

State of Oregon

***Department of Human
Services***

Child Welfare System

**Foster Care in Oregon:
Chronic management failures
and high caseloads jeopardize
the safety of some of the
state's most vulnerable
children**

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Report Highlights

Oregon's most vulnerable children are being placed into a foster care system that has serious problems. Child welfare workers are burning out and consistently leaving the system in high numbers. The supply of suitable foster homes and residential facilities is dwindling, resulting in some children spending days and weeks in hotels. Foster parents are struggling with limited training, support and resources. Agency management's response to these problems has been slow, indecisive and inadequate. DHS and child welfare managers have not strategically addressed caseworker understaffing, recruitment and retention of foster homes, and a poorly implemented computer system that leaves caseworkers with inadequate information.

Background

Since 2011, there have been over 11,000 children in the Oregon foster care system each year. These children are vulnerable and are often the victims of child abuse and neglect.

Purpose

The purpose of the audit was to determine what changes and improvements DHS can make to better promote the wellbeing of children in foster care and ensure they are better protected and cared for.

Key Findings

1. DHS and Child Welfare struggle with chronic and systemic management shortcomings that have a detrimental effect on the agency's ability to protect child safety. Management has failed to address a work culture of blame and distrust, plan adequately for costly initiatives, address the root causes of systemic issues, use data to inform key decisions, and promote lasting program improvements. As a result, the child welfare system, which includes the foster care program, is disorganized, inconsistent, and high risk for the children it serves.
2. DHS does not have enough foster placements to meet the needs of at-risk children, due in part to a lack of a robust foster parent recruitment program. The agency struggles to retain and support the foster homes it does have within its network. The agency also lacks crucial data regarding how many foster placements are needed and the capacity of current foster homes, inhibiting the agency's ability to fully understand the scope of the problem.
3. A number of staffing challenges compromise the division's ability to perform essential child welfare functions. These challenges include chronic understaffing, overwhelming workloads, high turnover, and a large proportion of inexperienced staff in need of better training, supervision, and guidance.

Recommendations

We make 24 recommendations that address the agency's management challenges, foster parent recruitment and retention, and child welfare staffing. Our recommendations also affirm the foundational recommendations Public Knowledge LLC made in September 2016.

The Department generally agrees with our recommendations. The Department's response can be found at the end of the report.



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We sincerely appreciate the courtesies and cooperation extended by officials and employees of the Department of Human Services during the course of this audit.



Secretary of State Audit Report

Foster Care in Oregon: Chronic management failures and high caseloads jeopardize the safety of some of the state's most vulnerable children

Introduction

The Office of Child Welfare serves some of Oregon's most vulnerable children

In 2016, there were 11,191 children recorded as spending at least one day in the foster care system for the whole year, and a daily average of 7,600. Many are considered to be among the most vulnerable population of children and are often the victims of child abuse and neglect.

The Office of Child Welfare, one of five divisions under the Department of Human Services (DHS), is responsible for fielding and responding to reports of potential child abuse or neglect, securing appropriate alternative placements when children must be removed from their homes, and assisting local courts with custody decisions.

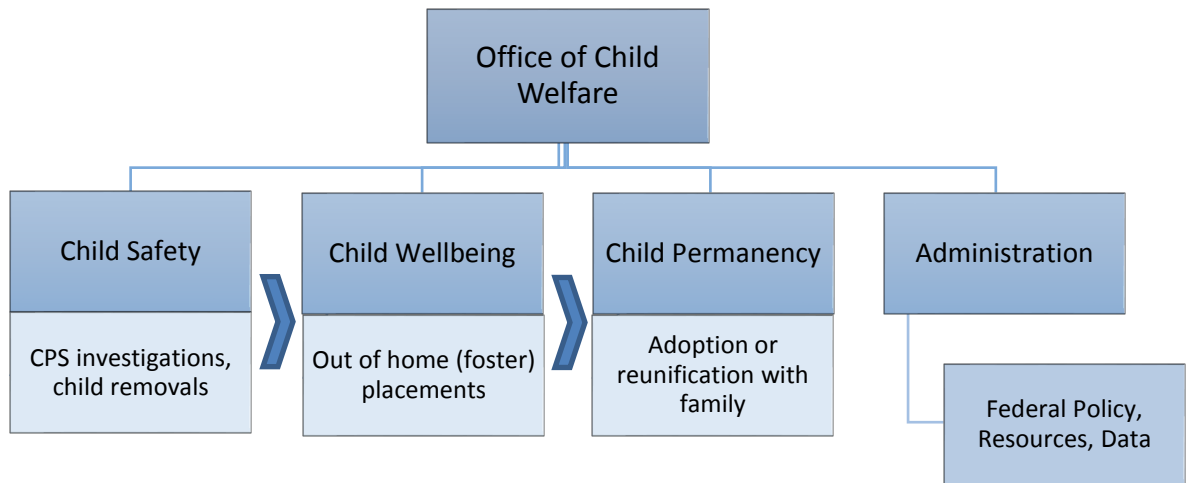
Children in foster care may be any age, from infants to age 18, but can receive services longer under certain circumstances.¹ They also come from many types of backgrounds, cultures, and families. Most children entering foster care have experienced abuse or neglect. They may have higher needs as a result of these experiences, including the grief and loss of being taken from their families.

Department of Human Services and the Office of Child Welfare

DHS employs about 8,000 staff and is divided into five key human service programs: Child Welfare, Aging and People with Disabilities, Self Sufficiency, Vocational Rehabilitation, and Intellectual or Development Disabilities. The agency's 2017-2019 biennial operating budget is \$11.3 billion. Child Welfare's total biennial budget is \$1.06 billion, or roughly \$500 million per year, half of which comes from the state's General Fund.

¹ Most often children "age out" of the foster care system at 18 years old. Under certain conditions, some services can be extended until 21 years of age.

Figure 1: Child Welfare Functions



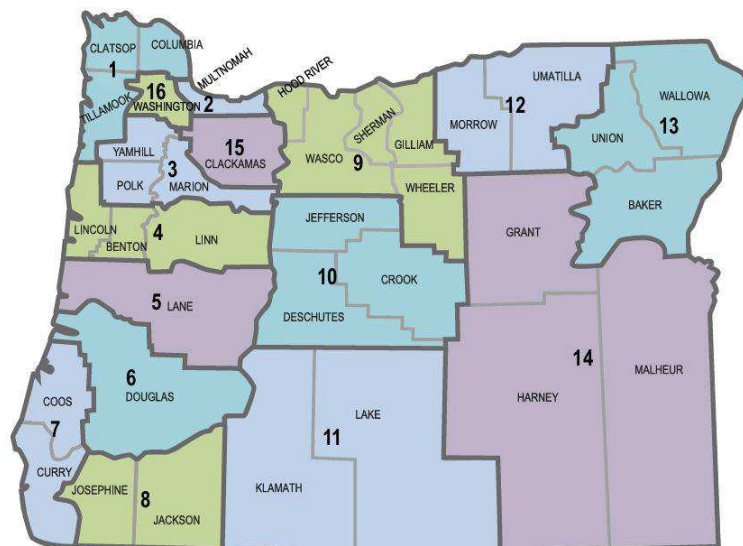
Source: DHS Organizational Chart

The Office of Child Welfare has three units as noted above, as well as Administration. All three units serve children that enter the foster care system, although the foster care program is housed in Child Wellbeing.

The districts all function very differently with little oversight

Child Welfare is divided into 16 districts and 47 field offices covering all Oregon counties. Each district is run by a District Manager that oversees both Child Welfare and Self Sufficiency. Districts report to the central office, but function independently to serve local communities. Prior management encouraged a more autonomous governance model for the districts, including budgeting and contracting activities. Recent agency reorganizations have left many districts with little oversight and support.

Figure 2: Child Welfare Across the State is Separated Into 16 Districts with Offices in all 36 Counties

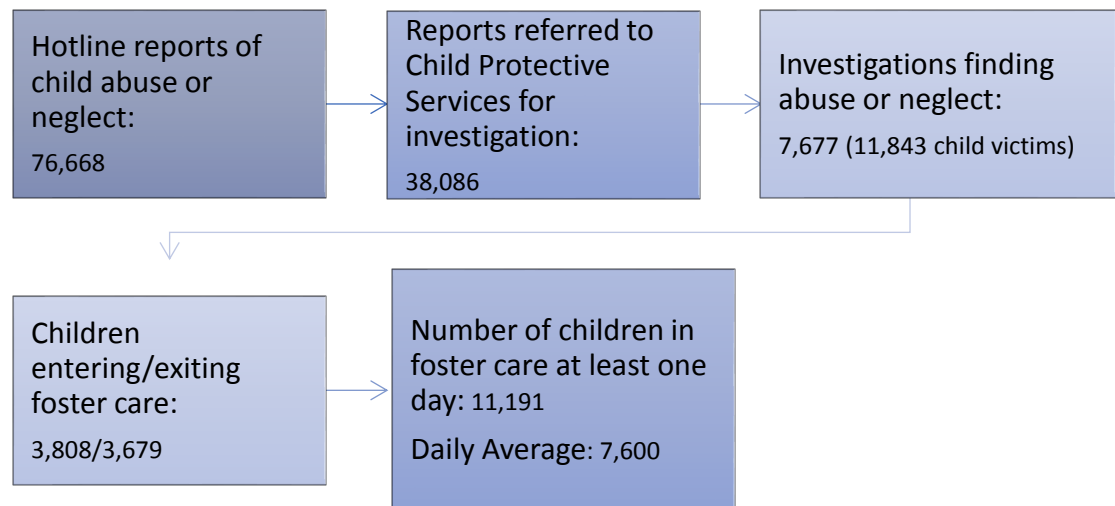


Source: Oregon Department of Human Services District (Feb 2016)

The child welfare system involves multiple steps

Reports of child abuse and neglect are screened through a hotline staffed by caseworkers who review and refer reports to Child Protective Services (CPS) workers for investigation. Public and private officials, required by law to report suspected abuse and neglect, made up about three quarters of the reports received by DHS in federal fiscal year (FFY) 2016. The majority of these reporters were from schools and law enforcement. The remaining reports were from parents and other individuals not required by law to report abuse.

Figure 3: Entries to Oregon Foster Care During FFY 2016



Source: 2016 Child Welfare Data Book

When investigators determine abuse or neglect occurred, a CPS caseworker may decide to close the investigation because the child is safe, open the case and implement an in-home safety plan, or remove the child from the home.² Once removed, the child enters state custody and is assigned a permanency caseworker to manage and monitor their case. After removal, the child may be placed back in the home with a period of caseworker monitoring, though most are placed with foster families or relatives.

High needs children and teens may be placed in more restrictive institutional settings or behavior rehabilitative programs. A local court makes the decision on whether and how long the child stays in state custody. After leaving state custody, the child may be returned to their home, become available for adoption through foster care, or enter long-term foster care or guardianship.³

² CPS statutory authority: ORS 409.050, 418.005

³ Guardianship is a legal relationship where a person is named as a child's caretaker by the court, but does not have full legal custody of the child. Guardianships are technically under court supervision until the child turns 18.

Who enters foster care?

DHS field offices receive emails every day about children who desperately need an immediate foster placement.

