Child and Family Services Review Round 3

Program Improvement Plan

State/Territory: **Oregon**

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End of Non-Overlapping Year: (specified by Children's Bureau)

Reporting Schedule and Format: Oregon will report 30 days after the end of each quarter on the progress made on PIP goals.

Introduction

The following Program Improvement Plan (PIP) will describe the efforts Oregon is undertaking to improve the Child Welfare Program and outcomes for children and families. The plan has been organized into four sections. This best represents Oregon's Child Welfare Program organizational and functional structure:

- Improving Child Safety
- Improving Child Permanency
- Improving Child Well-being
- Improving Workforce Development

Through this PIP, Oregon will explain how each strategy and its underlying activities will contribute to improved CFSR outcomes over the next two years. The goals, strategies, and key activities have been revised to clarify the intent of each strategy as well as to explain how Oregon will measure and sustain practice changes. The expected impact of strategies and activities is also noted.

Each PIP goal and strategy addresses the CFSR findings and strikes at the root of individual outcome areas measured by the CFSR. A comprehensive analysis of both quantitative and qualitative CFSR data was conducted by central office and field staff, in conjunction with partners, to gain an in-depth understanding of Oregon's review findings. Through this process, several practice themes were identified, including lack of concerted efforts to locate and engage parents, and inadequate safety assessments, both initially and ongoing. Furthermore, Oregon has struggled with recruitment and retention of caseworkers and foster parents. The lower staffing levels, combined with the lack of experienced workers and foster parents, have had a direct impact on the level of service provided to children and families engaged with the agency.

What emerged from Oregon's comprehensive analysis was that many of the selected strategies result in activities that cross over multiple aspects of child welfare practice model, including safety, permanency, well-being and the systemic factors. A common element incorporated in the PIP is the development and utilization of data to measure performance. Each main goal has incorporated fidelity to the model and continuous quality improvement strategies to improve overall practice. The utilization of data from fidelity reviews and predictive analytics research, will enable the agency to develop better performance improvement plans and make better data-informed decisions.

Oregon has developed several strategies to increase the retention rate and knowledge level of new and experienced staff, including supervisors. A steady, knowledgeable and committed workforce is key to Oregon's accomplishment of the Program Improvement Plan goals (see Goal 4- Improving workforce development). Based on the new strategies, Oregon expects to see positive multiplier effects to its child welfare practice. For example, a key activity to improve training will have a cumulative, even if difficult to measure, positive impact on child safety and stabilization over time. A brief analysis of these impacts is included in a summary before each action plan item.

As the PIP came together into one cohesive plan, the draft was sent to the following groups for review:

- Child Welfare District and Program Managers
- Child Welfare Advisory Committee
- Indian Child Welfare Advisory Committee
- Youth Advisory Committee
- Parent Advisory Committee
- Racial Equity Advisory Committee Tillicum - R.E.A.C.T.

The feedback from these staff and community partners was reviewed with the central office Program Managers, Executive Projects staff, and Department leadership.

Moving forward with the execution of the PIP, the Oregon Child Welfare Program will conduct quarterly reviews to track PIP progress and will conduct routine reviews of PIP progress with the Child Welfare Advisory Committee.

The PIP also works to align the resources and work underway with the Department's Unified Child and Youth Safety Implementation Plan (Unified Plan) and the Child and Family Services Plan. Oregon's Child Welfare Program will use formal project management to develop detailed project plans, work teams, and work plans for those areas of the PIP that require project planning.

PIP strategies, Unified Plan tasks and items in the State's Child and Family Services Plan, have been aligned to prevent duplication

Please see the following attachments for additional information:

Attachment 1: PIP Workgroups Membership
Attachment 2: Child Welfare Advisory Committee Membership
Attachment 3: PIP Measurement Plan Goal Calculation Worksheet
Attachment 4: First Year of Caseworker Professional Development Plan

Background and Oregon's CFSR Development Method

Oregon worked in conjunction with Region X Children's Bureau staff in the development of a multi-year work plan to prepare for and implement the Round 3 CFSR Review, which commenced with the approval of the 5-year Child and Family Services Plan in 2014.[1] Over the course of several months during 2015 and early 2016, Oregon engaged in the state self-assessment process, examined qualitative case review and statistical data review measures, conducted stakeholder interviews, administered surveys, and provided multiple opportunities for stakeholder feedback and review of the state self-assessment, which was submitted in March, 2016.[2]

Oregon's Child Welfare Program received the final data from the case reviews conducted during the Round 3 period. The PIP kickoff event took place on January 31, 2017. The kickoff, which provided information from the final report and outlined the process for PIP development, was attended by over 70 staff, stakeholders, and community partners.

Subsequent to the kickoff, the Child Welfare Program initiated six workgroups to address the areas where Oregon was not found to be in substantial conformity (Attachment 1: Implementation Supports: PIP Workgroup Membership). These workgroups, composed of staff in various positions within the Child Welfare Program, tribal representatives, clients, and stakeholders, were actively involved in the causal analysis of current outcomes and the development of strategies and proposed activities included in this PIP. The Child Welfare Advisory Committee, which is serving as the Steering Committee for the PIP, provided oversight of this workgroup process, in addition to staff leading the workgroups. (Attachment 2: Implementation Supports: DHS CWAC Membership).[3] The workgroup facilitators met weekly to share findings and identify common causal factors, cross program, and/or cross system issues. This iterative process allowed for shared learning as well as shared development of the PIP goals, strategies, activities, and proposed measures.[4]

[1] Oregon was approved to engage in the state-conducted case review process. Oregon engaged in an intensive and comprehensive process of training staff and stakeholders in the case review, using the On-Site Review Instrument and the guidance developed by the Children's Bureau. Our training and review process, including the curriculum, the sampling methodology and the case review process was reviewed and approved by the Children's Bureau CFSR team.

[2] Oregon's sampling methodology for Round 3 resulted in the review of 96 cases from April 1, 2016 through September 30, 2016 (64 foster care cases and 32 in-home cases). Each case review was conducted by trained case reviewers, and received additional quality assurance review by both a member of Oregon's QA team and a member of the Federal CFSR Review team prior to final authentication of the review.

[3] Oregon's case sampling methodology for the purpose of establishing a baseline for PIP case review measurement and continuous quality improvement began February 1, 2017. The period to develop the baseline is February 1, 2017 through January 31, 2018. This will be followed by a second 12-month period, February 1, 2018 through January 31, 2019, where results will be measured against the baseline on a rolling monthly basis. For the baseline and PIP periods, Oregon will select cases for review from all branches rather than the stratified schedule of selected districts and branches used in Round 3. This will advance Oregon's Program Improvement and continuous quality improvement more broadly than was possible during the 6-month period used in Round 3.

[4] All strategies and activities will be conducted within the confines of available resources, which at the time of the PIP development, are undetermined in either the federal or state budgets. The PIP builds upon work already underway with key strategies for targeted practice improvement. The plan uses the CFSR case review process, the Quality Assurance review tools, and Oregon's reliance on data for routine business review to monitor progress towards the PIP goal, including both statewide routine monitoring and improvement plans and monitoring progress at the District or regional and branch levels. Measures toward progress on the Quality Assurance Review tools and the Quarterly Business Review data measures will be focused on reaching the established target goals for each measure. Measures toward progress on CFSR data items 1, 2, 3, 4, 5, 6, 12, 13, 14, and 15 will be established once the baseline has been determined after January 31, 2018 (Implementation Supports: Attachment 4, PIP Measurement Plan Goal Calculation Worksheet).

Goal 1: Improving Child Safety

Goal Statement
Oregon will ensure a swift, safe, and comprehensive response to reports of child abuse.

CFSR Results Round 3 (2016):
Item 1 – Timeliness of Initiating Investigations of Report of Child Maltreatment = 57.5% Strength
Item 2 – Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-entry into Foster Care = 82% Strength
Item 3 – Risk and Safety Assessment and Management = 60% Strength
- Comprehensive and accurate initial assessments – 54% of applicable cases
- Comprehensive and accurate ongoing assessments – 70% of applicable cases
- Appropriate safety planning – 39% in of applicable cases
- Recurrence of Maltreatment – 10.9
- Maltreatment in Foster Care – 14.34

Much of the root cause for poor safety outcomes in Items 1, 2, and 3, can be attributed to a fragmented system of response to abuse, incomplete or insufficient safety assessments and oversight to assure maintenance of safety decisions and planning. The goal was selected based on information gathered through CFSR data from Round 3, field staff and management discussions, data and conclusions in various internal and external audits and fidelity reviews that consistently showed findings in this area.

Analysis of the Data & Underlying Issues:
Over the Federal Fiscal Years 2014-2017 there was an increase of approximately 5000 reports per year referred for assessment; this increase was discussed frequently in the reviews and field staff discussions as an overburden of workload. Aggregate system data from 2016 found that of 35,145 assessments, 38% were completed within the mandated 60 days, with an average number of days to complete an assessment as 78 days. In addition, in 2016, caseworker turnover was 23%. This turnover impact fidelity to the practice model at both the caseworker and supervisor level.

