EVALUATION OF THE EASTER SEALS NORTH TEXAS AUTISM TREATMENT PROGRAM: PROGRESS IN MEETING PROGRAM MISSION

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Applied behavior analysis (ABA) remains at the forefront of effective interventions for children with autism. In some cases, the high cost of treatment and other environmental factors limit families from accessing services. The Easter Seals North Texas (ESNT) Autism Treatment Program (ATP) was created to reach high risk, underserved families in the North Texas area by providing early intensive behavioral intervention (EIBI) services to children with autism. This evaluation was conducted to analyze the success of meeting the ESNT ATP program mission to provide culturally responsive ABA to children. The evaluation includes the design of assessments, the analysis of the assessment data, and a set of recommendations to maintain and increase program accessibility.

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INTRODUCTION

Many factors can limit a families' ability to access interventions for their children. The Easter Seals North Texas (ESNT) Autism Treatment Program (ATP) was created as an effort to increase access to services in the North Texas region. The purpose of this evaluation is to establish baseline measures in order to determine the success in meeting the program's mission. Specifically, the mission is "to provide a comprehensive program utilizing evidence-based practices that is culturally responsive and collaborative in nature, regardless of ability to pay" (Easter Seals North Texas, n.d.a). Two distinct literatures informed the development of a method to evaluate the program mission: access to Applied Behavior Analysis (ABA) intervention services and general strategies in program evaluation.

The Center for Disease Control (2007) estimates an average of 1 in 150 children have an autism spectrum disorder (ASD). Data indicate that autism is not specific to one group of people (Cuccaro et al., 1996) and the growth of autism diagnoses occurs in diverse populations, all in need of intervention services. Applied behavior analysis remains at the forefront of effective, evidence-based services in the treatment of children with autism (Myers & Johnson, 2007). Effective early intensive behavioral intervention (EIBI) services should include a minimum of 20 hours per week of individualized behavioral intervention using ABA techniques (New York State Department of Health, 1999). Research shows that early intervention treatment services can greatly improve a child's long-term development (e.g., Dawson & Osterling, 1997; Matson, 2008). There is,

however, an apparent disparity in who has access to ABA services. There appear to be at least two general factors that may limit access: risk and culture.

Service Access

Risk

The ESNT ATP concentrates its efforts on children in North Texas. Due to the complexity of the health care system and lack of funded resources in Texas, it can be safely assumed that many families do not have access to ABA because services and funding options are scattered, fragmented, and often difficult to access (Texas Council on Autism and Pervasive Developmental Disorders, 2008). Chasson, Harris and Neely (2007) have proposed that providing EIBI to all children with autism in Texas, in an effort to insulate these children from restrictive and costly lifetime services, will result in millions, and possibly billions, of dollars in savings. However, EIBI services can be extremely costly. If a family pays for treatment out-of pocket, they may spend between $20,000 to $60,000 per child per year depending on certain factors like economies of scale, parent and family involvement (Chasson, Harris, & Neely, 2007). In some states, payment for services may be provided by private insurance companies, federal medical programs such as Medicaid, or state agencies (Autism Speaks, 2009). For example, states such as Maine currently have active state provisions for children with autism. The Maine Department of Health and Human Services and the Department of Education are required to collaborate and develop statewide protocols for the diagnosis of autism for children ages 18-30 months old. If a diagnosis is made an early intensive treatment program is

developed for each diagnosed child (Department of Health and Human Services, 2007). Texas, however, does not have such state provisions in place.

One avenue to obtaining treatment in the absence of public funding is insurance reimbursement. As of June 19, 2009, the State of Texas signed House Bill 451 into law which requires insurance companies to provide coverage of medically necessary autism therapies, such as ABA therapy, to children with autism between ages 3 to 10 years old. This law applies to benefit plans new or renewed after January 1, 2010 and only applies to health plans that are regulated by state law (Autism Votes, 2008). According to Autism Speaks (2009), many families are denied coverage by private group health insurance companies through diagnostic exclusions or limits on behavioral services, which requires parents to either pay out-of-pocket or forego treatment. How this will play out in Texas remains to be seen.

Access to behavioral services may also be done through Medicaid, but Texas Medicaid does not cover ABA services (Texas Council on Autism and Pervasive Developmental Disorders, 2008). Instead, some counties offer Medicaid waivers which approve Board Certified Behavior Analysts (BCBAs) as service providers. However, not all counties provide Medicaid waivers (FEAT Houston, 2008). In addition, Medicaid suffers from low reimbursement rates that make it difficult for many locations to retain service providers. In addition, services that can be accessed through the Medicaid system are often inadequate (Autism Speaks, 2009).

The Texas State Autism Plan (2008) notes that the coordination of services from screening to diagnosis and early intensive behavioral therapies for children with an ASD

is critical. It is anticipated that the state plan to address a continuum of services from early screening to treatment will be completed by December 2009 and that recommendations to agencies will then be considered.

As a result of poor Medicaid services, issues with private insurance companies, and inadequate state provisions, the best ABA services with the most skilled professionals are reserved for families who can afford to pay out-of-pocket, and other families are left without ABA services. Thomas et al. (2007) conducted a study in North Carolina and found that access to autism-related care was limited for racial and ethnic minority families, those with low levels of education, those who were not using a major treatment approach, and those living in nonmetropolitan areas. This disparity is extremely unfortunate because autism varies little across culture, ethnic group membership, and socioeconomic status (SES) (Cuccaro et al., 1996). It is likely that the groups described by Thomas et al. are not accessing ABA services.

Affordability is not the only factor effecting accessibility for these groups. Other risk factors include, but are not limited to, job stability, parental health, the number of children in the home, and availability of outside caregivers and supports (Dunst, 1993). It is important to note risk factors are markers, not determinants, of poor outcomes. Given the interest of the ESNT ATP, these risk factors are important to assess so recommendations may be made regarding program accessibility. In summary, the ESNT ATP was most concerned with providing a culturally inclusive and welcoming environment to families that are traditionally underserved.

Culture

The role of culture may be especially important with respect to serving underserved families in North Texas. For the purpose of this evaluation, culture is defined as "a pattern of human behavior that includes the thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social groups" (Cross, 1989). The mission of the ESNT ATP states services are provided "in a culturally responsive manner." Presumably, this means that interventions are delivered in a way that reflects knowledge and competence in interacting with people from diverse social groups. Cultural responsivity has importance in the literature. For example, Hayes and Toarmino (1995) note that therapists who understand cultural groups can better treat individuals by using cultural knowledge as a source of hypotheses about the history of individuals and the functions of their behaviors. Furthermore, the ethnicity and culture of staff may also be a factor in how services are provided and there is a need to examine and begin to understand how culture can influence therapy (Iwamasa, 1997), including behavioral therapies.

One step further than cultural responsivity is cultural competence. Cultural competence is a developmental process agencies should use in order to evaluate where they stand on a continuum of cultural competence. The cultural continuum, suggested by Cross (1989), spans from *cultural destruction* - an agency that dehumanizes clients outside their own culture, to *cultural proficiency* - an agency that holds diversity of cultures in high esteem. Cultural competency is a set of congruent behaviors that describes attitudes and policies that come together in a system, agency, or among

professionals. Being culturally competent enables that system, agency, or those professionals to work effectively in cross-cultural situations.

A large part of developing, maintaining, and improving cultural competence is accomplished through training, staffing, increasing contact with healthy community members, conducting a self assessment, and normalizing conversation (Cross, 1989). Both risk (evidence based services regardless of ability to pay) and culture (culturally responsive services) are important parts of the ESNT ATP mission and an important dimension to evaluate. How this is evaluated is complex.

Program Implementation and Evaluation

The ESNT ATP was created in part, to serve families by providing ABA services to their children with autism. The program is designed to include three core features: (a) only providing evidence-based services, (b) providing services that will be culturally responsive and train personnel to work with all participants and families in a respectful manner with understanding, and (c) service provision that will occur in a complementary manner with other services children receive in the community and schools (Easter Seals North Texas, n.d.a). The importance of providing services in a culturally responsive manner is also iterated in the program mission: "To provide a comprehensive program utilizing evidence-based practices that is culturally responsive and collaborative in nature, regardless of ability to pay" (Easter Seals North Texas, n.d.a).

The purpose of this study is to provide an evaluation of the ESNT ATP's program mission through a collection of measures. Program evaluation is a means to answer a

crucial question: how well any particular program solves the problem (Baer, 1996). A program evaluation is not a luxury for programs, it is a responsibility. According to Lutzker & Campbell (1994), all clinical projects in human services should conduct evaluations for the sake of their consumers and their funding agents, and a failure to evaluate should be considered an ethical flaw. In addition, Liptak et al. (2008) suggests programs that target traditionally underserved groups of children in a culturally appropriate and supportive way should be tested and, if effective, implemented in order to optimize case finding of children with autism and to eliminate disparities to optimal treatments. From this evaluation we hope to establish baseline measures to evaluate program accessibility, validity and quality.

Six questions were developed to provide a framework for this evaluation: (1) What are the family demographics? (2) What are the staff demographics? (3) What types of services do clients receive? (4) Are the parents satisfied and do they find the program culturally responsive? (5) Are the staff satisfied? (6) What level of quality does the program provide in comparison to descriptions of ABA programs in the literature? These questions were developed in order to evaluate program diversity and risk factors, staff characteristics and how they compare to client characteristics, treatment services provided as compared to the other services found in the literature, social validity (Fawcett, 1991), and the Autism Quality Indicators (New York State Education Department, 2001). Answering these questions should provide accountability and understanding of how the program could be improved in order to provide the most accessible services for a diverse population.

METHOD

Easter Seals North Texas Autism Treatment Program Participants

This study included the clients (children), their families, and staff of the Easter Seals North Texas Autism Treatment Program (ESNT ATP). The 47 clients were all children between the ages of 3 and 8 years of age. Clients with an autism spectrum disorder (ASD) diagnosis could be involved in the program. If a client did not have a diagnosis, they could still be admitted to the program on suspicion of an ASD and receive services while they awaited diagnosis (Easter Seals North Texas, n.d.a). Some clients belonged to the same household, so 42 families participated in this evaluation. In addition to the clients and their families, 34 junior and senior applied behavior analysis (ABA) coaches, 3 board certified behavior analysts (BCBAs), one case manager, and one vice president of clinical services, also participated in this evaluation. Support services for the program were provided by one social worker and one interpreter, as well as a human rights committee which was composed of two Ph.D. level behavior analysts, one Ph.D. level applied anthropologist and her graduate student and one community representative, an advocate and mother of a child with autism (Table 1).

Comparison Demographics

There are approximately 3,000 children with an ASD diagnosis in the North Texas region (Easter Seals North Texas, n.d.a). According to the North Central Texas

Council of Governments (n.d.), North Texas is composed of 16 counties, 225 cities, and 132 independent school districts. The ESNT ATP served two of the 16 counties, Denton and Dallas County, and an additional DARS grant was awarded to serve children in Tarrant County.

In Dallas County, 22% of children are Black and 47% are Hispanic. In Denton County, 8% of children are Black and 19% are Hispanic (Easter Seals North Texas, n.d.a). These families make up a diverse group of families from a variety of ethnic backgrounds and languages spoken in the home. In Dallas County, Spanish is spoken in 33.2% of the homes. In Denton County, Spanish is spoken in 15.9% of homes. Also, in approximately 35% of the homes in Dallas County, the adults have not earned a high school diploma. 9% of the homes in Denton County have adults who have not earned a high school diploma (Easter Seals North Texas, n.d.a). According to the Texas Association of Counties (2007) 16.9% of families in Dallas County live in poverty and 7.1% Denton County.

At the onset of recruitment for the program, each family interested in receiving services was asked to complete an application for admission. This application collected information ranging from parent's medical history to child's favorite activities. There were also a collection of questions on the application that were used to assess each families' risk factor score (Dunst, 1993).

Eleven risk factors were given a numerical score which varied for each family depending on the level of risk. The prioritization was based on an analysis of risk and opportunity factors related to child outcomes (Dunst, 1993). For example, a family who

reported having no high school education was given a higher score than a family who reported a graduate-level education. After each risk factor was given a score, the scores were transferred to a weighted prioritization form. A total risk factor score was calculated and then added to each family's interest number. Interest numbers were assigned to families by order of application request. So, the first family to contact the program and apply was given an interest number of one, the second family to request an application for services was given an interest number of two, and so on. In order to assess who gained admittance to the program, two main factors were taken into consideration: risk factor score and interest number. This was done to give priority admittance to families that needed the services the most. Other factors such as scheduling, transportation ability to and from the center, and age of child were also considered.

Setting

Easter Seals Disability Services is the national leading non-profit provider of services for individuals with autism, developmental disabilities, physical disabilities and other special needs (Easter Seals, n.d.). The ATP was initiated through a grant from the Texas Department of Assistive and Rehabilitative Services (DARS) with a focus on Dallas and Denton Counties. The grant awarded to ESNT was $1.25 million to provide services for approximately 50 children between May 2008 and August 31, 2009 (Easter Seals North Texas, n.d.a). Families can visit one of two Easter Seals sites in the North Texas area, the Oak Cliff center in Dallas County or the Trinity center in Denton County.

The Trinity center, in Carrolton, Texas served 34 clients. The Oak Cliff center, in Dallas, Texas served 13 clients.

Both clinic-based treatment centers have treatment rooms equipped with a table and chairs, a variety of play and academic items, and waiting areas. At the Trinity center, parents are able to observe their child's therapy session through the use of observation booths equipped with audio speakers and one-way glass. The Trinity center also has two gym areas, an outdoor play area, a lunchroom, and a schoolroom for group activities. At both sites clients and families could receive additional services such as parent training, speech therapy, occupational therapy, physical therapy, social work services, and interpretation services.

Measures and Data Collection Procedures

Measures for this evaluation came from a variety of sources including client intake paperwork which included an application to the program and a weighted prioritization form (Dunst, 1993), client monthly reports, parent satisfaction surveys, staff satisfaction surveys, staff demographics questionnaires, consumer data reports, program surveys, and accounting documents. For the purpose of this evaluation, all data represented spans one year: May 2008 – May 2009. All data collected were put into specific data sets and various graphs were created to visually represent the program makeup. Monthly reports, consumer data reports, and program cost and time information were provided by accounting personnel, BCBAs, and the vice president of clinical services.

In order to collect and analyze this data, identifiable client information was not included in the database. A coding system was used along with password protected electronic documents to protect personal information. In addition, all data collection took place at the Trinity center or Oak Cliff center to ensure client records and documents could remain in a secure location at the center serving that group of children. If data was removed from the site identifiable information was removed and paperwork was coded.

Client Demographics

Client demographics included the languages spoken in the home and the race/ethnicity of the clients. This information was collected from consumer data reports, speech evaluation paperwork, and intake applications. The languages spoken in the home were analyzed by combining the total number of languages spoken in each household and then calculating the percentage of families that spoke each language. This was done to get a representative analysis of every language used in each household as well as an analysis of how prevalent each language was across all families in the program. Client race/ethnicity used the US Census Bureau categories. Race/ethnicity information was collected from consumer data reports which categorized each client according to one of the US Census Bureau race/ethnicity categories. Each client's race/ethnicity was totaled and then a percentage of families were determined to give an overall picture of the race/ethnicity of the clients served.

Client Risk Factors

By looking at a collection of variables proposed by Dunst (1993), the ESNT ATP developed a quantitative measure for each family's level of risk because multiple risk factors are associated with poorer in outcomes for children with autism. Eleven risk factors were selected and given a rating for the purpose of intake into the ESNT ATP. For the purpose of this study, the risk factors selected and analyzed included parent education and occupational status as well as household gross income and medical expenses. Each risk factor was represented through a percentage to represent families at risk in each category.

Staff Demographics

Staff demographics included the primary language spoken by each staff member, any secondary languages spoken, staff member's race/ethnicity, the highest level of education completed at the time of data collection, experience providing ABA services, and their major course of study in their highest level of education completed. Staff demographic information was collected by administering demographics questionnaires to each staff member. Questionnaires were attached to staff timesheets and once complete, staff were instructed to place the completed questionnaire in a folder labeled "completed staff demographic surveys." Each demographic category was then represented through a percentage to represent the demographics of the entire staff.

Amount of services received. The average number of direct ABA hours each client received was defined by the time each client spent in one-on-one or group

treatment. The number of hours each client spent receiving direct services was collected each day and submitted to the accounting director at the end of each treatment day. Monthly reports calculated the total number of hours each client spent in the center receiving one-on-one or group ABA therapy. The number of direct hours was analyzed by calculating the total number of direct ABA hours for the year for all clients. The clients' data was then separated into one of two age groups: 3 to 5 years or 6 to 8 years. In each category then the data were analyzed in order to determine the average number of hours clients spent in treatment per week.

