
Unified Child and Youth Safety Implementation Plan for Oregon

Nathan Rix, Director of Executive Projects

Office of the Director and Policy, Department of Human Services

Author Note

We commend the Tribes and our community partners for their continued contribution to the culture transformation that is happening within Oregon's Department of Human Services (DHS) to put children and youth and families at the center of agency services. We commend all DHS staff, especially case workers, who care deeply about child and youth safety and are committed to finding every child a safe and permanent home.

Acknowledgements

This implementation plan responds to the Public Knowledge independent review of child and youth safety in Oregon's substitute care system conducted between February and September 2016 at the behest of the Governor, in coordination with numerous Oregonians, institutions, providers and families and research groups. The plan benefited from review by many community partners:

- Youth who received DHS substitute care services
- Current certified foster care families and related organizations
- Caretakers licensed by the Department of Human Service and community partners that contract with the agency
- Oregon Judicial Department
- Citizen Review Board members
- DHS case workers, supervisors and program management staff in the Child Welfare Program and Office of Adult and Abuse Prevention Program
- DHS Executive Leadership
- Oregon legislators

Existing reports, policy and law reviewed and referenced includes but is not limited to:

- 2005 NRCCPS Expert Review of the Safety Intervention System
- 2008 Sensitive Review Committee Report
- 2009 Foster Care Safety Final report
- 2011 Governor's Task Force on Disproportionality in Child Welfare - Final Report
- 2011 Sensitive Review Committee Report
- 2012 Sensitive Review Committee Report
- 2013 NRCCPS Expert Review of the Safety Intervention System
- 2014 Oregon Child and Family Services Plan 2015-2019
- 2014 ORS 418.485 and 418.580 Report to Legislative Assembly for 2014 Strengthening, Preserving and Reunifying Families Programs Department of Human Services
- 2014 Joint Interim Task Force on Juvenile Court Dependency Proceedings - Final Report
- 2014 Sensitive Review Committee Report
- 2015 Legislative Commission on Indian Services Government to Government Report
- 2015 Oregon Home Study Audit Findings
- 2016 Oregon Child Safety in Substitute Care Independent Review
- 2016 U.S. Department of Health and Human Services, Administration for Children & Families, Children's Bureau: Child and Family Services Review, Oregon Final Report

The implementation plan was prepared by Nathan Rix and Jeannine Beatrice of the Department of Human Services, Director's Office. For more information, please contact:

Nathan Rix, Executive Projects Director
500 Summer St NE E15
Salem, OR 97301

Nathan.K.Rix@state.or.us
503-302-5212

Table of Contents

Overview Page 4
Problem statement and purpose Page 5-6
Plan methodology Page 6-7
Governance Page 7
Business objectives Page 7-9
Goal 1 Page 10-16
Goal 2 Page 16-20
Goal 3 Page 21-24
Goal 4 Page 24-30
Goal 5 Page 30-35
Resource requirements Page 36-38
Proposed plan schedule..... Page 38
Risk management plan Page 39
Glossary Page 40-41
Document control history Page 41

Overview

The Unified Child and Youth Safety Implementation Plan will enact organizational change throughout the child and youth safety system in order to put children and youth at the center of Department of Human Services' service delivery. Implementation project work will cross the department and seeks to cultivate responsibility for children and youth safety beyond the Child Welfare Program. It is built upon trauma informed and race and culture informed principles, with youth and families in the center. In achieving the goals and business objectives, each project within the plan will engage a broad range of partners in an inclusive and transparent way. These partners will include but not be limited to foster youth and certified foster care families, other licensed providers, and Tribes and community groups. The portfolio of projects will be run out of the Department of Human Service Director's Office.

Keywords: child safety, youth safety, substitute care services

Unified Child and Youth Safety Implementation Plan for Oregon

The Unified Youth Safety Implementation Plan¹ for Oregon aims to achieve five strategic goals:

1. Build trust between DHS, certified families and licensed child caring agency providers, and youth receiving DHS services;
2. Ensure child and youth needs are considered when delivering services, especially substitute care placement decisions;
3. Ensure swift, safe and comprehensive response to reports of child abuse;
4. Cultivate a youth-centered, safety-first culture within the DHS;
5. Retain, train, develop and recruit for certified families and licensed child caring agency providers that meet or exceed the applicable standards for substitute care providers.

Business objectives support each goal and project work will be supported with a specified scope, deadline and dedicated resources. All project work will be complete by December 2018.

Problem statement

Since 2004, reports, reviews and various other forms of feedback have been given to the Department of Human Services (DHS) to ensure safety and success for Oregon's youth, families and vulnerable populations.² This feedback nearly always contained recommendations that directly and indirectly impact the safety and well-being of youth in substitute care.³ In many cases, some action was taken in crisis situations. In too many cases, recommendations were not implemented or leadership did not sustain change efforts. Full consideration was not given to the systemic impacts of policy and operational changes and the result is an unharmonious system child safety system. Only recently has agency leadership begun to identify and respond to critical child and youth safety needs in a systematic and transformative way.⁴ The new leadership at DHS assumes that the component parts of the youth safety system must harmonize a chorus of stakeholders that put Oregon youth, children, and families at the center of substitute care.⁵

¹ This is a living document that will be updated at least every six months. Additional goals and business objectives may be added as the needs and priorities shift. Status reports will reflect progress toward the goals of the plan.

² DHS provides these reports, in their entirety, to the public through its website.

³ The number of children and youth with substantiated reports of abuse in care has stayed steady around 100 for the past four years (Public Knowledge 10). As far back as September 2009, Child Welfare began to strategically refocus its efforts to aggressively reduce youth abuse and neglect, beginning with the youth in state substitute care. The Foster Care Safety Team (FCST) determined in 2009 that communication and documentation of work were two of the three primary issues that must be resolved in order to move toward ending abuse in foster care. The third issue was field district work load. The team recommended placing the highest priority on addressing these issues, but no statewide implementation plan was developed to make forward movement on this recommendations.

⁴ DHS Director Clyde Saiki's October 3rd, 2016 memo to Governor Brown describes the progress made since the new leadership was established in November 2015. Improvement actions range from establishing a 24/7 "Foster Parent Support Line" to equipping DHS protective service workers with smart phones to assist with communication and documentation for Karly's law.

⁵ Former foster youth and advocacy organizations that represent foster youth and foster families have reported since at least 2014 that policy and operational recommendations have not been sufficiently addressed by the agency and integrated into practice in order to keep youth and families at the center of practice.

Purpose

The Governor and DHS Director commissioned this plan to develop tangible, strategic goals to speed up and scale up work that is creating a safer system for children, youth, and families and remove barriers with DHS divisions that do not contribute to child safety. This plan assumes that safety is more than the absence of abuse. It also assumes that the agency is trying to build a best practice and sustainable system that keeps children and youth safe. Within two years, our intent is to improve how multiple parts of the child and youth safety system effectively engage one another to ensure child safety is managed. The work described in this plan will complement rather than compete or supplement the strategic plan development led by the DHS Child Welfare Director. It will reflect the vision of the DHS Director and Child Welfare Director and ensure that DHS, Tribes, and community partners are unified around child safety.

Plan methodology

This implementation plan was developed using the Public Knowledge Child Safety in Substitute Care Independent Review,⁶ input from foster youth and the partners and foster families that care for them,⁷ related and relevant youth safety reports, Critical Incident Response Team (CIRT) reports⁸ and recommendations from staff at all levels within the agency and external stakeholders.⁹ The Casey Family Foundation and agency executive leadership who are already implementing related projects have also shaped the plan.¹⁰ Project work will be developed and tracked in a project plan document, which will be made publically available.

The goal of this plan is to provide a laser focus on safety across DHS, putting children and youth safety first. Implementation project work will cross DHS programs and seeks to cultivate responsibility for safety beyond the Child Welfare Program. The Oregon Health Authority is a critical partner for providing mental health services and for higher level of care placement capacity and approval/access (PRTS, Sub-Acute, SCIP and SAIP). The Oregon Youth Authority is a partner in Behavior Rehabilitation Services. Each project will be built upon

⁶ The Public Knowledge Child Safety in Substitute Care Independent Review analyzed comprehensively the substitute care system and submitted recommendations to the DHS Director on September 13, 2016. <http://www.oregonchildsafetyplan.org>.

⁷ This implementation plan was built using substantial community input. For example, the plan reflects policy recommendations created by former substitute care alumni through the Oregon Foster Youth Connection. It captures opportunities posited by the Governor's Task Force on Disproportionality in Child Welfare, which highlighted serious injustice and economic ramifications of having communities of color overrepresented in Oregon's substitute care system. Finally it integrates the Oregon Judicial Department's Citizen Review Board's affirmation of the independent review findings, which represents a broad spectrum of perspectives from over seventeen (17) counties.

⁸ Project work in this plan is also based on internal analysis of CIRTs related to children in substitute care who have died from 2004 to 2015. Dominant themes in this analysis revealed improvement needed within DHS culture, education and training for staff, oversight and standards redesign, process improvement, support and training for substitute care families, recruitment and retention of providers and families, IT systems improvement and system resources to provide relief for DHS protective service workers.

⁹ In the last quarter of 2015, a Behavior Rehabilitation Services Committee performed a standards review and also proposed changes in program design. Implementation of the recommendations are in varying degrees. Funding for BRS providers is being addressed through a Policy Option Package (POP) in the 2017 Legislative session. The DHS Office of Continuous Improvement has provided business process mapping, gap analysis and support for the Child Welfare Program's safety-related initiatives since Summer 2015.

¹⁰ Many initiatives to put youth and family at the center of DHS business are already underway within the agency, specifically in the Child Welfare Program. The work in this plan will reflect existing work by the Child Welfare Program to assure the safety of children and youth and meet federal reporting requirements, including those in Oregon's Program Improvement Plan (PIP) currently being developed to achieve the five year strategic Child and Family Services Plan (CFSP). The Executive Projects team and Child Welfare division will align work when it is related and relevant to avoid duplication.

trauma-informed and race and culture informed principles. Project portfolio management will be used as the day-to-day tool to ensure the goals are achieved.

In taking an open posture, this plan does not pretend to have all the answers. Rather each project that supports it will have a place for partner input. The project steering committee, project portfolio director, and project managers welcome comments and reflections on this vital work.

Governance

The primary governance body for this work will be the Unified Child and Youth Safety Steering Team. They will provide oversight and adherence to goals and will monitor and control projects. It will include but is not limited to the following representatives: former foster youth, different types of substitute care providers, tribal leaders, staff from other related and relevant programs, such as Intellectual and Developmental Disabilities Services, members of past and existing legislative and executive task forces related to youth safety and well-being, Oregon legislators, the Oregon Health Authority (OHA), DHS field staff, DHS Executive Projects Director, DHS Child Welfare Director, DHS Chief of Staff and DHS Director. Members will be appointed by the DHS Director.

Large-scale internal change is a necessary but alone insufficient tool to improve the culture of safety across state government that Oregon youth deserve. To meet the goals of this plan, the state must address larger structure problems in the designs of its education, workforce, and safety net systems. The DHS will work closely with the Governor's Office and Legislature to procure funding, garner public support, and change laws if necessary in order to ensure the safety of youth.

Business objectives

This plan is organized around goals, which are supported by business objectives. Business objectives will be supported by project work. Each project will have a scope, schedule and a person ultimately responsible to ensure that work is completed. A team of project managers from the Director's Office will utilize consensus building techniques and convening authority to drive work forward in coordination with existing staff, Tribal representatives, and an array of community partners.

The business objectives will achieve the following goals:

1. The following three strategic objectives will build trust between DHS, certified families and licensed child caring agency providers, and children, youth, and families receiving DHS services.



