



Kansas Intensive Permanency Project (KIPP) Program Manual

University of Kansas School of Social Welfare

Kansas Department for Children and Families

KVC Kansas

Saint Francis Community Services



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- KVC Kansas
- Saint Francis Community and Family Services, Inc.
- TFI Family Services, Inc.
- University of Kansas School of Social Welfare
- Youthville

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1 FOUNDATIONAL INFORMATION

1.1. History of the PII Project

The Permanency Innovations Initiative (PII) was a 5-year, \$100 million initiative of the Children’s Bureau undertaken in 2010 that included 6 grantees,¹ each with an innovative intervention designed to help a specific subgroup of children leave foster care in less than 3 years. The project combined requirements for purposeful application of implementation science, rigorous evaluation, and coordinated dissemination of findings. PII aimed to:

- Implement innovative intervention strategies, informed by relevant literature, to reduce long-term foster care (LTFC) stays and to improve child outcomes;
- Use an implementation science framework enhanced by child welfare expertise to guide technical assistance (TA) activities;
- Rigorously evaluate the validity of research-informed innovations and adapted evidence-supported interventions (ESIs)² in reducing LTFC; and
- Build an evidence base and disseminate findings to build knowledge in the child welfare field.

This integration of implementation science and program evaluation in a coordinated framework was intended to build or enhance the capacity of child welfare agencies to develop, implement, and evaluate research-informed innovations and adapted ESIs and

to provide evidence about program effectiveness. An overarching objective of PII was to increase the number of ESIs available to the child welfare community. To this end, grantees followed a systematic approach (the PII Approach) focusing on clearly operationalizing the infrastructure needed to support practitioners’ implementation of the interventions as intended.

The PII Approach³ readied interventions for broad-scale use, which is more likely to be warranted and feasible when interventions have been well operationalized with specified core components, and implementation teams have documented necessary infrastructures to support, sustain, and improve implementation integrity over time. The PII Approach provides a model for child welfare administrators and agency directors to add evidence to the body of knowledge about what works in child welfare. Its systematic approach offers a guide for child welfare stakeholders to identify existing interventions or to develop innovations to solve complex problems and to evaluate them for effectiveness.

The federal government supported grantees as they implemented and evaluated their interventions through two offices within the Administration for Children and Families: the Children’s Bureau and the Office of Planning, Research and Evaluation (OPRE). The Children’s Bureau provided training and technical assistance (T/TA) to grantees to strengthen their use of best practices in implementation. OPRE supported rigorous within- and cross-site evaluations of grantees’ interventions.⁴ Both offices worked together to disseminate the lessons learned from PII.

1 The Grantees include Arizona Department of Economic Security; California Department of Social Services; Illinois Department of Children and Family Services; Los Angeles LGBT Center; University of Kansas; and Washoe County, Nevada Department of Social Services. For more information about Grantees’ target populations and interventions, please visit <http://www.acf.hhs.gov/programs/cb/resource/pii-project-resources>.

2 Evidence-supported interventions are specific well-defined policies, programs, and services that have shown the potential, through rigorous evaluation, to improve outcomes for children and families (Framework Workgroup, 2014).

3 More information about PII, PII Grantees, and the PII Approach is on the Children’s Bureau website at <http://www.acf.hhs.gov/programs/cb/resource/pii-project-resources>.

4 For more information about the evaluation, see: <http://www.acf.hhs.gov/programs/opre/research/project/permanency-innovations-initiative-pii-evaluation>.

1.2. Purpose of This Manual

This program manual provides detailed information about the implementation process of the Kansas Intensive Permanency Project (KIPP) to assist others in the field in replicating or adapting KIPP for their local use. Replicating or adapting KIPP with fidelity to the interventions builds evidence in child welfare and expands the range of intervention effectiveness to different target populations and organizational contexts. These efforts to build evidence serve several purposes, including preparing an intervention for evaluation (either during implementation or later, depending on the organizational context in which an intervention is implemented) and building a base of replicable interventions that can serve the complex needs of diverse communities of children and families.

The intended audience for this program manual comprises potential implementers of the intervention, including child welfare administrators and staff, evaluators, and purveyors. This document contains background information about the explorative stage of implementation and detailed explanation of processes related to:

- Foundational information
- Governance and team structures
- Protocols
- KIPP staff positions and lead roles
- Parent Management Training - Oregon Model (PMTO)

It also includes reflections, lessons learned, and other practical information based on the experience of the KIPP's Steering Committee (SC) and Implementation Team (KIT). The appendices include numerous program documents, including a glossary of terms, terms of reference, staff selection guides, and an implementing to fidelity guide.

Reader note: KIPP refers to the overall project description. PMTO® is an evidence-based intervention implemented as part of the KIPP. As KIPP moved to full implementation of PMTO, it is referenced as Kansas PMTO in this manual.

PMTO materials supplied by Implementation Sciences International, Inc. (ISII) for PMTO implementation projects are protected by copyright. When ISII enters into a contract to conduct a PMTO implementation project, it supplies all materials needed by trainees and parents to the client (PMTO site) as part of the training package. The contract for ISII training services outlines the copyright restrictions concerning permission for use of the PMTO materials. If the PMTO site uses these materials essentially unchanged, the copyright remains unchanged, and ISII is the copyright owner for these PMTO implementation materials. Because of this copyright restriction, the description and materials shared in this manual do not include specific descriptions of behaviorally based essential functions, training curriculum, coaching protocols, fidelity rating, or other proprietary materials. For more information about PMTO, please contact ISII directly.⁵

1.3. KIPP Overview

1.3.1. Project Description

KIPP's goals were to (1) develop and implement innovative intervention strategies that result in permanence for a subpopulation of children that is at highest risk of LTFC and (2) rigorously evaluate these efforts and provide information about the effectiveness of the chosen interventions to reduce LTFC.

The vision of KIPP was to facilitate permanence in the lives of children with serious emotional disturbance (SED) by creating sustainable changes in families and larger systems.

⁵ ISII Headquarters: 10 Shelton McMurfhey Boulevard, Eugene, OR 97401, tel: (541) 485-2711, website: www.isii.net

1.3.2. Major Components of KIPP

To achieve the KIPP vision, the four major components included:

- Collaborative planning and governance for statewide implementation
- Intensive, in-home, evidence-based behavioral parent management training program, PMTO
- Increase in workforce by approximately 40 full-time employees (FTE)
- Sustainability strategies to bring about long-term systems changes

1.3.3. KIPP's Project Objectives

The project objectives included the following:

- Accelerate stable permanency for children with SED
- Improve Kansas performance on the Child and Family Services Reviews for Permanency Outcome 1⁶ and Well-Being Outcome 1⁷
- Address the critical barriers to permanency faced by parents of children with SED
- Connect families to longer-term community services and supports
- Provide sustainable services to permanency families

1.3.4. Partners

At project inception in 2010, the partners were the University of Kansas (KU), the Kansas Department for Children and Families (DCF), and Kansas' four private providers of foster care:

- KVC Kansas (KVC)
- Saint Francis Community Services (SFCS)
- TFI Family Services
- Youthville

Kansas contracts out family preservation, foster care, and adoption services to private providers.

This initiative represented a collaboration that is rare in this child welfare system. Because the partners are also competitors in this system, it took a shared goal of addressing the LTFC problem to bring everyone to the table. The partners were involved with submitting the proposal for funding, defining the target population, and implementing the project. Focusing on the objective of reducing LTFC was important to all of the partners involved with KIPP.

In January 2013, statewide foster care contracts were awarded to two contractors, KVC and SFCS. In April 2013, the KIPP cases from the other providers, TFI Family Services and Youthville, were transitioned to the two agencies awarded the contract. After July 1, 2013, and until the end of the project, KVC, SFCS, DCF, and KU were partners in KIPP.

1.4. Identification of Target Population

This section (1) describes KIPP's target population, (2) summarizes and prioritizes characteristics of the target population that put its members at risk of LTFC, and (3) describes the needs of the identified target population.

1.4.1. KIPP's Target Population

After being awarded the funding for the project, the KIPP partners were given 10 months to clearly define the target population and barriers to permanency and to select an intervention. The project partners sought to answer three questions in the process to define the target population:

- Is a child's mental health status a risk factor of LTFC?
- What are the parental barriers to permanency?
- What are the systemic barriers to permanency?

⁶ Children have permanence and stability in their living situations.

⁷ Families have enhanced capacity to provide for their children's needs.

Examination of statewide data on the children who entered and remained in foster care revealed that children with SED had a 19.6 percent LTFC rate. The rate was 7.2 percent for children in foster care who were not classified as SED.

To examine the parental barriers to permanency, the project partners conducted case record reviews on a random sample of cases. The five most prevalent risk factors were poverty, parental mental health issues, parent alcohol and drug problems, parental history of trauma, and parenting attitude.

The systemic barriers to permanency were examined by surveying child welfare stakeholders, including case managers, clinicians, supervisors, and child welfare agency administrators. The 232 survey respondents identified 5 barriers: lack of dedicated parent services, high foster care caseloads, high caseworker turnover, lack of parental transportation, and court system issues.

The identification of the target population was a very important part of the planning process. By identifying that a foster child's mental health issues was a major predictor of LTFC, the project partners were able to determine their target population for this project.

A secondary benefit of the process of identifying the target population was the recognition by the project partners of the value of university-public-private partnerships. Each partner contributed significantly by bringing his or her expertise to the process. The public child welfare agency is responsible for ensuring the safety and well-being of children in the foster care system. The private agency partners have the frontline experience of working with the families and children and of helping them achieve permanency. The university partners have expertise in collecting and analyzing data to test hypotheses. Each partner brings a level of expertise that assists the project during all phases from implementation to evaluation.

The target population for KIPP was children and youth, aged 3-16, who met criteria for SED. While KIPP's target population consisted of children and youth with a SED, the proposed focal point of the intervention was the parents of these children.

Families were eligible for KIPP services by meeting the following criteria:

- The child entered or re-entered foster care during the study period. If the case plan goal was reunification, then KIPP allowed referrals from children who "returned to out-of-home care."
- The family had a case plan goal of reunification and no legal termination of parental rights or legal abdication of parenting role had been initiated.
- At least 1 parent was available to participate in KIPP throughout the duration of the 6-month service period and:
 - Resided within the service area
 - Had not been incarcerated for longer than 3 months at the time of study invitation
 - Had not been in inpatient treatment for longer than 3 months at the time of study invitation
- The family did not have a "no contact" order from the court system.
- The family had one child (or more) who met one of the following criteria:
 - Had been determined SED by a community mental health center (CMHC)
 - Had been admitted for inpatient psychiatric care at an acute care facility, state hospital, or psychiatric residential treatment facility within the last 365 days
 - Had an Individual Education Plan for an emotional or behavioral disorder
 - Currently had a diagnosed mental illness and symptoms of that illness that contribute to a lack of stability in foster home or other placement, permanent home, school, or community

- Previously had a diagnosed mental illness, had a history of outpatient or inpatient mental health treatment, and was currently on psychotropic medications
- Was between the ages of:
 - 5–16 and scored 1 of the following on an intake Child and Adolescent Functional Assessment Scale (CAFAS)
 - A total score of 60
 - A score of 30 on one subscale
 - 3–4 and scored 1 of the following on an intake Preschool and Early Childhood Functional Assessment Scale (PECFAS)
 - A total score of 50
 - A score of 20 on one subscale

LESSONS LEARNED

Conducting in-depth data mining was useful to KIPP because it more accurately identified the children that experienced the most serious barriers to permanency.

1.4.2. Child Characteristics

The KU research staff conducted logistic regression on Kansas administrative data, which indicated that children with a SED were 3½ times more likely than children without a SED to experience LTFC, while controlling for all other variables. Survival analysis of exit to reunification indicated that children with a SED were 90 percent less likely to reunify than children without a SED, while controlling for all other variables. Diagnostically, compared to all other children in foster care, children with SED who experience LTFC have more externalizing and internalizing diagnoses and more co-occurring developmental disabilities. These children are at the highest risk of poorly evidenced psychopharmacological interventions and institutional placements. Compared to the non-SED population, children with SED have more placements and fewer

and slower exits to permanency and are more likely to age out of care. They make up nearly two-thirds (63 percent) of children in care for 3 years or more. In bivariate and multivariate analyses of multiple variables, SED was the most robust predictor of LTFC for children and youth in Kansas.

The KIPP initiative grew out of a desire to address the emotional and behavioral issues that result in children receiving a SED determination and experiencing significant placement instability and, eventually, imperiled permanency outcomes. As discussed below, KIPP intervened with the parents of these children to increase parental competence. PMTO was selected as an intervention because it is behaviorally based and addresses the needs of children with internalizing and externalizing symptoms, SED, and co-occurring developmental disabilities.

1.4.3. Parent/Family Needs

Empirical literature indicates that families of children with SED have high rates of mental health problems, drug use, and violence (Farmer, Stangl, Burns, Costello, & Angold, 1999; Quinn & Epstein, 2003). Children with a SED from especially vulnerable families (e.g., single mothers, living in poverty, families of color) are least likely to stay in treatment past the first session and are more likely to terminate service prematurely (Tuma, 1989). Importantly, “efforts to enhance a family’s service engagement” can be successful (Ringeisen & Hoagwood, 2002) and thus improve retention of needed mental health services. These findings undergird our rationale to increase parental competence and parental ability in order to manage problematic child behavior rather than to focus directly on decreasing problematic child behavior.

Indeed, there was consensus among the Kansas privatized foster care agencies that the single biggest obstacle to serving children with SED was the current inability of foster care contractors to deliver meaningful, intensive, home-based services and

concrete supports to birth/permanency parents prior to the achievement of permanency. The KU research staff completed case record reviews of 30 randomly selected LTFC cases of Kansas children with SED. These reviews demonstrated that five family-level variables were associated with LTFC. These were, by prevalence:

- Parenting competency or attitude (97 percent)
- Parent mental health problems (90 percent)
- Poverty related issues (87 percent)
- Parent alcohol and drug problems (83 percent)
- Parent history of trauma (80 percent)

KIPP services were targeted to meet these needs.

1.5. Theory of Change

1.5.1. Initiative Theory of Change

KIPP's theory of change aligned with the vision statement: The goal of KIPP is to facilitate permanence in the lives of children with SED by creating permanence in the systems of care that served the families. Our project infused child welfare practice-as-usual with dedicated parent resources for parents of children with SED. To mitigate four significant implementation barriers identified in the current system of care—lack of dedicated parent services, high caseloads, high caseworker turnover, and lack of transportation—our intervention was directed specifically toward parents of children with SED, delivered in-home, and provided exclusively by master's level KIPP therapists with low caseloads (four to six families).

1.5.2. Hypothesized Change Brought About by Intervention

KIPP's theory of change was premised on six sequential and interconnected assumptions:

1. Parents of children with SED face multiple problems which are complex in nature and not easily alleviated by current child welfare practice or within current child welfare timeframes.
2. To bring about change of a sufficient magnitude, resources must be dedicated to improve ineffective parenting practices, such as coercion, and to connect parents with community resources and social supports, such as mental health and substance abuse treatment.
3. When parenting and community connections are strengthened (proximal outcomes), a more adequate and prosocial environment for children is created.
4. When the family's interpersonal and social environment is bolstered, child functioning increases and behavior problems decrease (proximal outcome).
5. These changes combine to create readiness for family reunification (proximal outcome).
6. Readiness for family reunification leads to more timely and stable reunifications (distal outcomes).

Compared to children with SED in the comparison group, children in the KIPP treatment group were expected to reunify at a higher rate and to experience shorter stays in foster care before exiting to permanency. Beyond reunification, the treatment group was also expected to experience higher rates of stable permanency without a loss of child safety.

We hypothesized that during the early phase of treatment, while a child was placed in foster care, the KIPP therapist would work with the parent to meet immediate material needs, connect the parent to community resources, and strengthen parenting skills to ready the parent for the child's return home. Given the strong hypothesized connection between social support and family reunification, KIPP therapists would forge trusting relationships with parents that enable parents to access and accept support from childcare providers, schools, and other extracurricular programs (e.g., neighborhood and cultural communities; religious or spiritual resources; and, if necessary, mental health and substance abuse treatment providers).

We hypothesized that improved parenting skills and stronger connections to community (proximal

outcomes) would facilitate greater readiness for family reunification (proximal outcome). This outcome was measured by the resolution of risk factors for which the child was removed, including timely completion of case plan goals, resolved legal issues, greater parent knowledge of child needs, and established back-up support and service plans. Lastly, we hypothesized that bolstered reunification readiness would lead to a higher percentage of timely and stable reunifications for the target population (distal outcomes).

KIPP’s theory of change is depicted graphically in **Figure 1**.

1.6. Selection of Intervention

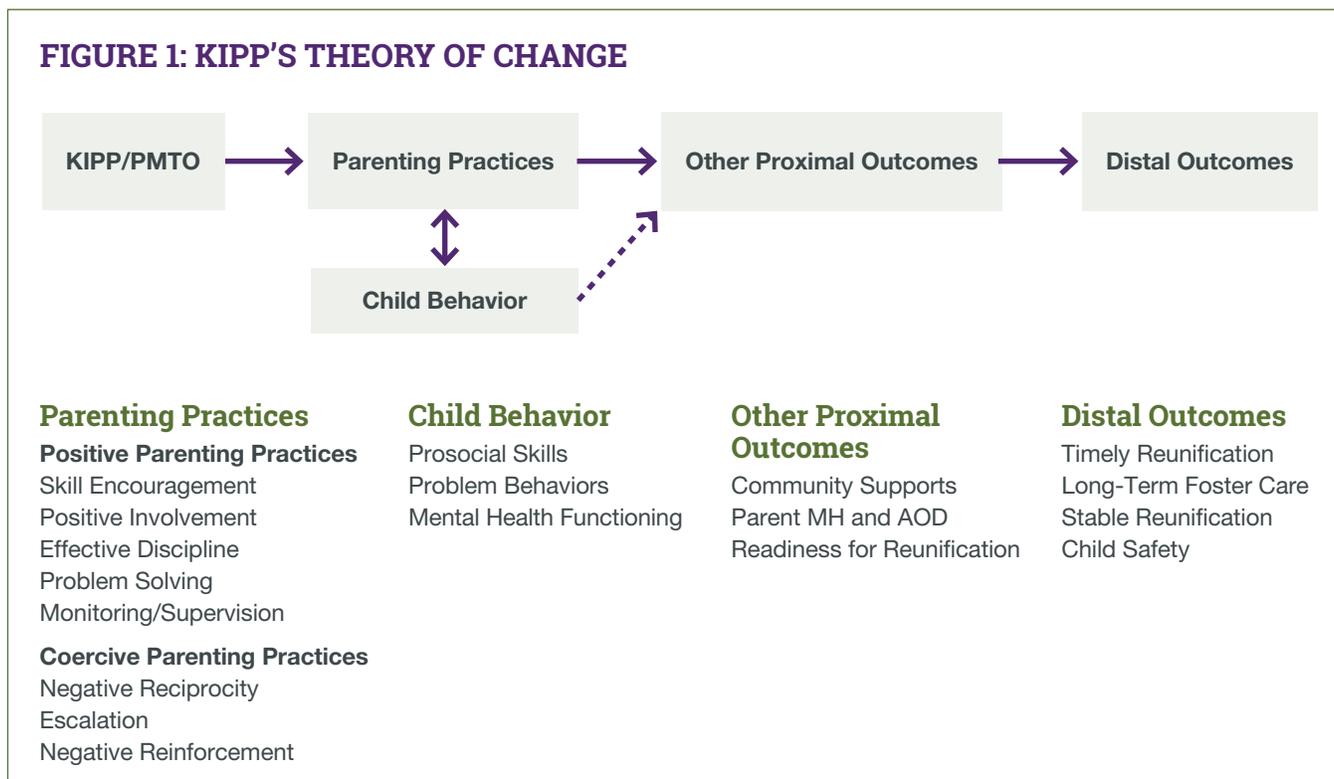
1.6.1. Process to Select Intervention

The SC went through a four-step process to select its intervention. The first step was a literature review on which early intervention models were most effective in working with parents. Next, child welfare researchers were interviewed to gather information about effective

intensive in-home interventions. Four purveyors, 10 child welfare experts, and 6 implementers were interviewed. Over 224 hours were dedicated to this activity. The third step was to narrow down the options to two choices. The final step of the process was to compare the two models to determine which could be adapted to the Kansas child welfare population and could be sustained in Kansas.

1.6.2. Decision to Select Intervention

The SC chose PMTO after a careful review of the research on evidence-based parenting programs. The 10-month review process included examining the current research and consulting with experts. PMTO was deemed an appropriate intervention because it focused on improving the parenting practices of parents who may have complex problems. Further, PMTO is a progenitor model. A progenitor model allows the implementation site to develop its own trainers, coaches, fidelity raters, etc. and, therefore promotes long-term sustainability at the site. KIPP was also interested in implementing an intervention



that could be sustainable, as this would not require continuous expenses to the purveyor for training and coaching. At full implementation, KIPP would have its own trainers, coaches, and fidelity raters through a certification process from the PMTO purveyors

1.6.3. Introduction to PMTO

PMTO is an evidence-based structured intervention to help parents and caregivers manage the behavior of their children. It was designed to promote pro-social skills and cooperation and to prevent, reduce, and reverse the development of conduct problems. PMTO empowers parents as the primary treatment agent to promote and sustain positive change in families.

1.6.4. History of PMTO, OSLC, and ISII

Over the past 35 years, colleagues at the Oregon Social Learning Center (OSLC) have developed and tested theory-based interventions to treat and prevent conduct and associated problems in children and youth. This research, which has been supported by the National Institutes of Health (NIH), has generated a set of intervention programs that are now recognized as evidence-based practices (EBP). The basic model underlying these methods is PMTO. In order to extend these programs to the families who need help, a network of OSLC-affiliated organizations was established. ISII is a research-based, nonprofit organization providing training for mental health professionals in PMTO. Since 2001, ISII has become the driving force behind PMTO training for mental health professionals. A primary ISII mission is to ensure that PMTO is implemented with fidelity in community agencies that serve children and families.

The theoretical foundation underlying PMTO is social interaction learning (SIL), which fuses social interaction, social learning, and behavioral perspectives (Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Patterson, 2005).

1.6.5. PMTO Assumptions and Guiding Principles

PMTO is based on the following assumptions and principles:

- Parents are important teachers for their children.
- Therapists teach parents the skills to serve as treatment agents for their children.
- Having parents as the treatment agents ensures continuity in practice-of-treatment methods when children are at home.
- The intervention is designed to empower parents to be effective teachers and positive influences in their children's lives.
- Therapists help parents identify their own strengths and strengths of family members and build upon them over the course of treatment.
- The central role of the PMTO therapist is to teach and coach parents on the use of effective parenting strategies (e.g., establishing goals, promoting appropriate behavior, using effective praise, consistently using mild negative consequences, and keeping track of children's activities and routines) (Forgatch & Domenech Rodriguez, 2016).

1.6.6. Evidence in Support of the Theory of Change

PMTO has an impressive array of research that supports its effectiveness. Additionally, published work from PMTO's developers is notable for its emphasis on theory building. For example, in an article describing results from a study of 238 recently separated families, Patterson, DeGarmo, and Forgatch (2004) observed that mothers in the treatment group who improved their parenting skills during the first 12 months of the intervention also showed significant reductions in maternal depression. Reductions in maternal depression during the study's first year predicted stability

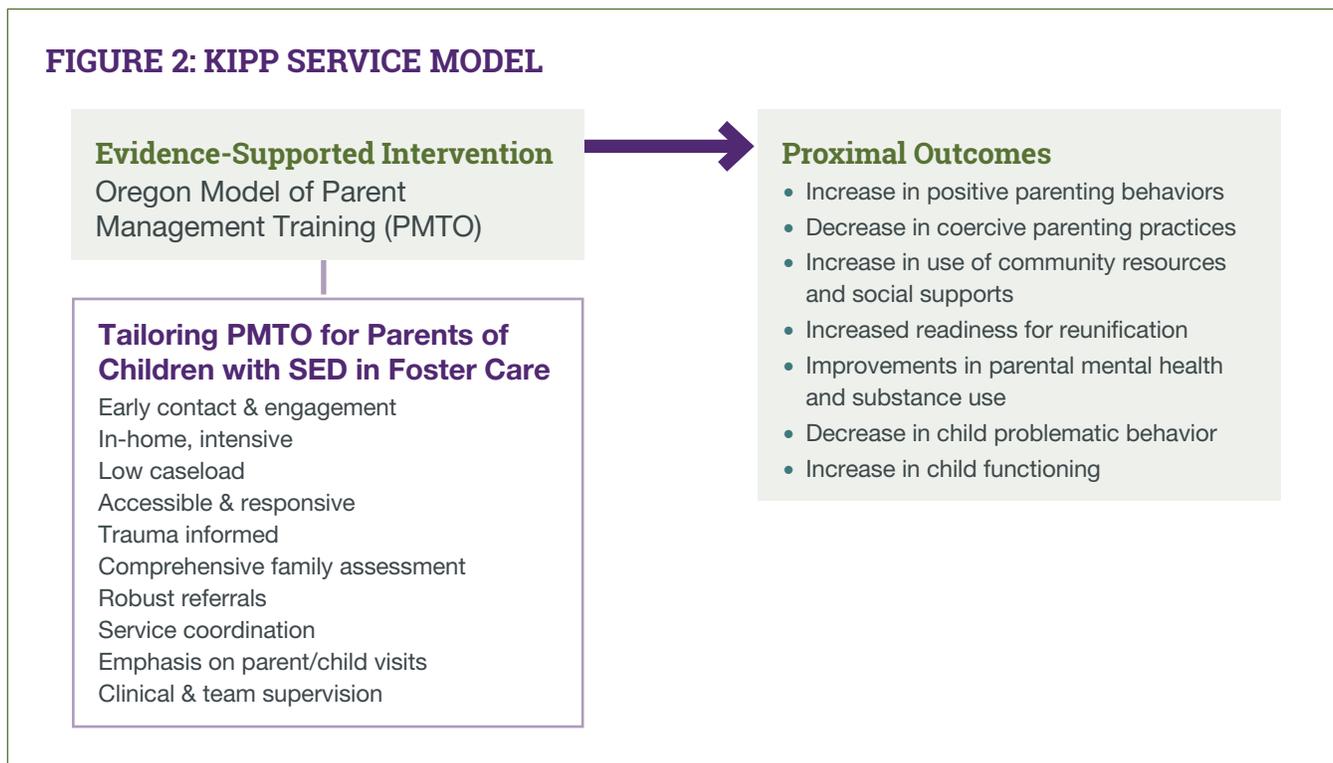
or continued improvement during the subsequent 18 months. The authors note:

The findings are consistent with the idea that some early improvements in parenting practices are responsible for the improvements in maternal depression. However, we cannot make a compelling argument that the direction of the effects is from parenting changes to changes in depression... We need to develop a theory about intervention process that details the sequence of variables that change during prevention trials (p.631).

Patterson, Forgatch, and DeGarmo (2010) describe 9-year repeated assessment results from the study referenced above. In this article, the authors refine their theory about maternal depression; they reported that maternal depression diminished simply by virtue of being assigned to the treatment group and hypothesized that mothers felt supported and hopeful that things will change. Moreover, the authors described

collateral changes in family systems following PMTO intervention. For example, as mothers improved their parenting, their sons' deviant behavior diminished. Mothers then responded powerfully to positive changes in their children in a continuing feed-forward loop. In the 9-year follow-up, mothers demonstrated improvements in standard of living and reductions in arrest rates. Over time, it appears that the reduction of coercion brought about by successful PMTO can fundamentally alter the family's social environment, opening doors to new social communities and, thus, new peers, opportunities, and identities for child and mother alike. We hypothesized that the changes in family life brought about by other successful PMTO implementations would be replicated in the Kansas implementation, thus altering readiness for family reunification and, ultimately, improving permanency for families in the treatment condition.

