

QIC•AG

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# WINNEBAGO TRIBE OF NEBRASKA IMPLEMENTATION MANUAL

FAMILY GROUP DECISION MAKING

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## CHAPTER 1

# INTRODUCTION USING THE IMPLEMENTATION MANUAL

The Implementation Manual provides detailed information a child welfare system/agency would need to implement one of seven interventions that were implemented and evaluated as part of the Quality Improvement Center for Adoption/Guardianship Support and Preservation (QIC-AG). All of these interventions are geared for children and families who are moving toward adoption or guardianship or children and families who have already achieved permanence through adoption or guardianship.

The Implementation Manual provides a roadmap for using a structured process to 1) determine if an intervention is the “right” intervention for your site and 2) implement the intervention with integrity. The manual will assist with the following:

- » Conducting a system assessment to identify the problem that needs to be addressed and the target population that has the need;
- » Developing a Theory of Change that explains why the change is proposed and the steps needed to achieve the desired outcome;
- » Ensuring the intervention meets the identified need by assessing fit, available resources, expected outcomes, and system readiness and capacity for implementation;
- » Developing a plan to implement the intervention;
- » Identifying and operationalizing supports necessary for implementation;
- » Testing the process to ensure that the intervention is implemented as intended.

Implementing a new intervention will require significant time and resources, and accordingly the manuals that describe the implementation are necessarily detailed. Each chapter contains practical considerations for implementation as well as lessons learned from the pilot sites. You can stop reading the manual if at any point you determine the intervention is not the right intervention for your site.

The manual chapters are as follows:

### CHAPTER 2: OVERVIEW OF THE INTERVENTION:

This chapter provides a brief introduction to the intervention including core components, or key elements. In addition, the chapter identifies the supports needed to successfully implement the intervention with special attention to those supports that are most critical.

### CHAPTER 3: CORE COMPONENTS:

Only read chapter 3, if after reading chapter 2 you would like to have a more in depth understanding of the intervention. Building on the overview in Chapter 2, core components are further defined and operationalized. Additionally, important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given.

### CHAPTER 4: CHOOSING THE RIGHT INTERVENTION

Once you understand the intervention, it is important to determine if it meets the needs of your clients and system. This chapter guides the reader through the **Identify and Explore** phase of implementation, helping to determine if the intervention is right for their system/agency. This chapter includes methodology and tools to identify 1) the problem in need of attention, 2) the target population, and 3) whether the named intervention can be implemented to meet the needs of the target population. Important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given. If the intervention seems like a good fit then move on to chapter 5. If the intervention is not a good fit consider some of the other interventions implemented by the QIC-AG.

### CHAPTER 5: PLANNING TO IMPLEMENT

This chapter takes the reader through the critical steps of **Implementation Planning**, focusing on the components critical to support implementation. These components include: 1) research considerations 2) what must be done to ready a system to support high quality implementation, and 3) teaming and communication structures. This chapter also includes a discussion of the structural and functional changes to the system that may be needed to ensure that the intervention can be implemented (installation phase). Important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given.

## CHAPTER 6: ASSESSING READINESS: USABILITY TESTING

Usability testing is a process used during the ***Initial Implementation*** phase to ensure the intervention can and is being implemented as intended. This testing period allows for adjustments to be made before full implementation begins. Site-specific strategies and examples of usability testing are given.

## CHAPTER 7: TRACKING PROGRESS THROUGH WORK PLANS

Establishing and documenting time frames and responsible parties ensures the project stays on track and progresses as planned. This chapter includes a discussion of the key elements needed in a work plan to effectively track the progress of activities over time and by implementation phase, as well as the benefit of documentation and periodic review.

# POST PERMANENCY STRATEGIES

The QIC-AG is a five-year project that worked with sites across the United States to implement evidence-based interventions or develop and test promising practices, which, if proven effective, could be replicated or adapted in other child welfare jurisdictions. The following interventions were implemented:

## PATHWAYS TO PERMANENCE 2: PARENTING CHILDREN WHO HAVE EXPERIENCED TRAUMA - TEXAS

The Texas site team implemented Pathways to Permanence 2: Parenting Children Who Have Experienced Trauma and Loss, hereafter, referred to as Pathways 2, developed by the nonprofit Kinship Center a member of the Seneca Family of Agencies in California. The Pathways 2 program uses a seven-session group format to guide adoptive parents, foster parents, kinship caregivers, and guardians through robust discussion and activities designed to strengthen their family. Participation in Pathways 2 is limited to “active caregivers” who are either temporary or permanent caregivers for a child living in the home, or an adult who is engaged with the child through visitation, phone calls, or therapy and is willing to have the child return to the home.

## FAMILY GROUP DECISION MAKING - THE WINNEBAGO TRIBE OF NEBRASKA

The Winnebago Team adapted and implemented Family Group Decision Making (FGDM) a practice model that honors the inherent value of involving family groups in decisions about children who need protection or care. As opposed to decisions, approaches, and interventions that are handed down to families, FGDM is designed as a deliberate practice where families lead the decision-making process, and agencies agree to support family plans that adequately address child welfare concerns. A trained FGDM coordinator supports the family throughout the process.

## THE VERMONT PERMANENCY SURVEY - VERMONT

The Vermont site team implemented the Vermont Permanency Survey. The survey consisted of validated measures and questions identified by the Vermont site team that fell into the following categories:

- » Family well-being: To better understand the factors that can impact the family’s safety, permanency, and stability.
- » Child well-being: To identify and understand the strengths and challenges of children and youth who were adopted or are being cared for through guardianship.

- » Caregiver well-being: To identify and understand the strengths and experiences of caregivers who have adopted or assumed guardianship of a child.
- » Community services: To identify and rate the level of helpfulness of the preparation services families used prior to adoption or guardianship and family support services available after achieving permanence.

### **TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY – ILLINOIS**

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is designed to serve youth ages 10 years and older who have experienced trauma and adverse childhood experiences. TARGET uses a strengths-based, psycho-educational approach and teaches youth about the effects trauma can have on human cognition; emotional, behavioral, and relational processes; and how thinking and memory systems can be impeded when the brain's stress (alarm) system is stuck in survival mode. The target population was a child between 11 and 16 years old living with an adoptive parent or guardian and youth over 10 years of age, living in families who finalized private domestic or inter-country adoptions.

### **TUNING IN TO TEENS - NEW JERSEY**

Developed at the Mindful Centre for Training and Research in Developmental Health at the University of Melbourne, Australia and implemented by the New Jersey Team, Tuning in to Teens (TINT) © is an emotion-coaching program designed for parents of youth ages 10 to 18 years. The program equips parents with strategies for not only responding empathically to their adolescent's emotions but also helping their teens develop skills to self-regulate their emotions.

### **ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT - WISCONSIN**

The Wisconsin Team created a new intervention, Adoption and Guardianship Enhanced Support (AGES), an enhanced case management model. Designed with the goal of responding to families who expressed feelings of being unprepared, ill-equipped, or unsupported in trying to meet the emerging needs of their children after adoption or guardianship permanence was finalized. An AGES worker assesses the family's strengths and needs and with the family develops a support plan, covering critical areas such as social supports, case management, parenting-skills development, education, and other capacity-building activities. The intervention was implemented in the Northeast Region of Wisconsin.

The development of AGES was informed by two post-adoption programs: Pennsylvania SWAN and Success Coach in Catawba County, North Carolina.

## THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT) - TENNESSEE

The Neurosequential Model of Therapeutics developed by the Child Trauma Academy, is a developmentally informed, biologically respectful approach to working with at-risk children. NMT is not a specific therapeutic technique or intervention, rather NMT provides a set of assessment tools (NMT metrics) that help clinicians organize a child's developmental history and assess current functioning to inform their clinical decision-making and treatment planning process. NMT integrates principles from neurodevelopment, developmental psychology, trauma-informed services, as well as other disciplines to enable the clinician to develop a comprehensive understanding of the child, the family, and their environment. The NMT model has three key components: (a) training/capacity building, (b) assessment, and (c) specific recommendations for selecting and sequencing therapeutic, educational, and enrichment activities matched with the needs and strengths of the individual.

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## CHAPTER 2

# OVERVIEW OF THE INTERVENTION

Child welfare professionals from the Winnebago Tribe and QIC-AG consultants and evaluators implemented the Family Group Decision Making (FGDM) model in the Winnebago Tribe of Nebraska. Hereafter, this group is referred to as the Winnebago Team or Team. The Winnebago Tribe implemented FGDM because they wanted, but did not have, a recognized, culturally competent, family engagement practice to promote decision-making related to permanence.

This chapter provides an introduction to the intervention and an overview of the core components, or key elements that define an intervention. In addition, the chapter identifies the supports needed to successfully implement the intervention with special attention to those supports critical.

# I. OVERVIEW

The original version of the Family Group Decision Making (FGDM) intervention, rooted in indigenous Maori practices, supports families in determining the best permanency option for their children. Once FGDM was selected, the Winnebago Team worked with the purveyor of the FGDM model, the Kempe Center at the University of Colorado in Denver (Kempe), to adapt FGDM to reflect the Ho Chunk culture and language of the Winnebago Tribe of Nebraska. These adaptations enabled the Winnebago Tribe to implement a culturally relevant permanency practice and increase legal permanence outcomes for Winnebago children. The adapted version of the FGDM intervention is used to support Winnebago families in determining the best permanency option for their children.

More information about FGDM is available from the following websites:

- » [http://www.ucdenver.edu/academics/colleges/medicalschoo/department/pediatrics/subs/can/FGDM/Documents/FGDM Guidelines.pdf](http://www.ucdenver.edu/academics/colleges/medicalschoo/department/pediatrics/subs/can/FGDM/Documents/FGDM%20Guidelines.pdf)
- » <https://pdfs.semanticscholar.org/fc03/4b5805aa23490f628631061ef319944f5d7a.pdf>



## II.

## INTERVENTION CORE COMPONENTS

The various elements making up interventions vary widely but some core components are critical to the identity and aim of each intervention. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “core components are the most essential and indispensable components of an intervention, practice or program.”

The Kempe Center articulates six core components of FGDM:

- 1. An independent (i.e., non-case carrying) coordinator is responsible for convening the family group with agency personnel.**
- 2. Agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group.**
- 3. Family groups meet without statutory authorities or other non-family members present to work through the information they have been provided and to formulate their responses and plans.**
- 4. When agency concerns are adequately addressed, preference is given to family group’s plan over any other possible plan.**
- 5. Follow-up processes after the FGDM meeting occurs until the intended outcomes are achieved to ensure that the plan continues to be current, relevant, and achievable. FGDM is not a one-time event but an ongoing, active process.**
- 6. Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans.**

## CORE COMPONENT 1: AN INDEPENDENT COORDINATOR

*An independent (i.e., non-case carrying) coordinator is responsible for convening the family group with agency personnel.*

An independent coordinator is charged with creating an environment in which transparent, honest, and respectful dialogue occurs between agency personnel and family groups. The coordinator must be independent from the family's caseworker. The coordinator must be viewed as independent by the family and act in a fair and equitable manner. The availability of this person signifies the agency's commitment to empowering practices.

## CORE COMPONENT 2: FAMILY GROUP IS THE AGENCY'S KEY DECISION-MAKING PARTNER

*The agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group.*

Providing the time and resources to seek out family group members and prepare them for their roles in the decision-making process signifies the agency's acceptance of the importance of the family group in formulating permanency plans.

## CORE COMPONENT 3: FAMILY GROUP CONFERENCE INCLUDES PRIVATE FAMILY TIME

*Family groups meet on their own, without statutory authorities or other non-family members present, to work through the information they have been provided and to formulate their responses and plans.*

Providing family groups with time to meet on their own enables them to apply their knowledge and expertise in a familiar setting and in ways that are consistent with their cultural decision-making practices. Acknowledging the importance of this time and taking active steps to encourage family groups to plan in this way signifies an agency's acceptance of its own limitations as well as demonstrates the agency's commitment to ensuring that the best possible decisions and plans are made. The Family Group Conference always includes private family time.

## CORE COMPONENT 4: PREFERENCE GIVEN TO FAMILY GROUP'S PLANS

*When agency concerns are adequately addressed, preference is given to the family group's plan over any other possible plan.*

In accepting the family-group plan, an agency signifies its confidence and commitment to partnering and supporting family-groups in caring for and protecting their children, and, to building the family-groups' capacity to do so.

## CORE COMPONENT 5: FOLLOW-UP ENSURES INTENDED OUTCOMES ARE ACHIEVED

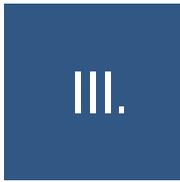
*Follow-up processes after the FGDM meeting occur until the intended outcomes are achieved to ensure that the plan continues to be current, relevant, and achievable because FGDM is not a one-time event but an ongoing, active process.*

Follow-up efforts include, but are not limited to, ongoing family group-driven follow-up FGDM meetings. Such meetings are scheduled to accommodate the family group's needs and availability. The meetings are focused on progress, achievements, unresolved issues or concerns, new information, and additional resources. The result is that the family's plan is updated and revised as needed. In addition, the frequent, proactive communication between representatives of the Child and Family Services (CFS) system and the family group support the successful implementation of the family's plan.

## CORE COMPONENT 6: REFERRING AGENCIES SUPPORT THE FAMILY GROUP'S PLAN

*Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans.*

In assisting family groups in implementing their plans, agencies must uphold the family group's responsibility for the care and protection of their children and contribute to the success of the plan by aligning agency and community resources to support the family group's efforts.



## GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

Once an intervention is selected, it is important to know how the system will be readied to support service delivery. The term *implementation supports* refers to the infrastructure developed to facilitate the successful implementation of an intervention, which also helps to ensure the stability of the intervention over time. Without implementation supports, the system will not have the capacity to support the delivery of the intervention to the target population. Because implementation supports facilitate intervention delivery, assessing these supports is crucial.

### 1. Staffing

Staff included FGDM coordinators, the CFS Director and supervisor, CFS case workers, providers, elders and other members of the community. The two staff identified as coordinators were both younger members of the Winnebago Tribe, and had compatible strengths and skill sets. The first coordinator hired was a social worker who was detail oriented and enjoyed producing documents. The second coordinator was a non-degreed member of the community with deep cultural connections, and a good grasp of the Hocak, (Ho Chunk) language and history. Neither coordinator had experience with FGDM or with convening any type of family meetings.

### 2. Training, Coaching, and Supervision

To prepare for implementation, the Winnebago Team participated in basic FGDM training, consisting of a manualized 3-day training available through the Kempe Center (University of Colorado Denver). An additional day was added to the training to introduce adaptations chosen to make FGDM practice culturally relevant for Winnebago families. The FGDM training was delivered to a group composed of the coordinators, prospective supervisors, Tribal Elders, and providers (child welfare and mental health staff). In addition to the basic training, supervisors received an additional 12 sessions of FGDM supervisory training. Additional professional development for FGDM was provided through Kempe's annual conference. FGDM does offer advance practice training and a train-the-trainer option. Train-the-trainer standards are rigorous. Criteria are detailed on the Kempe website: [www.fgdm.org](http://www.fgdm.org).

External coaching may be necessary for successful implementation. To build-in live coaching and observation, the Winnebago Team contracted with Family Service Rochester (FSR), a Minnesota-based agency with exper-

tise in implementing the FGDM model. The Winnebago Team engaged in bi-weekly phone conferences with coaches throughout the initial implementation. The Winnebago Team also made periodic visits to Minnesota to observe practice and engage in supervision.

Direct supervision of the FGDM Coordinators is provided by the Child Welfare Director and Manager. These two roles were selected to provide supervision because they are aware of the child welfare requirements and expectations, but they are not involved in providing supervision to case managers. This degree of separation is essential to maintaining the autonomy of the FGDM Coordinators.

### 3. Fidelity

In FGDM, fidelity is measured by adherence to the four phases of practice including the three stages of the family group conference: a) information sharing; b) private family time; and c) the planning/decision stage. The team developed a brief post meeting survey to capture the family's experiences with the FGDM process. The survey considers how prepared families feel they are for the meeting and how well the meeting process was executed. The coordinators also complete a brief survey after the meeting to capture whether the meeting ran according to plan.

In addition to the subjective reports and surveys collected after the meetings, an independent observer or supervisor can observe the coordinator during the *preparation* phase as well as the *information sharing* and *planning/decision* stages of FGDM to ensure fidelity. As practice concerns arise, they are discussed with the purveyor and coaching team.