All project work toward this goal will be complete by December 2018.¹¹ The objectives are listed here:

- Develop and implement a partnership engagement plan with certified families, youth, providers, Tribes and other key partners by December 2017
 - Develop and implement an internal and external communication plan for implementation plan changes by December 2017
 - Implement a comprehensive training, development, recruitment and retention plan for DHS case workers and supervisors by December 2018
2. Pursuing the following two strategic objectives will achieve the goal of ensuring child and youth needs are considered when delivering services, especially substitute care placement decisions. All project work to achieve the business objectives will be complete by Summer 2018. The objectives are listed here:
 - Adopt criteria and implement an assessment tool to determine the appropriate level of care for youth in placement decisions by Summer 2018
 - Develop and apply effectively Oregon's continuum of care for providers and foster care families by Summer 2018
 3. Pursuing the two objectives below will ensure swift, safe and comprehensive response to reports of child abuse. All project work to achieve the business objectives will be complete by Summer 2018. The objectives are listed here:
 - Redesign the process of responding to allegations of abuse using a department-wide approach by Summer 2018
 - Make a decision about centralized hotline operations and enhance standard protocols for screening by Summer 2018.
 4. The following four strategic objectives will cultivate a youth-centered, safety-first culture within the DHS. All project work to achieve the business objectives will be complete by December 2018. The objectives are listed here:
 - Streamline caseworker tasks and maximize time spent on family engagement and child and youth centered relationships by December 2018
 - Develop and apply a proactive and safety-oriented *case management practice* led by case workers in collaboration with youth, family, Tribes (when applicable) and community partners by Summer 2018
 - Develop and implement an employee engagement plan to cultivate shared ownership and accountability for youth safety among DHS staff by Spring 2018
 - Develop and implement data-driven decision making processes for use across the child safety system by December 2018
 5. The four objectives below will retain, train, develop and recruit for certified families and licensed child caring agency providers that meet or exceed the applicable standards substitute care providers. All project work to achieve the business objectives will be complete by December 2018. The objectives are listed here:
 - Develop and implement a child and youth focused, compliance philosophy with substitute care providers and families of origin by Spring 2018

¹¹ The Public Knowledge independent review recommended increasing provider rates for all provider types. This implementation plan creates project work that is broader than merely increasing provider and family foster care rates, in recognition that partnerships are not limited to providers and include foster care families. Both of these partnerships rely on mutual trust in order to ensure that youth safety are the top priority.

Unified Child and Youth Safety Implementation Plan

- Develop and implement a substitute care retention, training, development and recruitment plan that applies a foster care family lifecycle model in coordination with community partners by Summer 2018
- Develop and implement data-driven placement plan for substitute care by December 2018
- Improve certification and licensing processes for providers and certified foster care families without sacrificing accountability by Summer 2018

Analysis of Goal 1 with supporting business objectives

Pursuing the following three strategy objectives below will build trust between DHS, certified families and licensed child caring agency providers, and youth receiving DHS services. Project work will begin immediately and will be complete by December 2018.

- Develop and implement a partnership engagement plan with certified families, youth, providers, Tribes and other key partners by December 2017
- Develop and implement a communication plan with children, youth, families, providers, Tribes and other key partners by December 2017
- Implement a comprehensive training and development plan and a recruitment and retention plan for DHS case workers and supervisors by December 2018

Develop and implement a partnership engagement plan with certified families, children, youth, providers, Tribes and other key partners by December 2017.

By certifying foster care families and licensing providers, DHS extends state responsibility to ensure children and youth safety in substitute care. Furthermore the agency maintains regulatory oversight over them to ensure that youth safety are the paramount concern, which has been enhanced by recent legislation.¹² While pockets of great collaboration exist between DHS and community partners,¹³ providers, foster care families and youth, the Public Knowledge independent review revealed strained and failed partnership engagement by DHS.¹⁴

Thematically, the Public Knowledge third party report showed DHS' failure to communicate effectively at critical junctures. For example, focus groups revealed that foster parents often received little information on children and youth prior to placement, including mental health history and emotional triggers.¹⁵ In 2015, CIRTs revealed that DHS failed to effectively communicate the complexity of a child's medical issues to caretakers. Tense relationships can also develop between providers and DHS, which can prevent the free-flow of information.¹⁶ Not all statutorily required CPS assessments are delivered to the Citizen Review Board (CRB), as required by statute, creating a gap in monitoring and missing opportunities for the improvement of cases among community partners.¹⁷ In this environment, the fabric of trust is frayed, with little slack for working through problems systematically.

¹² The 2016 Oregon Legislature enacted two bills addressing the safety of youth. First, SB1515 created stronger accountability mechanisms between DHS and substitute care agencies. Second, HB4080 established the Governor's Child Foster Care Advisory Committee to craft program recommendations.

¹³ The DHS and Portland Leadership Foundation's Embrace Oregon partnership has grown in size considerably over the past four years. From 2015 to 2016, Embrace Oregon saw foster care inquiries increase 175% and volunteer inquiries increased 348%. Embrace Oregon, a faith-based organization, was recently awarded a grant by DHS to expand their support work for field offices and foster families.

¹⁴ The Jackson County Foster Parent Association reports that foster families are often given less than 24 hours' notice when a youth will be removed from the foster home for adoption. Likewise the foster parents are often left out of the youth's transition planning. This breaks down trust and can prevent the agency from retaining excellent foster families in the future. Public Knowledge recommended that the agency create a statewide recruitment strategy for foster families. In the last quarter of 2016, the Child Welfare Division began this work and is described in more detail within a later section of this plan.

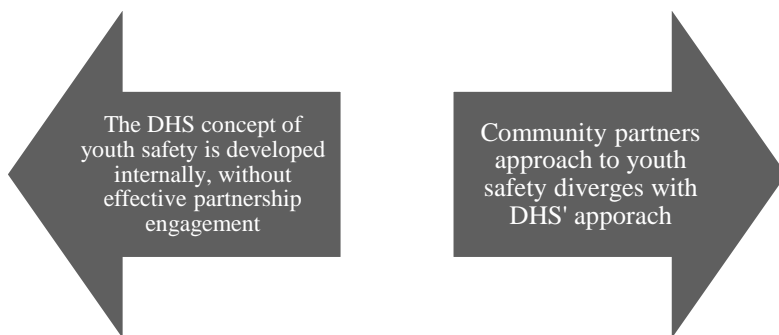
¹⁵ Evidence includes youth feeling like foster care families, providers, and DHS caseworkers are not hearing their concerns. Also, the Jackson County Foster Parent Association estimates that 70% of foster parents feel they are only sometimes or never a valued member of their foster youth's "Team." In the 2016 Oregon Foster Youth Connection Policy Recommendations, former foster youth alumni feel left out because they are unsure of where they stand with their new home and foster parent. In 2014, former foster youth alumni described being seen as a statistic rather than individuals within the substitute care system.

¹⁶ The agency did not effectively implement SB1515. To date, definitions of abuse across the youth safety system are not aligned, but SB 243 (2017 Legislative Session) was proposed to fix this issue.

¹⁷ Public Knowledge (59). While DHS does effectively involve the CRB when a youth is brought into the substitute care system, CRB does not receive dispositions from the abuse hotline. The CRB and judges involved in youth cases receive little training from DHS about how to

This plan proposes projects to implement a partnership engagement plan between DHS, Tribes, providers, foster care families and youth receiving DHS services. For DHS staff, work to reimagine and better resource partnerships require DHS staff at all levels to take an open posture to new concepts and ideas for achieving youth safety and addressing the needs of a child holistically.¹⁸ Project work to achieve this may include standardized training on collaborative problem solving for caseworkers¹⁹ and managers. It may also include creating DHS district-level community roundtables charged with identifying what is working and what is not working among DHS, youth, and foster families and providers.²⁰ Work under this objective will support agency-wide work already underway to provide administrative relief for current caseworkers with high caseloads²¹ and efforts to secure funding from the Oregon legislature for legal representation in court cases. Project work will also develop and implement new processes to hold caretakers accountable for youth safety, based on a clearer understanding of the roles and responsibilities of all community partner’s role in a youth’s life. Cumulatively, these approaches will enable caseworkers to spend more time on the vital work of building relationships with caretakers.

Current model: The DHS and providers and families often do not agree on how to ensure child and youth safety and the voice of youth receiving DHS services has often been absent.



Proposed redesign model: Mutual trust exists between all of the partners that engage with the DHS system of care. The change in approach and intentional engagement ultimately fosters the safest service for children and youth.

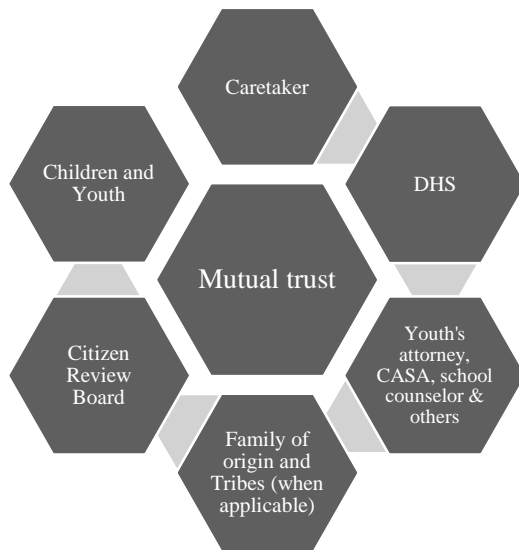
best interact with the agency. The CRB affirmed many of the Public Knowledge recommendations in a December 9, 2016 letter to Oregon Governor Brown.

¹⁸ Consistent feedback the agency hears from community partners is the power differential in the certified foster home and DHS relationship. A healthy relationship between DHS and a certified foster home is where each member of a foster child’s team feels that their input is valued. The medical needs of a child must be communicated to the caretakers.

¹⁹ This stems from a July 19th, 2016 policy recommendation to improve the quality of foster homes and providers. It was developed by Oregon foster youth alumni in coordination with the Oregon Foster Youth Connection. The Governor’s Task Force on Disproportionality in Child Welfare discusses the human impact—the cost of voices lost and cost of instability and losing a sense of cultural identity. Child Welfare has some limited experience with collaborative problem solving through a partnership with OHSU. Cost and capacity by OHSU to deliver training is a barrier that the agency will need to overcome to meet this objective.

²⁰ The Governor’s Task Force on Disproportionality in Child Welfare discusses at length the root causes of racial disproportionality. Community-based solutions, where Oregon communities and DHS influence one another in a reciprocal way, a first step to overcoming the challenges of structural inequalities such as culturally-bias decision making, external disparities such as poverty, access to health care and inadequate education, and a lack of diversity in the DHS workforce. The agency will look to the community is assist with improving the cultural responsiveness of the system and eliminate disparities.

²¹ An agency-wide work group convened to develop recommendations to reduce the administrative burden on case workers in order to increase their face-to-face time with youth and families.



Develop and implement an internal and external communication plan for implementation plan changes by December 2017.

Historically, DHS has ineffectively communicated “with one voice” to foster care families, providers, Tribes and community partners. Only recently has the DHS begun implementing internal and external communication that is clear between DHS programs, Tribes and our community partners.²² Where participation was encouraged in the past, the primary focus was on following up on mandated reports of child abuse and lawsuits rather than an engagement-based approach, where stakeholders impact the agency’s approach to broad-based organizational change.²³ Most broad-based communication responded to crisis-events,²⁴ but did not address how agency responses to crises related to the whole child and youth welfare system, nor did they cultivate an urgency around the agency’s mandate to put youth first. In fact, analysis of CIRTs from 2004 to 2011 revealed the persistent theme of insufficient communication, sharing of data and coordination between appropriate partners.²⁵

Likewise there was no communication between Child Welfare and OAAPI around rules alignment, operational and policy changes, at the field or central level. An analysis of CIRTs from 2004 to 2011 also revealed a lack of follow-through and documentation among DHS investigative staff.²⁶ Currently, there is no internal or external comprehensive communication

²² Some districts do engage in regular interaction with external stakeholders. Likewise, DHS has utilized communication and participation strategy to vet ideas and generate recommendations. These have primarily been done without a partnership engagement model where ideas are generated from the ground up.