Figure 2 below visually describes the service model of the KIPP intervention. PMTO is the ESI that was



selected by KIPP for parents of children with SED in foster care. By focusing on the 10 aspects listed in Figure 2, KIPP sought to achieve the proximal outcomes.

1.6.7. Referral to the KIPP Intervention

The agency partners administered the CAFAS to children who entered foster care during the project period. The assessments were administered by day 14 of entry into foster care. Children could be re-screened through the 45th day of entry. The KIPP data liaison entered the data from these two assessments into the REDCap (Research Electronic Data Capture) data system. All cases entered into the REDCap would be determined to be eligible based on their assessment scores and then randomly assigned as treatment or comparison. When agency staff contacted KU to request a new case, the KU research staff would assign a treatment and a comparison case based on the location of the therapist requesting a new case. The agency staff would obtain verbal and written consent from families to participate in KIPP. Agency staff became skilled at explaining the purpose of the project, as well as the probable benefits of involvement, to potential participants. The overall consent rate was 74 percent during the project.

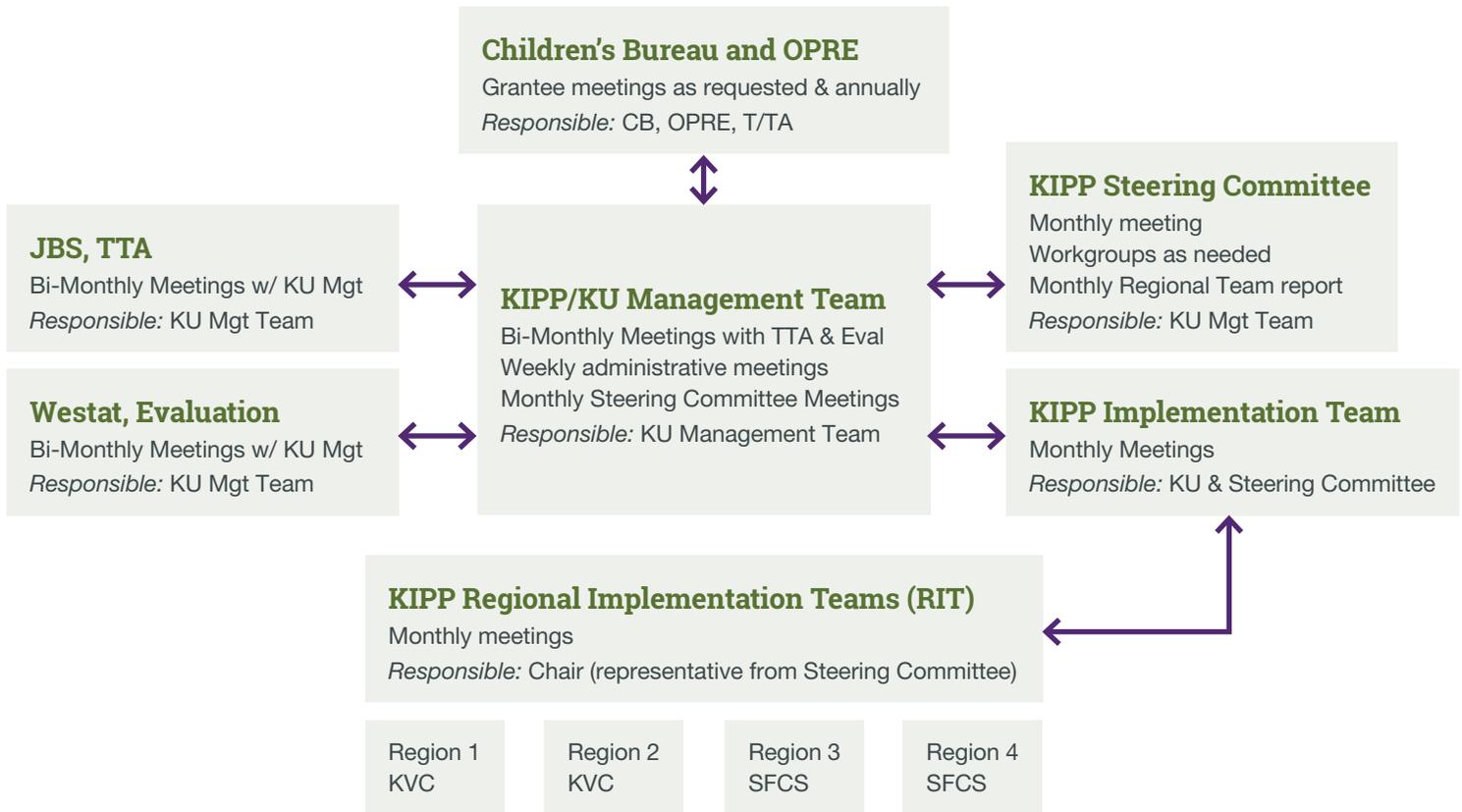
2 GOVERNANCE AND TEAMING STRUCTURES

2.1. KIPP Governance Structure

The figures below illustrate the governance and teaming structure for KIPP. It was important to the implementation of the project to have effective communication and processes to inform the partners of implementation progress and issues. For this project, the grantee, KU, had direct contact with the Children’s Bureau and its contractors. JBS International, Inc. and its subcontractors (as the PII Training and Technical Assistance Project or PII-TTAP) provided T/TA to KU and its partners. Westat and its subcontractors performed the evaluation of PII (as the PII Evaluation Team or PII-ET). KU was responsible for providing leadership and oversight for the grantee, including compliance with Children’s Bureau requirements, facilitating SC and KIT meetings, and managing the data collection and evaluation activities. KU had ultimate responsibility to communicate and disseminate project information and reports.

KIPP formed the SC and KIT; the terms of reference for these two groups are included in the Appendix of this manual. Additionally, the agency partners formed Regional Implementation Teams (RITs). The teams were the connection between the frontline staff and the SC and KIT. **Figure 3** below demonstrates the overarching governance and teaming structure for KIPP during the project period, as well as the communication structure developed and used. It is important to note that the arrows flow in both directions between all of the entities. Linking communication assists in troubleshooting issues and barriers as the issue can be moved up to the person or group who is in a position to resolve it. Communicating actions and

FIGURE 3: GOVERNANCE AND COMMUNICATION LINKING



decisions becomes the responsibility of all the parties. **Figure 4** describes each KIPP team and its purpose, frequency of contact, and means of documenting the members' activities.

Lack of effective communication can be a barrier to implementing a new EBP intervention. Creating a communication and teaming structure can be challenging, but having a structure that emphasizes the sharing of data, acknowledging the expertise from the frontline staff, and being responsive can contribute to successful implementation.

LESSONS LEARNED

Establishing a governance structure at the very beginning of the project is important. Constant attention to linking communication will assist in trouble shooting issues as they arise.

2.2. KIPP Principles for Problem Solving and Decision Making

The SC established the following principles for problem solving and decision making:

- Understand what is non-negotiable and why that is so.
- Use data to drive decisions.
- Take time to understand each other's perspective.
- Honor the decisions made.
- Critically consider the impact of the problem and the decisions in all areas and for all partners.
- Include all those who are affected in the decision-making process.
- Make consensus-driven decisions with a focus on function.
- Begin each decision-making process with a clear statement of the goal and agreement on the goal.

FIGURE 4: KIPP TEAMS

This table provides information on the various teams for KIPP and their purpose. The frequency of meeting and means for documenting is also noted. A deliberate and focused approach in forming teams is the first step. Developing the structure for the teams contributes to making sure the teams serve a purpose in the project. Communicating within and between the teams contributes to being able to address any barriers or issues that will most certainly be encountered in an implementation.

Team	Frequency	Purpose	Documentation
KIPP/KU Management	Weekly	Planning, coordination & integration, budget, oversight, federal compliance, evaluation, problem solving, quality assurance (QA), dissemination, reporting on actions	Agenda and Notes
KU and ISII	Monthly	Planning, tailoring, problem solving, budget, contract oversight, research	Agenda and Notes, Issues for KIT/SC
KIT	Once a month	Problem solving, procedures, across-region sharing, work group, leadership for competency drivers, local implementation oversight, communication link with region, QA for region	Agenda and Notes, Action Items, Items for SC
SC	Once a month	Info sharing, problem solving, policy, budget, leadership, removal of barriers, long-term planning for sustainability, stakeholder networking & engagement	Agenda and Notes, Supporting Docs, Action Items, Items for ISII
SC/ISII	1 hour during SC meetings	Coordination of implementation and troubleshooting	Notes of attended portion
KU-Supervisors	Monthly	Information sharing across regions, QA of evaluation, implementation, training, coaching	Agenda and Notes, Action Items, Items for SC
KU-Data Liaison (DL)	Quarterly	Information sharing across regions, QA of evaluation, implementation	Agenda and Notes, Action Items
ISII and Local Teams	Periodically as requested	Troubleshooting PMTO implementation, coaching of supervisors, tracking certification of therapist	Action Items as Needed
KIT-KIPP Supervisors	Monthly	Sharing of decisions from SC and KIT, QA for region, identification of barriers & successes for KIT and SC local problem solving	Agenda and Notes
KIPP Supervisors-Therapists/DL	Weekly	Supervision, PMTO coaching, QA for region	Report

2.3. Teaming

KIPP determined that there would be four teams to implement the intervention: KIPP/KU Management Team, SC, KIT, and RITs. These teams were formed in order to divide the tasks to be completed; match expertise

with project objectives; and build the infrastructure to implement, evaluate, and ultimately sustain the ESI. The project partners were involved from the beginning when application for funding was initially submitted, which helped to insure commitment to the project when it was funded.

The KIPP/KU Management Team members included three principal investigators and a program manager. This team was responsible for providing leadership and oversight to the other three teams. It had the ultimate responsibility and accountability to the Children’s Bureau and PII. Initially, the team met face to face weekly and, on occasion, increased the frequency of meetings as needed at key junctures of project. This team continued to meet throughout the whole project. Membership changed when a principal investigator and the program manager resigned from the project. Another program manager joined the project, but the principal investigator was not replaced.

The SC’s main purpose was to develop and implement KIPP in Kansas; it was the driver of the KIPP vehicle. The SC managed the RITs, created policies and procedures, communicated and disseminated project updates and reports, and engaged stakeholders. The members included representatives from each of the foster care contract agencies, a state child welfare agency administrator, and the KIPP/KU Management Team. The SC met monthly face to face. Also participating in the meetings were the partners from PII-TTAP, PII-ET, and the purveyor, ISII.

The KIT’s focus was to support and troubleshoot the KIPP intervention. If the SC was the driver of the vehicle, then the KIT was the engine. It assisted in making sure all of the components of the intervention were in place and working as designed. The KIT would address the barriers that arose and resolve issues as they presented. The policies, procedures, and protocols that were developed came from the KIT. It was responsible for monitoring the activities of the KIPP therapists, supervisors, and data liaisons. The members included representatives from each of the foster care contract agencies who directly supervised KIPP staff, a state child welfare agency administrator, KIPP principal investigator, and KIPP program manager.

Teams are very important to implementing an intervention, especially when there are project partners who come from different agencies. Each agency has its own ways of doing work. When bringing agencies together on a collaborative project, developing a shared vision and goals will greatly assist the project when there are difficult decisions or issues to be addressed. The Terms of Reference described below were one way that KIPP brought together the teams and operationalized how the partners would work together to accomplish the stated goals.

2.4. Terms of Reference

The Terms of Reference (also referred to as a “Team Charter”) required creating a clear and mutually agreeable definition of the scope of work and stipulating how the work will be developed and implemented; they may be revised as better ways of functioning emerge. The Terms of Reference for the KIPP/KU Management Team, SC, KIT, and RITs are included in **Appendices C–F**. KIPP reviewed the terms twice a year to determine if they were still relevant or if they needed modifications. It serves as a reminder of how the teams are communicating and working together with a common goal.

LESSONS LEARNED

We suggest that the Terms of Reference be revisited at least once per year. Terms of Reference are a valuable tool for focusing on the shared vision and means of accomplishing the goals of the project.

3 READINESS⁸

Implementation of innovations often occurs in a complex organization. As a result, the organization must pay constant and ongoing attention to readiness. Attention to ongoing readiness means paying close attention throughout the implementation process to the entire organization—to both the people and the overall structure in which an innovation is being implemented. This can take multiple forms, for example, administration of a readiness assessment before beginning implementation or targeted information gathering through meetings and outreach sessions. However, as information gathering occurs, it should include ongoing exploration of how an organization is currently operating and how it should or could be operating to support the innovation more effectively. A readiness assessment could reveal that, in general, a certain innovation does not fit into the organization's current mission and vision or that the organization needs to involve more partners. A targeted look could reveal that current hiring practices do not assess for the specific competencies needed for the innovation. Although assessment methods and results vary by organization and implementation stage, attention to ongoing readiness is crucial throughout the process.

3.1. Selection/Recruitment

ISII provided support in developing selection criteria for KIPP clinicians and other associated positions. These documents were further developed and refined throughout KIPP. ISII had very clearly defined selection criteria for the therapist positions required to ensure sustainable fidelity and quality to the model. As the project progressed, ISII worked with the SC to define selection criteria fully for all of the positions: PMTO clinician/therapist, PMTO FIMPer (i.e., fidelity rater for Fidelity of Implementation Rating System), PMTO

coach, and PMTO trainer. Full position descriptions, roles and responsibilities, and requirements for PMTO certification were developed in collaboration between ISII and the SC and are provided in **Appendix M**. It is important to note that ISII prefers to identify leaders from within training cohorts and to shape them into successive PMTO coaches, trainers, and fidelity raters. In addition to agency readiness checklists, criteria, and instruments to aid with selection, ISII trainers provided regular consultation to KIPP partner agencies during the hiring process. ISII staff have reviewed resumes of applicants and provided feedback to hiring teams as needed. KIPP partners also worked with ISII to fashion a KIPP-specific roleplay to help discern which applicants would best be able to implement an intervention, which relies heavily on role play with family members.

3.2. Training

Readiness for training required minimal work at the implementation site as ISII provided the entire first round of training. All necessary materials, including manuals, other training supplies, equipment (e.g., video recorders), and PMTO-related assessment instruments (e.g., Family Interaction Task or FIT) were initially provided by ISII and included in its final bid. Materials developed specifically for KIPP remain in Kansas and can be used by successive generations of Kansas PMTO trainers after funding for the demonstration project has concluded.

KIPP's role in this area of readiness mainly pertained to assuring that staff were hired and had the time to participate in the rigorous PMTO training regimen. KIPP timelines were established for the first generation training sessions, which were provided onsite in Kansas. Two KIPP cohorts, comprising about 20 KIPP clinicians and supervisors, attended trainings in a staged manner, with one cohort beginning training in October 2011 and the other in November 2011.

8 Dymnicki, A., Wandersman, A., Osher, D., Grigorescu, V., & Huang, L. (2014, September). Willing, able → ready: Basics and policy implications of readiness as a key component for implementation of evidence based practices. ASPE Issue Brief. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/77076/ib_Readiness.pdf.

Training in cohorts of fewer than 20 is a requirement of ISII as no more than 20 people may attend training at any one time to ensure a high-quality, interactive training environment.

The average time from Workshop 1 to certification as a PMTO Specialist is 22 months. In order to fulfill requirements of our evaluation plan (e.g., sufficient number of families for sample size based on power analysis), we asked ISII to expedite this process, if possible, so that KIPP clinicians could be certified within 18 months. However, our experience showed that it took clinicians 20–22 months on average to become certified in PMTO

3.3. Coaching

Direct observation is the basis for PMTO supervision and coaching and is regarded as the gold standard for achievement of fidelity (Schoenwald et al., 2011). Coaching is an integral component of PMTO during training and post-certification. Sessions with PMTO families are video-recorded, and coaching was provided in three formats: (1) group-style coaching with peer feedback during five workshops, (2) videoconference coaching directed by the PMTO trainer or coach, and (3) individual written feedback provided to each candidate by the PMTO trainer or coach. Initially, coaching was provided at least twice monthly. While agency partners expressed initial concerns about the amount of video recording required for PMTO, ISII reassured the SC that initial trainings would increase buy-in among practitioners—often the group most resistant to this practice. Furthermore, all necessary precautions were taken to ensure protection of clients from subpoena of video recordings or other breaches of confidentiality.

ISII staff provided initial supervision and coaching. Because PMTO is a progenitor model whose goal is full transfer of the PMTO program to the state of Kansas, ISII incrementally transitioned training and coaching elements and responsibilities to the Kansas

team. The transition was planned in manageable steps and with support. Phase 1 activities, which occurred in Years 1 and 2, consisted of clinician training, building leadership (e.g., identifying future leaders from within Generation 1 candidates), designing infrastructure for PMTO's ongoing success, and tailoring PMTO for the Kansas context. In Phase 2, in Years 3–5, leaders selected and pre-trained for identified roles: coaches, FIMPers/fidelity raters, and trainers. Also during Years 3–5, ISII's support focused on coaching and care of leadership to secure the full transfer of PMTO. Finally, in Year 4, Kansas PMTO joined ISII's FIMP Central, an international PMTO fidelity network, to ensure self-sufficient fidelity and to connect with the worldwide PMTO community.

3.4. Fidelity System

To ensure that video-recordings, assessment instruments, and other data required for fidelity assessment of PMTO were collected and entered in a timely fashion, ISII recommended the hiring of a half-time support person. This position was budgeted for in the KIPP implementation and proved to be a very important position. ISII has a data system and manual for fidelity assessment that it provides to each implementation site. Fidelity ratings occurred at least quarterly throughout the training process until certification and annually after certification.

3.5. Data Systems

KIPP staff at KU developed a data collection infrastructure that supported KIPP's evaluation and Quality Assurance (QA) Plan. Evaluation efforts were linked to the plan, including process, fidelity, and outcomes measures. Regular reports were developed and then provided to the SC and the RITs so that data could be used to inform the implementation and good decision-making for continuous quality improvement. KIPP used REDCap, a secure, web-based application designed to support data capture for research studies. Vanderbilt University developed REDCap with

financial support from NIH and the National Center for Research Resources. The Center for Research Methods and Analysis at KU is a consortia partner of REDCap and supported its use for KIPP. REDCap provided:

- An intuitive interface for validated data entry
- Audit trails for tracking data manipulation and export procedures
- Automated export procedures for seamless data downloads to common statistical packages
- Procedures for importing data from external sources.

Importantly, REDCap is HIPAA compliant.

3.6. Organizational Supports

Because of the longstanding, collaborative relationship between KU and the Kansas privatized foster care providers, KIPP's host agencies had been partners in this cooperative agreement from its very inception. As the creators of KIPP, agency partners carried the vision for KIPP back to their respective agencies, and this vision infused all administrative levels in each agency.

Regarding administrative supports, each Kansas child welfare region was represented on the main administrative/leadership body for KIPP, SC, which met twice monthly during Years 1–5. Moreover, each region was represented by a director or co-director, who oversaw implementation at the local level and had sufficient power to enact needed changes to policies and procedures. In this way, KIPP institutionalized accountability and established buy-in from the very start of the project. The data coordinator position in each agency also supported KIPP implementation at the local level. This position helped to keep KIPP clinicians organized and focused on key milestones for implementation and evaluation.

SC members worked with RITs to change policies and procedures to support KIPP at the local level. These changes were too numerous to fully detail in this

report. One of KIPP's agency partners estimated that KIPP implementation affected more than 35 discrete agency policies and most departments, including human resources (HR), intake/admissions/care management, training, data, and finance. Representative examples of changes each agency made included:

- Identifying/reassigning office space and equipment for new KIPP staff
- Working with HR to post job descriptions and hire KIPP supervisors
- Working with supervisors and HR to post job descriptions and hire new KIPP clinicians
- Replacing positions vacated when internal staff are reassigned
- Training:
 - The leadership team in basic PMTO
 - Supervisors and KIPP clinicians
 - Case managers to administer screening instruments to make SED determinations
- Ensuring timely completion of assessments and data entry/upload for KIPP and comparison group families
- Creating and managing a new layer of case coordination between KIPP clinicians and other teams and departments
- Providing transportation to ensure that child-family visits occur frequently enough for parents to practice PMTO core skills
- Troubleshooting dropouts
- Tracking the progress of treatment and comparison families from intake to 12-months post-entry.

3.7. Financial Resources

KIPP was wholly funded by a cooperative agreement between the KU (through the KU Center for Research) and the Children's Bureau. No changes in funding were required during the grant period. KIPP leadership worked with several collaborators, including Casey Family Programs, to leverage additional support and

strategies for future sustainable funding. No other financing tasks were necessary during the readiness phase.

3.8. System Partners

KIPP was fortunate to have had the full cooperation and support of the state public child welfare agency throughout KIPP's planning year and as it moved toward implementation. A representative from Kansas DCF participated as a full member of the KIPP team, sat on the SC, and attended national PII grantee meetings.

Key stakeholder collaboration during the planning year was also important. KIPP leaders had a number of very positive meetings by region, between foster care contractors and CMHC staff and with members of the judiciary, and other key stakeholders. SC members presented to several state, county, and local consortiums and committees with oversight responsibility for foster care. All parties pledged cooperation with the goals of KIPP. To ensure full cooperation throughout the initiative, we asked the RITs to advocate more in some regions, court systems, and CMHC catchment areas than in others. However, we were aware of the challenges that we would face in these areas. These challenges are largely known, historical challenges, such as judges who terminate parental rights at high rates or gaps in availability of substance abuse treatment. RITs identified areas that warranted targeted attention.

Importantly, anticipated antagonism between CMHCs and foster care agencies did not materialize. Rather, CMHCs expressed full support of KIPP and acknowledged that they do not have the capacity to adequately serve parents of children in foster care. At higher organizational levels, KIPP leadership received assurance that CMHCs would continue to serve children with SED and work to address gaps in the current system of care.

3.9. PMTO Tailoring

When KIPP initiated its work to bring PMTO to Kansas, PMTO had been implemented with child welfare families in Michigan and elsewhere and required only modest modification for use with the Kansas SED population. Tailoring occurred in three main areas: engagement, assessment, and trauma. A brief description of these enhancements follows.

First, to promote engagement, PMTO was delivered in-home, beginning within approximately 6 months of the child's removal from the home. Agency partners had identified a current pattern, especially among children with SED, in which the child is removed from the home and services quickly focus exclusively on the child. Parents recede in relevance with each successive crisis and/or placement move. Children with a SED often experience placement instability, which means they may be placed many miles and hours from their parents. As geographic distance between parents and children increases, parent-child visits become logistically challenging. The emotional and physical distance between parents and children also grows. The result is a group of children with poor permanency outcomes and of parents who were not meaningfully engaged or encouraged to make substantive changes. While it may seem counterintuitive to intervene immediately after removal, when the pressure is putatively "off" the parents, the timing of this intervention was crucial to ensure that an "irrelevance" gap does not appear for parents. Furthermore, PMTO services focused, in the beginning of the case, on emotion regulation and problem solving in adult-adult relationships. PMTO's developers had found that parents respond very powerfully to this content and find it rewarding and so engaging that they continue the hard work of changing their parenting practices.

Second, to ensure robust referrals to other specialty providers, a comprehensive assessment was conducted and needed mental health and substance abuse services coordinated. This area required additional

study and consideration to ensure that adjunctive treatment did not work at cross-purposes to PMTO. The SC addressed this issue with ISII and developed protocols to ensure an individualized-but-consistent approach to case coordination and referral across agencies and regions. When appropriate, the KIPP therapist facilitated a referral follow-up with the parent and the adjunctive provider to promote a successful intake and a follow-up with the parent and adjunctive provider to gauge satisfactory treatment progress.

Third, to increase its trauma focus and to help parents and children cope with domestic violence and other trauma to which they have been exposed, PMTO training maximized content on trauma sequelae and emotion regulation.

3.10. KIPP Service Model

In addition to the above tailoring of PMTO, in accordance with the needs of the target population identified during the exploration phase of the project, KIPP services were meant to emphasize:

- Early contact and meaningful engagement with family members
- Comprehensive family assessment
- Provision of concrete services when appropriate
- In-home, intensive parent training
- Accessible and responsive service delivery by clinicians with low caseloads and vigorous clinical and team supervision
- A thoroughly trauma-informed intervention
- Service coordination and referrals to alcohol and other drug (AOD), mental health, and developmental disability (DD) specialists when needed
- Expeditors of permanency, such as frequent parent/child visits and concurrent planning

ISII staff and trainers defined rigorous training content practice procedures, and/or fidelity measurement around KIPP's programmatic and fidelity needs including engagement; supervision; in-home, intensive, trauma-informed service provision; specific caseload requirements; and service coordination.

The feature of Kansas PMTO requiring the greatest TA from ISII was trauma. To address pervasive trauma in both child and parent populations, we requested that Kansas-specific training include two emphases: trauma-specific content and a maximum focus on emotion regulation. Abi Gewirtz, PhD, a PMTO implementer who has developed the intervention for use with veterans of the Iraq and Afghanistan wars and their families, consulted with the KIPP team on our need for a systematically trauma-informed version of PMTO. Given the breadth and depth of PMTO's implementation history in many countries, over many years, we were confident that KIPP's specific needs could be met by ongoing consultation and collaboration with ISII.

Casework-related features of KIPP were beyond the purview of ISII and included comprehensive family assessment, provision of concrete services, frequent parent/child visits, referrals to collateral specialists, and contractually stipulated accessibility and responsiveness. While these practice framework elements were important to the success of KIPP, we did not believe that they represented significant systems changes. Rather, to ensure uniformity and fidelity to these principles across our four agency partners, the SC and RITs developed a KIPP orientation, which included guidelines and training around each of these areas. Additionally, KIPP clinicians received ongoing supervision and feedback at the case level. KIPP's QA plan also put in place several measures to track these casework components of the project.⁹

⁹ Additional information about KIPP's readiness and initial implementation can be found in Akin, Bryson, Test, Blasé, McDonald, & Melz (2013) and Bryson, Akin, Blasé, McDonald, & Walker (2014).

4 PROTOCOLS FOR SERVICE DELIVERY

4.1. KIPP's Expectations for Implementation of PMTO

The SC and ISII jointly created the following expectations for therapists implementing PMTO. They shared these with the therapists during training and reinforced them during coaching and supervision. Prior research on PMTO identified these as critical to successful implementation and outcome achievement. These provided guidelines to help ensure the intervention was delivered consistently and with high fidelity.

- PMTO content was covered with all treatment families to the greatest extent possible.
- PMTO content was covered in the prescribed sequence with adaptations based on families' needs, circumstances, and abilities.
- The pace of KIPP services was monitored in order to promote completion of KIPP content whenever possible, but with consideration and accommodation for the families' needs, abilities, and circumstances.
- The duration of KIPP services was appropriate relative to the maximum service duration (6 months); the families' needs, abilities, and circumstances; and the families' pace for learning PMTO content.
- Therapists were encouraged to practice flexibly and creatively within the PMTO and the KIPP service model to address families' unique circumstances and needs effectively.
- Therapists provided high-quality services consistent with the KIPP service model, including the following core components: early intervention, in-home services, intensive services, low caseloads, PMTO, and engagement.