Boy, age 7: He has been homeless with his mother for over a year, and is currently living in a hotel. He has been subjected to drug abuse and neglect. He is behind in school, but just started going last month. He is now attending elementary school and an after school program, and is a very sweet child who likes doing arts and crafts, playing outside, and riding his bike.



Girl, age 10: This child loves animals and being active. She has Type 1 diabetes that is controlled with insulin and diet. She struggles with ongoing grief and loss, and is angry over her current situation. She has a history of physical aggression but this has not happened in a long time. She comes with a rabbit and a small tank with a fish and frog. She has court-ordered visits with her grandfather up to two weekends a month. She is smart and curious, does great in school, and is an excellent reader.

Girl, age 13: This child suffers from post-traumatic stress disorder as she was sexually assaulted on multiple occasions. She has anger issues which are being treated. She struggles with self-harming behaviors and suicidal ideation. She is currently placed back with her mother and this is not going well. Her mother is not following the safety plan. She does well with adults who support her and provide consistent boundaries. She has a good imagination and enjoys fantasy novels.

Source: DHS District Office

The Child welfare caseworker plays an important role

As of November 2017, Oregon employed just over 2,100 child welfare field staff, including approximately 1,300 caseworkers and 800 support, supervisory, and program staff.

The Social Service Specialist 1 classification includes five child welfare caseworker positions. Each focuses on a different aspect of the child's path through the system, including custody and placement decisions. CPS, and permanency and adoption caseworkers interact directly with children to investigate reports of abuse and neglect, determine child safety, monitor safety plans, make appropriate foster placements and, when applicable, manage the adoption process.

Figure 4: There are Five Types of Child Welfare Caseworkers in Oregon

Screening	Receives and assigns reports of potential child abuse and neglect submitted through hotline calls
Child Protective Services	Conducts child abuse and neglect assessments (investigations), initiates child removals
Permanency	Manages cases for children and teens in state custody, typically in foster placements
Certification	Conducts home studies and certifies foster providers, responsible for recruitment and retention of foster homes
Adoption	Manages cases for children and teens eligible for adoption

Source: DHS

DHS and the Office of Child Welfare have undergone several transformations that affect service delivery for foster children

Over the past decade, DHS has undergone structural changes, often prompted by new state and federal requirements. The following are a few of the large and far-reaching initiatives that have affected child welfare services:

Karly's Law⁴: Passed in 2008, this law mandates that children involved in a child abuse or neglect investigation who have suspicious injuries, as defined in law, receive medical attention within 48 hours.

Workload reporting⁵: House Bill 2123 was passed in 2009 and requires that DHS report every biennium on its workload and efforts to increase workforce efficiencies. DHS, in conjunction with a consulting firm, developed a workload model for field staff in all five divisions.

In 2013, DHS updated the model and has continued to report on its staffing needs to the Legislature. The model has never been fully funded or staffed to 100%.

The Strengthening, Preserving and Reunifying Families Act (SPRF)⁶: Passed as Senate Bill 964 in 2011 the act has had substantial and far-reaching effects on Child Welfare services in Oregon, though its effect on child outcomes is not clear. Since 2012, the agency has spent at least \$35 million on SPRF programming, which refocused agency efforts on keeping children with their families when possible.

⁴ Oregon Revised Statute (ORS) 419B.022 through 419B.024

⁵ ORS 409.161

⁶ ORS 418.580

Erin's Law⁷: Erin's law was passed by the state Legislature in 2015. It requires schools to provide instruction in child sexual abuse prevention to students in kindergarten through 12th grade.

Senate Bill 1515⁸: Passed in 2016, this bill and expanded oversight of Child Caring Agencies in Oregon and strengthened DHS's ability to monitor these programs.

In addition, there have been 11 substantive federal acts passed in the last 10 years that have impacted Child Welfare.

DHS performed poorly on the 2016 Federal Child and Family Services Review

This review,⁹ which states receive approximately every six years, assesses the overall ability of the child welfare system to serve and protect vulnerable children.

Historically, Oregon has not done well on these measures and has gotten worse over time. For the 2016 review, the state did not meet any of the seven outcome measures and did not meet five of the seven systemic factors. For example, the review showed inconsistent application of procedures across the state during the investigatory process and a lack of follow-up on allegations of abuse of children in foster care.

In addition, the review identified confusing DHS investigatory rules, policies, and processes. It also highlighted a lack of coordination among the multiple entities responsible for responding to allegations of abuse and neglect.

Recent scandals and intense public scrutiny have spurred actions targeting child welfare and foster care management

In 2015, news broke about ongoing child safety issues and misspent funds totaling close to \$2 million at Give Us This Day, a Child Welfare provider contracted to provide residential care and therapeutic foster care. The allegations included delayed payments to their staff and contracted foster families, substandard facilities, and improper use of force against foster children in their care by staff.

DHS compliance staff noted concerns about Give Us This Day as early as 2005 and recommended not renewing its license but DHS management opted to extend it.¹⁰ Concerns were raised again in 2009 and 2014, when former Give Us This Day staff reported poor facility conditions to the Legislature. From 2012 to 2015, Give Us This Day was one of several

⁷ ORS 326.051

⁸ Amendment to ORS 418.205

⁹ The Child and Family Services Review (CFSR) is conducted by the US Department of Health and Human Services Administration for Children and Families.

¹⁰ In 2005, the DHS Office of Licensing and Regulatory Oversight recommended not renewing Give Us This Day's operating license. DHS management chose instead to put Give Us This Day on a temporary action plan that extended the license.

organizations on an internal “radar list” of troubled providers.¹¹ DHS stopped sending children to Give Us This Day in September 2015, and the following month the Department of Justice forced the provider to cease operations. In November 2015, Governor Brown ordered an external review of DHS child safety practices in response to the safety concerns revealed by the Give Us This Day scandal.

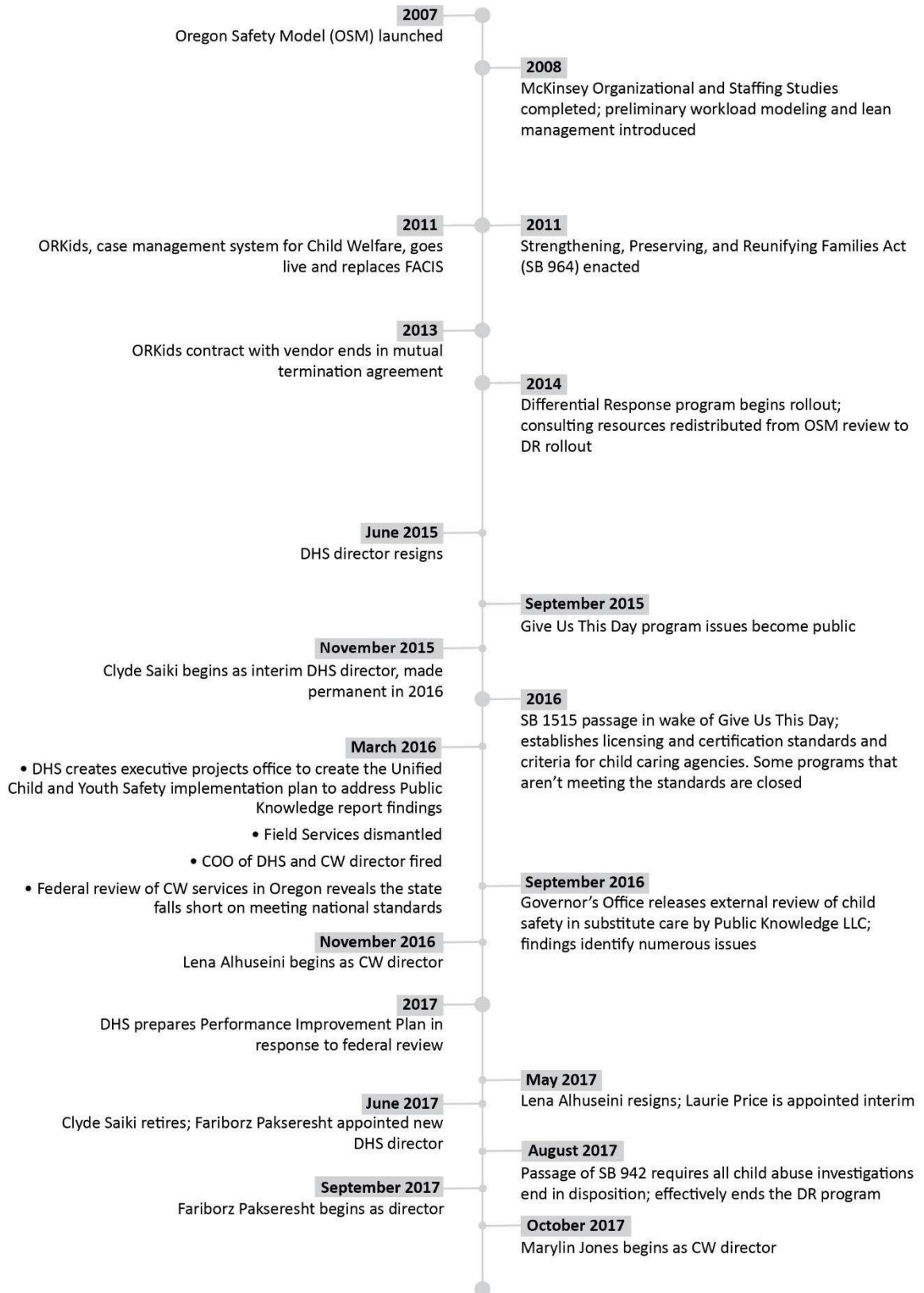
In 2016, news broke that lawyers for two children in DHS’ care had filed a federal class action lawsuit alleging that DHS’ increasing practice of housing children in hotels and offices violated state and federal laws. DHS management has acknowledged the ongoing and increasing shortage of placements, including available foster homes, that contribute to these practices.

Hoteling is an undesirable option with multiple drawbacks. Those include being significantly more expensive than foster care, difficult to administer on a day-to-day basis, and posing physical and psychological safety risks to children and staff that are hard to manage. Shortly after news broke that the lawsuit was filed, DHS ended the practice of allowing children to sleep overnight in its offices. However, the agency continues to house children in hotels or other institutions when placements are not available.

Figure 5 on the following page outlines the timing of major initiatives, actions taken by the agency to respond to those initiatives, and major staff and organizational changes that took place from 2007 to 2017.

¹¹ DHS internally tracked licensed providers on a document informally called the radar list. Criteria for inclusion on the list included high severity or number of complaints, high number of deficiencies and volume of complaints, denial of payment, and the potential for stakeholder interest and media attention.

Figure 5: DHS and Child Welfare System Changes, 2007-2017



Objective, Scope and Methodology

Objective

Our audit objective was to determine what changes and improvements DHS can make to better promote the wellbeing of children in foster care and ensure they are better protected and cared for.

Scope

The audit focused on three questions related to the foster care program within Child Welfare at DHS:

Management oversight and support: How can DHS management better guide and support the safety and wellbeing of children in foster care?

Foster parent recruitment and retention: How can the retention and recruitment of foster placements in Oregon be improved?

Staffing and workload: Are Child Welfare staff able to perform case management according to accepted best practices to the benefit of children in foster care?

