Planning Title IV-E Prevention Services: A Toolkit for States

Assessing Population, Service Needs, and Service Coverage

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ASSESSING POPULATION, SERVICE NEEDS, AND SERVICE COVERAGE

To best meet the needs of families with children at risk of entering foster care, states can assess population needs, access to services, and funding and coverage of prevention services. This part of the toolkit includes questions, information, and resources to help states identify potential opportunities and goals to prevent maltreatment, whether through reimbursement for Title IV-E prevention services or other activities more broadly. Assessing the population, needs, and coverage will help agencies understand their current landscape, including gaps in funding and opportunities to braid funds so they can build a comprehensive array of services.

The questions in this part of the toolkit will be best answered in partnership with other stakeholders (as discussed in the "Identifying and engaging partners" companion document in this toolkit). To support planning, this part of the toolkit covers three key areas for states to assess, with questions focusing on the following:

1. Population and service needs (Section A),
2. The landscape of services and providers (Section B)
3. Insurance coverage and funding (Section C)

These three components fit together to provide information about the current needs in your state and can help you identify goals and priorities (see the "Determining priorities, goals, and actions" companion document in this toolkit). Broadly, the goal is to consider population needs and factors that contribute to families' access to services, focusing especially on factors that the child welfare agency and its partners can address in planning.

In considering service needs and availability, it is important for states to understand the wide range of factors that can affect access to services. For example, it might be useful to consider the following:

- **Family-centered services.** Multiple service sectors (including behavioral health, child welfare, and early childhood services) strive to offer family-centered services, which are services that incorporate the needs of family members as a whole system to improve

individual health or child safety. Family-centered practice is a strengths-based approach, not only to identify parent and child needs but also to coordinate service referrals across systems. One example of a family-centered practice is family group decision making, a team approach to child welfare practice in which families are encouraged to share their priorities and concerns in order to improve case outcomes. It has been widely implemented in child welfare agencies in the United States (Child Welfare Information Gateway n.d.). Aspects of family-centered practices can also be incorporated in mental health, substance use disorder, and parenting programs. See Box 1 for more resources on family-centered services.

- **Cultural appropriateness.** As agencies examine the current landscape of services and implement prevention services, the appropriateness of services in relation to families' cultures and values is an essential concern. For example, evidence-based practices might have to be adapted to more effectively address differing needs of African American, Hispanic, Native American, and other populations.[1]

Box 1. Resources for understanding and implementing family-centered services

1. National Resource Center for Family-Centered Practice: The University of Iowa's School of Social Work provides resources for human service agencies to promote family-centered, community-based, and culturally competent practices within organizations and across systems.
2. SAMHSA's Family-Centered Treatment page: This page offers policy and practice resources, including state examples of implementing family-centered treatment in substance use and mental health agencies. It also provides a guide for developing a coordinated network of community-based services.
3. State Policy Levers for Expanding Family-Centered Medication-Assisted Treatment: This study from the Office of the Assistant Secretary for Planning and Evaluation helps states consider opportunities and challenges regarding combining medication-assisted treatment with family-centered services. It includes examples from state programs.

- **Dimensions of accessibility.** One framework defines access to services as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services, and to actually have a need for services fulfilled" (Levesque et al. 2013). The framework shown in Table 1 describes dimensions of access related to

[1] For more information and resources about child welfare and cultural competence, see https://www.childwelfare.gov/topics/systemwide/cultural/.

features of health systems and providers as well as the corresponding population's abilities to interact with systems and providers. Although some of these dimensions, such as affordability, might be a focus of planning for Title IV-E prevention services, in planning for a broad service array, it is important to consider that all of the dimensions contribute to families' access to services. In addition, although Levesque et al.'s framework was designed in relation to families seeking health care services voluntarily, many aspects also apply to families for whom prevention services can help reduce the need for foster care placement.

Table 1. Dimensions of accessible prevention services

Supply side (features of health systems and providers)		Demand side (features of populations)
1. **Approachability** – Services can be identified by people with needs and can be identified as reachable and as able to impact people's health.		1. **Ability to perceive** – People perceive a need for services (which is impacted by knowledge and beliefs).
2. **Acceptability** – Services are provided in a way that is acceptable to people and in accordance with their beliefs (which is impacted by cultural and social factors).		2. **Ability to seek –** People perceive that services are acceptable for them to seek and receive and have the autonomy and capacity to seek services.
3. **Availability and accommodation** – Services can be reached both physically and in a timely manner.		3. **Ability to reach –** People have mobility, availability of transportation, and schedule flexibility to reach services.
4. **Affordability –** Services are affordable to the population served in terms of resources spent and time used.		4. **Ability to pay –** People have the time and economic ability to pay for services (including cost of potential loss of income).
5. **Appropriateness** – Services fit client's needs and are appropriate in timeliness and quality.		5. **Ability to engage –** People can participate and be involved in treatment and related decisions (which is related to both capacity and motivation to participate).

Source: Adapted from Levesque et al. 2013

Tables 2 through 6 below can help your assessment process. The "Information or resources to consider" column in the tables provides background information and highlights relevant sources and data to help states looking for information about particular questions and topics.

