California Family First Prevention Services Continuous Quality Improvement Plan

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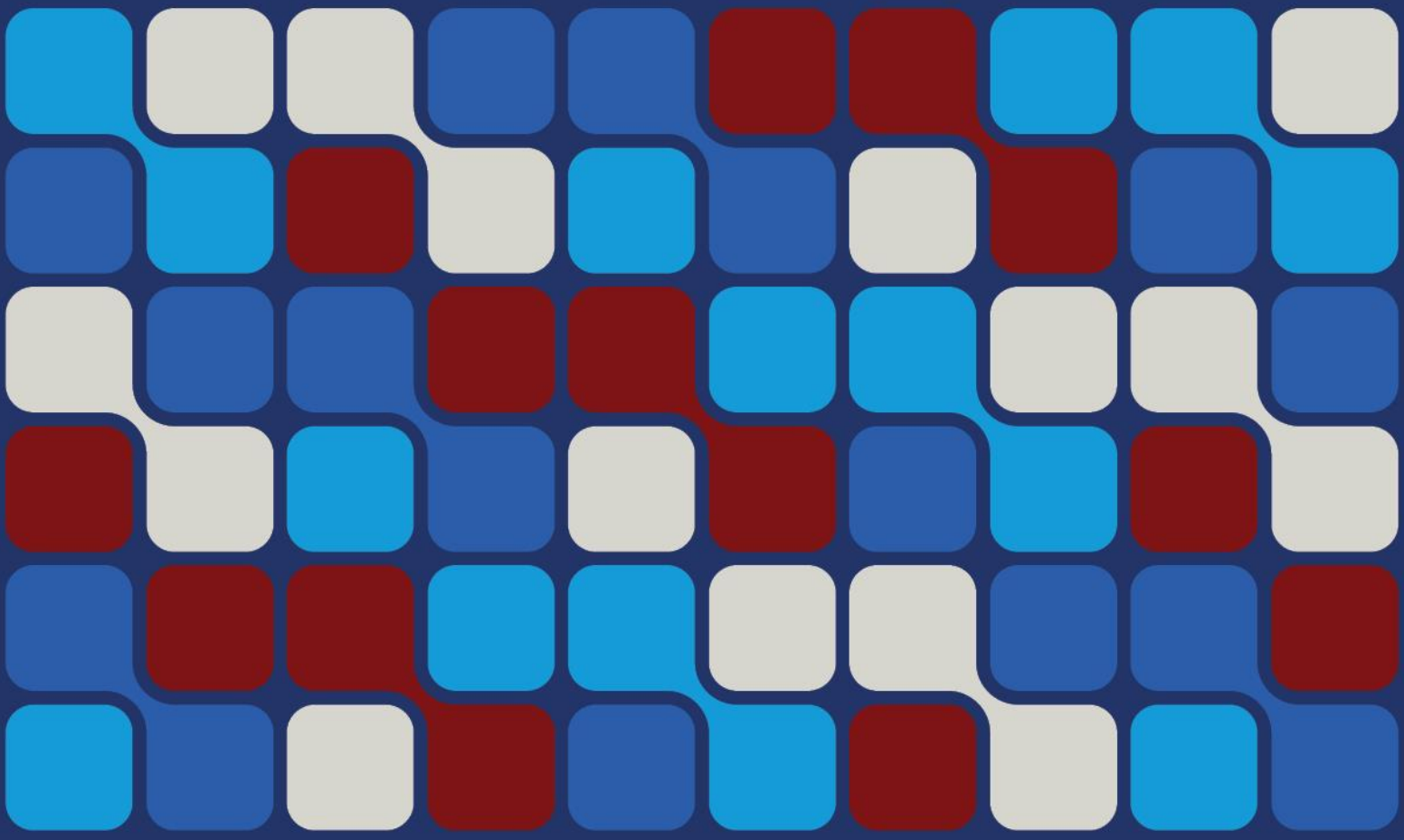

March 2025

Acknowledgements

Thank you to the Family First Prevention Services (FFPS) Leadership Team and the FFPS committees whose contributions have been instrumental in developing this plan. This includes the FFPS Advisory Board, the Prevention Services Continuous Quality Improvement Subcommittee, the Training and Technical Assistance Subcommittee, the Community Pathway Subcommittee, and the IV-E Advisory Subcommittee.

Additionally, thank you to the representatives from the California Department of Social Services (CDSS), including the Children Services Operations Bureau, CDSS FFPS Team, Office of Child Abuse Prevention, Case Review Support Branch, Adoption Services Branch, System of Care Branch, Child Welfare Learning and Evaluation, Office of Tribal Affairs, Family Permanency and Support Branch, and the Child Welfare System Branch. Special thanks as well goes to representatives from the Child Welfare Director's Association and the Child and Family Policy Institute of California. Everyone's dedication and collaboration are essential to achieving meaningful and sustainable improvements.

Disclaimer

The points of view, analyses, interpretations, and opinions expressed here are solely those of the authors and do not necessarily reflect the position of California's Department of Social Services.

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EXECUTIVE SUMMARY

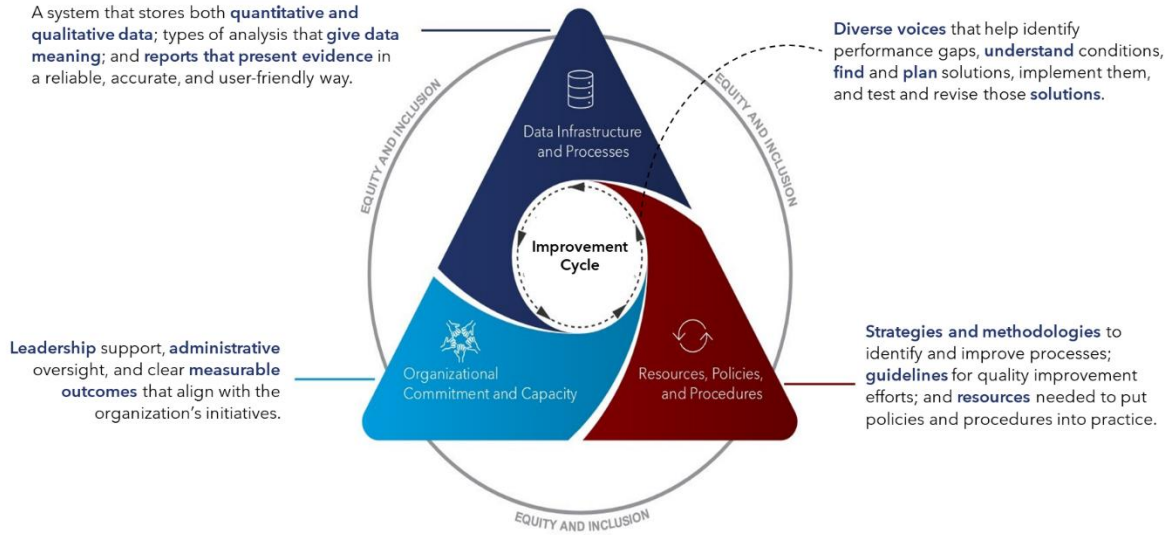
The California Department of Social Services (CDSS) is committed to strengthening the well-being of children, families, and communities through a prevention-focused and equity-driven approach, as outlined in the state's approved Title IV-E Family First Prevention Services Act plan. This vision emphasizes reducing foster care entries, addressing disparities in outcomes, and increasing support for families through evidence-based practices and community-driven solutions.

In collaboration with CDSS leadership, county staff, and partners, Chapin Hall developed a comprehensive statewide Continuous Quality Improvement (CQI) plan. This plan builds on the commitments made to the Administration for Children, Youth, and Families and the Children's Bureau to align with federal guidance and the state's prevention goals. It reflects California's dedication to using CQI practices to enhance service delivery, improve outcomes, and ensure accountability across all levels of the child welfare system.

The purpose of the CQI Plan is to provide leadership and staff with a clear framework for prioritizing goals and driving performance improvement. By focusing on equity and measurable outcomes, the plan seeks to reduce foster care entries, address systemic disparities, and improve the overall well-being of children and families. It also emphasizes the importance of collaboration, bringing together voices from across the system, including individuals with lived experience and external partners.

This plan provides a comprehensive overview of the CQI framework, with a phased implementation plan underway to specify staffing needs, CQI curricula, data collection improvements, and provider contract expectations. The implementation plan will be released in late fall 2025.

Figure 1: Core Components of a CQI System



Adapted from Children's Bureau (2018) and Wulczyn, et al. (2014).

Drawing from the Children's Bureau's recommended CQI practices, as visualized in Image 1, this plan begins with examining the state's organizational commitment to CQI, elevating key recommendations. The plan then delves into the data collection, analysis, and reporting processes, specifically for implementing improvement cycles, highlighting how communication pathways are leveraged to adapt programs and practices effectively.

Recommendation One: Robust Governance Structure: The governance structure ensures coordination and oversight with 1) Statewide advisory and subcommittees leading CQI activities, 2) Regional representatives facilitating collaboration between state and local efforts, and 3) County-level workgroups tailoring implementation to community needs.

Recommendation Two: Targeted CQI Resources: The CARES data system, designed to track service delivery and outcomes, must be supported by clear policies, dedicated staff, ongoing training, and technical assistance to strengthen capacity at the state, regional, and county levels, ensuring both alignment and sustainability.

Recommendation Three: Aligned Priority Outcomes: FFPS priority outcomes focus on reducing foster care entries, minimizing maltreatment recurrence, and measuring the effectiveness and fidelity of evidence-based programs. These goals align with federal and state frameworks, including the Child and Family Services Review (CFSR) and California's Child and Family Services Plan (CFSP).

Recommendation Four: Core Data Infrastructure and Processes: At the heart of the plan is the Five-Step CQI process and county-wide CQI workgroups which provide a structured method for achieving continuous improvement:

Five-Step CQI Process:

- **Identify and analyze the problem**
- **Develop a theory of change**
- **Test and implement solutions**
- **Monitor and evaluate**
- **Sustain and scale successful practices**

Recommendation Five: Commitment to Equity and Inclusion: Equity is a foundational principle of the CQI Plan. The plan ensures that strategies are informed by diverse perspectives, including compensated Tribal representatives and individuals with lived expertise. By embedding equity into every aspect of the CQI process, the plan addresses systemic disparities and ensures that services are accessible and effective for all families.

Call to Action: This Plan is not just a roadmap for improvement but a shared commitment to better outcomes for children and families. By aligning efforts, leveraging data, and fostering collaboration across state, regional, and local teams, the plan creates a sustainable system for prevention services. California's leaders, staff, and partners are invited to embrace this framework, ensuring that children and families benefit from meaningful, measurable, and lasting improvements.

CQI SYSTEM CORE COMPONENTS: ORGANIZATIONAL COMMITMENT & CAPACITY

A CQI process cannot be completed without an organizational culture that is proactive and consistently enables and supports continuous learning. Prioritizing shared understanding is a defining characteristic of this culture, with leadership using consistent language that sets the norms and expectations of utilizing evidence to inform change. Openness to innovation must also be embedded within the culture, with the understanding that not all efforts to improve quality will happen immediately and seamlessly. Other defining characteristics of a culture committed to and capable of CQI practices include emphasizing:

- Data accuracy before informing changes,
- Providing ongoing support to staff as they persevere through inevitable barriers to change,
- Developing a comfortable atmosphere for sharing information across departments and with partners (Capacity Building Center for States, 2019).

To demonstrate organizational commitment and capacity to CQI, a governance structure must be in place to support moving beyond compliance to inspire changes in practice by integrating evidence into informed plans for improvements. Strategic priorities must also be clear to help guide the organization's work toward common goals. Additionally, resources must be available to allow staff to engage in evidence-based CQI activities and implement the resulting findings.

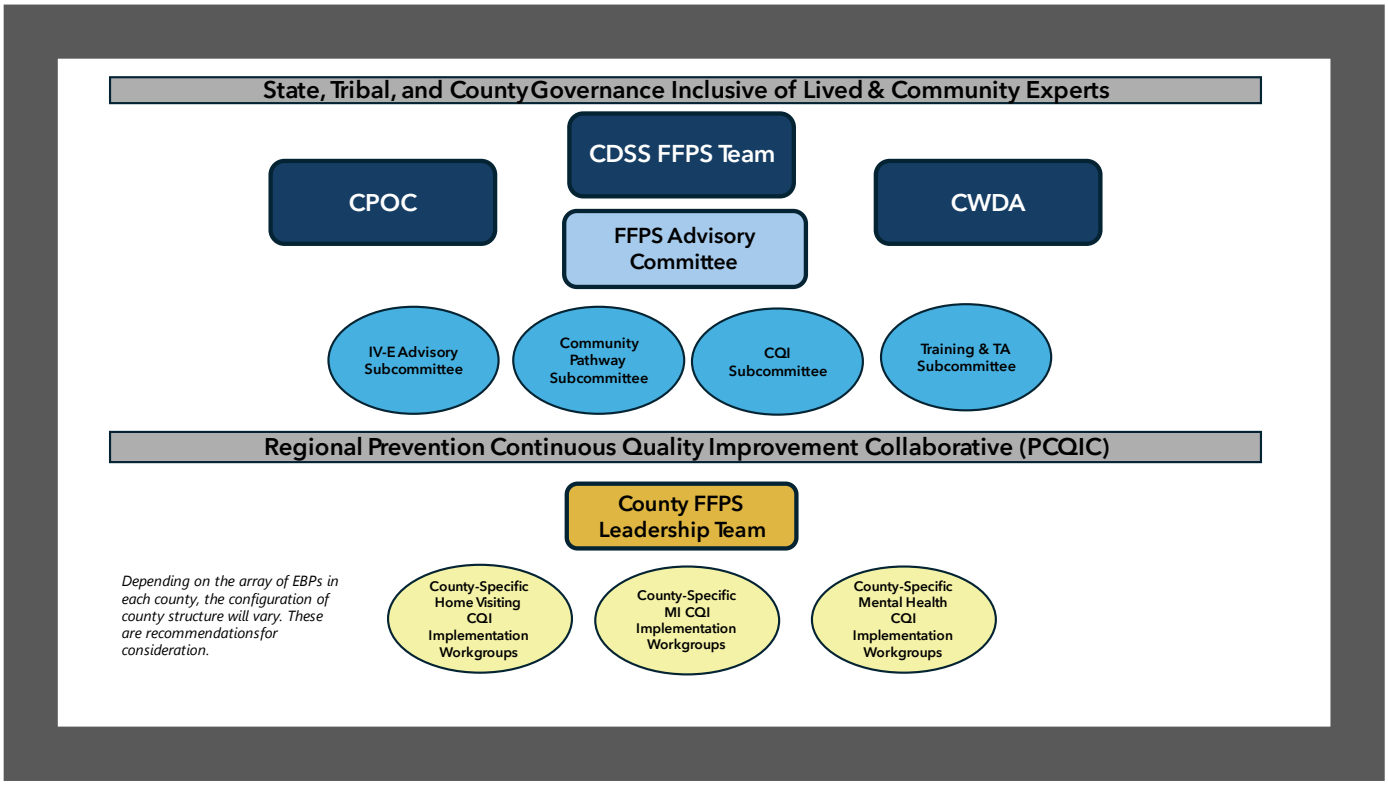
Recommendation One: Robust Governance Structure

A CQI governance structure—including consistent leadership support—has been one of the strongest indicators for a successful CQI program. According to the Children's Bureau, this includes administrative oversight to ensure that the CQI process systematically reviews, modifies, and consistently implements improvement strategies across the state. Other priority responsibilities include providing clear standards and requirements for all internal staff and external partners that are needed to support program improvement strategies and resulting changes.