Types of services received. The types of services each client received was defined by the number of clients who received various types of treatment. Treatments included one-on-one and group ABA therapy, speech therapy, occupational therapy, and physical therapy. All of these services are considered ABA services because the service provision was provided under a behavioral construct. The number of clients who utilized social work and interpretation services was also analyzed. The number of hours each client spent receiving direct and support services was collected each day and submitted to the accounting director at the end of each treatment day. Monthly reports were generated to illustrate the total number of hours each client spent in the center receiving each type of service. The clients' data was then counted to obtain the number of clients who received each type of service throughout the year.

Parent Satisfaction

The parent satisfaction survey was a social validity measure used to measure the

social acceptability of the ESNT ATP goals, procedures, and effects (Fawcett, 1991). Parent satisfaction was captured through survey questions related to child's happiness, progress, teaching program, and the treatment team. Surveys were administered twice during the data collection period. All surveys remained anonymous and were completed by parents, placed in an unmarked envelope and placed in the director of ABA services' mailbox by a neutral staff member of Easter Seals such as a front office administrator. Each question on the survey gave parents the opportunity to answer each question according to a 7-point Likert scale. A score of 1 indicated *not at all* and a score of 7 indicated *very*. There was also extra room on each survey form for the parents to write any additional comments. Survey completion was strictly voluntary. Once the surveys were completed the researchers calculated the total scores for each question on the survey. Each question was then analyzed to assess how many parents answered each question the same way.

Staff Satisfaction

The staff satisfaction surveys were an additional social validity measure captured through questions related to mission importance, job performance, tools needed, work relationships, and likelihood job recommendation. Surveys were administered twice during the data collection period. Blank surveys were placed in the staff common areas and once staff completed their survey they placed it in a folder marked "completed satisfaction surveys." All surveys remained anonymous and were kept in a neutral office location. Staff was reminded via verbal prompts and email that the surveys were available

to complete, however survey completion was strictly voluntary. Once the folders were collected, the data was input by a third party data processing office on the University of North Texas campus.

Quality Indicators

The Autism Program Quality Indicators (APQI) consists of a self-review and quality improvement guide for schools and programs serving students with autism spectrum disorders (New York State Education Department, 2001). Several different categories defined as quality indicators such as individual evaluation, curriculum, instructional activities, methods and environments, review and monitoring of progress and outcomes, family involvement and support, planning the move from one setting to another, challenging behavior, personnel, and program evaluation. Each category was scored by the Lead Behavior Analyst according to a Likert scale where 0 indicated no evidence and a score of 3 indicated clear evidence.

RESULTS AND DISCUSSION

A series of questions were developed for this program evaluation: 1. What are the family demographics? 2. What are the staff demographics? 3. What types of services do clients receive? 4. Are the parents satisfied and do they find the program culturally responsive? 5. Are the staff satisfied? 6. What level of quality does the program provide in comparison to descriptions of applied behavior analysis (ABA) programs in the literature? Each data set will be described, the results presented, and recommendations will follow.

Client Demographics

The client demographics measure was established in order to get a picture of the cultural makeup of the Easter Seals North Texas (ESNT) Autism Treatment Program (ATP) clients (Figure 1). The majority of families, 75%, reported speaking English in the home. However, 11 other languages are represented in families as well. The variety of languages spoken in the home gives an initial look into the diverse makeup of families. To expand this measure additional questions could be asked to families such as their country of origin and all languages spoken in the home which would include extended family members information, not only parent information.

Though there are a variety of languages represented in this data, Spanish made up a very small percentage, 3%, which may be an area of concern because in comparison, Spanish speaking families make up a large portion of the demographics of the Dallas

area. In Dallas County, Spanish is spoken in 33.2% of the homes. In Denton County, Spanish is spoken in 15.9% of homes (Easter Seals North Texas, n.d.a). At the ESNT ATP only 3% of families reported Spanish as a language spoken in the home. This may be an indicator that more efforts to educate staff on clients' cultural backgrounds and histories may provide valuable insight into the best ways to serve and recruit families. Also, more efforts to recruit Spanish-speaking families would help this underrepresentation (Cross, 1989).

Client race/ethnicity showed a majority of the clients served, 53%, were White/Caucasian. The remainder of the client makeup was 19% Asian and 24% Black/African American, and 4% Hispanic/Latino. This measure uses United States Census Bureau race/ethnicity classifications which may limit the range of diversity one can identify. As a result, cultural diversity of the families served could be greatly lost in this measure. Future efforts should focus on obtaining race/ethnicity information from the families without using predetermined categories. In order to amend this issue, families could be asked to report race/ethnicity information through an open-ended question such as "How do you classify your race/ethnicity?" However, without using US Census Bureau categories it would be difficult to compare state and county race/ethnicity demographic data to the ESNT ATP client demographic data. In addition, client race/ethnicity information was not reported by the families. Instead, the case managers and BCBAs placed each client into 1 of 6 categories based on their perception of the client's race. Intake paperwork should be changed in order to allow families to report race/ethnicity information themselves (Wolery & Garfinkle, 2002).

Again, there is a disproportionate representation of Hispanic families that do not match the demographics of the Dallas area. This indicates a failure to recruit Hispanic families to the program which could be due to a number of factors including availability of program information (i.e. websites, flyers, announcements) in Spanish, a lack of representation or contact with the community, or a lack of recruiting attempts altogether.

Client Risk Factors

The client risk factors measure was established in order to get a picture of the socioeconomic makeup of the families served (Dunst, 1993). Almost half of parents, 48%, reported having an undergraduate degree compared to a very small percentage of parents who reported a high school level education (12%) or no high school education (5%). This data may imply that those who have higher education levels are more aware and able to access services for their families (Thomas et al., 2007). In approximately 35% or homes in Dallas County and 9% of the homes in Denton County have adults who have not earned a high school diploma (Easter Seals North Texas, n.d.a). The comparison of these two data sets indicates that the ESNT ATP may limit access to families with low levels of education (Thomas et al., 2007). Recruitment strategies should be modified and redirected in order better serve these populations.

The parent occupational status measure allows us to get a picture of the employment status and stability of parents in the program. Most parents reported good job stability, 54% reported they have been employed at their current job for 36 months or longer and there was only 15% of families who reported being unemployed. This may

mean that most parents were working parents who experience a good amount of job security. This data may be static view of occupational status for many families because if job loss or gain is experienced after intake, this information is not captured.

Forty-one percent of families reported an annual income of $0 - $25,000 a year. This number seems low when compared to parent education and occupational status. This may indicate though parents have high levels of education and job stability, household income remains low. This may be a function of economic instability, representative of one of the parents staying in the home to care for the household, or other personal factors such as poor mental health, which may prevent the parent from obtaining and retaining an occupation which would gross higher household income.

Lastly, medical expenses do not seem to comprise a large portion of most families' income as 59% reported that 0-9% of net income was dedicated to medical expenses. This measure could be expanded in the future. A better understanding of household income and expenses could be captured by considering both parent's information and extraneous sources of financial stress on the families income supply such as living and household expenses. The program might collect data on what type, if any, of insurance coverage each family has and how much of their income is dedicated to using alternate treatments in addition to the services received at the ATP.

Staff Demographics

Staff demographics data showed 97% of staff spoke English as their primary language and 72% did not report use of a second language. In addition, 83% of staff

reported White/Caucasian. At the same time, the senior supervisory personnel were primarily of Hispanic and Asian descent and spoke at least three languages in addition to English (Spanish and Arabic). It should be noted that the human rights committee (Advisory Board and Community Advisory) provides advisory support for the program; however none of the HRC committee members had any direct contact with clients, so their demographic data was not included in this evaluation. However, the direct contact staff demographic data show there is limited staff diversity as compared to client demographic information. Since the staff and client makeup are incongruent, it may be the case that the cultural differences affect client outcomes (Iwamasa, 1997).

Demographic data for the staff also show that staff are highly educated, 69% reported some graduate school experience. In addition, 64% of staff reported a focus in behavior analysis as a major. Also, the amount of ABA experience among staff varies. The highest amount of similar experience was six months to a year which was reported by 19% of staff. These data imply that though the staff is very educated and from the field of interest for the ATP, not all staff members are entering the program with a great deal of experience. In addition, the lack of staff diversity and unmatched education levels with families served may be an area to heighten staff diversity and change staff recruitment styles or develop some form of training in order to help staff serve the families with a higher level of cultural understanding (Cross, 1989).

Types of Services Received

For clients between the ages of 3 to 5, the average number of hours in therapy is

about 13 hours per week. The average number of therapy hours for children 6-8 years is about 8 hours a week. Though the clinic is open 4 days a week for a total of 40 hours per week, the time clients are served fall below the recommended minimum of 20 hours per week of ABA services (New York State Department of Health, 1999). This may indicate issues with transportation, illnesses and family issues, inadequate clinic space, low numbers of staff, high enrollment, or division of time spent in the clinic among other services such as speech and occupational therapy. More information should be collected to assess why treatment hours remain below the recommended number of hours. Also, very few families utilized the support services available such as social work and interpretation services. This could also be an indicator of client demographics not being diverse enough to require many interpretation services or social work services. It should also be noted that for the majority of the year this evaluation took place the ESNT ATP did not have a social worker available to provide such services which may be the reason for the low number of clients served in this category.

Parent Satisfaction

Parent satisfaction data shows most parents are "very" satisfied with their child's happiness at the center, their child's progress, the types of skills and teaching procedure used and the treatment team. Question seven, "Have you learned to use the procedures?" show some parents were very unsatisfied with the lack of parent training provided at the center. It would be a great service to the families to provide parent training services both at the center and in the home in order to promote higher satisfaction and generalization of

skills to the home. In addition to parent training, in-home follow ups to test for generalization of skills is highly recommended. In addition, there is no measure on the satisfaction form to ask parents if they would still choose the ESNT ATP if they had other service options. It should also be noted that two questions on the parent satisfaction survey were not used for the purpose of this evaluation: Questions 3. How well can your child communicate with you? and 4. How well can your child play? The data for these measures were not included because they did not capture social validity, but rather they are questions directly related to the cluster of symptoms for which the families are seeking treatment. In the future, these questions should be omitted from the parent satisfaction survey.

Staff Satisfaction

Staff satisfaction data shows most staff members were generally satisfied with the mission, service effectiveness, relationships with coworkers and supervisors, and they would recommend their job to another person. In order to maintain high levels of satisfaction in these areas, the agency is encouraged to continue fostering staff unity through the use of staff meetings and gatherings which can boost morale and unite staff in accordance to the program mission. Although staff reported higher satisfaction in areas related to mission and morale, two categories showed lower levels of satisfaction. Questions 3, “How do you feel about your job performance?” and 4, “Do you feel you have the necessary tools to perform your job?” indicates that staff do not always feel they have the necessary tools to perform their jobs and many staff are not satisfied with their

job performance. As the program develops, a greater emphasis should be placed on supervision and training systems. With regards to question number four, there may also be some ambiguity in the definition of "tools." A tool could indicate instructional materials or it could relate to experience and training. In order the better understand what is lacking, more explicit questions should be asked.

In addition, providing more supervision, higher levels of training, and feedback systems may improve these staff satisfaction in these areas. Staff focus groups and interviews could be used as follow-up measures after the administration of staff satisfaction surveys to provide a medium for communication among staff and supervisors. Also, the use and clarification of staff roles and responsibilities can be done through the use of organizational charts. These charts will help the agency better define the roles of each staff member which can be used in performance evaluations in the future.

Quality Indicators

The quality indicators reported clear evidence of quality in the majority of indicators. There were only a few indicators of concern: curriculum, instructional activities, family involvement and support, and transitions. Altogether, the data represented show a high level of quality in the program. In order to raise some of the scores for future evaluations, the treatment team should discuss recommendations in a collaborative setting to provide broader curriculum and instructional activities. In addition, the family involvement and support as well as transitions could be addressed

with the parent training suggestion noted from the data received by the parent satisfaction survey. Lastly, it would be highly recommended that the treatment team seek third-party evaluations to avoid evaluation bias and capture any overlooked areas.

CONCLUSIONS

The purpose of this evaluation was to establish baseline measures to evaluate program accessibility, validity and quality. In order to provide a framework for this program evaluation, six questions were asked: 1. What are the family demographics? 2. What are the staff demographics? 3. What types of services do clients receive? 4. Are the parents satisfied and do they find the program culturally responsive? 5. Are the staff satisfied? 6. What level of quality does the program provide in comparison to descriptions of applied behavior analysis (ABA) programs in the literature? The results of this evaluation are a good start to understanding a variety of program features. The measures give a snapshot of access to services, client and staff demographics, amount of service being provided to clients, as well was client and staff perspectives on the services provided. The Easter Seals North Texas (ESNT) Autism Treatment Program (ATP) was evaluated after only one year of operation. Within the first year of service provision, the ESNT ATP has started in a precise trajectory to fulfill their mission to provide services in a culturally responsive manner.

By reporting client demographics, practitioners can begin to understand if access is limited due to cultural or ethnic factors. Wolery and Garfinkle (2002) proposed that there is an under-reporting of family characteristics and children's race or ethnicity in intervention research. Though the ESNT ATP was not established as a research project, it may be a logical extension to assume that some grant-funded programs have not reported or included families from diverse backgrounds. The ATP has taken a step in the right

direction by reporting this demographic information; however action should be taken to increase client diversity in order to better serve a more representative sample of the demographics of the North Texas area.

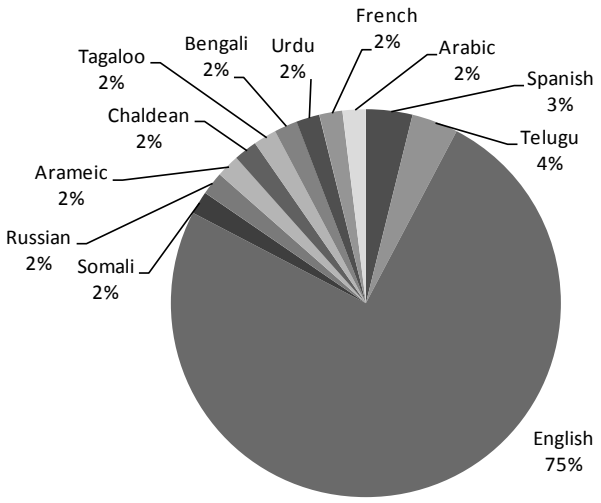
It is difficult for agencies to become culturally proficient if they are not serving culturally diverse families. In addition, culture may affect treatment decisions inasmuch as it is often associated with certain socioeconomic or geographical constraints related to accessing care (Mandell & Novak, 2005). Based on the data gathered there are some cultures that are underrepresented in the ATP. There should be more efforts to recruit and serve more diverse families and staff by using recruiting and training recommendations from the literature (Cross, 1989).

Though the ESNT ATP has done a commendable job of providing comprehensive services, it is an area of high concern that the clients are not receiving an EIBI program at a minimum of 20 hours per week as recommended in the literature (New York State Department of Health, 1999). This is an area that deserves attention and modifications in order provide the amount of services required for the most impactful behavioral change.

Altogether, the staff and the parents of the ESNT ATP seem to be generally satisfied with the program. Efforts should be made to increase satisfaction by addressing areas of concern represented by the data obtained by these measures. Also, adjusting these measures could help the program expand and develop in the future based on client and staff recommendations.

Behavior analysis can promote social change and improve the lives of people by studying and identifying socially relevant problems and improving on those issues (Baer,

Wolf, & Risley, 1968). Ethically, we cannot allow behavior analytic services reserved to select members of the population. Access to ABA therapy should be a right for each family, not a privilege. Though culture may be factor in the treatment access, we don't fully understand how those cultural differences influence retention and outcomes for families of children with autism. The goal is equal accessibility for families regardless of ability to pay. These measures establish a context through which modifications should be made in order to improve service provision and accessibility in the future.