A. Population and service needs

Table 2. Assessing population and service needs

Questions to consider	Information or resources to consider
1. **Populations at risk of entering foster care** a. Which populations do we consider to be at risk of entering foster care—especially those for whom prevention services might help to prevent entry? b. What are their demographics and the factors that contribute to risk for foster care entry? c. What are the factors related to adoption or guardianship disruption?	• **Individual risk factors and risk prediction.** A number of individual factors put families at risk of child maltreatment. - The 2019 KIDS COUNT Data Book (also available in the KIDS COUNT Data Center) provides a snapshot of child well-being in the United States by state. It ranks states in the domains of economic well-being, education, health, and family and community. It also has information related to how placements for young people in foster care have changed from 2007 to 2017. - The Children's Bureau Child Welfare Data Outcomes data page provides demographic and context data for states as well as outcomes on seven key child welfare performance metrics. It also provides information about state performance over time. - The Centers for Disease Control and Prevention's National Vital Statistics System includes all deaths with drug poisoning as the underlying cause of death. For more information, see the related ASPE brief, The Relationship Between Substance Use Indicators and Child Welfare Caseloads. - The Allegheny Family Screening Tool predicts a child's risk score at the time of hotline report. Although this will not help you determine the needs of your population, it could be useful for understanding levels of risk that might help define target populations for prevention services. - The Evidence Base: Child Maltreatment Risk Factors, from the University of Texas, explains child maltreatment risk factors. This information might be useful for identifying families with children who are at risk of entering foster care in your state. • **Geographic risk factors and risk prediction.** Some states focus on the needs in particular geographic regions within their states. Geographic risk prediction can be useful in targeting areas for services and resources, but identifying candidates for services is done on an individual basis. In relation to geographic risk factors, Predict Align Prevent offers resources for identifying risk and prevention before child maltreatment has occurred. It uses location-based predictive analytics (geo-mapping) to identify 500 by 500 foot areas in which maltreatment is likely to occur based on environmental risk and protective factors. It overlays maps with public health and community asset locations. The website includes free data tools and maps of risk factors, such as SUD and crime. - For an example, see Virginia's report on its use of Predict Align Prevent

Table 2 *(continued)*

Questions to consider	Information or resources to consider
2. **Needs for MH and SUD services** a. What are the MH and SUD service needs of families with children at risk of entering foster care (including needs of parents, caregivers, and youth)? b. What is the extent of MH and SUD conditions and service needs in our state—and what are the relevant child safety issues?	• **Prevalence of MH and SUD conditions.** SAMHSA's annual National Survey on Drug Use and Health gathers data on MH and SUD conditions among people ages 12 and older. Available resources include tables with 2016–2017 survey information for each state and state-specific Behavioral Health Barometer reports that combine results with information about MH and SUD service use. • **Comprehensive services to address MH and SUD needs.** Understanding comprehensive arrays of MH and SUD services might help states evaluate the continuum of services that they require to address families' needs. Appendix B of this toolkit reviews descriptions of comprehensive arrays of MH and SUD services. It is important to note that appropriate services can vary by diagnosis. For example, the National Institute on Drug Abuse provides a description of different SUD treatment approaches depending on the substance used. • **Maternal and child health needs assessments.** Each state completes a Title V Maternal and Child Health Services Block Grant needs assessment every five years (which will be updated by July 2020) and a MIECHV needs assessment update every five years (which will be updated by October 2020). The assessments might provide useful information for planning, for example, information about the health needs of women, children, and families in each state. A resource from the Health Resources and Services Administration crosswalks information about each type of needs assessment. • **State child welfare information systems and Medicaid data systems.** State child welfare information systems typically provide data on reasons for foster care entry and reasons for adoption or guardianship disruptions. State Medicaid data systems can provide information on behavioral health services use, including by those in foster care. • **See Section B of this document for information about services currently provided and Section C for information regarding insurance coverage and funding.**
3. **Needs of in-home parent skill-based programs** a. What are the service needs for in-home parent skill-based programs among families with children at risk of entering foster care?	• **Sources of information.** State child welfare agencies can consult with various partners and stakeholders (such as MIECHV grantees, CBCAP grantees, and Title V agencies) regarding needs for in-home parent skill-based programs. Further, based on experience, states that have implemented parenting education as part of Title IV-E waivers might also have insights on population needs. In addition, the Title V and MIECHV needs assessments mentioned previously in this table could help identify population needs for programs. (In relation to the MIECHV needs assessment, guidance for states and territories details what is included in the assessment and requirements for coordination with other programs.) • **Estimate of families that can benefit from programs, by state.** In its Home Visiting Yearbook, the National Home Visiting Resource Center offers state-by-state estimates of the number of families in each state that could benefit from receiving home visiting programs (based on having a child under the age of 1, being headed by a single mother, having a parent with no high school diploma, having low income, being a pregnant woman or mother under the age of 21). This analysis can also give insight on population need for other in-home parent skill-based programs. • **See Section B of this document for information about services currently provided and Section C for information regarding insurance coverage and funding.**

