EXHIBIT F3

EVIDENT CHANGE
Inform Systems. Transform Lives.

ARKANSAS HOTLINE CQI REPORT

April – June 2026

CONTENTS

ABOUT EVIDENT CHANGE

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EXECUTIVE SUMMARY

The Arkansas Division of Children and Family Services (DCFS) Hotline Continuous Quality Improvement (CQI) process was developed to examine how screening decisions are made, including how operators engage in information gathering with reporters; whether the Structured Decision Making® (SDM) hotline assessment is used with fidelity; and whether referrals are screened as expected based on policy and best practice.

The CQI process leveraged multiple data sources to reflect a more nuanced understanding of practice at screening. The data analyzed for this process included administrative data; review of screening narrative, decisions, and assessments; and observation. This report summarizes the first quarter of reviews and will be updated each quarter based on a new sample of referrals.

KEY FINDINGS

- **History searches are frequent:** Most referrals have a documented history search based on narrative review (88%) and central registry queries from admin data (92%).
- **Agency assignment is typically accurate:** Most referrals assigned to the Arkansas State Police Crimes Against Children Division (CACD) (93%) are sexual abuse/exploitation, compared to 13% of assigned referrals at DCFS.
- **Override use higher than expected, particularly for screening out:** 17% of screened-out reports relied on an override compared to 7% of screened-in (or accepted) reports. A majority (60%) of overrides are applied by DCFS staff rather than at the time of CACD initial screening.
- **Re-referred concerns tend to be assigned for investigation:** 17% of the current sample was re-referred within six months, and most were assigned to investigation at re-referral (59%).
- **Screening rates were comparable across Areas:** Area 1 had the highest screen-out rate (47%), and Areas 7 and 10 had the lowest (40%).

PRACTICE IMPLICATIONS

- **SDM® hotline assessment completion decoupled from screening decision:** 26% of SDM hotline assessments were completed the day following referral. This is exacerbated by technological barriers, as well as a delayed keying process for referrals submitted via the Mandated Reporter Portal (MRP).
- **Narrative does not always align with hotline assessment selections:** 12% of reviewed narratives had misalignment with assessment selections. Half of these errors related to referrals of sexual abuse/exploitation, suggesting a potential area of strengthening screening practice.
- **Information gathering lacks documentation of protective capacities:** Only 4% of reviewed narrative mentioned protective capacities of the family.

Detailed data are provided in the report that follows.

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REVIEW PERIOD BY THE NUMBERS

This *by the numbers* section provides a high-level overview of data reviewed and outcomes from April to July 2026 for CQI purposes. These data will be tracked over time across periods of review.

Data Sources

11,343
referrals from **administrative** data

50
referral **narratives**

15
screenings **observed**

Data Outcomes by Process Step

Referral Initiation ***Strong***	Operators respond to calls promptly and professionally, but technological barriers can slow down the process and contribute to documentation errors. **73%** Calls with steady pacing by operators **100%** Operator confidence
Information Gathering ***Mixed***	Allegation concerns are documented consistently, but protective capacities and environmental concerns are asked about much less often. **91%** Documented allegation concerns thoroughly **<5%** Documented protective capacities/environmental concerns **92%/88%** With CHRIS history search
SDM Hotline Assessment ***Mixed***	Most SDM hotline assessments are completed accurately; fewer are completed timely. Override use is higher than recommended for screen-outs and often occur at DCFS. **88%** Completed accurately **73%** Completed same day as referral **17%** Override rate for screen-outs **60%** Of overrides at DCFS
Decisions and Next Steps ***Mixed***	Almost all screened-in referrals receive an investigation and are routed to the expected agency, although some lack necessary supervisor review. **>99%** Of screened-in referrals receive investigation **59%** Had required supervisory review documented **89%/96%** Of abuse/neglect referrals assigned to DCFS **86%** Of sexual abuse/exploitation referrals assigned to CACD

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INTRODUCTION

Evident Change began to develop a Hotline Continuous Quality Improvement (CQI) process for the Arkansas Division of Children and Family Services (DCFS) in January 2026. At present, screening reports for suspected abuse and neglect in Arkansas is conducted by the Arkansas State Police Crimes Against Children Division (CACD).

Between January and March 2026, Evident Change conducted a series of conversations with DCFS and CACD to (1) understand relevant policies and expected practice for screening referrals and (2) determine priorities for CQI. This report summarizes the CQI process that was developed and provides findings from the first review period, April–June 2026.

HOTLINE SCREENING PROCESS AND CQI PRIORITIES

To begin the development of a hotline CQI process, Evident Change reviewed relevant policies, procedures, and practices related to screening at the Child Abuse Hotline. Using this information, a process map was developed that outlined the typical steps that occur from the point a referral is made to the hotline to the time a screening decision is reached. DCFS and CACD staff were consulted to identify where screening aligns or diverges, in practice, from the expected process flow. Each step of the process flow was mapped on to a related CQI priority area and corresponding data metrics that could help identify where practice occurs with fidelity and where there are practice gaps.

SCREENING PROCESS FLOW

Referral Initiation

A typical screening process begins at the time a referral is made to the Child Abuse Hotline, either by phone (by anyone), or through a written concern by mandated reporters using the Mandated Reporter Portal (MRP).

Information Gathering

If a referral is called in, one of the CACD staff or supervisors is responsible for gathering a variety of concern-related information from the caller. This information is intended to gather the minimum amount of information required to determine whether a concern meets the legal threshold for potential abuse or neglect requiring an in-person response by DCFS or CACD. Information that is typically gathered at this

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stage includes details about the concern/allegation, prior history or client relationship with the agency, collateral contacts, and client demographics. In some instances, referrals are screened out at the initial stages without further information gathering, such as if a referral is a duplicate report that has already been screened.

Concerns submitted electronically by mandated reporters through the MRP vary in level of detail. It is within the scope of CACD hotline operators to reach out to reporters to try and gather additional details or information when relevant.

Assessment and Screening

While gathering information related to a concern, policy and best practice indicates that CACD operators reference and complete the Structured Decision Making® (SDM) hotline assessment.

The SDM® hotline assessment is a structured decision support tool that provides shared, consistent definitions of allegation criteria to ensure screening decisions reflect Arkansas statute. The hotline assessment uses decision-tree logic to support three main decisions at screening: (1) whether a referral meets the minimum threshold to be screened in (or accepted) for an in-person response; and (2) if so, how soon an in-person response must occur; and (3) by which agency. Typically, more serious concerns require a faster response time. The hotline assessment was customized by an Arkansas stakeholder workgroup in 2018; tested to ensure it supported consistent, accurate decisions by hotline staff; and underwent a review process for fidelity by Evident Change in 2021. This assessment provides definitions and examples to support operators in their decision-making process. The assessment has override options built in that allow for professional judgment or nuanced circumstances to alter the screening or response priority decision, while ensuring that such deviations continue to align with policy and are recorded for clarity and quality assurance. When used during the information-gathering stage of screening, the hotline assessment can support operators in ensuring they are asking necessary questions to gather the most comprehensive information needed to justify whether a concern does or does not meet legal requirements for screening. However, this can often be limited by the information reporters have available to them about a child, family, or allegation.

Decision and Next Steps

Once an operator has received all the information available or that they need from a reporter, reviewed potential client history with the agency, and completed the hotline assessment (including potential overrides), a screening decision and, when relevant, priority response time, is determined. Depending on the concern type, screened-in referrals are assigned to the most relevant agency; for example, concerns related to sexual abuse or trafficking would be routed for a CACD response, whereas a neglect concern would typically go to DCFS for either an investigation or differential response (DR). Certain screening decisions

