe	Moderate	Level II	*Level II* cases will maintain a minimum of three hours of direct face-to-face contact over a two-week period
Safe	High		
Safe	Moderate, Low, or no risk	Level III	*Level III* cases will maintain a minimum of three hours of direct face-to-face contact over a thirty-day period

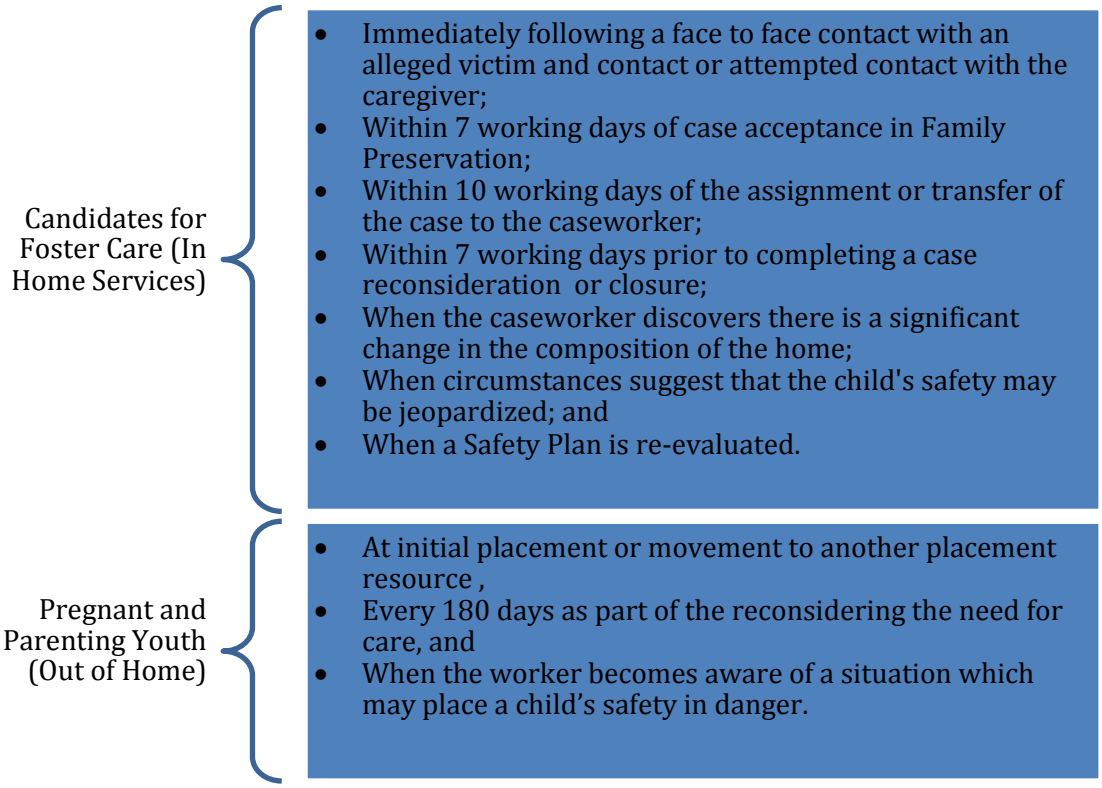
Out of home workers visit children at least monthly, with more frequent visits for certain children depending on need and type of placement.

During all family and child contact, caseworkers are continuously assessing:

- New safety issues and unaddressed risk factors;
- Progress toward reducing ongoing safety issues or risk factors;
- Progress toward meeting case objectives and service receipt and progress; and,
- Barriers to progress in improving child safety or reducing risk factors upon review of service provision and progress by contracted providers.

Maryland's protocols and tools for assessing and monitoring the safety of children are longstanding. For children receiving in-home services or with their families on a trial home visit in preparation for reunification, workers use the Maryland Safety Assessment for Every Child tool (SAFE-C). Maryland's SAFE-C allows workers to assess a child's vulnerabilities as well as any protective factors that may exist to help mitigate safety concerns. Out-of-Home Placement Services staff use the Maryland Safety Assessment for Every Child Out-of-Home-Placement (SAFE-C OHP) to assess the safety of children in active Out-of-Home placement up to their 21st birthday, including pregnant and parenting youth. This tool is used to assess youth in every type of placement or living arrangement (i.e., kinship, regular foster homes, private treatment agency homes, group homes, and residential treatment centers). Figure 2 provides an outline of key timeframes and milestones in which safety is assessed.

Figure 2. Key safety assessment milestones for in-home and out-of-home care



Child welfare staff are also required to monitor risk of future maltreatment. The Maryland Family Risk Assessment (MFRA) tool helps the worker to formally assess and identify risk factors in the family. Risk assessments are completed prior to the receipt of ongoing services in the home, at least every 3 months during ongoing services and to prepare for the end of services and closing the family's case. If at any time the worker determines the risk of out of home placement remains high, despite the services being provided, the worker will reassess the child's prevention plan including the types of services.

Section 6: Evaluation and Continuous Quality Improvement Strategy

Family First requires that each program in the Prevention Plan have a well-designed and rigorous evaluation strategy, unless a state is granted a federal waiver of the requirement. While we are seeking this waiver for all of the five reimbursable programs at this time, Maryland intends to continue to further its research to practice agenda related to prevention services. Maryland will work with the evaluation team at the UMB/SSW to ensure that evaluation or continuous quality improvement (CQI) efforts identified for each evidence-based program in the Prevention Plan are implemented. DHS/SSA contracts with UMB/SSW to support its current CQI and evaluation activities. The UMB/SSW has extensive experience supporting several of the interventions in this plan and more generally in providing key technical assistance.

Evaluation Waivers for Well-Supported Interventions

Maryland is seeking an evaluation waiver for all of the programs for which we are requesting title IV-E reimbursement at this time. A waiver is permitted for an evidence-based program designated at the well-supported evidence level by the Clearinghouse if the evidence of effectiveness of the practice is deemed compelling and the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II) are met. We are requesting waivers for Healthy Families America (HFA), Nurse Family Partnership (NFP), Functional Family Therapy (FFT), Parent Child Interaction Therapy (PCIT), and Multisystemic Therapy (MST), as identified in Table 4. See Appendix E for Maryland's official evaluation waiver requests for well-supported interventions.

Table 4. Evaluation or requested CQI per evidence-based program

Type	Evidence-Based Program	Planned/Future Evaluation	CQI (evaluation waiver request)
Parenting	Healthy Families America		✓
	Nurse Family Partnership		✓
	Nurturing Parenting Program *(not currently title IV-E reimbursable)*	✓	
Mental Health	Family Centered Treatment *(not currently title IV-E reimbursable)*	✓	
	Functional Family Therapy		✓
	Parent Child Interaction Therapy		✓
	Multisystemic Therapy		✓
Substance Use Disorder	Sobriety Treatment and Recovery Teams *(not currently title IV-E reimbursable)*	✓	

Our justifications for the waivers follow:

Compelling Evidence Review for Healthy Families America

The evidence in favor of the use of HFA as a means of promoting positive family dynamics and reducing the risk of foster care placements in Maryland is compelling enough to warrant a waiver. This request for a waiver of the evaluation requirement for Healthy Families America is based on the following:

> (1) HFA has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability,
> (2) HFA has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability, and
> (3) HFA has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

HFA is efficacious in a wide variety of geographic locations, suggesting wide applicability. The Clearinghouse identifies a number of well-designed studies demonstrating the efficacy of HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors in a variety of geographical locations, including Alaska (Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Cluxton-Keller et al., 2014), Hawai'i (El-Kamary et al., 2004; Bair-Merritt et al., 2010; McFarlane et al., 2013), New York (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010; Kirkland & Mitchell-Herzfeld, 2012; Lee, Kirkland, Miranda-Julian, & Greene, 2018), and Oregon (Green, Tarte, Harrison, Nygren, & Sanders, 2014; Green, Sanders, & Tarte, 2017; Green, Sanders, & Tarte, 2018). HFA's effectiveness in this diverse array of geographic locations indicates the model's wide applicability and suggests that it will also produce positive outcomes in Maryland.

A closer analysis of two key studies of HFA further illustrates two different, successful approaches to utilizing HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. First, in their study of Healthy Families Oregon, Green et al. (2018) found that HFA participation was associated with fewer gaps in health insurance coverage and with completion of more well-baby visits and immunizations—and that the magnitude of the program's effect grew with longer lengths of participation. Lee et al. (2018) conducted a randomized controlled trial of Healthy Families New York for a subgroup of mothers who had at least one substantiated child protective services report before enrolling in the program. They found that by the child's seventh birthday, mothers enrolled in HFA were as half as likely as mothers in the control group to have been substantiated for child maltreatment.

The immense body of literature demonstrating HFA's efficacy in a variety of geographical locations suggests the intervention would be successful in Maryland, as well.

