Nebraska IV-E Waiver Final Report

Submitted to
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Executive Summary

Through a Title IV-E waiver demonstration project, the Nebraska Division of Children and Family Services (DCFS) planned to improve contractor accountability and child and family outcomes with two interventions: Results-Based Accountability (RBA) and Alternative Response (AR). RBA was meant to provide a framework and process for measuring and improving the performance of contracted service providers, which in turn was expected to improve the outcomes of children and families receiving those services. AR allowed for Nebraska's child welfare system to engage with families in a non-investigative and more collaborative way, based on the severity of allegations received at initial intake. It was also expected that this family-centered response would lead to improved outcomes for children and families participating in this approach. It should be noted that DCFS transitioned from RBA to the current contract monitoring process, Provider Performance Improvement (PPI), beginning in April 2016. Therefore, the original evaluation plan for the RBA program could not be completed as proposed; additionally, a process-only evaluation was conducted for the PPI program in order to provide DCFS with feedback about their current program. Ultimately, the evaluation of AR will contribute to an understanding of whether and how the demonstration accomplished its goals by assessing the planning and implementation process, contextual factors, and barriers and facilitators; achievement of intended outcomes; and the cost effectiveness of the intervention. DCFS contracted with the UNL-Center on Children, Families and the Law (UNL-CCFL) to conduct the program evaluation.

Alternative Response

Evaluation Overview

In accordance with Nebraska's Waiver Terms & Conditions, AR was evaluated through a randomized controlled trial. Meaning, after initial eligibility was determined, cases were randomly assigned to either AR or TR and all AR-eligible families were included in the evaluation. AR-eligible cases assigned to TR constituted the control group, allowing UNL-CCFL to draw conclusions about the effect of AR on key child and family outcomes when compared to traditional case practice. To assess the processes, outcomes, and costs associated with AR, UNL-CCFL compiled and examined a variety of data sources. Refer to *Appendix A: Summary of Evaluation Data Sources and Data Collection* for detailed information about these data sources.

Evaluation Findings

- Stakeholder and Community Engagement
    - Regular meetings occurred throughout the demonstration with external and internal stakeholders. These meetings allow for DCFS to share project implementation and evaluation updates. External stakeholders were asked to provide feedback on opportunities for growth, especially during early planning and implementation of the AR program. Internal stakeholders were asked to share experiences from the field and to discuss suggestions to improve the program among administrators and staff. Engagement with external stakeholders declined over the course of the demonstration, particularly after the AR program was expanded statewide and the program manual became more solidified.
    - External and internal stakeholders were surveyed in December 2014 and again in October 2017. Overall, findings from the survey efforts were positive. Stakeholders

expressed general buy-in for the goal of the AR program; however buy-in for specific program elements was mixed. The results suggested that communication could be improved between DCFS and all stakeholders. Additional efforts should be made to actively engage stakeholders in meaningful discussions and involve them as active participants in the decision-making process. Current stakeholders also noted gaps in representation (including families and community service providers).

- Staff Qualifications, Training, and Support
    - The initial training for AR was conducted by UNL-CCFL. This training included a broad range of staff involved in the delivery of child welfare services. According the majority of participants' ratings on reaction-level measures, AR-related trainings were well-received and allowed for participants to gain new information about the AR program in a satisfactory way. Additionally, training for front-line staff included a pre and post knowledge assessment. This test indicated significant gains in participants' understanding of AR knowledge as the result of attending training.
    - In January 2016, a Project Harmony assumed responsibility for AR training. The evaluators were unable to obtain the curriculum needed to develop a knowledge assessment. All AR training from January 2016 forward only includes reaction-level measures. According to the new reaction-level measures, trainees still indicated positive reactions to the AR training.
    - In January 2019, AR training transitioned back to UNL-CCFL. AR training for front-line staff was incorporated into the new worker training model, meaning new workers attending AR training regardless of whether they were expected to assigned AR cases or not. Reaction-level measures continued to indicate favorable reactions to the AR training.
    - The evaluators requested HR data related to the AR hiring processes and the composition of the applicant pool. It is unclear to what degree the original competency-based hiring process was used to select AR workers. It appears AR staff were largely assigned to take on this role. Additionally, it was discovered that education degree information for DCFS job applicants is not stored in a database as originally thought; therefore this research question could not be addressed.
    - Based on interviews with RED team members, RED team reviews are seen as fair, having the right composition of people participating, and that everyone has the opportunity to voice their concerns. However, less than half of the participants said that the RED team review process worked well or was a good use of time. Additionally, over half of the participants not only felt that their interpretations of the RED team review process changed over time, but interpretations of the RED team review criteria changed over time as well. However, many of the participants indicated that they felt adequately trained and that they were pleased with the guidance and support they've received.
    - Based on interviews with intake staff, the AR screening process is working well. A majority of the participants said that they received enough training prior to implementing the AR screening process, but they also indicated that ongoing training would be helpful. Particularly since some said that their interpretations of the exclusionary and RED team criteria have changed over time. However, many participants indicated that they have been pleased with the support and guidance they've received. Additionally, the AR screening process does not appear to be seriously impacting workload for Intake staff.

- Exclusionary and RED Team Criteria
    - The most frequently selected exclusionary criteria were those related to use of controlled substances, domestic violence, and abuse/neglect of a child. Overall, 91% of intakes were excluded, meaning only 9% of intakes were eligible for AR.
    - Overall, only 4% of intakes had a RED team criterion applied. The most frequently selected RED team criterion was related to physical abuse that did not rise to the level of the exclusionary criterion.
    - According to RED team documentation provided by DCFS, the RED team reviewed an average of 41 intakes per month. The number of intakes reviewed each month increased over time as more counties implement the program. On average, 3 intakes were reviewed per meeting (ranging from 1 to 12). Additionally, meetings included 4 individuals and lasted approximately 5 minutes per intake, on average.
- Response Reassignment
    - Families may be reassigned from AR to TR if circumstances change or information is learned about the family after the initial intake that warrants heightened concerns.
    - Overall, approximately 15% of AR cases were reassigned to TR. The most frequent reason was due to a correction or update to the Intake Screening Decision, Response Priority, or Alternative Response Ineligible Criteria.
- Program Data and Fidelity
    - UNL-CCFL worked with DCFS to negotiate and execute data sharing and confidentiality agreements to access AR program data collected through the DCFS administrative data system, N-FOCUS. Multiple confidentiality and data sharing agreements were executed and a protocol was established to allow the evaluators to access downloadable data extracts via a secured web-based site internal to DCFS. Substantial effort was expended by DCFS staff to program weekly and monthly reports. Full downloadable access to the data extracts was accomplished by the end of the first quarter of AR implementation.
    - Additionally, as a critical component of the evaluation of the AR program, a comprehensive review of AR case practice was proposed to be completed through a case file review process. Although UNL-CCFL had originally intended to partner with DCFS to conduct fidelity reviews to inform statewide rollout of the AR program, ongoing challenges were experienced throughout the demonstration period, resulting in delayed access to case files and limiting the review to an assessment of fidelity in order to mainly serve as context to the larger outcome evaluation. Ultimately, printed AR case files were given to the evaluators in February 2019.
    - In general, when reviewed cases were problematic, it was due to very little substantive information or repeated information throughout the case file. Minimal efforts on behalf of some CFS Specialists were observed through delayed contacts, poor information gathering, and sparse documentation. However, many CFS Specialists demonstrated an understanding of the Alterative Response philosophy and strongly displayed these concepts through their casework. For cases that appeared to have worked well, common characteristics were observed: 1) identified concerns were addressed; 2) family issues outside of the Intake report were identified; 3) good report and engagement was evident through quality information; and 4) parents appeared to have been provided support to better meet their child(ren)'s needs. When these characteristics were present, associated improvements in the family's stability due to DCFS involvement was observed.

- Safety Assessments
    - The overwhelming majority of AR-eligible families that were assessed for safety (97% of AR and 95% of TR) were found to be safe, compared to conditionally safe or unsafe. In fact, AR families are nearly twice as likely to be found safe compared to AR-eligible TR families
    - This finding supports the research question that AR families are as safe (or safer) than TR families; however, it also brings the safety assessment conclusions into question, as equivalent groups should result in no differences in safety assessment determinations.
- Family Needs
    - For all AR-eligible families that presented with needs, the most common needs were in the areas of parenting skills, child's emotional/behavioral adjustment, mental health of a child, and material needs.
    - Looking at the differences between AR and TR families, AR families were more likely to be identified as having needs related to physical health of an adult, management of resources, and material needs. TR families were more likely to present with needs related to parenting skills, social supports, and the physical health of a child. Both AR and TR workers indicated that they were able to address family needs through their work with the family; however, workers indicated that they were significantly more likely to address the needs of AR families than TR families regarding material needs, employment, and needs associated with the mental health of a child. Furthermore, both AR and TR workers indicated that they were able to improve the families' needs at least somewhat. Workers indicated a significantly greater improvement for AR families related to education, transportation, and material needs, while a significantly greater improvement in needs associated with domestic violence were found for TR families.
- Services Provided to Families
    - AR families were more than twice as likely to receive a service compared to TR families. AR families also received a greater variety of services. For contracted services documented in N-FOCUS, the two most common types of services provided for both AR and TR families were around family support services and travel time/distance. AR families were more likely to receive services related to material needs, while TR families were more likely to be provided services around out out-of-maintenance, parent time/supervised visits, and were more likely to be drug tested.
    - According to the worker survey, the most commonly provided services for AR and TR families were related to mental health, social support services, and services to address material needs. AR families were more likely to receive mental health services, services to address material needs, and transportation services. The most common categories of service providers were mental health providers, neighbors/ friends/ extended family, and schools for both AR and TR families; however, AR families were more likely than TR families to receive services from mental health providers, neighborhood organizations, mental retardation/developmental disability (MR/DD) providers, youth organizations, legal service providers, or contractors.
- Match Between Needs and Services
    - Most workers reported that they were able to match services to the needs of the family; there was no difference between AR workers' reported a greater degree of match compared to TR workers.

    - The majority of AR-eligible families indicated that they received the help that they needed; however, AR families reported this significantly more frequently than TR families. Additionally, AR families were significantly more likely to report that the support and services they received was the kind of help they needed. Both AR and TR families reported that the supports and services received were enough to really help them.
- Timeliness of Service Delivery
    - Based on administrative data, TR families appear to receive services significantly sooner than AR families, with TR families receiving services approximately two weeks sooner than AR families. However, AR workers are reporting significantly more often than TR workers that services are provided within 1-2 weeks, 2-3 weeks, 3-4 weeks, or more than 4 weeks. From the family's perspective, most AR-eligible families indicated receiving support or services when they needed it; however, AR families reported this significantly more often than TR families.
- Barriers to Providing Services
    - Across all AR-eligible families, nearly half of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by other pressing cases on their caseload, and limited staff time to work with families. AR workers were significantly more likely than TR workers to report barriers due to caseload, other pressing cases, and limited time. However, TR workers were significantly more likely than AR workers to report barriers due to limited funds or to report no barriers were experienced.
- Family Engagement
    - AR families reported they were more satisfied with their experience with DCFS than TR families. Likewise, AR families were more likely to report that their family is better off due to their involvement with DCFS than TR families.
    - Family engagement was measured from the family's and the worker's perspectives. AR families reported greater levels of buy-in and receptivity, better relationships with their worker, lower mistrust, and greater overall engagement than TR families. Workers reported that AR families had greater levels of receptivity, buy-in, and greater overall engagement than TR families.
    - AR families were more likely to report having a collaborative relationship with their worker and were more likely to report that they learned a skill or received a service that made them feel like a better parent, allowed their child to be safer, and helped them provide necessities.
- Family and Child Protective Factors
    - Of the six protective factors assessed, two protective factors (knowledge of parenting and child development; and social and emotional competence of children) significantly improved from the beginning to the end of the case for AR families. No significant differences in protective factors were observed between AR and TR families at the end of the case.
- Child Well-Being
    - AR children showed improvements in three domains of well-being (emotional symptoms, hyperactivity, and conduct problems) from the beginning to end of the case. However, the domain of prosocial behavior was found to be lower at the end of the

case, which is opposite of what was hypothesized. Ultimately, three of the four significant differences were in the hypothesized direction.
    - AR children exhibited higher well-being in one domain at case closure, compared to TR children. According to workers' responses, AR children were perceived to exhibit significantly higher prosocial behavior at case closure, compared to TR children. This significant difference was in the hypothesized direction. The remaining well-being domains were equal for AR and TR children.
- Children and Family Services Organizational Outcomes
    - The evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.
    - In order to assess the CFS workforce composition becoming more social-work oriented, self-reported educational data were obtained from tables within Nebraska's published Annual Progress and Services Reports from 2012 to 2018. Overall, the trends of self-reported degree do not support the hypothesis that the CFS workforce has become more social work oriented during the implementation of AR. Additionally, the percentages of trainees, workers, and supervisors with a social work-related degree either remained stable or decreased over the course of the demonstration period.
    - To assess the hypothesized change in job satisfaction over time, UNL-CCFL originally planned on using DCFS Human Resources job satisfaction survey data that is collected annually. However, it was later discovered that these data could not be disaggregated to an individual level to permit the necessary breakdowns to analyze differences between AR and TR-involved staff. Instead, UNL-CCFL distributed a brief survey and facilitated focus groups with a small sample of workers. Results support the hypothesis that AR workers experience higher job satisfaction, especially for those workers who are able to primarily carry AR caseloads.
    - When assessing for differences in the turnover rates for AR and TR CFS Specialists, involvement in AR was defined 2 ways: 1) working on AR cases during or prior to the given time period, and 2) having received AR training during or prior to the given time period. Because AR workers make up such a small percentage of the CFS workforce, the AR turnover rate fluctuated substantially throughout the demonstration project. Ultimately, there were no differences in the average turnover rates for AR and TR CFS Specialists, regardless of how AR involvement was defined.
- Recurrence and Permanency analyses
    - There was a significant relationship between repeated accepted Intakes and track assignment. Furthermore, when controlling for risk, a significant increased probably of repeated accepted reports was observed for TR families compared to AR families.
    - The relationship between number of subsequent substantiations and track assignment was also significant. However, neither of the examined models were significant; this may have been due to the small sample size.
    - Although the overall relationship between out-of-home removals and track assignment was not significant at the family level, it was significant at the individual level, indicating a significant difference in out-of-home placements for individuals assigned to the AR and TR programs.

- Cost Analysis
    - In general, average worker costs for time spent in direct contact with families, time spent on behalf of families, and time spent altogether on a case, were significantly higher for AR families than TR families.
    - For AR-eligible families that received services, TR families experienced significantly higher average service costs and total costs, compared to AR families; however, the average cost of worker time was not significantly different between AR and TR families receiving services.
    - The majority of administrative costs were for supervisors, upper-level administrators, RED team, and AR-related trainings. Overall, administrative costs have fallen since initial implementation and statewide rollout. This is likely due to moving past start up needs and expansion of program implementation.

Results-Based Accountability

Evaluation Overview

In accordance with Nebraska's Waiver Terms & Conditions, RBA was planned to be evaluated through a longitudinal research design. For the contracted provider outcomes and the DHHS performance-based contracting outcomes, outcomes were to be measured multiple times across the life of the project, but there was no pre-intervention data against which to compare. For the DCFS child and family outcomes, outcomes were to be compared pre- and post-RBA implementation. Refer to *Appendix A: Summary of Evaluation Data Sources and Data Collection* for detailed information about the RBA data sources.

RBA was launched statewide on July 1, 2014. However, DCFS decided to shift from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. Due to this change in programs the evaluation team was unable to assess many aspects of RBA, specifically: contracted provider outcomes, DHHS performance-based contracting outcomes, and DCFS child and family outcomes were unable to be assessed. This report summarizes the findings for the RBA program during the demonstration period of July 2014 through October 2016.

Evaluation Findings

- Contracted Provider Understanding and Buy-In
    - A survey was administered to contracted providers in January 2015, near the beginning of implementation. The results revealed a number of strengths and challenges for the newly implemented program. Respondents generally agreed with the need for increased accountability, and felt that RBA aligned well with their own agency priorities. Participants understood their role and the department's expectations of them regarding RBA, and for the most part, they were able to compile and enter their data without much difficulty. Most respondents appeared to recognize DCFS' commitment to RBA, and acknowledged the department's recent history of collaboration with them. However, the RBA performance measures were generally not accepted as important, relevant, or accurate indicators of successful outcomes. Many of the participants did not feel a sense of ownership in the system, and did not see value in the data that was being compiled and reported monthly. There was some skepticism about how the RBA program would be used by the department in the coming years. There was also

dissatisfaction with the limited role providers had played in the development and refinement of the performance measures.
    - Additional surveys with contracted providers subject to RBA were planned, but not administered due to the shift in programs.
- Children and Family Services Performance-Based Contracting Outcomes
    - A survey was developed to assess program fidelity, perceptions of the RBA program, challenges, and barriers to implementation for DCFS staff involved in RBA implementation; however, it was not distributed due to shifts in the program.
- Contracted Provider and Child and Family Outcomes
    - Based on the RBA model, provider changes are brought about through Turn-the-Curve (TTC) discussions. Once performance measure baseline data was established, DCFS was meant to partner with provider agencies to collectively review the data and determine whether or not they are satisfied with the direction the baseline data appears to be heading. If not, the team decides what actions need to be taken to "turn the curve" of the baseline. TTC meetings were scheduled to occur semi-annually during the RBA program's implementation.
    - Documentation of TTC meetings was reviewed for the project period between July 2015 and June 2016. It was observed that documentation was not being completed consistently. Specifically, between January and June 2016, 38% to 100% of utilized providers (depending on the service) had a TTC meeting documented. Nine providers had no documented TTC meetings during the 12-month time period reviewed. Furthermore, there was variability among individual DCFS staff in TTC documentation, indicating that follow up with these staff would likely improve future documentation.
    - Examination of child and family outcomes did not occur, as logical links between the RBA performance measures developed by the department and the child and family outcomes outlined in the Waiver Terms and Conditions were never established.
    - Ultimately, no further examination of these outcomes was possible, due to program shifts.
- Cost Analysis
    - The greatest costs associated with RBA were for personnel. Overall, personnel and total costs were increasing each quarter from October 2014 through October 2016.
    - Average rates for agency supported foster care and family support services remained steady pre- and post-RBA. Average rates for intensive family preservation nearly doubled.
    - A supplemental case study was conducted with RBA providers to gather provider costs incurred due to participation in RBA. The highest costs directly related to RBA were associated with collecting and analyzing RBA data. However, the majority of costs were associated with time spent filling out our case study survey.

Provider Performance Improvement

Evaluation Overview

DCFS shifted from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. This program was initially piloted with some provider agencies in July 2016, with full implementation occurring in October 2016. According to DCFS, the purpose of PPI is to improve the outcomes of children and families that receive one or more of the most frequently provided services from a private agency contracted with DCFS. This includes: family support (in-home and out-of-home),

intensive family preservation, and agency supported foster care. This program has evolved over time and the evaluation team at UNL-CCFL has worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, it was ultimately determined that a change mechanism could not be isolated and that a process-only evaluation would be completed for the PPI program.

Evaluation Findings

- Key Stakeholder Perceptions of the PPI Program
    - In order to gather perceptions from key stakeholders of the PPI program, three surveys were developed and administered as a part of the PPI program process study: 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. These surveys were the main means of data collection and developed in response to the research questions outlined by DCFS.
    - Overall, a number of strengths and challenges were identified for the PPI program. Identified potential areas for improvement include:
        - Additional training on the features of Salesforce may be helpful. This could be achieved through video trainings or one-on-one demonstrations.
        - The Salesforce website could be enhanced through improved email interface, inclusion of a comment section for narrative information especially regarding performance concerns, the ability to track internal issues, improved ability to sort and view data in graphs/tables, the ability to view anonymous data from providers for comparison, and access to service delivery performance data for DCFS and PromiseShip.
        - Additional training outlining job expectations for CMRD could be useful, as comments suggested that PPI updates are not being communicated thoroughly and can lead to unclear job expectations for CMRD.
        - Communications with DCFS could be improved as there seems to be a need for CMRD staff to be better informed on important issues and changes with the PPI program.
        - It is recommended that DCFS and provider agencies work collaboratively to refine the performance measures.
        - Increased communication from DCFS about how PPI data are used to inform decision-making could increase participants' understanding of the PPI program's impact.
        - Additional guidance for reviewers may be needed to improve the consistency of quality reviews as some providers indicated a lack of consistency.
        - Information about how to best access the ASFC and Placement Support Plan reports and/or regular dissemination processes may be helpful to ensure all necessary parties are receiving this information.
        - Additional meeting structure (e.g., agendas) may be helpful to improve the efficiency and usefulness of the Performance Quality Conversations.

        - Providers' implementation of action items may be improved by increased communication between DCFS, providers, and CMRD, and clearer expectations regarding goals and priorities from DCFS.
- Cost Analysis
    - The greatest costs associated with PPI were for personnel, followed by overhead and indirect costs, and software costs.
    - Overall, personnel and total costs have decreased since October 2017, and remained relatively steady throughout the remainder of the demonstration.

Major Changes to Demonstration and Evaluation

Beginning in April 2016, DCFS began the transition from RBA to PPI. While the PPI program shares a similar goal as RBA, it included a number of important changes resulting in the need to assess PPI as a separate program. The evaluation team at UNL-CCFL worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, a meeting between UNL-CCFL, DCFS, CB, and JBA resulted in the determination that the RBA program had ended and a final evaluation report summarizing any findings during its implementation would be submitted with the July 2018 semi-annual report. Additionally, through much discussion and attempt to develop a theory of change, it was ultimately determined that a change mechanism could not be isolated for the PPI program. Therefore, a process-only evaluation would be completed to examine the current PPI program's status and to provide DCFS with insights for any potential areas for ongoing program improvement. DCFS provided UNL-CCFL with their desired research questions associated with the PPI program. UNL-CCFL and DCFS worked collaboratively to define and refine these questions and ultimately developed a data collection plan to complete the PPI program evaluation.

Introduction and Overview

Background and Context

Nebraska has historically had one of the highest removal rates in the nation. DCFS sought a Title IV-E Waiver to reduce this number and thus reduce the trauma experienced by Nebraska's children when removed from their home of origin. Upon examination of data from the period between FY 2005 and FY 2011, Nebraska determined that its highest removal rates occurred for children between the ages of 0-1 year and approximately 60-70% of those removals were due to allegations of neglect. A review of Nebraska's data by county revealed a relationship between the rate of removals per 1,000 children, and the counties experiencing higher rates of poverty. Thus, to mitigate Nebraska's removal rate, Alternative Response was chosen as an intervention due to the large number of children entering foster care when the primary allegation is related to neglect. The agency's analyses suggested that providing families with interventions and resources to increase their protective factors would negate the need to remove a child from their home; ultimately reducing the trauma children experience. Nebraska sought a Title IV-E Waiver to decrease the rate of removal of children from their family home of origin and provide interventions prior to incidences of maltreatment. It was hypothesized that implementing an alternative approach to how Child and Family Services Specialists are able to work with families and provide necessary services would aid Nebraska in achieving this goal.

Prior to the start of Nebraska's Title IV-E Waiver, DCFS had been working to rebuild the child welfare system as a result of privatization efforts. Stakeholder trust in DCFS was damaged, which led to legislative intervention encouraging DCFS to apply for a waiver. DCFS desired to change this culture by concentrating on collaboration, coordination, and communication with stakeholders. Working with providers to mutually develop and monitor performance measures was hypothesized to lead to increased system accountability for performance based upon the identified milestones and indicators. Ultimately, improvements in service provision were expected to occur, which would in turn ensure that family needs would be met, thus improving the safety, permanency, and wellbeing of children and families in Nebraska.

Purpose of the Waiver Demonstration

Through a Title IV-E waiver, the Nebraska Department of Health and Human Services (DHHS) Division of Children and Family Services (DCFS) planned to improve contractor accountability and child and family outcomes by conducting a demonstration project with two interventions: Results-Based Accountability™ (RBA; now called PPI) and Alternative Response (AR).

Interventions, Components and Target Populations

As originally conceptualized in Nebraska's Waiver demonstration, RBA was designed to provide a framework and process for measuring and improving the performance of contracted service providers. The core components of RBA included:

1. Training and collaborative development of concrete performance measures that reflect how much of a service was delivered, how well the service was delivered, and the impact of the service on its target customers.

2. Written contracts between DCFS and service providers that include RBA performance expectations.
3. Use of the online Results Scorecard to store and graphically display monthly performance measure data for each service provider, to be used to monitor performance trends.
4. Semi-annual discussions between DCFS and each provider to examine performance trends, forecast future performance, identify barriers and facilitators, and develop action plans for improving performance. Subsequent discussions include follow-up on the effects of previous action plans.

Because contracted direct service providers are the recipient of the RBA intervention, they were the direct target population. As the beneficiaries of RBA, the children and families they serve were the indirect target population. DCFS anticipated that this population would include all but a small proportion of children receiving child welfare services.

In May 2016, DCFS transitioned from Results Based Accountability to the Provider Performance Improvement (PPI) program, which was developed in-house as a contract monitoring process to establish performance accountabilities and identify improvement opportunities with contracted provider agencies. According to DCFS, the purpose of PPI was to improve the outcomes of children and families that receive one or more of the most frequently provided services from a private agency contracted with DCFS. These services included: family support (in-home and out-of-home), intensive family preservation, and agency supported foster care. This program was initially piloted with a few provider agencies in July 2016, with full implementation occurring in October 2016. The program evolved over time and the evaluation team at UNL-CCFL worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, it was ultimately determined that a change mechanism could not be isolated for PPI and that only a limited process evaluation would be completed for the PPI program.

The second component of Nebraska's Title IV-E Waiver Demonstration was the implementation of Alternative Response (AR). This program was developed to allow for Nebraska's child welfare system to engage with families in a non-investigative and more collaborative way, based on the severity of allegations received at initial intake. Nebraska's AR practice model was developed to include the following:

1. A comprehensive assessment of safety and risk conducted on all cases, regardless of track assignment.
2. AR cases will not include an investigation or a formal determination as to whether child abuse or neglect has occurred, and the subject of the report will not be entered into the central registry.
3. Family-centered practice is at the center of AR. To support this, labels like "victim" and "perpetrator" would not be used; rather, family members would be referred to as "children" and "caregivers" respectively. Additionally, children would be interviewed after contact is made with the parent(s), whenever possible.
4. AR caseworkers would have weekly contact with families during the initial period of the case.
5. Families would receive services and supports faster, due to earlier assessment of the family's needs/strengths and access to flexible funding sources.
6. Because AR cases are less severe, families would have limited to no law enforcement involvement, the children would remain in the home, and the courts would not be involved. If circumstances required these interventions, then the family would be transferred to a Traditional Response.

The target population for AR included any family that does not meet one or more of the ineligibility criteria. Additionally, some families were eligible for AR based on the decision of a Review, Evaluation, and Decide (RED) team. This program included children and youth of all ages, race, and ethnicities.

Statewide, Nebraska accepts approximately 12,000 child abuse and neglect reports each year. At the outset of the demonstration, DCFS expected that AR would eventually serve 30-40% (3,600-4,800) of these families through AR. Initial implementation occurred in 5 out of 93 (5%) counties on October 1, 2014. These 5 counties represented approximately 33% (over 4,000 intakes) of the child welfare population in Nebraska. Of those, approximately 1,100 intakes (27%) were expected to be eligible for AR. A gradual phased implementation was planned after January 1, 2016, with legislative approval required for expansion after July 1, 2017.

Original Hypotheses for Results-Based Accountability

The original RBA evaluation research questions addressed three types of anticipated outcomes: 1) contracted provider outcomes, 2) DCFS performance-based contracting outcomes, and 3) DCFS child and family outcomes, as follows.

Provider Outcomes

- Through the RBA implementation process, contracted providers would a) develop an understanding of and buy-in for RBA, b) implement changes to enhance practice in their agencies, and c) achieve improvements in contracted performance measures.

DCFS Performance-Based Contracting Outcomes

- As a result of having implemented RBA, Nebraska DCFS would a) have a system for measuring and comparing the effectiveness of contracted providers, b) hold providers accountable for their contracted performance measures, and c) be positioned to make contract decisions on the basis of contractor performance results.

DCFS Child and Family Outcomes

- To the extent that contractors achieve improvements in contract performance measures through the RBA process, it is anticipated that DCFS will see improvements in associated safety, permanency, and well-being outcomes, including:
  1. Reduced maltreatment in out-of-home care
  2. Reduced likelihood of out-of-home placement
  3. Increased placement stability
  4. Increased likelihood and timeliness of reunification
  5. Increased likelihood and timeliness of adoption after TPR
  6. Reduced likelihood of discharge to independent living after 3 years
  7. Reduced likelihood of discharge to emancipation (i.e., aging out)
  8. No increase in maltreatment recurrence
  9. No increase in re-entry into out-of-home care

These hypotheses were revised, with Children's Bureau approval, to drop outcomes #6 and #7, as it became clear that the RBA intervention would not be expected to impact these outcomes. In addition, in 2017, an additional request was made to the Children's Bureau to drop outcome #5 for similar reasons.

Finally, in February 2018, in consultation with and in full approval of the Children's Bureau, the evaluation plan for RBA was abandoned entirely, in recognition of the fact that the PPI program which replaced RBA was not evaluable. A limited process evaluation of selected program elements was ultimately conducted.

Original Hypotheses for Alternative Response

The AR evaluation sought to address the following research questions:

CFS Organizational Outcomes

1. To what extent do CFS staff and supervisors understand and buy into AR?
2. To what extent do CFS staff and supervisors have the knowledge and skills they need to implement AR (including family engagement)?
3. Is AR implemented with fidelity across all participating sites?
4. Over the course of the waiver demonstration, does job satisfaction increase for staff involved in providing AR services?
5. Over the course of the waiver demonstration, is retention improved for staff providing AR services?
6. Does partnership between DCFS, community stakeholders, and provider agencies improve over the course of the waiver demonstration?

Child and Family Outcomes

1. Do families report experiencing a greater degree of respect, inclusion, and engagement when receiving AR services than when receiving Traditional Response (TR) services?
2. Do services and supports received by AR families differ from those received by TR control families?
3. Are the services received by AR families more tailored to their individual needs than services received by the TR control families?
4. Do AR families differ from TR control families in incidence of maltreatment allegations (reports) after initial intake?
5. Do AR families differ from TR control families in incidence of substantiated maltreatment after initial intake?
6. Are AR families connected to and receiving services more quickly than TR control families?
7. Do AR families differ from TR control families in removals to out-of-home care?
8. Do children and families under AR and the TR control children and families differ on measures of well-being?
9. Do caregivers under AR and the TR control caregivers differ on measures of protective factors?
10. To what extent and under what circumstances are families in the AR track reassigned to the TR track?

The IV-E Waiver Demonstration evaluation was expected to contribute to an understanding of whether and how the demonstration accomplished its goals by assessing the planning and implementation process, contextual factors, and barriers and facilitators; achievement of intended outcomes; and the cost-effectiveness of each intervention.

The Evaluation Framework

Theory of Change and Logic Model

The Nebraska Title IV-E Demonstration Project was based upon changing the culture within the child welfare system by building trusting supportive relationships with stakeholders and providers. For the proposed interventions to be successful, all providers and stakeholders needed to be engaged and willing to work together. While Nebraska was implementing two distinct interventions, the comprehensive theory of change was:

Implementing Alternative Response and RBA are mechanisms enabling DCFS to build partnerships to be more supportive
So that
Others are willing to engage with DCFS
So that
All work together to determine appropriate performance goals
So that
Milestones and indicators can be measured
And
There is accountability for performance based upon these measurements
So that
Effectiveness is increased
So that
Family's needs are met
So that
Safety, permanency and wellbeing can be improved

While this theory of change was broad and macroscopic, the capability was present to apply this logic to both interventions. The implementation of these interventions gave DCFS the opportunity to collaborate with stakeholders, providers, families, and children. The partnership with stakeholders began at the planning stage for each intervention; various stakeholders were involved and engaged throughout the planning and development process of Alternative Response while for RBA, Nebraska DCFS collaborated with providers to write service definitions and performance measures for direct services. As planning and implementation continued, stakeholders, providers, families, and children became more involved. It was expected through teamwork and engagement that all parties would be motivated to achieve the identified goals; for families it was the goals outlined in their family plan and for providers it was the effectiveness of services positively impacting safety, permanency and wellbeing outcomes.

Taking a closer look at the individual interventions, the following theory of change was developed by DCFS for the Alternative Response program and for RBA.

Nebraska is implementing Alternative Response
So that
The Nebraska Child Welfare System has more than one approach to work with children and families based on the severity of allegations and needs of the family

So that
Families are approached in a more collaborative way
And
Families are viewed as experts in their own family
So that
Families are more involved in the process early on
And
Families are active participants in the identification of their strengths and needs
So that
The root of the problem is identified
And
Families' needs are met earlier in the assessment process utilizing the appropriate services
So that
Caregivers' protective factors are increased
So that
Caregivers' ability to care for children in their own home is enhanced
So that
Safety permanency and wellbeing for children and families in Nebraska is improved

Nebraska is implementing RBA
So that
Nebraska has a way of measuring and tracking effectiveness of contracted services
And
Providers understand the measures that will be used to assess their performance
So that
Providers can develop procedures for collecting data
So that
Score cards can be completed
So that
Nebraska can examine provider performance and interpret results
So that
Results can be used to collaboratively develop action plans
So that
Service effectiveness will improve
So that
Children and Families will have an increase in permanency, safety and wellbeing

At the start of the Title IV-E Waiver in Nebraska, services provided to families through contracted service providers were not measured or monitored to determine effectiveness. Although DCFS was able to understand overall outcome measures of families, standardizing performance measures for each service was expected to lead to more effective services delivered to children and families. Standard performance measures for individual services and requiring each provider to report performance

measures was expected to enable DCFS and the service providers to monitor the effectiveness of each service. Additionally, these numbers were expected to provide DCFS the ability to glean data as to which services positively impacted family outcomes.

With DCFS' change from RBA to PPI over the course of the demonstration project, it was assumed that similar goals could be achieved. However, the mechanism to drive change in these outcomes was unclear and could not be isolated for the PPI program, and thus an outcome evaluation was determined to be no longer feasible.

Logic Models. The overall evaluation originally included three components for each intervention: a process evaluation, an outcome evaluation, and a cost evaluation. All of the logic models were collaboratively designed with DCFS and efforts were made to ensure that the models remained an accurate representation of the intervention activities. However, as noted previously, the PPI program logic was not the same as RBA, and thus this logic model does not represent PPI.

The first logic model broadly depicts the integrated process and outcomes for both RBA and AR. This multilevel model shows how RBA was primarily a system-level intervention, whereas AR was both a system-level and worker- and family-level change. In a complementary fashion, both interventions were intended to improve child safety, permanency, and well-being.

Because the two interventions served different target populations, it was important to have specific logic models for each demonstration. The intervention-specific logic models guided the evaluation by outlining the activities and processes of each intervention that were believed to impact specific child and family outcomes.

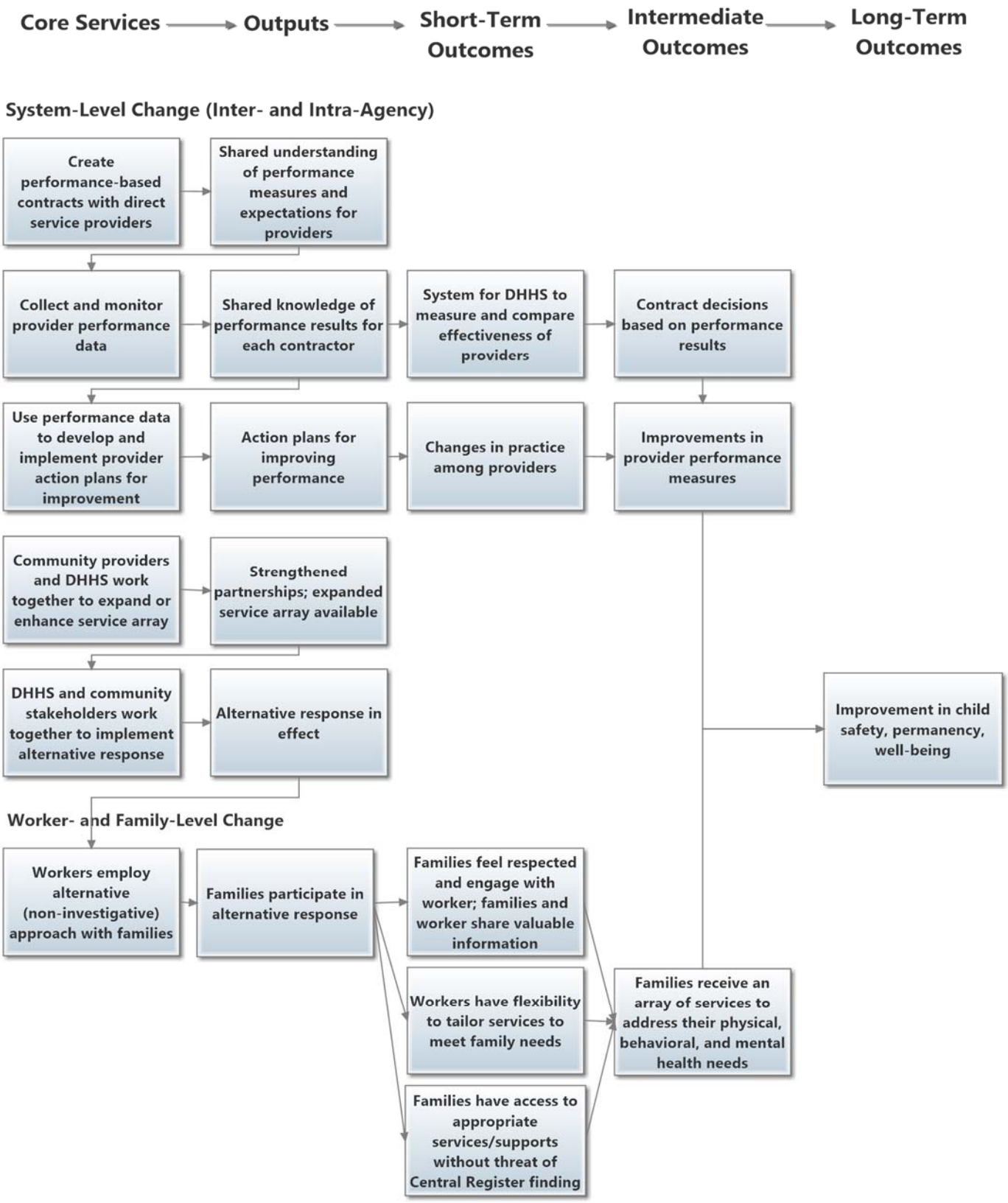
The second logic model depicts the anticipated inputs, activities, outputs, and outcomes that were originally associated with developing and implementing RBA. Note that the cycle symbol in the activities column indicates recurring activities that were expected to continue after implementation. Because time was not the most important factor in distinguishing the expected outcomes, they were instead categorized as 1) provider outcomes, 2) performance-based contracting outcomes, and 3) DHHS-CFS outcomes (safety, permanency, and well-being). Within each category of outcomes, the timing of outcomes was expected to vary. For example, within the provider outcomes category, preliminary understanding of RBA should precede practice changes, which should precede improvements in contracted performance measures.

Note that multiple changes, approved by the Children's Bureau, were made to the RBA logic model over time, in response to the realization that the RBA program would not be expected to impact adoption and independent living outcomes. As such, the revised RBA logic model follows. In 2018 it was determined that the PPI program, which replaced RBA, did not have a clear mechanism of change, and thus the RBA logic model, and its associated evaluation plan, were abandoned.

The third logic model depicts the anticipated inputs, activities/outputs, and outcomes associated with developing and implementing AR. This logic model remained intact from the beginning of AR implementation throughout the demonstration.

The following logic models are included on subsequent pages: 1) multilevel 2) original RBA, 3) revised RBA, and 4) AR program logic model.

Nebraska IV-E Waiver Demonstration Projects



RBA Logic Model

INPUTS

- RBA Committees (Sr. Leadership Team and Workgroup)
- IV-E Waiver Team
- Consultation from Results Leadership Group, Children's Bureau, & JBA
- Contractor/Provider Leadership and Staff
- Results Scorecard Software
- DHHS Office Space, Equipment, and Staff
- Contractor/Provider Office Space and Equipment
- Title IV-E Funding

ACTIVITIES

- Hold RBA Summit for providers, stakeholders, and DCFS staff
- Attend RBA train-the-trainer workshop
- Develop or customize training (NE RBA Initiative and Scorecard)
- Deliver training on NE RBA Initiative to RBA committees, DHHS staff and providers (initial and ongoing)
- Provide ongoing RD and provider support
- Develop and refine performance measures in collaboration with each provider
- Deliver RBA Scorecard training (initial and ongoing)
- Configure Results Scorecard for each provider
- Providers develop instruments or procedures for collecting performance measure data
- Create contracts with performance measures incorporated
- Providers collect performance measure data and enter into Scorecard
- Verify provider data entry and accuracy (Data Fidelity Reviews)
- Monitor provider performance and collaboratively develop action plans for improvement (Turn-the-Curve)
- Providers implement action plans
- Monitor RBA implementation and revise strategies as needed

OUTPUTS

- Providers, stakeholders, and DCFS staff attend Summit
- RBA Trainers prepared to train
- NE RBA Initiative and Scorecard training curriculum
- Staff and providers attend NE RBA Initiative training
- RD and providers receive implementation support
- Mutually agreed-upon performance measures for each provider/service type
- Providers attend Scorecard training
- Results Scorecard configured for each provider
- Instruments and procedures for collecting performance measure data
- Contracts with performance measures incorporated
- Scorecard populated with data for each provider
- Knowledge of Scorecard compliance and data accuracy
- Shared knowledge of performance results and action plans
- Knowledge of RBA implementation issues and revised strategies

OUTCOMES

Contracted Provider Outcomes

- Understanding of and buy-in for RBA process, Scorecard use, and contracting process
- Changes in practice
- Improvements in performance measures

DHHS–CFS Performance-Based Contracting Outcomes

- System for measuring and comparing effectiveness of providers
- Providers held accountable for performance measures
- Contract decisions based on performance results

DHHS–CFS Child and Family Outcomes

SAFETY

- Reduced entry into out-of-home care
- Reduced maltreatment in out-of-home care
- No increase in maltreatment recurrence after discharge or closure

PERMANENCY

- Improved placement stability
- Increase in timely reunification and adoption
- Reduced discharge to independent living after extended time in out-of-home care
- Reduced discharge to emancipation
- No increase in re-entry into out-of-home care

RBA Logic Model – rev. 02/04/15

INPUTS

- RBA Committees (Sr. Leadership Team and Workgroup)
- IV-E Waiver Team
- Consultation from Results Leadership Group, Children's Bureau, & JBA
- Contractor/Provider Leadership and Staff
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- DHHS Office Space, Equipment, and Staff
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- Reduced discharge to emancipation
- No increase in re-entry into out-of-home care

Nebraska ALTERNATIVE RESPONSE IMPLEMENTATION Logic Model DRAFT version 8 06/18/14

Inputs	Implementation Driver	Activities	Outputs
Nebraska Legislature & NE Children's Commission; Director's Steering Committee, Statewide Advisory Team, Internal Workgroups	Stakeholder Engagement	Advisory and local leadership bodies meet regularly	Advisory and local leadership bodies review & make recommendations on AR program components, implementation plans and data to DHHS
IV-E Waiver Leadership Team; CFS Operations Strategic Plan	Leadership	Develop strategic plan for AR implementation (IDIR) structures, financial, human resources, training, sustainability	Receive approval to implement AR according to IDIR
DHHS Employees	Selection	Identify staff/supervisor qualifications and competencies for AR	Assess interest and select staff/supervisors
		Integrate identified competencies into CFS hiring process for future new staff/supervisors	
DHHS HRD Unit and Contracted Training Provider	DHHS Training & Coaching	Identify training needs for AR	Develop multiple levels of AR training curricula
		Deliver AR training to necessary staff	Participants attend AR training
DHHS CQI Framework	Performance Assessment	Develop staff/supervisor performance measures	Evaluate performance and provide feedback
DHHS Comm. Unit and Consultants; DHHS Contracted Service Providers and Local Community Resources	Systems Intervention (Communications, Service Array)	Develop and deliver AR communication to all levels	Sustain involvement of leadership (internal and external) in communication role
		Assess community readiness (current services, resources, gaps, and organizational readiness for implementation)	Community resources, gaps, and organizational readiness for implementation is identified
		Create plans with community providers for development of new or expanded capacity of current services	Establish contracts to provide services
Nebraska Statute Authorizing AR; Title IV-E Funding; DHHS Office Space and Equipment	Facilitative Administration (e.g., Policy and Practice)	Determine and incorporate needed policies and/or regulation changes	Disseminate policy/regulation changes (including thru training)
DHHS N-FOCUS and CQI Systems	Decision Support Data Systems	Identify N-FOCUS changes needed to support work performed under AR track	Modify N-FOCUS to reflect AR case practices
		Develop CQI feedback mechanisms for AR program monitoring	Incorporate into CQI monthly meeting
		Identify data required by oversight bodies and evaluators	Develop schedule to pull data

Outcomes

Short Term Outcomes

- Stakeholders and community members are engaged and offer meaningful input in program development and implementation
- Staff have the necessary qualifications and competencies to do AR
- Understanding of and buy-in for AR program
- Community providers work together and with DHHS to expand or enhance services/supports

Intermediate Term Outcomes

- Ongoing monitoring and revision of implementation plans with stakeholders
- CFS applicant pool draws more individuals with SW experience and degrees
- CFS staff receive the training, supervision and supports needed to perform the work
- AR program is implemented with fidelity across the entire state
  - AR workers do not use the labels of "victim" or "perpetrator" and no one is placed on the Central Register
  - AR workers have flexibility to tailor services to meet family needs
  - Families feel respected and engage with AR worker
  - Families and workers share valuable information
  - Collaborative problem solving and learning occurs
  - Families receive services/supports to address their specific needs sooner
  - Protective factors are enhanced
  - Families can safely care for their children in home
- AR case practice is documented in N-FOCUS
- AR program data is available

System / Child and Family Impacts

CFS Org Outcomes

- Strengthened partnership between DHHS, provider agencies, and community stakeholders
- Agency workforce composition becomes more SW oriented
- CFS staff and supervisors doing AR have increased job satisfaction
- Retention for CFS staff improves

Child and Family Outcomes

SAFETY

- Lowered repeat maltreatment allegations (screened in reports)
- Lowered substantiated maltreatment allegations
- Number and proportion of families that switch from AR to TR
- Increased timeliness of service delivery

PERMANENCY

- Lowered entries (removals) to out of home care

WELL-BEING

- Improved child and family behavioral and emotional functioning, physical health and development
- Increased child and family engagement
- Improved adequacy of services and supports to meet the family's needs after the initial report

Overview of the Evaluation

The overarching research methodology differed for the original two interventions (RBA and AR), as described below. It is important to note that the RBA program was dropped by DCFS in 2016 and replaced by the PPI program, which was determined to be not evaluable. However, the UNL-CCFL evaluators, in conjunction with the Children's Bureau, JBA, and DCFS representatives, agreed to conduct limited process monitoring of the PPI program to provide DCFS with valuable feedback on program implementation.

Results-Based Accountability. DCFS implemented RBA statewide on July 1, 2014, and stopped using RBA (to transition to PPI) in 2016. Because RBA was implemented statewide for all contracted providers at the same time, it was not possible to use a concurrent control or comparison group to assess its effect. Moreover, due to the absence of any previous contract management system, there was no historical data for some of the outcomes, which precluded comparison of pre- and post-implementation results for those outcomes. Thus, different categories of RBA outcomes called for different research methods. For the *contracted provider outcomes* and the *DCFS performance-based contracting outcomes*, a one-group, post-test only design was planned, with all of the outcomes measured multiple times across the life of the project to allow for assessment of post-intervention changes across time. Because RBA was likely to have a gradual effect (the full process and outcomes will likely take time to unfold), the evaluation team had planned to use *treatment partitioning* (Cook & Campbell, 1979), which involves dividing the single treatment group (i.e., all post-RBA cases receiving an RBA service) into multiple treatment groups, based on their participation in RBA. The evaluators had planned to create an *RBA Engagement Index* to assess various factors of program engagement among providers. For the *child and family outcomes*, an ambidirectional (both retrospective and prospective) cohort design was planned, to compare outcomes for entry cohorts of children and families receiving one or more RBA service prior to and after RBA begins on July 1, 2014. However, the child welfare system in Nebraska underwent a significant change in practice prior to 2012 and DCFS elected not to include historical data prior to this shift. In general, the biggest challenge with the planned longitudinal research design was that it would not permit causal inferences. Due to a number of inherent threats to internal validity, any conclusions about the effectiveness of RBA were recognized to be speculative.

With the change from RBA to the PPI program, insufficient time had elapsed in which to accrue enough cases under RBA to permit the RBA outcome evaluation to be conducted. Process and cost evaluation was conducted up until the time of the program change, as well as a sub-study in which the evaluators examined the costs incurred by a number of selected providers as a result of participating in the RBA program. Once the PPI program began, the evaluators conducted a limited process evaluation of PPI to provide DCFS with program implementation feedback.

Alternative Response. In accordance with Nebraska's Waiver Terms & Conditions, AR was evaluated through a randomized controlled trial (RCT). This research method was selected in order to limit sample bias and permit conclusions about how AR affected key child and family outcomes when compared to traditional case practice. Additionally, the evaluation team planned to examine certain organization outcomes (e.g., worker job satisfaction) by examining longitudinal trends. The evaluation included extensive process and cost elements, in addition to all elements depicted on the logic model. However, measurement of some logic model elements (notably, those associated with the organizational

outcomes of job satisfaction, social work background, and the retention of staff) were ultimately limited by the availability of less-than-optimal data sources.

Data Sources and Data Collection Methods

Outputs and Output Measures

Results-Based Accountability. The key inputs, activities, and outputs associated with developing and implementing RBA were studied as part of the process evaluation of RBA. Both objective information and subjective judgments were gathered about the aspects of interest. Examples included such things as the purpose and scope; people involved; the timing, frequency, or duration; decisions; procedures followed; work products; facilitators and barriers; lessons learned; and fidelity of implementation.

Alternative Response. As with RBA, the process evaluation for AR examined the key activities and outputs necessary for development and implementation of the demonstration project. Both objective data (where available) and subjective perceptions and judgments were collected where feasible. For some process elements, achievement of a milestone or completion of the activity will be assessed through examination of agency meeting documentation such as minutes and records of decisions made. Examples of specific, quantifiable output measures included: number of training sessions held, number and types of participants (in trainings and meetings), trainee satisfaction ratings, trainee knowledge test scores, number of intake reports that are ineligible for AR, number of reports screened in as eligible for AR, number of intakes referred to the RED team, number of staff implementing AR and TR, and some implementation fidelity measures. Participant perceptions were collected for many of the process components through interviews, surveys and focus groups.

Outcomes/Outcome Measures

Results-Based Accountability. The RBA evaluation was designed to address three types of anticipated outcomes: 1) contracted provider outcomes, 2) DCFS performance-based contracting outcomes, and 3) DCFS child and family outcomes. Due to the program stoppage, data were only available to be collected to assess provider outcomes (such as providers' understanding and buy-in for RBA, and changes to practice within the provider agency) and DCFS performance-based contracting outcomes (such as the agency's use of contractor performance results to make contract decisions). The DCFS child and family outcomes were unable to be assessed due to the short period of time for which the RBA program was implemented.

Process evaluation data was collected on limited PPI program elements. In order to examine the PPI program, DCFS presented UNL-CCFL with research questions related to the PPI program. The evaluators worked collaboratively with DCFS to understand and clarify the identified data elements. Data sources and collection methods were identified and a data collection plan was created, which included the development and administration of three separate surveys to assess the perceptions of 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. Additionally, a review of relevant PPI/Salesforce website data was conducted. Individual reports were provided to DCFS summarizing the findings from each survey. No outcome evaluation data was able to be collected on the PPI program.

Alternative Response. The evaluation of AR was focused on short-term outcomes, intermediate outcomes, impacts on the child welfare agency/system, and child and family impacts, as follows.

Short-term outcomes

1. Stakeholders and community members are engaged and offer meaningful input in program development and implementation
2. Staff have the necessary qualifications and competencies to do AR
3. Understanding and buy-in for AR program is developed
4. Community providers work together and with DCFS to expand or enhance services and supports

Intermediate outcomes

1. Ongoing monitoring and revision of implementation plans occurs with stakeholders
2. CFS applicant pool draws more individuals with social work experience and degrees
3. CFS staff receive the training, supervision and supports needed to perform the work
4. AR is implemented with fidelity across the entire state
5. AR workers do not use the labels of "victim" or "perpetrator" and no one is placed on the Central Register
6. AR workers have flexibility to tailor services to meet family needs
7. Families feel respected and engage with AR workers
8. Families and workers share valuable information
9. Collaborative problem solving and learning occurs
10. Families receive services/supports to address their specific needs sooner
11. Protective factors are enhanced
12. Families can safely care for their children in home
13. AR case practice is documented in N-FOCUS
14. AR program data is available

System/child and family impacts

CFS Organizational Outcomes

1. Strengthened partnership between DCFS, provider agencies, and community stakeholders
2. Agency workforce composition becomes more social work oriented
3. CFS staff and supervisors doing AR have increased job satisfaction
4. Retention for CFS staff improves

Child and Family Outcomes

The following outcome measures were assessed in the AR outcome evaluation:

1. Lowered number and proportion of repeat maltreatment allegations (screened in reports)
2. Lowered number and proportion of substantiated maltreatment allegations
3. Number and proportion of families assigned to AR track who are re-assigned to a traditional maltreatment investigation due to an allegation of maltreatment that warrants heightened concern regarding the safety of one or more children
4. Lowered number and proportion of entries (removals) to out-of-home care
5. Improved child and family behavioral and emotional functioning, physical health and development

6. Increased child and family engagement
7. Improved adequacy of services and supports to meet the family's needs after the initial report

Cost Evaluation Measures

Cost evaluation data were gathered to assess costs of the RBA and AR program implementation, as well as case-level costs of AR. In addition, a sub-study was conducted with a small number of providers to assess provider-level costs of implementing the RBA program.

Sampling Plan

Results-Based Accountability and PPI. The direct target population for RBA was contracted direct service providers. At the start of the Waiver demonstration, there were 75 providers that were contracted to provide direct services, and 100% of them were expected to participate in RBA starting on the implementation date. The following direct services were originally included in the RBA evaluation:

1. Agency-supported foster care
2. Drug screening and testing,
3. Group home A
    a. Group home A refers to a facility that provides supervision 24 hours a day, 7 days a week.
4. Group home B
    a. Group home B refers to a facility that provides supervision during awake hours only.
5. Shelter care
6. In-home safety services
7. Family support services
8. Intensive family preservation
9. Agency-supported respite care

The indirect target population was child abuse or neglect cases in which a child (or the child's family) receives one or more of the contracted direct services. DCFS anticipated that this population would include all but a small proportion of children receiving child welfare services. RBA was intended to apply to all open cases at the time of implementation, but the evaluation was designed to focus on entry cohorts.

The reconceptualization of the RBA program into PPI included DCFS' decision to limit PPI to a smaller number of provider services. According to DCFS, the purpose of PPI was to improve the outcomes of children and families that received one or more of the most frequently provided services from a private agency contracted with DCFS. Thus the PPI program targeted: family support (in-home and out-of-home), intensive family preservation, and agency supported foster care. For the RBA data, no sampling of the relevant populations occurred. For example, RBA (and later, PPI) surveys were sent to all relevant providers and all relevant DCFS staff.

Alternative Response. The target population included children entering the child welfare system that were eligible for AR. According to 2012 data, Nebraska accepted approximately 12,000 child abuse and neglect intakes, statewide, each year. By the end of the demonstration period, DCFS expected to serve

30-40% (3,600-4,800) of these families through AR. Initial implementation occurred in 5 out of 93 (5%) counties on October 1, 2014. All cases that were AR-eligible were randomly assigned to either the AR or TR group, using a randomizer that was programmed into the state's NFOCUS computerized case management system. Thus, there was no sample selection for child welfare cases. For surveys, such as the end-of-case worker and family surveys, all AR-eligible cases (that were randomized to AR or TR) were included in the survey outreach.

Data Analysis Plan

Process Data Analysis Plan

Results-Based Accountability/PPI & Alternative Response. A number of the process elements were assessed through qualitative data that were reviewed and summarized. For example, descriptive information about the development of AR trainings was of limited volume and was summarized without the need for statistical analyses. Survey comments and interviews were tabulated and summarized. Quantitative data, such as training evaluation or survey ratings, were analyzed using SPSS or, for survey data, using the descriptive statistics available in Qualtrics. Significance testing was performed when appropriate for assessing differences across time or among subgroups.

Outcome Data Analysis Plan

Results-Based Accountability/PPI. For the *contracted provider outcomes* and the *DCFS performance-based contracting outcomes* categories, there was a limited amount of qualitative and quantitative data gathered before the RBA program ended. Qualitative data, such as interviews with the small number of DCFS administrators were reviewed and summarized without rigorous coding.

Quantitative outcome data about RBA and PPI included survey results and Scorecard data, which were analyzed using descriptive statistics via SPSS.

Alternative Response. For the *CFS organizational outcomes*, data were not made available until the last year of the demonstration. Quantitative data were obtained from agency reports and a self-reported educational background database. Outcome analyses include descriptive statistics and t-tests performed in SPSS.

For *child and family outcomes*, outcome data related to child safety and permanency, specifically repeat maltreatment allegations, substantiated maltreatment allegations, and entries into out-of-home care, was analyzed using SPSS or Stata. An indicator variable was included to differentiate the experimental and control groups and allow statistical comparisons of AR and TR with respect to these outcomes. Analyses of group differences were evaluated using t-tests, ANOVA procedures, and regression analyses.

Sub-study

Provider Time Study for RBA

During the initial period of implementation of RBA, the evaluators worked with DCFS to identify a small number of services providers to participate in a sub-study to examine the providers' costs of participating in the RBA program. Because it was anticipated that the costs and potential burden of

participating might vary by the size of the agency, with smaller agencies experiencing more relative burden to collect and report the required RBA data each month, a small, medium, and large-sized agency were each asked to track and report to the evaluators their RBA program-related implementation costs each month. These data were collected using a Qualtrics survey template, and summarized. The sub-study was discontinued when DCFS transitioned from RBA to the PPI program.

Limitations

One limitation of the AR evaluation is the potential for contamination of the TR approach in some offices due to workers having mixed caseloads. Because these workers were cross-trained in both approaches and were aware of the ineligibility criteria for screening AR intakes, there is some potential that workers who were assigned mixed caseloads were unable to limit their AR case practice to AR-only cases. While the evaluators were ultimately able to conduct a case file review to assess AR practice fidelity in AR cases, it was not possible to review TR cases to assess the extent to which TR practice became more like AR for those workers with mixed caseloads.

Another limitation is the ongoing parallel implementation of "community response" in some parts of the state. A major feature for selection of the initial pilot sites was their use of community response. Community response is the community's alternative approach to traditional child protection services and has a strong emphasis on prevention, such that families do not enter the care of DCFS in the first place. Sites where community response was underway have already established a community coalition to support the community response project, connecting families with law enforcement agencies, faith-based organizations, Nebraska family helpline, and early childhood services. DCFS considered community response to be a readiness feature of the selected pilot sites. However, the roll out into subsequent parts of the state did not always have the benefit of a well-established community response initiative. It is unclear the extent to which family cases were addressed through community response and thus perhaps did not make it to the agency as a child welfare report, either initially or for subsequent re-reports.

The organizational outcomes (job satisfaction, social work composition of the workforce, and worker retention) were not able to be assessed using repeated measurements over the course of the demonstration, as originally planned. The data that were made available to the evaluators to address these outcomes were insufficient to permit causal inferences. Thus, it is unknown whether the observed trends were a direct result of implementation of AR at DCFS.

The discontinuation of the RBA program and replacement with PPI resulted in no outcome evaluation being conducted on either program. Thus, the impact of RBA or PPI on provider or child and family outcomes is unknown.

Evaluation Timeframe

The evaluation of the AR program was able to keep pace with the DCFS's implementation of AR and provided developmental feedback to assist in program refinements. However, the AR evaluation experienced some delays due to data unavailability. For example, the evaluators were unable to develop and implement an AR case practice fidelity measure in collaboration with DCFS until 2018. However, once this measure was developed and access to case files was granted, the evaluators were able to

effectively assess case practice fidelity. In a similar vein, the evaluators experienced significant delays in receiving access to HR data, and when these data were provided it was more limited than anticipated, which impacted the examination of some of the short term, intermediate and long term organizational outcomes of the AR program.

The evaluation of RBA began on pace with program implementation, however, it stalled when DCFS chose to re-conceptualize the entire RBA program into the PPI program. There was a significant subsequent period of delay during which time the evaluation was unable to continue due to a lack of clarity of the PPI program's core model components, fidelity measurement, and determination of alignment of provider performance measures with child and family outcome measures. After nearly two years of impeded progress, in February 2018 a meeting was held between DCFS, the Children's Bureau Regional Office Program Specialist, the Children's Bureau Waiver Program Administrator, JBA representatives, and the evaluators, to determine the viability of the PPI program for continued evaluation. It was determined at this meeting that the evaluation of PPI would be limited to providing process feedback to DCFS, and the evaluation of the former RBA program would be discontinued, as it was no longer relevant to the new PPI program.

Part I:

Alternative Response

Process Study

Chapter 1: Stakeholder and Community Engagement

Key Questions:

- Are stakeholders and community members engaged and do they offer meaningful input in program development and implementation?
- Does ongoing monitoring and revision of implementation plans occur with stakeholders?
- Does partnership between DHHS, community stakeholders, and provider agencies improve over the course of the waiver demonstration?

Data to address these questions has been being obtained through three main sources. First, primary data were gathered using surveys of AR stakeholders. Surveys were administered in 2014 and 2017, to gauge changes over time in the level of stakeholder engagement and involvement in program implementation. Each survey administration is summarized in this chapter. For more information on this data source, please see *Appendix A: Summary of Evaluation Data Sources and Data Collection*. The second source of data pertinent to these questions is the evaluators' ongoing participation in and observation of regular AR stakeholder meetings that have occurred throughout the demonstration project. Finally, archival records from the Director's Steering Committee meetings, a small group of key stakeholder representatives, were provided to UNL-CCFL.

AR Stakeholder Survey: Year 1

Purpose

As a part of the AR program evaluation, UNL-CCFL created and distributed an initial survey to gather information about the experiences and perceptions of AR stakeholders. Specifically, this survey sought to address stakeholder's perceptions of the following:

- Group functioning and effectiveness
- Effectiveness of local and statewide advisory structure
- Adequacy of meeting frequency and type of interactions
- Opportunities to provide meaningful input into development and implementation of AR
- Inclusiveness of advisory group process and resultant decisions and products
- Ongoing monitoring and revision of implementation plans
- The availability and utility of AR program data
- The extent of partnership with DCFS to expand services and results of those efforts, and perceived changes in level of partnership over time
- Stakeholder and community member knowledge of AR elements
- Stakeholder, community member, and CFS staff support/ endorsement of AR program

This survey was developed in collaboration with the DCFS AR Program Administrator and comprised of the following dimensions: Purpose of the Group, Meeting Schedule, Meeting Processes (Agendas, Minutes, Action Items), Participation, History of Collaboration, Appropriate Cross Section of Members, Perceived Utility, Inclusiveness in Process, Open Communication, Appropriate Pace of Development, Political and Social Climate for AR, and Perceptions of AR Program Elements. Possible respondents included a broad range of AR stakeholders, including statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), internal workgroups and subgroups (Alternative Response Internal Workgroup and Alternative Response Internal Subgroup), and

local implementation teams from the initial 5 pilot counties (Alternative Response External Leadership Team for the Southeast Service Area, Fremont Alternative Response External Team, Hall County Alternative Response External Stakeholder Group, Hall County Community Collaboration, Sarpy County Alternative Response External Steering Committee, Scotts Bluff County Alternative Response Advisory Team, and Internal Alternative Response Pilot Site Leadership Team). Because some of the survey items specifically addressed meeting effectiveness, which may vary from group to group, participants were asked to identify the one group with which they felt most strongly affiliated or attended most regularly, and respond to the survey items with that group in mind.

This survey was the first formal evaluation of stakeholders' input on the AR implementation process. The purpose of this survey was to address a number of short term and intermediate outcomes on the DCFS AR Program Logic Model:

- Stakeholders and community members are engaged and offer meaningful input in AR program development, including initial implementation and the ongoing monitoring and revision of implementation plans
- Building an understanding and buy-in for the AR program
- Community providers work together and with DCFS to expand or enhance services/supports

Ultimately, these outcomes are expected to lead to the long term outcome of strengthened partnership between DCFS, provider agencies, and community stakeholders.

Participants. DCFS provided CCFL with email contact information for all individuals that they considered to be AR stakeholders. This included a broad range of individuals internal and external to the department. In total, DCFS provided 477 names and email addresses. All of these individuals were invited to participate in the AR stakeholder survey. However, six individuals contacted the researchers and asked to be removed from the mailing list because they did not consider themselves to be involved in AR. Additionally, 94 respondents reported that they did not consider themselves a member of any of the groups listed in the survey, and thus did not complete the remaining survey items. Considering nearly 20% of stakeholders did not identify with the groups listed in the survey, future survey efforts will be more inclusive and designed to accommodate an even broader range of individuals participating in AR discussions (i.e., not exclusive to specific AR groups). For this survey, the resulting pool of valid respondents included 377 individuals. Of those, 166 completed the survey for a response rate of 44%. This included 23 statewide external stakeholders, 27 internal workgroup and subgroup members, and 116 local implementation team members.

Procedure. This survey was administered by CCFL using Qualtrics, an online survey site. Invitations asking stakeholders to complete an online survey were emailed on December 3, 2014. A reminder email was sent to individuals who had not yet completed the survey as of December 10, 2014 and again if they still had not completed the survey as of December 17, 2014. The survey was closed February 10, 2015; however, the last responses were received on December, 19, 2014.

Summary of Responses

The AR stakeholder survey included 45 items across 12 dimensions: Purpose of the Group (4 items), Meeting Schedule (2 items), Meeting Processes (4 items), Participation (6 items), History of Collaboration (2 items), Appropriate Cross Section of Members (2 items), Perceived Utility (3 items), Inclusiveness in Process (4 items), Open Communication (5 items), Appropriate Pace of Development (2

items), Political and Social Climate for AR (1 item), and Perceptions of AR Program Elements (10 items). Respondents included a broad range of AR stakeholders, which for the purpose of comparisons were grouped into three categories: 1) statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), 2) internal workgroup and subgroups (Alternative Response Internal Workgroup and Alternative Response Internal Subgroups), and 3) local implementation teams (Alternative Response External Leadership Team for the Southeast Service Area, Fremont Alternative Response External Team, Hall County Alternative Response External Stakeholder Group, Hall County Community Collaboration, Sarpy County Alternative Response External Steering Committee, Scotts Bluff County Alternative Response Advisory Team, and Internal Alternative Response Pilot Site Leadership Team). Ultimately, this included 23 statewide external stakeholders, 27 internal workgroup and subgroup members, and 116 local implementation team members.

Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). Generally, respondents indicated that they either agreed or strongly agreed with the survey items, indicating that overall AR stakeholders had favorable perceptions of the AR implementation process during early implementation of the program. The only exception was the item, "law enforcement should be involved in AR cases." Responses for this item were more moderate, tending towards neutral. For each survey item, Table 1.1.1 detail the number and percentage of responses selected for each response option, organized by dimension. *SD* = strongly disagree (1), *D* = disagree (2), *N* = neutral (3), *A* = agree (4), *SA* = strongly agree (5). *Total* represents the total number of respondents that provided a rating for that item. For the *Perceptions of AR Program Elements* dimension, *Don't Know* was also included as a response option. For these items *DK* = Don't Know. If a different rating scale was used for an item, it is defined within the table. Percentages may not total 100% due to rounding.

Table 1.1.1: Overall AR Stakeholder Item Frequencies

Purpose of the Group	*SD*	*D*	*N*	*A*	*SA*	Total
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	3 (2%)	6 (4%)	7 (4%)	95 (57%)	55 (33%)	166
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	1 (1%)	8 (5%)	13 (8%)	105 (63%)	39 (24%)	166
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	2 (1%)	14 (8%)	38 (23%)	80 (48%)	32 (19%)	166
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	1 (1%)	1 (1%)	14 (9%)	65 (39%)	84 (51%)	165
Meeting Schedule	*SD*	*D*	*N*	*A*	*SA*	Total
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	2 (1%)	10 (6%)	14 (9%)	96 (58%)	43 (26%)	165

6. Meetings occur with the right amount of frequency.	2 (1%)	6 (4%)	35 (21%)	99 (60%)	23 (14%)	165

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	Total
	-	1 (2%)	16 (38%)	24 (57%)	1 (2%)	42

Meeting Process (Agendas, Minutes, Action Items)	*SD*	*D*	*N*	*A*	*SA*	Total
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	5 (3%)	23 (14%)	27 (17%)	86 (53%)	22 (14%)	163
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	2 (1%)	17 (10%)	44 (27%)	85 (52%)	16 (10%)	164
10. Commitments made at our meetings are followed up and not forgotten.	2 (1%)	10 (6%)	35 (22%)	96 (59%)	20 (12%)	163
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3 (2%)	15 (9%)	41 (25%)	86 (53%)	17 (11%)	162
Participation	*SD*	*D*	*N*	*A*	*SA*	Total
12. The organizations that attend these meetings invest the right amount of time and effort.	0 (0%)	9 (6%)	39 (24%)	92 (58%)	20 (13%)	160
13. I feel involved in what's going on during our meetings.	2 (1%)	13 (8%)	23 (14%)	93 (58%)	29 (18%)	160
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	0 (0%)	6 (4%)	15 (9%)	87 (54%)	53 (33%)	161
15. I regularly participate in the discussions during our meetings.	1 (1%)	8 (5%)	28 (18%)	83 (52%)	39 (25%)	159
16. Other's participation is usually energetic and stimulating.	0 (0%)	8 (5%)	42 (26%)	90 (56%)	20 (13%)	160

17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	1 (1%)	6 (4%)	21 (13%)	104 (65%)	29 (18%)	161
History of Collaboration	*SD*	*D*	*N*	*A*	*SA*	Total
18. Trying to solve problems through collaboration has been common in this local community.	1 (1%)	16 (10%)	25 (15%)	86 (53%)	34 (21%)	162
19. Agencies in our local community have a history of working collaboratively with DCFS.	3 (2%)	27 (17%)	39 (24%)	73 (45%)	19 (12%)	161
Appropriate Cross Section of Members	*SD*	*D*	*N*	*A*	*SA*	Total
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	1 (1%)	5 (3%)	17 (11%)	97 (61%)	39 (25%)	159
21. All the organizations that need to be members of this group have become members of this group.	3 (2%)	18 (11%)	37 (23%)	87 (55%)	13 (8%)	158
Perceived Utility	*SD*	*D*	*N*	*A*	*SA*	Total
22. The quality of our discussions is high (e.g., issues are examined in depth; problems are addressed and not skirted).	3 (2%)	17 (11%)	25 (16%)	91 (57%)	24 (15%)	160
23. Our meetings are a valuable use of my time because we deal with important content.	4 (3%)	11 (7%)	29 (18%)	93 (58%)	23 (14%)	160
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	4 (3%)	15 (9%)	39 (24%)	82 (51%)	20 (13%)	160
Inclusiveness in Process	*SD*	*D*	*N*	*A*	*SA*	Total
25. The processes used to elicit the group's input are effective.	3 (0%)	11 (6%)	36 (24%)	96 (58%)	14 (13%)	160
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	6 (4%)	7 (4%)	44 (28%)	77 (48%)	25 (16%)	159
27. When major decisions are made about AR program design and implementation, we are always informed.	4 (3%)	26 (16%)	38 (24%)	76 (48%)	16 (10%)	160
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	4 (3%)	19 (12%)	35 (22%)	87 (55%)	13 (8%)	158
Open Communication	*SD*	*D*	*N*	*A*	*SA*	Total
29. People really listen to each other during our meetings.	0 (0%)	4 (3%)	24 (15%)	107 (67%)	25 (16%)	160
30. There is a high level of trust between participants in our meetings.	3 (2%)	13 (8%)	40 (25%)	80 (50%)	24 (15%)	160

31. People feel comfortable challenging the ideas and comments of others in our meetings.		1 (1%)	11 (7%)	40 (25%)	87 (54%)	21 (13%)	160
32. Different ideas and perspectives are often explored in our meetings.		3 (2%)	11 (7%)	34 (21%)	91 (57%)	20 (13%)	159
33. Other members in this group value my opinion.		2 (1%)	4 (3%)	46 (29%)	86 (55%)	19 (12%)	157
Appropriate Pace of Development		*SD*	*D*	*N*	*A*	*SA*	Total
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.		0 (0%)	7 (4%)	38 (24%)	88 (55%)	26 (16%)	159
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.		4 (3%)	14 (9%)	35 (22%)	85 (53%)	22 (14%)	160
Political and Social Climate for AR		*SD*	*D*	*N*	*A*	*SA*	Total
36. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.		4 (3%)	8 (5%)	33 (21%)	94 (59%)	21 (13%)	160
Perceptions of AR Program Elements	*DK*	*SD*	*D*	*N*	*A*	*SA*	Total
37. AR will be able to keep kids as safe as Traditional Response.	14 (9%)	1 (1%)	5 (3%)	14 (9%)	48 (30%)	76 (48%)	158
38. Nebraska's AR model is designed to serve families with less severe allegations.	0 (0%)	1 (1%)	3 (2%)	7 (4%)	67 (42%)	80 (51%)	158
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	21 (13%)	4 (3%)	13 (8%)	28 (18%)	70 (44%)	23 (14%)	159
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4 (3%)	0 (0%)	3 (2%)	18 (11%)	64 (40%)	70 (44%)	159
41. AR families should not be placed on the Central Registry.	7 (4%)	1 (1%)	8 (5%)	16 (10%)	43 (27%)	84 (53%)	159
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	19 (12%)	2 (1%)	7 (4%)	15 (9%)	50 (32%)	65 (41%)	158
43. Families will receive services faster in AR as compared to Traditional Response.	22 (14%)	0 (0%)	13 (8%)	36 (23%)	51 (32%)	37 (24%)	159

44. Concrete supports will be better addressed through AR as compared to Traditional Response.	16 (10%)	2 (1%)	11 (7%)	27 (17%)	63 (39%)	40 (25%)	159
45. Law enforcement should be involved in AR cases.*	9 (6%)	5 (3%)	23 (14%)	48 (30%)	46 (29%)	28 (18%)	159
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	8 (5%)	2 (1%)	9 (6%)	15 (9%)	58 (37%)	66 (42%)	158

**This item was reverse coded*

In order to make comparisons, participants were grouped according to membership (statewide external stakeholders, internal workgroup and subgroup members, and local implementation team members). Average item ratings for each question by survey dimension and group membership (statewide external groups, internal workgroup and subgroups, and local implementation groups) are summarized in Table 1.1.2. Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). *Average* = average item rating, *SD* = standard deviation, and *N* = number of responses. For the *Perceptions of AR Program Elements* dimension, *Don't Know* was included as a response option. For purposes of calculating the mean, these responses were excluded.

Table 1.1.2: Average AR Stakeholder Item Ratings by Group

Statewide External Groups						
Purpose of the Group				Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.				4.04	1.07	23
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.				3.96	0.98	23
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.				3.83	1.07	23
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.				4.57	0.66	23
Meeting Schedule				Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.				4.22	0.74	23
6. Meetings occur with the right amount of frequency.				3.91	0.79	23
If respondents did not agree or strongly agree with item 6, the following question was displayed:						
7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	50%	50%	-	6
Meeting Process (Agendas, Minutes, Action Items)				Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.				3.43	1.31	23

9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.57	0.95	23
10. Commitments made at our meetings are followed up and not forgotten.	3.65	1.07	23
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.78	1.00	23
Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.61	0.72	23
13. I feel involved in what's going on during our meetings.	4.13	0.69	23
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.22	0.90	23
15. I regularly participate in the discussions during our meetings.	4.35	0.78	23
16. Other's participation is usually energetic and stimulating.	3.87	0.82	23
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.09	0.67	23
History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.45	1.06	22
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.09	1.11	22
Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	3.91	1.11	22
21. All the organizations that need to be members of this group have become members of this group.	3.50	1.01	22
Perceived Utility	Average	*SD*	N
22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.77	1.11	22
23. Our meetings are a valuable use of my time because we deal with important content.	3.95	1.05	22
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.45	1.22	22
Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.82	1.05	22
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.68	1.17	22
27. When major decisions are made about AR program design and implementation, we are always informed.	3.41	1.18	22
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.82	1.01	22

Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.95	0.84	22
30. There is a high level of trust between participants in our meetings.	3.45	1.06	22
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.82	0.59	22
32. Different ideas and perspectives are often explored in our meetings.	3.68	0.95	22
33. Other members in this group value my opinion.	3.43	0.68	21
Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.82	1.10	22
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.36	1.22	22
Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.77	1.02	22
Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.11	1.15	22
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.23	0.81	22
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.68	0.95	22
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.18	0.91	22
41. AR families should not be placed on the Central Registry.	4.50	0.76	22
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	3.89	1.15	22
43. Families will receive services faster in AR as compared to Traditional Response.	3.47	1.22	22
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	3.33	1.07	22
45. Law enforcement should be involved in AR cases.*	4.06	1.11	22
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.00	1.17	22
Internal Workgroup and Subgroups			
Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.33	0.62	27
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.22	0.64	27
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.78	0.85	27
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.11	0.93	27

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	4.07	0.68	27
6. Meetings occur with the right amount of frequency.	3.70	0.91	27

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	11%	22%	56%	11%	9

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.74	0.94	27
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.52	0.89	27
10. Commitments made at our meetings are followed up and not forgotten.	3.81	0.74	27
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.70	0.91	27
Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.84	0.69	25
13. I feel involved in what's going on during our meetings.	3.80	0.96	25
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.23	0.71	26
15. I regularly participate in the discussions during our meetings.	4.12	0.73	25
16. Other's participation is usually energetic and stimulating.	3.96	0.60	26
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.00	0.49	26
History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.69	0.79	26
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.46	0.76	26
Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	4.00	0.76	25
21. All the organizations that need to be members of this group have become members of this group.	3.60	0.87	25
Perceived Utility	Average	*SD*	N

22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.96	0.92	26
23. Our meetings are a valuable use of my time because we deal with important content.	3.77	0.95	26
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.85	0.88	26
Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.69	0.84	26
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.77	0.82	26
27. When major decisions are made about AR program design and implementation, we are always informed.	3.31	1.01	26
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.31	0.97	26
Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.96	0.60	26
30. There is a high level of trust between participants in our meetings.	3.77	0.82	26
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.77	0.82	26
32. Different ideas and perspectives are often explored in our meetings.	3.88	0.82	26
33. Other members in this group value my opinion.	3.73	0.92	26
Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.81	0.63	26
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.81	0.80	26
Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.54	0.71	26
Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.54	0.58	26
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.77	0.43	26
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.43	0.99	26
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.56	0.65	26
41. AR families should not be placed on the Central Registry.	4.76	0.44	26
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	4.71	0.55	26
43. Families will receive services faster in AR as compared to Traditional Response.	3.82	1.01	26
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	4.29	0.69	26

45. Law enforcement should be involved in AR cases.*	3.88	1.05	26
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.60	0.58	26

Local Implementation Groups

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.15	0.79	116
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.02	0.72	116
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.74	0.89	116
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.43	0.66	115
Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	3.97	0.89	115
6. Meetings occur with the right amount of frequency.	3.83	0.72	115

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	41%	59%	-	27

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.59	0.93	113
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.61	0.83	114
10. Commitments made at our meetings are followed up and not forgotten.	3.75	0.75	113
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.55	0.83	112
Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.79	0.75	112
13. I feel involved in what's going on during our meetings.	3.79	0.86	112
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.13	0.72	112
15. I regularly participate in the discussions during our meetings.	3.87	0.83	111
16. Other's participation is usually energetic and stimulating.	3.72	0.74	111
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	3.95	0.77	112

History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.93	0.86	114
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.53	0.97	113
Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	4.11	0.63	112
21. All the organizations that need to be members of this group have become members of this group.	3.60	0.85	111
Perceived Utility	Average	*SD*	N
22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.70	0.87	112
23. Our meetings are a valuable use of my time because we deal with important content.	3.75	0.82	112
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.64	0.84	112
Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.68	0.75	112
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.68	0.90	111
27. When major decisions are made about AR program design and implementation, we are always informed.	3.51	0.91	112
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.55	0.85	110
Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.97	0.61	112
30. There is a high level of trust between participants in our meetings.	3.74	0.88	112
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.71	0.84	112
32. Different ideas and perspectives are often explored in our meetings.	3.71	0.83	111
33. Other members in this group value my opinion.	3.81	0.71	110
Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.87	0.69	111
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.70	0.86	112
Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.79	0.83	112
Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.33	0.83	111
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.35	0.74	110

39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.75	0.95	111
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.26	0.73	111
41. AR families should not be placed on the Central Registry.	4.19	0.98	111
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	4.16	0.92	110
43. Families will receive services faster in AR as compared to Traditional Response.	3.89	0.86	111
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	3.92	0.93	111
45. Law enforcement should be involved in AR cases.*	3.26	1.00	111
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.11	0.93	110

**These items were reverse coded*

Figures 1.1.1 – 1.1.3 display the range of average ratings for each dimension by group (statewide external groups, internal workgroup and subgroups, and local implementation groups). For example, the first vertical line on the left represents the range of averages for the *Purpose of the Group* dimension; for the statewide external groups, the lowest question average was 3.83 and the highest questions average was 4.57.

Figure 1.1.1: Ranges of Average Ratings of Statewide External Groups

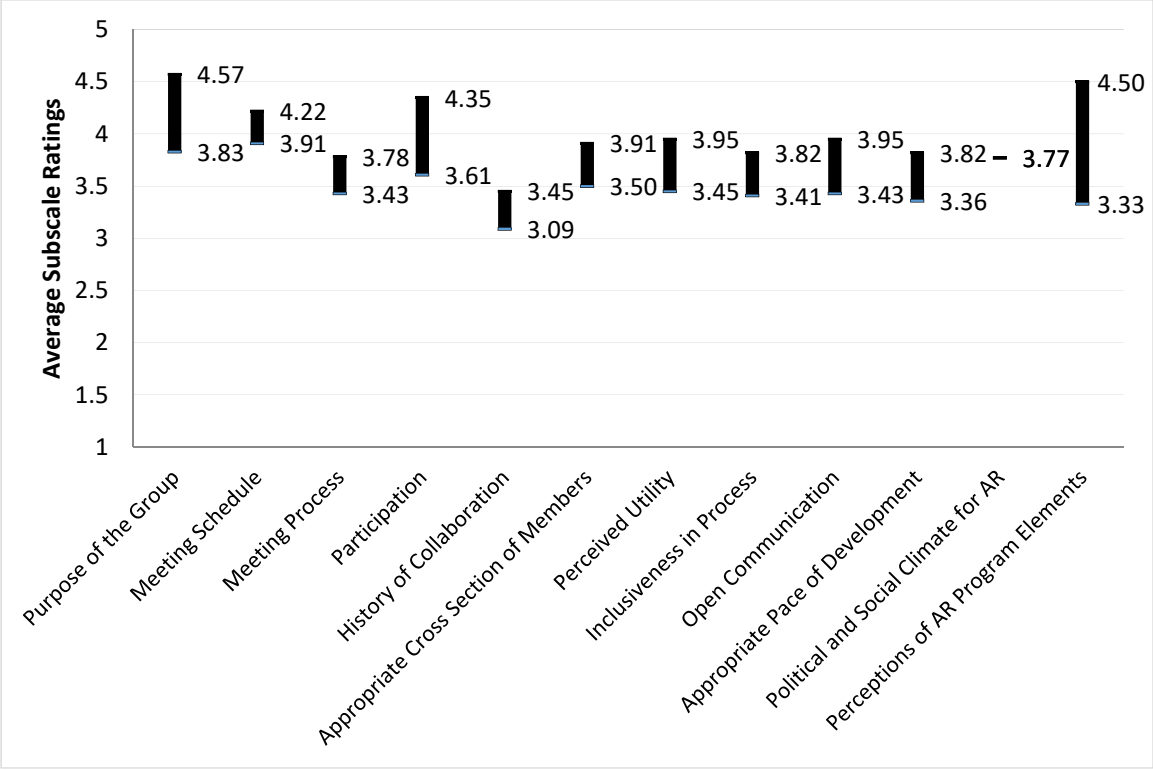


Figure 1.1.2: Ranges of Average Ratings for Internal Workgroup and Subgroups

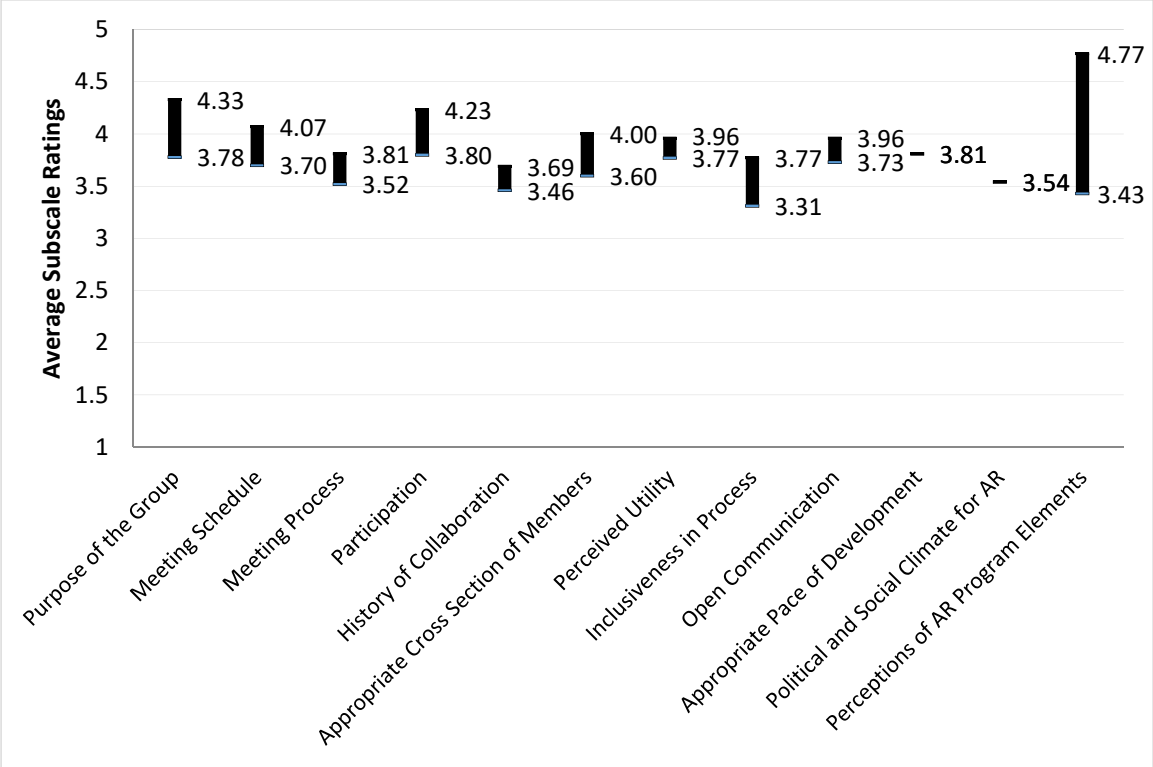
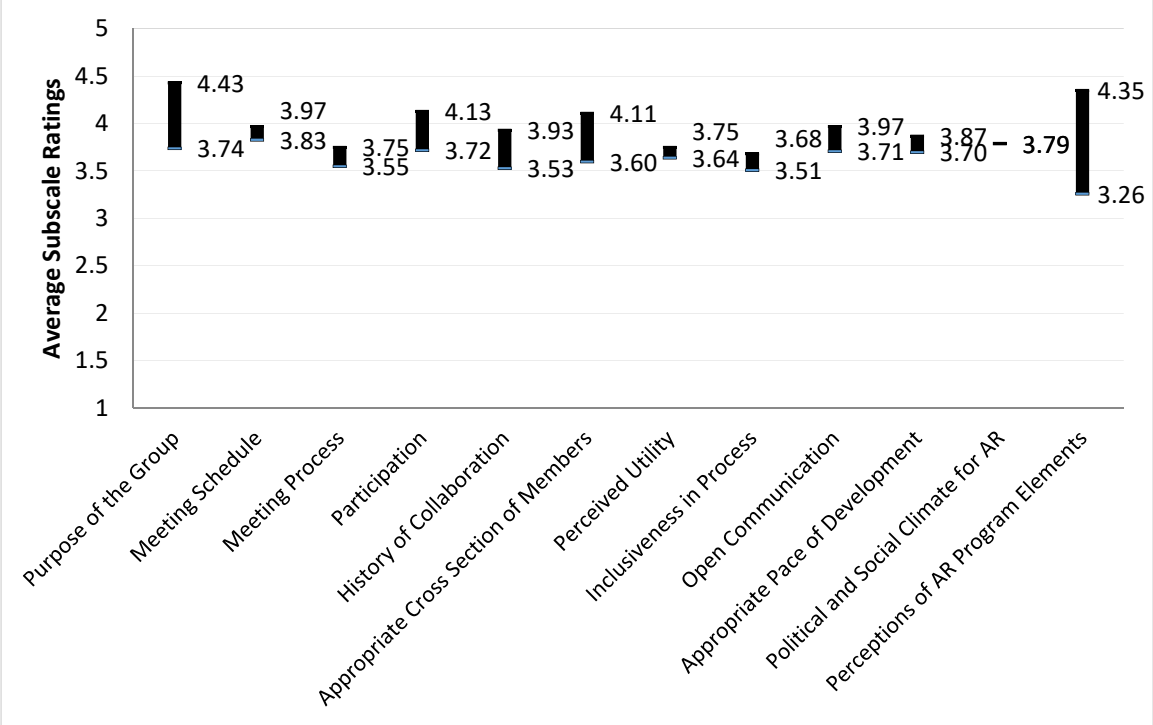


Figure 1.1.3: Ranges of Average Ratings for Local Implementation Groups



Significant Results

A one-way analysis of variance (ANOVA) was conducted to compare item means between the three overall groups: 1) statewide external stakeholders, 2) internal workgroup and subgroups, and 3) local implementation teams. For statistically significant differences, a Tukey post-hoc test was used to examine the specific group differences observed. For the 45-item survey, responses were generally positive and did not vary significantly between groups. This means that stakeholders generally feel positive about the AR implementation so far. However, significant differences were observed between groups on 8 items, most of which were in the *Perceptions of AR Program Elements* dimension. For these, the two main suggested strategies are 1) greater communication to convey DCFS's intent with the program element and/or a need to better understand stakeholders' insight about the program element, or 2) a need to better explain how DCFS intends to accomplish specific outcomes through AR. Statistically significant differences and potential strategies to address these items are discussed below.

Participation.

I regularly participate in the discussions during our meetings, F(2,156) = 4.60, *p* = 0.01. The average rating from the local implementation teams (3.83) was significantly lower than that from the statewide external stakeholders (4.35). This indicates a need to elicit greater participation from members of the local implementation teams. Because ratings were higher among statewide external stakeholders, perhaps strategies used to engage these members could also be helpful in raising the perceived level of participation for local implementation team members.

History of Collaboration.

Trying to solve problems through collaboration has been common in this local community, F(2,159) = 3.34, *p* = 0.04. The average rating from the local implementation teams (3.95) was significantly higher than that from the statewide external stakeholders (3.45). Meaning, local implementation team members perceive greater levels of community collaboration than statewide members. Perhaps this is due to the composition of the statewide external groups (if there were more members from areas with less community collaboration), or may simply be due to the fact that there is greater variety of members participating on the statewide groups.

Perceptions of AR Program Elements.

AR families should not be placed on the Central Registry, F(2,149) = 4.67, *p* = 0.01. The average rating from the local implementation teams (4.19) was significantly lower than that from the internal group (4.76). Meaning, while both groups tended to agree with this statement, local implementation team members were less likely to agree that AR families should not be placed on the Central Registry. Given that this is a central tenant of Nebraska's AR model, it appears greater communication may be necessary to convey the State's intent with this program element.

Law enforcement should be involved in AR cases, F(2,147) = 7.15, *p* = 0.001. The average rating from the local implementation teams (3.26) was significantly lower than those from the statewide (4.06) and internal (3.88) groups. Although this question is worded in the positive, responses were reverse-coded (meaning, *Strongly Agree = 1 and Strongly Disagree = 5*), as DCFS has indicated potential issues with law enforcement involvement in AR cases. Therefore, these ratings indicate a more moderate viewpoint on behalf of the local implementation teams. This may indicate a need for greater communication on behalf of DCFS to convey the importance of this program element or perhaps the local implementation

teams have greater insight about how law enforcement could be incorporated within the AR program model without issue.

Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement, F(2,147) = 3.25, *p* = 0.04. The average rating from the internal groups (4.60) was significantly higher than that from the local implementation teams (4.11) and approached significance with the statewide external stakeholders (4.00). Meaning, statewide and local stakeholders were less likely to agree with the need to contact parents prior to interviewing children in AR. Although this program element is considered to be best practice, it is understood that safety must be assessed within the required timeframes. This nuance is not explicit in the survey item. Therefore lower agreement levels could be due to respondents thinking less about the ideal and more about the relative importance of safety. However, it may also be possible that stakeholders have suggestions about how interviews can be accomplished without prior parental notification. Greater communication may be needed from DCFS to convey the importance of this program element.

Nebraska's AR model is designed to serve families with less severe allegations, F(2,155) = 4.42, *p* = 0.01. The average rating from the internal groups (4.77) was significantly higher than those from the statewide (4.23) and local (4.35) groups. Meaning, while all three groups generally agreed with the statement, statewide and local groups are less likely to agree that AR serves families with less severe allegations. This indicates a potential need for DCFS to better communicate their intentions with the AR model and explain to stakeholders how it has been designed to serve families with less severe allegations.

Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution, F(2,136) = 4.96, *p* = 0.01. The average rating from the internal groups (4.71) was significantly higher than those from the statewide (3.89) and local (4.16) groups. This means that statewide and local stakeholders are less likely to agree that AR will lead to better outcomes and quicker resolution for families as a result of more frequent contact with a caseworker. Further communication from DCFS may be necessary to explain to external stakeholders how this will be accomplished through AR.

Concrete supports will be better addressed through AR as compared to Traditional Response, F(2,140) = 6.26, *p* = 0.002. The average rating from the statewide external stakeholders (3.33) was significantly lower than those from the internal (4.29) and local (3.92) groups. Meaning, statewide external group members were less likely to agree that concrete supports will be better addressed through AR (as compared to TR). This indicates a need to better inform statewide external stakeholders on how DCFS plans to accomplish this outcome through AR. Perhaps strategies used to communicate with the local implementation teams would be helpful to raise statewide stakeholders' level of agreement with this statement.

Summary of Comments

The AR Stakeholder survey included areas for participants to write comments after each dimension and one general comment section. Out of 166 respondents, a total of 283 comments were provided by 108 individuals. These comments were reviewed overall and are summarized below.

Meeting Processes. Conversations appear to be open and honest between the different agencies and representatives that attend the various AR meetings. Some respondents also indicated a diligent effort on behalf of DCFS to keep stakeholders informed. However, others indicated that DCFS' style of communication has been too focused on the delivery of information, rather than asking questions or providing stakeholders with options to advise on the direction of the AR program. One respondent said, "I felt like I was there for show and tell only." This appears to be leading some stakeholders to view AR meetings as an inefficient use of their time, as they would like to more clearly see the effect of their input and observe more productivity result from these meetings. One respondent stated their sense was, "DHHS was going to go this direction despite the feedback." Another felt AR decisions were "driven internally and we were given documents to respond to, but often the feedback provided resulted in no changes." It was noted that apparent decision-makers are not always present at meetings; although stakeholders want to understand how their participation is impacting the final decisions being made by DCFS. One respondent said:

> "At times it feels as though decisions can't be made without certain people present and yet those folks aren't always available to attend the meeting, in turn decisions aren't made timely. I feel as though the meeting becomes stagnant at times and we circle around the same information with no clear decision even when the people at the table can make the decision."

Considering this feedback, it may be beneficial to provide stakeholders with a written summary or documentation of clear action items, details about how past action items have been addressed, or decisions that have been made since the last meeting. A possible solution would be for DCFS to more clearly communicate through the use of agendas (prior to meetings) and the distribution of meeting minutes (after meetings), as comments suggested these are not consistently being used. Stakeholders also commented on how they have assumed additional AR duties voluntarily and in addition to their regular responsibilities. One respondent suggested that if or when meetings are just to share information; email may be a better medium. It also appears that clearer communication is needed for some stakeholders regarding when meetings are scheduled or canceled.

Although comments indicated that the level of collaboration within communities is perceived to be strong, some comments indicated a lack of trust in DCFS to follow through with AR as discussed at meetings. Additionally, some are concerned about AR continuing to be made a priority through leadership changes. Comments suggest the need for greater collaboration between DCFS and the community to create more service links, breakdown divisions, and create sustainable change for families needing services after DCFS involvement ends. However, several respondents also remarked on the developing relationships between DCFS and community partners, indicating a recent shift in collaboration and that trust is evolving. On stakeholder remarked that "it was good to see them ask for stakeholder input and participation." Another said, "I think working collaboratively is something we are striving towards and becoming better at. Over the last 5 years we have broken down many silos and are doing a much better job." Stakeholders appear to see the need for AR and feel like progress has been made regarding the relationships and level of trust in DCFS. Some commented on the level of community involvement in AR thus far and feel that collaboration between DCFS and most agencies is good. One respondent indicated:

> "This is the great thing we have accomplished! Before starting this process we had numerous local agencies and non-profit organizations working on the same issues but not communicating or working hand in hand. This resulted in too much redundancy in many areas and huge gaps of need in others. Getting everyone on the same page has resulted in a much more effective use of our time, our energy and our resources."

Moving forward, participants would like to hear more about how the AR program is progressing, especially as it rolls out to additional sites and the model is adjusted from the original implementation plans. External stakeholders are requesting more communication about what is being experienced by workers in the field, while some internal DCFS staff commented on their desire to be more involved regarding the current and ongoing status of the AR program. As implementation progresses, it may also be necessary to revisit the purpose of the different AR groups, as some respondents expressed a need for more defined roles and group direction. One stakeholder indicated that "it would be beneficial to regroup and ensure each party is aware of their role within the group and within AR as a whole. At times it feels as though people are unsure of their role and the goals of what DHHS is attempting to accomplish with this initiative." A local stakeholder stated, "I think the group is still trying to 'form' and see their purpose. People are interested, but don't yet see their own roles, responsibilities, and how each can contribute." Additionally, there may be a need to reach out to other stakeholders to make sure all necessary system partners are involved. Comments suggested the following stakeholders should be included in AR discussions: more people that are familiar with the research, additional provider agencies, faith-based community partners, cultural centers (including tribal), educational personnel, mental health professionals, law enforcement, legal partners (attorneys, CASA, GAL, judges), and youth and families.