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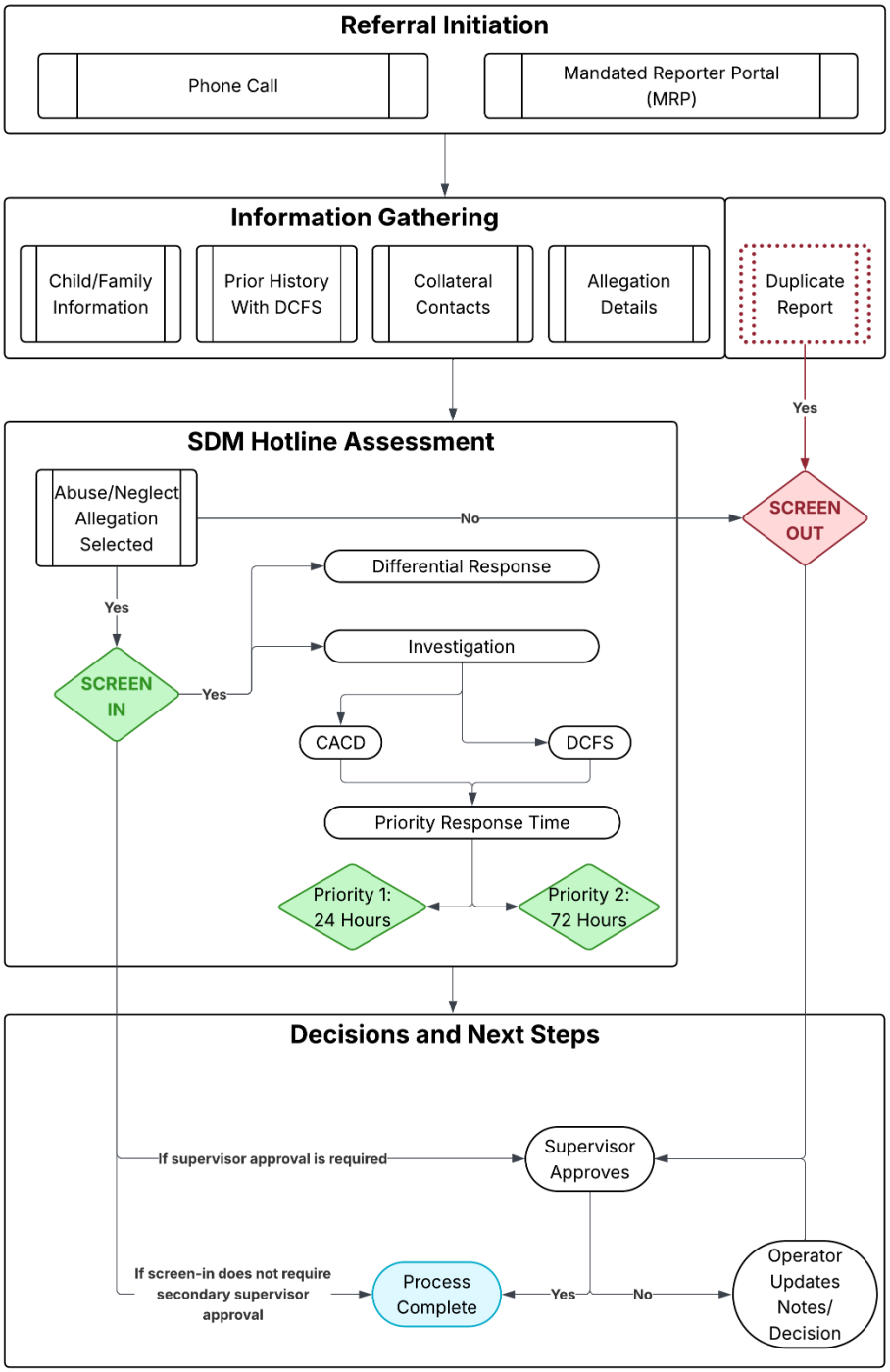
require additional supervisory approval, including most screened-out reports and certain screened-in allegations (e.g., sex trafficking). If a supervisor finds any errors in the decision, a worker may be asked to reevaluate and update the final decision.

This screening process is detailed in Figure 1.

Figure 1
Hotline Screening Process Flow



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CQI PRIORITY AREAS: AT A GLANCE

For each part of the screening process, CQI priorities were identified in collaboration with DCFS and CACD. These priorities were intended to directly assess whether practice was occurring as expected and where there were opportunities for practice improvement. Specific, available data points were identified for each priority to ensure that the CQI process could help answer each question. The priorities for each part of the screening process are detailed in Table 1.

TABLE 1

CQI PRIORITIES

PROCESS COMPONENT	PRIORITIES
Referral initiation	• Are calls received/responded to promptly? • Are staff prepared to conduct screening (e.g., they have adequate tools, training, etc.)? • Are there workplace barriers to screening?
Information gathering	• Is sufficient information about allegation/concern, history with DCFS, and other relevant information gathered during screening?
SDM hotline assessment	• Is the hotline assessment completed accurately? • Are overrides used with appropriate justification when making screening decisions?
Decision and next steps	• Are screening decisions accurate and consistent? • Are reports assigned to the correct agency? • Does appropriate supervisory review occur for screening decisions? • Are decisions made promptly? • Are screened-out reports returning to the system through re-reports?

Together, these CQI priorities are expected to provide a comprehensive assessment of screening practice.

CQI PROCESS AND METHODOLOGY

METHODOLOGY

The current review period began in April 2026 and sampled data from six months prior, capturing referrals that were made between October and November of 2025. To have the most comprehensive assessment of screening practices, Evident Change uses a triangulation methodology that relies on multiple forms of data collection to track CQI priorities both quantitatively and qualitatively. The types of methodology used for each of the CQI priorities are detailed in the Appendix.

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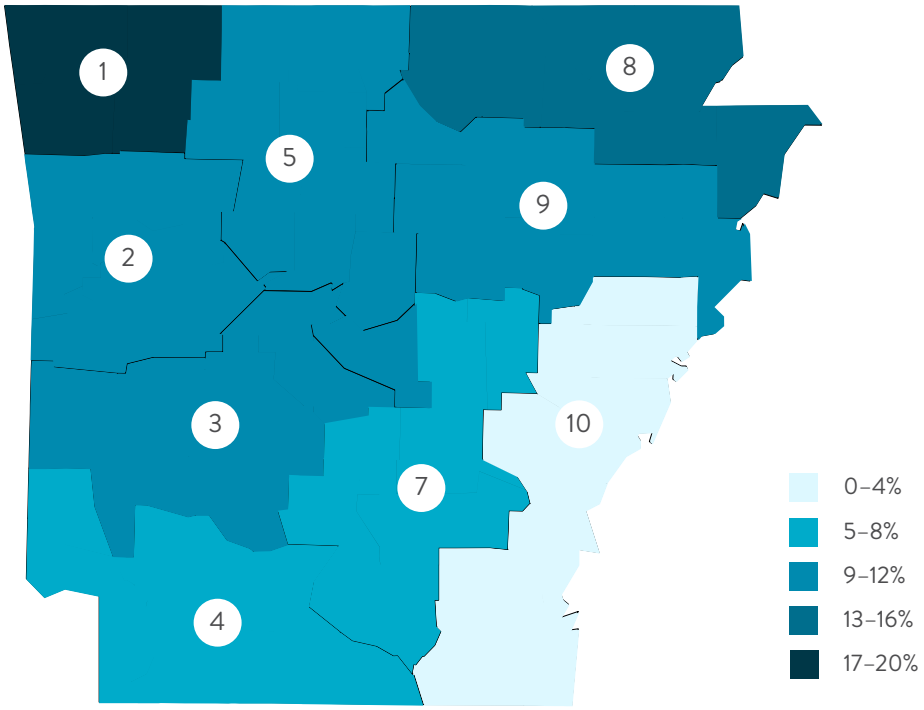
Administrative Data Analysis

Evident Change conducted administrative data analysis on all referrals that were made in October and November of 2025. The focus of administrative data was to understand general trends related to referrals coming into the Child Abuse Hotline at CACD, overall screening and response priority patterns, SDM hotline assessment completion, decision accuracy and consistency, and DCFS involvement outcomes (e.g., rate of re-reports for screened-out referrals).

A total of 11,343 referral records were analyzed for the current review period. Of these, close to half (45%) were screened in for investigation or DR (10%); the remainder were screened out (44%) or referred for assessment (<1%).

Figure 2 shows the breakdown of referrals included in this review from administrative data by Area.

Figure 2
Referrals by Area From Administrative Data
(N = 11,343)*



*1% had location indicated outside of Arkansas.

The reporter type was highly centralized among mandated reporting professions, especially law enforcement and school personnel. Figure 3 shows the breakdown for the top 10 highest reporting groups for this sample.

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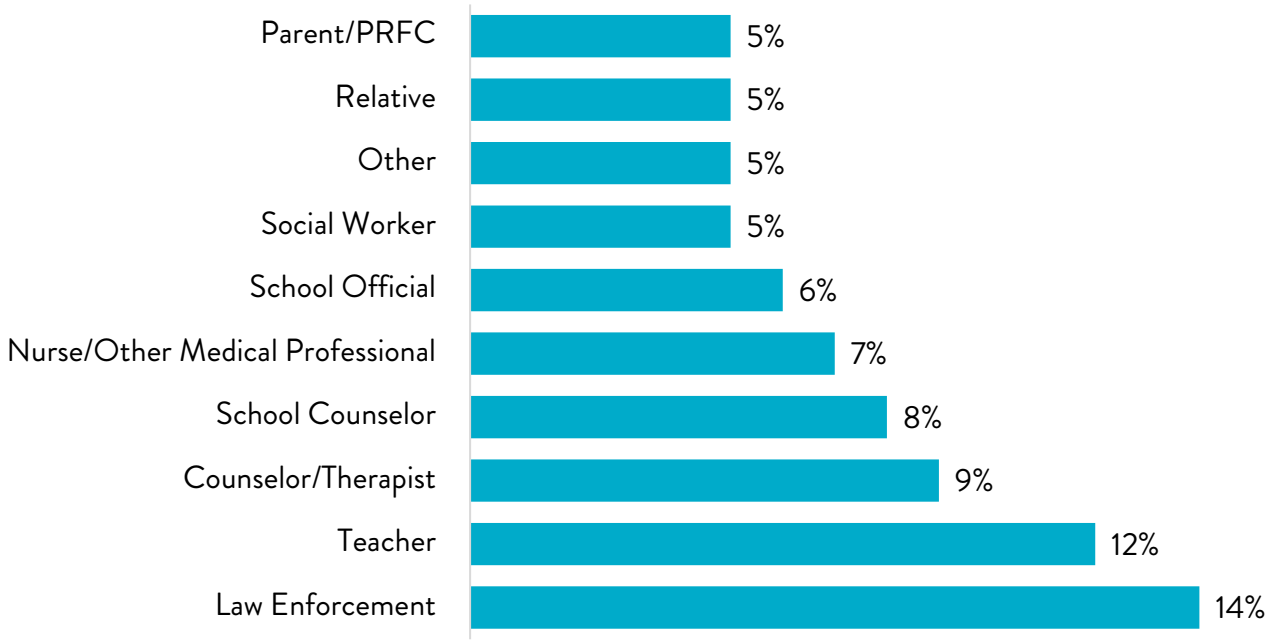
Figure 3
Frequency of Reporter Type (Top 10)
(N = 11,343)