HFA has demonstrated flexibility and favorable outcomes among children from various cultural backgrounds and with underlying problems, suggesting wide applicability. In addition to demonstrating favorable outcomes in multiple geographical locations, HFA has been found to be effective for families across a variety of cultural backgrounds and among children with various underlying problems. For example, Barlow et al.'s (2006) study assessing the impact of HFA on

pregnant American Indian adolescents demonstrates that mothers in the intervention compared with mothers in the control group had significantly better outcomes, including higher parent knowledge scores and scoring significantly higher on maternal involvement scales. Blair-Merritt et al.'s (2010) work also demonstrates HFA's treatment effect among mothers who reported instances of intimate partner violence, concluding that those who received HFA services reported lower rates of physical assault victimization and significantly lower rates of perpetration relative to the control group. Lee et al. (2009) found HFA to be effective for families across a variety of cultural backgrounds by demonstrating HFA's effectiveness in reducing adverse birth outcomes among socially disadvantaged pregnant women, two-thirds of whom were black or Hispanic.

Based on HFA's well-established track record producing positive outcomes for children and families with diverse cultural backgrounds and underlying problems, DHS/SSA posits that HFA is widely applicable. Therefore, DHS/SSA believes HFA can be effective across the myriad socio-cultural backgrounds and among children with a range of underlying problems in Maryland.

HFA has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. HFA has been proven effective for improving outcomes in its target population, pregnant and parenting families with young children. This target population also aligns with the characteristics of Maryland's Family First target population. Family First identifies pregnant and parenting foster youth as a uniquely eligible population for preventative services. Maryland's administrative data reveal that 83 pregnant and parenting young people were in foster care on June 30, 2018, with 49 dependent children. DHS/SSA believes this number does not account for all youth in foster care who are pregnant or parenting as there is some inconsistency across local departments in reporting this circumstance and how such young people receive parenting supports. Moreover, Maryland's foster care entry rate is nearly four times as high for children under age one than for children overall. It is clear that HFA's target population aligns well with the characteristics and needs of the children and families who will be service through Family First in Maryland.

Compelling Evidence Review for Nurse-Family Partnership

Considerable evidence exists to support using Nurse-Family Partnership (NFP) in Maryland as a way to improve pregnancy outcomes and women's health, promote early childhood development, build parenting capacity, and strengthen the economic well-being of mothers. This evidence is strong enough to merit a waiver. This request for a waiver of the evaluation requirement for NFP is based on the following:

(1) NFP has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability,
(2) NFP has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability, and
(3) NFP has demonstrated history of success with its target population of pregnant which shares characteristics with the target population in Maryland.

NFP has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability. The Clearinghouse review of NFP assessed a variety of well-designed studies to understand the program's effectiveness of improving the well-being of first time mothers and

their children. Through randomized controlled trials, various studies have revealed NFP's effects on parent and child outcomes in a variety of locations, contexts, and populations (e.g. Olds, 2002; Olds et al., 2004; Matone et al., 2012; Olds et al., 2014; Mejdoubi et al., 2015; Robling et al., 2016). Of the seven highest rated studies and evaluations assessed by the Clearinghouse, two focused on NFP application in the United Kingdom and the Netherlands (Mejdoubi et al., 2015; Robling et al., 2016) and two assessed NFP's effectiveness in the United States, focusing on implementation in Colorado, Tennessee, New York, and Pennsylvania (Olds, 2002; Matone et al., 2012; Thorland, Currie, Wiegand, Walsh, & Mader, 2017). All studies have demonstrated NFP's success with participants from a range of ethnicities, racial backgrounds, education levels, and marital status. Its universal application strongly suggests that it would be effective in Maryland to improve health and well-being outcomes for first-time, young mothers and their children from low-resource homes.

NFP has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability. Research has continuously shown a positive association between NFP use and favorable behavioral health, well-being, and education outcomes for new mothers and their children from a variety of races, ethnic backgrounds, education level, and marital status. Maryland is especially interested in implementing NFP to support low-resource, first-time mothers. In 2016, Maryland's teen pregnancy rate (women between the ages of 15 and 19) was approximately 15.9 births per 1,000 (HHS, 2018). While lower than the national average of 20.3 births per 1,000, approximately 45 percent of mothers under the age of 20 were non-Hispanic, black women (Health and Human Services, Office of Population Affairs, 2016). With this in mind, interventions to support pregnant and parenting youth in Maryland must be universal and applicable to a variety of racial and ethnic populations. All the studies included in this justification assessed NFP's impact in racially diverse study populations and demonstrated NFP's effectiveness.

Even more compelling is NFP's demonstrated flexibility in adapting to a variety of contexts and cultures. First developed in the United States by Dr. David L. Olds in 1977 (Nurse-Family Partnership, 2019), NFP has grown over four decades to be implemented in 41 states. It has even been adapted to serve young women and their children in the United Kingdom and the Netherlands (Mejdoubi et al., 2015; Robling et al., 2016). In the Netherlands context, it was successfully translated into Dutch and culturally adapted as an intervention that systematically addresses risk factors during prenatal and early infancy period. NFP's continued effectiveness in child and parent outcomes, even when adapted and translated to fit certain cultural contexts, further demonstrates that it is likely to be applicable in Maryland's context without compromising core elements of its design.

NFP has demonstrated history of success with its target population of pregnant which shares characteristics with the target population in Maryland. Randomized controlled trials in the United States showed success in achieving favorable outcomes for children's development and maternal health through higher breastfeeding and immunization rates. Breastfeeding is known to support positive health outcomes for both mothers and their children, including child cognitive and sensory development and lowered risk of common childhood illnesses and reduced likelihood of diabetes and lowered risk of ovarian and breast cancer in mothers (Stuebe, 2009). In a 2017 NFP evaluation, researchers from the Nurse-Family Partnership National Service Office, the Colorado School of Public Health, Chapin Hall at the University of Chicago, and the

University of Chicago found that first-time mothers receiving home visits from nurses through NFP were significantly more likely to breastfeed and maintain breastfeeding at 6 and 12 months compared to their counterparts (Thorland et al., 2017). The study also found that the children of NFP participants were significantly more likely to be up to date on immunizations at 6 months compared to the control group. Over three-quarters of the women included in this study's population were less than 22 years old, with over half 19 years old and younger, from urban and rural settings. Given Maryland's desire to implement NFP for young, first-time mothers across its rural and urban county environments, similar to this study's population, it is reasonable to assume that mothers and children receiving NFP in Maryland would achieve similar health and well-being outcomes through improved breastfeeding and immunization rates.

In addition, NFP has demonstrated effectiveness for young mothers with certain health risk factors. While these families are considered low risk of entering foster care, they may exhibit certain behaviors, such as alcohol and tobacco use, that can put them at risk of developing additional medical and behavioral health needs. A 2012 study found the relationship between NFP and tobacco use cessation during pregnancy to be particularly strong (Matone et al., 2012). Pregnant women who smoked and were recipients of NFP were more likely to quit smoking by the third trimester than that their counterparts in the control group. While smoking tobacco does not carry the same health risks or addictive qualities as other controlled substances, it does raise a compelling question if NFP application can have similar effects supporting young mothers with substance use disorders. NFP's model is built on the premise that nurses visiting young mothers in their homes can build trust with families, serve as a parenting resource, and provide a support network. For mothers struggling with addiction and facing the challenge of caring for substance-exposed newborns, NFP nurses could support mothers seeking treatment and monitor newborns for additional health concerns. This is especially pertinent in Maryland as DHS/SSA hopes to implement NFP in families with substance exposed newborns.

Prior success with pregnant and parenting youth in low-resource settings and long-term effects. The program has been especially successful for single, welfare-eligible mothers living in highly disadvantaged neighborhoods in urban areas. Substantial evidence is available to demonstrate NFP's longer-term effects on child development outcomes and child cognitive functioning in low-resource families, even after nurse home visits have stopped. Researchers followed up with study participants six years after they had received the NFP intervention when children were between six and nine years old (Olds et al., 2014). The evaluation found that children born to low-resource mothers from the NFP intervention group had improved behavioral functioning, better receptive language, and sustained attention in early childhood and at school entry, compared to the control group. In addition, this group was found to use fewer therapeutic services before the age of six and were less likely to be enrolled in special education or remedial services during the first three years of elementary school. While the strength of NFP's effects generally lessened by the time children were six years old, the program's sustained impact on child development outcomes for two to four years after nurse home visits stopped is compelling for Maryland as it looks to implement NFP with pregnant and parenting youth in low-resource settings.

From the evidence outlined above for NFP, it is clear that an evaluation of NFP, a well-supported evidenced-based practice, is not necessary for Maryland's five-year prevention plan. Multiple studies across the United States and globally demonstrate NFP's effectiveness supporting

pregnant and parenting youth to improve competent parenting, parent and child health outcomes, child development, and safety. With this in mind, DHS/SSA finds that current CQI measures and processes will provide sufficient monitoring and evaluation of NFP's implementation in Maryland.