Methodology

To address our objective, we used a multi-faceted methodology that included, but was not limited to: conducting interviews, focus groups, and questionnaires; reviewing survey results; and visiting field offices. We reviewed documentation on previous federal, state, and internal audits, and reviewed promising practices and information from multiple states. We also analyzed child welfare and foster care data and workload information.

We interviewed approximately 240 individuals, including DHS and Child Welfare executives, central office and field staff, central office program managers, district managers, and program managers. Interviews with external partners included stakeholders, foster parents, children in foster care, legislators, and one judge.

In addition to interviews, we developed a 60-item questionnaire for DHS' 14 district managers to get their perspectives on the foster care program specifically, and operations and trends generally. Collectively, the districts are responsible for all DHS child welfare field activities. We received a 100% response rate and followed the questionnaire with phone interviews and correspondence to obtain clarification on answers.

We visited five districts and nine field offices, including Portland, Bend, Prineville, Roseburg, Salem, and McMinnville. During these field visits, we interviewed caseworkers, supervisors, support staff, and managers. We shadowed caseworkers to obtain insight into their separate job duties within the caseworker classification. We also held focus groups with supervisors, caseworkers, and foster parents.

Related to Oregon's foster care program, we reviewed previous external and internal audits and reviews, published reports, contracts, and various forms of communication including memoranda, emails, newsletters, and announcements.

To provide context and a basis for comparison, we researched promising practices of foster care programs from other states.¹² We interviewed representatives from five states to learn more about specific practices. When available, we reviewed supporting documentation and results from the promising practices.

We reviewed child welfare and foster care related policies, procedures, laws, and promising national practices. We also collected and reviewed DHS workload modeling data, human resources data, and district staffing calculators.

We reviewed foster care and operational data from Oregon's system of record for child welfare, known as OR-Kids. In all but very few instances, the data was unreliable for our audit purposes. This was due to many factors, such as uncertain and untested data integrity and accuracy, incompleteness, data entry errors and poor quality data conversion.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained and reported provides a reasonable basis to achieve our audit objective.

¹² Interviews conducted with state Child Welfare agencies in Kansas, Utah, Kentucky, Michigan, and Washington.

Foster Care in Oregon: Chronic management failures and high caseloads jeopardize some of the state's most vulnerable children

The children in Oregon's foster care system are among the most vulnerable in the state. Children are served by overworked child welfare caseworkers who are leaving the Department of Human Services (DHS) in high numbers. Many caseworkers are struggling to have meaningful visits with children under their supervision even once a month, the bare minimum.

The supply of suitable foster homes and treatment facilities for these children is falling, leaving children entering foster care with increasingly limited placement options. At times, these options are inappropriate and even unsafe. The agency has also increasingly resorted to housing children with high needs in hotels, often leaving inexperienced caseworkers, who work full-time schedules during the day, to supervise them at night.

The foster parents who serve these vulnerable children are also struggling. Foster parents told us they do not feel adequately supported by DHS in dealing with the challenges of children in their homes. At the same time, the agency is asking foster parents to take on more duties, as caseworkers struggle to manage their caseloads, and to take on more children as the supply of homes dwindles.

Management's response to these problems has been slow, indecisive and inadequate. DHS and child welfare managers have not strategically addressed severe and chronic caseworker understaffing. Among other deficiencies, they have failed to provide the Legislature with accurate staffing data for funding and decision making.

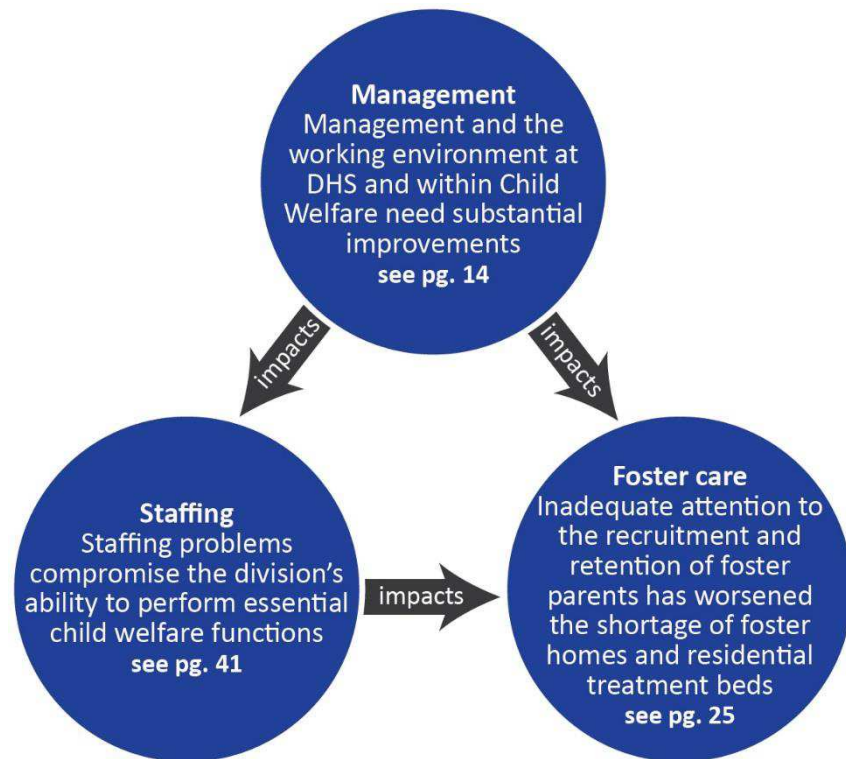
Agency managers have also not strategically addressed the recruitment and retention of high quality foster parents. They have not developed a statewide recruitment strategy, instead relying on a piecemeal outsourcing of recruitment that misses much of the state.

For over a decade, management's response to crisis and scrutiny has been to reorganize the system, not to effectively plan to fix it. Several substantial reform efforts have been poorly planned and executed, then abandoned. Management also oversaw installation of a faulty case management computer system that leaves caseworkers with inadequate information. This lack of strategic management has helped fuel an increase in lawsuits and legal payouts.

We deliberately expanded the scope of our audit to examine issues outside the foster care program that have a direct effect on the program and its management. We did this to address root causes that have persisted over time and across multiple management teams.

Poor management practices, starting at the highest levels within the agency and echoing down into the Office of Child Welfare and its district offices, impact the entire foster care system, including staffing resources and foster parent recruitment and retention.

Figure 6: Relationship of Audit Findings



These three findings are logically and functionally related and serve to reinforce each other. The management finding directly impacts both foster parent recruitment and retention, as well as staffing issues. In addition, staffing directly affects foster care recruitment and retention efforts in numerous ways. In the findings sections below, we detail the management problems, the foster care supply shortage, and the staffing challenges.

To begin reversing the growing foster care crisis, we concluded DHS must first address its management and organizational cultural deficiencies. Our recommendations provide a pathway for DHS to shift to strategic management that more effectively serves the vulnerable children in its care.

Finding: Management and the working environment at DHS and within Child Welfare need substantial improvements

In 2016, an independent review ordered by the Governor concluded a set of operational improvements were needed within DHS and across the Child Welfare system.¹³ More importantly, the independent review found there are foundational changes needed. These foundational issues are not being addressed.

The agency is slow to react to emerging crisis situations, does not strategically plan for how to address them, and does not proactively implement proper procedures and protocols.

Since 2006, DHS has paid out \$39 million in legal settlements due to the agency's inability to consistently keep children in their care safe from abuse and neglect. While some risk exposure is expected within the Child Welfare program, the frequency and amount of these legal awards suggest a lack of strategic risk management within the agency and an unhealthy tolerance for serious risks to children.

Management struggles with strategic planning, identifying root causes to chronic issues, and timely decision making

Our audit focused on foster care services, a program within DHS's Office of Child Welfare. However, we found critical problems with DHS management in addition to Child Welfare management that must be addressed for any program in the agency, including foster care, to function well.

The need for management improvements within the agency has existed for more than a decade. Management has resorted to frequent reorganizations and personnel shifts instead of addressing root problems identified by the Legislature, the Governor, and multiple consultants.

Management problems are widespread. We saw insufficient planning, execution, and financing of major change initiatives. We found managers unwilling to take responsibility for key decisions and results. On multiple occasions, staff told us they felt unsafe or uncomfortable with raising concerns to management about critical child welfare issues.

Poorly planned and implemented initiatives resulted in diminished effectiveness, increased risks to children, and wasteful spending

Over the years, DHS and Child Welfare management have tried to implement leading child welfare practices and install a data system that would help caseworkers and management improve child safety. Those time-consuming and costly initiatives have failed.

¹³ The external audit was performed by Public Knowledge LLC.

DHS and Child Welfare have not initiated thorough and timely reviews of their programs to support these initiatives and better understand and address the challenges staff face to ensure child safety and support effective case management. Major initiatives are rolled out before those challenges are clearly understood, often in quick succession and with little advance planning.

The four following examples illustrate the agency's struggles with strategic initiatives over the years that have, and still are, affecting decision-making with vulnerable children.

Oregon Safety Model: In 2006, DHS implemented the Oregon Safety Intervention Model (OSM), a best-practice method of managing child safety throughout the life of a case. The model is designed to help CPS and permanency workers take thorough and consistent steps to ensure child safety over the entire timeline of a case. This model required a significant shift for managers and workers including several abstract concepts for workers to understand. It was widely understood and accepted by management that the change to OSM would impact every phase of child welfare cases, and that it would require a large and high quality training effort.

The agency designed and implemented its own training, which staff and managers had at the same time in very large numbers. Initial training budgets were limited, resulting in inadequate training. The model was widely viewed as confusing and difficult. In addition, while the model required a considerable amount of time for caseworkers to complete, new positions were not added to cover caseworkers' time away from work and implement the model as intended.

A 2013 review identified shortcomings in the implementation of the model.¹⁴ When DHS rolled out the program statewide, managers and staff across the state resisted the model. Some openly refused to implement it. Still, executive management was steadfast in moving forward with the model and the resistance was tolerated.

DHS reportedly made significant investment¹⁵ in a statewide re-training of workers using the model, but halted that effort in 2014 and transferred resources set aside for the OSM training to another new child safety initiative, known as Differential Response. Formal training for the OSM, which is still in use, has never resumed. Managers still resisted the model in 2017, more than a decade after initial implementation.

Differential Response: Differential Response (DR) is an alternative approach to the CPS case assessment (investigation) process that gives caseworkers more flexibility to keep families together while keeping

¹⁴ The review was conducted by the National Resource Center for Child Protective Services.

¹⁵ DHS was unable to provide us with total dollar amounts spent on the initial rollout and training.

children safe. This approach was a major change, affecting decision making in many child welfare cases.

Initial program design began in 2009, but stalled in part due to management turnover and an extended design phase that included 13 different committees, all working in isolation.

DHS began a phased rollout of the new approach in 2012 and by 2014, the agency focus shifted from the OSM re-training to a statewide rollout of DR. However, DR sputtered in its development, was suspended once in 2016, and in 2017 key pieces of the program were canceled and the DR administrative rules were suspended indefinitely.¹⁶ These actions effectively ended the Differential Response program.

DHS did not explain the program well to legislators, some of whom said they found the program highly confusing. Internal communication was also poor with staff, who were notified via email the program was suspended. Central office staff who were directing and supporting the DR work were not notified prior, leaving many caught by surprise.