The governance structure for the Continuous Quality Improvement (CQI) plan within California's Child Welfare Prevention Services is established to ensure the effective coordination, oversight, and continuous improvement of Family First Prevention Services (FFPS) activities. This structure promotes collaboration across various levels of government and service providers, using data-driven decision-making to foster ongoing quality improvements.

California's Department of Social Services has demonstrated a strong commitment to successfully implementing the Family First Prevention Services. This commitment is evident in its focus on building a sustainable system of Continuous Quality Improvement. By integrating a clear governance structure with a diverse array of representatives (see Figure 2), a comprehensive CQI framework, resource allocation, workforce training, and a focus on priority outcomes, California aims to ensure that families receive effective prevention services while achieving measurable improvements.

Figure 2: California Family First Prevention Services Governance Structure



California Department of Social Services Family First Leadership

To support the CQI framework, California has designated a centralized unit within CDSS to oversee all FFPS CQI responsibilities, ensuring coordination across the state. The CDSS FFPS team will oversee the implementation of the CQI plan, which will reside in the Family-Centered Safety and Support Section within the Safety and Early Intervention Bureau. This team will work collaboratively with the Chief Probation Offices of California association (CPOC) and the County Welfare Directors' Association of California (CWDA).

Formation of the Advisory Committee and Subcommittees

At the core of the CQI governance structure is the FFPS Advisory Committee, which provides oversight and promotes CQI by reviewing data to monitor the implementation of the state's Five-Year Prevention Plan. The committee ensures that data from evidence-based practice (EBP) fidelity assessments and child and family outcomes are continuously evaluated and used to guide improvement efforts. The committee also coordinates feedback loops that allow for consistent communication between the state and county levels, ensuring that data and improvement strategies are shared effectively.

The governance framework includes systematic feedback loops that allow information to flow between state, Tribal, and county leadership, county teams, providers, lived experts, and partners. These feedback mechanisms ensure decisions are informed by accurate data and insights from local efforts, which drive continuous improvement. County-level teams play an integral role by aligning local efforts with statewide goals and

implementing CQI principles in their day-to-day operations. The shared responsibility between state and local entities creates a cohesive system that prioritizes both oversight and flexibility.

Beneath the FFPS advisory body are several subcommittees, each with a targeted focus broader than CQI, but for this plan collaboration and coordination of improvement efforts are identified:

1. **CQI Subcommittee**: This subcommittee oversees the entire CQI plan, ensuring that CQI processes are followed statewide and Family First Prevention services are engaged in continuous improvement. It also helps develop strategies for applying the CQI five-step framework across all prevention activities.

2. **Training & Technical Assistance (TA) Subcommittee**: This group focuses on capacity building by coordinating initial and ongoing staff training related to CQI processes and overall service delivery. The subcommittee ensures that staff at both state and county levels are prepared to implement CQI initiatives and receive technical assistance as needed.

3. **Community Pathway Subcommittee**: This subcommittee ensures that community-based providers are integrated into the prevention strategy and that their data and service outcomes are included in the broader CQI framework. It works closely with counties to ensure that community pathway providers are represented and engaged in improvement activities.

4. **IV-E Advisory Subcommittee**: This subcommittee provides specific guidance on implementing Title IV-E prevention services within the CQI framework. It focuses on aligning CQI processes with federal requirements and ensuring that funding is used efficiently to support evidence-based programs.

Integration of Promising Practices and Resources

The governance structure incorporates both evidence-based practices (EBPs) and promising practices into the CQI framework. This ensures that CQI processes are not limited to FFPS services but also encompass other prevention-related activities. The CDSS five-step CQI framework is applied across all prevention services, allowing for comprehensive and cohesive improvement efforts.

There are ongoing discussions about how to support counties, particularly smaller ones, the initial technical assistance mechanism will be in the form of regional Prevention Continuous Quality Improvement Collaboratives (PCQIC). Seven regional collaboratives will meet quarterly in the first year of implementation to review reach, capacity, outcome, and fidelity data strengths and challenges. Ongoing sustainable technical assistance is being explored by CDSS and CWDA and will be included in FFPS CQI Implementation Plan referenced in the executive summary of this CQI plan.

County level CQI efforts are depicted in the bottom half of the governance structure visual above. Members of the county FFPS CQI workgroups will participate in the regional PCQIC where they will bring data and brainstorm strategies with their regional colleagues.

Recommendation Two: CQI Focused Resources

It is necessary for organizations to have resources to structure and execute CQI activities at the state, regional, and local levels. What is needed will vary based on the agency's structure, staffing patterns, and organizational readiness, but—as found when speaking with child welfare jurisdictions across the nation about their CQI systems—there are likely many resources that are currently in place. The goal, then, is to first strengthen existing resources before funding or re-directing services. This includes articulating existing staffing responsibilities, policies, and training dedicated to CQI activities. An informed decision can then be made on areas still needing additional resources, providing support to fully equip internal and external partners to engage in the CQI cycle and identify the best way to include robust CQI activities related to FFPS.

As part of the CQI Implementation Plan, a statewide survey will be distributed to counties to gain insights into existing CQI resources and responsibilities such as data collection, analysis, and identification of strategies. Understanding these capacities will inform ongoing technical assistance.

Training and Skill-Building Opportunities

To be successful, jurisdictions must equip staff with expertise to use qualitative and quantitative evidence to inform change, specifically, how the evidence *is* and *should be* generated and applied to decision-making at each step of the CQI cycle. This includes providing role-specific training that clarifies the evidence's implications for different types of child welfare and probation work. It is also an opportunity to learn about interpreting outcomes that vary by ethnicity, race, or other demographics.

To support the implementation of FFPS CQI efforts, county FFPS leads, and state leaders will participate in training to build essential knowledge and skills for engaging in CQI activities effectively. The training will provide an overview of the FFPS CQI Plan, including its alignment with California's Prevention Plan and the EBP Measurement Framework, which helps assess capacity, reach, fidelity, and outcomes. Participants will also receive guidance on establishing CQI Implementation Workgroups by identifying members, creating charters, and developing feedback loops to ensure a structured and sustainable approach to quality improvement (EBP Measurement Framework and CQI Implementation Workgroups).

Additionally, the trainings will introduce the CDSS' five-step CQI framework for structured improvement and provide guidance on conducting root cause analyses to address underlying challenges. Training on the use of CARES and the Provider Portal will help participants collect, analyze, and apply EBP data effectively.

To prevent duplication of training requirements, a crosswalk of existing curricula will be conducted to assess alignment with FFPS prevention CQI needs. This will include reviewing and inventorying training materials, identifying necessary tools for evaluation, and refining content as needed. CPP/FFPS/CQI Leads will participate in these trainings unless individuals have already completed equivalent training that meets the identified standards through the crosswalk process. This structured approach ensures that all county and state leaders have the necessary tools to implement and sustain effective CQI practices while avoiding unnecessary

redundancy in training requirements. There is also a desire to explore the inclusion of community-based providers (CBO) in CQI training, more information will be shared as discussions continue.

The training content, and their sequence, include:

1. **FFPS CQI Plan and FFPS Outcomes**: This section provides an overview of the CQI plan and its connection to Family First Prevention Services. This foundational knowledge will ensure that participants understand how the CQI Plan directly connects to California's Prevention Plan.

2. **EBP Measurement Framework**: Ensures that counties are familiar with the Evidence-Based Practice Measurement Framework. This technical knowledge will enable them to effectively measure reach, capacity, fidelity, and outcomes, aligning with FFPS requirements.

3. **Developing or Refining Existing CQI Implementation Workgroups:** This section focuses on how counties can create their own CQI Implementation Workgroups. This includes identifying key workgroup members, developing a workgroup charter, and establishing feedback loops to ensure ongoing communication.

Training Content:

1. FFPS CQI Plan & FFPS Outcomes
2. EBP Measurement Framework
3. Developing or Refining CQI Implementation Workgroups
4. Introduction to the Five-Step CQI Framework
5. Conducting a Root Cause Analysis
6. Using CARES and the Provider Portal

4. **Introduction to the Five-Step CQI Framework**: This content provides a comprehensive overview of the five-step CQI framework, explaining how each step contributes to the improvement process. It will give counties a structured approach for their CQI Implementation Workgroups.

5. **Conducting a Root Cause Analysis, inclusive of descriptive and comparative analyses**: This content takes a deep dive into initiating a root cause analysis as part of their CQI process. This step helps identify underlying issues within FFPS systems and practices, ensuring that improvements are data-driven, and address identified problems.

6. **Using CARES and the Provider Portal**: Demonstrates how EBP reach, capacity, fidelity, and outcomes data will be collected and depicted in CARES and the Provider Portal. Provides guidance to counties and providers on utilizing this data in their CQI Implementation Workgroup.

Equity and inclusion are integrated throughout the training program to ensure CQI processes address systemic disparities and reflect diverse perspectives. Leaders and providers will be encouraged to embed equity considerations into decision-making and improvement planning, ensuring that all communities benefit from CQI efforts.

Leadership development is also a key focus, with specific training to help leaders guide their teams, align their efforts with strategic priorities, and sustain momentum in CQI initiatives. Collaborative approaches to engaging community-based providers will also be emphasized, ensuring that feedback from all relevant participants is incorporated into improvement efforts.

This training program is essential for building the capacity to implement FFPS CQI efforts effectively. By equipping county and state leaders with the required tools and knowledge, these training courses will ensure a unified and sustained commitment to continuous improvement and better outcomes for children and families. The pending FFPS CQI Implementation Plan, referenced in the executive summary of this CQI plan, will outline additional details regarding CQI training.

Recommendation Three: Alignment of Priority Outcomes and Initiatives

Defining and communicating priority outcomes that clarify agency goals and priorities is essential to establishing focus and clarity for leadership and staff charged with executing agency responsibilities and driving performance improvement. This is particularly important when individuals manage numerous policies, requirements, and focus areas. Ideally, these outcomes will be measurable, consistently monitored and reported, and developed with input from race equity specialists, those with lived experiences, external partners, and staff at all levels (Capacity Building Center for States, n.d.; Rogers & Love, 2018).

Federally Required Measures:

1. **Did the candidate enter foster care 12 months from the prevention plan start date?**
2. **Did the candidate enter foster care within 24 months of the prevention plan start date?**

The Family First Prevention Services Act (FFPSA) aims to support families through evidence-based prevention services that address challenges early, reducing the likelihood of foster care placements. This initiative prioritizes keeping children safe with their families to promote child well-being and family stability.

To achieve these goals, the FFPS CQI Plan ensures alignment with federal requirements by focusing on measurable outcomes, including:

1. Whether a child identified as a foster care candidate entered foster care within 12 months of the prevention plan start date.
2. Whether the child identified as a foster care candidate entered foster care within 24 months of the prevention plan start date.

To continually improve outcomes for children, youth, and families, public child welfare agencies and probation prevention programs regularly evaluate and assess the functioning of their systems/programs and engage in ongoing strategic planning, review, and other continuous quality improvement (CQI) processes to target improvement efforts. These include formalized processes such as (but are not limited to): Child and Family Services Review Program Improvement Plan (CFSR PIP), Child and Family Services Plan (CFSP) and Annual

Progress and Services Report (APSR). They also include ongoing efforts related to Family First Prevention Services Act (FFPSA) implementation planning. It is imperative for agencies to understand the connections between these ongoing federal and agency efforts by intentionally identifying points of alignment, as well as gaps between the agency's priorities and federal requirements.

There is a clear alignment between California's Family First Prevention Plan EBP outcomes, and the outcomes and casework practices evaluated in the federal CFSR process (C-CFSR in California). The data and information gathered in the FFPS CQI process, and the data collected in the C-CFSR can inform each other and shed light on how child welfare processes and practices impact safety and well-being outcomes for children and families receiving prevention services. A crosswalk outlining this alignment is presented in Appendix C.

Engaging External Voices and Partners

The process of defining and refining priority outcomes also creates opportunities for external voices, including individuals with lived experience, community advocates and grass-roots organizers, and Tribal representatives, to engage meaningfully in CQI efforts. These partners play a crucial role in improvement cycles by providing diverse perspectives that enrich the development and implementation of outcomes. Their involvement ensures that outcomes are equitable and inclusive, addressing the needs of all communities served.

Sustaining and Reporting on Priority Outcomes

Priority outcomes are not static; they evolve in response to ongoing monitoring, evaluation, and feedback. Regular reporting ensures that progress is tracked, and adjustments are made as needed. The alignment with CFSR and CFSP frameworks further ensures that outcomes remain relevant and effective, meeting both state and federal requirements.

CQI SYSTEM CORE COMPONENTS: DATA INFRASTUCTURE & PROCESSES

Recommendation Four: Data Processes

A strong data infrastructure is critical to the success of California's CQI Plan. It serves as the backbone for collecting, managing, analyzing, and using data to drive improvements at both the state and county levels. This section outlines the systems, processes, and practices that enable accurate, timely, and actionable data to support CQI activities.

California's child welfare system relies on a comprehensive data infrastructure to:

- Collect and integrate quantitative and qualitative information from diverse sources.
- Ensure data quality and consistency across counties and EBPs.
- Facilitate reporting and analysis to monitor performance, identify trends, and support decision-making.

By establishing reliable data processes, CDSS ensures that all partners—state agencies, counties, and community partners—have the information they need to effectively enhance outcomes for children and families. To ensure CQI activities are data-driven and evidence-based, it is essential to understand how data serves as the foundation for monitoring, decision-making, and continuous improvement. The following subsection explores the critical role of data within California's CQI framework and its connection to statewide goals.

Role of Data in CQI

In California's CQI framework, data is central to driving improvements and achieving better outcomes for children and families. It provides the evidence needed to monitor program performance, identify areas for improvement, and measure the impact of interventions. Reliable and actionable data ensures that the evidence-based programs approved in California's Prevention Plan are implemented effectively, equitably, and responsively to meet the diverse needs of communities.

Through consistent data collection, analysis, and reporting, CDSS and counties can evaluate the implementation and effectiveness of these EBPs. This detailed tracking allows CQI leaders to assess program success, ensuring that EBPs meet their intended outcomes while addressing prevention priorities and state-defined objectives.

Data analysis further enables CDSS and counties to identify trends and challenges affecting EBP implementation. This includes uncovering disparities in access or outcomes, highlighting service gaps, and addressing systemic barriers to ensure equitable service delivery. With clear governance structures and collaborative processes, identified challenges can be addressed efficiently and aligned with statewide priorities.

Evidence derived from data also supports strategic decision-making by guiding resource allocation and prioritizing initiatives that align with California's prevention goals. By leveraging data insights, CDSS and counties ensure that efforts remain focused on scaling and sustaining effective EBPs, with decisions firmly grounded in program performance and community needs.

Finally, data-driven practices enhance transparency and accountability in EBP implementation. Sharing results with partners—including families, community partners, Tribal representatives, and policy makers—builds trust and demonstrates a commitment to continuous improvement. The feedback loops and communication pathways established in the CQI Plan ensure that data informs decision-making and strengthens collaboration at every level of the child welfare and probation system.

Data serves as the foundation of CQI by transforming information into actional insights, enabling ongoing evaluation and improvement. To fully realize its potential, the systems and infrastructure supporting data collection, storage, and organization must be reliable and responsive. The Information Management System subsection focuses on the platforms and tools that ensure data is accessible, reliable, and actionable.