Analysis of aggregate maltreatment reports reviewed explored both 24-hour and 5-day response by age, gender, abuse type, response type (traditional or DR), race, and district/branch:
- Margin of missed timeliness — issue of how the system records time by hours and not date especially for 5-day. 10-11% of contact occurred the day it was due but minutes/hours after
- Data entry errors responsible for about 16% missed

Screening reports were reviewed by child safety consultants who identified inconsistent application of screening rule and procedure around the state, leading to inconsistent responses to child safety. Reviews identified differences by branches as to what was screened in or the response times assigned, and variations across 15 different intake units across 16 districts where consistency and fidelity was not maintained. Screening reviews also identified overextended supervisors resulting in delays in approving or assigning Closed at Screening reports. Those that end up assigned rather than closed are often already out of compliance with timely response. The Closed at Screening Fidelity Reviews also found that reviewers disagreed with decisions in the closing reports between 12-43% of the time. Root causes Identified include:
- Current structure of 15 independent hotlines around the state
- Inadequate training for screening staff and supervisors
- Lack of clarity in regard to responsibility for screening, assignment and assessment when multiple counties are involved

The safety consultant team also conducted a statewide review of completed CPS assessments in January 2017 focused on timeliness to initial contact and recurrence of maltreatment. CPS assessments from July

through December 2016 identified as not meeting mandated timelines were selected for the review. The findings from these reviews indicated that delays in making initial face to face contact and poor or inconsistent documentation of initial safety assessments had a negative impact on timely and accurate child safety decisions. Further, because assessments are overdue, case planning suffers as the case plan is built on the assessment.

There has been continued analysis regarding the comprehensiveness of the assessment and the appropriateness of the safety decisions on the first maltreatment episode. This new data is reviewed monthly by the Safety Consultant and district leadership and used to determine the focus of consultant and leadership activities for the month.

Analysis of the review findings is also indicative that lack of sufficient ongoing safety monitoring contributes to reoccurring maltreatment during trial home visits and after case closure (67.3% of reoccurring maltreatment occurred on closed cases). Ongoing consultant coaching has included a focus on ensuring conditions for return are accurately identified and monitored to meet the safety needs of the children, and the conditions are met before children are returned home with an ongoing safety plan. Additional data gathered during fidelity reviews indicate that assessments with family conditions involving domestic violence and substance abuse were not assessed thoroughly resulting in premature closure when impending danger safety threats were likely present. The subsequent report often resulted in recurrence of maltreatment.

While Oregon's maltreatment in foster care is approximately twice the federal standard, analysis has been done to determine the root causes. Our data analysis has determined that over half confirmed instances of maltreatment in foster care occur during THVs and involve a perpetrator(s) other than the foster parent. Reports of maltreatment in foster care currently include children who have experienced maltreatment during a trial home visit, as well as reports of historical familial abuse that arise while a child is in foster care. In addition, the lack of requested support to overtaxed foster parents has resulted in maltreatment to children in foster care. Child safety consultants have teamed with field staff and other program consultants in reviewing cases where maltreatment occurred in foster care.

Oregon's Practice Model

Oregon has greatly strengthened the commitment and resources allotted to the practice model which has been in place since 2006. Barriers to practicing the safety model with fidelity continue to be staff and supervisor turnover, high caseloads, inconsistent application of the practice model, and lack of ongoing, sustainable training on critical thinking and how to supervise to the practice model. New staff who complete new worker training indicate their supervisors do not always appear to fully understand the practice model making their newly learned skills difficult to maintain in that culture. Supervisors have also confirmed that new staff often do come back to their district with more advanced skills than they as supervisors may have in multiple areas of practice.

By investing additional resources in the practice model, Oregon intends to improve practice and retain workforce. However, fidelity to the practice model has been a challenge for staff. To understand the reasons for this, Fidelity Reviews to evaluate application of the practice model have been completed by the Child Safety Team in 9 of the 16 districts as an ongoing continuous quality improvement process. Trends identified in these reviews include lack of completion of all required interviews, insufficient collateral contacts, lack of comprehensive safety information gathering leading to incomplete application of the safety threshold criteria. Additionally, in recent audits and interviews, caseworkers noted "they are having to handle unsafe situations alone, adequate training has been slow to develop, and busy supervisors are not able to adequately support staff." Field staff also report too many tasks to complete and lack of clarity due to the complexity of the Oregon practice model with its numerous domains.

The PIP incorporates the reinforcement of the practice model, rather than replacing it for various reasons, including:

- The length, breadth, and depth of resources committed to the practice model;
- Legislative investment in it;
- Newly redesigned and implemented (2017) new worker training grounded in the practice model;
- There have been limited opportunities to develop fidelity to the model due to significant turnover amongst staff; and
- Supports to achieve fidelity have been lacking due to inexperienced supervisors, inadequate caseworker and supervisor training, and supervisory supports.

Strategies and Links to Outcomes:

Strategy A: Ensure a consistent statewide response to allegations of abuse.

Recognizing that consistent and accurate screening decisions are paramount to positive child safety outcomes, development is underway for Oregon's new 24/7 Centralized Child Safety Hotline. Implementation of the Centralized Hotline by April of 2019 is expected to support on-site leadership, enhanced training opportunities, and consistent application of statute, rules and procedures. Consistent and timely screening decisions should result in a direct impact on child safety outcomes, in particular around initial contact timeliness with alleged victims. New screening training on specific elements of the safety model along with administrative rule changes will ensure all screeners and supervisors have strong policy and practice guidance for assignment decisions and for gathering the right safety related information from callers. New predictive analytic algorithms will also be introduced to assist in reducing bias and streamlining assignment.

Multiple avenues of work related to a consistent statewide response have begun with hotline screeners to ensure documentation of screening reports after hours are completed accurately resulting in timely response to initial contact with alleged victims. Implementation of the Inter-County Case Responsibilities Procedure was developed in partnership with district leadership and has been disseminated statewide. This should result in more clarity around responsibility of consistency in screening assignment and assessment to the correct county. These technical solutions will lay the foundation for adaptive change to occur once implementation occurs and practice changes. Standardizing expectations, processes, and supports (e.g. information system modifications) are intended to minimize data entry error, decrease the margin of timeliness, and ensure consistent application of screening and assignment.

Strategy B: Improve timeliness to face to face contact with children and families during CPS assessments.

Oregon believes that timely face to face contacts with all child victims and completion of comprehensive child safety assessments is vital to ensuring child safety and well-being. Data is used to monitor timeliness to face to face contact in all 16 districts by collaboration between Child Safety Consultants, supervisors, program managers and other staff. The information is reviewed each month and a summary of root cause analysis is provided through monthly reports completed by the consultants and shared with district leadership. Action items including additional training on rule and face to face contact requirements, supervisor monitoring, correct data entry, computer system changes and updates reinforced by coaching and mentoring should improve outcomes for this strategy. Although data has been collected in the past to monitor timeliness to contact, the enhanced layer of action planning and CQI in this PIP is critical to practice change. The proposed CQI methods will improve the collection and use of data, assisting in management and decision making by data. Evidence based practice has shown that successfully managing by data leads to culture, behavioral, and practice change within units, districts and the state. Utilizing root cause analysis and action planning with field staff and managers will move the agency beyond knowing the "what" to understanding and continuously addressing the "why". The ongoing, focused efforts have already generated improvement in timely initial contacts in most districts throughout the state.

Strategy C: Improve comprehensive safety assessments and ensure safety services adequately manage child safety during in-home plans including during trial home visits.

Caseworkers must gather comprehensive and accurate safety related information to assess safety threats and the underlying family conditions that impact child safety. Child Safety and Permanency Consultants with safety model and coaching expertise are housed in child welfare branches around the state and provide in person coaching, training and ongoing consultation to caseworkers and supervisors. The Legislature provided Oregon Child Welfare with investments including the allocation for 50 MAPS (Mentoring, Assisting, Promoting Success)- formerly known as CETs (Consultant Education Trainers) -these are internal positions that augment our services by providing additional supports to supervisors, new caseworkers and more seasoned caseworkers. The MAPS' key responsibilities are to support caseworkers through their first year on the job with a focus on training and retention. The position will provide both general and case-specific consultation, support and training of new and existing caseworkers, and will facilitate the effective functioning of units within the branch. MAPS will provide the necessary bridge from practice model training to on the job skill development within the workforce. In addition, funding has been delegated for two additional professional development areas of advanced worker training and line child welfare supervisor skill development.

Case workers will improve their knowledge and skills in identifying correct safety threats and implementing sufficient safety plans in both in-home and out of home cases with ongoing coaching and consultation with the child safety and permanency consultants and MAPS. Monthly reviews by child safety consultants of cases with recurrence of maltreatment will occur and the root-cause analysis will be shared with leadership during ongoing debrief calls facilitated by consultants. Action plans will be developed with action items such as training, coaching, field work, etc. and will be implemented by program consultants in partnership with child welfare staff based on specific trends and themes.

Safety Model/CPS Fidelity Reviews have been completed in just over half of the state. Six- month follow-up reviews are also occurring in early reviewed districts and Action Plans are already being reviewed and adjusted as necessary when goals are met or new ones are developed based on the outcome of the follow up review. Leadership is engaged in the process and collaborating in development, implementation, and adjustment of Action Plans.