²³ Under recent leadership that is attempting to change how the agency engages with stakeholders, the statewide self-assessment was completed in conjunction with the Round 3 CFSR and stakeholders were involved in the development and review of the assessment prior to submission. During the staged rollout of Differential Response, over 100 internal and external stakeholders were involved but this did not cohere around a statewide, uniform vision for youth safety.

²⁴ An exception here is the extensive internal and external communication related to the implementation of Differential Response.

²⁵ This included probation officers, caseworkers, social service assistants and CPS.

²⁶ Of the twenty-two reports during the time period analyzed, ten were “Closed at Screening” and nine were assigned for a Child Protective Services assessment. Three referrals were addressed as part of already pending CPS assessments.

strategy or plan that describes how these three divisions will communicate information out to community partners and the public in a transparent and expeditious way. Community partners also report that they have trouble communicating constructive organizational change because it is difficult to understand from the existing DHS website how the youth safety system works. Community partners report that their process redesign and policy proposals to better provide for youth safety have not been adequately addressed by the agency.²⁷

For the implementation plan work to be successful, the agency needs to respond thoroughly and in a timely manner to all reports of abuse. There needs to be trust building, mutual understanding and an optimally user-friendly processes in place with community partners. Project work under this goal will resolve the known root causes related to internal and external communication that have contributed to children’s death in substitute care. Internally, this will overlap with training and development of screeners and caseworkers and the overall goal to orient the DHS culture around putting child safety first. The plan will also propose an open and transparent, coherent communication strategy to optimize trust between the agency, Tribes and community partners. The process redesign and training and development of internal staff assumes involvement of providers, families, Tribes and organizations that contribute to youth safety in substitute care. In fact, the agency will rely on stakeholders to be ambassadors to their respective organizations and communities.²⁸

The communications plan for this project will seek to implement long-standing recommendations from Tribes and community partners to improve communication, not only in Child Welfare but across other programs areas that are also responsible for ensuring child and youth safety.²⁹ All information for project work will be publically available on a dedicated DHS website. Materials will be developed for each work stream, such as the hotline centralization process or redesigned process for responding to abuse. They will be written in plain language. Regular updates for opportunities to engage will be central to the plan.

Current model: DHS does not “speak with one voice” as it relates to the child and youth safety system. Information about change in one program area may be misunderstood internally and externally.

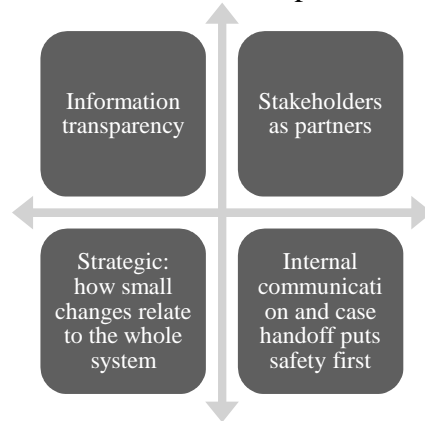


²⁷ Interviews with foster families and former foster youth indicate a strong desire be included in decision making processes. The Public Knowledge report described the current DHS practice as having a “culture of disbelief” toward youth in the substitute care system in which the youth’s experience and voice is discounted in making decisions (Public Knowledge 35).

²⁸ For example, communication will need to be surgical enough to penetrate close-knit organizations that may not be following DHS system change efforts underway and widespread enough to ensure that mandated reporters know how to report abuse immediately.

²⁹ Including the Public Knowledge report, 2009 Foster Care Safety Team recommendations and Governor’s Task Force on Disproportionality in Child Welfare.

Proposed model: DHS staff, Tribes and community partners across the child and youth safety system understand department-wide programmatic changes. DHS engages and empowers children, families, Tribes and community partners in transparent discussions regarding concepts for implementation. DHS removes communication-related barriers between programs and within programs that have contributed to unsafe placements and in the worst cases, death in care. Communication is clear and two-way. For example, partners know new processes for DHS’ response to allegations of abuse, how to respond and where to engage.



Implement a comprehensive training, development, recruitment and retention plan for DHS case workers and supervisors by December 2018.

Building trust between the department, Tribes and community partners means that everyone at DHS holds a common understanding of the agency priorities and the centrality of child safety therein. Currently, training, development, recruitment and retention within the agency are not strategically interrelated in a way that promotes accountability and good case management practice.

Training for incoming caseworkers and related staff is centrally managed and broad-based.³⁰ However, an analysis of CIRTs from 2005 to 2015 reveals that training is helpful but ultimately insufficient to sustain the multifaceted and complex work of case management over time. More specifically, the analysis of CIRTs revealed that critical safety concerns identified, specifically domestic violence history and previous history of child abuse, which were not accounted for and addressed in a child’s safety plan.³¹ Reviewing CIRTs from the same time period also revealed training improvements needed for inter-districts management, adequate use of and documentation of face-to-face contact with foster youth, and how to share data with community partners. Furthermore, the Public Knowledge independent review recommended that DHS should review best practices for improving worker recruitment and retention and adopt a strategy to increase retention by addressing some of the common barriers and issues causing workers to leave their positions.

³⁰ Portland State University developed a centralized training curriculum for new caseworkers through their first year only. There are three modules: Fundamentals of Child Welfare, which introduces staff to an array of social issues in youth safety, the Life of a Case, which introduces the Oregon Safety Model, and Trauma Informed Practice Strategies (TIPS), which aims to inculcate the impact of trauma on youth and families. The new iteration of this training will be deployed July 1, 2017.

³¹ The agency took action to provide training in this area in 2005, but it continues to be a significant ongoing finding across CIRTs.

Ongoing training is under-resourced and under-promoted across the department. Ongoing training is required only on an ad-hoc basis, in compliance with some federal, state and practice changes. There are limited training opportunities specific to meeting the child's racial or cultural needs, sexual orientation or disability needs. This puts a heavy burden on other caseworkers, district managers, program managers and supervisors to train staff.³² Some districts have an on-boarding process that includes mentorship and joint fieldwork. DHS Child Welfare managers attribute high caseworker turnover to the inherent difficulty of case work and general need for additional staff to relieve existing case workers.³³ These challenges contribute to a fragmented understanding of DHS priorities and how the department defines child safety.

Furthermore, there are few development opportunities for case managers and supervisors.³⁴ On-the-job learning continues to be the primary source of continuous improvement among caseworkers in DHS districts. Districts offer professional development opportunities; ambitious caseworkers may proactively pursue one-off conferences or seminars on their own.³⁵ The lack of ongoing development among caseworkers statewide leads to a fragmented case management practice.³⁶ Some district managers, program managers, and supervisors express they need to de-prioritize staff development because caseworker loads are too heavy. Without effective development, it is difficult to sustain morale around DHS safety priorities for children, youth and families.

The work under this business objective will develop and implement a statewide training, development, recruitment and retention plan to sustain case workers and supervisors across the department.³⁷ Training for caseworkers will enhance the child safety plan and ongoing development will develop accountability at all levels, to prevent internal communication from being a barrier to child safety. It will also bridge gaps in training around Domestic Violence and the failure of follow through in documentation, as identified by analysis of CIRTs. These will be comprehensive plans that promote supervisor accountability, case worker resiliency, and local community partnership engagement. Project work will also consider how to optimally apply the skillsets of central office consultants who are embedded within field offices.³⁸

³² The PSU redesign is providing supervisory support to facilitate this.

³³ Central office consultants embedded in the field provide training, coaching, support, review of work, and assistance with policies and procedures, but it is unclear if their use is being maximized. Last biennium Child Welfare was staffed at 67% of what it would take to do the work to fidelity using the current practice model. This biennium, Child Welfare is staffed at approximately 82% of what it would take to do the work to fidelity using our current practice model.

³⁴ Public Knowledge (63). A training agreement between DHS and Portland State University does provide for some training by consultants, but it is unclear how often this is promoted, utilized, or how effective it is.

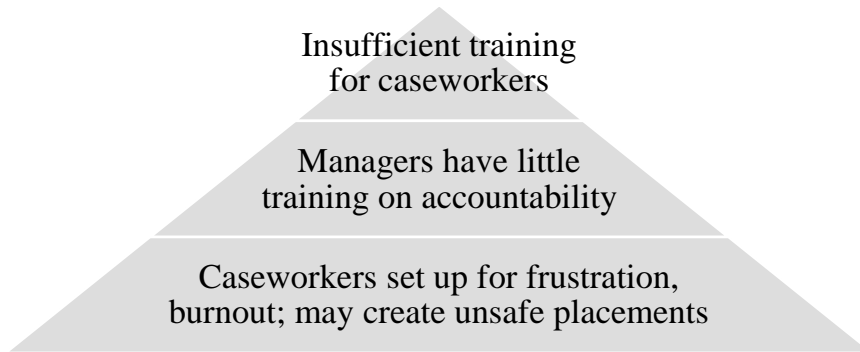
³⁵ All districts have local training funds for staff, but there is no statewide plan for ongoing training and development. The agency also supports the CWEP program, which provides tuition support for BSW and MSW degrees.

³⁶ Centralized and standardized training only exists when a case worker or manager is first hired.

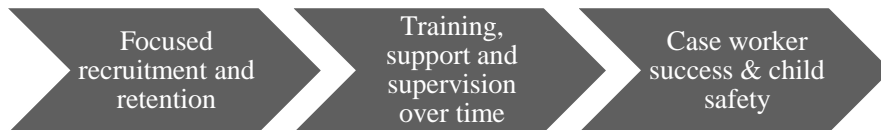
³⁷ DHS is currently undergoing a training redesign to better align core competencies, learning objectives and key content with current case practice. Portland State University will deliver the redesigned curricula in the second quarter of 2017. It focuses exclusively on a caseworker's first year of work. However new processes and policy that results from better communication and community engagement as well as new laws from the 2017 Legislative Session may necessitate updating the curricula again. In districts that have implemented Differential Response, there is an additional standardized series of trainings Child Welfare staff receive. This includes: one half day DR orientation, one half day of Advanced Family Engagement & Trauma Informed Practice, one half day partnership and collaboration (includes community partners & SSP), one full day Screening (just screeners & management), one full day CPS assessment (just CPS & management) and one full day Family Strengths and Needs Assessment for providers.

³⁸ For example, the agency has roughly 30 safety consultants imbedded in the field offices. There are four well-being (certification/foster care) consultants that are based out of central office.

Current model: Central training is broad-based and the practice of managing cases is largely learned “on the job.”³⁹ Failing to train and develop caseworkers effectively means children and youth receiving DHS services experience high turnover – and in the worst cases, may suffer injuries or die in care.



Proposed model: Training, development, recruitment and retention strategy drive caseworker success in the field. Accountability, increased engagement and a comprehensive understanding of what it means to be safe among caseworkers exists at all levels.



Analysis of Goal 2 with supporting business objectives

Pursuing the following two strategic objectives will ensure child and youth needs are considered when delivering services, especially substitute care placement decisions.⁴⁰ All project work to achieve the business objectives will be complete by Summer 2018.⁴¹

- Adopt criteria and implement an assessment tool to determine the appropriate level of care for youth to use before placement decisions by Summer 2018
- Develop and apply Oregon’s continuum of care for providers and foster care families by Summer 2018

³⁹ DHS does offer “field follow-ups” led by PSU and field embedded safety and permanency consultants from the central office. For those that take advantage of it, new staff work through an entire CPS assessment. Field follow ups are not standardized across the system, nor are they well-promoted among DHS caseworkers.

⁴⁰ If a youth needs to be removed from a home, the Child Welfare Program strives to place her or him with related family first. Likewise the agency makes every effort to keep siblings together. These approaches are best-practices that are well-supported by scholarly and field research. Both of these approaches also align with the policy and operational priorities of former foster youth.