4.2. Session Expectations and Protocols

KIPP asked supervisors and therapists to deliver services to families in a new and different way. For example, the intervention was deemed as intensive; therefore, providing a definition of "intensive" assisted in clarifying and operationalizing what is considered intensive. As described in more detail below, the therapist would meet with the family a minimum of three times per week. This was different from other family therapy sessions, which may only be weekly or monthly.

The expectations and protocols were modified and clarified over time. For example, there were questions from the therapists about whether they could classify extensive text messaging as a phone call. After discussion and feedback from the supervisors and therapists, it was determined that even though text messaging could be an important form of communication, it would not constitute a session. When protocols needed to be modified, the KIT would gather information from the supervisors and therapists, collect and analyze data, and add an agenda item to the next scheduled meeting. Frequently the purveyor, ISII, was consulted about its implementation experience with issues. The KIT and SC communicated the new protocols to the RITs through team meetings and emails. Modified protocols were also updated on the KIPP website regularly.

The following provides in-depth descriptions and definitions of key protocols pertinent to the delivery of KIPP services:

- **INTENSIVE:** Sessions are defined as either face to face or phone calls with substantial (PMTO) content (referred to as mid-week phone calls). KIPP therapists will provide a minimum of three sessions with each family weekly, two of which must be face to face. Typically, there will be two sessions with the parent (at least one face to face and one substantial phone call or two face to face) and one face-to-face

session with parent and child. If a parent cancels one or more of the three scheduled sessions in a week, additional options for rescheduling a make-up session should be offered. When it is not possible to reschedule sessions, and three are not held in any given week, additional sessions (beyond the expected three) should be offered in future weeks to ensure that each family maintains three or more sessions per week on average. Electronic forms of contact (e.g., email, text) do not meet the definition of a “session”. More than three sessions can be provided to a family in any given week. All sessions should be logged in REDCap and in the KIPP clinical chart.

- **HOME-BASED:** Sessions are to be delivered in the family’s home (natural environment) unless safety concerns place the KIPP therapist or family at risk of harm. If there are safety concerns, the KIPP therapist must staff the case with his/her supervisor and develop an alternate plan of service delivery (e.g., office or community) and plans for assessing continued risk level and for moving sessions to a home environment when safely possible. When a home environment is determined to be unsafe, a natural environment is always preferred to an office setting. Community settings may include a family member’s home, church, community meeting center, park, eating establishment, etc. All efforts should be made to ensure that families are provided with ample opportunities to learn and practice skills in the environment in which they will be residing.
- **CRITERIA FOR PHONE SESSION:** A mid-week phone call to the parent will count as a session if its purpose was to complete a specific task or intervention, was a minimum of 15 minutes long, and substantively addressed one of the following:
 - PMTO topics listed on the Visit/Session Log (e.g., goals, directions, emotion regulation, encouragement, active listening, debrief, etc.)

- Service coordination for previously identified service need
- Referral for services or social supports
- Clinical intervention to parent that is outside of PMTO content (e.g., assessing for safety, reviewing cycle of coercion relapse prevention plan, parent’s use of stress management, etc.)

If the family does not have access to a phone, the KIPP therapist should staff the case with the KIPP supervisor to determine what steps can be taken, including resource assistance, to remove this barrier. In the event that the family continues to lack access to a phone, then a face-to-face session should replace the mid-week phone call.

LESSONS LEARNED

Developing and revising protocols for the process of delivering PMTO was essential to ensure that the practices and policies were implemented with fidelity.

4.3. Defining the KIPP Service Model

The information provided in **Figure 5** below was the practice framework that defined the KIPP service model. For example, the agencies involved with KIPP and the staff implementing PMTO in Kansas recognized that focusing on a family’s strengths would have greater impact on the family and its motivation to improve its situation.

A KIPP Foster Parent Handout document is included as **Appendix K**. This document was provided to foster parents when a child who was participating in KIPP was placed in their home.

FIGURE 5: DEFINING THE KIPP SERVICE MODEL

Practice Framework	Definition
Values	Agencies and therapists recognize the importance of strengths-oriented and family-focused interactions.
Initial point of intervention	Early intervention is seen as a contributing factor to reunification. Families were referred to KIPP 20–45 days after referral to foster care services.
Early contact	The case is assigned to therapist on the day of referral to KIPP. The therapist makes initial contact within 72 hours of referral to KIPP.
Caseloads	The therapist has caseloads of 4–8 cases, depending on rural/urban factors.
Intensive services	Families receive 3–5 hours of direct contact services per week delivered by the therapist.
In-home services	Most services are delivered in the client’s home and to both parents if both are on path of reintegration.
Length of intervention	Families will receive up to 6 months of intensive service.
Accessible and responsive (24/7)	The therapist or supervisor is available to the family 24/7. The family is given as much time as it needs, when it needs it.
Comprehensive family assessment-NCFAS	An overall assessment of the family is used to assess the level of family functioning; the family functioning instrument includes multiple domains of functioning. Specialized assessments are also used in connection with AOD, mental health, DD, and other issues. It is critical for the worker to link all assessments to case planning, goal setting, determination of needed services, monitoring the family’s progress, and evaluation.
Goal driven	Service plans have specific, measurable, action-oriented, and attainable goals.
Trauma informed	Special topics training is provided for all clinical staff and supervisors.
Coordination with case manager and aftercare worker	The KIPP team (therapists and supervisors) works with case managers and aftercare workers to coordinate treatment, case plans, and transitions at the end of the intervention and at the time of reunification. Consultation between the KIPP therapist and aftercare worker occurs at the point of reunification. Between the end of KIPP and reintegration, a monthly check-in occurs for 3–6 months or ceases at reintegration.
Parent-child visits	Transportation can be an issue (e.g., getting the child to the parent). Special focus on parental visits is emphasized. The current standard is 1 visit per week or more when possible.
Concrete services	Therapists assist the family with accessing concrete supports and services, such as the use of flex funds. (Agencies have up to \$500 per family.)
Concurrent planning	Coordinating with the case manager is key to the involvement of relatives and kin and aggressive planning for permanency alternatives.
Coordination and Use of Community Supports	The therapist coordinates parent services and treatment with the child’s mental health treatment. Therapists will equip parents to navigate service systems for their SED child (ren) in care, especially DD, mental health, and school coordination problems, using a wraparound like approach. Access to domestic violence, AOD, DD, and mental health specialists is also key.
Coordination with foster parents	The therapist and case manager discuss the role of the KIPP worker with the foster parent. They also look at the issue of consistency between birth parents and foster parents and assist with placement stability.

5 KIPP STAFF POSITIONS AND LEAD ROLES

During the initial implementation of KIPP, it was determined that there would be five teams implementing KIPP based on the state being divided into five regions. Each region would have one team, and each team would comprise a KIPP supervisor, five therapists, and one data liaison. Below are the brief position descriptions, roles and responsibilities, and qualifications for the supervisor, therapist, data liaison, PMTO lead trainer, PMTO lead coach, and PMTO co-lead coach. **Appendices G** and **H** are selection guides for the supervisor and therapist and further detail the interview process, tools, checklist, interview questions, role-playing instructions, and scoring guide used in selecting appropriate candidates for those roles. Each partner agency was responsible for the selection of the staff to be on its specific team.

It should be noted that no matter their position, all KIPP personnel were expected to refer to their employing agency's guidelines and expectations for frequency, style, modality, documentation, performance evaluation, client rights, informed consent, and other components of supervision.

5.1. KIPP Supervisor

The KIPP supervisor provided case supervision and clinical oversight to KIPP practitioners and ensured the successful implementation and evaluation of KIPP services. **Figure 6** lists the position's roles and responsibilities.

To find and select the best candidates to be a KIPP supervisor, KIPP developed a set of requirements and preferences as laid out in **Figure 7**.

The purpose of supervision was to ensure that all personnel performed the tasks within their positions in a manner that best served the clients' needs and met applicable standards and regulations. It focused on evaluating employee performance and promoting the development of understanding and skills. Supervision was also intended to ensure implementation of KIPP according to established guidelines, while providing guidance supportive to fulfilling the KIPP vision and mission.

There were two types of supervision in KIPP: administrative and clinical. In both cases, supervision is the direction given to staff by direct supervisors, formally and informally, to ensure that employees perform their job duties in an ethical, professional, effective, and competent manner. Administrative supervision included providing feedback and resources to promote the development of the supervisee in understanding and skills related to the current position and positions of aspiration. It can ensue in a variety of formats, including individual, group, or team meeting and can occur regularly and as needed. Administrative supervision must meet the expectations specific to the agency that employs the supervisor and supervisee.

Clinical supervision was provided by a clinically licensed professional who meets required competency standards and is provided to licensed staff that deliver direct clinical services. It can also occur in a variety of formats, including individual, group, emergency, or advanced licensure supervision. Clinical supervision must not only meet the expectations specific to the agency that employs the supervisor and supervisee, but also the expectations specific to types of licensure in the state the services are provided.

Both the KIPP therapist and data liaison received administrative supervision on a regular basis from the KIPP supervisor (or agency-assigned supervisor) at least once a week. This was in addition to outlined training and coaching expectations and was to enhance PMTO learning and skill development.

FIGURE 6: KIPP SUPERVISOR ROLES AND RESPONSIBILITIES

- Recruit and retain KIPP participants. Supervisors are the first contact for families and invite them to participate in KIPP.
- Provide case oversight and clinical supervision for KIPP therapists
- Supervise staff, create individual work plans, and evaluate job performance
- Participate actively in PMTO training to achieve and sustain certification. They maintain a small case load (five families during training and certification and a minimum of one family post certification).
- Attend PMTO supervisory seminars to promote agency support and assistance for KIPP practitioners to achieve certification
- Monitor and ensure that trainees are compliant with training procedures
- Supervise the data liaison to:
 - Monitor assessment procedures and ensure completion in a timely and reliable manner
 - Ensure the data are being collected, tracked, and reported monthly and accurately
 - Oversee quality of the FIT videos
- Ensure success and training in PMTO and fidelity to the model through effective clinical supervision
- Identify potential barriers to effective service delivery and work to remove these barriers
- Participate actively in training, meetings, and consultations
- Monitor timelines and quality of reports and documentation weekly
- Serve as liaison across multiple levels (e.g., agency leadership, KIPP therapists, ISII, KU, and community partners)
 - Maintain and monitor lines of communication among all relevant parties
 - Support and maintain quality relationships with DCF, courts, PMTO staff, and other community partners

FIGURE 7: KIPP SUPERVISOR REQUIREMENTS AND PREFERENCES

Education and Licensure Requirements	Required Attributes and Skills	Preferred Attributes and Skills
<ul style="list-style-type: none"> • At least 3 years’ experience in child and family services, preferably with some time dedicated to supervising others • Master’s in Social Work, Counseling, Marriage and Family Therapy, or related field • Licensed by Kansas Behavioral Sciences Regulatory Board (BSRB) 	<ul style="list-style-type: none"> • Ability to : <ul style="list-style-type: none"> - Make a long-term commitment to KIPP (4 years) - Adopt new intervention strategies - Travel - Work flexible schedule, including evenings and weekends • Availability and eagerness to participate in demanding learning environment • Commitment to strength-based approach • Effective leadership and communication skills • Good judgment, empathy, ethics, and a sense of social justice • Qualities of being non-judgmental, flexible, creative and committed to working with troubled families in challenging circumstances • Willingness to have work video recorded 	<ul style="list-style-type: none"> • Comfort with and knowledge about behavioral approaches • Experience implementing evidence-based interventions • Knowledge of SED youth and foster care populations • Clinical license

The KIPP therapist also received clinical supervision as required by licensure expectations specific to the type of license held by the KIPP therapist in the State of Kansas, as overseen by the Kansas BSRB.

The KIPP supervisor also received both administrative and clinical supervision. Administrative supervision was provided on a regular basis (at least monthly) from a supervisor assigned by the employees' agency. The KIPP supervisor received clinical supervision as required by licensure expectations specific to the type of license held by the supervisor in the state where services are provided. As with the KIPP therapist and data liaison, supervision of the KIPP supervisor was in addition to outlined training and coaching expectations and was to enhance learning and skill development.

Appendix G provides a selection guide for the KIPP supervisor further detailing the interview process, tools, checklist, interview questions, role-playing

instructions, and scoring guide used in selecting appropriate candidates.

5.2. KIPP Therapist

The KIPP therapist provided intervention and clinical services to parents and their children as assigned in accordance to the KIPP PMTO training and credentialing. **Figure 8** lists the position's roles and responsibilities.

To find and select the best candidates to be a KIPP therapist, KIPP developed a set of requirements and preferences as laid out in **Figure 9**.

5.3. KIPP Data Liaison

The KIPP data liaison assisted with and facilitated implementation for KIPP supervisors and therapists to ensure the efficient and timely submission of session data for the successful implementation of KIPP services. **Figure 10** lists the position's roles and responsibilities.

FIGURE 8: KIPP THERAPIST ROLES AND RESPONSIBILITIES

Provide face-to-face, intensive in-home services to assigned parent, child, and families

- Participate actively in PMTO training to achieve and sustain certification (see below-right)
- Maintain a case load of 4–8 families
- Provide sessions in the home with parents and also with parent-child for 3–6 hours a week for 4–6 months
- Develop a transition plan with the family for discharge planning

Provide services to families in conjunction with caseworkers and other community service providers

- Develop treatment plans cooperatively with the caseworker assigned to the child in out-of-home placement (e.g., coordinating visits, transportation, etc.)
- Cultivate strong professional relationships with other community service providers working with the family to develop a treatment plan
- Participate in team meetings with the family, case-worker, and other community professionals

Complete assessments and documentation with the family

- Ensure data were documented and reported monthly and accurately
- Participate actively in training, meetings, and consultations
- Ensure timelines and quality reports are documented weekly

Obtain PMTO certification

- Participate actively in comprehensive, multi-phased training in PMTO and all scheduled workshops and trainings
- Video record parent, child, and family sessions
- Upload sessions and session information to secure database
- Participate actively in PMTO group and individual coaching
- Incorporate coaching feedback in session work

FIGURE 9: KIPP THERAPIST REQUIREMENTS AND PREFERENCES

Education and Licensure Requirements	Required Attributes and Skills	Preferred Attributes and Skills
<ul style="list-style-type: none"> • Master's in Social Work, Counseling, Marriage and Family Therapy, or related field • Licensed by Kansas BSRB 	<ul style="list-style-type: none"> • Ability to: <ul style="list-style-type: none"> - Make a long-term commitment to KIPP (3 years) - Adopt new intervention strategies - Travel and work flexible schedule, including evening and weekends • Availability and eagerness to participate in demanding learning environment • Commitment to strength-based approach incorporating research and EBP • Strong organization and time management skills • Effective verbal and written communication skills • Ability to receive and incorporate feedback • Good judgment, empathy, ethics, and a sense of social justice • Qualities of being curious, non-judgmental, flexible creative, open to new ideas, and committed to working with troubled families in challenging circumstances • Willingness to have work video recorded • Team orientation (i.e., collaborative and supportive of colleagues) 	<ul style="list-style-type: none"> • At least 3 years' experience in child and family services • Comfort with and knowledge about behavioral approaches • Knowledge of SED youth and foster care populations

Appendix H provides a selection guide for the KIPP therapist and further details the interview process, tools, checklist, interview questions, role-playing instructions, and scoring guide used in selecting appropriate candidates.

FIGURE 10: KIPP DATA LIAISON ROLES AND RESPONSIBILITIES

- Provide administrative support of KIPP supervisor and therapists
- Communicate with necessary staff and follow up regularly to ensure receipt of assessment information in a timely manner
- Communicate with KU to ensure accurate data are received according to timelines
- Partner with the management information system group to solve various reporting issues
- Provide clerical support to KIPP staff as needed
- Gather information on ancillary resources as needed
- Organize data, check data for completeness and accuracy, and transmit data in a timely manner
- Upload and make copies of videos to submit to ISII
- Perform other tasks to reduce the paperwork burden of KIPP staff (supervisor and therapists) in order to maximize therapy time for families
- Input accurately required data into data systems
- Perform other tasks as assigned

To find and select the best candidates to be a KIPP data liaison, KIPP developed a set of requirements and preferences as laid out in **Figure 11**.

FIGURE 11: KIPP DATA LIAISON REQUIREMENTS AND PREFERENCES

Education and Licensure Requirements	Required Attributes and Skills	Preferred Attributes and Skills
<ul style="list-style-type: none"> • High School Diploma or GED 	<ul style="list-style-type: none"> • Ability to: <ul style="list-style-type: none"> - Make a long-term commitment to KIPP (4 years) - Travel • Commitment to strength-based approach incorporating research and EBP • Effective organization, communication, and time management skills • Good writing, analytical, and problem-solving skills 	<ul style="list-style-type: none"> • Bachelor's degree in related field • Child welfare experience or experience in related field • Experience with data collection

5.4. PMTO Lead Trainer

The PMTO lead trainer was responsible for being the point of contact and directed the training activities for the Kansas PMTO implementation. The lead trainer organized, conducted, and sustained training of new generations of Kansas PMTO therapists. **Figure 12** lists the position's roles and responsibilities.

To find and select the best candidates to be a PMTO lead trainer, KIPP developed a set of requirements and preferences as laid out in **Figure 13**.

FIGURE 12: PMTO LEAD TRAINER ROLES AND RESPONSIBILITIES

- Attend and complete a training of trainers
- Collaborate with Kansas Governing Authority (KGA) to provide PMTO training for new therapists
- Provide leadership in organizing and facilitating PMTO workshops
- Coordinate fellow trainee trainers in facilitating Workshops 1–5
- Demonstrate ability to apply the theory of change
- Adhere to curriculum for PMTO
- Adapt materials to the needs of the trainees
- Enhance communication among PMTO teams to promote teamwork
- Demonstrate excellence in coaching and training skills
- Attend and complete training for FIMP

FIGURE 13: PMTO LEAD TRAINER REQUIREMENTS

Education and Licensure Requirements	Required Attributes and Skills
<ul style="list-style-type: none"> • Master's in Social Work, Counseling, Marriage and Family Therapy, or related field • Licensed by Kansas BSRB • Provider of PMTO services to children and families • Certified as a PMTO therapist and coach and/or selected by KGA 	<ul style="list-style-type: none"> • Ability to make a 12–18 month commitment to shepherd therapists-in-training toward certification • Strong commitment to sustain PMTO fidelity • Strong understanding of and commitment to working with PMTO populations • Extensive practice with PMTO application (varying family types and circumstances) • Skill in providing strength-based feedback • Commitment to coaching to improve therapist fidelity to and use of PMTO and to see coaching for self • Outstanding active teaching and process skills • Demonstration of exemplary clinical wisdom as evidenced by FIMP scores of 8s and 9s in PMTO work with families • Eagerness to continue learning and growing in own work • Leadership skills in small groups • Effective communication skills • Strong desire to be a PMTO trainer • Ability to receive and integrate feedback • Never-give-up attitude • Ability to manage multiple tasks • Outstanding performance in current role • Previous training experience and demonstrated successful training • Recommendation of direct supervisor • Charismatic presentation style

5.4.1. PMTO Lead Coach and Co-Lead Coach

The PMTO lead coach was responsible for being the point of contact for Kansas PMTO coaching activities. The lead coach organized, conducted, and sustained coaching of new generations of Kansas PMTO therapists. **Figure 14** lists the positions' roles and responsibilities.

FIGURE 14: PMTO LEAD AND CO-LEAD COACHES ROLES AND RESPONSIBILITIES

- Attend and complete coach training
- Collaborate with KGA to provide PMTO coaching for therapists
- Consult twice monthly with lead trainer to review candidates' progress
- Provide leadership in organizing and facilitating coaching sessions
- Coordinate fellow coach candidates in facilitating coaching sessions
- Submit to KGA a 6-month anticipated schedule of coaching for therapist-in-training
- Demonstrate excellence in coaching and training skills
- Attend and complete training for FIMP

To find and select the best candidates to be a PMTO lead or co-lead coach, KIPP developed a set of requirements and preferences as laid out in **Figure 15**.

FIGURE 15: PMTO LEAD AND CO-LEAD COACHES REQUIREMENTS

Education and Licensure Requirements	Required Attributes and Skills
<ul style="list-style-type: none"> • Master's in Social Work, Counseling, Marriage and Family Therapy, or related field • Licensed by Kansas BSRB • Provider of PMTO services to children and families • Certified as a PMTO therapist and coach and/or selected by SC 	<ul style="list-style-type: none"> • Ability to make a 12–18 month commitment to shepherd therapists-in-training toward certification • Strong commitment to sustain PMTO fidelity • Extensive practice with PMTO application (varying family types and circumstances) • Strong understanding of and commitment to working with PMTO populations • Skill in providing strength-based feedback • Effectiveness in coaching peers • Outstanding teaching and process skills • Effective communication skills • Demonstration of exemplary clinical wisdom as evidenced by FIMP scores in “Good Work” range • Effective leadership skills in small groups • Skill in promoting team spirit • Previous training experience and demonstrated successful training • Recommendation of direct supervisor • Charismatic presentation style

6 PARENT MANAGEMENT TRAINING - OREGON MODEL (PMTO®)

The model, core principles and practices of PMTO are based on decades of research and development of intervention programs for families of children with conduct problems as conceived by Gerald R. Patterson, Marion S. Forgatch, and colleagues at the OSLC. The group at ISII put theory into practice with the development of procedures and materials needed to implement the PMTO intervention in community settings. The PMTO therapist training and implementation materials were created by Laura Rains, Marion Forgatch, Nancy Knutson, and Abigail Gewirtz (authors); Kelly Bryson, Matthew Cooley, Will Mayer and Jan Mustoe (graphics); and Kelly Bryson, Margaret Lathrop, Cathy Scissors-Collins, Cheryl Hunter, Jeremy Jones, and Will Phillips (editors).

The information below provides an overview of PMTO and its implementation in Kansas. ISII, the purveyor, negotiates with each implementation site the full transfer of the tools required for implementing and independently sustaining the PMTO model.

6.1. Overview of PMTO

6.1.1. Essential PMTO

PMTO is an evidence-based structured intervention to help parents and caregivers manage the behavior of their children. It is designed to promote pro-social skills and cooperation and to prevent, reduce, and reverse the development of conduct problems. When

there is competence and adherence to the following key components, PMTO empowers parents as the primary treatment agent to promote and sustain positive change in families.

- PMTO incorporates skill encouragement, limit setting, monitoring, interpersonal problem solving, and positive involvement.
- Supporting components are woven throughout the treatment (e.g., emotional regulation, communication skills, giving children good directions to increase cooperation, identifying and building on strengths, promoting school success).
- PMTO is effective in producing the expected improvements in parenting (e.g., strengthen effective parenting; replace coercive parenting practices with positive parenting practices).
- Changes in the core parenting practices mediate treatment effects on child outcomes (e.g., reductions in delinquency, internalizing and externalizing behaviors, AOD use, arrests, and ratings of depression and deviant peer association; improvements in academic performance on standardized tests).
- Surprisingly, changes in core parenting practices also mediate the benefits to parent outcomes (e.g. increased standard of living in terms of income, occupation, and education; reduced arrests; improved marital relationships and satisfaction). Improvements in children's externalizing behavior mediate the intervention effects on maternal depression.

6.2. Overview of Session Modules

The PMTO model for KIPP consisted of three types of sessions. The first session per week introduced the specific content to the parent. This session included the therapist and the parent. The second session per week involved the therapist and parent and could be an in-person session or a check-in by telephone. The third type of session consisted of the therapist, parent,

FIGURE 16: PMTO ORDER OF SESSION MODULES

1. Therapist – Parent	2. Therapist – Parent	3. Therapist – Parent – Child
A1. Initial: Genogram, Storylines, Treatment Method, Building Hope	A2. Initial: Strengths, Values, Goals (adult and parent), MFP	A3. No Session
B1. Establishment: Goals, Values, Tracking, Structure, Visit Plan	B2. Directions: Structure, Tracking, MFP, Plan for Visit	B3. Therapist (T) structures and leads session; Parent (P) observes and tracks; T leads family game.
C1. Directions: Emphasis on Practice, Parent Emotion Identification	C2. Practice Directions: Child Emotion Identification, MFP, Role Play Visit	C3. T structures and leads Session; P practices directions (T coaches); P tracks directions and emotions; T leads game.
D1. Troubleshoot Directions: Praise, Mindfulness Practice (MFP)	D2. Emotion Regulation: Practice Directions, MFP	D3. P practices directions; P uses tokens (T coaches); T leads game.
E1. Encouragement: Tokens, Parent Focus, Self-Reinforcement, MFP	E2. Encouragement: Practice Directions, MFP	E3. P sets up token system (T coaches).
F1. Active Listening: Parent Communication, MFP	F2. Skills: Active Listening, Child Communication, MFP	F3. P leads collage (T coaches); T leads game.
G1. Debrief: Summarize, Re-teach, MFP, Parent Focus	G2. Debrief: Summarize, Re-teach, MFP, Child Focus	G3. P leads game (T coaches).
H1. Problem Solving: Parent and Child, MFP	H2. Second Weekly Session (to meet or not meet): Based on Parent Skills, Family Needs	H3. P plans fun activity next visit; P leads game.
I1. Managing Conflict: Emotion Regulation, Goals, Parent Focus, MFP	I2. Managing Conflict: Emotion Regulation, Goals, Child Focus, MFP	I3: T-P-C tailor sessions to respond to process of family, curriculum content.

and child. In this session, the parent would practice the content from the previous sessions. For example, in **Figure 16** above, the A1 session is the first session in a week with the parent; A2 is the second session in a week with the parent. The first week of the intervention is atypical in that there are two sessions with the parent before the parent and child session, A3. The first therapist, parent, and child session occurs after four sessions between the therapist and parents. This is done to set the parent up for success and to set the tone for the structure for future sessions. Additional information about the session modules can be obtained by contacting the purveyor, ISII.¹⁰

6.3. Training Requirements

After selection, supervisors and therapists were designated a cohort based on when they were trained as detailed in **Figure 17** below. The size of the cohorts varied based on the open vacancies and ranged from 10–20 trainees. Supervisors and therapists were required to attend 85 percent of the workshops to begin the certification process for PMTO therapists. This requirement was standard for PMTO implementation sites. In the event of an absence, the therapist had to plan for someone to video record the training and go over the recording with a supervisor or trainer. In addition, the therapist had to follow-up with a PMTO trainer to complete any assignments and to make sure that the material was understood.

¹⁰ ISII Headquarters: 10 Shelton McMurphey Boulevard, Eugene, OR 97401, tel: (541) 485-2711, website: www.isii.net

FIGURE 16: PMTO ORDER OF SESSION MODULES (CONTINUED)

1. Therapist – Parent	2. Therapist – Parent	3. Therapist – Parent – Child
J1. Limit Setting: Parent Focus, Self-Time out, Disengagement	J2. Limit Setting: Time Out During Visit	Possible Visit Activities: <ul style="list-style-type: none"> • Family Problem Solving – Child Issue • Family Problem Solving – Parent Issue • Family Meeting Each Week for 15 Minutes • Incentive Chart for School • Complete ‘Going Out?’ Check-in and Check-Out Routines • Complete ‘What I Know About My Child’s School’ • Parents Communicate with Therapist about Child’s Activities (e.g., Technology, Friends)
K. Limit Setting: Time Out, Privilege Removal, MFP	N/A	
L. Limit Setting: Work Chores (for use when children have visits at home), MFP		
M. Troubleshooting Limit Setting: Debrief Use, Focus on Encouragement, Review Emotion Regulation, MFP		
N. Balancing: Encouragement, Sandwich Game, MFP		
O. Goals: Advocating for Child, MFP		
P. Monitoring: Special Issues, Emotion Regulation, MFP		
Q. School: Support from Afar, Active Listening, Home-School Communication, Monitoring, MFP		
R. Goals: Problem Solving, Self-Improvement, Brain Training		
S. Positive Involvement: Active Listening, Family Activities, Engaging Children, MFP		
T. Transition Home		

Duration of modules varies based on family circumstances and need. PMTO is agenda driven and responsive to the family.

