Arizona Title IV- E Waiver Evaluation Plan

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Introduction to the Arizona Waiver

Arizona's IV-E Waiver is embedded in the Department's congregate care reduction model as described in the IDIR. The fundamental thesis to be examined in the evaluation of Arizona's Waiver is how the availability of flexible Title IV-E funds enables the state to reduce the number of children placed in congregate care. To do so, the Arizona Department of Child Safety (DCS or the Department) will provide targeted case management and specialized services to these children and their families by enhancing family/fictive kin search and engagement activities, and by expanding its Team Decision-Making (TDM) process. In addition, Arizona will support the action plans created in partnership with the family/fictive kin by enhancing the availability of needed services. It is proposed that enhancing these three evidence-informed practices—kin search and engagement, TDM, and in-home service array—will enable the Department to reduce the length of stay in congregate care, and hence expenditure patterns, and financially support other organizational changes that will ultimately improve the safety, permanency, and well-being of Arizona children.

As stated in the original Waiver application, increasing the use of evidence-based and evidence-informed interventions continues to be a goal of the Department. Implementing the selected evidence-informed practices highlights the importance that Arizona is placing on taking an evidence-based/evidence-informed approach to reducing congregate care. Arizona State University (ASU), in partnership with the Department, has designed an integrated process, outcome, and cost evaluation plan that balances rigor and feasibility. A sub-study focused on advancing the measurement of child well-being is also included. An additional strength of the evaluation plan is its potential to produce critical child welfare knowledge. Dr. Judy Krysik and Dr. Elizabeth Anthony will direct all aspects of the evaluation, including the dissemination of results.

Target Population

The Waiver will be focused on children, birth through 18 years, who are placed in congregate care. Consensus from focus groups with DCS staff revealed that children were often placed in congregate care due to a shortage of appropriate foster family homes or kin/fictive kin placement options for sibling groups, and not specifically due to the children's needs for therapeutic placements. This was also confirmed in preliminary case record reviews which identified children were at times placed in

congregate care to keep siblings together when first entering care. In contrast, case file reviews indicated that children who experienced long stays in congregate care demonstrated highly complex needs – medical and behavioral—that indicated congregate care was considered in the child's best interest due to the risk of harm to self and others. As a result, the evaluation will address reductions in congregate care across all age groups for children who are placed in congregate care settings, with the exception of children placed in residential treatment centers or therapeutic group homes.

On July 1, 2015, there were 2,260 children and youth in the custody of the Department who were placed in congregate care (defined as shelter, group home, or behavioral health group care). Of all children who entered out-of-home care in calendar year (CY) 2014, there were 2,444 (19%) initially placed in a congregate care setting. Arizona's large urban counties – Maricopa, Pima, and Pinal – were home to 95% of children placed in congregate care as of July 1, 2015, with the remaining five percent of children spread across the state's 12 rural counties. Of all children who entered care in CY 2014 and were initially placed in congregate care, 47% were ages 13 to 17 years, 33% were age six to 12 years, and 20% were age birth to five years. As of July 1, 2015, youth age 13 to 17 years made up 61% of the total congregate care population.

During the first six months of the initial implementation, the Department projects to serve approximately 30 children in congregate care settings each month. Once the intervention is underway, the Department projects to serve an additional 60 or more children per month throughout the life of the demonstration project.

Target Geographic Area

The Waiver intervention will be implemented by the Department through their administrative units, called 'regions.' Arizona has five regions that cover 15 counties. The Department is currently working on the specifics of the intervention, including the implementation process and the timing of the rollout. The Department is looking to engage Maricopa, Pima, and Pinal counties in the intervention with no significant difference in Waiver approach at the county level.

Figure 1 shows the current regional/county boundaries. The three Waiver counties map to three regions: Southwestern which includes part of Maricopa County; Central which also includes Maricopa County and all of Pinal County, and Pima which includes all of Pima County. Only one region

(Southwestern) covers county areas that extend beyond the Waiver counties. One county (Pima) covers only its own county; one region (Central) covers all of Pinal County and a portion of Maricopa County. This may become an advantage as the counties are distributed into administrative regions that naturally reflect urban/rural capacity and cost differentials for distance and service availability. As a result, the evaluation will collect data by county and administrative unit. Since the western part of the Southwestern Region falls under an administrative unit that includes counties other than Maricopa, only the Maricopa County component of the unit's administrative functions will be considered. Initially, the intervention will be provided in two purposively selected offices in Maricopa County: Avondale and Tempe. The intervention will then be rolled out to additional offices in Maricopa, Pima, and Pinal counties, and then to the remaining counties statewide.

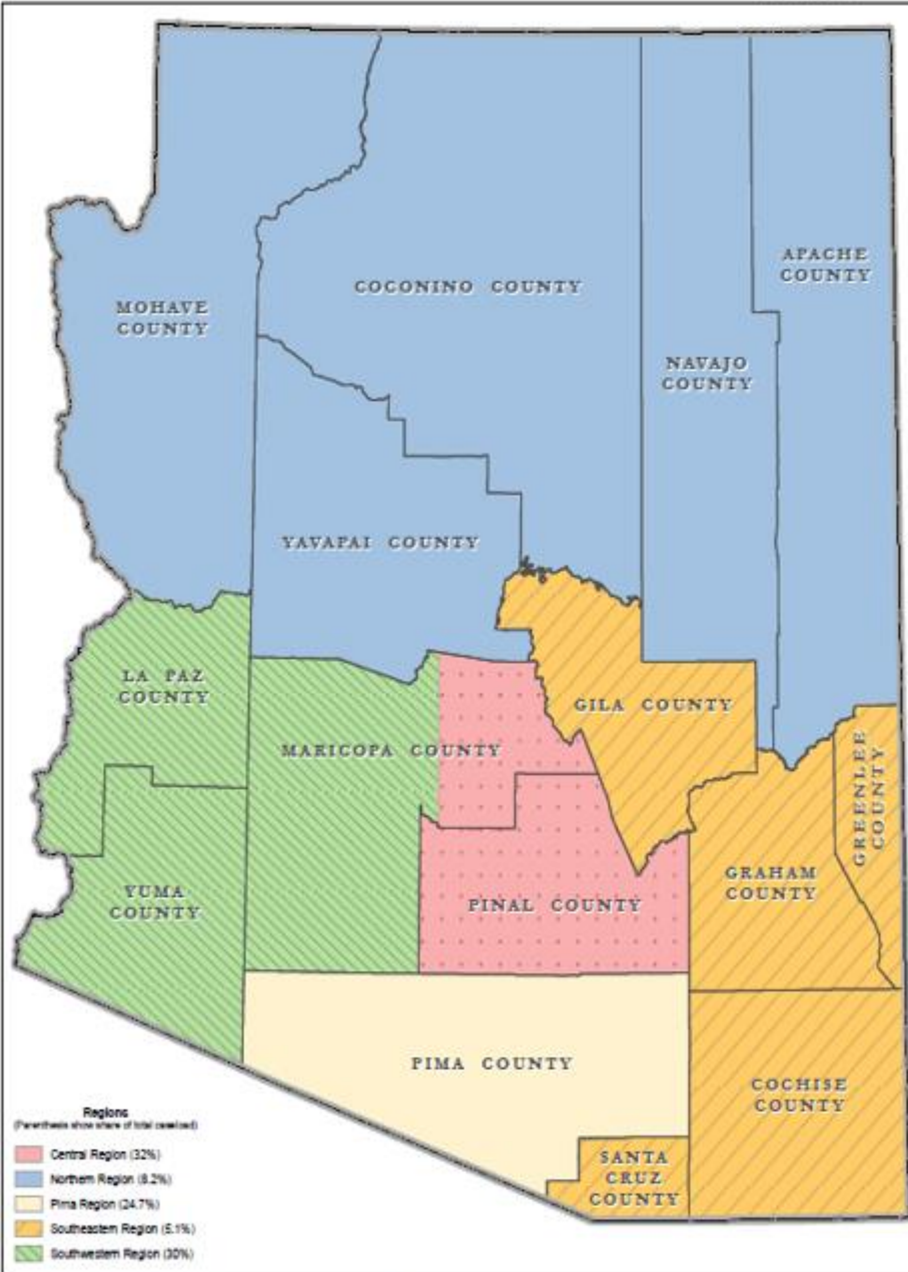

Figure 1. DCS Regions and Counties

Description of the Intervention

The Department will combine TDM with family/fictive kin search and engagement strategies through the Family Finding model with in-home and other needed services as the Waiver intervention. The Department is working on procedure and practice guides in preparation for the roll out. Each practice component as it is currently conceptualized is briefly described below.

Team Decision Making

TDM currently exists throughout the state, but is underutilized due to other assigned duties and does not target children who are in congregate care. TDM is an agency meeting where parents, children ages 12 or older if appropriate, family members, extended family and other support persons such as out-of-home placement providers if the child is in placement, service providers, community representatives, the DCS Specialist of record, and the supervisor come together when critical decisions regarding children must be made. The meeting is a sharing of all information relating to child safety and protection, and the functioning of the family. The goal is to reach consensus on a decision regarding the child, and to create a plan that protects children in the least restrictive environments.

The process is intended to be strengths-based with a focus on providing a forum for meeting with participants to share and hear their impressions about a child, as well as what is working well within the family. TDM provides families and the community an opportunity to participate in the decision-making process regarding the child, and allows participants to understand the reasons decisions are made. For the full policy describing TDMs in Arizona, see the Arizona Department of Child Safety: Policy and Procedure Manual Chapter 2 Section 8.[1]

Arizona's TDM meetings follow a six-step process based on the Annie E. Casey Family to Family Initiative:

1. Introduction
2. Identification (Why are we here?)
3. Assessment (Concerns & Strengths)
4. Brainstorming Ideas

[1] https://extranet.azdes.gov/dcyfpolicy/

5. Consensus Decision/Recommendation
6. Evaluation/Recap/Closing

There are five types of TDMs currently held in Arizona and described as follows:

1. An Emergency Removal TDM occurs when:
    a. A child has been physically removed from the custody of the parent, guardian or custodian and a Temporary Custody Notice (TCN) has been served; or
    b. The Department requests a court ordered pick-up due to present danger or impending danger.
2. A Considered Removal TDM occurs when:
    a. The results of the assessment of child safety threats and risk indicate the child is unsafe due to impending danger; or
    b. Voluntary services have been initiated and the safety threats and risk factors have not been sufficiently remediated and no safety plan can be implemented to ensure the child's safety in the home.
3. A Change of Placement Disruption/Placement Preservation TDM occurs when:
    a. There is a potential placement disruption; or
    b. An unplanned placement change occurs.
4. A Permanency Planning TDM occurs when:
    a. There may be a recommendation for a change in the permanency goal; or
    b. A child will begin the reunification transition to their family.
5. An Age of Majority/Program Disruption/Discharge TDM occurs when:
    a. A youth in care is within six months of turning 18;
    b. A youth is in voluntary foster care for Independent Living and wants to exit or is in non-compliance with the program (scheduled no later than 72 hours from the youth's request); or
    c. A youth is in voluntary foster care for Independent Living and is within 30 days of turning 21.

As part of the Waiver intervention, a Placement Options TDM will be introduced for the congregate care population. Children in congregate care settings will be selected for the Waiver intervention based on

case related data. Once selected, there will be two points of entry to the targeted TDM process for children placed in congregate care:

a. The child has a family/fictive kin placement identified or reunification is scheduled to take place in the next 30 days, and a TDM is needed to explore needs/supports for the placement/child/family.
b. If placement with family/fictive kin is not identified or reunification is not occurring within 30 days, family/fictive kin search and engagement activities will be conducted and the family will be prepared for a TDM meeting, if needed.

The IDIR presented two flowcharts of how the Placement Options TDM is intended to occur for children in congregate care. This process combines elements of the current Change of Placement Disruption/Placement Preservation, Permanency Planning, and Age of Majority TDMs. They also incorporate the family/fictive kin search and engagement activities and the increased use of in-home and other support services for the child and family. As noted in the flowcharts in the IDIR, the Placement Options TDM process can be supported through the family/fictive kin search and engagement activities.

Family/Fictive Kin Search and Engagement

Arizona DCS currently has search procedures to identify kinship and foster homes for children placed in out-of-home care. However, DCS believes that these practices can be enhanced to increase family engagement, in conjunction with the TDM process and in-home services array. The Department consistently places children with kinship or foster families at rates higher than the national average. However, children are often placed in congregate care settings directly upon removal due to caseload burden, as well as some barriers identified in the current kinship search practice. The Department decided to adopt the Family Finding model founded by Kevin A. Campbell.[2] The Family Finding model was chosen due to the Department's past success and experience with Seneca Family Agencies. Due to the desire to build the Department's program infrastructure and embed it into practice, a decision was made to have existing DCS staff administer this service. DCS has created non-case-carrying Family Engagement Specialist positions that will be trained to provide the family/fictive kin search and engagement activities.

[2] National Institute for Permanent Family Connectedness: http://www.familyfinding.org/

Using the Family Finding model, the Family Engagement Specialist will collaborate with the assigned DCS Specialist to mine the electronic and hard-copy case record to identify relatives/kin; engage the child currently in a congregate care placement along with the congregate care staff; encourage the child (age allowing) to talk about important people in his/her life; and reach out to identified relatives and fictive kin found to encourage their emotional support of the child. DCS believes that, once reconnected with family, the chances of a relative becoming a placement or reunification will greatly increase.

Depending on the response of family members and their commitment to supporting the child, there may or may not be a need for a Blended Perspectives Meeting, which originates within the Family Finding model. This is a meeting for family/fictive kin that have been disconnected from and who do not know the child. It will be facilitated by the Family Engagement Specialist in the hope of reintroducing and connecting the child and family with each other. One of the objectives of the meeting is for the family/fictive kin to explore how they can support the child and family. The Family Engagement Specialist will also help prepare the family/fictive kin for the Placement Options TDM meeting when needed where decisions will be made about placement, ways the family/fictive kin can support the child/family, and determining what services are needed for the placement, child, family, and fictive kin. In addition, the Family Engagement Specialist will assist the DCS Specialist with obtaining the needed services while working with the identified champions to monitor the action plan created in the TDM meeting. This may include monitoring the progress of the supports that are put in place for transitioning the child to the new placement and ensuring the child's needs are being met. The Family Engagement Specialist will further assist the DCS Specialist with evaluating the needs after placement, to ensure placement stability can be safely achieved post permanency.

In-Home Service Expansion/Services Array

From the point of intake into the child welfare system until permanency, case managers utilize targeted service provision in order to work toward successfully achieving timely permanency for child welfare involved children. Although comprehensive in nature, the effectiveness of the service array is dependent on children and families receiving services that are congruent with their identified needs.

Prior to the Waiver, service provision and planning was intended to occur throughout the entirety of a child welfare case, with the Child Safety and Risk Assessment (CSRA) driving the identification of child

and family needs, as well as classification of risk and safety concerns which compromise child safety. The CSRA is a standardized tool used to assess the safety and risk of a child. The CSRA is initiated during initial contact with the family and is continued throughout the investigation and into the life of the case with the Continuous Child Safety and Risk Assessment (C-CSRA). The C-CSRA is required whenever major changes in family circumstances occur and at key decision points during the life of a case.

When child and family needs and concerns identified throughout the continuous assessment process are incongruent with referred services, children may remain in restrictive congregate care settings awaiting permanency, and families experience stagnant progress towards addressing identified needs and concerns. In contrast, when service planning focuses on family engagement and tailored service provision, as within the Waiver intervention, children may spend less time in restrictive congregate care settings awaiting permanency, and families may experience improved outcomes including reduced re-entry.

With family engagement as a cornerstone of on-going assessment throughout the life of the child welfare case, services are intended to be tailored to each individual family, ensuring that families receive access to timely comprehensive service provision across all identified domains of need. The Department intends to improve outcomes for children placed in congregate care and their families through enhanced service matching, tailored to the targeted needs and concerns identified throughout the life of the child welfare case. With the use of Family Engagement Specialists and expansion of the Team Decision-Making process as well as Family Finding, team members will work collaboratively with children and their families to identify service needs with increased precision. Enhanced focus and attention to service matching for children in congregate care and their families will serve to identify and subsequently address the child and family's most salient barriers to permanency, safety, and well-being.

Currently, the Department's reunification or placement stabilization in-home services and behavioral health services are available statewide, but these services are underutilized. In order to assist parents to either have their children returned to their care or transition to a family/fictive kin placement, the availability of in-home, behavioral health services and other supportive services is a key component to the Waiver intervention. For the Waiver, DCS will be expanding utilization of the In-Home Services

Program (IHSP), but will also be mindful of community and contract services available as described above to create a larger services array. There are several avenues that services can be made available: through the community, through state contracts, and through the behavioral health system. Examples of such services are provided below.

Community Resources/Services

- Employment opportunities, job training
- Domestic violence support services and programs
- Housing services
- Tangible resources and food banks
- Respite services
- Disability services
- Vocational rehabilitation services
- Navigating community-based services and resources
- Family resource centers

State-Contracted and Behavioral Health Services

- Parent Training and Assistance (Parent Aide) are state contract and also available through behavioral health.

Purpose: Services can be intensive or moderate and include parenting skills, home management skills, education on accessing community resources, and arrangement and supervision of visitation.

- Substance Abuse Treatment - Arizona Families F.I.R.S.T. (AFF) is a joint partnership with DCS and the behavioral health system.

Purpose: To assist in the recovery from substance abuse issues that affect a parent's ability to care for a child, including both drugs and alcohol. Services can be intensive or moderate and include educational, outpatient/intensive outpatient, residential treatment, and recovery maintenance services.

- Counseling/Psychological Services are available through state contract and also available through behavioral health system.

Purpose: To provide psychiatric and psychological assessments to determine the mental status and behavioral health needs of clients including physical, emotional, educational, and social needs, and facilitate appropriate treatment/interventions, often through counseling.

- Transportation is available through state contract and also available through the behavioral health system for treatment purposes only.

Purpose: Available to provide families with transportation to participate in visitation or allow families to meet court-ordered or other necessary obligations in order to expedite the resolution of the case and help move children to reunification or other permanency.

- Prevention Services, Healthy Families and other home visitation models are available through several funding sources.

Purpose: Evidence based home visiting program that provide services that are voluntary and free to the public designed to strengthen families during the first five years of a child's life.

- In-Home Services are available through state contract and also available through the behavioral health system.

Purpose: To assist in supporting and preserving the family unit through a continuum of family-centered services that is coordinated, community-based, accessible, and culturally responsive. Services can be intensive or moderate and include: parent education, counseling, communication skills, behavioral management/ modification, and home management skills. The intent of Arizona's contracted In-Home Services Program is to provide services to families/fictive kin when the child/family/fictive kin does not qualify for services through the behavioral health system or other community services.

The In-Home Services Program also provides transitional supports from higher level of care placements to family homes, stabilization services of a child in relative/kin or adoptive placements, and services to a community-based families that have no DCS involvement. Currently, IHSP services are provided by 9 contracted agencies that serve families across Arizona. There are five levels of services in the IHSP that are detailed in the following chart.

Five Levels of Services within the DCS In-Home Services Program (IHSP)

Level	Description
1	Clinical Family Assessment – an assessment conducted by a master's level clinician to assist in identifying the nature of the problem, the treatment needs and services that might best be utilized to address the child's and/or family's problems. *Length of service – one time for the length of time it takes to conduct assessment
2	Family Support – short-term family supportive intervention services where conditions represent potential or low risk of abuse and/or neglect, in order to allow those children to safely remain in their home. This service may be provided to DCS-referred families, community families or self-referrals. *Length of service – maximum of 120 days (45 days extension upon approval)
3	Moderate – services where conditions represent no safety threat, but a high to moderate risk of abuse and/or neglect, in order to allow those children to safely remain in their home. *Length of service – maximum of 90 days (45 days extension upon approval)
4	Intensive – provide crisis-oriented activities where conditions represent a threat to child safety and whose children are at significant risk of out-of-home placement due to abuse and/or neglect, in order to allow those children to safely remain in their home. *Length of service – maximum of 120 days (45 days extension upon approval)
5	Family Reunification and Placement Stabilization – Safely expedite the return of children who are in out-of-home placement or in voluntary foster care back to their family, and transition a child from a more restrictive placement back to the community, such as from a residential treatment center to a foster or family home or from a foster home to a family home. Family Reunification and Placement Stabilization may also assist in the stabilization or safe maintenance of a child in a relative/kinship or adoptive home. *Length of service – maximum of 120 days (45 days extension upon approval)

Any level of service within the IHSP may be provided to the target population depending on the needs of the family and availability of services. The Department anticipates the levels that will be utilized more frequently will be family reunification and placement stabilization. IHSP services are provided to

the entire family and are delivered in the family's home, or in the case of reunification or placement stability services, in the child's current and transitional placement, which may include a foster, kinship, or adoptive home. The service is currently paid through non-Title IV-E funds and is intended to improve the safety and well-being of children and families. Flexible funding under the Waiver will allow for services to be provided to the target population. Services are intended to be initiated rapidly—between 12 hours and five working days from referral depending on the intensity of services—and the team is available 24/7 to families for crisis support.

DCS has observed that these services, particularly the family reunification, placement stabilization level, and the family support level of services, are underutilized in DCS cases. In addition, services through the community and behavioral health system are underutilized when the child/family/fictive kin may qualify. As noted from DCS staff and in-home providers, contributing factors are lack of staff knowledge of program availability both with the In-Home Services Program and in-home behavioral health programs and community services. Additionally, lack of appropriate referrals to the service level needed at the right time is a contributing factor. DCS Specialists may not ensure appropriate match between case and referral due to challenging demands of caseload size. As part of the Waiver effort, DCS will train and coach staff and supervisors, update policy and procedures, and create practice guides to assist staff in their decision-making. It is anticipated that staff knowledge will increase and appropriate referrals will be made with the addition and assistance of Family Engagement Specialists, Placement Options TDMs, and Family Finding.

Further, during the demonstration project DCS will engage with in-home providers to ensure that they are full partners in identifying cases where children can be moved to a family setting or home. This will be done through the site implementation teams, as well as with the statewide in-home coordinator. DCS anticipates that this engagement may help in-home service providers more fully participate in TDM planning and Family Finding than currently exists. This is expected to increase the use of in-home family reunification and placement stabilization services and other noted state contracted and community services, as well as services through the behavioral health system for the target population through this Waiver.

Theory of Change and Logic Model

The Department developed a theory of change that links the Waiver intervention with key expected outcomes (see the IDIR for the theory of change). Based specifically on this theory of change, an overarching logic model was developed (see Appendix A). It is hypothesized that through the Waiver intervention, the outputs and short and longer-term outcomes listed on the logic model will be achieved. These outputs and outcomes guided the development of the process, outcome, and cost evaluation plan. Additional work is underway to align the theory of change as presented in the IDIR and the logic model.

Process Evaluation Plan

The process evaluation addresses two general questions:

1. Was the intervention implemented as designed? (**fidelity**), and,
2. Did the state child welfare system support implementation of the intervention in a manner that optimized short, intermediate, and long-term outcomes (**implementation science**)?

Process evaluations assess the capacity of an organization to deliver on its intended outcomes. The process evaluation documents an intervention's implementation so that stakeholders understand *how* program outcomes or impacts were achieved. In a process evaluation, a review of the implementation of an intervention within a larger program is made to describe which processes were utilized to achieve outcomes including administrative processes, management functions, and infrastructure. The focus of a process evaluation is on the types, quantities, and qualities of services delivered, the resources used to deliver the services, the practical problems encountered, and the strategies used to resolve the identified problems.

Through the process evaluation the ASU evaluation team will examine how the Waiver is being implemented in each of the three Waiver counties and then overall, at multiple levels simultaneously. The Department's congregate care reduction model focuses the Waiver intervention specifically at the practice level by improving family engagement and providing evidence-informed practices. These actions engage the family, providers in the community, and other systems of care such as behavioral health, the courts, and juvenile probation. Experience has shown that regardless

of policies and procedures that might be created at the system level to support activities, making sure that providers and specialists in the field are following proscribed policies and practices can often be difficult. For this reason, it is critical to remain mindful that many different parts of the child welfare system are involved in implementation of the Waiver, including the Department, providers, and families. Consequently, the interventions must be evaluated in the broader context of the child welfare landscape (Bronfenbrenner, 1999).

Child Welfare Context

The Department of Child Safety is a relatively new organization that has experienced both external stakeholder pressure (e.g., legal challenges), and internal pressure (e.g., staff turnover at every level including leadership). The planning for the Waiver has coincided with a structural and functional reorganization of the Department, commanding resources and focus. Efforts have resumed to complete the design of a practice model to incorporate the Strategic Plan, along with the revision of existing processes and practices to promote better outcomes for children and families. The Waiver planning has, in many ways, served as a catalyst to promote innovation. It is important to keep in mind that although Arizona is selecting an intervention, other reform elements as described in the Strategic Plan and Child and Family Services Review may also be important to the goal of reducing congregate care. These non-Waiver activities serve as significant context for the implementation of the Waiver interventions, and may directly or indirectly affect the evaluation of the Waiver. The process evaluation will take these non-Waiver interventions into account by including them and other upcoming initiatives in updates to the Waiver Implementation Context document (see Appendix B). As part of the evaluation process, the Department's Implementation Team will be asked to periodically (every 6 months) update the Waiver Implementation Context document to reflect an understanding of how this broader context impacts the Waiver implementation process and outcomes. The outcome evaluation will account for the potential effect of these initiatives through tailored design features.