⁴¹ The Public Knowledge independent review recommended increasing provider rates and foster care family rates. This implementation plan creates project work that is broader than merely increasing rates, in recognition that partnerships are not limited to providers and include foster care families. Both of these partnerships rely on mutual trust in order to keep youth and family safety the top priority.

Adopt criteria and implement an assessment tool to determine the appropriate level of care for youth to use before placement decisions by Summer 2018.

There are at least four child safety problems with the current assessment approach. First, while there are standard tools that DHS staff use to determine youths overall needs, DHS staff and community partners report that they are not applied effectively or uniformly across the state.⁴² Second, there are too few providers to use the placement tools that are already in place.⁴³ Although placement matching is done whenever possible, many placements are made based on provider availability.⁴⁴ Third, field staff indicate that past efforts, including but not limited to Differential Response, were poorly communicated or halted before fully implemented, leaving district staff confused.⁴⁵ Fourth, there is not enough special consideration given to a youth's racial, cultural and sexual identity as well as their disability and mental health needs when making placement decisions.⁴⁶

This plan proposes to develop and apply uniform criteria which addresses the five key problems. A front-end assessment tool will support caseworkers and teams to determine the intensity, duration, and with the intention to place a child or youth in the least restrictive environment possible before a placement is made. Downstream, it will assist DHS to balance between individual clinical need and resources available across the state. The tool will need to indicate levels of care, which ranges from basic needs to 24-hour secure medically managed services.⁴⁷ Project work to accomplish this will subsist first of taking an inventory of existing criteria and assessment tools used in heavy coordination with OHA, reviewing nationwide literature in coordination with the Office of Child Welfare Programs and the Casey Family Foundation, collecting input from community partners and Tribes at all levels. The criteria and an agreed-upon assessment tool will need to be implemented comprehensively across DHS' child safety system and related DD and OHA programs. Accountability will be implemented among supervisors and district managers to ensure fidelity to the criteria and tool. Tribes, community

⁴² The Oregon Safety Model is the primary case management tool to assess and manage youth safety. Oregon uses the Child and Adolescent Needs and Strengths (CANS) assessment after a youth is placed in substitute care and expected to remain in care for more than 21 days. An analysis of CIRTs from 2004-2015 revealed that when the model is applied effectively, the number of CIRTs can be reduced. However there are numerous serious issues that persist with how it is applied across the state. The Structured Analysis Family Evaluation (SAFE) is used to certify family foster care homes, including relative homes.

⁴³ The Public Knowledge independent report surmised that DHS has not been able to adequately put the policy into practice due to scarce resources. The Citizens Review Board report that DHS does not effectively consider a child or youth's cultural or sexual identity statewide. Over 60% of attorneys and judges surveyed by Public Knowledge noted that abuse in substitute care is sometimes or very often related to a youth being placed in the wrong level of care for their needs (18). The agency will also need to secure the commitment on the part of OHA and in some instances, DD in order to implement improvements. Oregon Administrative Rules (413-070-0625), the Child Welfare Manual and the 2007 Children's Wraparound Initiative recognize the importance and role of assessments.

⁴⁴ Public Knowledge indicated that urgency to find placements often compromises certification and licensing standards (24).

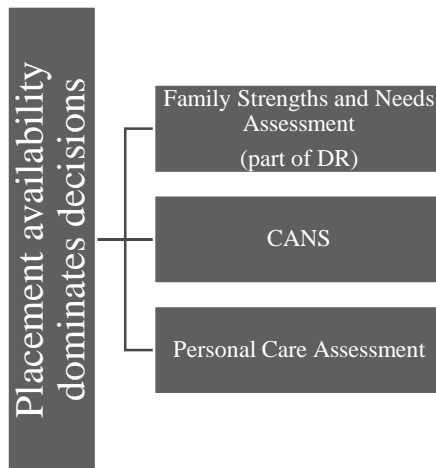
⁴⁵ In approximately half of Oregon, Differential Response (DR) is being implemented. Expansion of DR was paused in May 2016. Inconsistent application of frameworks gives a poor baseline for measurement of results.

⁴⁶ The findings of the Governor's Task Force on Disproportionality identifies the need for DHS to harness the invaluable cultural diversity that comes with culturally relevant and related placements. Furthermore, the criteria must reflect the needs and experiences of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. The Oregon Multnomah Judges Guide and social work best practices conducted outside of Oregon, such as the National Center for Child Welfare Excellence's resource department will be foundational in building the criteria.

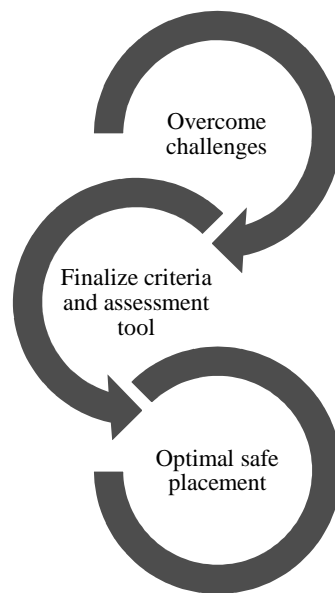
⁴⁷ One overarching challenge in developing standardized criteria for placement and assessment tool is that this level of care is contracted for and managed by OHA. It is paid for by the CCOs and each have their own requirements for approving this level of care, which can take days. Once approved for the level of care, a youth can wait weeks and even months before an appropriate placement is available. During this time, DHS must maintain the youth and is responsible for ensuring their safety and that of those around them. Partnering with OHA to resolve this challenge is included in the scope of this work. This work will also include federal placement consideration requirements for all youth, including specific requirements for ICWA eligible Indian youth.

partners and caseworkers will be included throughout this process. The work will be supported by a comprehensive training and development effort described later in this plan to transform case management practices more broadly.

Current model: Provider availability dominates placement decisions. Criteria and tools exist, but fidelity to the model is not applied statewide. Capacity is an ongoing issue that prevents adequate services from being provided.



Proposed redesign model: Uniform criteria inform a statewide assessment tool to indicate the optimally safe placement for children and youth in substitute care. Accountability exists to ensure fidelity to the tool. Critical capacity will then be developed among providers and families to sustain safe systems of care.



Develop and apply effectively Oregon’s continuum of care for providers and foster care families by Summer 2018.

The Public Knowledge independent review and other agency reports identified areas of improvement when determining if a substitute caretaker is the right fit with a youth.⁴⁸ First, CIRTs from 2012 to 2015 reveal that the Child Welfare Program may not be adequately assessing the capacity of caretakers to provide services for high-needs children and youth. Fifty percent of youth caring agencies surveyed by Public Knowledge report that youth placed in their care need a higher level of care than they are able to provide.⁴⁹ Second, providers and families do not sufficiently receive trauma-informed training and support, nor does match-making take into account the individual needs and characteristics of youth, specifically racial, cultural and sexual identity as well as the preferences and capabilities of caretakers, according to a Public Knowledge focus group.⁵⁰ Third, the foster home certification exception process is over-used⁵¹ due to the agency’s desire to place youth with relative families whenever possible.⁵² Lastly, DHS does not optimally engage with DD and OHA to employ a youth-centered continuum of care.⁵³ Failure to make a meaningful pairing may damage the likelihood of a child finding a permanent caretaker and impact a youth’s well-being in other community-based systems and impact the agency’s goal of foster family retention.⁵⁴ Overall, mismatching youth creates more risk for youth safety.⁵⁵

The purpose of this objective is to implement a range of care options that are safe for children and families.⁵⁶ Project work will consist of implementing a continuum that responds to the problems identified by the Public Knowledge report.⁵⁷ This will involve redesigning inter-agency work between DHS and OHA with youth and family at the center, such that definitions of care align in agency rule, training for staff aligns between agencies, exchanges of case information is timely, tracked and based on the services needed by the youth, not availability of providers. Project work will also redesign relevant and related processes, such that exception mechanisms are truly exceptions and that youth safety is at the center of all processes.⁵⁸ Underlying issues such as training and development, recruitment and retention of caretakers will be addressed later in the plan with Goal 4 and its corresponding business objectives. Foster care

⁴⁸ Public Knowledge (23-27). As far back as September 2009, DHS began to refocus its efforts to reduce youth abuse and neglect, beginning with the youth in state substitute care. The Foster Care Safety Team (FCST) determined in 2009 that one cause of abuse in foster care stemmed from inadequate placement matching. No action plan resulted from the report.

⁴⁹ This is partially due to OHA’s contracted mental health service and capacity issues. OAR 413-070-0625 outlines the DHS current practice around placement matching for substitute care. OAR 413-070-0110 outlines additional requirements and considerations for Indian youth. 413-070-0300 outlines additional requirements and considerations for Refugee youth.

⁵⁰ There is capacity in OR-Kids to record child characteristics a family accepts. It is not utilized at this time. There is also little transitional therapy or preparation for issues around separation and loss on both the part of the youth themselves, as reported by foster care families and related foster parent advocacy associations.

⁵¹ Child Welfare is currently working to improve timelines to completion of the full certification of these families, which will improve the safety of children in out-of-home care. This has been a challenge due to the lack of certification staff statewide.

⁵² Oregon has approximately a 30% placement rate with relatives over the past several years. Overall, there is a fairly high placement stability rate for the majority of youth in substitute care.

⁵³ Some youth can receive DD services, which are administered at the state and/or county level. OHA provides services for youth with the highest needs, such as hospitalization and residential psychiatric facilities.

⁵⁴ Public Knowledge (25).

⁵⁵ It also generates more turnover in the caretaker community, which exacerbates overuse of the exception process.

⁵⁶ The current continuum that exists begins with in-home services so youth can stay safely at home, to relative foster care, to non-relative foster homes, to crisis care, to specialized or professional foster care, to therapeutic foster care, residential and psychiatric residential treatment facilities.

⁵⁷ This will involve heavy coordination with OHA and DHS-DD.

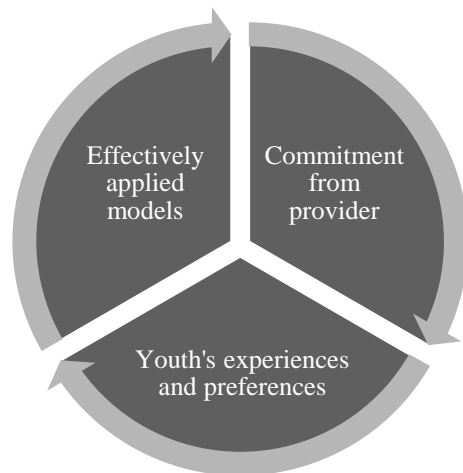
⁵⁸ This will be done with a focus on keeping congregant care numbers low and reducing Oregon’s out-of-state residential care that have recently increased.

family and community partner commitment to the continuum of care model is essential to success.⁵⁹

Current model: No continuum of care is applied uniformly when making a placement decision. Rather, provider availability drives decision-making.⁶⁰



Proposed redesign model: On the provider side, an optimal, safe placement is determined by an effectively applied continuum of care and community partners' buy-in to providing the LOC needed.⁶¹ The overall placement decision is based on a common commitment to adhering to the model.



⁵⁹ In order to make the BRS provider business model and certified family foster care more sustainable, DHS proposed a rate increase for the upcoming 2017-2019 biennium. These are first steps to creating an environment where caretakers commit to a youth-centered model. The agency is also seeking to give daycare stipends for foster parents beginning March 1, 2017.

⁶⁰ The depiction does not take into account in-home safety plans to keep youth safely served at home. Supporting families and a youth at home is the lowest level of care provided by DHS. DHS will not leave youth in unsafe environments, regardless of whether or not there is provider availability.

⁶¹ This includes standardized use of existing decision-making mechanisms, such as Family Decision Meetings and Youth Transition Meetings, in which all team members develop a plan.

Analysis of Goal 3 with supporting business objectives

Pursuing the following two objectives below will ensure swift, safe and comprehensive response to reports of child abuse. Project work will finish by Summer 2018.

