**State of Florida**
**Department of Children and Families**

**Rick Scott**
*Governor*

**Mike Carroll**
*Secretary*

July 20, 2018

Naomi Goldstein
Deputy Secretary for Planning Research, and Evaluation
Department of Health and Human Services
Administration for Children and Families
370 L'Enfant Plaza SW
Washington, DC 20560

Dear Deputy Secretary Goldstein:

Thank you for the opportunity to respond to the request for comments regarding the Decisions Related to the Development of a Clearinghouse of Evidence-Based Practices in Accordance with the Family First Prevention Services Act (FFPSA) of 2018.

**HHS Federal Register Subsection 2.2.1. Types of Programs and Services.** HHS intends to limit eligibility to mental health and substance abuse prevention and treatment services, in-home parent skill-based programs (including parenting skills training, parent education, and individual and family counseling), or kinship navigator programs. *This Notice requests comment on the scope of programs and services and topic areas of interest within the aforementioned categories that should be prioritized for inclusion.*

**Comments:** Within the scope of services described in section 471(e)(1) of the Social Security Act, and in an effort towards prioritizing topic areas towards safety, permanency, well-being and prevention target outcomes, the Florida Department of Children and Families (Department) supports the language on page 36 of the House of Representatives Committee on Ways and Means Report (114-628) that states:

> *"States have identified a range of program strategies to accomplish the goals of their waiver, a number of which have been previously evaluated as effective. Most commonly these include assessing the needs of the family using clinical and functional assessments (one or more, alone or combined) (18 states), including, for example, the Child and Adolescent Needs and Strengths Assessment, and the Ages and States Questionnaire. The purpose of these assessments, generally, is to better understand the particular strengths and needs of a child and family and to be able to individualize services accordingly. Many states indicate they use:*
>
> - *Evidenced-based parenting education models (e.g., Positive Parenting Program (Triple P) or the Incredible Years (17 states);*
> - *Therapeutic services, including those with specific awareness of effects of trauma, (e.g., Parent-Child Interaction Therapy or Multi-Dimensional Treatment Foster Care) (15 states);*

> *• Practices that facilitate greater parent and family member input in case planning and management through the use of Family Group Decision Making, Family Team Conferencing, and other family engagement strategies (14 states); and*
> *• Family preservation services (e.g., Homebuilders) (13 states).*
>
> *This list of interventions and specific models is by no means exhaustive, but is meant to suggest some of the more frequently used waiver interventions. Because the title IV–E waiver authority expires in FY 2019, it is necessary for Congress to act to ensure states may continue to use federal dollars to support foster care prevention activities like those outlined above."*

The Department recommends that these prevention services be broadly considered and that "Parent Skill-Based Programs" component of prevention services include programs and activities that promote family engagement and family preservation services. Further, the Department recommends to provide consideration of prioritizing programs that were implemented as part of child welfare demonstration waiver interventions.

The Department recommends prioritizing group-based parenting programs, as well as parent-child dyadic therapies that address parent-child relationships.

The Department would also like to note that the Federal Register notice includes references to kinship navigator services but conflates prevention services and kinship navigator services. Kinship navigator services include activities that may be discrete from the prevention services, although the evidence-based criteria may be the same. The Department recommends that the development of the clearinghouse include discrete consideration of kinship navigator programs in addition to consideration of prevention services.

**HHS Federal Register Subsection 2.2.2. Target Population of Interest.** HHS intends to prioritize programs or services for review that have been developed or used to target children and families involved in the child welfare system or populations similar to those involved in the child welfare system. *This Notice requests comment on populations that may be considered "similar" to those involved in the child welfare system.*

**Comments:** The Department recommends to broaden the target population described in Federal Register notice subsection 2.2.2 to include children that are at risk for entry into the child welfare system, as there may be services and programs supported by evidence that targets similar family dynamics in family environments that are not involved in the child welfare system, such as children who engage with Youth Crisis Centers and youth involved with the Florida Department of Juvenile Justice (DJJ).

The Department recommends that the target population described include children similar to those served in Prevention Resource Centers, who are at risk of child maltreatment and continue to be vulnerable populations for ongoing agency involvement, and children served by Substance Abuse and Mental Health (SAMH) community centers. The Department also recommends to include adults with behavioral health disorders and substance abuse issues regardless of their involvement with the child welfare system, children and adults who have demonstrated aggressive behaviors, and children and adults who have experienced trauma.

