



Utah Title IV-E Prevention Program

Five-Year Plan FFY 2020-2024



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ATTACHMENTS

Attachment I: State Title IV-E prevention program reporting assurance

Attachment II: State request for waiver of evaluation requirement for a well-supported practice

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Attachment IV: State annual maintenance of effort (MOE) report

Introduction

The Family First Prevention Services Act (FFPSA) (Public Law 115-123) authorizes new optional Title IV-E funding for time-limited prevention services for mental health and substance abuse prevention and treatment and for in-home parent skills based programs. These evidence-based prevention services and programs may be provided for children who are candidates for foster care and their parents or kin caregivers. The overall goal of Title IV-E prevention program is to prevent the need for foster care placement and the corresponding trauma of unnecessary parent-child separation.

The Utah Department of Human Services (DHS) is electing to implement the Title IV-E prevention program as authorized by FFPSA. As instructed in ACYF-CB-PI-18-09, the following is Utah's five-year prevention plan for FFY 2020 through FFY 2024. This plan builds upon Utah's Title IV-E waiver project, HomeWorks, which focused on strengthening parents' capacity to safely care for their children and safely reducing the need for foster care.

Utah's initial state Title IV-E Prevention Plan is deliberately modest in scope. Our intent is to first solidify a basic operational foundation, utilizing principles of implementation science, and then to expand capacity through subsequent amendments to the plan.

The prevention service array will be expanded through plan amendments as additional evidence-based services are approved through the Title IV-E prevention services clearinghouse or are reviewed and approved through the transitional payment review process authorized by the Children Bureau through ACYF-CB-PI-19-06, and based on availability of services in Utah. Expansion may also include extending prevention services to children at imminent risk of entering foster care that are not currently receiving ongoing services through the child welfare or juvenile justice systems and to their parents or kin caregivers.

SECTION 1. Service Description and Oversight

A. Service Categories

The Utah Department of Human Services will provide services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregiver's needs for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. Categories of prevention services and programs include:

Mental Health and Substance Abuse Prevention and Treatment Services

Approved, evidence-based mental health and substance abuse prevention and treatment services will be provided by a qualified clinician to a child or to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was

identified as a “child who is a candidate for foster care” in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

In-Home Parent Skill-Based Programs

Approved, evidence-based in-home parent skill-based programs will be provided to a child and to the child’s parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a “child who is a candidate for foster care” in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

B. Outcomes

Providing evidence-based prevention services and programs to families in Utah is expected to improve specific outcomes for children and families.

The evidence-based services that Utah has included in this plan, in combination with services under review for future amendments to this plan, have been carefully mapped to the needs of children and families throughout the state. This assessment has included extensive stakeholder input with significant consideration for contextual factors, such as the presence and adequacy of services in other systems addressing these needs.

The evidence-based programs in our plan are expected to improve outcomes for children and families in the following areas specific to our assessed needs:

- Improved parenting behaviors.
- Improved parenting knowledge.
- Improved emotional responsiveness.
- Improved parent/caregiver collaboration.
- Reduction in family conflict and improved skills in resolving family conflict.
- Reduction in symptomatic problem behavior exhibited by children and adolescents.
- Reduction in recidivism by adolescents.
- Reduction in substance abuse.
- Reduction in child maltreatment.
- Reduction in other mental health symptoms, including especially trauma, anxiety and depression.

Overall, we expect that the outcomes provided by the evidence-based prevention services and programs will ultimately result in parents being able to safely care for their children in their own homes or with kin, thus preventing unnecessary foster care placements.

C. Evidence-Based Services and Programs

The evidence based services and programs selected for Utah's five-year Title IV-E Prevention Plan are listed in the tables below.

Service	<i>Functional Family Therapy (FFT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	<p>FFT is a new service being implemented in Utah. To implement, the following steps are being completed:</p> <ul style="list-style-type: none">• Contract with FFT Certified Trainers to provide training to five identified sites, preferably three urban and two rural, in order to establish a network of providers credentialed to provide FFT.• Work with FFT trainers to identify start up resources necessary to support implementation.• Have providers apply for acceptance into FFT and, when accepted, offer funding for start-up resources.• Fund and host training sessions for prospective FFT providers.• Grant funds for start-up costs to new providers, which may include training costs for each site for the first 2 years, access to Youth Outcomes Questionnaire (YOQ) assessment protocols, and technology resources unique to FFT.• Establish contracts with qualified providers, using specific FFT enhanced rates and billing codes to capture required client and payment data.• Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas.• Train caseworkers on FFT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers. <p>The following steps will be completed to monitor for fidelity and to determine and use outcomes data to improve practice:</p> <ul style="list-style-type: none">• Include language in contracts that requires providers delivering FFT to complete FFT site certification protocols, per the developer's requirements.• Conduct ongoing contract monitoring to ensure the providers' fidelity and progress measures meet the standards established by