Client Race/Ethnicity

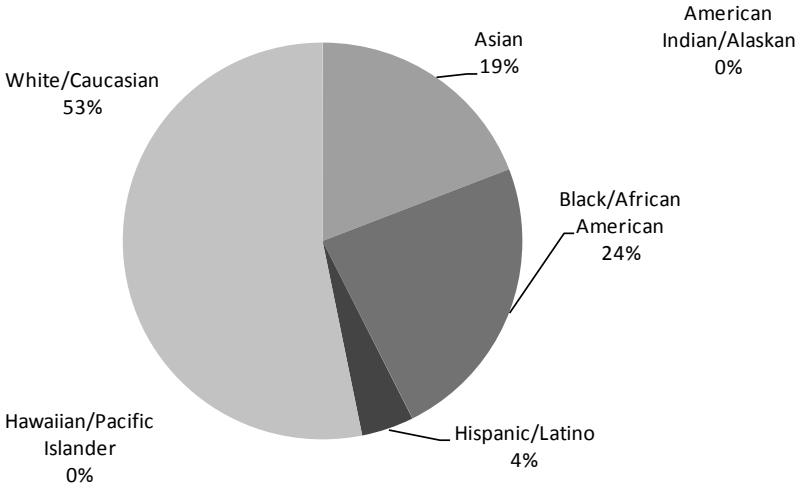


Figure 1. Languages spoken by families in the home and client race/ethnicity.

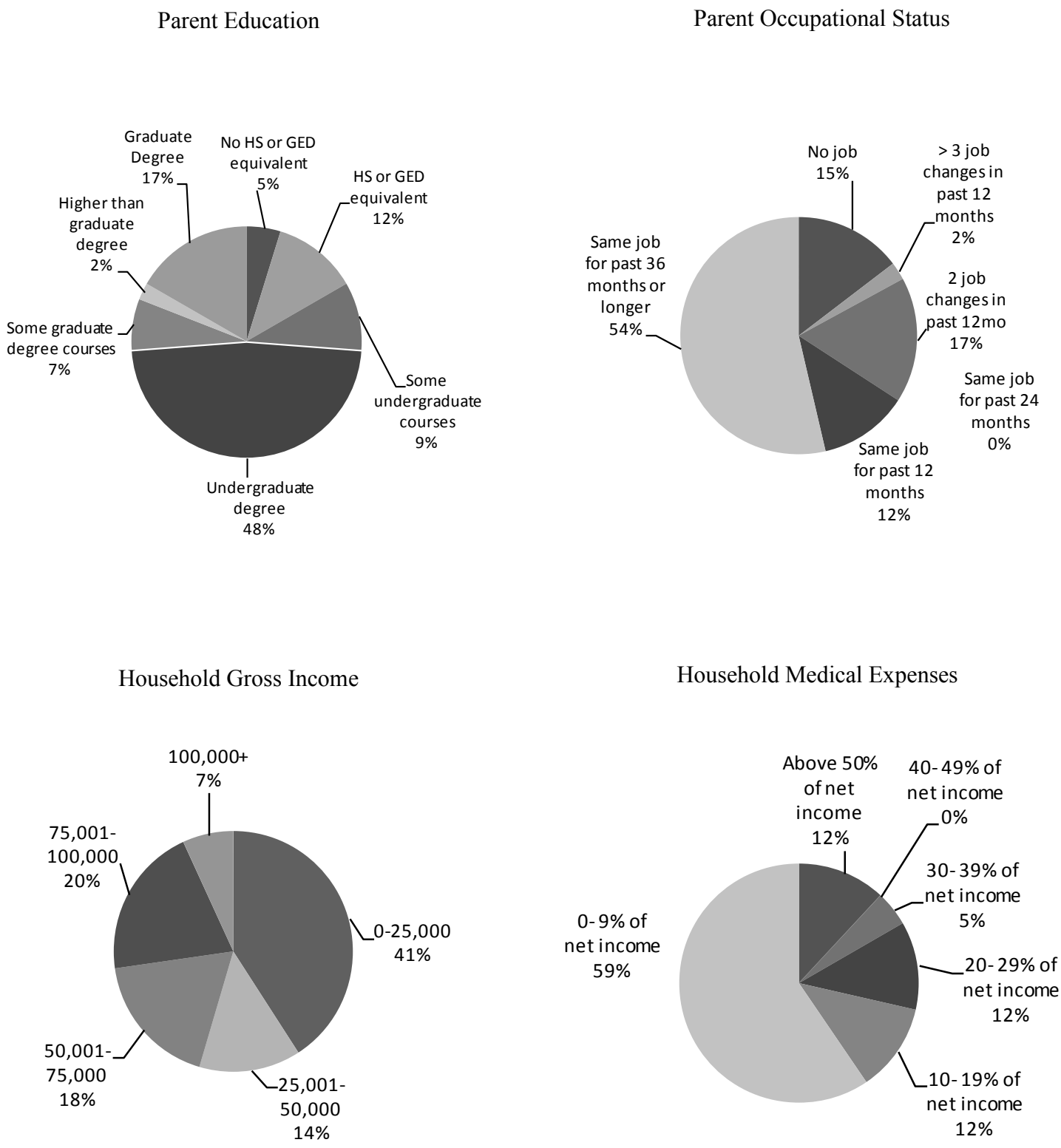


Figure 2. Parent education, occupational statues, household income and medical expenses.

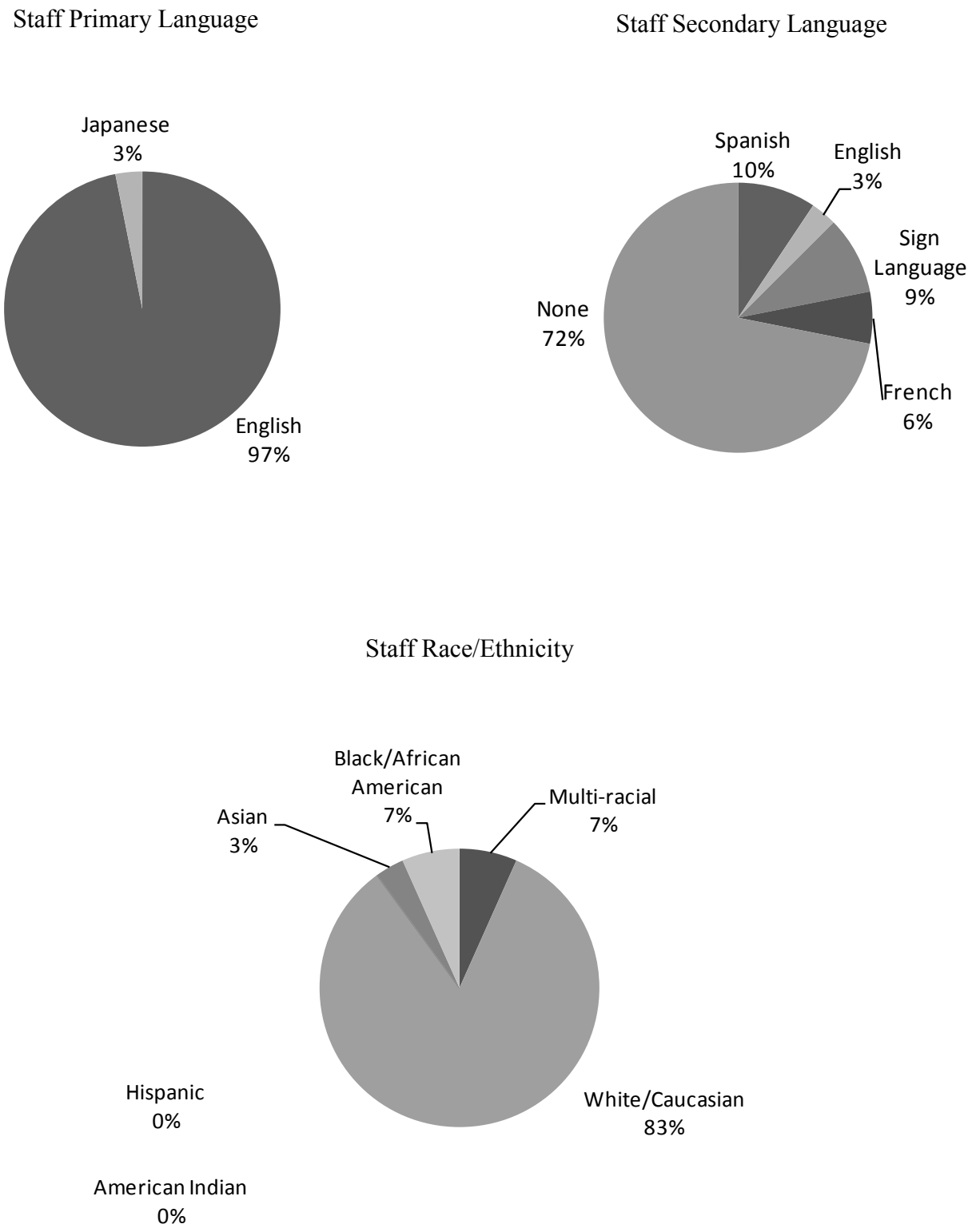


Figure 3. Staff primary and secondary language, staff race/ethnicity.

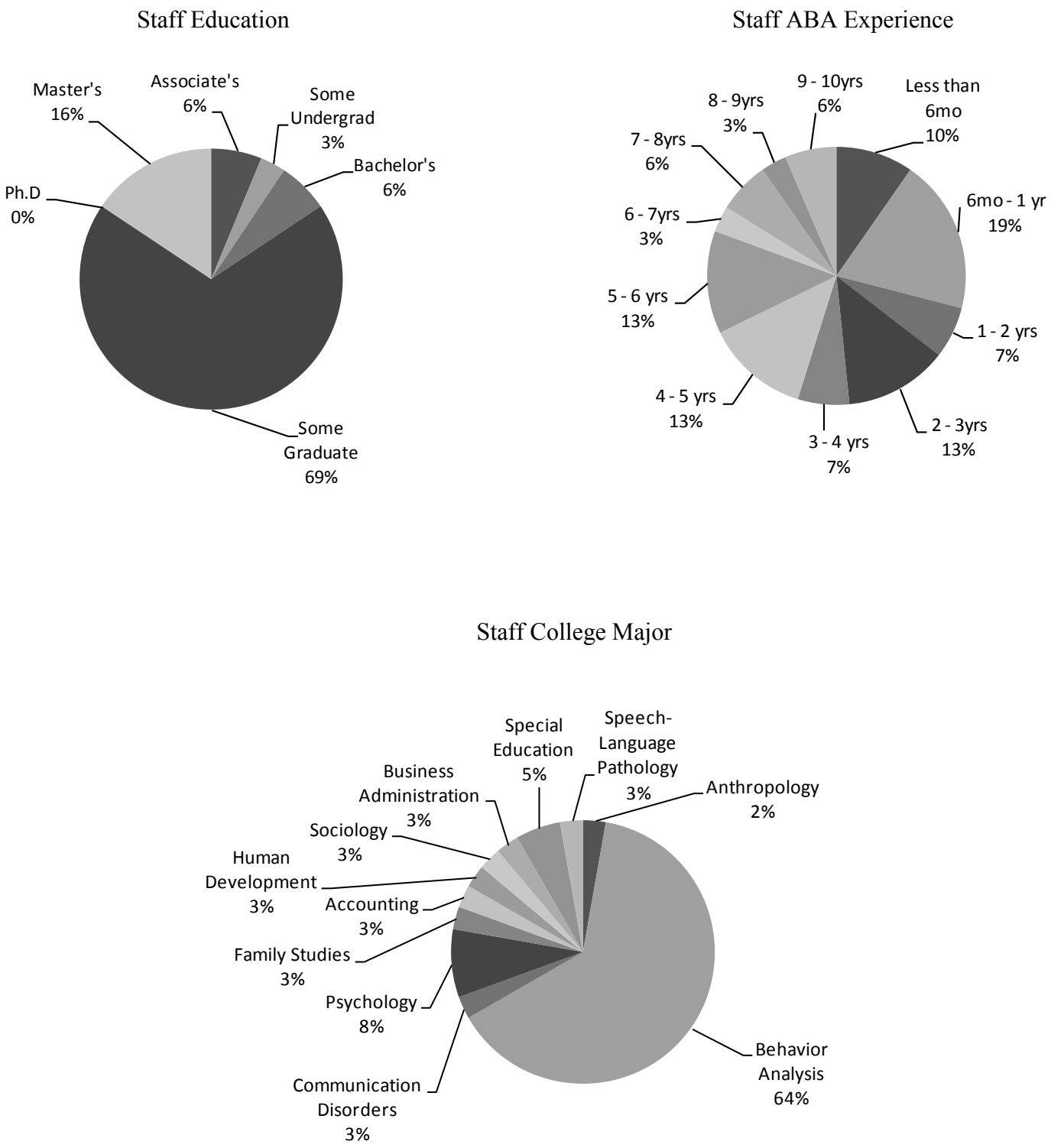


Figure 4. Staff education, ABA experience and college major.

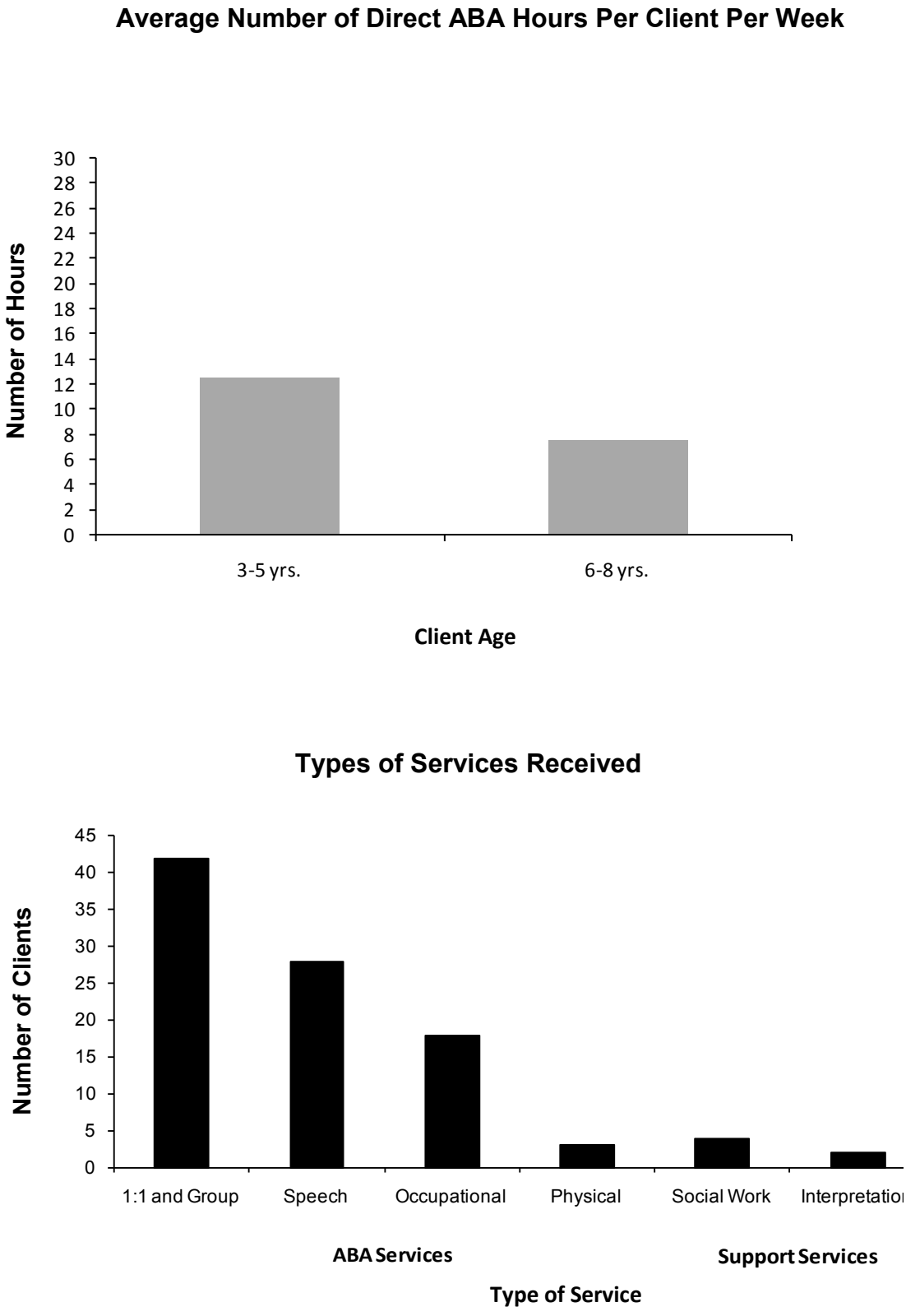
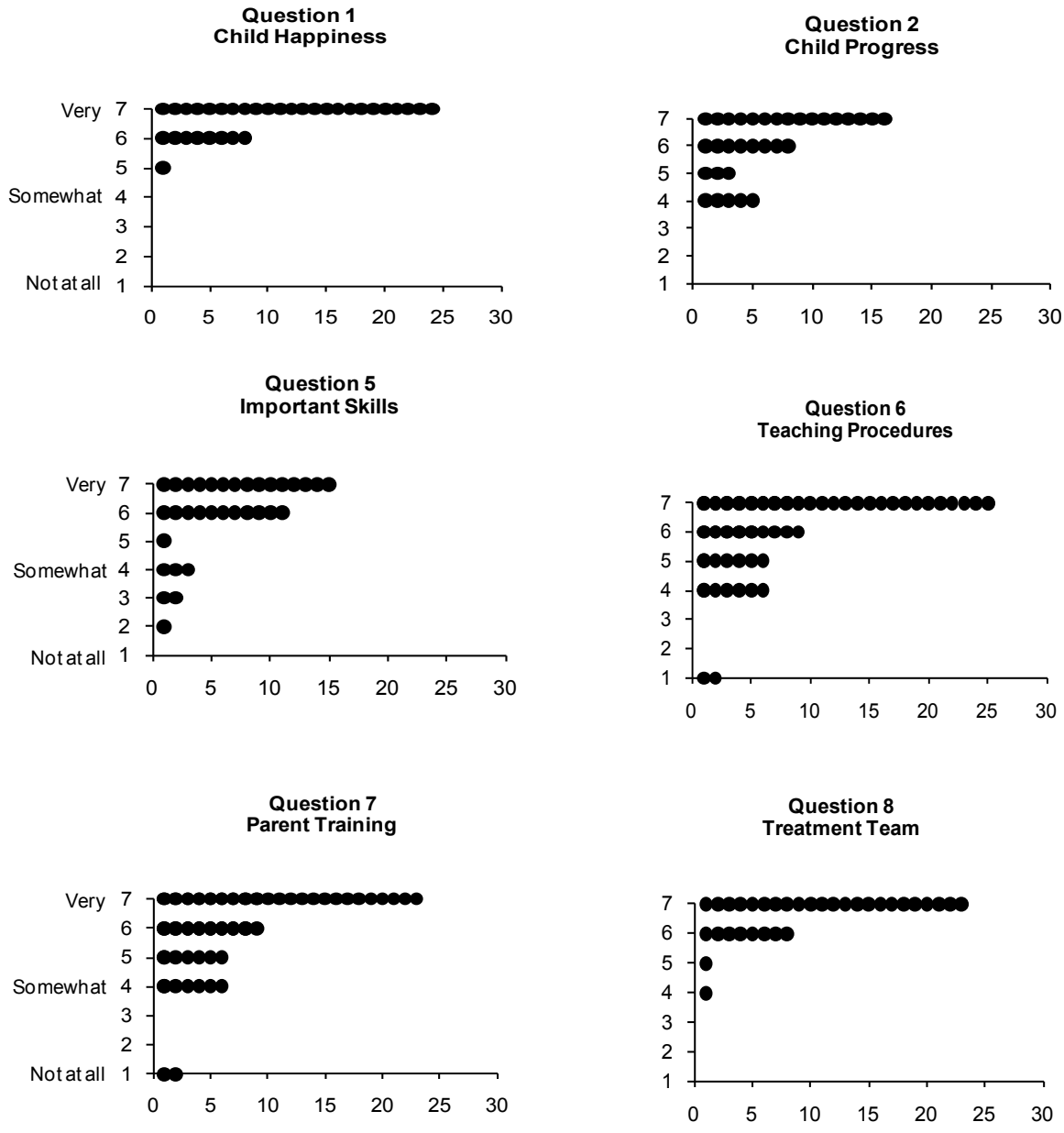