Risk factors of these populations include low income, low education levels, social isolation, and single parent households.

**HHS Federal Register Subsection 2.2.3. Target Outcomes.** HHS intends to prioritize programs or services for review that aim to impact target outcomes. Target outcomes should be defined in accordance with FFPSA statutory language [section 471(e)(4)(C)] and include those outcomes that "...prevent child abuse and neglect, and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children." These may include, but are not limited to, "...important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being." *This Notice requests comment on which types of mental health, substance abuse, and child and family outcomes should be considered as 'target outcomes' and requests research evidence to support recommendations of 'target outcomes'.* HHS does not intend to include access to service, satisfaction with programs and services, and referral to programs and services as 'target outcomes'.

**Comments:** The Department recommends that target outcomes selected be developed and normed to the target population selected in Federal Register notice subsection 2.2.3. Section 471(e)(4)(A)(ii)(II) of the Social Security Act creates two outcomes, "Pregnant foster youth are prepared to be a parent," and "Parenting foster youth are able to be a parent." Additionally, section 471(e)(6)(A)(i) of the Social Security Act introduces "Percentages of Candidates for Foster Care Who Do Not Enter Foster Care." Section 476(d)(3) of the Social Security Act introduces three outcome measures regarding programs and services in that they "reduce the likelihood of foster care placement," "increases use of kinship care arrangements," and "improves child well-being."

The Department offers the following outcome measures to support those children described in section 471(e)(2) of the Social Security Act and the outcomes measures required in the FFPSA:

- A parent or caregiver's continuation of treatment of 90 days or more (increased engagement).
- A parent or caregiver's completion of treatment for SAMH treatment programs.
- A parent or caregiver's completion of a parent education program that includes a pre and post assessment.
- Improved child-parent relationships or improved caregiver protective capacities.
- Reduction in parent stress index.
- Reduction in future risk behaviors.
- Placement stability or improvement in placement changes with a focus on children in kinship care.
- Two generation and multi-generational child and family outcomes, if measurable.
- Improved number of children that remain with families, or improved number of kinship care and stabilization of kinship care placement.
- School readiness well-being outcome.
- Reduced interruptions by a child in a child care setting.
- Well-being outcomes in the form of educational outcomes for children.
- Outcome measures related to transition of children to adulthood.

- Reduced arrests or reduced DJJ involvement
- Outcomes for children in extended living, extended foster care, and independent living.

The Department recommends that any outcome measure selected have face validity supported by subject matter experts related to the theory of change selected for the population selected, and that selected measures be reliable in that they remain consistent over time and replicable in regards to cultural, location and population-based, and practice adaptations.

The Federal Register notice requests comment on target outcomes on prevention services but not on kinship navigator services. The statement the "HHS does not intend to include access to service, satisfaction with programs and services, and referral to programs and services as `target outcomes'" is specifically contrary to kinship navigator services as stated in section 427(a)(1) of the Social Security Act. The Department recommends a separate discussion of target outcomes related to kinship navigator activities, and that consideration include activities that improve access to services, and referral to programs and services, which are integral to an effective kinship navigator program. The Department recommends that evidence-based programs related to kinship navigator should include consideration of research related to the Supplemental Nutrition Assistance Program (SNAP) and health-related programs that have found that participation in these programs improve child well-being.

**HHS Federal Register Subsection 2.2.7. Trauma-Informed.** HHS may also prioritize services and programs that have been implemented using a trauma-informed approach. FFPSA statutory language [section 471(e)(4)(B)] states, "The services or programs to be provided to or on behalf of a child are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing." *This Notice requests comment on the feasibility of prioritizing programs and services based on past implementation in accordance with trauma-informed principles.*

**Comments:** The Department recommends a broad definition of trauma-informed care as measurement for this concept is emerging. The Department also recommends that HHS distinguish "trauma-specific" treatment from "trauma-informed" systems.

The Department offers that including trauma-informed principles into the prioritization of programs through systematic review could impact feasibility, as evidence-based criteria may not have been specifically measured in research, which may limit the number of programs to consider when filtering for trauma-informed.