A Kansas PMTO Certificate of Completion template is included as **Appendix L**. This was given to parents and caregivers at completion of the PMTO program.

FIGURE 17: 2011-2015 SCHEDULE OF PMTO TRAINING EVENTS IN KANSAS

Training Event	Generation 1 (Cohorts 1 and 2)	Generation 1.5 (Cohort 3)	Generation 2.0 (Cohort 4)	Generation 3.0 (Cohort 5)
Workshop 1	October 2011	April 2013	February 2014	April 2015
Workshop 2	November 2011	April 2013	March 2014	April 2015
Workshop 3	January 2012	May 2013	April 2014	May 2015
Coaching Seminar 1	March 2012	June 2013	May 2014	June 2015
Workshop 4	April 2012	August 2013	June 2014	July 2015
Coaching Seminar 2	June 2012	September 2013	July 2014	N/A
Self-Assessment	July 2012	October 2013	August 2014	August 2015
Workshop 5	August 2012	November 2013	September 2014	August 2015

ISII staff trained the Generation 1 cohorts. ISII and Kansas PMTO trainers-in-training delivered the Generation 1.5 training. The trainers-in-training were candidates selected by the SC and ISII. Their selection was based on their skills and abilities in delivering PMTO content to families and their skills as coaches. The trainers-in-training attended a 3-day workshop in which skills in leading the workshops were practiced. Similar to the therapist and parent sessions, the training-of-trainers training and the PMTO workshops were very active and involved creating an agenda, role playing, mindfulness, and video recording. Participants completed evaluation forms after each workshop to provide feedback to ISII, Kansas PMTO Trainers, KIT, and SC members about trainees' perceptions, what went well, areas for improvement, and content that may need to be enhanced in coaching. An example of the evaluation form is included in **Appendix O**. The video-recorded training sessions were used for rating the trainers and trainers-in-training fidelity to the PMTO model.

A Kansas PMTO Trainee Candidate Participation Agreement document is included as **Appendix I**.

Appendix N is a document titled Pre-Reviewing Sessions for PMTO Certification. This document is used by the PMTO training team and the therapist in training to assess readiness to submit the four sessions for certification as a PMTO therapist.

6.4. Coaching Service Delivery Plan

Coaching is an integral component of training, implementing, and measuring fidelity to the Kansas PMTO model. This section provides information about the structure and procedures used during the KIPP implementation of PMTO. The amount of coaching was based on several factors. The therapists-in-training were coached twice a month. This coaching began

after they completed Workshops 1 and 2 and began work with families. The therapists upload their sessions with their family and provide information about the type of session and in what specific areas they would like coaching. The amount of coaching each therapist receives is based on where he or she is in the training process, whether he or she is experiencing difficulties, or if there are concerns about his or her ability to deliver the sessions to the fidelity of the model. The coaching frequency was as follows:

- Pre-certification: Minimum of twice a month an total coaching sessions should be at least 12 by the time the therapist is invited to certify
- New or difficult situations: As needed or requested by therapist
- Post-certification: Minimum of once per month

6.4.1. Coaching Formats and Procedures

In the beginning, the coaching was provided by ISII staff. After the supervisors were trained in the coaching delivery model, the KIPP supervisors provided coaching. After a therapist was certified as a specialist and completed a coaching training plan, then they could begin the process to become a coach. **Appendix M** provides additional information on the qualifications to be a coach.

Coaching was delivered through four required and routinized processes, listed below:

1. Training for therapists
 - Workshops 3-5
 - Coaching seminars (Seminar I after Workshop 3, Seminar II after Workshop 4)
 - Booster sessions
2. Regularly scheduled team meetings
3. Individual requests made for coaching to the therapist's supervisor
4. Group Coaching

Coaching may be delivered through any one of the processes above. However, it will usually occur in one of two formats, group or individual.

Group coaching occurred at workshops, coaching seminars, and team meetings. Coaches provided

feedback based on video-recorded sessions that KIPP therapists have uploaded to the Kansas Session Portal (Portal). The session segments are reviewed in a group format using a reflective team made up of fellow KIPP therapists or trainees. **Figure 18** describes group coaching with a reflective team in more detail.

FIGURE 18: GROUP COACHING WITH A REFLECTIVE TEAM

- The coach was the leader; one therapist was the recipient of the coaching (or coachee). All other participants (the reflective team) were behind an imaginary curtain.
- The coach's primary goal was to support the therapist, promote the therapist's development, and address the therapist's goals for the coaching.
- The coach structured the protocol and the seating to promote separation between the coaching recipient and the reflective team. For example, the coach and therapist sat together in front of the screen for viewing the video, with their backs to the reflective team. The reflective team sat in a half circle to facilitate its own interaction.
- The coach determined how to proceed through the video viewing. Often, the recipient chose a specific segment to watch. The coach moved rapidly through the session, stopping at random spots. Good spots to observe during the coaching were the opening (home practice debrief), midpoint, and closing (home practice assignment). The coach controlled the timing. Segments observed were relatively short. They attempted to stop on a positive note.
- The coach instructed the reflective team that it watch the interaction, but it is neither visible nor audible to the coaching recipient. When directed to do so, team members talked with each other, but did not speak directly to the recipient.
- The coach assigned each member of the reflective team a task. As the team observed the video segment, it identified one or two specific positive behaviors observed (with specific examples) that were within the assigned FIMP category (explained in more detail later in this chapter).
- Some reflective teams needed more guidance than others. The coach remained in charge of the reflective team regardless of which side of the curtain it was on.
- The coach asked the reflective team to describe the one or two positive behaviors it observed relevant to its FIMP category. The coach carefully structured this process, allotting time equally, and ensured a positive and supportive context by taking care that people did not cross the boundaries of their assigned category and that they stated only one or two behaviors.
- The way a coach interacted with the coachee may differ. The coach may have whisper-coached certain points to the coachee. He or she may have stopped the team to emphasize points to the coachee or to start a coaching dialogue with the coachee. The coach remained in charge to ensure that the reflective team promoted supportive relevant feedback.
- The coach asked the therapist to describe his or her own reactions to the clip observed and reflect on differences between those thoughts and feelings during the session and how he or she now saw it.
- The coach reminded the recipient of his or her coaching goal and asked the coachee to advance in that direction.
- Coaching took several forms at this point: brainstorming, role playing, and questioning process.
- The coach could pause and invite the reflective team to contribute again or could summarize and move forward.
- The coach invited the therapist to take what he or she wanted from the contributions of the reflective team—without any rationale or argument—and leave out what he or she does not need.
- Using a strengths-goals worksheet is recommended.

Individual coaching was delivered via written feedback or verbal feedback. This included in-person sessions, phone calls, and video conferences. **Figure 19** outlines the procedures for individual coaching.

FIGURE 19: COACHING: WHO DOES WHAT AND WHEN

Who	Does What	When
Therapist	Uploads all session videos to the Portal	Within 48 hours of session
Therapist	Completes session form on the Portal; identifies areas for feedback by completing session form	Within 48 hours of uploading video
Therapist	Emails request for additional coaching to supervisor	As needed
Supervisor	Determines need for local versus rotation coaching; emails request for rotation coaching to lead coach with cc to KU	Within 48 hours of receiving coaching request
KU	Identifies coach; emails coach with cc to supervisor of therapist, supervisor of coach, and lead coach	Within 24 hours of receiving coaching request
Coach	Views video and provides: Written feedback on the Portal <i>OR</i> Verbal feedback (in person, phone call, video conference). The occurrence of verbal feedback is also documented on the Portal.	Written feedback within 7 calendar days of receiving the assignment from a KU email <i>OR</i> Contact the coachee within 72 hours to schedule verbal feedback. The verbal feedback should occur within 7 calendar days of receiving the assignment.

Note on Documentation

Although not every coaching session required the coach to provide written feedback to the coachee, the coach was always required to document the occurrence of the coaching session. This was maintained in the Portal so that all coaches, as well as the KU research staff, had access to during the project. The KU research staff used this information to track coaching sessions by developing and maintaining an Excel spreadsheet. It tracked the coach, coachee, type of coaching, date of coaching, and total number of coachings. Additionally, information on the coaches was tracked to include whom they coached, type of coaching, and date of coaching. This information was provided to the lead and co-lead coaches, KIT, and SC at least monthly and more frequently when training a new cohort of therapists.

6.4.2. Coaching Skills and Strategies

The Kansas Matrix, found in **Appendix M**, provides specific and detailed information on the selection, training, and certification of Kansas PMTO coaches. A synopsis of coaching skills and strategies follows below.

- **STRUCTURE:** Keep an agenda, balance time among the participants, lead without dominating, spend appropriate time on different topics/parts/ participants, budget time, and assign a timekeeper; it's over when it's over (prevent continued conversation).
- **EMPOWER:** Shine the light on what you want to grow (i.e., focus on promoting skill development and understanding). Normalize problems. Support in difficult situations.
- **TALK AND COOPERATE:** Encourage each participant's contributions to the group. Engage the entire group while maintaining reflective team structure. Prevent monologuing. Avoid flooding the coachee with information. Acknowledge individual perspectives and competencies. Weave storylines together—PMTO, therapist, family, and the group.

- **POSITIVE INVOLVEMENT:** Express warm feelings and humor. Show genuine interest and provide support. Have fun together. Promote curiosity. Make it easy to ask “dumb” questions.
- **GUIDE AND SHAPE TO ARTICULATE COACHEE’S SPECIFIC QUESTIONS:** Enrich the coaching experience by asking the therapist to pinpoint one or two questions or concerns (e.g., use session form to identify times and questions). Plant seeds, and use leading questioning process.
- **STRENGTHEN GROUP DYNAMICS:** Listen to suggestions to improve practice. When disruptive behavior patterns develop, seek support and coaching to change the pattern as soon as possible.
- **BE STRENGTH-BASED:** Always begin feedback with an emphasis on specific behaviors or actions the therapist is doing well. Create a supportive, positive, and safe environment before troubleshooting challenges. Avoid teaching or confronting at all costs. Provide positive feedback to participants for their contributions to the group.
- **WHEN THE LEARNING CLIMATE IS RIGHT, ADVANCE:** Apply PMTO content and process strategies to develop a plan. Make sure the therapist leaves with at least one (and not more than two) ideas to try in future sessions (e.g., talk less, ask more leading questions, slow down, more role plays, role plays of a different kind, more structure to the agenda, etc.).

LESSONS LEARNED

Coaching can be an effective means of training, supporting, and measuring fidelity to a model because it reinforces skills and behaviors learned in training, provides support when additional skill development is needed, and gives the coachee opportunities to try out approaches.

6.4.3. PMTO Fidelity Rating (FIMP)¹¹

FIMP is an observational system designed to quantify the extent to which a practitioner displays competent adherence (Waltz, Addis, Koerner, & Jacobson, 1993) to the core components of the PMTO intervention. FIMP is based on two prior OSLC observational systems designed to evaluate fidelity and to understand the intervention process: the Therapist Performance Observational System (TPOS) (Reid et al., 1979) and the Therapy Process Code (TPC) (Chamberlain et al., 1986).

PMTO intervention programs are based on social interaction learning (SIL) theory and principles. The SIL model identifies five parenting practices as core mechanisms of child/adolescent adjustment: skill encouragement, limit setting (i.e., discipline), monitoring, problem solving, and positive involvement. The primary focus of PMTO interventions is to strengthen these core parenting practices and thereby improve child/adolescent adjustment. FIMP is designed to assess practitioners’ adherence to and competence with the PMTO method; ratings are based on observations of segments of intervention sessions that focus on core PMTO parenting practices. PMTO practitioners are rated on their adherence and competence in application of PMTO principles and procedures using five theoretically relevant categories: knowledge, structure, teaching, process skills, and overall development. Each dimension is rated on a 9-point scale.

The five FIMP categories were developed in an iterative process that linked definition of a practitioner’s adherence to the core PMTO components, as specified by the theory, with competent delivery. A primary goal was to behaviorally specify each dimension relevant to competent PMTO delivery. Based on findings from previous studies (e.g., Chamberlain et al., 1986; Chamberlain & Ray, 1988; Patterson, 1988; Patterson & Forgatch, 1985; Patterson & Chamberlain, 1988; Stoolmiller, Duncan, Bank, & Patterson, 1993),

¹¹ Knutson, N. M., Forgatch, M. S., Rains, L. A., & Sigmarsdóttir, M. (2009). *Fidelity of Implementation Rating System (FIMP): The manual for PMTO Implementation Sciences International, Inc.* Eugene, OR.

the developers retained categories from the TPOS and TPC that proved relevant, eliminated or combined categories with little empirical value, and expanded categories that required better definition.

A FIMP manual is designed to be used by certified PMTO practitioners. Raters must have a solid knowledge base in PMTO principles, techniques, and key components (core and supporting parenting practices). Raters must also be able to recognize competent adherence to and delivery of PMTO to families, as well as recognize and evaluate this in terms of the five FIMP categories. Raters require approximately 40 hours of training to become reliable coders. At the conclusion of training, 3–5 videos are scored, and an intra-class correlation (ICC) score of 70 percent or higher is required. Once reliable, raters have monthly meetings to maintain reliability and to prevent rater drift.

For KIPP, there were two types of FIMP ratings: quarterly and certification. ISII staff completed FIMP ratings for the KIPP therapists quarterly during the grant project. These ratings were shared with the KIT and SC members to gauge fidelity to the model. In situations where the ratings were in the “needs work” range, coaching or training provided additional support. The specific ratings were not shared with the therapists. Certification FIMP scores were used to determine if a therapist, coach, or trainer achieved certification or recertification based on the video(s) they submitted for certification. The individual scores were not shared with the therapist, coach, or trainer.

In September 2013, ISII trained the Kansas FIMP team in FIMP. Nine KIPP staff completed the 2-day training. A Kansas FIMP leader and co-leader were chosen to lead the team. Each KIPP staff person who completed the training took and passed a reliability test. An ICC of 70 percent was required to pass. Each month since completion of the training, the Kansas FIMP team has met by conference call or video conference for reliability calls. Prior to the call, each rater independently rates a specific video and submits the FIMP scores in

a portal. The monthly FIMP call consists of discussing the calibrated scores and points of disagreement. If a FIMP rater is unreliable based on his or her scores, then he or she will be assigned additional calibrated sessions until becoming reliable again.

In the first year after a FIMP team becomes reliable ISII participates in the monthly conference calls. In the second and third year, ISII participates quarterly. After the third year, there is an annual ISII FIMP certification test with the FIMP team leader.

The KIPP leadership and ISII leadership collaborated on developing the Kansas Matrix. This document is used to ensure that the Kansas PMTO is implemented with and continues to be monitored for fidelity to the model after the PII-grant period. The document may be revised as needed with the input and approval of the KIPP and ISII leadership. The Kansas Matrix and additional information about FIMP and fidelity raters can be found in **Appendix M**.

6.5. KIPP Quality Assurance Plan

Performance assessment activities provided regular and ongoing information on KIPP service integrity. These activities provided a feedback loop that yielded essential information about the quality of KIPP service implementation. The KIPP/KU Management Team, the SC, and PII-ET used these data to identify, describe, and analyze strengths and weaknesses in KIPP implementation. **Figure 20** details the KIPP QA plan.

To monitor fidelity to the PMTO model, KIPP worked with PMTO coaches and Kansas PMTO coaches who coached KIPP therapists twice per month during the initial training period. Coaches conducted quarterly fidelity ratings of the therapists up to the point of certification (about 18–24 months). Therapist had to score at least “Acceptable” on the fidelity rating to become certified to deliver PMTO. Once a therapist was certified, fidelity rating (i.e. performance assessment) occurred annually.

FIGURE 20: KIPP QUALITY ASSURANCE PLAN**Service Integrity (i.e., performance assessment)**

Major Activity	Methods	Frequency
Fidelity monitoring	1 PMTO FIMP process 2 KIPP service model fidelity process	Annual Quarterly
Process measures & benchmarks tracking	1 Service logs 2 Administrative logs	Semi-monthly Semi-monthly
Outcomes tracking	1 Practitioner assessments 2 Questionnaires (parent self-report) 3 Analysis of administrative data	Pre, post, & follow-up Pre, post, & follow-up Pre, post, & follow-up

Data Integrity

Major Activity	Methods	Frequency
Staff evaluation training	1 Initial training on instruments & data collection procedures 2 Booster training on instruments & data collection procedures	Initial Annual
Supervision & monitoring	1 Supervision at local level 2 Monitoring by KU 3 Feedback to and from KIPP teams	Weekly then monthly Weekly then monthly Ad hoc & monthly
Data review & analysis	Quality-checks of data in REDCap	Weekly then monthly

Stakeholder Experiences

Major Activity	Methods	Frequency
Staff feedback	1 KIPP Regional Teams regular reporting & feedback process 2 Training evaluations 3 Coaching & supervision evaluations 4 Survey and/or focus groups	Ad hoc & monthly At all trainings Semi-annual Annual
Consumer feedback	Survey and/or focus groups	Annual & Quarterly
External community providers	Survey and/or focus groups	Annual & Quarterly
Leadership	Survey and/or focus groups	Annual & Quarterly

A practice-to-policy (PTP) survey was administered three times to KIPP therapists and supervisors in REDCap. Each current KIPP therapist and supervisor were provided a secure link to access the survey. REDCap allowed the KU research staff to access critical data while protecting the anonymity of individual agency staff. The PTP survey comprised questions to capture information on two main topics, PMTO knowledge and skill gains from the KIPP training regimen and satisfaction with Implementation Drivers.

The data were analyzed and provided to the SC, purveyor, and KIPP supervisors. The survey results and recommendations were a mechanism to assess the coaching and training competency drivers. The KIPP SC and leadership shared the feedback and provided suggestions for improvement. The information was a valuable means to improve and continue to implement the intervention. The PTP survey document is included as **Appendix Q**.

APPENDIX

Appendix A: References

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Appendix B: KIPP Glossary of Terms

AOD: alcohol and other drugs

CAFAS: Child and Adolescent Functional Assessment Scale, a worker assessment of child functioning in eight domains: (1) school/work role performance, (2) home role performance, (3) community role performance, (4) behavior toward others, (5) moods/emotions, (6) self-harmful behavior, (7) substance use, and (8) thinking.

Children’s Bureau: Children’s Bureau, a division of the U.S. Department Health and Human Services, Administration of Children and Family Services. The Children’s Bureau is the agency with whom KU has the cooperative agreement for funding KIPP.

CFS: Children and Family Services, the division of the Kansas Department of Social and Rehabilitation Services that is responsible for child welfare.

CMHC: community mental health center

CPS: child protective services

CWL: Caregiver Wish List, a self-report questionnaire that asks parents about their child’s behavior and their parenting practices.

DCF: Kansas Department for Children and Families

DD: developmental disability

DL: data liaison

DSM: Diagnostic and Statistical Manual of Mental Disorders

FAS: functional assessment systems

Fidelity: Ensuring adherence to the program model

FIMP: Fidelity of Implementation Rating System, an observation-based measure that assesses competent adherence to the PMTO model. Coders watch digitally recorded sessions and score the therapist on each dimension of PMTO fidelity (knowledge, structure, teaching skill, clinical skill, and overall effectiveness).

FIMPPer: A fidelity rater that uses the Fidelity of Implementation Rating System.

FIT: Family Interaction Task, an observation-based assessment of parenting behavior. Parents are video recorded participating in several games and activities with their children. An expert rater observes the video and rates six domains of parenting: (1) providing direction and follow-up, (2) encouraging good behavior, (3) discouraging undesirable behavior, (4) monitoring, (5) connecting positively with youth, and (6) problem solving.

FTE: full-time employment

HIPAA: Health Insurance Portability and Accountability Act

Implementation Science: The science related to implementing “evidence-based practices and programs.”

ICC: intra-class correlation

ISII: Implementation Sciences International, Inc.

JBS International, Inc.: PII Training and Technical Assistance Project (PII-TTAP) lead

James Bell Associates: PII Evaluation Team (PII-ET) member

Kansas BSRB: Kansas Behavioral Sciences Regulatory Board

KGA: Kansas Governing Authority

KIPP: Kansas Intensive Permanency Project

KIT: KIPP Implementation Team

KVC: KVC Behavioral Health Care, Inc. in Kansas

MFP: mindfulness practice

NCFAS: North Carolina Family Assessment Scale, an assessment instrument used to measure multiple domains of family functioning.

NIRN: National Implementation Research Network, a training and technical assistance provider of the Permanency Innovations Initiative

OPRE: Office of Planning, Research and Evaluation, a division of the U.S. Department Health and Human Services, Administration of Children and Family Services.

OSLC: Oregon Social Learning Center

PECFAS: Preschool and Early Childhood Functional Assessment Scale, a worker assessment of child functioning in seven domains: (1) school/preschool/daycare, (2) home role performance, (3) community role performance, (4) behavior toward others, (5) moods/emotions, (6) self-harmful behavior, (7) thinking.

PII: Permanency Innovations Initiative, the name of the federal grant under which KIPP was funded

PMTO: Parent Management Training -Oregon Model

Psychometrics: the science of measuring mental capacities and processes

PTP: practice to policy

Purveyor: Outside experts that work with KIPP to achieve fidelity to its evidence-based program. ISII is KIPP's purveyor.

REDCap: Research Electronic Data Capture, is a secure web application developed by Vanderbilt University and hosted by KU. REDCap allows users to build and manage online surveys and databases quickly and securely. It is HIPPA compliant.

SC: Steering Committee

SED: serious emotional disturbance

SFCS: St. Francis Community Services

SIL: social interaction learning

SRS: Kansas Department of Social and Rehabilitation Services, the public child welfare agency of Kansas

TFI Family Services: The Farm, Inc. Family Services

TPC: therapy process code

TPOS: Therapist Performance Observational System

T/TA: Training and Technical Assistance

Appendix C: Terms of Reference: KIPP/KU Management Team

1. Background

The Kansas Intensive Permanency Project (KIPP) is one of five Permanency Innovations Initiatives (PII) funded by the Children’s Bureau. Prior to submission of the proposal that ultimately funded KIPP, key members of the University of Kansas (KU) Management Team assembled representatives from Kansas’ four private foster care agencies: KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville. Based on discussions among these partners, the KIPP initiative emerged. In consultation with agency partners, KU Management Team wrote and submitted the proposal.

2. Vision and Mission

The vision of KIPP is to facilitate permanence in the lives of children with serious emotional disturbance by creating permanence in the systems of care that serve their families. KIPP’s two main goals are to (1) develop and implement innovative intervention strategies that result in permanence for a subpopulation of children who experience long stays in foster care and (2) rigorously evaluate these efforts to provide information about the effectiveness of the interventions to reduce long-term foster care with the target population.

3. Purpose

The KU Management Team provides leadership and oversight in all matters related to KIPP, including compliance with Children’s Bureau requirements, coordination of the KIPP Steering Committee (SC), KIPP Implementation Team (KIT), KIPP Supervisors Team, and Regional Implementation Teams (RITs). This team, in conjunction with the SC and KIT, serves as the primary organization for the development, guidance, implementation, and oversight of the PII initiative in Kansas, including installation, implementation, fidelity, evaluation, communication, dissemination, and fiscal accountability.

4. Scope and Objectives

The scope and objectives of the KU Management Team include, but are not limited to, the following:

- Manage and oversee KIPP
 - Provide leadership, oversight, fiscal accountability, and budgetary management
 - Interface and contract with the purveyor
 - Interface with federal partners, including PII-TAP, PII-ET, Children’s Bureau, and OPRE
 - Coordinate and align project activities
- Provide an accountability structure for federal grant compliance
 - Hold subcontractors accountable for deliverables
 - Manage all teams’ timely achievement of benchmarks
- Manage data collection and evaluation activities
 - Assure continuous quality assurance
 - Assure fidelity to intervention
 - Assure integrity of evaluation plan

- Use data to drive decision-making and continuous improvement
 - Data will be collected by local implementers and uploaded to a central data management system, REDCap
 - KIPP/KU Management Team will provide the SC and KIT aggregate data at regular intervals
 - SC will provide data to RITs at regular intervals
- Liaise with and support SC functions
- Facilitate intergroup and interagency communication and information transfer
- Communicate and disseminate project information
 - Participate in statewide and local planning meetings
 - State and local level external communications is a shared responsibility of KU and the SC
 - Research and national level information is primarily the responsibility of KU but can also be shared with the SC, if appropriate
- Problem solve in support of KIPP teams
 - Facilitate communication and problem solving for all KIPP teams

5. Boundaries and Limitations

KU Management Team provides leadership and oversight to all KIPP teams. The KU Management Team, in conjunction with the SC, leads the implementation of the KIPP intervention and is responsible for building capacity and sustainability structures and functions.

5a. Authority and Accountability

The KU Management Team has ultimate responsibility and accountability to the Children’s Bureau and PII. The team will provide leadership, oversight, and facilitate consensus within the SC, KIT, and the KIPP Supervisors Team. The KU Management Team will also act as liaison between the KIPP SC and the Children’s Bureau, T/TA (JBS International), and Evaluation (Westat).

The KU Management Team will be accountable to itself as well as to the SC, KIT, KIPP Supervisors Team, RITs, Children’s Bureau, and other system partners who contribute to the project. Formal feedback will be provided in a timely manner to all entities to which the KU Management Team is accountable.

5b. Reporting

The KU Management Team will provide regular updates and reports of their work to the KIPP SC. Information will also be shared with PII-TTAP and PII-ET via bi-monthly phone calls. In addition, formal decisions requiring a vote are documented in the SC minutes and reported to the SC and the Children’s Bureau, upon request.

6. Membership

All team members will:

- Attend meetings either in person or by phone and not designate others to attend in their place or on their behalf

- Provide connection and continuity between federal partners (PI-TTAP, PII-ET, Children’s Bureau, and OPRE) and the SC
- PII-TAP and provides regular feedback from PII-TAP to the KU Management Team

7. Meetings

The KU Management Team will meet face-to-face weekly and can increase or decrease frequency of meetings as necessary and warranted. Teleconference or web-based meetings may take place between face-to-face meetings as needed. The KU Management Team will have bi-monthly teleconference calls PII-TTAP and PII-ET to keep communication open and to troubleshoot implementation or evaluation issues as they arise.

8. Meeting Format and Minutes

Items for the agenda will be solicited before and at the beginning of the meeting. The meeting agenda will be distributed at the meeting. No formal minutes will be taken; but meeting notes and action items are summarized and provided to the KU Management members and others upon request.

9. Decision-Making Process

The KU Management Team will use consensus decision making. In the absence of consensus or in time-sensitive matters, the team will use a two-thirds majority vote.