	<p>the FFT program developer.</p> <ul style="list-style-type: none"> Initiate CQI protocol to clarify problem, outcomes, data measures, and theory of change; monitor implementation; measure outcomes; provide feedback; and adjust intervention as needed. Interview FFT providers during annual DHS Qualitative Case Reviews conducted in each region, when applicable in-home cases are being reviewed. Collect and analyze data for outcome and process measures and for required reporting. Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	<ul style="list-style-type: none"> A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. Based on input from each of these sources, DHS selected FFT as an intervention to be included in the prevention service array.
Target Population	FFT is intended for 11 to 18 year old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DHS is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of

	Evaluation Requirement for a Well-Supported Practice, with supporting documentation.
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Service	<i>Parent Child Interaction Therapy (PCIT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	<p>PCIT is a new service to be offered through contracts by DHS in Utah. To implement, the following steps are being completed:</p> <ul style="list-style-type: none"> • Contract with PCIT Master Level trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of providers credentialed to provide PCIT. • Work with PCIT Master Level trainers to identify start up resources necessary to support implementation. • Have providers apply for acceptance to participate in state-sponsored training for PCIT. • Fund and host training sessions for prospective PCIT providers. 23 clinicians participated in the first PCIT training session. • Explore options and capacity to grant funds for start-up costs to new providers, which may include technology resources unique to PCIT. • Establish contracts with qualified providers, using specific PCIT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PCIT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers. <p>The following steps will be completed to monitor for fidelity and to determine and use outcomes data to improve practice:</p> <ul style="list-style-type: none"> • Include language in the contracts that requires providers delivering PCIT to complete training protocols, per the developer's requirements, including clinician supervision. • Conduct ongoing contract monitoring to ensure the provider's fidelity to the model and progress measures meet the standards established.

	<ul style="list-style-type: none"> • Initiate CQI protocol to clarify problem, outcomes, data measures, and theory of change; monitor implementation; measure outcomes; provide feedback; and adjust intervention as needed. • Interview PCIT providers during annual DHS Qualitative Case Reviews conducted in each region, when applicable in-home cases are being reviewed. • Collect and analyze data for outcome and process measures and for required reporting. • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	<ul style="list-style-type: none"> • A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. • Based on input from each of these sources, DHS selected PCIT as an intervention to be included in the prevention service array.
Target Population	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process)	DHS is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

Service	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	<p>TF-CBT provided as a discrete service through contracts is new for DHS. To implement, the following steps are being completed:</p> <ul style="list-style-type: none"> • Contract with TF-CBT Certified trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of providers credentialed to provide TF-CBT. • Have providers apply for acceptance to participate in state-sponsored training for TF-CBT. • Fund and host training sessions for prospective TF-CBT providers. 20 clinicians participated in the first TF-CBT training session. • Establish contracts with qualified providers, using specific TF-CBT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on TF-CBT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers. <p>The following steps will be completed to monitor for fidelity and to determine and use outcomes data to improve practice:</p> <ul style="list-style-type: none"> • Include language in the contracts that requires providers delivering TF-CBT to complete training protocols, per the developer's requirements, including clinician supervision. • Conduct ongoing contract monitoring to ensure the provider's fidelity to the model and progress measures meet the standards established. • Initiate CQI protocol to clarify problem, outcomes, data measures, and theory of change; monitor implementation; measure outcomes; provide feedback; and adjust intervention as needed. • Interview TF-CBT providers during annual DHS Qualitative Case Reviews conducted in each region, when applicable in-home cases are being reviewed. • Collect and analyze data for outcome and process measures and

	<p>for required reporting.</p> <ul style="list-style-type: none"> Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	<ul style="list-style-type: none"> A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. TF-CBT was one of the services that more providers had familiarity with and/or had received training in. Based on input from each of these sources, DHS selected TF-CBT as an intervention to be included in the prevention service array.
Target Population	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process)	The evaluation of TF-CBT will be under the direction of the Management Information Center (MIC), an independent research team within DHS. This team has the capacity to design, lead, carry out, document, and communicate evaluations of EBP, and possesses expert knowledge of evaluation design and methodology. These data-analytics experts will partner with DHS clinically trained staff, who will provide context, as a TF-CBT evaluation plan is designed. The evaluation will be conducted internally by DHS staff or through

	partnership with university researchers. See also Section 2, Evaluation Strategy.
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Service	<i>Parents as Teachers (PAT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	<p>Parents as Teachers programs have been used for primary prevention in a limited number of sites in Utah, but generally have not served at-risk children and families involved with DCFS who will qualify as prevention candidates. To implement as a service under Utah's Title IV-E prevention plan, the following steps are being completed:</p> <ul style="list-style-type: none"> • Determine interest and contract with local health departments and other sites that are current PAT affiliates to expand their population served to include prevention candidates. • Identify local health departments or other sites that are willing to become PAT providers and assist in standing up the program (by helping fund initial trainings, affiliation costs, etc.). • Create an expansion plan to develop PAT programming in rural areas through the local health departments or other community providers • Establish contracts with qualified providers, using specific PAT rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PAT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers. <p>The following steps will be completed to monitor for fidelity and to determine and use outcomes data to improve practice:</p> <ul style="list-style-type: none"> • Include language in the contract that requires providers delivering PAT to become affiliates, per the developer's requirements. • Conduct ongoing contract monitoring to ensure the provider's fidelity to the model and progress measures meet the standards established.