The Department recommends HHS consider the Creating Cultures of Trauma-Informed Care (CCTIC) Fidelity Scale[1] that includes a six domain fidelity scale when addressing the components of a trauma informed system that may require a multiple year phase-in to allow states to create such a system. The domains of the scale are as follows:

1) Program Procedures and Settings
2) Formal Services Policies

[1] See CCTIC Program Fidelity Scale Instruction Guide Version 1.1 submitted with this response.

3) Trauma Screening, Assessment, and Service Planning; Trauma-Specific Services
4) Administrative Support for Program-Wide Trauma-Informed Services
5) Staff Trauma Training and Education
6) Human Resources Practices

**HHS Federal Register Subsection 2.3.6. Usual Care or Practice Setting.** HHS intends to limit eligibility to studies carried out in a usual care or practice setting in accordance with FFPSA [section 471(e)(4)(C)]. *This Notice requests comment on the definition of usual care or practice settings.*

**Comments:** The terms "usual care setting" and "practice setting" are generally used in regards to describing a study that utilizes a control group. In this context, the definition is that the usual care and practice setting is standardized with the control and treatment group and represent the best current practice available and possible.

The Department recommends that a usual care or practice setting within an evidence-based framework include services and programs that occur within a family and kin caregiver environment, and conversely that it excludes non-kinship foster care environments. Skill-based programs and services that include family engagement activities such as Family-Team Decision Making may be effective in settings other than the caregivers' place of residence, and the Department recommends that usual or practice settings for both in-home parent and SAMH services for children and families be broadened to include a community-based setting. These settings should include schools, recreational centers, libraries, etc.

The Department also recommends that care and practice settings be expanded to include kinship navigator settings where appropriate.

**HHS Federal Register Subsection 2.4.1. Implementation Period.** FFPSA [section 471(e)(1)(A) and (B)] states that the Secretary may make a payment to a State for providing services or programs "for not more than a 12-month period". *This Notice requests comment on whether studies with program or service implementation periods of longer than 12 months should be considered for review and if so, whether any other implementation period cutoff should be included as a study prioritization criterion.*

**Comments:** The Department suggests that a 12-month threshold for payment not be the sole criteria for the threshold of services to be provided towards an effective outcome for children and families. The 2016 Ways and Means Committee Report states, "It is also the Committee's expectation that states and tribes would provide some services which lasted more than 12 months, and would use the reimbursement for the first 12 months to reduce the state's overall cost of serving those children and families." The Department recommends that studies with implementation periods of longer than 12 months be included for prioritization and that states manage expenditures with case management for children and families who continue to engage in a program or service beyond 12 months. The Department also recommends that HHS track the outcomes of these children and families being served with states towards assessing future reimbursement models due to positive outcomes for children and families that engage a service or program longer than 12 months. Florida offers 18-24 months as an alternative implementation period cut-off.

**HHS Federal Register Subsection 2.4.2. Sample of Interest.** HHS intends to prioritize studies that include samples of children and families involved in the child welfare system or populations similar to those involved in the child welfare system. *This Notice requests comment on populations that may be considered "similar" to those involved in the child welfare system.*

**Comments:** In addition to and in support of the Department's comments to Federal Register notice sub-section 2.4.2, the Department recommends a broad definition of population that includes geographic areas where there is high risk for children, and include demographics similar to that of child welfare that include race and ethnicity and co-occurring issues such as domestic violence (DV), SAMH, and children served by DJJ. The Department recommends that the sample include children from geographic areas with high prevalence of DV and/or child abuse and neglect. This includes poverty levels and children with severe emotional disabilities.

The target population is important in that it supports construct validity to selected outcomes measures. Standardized outcome measures are often developed and normed on populations other than children and families involved in child welfare or similar.

**HHS Federal Register Subsection 2.5.1 Favorable Effects.** HHS intends to rate studies based on whether they demonstrate at least one meaningful favorable effect (i.e., positive significant effect) on a 'target outcome' as specified in section 2.3.2. Target Outcomes. A meaningful effect will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of $p<.05$). *This Notice requests comment on whether and how ratings should consider the number or magnitude of favorable effects.*

**Comments:** The Department suggests to define "a meaningful effect" by using both significance testing (set alpha level as .05 or more stringent level for .01, for example for a larger sample) and effect size. The Department also recommends to prioritize studies that:

- Employ high quality in their analyses (see Federal Register notice subsection 2.5.4),
- Use best practices in analysis that include statistical tests based on theory,
- Use a-priori power analyses,
- Meet assumptions of each statistical test,
- Account for baseline group differences,
- Use missing data mechanisms, and
- Utilize intent-to-treat analyses.