Given this broader context at the Department and the opportunity to sharpen the implementation process, the process evaluation will be guided by the National Implementation Research Network (NIRN) Applied Implementation Science model.[3] The implementation science framework specifies

[3] National Implementation Research Network (NIRN) (2016). *Active implementation*. http://nirn.fpg.unc.edu/learn-implementation

processes for the different phases of implementation, from conceptualizing and planning to project implementation, that are useful in evaluating the implementation factors linked to successful implementation.[4] Specifically, the evaluation team will pinpoint departmental characteristics and activities and inter- and intra-organizational processes that may contribute to or hinder successful implementation (JBA, 2013). The Waiver process evaluation will use the implementation science model to guide specification of the enabling context and preconditions (i.e., **organizational/system readiness to change** and **system collaboration**), the implementation process via the **implementation drivers,** and **fidelity assessment** of the intervention.

System-Level Enabling Context and Preconditions for Implementation

There are at least two critical preconditions for successful Waiver implementation. The first is organizational/system readiness to change. The second is an appropriate level of system collaboration to achieve outcomes that require new partnerships and merged functionality. Together, these elements reinforce implementation and should be evaluated to identify issues and concerns that may serve as barriers to successful implementation.

Readiness

According to Lehman et al. (2002), readiness directly influences the likelihood of successful change in a variety of ways. First, readiness defines conditions that are important at the individual level for change to occur, such as personal motivation, trust, and confidence in the mission of the agency, its goals, and the perception that sufficient resources to accomplish tasks are available. Second, readiness also characterizes critical organizational dynamics such as leadership adaptability, support for innovation, and organizational infrastructure that promote or impede movement from one stage to another. Because the Waiver engages system-wide partners, inter-agency readiness for change is also a critical feature of readiness as a precondition to successful implementation.

Organizational readiness engages many dimensions that determine whether specific interventions are adopted and implemented. For example, if an intervention is not relevant to the problem, easily adopted with the current workforce, or perceived to be appropriate and acceptable by the workforce, it

[4] James Bell Associates (JBA) (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs*. Arlington, VA: Author.

is not likely to be implemented as planned regardless of the overall readiness for change of the organization. Identifying readiness provides an opportunity to address differences where they are observed between what the organization desires and what is impeding progress toward their goals.

When instituting new training as an intervention or a new requirement such as an evidence-informed practice, extensive support in terms of resources from every level of the organization are required for the intervention to be adopted into practice. Evaluating this core precondition of implementation provides an opportunity for managers to understand how specific elements of the organization and the child welfare system as a whole may need additional support to adopt Waiver changes.

In part, emanating from the organizational climate and technology transfer literature, several tools have been developed to measure readiness (Davis & Salasin, 1977; Finney & Moos, 1984; Furnham & Gunter, 1993; James & McIntyre, 1996; Koys & DeCotiis, 1991; Moos, 1988; Moos & Finney, 1988; Moos & Moos, 1998). One of the easiest to utilize and one that assesses readiness at several different levels is the Organizational Readiness for Change (TCU-ORC) instrument (TCU, 2005). The TCU-ORC has been developed by adapting scales used in previous organizational climate research by Crandall et al. (1979), James et al. (1976) and Jones & James (1979), as well as incorporating new items written specifically to measure domains and constructs identified as critical elements of readiness to change. ASU will implement a version of the ORC (see Appendix C) that will be adapted to DCS processes. It includes 115 Likert-type items (scored on a 5-point agree-disagree response scale) to represent 18 domains. These include multiple scales in four major areas: motivation for change, institutional resources, personality attributes of the staff, and organizational climate. Leader and staff versions were created and will be used to accommodate different perspectives on some of the scales. Readiness will be assessed in the first year of the Waiver concurrent with implementation (for more detail, see the Data Collection and Procedures section of this report).

Collaboration

The intervention components in the Arizona Waiver plan require a coordinated and integrated effort to achieve efficient and effective implementation and to assure quality outcomes. In addition to readiness, a second critical pre-condition to implementing improved service delivery is the extent to which the system operates as an integrated and collaborative unit (JBA, 2012). Silos of funding and separate and sometimes duplicative activities limit the effectiveness of program interventions where a coordinated,

integrated plan is required. Despite the selection of evidence-informed practices, a siloed system of service delivery will undermine participant engagement. Deeper levels of collaboration serve to identify and resolve barriers not in *ad hoc* ways as is often typical of unintegrated systems, but in coordinated system-wide ways. The quality and quantity of interactions among agency partners and providers including shared values, areas of difference in viewpoint, understanding interpersonal communication styles, power differentials, information sharing, and other issues can easily impede collaborative functioning. These areas are equally important to integrated agency functioning.

ASU will utilize the Wilder Collaboration Factors Inventory (Mattessich et al., 2001) (see Appendix D) to assess the current status of collaboration within and among agency partners in the Waiver. This inventory has been tested for statistical reliability and includes questions regarding interpersonal and interagency relationships. The inventory promotes the norms and values of collaboration and affords agencies a deeper understanding of what collaborative organizational processes should look like. Further information on the use of this standardized instrument is provided in the Data Collection and Procedures section.

Specifying the Implementation of Waiver Interventions

The implementation science model describes intervention factors or components as Implementation Drivers, or "the key components of capacity and the functional infrastructure supports that enable a program's success" (NIRN, 2015, p. 1). The process evaluation will thus examine the Implementation Drivers that impact the Waiver intervention outcomes. The Department is currently in the Installation stage ("Assure the availability of resources necessary to initiate the project, such as staffing, space, equipment, organizational supports, and new operating policies and procedures") in the process of implementation (NIRN, 2015, p. 5). For example, a survey was recently conducted to obtain DCS staff members' perspectives on the proposed Waiver intervention and the three evidence-informed practices (see Appendix E). Thus, the question or framework that will guide the evaluation of the implementation process will initially be "How is the Department installing the intervention?" At the Initial Implementation phase the evaluation will ask, "How is the Department supporting the intervention?" And finally, at Full Implementation the evaluation will ask, "How is the Department improving and sustaining the intervention?"

Through an implementation lens, analysis of what is occurring in each Driver while the Department is actively engaged in the Waiver implementation will aide in the process of operationalizing best practices at the organizational and system level (NIRN, 2015). The NIRN model specifies the three different Implementation Drivers:

1) **Competency Drivers** – are mechanisms to develop, improve and sustain one's ability to implement an intervention as intended in order to benefit children, families and communities.
2) **Organization Drivers** – are mechanisms to create and sustain hospitable organizational and system environments for effective services.
3) **Leadership Drivers** – focus on providing the right leadership strategies for the types of leadership challenges. These leadership challenges often emerge as part of the change management process needed to make decisions, provide guidance, and support organizational functioning (NIRN, 2015, pg. 2).

The implementation lens will provide a structure to effectively use the Implementation Drivers since the process evaluation will work alongside the development of the Department's practice model. As the Department continues to work to sharpen the child welfare practice model, the impact of the Implementation Driver assessment and subsequent action plans will also be sharpened. The evaluation will utilize the assessment tools and action plan developed by NIRN (2015) for each of the Implementation Drivers.[5]

Intervention-Level Fidelity Assessment

In addition to the organizational level assessment of fidelity to the implementation science model, the process evaluation will assess the level of adherence to each of the three evidence-informed practices that are proposed in the Waiver. Evaluating implementation fidelity is necessary to determine if the intervention components were delivered as intended. Adherence and competence are important aspects of fidelity and as such, the training for individuals delivering the intervention and the protocols to ensure the intervention is delivered in a consistent manner will be examined (Breitenstein et al., 2010). We propose to use the fidelity tool developed by Kevin Campbell for Family Finding and adapt it

[5] http://implementation.fpg.unc.edu/sites/implementation.fpg.unc.edu/files/NIRN-ImplementationDriversAssessingBestPractices.pdf

for use with TDM and in-home services. The Family Finding "Training to Practice Survey" (Appendix F) assesses the training of the employee specific to the intervention, specific aspects of the delivery of the intervention by that employee, and supports from supervisors and other administrators to complete the work successfully. In addition to adherence to the practice model, we propose to assess the parent/caregiver/kin/family member satisfaction with the intervention and experience of intervention fidelity as it relates to participant responsiveness (JBA, 2009), specifically in this case, the engagement of parents/caregivers/kin/family members/children as a consequence of the Waiver intervention.

Research Design

The process evaluation will employ a longitudinal design that examines the implementation of the Waiver over time through an implementation science lens. The process evaluation will utilize a mixed-methods approach (Creswell, 1999; Geene, Caracelli & Graham, 1989; Greene & Caracelli, 1997; Patton, 1990; Tashakkori & Teddlie, 2003) that combines both simultaneous and sequential quantitative and qualitative assessments of key concepts that promote actionable information for managers. The mixed methods design combines the rich narrative of personal experiences with systematic data to provide a comprehensive interpretation of how the Waiver is being implemented. The approach also promotes partnership and legitimacy of the evaluation enterprise between the evaluators and the program by not giving too much weight to any single information source that may be in direct contrast to other data. Mixed-methods support action-oriented, transformational evaluation with the end-user in mind, allowing managers to make better-informed decisions as they can consider a range of quality information. Table 1 summarizes the two research questions and data collection for the process evaluation of the proposed Waiver intervention. Additional information for each method is provided after the table.

Table 1: Process Evaluation Research Questions and Data Collection

Research Questions	Sampling Plan	Measures	Data Collection
1. Was the intervention implemented as designed (**fidelity**)?			
• Family Finding • TDM • In-Home Services	Random sample: Minimum of 10 cases from each practice component per county	Adapted Training to Practice survey	Online survey and interviews
2. Did the child welfare system support implementation of the intervention in a manner that optimized short, intermediate, and long-term outcomes (**implementation science**)?			
• Context	Purposive sample: DCS Implementation Team, DCS administrators	Interviews; Documents	Group process assessment
• Readiness	Purposive sample: DCS staff, provider staff and admin.	Organization Readiness for Change (ORC)	Online survey
• Collaboration	Purposive sample: DCS staff, provider staff and admin., key community stakeholders	Wilder Collaboration Factors Inventory	Online survey
• Implementation Drivers and Action Plan Adherence	Purposive sample: DCS Implementation Team	NIRN's Assessing Best Practices; Action Plan Checklist	Group process assessment; Case review; interviews; focus groups
• Engagement/Satisfaction	Random sample: Parents and foster/kinship caregivers, congregate care staff, and kin/fictive kin members; children age 12 and older	Structured interview guide	Field-based interviews

Sampling

The sample for the process evaluation will include representatives from the DCS implementation and administrative teams and staff, partner agency administrators and staff, parents/caregivers, children

age 12 and older, and community stakeholders. Specifically, there will be four different samples for the different aspects of the process evaluation:

1) For the systems-level enabling context and pre-conditions for implementation, the sample for the Readiness and Collaboration measures will be stakeholders (**Department staff, partner agency staff, contracted provider staff, and key community stakeholders such as the court administrators**). We will use purposive sampling procedures covering the three counties to identify the appropriate participants. For Collaboration, new stakeholders will be added to the sample over time as collaboration increases in size.

2) For Implementation Science, the sample will consist of the **members of the Department's Implementation Team**. For the Implementation Drivers Assessment, NIRN (2015) recommends the process only involve team members who are directly involved in the development, monitoring, and improvement of the Competency, Organization, and Leadership Drivers.

3) For satisfaction/perceived engagement, **parents and foster/kinship caregivers, congregate care staff, kin/fictive kin members, and children age 12 or older** will provide the client voice as described in the Data Sources and Data Collection Procedures section. In addition, as part of the sub-study of well-being measurement (see sub-study section), the parents and foster/kinship caregivers will be asked about how they would conceptualize their child's well-being and children age 12 and older will be asked how they conceptualize their own well-being.

4) For the intervention-level fidelity assessment, the sample includes a **parent/caregiver/kin/family member** fidelity and satisfaction survey to be completed for those randomly selected cases. In the first month of implementation we propose to sample all Waiver participants. As the implementation expands, we propose to randomly sample at least 10 cases from each intervention practice component (TDM, FF, and service array) and then continue to sample as necessary to meet a saturation rate of 85% on the fidelity measure for each practice component. The staggered approach to data collection will mirror the implementation science model that informs the procedures and processes for implementation. We aim to obtain approximately 30 families per practice component, per county (recognizing some cases will involve more than one practice component and thus more cases will be

sampled to reach the desired sample size). A final sample size of 30 families is sufficiently large to minimize concerns about site-specific or provider-specific biases but not so large that it constitutes a data collection burden. To ease the data collection burden, we propose to sample only the parents/caregivers from the randomly selected cases. However, if we encounter difficulties obtaining a sufficient response rate to the voluntary survey, we will open the sample to include any parent/caregiver involved in the Waiver intervention. Overall, parents/caregivers involved in the Waiver intervention may be more accessible to complete a survey due to the increased contact with a Family Engagement Specialist.

Measures

The measurement of key concepts in the process evaluation is described below. The measurement plan includes a number of standardized instruments as well as qualitative approaches to measurement.

Readiness

To measure readiness, ASU will work with the Evaluation Oversight Committee to target key stakeholders at all levels from leadership to front line staff to administer the ORC readiness survey online (Appendix C), which will be adapted to reflect DCS processes. Interviews will be conducted with stakeholders from each of the three counties as the intervention is rolled out. The ORC tool is validated and relatively easy to use (Lehman et al., 2002). Four domains will be assessed: 1) individual motivation; 2) adequacy of resources; 3) staff attributes that promote readiness; and 4) organizational climate. Specific topics to be explored are also identified. For example, under staff attributes, staff professional growth, their perception of efficacy, their perception of their ability to influence activities, decisions in the organization or with a partner agency, and how adaptable they are to new ideas or innovation are explored. The readiness instrument asks questions in each of these areas to support a score for the domain. The evaluation team will summarize these scores and comments and where readiness is lacking will suggest opportunities to improve the pace or direction of change and then follow up with further assessment at regular intervals (6 months) until improvement is achieved. Results will be provided to the Continuous Quality Improvement (CQI) Office at DCS for discussion.

Collaboration

The collaboration component describes seven key domains: 1) how effectively core workgroups are convened; 2) how supportive the general environment is in promoting innovation; 3) the style of collaborators in terms of decision-making and consensus-building; 4) individual traits; 5) communication strategies that include data-sharing; 6) the purpose the group perceives and how concrete and attainable the goals are; and 7) the resources contributed by various group members. The Wilder Collaboration Instrument effectively asks questions over all seven domains (see Appendix D). ASU evaluators will work with the Evaluation Oversight Committee to target key stakeholders for the survey (Department staff, partner agency staff, contracted provider staff, and community partners). A purposive sampling strategy covering the three counties will be used and the Wilder will be administered using the Qualtrics online survey program. The survey will be repeated and new stakeholders will be added over time as the collaboration increases in size.

The on-line tool takes approximately 15 minutes to complete and supports organizations in using the data to improve organizational functioning. The results of this inventory will be utilized to establish a baseline of collaboration for the Waiver interventions and then will be re-administered at 6 months, 12 months, and 24 months post implementation to track collaboration progress. Results will be provided to the CQI Office at DCS for discussion.

Implementation Drivers

In preparation for the Waiver implementation, an online survey (see Appendix E) was developed and administered to DCS staff from November 24 to December 10, 2015. The purpose of the survey was to gain staff input on the proposed Waiver intervention, specifically Team Decision-Making (TDM), In-Home Services array, and Family Finding. Two hundred thirty-one staff completed the survey (out of approximately 2,000 staff members with varying job duties) and overall the respondents represented an experienced child welfare workforce. We propose to use data from the online survey as a baseline measure and to classify the results into the three Implementation Drivers- Competency, Organization, and Leadership. We will also conduct interviews with a subsample of participants on the Waiver implementation context. This classification will enable the identification of technical and adaptive challenges as a baseline measure for future assessments. We will re-administer the survey every 6 months throughout the course of the Waiver implementation to capture the implementation process at a broader Department level. Results will be provided to the CQI Office at DCS for discussion.

We propose to also collect data from the Drivers Assessment process (NIRN, 2015) at time points for the stages of implementation (Exploration, Installation, Initial Implementation, and Full Implementation). The Department is fully in the Installation stage, therefore the evaluation will begin there. The NIRN tool asks team members involved in the development, monitoring, and improvement of the intervention to come together in a facilitated group assessment process and respond to questions such as "To what extent are best practices being used?" in specific aspects of recruitment and selection of staff. The questions cover topics for each of the Implementation Drivers: Competency, Organization, and Leadership. After discussion, the facilitator assists the group in responding with a consensus score (Possible responses include "In place, Partially in Place, Not in Place, Don't Know, Don't Understand"). The Assessing Best Practices tool provides a summary of "next right steps" as an action plan by Driver for Selection, Training, Coaching, Performance Assessment (Fidelity), Decision Support Data Systems, Facilitative Administrative Supports, Systems Intervention, and Leadership. We will evaluate the Department's adherence to the action plan via case review, interviews with key stakeholders, and focus groups with staff.

Intervention-Level Fidelity

We propose to adapt the "Training to Practice" fidelity survey developed for the Family Finding model and administer it for Family Finding, TDM, and In-Home Services Array. The fidelity tool collects information adherence, integrity, and quality of implementation. Specifically, the tool inquires about the practitioner (such as their length of experience with the practice, training, and other supports) and the practice (such as number of family members contacted, number of meetings, etc.). DCS currently has three workgroups developing practice guides that identify the required practices and procedures for implementation of the three evidence-informed practices. In the month following the approval of the implementation plan we will work with the evaluation oversight committee to create fidelity tools that reflect best practices for each of the evidence-informed practices. Family Finding will match the fidelity tool as developed most closely and the other two fidelity tools will be tailored to the recommendations from the Implementation Team via the practice guides. DCS is finalizing the practice guides and work on the fidelity tool will commence once the guides are approved. The fidelity assessment will provide feedback to the Implementation Team aimed at quality improvement and adaptation efforts (Castro, Barrera, Martinez, 2004; JBA, 2009). Data collection will commence after 1 month of roll out to a new office and cases will be randomly sampled until we reach 85% compliance

,but at minimum 10 cases per component, per county. We propose to use the same method at one year intervals for each office.

Data Sources and Data Collection Procedures

ASU will utilize a range of data sources to support the process evaluation including survey instruments, key stakeholder interviews, group assessment processes, and site visits. Data will come from several levels within organizations (families, front-line staff, supervisors, executive leadership), and from different partners (contracted/non-contracted service providers). These are summarized in Table 2 and described below.

ASU is committed to minimizing the data collection burden on the State, participating contracted providers, and their constituency groups whenever feasible by clearly communicating the reasons for data collection and the expectations for staff, and by working collaboratively with DCS in the development and refinement of data collection plans. The process evaluation data collection will provide important contextual information in understanding the appropriateness, effectiveness, and efficiency of the service interventions that comprise Arizona's IV-E Waiver Demonstration. As the Department works to further define the specifics of each intervention and the implementation, we will further specify the process evaluation.

Table 2: Data Sources and Procedures for the Intervention Components

Method	Source	Frequency	Intervention		
			Family Finding	TDM	In-Home Services
1. Key stakeholder interviews	Child welfare specialists, administrators, other state agencies, providers, key stakeholders, parent/foster/kin caregivers, kin/fictive kin members, congregate care providers	Quarterly (in year 1) then semi-annually	✓	✓	✓
2. Site visits/structured observation	Site specific child welfare and behavioral health administrators and supervisors, specialists, community partners	Quarterly (in year 1) then semi-annually	✓	✓	✓
3. Fidelity and implementation data	Department, providers	Quarterly (in year 1) then semi-annually	✓	✓	✓
4. Client interviews	Parent/foster/kin caregivers, kin/fictive kin members, congregate care providers, children/adolescents age 12 or older	Quarterly (in year 1) then semi-annually	✓	✓	✓
5. Online Survey instruments	Department Specialists, supervisors, leadership, providers, agency partners	Baseline 6 months, 12 months 18 months 24 months	✓	✓	✓

1. **Key Stakeholder Interviews:** Structured interview protocol will be developed to gain an understanding of the Waiver implementation environment from key stakeholders. These interviews will target DCS administrators and Specialists, providers, and other community

partners to provide a critical context to the more formal assessment of context, readiness, collaboration, implementation drivers, and fidelity.

2. **Site Visits to Providers**: The ASU evaluation team will visit selected DCS offices quarterly in year 1, beginning one month after implementation, and then semi-annually to evaluate the implementation of the Family Finding, TDM, and In-Home Services interventions and assess the implementation. During the site visits we will observe a placement TDM and a Blended Perspectives meeting and utilize checklists designed to observe and document activities that support the core dimensions. We will also utilize the site visits to target interviews with key stakeholders as a follow up to the online survey data and an opportunity to collect narratives of implementation successes and challenges. We will document specific changes and the impact of these changes, how services and processes have changed, how agencies are collaborating across systems within and perhaps between counties, and the ways in which family members and kinship caregivers feel engaged and supported.

3. **Fidelity Data**: We will adapt and use the Family Finding fidelity tool to establish intervention-level fidelity for the intervention. Using the DCS practice guides for Family Finding, TDM, and In-Home Services, we will adapt items to meet the specific requirements. We will administer the adapted Training to Practice fidelity tools to a minimum of 10 randomly selected cases per county to assess fidelity at the component level. Additional cases will be randomly selected until a saturation rate of 85% has been reached. We will give regular feedback to each county on its aggregate performance (across all children/families served in the county) in adhering to the defined components of each intervention. Feedback will also be given at the office level given the potential for differences between offices.

4. **Client Interviews**: The ASU evaluation team will execute field-based interviews with parents and foster/kinship caregivers, congregate care staff, kin/fictive kin members, and children age 12 and older most likely as part of the site visits. The focus of these interviews is to (a) enhance our understanding through rich narrative of their perceptions of the Waiver interventions, specifically the impact of Family Finding, TDM, and In-Home Services, (b) the context within which the interventions are occurring, (c) how the activities of the Waiver are being received, and (d) activities for clients now as opposed to past experiences. Early

caregiver interviews will serve as baseline measures whereas later interviews will track changes. We would be specifically interested in level of engagement based on (a) how receptive they are to the involvement of the Department of Child Safety; (b) their level of buy-in; (c) the quality of their relationship with Department specialists and contracted providers; (d) their level of trust/mistrust of specialists and/or providers, and (e) their overall satisfaction. These interviews will contribute to an understanding of how family engagement interventions (Waiver and non-Waiver) are implemented and what caregivers and children perceive to be the crucial elements in the intervention. ASU will work with the Evaluation Oversight Committee to determine feasible ways to execute these interviews that respect the privacy of caregivers, are culturally sensitive, and place minimal burden on staff workload. An example of such an instrument, The Parent Partner Fidelity and Satisfaction Survey, used to survey parents on peer parent support programs is presented in Appendix G and will be adapted for this purpose. A similar measure will adapted for use with children age 12 and older. The evaluation is purposefully setting the Department up with protocol and tools that can be used to self-evaluate, providing quality control for this and other interventions going forward.

5. **Online Surveys of the Department, Agency Partners, and Providers:** Online surveys offer a powerful mechanism for inclusion of Waiver participation at every level of activity, assist in identifying systematic cross-cutting issues, and support managers' ability to track critical changes necessary for successful implementation with periodic assessment data. Three different online survey instruments will be utilized to assess core process evaluation components (Organizational Readiness for Change; Wilder Collaboration Factors Inventory; and the Adapted Training to Practice fidelity instrument) and will be administered via the online survey program Qualtrics.

Data Analysis

The evaluation will use administrative data, narratives from interviews, observations, and coded data from open and closed-ended questions on instruments to offer a portrait of the implementation of the interventions and the children and families served, DCS specialist activities and perceptions, services referred, types and amounts of services received, and those dimensions of implementation that pose a

risk to short, intermediate, and long-term outcomes. Data will be disaggregated by service intervention, county, and other relevant factors to assess how the services received vary over time and across sites. Where appropriate and useful, statistical tests will be utilized to compare sites by implementation science outcomes.

The evaluation team will use a variety of tools to track and analyze the data. Interview and focus group data will be transcribed and then entered into qualitative analysis software such as Atlas-ti. Survey data will be analyzed using SPSS, and for open-ended responses, SPSS Text Tool. Data from these various sources will then be integrated in order to provide a coherent description of readiness, collaboration, and implementation at baseline and follow-up periods. ASU will document the variability in both readiness and collaboration within the Department, among system partners, and at the provider level.

Intervention components will be assessed for their activities at baseline, six months, one year, 18 months, and two and three years, post-implementation. Analyses will reveal trends in readiness, collaboration, implementation drivers, fidelity, and how demonstration services differ or are enhanced from the services in place prior to the implementation of the Waiver. Variance in implementation over time will be assessed in order to identify where implementation has been strongest up to that point, and where more should be done.

Next Steps

The specific next steps that the Department plans or is currently engaging in to implement the intervention are listed below.

1. The Department is currently developing the specific intervention plans, procedure and practice guides, and specific target populations in the first quarter of the Waiver demonstration project. As these plans are formalized, the process evaluation plan will be adapted to align with the specifics of the interventions as proposed.