Figure 5. Average hours per client and types of services received.



1. Does your child seem happy at the center?

2. Has your child made progress since starting at ESNT?

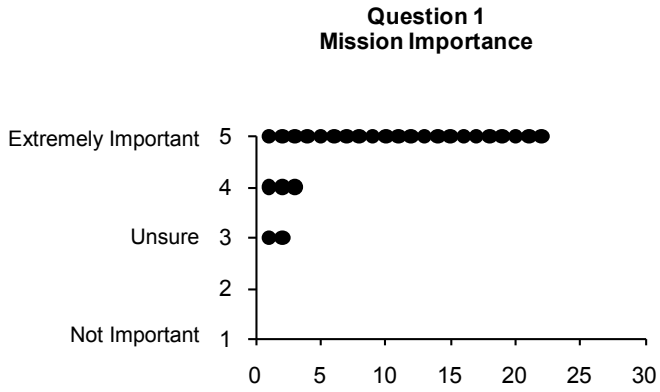
5. Has your child worked on important skills?

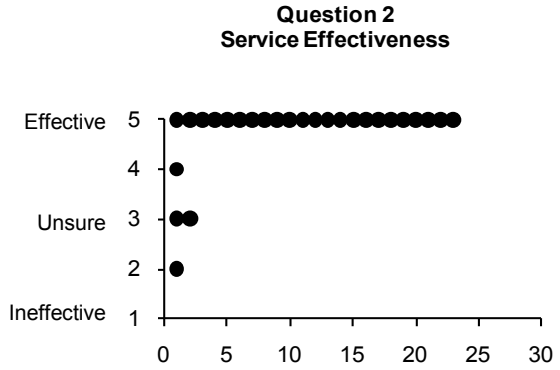
6. Are you happy with your child's teaching procedures?

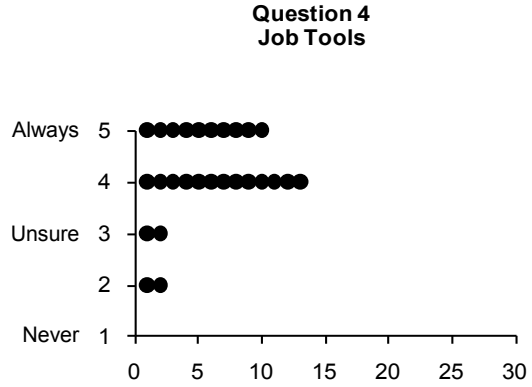
7. Have you learned to use the procedures?

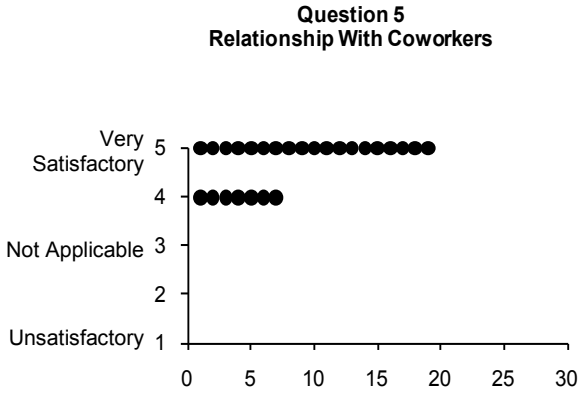
8. How well does your child's treatment team meet your child's needs?

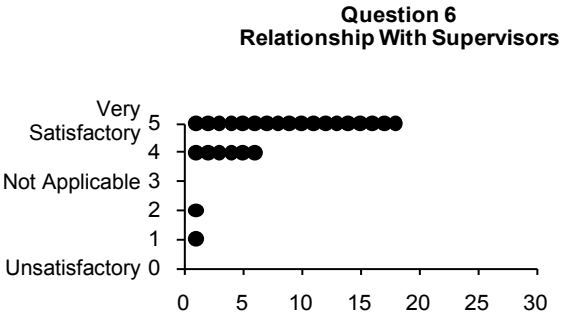
Figure 6. Parent satisfaction.

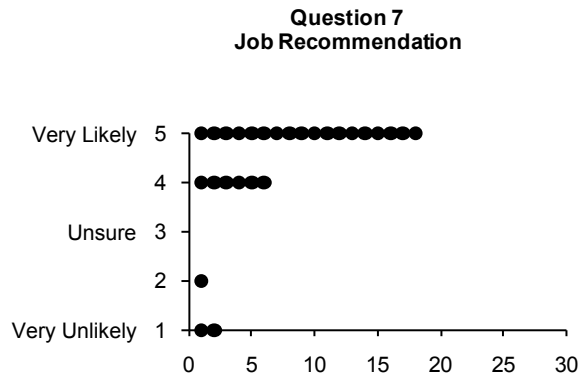












1. Do you feel the mission of the ATP of Easter Seals North Texas is important?

2. In your opinion, how effective are the services provided by the ATP of Easter Seals North Texas?

3. How do you feel about your job performance?

4. Do you feel you have the necessary tools to perform your job?

5. How would you describe your relationship with your coworkers?

6. How would you describe your relationship with your supervisors?

7. How likely would you be to recommend your job to another person?

Figure 7. Staff satisfaction.

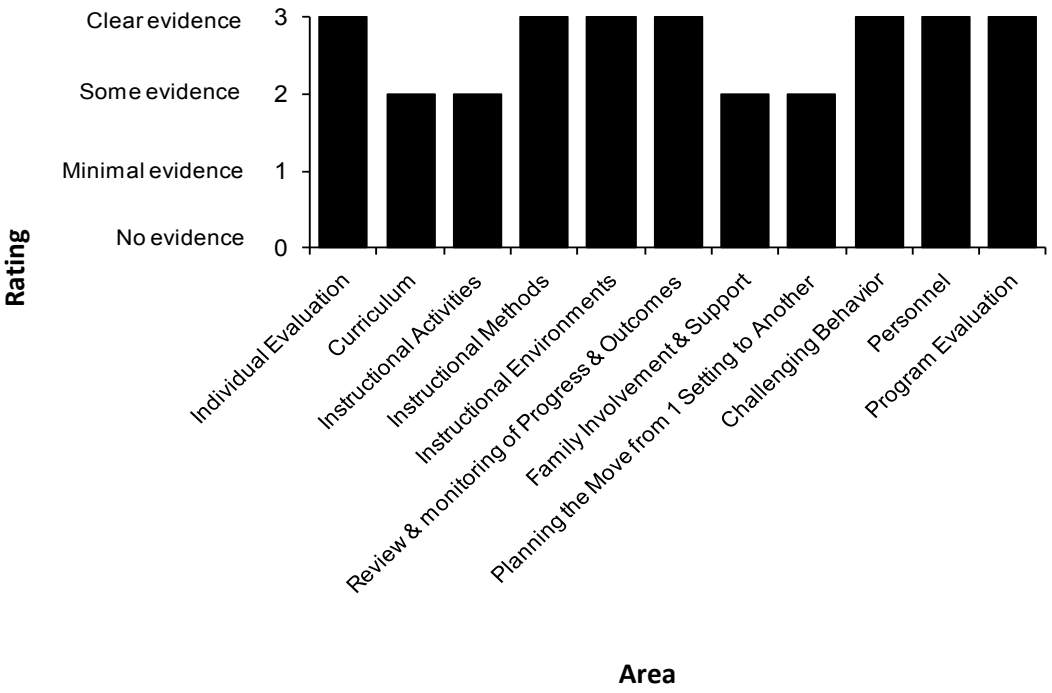


Figure 8. Autism Program Quality Indicators.

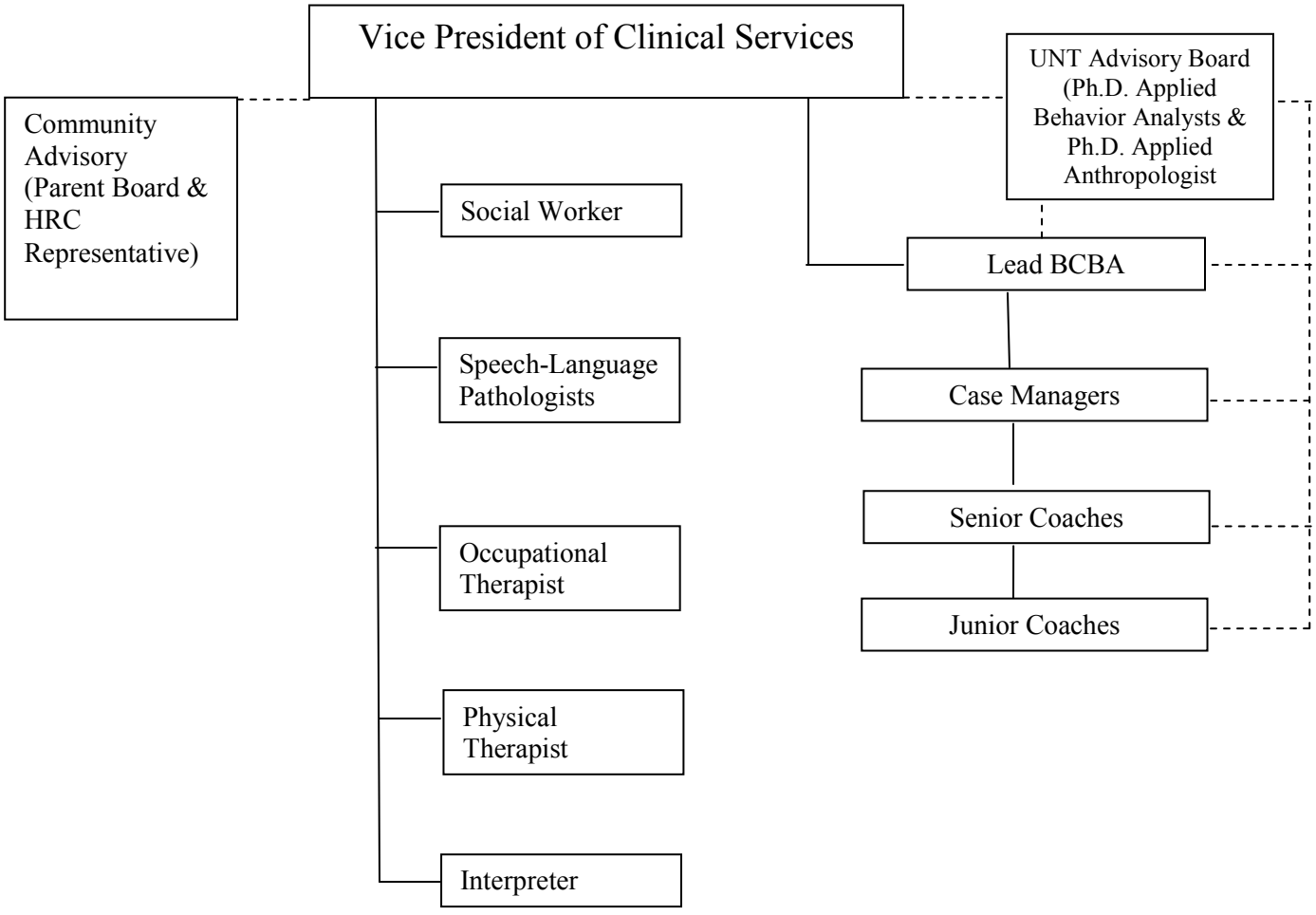
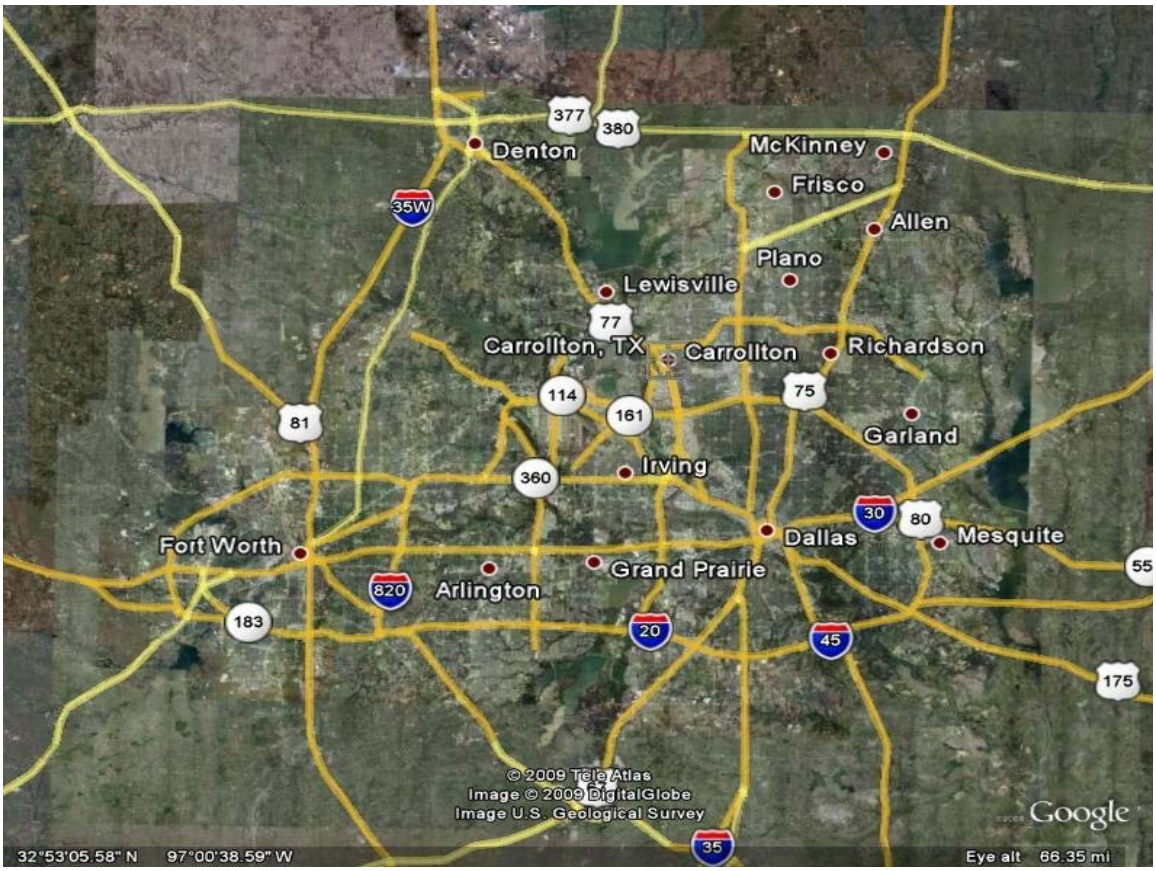


Figure 9. Autism Treatment Program organization chart.