The Department also recommends including qualitative methods in the eligibility of impact studies noted in Federal Register notice sub-section 2.3.1.

**HHS Federal Register Subsection 2.5.2 Unfavorable Effects.** Unfavorable Effects. HHS intends to rate studies based on the number of unfavorable effects (i.e., negative significant effects) on either 'target' or non-target outcomes as specified in section 2.3.2. Target Outcomes. Effects will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of $p<.05$). *This Notice requests comment on whether and how studies should also be rated on the number of null effects on 'target outcomes', and on whether and how ratings should consider the number or magnitude of unfavorable effects.*

**Comments:** The Department suggests that a meaningful negative effect be defined as both statistically significant and practically important based on effect size. Interpretation of null effects depends on the outcome of interest. Null effects are most important when examining hypothesized effects on child maltreatment or neglect. In contrast, some null effects do not indicate ineffectiveness. For example, a null direct effect on parent-child interactions may not indicate program ineffectiveness because other mechanisms may not have been explored.

The Department recommends that HHS consult resources such as the Campbell Collaboration and Cochrane, as well as established clearinghouses that have established similar ratings criteria.

**HHS Federal Register Subsection 2.5.4. Rigorous Study Design.** HHS intends to rate studies as either high, moderate, or low on the rigor and appropriateness of their study design. Study designs that receive the highest rating will be either Randomized Controlled Trials (RCTs) or rigorous quasi-experimental designs. HHS defines randomized controlled trials as a study design in which sample members are assigned to the program or service and comparison groups by chance. Randomized control designs are often considered the "gold standard" of research design because personal characteristics (before the program or service begins) do not affect whether someone is assigned to the program or service or control group. HHS defines a quasi-experimental design as a study design in which sample members are selected for the program or service and comparison groups in a nonrandom way. Similar to criteria considered in other federal evidence clearinghouses, rigorous study designs will be those that are appropriately powered, include an appropriate control group, maintain original assignment to study arms, and are appropriate to combat threats to internal validity. *This Notice requests comment on threats to internal validity that should be considered. This Notice requests comment on appropriate thresholds for evaluating and assigning a rating to a study design.*

**Comments:** The lack of randomization in a study introduces multiple internal validity concerns, and can complicate statistical analysis of the data yielded. Threats to internal validity generally occur in quasi-experimental designs due to the fact that they do not employ random sampling. A quasi-experimental design is one in which there is no random assignment when there is a comparison group. Instead, the comparison group is predetermined to be comparable to the treatment group in critical ways. Types of quasi-experimental designs include nonequivalent control group designs, time series designs, and ex post facto control group designs.

Non-random sampling can yield selection bias and more importantly, can cause impediments in discovering if the intervention may have contributed to a change or another environmental factor.

The Department recommends that programs and services that are selected through a study using a quasi-experimental research design utilize pre and post assessments. Additionally, during the systematic review employed by HHS, the Department recommends to adapt the inclusionary and exclusionary criteria outlined in Federal Register notice sub-sections 2.3.2, 2.3.3, 2.3.4, and 2.3.5 to the specific systematic review employed. The Department recommends that rather than establish restrictive parameters for criteria in Federal Register notice sub-sections 2.3.3 and 2.3.5, for example, for all studies, that the parameters of the

individual review guide the inclusion and exclusion criteria rather than establish restrictive exclusion criteria that may affect culturally-specific population-based adaptions of practices. The Department also recommends that inclusionary and exclusionary criteria for a systematic review be clearly communicated within the clearinghouse.

Additionally, the Department recommends that the limitation of studies to government and peer-reviewed journals in Federal Register notice sub-section 2.3.1 include all levels of government including State, County and Tribal governments. Academic studies, whether from public or private universities, may be as rigorous as government studies, as well as studies either funded by or performed by foundations, private research organizations, or public policy organizations.