Multiple ongoing training efforts are underway included Confirming Safe Environments training which has been provided to all staff, and has now been infused throughout new worker and Social Service Assistant (SSA) training, in May 2018. This topic will also be considered for advanced training opportunities in our ongoing training plan. Consultants are partnering with ORKIDS trainers throughout the state to provide enhanced learning opportunities on how to conduct a comprehensive assessment, assess for present and impending danger, develop safety plans, ongoing family assessment and case plan development, monitoring safety plans, developing expected outcomes and documentation requirements for case worker management. New enhanced worker training has been developed and implemented to help ensure the new workforce has the skills necessary to utilize the safety model in their day to day caseworker practice. Oregon has struggled with high rates of caseworker turnover and a large percentage of less experienced staff have entered supervisory positions in recent years. Supervisors are the key to ensuring caseworkers are assessing safety concerns through consistent application of the safety model therefore it is important that supervisors receive the training, and tools necessary. Oregon recognizes staff retention and a highly trained workforce are vital to impacting safety model fidelity resulting in better child safety outcomes. In addition, a higher level of coaching and supervision will be provided to field workers to address other identified gaps that training alone cannot address. Both the training and enhanced supervision emphasize and will reinforce the need for quality contact with children and families, as well as proper documentation of such contacts.

Strategy D: Improve child safety throughout the life of the case, by conducting frequent and accurate safety monitoring activities.

Supervisors are an integral part of ensuring child safety outcomes are met. In order to effectively determine whether case workers are making quality face to face contacts and monitoring ongoing child safety, they will

be provided with enhanced training on these subjects. Supervisors will subsequently be expected to use the 90-day staffing meetings to provide coaching and support to ensure consistent safety monitoring is occurring on all open cases and support the skill development of their staff. Data will be collected and monitored to determine if outcomes are improving on safety plan monitoring using CFSR case reviews, ROM reports and Quarterly Business Review (QBR) information.

Ongoing efforts to increase fidelity to the safety model will include providing mandatory training modules twice per year to all permanency workers and supervisors. Recognizing training alone will not support practice change structured group supervision sessions will occur in each branch facilitated initially by permanency consultants as a model for supervisors. Fidelity QA reviews will occur in each branch twice per year on a random sampling of cases to measure increased fidelity to the model. Training and mentoring support for supervisors and empowering them to lead group supervision should begin to ameliorate concerns that workers have more knowledge then their supervisors when they come back from training. (Please also reference Goal 4, Improving Workforce Development)

In order to ensure children are safer during their stay in foster care, it will be paramount to better prepare foster parents for difficulties they may experience while parenting children and young adults who have experienced trauma. Oregon will utilize both established programs that support and educate foster parents (KEEP and Maple Star) along with newer programs (GRACE and Every Child) focusing on recruitment and customer service. KEEP is an evidence-based support and skill enhancement education program for foster and kinship parents of children and teens who attend 16 weekly 90-minute sessions that focus on practical, research-based parenting techniques. Maple Star's Foster Care Training and Support (FCTS) program offers pre-service and ongoing training and support to DHS foster families. The program emphasizes initial and ongoing training, as well as proactive and crisis coaching and support in order to increase retention of foster parents and decrease disruption of youth in foster placements. GRACE (Growing Resources and Alliances through Collaborative Efforts) was a cooperative agreement that operated in 5 districts to develop a Statewide Diligent Recruitment Practice Model driven by data with a customer service approach to recruit and retain resource families who reflect the culture & characteristics of the children in foster care, develop and sustain thriving Community Partnerships, and build on Oregon's infrastructure of supporting early and active Permanency Planning to impact permanency outcomes. Every Child was created as a customer service, community engagement, and foster parent recruitment pilot program and developed in conjunction with three counties who are implementing the GRACE model. As a result of this success, the Portland Leadership Foundation (PLF) and DHS have contracted to expand Every Child to statewide by 2022. Currently Every Child is involved with intentional support and development in 11 of 36 counties. In the course of recruitment and support, Grace, Every Child, KEEP and Maple Star will be assisting in foster families being better prepared to support the needs of children placed in their homes through provision of necessary services, regular communication and supports, respite and placement matching which are vital to minimizing maltreatment in foster care. Better prepared and supported foster parents will be able to provide better care, safety and stability to foster children.

A. Ensure a consistent, statewide response to allegations of abuse (aligns with Unified Plan, Task G).

Activity	Expected impact of the strategy and collective activities
A.1 Supervisors, program managers and consultants will coach screening staff to accurately identify and document date and time of screening reports received outside of business hours. Activities started January 2017 and will continue through full implementation of Centralized Screening, as part of Oregon's continuous quality improvement effort. Quarter 1 and ongoing. A.2 Safety team completing monthly analysis of timeliness to initial contact utilizing ROM Report CPS.03 in all 16 Districts. Follow up debriefs then occurring on a bi-monthly basis with all districts in which these cases are identified and discussed. Quarter 1 and ongoing A.3 Statewide communication will be disseminated clarifying the date to document within the Screening Report as "date of incident". Quarter 1 and ongoing.	A.1-3 Increase accuracy of documentation and timely response to reports of abuse and neglect.
A.4 Revised "Inter-County Case Responsibilities Procedure" developed and implemented to address inconsistencies and timeliness of assignment delays when multiple counties are involved in a case. Statewide communication will be disseminated and ongoing coaching will be provided to staff by the Child Safety Consultants. Quarter 1 and ongoing.	A.4 Clarifies county of primary CPS assessment assignment reducing delay of timely contact.
A.5 Develop and implement a centralized hotline operation supported by consistent policies and on-site leadership. • Develop project implementation plan with the assistance for ACTION for Child Protection. Quarter 1 • Develop workforce and staffing plan with the assistance of ACTION for Child Protection. Quarter 1 • Develop rules and procedures with the assistance of ACTION for Child Protection. Quarter 2 • Develop training curriculum, coaching plan and CQI plan with the assistance of Action for Child Protection. Quarter 2 Implementation begins April 2019.	A.5 The centralized hotline will result in trained screening staff responding to reports of abuse/neglect 24/7. A.5 Hotline supervisors devoted only to screening will result in reports of child neglect and abuse being reviewed and addressed more timely, improving timeliness to initial contact. A.5 Timely supervisory staffing of reports will occur as a result of the dedicated staffing structure of the centralized hotline. A.5 Trained staff and adequately resourced supervisors will make accurate screening decisions, consistent with rule, and timely assignments of reports.

B. Improve timeliness to face to face contact with children and families during CPS assessments.

Activity	Expected impact of the strategy and collective activities
B.1 OR-Kids change request to reflect the due date and time of initial contact on the screening report and in the email notification of assignment to help workers identify and achieve initial contact timelines. Quarter 2.	B.1 Child safety will be improved by responding more timely to allegations of child abuse and neglect. B.1 The system updates will provide an immediate reminder of due dates which will result in increased accurate response time for seeing children.
B.2 Child Welfare data systems and reports modified to accurately capture the due date of initial contact on Within 5 Day Response referrals; defined as calendar days to be consistent with CPS Rule. Completed January 2018.	B.2. Clear and consistent definitions and tracking of timelines for contact will reinforce practice for CPS workers' response to safety.
B.3 Targeted data collection occurring in all 16 districts on a monthly basis regarding timeliness to initial contact utilizing ROM reports. Child Safety Consultants gathering and analyzing timeliness data including root cause analysis of all cases not meeting timeliness standards. Quarter 1 and ongoing	B.3. Ongoing analysis of timeliness data will identify root cause issues that will be the basis for action items to improve timely response of face to face contact with all children and adults.
B.4 Monthly timeliness data will be reviewed with local leadership in all 16 districts on a bi-monthly basis. Action items will be implemented and monitored on a bi-monthly basis, specific to the needs of each district. Quarter 1 and ongoing	B.4 Monthly reviews debriefed with each district will demonstrate a measured improvement in timeliness of response. B.4 Action items developed will result in sustained practice improvements and local accountability by district leadership. B.4. Trained staff who understand child safety implications as well as system requirements of timely initial contact.
B.5 CPS workers will utilize available technology including Surface Pros, Speak Write and iPhones to accurately enter initial contacts into OR-Kids that reflect timely response to reports of abuse. Quarter 1 and ongoing	B.5. Supervisors and program managers will be able to review work in real time to assess if all required contacts have occurred within timeframes.

C. Improve comprehensive safety assessments and ensure safety services adequately manage child safety during in-home plans including but not limited to trial home visits.

Activity	Expected impact of the strategy and collective activities
C.1 Targeted data collection regarding recurrence of maltreatment will be gathered and reviewed monthly with local leadership in all 16 districts. The reviews include root cause analysis on a representative sampling of children experiencing re-abuse in each district. Specific trends and themes will be identified and relevant action items that address child safety will be developed with district leadership. Quarter 1 and ongoing	C.1 Overall child safety will be improved by conducting consistent comprehensive safety assessments.