Overall AR Program. Several respondents remarked that AR is a "move in the right direction" and commented on the potential benefits of AR being implemented. One stakeholder commented, "I am excited about the potential outcomes for families serviced in AR." Another stated, "CFS is definitely on the right track with AR. AR should prove to keep families out of the system and address their needs in a much more proactive manner." It appears that stakeholders believe AR can be successful and are eager to see how AR is impacting families. Negative program comments were minimal and appeared to be specific to particular program features (e.g., contact requirements, interview protocol). Several comments expressed a need to figure out the specifics for funding, including funding services in the community, and how workers can access flexible funding sources for AR families. There were also concerns about AR overloading IA workers, especially with the requirement for more frequent family contacts and managing a mixed (AR and TR) caseload. More supports may be necessary to fully, or at least more quickly, realize some of the outcomes proposed to be associated with AR.
Stakeholders would like to see future efforts focused on providing additional training or more comprehensive training for future sites. Stakeholders would also like to further review and consider the exclusionary criteria. Comments indicated that there are too many criteria excluding families from AR, in other words the current criteria are too restrictive. Additionally, some comments underlined a need to manage external perceptions of the AR program, as not all conditions are within the department's control, nor can all conditions be predicted or managed. Respondents expressed recognition that some of the outcomes proposed will take a long time to occur, if at all. A couple of comments highlighted concerns about the evaluation, specifically the use of the randomizer. These comments indicated that

the randomizer is “just not right” and “is going to hurt people in the short run.” Further communication about the value of the evaluation and how it can be informative, not hurtful, may be necessary.

Conclusion from AR Stakeholder Survey

AR began implementation in 5 pilot counties on October 1, 2014. This survey was the first formal gathering of stakeholders’ input on the AR implementation process thus far. Contact information was provided by DCFS to CCFL for all individuals that DCFS considered to be AR stakeholders. This included individuals internal and external to the department. A total of 166 individuals participated in this online survey. The survey was emailed to participants on December 3, 2014. Responses were received between December 3, 2014 and December 19, 2014. Therefore, these responses are reflective of the early implementation period.

For comparison purposes, respondents were separated into three main groups: statewide external stakeholders, internal workgroup and subgroup members, and local implementation team members. Generally, AR stakeholders agreed or strongly agreed with the statements in the survey and most of the average ratings did not vary significantly between groups. Significant findings, along with comments, indicate that future efforts should be directed at actively involving stakeholders (both current and possibly inviting more stakeholders to attend AR meetings), examining or reexamining AR program elements, and communicating field-level experiences of AR implementation so far.

The purpose of this survey was to address a number of short term and intermediate outcomes:

- Stakeholders and community members are engaged and offer meaningful input in AR program development, including initial implementation and the ongoing monitoring and revision of implementation plans
- Building an understanding and buy-in for the AR program
- Community providers work together and with DCFS to expand or enhance services/supports

Although respondents generally agreed with the survey statements, it appears there is room for improvement with regards to these outcomes. Future survey efforts will examine any increases or changes in respondent ratings as well as the frequency and valence of comments. This survey will be conducted again midway through the demonstration (2017) and near the end of the project (January-March 2019). Ultimately, these outcomes are expected to lead to the long term outcome of strengthened partnership between DCFS, provider agencies, and community stakeholders.

AR Stakeholder Survey: Year 3

In partnership with DCFS, UNL-CCFL created and distributed a second survey to gather ongoing information about the experiences and perceptions of AR stakeholders. Specifically, this survey sought to address stakeholders’ perceptions of:

- Group functioning and effectiveness
- Adequacy of meeting frequency and type of interactions
- Opportunities to provide meaningful input into development and implementation of AR
- Inclusiveness of advisory group process and resultant decisions and products
- Ongoing monitoring and revision of implementation plans

- The availability and utility of AR program data
- The extent of partnership with DCFS to expand services and perceived changes in level of partnership over time
- Stakeholder endorsement of AR program

This survey was the second evaluation of stakeholders' input on the AR implementation process. The first survey was administered near the beginning of AR implementation, in December 2014. The purpose of this survey was to address a number of short term and intermediate outcomes:

- Stakeholders and community members are engaged and offer meaningful input in AR program development, including implementation and the ongoing monitoring and revision of implementation plans
- Building an understanding and buy-in for the AR program
- Community providers work together and with DCFS to expand or enhance services/supports

Ultimately, these outcomes are expected to lead to the long term outcome of strengthened partnership between DCFS, provider agencies, and community stakeholders.

Method

Participants

DCFS provided UNL-CCFL with email contact information for individuals that they considered to be AR stakeholders. This included individuals internal and external to the department. In total, DCFS provided 73 names and email addresses. All of these individuals were invited to participate in the AR stakeholder survey. Six respondents reported that they did not consider themselves to be a member of any of the groups listed in the survey; therefore, the resulting pool of valid participants included 67 individuals. Of those, 32 completed the survey for a response rate of 48%. This included 8 Director's Steering Committee members, 10 Statewide Alternative Response Advisory Board members, 21 Alternative Response Internal Workgroup members, and 5 Citizen Review Panel members.

Procedure

This 45-items survey included questions across 12 dimensions: Purpose of the Group (4 items), Meeting Schedule (2 items), Meeting Processes (4 items), Participation (6 items), History of Collaboration (2 items), Appropriate Cross Section of Members (2 items), Perceived Utility (3 items), Inclusiveness in Process (4 items), Open Communication (5 items), Appropriate Pace of Development (2 items), Political and Social Climate for AR (1 item), and Perceptions of AR Program Elements (10 items). This survey was administered by UNL-CCFL using Qualtrics, an online survey site. Participants were asked to identify their AR group affiliation (Director's Steering Committee, Statewide Alternative Response Advisory Board, Alternative Response Internal Workgroup, and the Citizen Review Panel) and provide ratings of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*) to a series of statements. Participants were also given the opportunity to write comments for each scale dimension and overall. Invitations asking stakeholders to complete the online survey were emailed on October 17, 2017. A reminder email was sent to individuals who had not yet completed the survey on October 24, 2017 and October 31, 2017. The survey was closed December 16, 2017, with the last responses received on December 1, 2017.

Results

Summary of Responses

For the 8 survey dimensions that included group-specific items (Purpose of the Group, Meeting Schedule, Meeting Process, Participation, Appropriate Cross Section of Members, Perceived Utility, Inclusiveness in Process, and Open Communication), participants were asked to identify their group affiliation (Director's Steering Committee, Statewide Alternative Response Advisory Board, Alternative Response Internal Workgroup, and the Citizen Review Panel) and respond to items with each groups in mind. For these dimensions, survey responses are presented by participants' group affiliation. For the remaining 4 survey dimensions (History of Collaboration, Appropriate Pace of Development, Political and Social Climate for AR, and Perceptions of AR Program Elements), survey responses are summarized and presented in aggregate in the *Overall AR Program Perceptions section* of this report. Additionally, participants were able to provide comments after each dimension and general comments at the end of the survey. Out of the 32 respondents, a total of 33 comments were provided by 21 individuals. Comments provided under a specific dimension are listed along with that section. All general comments are listed in the *Overall AR Program Perceptions* section of this report.

Director's Steering Committee

Eight respondents identified themselves as members of the Director's Steering Committee. In general, respondents indicated that they either agreed or strongly agreed with most survey items; however overall averages were impacted by one or two member's lower ratings. The lowest item average was 3.13 for the item "I have a good understanding of the purpose of the group. I know what we are trying to accomplish." Along with comments, this indicates a potential need to revisit and address the purpose of the Director's Steering Committee.

Table 1.1.3 displays the Director's Steering Committee members' average ratings, standard deviations, and the number of respondents for each group-specific survey item.

Table 1.1.3: Director's Steering Committee Response Summary

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	3.13	0.99	8
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.25	0.70	8
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.63	1.41	8
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.75	0.71	8
Purpose of the Group Comments • "The director has not been to a meeting since inception, so it is hard to understand the purpose of the group if the leader is not there."			
Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	4.38	0.74	8
6. Meetings occur with the right amount of frequency.	4.38	0.74	8

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	100%		-	2

No comments were provided for this section.

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.38	1.06	8
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.50	1.31	8
10. Commitments made at our meetings are followed up and not forgotten.	3.75	1.28	8
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.63	1.69	8

Meeting Process Comments

- "I am not sure what recommendations are followed up on."

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.63	1.41	8
13. I feel involved in what's going on during our meetings.	4.00	1.41	8
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.13	1.36	8
15. I regularly participate in the discussions during our meetings.	4.00	1.31	8
16. Other's participation is usually energetic and stimulating.	3.63	1.41	8
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.13	1.36	8

No comments were provided for this section.

Appropriate Cross Section of Members	Average	*SD*	N
18. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	3.63	1.41	8
19. All the organizations that need to be members of this group have become members of this group.	3.38	0.92	8

No comments were provided for this section.

Perceived Utility	Average	*SD*	N
20. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.88	1.55	8
21. Our meetings are a valuable use of my time because we deal with important content.	3.88	1.36	8

22. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.63	1.41	8

Perceived Utility Comments

- "Not sure what recommendations/influence this group has, if any."

Inclusiveness in Process	Average	*SD*	N
23. The processes used to elicit the group's input are effective.	3.50	1.31	8
24. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.38	1.06	8
25. When major decisions are made about AR program design and implementation, we are always informed.	4.14	0.69	7
26. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	4.00	1.41	8

Inclusiveness in Process Comments

- "Data is not openly shared."

Open Communication	Average	*SD*	N
27. People really listen to each other during our meetings.	4.13	1.36	8
28. There is a high level of trust between participants in our meetings.	3.63	1.60	8
29. People feel comfortable challenging the ideas and comments of others in our meetings.	4.00	1.31	8
30. Different ideas and perspectives are often explored in our meetings.	4.43	0.54	7
31. Other members in this group value my opinion.	3.88	1.25	8

No comments were provided for this section.

Statewide Alternative Response Advisory Board

Ten respondents identified themselves as members of the Statewide Alternative Response Advisory Board. In general, this group's respondents were more neutral. The 3 lowest rated items were, "All the organizations that need to be members of this group have become members of this group"; "Our meetings are a valuable use of my time because we deal with important content"; "People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results." These findings, along with comments, indicate that families may need more representation at these meetings and that additional efforts should be taken to ensure meeting participants are engaged in meaningful discussions and their expertise is utilized.

Table 1.1.4 displays the Statewide Alternative Response Advisory Board members' average ratings, standard deviations, and the number of respondents for each group-specific survey item.

Table 1.1.4: Statewide Alternative Response Advisory Board Response Summary

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	3.70	0.68	10
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	3.60	0.97	10
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.40	1.08	10

4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.30	0.68	10

No comments were provided for this section.

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	3.60	0.97	10
6. Meetings occur with the right amount of frequency.	3.60	0.97	10

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	40%	60%	-	-	5

Meeting Schedule Comments

- "The main reason that I stopped attending was because the times of the meetings changed and coincided with other meetings that I had. I think that they have switched the times now, but for me to drive 5 hours for a 2-hour meeting is not very cost effective."

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.10	0.99	10
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.22	0.83	9
10. Commitments made at our meetings are followed up and not forgotten.	3.60	0.84	10
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.30	0.95	10

Meeting Process Comments

- "I don't believe that I have ever gotten any minutes from these meetings."

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.60	0.84	10
13. I feel involved in what's going on during our meetings.	3.80	0.79	10
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.33	0.71	9
15. I regularly participate in the discussions during our meetings.	3.70	0.95	10
16. Other's participation is usually energetic and stimulating.	3.30	0.95	10
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	3.80	0.79	10

No comments were provided for this section.

Appropriate Cross Section of Members	Average	*SD*	N
18. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	3.70	0.82	10
19. All the organizations that need to be members of this group have become members of this group.	3.00	0.67	10

Appropriate Cross Section of Members Comments

- "Families are not represented. Not sure that Family Orgs are invited to the Statewide Advisory Board since the Federation for Families dissolved."
- "I'm not sure anymore who the members of the group are or if anyone even attends."
- "Would be helpful to have more family representation."

Perceived Utility	Average	*SD*	N
20. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.50	0.97	10
21. Our meetings are a valuable use of my time because we deal with important content.	3.00	1.41	10
22. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.00	1.25	10

No comments were provided for this section

Inclusiveness in Process	Average	*SD*	N
23. The processes used to elicit the group's input are effective.	3.50	0.71	10
24. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.20	0.63	10
25. When major decisions are made about AR program design and implementation, we are always informed.	3.60	0.84	10
26. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.60	1.08	10

Inclusiveness in Process Comments

- "I'm informed of changes in AR because I work for the Department. I'm not sure if outside members are or not."

Open Communication	Average	*SD*	N
27. People really listen to each other during our meetings.	3.50	0.97	10
28. There is a high level of trust between participants in our meetings.	3.10	1.10	10
29. People feel comfortable challenging the ideas and comments of others in our meetings.	3.56	1.01	9
30. Different ideas and perspectives are often explored in our meetings.	3.56	1.01	9
31. Other members in this group value my opinion.	3.50	0.85	10

No comments were provided for this section

Alternative Response Internal Workgroup

Twenty one respondents identified themselves as members of the Alternative Response Internal Workgroup. In general, respondents indicated that they either agreed or strongly agreed with most

survey items. Findings, along with comments, indicate that meeting length could be condensed and that the meeting location (Lincoln) may be a barrier for some.

Table 1.1.5 displays the Alternative Response Internal Workgroup members' average ratings, standard deviations, and the number of respondents for each group-specific survey item.

Table 1.1.5: Alternative Response Internal Workgroup Response Summary

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.24	0.44	21
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.05	0.59	21
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.95	0.67	21
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	3.95	0.87	21

No comments were provided for this section

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	3.71	0.96	21
6. Meetings occur with the right amount of frequency.	3.75	0.97	20

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	20%	30%	50%	-	10

Meeting Schedule Comments

- "I like the frequency, not necessarily the length of time."
- "This could probably be done less frequently or by phone at this point- or as we continue to develop."

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.86	0.79	21
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.76	0.99	21
10. Commitments made at our meetings are followed up and not forgotten.	3.81	0.81	21
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.81	0.75	21

Meeting Process Comments

- "All meetings are held in Lincoln, which makes participation from out state more difficult."
- "Alyson does a nice job running these meetings and making sure all voices are heard."

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.95	0.74	21
13. I feel involved in what's going on during our meetings.	3.86	0.79	21
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.10	0.70	21
15. I regularly participate in the discussions during our meetings.	3.81	0.75	21
16. Other's participation is usually energetic and stimulating.	3.71	0.56	21
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.00	0.55	21

Participation Comments

- "I believe these meetings can be shortened."

Appropriate Cross Section of Members	Average	*SD*	N
18. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	3.76	0.70	21
19. All the organizations that need to be members of this group have become members of this group.	3.57	0.75	21

Appropriate Cross Section of Members Comments

- "Since ending my employment with DHHS and being employed with an agency that collaborates closely with DHHS, I have found that there are many organizations that would be great to involve in what Alternative Response is striving to fulfill in this community, but are not currently involved with any AR groups."

Perceived Utility	Average	*SD*	N
20. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.90	0.62	21
21. Our meetings are a valuable use of my time because we deal with important content.	3.57	0.75	21
22. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.71	0.64	21

Perceived Utility Comments

- "I think the meetings could be condensed based on the information presented. I do not believe they need to last 4+ hours."
- "I feel that this meeting addresses important issues with AR performance/training; however, at this time it is not wholly applicable to what I am doing, or what my partners are doing."
- "I believe the meetings can be shortened/condensed."

Inclusiveness in Process	Average	*SD*	N
23. The processes used to elicit the group's input are effective.	3.86	0.57	21
24. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.86	0.57	21
25. When major decisions are made about AR program design and implementation, we are always informed.	3.86	0.85	21
26. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.95	0.87	21

No comments were provided for this section.

Open Communication	Average	*SD*	N
27. People really listen to each other during our meetings.	3.90	0.63	21
28. There is a high level of trust between participants in our meetings.	3.81	0.75	21
29. People feel comfortable challenging the ideas and comments of others in our meetings.	3.81	0.68	21
30. Different ideas and perspectives are often explored in our meetings.	3.95	0.67	21
31. Other members in this group value my opinion.	3.81	0.60	21

Open Communication Comments

- "Most of the information I am able to provide is not applicable to the rest of the stakeholders in this group."

Citizen Review Panel

Five respondents identified themselves as members of the Citizen Review Panel. In general, respondents indicated that they either agreed or strongly agreed with most survey items. Of all the surveyed stakeholder groups, the Citizen Review Panel had the highest average subscale ratings across all items.

Table 1.1.6 displays the Citizen Review Panel members' average ratings, standard deviations, and the number of respondents for each group-specific survey item.

Table 1.1.6: Citizen Review Panel Response Summary

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.60	0.55	5
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.80	0.45	5
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	4.60	0.55	5
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	5.00	0	5

No comments were provided for this section

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	4.80	0.45	5
6. Meetings occur with the right amount of frequency.	4.80	0.45	5

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	100%	-	-	1

No comments were provided for this section

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.80	1.30	5
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	4.00	0.71	5
10. Commitments made at our meetings are followed up and not forgotten.	4.20	0.45	5
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	4.40	0.89	5

No comments were provided for this section

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	4.40	0.55	5
13. I feel involved in what's going on during our meetings.	4.80	0.55	5
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.80	0.55	5
15. I regularly participate in the discussions during our meetings.	4.60	0.55	5
16. Other's participation is usually energetic and stimulating.	4.40	0.55	5
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.80	0.45	5

No comments were provided for this section

Appropriate Cross Section of Members	Average	*SD*	N
18. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	4.40	0.55	5
19. All the organizations that need to be members of this group have become members of this group.	3.80	0.84	5

No comments were provided for this section

Perceived Utility	Average	*SD*	N
20. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	4.80	0.45	5
21. Our meetings are a valuable use of my time because we deal with important content.	4.60	0.55	5

22. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	4.40	0.55	5

No comments were provided for this section

Inclusiveness in Process	Average	*SD*	N
23. The processes used to elicit the group's input are effective.	4.40	0.55	5
24. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	4.00	0.71	5
25. When major decisions are made about AR program design and implementation, we are always informed.	4.40	0.55	5
26. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	4.80	0.45	5

No comments were provided for this section

Open Communication	Average	*SD*	N
27. People really listen to each other during our meetings.	4.80	0.45	5
28. There is a high level of trust between participants in our meetings.	4.60	0.89	5
29. People feel comfortable challenging the ideas and comments of others in our meetings.	4.60	0.55	5
30. Different ideas and perspectives are often explored in our meetings.	4.60	0.55	5
31. Other members in this group value my opinion.	4.40	0.55	5

No comments were provided for this section

Overall AR Program Perceptions

Overall, stakeholder respondents indicated that they either agreed or strongly agreed with the survey items, signifying that they generally have favorable perceptions of the AR program. However, for the item, "the exclusionary and RED (Review, Evaluate, Decide) team criteria DCFS is using to identify AR-eligible families are the right criteria" the majority of stakeholders either disagreed or strongly disagreed. This indicates a need for DCFS to reexamine and possibly edit the exclusionary and RED team criteria. The following items are not group-specific, therefore these data are being reported in aggregate for all stakeholder respondents. Table 1.1.7 displays response summaries of AR program perceptions for AR stakeholders, overall.

Table 1.1.7: Overall AR Stakeholder Response Summary for AR Program Elements

History of Collaboration	Average	*SD*	N
1. Trying to solve problems though collaboration has been common in our local community.	3.47	0.76	32
2. Agencies in our local community have a history of working collaboratively with DCFS.	3.34	0.45	32

History of Collaboration Comments

- "I'm not sure about a history, but within the past 3 to 4 years it has gotten much better."
- "Collaboration gets derailed when solutions or changes are not shared and are handed down."

- "We have several community partners that don't work well with us and at times feel that kids out of home is the only way to go."
- "I think collaboration is better than it has been in the past. Still room to grow in that area."

Appropriate Pace of Development	Average	*SD*	N
3. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.84	0.92	32
4. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.78	0.87	32

Appropriate Pace of Development Comments

- "Work load issues and case worker shortage is a problem for successful roll out of AR."

Political and Social Climate for AR	Average	*SD*	N
5. The political and social climate seems to be "right" for AR to be successful.	3.62	0.79	32

Political and Social Climate for AR Comments

- "Significant changes in HHS leadership cause some slow down as the trust will need to be re-established."
- "Too many people ignore the very high quality research done in other states that conclusively demonstrates that AR works. These people are seemingly intent upon denying the science at the expense of families and taxpayers."
- "We really need to get rid of some of the exclusionary criteria so we can open this up to more families and get to a point where we can have staff who specialize in AR."

Perceptions of AR Program Elements	Average	*SD*	N
6. AR will be able to keep kids as safe as Traditional Response.	4.38	0.79	32
7. Nebraska's AR model is designed to serve families with less severe allegations.	4.09	0.93	32
8. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	2.81	1.20	32
9. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.52	0.63	31
10. AR families should not be placed on the Central Registry.	4.69	0.47	32
11. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	4.13	0.87	32
12. Families will receive services faster in AR as compared to Traditional Response.	3.83	1.02	30
13. Concrete supports will be better addressed through AR as compared to Traditional Response.	4.00	0.98	32
14. Law enforcement should be involved in AR cases.*	4.06	0.76	32
15. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.48	0.72	32

Perceptions of AR Program Elements Comments

- "I chose 'Disagree' to AR families receiving faster services and better concrete supports because both AR and TR should get services fast and better concrete supports. There are things like amazing family engagement that should be a hallmark of both AR and TR, not only AR."
- "HHS has not been openly discussing the data, so it is hard to know if AR is working. Worker contacts with families don't seem to be consistent. We have not seen any reports of re-entry or measured success."
- "The AR cases are not getting better outcomes than our TR cases."
- "There are too many exclusionary and RED team criteria to make this program as beneficial as it could be."

General Comments

Stakeholders provided the following overall comments about the AR program:

- "There is little political appetite to spend and invest in the services necessary to ensure that AR is successful. Year after year DCFS underfunded and understaffed, though its leadership continues to insist that it will accomplish division goals by creating 'operational efficiencies.' This consistent message that our system will somehow be able to do more with less, coming from DCFS leadership, often undercuts the goals of AR-- if we are to meet the goals of this pilot, our entire child welfare system, from prevention through the deep end of the system, must be functional. We cannot hope that AR will be successful while DCFS and other political leaders insist that in light of our state budget shortfall, all state agencies must "tighten our belts," when in fact, children's lives are endangered each year that the DCFS budget is cut in the exact same manner as other state agencies."
- "It is incredibly frustrating, though I understand the reasoning behind it, that 1/2 of families eligible for AR, must go TR, especially if there are better outcomes, and less negative things happen (law enforcement, central registry, slower response, slower implementation of services) with AR. It just seems wrong, no matter how important the study is."
- "I think it is a great opportunity for the state if the program is implemented well. It is going to take a while for the workers to get used to the approach to AR vs TR. I hope that they get all the support they need."
- "I think the program has merit and is helping prevent some families from coming into the system and/or preventing their issues from intensifying."

Conclusion

Overall, the majority of participants' ratings did not vary significantly between groups, on average. Generally, AR stakeholders agreed or strongly agreed with the statements in the survey, meaning that generally AR stakeholders had favorable perceptions of the meetings in which they participate and of the AR program. Overall, the Alternative Response Statewide Advisory Board received the lowest ratings and the Citizen Review Panel was rated most favorably. Findings and comments indicated that future efforts should be aimed at actively engaging stakeholders in meaningful discussions and increasing stakeholder participation in decision-making processes. Additionally, there is some indication that other stakeholders may need to be represented (including families and community service providers); the

exclusionary and RED team criteria should be reexamined/edited; and the location and duration of meetings should be considered thoughtfully so that stakeholders throughout the state are able to participate in a way that is efficient and practical.

Overall AR Stakeholder Survey Summary

Overall, for both AR Stakeholder Survey administrations, stakeholders indicated positive ratings and had positive comments about the AR program. However, the utility of the various AR stakeholder group meetings appeared to vary and change over time. Based on the results of past survey efforts and the ongoing observations of stakeholder meetings, a final survey administration was not conducted. Ultimately, the AR Statewide Advisory Board, which had been instrumental in the initial development of the AR program, reduced their meeting frequency to annually in the final 2 years of the demonstration. Attendance also noticeably declined. Ratings were positive from members of the Director's Steering Committee, although the evaluators did not have an opportunity to directly participate in or observe these meetings. The AR internal workgroup continued to meet regularly throughout the demonstration to address programmatic and implementation issues. This internal team will continue post-demonstration as well. However, in general, outreach and collaboration with external AR stakeholders diminished during the latter half of the demonstration.

Document Review and Participant Observation of AR Stakeholder Meetings

The other sources of data regarding stakeholder engagement in the AR program come from the evaluators' observations as participants of stakeholder meetings as well as a review of archival documents provided by DCFS, and ongoing discussions with the AR Program Specialist and Title IV-E Waiver Administrator. During the latter stages of project planning and during the implementation of AR, the evaluators have attended the majority of stakeholder meetings (with the exception of Director's Steering Committee and Citizen Review Panel), to gain insight into the level of involvement and participation in program planning and modification. Evaluator participation in these meetings continued throughout the demonstration.

Table 1.1.8 summarizes the types of stakeholder meetings, membership and purpose of each group, frequency of meetings, dates of meetings, and representative agenda items. The most influential of these stakeholder meetings appears to be the Director's Steering Committee, which is a select group of key system stakeholders. These meetings have served as a venue for members to provide advice and feedback on the AR program during its developmental phase, early implementation and expansion. It should be noted that in 2018, the Citizen Review Panel moved to be called the Family Voice CRP and the members could choose if they wanted DHHS/Stakeholders Present. Ultimately a contract making these changes was signed into effect in October 2018. No meeting are documented after March 2018 for AR.

Table 1.1.8: Summary of Stakeholder Meetings

Stakeholder Group	Membership and Purpose of Group	Frequency Summary	Dates of Meetings Held	Illustrative Agenda Topics
Director's Steering Committee	• Members are key system stakeholders and are selected and formally invited by the AR Program Administrator. • Members provide feedback and advice on the development and implementation of AR; review CQI data; obtain feedback and brainstorm opportunities for growth	Meetings occurred nearly monthly in the first three years, then moved to quarterly. Meetings were 1 ½ hours in length.	12/10/14, 01/14/15, 02/19/15, 03/19/15, 04/16/15, 05/21/15, 06/18/15, 08/20/15, 09/17/15, 10/15/15, 11/19/15, 02/18/16, 04/21/16, 05/19/16, 07/21/16, 08/18/16, 10/20/16, 11/17/16, 02/16/17, 04/20/17, 05/18/17, 07/20/17, 08/17/17,	• Program updates • Regulatory hearings • Reviews of CQI data • Citizen Review panel updates • Service array/community scans • Reviewed implementation expansion criteria and proposals, when relevant • Reviewed RED team data

			10/19/17, 11/09/17, 02/15/18, 05/17/18, 08/16/18, 11/15/18, 04/14/19, 06/13/19, 09/09/19, 12/12/19	
AR Statewide Advisory Team	• Members represent external system stakeholder organizations • Members receive updates on project implementation and evaluation findings; review CQI data; provide input on programmatic issues identified by DCFS.	Meetings occurred every other month in first year, and then moved to quarterly. In December 2017, the group agreed to meet yearly and simply be notified via email of any updates with Regulations or Legislation:	12/15/14, 02/10/15, 03/10/15, 04/14/15, 06/9/15, 08/11/15, 10/13/15, 12/15/15, 02/11/16, 05/12/16, 08/11/16, 12/8/16, 02/9/17, 05/11/17, 08/10/17, 12/07/17, 08/09/18, 08/08/19	• Program updates • Status updates on regulatory and legislative hearings • Reviews of CQI data • Updates from UNL-CCFL evaluators • Discussion of Service Array/community scans • Updates regarding expansion status • Discussion of RED team data
Citizen Review Panel	• This panel was created approximately 1 year after the start of AR implementation • Members are key system stakeholders • Members provide feedback and advice on the development and implementation of AR; review CQI	Meetings occur quarterly for 1 ½ hours.	09/17/15, 12/17/15, 03/17/16, 06/16/16, 09/15/16, 12/15/16, 03/16/17, 06/15/17, 09/14/17, 12/14/17, 03/15/18	• Program updates • Regulatory hearings • Reviews of CQI data • Case Review of AR Cases • Reviewed RED team data • Provide recommendations for program implementation/ changes/ enhancements.

	data; reports and recommendations from this panel were used to identify areas of strength and areas of challenge			
AR All-Staff	• Members are all DCFS staff, supervisors, and service area administrators involved in AR implementation • Participants receive programmatic and evaluation updates, and provide input on implementation from the field's perspective	Periodic in-person meetings which later moved to virtual meetings by Skype or conference call. Eventually AR All-Staff Meetings ceased, as there were too many new staff to gather at one time. Bi-monthly emails were sent instead and refresher trainings were offered when requested.	01/21/15, 02/18/15, 10/21/15, 12/9/15, 02/17/16, 05/18/16, 12/7/16, 04/19/17, 04/12/18 (canceled due to site visits), 10/11/18 (skype)	• Program updates • Topical mini-trainings or question and answer sessions to enhance AR implementation • Problem solving discussions • Case mapping demonstrations • Presentations on evaluation findings
AR Internal Workgroup	• Workgroup began as the internal DCFS team charged with developing the AR program model; membership has evolved to include representatives (staff, supervisors) of field offices implementing AR, and the focus has shifted to internal monitoring and	Monthly initially, then moved to bi-monthly, and then quarterly:	02/11/14, 02/11/15, 03/11/15, 04/15/15, 05/13/15, 06/10/15, 07/16/15, 08/12/15, 09/16/15, 10/14/15, 11/10/15, 12/16/15, 02/11/16, 04/14/16,	• Project planning and implementation reports and updates • Reviews of CQI data • Periodic reviews of AR case files and debrief of findings • Any changes to the AR Program Manual

	process improvement	06/9/16, 08/11/16, 09/29/16, 10/13/16, 12/8/16, 02/9/17, 04/13/17, 06/08/17, 08/10/17, 10/12/17, 12/07/17, 02/08/18, 04/05/18, 07/12/18, 10/04/18, 02/14/19, 05/09/19, 08/08/19, 11/07/19	• Training needs or updates • Any updates or enhancements that needed to be communicated to the field

Overall Conclusion of Stakeholder and Community Engagement

While it would be difficult to ascertain an estimate of the proportion of program changes that have resulted from any of these meetings, our early interviews of the AR Program Specialist and the Title IV-E Waiver Administrator suggested that these meetings with key stakeholders have been critical to inform the ongoing program refinement and modification that has occurred. Often it appears that similar agenda items have appeared on the Director's Steering Team and AR Statewide Advisory Team meetings that are scheduled within a few weeks of each other, suggesting that DCFS has sought feedback and input from both groups on a particular topic, or that a discussion that occurred in one meeting may have been followed up on in the other group's meeting. However, while the AR Statewide Advisory Team began with a large number of external stakeholders in attendance during the period of program planning and initial implementation, the number of external participants who attend these meetings has dwindled in the past year to just a few. The AR All-Staff meetings were initially focused on providing programmatic support to the field and to serve as a mechanism for the field to share and problem-solve implementation challenges with program administrators. However, as AR was expanded across the state, the number of new caseworkers and those participating in AR case management became too cumbersome to coordinate. In lieu of an in-person meeting or large conference call/webinar, bi-monthly emails were disseminated to all staff and staff were encouraged to request refresher trainings as needed. The AR Internal Workgroup began as a program development team, and has evolved in purpose to focus on program monitoring, expansion, and refinement. This group has met consistently throughout the demonstration and will continue to monitor and refine the AR program ongoing, post-demonstration.

Overall, DCFS engaged with stakeholders and community members to gather input and to share information about the AR program's development and implementation during the planning and early implementation phases of the project. As the AR program became more solidified and there were less updates for DCFS to share, meetings focused on this purpose experienced reduced frequencies and attendance by external stakeholders. Ongoing monitoring and revisions happened more so with external stakeholders during early implementation as well. Overtime, ongoing monitoring and revisions has largely been limited to internal stakeholder input. Partnership between DHHS, community stakeholders, and provider agencies does not appear to have markedly improved, but has also not diminished, during the course of the waiver demonstration.

Chapter 2: Staff Qualifications, Training, and Support

Key Questions:

- Do staff have the necessary qualifications and competencies to do AR work?
- Do staff have an understanding and buy-in for the AR program?
- Does the CFS applicant pool draw more individuals with social work experience and degrees?
- Do CFS staff receive the training, supervision and supports needed to perform the work?

Data to inform these questions comes from AR staff training evaluation data and qualitative data from focus groups and interviews of Intake staff, AR field staff, and RED team participants. Human Resources data necessary to assess the experience and educational degree of job applicants was requested, but unavailable. Each of these data sources and resultant findings are described below.

AR Training Evaluation

Training for staff who provide Alternative Response was initially delivered under a contract to UNL-CCFL. In January 2016 thru April 2018, the contract for delivery of AR training transitioned to Project Harmony. Through the remainder of 2018, training was conducted internally by the AR Program Specialist. In January 2019, the contract transitioned back to UNL-CCFL, where the training was incorporated into new worker training. With these transitions, the training evaluation measures changed. The sections that follow summarize the evaluation of training conducted by both contractors over the course of the demonstration project. Training evaluation data was not collected during the time when training was conducted by the AR Program Specialist.

AR Staff Training Evaluation (2014-2015)

Purpose of AR Training

Multiple trainings were developed to increase the awareness, knowledge, and understanding of AR for those involved in the child welfare system. Specifically, these initial trainings, along with ongoing training throughout the demonstration, aimed to address the following short and intermediate term outcomes for DCFS staff:

(1) Necessary qualifications and competencies to do AR
(2) Understand and buy-in to AR program
(3) Training, supervision, and supports needed to perform AR work
(4) AR program is implemented with fidelity

Ultimately, these outcomes are expected to lead to broader Child and Family Services organizational outcomes, as well as child and family impacts related to safety, permanency, and well-being. This training evaluation report summarizes the training efforts leading up to AR implementation.

Participants

Training participants included a broad range of staff involved in the delivery of child welfare services; this included intake staff, front-line workers, supervisors, DCFS administration and other DCFS staff. In total, 270 individuals participated in an AR-focused training; specific curricula varied depending on the needs of the audience. Broad AR overview training was delivered to 85 AR pilot site administrators and

staff in 7 training sessions between May 1, 2014 and May 27, 2014. AR caseworker training was delivered to 74 front-line and direct supervisor staff, administrators, and other DCFS staff (e.g., Quality Assurance) in 9 training sessions held between June 24, 2014 and September 19, 2014. Fifteen supervisors and administrators attended a supervisor-focused training session from September 9, 2014 to September 11, 2014. In addition, specialized AR trainings were delivered to: 54 intake staff in 5 training sessions between September 9, 2014 and September 25, 2014; 29 RED team staff in 2 training sessions on September 23, 2014 and September 25, 2014; and 15 resource development staff in a single training session on October 10, 2014.

AR Trainings

Six different AR curricula were created for specific audiences:

1) AR Overview
2) AR Intake
3) AR RED Team
4) AR Supervisor
5) AR Resource Development
6) AR Primer

The AR Overview training was developed to provide a clear and consistent overview of the AR pilot program to members of the AR pilot sites' internal leadership teams as well as front-line staff and supervisors. AR Intake training provided intake workers with the specific information they needed to gather related to AR and how to document this information. AR RED Team training presented policy related to the role of RED Team members and practiced RED team decision making processes. AR Supervisor training was developed for supervisors of AR staff to help familiarize them with different AR processes, policy, and strategies for supervision. AR Resource Development training presented an overview of AR for Resource Development staff and discussed strategies for Resource Development's role with AR families. Finally, AR Primer training was developed for all pilot site staff identified to do AR (e.g., front-line staff, supervisors, administrators) and provided detailed information about AR policy.

Reaction-Level Training Evaluation

Reaction-level data was collected for each AR training to assess to what degree participants reacted favorably to the training experience. Trainee reaction surveys were developed, administered, and collected through the UNL-CCFL training partnership with DCFS (see *Evaluation of Trainers and Training* form on the next page). These surveys allowed training participants to provide ratings, indicating their level of agreement (*1 = Strong Disagree, 5 = Strongly Agree*) with statements and comments related to training content (e.g., sequence, teaching aids, activities, application) and trainer performance (e.g., trainer knowledge, presentation, preparedness, attitude, responsiveness; some trainings had multiple trainers). These evaluation forms were completed by participants at the end of each training session and CCFL provided the waiver evaluation team with these data.

Evaluation of Trainers and Training

Training Date(s):	Unit:	Location:	Group:
Trainer(s): 1)	2)	3)	4)

Please help us evaluate the quality of training by giving constructive and professional feedback.
Circle your rating of agreement with each statement using the following scale:

SD	D	N	A	SA
Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**

	Trainer 1	***Trainer 2***	***Trainer 3***	***Trainer 4***
1) The trainer showed a high level of knowledge about the training topic.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
2) The trainer presented information in a clear and concise manner.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
3) The trainer demonstrated a high level of preparation and organization.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
4) The trainer provided summaries and emphasized the main points.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
5) The trainer demonstrated a respectful attitude toward trainees.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
6) The trainer responded effectively to the trainees' questions and comments.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				
7) The training was well paced–not too fast/not too slow.	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺	SD D N A SA ☹ ☺
Comments and Suggestions (if multiple trainers, please include trainer name in comment):				

SD	D	N	A	SA
Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**

8) The training was arranged in a logical sequence. SD D N A SA ☹ ☺
Comments and Suggestions:

9) The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos). SD D N A SA ☹ ☺
Comments and Suggestions:

10) The training engaged me in the learning process (e.g., through activities, practice, or discussion). SD D N A SA ☹ ☺
Comments and Suggestions:

11) The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation. SD D N A SA ☹ ☺
Comments and Suggestions:

12) The training gave me new knowledge and skills that will be useful in my job. SD D N A SA ☹ ☺
Comments and Suggestions:

13) I am committed to applying what I learned in this training to my job. SD D N A SA ☹ ☺
Comments and Suggestions:

14) I feel confident that I can successfully apply what I learned in this training to my job. SD D N A SA ☹ ☺
Comments and Suggestions:

What did you find MOST helpful about the unit?

What did you find LEAST helpful about the unit?

Please provide any suggested changes or other comments you would like to share.

Knowledge Assessment of the AR Primer Training

For the AR Primer Training, learning was assessed using a pre-/post-test design. Participants completed the same test before and after training to measure knowledge gains as a result of training. The pre-test results give an indication to what degree participants were already familiar with the training's learning objectives prior to attending training. Although AR is a new practice for Nebraska, planning has been going on for years and communications about AR had been shared with most front-line staff and supervisors prior to being selected for an AR role and attending training. Furthermore, some aspects of the AR training should not have been new concepts to the participants (e.g., family engagement, family centered practice). Therefore, it was important to measure participants' baseline knowledge before the intervention of training. Without a pre-test we would not have be able to conclude that the post-test performance was a result of training, because participants may have already known the information before participating in training. However, by administering a pre- and post-test we were able to make a direct comparison of participant knowledge before and after training.

Test Development. The knowledge test for the AR Primer training was developed by reviewing the AR Primer training curriculum. A question bank was formed by developing items directly from the learning material being presented to participants. Subject matter experts were consulted to edit questions, create scenarios, and clarify the importance of testing certain information over another. The resulting test questions represent a sample of the information covered throughout the training. This includes questions about the purpose of AR, exclusionary criteria and how families are deemed eligible for AR, why AR and Traditional Response (TR) are both needed, the differences between AR and TR case practice, what circumstances require a family to switch from AR to TR and how to do this, family engagement, specific case practice for AR, and the 6 protective factors. Because the training was being delivered while policy was continuing to be finalized, the training and the knowledge test had to be very fluid and frequently changed within the relatively short amount of time in which training was delivered. The current test is comprised of 36 items and included multiple-choice, true/false, and matching item formats.

Testing Protocol. The test was completed before and after each AR Primer training session. Each testing session took approximately 15-20 minutes to complete. Both tests were completed in the classroom in paper-and-pencil format, with the trainers proctoring. Participants took their test individually and were not allowed to use their notes or resource materials to answer the test questions. Each participant received one test and one answer sheet. When participants finished the pre-test, they were instructed to hand in their tests and answer sheets. Because the same test items were used on the pre- and post-test, trainees did not receive feedback after completion of the pretest. However, when participants finished the post-test, they were instructed to hand in their answer sheets only and kept their test for a follow-up discussion. Once all participants had completed the test, the trainers reviewed each of the test items with the class and answered any questions. After the classroom review, participants handed in their tests and all testing materials were returned to the evaluators. Pre- and post-test data were then input and analyzed in a SPSS database.

Results

Reaction-Level Training Evaluation. These surveys were completed for each AR-related training. Participants were able to provide ratings for each trainer and once for training content. Therefore, the

number of responses was larger than the number of participants. Figure 1.2.1 shows the ranges of average ratings for the different AR trainings. For example, the first vertical line (on the left) represents the range of averages for the AR Overview training; the lowest question average was 3.17 and the highest question average was 4.37.

Figure 1.2.1: Reaction-Level Evaluations

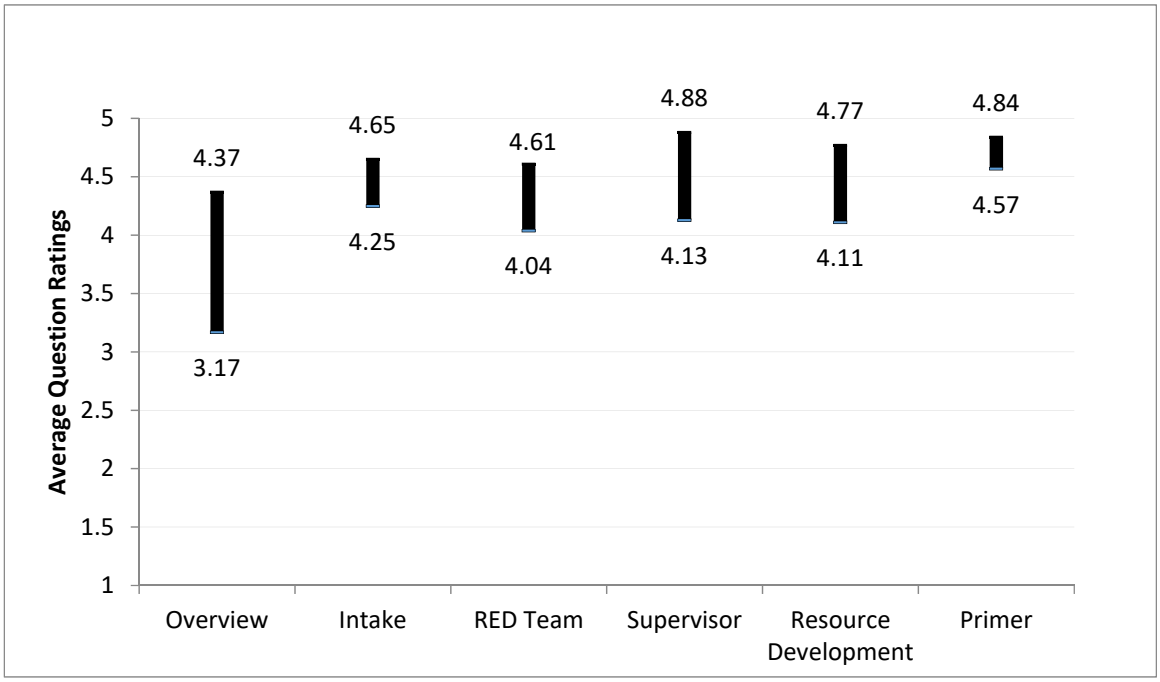


Table 1.2.1 details rating averages and standard deviations for each question, organized by training unit.

Table 1.2.1: Average Reaction-Level Item Ratings by Training Unit

AR Overview Unit Evaluation *N* = 62 to 65		
Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	3.88	0.80
2. The trainer presented information in a clear and concise manner.	3.98	0.80
3. The trainer demonstrated a high level of preparation and organization.	3.94	0.86
4. The trainer provided clear summaries and emphasized the main points.	3.98	0.79
5. The trainer demonstrated a respectful attitude toward trainees.	4.15	0.81
6. The trainer responded effectively to the trainees' questions and comments.	3.89	0.86

Evaluation Statement	Mean Rating	Std. Deviation
Training Content		
7. The training was well paced–not too fast/not too slow.	3.97	0.89
8. The training was arranged in a logical sequence.	4.08	0.72
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	3.78	0.85
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	3.46	0.95
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	3.17	1.02
12. The training gave me new knowledge and skills that will be useful in my job.	3.66	0.95
13. I am committed to applying what I learned in this training to my job.	3.94	0.77
14. I feel confident that I can successfully apply what I learned in this training to my job.	3.83	0.82
15. I was able to easily access the training and training materials.	3.98	0.90
16. The training technology enhanced the learning experience.	3.42	0.93
17. I was able to hear everything I needed to hear (e.g., videos, other trainees, or the trainer).	4.11	1.09
18. I was able to see everything I needed to see (e.g., slides, videos, documents, other trainees, or the trainer).	3.90	0.96
19. The trainer demonstrated proficiency in the use of the technology.	4.37	0.92
20. I was able to ask and answer questions or contribute comments.	3.84	0.85

AR Intake Unit Evaluation
N = 88 to 99

Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	4.48	0.63
2. The trainer presented information in a clear and concise manner.	4.51	0.68
3. The trainer demonstrated a high level of preparation and organization.	4.31	0.99
4. The trainer provided clear summaries and emphasized the main points.	4.43	0.70
5. The trainer demonstrated a respectful attitude toward trainees.	4.60	0.74

Evaluation Statement	Mean Rating	Std. Deviation
6. The trainer responded effectively to the trainees' questions and comments.	4.38	0.82
Training Content		
7. The training was well paced–not too fast/not too slow.	4.25	0.83
8. The training was arranged in a logical sequence.	4.55	0.60
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	4.45	0.82
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	4.63	0.53
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	4.59	0.54
12. The training gave me new knowledge and skills that will be useful in my job.	4.52	0.55
13. I am committed to applying what I learned in this training to my job.	4.65	0.48
14. I feel confident that I can successfully apply what I learned in this training to my job.	4.57	0.60

AR RED Team Unit Evaluation *N* = 34 to 70		
Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	4.42	0.55
2. The trainer presented information in a clear and concise manner.	4.11	0.79
3. The trainer demonstrated a high level of preparation and organization.	4.20	0.67
4. The trainer provided clear summaries and emphasized the main points.	4.13	0.92
5. The trainer demonstrated a respectful attitude toward trainees.	4.61	0.55
6. The trainer responded effectively to the trainees' questions and comments.	4.40	0.81
Training Content		
7. The training was well paced–not too fast/not too slow.	4.04	0.94
8. The training was arranged in a logical sequence.	4.29	0.63
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	4.41	0.61

Evaluation Statement	Mean Rating	Std. Deviation
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	4.50	0.62
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	4.50	0.62
12. The training gave me new knowledge and skills that will be useful in my job.	4.32	0.73
13. I am committed to applying what I learned in this training to my job.	4.47	0.51
14. I feel confident that I can successfully apply what I learned in this training to my job.	4.44	0.61

AR Supervisor Unit Evaluation *N* = 14 to 16		
Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	4.75	0.45
2. The trainer presented information in a clear and concise manner.	4.63	0.50
3. The trainer demonstrated a high level of preparation and organization.	4.56	0.51
4. The trainer provided clear summaries and emphasized the main points.	4.56	0.51
5. The trainer demonstrated a respectful attitude toward trainees.	4.88	0.34
6. The trainer responded effectively to the trainees' questions and comments.	4.75	0.45
Training Content		
7. The training was well paced–not too fast/not too slow.	4.13	1.03
8. The training was arranged in a logical sequence.	4.44	0.51
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	4.69	0.48
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	4.56	0.51
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	4.44	0.51
12. The training gave me new knowledge and skills that will be useful in my job.	4.63	0.50
13. I am committed to applying what I learned in this training to my job.	4.63	0.50

Evaluation Statement	Mean Rating	Std. Deviation
14. I feel confident that I can successfully apply what I learned in this training to my job.	4.64	0.50

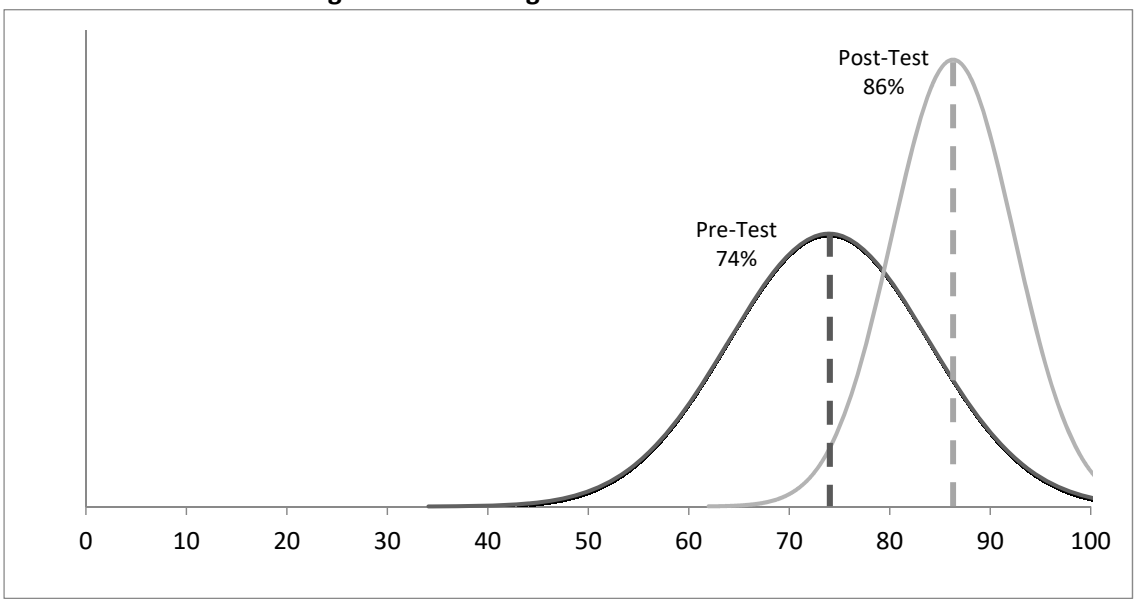
AR Resource Development Unit Evaluation *N* = 34 to 36		
Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	4.67	0.48
2. The trainer presented information in a clear and concise manner.	4.67	0.48
3. The trainer demonstrated a high level of preparation and organization.	4.64	0.59
4. The trainer provided clear summaries and emphasized the main points.	4.39	0.69
5. The trainer demonstrated a respectful attitude toward trainees.	4.75	0.44
6. The trainer responded effectively to the trainees' questions and comments.	4.77	0.43
Training Content		
7. The training was well paced–not too fast/not too slow.	4.14	0.90
8. The training was arranged in a logical sequence.	4.50	0.61
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	4.61	0.69
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	4.61	0.60
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	4.39	0.69
12. The training gave me new knowledge and skills that will be useful in my job.	4.11	1.01
13. I am committed to applying what I learned in this training to my job.	4.61	0.49
14. I feel confident that I can successfully apply what I learned in this training to my job.	4.41	0.78

AR Supervisor Unit Evaluation *N* = 339 to 350		
Evaluation Statement	Mean Rating	Std. Deviation
Trainer Performance		
1. The trainer showed a high level of knowledge about the training topic.	4.72	0.51

Evaluation Statement	Mean Rating	Std. Deviation
2. The trainer presented information in a clear and concise manner.	4.69	0.56
3. The trainer demonstrated a high level of preparation and organization.	4.77	0.46
4. The trainer provided clear summaries and emphasized the main points.	4.74	0.47
5. The trainer demonstrated a respectful attitude toward trainees.	4.84	0.38
6. The trainer responded effectively to the trainees' questions and comments.	4.73	0.58
Training Content		
7. The training was well paced–not too fast/not too slow.	4.57	0.77
8. The training was arranged in a logical sequence.	4.59	0.70
9. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	4.67	0.56
10. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	4.69	0.51
11. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	4.60	0.64
12. The training gave me new knowledge and skills that will be useful in my job.	4.65	0.59
13. I am committed to applying what I learned in this training to my job.	4.74	0.47
14. I feel confident that I can successfully apply what I learned in this training to my job.	4.65	0.52

Knowledge Assessment of the AR Primer Training. Pre- and post-test answers were graded against the answer key to calculate each participant's scores. Average scores and percentages were then calculated for each test across training sessions. The average pre-test score was 26 or 74%, and the average post-test score was 30 or 86%. Because this was part of a new training, many individuals sat in that were not direct-line staff. Several of these individuals completed the pre-test without completing a post-test. The pre-test was completed by 108 participants and the post-test was completed by 70 participants. An independent sample t-test was conducted to compare test scores. There was a significant difference between scores on the pre-test (M = 26, SD = 3.67) and post-test (M = 30, SD = 3.03), $t(176) = 8.28$, p = .00, indicating significant knowledge gains as a result of participating in the AR primer training. Figure 1.2.2 shows the changes in both the distribution and average scores for the pre- and post-test.

Figure 1.2.2: Changes from Pre to Post-Test



Psychometric properties of the AR test. To evaluate the overall psychometric properties of the test several analyses were completed. Table 1.2.2 summarizes these results for the pre- and post-test.

Table 1.2.2: Summary of AR Knowledge Assessment's Psychometric Properties

Overall Psychometric Properties	Pre-test	Post-test
Mean score	26	30
Standard Deviation	3.67	3.03
Average Item Difficulty	.72	.84
Average Item Discrimination	.20	.13
Internal Consistency (KR-20)	.42	.38
Standard Error of Measurement	2.79	2.39

The *mean score* and *standard deviation* were calculated to examine overall performance and variability. The mean is the average test score and the standard deviation represents how much variation there is around the mean. In other words, most participants scored within 4 points (higher or lower) of the mean on the pre-test and within approximately 3 points (higher or lower) of the mean on the post-test. *Average item difficulty* is the percentage of participants correctly answering test items. This index indicates that the test is moderately difficult and falls within a good range for a multiple-choice test. *Average item discrimination* is a measure of how well the test was able to discriminate between low and high performers. The index presented in the table above is the average and represents the proportion of high performers (based on overall score) answering test items correctly, minus the proportion of low performers (based on overall score) answering the same item correctly. It is typically recommended that this index be at least .20, which was achieved by the pre-test. However, the post-test is less capable of discriminating between low and high performers, likely because so many people did well on the post-test. The Kuder-Richardson Formula 20 (KR-20) was used to assess the test's *internal consistency*, or how homogenous the test is. Typically values greater than or equal to .70 are considered acceptable. This test performed lower than this standard on both the pre- and post-test administrations. This test

covered an array of learning objectives, which may have reduced internal consistency to some extent; however, because the overall focus of the test was AR, on a broader level the test should be assessing similar constructs. Two additional factors that likely impacted the internal consistency are 1) sample size and 2) similarity (lack of variance) of the participants' knowledge level. Overall, the pre-test was completed by 108 participants; the post-test was only completed by 70 participants. Furthermore, due to frequent changes in the test, the number of items included in these analyses for an individual ranged from 24-36 items. After accounting for missing values, only 81 cases were included from the pre-test and 59 from the post-test. This value may be considerably different if we were able to administer this test to a larger sample. Additionally, because the ability of the participants was similar (everyone had a similar knowledge base and performed well on the test), the diversity of test scores is small. This generally lowers the KR-20 value compared to tests administered to a more diverse sample of participants. The *standard error of measurement* was examined to determine to what degree the "true score" was displayed. This means that if participants took this test repeatedly, their scores would likely only vary by 2 to 3 points.

Implications of Findings

Reaction-Level Training Evaluation. The majority of ratings indicated a favorable response. It appears that the AR-related trainings completed prior to AR implementation were well received and allowed for participants to gain new information about the AR program in a satisfactory way.

Knowledge Assessment of the AR Primer Training. There were significant gains in participants' understanding of AR knowledge as a result of attending the AR Primer training. Participants knew significantly more information about AR after participating in training than they did before attending training; meaning training was a successful intervention for increasing understanding of AR policy.

Overall Implications. Training was developed to increase the awareness, knowledge, and understanding of AR for those involved in the child welfare system. Looking at the reaction-level data for the different trainings and the knowledge assessment for the AR Primer training, it appears that the AR-related trainings were successful in communicating AR program information to the different audiences and that the AR Primer training was able to significantly increase the understanding of AR policy for front-line staff. Ongoing training is anticipated throughout the implementation of this demonstration. Further evaluation will need to be completed in order to determine the extent to which the program outcomes have been achieved. However, the training developed and administered prior to AR implementation, appears to have been well received and valuable for staff in understanding AR. To the extent that the content covered in these and subsequent trainings represent the necessary information needed to perform AR work and that all front-line staff doing AR work participate in an AR training, it is reasonable to believe the AR staff will have the training and necessary competencies needed to perform AR work with fidelity. Additional data sources will need to be examined in combination with training evaluation data to ultimately determine to what extent the intended outcomes were achieved.

AR Staff Training Evaluation (2016)

Participants

In January 2016, Project Harmony assumed the development and delivery of AR training for all staff identified to do AR (e.g., front-line staff, supervisors). This three-day training provided information about AR policy. Five training sessions were offered in 2016, with 70 total attendees.

Reaction-Level Training Evaluation

Reaction-level data was collected for each AR training to assess to what degree participants reacted favorably to the training experience. Trainee reaction surveys were developed, administered, and collected by Project Harmony (see *Alternative Response* reaction-level evaluation form on next page). These surveys allowed training participants to provide ratings, indicating their level of agreement (*1 = Strong Disagree, 5 = Strongly Agree*) with statements and comments related to self-reported knowledge of training content, trainer performance (i.e. trainer knowledge, presentation, and enthusiasm), and other training characteristics (i.e. length, training materials, room and equipment, and benefit to professional life). Between January and June 2016 these evaluation forms were completed by participants at the end of each 3-day training session; beginning in September 2016 the forms were completed at the end of each training day. Project Harmony provided the waiver evaluation team with these data.

Knowledge Assessment of AR Training

Knowledge assessments for AR training were discontinued after the transition to the new training contractor. The evaluators attempted to develop a knowledge assessment prior to implementation of the new training program, but Project Harmony did not share the curriculum necessary for a test to be developed. Project Harmony developed and implemented their own pre/post-test; however, it lacks sufficient psychometric properties to be utilized in our training evaluation.

Alternative Response

Our goal is to provide you with excellent training.
Please provide your comments and feedback.

Your Agency: _____ Date: _____

Please check the box that most accurately reflects your opinion for each statement below.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Objectives						
I know the differences between AR and TR.		☐	☐	☐	☐	☐
I know how to apply protective factors in my work with families.		☐	☐	☐	☐	☐
I understand the difference between listening to understand		☐	☐	☐	☐	☐
I better understand how to address a family's concerns.		☐	☐	☐	☐	☐
I understand how and why to use a genogram and/or ecomap.		☐	☐	☐	☐	☐
I understand the difference between short-term and long-term designs.		☐	☐	☐	☐	☐
I know how to access supports and services for the families I serve.		☐	☐	☐	☐	☐
I understand my role in case mapping.		☐	☐	☐	☐	☐
I know how to close an alternative response case.		☐	☐	☐	☐	☐
Trainer1						
	Was enthusiastic and used effective presentation skills.	☐	☐	☐	☐	☐
	Was knowledgeable on subject matter.	☐	☐	☐	☐	☐
Trainer2						
	Was enthusiastic and used effective presentation skills.	☐	☐	☐	☐	☐
	Was knowledgeable on subject matter.	☐	☐	☐	☐	☐
Trainer3						
	Was enthusiastic and used effective presentation skills.	☐	☐	☐	☐	☐
	Was knowledgeable on subject matter.	☐	☐	☐	☐	☐
Trainer4						
	Was enthusiastic and used effective presentation skills.	☐	☐	☐	☐	☐
	Was knowledgeable on subject matter.	☐	☐	☐	☐	☐
The length of the session was appropriate for the content.		☐	☐	☐	☐	☐

The printed training materials were useful.	☐	☐	☐	☐	☐
The room/equipment contributed to a positive learning experience.	☐	☐	☐	☐	☐
This event has the potential to benefit my professional life.	☐	☐	☐	☐	☐

What aspects of this class contributed **most** to your learning?

_____

_____

_____

What could be done differently to make this a more successful learning event?

_____

_____

_____

Do you have any other suggestions related to Project Harmony training?

_____

_____

_____

Results

Reaction-Level Training Evaluation. Overall, respondents indicated positive reactions to the training, with average ratings for items ranging from 4.12 to 4.82 on a 5-point scale. Table 1.2.3 summarizes the item-level averages for each evaluation question.

Table 1.2.3: Average Item Rating for Project Harmony AR Training

Evaluation Statement	N	Average Rating	Std. Deviation
Self-Reported Knowledge			
1. I know the difference between AR and TR.	62	4.77	0.42
2. I know how to apply protective factors in my work with families.	61	4.31	0.56
3. I understand the difference between listening to understand and listening to respond.	62	4.68	0.47
4. I understand how and why to use a genogram and/or ecomap.	61	4.62	0.55
5. I know how to access supports and services for the families I serve.	63	4.33	0.72
6. I know how to close an alternative response case.	63	4.33	0.62
Trainer Performance			
7. The trainers were enthusiastic and used effective presentation skills.	113	4.77	0.49
8. The trainers were knowledgeable on subject matter.	114	4.82	0.38
Training Characteristics			
9. Length of the session was appropriate for content.	114	4.12	0.94
10. Printed training materials were useful.	114	4.53	0.68
11. The room/equipment contributed to a positive learning experience.	89	4.46	0.72
12. This event has the potential to benefit my professional life.	113	4.62	0.57

Note. These data were collected between January and October 2016. Changes were made throughout the year to the questionnaire; only the questions that remained constant over the year are included in this evaluation. Beginning in September 2016, trainees responded to the trainer and training characteristics questions after each day of training; thus, there are more responses for those question types.

Trainee Comments. Trainees provided a total of 166 comments in response to three question prompts. There were 91 comments in response to the question "What aspects contributed 'most' to your learning?"; 59 comments in response to the question "What could have been done 'differently' to make this a more successful learning event?"; and 16 comments in response to the question "Do you have any other suggestions related to Project Harmony training?". The evaluators read the comments and identified key themes. In response to the first question, 58 comments (64%) mentioned roleplaying, activities, or discussion as the aspect that contributed most to their learning. In response to the second and third questions, 30 comments (40%) mentioned the emphasis of the training was off-base, noting there was too much emphasis on foundational case management practices (e.g., family engagement, protective factors) and not enough emphasis on concrete AR details (e.g., where to document on N-FOCUS, documentation timelines, where to identify community resources).

AR Staff Training Evaluation (2017-2018)

Participants

Project Harmony continued the development and delivery of AR training for all staff identified to do AR (e.g., front-line staff, supervisors) in 2017 and thru April 2018. Beginning in June 2017, an online component was incorporated and the in-person portion of the training was reduced from 3 days to 2 days. Six training sessions were offered from March 2017 to April 2018, with 64 total attendees.

Reaction-Level Training Evaluation

Reaction-level data was collected for each AR training to assess to what degree participants reacted favorably to the training experience. Trainee reaction surveys were developed, administered, and collected by Project Harmony. These surveys allowed training participants to provide ratings, indicating their level of agreement (*1 = Strong Disagree, 5 = Strongly Agree*) with statements and comments related to coverage of learning objectives, trainer performance (i.e. trainer knowledge, presentation, and enthusiasm), and other training characteristics (i.e. length, training materials, and benefit to professional life). Participants completed the evaluations at the end of the multiple-day training session. Project Harmony provided the waiver evaluation team with these data.

Results

Reaction-Level Training Evaluation. Overall, respondents indicated positive reactions to the training, with average ratings for items ranging from 3.61 to 4.72 on a 5-point scale. The highest-rated items were related to the performance of the trainers (average ratings of 4.71 and 4.72). The lowest-rated items were related to the "stages of change" learning objective (average rating of 3.61) and the length of the training session (average rating of 3.85). Table 1.2.4 summarizes the item-level averages for each evaluation question.

Table 1.2.4: Average Item Rating for Project Harmony AR Training

Evaluation Statement	N	Average Rating	Std. Deviation
Learning Objectives			
1. Participants will learn the four elements of engagement and why they are important.	34	4.26	0.51
2. Participants will learn to consider the cultural aspects of families and implement steps to demonstrate humility.	34	4.29	0.68
3. Participants will understand what needs to be accomplished during the initial phone call and visit with a family.	34	4.38	0.65
4. Participants will understand the importance of body language and how to address it when it reflects disengagements.	34	4.38	0.65
5. Participants will learn how to use the Prevention Assessment and Protective Factors Questionnaire in developing a Family Plan.	34	4.06	0.74
6. Participants will learn more about the six Protective Factors that are identified in the Protective Factors Questionnaire.	55	4.15	0.76
7. Participants will learn the stages of change and how to evoke change talk.	36	3.61	1.00

Trainer Performance			
8. The trainers were enthusiastic and used effective presentation skills.	47	4.72	0.44
9. The trainers were knowledgeable on subject matter.	47	4.71	0.46
Training Characteristics			
10. Length of the session was appropriate for content.	46	3.85	1.24
11. Printed training materials were useful.	47	4.00	0.93
12. This event has the potential to benefit my professional life.	47	4.21	0.82

Note. These data were collected between March 2017 and April 2018. Several changes were made to the questionnaire during this time period; only the questions that were included on more than half of the evaluations were included.

Trainee Comments. Trainees provided a total of 92 comments in response to four question prompts. There were 42 comments in response to the question "What aspects contributed 'most' to your learning?"; 29 comments in response to the question "What could have been done 'differently' to make this a more successful learning event?"; and 8 comments in response to the question "Do you have any other suggestions related to Project Harmony training?". The evaluators read the comments and identified key themes. In response to the first question, 19 comments (45%) mentioned roleplaying, activities, or discussion as the aspect that contributed most to their learning; 10 comments (24%) referenced receiving information about specifics of the AR program as most beneficial. In response to the second and third questions, 13 comments (35%) mentioned the emphasis of the training was off-base, noting there was too much emphasis on foundational case management practices (e.g., family engagement, cultural competence) and not enough emphasis on concrete AR details (e.g., processes, timeframes of the program, where to document on N-FOCUS).

AR Staff Training Evaluation (2019)

Participants

In January 2019, AR training transitioned back to UNL-CCFL. AR training for front-line staff was incorporated into the new worker training model. Thus, all new workers attended the training, regardless of whether they were expected to be assigned AR cases or not. This is a one-day training, which provided information about AR policy. An online pre-work component was added in May, but no evaluations were received for that specific portion of the AR training. Training participants completed the evaluation at the end of the in-person training session. Five in-person training sessions were offered between January and June 2019, with 68 total attendees.

Reaction-Level Training Evaluation

Reaction-level data was collected for each AR training to assess to what degree participants reacted favorably to the training experience. Trainee reaction surveys were developed, administered, and collected by UNL-CCFL. These surveys allowed training participants to provide ratings, indicating their level of agreement (*1 = Strong Disagree, 5 = Strongly Agree*) with statements and comments related to trainer performance (e.g., trainer knowledge, presentation, and organization), and training content (e.g., usefulness of training materials, applicability to job duties). Between January and June 2019 these evaluation forms were completed by participants at the end of each one-day classroom training session.

Results

Reaction-Level Training Evaluation. Overall, respondents indicated positive reactions to the training, with average ratings for items ranging from 4.85 to 4.94 on a 5-point scale. Table 1.2.5 summarizes the item-level averages for each evaluation question.

Table 1.2.5: Average Item Rating for UNL-CCFL AR Training

Evaluation Statement	N	Average Rating	Std. Deviation
Trainer Performance			
13. The trainer showed a high level of knowledge about the training topic.	104	4.94	0.23
14. The trainer presented information in a clear and concise manner.	104	4.94	0.27
15. The trainer demonstrated a high level of preparation and organization.	104	4.94	0.27
16. The trainer provided clear summaries and emphasized the main points.	104	4.93	0.29
17. The trainer demonstrated a respectful attitude toward trainees.	104	4.93	0.32
18. The trainer responded effectively to the trainees' questions and comments.	104	4.94	0.27
Training Content			
19. The training was well paced–not too fast/not too slow.	60	4.87	0.47
20. The training was arranged in a logical sequence.	60	4.88	0.37
21. The training utilized helpful teaching aids (e.g., helpful visuals, examples, handouts, job aids, videos).	60	4.93	0.25
22. The training engaged me in the learning process (e.g., through activities, practice, or discussion).	60	4.87	0.47
23. The training allowed me a fair opportunity to demonstrate the knowledge and skills I learned through a test or other evaluation.	60	4.92	0.28
24. The training gave me new knowledge and skills that will be useful in my job.	60	4.87	0.50
25. I am committed to applying what I learned in this training to my job.	60	4.85	0.48
26. I feel confident that I can successfully apply what I learned in this training to my job.	60	4.87	0.43

Note. Each trainer was rated individually on their performance, which is why there are more responses for those questions.

Trainee Comments. Trainees provided a total of 51 comments in response to three question prompts. There were 33 comments in response to the question "What did you find most helpful about this training?"; 7 comments in response to the question "What did you find least helpful about this training?"; and 11 comments in response to the question "Please provide any suggested changes or other comments you would like to share". The evaluators read the comments and identified key themes. In response to the first question, 20 comments (61%) mentioned that they found the activities,

roleplaying, and handouts/job aids as most helpful. There weren't many trends in response to the second and third questions, 3 individuals (17%) mentioned that they would like the Power Point slides to be printed off for the online pre-work and for the in-person training. A couple of individuals stated that they didn't think the training needs to be a full day for those who are not working AR cases.

Human Resources Data Requested

Administrative data was requested from DHHS Human Resources regarding the selection process for identifying staff for AR positions. At the beginning of the AR implementation, one of the planning workgroups was focused on selection of staff. This team identified a set of necessary competencies that would be assessed for any staff desiring an assignment to an AR caseload. The evaluators requested data documenting the hiring process that was used to select AR case managers. It appears that while DCFS intended to utilize these competencies in identifying staff to do AR, it is unclear that this occurred, primarily because in some offices no staff volunteered to do AR and so administrators had to assign staff to take on this role. Archival records were available from early planning processes, but the extent to which these plans were implemented could not be confirmed, particularly for those counties beyond the initial program roll-out.

Regarding the research question about the composition of the applicant pool, during the evaluation planning process, the evaluators were assured that the necessary administrative data to answer this question existed, and negotiations with DCFS and DHHS Human Resources occurred in 2014, 2015, and again in 2019 to obtain these data. Ultimately, however, the evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.

RED Team Interviews

Purpose of RED Team Interviews

A key component of the AR program is related to determining a family's eligibility to participate in the AR program. Nebraska DCFS has designed and implemented a Review, Evaluate, and Decide (RED) team, which provides an additional level of review for intakes meeting one or more the 8 RED team criteria. RED team members meeting to review these families' intakes, weigh the information, and determine eligibility. Additionally, RED team members convene whenever new information is leaned about an active AR family that meets one or more of the 22 established exclusionary criteria or the 8 RED team criteria. In order to gain a more in-depth understanding of the RED team review processes, interviews were conducted with a sample of RED team members. These interviews focused on RED team members' overall experience and perceptions of the RED team review process.

Participants

UNL-CCFL staff conducted individual phone interviews with 17 RED team members during the month of December 2016. These RED team members were specifically asked to participate in an interview due to their level of involvement with the RED team review process. RED Team members' job roles included: RED Team Coordinator, Children and Family Services (CFS) Administrators, CFS Supervisors, CFS Specialists, and Hotline Intake Specialists. Participants had held their current job roles between 1 and

16.5 years. Participant's involvement with the RED team averaged about 1.5 years, ranging from 3 months to 2 years.

Interview Protocol

Participants were sent a link to read and sign an online informed consent form. All participants were assured that their responses would be confidential and were encouraged to be as honest as possible in their answers. All of the participants were asked the following questions:

1. What is your current job title?
2. How long have you worked in your current job role?
3. How long have you been doing RED team reviews?
4. Do you feel like you received adequate training prior to participating in the RED team review process? Do you think ongoing training would be helpful?
5. Do you feel like you receive adequate guidance and support regarding your involvement with the RED team? And if not, in what ways could this be improved?
6. What is your overall impression of the RED team review process? Do you think the current process works well? In what ways do you think it could be improved?
7. Have your impressions of the RED team review process changed over time? And if so, in what ways?
8. Do you think the right composition of people are participating in RED team reviews? And if not, who do you think should participate in RED team reviews?
9. Do you feel like all RED team members have the opportunity to voice their concerns and be heard during reviews?
10. Do you feel like interpretations of the RED team criteria have changed over time? And if so, in what ways?
11. Do you feel like the process for determining outcomes (whether or a not a family should be determined AR-eligible) has changed over time? And if so, in what ways?
12. What is your impression of the RED team review outcomes? Do you think the reviews are fair? Do you think the reviews are a good use of time?

Analysis of Interview Data

Each phone interview was recorded and transcribed. All of the interview responses were reviewed and major content themes were identified. Individual responses were then coded according to the major content themes. Once coding was complete, a frequency and percentage of how many individual responses aligned with a specific theme was tallied. Note that not all statements were coded, because not all statements fit within a particular theme. Additionally, some statements were coded for more than one theme.

Findings

Overall impression of RED team review process. Less than half of participants said that the RED team review process worked well (41.2%), with an equal number saying that RED team members are coming to RED team meetings unprepared (41.2%). A few participants felt that there needed to be more discussion during the RED team review process (17.6%), with other participants adding that they felt the RED team review process was done too quickly (23.3%). Nearly half of participants felt that RED team

reviews are a good use of time (47.1%). Also, some participants expressed that they believe the RED team reviews do provide an opportunity to help families (11.8%).

Changes in review process over time. Many of the RED team members said that their impressions of the RED team review process have changed over time (64.7%). However, some participants felt that RED team process had not changed over time (35.3%). A little over half of participants felt that the process for determining outcomes had changed over time (52.9%), while others felt that the process had stayed the same (41.2%).

Change in interpretation of the RED team review criteria. Many participants said their interpretations of the RED team review criteria have changed over time (64.7%), while a few participants stated that their interpretations of the RED team criteria had stayed the same (29.4%).

Training. The majority of the RED team members said that they received enough training prior to participating in the RED team review process (76.5%), but only a few stated that they received formal training (11.8%). In contrast, many of the RED team members said that they received no formal training prior to participating in the RED team review process (64.7%). Most RED team members indicated that ongoing training would be helpful (64.7%), with fewer saying that ongoing training is not necessary (35.3%).

Guidance and support. A majority of the RED team members said that they have received guidance and support while involved in the RED team review process (82.4%) but some felt that the support and guidance received in the RED team review process was not necessary (11.8%). Some respondents identified ways to improve guidance and support by increasing support for intake supervisors and staff (17.6%), providing ongoing training (11.8%), more communication (11.8%), and receiving the intake earlier (11.8%).

Composition of RED team. The majority of participants felt that the right composition of people have been participating in RED team reviews (94.1%), everyone has the opportunity to voice their concerns (94.1%), and that RED team reviews are fair (94.1%).

Table 1.2.6 summarizes the findings for each interview question, detailing the major content themes, the number of respondents, the percentage of respondents coded within a specific theme, and a sample of representative responses.

Table 1.2.6: RED Team Interview Summary Table

Do you feel like you received adequate training prior to participating in the RED team review process?			
Theme	Number of Respondents	Percentage	Illustrative Content
Received Enough Training Prior to Participating in the RED Team	13	76.5%	• Yes.

No Formal Training Prior to Participating in the RED Team	11	64.7%	• We didn't really have any formal training to speak of. • We didn't get training specific to the RED Team. • It was more hands-on training. I did not get the actual formal training. • Training that you get for Alternative Response provides some groundwork when you are on the RED Team.
Received Formal Training Prior to Participating in the RED Team	2	11.8%	• Lots of training and meetings about the purpose of the RED Team and how reviews were going to be conducted.

Do you think ongoing training would be helpful?			
Theme	Number of Respondents	Percentage	Illustrative Content
Ongoing Training Would be Helpful	11	64.7%	• It would have been more helpful to get more training. • It would be helpful, especially as Alternative Response things change
Ongoing Training is Not Necessary	6	35.3%	• The Red team review process was really self-explanatory. • I don't think so. • Our ongoing training is pretty much covered in our all-staff and internal conference call meetings.

Do you feel like you receive adequate guidance and support regarding your involvement with the RED team?			
Theme	Number of Respondents	Percentage	Illustrative Content

Guidance and Support have been Received	14	82.4%	• Yes. • Our supervisor and administrator were very supportive and helpful. • If we have questions, everybody on the team has been really good about discussing them.
Guidance and Support are Not Necessary	3	17.6%	• I really didn't need any guidance or support.

In what ways could the guidance and support for RED Team improve?			
Theme	Number of Respondents	Percentage	Illustrative Content
Increase Support for Supervisors and Staff	3	17.6%	• From a worker's perspective, I could see how having more support from their supervisors and administration would be helpful. • I think it would be helpful if supervisors had more support so they can participate more during RED team reviews.
Provide Ongoing Training	2	11.8%	• I think that ongoing training would be good.
More Communication	2	11.8%	• I think having ongoing discussions about the RED team review process is helpful. • As time has passed, there seemed to be less communication about where RED team members were meeting.
Receive Intakes Earlier	2	11.8%	• I am struggling to get the intakes read, plus juggle the things that come in from the night.

What is your overall impression of the RED team review process?			
Theme	Number of Respondents	Percentage	Illustrative Content

The RED Team Review Process Works Well	7	41.2%	• I think that it is a good way to talk about cases and intakes. • I think that the current process works well.
Need for Better Preparation Prior to RED Team Reviews	7	41.2%	• I don't think that everyone who gets on the call is as prepared as they should be. • It would be nice, if at all possible, to get the intakes sooner so that we have a little bit more time to review them prior to the call.
Need for More Discussion During the RED Team Review Process	3	17.6%	• I think we don't have as much discussion as there should be or feedback from different people.

Have your impressions of the RED team review process changed over time?			
Theme	Number of Respondents	Percentage	Illustrative Content
Impressions of the RED Team Review Process have Changed Over Time	11	64.7%	• I think so. • I feel more confident and comfortable as we move forward - that is just down to experience.
Impressions of the RED Team Review Process have Not Changed Over Time	6	35.3%	• No not really. • No it has been about the same.

Do you think the right composition of people are participating in RED team reviews?			
Theme	Number of Respondents	Percentage	Illustrative Content
The Right Composition of People are Participating in the RED Team Review Process	16	94.1%	• We have a good mix of workers, supervisors, and admins. I think that mixture helps get a better, more rounded view.

Additional Participants are Needed in the RED Team Review Process	5	29.4%	• The worker who is working the case should be attending the RED Team. • I think IA should be on the RED Team.

Do you feel like all RED team members have the opportunity to voice their concerns and be heard during reviews?			
Theme	Number of Respondents	Percentage	Illustrative Content
RED Team Members have the Opportunity to Voice Concerns	16	94.1%	• Yeah everyone is given the opportunity and is asked specifically to voice their opinion or concerns.
RED Team Members Do Not have the Opportunity to Voice Concerns	1	5.9%	• Other workers may not be so vocal and not so experienced on the team. I feel like they get run over.

Do you feel like interpretations of the RED team criteria have changed over time?			
Theme	Number of Respondents	Percentage	Illustrative Content
Interpretations of the RED Team Criteria have Changed Over Time	11	64.7%	• I think that some of the interpretations of how we work the cases and the exclusionary criteria have changed. • It is not as strict. I like the flexibility. • Yes. I believe that they have changed, because we have added criteria.
Interpretations of the RED Team Criteria have Not Changed Over Time	5	29.4%	• No, not really.

Do you feel like the process for determining outcomes (whether or a not a family should be determined AR-eligible) has changed over time?			
Theme	Number of Respondents	Percentage	Illustrative Content

The Process for Determining Outcomes has Changed Over Time	9	52.9%	• Yes.
The Process for Determining Outcomes has Not Changed Over Time	7	41.2%	• I don't think the outcomes have changed. • No I don't think so.

What is your overall impression of the RED team review outcomes? Do you think the reviews are fair? Do you think the reviews are a good use of time?			
Theme	Number of Respondents	Percentage	Illustrative Content
RED Team Reviews are Fair	16	94.1%	• Yeah I think that it is fair. • The RED team review process gives families the opportunity to go AR.
RED Team Reviews are a Good Use of Time	8	47.1%	• Yes. • I think that we have grown over time and I think some of the reviews are very quick and easy.
The RED Team Review Process is Completed too Quickly	5	29.4%	• I just wonder sometimes how thorough the reviews really are. • Reviews go fairly quickly.
RED Team Provides an Opportunity to Help Families	2	11.8%	• We look at a lot of things for these families and I think that we offer as much as we can for them.

Intake Staff Interviews

Purpose of Intake Interviews

A key component of the AR program is related to determining a family's eligibility to participate in the AR program. Nebraska DCFS has designed and implemented a set of 22 exclusionary criteria and 8 RED team criteria in order to make this determination. The application of these criteria are above and beyond the regular screening process in place prior to AR implementation. Therefore, in order to gain a more in-depth understanding of the AR screening process, interviews were conducted with a sample of intake workers.

Participants

UNL-CCFL staff conducted face-to-face interviews with 16 intake workers on December 14, 2016. Participants had held their job roles an average of 11.5 years, ranging from 3 months to 22 years.

Interview Protocol

Participants were asked to read and sign an informed consent form prior to participating in the interview. All participants were assured that their responses would be confidential and were encouraged to be as honest as possible in their answers. All of the participants were asked the following questions:

1. How long have you worked in your current job role?
2. Do you feel like you received adequate training prior to implementing the AR screening process? Do you think ongoing training would be helpful?
3. Do you feel like you receive adequate guidance and support regarding the AR screening process? And if not, in what ways could this be improved?
4. Approximately how much time do you spend on a typical intake now? Is this more, less, or about the same amount of time as you spent on a typical intake prior to implementation of the AR screening process? If more or less, how much? And can you explain what you think is contributing to the process taking more or less time?
5. Have your interpretations of the Exclusionary and RED team criteria changed over time? And if so, in what ways?
6. What parts of the current AR screening process work well? In what ways do you think it could be improved?

Analysis of the Interview Data

Each interview was audio recorded and transcribed. All of the interview responses were reviewed and major themes were identified. Individual responses were then coded according to the major content themes. Once coding was completed, a frequency and percentage of how many individual responses aligned with a specific theme was tallied. Note that not all statements were coded, because not all statements fit within an identified theme. Additionally, some statements were coded for more than one theme.

Findings

Overall impressions of the AR screening process. More than half of participants said that the AR screening process worked well (56.3%). However, a few respondents specifically cited parts of the AR screening process that they thought worked well (37.5%). For example, having information loaded into N-FOCUS has made it easy for them to process intakes. Additionally, some participants noted specific parts of the AR screening process that they feel need improvement (37.5%). For example, one respondent suggested that they did not like the fact that exclusionary criteria related to drug offenses exclude families from AR.

Changes in the interpretation of exclusionary and RED team criteria. Some participants said that their interpretations of the exclusionary and RED team criteria have changed over time (37.5%), while others felt that their interpretations had stayed the same (25.0%).

Training. Overall, most participants said they received enough training prior to implementing the AR screening process (75.0%). While half of the participants stated that they received formal training

(50.0%), the other half of the participants said that they did not receive any formal training (50.0%). However, many of the intake staff felt that ongoing training would be helpful (68.8%), while only a few felt that it was not necessary (18.8%). Furthermore, some participants recommended upgrading AR training by adding scenarios and role plays of typical calls (12.5%).

Guidance and support. A majority of participants said that support and guidance had been received while involved in the AR screening process (81.3%). However, a few participants stated that there were challenges (25.0%). For example, some felt that the changes in exclusionary criteria were not properly communicated. When asked how to improve the support and guidance, some of the participants recommended more training (18.8%) and the creation of a cheat sheet for intake staff to use when applying exclusionary criteria (12.5%).

Time spent on intakes. Participants stated that the amount of time spent on a typical intake currently varies between 15 minutes and 1 hour and 45 minutes. While some of the participants said that more time was being spent on intakes now, compared to before AR implementation (43.8%), others felt that they were spending about the same or less amount of time on intakes than before AR was implemented (43.8%). When asked for reasons why intakes take more or less time, some of the participants felt that experience doing the AR screening process was a major contributor for intake screening taking less time (18.8%).

Table 1.2.7 summarize the findings for each interview question, detailing the major content themes, the number of respondents, the percentage of respondents coded within a specific theme, and a sample of illustrative content.

Table 1.2.7: Intake Staff Interview Summary Table

Do you feel like you received adequate training prior to implementing the AR screening process?			
Theme	Number of Respondents	Percentage	Illustrative Content
Received Enough Training Prior to Implementing the AR Screening Process	12	75.0%	• I think so.
No Formal Training Prior to Implementing the AR Screening Process	8	50.0%	• No. • I learned it by using it and looking at it.
Received Formal Training Prior to Implementing the AR Screening Process	8	50.0%	• We had classroom training where we went over the criteria.

Do you think ongoing training would be helpful?			
Theme	**Number of Respondents**	**Percentage**	**Illustrative Content**
Ongoing Training is Needed	11	68.8%	• Yes. Definitely. • Ongoing training is always helpful, because there are a lot of changes.
Ongoing Training is Not Needed	3	18.8%	• I don't think that it is necessary.

Do you feel like you receive adequate guidance and support regarding the AR screening process?			
Theme	Number of Respondents	Percentage	Illustrative Content
Guidance and Support have Been Received	13	81.3%	• The supervisors are always available to answer questions.
Challenges with Guidance and Support	4	25.0%	• We have 4 supervisors and they all interpret criteria their own way, so it makes it difficult.

In what ways could the guidance and support improve?			
Theme	Number of Respondents	Frequency	Illustrative Content
More Training	3	18.8%	• I'd like see more in-depth training with scenarios or situations that show how all of our calls will go.
Create a Cheat Sheet	2	12.5%	• Have a sheet with key words so we can easily glance at it.

Do you spend more, less, or about the same amount of time on a typical intake prior to the implementation of the AR screening process?			
Theme	Number of Respondents	Percentage	Illustrative Content
More Time Spent on a Typical Intake	8	43.8%	• A little bit more time is spent on an intake now, because we have that new AR tool.
Less or the Same Amount of Time is Spent on a Typical Intake	7	43.8%	• I would say that it is pretty much the same. • Probably less.

What do you think is contributing to the process taking more or less time?			
Theme	Number of Respondents	Percentage	Illustrative Content
More Experience Helped the Intake Screening Process Take Less Time	3	18.8%	• The AR screening process gets easier with repetition. • I have memorized the exclusionary criteria. It makes the process go a lot faster.

Have your interpretations of the Exclusionary and RED team criteria changed over time?			
Theme	Number of Respondents	Frequency	Illustrative Content
Interpretations of Exclusionary and RED Team Criteria Have Changed Over Time	8	50.0%	• Yeah, I think the exclusionary have changed. • How we've dealt with controlled substances has changed since the beginning of AR.
Interpretations of Exclusionary and RED Team Criteria Have Not Changed Over Time	4	25.0%	• I think that the interpretations have been pretty much steady the whole way through. • I don't think that the interpretations have changed over time.

What parts of the current AR screening process work well?			
Theme	Number of Respondents	Frequency	Illustrative Content
All of the AR Screening Process Works Well	9	56.3%	• It is streamlined pretty well right now. • I think it all works well.
Some of the AR Screening Process that Works Well	6	37.5%	• We have got it down to almost every county in Nebraska. • I think that they changed how it looks in N-FOCUS and the computer system is easier to read. • I think that the supervisor checking our work probably does work well. • I like how there are different categories that break the criteria down.

Some of the AR Screening Process Does Not Work Well	6	37.5%	• I don't like that if law enforcement gives the parent a citation, that that excludes the family from AR. • Drug use knocks people out of AR when they shouldn't be.

Focus Groups with AR Field Staff

In spring of 2018, DCFS toured all five service areas of Nebraska and conducted a refresher training on Alternative Response (AR) to workers. At these trainings, CCFL distributed a brief survey and facilitated focus groups with workers in order to address a number of research questions for the AR program evaluation, including the questions around staff buy-in, competency, training, and support.

Questionnaire and Survey Results

The participants included a mix of initial assessment (IA) and ongoing workers that work either AR or TR cases or carry a mixed caseload. In total, 36 workers (25 IA, 7 ongoing, 4 unknown) completed the self-assessment questionnaire and survey. Nine survey questions were related to staff buy-in, competency, training, and support. Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). Table 1.2.8 displays the questions and the overall average item ratings.

Table 1.2.8: Staff Buy-In, Competency, Training, and Support Item Averages

Overall Average Item Ratings			
	Average	*SD*	N
1. Working with families through AR allows for collaborative problem solving with families.	3.91	0.75	34
2. I had sufficient training prior to working with families through AR.	3.12	1.09	34
3. I receive sufficient support in my work with AR families.	3.56	0.96	34
4. I understand the expectations associated with working with AR families.	3.88	0.78	33
5. I am confident that I am doing good work with AR families.	3.71	0.91	34
6. I would have benefited from additional training prior to working with AR families.	3.5	0.89	34
7. I could use additional support in my work with AR families.	3.32	0.91	34
8. I don't fully understand the expectations for working with AR families.	2.71	1.09	34
9. I'm unsure if the work I'm doing with AR families is really helping.	2.82	1.16	33

In order to make comparisons, workers were grouped by proportion of workload spent on AR or TR cases. 14 workers indicated the majority (greater than 50%) of their workload was spent on AR cases, while 15 workers indicated the majority of their workload was spent on TR cases. Additionally, 3 workers indicated their time was spent evenly between AR and TR, while an additional 3 workers did not indicate

a proportion; therefore, these 6 individuals were excluded from the following analyses. Table 1.2.9 presents the average item rating by caseload majority (AR/TR).

Table 1.2.9: Staff Buy-In, Competency, Training, and Support Item Averages by Caseload Majority

Average Item Ratings by Caseload Majority				
1. *Working with families through AR allows for collaborative problem solving with families.	AR	4.21	0.69	14
	TR	3.53	0.64	15
2. *I had sufficient training prior to working with families though AR.	AR	3.57	1.02	14
	TR	2.60	1.06	15
3. *I receive sufficient support in my work with AR families.	AR	3.86	0.77	14
	TR	3.07	0.96	15
4. I understand the expectations associated with working with AR families.	AR	4.15	0.56	13
	TR	3.60	0.91	15
5. I am confident that I am doing good work with AR families.	AR	3.93	0.73	14
	TR	3.33	0.98	15
6. I would have benefited from additional training prior to working with AR families.	AR	3.29	0.61	14
	TR	3.67	1.18	15
7. I could use additional support in my work with AR families.	AR	3.57	0.76	14
	TR	3.27	1.10	15
8. *I'm unsure if the work I'm doing with AR families is really helping.	AR	2.21	0.86	13
	TR	3.40	1.24	15
9. *I don't fully understand the expectations for working with AR families.	AR	2.31	0.58	14
	TR	3.40	1.18	15

Significant differences were observed for five items between the two groups. AR workers were more likely to agree that working with families through AR allows for collaborative problem solving ($t(27) = 2.74$, $p = .011$). AR workers were more likely to indicate that they had received sufficient training prior to working AR cases ($t(27) = 2.52$, $p = .018$) and that they receive sufficient support in their AR work ($t(27) = 2.43$, $p = .022$). TR workers were more unsure if their AR work is really helping families ($t(26) = 2.67$, $p = .013$) and less likely to agree that they fully understand the expectations for working with AR families ($t(20.64) = 3.46$, $p = .002$).

These findings suggest that workers who are able to work a caseload of mostly AR cases have greater buy-in for the program (e.g., believing that collaborative problem solving occurs and that the approach helps families). Workers carrying a mostly-AR workload also have better understanding of the expectations of the program and are more likely to indicate they've received the training and support they need. The focus group themes support these findings.

Focus Group Results

Following the training sessions, semi-structured focus groups were conducted. Workers were asked specific questions about job satisfaction, worker competency, and AR fidelity outcomes from the logic model, followed by probing questions for greater context as needed. In total, 36 workers participated, statewide.

Theme 1: Improved Family Engagement through AR. Across all focus groups, workers reported improved family engagement through AR. By engaging with families in a less investigative and punitive way, workers reported being able to build more meaningful rapport with families in AR compared to TR. Workers reported that by working with a family through the life of the case, families became more trusting, realizing that CFS workers weren't the "bad guy." Building up trust through the "softer" approach of AR allows workers to create positive relationships with the family, and in turn, the family is much more understanding and engaged throughout the process.

It was also reported that families that had previously experienced TR were more resistant to engage; however, building rapport with the family through AR helps break down negative perceptions of TR and distrust of DCFS. When workers are no longer considered a "threat" to the family, families are more willing to engage.

Theme 2: Inadequate Training. Across all focus groups, workers reported that AR training was inadequate. It was reported that AR training needed to be more focused on the practical implementation of AR and less so on engagement. It was reported that family engagement is not unique to AR and that too much time was spent on role-playing while not enough time was spent on the basic procedures and policies of AR. In two service areas workers had the opportunity to job-shadow experienced AR workers. It was reported that job-shadowing other experienced AR workers was helpful and should be utilized in addition to formal training.

Theme 3: Carrying Mixed Caseloads is Difficult. Workers in three service areas (Central, Western, and Northern) work a mixed caseload of both AR and TR cases, while in Eastern and Southeastern services areas there are workers that are primarily dedicated to working with AR families. This difference is largely attributed to limited staff resources and lower volume of AR cases in Central, Western, and Northern service areas; however, the impact of AR on workers carrying mixed caseloads is different than AR-only workers.

Workers carrying a mixed caseload of both AR and TR reported that it was difficult to switch mindsets and treat AR families differently than TR families. They found it challenging to "muddle their way through AR" if they are primarily TR workers. Mixed-case workers reported that ultimately they want to help families regardless of track. In all three service areas, workers reported that having at least one worker dedicated only to AR families could be better for consistency and fidelity to AR.

Theme 4: Flexibility with AR Funding and Services. Workers in most service areas reported that AR provides greater flexibility in helping families acquire services which leads to families getting the type of help they need. It was reported that having greater access to funds allows workers to get "more creative without involving the courts" allowing for "more control over the case." It was also reported that having the AR purchase card was "satisfying in that they can help families when they need it." However, it was also reported that using the funds could "feel like bribing the families."

Workers reported that, unlike in TR Initial Assessment, awareness of available services is greater with AR, much like with ongoing workers. AR's flexibility makes it easier for workers to help get families

services sooner by “not have as many hoops” and “not always waiting for referrals.” However, it was reported in both Western and Northern service areas that due to limited available services, “rural areas don’t have resources and they [workers] can’t help if there aren’t resources.”

Theme 5: Enhanced Collaborative Problem Solving. Workers in most service areas reported enhanced collaborative problem solving with families. It was reported that AR “allowed families to help decide what they need, as families are the experts of themselves.” One worker reported that the family initially did not want services but through the Protective Factors Questionnaire, the family and worker learned together how to best help the children in that family. Many workers view AR as a partnership with the family, allowing greater engagement and leading to more positive outcomes. It was reported that partnering with families to seek services not only creates more buy-in with families, but can help community perceptions of DCFS through success stories.

Theme 6: Barriers to Implementing AR with Fidelity. Workers in some service areas reported that there were barriers to implementing AR with fidelity. Workers reported feeling overwhelmed and unable to spend the time needed with families to meet the goals of AR. Some workers reported having strong buy-in for AR, however they felt unable to implement AR fully due to too much data entry and heavy caseload. This creates stress on workers as they report being unable to take time off and not wanting to burden their co-workers with more workload. It was most commonly reported that workers did not have enough time to implement AR due to high caseload.

Other reported barriers included not being able to get ahold of the family, but not having clear direction of when “enough is enough” in attempting to contact the family. It was reported that better guidelines were needed for workers to know how long to attempt to engage with families before giving up. Workers reported being concerned for being “dinged” for not making all the required contacts, even though all attempts have been made.

Overall Summary of Staff Qualifications, Training, and Support

Overall, it appears staff reacted favorably to AR training (throughout the entire demonstration project). A brief survey and facilitated focus groups with workers suggest that workers who are able to work a caseload of mostly AR cases have greater buy-in for the AR program (e.g., believing that collaborative problem solving occurs and that the AR approach helps families). Workers carrying a mostly-AR workload also appeared to have better understanding of the expectations of the program and were more likely to indicate that they've received the training and support they need.

Regarding the research question about the composition of the applicant pool, during the evaluation planning process, the evaluators were assured that the necessary administrative data to answer this question existed, and negotiations with DCFS and DHHS Human Resources occurred in 2014, 2015, and again in 2019 to obtain these data. Ultimately, however, the evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.

Chapter 3: Exclusionary and RED Team Summary

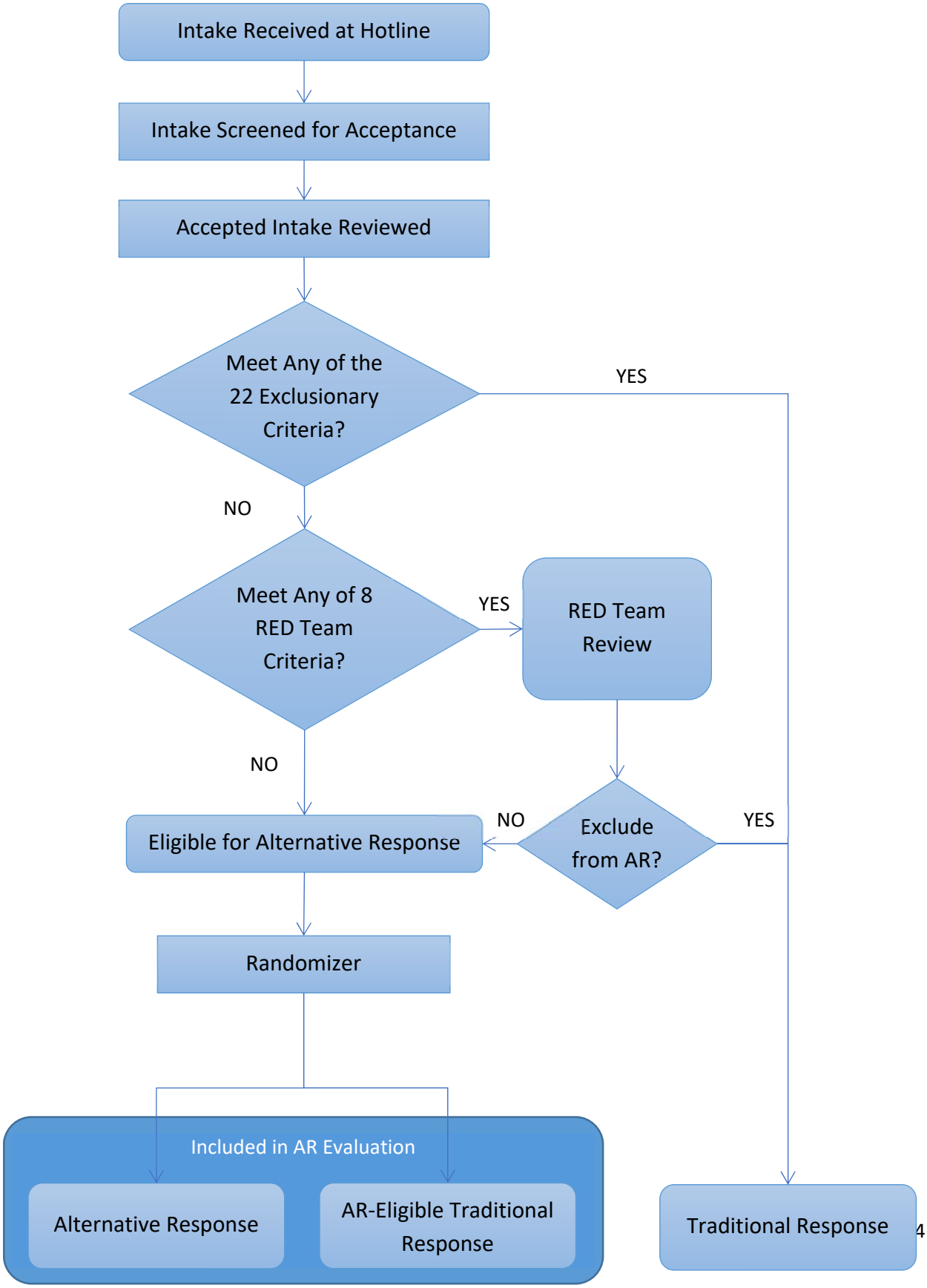
Key Question:

- How are the AR exclusionary and RED team criteria being applied?
- What does the RED team process look like?