- Redesign the process of responding to allegations of abuse using a department-wide approach by Summer 2018
- Centralize hotline operations and create standard protocols for screening by Summer 2018

Redesign the process of responding to allegations of abuse using a department-wide approach by Summer 2018.

Currently, the processes for responding to allegations of abuse in the substitute care system are not designed with youth and families at the center.⁶² Rather, the abuse in care definitions, associated screening and investigation procedures, and protocol for reporting critical events by licensing investigators, create a confusing and uncoordinated response system for reporting child abuse.⁶³ The Public Knowledge independent review noted that the system was so confounding that no one person understands how the whole system works.⁶⁴ An analysis of CIRTs from 2004-2015 revealed major internal communication barriers between programs and a failure to document medical neglect, domestic violence at drug use across CPS and OAAPI that prevented the agency from responding effectively to abuse.⁶⁵ Also, the analysis revealed that the relationships between department employees (CPS workers and certifiers) and some department-certified foster homes impact the objectivity of the CPS worker, the foster-home certifier, their supervisors and other managers, when determining how to address the concerns and allegations of child abuse.

Project work in this plan will fundamentally redesign the process of responding to allegations of abuse to make it faster and more effective, trauma-informed and youth and family centered. The redesign will convene experts and practitioners in child and youth abuse reporting and response, including DHS staff in Child Protective Services (CPS), Office of Licensing and Regulatory Oversight (OLRO) and the Office of Adult Abuse Prevention and Investigations (OAAPI) and agency rule and subject-matter experts to align policy, program and process, and technology with youth and families at the center.⁶⁶ Rules across the agency will likely need to be changed to align key definitions.⁶⁷ The new process should also be practically applicable for providers, foster care families, Tribes, and other community partners and mandated reporters. At

⁶² For example, the Oregon Safety Model is not designed for out-of-home care assessments. The agency needs inter-locking models that effectively prevent abuse throughout the services provided by DHS. As far back as September 2009, DHS began to refocus its efforts to reduce youth abuse and neglect. However many of these recommendations were not implemented or not fully implemented.

⁶³ The Public Knowledge report concluded that the convoluted system has led to safety information “falling through the cracks,” allowing abuse in care to continue in some cases. Public Knowledge (28). SB1515 improved this in that it explicitly requires DHS divisions to communicate with each other whenever abuse reports and contract violations that are received regarding CCAs. The 2017 Legislative Session will expand on these requirements with SB 243. Even with legislative changes, CPS has implemented the changes more effectively than OAAPI.

⁶⁴ Public Knowledge (28).

⁶⁵ Over multiple years and CIRTs, insufficient communication between DHS programs, sharing of data and coordination between appropriate partners have failed to keep children safe. Likewise comprehensive assessments and assessing child safety in cases specifically involving domestic violence have not been used effectively.

⁶⁶ The Oregon Health Authority and Oregon Youth Authority will be critical partners in completing this work.

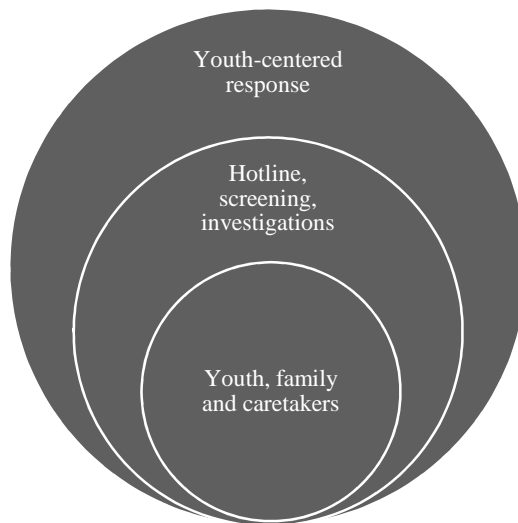
⁶⁷ SB 243 will help with this, but there is much alignment work needed through rules across Child Welfare, OAAPI and OLRO.

the end, the process to respond to abuse should be standardized and easy to remember for all mandated reporters.

Current model: Abuse response processes are confusing and are not optimized with children, youth and families at the center. Different definitions of abuse and unclear roles and responsibilities between Child Welfare (CPS), OAAPI, and OLRO contribute to child safety and process failures.



Proposed model: Alignment of reporting processes and investigations lead to the optimally safe path forward for children, youth and families. Definitions of abuse fit the clear roles and responsibilities allocated to each division.

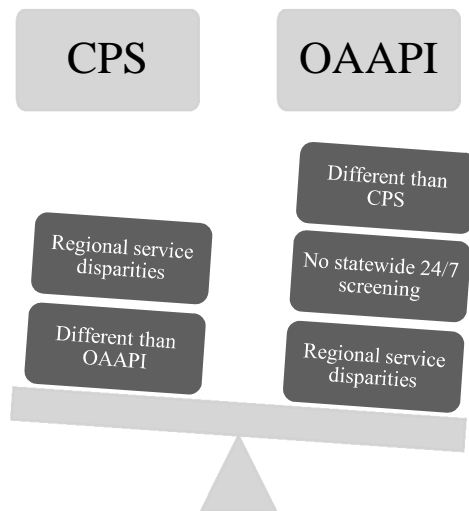


Make a decision about centralize hotline operations and enhance standard protocols for screening by Summer 2018.

Currently, hotlines are localized within the DHS District Offices and among CPS staff, there is little or no consistency to screening and decision-making across the state.⁶⁸ There is also a substantial disparity in how CPS and OAAPI conduct screening.⁶⁹ The Public Knowledge independent report and an internal review of CIRTs demonstrated the role that CPS hotline operations contribute to child safety problems.⁷⁰ Also, the public has shared experiences of long wait times, being told what they are reporting does not constitute abuse, and have little follow up after the alleged abuse is reported.

Based on the Public Knowledge independent report recommendation, the plan will assist in the decision making of a centralized hotline operation and standardize training and response criteria to add consistency to screening and decision-making.⁷¹ A centralized hotline will increase cases confirmed and referrals that are screened-in (compared to decentralized models), a lower percentage of referrals screened-out (compared to decentralized) and will bring consistency to the way abuse and neglect calls are managed.⁷² Other benefits include improving the screener’s ability to gather information from the caller and expediting the process of preparing reports and disseminating them to the local office for assessment.

Current model: The current model is decentralized and supports service disparity for hotline callers and how children and youth may be screened. Both CPS and OAAPI screen calls differently. This has a direct impact on child safety.



⁶⁸ Public Knowledge (32).

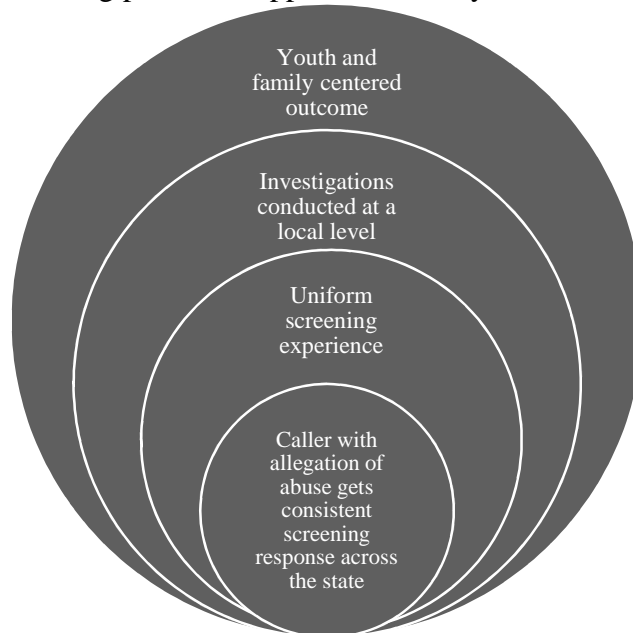
⁶⁹ There are other issues too. For example, statute (both ORS 418 and 419B) requires screening to occur immediately (which means within 24 hours). But OAAPI and some districts do not have a 24/7 screening function.

⁷⁰ Public Knowledge (33).

⁷¹ Child Welfare is poised to implement recommendations starting in February 2017.

⁷² Public Knowledge (56).

Proposed model: A centralized hotline and screening model supports swift and safe responses to alleged abuse. Screening process is applied uniformly across the state and CPS and OAAPI.



Analysis of Goal 4 with supporting business objectives

The following four strategic objectives will cultivate a youth-centered, safety-first culture within the DHS. Project work will be complete no later than December 2018.

- Streamline caseworker tasks and maximize time available to be spent on family engagement and youth centered relationships by December 2018
- Develop and apply a proactive and safety-oriented *case management practice* led by case workers in collaboration with children, youth, family, Tribes and community partners by Summer 2018
- Develop and implement an employee engagement plan to cultivate shared ownership and accountability for child safety among DHS staff by Spring 2018
- Develop and implement data-driven decision making processes for use across the child safety system by December 2018

Streamline caseworker tasks and maximize time available to be spent on family engagement and youth centered relationships by December 2018.

Case workers suffer from overly burdensome processes and documentation that may be streamlined to maximize time spent with youth and families.⁷³ Consequently, case workers struggle to fulfil case management duties that more directly impact child safety, such as

⁷³ They employ directly collaboratively the process of assessment, planning, facilitation and advocacy for options and services to meet a youth's safety needs. An internal review of case worker activity identified over 500 discrete tasks one takes during the life of a case.

conducting timely, comprehensive safety assessments in CPS and consistently applying OSM through the life of the case in permanency.⁷⁴ An analysis of CIRTs from 2006 to 2009 and past lawsuits and tort claims filed against DHS reveals that case workers often deemphasize monitoring and evaluation of youth in substitute care and fail to follow-up on termination cases in order to complete documentation required by other statute and rule.⁷⁵ They also revealed that the adequate use of and documentation of face-to-face contact were insufficient and a statewide solution to remedy these problems was not in place.

Project work in support of this objective will provide relief for caseworkers by streamlining documentation processes to reduce the burden while creating new standards and protocols for using face-to-face meetings and documenting them effectively. This will include developing better processes to coordinate safe outcomes for children with the Juvenile Courts and the Citizen Review Board. Engagement with field staff, Tribes and community partners will be essential to create an open and transparent process throughout the life of a case.

Current model: DHS case workers are overburdened with documentation that is not necessarily centered on child safety. This hampers other vital responsibilities that put youth and families at the center.

Proposed model: DHS case workers spend more time engaging children, youth and families and document processes around newly streamlined operations and policy.

Develop and apply a proactive and safety-oriented case practice led by case workers in collaboration with children, youth, families, Tribes and community partners by Summer 2018.

Over the course of the past 20 years, case management practices have changed in response to crises but a system-wide implementation change effort has not been comprehensively enacted. For example, only in the development of this plan have CIRTs been thematically analyzed over multiple years. The current system is overwhelmed and it is difficult for caseworkers to proactively provide for youth safety. An analysis of CIRTs from 2005 to 2015 revealed that gathering of relevant records during the CPS assessment process and the comprehensiveness of assessments varies from district to district. Fundamental decisions about what makes good case management practice across the state are essential to the implementation plan efforts. These need to be supported with training and development to ensure all children and youth are safe while receiving DHS services.