APPENDIX A

EASTER SEALS NORTH TEXAS CLINIC LOCATION AND SETTING



Map of the Dallas-Fort Worth Metroplex

Oak Cliff Center Entrance

Trinity Center Entrance

Trinity Center PT Gym

Trinity Center School Room

Trinity Center Outdoor Play Area

Trinity Center OT Gym

Oak Cliff Center Therapy Room

Easter Seals North Texas' Autism Treatment Program

Program Overview

Easter Seals North Texas, in collaboration with the University of North Texas, presents an Autism Treatment Program that offers children ages 3 to 8 & their families individualized care, including coaching & comprehensive therapeutic interventions. Each child receives an assessment that includes therapists' recommendations and a personalized treatment plan addressing his greatest challenges and building on his most notable strengths. All Easter Seals therapists and clinical staff will work together to ensure that every child receives unduplicated, complementary care dedicated to maximizing his abilities to live, learn and play.

Easter Seals firmly upholds that autism is treatable, and that with the right professional support every child can make significant progress.

Contact Easter Seals Today

If your child is under the age of 8 and you think he/she might have autism or if he/she has been diagnosed with an Autism Spectrum Disorder **call Easter Seals today to be placed on the Autism Treatment Program interest list. 972-394-8900 or 888-617-7171**

Although age specific limitations apply for select Applied Behavior Analysis (ABA) program components, therapy services & additional programs are available for children and adults of all ages living with autism and other disabilities.
Call today to learn more **972-394-8900 or 888-617-7171**

Our Comprehensive Approach Includes:

Applied Behavior Analysis (ABA) - addresses behavioral and social challenges and assists in skills development through care delivered in a clinical setting, at home and in other natural environments. Many younger children receive Early Intensive Behavior Intervention (EIBI) which is dedicated to maximizing functional skills and typically requires 20-40 hours of direct care per week.

Occupational therapy (OT) - assists the child with fine motor skills, sensory integration, attention span, and coordination. OT can help him develop abilities such as holding a ball, using scissors, or dressing independently.

Physical therapy (PT) - works on increasing strength, balance, and coordination to improve gross motor and sport skills such as running, jumping & catching to promote independent movement and play with same aged peers.

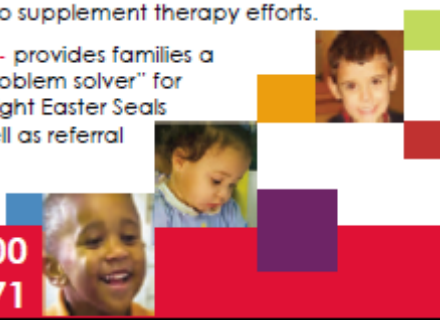
Speech-language therapy (ST) - helps the child and family with communication concerns. ST will work with the child to help their understanding and development of language as well as focusing on improving the child's ability to navigate social situations.

UNT support - University of North Texas partners provide the program professor support & supervision delivered by nationally recognized experts in Behavior Analysis, Anthropology and Educational Psychology.

Audiology - provides testing and professional counseling to ensure possible hearing concerns are identified and addressed.

Enrichment programs - seasonal and ongoing social skills groups, parent seminars and other therapeutic support programs offer the families additional training and programs to supplement therapy efforts.

Social Services - provides families a professional "problem solver" for accessing the right Easter Seals resources as well as referral support.



ntx.easterseals.com/autism | 972-394-8900 888-617-7171

Autism Treatment Program Flyer

APPENDIX B

EASTER SEALS NORTH TEXAS INTAKE PAPERWORK

Easter Seals North Texas
Autism Treatment Program Application

General Information

Client's Name: _____

Child's Date of Birth: _____ Child's Age: _____

Caregiver's Name: _____

Address: _____
Street Apt # City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Misc. Number: _____

Email address: _____

Preferred method of contact: Home Cell Work Misc. Email

Best time to contact you: _____

Emergency Contact Names and Numbers:

Name: _____ Number: _____

Name: _____ Number: _____

Name: _____ Number: _____

Name: _____ Number: _____

Referral Source: _____

Reason for Referral: _____

Family Demographics

Parents' Names

Mother: _____ Father: _____

Marital Status (please circle one):

Married Divorced Separated Other: _____

Parents' Current Address

Mother: _____
Street Apt # City State Zip

Father: _____
Street Apt # City State Zip

Do you own or rent your current place of residence? _____

Parents' Birthdates

Mother: _____ Father: _____

Parents' Primary Language Spoken

Mother: _____ Father: _____

Parents' Highest Level of Education Completed

Mother: _____ Father: _____

Parent's Occupations:

Mother: _____ Father: _____

Length of Employment at Current Position:

Mother: _____ Father: _____

Estimated Annual Gross Income:

Mother: _____ Father: _____

Estimated Annual Medical Expenses for Applicant: _____

Do you have transportation to get to/from therapy?

No Yes, own a car Yes, borrow a car Yes, public transportation

If you own a car, how many cars do you own? _____

Do you have an alternate caregiver/ outside supports available? Yes No
If yes, who/what? _____
_____

Siblings (Gender and Age)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all individuals and their relationship to the child residing in the home

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____
6. _____ Relationship: _____

List any family members that have health problems/ special needs

1. _____ Diagnosis: _____
2. _____ Diagnosis: _____
3. _____ Diagnosis: _____

4. _____ Diagnosis: _____
5. _____ Diagnosis: _____
6. _____ Diagnosis: _____

Child's Demographics

Child's Name: _____
Last First Middle Initial

Nickname: _____

Date of Birth: _____ *Place of Birth*: _____

Gender (please circle): Male Female

Diagnosis, Date Received, and By Whom:

Diagnosis: _____ Diagnosis: _____
Date Rec'd: _____ Date Rec'd: _____
By Whom: _____ By Whom: _____

Diagnosis: _____ Diagnosis: _____
Date Rec'd: _____ Date Rec'd: _____
By Whom: _____ By Whom: _____

Pregnancy/ Birth History

Prenatal care received from _____ to _____ (dates)
Obstetrician: _____
Please circle Yes or No for the following:

a) IVF, other technology:	Yes	No
b) Prenatal Vitamins:	Yes	No
c) Bleeding or spotting:	Yes	No
d) Mother's infections:	Yes	No
e) Mother's alcohol/drug use:	Yes	No
f) Mother's cigarette smoking:	Yes	No
g) Mother's illness (i.e. diabetes, high blood pressure):	Yes	No

h) Prescription drugs during pregnancy: Yes No
i) Accidents or Stress: Yes No
j) Decreased Fetal Movement: Yes No
If you answered Yes to(a) or (c) through (j), please explain:

_____
_____
_____

Other Problems:

_____
_____

Special Tests during Pregnancy (i.e. triple test, amniocentesis):

_____
_____

Duration of Pregnancy: _____ weeks
Birth weight: _____ lbs _____oz Birth length: _____
List any complications (i.e. breech, induced labor, meconium, caesarian, resuscitation): _____
_____

Neonatal Intensive Care Stay: Yes No
If Yes, how many days: _____ Problems: _____
Regular Nursery Stay: _____
Please circle if any of the following apply:

Bottle-fed	*Breast-fed*	*Poor feeding*	*Jaundice*
Low tone	*Anemia*	*Fast breathing*	*Infections*

Explanations: _____

Medical/ Childhood History

Milestones (please list approximate ages your child achieved milestone):

Held up head: _____		Rolled front to back:	_____
Sat w/o support: _____		Crawled:	_____
Pulled up to stand: _____		Walked:	_____
Babbled: _____	First Word: _____		Combined words: _____
Finger-fed: _____	Fed self: _____		Toileting: _____

Please list any medical conditions your child has: _____
_____
_____

Please list past treatments (with dates of service): _____
_____
_____

Please list past and currents medications (with dates and dosage):
_____
_____
_____

Please list any allergies (i.e. latex, food, seasonal): _____
_____
_____

Please list any other important medical or physical information about your child: _____
_____
_____

Treatment and School History

School: _____ District: _____
Grade: _____
Special Services at School (please list frequency):
Speech Therapy: _____ *Occupational Therapy:*_____
Physical Therapy: _____ *Behavioral Supports:* _____
Special Education Classroom: _____
Other: _____

Please list any private services your child receives: _____
_____

Rapport and Communication

Does your child approach you to play? Yes No

Are you able to play for extended periods of time with your child?

Yes No

Does your child take turns during play interactions?

Yes No

Do you usually understand what your child wants and does not want?

Yes No

Are there situations when it is more or less difficult to be patient with your child? Yes No

What are the situations that you enjoy the most with your child?

_____

_____

How does your child respond when your or others approach him/her to:

Play:	*happy*	*neutral*	*agitated*	*fearful*
Eat:	*happy*	*neutral*	*agitated*	*fearful*
Watch tv/videos:	*happy*	*neutral*	*agitated*	*fearful*
Transition:	*happy*	*neutral*	*agitated*	*fearful*
Go outside:	*happy*	*neutral*	*agitated*	*fearful*
Go in the car:	*happy*	*neutral*	*agitated*	*fearful*
Go to school:	*happy*	*neutral*	*agitated*	*fearful*
Go to bed:	*happy*	*neutral*	*agitated*	*fearful*

How well does your child communicate with you? _____

_____

_____

How well does your child communicate with other family members? _____

_____

_____

How well does your child communicate with others outside your family?

_____

_____

Describe the methods you use to help your child communicate. _____

_____

_____

What kinds of things make your child happy? _____

_____

_____

How often does your child seem happy? _____

_____

_____

What kinds of things make your child upset? _____

_____

_____

How often does your child seem upset? _____

_____

_____

Play and Preferences

Please list your child's preferences for the following:

Toys, Games, Books: _____

_____

Songs: _____

_____

Television/ Videos: _____

_____

Praise (such as hugs, tickling, etc.): _____

_____

Food Items: _____

_____

Activities (such as peek-a-boo, soccer, coloring, etc.): _____

_____

Are there things he/she does NOT seem to enjoy? _____

_____

Approximately how long will he/she play on his/her own? _____

Approximately how long will he/she play with others (please list)?
Person: _____ Length: _____
Person: _____ Length: _____
Person: _____ Length: _____
Person: _____ Length: _____
Person: _____ Length: _____

Goals and Priorities
Overall, what is most important to you for your child?
_____
_____
_____
List some of your child's strengths:
_____
_____
_____
List some of your family's strengths:
_____
_____
_____
What support/ training do you feel would be most beneficial for you and your family over the next 6-12 months?
_____
_____
_____

In each of the following areas, what would you most like your child to learn in the next 6-12 months?
Communication Skills: _____
_____
Social Skills: _____
_____
Play Skills: _____
_____
Self-care Skills: _____
_____
Other: _____
_____

Other: ____
____

EASTER SEALS NORTH TEXAS
AUTISM TREATMENT PROGRAM
Weighted Prioritization Criteria Form

Client Name:

_____

Parent Contact Name/ Number: _____

Income:	**Points**
100% of poverty level	15
125% of poverty level	10
150% of poverty level	8
175% of poverty level	6
200% of poverty level	4
Above 201% of poverty level	2

Medical Expenses:	**Points**
Above 50% of net income	15
40-49% of net income	10
30-39% of net income	8
20-29% of net income	6
10-19% of net income	4
0-9% of net income	2

Number of children in home:	**Points**
6 or more children in home	15
5 children in home	10
4 children in home	8
3 children in home	6
2 children in home	4
1 child in home	2

Number of children with disability:	**Points**
3 or more children in home	15
2 children in home	8
1 child in home	2

Home ownership:	**Points**
No ownership, renting	10
Own 1 home	6

Number of cars:	**Points**
No car	15
1 car	10
2 cars	6
3 or more cars	2

Single parent family:	**Points**
Single parent family	10
Two parents in home	4

Parent education:	**Points**
No High School or GED equivalent for one or both parents	15
High School or GED equivalent for one or both parents	10
Some undergraduate courses for one or both parents	8
Undergraduate degree for one or both parents	6
Some graduate degree courses for one or both parents	4
Graduate degree for one or both parents	2
Higher than a graduate degree for one or both parents	1

Parental Health:	**Points**
Documented psychological disorder, substance abuse, or physical disability for one or both parents	15

Occupational status:	**Points**
No job	15
More than 3 job changes in past 12 months	10
2 job changes in past 12 months	8
Same job for past 12 months	6
Same job for past 24 months	4
Same job for past 36 months or longer	2

Alternative caregivers/ outside supports available:	**Points**
No alternative caregivers/ outside supports available	10
Limited alternative caregivers/ outside supports available (1-2)	6
Many alternative caregivers/ outside supports available (more than 3)	2

Contact Status:	**Points**
Numbers 1- 15 on Interest List	15
Numbers 16- 30 on Interest List	10
Numbers 31- 45 on Interest List	8
Numbers 46- 60 on Interest List	6
Numbers 61- 75 on Interest List	4
Numbers 75+ on Interest List	2

EASTER SEALS NORTH TEXAS

Autism Treatment Program

Child Intake Process

Client Name: _____ Case Number: _____

Parent(s) Name(s): _____ Phone Number: _____

- ☐ Family calls for information regarding the ATP. If family interested in program, ESNT sends an application via mail or email.
- ☐ Inform VP of Clinical Services of family name, contact information, date of contact, and date application sent. This information will then be added to Interest List Database.
- ☐ Within 10 business days of receiving the completed application, the BCBA will:
  - ☐ Call or email for any additional information, if needed,
  - ☐ Score the Weighted Prioritization Criteria Form, and
  - ☐ Call or email the family the approximate status on weighted list.
- ☐ Once a child is approved to enroll in the ATP, the BCBA will call to inform the family. BCBA will let family know that they will have contact with at least 3 individuals at ESNT:
  - ☐ Financial Counselor prior to the evaluation to review any potential insurance benefits and financial obligations of family,
  - ☐ BCBA during the Initial Interview and Assessment, and
  - ☐ Social Worker shortly after the Initial Interview and Assessment.
- ☐ BCBA will also inform family that additional referrals could be made at time of Initial Interview and Assessment or after enrollment to ATP (OT, PT, ST, Audio).
- ☐ BCBA informs Financial Counselor of new patient. BCBA provides the following to the Financial Counselor:
  - ☐ First 3 sheets of application,
  - ☐ Additional information sheet (if applicable), and
  - ☐ Weighted Prioritization Criteria Form.
- ☐ Financial Counselor calls family and completes Sliding Scale Application. Appropriate documentation is gathered. Financial Counselor informs BCBA once financial approval is granted.
- ☐ BCBA calls family to schedule Initial Interview and Assessment with parent(s) and child(ren).
- ☐ BCBA sends Intake Letter to family via mail or email.
- ☐ When family arrives at center for Initial Interview and Assessment, they will:
  - ☐ Sign all Intake paperwork (consent to treat, financial agreement, emergency contact form, etc.),
  - ☐ Pay $30 for initial visit,

- ☐ Meet with BCBA, and
- ☐ Meet with Financial Counselor.