Information Management System

A robust data system is essential for storing and accessing both quantitative and qualitative data. Such a system must enable performance monitoring and testing the effects of the EBP being implemented, while ensuring accurate and up-to-date information is readily available to those working directly with children and families. This includes the ability of the system to aggregate data from multiple systems that the agency collaborates with to support the families' needs (e.g., information from mental and physical health providers; Administration for Children and Families, 2018).

California's child welfare system operates under a state-supervised, county-administered structure, requiring a strong data infrastructure to connect state-level priorities with local implementation. The Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) is being designed to fulfil this need. As a planned platform, CWS-CARES will provide critical tools for data collection, management, analysis and reporting, supporting the implementation and monitoring of EBPs approved in California's Prevention Plan. Although its full functionality is still under development, CWS-CARES is anticipated to become a cornerstone for CQI efforts, ensuring that accurate, timely, and actionable data flows seamlessly across the child welfare system and will inform probation prevention CQI efforts.

CWS-CARES will generate **reports and dashboards** that state and county CQI teams can use to:

- **Identify trends**
- **Perform root cause analyses**
- **Develop actionable insights**

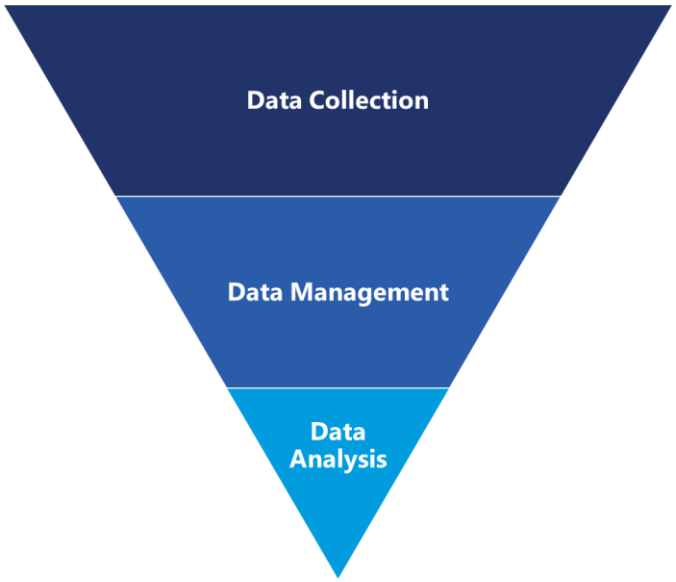
These tools will guide program improvements and support data-driven decision-making at all levels.

When implemented, CWS-CARES will play a critical role in supporting key processes outlined in this plan. The system is designed to standardize the collection of quantitative data, ensuring alignment with California's EBP Measurement Framework and providing consistency in tracking program performance and outcomes. It will also include secure storage and organizational tools that structure data effectively, enabling state and county teams to access, analyze, and use the information to inform decision-making. Additionally, CWS-CARES will generate reports and dashboards that state and county CQI teams will use to conduct data analysis, including identifying trends, performing root cause analyses, and developing actionable insights to guide program improvements. Finally, these reporting and visualization tools will enhance transparency and streamline the sharing of information with partners, including families, policymakers, and community partners. Collectively, these capabilities will ensure that CWS-CARES supports the implementation, monitoring, and refinement of California's evidence-based programs. With CWS-CARES as a planned cornerstone of California's data efforts, the broader data infrastructure ensures that information flows seamlessly across counties and the state. The CQI Data Infrastructure subsection elaborates on how this infrastructure facilitates the movement and transformation of data through collection, refinement, and analysis.

CQI Data Infrastructure

For CQI processes to be effective, the infrastructure must support the seamless flow of data from collection to analysis, ensuring it is accurate, accessible, and actionable. This infrastructure enables partners at both state and county levels to monitor program performance, identify trends, address barriers, and implement targeted changes to improve outcomes for children, youth and families. By establishing a robust data infrastructure, California ensures that CQI efforts are grounded in evidence and aligned with the state's prevention priorities.

Figure 3: The Data Hierarchy: From Collection to Analysis



At the top of the CQI data flow is the critical process of data collection, where comprehensive, accurate, and reliable information forms the foundation for all subsequent analysis and decision-making. This data is then refined and secured through data management, which organizes it into a structured format. At the narrowest point of the triangle, data analysis and interpretation distill the information into actionable insights, enabling informed decision-making and continuous quality improvement at both county and state levels. This layered approach ensures data serves as the essential foundation for effectively implementing EBPs and driving meaningful outcomes. The next section delves into how California's child welfare system gathers this data to monitor EBP implementation and outcomes effectively.

Data Collection

Accurate and comprehensive data collection is critical to ensure that the information feeding into the system provides a precise and complete picture of how EBPs are being delivered and their outcomes. This step provides the raw information needed to assess performance, monitor progress, and inform decisions across all stages of the CQI process. By capturing reliable data at this stage, the foundation is laid for effective management, analysis, and reporting, making it a key driver to improvement efforts.

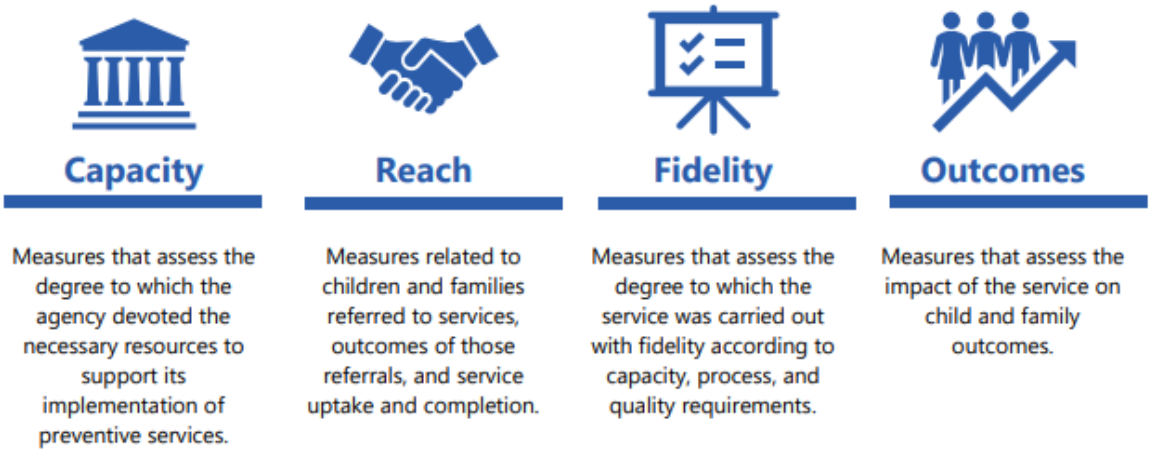
The primary purpose of data collection is to gather information about reach, capacity, outcomes and fidelity of each EBP. These data elements collectively provide a detailed picture of how EBPs are implemented, their adherence to model standards, and their effectiveness in meeting the needs of children and families. Quality data at this stage ensures that all CQI processes, including performance monitoring, are built on a solid foundation.

EBP Measurement Framework

An EBP Measurement Framework provides a structured method to systematically collect data to evaluate the implementation and effectiveness of EBPs. It establishes clear metrics and consistent data collection practices to provide insight into key components of EBP delivery. An EBP Measurement Framework supports CQI processes by ensuring that data related to capacity, reach, fidelity, and outcomes is consistently captured, analyzed, and used to inform improvement efforts. By focusing on these areas, the EBP Measurement Framework ensures alignment with California's Prevention Plan and fosters accountability, equity, and collaboration across all levels of the child welfare system.

The EBP Measurement Framework evaluates four critical data domains, each essential for understanding and improving EBP implementation.

Figure 4: Key Data Domains in the EBP Measurement Framework



Capacity data examines program availability, provider caseloads, and waitlists to assess service accessibility and operational efficiency. By understanding capacity, partners can identify gaps in service availability, address bottlenecks, and optimize resources to meet community needs.

Reach data tracks the number of families served by each EBP, ensuring that target populations are being effectively reached and that services are equitably distributed. This data provides insight into the extent of program utilization and whether the intended beneficiaries are accessing the services.

Clear reporting responsibilities, standardized templates, and defined schedules ensure consistent, accurate data collection. This approach supports both **real-time monitoring** and **long-term evaluation**, with responsibilities shared between **EBP providers** and **purveyors** to drive continuous improvement.

Fidelity data monitors adherence to EBP model standards, ensuring that interventions are delivered as designed. Maintaining fidelity is essential for preserving the effectiveness of EBPs and achieving consistent results across service settings.

Outcome data evaluates client progress and measures the overall effectiveness of each EBP in achieving desired results. This data helps to determine whether programs are delivering their intended benefits and supports evidence-based decision-making for program improvement.

These domains provide a consistent and structured approach to assessing and delivering the impact of EBPs, ensuring alignment with statewide prevention goals and the broader CQI framework. For outcome and fidelity data collection requirements, these measures align with existing data expectations set by each model's purveyor/developer. Therefore, these are not new or additional data points; rather, these data should be tracked and reported to the state to ensure compliance with the federally approved Prevention Plan. However, because Motivational Interviewing (MI) does not have a purveyor/developer, new data elements have been identified to assess fidelity and effectiveness. Counties implementing MI will be expected to track and report these data points to ensure compliance.

The EBP Measurement Framework is critical to the success of CQI efforts because it provides a comprehensive and consistent method for monitoring EBP implementation. By focusing on capacity, reach, fidelity, and outcomes, the framework ensures that CQI processes are data-driven and grounded in evidence. Additionally, the framework's emphasis on equity helps monitor and address disparities in service access, delivery, and outcomes across diverse populations. This approach aligns local prevention CQI efforts with statewide goals, fostering continuous learning and improvement across California's child welfare system.

Standardized Data Collection

Data collection for EBPs relies on multiple partners and systems to ensure accuracy and consistency. This process gathers all necessary information about EBP capacity, reach, fidelity, and outcomes. CWS-CARES will serve as the primary platform for collecting and organizing data through two methods: the Provider Portal and backend uploads. These mechanisms focus on gathering raw data using clear reporting responsibilities, schedules, and standardized templates, creating a foundation for the CQI process. By maintaining uniformity across all reporting activities, these mechanisms support both real-time monitoring and the long-term evaluation of preventive services, with data collection responsibilities shared between EBP providers and purveyors.

Counties are responsible for collaborating with their EBP providers to ensure the accurate collection of reach, capacity, fidelity, and outcome data. This data must be collected at the individual level to allow detailed tracking

of service utilization, client progress, and adherence to EBP standards. To achieve this, counties may need to revise existing Memoranda of Understanding (MOUs) or establish new agreements that clearly define the specific data each EBP provider must collect, as well as the frequency and format of reporting. These agreements help standardize expectations and ensure that data collection processes align with the requirements of both the county and state-level CQI framework.

In addition to data collection at the county level, data will also be collected at the state level. The Provider Portal is the centralized platform through which local EBP providers will submit capacity and reach data. This information must be submitted monthly, allowing for real-time tracking of service delivery at both the state and county levels. Providers are responsible for entering this data directly into the portal, ensuring accurate and timely visibility into program operations. This frequent reporting schedule enables partners to quickly identify and address trends or gaps in service referrals or delivery, and ensures resources are allocated effectively.

In contrast, aggregate fidelity and outcome data will be submitted through backend uploads, which involve standardized templates uploaded into CWS-CARES. Providers or purveyors will compile these aggregate data points on a biannual or annual basis, depending on each EBPs specific requirements. (CDSS is exploring a contractual relationship with model purveyors who store and produce EBP fidelity and outcomes data. Each purveyor has agreed to use the templates and share the data with CDSS for a fee). These data submissions will go directly to the CDSS FFPS team who will ensure the data is uploaded securely into CWS-CARES. This structured process guarantees fidelity and outcome data are captured consistently and integrated into broader CQI activities. Additionally, the data provides critical insight into program effectiveness, adherence to model standards, and ensures the state is in compliance with the federal expectation to monitor EBP fidelity and outcomes, complementing the monthly information collected through the Provider Portal.

Responsibilities for data reporting and schedules vary by EBP, as outlined in Appendix A. For fidelity and outcome data, standardized templates are used to ensure consistency across diverse partners. Providers and purveyors submit this data in alignment with each EBP's unique reporting schedule, with some programs, like Homebuilders® and MST, requiring collaboration between both groups. Others, like PAT, rely solely on annual submission by providers. These tailored reporting schedules ensure that data collection meets the needs of individual EBPs while supporting consistent evaluation across the system.

Together, the Provider Portal and backend uploads establish a robust reporting infrastructure that balances the need for real-time tracking with the in-depth evaluation of program performance. This dual approach ensures that the child welfare system has access to both immediate and long-term data insights, which inform decision-making and drive continuous quality improvement. By leveraging these tools, California can monitor the implementation and impact of its preventive services with precision and consistency.

Data Management

While data collection focuses on gathering the raw information necessary for CQI processes, data management ensures that this information is validated, securely stored, and organized for effective use. The following section

outlines the rigorous quality assurance measures and tiered storage systems underpinning California's approach to data management.

Effective data management begins after data collection, with an emphasis on ensuring the quality and validation of the data to maintain its accuracy, completeness, and reliability. Rigorous quality assurance measures will be applied to all collected EBP data to ensure it supports meaningful analysis and evidence-based decision-making. Once validated, the data will be securely stored and organized within CWS-CARES, the centralized system designed to provide consistent access to reliable information for partners at both the state and county levels. This system will enable the monitoring of program performance, analysis of trends, and the implementation of continuous quality improvement efforts.

Data Validation and Quality Assurance

Maintaining data integrity is essential to the success of California's CQI efforts. To achieve this, the state has developed quality assurance processes that are customized for capacity, reach fidelity, and outcome data. These processes ensure that each type of data meets the standards required for effective decision-making and continuous improvement.

Capacity and reach data will be validated through automated tools within the CWS-CARES Provider Portal. These tools are expected to flag missing or inconsistent entries, enabling providers to correct errors promptly through built-in feedback loops. Once implemented, this system will ensure the reliability of real-time data critical for monitoring service delivery and resource allocation.

For outcome and fidelity data, providers and purveyors will use standardized templates to submit aggregate information. Before this data is uploaded to CWS-CARES, the FFPS Team will conduct validation checks and verify proper formatting, detect inconsistencies, and ensure compliance with reporting standards. These processes are essential for maintaining high-quality data related to program effectiveness and adherence to EBP models.

By incorporating rigorous quality control measures into the CARES system, California aims to ensure that high-quality data informs every aspect of the CQI process. These measures will enable partners at all levels to monitor performance effectively, address challenges, and drive continuous improvement to benefit children, youth and families.

Secure Data Storage

California's data management framework uses a tiered storage system to balance the immediate needs of local-level monitoring with the broader requirements of centralized state oversight. At the local level, data is stored in provider-, or purveyor-, specific data management systems. This local storage enables providers and counties to monitor EBP implementation and performance in real time, ensuring they have immediate access to the information necessary to support service delivery. Data at this level must be collected and stored at the individual level to allow for detailed tracking of service utilization, client progress, and adherence to EBP

standards. This granularity ensures that providers and counties can make informed adjustments to improve service delivery and address the unique needs of children and families in their county.