	<ul style="list-style-type: none"> • Initiate CQI protocol to clarify problem, outcomes, data measures, and theory of change; monitor implementation; measure outcomes; provide feedback; and adjust intervention as needed. • Interview PAT providers during annual DHS Qualitative Case Reviews conducted in each region, when applicable in-home cases are being reviewed. • Collect and analyze data for outcome and process measures and for required reporting. • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	<ul style="list-style-type: none"> • A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. The number of children served in DCFS in the 0-5 age range supported targeting services to this age group. • PAT was already available in the state in some capacity, including DCFS contracts funded by CBCAP. • Local health departments are available in all areas of the state, including rural and frontier areas, and have shown in some areas that this service is a good match for their structure. • Based on input from each of these sources, DHS selected PAT as an intervention to be included in the prevention service array.
Target Population	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population.
Assurance for Trauma-	See Attachment III, State Assurance of Trauma-Informed Service-

informed Service Delivery	Delivery
How Evaluated (Well-Designed and Rigorous Process)	DHS is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

SECTION 2. Evaluation Strategy and Waiver Request

Evaluation Strategy

The Utah Department of Human Services (DHS) will utilize the evaluation strategy described below to ensure that evidence-based prevention programs and services, for which no evaluation waiver has been granted, are evaluated through a well-designed and rigorous process. DHS is implementing rigorous program evaluation to ensure that services the state is investing in under the Title IV-E Prevention Plan are benefiting children and families. Administrators, policymakers, service providers, and other stakeholders want to know what programs and services are accomplishing, what they cost, and how they should be operated to achieve the best possible outcomes.

Program evaluations will be conducted under the direction of the DHS Management Information Center (MIC). The MIC is an executive research team of six analysts consisting of the director and five research consultants whose education and experience qualify them as professional analysts of complex and critical program evaluation. There are three levels of research consultants at the MIC including entry-level with bachelor's level education and/or up to two years' experience as an analyst, researcher, and/or statistician; working-level with master's level education and/or up to six years' experience as an analyst, researcher, and/or statistician; and senior-level with PhD level education and/or more than six years' experience as an analyst, researcher, and/or statistician. All research consultants are trained on systematic standards and procedures of program evaluation. The MIC has the capacity to design, lead, carry out, document, and communicate evaluations of EBP, and possesses expert knowledge of evaluation design and methodology. These data-analytics experts will partner with DHS clinically trained staff, who will provide context, and may also partner with university researchers as evaluation plans are designed. Evaluations will be conducted internally by DHS staff or through partnership with university researchers.

A well-designed, rigorous evaluation plan will be developed for each program or service approved in Utah's Title IV-E Prevention Plan for which no evaluation waiver has been granted. The evaluation type and design will be based on the desired purpose for each individual study, e.g., how to operate to achieve the best possible outcomes, determining cost effectiveness, or adding to the body of evidence as a means to increase the evidence-level rating. The scope of

each DHS evaluation plan will take into account existing evaluation activities or measures being completed by service or program developers, and may result in a request to the Secretary for approval for participation in an ongoing, cross-site evaluation.

The first two years of Utah's implementation of FFPSA will focus on formative evaluations to establish fidelity in service delivery, as evidence-based programs are being newly installed in the state. The first of these formative program evaluations is planned for Trauma-Focused Cognitive Behavior Therapy (TF-CBT). Starting in October 2019, the details for the evaluation plan will be confirmed, and formative evaluation readiness activities will begin, such as identifying contextual factors; developing theory of change and logic model; identifying operational factors such as organizational drivers, leadership support, and competency factors; determining availability and strength of a coaching or support system for providers; identifying data capacity and sources for collection; and conducting usability testing. The evaluation plan will include specific time frames, roles, and measures for ongoing evaluation. A baseline evaluation is anticipated to begin in February 2020. Later, reviews and studies for EBPs may transition to summative evaluations directed at analyzing client outcomes.

The following key components will be considered in developing well-designed, rigorous evaluation plans for specific evidence-based programs or services.

Program or Service Background

Provides context of the current situation to better understand the need for the intervention and its objective

- Describe the treatment or intervention, the target population, and the goal or desired outcome.
- Articulate the theory of change. Define the key issues/problems the intervention seeks to address; and theoretical or causal links between intervention activities and expected changes. State the key questions the research or study will address.

Evaluation Design

Communicates the framework or process to be followed

- Determine the type of evaluation (process, outcome, or cost).
- List relevant performance targets and associated indicators/measures.
- Define the sources and methodologies for measures.
- Describe the research design (RCT, QED/propensity scoring, etc.), if applicable, and/or provide the evaluation criteria and procedures for review.
- Map the process using a logic model and specify short- and long-term outcomes.

Data Collection

Provides the raw material needed to calculate results and to assess program effectiveness

- Confirm that all indicators are noted on the logic model.
- Ensure indicators are discrete and quantifiable.
- List and explain tools, instruments, and/or other methods of data collection.