OR-KIDS: Development of the current child welfare information system of record — known as OR-Kids — began in 2006. DHS began using the system in 2011. After more than a year of working with the vendor to complete the system while it was in operation, DHS executives and the vendor entered into a mutual termination agreement,¹⁷ effectively ending the contract and transferring the system to DHS even though known system flaws existed.

For many reasons, the system was problematic from the beginning. DHS took over maintenance of a system with incomplete documentation, unprepared technical staff, and hundreds of fixes needed to ensure the system was functional. This left DHS with a system that was difficult to manage and inefficient from day one. Currently, there are still more than 1,000 outstanding change requests, fixes and defects waiting to be addressed, even though the system has been in operation for nearly seven years. For example, one outstanding request submitted in 2012 states that a manager can make changes to a payment and then issue final approval. Another one from 2012 states that displayed contract balances are incorrect based on payments and adjustments.

Today, workers regularly report the system takes more time than the prior system to do the same work. They report lost data, inconsistent and inaccurate search results, and inaccurate information displayed. In dozens of interviews with caseworkers in nine field offices, the most common frustration we heard was the inadequacy of the data system.

¹⁶ While all investigations must now end in a disposition, it is not clear how Differential Response will be used (if at all) in the future.

¹⁷ In March 2008, DHS and CGI Technologies and Solutions Inc. entered into a Design, Development and Implementation contract for a Statewide Automated Child Welfare Information System (SACWIS).

During our audit, it became clear that management is not confident in the accuracy or completeness of the data coming from the OR-KIDS system. After reviewing caseworker attempts to work with the system and our own data pulls, we also concluded this system does not provide adequate oversight of the division's activities, including tracking trends and outcomes.

Information system projects routinely run long and over budget. For example, Oregon's previous child welfare system (FACIS) was twice as long as the average delay compared to other states. OR-Kids, which replaced FACIS, cost over \$74 million dollars, exceeding the original budget by almost 100%. The project lasted 70 months, twice as long as originally projected to complete. It did not work correctly when launched, and is difficult to maintain and modify to meet changing business needs.

5 Key Lessons from the OR-Kids case management database development and implementation:

1. Establish and maintain strong, consistent, ongoing contract management
2. Effective project management is essential to project success
3. Prepare a detailed staffing plan for the length of the project
4. Adhere to project criteria before moving between project phases
5. Apply a consistent and clearly defined methodology to all major project deliverables

-Lessons Learned: Project Execution Phase (prepared by MAXIMUS and the Human Services Consulting Division), April 2012

Problems with the system's billing, invoice, and payment functions also forced DHS to pay for a separate case management system in the Portland area. Development of a new system was added to an existing contract with the Multnomah Education Service District (MESD), which was also tasked with working with community providers to reduce the number of children in foster care. DHS paid MESD an additional \$1 million to develop and administer the system on behalf of DHS. The system was separate from OR-Kids and required caseworkers to perform dual entry into both systems. DHS's contract with the service district ended in 2017, and now the system is not being used. DHS is also not sure if the goal of reducing children in foster care was met, as the agency did not include goals or performance outcomes in its agreement with the district. The total amount paid to MESD over the life of the contract was approximately \$20 million.

DHS' decision not to publicly disclose the mutual termination agreement and the related system imperfections did not allow stakeholders, policy makers and DHS leadership to learn from the mistakes that occurred. Many of the staff and contractors who worked on OR-Kids went on to other projects, including Cover Oregon. Publicly disclosing the mutual termination agreement — or the possible need for such an agreement — would have informed policy makers and citizens about conditions potentially affecting multiple projects.

Washington used the same contractor to set up their child welfare case management system a few years before Oregon. According to their Program and Policy Division Director, Washington's system has numerous issues and they are considering a full replacement.

In 2012, MAXIMUS (contracted by DHS to perform quality assurance services) and the Human Services Consulting Division reviewed the OR-Kids project and prepared a report on the issues that negatively impacted

OR-Kids execution.^{18 19} The report also provided recommendations on how to replicate successful strategies and activities in future projects.

In addition to these reviews, the Secretary of State Audits Division plans to conduct an IT audit of the OR-Kids system in 2018.

In response to problematic IT projects, the state is currently taking steps to improve processes for implementing new computer systems. However, much work remains to ensure investments in computer systems are not wasted and state agencies are able to obtain computer systems to better meet their business needs.

Completion of Child Abuse and Neglect Investigations: Though it was not a formal initiative, DHS and Child Welfare pushed a mandate in 2016 to complete more child abuse and neglect investigations (known as comprehensive assessments) in a timely manner. It was reported to the legislature that the agency had made big improvements on completing these investigations. However, the push to complete investigations lasted about 3 months, after which the agency's completion rate returned to previous levels. Field staff reported the use of questionable management tactics to push staff to complete more investigations, including threatening to take away scheduled leave time or put staff on administrative leave. Caseworkers in other units reported being moved temporarily into CPS to perform investigations, despite already having full caseloads. No additional resources were provided to the field.

These examples individually and collectively illustrate DHS' struggles with addressing root causes of problems and challenges, along with strategic planning, communication, training, and follow-through.

Reorganization, personnel changes, and a lack of accountability and transparency contribute to management dysfunction

Twelve years ago, the division of Children, Adults and Families was established to include Child Welfare. Since then, DHS has reorganized and renamed Child Welfare or its major functions and divisions at least six times. Almost 10 years ago, DHS reportedly paid consulting firm McKinsey & Company more than \$3 million to prepare a plan aimed at making DHS a world class organization.²⁰ In 2008, McKinsey released its first public

¹⁸ Walter R McDonald and Associates (WRMA) was the Quality Control Vendor for the OR-Kids Project. Like Maximus, WRMA prepared a lessons learned report. The document details are "WRMA Lessons Learned- Project Evaluation" WRMA Deliverable 4.4.1; 11/13/11, Version 1.0. In addition, the DHS Office of Information Services produced a lessons learned report for the OR-Kids project. Our team requested that report from DHS, but they were unable to locate it.

¹⁹ Maximus reports that it identified appropriate staff together with project management. We note here that this method excludes a random or other control procedure and therefore could have the effect, intentionally or unintentionally, of excluding certain perspectives. As the selectors of all respondents Maximus and Project management assumed the risk, intentionally or unintentionally, of biasing the responses set through selection bias.

²⁰ In 2007 DHS contracted with McKinsey and Company to diagnose performance problems, identify opportunities for improvement, and design a set of actions to help the agency make the needed

report and identified both the frequency of reorganizations and the resulting staff distrust as possible obstacles to the projects' success. Despite those conclusions, the reorganizations have continued. Examples of reorganizations include the following:

- Six years ago, Children, Adults and Families was disbanded, leaving Child Welfare as a standalone program.
- Five years ago, DHS management rolled out an organization design that ensured two administrators were assigned to each major program area.
- Two years ago, Child Welfare disbanded its formal field services administrative office that provided an array of support services to the field.²¹

From responses to a questionnaire we sent to all district managers, we learned of another proposed reorganization between the Child Welfare and Self-Sufficiency offices that has been under consideration for over a year. The central office has not let districts hire new managers while the reorganization is evaluated. As a result, many districts have interim district managers while other managers are covering more than one district. In addition, half of the current district managers have less than two years of experience.

Changes in executive staff since the summer of 2015 also point to management instability. In the wake of the Give Us This Day scandal in 2015, several top DHS executives either quit, were fired, or were reassigned.

Key staff throughout the Office of Child Welfare move frequently and with little warning. In fact, so many staff and programs have moved, the agency has not been able to keep an accurate organizational chart. We requested an up-to-date chart in December 2016, but did not receive one until April 2017. Upon review, we found it included key positions that were no longer in place, made no mention of the district offices, and several managers listed left the agency over the course of our audit.

We also spoke with dozens of managers and other staff about DHS's failed programs and initiatives. Many named other individuals and programs who, in their view, have noteworthy shortcomings. None were willing to take responsibility for the conditions they described, even in programs they directly oversaw, and none viewed themselves as direct contributors to an atmosphere of blame and distrust. Not one noted or described what they could have done differently to address the issues they observed.

changes. That diagnosis and the associated action items aimed at improving DHS performance were known as the Transformation Project.

²¹ DHS recently brought back a field administrator to stabilize the field.

In September 2016, the newly-appointed DHS Director hired a new director of Child Welfare. That director started in November 2016, resigned six months later, and was replaced on an interim basis. The DHS Director announced his planned retirement shortly thereafter. In June 2017, the Governor appointed a new Director, who began in September 2017. The new Director appointed a new director of Child Welfare who started the following month.

The agency's long delay in centralizing child abuse and neglect screening has put children at risk and created turmoil in the Child Welfare Division

A move to centralize the evaluation (or screening) of reports of child abuse has been recommended at least five times going back over a decade. Screeners, who can decide whether or not an abuse case proceeds to investigation, are critical to the Child Welfare Division's mission. In general, centralized screening helps protect children by ensuring that abuse reports are evaluated consistently and referred appropriately.

In 2002, the consultant firm Public Knowledge²² documented inconsistencies in the child abuse screening and assessment criteria used in the branch offices. In 2006, a report to DHS from the National Child Resource Center for Organizational Improvement recommended DHS move to a statewide screening and intake unit to address differences in practice. Other recommendations to move to centralized screening included a reorganization report by McKinsey in 2008, and in 2011 by a DHS Critical Incident Response Team (CIRT)²³ after a child death and subsequent investigation. The latest recommendation was again reported by Public Knowledge in 2016.

Laws in 33 states require centralized hotlines for child maltreatment reports, instead of allowing separate hotlines by districts. Oregon's laws do not require centralization, and the state has 15 different hotlines serving 16 child welfare districts.

DHS has considered centralization multiple times. Currently, a new committee is charged with implementing a centralized approach, including finding a location for the central hotline. As of November 2017, the committee had been working for more than a year and was only at the stage of approving sub-committee charters to move forward with a plan. A location was announced in January 2018.

Management communication about the change has been poor, creating anxiety among screeners in field offices across the state. The first communication with employees occurred shortly before the holidays in

²² Public Knowledge is a limited liability corp (LLC) based in the state of Washington. DHS has engaged Public Knowledge in external reviews of child welfare programming.

²³ The primary purpose of the CIRT process is to rapidly draw lessons for the improvement of agency actions when there is an incident or serious injury or death caused by abuse or neglect involving a child who has had contact with the Oregon Department of Human Services. In each particular case, the CIRT process identifies what improvements can be made to DHS policies or practices and to make the report public information.

December 2016, which raised fears employees might be losing their jobs in the coming year. The information was disseminated with no assurances or details. Screeners and district management have had to make multiple requests to the central office for information, and still do not know if their jobs will be affected.

Based on the number of caseworkers and support staff needed to run the 15 current child abuse and neglect hotlines across the state, it was determined that the move to centralize the function and provide 24/7 coverage would require an increase of approximately 124 FTE. The initiative has not been fully funded, however, and DHS does not currently plan on increasing central screening staff. Instead, some screening duties at the district level will be streamlined or reassigned to other staff. However, an analysis of screening duties has not yet been performed by DHS and they were unable to clarify whether they would be able to sufficiently reduce individual screener workloads, or reassign a substantial portion of the work, to centralize the function with current staff levels. Without an overall increase in field staffing, the centralized hotline may further impact already strained field staffing resources.