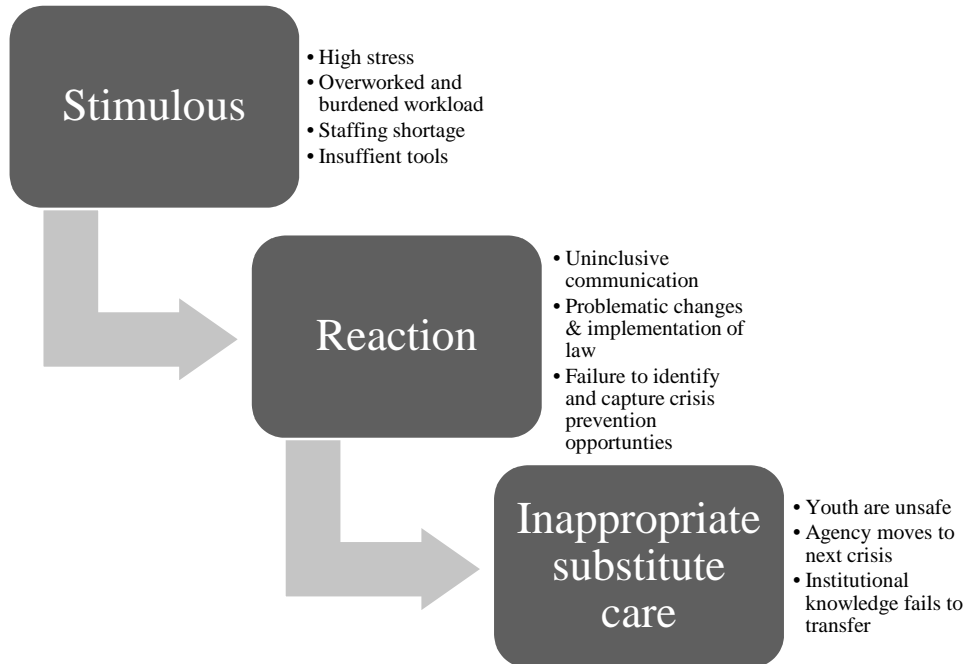
The implementation project work will develop and apply proactive, protective case management practice in coordination with internal and external stakeholders. Project work will include preventing abuse and re-abuse, level-setting on what constitutes good case practice, followed by developing stronger, more holistic safety plans, strategy around maximizing face-to-face contact, and relieving case workers of other duties that may take away from putting youth and families first. In support of this objective, the plan will also develop means of holding

⁷⁴ Public Knowledge concluded that CPS, OAAPI, OLRO and others need reasonable workloads. They recommend a caseworker have on average 12-15 youth (not cases) at any time. Case workers also do not have capacity to equip youth and families with tools to confront social, psychological, and behavior problems.

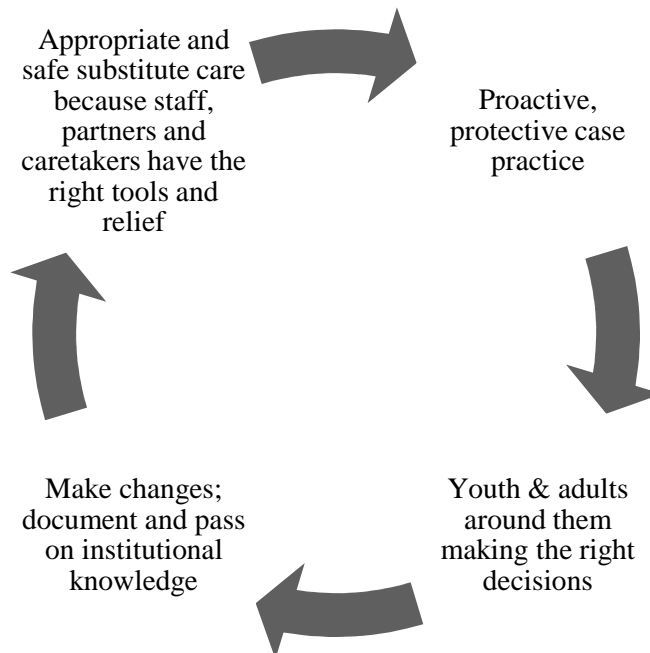
⁷⁵ Public Knowledge (43).

supervisors, program leaders and managers accountable when the face-to-face interaction does not occur. Developing the proactive, protective case practice may capture quick fixes, but it is more fundamentally focused on ensuring that children and youth are safe when receiving services from DHS.

Current model: Divisions of the DHS that support youth safety respond reactively to crises, often creating downstream safety risks for vulnerable youth.



Proposed model: The DHS staff maintain reasonable caseloads and receive and apply adequate tools to analyze, act and reflect about the priority of child safety throughout the life of a case.



Develop and implement an employee engagement plan to cultivate shared ownership and accountability for child safety among DHS staff by Spring 2018.

Currently, DHS staff and partners perceive the DHS Child Welfare Program workforce to be the responsible for statewide youth safety.⁷⁶ Responsibility and accountability for safety is held by partners through rules and regulations, rather than a common framework where each entity involved in a youth's life understands her or his role in keeping that youth safe.⁷⁷ Historically, the DHS leadership has not implemented many key recommendations related to child safety.⁷⁸ For example, communication between branch offices that co-manage cases was identified as a barrier to child safety in a 2015 CIRTs but no statewide action plan resulted to ensure effective co-management.

The focus of project work under this objective will craft explicitly a sense of shared ownership and accountability among all DHS staff for child safety. It will also co-create and apply a framework for community-based child safety and develop structured processes to guide communication between branches and districts across the state. Shared responsibility will be developed over time through continued collaboration and trust building by the DHS Leadership team. Shared responsibility for child safety also needs to be cultivated with the Oregon Health Authority and the Oregon Youth Authority, in order to smooth transitions for children that move between systems. Employee supports from the community are necessary for effective case work and the work in this plan will pursue such work.⁷⁹ Project work will also design a clear structure of accountability for DHS staff, which will set roles and responsibilities that are appropriate and balanced for each job in the system. Ultimately, the plan will enable all programs within the department to trace decisions back to their origin and respond effectively to concerns for children, youth and family safety.⁸⁰ When these steps are taken, youth benefit from the synergy of the department and partners speaking with "one voice."

⁷⁶ Child Welfare caseworkers are responsible for child safety *decisions*. They make the final call on what plan can manage child safety. However others within the agency need to assume a role in providing child safety and being accountable for the effective provision of child safety services.

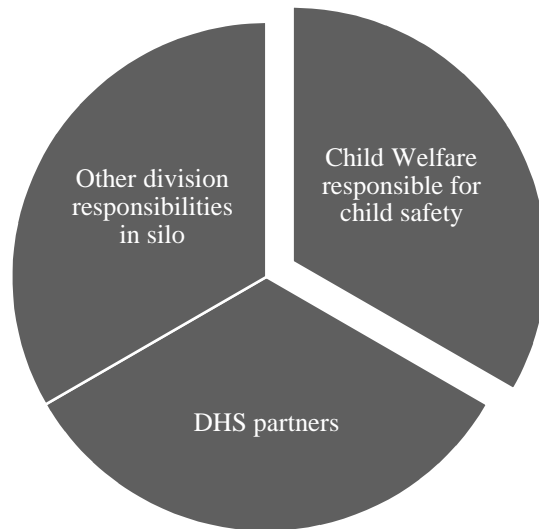
⁷⁷ The Public Knowledge report was conducted partly from the perspective of youth in care. Currently, rules and regulations allow too many youth to fall through the cracks which means that the whole agency needs to re-baseline policy and practice on keeping them safe.

⁷⁸ 2009 Oregon Foster Care Safety Team Final report, which provide concise analysis and concrete recommendations but were never implemented. Also, the 2015 BRS report recommendations have not been comprehensively addressed to date.

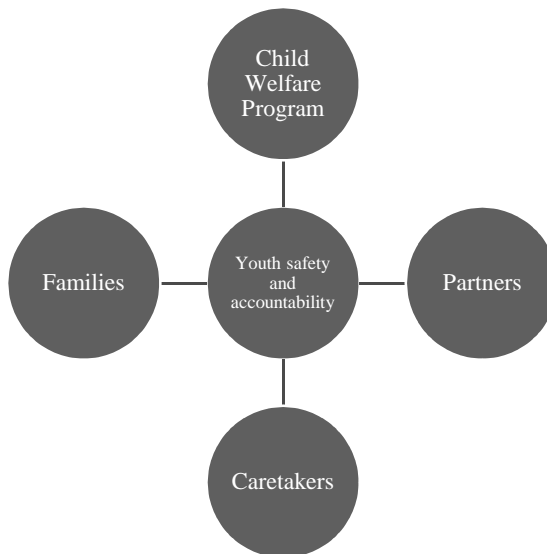
⁷⁹ The State of Tennessee has done extensive work in this area to which Oregon can look for a model. It will include creating healthy priorities for psychological safety and stress recognition techniques.

⁸⁰ Currently, Child Welfare can do this through the use of OR-Kids but other divisions do not use the system.

Current model: Within the department, the Child Welfare Program is perceived as exclusively responsible program for statewide youth safety. Other divisions and even some partners do not perceive their role in child safety something they contribute to.



Proposed model: Vulnerable children and youth are safe due to joint DHS and partner expectation that child safety is top priority.

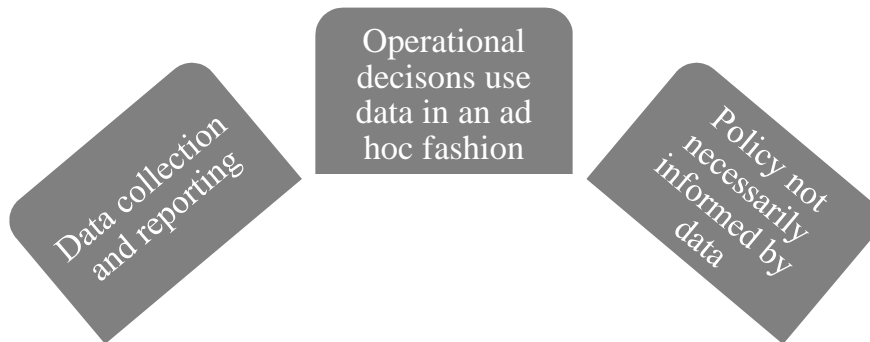


Develop and implement data-driven decision making processes for use across the youth safety system by December 2018.

To make appropriate placements, the agency must use data to drive decision-making to support youth safety.⁸¹ Currently, the data that Oregon collects is primarily used for reporting purposes rather than formulating policy or improving operations that support youth safety.⁸² Staff do not utilize ROM to the extent available and the existing training and development opportunities are not well promoted across the agency.⁸³ Until recently, single incident cases and anecdotal information were driving policy, decision making and case management practice.⁸⁴ To date, OLRO, OAAPI, and Child Welfare do not all use the same database for investigations.

Project work within this plan will first evaluate existing data systems and then implement training and development at all levels within DHS to ensure the right data is used at the right time to support child safety.⁸⁵ It will also implement department changes in how data drives accountability at all levels of the organization. This will involve bringing together data from several divisions and technology systems of varying maturity levels, then synthesizing data into coherent pictures. Pilots may form the basis of new accountability structures. Project work will also take advantage of national experts in child welfare to consider new investments and larger scale efforts for data to support youth safety work. Data systems will be harmonized to ensure child and youth safety.

Current model: Data is collected and informs required reports. The fragmented nature of data entry and multiple systems used means data are not used as an effective tool to monitor early warning signs for child safety or effectively meeting a child’s racial, cultural, sexual orientation or disability needs.



⁸¹ The Public Knowledge report concluded that Oregon has a disjointed data enterprise for tracking information about youth maltreatment in substitute care. Existing reporting capabilities are insufficient to generate advanced analytics that can drive a better case management practice in the field and at the central office (38).

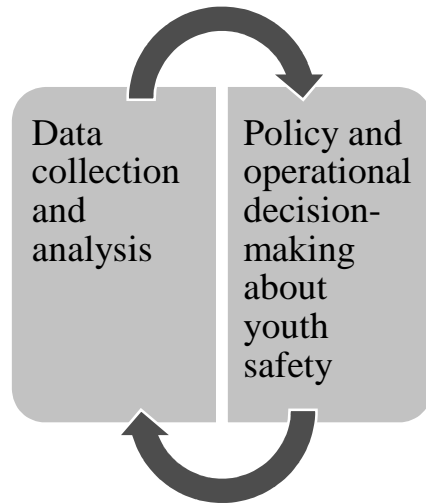
⁸² Historically, federal reporting such as the CFSR have not been done with youth safety at the center, nor as a tool for system-wide transformation.