- Determine frequency intervals for extraction.
- Develop a sampling plan, if appropriate.

Data Analysis

Cleanses, transforms, and models data to confirm whether the intervention fulfills its purpose

- For quantitative data, describe specific statistical methods to be used to analyze data. Identify statistical software applications and packages, and strategies to address anomalies (outliers, missing data, etc.). Describe how results will be presented to mitigate bias and to ensure objectivity.
- For qualitative data, describe analysis methods to be used to analyze qualitative data. Indicate strategies to minimize personal bias of observers/data collectors.
- Describe how results are validated using multiple data sources to corroborate accuracy.
- List potential confounding factors and efforts to manage effects.
- Articulate potential weaknesses or limitations in the selected research design and explain how these will be addressed or minimized.

Distribution of Reports and Use of Findings

Promote transparency and make information about programs and services available to the public

- Identify appropriate reports and level of detail for different audiences.
- Indicate the frequency and format of methods for communicating evaluation findings.
- Describe plans for disseminating evaluation findings.
- Explain whether and how findings that emerge during the evaluation will inform intervention activities and program/organizational improvements (e.g., continuous quality improvement plan).

Logistics

Coordinate staffing, timelines, budgets, and other infrastructures needed to perform program and service evaluations

- Staffing. Determine the level of staffing resources needed. Describe the evaluation roles and responsibilities of staff and others. List their relevant knowledge, skills, and experience. Identify entities/organizations outside the core evaluation team that will be involved in the evaluation and specify their roles and responsibilities. Utah is still exploring whether some evaluation functions will use external consultants.
- Timelines. Provide a timeline that specifies the estimated start and end dates of all major evaluation activities, including initial planning and startup, staff recruitment and training, IRB approval, instrument development, data collection, data analysis, submission of reports, and other dissemination activities.
- Budget. Estimate costs for staff salaries, administrative overhead, external consultants, data collection, statistical software, printing, supplies, equipment, or other expenses.
- Data security, informed consent procedures, and institutional review board (IRB) approval. Describe protocols for maintaining the security and confidentiality of electronic and hard-copy data sources. Determine procedures for obtaining informed consent, as needed.

Identify the IRB that will review and approve the evaluation and associated research activities including the process for obtaining IRB approval.

Waiver Request

DHS is submitting Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice, for the following well-supported services for which the evidence of the effectiveness of the practice is compelling. Documentation of that evidence is also attached.

- Functional Family Therapy.
- Parent Child Interaction Therapy.
- Parents as Teachers.

In addition, with each request for a waiver of an evaluation, DHS has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II), including:

- How the State plans to implement the services or programs.
- How implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved.
- How information learned from the monitoring will be used to refine and improve practices.

SECTION 3. Monitoring Child Safety

A. Periodic Risk Assessment

DCFS will monitor and oversee the safety of children who receive prevention services under Utah's Title IV-E prevention plan. Children's safety is paramount and is central to child well-being. Children must be protected from the trauma of abuse and neglect. When safe to do so, children must also be protected from the compounding trauma of separation from their families by effectively utilizing prevention services. Assessing safety and risk is an ongoing process throughout the entire in-home services case.

DCFS uses a variety of tools and practices to assess and monitor the safety of children receiving prevention services. Structured Decision Making (SDM) tools are used to assess and monitor the safety and risk of children and families. The SDM Safety and Risk Assessments are used to:

- Help determine which families are appropriate for prevention services.
- Assist with the development of safety plans.
- Identify the level of intensity needed for intervention with a family, including how frequently the family needs to be seen.
- Determine when it is appropriate to recommend closing an in-home services case.

SDM Safety Assessment

The SDM Safety Assessment is used to identify possible threats to a child's safety and what interventions are necessary to protect a child from threats to their safety. The final outcome of the SDM Safety Assessment helps guide the decision about the need for ongoing intervention with the family. Interventions may include a safety plan that is implemented immediately to

control or mitigate the identified threat. The caseworker will complete an SDM Safety Plan for all children in the household when any threat to safety has been identified.

When an in-home services case is opened as a result of a child protective services (CPS) case, the CPS caseworker will complete the initial SDM Safety Assessment prior to referring the case for in-home services. If the in-home services case is not the result of a CPS case, the caseworker will complete the SDM Safety Assessment. The initial SDM Safety Assessment is required during the first face-to-face contact with the children. The SDM Safety Assessment is completed on each household.

Assessing child safety is a critical consideration throughout DCFS involvement with the family. Threats to safety will be evaluated during each contact with the family, and an SDM Safety Assessment will be completed whenever a change in the family's circumstances poses a safety concern, prior to removing from or returning a child home, or prior to an SDM Safety Plan being changed or concluded.

A final SDM Safety Assessment is required prior to closure of an in-home services case at the final face-to-face contact with the family. Resolution of any identified safety threat must be documented in the case record.

SDM Risk Assessments

Initial and ongoing assessment of risk is another key component of prevention services. The SDM Risk Assessment and SDM Risk Reassessment are used to help identify the level of risk of future maltreatment.