Table 2 *(continued)*

Questions to consider	Information or resources to consider
4. Input from families a. What mechanisms do we have to hear directly from parents and youth with lived experience about what they need?	• **See Section A and Box 2 of the "Identifying and engaging partners" companion document in this toolkit for resources regarding engaging families in planning services.**
5. Primary prevention a. What other prevention needs (e.g., primary prevention) does the population have, and how can we address them?	• **Factors to consider.** In planning services for families with children at risk of entering foster care, it is important to consider primary prevention supports that could help prevent conditions that affect child maltreatment. An Administration for Children and Families memorandum (ACYF-CB-IM-18-05) includes information about strengthening families through primary prevention of child maltreatment and unnecessary parent–child separation, including examples of promising programs. Primary prevention can involve education or support (such as financial or social) to help reduce the likelihood of neglectful parenting, mental illness, or SUD issues, which can in turn impact a family's ability to care for its children. The following are examples of such education and support: - Income supports help families maintain economic self-sufficiency that is important for child safety (Berger and Font 2015) - Lack of stable housing puts families at risk of child neglect (Fowler et al. 2018; Marcal 2018; Rog et al. 2017) - Childcare service coordination and childcare subsidies are associated with a reduction in maltreatment (Ha et al. 2015; Maguire-Jack et al. 2019) - Education and employment services might help support family stability, but family outcomes associated with such services have not been well researched (Cheng and Li 2012) • **Funding sources.** The National Academy of State Health Policy has compiled a matrix of funding sources available to states in order to address the health-related social needs (such as transportation, housing, and childcare) of people with low income (see Meeting the Health-Related Social Needs of Low-Income Persons: Funding Sources Available to States).

ASPE = Assistant Secretary for Planning and Evaluation; CBCAP = Community Based Child Abuse Prevention; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; MH = mental health; SAMHSA = Substance Abuse and Mental Health Services Administration; SUD = substance use disorder.

B. Landscape of services and providers

1. Behavioral health services

Table 3. Understanding the landscape of behavioral health services and providers

Questions to consider	Information or resources to consider
1. Behavioral health service system capacity, strengths, and gaps a. How do families with children at risk of entering foster care access MH and SUD services? b. What service system-related barriers do they face? c. In addition to insurance coverage and funding (see Table 6), what factors impact access to and timeliness of care in our state? Do any existing or planned initiatives address these factors? *(Note: These questions should be considered for both adults and children.)*	• **Information from state agencies.** Partnering with your state's MH or SUD and Medicaid agencies can give you the most up-to-date information about the behavioral health service system in your state. Agency websites might also have information about state-specific access issues, provider availability, or initiatives to improve care. Other partners described in the "Identifying and engaging partners" companion document in this toolkit, such as child and youth policy coordinating bodies, might also have information about these topics. • **States' assessments of service availability.** States might have a variety of existing analyses of MH and SUD service availability such as the following: - To apply for SAMHSA block grants[a] states must identify the strengths and capacity of their service system, unmet service needs, and critical gaps in the current delivery system. SAMHSA's application and plan document also identifies several SAMHSA data sets that can support these analyses. - As part of applications for Medicaid section 1115 demonstrations for SMI or serious emotional disturbance[b] (and annually thereafter), states are strongly encouraged by the Centers for Medicare & Medicaid Services to assess the current availability of MH services. - MIECHV and Title V needs assessments (discussed in Table 2) must include information about capacity for providing SUD treatment and counseling services. • **Provider availability.** Access to SUD services can be impeded by a lack of SUD treatment providers (MACPAC 2018). Some barriers to access affect certain types of treatment or geographic areas in particular. For example, opioid treatment programs are the only settings in which methadone can be dispensed, and they are mostly located in urban areas (MACPAC 2018). The absence of timely, appropriate SUD treatment options (especially medication-assisted treatment) can be a formidable barrier to care for parents who have SUD (Radel et al. 2018a, 2018b). The same is true for MH services. Some areas have a shortage of service providers, especially in rural regions (HRSA 2019a), and for intermediate levels of care (CMCS 2018a). If your state has existing behavioral health integration efforts, you might also want to consider how those impact access to care. The following resources could be useful in considering provider availability: - SAMHSA's Data Archive and Data Page have multiple data sets and reports about available MH and SUD treatment facilities and services as well as characteristics of the people receiving services. As noted in Table 2, SAMHSA's state-specific Behavioral Health Barometer reports also include data about MH and SUD service use.