At the state level, capacity, reach, outcomes, and fidelity data will also be stored in CWS-CARES. Individual-level data for capacity and reach metrics will be stored alongside aggregate fidelity and outcome data by provider and county. This system serves as the unified repository, ensuring consistency and alignment between local implementation efforts and state-level priorities. By aggregating data from multiple sources, CARES creates a comprehensive repository accessible to both counties and the state, enabling strategic oversight and performance monitoring.

This tiered approach to data storage ensures that both local and state-level partners can access the information they need to effectively manage and enhance service delivery. Secure storage, combined with rigorous quality assurance, forms the backbone of California's data management framework.

By integrating these processes— including validation, secure storage, and centralized organization—California's data management framework supports the broader goals of the CQI plan. It ensures that all partners, from local providers to state leaders, have access to the high-quality data needed to monitor performance, implement evidence-based practices effectively, and achieve meaningful outcomes for children, youth and families. With validated, securely stored, and well-organized data as a foundation, the next critical step is transforming this information into actionable insights. The following section focuses on data analysis and reporting, which enables partners to monitor trends, evaluate performance, and drive continuous improvement.

Data Analysis and Reporting

Data Reporting and Visualization

If CQI is about doing something different to make positive changes, reports are vital to clarifying existing challenges and demonstrating whether changes made were impactful. The ability to connect evidence to inform policy and practice decisions means that all child welfare staff and partners have access to information that monitors performance. This includes access to reports that demonstrate how changes done by the individual worker or organization *is* or *is not* impacting the children, youth and families they support (Administration for Children and Families, 2018).

The sources of this information can vary (e.g., agency-generated reports or federal monitoring updates), but should include reliable and timely information about the evidence that would directly connect personal work to priority outcomes in a user-friendly way. Meaningful reports should also include information that recognizes variations in results and be presented in a way that decreases the likelihood of invalid conclusions. This is particularly important for communicating with external partners needed in each stage of the CQI process (Blancato & Kleiman, n.d.).

Robust reporting and visualization processes are fundamental to effective data analysis within California's Continuous Quality Improvement (CQI) system. These processes ensure that data is not only accessible but also actionable, enabling partners to identify trends, measure performance, and prioritize areas for improvement.

The planned CARES system[1] is being designed as an integrated platform for generating automated and customizable reports that support consistent data tracking at both the state and county levels. Monthly and quarterly reports are designed to offer transparency and insight into key performance metrics, including service reach, capacity, and adherence to EBPs. These reports must ensure that all partners—state leaders, county teams, and providers—can access standardized and reliable information to inform decision-making.

> The CARES system delivers an integrated platform for generating **automated, customizable reports** to ensure consistent data tracking across state and county levels. Its visualization tools, including **interactive Tableau dashboards**, provide real-time insights that bring data to life and support informed decision-making.

In addition to reporting, visualization tools are planned within CARES, such as Tableau dashboards, which will offer real-time interactive features that bring data to life. Dashboards will be equipped with charts and graphs that allow users to monitor trends continuously, compare performance across regions, and conduct deeper analyses. These tools support a proactive approach to CQI, enabling partners to identify emerging issues early and prioritize targeted improvements.

By integrating reporting and visualization into the CQI process, California's child welfare system ensures that data is transformed into actionable insights that support continuous learning and improvement at all levels.

Data Analysis

A common phrase used in CQI is that policy and practice should be "data driven." Data alone, however, does not have meaning; data are pieces of information that a child welfare system collects about the children and families it serves. Evidence is what provides guidance toward problem solving processes and the analytical method used with data is what gives evidence its meaning. Thus the process of selecting the correct type of analysis is critical to producing the evidence appropriate for supporting an observation, claim, hypothesis, or decision made (Wulczyn, Alpert, Orlebeke, & Haight, 2014).

Data analysis within the CQI framework is not a one-size-fits-all approach. Depending on the specific questions being addressed and the nature of the available data, different analytical techniques are used. Descriptive analysis provides an overview of current performance, root cause analysis delves into systemic challenges, and comparative analysis assesses progress and identifies opportunities to promote equity and consistency across regions. Together, these methods create a comprehensive strategy for interpreting data and using it to improve outcomes for children, youth and families.

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[1] Real-time data tools, like CARES dashboards, will provide timely insights to help counties monitor progress, test changes, and refine strategies within continuous improvement cycles. Should CARES v1 require enhancements, county CQI teams should collaborate with providers or purveyors to share reports from existing systems.

Data analysis in the CQI framework is tailored to fit the specific questions and data available. Descriptive analysis offers insights into current performance, root cause analysis identifies systemic challenges, and comparative analysis assesses progress to promote equity and consistency across regions. Together, these techniques form a **comprehensive approach to interpreting data and driving improvements for children and families**.

Descriptive analysis identifies trends and patterns within the data, offering a snapshot of current performance. This method highlights both low-performing areas requiring attention and high-performing practices that can be replicated. Metrics outlined in the EBP Measurement Framework—such as service utilization, capacity, fidelity, and family outcomes—are intended to be accessible through CARES dashboards. These real-time metrics facilitate continuous monitoring and provide a foundation for data-informed decision-making at the provider, county, and state levels.

Root cause analysis dives deeper to uncover systemic factors contributing to performance gaps. This technique is especially valuable for addressing challenges that persist across multiple counties. Tools like the 5 Whys and fishbone diagrams are used to identify barriers and guide the development of targeted solutions.

Comparative analysis helps counties assess performance, align strategies with statewide goals, and identify opportunities to promote equity and consistency in EBP implementation. By identifying disparities and aligning counties with best practices, this method supports the adoption of strategies proven successful in other regions. Comparative analysis fosters a culture of shared learning and drives continuous improvement by ensuring that all counties work toward consistent, equitable outcomes.

By applying descriptive, root cause, and comparative analysis, partners at both the county and state levels can address localized challenges and systemic trends effectively. This dual-level approach ensures that local strategies are informed by statewide priorities, while state-level insights are grounded in local realities. The next subsection details how these analytical methods are operationalized to support CQI efforts at different levels of the child welfare and probation prevention system.

State-Level and County-Level Data Analysis

Provider and purveyor data that is entered or uploaded into the CARES database can be aggregated at both the county and state levels. This will enable analyses of how specific EBPs are performing within a county or across the state. By transforming this data into actionable insights, counties and the state can make informed decisions that drive program improvements, enhance service delivery, and address systemic challenges.

At the county level, data analysis allows counties and their EBP providers to assess program performance in real time, identify trends, and address localized challenges. Counties will use descriptive analysis to monitor service delivery and outcomes, identify populations and geographic regions who may not be effectively reached, and pinpoint areas where additional resources or adjustments to service delivery are needed. Root cause analysis will help counties address barriers to service access or fidelity, enabling them to develop targeted solutions tailored to their specific contexts. Comparative analysis will allow counties to assess their progress in relation to other jurisdictions, fostering shared learning and the adoption of effective practices. For example, counties may analyze how many caregivers enroll in Parents as Teachers programs in Los Angeles County or the percentage of all youth who received MST through CA FFPSA programs who have no new arrests and no foster care entries. These insights help counties focus on performance and/or areas needing attention.

Provider and purveyor data that is entered or uploaded into the CARES database can be aggregated at both the county and state levels. This will enable analyses of how specific EBPs are performing within a county or across the state.

At the state level, aggregated data analysis will offer a macro-level view of EBP implementation and its impact across California. The state will leverage these insights to monitor the overall fidelity and effectiveness of EBPs, ensure alignment with statewide prevention goals, and identify systemic trends that require statewide coordination or policy adjustments. For instance, through comparative analysis, the state can identify differences between counties, enabling tailored technical assistance or resource allocation to enhance performance, or facilitating sharing of best practices. Root cause analysis at the state level will focus on identifying structural barriers, such as funding or workforce capacity, that impact EBP implementation across multiple counties.

The integration of county- and state-level analyses is crucial for fostering a collaborative CQI environment. While county-level analyses focus on local performance and service delivery improvements, state-level analyses provide a strategic overview that supports coordinated CQI efforts across the state. State-level findings will be shared with counties to support local improvement efforts, while county-level insights will inform state strategies and priorities. This reciprocal flow of information ensures that data analysis is not only a tool for identifying problems but also a mechanism for shared learning, successes, and continuous improvement across all levels of the system.

Improvement Cycle

A CQI cycle includes using reliable data to improve the quality of services on an ongoing basis. A complete cycle will be able to (1) identify gaps in performance, (2) understand underlying conditions, (3) identify solutions and plan for implementation, (4) implement the solution, (5) and test the solution and revise the approach, all while using evidence and relevant voices at each step of the process to support observations, claims, or decisions (Administration for Children and Families, 2012). To translate these principles into actionable steps, California has developed a robust framework that leverages data, collaboration, and feedback loops at every stage of the CQI cycle.

In addition to the characteristics already discussed in this report, there are additional components that must be in place for the CQI cycle to be successful. Child welfare agencies should regularly examine variation in outcomes when guiding decisions for change (e.g., differences between age groups, racial/ethnic backgrounds, geography). Those with lived experiences and who could support the change occurring should also be integrated in each step of the cycle. Similarly, consistent and clear communication with all those impacted by changes in the process is imperative to a productive CQI cycle.

Operationalizing Improvement Cycles

Operationalizing improvement cycles involves translating data-driven insights into actionable steps that enhance program performance and outcomes. Within California's child welfare system, the CDSS Five-Step CQI Process serves as the foundation for identifying challenges, testing solutions, and refining practices. By integrating EBP data with other child welfare metrics such as child safety outcomes and permanency rates, counties and the state can collaboratively monitor progress and implement targeted improvements. The following subsections outline the practical application of data in CQI cycles, the roles of county implementation workgroups, and the mechanisms for fostering continuous learning through feedback loops and regional collaboration.

Data Use in CQI Cycles

Data serves as the foundation for effective CQI efforts, enabling child welfare systems to monitor performance, identify trends, and make informed decisions. At both the state and county levels, data is a critical tool for driving systemic improvements, ensuring that interventions meet the needs of children and families while advancing statewide prevention goals. The integration of EBP data, including insights into capacity, reach, fidelity, and outcomes, enhances this process.

California's EBP Measurement Framework will generate valuable data related to prevention services. Metrics such as service utilization, adherence to EBP model standards, and client outcomes will provide a detailed picture of how prevention programs are implemented and whether they are achieving their intended goals. This data must be intentionally incorporated into the larger CQI efforts, ensuring that the insights gained from prevention services inform broader analyses of child welfare/probation prevention performance. While EBP data is only one part of a county or the state's overall data ecosystem, it serves as a vital input that complements other sources of information, such as child safety outcomes, permanency rates, and workforce capacity metrics.

At the county level, EBP data helps local CQI teams evaluate how well prevention services are meeting the needs of families within their communities. For example, reach and capacity data can highlight whether eligible families are being served equitably, while fidelity and outcome data can reveal opportunities to refine service delivery. Counties can then integrate this information with other child welfare data to build a comprehensive understanding of their system's performance and inform targeted improvements.

At the state level, aggregated EBP data provides a statewide view of how prevention services are contributing to broader system goals. By combining this data with insights from county CQI efforts, the state can monitor

trends across jurisdictions, identify disparities, and provide technical assistance to counties that face implementation challenges. This integration ensures that EBP data is not siloed but is actively used to inform strategic planning, policy development, and resource allocation within California's child welfare system.

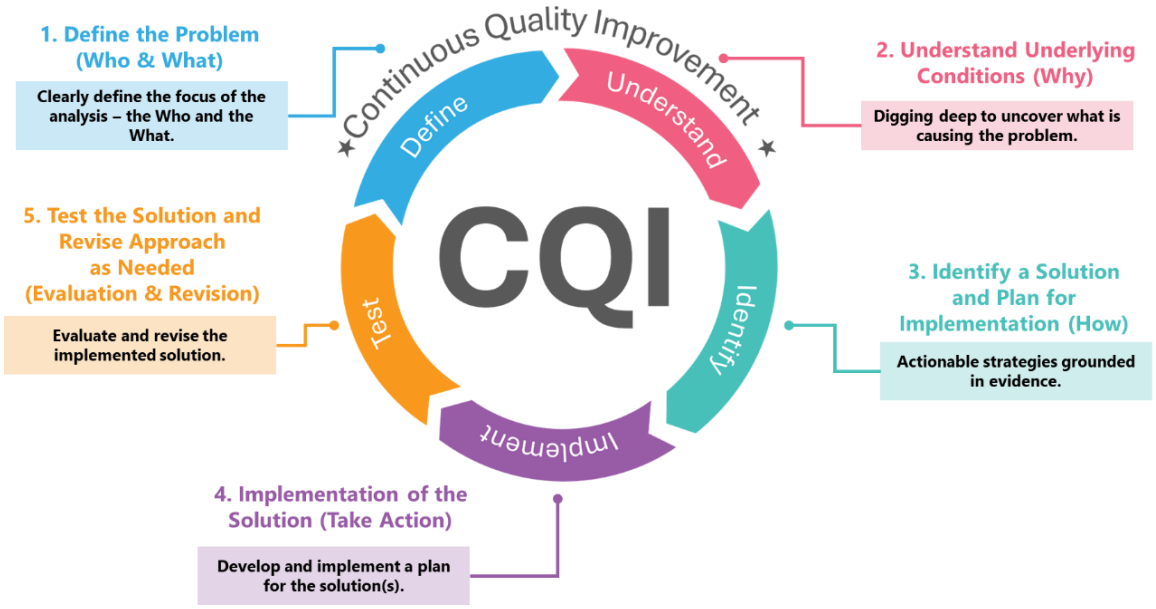
Embedding EBP data into CQI ensures that prevention services play a central role in driving meaningful and measurable outcomes. This approach aligns with the state's commitment to data-driven decision-making, fostering a culture of continuous learning and systemic improvement at all levels of the child welfare system. The next section delves into the Five-Step CQI Process, illustrating how data is systematically applied to guide problem identification, solution development, and iterative refinements within CQI cycles.

California's Five-Step CQI Process

At the core of California's CQI efforts is the Five-Step CQI Process, a structured framework designed to systematically improve child welfare services. Developed by the California Department of Social Services (CDSS), this process provides a step-by-step guide for identifying challenges, implementing solutions, and refining practices to achieve better outcomes for children, youth and families (CDSS, 2019). The five steps are:

1. **Identifying and Understanding the Problem**: Recognizing performance gaps and analyzing underlying conditions using data-driven insights.
2. **Developing and Implementing Solutions**: Crafting and executing targeted strategies to address identified challenges.
3. **Monitoring and Evaluating Outcomes**: Assessing the effectiveness of implemented solutions to ensure they meet intended goals.
4. **Applying Findings to Practice and System Improvements**: Using successful strategies to inform standard practices and broader system enhancements.
5. **Reviewing and Revising the Process**: Continuously refining the CQI process based on feedback and evolving needs.

Figure 5: California 5-Step CQI Process



This structured framework ensures that data collected and analyzed through California's robust data infrastructure is systematically applied to enhance service delivery. By integrating evidence at every stage, the Five-Step CQI Process fosters a culture of continuous learning and improvement, aligning with the state's goal of delivering effective, equitable, and responsive child welfare services (CDSS, 2019). In the following section, the Five-Step CQI Process is operationalized to demonstrate how data collection and analysis are integrated into each stage to drive effective decision-making and improvement efforts.