### 4. Policies and Procedures

The need for policy changes is system specific and may or may not be necessary.

### 5. Data Systems

A methodology or system for tracking the completion of activities associated with the phases of the project is recommended. The need for a database may be contingent on the number of clients being served over time.

### 6. Program Expert

The purveyor, Kempe Center, assigned a program representative, an expert in FGDM, to support the Winnebago project and to provide training, observation, and coaching. The program expert was experienced in

working with groups developing FGDM practice and in working with native and indigenous people. The program representative recommended a nearby agency as a resource for coaching. Two consultants from that agency, who were experienced in providing FGDM with high fidelity and good outcomes, provided coaching to the Winnebago Coordinators.

### **7. Financial and Material Considerations:**

The primary costs associated with FGDM are the initial 3-day training and staffing. FGDM training costs include the trainer's time, travel, and administrative overhead as well as the cost of the manuals for trainees. Additional costs for space and food associated for families and training should be considered.

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## CHAPTER 3

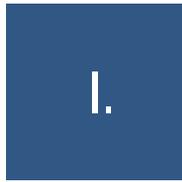
# CORE COMPONENTS

The various elements making up interventions vary widely but some core components are critical to the identity and aim of each intervention. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “core components are the most essential and indispensable components of an intervention, practice or program.”

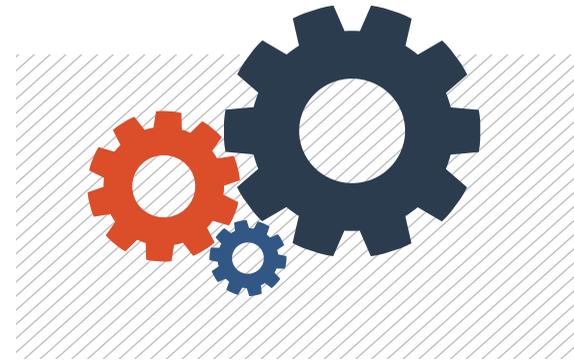
This chapter addresses the following topic:

### I. INTERVENTION CORE COMPONENTS

Each section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Winnebago Team implemented the process, activity, or task; (d) lessons the Winnebago Team learned during implementation.



## INTERVENTION CORE COMPONENTS



The Kempe Center articulates six core components of FGDM:

1. **An independent (i.e., non-case carrying) coordinator is responsible for convening the family group with agency personnel.**
2. **Agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group.**
3. **Family groups meet on their own, without statutory authorities or other non-family members present, to work through the information they have been provided and to formulate their responses and plans.**
4. **When agency concerns are adequately addressed, preference is given to family group's plan over any other possible plan.**
5. **Follow-up processes after the FGDM meeting occur until the intended outcomes are achieved to ensure that the plan continues to be current, relevant, and achievable. FGDM is not a one-time event but an ongoing, active process.**
6. **Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans.**

## CORE COMPONENT 1: AN INDEPENDENT COORDINATOR

*An independent (i.e., non-case carrying) coordinator is responsible for convening the family group with agency personnel.*

An independent coordinator is the person charged with creating an environment in which transparent, honest, and respectful dialogue occurs between agency personnel and family groups. The coordinator must be independent from case decision-making for the specific family for which they are coordinating the conference. The coordinator must be viewed as independent by the family and act in a fair and equitable manner. The availability of this person signifies the agency's commitment to empowering practices.

### WHEN DEVELOPING THE INDEPENDENT COORDINATOR ROLE FOR FGDM, START WITH THE FOLLOWING TASKS:

- » Determine who should employ the coordinator to ensure that this person is able to work independently of the child welfare case.
- » Develop a process to ensure that coordinators are not assigned to families with whom they have prior relationships that might pose a conflict of interest.
- » Identify how independent coordinators will be supervised; supervision must be provided by someone other than the person supervising the child welfare case.
- » Determine how information will be exchanged between coordinator and families, child welfare staff and other providers.

*Note: In FGDM practice, those who might otherwise be called **experts** or **professionals**, such as teachers and therapists, are simply referred to as **providers**.*

The Winnebago Team created two new Family Support Worker positions to serve in the independent coordinator role. Both persons hired to fill these positions were younger members of the Winnebago community, and each had personal relationships with families engaged in child welfare services. For each case, the coordinator assigned had to assess whether their existing relationships posed any conflict of interest; if a conflict existed, the coordinators could exchange cases. To increase the autonomy of the coordinators, they were housed in a family meeting space separate from the child welfare staff and supervised by staff other than the supervisor assigned to the child welfare case.



## LESSONS LEARNED

- » Selecting and preparing the “right” staff is essential to intervention success. It is imperative to select coordinators who embody the principles and values of the FGDM model, as well as to train staff in the specific skill set of FGDM practice.
- » In small communities, it is inevitable that personal relationships exist between the families being served and the coordinators. Agencies should establish a protocol to assess potential conflict of interest and include a plan for addressing this issue in the practice model.

## CORE COMPONENT 2: FAMILY GROUP IS THE AGENCY'S KEY DECISION-MAKING PARTNER

*The agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group.*

Providing the time and resources to seek out family group members and prepare them for their roles in the decision-making process signifies the agency's acceptance of the importance of the family group in formulating permanency plans.

### WHEN CONSIDERING THE COMPLEX TASK OF IDENTIFYING AND PREPARING FAMILY GROUP MEMBERS, START WITH THE FOLLOWING TASKS:

- » Address policies and practices that limit information sharing and might inhibit participation in the meeting.
- » Include child welfare staff in FGDM training with coordinators to promote staff understanding of and support for family-driven decision making.
- » Create a process to identify and provide outreach to as many family members as possible.
- » Meet with each member of the family and each provider to ensure that everyone has the information needed to prepare for the meeting. Typically, this preparation occurs over the course of several individual and small-group meetings before convening the Family Group Conference.
- » Arrange the travel needs of families, thereby reducing barriers to participation.
- » Consider whether the family wants to meet in the home, and when this is not an option identify a place for the family meeting that ensures that everyone is safe from physical or emotional harm and accessible to and comfortable for the family group.
- » Allow time for the coordinators to thoroughly prepare families.

FGDM is consistent with the communal values of the Winnebago people and their sophisticated kinship system of caring for children. Because formal child welfare services in the Winnebago community are based on Western cultural models, and many child welfare workers have been trained to protect children in care from

their families rather than to entrust decision making to families, the Winnebago Team chose to train child welfare staff in FGDM alongside the coordinators. In training workers were reminded of the importance with entrusting major decisions to families.

FGDM practice requires that child welfare staff and other providers share information broadly across the family group, not just with the biological parents. To incorporate this requirement in practice, the Winnebago Child and Family Services revised expectations about family engagement and protocols for information sharing. The site decided that because CFS had statutory authority over the children, CFS staff could consent to inviting family members to participate in FGDM, and CFS could authorize the coordinators to provide family members with the information necessary to partner in the decision-making process. Once this was established the coordinators reviewed the cultural eco-map and Winnebago Kinship chart with youth and families to identify family members that might participate in the Family Group Conference and support the process of planning for the youth in need of permanency.

To ensure that everyone in the family enters the Family Group Conference (FGC) prepared to make plans, many individual or small-group family meetings took place in advance of the conference. FGDM refers to this preliminary work as the *preparation phase*. In addition to meeting with family members, the coordinators met regularly with CFS staff to gather information, prepare staff to share information in the context of the Family Group Decision Making Meeting, and to clarify any “non-negotiables” that were required to be addressed in the plan to ensure the plans made during the FGC would be accepted by statutory authorities.

Since not all children and family members live in the Winnebago community, these meetings frequently involved commutes as much as 4 hours. As a result, the Team budgeted significant time and travel costs for coordinators and travel costs for family members. The coordinators honored family engagement by offering flexible meeting times, including evenings and weekends, as well as a providing safe meeting place on the reservation if other options were not available.



## LESSONS LEARNED

- » It is important to allow time for preparation. The preparation phase cannot be rushed without compromising outcomes. Kempe estimates an average of 30 hours is needed to identify, locate, and prepare families to participate in the Family Group Conference. The experience of the Winnebago Team showed that with some families it took up to 100 hours to accomplish the preparation tasks.

- » It is important to consider geographic and technological constraints when planning for outreach and preparation. Families who live in rural areas may not have a physical street address, land lines, cell phones, or Internet connections. Making contact may require the coordinator to search for families in the community and leave messages at their homes.
- » It is important to allow extra time to work with youth living in out-of-home placements that are far from their community or family group. Many of the youth lived in congregate care settings several hundred miles from the reservation. Therefore, plans for FGDM outreach, recruitment, and engagement had to include time for travel and account for schedules and other limitations imposed by the congregate care facilities.
- » Staff turnover is likely to occur throughout the life of the project. Therefore, it is important to have a plan to onboard, train, and supervise new staff to ensure that workers and providers understand their roles and deliver the intervention consistent with the family empowerment model.

## CORE COMPONENT 3: FAMILY GROUP CONFERENCE INCLUDES PRIVATE FAMILY TIME

*Family groups meet on their own, without statutory authorities or other non-family members present, to work through the information they have been provided and to formulate their responses and plans.*

Providing family groups with time to meet on their own enables them to apply their knowledge and expertise in a familiar setting and in ways that are consistent with their cultural decision-making practices. Acknowledging the importance of this time and taking active steps to encourage family groups to plan in this way signifies an agency's acceptance of its own limitations as well as demonstrates the agency's commitment to ensuring that the best possible decisions and plans are made. The Family Group Conference always includes private family time.

### WHEN PLANNING FOR PRIVATE FAMILY TIME, START WITH THE FOLLOWING TASKS:

- » Inform the family about any elements that are required to be addressed in the plan, in order for the court and CFS to accept the plan.
- » Anticipate and protect against threats to family members' safety and well-being. Each family member must be and feel safe to participate in the meeting.
- » Be mindful that the family defines who is included in the Family Group Conference (FGC) and determines who should be invited to the family group meetings. Only legal safety issues can limit who the family decides to include.
- » Ensure the providers understand the scope and limits of their role, how family group decisions are reached, and that families are tasked with "drafting" their plans during the private family time of the FGC.
- » Anticipate the extent of the time commitment family members and providers will need to make for the FGC. Ensure private family time is not constrained (private family time often last 4 hours or more). Although providers are not included in private family time, they are expected to be available to share information at the beginning of the FGC and again at the

end of the FGC when the family shares its plan. The length of the meeting will vary depending on the dynamics of the group and the complexity of the needs being planned for.

- » Plan to provide a meal that the family can share together during their private family time.
- » Prepare child welfare staff and providers to remain at the FGC venue for the entire meeting, even though they are not included in the meeting. Sometimes a family member will step out of the family meeting to seek clarification or information from providers or staff. In addition, when the family completes their plan, they will present it to the child welfare staff for review.
- » Prepare the family to develop and present their plan at the conclusion of the FGC meeting.

For the Winnebago Tribe, as prescribed by FGDM, the private family meeting time begins after the providers make brief statements of information, review the non-negotiables, and answer questions raised by the family. At that point, coordinators and providers leave the family alone to discuss the needs and create their plan. Due to the length of time these meetings take, a meal is often provided for the families. coordinators and providers retreat to a nearby room where they remain available to provide additional information to the family, as needed. Once the family is ready to share their plan, the coordinator, providers, and child welfare staff return to the meeting room so the family can present their plan.



## LESSONS LEARNED

- » It is important to demonstrate trust in the family's ability to make decisions for their children. coordinators need to work with child welfare staff and other providers to ensure that they do not overstep their role in the FGC meeting. The information that providers share needs to be presented in an unbiased way. Coordinators must also preserve the sanctity of the private family time by ensuring providers who might see themselves as "family" or as "trusted allies" of the family leave the room during the private family time.

## CORE COMPONENT 4: PREFERENCE GIVEN TO FAMILY GROUP'S PLANS

*When agency concerns are adequately addressed, preference is given to the family group's plan over any other possible plan.*

In accepting the family-group lead (plan), an agency signifies its confidence and commitment to partnering and supporting family-groups in caring for and protecting their children, and, to building the family-groups' capacity to do so.

### TO ENSURE THAT THE FAMILY PLAN IS GIVEN APPROPRIATE PREFERENCE, START WITH THE FOLLOWING TASKS:

- » Identify and remove any systemic barriers that might unnecessarily inhibit the families' ability to lead the decision-making process.
- » Educate the courts, providers, and workers about FGDM and ensure that as long as all "non-negotiables" are addressed, these parties will accept the family's plan.
- » Create an organizational and systemic culture that recognizes the family as leaders in decision-making.
- » Limit non-negotiables so the family's options in decision making are not constrained unnecessarily.
- » Ensure that all non-negotiables are clearly articulated prior to the FGC and the private family time since these issues must be considered in the family's planning.

Prior to the private family time, statutory authorities (in this case, the CFS staff and Tribal Court) clearly defined all non-negotiables. The Winnebago Team spent time making sure that the Tribal Court judges and attorneys understood and supported FGDM as an evidence-supported practice. Some changes to permanency options needed to be made in the Tribal Code to allow families a broader range of permanency options and to clarify the "kinship preferences", (order of preference given to family members when multiple placement or permanency options are available. The CFS director secured the Tribal Court's agreement to accept the plans that families developed when the non-negotiables were satisfactorily addressed.

Non-negotiables must represent the minimum requirements necessary to ensure child safety and promote permanence. Coordinators first identified non-negotiable policies and practices from the Tribal Court and the CFS agency, and then clearly articulated the non-negotiables to family members during the preparation phase. A written document describing the non-negotiables was provided to families during information sharing at the beginning of the Family Group Conference. Non-negotiables cannot be altered once private family time begins.

At the conclusion of the private family time, Coordinators, providers, and CFS staff rejoined the meeting and listened as the family group shared the plan they developed. When needed, the CFS staff and Coordinator worked with the family group to ensure that non-negotiables were adequately incorporated into the family's plan, and to ensure that all family group members understood the plan and supported the plan as written. Then the family group and providers worked together to clarify the resources needed to support the plan and outline the steps to activate the plan. Once the planning is completed, the Family Group Conference concludes. Afterwards, the Coordinator represented the family's plan as The Accepted Plan to the Tribal Court.



## LESSONS LEARNED

- » It is important to understand that FGDM represents a major shift in the culture of child welfare practice. FGDM moves systems from *planning for* to *planning with* through a process that restores the family's decision-making authority. Relinquishing control of the plan can be hard for child welfare workers and requires supervisory support. Without a clear message around the values of FGDM practice, workers become hesitant to refer families for FGDM. In the Winnebago implementation of FGDM, the Director and Manager realized that they had not sufficiently onboarded new CFS staff regarding the FGDM values and process. Consequently, referrals lagged. When coordinators would ask workers for cases, workers would share that they were not confident that the family could plan adequately, or they would share that the CFS team had a plan and that engaging the family would increase their workload when they were already stretched thin. To address this barrier, the Director and Manager met with the Winnebago Team, oriented them around the FGDM practice and around Winnebago's commitment to honoring family voices. Following this orientation, the Director and Manager shifted CFS practice to require that all cases be screened for FGDM eligibility by the coordinators.

## CORE COMPONENT 5: FOLLOW-UP ENSURES INTENDED OUTCOMES ARE ACHIEVED

*Follow-up processes after the FGDM meeting occur until the intended outcomes are achieved to ensure that the plan continues to be current, relevant, and achievable because FGDM is not a one-time event but an ongoing, active process.*

Follow-up efforts include, but are not limited to, ongoing family group-driven follow-up FGDM meetings. Such meetings are scheduled to accommodate the family group's needs and availability. The meetings are focused on progress, achievements, unresolved issues or concerns, new information, and additional resources. The result is that the family's plan is updated and revised as needed. In addition, the frequent, proactive communication between representatives of the CFS system and the family group support the successful implementation of the family's plan.

### TO ENSURE THAT APPROPRIATE FOLLOW-UP OCCURS, START WITH THE FOLLOWING TASKS:

- » Develop a method to ensure the plan is revisited and remains current, relevant, and achievable.
- » Identify someone to track progress on the plan; ensure this person will ask the Coordinator for support if the plan stalls or needs to be revisited.
- » Prepare families to reconvene when a new plan is needed due to changes within the family or when established plans do not work as intended.
- » Determine the protocol for how providers will work with families when plans require modifications.