2. The Department is developing an Evaluation Oversight Committee that will work with the ASU evaluation team to identify key informants who have specific responsibilities related to the evaluation, as well as those who are involved in the Waiver implementation process, to better understand their role and how they can contribute to the evaluation. The Evaluation Oversight

Committee will help to keep activities coordinated, promote a common understanding of evaluation tasks and purpose, provide a check on outstanding items, etc.

3. The Department will work with the ASU evaluation team, system partners, and community providers to implement survey and interview protocol required to assess two critical pre-conditions for implementation: system readiness and system collaboration.

4. In collaboration with ASU, intervention-specific workgroups, key stakeholders and providers, the Department will identify a comprehensive list of performance measures and other fidelity items. These measures are based on the specific components of the intervention. Key stakeholders and the providers will have the opportunity to review and refine these before implementation.

5. As the Department develops its implementation plan, it will engage Department data base administrators and analysts to identify and interpret elements and codes as needed to produce timely and accurate data for the evaluation.

6. The Department is currently developing a formal communication strategy along with an ongoing reporting mechanism for the evaluation team to provide ongoing feedback regarding the implementation of the intervention, the process evaluation, and other evaluative components. Ongoing communication will also report progress on data collection instruments, procedures, timeframes, and protocols. In conjunction with the Department, ASU will develop reports with an eye towards making these reports easily utilized by DCS administrators. The reports will be vetted by Department staff to ensure utility and ease of use; this process will be ongoing.

7. The Department is in the process of approving the Operating Procedures specific to the Intervention.

Tasks and Timelines

In order to address the basic evaluation requirements of Arizona's Terms & Conditions, the evaluation team will carry out the following tasks and responsibilities in collaboration with the Department. The

dates in Table 3 are estimates as the exact nature and dates of implementation are yet to be determined.

1. Collect data regarding the selection of intervention practices, planning, and implementation via the Implementation Drivers assessment process. Basic questions to be answered by DCS as they further specify the plans for the three evidence-informed intervention components include:
    a. Family Finding: Who (by position) will be trained, when, at what level, by whom, with what measure of competency, and what level of ongoing support and supervision?
    b. TDM: What model will be implemented, how will it be staffed and supervised, and how will DCS specialists be informed of the availability, and how will they access services, and for what period of time?
    c. In-Home Services: What will be supported, how will providers be contracted, how will families be screened and referred for services, and how will families access services?
2. Evaluation training: In order to explain the evaluation tasks that specialists and providers need to understand and participate in, ASU will conduct Waiver evaluation trainings by webinar.
3. Develop and execute baseline key stakeholder interviews and surveys.
4. ASU will coordinate with Department staff and providers to facilitate logistics for visits to intervention sites, including scheduling interviews and focus groups.
5. Report on the number of children/families receiving Waiver intervention services, on preconditions of implementation (readiness and collaboration), and on some initial implementation outcomes (adoption, feasibility, acceptability, appropriateness).

Table 3. Timeline for the Process Evaluation

Evaluation Task: Process Evaluation	Year 1/2016			Year 2/2017				Year 3/2018				Year 4/2019			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Monitor approval of intervention practice guides, planning, implementation, and training															
Design Qualtrics survey and administer readiness and collaboration instruments															
Facilitate group assessment process of implementation drivers															
Implement fidelity tools															
Administer key stakeholders interviews as part of pre-implementation review															
Conduct initial site visits to intervention pilot sites															
Report on the number of children/families receiving Waiver intervention services															
Report on some initial implementation outcomes (adoption, fit, feasibility, training, resources)															
Report on year 2 implementation outcomes (fidelity, buy-in, problem-solving)															
Report on year 3 implementation outcomes (integration and functionality, skillful delivery)															
Develop and implement client interview protocols															
Quarterly reports															
Semi-annual reports															
Interim/final evaluation reports															

Reporting

The evaluation team is committed to providing high quality quarterly performance reports with actionable recommendations provided to the Department. ASU will provide feedback on how the Department's efforts within and outside the context of the Waiver may promote or impede intended outcomes and what steps can be made to address any implementation barriers that arise. The process evaluation serves both as an assessment tool that helps practitioners make sense of the efforts they have undertaken to achieve outcomes with children and families, and provides specific direction to the Continuous Quality Improvement unit of the Department to address the constraints and uncertainty surrounding their findings. By leveraging implementation science, ASU is committed to clear and effective reporting that identifies issues and develops recommendations for remedies grounded in the research and implementation literature. This approach will optimize the utility of the process evaluation and provide an organic roadmap for implementation issues at the system and family levels. The process evaluation will describe the progress and achievements of the Waiver and the evaluation in each of the required reports, as noted in Table 4.

Table 4. Process Evaluation Reports

Required Report	Process Evaluation Tasks
Quarterly reports (Every 3 months)	• Describe efforts to conduct interviews, site visits, observations, and surveys and discuss results. • Provide data on the number of children/families receiving Waiver intervention services. • On an annual basis, provide data on the level of fidelity achieved thus far.
Semi-annual reports (Every six months)	• Describe efforts to conduct interviews, site visits, observations, and surveys and discuss results. • Provide data on the number of children/families receiving Waiver intervention services. Provide data on performance contracting to assure fidelity.
Interim Evaluation Report (June 2018)	• Provide preliminary descriptive analysis, summarizing implementation in the demonstration counties, using information from interviews and completed focus groups. • Provide data on the number of children/families receiving Waiver

	intervention services in the first two years of implementation. • Provide data on the level of fidelity achieved across interventions in the demonstration counties, for all children served by Waiver interventions in the first two years of implementation.
Final Evaluation Report (January 2020)	• Provide full descriptive analysis, using all interview, focus group, observation, and survey data (collected through June 2019) at both the county and systems levels.

Outcome Evaluation Plan

The outcome evaluation provides feedback on the extent to which the intervention is achieving its intended results, in the short, intermediate, and long term. In the evaluation of the Waiver, data will be monitored during implementation to compare current results with those achieved prior to administration of the intervention, and in comparison to offices which have not yet implemented the intervention. The outcome evaluation is formative, fits well with the implementation science approach, will integrate with CQI efforts, and will help guide mid-course corrections. Additional work will be done prior to implementation to align the logic model (see Appendix A) with the theory of change presented in the IDIR. The following sections detail the outcome evaluation questions, hypothesized relationships, data sources, sampling, and plan for analysis.

Outcome Domains, Evaluation Questions, and Hypotheses

As addressed earlier, the target population for the Waiver includes all children in congregate care at the time the Waiver is implemented (legacy children), as well as those entering congregate care throughout the Waiver period (new entries), with the exception of those placed in residential treatment facilities and therapeutic group homes. The cohort of children to be analyzed, and the potential for comparison, varies by outcome domain. Table 5 identifies 10 outcomes, associated evaluation questions, and hypotheses. The term treatment as usual, abbreviated by TAU, refers to the existing state of practice in DCS offices that have not implemented the Waiver at the time of data collection (i.e., comparison offices). Data sources and data collection are addressed later in this section.

Table 5. Outcome Domains, Evaluation Questions, and Hypotheses

Outcome Domain	Evaluation Questions	Hypotheses
Identification of child/family service needs, matched with service referrals, and timely service access. Service delivery mechanisms to be analyzed include the In Home Service Program, community and behavioral health services, and informal supports (e.g., kin provided transportation for visitation)	How does the identification of need vary between children/families in the intervention group and TAU? How congruent are identified need and service referrals in the intervention group compared to TAU? Are services accessed more quickly under the Waiver compared to TAU?	The intervention (placement TDM/ with or without Family Finding/ and service only cases) will result in better identification of child/ family service needs; better matching of needs to services as indicated by referrals, and faster access to needed services compared to TAU in comparison offices with matched cases.
Increased number of family/fictive kin identified and involved in the case.	How does family/fictive kin identification compare between the Waiver offices and TAU? Is there an increased number of searches (Family Locate or Seneca) for family members in the intervention group compared to TAU?	The Family Finding process will result in increased numbers of family/fictive kin identified and involved in the child's case compared to TAU in comparison offices with matched cases.
Permanency	Is there a difference in the probability of permanency based on practice component (TDM/ Family Finding/services only/ a combination of the three/ and TAU)?	There is a greater probability of permanency under the Waiver.
Safety: no substantiated	Does the likelihood of safety	Children who achieve

Outcome Domain	Evaluation Questions	Hypotheses
reports 12 months post permanency/and post exit from congregate care to a family-like setting.	vary between intervention and comparison groups controlling for practice component and type of permanency achieved?	permanency in the intervention offices will have lower rates of subsequent substantiated reports at 12 months post permanency than children in TAU.
Stability: no re-entry 12 months post permanency	Does the likelihood of stability vary between intervention and comparison groups controlling for practice component and type of permanency achieved?	Children who achieve permanency in the intervention offices will have lower rates of re-entry 12 months post permanency than children in TAU.
Restrictiveness of Living Environment	How does change in restrictiveness vary by age and race of child and is there a difference across the intervention and TAU groups?	Children in the intervention offices will achieve a greater monthly average decrease in restrictiveness of living score than children in nonintervention offices. Children in the intervention offices who are still in care within 12 months of their most recent congregate care placement date are more likely to move to family-like settings such as foster care or relative placement) compared children in TAU.
Days in congregate care/days in out of home	What are the differences in length of stay in congregate	Children entering congregate care after

Outcome Domain	Evaluation Questions	Hypotheses
care for children who enter congregate care after implementation of the Waiver	care by age and race of child and does the difference, if any hold across intervention and comparison groups? This will be calculated separately for children achieving permanency and children who move to family-like placements. Children moving to detention, hospitalization (medical or behavioral health) and the need for more restrictive placements will not be included, nor will children who experience death or runaway.	Waiver implementation will experience fewer overall days in congregate care as well as overall days in out of home care in the intervention offices compared to children entering congregate care in non-intervention offices
Social/emotional well being	Is the socio/emotional well-being scale sensitive to change over time? Is the scale useful for case planning? Do the perceived benefits of the scale outweigh the opportunity costs? Decision to be made on adoption Q1, 2017.	Children in the intervention offices will experience improved socio-emotional well-being measured prior to the placement TDM or FF process and 6 months post TDM, and compared to a matched sample in the nonintervention offices.
Rate of Exit from Congregate Care	Do contextual factors outside of the Waiver help explain trends and changes in the exit and entry rates?	Intervention offices will have higher monthly rates of exit from congregate care than comparison offices, and in comparison to exit rates 24-30 months prior to Waiver implementation.

Measurement and Data Sources

This section describes measurement of the 10 outcome domains listed in Table 5 above. Measures were chosen for validity (i.e., they measure the intended concept), and reliability (they measure it consistently). Measurements were also considered in relation to a balance among accuracy, feasibility, burden, and cost considerations.

Matching Service Need, Service Referral, and Service Receipt

To measure congruence in service need, referral, and access, the Comprehensive Assessment and Planning Model-Interim Solution (CAMPIS) will be utilized. The CAMPIS was developed in Ohio as a standardized, comprehensive procedure for assessing across multiple domains of children and family need. The CAMPIS tool will be used to assess the congruence between identified need and service referral for target children and their families.

The CAMPIS measurement tool encompasses a number of distinct components which utilize specific elements for specialized types of child welfare involved cases varying from families involved in child welfare services solely at the point of investigation, to children involved in more long-term legal dependency actions. The CAMPIS encompasses Case Review (CR), Semiannual Administrative Review (SAR), and Reunification Assessment (RA). Through in-depth case reviews utilizing information documented in Arizona's SACWIS system, the CAMPIS tool will be used to systematically extract identified family needs and concerns from the Child Safety and Risk Assessment (CSRA) and Continuous CSRA (CCSRA) documentation, and will match this data to evidence pertaining to service referrals and service receipt from Arizona's case planning component within the SACWIS system. Due to heavy workload in the field, the CSRA and CCSRA are known to lack detail. Information on identified need will also be gleaned from case notes and the Court Document Directory (which may contain information about services requested and their status), court reports that answer the question of services provided to date or needed, and service authorizations for the services provided. The particular data sources needed in order to complete the tool in the most thorough and accurate manner will be discussed with the Data and Evaluation Team and will be determined as the first case reviews are conducted.

The CAMPIS tool measures service matching by utilizing data collected through the process of detailed case file assessments to determine the level of agreement between child and family needs and concerns,

and subsequent service referrals. The tool will be adapted to capture the match between referrals and service receipt in the same manner it examines the match between need and referral. Data will also be collected on date of referral and first service receipt for the different types of services requested in order to assess the timeliness of service receipt.

Through systematic case file reviews, the CAMPIS tool identifies and subsequently classifies child and family needs and concerns as well as corresponding service referrals into categories including: a) concrete concerns, b) educational concerns, c) emotional and behavioral clinical concerns, d) placement concerns, e) safety concerns, f) general child abuse and neglect concerns, and g) legal concerns. This systematic process provides for detailed outcome measurements, in identifying consistency in matching between family needs and concerns and subsequent referrals and service receipt for system wide services. The matching process will retrospectively identify families where needs and concerns were appropriately matched, as well as instances where a mismatch occurred during the assessment and case planning process. These instances may include children and their families for whom a need or concern was identified without a corresponding service referral, or instances when a service referral was made without identification of a corresponding identified need or concern.

As outcome measurements are made available pertaining to the precision of service matching for children placed in congregate care and their families, the analysis will provide the Department with opportunities for practice modifications. Through CQI efforts pertaining to service provision matching, the Department can ensure that service provision contributes to the best possible opportunities for ensuring that the children are safe, that family well-being remains a long-term priority, and that permanency is established in a timely manner.

Family/Fictive Kin Identification and Involvement

To measure the number of family/fictive kin identified in a case, the evaluation team will collect data from the Family Finding Model (steps one through four) which include the discovery of family members through kinship search and meeting with family members and engaging them in planning and decision making. The evaluation will document the number of family/fictive kin initially named as a case participant in CHILDS (the Children's Information Library and Data Source) as of the most recent placement date and the number of additional case participants named in CHILDS, post Family Finding at

the stage of follow-up and support. Because case participants in CHILDS may include a large number of non-relative persons that may be added to the case (e.g., therapists, BH case managers, GALs, CASAs, Special Ed teachers, probation officers, etc.), only those that carry the role of family/fictive kin will be counted.

The best manner of identifying all found kin and fictive kin will be identified as the case reviews commence. It is possible that adding all found relatives to the Case Participant Directory in CHILDS may be overly cumbersome and an alternate means of identification may need to be devised. Involvement will be identified through case file review and the review will identify the roles and tasks that family members agree to carry out in relation to the case in both the Waiver and comparison cases.

Permanency

In Arizona, legal permanency is defined as one of the following outcomes: reunification, adoption by foster parent, adoption by non-relative, adoption by relative, guardianship by foster parent, guardianship by non-relative, and guardianship by relative. Permanency will be assessed by examining data from the CHILDS system. The best manner to identify permanency in CHILDS is to examine removals with an end date, and one of the following values for removal end reason: reunification, adoption by foster parent, adoption by non-relative, adoption by relative, guardianship by foster parent, guardianship by non-relative, guardianship by relative. Removals that ended for other reasons that are not permanency include: living with other relative, added in error, death of child, transfer to another agency (such as tribal jurisdiction), and runaway. These removal reasons will not be counted as permanency, but will be documented, the frequency reported, and removed from the numerator and denominator in the calculation of permanency.

Safety

Safety will be operationalized as the absence of a substantiated report of child abuse and neglect that occurs within the 12 month period following the end date of the last congregate care placement, plus one week (7 days). The one week lag time is an accepted correction for reports of child abuse and neglect incidents that become known after a child is no longer in a congregate care setting, but that occurred prior to the end of the congregate care placement. Because CHIILDS does not have an incident

date, this has been used as a solution. Safety will be reported separately for those children achieving permanency and those children who have moved out of congregate care into family-like settings such as foster care or living with a relative absent of guardianship or adoption.

Stability

Stability is the absence of a subsequent placement date indicating a removal within 12 months of the congregate care end date. Data to measure stability will also be accessed from a CHILDS extract. Stability will be examined separately for those children achieving permanency and those children who have moved out of congregate care into family-like settings such as foster care of living with a relative absent of guardianship or adoption.

Restrictiveness of Living Environment

In order to systematically identify children in congregate care settings by level of placement restrictiveness, a standardized measure that has the capacity to measure changes in levels of restrictiveness between subsequent placement changes will be utilized. The Restrictiveness of Children's Living Environment (RCLE) instrument is shown in Appendix H. The RCLE was developed in 1992 by Thomlinson and Krysik and is a well-established measure of placement restrictiveness pertaining to children's living environments. The reliability and validity of the RCLE was established through the use of two expert panels, in addition to scale comparison against existing validated measures of environmental restrictiveness. The resulting scale ranks living environments and assigns each placement a restrictiveness value. The measure scores family-based settings as low in restrictiveness, treatment-focused settings such as specialized foster care or group home placement as middle range, whereas placements characterized by psychiatric care in a hospital or behavioral health setting are rated the most restrictive. The measure will be examined for the range of possible placements in Arizona and any adaptations will be reviewed by the Data and Evaluation Committee.

The RCLE does not require child, family, or staff participation, and therefore the information gathered is strictly collected through administrative data obtained through the CHILDS system. At the end of each calendar year, through a restrictiveness score will be calculated for each child. The first score will be that associated with the congregate care placement (P1), and the second will be the restrictiveness score associated with the following placement (P2). P2 will be subtracted from P1 to arrive at the change in restrictiveness score which could be a positive or negative number. Additional placements will be treated similarly. An average change in restrictiveness score can be calculated within county to examine Waiver offices and comparison offices. The distribution by office will be examined to determine whether or not it makes sense to report an aggregate score for the Waiver and comparison offices. Data collection will be cut off September 1, 2019 to allow for preparation of data for the final report. An effort will be made to determine the placement types for children who are placed in detention, hospitalized (medical or behavioral health), and for other types that are not apparent in the CHILDS data base. This may require follow-up with the CHILDS User Group and site specific offices.

Time in Congregate Care

Length of time in care (in days) will be calculated only for those children entering congregate care after the first day of Waiver implementation and who achieve permanency or who move to a family-like placement. The number of days is the difference between the date of placement in congregate care and the date of permanency (as indicated by removals with a removal end date and one of the following values for removal end reason: reunification, adoption by foster parent, adoption by non-relative, adoption by relative, guardianship by foster parent, guardianship by non-relative, guardianship by relative), or for those still in care but placed indicated by 'living with other relative,' or other types of non-group care such as foster care. These data will be extracted retrospectively from the Department's SACWIS system. Extraction will be at the end of each calendar year with a negotiated lag time to allow for completion of data entry after December 31st. The program to extract the data will be developed by the CHILDS User Group and the ASU Evaluation Team. Data will be reported separately for those achieving permanency and those who are still in out of home care in family-like settings. The final report will present a historical analysis for all new entries during the Waiver for the entire period.

Social Emotional Well-Being

The recent CFSR self-assessment process identified the need for practice standards to assess the social and emotional developmental needs of children. A measure is needed that examines constructs such as social competencies, attachment, social relationships, and social and coping skills. The Waiver presents an opportunity to explore available standardized measures, pilot them, and determine their relative usefulness in terms of case planning and opportunity cost. Appendix I displays a table of social/emotional well-being measures under consideration and their characteristics. Through a group assessment process with the Data and Evaluation Team, measures will be selected to pilot and the data will be evaluated with a decision on adoption to be made by DCS the first quarter of 2017. In addition, the sub study described later in the plan will address the validity of the existing standardized measures of well-being. Data will be gathered directly from parents/caregivers/foster parents/ or the adult in the best position to answer questions knowledgeably about the child.

Exit from Congregate Care

The Department produces a weekly spreadsheet of all children in congregate care. This spreadsheet will be used to calculate the monthly rate of exit from congregate care within county by office. Exit occurs when there is a placement end date for a placement type coded as group care. Children in residential treatment and behavioral health group facilities will not be included in the calculation. Placement end dates that are associated with added in error, death of child, transfer to another agency (such as tribal jurisdiction, detention, or hospitalization), and runaway also will not be included as valid exits from congregate care and will not be included in the numerator or denominator of the calculations, however, the frequency of these types of exits will be reported. Exit rates will be presented as a rate per 100 children. Offices will be examined separately, and the decision to aggregate data across offices will depend on an examination of variability among individual offices within the Waiver and comparison offices. Twenty-four monthly congregate care exit rates will be calculated for each office retrospectively for the period prior to Waiver implementation (April 2016) for use as baseline data.

Data Collection

Most of the 10 outcomes are assessed in the Waiver evaluation require the extraction of data from the state SACWIS system. The evaluation team will collaborate closely with the CHILDS User Group to identify available CHILDS data needed to answer the research questions. Once needed data elements are identified, the ASU Evaluation Team will work with the CHILDS User Group to develop the file specifications, extraction procedures, cleaning and quality checks, and security protocols to assure transfer of complete analytic data files. The evaluation team will ensure that data extraction/collection processes and procedures are coordinated with the activities of the DCS's Data Division throughout the evaluation. There will be checks to ensure that placement end dates are entered promptly into CHILDS and a reasonable lag time to access complete data will be agreed upon and communicated to the field by leadership and administration. Incomplete data entry is an acknowledged issue due to workload and as such every child without permanency at the end of the Waiver data collection will be verified. Ongoing quality checks will be done purposively for out of range data as well as at random and the results communicated to CQI. In some instances late data entry will change results that may have been previously reported. Thus data will be labeled as preliminary until the final report.

Although most of the data necessary to address the evaluation research questions are already being tracked in CHILDS, the evaluation team will need some information not currently collected. For example, it will be crucial to have data indicating which children and family members received what services, and the involvement of parents, caregivers, and kin in case planning and informal supports. The ASU evaluation team will also work with the Data and Evaluation Committee to identify the best approach to conduct case record reviews and to access the weekly spreadsheet of children in congregate care.

Research Design

The research design varies across outcome domains and is tailored to answer the research questions and test the stated hypotheses (see Table 6). The overall outcome evaluation approach utilizes longitudinal data at the level of the child and family. Our approach to utilizing longitudinal data offers a robust method. Rather than creating point-in-time aggregate measures which indicate a county's performance on a particular output or outcome indicator, we utilize a cohort approach which tracks

child/family information on particular indicators for entry, legacy cohorts, and calendar year cohorts, and which utilizes the roll out to designate intervention and comparison offices. The exit rate analysis allows for a comparison to trends within offices prior to the Waiver, and controls for other contextual factors outside of the Waiver by comparing offices in the period of the Waiver. Through the presentation of results for multiple offices, evidence that the Waiver was or was not the cause of the change becomes stronger (multiple baseline design).

Sample

The outcome evaluation will focus its attention on analyzing cohorts of children/families as they become eligible for the interventions in their county. If the Department implements at a single point in time, e.g., July 1, 2016, then the evaluation will follow that date as the start date. However, to address the research questions across the full intervention, i.e., to assess the overall impact of the Waiver, the evaluation will construct a database that consolidates all of the children/families (legacy and new entry) across the three counties. We will not include children and families outside the three counties (Maricopa, Pinal, and Pima) other than in the cost analysis because these would not be representative of the predominantly urban counties. Instead, we will utilize within-county comparisons. The sample sizes for all outcomes will be sufficiently large as the population of children in eligible congregate care placements is over 2,000. As the roll out progresses the available sample size for the comparison group will become smaller until eventually all offices will be considered Waiver offices. The Department estimates serving 30 children per month in the first six months, and an additional 60 per month in the following months. See Table 6 for a description of the sample for each outcome domain.

Matching Procedure

Matching was chosen as a technique for sample construction because a relatively small sample size was required to examine three outcomes: services, child well-being, and family involvement. The reason for the smaller sample for these outcomes is that the data collection requires intensive case file review and interviewing. It was also determined that the conditions for matching were feasible. That is, the following conditions exist: there is a pool of cases of sufficient size for matching, common information can be assembled, the information for matching can be obtained reliably and economically, it is possible to measure important outcomes for all cases, and it is possible for the evaluation team to conduct the matching process and document the process. The pool of children to randomly select from for the

intervention group (pool of intervention clients) will be small as the intervention rolls out. The plan is to randomly select 30 intervention cases per year and compare them to 30 matched cases from comparison offices in each of the four years. The pool of potential matches for the comparison group will be relatively large given that over 2,000 children are placed in congregate care. The matching procedure involves: (1) determining the common variables available for the children/families in the intervention group and the pool of potential matches in the non-intervention offices; (2) selecting the most relevant demographic, care history, and program-related variables. Examples of demographic variables that are available include age of child, gender, race/ethnicity, primary language of caretaker, number of siblings, and family structure. Examples of care history variables are number of placements, placement with siblings/or apart from siblings, and age of entry into out of home care. Program related variables include type of placement and primary case plan goal; (3) determination of the hierarchy of importance of the variables (as determined by the FSC Evaluation Committee); (4) set up a method for collecting and updating these variables for cases in the pool, and (5) monitor the cases to determine if and when the comparison status ends (i.e., the child may become an intervention case).

We anticipate that there will be a great deal of variation in the intervention sample given that the age of the children span from birth to young adult. Arizona proposes to use propensity score matching to create a one-to-one matched sample. However, as opposed to matching the group of 30 randomly selected children each year, we propose to match the entire waiver-eligible population in the intervention offices (beginning with the Avondale and Tempe sites). As the random selection of intervention children proceeds from the sampling frame of those families who are served by the Family Engagement Specialists, the matched partner from a comparison office will be included in the matched comparison group (n = 30) in each year. This sampling procedure will be repeated as long as there is a sufficient pool of comparison group children available to conduct the matching procedure.