Compelling Evidence Review for Functional Family Therapy

More than 30 years of clinical research shows that FFT has positive outcomes for youth from diverse ethnic and cultural backgrounds, including but not limited to significant and long-term reductions in youth re-offending and substance use; significant effectiveness in reducing sibling entry into high-risk behaviors; high treatment completion rates; and positive impacts on family communication, parenting, and youth problem behavior; and reduction of family conflict. FFT been identified as an evidence-based model (or equivalent rating) on several nationally-recognized EBP registries, and has been rated as a well-supported program on the Clearinghouse. An evaluation waiver is requested for FFT is requested due to evidence of the following:

> (1) FFT has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability, and
> (2) FFT has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

FFT has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability. FFT has been successfully implemented across a range of community-based settings and child-serving systems (e.g., Alexander & Parsons, 1973; Alexander, Pugh, Parsons, & Sexton, 2000; Alexander, Waldron, Robbins, & Neeb, 2013). For example, studies reviewed by the Title IV-E Clearinghouse demonstrated a moderate or high degree of effect on target populations in locations as diverse as the United Kingdom, New Jersey, Washington State, and New York City. Across these studies, effects were shown for young people residing in rural, suburban, and urban settings. Moreover, research demonstrates FFT's effectiveness with racially diverse target populations. Whereas much literature demonstrates effectiveness with white youth (Barnoski, 2002, 2004), a subset of studies demonstrate positive effects among predominantly Latino and African American youth (Darnell & Schular, 2015). In summary, the effectiveness of FFT across diverse geographic settings and with racially diverse target populations suggests that it is likely to work across Maryland's geographically diverse localities and racially diverse target population.

FFT has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. FFT has been shown to be effective with target populations similar to those served by Maryland under Family First, and to improve outcomes that reflect key reasons why youth in Maryland enter foster care.

According to the Title IV-E Clearinghouse, multiple studies have demonstrated significant evidence that FFT is effective in addressing youth substance use (Slesnick & Prestopnik, 2009), delinquent behavior (Barnoski, 2004; Darnell & Schuler, 2015), and behavioral functioning (Sexton & Turner, 2010; Celinska, Furrer, & Chang, 2013). These outcomes are highly relevant

to Maryland's Family First target population, as criteria for imminent risk include Children and Youth with current Department of Juvenile Services involvement, youth substance use disorders. Moreover, child substance abuse is contributes to 7% of removals in Maryland, and 10% in Baltimore, the state's largest jurisdiction that also has one of the highest foster care entry rates statewide. Child behavior contributes to 15% of removal statewide, and 8% of those in Baltimore. Due to the alignment of FFT's target population and youth targeted through Family First in Maryland, as well as FFT's demonstrated effectiveness to address outcomes shown to be significant contributors to foster care entry statewide, DHS/SSA is confident that this program will produce positive effects in Maryland.

Compelling Evidence Review for Parent-Child Interaction Therapy

There is compelling evidence in favor of using PCIT to reduce the risk of foster care placements, and promote positive family dynamics and healthy parenting, and improve child behavioral health in Maryland. Furthermore, the weight of this evidence prompts the DHS/SSA to request a waiver from the Family First evaluation requirements for PCIT. This waiver request is based on the following:

(1) PCIT has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability, and
(2) PCIT's target population has a high degree of relevance to the Family First target population in Maryland.

PCIT has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability. PCIT has demonstrated positive outcomes for children and families of multiple ethnicities, languages, and cultural backgrounds. For example, randomized clinical trials have shown positive outcomes for Mexican-American children and their families in the United States (McCabe & Yeh, 2009), Chinese families in Hong Kong (Leung, Tsang, Sin, & Choi, 2015), children and adolescents in Norway (Bjorseth & Wichstrom, 2016), and children and families in the United States (Solomon, Ono, Timmer, & Goodlin-Jones, 2008). This evidence suggests that PCIT is highly effective across a wide variety of geographic and cultural contexts, and therefore is also likely be effective with the diverse children and families throughout the state of Maryland. Moreover, PCIT has been shown effective for children with a wide range of underlying problems and psychological needs, such as ADHD (Leung, Tsang, Ng, & Choi, 2017), autism (Solomon et al., 2008), mental retardation (Bagner & Eyberg, 2007), and disruptive behavior (Abrahamse, Junger, van Wouwe, Boer, & Lindauer, 2016). PCIT has also had significant success with children who have experienced maltreatment (Thomas & Zimmer-Gembeck, 2011). Research demonstrated that the core components of PCIT are widely applicable. These results suggest that PCIT is likely to be effective for a range of children and families in Maryland as well.

PCIT has a high degree of relevance to the Family First target population in Maryland. According to the research reviewed by the Clearinghouse, PCIT is particularly effective in

bringing about improvements in child emotional and behavioral health. Child emotional and behavioral health problems are prevalent in many child welfare system's in-home and foster care populations, but are particularly prominent in Maryland's caseloads. As described in Maryland's Prevention Plan, parents, caregivers, and children who have complex psychological and behavioral needs are vulnerable for entry into foster care. This group makes up approximately 15% of foster care entries. Families with prior child welfare experience, many of whom have had history with child maltreatment, are another target population described in the Prevention Plan. Because of PCIT's demonstrated effectiveness addressing one of the most prevalent problems contributing to foster care entries in Maryland, DHS/SSA believes that it will be highly effective in the state.

As detailed above, the literature makes a strong case for the flexibility and efficacy of PCIT for children and families from a wide array of cultural backgrounds and underlying problems. Moreover, the target population for whom PCIT has been found effective aligns with the needs and characteristics of children and families targeted through Family First in Maryland. Therefore, DHS/SSA requests an evaluation waiver for PCIT.

Compelling Evidence Review for Multisystemic Therapy

There is compelling evidence in favor of using MST to decrease engagement in delinquent activity, promote youth behavior change, and reduce the risk of out-of-home placements for youth and adolescents in Maryland. The weight of this evidence DHS/SSA to request a waiver from the Family First evaluation requirements for MST. This evaluation waiver request is based on the following:

> (1) MST has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability, and
> (2) MST has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

MST has demonstrated flexibility and favorable outcomes across geographic locations and contexts. Studies have demonstrated the effectiveness of MST across geographic locations. For example, studies have demonstrated positive outcomes for MST in the Netherlands (Asscher et al., 2014), England (Fonagy et al., 2018), Norway (Ogden & Halliday-Boykins, 2004), and the United States (Johnides, Borduin, Wagner, & Dopp, 2017). MST has also been shown effective in a range of settings, including community mental health (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997) and juvenile justice systems (Weiss et al., 2013). MST's effectiveness across geographic locations and contexts suggests its wide applicability, and suggests that it will also be effective in Maryland.

MST has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. MST has been shown to be extremely effective at improving conduct among youth and adolescents with behavior problems, including antisocial and violent behaviors (Henggeler et al., 1997; Jansen et al., 2013), justice system involvement (Schaeffer & Borduin, 2005; Weiss et al., 2013), and substance abuse

(Henggeler et al., 1991). Child behavior problems contribute significantly to foster care entry in Maryland, as child behavior contributed to 14% of entries and child substance abuse contributed to 7% of entries.[2] Moreover, Maryland is specifically targeting these populations through Family First. As described in Maryland's Prevention Plan, target populations include children and youth who are involved with the Department of Juvenile Services who are at risk of entering an out-of-home placement, children with substance use disorders, and children with complex psychological or behavioral needs. Because of the alignment between MST's target population and the children and families who Maryland will serve under Family First, DHS/SSA believes that MST will be highly effective in Maryland.

In conclusion, MST has been validated as an effective means of improving outcomes among groups that bear great similarity to two target populations in Maryland. A large body of literature supports it as an intervention with violent juvenile offenders, juvenile delinquents, and youth with antisocial behavior and chronic conduct problems, suggesting it will be effective in Maryland. Furthermore, because research presents strong evidence for the flexibility and efficacy of PCIT to improve outcomes for children and families in varied geographic locations and settings, and for target populations are aligned with those of Maryland's Family First target population, DHS/SSA believe that MST will be highly effective in Maryland. Therefore, DHS/SSA requests an evaluation waiver for PCIT.