The fourth stage of FGDM is follow-up. The need for follow-up is introduced while preparing families and providers for their meeting. Families are reminded to anticipate that plans may fail or need to change. Family plans often require modification when family circumstances or resource availability changes, making a proposed permanency option no longer viable. Coordinators work to normalize this experience for the family group, providers, and child welfare staff. Families are also encouraged to identify someone in the family monitor the plan and ask for support if glitches occur or changes are needed in executing the plan. If the plan the

family developed during the Family Group Conference meeting did not include follow-up, the Coordinator will prompt the family to consider the need for it. Since this process is family driven, families are not required to have follow-up meetings.



## LESSONS LEARNED

- » It is important to recognize that most families will need multiple meetings to address concerns and achieve their goals. Early in this practice, the Winnebago Team considered the Family Group Conference to be a single meeting. However, The Team soon learned that it is likely to take a series of follow-up conferences for family groups to make permanency decisions. The planning evolved to include the likelihood that a family might need several meeting times, spaces, and several meals throughout the planning process.
- » It is imperative that the project team remain consistent throughout the process. Throughout the preparation phase and during the initial Family Group Conference, families develop a trusting relationship with their coordinator. When follow-up meetings are scheduled, it is essential that the same coordinator and providers participate to ensure continuity. When this is not possible, the transition must be thoughtfully managed and include communication, information exchange and a “warm” handoff between coordinators. Without this transition process, the family is likely to experience follow-up as “starting over.” It is important to understand that some plans will need to be revisited and to avoid the perception that this indicates that the process has failed.

## CORE COMPONENT 6: REFERRING AGENCIES SUPPORT THE FAMILY GROUP'S PLAN

*Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans.*

In assisting family groups in implementing their plans, agencies must uphold the family group's responsibility for the care and protection of their children and contribute to the success of the plan by aligning agency and community resources to support the family group's efforts.

### WHEN EVALUATING THE ALIGNMENT OF SERVICES AND RESOURCES TO SUPPORT FAMILIES, START WITH THE FOLLOWING TASKS:

- » Introduce child welfare staff and providers to the guiding principles of FGDM.
- » Assess whether formal and informal resources are flexible, accessible, and support family plans.
- » Work with provider staff to modify available supports to meet the needs of family groups.
- » Develop a process to ensure that families are aware that resources and supports are available to them.

Providers play a vital role in supporting the family plan. CFS staff and other providers were included in FGDM training as a means of familiarizing them with the guiding principles and practice of FGDM. Through the Winnebago Team's planning meetings with stakeholders, the Team learned that families, and sometimes staff, were not aware of the array resources and supports available to support them. In response, CFS created a resource directory for families. The directory shares the type of service, the location of the service, and whether the resource is provided by a tribal, local, county, or state agency. At the beginning and ending of the Family Group Conference, CFS workers and providers inform the family about resources available to support the plan.



## LESSONS LEARNED

- » A family's plan may need to be supported by available community services.
- » Building partnerships that are inclusive and transparent by fostering and developing an ongoing dialogue with stakeholders is important when developing supports and resources for the families.
- » Do not assume because resources exist that everyone (families and professionals alike) is aware of available resources, knows how to access resources, or even understand how resources might be used creatively to meet the needs of families.

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## CHAPTER 4

# CHOOSING THE RIGHT INTERVENTION

This chapter helps determine if the intervention is a good fit for your site, and if so, provides guidance on how to implement the intervention.

This chapter addresses the following topics:

**I. IDENTIFY THE PROBLEM AND THE  
TARGET POPULATION**

**II. DEVELOP A THEORY OF CHANGE**

**III. RESEARCH AND SELECTION OF AN  
INTERVENTION**

Each section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Winnebago Team implemented the process, activity, or task; (d) lessons the Winnebago Team learned during implementation.

## I.

## IDENTIFY THE PROBLEM AND THE TARGET POPULATION

To determine if an intervention is the right intervention for your site, make sure the intervention addresses the root cause of the problem and meets the needs of your identified population. The QIC-AG Population Template (Appendix A) is a helpful tool for (a) clearly defining the population that will be the target of the intervention and (b) for gaining a clear understanding of the problem that the intervention must address. By using system data and other available information sources, the Population Template can help identify the underlying causes of the needs of the target population.

Notably, the QIC-AG Population Template can help a project team accomplish the following foundation tasks:

- » Identify the population most affected by the problem
- » Understand the needs of the target population
- » Refine the eligibility criteria for intervention participation
- » Develop a theory of change
- » Provide a geographic focus for implementation and evaluation of an evaluable intervention

The next step in determining if the intervention is right for your site is to determine the system strengths and needs. This step can be accomplished by completing a critical assessment. The Winnebago Team used the QIC-AG Continuum Assessment Template (Appendix B) to guide their macro- and service-level assessment of system functioning and services availability.

When completed, the Continuum Assessment enables a site to:

- » Identify existing services offered at each interval of the continuum
- » Identify gaps and strengths along the continuum of service provision
- » Identify areas within the system in need of strengthening



Ultimately, completion of the Continuum Assessment and the Population Template are critical steps in determining if an intervention such as Family Group Decision Making is a worthwhile intervention for your site and population of interest.

The final piece of the system assessment is to obtain the feedback of consumers of post-permanency services and providers who serve that population. This assessment can be carried out using a structured stakeholder interview guided by the Stakeholder Focus Group Questions (Appendix C).

To complete the Population Template, the Child Welfare Supervisor reviewed existing case data, and identified children who had a court-ordered non-reunification Permanency goal. The list was refined to include the ages of the children, the size of the sibling group, and whether siblings were divided across multiple households. Additionally, the identified child or youth had to have someone in the caregiver role who could provide information about the child. All children meeting these criteria were considered eligible for, and likely to benefit from, the intervention.

A system assessment revealed that although existing community services were available to families, families were frequently unaware of these resources. The system assessment also clearly indicated that when working cross-culturally, even commonly used terms might need to be clarified. In the Winnebago culture, children “belong” within extended families, clans, and the tribe. Therefore, the concept of permanence was foreign; however, through a series of conversations with the staff, Tribal Elders, and families, the Team learned to understand that the need for permanence was better defined as a *need for stability*. In fact, the term guardianship was not intended to connote permanence, but represented a short-term form of care when the parent was unavailable. Families mentioned that a major challenge to parenting was being unsure if/when a biological parent or other extended family member would go to court and take custody or guardianship of the child or children for whom they were caring. These challenges to guardianship were occurring without the child welfare staff being consulted or even notified by the courts.

Additionally, the Winnebago Team observed that other than funding of private guardianship, that no services were intentionally directed to achieve permanence. There were no supports that addressed the changes in family dynamics post permanence. The team also identified the need to clarify terms and processes in the Tribal Code to protect the child(ren) and guardian by re-engaging child welfare staff when a decision to rescind guardianship was being considered. Other needs included creating guardianship language specific to child welfare circumstances and expanding the permanency options to include customary adoption.



## LESSONS LEARNED

- » When working cross-culturally, it is important to ensure that the words and terms used con-  
note a common meaning, and when they do not, it is important to develop language that sup-  
ports a shared understanding of the need, practices, and concepts.
- » It is important to ensure that staff and families are familiar with resources available to support  
families moving toward or sustaining permanence.
- » It is important to ensure that the laws, codes, policies, procedures and so forth support the  
planned intervention.

## II.

## DEVELOP A THEORY OF CHANGE

The theory of change provides a road map that addresses how and why change will happen in a practice, program, or organizational system to promote the attainment of a desired result. Essentially, the theory explains why the change being proposed should work by explaining how the steps being taken are expected to lead to the desired results. A well-crafted theory of change serves many purposes. Most important, the theory of change serves as a guide for identifying the intervention that will be implemented.

The theory of change should be based on research. To avoid theories based on assumptions, it is important to consider available theories and existing research evidence. Examples of existing research evidence include peer-reviewed articles and other less rigorously reviewed child-welfare products/publications. The research evidence should support the pathway to change proposed in the theory of change.

Developing a theory of change can be a time-consuming practice, but given that the theory of change guides the selection of the intervention, it is crucially important to invest the time needed. If chosen correctly, the intervention, in Winnebago's case, FGDM should facilitate the change identified in the theory of change.

### WINNEBAGO THEORY OF CHANGE

The Winnebago Tribe does not have a practice intervention supporting culturally competent, family engagement to promote decision making regarding sustainable permanence.

Therefore, what is needed is to implement a culturally relevant child welfare practice intervention for the Winnebago Tribe based on indigenous practices that will ensure culturally viable decisions are made and that these decisions promote the timely achievement of permanence through customary adoption or guardianship.

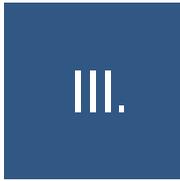
If a practice intervention is adapted to meet the needs of the Winnebago Tribe, then the Winnebago people will be able to implement a culturally relevant child welfare practice, which will increase legal permanence for Winnebago children.

A site can use the Winnebago Team's theory of change to support the rationale for implementing the FGDM, but each site must ensure the theory of change applies to what has been learned about their target population and system gaps.



## LESSONS LEARNED

- » When adapting an intervention for a specific culture, it is important to build partnerships that are inclusive and transparent by fostering and developing ongoing dialogue with stakeholders. The Winnebago Team engaged in ongoing communication with the Winnebago Tribal Elders, the community, service providers, Ho Chunk Renaissance (a language support and cultural etiquette service provider), legal counsel, the Winnebago Tribal Court, and the intervention purveyor.
- » Engaging in a “by the tribe, for the tribe” process not only enhances and strengthens tribal sovereignty and existing relationships but also supports new relationships built upon a common understanding of the project, resulting in establishing trust, respect, and buy-in.
- » Partnerships built on trust and respect with a common understanding of the goals of the project and clearly defined roles are more likely to support the intervention throughout the life of the project from implementation to sustainability. The Winnebago Team was deliberate in building a model of practice that was sustainable and would therefore transcend the project period. FGDM aligns well with the tribe’s other efforts to restore its language and culture.



## RESEARCH AND INTERVENTION SELECTION

Once a site selects one or more interventions to address the identified need, tools can be used to explore the viability of implementing the intervention. One such tool is the Hexagon Tool, which was developed by the National Implementation Research Network.<sup>1</sup> Using the Hexagon Tool to explore and ask questions in broad areas will help determine if FGDM is the right intervention to implement in your site.

Although an intervention might sound exciting and innovative, the program might not be practical to implement. The Hexagon Tool helps a site consider the practicality of implementing a specific intervention.

- » **NEED:** What are the community and consumer perceptions of need? Are data available to support that the need exists?
- » **FIT:** Does the intervention fit with current initiatives? Is the intervention consistent with the site's practice model?
- » **RESOURCES AND SUPPORTS:** Are training and coaching available? Are technology and data needs supported? Are there supports for an infrastructure?
- » **OUTCOMES:** Is there evidence to support the outcomes that can be reasonably expected if the intervention is implemented as designed. Are the outcomes worth it?
- » **READINESS FOR REPLICATION:** Is a qualified purveyor or technical assistance available? Is a manual available? Are there mature sites to observe?
- » **CAPACITY:** Does staff meet minimum requirements? Can the intervention be implemented and sustained structurally and financially over time?

Completing the Hexagon Tool helped the Winnebago Team refine and clarify questions regarding existing implementation supports around training and resources that might be available from the purveyor (Kempe). The Hexagon Tool allowed the Team to select an intervention most likely to support adaptations that reflect cultural values. Finally, using the Hexagon Tool moved the Winnebago Team from thinking about what they would like to do, to thinking through what was reasonable for them to do and feasible to sustain given the available resources.

The Hexagon Tool completed by the Winnebago Tribe of Nebraska's Team is located in Appendix D.

<sup>1</sup> <https://implementation.fpg.unc.edu/resources/hexagon-exploration-tool>



## LESSONS LEARNED

- » Do not rush through the Hexagon Tool. It is important to thoughtfully consider each category. Completing the Hexagon Tool will help prevent a site from expending energy on an intervention that the system is not equipped to administer.

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## CHAPTER 5

# PLANNING TO IMPLEMENT

Successful implementation, defined as implementation with fidelity and integrity, takes planning. If done well, planning has multiple benefits, including the promotion of a well-developed, logical approach to implementation and the description of strategies to address ongoing implementation issues.

Planning activities provide the process for thinking through each of the intervention's critical components, enabling planners to anticipate possible barriers and develop steps to address these barriers. Moreover, the planning process also helps to develop a common understanding of how the identified program goal will be achieved. In addition, a carefully considered plan can serve as a communication tool with leadership to promote buy-in and sustain support.

Planning should be captured in an Initial Design and Implementation Plan (IDIP) Appendix E. The IDIP document guides the implementation of the evaluable intervention, supports the use of an intervention to address an identified problem, and outlines the steps to be taken to ensure the intervention is delivered as the intervention's developers intended. Having a single, comprehensive document can help organize and guide the work as the project moves forward. In addition, the IDIP helps bridge knowledge gaps if turnover occurs in key positions.

The Winnebago Team experienced complete turnover including both CFS staff and tribal leadership. The Site Implementation Manager (SIM) role turned over several times prior to implementation. As turnover occurred, the Team used the IDIP to orient each new team member to the project.

This chapter addresses the following topics:

### I. RESEARCH CONSIDERATIONS

### II. GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

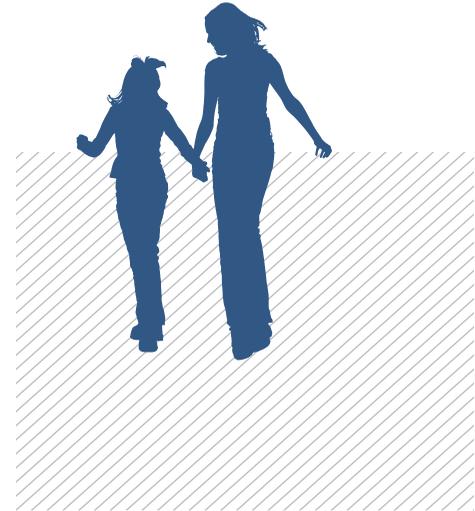
### III. WHO WILL DO THE WORK: TEAMING AND COMMUNICATION

Each section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) how the Winnebago Team implemented the process, activity, or task; and (d) lessons the Winnebago Team learned during implementation.

## I.

## RESEARCH CONSIDERATIONS

It is always important to evaluate the impact of the intervention to ensure the intervention is effective and achieving the delineated goals. Given the critical role of evaluation, it is important to implement the intervention in collaboration with partners with research skills such as an in-house evaluator or university partner. Evaluation starts with a well-formed research question that is directly relevant to the problem at hand and phrased in a way that leads to precise answers.<sup>2</sup> Testa and Poertner have recommended the PICO framework, which requires careful articulation of four key components:<sup>3</sup>



- P** a well-defined target population;
- I** the intervention to be evaluated;
- C** the comparison group; and
- O** the outcomes expected to be achieved.

This section addresses the following topics:

1. **Developing the research question**
2. **Creating a logic model**
3. **Case flow/project enrollment**
4. **Data collection**



<sup>2</sup> Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123, A12.

<sup>3</sup> Testa, M. F. (2010). Evaluation of child welfare interventions. In M. F. Testa & J. Poertner (Eds.), *Fostering accountability: Using evidence to guide and improve child welfare policy* (pp. 195–230). New York, NY: Oxford University Press.

## 1. DEVELOPING THE RESEARCH QUESTION

The importance of having a clearly defined research question cannot be overstated. The research question will be answered by the evaluation of the intervention. Following the PICO framework, a well-formed research question has four components that must be delineated:

**P** **TARGET POPULATION:** Using the Population Template (Appendix A) as a starting point, additional data from a data system should be used to clearly define the population that will receive the intervention. Developing this component can include incorporating the following types of data from the target population:

- » Characteristics, demographics, or past experiences (e.g., age, race, ethnicity, placement history, family structure)
- » Eligibility and exclusionary criteria
- » Geographic service areas
- » Needs (e.g., parents or guardians who lack the capacity to address trauma-related issues, or lack of parental skills and ability to manage behavior)
- » Estimates of the total number of children or families who will be served

**I** **INTERVENTION:** An intervention is an intentional change strategy offered to the target population.<sup>4</sup> An intervention has core components designed to affect a desired outcome.