The AR evaluation includes any family that does not meet one or more of the exclusionary criteria outlined by DCFS. Additionally, some families may be eligible for AR based on the decision of a Review, Evaluate, and Decide (RED) team. Staff of the centralized hotline unit use the exclusionary criteria to determine whether a case is eligible for AR or in need of further review by a RED team. Any intake accepted for assessment that alleges one (or more) of the 22 exclusionary criteria will be automatically assigned to TR and will be excluded from the AR evaluation. Any intake accepted for assessment that alleges one (or more) of the 8 RED team criteria will be flagged for further review. Any intake that does not allege any of the exclusionary or RED team criteria will be automatically designated as AR eligible and will be included in the evaluation.

After AR eligibility is determined, intakes are randomly assigned to either AR or TR at a 1:1 ratio. This process is automated through the state's administrative data system, N-FOCUS. A flowchart on the following page details the AR case assignment process.

Alternative Response Case Assignment Process



Exclusionary criteria analyses

In order to assess the application of the exclusionary criteria over time, data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Overall, from October 1, 2014- June 30, 2019 there were 56,458 accepted intakes statewide. Of those, 5,262 (9%) were eligible for AR. This indicates that 51,196 (91%) had at least 1 exclusionary or RED team criteria selected.

The exclusionary criteria selected most often were for cases involving:

- Household member uses/manufactures meth/other controlled substance- 31%
- Domestic violence - 21%
- Abuse/neglect of a child residing with subject of an active TR case – 12%
- Household member on the CPS Central Registry – 12%
- Household member has a prior court substantiated child abuse/neglect report/sex offender household member – 12%

Percentages indicate the percent of total intakes that had that exclusionary criterion selected. Please note that each intake could have multiple exclusionary criteria apply.

RED team Analyses

RED team criteria analyses

In order to assess the application of the RED team criteria over time, data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Overall, from October 1, 2014 – June 30, 2019 there were 2,389 intakes sent to RED team for review. The RED team criteria selected most often were for intakes involving physical abuse (70%), current or former state wards (22%), or issues surrounding mental health of the caretaker (14%).

RED team process analyses

In order to assess the RED team process, UNL-CCFL reviewed RED team documentation provided by DCFS from October 1, 2014 – June 30, 2019. During this time, an average of 41 intakes per month were reviewed by the RED team. On average, 3 intakes were reviewed per meeting; this ranged from 1 to 12 intakes. Additionally, meetings included 4 individuals and lasted approximately 5 minutes per intake, on average. Overall, 91% of intakes reviewed by the RED team were assigned AR.

Conclusion

Exclusionary Criteria Analyses. The most frequently selected exclusionary criteria were those related to use of controlled substances, domestic violence, and abuse/neglect of a child. Overall, 91% of intakes were excluded, meaning only 9% of intakes were eligible for AR.

RED Team Criteria Analyses. The most frequently selected RED team criterion was related to physical abuse that did not rise to the level of the exclusionary criterion. Overall, only 4% of intakes had a RED team criterion applied.

***RED Team Process Analyses*.** The RED team reviewed an average of 41 intakes per month. On average, 3 intakes were reviewed per meeting (ranging from 1 to 12). Additionally, meetings included 4 individuals and lasted approximately 5 minutes per intake, on average.

Chapter 4: Services

Key questions:

- Do AR workers have increased flexibility to tailor services to meet the needs of AR families compared to TR workers?
- Do AR families get connected to and receive services sooner than TR families?

During the family's initial assessment, the worker and family identified unmet needs. Families were then connected to supports and services based on those needs. The AR worker and the family work collaboratively to determine the right services and supports for the family. Families were connected to supports as soon as the family and the AR worker identified a specific need. This could occur as early as the first visit with the family and was not dependent on a safety threat or risk level identification. When possible, AR workers were encouraged to locate a community resource for the family with the intent to build sustainable solutions, even after DCFS is no longer involved.

AR workers provide case management services to the family, assist the family in accessing the identified services, help the family complete application forms, provide transportation to appointments, assist in making phone calls, and provide other supports as needed. AR workers assist the family in locating and connecting with community services, while also helping families engage in services that are affordable or are offered at low-cost or on a sliding-fee scale, whenever possible. Additionally, AR workers have the ability to utilize a DCFS purchase card to purchase concrete support services for families receiving AR. The use of a DCFS purchase card was available for the AR worker to access resources that will provide for child safety and/or reduce the future risk of maltreatment. The purchase card was used when other funding resources have been exhausted.

According to the AR Program Manual, AR workers are able to utilize the DCFS purchase card to purchase up to $500 of concrete support services per family (per case) based on the family's needs without supervisory approval. Concrete support services exceeding $500 must be approved by an AR Supervisor, up to $1000 per family. Costs that exceed $1000 must be approved by an AR Administrator. All purchases are tracked in a SharePoint database on the DCFS intranet.

A DCFS purchase card can be used for the following (but is not limited to):

1. Food (including formula)
2. Initial clothing needs (including diapers)
3. Identification cards
4. Housing:
    a. One-time deposit on a residence
    b. Rent per month
    c. Housing repairs (e.g., window/door repair, locks, electrical, plumbing)
    d. Household items (e.g., refrigerator, washer, dryer, crib, beds, other)
    e. Assistance with payment of utilities (excluding cable, cell phone/TracFone - bills evaluated on an individual basis)
5. Child care (e.g., registration, monthly fees)
6. Pest control

7. Garbage removal (e.g., regular pickup, large dumpster)
8. Transportation
    a. Personal vehicle expenses (e.g., gas, minor car repair, license, insurance)
    b. Taxi, bus pass, Handi-Van, moving truck, other
9. Medications
10. Laboratory work (excludes substance abuse related laboratory expenses)
11. Medical and mental health services
12. Emergencies
    a. Purchase and use of gift cards should be limited to emergency situations only. Workers are responsible to notify families they cannot use the gift cards to purchase alcohol or tobacco products.

In order to get a complete picture of family needs and the services being used to address those needs, the evaluators examined data from a number of sources, including administrative data from N-FOCUS, SharePoint data, Worker Survey data, and Family Survey data. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*. For outcome analyses of the findings, see Part IV: Alternative Response Outcome Study, Chapter 4: Needs and Services.

Chapter 5: Family Engagement

Key Questions:

- Do AR families feel respected and engage more with their worker compared to TR families?
- Do more AR families and workers share valuable information than TR families and workers?
- Does collaborative problem solving and learning occur more with AR families than with TR families?

Family Engagement Scale

DCFS has hypothesized that family engagement will be higher for families receiving AR than AR-eligible families receiving TR. To test this hypothesis UNL-CCFL has collected survey data from the family's perspective through the AR Family Survey as well as from the worker's perspective through the AR Worker End-of-Case Survey. Family engagement is being measured using an adapted version of Yatchmenoff's Client Engagement Scale (YCES; 2005). This measure has previously been used successfully in other evaluations of Differential Response programs in other states by the QIC-DR. Family engagement is assessed through 16 items across 4 subscales: receptivity (4 items), buy-in (6 items), working relationship (4 items), and mistrust (2 items). Each item is rated on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). An overall engagement score is created by calculating the average of all 16 items. Table 1.5.1 shows the individual items for the family and worker surveys.

Table 1.5.1: YCES Items in the Worker and Family Surveys

Family Experience Survey Items	Worker End-of-Case Survey Items
RECEPTIVITY: (4 items) "openness to receiving help, characterized by recognition of problems or circumstances that resulted in agency intervention and by a perceived need for help."	
I realize I needed some help to make sure my kids have what they need.	I think the primary caregiver realized they needed some help to make sure their children have what they need.
I was fine before my worker got involved. (Reverse)	I think the primary caregiver would say that they were fine before DCFS got involved. (Reverse)
There was a good reason my worker was involved with my family.	I think the primary caregiver would say that there was good reason for DCFS to be involved with their family.
There were definitely some concerns in my family that my worker saw.	I think the primary caregiver would say that there were definitely some concerns in their family that DCFS recognized.
BUY-IN: (6 items) "perception of benefit; sense of being helped or expectation of receiving help through the agency's involvement; a feeling that things will change for the better; commitment to the helping process, characterized by active participation in planning or services."	
My family got the help we really need from my worker.	I think the primary caregiver believed they would get the help they really needed from DCFS.
Working with my worker has given me more hope about how my life is going to be in the future.	I think the primary caregiver would say that working with DCFS has given them more hope about how their life is going to go in the future.
I think things are better because my worker was involved with my family.	I think the primary caregiver would say that things will improve for their children because DCFS was involved.

Family Experience Survey Items	Worker End-of-Case Survey Items
My worker wanted me to do the same things that I wanted to do.	I think the primary caregiver would say that what DCFS wanted them to do is the same as what they wanted.
My worker helped me take care of some challenges in my life.	I think the primary caregiver would say that DCFS helped their family take care of some of their challenges.
My worker helped make my family stronger.	I think the primary caregiver would say that DCFS helped their family get stronger.
WORKING RELATIONSHIP: (4 items) "interpersonal relationship with worker characterized by sense of reciprocity or mutuality and good communication."	
It was hard for me to work with my worker. (Reverse)	I think the primary caregiver found it difficult to work with me. (Reverse)
My worker and I respected each other.	I think the primary caregiver would say that we respected one another.
My worker and I had the same opinions about what was best for my child(ren).	I think the primary caregiver would say that we agreed about what was best for their child(ren).
My worker did not understand where I was coming from at all. (Reverse)	I think the primary caregiver would say that I didn't understand where they were coming from at all. (Reverse)
MISTRUST: (2 items) "the belief that the agency or worker is manipulative, malicious, or capricious, with intent to harm the client."	
I felt like I could trust my worker to be fair and see my side of things. (Reverse)	I think the primary caregiver feels that they could trust DCFS to be fair and to see their side of things. (Reverse)
My worker was out to get me.	I think the primary caregiver does not think that DCFS was out to get them. (Reverse)
OVERALL ENGAGEMENT (average of 16 items)	

Table 1.5.2 details 1) the number and percentage of responses for each response option, 2) the overall average rating, and 3) the total number of responses for each item. *SD* = Strongly Disagree (1), *D* = Disagree (2), *N* = Not Sure (3), *A* = Agree (4), *SA* = Strongly Agree (5). The total sum of percentages may total over 100% due to rounding. Data included in these analyses are for cases that closed between October 2014 and June 2019.

Table 1.5.2: YCES Item Frequencies for AR and TR Families and Workers

Caregiver Ratings of Family Engagement for AR Families							
Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Receptivity							
1. I realize I needed some help to make sure my kids have what they need.	81 17%	76 16%	73 15%	147 30%	110 23%	3.26	487
2. I was fine before my worker got involved.*	34 7%	82 17%	99 20%	137 28%	137 28%	3.53	489
3. There was a good reason my worker was involved with my family.	127 26%	88 18%	85 17%	128 26%	62 13%	2.82	490

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
4. There were definitely some concerns in my family that my worker saw.	112 23%	102 21%	107 22%	132 27%	37 8%	2.76	490
Buy-In							
5. My family got the help we really need from my worker.	43 9%	37 8%	75 15%	178 37%	154 32%	3.75	487
6. Working with my worker has given me more hope about how my life is going to be in the future.	53 11%	55 11%	130 27%	162 33%	86 18%	3.36	486
7. I think things are better because my worker was involved with my family.	56 11%	65 13%	124 25%	140 29%	105 21%	3.35	490
8. My worker wanted me to do the same things that I wanted to do.	19 4%	21 4%	102 21%	187 39%	157 32%	3.91	486
9. My worker helped me take care of some challenges in my life.	61 12%	74 15%	95 19%	160 33%	100 20%	3.33	490
10. My worker helped make my family stronger.	55 11%	75 15%	112 23%	153 32%	91 19%	3.31	486
Working Relationship							
11. It was hard for me to work with my worker.*	243 50%	146 30%	48 10%	25 5%	26 5%	1.86	488
12. My worker and I respected each other.	15 3%	8 2%	40 8%	153 31%	275 56%	4.35	491
13. My worker and I had the same opinions about what was best for my child(ren).	14 3%	25 5%	62 13%	171 35%	220 45%	4.13	492
14. My worker did not understand where I was coming from at all.*	226 46%	142 29%	70 14%	31 6%	19 4%	1.92	488
Mistrust							
15. I felt like I could trust my worker to be fair and see my side of things.*	25 5%	20 4%	56 11%	157 32%	234 48%	4.13	492
16. My worker was out to get me.	318 65%	104 21%	41 8%	10 2%	15 3%	1.57	488

Caregiver Ratings of Family Engagement for TR Families

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Receptivity							
1. I realize I needed some help to make sure my kids have what they need.	107 26%	74 18%	65 16%	108 26%	62 15%	2.87	416
2. I was fine before my worker got involved.*	24 6%	48 12%	68 16%	132 32%	145 35%	3.78	417
3. There was a good reason my worker was involved with my family.	120 29%	83 20%	64 15%	95 23%	53 13%	2.71	415
4. There were definitely some concerns in my family that my worker saw.	112 27%	85 21%	110 27%	77 19%	31 8%	2.59	415

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Buy In							
5. My family got the help we really need from my worker.	41 10%	38 9%	85 21%	154 37%	96 23%	3.55	414
6. Working with my worker has given me more hope about how my life is going to be in the future.	64 16%	59 14%	118 29%	127 31%	44 11%	3.07	412
7. I think things are better because my worker was involved with my family.	67 16%	66 16%	113 27%	112 27%	55 13%	3.05	413
8. My worker wanted me to do the same things that I wanted to do.	28 7%	125 6%	91 22%	156 38%	115 28%	3.73	415
9. My worker helped me take care of some challenges in my life.	67 16%	76 19%	123 30%	113 28%	31 8%	2.91	410
10. My worker helped make my family stronger.	64 16%	69 17%	123 30%	109 27%	47 11%	3.01	412
Working Relationship							
11. It was hard for me to work with my worker.*	166 40%	144 34%	59 14%	21 5%	28 7%	2.05	418
12. My worker and I respected each other.	14 3%	10 2%	47 11%	139 34%	202 49%	4.23	412
13. My worker and I had the same opinions about what was best for my child(ren).	25 6%	22 5%	73 18%	148 36%	145 35%	3.89	413
14. My worker did not understand where I was coming from at all.*	165 40%	129 31%	64 16%	36 9%	20 5%	2.07	414
Mistrust							
15. I felt like I could trust my worker to be fair and see my side of things.*	30 7%	22 5%	61 15%	131 32%	169 41%	3.94	413
16. My worker was out to get me.	254 62%	91 22%	45 11%	13 3%	10 2%	1.63	413

Worker Ratings of Family Engagement for AR Families

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Receptivity							
1. I think the primary caregiver realized they needed some help to make sure their children have what they need.	117 9%	403 32%	222 18%	398 32%	104 8%	2.98	1244
2. I think the primary caregiver would say that they were fine before DCFS got involved.*	38 3%	231 18%	254 20%	517 41%	224 18%	3.52	1264
3. I think the primary caregiver would say that there was good reason for DCFS to be involved with their family	161 13%	472 37%	319 25%	248 20%	61 5%	2.66	1261

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
4. I think the primary caregiver would say that there were definitely some concerns in their family that DCFS recognized.	84 7%	310 25%	323 26%	464 37%	70 6%	3.10	1251
Buy In							
5. I think the primary caregiver believed they would get the help they really needed from DCFS.	79 6%	269 22%	402 33%	374 30%	115 9%	3.14	1239
6. I think the primary caregiver would say that working with DCFS has given them more hope about how their life is going to go in the future.	92 8%	267 22%	470 39%	316 26%	67 6%	3.00	1212
7. I think the primary caregiver would say that things will improve for their children because DCFS was involved.	54 5%	225 19%	552 46%	297 25%	78 7%	3.10	1206
8. I think the primary caregiver would say that what DCFS wanted them to do is the same as what they wanted.	34 3%	123 10%	324 26%	608 49%	147 12%	3.58	1236
9. I think the primary caregiver would say that DCFS helped their family take care of some of their challenges	55 5%	242 20%	377 32%	414 35%	101 9%	3.22	1189
10. I think the primary caregiver would say that DCFS helped their family get stronger.	53 5%	244 21%	500 42%	322 27%	70 6%	3.09	1189
Working Relationship							
11. I think the primary caregiver found it difficult to work with me.*	326 26%	679 54%	187 15%	44 4%	18 1%	2.00	1254
12. I think the primary caregiver would say that we respected one another.	7 1%	19 2%	144 11%	682 54%	410 33%	4.16	1262
13. I think the primary caregiver would say that we agreed about what was best for their child(ren).	16 1%	52 4%	229 18%	695 55%	266 21%	3.91	1258
14. I think the primary caregiver would say that I didn't understand where they were coming from at all.*	204 16%	731 58%	227 18%	80 6%	14 1%	2.18	1256
Mistrust							
15. I think the primary caregiver feels that they could trust DCFS to be fair and to see their side of things.*	24 2%	65 5%	260 21%	678 54%	232 18%	3.82	1259
16. I think the primary caregiver does not think that DCFS was out to get them.*	35 3%	64 5%	254 20%	692 55%	214 17%	3.78	1259

Worker Ratings of Family Engagement for TR Families							
Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Receptivity							
1. I think the primary caregiver realized they needed some help to make sure their children have what they need.	141 12%	416 35%	197 17%	347 29%	79 7%	2.84	1180
2. I think the primary caregiver would say that they were fine before DCFS got involved.*	40 3%	177 15%	220 18%	523 43%	268 22%	3.65	1228
3. I think the primary caregiver would say that there was good reason for DCFS to be involved with their family	195 16%	495 40%	237 19%	259 21%	40 3%	2.55	1226
4. I think the primary caregiver would say that there were definitely some concerns in their family that DCFS recognized.	87 7%	315 26%	287 24%	457 38%	62 5%	3.08	1208
Buy In							
5. I think the primary caregiver believed they would get the help they really needed from DCFS.	106 9%	269 23%	378 32%	336 29%	91 8%	3.03	1180
6. I think the primary caregiver would say that working with DCFS has given them more hope about how their life is going to go in the future.	113 10%	342 29%	468 39%	228 19%	40 3%	2.78	1191
7. I think the primary caregiver would say that things will improve for their children because DCFS was involved.	87 7%	279 24%	501 42%	264 22%	51 4%	2.93	1182
8. I think the primary caregiver would say that what DCFS wanted them to do is the same as what they wanted.	39 3%	121 10%	303 25%	606 51%	124 10%	3.55	1193
9. I think the primary caregiver would say that DCFS helped their family take care of some of their challenges	68 6%	277 24%	414 35%	373 32%	44 4%	3.04	1176
10. I think the primary caregiver would say that DCFS helped their family get stronger.	81 7%	264 22%	524 44%	285 21%	30 3%	2.93	1184
Working Relationship							
11. I think the primary caregiver found it difficult to work with me.*	363 30%	618 51%	164 14%	54 4%	19 2%	1.97	1218
12. I think the primary caregiver would say that we respected one another.	14 1%	21 2%	109 9%	653 53%	429 35%	4.19	1226
13. I think the primary caregiver would say that we agreed about what was best for their child(ren).	32 3%	58 5%	175 14%	660 54%	297 24%	3.93	1222

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
14. I think the primary caregiver would say that I didn't understand where they were coming from at all.*	240 20%	694 57%	199 16%	68 6%	21 2%	2.13	1222
Mistrust							
15. I think the primary caregiver feels that they could trust DCFS to be fair and to see their side of things.*	33 3%	63 5%	223 18%	662 54%	242 20%	3.83	1223
16. I think the primary caregiver does not think that DCFS was out to get them.*	43 4%	78 6%	221 18%	654 53%	229 19%	3.77	1225

**These items were reverse coded when creating the subscale average.*

Family Engagement

Engagement Results from Family's Perspective

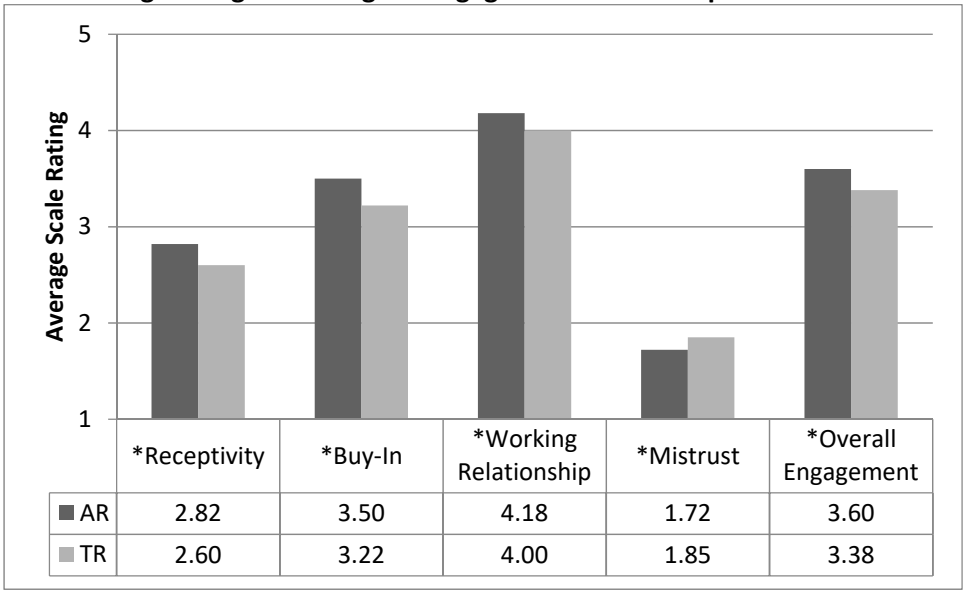
Average subscale scores were computed for each of the four YCES subscales and overall engagement, which includes all four subscales. Coefficient alpha reliabilities for each of the subscales and overall engagement are presented in Table 1.5.3. All subscales demonstrated acceptable reliability, ranging from .73 to .92.

Table 1.5.3: Internal Consistency Reliability for YCES - Family Perspective

Scale	Number of items	Number of cases included in analysis	Coefficient alpha
Receptivity	4	890	.82
Buy-In	6	884	.91
Working Relationship	4	890	.86
Mistrust	2	900	.73
Overall Engagement	16	867	.92

AR Family Survey data were examined to assess for differences in engagement (from the family's perspective) between AR and TR families at the end of the case. To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale. Data included in these analyses are from cases that closed between October 2014 and June 2019. A total of 900-906 families (depending on the subscale) were included in this analysis; this included 488-490 AR families and 411-415 TR families. Significant differences were observed for all five scales, all in the hypothesized direction. AR families reported greater levels of receptivity, buy-in, better relationships with their worker, lower levels of mistrust and greater overall engagement than TR families. Figure 1.5.1 summarizes of the average ratings of AR and TR families.

Figure 1.5.1: Average Caregiver Ratings of Engagement: Post Comparison of AR vs. TR Families



	*Receptivity	*Buy-In	*Working Relationship	*Mistrust	*Overall Engagement
AR	2.82	3.50	4.18	1.72	3.60
TR	2.60	3.22	4.00	1.85	3.38

*$p < .05$. (Independent samples *t*-tests for receptivity, buy-in, working relationship, mistrust, and overall engagement respectively: $t(901) = 3.20$, $p = .001$; $t(899) = 4.17$, $p < .001$; $t(903) = 3.07$, $p = .002$; $t(842.04) = -2.08$, $p = .038$; $t(901) = 4.20$, $p < .001$).

Engagement Results from Worker's Perspective

Average subscale scores were computed for each of the four YCES subscales and overall engagement. Coefficient alpha reliabilities for each of the sub-scales as well as the overall engagement are presented in Table 1.5.4. Each subscale and the overall engagement scale demonstrated acceptable reliability.

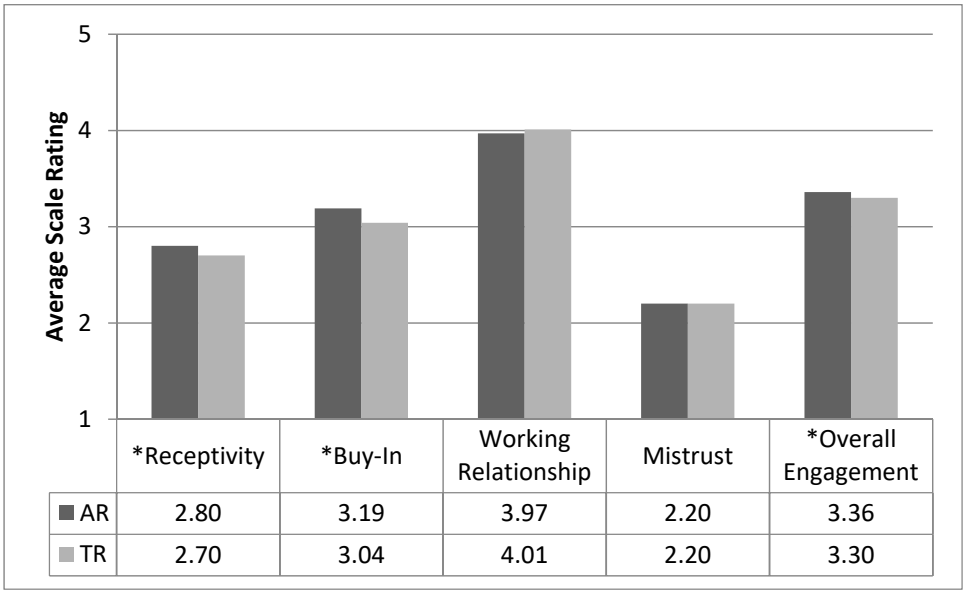
Table 1.5.4: Internal Consistency Reliability for YCES - Worker Perspective

Scale	Number of items	Number of cases included in analysis	Coefficient alpha
Receptivity	4	2401	.84
Buy-In	6	2284	.91
Working Relationship	4	2447	.82
Mistrust	2	2474	.77
Overall Engagement	16	2239	.92

AR Worker End-of-Case Survey data were used to assess differences in family engagement (from the worker's perspective) between AR and TR families at the end of the case. To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale. Data included in these analyses are from cases that closed between October 2014 and June 2019. A total of 2387-2481 families (depending on the subscale) were included in this analysis; this included 1203-1259 AR families and 1184-1222 TR families. Three significant differences, all in the hypothesized directions, were observed between AR and TR families. Workers perceived that AR families had greater levels of receptivity, buy-in, and overall engagement than TR families. There were no significant differences

between worker perceptions of mistrust or the working relationship between AR and TR families. Figure 1.5.2 summarizes average ratings of AR and TR families.

Figure 1.5.2: Average Worker Ratings of Family Engagement: Post Comparison of AR vs. TR Families



	*Receptivity	*Buy-In	Working Relationship	Mistrust	*Overall Engagement
AR	2.80	3.19	3.97	2.20	3.36
TR	2.70	3.04	4.01	2.20	3.30

*$p < .05$. (Independent samples t-test for receptivity, buy-in, and overall engagement respectively: $t(2468.94) = 2.71$, $p = .007$; $t(2381.49) = 4.69$, $p < .001$; $t(2466.45) = 2.61$, $p = .009$).

Family Satisfaction, Collaboration with their Worker, and Skills Learned

DCFS has hypothesized that families receiving AR will feel respected and engage with their worker more than families receiving TR. Further, AR families are expected to share valuable information and engage in collaborative problem solving and learning more than similar TR families. To test these hypotheses, UNL-CCFL has collected survey data related to family's satisfaction, perceptions of collaboration with their worker, and skills learned for all AR-eligible families (assigned to either AR or TR) at the end of the case through the AR Family Survey. These items were adapted from measures that have previously been used in other evaluations of Differential Response programs in other states by the QIC-DR. To be included in subscale comparison analyses, the respondent must have completed at least 60% of the items for the given subscale. Data included in these analyses are from cases that closed between October 2014 and June 2019.

Satisfaction

Families are asked four questions about their satisfaction with their experience with DCFS. The individual item frequencies and averages are included in Table 1.5.5. *Nt = not at all, S = Somewhat, V=Very. W = Worse Off, Sa = The Same, B = Better Off.*

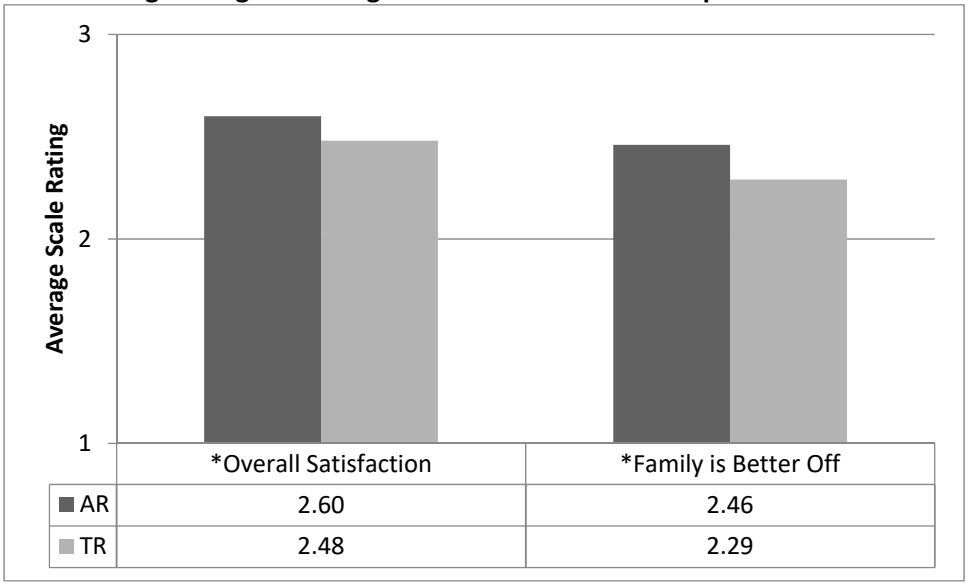
Table 1.5.5: Item Frequencies for Family Satisfaction

AR Families					
Survey Item	*Nt*	*S*	*V*	Average	Responses
1. How satisfied are you with how you and your family were treated by the worker who visited your home?	32 7%	61 12%	403 81%	2.75	496
2. How satisfied are you with the support you and your family received?	45 9%	96 19%	356 72%	2.63	497
3. How likely would you be to call your worker or DCFS if you or your family needed support in the future?	80 16%	121 24%	295 60%	2.43	496
Survey Item	*W*	*Sa*	*B*	Average	Responses
4. Overall, are you and your family better off or worse off because of your experience with DCFS?	23 5%	215 45%	242 50%	2.46	480
TR Families					
Survey Item	*Nt*	*S*	*V*	Average	Responses
5. How satisfied are you with how you and your family were treated by the worker who visited your home?	29 7%	84 20%	313 74%	2.67	426
6. How satisfied are you with the support you and your family received?	51 12%	111 26%	262 62%	2.50	424
7. How likely would you be to call your worker or DCFS if you or your family needed support in the future?	98 23%	111 26%	215 51%	2.28	424
Survey Item	*W*	*Sa*	*B*	Average	Responses
8. Overall, are you and your family better off or worse off because of your experience with DCFS?	26 6%	238 58%	145 36%	2.29	409

Satisfaction items 1-3 (shown above) were combined into a subscale, *overall satisfaction*, which had good internal consistency reliability (α=.86, N=915). Subscale responses range from 1 (*Not at all satisfied*) to 3 (*Very satisfied*). An additional item asks whether the family is better off or worse off because of their involvement with DCFS and was analyzed separately. Responses for this item range from 1 (*We are worse off*) to 3 (*We are better off*).

UNL-CCFL examined whether there were differences in family satisfaction between AR and TR families. A total of 925 families were included in the analysis of overall satisfaction; this included 498 AR families and 426 TR families. A total of 890 families were included in the analysis of whether families are better off; this included 480 AR families and 409 TR families. Both analyses were statistically significant, in the hypothesized direction. AR families reported higher overall satisfaction and were more likely to report their family was better off because of their involvement with DCFS than TR families. Figure 1.5.3 and Table 1.5.5 summarize average ratings of AR and TR families.

Figure 1.5.3: Average Caregiver Ratings of Satisfaction: Post Comparison of AR vs. TR Families



*$p < .05$. (Independent samples t-tests for overall satisfaction and family is better off, respectively: $t(872.88) = 3.06$, $p = .002$; $t(868.69) = 4.22$, $p < .001$).

Collaboration with Their Worker

AR families are expected to share valuable information and engage in collaborative problem solving with their worker more than AR-eligible TR families. Families are asked seven questions about the extent to which their worker collaborated with them during the case on the AR Family Survey. The individual item frequencies and averages are included in Table 1.5.6. *Nt = not at all, S = Somewhat, V=Very. N = No, Y = Yes.*

Table 1.5.6: Item Frequencies for Collaboration with Worker

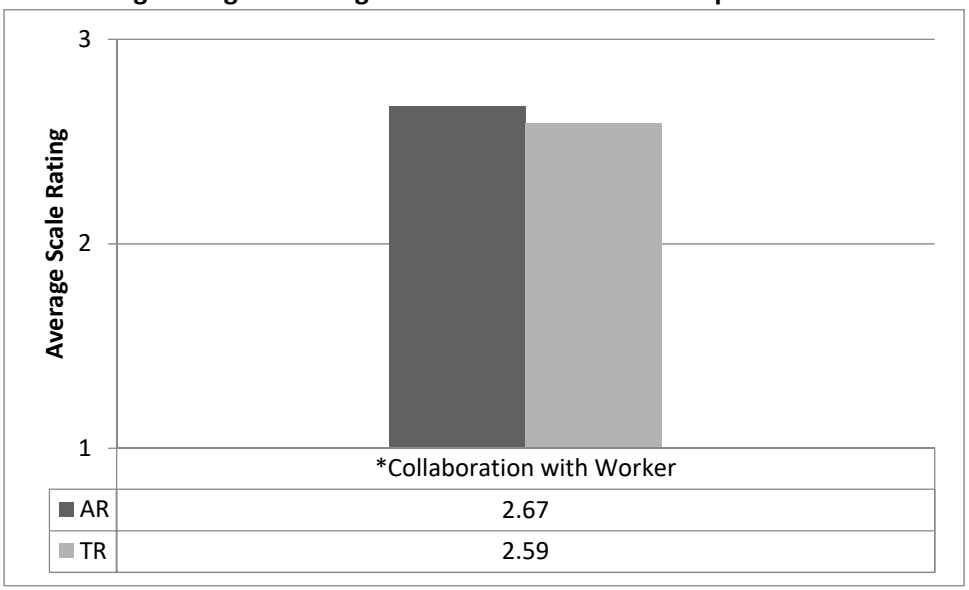
AR Families					
Survey Item	*Nt*	*S*	*V*	Average	Responses
1. How often did your worker encourage you to say what you thought?	49 10%	93 19%	354 71%	2.61	496
2. How often did your worker consider your opinions before making decisions that concerned you and your family?	45 9%	83 17%	367 74%	2.65	495
3. Overall, how carefully did your worker listen to what you had to say?	29 6%	67 14%	399 81%	2.75	495
4. Overall, how well do you feel your worker understood your needs?	39 8%	90 18%	366 74%	2.66	495
5. How easy was it to contact your worker?	37 8%	115 24%	338 69%	2.61	490
Survey Item	*N*	*S*	*Y*	Average	Responses
6. Did your worker see the things that you do well?	38 8%	57 12%	398 81%	2.73	493

Survey Item	*N*	*S*	*Y*	Average	Responses
7. Were there things that were important to you that did not get talked about with your worker?	374 77%	59 12%	56 12%	1.35	489
TR Families					
Survey Item	*Nt*	*S*	*V*	Average	Responses
1. How often did your worker encourage you to say what you thought?	55 13%	101 24%	264 63%	2.50	420
2. How often did your worker consider your opinions before making decisions that concerned you and your family?	41 10%	96 23%	283 68%	2.58	420
3. Overall, how carefully did your worker listen to what you had to say?	33 8%	65 15%	324 77%	2.69	422
4. Overall, how well do you feel your worker understood your needs?	51 12%	88 21%	286 67%	2.55	425
5. How easy was it to contact your worker?	44 10%	110 26%	269 64%	2.53	423
Survey Item	*N*	*S*	*Y*	Average	Responses
6. Did your worker see the things that you do well?	40 10%	73 17%	308 73%	2.64	421
7. Were there things that were important to you that did not get talked about with your worker?	313 75%	50 12%	53 13%	1.38	416

All seven items were combined into a subscale, called *collaboration with worker*, which had very good internal consistency reliability (α=.90, *N*=884). Subscale responses range from 1 (*Poor collaboration*) to 3 (*Good collaboration*).

A total of 920 families were included in the analysis; this included 495 AR families and 424 TR families. The analysis was statistically significant, in the hypothesized direction. AR families reported having a more collaborative relationship with their worker than TR families. Figure 1.5.4 and Table 1.5.6 summarize average ratings of AR and TR families.

Figure 1.5.4: Average Caregiver Ratings of Collaboration: Post Comparison of AR vs. TR Families



*$p < .05$. (Independent samples *t*-tests for collaboration with worker: ($t(917) = 2.38$, $p = .018$).

Skills Learned

AR families are expected to engage in more learning than TR families. Families responded to three questions on the AR Family Survey, which assessed whether they learned skills or were provided with services to achieve three common goals. Responses range from 0 (*No*) to 1 (*Yes*) for each item. The individual item frequencies and averages are included in Table 1.5.7.

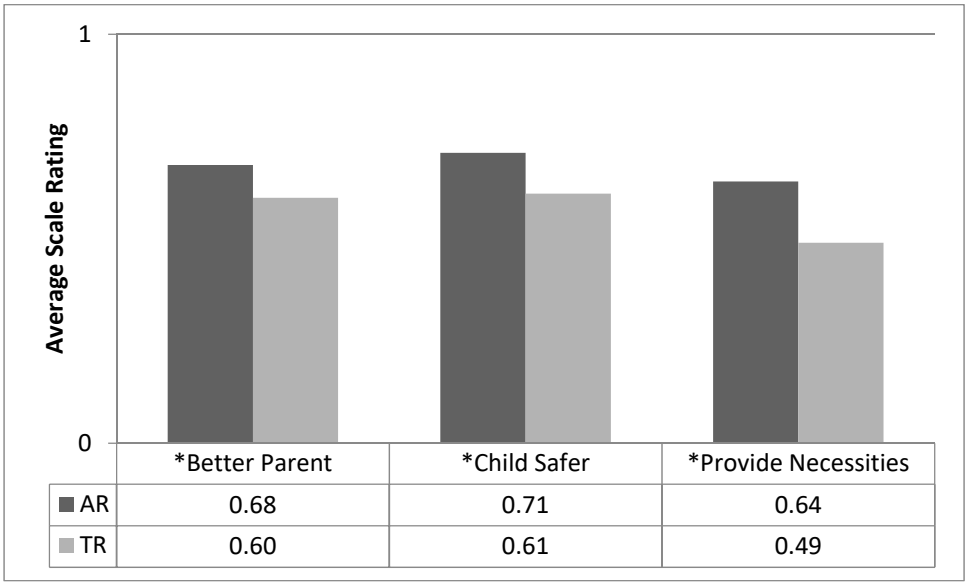
Table 1.5.7: Item Frequencies for Skills Learned

AR Families				
Survey Item	*N*	*Y*	Average	Responses
1. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that makes me feel like I am a better parent.	153 32%	326 68%	.68	479
2. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that allows my child to be safer.	141 29%	338 71%	.71	479
3. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that helps me provide necessities like food clothing, shelter, or medical care.	174 36%	304 64%	.64	478
TR Families				
Survey Item	*N*	*Y*	Average	Responses
1. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that makes me feel like I am a better parent.	164 40%	244 60%	.60	408

2. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that allows my child to be safer.	155 39%	246 61%	.61	401
Survey Item	*N*	*Y*	Average	Responses
3. Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that helps me provide necessities like food clothing, shelter, or medical care.	205 51%	197 49%	.49	402

Each item was analyzed for differences between AR and TR families. A total of 881-888 families (depending on the item) were included in the analysis; this included 478-479 AR families and 401-408 TR families. All three analyses were significant, in the hypothesized direction. AR families were more likely than TR families to report that they learned a skill or received a service that made them feel like a better parent, allowed their child to be safer, and helped them provide necessities. Figure 1.5.5 and Table 1.5.7 summarize average ratings of AR and TR families.

Figure 1.5.5: Average Caregiver Ratings of Skills Learned: Post Comparison of AR vs. TR Families



*$p < .05$. (Independent samples *t*-tests for better parent, child safer, and provide necessities, respectively: $t(847.33) = 2.55$, $p = .011$; $t(828.72) = 2.88$, $p = .004$; $t(840.34) = 4.38$, $p < .001$).

Conclusion

AR families reported greater levels of buy-in and receptivity, better relationships with their worker, lower mistrust, and greater overall engagement than TR families. Workers reported that AR families had greater levels of receptivity, buy-in, and greater overall engagement than TR families. AR families reported they were more satisfied with their experience with DCFS than TR families. Likewise, AR families were more likely to report that their family is better off due to their involvement with DCFS than TR families. AR families were more likely to report having a collaborative relationship with their worker and were more likely to report that they learned a skill or received a service that made them feel like a better parent, allowed their child to be safer, and helped them provide necessities.

Chapter 6: Protective Factors

Key Question:

- Do AR families demonstrate enhanced protective factors compared to TR families?

DCFS has hypothesized that protective factors will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected survey data related to family protective factors for all AR-eligible families. For families receiving AR, protective factor data are collected at the beginning (pre) and throughout the life of the case on the PFQ/PFQWB and at the end (post) of the case (note that this report only focuses on beginning (pre) and end (post) measures). For AR-eligible families receiving TR, protective factor data are collected at the end (post) of the case only. All post measures are collected through the family survey.

Protective factors are assessed through 25 items across 6 subscales (refer to *Appendix A: Summary of Evaluation Data Sources and Data Collection* for more information about this measure): social connections (3 items), concrete supports for parents (3 items), parental resilience (5 items), knowledge of parenting and child and youth development (4 items), nurturing and attachment (4 items), and social and emotional competence of children (6 items). Each item is rated on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*) or frequency (*1 = Never, 5 = Always*). Note that social connections, concrete supports, and parental resilience are based on family characteristics and therefore yield one set of responses on both the PFWBQ and family survey. However, knowledge of parenting and development, nurturing and attachment, and social and emotional competence of children are specific to each child. These three child-specific protective factors are measured for each child on the PFWBQ and only for the child expected to benefit most from services on the family survey.

Tables 1.6.1-1.6.3 detail 1) the number and percentage of responses for each response option, 2) the overall average rating, and 3) the total number of responses for each item. SD = Strongly Disagree (1), D = Disagree (2), N = Not Sure (3), A = Agree (4), SA = Strongly Agree (5). Nv = Never (1), R = Rarely (2), S = Sometimes (3), F = Frequently (4), Al = Always (5). The total sum of percentages may total over 100% due to rounding.

Initial (Pre) Measure of Protective Factors for AR Families

The following set of responses represents the initial (pre) measure of protective factors through the PFQ/PFWBQ for families that received AR. Note that some protective factors are measured at the family level (Social Connections, Concrete Supports, and Parental Resilience), whereas others are measured at the child level (Knowledge of Parenting/Development, Nurturing and Attachment, and Social and Emotional Competence of Children). Additionally, prior to July 2015, data for the child-level protective factors were only collected for one child; after that date data were collected for all children.

Table 1.6.1: Average Protective Factor Ratings for Pre Survey of AR Families

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Social Connections							
1. I have others who will listen when I need to talk about my problems.	52 5%	27 3%	52 5%	380 36%	543 52%	4.27	1054
2. I have others who I can talk to when I'm lonely.	52 5%	31 3%	66 6%	382 36%	522 50%	4.23	1053
3. I have others who I can talk to if there is a crisis.	46 4%	30 3%	53 5%	369 35%	547 52%	4.28	1045
Concrete Supports for Parents							
4. I would know where to go for help if my family needed food or housing.	56 5%	36 3%	88 8%	427 41%	447 42%	4.11	1054
5. I would know where to go for help if I had trouble making ends meet.	56 5%	68 7%	115 11%	418 40%	394 38%	3.98	1051
6. I would know where to go for help if I needed help finding a job.	76 7%	52 5%	100 10%	413 39%	410 39%	3.98	1051
Knowledge of Parenting/Development							
7. I know how to help my child learn.	77 3%	48 2%	164 7%	992 41%	1131 47%	4.27	2412
8. I think my child misbehaves just to upset me.*	861 36%	782 33%	325 14%	269 11%	152 6%	2.19	2389
9. I praise this child for good behavior.	1 <1%	14 1%	159 7%	751 31%	1487 62%	4.54	2412
10. I discipline this child without losing control.	39 2%	35 2%	220 9%	638 27%	1457 61%	4.44	2389
Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
Parental Resilience							
11. In my family we talk about problems.	8 1%	45 4%	178 17%	405 39%	417 40%	4.12	1053
12. In my family we listen to both sides of the story when we argue.	9 1%	47 5%	198 19%	399 38%	400 38%	4.08	1053
13. In my family we take time to listen to each other.	7 1%	39 4%	174 17%	389 37%	445 42%	4.16	1054
14. In my family we pull together when things are stressful.	10 1%	35 3%	118 11%	343 33%	545 52%	4.31	1051
15. In my family we manage to solve our problems.	8 1%	24 2%	137 13%	379 36%	493 47%	4.27	1041
Nurturing and Attachment							
16. I am able to soothe this child when he/she is upset.	11 1%	48 2%	297 12%	693 29%	1346 56%	4.38	2395
17. I spend time with this child doing things that he/she likes to do.	4 <1%	37 2%	319 13%	962 40%	1073 45%	4.28	2395
18. I feel close to this child.	5 <1%	30 1%	157 7%	416 17%	1798 75%	4.65	2406

19. I enjoy being with this child.	3 <1%	11 1%	75 3%	375 16%	1952 81%	4.76	2416
Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
Social and Emotional Competence of Children							
20. This child gets along well with family members.	12 1%	40 2%	299 13%	797 33%	1240 52%	4.35	2388
21. This child gets along well with others his/her age.	15 1%	56 2%	280 12%	793 34%	1220 52%	4.33	2364
22. This child shows concern for others' feelings.	12 1%	70 3%	365 16%	675 29%	1216 52%	4.29	2338
23. This child "loses it" when he/she is upset.*	511 22%	669 28%	612 26%	374 16%	196 8%	2.61	2362
24. This child has trouble talking about his/her feelings.*	613 27%	646 28%	594 26%	278 12%	183 8%	2.47	2314
25. This child misbehaves or gets in trouble.*	482 21%	700 30%	729 31%	300 13%	120 5%	2.52	2331

**These items were reverse coded when creating the subscale average.*

End-of-Case (Post) Measure of Protective Factors for AR Families

The following set of responses represents the final (post) measure of protective factors, through the family survey, for families that received AR.

Table 1.6.2: Average Protective Factor Ratings for Post Survey of AR Families

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Social Connections							
1. I have others who will listen when I need to talk about my problems.	7 1%	16 3%	24 5%	179 37%	257 53%	4.37	483
2. I have others who I can talk to when I'm lonely.	5 1%	22 5%	16 3%	176 37%	261 54%	4.39	480
3. I have others who I can talk to if there is a crisis.	5 1%	20 4%	25 5%	162 34%	271 56%	4.40	483
Concrete Supports for Parents							
4. I would know where to go for help if my family needed food or housing.	15 3%	17 4%	40 8%	159 33%	252 52%	4.28	483
5. I would know where to go for help if I had trouble making ends meet.	32 7%	32 7%	53 11%	156 32%	211 44%	4.00	484
6. I would know where to go for help if I needed help finding a job.	27 6%	21 4%	46 10%	181 38%	208 43%	4.08	483
Knowledge of Parenting/Development							
7. I know how to help my child learn.	4 1%	8 2%	38 8%	232 48%	201 42%	4.28	483
8. I think my child misbehaves just to upset me.*	147 31%	169 35%	99 21%	51 11%	13 3%	2.19	479

9. I praise this child for good behavior.	0 --	0 --	22 5%	148 31%	314 65%	4.60	484
10. I discipline this child without losing control.	5 1%	6 1%	33 7%	148 31%	289 60%	4.48	481
Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
Parental Resilience							
11. In my family we talk about problems.	3 1%	12 3%	91 19%	173 36%	203 42%	4.16	482
12. In my family we listen to both sides of the story when we argue.	3 1%	16 3%	92 19%	187 39%	182 38%	4.10	480
13. In my family we take time to listen to each other.	2 <1%	11 2%	78 16%	167 35%	224 47%	4.24	482
14. In my family we pull together when things are stressful.	4 1%	9 2%	79 16%	136 28%	254 53%	4.30	482
15. In my family we manage to solve our problems.	2 <1%	8 2%	100 21%	180 38%	190 40%	4.14	480
Nurturing and Attachment							
16. I am able to soothe this child when he/she is upset.	0 --	9 2%	61 13%	133 28%	280 58%	4.42	483
17. I spend time with this child doing things that he/she likes to do.	1 <1%	3 1%	72 15%	186 39%	221 46%	4.29	483
18. I feel close to this child.	2 <1%	9 2%	56 12%	84 17%	333 69%	4.52	484
19. I enjoy being with this child.	0 --	2 <1%	30 6%	76 16%	375 78%	4.71	483
Social and Emotional Competence of Children							
20. This child gets along well with family members.	0 --	14 3%	69 14%	135 28%	264 55%	4.35	482
21. This child gets along well with others his/her age.	0 --	17 4%	78 16%	162 34%	223 47%	4.23	480
22. This child shows concern for others' feelings.	4 1%	15 3%	88 18%	134 28%	240 50%	4.23	481
23. This child "loses it" when he/she is upset.*	36 8%	144 30%	203 42%	66 14%	32 7%	2.82	481
24. This child has trouble talking about his/her feelings.*	73 15%	106 22%	202 42%	71 15%	27 6%	2.73	479
25. This child misbehaves or gets in trouble.*	41 9%	155 32%	213 45%	51 11%	18 4%	2.69	478

**These items were reverse coded when creating the subscale average.*

End-of-Case (Post) Measure of Protective Factors for TR Families

The following set of responses represents the (post) measure of protective factors, through the family survey, for families that received TR.

Table 1.6.3: Average Protective Factor Ratings for Post Survey of TR Families

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Social Connections							
1. I have others who will listen when I need to talk about my problems.	8 2%	7 2%	26 6%	158 39%	206 51%	4.35	405
2. I have others who I can talk to when I'm lonely.	8 2%	12 3%	28 7%	160 40%	196 49%	4.30	404
3. I have others who I can talk to if there is a crisis.	10 3%	8 2%	23 6%	148 37%	215 53%	4.36	404
Concrete Supports for Parents							
4. I would know where to go for help if my family needed food or housing.	8 2%	13 3%	41 10%	128 32%	214 53%	4.30	404
5. I would know where to go for help if I had trouble making ends meet.	20 5%	26 7%	50 12%	122 30%	185 46%	4.06	403
6. I would know where to go for help if I needed help finding a job.	16 4%	16 4%	42 11%	147 37%	180 45%	4.14	401
Knowledge of Parenting/Development							
7. I know how to help my child learn.	1 <1%	10 3%	35 9%	203 50%	156 39%	4.24	405
8. I think my child misbehaves just to upset me.*	128 32%	152 38%	70 17%	48 12%	6 2%	2.14	404
9. I praise this child for good behavior.	0 --	1 <1%	22 5%	124 31%	258 64%	4.58	405
10. I discipline this child without losing control.	6 2%	4 1%	33 8%	128 32%	232 58%	4.43	403
Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
Parental Resilience							
11. In my family we talk about problems.	3 1%	10 3%	85 21%	141 35%	167 41%	4.13	406
12. In my family we listen to both sides of the story when we argue.	1 <1%	18 4%	100 25%	120 30%	166 41%	4.07	405
13. In my family we take time to listen to each other.	2 1%	10 3%	76 19%	145 36%	171 42%	4.17	404
14. In my family we pull together when things are stressful.	2 1%	12 3%	56 14%	118 29%	216 54%	4.32	404
15. In my family we manage to solve our problems.	1 <1%	9 2%	63 16%	147 37%	183 45%	4.25	403
Nurturing and Attachment							
16. I am able to soothe this child when he/she is upset.	1 <1%	5 1%	61 15%	121 30%	217 54%	4.35	405
17. I spend time with this child doing things that he/she likes to do.	1 <1%	3 1%	59 15%	154 38%	188 46%	4.30	405
18. I feel close to this child.	1 <1%	4 1%	40 10%	88 22%	270 67%	4.54	403

19. I enjoy being with this child.	0 --	2 1%	21 5%	66 17%	311 78%	4.71	401
Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
Social and Emotional Competence of Children							
20. This child gets along well with family members.	2 1%	5 1%	72 18%	109 27%	217 54%	4.32	405
21. This child gets along well with others his/her age.	0 --	11 3%	78 19%	130 32%	184 46%	4.21	403
22. This child shows concern for others' feelings.	4 1%	12 3%	72 18%	132 33%	182 45%	4.18	402
23. This child "loses it" when he/she is upset.*	35 9%	119 30%	160 40%	64 16%	23 6%	2.80	401
24. This child has trouble talking about his/her feelings.*	56 14%	110 28%	159 40%	51 13%	24 6%	2.69	400
25. This child misbehaves or gets in trouble.*	42 11%	119 30%	169 42%	59 15%	12 3%	2.70	401

**These items were reverse coded when creating the subscale average.*

Internal Consistency Reliability for Protective Factors Scales

Coefficient alpha reliabilities for each of the protective factors subscales, for both the pre and post measures are presented in Table 1.6.4. The knowledge of parenting and child development protective factor had lower than desired reliability at both measurement time points, ranging from .51-.62. All other subscales demonstrated acceptable reliability at both measurement time points, ranging from .79 to .93.

Table 1.6.4: Protective Factor Subscale Reliability Coefficients for Pre and Post Administrations

Data Source: PFWBQ (pre-measure)			
Scale	**Number of items**	**Number of cases included in analysis**	**Coefficient alpha**
Social Connections	3	1044	.93
Concrete Supports for Parents	3	1045	.89
Parental Resilience	5	1034	.91
Knowledge of Parenting and Child Development	4	2519	.51
Nurturing and Attachment	4	2555	.79
Social and Emotional Competence	6	2424	.80
Data Source: Family Survey (post-measure)			
Scale	**Number of items**	**Number of cases included in analysis**	**Coefficient alpha**
Social Connections	3	882	.93
Concrete Supports for Parents	3	882	.82
Parental Resilience	5	875	.90
Knowledge of Parenting and Child Development	4	878	.62

Nurturing and Attachment	4	883	.84
Social and Emotional Competence	6	869	.82

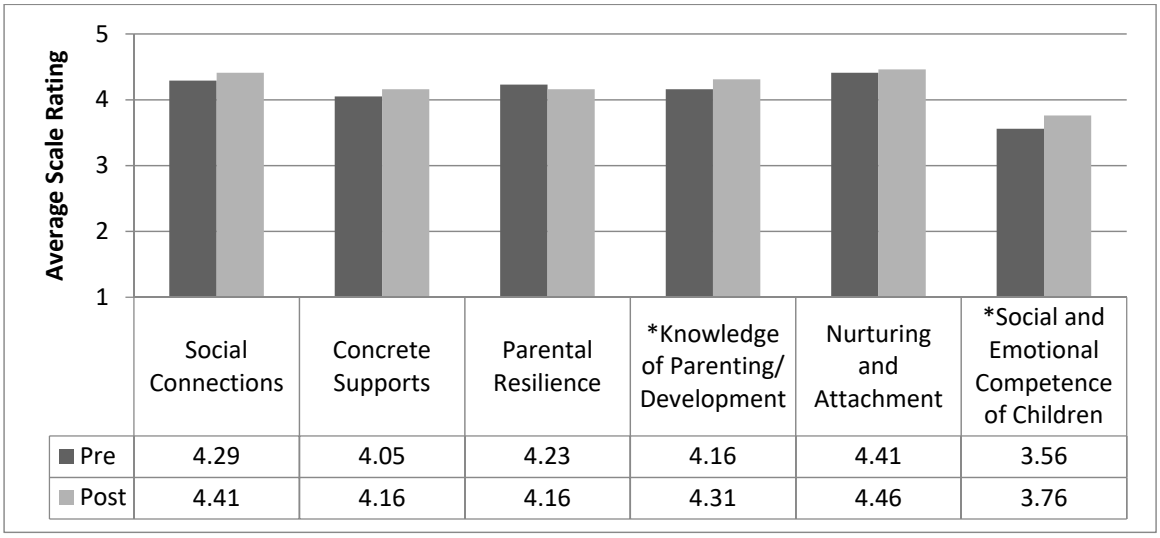
Changes Over Time for Families Assigned to AR

Matched family data from the PFQ/PFWBQ (pre) and family survey (post) was examined to assess for differences within cases from their first assessment (completed with their worker during the first 2 weeks of involvement with DCFS) to their final assessment (completed by the family after case closure). To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale. Data included in these analyses are from cases that closed between October 2014 and June 2019.

A total of 257-259 families were matched between pre and post survey administrations for the family-specific protective factors, including social connections, concrete supports, and parental resilience protective factors. A total of 184-189 families were matched between pre and post survey administrations for the child-specific protective factors, including knowledge of parenting and development, nurturing and attachment, and social and emotional competence of children. The number of matched families for the child-specific protective factors is smaller than the number of matched families at the family level, due to missing data on the PFWBQ form. Respondents are asked to indicate the child who is expected to benefit most from services to allow the evaluators to link that child's pre data with the data from the family survey (post) measure. However, this item is frequently left blank. When this item is not completed and there are multiple children, we are unable to match the data; therefore, we must exclude families with more than one child, reducing the sample size.

Two significant differences were observed, both in the hypothesized direction. A significant difference was observed for knowledge of parenting and child development from pre to post measure, such that AR families reported significantly higher ratings on the post measure than on the pre measure, indicating improvement on this protective factor from the beginning to the end of the case. A significant difference was observed for social and emotional competence of children from pre to post measure, such that AR families reported significantly higher ratings on the post measure than on the pre measure, indicating improvement on this protective factor from the beginning to the end of the case There were no significant differences between pre and post measures of the remaining four protective factors. Figure 1.6.1 summarizes average ratings within AR families from pre to post measure.

Figure 1.6.1: Average Protective Factor Scale Ratings: Pre/Post Comparison of AR Families



	Social Connections	Concrete Supports	Parental Resilience	*Knowledge of Parenting/ Development	Nurturing and Attachment	*Social and Emotional Competence of Children
Pre	4.29	4.05	4.23	4.16	4.41	3.56
Post	4.41	4.16	4.16	4.31	4.46	3.76

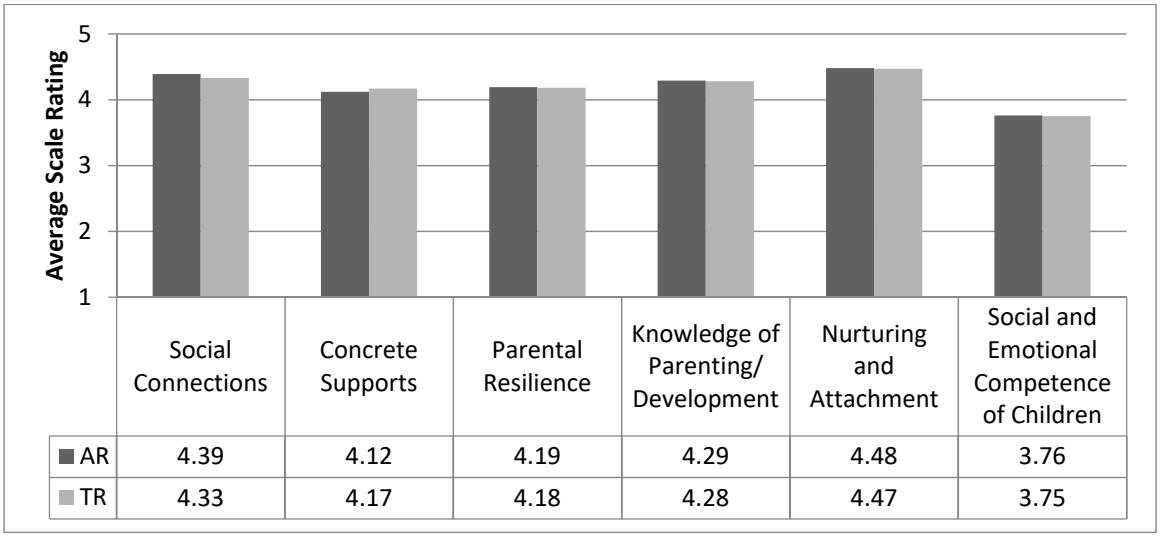
*$p < .05$ (paired samples t-test for knowledge of parenting/development and social and emotional competence, respectively, $t(183) = -3.54$, $p = .001$; $t(184) = -4.18$, $p < .001$)

Differences Between AR-eligible Families Assigned to AR and TR

Family survey data (post) was examined to assess for differences between AR and TR families at the end of the case. To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale. Data included in these analyses are from cases that closed between October 2014 and June 2019.

A total of 882-889 families (depending on the subscale) were included in this analysis; this included 477-484 AR families and 403-406 TR families. No significant differences were observed between AR and TR families on any of the protective factors, indicating AR and TR families do not differ meaningfully on any of the protective factors following case closure. Figure 1.6.2 summarizes average ratings of AR and TR families.

Figure 1.6.2: Average Protective Factors Scale Ratings: Post Comparison of AR vs. TR Families



	Social Connections	Concrete Supports	Parental Resilience	Knowledge of Parenting/ Development	Nurturing and Attachment	Social and Emotional Competence of Children
AR	4.39	4.12	4.19	4.29	4.48	3.76
TR	4.33	4.17	4.18	4.28	4.47	3.75

Conclusion

DCFS has hypothesized that protective factors will be enhanced through AR. To test this hypothesis, UNL-CCFL tested whether protective factors for AR families improved from the beginning to the end of the case and whether AR families reported higher protective factors than TR families at the end of the case. Of six protective factors assessed, two protective factor (knowledge of parenting and child development; and social and emotional competence of children) improved from the beginning to end of case for AR families. No significant differences in protective factors were observed between AR and TR families at the end of the case.

Chapter 7: Safety Assessment Analyses

Key Question:

- Are children who experience AR at least as safe (or safer) than children who experience the TR track?

In order to examine safety assessment determinations, administrative data on AR-eligible intakes were examined. For more information on this data source, see Appendix A: Summary of Evaluation Data Sources and Data Collection.

Safety Assessment Decision

Safety assessments were completed for 4754 AR-eligible families (2458 AR, 2296 TR) during the demonstration period. The overwhelming majority of AR-eligible families that were assessed for safety (2395 AR families, 97% and 2184 TR families, 95%) were concluded to be "safe," meaning there were no identified safety threats. Table 1.7.1 details the safety assessment conclusions for the AR and TR families.

Table 1.7.1 Safety Assessment Conclusions for AR and TR Families

Safety Assessment Conclusion	Initial Track Assignment		
	AR	*TR*	*Total*
Safe	2,395 97%	2,184 95%	4,579 96%
Conditionally Safe	39 2%	68 3%	107 2%
Unsafe	24 1%	44 2%	68 1%
Total	2,458	2,296	4,754

In order to examine differences between safety decisions for AR and TR families a logistic regression analysis was performed. A safety assessment conclusion of safe was coded as 1 and conclusions of conditionally safe and unsafe were coded as 0. The results indicate that the odds ratio for TR families has a coefficient of 0.51 ($p = 0.00$) with a 95% confidence interval of [0.37, 0.70]. This suggests that families assigned to AR are nearly 2 times more likely to be found safe than those assigned to TR.

Conclusion

The overwhelming majority of AR-eligible families that were assessed for safety (97% of AR and 95% of TR) were found to be safe, compared to conditionally safe or unsafe. In fact, AR families are nearly twice as likely to be found safe compared to AR-eligible TR families. This supports the research question that AR families are as safe (or safer) than TR families; however, it also brings the safety assessment

conclusions into question, as equivalent groups should result in no differences in safety assessment determinations.

Chapter 8: Program Data and Fidelity

Key Questions:

- Is AR program data available?
- Is AR case practice being documented in N-FOCUS?
- Is AR implemented with fidelity across the state?
- Do AR workers refrain from using the labels of "victim" or "perpetrator" and are no AR families placed on the Central Register?

Immediately upon approval of the evaluation plan, the evaluators began working with DCFS to negotiate and execute data sharing and confidentiality agreements to access AR program data collected through the DCFS administrative data system, N-FOCUS. Negotiations took place throughout the first quarter of the demonstration. Ultimately, multiple confidentiality and data sharing agreements were executed in order to meet the needs within distinct functional areas of the agency. A protocol was established to allow the evaluators to access downloadable data extracts via a secured web-based site internal to DCFS. Substantial effort was expended by DCFS staff to program weekly and monthly reports of the data fields requested by the evaluators. Full downloadable access to the data extracts was accomplished by the end of the first quarter of AR implementation.

Additionally, as a critical component of the evaluation of the AR program, a comprehensive review of AR case practice was proposed to be completed through a case file review process. The proposed process has always included a review of N-FOCUS data entries and case file narratives for the purpose of assessing AR practice and fidelity to Nebraska's AR model, as outlined in the AR program manual. However, while UNL-CCFL had originally intended to partner with DCFS to conduct fidelity reviews to inform statewide rollout of the AR program, ongoing challenges were experienced throughout the demonstration period, resulting in delayed access to case files and limiting the review to an assessment of fidelity in order to mainly serve as context to the larger outcome evaluation.

Initial efforts to develop the AR case file review protocol began in early 2015, shortly after the AR program implementation began. At DCFS' request, UNL-CCFL planned to partner with the Foster Care Review Office (FCRO) to conduct the case file reviews. The plan was for FCRO to provide the reviewers (who were already familiar with N-FOCUS and had access to the system) and UNL-CCFL was to provide the review tool, analyses, and summary reports. However, after initial plans began, DCFS recognized that FCRO does not have authority to access AR cases, as FCRO only has statutory authority to review cases for children placed in out-of-home care. So, DCFS decided the next step would be to try to amend statute and allow FCRO access to AR cases in order to conduct these reviews. Eventually, it became clear this method was not viable, so DCFS and UNL-CCFL began to develop another plan.

During the planning for the revised process, the evaluation team was assured by the DCFS waiver administrator that access to case files would be provided in order to complete the reviews. However, due to an ongoing series of challenges, these plans were delayed further. Ultimately, in February of 2019, the evaluation team was given printed case files in order to complete the reviews.

AR Case File Review

A systematic review of AR case files was conducted in order to address the following research questions:

(5) Is AR case practice documented in N-FOCUS?
(6) Is AR implemented with fidelity across the state?

Ultimately, the outcome of the AR program being implemented with fidelity is expected to lead to enhanced Child and Family Services organizational outcomes and better child and family outcomes related to safety, permanency, and well-being.

Sampling Procedure

UNL-CCFL worked collaboratively with DCFS to arrive at a mutually agreeable plan to limit the case file review to only cases that had been a) fully worked through AR and b) had opened and closed during the specified timeframe. Due to significant AR program requirement changes, the earliest cases included in the review were opened after July 1, 2015 (when the updated AR program manual was implemented). This review includes cases worked through December 31, 2018. A total of 243 cases were reviewed, which constitutes approximately 16% of total cases (1489 cases) fully worked through AR during the review timeframe.

Case File Review Tool Development

All iterations of the AR case file review tool were reviewed with DCFS. The original case file review tool development began in 2015. At that time, it was hoped that case file reviews could not only speak to AR model fidelity, but would also be a means of collecting rich data to inform the AR program implementation, statewide rollout, and ongoing development of service array. After time and as implementation progressed, it was determined to limit the case review to an assessment of fidelity. The current tool was originally drafted in the summer of 2018. This tool was developed by reviewing and incorporating 4 iterations of the AR program manual. The resulting case review tool included items related to basic case data, assessment of safety, interviewing protocol, safety planning (when necessary), numbers and types of contacts, completion of the Prevention Assessment, documentation of required forms, and purchase card use. After a thorough review by DCFS, the case review tool was built within the Qualtrics survey platform. Early reviews were used to solidify the tool and ensure all necessary data points were collected and that any skip logic was correctly functioning. The tool was finalized in April 2019. For more information about this data source and collection method, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*.

Case File Review Protocol

UNL-CCFL provided DCFS with a list of master case numbers and DCFS printed redacted case files for these reviews. UNL-CCFL was provided physical and electronic versions for each case requested. The electronic versions were sent via secure email and hard copies were stored in a locked file cabinet. At the approval of DCFS, UNL-CCFL contracted with a retired DCFS Program Specialist in order to complete the case file reviews. This individual retired in good standing with DCFS and has extensive knowledge and experience conducting case file reviews for the department. Reviews were completed between April and July of 2019. As the reviews were being completed, if documentation appeared to be missing, additional information was requested or asked to be confirmed prior to finalization of each review.

Analyzed data were summarized and reviewed with the reviewer. Overall observations, key takeaways, and recommendations were summarized by the reviewer and provided to the department, along with references to specific master case numbers for continued program improvement.

AR Case File Review Results

Case Information

The vast majority of cases included in this review were for allegations of child abuse/neglect. Out of 243 cases reviewed, 231 (95%) were for abuse/neglect and 12 (5%) were identified as dependency. Very few cases had prior substantiated assessment: only 7 (3%) cases had a prior substantiation and 236 (97%) cases had no prior substantiations.

The majority of cases had a single worker: 219 (90%) cases had one case manager and 24 (10%) had more than one CFS Specialist involved. Of those 24 cases with multiple case managers, 23 (96%) had 2 case managers in total, and 1 case (4%) had 3 case managers involved through their AR case. For cases with multiple case managers, case file documentation indicated this was due to the children living in different areas or because additional assistance was needed; some cases appeared to have been transferred due to staff turnover.

Response Timeframe

In order to assess the response timeframe, the reviewer examined the contact date in the Safety Assessment or narrative, whichever was earliest. The majority of reviewed cases indicated that face-to-face contact is being made with children in AR cases most of the time: 167 (69%) cases met the AR contact timeframe (within 5 calendar days of the intake accepted date), and 76 (31%) did not meet this timeframe. Of those families where the contact timeframe was not met, only 13 (17%) had a contact exception narrative documented by the supervisor or CFS administrator and 63 (83%) had no associated narrative. In some cases, a CFS Supervisor or another CFS Specialist made initial contact with the family in order to meet the timeframe. This resulted in more than one CFS Specialist being involved with the family (as presented above). The reviewer noted that it was sometimes difficult to clearly identify if, when, how, or where contact was made with all family members due to lack of documentation. However, it appears most cases included a documented visit to the home at least once during the case: 219 (90%) cases had documentation of a visit to the family home, 6 (3%) cases had documentation of family refusal, and just 18 (7%) cases had no documentation.

Interview Protocol

In the majority of AR cases reviewed there was evidence that the CFS Specialist attempted to contact the family prior to meeting with the child(ren): 210 (86%) cases provided some documented evidence of this effort, compared to 33 (14%) with no provided documentation. An attempt included any documentation of phone calls, letters, notes left on the family's door, or other similar efforts. Of the 210 cases with evident attempts, 192 (91%) cases documented that the parent was successfully contacted prior to interviewing the child(ren), with only 18 (9%) cases indicating that their attempts were unsuccessful. The reviewer noted that detailed, substantive summaries of interviews were sometimes lacking, making it difficult to tell who all participated, what was discussed, and to ensure that an interview and observation was completed with all children in the household. Table 1.8.1 details the counts of participants in the initial interview.

Table 1.8.1: Counts of Participants in Initial Interview

Role	Participated in Initial Interview	Not present
Child	216	27
Mother	180	63
Father	97	146
Parent's partner	10	233
Other household member	13	230
Other	32	211

Note: multiple household members could participate in the initial interview. All rows total 243, the number of cases reviewed. "Other household member" most frequently included parent's relatives (e.g., grandparent, stepparent). "Other" most frequently included other family members (e.g., grandparents), family friends, and interpreters.

Safety Assessment

Out of the 243 cases reviewed, all but one included a completed safety assessment. The reviewer noted this was an aberration, likely due to improper documentation or issues with pulling/printing the case file. For cases with a documented safety assessment, most (Yes = 191, 79%; No = 51, 21%) safety assessments were completed at the time of first contact with the children. However, less than half of the reviewed cases had safety assessments documented within 1 calendar day of the initial contact: 109 (45%) were documented with 1 calendar day and 133 (55%) were documented outside this required timeframe. For most cases reviewed, the CFS Supervisor reviewed and finalized the safety assessment within the required timeframe of 3 business days (Yes = 168, 69%; No = 74, 31%). In some instances, the CFS Specialist reviewed and finalized their own safety assessment (Yes = 33, 14%; No = 209, 86%). The reviewer noted that for cases with completed safety assessments outside the required timeframe, some appeared to be the result of the cases coming in on a Friday, perhaps necessitating overtime in order to document the safety assessment within the 1 calendar day timeframe. In these instances, most were documented the following Monday.

Of the 243 AR cases reviewed, only 3 (1%) safety assessments identified the presence of a safety threat, with the remaining 240 (99%) having no safety threat(s) identified. Overall, the reviewer agreed with the Specialist on the determination of safety threats, but disagreed with the determination of no safety threat on several cases. Several of the reviewed cases involved very young or vulnerable children, or children with medial issues. The reviewer stated that none of these cases should have necessitated a removal, based on the available documentation; however, a safety threat and subsequent in-home safety plan would have provided additional protections for these families. For those cases with an identified safety threat, the selected safety threats included: 1) the caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care; 2) the physical living condition are hazardous and immediately threatening to the health and/or safety of the child; and 3) child behaviors place the child at immediate threat of serious harm, in spite of appropriate response by caregiver(s).

The reviewer noted that some cases did provide documentation about which safety threats were considered and ruled out, whereas others simply concluded that the child was safe without providing any supporting information. There was inconsistent documentation in the narratives regarding whether

or not the CFS Specialist determined the validity of the concerns reported in the Intake that brought the family to the attention of the department. Determining the accuracy of the initial information is a necessary component of the safety and risk assessment to assure that all concerns are considered. Additionally, use of collateral contacts (e.g., schools, medical personnel, family members) to obtain additional information to verify the accuracy of reports provided by the family varied amongst the cases reviewed. Use of collateral contacts for additional information is very important in cases involving children especially vulnerable due to age, special needs, or with medical concerns.

Cases with a Safety Threat Identified

For the 3 cases with an identified safety threat, all completed a safety plan with the family and most included each identified safety plan component as outlined in the AR Program Manual. Two of the 3 cases were documented on N-FOCUS within the required timeframe of 1 calendar day of implementing the safety plan and one was finalized by the CFS Supervisor within the required timeframe of 1 calendar day of the CFS documenting the safety plan. Additionally, 2 of the 3 CFS Specialists met with the children and family at least once a week throughout the period of the safety plan (as required for AR families with an active safety plan). Contacts included face-to-face, phone, and other provider reported information.

Cases with No Safety Threat Identified

For the 240 cases without an identified safety threat, first month contacts varied. Some (52, 21%) of the reviewed cases had clearly documented face-to-face contacts with the family 3 times within the first month, as required. However, most (191, 79%) reviewed cases either did not meet this requirement or did not have sufficient documentation to make a determination. The reviewer noted that documentation of contacts was sometimes unclear. Some case files included summary statements that multiple contacts were made, without documentation of specific instances or content related to those interactions. This prevented counting actual contacts for these cases. In total, most (149, 61%) of the reviewed cases were indicated as being open longer than 30 days, requiring 2 ongoing face-to-face visits with the family in all subsequent months. Ongoing contact documentation indicates that just 25 (10%) of cases reviewed had clear documentation of face-to-face contacts twice per month; 80 (33%) cases did not have the documentation necessary to meet this requirement; 41 (17%) cases closed shortly after the first month. In total, 61 (25%) of the AR cases included in this review were open longer than 90 days. The reviewer noted regular contact with the family was key and appeared to improve the outcomes of the cases, regardless of whether or not frequency of contact adhered to the specific contact expectations as outlined the AR program manual.

Prevention Assessment

A prevention assessment was completed for the vast majority of the reviewed cases: 240 (99%) had a completed prevention assessment and 3 (1%) did not have a documented prevention assessment. Most prevention assessments were completed within 60 days of the intake being accepted for assessment, as required: 142 (59%) were completed within 60 days and 98 (41%) were not. Furthermore, just over half of the reviewed cases had a documented prevention assessment completed prior to case closure as expected, allowing the information in the assessment to be used in working with the family: 138 (58%) completed a prevention assessment prior to case closure and 102 (42%) did not. Most prevention assessments were finalized by the CFS Supervisor within 5 days of the assessment being placed in ready

to review status: 157 (65%) were completed within 5 days and 83 (35%) were not. The reviewer noted that in some instances, the prevention assessment appeared to have been completed without information from the family or others, but rather through the use of information available on N-FOCUS, NDEN, or through law enforcement reports.

Required Documentation

The reviewer noted that for AR cases that appeared to have gone well, there was an apparent correlation between these outcomes and the Specialists' early completion of required forms and chronological detailed documentation of case activity.

Release of Information Form

The majority of reviewed cases did not require a Release of Information form: 190 (78%) cases did not require this form, 19 (8%) cases had a completed form documented in the case file, and 34 (14%) required this form, but did not have one documented. For cases where a Release of Information form was needed, but not documented, this generally involved a medical concern where it was appropriate to contact the medical provider.

Consent to Alternative Response Assessment Form

Most cases included documentation of the Consent to Alternative Response Assessment form: 139 (57%) cases had a signed form documented and an additional 26 (11%) cases included unsigned forms along with the date of discussion with the family; the remaining 78 (32%) cases did not have a Consent to Alternative Response Assessment form uploaded.

Protective Factors and Well-Being Questionnaire

Most of the cases reviewed included an initial Protective Factor and Well-Being Questionnaire (PFQ) for the family: 148 (61%) had a completed PFQ, 64 (26%) did not have a completed PFQ, and 31 (13%) of reviewed cases indicated that the family had refused to complete the PFQ.

Genogram and Eco-Map

Of the 243 cases reviewed, only 51 (21%) included documentation of a genogram, with 192 (79%) cases having no documented genogram. Additionally, only 25 (10%) included documentation of an eco-map and 218 (90%) of the reviewed cases had no documentation of an eco-map being completed with the family. Furthermore, only 1 case included evidence of the CFS Supervisor reviewing these documents in the staffing narrative.

Family Plan

A written family plan was completed with 54 (22%) of the reviewed cases; 189 (78%) cases did not have documented family plans within the case file. Although a written family plan may not have been necessary for cases open a month or less, a written plan was useful in those cases open longer. Some Specialists reviewed and updated plans on a regular basis. For those cases with completed family plans, most included information about needs of the family, strategies, and resources for the family which are specific sections of the plan. However, few included information about family strengths and goals. This was likely due to the fact that the form most commonly observed in the reviewed case files did not include sections asking about family strengths and goals.

Supervision

While there was evidence that some supervisors are attempting to use group supervision and case mapping with Alternative Responses cases, additional training on these concepts may be helpful. Documentation of group supervision was only included in 7 (3%) of the reviewed cases. The remaining 236 (97%) cases did not include any indication of group supervision. Indications of case mapping were documented in 20 (8%) reviewed cases, with 223 (97%) cases not including any documentation of case mapping. For cases including documentation of case mapping, 5 (25%) included a partially completed scanned copy of the case map in N-FOCUS and 15 (75%) did not include a scanned case map. Additionally, 14 (70%) cases included narrative documentation of the case map. Most narratives included minimal information about items discussed and next steps; information about decisions made and parties involved were rarely included in the narrative documentation. The reviewer noted that documentation of involvement of supervisors was generally limited to cases that had complex issues, needed approvals for expenditures, or signing off on completed assessments.

DCFS Purchase Card Usage

Based on receipts provided in the reviewed case file, the DCFS purchase card was used to obtain resources for 64 (26%) families; 179 (74%) cases did not have documentation of DCFS purchase card usage. The reviewer noted that many more cases included narrative documentation indicating the use of vouchers to pay rent or purchase goods like food, gas, and diapers. However, there were some cases where narrative documentation was unclear, and it could not be determined if payment was actually made for various expenses. Table 1.8.2 displays the goods provided to families through the use of the DCFS purchase card based on receipts included in the file.

Table 1.8.2: Counts of Purchase Card Purchases by Category

Item Category	Number of Cases with Purchase Card Purchase
Food/formula	7
Clothing needs (including diapers)	15
Identification cards (e.g., associated fees)	2
Housing	0
One-time deposit on a residence	1
Rent per month	5
Housing repairs (e.g., window or door repair, locks, electrical, plumbing)	3
Household items (e.g., refrigerator, washer, dryer, crib, beds)	9
Assistance with utilities (does not include cable, cell phone/trac phone)	12
Child care (e.g., registration fee, tuition)	2
Pest control	2
Garbage removal (e.g., regular pickup, large dumpster)	0
Transportation	1
Personal vehicle expenses (e.g., gas, minor car repair, license, insurance)	14
Taxi, bus pass, handi-van, truck for moving, etc.	4

Item Category	Number of Cases with Purchase Card Purchase
Medications	0
Lab work (excludes substance abuse related laboratory expenses)	0
Medical and mental health serves	1
Other	23

Note: multiple services could be provided to a single family. "Other" services most frequently included purchases related to books and school supplies, attorney and court fees, personal hygiene supplies, and household cleaning supplies.

Based on expenditures indicated in the case file, no approvals were needed for the majority of purchases: 38 (59%) cases were indicated as having spent less than $500 in total for the family. CFS Supervisor approvals were indicated in 18 (28%) cases; CFS administrator approvals were indicated in 3 (5%) cases; and no approvals were indicated for 5 (8%) cases. None of the reviewed cases included approvals by the Service Area Administrator or the AR Program Specialist.

Overall Findings of AR Case File Review and Case Examples

Based on the review of 243 AR cases, the following observations were noted:

- Most AR cases included in this review were for allegations of child abuse/neglect.
- The majority of cases involved only 1 case manager.
- While most cases indicated that face-to-face contact was made within the 5-day response timeframe, nearly a third of cases did not meet this timeframe. Furthermore, contact exception narratives were only provided for a limited number of reviewed cases.
- The majority of cases included evidence that the CFS Specialists followed AR interview protocol and attempted to contact the family prior to meeting with the child(ren).
- Nearly all cases included a documented safety assessment; however, these were not always completed timely. Additionally, only 3 cases had an identified safety threat, although some other cases appeared to have safety threats present from the case file review.
- For the 3 cases with an identified safety threat, all completed a safety plan with the family and most included each identified safety plan component as outlined in the AR Program Manual. Additionally, 2 of the 3 CFS Specialists met with the children and family at least once a week throughout the period of the safety plan (as required for AR families with an active safety plan).
- For the 240 cases without an identified safety threat, first month contacts varied, but most of the reviewed cases did not meet this requirement for varied reasons (e.g., family refusal, cases were open less than 1 month). Nearly half of the reviewed cases did not meet the contact requirements and provided no explanation. Furthermore, ongoing contact documentation indicated very few of the cases reviewed had clear documentation of face-to-face contact 2 times per month, as required by the AR program manual.
- A prevention assessment was completed for the vast majority of the reviewed case and most were completed within 60 days of the intake being accepted for assessment, as required. Furthermore, just over half of the reviewed cases had a documented prevention assessment

completed prior to case closure as expected, allowing the information in the assessment to be used in working with the family.

- The majority of reviewed cases did not require a Release of Information form.
- Most cases included documentation of the Consent to Alternative Response Assessment form.
- Most of the cases reviewed included documentation of an initial Protective Factor and Well-Being Questionnaire for the family.
- Most cases omitted documentation of a genogram or eco-map completed with the family.
- Most of the reviewed cases did not include documentation of the family plan. For those cases with completed family plans, it was noted that the form most commonly observed in the case files did not include sections asking about family strengths or goals.
- Very few cases included any documentation of group supervision or case mapping. Most supervisor narratives included minimal information about items discussed and next steps; information about decisions made and parties involved were rarely included in the supervisor narrative documentation.
- About a quarter of reviewed cases included documentation of DCFS purchase card purchases. This was most commonly used to purchase things like clothing and diapers; assistance with utilities; supplement personal vehicle expenses (e.g., gas, minor repairs); and other expenses like books or school supplies, attorney and court fees, personal hygiene supplies, and household cleaning supplies.

In general, when reviewed cases were problematic, it was due to very little substantive information or often repeated information throughout the case file. Additionally, minimal efforts on behalf of some CFS Specialists were observed through delayed contacts, poor information gathering, and sparse documentation. It is possible that in some cases, AR expectations were met, but not documented. Conversely, some CFS Specialists had a noticeable understanding of the Alterative Response philosophy and strongly displayed these concepts in their casework. For cases that appeared to have worked well, the reviewer noted several common characteristics: 1) addressing identified concerns; 2) identifying family issues outside of the Intake report; 3) building good report and engaging with the family to obtain quality information; and 4) providing parents support to better meet their child(ren)'s needs. When these characteristics were present, associated improvements in the family's stability due to DCFS involvement was observed.

Addressing Identified Concerns

Successful cases addressed the identified concerns and helped the family access needed supports and services. In one example, a mother of a three-year-old child with multiple physical and cognitive needs was provided supports to complete applications for medical and other assistance, obtained evaluations so that the child received necessary services, and assisted the parent in arranging transportation in order to keep medical appointments. In other cases, workers provided in-home services to address and model appropriate ways for the parents to manage the child(ren)'s behavior.

Recognizing Issues Outside Identified Concerns

In other cases, the documentation included a recognition of family issues, other than those identified in the Intake report, allowing for a comprehensive assessment of the family situation, and appropriate provision of service and use of Alternative Response funding. For example, the payment of car repairs

enabled several parents to maintain employment and assume payment of utilities and other bills themselves. Additionally, the provision of clothing and hygiene products, especially for teens, helped youth be more accepted at school, reduced stress, and improved school performance. In one case, the CFS Specialist was able to recognize the child's depression, even though it was not part of the Intake report; the family was assisted in getting the child appropriate therapy and family interactions were greatly improved.

Rapport Building and Engagement

In reading case narratives, the reviewer was able to see evidence of good rapport building and engagement with the family through the quality of information obtained. For example, in one case a parent discussed a series of traumatic losses that impacted his behavior at work and resulted in depression. In another case, the parent admitted that she was self-medicating with over-the-counter medications and alcohol in an attempt to address unresolved medical issues.

Family Improvement as a Result of DCFS Involvement

In general, based on the reviewed sample of AR cases, when CFS Specialists provided parents with emotional support and encouragement, parents were able to more adequately meet their child(ren)'s needs. For these cases, there was evidence that the family's situation was improved by DCFS involvement. For example, in one case, the case manager worked with the family to increase the child's compliance in taking medications for behavior issues, ensuring medical and therapy appointments were kept, and understanding the importance of on-time school attendance. This resulted in the child receiving appropriate treatment and, in turn, the child demonstrated improved behavior at school. In another case, when the Intake report was to address minor discipline, the AR case manager helped the family to pay utility bills, buy groceries, and provided the family with some clothing. This financial relief reduced the family's stress and resulted in improved capacity to handle routine conflicts. In a third case, the case manager worked with a parent to identify and utilize other family members as resources to assist with the children, allowing for the parent to return to work.

Overall Conclusion of AR Program Data and Fidelity

AR program data are available and documented in the DCFS administrative data system, N-FOCUS. When AR was implemented, the N-FOCUS system was modified so that AR cases no longer required the identification of a victim or perpetrator. Similarly, N-FOCUS no longer requires workers to make a case status determination for AR cases. Therefore, no individuals are placed on the Central Register through their involvement with an AR case. While fidelity appeared to be somewhat variable, the case file review revealed many strengths. In general, when reviewed cases were problematic, it was due to very little substantive information or repeated information throughout the case file. Minimal efforts on behalf of some CFS Specialists were observed through delayed contacts, poor information gathering, and sparse documentation. Because the case file review was based solely on available program data, it is possible that in some cases, AR expectations were met, but not documented. However, many CFS Specialists demonstrated an understanding of the Alterative Response philosophy and strongly displayed these concepts through their casework. For cases that appeared to have worked well, the case file review process identified several common characteristics: CFS Specialists worked with the family to 1) address identified concerns; 2) identify family issues outside of the Intake report; 3) build good report and engage with the family to obtain quality information; and 4) provide parents support to better meet their child(ren)'s needs. When these characteristics were present, associated improvements in the family's stability due to DCFS involvement was observed.

Part II:
Results-Based Accountability
Process Study

Chapter 1: Summary of RBA Program Evaluation

As part of a Title IV-E waiver demonstration project, the Nebraska Division of Children and Family Services (DCFS) intended to improve contractor accountability and child and family outcomes through the Results-Based Accountability (RBA) intervention. The RBA program provided a framework and process for measuring and improving the performance of contracted service providers, which in turn was expected to improve the outcomes of children and families receiving these services. The evaluation of this intervention was planned to contribute to an understanding of whether and how the demonstration accomplished its goals by assessing the planning and implementation process, contextual factors, and barriers and facilitators; achievement of intended outcomes; and the cost effectiveness of this intervention. An evaluation plan was created by UNL-CCFL, which was submitted and approved in September 2014. RBA was launched statewide on July 1, 2014. However, DCFS decided to shift from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. Due to this change in programs the evaluation team was unable to assess many aspects of RBA.

Evaluation Overview

In accordance with Nebraska's Waiver Terms & Conditions, RBA was to be evaluated through a longitudinal research design. For the contracted provider outcomes and the DHHS performance-based contracting outcomes, outcomes were to be measured multiple times across the life of the project. For these data, there were no pre-intervention data against which to compare. For the DCFS child and family outcomes, outcomes were to be compared pre- and post-RBA implementation. However, due to the shift in programs, contracted provider outcomes, DHHS performance-based contracting outcomes, and DCFS child and family outcomes were unable to be assessed.

Key Research Questions for the RBA Program

The key research questions for RBA were organized into four main categories: 1) contracted provider outcomes, 2) DCFS performance-based contracting outcomes, 3) DCFS child and family outcomes, and 4) cost. The specific research questions for RBA are listed below:

Contracted provider outcomes

- Do RBA providers have an understanding of and buy-in for the RBA process, Scorecard use, and contracting process?
- Do RBA providers demonstrate changes in practice as a result of participation in the RBA program?
- Does participation in the RBA program result in improvements in provider's performance measures?

DCFS performance-based contracting outcomes

- Does RBA provide DCFS with a system for measuring and comparing effectiveness of providers?
- Does RBA provide DCFS with a system to hold providers accountable for performance measures?
- Does RBA provide DCFS with a system to make contract decisions based on provider performance results?

DCFS child and family outcomes

Safety

- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce entry into out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce maltreatment in out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on maltreatment recurrence after discharge or closure?

Permanency

- For children and families being served by a provider subject to RBA, does the RBA program appear to improve placement stability?
- For children and families being served by a provider subject to RBA, does the RBA program appear to increase timely reunification and adoption?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce discharge to emancipation?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on re-entry into out-of-home care?

Cost

- How do RBA administrative costs evolve over time?
- How do rates for contracted services compare between pre- and post- RBA implementation?

Ultimately, contracted provider understanding and buy-in was assessed during early implementation of the RBA program and is summarized in the next chapter, Chapter 2: Contracted Provider Understanding and Buy-In. A summary of early turn-the-curve (TTC) meeting compliance is summarized in Part V, Chapter 2: Contracted Provider and Child and Family Outcomes. Finally, cost data associated with the RBA program, including a supplemental case study of provider costs, is included in Part VI, Chapter 3: Results-Based Accountability Cost Study.

Chapter 2: Contracted Provider Understanding and Buy-in

Key Question:

- Do RBA providers have an understanding of and buy-in for the RBA process, Scorecard use, and contracting process?

RBA Provider Survey

Purpose

In order to gain a better understanding of provider's buy-in for the RBA program, a survey of providers participating in RBA was conducted in January 2015. This was the first administration of the RBA Provider Survey. For more information about this survey, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*. To assess changes in these important factors over time, this survey was planned to be administered three times over the course of the demonstration: early implementation, at approximately the mid-point of the project, and near the end of the demonstration. When viewed collectively, responses to these three surveys was anticipated to reflect the degree to which providers understand and are engaged in the RBA process, use of Scorecard, and DCFS' contracting process, as well as any changes in these areas over the course of the demonstration. However, at approximately the midpoint of the demonstration project, DCFS shifted from RBA to the current contract monitoring program known as Provider Performance Improvement (PPI). Therefore, the following is a summary of the single RBA Provider Survey administration.

This administration of the RBA Provider Survey assessed providers' perceptions of RBA's core components, as well as the impact of RBA on provider agency operations. Specifically, an understanding of the following areas was gained:

- Provider agencies' assessment of readiness and capacity to implement RBA
- Process to develop and refine performance measures
- Time and effort required of provider agencies to develop procedures to collect agency's performance data and enter into Scorecard monthly
- Use of Results Scorecard system
- Impact of RBA performance data collection and monitoring on their internal agency operations
- Overall impressions of RBA process and products (including meeting effectiveness and barriers)
- DCFS' fidelity to RBA model (as understood by providers)

Evaluators from UNL-CCFL worked collaboratively with the DCFS RBA Program Administrator to develop survey items designed to assess provider perceptions of the planning and early implementation of RBA. At the time of this survey administration, some RBA components had not yet been implemented (i.e., data fidelity reviews; Turn the Curve meetings; and the development, monitoring, and implementation of action plans), and therefore these elements were not included. However, these areas will be added to future surveys as RBA implementation progresses.

Participants

For each of the providers participating in RBA, DCFS was asked to provide UNL-CCFL with contact information for individuals entering Scorecard data, Scorecard license holders, and CEO/Administrator-level personnel. The list provided contained 96 names from 61 provider agencies. Six individuals contacted the evaluators and asked to be removed from the mailing list because they did not consider

themselves to be involved in RBA. Thus, out of 90 individuals, 55 participants completed the survey for a response rate of 61%. These individuals represented 48 unique provider agencies, or 80% of the provider agencies participating in RBA.

The survey was intended to assess the perceptions of individuals within provider agencies. Thus, an artifact of this design was the result that some agencies had more than one respondent. Specifically, seven agencies had two respondents each; these individuals represented different roles, such as CEO, Scorecard license holder, or data entry. Additional analyses were conducted to assess the potential impact that these seven agencies had on the aggregated survey results through the multiple respondents. An "agency average" score was calculated for each item for each of these agencies, and then this average score was used as the sole data point in a new data set using a single respondent per agency (N=48 respondents). Paired sample t-tests were conducted to compare each of the original item means with the new "agency average" item means. Results revealed no statistically significant differences: the average item rating using one response per agency was not significantly different from the average rating when the complete data set was used (i.e., when the two ratings for these seven agencies were included). However, the creation of agency average ratings resulted in findings that were difficult to interpret (e.g., scores of 1.5 that did not align with the scale values such as *Agree* or *Disagree*). Because the purpose of the survey was to provide DCFS with feedback on RBA implementation, it was decided to use the original, unadjusted, survey responses from the full data set, to facilitate interpretation of results.

Procedure

The current report provides a summary of results of the first administration of the survey, which was sent on January 5, 2015, roughly six months after the start of RBA implementation. The survey was administered by UNL-CCFL using Qualtrics, a web-based survey system. Individuals were sent a survey invitation via email and received two weekly follow-up reminders. The survey closed on February 10, 2015.

Results

Survey items were organized into the following dimensions:

- Readiness and capacity to implement RBA
- RBA performance measures
- Use of Results Scorecard
- RBA Training
- Shared vision for RBA program
- Participation and utility of RBA program
- History of collaboration
- Inclusiveness in the process
- Open communication
- Appropriate pace of development
- Political and social climate for RBA
- RBA program elements

Table 2.2.1 details the frequency of responses and overall rating averages for each item. Avg = the item average, Sd = the item standard deviation, and # = the number of respondents for that item. The

majority of items were rated on a 5-point scale from *Strongly Disagree* to *Strongly Agree*: *SD* = Strongly Disagree (1), *D* = Disagree (2), *N* = Neutral (3), *A* = Agree (4), *SA* = Strongly Agree (5). Some items used a different rating scale, rating a statements from *Very Difficult* to *Very Easy*: *VD* = Very Difficult (1), *D* = Difficult (2), *N* = Neutral (3), *E* = Easy (4), *VE* = Very Easy (5). One item asked participants to rate frequency from Never to Daily: *Nv* = Never (1), *M* = Monthly (2), *W* = Weekly (3), *Da* = Daily. Some responses included the options *Don't Know* and *Not Applicable*: *DK* = Don't Know, *NA* = Not Applicable. *DK* and *NA* responses were excluded from the calculation of the mean. Percentages may not total 100% due to rounding.