CQI Strategy

DHS/SSA will partner with the Institute and the Maryland Department of Health (MDH), Maternal and Child Health Bureau to continue and enhance CQI strategies for the well-supported evidence-based programs included in Maryland's Prevention Plan (i.e. HFA, NFP, FFT, PCIT, and MST). Each service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and ensure that information gleaned from the continuous monitoring efforts will be used to refine and improve practices. Specific CQI processes for each well-supported intervention is as follows:

Healthy Families America and Nurse Family Partnership. Both home visiting EBP models, HFA and NFP, are overseen by the MDH as the managing entity of MIECHV grants to local implementing agencies. MDH's CQI framework supports quality services so programs can better meet the requirements of their respective home visiting models and, ultimately, ensure that the maximum number of families can achieve the highest level of success. MDH employs a CQI Consultant who is responsible for the implementation of CQI activities among the MIECHV funded home visiting sites. CQI activities include quarterly monitoring of CQI projects, training and technical assistance.

MDH utilizes the Lean Six Sigma strategies which are an introduction to tools, techniques, and methodologies that empower and encourage improvement. These strategies take a deeper dive into the lenses of providing quality work for better public health outcomes. Strategies learned assist the CQI leads to better problem-solve and identify frameworks for improvement. CQI

[2] For children entering foster care 4/1/2018 – 3/31/2019.

efforts are localized, ensuring that each program is able to identify the performance successes and challenges, and implement plan-do-study-act cycles that are tailored to their specific context. Fidelity is monitored directly with the model purveyors, HFA and NFP, and periodically verified by MDH.

A Data and Fiscal Program Administrator collects quarterly data from each local implementing agency and analyzes child and family outcomes, service use and capacity. MDH and DHS/SSA have a data sharing agreement to support sharing data on the child welfare history and involvement of families served in the home visiting programs. MDH and DHS/SSA are refining these data sharing agreements and developing memoranda of understanding (including with local agencies as appropriate) to share service, fidelity and outcomes data proactively and align CQI activities related to the families served through this Prevention Plan.

Functional Family Therapy. Both DHS/SSA and DJS contract with The Institute to assist with implementation and CQI/evaluation efforts. Further, DHS/SSA and DJS have implementation teams at the State and local levels that regularly (monthly and quarterly) review data, monitor performance, identify solutions for implementation challenges, and identify opportunities to enhance implementation, sustainability, and outcomes, using a continuous quality improvement approach. These teams include referring agency staff, provider staff, as well as other stakeholders who can contribute to successful implementation (e.g., from the Local Management Boards or Core Service Agencies).

The Institute receives data extracts from FFT, LLC on treatment-specific data, including fidelity indicators as well as additional implementation data from providers. The implementation data includes information regarding the referral process and other data elements useful to support CQI. Both data sets are collected monthly, merged, reviewed for potential errors and/or missing data, and cleaned with providers, if necessary. The data are compiled into monthly, quarterly, annual, and ad hoc reports that summarize utilization, fidelity, and outcomes (including child welfare and juvenile justice involvement) on an annual basis, among other data elements. The implementation teams use this data in regular meetings to inform implementation monitoring. Technical assistance staff from FFT LLC and The Institute assist stakeholders to assess implementation data and other qualitative information to devise strategies and make program/practice improvements as needed. The Institute also coordinates Learning Collaboratives for referring agencies, providers and other stakeholders, organizing agendas geared towards strengthening FFT practice and implementation across the State.

Parent Child Interaction Therapy. Under previous initiatives, The Institute worked with PCIT International to establish a logic model, data collection template, and data reports that support model implementation and fidelity monitoring. Like other models, SSA established local and state implementation teams who review the data as well as feedback from the PCIT Master Trainer and stakeholders to assess implementation and devise strategies to improve/enhance implementation, as needed. The Institute uses procedures for compiling, cleaning, analyzing, and reporting the data, so that it informs implementation monitoring efforts. Institute staff, along with the PCIT Master Trainer, also provide technical assistance on implementation and organize PCIT Learning Collaborative meetings to bring stakeholders together with the goals of increasing awareness and education of PCIT as well as supporting potential expansion.

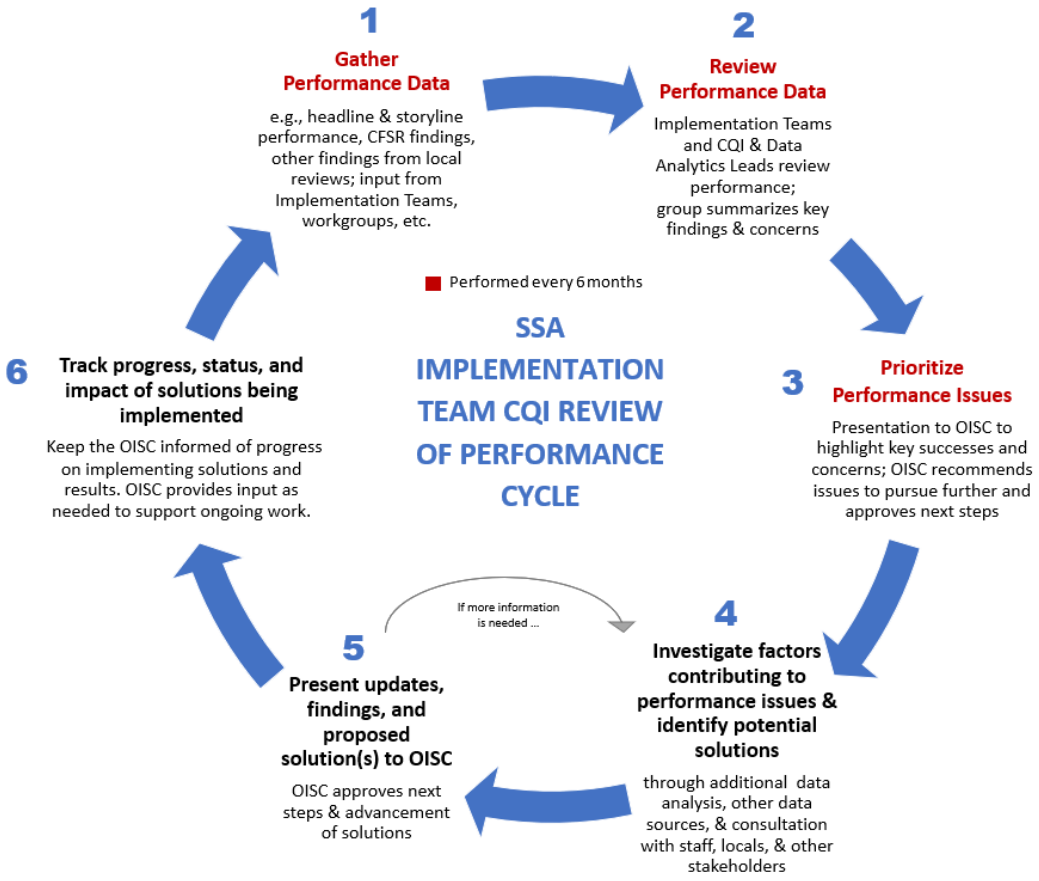
Multisystemic Therapy. Both DHS/SSA and DJS contract with The Institute to assist with implementation and CQI/evaluation efforts. Further, both DHS/SSA and DJS have implementation teams at the State and local levels that conduct monthly and quarterly reviews of the data, monitor performance, identify solutions for implementation challenges, and identify opportunities to enhance implementation, sustainability, and outcomes, using a continuous quality improvement approach. These teams include referring agency staff, provider staff, as well as other stakeholders who can contribute to successful implementation (e.g., from the Local Management Boards or Core Service Agencies).

Similar to other EBP CQI procedures, The Institute receives monthly data extracts from MST Services as well as additional implementation data from providers (e.g., more specific information regarding the referral process and other data elements useful to support CQI/evaluation in Maryland). The data sets are merged, reviewed for potential errors and/or missing data, and cleaned with providers, if necessary. The data are compiled into monthly, quarterly, annual, and ad hoc reports that summarize utilization, fidelity, and outcomes, among other data elements, for stakeholders to use in their regular meetings to inform implementation monitoring. The MST Expert and other Institute staff provide technical assistance to assist stakeholders in implementation meetings to assess data and other qualitative information to devise strategies and make program/practice improvements as needed. Institute staff also coordinate and facilitate MST Learning Collaboratives for referring agencies, providers and other stakeholders.

In addition, DHS/SSA will work with UMB/SSW and The Institute to ensure collaboration among key stakeholders in program level CQI and use of data to guide implementation strategies by: (1) convening regular meetings with the purveyors to coordinate implementation activities (e.g., training), discuss/resolve implementation issues, and plan for program changes, as needed; (2) supporting training and technical assistance for DHS/SSA, local departments, and provider partners to form and maintain implementation teams; (3) supporting the provision of on-going technical assistance to local implementation teams to use data to identify implementation challenges and to develop strategies and solutions; and, (4) supporting the development and facilitation of an evidence-based program Stakeholder Collaborative to include opportunities for public and private agencies across jurisdictions to share data, outcomes, implementation challenges, and potential strategies for improvements.