Management's response to weaknesses identified after the Give Us This Day scandal has been inadequate

The scandal at Give Us This Day, a state-funded provider, spurred internal audit reports and an external review by Public Knowledge at the Governor's request.

The DHS internal audits identified 50 problems with Child Welfare's investigation and provider compliance process that left children at risk of abuse and neglect. Also, the Public Knowledge review confirmed the existence of gaps and spelled out four foundational recommendations that must be addressed for other improvements to succeed. These recommendations were to:

- improve the DHS culture;
- focus the whole agency and Child Welfare on safety;
- adopt data-driven decision making; and
- increase staffing resources for Child Protective Services and other DHS entities.

A DHS working group identified 15 of the 50 problems as critical to ensuring child safety. The remaining 35 were put on hold. More than two years after the scandal surfaced, the agency has not addressed most of the 50 identified problems that put children at risk. It is unclear who, if anyone, is responsible for coordinating the responses and ensuring the work is completed. For example, the 15 critical problems were assigned to two separate units, one of which reports to the DHS director, while the other does not. As of this writing, all of the issues are still not clearly resolved.

DHS's decision to retain two investigative units lacks support

Prior to 2007, CPS workers performed investigations of child abuse and neglect in all settings, including residential programs like Give Us This Day.

In 2007, the Office of Adult Abuse Prevention and Investigation (OAAPPI) began handling a subset of child abuse investigations that were previously investigated by CPS. This change led to some types of child abuse allegations, specifically child-on-child, not being investigated by the agency. From 2007 until 2015, CPS assumed that OAAPPI was investigating incidents of children abused by other minors living in their residential facility. Those investigations reportedly never happened. By moving some types of child investigations in some facilities to OAAPPI, the agency solved one problem, but created others.

Both the internal audit and the external review highlighted the complexity, differing processes, and potential risks that were created by splitting child abuse investigations between OAAPPI and CPS. Nonetheless, in 2017, the agency made the decision to expand the types of child investigations that are to be conducted by OAAPPI. At no point, either at the initial decision or after the serious concerns arose, did the agency complete a formal analysis of the impact this would have on the safety of children nor did they require appropriate training for OAAPPI caseworkers that meets or exceeds the demands of CPS training.

The internal audits and external reviews also pointed to important differences between investigations done by CPS and OAAPPI that could leave children at risk. These include potentially inconsistent responses to allegations and investigations. The evaluations found that report findings may vary, which could leave children in unsafe situations. Multiple senior child safety staff and managers reported that OAAPPI is uncomfortable making decisions on some types of child abuse investigations and stated that if serious abuse occurs, OAAPPI may contact CPS to complete the determinations about child safety and abuse investigations.

Agency upper management has decided to maintain the two separate investigative units, instead of creating one central unit, which would have solved at least four of the 15 critical gaps, despite advocacy for a central unit from child safety specialists within the agency. DHS has still not completed a formal analysis to support this decision nor have they gathered or analyzed basic data on child abuse investigations for each investigative unit which could help determine the best way for the agency to protect vulnerable children.

Making a decision which directly impacts the safety and wellbeing of Oregon children, without any documentation and analysis, is inconsistent with basic management principles and indicates that the agency may have an unhealthy appetite for risk -- particularly where child safety is concerned.

CPS uses a comprehensive investigation method. It conducts the vast majority of child abuse investigations in the state and is managed under the same program as the office that screens the calls regarding child abuse. CPS also has training programs for its workers that have evolved over several decades and include technical support from Portland State University and national child welfare associations.

OAAPI has a investigation method that differs from CPS . They lack a core training program, and the existing training does not focus on the unique requirements of child abuse investigations. They do not have the same historical base of knowledge and network of technical support. OAPPI requires four years of investigative experience for new hires, but does not require that new hires have any experience specifically in child abuse investigations. The inconsistency between OAAPI and CPS operations, investigative approaches and resources to conduct child abuse investigations may leave some children unprotected.

OAAPI does not have all of the resources and tools to investigate child abuse and neglect that CPS does. In fact, the Office of Adult Abuse Prevention and Investigations utilizes CPS work and products. Their draft procedure manual includes CPS rules, contact persons, and other CPS support documents. DHS has not conducted a formal risk analysis or provided any other justification for the two track investigative approach, or why OAAPI should be conducting child abuse investigations. DHS has not provided evidence of how the two track model improves child safety outcomes for children in CCA facilities.

DHS has not given a complete accounting of progress on Give Us This Day issues

DHS issues quarterly updates to the Governor's Office on actions the agency has taken to resolve Give Us This Day issues. The most comprehensive letter, issued in June 2017 by the former director, lists actions taken to fill some of the need for beds in residential centers, centralize the abuse and neglect hotline, and modernize the Child Welfare workforce. However, key pieces of context are missing from the letter that, had they been included, would have substantially altered the message.

The first action outlined in the June letter is the certification of 660 foster families in the first quarter of 2017. The letter does not mention how many homes lost or ended their certifications in that same period, or whether there was actually a net gain or a net loss in the number of certified homes in that quarter.

Data on 2016 foster home certifications indicates there are a significant number of closures each year — in fact, the number of foster home closures in 2016 outpaced the number of new certifications, resulting in a net loss of over 100 foster homes in Oregon in 2016. The letter does not discuss this critical information.

Changing agency culture, focusing on safety, adopting data driven decision-making, and increasing staffing resources are “foundational to any change efforts to address gaps in Oregon’s substitute care system. If these areas are not addressed, the other recommendations in this report will gain little or no traction.”

***-Public Knowledge Report
September 2016***

The June letter also highlights an investment of \$6 million to add 85 new shelter and residential beds and 150 new treatment foster beds in the 2017-2019 biennium. Again, important context is missing. While an increase of 235 beds may help ease some of the burden, it falls far short of filling the gap between contracted capacity and the actual availability of beds.²⁴

The four foundational recommendations made in the Public Knowledge report — improving DHS culture, an agency focus on safety, adopting data-driven decision making, and increasing field staffing — are not mentioned in any of the four letters issued to date.

Addressing these foundational recommendations is critical to solving the many other problems at DHS and in Child Welfare. Our audit confirms that these foundational issues persist and continue to undermine agency efforts to ensure child safety and wellbeing in Oregon.

This also means DHS must move beyond reorganizing its structure or personnel. The Public Knowledge report observed that DHS must change its culture, and that this requires people to change their behaviors.

²⁴ Residential facilities contract with DHS for a certain number of beds using a 'per bed' rate. However, many programs cannot staff to the contracted number of beds using that rate structure, which reduces the overall availability of residential beds.

Finding: Inadequate attention to the recruitment and retention of foster parents has worsened the shortage of foster homes and residential treatment beds

DHS management has not prioritized foster care recruitment and retention, which has contributed to a steep decline in career²⁵ foster homes that serve the majority of Oregon's foster children.

The reduction in the number of career foster placements, which provide relatively stable placement capacity in the foster care system, stems from the agency's recent focus on recruiting relatives and family friends to serve as foster parents. These "relative placements" are often the most appropriate placements to keep children out of the foster system in the long term, but a substantial portion of Oregon's foster children do not have access to appropriate family options, and many have acute mental and physical health needs that career foster homes may be better equipped and specifically trained to handle.

For a variety of reasons, the agency has struggled to recruit and keep enough foster homes. Due to DHS staff turnover and staff shortages, some foster families have been asked to take on DHS staff duties with limited support and guidance, which may contribute to career foster families leaving the system. Career foster families have also reported being asked to take more children than they can accommodate, or to take children on an emergency basis that turns into weeks and months. Foster families have taken on tasks normally assigned to caseworkers, such as arranging meetings with birth parents and transporting both foster children and their birth parents to appointments. The burdens on existing foster parents hurt recruitment as well, because they are the primary recruiters for new foster parents.

With limited appropriate placement options available, some of Oregon's highest need children are moved from place to place and sometimes end up housed by DHS in hotels because there is nowhere else for them to go.

Currently, there is no statewide plan to inform placement decisions in the foster care system, and no organized approach to addressing the foster placement shortage. DHS does not know the true capacity in current foster homes, what homes have openings, and what behavioral and special needs the family is trained and equipped to accept.

Managers are not tracking prospective foster parent inquiries statewide nor are they monitoring how long the process takes from an initial inquiry to their certification as a foster parent. The agency is also not tracking

²⁵"Career foster homes" serve the general population of foster children in the community. They usually serve multiple children over a period of time. In contrast, foster parents who are relatives, or "Relative foster homes," often serve only a specific child.

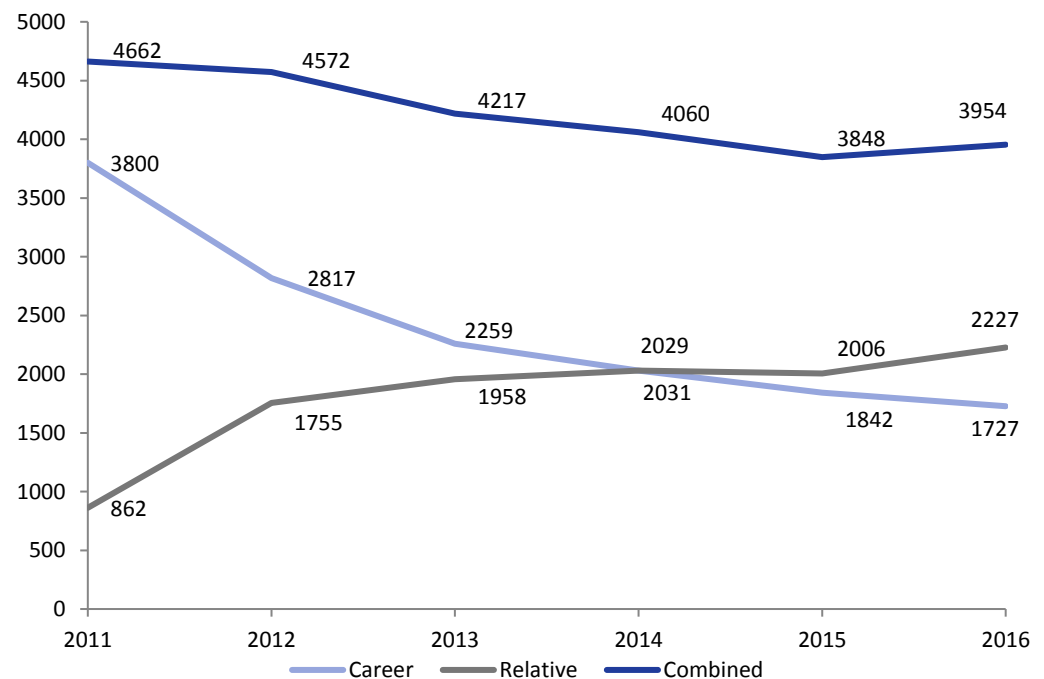
where foster parents are most needed or reasons why foster parents are leaving.

Oregon does not have enough foster homes and residential treatment facilities to meet the need

In 2016, about 9 of every 1,000 children in Oregon were in foster care, nearly double the national average of 5 out of 1,000. The number of Oregon children in foster care has declined by 14% since 2011, but the total number of available foster homes has also declined by 15% since that time.