Table 3 *(continued)*

Questions to consider	Information or resources to consider
	- The HRSA has data on MH professional shortage areas, and its online information enables you to search for shortage areas by state and county. For information about the MH professional shortage area designation, see https://bhw.hrsa.gov/shortage-designation. • SAMHSA's 2017 report, Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015, includes state-specific profiles for MH (Appendix A) and SUD (Appendix B) agencies. The profiles include details about topics such as agency structure, policies, and services (including EBPs, when data are available). • See Table 1 and related narrative in this document regarding other dimensions of access to services, including appropriateness of services. For example, for resources about child welfare and cultural competence, see https://www.childwelfare.gov/topics/systemwide/cultural/. • See Section C of this document for information regarding coverage and funding of services.
2. Current provision of MH and SUD EBPs a. What MH and SUD EBPs are currently being provided in the state? b. Are any of these EBPs rated in the Title IV-E Prevention Services Clearinghouse (the Clearinghouse) or planned for systematic review? c. Who provides them? Where are they provided? d. To whom are they provided? e. What age group(s) and needs do the EBPs target?	• **Sources to consider.** To find out which MH and SUD EBPs are currently available in your state, it might be helpful to check with state MH or SUD agencies, providers or provider associations, or purveyors of particular EBPs. For example, some states that are planning Title IV-E prevention services have conducted surveys of MH and SUD providers to understand which EBPs they are providing. • **SAMHSA resources.** SAMHSA offers a number of resources regarding evidence-based treatment: - SAMHSA's EBP Resource Center provides treatment protocols, toolkits, resource guides, practice guidelines, and other evidence-based resources. - SAMHSA's Center for Excellence provides implementation support for states to use EBPs and has helped some states assess their current use of EBPs. - SAMHSA's Uniform Reporting System has state-specific reports that include data on particular EBPs (such as multi-systemic therapy) used by state MH agencies, including whether they measure fidelity to the model. - SAMHSA's Technology Transfer Centers program aims to develop and strengthen the specialized behavioral health care and primary health care workforce that provides prevention, treatment, and recovery support services for SUD and mental illness. The program comprises three networks: (1) the Addiction Technology Transfer Centers, (2) the Mental Health Technology Transfer Centers, and (3) the Prevention Technology Transfer Centers. - SMI Adviser, which is funded by SAMHSA and administered by the American Psychiatric Association, aims to advance the use of a person-centered approach to care for people with SMI, including by providing resources to clinicians about evidence-based treatment.

[a] See Section A.3 of the "Understanding roles of funding and decision points" companion document in this toolkit for more details. All states, as well as multiple territories, receive these grants (SAMHSA n.d.).

[b] All references in this toolkit to Medicaid section 1115 demonstrations refer to demonstrations authorized by section 1115(a) of the Social Security Act.

EBP = evidence-based practice; HRSA = Health Resources and Services Administration; MH = mental health; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; SAMHSA = Substance Abuse and Mental Health Services Administration; SMI = serious mental illness; SUD = substance use disorder.

Box 2. Understanding in-home parent skill-based programs.

States can use Title IV-E prevention services reimbursement to pay for time-limited, in-home parent skill-based programs that meet the statutory criteria for otherwise eligible children. This box describes the difference between the terms "in-home services," "home visiting," and "in-home parent skill-based programs." Although there is some overlap in the terms, they refer to different concepts.

- **In-home services.** As used in this toolkit, the term in-home services refers specifically to services offered by a child welfare agency that are typically provided to families who have been brought to the attention of the child welfare agency because of a report of abuse or neglect but for whom the risk for maltreatment does not appear high enough to warrant child removal. Some child welfare agencies provide services to these families, including regular child welfare caseworker home visits, to ensure children's safety. These families might also be linked with other referrals to ensure their well-being and family stability.
- **Home visiting.** As used in this toolkit, home visiting programs refer to services provided in families' homes as part of a broader public health approach to preventing child maltreatment. Services may also address other goals, such as improving maternal and child health, and promoting child development. Home visiting programs commonly include components such as screening, case management, family support, counseling, and parent skills training (CMCS/HRSA 2016). The services might be offered by nurses (such as with Nurse-Family Partnership) or community-based agencies (such as with Healthy Families America). Home visiting programs often focus on a particular demographic within an area, such as young pregnant or parenting women or fathers.
- **In-home parent skill-based programs.** This term is used in the Family First Prevention Services Act legislation. It does not necessarily refer to the location in which services are provided; it could mean, for example, that the child continues to live in the home of a parent or relative caretaker during the time the state is providing the services (ACYF-CB-PI-18-09). These programs can include parenting skills training, parent education, and individual and family counseling. The first three in-home parent skill-based programs approved by the Clearinghouse were all home visiting programs. See Table 5 for information on these three programs, and see the Clearinghouse website for information on any additional in-home parent skill-based programs that are under review or approved. In addition, Wilson et al. (2019) describes characteristics of in-home parent skill-based programs that could be eligible for the Clearinghouse.

2. In-home parent skill-based programs

Table 4. Understanding the landscape of in-home parent skill-based programs

Questions to consider	Information or resources to consider
1. In-home services provided by child welfare agency a. What in-home services are currently being provided and to whom? b. What are the referral linkages to other services for families who receive in-home services, and can they be improved? What needs do the resources meet? c. Has the state previously received a Title IV-E waiver to provide in-home services? Will the programs continue, and if so, how will they be funded?	• In-Home Services in Child Welfare, an issue brief from the Children's Bureau, provides an overview of child welfare in-home services and examines issues related to service delivery, funding, and program evaluation. • Evidence-Based Elements of Child Welfare In-Home Services describes a common elements approach to in-home services and helps to categorize various interventions for serving families who live together and could be at risk for maltreatment. • Summaries and Profiles of Child Welfare Waiver Demonstrations Active Between 2012 to 2019, from the Children's Bureau, describes states' Title IV-E waiver demonstrations. Some of the demonstrations included goals such as preventing maltreatment and foster care entry. The profiles provide demonstration and evaluation information by state.
2. Home visiting programs a. What home visiting programs, including EBPs, are currently being provided in the state? b. Are any of the EBPs rated in the Clearinghouse or planned for systematic review? c. Who provides them? d. To whom are they provided? e. Where are they provided?	• **Sources to consider.** To find out which home visiting programs, including EBPs, are currently available in your state (and which populations they serve), it will be helpful to check with MIECHV grantees. Providers and purveyors of particular EBP models can also be useful resources. In addition, the following sources might be useful: - MIECHV needs assessments. As described in Table 2, states conduct a needs assessment every five years to receive MIECHV funding. The assessment includes identifying the quality and capacity of existing programs or initiatives for early childhood home visiting. - MIECHV state fact sheets. These fact sheets list the MIECHV-funded home visiting programs implemented by each state, the scope of program coverage by county (including rural and non-rural), the populations served, and the performance outcomes. - National Home Visiting Resource Center 2019 Home Visiting Yearbook. The yearbook describes the evidence-based models implemented with MIECHV and non-MIECHV funding by state in 2018. Each state profile includes sociodemographic information about the children served by the programs (such as age and insurance status) and information about caregivers (such as education level). The yearbook also contains state-specific data tables with additional detail about people served by MIECHV-funded programs.