Table 6. Research Design and Sample by Outcome Domain

Outcome Domain	Research Design	Sampling Method
Identification of child/family service needs matched with service referrals and timely service access.	Two-group, matched sample design (matching criteria include county, child's age, race, gender, type of placement, family structure, and primary language).	Create a matched sample using PSM from within-county comparison offices. Random sampling of children served by the FES in intervention offices will be stratified by waiver practice (with at least 10 of each TDM, Family Finding, and service only being randomly selected) Total sample is 60 per year for four years (N = 240) with ½ from each condition.
Increased number of family/fictive kin identified and involved in the case.		
Legal Permanency	Two group, retrospective comparison.	Population, analyzed by county for calendar year cohorts and aggregated for the final report. Safety and Stability will not be examined for the 2016 cohort until the end of 2017 to allow 12 months of follow up. Children are classified as intervention if case managed through an office that is part of the roll
Safety: substantiated reports post permanency		
Stability: re-entry post permanency		
Restrictiveness of Living Environment		

Outcome Domain	Research Design	Sampling Method
Days in congregate care for those achieving permanency and those stepping down to a less restrictive form of care.		out 1 month prior to date of permanency. Will examine legacy and new entries separately.
Social/emotional well being	Prospective, two-group, matched comparison	New entries only. Random sampling in intervention offices and matched on case characteristics to cases in comparison offices within county. N = 60 split between intervention/comparison and stratified by county (n =20). If measure adopted and added to CHILDS in 2017, will analyze for population.
Rate of Exit from Congregate Care	Pre/post intervention within office and two-group comparison within county	30 months of pre intervention data points per office. Population for all months from point of implementation through December 2019.

Data Analysis

A variety of data analytic approaches will be used which will vary by outcome domain as shown in Table 7. Effect size calculations will be made for all outcomes and will be selected based on level of measurement. Data analysis will be carried out with SPSS software, EXCEL, and Atlas ti for qualitative data.

Table 7. Analysis by Outcome Domain

Outcome Domain	Analysis	Controls
Identification of child/family service needs matched with service referrals and timely service access.	Examines proportions of matches and mismatches pre/post, and intervention/comparison. Analysis by county and aggregate. Case narrative analysis.	Components of intervention (TDM, FF, service array).
Increased number of family/fictive kin identified and involved in the case.		
Legal Permanency	Descriptive analysis on number and proportion by county and aggregate. Multivariate modeling with logistic regression for binary outcomes on permanency, safety, and stability. Linear regression for continuous outcome including change in	Intervention components, race, age, county, type of permanency.
Safety: substantiated reports post permanency		
Stability: re-entry post permanency		
Restrictiveness of Living Environment		

Outcome Domain	Analysis	Controls
Days in congregate care and out of home care	restrictiveness and time in congregate care and out of home care.	
Social/emotional well being	Paired sample t test for pre/post and independent sample t-tests for between groups.	Examine separately for race, age, and time in care
Rate of Exit from Congregate Care	Empirical methods of outlier detection for baseline data points, plot of baseline trend line. Analysis of rate change using 2-standard deviation method for single subject research.	Analysis by office, intervention and comparison.

Tasks and Timelines

The outcome evaluation will include the following major tasks:

1. Develop a protocol describing all data elements and data collection points. The complete protocol will include procedures for collecting all required data and processes for monitoring data collection including data extractions from CHILDS. Any necessary training or guidance on the evaluation will be developed during this period by the ASU Evaluation Team and will continue as needed

2. Establish a data sharing agreement with the Department that outlines publication parameters including DCS right to review and approve manuscripts prior to submission for consideration of publication or presentation.
3. Develop programs for data extraction from CHILDS and negotiate dates for data downloads to continue on an annual basis through the evaluation period up until an agreed-upon point when data collection ceases to allow time for final analyses and reports. This will be dependent in part on the time lag for the entry of complete data. The ASU Evaluation Team will work closely with the CHILDS User Group for consultation and data validation testing.
4. Develop procedures for data quality checks in preparation for the first CHILDS download, and protocols for discussion of any data-related issues (point of contact, means of communication, etc.) A data management plan will be developed and implemented in this phase as well. The Department will be primarily responsible for the data quality checks and for the creation and submission of the analytic files to ASU. However, ASU also performs extensive integrity checks on CHILDS downloads which may result in re-requests.

The following timeline in Table 8 is an estimate and will be further developed as the intervention specifics and implementation plans are finalized.

Table 8. Timeline for Outcome Evaluation Tasks

Eval. Task	Year 1/2016			Year 2/2017				Year 3/2018				Year 4/2019			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Identify all data elements and develop code book and data bases															
Access social Emotional Well-being measures and develop protocol															

Develop data sharing agreements and IRB applications															
Develop CHILDS programming for data extracts															
Develop data protocol and quality check plan															
Secure data storage space, software															
Mock tables and plan for analyses															
Data collection in field (case reviews)															
Analyses and reporting															

Reporting

In addition, the outcome evaluation will contribute to all reports as noted in Table 9. All reports will be due on the last day of the month.

Table 9. Outcome Evaluation Tasks for Required Reports

Required Report	Outcome Evaluation Tasks
Quarterly reports (Every 3 months)	• Describe efforts to collect data • Provide initial data analysis
Semi-annual reports (Every six months)	• Update on potential problems/challenges and recommended solutions

Interim Evaluation Report	• Describe study design and research questions. • Provide preliminary statistical work indicating equivalence between demonstration and comparison children. • Provide preliminary outcomes analyses.
Final Evaluation Report	• Provide full outcomes analyses as delineated above.

Cost Evaluation Plan

The flexibility allowed under the Waiver is intended to open Title IV-E funds to a greater variety of uses. The flexible funding will stimulate investments through the intervention practices that are the core focus of the Waiver: TDM, Family Finding, and service array. The cost evaluation will have two foci that will illuminate the financial impact of the Waiver, one at the systems level and the other at the individual level, both which will involve a simple cost analysis.

Systems Level Cost Analysis

At the system level, the primary research questions is:

1. What was the effect on expenditure patterns for the Department (e.g., did costs change among categories of placement types?) Did DCS service costs change (increase/decrease within categories)? Examples of DCS services and contracted services include the In-Home Service Program by service type and contracted services such as counseling, parent aid, and AZ Families F.I.R.S.T. (substance abuse treatment)?

Case Level Cost Analysis

At the case level, the primary research questions are:

1. What is the average change in placement cost associated with a one-unit increase or decrease in restrictiveness?
2. Is the change in placement cost over time associated with the intervention?

Individual level placement cost data are available from CHILDS and will be used to calculate the cost of placement per child. The analysis will relate cost per placement to changes (increases or decreases) in restrictiveness of placement. The design, a simple cost analysis, will compare the change in restrictiveness between children in the Waiver and children in the comparison group, with associated changes in placement cost over time

Research Design

The ASU evaluation team has met with DCS financial staff to determine the availability of cost data. The analysis will be reported by yearly cohort and the comparison group will be children served by those offices yet to implement the Waiver within county.

Scores from the standardized measure RCLE will be considered in relation to the individual cost of placement for each child, and the cost savings associated with a unit of decrease in restrictiveness will be calculated, as will cost increase of an increase in restrictiveness. A comparison will be made across intervention and comparison sites by yearly cohort. For instance, for each placement there is a restrictiveness value, a number of days in placement, and a cost per day of placement. The cost per day will be multiplied by the number of days in placement since the start of the Waiver in 2016 and the last day of placement or the last day of 2016, whichever is first.

Cost Database

In collaboration with the Department, the ASU Evaluation Team will develop and utilize a cost database specifically for the cost evaluation. The database will provide the flexibility to compare Department spending for the systems analysis to their own history (for instance, one to three years, baseline yet to be decided). The creation of this database will take place in four steps:

- Step 1: The evaluation team will collaboratively define the expenditure elements in consultation with the Department. For example, there are a limited number of behavioral health providers agreeing to provide services to non-Title XIX eligible children. The DCS psych services contracts are accessed when needed to provide these services, and that funding will also need to be included in this computation. The ASU Evaluation Team will work with the Department financial staff and the Data and Evaluation Team to consider all DCS expenditure elements.

- Step 2: The team will assess the available administrative data resources for their appropriateness to answer the research questions. The point of data capture for each yearly cohort will need to be determined and cost data will be included up to the end of 2018 to provide sufficient time to develop complete records for analysis is 2019 and reporting in January 2020.

- Step 3: The Department will then either modify existing data capture mechanisms or create a database structure for the cost study. In collaboration with the Department, the evaluation team will then collect this data for annual cohorts from implementation through the end of 2016, 2017, and 2018.

- Step 4: The database will be populated with all the information. It will be updated annually. The cost study will provide information on any costs that are not included.

Cost Comparison of Key Elements of the Intervention

A simple cost analysis will be conducted to estimate the cost of decreasing restrictiveness of living environment (as indicated by a finding of permanency; and for those not achieving permanency, a move to a family-like setting). To the extent feasible, the second part of the cost evaluation will use the individual level data in the database created above to compute the costs associated with a group of children and families who were served by the Waiver intervention and who received or did not receive (TDM, FF, and in home services).

Data Sources and Data Collection Procedures

The section above delineated much of the detail related to the collection of data elements needed for the two parts of the cost study. With respect to data sources, the cost evaluation will utilize data collected as is feasible, from existing DCS data sources. The evaluators will work with the Department to design, a simple, annual data collection process to capture direct expenditures. As with the other evaluations to be conducted, the evaluation team will take advantage of existing data resources with common identifiers to make use of efficient analytic files that can be used to answer core questions and provide the flexibility to revise or target those questions.

Data Analysis

For the analysis of changes in expenditure, the evaluation team will focus on exploring whether there are significant differences in spending patterns within the three initial demonstration counties (Pima, Pinal, Maricopa) over time. This will take the form of a simple cost analysis. The impact of counties and regions not aligning, as described in the introduction, on the cost study will be explored with DCS

financial staff and any workarounds will be described along with the potential impact on the data. The analysis will be conducted using SPSS.

Next Steps

The Cost evaluation relies on the Department to carry out the following tasks:

1. Present and explain to evaluation team all Department and other relevant sources of expenditure data by expenditure category.

2. Make available Department staff for consultation to obtain clarification and additional data as necessary.

3. Design target database and populate with data from prior to the Waiver by county (systems level data).

4. Design target database and populate with data at the point of Waiver implementation for individual level data.

5. Develop and utilize any data collection template to assure comprehensive compilation of needed data each year.

6. Make available Department staff and providers for consultation to obtain clarification and updated data as necessary.

Tasks and Timelines

Table 10 outlines the major tasks and timelines for the cost study.

Table 10. Timeline for Cost Evaluation Tasks

Evaluation Task: Cost Evaluation	Year 1/2016			Year 2/2017				Year 3/2018				Year 4/2019			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Identify all data elements and develop code book and data bases															
Download pre Waiver cost data supplied by DCS and clarify definitions and missing or unclear data															
Compile and analyze retrospective cost data and data at the end of each year accounting for lag time															

Describe alternative use of funds /contracting under the Waiver															
Quarterly reports															
Semi-annual reports															
Interim/final evaluation reports															

Reporting

Table 11 describes the content of the cost study for the different types of reports.

Table 11. Cost Evaluation Tasks for Required Reports

Required Report	Outcome Evaluation Tasks
Semi-annual reports	• Update on process and progress of county-level collection of expenditures data. • Potential problems/challenges and recommended solutions
Interim Evaluation Report	• Compile and analyze the data from the pre-Waiver period and data from the post-Waiver period • Describe any changes in contracting that may influence cost. For example, there are draft scopes of work for both group home and shelter contracts being proposed. Burns & Associates is doing a cost study to determine appropriate pricing, which are required prior to the RFIs/RFPs being released, which may include basing rates on the age of the child (a new practice). The shelter contracts expire May 2016 and the group home contracts expire October 2016 and they may be extended. Currently there is no cost differential for age specifically.
Final Evaluation Report	• Compile and analyze cost data from all years of the cost evaluation (2016-2018), conducting the analysis for the entire Waiver period to include the simple cost analysis at the systems level and the individual level.

Sub-Study Plan

The Waiver evaluation provides a unique opportunity to build knowledge in an under-developed area of child welfare practice, specifically the assessment of child well-being as an outcome. Through existing data collection proposed in the process evaluation (parent/caregiver and child interviews) and the outcome evaluation (measure of social/emotional well-being), we propose to investigate the following research questions:

1. How do parent/foster/kin caregivers, kin/fictive kin members, and congregate care providers conceptualize well-being for their children?
2. How do children (age 12 and older) conceptualize their own well-being?

3. What are the content validity, face validity, and sensitivity of select standardized measures of child well-being among children and adolescents living in congregate care?

Child Well-Being Measurement

There is considerable scholarly and political interest in perspectives of healthy development among vulnerable children and adolescents (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002; Lerner, Dowling, & Anderson, 2003) and a growing understanding that such perspectives represent an important and necessary shift in how we assess and intervene with vulnerable children and adolescents. For example, there has been movement at the federal level to make child well-being an outcome of interest (ASFA, 1997) and the recent adoption of a well-being framework by the Administration for Children, Youth and Families (ACF, 2012; Lou, Anthony, Stone, Vu, & Austin, 2008). However, less attention has been given to developing measures of the complexity of risk and well-being among young people involved in child welfare that could be used to inform practice.

In our prior review (Lou et al., 2008) we located measures that have been developed and tested for specific areas of child well-being (such as socio-emotional, intellectual/cognitive, and physical development) that might be relevant in a child welfare context. However, subsequent studies (Anthony & Stone, 2010; Anthony & Booth, 2015) suggest greater complexity in measuring child-well-being and the need for parent/caregiver and child perspectives on child well-being. The opportunity to interview parents/caregivers and children in the Waiver evaluation enables a content and face validity analysis of the relationship between items from the standardized tool of child well-being and parent/caregiver and child perspectives. The longitudinal design also enables examination of the measure's sensitivity to change over time. Table 12 summarizes the sampling, measures, and data sources and data collection procedures for the sub-study.

Table 12: Sub-Study Research Questions and Data Collection/Analysis

Research Questions	Sampling Plan	Measures	Data Collection/Analysis
1. How do parents/caregivers define well-being for the children under their care?			
	Random sample of parent/foster/kin caregivers, kin/fictive kin members, congregate care providers	Semi-structured interview guide	Field-based interviews; Constant comparative analysis
2. How do children (age 12 and older) conceptualize their own well-being?			
	Random sample of children age 12 and older	Semi-structured interview guide	Field-based interviews; Constant comparative analysis
3. What are the content validity, face validity, and sensitivity of a measure of child well-being among children living in congregate care?			
	Random sample of parent/foster/kin caregivers, kin/fictive kin members, congregate care providers	Child Well-Being Measure-Social/Emotional	Psychometric testing; Content analysis

Research Design

The sub-study will employ a longitudinal exploratory design that examines parent/caregiver and child (age 12 and older) perspectives on the measurement of child well-being in relationship to a standardized measure. The design enables an examination of the content validity and face validity of standardized measures of child well-being for their utility among a sample of children and adolescents living in congregate care settings, and the sensitivity of these measures to change over time.

Sampling

The random sample for the sub-study utilizes the same parent/foster/kin caregivers, kin/fictive kin members, and congregate care providers and children aged 12 or older from the process evaluation

sample. The parents/caregivers who are randomly selected to participate in the engagement/satisfaction component of the process evaluation will be asked questions about how they would conceptualize child or adolescent well-being for their children. Children age 12 and older will be asked how they conceptualize well-being for themselves.

Measures

For the sub-study, three different measures will be utilized. First, the child well-being measure that is selected as part of the outcome evaluation will be employed. Second, a semi-structured interview guide will be developed once the child well-being measure has been selected for pilot testing. While the final interview guides will be developed after the measure is selected, the parent/caregiver interview generally will ask parents/caregivers about different domains of well-being (social/emotional, cognitive, physical, etc.) and how parents/caregivers measure well-being for the children in their care in the multiple contexts of their life (home, school, community). The interview guide will also ask parents/caregivers to prioritize the most important aspects of child well-being for their children. Third, the child interview guide will address similar areas, in a developmentally-appropriate format.

Data Sources and Data Collection Procedures

To ease the data collection burden, the data sources and data collection procedures for the sub-study will employ sources and procedures already in place from the process and outcome evaluations. The sub-study will utilize data that are gathered from the administration of the standardized child well-being instrument. The sub-study will also collect data from parents/caregivers using the semi-structured interview guide as part of the field interviews conducted as part of the process evaluation.

Data Analysis

For data collected from the semi-structured interview guides, analytic procedures will follow the method of constant comparative analysis (Lincoln & Guba, 1985) during which initial codes are developed from the local language (in-vivo codes) of the participants. The initial use of in-vivo codes is especially important in analysis of client data as it allows the parent/caregiver and child voice to come through the analysis. The second level of coding will assess the in-vivo codes for commonalities across the participants. At this stage of the analysis, general categories will be developed, such as aspects of

child well-being that were commonly described. Further analysis of the in-vivo codes and quotes for their support of the initial categories will result in maintenance of some original categories and the combination or removal of other categories as necessary. A fourth round of analysis will examine the codes and quotes in each category for further commonalities within each category. This will provide the final results that will be compared to the categories of well-being in the structured interview guides.

The psychometric properties of the child well-being measure will be analyzed, and content analysis will be used to examine the face validity and content validity of the measure based on parent/caregiver and child feedback.

Tasks and Timelines

The sub-study will include the following major tasks:

1. Develop the semi-structured interview guide once the child and adolescent measurement instrument has been selected.
2. Collect parent/caregiver and child data as part of the process evaluation.
3. Conduct analysis of parent/caregiver and child data and standardized measures.
4. Report on the content validity and face validity of the standardized measure, and the sensitivity to change over time.

Reporting

Table 13 summarizes the reports required for the Sub-Study for each task area.

Table 13. Sub-Study Tasks for Required Reports

Required Report	Sub-Study Tasks
Semi-annual reports	• Report on number of parents/caregivers and children interviewed • Report on number of child well-being measures collected
Interim Evaluation Report	• Compile and analyze data on content validity, face validity, and sensitivity from start of Waiver until interim report
Final Evaluation Report	• Compile and analyze data on content validity, face validity, and sensitivity for entire report period

The Waiver Evaluation Team

In contracting for the Title IV-E Waiver evaluation, the Department has chosen a partner in the ASU School of Social Work. ASU will provide critical and ongoing support to the Department through collaboration directly with key state-level staff and as the evaluation progresses to other critical community and Waiver partners. ASU works from the assumption that collaboration enhances communication, continuous quality improvement, and effective teamwork. Our approach to evaluation incorporates the (Rossi et al., 2011) view that stakeholder engagement and ongoing involvement is critical to improving the utilization and impact of evaluation. Our plan incorporates a formal structure of collaboration and communication to empower stakeholders and provide timely feedback on evaluation activities. To this end, we are in the initial stages of forming an *Evaluation Advisory Committee* with members from within the evaluation team, the Department, other community stakeholders. This collaborative group will have advisory responsibilities and will provide leadership and communication with regard to the evaluation.

Below, we describe the structures that are currently in place or are under development that will be key to the evaluation, as well as the ways in which we envision working with them. Collaboration with these and other groups within the state will ensure that the evaluation design meets the

expectations of key state staff who have particular responsibilities related to the Waiver evaluation, and will provide a vehicle to insure that all parties within the state are kept apprised of evaluation activities.

The Statewide Implementation Team. The Department has established a stakeholder collaborative—composed of state officials, regional and county stakeholders, key agency partners (mental health and behavioral health representatives, juvenile court, child advocates), and representatives of foster parents, kinship caregivers, parents and youth. This group will be requested to provide representation to the Data and Evaluation Committee.

The Data and Evaluation Committee. This group includes those members of the Statewide Implementation Team who are more directly engaged in the evaluation and communications. ASU will work closely with the Data and Evaluation Committee around data collection, data system capabilities, and quality assurance efforts. The ASU evaluation team will work with the Data and Evaluation Committee to review components of the evaluation including the overall plan, surveys, process and outcomes measures, review preliminary findings related to process, outcome, and cost evaluations and the sub study, and to discuss ways to address challenges, possible requirements of modifications of the original plan and any other aspects of the evaluation process that are appropriate. This Committee will advise the evaluation team in planning and carrying out its evaluation activities, especially in minimizing data collection burden, but and will also be instrumental in orienting stakeholders in the counties, and at the state level, to the purpose and value of the Waiver and its evaluation. Monthly meetings between this group and the ASU evaluation team will be essential to maintaining good communication and a trusting relationship among the parties.

CHILDS User Group. This group is designed to engage with the Waiver counties, the evaluators, and the Department to understand and utilize the Department's database (CHILDS) to enhance the Waiver implementation and assure that this critical component of the Waiver can be leveraged for success. CHILDS is an important asset for the evaluators. This collaboration will help us to assess the applicability and need for modifications to the CHILDS for purposes of the evaluation, ensuring a full understanding of data elements, and establishing protocols for data extraction and transfer, including the responsibilities of all parties. The evaluators have already

been working closely with the key CHILDS administrators in the Department and expect that going forward the Waiver CHILDs User Group will serve to support and enhance the data collection for the evaluation.

Program Development Unit. ASU's prime source of contact will be through the Supervisor and staff of the Program Development Unit.

Technical Assistance

The Children's Bureau offers a variety of resources through its Capacity Building for the States Collaborative. The Department recently participated in a capacity assessment visit with the Collaborative and is now engaged in a technical assistance phase to build capacity. The evaluation team will draw on the services of the Collaborative as the Department finalizes the details of the intervention, the plan for implementation, and as a result refines the theory of change and the logic model. James Bell Associates (JBA) is available to assist with advice on measures and other aspects of the evaluation.

Key ASU Personnel

The evaluation team is comprised of ASU faculty and evaluation staff from the School of Social Work and the Center for Child Well-Being. Our approach emphasizes open lines of communication among principal investigators and across partner organizations. Expertise and staff are shared across evaluation areas in order to create a cohesive approach to all evaluation activities, ensure that program expertise is utilized optimally, and the skills of all staff are well utilized. Please refer to Appendix J for expanded bios.

Deliverables and Timelines

All members of the evaluation team will participate in developing and writing a total of seventeen (16) reports—3 quarterly reports the first year (2015-2016), 8 semi-annual reports (2016, 2017, 2018, 2019), 4 annual reports (2016) (2017) (2018) (2019) and one final summative outcome report (January 2020). The quarterly and semi-annual reports will provide a process evaluation and fidelity review for each intervention and evaluation research question. First year quarterly reports and second year semi-annual reports will contain more descriptive information, whereas reports in later years will have more comprehensive quantitative data on outcomes.

The Interim Evaluation Report, due June 2018, will outline any mid-Waiver results as well as provide a detailed description of the accomplishments to date. This report will include information on process, cost and outcome evaluation progress and include some preliminary outcome analysis (see "Tasks and Timeline" discussions in each evaluation section above). In addition, the report will discuss any challenges encountered and how those have been or will be resolved, and identify any future issues anticipated. The Final Report, due January 2020, will present detailed final results in each of the three evaluations (process, outcome, and cost) and will offer a comprehensive description of what occurred over the course of the entire Waiver period. This final report will integrate the process, cost and outcome evaluations.

Quality Control and Human Subjects Protection

The ASU team has several layers of quality control in place to ensure the integrity of data and to make certain that results are conveyed with the utmost adherence to accuracy and precision. ASU has developed procedures and safeguards for data quality. As an experienced research University, ASU maintains the highest standards for data integrity with exceptionally qualified staff and oversight procedures for staff work.

Clear guidelines have been developed and documented that define conventions for labeling and filing, how editorial changes in drafts are managed and the development of tables, graphs, and charts. ASU has access to the most sophisticated software for charts, graphs, maps and other visual data. The ASU team will also assure the highest quality production of reports for clarity, consistency, and readability – and to align reports with the federal standards promoting the use of plain language.

The ASU Evaluation team will comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. ASU will follow ASU protocol for IRB approval and submit an application for expedited review based on the research that involves minimal risk to the subjects: research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b) (2) and (b) (3). This listing refers only to research that is not exempt.) (ASU

Office of Knowledge Enterprise Development, Research Integrity and Assurance (https://researchintegrity.asu.edu/humans).

The ASU evaluation team will prepare the necessary evaluation protocols and supporting documents, including consent forms, and will submit a formal IRB package to the ASU IRB (Institutional Review Board) for approval. The specific steps in the application process for expedited review are:

The research Principal Investigator (PI) submits an application containing the following elements:

- A full description of the research protocol and study personnel;
- Identification of any risks;
- Disclosure of any financial interests;
- Security and privacy protocol for data;
- Consent forms and data collection instruments;
- Recruitment materials and any foreign language versions of the materials for subjects.

The IRB review shall be conducted by the IRB chairperson or by one or more of the experienced IRB members designated by the chairperson to conduct the review. The IRB member conducting the expedited review may exercise all of the authorities of the IRB except that the reviewer may not disapprove the research. The reviewer shall refer any research protocol which the reviewer would have disapproved to the Full IRB for review. The reviewer may also refer other research protocols to the Full IRB whenever the reviewer believes that Full IRB review is warranted. IRB approval will be obtained prior to engaging in any data collection. ASU will provide as a condition of award, documentation of IRB approval and that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP).