10. Values and Ways of work

- The KU Management Team is a collaborative entity.
- Transparency is valued and expected.
- The KU Management team is committed to a “ground up” approach. The SC, KIT, KIPP Supervisors Team, RITs, and other key stakeholders inform the work and decisions of the KU Management Team.
- It is expected that all members of the Management Team will arrive prepared to discuss the topics at hand.

Appendix D: Terms of Reference: KIPP Steering Committee (SC)

1. Background

The Kansas Intensive Permanency Project (KIPP) is one of five Permanency Innovations Initiatives (PII) funded by the Children’s Bureau. Prior to submission of the proposal which ultimately funded KIPP, the University of Kansas (KU) Management team assembled representatives from Kansas’ four private foster care agencies: KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville. Based on discussions among these partners, the KIPP initiative emerged. In consultation with agency partners, KU Management wrote and submitted the proposal. Once KU Management received notice that KIPP had been funded initially, KU Management sought representation from each agency and from the Kansas Department for Children and Families (DCF) for its Steering Committee (SC). The current SC is composed of the KU Management Team, one to two leaders from each partner agency, and a representative from the state (Kansas DCF).

2. Vision and Mission

The vision of KIPP is to facilitate permanence in the lives of children with serious emotional disturbance by creating permanence in the systems of care that serve their families. KIPP’s two main goals are to (1) develop and implement innovative intervention strategies that result in permanence for a subpopulation of children who experience long stays in foster care and (2) rigorously evaluate these efforts to provide information about the effectiveness of the interventions to reduce long-term foster care for the target population.

3. Purpose

The purpose of the SC, in conjunction with the KU Management Team, is to develop and implement the PII initiative in Kansas. While the KU Management Team, as the grant recipient, must accept ultimate responsibility for the entire KIPP initiative, the SC drives the entire initiative with regard to intervention decisions and implementation. The SC will use implementation science to develop, implement, and evaluate KIPP.

4. Scope and Objectives

The scope and objectives of the KIPP SC include, but are not limited by, the following:

- Manage and oversee KIPP Regional Implementation Teams (RITs)
 - Chair RITs (foster care agencies only)
 - Develop and implement infrastructure for service delivery
 - Develop infrastructure to implement PMTO with fidelity
 - Define necessary common elements of extra-PMTO service model (e.g., delivery of concrete services)
 - Develop infrastructure to implement extra-PMTO KIPP activities with consistency across sites (KIPP Orientation)
 - Provide leadership and decision-making for KIPP field implementation
 - General oversight and problem solving related to consistency of operating procedures
- Provide accountability structure to RITs

- Address the challenges of KIPP implementation/evaluation
- Create policies, operating procedures, guidance documents, and funding that will support the new ways of work brought about by KIPP
- Use data to drive decision-making and continuous improvement
 - Data will be collected by local implementers and uploaded to a central data management system, REDCap
 - KU Management will provide the SC aggregate data at regular intervals
 - SC will provide data to RITs at regular intervals
- Communicate and disseminate project information
 - Participate in statewide and local planning meetings
 - State and local level information is a shared responsibility of KU and the SC
 - Research and national level information is primarily the responsibility of KU, but can also be shared with the SC, if appropriate
- Engage key stakeholders
 - Meet regularly with stakeholder groups
 - Anticipate challenges and work through barriers to KIPP's successful implementation
 - Share outcomes data

5. Boundaries and Limitations

The SC provides leadership and oversight to the RITs and to the KIPP Implementation Team (KIT). See Sections 6 and 9 for other information related to boundaries and limitations.

6. Authority and Accountability

The SC shares decision-making authority for intervention and implementation decisions with the KU Management Team. The SC will be accountable to itself, as well as to the KU Management Team, RITs, KIT, and other system partners who contribute to the project. Formal feedback will be provided in a timely manner to all entities to which the SC is accountable.

7. Reporting

- There will be target dates set by which time recommendation and reporting must be made in order for this project to move forward.
- Members of the SC will chair the RITs and will serve as liaisons among the SC, KU Management Team, and RITs. They will facilitate bi-directional communication between all entities.
- The SC is accountable to itself, and it is expected that through linked communication protocols, bi-directional communication and information sharing will flow among groups.

8. Membership

The SC shall consist of no more than 18 people and shall include representatives from DCF, at least one member from each of Kansas' foster care agencies, and the three members of the KU Management Team. Consultant partners from PII-TTAP, PII-ET, ISII, and other T/TA or purveyor organizations are welcome to attend meetings unless meetings are work group sessions open only to SC Committee members. Written notice will be provided to consultant partners prior to work group meetings.

9. Role of Members

Members of the SC are experts in state policy, child welfare research, foster care service delivery, and program evaluation. Individually, the role of members is to:

- Provide connection and continuity between RITs and KU Management Team
- Guide implementation decisions in RITs
- Accurately represent and effectively convey the decisions and recommendations of the SC and RITs
- Problem solve to overcome implementation challenges
- Complete assigned tasks between meetings

Members of the SC are expected to attend meetings either in person or by phone and not designate others to attend in their place or on their behalf

10. Working Teams

The SC may form working teams to complete its work. A working team should have at least one member from each region in order to have full representation and facilitate full exploration of the subject of the meeting. Working Teams will report information to the SC.

11. Meetings

The SC will meet face to face once a month and can increase or decrease frequency of meetings as necessary and warranted. Teleconferencing will be made available for those members who cannot attend in person. Teleconference or web-based meetings may take place between face-to-face meetings as needed. KU Management team facilitates and coordinates these meetings.

12. Minutes

Meetings will be conducted according to a written agenda, and minutes will be taken. A meeting summary will be sent to the members prior to next meeting. An action item chart will be sent to SC members within 1-3 days following the meeting.

13. Decision-Making Process

KU management Team and the SC will make decisions collaboratively by consensus of the members. In the event that consensus cannot be reached, the SC will make recommendations to the KU Management Team and each agency has one vote. PII-TTAP and PII-ET sit on this committee as consultants and are non-voting members. KU has final decision-making authority for all fiscal decisions related to KIPP.

14. Values and Ways of Work

- The SC is a collaborative entity.
- Transparency is valued and expected.
- The SC is committed to a “ground-up” approach. The RITs, KIT, and other key stakeholders inform the work and decisions of the SC.
- It is expected that all members of the SC will arrive prepared to discuss the topics at hand.

Appendix E: Terms of Reference: KIPP Regional Implementation Teams (RITs)

1. Background

The Kansas Intensive Permanency Project (KIPP) is one of five Permanency Innovations Initiatives (PII) funded by the Children’s Bureau. Prior to submission of the proposal that ultimately funded KIPP, key members of the University of Kansas (KU) Management Team assembled representatives from Kansas’ four private foster care agencies: KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville. Based on discussions among these partners, the KIPP initiative emerged. In consultation with agency partners, KU Management Team wrote and submitted the proposal.

2. Vision and Mission

The vision of KIPP is to facilitate permanence in the lives of children with serious emotional disturbance by creating permanence in the systems of care that serve their families. KIPP’s two main goals are to (1) develop and implement innovative intervention strategies that result in permanence for a subpopulation of children who experience long stays in foster care and (2) rigorously evaluate these efforts to provide information about the effectiveness of the interventions to reduce long-term foster care with the target population.

3. Purpose

The Regional Implementation Teams (RITs) will provide KIPP with an accountable structure for ensuring the statewide implementation of KIPP and making recommendations for early and midcourse corrections that will increase the likelihood of consistent, high-fidelity implementation of the project in every region.

4. Scope and Objectives

The scope and objectives of the KIPP Implementation Team (KIT) include, but are not limited to, the following:

- Develop site specific policies and procedures to ensure consistent KIPP implementation within each agency
- Create operating procedures and internal guidance documents that will support the new ways of work brought about by KIPP
- Lead regional KIPP service delivery
 - Install, sustain, improve staffing, training, and coaching
- Anticipate challenges and work through implementation barriers
 - Install and sustain Improvement Cycles – planning, studying the impact of the plan, planning again
- Implement KIPP with fidelity
 - Use data and guidance from the KIPP Steering Committee (SC) to make early or midcourse corrections
 - Data will be collected by local implementers and uploaded to a central data management system, REDCap

- KU Management will provide the SC aggregate data at regular intervals
- Disseminate information about the innovation and its support from leaders to support and sustain the change
- Engage key stakeholders
 - Attend regional stakeholder meetings and committees
- Provide input, data, and communicate problems and successes to SC
- Maintain integrity of evaluation

5. Boundaries and Limitations

RITs oversee on-the-ground implementation of KIPP. RITs, in conjunction with the SC, lead the implementation of the KIPP intervention and are responsible for achieving implementation timelines and benchmarks. Through their representative on the SC, RITs have voting and decision-making authority in matters of implementation.

6. Authority and Accountability

RITs will be accountable to themselves as well as to the SC, KU Management teams, the Children’s Bureau, OPRE, and other system partners who contribute to the project. Formal feedback will be provided in a timely manner to all entities to which the KU Management Team is accountable.

7. Reporting/Linking Communications

Local teams will provide written and verbal report through their representative from the KIPP SC.

8. Membership

The RITs shall include representatives from each of the foster care regions in Kansas. Membership should be broad based so as to represent a cross-section of interests related to the purpose of the Implementation Teams, and represent the gender, racial, ethnic, county populations six, and geographic diversity of Kansas. Foremost, RITs should contain members with sufficient authority and decision-making power to enact needed policy and procedure changes and to be flexible with regard to ongoing service delivery needs.

9. Roles of Members

Members agree to:

- Provide alignment, continuity, and coordination of KIPP
 - The team will use implementation science framework to assess drivers (core implementation components), integration and systems alignment, and create sustainable practice-policy-practice loops
- Provide input to the SC on critical implementation decisions
 - As a part of a continuous program improvement cycle, the RITs will work collaboratively with the SC to address implementation challenges and to make key implementation recommendations. While final decision rests with the SC, the RITs play a critical role in filtering information to the SC, making preliminary recommendations, and providing feedback on decisions
- Assist in the development of a communication plan to message KIPP

- The RITs will develop recommendations on how to effectively communicate and market KIPP internally to staff and externally to system partners and stakeholders. Implementation Team members also play a key role in ongoing communication activities and serve as “champions” of the project. They will facilitate bi-directional communication and play a critical role in bringing information back to the SC and stakeholders.
- Give input on strategies that support high fidelity implementation of KIPP
 - Team members, in collaboration with the SC and purveyor, will assist in recommending strategies for strengthening each implementation driver (e.g., selection, training, coaching, assessment, data supports, facilitative administration and systems intervention).
 - Team members will serve as “trouble shooters” along with the SC and KU Management Team on the problems that occur in the development and execution of implementation plans.
 - Team members, along with purveyor, will also provide oversight to assure fidelity of KIPP.

10. Meetings

The frequency and conduct of RIT meetings will be determined by each RIT.

11. Decision-Making Process

RITs will use consensus decision making. In the absence of consensus or in time sensitive matters, the team will use a two-thirds majority vote.

12. Values and Ways of Work

The RITs are committed a “ground up” approach.

- RITs are collaborative entities.
- Transparency is valued and expected.
- It is expected that all members of the RIT will arrive prepared to discuss the topics at hand.

Appendix F: Terms of Reference: KIPP Implementation Team (KIT)

1. Background

KIPP is one of five Permanency Innovations Initiatives (PII) funded by the Children’s Bureau. Prior to submission of the proposal that ultimately funded KIPP, key members of the University of Kansas (KU) Management Team assembled representatives from Kansas’ four private foster care agencies: KVC Behavioral Healthcare (KVC), St. Francis Community Services (SFCS), TFI Family Services, and Youthville. Based on discussions among these partners, the KIPP initiative emerged. In consultation with agency partners, KU Management wrote and submitted the proposal.

2. KIPP Vision and Mission

The vision of KIPP is to facilitate permanence in the lives of children with serious emotional disturbance by creating sustainable changes in families and larger systems.

The mission of KIPP is to (1) develop and implement an intensive, parent-focused intervention that results in permanence for children with serious emotional disturbance and (2) rigorously evaluate this intervention and provide information about its effectiveness in reducing long-term foster care.

3. Purpose

The purpose of the KIT is to support the implementation of the PII initiative in Kansas.

4. Scope and Objectives

The scope and objectives of the KIT include, but are not limited to, the following:

- Develop and troubleshoot KIPP intervention
 - Resolve immediate implementation issues
 - Change, modify, recommend new KIPP procedures
 - Contribute to development of KIPP Policy and Procedure Manual
 - Complete specific assigned projects (e.g., tailoring the KIPP intervention, developing engagement protocols)
- Make agency-specific procedural changes to ensure that processes and protocols are in place to support KIPP’s implementation (intra-agency)
- Document services as delivered across agencies (inter-agency) (e.g., define the role of non-KIPP supervisors)
- Communicate with KU Management and the full KIPP Steering Committee (SC) about barriers, successes, and lessons learned so information can be shared statewide (e.g., regional issue or statewide issue)
- Assure training and support of KIPP staff for timely and accurate data collection
 - Communicate process, flow, and data needs to KIPP staff (e.g., supervisors, data liaisons, therapists)
- Assume responsibility for ongoing personnel issues (e.g., hiring, training)
- Maintain and share with the full SC an accurate account of how the intervention is actually implemented in the field
- When empowered by the full SC, act in its stead
- Ensure cross site sharing

5. Boundaries and Limitations

By decision of the SC, KIT members are empowered to make decisions, without the prior permission of the entire SC, on *procedural* items, such as PMTO procedures, evaluation procedures, agency procedures, and other KIPP-related procedures.

KIT members are not empowered to make policy decisions without the prior approval of the SC. Policy decisions include items related to budget and resources for the entire KIPP, changing functions of agency staff (e.g., decisions that increase non-KIPP staff burden at the agency level), and decisions that fundamentally change current ways of work in KIPP or the agency.

6. Authority and Accountability

The KIT is a subcommittee of the full SC. The KIT is accountable to itself and to the full SC.

7. Reporting/Linking Communications

Chain of Communication

Each KIPP therapist reports to the KIPP supervisor. KIPP supervisors report to their KIT representative. If the KIPP supervisor cannot answer a question, he or she requests assistance from the KIT representative. KIT members address procedural issues within their agency. If a procedural issue is an inter- rather than intra-agency issue, the KIT representative brought it to the entire KIT for deliberation. If the issue is beyond the KIT's purview, the KIT brings the issue to the full SC for deliberation.

8. Membership

The KIT consists of the two agencies' clinical or reintegration director/managers and a representative or representatives of KU Management, which may include the KIPP project manager and KIPP PIs and a representative of the Kansas Department for Children and Families (DCF). Note: Prior to July 2013, there were four agencies with foster care contracts with DCF who were represented on the KIT. As of July 1, 2013, there were two agencies (KVC and SFCS) who were awarded the foster care contracts with DCF; therefore, two agencies will be represented on the KIT.

9. Role of Members

Members of the KIT are experts in child welfare, foster care service delivery, and program implementation and administration. Individually, the role of members is to:

- Provide connection and continuity between KIPP supervisors and the full SC
- Problem-solve to overcome implementation challenges
- Complete assigned tasks between meetings
- Communicate with agency presidents, chief operating officers, and other high-level administrative staff
- Make agency-level procedural changes
- Together, "collect" common procedural issues to take to SC or problem solve among themselves

- Ensure linking communication between the full SC (including KU Management) and the intervention purveyor (ISII)

10. Meetings

The KIT will meet in person once a month and can increase or decrease frequency of meetings as necessary and warranted. The KU Management Team facilitates and coordinates these meetings. Members of the KIT are expected to attend meetings either in person or by phone and may not designate others to attend in their place or on their behalf. As needed, calls may include representatives from ISII, if training/coaching/fidelity issues need immediate resolution. If an issue for ISII comes up in a meeting that they are not attending, KU will communicate the information.

11. Decision-Making Process

The KIT will make decisions collaboratively, by consensus of the members present at the meeting in which the decision is made. In the event that consensus cannot be reached, the full SC will make recommendations to the KIT.

12. Values and Ways of Work

- The KIT is a collaborative entity.
- Transparency is valued and expected.
- The KIT is committed to a “ground-up” approach.
- It is expected that all members of the KIT will arrive prepared to discuss the topics at hand.
- The KIT relies on data, including clinical and administrative data, in its decision-making processes.

Appendix G: KIPP Supervisor Selection Guide

KIPP Supervisors Interview Process

1. Post job.
2. Screen resumes and cover letters with Interview Selection Tool.
3. Choose candidates for interviews.
4. Provide the applicant with the KIPP Brief Description and four written questions for the applicant to answer and bring to the interview.
5. Conduct In-person Interview using the following interview format:
 - i. Introductions
 - ii. 11 standard interview questions
 - iii. Role play
 - iv. Questions for interview committee
6. Score applicants based on:
 - a. Application materials
 - b. Written interview questions
 - c. In-person Interview
 - d. Role play
7. Choose finalists and call references.
8. Make final selection.
9. Offer position.

KIPP Supervisor Interview Selection Tool

Requirements	How assessed – Fill in or circle	Score 1-5	Notes
Three years' experience in child and family services	Résumé		
Master's degree in Social Work, Counseling, Marriage and Family Therapy or related field	Résumé		
Licensed by Kansas BSRB	Résumé, BSRB check		
Ability to travel	Cover letter		
Ability to work flexible schedule, including evenings and weekends	Cover letter		
Available and eager to participate in demanding learning environment	Cover letter		
Commitment to strengths-based approach	Cover letter		
Preferences			
LCSW or equivalent	Résumé		
Supervision experience in child and family services	Résumé		

Requirements	How assessed – Fill in or circle	Score 1-5	Notes
Knowledge of SED youth and foster care populations	Résumé, cover letter		
Comfortable and knowledgeable about behavioral approaches	Résumé, cover letter		
Notes re: Selection for Interview			

KIPP Brief Description

The Kansas Intensive Permanency Project (KIPP) is a 5-year demonstration project funded by a cooperative agreement between Children’s Bureau, Administration of Children and Families, and the University of Kansas (KU) School of Social Welfare in partnership with Kansas Department of Social and Rehabilitation Services and Kansas’ four private foster care providers—KVC Behavioral Health Systems, St. Francis Community Services, TFI Family Services, Inc., and Youthville. Upon approval of the final implementation plan, KIPP will have received \$13 million over 5 years, with the possibility of additional funding if project benchmarks are achieved.

The goal of KIPP is to expedite permanency for children with serious emotional disturbance (SED), a subpopulation of children that is currently at highest risk of long-term foster care (LTFC). Importantly, while KIPP’s target population consists of children and youth with an SED, the proposed focal point of intervention is the parents of these children. The rationale for this approach finds support in both national and local data. Fundamentally, KIPP will strengthen families as the long-term solution to caring for their children.

KIPP will serve the families of children with SED by delivering an intensive, in-home, evidence-based behavioral parent management training program, Parent Management Training-Oregon Model (PMTO). PMTO is a preventive intervention aimed at enhancing effective parenting and reducing coercive practices, especially in families with risk factors such as parent mental health problems, poverty, and trauma. According to the California Evidence-Based Clearinghouse for Child Welfare, PMTO has attained the highest level of evidence for its ability to improve parenting capacities and reduce problematic child behavior. It is hypothesized that reductions in problematic child behavior and improvements in parenting will lead to greater reunification readiness and to timely, stable reunification for families of children with an SED.

PMTO is a progenitor model that has been implemented internationally. At the end of the 5-year demonstration project, Kansas foster care providers will have the ability to continue implementing PMTO and to train new workers in the intervention. In brief, KIPP will (1) increase the state’s workforce by approximately 40 FTE, (2) provide a dedicated workforce for intensive reunification, (3) implement an evidence-based practice, (4) address the critical barriers to permanency faced by parents of children

with SED, (5) connect families to longer-term community services and supports, and (6) increase permanency for youth at highest risk for LTFC.

Four Questions for Written Response

Please provide a written response to the following questions and bring to the interview. Please do not exceed two pages.

1. Describe a time when you were surprised by the strengths demonstrated by a family or staff member. Why were you surprised? What did you learn about them and about yourself?
2. What staff behaviors are/would be the most difficult for you to handle? What have you learned about dealing with these behaviors?
3. Describe some of the challenges and benefits you've experienced partnering with community stakeholders, such as child protective services, the legal system, and community service providers. How might you overcome these challenges? And strengthen the benefits?
4. After reading about KIPP, comment on your commitment to the research being done and your ability to make a 4-year commitment to the project.

Standard Interview Questions

1. What supervisory skills, both clinical and managerial, would you bring to this position? Please provide examples of supervising with child welfare, if applicable.
2. Describe your experiences working with children with SED? What did you find rewarding about this work?
3. If we were to talk to the last five people you've supervised, what do you think they would say about your leadership style?
4. Given your leadership style, what areas or skills might need further development?
5. Describe a time when the course of action you took or the decision you made turned out not to be the right thing to do. What led you to take this action or make this decision? How did you know it was the wrong course of action? How have you reconciled the experience? What did you learn about yourself?
6. What are your expectations for your own supervision? How do you like to receive feedback regarding your work?
7. Describe your vision/perspective of teamwork – and ways that you promote it.

8. A worker is consistently not meeting work goals or expectations. When would you intervene, how would you know that an intervention is needed, and what steps would you take to address the issue?
9. How does this position fit with your long-term career goals? Where do you see yourself, personally and professionally, in 5 years?
10. Are there any factors that might cause you to be unable to fulfill the expectations of the job (e.g., some after-hours work, travel, staying in the job for 4 years, etc.)?
11. May we talk with your current and past employers? What might they tell us about you?

Role Play Instructions

Instructions to the applicant (read text in *italics* to applicant)

Now we are going to ask you to participate in a role-play. You will be presented with a “real-life” situation that you could encounter as the KIPP Supervisor. The person helping you with the role-play will play the part of a KIPP Therapist and you will play the part of the KIPP Supervisor.

You both have a section of the scenario to read that will describe the situation. Once you have read your description of the scenario you may ask us, the interviewers, any questions. Then you may begin the role-play when you are ready.

Supervisor: This is your weekly meeting with this Supervisee. She/he has been working on the project for 6 months. She/he is active in PMTO Training, working with families, and is known in your agency as the “go to” person for information about KIPP. The goal of this meeting is to talk with the Supervisee about emails you’ve been receiving from PMTO asking why she/he is not getting her/his sessions uploaded in the database. At this point, she/he should have upload video for three families with 10-15 sessions each; instead she/he has uploaded two families, with 6 sessions for the first family and 4 sessions for the second family.

Instructions to the person playing Supervisee:

This is your weekly meeting with your Supervisor. You have been working on the project for 6 months. You are active in PMTO Training, working with families, and are known in your agency as the “go to” person for information about KIPP. At this point, you should have upload video to PMTO for 3 families with 10-15 sessions each; instead you have uploaded 2 families, with 6 sessions for the first family and 4 sessions for the second family. You are struggling to get your sessions uploaded because you are starting to feel overwhelmed as you case load has grown as well as the needs of the families with whom you are working and you are finding it more difficult to balance the in-home work and the video uploading.

Instructions and Information for Interviewer

Take notes during the role play. Pay careful attention to the coachability of the applicant. After the role-play is complete, offer a lot of positive feedback on one or more of the following concept areas: **engagement, probing questions to find the real issues, listening skills, support of the supervisee, problem solving skills, concern for the best interest of the Therapist, and finding a solution to address concern.**

Now choose one concept area and offer constructive feedback. If there is no real critical feedback to give, note that and move on. Describe the appropriate alternative behavior and clearly ask the applicant to practice doing/saying the appropriate alternative behavior with you “to make sure you’ve got it.” Then restart the role-play at the point where the applicant can implement the “new skill” in the interaction with the Interviewer (person taking part in the role-play with the applicant).

Pay close attention to the applicant’s abilities in each of the concept areas during the interaction with the interviewer participating in the role-play and with the other Interviewers. Also, carefully note the applicant’s ability to accept praise, accept critical feedback, listen and learn the new skill you teach, and implement that new skill in the restart of the role-play situation. At the end of the restarted role-play, offer one positive comment about how the applicant performed and move on.

Role Play – Impressions Form

To be filled out by the person playing the Supervisee.

Candidate: _____

Rate the following statements using the scale:

- 1= Strongly disagree
- 2= Disagree
- 3= Neither agree or disagree
- 4= Agree
- 5= Strongly agree

I felt comfortable.	
The candidate seemed real and/or genuine.	
I felt gently guided during the feedback sessions.	
I felt understood.	
This person built rapport.	
I felt appropriately engaged.	
I liked the candidate.	

Did this supervisor provide you with one or more strategies for dealing with the issue effectively?

How likely are you to follow through?

Reference Check Protocol

Candidate: _____

Reference: _____

Relationship to Candidate: _____

1. Could you start by telling me what kind of work he or she did for you, and what is your opinion of the quality of that work?
2. What would you see as his or her strengths and weaknesses?
3. How would you characterize this person's approach to management? (Probes: does he or she have more of an independent management style, a collaborative management style, etc.). Please could you give me an example of an occasion when you observed his or her management abilities and thought them effective? In what way were they effective? Can you think of an occasion when you thought his or her management approach did not work so well? Why not?
4. How does he or she handle stressful situations?
5. Did you ever have to talk with him or her about performance problems? Was he or she able to accept feedback?

Rate the following statements using the scale:

- 1= Strongly disagree
- 2= Disagree
- 3= Neither agree or disagree
- 4= agree
- 5= Strongly agree

The candidate	Rating	Notes
Demonstrates excellent leadership qualities/abilities		
Shows commitment to strengths-based approaches		
Uses good judgment		Example?
Shows empathy, flexibility, creativity, and commitment to working with troubled families in challenging circumstances		
Demonstrates understanding and adherence to the ethics		
Demonstrates a sense of social justice		
Practices from a non-judgmental lens		
Additional Information:		

FINAL SCORING	
Measurement	Score 1-Lowest 5-Highest
Application Materials	
Ability to travel	
Ability to work flexible schedule including evenings and weekends	
Available and eager to participate in demanding learning environment	
Commitment to strength-based approach	
LSCSW or equivalent	
Supervision experience in child and family services	
Knowledge of SED youth and foster care populations	
Comfortable and knowledgeable about behavioral approaches	
Written Questions	
After reading about KIPP, comment on your commitment to the research project and to your ability to make a 4-year commitment to the project.	
Describe a time when you were surprised by the strengths demonstrated by a family or staff member. Why were you surprised? What did you learn about them and about yourself?	
What staff behaviors are/would be the most difficult for you to handle? What have you learned about dealing with these behaviors?	
Describe some of the challenges you've experienced partnering with community stakeholders, such as child protective services, the legal system, and community service providers. How might you overcome these challenges?	
Interview Questions	
How does this position fit with your long-term career goals? Where do you see yourself, personally and professionally, in 5 years?	
What supervisory skills, both clinical and managerial, would you bring to this position?	
Give examples of supervising in child welfare and experience working with children with SED.	
If we were to talk to the last five people you've supervised, what do you think they would say about your leadership style?	
Given your leadership style, what areas or skills might need further development?	