At the agency level, Maryland will integrate the data and implementation reports into its ongoing CQI processes. As noted above, CQI is carried out within DHS/SSA's Implementation Structure, an organizational structure nested within DHS/SSA in partnership with system partners, to advance key priorities in order to achieve the agency's strategic direction. Figure 3 shows the CQI cycle operationalized in Maryland.

Figure 3. SSA Implementation Team CQI Review of Performance Cycle



During the first year of Family First, the CQI cycle will focus on a review of data and information related to implementation, including but not limited to data to address the process evaluation questions noted below. This will provide SSA with a firm understanding of how evidence-based programs are being implemented, the status of implementation drivers and supports and allow for proactive management of the evidence-based programs to ensure implementation success. In subsequent years, proximal and distal outcomes will be examined, as data become available and as implementation stabilizes sufficiently to allow for outcomes assessment.

Finally, DHS/SSA engages each local jurisdiction as they participate in Maryland Child and Family Service Reviews (CFSR) with a focused discussion on the local department's performance. This discussion focuses on DHS/SSA headline indicators related to safety, permanency and well-being, the story that provides context for that performance and the use of particular approaches interventions that may impact child and family outcomes. DHS/SSA and the local department identify areas of outstanding performance and those in need of improvement during this engagement and couple them with the local department's MD CFSR findings to guide the local department's improvement efforts. Additionally, Maryland anticipates

that some of the children and families served by the Prevention Plan will be a part of the cases sampled to undergo a qualitative review in a MD CFSR, allowing SSA an additional opportunity to explore the contributions of prevention programs to child and family outcomes and areas for improvement.

Evaluation Strategy

DHS/SSA has mentioned three evidence-based programs in this Prevention Plan that currently are not identified as well-supported by the Clearinghouse: Family Centered Treatment, Sobriety Treatment and Recovery Teams and Nurturing Parenting Program. As previously stated, their inclusion here is to indicate Maryland's intent to include these programs in an amended Prevention Plan when they are deemed allowable by the Children's Bureau. As such a full evaluation plan is not included here. The evaluation strategy for each, if required because of their evidence level, will be designed to meet the particular circumstances of each evidence-based program. SSA will work with our evaluation partners to develop a specific evaluation plan to determine the evaluation questions, appropriate measures, indicators, data sources, and analytic approaches for each intervention that is not rated as well-supported by the Clearinghouse. Included in our evaluation strategy will be the development of a dissemination plan to share the evaluation findings.

Research Questions

SSA plans to use a mixed-methods approach to conduct process and outcome evaluations of the promising and supported evidenced based programs included in the Prevention Plan. Preliminary research questions that have been identified to drive the evaluations and our CQI efforts include:

Processes:

- To what extent was the program delivered with fidelity to the program model?
- To what extent did the service get delivered to the target population of evidence-based program?
- To what extent did targeted populations enroll and to what extent did they sustain participation?
- To what extent did DHS/SSA (and sister agencies and partners, as applicable) support implementation of the evidence-based program?

Outcomes:

- To what extent are participating children and families experiencing better mental health, substance abuse, and parenting outcomes as prescribed by each evidence-based program model?
- To what extent has the program kept a child from entering foster care within one and two years of receipt of the evidence-based program?

In addition, SSA will examine research questions that transcend individual evidence-based programs and instead examine the degree to which the state's comprehensive prevention strategy is working. These questions may include:

- To what extent is the Family First eligibility assessment and documentation process being performed consistently by workers?
- To what extent are families being referred to the right services to meet their needs?

- To what extent does SSA's preventive service array align with the needs of the target populations?
- To what extent is SSA's coordination and collaboration successful with sister agencies on individual shared cases?

Section 7: Child Welfare Workforce Training and Support

Training and Supporting the Evidence-Based Program Provider Agency Workforce
As indicated earlier in the Prevention Plan, all evidence-based programs are administered within a trauma-informed framework and our array of services in this plan build on an existing provider network. As such, Maryland enters into this plan with an accomplished workforce with the skills and capacities necessary to deliver evidence-based programs. Via the Program Questionnaire, described earlier in this plan, compliance with all of the trauma informed requirements will be reviewed annually by DHS/SSA staff.

DHS/SSA recognizes that ongoing training is needed in order to support continuous learning and growth. As contracts or agreements expand the scale of programs, DHS/SSA will require evidence-based program providers to provide initial and ongoing trauma training to sustain the trauma-informed framework, meet the necessary training, credentialing and fidelity monitoring requirements of each model, and take advantage of additional training and coaching offered by the evidence-based program purveyor. Additionally, the technical assistance DHS/SSA provides in conjunction with UMB/SSW will ensure that both public and private workers and clinicians have the opportunity for collaborative peer-learning opportunities. DHS/SSA will also explore opportunities to offer additional training if needed, including collaborating with sister agencies on training existing and new providers.

Training and Supporting the Child Welfare Agency Workforce
DHS/SSA, in partnership with the Child Welfare Academy (CWA), currently offers a robust curriculum of *Pre-Service, Foundations* and *In-service* trainings that align with various components of the Prevention Plan. This training series, coupled with SSA's newly developed and implemented *Integrated Practice Model (IPM*), will integrate and build upon each other to ensure best practice and desired outcomes to children and families served under the Prevention Plan.

- *Pre-Service* is a six-week training series required by law for all new child welfare staff. Workers must successfully complete pre-service training and pass a competency exam. The training series is designed to equip new workers with foundational knowledge, skills and competencies to meet the complex needs of children and families involved in the various facets of the child welfare system, and to improve safety, permanency and well-being outcomes of children and families. The six training modules include: *1. Foundations of Practice, 2. Indicators and Dynamics of Abuse and Neglect and Three Contributing Factors, 3. Engaging with Children and Families, 4. Conducting Family Centered Assessments, 5. Planning with the Family,* and *6. Working Effectively with the Court***.** Modules 1 through 5 in particular will be refined to bolster the Prevention Plan.

- *Foundations Track Training Series* is also required for new child welfare workers and builds upon the knowledge and skills introduced in pre-service with a more intensive focus on practice competencies and transfer of learning opportunities to the actual work setting. All new child welfare workers are required to complete the two-day *Assessing and Planning for Risk and Safety Course* and are then enrolled in one of three tracks: *Introduction to Child Protective Service Responses, Introduction to Family Preservation* or *Introduction to Placement and Permanency.* These will be modified to incorporate aspects of the Prevention Plan as needed.
- *In-Service* trainings are on-going and ever-evolving to meet the diverse needs of the state-wide workforce. These trainings encompass a variety of interests, knowledge and skill development areas. Currently there are over 100 in-service trainings offered each year covering a range of specialized topics in human behavior, family assessment and engagement, family health and well-being, cultural competency, trauma informed care and evidenced based practice. Maryland will add specific trainings that focus on the components of the Prevention Plan.
- *Maryland's Integrated Practice Model (IPM)* was designed with the ultimate goal of achieving better outcomes for children, families and vulnerable adults served throughout Maryland. The model is predicated on the CARE-Collaboration, Advocacy, Respect and Empowerment framework. The IPM provides an integrated, individualized and standardized framework for children and families and incorporates the following practice principles: trauma-responsive, family-centered, culturally & linguistically responsive, outcomes-driven, individualized and strength-based, safe, engaged and well-prepared professional workforce and community-focused. All current Maryland child welfare staff will receive training on the IPM which will be the foundation for all case work practice provided in service to children and families. In addition, the IPM will become the foundation for all pre-service and in-service learning opportunities for child welfare staff. Maryland has begun initial training on the IPM through various forums and will be providing more intensive training throughout the Fall of 2019 and the calendar year 2020. Included in the rollout will be tailored transfer of learning opportunities and coaching to support staff with implementation and integration of the IPM into day to day practice, including how such practices apply in prevention services.

Appendix G contains more detail on how specific staff training will be modified to prepare staff for implementing Maryland's Prevention Plan.

While there is significant alignment with the Prevention Plan, DHS/SSA will review and refine current training modules and practice frameworks throughout the Fall of 2019 and the first quarter of 2020, to ensure the highest fidelity to the Prevention Plan. DHS/SSA will utilize its training framework to ensure that the workforce has the requisite skills to effectively and authentically engage and partner with youth and families, assess youth and families' strengths and needs, and develop appropriate prevention focused service plans with youth and families to mitigate risk factors and promote safety, permanency and well-being.

Section 8: Prevention Caseloads

Caseload size is an important factor to ensure effective case management for families and children receiving preventive services. Maryland has determined the prevention caseload sizes can be maintained at their current rates given that the candidates for prevention services will initially be limited to the population of children who receive In-Home Services and pregnant and parenting foster youth. Table 5 indicates the approximate staff-to-case ratios across the variety of program staff who will manage prevention services cases.