Activity	Expected impact of the strategy and collective activities
C.2 Based on CPS Fidelity Reviews completed in 9 of 16 districts statewide practice areas impacting child safety planning and decisions have been identified. District specific Action Plans have been developed for nine of the sixteen districts. While each district is able to individualize their Action Plan accordingly, all districts have similar elements of focus including but not limited to: ensuring all required interviews are completed, making sufficient collateral contacts, gathering comprehensive safety related information and accurately applying the safety threshold criteria. The remaining districts will have Action plans completed by December of 2018 that will include the following statewide practice areas: ensuring all required interviews are completed, making sufficient collateral contacts, gathering comprehensive safety related information and accurately applying the safety threshold criteria. In addition, specific district practice trends will be included. Quarter 2.	C.2 Reduction in recurrence of maltreatment specifically related to identified abuse types specific to threat of harm, domestic violence, neglect, etc.
C.3 Action Plans will be reviewed with districts at 6 months from development to monitor results of activities and goal progression and adjust the Action Plan as necessary based on the individual needs relating to safety in each district. Quarter 3 and quarterly, ongoing C.4 Action plans will include continuous quality improvement plans including topic specific labs, mini-trainings focused on domestic violence and substance abuse, group supervision, targeted fidelity reviews of in-home criteria, safety plans, face to face contacts, collateral contacts, 60-90-day check-ins, and quality assurance by supervisors and consultants. Quarter 3 and ongoing.	C.3 Increased local leadership understanding and accountability for managing improvements in conducting assessments that ensure safety threats are identified and managed sufficiently when present or impending danger is identified. C.2-4 Action plans will provide clear structure and accountability for each district to conduct comprehensive assessments that sufficiently manage safety. C.4 Casework staff will make improved safety decisions in cases involving domestic violence and substance abuse. In addition, recurrence of maltreatment will be decreased.
C.5 CPS consultants will partner with OR-Kids trainers and provide ongoing OR-Kids documentation (documenting to safety) trainings to staff completing CPS assessments. These trainings review the practice model and provide structured coaching to demonstrate the proper and timely documentation of safety assessment activities including accurate documentation of all safety decisions and actions. Quarter 1 and ongoing. C.6 Classroom training for new hires will include practice model review, as well as in depth discussion and training on how to conduct a comprehensive assessment, assessing for present and impending danger, developing safety plans, ongoing family assessments/case plans, monitoring child safety, and meeting expected outcomes timelines during initial and ongoing safety assessments and documentation requirements in OR-Kids are included in new worker training (Refer to Goal 4, Strategy C, Workforce Development, for further details). Quarter 1 and ongoing.	C.5-6 Casework staff and supervisors will understand Oregon's practice model and be able to assess safety, evaluate the in-home criteria, and make necessary adjustments to safety plans.

Activity	Expected impact of the strategy and collective activities
C.7 The ongoing CFSR will continue to measure items 2 and 3 to determine effectiveness of structured training and action plans. C.8 ROM reports will be utilized to measure and identify practice issues and training needs. Quarter 1 and ongoing.	C.7 Oregon Child Welfare will increase and improve child safety and ongoing risk assessments. C.8 Oregon will utilize real time data and reports to continuously assess practice and develop benchmark goals for improved child safety outcomes.

D. Improve child safety throughout the life of the case, by conducting frequent and accurate safety monitoring activities.

Activity	Expected impact of the strategy and collective activities
D.1 Supervisors will receive training to effectively determine whether quality of face to face contact is taking place, and ongoing safety is being monitored. Supervisors will in turn utilize the 90-day staffing meetings to provide coaching, support and to ensure frequent and accurate safety monitoring is consistently occurring. Quarter 1 and ongoing. (Refer to Goal 2, Strategy A, activities A.1 and A.2 for further details). D.2 Consultants will collect data resulting from the CFSR case reviews, ROM reports and QBR information that demonstrate if safety is being monitored ongoing and accurately on a consistent basis. Action plans will be implemented and monitored at the district level to address gaps identified by the reviews. Quarter 1 and ongoing Other activities in the Program Improvement Plan, are designed to improve overall safety, in conjunction with this strategy. (Refer to Goal 2, Strategy D, Increase Fidelity to Oregon's Practice Model, Activities D1-4, and Strategy F, Strengthen the Support for Certified Families, for further details).	D.1-2 Children in substitute care and in-home will be safer. Caseworkers will have more clear direction, coaching and frequent reminders of how to assess and ensure safety throughout the life of the case. D.1-2 Maltreatment rates both in-home and in foster care will decrease as a result of frequent and ongoing safety monitoring

Goal 2: Improving Child Permanency

Goal Statement

Oregon children and youth in substitute care will achieve legal permanency in a more timely and efficient way.

Analysis of the Data & Underlying Issues

All of Oregon's Child and Family Services Review (CFSR) Items and Systemic Factors in the areas of Permanency were identified as Areas Needing Improvement (ANI). In order to put together a plan with effective activities to address those ANI, several groups were formed to perform root cause analysis. Multiple groups consisting of agency field and program staff and community partners were consulted around causes and possible interventions to address the items being ANI. After a good deal of qualitative and quantitative data was gathered, analysis has been done to determine practice areas needing improvement that could potentially impact multiple items in the CFSR.

Data was collected as follows:

Qualitative:

- Full analysis of the narrative results of the CFSR
- Analysis of QA reviews completed on Permanency cases
- Program and District Managers across the state and the Legal Assistance Specialists were engaged in discussion about barriers to timely Permanency
- Qualitative and Quantitative evaluation data from the Leveraging Intensive Family Engagement (LIFE) demonstration project

Quantitative:

- Discharge reasons for FFY16
- Length of Stay for each discharge type FFY16
- Permanency for children in care over 24 months 10/15 – 9/16
- Permanency for children in care between 12-23 months 10/15 – 9/16
- Permanency in 12 months 10/15 – 9/16
- Time in care- point in time
- Time care at Permanency – discharge data
- Adopted in 12 months of TPR by district, branch, race and age
- Perm in 12 months FFY 16
- Perm in 24 months FFY 16
- Three separate work groups addressing sets of items on the CFSR findings:
    1. Meeting Children's Needs (items 12A, 13, 14, 16, 17, 18, 26, 27, 29, 30) This group's focus was root cause analysis for addressing why the items being assessed were ANI, as well as proposing potential interventions to improve performance. The group was made up of Central Office staff, provider stakeholders, caseworkers, supervisors and field program managers, a former foster youth, and a foster parent
    2. Meeting Parent's Needs (items 8, 11, 12B, 13, 15, 16, 20, 26, 27, 29, 30) This group's focus

was root cause analysis for addressing why the items being assessed were ANI, as well as proposing potential interventions to improve performance. The group was made up of Central Office staff, service providers, caseworkers, supervisors, field program managers, and parents.

3. Achieving Permanency for Children (items 5, 6, 8, 20, 23, 26, 27, 36) This group's focus was analysis of poor performance of items related to timely permanency, as well as proposing potential interventions to improve performance. The group was made up of Central office staff, field caseworkers supervisors and program managers, representatives from OJD, JCIP and CASA organizations, and attorneys and judges.

Strategies and Links to Outcomes

Four practice areas, that if improved, could potentially impact all areas of Permanency were identified.

Quality Engagement and Ongoing Assessment of Needs

The importance of caseworkers having the skills and expectations to engage children and families that they interact with, appropriately assess and meet the needs of children and families, and document those interactions was highlighted in multiple groups. The work groups proposed solutions suggesting statewide guidelines for caseworkers and supervisors that provide tools to prompt planning for quality face-to-face contact, the documentation of the results of the contact, and the decision and review points for supervisors to move the work to consistency and quality across the state. Better engagement of families throughout the life of the case will lead to more timely permanency. The LIFE demonstration project is built on a foundation of quality, consistent engagement and is evidencing short-term outcomes that suggest more timely permanency for children and families involved in the project. The LIFE project also provides one example of how to continually assess the needs of children and families. The proposed activities that create guidance tools for both caseworkers and supervisors was based on the gap in consistency across units, branches, and the state in the regular, ongoing assessment of the needs to children and families.

Case transfers:

The case transfer process arose in two separate ways as a potential cause of ANI findings. The first process is the case transfer between Child Protective Services (CPS) and Permanency. The second process is from worker to worker and /or unit to unit. The transfer process between CPS and Permanency has been identified as a barrier to timely case planning. Historically, there has not been a statewide expectation regarding when a case transfers, and what pieces of work are required to be completed at the time of transfer. Each local district and branch have individually created and edited their transfer protocols, with varying degrees of success. Workers reported that they had to start over with paperwork and engagement delaying movement in the case. A consistent, statewide guideline to have cases transfer in a timely way will provide Permanency workers with the time and information necessary to engage with families in case planning, and document the permanency plan in the record system within federally outlined timelines. The second case transfer that is repeatedly identified as impeding timely permanency is when cases transfer between workers, and/or units. Increasing the competencies of supervisors in coaching and clinical supervision through the 90-day staffings and developing transfer guidelines will help bridge information about decisions that have been made, and will assist in mitigating some of the impact on families when cases transition to different caseworkers.

Fidelity to the practice model

Fidelity to, or lack thereof, was identified across the data as a barrier to timely permanency. Practice still is inconsistent across the districts, and when caseworkers are not appropriately applying the practice model components, it can delay reunification because children stay in care who could go home safely. Conversely, it can also delay moving to the concurrent plan if workers are not able to articulate what efforts

have been made to assist in changing protective capacity, and why those efforts were not successful. There has been attempts statewide to lift practice to fidelity over the last several years. In some areas, it has seen moderate success, in other areas, it has not been successful. (Please also refer to Goal 1, Strategy D narrative) The proposed interventions in the strategy addressing fidelity will improve performance by adding components that support a structure of assessment and feedback to field staff around the use of the practice model consistently and accurately. Accountability will be in place through the expectation that trainings and reviews are mandatory for all casework staff and branch management. Additionally, moving the group supervision facilitation from Permanency Consultants to field Supervisors begins to inherently build a plan for practice sustainability that has been missing in the past. By creating a clear structure of statewide assessment and feedback around correct use of the practice model, children will safely go home in a more timely way, or workers will clearly be able to articulate why children cannot safely reunite and the concurrent permanent plan for the child(ren) should be implemented.