Table 4 *(continued)*

Questions to consider	Information or resources to consider
	• **Understanding home visiting EBPs and differences between programs.** Home visiting programs differ along various dimensions such as target population and program components: - Table 5 describes three examples of home visiting EBPs, all of which have been rated as "well-supported" in-home parent skill-based programs in the Clearinghouse. • The HomVEE project website describes additional home visiting models. Programs that have met the U.S. Department of Health and Human Services' evidence-based criteria are listed under the Effectiveness Research page, and each program page summarizes the model, implementation, and outcomes. Please note that the effectiveness criteria used in HomVEE and the Title IV-E Clearinghouse differ.
3. Other in-home parent skill-based programs a. Which other in-home parent skill-based programs, including EBPs, are currently being provided in the state? b. Are any of the EBPs rated in the Clearinghouse or planned for systematic review? c. Who provides them? d. To whom are they provided? e. Where are they provided?	• Parent Education to Strengthen Families and Prevent Child Maltreatment, an issue brief from the Administration for Children and Families, Children's Bureau, provides an overview of parent education programs, including evidence-informed programs, information on some state and local examples, and information about additional resources. • **Sources to consider.** Compared with information about home visiting programs, there is less centralized information about which other in-home parent skill-based programs are provided in each state. Some potential sources of information about existing programs in your state include the following: - Various partners and stakeholders mentioned in the "Identifying and engaging partners" companion document in this toolkit, such as Community Based Child Abuse Prevention grantees and child and youth policy coordinating bodies - Purveyors of EBPs - The National Parenting Education Network website, which includes a list of parenting education networks and organizations by state - Some child welfare agencies have implemented parent education programs though Title IV-E waiver demonstration projects (See Summaries and Profiles of Child Welfare Waiver Demonstrations Active from 2012 to 2019.)

EBP = evidence-based practice; HomVEE = Home Visiting Evidence of Effectiveness; MIECHV = Maternal, Infant, and Early Childhood Home Visiting.

Table 5. Information about home visiting programs in the Title IV-E Prevention Services Clearinghouse as of October 2019

Program name	Program components[a]	Target population[a]	Home visitor credentials[a]	Subdomains with favorable impacts[a]	Implementation[b]
Healthy Families America	• Healthy Families America includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services and linking families to a medical provider and other community services as needed. • Visits begin prenatally or within first three months of child's birth through 3 to 5 years old. When referred from child welfare, families might be enrolled with a child up to 24 months old. • During the first six months following a child's birth or following enrollment (whichever is later), in-home visits are offered weekly. After six months, families receive visits less frequently depending on their needs and progress.	Pregnant women, families with children ages 0 to 5 who are at-risk for maltreatment or adverse childhood experiences. Each Healthy Families America site can determine target characteristics (such as low-income families or families who have experienced substance use disorder, mental health issues, or domestic violence).	Home visitors are required to have a high school diploma or equivalent.	• Child safety • Child well-being: Behavioral and emotional functioning, cognitive functions and abilities, delinquent behavior, educational achievement and attainment • Adult well-being: Positive parenting practices, parent or caregiver mental or emotional health, family functioning	Operates in 37 states and the District of Columbia as well as some territories
Nurse-Family Partnership	• Nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. But the content of the program can vary based on the needs and requests of the mother. • Home visits begin no later than the 28th week of pregnancy and may continue until child turns 2 years old. • Visits conducted weekly during the first month after enrollment. Afterward, visits continue biweekly or as needed.	Young, first-time, low-income pregnant women and mothers with children ages 0 to 2. Primarily focuses on mothers and children, but fathers and other family members are encouraged to attend	Home visitors are typically nurses with a bachelor's degree or higher.	• Child safety • Child well-being: Cognitive functions and abilities; physical development and health • Adult well-being: Economic and housing stability	Operates in 42 states and the Virgin Islands

Table 5 *(continued)*

Program name	Program components[a]	Target population[a]	Home visitor credentials[a]	Subdomains with favorable impacts[a]	Implementation[b]
Parents as Teachers	• The Parents as Teachers model includes personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. • Visits begin prenatally and continue until child reaches kindergarten. • Services are offered on a biweekly or monthly basis, depending on family needs. The intensity of the visit schedule depends on assessment of risk factors.	Pregnant women; families with children ages 0 to 5. Although Parents as Teachers can be used with anyone, many Parents as Teachers programs target families in possible high-risk environments (such as families with low income or history of substance use disorder).	Home visitors are required to have a high school diploma or GED and at least two years of experience working with children and parents.	• Child safety • Child well-being: Social functioning, cognitive functions and abilities	Operates in 49 states and District of Columbia

Notes: All of these programs were rated "well-supported" in the Title IV-E Prevention Services Clearinghouse. See the Clearinghouse website for information on any additional in-home parent skill-based programs that are under review or approved, and see ACYF-CB-PI-19-06 for information on transitional payments for programs that have not yet been rated by the Clearinghouse.