Table 5. Staff-to-case ratio by child welfare program types

Child Welfare Program	Staff-to-Case Ratio*
Child Protective Services/Services to Families with Children-Intake	1:12 families
Family Preservation	1:12 families
Out-of-Home	1:15 children

*Staff-to-case ratio is dependent on the level of services required to meet the assessed needs of each family/child.

Caseload ratios will be monitored and managed by local department child welfare supervisors and administrators. For families with higher needs, supervisors and case managers may determine a family could benefit from additional supportive services and assign a case associate to assist the case manager working with the family.

Section 9: Assurance on Prevention Program Reporting

Appendix F contains DHS/SSA's assurance as required by ACYF-CB-PI-18-09 Attachment I, that DHS/SSA will comply with all prevention program reporting requirements put forward by the Children's Bureau. The Children's Bureau reporting requirements to date are contained in the Title IV-E Prevention Program Data Elements, Technical Bulletin #1, issued on August 19, 2019. Consistent with this guidance (or subsequent guidance), DHS/SSA will provide the following information for each child that receives Title IV-E prevention services:

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

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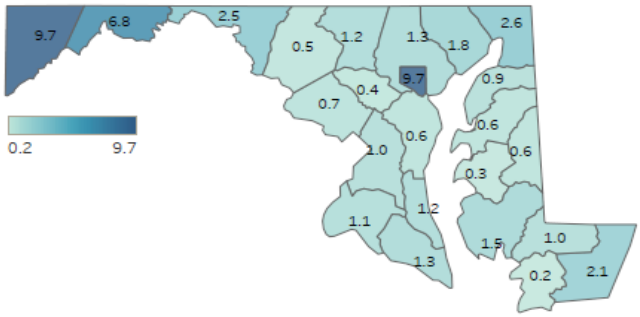
Appendix A: Select Data on Children Entering Foster Care

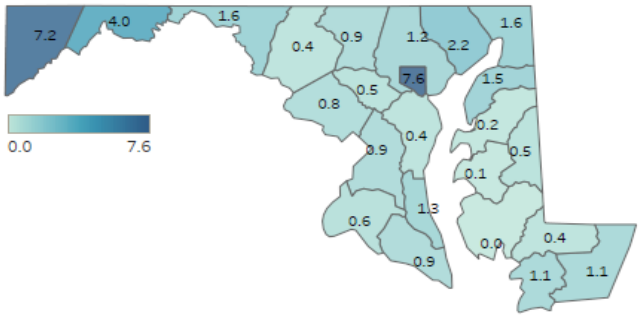
entering per 1,000 children (entry rate) *

What is the number of children entering for every 1,000 children in the population? (# of entries / population * 1,000)

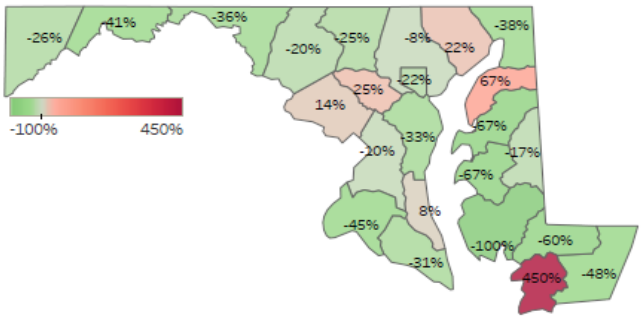
Last year performance
Apr '17 - Mar '18



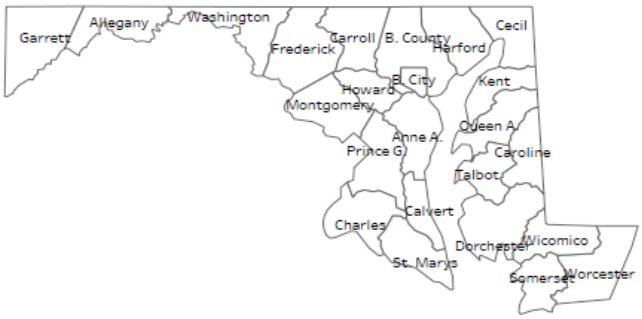
Most recent performance
Apr '18 - Mar '19



Percent change from last yr to most recent year



Legend



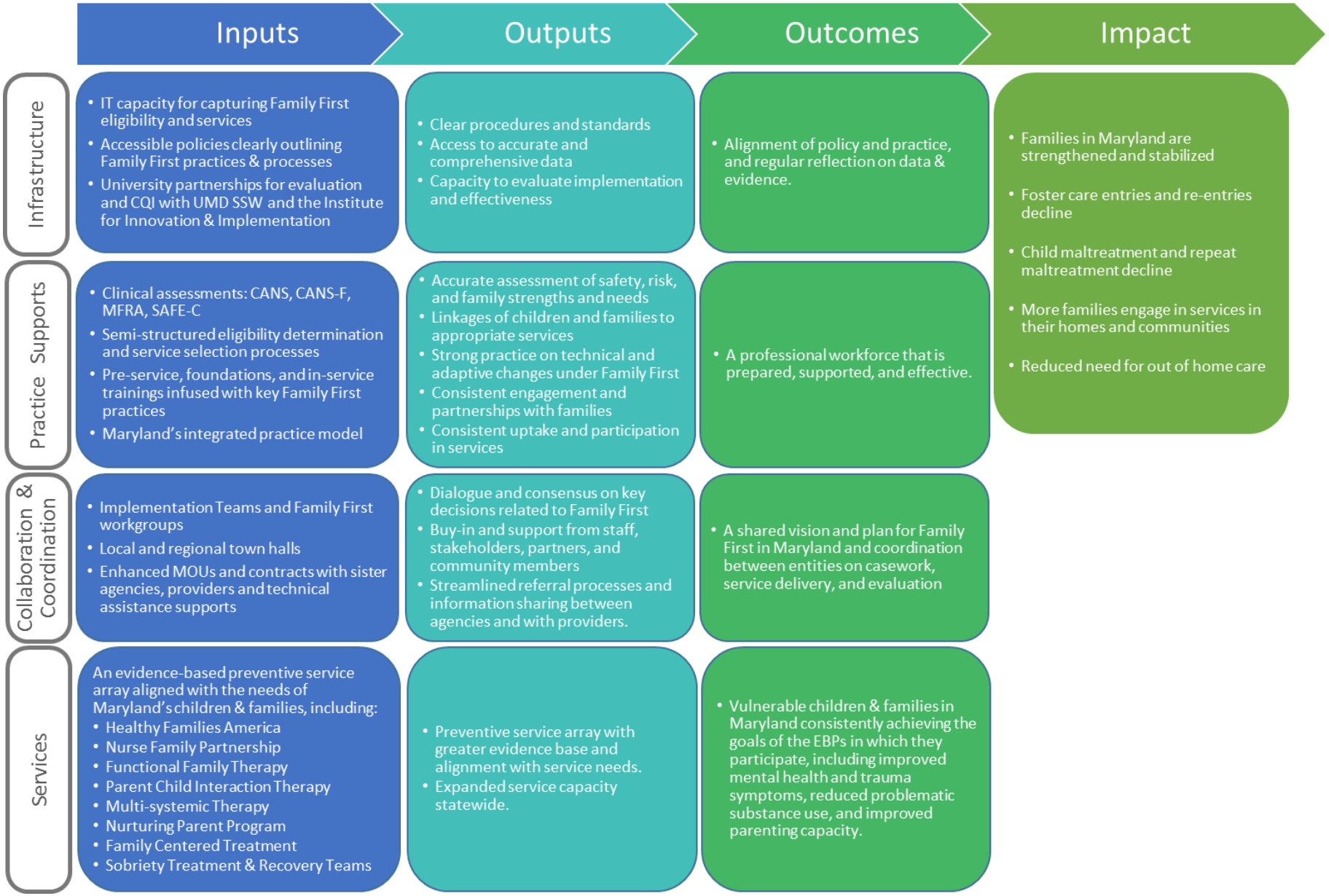
Percent of children entering care by circumstance of removal

Of all children entering care, what percent entered with each circumstance of removal?

	Last year (Apr '17 - Mar '18)			Most recent year (Apr '18 - Mar '19)			Change in entries w/this circumstance from last to most recent yr	% change in % of children entering w/this circum. from last to most recent yr
		Numerator	Denominator		Numerator	Denominator		
Neglect	72	1,881	2,602	72	1,559	2,153	-322	0%
Caregiver SA	28	723	2,602	25	539	2,153	-184	-11%
Physical Abuse	15	385	2,602	16	351	2,153	-34	7%
Child behavior	14	358	2,602	15	320	2,153	-38	7%
Relinq.	14	357	2,602	12	257	2,153	-100	-14%
Inability to cope	12	312	2,602	11	245	2,153	-67	-8%
Inadequate housing	9	224	2,602	9	187	2,153	-37	0%
Aband.	7	195	2,602	7	150	2,153	-45	0%
Child AA or SA	7	170	2,602	7	154	2,153	-16	0%
Caregiver AA	5	142	2,602	6	124	2,153	-18	20%
Child disability	5	136	2,602	6	129	2,153	-7	20%
Other	7	183	2,602	6	121	2,153	-62	-14%
Sexual Abuse	6	155	2,602	5	117	2,153	-38	-17%

A child can have more than one circumstance, so the counts will exceed the total number of children who entered.
"Other" includes death of parent and incarceration. AA = Alcohol abuse, Aband. = Abandonment, Relinq. = Relinquishment, SA = Substance abuse.