Referral Review

Evident Change staff reviewed a random subsample of 50 referrals from October and November 2025 to determine whether screening decisions were made per policy and in alignment with the available information regarding the reported concern. Of these, 54% were screened in and 46% screened out. Half (50%) were received by phone and the remaining through the MRP. For this, Evident Change staff used a review tool that was tailored for this CQI effort and co-created alongside DCFS and CACD. The review tool was designed to identify whether documentation aligned with expected practice and/or the final screening decision. The referral review, in part, assessed whether the SDM hotline assessment was completed accurately (e.g., the selections made on the tool aligned with the information shared in the referral), as well as other key elements of practice, such as whether a CHRIS, the agency's current electronic case management system, history check was completed on the family referred or whether a supervisor signed off on the final decision.

Observation

To better understand the context in which operators are engaging in the screening process, Evident Change spent two days observing operators screening referrals. Both observation days occurred during the week and between the hours of 9:00 a.m. and 4:00 p.m. One observation day occurred while schools were still in

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session and the second after summer break started, when call volume tends to be lower. Staff each day included senior operators and newer staff, providing an opportunity to observe how years of experience impacts overall screening. The first observation day also included minimal operators available due to staffing constraints. The second observation day was well-staffed. Over the course of each day, one Evident Change reviewer observed operators either screening incoming MRPs or taking phone calls. Eleven telephone referrals and four MRPs were observed, totaling 15 observed screenings. During each observed screening, the Evident Change reviewer completed an observation tool that was designed to capture key elements of the screening process, such as when the hotline assessment gets completed, how thorough and professional conversations with callers were, and any challenges experienced by operators while trying to complete a screening decision. When time allowed, the Evident Change reviewer additionally debriefed with the operators they observed following each decision to better understand their thinking and decision-making process in real time.

SAMPLE: AT A GLANCE

Table 2 highlights the sample characteristics for each form of review in this report.

TABLE 2

SAMPLE CHARACTERISTICS BY METHODOLOGY

CHARACTERISTIC	ADMINISTRATIVE DATA	REFERRAL REVIEW	OBSERVATION*
Sample Size			
N	11,343	50	15
Final Screening Decision			
Screened in	56%	54%	N/A
Screened out	44%	46%	
Reporter Type			
Mandated	81%	88%	N/A
Non-mandated	19%**	12%	
Allegation Type			
Abuse	28%	26%	N/A
Neglect/abandonment	39%	22%	
Sexual abuse/exploitation	11%	12%	
None	31%	42%	

*Observations focused on the process and actions taken by operators and did not gather information about the report content since observers were not hearing reporters/referral content.

**These data include reporter types that may or may not also have mandated reporting requirements but there was insufficient data to confirm (e.g., "private agency" may depend on the type of agency).

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FINDINGS BY HOTLINE PROCESS COMPONENT

REFERRAL INITIATION

Referral initiation prioritizes examining staff responsivity and readiness to screen calls. This was examined mostly through observation. In general, referral initiation practices exhibited by operators were strong, demonstrating confidence and professionalism in the ways they interacted with reporters.

OPERATOR RESPONSIVITY

During the observation days this period, there was not a significant call volume and no significant delays in call response noted by observers. Operators responded to calls promptly and maintained effective practices described above throughout these calls.

STAFF READINESS AND CONFIDENCE

For the applicable referrals made by telephone that were observed, there was a high degree of professionalism maintained throughout the call. Operators for all applicable calls were observed to:

- Clearly identify self/agency when beginning the call;
- Clarify the purpose of the call/referral;
- Address confidentiality and its limits;
- Assess for immediate safety/need for law enforcement;
- Maintain a calm, respectful tone;
- Use trauma-informed practice responses;
- Maintain non-blaming, open, and non-judgmental tone; and
- Identify reporter type.

Throughout the call, operators generally maintained a steady flow that focused on information gathering. The flow and pace of observed calls reflects operator comfort with the information gathering process and caller experience. These practices and the rate they were observed appear in Figure 4.

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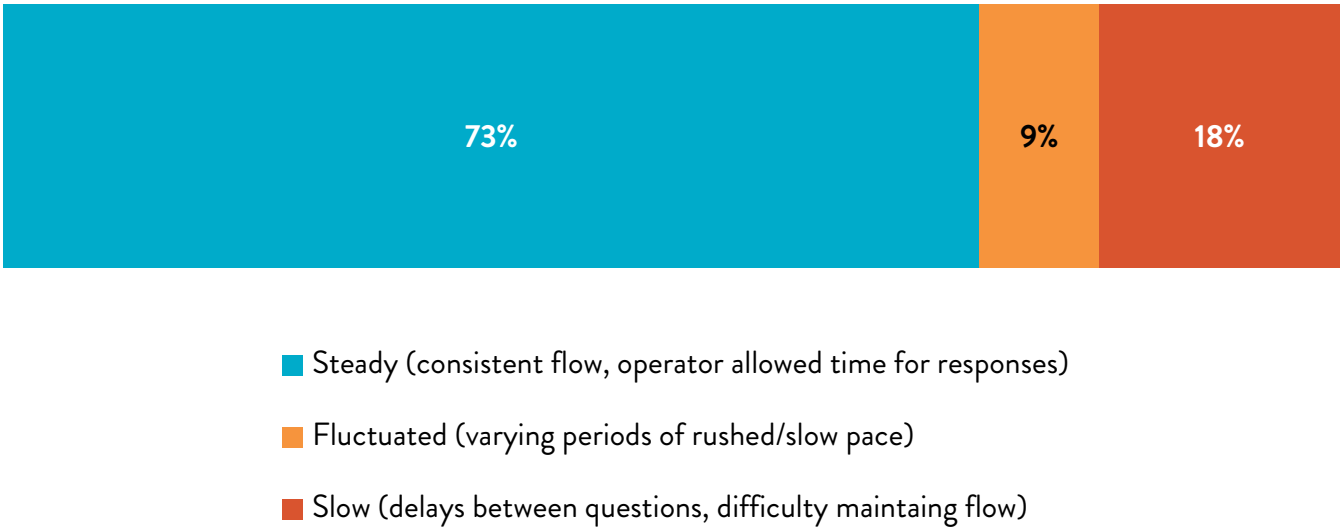
Figure 4
Call Pacing by Operators
(n=11)



During the observation days, all operators for all reports indicated feeling either confident or very confident in their screening decision, and only one referral was noted as more complex than average. Prior to ending a screening, operators demonstrated effective practice, including providing information on what happens after a call, phone numbers for follow-up, and thanking the reporter. Only one observed referral required referral to law enforcement, which was completed by the operator. For this example, the reporter did not have any information on the alleged victim's name or location but was able to share that the mother was incarcerated. This prevented the referral from being screened in (accurately) but was shared with law enforcement as an alternative. Table 3 shows observed practices at call conclusion for observed referrals.

TABLE 3

OBSERVED PRACTICES FOR ENDING REFERRAL CALLS
(n = 11)

PRACTICE	%
Explain to reporter what happens next	91%
If applicable, refer to law enforcement (n=1)	100%
Ask if caller has additional questions	91%
Provide phone number to reporter for follow up	83%
End the call professionally and thank the reporter	100%

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BARRIERS TO SCREENING PROCESS

Based on observations and interviews with operators, the biggest barrier to the screening process is due to navigating multiple information and data entry systems that are not connected to one another and are not able to auto-populate information between systems. This increases the risk of human error from having to input the same data multiple times in different places and can interfere with a seamless process at all steps of screening, beginning with information gathering. It also impacts the timely completion of the screening process because operators cannot begin taking a new call until the information from a received referral is entered into the data system. In practice, this means that following a call, operators are inputting gathered information into multiple systems. This process is often streamlined by using copy/paste functions across multiple windows, which in turn can lead to errors such as template text being carried over from one document into another without complete information.

INFORMATION GATHERING

Information gathering is critical for ensuring reported concerns are addressed with an accurate response, as designated by legal statute. Not all reported concerns rise to the threshold required to warrant an in-person response, and different levels of concern require responses with different urgency and/or agency assignment.