[a] Information based on Title IV-E Prevention Services Clearinghouse, available at https://preventionservices.abtsites.com/program.

[b] Information taken from National Home Visiting Resource Center's 2019 Home Visiting Yearbook, https://nhvrc.org/yearbook, as of 2018.

Box 3. Trauma-informed practice

The Title IV-E prevention program has a clear focus on ensuring that states' prevention programming is trauma informed (ACYF-CB-PI-18-09).

A trauma-informed approach refers to understanding how trauma influences clients' response to treatment, ensuring that services are offered in an environment that feels safe to clients and reduces re-traumatizing experiences, and understanding the role of secondary trauma in service provision. Families who interact with the child welfare system have often experienced a number of traumatic stressors. For example, they might have experienced homelessness, domestic violence, or a parent or caretaker's substance use disorder. Some states have already been involved in efforts to train staff in trauma-informed practices. For example, Maryland used a Title IV-E waiver to develop a trauma-informed system of care throughout the state. Multiple promising practices and evidence-based practices were tested and evaluated to learn how to offer services that are responsive to the role of trauma in families' lives.

Relevant resources include the following:

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014) provides a framework for defining a trauma-informed approach to serving people who interact with multiple systems (including health, behavioral health, and social services). This resource could be helpful for states as they implement evidence-based, trauma-informed practices.
- The National Child Traumatic Stress Network's website offers information about interventions that use a trauma-informed approach and includes information about training and certification requirements. In addition, the network's Creating Trauma-Informed Systems (2016) defines a trauma-informed approach to system collaboration with families involved in the child welfare system.

C. Insurance coverage and funding

Table 6. Assessing insurance coverage and funding

Questions to consider	Information or resources to consider
1. Insurance coverage a. Do people in families with children at risk of entering foster care have health insurance coverage? b. What type of coverage (such as Medicaid, CHIP, or private health insurance)?	• **Health insurance coverage by state.** Understanding existing coverage will help your state identify opportunities to braid funds for people or services that are not currently covered by other mechanisms. KFF's State Health Facts compiles state-specific data on health insurance coverage and uninsurance, with data available stratified by various factors (such as age, adults with or without dependent children, poverty level, and gender). The data are not specific to those involved with child welfare. You might also wish to consider whether your state has any data on insurance coverage of those involved with child welfare. For example, some states have linked Medicaid and child welfare data in their evaluations of Regional Partnership Grants. • **Sources of insurance.** Medicaid and private health insurance will be the most important sources of coverage to consider in relation to families in your state who have children at risk of entering foster care. Some people, however, might qualify for CHIP, which in some states, notably, also covers some pregnant women. (See CMS data on Medicaid and CHIP income eligibility levels, by state and population.) • As discussed in Section A.6 of the "Understanding roles of funding and decision points" companion document in this toolkit, other sources of coverage will also be relevant to some people in families with children at risk of entering foster care.
2. Medicaid eligibility and enrollment a. What Medicaid eligibility criteria in our state are important for understanding which people in families with children at risk of entering foster care will be Medicaid eligible? b. Are there particular populations that are prone to coverage gaps or loss (for example, postpartum Medicaid)? c. To what extent are people who are eligible for Medicaid actually enrolled?	• **Background about Medicaid is in Appendix C of this toolkit.** • **Eligibility for Medicaid.** State Medicaid programs must cover children who receive foster care, adoption assistance, or kinship guardianship assistance under Title IV-E as well as certain former foster care youth (Mitchell 2019). Key aspects of Medicaid eligibility requirements for other populations vary by state. When considering which people in families with children at risk of entering foster care will be Medicaid eligible, keep the following in mind: - **Income eligibility limits.** Income-related eligibility criteria for Medicaid varies greatly by state. For example, for those who qualify for Medicaid because they are parents, the income eligibility limit ranged from 13 percent of the federal poverty level in Alabama to 216 percent of the federal poverty level in the District of Columbia as of April 2019. (See CMS data on income eligibility levels by state and population.) - **Immigration status.** Immigration status also impacts Medicaid or CHIP eligibility (see Brooks et al. 2019 regarding states' policies). For example, to be eligible for Medicaid or CHIP, lawfully residing immigrants generally must have a qualified immigration status, and many must wait five years after obtaining qualified status before being eligible. Most states, however, have eliminated this five-year wait for children and pregnant women. Undocumented immigrants are not eligible to enroll except to receive emergency services, but some states have fully state-funded programs that cover people regardless of immigration status. • **Postpartum lapses in Medicaid coverage.** States' Medicaid income eligibility limit for pregnant women ranges from 133 percent to 375 percent of the federal poverty level as of April 2019. (See CMS data on income eligibility levels for information by state.) This pregnancy-related coverage extends to 60 days postpartum. After 60 days, Medicaid income eligibility limits for parents are more restrictive, especially in states that have not adopted the Affordable Care Act's Medicaid expansion (see Ranji et al. 2019, especially Figure 1). Therefore, some low-income women lose Medicaid coverage after 60 days postpartum.