Appendix B: Maryland's Prevention Plan Theory of Change



Appendix C: Table of Proposed Evidence-Based Programs for Maryland's Prevention Plan

Evidence-Based Program Name, Description & Requested Funding	Target Age & Clients	Targeted Outcomes/ Select Program Goals	Evidence Rating & Source	Installed Jurisdictions	
Healthy Families America (HFA) HFA is a home visiting program with a goal of preventing abuse or neglect or intervening with families at high risk of abuse and neglect. Families are eligible to receive HFA services beginning prenatally or within three months of birth. When referred from child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experience. *Title IV-E Prevention Services Funding Requested*	☒ 0-2 ☐ 3-5 ☐ 6-11 ☐ 12-17 ☐ 18+ ☐ Individual ☒ Family ☐ Group	*Child Safety, Child Well-Being, Family Well-Being* • Reduce child maltreatment • Improve parent-child interactions and children's social-emotional well-being • Increase school readiness • Promote child physical health and development • Promote positive parenting • Promote family self-sufficiency • Increase access to primary care medical services and community services • Decrease child injuries and emergency department use[2]	*Clearinghouse –Well supported*	☒ Allegany ☐ Anne Arundel ☒ Baltimore ☒ Baltimore City ☒ Calvert ☒ Caroline ☐ Carroll ☐ Cecil ☒ Charles ☒ Dorchester ☒ Frederick ☒ Garrett *20 jurisdictions*	☒ Harford ☒ Howard ☒ Kent ☒ Montgomery ☒ Prince George's ☒ Queen Anne's ☒ St. Mary's ☒ Somerset ☒ Talbot ☒ Washington ☒ Wicomico ☒ Worcester
Nurturing Parenting Program (NPP) NPP for Parents and their Infants, Toddlers and Preschoolers is a family-centered program designed for the prevention and treatment of child abuse and neglect. Both parents and their children birth to five years participate in home-based, group-based, or combination group-based and home-based program models. Lessons are competency-based ensuring parental learning and mastery of skills. The program lessons focus on remediating five parenting patterns known to form the basis of maltreatment. The Nurturing Parenting Program for Parents and their	☒ 0-2 ☒ 3-5 ☒ 6-11 ☐ 12-17 ☐ 18+ ☐ Individual ☒ Family ☒ Group	*Child Safety, Child Well-Being, Family Well-Being* • Measurable gains in the individual self-worth of parents and children • Measurable gains in parental empathy and meeting their own adult needs in healthy ways. • Measurable gains in parental empathy towards meeting the needs of their children. • Utilization of dignified, non-violent disciplinary strategies and practices. • Measurable gains in empowerment of the parents and their children. • Measurable gains in nurturing parenting	*CEBC – Promising* *Clearinghouse - Pending Review*	☐ Allegany ☐ Anne Arundel ☐ Baltimore ☐ Baltimore City ☐ Calvert ☒ Caroline ☐ Carroll ☒ Cecil ☐ Charles ☐ Dorchester	☒ Harford ☐ Howard ☒ Kent ☐ Montgomery ☐ Prince George's ☒ Queen Anne's ☐ St. Mary's ☐ Somerset ☒ Talbot ☐ Washington

School Age Children 5 to 12 Years is a 15-session program that is group-based, and family-centered.		beliefs, knowledge and utilization of skills and strategies as measured by program assessment inventories • Reunification of parents and their children who are in foster care		☐ Frederick ☐ Garrett *6 jurisdictions*	☐ Wicomico ☐ Worcester
Nurse Family Partnerships (NFP) NFP is a home-visiting program where nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. NFP targets young, first time low income mothers from early pregnancy through the child's first two years. *Title IV-E Prevention Services Funding Requested*	☒ 0-2 ☐ 3-5 ☐ 6-11 ☐ 12-17 ☐ 18 ☐ Individual ☒ Family ☐ Group	*Child Well-Being, Family Well-Being* • To improve pregnancy outcomes by promoting health-related behaviors • To improve child health, development and safety by promoting competent care-giving • To enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment[3]	*Clearinghouse - Well Supported*	☐ Allegany ☐ Anne Arundel ☐ Baltimore ☒ Baltimore City ☐ Calvert ☒ Caroline ☐ Carroll ☒ Cecil ☐ Charles ☐ Dorchester ☐ Frederick ☒ Garrett *8 jurisdictions*	☒ Harford ☐ Howard ☒ Kent ☐ Montgomery ☐ Prince George's ☒ Queen Anne's ☐ St. Mary's ☐ Somerset ☒ Talbot ☐ Washington ☐ Wicomico ☐ Worcester
Family Centered Treatment (FCT) FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. FCT is targeted towards family members at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities.	☐ 0-2 ☐ 3-5 ☐ 6-11 ☒ 12-17 ☐ 18+ ☐ Individual	*Child Permanency, Child Well-Being, Family Well-Being* • Enable family stability via preservation of or development of a family placement • Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution • Reduce hurtful and harmful behaviors affecting family functioning	*CEBC – Promising* *Systemic Review*	☒ Allegany ☒ Anne Arundel ☒ Baltimore ☒ Baltimore City ☒ Calvert ☒ Caroline ☒ Carroll ☒ Cecil	☒ Harford ☒ Howard ☒ Kent ☒ Montgomery ☒ Prince George's ☒ Queen Anne's ☒ St. Mary's ☒ Somerset

	☒ Family ☐ Group	• Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges.[3]		☒ Charles ☒ Dorchester ☒ Frederick ☒ Garrett *Statewide*	☒ Talbot ☒ Washington ☒ Wicomico ☒ Worcester
Functional Family Therapy (FFT) FFT a short-term, high-quality intervention program for youth demonstrating behavioral health problems. *Title IV-E Prevention Services Funding Requested*	☐ 0-2 ☐ 3-5 ☐ 6-11 ☒ 12-17 ☐ 18+ ☐ Individual ☒ Family ☐ Group	*Child Well-Being, Family Well-Being* • Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e., school attendance) • Improve family and individual skills[3]	*Clearinghouse – Well Supported*	☐ Allegany ☒ Anne Arundel ☒ Baltimore ☒ Baltimore City ☒ Calvert ☒ Caroline ☒ Carroll ☒ Cecil ☒ Charles ☒ Dorchester ☐ Frederick ☐ Garrett *21 jurisdictions*	☒ Harford ☒ Howard ☒ Kent ☒ Montgomery ☒ Prince George's ☒ Queen Anne's ☒ St. Mary's ☒ Somerset ☒ Talbot ☒ Washington ☒ Wicomico ☒ Worcester
Parent-Child Interaction Therapy (PCIT) PCIT is a behavioral parent training program with coaching by a trained therapist in behavior-management and relationship skills. PCIT targets 2 -7 year olds with emotional/behavioral issues and their parents/caregivers.	☒ 0-2 ☒ 3-5 ☒ 6-11 ☐ 12-17 ☐ 18+ ☐ Individual	*Child Well-Being, Family Well-Being* • Build close relationships between parents and their children using positive attention strategies • Help children feel safe and calm by fostering warmth and security between parents and their children • Increase children's organizational and play skills • Decrease children's frustration and anger	*Clearinghouse - Well Supported*	☐ Allegany ☒ Anne Arundel ☒ Baltimore ☐ Baltimore City ☒ Calvert ☐ Caroline ☒ Carroll	☐ Harford ☐ Howard ☐ Kent ☐ Montgomery ☐ Prince George's ☐ Queen Anne's ☒ St. Mary's