Several pieces of information are relevant to the screening process. Most direct is learning who is the alleged victim and who is the alleged offender, and understanding the reporter's allegation as it relates to caregiver action (or inaction) and impact on child. Understanding this helps determine whether the legal definitions of abuse/neglect have been met to initiate an in-person response and who that response should focus on. It is recommended that operators use the SDM hotline assessment as a tool to support information gathering that directly addresses the types of information necessary to determine whether screening criteria are met. However, operators are not often leveraging the hotline assessment in this way. Some identified challenges include: difficulty reading definitions and formulating appropriate prompts in live time while presenting as engaged with a caller; overreliance on operator's own best recollection of statute; technology barriers that require multiple screens to access both the agency's electronic case management system and the hotline assessment; and variability in reporter communicability.

In addition to this, family information (e.g., demographics, languages spoken), family composition (e.g., who is in the home), collateral contacts, safety and risk concerns beyond the specific allegation, vulnerabilities (e.g., developmental delays), and protective capacities/environmental factors (e.g., family involved with therapy), help provide context on the overall family functioning and capacities that can support screening decisions, and readiness of agency staff should they be assigned to a screened-in referral. Finally, it is expected that operators check for family history of involvement with DCFS or CACD for all referrals that come in. Understanding prior history helps speak to patterns or escalation of concerns over time that can factor into the final screening decision.

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Despite being the crux of accurate screening, information gathering is a fluid process, guided by best practice, and limited by the availability of information and communicability of reporters. It happens in real time; so while some CHRIS inputs require operators to mark what was or was not done during this part of the screening process (e.g., whether a history search was completed), administrative data cannot fully capture how information was gathered. Referral review, which looks at the level of documented information, helps understand what available information was deemed relevant to describing the concern and providing rationale for the screening decision. Documented narrative alone does not speak to what information was asked about/available during a report, only what an operator determined was relevant enough to document within the agency's case management system. Observations can attend to this gap by offering a window into how operators determine the questions to ask reporters, the extent to which operators focus questions on impact/harm on the child and action by caregivers, and how missing information is factored into the decision-making process. Despite these challenges, a more comprehensive understanding of the information-gathering process for the current review was possible through the triangulation of observation, referral review, and administrative data.

Based on documented narrative and observation, operators prioritize information gathering related to the alleged concerns and consistently gather information on history with DCFS. Gaps in information gathering emerged for contextual information such as environmental concerns and protective capacities of referred families.

Based on reviews, a majority of referrals had sufficient information documented about allegation concerns (80%) and the relationship between alleged victims and perpetrators (86%). Documentation was less frequent for other types of information; the biggest gap was in the documentation of family protective capacities (4%) and environmental factors (2%). Breakdown of what information was available in reviewed referrals are in Figure 5.

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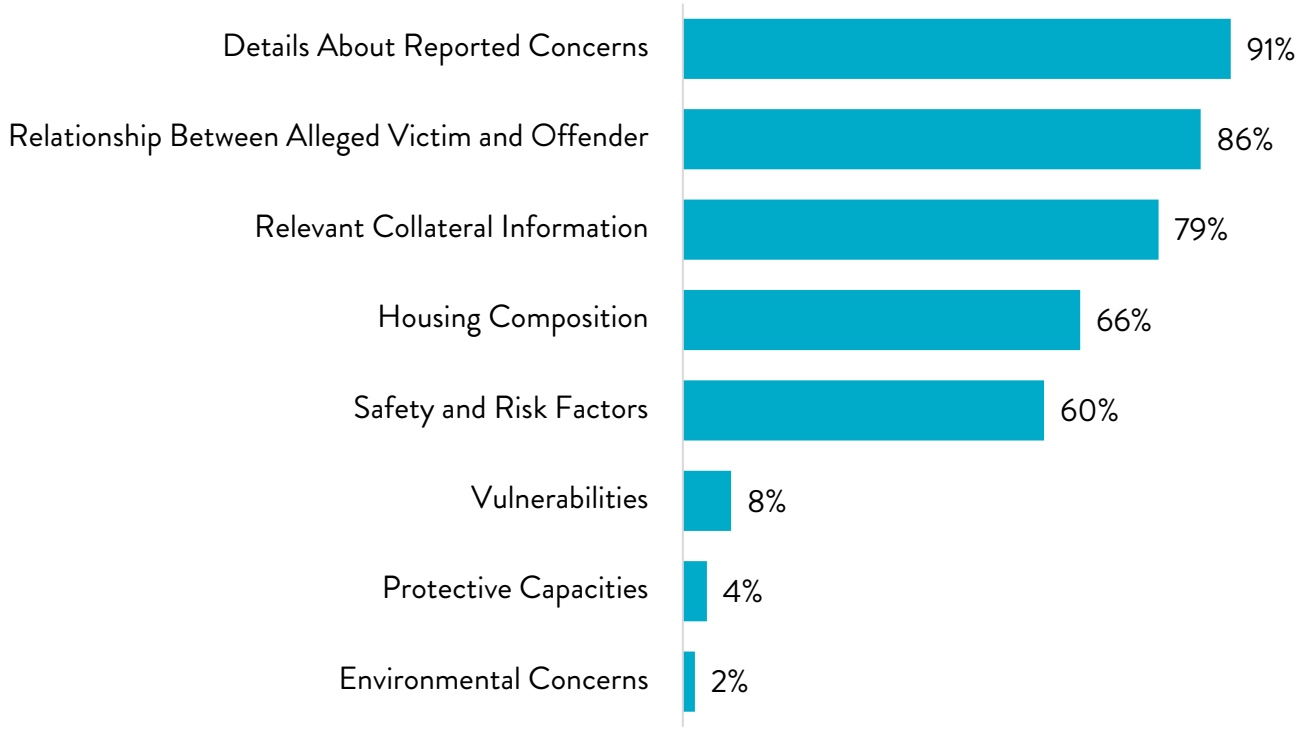
Figure 5
Information Documented in Referral Review Narrative
(N = 50)



Similar trends in information gathering were noted from observations. These data are in Table 4.

TABLE 4

OBSERVED INFORMATION GATHERING
(n=10)*

INFORMATION TYPE	%
Child located in Arkansas	100%
Sufficient information to locate child/family	100%
Asked about alleged offender	100%
Asked open-ended questions	90%
Asked clarifying questions	90%
Asked about other collaterals	90%
Asked about vulnerabilities	90%
Asked about other children in the household	70%
Explored environmental risks in the home	60%
Asked about caregiver protective capacities	30%
Asked about known prior incidents	20%

*Of the 11 observed telephone referrals, one was information request online and not included in these data.

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Further, all observed operators applied reasonable cause to suspect thresholds and documented screen-out rationales when appropriate. While some trends align between review and observation (e.g., infrequent inquiry about protective capacities), others suggest that while some information may be asked about (e.g., vulnerabilities) it is not as often documented. Both components are necessary to ensure decisions are based on all available information, and that information is available for future reference and CQI.

Based on reviewed referrals, 88% (n=44) had a CHRIS History Search completed and documented properly. All observations by Evident Change staff included a CHRIS History Search.

PRACTICE EXAMPLE

One referral from reviews was screened out via override at Central Office because the alleged victim was over the age of 18. This referral was initially screened in at the hotline; there was documentation in the screening that there was no CHRIS history and the "Central Registry Queried" box was not selected, but the family did show as having history upon review. This accurate search of history would have confirmed child victim age to be over 18, and the pre-screening would have resulted in a screen-out on the SDM hotline assessment.

These generally high completion rates during review and observations were supported by available administrative data, where 92% of referrals had a Central Registry Query, or CHRIS History Search, noted. However, of the 12% (n=6) of reviewed referrals that did not have adequate history documented, four had the Central Registry Query selected in the administrative data. This indicates either a lack of documentation about the outcome of the history search or that operators may sometimes select the query box within the agency's electronic case management system without completing a full search. Table 5 shows the rate by allegation type that had a Central Registry Query selected within the administrative data.

TABLE 5

CENTRAL REGISTRY QUERIED BY ALLEGATION (n=8,803)*

INFORMATION TYPE	%
Neglect/abandonment	93%
Abuse	92%
Sexual abuse/exploitation	93%

*Sample for this is limited to referrals with an allegation selected.

Collateral information was collected in a majority of referrals where applicable (79%); however, 21% did not have documentation of collateral contacts or collateral follow-up. This is especially relevant to the screening

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of concerns submitted via MRP. Because MRPs are completed by reporters electronically, there is a missed opportunity for operators to ask about much of the detailed information necessary to confirm whether legal thresholds for screening have been met. Absent these opportunities, screening decisions may be based on incomplete information. In some instances, reporters may not have additional information. In other instances, however, reporters may not know what information they have that is pertinent to the screening decision; this is the role of operators versed in statute.