Data Protection, Privacy, Storage and Security

In accordance with ASU standards for human subjects review, ASU staff will adhere to precautions to protect participant privacy, confidentiality of information provided by respondents, and reduce risks and discomforts that might result from participation in the study. ASU requires all staff to sign confidentiality agreements and to complete the CITI human subjects training upon employment. ASU will hold the master key of participant names and unique identifiers for use in tracking cases,

connecting CHILDS data, and de-identifying data. CHILDS data will be requested by ASU, de-identified, and information will be entered into a secure server. De-identified data utilized by ASU will be kept on a secure, password protected network for storage and analysis. Audio recording devices, interview notes, and hard copies of interview notes will be kept in locked file cabinets in a locked room, in the secure facility at ASU's School of Social Work Center for Child Well-Being at the downtown campus. Data tapes will be prepared following the instructions of the Children's Bureau.

Interviews will be transcribed, de-identified, coded, and kept in electronic files on computers that are password protected, on the secure network, and kept in secure offices to which only authorized staff has access. All identifying information will be kept separately from the transcribed interviews with password protection. Responses to the interviews will be reported in aggregate form so individual answers will not be connected to a specific interview. Interview participants' identifying information will be retained up to three months after acceptance of the first scholarly journal article; coded data that does not have identifying information will be retained indefinitely for scholarly purposes and future contributions to the field. For data identified for disposal, appropriate measures will be taken when disposing of data, electronic data will be deleted from office computers and primary location of storage in the network drive, hardcopies and CDs or other devices containing data will be shredded and disposed of in accordance with ASU policy.

Consent Procedures

All consent forms will be developed in accordance with ASU IRB protocol. Consent forms include the following required elements:

- The purpose of the informed consent;
- Identification of the investigator;
- Description of the study procedures;
- The voluntary nature of participation;
- The absence of any penalty for not choosing to participate;
- The benefits and risks involved in participation;
- The protection of data confidentiality and privacy;
- Additional information if the participant has questions;
- Place to give written consent to participate in a research study;

- Risk/benefit discussion; and
- Any risks of participating in the evaluation fully explained.

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Appendix A: Logic Model

INPUTS

Children birth to 18 years currently placed in or entering congregate care in Arizona

Parents/Caregivers/Kin/Fictive Kin

DCS Staff and Leadership including CQI, Placement Coordinators & Family Engagement Specialists

DCS Policy and Procedure Guides

Out-of-Home Care Providers

Service Providers (Behavioral Health, DCS, Community)

Foster Care Providers

DCS Training and Data Units

Federal Agency funding and technical assistance (e.g., Children's Bureau/Center for States, JBA)

Other stakeholders (e.g., state legislators, courts)

OUTPUTS

Number and type of TDM meetings, Blended Perspective meetings, action plans

Family search (Seneca and Family Locate)

Identification of service needs and matching of needs to service referrals

Family satisfaction

System-level
Waiver communication
Readiness
Collaboration
Fidelity of intervention
Contracts

SHORT TERM OUTCOMES

Increase in parent/caregiver and child > 12 years participation in case plan development (TDM)

Increased number of family/fictive kin available (Family Finding)

Increased involvement of family/fictive kin (Family Finding)

Increase in timely service receipt to meet identified need of family and child (Service Array)

Increase utilization of in-home, community, and behavioral health services to support reunification and aftercare (Service Array)

INTERMEDIATE OUTCOMES

Increase in reunification and other types of permanency (P)

Decreased length of stay in congregate care (P)

Increased rates of exit from congregate care (P)

Lower restrictiveness of living environment for children in congregate care (WB)

LONGER TERM OUTOCMES

Reduction in congregate care (WB)

Improved child social/emotional well-being (WB)

Fewer substantiated re-reports and re-entries to out of home care post permanency (S)

Cost savings from less time in congregate care

Change in expenditure categories as DCS In-Home Service Program expanded

P = Permanency
WB = Well-being
S = Safety

Appendix B: Waiver Implementation Context

The Department of Child Safety is a relatively new organization that has experienced both external stakeholder pressure (e.g., legal challenges), and internal pressure (e.g., staff turnover at every level including leadership). The planning for the Waiver has coincided with a structural and functional reorganization of the Department, commanding resources and focus. Efforts have resumed to complete the design of a practice model to incorporate the Strategic Plan, along with the revision of existing processes and practices to promote better outcomes for children and families. The Waiver planning has, in many ways, served as a catalyst to promote innovation. It is important to keep in mind that although Arizona is selecting an intervention, other reform elements as described in the Strategic Plan and the CFSR self-assessment may be important to the goal of reducing congregate care. These non-Waiver activities that occur within the Department and outside through partner agencies, state, local, and legislative changes serve as significant context for the implementation of the Waiver interventions, and may directly or indirectly affect the evaluation of the Waiver. The process evaluation will take these non-Waiver interventions into account by including them and other upcoming initiatives in the description of context. Data to update the context will be gathered through interviews with key stakeholders, meetings, and other publications. The outcome evaluation will account for the potential effect of these initiatives through tailored design features.

Implementation of a Practice Model

Arizona continues to work on the development of a child welfare practice model. This model along with the Department's Strategic Plan articulates the Department's vision, mission, and values; identifies best practices; and creates a level of expectation regarding the overall approach to working with Arizona children and families. In relation to the Waiver, the practice model will define child and family engagement, as well as overall community engagement. Once the practice model is finalized, DCS will provide additional information to the Children's Bureau about how this base will further support the Waiver.

Engagement of the Community

Strengthening families is a community effort and requires a team approach in which roles and responsibilities are clear. Effective partnerships require a commitment to create and support meaningful connections in a safe and nurturing environment for children, youth, and families. Community engagement includes both the ongoing development of a community-based service array

that meets the needs of children and families, and the active engagement of community supports such as faith-based organizations, schools, and other community organizations. Arizona is currently engaged in a Safe Reduction effort led by Casey Family Programs in Maricopa County where several subgroups are working on community engagement, consistent decision making, targeted services, and other related efforts to safely reduce the number of children in out of home care. The KARE Centers in Pima and Maricopa Counties are examples of this community work.

Targeted Permanency Roundtables

Establishing timely permanency for children placed in out of home care is both a state as well as a national priority. In response, the Department has established permanency roundtables to develop permanency plans for targeted children, stimulate critical thinking, learn about pathways to permanency, and identify barriers to successful permanency. The targeted permanency roundtables hosted by the Department are part of a larger system-wide effort to improve permanency timeliness through professional development, policy transformation, resource development, and system partner engagement. The model offices are also involved with Targeted Permanency Staffing efforts.

Strengthening Clinical Supervision

In collaboration with ASU and Yale University, the Department plans to improve practice through the strengthening of clinical supervision techniques for supervisory and management staff, with a focus on the safety and risk assessment process. Accurate use of the state's Child Safety and Risk Assessment tool and consistent decision making throughout the entirety of a family's involvement in the child welfare system will be important in the identification of families' strengths and needs.

Specialized Training

Developing a highly trained workforce is essential to the mission of the Department in ensuring the safety, well-being, and timely permanency of children involved with the state's public child welfare system. The Department has been working in collaboration with ASU to strengthen existing case manager and supervisor pre-service training, as well as to develop advanced training to enhance the on-going practice of front-line staff and supervisors. The Department is currently moving towards further expansion of the training curriculum efforts in implementing specialized training tracks for front-line staff based on unique needs of specialized positions within the agency.

Trauma Informed Training

Addressing the needs of Arizona's child welfare involved families requires a comprehensive approach to practice which examines each family using a trauma informed lens. The use of a trauma informed lens in child welfare practice has the potential of improving family engagement, enhancing risk and safety assessments, and developing more comprehensive case plans with targeted service provision. The Department is currently working towards further developing the skills of front-line staff through pre-service and advanced trauma-informed training provided by the Department's training component, the Child Welfare Training Institute.

Hotline Report Decision Tool

The centralized State of Arizona Child Abuse Hotline is the first point of contact into Arizona's public child welfare system. Arizona has been actively engaged in improvement efforts at the Child Abuse Hotline, and significant enhancements in streamlining practice and improving efficiency have resulted in shorter wait times for callers, and initiation of several automated processes. As practice improvement efforts continue, the Department has moved forward with the development of an enhanced standardized report decision tool with support of internal staff and community stakeholders. This modified tool is intended to standardize decision-making amongst Child Abuse Hotline Specialists, and shift child vulnerability to the centralized focus of decision-making.

Enhanced Engagement

Engagement in child welfare services has been associated with multiple positive outcomes for children and families across psychosocial domains. Arizona has continued to work towards improving frontline case manager and supervisor skillsets as it pertains to engaging with children and families involved in Arizona's child welfare system. In collaboration with ASU, the Department has developed an advanced engagement curriculum for use in improving engagement with child welfare involved families and system partners. In addition, an emphasis on family engagement has been infused into system-wide change in the Department's vision mission and values as well as several additional agency initiatives.

Increase the Accuracy of the Safety and Risk Assessments in Investigations

Arizona has integrated the Child Safety and Risk Assessment tool into multiple levels within the Department in order to standardize practice, and ensure that a child's safety is accurately and consistently assessed across the lifespan of a child welfare case. To accomplish this, the Department

has initiated several on-going efforts to ensure that established protocols and assessment measures are being implemented and applied with fidelity across the workforce, and that utilized measures are both reliable and valid. Several enhancements have been made to practice including the institution of a removal review guide, revised safety and risk assessment documentation tools, as well as administrative and clinical supervision guides for use in practice monitoring and supervision. In addition, the Department has engaged Department management in several new initiatives designed to increase the accuracy of risk and safety assessments including multi-disciplinary team reviews of fatality and near fatality cases, and expansion of considered removal Team Decision Making meetings.

Streamline Foster Care Licensing Process

Kinship placements do not need to be licensed, they only need to have a home study that is approved by the court. They do not need to go through OLR or PSMAPP. They are encouraged to do so, however, in order to be able to provide them with additional funding and support that comes with being licensed. Arizona currently has a standardized process to become licensed as a foster care or kinship placement. In its current format, potential licensed foster and kinship providers engage in a comprehensive background and home-study process with DCS-contracted licensing agencies, which requires completion of a standardized 30-hour training curriculum, PS-MAPP (Partnering for Safety and Permanency-Model Approach to Partnerships in Parenting), all of which are then submitted to the Office of Licensing and Regulation (OLR) for license processing. The Department is in the process of modifying the foster care licensing process by substantially reducing the amount of time necessary to complete the licensure process through the establishment of a revised 15-hour initial training curriculum to be followed by 15 hours of advanced training over the following two years, elimination of unnecessary documentation, and improving coordination between the community-based licensing agencies and the state Office of Licensing and Regulation.

Increase Number and Availability of Foster Home Placements

Recruiting and retaining foster parents in Arizona has been an on-going effort of the Department in coordination with community based providers and child welfare stakeholders. Children thrive in family-like settings that have the ability to meet their biopsychosocial needs, therefore the Department's placement preferences and Federal law require field staff and supervisors to utilize placements for children in out of home care that are least restrictive. The Department continues to

coordinate with community based providers and stakeholders to increase awareness and interest in foster parent licensing through the community based Arizona Kids Consortium and state administered foster care and adoption KIDS NEED U program. In addition, the Department has continued to engage in active retention efforts for existing foster parents through advanced training, enhanced collaboration, and increased Department support.

Increase the Number of Children Placed in Kinship Placements

The Department has identified kinship care as the preferred placement option for children entering out of home care. These placements with relatives and fictive kin provide many benefits for children separated from their parents, by providing support and frequent contact with birth parents and siblings. Relative and fictive kin placements are able to provide increased stability for children in their care, and are more likely to have the ability to accept sibling placements. Additionally, children in their care are less likely to re-enter foster care upon reunification. The Department has increased active efforts to ensure placement with relatives or fictive kin when children enter out of home care through the implementation of placement coordinators, and the expansion of family-search technology. In Tucson, the Tucson Kinship Liaison Support Specialists, which have been in effect in some form since the late 1990s, is a separate specialized unit that exists to provide support to all kin placements in Pima County, greatly increasing retention of these homes. The SE Region also has 1 case aide in each of their field offices who visits each new kinship home and offers information on resources, assistance and dependency/child welfare information. They follow up with the families every 30 days for 3 months to ensure the family has what it needs, resulting in kinship placement retention. Lastly, there are Permanency Planning units in Maricopa County that recently began (January 1, 2016) whose main goal appears to be finding permanency for children who will not be able to reunify.

Implement Improved Placement Assessments

Identifying appropriate out of home care placements for children who have been removed from their home of origin is a collaborative inter-agency effort to ensure timely placements are made with out of home care providers who are best able to meet the needs of each individual child. The Department currently has procedures in place to identify kinship and foster homes for children placed in out of home care, however existing efforts have been enhanced through the utilization of placement assessments for use in placement coordination. These in-depth assessments are designed to collect critical information about a child's placement needs, as well as identify and locate potential kinship

placements in order to increase the number of children who are placed in a kinship or foster home placement as their first placement instead of a congregate care setting.

Improve Timeliness of Reunification, Guardianship and Adoption

It is the responsibility of the Department to provide timely permanency to children placed in out of home care. Permanency planning occurs on a continuum within the Department, beginning when a child enters out of home care, progressing through the process of continuous reassessment until permanency is achieved. The Department is engaged in on-going permanency improvement efforts through collaboration with the local courts, child welfare stakeholders, and child welfare involved families. In particular, targeted adoption recruitment has been an on-going effort for the Department to assist in placing children in conjunction with performance based community contracting, and the Department's Team Decision-Making process.

Implementation of Family Assessment Response

Arizona is currently in the design stage of development for a family assessment response to be incorporated into system intake in Arizona with implementation occurring in 2017. The family assessment response effort is designed to shift practice to respond with an alternate response to child abuse and neglect reports, and better meet individual needs of system involved families. With a growing recognition pertaining to the importance of engagement in child welfare services, the family assessment response will utilize family engagement as a cornerstone of practice in building strong relationships with parents. As families become more engaged in the child welfare system services under a Family Assessment Response model, services will be better tailored to meet their needs, and their involvement in service provision will be enhanced. Once implemented, Family Assessment Response is designed to intervene with at-risk families earlier with targeted service provision in order to reduce the need for placement in out of home care.

Behavioral Health Assessments

Children who enter out of home care are at an elevated level of risk for experiencing developmental delays, or have increased physical and behavioral needs compared to their peers. In order to most effectively meet the needs of children placed in out of home care, community based behavioral health providers conduct a behavioral health screening of all children who enter out of home care. This assessment then serves as the starting point to identify needs, and begin coordination of care with the behavioral health and medical systems in Arizona. The Department is currently working towards

enhancing inter-system collaboration in order to ensure that child welfare involved children receive the services they need to meet their optimal potential including behavioral health services, medical examinations, and placement coordination when appropriate.

Appendix C: Readiness Instrument

***(This instrument will be adapted for the Waiver)**

ORGANIZATIONAL READINESS FOR CHANGE (ORC-D4)

INSTRUCTION PAGE

This survey asks questions about how you see yourself as a counselor and how you see your program. It begins on the next page with a short demographic section that is for descriptive purposes only. The *Anonymous Linkage Code* is requested so that information you give now can be "linked" to your responses to similar questions you may be asked later.

To complete the form, please mark your answers by completely filling in the appropriate circles. If you do not feel comfortable giving an answer to a particular statement, you may skip it and move on to the next statement. If an item does not apply to you or your workplace, leave it blank. PLEASE DO NOT FOLD FORMS. The examples below show how to mark the circles –

Please complete the following items for your anonymous code. The anonymous linkage code can be used to match your ratings from different survey forms without using your name.

This program is located in which zip code? |___|___|___|___|___|

First letter in your mother's first name: |___| First letter in your father's first name: |___|

First digit in your social security number: |___| Last digit in your social security number: |___|

1. Today's Date? |__|__||__|__||__|__|
MO DAY YR

2. Are you? ○ *Male* ○ *Female*

3. Your Birth Year? 19 |__|__|

4. Are you Hispanic (or Latino)? ○ *No* ○ *Yes*

5. Are you? [MARK ONE]

○ *American Indian/Alaska Native*
○ *Asian*
○ *Native Hawaiian or Other Pacific Islander*
○ *Black or African American*
○ *White*
○ *More than one race*
○ *Other (specify)* ____________________

6. Your Highest Degree Status? [MARK ONE]

○ *No high school diploma or equivalent*
○ *High school diploma or equivalent*
○ *Some college, but no degree*
○ *Associate's degree*
○ *Bachelor's degree*
○ *Master's degree*
○ *Doctoral degree or equivalent*
○ *Other (specify)* ____________________

7. Your Discipline/Profession? [MARK ALL THAT APPLY]

○ *Addictions Counseling*
○ *Other Counseling*
○ *Education*
○ *Vocational Rehabilitation*
○ *Criminal Justice*
○ *Psychology*
○ *Social Work/Human Services*
○ *Administration*
○ *Military*
○ *Law Enforcement*
○ *Medicine*
○ *Other (specify)*

____

8.* Your Certification Status in Addictions Field*? *[MARK ONE]*

○ *Not certified or licensed* ○ *Currently certified or licensed*

○ *Previously certified or licensed, not now* ○ *Intern*

9. Your Job Level? [MARK ONE]

○ *Program Director* ○ *Clinical Supervisor* ○ *Counselor* ○ *Support Staff*

10. How much experience do you have in drug abuse counseling?

○ *0-6 months* ○ *6-11 months* ○ *1 to 3 years* ○ *3 to 5 years* ○ *over 5 years*

11. How long have you been in your present job?

○ *0-6 months* ○ *6-11 months* ○ *1 to 3 years* ○ *3 to 5 years* ○ *over 5 years*

12. How many clients are on your treatment caseload?

○ *1-10* ○ *11-20* ○ *21-30* ○ *31-40* ○ *> 40*

ORGANIZATIONAL READINESS FOR CHANGE (ORC-D4)

How strongly do you agree or disagree with each of the following statements?

PLEASE FILL IN THE CIRCLE THAT SHOWS YOUR ANSWER TO EACH ITEM.

Disagree Strongly (1)	*Disagree* (2)	*Uncertain* (3)	*Agree* (4)	*Agree Strongly* (5)

PART A

Clinical staff at your program needs guidance in –

Item					
1.assessing client needs.	.○	○	○	○	○
2. using client assessments to guide clinical care and program decisions.	.○	○	○	○	○
3. using client assessments to document client improvements.	.○	○	○	○	○
4.matching client needs with services.	.○	○	○	○	○
5. increasing program participation by clients.	.○	○	○	○	○
6.improving rapport with clients.	.○	○	○	○	○
7. improving client thinking and problem solving skills.	.○	○	○	○	○
8. improving behavioral management of clients.	.○	○	○	○	○
9.improving cognitive focus of clients during group counseling.	.○	○	○	○	○
10.identifying and using evidence-based practices.	.○	○	○	○	○

Your organization needs guidance in –

11.defining its mission. .○○ ○ ○ ○

12. setting specific goals for improving services. .○○ ○ ○ ○

13. assigning or clarifying staff roles. .○○ ○ ○ ○

Disagree				***Agree***
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1) ***(2)***	***(3)***	***(4)***	***(5)***	

14. establishing accurate job descriptions for staff. .○○ ○ ○ ○

15. evaluating staff performance. . .○○ ○ ○ ○

16.improving relations among staff. .○○ ○ ○ ○

17. improving communications among staff. .○○ ○ ○ ○

18. improving record keeping and information systems. .○○ ○ ○ ○

19. improving billing/financial/accounting procedures. .○○ ○ ○ ○

You need more training for –

20. basic computer skills/programs. .○ ○ ○ ○ ○

21. specialized computer applications (e.g., data systems). .○ ○ ○ ○ ○

22. new methods/developments in your area of responsibility. .○ ○ ○ ○ ○

23. new equipment or procedures being used or planned. .○○ ○ ○ ○

24. maintaining/obtaining certification or other credentials. .○○ ○ ○ ○

25. new laws or regulations you need to know about. .○○ ○ ○ ○

26. management or supervisory responsibilities. .○○ ○ ○ ○

Current <u>pressures</u> to make

program changes come from –

27.the people being served. .○○ ○ ○ ○

28.other staff members. .○○ ○ ○ ○

Disagree				***Agree***
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	***(2)***	***(3)***	***(4)***	***(5)***

29.program supervisors or managers. .○○ ○ ○ ○

30.board members or overseers. .○○ ○ ○ ○

31.community groups. .○○ ○ ○ ○

32.funding agencies. .○○ ○ ○ ○

33.accreditation or licensing authorities. .○○ ○ ○ ○

PART B

1. You have good program management at your program. .○○ ○ ○ ○
2. Frequent staff turnover is a problem for your program. .○○ ○ ○ ○
3. Staff training and continuing education are priorities in your program. .○○ ○ ○ ○
4. Your facilities are adequate for conducting group counseling. .○○ ○ ○ ○
5. You have clinical supervisors who are capable and certified. .○○ ○ ○ ○
6. Policies limit use of the Internet for work-related needs at your program. .○○ ○ ○ ○
7. You learned new skills or techniques at a professional training in the past year. .○○ ○ ○ ○
8. Computer problems are usually repaired promptly at your program. .○○ ○ ○ ○
9. Much time and attention are given to staff supervision when needed. .○○ ○ ○ ○
10. You have convenient access to e-mail at work. .○○ ○ ○ ○

11. Counselors in your program are able to spend the time needed with clients. .○○ ○ ○ ○

Disagree				Agree
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	***(2)***	***(3)***	***(4)***	***(5)***

12. Equipment at your program is mostly old and outdated. .○○ ○ ○ ○

13. Clinical and management decisions for your program are well planned. .○○ ○ ○ ○

14. More computers are needed for staff in your program to use. .○○ ○ ○ ○

15. Most client records for your program are computerized. .○○ ○ ○ ○

16. Support staff in your program have the skills they need to do their jobs. .○○ ○ ○ ○

17. Offices in your program allow the privacy needed for individual counseling. .○○ ○ ○ ○

18. Your program holds regular inservice training. .○○ ○ ○ ○

19. Your program has enough counselors to meet current client needs. .○○ ○ ○ ○

20. Clinical staff in your program are well-trained. .○○ ○ ○ ○

21. You used the Internet at work recently to access drug treatment information. .○○ ○ ○ ○

22. You have confidence in how decisions at your program are made. .○○ ○ ○ ○

23. You have easy access for using the Internet at work. .○○ ○ ○ ○

24. Offices and equipment in your program are adequate. .○○ ○ ○ ○

25. Your program provides a comfortable reception/waiting area for clients. .○○ ○ ○ ○

26. You have a computer to use in your personal office space at work. .○○ ○ ○ ○

Disagree				*Agree*
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	*(2)*	*(3)*	*(4)*	*(5)*

27. You meet frequently with clinical supervisors about client needs and progress. .○○ ○ ○ ○

28. A larger support staff is needed to help meet needs at your program. .○○ ○ ○ ○

29. The budget in your program allows staff to attend professional training. .○○ ○ ○ ○

30. Staff in your program feel comfortable using computers. .○○ ○ ○ ○

31. Staff concerns are ignored in most decisions made in your program. .○○ ○ ○ ○

PART C

1. You have the skills needed to conduct effective group counseling. .○○ ○ ○ ○
2. Other staff often ask your advice about program procedures. .○○ ○ ○ ○
3. You are satisfied with your present job. .○○ ○ ○ ○
4. Learning and using new procedures are easy for you. .○○ ○ ○ ○
5. You are considered an experienced source of advice about services. .○○ ○ ○ ○
6. You feel appreciated for the job you do at work. .○○ ○ ○ ○
7. Your program encourages and supports professional growth. .○○ ○ ○ ○
8. You are effective and confident in doing your job. .○○ ○ ○ ○
9. You are able to adapt quickly when you have to make changes. .○○ ○ ○ ○
10. Keeping your counseling skills up-to-date is a priority for you. .○○ ○ ○ ○

Disagree				*Agree*
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	***(2)***	***(3)***	***(4)***	***(5)***

11. You give high value to the work you do. .○○ ○ ○ ○

12. You regularly influence the decisions of other staff you work with. .○○ ○ ○ ○

13. You usually accomplish whatever you set your mind on. .○○ ○ ○ ○

14. You do a good job of regularly updating and improving your skills. .○○ ○ ○ ○

15. 12-step programs (AA/NA) are recommended to many of your clients. .○○ ○ ○ ○

16. You regularly read professional articles or books on drug treatment. .○○ ○ ○ ○

17. You review new techniques and treatment information regularly. .○○ ○ ○ ○

18. Psychodynamic theory is commonly used in your counseling. .○○ ○ ○ ○

19. Other staff often ask for your opinions about counseling and treatment issues. .○○ ○ ○ ○

20. You are willing to try new ideas even if some staff members are reluctant. .○○ ○ ○ ○

21. Behavior modification (contingency management) is used with many of your clients. .○○ ○ ○ ○

22. You have the skills needed to conduct effective individual counseling. .○○ ○ ○ ○

23. You frequently share your knowledge of new counseling ideas with others. .○○ ○ ○ ○

24. You are sometimes too cautious or slow to make changes. .○○ ○ ○ ○

25. You are proud to tell others where you work. .○○ ○ ○ ○

Disagree				*Agree*
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	***(2)***	***(3)***	***(4)***	***(5)***