When an in-home services case is opened as a result of a CPS case, the CPS caseworker completes the initial SDM Risk Assessment prior to referring the case for in-home services. If the in-home services case is not the result of a CPS case, the caseworker will complete the SDM Risk Assessment.

The initial SDM Risk Assessment is required within 45 days of the case open date and before the creation of the Child and Family Plan. The SDM Risk Assessment rating defaults to "very high" until the SDM Risk Assessment has been completed. The SDM Risk Assessment is completed on each household.

The SDM Risk Reassessment is used to determine if the likelihood of future harm has been sufficiently reduced to support case closure or if the family will continue to receive services.

The SDM Risk Reassessment is completed or updated at a minimum of every six months. An SDM Risk Reassessment needs to be completed sooner if there are new circumstances or new information that would affect risk.

Client Contacts

Client contacts are used to help monitor safety and ongoing assessment of risk. Regular and purposeful visiting with the child and family enables the caseworker to assess how well the parents and other caregivers are meeting the children's needs for safety and well-being, as well as the family's progress towards case goal achievement. Private conversations with the children outside the presence of the caregiver are used as part of the ongoing monitoring of the child's safety.

Client contacts and home visiting standards for each case are determined based on the outcome of the SDM Risk Assessments. The SDM Risk Assessment makes the initial determination of the frequency of contact. When a Risk Reassessment is completed, the new risk level guides minimum contact standards that remain in effect until the next reassessment is completed. The contact matrix below specifies the frequency of contacts associated with each risk classification.

Ongoing Worker Minimum Contact Guidelines for In-home Services		
Risk Level	Caregiver and Child Contacts	Location
Low	One face-to-face per month with caregiver and child	Must be in caregiver's residence
Moderate	Two face-to-face per month with caregiver and child	One must be in caregiver's residence
High	Three face-to-face per month with caregiver and child	One must be in caregiver's residence
Very High	Four face-to-face per month with caregiver and child	Two must be in caregiver's residence
Additional Considerations		
Contact Definition	Each required contact shall include at least one caregiver and one child. During the course of a month, each caregiver and each child in the household shall be contacted at least once.	

Designated Contacts	<p>The ongoing worker/supervisor/service team may delegate face-to-face contacts to providers with a professional relationship to the agency and/or other agency staff, such as social work aides. However, the ongoing worker must always maintain at least one face-to-face contact per month with the caregiver and child, as well as monthly contact with the service provider designated to replace the ongoing worker's face-to-face contacts.</p>
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DJJS also monitors youth safety on an ongoing basis through caseworker contacts with youth and families. In addition, when family conflict is identified as a need through the UFACET, a safety plan is established with the family to provide for temporary crisis support for the youth away from the residence when needed for youth or parent safety.

B. Prevention Plan Review

Prevention plans are routinely reexamined to help monitor and track the child and parent or kin caregiver's progress during the provision of services. The written plan is developed with input from the Child and Family Team, and is tracked and adapted throughout the case. All parents and kin caregivers will have the opportunity to participate in the development and reexamination of the written plan. All children listed on the plan who are developmentally appropriate will have the opportunity to participate in the development of the plan to the degree that they are capable of contributing. The Child and Family Team should include the family's formal and informal supports, including service and treatment providers. Updated UFACET and SDM risk assessments may be used to inform the plan review. The written plan will be reviewed as needed, and updated at a minimum of every six months.

SECTION 4. Consultation and Coordination

A. Consultation

The Department of Human Services has consulted with other state agencies responsible for administering mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services. DHS established a steering committee to oversee and guide overall implementation of provisions of the Family First Prevention Services Act. The steering committee consists of members of executive leadership within the department, including the executive director, and directors of multiple divisions and offices within the department, and other key staff. A parent representative also participated in meetings of the steering committee.

The steering committee created several multi-agency committees to address implementation of the Family First Prevention Services Act. Multi-agency committees have included state office and regional office representatives from the Division of Substance Abuse and Mental Health, the Division of Services for People with Disabilities, Division of Juvenile Justice Service, System of Care, the Division of Child and Family Services, the Office of Quality and Design, and Office of

the Attorney General. Multi-agency committees also consulted with additional state agencies, community organizations, private providers, and EBP developers and trainers.

In-person meetings were held with community providers in order to gain their feedback. A statewide provider survey was conducted asking about availability of current services and interest in being trained in approved EBPs. DHS has also met with the Department of Health Office of Home Visiting to assist with aligning services for at risk families, without duplicating efforts, and has consulted with the DOH Medicaid office on FFPSA related issues.

Consultation efforts helped guide selection of the service array for the Utah's Title IV-E Prevention Plan, and will continue to guide development of a continuum of mental health and substance abuse prevention and treatment services, and in-home parent skill-based programs, to be added through future plan amendments.