Data collection and analysis are integral to the Five-Step CQI Process, providing the foundation for evidence-based decision-making at each stage. In the first step, descriptive data helps clearly define the problem and assess its scope. For example, metrics related to program capacity from the EBP Measurement Framework can quantify issues such as insufficient service availability and measure the extent of the problem. This baseline data is critical for evaluating the success of any solutions implemented during the improvement cycle. In the second step, root cause analyses rely on targeted data collection to understand the underlying factors contributing to identified problems. Steps 3-5 integrate multiple types of data to monitor the implementation of solutions, measure outcomes, and refine approaches to ensure effectiveness and sustainability. In step 3, implementation data tracks whether solutions are being carried out as planned, identifying any deviations or barriers to execution. Step 4 uses outcome data to assess the impact of the interventions on the targeted issues, helping determine whether adjustments are needed. Finally, in step 5, a combination of fidelity and performance metrics is analyzed to refine approaches, ensuring that solutions remain effective, adaptable, and aligned with long-term goals.

Recommendation Five: Commitment to Equity & Inclusion

State CQI Efforts

California's state-level CQI efforts are designed to support the effective implementation and continuous improvement of EBPs across counties. By leveraging statewide data analysis and facilitating regional collaboration, CDSS ensures that CQI processes remain equitable, data-driven, and aligned with statewide prevention goals. This section focuses on two critical components of state-level CQI efforts: statewide data analysis and the regional Prevention CQI Collaborative.

State-Level Data Analysis

State-level data analysis plays a critical role in supporting effective CQI practices within California's child welfare system. The following recommendations outline best practices for who should conduct these analyses and how often they should occur, ensuring that data is used effectively to monitor trends, address challenges, and promote equitable service delivery.

Descriptive analysis is recommended to be conducted by the CDSS FFPS Team. This type of analysis focuses on identifying trends in EBP measures and priority outcomes across the state, enabling the monitoring of county performance and identifying high-performing areas as well as those needing targeted support. For instance, descriptive analysis can be used to evaluate trends in service utilization or gaps in program capacity, providing actionable insights for resource allocation. It is recommended that this analysis occurs monthly to ensure data remains timely and relevant. The results should be incorporated into state-level CQI meetings and shared with the FFPS Advisory Committee during quarterly updates, in line with best practices for continuous monitoring.

Root cause analysis is recommended to be led by the CQI Subcommittee to address systemic challenges impacting multiple counties. By identifying the underlying factors contributing to recurring issues—such as disparities in service access or workforce capacity—root cause analysis ensures that interventions are targeted and effective. Collaboration with the FFPS Advisory Committee is recommended to enhance this process by integrating diverse perspectives and leveraging county-level insights. Best practices suggest conducting root cause analyses quarterly or as specific issues arise, ensuring that challenges are addressed promptly, and solutions are informed by comprehensive data.

Comparative analysis is another essential component and is recommended to be conducted by the CQI Subcommittee. This analysis examines county-level performance against standards, specifically outlined in the Measurement Framework for each of the EBPs approved in California's Prevention Plan. These standards are established by the EBP developers/purveyors and define critical benchmarks such as fidelity metrics and outcome measures. Comparative analysis focuses on assessing how well counties meet these EBP-specific requirements, ensuring adherence to established guidelines without imposing additional standards. For example, comparative analysis can identify variations in fidelity or outcomes achievement, providing actional insights to inform technical assistance and resource allocation to underperforming counties. It is recommended

that comparative analysis be conducted biannually, allowing sufficient time to assess progress toward statewide goals and ensure alignment with the California Prevention Plan.

These recommendations ensure that descriptive, root cause, and comparative analyses are systematically integrated into the CQI process at the state level. By specifying who conducts these analyses and how often they are completed, CDSS can maintain a consistent and rigorous approach to data analysis. These practices align with CQI best practices and provide the foundation for data-driven decision-making, fostering systemic improvements that advance California's prevention goals.

Regional Prevention CQI Collaborative

To complement statewide data analysis and support county-level CQI efforts, the CQI Plan recommends establishing a regional CQI structure through a regional Prevention CQI Collaborative (PCQIC). The PCQIC is envisioned as a strategic opportunity for counties to engage in a structured, data-driven approach to improving EBP implementation, enhancing regional collaboration, and promoting shared learning.

The PCQIC is an opt-in initiative, meaning that participation is highly encouraged but not required. It is not a federal CQI requirement, but it provides counties with an invaluable opportunity to enhance their CQI processes and implementation efforts.

The PCQIC is designed to serve as a structured, regional approach to strengthening county-level CQI efforts, promoting shared learning, and enhancing the implementation of EBPs. Participation in the PCQIC provides counties with several key benefits, including:

- **A structured venue for shared learning**, allowing counties to exchange best practices, problem-solve challenges, and collaborate on solutions tailored for their regional contexts.
- **Access to technical assistance and specialized implementation support**, including guidance from CQI experts, peer-to-peer collaboration, and real-time application of best practices.
- **Enhanced data utilization**, supporting counties in leveraging descriptive, root cause, and comparative analysis to drive system improvements, identify gaps in service accessibility and outcomes, and improve service delivery.
- **A collaborative environment to co-develop and test strategies**, ensuring that counties can align efforts with statewide priorities while addressing unique local needs.
- **Stronger regional coordination**, promoting consistency and alignment in CQI implementation across counties while maintaining flexibility for county-specific approaches.

At its core, the PCQIC is intended to support continuous quality improvement, data-driven decision-making, and the integration of evidence-based practices into county prevention and child welfare systems. The following focus areas will guide the collaborative's efforts and provide a framework for its activities:

- **Strengthening CQI Capacity**: Enhancing county-level CQI infrastructure by fostering sustainable practices that integrate data review, partner engagement, and improvement cycles.

- **Enhancing Implementation Fidelity**: Supporting counties in monitoring and improving fidelity to selected EBPs, addressing barriers, and promoting consistent, high-quality service delivery.
- **Using Data to Drive Change**: Ensuring counties have the tools and processes needed to apply data-driven decision-making to monitor capacity, reach, fidelity and outcomes, assess program effectiveness, and make informed improvements in service delivery.
- **Promoting Cross-County Learning**: Establishing a structured learning environment where counties can share effective strategies, generate insights, and develop regionally informed solutions.
- **Aligning with Priority Outcomes**: Ensuring that county-level CQI efforts align with broader county and statewide strategies while remaining adaptable to local implementation needs.

The PCQIC will take place quarterly from October 2026 through September 2027, providing counties with a structured opportunity to engage in regional CQI collaboration. The first year will serve as a foundation for shared learning, data-driven decision-making, and implementation support. The structure and focus of the PCQIC in subsequent years may evolve over time based on implementation experience, emerging priorities, and ongoing discussions with partners.

Counties that are unable to participate in PCQIC sessions will have access to key takeaways, tools, and best practices developed within the collaborative. CDSS is exploring additional support mechanisms, such as consulting or targeted technical assistance, to ensure non-participating counties can still apply relevant insights.

This collaborative approach aligns with statewide priorities while empowering counties to adapt strategies to their unique circumstances. It also ensures that regional-level CQI efforts reflect the needs and experiences of diverse communities while driving improvements in EBP implementation and outcomes.

Grouping counties by training regions within the PCQIC framework is recommended to optimize support and enhance regional collaboration. To ensure that the unique needs of small counties are addressed, it is also recommended to create a separate PCQIC group specifically for these jurisdictions. Small counties face distinctive challenges, such as resource constraints and limited workforce capacity, which necessitate tailored approaches and support structures.

Each county participating in the PCQIC will form a team. These teams should include representatives from:

- The county's child welfare and probation department FFPS/CQI lead(s)
- County child welfare and probation administrators
- EBP service provider contract holders (if applicable)
- EBP providers (compensated through contractual agreements or memorandums of understanding)
- Compensated[2] individuals with lived expertise
- Compensated[2] Tribal representatives

[2] CDSS is committed to supporting counties that opt to participate in the PCQIC by providing compensation to Tribal representatives and individuals with lived expertise for their involvement in the collaborative.

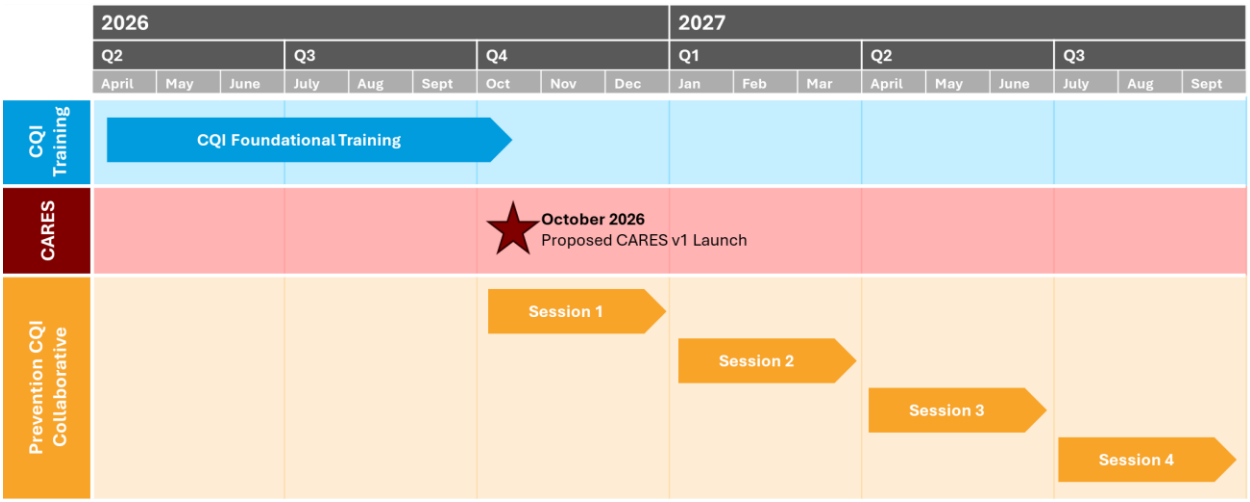
To foster team cohesion and collaboration, it is recommended that counties have all team members convene in the same location to participate virtually in the PCQIC sessions. This approach eliminates the need for large, in-person regional meetings while ensuring that county teams work together in a shared space for more effective engagement. Bringing together a diverse group of participants enriches decision-making and ensures broad representation within the collaborative. If counties have concerns about capacity to attend the PCQIC, support will be available to assist in preparing teams and ensuring meaningful engagement.

The PCQIC will use data as the foundation for its work, leveraging the same robust data infrastructure outlined in the statewide CQI plan. Participants will employ data analysis techniques—including descriptive, root cause, and comparative analyses—to identify trends, disparities, and opportunities for improvement. These analyses will be supported by tools such as real-time dashboards in the CWS-CARES system, ensuring that data is used to drive actionable insights and meaningful improvements.

The PCQIC will serve as an essential link between regional and state-level CQI efforts. Regional insights will inform statewide strategies and goals, while CDSS will offer technical assistance, guidance, and resources to counties. This bidirectional flow of information ensures alignment across all levels of the child welfare system, reinforcing the collaborative nature of California's CQI approach.

The integration of state-level data analysis and the regional PCQIC exemplifies California's commitment to equity, collaboration, and continuous improvement. These recommendations empower counties to leverage shared learning and targeted support while aligning with broader statewide priorities. These efforts build a foundation for county-level CQI implementation, which translates statewide and regional strategies into actionable local practices tailored to meet community needs.

Figure 6: Proposed Training and TA Timeline



County CQI Efforts

California's counties play a critical role in implementing CQI processes to ensure effective service delivery and improvement for children and families. This CQI Plan recommends that each county establish CQI

Implementation Workgroups to support the systematic evaluation and improvement of the EBPs identified in their Comprehensive Prevention Plan (CPP). These workgroups provide a collaborative and data-driven forum to monitor program performance, address challenges, and enhance service delivery. By focusing on implementation priorities at the local level, these workgroups complement state and regional CQI efforts while tailoring solutions to community-specific needs.

County CQI Implementation Workgroups

To support compliance with the California Prevention Plan (California Department of Social Services [CDSS], 2023, p. 40), counties must facilitate the exchange of aggregate data on implementation progress, model fidelity, and child, youth, and family outcomes between local cross-sector planning entities and the state's oversight bodies. This data-sharing process helps counties track progress, address emerging needs, and collaboratively develop solutions within the CQI framework. While counties have flexibility in how they structure their CQI efforts, they must ensure there is a clear process in place for reviewing data, identifying challenges, and adjusting improvement outcomes to support the implementation, monitoring, and continuous improvement of EBPs.

The best practice recommendation is to establish dedicated CQI Implementation Workgroups aligned with the EBPs being implemented. However, if a county already has existing cross-collaborative teams that fulfill these functions, they may leverage those teams instead of creating additional groups, as long as the team includes diverse partners, meets regularly, and embed a structured CQI process.

While counties have flexibility in how they structure these efforts, they must ensure that there is a clear process in place for reviewing data, identifying challenges, and adjusting improvement outcomes. The best practice recommendation is to establish dedicated CQI Implementation Workgroups aligned with the EBPs being implemented.

To align with best practices, counties should evaluate their existing CQI structures and determine whether adjustments are necessary to support EBP implementation. If current teams are unable to fully meet this need, counties should establish or restructure CQI workgroups focused on each group of EBPs being implemented. The number and type of workgroups should align with the EPBs selected in each county's Comprehensive Prevention Plan (CPP). For example, a county that does not implement any mental health EBPs would not need to establish a Mental Health CQI Workgroup. Small counties may also modify this structure to mee their unique needs, ensuring that CQI efforts are practical and responsive to local priorities while optimizing available resources.

Where applicable, counties should establish the following CQI Implementation Workgroups:

1. **Motivational Interviewing (MI) CQI Workgroup**: Focused on supporting the implementation and fidelity monitoring of motivational interviewing.

2. **Home Visiting (HV) CQI Workgroup**: Designed to oversee the implementation of EBPs such as Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents As Teachers (PAT), Homebuilders, and Family Check-Up.
3. **Mental Health (MH) CQI Workgroup**: Dedicated to overseeing the implementation of EBPs such as Paren Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Brief Strategic Family Therapy (BSFT).

Counties that do not establish separate workgroups must ensure that their existing CQI teams are structured to address the specific needs of EBP implementation. This may involve modifying members, meeting frequency, the agenda focus to ensure that CQI activities are meaningfully embedded into ongoing work. Regardless of structure, counties should ensure that these teams provide a dedicated space for monitoring EBP implementation and fidelity, identifying disparities, and driving continuous improvement.

Each workgroup[3] or cross-collaborative team should include diverse membership to ensure that decisions are informed by multiple perspectives. Best practice recommends the following participants:

- County child welfare and probation FFPS and/or CQI leads
- County child welfare and probation administrators
- Contract holders (if applicable)
- EBP providers (compensated through contractual agreements or memorandums of understanding)
- Compensated[4] Tribal representatives
- Compensated[3] individuals with lived expertise

This diverse composition ensures that CQI structures reflect the county's unique context and foster equity and collaboration in the CQI process. Incorporating lived expertise is best practice to ensure that strategies and improvements are grounded in the lived realities of the families and communities they serve.

By aligning their CQI structures with these best practices, counties can enhance their ability to use data effectively, support implementation fidelity, and drive meaningful improvements in service delivery while maintaining flexibility to structure their teams in a way that best fits their local context.