PRACTICE EXAMPLE

One referral from the reviews that was submitted via MRP was **screened out** due to a lack of descriptive specificity. In this referral, a child (age 11) disclosed sexual abuse to school officials. When the report was submitted to the MRP it was screened out because it lacked description of what parts of the child's body had been touched.

This referral had no documentation of attempts to reach out to the mandated reporter to attempt to get additional information, despite contact information being available. Reporters may not always know the specificity with which they need to report. Operators are trained to ask for such descriptors as part of their information-gathering process, which could have strengthened the decision-making process and potentially altered the screening outcome.

SDM HOTLINE ASSESSMENT

The SDM hotline assessment is expected to be completed for every screening decision; administrative data analysis confirmed that almost all (99.98%) referrals had a completed SDM assessment. The hotline assessment populates a screening decision and priority response assignment (when relevant) that reflects item selection related to reported concerns and their alignment with legal statute for screening. If operators believe there are extenuating circumstances or alternative reasons why the populated screening decision needs to change, they are able to apply overrides. This process ensures operators can make judgments based on professional expertise while ensuring that such decisions are documented adequately, ensuring rationale for decisions is available.

A majority of hotline assessments that were reviewed were completed accurately, in alignment with documented information about the concern being reported. Half of the errors that emerged were related to referrals about concerns of sexual abuse or exploitation. Override use on the assessment was higher than expected, particularly for screening out referrals.

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ACCURATE COMPLETION

Referral review was used to determine whether hotline assessment selections aligned with available descriptions of the referral concerns. Of the 50 referrals reviewed, six (12%) had inconsistencies between the hotline assessment selections and documented referral information. Two types of errors in documentation were observed, over-selection and under-selection, as described in Figure 6.

Figure 6
Error Types in Referral Review

Over-Selection	Under-Selection
Description and Frequency	Description and Frequency
Over-selection occurs when an item on the hotline assessment is selected, but there is **no documented narrative** that indicates a selection should have been made. This occurred in two of the reviewed referrals, or 4% overall.	**Under-selection** occurs when something is described in documented narrative that meets criteria for item selection on the hotline assessment but is **not selected.** This occurred in five of the reviewed referrals, or 10% overall.
Practice Example	Practice Example
A hotline assessment was completed with medical neglect selected, but no narrative was provided that related to medical concerns. The referral was ultimately screened in per a different completed SDM assessment that accurately scored shelter/neglect.	A referral that was screened in for neglect named the alleged offender as the parent, but the DR selection on the hotline assessment did not reflect this information. A referral that was screened in for neglect named the alleged offender as the parent, but the DR selection on the hotline assessment did not reflect this information. This would not have changed the screening decision.

Either type of error can lead to inaccuracies in screening decision or agency assignment. Reviewers noted that either the screening decision or agency assignment may have been different if appropriate hotline assessment selections were made in three of the referrals; for one of the referrals, the outcome would have

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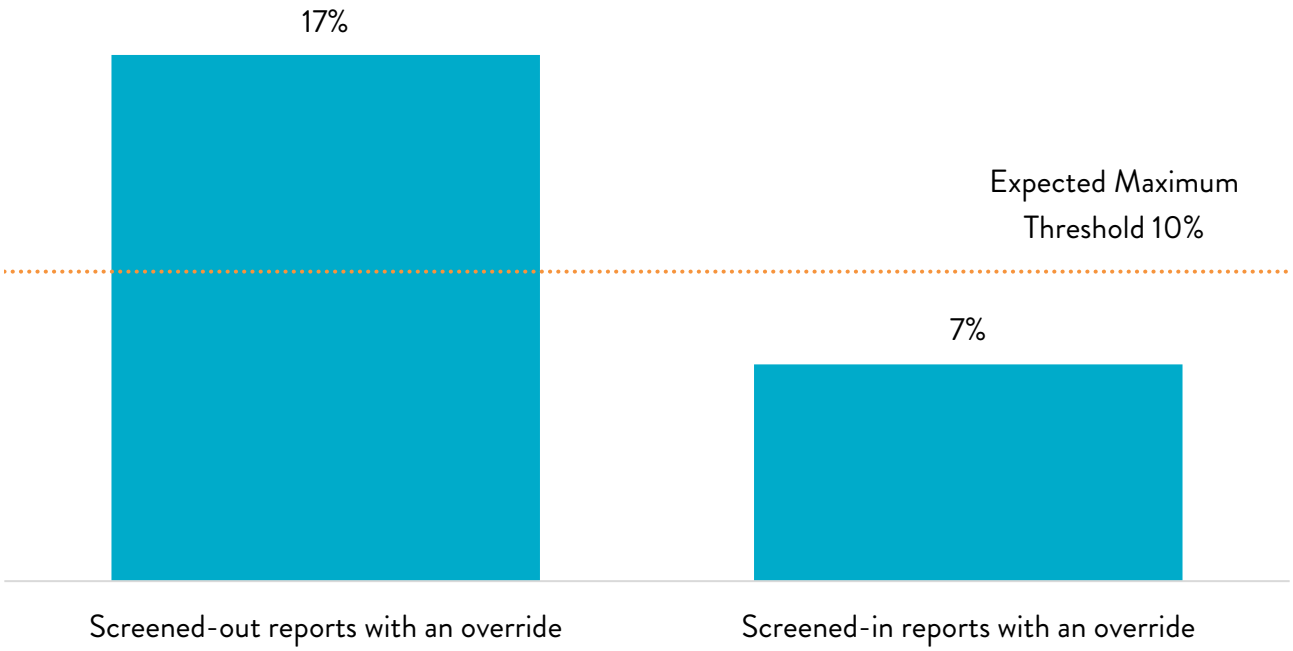
remained the same, but it would not have required the override that was used. Three of the six errors involved referrals with some mention of sexual abuse or exploitation.

OVERRIDE USE

The hotline assessment has different override options for operators to apply discretionary (professional judgment) or policy exceptions to referrals. Discretionary overrides always require written justification. Best practice is to use overrides minimally; Evident Change expects to see less than 10% of referrals with an override. Anything greater would indicate either (1) misalignment of assessment definitions with current practice/policy or (2) inaccurate application of override criteria. Concerns with override use would best be followed up with CQI of referrals with an override specifically. Figure 7 shows override use by screening decision based on administrative data.

Figure 7
Override by Final Screening Decision
(n=1,288)



Administrative data indicate a higher-than-expected use of overrides to screen-out reports. Understanding how to better align practice with assessment to minimize the need for overrides would strengthen current practice. Table 6 shows how initial and final screening decisions compare for reports with overrides; orange-shaded cells indicate the percentage of referrals where the final decision differed from the initial as a result of the override used.

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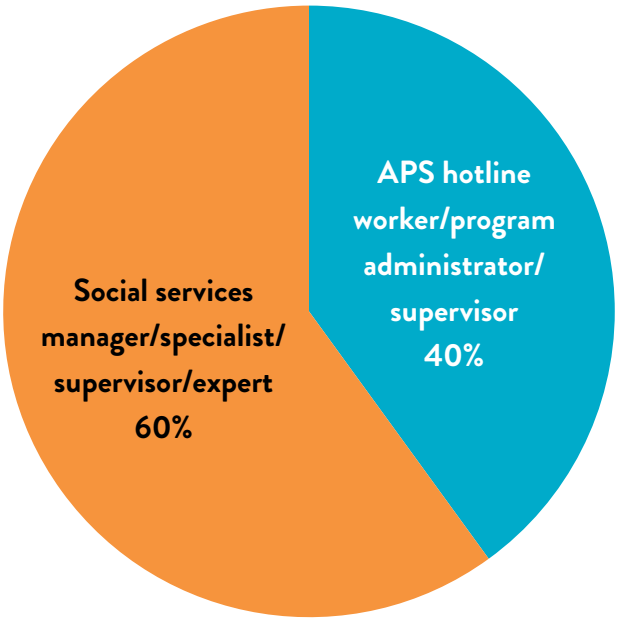
TABLE 6 INITIAL VERSUS FINAL SCREENING DECISION FOR REFERRALS WITH OVERRIDES (n=1,284)		
INITIAL DECISION	FINAL DECISION	
	SCREEN IN	SCREEN OUT
Screen in	34%	66%
Screen out	43%	57%

Note: Screen in includes DR or investigation.

Of note, 34% of screen-ins and 57% of screen-outs that had an override applied did not actually have a change in screening decision. This may indicate that the overrides are being used as a "documentation" of information rather than a true override (intended to *change* an initial screening decision). This interpretation further suggests that override use may be more effective when used with initially screened-in reports in order to screen out, since the proportion of screen-ins that have a decision changed by use of an override is higher than in instances where it is used to screen something in. Alternately, it could indicate a misunderstanding of override criteria that may require practice support.

Additionally, data indicate that a greater proportion of overrides are being applied by DCFS staff. Figure 8 shows the role of individuals applying overrides.

Figure 8
Override Use by Role
(n=1,288)



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DECISION AND NEXT STEPS

ACCURACY AND CONSISTENCY OF DECISIONS

Although accuracy is best assessed through referral review, according to administrative data almost all screened-in referrals received an investigation (99.55%); this can be used as a proxy for accurate screening beyond what was reviewed. From referral reviews, 12% of referrals were found to have documentation errors, and at least two may have resulted in a different outcome had accurate information been selected on the hotline assessment.