B. Coordination

Services provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with services provided under Title IV-B Parts 1 and 2 of the Social Security Act. Title IV-B Part 1 funds are primarily used for child welfare caseworker costs. In this capacity, these funds support critical activities essential to caseworker activities with children and families. Title IV-B Parts 2 funds were shifted during the IV-E waiver to maximize support for HomeWorks implementation, and will continue to be used post-waiver to support in-home and prevention services goals, within allowable funding parameters, to strengthen parents' capacity to safely care for their children and safely reduce the need for foster care.

The proportion of PSSF funds allocated to Family Preservation will continue to exceed the minimum proportion requirement of 20%, which will enable caseworkers to have additional resources beyond specific prevention EBPs available to support families, such as for a family's concrete needs such as assistance with rent or utilities or other one-time costs. PSSF Family Support funds will continue to be allocated to support expansion or start-up of additional services for community services that may not yet be available as EBPs under the clearinghouse. PSSF Adoption Promotion and Support Services funds may be used for post-adoption services outside of the EBP service array that help prevent reentry of children into foster care. PSSF Family Reunification funds may be used to help facilitate return of a child home from foster care, after which the child may be identified as a prevention candidate and receive supportive EBP services under Title IV-E and non-EBP resources under PSSF within the allowable funding period to safely sustain the child at home.

SECTION 5. Child Welfare Workforce Support

In Utah, child welfare and juvenile justice services are state administered and state supervised. Both DCFS and DJJS are committed to supporting and enhancing a competent, skilled and professional workforce, and providing state agency supports to staff working in field offices throughout the state.

Frontline caseworkers have the support of supervisors, mid-level managers, and local level administrators, in addition to statewide leadership at both the division and department levels. One of the DCFS overarching Practice Model Principles is Organizational Competence, which is that “Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, helps ensure positive outcomes for children and families.”

DCFS and DJJS also have state agency training teams that support development of competency and skills of the workforce in delivering quality casework and trauma-informed and evidence-based services.

For DCFS, all training provided by DCFS to employees, providers, and families is based on the DCFS Practice Model, the foundation on which all policies, procedures, programs, and services are anchored. This model provides caseworkers a structure for approaching work with children and families. Practice Model Principles include protection, development, permanency, cultural responsiveness, partnership, organizational competence, and professional competence.

The Practice Model Principles are at the core of the five Practice Skills, which constitute the framework for all agency training. The five Practice Skills are designed to “put the agency’s values into action” and are universally applied by workers across all of the division’s programs and services. The Practice Model Skills include engaging, teaming, assessing, planning, and intervening.

Workforce skills are assessed and strengthened through the support of supervisors, trainers, and administrators, and are also measured and reinforced through qualitative case review and quantitative case process reviews. Department operational excellence initiatives that are currently underway will also provide support to workers to enhance quality casework and focus caseworker time on critical case activities most important to help achieve positive outcomes for children and families.

All of these state agency supportive activities will enhance implementation of the Title IV-E Prevention Plan, by ensuring that the workforce is qualified, and that caseworkers develop appropriate prevention plans and conduct risk assessments to ensure ongoing child safety.

SECTION 6. Child Welfare Workforce Training

DCFS and DJJS are committed to having a prepared, well-trained workforce. Both agencies provide training and support for caseworkers in assessing what children and their families need, connecting to families served, knowing how to access and deliver needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services.

In DCFS, casework for prevention services aligns with the practice model, which focuses on the skills of engaging, assessing, teaming, planning, and intervening. As such, DCFS training for caseworkers for prevention services will serve as a reinforcement of training for overall good case practice.

Caseworker training addresses engaging families in a trauma-informed way to conduct safety and risk assessments using SDM and to assess overall family strengths and needs with UFACET. For prevention training, additional emphasis will be given to incorporating those assessed needs into the written prevention plan in a way that identifies the strategy to allow the child to remain safely at home or with a kin caregiver, and connecting to appropriate evidence-based trauma-informed services and programs. The training will reinforce the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the importance and priority of kinship placement in the event a child cannot safely remain at home.

Prevention training will be provided to existing caseworkers, supervisors, and administrators at the local level. The prevention services concepts will also be incorporated into new employee Practice Model training, which will include in-class training, simulation training, and field experience.

Additional resources will also be provided to caseworkers for each of the specific evidence-based mental health, substance abuse, and in-home parent skills services included in Utah's Title IV-E Prevention Plan to help workers understand the service target population, needs the service addresses, and availability.

In DJJS, core trainings and support provided to all Youth Services workers will also address and reinforce requirements for prevention services.

Caseworker training will address assessment of youth and family strengths and needs with the UFACET, and will also address identifying risk and protective factors using the Protective and Risk Assessment (PRA). Training will also be provided on case planning, which focuses on skills needed to engage with a youth and family, reducing risk through building skills and assisting the youth to remain or transition back into their community. Casework skills will be further strengthened with training on Motivational Interviewing and High Fidelity Wrap-Around. Supervisors will provide feedback of critical Youth Services processes. Supervisors will observe and rate the worker's use of motivational interviewing skills with youth and families, assessment scoring, coordination of child and family team meetings, and developing Youth and Family Plans.