Career foster homes declined by 55% from 2011 to 2016, from 3,800 homes to 1,727 homes. Over the same time period, relative homes²⁶ increased by 158% from 862 homes to 2,227 homes.

Figure 7: Career and Relative Foster Homes 2011-2016



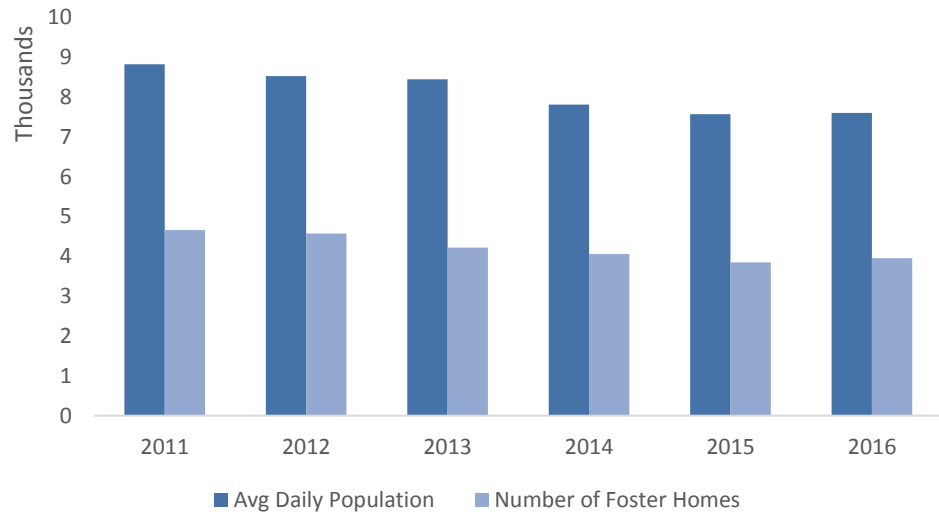
Source: Data provided by Office of Business Intelligence

In contrast to relative foster homes, career foster home providers serve multiple children over a period of time, building capacity in the foster home system. From 2013 to 2016, career foster homes served about four times more children on average than relative foster homes. Career homes typically stay certified for about 40 months, while relative foster

²⁶ Relative foster homes are typically kith and kin placements, meaning the child is placed with a family member, teacher, or neighbor that is known to the child. These placements are usually specific to the child or sibling group and are not necessarily open to general placements of children from the community.

placements stay certified for an average of 14 months. Relative foster homes tend to serve only specific children for a short amount of time, as opposed to career foster parents who tend to serve multiple children over an extended period of time.

Figure 8: Average Daily Population of Foster Children and Foster Homes 2011-2016



Source: Child Welfare Data books, 2011-2016

Placement needs and foster home availability fluctuates. In 2016, there were about 7,600 children in out-of-home care on any given day.

Building capacity in the foster care system is a constant undertaking, and requires the ongoing strategic recruitment and retention of foster families. Even if an agency has a licensed home for each child in out-of-home placement, a greater number of homes should be recruited and retained in order to ensure a good fit between a child and a family, and a family-based placement that can best meet that child's needs. Additional providers can also mentor new families and provide respite care²⁷ when foster parents need a break.

Residential treatment beds serving children with acute needs are diminishing

Many of the children transitioning into the foster care system have care needs related to trauma, behavioral and mental health issues, and even drug addiction, and require a higher level of care and supervision than many foster homes can provide.

²⁷ Respite care is short term childcare. When foster parents go through their certification, they are encouraged to ask friends and family members to be their respite providers. The background check form is requested through a foster family's DHS certifier, and can be given to any individual interested in providing respite care for them. With respite care, there is no DHS training and no payment from the agency. It is a foster parent working out childcare needs with a background-checked individual. Respite care can last no longer than 14 days.

DHS contracts with private agencies throughout the state to provide behavioral rehabilitation services to children with debilitating psychosocial, emotional, and behavioral disorders. Behavioral residential treatment facilities provide behavioral intervention, counseling, and life skills training. These include therapeutic foster homes, as well as larger residential facilities.

DHS has lost 33% of its contracted behavioral residential capacity since 2007 due to the closure of facilities — declining from 671 contracted beds in 2007 to 446 contracted beds in December 2016. Furthermore, due in part to low per-bed rates²⁸ and lack of available staff, 43% of residential beds contracted in December 2016 were held vacant, leaving the state with only 255 available residential beds in total.

This impact is even more pronounced when considering the 30-40% reduction in bed capacity in the Oregon Health Authority's Children's Mental Health Services program for high level psychiatric conditions.

In addition, the State Office of Developmental Disabilities Services eliminated a service level of homes for youth with developmental disability needs. This impact included an additional loss of 50+ beds to serve children with this level of need.

Some program closures and loss of licensing have been prompted by chronic issues, including high numbers of reports of abuse and neglect of children in care over several years, and media scrutiny in the wake of the Give Us This Day scandal and the passage of Senate Bill 1515. These include a Youth Villages program in Lake Oswego and Chehalem Youth and Family Services in Newberg, which were included on DHS' internal radar list.

Although the radar list was discontinued in 2015, DHS informed us they do meet regularly to discuss concerns on residential facilities. In these meetings, we learned data trending and information is not readily used, but the group is hoping to be moving in that direction.

With increasingly limited options available, children with acute needs may end up in foster placements that are not equipped to handle their specific issues. They may be placed with foster families or relatives that have no experience in providing the appropriate level of care and have little training and inadequate guidance and support from the agency. In these cases, children tend to burn out of placements, often repeatedly, and may never achieve permanency with a family or stability in a foster home placement.

²⁸ Funding for BRS facilities through DHS is based on a daily rate per bed when in use in the facility.

The lack of available foster homes, rather than the needs of foster children, currently drive placement decisions

The number of foster homes in the state has decreased since 2011, primarily among career foster homes. As a result, it has become increasingly difficult to secure appropriate foster placements across the system. Appropriate placements meet the needs of children and consider the best interests of the child, including physical, emotional and mental health, and educational needs. Inappropriate placements can negatively affect child safety and wellbeing. DHS district offices exchange daily emails seeking emergency placements for children. These emergency placements may not always be appropriate or match the needs of the child, as they are driven by urgency rather than best fit.

Inappropriate placements increase the risk of abuse and lawsuits. They also increase the odds that a placement simply will not work for the foster child, adding more disruption to the child's life.

Research indicates that children may do better when matched from the communities from which they originate. However, Oregon does not have enough Black, Hispanic, and Native American foster parents to meet the need of foster children. Oregon provider data shows an under-representation of Black, Hispanic, and Native American homes — most foster parents are likely to be white, whereas nearly a third of foster children are non-white. Refugee children, and English as Second Language speakers also have difficulty finding placements which are culturally appropriate.

As a result, some culturally inappropriate foster placements are occurring in the foster system, as the recruitment of foster parents does not closely match the demographics of foster children in Oregon.

Poor placement choices can lead to poor outcomes or dangerous situations for the child. In a recent example, the state of Oregon paid \$750,000 to three children who were allegedly abused in their foster home. The suit alleged children were living in deplorable conditions and could not communicate abuse inflicted on them by another child to their foster parents because they did not speak the same language. In addition, they had no caseworker visits in the eight months of their placement, despite rules requiring visits every 30 days.

The inadequate recruitment and retention of foster parents also negatively impacts LGBTQ+²⁹ foster children. These children told us how painful it was to be in a home where their gender identity and sexual orientation were treated as problems rather than an important part of their identity.

Placement Instability

The lack of appropriate foster placements allows children to fall through the cracks in the system, moving repeatedly from placement to placement. One child we talked with had been moved close to 20 times, and one caseworker shared an instance of a child who had been moved over 50 times since entering the foster system. Each move from a placement causes damage to a child's wellbeing.

²⁹ LGBTQ+ stands for Lesbian, Gay, Bisexual, Transgender, Queer, and other terms used to denote sexual and gender orientation and self-identification.

Recruitment of LGBTQ+ friendly foster homes is limited to a handful of scattered efforts, and in part, the lack of appropriate LGBTQ+ placements also stem from poor recruitment efforts of the agency overall. Children we spoke with also reported not feeling respected or listened to and attributed this to an organizational culture at DHS which is unwelcoming and unequipped to work with LGBTQ+ youth.

Foster parents are overburdened and underprepared for fostering children

Oregon's foster parents face a lack of ongoing support and training, burdensome costs, and a lack of respite care options. With the number of foster homes declining, DHS is asking the remaining foster parents to do more, and they are burning out. At the same time, a slow certification process discourages potential foster parents who could help relieve the strains on the system.

Strained systems fail to support the needs of foster parents

Foster parents report not getting enough information from DHS about the mental or behavioral health needs of children prior to placement. This can inadequately prepare foster parents for the reality of caring for abused and neglected children.

However, unlike other institutions such as hospitals, residential centers, and correctional facilities, DHS is legally required to find a placement for children immediately following their removal from an abusive or neglectful home regardless of the availability of appropriate placement resources. Caseworkers often must scramble to find an immediate placement upon removal and may have little to no information about the child. This can include a lack of important information about the child's mental and physical health, as well as relevant information about trauma the child may have experienced.

In addition, foster parents from the community are required to undergo training prior to serving as foster parents, but relatives who serve as foster parents are often getting rushed through an emergency certification process. In these cases, relatives are only getting partial training or not getting trained at all before they start fostering.

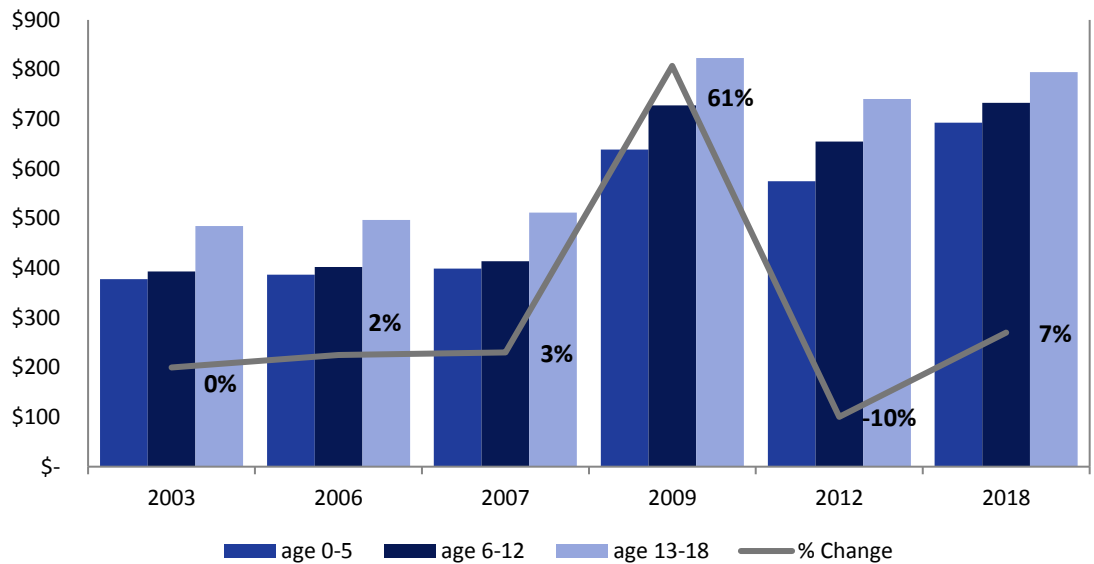
Foster families face burdensome costs

The current foster system is based on an outdated model that assumes at least one foster parent is staying home full time and foster families have ample financial resources to raise children. In Oregon, fewer families may have the financial resources to be foster parents

DHS has not adjusted reimbursement rates for Family Foster Care to the cost of living since 2009, when rates increased 61% over those of 2007. In 2011, rates declined 10% due to department budget cuts. Foster care

payments are again set to increase 7% in 2018, and will range from \$693 to \$795 per month, depending on the child's age.