26. Cognitive theory (RET, RBT) guides much of your counseling. .○○ ○ ○ ○
27. You like the people you work with. .○○ ○ ○ ○
28. You are viewed as a leader by the staff you work with. .○○ ○ ○ ○
29. You consistently plan ahead and carry out your plans. .○○ ○ ○ ○
30. You would like to find a job somewhere else. .○○ ○ ○ ○
31. Pharmacotherapy and related medications are important for many of your clients. .○○ ○ ○ ○

PART D

1. Some staff members seem confused about the main goals for your program. .○○ ○ ○ ○
2. The heavy staff workload reduces the effectiveness of your program. .○○ ○ ○ ○
3. You frequently hear good ideas from other staff for improving treatment. .○○ ○ ○ ○
4. Treatment planning decisions for clients in your program often get revised by a counselor supervisor. .○○ ○ ○ ○

5. The general attitude in your program is to accept new and changing technology. ○ ○ ○ ○ ○

6. More open discussions about program issues are needed where you work. .○○ ○ ○ ○

7. Ideas and suggestions in your program get fair consideration by management. .○○ ○ ○ ○

8. Staff members at your program work together as a team. .○○ ○ ○ ○

9. Your duties are clearly related to the goals for your program. .○○ ○ ○ ○

Disagree				*Agree*
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	*(2)*	*(3)*	*(4)*	*(5)*

10. You are under too many pressures to do your job effectively. .○○ ○ ○ ○

11. Counselors in your program are given broad authority in treating their clients. ○ ○ ○ ○ ○

12. Your program staff is always kept well informed. .○○ ○ ○ ○

13. Novel treatment ideas by staff are discouraged where you work. .○○ ○ ○ ○

14. Mutual trust and cooperation among staff in your program are strong. .○○ ○ ○ ○

15. Your program operates with clear goals and objectives. .○○ ○ ○ ○

16. Staff members at your program often show signs of high stress and strain. .○○ ○ ○ ○

17. It is easy to change procedures at your program to meet new conditions. .○○ ○ ○ ○

18. Counselors in your program can try out different techniques to improve their effectiveness. .○○ ○ ○ ○

19. Staff members at your program get along very well. .○○ ○ ○ ○

20. Staff members are given too many rules in your program. .○○ ○ ○ ○

21. Staff members at your program are quick to help one another when needed. .○○ ○ ○ ○

22. The formal and informal communication channels in your program work very well. .○○ ○ ○ ○

23. There is too much friction among staff members you work with. .○○ ○ ○ ○

Disagree				***Agree***
Strongly	***Disagree***	***Uncertain***	***Agree***	***Strongly***
(1)	***(2)***	***(3)***	***(4)***	***(5)***

24. Staff members at your program understand how program goals fit as part of the treatment system in your community. .○○ ○ ○ ○

25. Some staff in your program do not do their fair share of work. .○○ ○ ○ ○

26. Management fully trusts professional judgments of staff in your program. .○○ ○ ○ ○

27. Staff members always feel free to ask questions and express concerns in your program. .○○ ○ ○ ○

28.	Staff frustration is common where you work.	.○○	○	○	○
29.	Management for your program has a clear plan for its future.	.○○	○	○	○
30.	You feel encouraged to try new and different techniques.	.○○	○	○	○

Appendix D: Wilder Collaboration Factors Inventory

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
History of collaboration or cooperation in the community	1. Agencies in our community have a history of working together	1	2	3	4	5
	2. Trying to solve problems through collaboration has been common in this community. It's been done a lot before.	1	2	3	4	5
Collaborative group seen as a legitimate leader in the community	3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
	4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
Favorable political and social climate	5. The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
	6. The time is right for this collaborative project.	1	2	3	4	5
Mutual respect, understanding, and trust	7. People involved in our collaboration always trust one another.	1	2	3	4	5
	8. I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
Appropriate cross section of members	9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
	10. All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
Members see collaboration as in their self-interest	11. My organization will benefit from being involved in this collaboration.	1	2	3	4	5
Ability to compromise	12. People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5
Members share a stake in both process and outcome	13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
	14. Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
	15. The level of commitment among the collaboration participants is high.	1	2	3	4	5
Multiple layers of participation	16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
	17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
Flexibility	18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
	19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5
Development of clear roles and policy guidelines	20. People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
	21. There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5
Adaptability	22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
	23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
Appropriate pace of development	24. This collaborative group has tried to take on the right amount of work at the right pace.	1	2	3	4	5
	25. We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5

Open and frequent communication	26. People in this collaboration communicate openly with one another.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
	27. I am informed as often as I should be about what goes on in the collaboration.	1	2	3	4	5
	28. The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
Established informal relationships and communication links	29. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
	30. I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5
Concrete, attainable goals and objectives	31. I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
	32. People in our collaborative group know and understand our goals.	1	2	3	4	5
	33. People in our collaborative group have established reasonable goals.	1	2	3	4	5
Shared vision	34. The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
	35. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
Unique purpose	36. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
	37. No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
Sufficient funds, staff, materials, and time	38. Our collaborative group had adequate funds to do what it wants to accomplish.	1	2	3	4	5
	39. Our collaborative group has adequate "people power" to do what it wants to accomplish.	1	2	3	4	5

Skilled leadership	40. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5

Appendix E: DCS Survey for IV-E Waiver

The Department of Child Safety (DCS) has selected the modification and expansion of Team Decision Making, In-Home Services, and Family Finding as the intervention for the Title IV-E Waiver to safely reduce the number of children placed in congregate care settings.

DCS is conducting a survey to assess current strengths as well as challenges to implementing this intervention. We are interested in receiving your open and honest responses and suggestions in an effort to increase the chances of a successful Waiver demonstration.

Although your participation in this survey is voluntary, we ask that you take 10 minutes of your time to participate and answer all questions. All data from the survey will be aggregated with data from other staff. No personal information will be identifiable, and we ask that you please not share any case specific identifying information in any of your comments.

1. Which of the following best describes your current job title?

DCS Specialist Ongoing
DCS Specialist Investigations
DCS Specialist, Specialty Unit (YAP, Adoptions, ICWA, etc.)
DCS Supervisor
DCS Assistant Program Manager
DCS Case Aide
DCS Program Manager
DCS Specialist IV
DCS Program Specialist
DCS TDM Facilitator
Other (please indicate): ______________________

The next set of questions relate to Team Decision Making (TDMs).

On average, how many times per month do you participate in Team Decision Making (TDM) meetings? Please indicate the number of times. (include a box for not applicable)

On average, how many minutes do you devote to setting up a TDM? Please indicate number of minutes (include a box for Not Applicable)

In the past, have you participated in a TDM for a child who was placed in congregate care prior to the TDM? (Yes/No, not applicable)

In your experience how consistent do you consider the following aspects of TDMs are? (1= inconsistent, 2 = somewhat consistent, 3 = often consistent, 4 = always consistent, not applicable)

Who receives a TDM
Planning and preparation
Scheduling/availability of TDMs
Participants invited to the TDM
Location of the TDM
Introductions and rule setting
Duration of the TDM meeting
Documentation of the TDM

On a scale from 1 to 5 with 1= Not at all, 2 = a little, 3 = somewhat, 4 = a lot, 5 = completely
Please rate how effective TDMs are at the following:
engaging families in decision making;
engaging teens in decision making;
engaging community support
including all team members in the decision making process
identifying family placements for children during removal
moving children from congregate care to family settings
improving case planning
availability of time slots to meet the demand
providing time slots to meet the needs of families

Please name two of the biggest barriers to successful TDMs. (open ended)

Please name two of the main strengths to holding TDM meetings. (open-ended)

In-Home Services Questions

The next set of questions relate to the In-Home Service Program.

In the past month (October 2015) how many families did you refer to the In-Home Service Program (Intensive Family Preservation, Moderate Level Services, Reunification and Placement Stabilization, Family Support or Clinical Family Assessment)? (write number and include a box for N/A)

Of the families you referred to the In-Home Service Program in October 2015, how many do you think would have resulted in a removal if you would not have referred them to the in-home program?

Which In-Home Service Program services have you referred to in the past? *Please check all that apply.*

1) Intensive Family Preservation
2) Moderate Level Services
3) Reunification & Placement Stabilization Services
4) Family Support
5) Clinical Family Assessment

If there are services to which you do not refer families, please explain your reasons (open ended)

Please indicate specific providers to which you refer families? *Please check all that apply (We need this by region)*

Central Region (add a not applicable)

TERROS

Family Services Agency

Crisis Network Response

Child and Family Support Services

Human Resource Training

Jewish Family and Children’s Services

Rite of Passage

Crisis Response, Child Resource Center

Arizona Children’s Association

Sage Counseling

Other: ___________________

Northern Region (add a not applicable)

Arizona Partnership for Children

Arizona Children’s Association

Catholic Charities Community Services

Other: ___________________

Pima Region (add a not applicable)

Child & Family Support Services

Casa de los Niño’s

Arizona Children’s Association

Other: ___________________

Southeastern Region ***(add a not applicable)***

Arizona Partnership for Children

Arizona Children's Association

Other: __________________

Southwestern Region ***(add a not applicable)***

TERROS

Family Services Agency

Crisis Network Response

Human Resource Training

Jewish Family & Children's Services

Rite of Passage

Crisis Response, Child Resource Center

Southwest Human Development

Easter Seals Blake Foundation

Arizona Partnership for Children

Arizona Children's Association

Devereux

Catholic Charities Community Services

Other: __________________

Please comment on the criteria you use for selecting providers for referrals? (open ended)

How do you stay in contact with the in-home providers during the length of service with families on your caseload? *Check all that apply*

Via email
Phone
Fax
Other means, please indicate__________
Not applicable

How often do you participate in-home visits alongside the team leads or family support workers?

(1= never, 2 = hardly ever, 3 = sometimes, 4 = often, 5 = always, not applicable)

Please rate your opinion on how effective the In-Home Service Program is at the following:
On a scale from 1 to 5 with 1= Not at all, 2 = a little, 3 = somewhat, 4 = a lot, 5 = completely, not applicable

engaging families in decision making;
engaging teens in decision making;
engaging community support
including all team members in the decision making process
preventing removals
identifying family placements for children
reunification
moving children from congregate care to family settings
improving case planning
tracking services children/families receive

Please name two of the main strengths of the In-Home Service Program. (open-ended)

Please name two of the biggest barriers to the success of the In-Home Service Program. (open ended)

Family Finding Questions

The following questions relate to searching for kinship families.

- Does your position require you to perform kinship searches for family members to be placements or supports for children who are removed from their biological or natural family? **Yes**
- **No**

In your experience what is the average turnaround time for a Family Locate referral?

- Under 1 week
- 1 to 2 weeks
- 2 to 3 weeks
- More than 3 weeks
- Not applicable

On average, how often are you able to search for kinship families on your cases?

- Never
- Once every 3 months or less
- Once every 4 to 6 months
- Once every 7 to 12 months
- Other: _________
- Not applicable

How often have you experienced the each of the following items as barriers to finding/placing children with kinship families (1 = never, 2 = seldom, 3 = sometimes, 4 = often, 5 = always, not applicable)

  - The parents will not provide kinship family names/contact information
  - Inability to find a kinship placement
  - Time it takes to have a kinship family placement approved
  - Kinship family cannot meet criminal background check requirements
  - Kinship family lacks resources to care for the child
  - Kinship family members were undocumented
  - Kinship family would not agree to be considered for placement
  - Did not have time to search for kinship family due to workload demands
  - Behavioral issues of the child

    - Child disrupted from relative setting
    - Family Locate was unable to find identified family members
    - Family Locate referral process took too long
    - Lack of response from kinship families
    - Other: (please indicate)

- Do you have any suggestions for ways to improve the current kinship search process? (open ended)

- What strategies have worked best for you in finding/engaging kinship family members? (open ended)

Demographic Questions

These final questions are about you and are important for the purpose of assessing training needs and readiness for the Waiver demonstration project.

What is the highest level of education you have completed?

❍ High school/GED
❍ Some College
❍ 2 year College Degree/Associates
❍ 4 year College Degree/BA, BS
❍ Master's Degree
❍ Doctoral Degree
❍ Professional Degree/MD, JD

In what area was your degree (or area of emphasis)?

- ❍ social work
- ❍ other human services, please specify: ____________________
- ❍ other, please specify: ____________________

How many years have you worked for DCS?

- ❍ less than one year
- ❍ 1 to 2 years
- ❍ 3 to 5 years
- ❍ 6 to 10 years
- ❍ More than 10 years

In what DCS Region are you currently employed?

- ❍ Central
- ❍ Pima
- ❍ Northern
- ❍ Southeastern
- ❍ Southwestern
- ❍ Central Office
- ❍ Other, please specify ____________________

In what DCS office do you currently work?

Central

- ❍ (4311) 3221 N. 16th Street, Ste 400, Phx-Region Office
- ❍ (4312) 3221 N. 16th Street, Ste 300, Phx-In Home E
- ❍ (4313) 4000 N. Central, Phx
- ❍ (4314) 4635 S. Central, Phx
- ❍ (4315) 1201 S Alma School Road, Mesa
- ❍ (4316) 2328 W. Guadalupe Road, Gilbert
- ❍ (4317) 3310 N. 19th Avenue, Phoenix
- ❍ (4318) 225 E. 1st Street, Ste 102 Mesa
- ❍ (4319) 120 W. 1st Ave, Mesa
- ❍ (431A) 2510 N. Trekell Road, Casa Grande-Reg Sat Ofc
- ❍ (431B) 11518 W. Apache Trail, St 109 Apache Junction
- ❍ (431C) 331 Alden Road, Kearny
- ❍ (431D) 228 Main Street, Mammoth
- ❍ (431E) 1155 N. Arizona Blvd, Coolldge
- ❍ (431F) 555 W. Main Ave, Casa Grande
- ❍ (431G) 2510 N. Trekell Road, Casa Grande
- ❍ (431T) 3443 N. Central, 1st Fl, Phoenix – SWAT
- ❍ Other_________________________

Pima

(4321) 400 W. Congress Street, Ste 420, Tucson-Reg Ofc

- ❍ (4322) 4433 E. Broadway Blvd, Ste 101, Tucson
- ❍ (4323) 1700 E. Broadway Blvd, Tucson
- ❍ (4324) 1011 N. Craycroft Road, Ste 404, Tucson
- ❍ (4325) 432 S. Williams Blvd., Tucson
- ❍ (4326) 6840 E. Broadway Blvd., Ste 102, Tucson
- ❍ (4327) 38 W. Plaza Street, Ajo
- ❍ (4328) 2329 E. Ajo Way, Tucson
- ❍ (4329) 2750 S. 4th Ave., Tucson (Madera)
- ❍ (432A) 6363 S. Country Club Road, Ste 151, Tucson
- ❍ (432B) 800 E. Wetmore, Ste 100, Tucson
- ❍ (432D) 3000 E. Valencia, Ste 120, Tucson
- ❍ (432F) 3000 E. Valencia, Ste 120, Tucson (ASU Training)
- ❍ (432G) 3000 E. Valencia, Ste 130, Tucson (CSI)
- ❍ (432T) 3000 E. Valencia, Ste 130, Tucson (SWAT)

Other_______________________________

Northern

(4331) 220 N. Leroux Street, Flagstaff-Region Ofc

- ❍ (4333) 1057 Vista Avenue, 21, Page
- ❍ (4334) 1200 W. Cleveland, Ste 2, St. Johns
- ❍ (4335) 3274 Bob Drive, Prescott Valley
- ❍ (4336) 319-321 E. 3rd Street, Winslow
- ❍ (4337) 2500 E. Cooley Street, Ste 410, Showlow
- ❍ (4339) 1500 E. Cherry Street, Ste B, Cottonwood
- ❍ (433A) 2601 Highway 95, Bullhead City
- ❍ (433B) 228 London Bridge Road, Lake Havasu City
- ❍ (433C) 910 N. Main Street, Fredonia
- ❍ (433D) 519 E. Beale Street, Ste 150, Kingman
- ❍ Other_______________________________

Southeastern,

(4341) 820 E. Fry Blvd., Sierra Vista-Region Ofc

- ❍ (4342) 270 Bisbee Road, Bisbee
- ❍ (4343) 1140 F Avenue, Douglas
- ❍ (4344) 256 S. Curtis Avenue, Willcox
- ❍ (4345) 595 S. Dragoon Street, Benson
- ❍ (4346) 333 N. 8th Ave, Safford
- ❍ (4347) 300 W. Coronado Blvd, Clifton
- ❍ (4348) 2981 E. Tacoma Street, Sierra Vista
- ❍ (4349) 1843 N. State Drive, Nogales
- ❍ (434A) 100 N. Tonto Street, Ste 100, Payson
- ❍ (434B) 605 S. 7th Street, Globe
- ❍ Other______________________________

Southwestern,

(4351) 3221 N. 16th Street, Ste 400/200, Phx, Reg Ofc

- ❍ (4352) 3221 N. 16th Street, Ste 400, Phoenix, Reg Ofc
- ❍ (4353) 8990 W. Peoria, Fl 2, Peoria
- ❍ (4354) 13450 N. Black Canyon Hwy., Ste 170, Phx
- ❍ (4355) 6010 N. 57th Drive, Glendale
- ❍ (4356) 290 E. La Canada Blvd., Avondale
- ❍ (435A) 1185 S. Redondo Center Drive, Yuma-Reg Sat Ofc
- ❍ (435B) 1185 S. Redondo Center Drive, Yuma
- ❍ (435C) 342 Main Street, Somerton
- ❍ (435D) 1032 Hopi Avenue, Parker
- ❍ (4353) 1925 W. Pinancle Peak Rd., Phoenix
- ❍ (4354) 1860 N. 95th Lane, Ste # 200, Phoenix
- ❍ Other_____________________________

Appendix F: Training to Practice Fidelity Tool

*(This instrument will be adapted for the Waiver)

This survey is designed to obtain an assessment of practice and to learn whether the goals established (for advancing the family finding and engagement initiative in your county) have been met.

Please answer the questions as honestly as possible, as your responses will help to refine the process of family finding and engagement in your and other counties.

SECTION ONE:
GENERAL INFORMATION ABOUT YOU

1. Today's Date:	
2. Sponsoring Agency Contact:	
3. What is your current position:	
4. How long have you served in your current position?	

☐ 0 – 6 months ☐ 7 months to 2 years
☐ 2.5 years to 5 years ☐ 5.5 to 10 years
☐ 10+ years

5. How long have you worked in this field (Family Finding and Engagement)?

☐ 0 – 6 months ☐ 7 months to 2 years
☐ 2.5 years to 5 years ☐ 5.5 to 10 years
☐ 10+ years

6. What is your role in the process of family finding and engagement? Select from the following options.

☐ Parent or Community Partner ☐ Parent's Attorney
☐ Child Welfare ☐ CSE
☐ CASA ☐ GAL
☐ Other Court Personnel ☐ FFC
☐ Probation ☐ Other Law Enforcement
☐ Service Provider (mental health, substance abuse, etc.)
☐ Other: (Enter Text in the box):

7. Did you receive the training as part of the Family Finding and Engagement program?

☐ Yes ☐ No

8. If yes, Date of Training:

9. Target or non-target population

☐ Yes ☐ No

10. Immediately following the Family Finding Training, I have used approaches and skills I learned:

☐ 0 times ☐ 1 to 5 times ☐ 6 to 10 times ☐ 11 to 20 times ☐ 20+ times ☐ N/A

11. One month following the Family Finding Training, I have used approaches and skills I learned:

☐ 0 times ☐ 1 to 5 times ☐ 6 to 10 times ☐ 11 to 20 times ☐ 20+ times ☐ N/A

SECTION TWO
INFORMATION ABOUT YOUR PRACTICE

12. Does your current practice include family finding[1]?

☐ Yes ☐ No

13. Does your current practice draw from the work of staff at your agency dedicated to family finding?

☐ Yes ☐ No

14. Does your current practice draw from the work of other agencies that perform outreach to family members?

☐ Yes ☐ No

15. About how many family members, on average, do you come into contact with for each case?

☐ 0 ☐ 1 – 3 ☐ 4 – 6 ☐ 7 – 10 ☐ 10+

16. How much time per week does family find take for each case?

☐ 0 ☐ 1 – 3 ☐ 4 – 6 ☐ 7 – 10 ☐ 10+

Which (maternal, paternal and other) family members, from the following list, do you routinely seek and attempt to contact? Check all that apply

17. Which maternal family members do you routinely seek and attempt to contact? (Check all that apply)	18. Which paternal family members do you routinely seek and attempt to contact? (Check all that apply)	19. Which (other) family members do you routinely seek and attempt to contact? (Check all that apply)
1. ☐ Mother	1. ☐ Mother	1. ☐ Stepmother
2. ☐ Grandmother	2. ☐ Grandmother	2. ☐ Stepfather
3. ☐ Grandfather	3. ☐ Grandfather	3. ☐ Sister of step-parent

[1] Family Finding refers to the practice of identifying, locating and contacting more than six (6) family members

4. ☐ Aunt	4. ☐ Aunt	4. ☐ Brother of step-parent
5. ☐ Aunt	5. ☐ Aunt	5. ☐ Mother of step-parent
6. ☐ Uncle	6. ☐ Uncle	6. ☐ Father of step-parent
7. ☐ Uncle	7. ☐ Uncle	7. ☐ Child's sister(s)
8. ☐ Great-aunt	8. ☐ Great-aunt	8. ☐ Child's brother(s)
9. ☐ Great-uncle	9. ☐ Great-uncle	9. ☐ Family friend
10. ☐ Child's cousin	10. ☐ Child's cousin	10. ☐ Family friend
11. ☐ Child's cousin	11. ☐ Child's cousin	11. ☐ Other:
12. ☐ Mother's cousin	12. ☐ Mother's cousin	
13. ☐ Child's great grandmother	13. ☐ Child's great grandmother	
14. ☐ Other:	14. ☐ Other:	

20. For family members ***identified***, what activities involve them during service provision?

21. For family members ***located***, what activities involve them during service provision?

22. For family members ***contacted***, what activities involve them during service provision?

23. What supports do you receive from the higher administration to engage family in the child's service and permanency **planning**?

24. What supports do you receive from the higher administration to engage family in the child's service and permanency planning **activities**?

25. What forms of long-term commitment do family members provide?

26. On average, how many family members do you find by mining the case file (check one):

☐ 1 to 10 ☐ 11 to 20 ☐ 21 to 30 ☐ 31 - 40 ☐ N/A

27. On average, how many family members do you find by other means, after you have mined the case file (check one):

☐ 1 to 10 ☐ 11 to 20 ☐ 21 to 30 ☐ 31 - 40 ☐ N/A

Please state whether you agree with the following statements by selecting **one** response.

	Not at all	A little	Somewhat	Yes	N/A
28. My supervisor supports my efforts to locate and contact family(ies).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
29. We have staff support dedicated to family finding.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
30. The training was valuable; I have additional skills in finding and communicating with extended family members.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
31. I have to work harder at finding paternal family (first 5 family members) than maternal family (first 5 family members).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
32. After the first 5 family members on each side, the differences between finding paternal and maternal family lessen	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
33. Family finding does not figure into my performance is evaluated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

What **family engagement** activities have taken place among those you serve? (Answer "yes" if these activities have taken place for over ½ of your case load)

	The following activities were mandated by court order in my cases	The following activities were conducted in my cases	Select all the family members who were present Ch = Child M = Mother F = Father Sb = Sibling MR = Maternal Relative PR = Paternal Relative NRE = Non-relative Extended family	Number of family members involved, on average *(Click on the 0 to reveal additional responses)*

	a.	b.	c.	d.
34. FTM Meeting	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
35. Plan with family input	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
36. Plan with family as main decision maker	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
37. Supervised visitation	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
38. Discharge with permanency	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
39. Follow-up care	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
40. Behavioral health services referred	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
41. Behavioral health services provided	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
42. Job readiness services referred	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
43. Job readiness services provided	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0
44. Other: Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐Ch ☐M ☐F ☐Sb ☐MR ☐PR ☐NRE	0

(Optional) Please comment on the Family Engagement Activities you have been involved with so far.

	Comments on Activities
FTM Meeting	
Plan with family input	
Plan with family as main decision maker	
Supervised visitation	
Discharge with permanency	
Follow-up care	
Behavioral health services referred	
Behavioral health services provided	
Job readiness services referred	
Job readiness services provided	
Other:	
Other:	
Other:	
Are there any other concerns or comments that should be raised?	

