Co-Creating the Infrastructure for Implementing Evidence-Based Practice

A Case Study of New York City's Child Welfare Preventive Services

Blueprints Conference

Denver, CO

April 12, 2016

Allison Metz, Ph.D., Director
National Implementation Research Network
Senior Scientist, FPG Child Development Institute
University of North Carolina, Chapel Hill

David Collins, Asst. Vice President
The Children's Village

nirn National Implementation Research Network

Goals for Today

- **Set the stage for New York City's Preventive EBM initiative**
- **Describe the necessary infrastructure to support mainstreaming evidence in preventive services**
- **Reflect on early outcomes, next steps & questions**

Preventive EBMs in NYC

- **Starting in 2013, New York City's Administration for Children's Services (ACS) undertook a major overhaul of its preventive services network.**
- **Existing preventive providers had the opportunity to convert from "business as usual" to evidence-based or evidence-informed models within their existing contract awards.**
- **New contracts for a variety of EBMs were awarded in each of the five boroughs.**
- **End result: 3,000+ point-in-time slots using 11 different models with contracted capacity to serve 8,000+ families per year.**

Background: NYC ACS

- Responsible for child protection, child welfare services, juvenile justice prevention and placement, and early childhood care and education in New York City.
- Approximately 6,000 direct FTEs and 75+ contract agencies.
- Investigates 55,000+ allegations of child maltreatment each year.
- 25,000+ annual families served in preventive; foster care population of ~9,800 (down from 49,000+ in 1991).
- Preventive and foster care systems are privately contracted and use a delegated case management approach.
- In contrast to many other child protective jurisdictions in the US, evidence-based preventive models are provided using local child welfare funds, rather than Medicaid or commercial insurance.
- This means that providers of EBMs are also responsible for child welfare case management, and are primarily accountable to ACS for service uptake and outcomes.

Goals of the EBM Initiative

- Improve outcomes: prevent placement, reduce repeat maltreatment, improve family functioning and child wellbeing.
- Reduce the need for out-of-home care by helping parents safely care for their children in the community.
- When children are removed or confined, shorten their length of stay in out-of-home care by providing intensive aftercare services.
- Expand the continuum of available services to better meet the needs of all children and families.

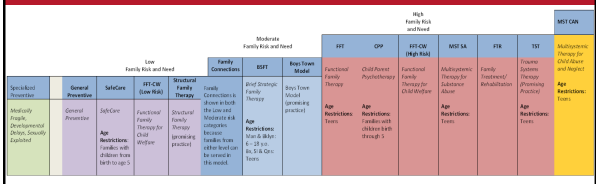
Why Use EBMs?

- **Increasing emphasis in child welfare on data-driven decision-making.**
- **Positive experiences in other settings / pilot programs create shared commitment with major stakeholders.**
- **Preventive EBMs align with emerging consensus on best practice / system design:**
  - Brief, intensive services
  - Treating families in their homes / in their communities
  - Focus on facilitating real change rather than "monitoring" or offering services for services' sake
  - Robust consultation and adherence protocols produce a more skilled and responsive workforce

Pre-Implementation: Model Selection

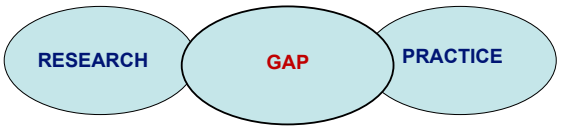
- Conducted National Search / Environmental Scan
  - Few "homegrown" child welfare models; many originate in JJ or MH settings
  - Review evidence base for each model
  - Consider how the developer addresses and supports implementation with provider agencies. What types of assistance do they provide? What do they monitor and emphasize?
- Held an Open House for Model Developers and Provider Agencies
- Post-Selection Analysis of Models Facilitated by NIRN:
  - Strengths / weaknesses in each developer's infrastructure
  - Areas of emphasis relative to implementation drivers
  - Anticipating the nature and intensity of support needed from ACS