**C** **COMPARISON GROUP:** Randomized controlled trials (RCTs) are considered the “gold standard” of research because this true experimental design enables researchers to determine if the observed outcomes are the result of the intervention. An RCT design includes a treatment group that receives the intervention and a comparison group that receives “services-as-usual.” RCTs use random assignment of participants to either the treatment/intervention group or the control group. Comparison groups are also used in research using quasi-experimental designs. The most common quasi-experimental design uses the pre-test/post-test comparison group design.

**O** **OUTCOMES:** A result or consequence of the intervention. Outcomes are specific to the intervention and linked to the theory of change.

<sup>4</sup> Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.

The elements of the PICO framework are identified below in the Winnebago Team project's research question:

Will Winnebago Tribal children and youth in care who are waiting for permanence (P) experience increased permanency outcomes; decreased time to finalization/permanency or time in care; increased placement stability; improved child and family well-being; and improved child or youth behavioral health outcomes (O) if families receive a culturally adapted version of Family Group Decision Making (I).

**P**

**TARGET POPULATION:** The target population for this intervention was defined as Winnebago children and youth in foster care. To be eligible for study inclusion, children and youth had to meet the following eligibility criteria: (a) children and youth who cannot reunify with their biological parents, and (b) have a non-permanency reunification goal, (e. legally free). The second criterion included children for whom a permanency placement was yet to be identified and for children who have an identified placement but whose prospective permanent families would benefit from FGDM to prepare for finalization. Children and youth ages 5–12 years could participate in the Family Group Conference, however only youth however, only youth 12 years and older were considered as subjects of the evaluation research part of the intervention.

**I**

**INTERVENTION:** Family Group Decision Making (FGDM). The team selected FGDM, which was subsequently adapted to reflect Ho-Chunk cultural values and practices. The adapted Winnebago Tribe Family Group Decision Making (Wažokj Wošgą Gicą Wo'ųpį FGDM model) process is a family centered, tribally specific, culturally based and permanency guided process. The Wažokj Wošgą Gicą Wo'ųpį FGDM model recognizes the importance of tribal specificity and cultural strengths as a pathway to permanency planning for Winnebago children and families.

**C**

**COMPARISON GROUP:** The Wažokj Wošgą Gicą Wo'ųpį FGDM intervention did not include a comparison group. The group size was insufficient to support a rigorous evaluation design.

**O**

**OUTCOMES:** The short-term outcomes are:

- » Increased permanency outcomes
- » Decreased time to finalization/permanence or decreased time in care
- » Increased placement stability
- » Improved child and family well-being
- » Improved child and youth behavioral health outcomes

Outcomes are measured through surveys and interviews with participants who engage in any stage of the FGDM process.

## 2. LOGIC MODEL

A logic model illustrates the conceptual linkages between core components and intervention activities and expected outputs and short and long-term outcomes. The logic model should clearly explain how specific activities or services are expected to produce or influence their associated outcomes. The Winnebago Logic Model is in Appendix F.

The logic model created by the Winnebago Team included short-term outcomes specific to the “Winnebago Pathway” conceptual framework that includes knowledge of kinship roles and responsibilities. Subsequently, the Winnebago Team also wanted to include a circular logic model, which is a more holistic approach that includes family and community outcomes such as improving professional relationships and developing community collaborations (typically considered long-term outcomes). The Winnebago Circular Logic Model is in Appendix F.



### LESSONS LEARNED

- » Be mindful of cultural norms and mores when working cross-culturally. The non-tribal members of the Winnebago Team learned that sometimes the processes and products such as the logic models outlined by QIC-AG were too “Western” and incongruent with the Winnebago culture and perspective.

### 3. CASE FLOW/PROJECT ENROLLMENT

As previously discussed, if an intervention uses an RCT design, then the project team/site team will need to determine a method for assigning participants to the intervention group and the comparison group (i.e., services-as-usual). This will include the development of a case flow that clearly depicts the criteria for assignment to the intervention group or the group receiving services-as-usual.

The Winnebago Child and Family Services agency caseworker reviewed the list of potential families. Those families eligible for the QIC-AG project were then referred to the FGDM Coordinator. The FGDM Coordinator reached out to the primary caregiver and designated youth. If outreach was successful, the coordinator would then prepare the caregiver, youth, and other family members for the FGDM Family Group Conference (FGC). Informed consent was obtained from caregivers and from youth 12 years and older. The caregiver completed the pre-test survey for the research project. After the preparation phase meetings were completed, the FGDM Coordinator would then convene the FGC. At the end of the FGC, the coordinator asked participants 12 years and older to complete a participant satisfaction survey. Last, the coordinator completed a meeting summary.

The Project Evaluator contacted participants 6 months after they had completed the pre-intervention survey and requested caregivers to complete a post-intervention survey.



#### LESSONS LEARNED

- » It is important to remember that families move through the FGDM process at varying paces. One family might be eager and accessible, and a FGC might occur within a few weeks, whereas it might take months for another family to be ready to convene an FGC.
- » Connecting with families often requires the use of various outreach methods over an extended time. The Winnebago site team started their recruitment effort by mailing a letter and flyer to target families, which asked families to voluntarily participate in the FGDM program called *Wažokį Wošgą Gicą Wo'ųpj* (Possible Cultural Family Choices). However, a lower than expected response rate made it apparent that a letter was not enough to encourage participation. Therefore, the site team modified their recruitment plans to incorporate follow-up to the letter using in-home visits and face-to-face meetings.
- » For this type of intervention, geographic placement of the children needs to be factored into the selection of the population. The team learned that distance and placement in residential care facilities impacted the time and costs invested in outreach and engagement. For example, in the cases of children living in residential care facilities, the facility staff and scheduling often conflicted with the accessibility and availability of children and youth to participate in the intervention.

## 4. DATA COLLECTION

The Health and Human Services, Office of Research Integrity defines data collection as “the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes.”

The data for the project was obtained through a caregiver survey used as a pre- and post- intervention survey, caregiver and youth interviews, a participant satisfaction survey, and a worker summary form. Caregivers completed a pre-intervention survey during the preparation phase before the FGC; caregivers were re-contacted 6 months later in the follow-up phase and asked to complete a post-intervention survey. Also, during the follow-up phase, separate interviews with the caregiver and youth were conducted 6 months after the FGC. Participants 12 years and older attending the FGC completed the participant satisfaction survey at the end of the FGC. The Family Support Workers, (i.e., the Coordinators) completed the worker summary form at the conclusion of the FGC.

The data were collected in a tracking form with five segments: Initial contact, preparation, logistics, FGC meeting, and follow-up. The coordinator was tasked with completing the tracking form to enable monitoring progress through the FGDM process. Data obtained from the survey and interview were mapped to the short-term outcomes by the Evaluation Team.

During the preparation phase, the coordinator reviewed the consent with the caregiver and youth and informed them that all their information shared would be de-identified and held in confidence. Further, written assurance of confidentiality was included in the consent / assent forms signed by the caregiver and youth, respectively.



### LESSONS LEARNED

- » According to the FGDM Coordinator, after meeting with the caregiver and designated child and providing an overview of the study and the Wažokj Wošgq Gicq Wo'ypj (Possible Cultural Family Choices) FGDM model, which is a child-centered and family-driven process, the caregiver and children have the information they need to make an informed decision to decline or to voluntarily participate in the study. The following quote from the FGDM Coordinator reveals the importance of clear communication during outreach efforts:

*“Once we were able to meet face-to-face with the families and share the Wažokj Wošgq Gicq Wo'ypj FGDM model, the families understood the study and processes, their role and responsibility, and they were more willing to consent and participate in the study.”*

## II.

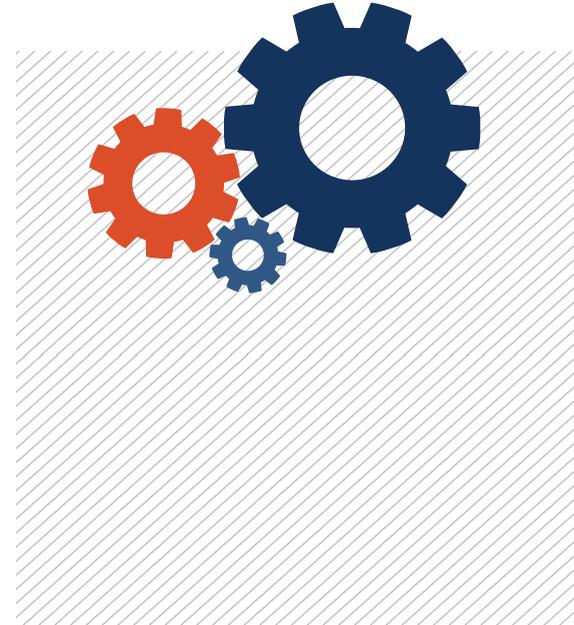
## GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

Once an intervention is selected, it is important to know how the system will be readied to support service delivery. The term implementation supports refers to the infrastructure developed to facilitate the successful implementation of an intervention, which also helps to ensure the stability of the intervention over time. Without implementation supports, the system will not have the capacity to support the delivery of the intervention to the target population. Because implementation supports facilitate intervention delivery, assessing these supports is crucially important and should be carried out during the initial implementation stage to allow modifications before full implementation.

In addition to identifying the system's capacity to support service delivery, the project team will need to identify the work that needs to be done to develop additional supports. Further, it is critically important that the project team not only identifies potential barriers to implementing the intervention but also determines strategies for addressing such barriers.

This section addresses the following topics:

1. **Staffing**
2. **Training, coaching, and supervision**
3. **Fidelity**
4. **Policies and procedures**
5. **Data systems**
6. **Program expert**
7. **Financial and material considerations**
8. **Leadership**
9. **System partners and community linkages**



## 1. STAFFING

*Staffing* is the process of recruiting, selecting, and hiring qualified people for the support positions.

### WHEN CONSIDERING STAFFING, START WITH THE FOLLOWING TASKS:

- » Determine the skills, knowledge, and abilities of designated implementation staff.
- » Determine what skills need to be developed in designated staff, and provide training to address those needs.
- » Determine whether the staff are viewed as culturally competent and impartial.
- » Determine the number of staff needed to implement the intervention by defining the workload-to-staff ratio.
- » Prepare to manage staff turnover or extended absences.

The Winnebago site project had 16 people who completed the 3-day FGDM Coordinator Training. The trainees included the two prospective FGDM Coordinators, the CFS Director and supervisor, CFS case workers, providers, elders and other members of the community. The two staff identified as coordinators were both younger members of the Winnebago Tribe, and had compatible strengths and skill sets. The first coordinator hired was a social worker who was detail oriented and enjoyed producing documents. The second coordinator was a non-degreed member of the community with deep cultural connections, and a good grasp of the Hocak, (Ho Chunk) language and history. Neither coordinator had experience with FGDM or with convening any type of family meetings.



### LESSONS LEARNED

- » FGDM practice does not require coordinators to come to the work with a prescriptive skill set or knowledge base. FGDM is learned by doing. If a prospective coordinator is willing to complete the basic training, is culturally competent, and is perceived to be fair and impartial, they can be coached to competently coordinate family groups.

## 2. TRAINING, COACHING, AND SUPERVISION

*Training* is the process of providing the information and instruction an individual will need to successfully execute a specific function within a program.

*Coaching* is a structured process in which a practitioner with expertise in a specific intervention works closely with someone who is learning the intervention to enhance his or her skills, with the goal of delivering the intervention with fidelity.

*Supervision* is the process of reviewing the work of another individual to determine the person's extent of alignment with established performance standards.

### WHEN CONSIDERING THE TRAINING, COACHING, AND SUPERVISION NEEDS OF YOUR PROJECT, START WITH THE FOLLOWING TASKS:

- » Determine the availability of training resources, including trainers, a training curriculum, supervision, and coaching, from the intervention purveyor or other entity.
- » Assess the content of training materials to determine whether adaptations or modifications are required to meet learning needs, cultural values, staffing patterns or organizational preferences.
- » Determine if ongoing training will be needed to reinforce or enhance the initial training; attend to both immediate and long-term costs of training and maintaining staff competency or certification.
- » Thoroughly consider supervision requirements to ensure familiarity with the model and impartiality.
- » Select a coaching model that helps staff hone their practice. Coaches should practice the model with fidelity and be accessible to support observations. Agencies should factor in the costs of coaching over the period needed for the coordinators to achieve mastery.

To prepare for implementation, the Winnebago Team participated in basic FGDM training, consisting of a manualized 3-day training available through the Kempe Center (University of Colorado Denver). An additional day was added to the training to introduce the Team to the adaptations chosen to make FGDM practice culturally relevant for Winnebago families. The FGDM training was delivered to a group composed of the coordinators, prospective supervisors, Tribal Elders, and providers (child welfare and mental health staff). In addition

to the basic training, supervisors received an additional 12 sessions of FGDM supervisory training. Additional professional development for FGDM was provided through Kempe's annual conference.

The Team determined that external coaching was necessary for successful implementation. To build-in live coaching and observation, the Winnebago Team contracted with Family Service Rochester (FSR), a Minnesota-based agency with expertise in implementing the FGDM model. The Winnebago Team engaged in bi-weekly phone conferences with coaches throughout the initial implementation. The Winnebago Team also made periodic visits to Minnesota to observe practice and engage in supervision.

Direct supervision of the FGDM Coordinators is provided by the Child Welfare Director and Manager. These two roles were selected to provide supervision because they are aware of the child welfare requirements and expectations, but they are not involved in providing supervision to case managers. This degree of separation is essential to maintaining the autonomy of the FGDM Coordinators.



## LESSONS LEARNED

- » Coaching should be available until those providing supervision can competently navigate the nuances of practice. Although the purveyor requires only the basic training in FGDM, the Winnebago Team found specialized supervisor training and coaching were well worth the extra investment. Coordinators needed someone who was experienced in FGDM to inform each phase of the process. Coaches helped identify strategies and clarified processes during each phase of the intervention.

### 3. FIDELITY

*Fidelity* can be defined as the extent to which the delivery or performance of an intervention is in accordance with the protocol or program design as originally developed.

#### WHEN DETERMINING HOW BEST TO ENSURE FIDELITY, START WITH THE FOLLOWING TASKS:

- » Determine how you will ensure that the practice is implemented as intended and consistent with the model
- » Create or select from existing tools that measure the family's experience throughout the phases of FGDM practice.
- » Plan to observe coordinators periodically to provide support and ensure adherence to the practice model.

In FGDM, fidelity is measured by adherence to the four phases of practice including the three stages of the family group conference: a) information sharing; b) private family time; and c) the planning/decision stage. The team developed a brief post meeting survey to capture the family's experiences with the FGDM process. The survey considers how well-prepared families feel they are for the meeting and how well the meeting process was executed. The coordinators also complete a brief survey after the meeting to capture whether the meeting ran according to plan.

In addition to the subjective reports and surveys collected after the meetings, an independent observer or supervisor can observe the coordinator during the *preparation* phase as well as the *information sharing* and *planning/decision* stages of the FGDM to ensure fidelity. As practice concerns arise, they are discussed with the purveyor and coaching team.

During one live observation, the coach noticed that the coordinator had not prepared all members of the family prior to the meeting; this gap occurred because some family members did not agree to participate until the last minute. The coordinator was also unable to fluidly articulate the reason for the meeting and convey the information that the group needed to make decisions. Similarly, the providers attending the information sharing did not seem prepared to share information concisely, respond to the family's questions, or clearly articulate the non-negotiables that the court and family services required be addressed. Based on the observation, coaches were able to help coordinators focus on the preparation phase of FGDM and to help coordinators script discussing the reason for the meeting and information sharing.

The Winnebago Coordinators traveled to Rochester, MN periodically to observe how their mentors from Family Service Rochester engaged in *preparation*, *information sharing* and *planning*. The supervisors at Winnebago also traveled to FSR to observe their supervision process.



## LESSONS LEARNED

- » When introducing a new practice, it is critical to ensure that meetings are observed by a trained observer who will provide written feedback to support coordinators in developing the practice. Doing this ensures that the FGDM model is being implemented as intended.
- » An effective means of ensuring fidelity is to have the participants complete a brief survey at the end of each meeting. At a minimum, the survey should ask questions that allow participants to describe or rate their level of preparation for the meeting, the extent to which they believe that the meeting was individualized and family-driven, their satisfaction with and support of the plan, the extent to which they view the meeting as impactful, and whether they felt safe throughout the process.

## 4. POLICIES AND PROCEDURES

*Policies and procedures* are formalized directives guiding the delivery of an intervention or program, and give detailed explanations of program activities. Policies are the principles that guide the decision-making process.