Knowledge and sharing of effective practices toward timely Permanency

Oregon's permanency practice, as a whole, has been lacking in a consistent and structured format to analyze performance data, hypothesize interventions to improve performance, test the interventions, and then spread effective best practices across the state. Oregon is also a state with significantly different geography- there are some urban, large child welfare branches, some mid-size branches, and some very small, rural branches. Recognizing that there is not always an intervention that will fit any branch in Oregon, the work group that met and discussed timeliness data recommended a structure be built to implement interventions on a small scale, and then spread the information about what interventions supported effective practice change, and include the size of the branches in that communication.

Lack of timely permanency has been identified as an area needing improvement in the Department of Human Services' (DHS) Child and Family Services Review (CFSR) self-assessment, the Round 3 CFSR file reviews, and by the JCIP Advisory Committee. Data analysis conducted by the National Center for State Courts (NCSC) also shows that Oregon's percentage of children in care longer than two years is higher than the national average. It should be noted, however, that Oregon's permanency in 12 months indicators were found to be within 2-4 percentage points of national performance. During FFY2016, 41.5% of children who entered care within the previous 12 months, achieved permanency. This measure decreased slightly to 39.2% during FFY2017. The data shows that as children get older, they are less likely to achieve permanency within 12 months, with the lowest performance being in children served between the ages of 15-17. Breaking down the numbers by race, American Indians/Alaskan Natives and Black/African American's are the least likely to achieve permanency within 12 months of entry, while Asian/Pacific Islander and Hispanic children continue to be the most likely to achieve permanency within 12 months.

During FFY 2016, 45.3% of children achieved permanency within 12 to 23 months of entry, and 43.8% during FFY2017. The data shows the majority, 57.1% and 53.5% for FFY2016 and FFY2017 respectively, were reunified with parents or primary caregivers. An analysis of this measure in distribution by age revealed that children who are 0 to 2 years old at time of entry are the most likely to achieve permanency within the timeframes of this measure. It also shows that children who enter care at age 15 years old and older are the least likely to achieve permanency within this time frame. Similarly to the 12-month measure, the population who is least likely to achieve permanency in measure is the Black/African American children. This is also true for children achieving permanency for 24 months or longer. This issue continues to highlight an ongoing need for focused strategies in order for to achieve Oregon's goal of Safe and Equitable Foster Care Reduction Efforts.

For children who had been in care for 24 months or longer, the data shows that during FFY2016, 34.4% of them achieved permanency, compared to 37.2% during FFY2017. Unlike the previous two measures, this measure is dominated by Adoption as the primary form of permanency for this measure with 61.2%. Guardianship at 21.7%, is the next most prevalent, and then Reunification at 15.7%. State funded guardianship assistance may account for the increase in the number of children achieving guardianship during this time. As can be expected, there are significant differences in who achieves permanency by age

group in this measure, with the youngest children being most likely to achieve permanency during this period, and the oldest children being least likely.

Oregon CFSR data shows that for Round 3, item 5 had a total of 64 applicable cases, in which 48% were rated as strength. Of all cases rated as area needing improvement, 59% had adoption and 41% had reunification as the primary permanency goal. Further data analysis has shown that timeliness of adoption is particularly problematic in Oregon, and a problem within the adoption process is the fact that over 50% of children who become legally free do not have their adoption finalized within twelve months. CFSR data indicates that TPR was filed timely in 87% of these cases. To address this issue, Oregon will work very specifically during this Improvement Plan period to build supports for getting children's adoptions finalized within twelve months of being legally free. The staff in Central Office Permanency program will track children on the adoption track, and work with field staff to ensure that caseworkers are working on legally freeing children while concurrently working on designating the adoptive placement. The work to track and finalize adoptions within twelve months of being legally free will impact over 50% of children who are legally freed in Oregon.

Three counties in Oregon- Lane, Douglas and Klamath- have been chosen to implement interventions to shorten timeliness to permanency. The counties were chosen based, in part, on their varying size. By choosing a small county, a medium-sized county, and a large county, the positive outcomes and lessons learned will be transferrable across the state. The Child Permanency Program Manager and District Managers from each site will communicate changes in practice and business processes that positively impact permanency.

Please also reference Goal 4, Improving Workforce Development.

In order to Improve Child Permanency, we also looked at having a stable and robust provider community to care for the children needing a substitute care environment as a critical element. The department held community workgroups to develop an agenda to better meet the needs of children requiring substitute care in Oregon.
The workgroups focused on two primary areas;

- Increase the placement resource capacity for all children
- Strengthen the support for certified families

In order to increase the number of available placement resource options for children, the state must create a comprehensive Recruitment, Retention and Support plan to better define and achieve the results we are needing. This overall plan may include current actionable items or other statewide initiatives but they must all have a consistent center point of the plan. These efforts must also develop a way in which to serve a more diverse community of children and young people in Oregon.

The workgroup feedback made it clear that one of the missing elements is the constant focus or request for Recruitment of new families or new programs but it does not have a companion approach to Retention and Support of caregiver families or providers. Efforts must be as equally important for the Recruitment, Retention and Support of the caregiving community.

A. Develop and implement caseworker and supervisor permanency practice improvement tools.

Activity	Expected impact of the strategy and collective activities
A.1 Develop standard expectations for quality casework and quality supervision, grounded in the practice model, by creating two permanency tools and training staff to use them. • Will create a tool for supervisors that describes what to cover in each 90-day staffing meeting. The guidelines will be completed by the end of quarter 1 and will address the following: • Caseworker engagement of parents, foster parents, and children in case planning, assessment of ongoing needs of children and parents, quality of caseworker visits, confirming that the child's home environment is safe, and efforts around concurrent planning including timely documentation and appropriateness of the current and concurrent plan. Quarter 1 • Will create a tool for caseworkers to prepare for and guide their interaction with families: Design a common case note tool for caseworkers, addressing the following: • Engagement of parents, foster parents, and children in case planning, confirming that the child's home environment is safe, assessment of ongoing needs of children and parents, and efforts around concurrent planning. Quarter 1 A.2 Permanency consultants in collaboration with the CW training unit, will train and coach to these permanency guides and tools with supervisors and caseworkers. (Refer to Goal 4, Strategy A.2, for further details). Quarter 2 through quarter 3 A.3 Will institutionalize these practice improvements by: • Will use focus groups with caseworkers and supervisors and ongoing CFSR results to measure changes in practice and make adjustments as necessary Quarter 4 and ongoing • Will focus on assessment of ongoing needs of children and families and quality family engagement in Permanency Consultant coaching and training. Quarter 4 and ongoing • Will integrate the guidance and use of the supervision tool and the casework tool in to the procedure manual and rule Quarter 6	A.1-2 Children will be safer in their home settings. More accurate, consistent and timely documentation will inform decision making at critical case junctures. A.1-2 Children and families will experience an increase in quality of engagement in their face-to-face contact with their assigned caseworker A.1-3 When cases transfer between workers and supervisors, the staffing documentation will allow newly assigned staff to see the progress of the case and understand how decisions were made which will lessen the negative impact of transition between workers on families. A.1-3 Caseworkers will more effectively assess and meet the ongoing needs of children, youth, parents, and foster parents. A.1-3 The tools and guidance will assist caseworkers and supervisors with engagement. A.1-3 Improved engagement and assessment of needs will improve timeliness to permanency.

B. Improve timeliness to legal permanency.

Activity	Expected impact of the strategy and collective activities
<u>Strategic plans Based on Best Practice in Identified Driver Districts, Phasing Implementation Across the State:</u> B.1. Three districts have been identified as the intervention districts. They are District 5 (Lane), District 6 (Douglas) and District 11 (Klamath). They were chosen based on the following considerations: • Size- Oregon intentionally chose one large district (5), one medium size district (6) and one small district (11) to ensure transfer of learning across the state • Court capacity- JCIP partners reached out to the courts in each identified district to ensure their willingness and ability to partner in this effort • Leadership buy-in- the Child Permanency Program Manager has spoken with each District Manager to ensure their willingness and ability to participate • Performance data- Districts 5 and 6 were both identified via data analysis as two districts in the state with significant timeliness issues • JCIP, in collaboration with National Center for State Courts (NCSC), conducted a predictive analysis on long-stayers to identify barriers to permanency and factors increasing the likelihood of remaining in foster care for two years or longer. B.2. Schedule and hold work groups with selected districts to include Central Office staff, local court partners, and District staff to draft strategic plans. • OR Model Court Teams (comprised of JCIP, DHS, Judges, and Stakeholders) and the partners listed above will analyze DHS and JCIP data from the intervention districts, and convene to identify barriers, root causes, and indicators of performance. DHS and JCIP data will be reviewed by Model Court Teams, DHS Permanency Manager, and relevant partners quarterly • DHS and JCIP will survey Judges in the intervention districts to identify systemic barriers to achieving timely permanency. Strategic plans will include action steps which both DHS and the intervention district courts will be engaged in and responsible for. • Draft plans will be submitted to Permanency Manager and JCIP or Intervention district courts for approval	B1-8 The department will set appropriate permanency goals for children and youth in a timely manner. B.1-4 More children and youth will achieve timely reunification, guardianship, or adoption. B.1-5 Children will spend less time in foster care