EBM Continuum



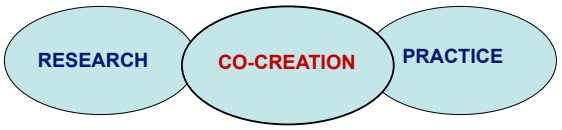
- Models categorized by level of risk / service need; developers and providers were consulted during this process.
- Created a structured decision-making tool for referrals known as the SCI
  - Web-based
  - Includes real-time service availability based on location and model
  - Provides options and allows for supervisory discretion

The Problem with the Research to Practice Gap



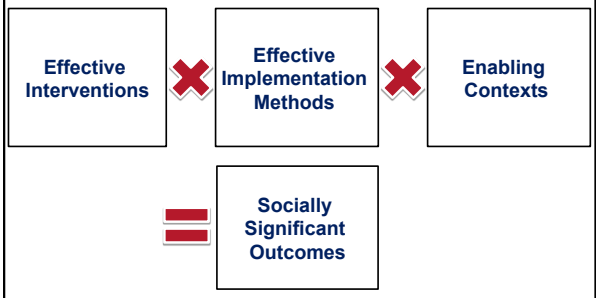
A challenge with this paradigm is the assumption that there is an empty space situated at the nexus of research to practice waiting to be filled, rather than a sphere populated by interconnected stakeholders acting on knowledge and driving decision-making.

Co-Creative Capacity for Implementation



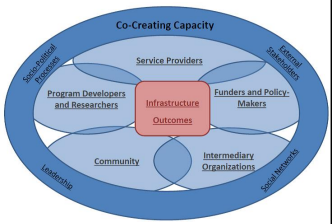
Moving away from the "gap" theory to one of "co-creation" allows for a renewed focus on assessing and understanding how various actors and groups must build trust and pathways for the use of evidence in practice to improve outcomes.

Formula for Success



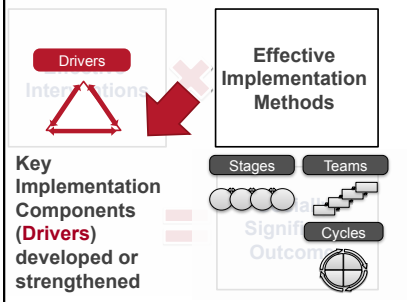
Co-Creating Capacity

Co-Creative capacity refers to deeply involving a range of key stakeholders across scientific, governance, and local practice boundaries to create the infrastructure and context that enables and sustains the use of evidence in practice. (Metz, 2014).



Active Implementation Frameworks

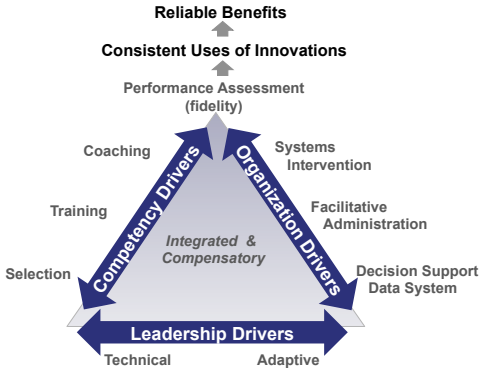
Formula for Success



Key Implementation Components (Drivers) developed or strengthened

nirn | UNC FPG CHILD DEVELOPMENT INSTITUTE

Implementation Drivers



Major Findings

Differences in Supports

Program Experts provide a range of supports

Half of program experts used best practices for all competency drivers

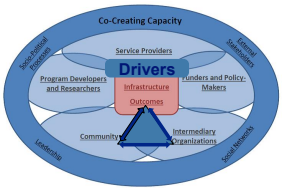
- Interview protocols, prerequisites
- Standard training, tailored supports
- Coach criteria
- Content, competency, fidelity

Most program experts did not use best practices for all organization and systems drivers