A review of administrative data showed rates of screened-in referrals and assigned agency in alignment with what was expected based on allegation type. Specifically, most screened-in DRs were for allegations of neglect, while investigations addressed both neglect and abuse comparably (Table 7). However, a small percentage of screened-out referrals (13%) had an allegation selected. Typically, it is expected that screened-out reports do not meet criteria for allegation thresholds. This may reflect actions such as a merging with an open report or instances of duplicate referrals. Detailed screen-out data was not included in this review period data but will be explored as a potential additional metric in future review periods. Of the 1,531 screen-outs with an allegation selected, about half (n=819; 54%) had an override, which would be expected for reports screened out with potential allegation selections present. This leaves a gap where about 6% of screened-out reports had an allegation selected but no documented override to justify the screen-out.

TABLE 7

SCREENING DECISION AND ALLEGATION TYPE*
(N = 11,343)

SCREENING DECISION	ABUSE/ ABANDONMENT	NEGLECT	SEXUAL ABUSE/ EXPLOITATION
Screen in for DR	1%	99%	0%
Screen in for investigation	48%	50%	19%
Refer for assessment	5%	0%	0%
Screen out†	13%	14%	6%

*Referrals may have multiple allegation types selected, so percentages do not add up to 100%.

†54% of screen-outs with an allegation selected had an additional override.

Using administrative data, trends by area were also examined and are shared below.

Screening rates did not vary significantly by area (Figure 9). Area 5 had the highest rate of referrals screened in for investigation, whereas Area 1 had the highest rate of screened-out referrals.

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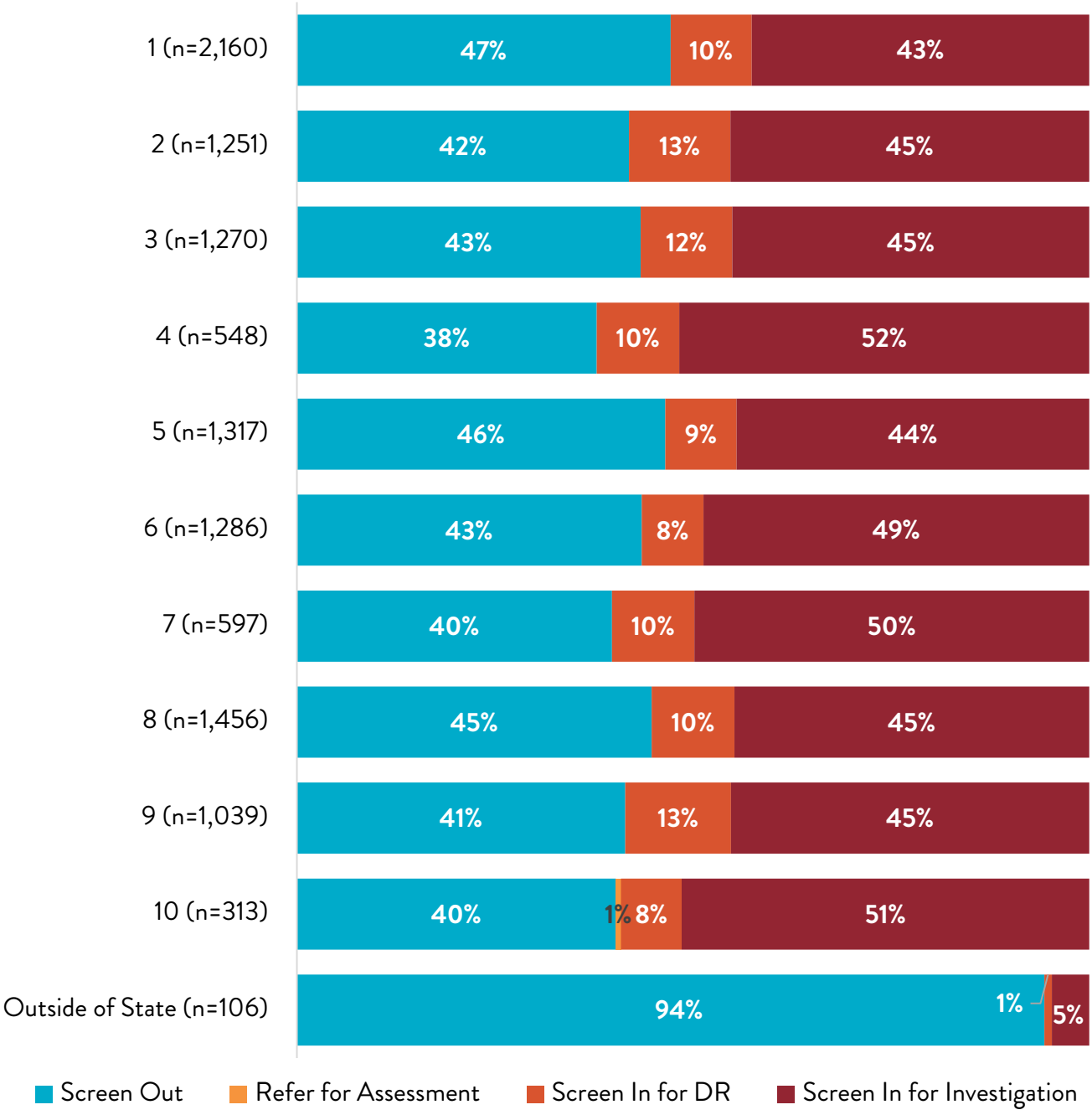
Figure 9
Screening Decisions by Area
(N = 11,343)



Screening decisions varied by reporter type. Figure 10 shows the top 10 reporter categories; the most frequent reporter categories were law enforcement, teachers, and counselors/therapists. Social workers and parents/PRFCs, although not in the top three most frequent reporters, had the highest rates of screen-ins, followed by law enforcement and nurse/other medical professionals. School professionals had the highest rates of screen-outs.

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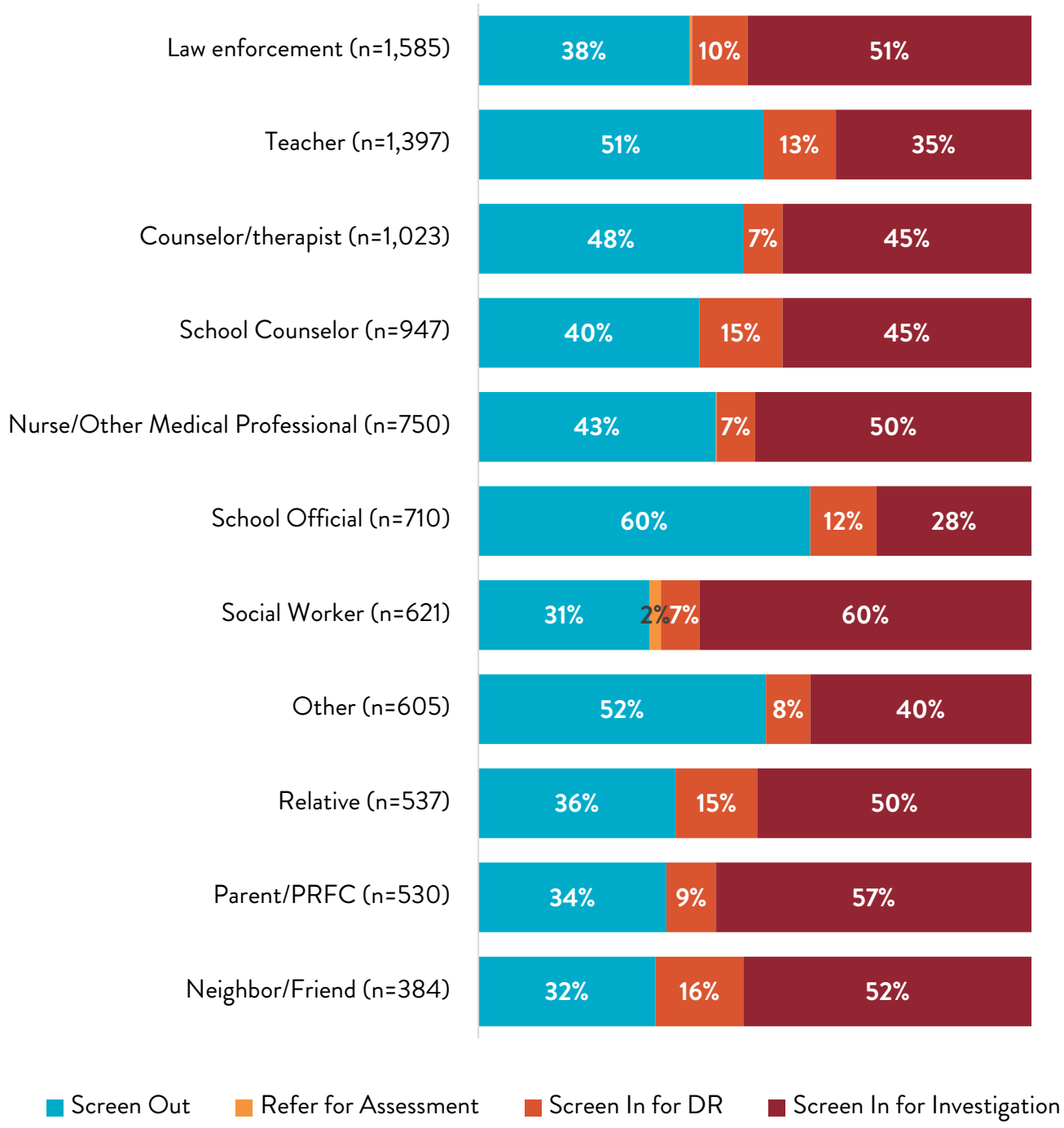
Figure 10
Screening Decisions by Reporter
(n=9,089)



In general, most documented overrides were used by Social Service staff from DCFS. Figure 11 shows the breakdown of overrides by agency for each Area. In Area 7, Arkansas State Police made up a higher proportion of overrides than Social Services.