Table 2.2.1: RBA Provider Survey Item Frequencies and Averages by Survey Dimensions

Assessment of Readiness and Capacity to Implement RBA									
Survey Item	*SD*	*D*	*N*	*A*	*SA*	*DK*	*Avg*	*Sd*	*#*
1. RBA matches the priorities of my organization.	3 (6%)	5 (9%)	16 (29%)	27 (49%)	3 (6%)	1 (2%)	3.41	0.94	55
2. My agency's leadership is encouraging all of us to embrace RBA.	1 (2%)	1 (2%)	9 (16%)	19 (34%)	23 (42%)	2 (4%)	4.17	0.91	55
3. My agency believes there are legitimate reasons for the Child Protection and Safety System to implement RBA.	2 (4%)	0	4 (7%)	31 (56%)	16 (29%)	2 (4%)	4.11	0.85	55
4. DCFS's senior leadership is committed to RBA.	1 (2%)	2 (4%)	6 (11%)	25 (45%)	13 (24%)	8 (14%)	4.00	0.88	55
5. My agency had the adequate "people power" to develop a process for collecting data.	3 (6%)	4 (7%)	6 (18%)	25 (37%)	13 (29%)	8 (2%)	3.79	1.13	54
6. My agency was ready to implement RBA in time for the start date.	3 (6%)	4 (7%)	5 (9%)	26 (47%)	16 (29%)	1 (2%)	3.89	1.09	55
7. My agency does not anticipate any problems adjusting to the work it will have as a result of RBA.	3 (6%)	9 (17%)	10 (19%)	20 (38%)	10 (19%)	1 (2%)	3.48	1.16	53

RBA Performance Measures									
8. The process to *develop* performance measures was collaborative between my agency and DCFS.	5 (9%)	8 (15%)	16 (30%)	17 (31%)	5 (9%)	3 (6%)	3.18	1.13	54
Survey Item	*SD*	*D*	*N*	*A*	*SA*	*DK*	*Avg*	*Sd*	*#*
9. The process to *refine* performance measures was collaborative between my agency and DCFS.	9 (17%)	12 (23%)	14 (26%)	13 (24%)	3 (6%)	2 (4%)	2.78	1.19	53
10. I have felt well informed during the performance measure development process (e.g., I understood the process, there was good communication, my questions were answered).	4 (7%)	6 (11%)	12 (22%)	24 (44%)	7 (13%)	1 (2%)	3.45	1.10	54
11. How difficult was it for your agency to develop procedures to collect performance measure data?	2 (4%)	7 (13%)	13 (24%)	22 (41%)	8 (15%)	2 (4%)	3.54	1.04	54
Use of Results Scorecard									
Survey Item	*Yes*	*No*					*Avg*	*Sd*	*#*
12. Does your agency regularly enter data into the Results Scorecard website each month?	51 (96%)	2 (4%)							*53*
Survey Item	*VD*	*D*	*N*	*E*	*VE*	*DK*	*Avg*	*Sd*	*#*
13. How difficult is it for your agency to compile and enter data into the Scorecard each month?	0	4 (8%)	10 (20%)	29 (57%)	7 (14%)	1 (2%)	3.78	0.79	51
14. Approximately how long does it take your agency to compile and enter data into the Scorecard each month?	*Number*	*Valid %*							50
Less than 15 minutes	4	8%							
15 to 29 minutes	11	22%							
30 to 44 minutes	8	16%							

45 to 59 minutes	6	12%
1 hour to less than 2 hours	9	18%
2 hours to less than 3 hours	4	8%
3 hours to less than 4 hours	2	4%
4 or more hours	3	6%
Don't Know	3	6%

Survey Item	*Nv*	*M*	*W*	*Da*		*DK*	*Avg*	*Sd*	*#*
15. How frequently are you using the Scorecard outside of entering your agency's data (e.g., to view your data or reports)?	24 (47%)	23 (45%)	0	0		4 (8%)	1.49	.50	51
Survey Item	*SD*	*D*	*N*	*A*	*SA*	*DK*	*Avg*	*Sd*	*#*
16. The Scorecard is a valuable tool for my agency.	3 (6%)	13 (25%)	20 (39%)	7 (14%)	4 (8%)	4 (8%)	2.91	1.02	51
RBA Training									
17. My agency has received training in the principles and philosophy of RBA.	3 (6%)	1 (2%)	8 (15%)	27 (52%)	10 (19%)	3 (6%)	3.82	0.99	52
18. I know how to request additional RBA training for my agency.	3 (6%)	6 (11%)	5 (10%)	23 (44%)	12 (23%)	3 (6%)	3.71	1.15	52
19. DHHS has been responsive to my request for additional RBA training.	0	0	2 (6%)	12 (34%)	2 (6%)	19 (54%)	4.00	0.52	35
Shared Vision for RBA									
20. My agency has a shared vision with DCFS regarding what RBA will accomplish.	1 (2%)	4 (7%)	15 (28%)	23 (43%)	4 (7%)	6 (11%)	3.53	0.86	53
21. My agency has a clear sense of their role and responsibility with regard to the RBA initiative.	2 (4%)	3 (6%)	7 (13%)	33 (62%)	6 (11%)	2 (4%)	3.75	0.89	53
Participation and Utility									
22. My agency has a clear primary point of contact for RBA-related questions.	1 (2%)	0	7 (13%)	23 (43%)	19 (36%)	3 (6%)	4.18	0.82	53

23. My agency feels involved in what's going on with the RBA initiative.	2 (4%)	9 (17%)	17 (33%)	20 (38%)	2 (4%)	2 (4%)	3.22	0.93	52
24. RBA meetings with DCFS are worthwhile because my agency's participation makes a difference in the outcomes, decisions, and results.	2 (4%)	10 (19%)	19 (36%)	11 (21%)	4 (7%)	7 (13%)	3.11	0.99	53
Survey Item	*SD*	*D*	*N*	*A*	*SA*	*DK*	*Avg*	*Sd*	*#*
History of Collaboration									
25. Trying to solve problems through collaboration has been common amongst provider agencies.	1 (2%)	4 (8%)	19 (36%)	20 (38%)	5 (10%)	3 (6%)	3.49	0.87	52
26. Provider agencies have a history of working collaboratively with DCFS.	1 (2%)	8 (16%)	15 (29%)	20 (39%)	3 (6%)	4 (8%)	3.34	0.91	51
Inclusiveness in Process									
27. The processes used by DCFS to elicit my agency's input about RBA are effective.	0	7 (14%)	15 (29%)	21 (41%)	2 (4%)	6 (12%)	3.40	0.81	51
28. My agency's input is heard and serves a valuable role in the decisions made by DCFS.	2 (4%)	9 (17%)	18 (35%)	13 (25%)	1 (2%)	9 (17%)	3.05	0.90	52
29. We are always informed when major decisions are made about RBA program design and implementation that affect our agency.	1 (2%)	5 (10%)	18 (35%)	19 (37%)	3 (6%)	6 (11%)	3.39	0.86	52
Open Communication									
30. When my agency meets with DCFS to discuss RBA, different ideas and perspectives are often explored.	1 (2%)	4 (8%)	17 (33%)	21 (41%)	2 (4%)	6 (12%)	3.42	0.81	51
31. When my agency meets with DCFS to discuss RBA, people feel comfortable challenging the ideas and comments of others.	2 (4%)	3 (6%)	14 (27%)	22 (43%)	4 (8%)	6 (12%)	3.51	0.92	51

32. When my agency meets with DCFS to discuss RBA, there is a high level of trust between participants.	3 (6%)	5 (10%)	21 (41%)	14 (27%)	2 (4%)	6 (12%)	3.16	0.93	51
Appropriate Pace of Development									
33. DCFS has tried to take on the right amount of work at the right pace implementing the RBA initiative.	1 (2%)	4 (8%)	11 (22%)	25 (50%)	4 (8%)	5 (10%)	3.60	0.86	50
Survey Item	*SD*	*D*	*N*	*A*	*SA*	*DK*	*Avg*	*Sd*	*#*
34. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to the RBA initiative.	1 (2%)	5 (10%)	13 (25%)	19 (37%)	3 (6%)	10 (20%)	3.44	0.90	51
Political and Social Climate									
35. The political and social climate seems to be "right" for RBA to be successful.	1 (2%)	6 (12%)	17 (33%)	19 (37%)	1 (2%)	7 (14%)	3.30	0.82	51
Perceptions of RBA Program Elements									
36. RBA has created clear service definitions and expectations for service providers.	4 (8%)	7 (14%)	8 (16%)	25 (49%)	5 (10%)	2 (4%)	3.41	1.12	51
37. RBA creates a system for measuring and comparing the effectiveness of providers.	6 (12%)	10 (20%)	5 (10%)	20 (39%)	3 (6%)	7 (14%)	3.09	1.23	51
38. RBA holds the system accountable for their performance measures.	3 (6%)	8 (16%)	16 (32%)	14 (28%)	3 (6%)	6 (12%)	3.14	1.02	50
39. RBA will influence contract decisions, based on performance results.	1 (2%)	3 (6%)	13 (25%)	15 (29%)	5 (10%)	14 (27%)	3.54	0.93	51
40. RBA will benefit the children and families we serve.	2 (4%)	3 (6%)	11 (22%)	24 (47%)	2 (4%)	9 (18%)	3.50	0.89	51
41. RBA will benefit my agency.	2 (4%)	4 (8%)	16 (31%)	15 (29%)	5 (10%)	9 (18%)	3.40	1.00	51
42. RBA will improve my agency's overall efficiency.	2 (4%)	9 (18%)	19 (37%)	12 (23%)	4 (8%)	5 (10%)	3.15	1.00	51

Additionally, respondents were allowed to provide comments. These comments were analyzed and categorized by theme. Table 2.2.2 summarizes the various comment sections included in the *RBA Provider Survey*. Each table represents a comment section. The total number of responses is presented under each question. The left column details the content themes that emerged, the middle column shows the number of individuals with comments related to that theme, and the right column displays illustrative responses for that theme. Within each section, certain statements were not coded (i.e., the statement did not fit into a theme), while other responses fit into multiple themes.

Table 2.2.2: RBA Provider Survey Summary of Comments by Comment Section

Any Comments or Suggestions about Assessment of Readiness and Capacity to Implement RBA? Total Response = 15		
Theme	*N*	Illustrative Responses
Good idea, but…	3	• The thought is positive, but the data collected may not prove as useful as initially thought. • This is a good idea but requires significant additional staff time to complete monthly • The concept behind RBA is positive, however the way the Department implemented it, it is extremely wasteful.
Agency impacts	2	• We've hired an employee to be able to gather the needed information. • Due date each month is very inconvenient.
No problems	3	• We've not had any issues getting measurements entered. • Our agency will be able to meet the needs of the state to do this.
Training	3	• Missed out on the training. • Needed more assistance than expected. • Tutorial instructions were clear and the process is easy.
Measures questionable	9	• Definitions and actual data being collected are not clearly defined. • Will be difficult to gather meaningful data given the way some measures are worded. • Measures are not consistent with what providers had suggested. • Many of the outcomes do not show the work being done or are unnecessary or difficult to collect.

For the instruments or procedures your agency uses to collect performance measure data, what methods (if any) were already in place? Total Response = 38		
Theme	*N*	Illustrative Responses
None existed	6	• None, we had to design new data collection procedures.
Some processes in place	4	• We had some measures in place in order to begin implementation, but did have to develop additional systems.
Most processes in place	12	• Most every aspect and function was in place. Some of the data collected needed to change. • All but one were already in place. • We already had a process but it had to be changed to fit the RBA requirements.
Everything was in place	7	• This is all data that was currently being collected.
Specific measures mentioned	9	• Number of referrals. • Intake and discharge dates.

What methods (if any) did you need to develop specifically to address the RBA performance measures? Total Response = 31		
Theme	*N*	Illustrative Responses
None needed	7	• The information was in our records already, just had to input the information.
Spreadsheets/databases for tracking	12	• Due to our original spreadsheet method being so time consuming, we are now in the process of creating a database in order to make tracking more efficient. • Some spreadsheets needed to be created. • We had to change our referral tracking processes.
Worker training	2	• Training system for workers to know about and understand the performance measures.
Additional data elements needed to be added to existing systems	13	• We had to define the term success, so we used our data to define success with a family. • Implement new ways to track/define successful and unsuccessful discharge. • Added additional data to our current tracking system. • No new methods needed to be developed, just additional data to track.

Any Comments or Suggestions about RBA Performance Measures? Total Response = 18		
Theme	*N*	Illustrative Responses
Agency burden	2	• They are probably good, but at what cost to agencies? • We had to design new data collection procedures. It has been very inconvenient overall.
Measures are problematic	12	• The performance measures do not seem to be measuring what was intended to measure. • Some of the current measures are not within our control. • Many of the RBA measures do not provide an accurate picture of success within the agency/service. • DHHS has admitted that many of the measures "don't capture what we want them to" and yet we continue to report, which does not seem efficient.
Waiting to see	2	• Somewhat apprehensive in providing information that the outcomes may be used against our agency in the future. • We are still waiting to see how the data will be used.
Positive	2	• It is necessary to ensure the best services are provided. • RBA is an easy tool to use to review performance.

Any Comments or Suggestions about Use of Results Scorecard? Total Response = 11		
Theme	*N*	Illustrative Responses
Positive reactions to Scorecard	2	• Simple to use and a fairly easy way to track data. The website is reliable and has always worked sufficiently. • I didn't like it in the beginning, [but after assistance from RD] I find it useful.
Desire to revise the performance measures	6	• Need to refine the performance measures to give us more useful data. • Reevaluate the definition of some of the measures. It can be disheartening to see a low number, when you know the measurement does not tell the true story.

Why Scorecard is or is not a Valuable Tool for your Agency? Total Response = 42		
Theme	*N*	Illustrative Responses
Positive (valuable)	10	• Allows all agency staff to see performance trends in an easy to read format. • It is nice to have shared outcomes and have it all located in the same location. • Assists me in keeping an eye on how well we are doing overall as opposed to just thinking that I know the information.
Mixed (has potential)	8	• It would be more valuable if it actually captured the performance of the agency – not so focused on variables the agency cannot control. • It has been mildly useful in tracking items we may not have considered tracking initially. • It does not address any of the story behind the data, or address the quality of the services provided. However, the quantitative results are interesting to help track trends of the agency and whether workload is increasing or decreasing. • With some changes to the measures and work with the providers on making these changes, we would find the RBA tool to be very valuable.
Negative (not valuable)	18	• This does not reflect any of our needs—what we do well or what we don't do well. • We already have and know the data you are asking for and that data is not the information we deem as most important in seeing which cases have been most successful and why. • The website is very slow and does not contain skip patterns or a way to N/A a service when we are not actively serving families. • The measures do not indicate change in clients and do not measure overall progress of the programs. It appears to simply be outputs of the agency rather than what we need, outcomes.
Don't know	3	• We are unsure at this time. • Don't know, I'm too far removed from it.

Any Comments or Suggestions about RBA Training? Total Response = 8		
Theme	*N*	Illustrative Responses
Positive	6	• The training provided was helpful and easy to apply. • They have been very supportive of our requests for help.
Negative/Indifferent	2	• It was confusing. • I have not pursued it.

Any Comments or Suggestions about A Shared Vision for RBA? Total Response = 8		
Theme	*N*	Illustrative Responses
Positive	3	• Having a clear vision as to the expected results is huge. • Agree overall with most of the performance measures and conveyed this to staff, which had them pay more attention to outcomes.
Guarded/Skeptical	5	• Since this first year is getting a baseline, it is difficult to see where this is headed. When actual outcomes are measured, I'm sure our agency will see the value of the time /resources to collect the data. • We are skeptical of how the results will be used in drafting future contracts. • Turn the Curve will be interesting but not meaningful if the data does not match what we are doing.

Any Comments or Suggestions about Participation and Utility of RBA? Total Response = 12		
Theme	*N*	Illustrative Responses
Positive	3	• We appreciate the opportunity to be included up front and input taken into consideration when formulating outcomes. • I feel DCFS listens to the providers and responds to their needs when they can.
Negative	3	• Whether or not agencies voices are truly heard, it always seems DCFS has made up their minds on what the process and outcomes of this initiative will be. We will comply but feel little ownership. • When they solicit feedback perhaps they might consider being more open to the feedback from the folks doing the data.

Meeting participation	6	• It is difficult to attend meetings held outside of our area. • We are a small agency with limited staff, so we are not able to attend meetings the state has had regarding RBA. • We have not had any meetings regarding RBA since it was implemented.

Any Comments or Suggestions about History of Collaboration? **Total Response = 8**		
Theme	*N*	Illustrative Responses
Positive	5	• In the last few years Nebraska leaders and agencies have been able to build rapport and respect for each other and work together as a team in a way never experienced before in the state. • It has only been a couple of years where there has been good collaboration. It has taken a while to build trust.
Negative/Mixed	3	• Some collaboration at worker and top levels [of DCFS], but don't think there is much collaboration in the middle levels. • There has never been real meaningful collaboration or shared decision making.

Any Comments or Suggestions about Inclusiveness in the RBA Process? **Total Response = 6**		
Theme	*N*	Illustrative Responses
Negative	5	• I don't recall being part of this process. • I don't feel like agencies are really "heard" during the process. • I would not know if something was decided and we did not hear.
Positive	1	• We are always included in emails and invited to meetings.

Any Comments or Suggestions about Open Communication? **Total Response = 11**		
Theme	*N*	Illustrative Responses
Positive	3	• Our contact person has always been approachable and open. • I feel comfortable talking to Nathan with regards to my questions.

Hopeful about the future	3	• Trust is something that is still evolving – things are better though. • Once we see how this impacts our organization, I'm sure we will become more involved in the future.
Negative	4	• There have been few discussions about RBA since its implementation. • There has not been much communication other than to make sure that the numbers get reported on time.

Any Comments or Suggestions about Appropriate Pace of Development? Total Response = 9		
Theme	*N*	Illustrative Responses
Unsure	2	• Seems like a lot of money and time to resources to collect data that might be useful. • I have no knowledge of whether or not they are able to keep up. Time will tell.
Not enough time or resources	4	• This could have been more robust…the pace seems slow to me. • There is very little horsepower available to do any real meaningful design or analysis.

Any Comments or Suggestions about Political and Social Climate for RBA? Total Response = 7		
Theme	*N*	Illustrative Responses
Cautiously optimistic	7	• I guess we will see with the changes in leadership with the new Governor. • The question is what is going to happen now. • Maybe in a year or two, as things shake out, the timing might be more right for RBA.

Any Comments or Suggestions about RBA Program Elements? Total Response = 11		
Theme	*N*	Illustrative Responses
RBA has positive potential if the measures are fixed	2	• RBA could be VERY beneficial to our agency if the outcomes are created in an effective way. • Outcomes need some tweaking but in the end RBA will be good for all involved.
Data give inaccurate picture	5	• Measures do not allow for circumstances beyond the agency's control, except in the "story behind the data." I don't believe those factors will be given appropriate attention, and inaccurate conclusions will be drawn. • Small number of families served skews the data.

RBA has no impact or is meaningless	4	• Currently the data means very little to us as an organization. • We were already and continue to hold ourselves accountable regardless of RBA. • RBA does not measure any sort of outcomes related to effectiveness of services, and do not look at practices or measures which determine success.

Any Comments or Suggestions about The RBA Program, Overall? Total Response = 10		
Theme	*N*	Illustrative Responses
Idea behind RBA is good, measures need fixing	8	• The general idea behind RBA is understandable. It is not useful data at this time. • We believe that RBA is needed. However, there are changes that need to be made to the outcomes that will provide more accurate results. • We would be interested in strategies of how larger agencies are using RBA to form programs or to better serve their families. • It will be interesting to see if there are any outside contributing factors that skew the results of the measurements and if those factors are taken into consideration.
Have providers help with fixing the measures	2	• If/when there is consideration to change the measures, it would be very beneficial to have agencies help create them.

Conclusions by Survey Dimension

The following sections summarize the results observed from this survey administration.

Readiness and Capacity to Implement RBA. Overall, survey participants strongly endorsed the need to implement RBA. The majority of respondents indicated that the RBA program aligned with their individual agency priorities (55%) and was embraced by their agency's leadership (76%). They recognized the commitment to RBA demonstrated by DCFS's senior leadership. In general, most providers (85%) agreed that their agency was ready and able to implement the necessary RBA processes to collect and report their data. However, roughly a quarter of respondents (23%) indicated that they anticipated some problems adjusting to the resultant workload. Individual comments shared by participants revealed that some providers believed the RBA concept was a good one, but they had some concerns about the meaning of the data being collected. This area is addressed further in subsequent survey sections.

RBA Performance Measures. More than half (57%) of the respondents agreed or strongly agreed that they felt well informed during the performance measure development process. However, a substantially lower percentage characterized this process of development and refinement as collaborative;

specifically, 40% agreed/strongly agreed that the *development* process was collaborative and 30% agreed/strongly agreed that the measure *refinement* process was collaborative.

Once the measures were finalized, agencies needed to develop internal procedures to collect and compile their data. The large majority (80%) of survey respondents indicated that developing these procedures was not difficult. Comments illustrated a range of readiness: some agencies had none of the needed procedures in place prior to RBA, some had basic tracking processes in place but needed to develop additional processes specifically to meet the needs of RBA, and other agencies had pre-existing processes in place that seemed to meet all the needs of RBA.

Those providers who needed to develop new methods most often cited the need to add new data elements to existing data systems, or a need to develop spreadsheets or databases to track information that had not previously been tracked. In addition, a few providers cited a need to train their staff on the new performance measures.

The vast majority of the comments shared in this section of the survey reflected respondents' concerns with the performance measures. Illustrative responses included:

- "The performance measures do not seem to be measuring what was intended to measure."
- "Some of the current measures are not within our control."
- "Many of the RBA measures do not provide an accurate picture of success within the agency/service."
- "DHHS has admitted that many of the measures 'don't capture what we want them to' and yet we continue to report, which does not seem efficient."

Use of Results Scorecard. Providers were asked about their use of the Results Scorecard, which is DCFS' web-based system for providers to report and view their data. The system provides summaries of trends on each performance measure over time, and permits users to view their individual agency's data as well as aggregated system-wide performance data for each type of service. Results Scorecard is an essential component of the RBA system, and was implemented July, 2014. Providers are expected to enter their data on each of their performance measures each month. As of the date of this survey (January 2015), nearly all of the survey respondents (96%) reported that they were regularly entering their data into Results Scorecard, as required.

The majority of respondents did not feel that compiling and entering data into the Scorecard each month was a difficult task; 71% indicated it was easy or very easy. A cumulative total of 76% (38 out of 50) respondents estimated that it took their agency less than 2 hours to compile and enter data into Scorecard each month. Eighteen percent of respondents said it took their agency 2 or more hours to complete this monthly task. Similar results were observed when this analysis focused solely on those respondents who were directly responsible for entering their agency's data.

Despite its relative ease of use, roughly half of the respondents (47%) said they never used the Results Scorecard to view their agency's data or reports, outside of the time they spend entering data. The other half of respondents used the Scorecard on a monthly basis to do so. These percentages may reflect the relative newness of the system, and that only six months of data had been entered at this

point. The differences in respondent use of the system appear to be somewhat related to the different roles that respondents serve in their agency: the survey was sent to those responsible for directly entering their agency's data, Scorecard license holders, as well as to agency executives who may not have a role in data entry, but may be logging onto the system each month to view their agency's data. Examination of responses by participant's role revealed that those who enter the data reported never (58%) or monthly (42%) use of Scorecard to view their agency's data, while those who were agency CEOs reported using the Scorecard never (40%), monthly (44%), or they didn't know (16%).

When asked whether they agreed or disagreed that the Results Scorecard was a valuable tool for their agency, the majority of respondents were unsure (39%), followed by 31% who disagreed/strongly disagreed that the Scorecard was a valuable tool for their agency, and 22% who agreed that it was valuable. This question elicited the highest number of additional comments of all the questions on the survey. Those who provided additional comments can be characterized by four general themes: some providers felt Scorecard was a valuable tool, in that it helped them to see trends; a second group of providers felt Scorecard is of mixed value, in that it has the potential to be helpful if the performance measures were modified; a third small group of respondents were unsure of the value; and the final group of providers felt that Scorecard is not a valuable tool for their agency. There were a number of commonly cited reasons for negative opinions of the value of Scorecard: the measures are seen as incorrect or irrelevant, it focuses on things outside of their control, it is redundant with their own internal agency data system, or it doesn't provide the information they had expected it would.

Finally, the additional comments provided by participants in this section of the survey reiterated the desire for changes to the performance measures, as well as reinforced earlier comments about the ease of use and value of the Results Scorecard.

RBA Training. Survey respondents were very positive about the training they had received on RBA. Most participants (71%) said their agency had received training, and 67% said they knew how to request additional training for their agency, if it was needed. While just over half (54%) of respondents had not requested additional training, of those who had, the majority (72%) agreed/strongly agreed that DCFS had been responsive to their request. Additional comments received generally reiterated that the training was helpful and DCFS was responsive.

Shared Vision for RBA Program. Fifty percent of those providers who responded to the survey agreed/strongly agreed that their agency shared DCFS' vision regarding what the RBA program will accomplish, while slightly more than a quarter (28%) of providers were neutral on this statement. There was a much higher level of certainty regarding providers' role and responsibility in RBA: 73% agreed/strongly agreed that they had a clear sense of their role and responsibility. Thus, even though providers may not fully share DCFS' vision for the program, the majority are very clear on the department's expectations of them. The fact that there still remains 10 – 27% of the respondents who are either unclear or don't know their role and responsibility regarding RBA represents an opportunity for the department to further engage with providers to build understanding and commitment. Additional comments suggest that some providers are guarded and skeptical about how the RBA program will evolve over time.

Participation and Utility of RBA Program. The majority of respondents (79%) agreed/strongly agreed that their agency had a clear primary point of contact for RBA questions. However, a smaller percentage reported that their agency feels involved in what's going on with the RBA initiative (42%), and only a quarter of respondents feel that RBA meetings with DCFS are worthwhile (28%). Thus, it appears that while the department has done a good job of communicating to providers where to go with program-related questions, a significant proportion of providers (54%) are either unsure or do not feel involved in the RBA initiative. These respondents did not endorse the RBA meetings as "worthwhile," indicating that they do not feel that their agency's participation in meetings has an impact on meeting outcomes, decisions and results. As one participant noted, "we will comply, but feel little ownership." Participant comments suggest that some providers struggled to attend those meetings that occurred prior to implementation, and once implementation began, regular RBA meetings have not been as frequent.

History of Collaboration. Nearly half of the survey respondents (48%) agreed/strongly agreed that collaborative problem solving has been common amongst provider agencies in the past. A slightly smaller percentage (45%) agreed that providers have also had a history of working collaboratively with DCFS. Comments illustrated this view, with several positive references to DCFS' recent history of rebuilding trust and respect with provider agencies. A smaller number of comments exemplified the opposing view, in which 18% of respondents disagreed/strongly disagreed that DCFS had worked collaboratively with providers in many areas. These two divergent perspectives are illustrated by the following two comments:

- "In the last few years Nebraska leaders and agencies have been able to build rapport and respect for each other and work together as a team in a way never experienced before in the state."
- "There has never been real meaningful collaboration or shared decision making."

Inclusiveness in the Process. Nearly half (45%) of participants agreed/strongly agreed that DCFS' processes for eliciting provider input about RBA were effective. A similar percentage (42%) felt that their agency was informed about major decisions about the RBA program. However, a much smaller percentage (27%) felt that their agency's input was heard and considered by DCFS in decision-making. These three items suggest that DCFS is soliciting input and communicating program decisions to providers, but that providers do not generally feel that their voice has meaning. Comments appear to support this interpretation, as illustrated by the following comment: "I don't feel like agencies are really heard during the process."

Open Communication. Providers responding to the survey report a generally positive climate for exploration and discussion of differences when they meet with DCFS to discuss RBA. Specifically, 45% agreed/strongly agreed that different ideas and perspectives are often explored, and 51% reported that people feel comfortable challenging others ideas and comments. However, a smaller percentage (31%) of providers characterized these meetings as being built on a high level of trust. In fact, the majority of respondents (41%) neither agreed nor disagreed with this statement, or they were unsure (12%) about whether RBA meetings occurred with a high level of trust. Comments further illustrate this uncertainty, with some suggesting that trust between parties is still evolving.

Appropriate Pace of Development. Participants generally agreed/strongly agreed (58%) that DCFS had taken on the RBA initiative at the right pace. They were slightly less certain whether DCFS was able to keep up with the pace of work, with 43% of respondents agreeing/strongly agreeing, and 20% saying they did not know.

Political and Social Climate for RBA. When asked if the political and social climate for RBA was right for success, participants were positive. While 39% agreed/strongly agreed that the timing was appropriate, a third of respondents were neutral on this question, and 14% said they didn't know. The few comments that were offered appeared to suggest a cautiously optimistic outlook about the future of RBA, given the recent changes in state leadership. As one provider noted, "Time will tell."

RBA Program Elements. *The* final section of the survey assessed the participant's level of agreement with a number of fundamental elements of the RBA program model. The purpose of these items was to explore the extent to which providers agreed or disagreed with the department's theory of change and purpose for implementing RBA. Half of respondents (51%) agreed/strongly agreed that the RBA program will benefit children and families, while 39% felt it would benefit their agency, and a smaller percentage (31%) felt it would improve their agency's efficiency. The strongest level of agreement was for the item "RBA will influence contract decisions, based on performance results," with an average rating of 3.54 on a 5 point scale (39% agree/strongly agree). However, this item also had the highest percentage of respondents endorsing "don't know" (27%), suggesting some uncertainty among providers about whether DCFS will eventually use RBA results to inform contract decision-making, as intended. The item with the lowest average rating (3.09 on a 5 point scale), "RBA creates a system for measuring and comparing the effectiveness of providers," had 32% of respondents disagreeing, and an additional 14% saying they did not know. This suggests that some providers do not see the utility of RBA for this particular purpose. Overall, the comments written in response to these questions illustrate a degree of skepticism regarding the value of the RBA system, given the current performance measures. Perceptions of the usefulness of the system range from those seeing positive potential if the measures were revised, to those who feel RBA currently has no value or is meaningless. The following responses illustrate these perspectives:

- "Outcomes need some tweaking but in the end RBA will be good for all involved."
- "Currently the data means very little to us as an organization."

As a final open-ended item, survey respondents were asked to provide any further comments about RBA in general. Among those who responded, the primary theme observed was that the overall purpose or intent behind RBA was endorsed, but concerns about the current performance measures limited the expected value of the program in the short term. Providers recommended DCFS work with them to revise the measures to make them more meaningful.

Overall Conclusion

Representatives of provider agencies participating in the early implementation of RBA were invited to share their perceptions on the planning, development and initial implementation of the RBA program through an online survey. Their candid responses highlighted a number of strengths of the RBA implementation, as well as a number of challenges. Respondents generally recognized and agreed with the need for increased accountability, and felt that RBA aligned well with their own agency priorities.

DCFS' efforts to communicate RBA program information to providers through trainings and meetings during the planning process appear to have been successful. Participants understand their role and the department's expectations of them regarding RBA, and for the most part, they have been able to compile and enter their data into the Scorecard system without much difficulty. Most appear to recognize DCFS' commitment to RBA, and acknowledge the department's recent history of collaboration with them. However, the RBA performance measures were generally not accepted as important, relevant, or accurate indicators of successful outcomes. Many of the participants did not feel a sense of ownership in the system, and did not see value in the data that was being compiled and reported monthly through the RBA program. There was some skepticism about how the RBA program would be utilized by the department in the coming years, and dissatisfaction with the limited role providers had played in the development and refinement of the performance measures. Collaboratively refinement of the RBA performance measures was identified as a determining factor in the ongoing buy-in for providers subject to the RBA program. Follow up assessment of providers' perceptions were scheduled to occur in 2017 and near the end of the demonstration project in 2019; however, due to shifts in the program, these assessments were unable to be completed.

Part III:

Provider Performance Improvement Process Study

Chapter 1: Overview of PPI Program Evaluation

As part of a Title IV-E waiver demonstration project, the Nebraska Division of Children and Family Services (DCFS) intended to improve contractor accountability and child and family outcomes through the Results-Based Accountability (RBA) intervention. RBA was launched statewide on July 1, 2014. However, DCFS decided to shift from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. This program was initially piloted with some provider agencies in July 2016, with full implementation occurring in October 2016. According to DCFS, the purpose of PPI is to improve the outcomes of children and families that receive one or more of the most frequently provided services from a private agency contracted with DCFS. This includes: family support (in-home and out-of-home), intensive family preservation, and agency supported foster care. This program has evolved over time and the evaluation team at UNL-CCFL has worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, it was ultimately determined that a change mechanism could not be isolated and that a process-only evaluation would be completed for the PPI program.

Key Research Questions

In order to examine the PPI program, DCFS presented UNL-CCFL with research questions related to the PPI program. Evaluators from UNL-CCFL worked collaboratively with DCFS to understand and clarify the identified data elements. The specific research questions for the PPI program are listed below:

1. Is PPI data meaningful?
2. Is PPI improving performance?
3. Does Salesforce self-training meet the provider needs?
    a. Is Salesforce user friendly?
    b. Is Salesforce easy to navigate?
    c. Is Salesforce a functional tool?
    d. If there have been issues with Salesforce, have they been resolved?
4. Is there consistency in performance quality conversations among:
    a. Providers
    b. CMRD
    c. Documentation
    d. Data
5. What component of PPI is most beneficial?
    a. IFP components
    b. Data reports – specifically the DCFS data that is uploaded
    c. Quality reviews:
        i. Foster care
        ii. Placement support plan
6. Has PPI improved foster care monthly reports?
7. Do providers find the QA of reports helpful?
8. Did PPI foster a conversation about provider performance/data?
    a. Is there evidence of the communication?
    b. Did the communication impact data?
9. Does the current workforce have the capacity to follow the program with fidelity?
10. Is PPI implemented according to the program manual?

11. Does the size of the provider agency impact:
    a. Support for PPI?
    b. Increased communication?
    c. Impact on data?
12. How has PPI improved services within an agency?
13. Are agencies inputting data timely?
14. What has an agency implemented as a result of PPI?
    a. Processes
    b. Policies
    c. Procedures
    d. Training
    e. Standardized forms
    f. Communications
15. Are all provider performance concerns are reported on PPI?
    a. Are CFS concerns addressed timely?
    b. Are provider concerns addressed timely?
    c. Are CFS and providers communicating more often?
    d. Have issues reduced due to addressing concerns?
    e. How does various service area practices affect concern resolutions?
    f. Are concerns being resolved?

Data Collection Plan

After the research questions were defined with DCFS, UNL-CCFL identified data sources and collection methods to complete the process study for the PPI program. A data collection plan was created by UNL-CCFL, which essentially included the development and administration of three separate surveys to assess the perceptions of 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. Additionally, a review of relevant PPI/Salesforce website data was conducted. The following table details the data sources/method for each PPI program research questions, and the associated timeframes and frequencies for each data source.

Potential Data Sources and Methods	PPI Program Research Question	Timeframe/Frequency

Survey of providers	• Is PPI data meaningful?
	• Does Salesforce self-training meet the provider needs?
	  o Is Salesforce user friendly?
	  o Is Salesforce easy to navigate?
	  o Is Salesforce a functional tool?
	  o If there have been issues with Salesforce, have they been resolved?
	• Is there consistency in performance quality conversations among: Providers; CMRD; Documentation; Data
	• What component of PPI is most beneficial?
	  o IFP components
	  o Data reports – specifically the DCFS data that is uploaded
	  o Quality reviews:
	  ▪ Foster care
	  ▪ Placement support plan
	• Do providers find the QA of reports helpful?
	• Did PPI foster a conversation about provider performance/data (outside of the PQCs)? Did the communication impact data?
	• Does the current workforce have the capacity to follow the program with fidelity?
	• Is PPI implemented according to the program manual?
	• Does the size of the provider agency impact support for PPI?
	• How has PPI improved services within an agency?
	• Are agencies inputting data timely? Ask providers what information has been communicated to them around this.
	• What has an agency implemented as a result of PPI?
	  o Processes
	  o Policies
	  o Procedures
	  o Training
	  o Standardized forms
	  o Communications
		• Develop and administer in summer/fall 2018, determine if ongoing data collection is needed

Potential Data Sources and Methods	PPI Program Research Question	Timeframe/Frequency
	• All Provider performance concerns are reported on PPI: Are concerns being resolved? • All Provider performance concerns are reported on PPI: Are provider concerns addressed timely? • All Provider performance concerns are reported on PPI: Are CFS and providers communicating more often?	

Survey of CMRD	• Is PPI data meaningful?
	• Does Salesforce self-training meet the provider needs?
	  o Is Salesforce user friendly?
	  o Is Salesforce easy to navigate?
	  o Is Salesforce a functional tool?
	  o If there have been issues with Salesforce, have they been resolved?
	• Is there consistency in performance quality conversations among: Providers; CMRD; Documentation; Data
	• Did PPI foster a conversation about provider performance/data (outside of the PQCs)? Did the communication impact data?
	• Does the current workforce have the capacity to follow the program with fidelity?
	• Is PPI implemented according to the program manual?
		• Develop and administer in summer/fall 2018, determine if ongoing data collection is needed

Survey of SAAs	• Is PPI data meaningful?
	• What component of PPI is most beneficial?
	  o Quality reviews:
	  ▪ Foster care
	  ▪ Placement support plan
	• Has PPI improved foster care monthly reports?
	• Do providers find the QA of reports helpful?
	• All Provider performance concerns are reported on PPI: Are concerns being resolved?
	• All Provider performance concerns are reported on PPI: Are CFS and providers communicating more often (answering on behalf of CFS, generally)?
	• All Provider performance concerns are reported on PPI: How does various service area practices affect concern resolutions? What is common practice in your service area?
		• Develop and administer in summer/fall 2018, determine if ongoing data collection is needed

Potential Data Sources and Methods	PPI Program Research Question	Timeframe/Frequency
Survey of CFS?	• All Provider performance concerns are reported on PPI: Are concerns being resolved? • All Provider performance concerns are reported on PPI: Are CFS concerns addressed timely?	• If needed, develop and administer in summer/fall 2018, determine if ongoing data collection is needed
Examination of Salesforce data	• Is PPI improving performance? • Is there consistency in performance quality conversations among: Providers; CMRD; Documentation; Data • Did PPI foster a conversation about provider performance/data (outside of the PQCs)? Is there evidence of the communication? • Does the current workforce have the capacity to follow the program with fidelity? • Is PPI implemented according to the program manual? • Does the size of the provider agency impact communication or data? • Are agencies inputting data timely? • All Provider performance concerns are reported on PPI: Are concerns being resolved [documentation of this]? • All Provider performance concerns are reported on PPI: Have issues reduced [over time] due to addressing concerns?	• Early 2019

Chapter 2: Key Stakeholder Perceptions of the PPI Program

In order to gather perceptions from key stakeholders of the PPI program, three surveys were developed and administered as a part of the PPI program process study: 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. These surveys were the main means of data collection and developed in response to the research questions as outlined in the data collection table presented in Chapter 3: Summary of the PPI Program Evaluation.

PPI Provider Survey

Evaluators from UNL-CCFL worked collaboratively with the DCFS PPI Program Administrator to develop survey items designed to assess provider perceptions of the PPI program. For more information about this survey, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*. The following results are a summary of these survey results only, not a comprehensive summary of the PPI program overall. The survey items were organized into the following dimensions:

- Provider agency demographics and participation in PPI
- PPI Training
- Use of Salesforce website
- Contract monitor communication
- Buy-In and perceived impact of the PPI program
- Perceived usefulness of PPI data elements/components
- Perceptions of Performance Quality Conversations

The PPI Provider Survey was emailed on August 3, 2018 by UNL-CCFL using Qualtrics, a web-based survey system. Individuals were sent a survey invitation via email and received multiple follow-up reminders from the Qualtrics system and from the DCFS PPI Program Administrator. The survey closed on September 17, 2018. The survey introduction included a link to a PDF version of the survey to allow the respondent to gather any unknown information from others in the agency and submit a single survey response per provider agency.

Table 3.2.1 presents detailed information about the frequency of responses and overall rating averages for each item. Additionally, respondents were allowed to provide comments. Comment themes are noted within each section.

The majority of items were rated on a 5-point scale from *Strongly Disagree* (1) to *Strongly Agree* (5). In the following tables SD = Strongly Disagree (1), D = Disagree (2), N = Neither (3), A = Agree (4), SA = Strongly Agree (5). Percentages may not total 100% due to rounding. M = Mean, SD = Standard Deviation, N = number of respondents. If a different rating scale was used for an item, it is defined within the table.

Table 3.2.1: PPI Provider Survey Response Summary

Provider Agency Demographics and Participation in PPI	***Frequency of Response (N and Valid %)***			***N***
43. Agency Size (A small agency has less than 50 staff members, a medium-sized agency has 50-100 staff members, and a large agency has more than 100 staff members.)	*Small* 17 (61%)	*Medium* 5 (18%)	*Large* 6 (21%)	28
44. Does the agency have a data team?	*Yes* 11 (39%)	*No* 17 (61%)		28
45. Types of services provided (ASFC = Agency Supported Foster Care, FSS = Family Support Services, IFP = Intensive Family Preservation)	*ASFC* 11 (39%)	*FSS* 24 (86%)	*IFP* 6 (21%)	28
46. Number of services provided	*One service* 19 (68%)	*Multiple services* 9 (32%)		28
47. Approximately how long does it take your agency to compile and enter data into Salesforce each month?	Number	Valid %		26
Less than 1 hour	2	8%		
1 hour to less than 2 hours	7	25%		
2 hours to less than 3 hours	6	22%		
3 hours to less than 6 hours	7	25%		
20 or more hours	4	14%		
48. Approximately how much time is spent in meetings or communicating with DCFS related to PPI each month?	Number	Valid %		28
None	4	14%		
Less than 1 hour	17	61%		
1 hour to less than 5 hours	3	11%		
5 hours to less than 10 hours	2	7%		
Unknown	1	4%		
49. Approximately how much time is spent implementing action plans related to PPI each month?	Number	Valid %		27
None	6	22%		
Less than 1 hour	9	33%		
1 hour to less than 2 hours	3	11%		
4 hours to less than 6 hours	4	15%		
8 hours to 15 hours	3	11%		
Unknown	2	7%		

PPI Training	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
	SD	*D*	*N*	*A*	*SA*			
50. My agency has received training in the principles and philosophy of PPI.	2 (7%)	4 (14%)	8 (29%)	11 (39%)	3 (11%)	3.32	1.09	28
51. My agency has received adequate training for using the Salesforce website.	2 (7%)	6 (21%)	8 (29%)	9 (32%)	3 (11%)	3.18	1.12	28
52. Additional training on the PPI program is needed for my agency.	1 (4%)	12 (43%)	6 (21%)	7 (25%)	2 (7%)	2.89	1.07	28
Use of Salesforce Website	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
53. Does your agency typically enter data into the Salesforce website each month?	*Yes* 26 (93%)	*No* 2 (7%)				--	--	*28*
	Very Difficult	*Difficult*	*Neutral*	*Easy*	*Very Easy*			
54. How difficult is it for your agency to compile and enter data into Salesforce each month?	2 (7%)	3 (11%)	8 (29%)	13 (46%)	2 (7%)	3.36	1.03	28
	SD	D	N	A	SA			
55. Salesforce is user friendly and easy to navigate.	1 (4%)	3 (11%)	8 (29%)	14 (50%)	2 (7%)	3.46	0.92	28
56. Salesforce is a valuable tool for my agency.	4 (14%)	5 (18%)	7 (25%)	11 (39%)	1 (4%)	3.00	1.16	28
57. How frequently is your agency using Salesforce outside of entering your	*Never* 14 (52%)	*Monthly* 11 (41%)	*Weekly* 1 (4%)	*Daily* 1 (4%)		--	--	27

agency's data (e.g., to view your data, data provided by DCFS, performance concerns)?								
Contract Monitor Communication	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
	SD	*D*	*N*	*A*	*SA*			
58. I know how to best contact my agency's contract monitor.	0 --	0 --	0 --	9 (32%)	19 (68%)	4.68	0.48	28
59. Conversations with my agency's contract monitor are meaningful.	0 --	3 (11%)	3 (11%)	6 (22%)	15 (56%)	4.22	1.05	27
60. I feel like I can communicate openly with my contract monitor.	0 --	0 --	4 (14%)	9 (32%)	15 (54%)	4.39	0.74	28
61. My contract monitor is responsive to my questions and concerns.	0 --	0 --	3 (11%)	9 (32%)	16 (57%)	4.46	0.69	28
62. How often is your agency in contact with your contract monitor?	*<once-a-month* 5 (18%)		*Monthly* 16 (57%)		*Weekly* 7 (25%)	--	--	28
Buy-In and Perceived Impact of the PPI Program	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
	SD	*D*	*N*	*A*	*SA*			
63. PPI has created clear performance level standards and expectations for service providers.	1 (4%)	7 (25%)	5 (18%)	14 (50%)	1 (4%)	3.25	1.01	28
64. PPI creates a system for measuring and comparing the effectiveness of providers.	3 (11%)	7 (25%)	6 (21%)	11 (39%)	1 (4%)	3.00	1.12	28
65. PPI influences contract decisions, based on performance results.	2 (7%)	6 (21%)	9 (32%)	10 (36%)	1 (4%)	3.07	1.02	28

66. PPI holds providers accountable for their performance.	2 (7%)	7 (25%)	7 (25%)	11 (39%)	1 (4%)	3.07	1.05	28
67. PPI holds DCFS accountable for their performance.	8 (29%)	10 (36%)	2 (7%)	8 (29%)	0 --	2.36	1.19	28
68. PPI benefits my agency.	5 (19%)	5 (19%)	5 (19%)	10 (37%)	2 (7%)	2.96	1.29	27
69. PPI benefits the children and families we serve.	4 (15%)	7 (26%)	6 (22%)	10 (37%)	0 --	2.81	1.11	27
70. PPI has improved my agency's overall efficiency.	5 (19%)	7 (26%)	6 (22%)	8 (30%)	1 (4%)	2.74	1.20	27
71. PPI has helped my agency to identify opportunities for improvement.	5 (19%)	4 (15%)	7 (26%)	9 (33%)	2 (7%)	2.96	1.26	27
72. Has your agency implemented changes in any of the following areas as a result of information learned through the PPI program? Select all that apply.	N Yes	Valid %				--	--	28
Communication	14	50%						
Processes	11	39%						
Training	10	36%						
Standardized Forms	10	36%						
Procedures	9	32%						
Policies	6	21%						
None	6	21%						

Perceptions of Performance Quality Conversations	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
	SD	*D*	*N*	*A*	*SA*			
1. The Performance Quality Conversation is a collaborative process.	1 (4%)	2 (7%)	10 (37%)	11 (41%)	3 (11%)	3.48	0.94	27
2. The Performance Quality Conversations allow me to see measureable results in the delivery and effectiveness of the services my agency provides.	1 (4%)	3 (11%)	8 (30%)	12 (44%)	3 (11%)	3.48	0.98	27
3. I have felt well informed during the Performance Quality Conversations (e.g., I understand the process, there is good	2 (7%)	3 (11%)	9 (33%)	9 (33%)	4 (15%)	3.37	1.12	27

communication, my questions are answered).								
4. My agency's people feel like they can openly communicate with DCFS during the Performance Quality Conversations.	2 (7%)	4 (15%)	6 (22%)	11 (41%)	4 (15%)	3.41	1.15	27
5. It is clear that my input is heard and serves a valuable role in the development of the action items for my agency.	3 (11%)	2 (7%)	10 (37%)	8 (30%)	4 (15%)	3.30	1.17	27
6. I believe that the Performance Quality Conversation process, including the development of action items, is useful.	2 (7%)	3 (11%)	9 (33%)	10 (37%)	3 (11%)	3.33	1.07	27
7. Has your agency developed action items as a result of the Performance Quality Conversations?	*Yes* 14 (54%)	*No* 12 (46%)				--	--	26
8. My agency has been successful in implementing our action items.	0 --	0 --	1 (3.6%)	10 (71%)	3 (21%)	4.14	0.54	14
9. My agency has experienced challenges in or barriers to implementing our action items.	2 (14%)	3 (21%)	7 (50%)	2 (14%)	0 --	2.64	0.93	14

For the following survey section, the majority of items were rated on a 5-point scale from *Not at all Useful* (1) to *Extremely Useful* (5). In the following table NU = Not at all Useful (1), SU = Slightly Useful (2), MU= Moderately Useful (3), VU = Very Useful (4), EU = Extremely Useful (5). Percentages may not total 100% due to rounding. M = Mean, SD = Standard Deviation, N = number of respondents.

Perceived Usefulness of PPI Data Elements/Components	***Frequency of Response (N and Valid %)***					***M***	***SD***	***N***
	NU	*SU*	*MU*	*VU*	*EU*			
10. Provider measures entered by your agency for Agency Supported Foster Care	2 (18%)	2 (18%)	5 (46%)	2 (18%)	0 --	2.64	1.03	11
11. Provider measures entered by your agency for Family Support Services	6 (27%)	4 (18%)	9 (41%)	3 (14%)	0 --	2.41	1.05	22
12. Provider measures entered by your agency for Intensive Family Preservation	1 (17%)	1 (17%)	1 (17%)	3 (50%)	0 --	3.00	1.27	6
13. Measures provided by DCFS for Agency Supported Foster Care	1 (9%)	2 (18%)	6 (55%)	2 (18%)	0 --	2.82	0.87	11

14. Measures provided by DCFS for Family Support Services	4 (17%)	5 (22%)	12 (52%)	2 (7%)	0 --	2.52	0.90	23
15. Measures provided by DCFS for Intensive Family Preservation	1 (17%)	1 (17%)	2 (33%)	1 (17%)	1 (17%)	3.00	1.41	6
16. Quality reviews of placement support plans (ASFC)	2 (18%)	4 (36%)	2 (18%)	3 (27%)	0 --	2.55	1.13	11
17. Quality reviews of Agency Supported Foster Care reports (ASFC)	1 (10%)	3 (30%)	2 (20%)	3 (30%)	1 (10%)	3.00	1.25	10
18. Quality reviews of placement change reasons (ASFC)	2 (25%)	1 (13%)	3 (38%)	1 (13%)	1 (13%)	2.75	1.39	8
19. Quality reviews of parenting time/supervised visitation monthly reports (FSS)	4 (20%)	6 (30%)	7 (35%)	3 (15%)	0	2.45	1.00	20
20. Documentation of performance concerns	3 (13%)	5 (21%)	8 (33%)	5 (21%)	3 (13%)	3.00	1.22	24
21. Documentation of placement concerns (ASFC)	1 (11%)	1 (11%)	4 (44%)	2 (22%)	1 (11%)	3.11	1.17	9
22. Documentation of kudos	2 (9%)	7 (30%)	6 (26%)	5 (22%)	3 (13%)	3.00	1.21	23
23. Compliance reviews (including Personnel File Reviews, Paid Claims Audits, and Foster Care Payment Audits)	3 (11%)	4 (15%)	12 (44%)	3 (11%)	5 (19%)	3.11	1.22	27

Results

The following section summarize the results from this survey administration.

Provider Agency Demographics and Participation in PPI

For each of the 39 providers participating in PPI, DCFS was asked to provide CCFL with contact information for the CEO. Of the 39 providers contacted, 28 completed the survey for a response rate of 72%. These participants included 17 small agencies (less than 50 staff members), 5 medium-sized agencies (50-100 staff members), and 6 large agencies (more than 100 staff members). Eleven (39%) of the agencies reported having a dedicated data team; most (10 out of 11) of these agencies reported their data teams consists of five or fewer staff members and one agency reported a data team of 30 staff members. The three services included in PPI are Agency-Supported Foster Care (ASFC), Family Support Services (FSS), and Intensive Family Preservation (IFP). Of the survey participants, 11 (39%) provided ASFC, 24 (86%) provided FSS, and 6 (21%) provided IFP. Other than a small underrepresentation of ASFC providers, this distribution is fairly representative of the population of providers the survey was sent to; for reference, of the 39 providers 49% provide ASFC, 90% provide FSS, and 23% provide IFP. Additionally, 19 respondents (68%) provided only one service, 9 (32%) provided multiple services. Providers that provide only one service are slightly overrepresented in our sample; for reference, of the 39 providers 59% provide only one service and 38% provide multiple services. Additionally, to get a better sense of the amount of time providers are spending participating in the PPI program, we ask three questions around the time it takes their agency to: 1) compile and enter data into

Salesforce, 2) participate in meetings or communications related to PPI, and 3) implement PPI-related action plans.

Most respondents (85%) estimated that it took their agency less than 6 hours to compile and enter data into Salesforce each month. Four respondents said it took their agency 20 or more hours to complete this monthly task. However, some providers mentioned that it is difficult to calculate how many hours this task takes because it has now been embedded into their internal processes. Because DCFS is interested in knowing if the demands of PPI vary by provider size, whether the provider has a dedicated data team, or services delivered, we examined the characteristics of these four agencies to identify any trends. Of these four agencies, two are small agencies and two are large agencies, three have a data team and one does not, three provide multiple services and one provides only one service, and all four provide FSS, three provide IFP, and two provide ASFC.

Most respondents (75%) estimated that their agency spends less than 1 hour each month in meetings or communications with DCFS related to PPI. Two respondents indicated that they spend more than 5 hours per month and one reported that they don't know how much time is spent on this task, but that they believe it is too much time. Of these three agencies, one is a medium-sized agency and two are large agencies, two have a data team and one does not, and all three agencies provide all three services. Most respondents (81%) estimated that their agency spends less than 6 hours each month implementing PPI action plans. Three respondents indicated that they spend 8 or more hours on this task and two indicated they don't know or that it varies widely from month to month. Of these five agencies, two are small agencies, one is a medium-sized agency, and two are large agencies, three have a data team and two do not, two provide only one service and three provide multiple services, and all five provide FSS, three provide ASFC, and three provide IFP.

> ***Main Takeaways****: One third of large agency respondents, one third of respondents providing multiple services, and half of respondents providing IFP reported spending substantially more time each month on at least one PPI-related activity. These findings suggest that PPI may be a greater time commitment for agencies with these characteristics. Follow up with large providers, those providing more than one service, and those providing IFP may help to better understand the extent to which providers are spending too much time on PPI activities and to identify potential strategies for efficiency.*

PPI Training

Survey responses indicated mixed perceptions about the training providers received on PPI. Half of the respondents agreed that their agency had received training in the principles and philosophy of PPI. Just 43% of participants agreed that their agency had received adequate training for using the Salesforce website; however, only 32% of participants indicated that additional training on the PPI program is needed for their agency. Four providers offered suggestions for additional training on the features of the Salesforce web-site. These suggestions included demonstrations of the different options and tabs of the website, and the various reports and data that are available to providers and how to access and analyze them.

> ***Main Takeaways:*** *Additional training on the features of Salesforce may be helpful. This could be achieved through video trainings or one-on-one demonstrations.*

Use of Salesforce Website

Providers were asked about their use of the Salesforce website, which is DCFS' web-based system for providers to report and view their data. The Salesforce website is an essential component of the PPI system. In addition to data uploaded by DCFS each month, providers are expected to enter monthly data on each of their performance measures. Nearly all of the survey respondents (93%) reported that they were regularly entering data into the Salesforce website, as required; 2 small providers indicated they do not typically enter data into Salesforce each month.

The majority of respondents (57%) agreed that the Salesforce website is user friendly and easy to navigate. Six providers reported that they have experienced technical issues with Salesforce; all but one of these providers indicated the issue had been resolved and the majority (80%) were satisfied with how quickly it was resolved. The issues reported included information being duplicated or erased or the website being temporarily down; all of these issues were reported as being resolved.

Providers had some ideas about additional features they would like to see added to the Salesforce website. These features include: comments sections for entering additional information for DHHS on performance concerns or when a performance measure was not met due to circumstances outside the provider's control; access to anonymous data from other providers providing the same service; access to service delivery performance data for DHHS and PromiseShip; more emphasis on progress and goals achieved; more Salesforce licenses per agency; and the ability to pull data down from the system in the form of graphs, tables, and charts.

The majority of respondents did not feel that compiling and entering data into the Salesforce each month was a difficult task, with 53% indicating it was easy or very easy. Survey participants were also asked to what degree they agreed that the Salesforce website was a valuable tool for their agency. Just 43% agreed it was valuable. Comments suggest that some of the reasons for negative responses include: the measures are seen as irrelevant and not assessing meaningful provider performance, the measures are not helpful because they do not include all of the services provided, and that the data collection is redundant with their own internal agency reporting processes and/or is time consuming. Half of respondents (52%) reported that they never use Salesforce outside of entering their agency's data.

> ***Main Takeaways:*** *Most respondents agreed that the Salesforce website is easy to navigate and that compiling and entering the data is not a difficult task. However, less than half of respondents agreed that Salesforce is a valuable tool for their agency and half reported that they never use Salesforce outside of entering their data. Some respondents indicated that the performance measures do not meaningfully assess the actual performance of their agency and that the data collection is redundant with their internal processes. Few technical issues have been reported and those that were reported have been resolved. Additional features that were recommended included: ability to provide comments related to performance concerns or when performance measures are not met, access to anonymous data for other providers for comparison, access to service delivery performance data for DHHS and PromiseShip, and more capabilities for viewing data in graphs, tables, and charts.*

Contract Monitor Communication

Each provider has an appointed contract monitor, with whom they communicate on PPI-related issues. All respondents indicated that they know how to best contact their agency's contract monitor. The majority of respondents (78%) agreed that their conversations with their contract monitor are meaningful and that they can communicate openly with their contract monitor (86%). Additionally, nearly all respondents (89%) agreed that their contract monitor is responsive to their questions and concerns. More than half of respondents (57%) reported being in contact with their contract monitor monthly, 25% reported weekly contact, and 18% reported contacts less than once per month. The comments regarding contract monitors were mostly positive, with respondents indicating that their contract monitor is responsive to their questions in a timely manner and provides helpful input and problem solving. The most commonly cited area for improvement was the need for enhanced communication to align messaging received at the provider meetings and what the contract monitors know. Responses indicated that the contract monitors tend to be out of the loop with regard to critical internal DHHS information since they do not attend the state-wide provider meetings.

> ***Main Takeaways:*** *The large majority of respondents seem to be satisfied with the quality of their conversations with their contract monitors. However, multiple respondents indicated that it would be helpful if the contract monitors were more informed about DHHS communications that impact providers and that having the contract monitors in attendance at the state-wide provider meetings may be a useful way to improve this deficiency.*

Buy-In and Perceived Impact of the PPI program

This section of the survey assessed providers' level of agreement with a number of fundamental elements of the PPI program and the perceived impact of the PPI program as a whole. Overall, responses conveyed a lack of buy-in for and perceived impact of the PPI program. Only 37% of respondents agreed that the PPI program benefits children and families, 44% felt PPI benefits their agency, 34% felt it has improved their agency's efficiency, and 40% agreed it has helped their agency identify opportunities for improvement. Additionally, just 43% of providers agreed PPI creates a system for measuring and comparing the effectiveness of providers, 40% agreed PPI influences contract decisions based on performance results, 43% agreed PPI holds providers accountable for their performance, and only 29% agreed PPI holds DCFS accountable for their performance. The strongest level of agreement was for the item "PPI has created clear performance level standards and expectations for service providers," with just over half (54%) of respondents in agreement.
Overall, the comments written in response to these questions illustrate a degree of skepticism regarding the value of the PPI program, particularly in regards to the current performance measures. Perceptions of the usefulness of the system range from those seeing positive potential if the measures were revised, to those who expressed that PPI currently has no value for their agency. The following responses illustrate these perspectives:

- "We need to reexamine the measures and outcomes to see if they are really the ones we want to measure. We need to be open to tweaking them to make them more useful."
- "PPI is not useful or effective. This process should end and alternative ways of tracking progress should be developed. The amount of time everything related to PPI takes from executive leadership must change."

Other comments highlighted concerns that the current measures do not provide an accurate reflection of provider performance, because they do not take into account many important contextual factors. For example, provider competition in their service area or family characteristics. They also stated it is difficult to see what changes DCFS has implemented as a result of the data providers enter. Multiple respondents stated that the program focuses too much on the negative and does not highlight the positive things agencies do or achieve. They also felt that the program does not hold DCFS accountable in ways that it could. For example, sharing data for DHHS-supported homes and PromiseShip-supported homes or holding case managers responsible in certain situations.

As an additional measure of the PPI program's impact, respondents were asked to indicate any change they have implemented as result of PPI. This included changes to communication, processes, training, standardized forms, procedures, or policies. Most respondents (79%) indicated that they have made at least one of these changes. However, some of the changes described below may not have been viewed as beneficial to the provider agency, but rather a change that needed to happen only to be in compliance with PPI, underscoring the finding that only 34% of respondents feel PPI has improved their agency's efficiency.

- *Communication.* Fourteen responding agencies (50%) reported making a communication change as a result of PPI. Some examples of communication changes included: more carefully documenting communication with CFS in case a performance concern is filed, communication with their staff about why specific information is needed for increased reporting requirements, increased internal communication to allow referrals to be processed more quickly, regular communication with open foster homes about referral demographics to help them understand current needs of youth in care, and increased communication with parents and foster parents to avoid communication errors.
- *Processes.* Eleven responding agencies (39%) reported making a process change as a result of PPI. Some examples of process changes included: changes to documentation requirements, changes to expedite the referral process, changes to accommodate the weekly IFP reporting, and changes related to foster care disruptions.
- *Training.* Ten responding agencies (36%) reported making a training change as a result of PPI. Some examples of training changes included: adding additional training hours for staff, adding information about PPI and expectations for utilizing the feedback from the contract monitor to their training, continually modifying their training based on the results of PPI data, providing quarterly training opportunities, and providing training to improve monthly reports and support plans. Additionally, these specific training topics were mentioned: out of home family support, working with the goals/expectations of parenting time/supervised visitation, family interaction, motivational interviewing, effective communication, and placement stabilization.
- *Standardized Forms.* Ten responding agencies (36%) reported making a change to standardized forms as a result of PPI. Some examples of changes to standardized forms included: creating or modifying existing forms and templates to ensure all information required is being captured for monthly progress reports and support plans and changes to documentation for tracking IFP hours and creation of a form to record why hours were not completed.
- *Procedures.* Nine responding agencies (32%) reported making a procedure change as a result of PPI. Some examples of procedure changes included: required discussion points before an

employee can move off of a case, expectations for clear and precise documentation, changes to placement stability procedure, and helping foster parents to recognize signs of disruption.

- *Policies.* Six responding agencies (21%) reported making a policy change as a result of PPI. Some examples of policy changes included: changes to documentation content and timeframe requirements and requiring staff to report mileage used.

Main Takeaways: *Overall, respondents conveyed a lack of buy-in for and perceived impact of the PPI program. About half agreed that PPI has created clear performance level standards and expectations for service providers; however, less than half of respondents agreed that PPI: benefits children and families; benefits their agency; has improved their agency's efficiency; has helped their agency identify opportunities for improvement; creates a system for measuring and comparing the effectiveness of providers; influences contract decisions based on performance results; holds providers accountable for their performance; and holds DCFS accountable for their performance. Generally, responses about the PPI program are similar to providers' responses when surveyed about RBA; therefore it seems that PPI and its inclusion of additional performance measures has not resulted in a large shift in providers' feelings about the usefulness of the program overall. Provider comments indicated that the current measures do not fully capture the meaningful aspects of provider performance. Multiple providers said that contextual factors need to be taken into account to accurately assess provider performance and that the program should place more emphasis on positive achievements because it is currently more focused on negative aspects. The large majority of respondents indicated that they have made at least one change as a result of PPI; however, some of these changes may have only occurred to be in compliance with PPI rather than adding value to the provider agency.*

Perceived usefulness of PPI Data Elements/Components

To assess the perceived usefulness of PPI data elements, providers were asked to rate each of the PPI data elements on a scale of usefulness for their agency's learning and decision making. Providers were only asked to rate measures specific to the services they provide. Each data element was rated on a scale of *Not at all Useful* (1) to *Extremely Useful* (5). The data elements rated included the following:

- Measures entered by providers
- Measures provided by DCFS
- Quality reviews of ASFC reports, placement change reasons, placement support plans, and parenting time/supervised visitation reports
- Documentation of performance concerns, kudos, and placement concerns
- Compliance reviews

Measures entered by providers

Each month, providers enter measures into Salesforce for the previous month. The measures are specific to each service type: ASFC (e.g., count of total foster homes with a placement, ratio of Foster Care Specialists to homes with a placement), FSS (e.g., percentage of families who safely maintained their children in the home upon discharge, ratio of Family Support Specialists to families served), and IFP (e.g., percentage of families who safely maintained their children in the home upon discharge, weekly

total of hours the Therapist/Skill Builder have direct in-person, direct-other, or indirect contact with each DHHS IFP family).

The average usefulness rating for provider measures across all services was 2.68 out of 5. Most ASFC provider respondents (64%), roughly half of FSS provider respondents (55%), and most IFP provider respondents (67%) rated these measures as at least moderately useful.

A total of ten providers wrote comments about the provider measures. Most comments weren't specific to a certain service, but some were. In general, the comments about the usefulness of the data for practice was mixed, with one respondent saying these data are used to assess every case and to determine what can be done better, and another saying they already know where they need to improve without these data. Multiple respondents stated that the data entry is redundant with their internal processes and that their internal processes capture even more detail than is required by PPI. Specific to the services delivered, some ASFC and FSS respondents feel the data required does not accurately reflect the quality of work being done because the measures do not take into account important factors (e.g., whether a placement change was positive or negative, provider capacity, amount of provider competition in their service area, and family context). These comments suggest that without this contextual information being taken into account the numbers alone do not provide meaningful information to improve their service delivery. Some IFP respondents stated that weekly data entry helps them to make sure minimum contact requirements are being met and that they have changed how they staff cases when the goals are not being met; however they could track this information without the PPI program.

> ***Main Takeaways:*** *Overall, most respondents indicated that the provider measures are at least moderately useful to their agency. The comments indicated that the data entry is redundant with their internal processes and that contextual information needs to be taken into account in order to enhance the meaningfulness to their agency.*

Measures provided by DCFS

Each month, DCFS provides updated data to internal measures on Salesforce for the previous month. There are nine DCFS-provided measures, which were added to the program when the switch was made from RBA to PPI. The addition of these measures was intended to increase the overall meaningfulness of the data included in the PPI program. Again, these measures are specific to each service type: ASFC (e.g., instances of maltreatment in foster care, instances of placement changes, distribution of youth's ages placed in foster care), FSS (e.g., average claims paid per in-home FSS on a rolling 12-month period, instances of maltreatment and out-of-home placement during or within 6 months of the FSS ending), and IFP (i.e. instances of maltreatment and out of home placement during or within 6 months of IFP service ending).

The average usefulness rating for DCFS measures across all services was 2.78 out of 5. Most ASFC provider respondents (73%), most FSS provider respondents (59%), and most IFP provider respondents (67%) rated these measures as at least moderately useful.

A total of 6 providers wrote comments about the DCFS measures, all of whom also left comments about the provider measures. There was a lot of overlap in the feedback for these two sections. In general, the comments about the usefulness of the data for practice was mixed, with one provider saying these data are used to assess every case and to determine what can be done better, and another saying they don't receive personalized feedback regarding their outcomes. It was mentioned that the post discharge information is useful for understanding long term outcomes of the services with families. One provider stated that they appreciate the competitive nature of the reports because they want to be a premier agency and they feel providers who push back on PPI are probably not doing well on the measures. Specific to the services delivered, FSS respondents said that CFS does not understand the measures and they never have opportunities to sit down with CFS to determine how the data can be helpful to either party. Also, the sentiments about the measures not reflecting the quality of work because they lack important nuanced factors was repeated. IFP respondents indicated that data on the weekly contacts can be helpful, but the other measures are not useful.

> ***Main Takeaways:*** *Overall, most respondents indicated that the DCFS measures are at least moderately useful to their agency. Several providers reported that the post discharge information is useful for understanding long term outcomes of their services; however for other measures contextual information needs to be taken into account in order for them to accurately reflect the quality of work being done and to be meaningful to their agency. The comments also indicated that opportunities to sit down with CFS to review the data would be helpful for the work done with families by both the providers and CFS.*

Quality Reviews

Qualitative reviews are another element that was added to the PPI program after the transition from RBA. As described in the PPI Program Manual, contract monitors and program accuracy specialists are to complete the quality reviews using pre-determined criteria on a monthly or quarterly basis, depending on the type of document. Currently, qualitative reviews are conducted for the following documents: ASFC reports, placement change reasons, placement support plans, and parenting time/supervised visitation monthly reports.

There are three quality reviews specific to providers of ASFC: reviews of ASFC reports, reviews of placement change reasons, and reviews of placement support plans. The reviews of ASFC reports and placement change reasons were rated as more useful than the review of placement support plans. Most respondents rated the reviews of ASFC reports and placement change reasons as at least moderately useful (60% and 64%, respectively). Only 45% of respondents rated the reviews of placement support plans as at least moderately useful.

Six providers wrote comments about the quality reviews specific to ASFC. Some comments related to the reviews in general and some were specific to the different types of reviews. One provider indicated they have not received feedback on their ASFC reports or reports of placement change reasons. Inter-rater reliability issues were reported for the ASFC reports and the placement support plans. Respondents indicated that the ASFC reports are not scored in a consistent manner and that the placement support plan reviewers often cite "best practice" or "personal preference" as reasons for deficiencies.

- Regarding ASFC report reviews, respondents indicated that the title of the review is misleading because it only includes review of monthly reports, however agencies keep pertinent information in other locations or forms. Therefore, deficiencies are noted when the information is available and used in practice. Three providers indicated that the ASFC report reviews were helpful and stated that it has improved the way they communication information to involved parties, the feedback helps them to do a better job, and they improved their monthly report template to capture all of the necessary information.
- The comments regarding reviews of placement change reasons varied in their level of support. One provider said the reviews are not useful because the incorrect reasons are often listed. One provider said these reviews consist of them explaining why the change occurred. One provider said that the feedback is useful and helps them do a better job.
- Regarding the review of placement support plans, the comments were mixed. Two providers stated that support plans themselves are not effective, therefore the reviews are not useful. One provider said support plans are given too much weight; while one is needed, many factors in the case change day to day so it is impossible to have a support plan that reflects all the support a home is given. One provider indicated they have improved their template to ensure they are capturing all essential information. One provider indicated they like the feedback and it helps them do a better job.

There is one quality review specific to providers of FSS: review of parenting time/supervised visitation reports. Exactly half of the FSS respondents rated this quality review as at least moderately useful. Three providers wrote comments about the reviews of parenting time/supervised visitation reports. One provider said the reports tell them nothing they don't already know. One provider said CFS in the field do not get the time to see how this report is beneficial. One provider indicated there are inter-rater reliability issues with this review as well.

> ***Main Takeaways:*** *At least half of respondents consider the reviews of ASFC reports, placement change reasons, and parenting time/supervised visitation reports to be at least moderately useful to their agency, but less than half found the reviews of placement support plans to be at least moderately useful. Some respondents indicated that the reviews are not scored in a consistent manner and that reviewers often cite "best practice" or "personal preference" as reasons for deficiencies. More guidance for reviewers on the requirements may help to ensure consistency.*

Documentation of performance concerns, kudos, and placement concerns

Contract monitors document 1) provider performance concerns reported by DCFS case management, families involved with DCFS, or other parties involved with a case; 2) provider kudos received by CFS; and 3) placement concerns identified through the Hotline into Salesforce on an ongoing basis. When a performance concern is received by the contract monitor, they will conduct an investigation and enter information about the details of the concern and progress being made toward resolution. This reporting process allows DCFS to have a documented history to easily refer back to. When a CFS or DHHS employee notices exemplary work being done by a provider agency or specific employee, they have the option to notify the contract monitor to share this example and document in Kudos. These kudos are

available in real-time by the agency. When a concern regarding a foster home is called into the Hotline, but it is not accepted for investigation, the placement concern is documented in PPI by the contract monitor and the provider is notified. The resolution to the concern should also documented within Salesforce.

The documentation of performance concerns and kudos are relevant to all providers. Most respondents rated the documentation of performance concerns and kudos as at least moderately useful (67% and 61%, respectively).

Six providers wrote comments about the documentation of performance concerns. Overall, the comments related to the documentation of performance concerns embody a perception that this feature is overused and misused and is a hindrance to effective communication between CFS and providers. Multiple providers felt that this feature results in reduced direct communication between CFS and providers that is crucial to resolving matters in a timely, collaborative, and professional manner. The comments indicate that it provides CFS an avenue to report concerns prematurely, rather than communicating with providers directly to understand the provider's point of view and resolve issues as they arise and assist families in an efficient manner. There are concerns about the permanency of the documented performance concerns, as one provider put it "once it is on there, it's there." There is a perception that this feature is negative and punitive and does not give providers a reasonable opportunity to provide their side of the story. It would be more effective and helpful for families for most of these matters to be discussed in person, among professionals, rather than filing a complaint on the website. One provider indicated that some performance concerns are submitted because they respond too late to receive the referral, or they refuse referrals for reasons they see as valid, such as, the drive time is too long to justify accepting the visitation referral or they've had previous experience with the family and the family does not want to work with them.

Seven providers wrote comments about the documentation of kudos. Most of these comments indicated that the kudos feature is seldom used. Some exemplary comments are: "I haven't seen any in months" and "We have had very few kudos. It is not used by CFS for positive means of reinforcement." When kudos are received, they seem to mean a lot to providers, to illustrate this one provider said, "Our staff have really appreciated the kudos that have been received!"

The documentation of placement concerns is specific to providers of ASFC. Most ASFC provider respondents (77%) rated the documentation of placement concerns as at least moderately useful. Two providers wrote comments about the documentation of placement concerns. One provider said "We always want to make sure our placements are safe. These issues are usually easy to resolve and are open to discussion." The other provider said "There is already a process in place for these kinds of things to be reviewed via phone with a team. This process is duplicative and not needed."

> ***Main Takeaways:*** *Most respondents indicated that the documentation of performance concerns, kudos, and placement concerns are at least moderately useful to their agency. Some respondents indicated that the performance concerns feature is over/misused and is a hindrance to effective communication between CFS and providers. Some respondents also indicated that the performance concern feature is too negative and kudos are rarely submitted. Future analysis of*

the Salesforce website will allow the evaluators to better understand how these features are being used and whether this sampling of comments is representative or not.

Compliance reviews

Compliance reviews are completed for providers of all services throughout the year. These reviews include, but are not limited to: Personnel File Reviews, Paid Claims Audits, and Foster Care Payment Audits. Per the PPI program manual, the Personnel File Reviews are to be conducted quarterly on-site for each provider to ensure compliance with background checks, training, and educational standards established in the contract. The Paid Claims Audit is a review of paid claims made by the provider and ensures that accurate documentation has been provided to support the claim. The Foster Care Payment Audit is a review to ensure that Foster Care Payments made to ASFC providers are made, in full, to foster parents.

Most respondents (74%) rated the compliance reviews as at least moderately useful. Seven providers wrote comments about the compliance reviews. Overall, the comments conveyed that the compliance reviews are useful to the system and are necessary, however providers feel they are done too often. These reviews can be costly for providers to dedicate staff to assist in the reviews. The respondents indicated that the compliance reviews could be completed less often, maybe once or twice per year, rather than quarterly. Some agencies reported that the current process is excessive and amounts to micromanaging by DCFS. Some providers indicated that they have been told or feel that if they have done well with previous audits, they would/should be required to complete them less often. One provider mentioned that having licensure and accreditation should be considered when determining how often these reviews need to be conducted.

> ***Main Takeaways:*** *Most respondents rated the compliance reviews as at least moderately useful. Respondents agreed that compliance reviews are useful to the system and are necessary, but that they could be completed less often, maybe once or twice per year, rather than quarterly.*

Participants were also asked if there are any other pieces of data that would be valuable to include in the PPI program. Five providers responded to this question. Two providers suggested that drug testing be added to the services included in PPI. One provider suggested that the PPI information be used by case workers when choosing agencies to work with. One provider suggested that there be more emphasis on outcomes and progress. One provider emphasized a need for DHHS to recognize providers for their time spent providing data for PPI and expressed a desire for DHHS to reward agencies who perform well with incentive pay to offset the costs of participating in PPI. This provider feels that promises have been made to reward exceptional providers that have not been honored.

Perceptions of Performance Quality Conversations (PQCs)

Per the PPI program manual, contract monitors are to meet with providers on a quarterly basis to talk about what has been discussed over the previous quarter in monthly, ongoing communications. These conversations are to be documented on Salesforce. Based on these conversations, action items are to be identified and agreed to as a means to collaborate and improve the provider's performance.

The feedback on PQCs was largely mixed. Just over half of the respondents (52%) agreed that the PQC is a collaborative process and that the PQC has allowed them to see measureable results in the delivery and effectiveness of the services their agency provides (55%). Nearly half of respondents (48%) agreed they have felt well-informed during the PQCs. Additionally, 56% agreed that their people feel like they can openly communicate with DCFS during the PQCs. However, just less than half (45%) agreed that it is clear their input is heard and serves a valuable role in the development of the action items for their agency. Overall, about half of the respondents (48%) agreed that the PQC process is useful.

When asked what is most useful about the PQC process, multiple respondents said that the brainstorming and discussions with their contract monitor about ways to improve was most helpful. One provider said "It is helpful to receive feedback about ways our agency can improved and also to hear about what things other agencies are finding success with." When asked what could be improved about the PQC process, respondents suggested having an agenda for the meeting to give it more structure, and for the contract monitors to receive the same information that is shared at provider meetings.

Just over half (54%) of the survey respondents reported that their agency has developed action items as a result of the PQCs. Comments related to this revealed that one provider was not familiar with the term "Performance Quality Conversation" and another was unsure if they had participated in one. Of the 14 providers who reported developing action items, 92% reported they have been successful in implementing the action items and just 14% reporting that they have experienced challenges or barriers to implementation. The types of action item successes described included: streamlining processes and/or forms and taking actions to improve ability to find placement for teens and difficult-to-place youth. The challenges/barriers to implementing action items that were shared were financial limitations and difficulty hiring, training, and retaining staff.

> ***Main Takeaways:*** *About half of respondents agreed the PQC process is useful. Suggestions for improving the PQC process included having a structured agenda for the meeting, and for the contract monitors to receive the same information that is shared at provider meetings. About half of respondents reported developing action items and most of them who have developed action items have been successful in implementing them.*

Conclusion

Respondents generally recognized and agreed with the need for accountability. DCFS' efforts to communicate PPI program information to providers through trainings and meetings have been successful, but some additional training on the Salesforce website could be helpful. Participants have been able to compile and enter their data into the Salesforce system without much difficulty. However, respondents reported a lack of buy-in for and perceived impact of the PPI program overall. Most participants rated the individual PPI data elements as at least moderately useful, but some participants did not see value in the data that is currently being compiled and reported monthly, due to a lack of consideration of important contextual factors. There were also some concerns about the consistency of the rating methods used for quality reviews. Some respondents felt the performance concerns feature is too negative and hinders direct communication between CFS and providers to resolve issues in a quick and efficient manner. There is skepticism about how the PPI program measures are used to improve provider performance and outcomes for children and families. Respondents were satisfied with their

interactions with their contract monitors, but suggested that contract monitors attend the statewide provider meetings to allow them to be better informed on important changes within DCFS. It appears that the extent to which the measures and website features can be collaboratively refined will help determine the degree to which providers embrace PPI in the future.

PPI CMRD Survey

A survey was designed to collect CMRD perceptions about PPI training, use of the Salesforce website, communication with provider agencies, buy-in and perceived impact of the PPI program, perceptions of performance quality conversations, and barriers experienced (for more information about this survey, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*). The PPI CMRD Survey was emailed to participants on December 13, 2018. Unfinished respondents received up to two reminder emails from the Qualtrics system. The last recorded response was January 3, 2019. All 15 CMRD completed the survey for a response rate of 100%.

Table 3.2.2 provides detailed information about the frequency of responses, overall rating averages, and associated comments. The majority of items were rated on a 5-point scale from *Strongly Disagree* to *Strongly Agree*: SD = Strongly Disagree (1), D = Disagree (2), N = Neither Agree nor Disagree (3), A = Agree (4), SA = Strongly Agree (5). M = Mean, Responses = number of responses. If a different rating scale was used for an item, it is defined within the table. Additionally, respondents were asked to provide comments. For open-ended questions, respondents' comments are first summarized into themes, as appropriate, and then individual comments are listed below (editing was done, if needed, to enhance readability and maintain anonymity).

Table 3.2.2: CMRD PPI Survey Response Summary

PPI Training							
	SD	**D**	**N**	**A**	**SA**	**M**	**Responses**
24. I received training in the principles and philosophy of PPI.	0 (0%)	1 (7%)	2 (13%)	8 (53%)	4 (27%)	4.00	15
25. I received adequate training for using the Salesforce website.	0 (0%)	0 (0%)	5 (33%)	5 (33%)	5 (33%)	4.00	15
26. I fully understand the expectations of my job as it relates to the PPI program.	0 (0%)	2 (13%)	3 (33%)	6 (38%)	4 (27%)	3.80	15
27. Additional training on the PPI would be helpful.	0 (0%)	1 (7%)	4 (27%)	8 (53%)	2 (13%)	3.73	15
							Responses
28. Please provide any additional comments about PPI training.							6

Themes

- *Unclear job expectations*
- *Updates to the PPI program are not being communicated thoroughly*
- *CMRD need better understanding of the importance/relevance of PPI data*

Individual Comments

- As DHHS continues to use PPI, ongoing training would be needed.
- At first it was all a little overwhelming when we were expected to do so much with the data that we feel may not be all that accurate. This isn't used as much as it was. Providers are very skeptical about the accuracy of the data which makes it feel like a waste of time to spend a lot of time making reports and graphs from the data. I'm also sure that it costs the state a lot in licenses and am not sure it is worth it.
- Job expectations seem very unclear at this point. Changes are not explained/trained in advance of implementation.
- Many things have changed in PPI as it we have moved through the process of using it. We are given information about changes, but often not enough to be able to make sense of it and be able to then explain it to our Providers.
- Sometimes understanding where the data comes from would be beneficial. Why is one measure collected monthly vs rolling averages.
- Would recommend that as PPI develops/changes, that the "definitions" for measures & respective guide be updated & maintained. A written/printed version of the principles & philosophy would be helpful; could be shared/referenced with working with service providers as well as our internal customers.

	Responses
If respondents indicated additional training would be helpful, they were asked about those additional trainings. 29. What additional training would be most helpful?	7

Themes

- *Additional trainings could be helpful in the following areas: 1) overall refresher training on PPI and the importance/relevance of data being collected/shared, 2) use of Excel, and 3) creating reports in Salesforce.*

Individual Comments

- How the collective data from reports is determined to meet the burden of the information entered on PPI. Does the information in PPI actually measure the targets we are looking for, and are the persons with control over the data held accountable for the measures/outcomes and the entry?
- I think an overall refresher would be very helpful.
- I would love to have additional Excel training. It's been 17 years since I was trained in college. I'm ok with it. However, I think it would be beneficial when exporting data into Excel and creating charts/graphs to become more efficient.
- Mainly a quarterly or semiannual refresher would be good.
- More training on creating reports from PPI/Salesforce
- More training regarding the reports function would be beneficial.

- Training on the basics of who, what, why and where. We know data is being put in there, but who is using it? What is it being used for? I was my understanding is that this was part of our plan from the CFSR, but then I have been told it was not. When the data we have does not match a provider's, why is that? How can we hold DHHS as accountable as we are holding our providers with this system?

Use of Salesforce Website

	SD	D	N	A	SA	M	Responses
30. Salesforce is user friendly and easy to navigate.	0 (0%)	0 (0%)	8 (57%)	4 (27%)	3 (20%)	3.67	15
31. Salesforce is a valuable tool for my provider agencies.	1 (7%)	3 (20%)	4 (27%)	4 (27%)	3 (20%)	3.33	15
32. Salesforce is a valuable tool for DCFS.	1 (7%)	4 (27%)	5 (33%)	3 (20%)	2 (13%)	3.07	15

	Yes	*No*		Responses
33. Have you experienced any technical issues with Salesforce?	2 (15%)	11 (85%)		13
34. Have the issues been resolved?	1 (50%)	1 (50%)		2
35. Were you satisfied with how quickly the issues were resolved?	1 (100%)	0 --		1

	Responses
If a respondent indicated that a Salesforce Website issue had not been resolved, they were asked the following item: 36. Please describe the issues that have not been resolved.	1

- In order to attach documents, staff have to use a different internet browser than our default browser. Sometimes using back arrow lose the section you are on. Using the email on salesforce does not allow reply all history of emails.

	Responses
37. Are there any additional features that you would like to see added to the Salesforce website?	6

Themes

- *Salesforce interface could be improved by 1) making it easier to communicate with providers through the website, 2) including a place for supporting narrative information to be entered, and 3) the ability to track internal issues and their resolution.*

Individual Comments

- Better capability to communicate with the providers through Salesforce.
- I have suggested the following to administration on what to add to Salesforce several times:
  - Service Quality Review for the audits that are completed for our agencies under Qualitative Reviews.

- The provider monthly matrix that we complete each month on contract variables requirements.
- Monthly report audits we complete monthly on our agencies under Qualitative Reviews.

- I think that PPI has potential to be valuable to external/internal customers, but there are several external partners that agree with the data nor do they utilize it to make any improvements on their side (conflicts with their own data/not reliable). DCFS staff (supervisors, case managers) generally don't have a clue about PPI & what/how it should be used or possibly influence how they work with providers or referrals they make.
- Options to add supporting narrative information and a clear path to it.
- The ability to have all of my Provider's on Salesforce would be helpful; however, due to the cost I also understand the reason it is limited currently.
- Tracking of internal issues and if they are being resolved or not.

	Responses
38. Please provide any additional comments about the Salesforce website below.	3

Individual Comments

- I believe there are better ways we could be spending the taxpayer's money like filling positions instead of doubling up work.
- My role has changed & I no longer work with PPI on a regular basis. But on occasion I may when covering for other CMRD staff
- Sometimes the data entered on Sales force is not accurate.

Contract Monitor Communication			
	Count and % Valid		***Responses***
39. How often are you in contact with your provider agencies?			15
<once-a-month	*1*	7%	
Monthly	*3*	20%	
Weekly	*7*	47%	
Daily	*4*	*27%*	
40. How often do you use e-mail to communicate with your provider agencies?			14
<once-a-month	*0*	*0%*	
Monthly	*2*	*14%*	
Weekly	*4*	*29%*	
Daily	*8*	*57%*	
41. How often do you use the phone to communicate with your provider agencies?			15
<once-a-month	*0*	*0%*	
Monthly	*4*	*27%*	
Weekly	*10*	*67%*	

Daily				*1*	*7%*		
				Count and % Valid			***Responses***
42. How often do you meet in-person to communicate with your provider agencies?							15
<once-a-month				*7*	*47%*		
Monthly				*8*	*53%*		
Weekly				*0*	*0%*		
Daily				*0*	*0%*		
	SD	**D**	**N**	**A**	**SA**	**M**	**Responses**
43. Conversations with my provider agencies are meaningful.	0 (0%)	0 (0%)	4 (27%)	5 (33%)	6 (40%)	4.13	15
44. My provider agencies feel that they can communicate with me.	0 (0%)	0 (0%)	0 (0%)	6 (40%)	9 (60%)	4.60	15
45. I receive timely updates from DCFS when changes are made that impact my work with providers.	3 (20%)	3 (20%)	5 (33%)	3 (20%)	1 (7%)	2.73	15
46. CFS and providers are communicating more often as a result of PPI.	2 (13%)	1 (7%)	7 (47%)	4 (27%)	1 (7%)	3.07	15
							Responses
47. Please provide any additional comments about contact monitor communications below.							7

Themes

- *Communication needs improvement between DCFS, contact monitors, and service providers.*
- *Salesforce email communication interface needs improvement.*

Individual Comments

- Contract monitors are not consistently included in the information loop at DCFS. Many times our providers are the first ones to bring changes to their contract monitor's attention. This is extremely frustrating and makes it difficult to work effectively in the interest of best outcomes for our clients.
- I believe PPI has hurt our relationships with our providers among other things. We used to have a great working relationship with openness and collaboration. I've heard the comment that we are going backwards and losing the teamwork approach.
- I don't think all communications are captured on Salesforce. I do not like to use the email on Salesforce - not user friendly
- I've tried to preview an email before sending it and it does not allow me to. It says "Internet Explorer has modified this page to help prevent cross-site scripting." It'd be nice to be able to preview an email the way the provider would see it before sending.

- PPI is a useful tool to start conversations with the providers about performance measures-what they are doing well and areas where they can improve. The providers find it helpful to see the data and how they are doing.
- The communication between Providers and the CMRD is great. It is all the other pieces that are not falling into place and then makes it confusing for all parties.
- We do monthly emails to providers on PPI data also.

Buy-In and Perceived Impact of the PPI Program							
Survey Item	**SD**	**D**	**N**	**A**	**SA**	**M**	**Responses**
48. PPI has created clear performance level standards and expectations for service providers.	1 (7%)	1 (7%)	5 (33%)	6 (40%)	2 (13%)	3.47	15
49. PPI creates a system for measuring and comparing the effectiveness of providers.	1 (7%)	2 (13%)	2 (13%)	8 (53%)	2 (13%)	3.53	15
50. PPI has fostered a conversation about provider performance and data.	0 (0%)	0 (0%)	3 (20%)	10 (67%)	2 (13%)	3.93	15
51. PPI influences contract decisions, based on performance results.	1 (7%)	2 (13%)	7 (47%)	5 (33%)	0 (0%)	3.07	15
52. PPI holds providers accountable for their performance.	0 (0%)	5 (33%)	3 (20%)	7 (47%)	0 (0%)	3.13	15
53. PPI holds DCFS accountable for their performance.	5 (33%)	4 (27%)	3 (20%)	3 (20%)	0 (0%)	2.27	15
54. PPI benefits the children and families we serve.	1 (7%)	2 (13%)	6 (40%)	6 (40%)	0 (0%)	3.13	15
55. PPI benefits my providers agencies.	1 (7%)	2 (13%)	4 (27%)	8 (53%)	0 (0%)	3.27	15
56. PPI has improved my provider agencies' overall efficiency.	1 (7%)	4 (27%)	2 (13%)	8 (53%)	0 (0%)	3.13	15
57. PPI has helped my provider agencies to identify opportunities for improvement.	0 (0%)	0 (0%)	7 (47%)	6 (40%)	2 (13%)	3.67	15
58. PPI measures are useful for provider agencies' learning and decision making.	0 (0%)	2 (13%)	5 (33%)	8 (53%)	0 (0%)	3.60	15
	Yes	*No*				**Responses**	
59. Does the support for the PPI program vary among the agencies you work with (e.g. timely data entry, frequency of mistakes, changes to services)?	11 (85%)	2 (15%)				13	
						Responses	
60. Please explain how support for PPI varies between agencies.						8	

Themes

- *Buy-in for PPI varies widely between service providers.*
- *Size of agency or the number of services provided may impact buy-in.*

Individual Comments

- Different comfort levels/skills of CMRD staff that work with the various agencies; some agencies have little to no value in the PPI data--they have only general idea of how they compare to the 'state' values, but not individual agencies--not transparent. I think being more transparent may increase accountability.
- I monitor various Providers - some who provide foster care to those that only provide services such as family support. So how I work within PPI varies for each Provider.
- In general, agencies are entering data timely, however, the opinion of usefulness of PPI varies among providers.
- Some agencies clearly use the data to improve performance, others do not.
- Some agencies do what they have to, some try to make the most of it - it varies according to the amount of services they provide.
- Some agencies try and buy into it and others feel it is a waste of their time.
- Some have needed more assistance with timeliness, questions & clarification, amount of placement concerns and some agencies offer more services than others, hence more data entry and analyzation.
- The size of agencies and the population and services they provide depends a lot on the time spent on each agency.

	Responses
61. Please provide any additional comments about PPI program elements below.	3

Theme

- *Salesforce interface needs improvement in order to better sort/review data.*

Individual Comments

- I wish there was a way to sort data once it has been entered into PPI on the provider's page. For instance, sort by types of placement concerns or various by percentages. Each entry of data once it is on the Provider's PPI page, cannot be reviewed/sorted unless you print it out or retype into Excel or handwrite OR go back to the very raw data pulled from a report that then needs filtered, etc. That would save so much time and frustration. :)
- Providers are not sold on the program and how it is being used.
- Too many errors/discrepancies with DCFS data & what providers 'own' data is. Some components/measures are difficult to maintain/track (i.e. complaints/placement disruptions) reportedly due to Salesforce own structure--not easily sorted/multiple pages.

Perceptions of Performance Quality Conversations							
Survey Item	**SD**	**D**	**N**	**A**	**SA**	**M**	**Responses**
62. The Performance Quality Conversation is a collaborative process.	1 (7%)	0 (0%)	4 (27%)	9 (60%)	1 (7%)	3.60	15

63. The Performance Quality Conversations allow me to see measurable results in the delivery and effectiveness of the services my provider agencies provides.	1 (7%)	3 (20%)	4 (27%)	6 (40%)	1 (7%)	3.20	15
64. I feel confident in my ability to synthesize PPI data in preparation for the Performance Quality Conversations.	0 (0%)	0 (0%)	4 (27%)	10 (67%)	1 (7%)	3.80	15
65. My provider agencies have felt well informed during the Performance Quality Conversations (e.g., they understand the process, there is good communication, their questions are answered).	0 (0%)	2 (13%)	3 (20%)	10 (67%)	0 (0%)	3.53	15
66. My provider agencies feel they can openly communicate with me during the Performance Quality Conversations.	0 (0%)	0 (0%)	1 (7%)	8 (53%)	6 (40%)	4.33	15
67. My provider agencies feel their input is heard and they serve a valuable role in the development of their action items.	0 (0%)	4 (27%)	3 (20%)	8 (53%)	0 (0%)	3.27	15
68. I feel confident in my ability to effectively facilitate the Performance Quality Conversations.	0 (0%)	0 (0%)	4 (27%)	10 (67%)	1 (7%)	3.80	15
69. I believe that the Performance Quality Conversation process, including the development of action items, is useful.	1 (7%)	2 (13%)	5 (33%)	7 (47%)	0 (0%)	3.20	15
	Yes	***No***					**Responses**
70. Have your provider agencies developed action items as a result of the Performance Quality Conversations?	12 (92%)	1 (8%)					13
	SD	**D**	**N**	**A**	**SA**	**M**	**Responses**
71. My provider agencies have experienced challenges in or barriers to implementing their action items.	0 (0%)	2 (13%)	3 (20%)	7 (47%)	0 (0%)	3.42	12
							Responses
If respondents indicated that there were barriers experienced implementing action items, respondents were asked the following item: 72. What challenges or barriers have your provider agencies experienced in implementing action items?							6

Themes

- *Unclear expectations/goals/priorities of provider agencies from DCFS*
- *Communication between DCFS and CMRD needs improvement*
- *Need to find accurate and meaningful measures that work for both DCFS and providers*

Individual Comments

- Challenge is obtaining SMART/clear goals from CFS with referrals, not clear on what CFS wants for parameters of service (vague/too broad); bio-families often times don't buy in with identified goals, don't have sense of commitment to making progress
- DHHS changes expectations and priorities with little warning, or changes communication protocols and contract monitors are not aware of and able to respond to agency questions.
- Many times the provider doesn't have control over things - for example they may be doing DHHS a favor by taking a few large sibling strips but all of the children are young and at the essential level. This is a great service for DHHS but it makes the availability of beds for enhanced and intensive level kids or older kids limited so we dock them on PPI for lower numbers in those areas.
- Number of referrals, appropriate referrals, inappropriate relative placements.
- The information changing. What is information is being shared with them and not being shared with them. Seeing actual results that the data that is being tracked is truly bringing change statewide and not just within their own agency.
- Trying to find and accurate measure outcomes that will be effective and useful over time.

	SD	D	N	A	SA	M	Responses
50. My provider agencies have been successful in implementing their action items.	0 (0%)	1 (7%)	4 (33%)	4 (33%)	3 (25%)	3.25	12

	Responses
If respondents indicated that their agencies were able to implement action items successfully, they asked the following item: 74. In what ways have your provider agencies been successful in implementing their action items?	4

Themes

- *Improvement in several areas have been observed: additional services being added, improved placements, increased training and recruitment, and follow-up with providers holds them accountable.*

Individual Comments

- My foster care is exceeding the statewide data for intensive level placements where they were trailing before.
- They have provided additional training, they have utilized community resources, they have recruited retired teachers for workers. They have implemented additional services
- Through using the PQC my Provider's know follow-up will be done thus they know goals they identify will be revisited and discussed.
- Two agencies have focused on recruiting and training homes to take placement of older youth, one agency has expanded family support services to another service area to better serve families.

	Responses
75. Is there anything that you find particularly useful about the Performance Quality Conversations process?	10

Themes

- *PQCs allow for better communication with providers about questions, concerns, and expectations within PPI.*
- *Reviewing PPI data together helps the provider "get behind the data" and better see how to improve.*

Individual Comments

- Being able to set an agenda ahead of time with my Provider.
- Conversations can lead to other pertinent discussions.
- Having a conversation with the provider about performance has been a useful way to ensure we are holding each other accountable for the work we are doing. It has been a useful tool to foster change and to encourage better outcomes for youth and families.
- Helpful to have face to face meetings with the providers to discuss any questions or concerns they have. Helpful to review the PPI data together, get the "behind the data" explanation from them, helps to understand what challenges they face.
- I like the one on one with my providers but I feel like we discuss the same things over and over. I'm glad that new measures are being incorporated into PPI to change it up a bit.
- It is good to hear how the Providers are feeling about PPI and the data in it.
- It lets me know all of the wonderful things that the agency has implemented. Opportunity to discuss strategies to improve and interventions that have been successful. Agency is able to explain what the numbers mean not always negative. Opportunity for DHHS to know where we need to improve in areas. DHHS has been able to implement changes due to these conversations.
- No - I do not feel we are using that component effectively.
- Opportunity to have discussion with provider about services, challenges, their perceptions/how trying to address for improvements. Their hands are somewhat tied as its typically DCFS that "drives" items/cases.
- Showing them their data over period of time and trends. Providers don't always take the time to look at their own data especially directors of the agencies as they have someone else entering them into PPI for them.

	Responses
76. Is there anything that could be improved about the Performance Quality Conversation process?	7

Theme

- *Data collected and shared may not always be accurate, attainable, or useful for providers.*

Individual Comments

- I still feel like some of the data we discuss is out of their hands and it makes it uncomfortable to give them goals for things that may be unattainable.
- Both entities having a better understanding of PPI.
- Ensuring that the data we are collecting is accurate, valuable and that is truly has a purpose beyond just having numbers to share with everyone.
- For Provider's that only do services, PQC isn't as useful.
- Instead of scheduling these quarterly and revisiting the data discussions we have had during the quarter (which is how we initially approached the PQC), we should have them when there are concerns to discuss, such as noted increases in claim errors, lack of meeting service contact targets, increases in removals especially after services are discharged, etc. We need to be able to look at trends over time, not one data point or two that fall out of line. We need to listen to the agencies more about what works to engage our clients toward successful outcomes and find ways to do that consistently.
- It'd be nice for the windows to be bigger to type in.
- Steps can be reduced.

	Yes	***No***		**Responses**
77. Are all provider performance concerns documented on Salesforce?	11 (73%)	4 (27%)		15

	Responses
78. Why aren't all performance concerns documented on Salesforce?	7

Themes

- *Concerns aren't always followed up on*
- *DCFS is not held as accountable as the providers*

Individual Comments

- DCFS concerns don't get consistently documented, and are largely not followed up on.
- I see DCFS as a Provider and yet we don't hold ourselves to the same standards that we do our contracted Providers. In other cases, sometimes they are resolved and we are not involved in the process, so it is not documented.
- So many billing concerns it would be too time consuming to explain on PPI.
- Some provider concerns are handled by Case Management staff and not reported to Contract Monitoring.

	Count and % Valid		**Responses**
79. How quickly are provider concerns resolved?			15
< 5 days	4	27%	
Within 5-7 days	6	40%	
Within 8-14 days	5	33%	
>14 days	0	0%	

	SD	*D*	*N*	*A*	*SA*	M	*Responses*
80. Issues have been reduced due to provider concerns being addressed timely.	0 (0%)	2 (13%)	6 (40%)	3 (20%)	3 (20%)	3.5	14
							Responses
81. Please provide any final comments.							4

Theme

- *Social work can't always be easily quantified*

Individual Comments

- I don't think DCFS staff always bring concerns to the attention of CMRD. When CFS are reminded to report concerns to CMRD they do, then just like anything else, they get busy and handle themselves but ultimately concerns are not documented accurately.
- I have significant concerns about how we are using PPI, but I do feel it could be an effective tool if all parties shared information appropriately with common goals in mind. The biggest thing to remember is that we are working with people and you can't always easily quantify that information.
- Many things that we do as DCFS and service providers are based on very individual types of cases which cannot be lumped into a "Salesforce" system designed for businesses. This is social work - it doesn't fit nicely into categories and numbers. I think this gets overlooked in all of this data. Providers are doing great things with our families but we are harping on numbers. I say scrap it and spend the money on more workers so we can do a better job with families.
- Performance Concerns are not addressed quickly and timely because they are on PPI but because both the department and the provider want to resolve any issues that may arise.

Results

The following sections summarize the results observed from this survey administration. In general, response means to survey items trended towards neutral. However, CMRD comments indicate that perceptions of the PPI program are largely positive and that CMRD can see the potential it has to improve provider performance.

PPI Training

In general, CMRD indicated that they received adequate training in the principals and philosophy of PPI and the use of the Salesforce website. However, additional and ongoing trainings could be helpful in the following areas: overall refresher training on PPI and the importance/relevance of data being collected/shared, general use of Excel, and how to best create reports within Salesforce. Additionally, training outlining job expectations could be useful, as comments suggested that PPI updates are not being communicated thoroughly and can lead to unclear job expectations.

Use of Salesforce Website

Responses regarding the usefulness of Salesforce trended more towards neutral. CMRD only reported two incidents of technical issues with Salesforce, of which one was resolved satisfactorily while the

other was not resolved. Comments suggest that the Salesforce interface could be improved by making it easier to communicate with providers via Salesforce email, including a place for supporting narrative information to be entered, the ability to track internal issues and their resolution(s), and improved ability to sort/view data within Salesforce.