SECTION 7. Prevention Caseloads

DCFS and DJJS have established processes to determine, manage, and oversee caseload size and type for prevention caseworkers.

In DCFS, prevention cases will be managed by region caseworkers with “ongoing services” caseloads. Ongoing services refer to both in-home cases and foster care cases. Prevention services are a component of in-home services. Whenever possible within existing region and office staff resources, specialization is encouraged. For example, in larger offices, some teams will specialize in managing in-home cases. Some smaller offices will have individual workers that specialize in managing in-home cases. In more rural, smaller offices, ongoing workers that manage combined in-home and foster care cases will be assigned prevention cases. Administrative costs related to mixed caseloads will be differentiated through the cost allocation process. The target caseload standard for caseworkers managing prevention cases is a ratio of 1:12 for DCFS.

Overseeing caseload size and type is essential. Manageable caseloads and workloads can make a significant difference in a caseworker’s ability to spend adequate time with children and families and on completing critical case activities, and ultimately having a positive impact on outcomes for children and families. One of our strategies to make caseloads and workloads more manageable is use of a workload report that is available to region staff. The formula used in the report converts “caseload” to “workload.” Caseload is defined as the number of cases (children or families) assigned to an individual worker in a given time period. Workload is defined as the amount of work required to successfully manage assigned cases and bring them to resolution. Supervisors and region administrators are able to consider both caseload and workload when new case assignments are given and in monitoring child and family progress and overall worker progress. Successfully managing caseworkers’ workload can help caseworkers be in a position to better serve the children and families on their caseload.

DCFS state administration and region administration will continue to provide oversight to the caseload size and case type for caseworkers. The state Data Administrator provides monthly data reports to state and region administrators. Reports include information about caseloads, and new and closed cases for CPS, foster care, and in-home services cases, which will include prevention candidates. Each of the state’s five regions has a practice improvement coordinator that monitors region and team specific caseload data, including overall number of cases and the different case types.

JJS has Youth Services Centers located at multiuse facilities throughout the state. Prevention cases will be managed by Youth Services administration and workers. JJS will be implementing a team approach to the prevention caseload. A team will consist of one Supervisor/Coach, two Youth Service workers/facilitators, and two or three Peer Support workers. One team can manage a caseload of up to twenty-five families. In rural areas, a team may have a reduced number of Youth Services workers and Peer Support workers based on the need of the community. Caseload oversight and targeted outcomes will be reviewed on a regular basis by the local facility Assistant Program Director and by the JJS Executive Management Team.

SECTION 8. Assurance on Prevention Program Reporting

The Utah Department of Human Services provides an assurance in Attachment I that DHS will report to the Secretary required information and data with respect to the provision of services and programs included in Utah's Title IV-E Prevention Plan. This will include data necessary to determine performance measures for the state and compliance. Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019. See Attachment I, State Title IV-E Prevention Program Reporting Assurance.

SECTION 9. Child and Family Eligibility for the Title IV-E Prevention Program

Child and family eligibility for the Title IV-E Prevention Program is based on a child being at imminent risk of entry into foster care, but able to safely remain at home or in a kinship placement with receipt of approved evidence-based services under the child's prevention plan. For the purpose of this document, the term "prevention candidate" is equivalent to the Federal term "child who is a candidate for foster care" and the term "serious risk" is equivalent to the Federal term "imminent risk."

A child in foster care who is a pregnant or parenting foster youth is also eligible for prevention services under the Title IV-E Prevention Program.

A. Prevention Candidate Definition

For the purposes of the Title IV-E Prevention Program, a child under age 18 is a prevention candidate when at serious risk of entering or reentering foster care, but able to remain safely in the home or kinship placement as long as mental health, substance use disorder, or in-home parenting skill-based programs or services for the child, parent or kin caregiver are provided. To be eligible for Title IV-E Prevention Services, the child's prevention candidate status must be designated in the child's prevention plan prior to provision of services. Pregnant or parenting foster youth are also eligible for prevention services when services are designated in the child's foster care plan prior to provision of services.

A child may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of individual parents, children, or kinship caregiver that may affect the parents' ability to safely care for and nurture their children.

Circumstances or characteristics of the child, parent, or kin caregiver that could put children at risk of entering foster care may include:

- Child maltreatment, including abuse or neglect

- Substance use or addiction
- Mental illness
- Lack of parenting skills
- Limited capacity to function in parenting roles
- Parents' inability or need for additional support to address serious needs of a child related to the child's behavior
- Developmental delays
- Physical or intellectual disability
- Adoption or guardianship arrangements that are at risk of disruption

Kin caregiver defined in Utah Code Section 78A-6-307 includes the child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, stepparent, first cousin, stepsibling, sibling of the child, first cousin of the child's parent, or an adult who is an adoptive parent of the child's sibling.

For the purpose of this plan, kin caregivers may also include individuals that are unrelated by either birth or marriage, but have an emotionally significant relationship with the child that takes on the characteristics of a family relationship.