☐ During the Initial Interview and Assessment, the BCBA will:

- ☐ Schedule additional assessment appointments (home/ecological observation)
- ☐ Refer to social worker for Social History Assessment

☐ Home observation/evaluation completed

☐ Clinic-based assessment (HELP) completed

- ☐ Start building rapport
- ☐ Start working on communication and engagement

☐ Refer to additional disciplines as appropriate

- ☐ Turn in PARS

☐ Complete Individual Program Plan

- ☐ Review with parents and current team

☐ Complete individual treatment book

☐ Write current treatment programs

☐ Put all Client Paperwork in file basket in Medical Records office

APPENDIX C

SURVEYS AND QUESTIONNAIRES

Parent Satisfaction Survey

Directions: The following information will be used to improve the services we are provide. Circle the number that correspond with the questions. Please answer honestly. Your feedback is important to us. When finished place survey in the feedback box. Results will be calculated by a third party.

Circle corresponding (below):
How long has your child been enrolled in the ESNT program?

1 to 3 months	*3 to 6 months*	*6 to 9 months*	*9 to 12 months*	*12 to 15 months*	*15 to 18 months*

Circle corresponding number (below):

1. Does your child seem happy at the center?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

2. Has your child made progress since starting at ESNT?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

If yes, in what areas (circle): communication play social self-help

3. How well can your child communicate with you?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

4. How well can your child play?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

5. Has your child worked on important skills?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

6. Are you happy with your child's teaching procedures?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

7. Have you learned to use the procedures?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

8. How well does your child's treatment team meet your child's needs?

Not at all			*Somewhat*			*Very*
1	2	3	**4**	5	6	**7**

Please list areas of improvement:

Any additional comments?

Easter Seals North Texas Autism Treatment Program
Staff Satisfaction Questionnaire

Directions: Please answer each question by placing a checkmark in the box that most closely matches your opinion. Use the lines provided to comment on your answer. Once complete, place the questionnaire in the envelope labeled '*Staff Satisfaction*.' Please do not put your name on the questionnaire so that all answers may be kept confidential.

1. Do you feel the mission of the ATP of Easter Seals North Texas is important?

☐ Not Important ☐ Somewhat Important ☐ Unsure ☐ Important ☐ Extremely Important

2. In your opinion, how effective are the services provided by the ATP of Easter Seals North Texas?

☐ Ineffective ☐ Somewhat Ineffective ☐ Unsure ☐ Somewhat Effective ☐ Effective

3. How do you feel about your job performance?

☐ Very Dissatisfied ☐ Somewhat Dissatisfied ☐ Unsure ☐ Somewhat Satisfied ☐ Very Satisfied

4. Do you feel you have the necessary tools to perform your job?

☐ Never ☐ Rarely ☐ Unsure ☐ Sometimes ☐ Always

5. How would you describe your relationship with your coworkers?

☐ Unsatisfactory ☐ Somewhat Unsatisfactory ☐ Not Applicable ☐ Satisfactory ☐ Very Satisfactory

6. How would you describe your relationship with your supervisors?

☐ Unsatisfactory ☐ Somewhat Unsatisfactory ☐ Not Applicable ☐ Satisfactory ☐ Very Satisfactory

7. How likely would you be to recommend your job to another person?

☐ Very Unlikely ☐ Unlikely ☐ Unsure ☐ Somewhat Likely ☐ Very Likely

Easter Seals North Texas Autism Treatment Program

Staff Demographic Information Form

Dear Staff,

In order to keep our staff information current and request new information, we ask that you please complete this form. This information is only used as a supplement and will not affect your Easter Seals employment status. Thank you for your time.

Sincerely,

Easter Seals

Name: _____

City of Residence: _____ **Age:** _____

Race/Ethnicity: _____

Primary Language: _____

Additional Languages: _____

Education (please circle one):