Contract Monitor Communication

CMRD appear to be in regular contact with their provider agencies: 57% of CMRD indicated that they communicate with their provider agencies daily via email, 67% reported weekly phone conversations, and 53% reported meeting in-person with providers monthly. CMRD reported that communications with provider agencies are meaningful (M = 4.13) and open (M = 4.60); however, CMRD indicated that they are less likely to receive timely updates from DCFS which impact their work with providers (M = 2.73). Comments suggested that there is a need for improved communication between DCFS, contact monitors, and service providers. Comments suggest that communication could be improved through enhancement of Salesforce email communication interface.

Buy-In and Perceived Impact of the PPI Program

Generally, buy-in for PPI trended towards neutral. CMRD reported that PPI has fostered an ongoing conversation about provider performance and data (M = 3.93); however, they generally do not feel that PPI holds DCFS accountable for their performance (M = 2.27). The majority of respondents (85%) indicated that support for PPI varies between provider agencies which is reflected through data entry (or lack thereof), provider agencies own perceptions of the PPI program's usefulness, the size of the provider agency, and the type and number of services that the agency provides.

Perceptions of Performance Quality Conversations

Generally, CMRD indicated that they believe provider agencies feel they can communicate openly with them during Performance Quality Conversations (M = 4.33). Most (92%) CMRD reported developing action items as a result of those conversations. Additionally, most (73%) CMRD indicated that provider performance concerns are documented on Salesforce, and 67% of provider concerns are resolved within a week. The most useful PPI measure reported was percent/count of youth in placement by age and level of care. Comments suggest that CMRD find Performance Quality Conversations are fostering meaningful discussions that allow for strategies to be developed and action items to be implemented, while holding both parties accountable; however, comments indicate that DCFS is not held to the same level expected of provider agencies. Additionally, CMRD indicated that their provider agencies have experienced barriers to implementing action items due to 1) unclear parameters of expectations, goals, and priorities from DCFS, and 2) lack of communication between DCFS, providers, and CMRD. Comments suggest a need to find accurate and meaningful measures that work for both DCFS and providers.

DCFS Administrator Survey

A survey was designed to collect DCFS Administrator perceptions of the PPI program (for more information about this survey, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*). The PPI Administrator Survey was emailed to participants on December 13, 2018 by CCFL. Unfinished respondents received up to two reminder emails from the Qualtrics system. The last recorded response was December 19, 2018. Out of 15 administrators, 15 completed the survey for a response rate of 100%. However, only partial responses were recorded for two respondents.

Table 3.2.3 provides detailed information about the frequency of responses, overall rating averages, and associated comments. Scales are defined for each item within the table. Percentages may not total 100% due to rounding. M = Mean, SD = Standard Deviation, N = number of respondents. Additionally, respondents were asked to provide comments. For open-ended questions, respondents' comments are first summarized into themes, as appropriate, and then individual comments are listed below (editing was done, if needed, to enhance readability and maintain anonymity).

Table 3.2.3: DCFS Administrator PPI Survey Response Summary

	Frequency of Response (Count and Valid %)							***N***
1. How often do you review the PPI data?	Count		Valid %					15
Weekly	1		7%					
Monthly	9		60%					
Quarterly	5		33%					
	Strongly Disagree	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*	***M***	***SD***	***N***
2. PPI data influences my workers' decisions to utilize certain providers.	--	3 (20%)	8 (53%)	4 (27%)	--	2.9	0.7	15
3. Are there any other ways PPI data influences your use or perceptions of certain providers?						**Responses** 6		

Themes

- *PPI data may be more useful in a more readily available/accessible format*
- *PPI data can be useful in decision making*

Individual Responses

- I am in the ESA, so the use of PPI is limited.
- I just don't think the workers have the time to look at [PPI data] this. They usually go off of their own experience with providers.
- I think the PPI data would have more of an influence if it was accessible in a format staff already utilize like our NREPORTS or on EZ Access Reporting.
- Outcomes for families

- The data tells me about how many referrals are going to which provider in addition to the quality.
- Yes, when deciding on a provider for IFP or IFR.

4. What is most helpful about the PPI Quality Reviews of ASFC Reports?	**Responses**
	6

Theme

- *PPI Quality reviews of ASFC reports provides a good overview on what is or is not happening.*

Individual Responses

- Gives me an idea as an administrator what is going on.
- Helps us see what is and is not being done.
- How many homes ASFC indicates they have vs. how many placements they actually take.
- Just informative
- Placement, disruptions, acceptance
- The acceptance or denial of placements

	Yes	*No*	***N***
5. Does your service area utilize the PPI Quality Reviews of Agency Supported Foster Care (ASFC) Reports?	10 (71%)	4 (29%)	14

6. Why doesn't your service area utilize the PPI Quality Reviews of ASFC Reports?	**Responses**
	4

Theme

- *ASFC reports may be used more if presented in a more readily available/accessible format*

Individual Responses

- Don't receive them to review.
- ESA providers do not report into the PPI in this same way.
- The Administrators do, but the front line staff do not find it helpful.
- The lack of access to the reports. It requires staff to go in a site they never utilize outside of just this purpose so getting to the reports is not very efficient for them.

	Yes	*No*	***N***
7. Does your service area utilize the PPI Quality Reviews of Placement Support Plans?	8 (57%)	6 (43%)	14

8. What is most helpful about the PPI Quality Reviews of Placement Support Plans?	**Responses**
	4

Theme

- *Review of Placement Support plans provides a good overview on what is or is not happening.*

Individual Responses

- To help ensure that proper support is provided that reduces placement disruptions
- Updates
- We can see what needs improved and what we can do to assist.
- What is working and what is not.

9. Why doesn't your service area utilize the PPI Quality Reviews of Placement Support Plans?	**Responses** 4

Theme

- *Administrators are unaware of or not receiving Placement Support Plans.*

Individual Responses

- Don't receive them.
- I haven't reviewed that.
- I've never seen the report; I wasn't aware that it is available.
- We try to be working every day when those plans are developed to make sure they are quality.

	Yes	*No*	***N***
10. Is your service area getting what you need from the review of the ASFC Reports?	9 (75%)	3 (25%)	12

11. What would make the review of the ASFC Report more useful?	**Responses** 2

Individual Responses

- I have never seen this report.
- More detail as to why placement referrals are denied.

	Yes	*No*	***N***
12. Has the quality of the ASFC Reports improved since the implementation of PPI?	7 (58%)	5 (42%)	12

13. In what ways has the quality of the ASFC Reports improved?	**Responses** 3

Theme

- *ASFC Report quality has improved by providing more specific, detailed information.*

Individual Responses

- Information about decision has improved vs having feelings about what is happening
- More specific and detailed.
- We are getting more detailed information in the reports, such as medication, doctor visits, etc.

	Yes	*No*	***N***
14. Has the quality of the Placement Support Plans improved since the implementation of PPI?	6 (50%)	6 (50%)	12

15. In what ways has the quality of Placement Support Plants improved?	**Responses**
	2

Individual Responses

- Able to drill down.
- More specific, timely, and detailed.

16. Are there any other pieces of data that would be valuable to include in the PPI program?	**Responses**
	2

Individual Responses

- Not sure what it currently does.
- The requirement in the ASFC sub-award that the foster parent have contact within 24 hours with the bio parent should be included in PPI and not NFOCUS so that the provider can enter the information.

	Yes	*No*	***N***
17. Have provider issues been reduced as a result of PPI?	2 (17%)	10 (83%)	12

	Strongly Disagree	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*	***M***	***SD***	***N***
18. When there is a concern with a provider, concerns are addressed in a timely manner.	--	4 (31%)	2 (15%)	7 (54%)	--	2.8	0.9	13

	Utilize the PPI reporting process	*Resolve the issue directly with provider*	***N***
19. When there is a concern with a provider, do you utilize the PPI reporting process or resolve the issue directly with the provider?	2 (17%)	10 (83%)	12
20. How often are you resolving issues directly with providers?			
Daily	--	--	10
Weekly	3	30%	

			Monthly	7	70%	
				Yes	*No*	***N***
21. Are you aware of whether provider performance concerns are documented within Salesforce?				6 (50%)	6 (50%)	12
22. Are service areas communicating more often with providers as a result of the PPI performance concern reporting process?				6 (50%)	6 (50%)	12
23. Do you review the kudos?				2 (17%)	10 (83%)	12
	Extremely Useless	*Slightly Useless*	*Neither Useful nor Useless*	*Slightly Useful*	*Extremely Useful*	***N***
24. How useful is the kudos information?			1 (50%)	1 (50%)		2

Results

The following sections summarize the results observed from this survey administration.

PPI Data Elements

- The majority (60%) of administrators reported that they review PPI data monthly; however, the extent to which this influences workers' decisions to utilize certain providers trended towards neutral (M = 2.9)
- 71% reported using PPI Quality Reviews of Agency Supported Foster Care (ASFC) Reports. Of these respondents, 75% reported getting what they need from these reports and 58% reported seeing an improvement in these reports since PPI implementation.
- 57% reported using the PPI Quality Reviews of Placement Support Plans. Of these respondents, half indicated seeing an improvement in the quality of these reports since PPI implementation. Comments suggest that through the reviews of Placement Support Plans, administrators have a greater understanding of what is (or is not) being done, especially in regards to the acceptance or denial of placements.
- Comments suggest that ASFC reports and Placement Support Plans aren't easily accessible or the administrators don't receive them.

Provider Performance Concerns

- Only 17% of respondents indicated that provider issues have been reduced as a result of PPI.
- Administrator responses were mixed for the item "When there is a concern with a provider, concerns are addressed in a timely manner." With the overall average trending towards neutral (M=2.8).
- 83% of administrators indicated that they respond to provider issues directly, while 17% indicated that they utilize the PPI reporting process. Of those administrators that indicated that they resolve issues directly with providers, 70% reported doing this monthly.
- Half of respondents indicated that they were aware of provider performance concerns being documented in within Salesforce.

- Half of respondents indicated that service areas are communicating more often with providers as a result of the PPI reporting process.
- Only 17% of respondents indicated that they review the kudos.
- Comments suggested PPI data may have a greater impact if data were accessible in a format that workers already use, such as NREPORTS.

Chapter 3: Summary of PPI Program Evaluation

As the current contract monitoring process, PPI is used by DCFS to establish performance accountabilities and identify improvement opportunities with contracted provider agencies. DCFS transitioned from Results Based Accountability to PPI in May 2016. This program was initially piloted with some provider agencies in July 2016, with full implementation occurring in October 2016. This program has evolved over time and the evaluation team at UNL-CCFL has worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, it was ultimately determined that a change mechanism could not be isolated and that a process-only evaluation would be completed for the PPI program.

According to DCFS, the purpose of PPI is to improve the outcomes of children and families that receive one or more of the most frequently provided services from a private agency contracted with DCFS. This includes: family support (in-home and out-of-home), intensive family preservation, and agency supported foster care. In order to examine the PPI program, DCFS presented UNL-CCFL with research questions related to the PPI program. Evaluators from UNL-CCFL worked collaboratively with DCFS to understand and clarify the data identified elements. Data sources and collection methods were identified and a data collection plan was created by UNL-CCFL. This essentially included the development and administration of three separate surveys to assess the perceptions of 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. Additionally, a review of relevant PPI/Salesforce website data was conducted.

To assess variance among PPI stakeholders, common items were examined between the three (provider, CMRD, and administrator) survey administrations. Common survey items were related to the following dimensions of the PPI program:

- PPI training efforts
- PPI/Salesforce website
- Communications between CMRD and Providers
- Buy-in and perceived impact of the PPI program
- Perceived usefulness of PPI data elements
- Perceptions of Performance Quality Conversations
- Provider performance concern data and perceptions

For each dimension, the relevant findings are summarized below. Additionally, data were supplemented with PPI/Salesforce website data, as appropriate. Note that not all stakeholder groups were asked about all dimensions. Suggested areas for further exploration or action are provided.

PPI Training Efforts

To understand the training provided to CMRD and providers regarding the principles and philosophy of PPI and how to use of the Salesforce website, these two stakeholder groups were asked about their experiences and perceptions. Survey responses indicated mixed perceptions about PPI-related training efforts. Most CMRD staff indicated that they had received adequate training. However, half or fewer provider respondents indicated agreement with statements related to PPI training efforts. Comments from CMRD suggest that clearer job expectations should be communicated to CMRD staff regarding their roles and responsibilities with the PPI program. Both the provider and CMRD respondents indicated an apparent lack of communication amongst all parties when PPI updates occur. Comments

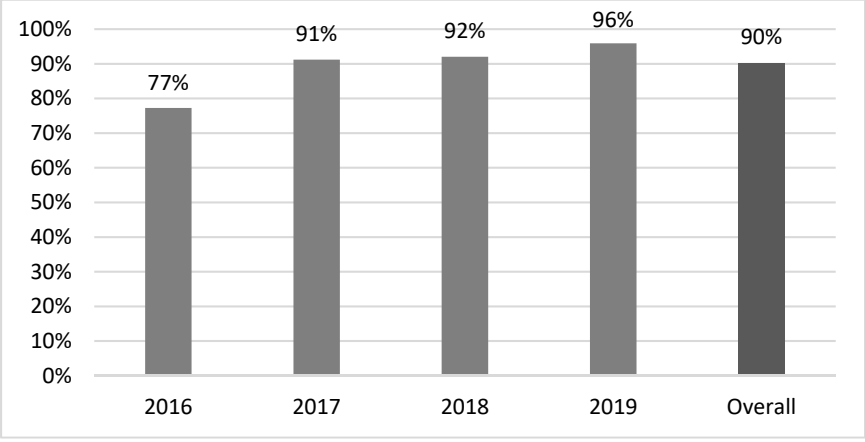
suggest that additional or ongoing trainings around the features of Salesforce may be helpful. Provider respondent comments suggested that these could be achieved through video trainings or one-on-one demonstrations. In addition, when PPI updates occur, thorough communication of changes to providers and CMRD are needed.

PPI/Salesforce Website

The Salesforce website is an essential component of the PPI program. In addition to data uploaded by DCFS each month, providers must enter regular data on each of their performance measures by the 15th of the following month to remain compliant with PPI expectations. In order to assess the perceptions and use of the PPI/Salesforce website, CMRD and providers were asked several questions related to this part of the PPI program.

Both CMRD and provider respondents agreed that the Salesforce website is easy to use. Few technical issues have been reported and those that were reported have been resolved. Nearly all (93%) provider survey respondents reported that their agency regularly enters data into the Salesforce website, as required; just 2 small providers indicated they do not typically enter data into Salesforce each month. These findings are in alignment with supplemental Salesforce data examined by the evaluators. Salesforce data from October 2016-April 2019 indicated that providers are generally entering their data into the PPI/Salesforce website in accordance with the program's requirements. Figure 3.3.1 shows the percentage of time data was entered by providers in accordance to the program requirements. Timely documentation appears to have increased and sustained over time.

Figure 3.3.1: Percentage of Time Data Entered On-Time



Overall, the Salesforce website is perceived as easy to use, however, improvements in the communication interface and additional space for narrative comments would allow for improved context around the usefulness of PPI program data. Both CMRD and providers included comments with suggestions to enhance the PPI/Salesforce website. CMRD staff indicated that the Salesforce interface could be improved by making it easier to communicate with providers via Salesforce email, including a place for supporting narrative information to be entered, the ability to track internal issues and their resolution(s), and improved ability to sort/view data within Salesforce. Providers suggested website enhancements that would allow them to provide comments related to performance concerns or when performance measures are not met, the ability to view anonymous data from other providers for

comparison, access to service delivery performance data for DCFS and PromiseShip, and more capabilities for viewing data in graphs, tables, and charts.

Communications between CMRD and Providers

Both CMRD staff and contracted providers were asked for their perceptions about the communications between CMRD and providers. In general, both survey groups indicated that they were satisfied with their individual interactions – communications appear to be meaningful, open, and regularly occurring. However, both providers and CMRD suggested that communications with DCFS could be improved. Comments from both survey groups indicate a need for CMRD staff to be better informed on important issues and changes with the PPI program.

Buy-in and Perceived Impact of the PPI Program

Providers, CMRD, and DCFS Administrators were asked about their buy-in for and perceived impact of the PPI program. Overall, responses were largely neutral. It appears that the PPI program has ensured ongoing and regular conversations around data and provider performance. However, efforts should be taken to enhance the meaningfulness and impact of PPI data. It is recommended that DCFS and provider agencies work collaboratively to refine the performance measures. Additionally, increased communication from DCFS about how these data are used (or could be used) to inform decision-making within DCFS and provider agencies could increase participants' understanding of the PPI program's impact.

Perceived usefulness of PPI Data Elements

Providers, CMRD, and DCFS Administrators were asked about their perceptions of the usefulness of PPI data elements. This included data input by contracted providers, uploaded from DCFS, and the quality reviews performed for specific services. Overall, most individual PPI data elements were indicated to be at least moderately useful. For the quality reviews, some providers indicated a lack of consistency, so it appears additional guidance for reviewers may be needed to improve the consistency of these reviews. Additionally, DCFS administrators' comments suggest that the ASFC and Placement Support Plans are difficult to access. Information about how to best access these reports, or regular dissemination processes may be helpful to ensure all necessary parties are receiving this information.

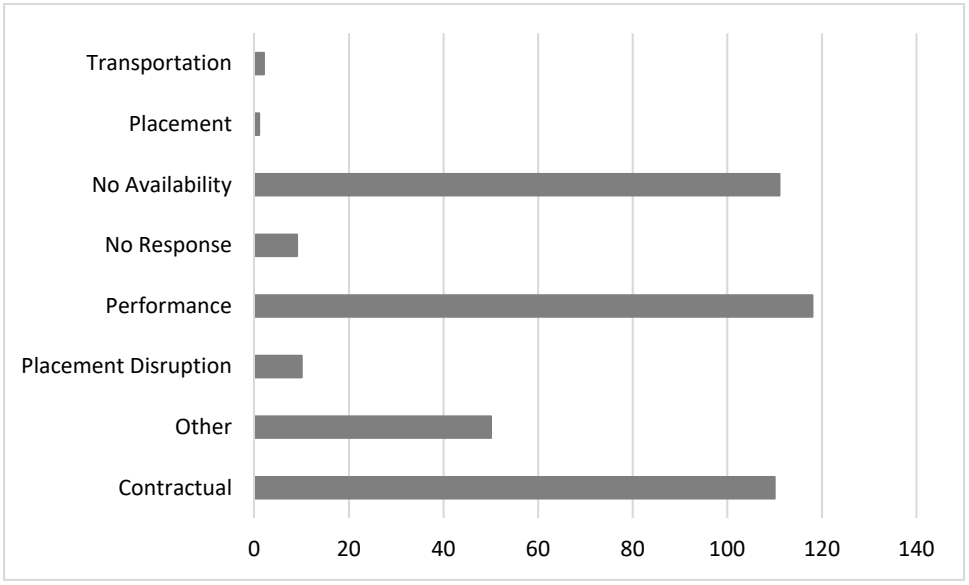
Perceptions of Performance Quality Conversations

CMRD and provider agencies were asked about their perceptions of the Performance Quality Conversations (PQC). These are the meetings between CMRD and providers to discuss PPI data and develop strategies to improve performance. According to DCFS, the overall goal of these meetings is system improvement and better outcomes for the children and families that are served. Overall, respondents agreed that PQC are meaningful and have led to action items and strategies for improving provider performance. However, additional meeting structure (e.g., agendas) may be helpful to improve the efficiency and usefulness of these meeting. Implementation of action items may be improved by increased communication and clearer expectations from DCFS.

Provider Performance Concerns Data and Perceptions

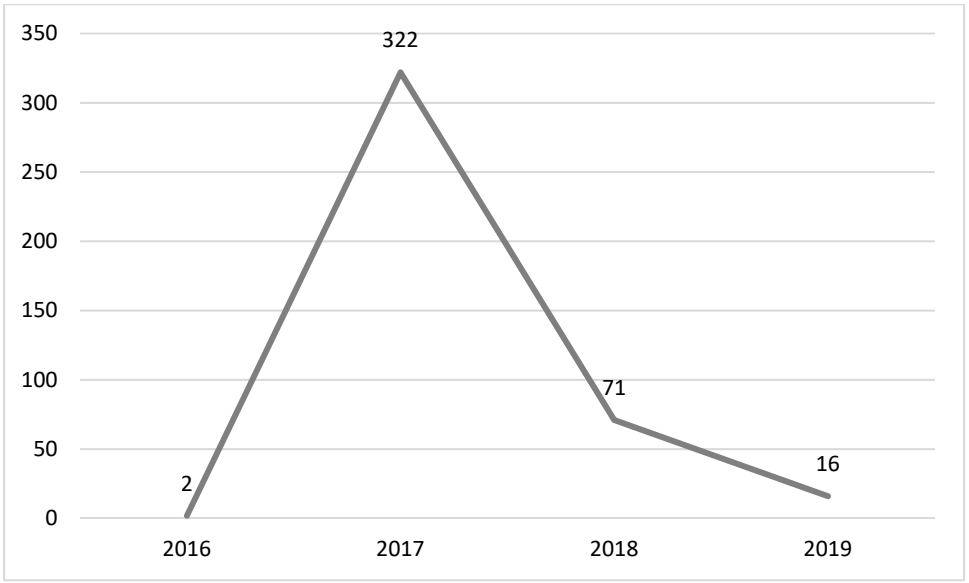
Providers, CMRD, and DCFS administrators were asked about their use and perceptions of the provider performance concern reporting process through the PPI/Salesforce website. Figure 3.3.2 displays the type of concerns being documents according to Salesforce data.

Figure 3.3.2: Frequency of Concerns Documented in Salesforce



Multiple provider respondents indicated that the performance concerns feature is overused/misused. Reviewing Salesforce data, there appeared to be a surge in performance concern report during 2017, tapering off over time. Figure 3.3.3 depicts the number of provider performance concerns documented within Salesforce for the time period October 2016 – April 2019.

Figure 3.3.3: Number of Provider Performance Concerns Over Time



The performance concerns feature of PPI was viewed by providers as a deterrent to direct communication between DCFS and providers to allow issues to be resolved in a timely, collaborative, and professional manner. This feature was also viewed as being negative and punitive for providers. However, DCFS administrator responses indicated that most administrators are communicating directly with providers and about half of the administrators indicated increased communication due to the PPI performance concern reporting process.

In terms of resolving the provider performance concerns, it appears that most are resolved timely. According to CMRD most (67%) provider concerns are resolved within a week. Salesforce data indicate that all performance concerns have been resolved, taking, on average, 10 days to resolve.
Overall, it appears increased clarification around the specific criteria for reporting concerns and the appropriate follow-up processes could improve this PPI program feature.

Overall Takeaways
Overall, potential areas for improvement within the PPI program include:

- Additional training on the features of Salesforce may be helpful. This could be achieved through video trainings or one-on-one demonstrations.
- The Salesforce website could be enhanced through improved email interface, inclusion of a comment section for narrative information especially regarding performance concerns, the ability to track internal issues, improved ability to sort and view data in graphs/tables, the ability to view anonymous data from providers for comparison, and access to service delivery performance data for DCFS and PromiseShip.
- Additional training outlining job expectations for CMRD could be useful, as comments suggested that PPI updates are not being communicated thoroughly and can lead to unclear job expectations for CMRD.
- Communications with DCFS could be improved as there seems to be a need for CMRD staff to be better informed on important issues and changes with the PPI program.
- It is recommended that DCFS and provider agencies work collaboratively to refine the performance measures.
- Increased communication from DCFS about how PPI data are used to inform decision-making could increase participants' understanding of the PPI program's impact.
- Additional guidance for reviewers may be needed to improve the consistency of quality reviews as some providers indicated a lack of consistency.
- Information about how to best access the ASFC and Placement Support Plan reports and/or regular dissemination processes may be helpful to ensure all necessary parties are receiving this information.
- Additional meeting structure (e.g., agendas) may be helpful to improve the efficiency and usefulness of the Performance Quality Conversations.
- Providers' implementation of action items may be improved by increased communication between DCFS, providers, and CMRD, and clearer expectations regarding goals and priorities from DCFS.

Part IV:
Alternative Response
Outcome Study

Chapter 1: Children and Family Services Organizational Outcomes

Key Questions:

- To what extent does the CFS applicant pool change during the implementation of AR? Does AR attract more applicants with social work experience and degrees?
- To what extent does the CFS workforce composition change during the implementation of AR? Does the implementation of AR have an effect on more applicants with social work experience and degrees being hired?
- Over the course of the waiver demonstration, does job satisfaction increase for staff involved in providing AR services?
- Over the course of the waiver demonstration, is retention improved for staff providing AR services?

These long term outcomes focus on organizational-level impacts not subject to the AR case randomization, and as such, this part of the evaluation will be a longitudinal design examining changes in aggregate measures over time. Sampling, data collection and expected data analyses for each of these four outcomes are briefly described below.

Agency Workforce Composition Becomes More Social Work Oriented

DCFS hypothesized that implementation of AR would be attractive to applicants with a social work background, resulting in a greater proportion of applicants and new CFS hires with social work experience and degrees. The evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.

DCFS also hypothesized that implementation of AR would result in an altered composition of the CFS workforce, with more staff having social work degrees. To attempt to answer this research questions, degree information for the CFS workforce was obtained from tables within Nebraska's published Annual Progress and Services Reports (APSRs) for the years 2012 to 2018.

These data represent educational degree information for current staff, which is self-reported in a database managed by the State of Nebraska Administrative Services. Because these data are self-report, degree information is not available for all employees. Beginning in 2012, workers and supervisors were expected to enter their educational background into the database as part of their new hire training responsibilities. In 2012, 87.5% of supervisors, 72.4% of CFS Specialists, and 63.3% of CFS Specialist trainees had entered their education information into this database. In December 2019, 94.8% of supervisors, 60.4% of CFS Specialists, and 21.7% of CFS Specialist trainees had entered their education information into this database. Due to the incomplete reporting, generalized conclusions cannot be made about the degree information for the entire CFS workforce. Additionally, from 2012 through 2014 only employee degree information was reported (e.g., Bachelors of Arts, Masters of Social Work). Beginning in 2015, degree major information was included along with degree type, allowing for more nuanced education information. However, these changes make it difficult to compare across time periods (pre- and post- intervention) because this information was not collected prior to 2015.

Therefore, trends for social work degrees and degrees with a social work focus (including social work degrees and other degrees with a social work major) were examined separately across all years from 2015 onward.

Figures 4.1.1 – 4.1.4 show the percentages of workers or supervisors with social work degrees or social work degrees or majors across the available time periods The denominators used to calculate the percentages is the number of workers included in the database (not the total number of employees).

Figure 4.1.1: Percent of CFS Specialists and Trainees with a Social Work Degree

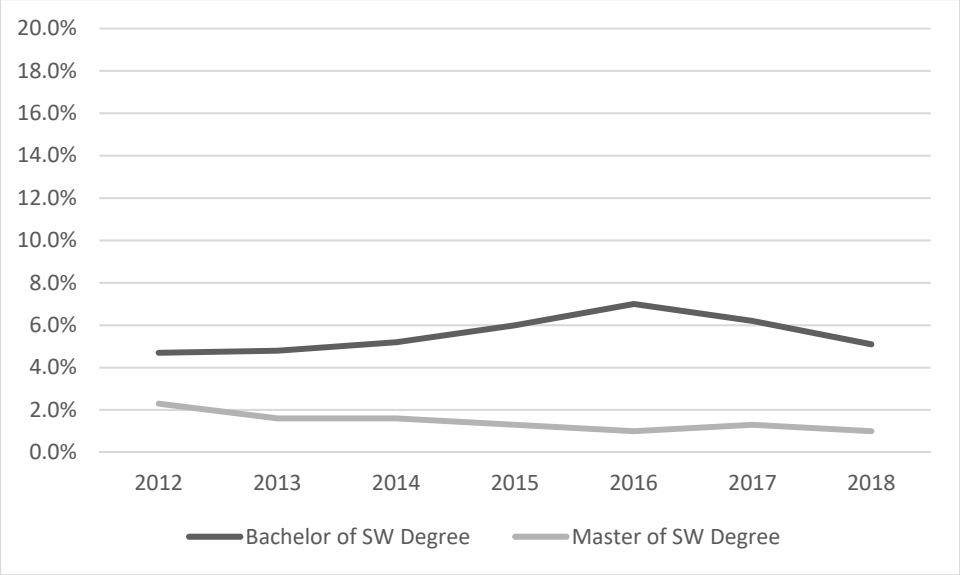


Figure 4.1.2: Percent of CFS Specialists and Trainees with a Social Work Degree or Major

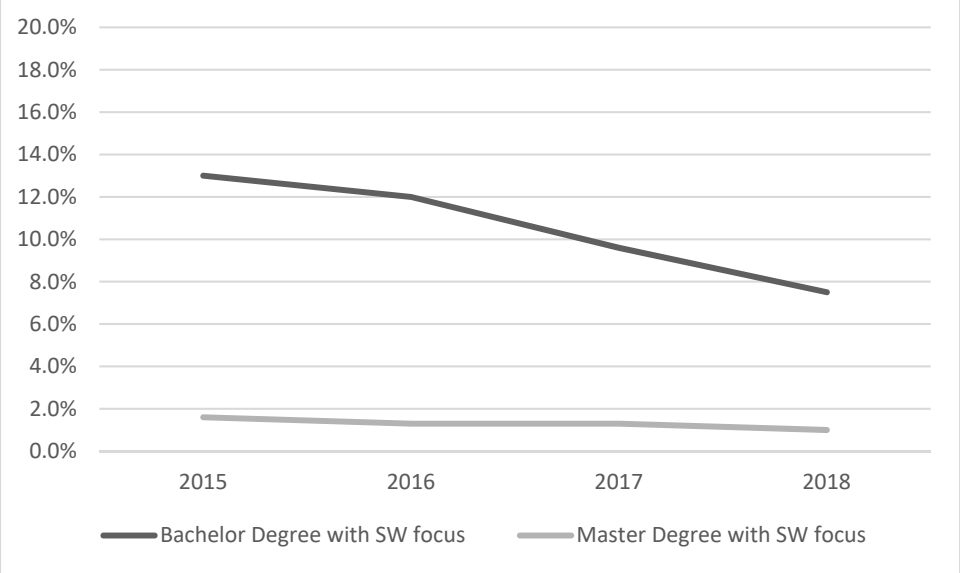


Figure 4.1.3: Percent of CFS Supervisors with a Social Work Degree

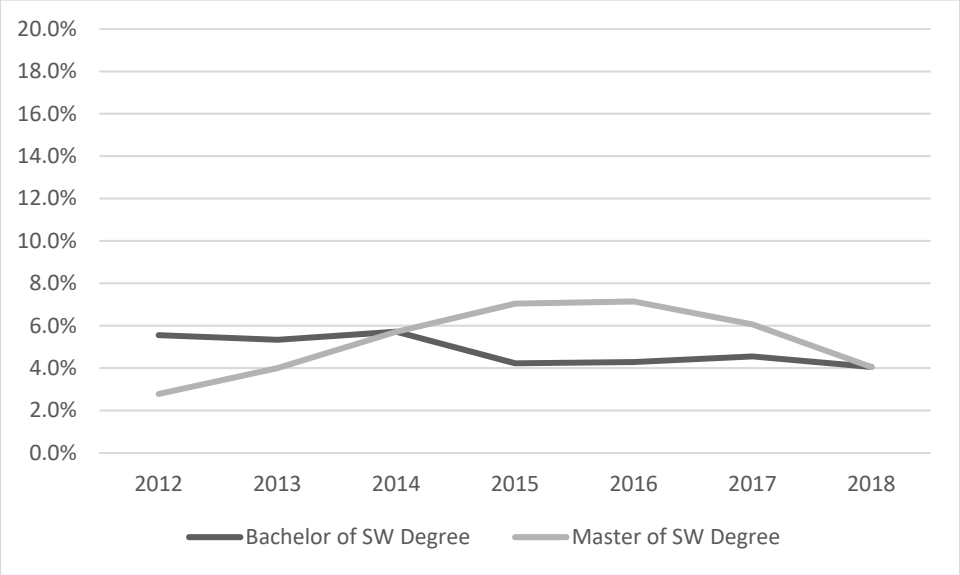
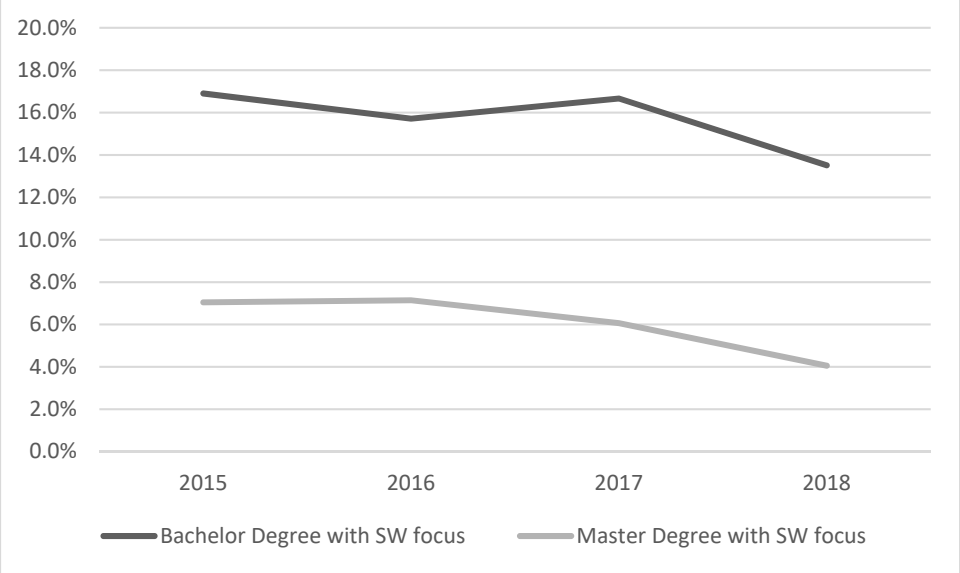


Figure 4.1.4: Percent of CFS Supervisors with a Social Work Degree or Major



Summary

Overall, the trends of self-reported degree do not support the hypothesis that the CFS workforce has become more social work oriented during the implementation of AR. Additionally, the percentages of trainees, workers, and supervisors with a social work-related degree either remained stable or decreased over the course of the demonstration period. The implementation of AR does not appear to have had an effect on the proportion of the CFS workforce with social work degrees as hypothesized.

CFS Staff and Supervisors Engaged in Delivering AR Services Will Experience Higher Job Satisfaction than Those CFS Staff and Supervisors Not Involved in AR Work

The evaluators had planned to assess the hypothesized change in job satisfaction over time using DCFS Human Resources job satisfaction survey data that is collected annually. However, it was later discovered that these data could not be disaggregated to an individual level to permit the necessary breakdowns to analyze differences between AR and TR-involved staff. By the time this was known, the opportunity to conduct a longitudinal survey of job satisfaction had passed. Instead, focus groups were conducted to address this research question.

Staff Questionnaires and Focus Groups

In spring of 2018, DCFS toured all five service areas of Nebraska and conducted a refresher training on Alternative Response (AR) to workers. At these trainings, UNL-CCFL distributed a brief survey and facilitated focus groups with workers in order to address a number of research questions for the AR program evaluation, including the question around enhanced job satisfaction.

The participants included a mix of initial assessment (IA) and ongoing workers that work either AR or TR cases or carry a mixed caseload. In total, 36 workers (25 IA, 7 ongoing, 4 unknown) completed the questionnaire and survey. Three survey questions related to job satisfaction. Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). Table 4.1.1 displays the questions and the overall average item ratings.

Table 4.1.1: Job Satisfaction Item Averages

Overall Average Item Ratings			
	Average	*SD*	N
10. Working with families through AR has increased my overall job satisfaction.	3.32	1.15	34
11. I prefer working with families through AR compared to TR.	3.18	1.4	34
12. AR is better aligned with my own beliefs about how to work with families compared to TR.	3.56	0.96	34

In order to make comparisons, workers were grouped by proportion of workload spent on AR or TR cases. 14 workers indicated the majority (greater than 50%) of their workload was spent on AR cases, while 15 workers indicated the majority of their workload was spent on TR cases. Additionally, 3 workers indicated their time was spent evenly between AR and TR, while an additional 3 workers did not indicate a proportion; therefore, these 6 individuals were excluded from the following analyses. Table 4.1.2 presents the average item rating by caseload majority (AR/TR).

Table 4.1.2: Job Satisfaction Item Averages by Caseload Majority

Average Item Ratings by Caseload Majority				
	Majority Caseload	Average	*SD*	N
10. *Working with families through AR has increased my overall job satisfaction.	AR	3.86	0.86	14
	TR	2.60	0.91	15
11. *I prefer working with families through AR compared to TR.	AR	4.07	1.27	14
	TR	2.20	0.94	15
12. *AR is better aligned with my own beliefs about how to work with families compared to TR.	AR	4.07	0.83	14
	TR	3.00	0.84	15

*$p < .05$.

AR workers were significantly more likely to agree with all three statements. AR workers were more likely to indicate that working with families through AR had increased their overall job satisfaction compared to TR workers ($t(27) = 3.81$, $p = .001$), more likely to prefer working with families through AR ($t(27) = 4.53$, $p < .001$), and more likely to believe that AR is better aligned with their own beliefs about how to work with families ($t(27) = 3.44$, $p = .002$).

These findings suggest that workers who are able to work a caseload of mostly AR cases gain more benefit and satisfaction from the AR program than workers who are assigned AR cases less frequently. Furthermore, focus group themes support this finding that dedicated AR workers experience greater job satisfaction than workers who carry mixed caseloads.

Following the training sessions, semi-structured focus groups were conducted. Workers were asked specific questions about job satisfaction, worker competency, and AR fidelity outcomes from the logic model, followed by probing questions for greater context as needed. In total, 36 workers participated, statewide.

Two service areas (Eastern and Southeastern) experience higher AR case volume, allowing some workers to either solely or primarily work with AR families. Those workers reported having greater job satisfaction, as they consider AR as better aligned with social work practices. It was reported that due to the "more relaxed and comfortable" approach of AR, families tend to be more open, leading to a stronger connection. One worker reported that the difference between TR and AR was "a night and day difference" and "without AR they wouldn't be in this job." Workers reported that while there may be more work with AR, it is more rewarding as they are able to see firsthand the positive changes within families.

Workers in the remaining three service areas (Central, Western, and Northern) work a mixed caseload of both AR and TR cases, while in Eastern and Southeastern services areas there are workers that are primarily dedicated to working with AR families. This difference is largely attributed to limited staff

resources and lower volume of AR cases in Central, Western, and Northern service areas; however, the impact of AR on workers carrying mixed caseloads is different than AR-only workers.

Workers carrying a mixed caseload of both AR and TR reported that it was difficult to switch mindsets and treat AR families differently than TR families. They found it challenging to "muddle their way through AR" if they are primarily TR workers. Mixed-case workers reported that ultimately they want to help families regardless of track. In all three service areas, workers reported that having at least one worker dedicated only to AR families could be better for consistency and fidelity to the AR program manual.

Summary

The evaluators were unable to assess job satisfaction through an annual survey as initially planned. Instead, a brief questionnaire and focus groups with a small group of AR workers was used. However, these efforts supported the hypothesis that AR workers experience higher job satisfaction, especially for those workers who are able to primarily carry AR caseloads.

Retention for CFS Staff Improves Over Time Due to AR Implementation

DCFS provided personnel data from April 2012 through July 2019, obtained from HR, to allow the evaluators to calculate turnover rates over time. The dataset included the following variables: employee ID, employee name, gender, ethnicity, position (CFS Trainee, Specialist, or Supervisor), service area, office, supervisor, the date the employee began employment with the state government, start dates for the CFS Trainee, CFS Specialist, and CFS Supervisor positions, and separation date from state government. The date of separation from DCFS was unavailable. AR training date and AR start and end dates were tracked manually by the AR Program Specialist. The program specialist contacted supervisors each month to ask which workers began and stopped working AR cases that month and added that information to the spreadsheet.

Turnover Rates Over Time

To get a sense of the normal fluctuations in turnover across time, the six-month turnover rates were calculated for 6-month periods, beginning with April-September 2012 to October-March 2019. Turnover rates were calculated by dividing the number of employees who left state government during the time period by the total number of employees who could have left during that time period. Separate turnover rates were calculated for CFS specialists, trainees, and supervisors. Table 4.1.3 details the number of employees in each job category who left, the total number of employees for that time period, and the resulting turnover rates for 6-month intervals from April 2012 through March 2019.

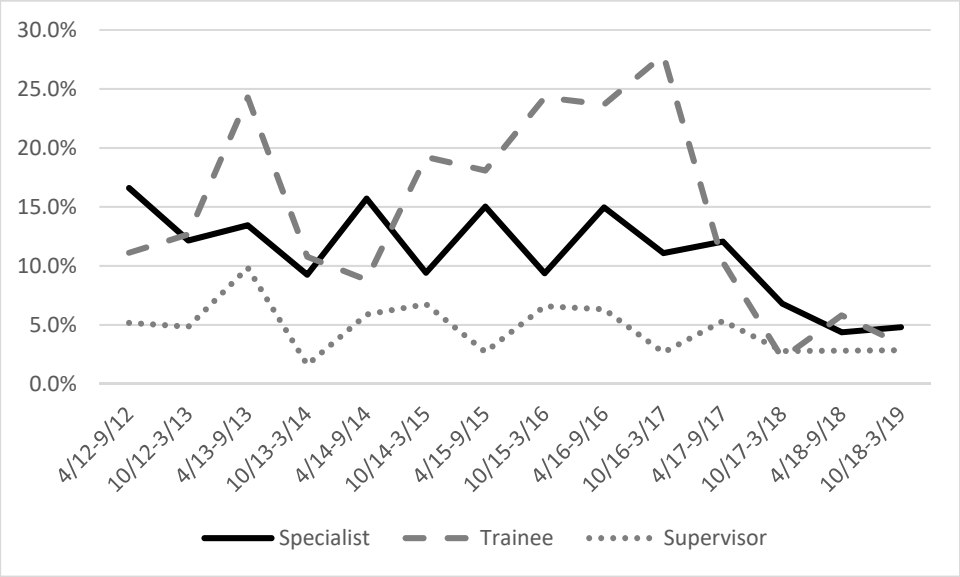
Table 4.1.3: 6-Month Turnover Rates by Job Position from April 2012 to March 2019

	CFS Specialist			CFS Trainees			CFS Supervisors		
	N who left	N employees	Turnover Rate	N who left	N employees	Turnover Rate	N who left	N employees	Turnover Rate
4/12-9/12	44	265	16.6%	7	63	11.1%	3	58	5.2%
10/12-3/13	35	288	12.2%	9	71	12.7%	3	62	4.8%
4/13-9/13	41	305	13.4%	17	70	24.3%	6	61	9.8%
10/13-3/14	26	281	9.3%	7	65	10.8%	1	62	1.6%
4/14-9/14	49	312	15.7%	6	68	8.8%	4	68	5.9%
10/14-3/15	29	308	9.4%	15	78	19.2%	5	74	6.8%
4/15-9/15	49	326	15.0%	17	94	18.1%	2	74	2.7%
10/15-3/16	33	352	9.4%	17	70	24.3%	5	76	6.6%
4/16-9/16	57	381	15.0%	18	76	23.7%	5	79	6.3%
10/16-3/17	42	379	11.1%	17	61	27.9%	2	75	2.7%
4/17-9/17	41	340	12.1%	10	97	10.3%	4	75	5.3%
10/17-3/18	23	338	6.8%	2	92	2.2%	2	72	2.8%
4/18-9/18	16	366	4.4%	5	86	5.8%	2	71	2.8%
10/18-3/19	19	395	4.8%	3	89	3.4%	2	70	2.9%

In general, the CFS Specialist turnover rate varied between 9-16% for most of the time periods. However, in October 2017 the turnover rate drastically decreased to 6.8% and continued to drop to under 5% by March 2019. Several DCFS central office and local administrative leadership changes occurred in August 2017, which may have been a factor in this observable drop in turnover; there were no other major interventions implemented at this time that could explain the difference. A similar drop in temporal drop in turnover was observed for the CFS Trainees. The CFS Trainee turnover rates varied widely over the years, peaking at 27.9% in October 2016. However, again, a notable drop in turnover was observed for CFS trainees after October 2017, with a final turnover rate of 3.4% by March 2019. CFS Supervisor turnover rates, on the other hand, have remained fairly stable over the years; the most variation occurred before the demonstration, peaking at 9.8% in April-September 2013. Figure 4.1.5

displays the 6-month turnover rates for CFS Specialists, Trainees, and Supervisors from April 2012 through March 2019.

Figure 4.1.5: 6-month Turnover Rates for CFS Specialists, Trainees, and Supervisors



In general, the average CFS Specialist 6-month turnover rate was lower during the intervention period, compared with the baseline data (9.8% average from October 2014 through March 2019, compared with 13.4% before the intervention, from April 2012 through September 2014). The average CFS Trainee 6-month turnover rate was higher during the intervention period, compared with the baseline data (15.0% average from October 2014 through March 2019, compared with 13.5% before the intervention, from April 2012 through September 2014). And finally, the average CFS Supervisor 6-month turnover rate was lower during the intervention period, compared with the baseline data (4.3% average from October 2014 through March 2019, compared with 5.5% before the intervention, from April 2012 through September 2014).

Differences in Turnover Rates for AR and TR Workers

To examine the difference in turnover rates between staff involved in AR and those doing TR case practice, CFS Specialist data were examined. There were no data distinguishing between AR and TR supervisors and trainees do not carry full caseloads. AR involvement was defined and examined two ways: 1) working on AR cases during or prior to the given time period, and 2) having received AR training during or prior to the given time period.

Working with AR Families

When defining AR involvement as working on AR cases during or prior to the given time period, the AR turnover rate fluctuated substantially over the demonstration project. Again, turnover rates were calculated by dividing the number of employees who left state government during the time period by the total number of employees who could have left during that time period. Separate turnover rates were calculated for AR CFS specialists and TR CFS Specialists. Table 4.1.4 details the number of AR and

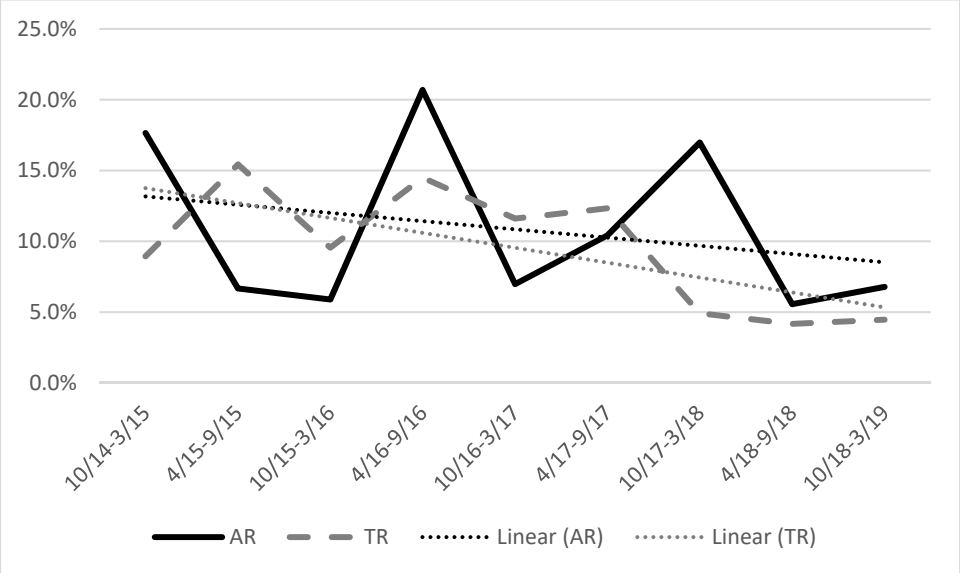
TR CFS Specialists who left, the total number of AR and TR CFS Specialists for that time period, and the resulting turnover rates for 6-month intervals from October 2014 through March 2019.

Table 4.1.4: 6-Month Turnover Rates for TR CFS Specialists and AR CFS Specialists Working AR Cases

	AR CFS Specialists			TR CFS Specialists		
	N who left	N employees	Turnover Rate	N who left	N employees	Turnover Rate
10/14-3/15	3	17	17.6%	26	291	8.9%
4/15-9/15	1	15	6.7%	48	311	15.4%
10/15-3/16	1	17	5.9%	32	335	9.6%
4/16-9/16	6	29	20.7%	51	352	14.5%
10/16-3/17	3	43	7.0%	39	336	11.6%
4/17-9/17	5	48	10.4%	36	292	12.3%
10/17-3/18	9	53	17.0%	14	285	4.9%
4/18-9/18	3	54	5.6%	13	312	4.2%
10/18-3/19	4	59	6.8%	15	336	4.5%

Because AR workers make up such a small percentage of the workforce (6% at the beginning 15% by the end of the demonstration), it is difficult to make meaningful comparisons with the TR workforce. On average, the 6-month turnover rate for AR-involved workers was 10.8% over the course of the demonstration period, compared with 9.5% for TR workers; an independent t-test indicated that this difference in average turnover rate was not statistically significant ($t(16) = 0.18$, $p = 0.598$). Figure 4.1.6 displays the 6-month turnover rates for AR and TR CFS Specialists during the demonstrations project.

Figure 4.1.6: 6-month Turnover Rates for AR and TR CFS Specialists



Receiving AR Training

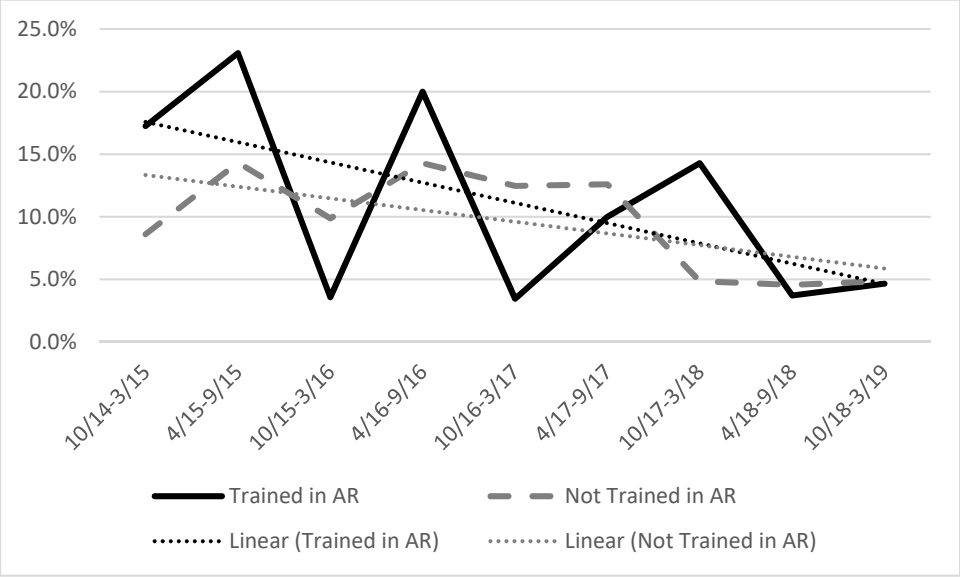
When defining AR involvement as having received AR training during or prior to the given time period, the AR turnover rate was still highly variable. Table 4.1.5 details the number of AR and TR CFS Specialists who left, the total number of AR and TR CFS Specialists for that time period, and the resulting turnover rates for 6-month intervals from October 2014 through March 2019.

Table 4.1.5: 6-Month Turnover Rates for TR CFS Specialists and AR CFS Specialist Trained in AR

	AR CFS Specialists			TR CFS Specialists		
	N who left	N employees	Turnover Rate	N who left	N employees	Turnover Rate
10/14-3/15	5	29	17.2%	24	279	8.6%
4/15-9/15	6	26	23.1%	43	300	14.3%
10/15-3/16	1	28	3.6%	32	324	9.9%
4/16-9/16	9	45	20.0%	48	336	14.3%
10/16-3/17	2	58	3.4%	40	321	12.5%
4/17-9/17	7	70	10.0%	34	270	12.6%
10/17-3/18	10	70	14.3%	13	268	4.9%
4/18-9/18	3	81	3.7%	13	285	4.6%
10/18-3/19	4	86	4.7%	15	309	4.9%

On average, the 6-month turnover rate for AR-trained workers was 11.1% over the course of the demonstration period, compared with 9.6% for workers not trained in AR; an independent t-test indicated that this difference in average turnover rate was not statistically significant ($t(16) = 0.02$, $p = .617$). Figure 4.1.7 displays the 6-month turnover rates for CFS Specialists trained and not trained in AR during the demonstration project.

Figure 4.1.7: 6-month Turnover Rates for CFS Specialists Trained and Not Trained in AR



Summary

In general, DCFS turnover rates trended downward during the demonstration project, with a noticeable drop occurring after October 2017. When assessing for differences in the turnover rates for AR and TR CFS Specialists, involvement in AR was defined 2 ways: 1) working on AR cases during or prior to the given time period, and 2) having received AR training during or prior to the given time period. Because AR workers make up such a small percentage of the CFS workforce, the AR turnover rate fluctuated substantially throughout the demonstration project. Ultimately, there were no differences in the average turnover rates for AR and TR CFS Specialists, regardless of how AR involvement was defined.

Overall Summary of CFS Organizational Outcomes

DCFS hypothesized that implementation of AR would be attractive to applicants with a social work background, resulting in a greater proportion of applicants and new CFS hires with social work experience and degrees. The evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.

DCFS also hypothesized that implementation of AR would result in an altered composition of the CFS workforce, with more staff having social work degrees. To attempt to answer this research questions, degree information for the CFS workforce was obtained from tables within Nebraska's published Annual Progress and Services Reports (APSRs) for the years 2012 to 2018. Overall, the trends of self-reported degree do not support the hypothesis that the CFS workforce has become more social work oriented during the implementation of AR. Additionally, the percentages of trainees, workers, and supervisors with a social work-related degree either remained stable or decreased over the course of the demonstration period. The implementation of AR does not appear to have had an effect on the proportion of the CFS workforce with social work degrees as hypothesized.

DCFS hypothesized that implementation of AR would increase job satisfaction for those involved in AR work. To assess the hypothesized change in job satisfaction over time, UNL-CCFL originally planned on using DCFS Human Resources job satisfaction survey data that is collected annually. However, it was later discovered that these data could not be disaggregated to an individual level to permit the necessary breakdowns to analyze differences between AR and TR-involved staff. By the time this was known, the opportunity to conduct a longitudinal survey of job satisfaction had passed. Instead, UNL-CCFL distributed a brief survey and facilitated focus groups with a small sample of workers. Results support the hypothesis that AR workers experience higher job satisfaction, especially for those workers who are able to primarily carry AR caseloads.

Finally, DCFS hypothesized that the implementation of AR would decrease turnover. In general, DCFS turnover rates trended downward during the demonstration project, with a noticeable drop occurring after October 2017. When assessing for differences in the turnover rates for AR and TR CFS Specialists, involvement in AR was defined 2 ways: 1) working on AR cases during or prior to the given time period, and 2) having received AR training during or prior to the given time period. Because AR workers make up such a small percentage of the CFS workforce, the AR turnover rate fluctuated substantially throughout the demonstration project. Ultimately, there were no differences in the average turnover rates for AR and TR CFS Specialists, regardless of how AR involvement was defined.

Chapter 2: Recurrence and Permanency Analyses

These long-term outcomes were assessed using DCFS administrative data on all intakes accepted for assessment and determined to be AR-eligible (for more information on this data source, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*).

Incidence of Maltreatment Allegations

In order to assess differences between AR and AR-eligible TR families and subsequent incidents of maltreatment allegations, intake reports provided by DCFS via N-FOCUS were examined for the demonstration period. A chi-square of independence was performed to examine the relationship between counts of accepted intakes and track assignment. In total, 1560 AR families only experienced one intake (the original intake that included this family in the demonstration study; no repeated accepted intakes were observed), compared to 1409 TR families only experiencing one intake. There were 380 AR families with a total of 2 accepted intakes (the family only came back to the system once after the initial intake), compared to 416 TR families. Overall, the relationship between counts of repeated accepted intakes and track assignment was significant, χ^2 (DF=4, N =6861) = 35.72, p = 0.00. Table 4.2.1 details the total number of repeated accepted intakes per family by track assignment. The rows represent families with as low as only 1 reported intake to up to more than 5 reported intakes through the demonstration period.

Table 4.2.1 Comparison of Total Accepted Intakes per Family

Total Accepted Intakes Per Family	AR	TR
1	1560	1409
2	380	416
3	192	159
4	77	74
>=5	61	76
Total	**2270**	**2134**

In order to examine the expected duration for a repeated intake report to happen, a survival analysis was performed to compare AR and TR groups. The Cox proportional hazard models (right censoring) were used for this analysis. The event was defined as a second accepted intake for the same family (Master Case). The time of failure was calculated as the time period between the first and second intake report (if ever) within the same family. A 10% increased probability of repeated accepted intakes was observed for AR-eligible TR families, compared to families assigned to AR; however, this result was non-significant. Table 4.2.2 displays the hazard ratios, standard errors, z-scores, p-values, and confidence interval for this analysis. When holding risk level constant, a 20% increased probability of repeated accepted intakes was observed for AR-eligible TR families, compared to AR families. The p-value for this model is 0.002, meaning the probability difference between AR and TR families is significant when controlled for risk level. Table 4.2.3 displays the hazard ratios, standard errors, z-scores, p-values, and confidence interval for this analysis when using risk level as a covariate.

Table 4.2.2: Survival Analysis of Repeated Accepted Intakes

	Haz. Ratio	SE	z-score	P-value	95% Confidence Interval	
Traditional Response	1.10	0.06	1.81	0.07	0.99	1.23

Table 4.2.3: Survival Analysis of Repeated Accepted Intakes using Risk Level as a Co-Variate

	Haz. Ratio	SE	z-score	P-value	95% Confidence Interval	
Risk Level	1.64	0.06	13.43	0	1.53	1.77
Traditional Response	1.20	0.07	3.12	0.002	1.07	1.35

Incidence of Substantiated Maltreatment

A chi-square of independence was performed to examine the relationship between counts of substantiated intakes and track assignment. In total, for AR families with only one accepted intake, 11 resulted in a substantiation, while for TR families with only one accepted intake, 39 resulted in a substantiation. For families with a total of 2 accepted intakes, there were 24 AR families with at least one substantiated incident of maltreatment, compared to 37 TR families. Overall, the relationship between counts of substantiations and track assignment was significant, χ^2 (DF=4, N =248) = 10.58, p = 0.032. Table 4.2.4 details the total number of families with at least one substantiation by total counts of accepted intakes and track assignment. The rows represent families with as low as only 1 intake to up to more than 5 reported intakes through the demonstration period.

Table 4.2.4: Comparison of Families with Substantiated Intakes by Track Assignment

Total Intakes per Family	AR	TR
1	11	39
2	24	37
3	22	21
4	13	15
>=5	20	25
Total	**90**	**137**

To examine the estimated time that it takes for a repeated substantiated case to occur for AR and TR families, a survival analysis was performed. Neither of the examined models were significant; however, this may have been due to the small sample size. Again, the Cox proportional hazard models (right censoring) were used for this analysis. The event was defined as a subsequent substantiated maltreatment allegation. The time of failure was calculated as the time period between the first intake and a repeated intake with a substantiated finding (if ever) within the same family. A 10% increase in the probability of a subsequent substantiated maltreatment was observed for AR-eligible TR families, compared to families assigned to AR; however, this result was non-significant (p =0.84). Table 4.2.5 displays the hazard ratios, standard errors, z-scores, p-values, and confidence interval for this analysis. When holding risk level constant, only a 5% increase in the probability of a subsequent substantiated

maltreatment was observed for AR-eligible TR families, compared to families assigned to AR. This difference is also not significant (p = 0.91). Table 4.2.6 displays the hazard ratios, standard errors, z-scores, p-values, and confidence interval for this analysis.

Table 4.2.5: Survival Analysis of Substantiated Maltreatment

	Haz. Ratio	SE	z-score	P-value	95% Confidence Interval	
Traditional Response	1.10	0.51	0.2	0.84	0.44	2.72

Table 4.2.6: Survival Analysis of Substantiated Maltreatment with Risk Level as Co-Variate

	Haz. Ratio	SE	z-score	P-value	95% Confidence Interval	
Risk level	1.15	0.29	0.56	0.58	0.70	1.90
Traditional Response	1.05	0.49	0.11	0.91	0.42	2.62

Incidence of Removals to Out-of-Home Care

A chi-square of independence was performed to examine the relationship between counts of out-of-home placements and track assignment. In total, 123 AR families had at least one child removed to an out-of-home placement during the demonstration period, compared to 145 TR families. Overall, the relationship between out-of-home removals and track assignment was not significant at the family level, χ^2 (DF=1, N =339) = 3.16, p = 0.075. Table 4.2.7 details the total number of out-of-home placement per family by track assignment.

Table 4.2.7: Counts of Families with a Placement

	AR	TR
Families with Out-of-Home Placements	123	145
Families with Other types of Placements	41	30
Total	**164**	**175**

Overall, the relationship between out-of-home removals and track assignment was significant at the individual level, χ^2 (DF=1, N =927) = 4.93, p = 0.026, meaning there was a statistically significant difference in out-of-home placements for individuals assigned to the AR and TR programs. Table 4.2.8 details the total number of individuals experiencing an out-of-home placement by track assignment.

Table 4.2.8: Counts of Individuals with a Placement

	AR	TR
Individuals with Out-of-Home Placements	279	321
Individuals with Other types of Placements	177	150
Total	**456**	**471**

Conclusion

There was a significant relationship between repeated accepted intakes and track assignment. Furthermore, when controlling for risk, a significant increased probability of repeated accepted reports was observed for TR families compared to AR families. The relationship between number of subsequent substantiations and track assignment was also significant. However, when examining the expected

duration for a subsequent substantiated case, neither of the examined survival models were significant; this may have been due to the small sample size. Finally, although the overall relationship between out-of-home removals and track assignment was not significant at the family level, it was significant at the individual level, indicating a significant difference in out-of-home placements for individuals assigned to the AR and TR programs.

Chapter 3: Response Reassignment Analyses

Key Questions:

- What is the number and proportion of families reassigned from AR to TR?
- What are the circumstances for track re-assignment?

If circumstances change or information is learned about families that that warrant heightened concerns after the initial intake, families may be reassigned from AR to TR. If a family is reassigned from AR to TR, the reason is documented in N-FOCUS. These data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*).

Response Reassignment Analyses

In total, 2649 intakes were assigned to AR throughout the demonstration period. A total of 402 intakes (15%) subsequently changed tracks to TR (TR, court, or non-court). These data included 8 reasons that track changes may occur:

1) A new intake for the family was accepted and assigned to a Traditional Response;
2) Correction or update to Intake Screening Decision, Response Priority, or Alternative Response Ineligible Criteria;
3) Law Enforcement accepts the report for investigation of child abuse and/or neglect;
4) Parent(s) request that the case be managed through a Traditional Response;
5) Safety Assessment concludes that a safety threat is present, and an in-home safety plan cannot manage child safety. Includes use of Approved Informal Living Arrangement as part of the safety plan;
6) The CFS Specialist is unable to assess child safety;
7) The CFS Specialist made contact with the family and additional information was identified that met Ineligible Criteria; and
8) The R.E.D. Team reviewed the case and made a decision to change to a Traditional Response.

Table 4.3.1 details the response reassignment reason selected, including 1) the total number of AR cases that had a response reassignment and 2) the number and percentage of AR cases for each response reassignment reason selected. Percentages indicate the percent of total AR cases for each reassignment reason selected (out of all cases with an associated reason). The discrepancy in the total is due to AR cases changing tracks without an associated response reassignment reason selected.

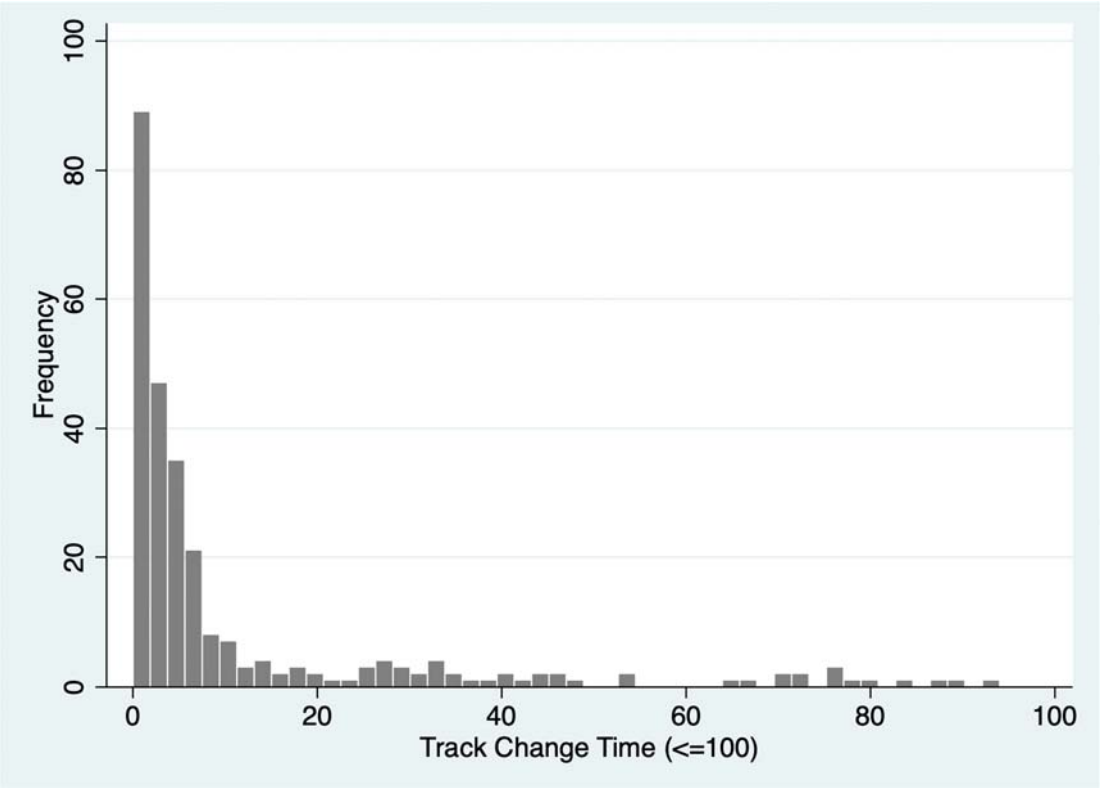
Table 4.3.1: Frequency of Response Reassignments by Selected Reason

Selected Reason	Frequency	Percentage
1	19	7%
2	97	34%
3	37	13%
4	2	1%
5	35	12%
6	4	1%
7	61	21%

8	31	11%
Total	286	100%

In order to assess when track changes most often occurred, the number of days between the intake received date and the track change date were calculated. In total, there were 274 intakes that had an associated track change date allowing for this calculation. Among those, 74% of the track changes occurred between 0-10 days after the initial intake received date, 11% changed tracks between 10-30 days, and the remaining 15% changed tracks after 30 days. Figure 4.3.1 details the distribution of track changes over time.

Figure 4.3.1: Distribution of Time to Track Change



Conclusion

The most common response reassignment reason selected was due to a correction or update to the Intake Screening Decision, Response Priority, or Alternative Response Ineligible Criteria. Nearly one third of track changes over the course the demonstration period were associated with this reason. This was followed by the CFS Specialist making contact with the family and learning additional information that met Exclusionary Criteria. Other common track change reasons included law enforcement notifying DCFS that they would continue investigating the child abuse or neglect intake; the presence of a safety threat that could not be managed through an in-home safety plan; or a RED Team review that resulted in a decision to change the case to TR. In total, approximately 15% of AR Intakes required response reassignment from AR to TR.

Chapter 4: Needs and Services

In order to get a complete picture of family needs and the services being used to address these needs, data were examined from a number of sources, including administrative data from N-FOCUS, SharePoint data, Worker Survey data, and Family Survey data (for more information on these data sources, see *Appendix A, Summary of Evaluation Data Sources*).

Needs of Families

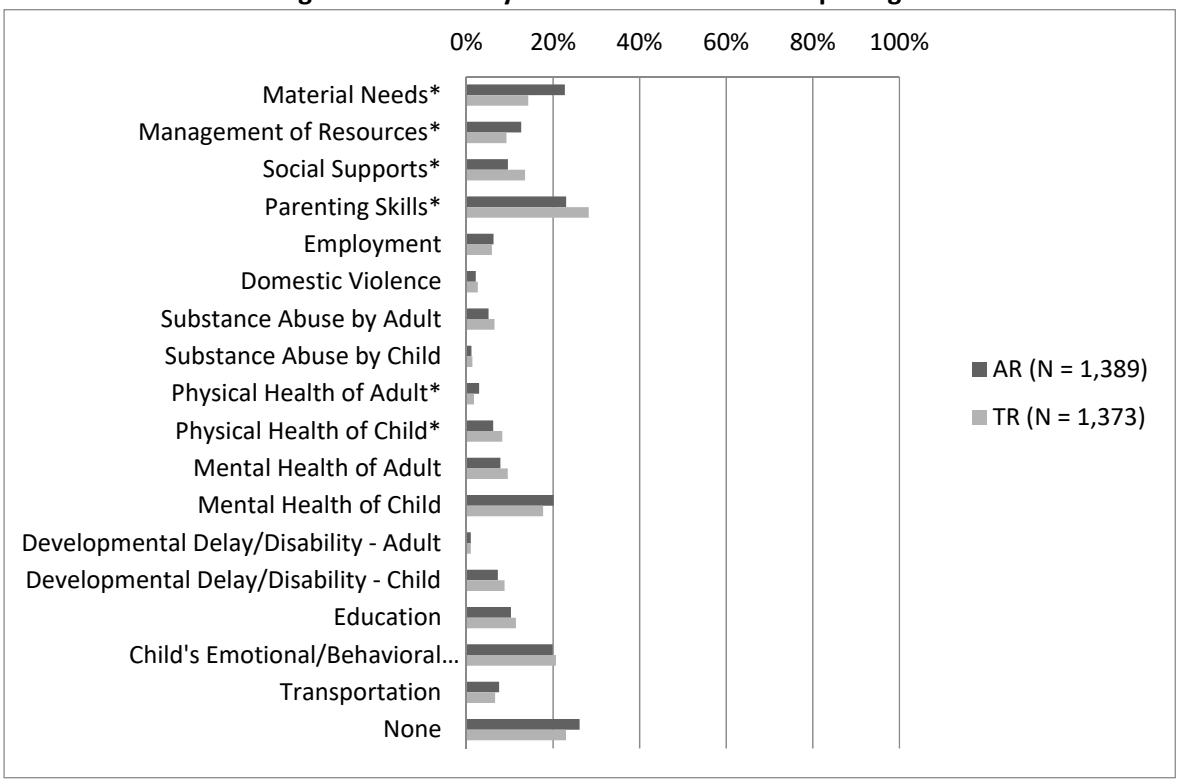
Key Question:

- Do the needs presented by AR families differ from needs presented by TR families?
- Are AR workers better able to address the needs of AR families compared to TR workers?

In the AR Worker End-of-Case Survey (Worker Survey), workers are asked to provide case-specific information about the types of needs the family presented with at the beginning of the case. A total of 2,762 (1,389 AR cases, 1,373 TR cases) worker surveys were completed for cases that closed between October 1, 2014 and June 30, 2019. The most common needs were in the areas of parenting skills (26%), child's emotional/behavioral adjustment (20%), mental health of a child (19%), and material needs (19%). Additionally, a quarter (25%) of families were identified as having none of the listed needs.

Due to random assignment we would expect the characteristics of AR and TR families to be similar, including the types of needs that families present. For the most common needs presented, AR families were significantly more likely to present with material needs, $\chi2(1, N = 2,762) = 32.84$, $p = 0.00$, while TR families were significantly more likely to present with parenting skills needs, $\chi2 (1, N = 2,762) = 9.87$, $p = 0.00$. Additionally, AR families were significantly more likely to present with management of resource needs, $\chi2 (1, N = 2,762) = 8.26$, $p = 0.00$, and physical health of an adult, $\chi2 (1, N = 2,762) = 4.35$, $p = 0.04$, while TR families were significantly more likely to present with social support needs, $\chi2 (1, N = 2,762) = 10.66$, $p = 0.00$, and needs associated with the physical health of a child, $\chi2 (1, N = 2,762) = 4.58$, $p = 0.03$. Figure 4.4.1 displays the distribution of family needs present at case opening for AR and TR families. Note that each family can have multiple needs.

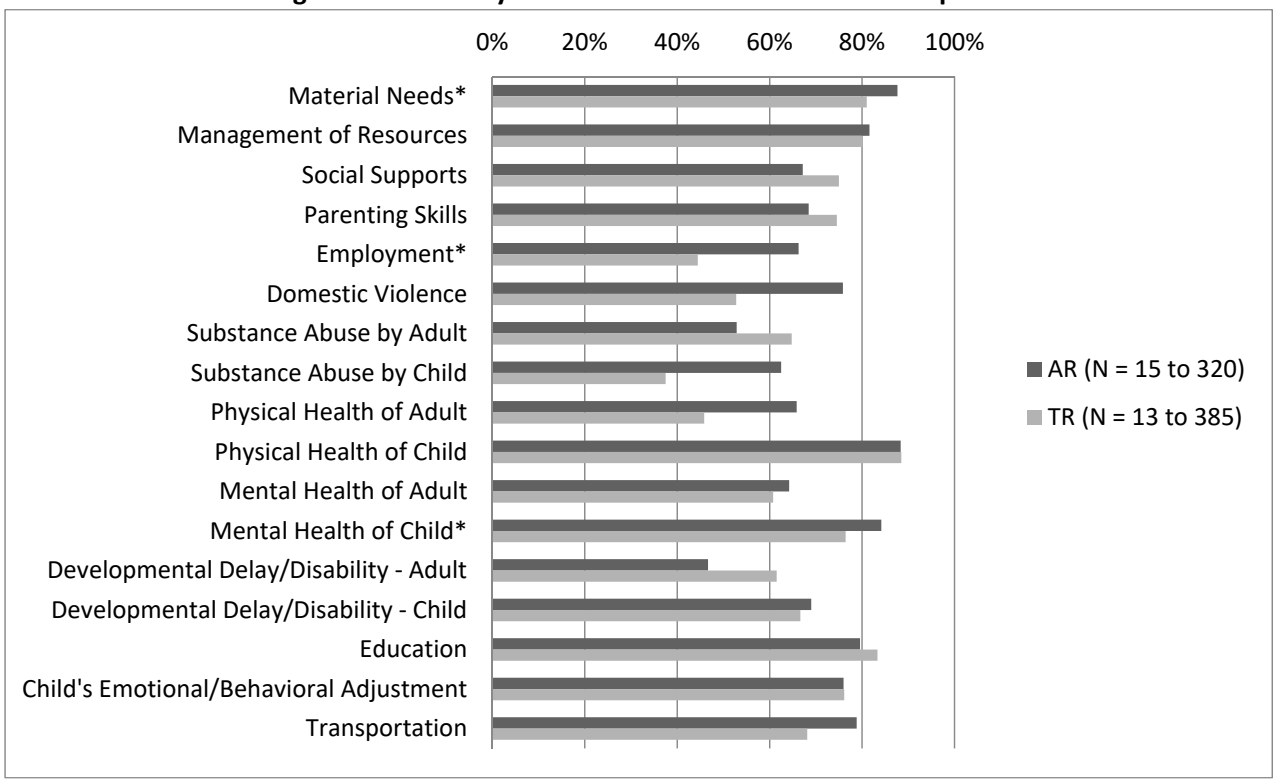
Figure 4.4.1: Family Needs Present at Case Opening



*These differences are statistically significant ($p < .05$)

If a family was identified as presenting with a need, workers were then asked to indicate whether or not they were able to address that need with the family while the case was open. Overall, workers indicated that they were usually able to address the identified needs with the family while the case was open, regardless of track assignment. However, workers indicated that they were significantly more likely to address the needs of AR families regarding material needs, χ^2 (1, N = 511) = 4.19, p = 0.04, employment, χ^2 (1, N = 167) = 8.06, p = 0.01, and needs associated with the mental health of a child, χ^2 (1, N = 520) = 4.94, p = 0.03, compared to TR families. Figure 4.4.2 displays the distribution of needs that were addressed with AR and TR families.

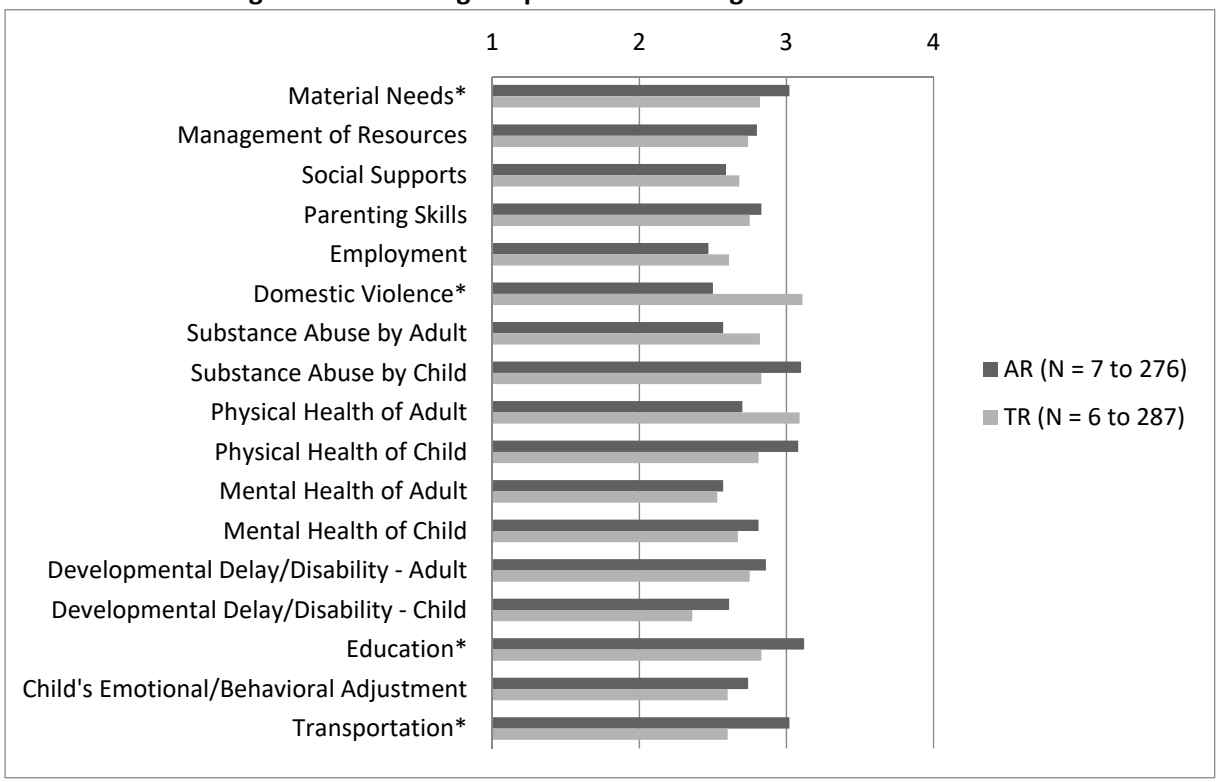
Figure 4.4.2: Ability to Address Need while Case Was Open



*These differences are statistically significant ($p < .05$)

If workers indicated that they were able to address a need during their work with the family, then they were asked to rate the extent to which the family improved on each of the identified needs. Each need was rated on a 4-point scale of improvement (1 = None, 2 = A little, 3 = Some, 4 = A lot). Overall, workers indicated that families' needs improved at least some during their involvement with DCFS. Workers indicated a significantly greater improvement for AR families regarding material needs, t (432) = 2.46, p = 0.01, education needs, t (240) = 2.44, p = 0.02, and transportation needs, t (142) = 2.59, p = 0.01. Significantly greater improvement in needs associated with domestic violence were found for TR families, t (39) = 2.31, p = 0.03. Figure 4.4.3 shows the average improvement rating of each need for AR and TR families.

Figure 4.4.3: Average Improvement Rating of Needs Addressed



Services Provided

Key Question:

- Are AR families more or less likely to receive contracted services than TR families?
- Do the services and supports received by AR families differ from those received by TR families?

Administrative Data

According to N-FOCUS data, a total of 4,715 AR-eligible cases opened and closed between October 1, 2014 and June 30, 2019. Most of these families (3,911 families, 83%) did not receive a service; although these data only include services paid for through a DCFS contract. In total, 804 cases (17%) received one or more types of services. Of those families that received a service, 572 (71%) were AR and 232 (29%) were TR. This indicates that AR families were more than twice as likely to receive a contracted service compared to TR families.

Of the 804 cases that received a service, the two most common service types being provided to both AR and TR families were family support services and travel time and distance. However, AR families were more likely to receive services based around material needs, such as electric, motor vehicle gas, and grocery/meal purchases, while TR families were more likely to be provided services around out out-of-maintenance, parent time/supervised visits, and were more likely to be drug tested. AR families received a greater variety of service types compared to TR families; AR families received a total of 109 different

types of services and TR families received a total of 95 different types of services. On average, both AR and TR received 3 types of services per family, with both AR and TR ranging from 1-9 service types per family. Table 4.4.1 lists the 5 most frequently provided service types and the number and percentage of AR and TR families receiving that type of service.

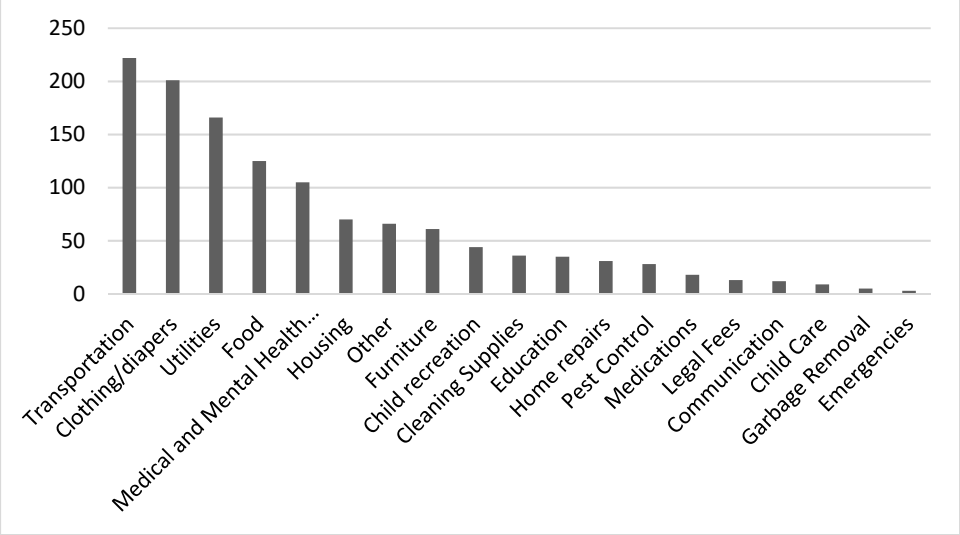
Table 4.4.1: Top 5 Service Types Provided to Families

AR Families (N=572)		TR Families (N=232)	
Service Type	# (%)	Service Type	# (%)
1. Family Support Services	251 (43%)	1. Family Support Services	97 (42%)
2. Travel Time and Distance	147 (26%)	2. Travel Time and Distance	51 (22%)
3. Electric	91 (16%)	3. Out-of-Home Maintenance	43 (19%)
4. Motor Vehicle Gas	88 (15%)	4. Drug Test Lab Confirmation	34 (15%)
5. Grocery/Meal Purchase	68 (12%)	5. Parent Time/Supervised Visits	32 (14%)

SharePoint Database

In addition to the regular reports generated from N-FOCUS, AR workers are asked to document service information in a SharePoint database. Although these data are not provided for AR-eligible cases assigned to TR, these data allow for a more complete examination of the services and service costs specific to AR families. In total, the SharePoint database included 610 families that received a service between October 1, 2014 and June 30, 2019. According to the SharePoint data, it appears that the majority (97%) of services were paid for by DCFS and the remaining 3% were paid for by an alternative source (e.g., donations, community response). Additionally, it appears that the majority of services (76%) are being used to address concrete supports for parents. Figure 4.4.4 lists the most frequently provided services for AR families documented in SharePoint.

Figure 4.4.4: SharePoint Services Provided to Families



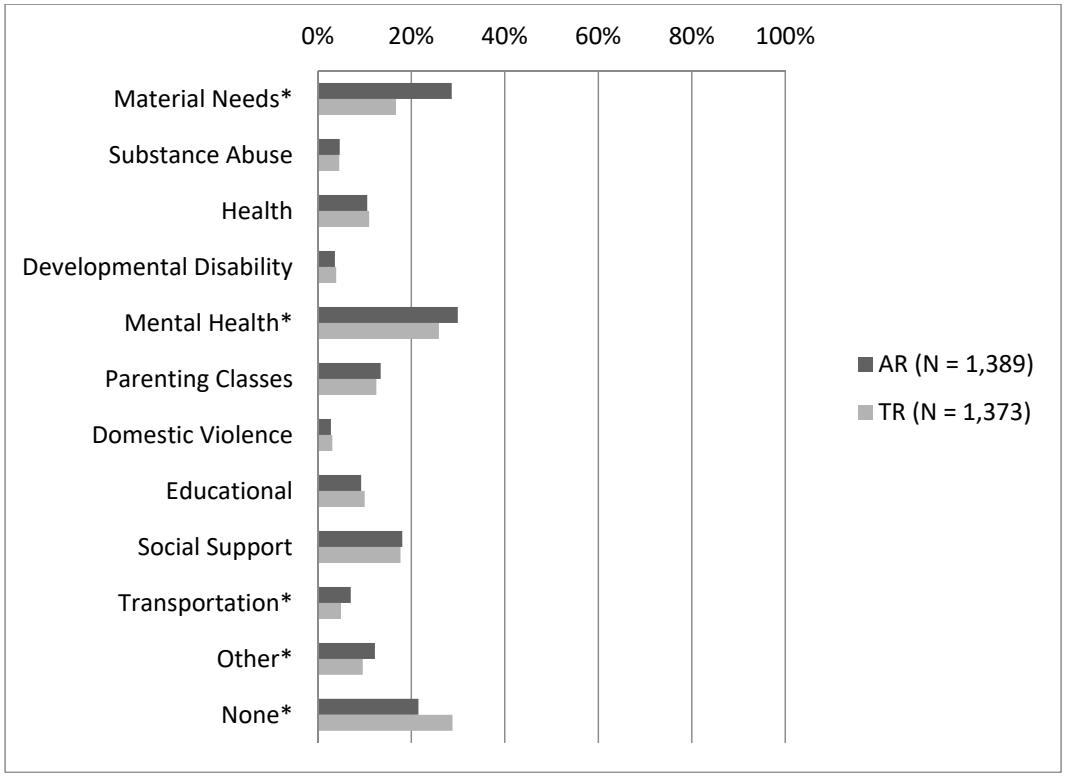
Worker Survey Data

Workers are asked to give case-specific information about the types of services provided to families, the categories of service providers, and indicate the families' level of participation in those services.

Workers for most families (1,738 families, 63%) indicated that they had either directly provided families with services or given them information about services. AR families were significantly more likely to receive at least one service compared to TR families, χ^2 (1, N = 2,762) = 35.82, p= 0.00.

The most commonly provided services were related to mental health, social support services, and services to address material needs. Furthermore, AR families were significantly more likely to receive mental health services, χ^2 (1, N = 2,762) = 5.54, p= 0.02, with 30% of AR families and 26% of TR families receiving this service. There was not a significant difference between AR (18%) and TR (18%) families in the receipt of social support services, χ^2 (1, N = 2,762) = 0.07, p= 0.78. However, AR families were also significantly more likely to receive services to address material needs, χ^2 (1, N = 2,762) = 55.68, p= 0.00, with 29% of AR families and 17% of TR families receiving this service. Additionally, AR families were significantly more likely than TR families to receive transportation services, χ^2 (1, N = 2,762) = 5.41, p= 0.02. If other services were provided that were not listed on the survey, workers were asked to fill in this information. Other common services listed include Family Supports, Intensive Family Preservation, and Legal Aid. Additionally, workers indicated that both AR and TR families were given DHHS Resource Guides, which detail where and how families can attain services to cover basic needs as well as information about child and family programs. Figure 4.4.5 displays the distribution of service types provided to AR and TR families.

Figure 4.4.5: Services Provided to Families

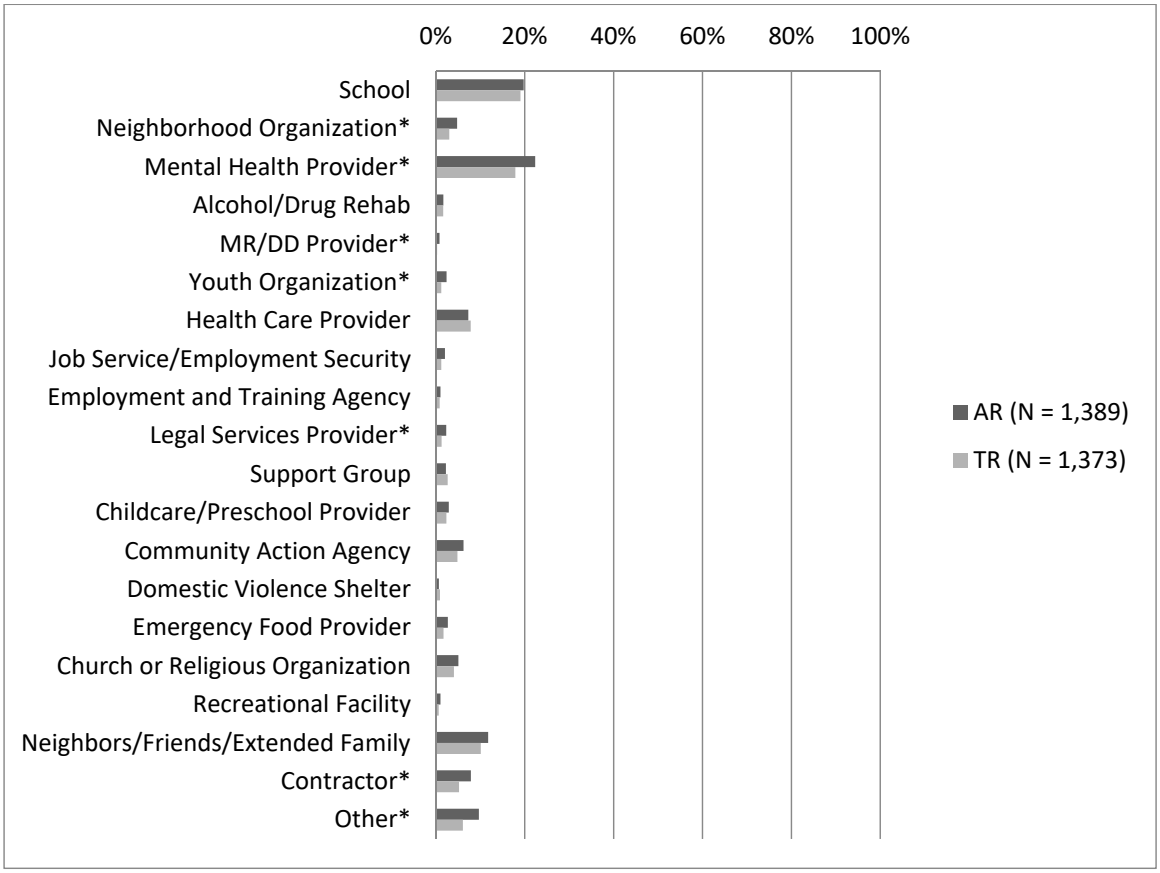


*These differences are statistically significant ($p < .05$)

Workers were also asked to give information about the categories of service providers that were involved with these families. Overall, the most common categories of service providers were mental health providers, schools, and neighbors/friends/extended family. AR families were significantly more

likely to receive services from mental health providers, χ^2 (1, N = 2,762) = 8.58, p= 0.00, with 23% of AR families and 18% of TR families working with these providers. However, there were no significant differences between AR and TR families receiving services from schools, χ^2 (1, N = 2,762) = 0.23, p= 0.63, (AR 20%; TR 19%), or receiving services from neighbors/friends/extended family, χ^2 (1, N = 2,762) = 2.01, p= 0.16, with 12% of AR families and 10% of TR families working with these providers. Additionally, AR families were significantly more likely than TR families to receive service from a neighborhood organization, χ^2 (1, N = 2,762) = 5.67, p= 0.02, a mental retardation/developmental disability (MR/DD) provider, χ^2 (1, N = 2,762) = 3.93, p= 0.05, a youth organization, χ^2 (1, N = 2,762) = 5.56, p= 0.02, legal service providers, χ^2 (1, N = 2,762) = 4.32, p= 0.04, or contractors, χ^2 (1, N = 2,762) = 8.03, p= 0.01. If there were other categories of service providers that were not listed on the survey, workers were asked to fill in this information. Other common service provider categories included DCFS, Alternative Response program/funds, and the Early Development Network. The following graph shows the distribution of service providers involved with AR and TR families. Figure 4.4.6 shows the distribution of service providers involved with AR and TR families.

Figure 4.4.6: Providers of Services



*These differences are statistically significant ($p < .05$)

Match Between Services and Family Needs

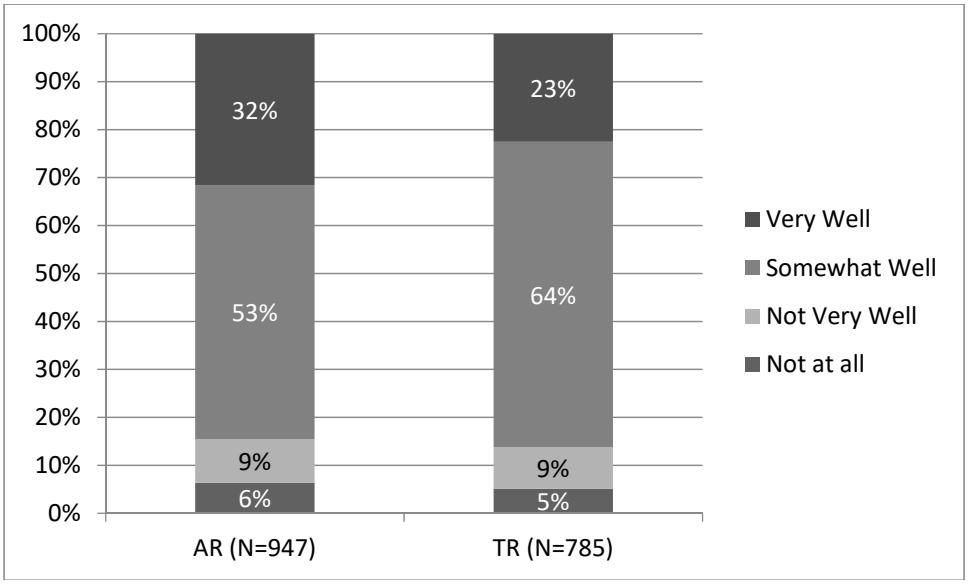
Key Question:

- Are the services received by AR families better matched to their individual needs than services received by TR families?
- Was the overall adequacy of services and supports provided to families improved as a result of AR implementation?

Worker Survey

If a worker indicated that a service was provided to a family, they were then asked to indicate the degree to which they believed they were able to match that service to the family's needs. Most workers (85%) reported that they were able to match services to the needs of the family somewhat well or very well. Overall, workers did not report a significantly greater degree of matching services to AR families compared to TR families, $t(1,730) = 1.65$, $p = 0.09$. Figure 4.4.7 shows the distribution of responses for AR and TR workers.

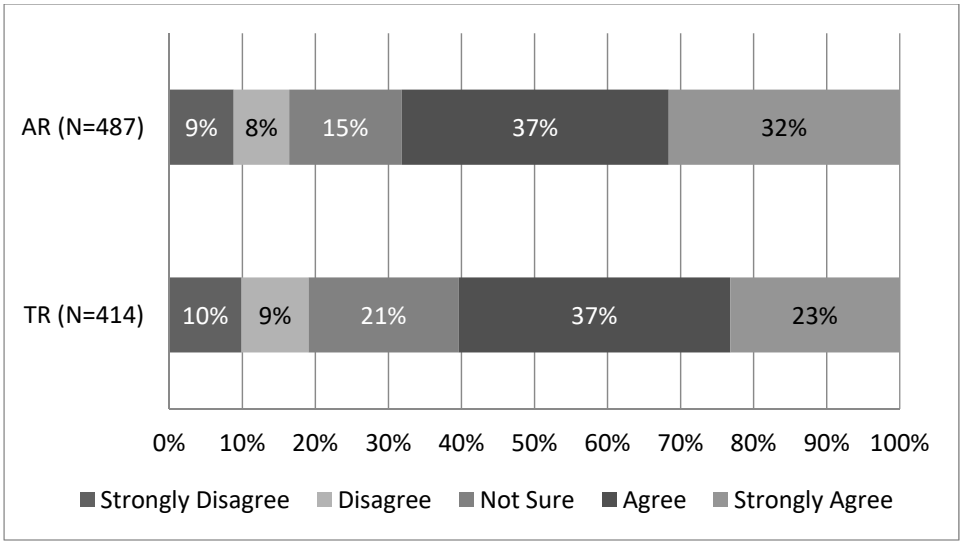
Figure 4.4.7: Ability to Match Service to Family's Needs



Family Survey

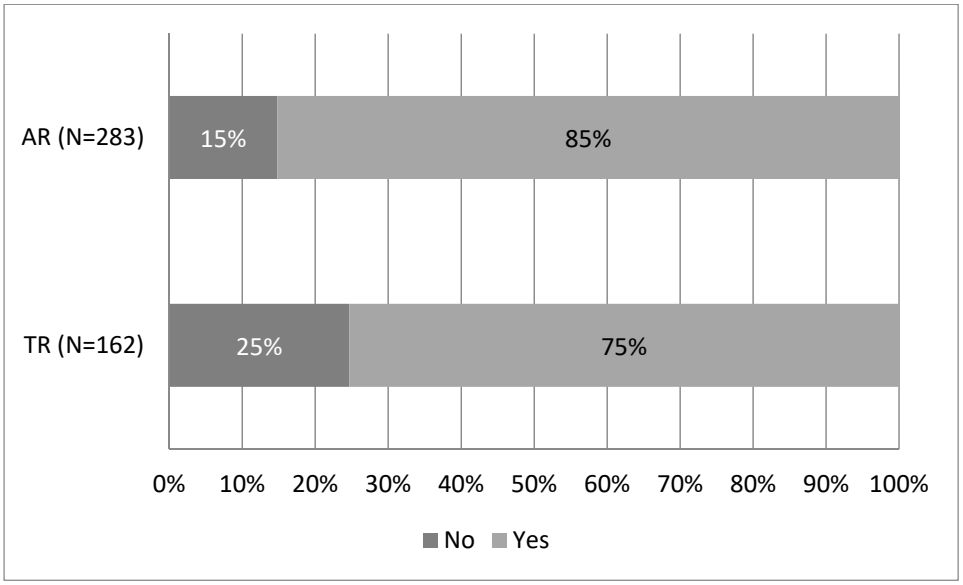
The AR Family Survey asks families to report their level of agreement with the statement, "My family got the help we really need from my worker." Overall, the majority of families (582 families, 65%) agreed or strongly agreed with this statement. When examining these responses by response assignment, AR families reported agreement at a significantly higher rate (332 families, 68%) than TR families (250 families, 60%), $t(899) = 2.44$, $p=0.02$. Figure 4.4.8 displays the distribution of responses between AR and TR families.