### WHEN CONSIDERING POLICIES AND PROCEDURES, START WITH THE FOLLOWING TASKS:

- » Examine the completeness and effectiveness of the policies or procedures to ensure they support the new work and clearly articulate the steps of the new processes.
- » Consider whether policies are accessible to those who need them.
- » Confirm whether policies and procedures have been sufficiently articulated and documented to allow someone else to run the program in the absence of current staff or leadership.
- » Confirm that policies and procedures reflect what has been learned during usability testing.

The Winnebago Team revisited the referral process several times before finally determining that scheduling appointments to discuss cases with case workers was more productive than waiting for case workers to make referrals. Coordinators applied the eligibility criteria and offered the FGDM practice to every family meeting the criteria.

The Winnebago Team developed a comprehensive practice manual that details processes and practices the Team implemented to gather information needed and tasks to be completed during each phase of FGDM practice. The manual articulates how and when during the process each culturally specific tool is shared.

The FGDM Coordinators worked closely with the child welfare staff to garner any consents needed to share information, outside of the family group. Youth and caregivers consented to information being shared within the family group as a condition of participating in the FGDM process.



## LESSONS LEARNED

- » It is essential to articulate how confidentiality and releases of information will be handled by coordinators, child welfare staff, community providers and families. Many child welfare agencies limit information sharing to biological parents; however, consistent with the FGDM model, information must be shared with all participating family members. Moreover, Winnebago children have several people who are recognized as mothers or fathers but who are not biological parents. The Winnebago kinship preferences (i.e., the chain of authority and responsibility for caring for children) are detailed in Tribal Code and must be adhered to.
- » It is important to document decision-making processes in writing. When the Winnebago Team discussed various proposed changes, people had different recollections or assigned different meanings to the decisions. Therefore, the Team documented each decision along the way and incorporated decisions into the procedures.

## 5. DATA SYSTEMS

A *data system* is the network that will identify, collect, organize, store, analyze, and transfer the data.

### WHEN DEVELOPING A DATA SYSTEM, START WITH THE FOLLOWING TASKS:

- » Determine if a data sharing agreement is necessary. Obtaining a data sharing agreement can take considerable time. If such an agreement is required, begin the process early in the project.
- » Determine if the system can capture the data needed to determine fidelity, outputs, and needs assessments of participants.
- » Determine how confidentiality will be maintained.
- » Determine whether data are reliable, collected on a standardized schedule, easily accessible, and reviewed by implementation support teams.
- » Determine whether secure electronic submission or mailing will work better if information will be shared to multiple locations.
- » Determine how data will be securely stored and who will have access to the data.
- » Determine how, where, and for how long data will be archived; determine procedures and responsibilities for disposing of data.
- » Determine whether there are tribal or other statutory requirements governing data collection, sharing, use or archival.

The Winnebago team developed a color-coded spreadsheet to track data. The colors represented the phases of the project, and each activity that occurs in a phase is captured in the corresponding area of the spreadsheet. Due to the small number of families engaged in FGDM, an electronic database was not needed.

A second smaller spreadsheet was developed to capture the number of families in each phase of the process. In addition to the spreadsheets, coordinators kept case notes chronicling interactions with each family member and each provider throughout the process.

The files are kept in a fire-safe locked cabinet in the coordinators' office. The de-identified spreadsheets were updated and shared with the project team on a weekly basis. De-identified fidelity surveys were sent to the evaluator within 2 business days of completing a Family Group Conference. No identifying information was shared with the evaluator or non-tribal members of the Winnebago Team.



## LESSONS LEARNED

- » A well-designed data tracking system that includes key elements of the intervention is an important management tool and aids in the assessment of individual cases as they progress through the phases of an intervention.
- » It is important to keep detailed notes of meetings so that those who miss a meeting can be apprised of changes in practice or actions needed to support a family.

## 6. PROGRAM EXPERT

A *program expert* is a person with extensive knowledge, skills, and ability based on experience, occupation, or research in a specific program or practice. Typically, a program expert is the individual or entity that developed the intervention.

### WHEN CONSIDERING INVOLVEMENT OF A PROGRAM EXPERT, START WITH THE FOLLOWING TASKS:

- » Examine the effectiveness and usefulness of the program expert in supporting the implementation of the intervention. For example, determine whether the program expert will provide your project with materials that facilitate implementation as intended such as manuals, fidelity measures, or a train-the-trainer curriculum.
- » Assess the program expert's availability for coaching.
- » Determine if the program expert supports the development of internal supervision.
- » Determine if the program expert supports adaptations to the intervention or changes to service delivery systems required by the intervention.
- » Ask others who have worked with the program expert about their experience.
- » Ensure that the program expert is culturally competent regarding the population with whom the intervention will be implemented.

The purveyor assigned a program representative, an expert in FGDM, to support the Winnebago project and to provide training, observation, and coaching. The program expert was experienced in working with groups developing FGDM practice and in working with native and indigenous people. The program representative recommended a nearby agency as a resource for coaching. Two consultants from that agency, who were experienced in providing FGDM with high fidelity and good outcomes, provided coaching to the Winnebago coordinators.



## LESSONS LEARNED

- » The expert's commitment to train, adapt, coach, and develop supervisors through implementation is essential to building capacity. Although FGDM is manualized, the Winnebago Team found the manual alone was insufficient for developing the requisite skills for this practice. For this type of intervention, especially when the coordinators are inexperienced with the model, the relationship with the expert will be a long-term collaboration.
- » A coach must be flexible, open, and willing to create a way of working that fits the personality of the project team. The expert was able to model the nuances of FGDM implementation for the Winnebago Team such as sharing strategies with the Team for sharing difficult information.

## 7. FINANCIAL AND MATERIAL CONSIDERATIONS:

*Financial and material considerations* are the costs and materials needed to develop and deliver the intervention.

### WHEN EXPLORING FINANCIAL AND MATERIAL CONSIDERATIONS, START WITH THE FOLLOWING TASKS:

- » Determine the costs associated with the implementation of the intervention, and then determine if resources are available to implement the intervention with fidelity.
- » Plan for and include associated costs such as purveyor fees, training or coaching fees, facility and technology fees, travel and food, and the cost of implementation staff.
- » Determine if opportunities exist to leverage the support or funding of existing programs.

The primary costs associated with FGDM are the initial 3-day training and staffing. FGDM training costs include the trainer's time, travel, and administrative overhead as well as the cost of the manuals for trainees. FGDM in Winnebago is staffed by two coordinators. The Winnebago Team incurred additional costs for space and food associated with the training. Throughout the first 18 months of implementation, the Winnebago Team invested heavily in additional coaching. FGDM does offer advance practice training and a training-of-trainer option. The training-of-trainer standards are rigorous and the practice in Winnebago was too new to meet the eligibility criteria. The criteria are detailed on the Kempe website: [www.fgdm.org](http://www.fgdm.org).

A community-based apartment was rented to serve as office space for coordinators and provide an accessible, neutral meeting space for families that chose to use it. Access to community spaces was often limited. It was also challenging to identify an office space for independent coordinators where they could have private conversations as they worked to prepare family members for the FGC. With the relatively low cost of housing, the Winnebago Team was able to secure an ADA accessible, one-bedroom apartment in the community. The bedroom was used as a secure private office and the common areas provided family meeting space. Having a kitchen allowed for storage and heating of the meals shared during the private family time of the FGC.



## LESSONS LEARNED

- » Providing a dedicated space minimizes scheduling challenges and creates a homelike setting where families can meet. Many families had many reasons for not wanting to host extended family gatherings in their own homes.
- » Anticipate that there will be unexpected costs associated with implementing a new intervention. Initially, the team did not plan for costs associated with leasing space for family meetings and office space for the two coordinators.

## 8. LEADERSHIP

*Leadership* refers to those in a position of influence within an agency, organization, or system.

### WHEN CONSIDERING PROJECT LEADERSHIP, START WITH THE FOLLOWING TASKS:

- » Assess the tribe or agency commitment to the program being implemented.
- » Identify elders who will inform the program and champion it.
- » Prepare to engage new champions as leadership changes occur.

Leadership within the Winnebago Tribe consisted of Tribal Elders, the Tribal Council, the Tribe CEO, Tribal Court, the leader of the Ho Chunk Renaissance (culture and language program) and the Director of Children and Family Services. Over the course of the project, and the first time in history, the Tribal Council had 100% turnover. Both the CEO and Director positions also changed hands. The Tribal Court also had significant changes. Onboarding new leaders was a constant activity. Throughout the project, and despite the turnover, the Team was able to successfully engage key leaders who committed to the program.



### LESSONS LEARNED

- » Define leaders in a way that is consistent with your system or culture. Leaders are defined differently in tribes than in state agencies. In the Winnebago community, the leaders who needed to be engaged first were (a) Tribal Elders, who could sanction the effort; and (b) the Ho Chunk Renaissance leaders, who worked to ensure that as FGDM restored family voices, it did so in their own language.

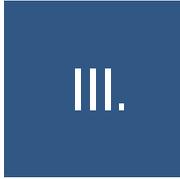
## 9. SYSTEM PARTNERS AND COMMUNITY LINKAGES

*Systems partners and community linkages* are those entities within the service network that provide services or supports to the target population. Some examples of system partners are other social service agencies, advocacy groups, mental health providers, and the education system.

### WHEN CONSIDERING SYSTEMS PARTNERS AND COMMUNITY LINKAGES, START WITH THE FOLLOWING TASKS:

- » Share the vision for the program with system partners.
- » Identify resources within the community/agency that can strengthen or support program objectives.
- » If community resources are required for providing the intervention, identify the availability and quality of linkages to community resources.

The Winnebago team engaged with the courts and Ho Chunk Renaissance as systems partners. The engagement with the courts involved opening and revising the Tribal Code to reflect all options for permanence. This included modifications to the Tribe's guardianship code to make guardianship more stable. Ho Chunk Renaissance provided insight on the cultural and linguistic components of FGDM.

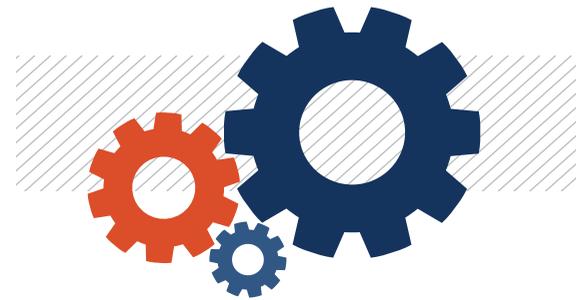


## WHO WILL DO THE WORK: TEAMING AND COMMUNICATION

Determining who will be responsible to complete the work is essential to moving the project forward. The teaming structure should include decision makers, stakeholders, and implementers. A plan is needed to communicate project progress internally and externally.

This section covers the following topics:

1. **Teaming Structure**
2. **Communication Strategies**



## 1. TEAMING STRUCTURE

An effective teaming structure ensures a site has the capacity and decision-making authority to get the work done. Sites need to think about a teaming structure that supports the work as well as the roles and responsibilities of members of the teams. Although structures will change over the life of a project, consider starting with the following structural components:

- a. **Project Management Team (PMT).** Forming a PMT can help not only to ensure leadership capacity for the duration of the project but also to ensure the sustainability of the intervention and leadership capacity. Members of a PMT are higher-level staff with decision-making authority in their respective departments.
- b. **Stakeholder Advisory Team (SAT).** A SAT is essential to providing the project with the perspective of the consumers of the service and community providers engaged in serving that population. The Winnebago Team SAT identified the unmet needs of children and families in the community. This SAT included representatives from agencies that serve the post-permanency population, other social service and adoption agencies, mental health and educational providers, and adoptive, guardianship and kinship families.
- c. **Implementation Team (IT).** An IT guides the overall project and attends to the key functions of the initiative. The IT has a two-fold purpose. First, the IT organizes and prioritizes the work that needs to be done, establishes tasks and timelines, analyzes data, and troubleshoots problems. Second, the IT provides leadership and guidance to support the staff implementing the intervention. Including decision-makers as members of the IT is important because the IT is charged with overseeing the implementation and will have to resolve challenges that arise.

In Winnebago, the PMT met during the installation of the intervention with the decision-making transitioning to the IT team. Quarterly meetings were held with the SAT to vet the survey instruments. The feedback from the SAT informed the development and revisions to the surveys. The PMT and SAT teams dissolved before implementation began due to inconsistent participation from members. Staff turnover within the organization also factored into the dissolution of the committee. The Winnebago Co-SIMs, (who were also the FGDM Coordinators), worked with Ho Chunk Renaissance and a tribal attorney to support the cultural adaptations to the FGDM intervention, and revisions to the Tribal Code. Stakeholders from the community were consulted individually throughout the implementation process.



## LESSONS LEARNED

- » Teams must be flexible, especially in the planning phases of a project. Teams are fluid over time and team composition and structure will change depending on the social norms of the community, and the tasks that need to be completed.

## 2. COMMUNICATION STRATEGIES

*Communication strategies* can range from face-to-face exchanges to electronic reports. Using a variety of communication strategies is key to keeping team members and stakeholders informed about the project status.

### WHEN CONSIDERING COMMUNICATION STRATEGIES, START WITH THE FOLLOWING TASKS:

- » Determine the methods you will use to communicate information about the intervention and to whom the information will be communicated (e.g., broad internal or external communication).
- » Think through the when and how information will be disseminated.
- » Put protocols in place that specify how information is communicated across networks.

Notes were taken at meetings and one of the Site Implementation Managers was responsible for ensuring the notes were shared with the Director of CFS. The Director reported to the Tribal CEO as needed and provided quarterly updates to the Tribal Council, including the Tribal Council's Child Welfare Committee.



### LESSONS LEARNED

- » Communication is critical to the success of a project. Effectively informing system partners encourages cooperation and engagement.

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## CHAPTER 6

# ASSESSING READINESS: USABILITY TESTING

Once the implementation planning is done, it is important to make sure the intervention is working as intended and the implementation supports are in place and effective.

The chapter addresses the following topic

### I. USABILITY TESTING

This chapter includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Winnebago Team implemented the process, activity, or task; and (d) lessons the Winnebago Team learned during implementation.

# I. USABILITY TESTING

According to the Children's Bureau's 2016 publication *Providing Technical Assistance to Build Implementation Capacity in Child Welfare*:

Usability testing is the process of establishing the innovation within the organization and learning whether procedures, processes, or innovation components need to be adapted for implementation to move forward. The purpose of usability testing is to help further operationalize the essential functions of the innovation, implementation supports (training, coaching, recruitment, selection, and fidelity assessment), and data collection. (p. 69)

Thus, usability testing is the initial implementation phase of the intervention when the first participants receive the intervention. This phase is a critical time to ensure implementation supports are effectively facilitating the delivery of the intervention and that the intervention is being delivered as intended.

Creating a structured process to evaluate findings from usability testing is the key to a successful full implementation. Findings from a critical evaluation will identify what worked, what did not, and what requires modification. Ongoing evaluation can be carried out by developing a matrix or grid that is reviewed regularly and allows for the usability findings to be documented for each intervention component.

It is important that usability reports include or describe the following:

- » Usability questions for each core component
- » Measures or metrics for each usability question
- » Summary of what the team learned from the metrics
- » What worked as intended and what did not work as intended
- » What needs to be done to address gaps or problems
- » What changes are needed or what changes have been made

By applying the findings from usability testing, modifications can be made to the project processes and procedures. Once all components are evaluated and modifications are made, the intervention is ready for full implementation.

The Winnebago Team tested the FGDM intervention with two families eligible for the intervention. Three components of the FGDM intervention (Outreach, Preparation, FGC) were reviewed. The fourth component is follow-up to the FGC; this could not be tested during the timeframe allotted for usability.

The Team modified processes that did not perform as intended in the usability test. Based on the usability testing, the Winnebago Team made four changes. First, the Team recognized that the turnover in casework staff made a re-orientation to the evaluation project and FGDM practice necessary. Second, the CFS leadership changed the case-flow process from requiring the case workers to refer families to FGDM to having coordinators “in-reach” to caseworkers and then filter out families that were ineligible. Third, the Team modified the tracking documents to capture *preparation* activities that were not consistently being tracked. Fourth, the Team set specific days and timelines for completing the tracking tool and for sending data to the evaluator.

The Usability Testing Plan and Tracking Tool (Appendix G) was used to complete usability testing. The tool provides a structure to delineate the questions to be answered and the metrics that will be used to answer the questions. The tool also allows for the tracking of changes made a result of the usability testing.



## LESSONS LEARNED

- » Critically assessing the processes of each intervention phase with a limited number of families is important to a team’s ability to determine what worked and what needed to be changed. Numerous modifications were made during usability testing that improved the effectiveness of the intervention.
- » Building in a “pause” indicates that the need to modify the initial plan is expected. This prevents the team from feeling like the need to make a change represents a failure. In the case of FGDM, this approach models the practice with families.

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## CHAPTER 7

# TRACKING PROGRESS

Establishing and documenting time frames and responsible parties ensures the project stays on track and progresses as planned. A work plan has maximum benefit when reviewed regularly and incorporates procedures for documenting progress and keeping track of unanticipated delays.

The chapter addresses the following topic:

### **I. TRACKING PROGRESS THROUGH WORK PLANS**

This chapter includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Winnebago Team implemented the process, activity, or task; (d) lessons the Winnebago Team learned during implementation.

## I.

## TRACKING PROGRESS THROUGH WORK PLANS

A work plan is a tool that can be used to track the progress of the activities that have to be completed at each implementation stage.

A work plan should include the following components:

- » **Activity**
- » **Responsible manager or team**
- » **Target date**
- » **Completion date**

For the Winnebago Team, having a work plan ensured a common understanding of the activities that needed to be completed during each phase. The Winnebago Team created a work plan with visual cues. The active items on the work plan were woven in to the weekly agenda. Activities were highlighted in green when they were completed. Activities with quickly approaching due dates were highlighted in yellow and prioritized in the next meeting, past due items were recorded in red and reassessed. The team had to determine whether the activity remained viable, and if so, when completion could be expected. Activities completed, which had not been planned at the outset of the quarter, were indicated in purple.



### LESSONS LEARNED

- » Using a work plan as the basis for the agenda ensured that every member of the Team was aware of project expectations. This is particularly useful when not all members can participate in every meeting. When adding the work plan to the agenda, consider when activities are due to be completed and add them to the agenda in time to allow for their successful completion. It is important to prioritize discussing the activities that need to be addressed within the next few meetings to ensure agendas remain manageable.

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# APPENDIX

- A. QIC-AG Population Template
- B. QIC-AG Continuum Assessment
- C. Stakeholder Focus Group Questions
- D. Hexagon Tool: Family Group Decision Making
- E. Initial Design and Implementation Plan
- F. QIC-AG Logic Model: Winnebago Tribe of Nebraska
- G. Usability Testing Plan and Tracking Tool

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## APPENDIX A

# QIC-AG POPULATION TEMPLATE

A

## QIC-AG POPULATION TEMPLATE: TARGET GROUP 2

*The population template is designed to help sites clearly define a population that will be the target of the evaluable intervention associated with the QIC-AG. Through this process each site will gain a clear understanding of the problem that needs to be addressed, the population that is most impacted by the problem, and ultimately, to initiate thinking about how the problem can best be addressed. Understanding the problem and the population can be accomplished by using data and other available information and anecdotes which allow you to consider the underlying causes of the needs of the identified population.*

*The population template will be used to: 1) understand the continuum of services; 2) understand the needs of the target population; 3) develop a theory of change and 4) provide a geographic focus for implementation and evaluation of an evaluable intervention.*

*Completion of the population template will be completed by the site with assistance from the evaluation team with support from the consultants. Each site is asked to complete as much of the template as is possible given the availability of quantitative data, qualitative data, and anecdotes. No new data should be collected to complete the template. In the event that no information is available to answer a question, please make a note of this and if possible, move on to the next question.*

## BACKGROUND: WHAT IS THE PROBLEM?

### PRIMARY PROBLEM DEFINITION

The primary problem to be addressed by the QIC-AG with Target Group 2 is post-permanency discontinuity. Post-permanence discontinuity occurs when a child experiences one of the following:

- » Re-enters state custody (e.g. a traditional foster care placement, residential or hospitalization) for behavioral, psychological or other issues
- » Re-enters state custody (e.g. a traditional foster care placement, residential or hospitalization) due to the death or incapacitation of their adoptive parent or legal guardian
- » Enters or resides in an out of home placement without re-entering state custody (e.g. residential or hospitalization, living with a relative) and remains in the legal custody of the adoptive parent or legal guardian
- » Termination of an adoption or guardianship subsidy for reason other than those listed above.

### BACKGROUND

The QIC-AG will build on an existing evidence base that recognizes that the problems facing families after legal permanence often stem from the complex behavioral and mental health needs of traumatized children and youth. Adoptive parents and legal guardians (caregivers) are often ill-prepared or ill-equipped to address these needs. Furthermore, the supports and services that are provided are often too late (when families have a weakened sense of commitment or are in crisis, rather than as a preventative measure), or inadequately address the needs of these families. The development of appropriate culturally responsive supports and services is needed to address the unique and challenging behavioral, mental health, and medical issues that may threaten stability and long-term permanency commitments of these families. Finally, interventions which support families from pre-permanence through post-permanence are necessary to successfully achieve safety, well-being, and lasting permanence.

Child welfare interventions that target families who have adopted or assumed legal guardianship of children previously in foster care who are having difficulties maintaining the adoptive or guardianship placement are often provided too late, and therefore, do not serve the best interests of children, youth and families. Even though most adoptive parents and permanent guardians are able to manage on their own, when the need arises, it is in everyone's best interest to receive evidence-supported, post-permanency services and supports (PPSS) at the earliest signs of trouble rather than at the later stages of weakened family commitment. Ideally preparation for the potential for post-permanency instability should begin prior to adoption or guardianship

finalization though evidence-supported, permanency planning services (PPS) that prepare and equip families with the capacity to weather unexpected difficulties and to seek services and supports if the need arises.

The best way to ensure that families will seek-out needed PPS and PPSS is to prepare them in advance for such contingencies and to check-in periodically after finalization to identify any unmet needs of the children, youth and families. It may also be necessary to assess the strength of the permanency commitments, which while firm at finalization, can weaken as unexpected difficulties arise and child problem behaviors strain the family's capacity to meet those challenges.

## 1. SOURCE OF PROBLEM DATA

### BACKGROUND

#### Child Welfare Adoptions and Guardianships

The QIC-AG wants to develop the ability to track children from pre-permanence through post-permanence. In order to do this, a system for linking children who have exited foster care through adoption or guardianship to their foster care records needs to be developed so that we can use these histories to identify potential risk and protective factors. For children who were previously adopted through the child welfare system, the linking of pre- and post-adoption IDs is complicated. One difficulty is that names and social security numbers associated with these youth often change after adoption and child welfare systems deliberately don't link pre and post adoption identities. As part of this initiative, we will work with sites to develop and use a linking file that allows pre- and post-adoption IDs to link. The same issue does not exist for guardianship cases as their IDs do not change.

An additional issue is that states may not have physical addresses and current contact information for these families. Many states have moved from mailing subsidy checks to direct deposits of subsidies. Often there is not a mechanism for keeping current contact information on this population after finalization. In addition, many states have stopped sending annual recertification letters to families receiving adoption or guardianship subsidies so states may not have updated contact information for the families.

Furthermore, the tracking of children after adoption or guardianship finalization is complicated by the fact that these children and their families are no longer under the care, protection and monitoring of the child welfare system. As such, changes in placements, difficulties the children and youth are experiencing, are not often tracked by the child welfare system. Children and youth can become homeless, enter residential treatment facilities, be placed in the care of relatives, or move out of the home for a variety of reasons (e.g., rehom-ing) and these actions may not be tracked through the child welfare data systems. Sometimes they may be known to child welfare staff, and other times they may not be known to the staff.

**Child welfare adoption and guardianship national data.** National data are available from 1984 through 2013. In 1984 there were 102,000 children in IV-E substitute care and 11,600 in receiving IV-E adoption subsidies; children in adoptive homes made up 10% of the subsidy population. By 2000, there were 287,000 children in IV-E subsidized substitute care and 228,300 children in IV-E adoptive homes; adoptions made up 44% of the IV-E population. The most recent data show 159,000 children in IV-E subsidized substitute care and 431,500 in IV-E subsidized adoptive placements and adoptions make up the majority (73%) of the IV-E population.

Source: Committee on Ways and Means of the U.S. House of Representatives. (2014). 2014 Green book: Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Retrieved from <http://greenbook.waysandmeans.house.gov>.

**International and Private Domestic Adoptions**

We know very little about these children and their families. Many states that provide post-permanency services allow families who have adopted by any means to access services. However, in some states non-child welfare families may not be eligible for post permanency services or may be eligible but required to pay for the services.

**International and private domestic adoption national data.** Between 1999 and 2013 there were 249,694 international adoptions. Majority of these adoptions were with children two or younger. Primary places for adoption were China and Russia.

In 2013 alone, there were 7,092 international adoptions. Most of the adoptions were with children two or younger but there was an increase in the number of older children being adopted (5 – 12 years).

Source: <http://travel.state.gov/content/adoptionsabroad/en/about-us/statistics.html>

Children receiving an adoption subsidy ffy13							
iv-e Reimbursable							
Not iv-e Reimbursable							
children receiving a guardianship subsidy ffy13							
gap reimbursable							
gap reimbursable							
not gap reimbursable							
children adopted internationally in 1999-2013							

### SITE SPECIFIC INFORMATION REQUEST

*In responding to the questions below, please include the source of data or information. When you have data, use it; otherwise do your best to tell the story.*

**A.** How many children in your site are currently receiving an adoption subsidy? Please provide state and county-level data.

**B.** How many children in your site are currently receiving a guardianship subsidy? Please provide state and county-level data.

**C.** How many children in your site have been adopted internationally in the past year? Please provide state and county-level data.

**D.** How many children in your site have been adopted privately in the past year? Please provide state and county-level data.

## 2. WHO IS AT RISK OF EXPERIENCING THE PROBLEM?

### BACKGROUND

While there is consistency in the finding that the vast majority of adoptive families do not formally disrupt or dissolve, researchers have cautioned the field not to overlook the needs of these families, noting that the child-parent relationship may break down in other ways, and that many families struggle after adoption from foster care (Festinger, 2002; Smith & Howard, 1991). Some factors that may impact discontinuity:

- » Behavioral problems
- » Caregiver commitment
- » Biological relationship between the child and caregiver
- » Marital status of caregiver
- » Siblings
- » Age of child at time of permanence
- » Formal supportive services
- » Number of moves in foster care

*Sources: Barth & Berry, 1988; Barth, Berry, Yoshikami & Carson, 1988; Festinger, 2002; Houston & Kramer, 2008; Koh & Testa, 2011; Rosenthal, Schmidt & Commer, 1988; Smith & Howard, 1991; Smith, Howard & Monroe, 2000; Zosky, Howard, Smith, Howard & Shelvin, 2005*

**SITE SPECIFIC INFORMATION REQUEST**

*Please include the source of data or information. When you have data, use it; otherwise do your best to tell the story.*

**CHILDREN ADOPTED THROUGH THE CHILD WELFARE SYSTEM**

*In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.*

*Responses to questions A, B, and C below will help to answer question D.*

**A.** Over the past year, how many children or families (post adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, monetary subsidy issues, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents’ inability to effectively address behavioral issues).
- » Who were the people asking for services (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

**B.** Over the past year, how many children or families (post adoption finalization) came to the attention of your

site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).
- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

**C.** Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

**D.** Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

CHILDREN EXITING FROM THE CHILD WELFARE SYSTEM THROUGH GUARDIANSHIP

*In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.*

*Responses to questions A, B, and C below will help to answer question D.*

**A.** Over the past year, how many children or families (post guardianship finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, monetary subsidy issues, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

**B.** Over the past year, how many children or families (post guardianship finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).

- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
  - » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
  - » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- 

**C.** Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
  - » How many families are targeted?
  - » Is there a geographic focus of your outreach?
  - » Why has this group been identified?
- 

**D.** Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

**INTERNATIONAL ADOPTIONS**

*In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.*

*Responses to questions A, B, and C below will help to answer question D.*

**A.** Over the past year, how many children or families (post international adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
- » Who were the people asking (e.g., children from specific countries, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

**B.** Over the past year, how many children or families (post international adoption finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).

- » Who were the people asking (e.g., children from specific countries, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

**C.** Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

**D.** Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

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**PRIVATE DOMESTIC ADOPTIONS**


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*In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.*

*Responses to questions A, B, and C below will help to answer question D.*

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**A.** Over the past year, how many children or families (post private domestic adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
  - » Who were the people asking (e.g., parents of teens, rural families, homeless youth)?
  - » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
  - » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
  - » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).
- 

**B.** Over the past year, how many children or families (post private domestic adoption finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).

- » Who were the people asking (e.g., parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

**C.** Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

**D.** Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

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## APPENDIX B

# QIC-AG CONTINUUM ASSESSMENT FOR PARTNER SITES

**B**

# QIC-AG CONTINUUM ASSESSMENT FOR PARTNER SITES

## OVERVIEW

The QIC-AG Continuum Assessment builds off of the initial assessments that have already been completed with the sites for target population 1 and 2. Target population 1 and 2 are defined as follows:

- » **Target Group 1:** Children with challenging mental health, emotional or behavioral issues who are waiting for an adoptive or guardianship placement as well as children in an identified adoptive or guardianship home for whom the placement has not resulted in finalization for a significant period of time.
- » **Target Group 2:** Children and families who have already finalized the adoption or guardianship. This group includes children who have obtained permanency through private guardianship and domestic private or international adoptions.

The continuum assessment is composed of two separate but inter-connected elements. The first element gathers macro level organizational information on the site. This information is organized by capacity domains that fall under process, outcomes and cost. Listed below are the capacity domains broken out by the categories.

## PROCESS

- » Infrastructure (includes questions related to legal and policy)
- » Functioning (includes questions related to structure, communication and assessment)
- » Operations (includes questions related to inter and intra agency relationships, monitoring/management , programs/interventions and availability/access)

## OUTCOMES

- » Knowledge (includes questions related to training)
- » Ability (includes questions related to provider capacity)

- » Attitudes (includes questions related to culture of the system)
- » Critical reflection and evaluation (includes questions related to needs identification and impact)

## COST

- » Resources (includes questions related to finances)

The second element gathers specific information about the programs/interventions that are offered at each of the intervals on the QIC-AG continuum framework:

- » Stage setting
- » Preparation
- » Focused
- » Universal
- » Selective
- » Indicated
- » Intensive
- » Maintenance

The completed continuum assessment will: 1) clarify the existing services offered at each interval of the continuum; 2) assist in identifying gaps and strengths along the site's continuum; 3) inform the identification of evaluable interval assignment; and 4) identify areas for capacity building. Ultimately, the continuum along with the population template will lay the foundation for the work that will be done with the sites over the course of the initiative. A similar assessment will be completed at the conclusion of the project with each site to assess changes that have been made to both the macro level system and the continuum of services since the start of the QIC-AG. This information will be critical to the evaluation of the QIC-AG.

# ELEMENT #1 MACRO LEVEL ORGANIZATIONAL INFORMATION

## PROCESS

### INFRASTRUCTURE

**Legal and Legislative:** Legislation is in place that supports the provision of services to target group 1 and 2.

- » What legal mandates/legislation/statutes positively or negatively impact target group 1 and/or 2? Please describe including date they were instituted.
- » Are there any active lawsuits and the impact on target group 1 and 2? If yes, please describe including start and estimated end date.
- » Is there any pending legislation that may impact target group 1 and 2? If yes, please describe.

**Policy:** The agency has written policies and procedures that promote and support service delivery to target group 1 and 2.

- » What are the policies and procedures that impact service delivery to target group 1 and 2 (i.e.: subsidy eligibility)?
- » Are there gaps in these policies and procedures that hinder the work with target group 1 and 2? What has been done to address these noted gaps? When did the efforts occur?

### FUNCTIONING

**Structure:** The agency has methods in place to identify needs of target group 1 and 2 and this information is used to develop and structure services for the Target Group 1 and 2.

- » What are the site’s current plan for the identification, development and refinement of services for adoptive and guardianship families? How is this plan used to inform your practice model?
- » Are post adoption/guardianship family’s needs and issues represented in the site’s current strategic plan? (If so, how? What process was used to get this information) (If their needs are not included, what is the willingness to include this information?)

- » What is the current structure to coordinate and support pre- and post-adoption/guardianship service providers?
- » Is there an existing committee or governance structure that coordinates work related to services for target group 1 and 2?
- » How does the site currently determine needs, develop strategies, and prioritize projects and initiatives related to target group 1 and 2? How does the site assess program effectiveness? What and how are stakeholders involved with this process?

**Communication:** The agency has developed strategies to ensure information is consistently obtained about target group 1 and 2 and that this information is shared among key services providers and stakeholders relevant to the population.

- » What are the current outreach and engagement plans that target adoptive/ guardianship families?
- » How is information shared across departments, systems, private and voluntary sectors related to the needs of adoptive and guardianship families?
- » Are there current statewide information systems/processes that collect information on target group 1 and 2 and provide this information to service providers (i.e. performance dashboard, monthly QA reports, survey results, policy transmittals)?

**Assessment:** The agency has established methods to gather information on the needs of individual children and families in target group 1 and 2 and uses this information to inform the development and delivery of services.

- » How is the site conducting comprehensive screening and functional assessments of children to ensure appropriate service intervention?
- » What standardized assessment tools are used to identify risks, protective factors and treatment needs of children and families in target group 1 and 2?
- » What is the linkage between assessments, interventions and outcomes? In other words, how is data from assessments used to target interventions and to determine the extent to which selected interventions contributed to the outcomes?

## OPERATIONS

**Interagency and Intra-Agency Relationships:** The agency has developed cross system, interdepartmental and community partnerships that maximize resources for target group 1 and 2.

- » Are there any relationships with private provider networks/associations involved with target group 1 and 2? If yes, please describe their role and relationship with the child welfare agency.
- » Does your site have a state/local foster/adoptive/guardianship parent association? If yes, describe their role and relationship with the child welfare agency. How do they provide input regarding the needs of Target Group 1? Target Group 2?
- » Are the coordinated referrals and hand-offs between pre and post adoption and guardianship services/workers? If yes, please describe.
- » Are there formal linkages between cross system service providers (i.e. mental health and child welfare committee meetings, human service coordinating bodies) that coordinate services for target group 1 and 2? If yes, please describe their role and relationship with the child welfare agency.

**Availability/Access:** The agency has developed methods and strategies to consistently inform adoptive parents and guardians of the availability and process for accessing services for target group 1 and 2.

*Pre Adoption/Guardianship (target group 1):*

- » How are families informed of services that will be available to them after finalization of adoption/guardianship?
- » Are there any services/vendors that start providing services prior to finalization and continue to provide services post finalization?

*Post Adoption/Guardianship*

- » How and when are adoptive and guardianship families made aware of the services that are available to them?
- » Are there families that you are aware of that do not know how to access services? How do you become aware of these families and what do you do to assist them?
- » Is there a centralized process for families to access services? If yes explain. If not explain the process for accessing services.
- » Is there currently a warm or hotline for pre- and post-adoptive/guardianship families to contact? If yes, what are the hours?

- » Is there currently an up to date online database that families can access to get information on pre- and post -adoption and guardianship services? Who keeps this up to date? If there is not an online database, what other methods are families using to get information on pre- and post-adoption and guardianship services?
- » Do you routinely track the reason families call for services? What barriers do adoptive and guardianship families most often report in accessing services?

**Monitoring and Management:** The agency has developed methods and strategies to gather detailed information on programs and services provided to target group 1 and 2 and uses this information to refine their processes.

- » How does your site monitor programs/interventions that serve the target groups?
- » How is this information used to increase staff effectiveness (improved knowledge, skills, attitudes/ perspectives, behaviors) or improve program components?
- » What challenges do you face in monitoring these programs/interventions?
- » Are there standard implementation/outcome expectations for vendors that provide services to target group 1 and 2? If yes, what are the expectations and how are they monitored?
- » Does your site have a current client satisfaction process for foster parents and/or adoptive parents/ guardians?

**Programs/Interventions:** The agency has developed culturally sensitive methods and strategies to identify the services and interventions that will respond to the needs of target group 1 and 2.

- » What assessments are done routinely to identify the needs of target group 1 and 2?
- » How are assessments and diagnoses currently used to identify the program or interventions that appropriately matches the identified need?
- » What is the process to roll out a new intervention in the state/county/tribe?
- » How does the site identify and assess the appropriateness of a new intervention before implementation? (i.e. Evidence Based Intervention (EBI) Integration Committee, a specific department/unit) Who are the key staff involved in these decisions? Can you describe any success or failures in trying to implement EBI in the past?

# OUTCOMES

## KNOWLEDGE

**Training:** The agency has a training and education process that includes components to prepare staff and families to respond to the needs of target group 1 and 2 in a culturally sensitive/relevant manner.

- » What trainings are offered to providers that serve target group 1 and 2 (i.e.: related to assessment, intervention, and evaluation)?
- » What regular trainings are offered to foster, adoptive and guardianship families? Are any offered to youth?
- » Are there current expectations and standards related to the level of adoption competency for staff that work with target group 1 or 2? If yes, describe.
- » Is there a training structure that will be included in the planning and support of the QIC-AG initiative?
- » What trainings are offered to integrate trauma informed practice into the service environment?

## ABILITY

**Capacity of Providers:** The agency has processes in place to identify and monitor the capacity of providers working with target group 1 and 2.

- » How does the site currently assess the capacity of providers to respond to the needs identified for target group 1 and 2?
- » Are there sufficient providers with adoption/guardianship competency to respond to the needs of target group 1 and 2?
- » How does the system measure the ability of providers to effectively serve target group 1 and 2?

## ATTITUDES

**Culture:** The agency has an understanding of its current culture and uses this information to guide the plans for positive change.

- » How often has the site implemented new interventions in the past year? past five years?

- » What is the history of the site in terms of implementation and expectation of utilizing new practices for target group 1 and 2?
- » How motivated are line staff, middle managers and directors to implement new practices for target group 1 and 2?
- » Does the agency administration perceive there to be a need to change the continuum of services for target group 1 and 2? Do line level staff?
- » What is the current workload and time pressures for staff providing services to target group 1 and 2?
- » Does the agency value the philosophy of trauma informed services? How has trauma informed practice been integrated into the practice philosophy?
- » How does the site feel about the significance of developing an evidence base to support child welfare practice? Does the agency culture support/value the use of evidenced supported intervention?

### CRITICAL REFLECTION AND EVALUATION

**Needs Identification:** The agency has developed strategies that routinely assess needs and preferences of target group 1 and 2.

- » Are there currently any standardized processes at a macro level to determine what needs and additional supports may be necessary for target group 1 and 2?
- » How are adoptive and guardianship families involved in the identification of services/interventions?

**Impact:** The agency has a process in place to collect outcome data on services/interventions offered to target group 1 and 2.

- » Is there a research/data division that does or can provide information about the outcomes of services that focus on target group 1 and 2? If yes, how frequently are the outcome data collected and what information is currently being collected on the continuum services?
- » Is there an outside vendor(s) that your system works with to collect outcomes on interventions for target group 1 or 2?
- » What data is currently available establishing the effectiveness of interventions designed for target population 1 and 2?

# COST

## RESOURCES

**Finances:** The agency has resources to develop and implement services to meet the needs of target group 1 and 2.

- » What is the site’s ability to financially support the development and implementation of services to meet the needs of target group 1 and 2?
- » What is your site’s current budget for target group 2?
- » Is the availability of services for target group 1 and 2 driven more by resources or need? Explain.
- » Are there any barriers to identifying and hiring sufficient staff with the necessary characteristics and attitudes to serve as implementers?
- » Is the site currently under or expecting any budgetary reductions that could impact their ability to allocate resources and staff time to this initiative?

# ELEMENT #2: PROGRAMS/INTERVENTIONS OFFERED AT EACH INTERVAL ON THE QIC-AG CONTINUUM FRAMEWORK

## DIRECTIONS

Conduct a thorough assessment of all services/interventions offered by the site that work with the QIC-AG target populations. For each service/intervention identified, answer all of the questions below. We are interested in collecting information for each of the intervals along the QIC-AG continuum: Stage Setting, Preparation, Focused, Universal, Selective Indicated, Intensive, and Maintenance. Services/interventions listed below should be directly related to target group 1 and/or 2. Please note that we are asking for specific services rather than programs. For example ASAP may be the program that provides post adoption services in TN. However, ASAP provides many services. Each of these services should be listed below and not lumped under one entry called ASAP. Please also note that we are looking for services/interventions that are offered anywhere in the site (i.e. designated state, county that is working with QIC-AG).

Following the interval specific questions, there are some broad questions about the site’s overall continuum.

### Questions to be asked for each service/intervention in the interval:

- » Type of service (Information and referrals, educational programs or materials, support programs (groups, mentors, buddy families, etc.), in-home counseling, out-of-home counseling, respite, residential/day treatment, mediation, assessment, specialized recruitment and development, educational advocacy, other )
- » Name of service/intervention
- » Length of time service/intervention has been in use
- » What is the primary goal of the service/intervention?
- » Who are the current providers?
- » Practitioner characteristics (Number of staff, minimum educational standards, training requirements, case ratio, clinical supervision, types of practitioner such as social worker, physician, parent, current workload and time pressures of staff who are providing current service)

- » **Regions/locations served:**
  - › Eligibility criteria for service/intervention
  
- » **Characteristics of service/intervention**
  - › Evidence supported/promising practice (name, if applicable)
  - › Risk factors/protective factors addressed by service/intervention
  - › Intended client
  - › Service delivery (frequency, duration, source of referrals)
  - › How did the site originally identify the need for the program?
  - › What assessment tools are used (functional, resiliency, mental health) and are these used to determine eligibility for the service/intervention
  
- » **Outcomes**
  - › Is output and/or outcome data collected?
  - › How is data collected?
  - › Number of clients served in last fiscal year?
  - › What was impact on families served in last fiscal year?
  - › Is there a standard set of outcome measures for this program/intervention?

**Questions to be asked for each the interval:**

- › What services/interventions are missing in this interval to meet the needs of target group 1 or 2?
- › What are the major barriers in this interval to providing services to target group 1 or 2?
- › Are there major barriers target group 1 or 2 encounter accessing services in this interval?
- › What are the major strengths in this interval to providing services for target group 1 or 2?

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## APPENDIX C

# QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS



# QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS

*As participants enter have them put their first name on the table tents and give them a copy of the consent form to read and sign. Answer any questions that may arise about the consent form. Have participants also fill out the sign in sheet.*

## INTRODUCTION

HELLO, I'M \_\_\_\_\_ FROM \_\_\_\_\_. I REPRESENT THE QIC-AG WHICH IS A NATIONAL PROJECT FUNDED BY THE CHILDREN'S BUREAU TO IMPROVE SERVICES OFFERED IN (NAME STATE) TO FAMILIES THAT HAVE ADOPTED AND ASSUMED GUARDIANSHIP OF A CHILD OR ARE PLANNING TO ADOPT OR TAKE GUARDIANSHIP OF A CHILD. WE WANT TO KNOW HOW YOU FEEL ABOUT THE SERVICES THAT ARE AVAILABLE TO HELP YOU SUPPORT THE CHILD IN YOUR HOME WHO YOU HAVE/OR PLAN TO ADOPT OR ASSUME GUARDIANSHIP. THIS INFORMATION WILL HELP (NAME STATE) IMPROVE THE SERVICES AVAILABLE TO FAMILIES WHO ARE WORKING TOWARD PERMANENCE OR WHO HAVE PERMANENCE THROUGH ADOPTION AND GUARDIANSHIP.

YOUR PARTICIPATION IN THIS MEETING IS VOLUNTARY, AND YOU MAY CHOOSE NOT TO ANSWER ANY OF THE QUESTIONS ASKED. THE INFORMATION WE LEARN FROM YOU WILL BE COMBINED TOGETHER WITH THE RESPONSES FROM OTHERS SO THAT NO ONE OUTSIDE OF THE ROOM WILL BE ABLE TO IDENTIFY WHO SAID WHAT. YOUR COMMENTS WILL BE USED TO HELP US GAIN AN OVERALL UNDERSTANDING OF THE SYSTEM.

AS MENTIONED ON THE CONSENT FORM, WE WILL NOT USE ANY OF YOUR PERSONAL INFORMATION. HOWEVER, WE WILL BE TAKING NOTES DURING THE MEETING.

THE MEETING IS SCHEDULED TO RUN ABOUT 2 HOURS. DO YOU HAVE ANY QUESTIONS FOR ME BEFORE WE START?

TO START, WE WOULD LIKE TO GET A SENSE OF WHO WE HAVE IN THE ROOM WITH US TODAY. EVERYONE SHOULD HAVE A PIECE OF PAPER TITLED DEMOGRAPHICS OF THE GROUP. DO NOT PUT YOUR NAME ON THE PIECE OF PAPER. WE WILL READ EACH QUESTION OUT LOUD AS WELL AS THE ANSWER CHOICES. PLEASE PUT AN "X" NEXT TO THE ANSWER THAT BEST DESCRIBES YOU.

*The rest of the questions will help us better understand the services that are offered in (name state) to children and families that have finalized adoptions or guardianships as well as children and families moving toward adoption and guardianship. This understanding will help the project determine where to focus efforts to improve services.*

## OPERATIONS

1. What services did you receive before the adoption or guardianship was finalized that helped you be the most prepared to adopt/assume guardianship?
2. What services/information would you have liked to have received prior to making a decision to adopt/assume guardianship?
3. Before your adoption/guardianship was finalized, were you told about services that you could get for your child after finalization?
4. If you needed services for your adopted/guardianship child today, who would you call to get help?
5. What services have you received after finalization that have been the most beneficial to your child or your family?
6. Since you adopted or assumed guardianship what services have you or your child needed that were difficult to get? Why were the services difficult to get?
7. Are you aware of a foster/adoptive/guardianship parent peer group (association or support group) that you can join? If yes, what is the name(s) of the group(s)?
8. What services have you needed that you have been unable to get?

## KNOWLEDGE

1. Have you attended any training to help you in your role as adoptive parent/guardian? If yes, what trainings did you find most helpful?
2. Are you aware of training in your state/county/tribe that is offered to adoptive parents/guardians?
3. Are you aware of training in your state/county/tribe for youth who have been adopted/moved to guardianship?
4. Has your child attended training regarding adoption/guardianship? If yes, what trainings did your child find most helpful?

## FUNCTIONING

1. How do you learn about services that you and your family can use?
2. Is there a place (number, person, etc.) that adoptive and guardianship parents can contact to voice their opinions or suggestions about the child welfare system?

## ATTITUDES

1. Overall how would you rate the following statement: The child welfare agency helps families make well thought out decisions about permanency for children who are not able to return home to either adoption or guardianship? *Strongly agree, agree, neutral, disagree, strongly disagree*
2. Overall how would you rate the following statement: The child welfare agency is there to help children and families that need help after adoption or guardianship has been finalized? *Strongly agree, agree, neutral, disagree, strongly disagree*

THAT IS ALL OF THE QUESTIONS THAT I HAVE FOR THE GROUP. WE TRULY APPRECIATE YOUR WILLINGNESS TO SHARE YOUR THOUGHTS.

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## APPENDIX D

# HEXAGON TOOL

## FAMILY GROUP DECISION MAKING

D

# HEXAGON TOOL: FAMILY GROUP DECISION MAKING

## NEED

	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
1. Was an analysis of data conducted to identify specific area of need(s)?	4	Yes
2. Is there evidence that the intervention addresses the specific areas of need identified?	4	The number of children awaiting permanency without a permanent home, demonstrates the need for advanced planning.
3. Is there evidence that the intervention addresses the needs of the community?	4	We know other tribal nations have modified FGDM to enhance their services.
4. Does it strengthen the current model?	5	There are two models that have been tested and tried in tribal communities.

## FIT

	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
1. How does the intervention fit with other existing initiatives?	5	Title 4-E (tribe wants to develop an adoption program that fits 4-E subsidies), Native Families for Native Children is implementing and testing TIPS-MAPP NA (culturally specific foster and adoption training program that could be used in adoption licensing). Pre-existing goal to develop tribally specific FTM model to support families based on cultural strengths and the HoChunk concept of family. It is an integral part of the overall goal to develop a tribally specific child welfare program.
2. How likely are implementation and outcomes of the intervention to be enhanced or diminished as result of interactions with other relevant innovations/initiatives?	5	FGDM will be highly dependent on the options ie.. customary adoption and the availability of subsidies.
3. How does it fit with priorities of the Winnebago tribe?	5	Overall good fit with goals to develop tribally specific models and ensure compliance with state and federal standards.
4. How does it fit with the tribe's current organizational infrastructure?	5	There are vehicles available in the current infrastructure for permanency options required that need to be fleshed out.

<b>FIT</b>	<b>RATE 1-5</b>	<b>NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)</b>
5. How does it fit with the tribe's current pedagogical views?	5	FGDM is a good fit with the roles and responsibilities outlined in the HoChunk concept of family ie... the kinship system.
6. How does it fit with community values?	5	FGDM is a good fit because we want to empower families to make the best decisions based on their cultural strengths. Additionally, FGDM focuses on natural supports rather than agency supports for families.

<b>RESOURCES</b>	<b>RATE 1-5</b>	<b>NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)</b>
1. Are there resources related to the intervention readily available? If so, list publisher or links.	4	There is an evidence based model, based on work with Maori people and two cultural adaptations. (See binder)
2. What is the cost? Enter in notes section	4	Unknown at this time.
3. Does the intervention require hardware or software? Use notes section to explain. List required hardware and/or software. Include costs if known.	4	Redcap software. The software is free. The budget for evaluation is \$12,000.00.
4. Are staffing resources available for this intervention?	4	Yes there are limited staffing resources available.
5. If yes, are the staff resources adequate?	3	Family Support Worker available. May need additional staff.
6. Are training resources available for this intervention (e.g. qualified staff at State, Regional and Tribal levels)?	4	Yes. The Lakota training, American Humane Association training, FTM Ohana training, Deb Denney trainer located in NE for American Humane model.
7. If yes, are training resources adequate for this intervention?	4	Yes there are adequate resources available to adapt for Winnebago model.
8. Are coaching resources available for this intervention (e.g. others at the tribal, District, Regional or State level know the intervention and have coaching skills and have time)?	5	Yes. Carol Iron Rope Herrera, Deb Denney and EPIC Conferencing (Ohana).
9. Are coaching resources adequate for this intervention?	-	Unknown

EVIDENCE	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
1. Are there research data available to demonstrate the effectiveness (e.g. randomized trials, quasiexperimental designs) of the intervention? If yes, provide citations or links to reports or publications.	5	There has been RCT studies done on FGDM. Sheets, et al, 2009; NcCrae & Fuscom, 2009; and Weisz, Korpas, & Wingrove, 2006 completed studies on user satisfaction. Benzim et. al, 2008 did a study on child safety.
2. If so, are the differences between the experimental and control groups academically significant (e.g. effect size)? Note the effect size(s).	4	Some studies on FGDM and kinship placement (Knorth et al, 2008; D’Cruz & Stagnitti, 2008) have found children who maintain connection to biological parents fare better. There were no effect sizes given in the study therefore, significance was not noted.
3. If research data are not available, are there evaluation data to indicate effectiveness (e.g. pre/post data, testing results, action research)? If yes, provide citations or links to evaluation reports.	5	Research data is available.
4. Do the studies (research and/or evaluation) provide data specific to effectiveness for Indigenous people (e.g., English Language Learners, Students With Disabilities, etc.)? If yes, provide citations or links specific to effectiveness for all learners.	4	Sheets, et. al, 2009 found the effect of family reunification after FGDM were larger for Black and Hispanic Children. Studies done on Native populations are few.

READINESS	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
1. Is there a qualified “expert”, TA provider, purveyor who can help QIC-AG team with implementation over time. (e.g. training, coaching methods, progress monitoring, data)? If yes, list names and/or organization (e.g. Center, University) and contacts.	4	Casey Family Programs (Judge Anita Fineday) Customary Adoption, NICWA, University of Nebraska Lincoln SBSR, Project Management Team, Mary Bissell, Kathy Desserly, Angelique Day, QIC-AG Advisory Team/Professional Consortia, Adoption Permanency Training State of Nebraska, Right Turn (Post Permanency Support).
2. Is this intervention currently in use in the region or state with demonstration of positive gains for families? If so, where?	4	The state of Nebraska uses Family Team Meeting model that is based on SDM and moving toward a family driven model.
3. Is the proposed intervention clearly defined (e.g. what it is, for whom it is intended)?	5	Yes. FGDM for children awaiting permanency.
4. Are the core features of the intervention identified, listed, named (e.g. key components of the intervention or practices that are required in order to be effective)?	5	Yes. Core components of FGDM are: Eligibility; Background & Guiding Values; Referral Process; FGDM Process; Family Meeting; Cultural Considerations; Training & Staff Development; and Evaluation. Adaptations need to be made.

## READINESS

	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
5. Is each core feature well operationalized (e.g. staff know what to do, how to prepare, how to assess progress)?	4	Yes
6. Is there a range of material (exemplars) available that demonstrates the instructional strategies or intervention strategies related to the core features (e.g., rubrics, practice profiles, videos, audio, scenarios)?	4	Yes
7. Is there a recommended trainer and community orientation and “buyin” process? If so, explain/describe briefly in Notes section.	4	Not yet
8. Are the processes related to professional development through training specified and ‘doable’ (e.g. staff, time, cost)?	TBD	TBD

## CAPACITY

	RATE 1-5	NOTES (E.G. HOW WAS THIS DETERMINED? IS THERE A DOCUMENTED PROCESS?)
1. Does current staff have the academic content knowledge needed to use the intervention to good effect?	5	Yes
2. Curriculum content and instructional strategy knowledge and capacity are adequate to support agency-level implementation?	TBD	TBD
3. Does the intervention intentionally advance staff knowledge and instructional or intervention practices?	5	Yes
4. Does the intervention foster and encourage community leadership?	5	Yes

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## APPENDIX E

# QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)



# QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)

## INTRODUCTION

The Initial Design and Implementation Plan (IDIP) is a document that serves as a tool for the QIC-AG site to thoughtfully and strategically plan for successful implementation of the initiative and to ensure that the initiative has intervention validity and implementation integrity. The result of the implementation plan should be a document that guides the implementation of the evaluable intervention, supports the use of an intervention to address an identified problem, and outlines the steps that need to be taken to ensure that the intervention is delivered to clients in the way that it was intended. To accomplish this, the Initial Design and Implementation Plan (IDIP) will describe the following:

1. Project Overview
2. Key Components of your Research Question
3. What will be implemented
4. How the system will be modified or readied to support the intervention
5. Who is going to do the work

If done well, an IDIP has many benefits, including the promotion of a well-developed, logical approach to implementation and the description of strategies to address on-going implementation issues. Planning activities provide the process for thinking through the intervention’s critical components, allowing for anticipation of possible barriers and the steps to address them and developing a common understanding of how the identified program goal will be achieved. In addition, the plan can serve as a communication tool with leadership to promote buy-in and sustain support.

**Please note: All components of the plan do not require the development of new materials or content. In some sections of the plan you will simply need to pull together and/or expand upon existing materials, documentation or products to complete that element of the plan. Having just one comprehensive document will help guide the work as the project moves forward.**

## I. PROJECT OVERVIEW

### A. PROBLEM

Using the information gathered during the “Identify and Explore” stage, briefly state the problem and the QIC-AG interval your intervention will address.

### B. THEORY OF CHANGE

Insert the QIC-AG approved site specific theory of change.

## II. KEY COMPONENTS OF YOUR RESEARCH QUESTION

A well-built research question is one that is directly relevant to the problem at hand and is phrased in a way that leads to precise answers (Wilson, Nishikawa & Hayward, 1995). Testa and Poertner (2010) recommend the PICO framework, which requires careful articulation of four key components: P – a well-defined target population; I – the intervention to be evaluated; C – the comparison group; and O – the outcomes expected to be achieved. Please note: Intervention (I) will be discussed in Section III. To complete this section, expand upon the QIC-AG approved PICO question.

### A. TARGET POPULATION

Using your population template as a starting point, supplemented with additional data from the evaluation team (as available) or through your site’s data system, clearly define the target population for the evaluable intervention. This may include data on the following:

- » Eligibility and exclusionary criteria
- » Geographic service areas
- » Characteristics, demographics, or past experiences (e.g., age, race, ethnicity, or placement history, family structure)

- » Needs (e.g., parents or guardians who lack the capacity to address trauma-related issues, or lack of parental skills and abilities to manage behavior)
- » Estimates of the total number of children that will be served by the QIC-AG each year

## B. COMPARISON GROUP

Describe the criteria for selecting your comparison group, and any anticipated concerns or processes that need to be developed for the comparison group. Please describe services as usual as they will be provided to the comparison group.

## C. OUTCOMES

*Short-term outcomes:* Short-term outcomes will be specific to your selected intervention. Describe the short-term outcomes you expect to achieve with this initiative. In your description, please discuss how your short-term outcomes are linked to your theory of change. Also explain how these outcomes are different or similar to outcomes previously examined with the intervention.

*Long-term outcomes:* Please note that each site will be examining the same long term outcomes regardless of the selected intervention. The long-term outcomes are as follows:

- » Increased post permanency stability
- » Improved child and family well being
- » Improved behavioral health for children and youth

## D. LOGIC MODEL

Present a logic model that illustrates the conceptual linkages between core components and your selected intervention, expected outputs, and short-term and long-term outcomes. The logic model should clearly explain how specific activities or services are expected to produce or influence their associated outcomes. Please include the visual representation of the logic model as an appendix.

## E. CASE FLOW/PROJECT ENROLLMENT

Describe how participants will be identified, selected or recruited to participate in the initiative. Please include

when and how randomization will occur and when and how consent will be obtained. Also please describe any anticipated issues that may prevent the processes from occurring as planned.

**F. DATA COLLECTION**

Describe the process for collecting information related to implementation (outputs, core components and fidelity measures). Indicate any concerns regarding the processes that need to be developed. In addition, describe the process for collecting data to support short- and long-term outcome measures. Indicate any concerns regarding the processes that need to be developed.

**III. DESCRIBING THE WHAT: INTERVENTION**

Using your completed Hexagon Tool as a starting point, describe the intervention that was chosen for the QIC-AG evaluable intervention including the following:

**A. PHILOSOPHY, VALUES, AND PRINCIPALS**

The philosophy, values and principals of the intervention and how the intervention’s fit with current initiatives and values of the site (examples: families are experts about their children, children with disabilities have the right to be integrated into classrooms, culture sensitivity is critical to child welfare service delivery).

**B. CORE COMPONENTS**

- » The core components of the intervention (if core components do not exist, then note that the development of core components is needed). Core components are features of the intervention that must be present to achieve the intended impact (examples: use of modeling, practice, and feedback to acquire parenting skills, acquisition of social skills, and recreation and community activities with high functioning peers). If there are optional intervention components specified, please describe.
- » The research and theory that demonstrates that the core components support the theory of change. Core components should be grounded in research or theory that supports the theory of change.
- » The operationalized definition of each core component. Core components must be operationalized

to ensure that they are teachable, learnable and doable and facilitate consistency across practice.

- » For the operationalized core components please describe any difficulties in execution that may arise.

### C. MATERIALS

Any materials that are available to support implementation such as manuals, training videos, assessment instruments, etc.

### D. FIDELITY

Any fidelity measures that have been created for the intervention. Please note if the fidelity measures have been positively correlated with better outcomes and if yes, what specific outcomes have been impacted.

### E. ADAPTATION

A description of any adaptation or development work that will need to be done to ensure that the intervention meets the needs of the target population and any concerns that exist regarding this work. If adaptation work is necessary please make sure to include this activity in the intervention specific work plan described in Section IV. B.

### F. DEVELOPMENTAL PHASE OF THE INTERVENTION

Using the “Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare” developed by the Child Welfare Research and Evaluation Framework Workgroup (AKA the “flower”), determine within which phase the intervention falls.

## IV. DESCRIBING THE HOW: IMPLEMENTATION SUPPORT

Once an intervention is selected it is important to know how the system will be readied to support service delivery. In this section describe the system’s exiting capacity to support service delivery, as well as work that needs to be done to develop supports that are not currently available. Please include discussion about any anticipated concerns and strategies for addressing them. Please note that any work that needs to be done

to support the development of the implementation supports should be reflected in the intervention specific work plan (See Section IV. B.). Use information documented in your completed Hexagon Tool and Purveyor Interview Tool as starting point for this section.

## A. IMPLEMENTATION SUPPORTS

- » **Staff:** Qualification of staff and other criteria needed to select, recruit, and retain staff as well as the number of staff needed. Any barriers to obtaining appropriate staff.
- » Training: Training curriculum and supervision or coaching plan, and the length of the training.
- » **Fidelity:** Measures and protocols to assess practitioner’s implementation of essential functions and core components.
- » **Policies and procedures:** Policies and procedures to support the new work; adaptations that are required and barriers to accomplishing this work.
- » **Data systems:**
  - › Required hardware and software or modifications needed to collect and manage information related to implementation (core components and fidelity measures). Anticipated barriers to accomplishing any modifications or acquisitions.
  - › Required hardware and software or modifications needed to collect and manage information related to short- and long-term outcome measures. Anticipated barriers to accomplishing any modifications or acquisitions.
- » **Leadership:** Current status of state, county, and local leadership buy-in and where further engagement may be needed.
- » **Community linkages:** Availability and quality of linkages to community resources if necessary to provide the intervention.
- » **Systems partners:** Availability of partners or collaborators, including those who are on board and those who are not yet on board (e.g., mental health, education, courts, substance abuse providers, other providers), and what is needed to engage these partners.
- » **Program experts:** Experts who have been engaged, or need to be engaged in the use of the intervention.

## B. INTERVENTION SPECIFIC WORK PLAN

The intervention specific work plan will be incorporated into the site specific work plan. It is necessary to create a plan that delineates the developmental activities that need to occur before the first clients can be served. These tasks will support the modification or adaption of the selected evaluable intervention as well as the development of implementation supports. The work plan should support the site work plan submitted to QIC-AG leadership, but will likely be more detailed with respect to tasks and will focus only on the evaluable intervention. The following detail should be captured:

- » Activity
- » Responsible team
- » Start date
- » End date

## V. DESCRIBING THE WHO: TEAMING AND GOVERNANCE STRUCTURE

Once you have determined the intervention and the necessary systems modifications, it is important to understand who will actually be responsible for the work that needs to be done. This section will capture the existing teaming structure and any additions/modifications that have been developed to ensure that the work can be completed. Please attach completed team charters as appendices.

### A. TEAMING STRUCTURE

Review the existing teaming structure and charters for the PMT and Stakeholder Advisory Teams as well as any other teams that have already been developed. Make necessary modification to support implementation, including expanding the teaming structure. For example, develop an implementation team if not already in place.

### B. TEAM CHARTERS

Develop team charters for newly defined team(s). A team charter describes the work a team will do, how the work will be done, and who on the team is responsible for the various work areas. The team charter should

support the Intervention Specific Work Plan.

### C. COMMUNICATION STRATEGIES

Detail the processes, procedures, and strategies for maintaining efficient and effective communication among leadership, staff, and partners who are:

- » Paid by the cooperative agreement
- » Members of a team as defined by the teaming structure

Critical to the successful implementation and utilization of the intervention (have an active role).

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## APPENDIX F

# QIC-AG LOGIC MODEL WINNEBAGO TRIBE OF NEBRASKA

**LONG-TERM OUTCOMES**

**SHORT-TERM OUTCOMES**

**PROGRAM OUTPUTS**

**IMPLEMENTATION**

**PROGRAM INPUTS**



**END VALUES**

Circular holistic world view

Healthy HoChunk Person:

1. Work/Mind
2. Social/relationships/kinship/ support
3. Spiritual beliefs/ceremonies
4. Physical body/health

Number Four; Four Seasons; Four Colors; Ties to the land; Clan system

**THEORY OF CHANGE**

» The Winnebago Tribe does not have a practice intervention supporting culturally competent, family engagement to promote decision making regarding sustainable permanence. Therefore, what is needed is to implement a culturally relevant child welfare practice intervention for the Winnebago Tribe based on indigenous practices that will ensure culturally viable decisions are made and that these decisions promote the timely achievement of permanence through customary adoption or guardianship.

» If a practice intervention is adapted to meet the needs of the Winnebago Tribe then the Winnebago people will be able to implement a culturally relevant child welfare practice which will increase legal permanence for Winnebago children.

**EXTERNAL CONDITIONS**

- » Change in government officials and tribal administration. Vacant administrative positions.
- » New legal representation and administration at State of NE DHHS and CFS.
- » Contracting year so the changes in key administration for the Tribe and State creates a challenge.
- » New ICWA Coordinator that went to the State from Ponca Tribe. They are advertising for a second ICWA Specialist.

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## APPENDIX G

# USABILITY TESTING PLAN AND TRACKING TOOL