To guide the activities of County CQI Implementation Workgroups, the CQI Plan recommends a phased meeting cadence that evolves over time to reflect the changing needs of implementation. Best practice is for counties to follow this phased approach for their CQI workgroups, whether they establish new groups or use existing cross-collaborative teams that fulfill these functions. This ensures consistent monitoring, data-driven decision-making, and continuous improvement throughout the implementation process.

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[3] The same individuals should represent their county in both the PCQIC and County CQI Implementation Workgroups to ensure consistency in CQI efforts and alignment between regional and county-level improvement activities. This approach also maximizes efficiency, particularly for counties with limited capacity.

[4] CDSS is committed to supporting counties in implementing CQI workgroups by providing compensation to Tribal representatives and individuals with lived expertise for their participation.

During the first year, monthly meetings for each CQI workgroup or designate team are recommended to ensure consistent monitoring of reach and capacity data using the CARES dashboards and provider data. These initial meetings should focus on identifying implementation challenges, tracking progress, and making timely adjustments to address issues such as underutilization or disparities in service access. While outcome and fidelity data will only be formally collected biannually or annually for PAT, early review of available data is critical to inform timely decision-making and course corrections.

In the second year, it is recommended that the meeting cadence shift to a quarterly schedule as counties move toward more in-depth analyses of EBP effectiveness and fidelity. This transition supports deeper evaluations of longer-term trends and outcomes, providing an opportunity to assess whether EBPs are achieving their intended goals and maintaining adherence to model standards. Capacity and reach data should continue to be reviewed regularly to monitor service accessibility and utilization, ensuring that counties remain responsive to family and community needs.

After the second year, counties may adjust the frequency of workgroup or team meetings on an ad hoc basis to address specific challenges or respond to emerging needs. This flexible approach enables counties to maintain a responsive CQI process while ensuring that data collection and analysis remain consistent and aligned with local and statewide goals. By adapting their meeting cadence over time, workgroups can sustain momentum while focusing on the most pressing issues at each stage of implementation.

Best practice is for counties to follow this phased approach for their CQI workgroups, whether they establish new groups or use existing cross-collaborative teams that fulfill these functions.

✓ **Year 1:** Monthly meetings for each CQI workgroup or designated team to monitor reach and capacity data, track challenges, and make timely adjustments.

✓ **Year 2:** Quarterly meetings to analyze long-term trends, assess EBP effectiveness, and maintain fidelity to model standards.

✓ **Year 3+:** Meetings may be adjusted on an **ad hoc basis** to address emerging needs while maintaining alignment with local and statewide CQI goals.

County CQI Implementation Workgroups, or the existing county teams responsible for CQI, will rely heavily on data analysis techniques to inform their decision-making processes. Descriptive analysis will identify trends and patterns in capacity and reach data, facilitating the identification of performance gaps and areas for improvement. Root cause analysis, guided by the Five-Step CQI Process, will uncover the underlying factors driving these challenges. Comparative analysis will help counties track progress, identify effective practices, and align efforts with statewide goals to promote consistency and improvement.

Real-time data tools, such as CARES dashboards, will play a central role in supporting these analyses. By providing timely and actionable insights, these tools empower counties to monitor progress, conduct small tests of change, and refine strategies in a continuous improvement cycle. This emphasis on data ensures that counties maintain a proactive and informed approach to addressing challenges and implementing solutions (should version one of CARES need enhancements/refinements to make the data dashboards fully functional,

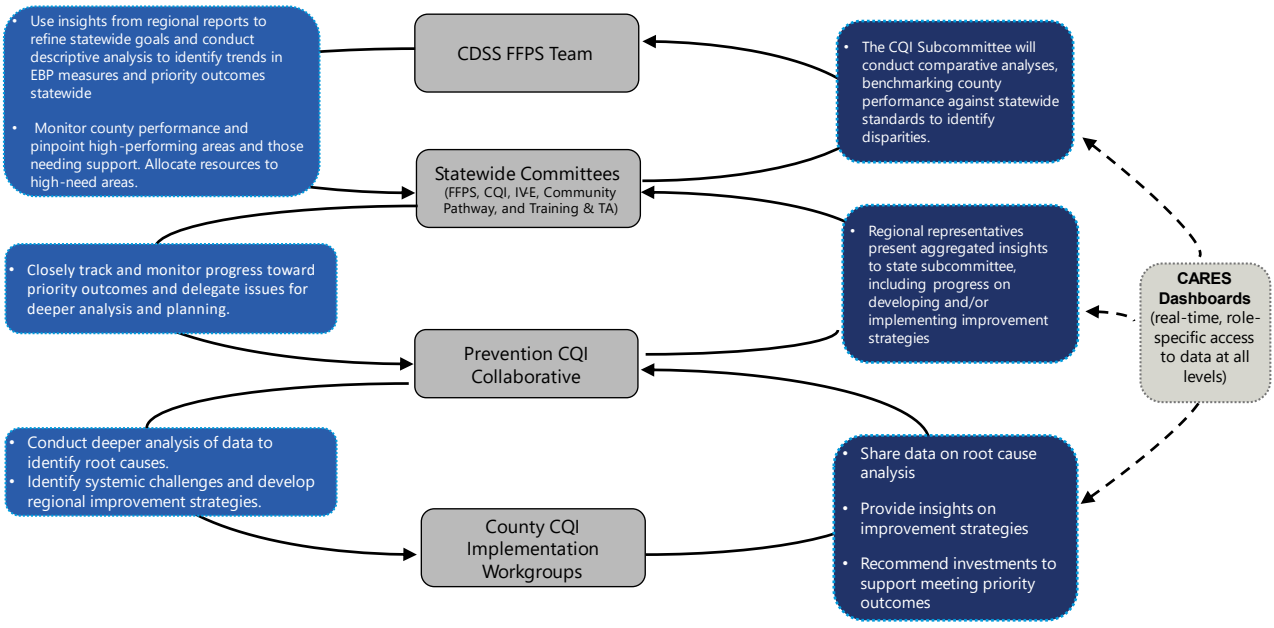
county CQI implementation workgroups or designated county teams should engage providers or purveyors (when possible) to share reports from their existing systems. It also serves as an opportunity to identify successes, gain an understanding of what is working well and drive counties toward improvements in other areas.

County CQI Implementation Workgroups or existing county CQI teams serve as a critical link between county-level implementation and regional and state-level CQI efforts. Insights and lessons learned from these workgroups will inform regional learning collaboratives, while technical assistance and guidance from CDSS will support counties in achieving their goals. This integration reinforces the importance of bidirectional communication, ensuring that both local innovations and statewide priorities are aligned. By grounding their work in the CPP, counties—whether through dedicated workgroups or existing CQI teams—can ensure that local CQI processes are directly aligned with prevention priorities and tailored to the specific needs of their communities.

CQI Feedback Loops

Feedback loops are the backbone of a dynamic and effective CQI process, fostering a culture of continuous learning and systemic improvement across all levels of California's child welfare system. For these loops to function effectively, information must flow bidirectionally among county, regional, and state CQI entities. By establishing clear pathways for communication and collaboration, California ensures that CQI efforts are responsive to local needs while advancing state-level priorities.

Figure 7: Visualization of CQI Feedback Loops



Adapted from Cooper, K. & Green-Rogers, Y. (2018, November 14). 21st Century Strategies for Outcome-Driven Quality Improvement. The Network for Social Work Management Webinar.

At the county level, CQI Implementation Workgroups provide a platform for reviewing data, addressing challenges, and testing solutions using real-time insights from the CARES dashboards. These workgroups synthesize data trends from EBP providers and elevate key findings to their County FFPS/CPP Leads. These teams, in turn, play a vital role in identifying actionable insights and ensuring that these insights inform higher-level discussions at the state and regional level. Regular communication between these entities ensures that local CQI processes remain aligned with state priorities.

At the regional level, the PCQICs serve as an essential hub for sharing insights, identifying systemic challenges, and promoting the adoption of best practices across counties. Feedback loops between the regional collaboratives and the state-level FFPS Advisory Subcommittees ensure that local experiences inform broader strategies. Leaders from regional collaboratives are encouraged to actively participate in state subcommittee meetings, presenting aggregated insights and offering actionable recommendations to CDSS and other statewide CQI partners. This ensures alignment between local and regional learnings and statewide goals.

The state level, led by CDSS and the FFPS Advisory Committee and subcommittees, the feedback process emphasizes using county and regional insights to refine statewide goals, prioritize technical assistance efforts, and allocate resources effectively. Real-time data from the CARES dashboards allows state and county leaders to track performance trends, monitor equity across jurisdictions, and respond proactively to emerging issues. Feedback loops ensure that lessons learned at the state level are communicated back to counties and regions, completing the cycle of continuous learning and improvement.

To support these feedback mechanisms, the CQI process leverages data visualization tools and storytelling techniques that convert raw data into actionable insights. CARES dashboards are being designed to provide accessible and aggregated insights across the county, regional, and state levels, enabling CQI partners to identify trends, track progress, and align decision-making with strategic priorities. This shared access to data and stories enhances transparency and encourages collaboration at all levels. Regular meetings and structured reporting processes further strengthen these feedback loops, providing forums for sharing information and co-developing solutions.

The interplay between data collection, extraction, interpretation, and feedback ensures that all levels of the child welfare system remain interconnected. Insights from county workgroups inform regional strategies, which in turn influence state-level planning and policymaking. This bidirectional flow of information enhances transparency, fosters shared accountability, and ensures that CQI efforts are grounded in the realities of service delivery while driving systemic improvements.

By establishing robust feedback loops, California's CQI system bridges the gap between data insights and actionable change. These mechanisms empower partners at all levels to collaborate effectively, ensuring that the child welfare system delivers equitable, effective, and evidence-based services to children and families. As a capstone to the improvement cycles outlined in this plan, these feedback loops operationalize the state's commitment to learning, collaboration, and achieving meaningful outcomes for children, youth, and families.

CQI SYSTEM CORE COMPONENTS: POLICIES & GUIDANCE

CQI Plan Sustainability

The CQI timeline outlined in Figure 1 incorporates federal reporting requirements for Title IV-E agencies under the Family First Prevention Services Act (FFPSA). Once the California Regional Evaluation and Support (CARES) system is launched, the state can begin claiming federal reimbursement and submitting required data reports.

Table 1: CQI Plan Review and Revision Timeline Aligned with CFSP Cycle and Federal Reporting

Timeline	Cycle	Focus Areas
2025–2026	Implementation and Monitoring Period	• Monitor progress within the CQI Subcommittee ○ CARES launch in October 2026
2027	Mid-Cycle Review and Revision	• Address gaps and successes identified through monitoring and evaluations ○ Ensure alignment with evolving prevention priorities • Federal reporting begins: First transmission due by May 15, 2027
2029	End of Cycle Revisions	• Refine processes and establish priorities for the next cycle • Ongoing federal reporting
Ongoing	Flexibility for Additional Revisions	• Respond to new federal guidance as needed

Federal Reporting Requirements

Once CARES is operational (expected October 1, 2026, at the start of Federal Fiscal Year 2027), California will submit federal reports every six months, in October and April, according to the federal fiscal year calendar. These reports must be transmitted within a 45-day submission period. For example:

- The first reporting period will cover prevention plans and claims for services provided from October 1, 2026, to March 31, 2027. This data must be transmitted by May 15, 2027.
- The second reporting period will cover services provided from April 1, 2027, to September 30, 2027, with a data submission deadline of November 14, 2027.

These reports will include all children and youth with active prevention plans, and they will remain on the submission for 24 months from the start of their prevention plan, unless they are pregnant or parenting youth in foster care. If a child or youth enters foster care during the 24-month reporting period, they will continue to

be included in the data submissions. Additionally, each submission will include services and costs dating back to the start of each child's prevention plan.

It is important to note the state Title IV-E agency (CDSS) is also responsible for submitting the quarterly financial information report documenting estimated and actual program expenditures for all IV-E programs using the CB-496.

CQI Plan Sustainability with CARES Integration

The launch of CARES in late 2026 marks a significant milestone in California's CQI process. CARES will enable streamlined data collection and reporting, allowing the state to meet federal requirements while maintaining a robust feedback loop for continuous improvement. These reporting activities will be integrated into the CQI cycle, ensuring that real-time data informs both state and county-level decision-making.

By aligning federal reporting schedules with the CQI Plan's structured timeline, California ensures that FFPSA implementation remains compliant with federal mandates while driving meaningful improvements in child and family outcomes. This dual focus on accountability and sustainability is central to achieving the goals of the CQI Plan and the Family First Prevention Services Act.

CONCLUSION

CDSS and the county IV-E agencies are well positioned to integrate the recommendations in this plan based on the existing infrastructure and clear commitment to enhancing existing practice and ensuring diverse voices are included and compensated for their contributions to the state, regional, and county CQI activities.

Recommendation One: Robust Governance Structure

- The statewide advisory and subcommittees are well-attended and robust in county, state, and partner representation.
- Regional Training Academy designations and relationships are solidified and tapped frequently to support large initiatives such as Family First.
- The System of Care Interagency Leadership Team exists in multiple counties and provides an infrastructure for which to build in FFPS CQI data. Some counties have also built EBP specific CQI teams with state block grant resources and are excited to formalize data collection with CARES and begin claiming.

Recommendation Two: Targeted CQI Resources

- The CARES data system developers are committed to reducing redundancy and streamlining FFPS data collection and have been excellent thought partners to members of the CQI Subcommittee.
- The CDSS FFPS Team is exploring policy and contractual relationships with EBP model purveyors who store and report fidelity and outcomes reports.

- The CA Prevention Plan includes a clear training and technical assistance roadmap which has been expanded upon and operationalized by the FFPS Subcommittees. The Training & Technical Assistance Subcommittee already in place will ensure coordination and execution.
- As part of the CQI Implementation Plan, a statewide survey will be conducted to help counties assess resources, define staffing roles, and identify technical assistance needs. To prepare, counties should start discussing their current CQI capacities.

Recommendation Three: Aligned Priority Outcomes

- The FFPS priority outcomes of reducing foster care entries, minimizing maltreatment recurrence, and measuring the effectiveness and fidelity of evidence-based programs align with federal and state frameworks, including the Child and Family Services Review (CFSR) and California's Child and Family Services Plan (CFSP).

Recommendation Four: Core Data Infrastructure and Processes

- CDSS laid the foundation for continuous quality improvement in child welfare services through an All County Information Notice (ACIN) in 2016, which includes a comprehensive Five-Step CQI process and operationalized each step.
- The training and technical assistance outlined in the CA Prevention Plan and further described in this plan will reinforce and drive the Five-Step process further into county, regional, and state practice.

Recommendation Five: Commitment to Equity and Inclusion

- CDSS is committed to ensuring each county can compensate Tribal representatives, individuals with lived expertise, and community advocates/grassroots individuals for their collaboration and involvement in county and regional CQI Workgroups.
- Chapin Hall has successfully compensated individuals with lived expertise in other projects across the country and has experience preparing system partners and supporting lived experts throughout their involvement. Exploration of funding to include transportation, childcare, translation services, and $100 an hour for participation in workgroups is underway. For more details, refer to these reports: Chapin Hall System Transformation Methods Report and the Authentic Youth Engagement Study Brief.

As you can see, California has spent years building a comprehensive infrastructure and is well-positioned to gain valuable insights into supporting children and families statewide through Family First Prevention Services, with this plan providing the CQI framework and a phased implementation plan in development to address staffing, CQI curricula, and data collection, set for release in late 2025.