Title IV-E Prevention Services Funding Requested	☒ Family ☐ Group	• Educate parent about ways to teach child without frustration for parent and child • Enhance children's self-esteem • Improve children's social skills such as sharing and cooperation • Teach parents how to communicate with young children who have limited attention spans[3]		☐ Cecil ☒ Charles ☐ Dorchester ☐ Frederick ☐ Garrett *6 jurisdictions*	☐ Somerset ☐ Talbot ☐ Washington ☐ Wicomico ☐ Worcester
Multisystemic Therapy (MST) MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. MST targets youth, ages 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors. *Title IV-E Prevention Services Funding Requested*	☐ 0-2 ☐ 3-5 ☐ 6-11 ☒ 12-17 ☐ 18+ ☐ Individual ☒ Family ☐ Group	*Child Permanency, Child Well-Being, Family Well-Being* • Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) • Empower parents with the skills and resources needed to: (a) Independently address the inevitable difficulties that arise in raising children and adolescents, and (b) Empower youth to cope with family, peer, school, and neighborhood problems[3]	*Clearinghouse - Well Supported*	☐ Allegany ☐ Anne Arundel ☒ Baltimore ☐ Baltimore City ☐ Calvert ☐ Caroline ☐ Carroll ☐ Cecil ☐ Charles ☐ Dorchester ☒ Frederick ☐ Garrett *5 jurisdictions.*	☐ Harford ☐ Howard ☐ Kent ☒ Montgomery ☒ Prince George's ☐ Queen Anne's ☐ St. Mary's ☐ Somerset ☐ Talbot ☒ Washington ☐ Wicomico ☐ Worcester
Sobriety Treatment and Recovery Teams (START) START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START targets families with at least one child age 5 or younger in the	☒ 0-2 ☒ 3-5 ☐ 6-11 ☐ 12-17 ☐ 18+	*Child Safety, Child Permanency, Family Well-Being* • Ensure child safety • Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible • Achieve child permanency within the ASFA timeframes, preferably with one or	*CEBC – Promising* *Systematic Review*	☐ Allegany ☒ Anne Arundel ☐ Baltimore ☐ Baltimore City ☐ Calvert	☒ Harford ☐ Howard ☒ Kent ☒ Montgomery ☐ Prince George's

child welfare system and have a parent where substance use is a primary child safety risk factor.	☐ Individual ☒ Family ☐ Group	both parents or, if that is not possible, with a relative • Achieve parental sobriety in time to meet ASFA permanency timeframes • Improve parental capacity to care for children and to engage in essential life tasks • Reduce repeat maltreatment and re-entry into out-of-home care • Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues • Improve collaboration and the system of service delivery between child welfare and mental health treatment providers.[3]		☒ Caroline ☒ Carroll ☒ Cecil ☐ Charles ☒ Dorchester ☒ Frederick ☐ Garrett *13 jurisdictions.*	☒ Queen Anne's ☐ St. Mary's ☒ Somerset ☒ Talbot ☐ Washington ☐ Wicomico ☒ Worcester

[1] Purveyor website.
[2] Home Visiting Evidence of Effectiveness (HomVEE) review project. https://homvee.acf.hhs.gov/
[3] The California Evidence-Based Clearinghouse for Child Welfare (CEBC). www.cebc4cw.org

Appendix D: Assurance of Trauma Informed Service Delivery

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT III
State of Maryland

State Assurance of Trauma-Informed Service-Delivery

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

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

The Maryland Department of Human Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

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

_____ _____
(Date) (Signature and Title)

_____ _____
(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

Appendix E: Evaluation Waiver Requests for Well Supported Programs

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT II
State of Maryland

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Maryland Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Healthy Families America (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

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

(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

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

_____ _____
(Date) (Signature and Title)

_____ _____
(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Maryland Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Nurse Family Partnership (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

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

(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Maryland Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parent Child Interaction Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

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

(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Multisystemic Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

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

(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

Appendix F: Prevention Program Reporting Assurance

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT I
State of Maryland

State Title IV-E Prevention Program Reporting Assurance

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

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

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

(Date) (Signature and Title)

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

Appendix G: Maryland Staff Training Modifications to Align with the Prevention Plan

Listed below are the specific trainings that will be provided and/or modified as needed to prepare staff for implementing specific components of Maryland's Prevention Plan:

Identifying candidates and developing child-specific prevention plans

Knowledge of common characteristics of vulnerable children and families is fundamental to effective child welfare practice, treatment planning and intervention. Current pre-service training will be enhanced to include information on identifying candidates for Maryland's prevention services as outlined in Section 2 of this plan as well as developing child-specific plans. The specific modules that will be modified include:

- Preservice Module 2 Indicators and Dynamics of Abuse and Neglect and Three Contributing Factors
- Foundation Track Training Series
- Introduction to CPS Responses (2 days)
- Introduction to Family Preservation
- Introduction to Placement and Permanency

For existing staff (caseworkers and supervisors), web-based trainings will be offered outlining the necessary changes required under Family First including identifying candidates and developing child-specific plans. In addition, planning is identified as a core practice of Maryland's IPM. Through the roll out of the IPM, case workers and supervisors will be engaged in interactive training to build skills and competencies around developing child and family driven plans of care that will support the requirement of child-specific prevention plans under Family First.

Conducting risk and safety assessments

New Child Welfare staff are currently trained to conduct risk and safety assessments as part of Preservice Module 4: Conducting Family Centered Assessments of Pre-Service. This module will be enhanced to support utilizing the risk assessment, SAFE-C, SDM, and CANS-F to inform the development of the child-specific prevention plan, including the identification of needs and appropriate evidence-based programs.

For existing staff, web-based trainings will be offered outlining the necessary changes required under Family First including conducting risk and safety assessments. In addition, conducting collaborative assessments is also identified as a core practice of Maryland's Integrated Practice Model (IPM). Through the roll out of the IPM, case workers will be engaged in interactive training to build skills and competencies to engage in a collaborative assessment process to understand individual and family strengths, needs and family vision that will drive the collaborative partnership and the development of mutually agreed upon child-specific prevention plans.

Engaging families in the assessment of strengths, needs, and the identification of appropriate services

For new Child Welfare staff Module 3: Engaging with Children and Families of pre-service teaches participants to explore effective techniques to engage and conduct interviews with children and families. Participants are provided opportunities to practice utilizing different types of questions and strategies based on situation, culminating in a mock interview videotaped session where they receive structured feedback from their peers. Additionally, participants learn about the process of change, strategies, strategies for working through anger, resistance and inertia, and ways to motivate families to improve service plans outcomes. This module will be enhanced to ensure alignment with engaging families in the assessing of strengths, needs, and the identification of services to assist with the development of child-specific prevention plans.

Authentic partnership and empowerment is a core principle of the IPM and the foundation on which the IPM was developed. Effective engagement is critical to building trust and respectful relationships with children and families receiving services. Engagement is an active process that serves as the foundation for individual and family healing and to building and maintaining strong relationships.

The IPM stresses that through relationship and partnership children, youth, families feel respected, empowered, included in all activities and decisions, and able to talk openly about their beliefs and experiences. This, in turn, leads to shared decision making and ownership of plans, which support sustainable outcomes.

As part of the IPM Child Welfare staff will be trained to authenticate partner with individual family members to understand their needs and strengths as well as how to use collaborative assessment to capture their experiences and identify services to meet their needs.

Linking families with appropriate, trauma-informed, evidence-based services to mitigate risk and promote family stability and well-being

New and existing child welfare staff will be trained to link families with appropriate, trauma-informed, evidence-based services as outlined in section 3 of this plan. As part of the IPM, staff will be introduced to an evidence informed case planning process that will support staff in planning with the child and family creating a shared ownership of the plan. The planning process includes developing outcomes, understanding contributing factors, strategizing, and monitoring and evaluating progress. This training will also focus on workers partnering with the child and family to identify interventions designed to meet their specific needs. Finally, a discussion on identifying appropriate, trauma-informed, evidence-based services to mitigate risk and promote family stability and well-being will be incorporated in this training.

Current in-service training offered by CWA includes a number of courses related to trauma informed assessment and practice which will also be modified to support staff implementing Maryland's Prevention Plan. DHS/SSA will review current coursework to ensure that there are ongoing opportunities to support staff in developing skills to effectively link families with

appropriate, trauma-informed, evidence-based services to mitigate risk and promote family stability and well-being.

Oversight and evaluation of the continuing appropriateness of the services

Pre-service course work for new child welfare staff includes a two-day Foundations course on Assessing and Planning for Risk and Safety. This module will be modified to assist staff in providing the needed oversight and evaluation of prevention plans and candidacy definitions to assess the ongoing need for prevention services are still needed.

As noted above the evidence informed case planning process being implemented as part of Maryland's IPM includes a monitoring and evaluating progress approach to planning. Specifically, monitoring progress involves direct feedback from family as to whether they believe they are getting closer to their vision as a result of the Plan of Care, as well as if they are satisfied with coordinated services being provided, and if they believe their identified challenges are getting better. Included in this training are discussions related to ongoing review of service plans at regularly established timeframes (i.e. once a month).

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

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

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

State Annual Maintenance of Effort (MOE) Report

State: MARYLAND DEPARTMENT OF HUMAN SERVICES	FFY:
Baseline Year:	2014
Baseline Amount: $	$380,433.00
Total Expenditures for Most Recent FFY:	$1,314,609 (FFY 2019)

This certifies that the information on this form is accurate and true to the best of my knowledge and belief. **This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.**
Signature, Approving Official:
Typed Name, Title, Agency:
Date: