B. Statistical Methods (Used for Collection of Information Employing Statistical Methods)

1. Respondent Universe and Sampling Method

The universe of respondents is up to 770 representatives from 28 local sites of state CW agencies, and 64 caregivers and 24 service providers from the eight in-depth data collection sites. The 28 local sites, selected per criteria from the Study Design Options report submitted to the CB during the design phase, will be invited to participate in the study which includes the information collection described in this request. Nonprobability sampling strategies will be used.

Excerpts from the Study Design Options report below describes the sampling method and selection criteria:

The two purposive sampling strategies that best align with the study purposes are Maximum Variation Sampling and Criterion-i Sampling. Maximum Variation Sampling (sometimes known as Heterogeneity Sampling and Diversity Sampling) is as its name implies: its objective is to produce a sample as diverse as possible on one or more features of interest and/or contextual factors. At the state and the agency levels, a diverse set of contexts will assist in understanding the current policies and practices regarding the identification of children who are at risk for or have experienced prenatal substance exposure (PSE). A sample with divergent contexts will strengthen any subsequent claims of transferability of findings and recommendations to other settings.[1] Criterion-i Sampling, in contrast, is focused on similarity and ensuring that selected cases fulfill a preset criterion of interest. Criterion-i Sampling will be used in the study to ensure that efforts to address PSE are underway and/or a large tribal population is served by at least one selected state, and multiple agencies.

The sampling plan includes two levels of sampling: state level and agency level. The **sampling design at the state level is a combination of Maximum Variation Sampling and Criterion-i Sampling**. Exhibit B-1 displays the State-Level Maximum Variation Sampling criteria and the Criterion-i Sampling criteria used to select states for the study. All 50 states are included in the sampling frame and up to 6 states will be selected using the Maximum Variation Sampling criteria. At least 1 state will be selected using each of the Criterion-i Sampling criteria.

Exhibit B-1 State-Level Maximum Variation Sampling Criteria and Criterion-i Sampling Criteria

Maximum Variation Sampling Criteria	Data Source(s) - *Potential Indicators*
Unique factors:	
Unique state policies or practices (e.g., requires foster parent training; strong data systems; uses screening instrument)	Policy Review; Stakeholders; ACF Regional Managers Survey; Knowledge Base Review; Child Welfare Information Gateway News Database
Unique state efforts (e.g., state funding for treatment of pregnant women/mothers; state FASD task force)	Policy Review; Stakeholders; ACF Regional Managers Survey; Knowledge Base Review; Child Welfare Information Gateway News Database
ACF review status/timing (e.g., no Child and Family Services Reviews)	ACF; ACF Regional Managers Survey
State contextual factors:	

[1] Drisko, J. W. (2013). Standards for qualitative studies and reports. In A. Fortune, W. Reid, & R. Miller, Jr. (Eds.), *Qualitative research in social work* (pp. 3-34). New York, New York: Columbia University Press.

Caseload dynamics (e.g., children in foster care/increase)	https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption-fy15 *Estimated count of children entering foster care FY2013–FY2015*
Privatized CW system	http://www.washingtongrp.com/child-welfare-privatization-and-foster-care-privatization/
Consent decrees	https://www.childwelfare.gov/topics/management/reform/litigation/ (ACF Regional Managers to update and confirm)
Child welfare administration:	
State, county, hybrid	https://www.childwelfare.gov/pubPDFs/services.pdf
Geographic Region:	
Northeast, Southeast, Midwest, Southwest, Rocky Mountain, Pacific	https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf *Regions of the United States, U.S. Census Bureau*
Legislated policy or practice:	
Prenatal substance exposure is child abuse and neglect	https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy https://alcoholpolicy.niaaa.nih.gov/Alcohol_and_Pregnancy_Legal_Significance_for_Child_Abuse_Child_Neglect.html *State policies alcohol use during pregnancy - child abuse and neglect*
Substance Use:	
Prevalence of binge drinking (Tertiles)	https://www.cdc.gov/alcohol/data-stats.htm *Prevalence of binge drinking among adults by state, 2015*
Opioid mortality rate	https://www.cdc.gov/drugoverdose/data/statedeaths.html *Drug overdose deaths per 100,000 2015*
Criterion-i Sampling Criterion	**Data Source(s)**
Presence of efforts to address PSE	Stakeholders; ACF Regional Managers Survey; Knowledge Base Review; Child Welfare Information Gateway News Database

The **sampling design at the agency level is also a combination of Maximum Variation Sampling and Criterion-i Sampling**. Exhibit B-2 displays the Agency-Level Maximum Variation Sampling criteria and the Criterion-i Sampling criteria that will be used to select 30 local agency sites for the study. Between 4 and 6 local agency sites will be selected within each of the six selected states. By nesting agency sites within states, the study team will be able to explore connections between agency and state practices and potentially describe response to PSE at the state level. At least one of the agency sites within the state selected using the Criterion-i Sampling criterion of the presence of efforts to address PSE[2] will also have that criterion present.

Exhibit B-2 Agency-Level Maximum Variation Sampling Criteria and Criterion-i Sampling Criterion

Maximum Variation Sampling Criteria	Data Sources
U.S. Census population per square mile: urban, suburban, rural	https://www.census.gov/dmd/www/pdf/512popdn.pdf *U.S. counties by population density*
Local child welfare and substance abuse efforts (e.g., city policies that influence hospital reporting; local collaborative efforts)	State Child Welfare Directors; Stakeholders; ACF Regional Managers
Court efforts (family drug infant/toddler)	http://www.nadcp.org/learn/find-drug-court
Local contextual policies or indicators (TBD)	State Child Welfare Directors
Criterion-i Sampling Criterion	**Data Sources**
Presence of efforts to address PSE	Stakeholders; ACF Regional Managers; Knowledge Base Review; Child

[2] Multiple states, and multiple agencies within states meeting Criterion-i Sampling Criteria, may be selected depending on federal input regarding desired focus of study.

Rationale for sampling criteria and sample size. The criteria used at both levels of sampling were identified from previous similar studies and input from the technical workgroup consultants, stakeholders, and other expert sources. The criteria were selected based on several factors. First, they were selected on the phenomena of interest—efforts to address PSE—and related factors, such as opioid mortality rate, that would provide differentiation in the two samples. Other factors such as CW administration and rates of children entering foster care were selected to provide differentiation on the systems implementing such efforts. A third set of factors targeted the context for such efforts as geographic region. At both levels of sampling, if a state or agency site is not able to participate, then the next best alternative state or agency site will be selected based on the previously described criteria.

States were included in the sampling design because of the important role they play in the CW system. Even in county-administered CW systems, states can have tremendous influence on CW practice through policies, regulations, funding, and technical assistance. The selection of six states strikes a balance between various factors; it allows for the possible selection of a state from each of the six regions of the country (Northeast, Southeast, Midwest, Southwest, Rocky Mountain, and Pacific) and the possibility that up to two of the three types of child welfare systems will be included (state administered, county administered, hybrid). Six states also allow for the possibility of variation on other characteristics such as policies, practices, legislation, and contextual factors, including serving tribal communities. Finally, study resources were a consideration. Travel to six states was determined to be feasible with the time frame of the study and within the study's budget. Selecting six states also organized the proposed 28 local agency sites into clusters that make site visits manageable.

Process. Although the final selected sample will reflect variation on Maximum Variation and Criterion-i criteria, the **proposed process for applying the criteria has been adapted** from traditional sampling for efficiency and to address specific requests from federal project leadership. The study team has built a matrix in a spreadsheet format (Excel) that depicts all study sampling indicators in columns (e.g., county/state/hybrid administration, opioid morality rate) and states in rows. The spreadsheet is structured to be easily coded and converted to a data set for contextual analysis later in the study. Although the sampling frame reflects all 50 states (all states are eligible and relevant sites for study inclusion), there are some criteria that applied early in the process—prior to constructing the matrix reduce(*s*) the number of states that will ultimately be considered for selection. For example, by applying the criteria "ACF review timing/status" (i.e., not including states that are undergoing time-intensive federal requirements or efforts, such as Child and Family Services Reviews and federal site visits), specific states are eliminated early from consideration and from inclusion in the matrix. Likewise, there are some states where federal project leadership or other stakeholders have indicated that PSE efforts of particular interest are taking place. Thus, the study team developed the matrix by applying select criteria to streamline data collection on the criteria used to develop a diverse sample. The final matrix includes fewer than 50 states. Using the final matrix, the study team developed a list of six candidate states and a list of replacement states that maintain the maximized variation (if initially selected sites decline participation). Federal project leadership reviewed and approved the final selected states. The plan for agency selection may follow a similar process; the study team will prepare a matrix and identify candidate sites, but the process will include review and

discussion of candidates with state child welfare directors in selected states as a way to facilitate streamlining, efficiency, and study buy-in.

Descriptions of the respondents to each instrument and calculation of the estimated response rates is shown in Exhibit B-3. Other details are provided by instrument following Exhibit B-3.

Exhibit B-3. Calculation of Estimated Response Rates

Instrument	Respondent	# Respond-ents/ # Sampled	Response Rate (%)
Interview Protocol for Local Agency Director	CW agency directors	28/28	100%
Interview Protocol for Data Staff	CW agency data staff, evaluators, analysts	12/12	100%
Interview Protocol for Local Agency Medical Staff	CW agency medical case workers or specialists, nursing staff	24/28	85%
Interview Protocol for Local Agency Staff – Frontline Only	CW agency intake or investigation caseworkers or staff	47/55	85%
Interview Protocol for Local Agency Staff – Ongoing Only	CW agency supervisors and ongoing caseworkers and case managers	47/55	85%
Interview Protocol for Local Agency Staff– Frontline and Ongoing	CW agency caseworkers involved in intake, investigation, and ongoing case work	26/30	85%
Survey Instrument for Local Agency Staff - Form A General	CW agency supervisors, intake/investigative staff, ongoing and medical caseworkers	238/280	85%
Survey Instrument for Local Agency Staff - Form B General	CW agency supervisors, intake/investigative staff, ongoing and medical caseworkers	153/180	85%
Survey Instrument for Local Agency Staff - Form B Differential Response	CW agency supervisors, intake/ investigative staff, ongoing and medical caseworkers in sites with Differential Response model	85/100	85%
Survey Instrument for Service Providers	Pediatricians, psychologists, nurse practitioners, developmental specialists who are referral sources to CW agencies	21/24	85%
Focus Group of Caregivers	Foster and adoptive parents (caregivers) working with CW agencies	55/64	85%

Respondents to the *Interview Protocol for Local Agency Director* will make up a census sample of the 28 directors from the 28 enrolled sites. These interviews will be administered once.

Using the conceptual framework and key constructs as a base, a multi-method, multi-informant matrix was constructed to identify appropriate respondents and to facilitate decisions regarding sampling strategy and sample size for each data collection type. The specific respondent types for agency-level data collection described below were identified and confirmed by the technical workgroup to be the best informants of the data.

Respondents to the *Interview Protocol for Local Agency Staff (Frontline only, Ongoing Only, Frontline and Ongoing)* will make up a purposive sample of up to 142 respondents identified from 28 local sites. The sample size of approximately 5 total staff interviewees from each site allows for at least 1 or 2 staff members working within similar positions within the agency while getting a diverse perspective on PSE-related information at different points in a child's pathway through the CW systems (e.g., frontline only to speak to intake and investigation activities, frontline and ongoing to speak to how staff consider PSE over time in cases, etc.). The respondents to the *Interview Protocol for Local Agency Medical Staff* will be a purposive sample of 28 respondents.

The respondents to the *Survey Instrument for Local Agency Staff* (*Form A General, Form B General, and Form B Differential Response*) will make up a purposive sample of 560 agency representatives drawn from the 28 sites. There is federal interest in getting a national and diverse perspective on these issues, but the funds were unavailable to support a nationally representative sampling strategy for the staff surveys. Such a strategy would have more than doubled the cost of the study. At each site, between 12-24 staff (total varying by size of agency) will complete the survey. This sampling decision, made in consultation with technical experts and the senior methodologist, sought to balance the need for breadth and depth. Because the variation in agency practice both within and across agencies is currently unknown (not able to be specified) the sample size was developed to have enough respondents to allow for a feasible representation or picture of current practice, while also recognizing that the study may not reach technical 'saturation' in the data if agency practice is highly variable. The largest number of respondents who could be surveyed given the budget and resource constraints were proposed.

The respondents to the *Interview Protocol for Data Staff* will make up a purposive sample of 12 data staff from the eight in-depth data collection sites. At smaller agencies, interviews will be conducted with one data staff member; at larger agencies, interviews will be conducted with two.

All instruments will be administered only once to each participant. For both the agency interview protocols and surveys, the respondents will be identified by each site director or a designee serving as a scheduling coordinator. The director or designee will provide a list of agency staff, stratified by role, and their contact information. The study team will select agency staff at random within role and invite them to participate in the survey. Staff not initially selected for the interviews will be put on a wait list from which the team will draw more respondents if those initially selected are nonresponsive until the target response rate of 85% is reached.

The respondents to the *Survey Instrument for Service Providers* will make up a purposive sample of 24 representatives drawn from the medical and service providers who expressly partner with or receive referrals from the in-depth data collection sites. The respondents will be identified by

the CW agency directors or a designee. Service providers not initially selected to receive the survey will be put on a wait list. From this list, the contractor will draw additional respondents if those initially selected are nonresponsive until the target response rate of 85% is achieved. The *Survey Instrument for Service Providers* will be administered once to individuals.

The respondents to the *Focus Groups of Caregivers* will make up a purposive sample of 64 foster and adoptive parents (caregivers) working with the CW agencies at the in-depth data collection sites. Focus groups will range in size from 4 to 10 participants, with 8 participants being the target size, and each focus group will last approximately 90 minutes. The focus groups will be administered once at each of the eight in-depth sites.

2. Procedures for Collection of Information

No statistical methodology for stratification and sample selection will be used for the information collection activities in this request. The information collected is descriptive and will not be used for formal hypothesis testing. The nonprobability sampling approach is the most efficient and appropriate method for generating the respondent groups for these information collection activities.

Because the Web-based surveys are electronic surveys, advance appointments will not be made. The study team will invite selected respondents to participate via email. Quality control procedures for the Web-based surveys will be implemented by the study team in regard to the following: (1) accuracy and completeness of survey distribution lists; (2) accuracy and completeness of electronic survey programming, including internal testing of all versions of the Web-based surveys; (3) monitoring response rates and completeness of returned survey data; (4) reminders to non-responders; (5) descriptive analysis; (6) completeness and accuracy of coding processes for qualitative responses to open-ended survey questions; and (7) completeness and accuracy in all reporting in consideration of respondent privacy.

Advance appointments will be made for all interviews. The study team will invite selected respondents to participate. Agency staff and service providers who express interest in the interviews will be scheduled for interviews on a first-come, first-served basis. The study team will follow up with each participant to schedule an appointment to conduct the interview.

Advance appointments will also be made for the *Focus Group of Caregivers* that will be conducted at the in-depth data collection sites. The study team will work with the CW agency director or designee to identify appropriate participants (foster and adoptive parents with experience caring for children with noted or suspected PSE). The study team will provide written descriptions of the purpose and process for the focus group interviews which will be used by the agency staff to invite participants. If caregivers indicate their agreement, the team will contact them with an invitation to participate in the focus group. The team will follow up with each participant to schedule the date and time of the focus group.

Quality control procedures for both interviews and the focus groups will be implemented by the study team in regard to the following: (1) accuracy and completeness of inclusion of appropriate respondents; (2) accuracy and completeness of questions and training of interviewers, including

pilot testing of all versions of interviews; (3) completeness and accuracy of coding processes for qualitative responses to open-ended questions; and (4) completeness and accuracy in all reporting in consideration of respondent privacy. Data collection and data management protocols have been developed that include steps to ensure that all data are reviewed at the time of data collection and during data coding to mitigate missing and/or incomplete data and to record aspects of the data collection such as inclusion of participants. Data codebooks will detail all decisions applied during coding and analysis. Subsets of data will be reviewed and/or coded for reliability across collectors, where appropriate. All private data will be removed during the data collection and coding process according to the established Privacy Impact Assessment and Data Security and Monitoring Plan approved by the COR and ACF's Office of the Chief Information Officers. All reports and deliverables will be carefully scrutinized by the Data and Reporting Leadership Team and the federal project officers before distribution to ensure that all privacy components have been followed.

3. Methods To Maximize Response Rates and Deal With Nonresponse

The content and format of the instruments for the PAODE-CW Study were designed in consultation with key stakeholders and expert consultants and the CB and the CDC with consideration of structuring instruments to facilitate high rates of participation. Maximizing response rates is crucial to the administration of the instruments, but issues can arise with logistical matters such as scheduling interviews. Strategies that emphasize flexibility, respect for privacy, and a respect for the respondent's time facilitate timely participation will be implemented to maximize participation in the information collection and achieve the desired response rates identified in Exhibit B-3.[3]

General Introduction, Notification, and Coordination. The study team and the CB will send a joint introductory email to the recruited site[4] CW agency director describing the PAODE-CW study. The email will invite representatives of the agency to participate in the information collection and will describe that information will be gathered during two- to three-day onsite study site visits. The introductory email will inform potential participants that their feedback is critical to helping the CB identify positive practices in identifying and serving children with PSE and improving documentation of PSE in CW data systems.

The bulk of the information collection will be conducted in person by two study team members to promote participation and improve data quality. The study team and the site's director or designee will work together to coordinate onsite interviews and information collection logistics. An introduction meeting will be held on the first day of the site visits, where the study team will be available to answer questions about the study to foster study awareness and promote excitement about participation. The study team will encourage staff to complete surveys either online or in person while the study team is onsite.

[3] Strategies that pertain to similar types of data collection (Web-based surveys, interviews) are discussed together.

[4] Each enrolled study site will have completed the following before data collection: the CW agency director will have signed a memorandum of understanding, which outlines data collection time lines and expectations; the study team and agency will have executed any required data sharing agreements; and the study team will have gained approval from the local IRB if required, as described in A.10.

Interviews. Introductory emails will be sent to each of the respondents regarding the purpose of the interview and scheduling and consent processes. Interviews will be scheduled at a time that is convenient to the respondent during the site visit. If the respondent is unable to complete the interview during the site visit, the interview will be conducted via telephone at the respondent's convenience. A follow-up email thanking the respondent for her or her participation will be sent.

Surveys. Introductory emails will be sent to each of the respondents with details regarding the purpose of the survey, administration timing, and consent processes. During the onsite data collection visit, the study team will send an email request to complete the survey with individualized links to the online survey. Follow-up reminder emails will be sent approximately one week after the initial email survey request for all respondents who have not completed the surveys. Follow-up phone calls will be made to non-responders one week after the reminder email. Surveys may also be administered in written format if requested.

Focus Group for Caregivers. The CW director or designee will be asked to contact possible respondents and inquire about their interest and willingness to be contacted by the study team to learn more about participation and their preferred method of contact (phone or email). The study team will contact each of the willing respondents, introduce the PAODE-CW Study, and provide details regarding the purpose, and scheduling and consent processes. The study team will schedule the interview at a time available to the most respondents during the time of the onsite data collection visit. A location most convenient to the respondents and with the capacity for private discussion will be identified and reserved for the meeting (e.g., a library meeting room space). The study team will engage a licensed childcare provider to provide care and provide a simple meal during the session. The study team will confirm the focus group via email or phone 2 to 3 days before the focus group. The contractor will send a follow-up email to thank the respondent for his or her participation and provide contact information for any questions.

4. Tests of Procedures or Methods To Be Undertaken

All instruments were subject to review and feedback from key stakeholders including federal staff and expert consultants from the study technical work group (see Appendix B). Multiple rounds of pre-testing (including cognitive pre-tests) were conducted for each instrument with no more than nine individuals who recently served in roles similar to the potential respondents. Pre-testers suggested wording and response scale changes. Instruments were then refined. Pre-tests helped to determining the time required to complete the instruments and develop burden estimates.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The contractor will collect and analyze the information for the CB.

PAODE-CW Study Contractor	Subcontractor
James Bell Associates 3033 Wilson Blvd., Suite 650 Arlington, VA 22201	ICF 9300 Lee Highway Fairfax, VA 22030

(703) 528-3230	

Appendix A: Research Questions Addressed by the Information Collection Activities

Appendix A: Research Questions Addressed by the Information Collection Activities

1. What are the current policies and practices in place in CW agencies and related organizations for the identification of children with prenatal substance exposure and/or diagnosed with a resulting condition (such as Fetal Alcohol Syndrome [FAS] or FASDs)?
2. What type of training and dissemination activities are currently used, and what consensus is there, if any, among CW professionals in the studied settings, regarding what practice changes are likely to improve identification and documentation of children with PSEs and resulting conditions in the CW system?

Key Study Constructs and Sub-Research Questions

a. Construct: State legislation/policy
    i. To what extent and how have state plans/planning processes related to the 2016 Comprehensive Addiction and Recovery Act influenced local CW agency policies and/or procedures for children in out-of-home care with PSE? Documentation and/or data collection for children in out-of-home care with PSE?
    ii. What state legislation/policy exists related to providing information on a child's PSE status to preadoptive families? How does local CW agency practice related to collection of maternal history of substance use during pregnancy, and child medical, developmental, and MH/behavioral documentation, reflect this legislation?
    iii. To what extent does CW agency practice in screening children for medical, developmental, and MH/behavioral services align with state plans developed as a result of the 2008 Fostering Connections Act? To what extent and how do these screening practices support identification of children with PSE?
    iv. To what extent does CW agency practice align with state guidance on updating child medical information? To what extent and how does current medical information in case records support referrals of children with PSE?
b. Construct: Agency policies
    i. What policies/instruments are used by CW agencies to guide collecting, interpreting, documenting, and/or sharing information related to maternal substance use during pregnancy? PSE?
    ii. What policies/instruments are used by CW agencies related to the identification of and service referrals for children with or at risk of PSE? FASD?
    iii. What policies are present in CW agencies that may support more consistent/reliable collection and documentation of information related to maternal substance use during pregnancy? Identification of PSE?
    iv. What training is available to CW agency staff related to PSE? What are training requirements? What content is covered? How is training delivered?
    v. What training is available to resource families/preadoptive families related to PSE? What are training requirements? What content is covered? How is training delivered?
c. Construct: Agency Staff knowledge/practice

i. What do CW agency staff know related to the impact of PSE? FASD? The prevention of FASD?
ii. How do CW agency staff obtain information about PSE? What training and information dissemination methods increase their knowledge of PSE?
iii. What training, information, and/or other supports enable CW agency staff to apply their knowledge of PSE to their work with children and families?
iv. To what extent and how do CW agency staff identify children in their caseload with PSE?
v. How do CW agency staff respond in identifying child needs and making service referrals to children in their caseload with PSE?
vi. What factors are associated with CW agency staff identification of a child with PSE? With their response to a child's service needs once identified with PSE? (e.g., training, years of experience, knowledge, access to services, child age)

d. Construct: Data
    i. Where in the data system is information entered regarding maternal substance use during pregnancy? PSE? How consistently is this information entered?
    ii. To what extent is information in the CW data system able to be used to determine trends related to PSE? FASDs? Related service referrals?
    iii. To what extent and how do CW agency staff use information related to an individual child's PSE status in regard to supervision/internal team meetings? Identification of service needs? Monitoring case plan progress? Quality assurance processes? Others?
e. Construct: Child and family services & supports
    i. What assessment/diagnostic services are available for children with PSE? Are those services accessible and timely?
    ii. What trends in children's referrals for assessment and service referral are observed in regard to identification of PSE? Child characteristics? Agency policies? Service array?
    iii. Are service providers knowledgeable about PSE?
    iv. Are services tailored to children with PSE?
    v. What CW agency/ provider collaborative service structures exist that serve children with PSE? How do these collaborative efforts affect service delivery?
    vi. How does the CW agency support caregivers of children with PSE, in regard to general information on PSE? Child-specific information on PSE status? Support services? Parenting strategies for children with PSE?

Appendix B: Individuals Providing Feedback on PAODE-CW Study Data Collection Strategies

Appendix B

Individuals Who Reviewed and Submitted Comments on the Data Collection Approach and Instruments	
Project Expert Technical Workgroup Members	
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