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APPENDICES

Appendix A. California EBP Measurement Framework

This appendix provides detailed guidance on the **EBP Measurement Framework** for all of the EBPs approved in California's Prevention Plan. It outlines the specific metrics, data collection methods, and reporting requirements for capacity, reach, fidelity, and outcomes. The framework is designed to help IV-E agencies track implementation progress, evaluate program effectiveness, identify gaps and opportunities for improvement, and ensure equity in service delivery and outcomes. By offering a consistent and structured approach to data collection and analysis, the EBP Measurement Framework supports data-driven decision-making and aligns CQI efforts with the broader goals of California's Prevention Plan.

Standardized Capacity Measures

Measure	Indicator
Staffing	Total # of provider agency sites
	Total # of full-time model-trained or certified practitioners per provider site
	Total # of supervisors per provider site
	Total # of available model slots per provider site
Supervisor / Practitioner Ratio	
Full-time/part-time Caseload	

Standardized Reach Measures

Measure	Indicator
Eligible Child Welfare & Probation Candidates *(This data will come from the Title IV-E agency)*	Total # of FM/VFM/602 youth who come to the attention of the agency*
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition **
	Total # identified as a Family First pregnant or parenting youth in care (PPY)
	Total # not identified as a candidate
Eligible Community Pathway Candidates *(This data will come from the Title IV-E agency)*	Total # of community pathway children granted IV-E agency candidacy approval

	Total # of community pathway children denied IV-E agency candidacy approval
	• Reason for denial
	  ○ MH, SA, or PS imminent risk/need not identified
	  ○ Child outside of age range of the recommended EBP

EBP Referrals to Providers	Total # candidates referred to an EBP provider
EBP Service Uptake	Total # candidates who started the EBP

	Total # candidates who did not start the EBP
	• Reason did not start the EBP
	  ○ No action taken; referral still in process
	  ○ Placed on waitlist; median days on waitlist
	  ○ Provider rejected referral
	  ○ Provider unable to contact or engage with the family
	  ○ Family did not consent, etc.
	  ○ Other

EBP Service Completion	Total # candidates who completed the full EBP	
	Total # candidates who did not complete the full EBP • Reason did not complete the full EBP ○ Provider unable to contact or engage with family ○ Family withdrew ○ Family no longer eligible ○ Provider capacity issues ○ Other	

**Total number of referrals to Probation (inclusive of citations and arrests)*

***Youth referred to Probation by a Law Enforcement Agency for alleged involvement in delinquent behavior that could result in a WIC 602 petition*

Healthy Families America (HFA)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Positive Parenting Practices	% of primary caregivers with children in the target age range whose caregiver-child interaction was assessed using a validated tool.	90%	CHEERS Check-In or another validated tool.	Collected based on child's age.	None; provider-specific
Improved Pregnancy Outcomes	% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment.	<15%	HFA Spreadsheet or site's custom report	Collected once at end of pregnancy.	
Improved Child Health & Development	% of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.	90%	ASQ-3	Collected twice a year from birth to age 3, then annually.	
	% of children enrolled in home visiting referred for services for a positive screen for developmental delays (measured using a validated tool) who receive services in a timely manner.	90%	HFA Spreadsheet or site's custom report	Collected after positive screen.	
Improved Caregiver Health	% of primary caregivers enrolled in home visiting for at least three months who were screened for depression within 3 months of enrollment OR 3 months of delivery (for those enrolled prenatally).	80%	None specified; providers may use the PHQ-9 or EPDS	If enrolled prenatally, collected during pregnancy and within 3 months after birth; if enrolled postnatally, collected at the time of enrollment.	
	% of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.	80%	HFA Spreadsheet or site's custom report	Collected after a positive screen.	

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of staff (including direct services staff, supervisors, and program managers) who have received intensive HFA Core Foundations training	100%	HFA Spreadsheet or	Collected as training occurs.	None; provider-specific

	by an HFA certified training within 65 months of date of hire.		site's custom report	
	% of staff (including direct service staff, supervisors, and program managers) hired more than 12 months ago wo have received ongoing, annual training.	100%		
Meets Staffing Qualification Requirements	% of program managers who have required qualifications.	100%		
	% of supervisors who have required qualifications.	100%		Collected during hiring process.
	% of direct service staff who have required qualifications.	100%		
Meets Supervision Frequency Requirements	% of direct service staff who receive weekly supervision.	100%		
	Ratio of supervisors to direct service staff is 1:6.	N/A		
Timely Completion of Home Visits	% of families using the HFA Standard Model who receive their first home visit within 3 months after the birth of the baby.	80%		Collected as needed.
	% of families referred by child welfare using the Child Welfare Protocol who receive their first home visit by the time their child is 24 months of age.	80%		

Nurse-Family Partnership (NFP)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Positive Parenting Practices	% of primary caregivers with children in the target level age range whose caregiver-child interaction was assessed using a validated tool.	75%	DANCE HOME (also accepted)	Collected based on child's age during the reporting period.	NFP Outcomes File
Improved Pregnancy Outcomes	% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment.	<15%	NFP Database Forms	Collected once at birth, or shortly after.	
	% of infants who are born within a normal birth weight (> 5.5lb or 2,500g).	90%		Collected once at birth.	
	% of infants who were given breastmilk at birth.	82%		Collected once at birth, or shortly after.	
	% of infants who were given any amount of breastmilk at 6 months of age.	50%		Collected once at 6 months.	
Improved Child & Health Development	% of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.	50%	Ages and Stages Questionnaire-3 (ASQ-3)	Collected at 4, 10, 18, and 24 months postpartum.	
	% of children enrolled in home visiting referred for services for a positive screen for developmental delays (measured using a validated tool) who received services in a timely manner.	50%	NFP Database Forms	Collected after a positive screen.	
Improved Caregiver Health	% of primary caregivers enrolled in home visiting for at least 3 months who were screened for depression within 3 months of	65%	PHQ-9 or EPDS	Collected at 1-8 weeks postpartum.	

	enrollment or 3 months of delivery (for those enrolled prenatally).			
	% of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.	65%	NFP Database Forms	Collected after a positive screen.

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of nurse home visitors who have completed initial education.	100%	NFP Learning Management System	Collected as needed by NFP sites and the purveyor.	NFP Fidelity Report
	% of nurse supervisors who have completed initial education.	100%			
Meets Staffing Qualification Requirements	% of nurse home visitors who have a minimum of a BSN.	100%			
	% of nurse supervisors who have a minimum of a BSN.	100%			
	% of NFP providers who have a nurse supervisor.	100%			
Meets Supervisor to Nurse Home Visitor Ratio Requirements	% of full-time nurse supervisors who provide supervision to no more than 8 individual nurse home visitors. 100%	100%			

Parents As Teachers (PAT)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Positive Parenting Practices	% of primary caregivers with children in the target level age range whose caregiver-child interaction was assessed using a validated tool.	60%	Approved, validated tool[1]	Collected at end of pregnancy.	Affiliate Performance Report (APR) and Performance Measures Report (PMR) for providers using Penelope or Visit Tracker; otherwise, provider-specific reporting methods.
Improved Pregnancy Outcomes	% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm and with very low birth weight following program enrollment.	<15%	PAT Forms or site's Data Management System (DMS)	Collected after the child's birth, usually during the first post-birth visit.	
Improved Child Health & Development	% of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.	60%	Approved, validated tool[2]	Collected within 90 days of enrollment for children aged 4 months or older, and then at least once annually.	
	% of children enrolled in home visiting referred for services for a positive screen for developmental delays (measured using a validated tool) who receive services in a timely manner.	56.8%	PAT Forms or site's Data Management System (DMS)	Collected after a positive screen.	

Improved Caregiver Health	% of primary caregivers enrolled in home visiting for at least 3 months who were screened for depression within 3 months of enrollment OR 3 months of delivery (for those enrolled prenatally).	80%	Approved, validated tool[3]	Collected within 90 days of enrollment for children aged 4 months or older, and then at least once annually.
	% of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.	41.4%	PAT Forms or site's Data Management System (DMS)	Collected after a positive screen.

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of parent educator (PE) and new supervisors who will deliver Parents as Teachers services to families have attended the required PAT trainings before delivering PAT services.	100%	Affiliate Performance Report (APR)	Collected as needed.	Affiliate Performance Report (APR) and Performance Measures Report (PMR) for providers using Penelope or Visit Tracker; otherwise, provider-specific reporting methods.
	% of PEs and supervisors delivering model services for the affiliate have a current Model Certified subscription.	100%			
Meets Supervisor to Parent Educator Ratio	# of PEs per 1.0 FTE supervisor (the number of parent educators assigned to the supervisor decreases proportionately when the supervisor is not full-time).	≤6			
Meets Visit Frequency Requirements	% of families with 1 or fewer stressors that received at least 75% of the required number of visits per month.	100%			
	% of families with 2 or more stressors that received at least 75% of the required number of visits per month.	100%			
Meets Developmental Screening Requirements	% of newly enrolled children who received a complete initial child developmental screening within 90 days of enrollment or birth.	100%			
	% of children who received a complete annual child developmental screening during the program year.	100%			
	Affiliate used one of the PAT approved developmental screening tools[4].	Yes/No			
Timely Submission of the PAT 21 Essential Requirements	Date of Affiliate Performance Report submission.	Date (MM/DD/YYYY)			
	% of affiliates that receive a score of ≥60% or pass on all 21 items in the Affiliate Performance Report (APR).	100%			

Homebuilders®

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Placement Prevention	% of youth who avoid placement at case closure.	80%	CPS Records	Collected at case closure.	HOMBUILDERS® Quarterly Annual Report
	% of youth who avoid placement 6 months after case closure.	70%		Collected 6 months after case closure.	
Improved Child Safety	% of families that have no new CPS reports during the intervention.	75%		Collected during intervention period.	
	% of families that improve in at least one high priority NCFAS domain related to safety.	80%	North Carolina Family Assessment Scale (NCFAS)	Completed once at beginning of intervention and at case closure.	
Improved Family Functioning	% of families that improve in at least one high priority NCFAS domain rated below the baseline at intake.	80%			
Improvements in Safety Concerns Addressed	Average rating on the *HOMEBUILDERS® Referent Feedback Survey* regarding whether the therapist adequately addressed the safety concerns.	4.0	HOMEBUILDERS® Referent Feedback Survey	Completed by family once at case closure.	
Improvements in Targeted Goals	Average rating on the *HOMEBUILDERS® Referent Feedback Survey* regarding whether the intervention goals were appropriate.	4.0			
Improvements in Skill Utilization	% of families completing the *HOMEBUILDERS® Referent Feedback Survey* that report that they are using a new skill.	85%			
Improvements in Goal Achievement	% of families who complete the service show progress on goal attainment ratings for at least one goal at service closure.	85%	Exponent Case Manager	Practitioner rating at end of intervention period.	

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	Therapists, supervisors, and program managers participate in all required HOMEBUILDERS® training and QUEST activities.	100%	Exponent Case Manager	Collected quarterly.	HOMEBUILDERS® Quarterly Annual Report
Provider Meets Staffing Qualification Requirements	% of therapists who have the required qualifications.	100%		Collected by purveyor at time of hire.	HOMEBUILDERS® Site Review Report
	% of supervisors who have the required qualifications.	100%			
Meets Supervision & Consultation Requirements	% of eligible interventions are staffed weekly, where staffing preferably occurs during ream consultation.	90%		Collected by purveyor after each intervention.	HOMEBUILDERS® Quarterly Annual Report
Meets Referral Response Requirements	% of families who receive their first face-to-face visit (receive an intake session) within 24 hours of referral.	75%			
	% of families who receive their first face-to-face visit no later than the end of the day after the referral (based on all eligible interventions).	85%			

	% of full-time, trained therapists that serve 17-18 families per year.	100%		Collected by purveyor annually.
	% of families that meet with their therapist at least 3 times per week.	80%		
	Average length of face-to-face contacts (excluding interventions that close prematurely).	38 hours		Collected by purveyor after each intervention.
	% of families that report that the therapist explained 24/7 availability.	90%	HOMEBUILDERS® Referent Feedback Survey	
	% of referents who report that the therapist maintained adequate contact with the referent.	85%		

Family Check-Up (FCU)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Child Behavioral Functioning	At service completion, % of cases with improved scores on items related to child behavioral functioning on the Youth Adjustment Domain.	85%	FCU Questionnaires: • CB Caregiver Report on Child (age 2-5) • CB Caregiver Report on Child (age 6-11) • CB Caregiver Report on Child (age 11-17) • CB Child Self Report (age 11-17)	Assessed before intervention and again at completion	None; provider-specific
Improved Child Emotional Functioning	At service completion, % of cases with improved scores on items related to child emotional functioning on the Youth Adjustment Domain.	85%			
Increased Positive Parenting Practices	At service completion, % of cases with improved scores on items related to positive parenting practices in the Parenting and Family Management Domain.	85%			

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of providers who have completed all required eLearning courses.	100%	N/A	Collected as training occurs	None; provider-specific
	% of providers who have completed interactive skills training.	100%			
Meets Staffing Qualification Requirements	% of FCU sites that have an onsite certified supervisor trainer.	100%	N/A	Collected as staff are certified & recertified	
Consistent Use of Core Tools for Implementing the FCU Model	% of providers who use core materials with the family.	100%	Family-completed questionnaires	Collected following each session.	
Use of the COACH Rating Form	% of provider's COACH fidelity rating falls into the "competent work" range (4-9).	90%	COACH Fidelity Rating System • Feedback Session COACH Rating Form • Everyday Parenting COACH Rating Form	Collected following each session.	

Sites Complete Annual Check-In	% of FCU sites that participate in an annual check-in with the model purveyor.	100%	N/A	Collected annually by purveyor	Purveyor can produce a written report.