Figure 4.4.8: Percent of Families Who Reported Receiving the Help They Needed



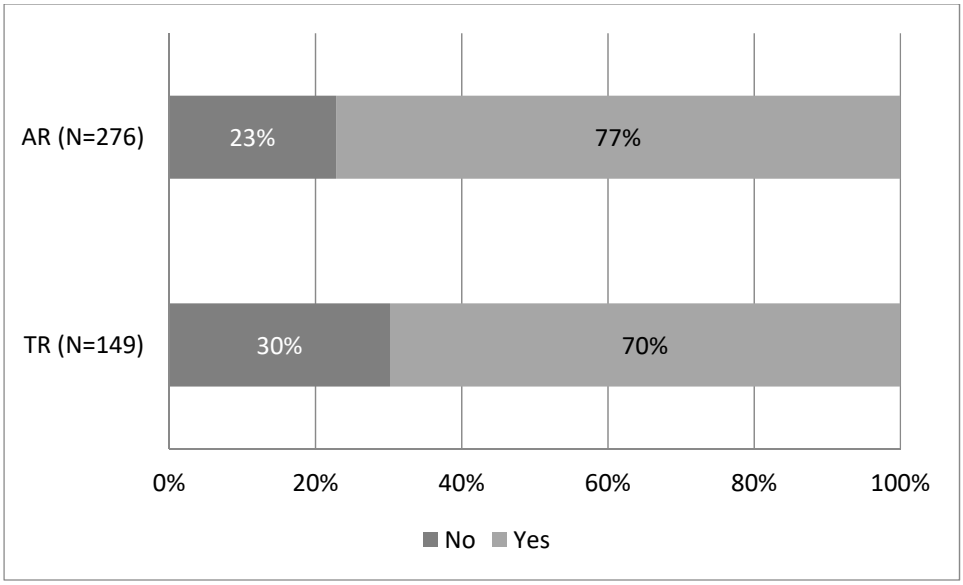
If families received support or services, they were asked to indicate if it was "the kind of help you needed?" AR families (241, 85%) reported that they received the kind of help the needed significantly more frequently than TR families (122, 75%), $\chi 2$ (1, N = 445) = 6.65, p= 0.01. Figure 4.4.9 displays the distribution of responses between AR and TR families.

Figure 4.4.9: Percent of Families Who Reported Receiving the Kind of Help They Needed



Additionally, families were asked if the support or services they received was "enough to really help?" Overall, AR families (213 families, 77%) reported receiving enough support or services to help more frequently than TR families (104 families, 70%); although this was not statistically significant, $\chi 2$ (1, N= 425) = 2.78, p= 0.09. Figure 4.4.10 displays the distribution of responses between AR and TR families.

Figure 4.4.10: Percent of Families Who Reported Receiving Enough Services to Really Help



Timeliness of services

Key Question:

- Do AR families get connected to and receive services sooner than TR families?

Administrative Data

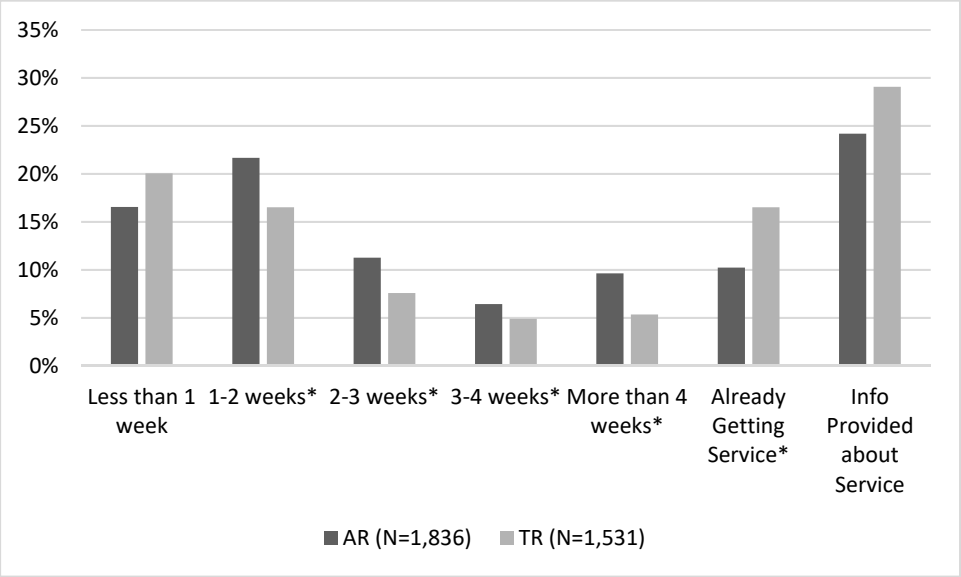
In order to assess the timeliness of service delivery, using N-FOCUS service data, the number of days to service was calculated using the date the first service was provided minus the date the initial intake was received. 804 families (572 AR/232 TR) were recorded as having received at least one service. On average, AR families received their first service after 44 days and TR families received their first service after 30 days. According to these data, TR families appear to be receiving services significantly sooner than AR families, $t(802) = 3.26$, $p = 0.00$.

Worker Survey

If a service was provided to a family, workers were asked to indicate how soon that service was provided. According to these data, it appears that TR families, more often than AR families, are receiving services within less than one week of the initial report, although these findings are not significant, χ^2 (1, *N = 3,367*) = 0.08, p= 0.77. However, AR workers are reporting significantly more often that TR workers that services are provided within 1-2 weeks, χ^2 (1, *N = 3,367*) = 34.54, p= 0.00; 2-3 weeks, χ^2 (1, *N = 3,367*) = 24.49, p= 0.00; 3-4 weeks, χ^2 (1, *N = 3,367*) = 8.16, p= 0.00; or more than 4 weeks, χ^2 (1, *N = 3,367*) = 34.16, p= 0.00. Workers reported that TR families were significantly more likely than AR families to already have services in place before DCFS involvement, (χ^2 (1, *N = 3,367*) = 10.38, p = 0.00). Additionally, workers for both AR and TR families indicated that families were only provided with

information about services at about the same frequency, χ^2 (1, *N = 3,367*) = 0.04, *p* = 0.85). Figure 4.4.11 shows the distribution of service timeliness for AR and TR families, as reported by AR and TR workers.

Figure 4.4.11: Timeliness to Service

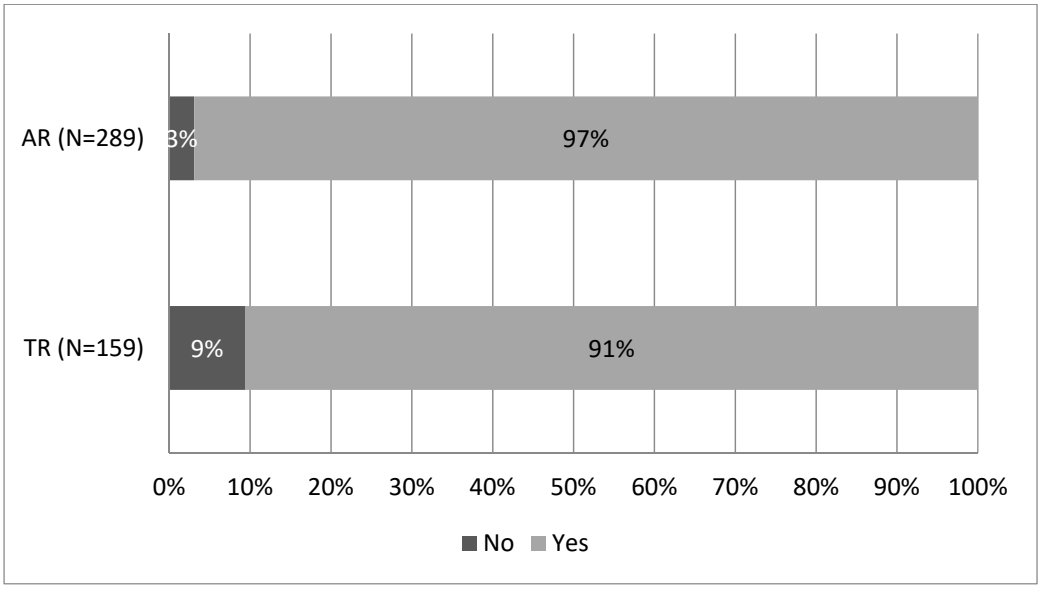


*These differences are statistically significant (*p* < .05)

Family Survey

Families were asked to indicate whether or not they received support or services at the time they needed it. Overall, most families (424, 95%)indicated that they received support or services when they needed it; however, AR families reported this significantly more (280 families, 97%) than TR families (144 families, 91%), χ^2 (1, N = 448) = 8.08, p= 0.00. The following graph shows the distribution of responses for AR and TR families. Figure 4.4.12 shows the distribution of responses for AR and TR families.

Figure 4.4.12: Percent of Families Who Reported Receiving Services at the Time They Needed



Barriers to Providing Services

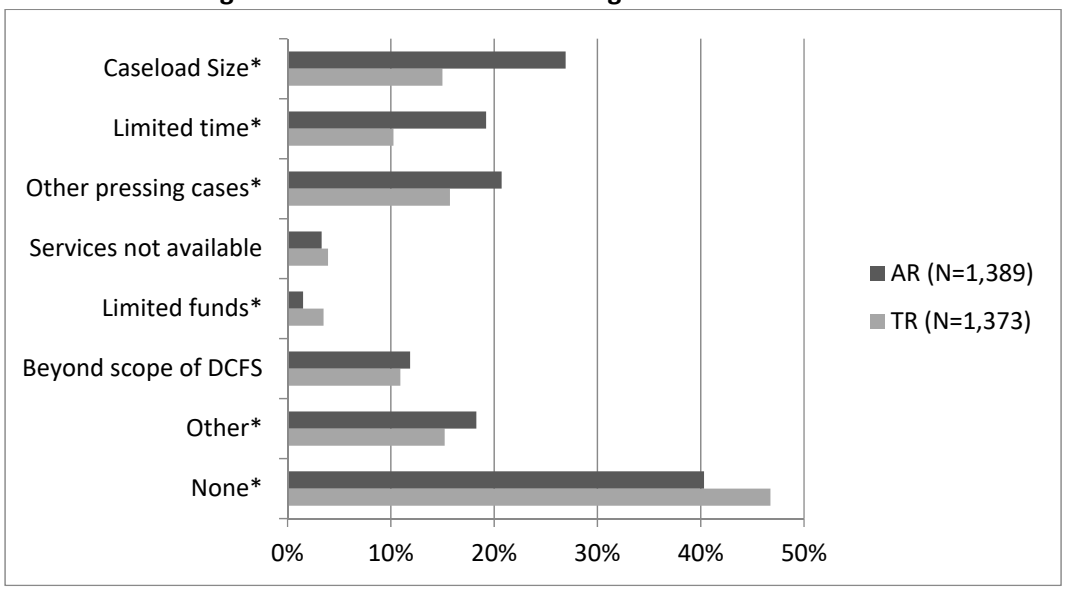
Key Question:

- Are AR workers more likely than TR workers to experience barriers in their provision of services to families?

Worker Survey

Workers were asked to provide information about any barriers they experienced in providing services to families. Overall, 44% of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by other pressing cases on their caseload, and limited staff time to work with families. AR workers were significantly more likely than TR workers to report barriers due to caseload, $\chi 2$ (1, N = 2,762) = 59.2, p= 0.00. AR workers were also significantly more likely than TR workers to report barriers due to other pressing cases, $\chi 2$ (1, N = 2,762) = 11.58, p= 0.00, and limited time, $\chi 2$ (1, N = 2,762) = 43.97, p= 0.00. However, TR workers were significantly more likely than AR workers to report barriers due to limited funds, $\chi 2$ (1, N = 2,762) = 11.16, p= 0.00, or to report no barriers were experienced, $\chi 2$ (1, N = 2,762) = 11.66, p= 0.00. If other barriers were experienced that were not listed on the survey, workers were asked to fill in this information. Workers on both tracks reported additional barriers such as cultural or language issues, problems with the family refusing to engage or being uncooperative, and custody issues between parents. Figure 4.4.13 displays the distribution of barriers experienced by AR and TR workers.

Figure 4.4.13: Barriers to Providing Services to Families



*These differences are statistically significant ($p < .05$)

Conclusion

Family Needs

Over a quarter of families were identified as having none of the needs listed in the Worker Survey. However, for all AR-eligible families that presented with needs, the most common needs were in the areas of parenting skills, child's emotional/behavioral adjustment, mental health of a child, and material needs. Looking at the differences between AR and TR families, AR families were more likely to be identified as having needs related to physical health of an adult, management of resources, and material needs. TR families were more likely to present with needs related to parenting skills, social supports, and the physical health of a child. Both AR and TR workers indicated that they were able to address family needs through their work with the family; however, workers indicated that they were significantly more likely to address the needs of AR families than TR families regarding material needs, employment, and needs associated with the mental health of a child. Furthermore, both AR and TR workers indicated that they were able to improve the families' needs at least somewhat. Workers indicated a significantly greater improvement for AR families related to education, transportation, and material needs, while a significantly greater improvement in needs associated with domestic violence were found for TR families.

Services Provided

Overall, it appears that most families did not receive a service; however, for those families that received a service, AR families were more than twice as likely to receive services than TR families. AR families also received a greater variety of services than TR families. For contracted services documented in N-FOCUS, the two most common types of services provided for both AR and TR families were around family support services and travel time/distance. AR families were more likely to receive services related to material needs, such as electricity, motor vehicle gas, and grocery/meal purchases, while TR families were more likely to be provided services around out out-of-maintenance, parent time/supervised visits, and were more likely to be drug tested. AR and TR families received an average of 3 types of services, with both AR and TR ranging from 1-9 service types per family.

Additional service information was provided by AR workers for AR families through SharePoint (similar information is not provided for TR cases). Most of these services were paid for by DCFS, with the majority of services being used to address concrete supports for parents.

According to the worker survey, workers for most families indicated that they had either directly provided families with services or given them information about services, however, AR families were more likely to receive at least one service compared to TR families. For all AR-eligible families, the most commonly provided services were related to mental health, social support services, and services to address material needs.

AR families were more likely to receive mental health services, services to address material needs, and transportation services. For all AR-eligible families, the most common categories of service providers were mental health providers, schools, and neighbors/friends/extended family. AR families were more likely to receive services from mental health providers, neighborhood organizations, mental

retardation/developmental disability (MR/DD) providers, youth organizations, legal service providers, or contractors.

Match Between Services and Family Needs

Most workers reported that they were able to match services to the needs of the family. Overall, workers did not report a significantly greater degree of matching services to AR families compared to TR families. The majority of both AR and TR families indicated that they received the help that they needed; however, AR families reported this significantly more frequently than TR families. Additionally, AR families were significantly more likely to report that the support and services they received was the kind of help they needed. Both AR and TR families reported that the supports and services received were enough to really help them; no significant difference was observed.

Timeliness of Services

Based on N-FOCUS data, TR families appear to receive services significantly sooner than AR families, with TR families receiving services approximately two weeks sooner than AR families. Worker survey data indicated that TR families, more often than AR families, are receiving services within less than one week of the initial report, although these findings are not significant. However, AR workers are reporting significantly more often than TR workers that services are provided within 1-2 weeks, 2-3 weeks, 3-4 weeks, or more than 4 weeks. If TR families received support or services, it was significantly more likely to have already been in place prior to DCFS involvement (compared to AR families). Additionally, workers indicated that both AR and TR families were provided with information about services at about the same frequency. From the family's perspective, most families (both AR and TR) indicated that they received support or services when they needed it; however, AR families reported this significantly more often than TR families.

Barriers to Providing Services

Across all AR-eligible families assigned to either AR or TR, nearly half of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by other pressing cases on their caseload, and limited staff time to work with families. AR workers were significantly more likely than TR workers to report barriers due to caseload, other pressing cases, and limited time. However, TR workers were significantly more likely than AR workers to report barriers due to limited funds or to report no barriers were experienced.

Chapter 5: Well-Being

Key Question:

- Do AR children and families display improved well-being compared to TR families?

Well-Being Analyses

DCFS has hypothesized that well-being will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected child-level survey data related to well-being for all AR-eligible families. For families receiving AR, child well-being data are collected throughout the life of the case (note that this report only focuses on beginning (pre) and end (post) measures). For AR-eligible families receiving TR, child well-being data are collected at the end (post) of the case. Pre measures of well-being for AR families are collected through the AR Protective Factors and Well-Being Questionnaire (PFWBQ). All post measures are collected through the AR Worker End-of-Case Survey (worker survey). For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

The well-being items aim to measure four child well-being outcome domains: 1) physical health/development, 2) cognitive functioning, 3) emotional/behavioral functioning, and 4) social functioning. The domains of physical health/development and cognitive functioning are assessed with yes/no items and are labeled as health and education respectively. The domains of emotional/behavioral and social functioning are rated on a 3-point scale (0 = *Not True*, 1 = *Somewhat True*, 2 = *Certainly True*) and are comprised of subscales. Emotional/behavioral functioning has two subscales: emotional symptoms and hyperactivity. Social functioning has three subscales: peer relationship problems, conduct problems, and prosocial behavior. The well-being items were implemented in July 2015, so data included in these analyses are for cases that closed between July 2015 and June 2019.

Tables 4.5.1 – 4.5.3 detail 1) the number and percentage of responses for each response option, 2) the overall average rating, and 3) the total number of responses for each item. *Y* = Yes (1), *N* = No (0), *DK* = Don't Know, *NA* = Not Applicable. *NT* = Not True (0), *ST* = Somewhat True (1), *CT* = Certainly True (2). The total sum of percentages may total over 100% due to rounding.

Initial (Pre) Measure of Well-Being for AR Children

The following set of responses represents the initial (pre) measure of well-being through the PFWBQ for each child that received AR.

Table 4.5.1: Average Well-Being Ratings for Pre Survey of AR Children

Survey Item	*Y*	*N*	*DK*	*NA*	Responses
Health					
1. This child is up to date on all immunizations.	2214 96%	47 2%	41 2%	5 <1%	2307
2. This child has a primary care physician.	2147 94%	97 4%	24 <1%	17 <1%	2285

Survey Item	*Y*	*N*	*DK*	*NA*		Responses
3. This child is in good physical health.	2239 97%	41 2%	12 1%	6 <1%		2298
4. This child shows age-appropriate physical and cognitive development.	2077 91%	172 7%	36 2%	11 <1%		2296
5. This child receives regular medical treatment, when needed.	2269 99%	28 1%	3 <1%	4 <1%		2304
6. This child receives regular dental care.	1984 87%	136 6%	33 1%	126 6%		2279
7. This child receives mental health treatment, if needed.	1475 64%	122 5%	30 1%	672 29%		2299
Education						
8. This child is enrolled in an early education program.	417 18%	716 31%	30 1%	1131 49%		2294
9. This child is working at his/her grade level in school.	1659 73%	226 10%	34 2%	361 16%		2280
10. This child participates in an Individualized Education Program (IEP), if eligible.	502 22%	792 35%	92 4%	908 40%		2294
11. This child has both parents participating in his/her IEP, if eligible.	362 16%	422 19%	62 3%	1431 63%		2277
12. This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	545 20%	706 31%	60 3%	983 43%		2294
Survey Item	*NT*	*ST*	*CT*		Average	Responses
Behavioral/Emotional Functioning						
Emotional Symptoms						
13. This child often complains of headaches, stomach-aches or sickness.	1722 82%	274 13%	113 5%		.24	2109
14. This child has many worries or often seems worried.	1520 72%	440 21%	148 7%		.35	2108
15. This child is often unhappy, depressed or tearful	1654 77%	368 17%	114 5%		.28	2136
16. Nervous or clingy in new situations, easily loses confidence	1404 66%	518 24%	208 10%		.44	2130
17. Many fears, easily scared	1628 77%	382 18%	113 5%		.29	2123
Hyperactivity						
18. This child is restless, overactive, cannot stay still for long.	1176 56%	597 28%	338 16%		.60	2111
19. This child is constantly fidgeting or squirming	1341 63%	532 25%	250 12%		.49	2123

20. Easily distracted, concentration wanders	1049 49%	721 34%	358 17%	.68	2128
Survey Item	*NT*	*ST*	*CT*	Average	Responses
21. Can stop and think things out before acting *	372 18%	1009 48%	726 35%	1.17	2107
22. Good attention span, sees work through to the end *	269 13%	1025 48%	829 39%	1.26	2123
Social Functioning					
Peer Relationship Problems					
23. This child is rather solitary, prefers to play alone.	1517 72%	431 20%	157 8%	.35	2105
24. This child has at least one good friend *	97 5%	377 18%	1641 78%	1.73	2115
25. Generally liked by other children *	66 3%	450 21%	1621 76%	1.73	2137
26. Picked on or bullied by other children or youth	1527 71%	431 20%	180 8%	.37	2138
27. Gets along better with adults than with other children or youth	1250 59%	575 27%	302 14%	.55	2127
Conduct Problems					
28. This child often loses his/her temper.	1235 59%	619 29%	255 12%	.54	2109
29. This child is generally well behaved, usually does what adults request *	157 7%	767 36%	1186 56%	1.49	2110
30. This child often fights with other children or bullies them	1732 82%	289 14%	105 5%	.23	2126
31. Often argumentative with adults**	626 62%	305 30%	81 8%	.46	1012
32. Can be spiteful to others**	774 79%	166 17%	40 4%	.25	980
33. Often lies or cheats***	1278 68%	422 23%	174 9%	.41	1874
34. Steals from home, school or elsewhere***	1612 87%	157 8%	89 5%	.18	1858
Prosocial Behavior					
35. This child is considerate of other people's feelings.	80 4%	690 33%	1338 64%	1.60	2108
36. This child shares readily with other children (e.g., toys, treats, pencils).	91 4%	816 39%	1206 57%	1.53	2113
37. This child is helpful if someone is hurt, upset or feeling ill.	118 6%	541 26%	1440 69%	1.63	2099
38. Kind to younger children	78 4%	432 20%	1613 76%	1.72	2123
39. Often offers to help others (parents, teachers, other children)	126 6%	684 32%	1324 62%	1.56	2134

**These items were reverse coded when creating the subscale average.*

***These items are only answered for children 2-4 years old.*

****These items are only answered for children 5 and older.*

End-of-Case (Post) Measure of Well-Being for AR Children

The following set of responses represents the final (post) measure of well-being, through the worker survey, for each child that received AR.

Table 4.5.2: Average Well-Being Ratings for Post Survey of AR Children

Survey Item	*Y*	*N*	*DK*	*NA*		Responses
Health						
1. This child is up to date on all immunizations.	2272 88%	31 1%	225 9%	54 2%		2582
2. This child has a primary care physician.	2306 89%	55 2%	178 7%	43 2%		2582
3. This child is in good physical health.	2366 92%	45 2%	130 5%	41 2%		2582
4. This child shows age-appropriate physical and cognitive development.	2195 85%	201 8%	141 6%	46 2%		2583
5. This child receives regular medical treatment, when needed.	2322 90%	29 1%	183 7%	48 2%		2582
6. This child receives regular dental care.	2033 79%	102 4%	294 11%	153 6%		2582
7. This child receives mental health treatment, if needed.	1622 63%	87 3%	213 8%	659 26%		2581
Education						
8. This child is enrolled in an early education program.	365 14%	621 24%	197 8%	1398 54%		2581
9. This child is working at his/her grade level in school.	1549 60%	263 10%	228 9%	542 21%		2582
10. This child participates in an Individualized Education Program (IEP), if eligible.	444 17%	625 24%	257 10%	1256 49%		2582
11. This child has both parents participating in his/her IEP, if eligible.	246 10%	320 12%	280 11%	1734 67%		2580
12. This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	468 18%	506 20%	272 11%	1335 52%		2581
Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
Behavioral/Emotional Functioning						
Emotional Symptoms						
13. This child often complains of headaches, stomach-aches or sickness.	1385 61%	201 9%	61 3%	617 27%	.20	2264
14. This child has many worries or often seems worried.	1173 52%	417 18%	100 4%	572 25%	.37	2262
15. This child is often unhappy, depressed or tearful	1397 62%	282 13%	66 3%	518 23%	.24	2263

16. Nervous or clingy in new situations, easily loses confidence	1228 54%	381 17%	86 4%	567 25%	.33	2262
Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
17. Many fears, easily scared	1366 60%	236 10%	48 2%	613 27%	.20	2263
Hyperactivity						
18. This child is restless, overactive, cannot stay still for long.	961 42%	602 27%	256 11%	449 20%	.61	2268
19. This child is constantly fidgeting or squirming	1102 49%	523 23%	157 7%	484 21%	.47	2266
20. Easily distracted, concentration wanders	959 42%	634 28%	155 7%	515 23%	.54	2263
21. Can stop and think things out before acting *	301 13%	881 39%	537 24%	547 24%	1.14	2266
22. Good attention span, sees work through to the end *	251 11%	873 39%	620 27%	520 23%	1.21	2264
Social Functioning						
Peer Relationship Problems						
23. This child is rather solitary, prefers to play alone.	1155 51%	434 19%	97 4%	577 26%	.37	2263
24. This child has at least one good friend *	93 4%	415 18%	1186 52%	568 25%	1.65	2262
25. Generally liked by other children *	84 4%	535 24%	1077 48%	567 25%	1.59	2263
26. Picked on or bullied by other children or youth	1273 56%	267 12%	79 4%	643 28%	.26	2262
27. Gets along better with adults than with other children or youth	923 41%	433 19%	110 5%	796 35%	.45	2262
Conduct Problems						
28. This child often loses his/her temper.	1159 51%	444 20%	166 7%	496 22%	.44	2265
29. This child is generally well behaved, usually does what adults request *	147 7%	756 33%	998 44%	366 16%	1.45	2267
30. This child often fights with other children or bullies them	1463 65%	213 9%	48 2%	536 24%	.18	2260
31. Often argumentative with adults**	263 67%	34 9%	4 1%	94 24%	.14	395
32. Can be spiteful to others**	279 71%	18 5%	2 1%	96 24%	.07	395
33. Often lies or cheats***	1203 63%	277 15%	81 4%	339 18%	.28	1900
34. Steals from home, school or elsewhere***	1394 73%	96 5%	45 2%	365 19%	.12	1900
Prosocial Behavior						
35. This child is considerate of other people's feelings.	69 3%	706 31%	1081 48%	408 18%	1.55	2264

36. This child shares readily with other children (e.g., toys, treats, pencils).	91 4%	725 32%	894 39%	557 25%	1.47	2267
Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
37. This child is helpful if someone is hurt, upset or feeling ill.	96 4%	577 26%	988 44%	602 27%	1.54	2263
38. Kind to younger children	36 2%	514 23%	1157 51%	555 25%	1.66	2262
39. Often offers to help others (parents, teachers, other children)	82 4%	717 32%	863 38%	600 27%	1.47	2262

**These items were reverse coded when creating the subscale average.*

***These items are only answered for children 2-4 years old.*

****These items are only answered for children 5 and older.*

End-of-Case (Post) Measure of Well-Being for TR Children

The following set of responses represents the (post) measure of well-being, through the worker survey, for each child that received TR.

Table 4.5.3: Average Well-Being Ratings for Post Survey of TR Children

Survey Item	*Y*	*N*	*DK*	*NA*	Average	Responses
Health						
1. This child is up to date on all immunizations.	2158 87%	48 2%	215 9%	69 3%		2490
2. This child has a primary care physician.	2213 89%	65 3%	149 6%	61 3%		2488
3. This child is in good physical health.	2268 91%	51 2%	114 5%	55 2%		2488
4. This child shows age-appropriate physical and cognitive development.	2122 85%	184 7%	120 5%	63 3%		2489
5. This child receives regular medical treatment, when needed.	2206 89%	43 2%	177 7%	64 3%		2490
6. This child receives regular dental care.	1848 74%	79 3%	409 16%	154 6%		2490
7. This child receives mental health treatment, if needed.	1421 57%	114 5%	257 10%	697 28%		2489
Education						
8. This child is enrolled in an early education program.	383 15%	688 28%	262 11%	1154 46%		2487
9. This child is working at his/her grade level in school.	1552 63%	223 9%	254 10%	456 18%		2485
10. This child participates in an Individualized Education Program (IEP), if eligible.	443 18%	680 27%	241 10%	1122 45%		2486
11. This child has both parents participating in his/her IEP, if eligible.	284 11%	282 11%	279 11%	1642 66%		2487

Survey Item	*Y*	*N*	*DK*	*NA*		Responses
12. This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	420 17%	522 21%	272 11%	1271 51%		2485
Survey Item	NT	ST	CT	DK	Average	Responses
Behavioral/Emotional Functioning						
Emotional Symptoms						
13. This child often complains of headaches, stomach-aches or sickness.	1059 48%	115 5%	58 3%	956 44%	.19	2188
14. This child has many worries or often seems worried.	876 40%	322 15%	103 5%	887 41%	.41	2188
15. This child is often unhappy, depressed or tearful	1092 50%	220 10%	67 3%	809 37%	.26	2188
16. Nervous or clingy in new situations, easily loses confidence	968 44%	246 11%	68 3%	906 41%	.30	2188
17. Many fears, easily scared	939 43%	199 9%	36 2%	1012 46%	.23	2186
Hyperactivity						
18. This child is restless, overactive, cannot stay still for long.	869 40%	473 22%	195 9%	653 30%	.56	2190
19. This child is constantly fidgeting or squirming	935 43%	369 17%	134 6%	749 34%	.44	2187
20. Easily distracted, concentration wanders	795 36%	423 19%	156 7%	815 37%	.54	2189
21. Can stop and think things out before acting *	313 14%	562 26%	358 16%	954 44%	1.04	2187
22. Good attention span, sees work through to the end *	220 10%	598 27%	492 23%	877 40%	1.21	2187
Social Functioning						
Peer Relationship Problems						
23. This child is rather solitary, prefers to play alone.	918 42%	262 12%	93 4%	913 42%	.35	2186
24. This child has at least one good friend*	51 2%	364 17%	895 41%	879 40%	1.65	2189
25. Generally liked by other children *	75 3%	421 19%	788 36%	903 41%	1.56	2187
26. Picked on or bullied by other children or youth	894 41%	205 9%	71 3%	1016 47%	.30	2186
27. Gets along better with adults than with other children or youth	495 23%	259 12%	86 4%	1345 62%	.52	2185
Conduct Problems						
28. This child often loses his/her temper.	901 41%	347 16%	119 5%	822 38%	.43	2189

29. This child is generally well behaved, usually does what adults request *	151 7%	628 29%	843 39%	567 26%	1.43	2189
Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
30. This child often fights with other children or bullies them	1118 51%	163 7%	46 2%	861 39%	.19	2188
31. Often argumentative with adults**	220 56%	24 6%	2 <1%	150 38%	.11	396
32. Can be spiteful to others**	222 56%	7 2%	4 1%	163 41%	.06	396
33. Often lies or cheats***	1005 56%	193 11%	45 3%	566 31%	.23	1809
34. Steals from home, school or elsewhere***	1146 63%	66 4%	39 2%	558 31%	.11	1809
Prosocial Behavior						
35. This child is considerate of other people's feelings.	71 3%	609 28%	837 38%	674 31%	1.50	2191
36. This child shares readily with other children (e.g., toys, treats, pencils).	94 4%	561 26%	600 27%	934 43%	1.40	2189
37. This child is helpful if someone is hurt, upset or feeling ill.	90 4%	456 21%	567 26%	1075 49%	1.43	2188
38. Kind to younger children	35 2%	426 20%	763 35%	964 44%	1.60	2188
39. Often offers to help others (parents, teachers, other children)	115 5%	528 24%	555 25%	988 45%	1.37	2186

**These items were reverse coded when creating the subscale average.*

***These items are only answered for children 2-4 years old.*

****These items are only answered for children 5 and older*.

Internal Consistency Reliability for Well-Being Scales

Coefficient alpha reliabilities for each of the well-being Strengths and Difficulties Questionnaire subscales, for both the pre and post measures are presented in table 4.5.4. The peer relationship problems subscale had lower than desired reliability at both measurement time points, ranging from .63-67. All other subscales demonstrated acceptable reliability at both measurement time points, ranging from .70 to .87.

Table 4.5.4: Well-Being Subscale Reliability Coefficients for Pre and Post Administrations

Data Source: PFWBQ (pre-measure)			
Scale	**Number of items**	**Number of cases included in analysis**	**Coefficient alpha**
Emotional Symptoms	5	2043	.75
Hyperactivity	5	2024	.82
Peer Relationship Problems	5	2041	.63
Conduct Problems (all ages)	3	2078	.70
Conduct Problems (ages 2-4)	5	931	.80
Conduct Problems (ages 5-19)	5	1794	.79

Prosocial Behavior	5	2044	.78
Data Source: Worker Survey (post-measure)			
Scale	**Number of items**	**Number of cases included in analysis**	**Coefficient alpha**
Emotional Symptoms	5	2434	.78
Hyperactivity	5	2638	.86
Peer Relationship Problems	5	2000	.67
Conduct Problems (all ages)	3	2841	.77
Conduct Problems (ages 2-4)	5	391	.71
Conduct Problems (ages 5-19)	5	2258	.83
Prosocial Behavior	5	2379	.87

Health and Education domains

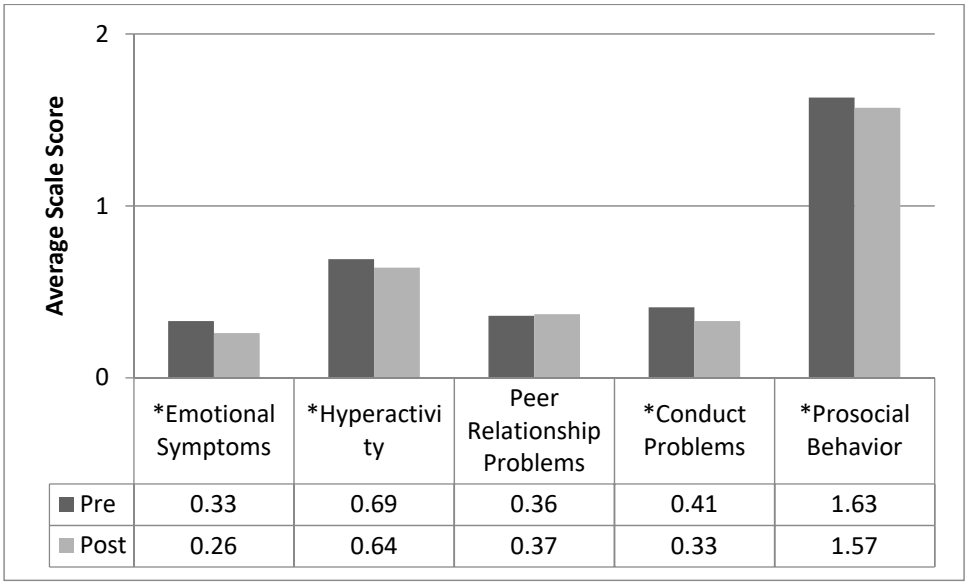
Health and education domains were not tested for significant differences, but item-level statistics are presented in the tables above. Overall, ratings indicate that children are in good health and generally educational needs are not a concern for AR nor TR families.

Changes Over Time for Children Assigned to AR

Matched child data from the PFWBQ (pre) and worker survey (post) were used to assess changes over time in the behavioral/emotional and social functioning domains of well-being for children assigned to AR. To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale.

A total of 808-849 children, within 378-393 families (depending on the domain), were matched between pre- and post-survey administrations. Three significant differences were observed in the hypothesized direction; emotional symptoms, hyperactivity, and conduct problems decreased from pre- to post-survey. These three reported decreases over time are in the desired direction and indicate an improvement in child well-being from the beginning to the end of the case. On the other hand, the dimension of prosocial behavior was significant in the opposite direction; prosocial behavior decreased from pre- to post-survey. This finding does not support the hypothesis of improved child well-being. There was no significant differences between pre and post measures for the peer relationship problems dimension. Figure 4.5.1 summarizes average ratings from the SDQ subscales for AR children from pre to post measure.

Figure 4.5.1: Average Well-Being Scale Ratings: Pre versus Post Comparison of AR Children



	*Emotional Symptoms	*Hyperactivity	Peer Relationship Problems	*Conduct Problems	*Prosocial Behavior
Pre	0.33	0.69	0.36	0.41	1.63
Post	0.26	0.64	0.37	0.33	1.57

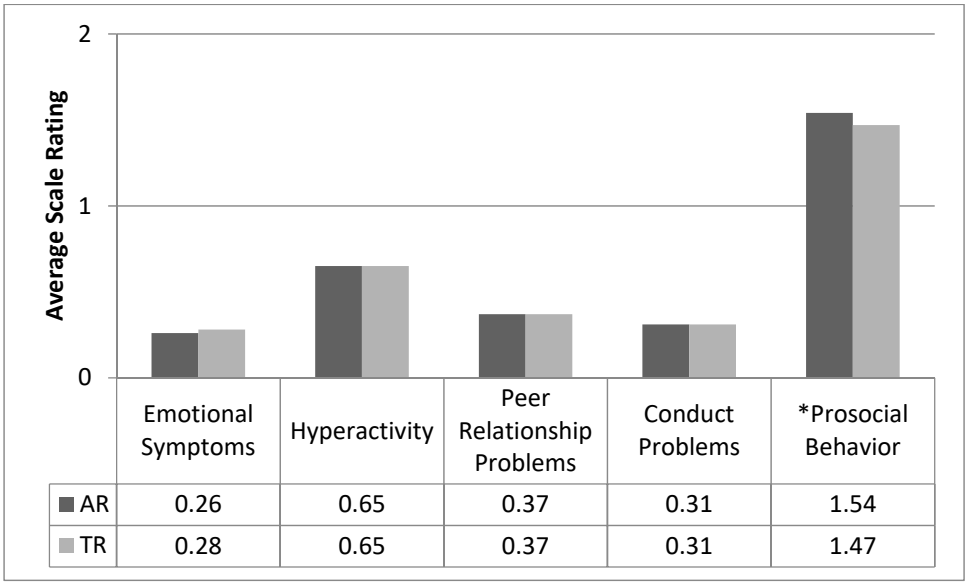
*$p < .05$. (paired samples t-tests for emotional symptoms, hyperactivity, conduct problems, and prosocial behavior respectively: $t(819) = 4.62$, $p < .001$; $t(835) = 3.33$, $p = .001$; $t(848) = 6.87$, $p < .001$; $t(807) = 3.75$, $p < .001$).

Differences Between AR-Eligible Children Assigned to AR and TR

Overall worker survey (post) data were used to assess differences in the behavioral/emotional and social functioning domains of well-being between AR-eligible children assigned to AR and TR at the end of their involvement with DCFS. To be included in the following analyses, the respondent must have completed at least 60% of the items for a given subscale. Because families are randomly assigned to AR or TR, it would be expected that well-being should, on average, present at the same level at the beginning of the case for both AR and TR families. Therefore, any difference at the end of the case should be due to the type of response that family received.

A total of 2904-3307 children, within 1401-1581 families (depending on the domain), were included in this analysis; this included 1675-1836 AR children (within 773-839 families) and 1229-1471 TR children (within 628-742 families). A significant difference, in the hypothesized direction, was identified for one well-being dimensions. Workers reported that AR children exhibited significantly more prosocial behaviors than TR children. Figure 4.5.2 summarizes average ratings between AR and TR children.

Figure 4.5.2: Average Well-Being Scale Ratings: Post Comparison of AR vs. TR Children



	Emotional Symptoms	Hyperactivity	Peer Relationship Problems	Conduct Problems	*Prosocial Behavior
AR	0.26	0.65	0.37	0.31	1.54
TR	0.28	0.65	0.37	0.31	1.47

*$p < .05$. (independent samples t-tests for prosocial behavior: $t(2589.99) = 3.88$, $p < .001$).

Conclusion

DCFS has hypothesized that child well-being will be enhanced through AR. To test this hypothesis, UNL-CCFL tested whether well-being for AR children improved from the beginning to the end of the case and whether AR children were perceived to have higher well-being than TR children at the end of the case.

AR children showed improvements in three domains of well-being from the beginning to the end of the case. According to workers' responses AR children were perceived to have significantly lower emotional symptoms, hyperactivity, and conduct problems at the end of the case, compared to the beginning of the case. However, the domain of prosocial behavior was found to be lower at the end of the case, which is opposite of what was hypothesized. Three of the four significant differences were in the hypothesized direction.

AR children exhibited higher well-being in one domain at case closure, compared to TR children. According to workers' responses, AR children were perceived to exhibit significantly higher prosocial behavior at case closure, compared to TR children. This significant difference was in the hypothesized direction. The remaining well-being domains were equal for AR and TR children.

Part V:
Results-Based Accountability
Outcome Study

Chapter 1: Children and Family Services
Performance-Based Contracting Outcomes

Key Questions:

- Does RBA provide DCFS with a system for measuring and comparing effectiveness of providers?
- Does RBA provide DCFS with a system to hold providers accountable for performance measures?
- Does RBA provide DCFS with a system to make contract decisions based on provider performance results?

Initially, providers participating in RBA were told that for the first 2 years of implementation that they would be "held harmless" for all performance measure data. Therefore, these data were not used to compare effectiveness or determine any accountability or contracting decisions. However, with the new program, PPI, no such promise was made. As outlined in the evaluation plan, these data were planned to be collected through surveys and interviews with Resource Development staff and leadership responsible for implementing RBA. However, the evaluators were unable to implement these planned evaluation activities due to shifts within the program, changes in leadership, and, ultimately, the transition from RBA to PPI. A survey was developed to assess RBA program fidelity, perceptions of the program, challenges, and barriers to implementation for DCFS staff involved in RBA implementation. This survey was shared with the RBA administrator at the time; however, it was not distributed to DCFS staff. Subsequently, the RBA program shifted to PPI. It was determined that a final report summarizing any findings of the RBA program would be compiled. Moving forward, a process-only evaluation was then completed for the PPI program.

Chapter 2: Contracted Provider and Child and Family Outcomes

Key Questions:

Contracted Provider Outcomes

- Do RBA providers demonstrate changes in practice as a result of participation in the RBA program?
- Does participation in the RBA program result in improvements in provider's performance measures?

DHHS-CFS Child and Family Outcomes:

- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce entry into out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce maltreatment in out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on maltreatment recurrence after discharge or closure?
- For children and families being served by a provider subject to RBA, does the RBA program appear to improve placement stability?
- For children and families being served by a provider subject to RBA, does the RBA program appear to increase timely reunification and adoption?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce discharge to emancipation?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on re-entry into out-of-home care?

Based on the RBA model, provider changes are brought about through Turn-the-Curve (TTC) discussions. Once performance measure baseline data has been established, DCFS was meant to partner with provider agencies to collectively review the data and determine whether or not they were satisfied with the direction the baseline data appeared to be heading. If not, the team was to decide what actions need to be taken to "turn the curve" of the baseline. RBA defined success as turning the curve away from the baseline and by using the TTC process, DCFS and service providers were expected to see measurable results in the delivery and effectiveness of the services being provided.

The evaluators had planned to assess the impact of the RBA program, through the TTC meetings, by assessing any resultant changes in performance measure data after greater fidelity was achieved. However, in order for changes in provider performance measures to logically have an impact on child and family outcomes, there needed to be a direct link between provider performance measures and the child and family outcomes. The evaluators worked with DCFS throughout the implementation of the RBA program and attempted to align RBA performance measures with the evaluation outcomes specified in the Waiver Terms and Conditions. Complete alignment between these was never achieved. Additionally, the performance measures changed in each year of RBA implementation, resulting in only 8 performance measures with data for the entire program implementation period. Additionally, not all of those performance measures were tied to a child and family outcome. Ultimately, there were no data to

present on provider performance measures or child and family outcomes for the RBA program - only a summary of early TTC compliance was completed during early implementation of the RBA program.

TTC meetings began implementation in 2015. Each service was scheduled for review during a particular month, with TTC meetings occurring semi-annually. The first summary of TTC data was completed in January 2016 for the project period of July 2015 - December 2015. These preliminary data were reviewed with DCFS. The final summary of TTC data for the RBA program, for the project period of January 2016 – June 2016, was compiled and presented to DCFS in July 2016. The results of the July 2016 report are presented below, as these encapsulates both TTC data review periods.

Turn-the-Curve Analyses

The purpose of the TTC data review was to gather information to assess the fidelity of DCFS implementation of TTC meetings, as documented in Results Scorecard. These meetings are an integral component of the RBA program, as delineated in the DCFS RBA Program Manual, in which departmental and provider agency representatives come together to review the provider's performance measure data, explore the "story behind the curve," and mutually develop action plans for continued improvement. The data presented below focuses primarily on the project period January 2016 – June 2016, but includes summaries for the previous project period (July – December 2015) for comparison purposes.

All data for providers in RBA as part of the Title IV-E Waiver Demonstration were retrieved from the Results Scorecard as of June 23, 2016. Each individual provider's scorecard was extracted and a single UNL-CCFL evaluator read and reviewed each record and narrative. A spreadsheet was created and entries were made to summarize the level of documentation for each provider for each service. During the current project period, there were 51 contracted providers included in RBA under the Waiver, and each was contracted for varying numbers of up to 7 services, resulting in a total of 135 potential TTC meetings that could have been documented. Documentation of a TTC meeting was counted as "present" if any narrative for that service was visible and included a date falling within this time period. Undated narratives were not counted if the evaluators were unable to deduce when the narrative had been entered. This criterion resulted in the exclusion of 16 narratives.

Presence of TTC Meeting Documentation

Table 5.2.1 summarizes the number of providers with TTC documentation available for each of the contracted RBA services included in Nebraska's Title IV-E Waiver Demonstration. For each service the table shows: 1) the total number of contracted providers, 2) the number and percentage of providers with a documented TTC meeting, 3) the number of providers who were actually used during the project period, as evidenced by non-zero data entries on the performance measures for that service, and 4) the number and percentage of utilized providers with a documented TTC meeting.

Table 5.2.1: Summary of TTC Documentation by Contracted Service for January 2016 – June 2016

Number of Contracted Providers:	Intensive Family Preservation	Agency Supported Foster Care	Agency Supported Respite Care	Family Support Services	Group Home Services	In-Home Safety Services	Emergency Shelter Care
Total	22	21	21	40	12	13	6
Documented TTC meeting	13 (59%)	11 (52%)	8 (38%)	28 (70%)	6 (50%)	5 (38%)	3 (50%)
Service was utilized	16	21	13	34	9	3	6
Documented TTC meeting	12 (75%)	11 (52%)	5 (38%)	25 (74%)	6 (67%)	3 (100%)	3 (50%)

As can be seen in Table 5.2.1 (above), the overall percentage of contracted providers who received a TTC meeting (regardless of utilization of the service) ranged from 38% to 70% of providers, depending on the service. While the most recent RBA Program Manual calls for Turn the Curve meetings to occur with each contracted provider, current practice may be to only have TTC meetings with providers of services that are being utilized with families. Thus, the evaluators also examined the subset of providers for each utilized service (i.e., those providers with non-zeros entered for at least one month for at least one performance measure for that service). For utilized providers, the percentage that received a TTC meeting ranged from 38% to 100%, depending on the service. It appears that inconsistencies in documentation of TTC meetings do not align with whether or not a service was used. Among providers whose service was not utilized, a small portion still received a TTC meeting for that service. Specifically, there were a total of 33 contracted provider services unused during this project period; seven of these had a documented TTC meeting, while the remaining 26 did not. These seven TTC meetings occurred across four different services (Agency Support Respite Care, In-Home Safety, Intensive Family Preservation, and Family Support).

During the evaluation time period, a total of 16 providers were contracted for one or more services but had no documented TTC curve meeting on any service. Table 5.2.2 lists these providers, including whether the services were utilized (i.e., had non-zero data entered in Results Scorecard for that service during this project period).

Table 5.2.2: Contracted Providers without Documented TTC Meetings for Any Service January 2016 – June 2016

Provider Name	Number of Contracted Services	Number of Utilized Services
Behavioral Health Specialists	4	2
Beneficial Behavioral Health Services	3	2
Christian Heritage	2	2
Christian Home Association Children's Square USA	3	3
Family Skill Building	2	1
Fremont Children's Academy	2	0

Heartland Boys Home	1	0
Mark of Honor	1	1
McConaughy Discovery Center	2	1
Norfolk Group Home	2	2
Nova Treatment Community	5	3
Omaha Home for Boys	2	1
Omni Behavioral Health	4	3
Paradigm Inc.	2	2
St. Francis	4	2
TFI Family Services Inc.	3	2

Comparison to Previous Project Period

For the initial project period (July 2015 – December 2015), TTC documentation was counted as "present" if any narrative was visible, with or without dates. This constitutes a lower threshold for inclusion, but was possible because this was the first review of the data. These data were retrieved from Results Scorecard as of January 8, 2016. Table 5.2.3 summarizes the TTC documentation from this previous project period. During the previous period, the percentage of providers with a documented TTC meeting ranged from 5% to 69%, depending on the service. As can be seen by comparing Tables 5.2.1 and 5.2.3, several services improved their rate of TTC documentation. For example, for Agency Supported Respite Care, TTC meeting documentation improved from 5% during the first period to 38% in the latter project period. TTC documentation for Intensive Family Preservation improved from 36% to 59%. However, for other services the level of documentation decreased (In-Home Safety Services and Agency Supported Foster Care), or remained fairly consistent over time (Family Support Services, Group Home Services, and Emergency Shelter Care). Because the evaluators did not examine the level of service utilization during the initial project period, no comparisons can be made to the latter project period with regards to TTC documentation for utilized service providers.

Table 5.2.3: Summary of TTC Documentation by Contracted Service for July 2015 – December 2015

Number of Contracted Providers	Intensive Family Preservation	Agency Supported Foster Care	Agency Supported Respite Care	Family Support Services	Group Home Services	In-Home Safety Services	Emergency Shelter Care
Total	22	21	21	40	12	13	6
With documented TTC meeting	8 (36%)	13 (62%)	1 (5%)	27 (68%)	6 (50%)	9 (69%)	3 (50%)

When the data on TTC documentation from both project periods is reviewed, it appears that nine providers never had a documented TTC meeting in either time period (July 2015 –December 2015, or January 2016 – June 2016). Collectively these providers contract for a variety of different services. These providers are listed in Table 5.2.4.

Table 5.2.4: Contracted Providers without Documented TTC Meetings for Any Service
July 2015 – June 2016

Provider Name	Number of Contracted Services	Number of Utilized Services (in current project period)
Behavioral Health Specialists	4	2
Beneficial Behavioral Health Services	3	2
Christian Heritage	2	2
Christian Home Association Children's Square USA	3	3
Heartland Boys Home	1	0
Mark of Honor	1	1
Omaha Home for Boys	2	1
Omni Behavioral Health	4	3
Paradigm Inc.	2	2

It is worth noting that none of the three providers currently participating in the RBA Cost Evaluation case study (*Christian Heritage*, *Christian Home Association Children's Square USA, Omni Behavioral Health)* have any TTC meetings documented. If in fact these three providers never participated in TTC meetings, it is likely that their administrative cost estimates for participation in RBA are under-estimates of their true costs. This has implications for the validity of the case study being included in the cost evaluation of the RBA program.

An additional exploratory analysis was conducted during the latter project period to examine variation in documentation of TTC meetings by Contract Monitoring Resource Development (CMRD) staff assignments. A listing of current CMRD staffs' assignments to providers was obtained from the CFS Administrator. Staff names were then linked to provider documentation in the spreadsheet. When these data were sorted by staff names, it appears that documentation of TTC meetings clearly varies by CMRD staff assignment, with some staff documenting TTC meetings for most or all of their assigned providers, and other staff documenting these meetings for few or none of their assigned providers. This finding suggests that follow up with CMRD staff to clarify expectations may significantly improve future TTC documentation.

Quality of Documentation of TTC Meetings

Some of the TTC narratives are very detailed and provided useful documentation, such as information about staffing issues, concerns about a lack of referrals, specific challenges presented in the client population, and provider action plans for improvement. As one example, the TTC documentation for the most recent time period for the service Agency Supported Foster Care for the provider *Lutheran Family Services* is very thorough and includes the name of the CMRD, staff RBA liaison, the date of the meeting, meeting attendees, the story behind the curve, information on what works, and action plans for improvement. However, the majority of the TTC narratives during the latter project period did not contain this level of detail.

An issue with many of the TTC narratives is a lack of complete date information, making it difficult to know when the meeting(s) occurred. Occasionally the month of the meeting was entered with no year, which will create challenges in the future when data are accumulated over multiple years. For 16 of the narratives, it was impossible to deduce which period the narrative referenced, and thus these were counted as missing. These 16 narratives were created by a subset of CMRD staff. In addition to variation in TTC documentation by CMRD staff assignments; analysis of TTC narratives suggests that the quality (i.e., level of detail and inclusion of dates and names of participants) appears to also vary by the assigned CMRD staff. Again, this points to the potential for future program improvement through the provision of additional training to CMRD staff regarding expectations for TTC meeting documentation. If the completion rate of TTC documentation improved in future project periods, a goal of the evaluation would have been to expand these analyses to provide a content analysis of common themes of the TTC meeting narratives.

Chapter 3: Summary of RBA Program Evaluation

Key Research Questions

The key research questions for RBA were organized into four main categories: 1) contracted provider outcomes, 2) DCFS performance-based contracting outcomes, 3) DCFS child and family outcomes, and 4) cost. The original research questions for the RBA program are listed below:

Contracted provider outcomes

- Do RBA providers have an understanding of and buy-in for the RBA process, Scorecard use, and contracting process?
- Do RBA providers demonstrate changes in practice as a result of participation in the RBA program?
- Does participation in the RBA program result in improvements in provider's performance measures?

DCFS performance-based contracting outcomes

- Does RBA provide DCFS with a system for measuring and comparing effectiveness of providers?
- Does RBA provide DCFS with a system to hold providers accountable for performance measures?
- Does RBA provide DCFS with a system to make contract decisions based on provider performance results?

DCFS child and family outcomes

Safety

- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce entry into out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce maltreatment in out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on maltreatment recurrence after discharge or closure?

Permanency

- For children and families being served by a provider subject to RBA, does the RBA program appear to improve placement stability?
- For children and families being served by a provider subject to RBA, does the RBA program appear to increase timely reunification and adoption?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce discharge to emancipation?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on re-entry into out-of-home care?

Cost

- How do RBA administrative costs evolve over time?
- How do rates for contracted services compare between pre- and post- RBA implementation?

As part of a Title IV-E waiver demonstration project, the Nebraska Division of Children and Family Services (DCFS) intended to improve contractor accountability and child and family outcomes through the Results-Based Accountability (RBA) intervention. The RBA program provided a framework and process for measuring and improving the performance of contracted service providers, which in turn was expected to improve the outcomes of children and families receiving these services. The evaluation of this intervention was planned to contribute to an understanding of whether and how the demonstration accomplished its goals by assessing the planning and implementation process, contextual factors, and barriers and facilitators; achievement of intended outcomes; and the cost effectiveness of this intervention. An evaluation plan was created by UNL-Center on Children, Families and the Law (UNL-CCFL), which was submitted and approved in September 2014. RBA was launched statewide on July 1, 2014. In accordance with Nebraska's Waiver Terms & Conditions, RBA was to be evaluated through a longitudinal research design. For the contracted provider outcomes and the DHHS performance-based contracting outcomes, outcomes were to be measured multiple times across the life of the project. For these data, there were no pre-intervention data against which to compare. For the DCFS child and family outcomes, outcomes were to be compared pre- and post-RBA implementation. However, DCFS decided to shift from the RBA program to PPI, beginning in April 2016. Due to this change in programs the evaluation team was unable to assess contracted provider outcomes, DHHS performance-based contracting outcomes, and DCFS child and family outcomes. Evaluation activities conducted throughout the RBA program implementation period of July 2014 through October 2016 are summarized below.

Summary of Findings and Lessons Learned

Contracted Provider Understanding and Buy-In

A survey was administered to contracted providers in January 2015, near the beginning of RBA implementation (these findings are summarized in Part II, Chapter 2: Contracted Provider Understanding and Buy-In). The results revealed a number of strengths and challenges. Respondents generally agreed with the need for increased accountability, and felt that RBA aligned well with their own agency priorities. Participants understood their role and the department's expectations of them regarding RBA, and for the most part, they were able to compile and enter their data without much difficulty. Most respondents appeared to recognize DCFS' commitment to RBA, and acknowledged the department's recent efforts to collaborate with them. However, the RBA performance measures were generally not accepted as important, relevant, or accurate indicators of successful outcomes. Many of the participants did not feel a sense of ownership in the system, and did not see value in the data that were being compiled and reported monthly. There was some skepticism about how the RBA program would be used by the department in the coming years. There was also dissatisfaction with the limited role providers had played in the development and refinement of the performance measures. Follow up assessment of providers' perceptions were scheduled to occur in 2017 and near the end of the demonstration project in 2019; however, due to shifts in the program, these assessments were unable to be completed.

Children and Family Services Performance-Based Contracting Outcomes

Providers were told that they would be "held harmless" for their performance measure data for the first 2 years of implementation. Therefore, these data were not used to compare effectiveness or determine any accountability or contracting decisions. As outlined in the evaluation plan, these data were planned

to be collected through surveys and interviews with Resource Development staff and leadership responsible for implementing RBA. A survey had been developed to assess program fidelity, perceptions of the program, challenges, and barriers to implementation for DCFS staff involved in RBA implementation; however, this survey was not distributed due to shifts within the program.

Contracted Provider and Child and Family Outcomes

Based on the RBA model, provider changes were expected to be brought about through Turn-the-Curve (TTC) discussions. Once performance measure baseline data had been established, DCFS was meant to partner with provider agencies to collectively review the data and determine whether or not they were satisfied with the direction the baseline data appeared to be heading. If they were unsatisfied, the team would then decide what actions needed to be taken to "turn the curve" of the baseline. RBA defined success as turning the curve away from the baseline and by using the TTC process, DCFS and service providers would be able to measure results in the delivery and effectiveness of the services being provided.

The purpose of the TTC data review was to gather information to assess the fidelity of DCFS implementation of TTC meetings, as documented in Results Scorecard. These meetings were an integral component of the RBA program, as delineated in the DCFS RBA Program Manual, in which departmental and provider agency representatives would come together to review the provider's performance measure data, explore the "story behind the curve," and mutually develop action plans for continued improvement. These findings are summarized in Part V, Chapter 3: Contracted Provider and Child and Family Outcomes.

The evaluators had planned to assess the impact of the RBA program, through the TTC meetings, by assessing any resultant changes in performance measure data after greater fidelity was achieved. However, in order for changes in provider performance measures to logically have an impact on child and family outcomes, there needed to be a direct link between provider performance measures and the child and family outcomes. The evaluators worked with DCFS throughout the demonstration in attempt to align RBA performance measures with the evaluation outcomes specified in the Waiver Terms and Conditions. Complete alignment between these was unable to be achieved. Additionally, the performance measures had changed in each year of the demonstration, resulting in only 8 performance measures with data for the entire project period of July 2014 through June 2016 (when the RBA performance measures expired and new provider contracts included language regarding compliance with the new PPI program), and not all of these performance measures were tied to a child and family outcome. Therefore, there are no data to present on provider performance measures or child and family outcomes.

Cost Study

Cost data associated with the implementation of RBA were collected in three areas: administrative costs, rates for services provided, and costs incurred by service providers.

Administrative costs are costs related to activities to implement RBA, such as developing, collecting and reviewing performance measure data; collaborative development of action plans; and monitoring the implementation of action plans. The administrative resources required for RBA implementation were personnel, overhead and indirect expenses, consulting services and software licenses. Personnel costs

were the predominant source of administrative costs, with these costs steadily climbing throughout the RBA program. Overall, average monthly administrative costs trended upward from July 2014 through October 2016. These findings are summarized in Part V, Chapter 3: Results-Based Accountability Cost Study.

Finally, in order to get an estimate of RBA-related costs incurred by service providers, three agencies agreed to voluntarily track and supply the evaluators with monthly cost data. These findings are also summarized in Part 5, Chapter 3: Results-Based Accountability Cost Study. These data were collected via a monthly Qualtrics survey sent directly to a representative of each of these three agencies. This survey aimed to collect data related to costs incurred by agencies subject to RBA (e.g., additional data collection, data entry, and meetings between the service provider agencies and DCFS). On average, costs to the three agencies implementing RBA was $296 per month, with the highest RBA-related costs being associated with collecting and analyzing RBA data. However, the majority of costs were associated with time spent filling out our case-study survey.

Part VI:

Cost Study

Chapter 1: Alternative Response Cost Study

Key Questions:

- Does worker time and cost vary between AR and TR families?
- Does worker time and cost vary for AR and TR families across time?
- Do the average number and cost of services vary between AR and TR families?
- Do worker costs vary between families that do and do not received contracted services?

Data Sources and Data Collection

Worker Time Data

Worker time was collected through surveys. These surveys asked workers to estimate the total amount of time spent on a case, as well as the amount of time spent in direct contact with the family. Surveys were completed for both AR and AR-eligible TR families, so that a comparison could be made of costs under each treatment. For cases that were open less than 90 days, only the AR Worker End-of-Case Survey (Worker Survey) was sent. In cases open longer than 90 days, a 90-Day AR Worker Time Survey was sent. Additionally, a 60-Day AR Worker Time Survey was sent every 60 days thereafter until the case closed, at which point the End-of-Case Survey was sent. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Surveys were sent to all workers that worked with AR and AR-eligible TR families and whose cases opened and closed between October 1, 2014 and June 30, 2019. Surveys were sent to workers associated with 4,715 unique intakes. Of those 4,715 intakes, 3,329 (71%) only received the End-of-Case survey, 646 (14%) received a 90-Day survey and the End-of-Case survey, while the remaining 740 (16%) received at least one 60-Day survey in addition to the 90-Day and End-of-Case surveys. Overall, complete survey responses with valid time estimates were received for 2,407 intakes (1,211 AR/1,196 TR). To ensure accurate worker time data, only intakes that had the original worker throughout the entirety of the case are included.

Worker Wage, Benefit, and Overhead Data

Hourly wage data were provided by DCFS for workers working with AR and AR-eligible TR families. In total, wage rates were provided for 441 DCFS workers. Additionally, PromiseShip (formerly Nebraska Families Collaborative), a private, nonprofit partnership, was contracted by DCFS to provide child welfare support to families in two counties (Douglas and Sarpy) within our study. DCFS was unable to provide wage rates for PromiseShip workers, so an average hourly rate of $18.81 was used for those 105 workers.

DCFS also provided benefit rates for each worker. Benefit rates are percentages of income that are incurred as benefits and are received in addition to the wages described above. This amount was 35% for all DCFS workers. The same benefit rate was applied to contracted PromiseShip workers.

To determine costs for overhead (space, equipment, and supplies), DCFS adds 48% of salary and benefits for workers. This percentage was used to estimate monthly overhead and indirect costs associated with each worker. The same rate was applied to contracted PromiseShip workers. After time estimate data were collected from workers, hourly wage rates (loaded for benefits, indirect costs and overhead) were multiplied by hours to estimate fully loaded costs for workers.

Administrative Cost Data

Administrative resources include administrators (champions, resource development staff, and central office staff); Review, Evaluate, and Decide (RED) team; AR supervisors; and contracted trainers. Each resource has a cost.

Administrators, champions, RD staff, and central office staff were sent the AR Administrative Monthly Time Survey. Respondents were asked to enter the estimated number of total hours they've spent on AR-related activities, rounded to the nearest hour. This survey captures a monthly estimate of administrator time from January 2015 – June 2019. Out of 1,310 surveys sent to administrators over that time period, 1,147 surveys (88%) were completed. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

To capture costs associated with the RED team, items were added to the RED Team Vulnerability Indicator Guides, which collected names of RED team participants and the amount of time spent on each RED team review. Responses to those items allowed valuation of their time spent. RED team Vulnerability Indicator Guides were sent to the evaluation team monthly.

Supervisors were sent the AR Supervisor Monthly Time Survey. Respondents were asked to enter the estimated number of total hours they spent on case-related and non-case-related AR activities, rounded to the nearest hour. This survey captures an estimate of supervisor time from January 2015 – June 2019. Out of 1,029 surveys sent to supervisors over that time period, 675 surveys (66%) were completed.

After data were collected from administrators, RED team, and supervisors estimating the amount of time spent on AR-related activities, hourly wage rates (loaded for benefits, indirect costs and overhead) were multiplied by hours to estimate fully loaded costs for administrative personnel.

Cost data regarding AR training costs were supplied by DCFS on an annual basis. Training costs were averaged over the 12-month period for each fiscal year of the evaluation.

Service Cost Data

Service costs were calculated using AR Expense data provided by DCFS via N-FOCUS. Data was provided for 4,715 AR-eligible cases which opened and closed between October 1, 2014 and June 30, 2019. Additional service costs were provided by DCFS via SharePoint, a dataset tracking service costs only for AR families that received a service through a purchase card. SharePoint data was provided for 610 families receiving a service during the same time period. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Data Analysis

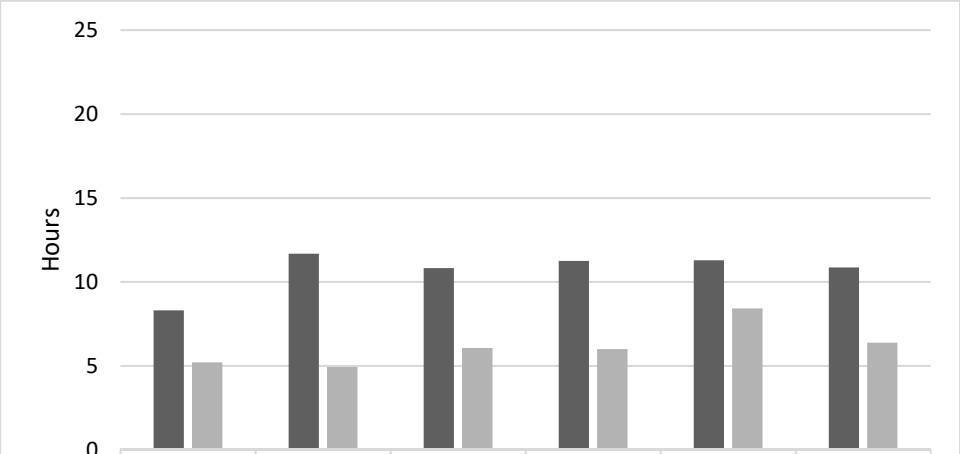
Analyses were conducted of costs related to worker time, services provided to families, and administrative time. With regard to worker time and service costs, the intent was to assess whether the costs/services for AR families differed from the costs/services for TR families. The interest in administrative cost was to investigate how costs vary over time.

Results

Worker Direct Contact Time

Figure 6.1.1 shows the average time workers spent in direct contact with AR and TR families on an annual basis and the average total direct contact time for the entire evaluation period from October 1, 2014 – June 30, 2019. The average total amount of direct contact time spent by workers with AR families was significantly greater than the average total direct contact time spent by workers with TR families, $t(2,405) = 7.16$, $p = 0.00$. Additionally, the average time spent by workers in direct contact with AR families was significantly greater than the average time spent by workers in direct contact with TR families for all years during the evaluation period, except for the 2018-2019 fiscal year where there was no significant difference. See below figure 6.1.1 for yearly significance testing.

Figure 6.1.1: Average Worker Time Spent Directly with Families



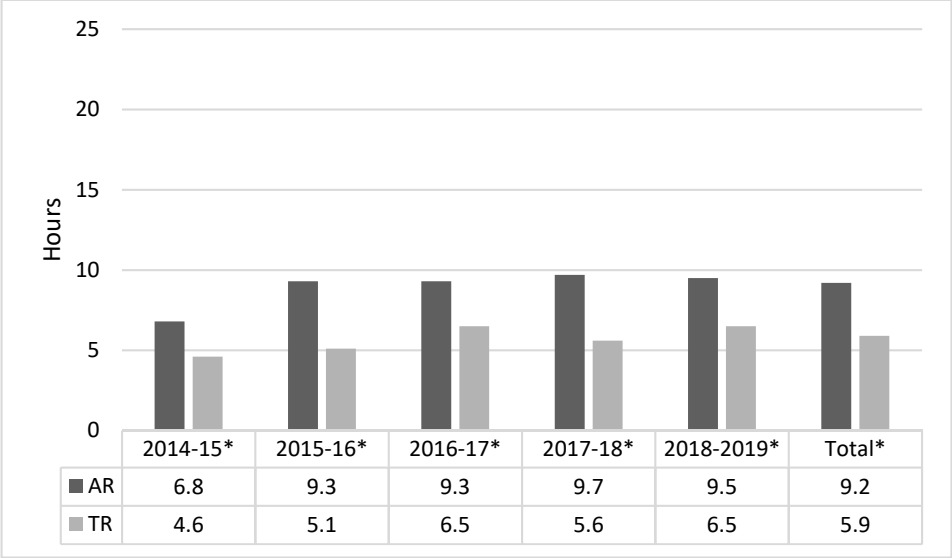
	2014-15*	2015-16*	2016-17*	2017-18*	2018-19	Total*
AR	8.3	11.7	10.8	11.3	11.3	10.9
TR	5.2	4.9	6.1	6.0	8.4	6.4

*p <.05 (2014-2015: $t(310) = 3.73$, $p = 0.00$; 2015-2016: $t(309) = 4.61$, $p = 0.00$; 2016-2017: $t(563) = 4.79$, $p = 0.00$; 2017-2018: $t(697) = 5.38$, $p = 0.00$; 2018-2019: $t(518) = 1.34$, $p = 0.18$)

Worker Indirect Time

Figure 6.1.2 shows the average indirect time workers spent in support of AR and TR families on an annual basis and the average total indirect time for the overall evaluation period from October 1, 2014 – June 30, 2019. Overall, the average amount of indirect time spent by workers in support of AR families was significantly greater than the average indirect time spent by workers in support of TR families, $t(2,405) = 7.37$, $p = 0.00$. Additionally, the average indirect time spent by workers in support of AR families was significantly greater than the average indirect time spent by workers in support of TR families for all years during the evaluation period. See below figure 6.1.2 for yearly significance testing.

Figure 6.1.2: Average Worker Time Spent in Support of Families



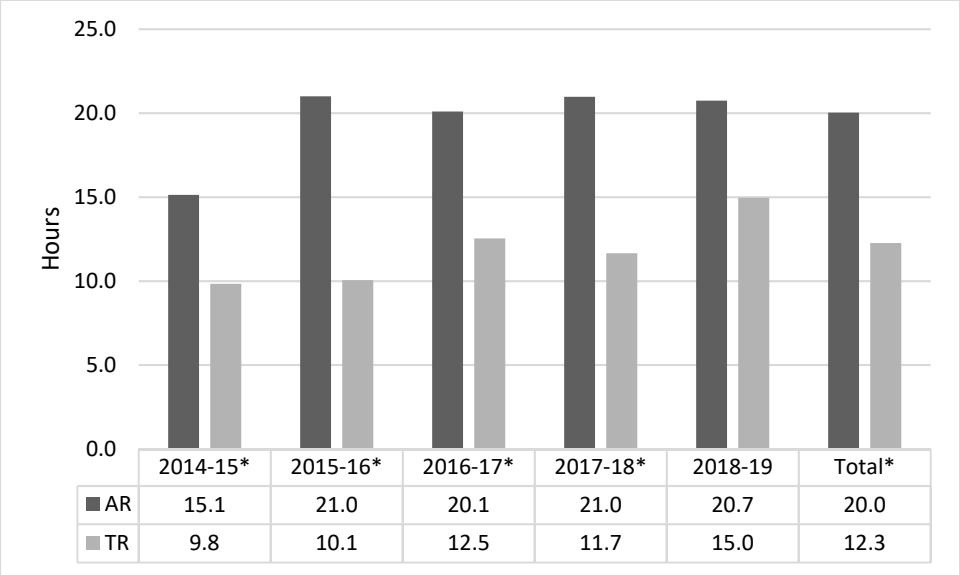
	2014-15*	2015-16*	2016-17*	2017-18*	2018-2019*	Total*
AR	6.8	9.3	9.3	9.7	9.5	9.2
TR	4.6	5.1	6.5	5.6	6.5	5.9

*p <.05 (2014-2015: $t(310) = 3.23$, $p = 0.00$; 2015-2016: $t(309) = 4.57$, $p = 0.00$; 2016-2017: $t(563) = 2.81$, $p = 0.01$; 2017-2018: $t(697) = 5.54$, $p = 0.00$; 2018-2019: $t(518) = 2.22$, $p = 0.03$)

Worker Total Time

Figure 6.1.3 shows the average time workers spent altogether (including direct and indirect time) with AR and TR families on an annual basis and the average total time for the entire evaluation period from October 1, 2014 – June 30, 2019. The average total time spent altogether by workers with AR families was significantly greater than the average total time spent altogether by workers with TR families, $t(2,405) = 7.76$, $p = 0.00$. Additionally, the average time spent altogether by workers with AR families was significantly greater than the average time spent altogether by workers with TR families for all years during the evaluation period, except for the 2018-2019 fiscal year where there was no significant difference. See below Figure 6.1.3 for yearly significance testing.

Figure 6.1.3: Average Total Worker Time



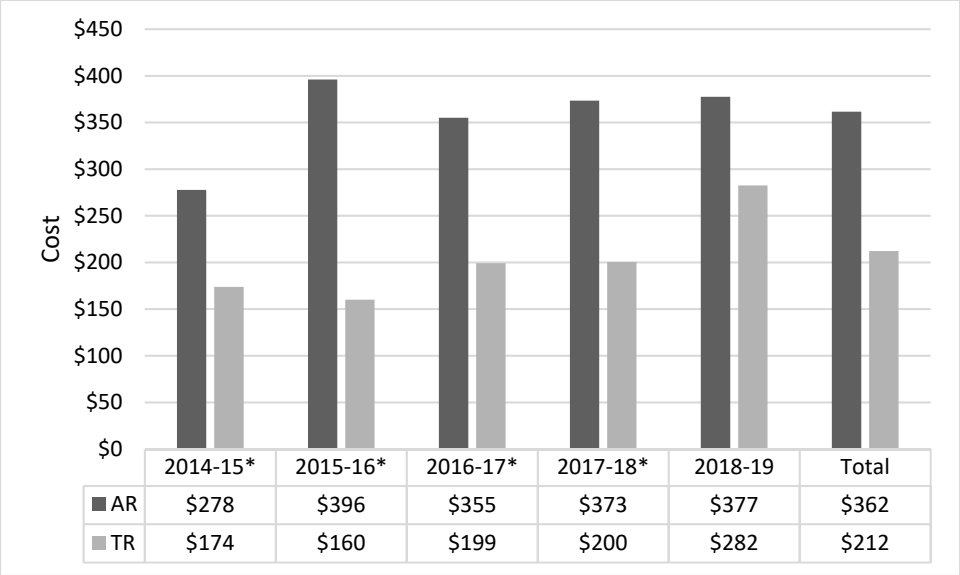
	2014-15*	2015-16*	2016-17*	2017-18*	2018-19	Total*
AR	15.1	21.0	20.1	21.0	20.7	20.0
TR	9.8	10.1	12.5	11.7	15.0	12.3

*$p < .05$ (2014-2015: $t(310) = 3.90$, $p = 0.00$; 2015-2016: $t(309) = 4.95$, $p = 0.00$; 2016-2017: $t(563) = 4.12$, $p = 0.00$; 2017-2018: $t(697) = 5.92$, $p = 0.00$; 2018-2019: $t(518) = 1.75$, $p = 0.08$)

Worker Direct Contact Costs

Figure 6.1.4 shows the average costs for time workers spent in direct contact with AR and TR families on an annual basis and the average total direct contact time for the entire evaluation period from October 1, 2014 – June 30, 2019. The average total costs for the amount of direct contact time spent by workers with AR families was significantly greater than for TR families, $t(2,405) = 7.76$, $p = 0.00$. Additionally, the average costs for time spent by workers in direct contact with AR families was significantly greater than TR families for all years during the evaluation period, except for the 2018-2019 fiscal year where there was no significant difference. See below Figure 6.1.4 for yearly significance testing.

Figure 6.1.4: Average Worker Costs Spent Directly with Families



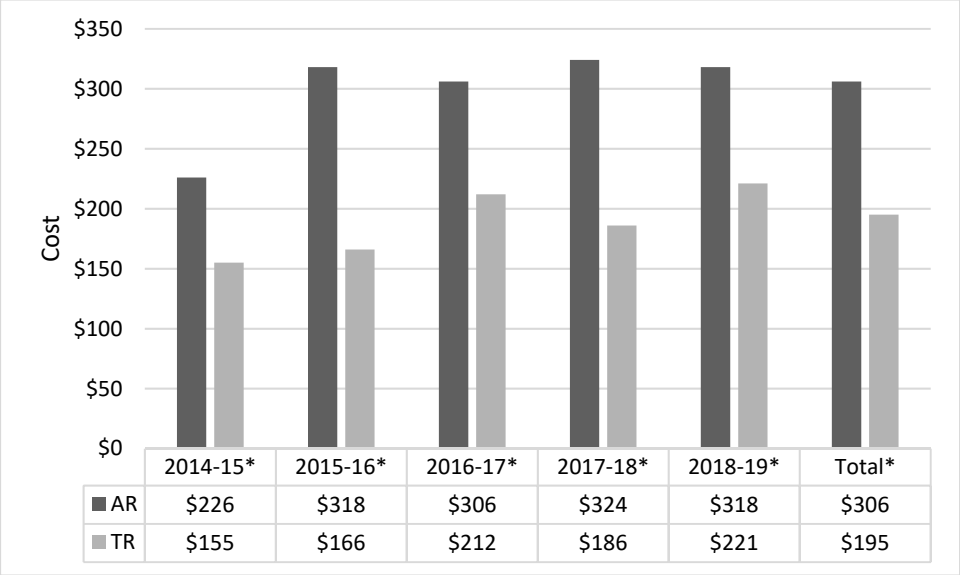
	2014-15*	2015-16*	2016-17*	2017-18*	2018-19	Total
AR	$278	$396	$355	$373	$377	$362
TR	$174	$160	$199	$200	$282	$212

*$p < .05$ (2014-2015: $t(310) = 3.73$, $p = 0.00$; 2015-2016: $t(309) = 4.62$, $p = 0.00$; 2016-2017: $t(563) = 4.79$, $p = 0.00$; 2017-2018: $t(697) = 5.38$, $p = 0.00$; 2018-2019: $t(518) = 1.34$, $p = 0.18$)

Worker Indirect Time Costs

Figure 6.1.5 shows the average costs for indirect time workers spent in support of AR and TR families on an annual basis and for the overall evaluation period from October 1, 2014 – June 30, 2019. Overall, the average amount costs of indirect time spent by workers in support of AR families was significantly greater than the average costs for indirect time spent by workers in support of TR families, $t(2,405) = 7.50$, $p = 0.00$. Additionally, the average costs for indirect time spent by workers in support of AR families was significantly greater than for TR families for all years during the evaluation period. See below Figure 6.1.5 for yearly significance testing.

Figure 6.1.5: Average Worker Costs in Support of Families



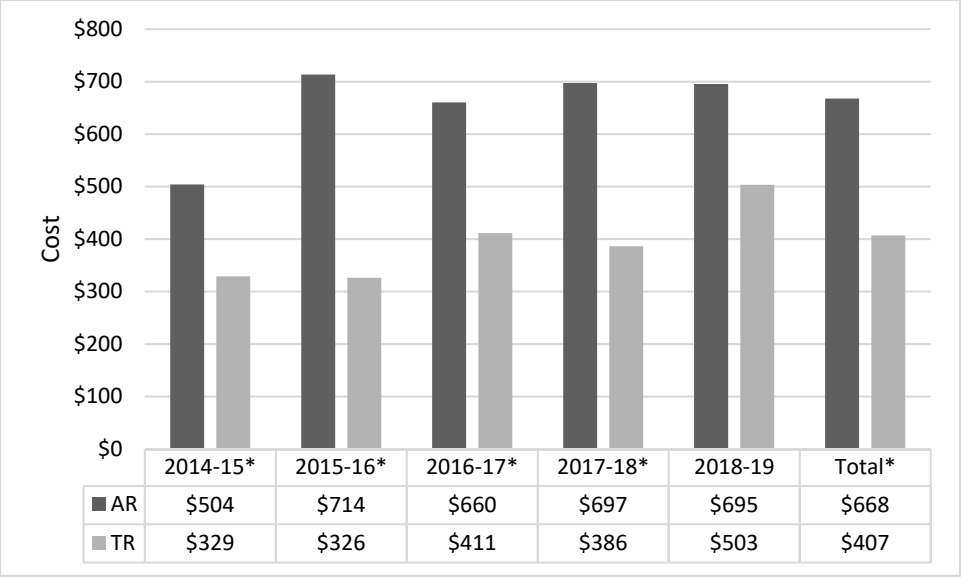
	2014-15*	2015-16*	2016-17*	2017-18*	2018-19*	Total*
AR	$226	$318	$306	$324	$318	$306
TR	$155	$166	$212	$186	$221	$195

*$p < .05$ (2014-2015: $t(310) = 3.02$, $p = 0.00$; 2015-2016: $t(309) = 5.05$, $p = 0.00$; 2016-2017: $t(563) = 2.87$, $p = 0.00$; 2017-2018: $t(697) = 5.54$, $p = 0.00$; 2018-2019: $t(518) = 2.32$, $p = 0.03$)

Worker Total Time Costs

Figure 6.1.6 shows the average worker cost per case for AR and TR families on an annual basis and for the overall evaluation period of October 1, 2014 – June 30, 2019. Overall, the average worker cost per case was significantly higher for AR families than TR families, $t(2,405) = 7.76$, $p = 0.00$. Additionally, the average worker costs associated with AR families was significantly greater than the average worker costs associated with TR families for all years during the evaluation period, except for the 2018-2019 fiscal year where there was no significant difference. See below Figure 6.1.6 for yearly significance testing.

Figure 6.1.6: Average Total Worker Cost per Case



	2014-15*	2015-16*	2016-17*	2017-18*	2018-19	Total*
AR	$504	$714	$660	$697	$695	$668
TR	$329	$326	$411	$386	$503	$407

*p <.05 (2014-2015: $t(310) = 3.72$, $p = 0.00$; 2015-2016: $t(309) = 5.38$, $p = 0.00$; 2016-2017: $t(563) = 4.19$, $p = 0.01$; 2017-2018: $t(697) = 5.93$, $p = 0.00$; 2018-2019: $t(518) = 1.76$, $p = 0.08$)

Service Costs

Using N-FOCUS data, service costs for 4,715 AR-eligible families (2,406 AR/2,309 TR) were examined for the time period of October 1, 2014 - June 30, 2019. The following analyses include both families with and without service costs. Among the 4,715 families, there were 20 (11 AR/9 TR) that comprised almost 50% of total service costs. In order to provide a more accurate view of the average service costs, data with and without the 20 outliers are summarized below.

Table 6.1.1 shows the total number of AR and AR-eligible TR families, average service costs per family, and average number of service types received. These data include service costs for 4,695 families (2,395 AR/ 2,300 TR), excluding the 20 outliers. There were no significant differences between AR and TR families for the average service costs per family, $t(4,714) = 1.34$, $p = 0.18$. The number of service types received were significantly higher for AR families than TR families, $t(4,694) = 7.33$, $p = 0.00$. However, since most families received no services, the averages are quite low – less than one service per family.

Table 6.1.1: Average Service Costs for All AR-Eligible Cases (Excluding Outliers)

	AR	TR	Total
Number of Families	2,395	2,300	4,695
Average Service Cost per Family	$1,076	$852	$966
Average Number of Service Types	0.6	0.3	0.5

Table 6.1.2 shows the total number of AR and AR-eligible TR families, average service costs per family, and average number of service types received. These data include service costs for 4,715 families (2,406 AR/ 2,309 TR), including the 20 outliers. There were no significant differences between AR and TR families for the average service costs per family, $t(4,714) = 0.24$, $p = 0.81$. The number of service types received were significantly higher for AR families than TR families, $t(4,714) = 6.22$, $p = 0.00$. Again, these

averages are quite low as most families did not receive a service. Average costs increase substantially once outliers are added to the data as is evidenced by comparing Tables 6.1.1 and 6.1.2.

Table 6.1.2: Average Service Costs for All AR-Eligible Cases (Including Outliers)

	AR	TR	Total
Number of Families	2,406	2,309	4,715
Average Service Cost per Family	$1,810	$1,710	$1,761
Average Number of Service Types	0.7	0.3	0.5

Of the 4,715 AR-eligible families, most families (3,911 families, 83%) did not receive a service. In total, 804 families (17%) received one or more services, as documented in N-FOCUS. Of those families that received a service, 572 (71%) were AR families and 232 (29%) were TR families, indicating that AR families were more than twice as likely to receive a service. Again, in order to provide a more accurate view of the average service costs, data with and without the 20 outliers (11 AR/9 TR) are summarized in the tables below. Please note that these data only include services paid directly by, or contracted through DCFS, and documented in N-FOCUS.

Table 6.1.3 includes service costs for the 784 families (561 AR/223 TR) identified as having received a service in N-FOCUS, excluding the 20 outliers. For those families receiving services, service costs for TR families were significantly higher than for AR families, $t(783) = 3.46$, $p = 0.00$. There were no significant differences between AR and TR families regarding the number of service types received, $t(783) = 1.67$, $p = 0.09$.

Table 6.1.3: Average Service Costs for Families Receiving Services (Excluding Outliers)

	AR	TR	Total
Number of Families	561	223	784
Average Service Cost per Family	$4,595	$8,787	$5,788
Average Number of Service Types	2.6	3.0	2.7

Table 6.1.4 includes service costs for the 804 families (572 AR/232 TR) identified as having received a service in N-FOCUS, including the 20 outliers. For those families receiving services, service costs for TR families were significantly higher than for AR families, $t(803) = 2.86$, $p = 0.01$. Additionally, TR families received significantly more types of services compared to AR families, $t(803) = 2.23$, $p = 0.03$. Average costs increase substantially once outliers are added to the data as is evidenced by comparing Tables 6.1.3 and 6.1.4.

Table 6.1.4: Average Service Costs for Families Receiving Services (Including Outliers)

	AR	TR	Total
Number of Families	572	232	804
Average Service Cost per Family	$7,613	$17,019	$10,327
Average Number of Service Types	2.8	3.5	3.0

SharePoint Service Costs

In addition to the AR Expense report provided via N-FOCUS, AR workers were asked to document service information in a SharePoint database. Although these data are not provided for AR-eligible cases assigned to TR, these data allow for a more complete examination of the services and service costs specific to AR families. While there were some duplicate data between SharePoint and N-FOCUS (45 instances), only unique data are summarized below.

Table 6.1.5 shows the number of families receiving at least one service recorded in SharePoint, total number of SharePoint services recorded per year, average number of services per family, total costs of services per year, and average service cost per family. This includes data from October 1, 2014 through June 30, 2019. Both the average number of services and the average cost of services per family remained relatively steady (excluding the 2014-15 fiscal year).

Table 6.1.5: SharePoint Service Costs

	2014-15	2015-16	2016-17	2017-18	2018-19	Total
Number of families receiving a service	24	64	142	182	198	610
Total number of services	36	122	319	422	352	1,251
Average number of services per family	1.5	1.9	2.2	2.3	1.8	2.1
Total cost of services	$35,797	$27,889	$49,870	$71,762	$61,907	$247,226
Average service cost per family	$1,492	$436	$351	$394	$313	$405

Figure 6.1.7 shows the total service costs documented in SharePoint from October 1, 2014 through June 30, 2019. These data are for 610 documented service expenditures.

Figure 6.1.7: Total SharePoint Expenditures by Year

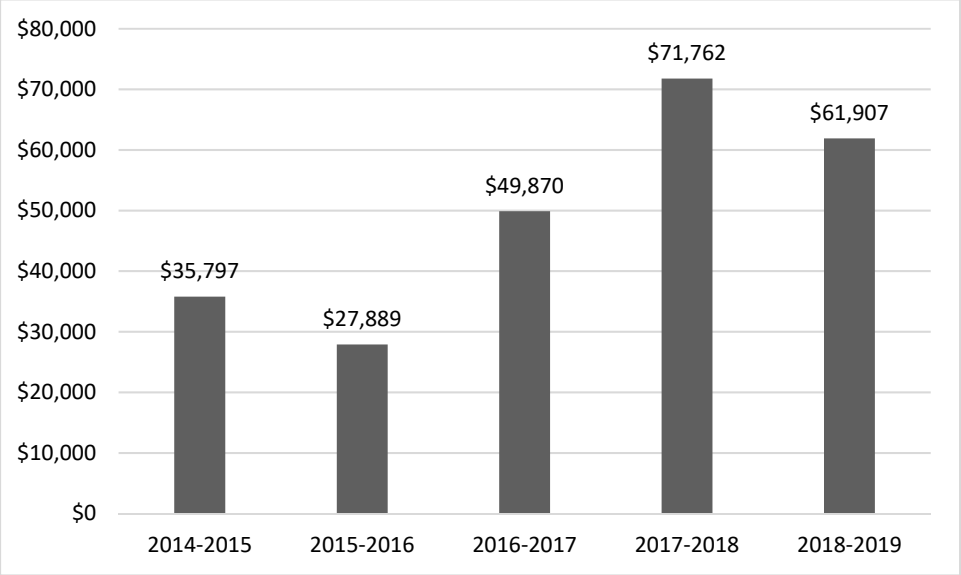
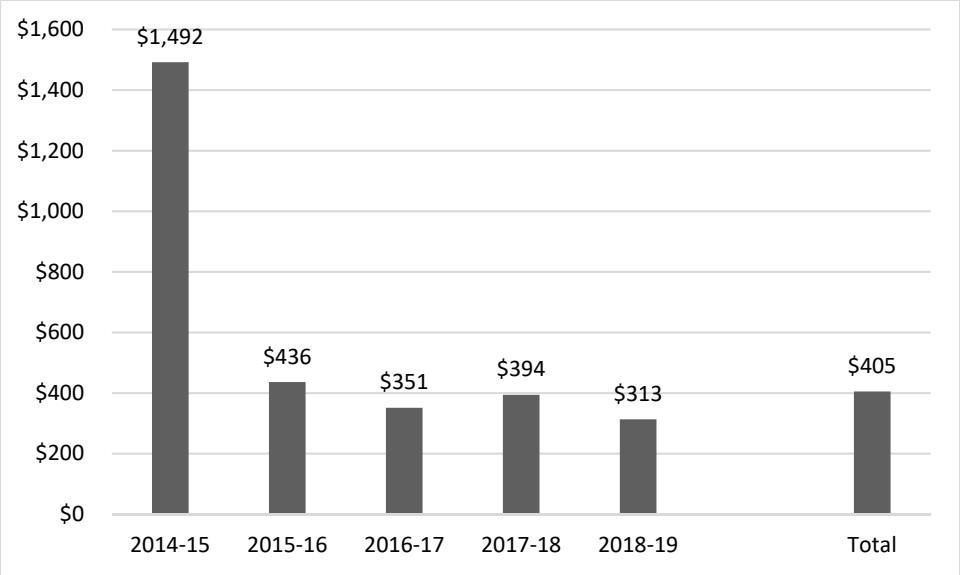


Figure 6.1.8 shows the average service costs per family for services documented in SharePoint, both on an annual basis and in total. While the average cost of services per family was higher in fiscal year 2014-15, average service costs for the remainder of the evaluation period have remained relatively steady.

Figure 6.1.8: Average SharePoint Service Cost per Family

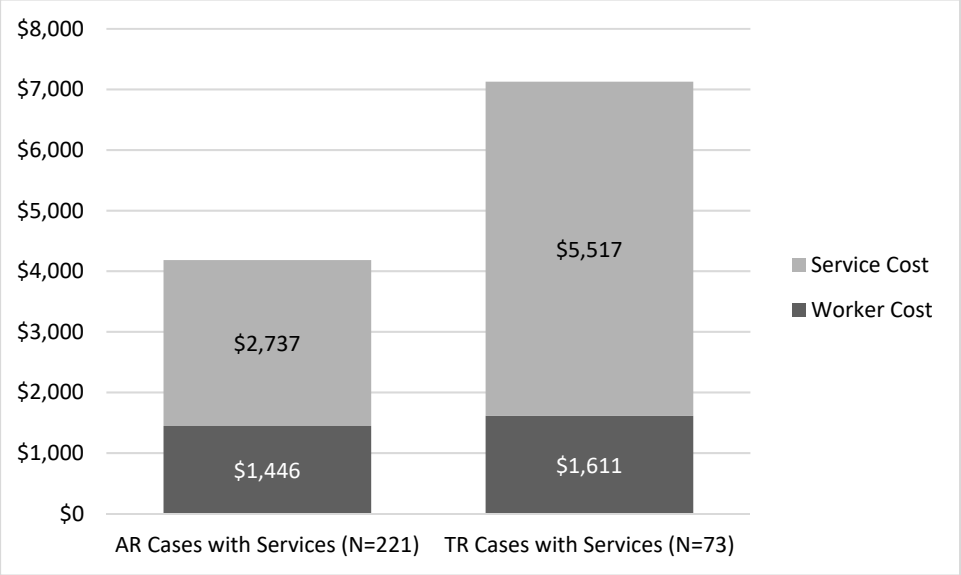


Combined Worker Costs and Service Costs

In order to holistically examine costs incurred for AR and AR-eligible TR families, worker time data collected through worker surveys were combined with service cost data from N-FOCUS where both worker costs and service costs were available. Between October 1, 2014 and June 30, 2019 there were 294 families (221 AR/73 TR) with valid worker cost data that also received at least one service recorded in N-FOCUS. There were four outliers (2AR/2TR) removed from this sample that effectively doubled average service costs.

For those families receiving services, the average cost of worker time was not significantly different between AR and TR families, $t(292) = 0.80$, $p = 0.43$. However, AR families that received a service experienced significantly lower average service costs compared to TR families, $t(292) = 2.89$, $p = 0.00$. Additionally, AR families receiving services experienced significantly lower total costs compared to TR families, $t(292) = 2.81$, $p = 0.01$. Figure 6.1.9 shows the combined average worker costs and average service costs for both AR and TR families that had valid worker time data and received at least one service.

Figure 6.1.9: Average Worker and Service Costs for Families Receiving a Service



Service Costs for Families that Changed Tracks

Service costs examined up to this point have been based on the intent-to-treat model; however, cases that changed track during the life of the case were examined in order to give a holistic view of costs incurred by AR families. Looking at all eligible cases that opened and closed within the evaluation time period, 4,715 AR-eligible families were included, of which 2,406 were initially assigned AR. Of those 2,406 AR cases, there were 278 cases (12%) that changed tracks from AR to TR. For this sample, there were 11 outliers that comprised more than 50% of service costs. In order to provide a more accurate view of the average costs of AR families, those 11 outliers have been excluded from the following analyses.

Please note that families initially assigned TR cannot change tracks to AR, only AR families can change tracks to TR. Due to the nature of intent-to-treat model, statistical comparisons of AR families to TR families based on final track are not provided as they would not be representative of the true costs incurred in relation to the AR program.

Figure 6.1.10 shows average service costs for AR families that remained AR and AR families that changed tracks to TR during the life of their case. These costs are averaged for all AR families, regardless of whether they received a service or not. The highest average service costs were for families that changed tracks from AR to TR before their case closed.

Figure 6.1.10: Average Service Costs for All AR Families – Final Track

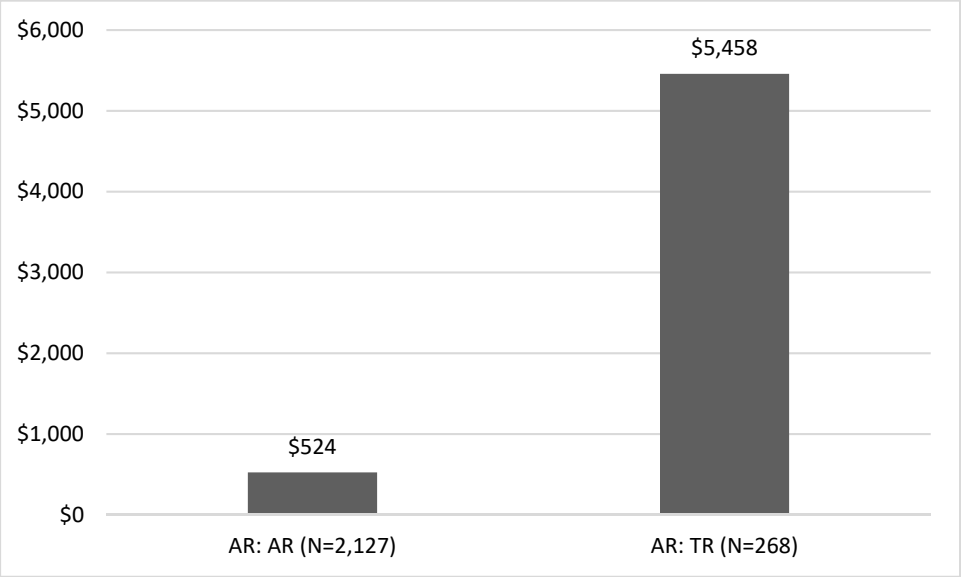


Figure 6.1.11 shows average service costs for AR families that remained AR and AR families that changed tracks to TR during the life of their case. These costs are averaged for all AR families that received a service excluding 11 outliers. Again, the highest average service costs were for families that changed tracks from AR to TR before their case closed.

Figure 6.1.11: Average Service Costs for AR Families that Received a Service – Final Track

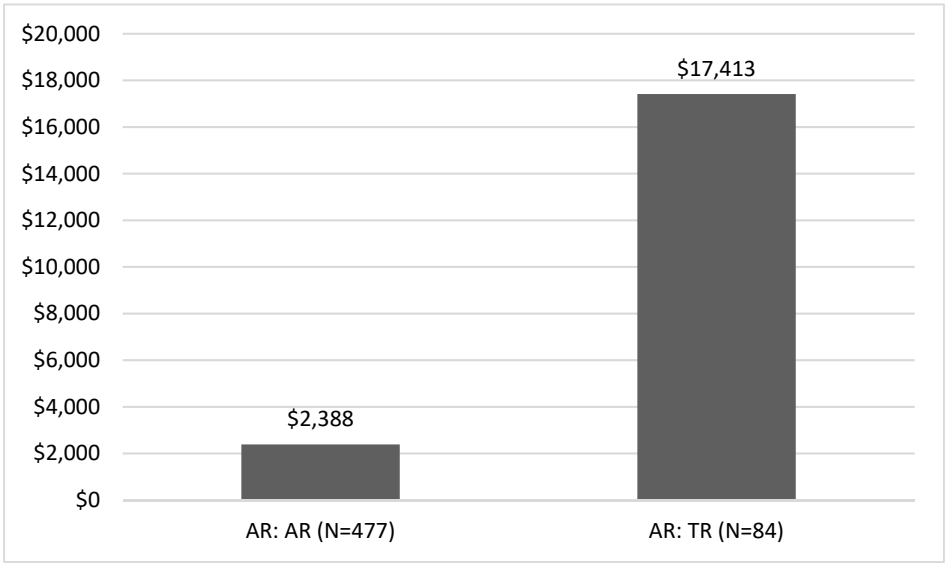


Figure 6.1.12 shows the ten highest expenditures by service type for services received by AR families that remained AR throughout their case. The highest service expenses for these families were related to in-home supports.