Table 6 *(continued)*

Questions to consider	Information or resources to consider
Medicaid eligibility and enrollment *(continued)*	• **Medicaid or CHIP eligibility versus enrollment.** The extent to which people eligible for Medicaid or CHIP are enrolled varies by state and is generally lower for parents than for children. KFF's state-specific Medicaid and CHIP participation rates data could help identify opportunities in your state. In 2016, the Medicaid and CHIP participation rate[a] for eligible **parents** was about 80 percent nationwide (ranging from 44 percent in Texas to 96 percent in Massachusetts). The participation rate for eligible **children** was about 94 percent nationwide (ranging from 81 percent in Alaska to 98 percent in Massachusetts and Vermont).
3. Medicaid structure and service administration a. How are Medicaid services administered in our state (for example, type of managed care, fee-for-service)? b. Does this differ by **population** (for example, children or parents versus those eligible because of disability, children in foster care versus not in foster care)? c. Does this differ by **service**—in particular, how are behavioral health services administered?	• **Understanding the Medicaid service delivery system.** It is important to understand the Medicaid service delivery system (including for behavioral health) in your state to know roles of various entities and how to coordinate between them. States' Medicaid service delivery systems vary. For example, in a state with comprehensive managed care provided by managed care organizations, behavioral health services might be provided under each separate managed care organizations or they might be carved out and administered under a statewide entity that administers behavioral health services only. Background about Medicaid, including Medicaid managed care, is in Appendix C of this toolkit. In addition, the presence of Medicaid managed care can impact services in various ways as discussed in Section A.2 of the "Understanding roles of funding and decision points" companion document in this toolkit. • **Information about Medicaid managed care by state.** To understand the service delivery system, speaking with Medicaid partners may be most useful. The following sources can provide useful information: - The state's Medicaid agency's website might contain information or a summary about the service delivery system, including for behavioral health. In particular, a state's Quality Strategy for managed care generally contains a summary about a state's managed care delivery system. - CMS's Medicaid Managed Care Enrollment Report includes state-by-state information about managed care programs, including populations and services included. The report includes state profiles, and other links include spreadsheets of data. - An annual survey of Medicaid directors includes information about managed care initiatives by state (see Gifford et al. 2019 regarding fiscal years 2019–2020, especially their Table 4 regarding behavioral health services in managed care). - KFF's Medicaid Managed Care Market Tracker includes some data on Medicaid managed care organizations enrollment by state. The data provide an overall picture of managed care enrollment but are not specific about behavioral health services.

Table 6 *(continued)*

Questions to consider	Information or resources to consider
4. Medicaid coverage of MH and SUD services a. Which MH and SUD services are covered in Medicaid? Does this differ by population**?** b. Are there limits on coverage that impact key MH or SUD services? c. Are there barriers to care or timeliness that are specific to Medicaid (for example, provider participation in Medicaid, prior authorization requirements)?	• **Medicaid coverage of MH and SUD services in each state.** Getting information directly from partners in your state's Medicaid agency can give you the most up-to-date information. Some existing resources, however, have information about Medicaid coverage of behavioral health benefits in each state: - **For SUD services,** MACPAC's 2018 analysis of access to SUD services is organized by the American Society of Addiction Medicine's levels of care and includes an analysis of three medication-assisted therapies. The analysis is current as of April 2018. Because additional states' section 1115 SUD demonstrations have been approved since then, some states' information will be out-dated.[b] See MACPAC (2019b) for a more recent analysis of Medicaid coverage of SUD recovery support services by state. - **For MH services,** Kaiser Family Foundation's 2019 Medicaid Behavioral Health Services Database details state-by-state coverage of behavioral health services covered as of July 1, 2018, in each state's fee-for-service programs for adults based on a survey of state Medicaid directors.[c] The database includes classifications of 22 MH services. It also includes information on copayments for and limits on services (when noted by responding states). - **For Medicaid section 1115 demonstrations,** Medicaid.gov's section 1115 demonstration website includes links to state-specific documentation about section 1115 demonstrations (such as states' implementation plans). The documentation includes information about states' coverage of services under the demonstrations as well as other planned efforts to improve care. See Section A.1 of the "Understanding roles of funding and decision points" companion document in this toolkit for more information about section 1115 demonstrations. • **Variation in coverage of services across populations.** Medicaid services usually must be available in equal amount, duration, and scope across types of Medicaid eligibility groups (details and exceptions are described in Subpart B of 42 CFR 440). But some mechanisms for Medicaid coverage of services focus on specific subgroups of enrollees (for example, based on diagnosis). See Table 1 and Section A.1 of the "Understanding roles of funding and decision points" companion document in this toolkit regarding mechanisms such as health homes and section 1915(c) waivers. In addition, as in Section A.2 of that document, some Medicaid managed care authorities can also impact coverage of services. • **Other barriers to care within Medicaid.** In addition to issues with provider availability generally (as in Section B of this document), access to services can also be impeded by low provider participation rates in Medicaid for SUD (MACPAC 2018) and for MH (Cummings et al. 2013). For most types of Medicaid managed care, states create a Quality Strategy that describes how they evaluate access to care, and their External Quality Review reports include information about access to care.[d]