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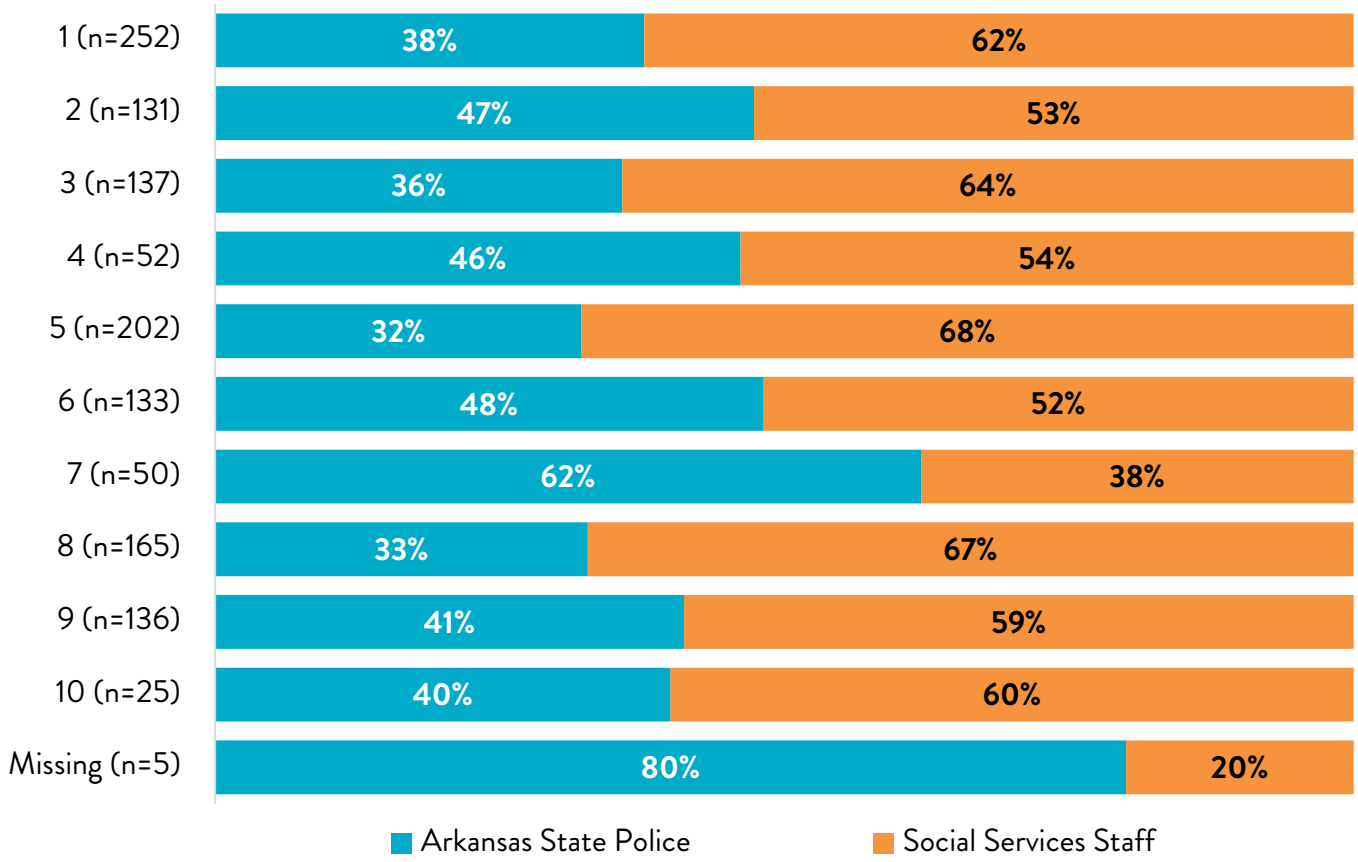
Figure 11
Agency Override Use by Area
(n=1,288)



ACCURATE AGENCY ASSIGNMENT

Typically, reports of alleged child maltreatment are assigned to DCFS unless the report involves severe maltreatment (e.g., sexual abuse), a child in out-of-home care, or a potential conflict of interest for DCFS. Administrative data confirmed this general trend, with a majority of neglect/abuse allegations being routed to DCFS and sexual abuse/exploitation to CACD, shown in Table 8.

TABLE 8

AGENCY ASSIGNMENT BY ALLEGATION TYPE*

ALLEGATION	DCFS	CACD
Abuse (n=3,119)	89%	11%
Neglect/abandonment (n=4,461)	96%	4%
Sexual abuse/sexual exploitation (n=1,223)	14%	86%

*Referrals may have multiple allegations.

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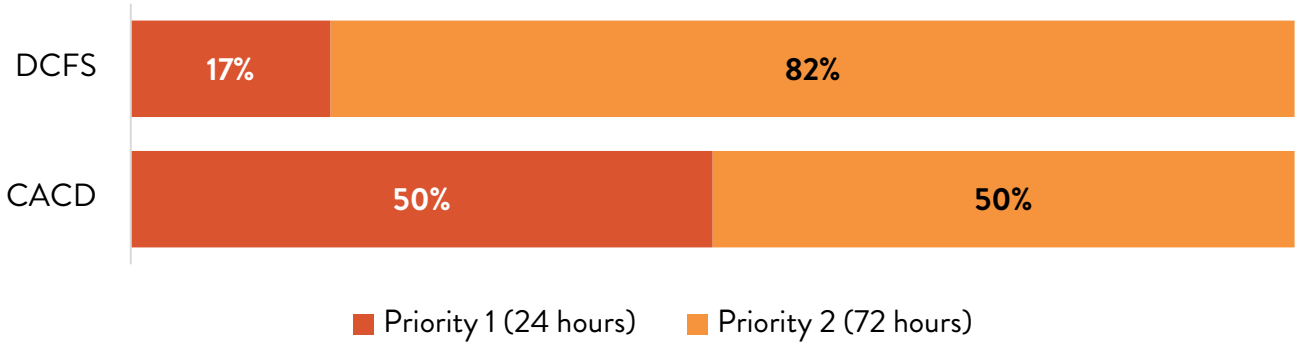
Although CACD typically responds to more serious allegations, the priority assignment was more evenly split between agencies. Alternately, DCFS has significantly more Priority 2 (P2) assignments than Priority 1 (P1). Priority 1 assignments require initiation within 24-hours, while Priority 2 assignments require initiation within 72 hours. These data are shown in Figure 12.

Figure 12
Priority Assessment by Agency
(n=5,809)



Additionally, the split between allegations is not as clear cut. Table 9 shows priority response assignment by agency and allegation type.

TABLE 9

AGENCY ASSIGNMENT BY PRIORITY TYPE AND ALLEGATION

PRIORITY LEVEL/ALLEGATION	DCFS	CACD
Priority 1 (n=1,352)	**58%**	**42%**
Abuse	61%	39%
Neglect/abandonment	79%	21%
Sexual abuse/sexual exploitation	13%	86%
Priority 2 (n=4,397)	**87%**	**13%**
Abuse	96%	4%
Neglect/abandonment	98%	3%
Sexual abuse/sexual exploitation	7%	93%

SUPERVISORY REVIEW

Supervisor review of screening decisions serves as an additional form of quality assurance. Policy indicates that supervisor review is required for most screen-outs and screen-ins of a more serious nature (e.g., all child

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deaths, near fatalities, referrals seeking elevated response). From reviewed referrals, 59% of applicable referrals (n=22) had documented supervisory approval. The 41% (n=9) that should have received supervisor approval but did not involved allegations of physical abuse (n=4), sexual abuse/exploitation (n=3), and neglect (n=2). Two of the referrals that were missing this supervisory approval were also referrals found to have misalignment between the narrative and the selections made on the hotline assessment; supervisor review might have caught these discrepancies.

PRACTICE EXAMPLE

One reviewed referral that was incorrectly screened had a neglect allegation selected; per policy, this would not require a supervisor review.