Figure 6.1.12: Top 10 Service Expenses – AR:AR

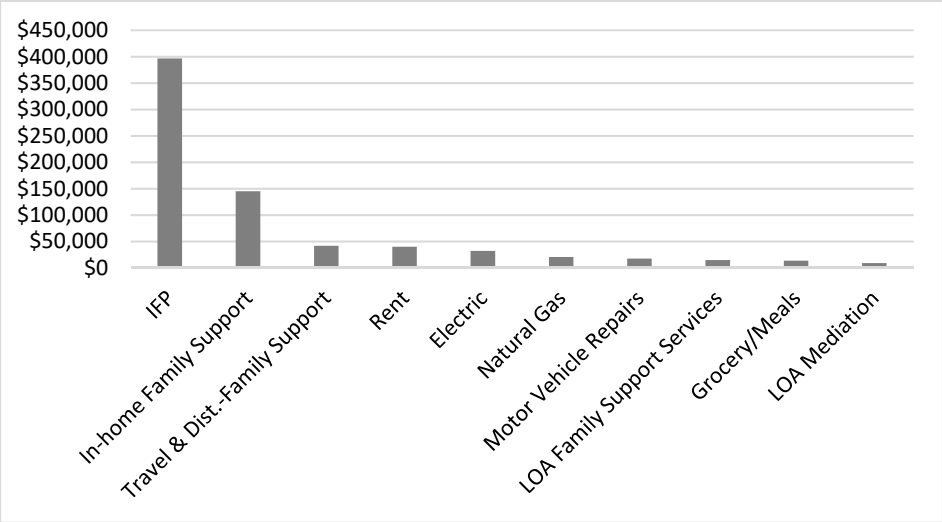
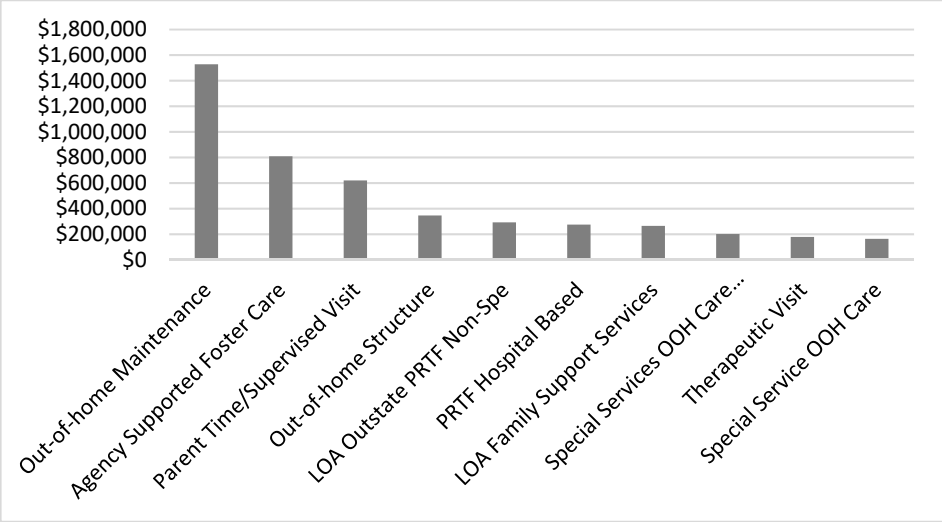


Figure 6.1.13 shows the ten highest expenditures by service type for services received by families initially assigned AR, but changed tracks to TR. For those families that changed tracks, the largest service expenditures were related to out-of-home care.

Figure 6.1.13: Top 10 Service Expenses – AR:TR

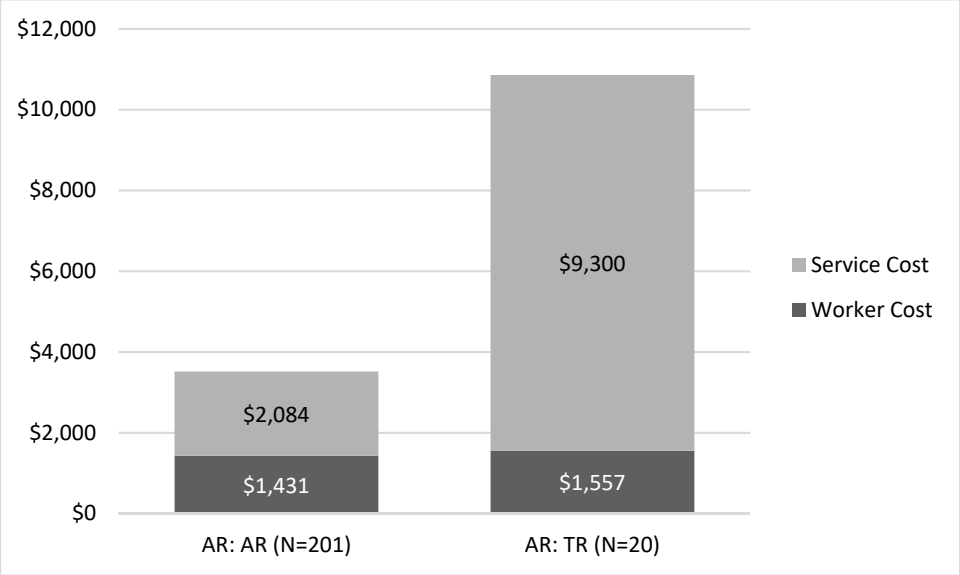


Combined Worker and Service Costs for Families that Changed Tracks

Again, in order to provider a holistic view of costs incurred, the following data compare AR families that remained AR and AR families that changed tracks to TR during the life of their case. For this sample, worker costs from the worker surveys were combined with service costs from N-FOCUS. There were 221 AR families with both valid worker and service costs. Of those 221 families initially assigned AR, 20 of those families changed tracks to TR during the life of their case.

Average cost of worker time was slightly higher for those families that changed tracks. However, average costs of services and average total costs were much higher for those families that changed tracks to TR, compared to those families that remained AR. Figure 6.1.14 shows the average worker costs and average service costs for AR families that remained AR and for those families that changed tracks to TR.

Figure 6.1.14: Average Worker and Service Costs for Families Receiving a Service – Final Track



Administrative Cost Results

Table 6.1.6 shows total and monthly average costs for supervisors, upper-level administrators, RED team members, and AR trainings for each fiscal year and for the overall evaluation period of October 1, 2014 through June 30, 2019.

Table 6.1.6: Administrative Costs

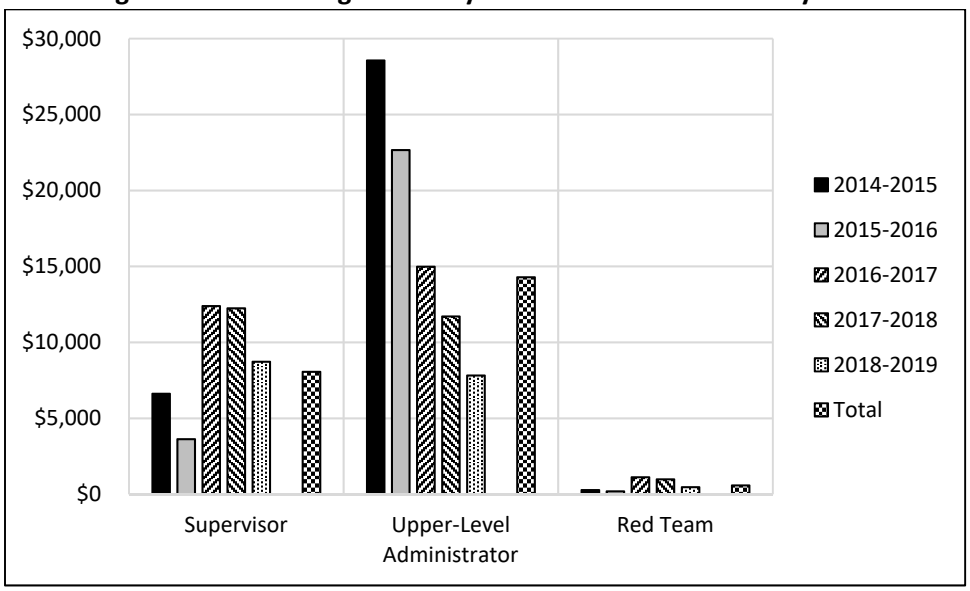
	Non Case-Related Supervisor Costs	Case-Related Supervisor Costs	Upper-Level Administrator Cost	RED Team Costs	Training Costs	Total
2014-2015: Total	$29,076	$10,614	$171,360	$1,644	$1,423,722	$1,636,410
Monthly Average	$4,846	$1,769	$28,560	$274	$237,287	$272,735
2015-2016: Total	$27,765	$15,775	$271,965	$2,265	$75,000	$392,771
Monthly Average	$2,314	$1,315	$22,664	$189	$6,250	$32,731
2016-2017: Total	$102,004	$46,639	$179,769	$13,477	$61,575	$403,464
Monthly Average	$8,500	$3,886	$14,980	$1,123	$5,131	$33,622
2017-2018: Total	$108,817	$38,098	$140,534	$11,803	$15,730	$314,982
Monthly Average	$9,068	$3,175	$11,711	$984	$1,311	$26,248

	Non Case-Related Supervisor Costs	Case-Related Supervisor Costs	Upper-Level Administrator Cost	RED Team Costs	Training Costs	Total
2018-2019: Total	$76,810	$27,930	$93,858	$5,632	$15,390	$219,619
Monthly Average	$6,401	$2,328	$7,821	$469	$1,283	$18,302
2014-2019: Total	**$344,472**	**$139,056**	**$857,486**	**$34,821**	**$1,591,417**	**$2,967,246**
Monthly Average	**$5,741**	**$2,318**	**$14,291**	**$580**	**$26,524**	**$49,454**

Figure 6.1.15 shows the monthly average administrative costs for AR, by fiscal year. Aggregate supervisor (case and non-case-related) costs leveled off in 2016-2017 and 2017-2018, and then fell in 2018-2019. Upper-level administrative costs have been falling throughout the five-year period. RED team costs have fallen slightly over the last three fiscal years.

All costs have fallen from peak levels in 2015-2016 or 2016-2017. This is likely due to moving past start up needs and expansion of program implementation. Training costs in the first year were likely much higher due to the initial implementation of the AR program and associated training needs for administrators, supervisors, and workers.

Figure 6.1.15: Average Monthly AR Administrative Costs by Year



Conclusion

Worker Time

Worker time was used as a key metric for determining costs associated with AR and AR-eligible TR families. UNL-CCFL collected time estimates from workers for time spent working directly with the family (e.g., face-to-face meetings, phone calls with family), time spent indirectly or on behalf of the family (e.g., researching service options, travel time, documenting assessments), and time altogether.

For direct time, indirect time, and time altogether, workers indicated that they spent significantly more time with AR families than TR families. These findings were true across all years of the evaluation period, with the exception of the fiscal year 2018-2019, in which workers still spent more time with and on behalf of AR families compared to TR families, but this difference was not statistically significant.

Worker Time Costs

Using worker time estimates and hourly wages, average worker costs were calculated for time spent in direct contact with families, indirect time spent on behalf of families, and time altogether. In general, average worker costs were significantly higher for AR families than TR families for time spent in direct contact with families, time spent on behalf of families, and time spent altogether on a case.

Service Costs

According to N-FOCUS data, across all families (regardless of whether they received services or not), AR families received significantly more types of services than TR families; however, there were no significant differences between AR and TR families on the average service costs per family. Although only 17% of families in the study received a service, AR families were more than twice as likely as TR families to receive a service. For those families that received services, service costs for TR families were significantly higher than for AR families; however, there were no significant differences regarding the number of service types received between AR and TR families.

Additionally, workers were asked to document services provided to AR families in SharePoint. There were 610 documented expenditures for an average of $405 per family. This average was much higher during the first nine months of AR implementation, but has remained relatively stable since June 2015.

Combined Worker and Service Costs

In order to examine overall average costs of a case, worker time costs were combined with service costs when both data were available. For those families receiving services, the average cost of worker time was not significantly different between AR and TR families; however, TR families experienced significantly higher average service costs and total costs, compared to AR families.

Service Costs for Families that Changed Tracks

Additional analyses were conducted for a more complete examination of costs comparing families that changed track from AR to TR during their case with families that remained AR. For all families initially assigned AR (regardless of receiving a service or not), average service costs were ten times higher for those families that changed tracks from AR to TR compared to families that remained AR throughout their case. For families initially assigned AR that received a service, average service costs were seven times higher for those families that changed tracks from AR to TR compared to families that remained AR throughout their case. The highest service expenses for AR families that remained AR were related to in-home supports. For those families that changed tracks, the largest service expenses were related to out-of-home care.

Combined Worker and Service Costs for Families that Changed Tracks

Again, for a more complete examination of costs, additional analyses were conducted comparing families that changed track from AR to TR during their case with families that remained AR for the entire case. For those families, worker time costs were combined with service costs when both data were available. Average costs of worker time is slightly higher for those families that changed tracks, however,

average costs of services and average total costs were three times higher for those families that changed tracks to TR compared to those families that remained AR.

Administrative Cost Results

Administrative costs were for supervisors, upper-level administrators, RED team, and AR-related trainings. Supervisor costs (both case and non-case related) peaked in fiscal years 2016-17 and 2017-18, but fell during the final year of the evaluation period. Upper-level administrative costs have steadily fallen throughout the five-year period. RED team costs have fallen slightly over the last three fiscal years. Training costs in the first year were much higher due to the initial implementation of the AR program and associated training needs for administrators, supervisors, and workers. Overall, administrative costs have fallen since initial implementation and statewide rollout. This is likely due to moving past start up needs and expansion of program implementation.

Chapter 2: Cost-Effectiveness of Alternative Response

Key Questions:

- Is AR a more cost-effective case practice than TR?

Data Sources and Data Collection

Worker Time and Costs

Worker time was collected through surveys. These surveys asked workers to estimate the total amount of time spent on a case, as well as the amount of time spent in direct contact with the family. Surveys were completed for both AR and AR-eligible TR families, so that a comparison could be made of costs under each treatment. For cases that were open less than 90 days, only the AR Worker End-of-Case Survey (Worker Survey) was sent. In cases open longer than 90 days, a 90-Day AR Worker Time Survey was sent. Additionally, a 60-Day AR Worker Time Survey was sent every 60 days thereafter until the case closed, at which point the End-of-Case Survey was sent. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Worker hourly rates were provided by DCFS. In order to account for indirect costs, multipliers of 35% and 48% are used to calculate costs associated with benefits and overhead, respectively. To ensure accurate worker time data, only cases that had the original worker throughout the entirety of the case are included.

Family Engagement

DCFS has hypothesized that family engagement will be greater for families receiving AR versus TR. To test this hypothesis, UNL-CCFL collected survey data related to family engagement for all AR-eligible families. Family perceptions of family engagement are collected from families at the end of the case through the Family Experience survey. Worker perceptions of family engagement are collected from workers at the end of the case through the Worker End-of-Case survey. This report summarizes differences in ratings of family engagement for AR and TR from both the family and worker perspective.

Family engagement is being assessed using an adapted version of Yatchmenoff's Client Engagement Scale (YCES; 2005). This measure includes 16 items across 4 subscales: receptivity (4 items), buy-in (6 items), relationship with worker (4 items), and mistrust (2 items). In addition to the 4 subscales, all items are combined into an overall engagement score. Each item is rated on a 5-point scale of agreement (1 = *Strongly Disagree*, 5 = *Strongly Agree*). For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*.

Data Analysis

Cost-effectiveness analyses were conducted examining costs related to worker time and family engagement. Family engagement was selected as the outcome measure for these analyses due to the hypothesis that increased family engagement is likely to lead to other long-term outcomes. These analyses include data on worker costs and family engagement over the evaluation period of October 2014 through June 2019. Data included are based on the intent-to-treat model, therefore comparisons between AR and AR-eligible TR families are reflective of initial track assignments.

Results

Family Engagement Cost-Effectiveness Analysis (from Family's Perspective)

Family survey data was used to assess differences in AR and AR-eligible TR families' perceptions of engagement after case closure. For these analyses, engagement data from the Family Experience survey were combined with worker time survey data to examine costs in cases where both data were available.

Table 6.2.1 shows the number of families, average family engagement scores from the family's perspective, and worker costs for both AR and AR-eligible TR cases, where complete engagement and cost data were available. There were 436 (238 AR/198 TR) cases with both family engagement data and worker time data. For this sample, AR families reported to be significantly more engaged than TR families, $t(407) = 3.93$, $p = 0.00$. Average worker costs for AR families were significantly higher than those for TR families for both time spent in direct contact with the family, $t(322) = 6.47$, $p = 0.00$, as well as time spent altogether on behalf of the family, $t(366) = 6.39$, $p = 0.00$. In sum, AR families reported significantly greater engagement than TR families; however, worker costs for AR families were significantly higher than worker costs for TR families.

Table 6.2.1: Family Engagement from the Family's Perspective Analysis

	AR	TR
Number of Families	238	198
Family Engagement Score	3.61	3.31
Worker Cost for Time Spent Directly with Family	$440	$183
Worker Cost for Time Spent on Behalf of Family	$783	$376

In order to examine the relative cost-effectiveness for AR and AR-eligible TR families, a ratio of worker cost to the average overall family engagement score was calculated. Table 6.2.2 shows the relative cost-effectiveness ratios for worker costs (both direct and altogether) and average family engagement scores from the family's perspective. Cost-effectiveness ratios for AR families were significantly higher than for TR families, both for worker time spent in direct contact with families and time spent altogether; $t(356) = 5.80$ and $p = 0.00$ and $t(396) = 5.66$, $p = 0.00$, respectively.

Table 6.2.2: Relative Cost-Effectiveness - Family Engagement

	AR	TR
$\frac{\text{Worker Direct Cost}}{\text{Family Engagement Score}}$	$120	$58
$\frac{\text{Worker Altogether Cost}}{\text{Family Engagement Score}}$	$215	$118

For this sample, the cost-effectiveness ratio for AR families is $120, meaning that each point in the overall engagement score is associated with $120 in worker time spent directly with the family. However, interpreting these results does not mean that spending another $120 will increase an AR family's engagement score by one point, but rather, every one point on the family engagement scale is associated with $120 in worker time spent directly with the family.

Family Engagement Cost-Effectiveness Analysis (from Worker's Perspective)
Worker data were used to assess differences in worker perceptions of AR and AR-eligible TR families' engagement after their case had closed. Worker End-of-Case survey engagement data were combined with worker time survey data to examine costs in cases where both data were available.

Table 6.2.3 shows the number of families, average family engagement scores from the worker's perspective, and worker costs for both AR and AR-eligible TR cases. There were 1,972 (1,010 AR/961 TR) cases with complete family engagement data combined with worker time data. For this sample, AR families were reported to be significantly more engaged than TR families, $t(1,966) = 3.12$, $p = 0.00$. Average worker costs for AR families were also significantly higher than those for TR families, for both time spent in direct contact with the family, $t(1,301) = 2.36$, $p = 0.02$, as well as time spent on behalf of the family, $t(1,497) = 3.22$, $p = 0.00$. In sum, workers reported significantly greater engagement for AR families than TR families; however, worker costs for AR families were significantly higher than worker costs for TR families.

Table 6.2.3: Family Engagement from Worker's Perspective Analysis

	AR	TR
Number of Families	1,010	961
Worker Engagement Score	3.39	3.30
Worker Cost for Time Spent Directly with Family	$423	$298
Worker Cost for All Time Spent on Behalf of Family	$772	$535

Table 6.2.4 shows the relative cost-effectiveness ratios for worker costs (both direct and altogether) and average family engagement scores from the worker's perspective. Cost-effectiveness ratios for AR families were higher than TR families, both for worker time spent in direct contact with families and time spent altogether, however these findings were not significant; $t(1,127) = 1.03$, $p = 0.30$ and $t(1,247) = 1.65$, $p = 0.10$, respectively.

Table 6.2.4: Relative Cost-Effectiveness - Family Engagement

	AR	TR
$\frac{\text{Worker Direct Cost}}{\text{Family Protective Factor Score}}$	$119	$97
$\frac{\text{Worker Altogether Cost}}{\text{Family Protective Factor Score}}$	$221	$173

For this sample the cost-effectiveness ratio for AR families is $119, meaning that each point in the engagement score is associated with $119 in worker time spent directly with the family.

Combined Family Engagement Cost-Effectiveness Analysis
For this sample, data were examined for cases in which both worker and family completed the respective survey (End-of-Case Worker survey and Family Experience survey) at case closure. Engagement data from both surveys were combined with worker time data to further examine costs.

Table 6.2.5 shows the number of families, average engagement scores from the family's perspective, average engagement scores from the worker's perspective, and worker costs for both AR and AR-eligible TR cases. There were 388 (217 AR/171 TR) cases with complete engagement data combined **with** worker

time data. From both the family's and worker's perspective, AR families have significantly higher engagement scores compared to TR families, $t(357) = 3.46$, $p = 0.00$ and $t(380) = 3.81$, $p = 0.00$, respectively. However, average worker costs (both direct and altogether) for AR families are significantly higher than those for TR families, $t(273) = 6.92$, $p = 0.00$ and $t(305) = 6.63$, $p = 0.00$, respectively. In sum, AR families are more engaged than TR families but also have higher average worker costs.

Table 6.2.5: Combined Family and Worker Engagement Analysis

	AR	TR
Number of Families	217	171
Family Engagement Score	3.62	3.34
Worker Engagement Score	3.58	3.35
Worker Cost for Time Spent Directly with Family	$471	$182
Worker Cost for All Time Spent on Behalf of Family	$831	$392

Table 6.2.6 shows the relative cost-effectiveness ratios for worker costs spent in direct contact with the family, altogether worker costs, average engagement scores from the family's perspective, and average engagement score from the worker's perspective. From the family's perspective, cost-effectiveness ratios for AR families are significantly higher than TR families, for both worker time spent in direct contact with families, $t(295) = 6.40$, $p = 0.00$, and altogether $t(331) = 6.38$, $p = 0.00$. Additionally, from the worker's perspective, cost-effectiveness ratios for AR families are significantly higher than TR families, for both worker time spent in direct contact with families, $t(286) = 6.59$, $p = 0.00$, and altogether $t(345) = 6.25$, $p = 0.00$.

Table 6.2.6: Relative Cost-Effectiveness – Family Engagement

	AR	TR
$\frac{\text{Worker Direct Cost}}{\text{Family Engagement Score}}$	$128	$57
$\frac{\text{Worker Direct Cost}}{\text{Worker Engagement Score}}$	$123	$54
$\frac{\text{Worker Altogether Cost}}{\text{Family Engagement Score}}$	$227	$115
$\frac{\text{Worker Altogether Cost}}{\text{Worker Score}}$	$219	$112

Conclusion

Cost-effectiveness analysis compares the relative costs and outcomes of different treatment types. The analysis measures the impact per dollar of spending on each treatment. In this analysis the costs were attributed to worker time, the outcome selected was family engagement, and the treatment types were AR and TR. Overall, the cost-effectiveness analysis indicates that while AR has significantly greater family engagement than TR, it comes at higher worker time costs. The cost-effectiveness data show that for worker time costs, the impact per dollar on family engagement is greater under TR than AR. It is recommended that future analyses examine the relationship between total case costs (worker time and

services) and effectiveness (family engagement or other metric). Due to a prohibitively small sample size, these analyses were unable to be completed during the demonstration project.

Chapter 3: Results-Based Accountability Cost Study

Key Questions:

- How do RBA administrative costs evolve over time?
- How do rates for contracted services compare between pre- and post-RBA implementation?

Data Sources and Data Collection

Administrative time

The administrative resources required for RBA implementation are personnel, overhead and indirect expenses, and consulting services and software licenses.

Personnel time estimates were initially tracked in Kronos - a time management and tracking system. All DCFS employees with a role in IV-E waiver activities were identified. Some employees were only involved in RBA, in which case all of their IV-E waiver activity time was attributed to RBA. Others were involved in both AR and RBA. For those personnel with dual roles, time was allocated 50/50 between AR and RBA. In October 2015, Kronos time tracking discontinued for RBA activities and was replaced with the RBA Monthly Time Survey in order to capture time estimates for workers identified by DCFS as participating in RBA. Respondents were asked to enter the estimated number of total hours they spent on RBA-related activities, rounded to the nearest hour. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection*.

Worker Wage, Benefit and Overhead Data

Hourly wage data were provided by DCFS for personnel associated with RBA. In order to account for indirect costs, a multiplier of 35% was used to calculate benefit costs. Additionally, a multiplier of 48% was used to calculate overhead. After data were collected from personnel estimating the amount of time spent on RBA-related activities, hourly wage rates (loaded for benefits, indirect costs and overhead) were multiplied by hours to estimate fully loaded costs for RBA personnel.

Results Leadership Group and Scorecard Costs

Fiscal year costs for consulting provided by the Results Leadership Group (RLG) and Scorecard licenses were acquired from billing records tracked by DCFS. There were no reported costs for either RLG or Scorecard for the third quarter of 2016.

Data Analysis

Analyses were conducted of costs related to administrative time to see how administrative costs evolve over time. Analyses were also conducted on rates, usage and expenditures for three services: agency supported foster care, family support services, and intensive family preservation.

Results

Table 6.3.1 shows quarterly administrative costs associated with RBA from July 2014 through October 2016 (note that October 2016 is included in quarter 16:III). For the time period studied, 28 administrators were included, of which personnel costs (including benefits) were $105,667, and

overhead costs of $50,720, for total personnel costs of $156,387. Total administrative costs, including RLG and Scorecard licensing, were $252,354.

Table 6.3.1: RBA Administrative Costs by Quarter

Year: Quarter	Personnel Costs With Benefits	Overhead Costs	Total Personnel Costs	RLG and Scorecard Costs	Total Costs
14: III	$5,283	$2,536	$7,819	$10,392	$18,211
14: IV	$2,800	$1,344	$4,144	$10,392	$14,536
15: I	$3,117	$1,497	$4,614	$10,392	$15,006
15: II	$8,820	$4,233	$13,053	$10,392	$23,445
15: III	$7,891	$3,787	$11,678	$13,600	$25,278
15: IV	$14,502	$6,961	$21,463	$13,600	$35,063
16: I	$21,249	$10,199	$31,448	$13,600	$45,048
16: II	$13,087	$6,282	$19,369	$13,600	$32,969
16: III	$28,917	$13,880	$42,798	$0	$42,798
Total	$105,667	$50,720	$156,387	$95,968	$252,354

Figure 6.3.1 shows the RBA monthly average total personnel cost over the 9-quarter period from July, 2014 through September, 2016. Using a monthly average removes any bias caused by including October, 2016 in quarter 16:III. A trend line is included and shows that average monthly total personnel costs were trending upward by quarter.

Figure 6.3.1: RBA Monthly Average Total Personnel Costs by Quarter

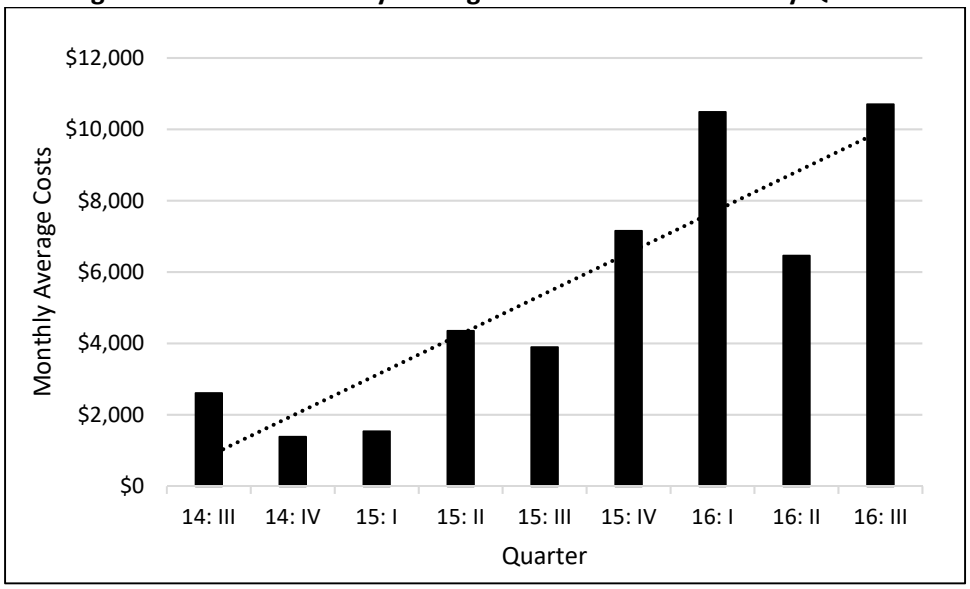
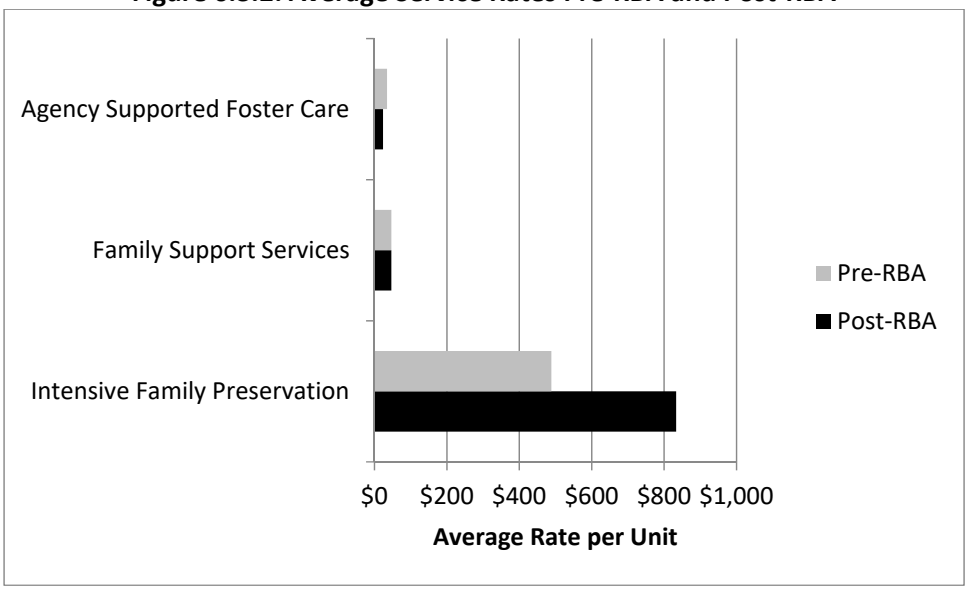


Figure 6.3.2 shows the average rate per use for agency supported foster care, family support services and intensive family preservation. Average rates for agency supported foster care (pre-RBA: $34, post-RBA: $24) and family support services (pre- and post-RBA: $47) have remained stable pre- and post-RBA. Average rates for intensive family preservation have nearly doubled (pre-RBA: $489, post-RBA: $833).

Figure 6.3.2: Average Service Rates Pre-RBA and Post-RBA



RBA: Provider Cost Case Study

In order to get an estimate of RBA-related costs incurred by service providers, a supplemental cost analysis "case study" survey was developed. A small, medium, and large-scale service provider agreed to voluntarily track and supply the evaluators with monthly cost data. The aim of this survey was to collect cost data from agencies subject to RBA as the implementation of the program required additional data collection, data entry, and meetings between the service provider agencies and DCFS.

These data were collected via a monthly Qualtrics survey sent directly to a representative of each of these three agencies. This case study allowed the evaluators to estimate the true *systemic* costs of the RBA intervention, beyond the estimates of the costs to DCFS of implementing RBA.

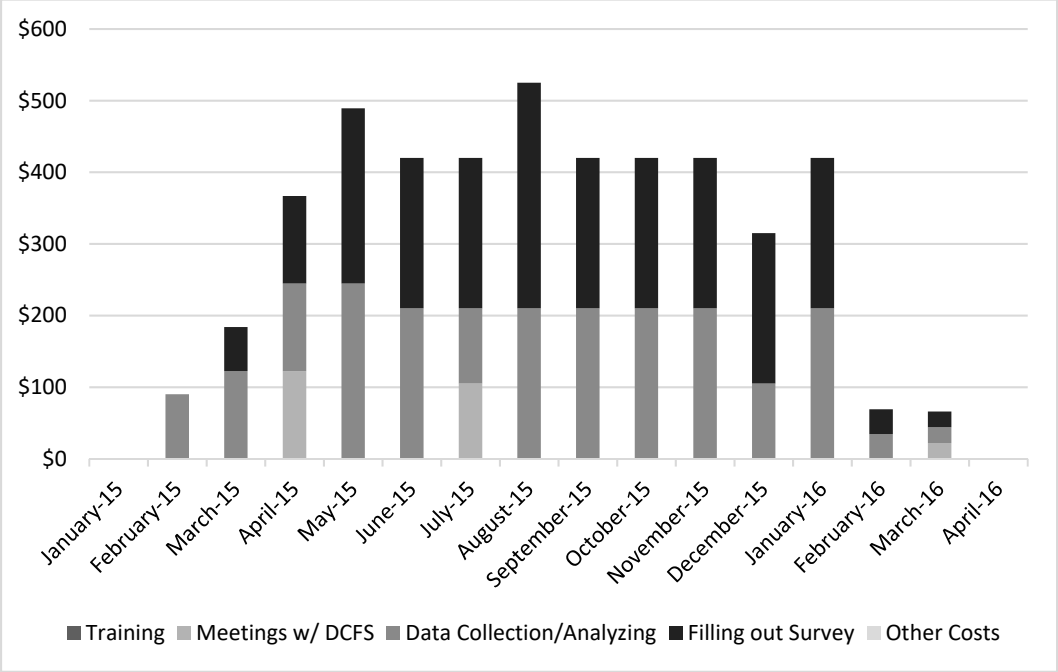
Survey efforts began in February 2015, collecting estimated time spent on RBA-related activities for the previous month (i.e., January 2015). Time estimates were collected for general RBA-related activities which included training, collecting and analyzing data, meetings with DCFS, and time spent completing the survey. Additionally, for each service subject to RBA (agency supported foster care, family support services, and intensive family preservation), time estimates were collected for any Turn-the-Curve meetings and action plan implementation that may have occurred. For all RBA-related activities, data were collected for total hours spent doing the activity, average wage per hour of the employees involved in the activity, average benefit costs, and average overhead costs.

The survey data in this report is for the time period January 2015 through April 2016. Overall, the response rate for this 16-month time period was 69%. Combined total average costs for all three agencies implementing RBA was $296 per month, with the majority of costs incurred from filling out the survey and collecting/analyzing data. Summaries for each agency are presented below

Small-Sized Agency

For the time period of January 2015 through April 2016, time estimates were received from the small-sized agency for 14 of the 16 months, resulting in an overall response rate of 88%. The average total cost of doing RBA-related activites was $330 per month for this agency. The majority of these costs were incurred due to time spent filling out the survey (averaging $162 per month), followed by collecting and analyzing data (averaging $150 per month). The small-sized agency provided two services subject to RBA: agency supported foster care and family support services. For the reporting period, $162 were spent in total doing RBA activites related to agency supported foster care. There were no costs reported for family support service activities. Figure 1 shows the total costs per activity for the small-sized agency.

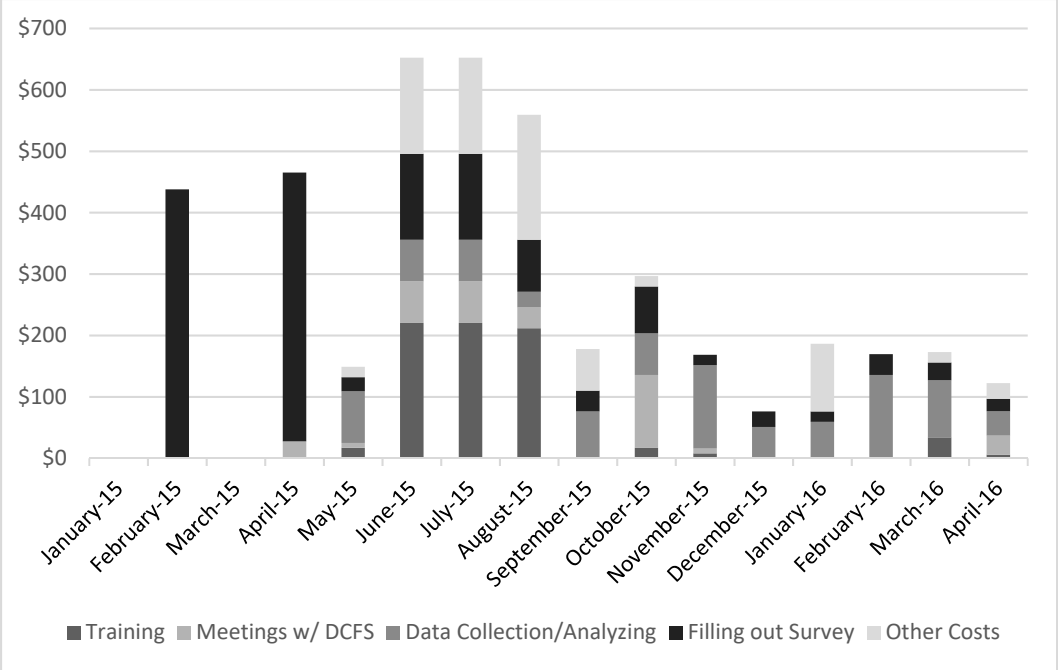
Figure 6.3.3: Small-Sized Agency Total Costs per Month for RBA-Related Activities



Medium-Sized Agency

For the time period of January 2015 through April 2016, time estimates were received from the medium-sized agency for 14 of the 16 months, resulting in an overall response rate of 88%. The average total cost for this agency doing RBA-related activites was $306 per month. The majority of those costs were due to time spent filling out the survey (averaging $101 per month), followed by collecting and analyzing data (averaging $60 per month). The medium-sized agency provided one service subject to RBA: agency supported foster care. For the reporting period, $34 were spent in total doing RBA activities related to agency supported foster care. Figure 2 shows the costs per activity for the medium-sized agency.

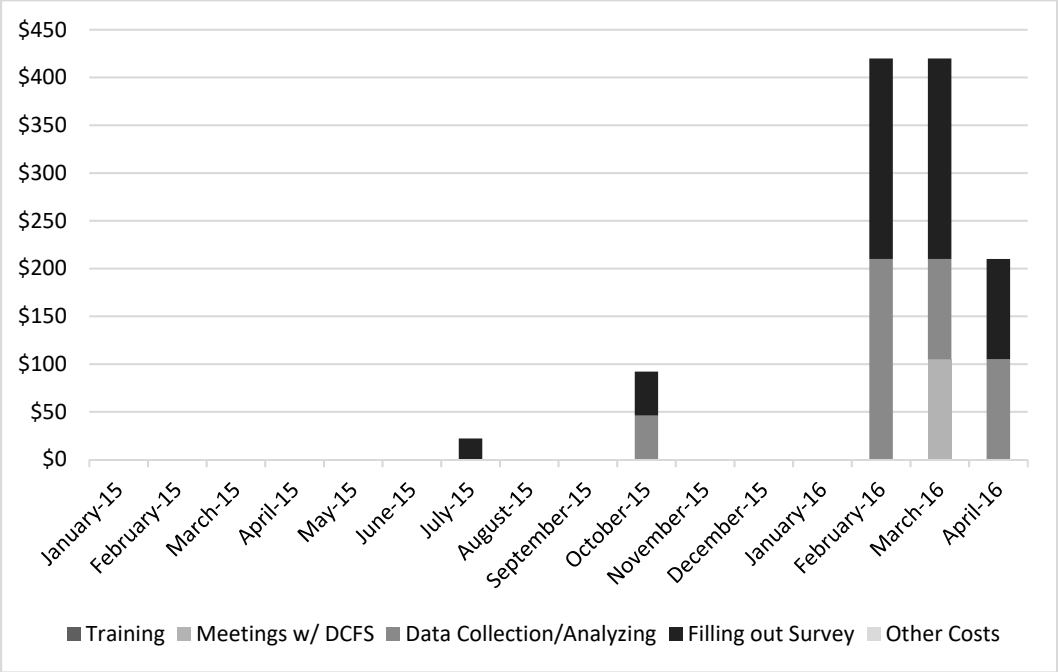
Figure 6.3.4: Medium-Sized Agency Total Costs per Month for RBA-Related Activities



Large-Sized Agency

For the time period of January 2015 through April 2016, time estimates were received from the large-sized agency for 5 of the 16 months resulting in an overall response rate of 31%. The average total cost of doing RBA-related activites was $166 per month for this agency. The majority of those costs were incurred due to time spent filling out the survey (averaging $85 per month), followed by collecting and analyzing data (averaging $67 per month). The large-sized agency provided three services subject to RBA: agency supported foster care, family support services, and intensive family preservation. For the reporting period, $118 were spent in total doing RBA activites related to agency supported foster care. In total, $26 were spent doing RBA activites related to family suport services. Finally, $105 were spent in total doing RBA activities related to intensive family preservation. Figure 3 shows the costs per activity for the large-sized agency.

Figure 6.3.5: Large-Sized Agency Total Costs per Month for RBA-Related Activities



Conclusion

The greatest costs associated with RBA were for personnel. Overall, personnel and total costs increased each quarter from October 2014 through October 2016. Average rates for agency supported foster care and family support services remained steady pre- and post-RBA. Average rates for intensive family preservation nearly doubled. Regarding the RBA case study, the majority of costs were incurred due to time spent filling out the survey, followed by collecting and analyzing data.

Chapter 4: Provider Performance Improvement Cost Study

Key Questions:

- How do PPI administrative costs evolve over time?

Data Sources and Data Collection

Administrative Data

The administrative resources required for PPI implementation are personnel, overhead and indirect expenses, and software licenses.

Personnel time estimates were collected through the PPI Monthly Time Survey. Monthly reports were received from DCFS listing all workers associated with PPI in order to stay current on who should receive time surveys. Respondents were asked to enter the estimated number of total hours they spent on PPI-related activities, rounded to the nearest hour. This survey captures a monthly estimate of administrator time from June 2016 – June 2019. Out of 910 surveys sent to administrators over that time period, 811 surveys (89%) were completed. For more information on these data sources, see *Appendix A: Summary of Evaluation Data Sources and Data Collection.*

Hourly wage data were provided by DCFS for personnel associated with PPI. In order to account for indirect costs, a multiplier of 35% was used to calculate benefit costs. Additionally, a multiplier of 48% was used to calculate overhead. After data were collected from personnel estimating the amount of time spent on PPI-related activities, hourly wage rates (loaded for benefits, indirect costs and overhead) were multiplied by hours to estimate fully loaded costs for PPI personnel.

Annual costs for Salesforce software licensing were acquired directly from DCFS.

Data Analysis

Analyses were conducted of costs related to PPI personnel time and software licensing to see how administrative costs evolved over time. Please note, due to the transition from RBA to PPI, there were some time data overlap from July 2016 through October of 2016 which had previously been reported on for RBA personnel costs. This is primarily due to UNL-CCFL's understanding of the new PPI program and when implementation of the program began. Surveyed personnel during that time period were largely the same as they transitioned from RBA to PPI, so those data are included below.

Results

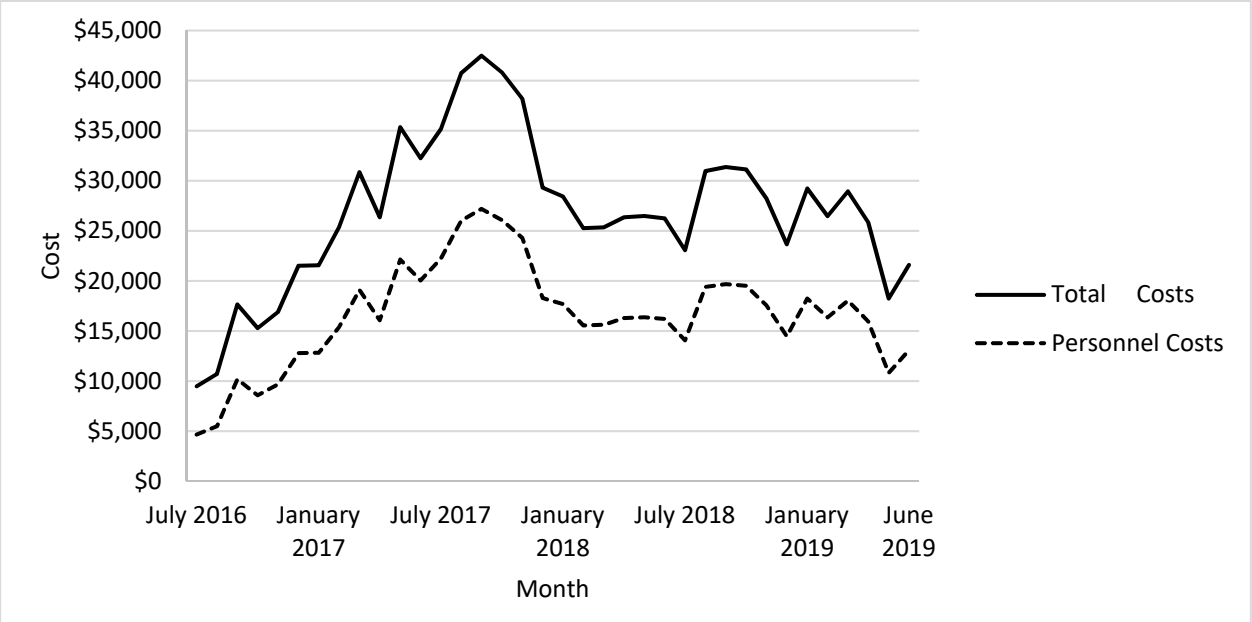
Table 6.4.1 shows the monthly average and total administrative costs associated with PPI through fiscal years 2016-2019. Personnel, overhead and indirect costs increased from the 2016-2017 fiscal year to the 2017-2018 fiscal year and then fell somewhat in the 2018-2019 fiscal year. Monthly personnel costs, and consequently, total costs were trending upward through October of 2017. Personnel and total costs decreased in the subsequent months and remained relatively constant through mid-2018 at around $15,000 per month in personnel costs and $25,000 per month in total costs. In the last fiscal year, monthly costs have showed more variance, but appeared to be trending downward.

Table 6.4.1: PPI Administrative Costs 2016-2019

	Personnel Costs with Benefits	Overhead Costs	Salesforce Software	Total Costs
2016-2017 Total	$156,942	$75,331	$31,000	$263,273
Monthly Average	$13,078	$6,278	$2,583	$21,939
2017-2018 Total	$241,808	$116,068	$26,957	$384,833
Monthly Average	$20,151	$9,672	$2,246	$32,069
2018-2019 Total	$197,154	$94,634	$26,957	$318,746
Monthly Average	$16,430	$7,886	$2,246	$26,562
2016-2019 Total	**$595,904**	**$286,033**	**$84,914**	**$966,852**
Monthly Average	**$16,553**	**$7,945**	**$2,359**	**$26,857**

6.4.1 shows monthly average PPI personnel costs and total costs for the period of July 1, 2016 through June 30, 2019.

Figure 6.4.1: PPI Administrative Costs July 2016 - June 2019



Conclusion

The greatest costs associated with PPI were for personnel, followed by overhead and indirect costs, and software costs. Overall, personnel and total costs have decreased since October 2017, and remained relatively steady through the remainder of the evaluation period. In the final year of the demonstration, monthly costs showed more variance, but appear to be trending downward.

Part VII:

Summary and Lessons Learned

Chapter 1: Alternative Response Summary and Lessons Learned

The key research questions for AR are organized into three main categories: 1) CFS Organizational Outcomes, 2) Child and Family Outcomes, and 3) cost. These questions are listed below:

CFS Organizational Outcomes

- To what extent do CFS staff and supervisors understand and buy into AR?
- To what extent are CFS staff implementing AR trained, supervised, and supported to providing services to AR families?
- To what extent do CFS staff and supervisors have the knowledge and skills they need to implement AR?
- To what extent does the CFS applicant pool change during the implementation of AR? Does AR attract more applicants with social work experience and degrees?
- To what extent does the CFS workforce composition change during the implementation of AR? Does the implementation of AR have an effect on more applicants with social work experience and degrees being hired?
- Over the course of the waiver demonstration, does job satisfaction increase for staff involved in providing AR services?
- Over the course of the waiver demonstration, is retention improved for staff providing AR services?
- Is AR case practice documented in N-FOCUS?
- Is AR implemented with fidelity across the state?
- Do AR workers refrain from using the labels of “victim” or “perpetrator” and no one is placed on the Central Register?
- Are stakeholder and community members engage and given the opportunity to provide meaningful input in the AR program development and implementation?
- Does ongoing monitoring and revision of implementation plans occur with stakeholders?
- Does partnership between DHHS, community stakeholders, and provider agencies improve over the course of the waiver demonstration?

Child and Family Outcomes

- Do families report experiencing a greater degree of respect, inclusion, and engagement when receiving AR services than when receiving TR services?
- Do services and supports received by AR families differ from those received by TR (control) families?
- Are the services received by AR families more tailored to their individual needs than services received by the TR control families?
- Are AR families connected to and receiving services more quickly than TR control families?
- Was the overall adequacy of services and supports provided to families improved as a result of AR implementation?
- Are children who experience AR at least as safe (or safer) than children who experience the TR track?
- Do AR families differ from TR control families in incidence of maltreatment allegations (reports) after initial intake?
- Do AR families differ from TR control families in incidence of substantiated maltreatment after initial intake?

- Do AR families differ from TR control families in removals to out-of-home care?
- Do AR and TR control children and families differ on measures of well-being?
- Do caregivers under AR and TR differ on measures of protective factors?
- What is the number and proportion of families who change tracks? What are the circumstances for track reassignment?

Cost

- Does worker time and cost vary between AR and TR families?
- Does worker time and cost vary for AR and TR families across time?
- Do the average number and cost of services vary between AR and TR families?
- Do worker costs vary between families that do and do not received contracted services?
- Is AR a more cost-effective case practice than TR?

Summary and Lessons Learned

In accordance with Nebraska's Waiver Terms & Conditions, AR was evaluated through a randomized controlled trial. After initial screening criteria were met through DCFS's use of the SDM intake tool, staff of the centralized hotline unit use the exclusionary criteria to determine whether a case was eligible for AR or in need of further review by a RED team. Any intake accepted for assessment that alleged one or more of the 22 exclusionary criteria was automatically assigned to TR and excluded from the AR evaluation. Any intake accepted for assessment that alleged one or more of the 8 RED team criteria was flagged for further review. Any intake that did not allege any of the exclusionary or RED team criteria was automatically designated as AR eligible and included in the evaluation. After AR eligibility was determined, intakes were randomly assigned to either AR or TR at a 1:1 ratio. This process was automated through the state's administrative data system, N-FOCUS.

The following aspects of the AR program were assessed throughout the demonstration project, from October 2014 through June 2019, with the highlighted findings and any applicable lessons learned described for each:

Stakeholder and Community Engagement

In order to address outcomes related to stakeholder and community engagement, data were gathered using surveys of AR stakeholders, interviews with AR program staff, and the evaluators' ongoing participation and observations of regular AR stakeholder meetings.

Overall, DCFS engaged with stakeholders and community members to gather input and to share information about the AR program's development and implementation during the planning and early implementation phases of the project. As the AR program became more solidified and there were less updates for DCFS to share, meetings focused on this purpose experienced reduced frequencies and attendance by external stakeholders. Ongoing monitoring and revisions happened more so with external stakeholders during early implementation as well. Overtime, ongoing monitoring and revisions has largely been limited to internal stakeholder input. Partnership between DHHS, community stakeholders, and provider agencies does not appear to have markedly improved, but has also not diminished, during the course of the waiver demonstration.

Internal and External Stakeholder Meetings. Regular meetings have occurred with external and internal stakeholders throughout the demonstration project. These meetings allowed for DCFS to share project

implementation and evaluation updates. External stakeholder were asked to provide feedback on opportunities for growth. Internal stakeholders were asked to share experiences from the field and to discuss suggestions to improve the program among administrators and staff. While it's difficult to ascertain an estimate of the proportion of program changes that have resulted from any of these meetings, early interviews of the AR Program Specialist and the Title IV-E Waiver Administrator suggested that these meetings with key stakeholders have been critical to inform the ongoing program refinement and modification that has occurred. For meetings where the evaluators are present, external stakeholder attendance has noticeably declined since the beginning of the project demonstration. The AR stakeholder survey efforts highlight a number of possible explanations for this decline.

AR stakeholder surveys. External and internal stakeholders were surveyed in December 2014 and again in October 2017. Overall, findings from the survey efforts were positive. Stakeholders expressed general buy-in for the goal of the AR program; however buy-in for specific program elements was mixed. The results suggested that communication could be improved between DCFS and all stakeholders. Additional efforts should be made to actively engage stakeholders in meaningful discussions and involve them as active participants in the decision-making process. Current stakeholders also noted gaps in representation (including families and community service providers).

Staff Qualifications, Training, and Support

Data to inform these questions comes from AR staff training evaluation data and qualitative data from focus groups and interviews of Intake staff, AR field staff, and RED team participants. Human Resources data necessary to assess the experience and educational degree of job applicants was requested, but unavailable.

AR training. Training for staff who provide Alternative Response changed throughout the demonstration project. The initial training for AR was conducted by UNL-CCFL. This training included a broad range of staff involved in the delivery of child welfare services. According the majority of participants' ratings on reaction-level measures, AR-related trainings were well-received and allowed for participants to gain new information about the AR program in a satisfactory way. Additionally, training for front-line staff included a pre and post knowledge assessment. This test indicated significant gains in participants' understanding of AR knowledge as the result of attending training. AR training transition to Project Harmony in 2016 and then back to UNL-CCFL in 2019. Only reaction-level data were collected after the initial trainings, but responses continued to positive throughout the demonstration. AR training should continue to collect reaction-level data, at least. Knowledge and skills assessments related to AR may be helpful.

Survey and focus groups CFS staff. A brief survey and facilitated focus groups with workers suggest that workers who are able to work a caseload of mostly AR cases have greater buy-in for the AR program (e.g., believing that collaborative problem solving occurs and that the AR approach helps families). Workers carrying a mostly-AR workload also appeared to have better understanding of the expectations of the program and were more likely to indicate that they've received the training and support they need. For ongoing AR implementation, it is recommended that dedicated AR workers be utilized whenever possible.

Human resource data requested. Regarding the research question about the composition of the applicant pool, during the evaluation planning process, the evaluators were assured that the necessary administrative data to answer this question existed, and negotiations with DCFS and DHHS Human

Resources occurred in 2014, 2015, and again in 2019 to obtain these data. Ultimately, however, the evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project.

***RED team member interviews*.** RED team members were interviewed to gather their perceptions of RED team processes. The majority of RED team members interviewed said that the RED team reviews are fair, have the right composition of people participating, and that everyone has the opportunity to voice their concerns. In addition, many of the participants were pleased with the guidance and support they've received while involved in the RED team and indicated that they've received enough training. However, less than half of the participants interviewed said that the RED team review process worked well and that the RED team review process was a good use of time. Over half of the participants not only felt that their interpretations of the RED team review process changed over time, but interpretations of the RED team review criteria changed over time as well. Ongoing trainings or check-ins with RED team participants is recommended and periodic reviews of RED team processes should be done by DCFS to ensure adherence to the RED team's protocol and purpose.

Intake staff interviews. Intake staff were interviewed to gather their perceptions of the AR eligibility screening process. More than half of the intake staff interviewed felt that the AR screening process worked well. A majority of the participants said that they received enough training prior to implementing the AR screening process, but also indicated that ongoing training would be helpful – particularly since some of the participants said that their interpretations of the exclusionary and RED team criteria have changed over time. However, many participants indicated that they have been pleased with the support and guidance they've received while applying the AR screening process. Additionally, the AR screening process does not appear to be seriously impacting Intake staff workload.

Exclusionary and RED Team Criteria Summary

Exclusionary criteria. The most frequently selected exclusionary criteria were those related to use of controlled substances, domestic violence, and abuse/neglect of a child. Overall, 91% of intakes were excluded, meaning only 9% of intakes were eligible for AR.

RED team criteria analyses. Overall, only 4% of intakes had a RED team criterion applied. The most frequently selected RED team criterion was related to physical abuse that did not rise to the level of the exclusionary criterion.

RED team process analyses. According to RED team documentation provided by DCFS, the RED team reviewed an average of 41 intakes per month. The number of intakes reviewed each month increased over time as more counties implement the program. On average, 3 intakes were reviewed per meeting (ranging from 1 to 12). Additionally, meetings included 4 individuals and lasted approximately 5 minutes per intake, on average.

Response Reassignment Analyses

Families may be reassigned from AR to TR if circumstances change or information is learned about the family after the initial intake that warrants heightened concerns. Overall, approximately 15% of AR cases were reassigned to TR. The most frequent reason was due to a correction or update to the Intake Screening Decision, Response Priority, or Alternative Response Ineligible Criteria. This indicates that

ongoing monitoring, and possibly training, needs to be completed at hotline to ensure the accurate and timely identification of AR exclusionary criteria.

Program Data and Fidelity

Access to AR program data. UNL-CCFL worked with DCFS to negotiate and execute data sharing and confidentiality agreements to access AR program data collected through the DCFS administrative data system, N-FOCUS. Multiple confidentiality and data sharing agreements were executed and a protocol was established to allow the evaluators to access downloadable data extracts via a secured web-based site internal to DCFS. Substantial effort was expended by DCFS staff to program weekly and monthly reports. Full downloadable access to the data extracts was accomplished by the end of the first quarter of AR implementation.

AR case file reviews. As a critical component of the evaluation of the AR program, a comprehensive review of AR case practice was proposed to be completed through a case file review process. Although UNL-CCFL had originally intended to partner with DCFS to conduct fidelity reviews to inform statewide rollout of the AR program, ongoing challenges were experienced throughout the demonstration period, resulting in delayed access to case files and limiting the review to an assessment of fidelity in order to mainly serve as context to the larger outcome evaluation. Ultimately, printed AR case files were given to the evaluators in February 2019. In general, when reviewed cases were problematic, it was due to very little substantive information or repeated information throughout the case file. Minimal efforts on behalf of some CFS Specialists were observed through delayed contacts, poor information gathering, and sparse documentation. However, many CFS Specialists demonstrated an understanding of the Alterative Response philosophy and strongly displayed these concepts through their casework. For cases that appeared to have worked well, common characteristics were observed: 1) identified concerns were addressed; 2) family issues outside of the Intake report were identified; 3) good report and engagement was evident through quality information; and 4) parents appeared to have been provided support to better meet their child(ren)'s needs. When these characteristics were present, associated improvements in the family's stability due to DCFS involvement was observed. This appears to corroborate other aspects of the AR program's evaluation, which indicate support for dedicated AR workers whenever possible.

Safety Assessments

The overwhelming majority of AR-eligible families that were assessed for safety (97% of AR and 95% of TR) were found to be safe, compared to conditionally safe or unsafe. In fact, AR families are nearly twice as likely to be found safe compared to AR-eligible TR families. This finding supports the research question that AR families are as safe (or safer) than TR families; however, given the significant difference (coupled with case review findings: 99% of reviewed cases had no identified safety threat), the safety assessment conclusions appear somewhat suspect. Equivalent groups should result in no differences in safety assessment determinations. It is recommended that DCFS look into this more thoroughly to gain a better understanding of these assessments for AR families.

Family Needs and Services

Family needs. For all AR-eligible families that presented with needs, the most common needs were in the areas of parenting skills, child's emotional/behavioral adjustment, mental health of a child, and material needs. Looking at the differences between AR and TR families, AR families were more likely to be identified as having needs related to physical health of an adult, management of resources, and material needs. TR families were more likely to present with needs related to parenting skills, social supports, and the physical health of a child. Both AR and TR workers indicated that they were able to

address family needs through their work with the family; however, workers indicated that they were significantly more likely to address the needs of AR families than TR families regarding material needs, employment, and needs associated with the mental health of a child. Furthermore, both AR and TR workers indicated that they were able to improve the families' needs at least somewhat. Workers indicated a significantly greater improvement for AR families related to education, transportation, and material needs, while a significantly greater improvement in needs associated with domestic violence were found for TR families.

Services provided to families. AR families were more than twice as likely to receive a service compared to TR families. AR families also received a greater variety of services. For contracted services documented in N-FOCUS, the two most common types of services provided for both AR and TR families were around family support services and travel time/distance. AR families were more likely to receive services related to material needs, while TR families were more likely to be provided services around out out-of-maintenance, parent time/supervised visits, and were more likely to be drug tested. According to the worker survey, the most commonly provided services for AR and TR families were related to mental health, social support services, and services to address material needs. AR families were more likely to receive mental health services, services to address material needs, and transportation services. The most common categories of service providers were mental health providers, neighbors/ friends/ extended family, and schools for both AR and TR families; however, AR families were more likely than TR families to receive services from mental health providers, neighborhood organizations, mental retardation/developmental disability (MR/DD) providers, youth organizations, legal service providers, or contractors. Given the research design, AR-eligible families would be expected to present with similar needs and therefore be provided similar services; however these findings indicate that variable services are provided based on differing identified needs. This points to differences in how AR workers are assessing family needs. It is recommended that DCFS examine this further to ensure all families receive adequate needs identification and service provision, as intended.

Match between needs and services. Most workers reported that they were able to match services to the needs of the family; there was no difference between AR workers' reported a greater degree of match compared to TR workers. The majority of AR-eligible families indicated that they received the help that they needed; however, AR families reported this significantly more frequently than TR families. Additionally, AR families were significantly more likely to report that the support and services they received was the kind of help they needed. Both AR and TR families reported that the supports and services received were enough to really help them.

Timeliness of service delivery. Based on administrative data, TR families appear to receive services significantly sooner than AR families, with TR families receiving services approximately two weeks sooner than AR families. However, AR workers are reporting significantly more often than TR workers that services are provided within 1-2 weeks, 2-3 weeks, 3-4 weeks, or more than 4 weeks. From the family's perspective, most AR-eligible families indicated receiving support or services when they needed it; however, AR families reported this significantly more often than TR families.

Barriers to providing services. Across all AR-eligible families, nearly half of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by other pressing cases on their caseload, and limited

staff time to work with families. TR workers were significantly more likely than AR workers to report barriers due to limited funds or to report no barriers were experienced. AR workers were significantly more likely than TR workers to report barriers due to caseload, other pressing cases, and limited time. This suggests that a reduced caseload for AR workers may be needed.

Family Engagement

Satisfaction with worker and DCFS. AR families reported they were more satisfied with their experience with DCFS than TR families. Likewise, AR families were more likely to report that their family is better off due to their involvement with DCFS than TR families.

Family engagement scale analyses. Family engagement was measured from the family's and the worker's perspectives. AR families reported greater levels of buy-in and receptivity, better relationships with their worker, lower mistrust, and greater overall engagement than TR families. Workers reported that AR families had greater levels of receptivity, buy-in, and greater overall engagement than TR families.

Skills learned. AR families were more likely to report having a collaborative relationship with their worker and were more likely to report that they learned a skill or received a service that made them feel like a better parent, allowed their child to be safer, and helped them provide necessities compared to TR families.

Protective Factors

Within AR families. Of the six protective factors assessed, two protective factors (knowledge of parenting and child development; and social and emotional competence of children) significantly improved from the beginning to the end of the case for AR families.

Comparison of AR and TR families. No significant differences in protective factors were observed between AR and TR families at the end of the case.

Child Well-Being

Within AR children. AR children showed improvements in three domains of well-being (emotional symptoms, hyperactivity, and conduct problems) from the beginning to end of the case. However, the domain of prosocial behavior was found to be lower at the end of the case, which is opposite of what was hypothesized. Ultimately, three of the four significant differences were in the hypothesized direction.

Comparison of AR and TR children. AR children exhibited higher well-being in one domain at case closure, compared to TR children. According to workers' responses, AR children were perceived to exhibit significantly higher prosocial behavior at case closure, compared to TR children. So while this appeared to have declined within AR children from the beginning to the end of the case, the final measurement was still significantly higher for AR compared to TR children. This significant difference was in the hypothesized direction. The remaining well-being domains were equal for AR and TR children.

Children and Family Services Organizational Outcomes

Agency workforce composition is more social work oriented. The evaluators were unable to access educational degree information for DCFS job applicants, as these data are not stored in a database by DCFS as originally thought. Therefore, the research question regarding the CFS applicant pool was unable to be answered for the demonstration project. However, in order to assess for any changes in

the CFS workforce composition over time, self-reported educational data were obtained from tables within Nebraska's published Annual Progress and Services Reports from 2012 to 2018. Overall, the trends of self-reported degree do not support the hypothesis that the CFS workforce has become more social work oriented during the implementation of AR. Additionally, the percentages of trainees, workers, and supervisors with a social work-related degree either remained stable or decreased over the course of the demonstration period. Improved HR metrics and data tracking would allow for DCFS to complete a more robust examination of these types of question in the future.

***CFS staff and supervisors engaged in delivering AR services have higher job satisfaction*.** To assess the hypothesized change in job satisfaction over time, UNL-CCFL originally planned on using DCFS Human Resources job satisfaction survey data that is collected annually. However, it was later discovered that these data could not be disaggregated to an individual level to permit the necessary breakdowns to analyze differences between AR and TR-involved staff. Instead, UNL-CCFL distributed a brief survey and facilitated focus groups with a small sample of workers. Results support the hypothesis that AR workers experience higher job satisfaction, especially for those workers who are able to primarily carry AR caseloads. It is recommended that individual level information attempt to be gathered in future to allow for a systematic collection and review of these data in the future.

Retention of CFS staff due to AR implementation. When assessing for differences in the turnover rates for AR and TR CFS Specialists, involvement in AR was defined 2 ways: 1) working on AR cases during or prior to the given time period, and 2) having received AR training during or prior to the given time period. Because AR workers make up such a small percentage of the CFS workforce, the AR turnover rate fluctuated substantially throughout the demonstration project. Ultimately, there were no differences in the average turnover rates for AR and TR CFS Specialists, regardless of how AR involvement was defined. Data used for these analyses were manually tracked by the AR Program Specialist. If an ongoing review of HR metrics related to CFS Specialists involved in AR is desired, it is recommended that a systematic and automated process be put in place by DCFS for the future.

Recurrence and Permanency Analyses

***Repeated accepted intakes*.** There was a significant relationship between repeated accepted Intakes and track assignment. Furthermore, when controlling for risk, a significant increased probably of repeated accepted reports was observed for TR families compared to AR families.

Subsequent substantiated intakes. The relationship between number of subsequent substantiations and track assignment was also significant. However, neither of the examined models were significant; this may have been due to the small sample size.

Subsequent out-of-home removals. Although the overall relationship between out-of-home removals and track assignment was not significant at the family level, it was significant at the individual level, indicating a significant difference in out-of-home placements for individuals assigned to the AR and TR programs.

Cost Analysis

Worker Time. UNL-CCFL collected time estimates from workers for time spent working directly with the family (e.g., face-to-face meetings, phone calls with family), time spent indirectly or on behalf of the family (e.g., researching service options, travel time, documenting assessments), and time altogether. In general, average time spent was significantly higher for AR families than TR families in all three areas.

Worker Time Costs. Using worker time estimates and hourly wages, average worker costs were calculated for time spent working directly with the family, time spent indirectly or on behalf of the family, and time altogether. In general, average worker costs were significantly higher for AR families than TR families in all three areas.

Service Costs. Only 17% of AR-eligible families received a service through N-FOCUS. For these families, average service costs were significantly higher for TR families than for AR families. When looking at AR services documented in SharePoint, the average service expenditures has remained relatively steady since June 2015.

Combined Worker and Service Costs. In order to examine overall average costs of a case, worker time costs were combined with service costs when both data were available. For those families receiving services, the average cost of worker time was not significantly different between AR and TR families; however, TR families experienced significantly higher average service costs and total costs, compared to AR families.

Administrative Cost Results. The majority of administrative costs were for supervisors, upper-level administrators, RED team, and AR-related trainings. Overall, administrative costs have fallen since initial implementation and statewide rollout. This is likely due to moving past start up needs and expansion of program implementation.

Cost-effectiveness Results. Overall, the cost-effectiveness analysis indicates that while AR has significantly greater family engagement than TR, it comes at higher worker time costs. The cost-effectiveness data show that for worker time costs, the impact per dollar on family engagement is greater under TR than AR. It is recommended that future analyses examine the relationship between total case costs (worker time and services) and effectiveness (family engagement or other metric). Due to a prohibitively small sample size, these analyses were unable to be completed during the demonstration project.

Chapter 2: Results-Based Accountability Summary and Lessons Learned

Key Questions for RBA:
The key research questions for RBA are organized into four main categories: 1) contracted provider outcomes, 2) DCFS performance-based contracting outcomes, 3) DCFS child and family outcomes, and 4) cost. These questions are listed below:

Contracted provider outcomes

- Do RBA providers have an understanding of and buy-in for the RBA/PPI process, Scorecard use, and contracting process?
- Do RBA/PPI providers demonstrate changes in practice as a result of participation in the RBA program?
- Does participation in the RBA program result in improvements in provider's performance measures?

DCFS performance-based contracting outcomes

- Does RBA provide DCFS with a system for measuring and comparing effectiveness of providers?
- Does RBA provide DCFS with a system to hold providers accountable for performance measures?
- Does RBA provide DCFS with a system to make contract decisions based on provider performance results?

DCFS child and family outcomes

Safety

- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce entry into out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce maltreatment in out-of-home care?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on maltreatment recurrence after discharge or closure?

Permanency

- For children and families being served by a provider subject to RBA, does the RBA program appear to improve placement stability?
- For children and families being served by a provider subject to RBA, does the RBA program appear to increase timely reunification and adoption?
- For children and families being served by a provider subject to RBA, does the RBA program appear to reduce discharge to emancipation?
- For children and families being served by a provider subject to RBA, does the RBA program appear to have no increased effect on re-entry into out-of-home care?

Cost

- How do RBA administrative costs evolve over time?
- How do rates for contracted services compare between pre- and post- RBA implementation?

Summary and Lessons Learned

In accordance with Nebraska's Waiver Terms & Conditions, RBA was planned to be evaluated through a longitudinal research design. For the contracted provider outcomes and the DHHS performance-based contracting outcomes, outcomes were to be measured multiple times across the life of the project, but there was no pre-intervention data against which to compare. For the DCFS child and family outcomes, outcomes were to be compared pre- and post-RBA implementation.

RBA was launched statewide on July 1, 2014. However, DCFS decided to shift from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. Due to this change in programs the evaluation team was unable to assess many aspects of RBA, specifically: contracted provider outcomes, DHHS performance-based contracting outcomes, and DCFS child and family outcomes were unable to be assessed. The following aspects of the RBA program were assessed from July 2014 through October 2016, with highlighted findings and any applicable lessons learned described for each:

Contracted Provider Understanding and Buy-In

A survey was administered to contracted providers in January 2015, near the beginning of implementation. The results revealed a number of strengths and challenges for the newly implemented program. Respondents generally agreed with the need for increased accountability, and felt that RBA aligned well with their own agency priorities. Participants understood their role and the department's expectations of them regarding RBA, and for the most part, they were able to compile and enter their data without much difficulty. Most respondents appeared to recognize DCFS' commitment to RBA, and acknowledged the department's recent history of collaboration with them. However, the RBA performance measures were generally not accepted as important, relevant, or accurate indicators of successful outcomes. Many of the participants did not feel a sense of ownership in the system, and did not see value in the data that was being compiled and reported monthly. There was some skepticism about how the RBA program would be used by the department in the coming years. There was also dissatisfaction with the limited role providers had played in the development and refinement of the performance measures. Additional surveys with contracted providers subject to RBA were planned, but not administered due to the shift in programs.

Children and Family Services Performance-Based Contracting Outcomes

A survey was developed to assess program fidelity, perceptions of the RBA program, challenges, and barriers to implementation for DCFS staff involved in RBA implementation; however, it was not distributed due to shifts in the program.

Contracted Provider and Child and Family Outcomes

Based on the RBA model, provider changes are brought about through Turn-the-Curve (TTC) discussions. Once performance measure baseline data was established, DCFS was meant to partner with provider agencies to collectively review the data and determine whether or not they are satisfied with the direction the baseline data appears to be heading. If not, the team decides what actions need to be taken to "turn the curve" of the baseline. TTC meetings were scheduled to occur semi-annually during the RBA program's implementation. Documentation of TTC meetings was reviewed for the project period between July 2015 and June 2016. It was observed that documentation was not being completed consistently. Specifically, between January and June 2016, 38% to 100% of utilized providers (depending on the service) had a TTC meeting documented. Nine providers had no documented TTC meetings during the 12-month time period reviewed. Furthermore, there was variability among individual DCFS staff in TTC documentation, indicating that follow up with these staff would likely improve future

documentation. Examination of child and family outcomes did not occur, as logical links between the RBA performance measures developed by the department and the child and family outcomes outlined in the Waiver Terms and Conditions were never established. Ultimately, no further examination of these outcomes was possible, due to program shifts.

Cost Analysis

The greatest costs associated with RBA were for personnel. Overall, personnel and total costs were increasing each quarter from October 2014 through October 2016. Average rates for agency supported foster care and family support services remained steady pre- and post-RBA. Average rates for intensive family preservation nearly doubled. Additionally, a supplemental case study was conducted with RBA providers to gather provider costs incurred due to participation in RBA. The highest costs directly related to RBA were associated with collecting and analyzing RBA data. However, it was found that the majority of costs were associated with time spent filling out our case study survey.

Chapter 3: Provider Performance Improvement Summary and Lessons Learned

In order to examine the PPI program, DCFS presented UNL-CCFL with research questions related to the PPI program. Evaluators from UNL-CCFL worked collaboratively with DCFS to understand and clarify the identified elements. The specific research questions for the PPI program are listed below:

16. Is PPI data meaningful?
17. Is PPI improving performance?
18. Does Salesforce self-training meet the provider needs?
    a. Is Salesforce user friendly?
    b. Is Salesforce easy to navigate?
    c. Is Salesforce a functional tool?
    d. If there have been issues with Salesforce, have they been resolved?
19. Is there consistency in performance quality conversations among:
    a. Providers
    b. CMRD
    c. Documentation
    d. Data
20. What component of PPI is most beneficial?
    a. IFP components
    b. Data reports – specifically the DCFS data that is uploaded
    c. Quality reviews:
        i. Foster care
        ii. Placement support plan
21. Has PPI improved foster care monthly reports?
22. Do providers find the QA of reports helpful?
23. Did PPI foster a conversation about provider performance/data?
    a. Is there evidence of the communication?
    b. Did the communication impact data?
24. Does the current workforce have the capacity to follow the program with fidelity?
25. Is PPI implemented according to the program manual?
26. Does the size of the provider agency impact:
    a. Support for PPI?
    b. Increased communication?
    c. Impact on data?
27. How has PPI improved services within an agency?
28. Are agencies inputting data timely?
29. What has an agency implemented as a result of PPI?
    a. Processes
    b. Policies
    c. Procedures
    d. Training
    e. Standardized forms
    f. Communications
30. Are all provider performance concerns are reported on PPI?
    a. Are CFS concerns addressed timely?
    b. Are provider concerns addressed timely?

c. Are CFS and providers communicating more often?
d. Have issues reduced due to addressing concerns?
e. How does various service area practices affect concern resolutions?
f. Are concerns being resolved?

31. How do PPI administrative costs evolve over time?

Summary and Lessons Learned

DCFS shifted from the RBA program to Provider Performance Improvement (PPI), beginning in April 2016. This program was initially piloted with some provider agencies in July 2016, with full implementation occurring in October 2016. According to DCFS, the purpose of PPI is to improve the outcomes of children and families that receive one or more of the most frequently provided services from a private agency contracted with DCFS. This includes: family support (in-home and out-of-home), intensive family preservation, and agency supported foster care. This program has evolved over time and the evaluation team at UNL-CCFL has worked with DCFS as well as the Children's Bureau and JBA to determine the best method for examining the PPI program's effectiveness. In February 2018, it was ultimately determined that a change mechanism could not be isolated and that a process-only evaluation would be completed for the PPI program. Evaluators from UNL-CCFL worked collaboratively with DCFS to understand and clarify the identified data elements. Data sources and collection methods were identified and a data collection plan was created by UNL-CCFL. This essentially included the development and administration of three separate surveys to assess the perceptions of 1) contracted service providers subject to PPI, 2) DCFS contract monitor/resource and development (CMRD) staff, and 3) DCFS administrators. Additionally, a review of relevant PPI/Salesforce website data was conducted.

Key Stakeholder Perceptions of the PPI Program

Through the administration of three stakeholder surveys, a number of strengths and challenges were identified for the PPI program. Areas for potential program improvement included:

- Additional training on the features of Salesforce may be helpful. This could be achieved through video trainings or one-on-one demonstrations.
- The Salesforce website could be enhanced through improved email interface, inclusion of a comment section for narrative information especially regarding performance concerns, the ability to track internal issues, improved ability to sort and view data in graphs/tables, the ability to view anonymous data from providers for comparison, and access to service delivery performance data for DCFS and PromiseShip.
- Additional training outlining job expectations for CMRD could be useful, as comments suggested that PPI updates are not being communicated thoroughly and can lead to unclear job expectations for CMRD.
- Communications with DCFS could be improved as there seems to be a need for CMRD staff to be better informed on important issues and changes with the PPI program.
- It is recommended that DCFS and provider agencies work collaboratively to refine the performance measures.
- Increased communication from DCFS about how PPI data are used to inform decision-making could increase participants' understanding of the PPI program's impact.
- Additional guidance for reviewers may be needed to improve the consistency of quality reviews as some providers indicated a lack of consistency.

- Information about how to best access the ASFC and Placement Support Plan reports and/or regular dissemination processes may be helpful to ensure all necessary parties are receiving this information.
- Additional meeting structure (e.g., agendas) may be helpful to improve the efficiency and usefulness of the Performance Quality Conversations.
- Providers' implementation of action items may be improved by increased communication between DCFS, providers, and CMRD, and clearer expectations regarding goals and priorities from DCFS.

Cost Analysis

The greatest costs associated with PPI were for personnel, followed by overhead and indirect costs, and software costs. Overall, personnel and total costs have decreased since October 2017, and remained relatively steady through the remainder of the evaluation period.

Appendix A:
Summary of Evaluation Data Sources and Data Collection

This appendix summarizes the data sources and collection methods used in the evaluation of Nebraska's Title IV-E Waiver Demonstration Project. These summarized sources are presented in alphabetic order.

60 Day AR Worker Time Survey

Respondents were asked to estimate the amount of time they spent on a case by rounding to the nearest hour. This survey was sent to workers of AR and AR-eligible TR cases every 60 days after a case had received a *90 Day AR Worker Time Survey*, until the case is closed. This survey asked:

- "Are you the original worker assigned to this family?"
    - If the respondent answered yes, then they were asked:
        - "In the last 60 days, how much time have you spent in direct contact with the family (e.g., face-to-face meetings with family, phone calls with family, driving with the family to services)?"
        - "In the last 60 days, how much time have you spent altogether on behalf of this family (e.g., interviewing family members and others involved with the family, researching service options, making phone calls to service providers, travel time, documenting assessments)?"
    - If the respondent answered no, then they were asked to provide the date they were assigned to the family and then asked:
        - "Considering only the number of days you have been assigned to this case, how much time was spent in direct contact with the family (e.g., face-to-face meetings with family, phone calls with family, driving with the family to services)?"
        - "Consider only the number of days you've worked with this family. How much time did you spend altogether on behalf of this family (e.g., interviewing family members and others involved with the family, researching service options, making phone calls to service providers, travel time, documenting assessments)?"

This survey began administration in March 2015, as this was the first point in time where enough time had passed for it to be appropriate to collect these data. From March 2015 through June 2019, 1,862 surveys were sent, with 1,110 completed responses received, for an overall response rate of 60%. Out of the 1,110 completed surveys, 784 (71%) were from AR workers and 326 (29%) from TR workers.

90 Day AR Worker Time Survey

Respondents were asked to estimate the amount of time they spent on a case by rounding to the nearest hour. This survey was sent to workers of AR and AR-eligible TR cases when an AR-eligible case had been open for longer than 90 days. This survey asked:

- "Are you the original worker assigned to this family?"
    - If the respondent answered yes, then they were asked:

        - "Considering the last 90 days, how much time was spent in direct contact with the family (e.g., face-to-face meetings with family, phone calls with family, driving with the family to services)?"
        - "Consider the last 90 days you've worked with this family. How much time did you spend altogether on behalf of this family (e.g., interviewing family members and others involved with the family, researching service options, making phone calls to service providers, travel time, documenting assessments)?"
    - If the respondent answered no, then they were asked to provide the date they were assigned to the family and then asked:
        - "Considering only the number of days you have been assigned to this case, how much time was spent in direct contact with the family (e.g., face-to-face meetings with family, phone calls with family, driving with the family to services)?"
        - "Consider only the number of days you've worked with this family. How much time did you spend altogether on behalf of this family (e.g., interviewing family members and others involved with the family, researching service options, making phone calls to service providers, travel time, documenting assessments)?"

This survey began administration in January 2015, as this was the first point in time where enough time had passed for it to be appropriate to collect these data. From January 2015 through June 2019, 1,586 surveys were sent, with 976 completed responses received, for an overall response rate of 62%. Out of the 976 completed surveys, 701 (72%) were from AR workers and 278 (28%) from TR workers.

Administrative Data

Information that is regularly collected on all families involved with DCFS is documented on the Nebraska Family Online Client User System, commonly referred to as N-FOCUS. N-FOCUS is the computer system created by the Department of Health and Human Services to document economic assistance programs, including children and family services. N-FOCUS is a part of the Nebraska Child Welfare Information System (CWIS), which is part of a federally mandated program for State Automated Child Welfare Information Systems (SACWIS). All family case information is to be documented on N-FOCUS. For the purposes of the evaluation, the evaluators received regularly scheduled downloads of this information.

AR Administrative Monthly Time Survey

Respondents were asked to enter the estimated number of total hours they spent on AR-related activities, rounded to the nearest hour. This survey was sent to a variety of DCFS administrative staff (e.g., service area administrators, service delivery administrators, RED team coordinator, DHHS attorney, CFS deputy director, AR champions) every month. This survey asked:

- "In the last month, how much time have you spent altogether on AR-related activities (e.g., attending meeting, writing policy, answering questions of staff, building connections with providers)?"

This survey began administration in February 2015. From February 2015 through June 2019, 1,130 surveys were sent, with 1,147 completed responses received, for an overall response rate of 88%.

AR Case File Review Tool and Guidebook

A systematic review of Alternative Response (AR) case files was conducted in order to address program implementation fidelity and practice documentation in N-FOCUS. UNL-CCFL worked collaboratively with DCFS to arrive at a mutually agreeable plan to limit the case file review to only cases that had been a) fully worked through AR and b) had opened and closed during the specified timeframe. Due to significant AR program requirement changes, the earliest cases included in the review were opened after July 1, 2015 (when the updated AR program manual was implemented). This review includes cases worked through December 31, 2018. A total of 243 cases were reviewed, which constitutes approximately 16% of total cases (1489 cases) fully worked through AR during the review timeframe. A copy of this measure and accompanying guidebook are provided on the next page.

AR Case File Review Tool

Q1 CFS Master Case Number:

_____

Q2 Intake number:

_____

Q3 Case Type:

O Abuse/Neglect

O Dependency

Q4 Select the date this case opened (case opening date is the earliest date the intake was accepted for AR)?
Be sure to enter the date specific to the intake identified for this review

Q5 Select the date this case was assigned to the CFS Specialist:

Q6 When did this case close?
Be sure to enter the date specific to the intake identified for this review

Q7 Did anyone in this household have a prior substantiated report of abuse or neglect?

O Yes

O No

Q8 Did anyone in this household have prior intakes that were screened out (did not meet definition)?

O Yes

O No

Q9 How many prior intakes were there on the children in this household?

_____

Q10 Were there any intakes accepted for assessment after this AR case closed?

O Yes

O No

Display This Question:

If Were there any intakes accepted for assessment after this AR case closed? = Yes

Q11 What were the case status determinations for these subsequent intakes?
List the number for each below.

Unfounded _____

AR _____

Agency substantiated _____

Court Pending _____

Court substantiated _____

Q12 Were there any intakes screened out after this AR case closed?

O Yes

O No

Display This Question:

If Were there any intakes screened out after this AR case closed? = Yes

Q13 How many subsequent intakes were screened out?

_____

Q14 Name of the assigned CFS Specialist at the beginning of this case:

_____

Q15 Name of CFS Specialist's Supervisor:

_____

Q16 Were there multiple CFS Specialists involved with this case?

O Yes

O No

Display This Question:

If Were there multiple CFS Specialists involved with this case? = Yes

Q17 How many CFS Specialist were involved with this case?

_____

Display This Question:

If Were there multiple CFS Specialists involved with this case? = Yes

Q118Name of CFS Specialist at case closure:

_____

Q19 Name of CFS Supervisor at case closure (if different from above):

_____

Q20 Was initial F2F contact made with the children within 5 calendar days of the intake accepted date?
Use the Safety Assessment date or the date of initial contact in the narrative, whichever is earliest.

O Yes

O No

Display This Question:

If Was initial F2F contact made with the children within 5 calendar days of the intake accepted date... = No

Q21 Was a contact exception narrative documented by the supervisor or CFS administrator?
If the CFS Supervisor completes the consultation, the narrative will be documented in the Intake narrative

under Contact Exceptions- Supervisor. If the CFS Administrator completes the consultation, the narrative will be documented under Contact Exceptions-Administrators.

O Yes

O No

Q22 Was there any evidence that the CFS Specialist attempted to contact the family prior to meeting with the child(ren)?

O Yes

O No

Display This Question:

If Was there any evidence that the CFS Specialist attempted to contact the family prior to meeting w... = Yes

Q23 Is there documentation that the parent was successfully contacted prior to interviewing the child(ren)?

O Yes

O No

Q24 When was the identified child(ren) interviewed?

O Prior to contact with the parent

O At the time of the initial F2F contact with the parent

O At another time

Q25 Was a F2F interview conducted with all the child(ren)?

O Yes

O No

Q26 Was a F2F interview conducted with the primary and secondary caretaker(s)?

O Yes

O No

Q27 Was a F2F interview conducted with all the adults in the household?

O Yes

O No

Q28 Who all participated in the initial interview?

Children

Mother

Father

Parent's partner

Other household member _____

Other DHHS staff _____

Other _____

Q29 Did the CFS Specialist document a visit to the home at any time? (Administrative Memo #2-2018 Section 1.I.8)

O Yes

O No

O No, family refused

Q30 Was a Safety Assessment completed?

O Yes

O No

Display This Question:

If Was a Safety Assessment completed? = Yes

Q31 Was the initial Safety Assessment completed at the first contact with the children?

O Yes

O No

Display This Question:

If Was a Safety Assessment completed? = Yes

Q32 Did the CFS Specialist document the Safety Assessment within 1 calendar day of initial contact? *Use Safety Assessment completed by date.*

O Yes

O No

Display This Question:

If Was a Safety Assessment completed? = Yes

Q33 Did the CFS Supervisor review and finalize the Safety Assessment within 3 business days of the assessment being submitted for review?

O Yes

O No

Display This Question:

If Was a Safety Assessment completed? = Yes

Q34 Did the CFSS review and finalize their own Safety Assessment?

O Yes

O No

Display This Question:

If Was a Safety Assessment completed? = Yes

Q35 Were additional safety assessments completed?

O Yes

O No

Display This Question:

If Were additional safety assessments completed? = Yes

Q36 Indicate the reason additional safety assessments were completed for this case:

Because the AR case was open longer than 90 days

The original safety decision was changed

There was a report of a different incident or involving different children or different adults

There was a change in family circumstances

Display This Question:

If Were additional safety assessments completed? = No

Q37 Were additional safety assessments needed?

O Yes

O No

Display This Question:

If Were additional safety assessments needed? = Yes

Q38 Indicate the reason additional safety assessments were needed for this case:

Because the AR case was open longer than 90 days

The original safety decision was changed

There was a report of a different incident or involving different children or different adults

There was a change in family circumstances

Q39 Was a Release of Information Form signed by the caretakers to contact others with information about the situation?
This should be scanned into Document Imaging - AR folder (caseworker folder)

- O Yes
- O No
- O No, none was needed

Q40 Was a Consent to Alternative Response Assessment Form signed by the family?
This should be scanned into Document Imaging - AR Folder (caseworker folder) - even if the family did not sign the consent form, workers should still upload with the date of this discussion

- O Yes
- O No; the caretaker did not sign, but the form was uploaded with the date of discussion
- O No; no form was uploaded

Q41 Was a safety threat identified?

- O Yes
- O No

Display This Question:
If Was a safety threat identified? = Yes

Q42 What was the safety threat(s)?
Check all that apply

Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm, as indicated by the following:

Current serious injury or abuse to the child other than accidental

Caregiver fears he/she will physically harm the child

Current threat to cause serious harm or retaliate against the child

Current excessive discipline or physical force

Drug-exposed infant

Domestic violence likely to physically injure child

Child sexual abuse is suspected AND circumstances suggest that the child's safety may be of immediate concern

Caregiver does not/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect

Caregiver's explanation for current injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern

The family actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child

Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional

Caregiver is not available, is unwilling to provide care, or has deserted the child

The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child

Child shows signs of significant emotional harm that present an imminent threat to child safety AND concerning caregiver behaviors are currently present, as indicated by the following:

Domestic violence among adults in the household

Caregiver behavior towards the child

Child behaviors place the child at imminent threat of serious harm, in spite of appropriate response by caregiver(s)

There is a pattern of prior CPS investigations of household members as alleged perpetrators, protective placements, or caregiver behavior AND current circumstances are near the threshold for any other safety threat

Display This Question:

If Was a safety threat identified? = Yes

Q43 Did the CFS Supervisor review and finalize the Safety Assessment within 1 business days of the assessment being submitted for review?

O Yes

O No

O No, CFSS finalized their own Safety Assessment

Display This Question:

If Was a safety threat identified? = Yes

Q44 Did the CFS Supervisor document the mandatory consultation narrative in N-FOCUS?
This consultation point should be documented under the Alternative Response Narrative

O Yes

O No

Display This Question:

If Did the CFS Supervisor document the mandatory consultation narrative in N-FOCUS? This consultatio... = Yes

Q45 Did the narrative include the following information?
Check all that apply

Information about the discussion

Decisions that were made

Parties involved

Next steps

Display This Question:

If Was a safety threat identified? = Yes

Q46 Was a safety plan completed with the family?
This should be under Safety Assessment/Safety Plan

O Yes

O No

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q47 Did the safety plan outline specific interventions to ensure the child's safety in the home?

O Yes

O No

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q48 Which of the following are evident in the Safety Plan?

Controls and manages safety threats

Has an immediate effect

Is immediately available and accessible to parents, children, and Safety Plan participants

Has supports and services that have the immediate effect of controlling for identified threats

Is agreed upon by parents, participants, and CFS Specialist as indicated by signatures on plan

Be monitored by CFS Specialist

Has a contingency plan

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q49 What specific interventions were listed in the safety plan?

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q50 Was the Safety Plan in effect for 30 days or less?

O Yes

O No

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q51 In the opinion of the reviewer, did the safety plan identify measures to control and manage safety threat(s) using the least intrusive services?

O Yes

O No

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q52 What services are being used to manage the safety threat(s)?

_____

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q53 Did the CFS Specialist document the Safety Plan on N-FOCUS within 1 calendar day of implementing the plan?

O Yes

O No

Display This Question:

If Was a safety plan completed with the family? This should be under Safety Assessment/Safety Plan = Yes

Q54 Did the CFS Supervisor finalize the Safety Plan within 1 calendar day of the CFS Specialist documenting it on N-FOCUS?

O Yes

O No

Display This Question:

If Was a safety threat identified? = Yes

Q55 How many F2F and phone contacts were made during the period of the Safety Plan? List the month and then the number of contacts.
Contacts should be documented in Required Contact Narratives (F2F) and CPS/APS Narrative, Contact, and Phone (phone).

_____

Display This Question:

If Was a safety threat identified? = Yes

Q56 Did the CFS Specialist meet at least once a week with the children and the family?
Contacts should be documented in Required Contact Narratives (F2F) and CPS/APS Narrative, Contact, and Phone (phone)

- O Yes
- O No

Q57 Was an Alternative Response case opened (meaning the case was open for longer than 30 days)?

- O Yes
- O No

Display This Question:

If Was a safety threat identified? = No

Q58 Did the CFS Specialist make 3 F2F contacts within the first month?

- O Yes
- O No
- O No, family refused
- O No, case was opened less than one month

Display This Question:

If Was a safety threat identified? = No

Q59 How many F2F contacts were made in the first month of the case?

_____

Display This Question:

If Was an Alternative Response case opened (meaning the case was open for longer than 30 days)? = Yes

And Was a safety threat identified? = No

Q60 Were 2 F2F contacts made in all subsequent months?

- O Yes
- O No
- O No, case closed

Display This Question:

If Were 2 F2F contacts made in all subsequent months? = No

Q61 How many contacts were made in all subsequent months? List the month and then number of contacts.
This includes F2F, phone, email, and text.

_____

Q62 Was a PFQ completed/documented for this case?

- O Yes
- O No
- O No, family refused

Display This Question:

If Was a PFQ completed/documented for this case? = Yes

Q63 Was the first PFQ documented within 14 regular business days from the date the intake was accepted for assessment?
Prior to December 2016 - the PFQ was scanned into Document Imaging under Alternative Response
After December 2016 - the PFQ should be entered within N-FOCUS

- O Yes
- O No

Q64 Did the CFS Specialist document the PFQ as “Unable to Obtain Information from Family”?
Prior to December 2016 - the PFQ was scanned into Document Imaging under Alternative Response
After December 2016 - the PFQ should be entered within N-FOCUS

O Yes

O No

Display This Question:

If Did the CFS Specialist document the PFQ as “Unable to Obtain Information from Family”?Prior to De... = Yes

Q65 Was there narrative completed to explain why the CFS Specialist was unable to complete the PFQ with the family?
This was only required after December 2016 - when the PFQ was built into N-FOCUS

O Yes

O No

O No, not required

Display This Question:

If Was there narrative completed to explain why the CFS Specialist was unable to complete the PFQ wi... = Yes

Q66 Which of the following is included in the narrative?
Select all the apply

Date the PFQ was presented to the family

Reasons why the PFQ was not completed

Protective Factors that could be enhanced or diminished

Q67 Was this case open longer than 90 days (from the date the case opened to the date of closure)?

O Yes

O No

Display This Question:

If Was this case open longer than 90 days (from the date the case opened to the date of closure)? = Yes

Q68 After 90 days, from the date the intake was opened, was a new safety assessment completed prior to case closure?

O Yes

O No

Display This Question:

If Was this case open longer than 90 days (from the date the case opened to the date of closure)? = Yes

Q69 After 90 days, from the date the intake was opened, was a new PFQ completed?
Prior to December 2016 - the PFQ was scanned into Document Imaging under Alternative Response
After December 2016 - the PFQ should be entered within N-FOCUS

O Yes

O No

Display This Question:

If Was this case open longer than 90 days (from the date the case opened to the date of closure)? = Yes

Q70 Did the CFS Specialist document the new PFQ as "Unable to Obtain Information from Family"?
Prior to December 2016 - the PFQ was scanned into Document Imaging under Alternative Response
After December 2016 - the PFQ should be entered within N-FOCUS

O Yes

O No

Display This Question:

If Did the CFS Specialist document the new PFQ as "Unable to Obtain Information from Family"?Prior t... = Yes

Q71 Was an associated narrative completed to explain why the CFS Specialist was unable to complete the additional PFQ with the family?

O Yes

O No

Display This Question:

If Was an associated narrative completed to explain why the CFS Specialist was unable to complete th... = Yes

Q72 Which of the following is included in the narrative?
Select all the apply

Date the PFQ was presented to the family

Reasons why the PFQ was not completed

Protective Factors that could be enhanced or diminished

Q73 Was a Prevention Assessment completed?

O Yes

O No

Display This Question:

If Was a Prevention Assessment completed? = Yes

Q74 Was the Prevention Assessment completed within 60 days of the Intake being accepted for assessment?

O Yes

O No

Display This Question:

If Was a Prevention Assessment completed? = Yes

Q75 Was the Prevention Assessment completed prior to case closure?

O Yes

O No

Display This Question:

If Was a Prevention Assessment completed? = Yes

Q76 What was the identified risk level in the latest Prevention Assessment?

- O Low
- O Moderate
- O High
- O Very High

Display This Question:

If Was a Prevention Assessment completed? = Yes

Q77 Did the Department response comply with the recommended case action?
Low = close case
Moderate = close case
High = recommended for ongoing services
Very high = recommended for ongoing services

- O Yes
- O No
- O No, family declined
- O No, family was participating in community support
- O No, case was kept open

Display This Question:

If Was a Prevention Assessment completed? = Yes

Q78 Did the CFS Supervisor finalize the Prevention Assessment within 5 days of the assessment being placed in ready to review status?

O Yes

O No

Q79 Was a genogram completed?

O Yes

O No

Q80 Was an eco-map completed?

O Yes

O No

Q81 Did the Supervisor document review of these documents in the staffing narrative?

O Yes

O No

Q82 Was a written Family Plan completed?
The Family Plan should be scanned into N-FOCUS under Alternative Response

O Yes

O No

Display This Question:

If Was a written Family Plan completed?The Family Plan should be scanned into N-FOCUS under Alternat... = Yes

Q83 Which of the following characteristics were identified in the Family Plan?
Check all that apply

Strengths of the family

Needs of the family

Goals

Strategies (how to get there)

Resources for the family (who or what can help)

Q84 Did a Family Team Meeting take place (as documented in the Family Team Meeting narrative)?

O Yes

O No

Display This Question:

If Did a Family Team Meeting take place (as documented in the Family Team Meeting narrative)? = Yes

Q85 Was the FTM documented on N-FOCUS within 7 calendar days of the meeting?

O Yes

O No

Display This Question:

If Did a Family Team Meeting take place (as documented in the Family Team Meeting narrative)? = Yes

Q86 Who participated in the FTM?

Caretaker

Child

CFSS

Other _____

Q87 Was there documentation about the ICWA status of this family?

O Yes

O No

Display This Question:

If Was there documentation about the ICWA status of this family? = Yes

Q88 Did this family possibly fall under ICWA guidelines?
Look under Detail Program Case - Program Person - Tribal or Kinships Search or Intake

O Yes

O No

Display This Question:

If Did this family possibly fall under ICWA guidelines?Look under Detail Program Case - Program Pers... = Yes

Q89 Did the CFS Specialist send Tribal Notices within 5 days of offering services?
Look under Detail Program Case - Program Person - Tribal

O Yes

O No

O No, no risk of removal so no need to notify tribe

Q90 Did the CFS Specialist document the case closure discussion with the family?

O Yes

O No

Q91 Did the CFS Supervisor document the case closure decision?
This should be documented under a Consultation Point in the Alternative Response narrative

O Yes

O No

Q92 Was group supervision documented in this case?

O Yes

O No

Q93 Is there evidence that case mapping was used with this case? (Case mapping is defined as supervisory consultation that includes all or some of the following: Concerns/safety concerns; Complicating factors; Strengths; History; Gray areas; Protective factors; Social connections; Concrete supports for parents; Resilience; Social and emotional competence of parents; and Next steps.)
This should be scanned under Alternative Response or documented by the supervisor in a consultation point narrative

O Yes

O No

Display This Question:

If Is there evidence that case mapping was used with this case? (Case mapping is defined as supervis... = Yes

Q94 Was the case map scanned into N-FOCUS?

O Yes

O No

Display This Question:

If Is there evidence that case mapping was used with this case? (Case mapping is defined as supervis... = Yes

Q95 Was there narrative documentation of the case map?

O Yes

O No

Display This Question:

If Was there narrative documentation of the case map? = Yes

Q96 Did the narrative include any of the following?

Item discussed

Decisions

Parties involved

Next steps

Q97 Although not required, was there evidence indicating a referral was made to the Early Development Network for any child in the family?

- O Yes
- O No
- O N/A, no eligible child

Q98 Was the family's primary language English?

- O Yes
- O No

Display This Question:

If Was the family's primary language English? = No

Q99 What was the family's primary language?

- O Spanish
- O Vietnamese
- O Russian
- O Other _____

Q100 Did the CFS Specialist use the DCFS Purchase Card to obtain resources for the family?
The presence of a receipt indicates that the Purchase Card was used. All receipts are required to be scanned into Document Imaging - Alternative Response Folder.

O Yes

O No

Display This Question:

If Did the CFS Specialist use the DCFS Purchase Card to obtain resources for the family?The presence... = Yes

Q101 What was purchased with the Purchase Card (according to receipts in the file)?