Figure 9: Foster Care Payments 2003-2018



Source: DHS Rate History

While this increase will help, foster care reimbursement only considers the cost of room and board and is not intended to cover the cost of daycare in Oregon, which ranges from \$530 to \$912 per month.

With the new rates, the state will be paying approximately \$26.50 per day,³⁰ which covers only 74% of the cost to raise a child in the Pacific Northwest, according to the USDA. Foster parents are expected to pick up the remaining costs, which can include everything from clothing, to school supplies, to medical care.

Unfortunately, in many states, the reimbursement rates for foster care fall short of the actual cost of raising a child. California has one of the highest reimbursement rates in the West, offering a basic rate between \$896 to \$1,032 per month. At the same time, Idaho offers one of the lowest

³⁰ Reimbursement rate is for children over the age of 13 years old.

Helping Other Foster Parents

Community members and DHS field staff throughout the state frequently work together to provide resources and support for foster families and foster youth in local communities.

To help other foster parents with basic needs, Jan Patton started the Foster Family Resource and Clothes Closet at the DHS office in Roseburg. As a longtime foster parent herself, Jan says she knows how critical it is to build community and support for other foster parents.

The Resource Room is managed by volunteers from the Foster Parent Association in Roseburg. The well-organized closet is stocked with high quality donated children's clothing and shoes, furniture, and school supplies. Foster families are allowed to visit and pick out things they need from the resource room, helping cut the sometimes high cost of foster parenting.

Jan and her husband have fostered hundreds of children in Douglas County for over 20 years. They take some children into their home for a few days or weeks. Others have stayed with them for years, maintaining contact as young adults. The Pattons continue to take in children for short term placements.

Jan Patton, right, and volunteer Angel Beck, left, in the Resource Room at the Roseburg DHS office.



reimbursement rates in the West, \$395 to \$584. By comparison, Oregon's foster care reimbursement ranks in the middle of the Western states at a basic rate of \$693 to \$795, and is only slightly higher than the state of Washington's basic rate of \$562 to \$703. However, the rising cost of living and the housing crisis in Oregon reduces the spending power of those payments in many areas.

In 2017, Oregon ranked among the highest-cost states for daycare, second only to the District of Columbia, indicating that the recent increase will still not meet the level of need.

Foster parents lack respite care options

Foster parents in Oregon lack access to affordable respite care where they can take their foster children so that they can take a break, which can help prevent burnout and increase the stability of foster placements. In addition, Oregon's foster parents have to pay for respite care on their own, without help from DHS. DHS does not track respite providers in Oregon and does not have a pool of approved respite providers that they can share with foster families.

Some local governments offer resources for respite care. The city of San Diego offers a program called the “Cool Down, Cool Bed” program, which offers short term (14 days maximum) stays in foster homes to children and families in stressful situations. Other states work hard to recruit respite providers who have been cleared with background checks and willing to help foster parents for short term situations.

Foster parents need respite care for many reasons, and some families who foster children with high needs or behavioral issues simply need a break. The National Foster Parent Association recommends that all foster parents receive at least two full days a month of planned respite care. However, foster parents in Oregon do not get breaks on a regular basis, because respite support for foster parents is minimal.

Foster parents often lack adequate DHS support

Foster parents we talked to reported receiving a lack of support from DHS, particularly when they required help with the behavior of a child in their care. Caseworkers try to do the necessary face to face visits, but are not always able to make time for foster families or assist them with accessing resources.

Overworked caseworkers have limited time to build relationships with foster parents. Foster parents reported they understood caseworkers were busy, but they still needed more hands on support from them. One foster parent even reported calling the CPS hotline to report an incident on themselves in order to get services from their caseworker they couldn't get ahold of otherwise.

Some foster parents reported having to navigate a difficult and sometimes intrusive relationship with the agency, which can at times be exacerbated by CPS investigations and frequent staff turnover. A few foster parents told us they felt more scrutinized than supported by DHS.

DHS does very little to track the concerns of foster parents in the system or to follow up with foster parents who have left the system.

In July 2016, DHS started a support line for foster parents in coordination with 211info. We reviewed the reported results from the first year and found only 236 calls were made to the hotline. Calls did not appear to be increasing each quarter and most of the calls were coming from the metro area compared to the rest of the state. As of October 2017, DHS has paid out approximately \$329,000 for this support line, but may not be getting the intended results of providing additional support to foster parents.

Public scrutiny and a slow certification process discourages potential foster parents

Child welfare systems and foster parents are often portrayed negatively in the media and are receiving increased public scrutiny. In recent surveys of foster parents, only about a third felt they were included as a valued member of the team that provides care and planning to foster children. Just

34% reported they were able to receive services they needed to care for foster children around the clock and just over half (57%) felt they received any support to assist in the care of foster children placed in their home.

The negative public perception, combined with foster parents not feeling valued, and a lack of support could be disheartening to foster parents — and discourage prospective foster parents.

While the foster certification process is very thorough, prospective career foster parents can disengage before completing foster certification because of the amount of time the certification process takes.

Except for the five districts in the GRACE program,³¹ DHS does not track the length of time it takes for most foster parents to actually get certified or the reasons why prospective foster parents drop out of the certification process. DHS administrative rules require that foster parent certifications should be completed in six months or less. According to the GRACE program report, it can take up to a year to certify regular foster parents in Oregon.

Oregon does not have a statewide strategy for foster care recruitment and retention

Current foster home recruitment and retention efforts are isolated, piecemeal, and inconsistent. DHS does not have a statewide foster care recruitment and retention strategy. Recruitment and retention efforts are left up to individual DHS districts and are a secondary task for DHS certifiers. In addition, each district approaches foster care recruitment differently.

The agency leans heavily on contracts with three recruitment programs: GRACE, Embrace, and Every Child. Embrace serves the Metro area in Multnomah, Clackamas, and Washington counties. As of 2017, Every Child serves six Oregon counties with plans to expand statewide by 2022. These three programs currently serve less than half of Oregon's counties, and the GRACE program is set to expire in 2018.

Targeted Recruitment

This includes using targeted social media strategies, special events for specific populations, foster parent networking and support groups, and predictive analysis to identify and address district placement shortages.

DHS lacks a clear strategy to measure outcomes for its in-house and contracted recruitment efforts. It is not known how effective these programs are at achieving actual recruitments. Every Child and Embrace only track inquiries, and DHS does not track how many of these inquiries lead to certification.

DHS foster home certification staff are supposed to help recruit new foster parents. However, overwhelming caseloads severely limit their ability to focus on recruitment.

³¹ (GRACE) Growing Resources and Alliances through Collaborative Efforts. The GRACE program is a foster care recruitment and retention program that is supported by a federal grant and set to end in 2018. The GRACE program is limited to five DHS districts in central and southern Oregon.

DHS also conducts limited “targeted recruitment,” to expand the number of homes that serve specific children needs and communities. Ideally, targeted recruitment should constitute around 60% of all outreach efforts, yet DHS spends only 10% of its efforts on targeted recruitment strategies. Instead, the agency casts a wide net by using broad based recruitment strategies aimed at recruiting the general public to fostering children.

Limited data on the foster home shortage and foster parent recruitment efforts restricts decision making

Collecting and using data is key to improving the foster care system. Information can help management identify problems and act on them before they become critical.

DHS maintains information on children in foster care and their characteristics, but key information needed to determine the size of the foster home shortage is missing. For instance, DHS does not know the true capacity in current foster homes, which homes have openings, and what behavioral and special needs families are trained for and equipped to accept.

DHS districts are not able to compare their performance on some key metrics with other districts in the state. The agency does not track the rate of foster parent turnover or the average length of foster parent retention. It tracks foster parents’ length of service only when they exit the system. In addition, while foster parent certifications are tracked, foster parent applications are not tracked, and the agency does not know the percentage of initial applicants that get certified.

Basic training information, such as how many foster parents have been trained each year and what classes they have attended, is not collected in OR-Kids for analysis of trends and gaps. DHS uses separate external systems to track training. Individual certifiers manually enter training data in its central database, but that may not occur. The state does not have complete and reliable data on the proportion of foster parents who participate in and finish training for certification.

Other states have developed data-intensive approaches to recruitment and retention of foster parents. Some states are even using mapping technology to visually identify where and what types of foster homes are needed and where recruitment efforts could be focused. Oregon has the ability to use technology and predictive analytics to help drive decision-making, but currently is not doing this.

“Having useful data on prospective and current parents gives a child welfare system crucial insight into how effective their current approaches are in recruiting, developing, supporting foster, adoptive, and kinship families.”

**-National Resource Centers for
Diligent Recruitment**

The increased use of hotels as placement options puts children and caseworkers at risk

Given placement shortages, hoteling children when no other placements can be found has transitioned from a rare emergency occurrence to an increasingly accepted practice within the agency.

From September 2016 to July 2017, DHS placed 189 individual children in hotels at least 284 times. Several of these instances involved the same child being placed in a hotel multiple times. One child was placed in a hotel nine separate times in a 14 month period. Several other children had three or four separate hotel stays. The average length of stay was approximately seven days, but 26 children were placed in hotels longer than 20 days. One ten year old child stayed 81 days. For each stay, two adults, including at least one DHS caseworker, is required to be with the child around the clock.

Placing vulnerable children in a hotel puts child welfare staff at risk, and is isolating and traumatic for foster children. Many of the children have disabilities and some have severe behavioral and mental health issues, which at times result in violent behavior such as setting fires and physical assault.

DHS provides minimal support systems and guidance for district staff and caseworkers. New caseworkers with the least amount of field experience are often assigned to cover hotel shifts. Some DHS districts told us they received little assistance from central office staff when they had an urgent need for placement. In one instance, the district reached out to the central office for help in placing four siblings. In response, the central office emailed the district a boilerplate reminder of placement policies with no other offer of assistance.

In September 2017, DHS opened a 12-bed emergency shelter called Robinswood in partnership with Youth Villages in Clackamas County. The agency also added 12 more short term foster beds in Multnomah and Lane Counties in partnership with Maple Star³² and the Boys and Girls Aid.³³ These are potentially positive steps, but it is unclear whether this additional capacity will help to prevent the hoteling of children and serve children in other parts of the state.