Activity	Expected impact of the strategy and collective activities
B.3. DHS and JCIP will conduct readiness activities in the intervention districts to support implementation to include: • Implementation of a communication plan which contains clear messaging from DHS and Court leadership requiring participation • Identification and use of judges in the intervention districts to act as champions of the work. Quarter 2 B.4. Selected districts will implement their plans as soon as they are approved according to a staggered schedule to allow for adjustments during implementation. In other areas of practice with work plans (Refer to Goal 1 Strategy C Activity C.3 and Goal 2 Strategy E Activity E.4 for further details), the Consultant and Management teams in those designated areas will collaborate around activities on each plan. • Each plan will have an activity for both DHS and intervention district courts across reunification, adoption and guardianship. • DHS Safety Consultants, Permanency Consultants, and Legal Assistance Specialists will support implementation at the field level. • JCIP will support implementation in the intervention districts. Quarter 3 and ongoing B.5. DHS, JCIP, Model Court teams, and Intervention districts will monitor, evaluate local plans, progress, and barriers, and make adjustments as necessary by: • DHS, JCIP, Model Court Teams, and intervention districts will use qualitative data such as focus groups with local CW staff, court personnel, and other partners, and ongoing CFSR results to measure changes in practice and make adjustments as necessary. (Refer to Goal 2, Strategy A, Activity A.3 for further details). • DHS, JCIP, Model Court Teams, and intervention districts will analyze quantitative data such as ROM and JCIP data and convene to measure changes and make adjustments as necessary and will occur after implementation begins and ongoing**.** (Quarter 5 and quarterly thereafter) ng • JCIP will participate in DHS' ongoing CFSR reviews to Identify issues for system improvement; collect data for monitoring the progress and success of PIP implementation (CIP plan, Project 14)	B.1-8 The department will set appropriate permanency goals for children and youth in a timely manner. B.1-4 More children and youth will achieve timely reunification, guardianship, or adoption. B.1-5 Children will spend less time in foster care B.5 Oregon will have a structured plan to consistently share effective practice changes across the Department and with stakeholders

Activity	Expected impact of the strategy and collective activities
B.6 DHS, JCIP, Model Court Teams, and intervention districts will implement communication plan for dissemination, discussion and implementation of effective practice changes by**:** • Standing agenda item on monthly Program Managers' Meeting, District Managers' Meeting, JCIP Quarterly Advisory, and other re-occurring applicable staff meetings • Standing agenda items on model court team meetings and JCIP meetings Quarter 5 and ongoing **Will Ensure Early Establishment and Evaluation of Permanency Goals** B.6 Will develop a statewide case transfer process for every type of case being opened. Workgroup to be identified by the end of quarter 1. Process will be piloted by the end of quarter 12, adjusted based on feedback, and implemented statewide by the end of quarter 4. B.7 Develop standard expectations for quality casework and quality supervision, grounded in the practice model. (Refer to Goal 2 Strategy A, Activity A.1 for further details). Quarter 1 B.8 Will measure timely establishment of permanency goal via ROM reports, and progress in timeliness and appropriateness of permanency plans via ongoing CFSR findings, and use results to inform continued effective practices and changes needed Quarter 4 and ongoing	B1-8 The department will set appropriate permanency goals for children and youth in a timely manner. B.6 Statewide standardized case transfer process will provide appropriate timelines for case plan to be entered in a timely way, with appropriate permanency goal. B.7 Appropriateness of permanency plans will be evaluated early and ongoing throughout the life of the case, making sure the agency is pursuing the most appropriate plans for the children. B.6-8 Permanency outcomes will be achieved more timely for children.

C. Increase adoption finalization within 12 months of children being legally freed.

Activity	Expected impact of the strategy and collective activities
C.1 From the time of approval to pursue the plan of adoption to adoption finalization, caseworkers and supervisors will receive regular guidance from Central Office staff who specialize in the processes of freeing and placing children for adoption: • The Legal Assistance Specialists will provide caseworkers and their supervisors with case-specific information that provides the most expedient steps to concurrently identify/select/designate the adoptive placement, while legally freeing the child Quarter 1 and ongoing • Central Office Permanency support staff will review case records to confirm completion of necessary adoption paperwork, inquire with assigned caseworker regarding the status of the work including barriers to completion and expected completion date, and continue to follow up at appropriate intervals based on estimated completion dates (Will begin in D1, 2,4, 5, 6,12, 13 & 14, and expand through the state) Quarter 1 through the end of quarter 4 • The assigned LAS and Central Office support staff will continue coordinating communication with branch staff to ensure timely completion of adoption work Quarter 1 and ongoing • Permanency Managers and Consultants will conduct analysis on available data to determine whether or not we have increased the percentage of cases that finalize within one year of child being legally free, identify barriers and potential solutions, and make changes in practice on an ongoing basis Quarter 3 and ongoing C.2 Will improve Court and CRB oversight of the adoption process by: • JCIP will create and deliver a webinar and bench book to train judges, CRBs, CASAs, and attorneys on the adoption process, the adoption tracking materials submitted by DHS, and potential questions to ask at various stages of the adoption process. • Caseworkers will submit materials on the status of each required activity in the adoption process, prior to each court hearing or Citizen's Review Board review of a case for which adoption is the permanency plan Quarter 1 and ongoing • DHS Supervisors will review the status of adoption cases in each 90-staffing (Refer to Goal 2, Strategy A., Activity A.1 for further details). Quarter 2 and ongoing • JCIP will conduct a survey of judges and CRB field managers to evaluate the usefulness of the materials submitted by DHS, the frequency with which materials are submitted, the effectiveness of the webinar and training materials, and any additional barriers to adoption finalization in their jurisdictions. The results of the survey will be used to identify any needs for further trainings, improvement of the materials submitted by DHS, and additional interventions to produce more timely adoption finalization Quarter 3	C.1 Child Welfare field staff will gain a better understanding of the steps and timelines to finalize adoptions C.1 The percentage of children who become legally free who have adoptions finalize within one year will increase C.1-3 Children will achieve permanency more timely. C.1-3 The percentage of children who become legally free who had adoptions finalize within one year will increase C.2 Caseworkers will be able to anticipate the adoption process related questions that will be asked by courts and CRBs, and will be more prepared to answer questions

Activity	Expected impact of the strategy and collective activities
C.3 Support local multi-disciplinary teams' continuous quality improvement efforts to improve the timeliness of adoption finalization by: • JCIP will disseminate data from ROM PA.12 report to the judges and CRB field managers so that courts and model courts teams can use the data for local continuous quality improvement efforts Quarter 1 and ongoing • The state-level multidisciplinary JCIP Advisory Committee will meet on a quarterly basis and collaborate to monitor statewide improvement in PA.12 statistics, identify barriers to more likely adoption finalization, and, if needed, devise and implement additional strategies for finalizing adoptions in a more timely manner Quarter 1 and ongoing	C.1-3 Children will achieve permanency more timely. C.1-3 The percentage of children who become legally free who had adoptions finalize within one year will increase C.3 Courts and CRBs will have the information readily available to them to provide more effective oversight over DHS efforts to finalize adoptions C.3 Local court improvement teams' regular analysis of the data and information relating to performance will lead to better quality assurance at the local level, which will positively impact local performance relating to timeliness C.3 The standing agenda item at the statewide Advisory for developing and sharing strategies statewide will impact timeliness for the whole state

D. Increase fidelity to Oregon's practice model throughout the life of the case (aligns with Unified Plan, Task D).

Activity	Expected impact of the strategy and collective activities
D.1 Permanency consultants in collaboration with the CW training unit, will deliver five mandatory 1 ½ hour training modules on Oregon's practice model post assessment twice per year to all permanency workers and permanency supervisors. Quarter 1 and ongoing D.2 Will provide monthly group supervision in each branch. Initially to be facilitated by permanency consultants as a model for supervisors. Supervisors will facilitate group supervision. It will be conducted on active permanency cases addressing the elements of the practice model, including family engagement strategies and assessing and meeting the needs of the family throughout the life of the case Quarter 5 and ongoing D.3 Using a practice model post assessment QA tool, quality assurance reviews will be provided to each branch on practice twice per year on a random sampling of cases open for at least six months to measure increased fidelity to the model Quarter 1 on a rolling timeline D.4 Will provide a report summary to each branch on the overall trends for the branch, as well as details of each individual case, after each QA review. This will be in conjunction with the CFSR once per year. Will develop action plans in collaboration with branch leadership. Supervisors will provide additional one-on-one coaching to staff regarding areas identified as needing improvement. Quarter 1 and ongoing	D.1-4 Improved training and supervision will result in a better skilled and more stable workforce. This improvement will in turn positively impact timelines for achieving permanency. D.1-4 Increased fidelity to the practice model will prevent children and youth entry into substitute care or re- entry after reunification. D.1, D.4 Increased fidelity to the practice model will enable caseworkers to better assess and address the risk of safety concerns relating to children and youth in their homes or while in foster care. D.1, D.4 Increased fidelity will result in appropriate goals for children. D.1-4 More children and families will be involved in the life of a case and the quality of visits between caseworkers and children will increase. D.1, D.2, D.4 The increase of parental engagement will lead to more planning and communication, leading to permanency plans being achieved more timely.