⁸³ Efforts are already underway within Child Welfare to educate supervisors and managers on how to use specific reports in ROM to manage daily work.

⁸⁴ Public Knowledge (38). The QA and CQI work that is happening will help to inform not only trends in the work but call out strengths to build on and help focus on areas needing improvement.

⁸⁵ OR-Kids and the University of Kansas have a partnership to provide descriptive statistics and informational reports, which are underutilized throughout the organization to drive case management performance and executive decision making. Much Child Welfare data is available publicly here: https://rom.socwel.ku.edu/Oregon_Public/MyHome.aspx.

Proposed model: Data will be in continuous conversation with policy and operational decision-making about child safety.



Analysis of Goal 5 with supporting business objectives

The four objectives below will retain, train, develop and recruit certified families and licensed child caring agency providers that meet or exceed the applicable standards substitute care providers. Project work will be complete by December 2018.

- Develop and implement a youth-focused, compliance philosophy with substitute care providers and families of origin by Spring 2018
- Develop and implement a substitute care retention, training, development and recruitment plan that applies a foster care family lifecycle model in coordination with community partners by Summer 2018
- Develop and implement data-driven placement plan for substitute care by December 2018
- Improve certification and licensing processes for providers and foster care families without sacrificing accountability by Summer 2018

Develop and implement a youth-focused, compliance philosophy with substitute care providers and families of origin by Spring 2018.

The current compliance approach deals with problematic caretakers using a primarily reactive response model.⁸⁶ Historically, DHS and partners do not have a common philosophical approach that ensures youth and families are at the center of substitute care. Rather, contractual

⁸⁶ The system does have many compliance checks that are not reactive. For example, Child Welfare compliance specialists review all contracted BRS (and non-BRS) providers on a regular schedule in conjunction with OLRO and OYA when appropriate. Certifiers have 180 contact requirements to review certified homes. Despite this, the agency is still unable to keep all children in care safe.

agreements lay out what is and is not mandated and this forms the foundation of case management practice and compliance work. Currently, when DHS interacts with certified families and providers, it usually because of a contracting violation. This is too late for preventative compliance work. OLRO has inconsistently applied licensing and civil penalty action. There are not statewide criteria for when action should be taken.

Work in this plan will establish and implement a compliance philosophy that is proactive and preventative of problems that caretakers may face without sacrificing child safety standards and required licensing and civil penalty action. Project work will help license investigators and family home certifiers to intercept problems before they occur, which will include creating an early warning system prior to civil penalty and licensing action. Other work to support this goal includes creating standards for when licensing action and civil penalty action should be taken. Work will also give managers better training and tools to hold themselves and their staff accountable for policy violations and bias in decision-making.⁸⁷

Current model: Civil penalty and licensing action is the only basis for compliance. The current approach leaves out preventative work that DHS can do to keep to ensure child safety.



Proposed model: Compliance with certification and licensing requirements are mandatory, but problems are intercepted before they occur using an early warning system.



⁸⁷ Thematic analysis of DHS’ lawsuits and tort claims reveals three overarching themes: staff removed youth when they should not have, staff did not remove youth when they should have, and staff knew youth were unsafe but did nothing to stop it. Case workers need adequate and appropriate training to prevent these safety missteps and managers need to use accountability tools to keep youth and families at the center of all district work. Project work under this goal will ensure DHS staff make and maintain appropriate placements to ensure youth safety is paramount.

Develop and implement a substitute care retention, training, development and recruitment plan that applies a foster care family lifecycle model in coordination with community partners by Summer 2018.

Retention, training, development and recruitment is essential to ensuring all children in Oregon are safe and that children, youth and families are at the center of substitute care. Currently, recruitment efforts are planned both at the central office and districts level. Within DHS, little work has assessed the best practice business models of providers.⁸⁸ There is some data that indicates how well DHS staff understand customer service standards and the results are beginning to impact recruitment and retention planning.⁸⁹ Furthermore, there is little training and development for providers and families once youth are in the home, which misses opportunities to close gaps in knowledge and ultimately ensure that good families continue to be substitute care providers.⁹⁰

Recruiting and retaining new providers and families to meet demand will require not only increasing financial incentives (e.g. increasing provider rates), but also new and robust training for foster families to meet children's needs. Recently, Child Welfare began to develop a comprehensive recruitment and retention strategy for foster families. Ultimately, DHS' understanding of caretakers needs to expand to include the whole life cycle of involvement with children, youth and families; recruitment is just the beginning.

The project work will design and implement an agency-wide recruitment and retention plan to create appropriate and adequate substitute care providers.⁹¹ The goal is to keep children and youth in the least restrictive environment possible. There will be a special emphasis on building out alternatives to congregate care for youth and youth with high needs, without segregating them. Once providers and families join the substitute care system, training and development needs to reinforce the priority of youth safety, as well as give them the continuous skills needed to thrive. Caretakers will come to see themselves as partners with the DHS in protecting youth while holding them to rigorous standards to prevent threat of harm, neglect and abuse. Project work will also reform how training and development is conducted and look to Tribes and community partners to create a comprehensive curricula.

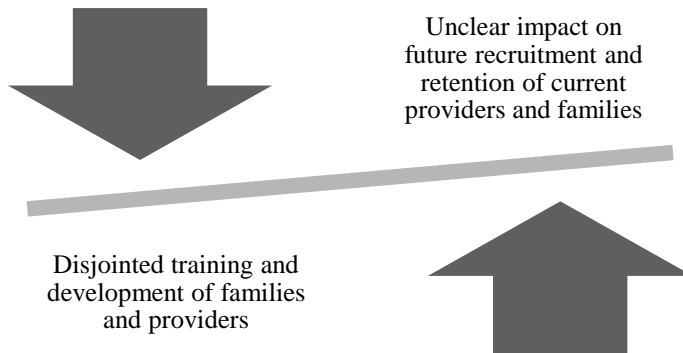
⁸⁸ This work is being tracked and evaluated through the GRACE grant. Oregon is piloting the customer service component of Growing Resources and Alliances through Collaborative Efforts (GRACE) sponsored by the National Resource Center for Diligent Recruitment. The Child Welfare Program is working to expand the effort statewide through Every Child, run by the Portland Leadership Foundation.

⁸⁹ Foster parents have been responding to customer service surveys sent out by Child Welfare for approximately three years. It is unclear how this information is used to drive training prioritization for field staff.

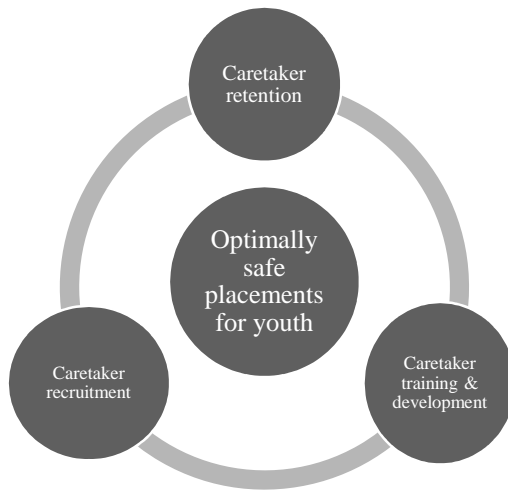
⁹⁰ Family foster care providers are required to take a certain number of hours of training per year, but the effectiveness of the training on retention is unclear. Oregon tracks all training funded through PSU.

⁹¹ Child Welfare has already begun this work.

Current model: Relies heavily on recruitment but does little to retain, train or develop providers and families once they enter the system.



Proposed model: Robust recruitment ensures that families and providers who join the system are aware of the agency's priority to protect youth, then stay in partnership with the DHS and develop new skills and abilities to care for the youth under their care.



Develop and implement data-driven placement plan for substitute care by December 2018.

Currently, there is an inadequate supply of foster care families and providers to meet the demand of children and youth needing substitute care in Oregon.⁹² In order to retain, train, develop and recruit for new caretakers, DHS needs to harmonize multiple data systems and then use them to inform planning efforts. Data projections are currently not used to anticipate

⁹² Public Knowledge (17). Child Welfare is under-resourced according to the workload model, which only takes into consideration the work associated with completing the SAFE home study, not any recruitment or retention efforts. Field-based certifiers were reassigned to complete overdue assessments for most of 2016. Since Child Welfare's priority is placing youth with family whenever possible, certifiers have spent much of their capacity doing emergency certifications of family members. These are youth-specific recruitments and typically do not result in building ongoing capacity.

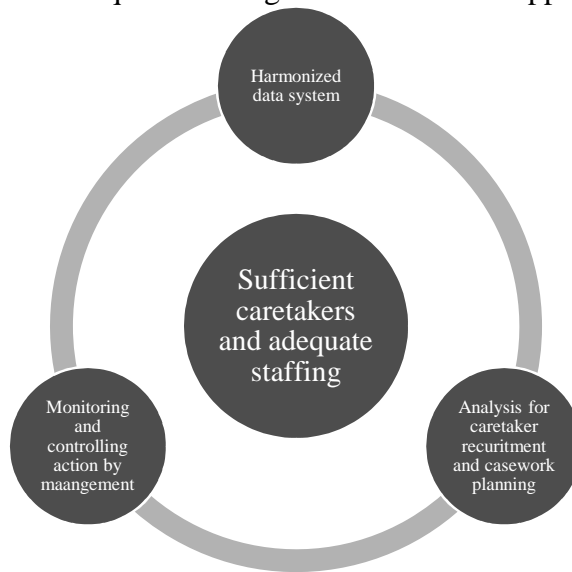
demand for substitute youth placements.⁹³ Rather data is used to describe how youth are placed as care becomes available.⁹⁴

Project work included in this plan aims to harmonize data systems to assist every layer of the youth safety system at DHS keep youth and families at the center of substitute care. The Child Welfare Director and Deputy Director are working with OEDA to capture this data. This will including helping staff in the central and field offices forecast how many children and youth will need substitute care at what time. It will also help field managers anticipate casework surges and then manage work to right-size caseload, easing caseworker burnout.⁹⁵ The recruitment plan for foster families will rely heavily on the new harmonized system.

Current model: Data does not inform caretaker recruitment or case management in a uniform, effective manner.



Proposed model: Data projections will enable recruiters and field managers to set and achieve goals. Managers have adequate staffing and data to make appropriate load assignments.



⁹³ In the past, there have been strategic efforts to expand DHS’ BRS capacity, however during the last two quarters of 2016, the agency has lost 38 beds and gained 61 totally a net gain of 23.

⁹⁴ Eventually, a predictive analytic model should guide decision making to make optimally safe placements for youth, keeping youth and family at the center.

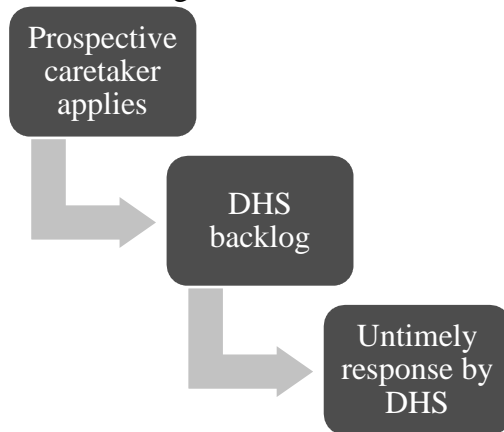
⁹⁵ Currently the agency is staffed at 82% of what it takes to do the work to fidelity. Data may help managers anticipate casework surges but additional relief is needed to help case workers manage workload and reduce burnout.

Improve certification and licensing processes for providers and foster care families without sacrificing accountability by Summer 2018.