Appendix

Describe a time when the course of action you took or the decision you made turned out not to be the right thing to do. What led you to take this action or make this decision? How did you know it was the wrong course of action? How have you reconciled the experience? What did you learn about yourself?	
What are your expectations for your own supervision? How do you like to receive feedback regarding your work?	
Describe your vision/perspective of teamwork– and ways that you promote it.	
A worker is consistently not meeting work goals or expectations. When would you intervene, how would you know that an intervention is needed, and what steps would you take to address the issue?	
Are there any factors that might cause you to be unable to fulfill the expectations of the job (e.g., involve some afterhours work, travel, etc.)	
May we talk with your current and past employers? What might they tell us about you?	
Role Play Overall Score	
Reference Check Overall Score	
Notes	

Appendix H: KIPP Therapist Selection Guide

KIPP Therapist Interview Process

1. Post job.
2. Screen resumes and cover letters with Interview Selection Tool.
3. Choose candidates for interviews.
4. Provide the applicant with the KIPP Brief Description, written questions, and self-report questionnaire to complete and bring to the interview.
5. Conduct In-person interview using the following interview format:
 - i. Introductions
 - ii. 10 standard interview questions
 - iii. Role play
 - iv. Questions for interview committee
6. Score applicants based on:
 - a. Application materials
 - b. Written interview or self-report questions
 - c. In-person Interview
 - d. Role play
7. Choose finalists and call references.
8. Make final selection.
9. Offer position.

KIPP Therapist Interview Selection Tool

Requirements	How assessed – Fill in	Y/N	Notes
Master’s degree in Social Work, Counseling, Marriage and Family Therapy, or related field			
Licensed by Kansas BSRB			
Ability to travel			
Ability to work flexible schedule, including evenings and weekends			
Available and eager to participate in demanding learning environment			
Commitment to strengths-based approach			
Preferences			
Three years’ experience in child and family services			
Knowledge of SED youth and foster care populations			
Comfortable and knowledgeable about behavioral approaches			
Notes re: Selection for Interview			

KIPP Brief Description

The Kansas Intensive Permanency Project (KIPP) is a 5-year demonstration project funded by a cooperative agreement between Children’s Bureau, Administration of Children and Families, and the KU School of Social Welfare in partnership with Kansas Department of Social and Rehabilitation Services and Kansas’ four private foster care providers—KVC Behavioral Health Systems, St. Francis Community Services, TFI Family Services, Inc., and Youthville. Upon approval of the final implementation plan, KIPP will have received \$13 million over 5years, with the possibility of additional funding if project benchmarks are achieved.

The goal of KIPP is to expedite permanency for children with serious emotional disturbance (SED), a subpopulation of children that is currently at highest risk of long-term foster care (LTFC). Importantly, while KIPP’s target population consists of children and youth with an SED, the proposed focal point of intervention is the parents of these children. The rationale for this approach finds support in both

national and local data. Fundamentally, KIPP will strengthen families as the long-term solution to caring for their children.

KIPP will serve the families of children with SED by delivering an intensive, in-home, evidence-based behavioral parent management training program, Parent Management Training-Oregon Model (PMTO). PMTO is a preventive intervention aimed at enhancing effective parenting and reducing coercive practices, especially in families with risk factors such as parent mental health problems, poverty, and trauma. According to the California Evidence-Based Clearinghouse for Child Welfare, PMTO has attained the highest level of evidence for its ability to improve parenting capacities and reduce problematic child behavior. It is hypothesized that reductions in problematic child behavior and improvements in parenting will lead to greater reunification readiness and to timely, stable reunification for families of children with an SED.

PMTO is a progenitor model which has been implemented internationally. At the end of the five-year demonstration project, Kansas foster care providers will have the ability to continue implementing PMTO and to train new workers in the intervention. In brief, KIPP will (1) increase the state's workforce by approximately 40 FTE, (2) provide a dedicated workforce for intensive reunification, (3) implement an evidence-based practice, (4) address the critical barriers to permanency faced by parents of children with SED, (5) connect families to longer-term community services and supports, and (6) increase permanency for youth at highest risk for LTFC.

Two Questions for Written Response

Please provide a written response to the following questions and bring to the interview. Please do not exceed two pages.

1. Describe a time when you were surprised by the strengths demonstrated by a family. Why were you surprised? What did you learn about them and about yourself?

2. What family behaviors are/would be the most difficult for you to handle? What have you learned about dealing with these behaviors?

Self-Report Checklist

Rating Scale:	Strongly Disagree 1	Somewhat Disagree 2	Somewhat Agree 3	Strongly Agree 4
1. I want to be a PMTO KIPP Therapist.				
2. I'm energetic.				
3. I possess good verbal skills.				
4. I'm a creative, interactive interventionist.				
5. I'm flexible and able to adjust quickly based on need.				
6. I'm committed to the longevity of the project (18-20 mos. of training/4 years of project).				
7. I'm comfortable being critiqued by peers and supervisors.				
8. I'm comfortable working with minimal supervision.				
9. I'm comfortable working in a group.				
10. I'm willing to work a flexible schedule based on need (including weekends).				
11. I have a positive attitude.				
12. I'm cooperative.				
13. I'm able to receive corrective feedback.				
14. I can become comfortable working while being video recorded.				
15. I'm comfortable working with coaching on professional work.				
16. I have a sense of humor.				
17. I believe in the families' ability to grow, change, and heal.				
18. I'm comfortable with home-based programs.				
19. I document therapeutic sessions well, in a timely manner.				

Appendix

Rating Scale:	Strongly Disagree 1	Somewhat Disagree 2	Somewhat Agree 3	Strongly Agree 4
20. I'm willing to use experiential methods (role play).				
21. I'm prepared to work primarily with the parent as opposed the child.				
22. I have good interpersonal skills.				
23. I have positive interactions with coworkers.				
24. I'm friendly.				
25. I'm open to others' ideas.				
26. I want to help children and families.				
27. I want to learn and improve my skills for working with parents to help children.				
28. I'm committed to developing my professional skills.				
29. I don't quit easily.				
30. I believe that parents can help their children's adjustment.				
31. I like working with troubled families.				
32. I believe in evidence-based practice.				
33. I'm enthusiastic about learning therapeutic skills that improve child outcomes.				
34. I'm willing to learn and troubleshoot as necessary the use of video-recording equipment.				
35. I complete work in timely manner.				
36. I complete work before last minute.				
37. I accept the necessity of documenting clinical work.				
38. I am well organized.				

Appendix

Rating Scale:	Strongly Disagree 1	Somewhat Disagree 2	Somewhat Agree 3	Strongly Agree 4
39. I'm willing to work with other agencies.				
40. I'm interested in becoming a leader.				
41. I'm interested in teaching/coaching others.				
42. I like assessment/evaluation strategies.				
43. I will be an advocate for KIPP PMTO within the agency.				
44. I will be a respected spokesperson for KIPP PTMO in the professional community.				
TOTAL SCORE :				

Standard Interview Questions

1. Why would you be a good fit for THIS position?
2. Describe your experiences working with children with SED? What did you find rewarding about this work? What did you find challenging?
3. Describe your perspective on working with parents as change agents.
4. Describe your experience implementing evidence-based practices (or with a grant or start-up project)? What is your experience with collecting research data?
5. Videotaping your sessions with families is a KIPP requirement. Can you talk about your comfort level with technology (video equipment, internet, etc.) and how you would create comfort with families?
6. What are your expectations for supervision? How do you like to receive feedback regarding your work?
7. How does this position fit with your long term career goals? Where do you see yourself, personally and professionally, in 5 years?
8. Describe your vision/perspective of teamwork.
9. Are there any factors that might cause you to be unable to fulfill the expectations of the job (e.g., some after-hours work, travel, staying in the job for 4 years, etc.)?
10. May we talk with your current and past employers? What might they tell us about you?

Role Play Instructions

Instructions to the applicant (read text in *italics* to applicant)

Now we are going to ask you to participate in a role-play. You will be presented with a “real-life” situation that you could encounter as a KIPP Therapist. The person helping you with the role-play will play the part of a family member and you will play the part of the KIPP Therapist.

You both have a section of the scenario to read that will describe the situation. Once you have read your description of the scenario you may ask us, the interviewers, any questions. Then you may begin the role-play when you are ready. You will have 20 minutes.

Therapist: This is an initial session with a new KIPP referral. You will be meeting with the mother of an 8 year - old boy with SED. He was removed because the mother was passed out and the child was burning something in their front yard, a neighbor called the police, and the child was removed. There were unsubstantiated reports of abuse and neglect in the past. Your goal for the session is to help the mother identify family strengths and treatment goals. (You might not get that far in the role play.) With that in mind, your goal for the role play is to form a therapeutic alliance and engage the mother.

Instructions to the person playing the mother

This is your first meeting with a KIPP Therapist. You have agreed to participate in a voluntary research project called KIPP. Your child is an 8 year-old boy who was removed after a neighbor called when you were passed out on the couch and your son was lighting fire to plants and wood in your front yard. You work at a part- time job at Arby’s and have a car. You are feeling angry and embarrassed that your child was removed. Demonstrate this anger and embarrassment by saying things like, “Who do they think they are any way! I’m his mother and they don’t have any right to take him away from me. I was just napping after work for a few minutes. Nobody understands how hard it is to be a single mom. You are probably just like those people. “

If the applicant validates your feelings (e.g., offers empathy) and gives you time to talk about how you are feeling, you can de-escalate and share that you are also somewhat relieved that your son has been removed because maybe he will get the help he needs. You are worn out from all the school problems (hitting, fighting) and you were afraid you were going to get fired for missing so much work. He does not listen to you and hurts animals. If you tell him he can’t have or do something, he just goes ahead anyway. You just give up and let him have his way.

IF you are asked for strengths: He is very artistic and loves to draw spaceships and monsters. **If you are asked about supports in your life:** Your sister, his auntie, is a big support to the two of you. **IF you are asked about what needs to be different:** You love him very much but you just want some peace in the house and to be respected by him.

After the role play, fill out the Impressions Form.

Instructions and Information for Interviewer

Take notes during the role play. Pay careful attention to the ability of the applicant to engage with the mother and also move the session forward to talk about strengths and goals, as well as the coachability of the applicant. After the role-play is complete, offer a lot of positive feedback on one or more of the following concept areas: **engagement, empathy, probing questions to find strengths and goals, listening skills, problem solving skills, concern for the best interest of the parent.**

Now choose one concept area and offer constructive feedback. If there is no real critical feedback to give, note that and move on. Describe the appropriate alternative behavior and clearly ask the applicant to practice doing/saying the appropriate alternative behavior with you “to make sure you’ve got it.” Then restart the role-play at the point where the applicant can implement the “new skill” in the interaction with the Interviewer (person taking part in the role-play with the applicant).

Pay close attention to the applicant’s abilities in each of the concept areas during the interaction with the interviewer participating in the role-play and with the other Interviewers. Also, carefully note the applicant’s ability to accept praise, accept critical feedback, listen and learn the new skill you teach, and implement that new skill in the restart of the role-play situation. At the end of the restarted role-play, offer one positive comment about how the applicant performed and move on.

After the second role-play is complete, ask the applicant to take a 10-minute break while reflecting on five things he/she did well in the role play, and one thing they would like to go back and do differently. After the 10-minute break have applicant share the reflection.

At the end of the reflection, offer one or more positive comments about how the applicant performed and move on.

After the interview is over, fill out the Impressions Form.

Role Play – Parent Impressions Form

To be filled out by the person playing the parent. Give to the person playing the parent before the role play, so they can see what they are to assess.

Candidate: _____

Rate the following statements using the scale:

- 1= Strongly disagree
- 2= Disagree
- 3= Neither agree or disagree
- 4= Agree
- 5= Strongly agree

I felt comfortable.	
The candidate seemed real and/or genuine.	
I felt gently guided during the feedback sessions.	
I felt understood.	
I felt respected.	
I felt appropriately engaged.	
I liked the candidate.	
I would continue meeting with this Therapist.	
Total Score	

Any other impressions you would like to share?

Role Play: Interviewer Impressions From

To be filled out by the Interviewers.

Candidate: _____

Rate the following statements using the scale:

1= Strongly disagree

2= Disagree

3= Neither agree or disagree

4= Agree

5= Strongly agree

The candidate was able to offer empathy and validate feelings.	
The candidate asked for strengths (e.g., <i>So what is one thing you might say is special about Joey?</i>)	
The candidate asked for supports (e.g., <i>Do you have someone you can talk to about the challenges you are facing?</i>).	
The candidate asked questions to get at motivation to change (e.g., <i>When Joey visits, how do you hope those visits will go? When Joey comes home, what do you want to be different for you? For him?</i>)	
The candidate avoided getting drawn into a debate or agreement (e.g., <i>Well, the report says you were drinking</i>)	
The candidate avoided making judgmental comments (e.g., <i>Well I think most parents and probably your neighbors are pretty concerned about fire setting</i>).	

Appendix

The candidate was accurate with positive self-reflections.	
The candidate was accurate with areas for improvement.	
The candidate listened to feedback and was willing to re-practice.	
The candidate was able to change behavior based on feedback.	
The candidate was able to engage with parent.	
Total Score	

Any other impressions you would like to share?

Reference Check Protocol

Candidate: _____

Reference: _____

Relationship to Candidate: _____

1. Could you start by telling me what kind of work he or she did for you, and what is your opinion of the quality of that work?
2. Part of the work of KIPP will be to video tape sessions with families. Can you talk about how you think he or she would do using this technology and putting families at ease?
3. What would you see as his or her strengths and weaknesses?
4. How would you characterize this person's approach to working with families in challenging circumstances? (Please could you give me an example of an occasion when you observed his or her clinical abilities and thought them effective? In what way were they effective? Can you think of an occasion when you thought his or her clinical approach did not work so well? Why not?)
5. How does he or she handle stressful situations?
6. Did you ever have to talk with him or her about performance problems? Was he or she able to accept feedback?

Rate the following statements using the scale:

- 1= Strongly disagree
- 2= Disagree
- 3= Neither agree or disagree
- 4= agree
- 5= Strongly agree

The candidate...	Rating 1-5	Notes
Demonstrates positive attitude.		
Shows commitment to strengths-based approaches.		
Is collaborative and supportive of colleagues.		Example?
Shows empathy, flexibility, creativity, and commitment to working with troubled families in challenging circumstances.		
Demonstrates understanding and adherence to ethics.		
Demonstrates a sense of social justice.		
Practices from a non-judgmental stance.		
Shows interest in research and evidence based practices.		

Final Scoring

Measurement	Overall Score 1(lowest) - 10 (highest)
Written Questions or Self report questionnaire	
Interview Questions	
Role Play	
Reference Check	
Total score	
Notes	

Appendix I: Kansas PMTO Trainee Candidate Participation Agreement

Kansas PMTO Training Trainee Candidate Participation Agreement

To ensure the successful completion of the Parent Management Training -Oregon Model (PMTO) Training program, (certification as a **PMTO Specialist** by Implementation Science International, Inc. (ISII)), the following training requirements must be followed. These requirements are based on the training experience of ISII.

1) Training format:

- A total of five (5) training workshops with interim coaching days –
 - Workshop 1 (4 days)
 - Workshop 2 (5 days)
 - One-day coaching workshops– attendance - at least 2 of the 3 days
 - Workshop 3 (3 days)
 - Workshop 4 (3 days)
 - Workshop 5 (3 days)

2) Candidate Training and Workshop Requirements:

- Trainees must focus their attention and energy on the training activities during these separate workshops and not be distracted by other commitments during these time frames.
- Trainees must arrive to all workshop days on time and remain for the entire training day.
- Cell phones must be turned **off** during workshop activities.

3) Participant Requirements and Availability:

- Available for complete attendance at full day workshops and coaching activities
- Attendance requires that each participant be on time and prepared
- Minimum of 8-12 hours/week dedicated to PMTO training work by trainee candidate
- Availability will grow to a minimum of 16 hours/week as PMTO caseload grows
- Conduct all activities relevant for training families (sessions, material prep, midweek phone calls, etc.)
- Complete all required assessment activities
- Ensure timely internet database entry and uploading of all intervention materials (DVD's for video coaching, family information, session information, etc.)

4) Timing of PMTO Caseload

- After Workshop 2, candidate begins with one to two PMTO families.
 - Agency preparation necessary to have an appropriate family ready to start work with therapist trainee immediately following the conclusion of Workshop 2 to build on training experience.
- After Workshop 3, candidate begins with one additional PMTO family.

- Agency preparation necessary to allow therapist trainee to begin working with additional PMTO training family immediately following the conclusion of workshop 3.
- After Workshop 4, candidate should be working with or toward completing treatment with three PMTO training families.
- At the conclusions of Workshop 5, candidate may be invited to begin work with two “certification” families, based on the progress of his or her work with training families.

5) Tasks / Activities Trainee Candidate Is Expected to Conduct:

- Follow the prescribed informed consent procedures with all training and certification families
- Conduct videotaped PMTO therapy session with each PMTO family, as prescribed
- Collect CAFAS data, as prescribed, on all youths treated during the training program
- Collect Caregiver Wish List data, as prescribed on all families treated during training program
- Complete sessions on all five core PMTO components
- Prepare for sessions (e.g., reviewing workshop materials, gathering and tailoring parent materials for family, brainstorming and role playing with colleagues)
- Complete family case form in internet database (one time per family for each family in group)
- Complete assessment package with each family in group, including videotaped Family Interaction Task prior to treatment and at the end of treatment
- Complete session form in internet database (one per session, within 24 hours after session)
- Complete weekly family satisfaction data for each case in internet database
- Upload DVD to Internet database to allow timely feedback to occur
- Review sessions (candidates watch all or parts of some session DVDs)
- Make midweek call (once per week per family)
- Read and review PMTO workshop notebooks and materials
- Attend coaching sessions twice monthly (two 90-minute sessions, plus drive time)
- Be available for occasional phone consultation with ISII Mentor (approx. 1-2 hours/month)
- Read and review session feedback and DVD (up to 4 hours monthly)

The average time span from Workshop 1 to certification as **PMTO Specialist** is 20 months. Certification will be based on Fidelity of Implementation (FIMP) scoring of portions of four sessions for each candidate. Thus, each candidate will present four sessions on the content required by ISII.

By signing this agreement, I _____ agree to the terms and conditions and will adhere to the aforementioned expectations and requirements as outlined.

PMTO Trainee Candidate

Date

PMTO Trainee Candidate Supervisor

Date

KIPP is Part of a Presidential Initiative



The Kansas Intensive Permanency Project (KIPP) is part of the Permanency Innovations Initiative (PII).

The goals of the PII are to improve permanency outcomes for children with the most serious barriers to permanency and to build the child welfare knowledge base by rigorously evaluating interventions designed to improve permanency.

KIPP has brought 40 new FTE to Kansas foster care. Therapists will serve families for 6 months and carry low caseloads (4-6 cases) so that they can provide intensive, in-home services early in the life of the case. Over the course of five years, KIPP's goal is to serve approximately 2880 families and to expedite permanency for children with serious emotional disturbance.

KIPP Contact

Phone Number/Email Address



Funding Provided by:
U.S. Department of Health & Human Services
Administration for Children and Families
Children's Bureau



**Kansas
Intensive
Permanency
Project**



*Supporting Families,
Creating Permanency*

What is KIPP?

KIPP is a statewide partnership between the University of Kansas; Kansas Department for Children and Family Services; and Kansas' four private providers of foster care—KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville.

KIPP's Goals:

Provide intensive services to support families with children in foster care.

Help families of children with serious emotional disturbance (SED) reintegrate earlier and more stably.

Increase families' capacity to provide for their children's needs.

Work with the family and community on addressing barriers to reintegration.

Connect families to community services and supports.

Who Can Participate?

KIPP will be studied as part of a rigorous cross-site evaluation to inform the child welfare field. Only families whose children meet clinical criteria are eligible for KIPP; they will be randomly assigned to receive therapy or assessments. Families cannot be court-ordered to KIPP; however, participation in KIPP may facilitate reintegration.

Parent Management Training-Oregon Model (PMTO)

PMTO stands for Parent Management Training—Oregon Model. PMTO is an evidence based practice, which means that it has been demonstrated, through scientific studies, to be effective in treating behavioral problems.

PMTO believes that parents are their children's most important teachers. Therefore, most of PMTO is done with the parents to empower them with effective child-rearing strategies, such as:

Skill Encouragement:

Teaching concern for others and other positive behaviors through effective instructions and encouragement.

Limit Setting: Giving consistent, short, non-physical sanctions such as time-out, privilege loss, and work chores for specific misbehavior.

Problem Solving: Setting goals, brainstorming, figuring out solutions, and carrying out plans.

Monitoring: Keeping track of children's whereabouts, friends, and ensuring adult supervision for children's activities.

Positive Involvement: The many ways parents show love for their children, including attention and support, participating in children's interests and activities, and showing care and concern.

What Will This Look Like?

What reintegrative and foster families may notice most is the increased visits and intensity of services for the first 6 months of reintegration efforts. This increase in visits is critical to KIPP's success.

Families will have:

- At least 1 parent session with a KIPP Therapist each week.
- At least 1 session with the parent, child, and KIPP Therapist each week.
- Four regular visits for the parent and child each month.

Visits will continue to be based on legal visitation arrangements.

Thank you for your support of KIPP's efforts to help parents and children strengthen their families!

Information

Kansas Intensive Permanency Project
Project Manager: Kim Bruns
KU School of Social Welfare
1545 Lilac Lane

Phone: 785-864-3737
Fax: 785-864-1912
E-mail: kbruns@ku.edu

Kansas Intensive Permanency Project (KIPP)

Family Guide on KIPP and PMTO

KIPP: KIPP is a statewide partnership implementing and evaluating an intensive, in-home, evidence-based parent training program. The partners for this project are University of Kansas; Kansas Department of Social and Rehabilitation Services, Children and Family Services; and Kansas' four private providers of foster care—KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville.

KIPP'S Goals:

- 1) Help families of children with serious emotional disturbance (SED) reintegrate earlier and more stably.
- 2) Increase families' capacity to provide for their children's needs.
- 3) Work with the family and community on addressing barriers to reintegration.
- 4) Connect families to longer-term community based services and supports.
- 5) Provide intensive and necessary services to support families with children in foster care.

How Are Families Chosen to Participate?

As part of a national evaluation, KIPP is being studied. If you were given this handout, a child in your care qualified for the program. Their family was randomly assigned to receive therapy and assessments.

Parent Management Training—Oregon (PMTO): KIPP has selected PMTO as the evidence-based strategy to help parents manage the behavior of their children. PMTO is designed to promote pro-social skills and cooperation and prevent, reduce, and reverse the development of conduct problems. Effective parenting skills are the core components of the PMTO model, including:

- Skill Encouragement
- Limit Setting
- Problem Solving
- Monitoring
- Positive Involvement

A Few Guiding Principles:

- Parents are important teachers for their children; PMTO empowers parents.
- KIPP Therapists teach parents skills to help their children effectively, using positive parenting.
- Sessions are video recorded so KIPP therapists can get hands-on coaching.
- PMTO helps parents identify their strengths and strengths of others and build upon them.

What Will This Look Like? What reintegrative and foster families may notice most is the increased visits and intensity of services for the first 6 months of reintegration efforts. This increase in visits is critical to KIPP's success. Increased visits will look like this:

- Families will have at least 1 parent session with a KIPP Therapist each week.
- Families will have at least 1 session with the parent, child, and KIPP therapist each week.
- Families will also have 4 regular visits for the parent and child each month.
- Visits will continue to be based on legal visitation arrangement.

Thank you for your support of KIPP's efforts to help parents and children strengthen their families!

Appendix L: Kansas PMTO Certificate of Completion

Kansas PMTO

Certificate of Completion

This Certificate is Awarded to:

On this ____ day of _____, _____



KANSAS PMTO

Appendix M: Kansas Matrix for Implementing PMTO with Fidelity

Kansas PMTO Governing Authority

Purpose

The purpose of the Kansas PMTO Governing Authority is to provide policy, direction and support for implementation and sustained adherence to the PMTO model throughout the state of Kansas and with agencies providing PMTO services in Kansas.

Membership

The Kansas PMTO Governing Authority includes one member from the Kansas Department for Children, Families (DCF), and one member from all participating agencies. Currently membership includes:

- Kansas DCF
- KVC Kansas (KVC)
- St. Francis Community and Family Services (SFCS)

Changes in agency leadership, state foster care contracts, or other service delivery structures that impact the implementation of KIPP will require transition plans to ensure that members of the Governing Authority are well-educated about PMTO, understand the key PMTO roles, and are knowledgeable about their governing and oversight responsibilities. This transition plan should endeavor to engage well-qualified administrators who are familiar with PMTO. The plan must allow sufficient time to transfer responsibilities from the outgoing members to incoming members. In the event of a change in foster care contractors, a transition plan must articulate the expectations of the Kansas DCF and the contracting agencies for continued implementation of PMTO with fidelity.

Therefore, all agencies implementing PMTO with certified Kansas PMTO Trainers and certified Kansas PMTO Coaches must participate in the Kansas PMTO Governing Authority and agree to adhere to the Scope and Objectives. A member must hold a leadership position in her or his agency and have sufficient authority to speak for and make decisions on the agency's behalf.

Additionally, during such changes efforts should be made to provide the opportunity for existing PMTO trained staff to continue implementing PMTO.

Scope and Objectives

The scope and objectives of the Kansas PMTO Governing Authority include, but are not limited to, the following:

The Kansas PMTO Governing Authority monitors, manages, and oversees the implementation and sustained adherence to PMTO. The Kansas PMTO Governing Authority has the power, authority, and obligation to oversee, supervise, monitor, and regulate all PMTO activities in the state. This includes the quality and sustainability of the infrastructure necessary for training, coaching, and fidelity rating. It also includes ensuring that the Kansas FIMP Team maintains reliability via the annual test on FIMP Central.

The Kansas PMTO Governing Authority provides leadership and decision-making for PMTO implementation throughout the state of Kansas, which includes general oversight and problem solving related to consistency of operating procedures.

The Kansas PMTO Governing Authority provides an accountability structure to the implementation of PMTO in Kansas.

The Kansas PMTO Governing Authority negotiates with ISII a set of oversight policies, rules, procedures, and guidance documents to be followed within the implementation site. These policies and procedures will support competent adherence and, as needed, enforce and address violations of the policies and procedures. See Non-compliance section below.

The Kansas PMTO Governing Authority monitors PMTO implementation among all participating agencies to ensure that they follow established policies and procedures.

The accountability structure includes responding to violations with an action plan and monitoring.

The Kansas PMTO Governing Authority maintains authority, processes, and contingencies to respond to any Kansas entity's attempt to alter or implement PMTO without prior approval from the Kansas PMTO Governing Authority and ISII or outside the entity's service jurisdiction.

The Kansas PMTO Governing Authority uses data to drive decision-making and to support continuous improvement.

Non-compliance

The Kansas PMTO Governing Authority will notify ISII of violations and consult with ISII for guidance on responding to and overcoming identified barriers to adherence. The following is the general plan to respond to a violation of established policies and procedures.

Following consultation with ISII, the Governing Authority, will engage in resolving issues with the agency or entity in violation. The Governing Authority will:

- Hold a meeting to discuss the violation
- Identify barriers to adherence to the policies and procedures
- Review any and all available data to understand the violation and related barriers
- Develop an action plan with timelines for achieving agreed upon objectives
- Monitor and enforce the action plan

If the entity is unsuccessful at adhering to the policies and procedures, ISII will be notified, and the entity will be notified that it is no longer permitted to practice PMTO or claim affiliation with the PMTO model in Kansas.

Authority and Accountability

The Kansas PMTO Governing Authority holds decision-making authority for implementation in Kansas. The Kansas PMTO Governing Authority is accountable to itself, the Site Coordinating Team, funding partners, and ISII. It consults with ISII on decisions and actions involving PMTO practice, materials, training, coaching, and fidelity monitoring, and general monitoring of adherence to the oversight policies and procedures. Formal feedback will be provided in a timely manner to all entities to which the Kansas PMTO Governing Authority is accountable.