E. Increase the placement resource capacity for all children.

Activity	Expected impact of the strategy and collective activities
E.1 Utilize the Oregon Foster Family Recruitment Retention and Support Diligent Recruitment planning tool (developed through the GRACE project) to create recruitment and retention plans at the Statewide level: • OFFRRS tool modified for Statewide perspective Quarter 1 • OFFRRS tool completed for Statewide use Quarter 2 • OFFRRS plan will be reviewed bi-annually, for the purpose of adjustments, data review, successes celebrated and challenges addressed. E.2 Explore other states and private agency models to determine factors that constitutes a supportive placement for children of color and LGBTQ youth: • Assess which models can be replicated and transferred into Oregon's practice Quarter 3 • Utilize OFFRRS plan to implement models Quarter 3 E.3 Every Child program model roll out through a statewide, 5-year Staged Implementation started in January 2017 and will conclude in 2022. • 12 of 36 counties will have active involvement the end of 2017. • 6 additional counties are projected to come online in 2018; Umatilla, Klamath, Deschutes, Curry, Douglas, Lincoln. • 4-6 counties (not currently identified) will come on line in 2019. *A component of the roll-out plan includes community readiness and interest. Quarter 2, selection of 2019 counties will be determined. E.4 Annual Foster Parent Survey to be completed and results compiled and distributed annually during the first quarter of the calendar year. • Results will be utilized in the OFFRRS reviews to create strategies to mitigate the areas of concern or negative findings. Quarter 3 E.5 Invest funds into the BRS system of care to increase capacity by 25 Shelter and Residential beds and an additional 50 BRS level foster homes (Proctor Care & Proctor Enhanced Services) Each quarter the providers will submit updates on both the expenditures of their funds and the impact on program/agency capacity Quarter 5 and ongoing	E.1 Statewide recruitment, retention and support plan will operate from a data-informed approach when recruiting and retaining additional foster families. E.2 Children of color and LGBTQ youth placement stability measures will be consistent with all children, youth in foster care. E.1, E.3 Increase the number of available family care providers each year utilizing 9/30/16 as a baseline. (time-period ties to the end of the CFSR Review period). E.3, E.4 State will increase coordination, and communities will have better knowledge of local-level capacity issues and needs of family foster care. E.5 Having an increase in BRS beds across the State will ensure that children in need of this level of care receive these services in a timely manner and decrease the overall need to use hotels for children in need of DHS BRS care and treatment.

F. Strengthen the support for certified families.

Activity	Expected impact of the strategy and collective activities
F.1 Monitor, Review and Analyze current foster parent support pilot projects (KEEP and Maple Star): • Identify and move to scale successful aspects of models. Quarter 5 F.2 Obtain foster parent recommendations through focus groups by the end of 2017, for Foster Parent supports ideas. Move the prioritized recommendations forward for legislative funding per SB 5526. Quarter 1 F.3 The Annual Foster Parent survey be completed and results compiled and distributed annually during the first quarter of the calendar year. Questions 4, 9, 12, 13, 15, 16, 18, 21 address different aspects of caregiver support. • Results will be utilized in the OFFRRS reviews to create strategies to mitigate the areas of concern or negative findings. Quarter 3 F.4 Department will move toward formalized Statewide Exit Survey's which can be reviewed to determine reasons for exiting care at the District level. • The Caregiver Exit Survey will provide qualitative information regarding reasons for exit and allow us to begin to track reasons that may be directly related to a lack of foster parent support. Quarter 3 F.5 Develop BRS services for children residing in their home of origin and kinship foster care. Develop goals and measurement tools to track prior to implementation. Quarter 5	F.1 Pilot models will identify successful components that can be supportive to foster parents and the program can be moved to expand within the pilot areas or replicated in additional counties. F.2 Foster parents request for supports will be implemented. F.1-4 Increased supports for foster parents and relative caregivers will enable more families to care for children: • Children will have increased placement stability. • Children will have increased safety in foster care • Caregivers of children will have increased satisfaction in their relationship with the department. • Foster Parents will increase their length of caregiving service. F.5 Children will be able to receive BRS services without needing to be removed from their families.

Goal 3: Improving Child Well-being

Goal Statement

Effective training and support of foster and adoptive families will improve the well-being of children and youth in substitute care in Oregon.

Summary

Analysis of CFSR data revealed many Oregon youth experience unstable placements. At worst, these can transform into unsafe settings. A core system improvement expected to directly impact children's well-being and improve Oregon's outcomes in this area, is the development of a better training infrastructure for foster and adoptive families. An enhanced and more effective training structure will provide foster parents with better tools and knowledge to better care for children. Better and more appropriate care will result in more placement stability, fewer placement moves, and will contribute to achieving timely permanency.

Aforementioned strategies and tasks, such as the development and implementation of permanency tools for caseworkers, will likely have a significant secondary impact on child well-being over time. For example, a caseworker's use of a common template and standardized guidance (Improving Child Permanency, Strategy A) could simultaneously improve permanency items 5 and 6 and well-being item 12A and 13.

A. Develop and support an infrastructure to ensure caregivers receive adequate training (aligns with Unified Plan, Task J).

Activity	Expected impact of the strategy and collective activities
A.1 Analyze budget of current training program, compare and contrast against national trends, and determine whether Oregon's training funds are being utilized in the most efficient way. Quarter 3	A.1 Oregon will better understand the financial impact of training needs per caregiver and can build a more realistic infrastructure for a quality training program to meet the needs of caregivers.
A.2 Develop a training website for prospective and current foster families. The website was completed in August 2017, and the agency continues to update it based on users' feedback and new activities.	A.2, A.6 Caregivers will have direct access to training opportunities within their community.
A.3 Consolidate training records into one area within the department information systems in order to track, assess, and analyze; access, utilization, timeliness appropriateness of training to meet the needs of caregivers. Quarter 6	A.1, 3-4 Consistent and comprehensive data will be available to better analyze ongoing needs, budget, and gaps in learning opportunities.
A.4 Annual Foster Parent Survey to be completed and results compiled and distributed annually during the first quarter of the calendar year. • The annual foster parent survey will include questions to gauge the effectiveness of training and supports to obtain training. Quarter 3	A.2, A.6 Caregivers will be able to access training with ample supports to complete the training. A.2, 4-6 Training opportunities and quality will be more consistent throughout the State.
A.5 The caregiver training redesign workgroup will develop caregiver core competencies and recommendations regarding the structure and delivery of Foundations Training. Quarter 3 (activity already underway)	A.6 Caregivers will have a consistent Foundation Training model statewide that more effectively meets their training needs.
A.6 The core competencies and recommendations developed in A.5 will be used to develop updated Foundation Training. Quarter 4	

Goal 4: Improving Workforce Development

Goal Statement

Oregon strives to develop and maintain an experienced and resilient child welfare workforce.

Summary

Improving the quality of training and the knowledge, skills, and abilities of the child welfare workforce will impact and improve outcomes across safety, permanency, and well-being outcome measures. Systemic factors 26 and 27 will be directly improved by the strategies and underlying activities in the plan below. This plan will include communication to all Child Welfare Program staff to develop a shared understanding of the strategic value and the role of our training system in the agency's achievement of family, worker, and organizational outcomes. This will include the development of an independent chapter in our child welfare procedure manual that is dedicated to clearly identifying our formal training system for all child welfare staff for pre-service training (training that is required prior to new workers being assigned cases), initial training requirements in the first year of employment, and ongoing advanced professional development yearly training requirements. This chapter will outline training requirements for all SSA's, SSS1's, and supervisors, and managers in order to foster a culture of accountability for professional development and creating stronger competency among our workforce.

Many different internal and external reviews as well as internal and external analysis of Oregon's Child Welfare practice has shown a common theme and that is the need for on-going and advanced training. This was identified most recently in the January 2018 Secretary of State Audit report, there were many areas in the report findings where chronic and systemic shortcomings that have a detrimental effect on our ability to protect child safety were referenced as key findings in the audit. This Audit confirmed what was identified in the Public Knowledge Report, Oregon's CFSR findings, and other internal fidelity reviews. The Unified Child and Youth Safety Plan was Oregon's response to the Public Knowledge Report and it includes a prioritized project for new worker and enhanced supervisor training (See description under Safety Goal). One of the specific recommendations of the Secretary of State audit was the need to continue to focus on and develop training for supervisors and casework staff to assist in their professional development. In addition, the legislature provided additional funding for the professional development needs of supervisors as well as funding for developing and expanding advanced training opportunities. Supervisors will still receive the current training and updates on practice in the Supervisor Quarterly meetings while a formal work group makes recommendations for redesigning supervisory training.

Inconsistency in supervision was determined to be a root cause for poor outcomes in safety, permanency and well-being. High workload issues and high turnover at the staff level has made it difficult to fill supervisor vacancies because it reduces the pool of experienced workers experienced enough to be supervisors. Currently, we have a very young supervisor group as a whole with approximately 30% of our supervisors have less than 5 years of experience in supervision. The excessive caseloads have not been sustainable and has caused significant turnover. This caused supervisors to not be able to adequately monitor caseloads, and created a continuous negative cycle. Addressing our workforce turnover and workload and improving supervisory training and supports will have direct and secondary impacts to strengthen our workforce by providing accountability for

the values and quality of consistent supervision. This will include professional development in coaching methodologies that supervisors, MAPS, and consultants will use in on the job skill building for all levels of staff. Training is often the first avenue in supporting a change and shift in culture. When coaching is added as an element, it can improve employee retention, productivity, and competency. Creating a coaching framework is critical to improved caseworker and supervisor retention, which are not directly reflected in the CFSR outcome measures, but directly impact the Child Welfare Program's capacity and ability to deliver services effectively in Oregon. A formal work group has been assembled to make recommendations for a redesigned and enhanced supervisory training curriculum. Until this work is complete supervisors will continue to receive training.