Appendix G: Parent Partner Fidelity and Satisfaction Survey

***(This instrument will be adapted for the Waiver)**

How much do you agree or disagree with the following statements? (Circle one answer for each statement.)	*1 =* ***Very strongly agree***	*2 = Mostly agree*	*3 = Neutral or no opinion*	*4 = Mostly disagree*	*5 =* ***Very strongly disagree***
1. My Parent Partner and I share many of the same experiences or circumstances	1	2	3	4	5
2. My Parent Partner understands me	1	2	3	4	5
3. My Parent Partner understands my child and my family	1	2	3	4	5
4. My Parent Partner took the time to get to know me and my circumstances	1	2	3	4	5
5. My Parent Partner helped me and others focus on my strengths and those of my child and family	1	2	3	4	5
6. My Parent Partner helped me find solutions to help me keep my family together	1	2	3	4	5
7. Because of my Parent Partner I feel more in control of my life	1	2	3	4	5

How much do you agree or disagree with the following statements? (Circle one answer for each statement.)	*1 =* ***Very strongly agree***	*2 = Mostly agree*	*3 = Neutral or no opinion*	*4 = Mostly disagree*	*5 =* ***Very strongly disagree***
8. Because of my Parent Partner I feel more in control of decisions about my child	1	2	3	4	5
9. My Parent Partner helped me organize my time	1	2	3	4	5
10. My Parent Partner helped me to change as a person	1	2	3	4	5
11. My Parent Partner helped me to accept responsibility for my decisions and my family	1	2	3	4	5
12. My Parent Partner helped me get through the system by advocating for me or giving me information	1	2	3	4	5
13. My Parent Partner educated me about the child welfare and legal system basics	1	2	3	4	5
14. My Parent Partner helped me get community resources	1	2	3	4	5
15. My Parent Partner helped me find services that fit my needs and the needs of my family	1	2	3	4	5

How much do you agree or disagree with the following statements? (Circle one answer for each statement.)	*1 =* ***Very strongly agree***	*2 = Mostly agree*	*3 = Neutral or no opinion*	*4 = Mostly disagree*	*5 =* ***Very strongly disagree***
16. My Parent Partner was respectful of my own lifestyle and environment	1	2	3	4	5
17. My Parent Partner took my cultural or ethnic background seriously	1	2	3	4	5
18. My Parent Partner responded to me in a timely fashion	1	2	3	4	5
19. My Parent Partner was available during days and times that were convenient to me	1	2	3	4	5

How satisfied were you with the services? (Circle one answer for each question.)	*1 =* ***Very satisfied***	*2 = Satisfied*	*3 = Neutral or no opinion*	*4 = Dissatisfied*	*5 =* ***Very dissatisfied***
20. Overall, how satisfied were you with the services you received?	1	2	3	4	5
21. How satisfied were you with your Parent Partner's respect for your family's beliefs and values?	1	2	3	4	5

How satisfied were you with the services? (Circle one answer for each question.)	*1 =* ***Very satisfied***	*2 = Satisfied*	*3 = Neutral or no opinion*	*4 = Dissatisfied*	*5 =* ***Very dissatisfied***
22. How satisfied were you with your Parent Partner's understanding of your family's (cultural) traditions?	1	2	3	4	5

23. How satisfied were you with your Parent Partner's ability to find services that fit your family's culture and traditions?	1	2	3	4	5
24. How satisfied were you with your child's progress in the last six months?	1	2	3	4	5

Circle one answer for the following questions.	*1 =* ***Always***	*2 = Usually*	*3 = Some-times*	*4 = Seldom*	*5 =* ***Never***
25. How often did your Parent Partner ask for your ideas and opinions concerning your child's placement, needs or services?	1	2	3	4	5
26. How much were you involved in planning services for your child?	1	2	3	4	5

27. How much were you asked to participate in meetings where services for your child were discussed?	1	2	3	4	5
28. How much were your needs met by other professionals in the county?	1	2	3	4	5
	*1 = **Strongly agree***	*2 = Agree*	*3 = Not sure*	*4 = Disagree*	*5 = **Strongly disagree***
29. How much do you agree with this statement: "Parent Partner will stick with us no matter what?"	1	2	3	4	5

Overall, since you started the Parent Partner program…	*1 = **Yes***	*2 = Somewhat*	*3 = **No***
30. Did you get the help you needed?	1	2	3
31. Did you need more help than you got?	1	2	3
32. Has the Parent Partner program helped you with your life?	1	2	3
33. Are you satisfied with how your life is going right now?	1	2	3

34. How long have you had or did you have a Parent Partner? (Please give your best estimate in days, weeks, or months.)

35. What has been the most helpful thing for you about the Parent Partner program?

36. Is there anything that you felt would have really made things better, or would improve any of the services you and your child received from the child welfare agency?

37. Do you have needs that are not currently being met with the services you received? What sorts of services do you need that you do not currently receive?

Appendix H: Restrictiveness Instrument

May require some adaptation

Children's Restrictiveness of Living Environments Instrument

Instructions for calculating the restrictiveness of children's living environments:

A. Complete the child and rating information.

B. On the right side of the items in column B, number the child's placements in sequential order and record the corresponding number of days in each placement, e.g., (1,30) indicates first placement, 30 days.

C. Record the corresponding Restrictiveness Score for each placement into the Restrictiveness Formula in column C, i.e., R_{p1}, represents the restrictiveness score of the child's first placement. Calculate the totals.

D. Record the corresponding per diem cost and the number of days in each placement in column D. Calculate the totals.

A. Child Name: ________________ (last) (first) Rater Name: ________________

Child Birthdate: ____ / ____ / ____ (year) (month) (day) Date Completed: ____ / ____ / ____ (year) (month) (day)

Child Identification Number: ________________

B. Restrictiveness Scores

Rank	Mean	Living Environment Value
1.	1.51	Self-maintained residence
2.	2.10	Private boarding home
3.	2.18	Home of child's friend
4.	2.33	Home of family friend
5.	2.40	Home of relative
6.	2.45	Home of biological parent
7.	2.60	Homeless
8.	2.66	Adoptive home
9.	2.75	Supervised independent living
10.	3.09	Independent-living preparation group home
11.	3.13	Regular foster care home
12.	3.38	Family emergency shelter
13.	3.48	Receiving foster care
14.	3.57	Treatment foster family care home
15.	3.58	Special-needs foster home
16.	3.61	Long-term group home
17.	3.85	Youth emergency shelter
18.	3.86	Receiving group home
19.	4.00	Medical hospital
20.	4.14	Private residential school
21.	4.18	Wilderness camp
22.	4.45	Ranch-based treatment center
23.	4.60	Open youth correction facility
24.	4.62	Adult drug/alcohol rehabilitation center
25.	4.63	Cottage-based treatment center
26.	4.85	Psychiatric group home
27.	4.97	Youth drug/alcohol rehabilitation center
28.	5.13	Armed services base
29.	5.40	Young offender group home
30.	5.50	Psychiatric ward in a hospital
31.	6.10	Psychiatric institution
32.	6.40	Closed youth correction facility
33.	6.56	Adult correction facility
34.	6.58	Secure treatment facility

C. Restrictiveness Equation

R_{p1} ____ − R_{p2} ____ = ____

R_{p2} ____ − R_{p3} ____ = ____

R_{p3} ____ − R_{p4} ____ = ____

R_{p4} ____ − R_{p5} ____ = ____

Total ____

D. Cost Equation

T_{p1} ____ × C_{p1} ____ = ____

T_{p2} ____ × C_{p2} ____ = ____

T_{p3} ____ × C_{p3} ____ = ____

T_{p4} ____ × C_{p4} ____ = ____

T_{p5} ____ × C_{p5} ____ = ____

Total # Days in Placement ____ Total Cost of Placement ____

Figure 1: The Children's Restrictiveness of Living Environments Instrument.

Appendix I: Potential Measures for Social/Emotional Well-Being

Name of Measurement	Areas measured	Respondent	# of Sub-scales	# of Items	Time to complete	Age Range	Sensitive to change?	Type of Scale	Valida-ted?	Cost	Articles to support
CWBS (Child Well-Being Scale	Parenting performance: parental role performance, familial capacities, child role performance, and child's capacities.	Service Provider based on observation	14	43	25 min	N/A	Yes	Scaled	Yes	NONE	(Magura & Moses 1986) (Lyons & Doueck 2009; Glad *et al*. 2012) http://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds[]=citjournalarticle_74047_28
CYRM – 28 (Child and Youth Resilience Measure	Assesses overall resilience, individual traits, relationship to caregiver, and contextual factors that facilitate a	Child (Administered by Service Provider)	3	28	20 min	5-9 10-23	Yes	Scaled	Yes	NONE	http://www.resilienceproject.org/research/resources/tools/33the-child-andyouthresiliencemeasure-cyrm

	sense of belonging.										
BERS -2 (Behavior and Emotional Rating Scale)	Multi-modal assessment of children's emotional and behavioral strengths : Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength.	Child (Administered by parents, teachers, counselors and clinicians)	6	10	10 min	5-18	Yes	Scaled and Qualitative	Yes	Yes	http://cssr.berkeley.edu/research_units/bassc/documents/BASSCChildWell-BeingFULLREPORT09.26.06.pdf
BITSEA (Brief Infant and Toddler Social Emotional Assessment	Measures social-emotional development and competencies.	Caregiver of social worker based on observation	17	42	7-10 min	1–3 years	Yes	Scaled	Yes	yes	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4575038/
Quality of Life Questionnaire (Adolescent Version)	To assess children's perceived satisfaction with several adolescent	Child	6	54	10 min.	11-18	Yes	Scaled	Yes	yes	DOI: 10.1016/j.jval.2014.12.006

	life domains: Leisure and relationships, school, family, self-esteem, and self-image										
Child's Inventory of Anger	Assesses children's anger and their ability to cope with it: frustration, physical aggression, peer relationship, and authority relations	Child	4	39	10 min.	6-16	Yes	Scaled	Yes	yes	(Nelson & Finch, 2000) (Shoemaker, Erickson, & Finch, 1986) (Nelson, Hart, & Finch, 1993) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2722119/

Coping Scale for Children and youth	Measures assistance seeking, cognitive-behavioral problem solving, cognitive avoidance, and behavioral avoidance	Child	4	29	N/A	10-15	Yes	Scaled	Yes	NONE (Measure can be found in the development article.)	http://www.excellenceforchildandyouth.ca/resource-hub/measure-profile?id=466
Emotional Quotient Inventory: Youth Version (EQ-i:YV)	Assesses self-regard, emotional self-awareness, assertiveness, independence, self-actualization, empathy, social responsibility, interpersonal relationship, stress tolerance, impulse control, reality testing, flexibility, problem solving, optimism, and happiness.	Child	5	Full 60 items Short version 30	Full length 30 min Short version 10 min	7-18	Yes	Scaled	Yes	Yes	(Bar-On, 2004) (Butler & Chinowsky, 2006) (Dawda & Hart, 2000) (Plake, Impara, & Spies, 2003) (Shuler, 2004)

Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire	Assesses quality of life enjoyment, and life satisfaction	Administered by practitioners or self-administered		23	<4	6-17 yrs.	Yes	Scaled	Yes	Yes	http://www.massgeneral.org/psychiatry/services/psc_home.aspx (Jellinek et al., 1999) (Jellinek et al., 1988) (Little, Murphy, Jellinek, Bishop, & Arnett, 1994) (Pagano, et al., 1996)

Appendix J: Qualifications of Staff and Consultants

BIOGRAPHICAL SKETCH

NAME Elizabeth K. Anthony	POSITION TITLE Associate Professor (Tenured) of Social Work
eRA COMMONS USER NAME EKANTHONY	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
University of California, Davis, Davis CA	BA	1995	Psychology
Santa Clara University, Santa Clara CA	MA	1998	Counseling
University of Denver, Denver CO	MSW	2004	Social Work
University of Denver, Denver CO	PhD	2006	Social Work
University of California, Berkeley, Berkeley CA	Post-Doctoral	2006-2008	Social Welfare

A. **Personal Statement**

Dr. Elizabeth K. Anthony's role in the Waiver evaluation is to lead the process evaluation components and the sub-study on child and adolescent well-being measurement. In 2009 Anthony worked on a team from the University of California, Berkeley that evaluated one of the first comprehensive parent peer programs (Parent Partners) in Contra Costa County, California. In addition, she has more than 10 years of clinical and research experience in community-based programs for children, youth, and families living in poverty. Anthony is the author of 30 peer-reviewed publications on "at-risk" youth and children and youth involved in child welfare, the majority of which are sole- or first-authored and published in top-tier disciplinary journals such as *Children and Youth Services Review* and *Social Work Research*. She will use her combined program and evaluation experience to support the implementation and evaluation of the Waiver to safely reduce congregate care. Her scholarly work has focused on resilience and well-being measurement among vulnerable youth and she brings this expertise to the sub-study.

B. **Selected Positions and Honors**

Research Director, University of Denver, Graduate School of Social Work, 2004-2006

The Bridge Project

Research Director, University of California, Berkeley, School of Social Welfare, 2006-2008

Bay Area Social Services Consortium

Assistant Professor, Arizona State University, School of Social Work 2008-2014

Research Faculty Affiliate, Southwest Interdisciplinary Research Center 2008-Present

(SIRC), Arizona State University

Associate Professor, Arizona State University, School of Social Work 2014-Present

C. **Selected Peer-reviewed Publications**

Lou, C., **Anthony, E. K.**, Stone, S., Vu, C. M., & Austin, M. J. (2008). Assessing child and youth well-being: Implications for child welfare practice. *Journal of Evidence-Based Social Work, 5*(1/2), 91-133.

Anthony, E. K., & Austin, M. J. (2009). Strategies for engaging adults in welfare-to-work activities. *Families in Society*, *90*(4), 359-366. doi:10.1606/1044-3894.3929

Anthony, E. K., Austin, M. J., & Cormier, D. (2010). Early detection of prenatal substance exposure and the role of child welfare. *Children and Youth Services Review, 32*, 6-12.

Anthony, E. K., & Stone, S. I. (2010). Individual and contextual correlates of adolescent health and well-being. Families in Society, 91(3), 225-233.

Berrick, J. D., Cohen, E., & **Anthony, E.** (2011). Partnering with parents: Promising approaches to improve reunification outcomes for children in foster care. *Journal of Family Strengths*, *11*(1), 1-13. http://digitalcommons.library.tmc.edu/jfs/vol11/iss1/14

Berrick, J. D., Young, E. W., Cohen, E., & **Anthony, E.** (2011). 'I am the face of success': Peer mentors in child welfare. *Child & Family Social Work, 16*(2), 179-191. doi:10.1111/j.1365-2206.2010.00730.x

Anthony, E. K., King, B., & Austin, M. J. (2011). Reducing child poverty by promoting child well-being: Identifying best practices in a time of great need. *Children and Youth Services Review, 33*, 1999-2009.

Williams, L. R., & **Anthony, E. K.** (2013). A model of positive family and peer relationships in adolescence. *Journal of Child and Family Studies*. doi:10.1007/s10826-013-9876-1

Anthony, E. K., Williams, L. R., & LeCroy, C. W. (2014). Trends in adolescent development impacting practice: How can we catch up? Journal of Human Behavior in the Social Environment, 24, 487-498. doi: 10.1080/10911359.2013.849220

Forrest-Bank, S., Nicotera, N., **Anthony, E. K**., Gonzales, B., & Jenson, J. M. (2014). Risk, protection, and resilience among youth residing in public housing neighborhoods. Child and Adolescent Social Work, 31(4), 295-314. doi: 10.1007/s10560-013-0325-1

Forrest-Bank, S., Nicotera, N., Jenson, J. M., & **Anthony, E. K.** (in press). Finding their way: Perceptions of risk, resilience, and positive youth development among adolescents and young adults from public housing neighborhoods. Children and Youth Services Review.

D. Research Support

Ongoing

National Institute on Minority Health and Health Disparities (Marsigilia, PI) 6/1/2011-Present

Health Disparities Research at SIRC: Cultural Processes in Risk and Resiliency.

The major goal of this study is to adapt interventions to increase coping skills and reducing symptoms of anxiety among early adolescents living in public housing neighborhoods in Phoenix, Arizona.

Role: Early Career Fellow in Health Disparities

Arizona State University-OVPREA (Anthony, PI) 01/1/10-Present

Validating Typologies of Risk and Resilience Among Youth Living in Urban Poverty

The major goal of this study is to cross-validate typologies of risk and resilience identified in a prior study among a sample of middle school youth (*N*=164) from public housing neighborhoods in Phoenix, Arizona.

Role: PI

Completed

University of Denver (Anthony, PI) 7/1/05-6/30/06

Patterns of Risk and Resilience among Urban Youth: An Ecological Perspective

The major goal of this study was to examine risk and protective factors among a sample of 157 youth between 6th and 8th grade who resided in three urban public housing developments. The relationship between identified patterns of risk and protection and educational and behavioral outcomes was assessed.

Role: PI

Arizona State University (Anthony, PI) 8/1/08-7/30/09

AOD Prevention for Transition-Age Youth in Behavioral Health Services

The major goal of this pilot study was to assess the capacity for a larger investigation of screening and early intervention substance abuse practices for transitioning youth.

BIOGRAPHICAL SKETCH – Systems Change Consultant

NAME Robert Cohen	POSITION TITLE Children and Family Policy and Program Development Consultant
eRA COMMONS USER NAME	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Drew Univerity, Madison, NJ	BA	1962	Psychology
Syracuse University, Syracuse NY	MS	1966	Psychology
Syracuse University, Syracuse NY	Ph.D.	1968	Clinical Psychology

D. **Personal Statement**

Dr. Robert Cohen is a community and clinical psychologist. Until recently Cohen was a Professor at Virginia Commonwealth University engaged in a variety of activities, primarily focused on child mental health and youth violence. His work has included teaching, writing, research and consultation on program and system development and evaluation. Cohen has been active in assisting universities to be more engaged with their surrounding communities and most of his work has been interdisciplinary.

E. **Selected Positions and Honors**

Children and Family Policy and Program Development Consultant 2011-Present

Executive Director, Society for Community Research and Action 2012-2013

Policy and Program Development Consultant 2011-Present

Director, Virginia Treatment Center for Children 2007-2012

Professor, Virginia Commonwealth University 1991-2011

Vice Chair, Department of Psychiatry 1995-2011

Director, Commonwealth Institute for Child and Family Studies 1998-2007

F. **Selected Peer-reviewed Publications**

Cohen, R. and Ventura, A. (in press. Witness to a Transformation: Virginia's Bold Attempt to Establish and Sustain a Comprehensive System of Care for At-Risk Youth.

Aboutanos, M., Jordan, A., **Cohen, R**., Foster, R., Goodman, G., Halfond, R., Charles, R., Smith, S., Wolfe,. Hogue, B., & Ivatury, R. (July 2011) Brief Violence Interventions with Community are Management Services are Effective for High-Risk Trauma Patients. *Journal of Trauma*, 71, 228-237.

Hoffman, J.S., Knox, L. and **Cohen, R**. (2010). Beyond Suppression: Global Perspectives on Youth Violence. Santa Barbara: Praeger Publishers.

Corona, R., Gonzalez, T., **Cohen, R**., Edwards, C., & Edmonds, T. (2009). Richmond Latino needs assessment: A community-university partnership to identify health concerns and service needs for Latino youth. *Journal of Community Health, 34,*195-201.

Meyer, A., **Cohen R**., Edmonds, T., & Masho, S. (2008) Developing a comprehensive approach to youth violence prevention in a small urban city. *American Journal of Preventive Medicine. 34, 3S,* S13-S20.

Cohen, R., Linker, J. & Stutts, L. (2006) Working together: Lessons learned from school, family and community collaboration. Psychology in the Schools. *43, 4,* 419-428.

Oswald, D., **Cohen, R**., Best, A., Jenson, C., & Lyons, J. (2001). Child strengths and level of care for children with emotional and behavioral disorders. Journal of Emotional and Behavioral Disorders. 9, 3, 192-199.

Cohen, R. and Cohen, J. (2000*). Chiseled In Sand: Perspectives on Change in Human Service Organizations*, Brooks/Cole, Belmont, CA: Wadsworth ITP Publishing.

Vitanza, S., **Cohen, R**., Hall, L. Families on the brink: The impact of ignoring children with serious mental illness. Results of a national survey of parents and other caregivers conducted by the National Alliance for Mental Illness. July, 1999.

Cohen, R., Wiley, S., Oswald, D., Eakin, K., & Best. A. (1999). Applying utilization management principles to a comprehensive service system for children with emotional and behavioral disorders and their families: A feasibility study. Journal of Child and Family Studies, 8, 4, 463-476.

Cohen, R., Wiley, S., Oswald, D., Eakin, K., & Best. A. (1999). Applying utilization management principles to a comprehensive service system for children with emotional and behavioral disorders and their families: A feasibility study. Journal of Child and Family Studies, 8, 4, 463-476.

E. Research Support

Completed

CDC 9/15/05-9/14/10

National Academic Centers of Excellence on Youth Violence Prevention

Conduct research as well as outreach and education through university-community partnerships

Role: Investigator, Director of University-Community Relations.

City of Richmond 7/1/04-6/30/05

Establishing an Accountability and Evaluation System for the City Manager's Crime Reduction Campaign.

Assisted the City Manager and his staff to design and implement a data tracking system for the purposes of assessing the effectiveness of strategies for reducing violence and other crimes in Richmond.

Role: Co-PI

City of Richmond 7/1/04-2/28/05

Developing Successful Partnerships on behalf of Children in the City of Richmond Public Schools. Provided technical assistance to the Superintendent of Richmond Public Schools in developing a template for effective school-community partnerships to enhance student performance. Conducted surveys of existing programs, identified best practices from the literature and supported a task force in establishing guidelines and a partnership assessment instrument.

Role: PI

R49 CCR318597 Cohen (PI) 9/30/00-9/29/05

CDC

VCU Center for the Study and Prevention of Youth Violence.

The goal of this project was to establish an academic center of excellence to address issues of youth violence prevention through community-university partnerships.

Role: PI

Virginia Department of Criminal Justice Services 6/01-9/02

Alternative Pathways for At Risk Youth

A study of potential early intervention opportunities for children with severe emotional and behavioral disorders.

Role: Co-PI

Virginia Department of Criminal Justice Services 1/00-12/00

Providing Mental Health Services for Children in the Juvenile Justice System: Balancing Record Sharing and Confidentiality.

Qualitative study of problems and advantages of sharing information among child serving agencies.

Role: PI

Virginia Department of Criminal Justice Services 1/00-12/00

Providing Mental Health Services for Children in the Juvenile Justice System: Balancing Record Sharing and Confidentiality.

Qualitative study of problems and advantages of sharing information among child serving agencies.

Role: PI

Virginia Office of Comprehensive Services 3/99-12/99

Initial Assessment of the Comprehensive Services Act Utilization Management Initiative

Statewide evaluation of the effectiveness of using decision support tools to improve placement and treatment of children and adolescents with serious emotional and behavioral disorders.

Role: PI

National Alliance for the Mentally Ill 3/99-12/99

The Experiences of Children with Serious Mental Illness: A National Survey of Parents and other Caregivers.

Role: Co-PI

Virginia Office of Comprehensive Services 2/96-11/96

Applying Utilization Management Principles to the Comprehensive Services Act for At Risk Youth and their Families.

Statewide study to assess the need, receptivity and potential benefit of introducing a data driven decision support system to an interagency system of care for children with serious emotional and behavioral disorders.

Role: PI

BIOGRAPHICAL SKETCH

NAME	POSITION TITLE
Francie Julien-Chinn	Research Specialist, Center for Child Well-Being
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Northern Arizona University, Flagstaff, AZ	BSW	2000	Social Work
Arizona State University, Phoenix, AZ	MSW	2005	Social Work
Arizona State University, Phoenix, AZ	Ph.D.	05/2017 (Anticipated)	Social Work

A. Personal Statement

Francie Julien-Chinn is a third year Ph.D. student in the School of Social Work at Arizona State University and has research interests in organizational factors within child welfare agencies, management and supervision in child welfare, and outcomes for children in the child welfare system. Prior to beginning her doctoral program, Ms. Julien-Chinn worked in the field of child welfare for over 12 years. As a research specialist at ASU, Ms. Julien-Chinn has evaluated training programs, developed training curriculum and facilitated training for child welfare specialists, supervisors, and managers. Through her role at ASU's Center for Child Well-Being, Ms. Julien-Chinn was part of a team that updated and revised the supervisor core training for the Department of Child Safety. She also helped develop trainings for specialists and supervisors on the following topics: introduction to supervision, partnering with foster parents, in-home services, clinical supervision, and case planning. Ms. Julien-Chinn also teaches undergraduate and graduate social work classes,

including Advanced Social Work Practice with Child Welfare Families for MSW students who are part of the IV-E child welfare program. Ms. Julien-Chinn's professional experience in child welfare combined with her educational training through her Ph.D. program will allow her to effectively support implementation and evaluation of the identified Waiver intervention activities.