⊗No documentation in N-FOCUS

Food/Formula

Clothing needs (including diapers)

Identification cards (e.g., associated fees)

Housing

One-time deposit on a residence

Rent per month

Housing repairs (e.g., window or door repair, locks, electrical, plumbing)

Household items (e.g., refrigerator, washer, dryer, crib, beds)

Assistance with payment of utilities (does not include cable, cell phone/trac phone)

Child care (e.g., registration fee, tuition)

Pest control

Garbage removal (e.g., regular pickup, large dumpster)

Transportation

Personal vehicle expenses (e.g., gas, minor car repair, license, insurance)

Taxi, bus pass, handi-van, truck for moving, etc.

Medications

Laboratory work (excludes substance abuse related laboratory expenses)

Medical and mental health services

Other _____

Display This Question:

If Did the CFS Specialist use the DCFS Purchase Card to obtain resources for the family?The presence... = Yes

Q102 How much was spent in total for this family using the Purchase Card?

O $1 - $500

O $501 - $1000

O $1001 - $2000

O More than $2000

O Cannot be determined

Display This Question:

If Did the CFS Specialist use the DCFS Purchase Card to obtain resources for the family?The presence... = Yes

Q103 Who all approved these Purchase Card transactions?
CFS Specialist should get approvals for all transactions (at the appropriate level, based on amount) once they've spent over $500 on the family.

No approvals needed (amounts up to $500 per family)

Supervisor (amounts up to $1,000 per family)

Administrator (amounts up to $2,000 per family)

Service Area Administrator (amounts over $2,000 per family)

AR Program Specialist (amounts over $2,000 per family)

⊗No approvals documented

Q104 Were other services purchased for the family (that were not purchased with the Purchase Card)?

O Yes

O No

Display This Question:

If Were other services purchased for the family (that were not purchased with the Purchase Card)? = Yes

Q105 What other services were provided to the family (not purchased with the Purchase Card)?

⊗No documentation in N-FOCUS

Food/Formula

Clothing needs (including diapers)

Identification cards (e.g., associated fees)

Housing

One-time deposit on a residence

Rent per month

Housing repairs (e.g., window or door repair, locks, electrical, plumbing)

Household items (e.g., refrigerator, washer, dryer, crib, beds)

Assistance with payment of utilities (does not include cable, cell phone/trac phone)

Child care (e.g., registration fee, tuition)

Pest control

Garbage removal (e.g., regular pickup, large dumpster)

Transportation

Personal vehicle expenses (e.g., gas, minor car repair, license, insurance)

Taxi, bus pass, handi-van, truck for moving, etc.

Medications

Laboratory work (excludes substance abuse related laboratory expenses)

Medical and mental health services

Other _____

ALTERNATIVE RESPONSE CASE FILE REVIEW TOOL GUIDEBOOK

The following guide was developed by the reviewer in order to standardize and operationalize all items on the AR case file review tool.

1. CFS Master Case Number: (Use CFS Master Case as provided by DHHS.)
2. Intake Number: (Intake number is located at the top of the Intake form.)
3. Case Type: (Case type is located at the top of the Intake report. If not designated Dependent Child, Intake is Abuse/Neglect.)
4. Select the date this case opened: (Case opening date is the earliest date the Intake is closed for AR. This is located on the last page of the Intake form under Department Decision.)
5. Select the date the case was assigned to the CFS Specialist: (Date is near the top of the Intake form. Assignment date can also be located on the Detail Program Case Assignments screen print.)
6. Select the date this case closed: (Date the case closed can be determined from narrative statements by the CFSS or supervisor that the case will close effective a specific date, by other narrative references to case closure, or by the last date of contact with the family. Determine case closure date from narratives, not from date of computer closure. Completion of all documentation can be significantly delayed.)
7. Did anyone in this household have a prior substantiated report of abuse or neglect? (Review Intake Report, Prior Involvement. Intake reports are listed by each member of the household. Using the adults only, include any intake reports that have a finding of agency substantiated, court pending, or court substantiated.)
8. Did anyone in this household have prior Intakes that were screened out? (Review Intake Report, Prior Involvement. Intake reports are listed by each member of the household. Using the adults only, count any reports identified as not meeting definition. Be careful not to duplicate counts.)
9. How many prior Intakes were there on the children in this household? (Using Intake Report, Prior Involvement, count by individual Intake numbers. Be careful not to duplicate counts.)
10. Were there any Intakes accepted for assessment *after* this AR case closed? (Determine the date of case closure. See item #6. Review list of Intakes on Intake Report Section Intakes/Allegations to determine if any Intakes were received after closure date.)
11. What were the case status determinations for these subsequent intakes? List the number for each below. (For each intake received after date of case closure, count each finding, located in the Intake Report, Section Intakes/Allegations, again being careful to avoid duplicate counts.)
12. Were there any Intakes screened out after this AR case closed? (Review the Intake Report and include those not meeting definition.)
13. How many subsequent Intakes did not meet definition? (Using the Intake Report Section Intakes/Allegations, count the number of Intakes received after the date of closure that did not meet definition, again being careful to avoid duplicate counts.)

NOTE: For questions 7 through 13, if the Intake Report does not contain the Section Intakes/Allegations information, request that the intakes be reprinted to include this information

14. Name of assigned CFS Specialist at beginning of case. (This is located in the narratives, or on various documents in the file.)
15. Name of CFS Specialist's Supervisor. (This name should be located at the bottom of the last page of the Safety or Prevention Assessment, along with their title, or in consultation narratives.)
16. Were there multiple CFS Specialists involved with this case? (Review entire case narrative and documents to determine if other CFS Specialists are referenced.)
17. How many CFS Specialists were involved with this case? (Count identified individuals whose names appear in assessments or narratives.)
18. Name of the CFS Specialist at case closure if different from above. (CFS Specialist's name is located at the end of the final Safety or Prevention Assessment or on the case closure narrative.)
19. Name of CFS Supervisor at case closure. (Supervisor's name is located at the end of the final Safety or Prevention Assessment or in the Supervisor consultation narrative.)
20. Was the initial face-to-face contact with the children made within 5 calendar days of the Intake accepted/open date? (Using the initial contact date in the Safety Assessment or narratives, whichever is earliest, count number of days from date of opening to contact-item 4.)
21. If no, was a contact exception narrative documented by the Supervisor or CFS Administrator? (Review Contact Exceptions Supervisor narrative or Contact Exceptions-Administrator narratives.)
22. Was there any evidence that the CFS Specialist attempted to contact the family prior to meeting with the children? (Answer yes if narratives document phone calls, letters, notes on the door, or other attempts.)
23. Is there documentation that the parent was successfully contacted prior to interviewing the child(ren?) (Answer yes if narratives indicate parents were successfully contacted first, or if facts indicate parents had to be contacted first due to ages of the children.)
24. When was the identified child(ren) interviewed? (Review Safety Assessment and narrative to determine sequence of contact.)
25. Was a face-to-face interview conducted with *all* the children? (Review Intake to determine children in the household. Review Safety Assessment and contact narratives to determine that all children were interviewed, or if too young to interview, were observed.)
26. Was a face-to- face interview conducted with the primary and secondary caregivers? (Review Intake report to determine adults in the household and the Safety and Prevention Assessments and contact narratives to determine which adults were interviewed.)
27. Was a face-to-face interview conducted with *all* the adults in the household? (Review Intake Report to determine adults in the household, review the Safety and Prevention Assessments and narratives to determine if all were interviewed.)
28. Who all participated in the initial interview? (Review Safety Assessment and check all that apply.)
29. Did the CFS Specialist document a visit to the home at any time? (Review Safety and Prevention Assessments, contact narratives, and all other documentation.)
30. Was a Safety Assessment completed?

31. Was the initial Safety Assessment completed at the first contact with the children? (Review Safety Assessment and contact narrative. Answer yes if the documentation date was within a few days of the initial contact date. Documentation actually indicates completion.)
32. Did the CFS Specialist document the Safety Assessment within one calendar day of initial contact? (Compare initial contact date with "Completed By CFS Specialist" date at the end of the Safety Assessment.)
33. Did the CFS Supervisor review and finalize the Safety Assessment within 3 business days of the assessment being submitted for review? (Compare date of "Completed By" CFS Specialist with date of "Reviewed By" Supervisor date at the end of the Safety Assessment. Actual signatures or initials are not required. Answer no if the CFS Specialist approved their own assessment.)
34. Did the CFS Specialist review and finalized their own Safety Assessment? (Answer yes if the CFS Specialist is named in both the Specialist and the Supervisor signature lines.)
35. Were additional Safety Assessments completed? (Review file to determine if there is more than one Safety Assessment.)
36. If yes, indicate the reason. (Check all that apply.)
    - The AR case was open longer than 90 days; (Compare case open date-question 4 to case closure date-question 6.)
    - The original safety decision was changed; (Review narrative to determine if a safety threat might have developed.)
    - Due to report of different incident or involving different children or different adults; (Review narrative describing report of new Intake during the time the case was open.)
    - Due to change in family circumstances; (Review narrative to determine if there was a significant event in the family, for example, a job loss, medical concern, birth, or someone moving in or out of the home.)
    - No
37. Were additional Safety Assessments needed?
38. If yes, indicate the reason. (Check all that apply.)
    - The AR case was open longer than 90 days. (Compare case open date-question #4 to case closure date-question 6.)
    - The original safety decision was changed; (Review narrative to determine if a safety threat might have developed.)
    - There was a report of different incident or involving different children or adults; (Review narrative describing report or new Intake during time the case was open.)
    - There was a change in family circumstances; (Review narrative to determine if there was a significant event in the family, for example, a job loss, medical concern, birth, or someone moving into or out of the home.)
39. Was a "Release of Information" form signed by caretakers to contact others with information about the situation? (Forms should be located in the file. Answer yes if narratives indicate that release forms were completed, but note in comment section that they were not documented in the file.)
40. Was a "Consent to Alternative Response Assessment Form" signed by the family? (Form should be located in the file. Indicate no, if no form is located.)

SAFETY THREAT IDENTIFIED

41. Was a Safety Threat identified? (Review the Safety Assessment to determine if a threat was identified.)
42. What was the safety threat? (Determine which threats are marked in the Safety Assessment indicating a threat was found.)
43. Did the CFS Supervisor review and finalize the Safety Assessment within 1 business days of the assessment being submitted for review?
44. Did the CFS Supervisor document the mandatory consultation narrative in N-FOCUS? (Review Supervisor consultation narrative.)
45. Did the narrative include the following information? (Review consultation narrative.)
46. Was a Safety Plan completed with the family? (Safety Plan should be located in the case file.)
47. Did the Safety Plan outline specific interventions to ensure the child's safety in the home? (Answer yes if there are specific items listed.)
48. Which of the following are evident in the Safety Plan? (Check all that apply.)
    - Controls or manages safety threats? (Does the identified action mitigate the identified threat?)
    - Has an immediate effect? (Are actions beginning now?)
    - Are actions in the plan immediately available and accessible to the parents, children, and Safety Plan participants? (Are Safety Plan participants able to fulfill their role now?)
    - Has supports and services that have the immediate effect of controlling for identified threats? (Are supports and services available now?)
    - Is signed by parents, participants and Specialist indicating agreement?
    - Will be monitored by the CFS Specialist? (Plan describes steps the CFS Specialist will take to assure the plan is working.)
    - Has a contingency plan? (An acceptable plan provides another person or action to manage the threats. Calling police or CFS Specialist is not an acceptable contingency plan.)
49. What specific interventions are listed in the Safety Plan? (List identified interventions.)
50. Was the Safety Plan in effect for 30 days or less? (Compare the Safety Plan Begin Date on the Safety Plan to the Status Final date.)
51. In the opinion of the reviewer, did the Safety Plan identify measures to control and manage safety threats using the least intrusive services? (For example, these might include dangerous person leaving the home; removing items of self-harm; friend or relative caring for the children or staying in the home, and others.)
52. What services are being used to manage safety threats? (List. These should to be specific, identified, and not promissory.)
53. Did the CFS Specialist document the Safety Plan in N-FOCUS within one calendar day of implementing the plan? (Compare date of Safety Assessment to the Safety Plan begin date.)
54. Did the CFS Supervisor finalize the Safety Plan within one calendar day of the CFS Specialist documenting it on N-FOCUS? (Compare the Safety Plan Begin date to Status Final date.)
55. How many face to face, and phone contacts were made during the period of the Safety Plan? (Count all contacts that occurred during the duration of the Safety Plan using contact narratives.)

56. Did the CFS Specialist meet at least once a week with the children and family? (Compare date of Safety Assessment with dates of in person contacts documented in Required Contact narratives.)
57. Was an AR case opened? (An AR case was considered open if there was more than 30 days from the date the case opened –item 4 and the date the case closed-item 6. Length of time is the determining factor, not service provision.)
58. Did the CFS Specialist make 3 face to face contacts within the first month? (Compare the date of initial contact and one month later. Count contacts documented in the Assessments or Contact narrative.)
59. How many face-to-face contacts were made in the first month of the case? (Use date case opened as begin date and date one month later as end date to determine period to count.)
60. Were two face-to-face contacts made in all subsequent months? (Using end date of month one in the above question to date of case closure-item #6, determine if two face-to-face contacts occurred each month, by reviewing Assessments and Contact narrative.
61. How many contacts were made in all subsequent months? (Count all contacts including face-to- face, phone, email and text between end of the first month date and date of case closure-item #6.)
62. Was the Protective Factors and Well-Being Questionnaire (PFQ) completed? (Answer yes if completed PFQ is located in the case file.)
63. Was the first PFQ documented within 14 business days from the date the Intake was accepted for assessment? (Use date the case was opened-item 4, and using calendars, count the number of days between open date and date on the PFQ.)
64. Did the CFS Specialist document the PFQ as "Unable to Obtain Information from Family? (If no PFQ is located in file, the response is no. In some versions of the PFQ there will be a box in the upper right corner of page 1, which should be checked if the family declined to participate. There may also be screen shot narrative indicating the family declined to complete the PFQ.)
65. Was there narrative completed to explain why the CFS Specialist was unable to complete the PFQ with the family? (Narrative is located on the last page of the PFQ or refusal can be documented in the Safety Assessment or in screenshot narratives.)
66. Which of the following is included in the narrative? (Use narrative in the PFQ and any narrative in the Safety Assessment, Contact, screen shots, or other narratives.)
67. Was this case open longer than 90 days from the date the case opened to date of closure? (Compare date the case was opened-item 4, with the date of case closure, item 6.)
68. After 90 days from the date the Intake was accepted for assessment, was a new Safety Assessment completed prior to case closure? (Answer yes, if there is a second Safety Assessment prior to case closure.)
69. After 90 days from the date the Intake was accepted for assessment, was a new PFQ completed? (Answer yes, if there is a second PFQ completed more than 90 days from acceptance-question 4.)
70. Did the CFS Specialist document the new PFQ as "Unable to Obtain Information from the Family? (If there is no additional PFQ in the file, or note in the supervisor consultation narrative, the response is no. In some versions of the PFQ there will be a box in the upper right corner of page 1, which should be checked if the family declined to participate.)

71. Was an associated narrative completed to explain why the CFS Specialist was unable to complete the additional PFQ with the family? (The narrative section located at the end of the PFQ was seldom used. Information may be located in contact narrative, supervisor consultation, or PFQ screenshot narrative.)
72. Which of the following is included in the narrative? (Check all that apply.)
73. Was a Prevention Assessment completed?
74. Was the Prevention Assessment completed within 60 days of the Intake being accepted for assessment? (Compare the date the case was opened-item 4 to the date of the Prevention Assessment was completed and determine number of days.)
75. Was the Prevention Assessment completed prior to case closure? (Compare date of Prevention Assessment to case closure date-item #6.)
76. What was the identified risk level in the latest Prevention Assessment? (Prevention Assessment Section 3 Recommended Decision)
77. Did the Department response comply with the recommended case action? (Compare the identified risk level with the Department's stated action found in the narrative in Section 3 recommended Decision-Conclusion of the Prevention Assessment.)
78. Did the CFS Supervisor finalize the Prevention Assessment within 5 days of the assessment being placed in Ready to Review status? (Compare date completed by the CFS Specialist to the Reviewed by CFS Supervisor date with the CFS Supervisor's name. Signature lines are at the end of the Assessments, but prior to the section on Family Functioning. Actual signatures are not required.)
79. Was a genogram completed? (Genogram will be located in the case file. Genograms can be documented on the formal document, hand written on a piece of paper, or otherwise documented.)
80. Was an Eco-map completed? (Eco-map will be located in the case file. It can be documented on the formal document, hand written on a piece of paper, or otherwise documented.)
81. Did the Supervisor document review of these documents in the staffing narrative? (Review Supervisor consultation narratives.)
82. Was a written Family Plan completed? (The Family Plan will be located in the case file. It can be documented on the Department's form Family Plan (CFS-44) or in narrative format.)
83. Which of the following characteristics were identified in the Family Plan? (Check all that apply.)
84. Did a Family Team Meeting take place? (Review documentation in the Family Team Meeting narrative.)
85. Was the Family Team Meeting documented on N-FOCUS within 7 calendar days of the meeting? (Compare date of meeting to date of documentation.)
86. Who participated in the Family Team Meeting? (Mark all who are identified as being present.)
87. Was there documentation about the Indian Child Welfare Act (ICWA) status of the family? (Answer yes if there is a statement in the CFSS narrative that the family is or is not of Native American ancestry, entry on Detail Tribal Information screen print, or inclusion of the N-FOCUS document with questions about Native American ancestry.)
88. If yes, did this family possibly fall under ICWA guidelines? (Answer is yes, if there is indication that anyone in the family is of Native American ancestry.)

89. Did the CFS Specialist send Tribal Notices within 5 days of offering services? (Copies of notices will be located in case file. Compare date of ICWA determination and dates of notice letters. If there was no risk of removal, notice to the tribe is not required.)
90. Did the CFS Specialist document the case closure discussion with the family? (Review Contact narratives and assessments.)
91. Did the CFS Supervisor document the case closure decision? (Review Supervisor consultation narratives.)
92. Was Group Supervision documented in this case? (Answer yes if Supervisor consultation narratives indicate participants other than the Specialist and Supervisor at any documented supervision meeting.)
93. Is there evidence that case mapping was used with this case? (Case mapping is defined as supervisory consultation that includes all or some of the following: Concerns/safety concerns; Complicating factors; Strengths; History; Gray areas, Protective factors; Social connections; Concrete supports for parents; Resilience; Social and emotional competence of parents; and Next steps. (Answer yes if any of the above are indicated in narrative, on specific forms or otherwise.)
94. Was the case map scanned into N-FOCUS? (Answer yes if there is any documentation other than in narratives indicating case mapping occurred.)
95. Was there narrative documentation of the case map? (Review Supervisor narratives to determine if there was discussion of the elements of case mapping.)
96. Did the narrative include any of the following? (Review narratives attached to assessments as well as contact and supervisor narratives.)
97. Although not required, was there evidence indicating a referral was made to the Early Development Network for any child in the family? (Answer yes if any narrative reflects this. Any child age three or under with possible developmental delays is eligible for referral.)
98. Was the family's primary language English? (Review narratives. This may also be located on the Intake form under Parent Name-Interpreter.)
99. What was the family's primary language? (This may be indicated on the Intake form or in narratives.)
100. Did the CFS Specialist use the DCFS Purchase Card to obtain other resources for the family? (This information can be located in the assessments and other narratives. If used, receipts should be included in the case file.)
101. What was purchased? (Use receipts and narratives to determine how money was spent.)
102. How much was spent? (Total receipts to determine amount spent. If narrative reflects purchases for which there are not receipts, select Unable to determine.)
103. Who all approved the purchase? (Approval should be documented in Supervisor or Administrator narratives or in the separate financial tracking process.)
104. Were other services purchased for the family that were not purchased with the purchase card? (Answer yes if narratives indicate vouchers were used for rent, gas, diapers, or other expenses.)
105. What other services were provided to the family (not purchased with the Purchase Card)?

Note:

1. *Ages of the children on the first page of the Intake form reflect the age at the time the Intake was printed. Child's age at the time of the case must be calculated.*
2. *Comment sections at the end of some questions can be used to clarify information or highlight unique issues with the case.*
3. *Comment section at the end of the tool can be used for general comments about issues presented by this case, problems with how the case was worked, or to identify especially good casework.*

AR Family Survey

The AR Family Survey (family survey) has been in practice since December 2014. This survey was adapted and extended from the family survey originally used by the QIC-DR and designed to assess families' satisfaction and relationship with their assigned worker, engagement, protective factors, and overall perceptions of outcomes as a result of involvement with the child welfare system. This survey was administered in English and Spanish. Primary caregivers were asked to complete this survey at the end of every AR-eligible case, assigned to either AR or TR. Initially, the family survey was only sent via U.S. mail, along with a postage-paid envelope for the survey's return. As an incentive, each family received a $10 Walmart gift card upon receipt of their completed survey. However, due to low response rates, UNL-CCFL modified the protocol to increase the survey's access and incentives. Beginning in July 2015, families with provided email addresses were asked to complete the survey online. Two weekly follow-up reminder emails were sent for missing or incomplete responses. If online responses were not received, then a paper survey was mailed to the family. Additionally, beginning at the end of October 2015, an anonymous link was added to the informed consent letter mailed out with the paper surveys, allowing for families to complete the survey online, if preferred. Also, the incentive was increased from a $10 Walmart gift card to a $20 Walmart gift card and respondents were entered into a raffle for a chance to win a $100 Walmart gift card, which was raffled off every 6 months. In April 2018, it was determined that response rates were relatively steady and participants no longer needed the $100 Walmart gift card incentive, at which time it was discontinued.

From October 2014 through June 2019, 4,715 family surveys were sent, with a total of 916 completed surveys received, resulting in an overall response rate of 19%; a total of 497 AR families completed the survey (54%) and 419 TR families completed the survey (46%). A copy of this measure is provided on the next page.

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Michelle Graef
Research Associate Professor

Kate Stephenson
Project Director

Confidential Family Experience Survey

The Nebraska Division of Children and Family Services (DCFS) contacted you in the past several months about one or more children in your home. We want to know about your experience.

After you complete your survey, please use the enclosed postage paid envelope to return it directly to the researchers at the University of Nebraska-Lincoln.

For your convenience, you can complete this survey online at ***go.unl.edu/familysurvey***

To thank you for your help, we will mail you a Walmart gift card when we receive your completed survey.

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Confidentiality

The information you provide on this survey will be combined with the answers of others to help improve future contacts with families.

All of your answers will be kept confidential. Your name will NOT be on your individual survey, so no one at DCFS will ever know which answers were yours.

Instructions

Please answer the following questions as completely and honestly as possible about your experience with the following worker:

_____

Satisfaction

	Not at all	Somewhat	Very
How *satisfied* are you with how you and your family were treated by the worker who visited your home?	☐	☐	☐
How *satisfied* are you with the support you and your family received?	☐	☐	☐
How *likely* would you be to call your worker or DCFS if you or your family need support in the future?	☐	☐	☐

Relationship with your worker

	Not at all	Somewhat	Very
How *often* did your worker encourage you to say what you thought?	☐	☐	☐
How *often* did your worker consider your opinions before making decisions that concerned you and your family?	☐	☐	☐
Overall, how *carefully* did your worker listen to what you had to say?	☐	☐	☐
Overall, how *well* do you feel your worker understood your needs?	☐	☐	☐
How *easy* was it to contact your worker?	☐	☐	☐

	No	Sometimes	Yes
Did your worker see the things that you do well?	☐	☐	☐
Were there things that were important to you that did not get talked about with your worker?	☐	☐	☐

If yes, what were they?

_____

_____

_____

How did you feel after the first time your worker came to your home? Check all that apply:

☐ Afraid	☐ Respected	☐ Comforted
☐ Angry	☐ Disrespected	☐ Relieved
☐ Worried	☐ Encouraged	☐ Thankful
☐ Stressed	☐ Discouraged	☐ Hopeful

Please read each statement and think about how you feel ***right now*** *about your involvement with your worker. There are no right or wrong answers to any of the questions. Please answer as openly and honestly as you can.*

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
My family got the help we really need from my worker.	☐	☐	☐	☐	☐
I realize I needed some help to make sure my kids have what they need.	☐	☐	☐	☐	☐
I was fine before my worker got involved.	☐	☐	☐	☐	☐
It was hard for me to work with my worker.	☐	☐	☐	☐	☐

Open to Continue

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
There was a good reason my worker was involved with my family.	☐	☐	☐	☐	☐
Working with my worker has given me more hope about how my life is going to be in the future.	☐	☐	☐	☐	☐
My worker and I respected each other.	☐	☐	☐	☐	☐
My worker and I had the same opinions about what was best for my child(ren).	☐	☐	☐	☐	☐
I felt like I could trust my worker to be fair and see my side of things.	☐	☐	☐	☐	☐
I think things are better because my worker was involved with my family.	☐	☐	☐	☐	☐
My worker wanted me to do the same things that I wanted to do.	☐	☐	☐	☐	☐
There were definitely some concerns in my family that my worker saw.	☐	☐	☐	☐	☐
My worker did not understand where I was coming from at all.	☐	☐	☐	☐	☐
My worker helped me take care of some challenges in my life.	☐	☐	☐	☐	☐
My worker helped make my family stronger.	☐	☐	☐	☐	☐
My worker was out to get me.	☐	☐	☐	☐	☐

Open to Continue

Services and Needs

	No	Yes
Was there any help that you or your family needed but did not get?	☐	☐

If yes, what?

	No	Yes	N/A
If you got support or services from your worker (or a referral they gave you) was it:			
The kind of help you needed?	☐	☐	☐
Enough to really help you?	☐	☐	☐
Offered at the time you needed it?	☐	☐	☐
Offered to you in your preferred language?	☐	☐	☐

Protective Factors

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
I have others who will listen when I need to talk about my problems	☐	☐	☐	☐	☐
I have others who I can talk to when I am lonely	☐	☐	☐	☐	☐
I have others who I can talk to if there is a crisis	☐	☐	☐	☐	☐
I would know where to go for help if my family needed food or housing	☐	☐	☐	☐	☐
I would know where to go for help if I had trouble making ends meet	☐	☐	☐	☐	☐
I would know where to go for help if I needed a job	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Frequently	Always
In my family we talk about problems	☐	☐	☐	☐	☐
In my family we listen to both sides of the story when we argue	☐	☐	☐	☐	☐
In my family we take time to listen to each other	☐	☐	☐	☐	☐
In my family we pull together when things are stressful	☐	☐	☐	☐	☐
In my family we are able to solve our problems	☐	☐	☐	☐	☐

For the rest of the questions in this section we would like you to answer thinking about the child that you hope will benefit the most from your participation in services. For these questions, please answer only with that child in mind.

	Never	Rarely	Sometimes	Frequently	Always
I praise my child for good behavior	☐	☐	☐	☐	☐
I discipline my child without losing control	☐	☐	☐	☐	☐
I am able to soothe my child when he/she is upset	☐	☐	☐	☐	☐
I spend time with my child doing things that he/she likes to do	☐	☐	☐	☐	☐
I feel close to my child	☐	☐	☐	☐	☐
I enjoy being with my child	☐	☐	☐	☐	☐
My child gets along well with family members	☐	☐	☐	☐	☐
My child gets along well with others his or her age	☐	☐	☐	☐	☐
My child shows concern for others' feelings	☐	☐	☐	☐	☐
My child loses it when he or she is upset	☐	☐	☐	☐	☐
My child has trouble talking about his or her feelings	☐	☐	☐	☐	☐
My child misbehaves or gets in trouble	☐	☐	☐	☐	☐

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
As a parent there are many times I don't know what to do	☐	☐	☐	☐	☐
As a parent I know how to help my child learn	☐	☐	☐	☐	☐
As a parent I think my child misbehaves just to upset me	☐	☐	☐	☐	☐

Overall Feedback

	No	Yes
Because of my experience with DCFS, I have learned at least one skill or been provided with a service/support that…		
Makes me feel like I am a better parent	☐	☐
Allows my children to be safer	☐	☐
Helps me better provide necessities like food, clothing, shelter, or medical care	☐	☐

Overall, are you and your family better off or worse off because of your experience with DCFS?

- ☐ We are worse off
- ☐ We are the same
- ☐ We are better off

Please provide any additional comments you would like to share about your experience with DCFS or your worker. Only the researchers at UNL will see your individual comments. Use back page, if needed.

THANK YOU!

Please return your completed survey using the provided postage paid envelope.

After your completed survey is received, we will mail you a Walmart gift card as a thank you for your participation.

AR Human Resource Data

DCFS provided personnel data from April 2012 through July 2019, obtained from HR. The dataset included the following variables: employee ID, employee name, gender, ethnicity, position (CFS Trainee, Specialist, or Supervisor), service area, office, supervisor, the date the employee began employment with the state government, start dates for the CFS Trainee, CFS Specialist, and CFS Supervisor positions, and separation date from state government. The date of separation from DCFS was unavailable. AR training date and AR start and end dates were tracked manually by the AR Program Specialist. The program specialist contacted supervisors each month to ask which workers began and stopped working AR cases that month and added that information to the spreadsheet.

AR Protective Factors and Well-Being Questionnaire

At the request of DCFS, UNL-CCFL assisted the AR leadership with the development of an adapted version of the FRIENDS National Center's Protective Factors Survey, entitled the *Nebraska DCFS Protective Factors Questionnaire* (PFQ). This survey was designed to assess families' protective factors, which were assessed through 25 items across 6 subscales: social connections (3 items), concrete supports for parents (3 items), parental resilience (5 items), knowledge of parenting and child and youth development (4 items), nurturing and attachment (4 items), and social and emotional competence of children (6 items). Each item was rated on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*) or frequency (*1 = Never, 5 = Always*). These questions were implemented in October 2014 and data were collected through June 2019. Additionally, new AR guidelines were released in the AR Program Manual in July 2015. At that time, an updated version of the PFQ was developed, now titled the *Nebraska DCFS Protective Factors and Well-Being Questionnaire* (PFWBQ). The PFWBQ expanded upon the PFQ to include the measurement of well-being. The additional well-being items were taken or adapted from the *Child Protection Best Practices Well-Being Checklist* developed by the New Mexico Court Improvement Project and the *Strength and Difficulties Questionnaire* (SDQ). Well-being was assessed through 39 items that aim to measure four child well-being outcome domains: 1) physical health/development, 2) cognitive functioning, 3) emotional/behavioral functioning, and 4) social functioning. The domains of physical health/development and cognitive functioning were assessed with yes/no items and were labeled as health (7 items) and education (5 items) respectively. The domains of emotional/behavioral and social functioning were rated on a 3-point scale (*0 = Not True, 1 = Somewhat True, 2 = Certainly True*) and were comprised of subscales. Emotional/behavioral functioning had two subscales (with 5 items each) from the SDQ: emotional symptoms and hyperactivity. Social functioning had three subscales (with 5 items each) from the SDQ: peer relationship problems, conduct problems, and prosocial behavior. These additional questions were implemented in July 2015 and data were collected through June 2019. The PFWBQ was to be completed with AR families at the beginning of their case, and should have been re-administered every 90 days. The overall response rate from October 2014 through June 2019 is 73% (note, this measure is only for AR cases); 1667 master cases had at least one PFQ/PFWBQ form documented (i.e., form was completed or family refusal was documented) out of a total of 2294 master cases with at least one closed AR case. A copy of this measure is provided on the next page.

Nebraska DCFS Protective Factors & Well-Being Questionnaire

Scan completed forms and email to waiver@ccfl.unl.edu

CFS Specialist Name: _____ **Today's Date:** _____

Family Name: _____ **MC #:** _____

Number of children: _____ **Intake #:** _____

☐ Please check this box if the family has declined to complete this questionnaire.
The information gathered by this questionnaire is important and partial completion is acceptable, if possible.

<u>This questionnaire is meant to be filled out from the family's perspective.</u>

For each statement, check the box under the rating that best describes the <u>primary caretaker's</u> level of agreement or frequency.

	I have others who…	***Strongly disagree***	***Disagree***	***Neutral***	***Agree***	***Strongly agree***
Social Connections	will listen when I need to talk about my problems.	☐	☐	☐	☐	☐
	I can talk to when I am lonely.	☐	☐	☐	☐	☐
	I can talk to if there is a crisis.	☐	☐	☐	☐	☐
	I would know where to go for help if…	***Strongly disagree***	***Disagree***	***Neutral***	***Agree***	***Strongly agree***
Concrete Supports for Parents	my family needed food or housing.	☐	☐	☐	☐	☐
	I had trouble making ends meet.	☐	☐	☐	☐	☐
	I needed help finding a job.	☐	☐	☐	☐	☐
	In my family we…	***Never***	***Rarely***	***Sometimes***	***Frequently***	***Always***
Parental Resilience	talk about problems.	☐	☐	☐	☐	☐
	listen to both sides of the story when we argue.	☐	☐	☐	☐	☐
	take time to listen to each other.	☐	☐	☐	☐	☐
	pull together when things are stressful.	☐	☐	☐	☐	☐
	manage to solve our problems.	☐	☐	☐	☐	☐

Please fill in the name, gender, and age for each child in the family.

Child 1 Name: Gender: M / F Age:	Child 2 Name: Gender: M / F Age:	Child 3 Name: Gender: M / F Age:	Child 4 Name: Gender: M / F Age:	Child 5 Name: Gender: M / F Age:

Name the child you hope will benefit most from your participation in services: _____

		Child 1					***Child 2***					***Child 3***					***Child 4***					***Child 5***				
Knowledge of Parenting/Development	**For each statement, please check the box under the rating that best describes the <u>primary caretaker's</u> level of agreement or frequency. Please answer for each individual child, with only that child in mind.**	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	I know how to help this child learn.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I think this child misbehaves just to upset me.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I praise this child for good behavior.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I discipline this child without losing control.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nurturing and Attachment		Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always
	I am able to soothe this child when he/she is upset.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I spend time with this child doing things that he/she likes to do.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I feel close to this child.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	I enjoy being with this child.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social and Emotional Competence of Children	This child gets along well with family members.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child gets along well with others his/her age.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child shows concern for others' feelings.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child "loses it" when he/she is upset.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child has trouble talking about his/her feelings.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child misbehaves or gets in trouble.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Well-Being	This child has regular contact with both parents and with all their siblings.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*Items marked with an asterisk may be skipped if deemed inappropriate due the child's age.

Well-Being

	Child 1				Child 2				Child 3				Child 4				Child 5			
	Yes	No	Don't Know	N/A	Yes	No	Don't Know	N/A	Yes	No	Don't Know	N/A	Yes	No	Don't Know	N/A	Yes	No	Don't Know	N/A
This child is up to date on all immunizations.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child has a primary care physician.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child is in good physical health.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child shows age-appropriate physical and cognitive development.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child receives regular medical treatment, when needed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child receives regular dental care.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child receives mental health treatment, if needed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child is enrolled in an early education program.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child is working at his/her grade level in school.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child participates in an Individualized Education Program (IEP), if eligible.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child has both parents participating in his/her IEP, if eligible.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
***** **If child is <u>under age 2</u>, stop here** *****																				
The following items are for children <u>age 2 and older</u>. Please give your answers based on the child's most recent behavior.	Not True	Somewhat True	Certainly True		Not True	Somewhat True	Certainly True		Not True	Somewhat True	Certainly True		Not True	Somewhat True	Certainly True		Not True	Somewhat True	Certainly True	
This child is considerate of other people's feelings.	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child is restless, overactive, cannot stay still for long.	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child often complains of headaches, stomach-aches or sickness.	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child shares readily with other children (e.g., toys, treats, pencils).	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child often loses his/her temper.	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child is rather solitary, prefers to play alone.	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child is generally well behaved, usually does what adults request	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child has many worries or often seems worried	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	
This child is helpful if someone is hurt, upset or feeling ill	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐	

		Child 1			Child 2			Child 3			Child 4			Child 5		
		Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True
Well-Being	This child is constantly fidgeting or squirming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child has at least one good friend	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child often fights with other children or bullies them	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	This child is often unhappy, depressed or tearful	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Generally liked by other children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Easily distracted, concentration wanders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Nervous or clingy in new situations, easily loses confidence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Kind to younger children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Picked on or bullied by other children or youth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Often offers to help others (parents, teachers, other children)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Gets along better with adults than with other children or youth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Many fears, easily scared	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Can stop and think things out before acting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Good attention span, sees work through to the end	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	The following items are for children <u>2-4 years old</u> (otherwise skip to next section):															
	Often argumentative with adults	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Can be spiteful to others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	The following items are for children <u>age 5 and older</u>:															
	Often lies or cheats	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Steals from home, school or elsewhere	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If there are additional children, please complete the *Protective Factors & Well-Being Child Supplement*.

Thank you!

AR Services SharePoint Database

AR workers were asked to document additional information about goods or services provided to AR families in a SharePoint database housed on the DCFS intranet. This spreadsheet included information about the types of goods or services being provided, service providers, support categories (e.g., transportation, food, housing), costs, funding sources, and protective factors. From October 2014 through September 2016 AR workers were expected to document this information for all goods or services provided to AR families, including information about those being provided by DCFS and any donations from the community. However, in September 2016, AR workers were instructed to only document this information for goods or services that were not provided through a DCFS contracted provider, as these data were already tracked through DCFS's administrative data system, N-FOCUS. It is important to note that these data were collected for AR families only, and similar data were not collected for AR-eligible TR cases.

AR Stakeholder Survey: Year 1

This survey was intended to gather information about the experiences and perceptions of AR stakeholders. This survey was developed in collaboration with the DCFS AR Program Administrator and was comprised of the following dimensions: Purpose of the Group, Meeting Schedule, Meeting Processes (Agendas, Minutes, Action Items), Participation, History of Collaboration, Appropriate Cross Section of Members, Perceived Utility, Inclusiveness in Process, Open Communication, Appropriate Pace of Development, Political and Social Climate for AR, and Perceptions of AR Program Elements. Specifically, this survey addressed stakeholder's perceptions of: group functioning and effectiveness; effectiveness of local and statewide advisory structures; adequacy of meeting frequency and type of interactions; opportunities to provide meaningful input into development and implementation of AR; inclusiveness of advisory group processes and resultant decisions and products; ongoing monitoring and revision of implementation plans; the availability and utility of AR program data; the extent of partnership with DCFS to expand services and results of those efforts; perceived changes in level of partnership over time; stakeholder and community member knowledge of AR elements; and stakeholder, community member, and CFS staff support/endorsement of AR program.

This survey was first administered in December 2014. Respondents included a broad range of AR stakeholders, including statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), internal workgroups and subgroups (Alternative Response Internal Workgroup and Alternative Response Internal Subgroup), and local implementation teams from the initial 5 pilot counties (Alternative Response External Leadership Team for the Southeast Service Area, Fremont Alternative Response External Team, Hall County Alternative Response External Stakeholder Group, Hall County Community Collaboration, Sarpy County Alternative Response External Steering Committee, Scotts Bluff County Alternative Response Advisory Team, and Internal Alternative Response Pilot Site Leadership Team). Because some of the survey items specifically addressed meeting effectiveness, which may vary from group to group, participants were asked to identify the one group with which they felt most strongly affiliated or attended most regularly, and respond to the survey items with that group in mind.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Default Question Block

INFORMED CONSENT

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to evaluate the implementation of Nebraska's Title IV-E Waiver Demonstration Project. As part of this project, we are studying the process and outcomes of the Alternative Response (AR) program. This survey focuses on your experiences and perceptions as a stakeholder. Please answer as honestly and thoroughly as possible. Your feedback will provide valuable insight to inform the future direction of the program.

Who is being asked to participate in this survey?
Stakeholders involved in the statewide and local pilot committees are asked to participate in this survey.

How much time will it take to complete the survey?
The survey should take about 10-15 minutes to complete.

Are there any risks or benefits for me by participating in the survey?
There are no known risks associated with participation in the survey. However, the overall results of the study will be used to inform potential improvements to the AR program as it is implemented across the state.

Are my responses confidential?
Any information provided in this survey will be kept confidential. Your individual responses will be combined with those shared by others to create a report to be shared with personnel at DCFS. All reports generated and any published or presented summaries from this data will only be in a manner that does not allow individual participants or their agencies to be identified. Summaries of data will be reported back to DCFS in aggregate form at the community level or by type of agency only when the number of respondents is sufficient to maintain anonymity.

Can I choose not to participate?
You are free to decide not to participate in this survey or to withdraw at any time without adversely affecting your relationship with the researchers, the University of Nebraska-Lincoln, or the Nebraska Division of Children and Family Services. Your decision will not result in any loss of benefits to which you are otherwise entitled. You do not have to answer any questions that you do not wish to answer and you may end your participation at any time.

Who can I contact about this survey?
Should you have any questions about this survey or the project itself, please contact the Principal Investigators:

- Michelle Graef (mgraef1@unl.edu) or Kate Stephenson (kstephenson@unl.edu)
- Phone: (402) 472-3479

If you have questions or concerns about your rights as a participant, please contact:

- UNL Research Compliance Services (irb@unl.edu)
- Phone: (402) 472-6965

If you would like to know more about your data security through the Qualtrics survey site:

- http://www.qualtrics.com/security-statement/

By clicking on the double-arrow button below, you are voluntarily making a decision whether or not to participate in this research study. Your response to the survey is your indication that you agree to participate, having read and understood the information presented above. Please print a copy of this page for your records.

We look forward to your feedback!

IRB#20141214837 EX

Please select any of the following teams, groups, committees, and advisory bodies of which you are (or have previously been) a member:

- [ ] Director's Steering Committee
- [ ] Statewide Alternative Response Advisory Board
- [ ] Alternative Response External Leadership Team for the *Southeast Service Area* (Local Implementation Team)
- [ ] *Fremont* Alternative Response External Team (Local Implementation Team)
- [ ] *Hall County* Alternative Response External Stakeholder Group (Local Implementation Team)
- [ ] *Hall County* Community Collaboration, "H3C" (Local Implementation Team)
- [ ] *Sarpy County* Alternative Response External Steering Committee (Local Implementation Team)
- [ ] *Scotts Bluff County* Alternative Response Advisory Team (Local Implementation Team)
- [ ] Alternative Response *Internal* Workgroup
- [ ] Alternative Response *Internal* Subgroup
- [ ] *Internal* Alternative Response Pilot Site Leadership Team
- [ ] I do not consider myself a member (nor have I been a member) of any of the groups listed above

This survey contains items specific to meeting effectiveness. For the purpose of this survey, we are asking that you please select just one of the groups with which you are affiliated.

Of the groups you selected, please identify which group you feel most strongly affiliated with or attend most regularly.

- ( ) Director's Steering Committee
- ( ) Statewide Alternative Response Advisory Board

- *Internal* Alternative Response Pilot Site Leadership Team
- Alternative Response *Internal* Subgroup
- Alternative Response *Internal* Workgroup
- *Scotts Bluff County* Alternative Response Advisory Team (Local Implementation Team)
- *Hall County* Community Collaboration, "H3C" (Local Implementation Team)
- *Hall County* Alternative Response External Stakeholder Group (Local Implementation Team)
- *Sarpy County* Alternative Response External Steering Committee (Local Implementation Team)
- Alternative Response External Leadership Team for the *Southeast Service Area* (Local Implementation Team)
- *Fremont* Alternative Response External Team (Local Implementation Team)

You selected ${q://QID125/ChoiceGroup/SelectedChoices}
Please respond to the following items with this group in mind.

You selected ${q://QID124/ChoiceGroup/SelectedChoices}
Please respond to the following items with this group in mind.

Purpose of the Group

I have a good understanding of the purpose of this group. I know what we are trying to accomplish.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the purpose of the group.

Meeting Schedule

The meeting format (e.g., location, time) makes it easy for me to attend in person.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Meetings occur with the right amount of frequency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the meeting schedule.

How frequently should these meetings take place?

Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month
○	○	○	○	○

Meeting Processes (Agendas, Minutes, Action Items)

All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Commitments made at our meetings are followed up and not forgotten.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the meeting processes.

Participation

The organizations that attend these meetings invest the right amount of time and effort.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

I feel involved in what's going on during our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

I regularly participate in the discussions during our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Other's participation is usually energetic and stimulating.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about participation.

History of Collaboration

Trying to solve problems through collaboration has been common in this local community.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Agencies in our local community have a history of working collaboratively with DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the history of collaboration.

Appropriate Cross Section of Members

The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

All the organizations that need to be members of this group have become members of this group.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about cross section of members.

Perceived Utility

The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Our meetings are a valuable use of my time because we deal with important content.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about perceived utility.

Inclusiveness in Process

The processes used to elicit the group's input are effective.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

When major decisions are made about AR program design and implementation, we are always informed.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the inclusiveness in process.

Open Communication

People really listen to each other during our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

There is a high level of trust between participants in our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

People feel comfortable challenging the ideas and comments of others in our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Different ideas and perspectives are often explored in our meetings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Other members in this group value my opinion.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about open communication.

Appropriate Pace of Development

DCFS has tried to take on the right amount of work at the right pace with this AR initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the pace of development.

Political and Social Climate for AR

The political and social climate seems to be "right" for AR to be successful.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the political and social climate for AR.

Perceptions of AR Program Elements

AR will be able to keep kids as safe as Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Nebraska's AR model is designed to serve families with less severe allegations.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

AR families should not be placed on the Central Registry.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Families will receive services faster in AR as compared to Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Concrete supports will be better addressed through AR as compared to Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Law enforcement should be involved in AR cases.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about your perceptions of AR program elements.

Please provide any comments or suggestions you have regarding the AR program, in general.

AR Stakeholder Survey: Year 3

The second administration of this survey occurred in October 2017. Again, respondents included a broad range of AR stakeholders, including statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), Alternative Response Internal Workgroup, and members of a Citizen Review Panel. Because some of the survey items specifically addressed meeting effectiveness, which may vary from group to group, participants were asked to identify the one group with which they felt most strongly affiliated or attended most regularly, and respond to the survey items with that group in mind.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Default Question Block

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Who is being asked to participate in this survey?
Stakeholders involved in AR implementation are asked to participate in this survey.

How much time will it take to complete the survey?
The survey should take about 10-15 minutes to complete.

Are there any risks or benefits for me by participating in the survey?
There are no known risks associated with participation in the survey. However, the overall results of the study will be used to inform potential improvements to the AR program as it is implemented across the state.

Are my responses confidential?
Any information provided in this survey will be kept confidential. Your individual responses will be combined with those shared by others to create a report to be shared with personnel at DCFS. All reports generated and any published or presented summaries from this data will only be in a manner that does not allow individual participants or their agencies to be identified. Summaries of data will be reported back to DCFS in aggregate form at the community level or by type of agency only when the number of respondents is sufficient to maintain anonymity.

Can I choose not to participate?
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We look forward to your feedback!

Please select any of the following teams, groups, committees, and advisory bodies of which you are (or have previously been) a member:

- [ ] Director's Steering Committee
- [ ] Statewide Alternative Response Advisory Board
- [ ] Alternative Response Internal Workgroup
- [ ] Citizen Review Panel
- [ ] I do not consider myself a member (nor have I been a member) of any of the groups listed above

Purpose of the Group

I have a good understanding of the purpose of this group. I know what we are trying to accomplish.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about the purpose of the group.

Meeting Schedule

The meeting format (e.g., location, time) makes it easy for me to attend in person.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Meetings occur with the right amount of frequency.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about the meeting schedule.

How frequently should these meetings take place?

	Never	Annually	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month
Director's Steering Committee	○	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○	○

Meeting Processes (Agendas, Minutes, Action Items)

All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Commitments made at our meetings are followed up and not forgotten.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about the meeting processes.

Participation

The organizations that attend these meetings invest the right amount of time and effort.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

I feel involved in what's going on during our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

I regularly participate in the discussions during our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Other's participation is usually energetic and stimulating.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about participation.

History of Collaboration

Trying to solve problems through collaboration has been common in our local community.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Agencies in our local community have a history of working collaboratively with DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the history of collaboration.

Appropriate Cross Section of Members

The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Statewide Alternative Response Advisory Board					
Alternative Response Internal Workgroup					
Citizen Review Panel					

All the organizations that need to be members of this group have become members of this group.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee					
Statewide Alternative Response Advisory Board					
Alternative Response Internal Workgroup					
Citizen Review Panel					

Please provide any comments or suggestions about cross section of members.

Perceived Utility

The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee					
Statewide Alternative Response Advisory Board					
Alternative Response Internal Workgroup					
Citizen Review Panel					

Our meetings are a valuable use of my time because we deal with important content.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about perceived utility.

Inclusiveness in Process

The processes used to elicit the group's input are effective.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Citizen Review Panel	○	○	○	○	○

It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

When major decisions are made about AR program design and implementation, we are always informed.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about the inclusiveness in process.

Open Communication

People really listen to each other during our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

There is a high level of trust between participants in our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

People feel comfortable challenging the ideas and comments of others in our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Different ideas and perspectives are often explored in our meetings.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Other members in this group value my opinion.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Director's Steering Committee	○	○	○	○	○
Statewide Alternative Response Advisory Board	○	○	○	○	○
Alternative Response Internal Workgroup	○	○	○	○	○
Citizen Review Panel	○	○	○	○	○

Please provide any comments or suggestions about open communication.

Appropriate Pace of Development

DCFS has tried to take on the right amount of work at the right pace with this AR initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the pace of development.

Political and Social Climate for AR

The political and social climate seems to be "right" for AR to be successful.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
○	○	○	○	○

Please provide any comments or suggestions about the political and social climate for AR.

Perceptions of AR Program Elements

AR will be able to keep kids as safe as Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Nebraska's AR model is designed to serve families with less severe allegations.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

AR families should not be placed on the Central Registry.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Families will receive services faster in AR as compared to Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Concrete supports will be better addressed through AR as compared to Traditional Response.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Law enforcement should be involved in AR cases.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about your perceptions of AR program elements.

Please provide any comments or suggestions you have regarding the AR program, in general.

AR Supervisor Monthly Time Survey

Respondents were asked to enter the estimated number of total hours they spent on AR-related activities, rounded to the nearest hour. This survey was sent each month to supervisors identified by DCFS as having participated in AR. This survey asked:

- "Consider the last month and the amount of time you've spend on case-related AR activities (e.g., mandatory consultation points, advising workers, family mapping, staffings, documentation). On average, how much time have you spent per case?"
- "Consider the last month and the amount of time you've spend on non-case-related AR activities (e.g., attending meetings or trainings, conference calls, reviewing draft policy). On average, how many total hours have you spent?"
- "Consider the last month and the amount of time you've spend on case-related TR activities (e.g., mandatory consultation points, advising workers, family mapping, staffings, documentation). On average, how much time have you spent per case?"
- "Consider the last month and the amount of time you've spend on non-case-related TR activities (e.g., attending meetings or trainings, conference calls, reviewing draft policy). On average, how many total hours have you spent?"

This survey began administration in February 2015. From February 2015 through June 2019, 1,029 surveys were sent, with 675 completed responses received, for an overall response rate of 66%.

AR Worker Survey

The *AR Worker Survey* (worker survey) has been in practice since December 2014. Core items included in this survey were adapted and extended from the worker survey originally used by the QIC-DR. These items were designed to assess workers' perceptions of their work with AR-eligible families, including: their relationship and engagement with the family, the needs of the family, services provided, judgments of changes in protective factors, and estimates of time spent on the case. In July 2015, the worker survey was extended to also include well-being items taken or adapted from the *Child Protection Best Practices Well-Being Checklist* developed by the New Mexico Court Improvement Project and the *Strengths and Difficulties Questionnaire*. The additional well-being items are identical to those collected through the PFWBQ, which began implementation at the same time. In March 2018, two additional items were added to the worker survey. One item was added to acquire consent for worker data to be used in future research. The second item was added after receiving feedback from workers, allowing respondents to enter if the family was unable to be located. Workers were asked to complete this survey at the end of every AR-eligible case, assigned to either AR or TR, and were encouraged to consult N-FOCUS to refresh their memory about the specific case, if needed. A survey link was emailed to the worker after case closure. Two weekly follow-up reminder emails were sent for missing or incomplete responses. DCFS leadership encouraged staff to complete these surveys. From October 2014 through June 2019, 4,715 worker surveys were sent, with a total of 2,762 completed surveys received, resulting in an overall response rate of 59%; a total of 1,388 completed surveys from AR workers (50%) and 1,374 completed surveys from TR workers (50%). Looking at these data by track assignment, 2,405 AR workers were sent a survey, with 1,388 completed surveys received, resulting in a 58% response rate for AR workers. Likewise, 2,310 TR workers were sent a survey, with 1,374 completed surveys received, resulting in a 59% response rate for TR workers. A copy of this measure is provided on the next page.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

For this survey, please refer to Master Case ${e://Field/MasterCase}

Intro

INFORMED CONSENT

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to evaluate the implementation of Nebraska's Title IV-E Waiver Demonstration Project. As part of this program evaluation project, we are studying the processes and outcomes of the Alternative Response (AR) program. In order to accurately determine the effectiveness of the AR program, it is essential that we gather complete data about the process and outcomes of all AR-eligible families that are assigned to AR or Traditional Response (TR). A high response rate to this survey will enable CCFL to fully assess the impacts of AR on the families DCFS serves.

Who is being asked to complete this survey?
Children and Family Services Specialists (CFSS) who have recently completed working with a family through either Traditional Response or Alternative Response services within one of the designated AR pilot sites.

What am I going to be asked to do?
For purposes of program evaluation we ask that you complete this survey for a specific family (as indicated by the Master Case number in the header of this survey) with whom you recently completed working. The survey should only take between 10-15 minutes and should be viewed as part of your documentation of the closeout process for this family. The survey focuses on your experiences and perceptions of the case management process with this particular family. Please answer as honestly and thoroughly as possible. Your input is vitally important to this program evaluation and will help determine the future direction of the AR program.

Why are we doing this?
Your completion of the survey is critical to provide sound programmatic data to DCFS leadership and Nebraska policymakers regarding the AR program. The results of this survey will be used to inform important decisions about the implementation of the AR program and to ensure that families are appropriately and effectively served.

Are there any risks or benefits to me by participating in the survey?
There are no known risks associated with participation in the survey. The overall results will be used to inform potential improvements to the AR program as it is implemented across the state.

Are my responses confidential?
Any information provided in this survey will be kept confidential. None of your individual responses will be shared with your supervisors or other personnel at DCFS. Identities of individuals who have or have not completed the survey will not be shared with DCFS; however, information about survey completion rates will be shared with DCFS leadership in order to meet evaluation requirements. Information you provide on this survey will be linked by UNL-CCFL to the Master Case number in DCFS administrative N-FOCUS data. Summarized reports of this study will be provided to DCFS and may also be published or presented at professional conferences. All reports generated and any published or presented summaries from this data will only be in a manner that does not allow individual participants to be identified. Only aggregate responses will be analyzed.

Can I choose not to participate?
While your involvement in the program evaluation and completion of this survey is required, you can opt out of having your responses used for research purposes if UNL-CCFL conducts additional analyses outside of evaluating the effectiveness of the AR program. You can indicate your desire to exclude your responses from the research by clicking the “opt out” box at the end of the survey. Opting out will not affect your relationship with the researchers, the University of Nebraska-Lincoln, or the Nebraska Division of Children and Family Services. Your decision to exclude your responses from research uses will not result in any loss of benefits to which you are otherwise entitled.

Who can I contact about this survey?
Should you have any questions about this survey or the project itself, please contact the Principal Investigators:

- Michelle Graef (mgraef1@unl.edu) or Kate Stephenson (kstephenson@unl.edu)
- Phone: (402) 472-3479

If you have questions or concerns about your rights as a participant, please contact:

- UNL Research Compliance Services (irb@unl.edu)
- Phone: (402) 472-6965

To proceed to the survey, click on the double arrow button below.

We look forward to your feedback!

IRB Approval #: 20141114747 EP

INSTRUCTIONS

Please take a few minutes to familiarize yourself with *Master Case ${e://Field/MasterCase}*

You may need to review your N-FOCUS documentation in order to answer some of the case-specific questions in this survey. The questions in this survey focus on the following:

- Relationship between you and the primary caretaker
- Hours of time spent on this case (in total and specifically in contact with the family)
- Family needs present at case opening
- Information, referrals, and services received by the family throughout the case
    - Types of services
    - Timing of services
    - Who provided services
    - Family's level of participation in services
    - Barriers to services
- Improvements in protective factors
- Child demographics (name, gender, age)
- Child well-being

The Master Case # will be repeated in the header throughout this survey for your convenience.

Are you the initial worker assigned to this family?

- ○ Yes
- ○ No

You selected "No" to the previous questions, indicating that you are not the initial worker for this family.

Please explain how you ended up working with this family. We would like to get a sense of how much interaction you've had with them. This will help give us context to your answers.

Please select the date that you were assigned to this family.

Enter a date:

December 2019

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

Initial Contact

Was this family unable to locate?

- ○ Yes
- ○ No

You selected "Yes" to the previous question, indicating that this family was unable to locate.

How much time did you spend attempting to locate or interact with this family (e.g., making phone calls to family, travel time in attempt to visit family, documenting attempts)?

Please enter the estimated number of total hours (round to nearest hour).

Opt Out

Thank You

Your responses will be included in the program evaluation of AR and any reports necessary to inform DCFS about the AR program. Please indicate whether you wish to have your responses from this survey included in potential additional analyses conducted for research on AR. As with the program evaluation, any analyses or reports generated for research purposes from this data will only be in a manner that does not allow individual participants to be identified.

- ○ Yes, CCFL may include my responses in potential additional analyses
- ○ No, CCFL may not include my responses in potential additional analyses

Time Questions

How much time did you spend altogether on behalf of this family (e.g., interviewing family members and others involved with the family, researching service options, making phone calls to service providers, travel time, documenting assessments)? *Note: If you have previously filled out a time survey for this family, please consider only the amount of time spent since your last response.*

Please enter the estimated number of total hours (round to nearest hour).

How much time was spent in direct contact with the family (e.g., face-to-face meetings with family, phone calls with family, driving with the family to services)? *Note: If you have previously filled out a time survey for this family, please consider only the amount of time spent since your last response.*

Please enter the estimated number of specific contact hours (round to the nearest hour).

Family Engagement

Please rate your level of agreement with each of the following statements.

I think the primary caretaker...

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	N/A
believed they would get the help they really needed from DCFS.	○	○	○	○	○	○
realized that they needed some help to make sure their children have what they need.	○	○	○	○	○	○
would say that they were fine before DCFS got involved.	○	○	○	○	○	○
found it difficult to work with me.	○	○	○	○	○	○
would say there was good reason for DCFS to be involved with their family.	○	○	○	○	○	○

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	N/A
would say that working with DCFS has given them more hope about how their life is going to go in the future.	○	○	○	○	○	○
would say that we respected one another.	○	○	○	○	○	○
would say that we agreed about what was best for their child.	○	○	○	○	○	○
feels that they could trust DCFS to be fair and to see their side of things.	○	○	○	○	○	○
would say that things will improve for their children because DCFS was involved.	○	○	○	○	○	○
would say that what DCFS wanted them to do is the same as what they wanted.	○	○	○	○	○	○
would say that there were definitely some concerns in their family that DCFS recognized.	○	○	○	○	○	○
would say that I didn't understand where they were coming from at all.	○	○	○	○	○	○
would say that DCFS helped their family take care of some of their challenges.	○	○	○	○	○	○
would say that DCFS helped their family get stronger.	○	○	○	○	○	○
does not think that DCFS was out to get them.	○	○	○	○	○	○

Family Needs

Which of the following family needs were present at case opening? (check all that apply)

- ☐ None
- ☐ Material Needs (e.g., housing, food/clothing, income, employment, utilities)
- ☐ Transportation
- ☐ Management of Resources (to meet basic needs)
- ☐ Social Supports (e.g., extended family, friends, & neighbors)
- ☐ Parenting Skills
- ☐ Employment
- ☐ Domestic Violence
- ☐ Substance Abuse by Adult (e.g., alcohol, prescription drugs, illicit drugs)
- ☐ Substance Abuse by Child (e.g., alcohol, prescription drugs, illicit drugs)
- ☐ Physical Health of Adult
- ☐ Physical Health of Child
- ☐ Mental Health of Adult
- ☐ Mental Health of Child
- ☐ Developmental Delay/Disability of Adult
- ☐ Developmental Delay/Disability of Child
- ☐ Education (e.g., school attendance, progress)
- ☐ Child's Emotional/Behavioral Adjustment

Family Needs (loop & merge)

For ${lm://Field/1}:

Were you able to address this need with the family while the case was open?

- ○ Yes
- ○ No

For ${lm://Field/1}:

To what extent did this need improve?

None	A little	Some	A Lot
○	○	○	○

Services

During your involvement with the family, how much did relatives and/or friends provide needed support/assistance?

Not at all	Very little	Moderately	Extensively
○	○	○	○

How much were no-cost neighborhood or community resources (e.g., churches, schools) used to assist this family?

Not at all	Very little	Moderately	Extensively
○	○	○	○

If this family was eligible for Alternative Response services, did they engage with ongoing services?

- ○ Yes
- ○ No
- ○ N/A

Which of the following types of services was the family either given information about or directly provided? (check all that apply)

- ☐ None
- ☐ Services to Address Material Needs (e.g., help with housing payments, emergency shelter or food, TANF, employment assistance)

- [ ] Transportation Services
- [ ] Substance Abuse Services (e.g., alcohol or drug abuse treatment)
- [ ] Health Services (e.g., medical or dental care)
- [ ] Developmental Disability Services
- [ ] Mental Health Services
- [ ] Parenting Classes
- [ ] Domestic Violence Services
- [ ] Educational Services
- [ ] Social Support Services (e.g. marital/family counseling, support groups)
- [ ] Other (specify)

Service Type (loop & merge)

For ${lm://Field/1}:

How soon after the initial report date did the family receive this service?

▼

Please indicate the family's level of participation in this service

None	Some	A lot	Uncertain	N/A
○	○	○	○	○

Service Providers

Who provided services to this family? (check all that apply)

- [ ] School
- [ ] Neighborhood Organization
- [ ] Mental Health Provider
- [ ] Alcohol/Drug Rehabilitation Program/Agency
- [ ] MR/DD Provider
- [ ] Youth Organization
- [ ] Health Care Provider
- [ ] Job Service/Employment Security
- [ ] Employment and Training Agency (e.g., JTPA)
- [ ] Legal Services Provider
- [ ] Support Group
- [ ] Childcare/Preschool Provider (e.g., Head Start)

- [ ] Community Action Agency
- [ ] Domestic Violence Shelter
- [ ] Emergency Food Provider
- [ ] Church or Religious Organization
- [ ] Recreational Facility (e.g., YMCA)
- [ ] Neighbors/Friends/Extended Family
- [ ] Contractor (please specify)
- [ ] Other (please specify)
- [ ] None

Service/Need Match

Overall, how well were you able to match the services provided (or that you provided information about) to the needs of the family?

Not at All	Not Very Well	Somewhat Well	Very Well
○	○	○	○

Please explain why you were unable to match the services provided to the needs of the family.

Barriers

Did you experience any of the following barriers while working with this family? (check all that apply)

- [ ] None
- [ ] Size of worker caseload
- [ ] Limited staff time to work with family
- [ ] Other pressing cases on caseload
- [ ] Problems beyond scope of DCFS to remedy
- [ ] Limited funds for needed services
- [ ] Needed services not available
- [ ] Other

Protective Factors

To what extent did the services provided to the family improve each of the following Protective Factors? *Hold your cursor arrow over each protective factor for a definition.*

	Not at all effective	Somewhat effective	Very effective	Not a focus for this family
Nurturing and Attachment	○	○	○	○
Knowledge of Parenting and Child/Youth Development	○	○	○	○
Parental Resilience	○	○	○	○
Concrete Supports for Parents	○	○	○	○
Social Connections	○	○	○	○
Social and Emotional Competence of Children	○	○	○	○

Child Demographics

How many children are in this family?

Please enter the name, gender, and age for each child in this family.

	Name Enter each child's name below	Gender Male	 Female	Age
Child 1		○	○	▼
Child 2		○	○	▼
Child 3		○	○	▼
Child 4		○	○	▼
Child 5		○	○	▼
Child 6		○	○	▼
Child 7		○	○	▼
Child 8		○	○	▼
Child 9		○	○	▼
Child 10		○	○	▼

Child Well-Being

Thinking only of ${lm://Field/2}, please select the option that best describes the frequency of contact.

	Never	Rarely	Sometimes	Frequently	Always	Don't Know
Has regular contact with both parents and with all his/her siblings.	○	○	○	○	○	○

Thinking only of ${lm://Field/2}, please select the appropriate option.

	Yes	No	Don't Know	N/A
Is up to date on all immunizations	○	○	○	○
Has a primary care physician	○	○	○	○
Is in good physical health	○	○	○	○
Shows age-appropriate physical and cognitive development	○	○	○	○
Receives regular medical treatment, when needed	○	○	○	○
Receives regular dental care	○	○	○	○
Receives mental health treatment, if needed	○	○	○	○
Is enrolled in an early education program	○	○	○	○
Is working at their grade level in school	○	○	○	○
Participates in an Individualized Education Program (IEP), if eligible	○	○	○	○
Has both parents participating in their IEP, if eligible	○	○	○	○
Receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed	○	○	○	○

Thinking only of ${lm://Field/2}, please select the appropriate option. It would help us if you answered as best you can, even if you are not absolutely certain. Please give your answers on the basis of the child's recent behavior.

	Not True	Somewhat True	Certainly True	Don't Know
Considerate of other people's feelings	○	○	○	○
Restless, overactive, cannot stay still for long	○	○	○	○
Often complains of headaches, stomach-aches or sickness	○	○	○	○
Shares readily with other children, for example toys, treats, pencils	○	○	○	○
Often loses temper	○	○	○	○
Rather solitary, prefers to play alone	○	○	○	○
Generally well behaved, usually does what adults request	○	○	○	○
Many worries or often seems worried	○	○	○	○
Helpful if someone is hurt, upset or feeling ill	○	○	○	○
Constantly fidgeting or squirming	○	○	○	○
Has at least one good friend	○	○	○	○
Often fights with other children or bullies them	○	○	○	○
Often unhappy, depressed or tearful	○	○	○	○
Generally liked by other children	○	○	○	○
Easily distracted, concentration wanders	○	○	○	○
Nervous or clingy in new situations, easily loses confidence	○	○	○	○
Kind to younger children	○	○	○	○
Picked on or bullied by other childen or youth	○	○	○	○
Often offers to help others (parents, teachers, other children)	○	○	○	○

	Not True	Somewhat True	Certainly True	Don't Know
Gets along better with adults than with other children or youth	○	○	○	○
Many fears, easily scared	○	○	○	○
Can stop and think things out before acting	○	○	○	○
Good attention span, sees work through to the end	○	○	○	○

Thinking only of ${lm://Field/2}, please select the appropriate option. It would help us if you answered as best you can, even if you are not absolutely certain. Please give your answers on the basis of the child's recent behavior.

	Not True	Somewhat True	Certainly True	Don't Know
Often argumentative with adults	○	○	○	○
Can be spiteful to others	○	○	○	○

Thinking only of ${lm://Field/2}, please select the appropriate option. It would help us if you answered as best you can, even if you are not absolutely certain. Please give your answers on the basis of the child's recent behavior.

	Not True	Somewhat True	Certainly True	Don't Know
Often lies or cheats	○	○	○	○
Steals from home, school or elsewhere	○	○	○	○

General Comments

Please provide any comments in the space below.

PPI Administrator Survey

Administrative staff associated with PPI were asked to give feedback on the Provider Performance Improvement (PPI) program. This survey focused on experiences and perceptions of administrators to help inform the future direction of the program. The survey included items on PPI data elements and provider performance concerns.

This survey was administered online in December 2018. Individuals were sent a survey invitation via email and received two weekly follow-up reminders. 15 surveys were sent, with 15 completed responses received, for an overall response rate of 100%. A copy of this measure is provided on the next page.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Block 2

Provider Performance Improvement Evaluation: Administrator Survey

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to collect feedback on the Provider Performance Improvement (PPI) program. This survey focuses on your experiences and perceptions as an Administrator to inform the future direction of the program.

The survey should take about 5-10 minutes to complete. Any information provided in this survey will be kept confidential. Your individual responses will be combined with others and summaries of data will be reported back to DCFS in aggregate form.

If you have any questions about this survey, please contact Kate Stephenson, kstephenson@unl.edu

We look forward to your feedback!

PPI Data Elements

How often do you review the PPI data?

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly

PPI data influences my workers' decisions to utilize certain providers.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

Are there any other ways PPI data influences your use or perceptions of certain providers?

Does your service area utilize the PPI Quality Reviews of Agency Supported Foster Care (ASFC) Reports?

- ◯ Yes
- ◯ No

What is most helpful about the PPI Quality Reviews of ASFC Reports?

Why doesn't your service area utilize the PPI Quality Reviews of ASFC Reports?

Does your service area utilize the PPI Quality Reviews of Placement Support Plans?

- ◯ Yes
- ◯ No

What is most helpful about the PPI Quality Reviews of Placement Support Plans?

Why doesn't your service area utilize the PPI Quality Reviews of Placement Support Plans?

Is your service area getting what you need from the review of the ASFC Reports?

- ◯ Yes
- ◯ No

What would make the review of the ASFC Report more useful?

Has the quality of the ASFC Reports improved since the implementation of PPI?

- ◯ Yes
- ◯ No

In what ways has the quality of the ASFC Reports improved?

Has the quality of the Placement Support Plans improved since the implementation of PPI?

- ◯ Yes
- ◯ No

In what ways has the quality of Placement Support Plants improved?

Are there any other pieces of data that would be valuable to include in the PPI program?

Provider Performance Concerns

Have provider issues been reduced as a result of PPI?

- ◯ Yes

- ◯ No

When there is a concern with a provider, concerns are addressed in a timely manner.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

When there is a concern with a provider, do you utilize the PPI reporting process or resolve the issue directly with the provider?

- ◯ Utilize the PPI reporting process
- ◯ Resolve the issue directly with the provider

How often are you resolving issues directly with providers?

- ◯ Daily
- ◯ Weekly
- ◯ Monthly

Are you aware of whether provider performance concerns are documented within Salesforce?

- ◯ Yes
- ◯ No

Are service areas communicating more often with providers as a result of the PPI performance concern reporting process?

- ◯ Yes
- ◯ No

Do you review the kudos?

- ◯ Yes
- ◯ No

How useful is the kudos information?

- ◯ Extremely useful
- ◯ Slightly useful
- ◯ Neither useful nor useless
- ◯ Slightly useless
- ◯ Extremely useless

This is the end of the survey, if you wish to change any of your responses, please click the back button and make your edits at this time. Otherwise, please provide any final comments and submit your responses by proceeding below.

PPI CMRD Survey

Contract Monitor/Resource Development (CMRD) staff were asked to give feedback on the Provider Performance Improvement (PPI) program. This survey focused on the experiences and perceptions of CMRD staff to help inform the future direction of the PPI program. The survey items were organized into the following dimensions:

- PPI training
- Use of the Salesforce website
- Contract monitor communications
- Buy-in for PPI
- Usefulness of PPI measures
- Performance quality conversations
- Provider performance concerns

This survey was administered online in December 2018. Individuals were sent a survey invitation via email and received two weekly follow-up reminders. 15 surveys were sent, with 15 completed responses received, for an overall response rate of 100%. A copy of this measure is provided on the next page.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Intro

Provider Performance Improvement Evaluation: CMRD Survey

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to collect feedback on the Provider Performance Improvement (PPI) program. This survey focuses on your experiences and perceptions as CMRD staff to inform the future direction of the program.

The survey should take about 10-15 minutes to complete. Any information provided in this survey will be kept confidential. Your individual responses will be combined with others and summaries of data will be reported back to DCFS in aggregate form.

If you have any questions about this survey, please contact Kate Stephenson, kstephenson@unl.edu

We look forward to your feedback!

PPI Training

PPI Training

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I received training in the principles and philosophy of PPI.	○	○	○	○	○
I received adequate training for using the Salesforce website.	○	○	○	○	○
I fully understand the expectations of my job as it relates to the PPI program.	○	○	○	○	○
Additional training on the PPI would be helpful.	○	○	○	○	○

Please provide any additional comments about training below.

What additional training would be most helpful?

Salesforce Website

Salesforce Website

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Salesforce is user friendly and easy to navigate.	○	○	○	○	○
Salesforce is a valuable tool for my provider agencies.	○	○	○	○	○
Salesforce is a valuable tool for DCFS.	○	○	○	○	○

Have you experienced any technical issues with Salesforce?

- ○ Yes
- ○ No

Have the issues been resolved?

- ○ Yes
- ○ No

Were you satisfied with how quickly the issues were resolved?

- ○ Yes

- No

Please describe the issues that have not been resolved.

Are there any additional features that you would like to see added to the Salesforce website?

Please provide any additional comments about the Salesforce website below.

Contract Monitor Communication

Contract Monitor Communication

How often are you in contact with your provider agencies?

- Daily
- Weekly
- Monthly
- Less than once-a-month

How often do you use the following methods to communicate with your provider agencies?

	Daily	Weekly	Monthly	Less than once-a-month

	Daily	Weekly	Monthly	Less than once-a-month
Email	○	○	○	○
Phone	○	○	○	○
In-person	○	○	○	○

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Conversations with my provider agencies are meaningful.	○	○	○	○	○
My provider agencies feel they can communicate openly with me.	○	○	○	○	○
I receive timely updates from DCFS when changes are made that impact my work with providers.	○	○	○	○	○
CFS and providers are communicating more often as a result of PPI.	○	○	○	○	○

Please provide any additional comments about contract monitor communications below.

Buy-In for PPI

Buy-In for PPI

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PPI has created clear performance level standards and expectations for service providers.	○	○	○	○	○
PPI creates a system for measuring and comparing the effectiveness of providers.	○	○	○	○	○
PPI has fostered a conversation about provider performance and data.	○	○	○	○	○
PPI influences contract decisions, based on performance results.	○	○	○	○	○
PPI holds providers accountable for their performance.	○	○	○	○	○
PPI holds DCFS accountable for their performance.	○	○	○	○	○
PPI benefits the children and families we serve.	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PPI benefits my providers agencies.	○	○	○	○	○
PPI has improved my provider agencies' overall efficiency.	○	○	○	○	○
PPI has helped my provider agencies to identify opportunities for improvement.	○	○	○	○	○

Does the support for the PPI program vary among the agencies you work with (e.g. timely data entry, frequency of mistakes, changes to services)?

- ○ Yes
- ○ No

Please explain how support for PPI varies between agencies:

Please provide any additional comments about PPI program elements below.

Usefulness of Measures

Usefulness of Measures

PPI measures are useful for provider agencies' learning and decision making.

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagee
- ○ Strongly disagree

Which PPI measures have been most useful?

Which PPI measures have been least useful?

Are there any other pieces of data that would be valuable to include in the PPI program?

Performance Quality Conversations

Performance Quality Conversations

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Performance Quality Conversation is a collaborative process.	○	○	○	○	○
The Performance Quality Conversations allow me to see measurable results in the delivery and effectiveness of the services my provider agencies provides.	○	○	○	○	○
I feel confident in my ability to synthesize PPI data in preparation for the Performance Quality Conversations.	○	○	○	○	○
My provider agencies have felt well informed during the Performance Quality Conversations (e.g., they understand the process, there is good communication, their questions are answered).	○	○	○	○	○
My provider agencies feel they can openly communicate with me during the Performance Quality Conversations.	○	○	○	○	○
My provider agencies feel their input is heard and they serve a valuable role in the development of their action items.	○	○	○	○	○
I feel confident in my ability to effectively facilitate the Performance Quality Conversations.	○	○	○	○	○
I believe that the Performance Quality Conversation process, including the development of action items, is useful.	○	○	○	○	○

Have your provider agencies developed action items as a result of the Performance Quality Conversations?

- Yes
- No

My provider agencies have experienced challenges in or barriers to implementing their action items.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

What challenges or barriers have your provider agencies experienced in implementing your action items?

My provider agencies have been successful in implementing their action items.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree

In what ways have your provider agencies been successful in implementing their action items?

Is there anything that you find particularly useful about the Performance Quality Conversations process?

Is there anything that could be improved about the Performance Quality Conversations process?

Please provide any additional comments about Performance Quality Conversations below.

Provider Performance Concerns

Are all provider performance concerns documented on Salesforce?

- Yes
- No

Why aren't all provider performance concerns documented on Salesforce?

How quickly are provider concerns resolved?

- Less than 5 days
- Within 5-7 days
- Within 8-14 days
- More than 14 days

Issues have been reduced due to provider concerns being addressed timely.

- Strongly agree
- Somewhat agree

- ○ Neither agree nor disagree
- ○ Somewhat disagree
- ○ Strongly disagree

This is the end of the survey, if you wish to change any of your responses, please click the back button and make your edits at this time. Otherwise, please provide any final comments and submit your responses by proceeding below.

PPI Monthly Time Survey
Respondents were asked to enter the estimated number of total hours they spent on PPI-related activities, rounded to the nearest hour. This survey was sent each month to individuals DCFS had identified as having participated in PPI. This survey asked:

- "In the last month, how much time have you spent altogether on PPI-related activities (e.g., attending meetings, writing policy, answering questions of staff, building connections with providers)?"

This survey began administration in June 2016. From June 2016 through June 2019, 910 surveys were sent, with 811 completed responses received, for an overall response rate of 89%.

Please note that due to the transition from RBA to PPI, there were some time data overlap from July 2016 through October of 2016. This is primarily due to UNL-CCFL's understanding of the new PPI program and when implementation of the program began. Surveyed personnel during that time period were largely the same as they transitioned from RBA to PPI.

PPI Provider Survey
Service providers subject to the Provider Performance Improvement (PPI) were asked to give feedback on the program. This survey focused on experiences and perceptions of service providers subject to PPI to help inform the future direction of the program. The survey items were organized into the following dimensions:

- Provider agency demographics and participation in PPI
- PPI Training
- Use of Salesforce website
- Contract monitor communication
- Buy-In and perceived impact of the PPI program
- Perceived usefulness of PPI data elements/components
- Perceptions of Performance Quality Conversations

This survey was administered online in August 2018. Individuals were sent a survey invitation via email and received three weekly follow-up reminders. Each agency was asked to submit a single survey response, as some questions may have required consultation with others within their agencies. 39 surveys were sent, with 28 completed responses received, for an overall response rate of 72%. A copy of this measure is provided on the next page.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Intro

Provider Performance Improvement Evaluation: Provider Survey

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to collect feedback on the Provider Performance Improvement (PPI) program. This survey focuses on your experiences and perceptions as a provider. Please answer as honestly and thoroughly as possible. Your feedback will provide valuable insight to inform the future direction of the program.

The survey should take about 10-15 minutes to complete. Any information provided in this survey will be kept confidential. Your individual responses will be combined with others to create a report for DCFS. All reports generated and any published or presented summaries from this data will only be in a manner that does not allow individual participants or their agencies to be identified. Summaries of data will be reported back to DCFS in aggregate form at the community level or by type of agency only when the number of respondents is sufficient to maintain anonymity.

If you have any questions about this survey, please contact Kate Stephenson kstephenson@unl.edu

We would like to receive only one survey response per provider agency. If you need to consult with others at your agency to answer any of the questions, please download a PDF version of the survey items HERE. Once you have collected answers for your agency, please return to this survey and submit your responses electronically.

We look forward to your feedback!

Agency Size and Basic Info

How many staff members (including direct care and administrative staff) does your agency employ?

- Less than 50
- 50-100
- 100-150
- More than 150

Does your agency have a dedicated data team?

- Yes

- [ ] No

How many staff are on your agency's data team?

Which of the following best describes the individual responsible for entering your PPI data into the Salesforce website?

- [ ] CEO
- [ ] Member of data team
- [ ] Support staff
- [ ] Other

Does your agency typically enter performance measure data into the Salesforce website each month?

- [ ] Yes
- [ ] No

Please tell us why your agency does not enter data into the Salesforce website each month.

How difficult is it for your agency to compile and enter data into Salesforce each month?

- [ ] Very Difficult
- [ ] Difficult
- [ ] Neutral
- [ ] Easy
- [ ] Very Easy

Please provide any comments below.

Approximately how long does it take your agency to compile and enter data into Salesforce each month? (this includes the time spent tracking and collecting performance measurement data, entering data into Salesforce, and any internal use of Salesforce/PPI data to manage performance (e.g., pulling reports, analyzing trends))

Please enter the estimated number of hours (round to the nearest hour).

Please provide any comments below.

PPI Training

PPI Training

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
My agency has received training in the principles and philosophy of PPI.	○	○	○	○	○
My agency has received adequate training for using the Salesforce website.	○	○	○	○	○
Additional training on the PPI program is needed for my agency.	○	○	○	○	○

Please provide any comments below.

What additional training would be most helpful?

Salesforce Website

Salesforce Website

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Salesforce is user friendly and easy to navigate.	○	○	○	○	○
Salesforce is a valuable tool for my agency.	○	○	○	○	○

Have you experienced any technical issues with Salesforce?

- ○ Yes
- ○ No

Please provide any comments below.

Have the issues been resolved?

- ○ Yes
- ○ No

Were you satisfied with how quickly the issues were resolved?

- Yes
- No

Please provide any comments below.

Please describe the issues that have not been resolved.

Are there any additional features that you would like to see added to the Salesforce website?

Contract Monitor Communication

Contract Monitor Communication

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I know how to best contact my agency's contract monitor.						
Conversations with my agency's contract monitor are meaningful.						
I feel like I can communicate openly with my contract monitor.						
My contract monitor is responsive to my questions and concerns.						

How often is your agency in contact with your contract monitor?

- ○ Less than once-a-month
- ○ Monthly
- ○ Weekly
- ○ Daily

Please provide any comments below.

Is there anything that you find particularly useful about your communication with your contract monitor?

Is there anything that could be improved about your communication with your contract monitor?

PPI Measures

PPI Measures

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PPI has created clear performance level standards and expectations for service providers.					
PPI creates a system for measuring and comparing the effectiveness of providers.					
PPI influences contract decisions, based on performance results.					
PPI holds providers accountable for their performance.					
PPI holds DCFS accountable for their performance.					

Please provide any comments below.

PPI Impact

PPI Impact

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PPI benefits my agency.					
PPI benefits the children and families we serve.					
PPI has improved my agency's overall efficiency.					
PPI has helped my agency to identify opportunities for improvement.					

Please provide any comments below.

Usefulness of Elements

How useful have the *provider measures entered by your agency for Agency Supported Foster Care* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful
- ○ My agency is not familiar with these measures

Please provide any comments below.

How useful have the *provider measures entered by your agency for Family Support Services* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful
- ○ My agency is not familiar with these measures

Please provide any comments below.

How useful have the *provider measures entered by your agency for Intensive Family Preservation* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful

- My agency is not familiar with these measures

Please provide any comments below.

You indicated that the *provider measures entered by your agency for Agency Supported Foster Care* are not useful. Please tell us why they are not useful.

You indicated that the *provider measures entered by your agency for Family Support Services* are not useful. Please tell us why they are not useful.

You indicated that the *provider measures entered by your agency for Intensive Family Preservation* are not useful. Please tell us why they are not useful.

How useful have the *measures provided by DCFS for Agency Supported Foster Care* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful

- My agency is not familiar with these measures

Please provide any comments below.

How useful have the *measures provided by DCFS for Family Support Services* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
- My agency is not familiar with these measures

Please provide any comments below.

How useful have the *measures provided by DCFS for Intensive Family Preservation* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
- My agency is not familiar with these measures

Please provide any comments below.

You indicated that the *measures provided by DCFS for Agency Supported Foster Care* are not useful. Please tell us why they are not useful.

You indicated that the *measures provided by DCFS for Family Support Services* are not useful. Please tell us why they are not useful.

You indicated that the *measures provided by DCFS for Intensive Family Preservation* are not useful. Please tell us why they are not useful.

How useful have the *quality reviews of placement support plans* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
- My agency is not familiar with these reviews

Please provide any comments below.

How useful have the *quality reviews of Agency Supported Foster Care reports* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
- My agency is not familiar with these reviews

Please provide any comments below.

How useful have the *quality reviews of placement change reasons* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
- My agency is not familiar with these reviews

Please provide any comments below.

How useful have the *quality reviews of parenting time/supervised visitation monthly reports* been for your agency's learning and decision making?

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
-

My agency is not familiar with these reviews

Please provide any comments below.

You indicated that the *quality reviews of placement support plans* are not useful. Please tell us why they are not useful.

You indicated that the *quality reviews of Agency Supported Foster Care reports* are not useful. Please tell us why they are not useful.

You indicated that the *quality reviews of placement change reasons* are not useful. Please tell us why they are not useful.

You indicated that the *quality reviews of parenting time/supervised visitation monthly reports* are not useful. Please tell us why they are not useful.

How useful have the *documentation of performance concerns* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful
- ○ My agency is not familiar with this documentation

Please provide any comments below.

How useful have the *documentation of placement concerns* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful
- ○ My agency is not familiar with this documentation

Please provide any comments below.

How useful have the *documentation of kudos* been for your agency's learning and decision making?

- ○ Not at all Useful
- ○ Slightly Useful
- ○ Moderately Useful
- ○ Very Useful
- ○ Extremely Useful

- My agency is not familiar with this documentation

Please provide any comments below.

You indicated that the *documentation of performance concerns* is not useful. Please tell us why it is not useful.

You indicated that the *documentation of placement concerns* is not useful. Please tell us why it is not useful.

You indicated that the *documentation of kudos* is not useful. Please tell us why it is not useful.

How useful have the *compliance reviews* been for your agency's learning and decision making?
This includes Personnel File Reviews, Paid Claims Audits, and Foster Care Payment Audits.

- Not at all Useful
- Slightly Useful
- Moderately Useful
- Very Useful
- Extremely Useful
-

My agency is not familiar with the compliance reviews

Please provide any comments below.

You indicated that the *compliance reviews* are not useful. Please tell us why they are not useful.

Are there any other pieces of data that would be valuable to include in the PPI program?

How frequently is your agency using Salesforce outside of entering your agency's data (e.g., to view your data, data provided by DCFS, performance concerns)?

- Never
- Monthly
- Weekly
- Daily

Has your agency implemented changes in any of the following areas as a result of information learned through the PPI program? *Select all that apply.*

- Processes
- Policies
- Procedures
- Training
- Standardized forms
- Communication

- [ ] None

Please provide any comments below.

Please provide an example of a *process* change your agency made as a result of the PPI program.

Please provide an example of a *policy* change your agency made as a result of the PPI program.

Please provide an example of a *procedure* change your agency made as a result of the PPI program.

Please provide an example of a *training* change your agency made as a result of the PPI program.

Please provide an example of a change to *standardized forms* your agency made as a result of the PPI program.

Please provide an example of a *communication* change your agency made as a result of the PPI program.

Performance Quality Conversations

Performance Quality Conversations

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Performance Quality Conversation is a collaborative process.	○	○	○	○	○
The Performance Quality Conversations allow me to see measureable results in the delivery and effectiveness of the services my agency provides.	○	○	○	○	○
I have felt well informed during the Performance Quality Conversations (e.g., I understand the process, there is good communication, my questions are answered).	○	○	○	○	○
My agency's people feel like they can openly communicate with DCFS during the Performance Quality Conversations.	○	○	○	○	○
It is clear that my input is heard and serves a valuable role in the development of the action items for my agency.	○	○	○	○	○
I believe that the Performance Quality Conversation process, including the development of action items, is useful.	○	○	○	○	○

Please provide any comments below.

Has your agency developed action items as a result of the Performance Quality Conversations?

- ○ Yes
- ○ No

My agency has been successful in implementing our action items.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Please provide any comments below.

What successes has your agency experienced in implementing your action items?

My agency has experienced challenges in or barriers to implementing our action items.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Please provide any comments below.

What challenges or barriers has your agency experienced in implementing your action items?

Approximately how much time is spent in meetings or communicating with DCFS related to PPI each month? (e.g., updates about the PPI program, troubleshooting Salesforce issues, participating in Performance Quality Conversations)

Please enter the estimated number of hours (round to the nearest hour).

Approximately how much time is spent implementing action plans related to PPI each month?
This includes any time your agency spends carrying out the action plan (e.g., planning, meetings, training).

Please enter the estimated number of hours (round to the nearest hour).

Is there anything that you find particularly useful about the Performance Quality Conversations process?

Is there anything that could be improved about the Performance Quality Conversations process?

This is the end of the survey, if you wish to change any of your responses, please click the back button and make your edits at this time. Otherwise, please provide any final comments and submit your responses by proceeding below.

RBA Monthly Time Survey

Respondents were asked to enter the estimated number of total hours they spent on RBA-related activities, rounded to the nearest hour. Originally these data were collected through DCFS's time-tracking system, KRONOS. However, in order to increase data accuracy and at the request of DCFS, this monthly time survey was administered instead. This survey was sent each month to individuals DCFS had identified as having participated in RBA. This survey asked:

- "In the last month, how much time have you spent altogether on RBA-related activities (e.g., attending meetings, writing policy, answering questions of staff, building connections with providers)?"

This survey began administration in November 2015. From November 2015 through October 2016, 290 surveys were sent, with 283 completed responses received, for an overall response rate of 96%.

RBA Monthly Provider Cost Matrix

Small, medium, and large-scale service providers each agreed to voluntarily track and supply the evaluators with monthly data on the costs they incurred due to participation in the RBA intervention. These data were collected via a monthly survey sent directly to a representative of each of these three agencies. These data will extend and enrich the cost evaluation by allowing the evaluators to estimate the true systemic costs of the intervention, beyond the estimates of the costs to DCFS of implementing RBA/PPI. Administration of this survey started in February 2015 with three providers. During the shift from RBA to PPI, this survey was put on hold from September 2016 through December 2016. When this monthly survey resumed in December 2016, a fourth provider was added to better represent the current services subject to PPI. From February 2015 through August 2016, 58 surveys have been sent, with 43 completed responses received, for an overall response rate of 74%. A copy of this measure is provided on the next page.

Overall PPI Monthly Costs

Considering the ***previous month only***, please enter the following information for costs associated with PPI *(hold your cursor arrow over each activity for a definition):*

	Total Hours Spent doing this activity by all employees.	Average Wage per Hour of the employees involved in the activity.	Average Benefit Cost per Hour of the employees involved in the activity.	Average Overhead Cost (space, computers, etc.) per hour of the employees involved in the activity.
Preparing Information and Filling out this Matrix				
Collecting, Entering, and Analyzing Scorecard Data				
Meeting with DCFS Regarding PPI				
PPI Training				
Other				

Agency Supported Foster Care

Considering the ***previous month only***, please enter the following information for Agency Supported Foster Care *(hold your cursor arrow over each activity for a definition):*

	Total Hours Spent doing this activity by all employees.	Average Wage per Hour of the employees involved in the activity.	Average Benefit Cost per Hour of the employees involved in the activity.	Average Overhead Cost (space, computers, etc.) per hour of the employees involved in the activity.
Turn-the-Curve Discussions				
Action Plan Implementation				
Other				

Family Support

Considering the ***previous month only***, please enter the following information for Family Support *(hold your cursor arrow over each activity for a definition):*

	Total Hours Spent doing this activity by all employees.	Average Wage per Hour of the employees involved in the activity.	Average Benefit Cost per Hour of the employees involved in the activity.	Average Overhead Cost (space, computers, etc.) per hour of the employees involved in the activity.
Turn-the-Curve Discussions				
Action Plan Implementation				
Other				

Intensive Family Preservation

Considering the ***previous month only***, please enter the following information for Intensive Family Preservation *(hold your cursor arrow over each activity for a definition):*

	Total Hours Spent doing this activity by all employees.	Average Wage per Hour of the employees involved in the activity.	Average Benefit Cost per Hour of the employees involved in the activity.	Average Overhead Cost (space, computers, etc.) per hour of the employees involved in the activity.
Turn-the-Curve Discussions				
Action Plan Implementation				
Other				

RBA Provider Survey

The evaluators worked collaboratively with the DCFS RBA Program Administrator to develop survey items designed to assess provider perceptions of the planning and early implementation of RBA. The survey items were organized into the following dimensions:

- Readiness and capacity to implement RBA
- RBA performance measures
- Use of Results Scorecard
- RBA Training
- Shared vision for RBA program
- Participation and utility of RBA program
- History of collaboration
- Inclusiveness in the process
- Open communication
- Appropriate pace of development
- Political and social climate for RBA
- RBA program elements

At the time of this survey administration, some RBA program elements (i.e., data fidelity reviews, Turn-the-Curve discussions, and action planning) had not yet been and therefore were not included. These areas will be added to future surveys, as RBA/PPI implementation progresses.

This survey was administered online. Individuals were sent a survey invitation via email and received two weekly follow-up reminders. To assess changes in these important factors over time, this survey will be administered three times over the course of the demonstration: early implementation, at approximately the mid-point of the project, and near the end of the demonstration. When viewed collectively, responses to these three surveys should reflect the degree to which providers understand and are engaged in the RBA/PPI process, use of Scorecard/Salesforce, and DCFS' contracting process, and any changes in these areas over the course of the demonstration. The next administration of this survey is planned for spring 2017. A copy of this measures is provided on the next page.

CENTER ON CHILDREN, FAMILIES, AND THE LAW

Informed Consent

INFORMED CONSENT

The University of Nebraska-Lincoln Center on Children, Families and the Law (UNL-CCFL) is partnering with the Nebraska Division of Children and Family Services (DCFS) to evaluate the implementation of Nebraska's Title IV-E Waiver Demonstration Project. As part of this project, we are studying the process and outcomes of the Results-Based Accountability (RBA) program. This survey focuses on your experiences and perceptions as a provider. Please answer as honestly and thoroughly as possible. Your feedback will provide valuable insight to inform the future direction of the program.

Who is being asked to participate in this survey?
Contracted direct service providers subject to RBA are asked to participate in this survey.

How much time will it take to complete the survey?
The survey should take about 10-15 minutes to complete.

Are there any risks or benefits for me by participating in the survey?
There are no known risks associated with participation in the survey. However, the overall results of the study will be used to inform potential improvements to the RBA program.

Are my responses confidential?
Any information provided in this survey will be kept confidential. Your individual responses will be combined with those shared by others to create a report to be shared with personnel at DCFS. All reports generated and any published or presented summaries from this data will only be in a manner that does not allow individual participants or their agencies to be identified. Summaries of data will be reported back to DCFS in aggregate form at the community level or by type of agency only when the number of respondents is sufficient to maintain anonymity.

Can I choose not to participate?
You are free to decide not to participate in this survey or to withdraw at any time without adversely affecting your relationship with the researchers, the University of Nebraska-Lincoln, or the Nebraska Division of Children and Family Services. Your decision will not result in any loss of benefits to which you are otherwise entitled. You do not have to answer any questions that you do not wish to answer and you may end your participation at any time.

Who can I contact about this survey?
Should you have any questions about this survey or the project itself, please contact the Principal Investigators:

- Michelle Graef (mgraef1@unl.edu) or Kate Stephenson (kstephenson@unl.edu)
- Phone: (402) 472-3479

If you have questions or concerns about your rights as a participant, please contact:

- UNL Research Compliance Services (irb@unl.edu)

- Phone: (402) 472-6965

If you would like to know more about your data security through the Qualtrics survey site:

- http://www.qualtrics.com/security-statement/

By clicking on the double-arrow button below, you are voluntarily making a decision whether or not to participate in this research study. Your response to the survey is your indication that you agree to participate, having read and understood the information presented above. Please print a copy of this page for your records.

We look forward to your feedback!

IRB#20141214963 EX

Assessment of Readiness and Capacity to Implement RBA

Assessment of Readiness and Capacity to Implement RBA

RBA matches the priorities of my organization.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency's leadership is encouraging all of us to embrace RBA.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency believes there are legitimate reasons for the Child Protection and Safety System to implement RBA.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

DCFS's senior leadership is committed to RBA.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency had the adequate "people power" to develop a process for collecting data.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency was ready to implement RBA in time for the start date.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency does not anticipate any problems adjusting to the work it will have as a result of RBA.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about the assessment of readiness and capacity to implement RBA.

RBA Performance Measures

RBA Performance Measures

The process to *develop* performance measures was collaborative between my agency and DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

The process to *refine* performance measures was collaborative between my agency and DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

I have felt well informed during the performance measure development process (e.g., I understood the process, there was good communication, my questions were answered).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

How difficult was it for your agency to develop procedures to collect performance measure data?

Very Difficult	Difficult	Neutral	Easy	Very Easy	Don't Know
○	○	○	○	○	○

For the instruments or procedures your agency uses to collect performance measure data, what methods (if any) were already in place?

What methods (if any) did you need to develop specifically to address the RBA performance measures?

Please provide any comments or suggestions about the RBA performance measures.

Use of Results Scorecard

Use of Results Scorecard

Does your agency regularly enter data into the Results Scorecard website each month?

No ○ Yes ○

Please tell us why your agency is not entering data into the Results Scorecard website each month.

Use of Results Scorecard

How difficult is it for your agency to compile and enter data into the Scorecard each month?

Very Difficult	Difficult	Neutral	Easy	Very Easy	Don't Know
○	○	○	○	○	○

Approximately how long does it take your agency to compile and enter data into the Scorecard each month?

▼

How frequently are you using the Scorecard outside of entering your agency's data (e.g., to view your data or reports)?

Never	Monthly	Weekly	Daily	Don't Know
○	○	○	○	○

The Scorecard is a valuable tool for my agency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please tell us why the Scorecard is or is not a valuable tool for your agency.

Please provide any comments or suggestions about the use of Results Scorecard.

RBA Training

RBA Training

My agency has received training in the principles and philosophy of RBA.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

I know how to request additional RBA training for my agency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

DHHS has been responsive to my request for additional RBA training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	My agency has not requested additional training
○	○	○	○	○	○

Please provide any comments or suggestions about RBA training.

Shared Vision for RBA

Shared Vision for RBA

My agency has a shared vision with DCFS regarding what RBA will accomplish.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency has a clear sense of their role and responsibility with regard to the RBA initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about a shared vision for RBA.

Participation and Utility

Participation and Utility

My agency has a clear primary point of contact for RBA-related questions.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency feels involved in what's going on with the RBA initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

RBA meetings with DCFS are worthwhile because my agency's participation makes a difference in the outcomes, decisions, and results.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about participation and utility.

History of Collaboration

History of Collaboration

Trying to solve problems through collaboration has been common amongst provider agencies.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Provider agencies have a history of working collaboratively with DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about the history of collaboration.

Inclusiveness in Process

Inclusiveness in Process

The processes used by DCFS to elicit my agency's input about RBA are effective.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

My agency's input is heard and serves a valuable role in the decisions made by DCFS.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

We are always informed when major decisions are made about RBA program design and implementation that affect our agency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about inclusiveness in process.

Open Communication

Open Communication

When my agency meets with DCFS to discuss RBA, different ideas and perspectives are often explored.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

When my agency meets with DCFS to discuss RBA, people feel comfortable challenging the ideas and comments of others.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

When my agency meets with DCFS to discuss RBA, there is a high level of trust between participants.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about open communication.

Appropriate Pace of Development

Appropriate Pace of Development

DCFS has tried to take on the right amount of work at the right pace implementing the RBA initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to the RBA initiative.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about the appropriate pace of development.

Political and Social Climate

Political and Social Climate

The political and social climate seems to be "right" for RBA to be successful.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know

Please provide any comments or suggestions about the political and social climate.

Perceptions of RBA Program Elements

Perceptions of RBA Program Elements

RBA has created clear service definitions and expectations for service providers.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know

RBA creates a system for measuring and comparing the effectiveness of providers.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know

RBA holds the system accountable for their performance measures.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Don't Know

RBA will influence contract decisions, based on performance results.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

RBA will benefit the children and families we serve.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

RBA will benefit my agency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

RBA will improve my agency's overall efficiency.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
○	○	○	○	○	○

Please provide any comments or suggestions about the RBA program elements.

Please provide any comments or suggestions you have regarding the RBA program, in general.