Decision-Making Process

The Kansas PMTO Governing Authority will make decisions collaboratively by consensus of the members. In the event that consensus cannot be reached, the final decision making authority will rest with DCF.

Site Coordinators

Each participating agency must designate a Site Coordinator. Site Coordinators oversee local implementation of PMTO and are responsible for meeting regularly with their agency's member of the Kansas PMTO Governing Authority.

Site Coordinating Team and Other Working Teams

The Site Coordinating Team comprises the Site Coordinators from each participating agency. Additionally, the Site Coordinating Team includes the PMTO-certified individuals in the role of Lead Trainer, Lead Coach, and Lead FIMPer. The Site Coordinator and the Lead role may be held by the same individual.

As necessary, the Kansas PMTO Governing Authority forms working teams to assist in effective completion of its work. Working teams may meet separately but must report full information to the entire Kansas PMTO Governing Authority. Working teams make recommendations to the Kansas PMTO Governing Authority, which makes all implementation decisions.

The Kansas PMTO Governing Authority will draw on multiple sources of feedback, including feedback from parent consumers, youth consumers, and frontline staff. All of these perspectives will be used to gain the most complete understanding of effective implementation of the PMTO model in Kansas. Based on the data-sharing agreement, the Kansas PMTO Governing Authority will share such data/feedback with ISII.

Meetings

The Kansas PMTO Governing Authority meets monthly and can increase or decrease frequency of meetings as necessary and warranted; however, a minimum of nine meetings per calendar year are required.

The Kansas PMTO Governing Authority meets with ISII regularly, at least once per quarter. Meeting frequency can increase or decrease in frequency as necessary and warranted. It consults with ISII on decisions and actions involving PMTO practice, training, coaching, and fidelity monitoring, and general monitoring of adherence to the oversight policies and procedures. The Kansas PMTO Governing Authority collaborates with ISII on adaptations to programmatic content, materials, etc.

Kansas PMTO Therapist

The PMTO Therapist provides PMTO treatment to families and ensures timely treatment documentation and submission of video recordings of therapy sessions for coaching and to demonstrate model fidelity.

Professional Qualifications Required

1. Master's Degree in Social Work, Counseling, Marriage & Family Therapy or related field
2. Licensed by Kansas BSRB or working towards licensure
3. Experience working with children and families

Attributes and Skills

1. Commitment to strength-based approach
2. Experience working with families of youth with SED and the foster care population
3. Available and eager to invest in a demanding learning process
4. Expects to remain with the agency long enough to offset the investment in the extensive training program (e.g., 2 years post-certification)
5. Comfortable working with caregivers (e.g., birth parents, stepparents, adoptive parents, grandparents, guardians, aunts/uncles, etc.)
6. Willing to video record all sessions
7. Comfortable participating in group learning experiences
8. Flexible, creative, and committed to working with families
9. Able to adopt and implement new intervention strategies
10. Comfortable with behavioral approaches
11. Effective communicator
12. Ability to travel
13. Ability to work flexible schedule to include evenings and weekends

Roles and Responsibilities

1. Provides face-to-face services to assigned parent(s), child(ren) and families
2. Participates actively in training, meetings, regular coaching sessions, and consultations
3. Completes parent assessments and documentation
4. Ensures evaluation data is documented and reported regularly and accurately according to protocols
5. Video records all parent, child, and family sessions prior to certification
6. Completes session information and uploads video recorded sessions to secure portal within five business days of the session
7. Incorporates coaching feedback into subsequent session work

Training Requirements

1. Participates actively in comprehensive, multi-phased training in PMTO
2. Attends a minimum of 85% of required workshop days (requirement is 18 workshop days or 17 workshop days plus 1 coaching day)
3. Secures treatment consents from all families receiving PMTO
4. Begins work with training families after completion of Workshops 1 and 2
5. Works with a minimum of 5 families during training period
6. Completes PMTO documentation requirements according to the Kansas PMTO video uploading protocol
7. Actively participates in PMTO coaching during workshops, including group and individual coaching
8. Prepares for and participates in PMTO certification
 - a. Completes a mid-course self-assessment during pre-certification

- b. Completes a minimum of three training families during pre-certification
- c. Completes PMTO content with three training families, up to and including Limit Setting
- d. Prior to invitation to certification, participates in coaching one time per month for an average of 12 coaching sessions per year. Six (6) sessions will be based on the therapist's own work; the other sessions may be based on another therapist's work (i.e., coaching via reflective team). *Note:* These requirements are minimum standards. The Lead Trainer and Lead Coach will work collaboratively to assess and monitor each trainee's progress and to consult with the trainee's supervisor through the time of certification. Each trainee's coaching plan will be individualized by the Lead Trainers and Lead Coaches. If needed, coaching frequency will increase to support the trainee's progress toward certification.
- e. After invitation to certification, participates in 6 coaching sessions per year (Four sessions will be based on the therapist's own work; the other sessions may be based on another therapist's work.)

Path to Certification

1. Receives invitation to begin work toward certification
2. Begins work with two new families or proceeds with non-training families (i.e., families that are not the three training families)
3. Identifies four certification videos from non-training families covering the following topics:
 - Introduction to Encouragement (IE)
 - Troubleshooting Encouragement (TE)
 - Introduction to Limit Setting Limit Setting (ILS)
 - Troubleshooting Limit Setting Limit Setting (TLS)
4. Selects sessions that qualify for submission of certification videos as follows:
 - Session is dated after the invitation to certification.
 - Session does not come from any of the three training families that would have been served prior to the invitation to certification.
 - Sessions were video-recorded.
 - Topics from these sessions were incorporated into coaching sessions.
 - Therapist must have received at least one coaching session for each family from which a session is submitted for certification.
5. Notifies Lead Coach, Lead Trainer, and FIMP Lead that certification videos are ready for pre-review
6. Participates in consultation with Kansas PMTO Trainer and/or Kansas PMTO Coach before submitting certification videos (See the Certification Pre-Review Process protocol in the appendix)
7. Demonstrates fidelity by achieving a mean FIMP score of 6 across the 5 FIMP dimensions with no individual domain score at 3.0 or lower. The five FIMP dimensions are knowledge, structure, teaching, process, skills, and overall quality
8. Emails supervisor, FIMP Leader, Lead Trainer, and Lead Coach to notify them that the certification videos are ready for rating
9. After all four sessions have been scored, the FIMP leader will notify the Kansas PMTO Governing Authority. The FIMP leader will contact the Therapist about the overall certification decision (e.g., pass/not pass). Extensive feedback in a bullet point format is provided to the Therapist. No FIMP scores are provided to the Therapist.
10. If the certification sessions do not achieve passing FIMP scores, the Kansas PMTO Therapist will be invited to submit additional certification sessions. Feedback related to the session(s) needing improvement is provided to the candidate and a conversation takes place among the Lead Coach, Lead Trainer, and the candidate to support the candidate in a successful resubmission.

Maintaining Certification and Competency

1. Actively participates in booster sessions and other PMTO trainings that are designated as required
2. Maintains a caseload in which PMTO is practiced
3. Committed to involving parents as treatment agents in use of positive parenting practices to help children make healthy adjustments
4. Cooperates with policies, procedures and structure as outlined in the Kansas Matrix
5. Participates in fidelity monitoring throughout the year via regular coaching (minimum of an average of once per month)
6. Submits one video-recorded session annually from current PMTO work to the FIMP Leader
 - The content of the recertification video will be either Troubleshooting Encouragement or Troubleshooting Limit Setting. The Therapist's recertification video will alternate annually between these two content areas.
7. Achieves a minimum mean FIMP score of 6.0 across the five areas, with no individual area's score at 3.0 or lower, on the annual recertification video
8. If recertification videos do not meet fidelity criteria, additional coaching is required. An action plan will be developed with the Kansas PMTO Governing Authority, Lead Coach and Lead Trainer. ISII may be invited for consultation.

Kansas PMTO Coach

The PMTO Coach provides coaching to certified therapists, therapists-in-training, and coach peers in individual and group format.

Professional Qualifications Required

1. Master's Degree in Social Work, Counseling, Marriage & Family Therapy or related field
2. Licensed by Kansas BSRB
3. Certified PMTO Therapist (preferred experience for a minimum of 1 year)
4. Provides PMTO services to children and families, minimum of one family per year

Attributes and Skills

1. Strong commitment to sustain PMTO fidelity
2. Strong desire to be a PMTO Coach
3. Strong understanding of and commitment to working with families of children with SED who are currently living in foster care
4. Skillful at providing strengths-based feedback
5. Commitment to coaching
6. Seeks coaching for self
7. Effective at coaching peers
8. Outstanding teaching and process skills
9. Demonstrates exemplary clinical wisdom as evidenced by FIMP scores in "Good Work" range
10. Eager to continue learning and growing in own work
11. Effective leadership skills in small groups
12. Effective communication skills
13. Skillful at promoting team spirit
14. Recommendation from the lead coach and from the agency's Kansas Governing Authority member

Roles and Responsibilities

1. Provides coaching sessions (e.g. group, individual, phone, portal, video conferencing, and written) for certified and candidate therapists.
2. Participates in PMTO trainings for therapists and helps during workshops as necessary.
3. Provides a minimum of 1 coaching session per month, on average (i.e., annual average of 12 coaching sessions). The coaching must be observation based, and sessions must be evenly spaced throughout the year.
4. Video records all coaching sessions (including video conferencing).
5. Uploads coaching sessions on Kansas Session Portal with documentation within 5 business days of session.
6. Participates in a monthly coaches' meeting with Lead Coach and other coaches to review coaching videos, troubleshoot issues, receive support/coaching, review adherence to the coaching service delivery plan, and evaluate candidates' progress. Must attend a minimum of six coaches meetings per year, including two required in-person meetings.

Training Requirements

1. Attends a minimum of 90% of the 1.5-day PMTO Coach Workshop provided by an ISII Mentor or Lead Coach, or completes a tiered coaching process. The Tiered Approach must begin with an opportunity for written coaching followed by individual and group coaching. (*Please see Tiered Approach section for additional information.*)

2. Attends monthly coaches' meetings with Lead Coach and peer coaches. These meetings will include coaching for coaches
3. Conducts coaching sessions with a variety of non-certified therapists and in a variety of coaching formats (written, video, in-person, individual, and group), based on non-certified therapist's video-recorded family sessions as assigned through the Lead Coach
4. Uploads and completes session form for each video-recorded coaching session (individual or group) in the Kansas Coaching Matrix
5. Receives coaching on own coaching as indicated in individual coaching plan
6. Seeks and responds to feedback from Lead Coach and/or ISII
7. Is monitored by Lead Coach and Kansas Governing Authority through the use of coaching FIMP scores, consultations, evaluations, staff surveys, site visits, review of videos, and written coaching
8. Demonstrates the following:
 - a. Ability to provide strength-based and FIMP-based PMTO feedback
 - b. Ability to communicate supportively to enhance understanding of PMTO core competencies
 - c. Proficient use of role play and problem solving as teaching tools with PMTO therapists
 - d. Ability to problem solve and brainstorm PMTO challenges with therapists
 - e. Ability to be highly and consistently organized
 - f. Excellent communication across PMTO network (Trainer, Lead Coach, etc.), and consistent professional growth in coaching competencies

Path to Certification

1. Attends a minimum of six coaches' meetings with peer coaches and Lead Coach, which includes a minimum of two in-person coaches' meetings, within the first year of beginning coach training
2. Completes minimum of seven coaching sessions (combination of group and individual) with at least three different individual therapist candidates
3. Receives invitation to submit coaching videos for pre-review process by Lead Coach and Kansas Governing Authority
4. Identifies two coaching videos for pre-review with the following requirements:
 - a. Content of one of the submitted coaching videos must demonstrate principles of a Reflective Team approach as outlined in the PMTO Coaching documents Coaching (2012) and FIMP Supplement for PMTO Coaching (2012)
 - b. Format of the coaching videos can be either one individual coaching and one group coaching session or two group coaching sessions; however, it is not acceptable to submit two individual coaching sessions
5. Uploads two coaching videos for pre-review by the Lead Coach, the Lead Coach's designee and/or ISII and notifies Lead Coach that coaching certification videos are ready for pre-review
6. Participates in consultation on certification videos with Lead Coach before submitting certification videos
7. Demonstrates fidelity by achieving a passing score on two submitted coaching sessions (Passing score is a mean FIMP score of 6.0 attained on each session, with no scores of 3.0 or lower in any 1 FIMP dimension.)

Maintaining Certification and Competency

1. Participates in annual coaching booster workshop/seminars
2. Continues utilizing PMTO model in his or her own work with families
3. Continues to provide coaching to therapists and peer coaches with a minimum of 1 coaching session per month, on average (i.e., annual average of 12 coaching sessions). The coaching must be observation-based and sessions must be evenly spaced throughout the year.
4. Uploads and completes session form for video-recorded coaching sessions (individual or group) in the Kansas Coaching Matrix (minimum of one per month)

5. Receives coaching on one's own coaching (minimum of two per year) and provides coaching on coaching (minimum of two per year)
6. Attends monthly coaches' meeting/workshop at least six times per year
7. For annual recertification, uploads one coaching video for review by ISII or KIPP FIMP rater with the following requirements:
 - a. The coaching session is in a group format that incorporates principles of a Reflective Team approach as outlined in the PMTO Coaching documents Coaching (2012) and FIMP Supplement for PMTO Coaching (2012).
 - b. The session being coached covers one of the core content areas (IE, TE, ILS, TLS).
 - c. The session form for videos is completed on the Kansas Coaching Matrix.
 - d. The Coach achieves a mean FIMP score of 6.0, with no scores of 3.0 or lower in any one FIMP dimension.
 - e. In alternate years, coaches may submit a family session on core content (IE, TE, ILS, TLS) or training session on core content (IE, TE, ILS, TLS) in place of a coaching session.

Tiered Approach to Coaching:

1. A coach or trainer recommends a certified therapist to begin training as a coach.
2. The new coach-in-training receives a minimum of four assignments for provision of written coaching.
3. The coach-in-training receives feedback on written coaching.
4. Following feedback on written coaching, the coach-in-training identifies a written coaching from those submitted for feedback to then be submitted for FIMP rating.
5. If scores are at or above passing, the coach-in-training becomes a coach candidate who attends a coaching seminar day (either with a training group or at a coaches' quarterly meeting) with the task of observing group coaching and completing coaching observation questions.
6. If the coach candidate and Lead Coach concur, the coach candidate is ready to progress. The next assignments will be to provide individual coaching.
7. The coach candidate receives a minimum of four individual coaching assignments. Individual coaching sessions are recorded, and the coach candidate receives feedback on individual coaching.
8. Following feedback on the individual coaching sessions, the coach candidate identifies an individual coaching session from among those submitted for feedback for FIMP rating.
9. If FIMP scores are passing for the individual coaching session, with a mean FIMP score of 6.0 with no scores of 3.0 or lower in any one FIMP dimension, the coach candidate receives a minimum of 4 group coaching assignments.
10. The coach candidate identifies one group coaching for FIMP rating.
11. If scores are passing with a mean FIMP score of 6.0 and no scores of 3.0 or lower on any one FIMP dimension, the coach candidate is invited to continue with "Path to Certification" steps 4-7 (see section above).

Kansas PMTO Trainer

Kansas PMTO Trainers conduct and sustain training of new PMTO Therapists. Kansas PMTO Trainers train on the individual format of PMTO with a clear goal of maintaining adherence to the PMTO model. Certification as a Kansas PMTO Trainer applies only to the implementation of PMTO within the established infrastructure in Kansas.

Professional Qualifications Required

1. Master's Degree in Social Work, Counseling, Marriage & Family Therapy or related field
2. Licensed by Kansas BSRB or working towards licensure
3. Provides PMTO services to children and families
4. Certified as a PMTO Therapist and as a PMTO Coach and selected by the Kansas Governing Authority

Attributes and Skills

1. Strong desire to be a PMTO Trainer
2. Strong commitment to sustain PMTO fidelity
3. Ability to be cooperative and collaborative
4. Strong co-leadership skills (negotiation, problem solving, compromise, sharing)
5. Extensive experience applying the PMTO model in therapeutic settings (with a variety of family types and circumstances)
6. Strong understanding of and commitment to working with PMTO populations
7. Skillful at providing strength-based feedback
8. Commitment to coaching to improve therapist fidelity
9. Seeks coaching for self
10. Clinical wisdom evidenced by therapist or coach FIMP scores in the exemplary range (≥ 7.6)
11. Strong leadership skills in small groups
12. Never-give-up attitude
13. Effective communication skills
14. Ability to receive and integrate feedback
15. Outstanding active teaching and process skills
16. Skillful at managing multiple tasks
17. Eager to continue learning and growing in own work
18. Outstanding performance in current role
19. Previous training experience and demonstrated successful training
20. Charismatic presentation style
21. Recommendation of Kansas Governing Authority

Roles and Responsibilities

1. Organizes and facilitates content in PMTO workshops with fidelity to PMTO training model
 - a. Workshop content is covered and delivered as outlined in approved PMTO workshop agendas and curricula.
 - b. Minor modifications (e.g., fewer sessions, more time on focused content, additional coaching) to training are possible under certain circumstances (e.g., small cohorts) if fidelity to the PMTO training model is maintained.
2. Follows procedures outlined in the *Manual for PMTO Workshop Educators* (Rains, Forgatch, Knutson, Sigmarsdóttir, & Duckert, 2013)*
3. Coaches PMTO therapist trainees to certification to ensure fidelity to the PMTO model
4. May participate with Kansas Governing Authority and Lead Trainer in the selection of PMTO Therapist, Coach, and Trainer trainees

Training Requirements

1. Attends a minimum of 90% of the 3-day PMTO Educators Workshop provided by an ISII Mentor or completes a tiered training process
2. Participates as co-trainer in a complete set of PMTO Therapist Workshop training days. A complete set of PMTO Specialist Workshops is defined as:
 - a. Workshop 1 and/or Workshop 2 plus other Workshops to equal 3 Workshops.
 - b. The third Workshop can be a combination of other Workshops.
 - c. Must attend 90% of 2 full Workshops, plus at least 3 days of other Workshops
3. Submits a minimum of three Workshop videos (see details below)
4. Participates in preparation, consultation and debrief of workshop activities with Lead Trainer
5. Is monitored by Kansas Governing Authority and ISII through FIMP scores, consultations, feedback, workshop evaluations, staff surveys, site visits, and review of videos
6. Demonstrates the following:
 - a. Ability to apply the PMTO model
 - b. Proficient and creative use of training material with fidelity
 - c. Capacity to adapt materials in consultation with Lead Trainer to the needs of the trainees (Lead Trainer must consult with ISII about any adaptation to materials)
 - d. Ability to enhance communication within and across PMTO teams
 - e. Proficiency in application of FIMP language and skills
 - f. Excellence in training and coaching skills

Path to Certification

1. Submit a minimum of three Workshop videos
 - a. Video must be a minimum of 30 minutes showing trainer leading content-rich material (i.e., PMTO core or supporting content and process)
 - b. Trainer is the primary leader (with co-leader)
 - c. Content being taught is PMTO core or supporting content (e.g., encouragement, active communication, Therapist-Parent-Child session)
2. Receive passing training FIMP mean score of 6.0 or above, with no scores below 5.0
3. If scores are not passing, may be required to re-select and re-submit new segments for certification and seek consultation with leadership (Lead Trainer, ISII, Kansas Governing Authority, etc.)

Maintaining Certification and Competency

1. Participates in annual training booster workshop/meetings
2. Continues to utilize the PMTO model in his or her own work with families
3. Participates as trainer in at least five workshop days per year
4. Submits 60 minutes of video from each training series in which trainer is leading content-rich material from no more than 2 workshop segments (i.e., submit either one 60-minute video or two 30-minute videos) [Define frequency after developing matrix on certification]
5. Recertification submission may be alternated with recertifying as a PMTO therapist or coach.
6. Receive a passing training FIMP score on the submitted video (i.e., FIMP score of 6.0 or above (average), with no scores below 5.0)

*Rains, L. A., Forgatch, M. S., Knutson, N. M., Sigmarsdóttir, M., & Duckert, M. (2013). *Manual for PMTO Educators* (Revised for KIPP). Eugene, OR: Implementation Sciences International, Inc.

Kansas PMTO Fidelity Rater (FIMPer)

Scores treatment sessions with the Fidelity of Implementation Rating System (FIMP) for purposes of sustaining fidelity of the PMTO model in Kansas:

- Certification of therapists, coaches and trainers
- Recertification of therapists, coaches and trainers
- Monitoring continuing fidelity for therapists, coaches, trainers
- Evaluation and support of development of practitioners with scores and bulleted feedback that can be used by coaches, supervisors and trainers
- Scores sessions to assess reliability within team and across PMTO implementation sites

Professional Qualifications

1. Master's Degree in Social Work, Counseling, Marriage & Family Therapy or related field
2. Licensed by Kansas BSRB or working towards licensure
3. Experience working with children and families
4. Certified PMTO Therapist

Attributes and Skills

1. Demonstrated interest in sustaining PMTO fidelity within Kansas
2. Ability to specify behaviors related to each of the FIMP categories
3. Availability in terms of time and agency resources/interests
4. Willing to make a minimum two-year commitment to the FIMP team
5. References for and demonstration of following (see additional description under Roles and Responsibilities):
 - Collaborative team player
 - Flexibility
 - Rigorous attention to detail
 - Ability to meet deadlines
 - Diplomatic in delivery of feedback

Selection Process

1. Kansas PMTO trainers and coaches make recommendation to the FIMP Leader.
2. FIMP Leader consults with Kansas Governing Authority and ISII on recommendation.
3. FIMP Leader invites selected candidates to begin FIMP training process.

Roles and Responsibilities

1. Maintain a minimum PMTO caseload of one family per year
2. Follow procedures outlined in *FIMP Central: Training Manual for Reliability and Maintenance* (Sigmarsdóttir, Rains, Knutson, & Forgatch, 2010)*
3. Demonstrates the following:
 - Collaborative team player
 - Uses active communication skills during FIMP training and reliability meetings.
 - Flexibility
 - Respectfully balances listening to and presenting rationales.
 - Rigorous attention to detail
 - Prepares for training sessions by reviewing FIMP scoring guidelines, viewing videos, and preparing brief written justification (e.g., bulleted list of FIMP qualities observed)
 - Carefully and accurately records FIMP ratings
 - Ability to meet deadlines

- Scores sessions and provides FIMP ratings and comments on the agreed upon schedule(s)
- Diplomatic in delivery of feedback (bulleted comments)
 - Consistently begins feedback with genuine, positive statements
 - Provides brief, descriptive statements related to the rating
 - Refrains from making judgmental comments or global statements
 - Constructive feedback consistently includes a description of possible alternative appropriate PMTO practices and a brief family- or therapist-oriented rationale
- 4. Observe videos and score videos using the FIMP as assigned by Kansas FIMP Leader (minimum of once per month)
 - FIMP raters observe and score videos for four distinct purposes:
 - To maintain one’s own reliability on the FIMP scoring system within the KIPP fidelity team and with the ISII fidelity team (see *FIMP Central: Training Manual for Reliability and Maintenance*);
 - To provide fidelity ratings on individuals in training to become Kansas PMTO Therapists, Coaches and Trainers;
 - To provide fidelity ratings on individuals who have submitted videos for certification or recertification as Kansas PMTO Therapists, Coaches and Trainers
- 5. Provide written justification for ratings (short, bulleted list of FIMP qualities observed)
- 6. Email FIMP scores and written feedback to Kansas FIMP Leader using the FIMP Rating spreadsheet by the date specified by the Kansas FIMP Leader
- 7. Participate monthly in Kansas FIMP calibration meetings, in-person or via conference call
 - To maintain reliability, FIMP raters must participate in 9 of 12 calibration meetings annually.
- 8. If a FIMP rater is not reliable for two consecutive meetings in which reliability is assessed, she or he must participate in retraining activities as assigned by the Kansas FIMP Leader.
- 9. Participate in annual reliability checks with ISII (see *FIMP Central: Training Manual for Reliability and Maintenance*).

Training Requirements

1. Attend a minimum of 90% of the 2-day FIMP training as provided by an ISII or Kansas FIMP Leader
2. Attend 90% of monthly FIMP training meetings
3. Complete all FIMP reliability and training assignments
4. Meet deadlines for monthly FIMP training meeting
 - Assignments will be given 1 week prior to the monthly FIMP training meeting
5. Follow procedures outlined in *FIMP Central: Training Manual for Reliability and Maintenance*

FIMP Reliability Requirements

1. Complete reliability test of up to five FIMP segments (minimum of four) as assigned by ISII.
2. Achieve reliable FIMP scores according to procedures outlined in *FIMP Central: Training Manual for Reliability and Maintenance*
 - Percent agreement must be $\geq 80\%$ with scores from ISII’s consensus team. A FIMP dimension score is considered “in agreement” if it is within 1 point above or below ISII’s reliable FIMP rater’s score. Among the five FIMP dimensions, four of the five dimensions must be in agreement (i.e., 80%).

Demonstrated Competency After Achieving Reliability

1. Participate in monthly Kansas FIMP calibration meetings
 - To maintain reliability, FIMP raters must participate in 9 of 12 calibration meetings annually.
2. Complete all FIMP reliability and certification assignments
3. Provide written justification for ratings (short, bulleted list of FIMP qualities observed)

4. Meet deadlines for all FIMP reliability and certification assignments
 - Quarterly FIMP ratings must be completed within 2 weeks of assignment
 - Certification ratings must be completed within 1 month of assignment
 - Calibration meeting ratings must be completed within 1 week of assignment
5. Complete FIMP ratings on a minimum of 9 out of 12 monthly reliability video segments annually
6. Maintain reliable FIMP scores (Intra-class Correlation (ICC) \geq 70% or percent agreement \geq 80%) on each reliability check
7. If a FIMP rater is not reliable for two consecutive reliability checks, she or he must participate in retraining activities as assigned by the Kansas FIMP Leader.
8. Demonstrate reliability and prevent rater drift from established standards by completing the annual ISII FIMP Reliability Test provided by ISII in cooperation with the KIPP FIMP leader. (See *FIMP Central: Training Manual for Reliability and Maintenance*.)

*Sigmarsdóttir, M., Rains, L., Knutson, N., & Forgatch, M. S. (2010). *FIMP central: Training manual for reliability and maintenance*. Eugene, OR: Implementation Sciences International, Inc.

Appendix N: Pre-Reviewing Sessions for PMTO Certification

In preparation for a therapist to submit the four sessions for PMTO certification, it is useful for the training team to develop a pre-review plan. This plan will greatly assist both the therapist and the training team to avoid having to resubmit sessions. This helps set up the therapist for success.

1. Explaining the pre-review procedure to therapists

- A. Set a target date for the therapist to identify the four sessions and complete the session forms.
- B. Review the “Guidelines for PMTO Certification” (2009) with the therapist so that he or she can be prompted as to what is expected in the content of the sessions (e.g., what constitutes a good Troubleshooting session), as well as session eligibility (e.g., must contain at least 30 minutes of the specified content; if longer than 60 minutes, choose which 60 minutes is being certified; Encouragement sessions from different families and Limit Setting sessions from different families; Technology must be good so that the work can be seen and heard.).
- C. Before identifying the final four sessions, therapists can be “scouting” for potential certification tapes to consider. This gives them sessions to compare in order to find the best ones. Supervisors may also notice sessions that may seem like a potential certification tape (e.g., “This segment you showed in yesterday’s coaching contained a great role play. Are you considering possibly reviewing that session to see if you feel it might be one of your certification tapes?”). Note: We never promise that a session is a Pass or a No-pass.
- D. Therapist identifies sessions that are best examples of ability to do active teaching.
- E. Prompt therapists to use the session form as a communication tool with certified FIMPers to “spotlight” their knowledge and skill (e.g., highlight role play; explain context; say what they would have done differently).