Some High School High School Diploma Some College

Associate's Degree Bachelor's Degree Master's Degree

Major(s): _____

Minor(s): _____

Experience in ABA (in months and years): _____

Long-term Career Goals: _____

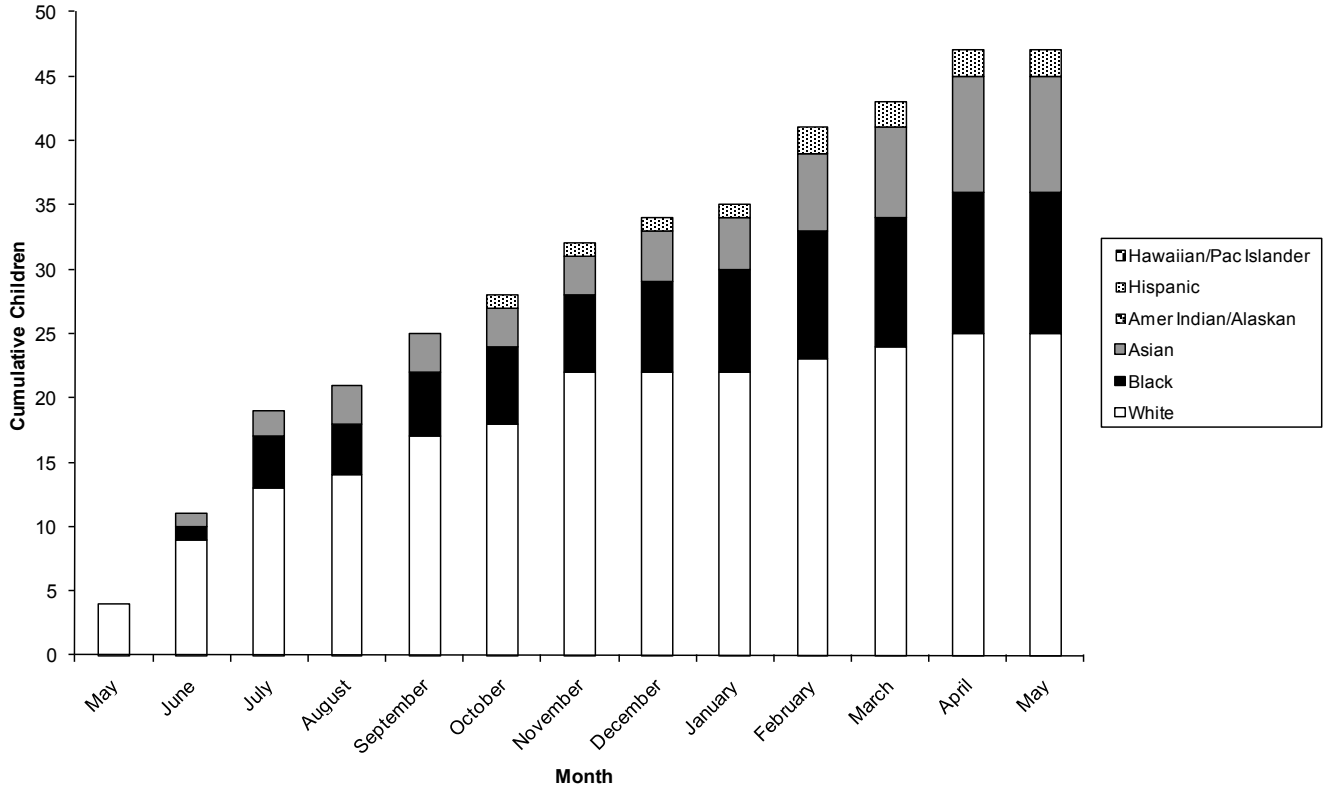
_____

_____

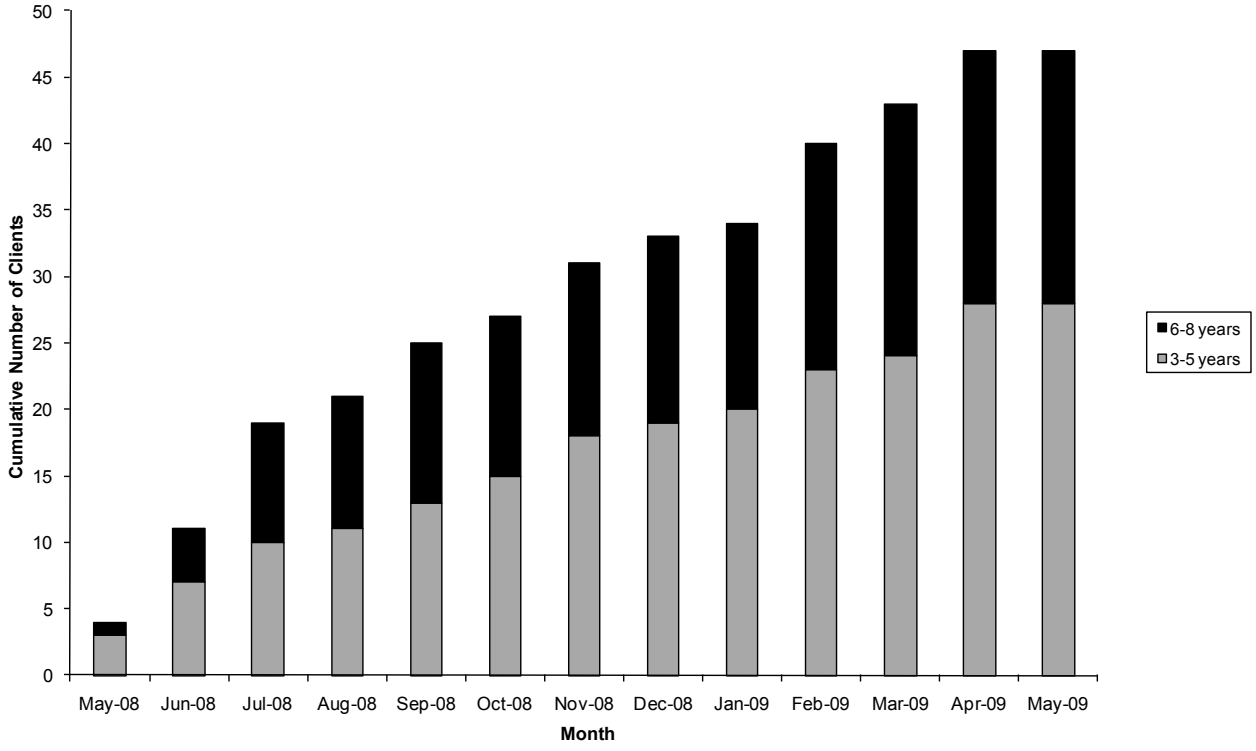
APPENDIX D

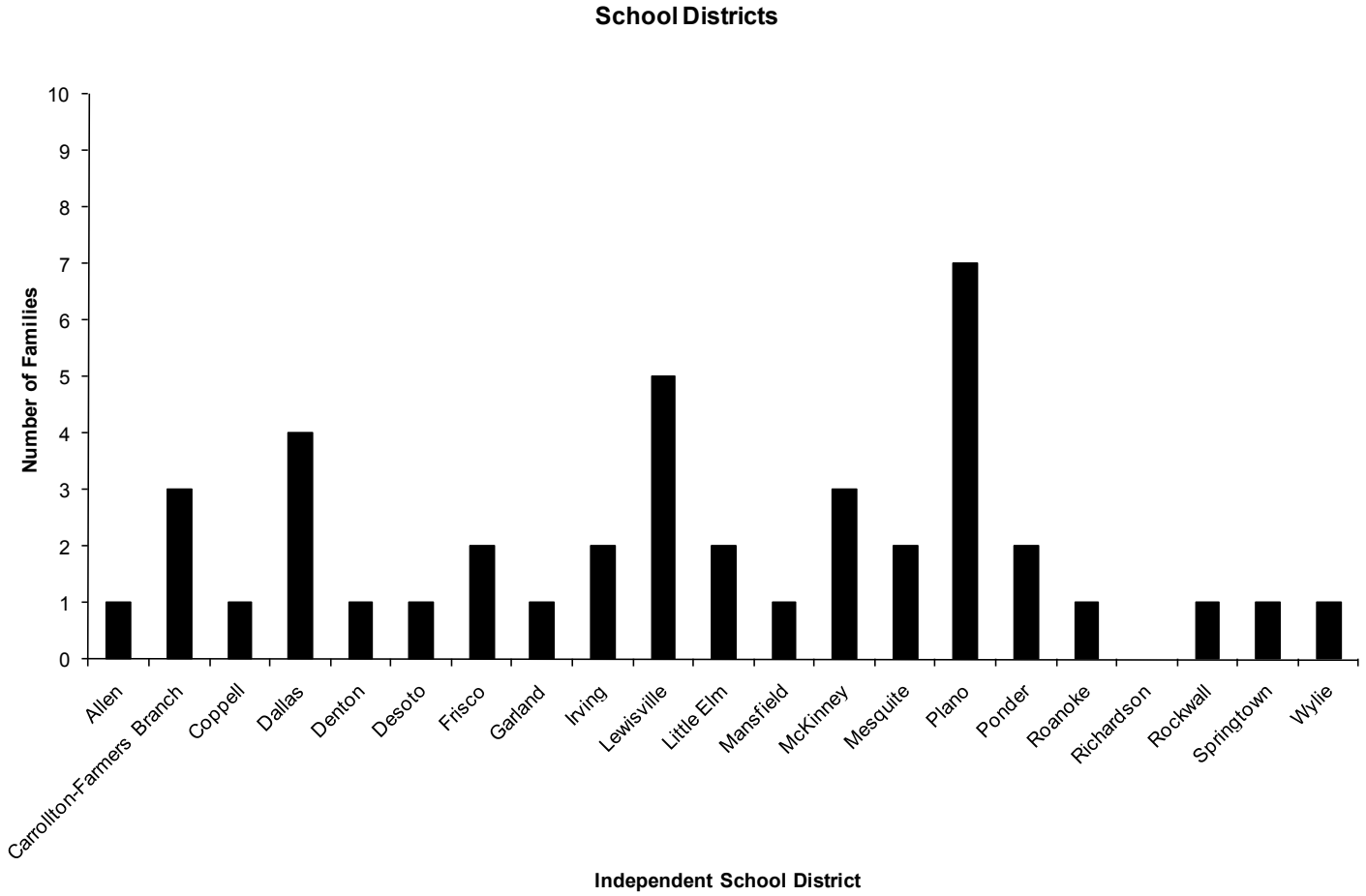
CLIENT DEMOGRAPHICS AND RISK FACTORS

Cumulative Race/Ethnicity

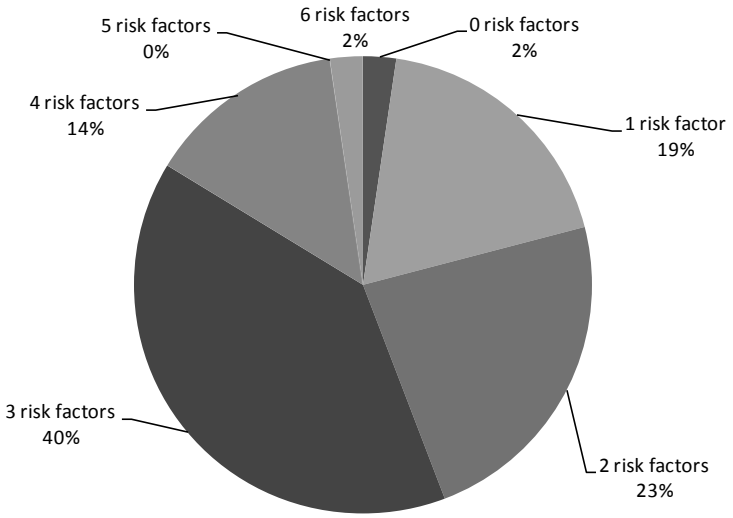


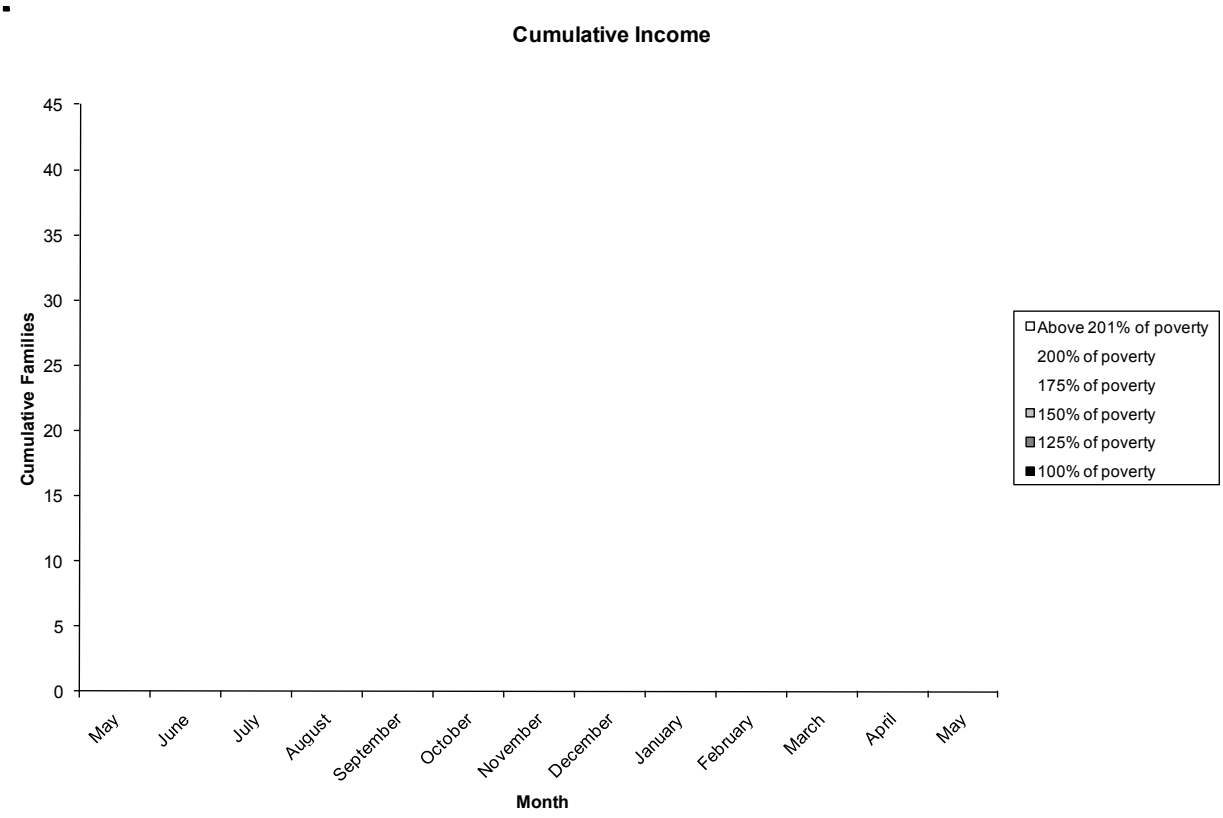
Cumulative Clients in Program by Age



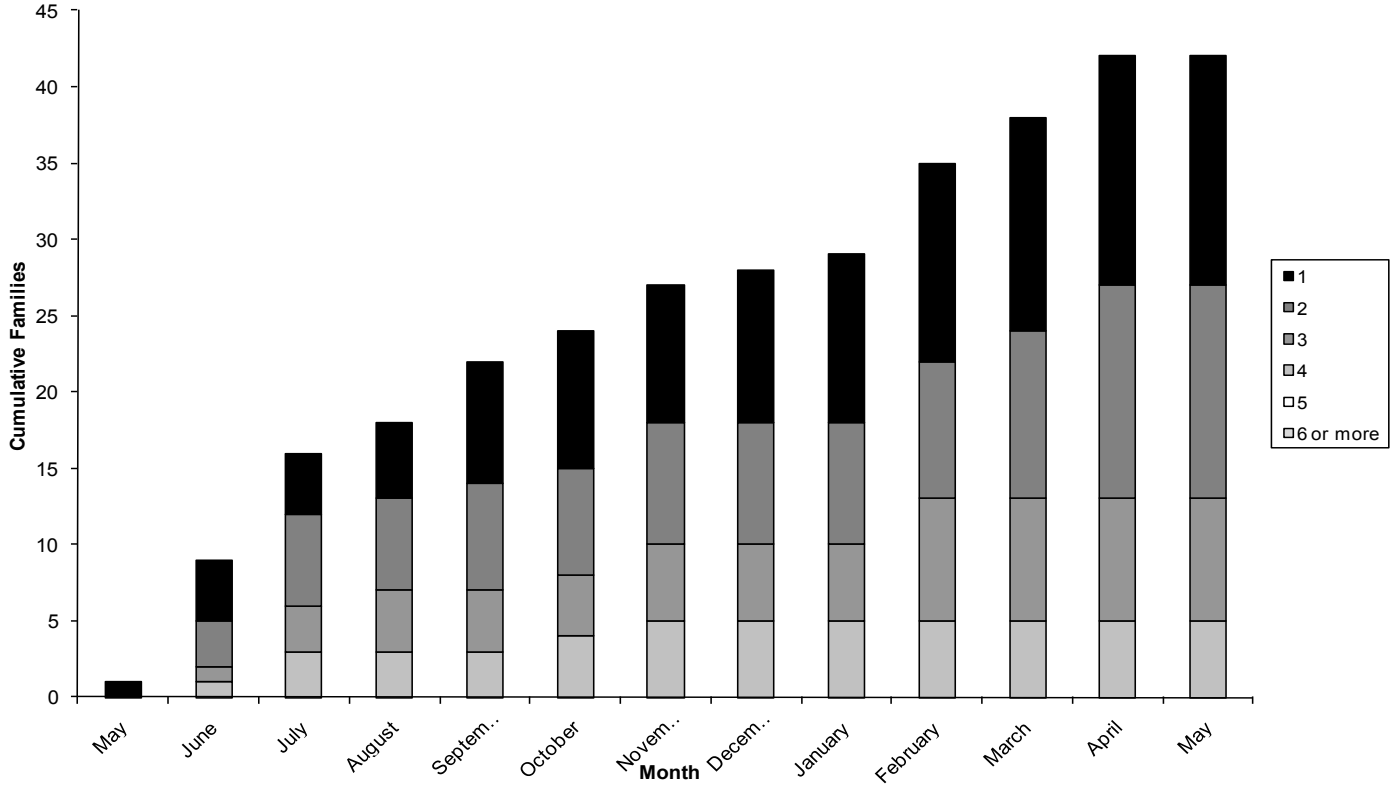

School Districts
Number of Families
10
9
8
7
6
5
4
3
2
1
0
Allen
Carrollton-Farmers Branch
Coppell
Dallas
Denton
Desoto
Frisco
Garland
Irving
Lewisville
Little Elm
Mansfield
McKinney
Mesquite
Plano
Ponder
Roanoke
Richardson
Rockwall
Springtown
Wylie
Independent School District

Number of Risk Factors

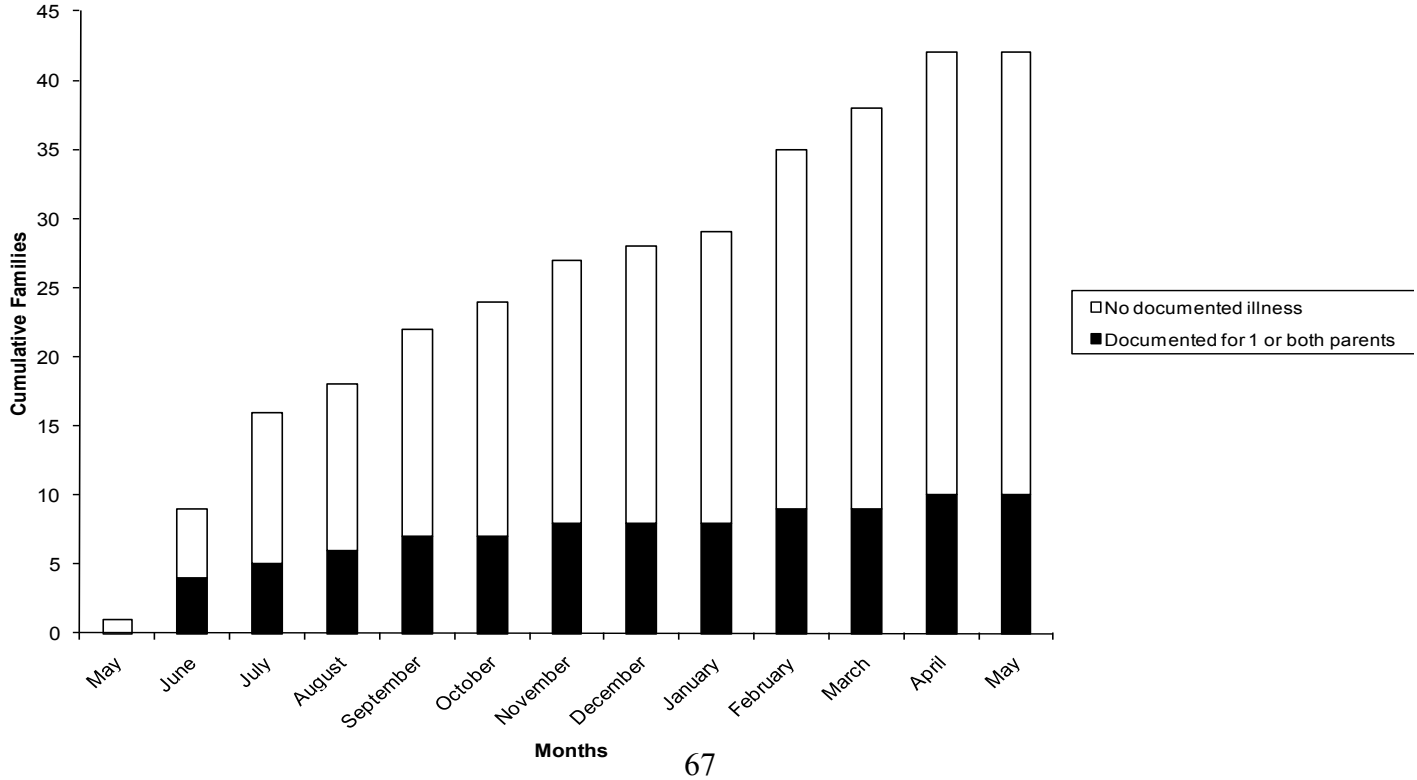


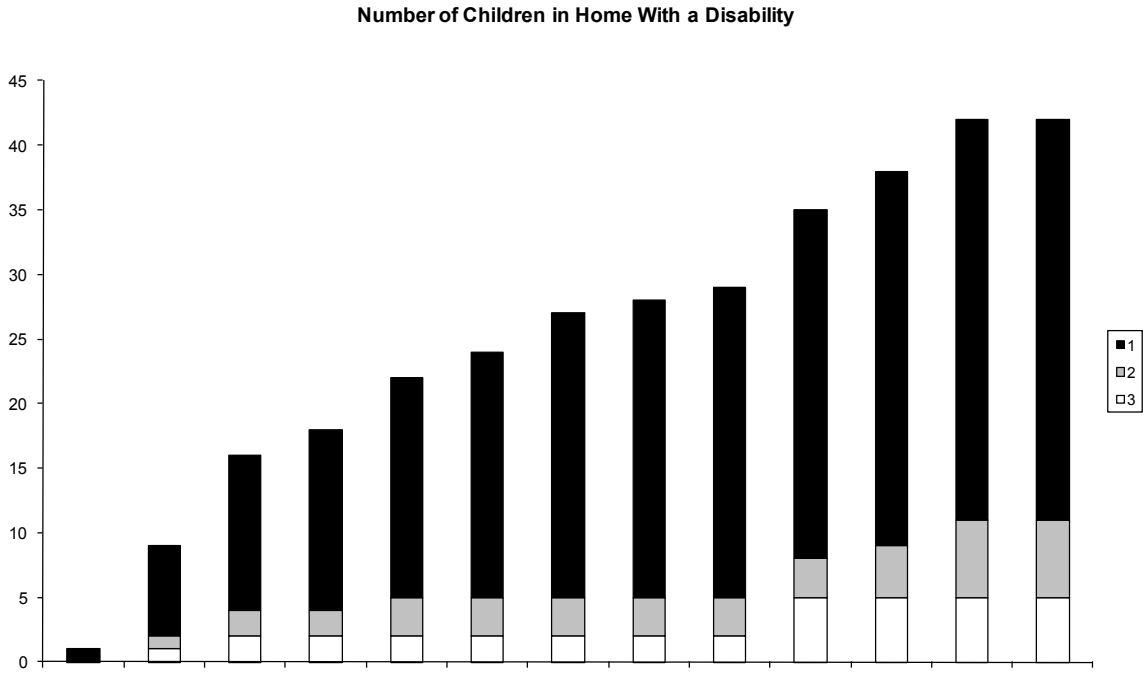


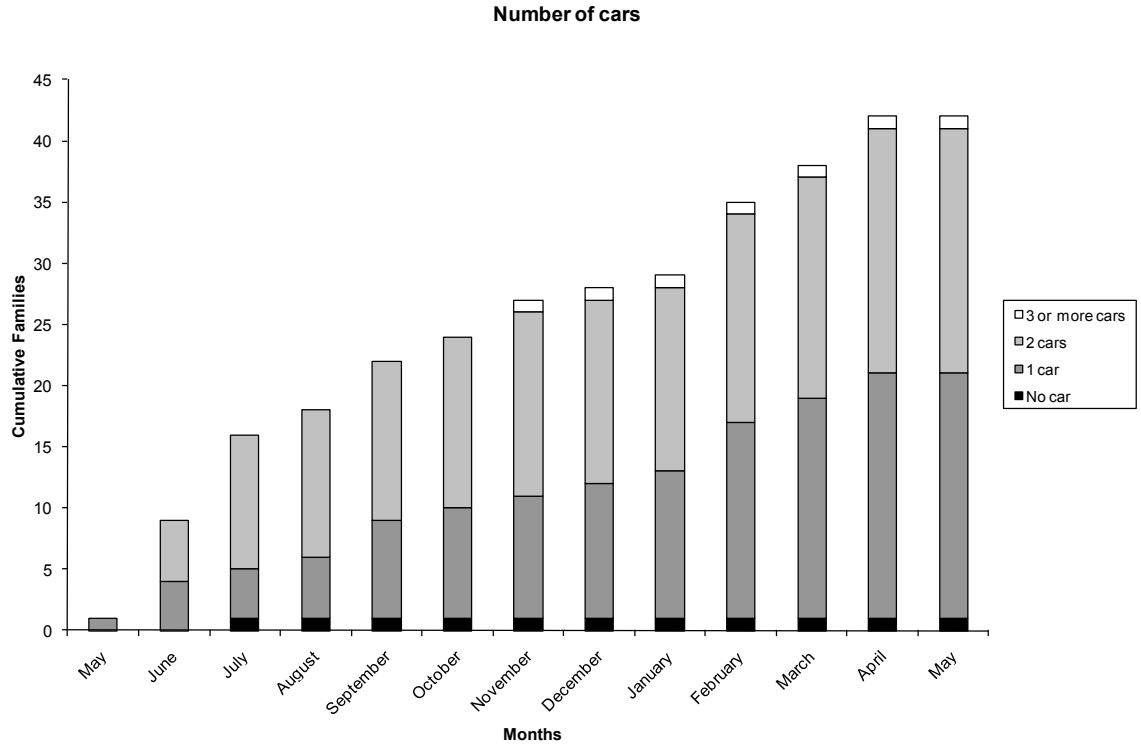
Cumulative Number of Children in Home

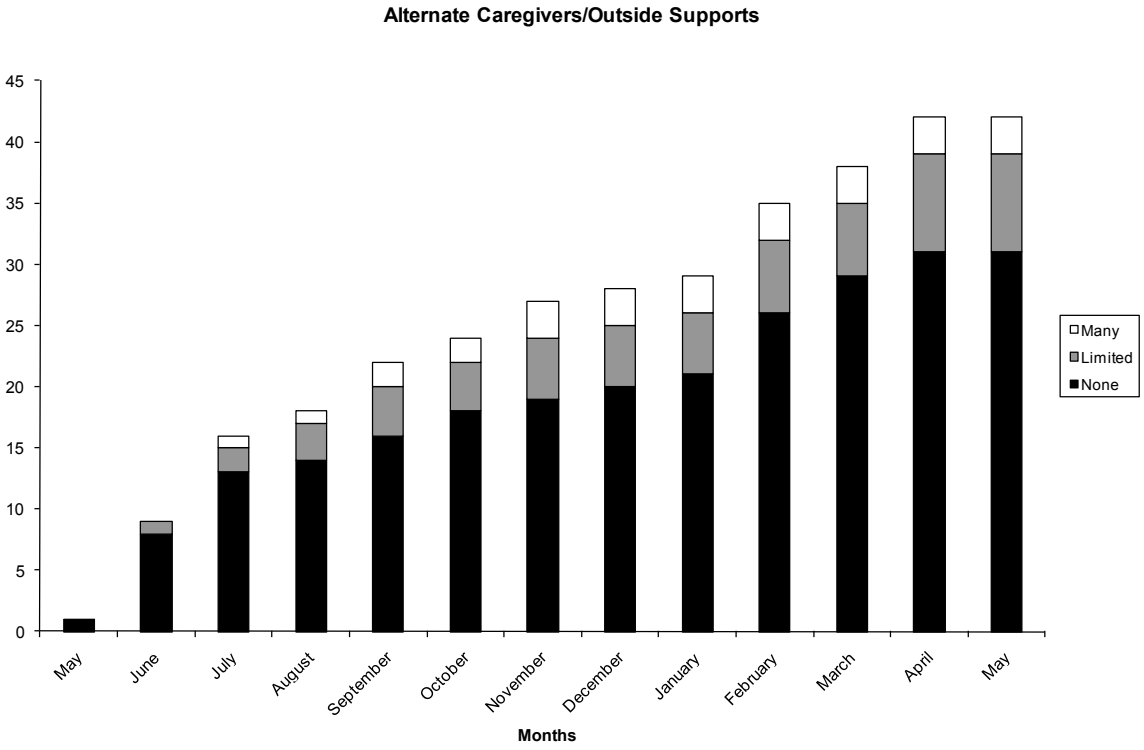


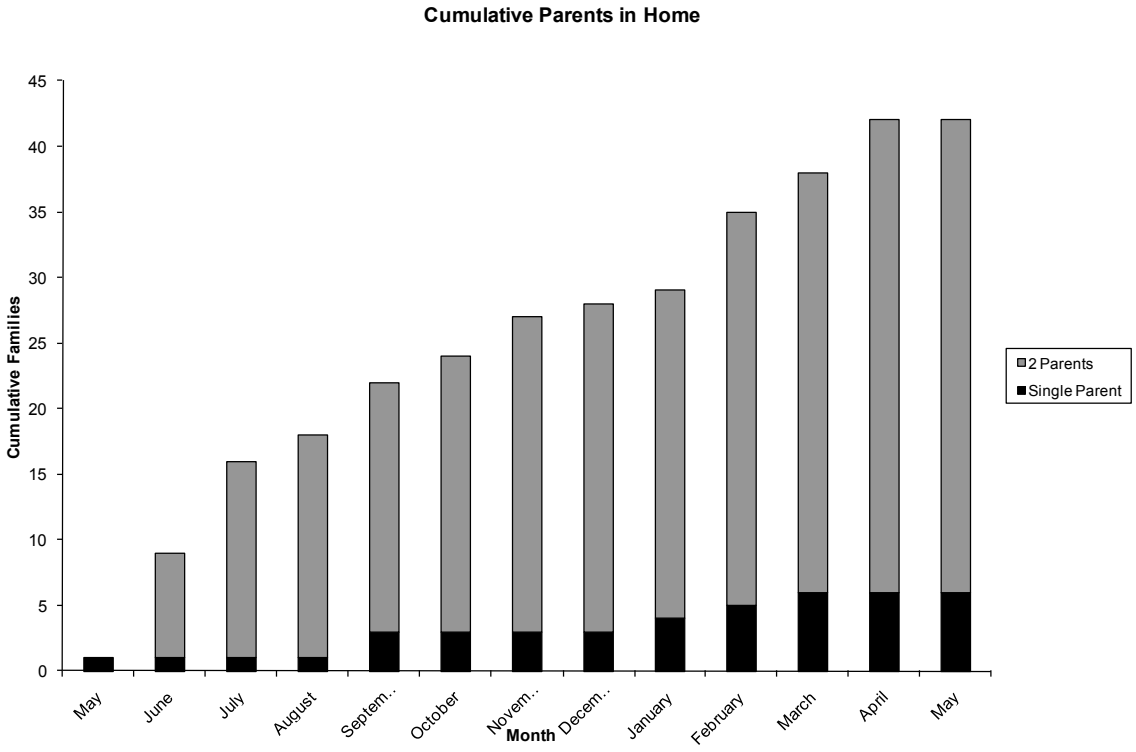
Parent Health

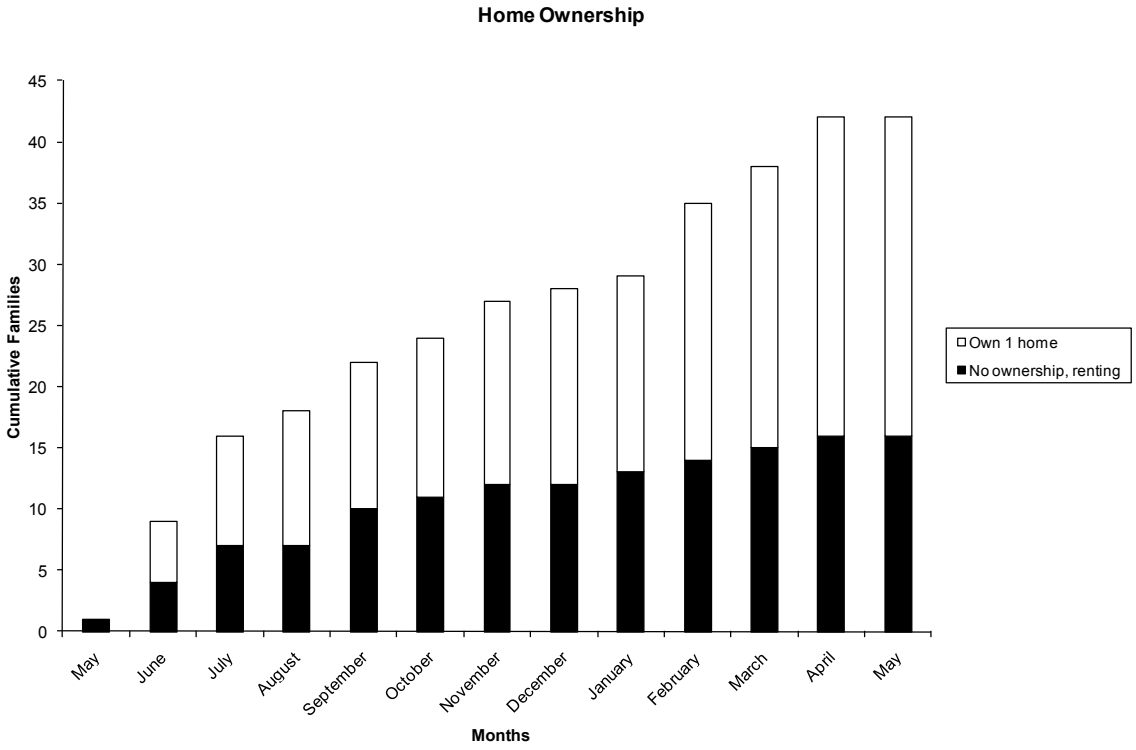



Number of Children in Home With a Disability
45
40
35
30
25
20
15
10
5
0
1
2
3


Number of cars
Cumulative Families
45
40
35
30
25
20
15
10
5
0
May
June
July
August
September
October
November
December
January
February
March
April
May
Months
3 or more cars
2 cars
1 car
No car


Alternate Caregivers/Outside Supports
45
40
35
30
25
20
15
10
5
0
May
June
July
August
September
October
November
December
January
February
March
April
May
Months
Many
Limited
None

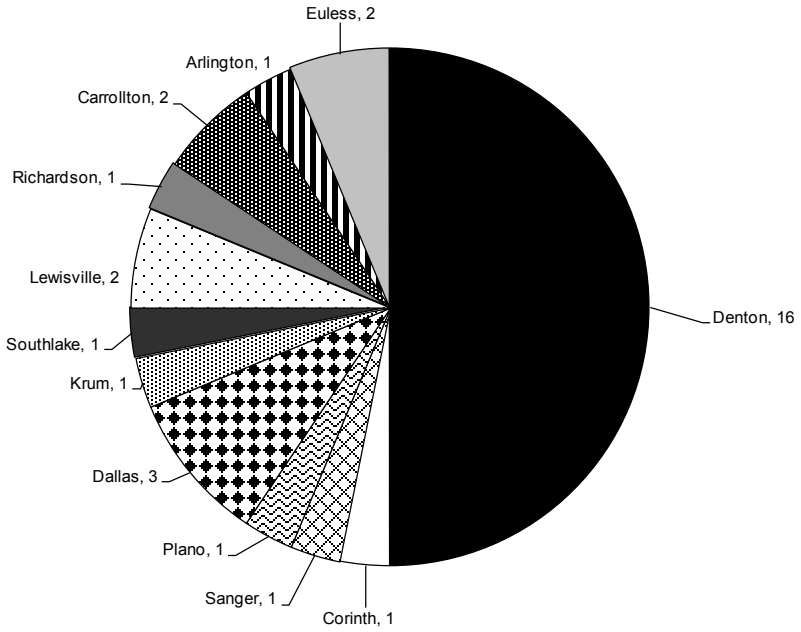

Cumulative Parents in Home
45
40
35
30
25
20
15
10
5
0
Cumulative Families
May
June
July
August
Septem..
October
Novem..
Decem..
January
February
March
April
May
Month
2 Parents
Single Parent


Home Ownership
Cumulative Families
45
40
35
30
25
20
15
10
5
0
May
June
July
August
September
October
November
December
January
February
March
April
May
Months
Own 1 home
No ownership, renting

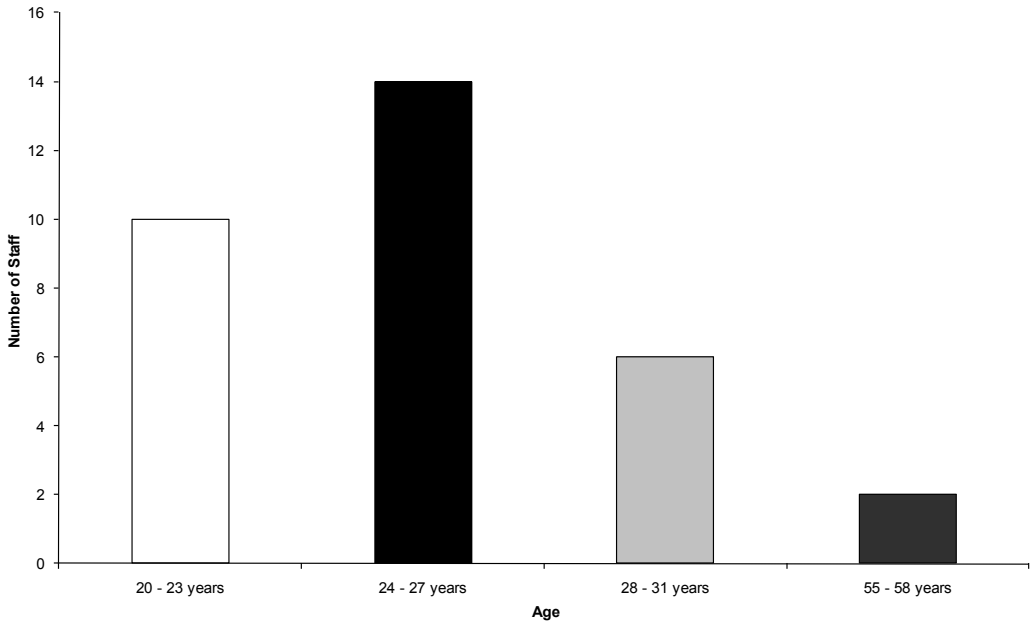
APPENDIX E

STAFF DEMOGRAPHICS

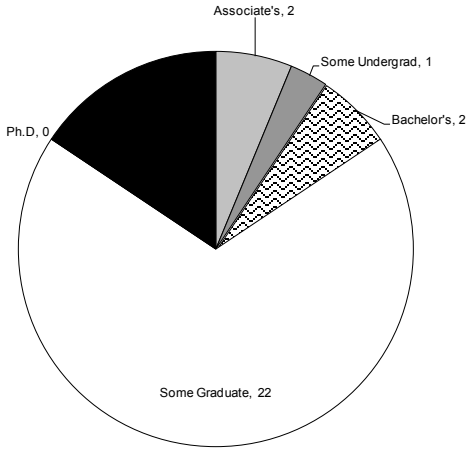
Staff City of Residence



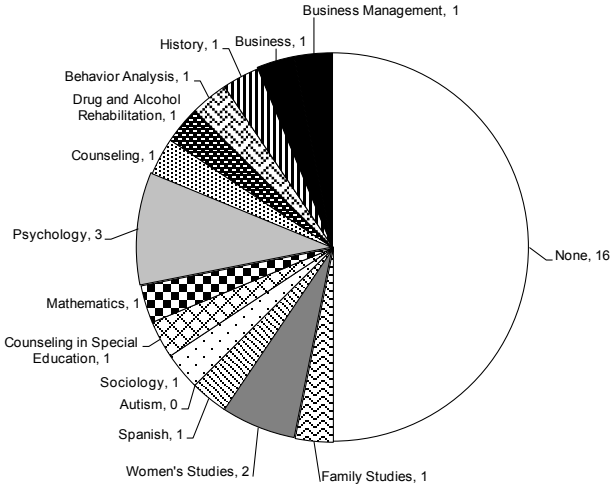
Staff Age

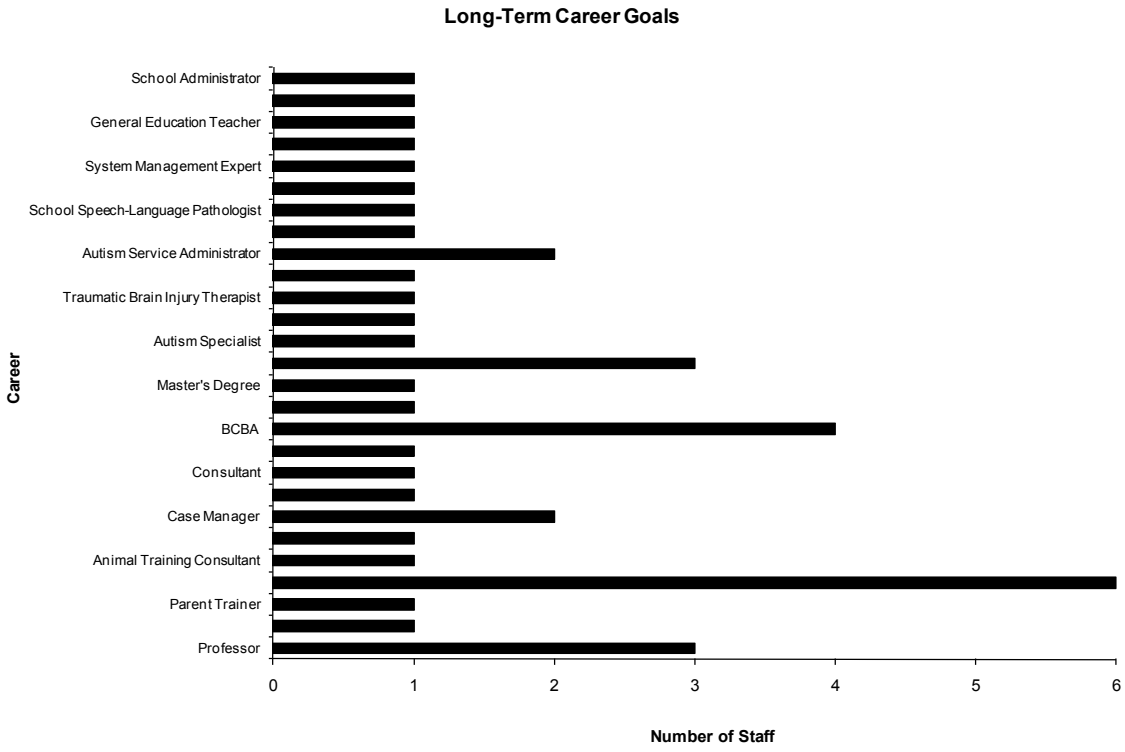


Staff Education



Staff College Minor




Long-Term Career Goals
School Administrator
General Education Teacher
System Management Expert
School Speech-Language Pathologist
Autism Service Administrator
Traumatic Brain Injury Therapist
Autism Specialist
Master's Degree
BCBA
Consultant
Case Manager
Animal Training Consultant
Parent Trainer
Professor
Career
0
1
2
3
4
5
6
Number of Staff

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