- Decision support data system focused solely on practitioner fidelity
- Limited leadership involvement
- Limited used of organizational data for improvement
- Limited policy guidance

nirn | UNC FPG CHILD DEVELOPMENT INSTITUTE

Co-Creating Capacity



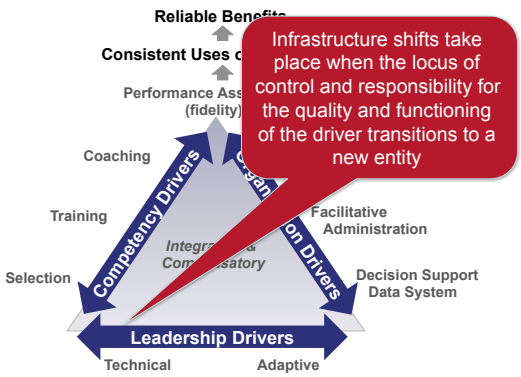
nirn | UNC FPG CHILD DEVELOPMENT INSTITUTE

A Time of Transition

Shifting accountability for the infrastructure

- New administration and leadership
- Program developer supports diminishing or ending
- Monitoring protocols changing
- Formal communication decreasing in intensity
- New efforts to increase buy-in and sustainability

Implementation Drivers



When do these shifts happen?

- **Program developer or purveyor supports diminish**
  - Coaching, fidelity assessments transition to local jurisdiction
- **Research and evaluation funding ends**
  - Decision-support data systems are no longer funded
- **"Special" accommodations end**
  - Planning periods end; integration of new services into overall service system takes place
- **Scaling Up is a focus**
  - The goal is to develop more proximate implementation capacity that is effective, efficient, and integrated; regional or local capacity developed

NYC Example | Role Ambiguity

Stakeholder groups have trouble navigating the complexities of implementation and understanding their roles related to…

Building, sustaining, and improving practitioner competency

Aligning polices and practices

Collecting and using data for improvement

Collaborating, linking and communicating

Navigating authority and making decisions

Attending team meetings and contributing to strategy development

Voicing concerns and sharing what is "not known" or "not understood"

Formula for Success

- Effective collaboration of cross-sector child welfare stakeholders
- Facilitative agency administration (aligned agency policy and procedures)
- Organizational and system structures to support and sustain improvement efforts
- Effective systems interventions (aligned state policy and procedures)
- A commitment to learning and intentional improvement

Enabling Contexts

Stakeholder Roles in Supporting the Use of Evidence

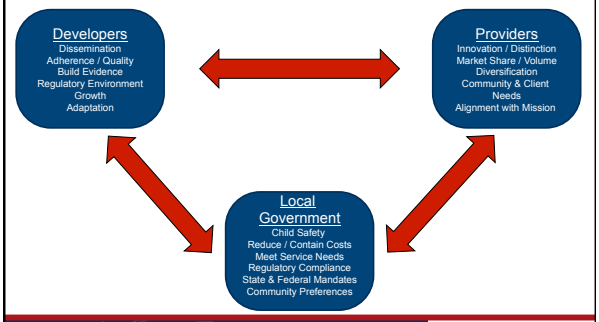
Stakeholder Interactions

Research demonstrates that successful uptake of evidence requires genuine interaction among researchers, service providers, policy makers, and other key stakeholders. Implementation efforts must address the various needs of these stakeholders.

However, we know that in many instances, collaborations among stakeholders, including researchers and community members, are strained by a lack of mutual understanding of each other's goals and expectations.

Through the vantage point of ecological systems theory, we also know that collaborative efforts of stakeholders are influenced by microsystem conditions such as leadership changes and socio-political processes.

Stakeholder Priorities & Shared Interests



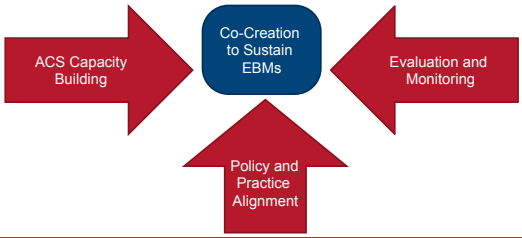
Mutual Consultation

The interactive model includes “iterative, messy, and dynamic” interactions among ACS leadership and staff, evidence-based program developers, and child welfare service providers.

Interactions take the shape of “mutual consultations” that mediate the use of research evidence in complex child welfare service systems and political contexts.