Table 6 *(continued)*

Questions to consider	Information or resources to consider
5. Private health insurance a. What do we know about coverage of MH and SUD services under private health insurance plans in the state? b. Is there a main insurer in our state from which we can find out about coverage, limitations, and access issues that we might want to consider addressing?	Private insurance coverage of services (including cost-sharing) can vary greatly, both between insurers and between health plans offered by the same insurer. The following points might be useful as you consider what is covered by private insurers in your state: • **Mental health parity.** Under many private health insurance plans, insurers that provide MH or SUD benefits can't impose less favorable benefit limitations on MH or SUD benefits than on medical or surgical benefits. For details, see the Center for Consumer Information & Insurance Oversight's website about parity. • **Insurers with large market share.** KFF's State Health Facts has information on insurance market competitiveness by state. For example, in 32 states, the market share of the largest insurer in the state was greater than 50 percent (in 2018, in the large group insurance market). If your state has an insurer with a very large market share, it might be useful to engage with the insurer to understand typical coverage of particular services under their health plans and any notable care access issues.
6. Safety net services for people without insurance a. Which other funding sources are used in our state for MH and SUD services? How, and for whom?	• **Information about various funding sources for MH and SUD services is in Section A of the "Understanding roles of funding and decision points" companion document in this toolkit.** Funding sources include federal, state, and local funds (including funds spent by child welfare agencies). • **State-specific sources of information.** In addition to information available directly through your state's MH and SUD agencies and their websites, some state-specific sources of information about funding for services could be useful: - Stakeholders can find information about their state MH agency's spending through SAMHSA's Uniform Reporting System reports. For example, see the section on "state mental health agency controlled expenditures" for information by funding source and type of care. From July 2017 to June 2018, about half of state MH agency expenditures were from Medicaid (federal, state, and local), about 43 percent were other state or local funds, and about 5 percent were from SAMHSA block grants or other federal funds (data from 2018 Uniform Reporting System). - Information about state MH agency spending is available in SAMHSA's 2017 report, Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015. It includes state-specific profiles for MH (Appendix A) and SUD (Appendix B) agencies, including topics such as funding for services. - HRSA provides some organizations, such as community health centers, funding for MH and SUD services. For information about 2019 awards, including links to awardees by state, see HRSA 2019b. Information about additional HRSA-funded programs regarding integrating behavioral health with primary medical care is available on HRSA's behavioral health website.

Table 6 *(continued)*

Questions to consider	Information or resources to consider
7. Coverage and funding of in-home parent skill-based programs a. Which funding sources does our state currently use for in-home parent skill-based programs? How, and for whom?	• **Information about various funding sources for in-home parent skill-based programs is in Section B of the "Understanding roles of funding and decision points" companion document in this toolkit.** Resources with state-specific information regarding Medicaid and HRSA coverage and funding mechanisms for in-home parent skill-based programs include the following: - **Medicaid.** Several sources describe examples of how states use Medicaid funding for home visiting programs. For examples, see Normile et al. (2017), Johnson (2019), and Herzfeldt-Kamprath et al. (2017). CMS and HRSA have issued a joint informational bulletin about coverage of home visiting (CMCS/HRSA 2016). Smith et al. (2017) includes some state-specific information about Medicaid coverage of parenting programs to help parents promote children's social-emotional development and address child MH needs. - **MIECHV.** See Table 4 for sources regarding state-specific information on MIECHV-funded home visiting programs. - **Title V Maternal and Child Health Services Block Grant.** To receive Title V funding, states create five-year state action plans to address priority needs of populations served by the program. HRSA has compiled State Action Plans, which include examples of Title V implementation. HRSA has also made available State Snapshots that offer state-specific Title V program details about funding, service level, population served, and performance.

[a] This is defined as the ratio of Medicaid or CHIP–eligible enrolled parents to Medicaid or CHIP–eligible enrolled parents plus Medicaid or CHIP–eligible uninsured parents.

[b] Kaiser Family Foundation (2019) and MACPAC (2016) also include SUD services, but they are not fully aligned with the American Society of Addiction Medicine's levels of care.

[c] The database focused on adults who are in categorically needy eligibility groups. See http://files.kff.org/attachment/Survey-2018-Medicaid-Behavioral-Health-Services-Database-Notes-and-Methods.

[d] For fee-for-service Medicaid, states created Access Monitoring Review Plans in 2016, which described access to care (including behavioral health services). Further information and available plans are available on CMS's website. In 2019, CMS proposed to remove the requirement that states complete Access Monitoring Review Plans.

CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; KFF = Kaiser Family Foundation; MH = mental health; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; SAMHSA = Substance Abuse and Mental Health Services Administration; SUD = substance use disorder.

Box 4. Oregon Example: Oregon's Behavioral Health Mapping Tool

Oregon's Behavioral Health Mapping Tool maps behavioral health data in an interactive way. The online tool displays a variety of county-level data, such as data about prevalence of mental health and substance use disorder conditions, population statistics, and Medicaid and non-Medicaid funding for behavioral health services. It also maps locations of behavioral health services and shows which areas are within a 30-minute drive of these services.

For additional information and link to the tool, see https://www.oregon.gov/oha/HSD/AMH/Pages/BH-Mapping.aspx.

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