2. Conducting the pre-review

- A. Read the session form and open the video to see the length.
- B. Choose 20 minutes to view. In general, try to choose segments from beginning, middle, and end of the category.
- C. We are looking for the potential extremes. What seems to be the “juiciest” portion of active teaching in PMTO, and what might be a “deal breaker?”
- D. Remember: We are looking for really good PMTO. We are not looking for perfection.

3. Using the form

- A. These two forms are the same. One is for using on your computer, and one is for printing out as a paper form—your choice!
- B. These forms mirror the Certification Guidelines, formatted for our scientific data collection.
- C. Notice how many “yes’s” you observe in the “Observed?” column.
- D. Notice if there are important mistakes (or lots of little mistakes).
- E. Using your best guess, rate the session as to whether you feel it meets enough criteria to pass.

4. Conducting the Fact-Finding meeting

- A. Prior to the meeting, we let therapist know that the format of the meeting is different than coaching. Whereas coaching punctuates strengths, the fact-finding meeting is more data focused. The purpose is to compare the session with the certification standards to assist the therapist in determining if the session(s) is a good one to submit.
- B. Meetings may be in-person, Skype, or telephone. Schedule for 60 minutes; aim for 30.
- C. Pre-reviewer identifies what seems to meet the criteria and what might cause a problem in the scoring standards.
- D. Be as neutral and scientific as possible (e.g., “I did not observe or read about any role playing in this session on teaching Time Out. That might make this session a no-pass.”).
- E. If needed, help therapist think about submitting another session or doing another session of that type. This is really hard for therapists to face. We need to balance support with our observed data (e.g., “I know how discouraging it can feel to have to find another session. Making a change now is more practical because it will save time. You have more access to families now than you may have in the future if you received a no-pass, which would require a resubmit.”)

5. Helpful hints

- A. Keep responsibility of the work in the therapist’s hands.
- B. Once a therapist “gets it” on a problem, be ready to offer coaching.
- C. We aim to balance coaching and support. Avoid saying, “Yes this will pass certification.”
- D. We are helping the therapists make their decisions, and this process saves time for everyone. our best estimates may be off from time-to-time. We do not have to be perfect in our pre-reviews!

Invitation to PMTO Therapist Certification Protocol

1) Trainee Requirements

- a. Trainee attended a minimum of 85% of Workshops 1-5.
- b. Trainee successfully completed the mid-course self-assessment.
 - i. Participants of the mid-course self-assessment will include the trainee, Lead Trainer or Co-Lead Trainer, Lead Coach or co-Lead Coach, or the Kansas Governing Authority member. There should be two independent raters participating. Each non-trainee participant independently completes the “readiness for certification” scale (0-5, 0 is not at all ready; 5 is very ready). The two raters will then discuss their ratings and arrive at a consensus rating if ratings are more than one point apart.
- c. Trainee must have completed three training families and have received acceptable FIMP scores on the most recent scored session.
 - i. Although exceptions are not encouraged, they have occurred in the past and could occur in unpredictable ways in the future. Any exceptions will be made as a team decision that requires consultation among the Lead Coach, Lead Trainer, ISII, and a Governing Authority member.
 - ii. Training families are considered “completed” when the therapists has covered the core PMTO content with them (i.e., through sessions on Limit Setting).
- d. Lead Coach and Lead Trainer will obtain feedback from coaches, where the coaches will provide a general rating of the therapist-in-training in each of the FIMP categories. The coach will provide feedback noting whether the therapist-in-training appears to be in the “Needs Work,” “Adequate Work,” or “Good Work” range in each FIMP category. This information will be gathered to inform the Lead Coach and Lead Trainer on a therapist-in-training’s readiness for invitation to certification.
- e. Trainee should have received a minimum of one coaching session per month on average since beginning PMTO training until being invited to certify. Trainee also should have received coaching on all PMTO core content areas (i.e., encouragement, problem solving, limit setting, monitoring/supervision, and positive involvement).
 - i. Trainee should demonstrate that she or he has incorporated feedback from coaching into future sessions.

2) Process followed by Lead Trainer and Lead Coach to determine whether to invite trainee to begin certification

- a. Lead Trainer and Lead Coach will consult with about feedback from coaches and FIMPers.
- b. Lead Trainer and Lead Coach will review coaching written feedback and scores from the readiness for certification scale that was used during the mid-course self-assessment. They may also have conversations with coaches to obtain further feedback regarding readiness for receiving an invitation to certify.
- c. Lead Trainer and Lead Coach will gather information from all of the sources listed above and hold a meeting with the Kansas Governing Authority member to finalize the decision to invite a trainee to begin the certification process.

3) Communication with the trainee

- a. When a decision has been made to extend an invitation to certification, the Lead Trainer or Lead Coach will email the trainee and other relevant parties (i.e., Kansas Governing Authority members, supervisor, FIMP Lead).

Kansas PMTO Video Recording and Uploading Protocols

Pre-certification:

1. Kansas PMTO Therapists video record all sessions with all families, including non-training families.
2. Kansas PMTO Therapists upload *all* video-recordings of training and certification families to the Kansas Session Portal. Videos should be uploaded within 48 hours of the session. Note: Session documentation is not considered complete until the video is uploaded, and the PMTO session form is completed.
3. For video recordings of *non-training* families, Kansas PMTO Therapists select video recordings to be uploaded to the Kansas Session Portal by following these criteria:
 - a. The therapist would like to receive coaching on this session. Examples: The therapist may have tried a new activity and wants to receive feedback on it; the session did not go as the therapist expected or desired; etc.
 - b. The session would provide an exemplary demonstration of PMTO for training activities of other therapists and/or stakeholders.
 - c. Non-training family sessions for which there is a request for coaching will be uploaded to a designated area. There will also be a designated area for exemplary sessions.
4. Kansas PMTO Therapists delete all video-recordings from temporary storage devices (e.g., SD cards) after they have uploaded them to the Kansas Session Portal or viewed them and determined that they will not be uploaded. Therapists should strive to have the video uploaded within 48 hours of the session as this facilitates an effective coaching process (see #3 above). All videos should be uploaded or deleted within 5 business days. Video-recordings should *not* be stored on temporary storage devices for longer than 5 business days.
5. Kansas PMTO Certification requires therapists to submit, for two certification families, four certification videos on four specific skills: (1) introducing encouragement, (2) troubleshooting encouragement, (3) introducing limit setting, and (4) troubleshooting limit setting.

Post-Certification:

1. Kansas PMTO Therapists video record all sessions with all families.
2. Annual PMTO certification has the following minimum requirements:
 - a. Therapists must (1) upload at least one family session per month and (2) participate in at least one coaching session per month.
 - b. Therapists must upload (1) all sessions on troubleshooting encouragement and (2) one session on troubleshooting limit setting.
 - c. Therapists must submit two sessions for re-certification: (1) one session on troubleshooting encouragement and (2) one session on troubleshooting limit setting.
3. Beyond the minimum requirements listed in #2, Kansas PMTO Therapists may select video recordings to be uploaded to the Kansas Session Portal for following criteria:
 - a. The therapist would like to receive coaching on this session. Examples: The therapist may have tried a new activity and wants to receive feedback on it; the session did not go as the therapist expected or desired.
 - b. The session would provide an exemplary demonstration of PMTO for training activities.

4. Kansas PMTO Therapists delete all video recordings from all storage devices (e.g., hard drives, external hard drives, SD cards) after they have uploaded them to the Kansas Session Portal or viewed them and determined that they will not be uploaded. Therapists should strive to have the video uploaded within 48 hours of the session as this facilitates an effective coaching process. All videos should be uploaded or deleted within 5 business days. Video recordings should *not* be stored on computers or other storage devices for longer than 5 business days.

Appendix O: PMTO Training Evaluation Template

A Course in the Basic PMTO Model: Promoting Stable Reunification Workshop #1 Evaluation

Thank you for taking a few minutes to complete and return this evaluation. Please answer the following questions by circling the number that best describes your response. Your comments and feedback are very important to us.

1. The materials provided in the *workshop notebook* facilitated learning PMTO.

Not at all True		Somewhat True		Very True
1	2	3	4	5

2. The materials provided in the *workshop notebook* were well-organized.

Not at all True		Somewhat True		Very True
1	2	3	4	5

3. There was a good balance of discussion and role-play in the workshop.

Not at all True		Somewhat True		Very True
1	2	3	4	5

4. Role playing during the workshop was an effective tool for mastering principles.

Not at all True		Somewhat True		Very True
1	2	3	4	5

5. The presentation style of the workshop facilitated learning.

Not at all True		Somewhat True		Very True
1	2	3	4	5

6. The workshop was well organized.

Not at all True		Somewhat True		Very True
1	2	3	4	5

7. I can teach parents “Good Directions.”

Not at all True		Somewhat True		Very True
1	2	3	4	5

8. I can teach parents to use a token system.

Not at all True		Somewhat True		Very True
1	2	3	4	5

9. I can teach parents about emotional regulation.

Not at all True Somewhat True Very True
1 2 3 4 5

10. I have a good understanding of how trauma impacts parenting and families.

Not at all True Somewhat True Very True
1 2 3 4 5

11. I can use the Questioning Process.

Not at all True Somewhat True Very True
1 2 3 4 5

12. I can use role play as an active teaching strategy.

Not at all True Somewhat True Very True
1 2 3 4 5

13. I have a good understanding of FIMP.

Not at all True Somewhat True Very True
1 2 3 4 5

14. I like to role play.

Not at all True Somewhat True Very True
1 2 3 4 5

15. At the end of these 4 workshop days, I am satisfied.

Not at all True Somewhat True Very True
1 2 3 4 5

16. The length of this workshop was:

a. Too long _____; b. Too short _____; c. Just right _____

17. What was most useful about this workshop?

18. Is there anything that could help you to learn the material better?

19. Any other comments?

Thank you!

Appendix P: KIPP Articles and Abstracts

Akin, B., Brook, J., & Lloyd, M. (2015). Co-occurrence of parental substance abuse and child serious emotional disturbance: Understanding multiple pathways to improved child and family outcomes. *Child Welfare, 94(4)*, 71-96.

This study is a mixed-methods examination of the prevalence and impact of parental substance abuse among families involved in foster care who have a child with a serious emotional disturbance. Data utilized for this study were both administrative and assessment data collected by case managers and parents as part of a federally funded demonstration project in a Midwestern state. At baseline, parent self-report and case manager ratings of family functioning found that parents affected by substance abuse fared worse in domains related to socioeconomic, parental trauma, parental mental health, and social supports when compared to families without parental substance abuse. Case managers and independent raters scored parents affected by substance abuse higher on effective parenting than parents not affected by substance abuse. While all children in the sample have a serious emotional disturbance, parents and case managers rated children's functioning higher among children whose families were characterized by parental substance abuse. These results suggest that, among families who have children with a serious emotional disturbance and are in foster care, those with and without substance abuse may represent two distinct service groups, each with a unique set of needs and contextual factors. For families with parental substance abuse, findings suggest that an appropriate child welfare response should attend to both children's and parent's behavioral health needs and include strategies that are well matched to the families' socioeconomic and social support needs.

Akin, B., Bryson, S. A., McDonald, T.P., & Walker, S. (2012). Defining a target population at high-risk of long-term foster care: Barriers to permanency for families of children with severe emotional disturbances. *Child Welfare, 91(6)*, 79-101.

Long-term foster care (LTFC) is an enduring problem that lacks evidence of effective strategies for practice or policy. This article describes initial activities of a statewide project of the national Permanency Innovations Initiative. The authors sought to: (1) verify the relevance of children's mental health as a predictor of LTFC, (2) describe critical barriers encountered by parents of children with serious emotional disturbances, and (3) identify systems barriers that hinder permanency for this target population.

Akin, B., Bryson, S., McDonald, T., & Wilson, C. (2014). A case example of the ACYF's well-being framework: The Kansas Intensive Permanency Project (KIPP). In *Integrating Safety, Permanency, and Well-being Series* (pp. 16). U.S. Department of Health and Human Services, Administration for Children and Families.

Integrating Safety, Permanency and Well-Being in Child Welfare, describes how a more fully integrated and developmentally specific approach in child welfare could improve both child and system level outcomes. The papers were developed to further the national dialogue on how to more effectively integrate an emphasis on well-being into the goal of achieving safety, permanency and well-being for every child. The third paper, *A Case Example of the Administration on Children, Youth and Families' Well-Being Framework: KIPP* (Akin, Bryson, McDonald, and Wilson), presents a case study of the Kansas Intensive Permanency Project and describes how it has implemented many of the core aspects of a well-being framework.

Akin, B., Bryson, S., Testa, M., Blasé, K., McDonald, T., & Melz, H. (2013). Usability testing, initial implementation and formative evaluation of an evidence-based intervention: Lessons from a demonstration project to reduce long-term foster care. *Evaluation and Program Planning, 41*, 19-30.

The field of child welfare faces an undersupply of evidence-based interventions to address LTFC. The Permanency Innovations Initiative is a five-year federal demonstration project intended to generate evidence to reduce long stays in foster care for those youth who encounter the most substantial barriers to permanency. This article describes a systematic and staged approach to implementation and evaluation of a PII project that included usability testing as one of its key activities. Usability testing is an industry-derived practice which analyzes early implementation processes and evaluation procedures before they are finalized. This article describes the iterative selection, testing, and analysis of nine usability metrics that were designed to assess three important constructs of the project's initial implementation and evaluation: intervening early, obtaining consent, and engaging parents. Results showed that seven of nine metrics met a predetermined target. This study demonstrates how findings from usability testing influenced the initial implementation and formative evaluation of an evidence-supported intervention. Implications are discussed for usability testing as a quality improvement cycle that may contribute to better operationalized interventions and more reliable, valid, and replicable evidence.

Akin, B., Byers, K., Lloyd, M., & McDonald, T. (2015). Joining formative evaluation with translational science to assess an EBI in foster care: Examining social-emotional well-being and placement stability. *Children and Youth Services Review, 58*, 253-264.

This study examined measures of placement stability and social–emotional well-being for a federally-funded demonstration project of in-home Parent Management Training-Oregon model (PMTO) for children in foster care with serious emotional disturbance (SED). Following a cultural exchange framework for translational research and a tollgate approach to evaluation, this formative study tested these measures prior to further investment in summative evaluation. The research aim was to observe whether measures of social–emotional well-being and placement stability performed as expected. Using a pretest–posttest randomized consent trial, children identified as SED within six months of entering foster care were randomly assigned to PMTO or to a services-as usual comparison group (N=121). A multi-group structural equation model was tested to observe the relationship of baseline social–emotional wellbeing and placement stability on post-test social–emotional well-being. Results showed that post-test well-being was significantly predicted by baseline well-being for both groups and, importantly, only the intervention group demonstrated significant effects of placement stability on posttest well-being. For the intervention group, as placement stability increased, post-test social skills significantly improved, demonstrating an association between well-being and placement stability that was not evident in the comparison group. Overall, wellbeing measures performed as expected and detected relationships between variables and variation as hypothesized. Additionally, placement stability may have been mediated by the PMTO intervention. In conclusion, by using a real world example of the translational research concept of cultural exchange between university-based researchers and agency-based practitioners, this study shows that formative evaluation offers an

important opportunity to test ad hoc research questions inspired by the process of implementation itself.

Akin, B., Mariscal, S., Bass, L., Bhattarai, J., McArthur, V., & Bruns, K. (2014). Implementation of an evidence-based intervention to reduce long-term foster care: Practitioner perceptions of key challenges and supports. *Children and Youth Services Review, 46*, 285-293.

Although a growing literature defines significant components of systematic and effective implementation of evidence-based interventions (EBIs), little information exists about real-world successes and setbacks from child welfare practitioners' perspectives. This study sought to identify key challenges and supports during implementation of an EBI to reduce long-term foster care. Semi-structured, individual interviews were conducted with 28 child welfare practitioners implementing an EBI—Parent Management Training, Oregon Model (PMTO). Transcripts were coded and analyzed using theoretical thematic analysis. Member checking was used to confirm identified themes across interviews. Using six implementation factors to organize the results, multiple facilitators and barriers were identified. Study findings suggest that implementation of EBIs in child welfare should consider promoting and ensuring: (a) a learning culture with effective communication, rapid improvement cycles, and timely feedback loops; (b) frequent, direct, supportive, and high-quality coaching and supervision; (c) strong leadership and organizational fit; and, (d) strategies for tailoring the EBI to the child welfare setting, including responses to families' multiple and complex needs and practices for effective client engagement.

Akin, B., McDonald, T., Testa, M., Melz, H., Blasé, K., & Barclay, A. (2014). Formative evaluation of an evidence-based intervention to reduce long-term foster care: Assessing readiness for rigorous impact evaluation. *Journal of Public Child Welfare, 8*(4), 354-374.

As part of the federal Permanency Innovations Initiative, this local grantee implemented an evidence-based intervention to improve outcomes for children with serious emotional disturbance. The project approach integrates the tenets of implementation science and program evaluation. Formative evaluation used a small sample (n = 76) to assess implementation integrity and statistical association to recommend whether the intervention was ready for summative evaluation (SE). Results showed that most process expectations were met. Statistical findings suggested that the intervention was associated with higher rates of reunification for treatment families as compared to families receiving services-as usual. Thus, the intervention was recommended for SE.

Bryson, S., Akin, B., Blasé, K., McDonald, T. & Walker, S. (2014). Selecting an EBP to reduce long-term foster care: Lessons from a university-child welfare agency partnership. *Journal of Evidence-Based Social Work, 11*(1-2), 208-221.

A growing implementation literature outlines broad evidence-based practice implementation principles and pitfalls. Less robust is knowledge about the real-world process by which a state or agency chooses an evidence-based practice to implement and evaluate. Using a major U.S. initiative to reduce LTFC as the case, this article describes three major aspects of the evidence-based practice selection process: defining a target population, selecting an evidence-based practice model and purveyor, and tailoring the model to the practice context. Use of implementation science guidelines and lessons learned from a unique private-public-university partnership are discussed.

Appendix Q: KIPP Practice to Policy Survey

Confidential

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2014-Practice to Policy Survey

The purpose of this survey is to identify those areas in which you feel optimally supported as KIPP Therapists and Supervisors and those areas in need of development. In addition, we want to hear from you about what you are learning so that we understand more about how you are using PMTO.

The survey is being developed in partnership with the Permanency Innovation Initiative Training and Technical Assistance Project (PII-TTAP), KIPP's technical assistance provider for the Permanency Planning Initiative (PII). So that we can more effectively target needed professional development and administrative supports, we need to know your position; thus, we are asking you to identify your position. However, we are not asking you to identify your region. The survey is entirely anonymous. The survey is being conducted in REDCap because it is the University of Kansas's (KU) primary data capture mechanism. KIPP maintains a subcontract with the KU Center for Research Methods and Data Analysis for all KIPP-related surveys.

The KU School of Social Welfare, the PII grantee, protects human subjects participating in research. This information is provided to help you decide if you wish to participate in this study. You can decide not to complete this survey and not to participate in this study. Even if you agree to participate, you are free to withdraw from the study at any time. If you do withdraw, it will not affect your relationship with KU or any other participating agency.

1) Cohort

- 1 or 2 (G 1.0)
- 3 (G 1.5)
- 4 (G 2.0)
(1 or 2=Trained in 2011; 3=Trained in 2013;
4=Trained in 2014)

2) I have read this consent and authorization form.

Yes

INSTRUCTIONS

Please indicate, using the scale below, your level of KNOWLEDGE about the following topics before and after completing PMTO training. Please use the following key for rating:

- 3) Before PMTO training: How to structure a PMTO session
 Very low Low Moderate High Very High
- 4) After PMTO Training: How to structure a PMTO session
 Very low Low Moderate High Very High
- 5) Before PMTO Training: How to teach PMTO content verbally (e.g., PMTO raps, rationales)
 Very low Low Moderate High Very High
- 6) After PMTO Training: How to teach PMTO content verbally (e.g., PMTO raps, rationales)
 Very low Low Moderate High Very High
- 7) Before PMTO Training: How to teach PMTO content actively (e.g., variety of activities, elicit goal behavior, engage family, pre-corrects)
 Very low Low Moderate High Very High
- 8) After PMTO Training: How to teach PMTO content actively (e.g., variety of activities, elicit goal behavior, engage family, pre-corrects)
 Very low Low Moderate High Very High
- 9) Before PMTO Training: How to set up roleplays
 Very low Low Moderate High Very High
- 10) After PMTO Training: How to set up roleplays
 Very low Low Moderate High Very High

INSTRUCTIONS

Please indicate, using the scale below, your level of KNOWLEDGE about the following topics before and after completing PMTO training. Please use the following key for rating:

11) Before PMTO Training: How to coach roleplays

Very low Low Moderate High Very High

12) After PMTO Training: How to coach roleplays

Very low Low Moderate High Very High

13) Before PMTO Training: How to debrief roleplays

Very low Low Moderate High Very High

14) After PMTO Training: How to debrief roleplays

Very low Low Moderate High Very High

15) Before PMTO Training: How to use process skills (e.g., questioning process, normalizes, interprets/reframes, supportive interrupts)

Very low Low Moderate High Very High

16) After PMTO Training: How to use process skills (e.g., questioning process, normalizes, interprets/reframes, supportive interrupts)

Very low Low Moderate High Very High

17) Before PMTO Training: Overall application of model (e.g., Skill Encouragement, Limit Setting, Monitoring, Problem Solving, Positive Involvement)

Very low Low Moderate High Very High

18) After PMTO Training: Overall application of model (e.g., Skill Encouragement, Limit Setting, Monitoring, Problem Solving, Positive Involvement)

Very low Low Moderate High Very High

INSTRUCTIONS

Please indicate, using the scale below, your level of SKILL about the following topics before and after completing PMTO training. Please use the following key for rating:

19) Before PMTO Training: How to structure a PMTO session

Very low Low Moderate High Very High

20) After PMTO Training: How to structure a PMTO session

Very low Low Moderate High Very High

21) Before PMTO Training: How to teach PMTO content verbally (e.g., PMTO raps, rationales)

Very low Low Moderate High Very High

22) After PMTO Training: How to teach PMTO content verbally (e.g., PMTO raps, rationales)

Very low Low Moderate High Very High

23) Before PMTO Training: How to teach PMTO content actively (e.g., variety of activities, elicit goal behavior, engage family, pre-corrects)

Very low Low Moderate High Very High

24) After PMTO Training: How to teach PMTO content actively (e.g., variety of activities, elicit goal behavior, engage family, pre-corrects)

Very low Low Moderate High Very High

25) Before PMTO Training: How to set up role plays

Very low Low Moderate High Very High

26) After PMTO Training: How to set up role plays

Very low Low Moderate High Very High

INSTRUCTIONS

Please indicate, using the scale below, your level of SKILL about the following topics before and after completing PMTO training. Please use the following key for rating:

27) Before PMTO Training: How to coach roleplays

Very low Low Moderate High Very High

28) After PMTO Training: How to coach roleplays

Very low Low Moderate High Very High

29) Before PMTO Training: How to debrief roleplays

Very low Low Moderate High Very High

30) After PMTO Training: How to debrief roleplays

Very low Low Moderate High Very High

31) Before PMTO Training: How to use process skills (e.g., questioning process, normalizes, interprets/reframes, supportive interrupts)

Very low Low Moderate High Very High

32) After PMTO Training: How to use process skills (e.g., questioning process, normalizes, interprets/reframes, supportive interrupts)

Very low Low Moderate High Very High

33) Before PMTO Training: Overall application of model (e.g., Skill Encouragement, Limit Setting, Monitoring, Problem Solving, Positive Involvement)

Very low Low Moderate High Very High

34) After PMTO Training: Overall application of model (e.g., Skill Encouragement, Limit Setting, Monitoring, Problem Solving, Positive Involvement)

Very low Low Moderate High Very High

INSTRUCTIONS

Please respond to each question, including a brief description in the text box following each question. Thank you.

- 35) Have PMTO trainings met your expectations? Yes
 No
- 36) Please explain briefly: _____
- 37) Would you recommend this training to others? Yes
 No
- 38) Please explain briefly _____
- 39) What have you liked most about training thus far? _____
- 40) What have you liked least about trainings? _____
- 41) How could trainings be further improved? _____

INSTRUCTIONS

Please indicate, using the scale below, your level of satisfaction.

7 = Very Satisfied

6 = Satisfied

5 = Slightly Satisfied

4 = Neither Satisfied nor Dissatisfied

3 = Slightly Dissatisfied

2 = Dissatisfied

1 = Very Dissatisfied

42) Overall, how satisfied are you that the information you received during your hiring process reflects the work you are being asked to do as a PMTO practitioner in your region?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

43) Please explain briefly:

44) Overall, how satisfied are you that the training you are receiving is preparing you to work effectively with families and children?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

45) Please explain briefly:

46) Overall, how satisfied are you that the coaching you are receiving is improving your skills and abilities to work effectively with families and children?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

47) Please explain briefly:

48) How satisfied are you that the challenges you encounter in providing effective services are understood in your agency?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

49) Please explain briefly:

INSTRUCTIONS

Please indicate, using the scale below, your level of satisfaction.

7 = Very Satisfied

6 = Satisfied

5 = Slightly Satisfied

4 = Neither Satisfied nor Dissatisfied

3 = Slightly Dissatisfied

2 = Dissatisfied

1 = Very Dissatisfied

50) How satisfied are you that the challenges you encounter in providing effective services are being actively addressed by your agency?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

51) Please explain briefly:

52) How satisfied are you that the challenges you encounter in providing effective services are understood by the KIPP Steering Committee?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

53) Please explain briefly:

54) How satisfied are you that the challenges you encounter in providing effective services are being actively addressed by the KIPP Steering Committee?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

55) Please explain briefly:

56) FOR THERAPISTS ONLY: Overall, how satisfied are you that your immediate supervisor helps you develop your PMTO skill set?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

57) Please explain briefly:

INSTRUCTIONS

Please indicate, using the scale below, your level of satisfaction.

7 = Very Satisfied

6 = Satisfied

5 = Slightly Satisfied

4 = Neither Satisfied nor Dissatisfied

3 = Slightly Dissatisfied

2 = Dissatisfied

1 = Very Dissatisfied

58) FOR SUPERVISORS ONLY: Overall, how satisfied are you that your immediate supervisor facilitates your ability to provide effective supervision, coaching, and support to therapists using PMTO?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

59) Please explain briefly:

60) How satisfied are you that your agency's administrators effectively develop the supports and conditions that make it possible for you to work effectively with children and families?

- Very Satisfied
 Satisfied
 Slightly Satisfied
 Neither Satisfied nor Dissatisfied
 Slightly Dissatisfied
 Dissatisfied
 Very Dissatisfied

61) Please explain briefly:

62) What conditions and/or factors most support your ability to provide effective services?

63) What conditions and/or factors most need development in order to enhance your ability to provide effective service?

64) What haven't we asked you about that you think it is important for us to know?