Co-Creative Capacity

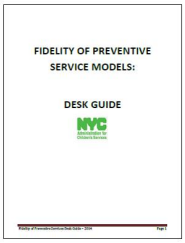
Co-Creating the infrastructure for implementing and sustaining EBMs in a child welfare context



NYC Co-Creation

Fidelity Desk Guide to Align Policy and Practice

- **Summarizes fidelity assessment information across the preventive service program models.**
- **Information used by ACS to interpret fidelity reports, monitor program implementation, and communicate with developers and service providers.**
- **Fidelity measures and thresholds, type of fidelity, data sources, frequency of data collection, reporting, unit of analysis, key domains, developer support**


FIDELITY OF PREVENTIVE SERVICE MODELS:

DESK GUIDE

NYC

NYC Co-Creation

- **Logic Models**
  - **Translate evidence-based models to a child welfare context**
  - **Integrate evidence-based practices with child welfare preventive standards**
  - **Communicate about how evidence-based models contribute to child welfare outcomes**
- **Preventive Standards**
  - **Tailor Systems**
  - **Tailor Models**
- **Sustaining & Integrating Preventive EBMs (SIPE)**
  - **Committee including key staff from child protection, preventive services, policy & planning, etc.**
  - **Developers and providers present case examples and program overviews to give public agency staff a real-world sense of how models meet child welfare goals**
  - **Venue for resolving logistical issues, increasing buy-in, etc.**


CHILD-PARENT PSYCHOTHERAPY

PREVENTIVE STANDARDS inform MODEL ACTIVITIES that are linked to signs of MEASURABLE PROGRESS and OUTCOMES

SAFETY AND RISK

WELL-BEING

CASE MANAGEMENT

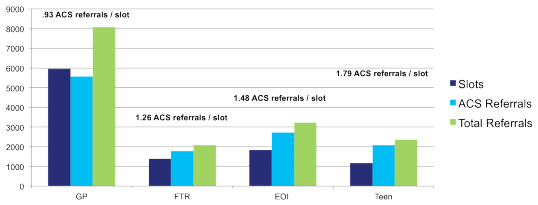
CONSULTATION AND/OR COACHING

SUCCESSFUL COMPLETION

Key Findings

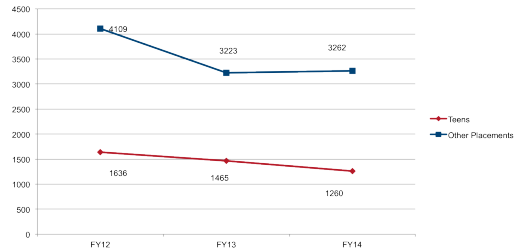
- **Guide to Terminology:**
  - GP : General Preventive (low risk, business as usual)
  - FTR: Family Treatment & Rehabilitation (high risk, BAU)
  - EOI: First wave of EBM contracts, serving families with children of all ages (subject to model age limits)
  - Teen: Second wave of EBM contracts, serving families with at least one teem
- **Average risk / need levels for EBM contracts fall somewhere between those for GP (low) and FTR (high)**
- **Preventive “slots” represent point-in-time capacity to serve 1 family**

Referrals / Service Uptake



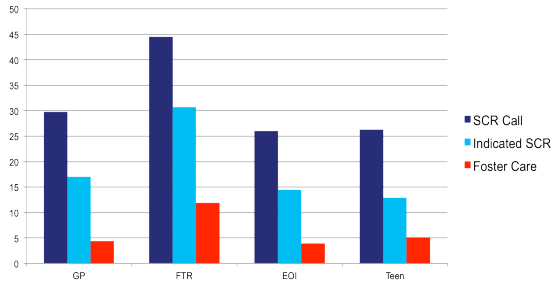
- Unlike many other child welfare jurisdictions implementing preventive EBMs, service uptake is fairly high in the first year.
- The shorter length of service means that EBMs operating at 75% utilization or less can still serve more families than non-EBM programs at 90-95%.
- Because per-slot costs are similar to GP and FTR, this means the cost-per-use of EBMs is also lower.