However, documented narrative in the referral supported selection of sexual abuse and/or trafficking due to descriptions of exposing the child to sexual activity. Due to the neglect selection, supervisor review during which the error might have been identified was bypassed. The report was screened in, so the screening decision would not have been different necessarily; however, it was assigned as a DR. Given the documented allegations related to sexual abuse, CACD may have been a more appropriate assignment.

This demonstrates the interconnection between accurate assessment completion and secondary review.

DECISION PROMPTNESS

Administrative data provided an additional look into responsivity, by examining the length of time between referral and hotline assessment completion, shown in Table 10.

TABLE 10

TIME BETWEEN REFERRAL AND COMPLETED SDM HOTLINE ASSESSMENT (N = 11,343)

TIME	n	%
Same day	8,313	73%
Next day	2,947	26%
Two or more days	53	0.5%
Missing/inaccurate data	30	<.05%

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These data are limited by data quality. Specifically, looking at exact differences in time through timestamps yielded several negative timeframes, indicating a discrepancy in the time referral information was entered into the hotline assessment, which is required to make a screening decision.

In following up on these data trends with CACD, Evident Change learned that it is common for MRPs to be forwarded with a screening decision to operators who work evening or night shifts to key into the system. This helps with workflow management and allows for data entry to happen when there are the fewest on-call needs from operators. This means that if an MRP was received during the day, screened "informally," and assigned to an operator to key in later, then any MRP keyed in at 12:01 a.m. or later would show up as being completed next day. In addition to a delay in decision-making time, this process decouples assessment completion from the decision-making process. By the time information is entered and the hotline assessment is completed, a decision has been made, and any opportunity to gain additional information may be limited.

These trends were further affirmed during observation, when all (100%) referrals by telephone had a hotline assessment completed following the call. While this procedure is not in alignment with recommended practice, it appears to be driven by technological barriers resulting from multiple entry platforms not being able to auto populate or share information between each other. Since CHRIS and the hotline assessment, housed in the Practice Hub, do not interconnect, operators are required to duplicate their entry across different systems, which gets delayed until after they are off the call. Operators often take written notes or use a blank document to collect information to copy and paste or view information while working across these systems. While waiting to complete the assessment addresses the challenge of multiple entries while maintaining a conversation with the caller, it creates new challenges in terms of truly integrating the hotline assessment into the screening decision. Specifically, it decouples the assessment from the decision being made; operators have a sense of whether the referral they heard will be screened in or not *before* they review/complete the hotline assessment. This can lead to item selection that affirms the decision made, rather than using the tool to help guide information gathering or decision making. This order of operations, especially in response to referrals that may be less clear-cut or when operators are relying on inaccurate/incomplete memory of legal statute, can contribute to less consistency and accuracy in screening.

Investigation Initiation

Each screened-in report is assigned to a Priority 1 (24 hours) or Priority 2 (72 hours) response; priority response level is based on the urgency with which a responding agency should make contact with an alleged victim. More serious allegations typically require a quicker response. Table 11 shows the average time to investigation initiation, with both priority levels falling within expected time frames.

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TABLE 11 TIME BETWEEN SCREEN-IN AND INVESTIGATION INITIATION (n=5,107)	
PRIORITY	**AVERAGE TIME TO INVESTIGATION INITIATION**
Priority 1	17.76 Hours
Priority 2	71.76 Hours

On average, these times to investigation initiation align with expected timeframes of 24 and 72 hours. The review found that 466 screened-in referrals had an investigation initiated in a timeframe exceeding 72 hours; these timeframes ranged from four to 92 days. Table 12 shows the breakdown between Priority 1 and Priority 2 assignments for investigation initiations that occurred after three days of screening.

TABLE 12 TIME BETWEEN SCREEN-IN AND INVESTIGATION INITIATION FOR DELAYED INITIATION (n=5,107)			
PRIORITY	**4–9 DAYS**	**10–29 DAYS**	**30 DAYS OR LATER**
Priority 1	5%	1%	<1%
Priority 2	55%	21%	17%

Most investigations initiated outside of expected timeframes occurred for Priority 2 assignments.

RE-REPORT OUTCOMES

Out of the 11,343 reports that were received during this review period, 1,982 (17.47%) were re-referred within six months of the initial referral. All analyzed re-referrals occurred following an initial screening decision, indicating that they were not a duplicate referral for the same initial concern. Most referrals that experienced re-referral were those that had originally received an investigation (58%). Table 13 shows the breakdown of the initial screening decision of the subsequent referrals.

TABLE 13 INITIAL SCREENING DECISION OF SUBSEQUENT REFERRALS (n=1,982)	
INITIAL SCREENING DECISION	**%**
Screen in for DR	11.10%
Screen in for investigation	58.17%
Screen out	30.73%

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Slightly more than half of the subsequent referrals were screened in for investigation (59%). Table 14 shows the breakdown of the subsequent screening decision.

TABLE 14 SUBSEQUENT SCREENING DECISION FOR RE-REFERRALS (n=1,982)	
SUBSEQUENT SCREENING DECISION	**%**
Screen in for DR	<1%
Screen in for investigation	59%
Screen out	41%

Table 15 shows initial screening decisions broken down by subsequent screening decisions; orange-shaded cells indicate the percentage of cases where the subsequent decision differed from the initial one. About 59% of the initial referrals, regardless of the initial screening decision, were screened in at the time of re-referral. About 41% of the initial referrals, regardless of the initial screening decision, were screened out at re-referral. This suggests that subsequent referrals may truly be treated as new referrals regardless of the previous screening decisions.

TABLE 15 INITIAL VERSUS SUBSEQUENT SCREENING DECISION (n=1,982)		
INITIAL DECISION	**SUBSEQUENT DECISION**	
	SCREEN IN	**SCREEN OUT**
Screen in	59%	41%
Screen out	59%	41%

Note: Screen in includes DR or investigation.

Table 16 shows the a breakdown of screen-in type for both initial and subsequent referral screening. Among initial DRs, 69% were screened in for investigation at re-referral, a rate higher than initial screen-outs (59%). Being screened in at re-referral for investigation rather than DR (again) indicates there was a higher level of concern that met thresholds for a more intensive response as investigation. This may indicate a limited threshold for initial DR to prevent subsequent referral and/or investigation.

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TABLE 16 SUBSEQUENT REFERRALS OF INITIAL SCREENING DECISION (n=1,982)			
INITIAL SCREENING DECISION	**SCREEN IN FOR DR**	**SCREEN IN FOR INVESTIGATION**	**SCREEN OUT**
Screen in for DR	1%	69%	30%
Screen in for investigation	0	57%	43%
Screen out	<1%	59%	41%

CONCLUSION

The current CQI process will gather and review comparable data on a quarterly cycle. Between these cycles, key data and insights will be shared with DCFS and CACD to facilitate ongoing conversation about how to best support and strengthen hotline practice.

The current CQI review of hotline practice highlighted several strengths and practice opportunities at each part of the screening process. These are shown in Figure 13.

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Figure 13
Practice Strengths and Opportunities from April to June 2026 Review Period

General Screening Process	Practice Strengths	Practice Opportunities
Referral initiated via phone or MRP.	Operators keep a steady pace during calls, and all demonstrated **professionalism and confidence** in screening.	**Address technological barriers that** slow down screening process and contribute to de-coupling of decision making and assessment/system use.
Information gathered by operator.	Almost all referrals document **concerns, alleged victim/offender relationships, and history** searches sufficiently.	Strengthen documentation of **protective capacities and environmental concerns** would strengthen concern description.
Screening decision made with support from SDM hotline assessment.	Most reviewed referrals had accurate alignment between **documented concerns and hotline assessment selections**.	Update assessment or practice guidance on screening **sexual abuse/exploitation concerns**, which made up half of the errors noted in referral reviews.
Decision finalized and next steps initiated for screened-in reports.	Allegations were generally **assigned to the appropriate agency** (DCFS/CACD). Average investigation initiation timeframe **aligns with priority assignment.**	Address practice gaps that may contribute to higher-than expected **rate of override use** for screen-outs. Ensure applicable referrals have consistent **documented supervisor review**.

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APPENDIX

Below are the types of methodology used for each of the hotline CQI priorities.

PROCESS COMPONENT	PRIORITIES	ADMIN DATA	REFERRAL REVIEW	OBSERVATION
Referral initiation	Are calls received/responded to promptly?			✓
	Are staff prepared to conduct screening?			✓
	Are there workplace barriers to screening?			✓
Information gathering	Is sufficient information gathered during screening?	✓	✓	✓
SDM hotline assessment	Is the hotline assessment completed accurately?	✓	✓	✓
	Are overrides used with appropriate justification when making screening decisions?	✓	✓	✓
Decision and next steps	Are screening decisions accurate and consistent?	✓	✓	
	Are reports assigned to the correct agency?		✓	
	Does appropriate supervisory review occur for screening decisions?		✓	✓
	Are decisions made promptly?			✓
	Are screened-out reports returning to the system through re-reports?	✓		

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