The Department recommends that HHS consult resources such as the Campbell Collaboration and Cochrane, as well as established clearinghouses that have adopted rating assignment protocols. These clearinghouses are not limited to, and include:

- California Evidence-Based Clearinghouse for Child Welfare
- Promising Practices Network
- What Works Clearinghouse
- National Registry of Evidence-Based Programs and Practices
- HHS Strengthening Families Evidence Review
- Washington State Institute for Public Policy

**HHS Federal Register Subsection 2.5.5. Rigorous Study Analysis.** HHS intends to rate studies as either high, moderate, or low on the rigor and appropriateness of their analysis. Study analyses that receive the highest rating may be those that tested and established baseline equivalence, appropriately accounted for overall and differential sample attrition, appropriately accounted for multiple comparisons, and when necessary accounted for clustering. *This Notice requests comment on appropriate thresholds for evaluating and assigning a rating to a study analysis.*

**Comments:** The Department recommends that HHS consult resources such as the Campbell Collaboration and Cochrane, as well as established clearinghouses that have adopted rating assignment protocols. Though FFPSA provides three categories of practices that will be included in the clearinghouse, the Department recommends that other practice levels of evidence (LOE) be added to include, at minimum, "Evidence Fails to Demonstrate Effect" and "Concerning Practice" so that states can have access to a spectrum of rating scales rather than just program and services that meet a higher LOE standard.

Further, the Department recommends that HHS convene a rigorous advisory group to include states and associations to assist HHS in establishing the EPB clearinghouse. As the prioritized and identified programs and services start to be implemented, there are going to be issues that arise, and feedback loops are going to be essential to maintain consistency around continuous quality improvement. This advisory group should include, at minimum, states and providers to assist in evaluating the process of establishing the clearinghouse and to modify criteria and concepts in accordance with findings acquired moving forward to also avoid unintentional consequences. This advisory group is recommended to also include program administration and operational staff that represents a cross-section of programmatic experience.

The Department recommends that as services and programs are added to the clearinghouse, a directory of terms and definitions be created and made available by HHS for clarity of terms to ensure better validity and adaptability for states.

Additionally, the Department recommends to initially widen the prioritization criteria in Federal Register notice 2.2.4 to programs and services with at least one impact study.

**HHS Federal Register Subsection 2.5.6. Reliability, Validity, and Systematic Administration of Outcome Measures.** HHS intends to rate studies as either high, moderate, or low on the extent to which 'target outcome' measures are reliable (i.e., the extent to which a measure produces the same results when used repeatedly), valid (i.e., the extent to which a measure captures what it is intended to measure), and were administered consistently and accurately across all those receiving the practice in accordance with FFPSA statutory language [section 471(e)(4)(C)] or receiving the appropriate comparison practice. *This Notice requests comment on appropriate thresholds for evaluating and assigning a rating to the reliability, validity, and administration of 'target outcome' measures.*

**Comments:** It is critical that measures have construct validity, i.e. the measure is related to a number of other measures as specified by theory. This is particularly important because standardized outcome measures are often developed and normed on populations other than children and families involved in child welfare. Second, measures must be reliable. The Department recommends measures that have been assessed by indicators of internal consistency, test-retest reliability, and inter-rater reliability. Finally, the measure results must remain consistent over time.

Quantitative indices are available to evaluate reliability and validity of outcome measures. Reporting the indices and clarifying the procedures for the assessment should be a standard practice for any outcome measures. Ratings of the studies in terms of their measurement quality could be based on what is reported or known knowledge of established scales and instruments.

**HHS Federal Register Subsection 2.6. Program or Service Rating Criteria.** HHS intends for programs or services to be rated as promising, supported, or well-supported practices if they meet the below criteria that collectively assess the strength of evidence for a practice and build from the individual study criteria described in section 2.5. Study Rating Criteria. These criteria were developed in accordance with FFPSA statutory language [section 471(e)(4)(C)]. HHS does not intend to rate a program or service as a 'promising', 'supported', or 'well-supported practice' if there is an empirical basis, as evidenced by multiple unfavorable effects on target or non-target outcomes across reviewed studies, as described in 2.5.2. Unfavorable Effects, that suggest the overall weight of evidence does not support the benefits of the program or service. *This Notice requests comment on approaches for determining that promising, supported, and well-supported practices do not constitute a risk of harm.* As described in FFPSA [section 471(e)(4)(C)], "There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it", "If multiple outcome studies are conducted, the overall weight of evidences supports the benefits of the practice", and "There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent".