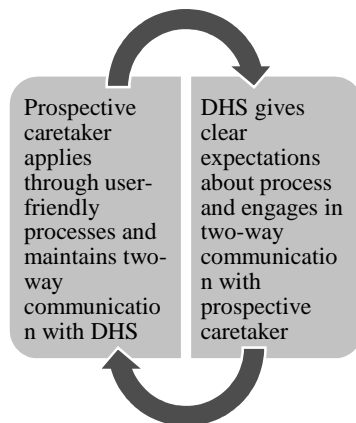
Prospective caretakers report that the family foster home provider certification process and licensing process for providers is too time-consuming. Requirements from different divisions within DHS sometimes result in duplicative requests, long wait times, and ultimately the frustration felt by prospective caretakers may result in a decision to withdraw from partnering with DHS. Key pinch points that contribute frustration with DHS’ licensing and certification processes include underlying process behind background checks, and roles and responsibilities in the field when it comes to processing the respective application.

Project work in this plan will streamline existing licensing and certification processes. It will seek to do work in parallel through internal coordination to reduce wait times and add in feedback loops with prospective caretakers in order to keep them up to date at where they are in the application process. This may include but is not limited to changing the way in which background checks are run and how DHS works with organizations that help foster care families to prepare initial applications. Tribal and community input will be critical in developing new parts of the process and changing parts of the process that do not help applicants become successful licensees or certification holders in a fast and efficient manner. This will be done without reducing scrutiny that the agency applies to keep children safe.

Current model: Caretakers report that the model for licensure and certification is cumbersome and sometimes confounding, with little clear communication about next steps.



Proposed model: Caretakers and organizations that facilitate their application abide by a streamlined process in which clear communication is a cornerstone.



Resource requirements

Work within Child Welfare, OAAPI and OLRO is already underway to achieve some of the goals mentioned in the Unified Child and Youth Safety Implementation plan. But the work set out in the plan is aggressive to do within two years in a department that is perceived as having poor implementation capabilities. In order to achieve the plan, the resources below will work across the agency to implement project planning work. The table below documents needed resources and associated roles and responsibilities.

Role	Responsibility	Name
DHS Director	Responsible for Unified Youth Safety Improvement Plan oversight.	Clyde Saiki
Chief of Staff and Plan Sponsor	Responsible for securing spending authority. Ensure identified roadblocks are removed to facilitate forward movement of the project. Ultimate decision making authority.	Jeannine Beatrice
Child Welfare Director	Ensures alignment with Child Welfare Program activities. Ensure identified roadblocks are removed to facilitate forward movement of the project.	Lena Alhusseini
Executive Projects Director	Develop implementation plan and oversees plan execution. Ensure project tasks are moving forward in alignment with youth and family needs; participate in project planning and provides support for project manager by assisting with major issues, scope decisions; ultimately responsible for outcomes.	Nathan Rix
Rules and Policy Project Manager	Develop comprehensive review of youth safety-related rules; convene subject-matter experts and relevant and related managers to implement rule changes across CW, OAAPI, and OLRO; vets rule changes with stakeholder groups; write new rules.	TBD
Communication Project Manager	Develop, enact and maintain communications plan; develop messages and effects that explain change, exploit success, and take responsibility for challenges; analyze perceptions and expectations of internal and external stakeholders; coordinate communication delivery with CW, OAPPI, OLRO and field	TBD

Unified Child and Youth Safety Implementation Plan

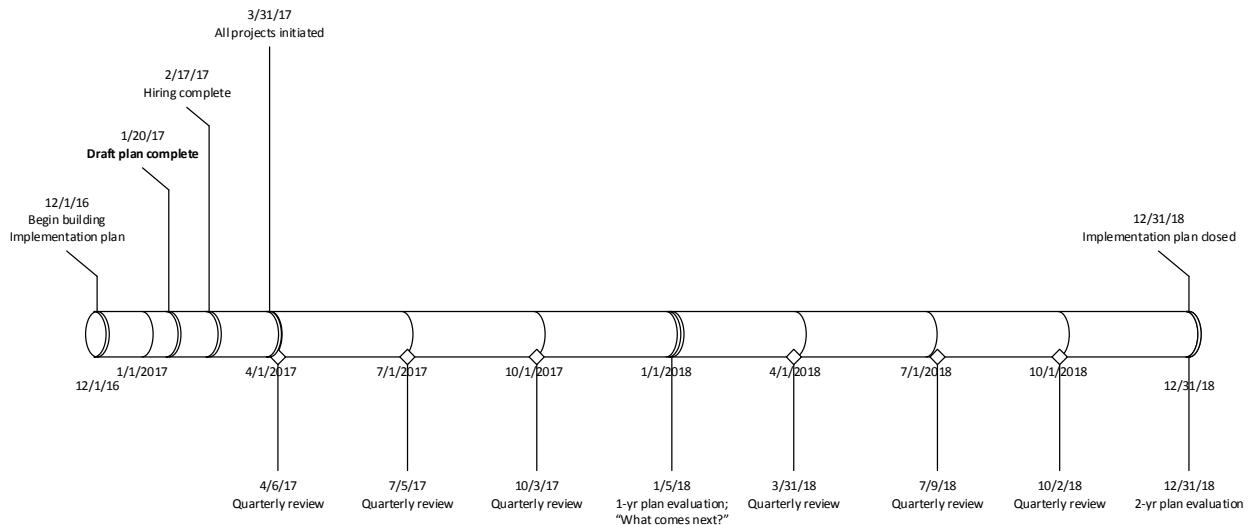
Role	Responsibility	Name
	communication staff; copy edits documents before publication. Manage feedback from new communication channels (e.g. listserv and website)	
Data and Policy Project Manager	Develop and implement data use plan across the youth safety system; convene technical staff across CW, OAAPI, OLRO, and field staff to drive decisions around data use; document technical changes and integrate into data use plan; co-train and co-develop staff at all level of the organization to use new systems; coordinates data analysis with existing DHS data staff.	TBD
Organizational Change Project Manager	Develop and implement organizational change management plan across the youth safety system; generate support system transformation across the agency; monitor projects for ways to adapt and add on features that promote trust; coordinate with existing CW, OAAPI, and OLRO, and field staff to identify barriers and opportunities as they emerge in order to keep projects moving.	TBD
Business Project Manager	Develop and implement project plans for redesign across CW, OAAPI, and OLRO; convene SMEs and generate alternatives analyses, process maps, traceability matrix, etc. Implement new processes in partnership with Tribes, community partners and DHS staff; ensure deadlines are met across CW, OAAPI, and OLRO and manage project risks as they emerge.	TBD
Business Project Manager	Develop and implement project plans for redesign across CW, OAAPI, and OLRO; convene SMEs and generate alternatives analyses, process maps, traceability matrix, etc. Implement new processes in partnership with Tribes, community partners and DHS staff; ensure deadlines are met across CW, OAAPI, and OLRO and manage project risks as they emerge.	TBD

Unified Child and Youth Safety Implementation Plan

Role	Responsibility	Name
Public Engagement Project Manager	Develop and implement public engagement plan; convene stakeholders and ensure work streams are executed in accordance with an engagement rather than participation model; educate and clarify across-system work in public settings; anticipate stakeholder perceptions and expectations; analyze and respond to questions, suggestions and concerns; co-create website documents with Communications PM.	TBD
Training and Development Project Manager	Develop and implement foster care family recruitment and retention plan in coordination with Child Welfare; develop and implement case worker training and development, recruitment and retention plans in coordination with Human Resources and district offices; develop business and policy solutions to enhance training and development, recruitment and retention across DHS youth safety system.	TBD
Website Developer	Presents user-friendly information; keeps information up to date; ensures coherence and continuity of information; continuously looks for gaps in and what could be put online.	TBD

Proposed plan schedule

A high level timeline is shown below. This plan will be updated with a detailed schedule when the projects and associated duration are finalized.



Risk management plan

The project director will identify risks within project work related to schedule, costs, and/or quality. An agreed-upon mitigation will be determined for each identified risk. Some mitigation is expected to be informal and handled by the Chief of Staff (Plan Sponsor) or Executive Projects Director. Other mitigation will be planned and the responsibility assigned for carrying out the mitigation plan. A monthly review of risks will be conducted with the whole project team. Risks will be described, categorized, dated and given a risk score based on the percent likelihood and impact. This will be publically available on the website: <http://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Pages/index.aspx>

Glossary

Casey Family Foundation: A nationwide foundation focused on the pursuit of safely reducing the need for foster care and building Communities of Hope for all of America's children and families.

CFSR: The Child and Family Services Reviews (CFSR) are conducted by the Children's Bureau, within the United States Department of Health and Human Services, to help States improve safety, permanency, and well-being outcomes for children and families who receive services through the child welfare system.

CIRT: Critical Incident Review Team is a statewide workgroup that convenes when there is an incident or serious injury or death caused by abuse or neglect involving a child who has had contact with the Oregon Department of Human Services. In each case, the CIRT prepares a report, called a CIRT Report, to identify what improvements can be made to DHS policies or practices and to make the report public information. The CIRT Report is a tool to review Department practices and recommend improvements and actions the Department needs to take.

Clinical Supervision: Focused on the work that caseworkers do with children and families. Good clinical supervision is critical to building worker competencies, including reinforcing positive social work ethics and values, encouraging self-reflection and critical thinking skills, building upon training to enhance performance, and supporting the worker through casework decision-making and crises.

File Review: A peer or supervisor review of all items in a case file pertaining to a child and the decisions made.

Foster Children Bill of Rights: Established in June 2013 for foster youth to know their rights and be empowered to assert those rights. Ensures foster youth have access to tools and support.

ICPC: The ICPC is a contract among member states and U.S. territories authorizing them to work together to ensure that children who are placed across state lines for foster care or adoption receive adequate protection and support services.

ICWA: Indian Child Welfare Act – a statute passed by Congress and that seeks to keep American Indian children with American Indian/Alaska Native families. Congress passed ICWA in 1978 in response to the alarmingly high number of Indian children being removed from their homes by both public and private agencies.

OR-Kids: See Statewide Automated Child Welfare Information System.

Oregon Safety Model: The model represents an overarching process that requires safety assessment and safety management at all stages of case management from screening through case closure. The safety intervention model includes all actions and decisions required throughout the life of a case to:

- Assure that an unsafe child is protected;

- To support and facilitate the parent taking responsibility for the child’s protection whenever possible;
- Reconfirm the child’s safety at home or in out-of-home care throughout the life of the case; and
- To achieve the establishment of a safe, permanent home for the unsafe child.

Placement: The act of placing a child into a foster family home for a period of time.

Quarterly Business Review or QBR: Quality Business Review is part of a management system designed to enhance customer services, reduce costs and drive innovation. Frequently called QBR, it’s a way to review progress towards goals, identified as measures, and adjust any planning based on a quarterly review of defined metrics. The QBR is an examination process, outcomes are monitored and focused improvement plans are being implemented to meet the goals established for each measure.

SACWIS: Statewide Automated Child Welfare Information System – in Oregon know as OR-Kids. A database each U.S. state is federally required to maintain with a complete electronic case management history of each child receiving support.

SAFE Home Study: Systematic Analysis Family Evaluation. Analytical tool used in the assessment of foster applicants. Provides a structured approach to analyzing strengths and areas of addressing concerns that may impede current functioning as well as safe and effective parenting for families that come to the department to foster or adopt. The model supports matching skills and abilities of foster or adoptive parents with the identified needs of children. Pilot began in 2010 with a staged rollout of the tool statewide in 2011.

Systemic Issue: In this report, “systemic” means an issue that has been identified as a system wide problem that needs to be addressed across a DHS program or the department.

Document control history

This document will be updated on an as-needed basis to reflect changes in priorities.

Version	Date	Author	Changes
0.1	1/10/17	Nathan Rix	Discussion draft based on Public Knowledge audit, numerous internal and external reports, and one-on-one interviews with some DHS youth safety managers and staff.
0.2	1/17/17	Nathan Rix	Updated based on community partner input
0.3	1/26/17	Nathan Rix	Updated based on community partner input
0.4	2/9/17	Nathan Rix	Updated based on community partner input
1.0	2/10/17	Nathan Rix	Final Version 1.0