Executive Summary

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

Alternative Response

Evaluation Overview

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

Evaluation Findings

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

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

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

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

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

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

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

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

Results-Based Accountability

Evaluation Overview

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

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

Evaluation Findings

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

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

Provider Performance Improvement

Evaluation Overview

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

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

Evaluation Findings

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

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

Major Changes to Demonstration and Evaluation

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