Teen Placements Declined In Year One of the EBM Initiative

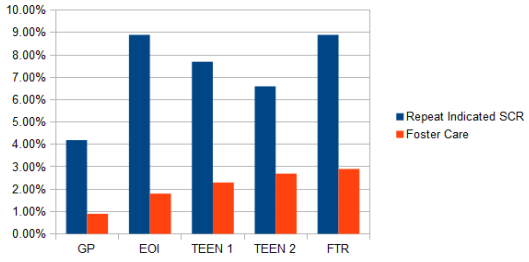


- Teen placements declined by 14% from FY13 to FY14, even though the non-teen placement rate actually went up over the same period.

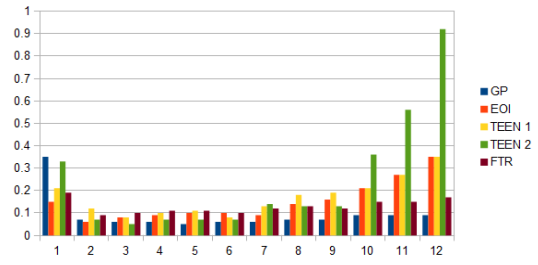
Repeat Maltreatment During Services



Repeat Maltreatment Following Services



Risk of Repeat Report During Services (by Month, 2013 cases)



Research Questions (Process)

Co-Creating the Infrastructure:

•What processes contribute to leveraging relationships among evidence-based program developers, private service providers, and the public child welfare agency to support the use of research evidence?

•How can relationships among evidence-based program developers and researchers, private service providers, the public agency and consumers help to establish the conditions necessary for optimizing and sustaining the use of research evidence after initial implementation supports diminish?

Process / Implementation:

•Examination of employee turnover at provider agencies, and any relationship to developer supports, model requirements, etc.

•How do caseworkers / therapists understand and reconcile their roles as child welfare practitioners and model practitioners? Can we maximize the extent to which they use the latter in service of the former?

•Child and family perspectives on models and providers.

Research Questions (Outcomes)

- More data on repeat maltreatment after case closure
- Further investigate relationship between LOS and repeat maltreatment during services
- Explore perceived causative relationship between increased preventive enrollment & decline in foster care placements
- Explore any potential relationship between model fidelity and case outcomes
- Seek opportunities to match data with other city agencies and systems to monitor long-term wellbeing and quality of life, e.g. shelter and ER utilization, justice system contact, school outcomes, etc.

Right Next Steps

- Form a multidisciplinary Preventive EBM Sustainability Workgroup (implementation team) to lead implementation work in this new phase.
- Promote model mastery and a deep, detailed understanding of model-based change processes and core activities among a broad base of ACS staff.
- Maintain and expand feedback loops (developers, providers, internal and external stakeholders), develop formal communication plans that promote ongoing dialogue.
- Refreshers and expanded / advanced content trainings on EBMs generally, models specifically, and system change issues for ACS staff in various roles.
- Specialized training for ACS' contractor monitoring units related to understanding and monitoring EBMs, managing developer relationships, etc.
- Analyze, revise and validate the SCI tool, and continue to monitor and refine referral process.
- Develop resources that connect underlying logic of EBMs to high quality child welfare outcomes. Create a FAQ document for commonly asked questions regarding policy-practice alignment.
- Collaborate with model developers on research questions and evaluation activities.
- Develop internal capacity to train provider agencies on implementation of EBMs.

For More Information

Deborah Rubien LCSW
Senior Advisor
Division of Policy, Planning & Measurement
150 William Street, 17H1
New York, NY, 10038
Deborah.Rubien@acs.nyc.gov

David Collins
Assistant Vice President
Echo Hills
Dobbs Ferry, NY, 10522
dcollins@childrensvillage.org

For More Information

Allison Metz
allison.metz@unc.edu

National Implementation Research Network

Frank Porter Graham Child Development Institute
University of North Carolina
Chapel Hill, NC

http://nirn.fpg.unc.edu/
www.scalingup.org
www.implementationconference.org