Brief Strategic Family Therapy (BSFT)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Child Behavioral Functioning	% of youth with clinical improvement in the Social Functioning subset.	70%	Child and Adolescent Needs & Strengths (CANS) Assessment	Assessed before intervention and again at completion	None; provider-specific
	% of youth with clinical improvement on the Family Functioning subset.	65%			
Improved Child Emotional Functioning	% of youth with clinical improvement in the Behavioral/Emotional Needs domain.	70%			
Decrease in Youth Delinquent Behavior	% of youth with reduction in association with antisocial peers.	60%			
	% of youth with clinical improvement in the Conduct & Socialized Aggression subset.	60%			
Decrease in Parent/Caregiver Substance Use	% of parents with reduced alcohol use.	65%	Addiction Severity Index		
Effective Parenting Practices	% of parents who move out of the "non-clinical" range on the Parenting Practices Questionnaire.	75%	Parenting Practices Questionnaire		
Overall Family Functioning	% of families who have a significant reduction on the general Family Assessment Device subscales.	75%	McMaster Family Assessment Device		

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	*% of providers who have completed Training Workshop #1.*	*100%*	*Class Attendance Matrix*	*Collected by BSFT trainers as training occurs*	*BSFT Training Class Attendance Report*
	% of providers who have completed Training Workshop #2.	*100%*			
	% of providers who have completed Training Workshop #3.	*100%*			
	% of supervisors who have completed supervisor training and have had a minimum of 1 year of fidelity adherence.	*100%*			
Meets Staffing Qualification Requirements	*% of therapists who have at least a master's degree in mental health, social work, marriage and family*	*100%*	*BSFT Hiring Toolkit*	*Collected by purveyor upon hire*	*BSFT Summary Sheet of Provider Qualifications*

	therapy, or a related field, or a bachelor's degree plus 5 years of clinical experience.			
	% of supervisors who have at least a master's degree in mental health, social work, marriage and family therapy, or a related field.	*100%*		
Ongoing Completion of the BSFT Adherence Certification Checklist	*% of therapist who score at least a 3.8 on the BSFT Adherence Certification Checklist at the end of their first year.*	*100%*		*Collected by BSFT Certified Supervisor every other month*
	% of therapists who score at least a 3.8 on the BSFT Adherence Certification Checklist at the end of their second year.	*100%*	*BSFT Adherence Certification Checklist*	*Collected by BSFT Certified Supervisor every quarter*
	% of therapists who score at least a 3.8 on the BSFT Adherence Certification Checklist at the end of their third year.	*100%*		*Collected by BSFT Certified Supervisor every 6 months*

Multisystemic Family Therapy (MST)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Maintain Family Stability	At discharge, % of youth still at home.	90%	Case Discharge Form	Collected at discharge	Program Implementation Review (PIR) and MST Dashboard Report
Maintain Educational & Vocational Involvement	At discharge, % of youth in school or working.	90%			
Reduce Arrests	At discharge, % of youth not arrested during treatment.	90%			

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of therapists who have been working more than 2 months who complete the 5-day orientation training and obtain certification in MST.	100%	Collected by provider agencies	Collected once initial therapist training is completed	Program Implementation Review (PIR)
	% of supervisors who complete supervisor orientation training.	100%		Collected once initial supervisor training is completed	Reported by provider agencies
	% of therapists who participate in quarterly booster training.	100%		Collected quarterly	
Provider Meets Staffing	% of therapists that have a master's degree in social work or counseling.	66%		Collected at program start-up	Reported by provider agencies

Qualification Requirements	% of clinicians who are part of a licensed MST program.	100%	Collected by provider agencies	and every six months during the Program Implementation Review	
Completion of the Therapist Adherence Measure Revised (TAM-R)	% of TAM-R due that are completed.	70%	Therapist Adherence Measure Revised (TAM-R)	Completed by caregivers during the second week of therapy and approximately every 4 weeks thereafter	MST Dashboard Report
	% of youth with at least one TAM-R interview.	100%			
	Overall average TAM-R adherence score.	0.61			
	% of youth reporting adherence above the threshold of 0.61.	80%			

Functional Family Therapy (FFT) LLC

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Child Behavioral Functioning	% of youth who demonstrate significant improvement between the pre- and post-measure.	80%	Youth Outcome Questionnaire (YOQ) 2.01 and YOQ-Self Report (YOQ-SR) 2.0	Therapist administers at pre- and post-intervention	Purveyor-generated Outcomes Spreadsheet and Tri-Yearly Performance Report
Improved Child Emotional Functioning	% of youth who demonstrate significant improvement between the pre- and post-measure.	80%	YOQ 2.01 YOQ-SR 2.0		
Decrease in Youth Substance Use	% of youth who achieve a 3 or higher on the COM-Y.	80%	Client Outcome Measure-Youth (COM-Y)	Therapist administers at completion	
Improved Family Functioning	% of families who achieve a 3 or higher on all three outcome measures.	80%	COM-Y, Client Outcome Measure-Caregiver (COM-C), and Therapist Outcome Measure (TOM)		

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of teams that receive initial 2-day clinical training.	100%	Training Spreadsheet	Collected as training occurs.	Training Spreadsheet (purveyor-generated upon request)
	% of teams that receive ongoing training, depending on which phase they are in.	100%			
Meets Staffing Qualification Requirements	% of supervisors who have a master's degree.	100%	Qualifications Spreadsheet	Collected during hiring process.	Qualifications Spreadsheet (purveyor-generated upon request)
	% of staff who have a master's degree or bachelor's degree with relevant experience.	100%			
Completion of the Weekly Supervision Checklist	% of teams that meet with their respective consultant/site supervisor weekly.	100%	Weekly Supervision Checklist	Completed by FFT consultant or site supervisor weekly.	Weekly Supervision Checklist Spreadsheet Tri-Yearly Performance Report
Completion of Global Therapist Ratings	% of teams that complete the Global Therapist Rating.	100%	Global Therapist Rating	Completed by FFT consultant or site supervisor every 4 months.	Global Therapist Ratings Spreadsheet Tri-Yearly Report

Functional Family Therapy (FFT) Partners

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Improved Child Behavioral Functioning	% of youth who have scores in the average/normal range on the total difficulties, conduct, and emotional subscales.	75%	Strengths & Difficulties Questionnaire (SDQ)	Therapist administers a pre- and post-intervention	Outcomes Spreadsheet (purveyor-generated)
Improved Child Emotional Functioning	% of youth who have scores in the minimal/mild/moderate range (Youth Depression).	75%	PHQ-A		
	% of youth who have scores in the minimal/mild/moderate range (Youth Anxiety).	75%	GAD-7		
Decrease in Youth Substance Use	% of youth who have scores in the Low/Medium risk category.	75%	CRAFFT		
Improved Family Functioning	% of youth and caregivers who have scores in the average to high functioning areas on the family functioning subscales.	75%	Client Outcome Measure-Caregiver (COM-C) & Client Outcome Measure-Youth (COM-Y)		
	% of youth and caregivers who have scores in the medium to high functioning areas on the family stability subscales.	75%	COM-C & COM-Y		

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of therapists at a Community Site who have met all of the training requirements.	95%	Training Attendance Log	Collected as training occurs.	Fidelity Spreadsheet (purveyor-generated)
Meets Staffing Qualification Requirements	% of staff that have at least a master's degree and meet the requirements of the local regulatory agencies.	100%	Hiring Spreadsheet	Collected during hiring process.	
Meets All Components of Model Fidelity Requirements	% of therapists with Conceptual, Service Delivery, and Session Fidelity that is in the average range of all other FFT therapists in the jurisdiction.	75%	Therapist Fidelity Measure	Completed 4 times in first year and 2 times every year thereafter.	
	Ther program will rank in the average to high range of Program, Fidelity Key Performance Indicators.	80%	Program Fidelity Measure	Completed every 6 months.	

Parent-Child Interaction Therapy (PCIT)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Positive Parenting Practices	% of caregivers who demonstrate improvement on the PRIDE skills.	50%	Dyadic Parent-Child Interaction Coding (DPICS-IV) Coding Sheet	Therapist administers every session; may also	None; provider-specific

	% of caregivers who demonstrate goal criteria in Phase 2, Parent-Directed Interaction (PDI). Note: "Goal criteria" means at least 75% of caregivers' commands meet criteria for being "effective".	75%	DPICS-IV Coding Sheet	be administered at completion.
	% of caregivers who have a decrease in ECBI score at service completion/discharge.	75%	Eyberg Child Behavior Inventory (ECBI)	
Reduction in Negative Child Behaviors	% of children whose behavior is rated in the normal range (≤114) per the ECBI Intensity Scale.	75%	Eyberg Child Behavior Inventory (ECBI)	

Fidelity Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of therapists who complete basic and consultation training.	100%	N/A	Collected as training occurs.	None; provider-specific
	% of therapists who complete at least 3 hours of PCIT Continuing Education credit.	100%		Collected after therapist completes Continuing Education credit.	
Meets Staffing Qualification Requirements	% of therapists that have a least at master's degree and are licensed as mental health practitioners.	100%	N/A	Collected during hiring process.	
Use of Eyberg Child Behavior Inventory (ECBI) ***or*** *Use of the Weekly Assessment of Child Behavior (WACB)*	% of cases were ECBI was completed for every session. OR % of cases where the WACB was completed for every session.	90%	Eyberg Child Behavior Inventory (ECBI)/Weekly Assessment of Child Behavior (WACB)	Completed by parents of children ages 2-16 years old at every session.	
Use of Dyadic Parent-Child Coding System (DPICS-IV)	% of cases were DPICS-IV was completed for every session, except session when the child is not present.	90%	Dyadic Parent-Child Coding System (DPIS-IV)	Completed by therapist to evaluate parent-child interactions during pre-, mid-, and post-treatment.	

Motivational Interviewing (MI)

Outcome Measures

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Parent/Caregiver Engagement	% of families with an open child welfare or probation case that had one or more in-person contacts per month.	100%	Included in the case contact	Quarterly	County-specific
	% of families with an open child welfare or probation case where staff documented MI was used during the monthly contact.	100%	Included in the case note	Quarterly	County-specific
	# of staff delivering MI that demonstrate "Competent," "Proficient," or "Good" work on the relevant measurement tool in the last month.	N/A	MICA 3.2 or MITI 4.2.1	Quarterly	County-specific

Completion of Substance Use Treatment	# of adolescents receiving MI for substance abuse in the last month.	N/A	County-specific	Quarterly	County-specific
	# of adults receiving MI for substance abuse in the last month.	N/A	County-specific	Quarterly	County-specific
Federally Required Measures	# of adolescents who received MI, whose Child Specific Prevention Plan (CSPP) ended, and who entered foster care within 12 months.	N/A	County-specific	Quarterly	County-specific
	# of adolescents who received MI, whose Child Specific Prevention Plan (CSPP) ended, and who entered foster care within 24 months.	N/A	County-specific	Quarterly	County-specific
	# of adults who received MI, whose Child Specific Prevention Plan (CSPP) ended, and their child entered foster care within 12 months.	N/A	County-specific	Quarterly	County-specific
	# of adults who received MI, whose Child Specific Prevention Plan (CSPP) ended, and their child entered foster care within 24 months.	N/A	County-specific	Quarterly	County-specific

***Fidelity Measures (*future guidance will include more detail about ongoing training)*[5]**

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training *(This will **not** be automated from CARES; providers will need to enter this data)*	# of staff who have completed approved MI Foundational Training.	N/A	County-specific	Monthly	County-specific
	# of staff who have completed approved MI Advanced Training.	N/A	County-specific	Monthly	County-specific
	# of supervisors who have completed approved MI Foundational Training.	N/A	County-specific	Monthly	County-specific
	# of supervisors who have completed approved MI Supervisor Training.	N/A	County-specific	Monthly	County-specific
	# of staff who received a "Client-Centered" score and participated in *ongoing training every six months.	N/A	County-specific	Monthly	County-specific
	# of staff who received a "Generally Inconsistent" score and participated in *ongoing training every six months.	N/A	County-specific	Monthly	County-specific
	# of staff who received a "Fundamentally Inconsistent" score and participated in *ongoing training every six months.	N/A	County-specific	Monthly	County-specific
	# of staff who received a "Fair" score and participated in *ongoing training every six months.	N/A	County-specific	Monthly	County-specific

[5]Until a trainee reaches "Competent" or "Proficient" on the MICA or "Good" on the MITI, they are required to participate in ongoing training every six months and receive coding and coaching on a monthly basis. Once a trainee has reached a score of "Competent", "Proficient", or "Good", coding and coaching will be required every six months.

Meets Trainer Qualification Requirements *(This will **not** be automated from CARES; providers will need to enter this data)*	Who is training your staff? (e.g., RTA, MINT trainers, other)	N/A	County-specific	Monthly	County-specific
	Total # of qualified MI trainers.	N/A	County-specific	Monthly	County-specific

*MI Fidelity Monitoring Requirements for the **MICA 3.2***

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Meets fidelity monitoring requirements (MICA) *(This will **not** be automated from CARES; providers will need to enter this data)*	# of staff delivering MI who achieved a "Proficient" coding score (on the relevant tool) in the last month.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who achieved a "Competent" coding score (on the relevant measurement tool) in the last month.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who achieved a "Client-Centered" coding score (on the relevant measurement tool) in the last month.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who achieved a "Generally Inconsistent" coding score (on the relevant measurement tool) in the last month.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who achieved a "Fundamentally Inconsistent" coding score (on the relevant measurement tool) in the last month.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who received coding/coaching within one month after receiving a "Client-Centered" coding score.	N/A	MICA	Monthly	County-specific
	# of staff delivering MI who received coding/coaching within one month after receiving a "Generally Inconsistent" coding score.	N/A	MICA	Monthly	County-specific

*MI Fidelity Monitoring Requirements for the **MITI 4.2.1***

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Meets fidelity monitoring requirements (MITI)	# of staff delivering MI who achieved a "Good" coding score (on the relevant measurement tool) in the last month.	N/A	MITI	Monthly	County-specific
	# of staff delivering MI who achieved a "Fair" coding score (on the relevant measurement tool) in the last month.	N/A	MITI	Monthly	County-specific

*(This will **not** be automated from CARES; providers will need to enter this data)*	# of staff delivering MI who received coding/coaching within one month after receiving a "Fair" coding score.	N/A	MITI	Monthly	County-specific
	# of staff delivering MI who received ongoing coding/coaching every six months after receiving a "Good" coding score.	N/A	MITI	Biannually	County-specific

Appendix B. EBP Reporting Frequency

Model	Reporting Frequency	Reporting Responsibility
BSFT	Biannually	Providers
FCU	Biannually	Providers
FFT (both versions)	Biannually	Purveyor
HFA	Biannually	Providers
Homebuilders	Biannually	Both purveyor and providers
MI	Biannually	Providers
MST	Biannually	Both purveyor and providers
NFP	Biannually	Purveyor
PAT	Annually	Providers
PCIT	Biannually	Providers

Appendix C. CFSR – CA Prevention Plan and EBP Outcomes/CFSR Crosswalk

Model	EBP Outcome	CFSR Indicators	CFSP Goals
BSFT	Improved family functioning and communication. Reduced youth behavioral problems (e.g., conduct issues, delinquency, and substance abuse).	Safety Outcome 1: Children are protected from abuse and neglect. Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs.	Strengthen family capacity and reduce risk factors contributing to child welfare involvement.
FCU	Increased parental involvement and positive parenting practices. Reduction in child problem behaviors and substance use.	Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs. Permanency Outcome 2: Continuity of family relationships and connections is preserved for children.	Promote safe, stable, and nurturing relationships for children.
FFT (both versions)	Improved family relationships. Reduced recidivism and delinquent behaviors in youth.	Permanency Outcome 1: Children have permanency and stability in their living situations. Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs.	Improve permanency and stability while addressing behavior challenges to keep children safely at home.
HFA	Enhanced child well-being and developmental outcomes. Reduced incidence of child abuse and neglect.	Safety Outcome 1: Children are protected from abuse and neglect. Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs.	Ensure children's safety and developmental needs are met through early intervention.
HB	Reduced out-of-home placements. Improved family functioning and stability.	Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate. Permanency Outcome 1: Children have permanency and stability in their living situations.	Provide family-centered interventions that preserve and stabilize families.
MI	Enhanced family engagement. Improved caregiver capacity to address children's needs.	Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs.	Build family capacity to provide safe and nurturing environments for children.
MST	Reduced youth antisocial behavior and recidivism. Improved family functioning and parental skills.	Permanency Outcome 1: Children have permanency and stability in their living situations.	Address youth behavior challenges to promote family and community stability.

		Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs	
NFP	Improved maternal and child health outcomes. Increased parenting skills and child development outcomes.	Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs.	Enhance maternal and child health and development to prevent maltreatment.
PAT	Improved school readiness and child developmental outcomes. Strengthened parent-child interactions and parenting skills.	Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs.	Foster early learning and positive parent-child relationships to reduce risks.
PCIT	Reduced child behavioral problems. Strengthened parent-child relationships.	Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs. Safety Outcome 1: Children are protected from abuse and neglect.	Improve parent-child interactions to strengthen family functioning and reduce behavioral challenges.