Also, for Indian children, the definition of kin caregiver under ICWA (25 U.S.C. Sec. 1903) will be utilized, which includes:

- An "extended family member" as defined by the law or custom of the Indian child's tribe or,
- In the absence of such law or custom, a person who has reached the age of 18 and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent, or
- An Indian custodian, as defined by ICWA case law.

Children who are under the placement and care responsibility of the state are, by definition, in foster care and are not prevention candidates when placed with a kin caregiver.

B. Prevention Candidate Determination

Child and family eligibility for the Title IV-E Prevention Program is determined through assessments conducted by caseworkers for the Division of Child and Family Services (DCFS) or the Division of Juvenile Justice Services (DJJS), utilizing designated assessment tools. These assessments (of children identified in a prevention plan) determine if the child is at serious risk of entering foster, but can remain safely in the home or in a kinship placement as long as the title IV-E prevention services that are necessary to prevent the entry of the child into foster care are provided.

DCFS caseworkers assess children and families utilizing safety and risk assessment tools and through a functional assessment, which together identify a child's risk of entry into foster care and the child and family's needs related to mental health, substance abuse, and/or parenting skills.

Structured Decision Making (SDM) Safety and Risk Assessments are utilized during a child protective services investigation or assessment, and identify if a child can remain safely at home with a safety plan, and if families have needs related to substance use, mental health, and/or parenting skills.

The Utah Family and Child Engagement Tool (UFACET) is a functional assessment completed with the family at the beginning of an ongoing case that also informs the prevention candidate determination. UFACET is a CANS/FAST-based assessment developed as part of Utah's Title IV-E waiver project. It has been endorsed by Dr. John Lyons from the Praed Foundation and Chapin Hall.

UFACET is used to create a shared understanding of the reasons for agency involvement and to create plans and strategies to address the concerns assessed. UFACET focuses on the unique dynamics of each family and the role each individual plays in this dynamic. UFACET is comprised of four main sections: (1) Family Together, which focuses on how the family interacts with each other and the family's culture; (2) Household, which focuses on more basic needs such as finances and shelter; (3) Caregiver, in which each caregiver/parent is rated individually on their own strengths and needs related to stress management, parenting skills, mental and physical health, development and trauma; (4) Child, in which each child is rated individually on their own response to stress, social skills, mental health, education, physical health, development, and trauma.

For children placed with a kin caregiver, there is also a Substitute Caregiver section in UFACET with items related to supports the kin caregiver needs in order to maintain the child in the home. The Substitute Caregiver section is completed for each individual kin caregiver.

When needs justify opening a child welfare ongoing in-home services case, the SDM results and UFACET items requiring action are both taken into account to determine if the child is a prevention candidate.

DCFS will develop an individualized Child and Family Plan based on the needs requiring action identified in UFACET and with input of the child and family team. For children that are prevention candidates, evidence based programming in the areas of substance use, mental health, and parenting skills will be incorporated into the Child and Family Plan, which serves as the child's prevention plan. Candidate status is confirmed through finalization of the child's prevention plan.

DJJS caseworkers assess youth and families utilizing UFACET and a risk assessment tool, which identify a youth's risk of entry into foster care and the youth and family's needs related to mental health, substance abuse, and/or parenting skills.

Title IV-E prevention services tie to DJJS implementation of a statewide Youth Services Model to prevent delinquent behavior through positive youth and family development. All youth are screened to identify immediate needs and areas for future assessment. Youth and parents/guardians that move to the Youth Services assessment phase are administered a Utah Family and Children Engagement Tool (UFACET) Screener if the youth has no delinquency history.

If a youth has a prior delinquency history, the youth and parents/guardians will be administered the Protective and Risk Assessment (PRA) and UFACET-Family Focused.

The PRA is used by Utah's juvenile justice system to determine risk to reoffend, need for supervision, protective factors, and need for services. Separate studies showed that youth scoring "low" on the assessments reoffend at a lower rate than youth scoring "moderate", and youth scoring "moderate" reoffend at a lower rate than youth scoring "high." Differences between risk levels for overall, felony, and misdemeanor reoffending were statistically significant for both assessments. With few exceptions, these findings generalize across demographic categories of gender, age at first assessment, minority status, and geographical location (DeWitt & Lizon, 2008 and DeWitt, Wetherley, & Poulson, 2016).

A youth is considered a candidate for foster care when a youth scores "moderate" or "high" on the PRA and is assessed as having one or more risk factors that identify the need for mental health, substance abuse, or in-home parenting skills services. A youth is also considered a candidate for foster care when UFACET-Family Focused items are assessed as requiring action.

DJJS will develop an individualized Youth and Family Plan based on screening results, assessments, and collateral information from allied agencies. For youth that are a prevention candidate, evidence based programming in the areas of substance use, mental health, and parenting skills will be incorporated into the Youth and Family Plan, which serves as the child's

prevention plan. Candidate status is confirmed through finalization of the child's prevention plan.

A child may be reassessed for prevention candidate status at the end of each 12-month prevention episode utilizing the processes described above, based on continuing serious risk for entry into foster care and continuing need for evidence-based prevention services to prevent the entry of the child into foster care. Candidate status is confirmed through a new prevention plan.