A well trained, highly skilled workforce is foundational to achieving best outcomes for children, youth, and families. As staff are being added to address our workload concerns, training and adequate transfer of learning modalities are critical. The additional 50 MAPS positions will be solely focused on onboarding, and transfer of learning for all new workers. This plan will include working in close collaboration with central administration to focus on training deliverables that influence placement stability, consistent practice, decreasing maltreatment reoccurrence, reunification, and foster care and permanency outcomes. Training is not only for new staff. Multiple regional advanced training courses are being added for caseworkers to have continued learning opportunities while the advanced training workgroup begins to design a formal advanced training plan.

A. Implement New Caseworker year one professional development.

Activity	Expected impact of the strategy and collective activities
A.1 Implement new caseworker classroom training, which includes evaluation and monitoring of new employee development and evaluation of core competencies. This training began on 9/11/17, and is ongoing. A.2 Train all Program Managers, supervisors and MAPS (Mentoring, Assisting and Promoting Success statewide on the new year-one professional development for caseworkers. First training was completed in February 2018, and additional trainings will be offered bi-annually, for new hires in these positions A.3 Transfer of learning from theory to practice will be measured and observed through the first year of a new caseworkers' employment and monitoring staff completion of training. Formal supervisor portfolios regarding new employees will be provided by PSU and incorporated into the formal training process. Supervisors will use these tools and evaluations to drive individualized improvement for each caseworker. This will be achieved through MAPS working in close collaboration with supervisors, consultants, assigned field program manager, and central office program. MAPS will work in close collaboration with their child welfare program managers and central administration to ensure field observation and help is available, and all defined transfer of learning activities are completed. Three significant tools have been developed to help: • Guides to equip MAPS and Supervisors with ideas, activities, and coaching supports. • OSM Conceptual Skills is a tool that has been developed for coaching feedback that includes rules/procedure references; learning activities and ideas; conceptual skill reviews; questioning techniques. • Oregon Child Welfare competency and Depth of Knowledge Matrix with competencies that are converted into observations. These tools have been developed and currently available online	A.1, A.3 New caseworkers will make concerted efforts to ensure continuity of family relationships and connections are preserved for children. A.1, A.3 New caseworkers will be more skilled in the art of engagement as a result of their professional development in their first year of employment. A.1, A.3, A.5 Worker retention rates will increase. A.2-6 Supervisors, and MAPS have the tools, resources, and support available to be successful supporting new caseworkers following their initial training. A.2, A.3, A.5 Supervisors and MAPS will better understand the expectations and be better prepared for the critical role they play in the success of training, transfer of learning, and on-the-job mentoring. A.2-3 MAPS and Supervisors will better understand how to bring their existing staff into understanding training expectations by offering opportunity to address knowledge gaps by attending training. A.2-4 Supervisors will better understand progress in new employee professional development through in-depth new employee portfolios that include all evaluation reports. A.1, A.3-4 All staff will better understand and have improved confidence in their role and responsibilities in child safety and the well-being of children and families. A.2-3, A.6 MAPS, Supervisors, and Consultants will have the skills to implement coaching supports for staff to create effective change.

Activity	Expected impact of the strategy and collective activities
A.4 Quarterly reports at the district level regarding new employee training and retention will inform central office curriculum reviews. In our strong partnership with PSU, regular evaluation and curriculum reviews are occurring now and will continue through PIP implementation period. This process started in January 2018, and is ongoing	A.2-6 Supervisors, and MAPS have the tools, resources, and support available to be successful supporting new caseworkers following their initial training. A.2-4 Supervisors will better understand progress in new employee professional development through in-depth new employee portfolios that include all evaluation reports. A.1, A.3-4 All staff will better understand and have improved confidence in their role and responsibilities in child safety and the well-being of children and families. A.4-6 MAPS and Supervisors will be better informed with data to conduct better analysis of needs, resources, and gaps in learning opportunities. A.4 Curriculum reviews will ensure policy and procedure alignments are accurate and up to date.
A.5 Implement Curriculum Reviews to assure QA. Program Managers and Consultants have observed and audited redesigned classes and provided important feedback on curriculum to assure fidelity between session summaries, curricula, and classroom delivery. We will utilize the Child Welfare Training Advisory Committee throughout PIP implementation period to share implementation findings and get feedback and recommendations in developing a formal evaluation process on the effectiveness of new training design. This process started in October 2017, and is ongoing	A.1, A.3, A.5 Worker retention rates will increase. A.2-6 Supervisors, and MAPS have the tools, resources, and support available to be successful supporting new caseworkers following their initial training. A.2, A.3, A.5 Supervisors and MAPS will better understand the expectations and be better prepared for the critical role they play in the success of training, transfer of learning, and on-the-job mentoring. A.4-6 MAPS and Supervisors will be better informed with data to conduct better analysis of needs, resources, and gaps in learning opportunities.
A.6 Develop and implement a Quality Assurance process through the Child Welfare Training Advisory Committee, central office administration, and PSU throughout PIP implementation period. Quarter 1 and ongoing	A.2-6 Supervisors, and MAPS have the tools, resources, and support available to be successful supporting new caseworkers following their initial training. A.4-6 MAPS and Supervisors will be better informed with data to conduct better analysis of needs, resources, and gaps in learning opportunities. A.2-3, A.6 MAPS, Supervisors, and Consultants will have the skills to implement coaching supports for staff to create effective change.

B. Revise professional development for field supervisors (aligns with the Unified Plan, Task C).

Activity	Expected impact of the strategy and collective activities
B.1 Form Supervisor Training Advisory Sub-Committee from the CW Training Advisory Committee. Quarter 1 • Subcommittee will conduct gap analysis and resource capacities of Supervisor training. The analysis will indicate the gaps between existing trainings at the local level and national research on best practice models for standardized supervisor clinical training. It will also respond to the known supervisory needs at the local level. Quarter 2 B.2 Develop a detailed project plan for supervisor professional development redesign. The project plan will contain key milestones for the development of a supervisor professional development curriculum, clear roles and responsibilities. Quarter 2. B.3 Develop and implement new clinical core curriculum for supervisors statewide that includes fidelity to the practice model. A successful new clinical core curriculum for supervisors will include core competencies in at least the following areas: clinical case practice, resource management, use of data to inform performance enhancements, and new worker development and retention. Quarter 6 B.4 Development of additional Supervisor supports that reinforce ongoing professional development beyond initial supervisor training. This includes a monthly newsletter, distance delivery training opportunities, advanced training 4 times per year at supervisor quarterlies, peer mentoring, communities of practice, and coaching. Two Supervisor Trainers and one support position (AS2) have been allocated and hired to join the DHS Child Welfare Training Team for successful implementation of supervisor professional development. Process started in January 2018, and is ongoing B.5 Ongoing Website enhancement that houses resources and interactive tools for supervisors, MAPS and stakeholders and is a primary reference point for caseworker support and guidelines. The website was completed in September 2017 and the agency continues to update it based on users' feedback and new activities.	B.1 Initially, the Child Welfare Program will be better informed of gaps that currently exist regarding developing and supporting clinical supervision skills and practice model skills. B.2-5 Accountability for supervisory outcomes, based on new core competencies, will improve quality of supervision for new employees and ultimately improve caseworker retention and improved outcomes across child and youth safety, permanency and well-being. B.3-5 Supervisors statewide will have common expectations for clinical supervision, understand and apply data to improve outcomes across child and youth safety, permanency and well-being. B.2-5 Clear expectations will result in improved retention of highly skilled supervisors. B.3-5 Supervisors will be better prepared to provide clinical supervision and fidelity of Oregon practice model through specific training that is provided to them.

C. Evaluate and redesign ongoing caseworker training.

Activity	Expected impact of the strategy and collective activities
C.1 Form Sub Committee from the CW Training Advisory Committee. • Subcommittee will develop an advanced professional development structure that begins with an annual ongoing training requirement for all child welfare staff. • Subcommittee will do a gap analysis to identify what advanced training exists and what advanced training needs to be contracted or developed for CW staff. • Subcommittee will consider what training is needed to develop a qualified and stable staff capable of delivering effective child welfare services. Quarter 2 C.2 Develop the project plan for caseworker ongoing professional development. Quarter 2 C.3 Develop an advanced ongoing training catalogue • This catalog will be a combination of on line training, classroom instruction, simulation, and other distance delivery training options. • The training catalog will be evaluated to ensure it reflects the needs of caseworkers, as measured by surveys, and strengthens casework practice. This catalog development will also incorporate program consultant feedback from assessment reviews, action planning, and coaching efforts as well as regular feedback from MAPS training and retention efforts in local offices. Quarter 3 C.4 Develop curriculum to enhance advanced training catalogue. • The Subcommittee will provide quality assurance oversight over the curriculum development. • Ongoing training needs for workers will be assessed through evaluation reports from training, field observation reports from MAPS, and tools provided to supervisors to drive individualized employee development plans throughout PIP timeline period and beyond. Quarter 6	C.1-2 The Child Welfare Program will be better informed about identifying, documenting, and measuring the impact of training on child and youth safety, permanency, and well-being outcome measures. C.2-4 Caseworkers will have a clearly defined path for ongoing professional development opportunities and requirements, using an advanced training catalogue. C.3-4 Ongoing training opportunities will enhance worker competencies in their specific casework disciplines C.2-4 Over time, the culture of learning and professional development among caseworkers will improve. C.2-4 When workers possess adequate skills, knowledge, abilities, DHS will be better positioned to engage clients and improve outcomes for children and families.