B. Positions and Honors

Positions

2013- Current	Research Specialist, Arizona State University, Center for Child Well-Being Phoenix, Arizona
2013 – Current	Faculty Associate, Arizona State University, Tucson, Arizona Campus (Courses Taught: Integrative Field Seminar; Foundations of Social Work Practice; Statistics for Social Workers (online); Advanced Social Work Practice with Child Welfare Families)
2002-2013	Deputy Program Manager (Final Position Held), Department of Economic Security, Child Protective Services, Tucson, Arizona
2001-2002	Case Manager, Our Town Family Center, Tucson, Arizona

Honors

2015	Doris Duke Fellowship for the Promotion of Child Well-Being: *Seeking Innovations to Prevent Child Abuse and Neglect.* Chapin Hall, University of Chicago & Doris Duke Charitable Foundation ($60,000 Fellowship)
2015	Nomination - GADE Student Award for Leadership and Service
2013	ASU University Graduate Fellowship ($2000)
2004-2005	IV-E Stipend, Arizona Department of Economic Security and ASU School of Social Work
1996-2000	Arizona Board of Regent's Scholarship, Northern Arizona University

BIOGRAPHICAL SKETCH

NAME Cara Kelly	POSITION TITLE Research Specialist, Center for Child Well-Being
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE (*if applicable)*	YEAR(s)	FIELD OF STUDY
Arizona State University, Tempe, AZ	B.I.S	05/07	Family and Human Development/Sociology
Arizona State University, Phoenix, AZ	MSW	05/09	Social Work
Arizona State University, Phoenix,, AZ	PhD	05/2018 (Anticipated)	Social Work

A. Personal Statement

Cara Kelly is a second year School of Social Work PhD student at Arizona State University with research interests in child maltreatment intervention and prevention, and outcome measurements for children and family services. During her doctoral studies, Cara has taken coursework which offers an interdisciplinary perspective on research and evaluation in child welfare from the fields of criminal justice, family studies, nursing, and public administration. As a research specialist at the ASU Center for Child Well-Being, Cara has been involved in on-going training support for the Department of Child Safety through the ASU Advanced Child Welfare Training Academy. Additionally, she has more than 12 years of social work experience in child welfare services as a practitioner working in the areas of foster parent training and support, family preservation, and child abuse and neglect investigations. Cara will use her experience as a child welfare practitioner combined with her educational training in research and evaluation to support implementation and evaluation of the identified Waiver intervention activities.

B. Positions and Honors

2014- Current	Research Specialist, Arizona State University, Phoenix, Arizona
2009-2015	Child Protective Services Specialist IV (Final Position Held), Department of Economic Security, Child Protective Services, Phoenix, Arizona
2006-2012	Team Lead (Final Position Held), Family Preservation, Ameripsych Inc., Phoenix, Arizona
2004-2006	Foster Parent Trainer/ Licensing Specialist, Barnes Family Services, Phoenix, Arizona
2001-2004	Residential Program Manager (Final Position Held), Developmental Behavioral Consultants, Phoenix, Arizona

BIOGRAPHICAL SKETCH

NAME Karin Kline	POSITION TITLE Program Manager, Workforce Development Center for Child Well-Being
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Arizona State University, Tempe, AZ	BSW	05/85	Social Work
Arizona State University, Tempe, AZ	MSW	05/90	Social Work

A. Personal Statement

Karin Kline, MSW is a Program Manager at Arizona State University's Center for Child Well-Being. While at ASU Karin has been responsible for developing a strong relationship with the state's child welfare training and administrative units and has worked to support and advance the training of new and existing child welfare front line workers, supervisors and managers as well as child welfare system partners. Karin has over 30 years of professional experience in child welfare in Arizona and is committed to contributing to the improvement of child welfare in any capacity. Karin is interested in contributing to the Waiver evaluation team in order to improve well-being outcomes for children who spend time involved with that child welfare system. She will use her knowledge and experience to support implementation and evaluation of the Waiver intervention activates.

B. <u>Positions and Honors</u>

April 2012 — Awarded by the Greater Phoenix Child Abuse Prevention Council, "Cherish the Children Award, Phoenix, Arizona

1995 – Present Member of the Arizona Child Fatality Review Committee, serving on unexpected infant death and maltreatment subcommittees and a member of the Statewide committee.

2011 to Present Program Manager, Arizona State University, Center for Child Well-Being, Phoenix, Arizona

2007 to 2011 Human Service Program Development Specialist, Arizona Department of Economic Security, Division of Children, Youth and Families, Phoenix, Arizona

2002 to 2007 Program and Project Specialist II - Child Protective Services Spokesperson, , Arizona Department of Economic Security, Office of the Director, Phoenix, Arizona

1997 to 2002 Executive Staff Assistant, Arizona Department of Economic Security, Administration for Children, Youth and Families, Phoenix, Arizona

1995 to 1997 Site Manager for Healthy Families Program, Southwest Human Development, Gilbert, Arizona

1990-1992 Member of the Healthy Options for Parenting Children (HOPE) council, Child Crisis Arizona, Mesa, Arizona. While on the board was involved in creation and implementation of a local Community Multi-Disciplinary Team, Mesa Arizona

1990 to 1995 Child Protective Services Unit Supervisor, Arizona Dept. of Economic Security, Division of Children, Youth and Families, Tempe, Arizona

1989 Semi-Finalist proposal to Harvard - Innovations in Government. Developed and implemented program for families with substance exposed newborns

1985 to 1987 Human Service Specialist II, Arizona Department of Economic Security, Division of Children, Youth and Families, Tempe and Mesa, Arizona

BIOGRAPHICAL SKETCH

NAME Krysik, Judy L.	POSITION TITLE Associate Professor, of Social Work
eRA COMMONS USER NAME (credential, e.g., agency login) krysikjl	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
University of Calgary, Canada	BSW	05/88	Social Work
University of Calgary, Canada	MSW	05/91	Social Work
Arizona State University, Tempe, AZ	PhD	03/95	Social Work

A. Personal Statement

The overarching goal for Waiver Evaluation is to evaluate efforts to safely reduce congregate care. My extensive research experience with Healthy Families Arizona, a child abuse and neglect prevention program aimed at high risk families from birth through age five and delivered in the home, and Safe Babies Court Teams in Arizona, has given me the opportunity to develop the necessary expertise to assist in the proposed research. Specifically I have experience recruiting participants for an experimental study, retaining and tracking participants over time, training and supervising research assistants to administer multiple measures during home visits, and assisting with data management and analysis as well as writing for peer-reviewed publications. I also have extensive involvement with the child welfare and social work education systems as the Associate Director of the ASU School of Social Work, the Chair of the ASU School of Social Work Curriculum Committee, and as the PI on the ASU Advanced Child Welfare Training Academy and Citizen Review Panel Program. More recent evaluation work has included the evaluation of child welfare outcomes for the Cradle to Crayons program. These roles will help me to navigate systems and data for the proposed project.

B. Positions and Honors

1993-1996 Assistant Professor, University of Calgary, Canada

1998-2001 Assistant Professor, University of Denver, Colorado

2005-present Associate Professor (tenured), Arizona State University, Phoenix, Arizona

C. Selected Peer-reviewed Publications

Krysik, J., & LeCroy, C. W. (2007). The evaluation of Healthy Families Arizona: A multisite home visitation program. *Journal of Prevention and Intervention in the Community, 34,* 109-127. (co-published simultaneously In J. Galano. (Ed.). (2007) The Healthy Families America Initiative: Integrating Research, Theory, and Practice (pp. 109 – 128). Binghamptom, NY: Haworth Press)

Krysik, J., Ashford, J. B., & LeCroy, C. W. (2008). Participants' perceptions of Healthy Families: A home visitation program to prevent child abuse and neglect. *Children and Youth Services Review, 30*, 45-61.

LeCroy, C. W., & Krysik, J. (2008). Predictors of academic achievement and school attachment among Hispanic adolescents. *Children and Schools, 30*, 197-210.

LaMendola, W., & Krysik, J. (2008). Design imperatives to enhance evidence-based interventions with persuasive technology: A case scenario in preventing child maltreatment. *Journal of Technology in the Human Services, 26,* 397-422

Roe-Sepowitz, D.E., & Krysik, J. (2008). Examining the sexual offenses of female juveniles: The relevance of childhood maltreatment. *American Journal of Orthopsychiatry: Interdisciplinary Perspectives on Mental Health and Social Justice, 78,* 405-412.

LeCroy, C. W., & Krysik, J. (2010). Measurement issues in home visitation: A research note. *Children and Youth Services Review, 32, 1483-1486.*

Shapiro, A., & Krysik, J. (2010). Finding fathers in social work research and practice. *Journal of Social Work Values and Ethics, 20.*

LeCroy, C. W., & Krysik, J. (2011). Randomized trial of the Healthy Families Arizona home visiting program. *Children and Youth Services Review, doi:10.1016/j.childyouth.2011.04.36*

Shapiro, A., Krysik, J., & Pennar, A. (2011). Who are the fathers in Healthy Families Arizona? An examination of father data in at-risk families. *American Journal of Orthopsychiatry: Interdisciplinary Perspectives on Mental Health and Social Justice, 81*(3), 327-336.

Krysik, J. & LeCroy, C. W. (2012). The development and initial validation of an outcome measure for home visitation: The Healthy Families Parenting Inventory. Infant Mental Health Journal, 33(5), 496-505. Doi: 10.1002imhj.21343

LaMendola, W., & Krysik, J. (2012). Ethic and value considerations in the design of interactional agency. Information, Communication and Society, doi: 10.1080/1369118X.2012.687394

Pennar, A., Shapiro, A., & Krysik, J. (2012). Drug endangered children: Examining children removed from methamphetamine laboratories. Children and Youth Services Review, 34, 1777-1785.doi: 10.1016/j.childyouth.2012.05.006

Krysik, J. L., & Finn, J. (2013). *Research for effective social work practice (3rd edition).* United Kingdom: Francis Taylor Group.

D. Research Support

Ongoing Research Support

Prevent Child Abuse Arizona 6/12-7/15

The goal of this study is to evaluate outcomes of a model court program targeted to dependent children less than 3 years of age. The study includes two comparison groups and merges data from two state agencies.

Role: PI

Completed Research Support

ACYF, DHHS (Sub -recipient with AZ Supreme Court) 10/12-5/15

The goal of this study is to provide quality early education to children less than 5 years of age in foster care. The grant includes development of the collaboration, environmental scan, design of the measurement model, and pilot with a sample of 20 families.

Role: Evaluator

ChildHelp 3/10-6/11
The goal of this study was to conduct research to lead to the design and implementation of a national prevention program known as Speak Up Be Safe which is targeted to students in first through sixth grades and their primary caretakers.

Role: PI

BIOGRAPHICAL SKETCH

NAME Jessica Mueller	POSITION TITLE Research Specialist, Center for Applied Behavioral Health Policy
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Arizona State University, Tempe AZ	BS	12/2014	Psychology
Arizona State University, Tempe AZ	BS	12/2014	Family and Human Development

A. Personal Statement

Jessica Mueller holds a B.S. in Psychology and a B.S. in Family and Human Development. While pursuing her baccalaureate degrees, she participated in several research labs across the fields of psychology and family studies. During her time with the Prevention Research Center at Arizona State University, Tempe campus, she developed and managed several databases in Microsoft Access involving family and child welfare. She has consulted with PhD students of Clinical Psychology and Family Studies on their dissertation data management projects. For the Center for Applied Behavioral Health Policy, she performed data analysis for research and evaluation activities in criminal justice, child welfare, and behavioral health. She has assisted in the creation of conceptual data analysis plans and data reporting methods along with procedures manuals.

B. Positions and Honors

Data Analyst Research Aide, Center for Applied Behavioral Health Policy September 2012-December 2014

ASU at the Downtown campus, Phoenix AZ.

Research Assistant, Prevention Research Center August 2009-November 2011

ASU at the Tempe campus, Tempe, AZ

Research Assistant, Bridges to High School/Puentes a la Secundaria January 2013-April 2013

ASU at the Tempe campus, Tempe, AZ

Research Assistant, Child and Family Programs January 2011-April 2012

ASU at the Tempe campus, Tempe, AZ

Psychology Undergraduate Research Scholarship August 2011-May 2012

ASU at the Tempe campus, Tempe, AZ

BIOGRAPHICAL SKETCH

NAME Lois W. Sayrs	POSITION TITLE Director of Research and Evaluation., Center for Applied Behavioral Health Policy (CABHP)
eRA COMMONS USER NAME (credential, e.g., agency login) n/a	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
University of South Carolina, Columbia SC	BA	05/1979	International Studies
Northwestern University, Evanston IL	MA	06/1980	Counseling Psychology
Northwestern University, Evanston IL	Ph.D.	06/1985	Behavioral Health

A. Personal Statement

Evaluation Methodologist **Lois Sayrs** is the Director of Research and Evaluation for the ASU Center for Applied Behavioral Health Policy. Dr. Sayrs is a specialist in Evaluation Research Methods. She has designed and implemented evaluations, performance audits and program reviews in Arizona for over twenty years. Dr. Sayrs has contributed to the research literature on methods and has specific expertise in mixed-methods evaluations. She has extensive experience in reviewing programs that are culturally responsive and respective of linguistically diverse populations in Arizona including the At-Risk Preschool Project, Healthy Families and Health Start. In addition, Dr. Sayrs has evaluated programs intended to improve outcomes for some of Arizona's most vulnerable at-risk populations, for example, programs for persons with serious mental illness, children and adults with developmental disorders, homeless youth, pregnant teens, and children in juvenile detention. She is currently the Program Evaluator for the Arizona Title IV-E Waiver Demonstration Project to reduce the number of dependent children who currently reside in congregate care.

B. Selected Positions and Honors

Editorial/Reviewing Activities

Maricopa County Detention Officer annual behavioral health training curricula,
2014
subject matter expert reviewer

Journal of Psychoactive Drugs, peer reviewer
2012

SAMHSA Science and Service Awards reviewer
2011, 2010

C. Research Support

Ongoing

Engaging, Motivating and Providing Options within Recovery for Veterans (EMPOWR), Evaluator, 2014-Present
A SAMHSA funded transitional housing program for Operation Enduring Freedom and Operation Iraqi Freedom veterans with co-occurring substance abuse and mental health conditions.

Pacific Southwest Addiction Technology Transfer Center, Researcher & Trainer, 2008-Present
Center for Applied Behavioral Health Policy, Tucson, AZ in partnership with UCLA, Los Angeles, CA
Network for dissemination of evidence-based and promising practices, funded by the Substance Abuse Mental Health Services Administration (SAMHSA).

Completed

Criminal Justice Drug Abuse Treatment Studies II (CJDATS II), Co-Investigator, 2009-2014
A National Institutes of Health (NIH) grant intended to improve implementation of substance abuse treatment interventions for offender populations.

Co-Occurring State Incentive Grant (COSIG), Evaluator, 2007-2009
A SAMHSA pilot program that served offenders with co-occurring mental health and substance abuse disorders.

IV-E Waiver Expedited Reunification Demonstration Project, Evaluator, 2007-2008
Arizona DES-funded project providing a wide range of support services aimed at reunifying CPS-involved children and families.

Appendix K: Evaluation Budget and Budget Justification

The total four year (45 month) project period is estimated at $2,286,796. A breakdown of major cost categories for budget years 1-4 is provided below. The first year project period is 9 months from 4/1/2016 – 12/31/2016. For this 9-month period the budget is estimated at $440,134, and is estimated as follows:

A. **PERSONNEL COSTS**

Position	Name	Annual Salary/Rate	Level of Effort	Cost Year 1
Principal Investigator	Judy Krysik	$88,416	28%	$23,578
Co-Principal Investigator	Elisabeth Anthony	$82,778	32%	$26,673
Director	Robert Cohen	$100,000	20%	$15,750
Evaluation Director	Lois Sayrs	$90,000	50%	$33,938
Project Manager	Karen Kline	$78,080	50%	$29,280
Project Coordinator	Andrea Hightower	$63,294	50%	$23,736
Research Specialist	Jessica Mueller	$33,840	50%	$12,690
Research Specialist	Francie Julien-Chinn	$37,440	50%	$14,040
Research Specialist	Cara Kelly	$37,440	50%	$14,040
Project Coordinator Sr.	Nicholas Klofkorn	$59,948	20%	$8,992
Project Coordinator Sr.	Lisa Moen	$53,521	20%	$6,000
Program Coordinator	Suzanne Collett	$40,000	20%	$8,028

MSW Student Stipend	TBH	$2,000	25%	$2,000
			TOTAL:	**$218,745**

PERSONNEL JUSTIFICATION

Judy Krysik, PhD., will serve as Principal Investigator and will have overall responsibility for the ASU portion of the project. Dr. Krysik will devote 28% effort to this project for a total cost of $23,578 in year 1. Dr. Krysik will work 20% in years 2-4 during the academic year on the project with one and a half months of summer effort at 100%.

Elizabeth Anthony, Ph.D., will serve as co-Principal Investigator on this project and will devote 32% of effort in year one for a total of $26,673. Dr. Anthony will work 20% in years 2-4 during the academic year on the project with two months of summer effort at 100%.

Robert Cohen, Ph.D., will assist with training of management and project oversight under direction of Dr. Judy Krysik. Dr. Cohen will devote approximately 20% effort in year one for a total of $15,750. Dr. Cohen will devote 20% of effort in years 2-4 on this project.

Lois Sayrs, will serve as lead of the staff evaluation team and will oversee all evaluation, participant follow-up activities, and contractual and human subjects administration of the project. She will devote 50% effort to the project for a total cost of $33,938. Dr. Sayrs will devote 50% of effort in years 2-4 on this project.

Karen Kline, MSW, will serve as project manager on this project and devote 50% of time for a total of $29,280 in Year 1. Ms. Kline will devote 50% of effort on this project in years 2-4.

Andrea Hightower will serve as project coordinator on project, coordinating project activities and maintaining daily logistical planning. Ms. Hightower will devote 50% of effort for a total of $23,736 in year 1. Ms. Hightower will devote 50% of effort on this project in years 2-4.

Research Specialist Jessica Mueller, will assist with evaluation data under supervision of Dr. Sayrs. Ms. Mueller will devote 50% of effort for a total of $12,690 in year 1. Ms. Mueller will devote 50% of effort on this project in years 2-4.

Research Specialist Francie Julien-Chinn, will assist with programmatic evaluation under supervision of Dr. Krysik. Ms. Julien-Chinn will devote 50% of effort for a total of $14,040 in year 1. Ms. Julien-Chinn will devote 50% effort in years 2-4.

Research Specialist Cara Kelly will assist with programmatic evaluation under supervision of Dr. Krysik. Ms. Kelly will devote 50% of effort for a total of $14,040 in year 1. Ms. Kelly will devote 50% of her effort in years 2-4.

Nicholas Klofkorn will serve as project manager, providing ongoing logistical planning and deliverable tracking of project, coordinating employee effort and assisting with coordination of project activities under supervision of principal investigator Judy Krysik. Mr. Klofkorn will devote 20% of effort for a total of $8,992 in year 1, and 20% in years 2-4.

Lisa Moen will serve as project coordinator for this project coordinating staff labor efforts, reporting and general logistical support under the supervision of Nicholas Klofkorn. Ms. Moen will devote 20% of effort for a total of $8,028 in year 1 and 20% effort in years 2-4.

Suzanne Collett will serve as project coordinator for this project for daily logistical planning and deliverable tracking of project, organizing project related documentation and assisting project staff with internal and external logistical planning as they pertain to project deliverables. Ms. Collett will devote 20% of effort for a total of $6,000 in year 1 and 20% effort in years 2-4.

Two stipends will be provided to students at $2,000/year for MSW student interns to be disbursed in fall and winter semesters. These MSW students will provide assistance with miscellaneous document organization and filing, general research efforts and report writing under supervision of Karen Kline, Lois Sayrs and Judy Krysik.

B. <u>FRINGE BENEFITS*</u>

Classification	Names	Cost

Faculty	Dr. Krysik, Dr. Anthony	$14,855
Staff	Sayrs, Kline, Cohen, Hightower, Mueller, Julien-Chinn, Kelly, Klofkorn, Moen, Collett	$63,038
Wages<50% FTE		$1,785
Student Workers	TBA MSW Student Interns	$36
	TOTAL:	**$79,714**

Arizona State University defines fringe benefits as direct costs, estimates benefits as a standard percent of salary applied uniformly to all types sponsored activities, and charges benefits to sponsors in accordance with the Federally-negotiated rates in effect at the time salaries are incurred. Benefit costs are expected to increase approximately 3% per year; the rates used in the proposal budget are based on the current Federally-negotiated Rate Agreement rate plus annual escalation for out years. Published composite benefit rates for personnel were utilized in this application. Fringe Benefits are calculated based upon the classification of the employee and are disclosed as below:

	FY17	FY18	FY19	FY20
* Faculty	29.56%	30.45%	31.36%	32.30%
* Staff&PostDoc	41.82%	43.07%	44.36%	45.70%
Wages<50%FTE	11.33%	11.67%	12.02%	12.38%
Student Wages	1.75%	1.80%	1.86%	1.91%
* GRA's	12.98%	13.37%	13.77%	14.18%
Post Doc	25.75%	26.52%	27.32%	28.14%

C. TRAVEL COSTS

Location	**Item**	**Rate**	**Cost**	**Total**
Maricopa	Mileage @ 250 miles	0.445	$111.25	
	x12 trips			$1335.00

Pima County	Mileage @ 250 miles	0.445	$111.25	
	Per Diem @ 49.00		$49.00	
	Hotel Overnight @ 89.00		$89.00	
	x 6 trips			$2324.00
Pinal County	Mileage @ 250 miles	0.445	$111.25	
	Per Diem @ 41.00		$41.00	
	x 6 trips			$1160.00
Phoenix Metro	Local Mileage @ 2000	0.445	$890.00	
				$890.00
Title IV Conference	Airfare	$950	$950	
	Hotel and room tax – 2 nights	$188+20	$416	
	Per Diem 3 days	$59	$177	
	Ground Transportation	$100	$100	
	Misc. Baggage, Baggage tips, Ground Transportation/Parking	$250	$250	

	PHX			
	Total per trip		$1,500	
	2Trips			$3,000
			TOTAL:	**$8,709**

TRAVEL JUSTIFICATION

Travel is budgeted for two staff to attend on-site meetings with research cohorts. Travel budgets are split by region – Pinal, Pima, and Maricopa county. Overnight and per-diem is budgeted for locations that will require overnight travel. In addition there is an allocation for two persons (principal and designee) to attend national conference in year 1-2.

D. EQUIPMENT COSTS

Equipment<$5,000		**$6,750**

EQUIPMENT JUSTIFICATION

We are budgeting for 3 workstations in year one and replacement costs for equipment failure in years 2-4.

E. SUPPLY COSTS

Supplies		**$1,500**

SUPPLY JUSTIFICATION

Office supplies (workbooks, folders, pens, etc) estimated at $1,500 in year one.

F. CONSULTANT COSTS AND CONTRACTUAL AGREEMENTS

CONSULTANT COSTS – N/A

CONTRACTUAL AGREEMENT COSTS – N/A

G. CONSTRUCTION

CONSTRUCTION COSTS – N/A

H. OTHER EXPENSES AND JUSTIFICATION

	Description/Unit Cost	Cost
Data Storage/ASU	Data Storage one year	$1,500
Scientific Instruments	Licensing fee for scientific instrument use	$1,000
Printing	Paper	$300
Copier Rental	Copier rental and all associated fees for one year	$1,800
Software	ASU software installation	$80
	TOTAL:	**$4,680**

Indirect Costs

Per ASU, standard indirect rate for community service grants is 37.5%, indirect costs in year 1 are estimated at $120,036.

Project Summary

Salary and Wages	$218,745
ERE (Fringe Benefits	$79,714
Travel	$8,709
Equipment<$5,000	$6,750
Supplies	$1,500
Consultants	$0
Other Direct Expense	$4,680
Indirect Expense	$120,036
Total	$440,134

Year 1-4 costs by category

IV-E Waiver Evaluation

Budget Summary 2/24/16

NAME	FY17		FY18		FY19		FY20	
	5 Months YEAR 1	Summer YEAR 1	9 Months YEAR 2	Summer YEAR 2	9 Months YEAR 3	Summer YEAR 3	9 Months YEAR 4	Summer YEAR 4
Total Faculty Salaries	17,120	33,131	35,266	34,125	36,324	35,148	37,414	36,202
Fringe Benefits Faculty	5,061	9,794	10,738	10,390	11,392	11,023	12,086	11,694
Total Staff Salaries	100,496	50,248	155,265	51,754	159,923	53,308	164,721	54,906
Fringe Benefits Staff	42,025	21,013	66,877	22,292	70,949	23,650	75,261	25,087
Total Part Time Staff	10,500	5,250	16,223	5,408	16,710	5,570	17,211	5,737
Fringe Benefits Part Time Staff < 50%	1,190	595	1,893	631	2,009	670	2,131	710
Total Student Salaries	1,000	1,000	11,618	-	11,967	-	12,327	-
Fringe Benefits Students	18	18	210	-	221	-	235	-
Total Personnel	177,410	121,049	298,090	124,600	309,495	129,369	321,386	134,336
Total Travel	8,709	-	4,355	-	2,178	-	2,178	-
OTHER DIRECT COSTS Field supplies 7320-04	1,500		1,500		1,500		1,500	
Scientific Instrument License - 7320 year 1 only	1,000							
Computers - 7325_01	6,750		500		500		500	
Software - 7325_01	80		80		80		80	
Data Storage 1 TB/year UTO 7325_03	1,500		1,500		1,500		1,500	
Copier Rental (2,000 * .09 per copy) - 7340	1,800		1,800		1,800		1,800	
All Printing - 7340	300		300		300		300	
TOTAL Other Direct Cost	12,930	-	5,680	-	5,680	-	5,680	-
TOTAL DIRECT COSTS Allowed Actual	199,049	121,049	308,125	124,600	317,353	129,369	329,244	134,336
TOTAL MODIFIED DIRECT COST BASE	199,049	121,049	308,125	124,600	317,353	129,369	329,244	134,336
F&A COSTS (Indirect) 37.50% 37.50% 8201	74,643	45,393	115,547	46,725	119,007	48,513	123,467	50,376
TOTAL COSTS	273,692	166,442	423,672	171,325	436,360	177,882	452,711	184,712
	YEAR 1	440,134	YEAR 2	594,997	YEAR 3	614,242	YEAR 4	637,423 Grand Total