**Comments:** The Department recommends that in addition to implementation and fidelity support for prioritized programs noted in Federal Register notice subsection 2.2.6, that program and services have a Train-the Trainer (TTT) model and framework. The Department also requests that HHS clarify the implementation and fidelity support described in Federal Register notice section 2.2.6 in regards to the costs of implementation training and staff support and the duration that will be allotted to put into place effective monitoring, fidelity assessments and continuous quality improvement efforts.

The Department recommends that HHS consult resources such as the Campbell Collaboration and Cochrane, as well as established clearinghouses and service array subject matter experts that have recommended and adopted rating assignment protocols. For example, as written in Federal Register notice sub-sections 2.6.1 through 2.6.3, and specific to the rating criteria described, what would the methodology criteria be when there are different studies with equally good qualities, yet show completely different directions of effects, one favorable effect and one non-favorable effect, for example? Similarly, what would the methodology be for additional studies with equally good qualities that show mixed effects?

The description of the proposed rating criteria indicates a 'vote counting' methodology of determining the effectiveness of a service or program, which is an often criticized procedure in systematic reviews. The Department recommends to follow the procedure of conducting a rigorous systematic review/meta-analysis and present a 'typical effect' of a program, as well as taking into consideration multiple factors which might impact the effect.

**HHS Federal Register Subsection 3.0. Recommendations of Potential Candidate Programs and Services for Review**. *This Notice requests comment on potential candidate programs and services to consider for the systematic evidence review.* Comments should identify how recommended programs and services meet the criteria described in section 2.1. Program or Service Eligibility Criteria. These criteria include: Types of Programs and Services and Book/Manual/Writings Available. Comments should also identify how recommended programs and services meet the criteria described in section 2.2 Program or Service Prioritization Criteria. These criteria include: Types of Programs and Services, Target Population of Interest, Target Outcomes, Number of Impact Studies, In Use/Active, Implementation and Fidelity Support, Trauma-Informed, and Delivery Setting for In-Home Parent Skill-Based Programs and Services. In order to leverage new insights from the field, HHS may put forth additional future Notices requesting recommendations of potential candidate programs and services for review.

**Comments:** The Department recommends that HHS include the 29 evidence-based and promising interventions referenced in the Florida Department of Children Child Service Array Report Phase I document dated June 2018. [2]

[2] See Florida Department of Children and Families Child Service Array Report Phase I, June 2018 submitted with this response.

Additionally, the Department recommends that HHS include the interventions that are included in the following categories in the Casey Family First Interventions Catalog document dated June 5, 2018[3]:

- Mental Health Services for Children and Parents
- Substance Abuse Prevention and Treatment for Children and Parents
- In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education
- In-Home Parent Skill-Based Programs: Individual and Family Counseling

The Department recommends that HHS collaborate with Casey Family Programs and, at minimum, the California Evidence-Based Clearinghouse for Child Welfare to include these programs and services, at minimum, in the pre-approved list of services to be released on October 1, 2018 per section 471(e)(4)(D)(i) of the Social Security Act.

The Department recommends that kinship navigator programs be considered more broadly than prevention services programs. Evidence-based services and programs should include increased access to benefit programs and services that have been demonstrated to improve child well-being and child health. Given that allegations of child maltreatment often include neglect, then access to SNAP, Medicaid, Early Childhood Development, Housing, etc. should be evaluated according to whether there is an evidence-base that such programs reduce adverse childhood experiences that are associated with increased risk.

Additionally, the Department requests that HHS communicate to states whether a list of pre-approved programs will be provided with the technical assistance in October 2018 or if the intent is to provide a clearinghouse by October 2018 that will serve as the pre-approved list.

Sincerely,

Patricia Badland for JoShonda Guerrier

JoShonda R. Guerrier
Assistant Secretary for Child Welfare
Florida Department of Children and Families

Attachments

[3] See Interventions with Special Relevance for the Family First Prevention and Services Act (FFPSA) submitted with this response.