Adequate planning systems are not in place

DHS did not begin formally tracking the hoteling of children until September 2016, when two community organizations filed a federal lawsuit to stop DHS from housing abused and neglected children in DHS offices or hotels. After the lawsuit, the agency stopped the practice of

³² Maple Star Oregon is a nonprofit agency specializing in therapeutic foster care. Therapeutic foster care is a clinical intervention, which includes placement in specially trained foster parent homes, for foster children with severe mental, emotional, or behavioral health needs.

³³ Boys & Girls Aid is a non-profit organization that offers foster care services, including shelters and homes, to children in DHS custody.

housing children overnight in district offices, but it continues to house children in hotels or other residential placements when normal placements are not available.

Since September 2016, DHS has informally tracked the hoteling of children, but we found the data is not always complete and consistent. For example, we were unable to conclude on the behavioral needs of these children, as over 60% of them did not have an assessment completed. These assessments determine the child's needs and strengths for the purposes of case planning, service planning and determining supervision needs of the child. Other information was not always complete, including the child's previous placement and information regarding why the child could not be placed elsewhere. This data, if complete and reliable, could help DHS better identify trends and possible solutions to reduce hoteling.

We also learned DHS is not tracking or reviewing the costs of hoteling. We reviewed data from DHS state credit cards, which is the primary way the agency pays for these hotel stays. Child Welfare employee charges for hotels from 2016 to 2017 increased by 72%, from \$507,648 to \$871,478.

Although some of these charges could be for approved employee training and conferences, much of this increase is likely due to the increased use of hoteling foster children. Not included in the figures above, are costs for overtime for two round-the-clock caseworkers, shift differential payments, meals for children and caseworkers, and other incidental costs.

We estimate that one hotel room, overtime, meals and one activity for one child and two caseworkers is about \$1,350 per day. We also estimate total hoteling costs from September 2016 to July 2017 are over \$2.5 million.³⁴

Other states and foster care agencies use data and targeted strategies to enhance their recruitment and retention efforts

Targeted recruitment efforts are critical to maintaining the capacity of a state's foster care system. Although DHS has implemented some targeted recruitment efforts other states have initiated more robust recruitment programs. We found that other states use data and targeted strategies to recruit and retain foster parents. Promising practices in other states also include establishing networks and encouraging supportive relationships between foster parents. Other states also provide ongoing training and support to retain foster parents before they burn out and opt out of the system.

³⁴ Estimates are based on a snapshot of one hotel stay on July 8, 2017. The hotel room was \$169 for one night, per diem of \$32 each for two caseworkers and a child, \$14 for one activity, and overtime and shift differential pay of \$1,069.40 totaling \$1,348.40. This was multiplied by 1,904 - the number of nights 189 children have stayed in a hotel from September 2016 to July 2017.

Goal setting and metrics are used to assess effectiveness

The Utah Foster Care Foundation is a non-profit established in 1994 after the state's Child and Family Services Division was sued. In response to the lawsuit, the Governor took the foster care recruitment, retention, and training functions out of the state agency, and charged the Foundation with meeting recruitment and retention goals to build the state's foster care capacity. The Foundation was authorized by the Utah State Legislature and operates under a performance contract.

The Utah State Legislature mandated that the Foundation achieve the goal of recruiting 500 non-relative placements every year. To do this, the Foundation uses data metrics, such as measuring the ratio of inquiries to certifications of foster parents, to gauge the success of their recruitment efforts. They also administer semiannual foster parent satisfaction and exit surveys in order to stay abreast of the needs and concerns of foster families. We also found that other states such as Kentucky and Washington have robust metrics for their targeted recruitment efforts.

Utah uses targeted recruitment to build foster system capacity

The Utah Foster Care Foundation targets neighborhoods for two months of focused recruitment. During that time, they contact newspapers to issue press releases and articles about the need for foster parents. Foster families help the Foundation by hosting panel discussions where community members come to learn more about foster parenting. One neighborhood recruitment strategy has been the partnerships that have been created with schools in the communities. The schools agree to distribute flyers announcing open houses and other community recruitment efforts.

Other foster parent recruitment techniques the Foundation uses include using social media for targeted outreach and tracking, Spanish language radio ads, statewide media ads, and a mobile-friendly website. The Foundation has staff in every region of the state who can hold recruitment events, including a full-time Native American Tribal specialist who works with federally recognized tribes to recruit foster parents.

The Foundation holds foster parent panels for current LGBTQ+ foster parents to share their experiences with other prospective LGBTQ+ foster parents. Last, the Foundation uses social media so foster families can connect with each other quickly and easily if they have questions or concerns, or if they just need a moral support.

Other promising practices to recruit and retain foster families

One of the most effective strategies includes directly involving experienced foster parents in recruitment and retention efforts. Foster parents are the most effective recruiters because they share information about the dire need for foster parents through word of mouth and can promote fostering just by their presence in the community. Effective training is an important piece of ensuring foster parents are prepared and successful.

The Florida Department of Children and Families created paid mentoring positions for current foster parents to help with recruitment and retention. It also created a user-friendly website that highlights success stories and includes a video page that shows current foster parents sharing, in their own words, what it means to be a foster parent. This helps to counteract negative perceptions of foster parenting.

Another community-based effort, Family to Family, is an initiative of the Annie E. Casey Foundation that is currently operating in eight states. It promotes a neighborhood-based system of foster care that involves finding and maintaining foster and kinship homes that can support children and families in their own neighborhoods. In this model, recruitment efforts target those communities where foster parents are needed most.

Foster Parent College is an online training venue for career and relative foster parents and adoptive parents. Interactive multimedia courses offered through the site provide foster parents with in-service training on clinical aspects and interventions for their child's behavior problems. There are currently 23 courses, 14 of which address specific child behavioral and emotional problems. Course topics also include safe parenting, positive parenting, working with schools and birth parents, and home safety.

Finding: Staffing problems compromise the division's ability to perform essential child welfare functions

Oregon's child welfare system is critically understaffed, turnover and overtime are high, and an inexperienced workforce is taking on heavy caseloads, increasing the risks of child endangerment.

Reported caseloads are three to four times higher than what is optimal, contributing to staff burnout, increased turnover and difficulty recruiting new workers. In 2016, caseworker turnover was 23%.

When caseworkers leave their positions, field offices often resort to redistributing caseloads among remaining staff. Staff overtime has risen to meet basic case management demands, contributing to the potential burnout and turnover of caseworkers in the field.

High caseloads compromise the ability of even the most experienced caseworkers to effectively serve Oregon's children. Many newer and relatively inexperienced caseworkers are expected to take on full caseloads without adequate guidance and support. About one-third of Child Welfare staff are in their first 18 months on the job.

Management actions to address the system's chronic staffing and training problems have been limited, with no meaningful increases in front-line staffing. The agency's workload model, critical to estimating the correct number of caseworkers needed, is also inaccurate and outdated. Approaches used in other states may help DHS more effectively address these challenges.

Child Welfare is critically understaffed

In order to meet the current needs of Oregon's child welfare system, DHS would need to increase field staff positions by about 35%. That increase would require hiring, training, and retaining about 769 more child welfare field staff, in addition to the 2,190 Full Time Equivalent (FTE) staff in field positions as of November 2017.

The current workload model is outdated and lacks key information

A regularly updated workload model is critical to determining how many child welfare workers DHS needs. DHS began building a workload model in 2008 and updated it in 2013.

However, in 2015, DHS transferred its workload modeling team to a different unit, cut positions, and demoted key staff.

Since the move, the workload modeling team has not been allowed to update the workload model using more recent timing studies, despite the introduction of legislation (such as Erin's Law) that directly impacts caseworker workloads. Further, as a result of the move, the team had difficulty maintaining communication with key central office and field staff,

Workload Modeling

Workload models use three fundamental measurements in their calculations: hours available to work, hours spent on work outside caseload management, and the time it takes to complete a case from start to finish.

The key to applying the workload model is an understanding of how many cases a single staff person can reasonably handle at one time.

and lost access to key data needed to update and maintain the workload model.

In addition, the workload modeling team was not informed that the agency planned to centralize child abuse and neglect hotline screening, a change that required 124 new FTE. They were also not informed of plans to update the Core training delivered to new caseworkers in late 2017, which initially was required for all current staff as well and would have had a significant impact on field staffing resources.³⁵ This led to DHS preparing an inaccurate workload report for the 2017 Legislature that was missing these additional staff.

Additionally, the previous Child Welfare director admitted to a legislative committee in April 2017 that she did not know how many staff were needed in her division. The DHS Chief Financial Officer later shared workload model information stating that the agency needed 307 more positions to be at 100% staffing under the workload model, although the 2017-2019 workload report estimated the position needs at 379. Both estimates are far below the current field staffing deficit of 769 positions.

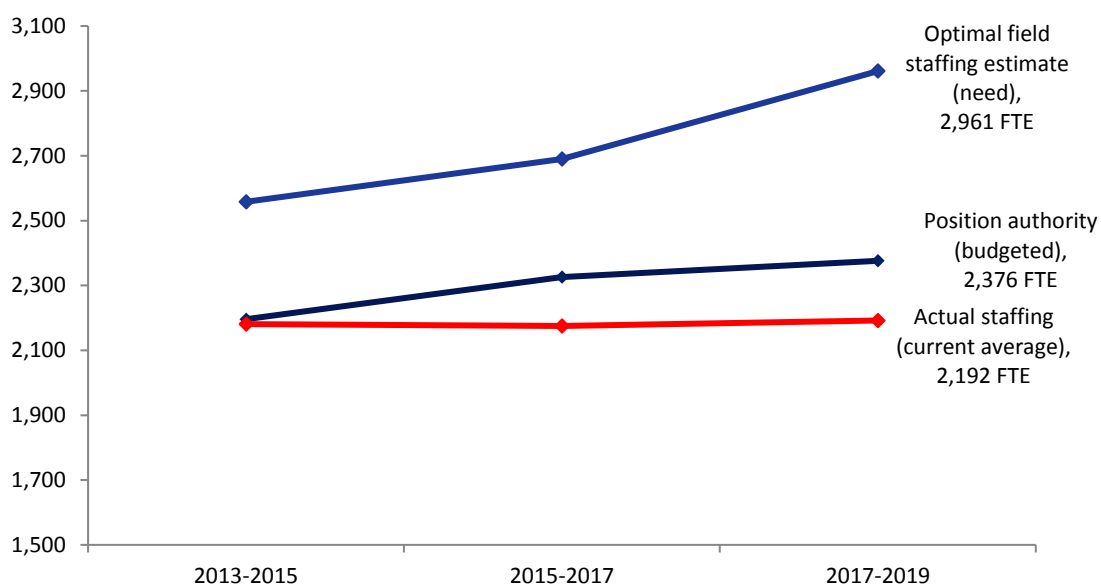
Child Welfare is operating under a substantial and growing staff deficit

Since introducing workload modeling in 2008, DHS has never been fully budgeted or staffed to the model's recommended level (see Figure 10). Child Welfare's overall staffing budget increased from 71% of the recommended level in 2011, to 86.7% in 2017, following the update of the staffing model in 2013. However, the number of actual staff in the field has not grown sufficiently to meet the need, and does not account for recent updates to field staffing estimates that include centralizing the child abuse and neglect hotline and adding paralegal support. Additionally, DHS holds 150 field positions vacant every year for budgeting purposes.

Since 2013, Child Welfare has only gained 11 active field positions, increasing from 2,181 to 2,192.

³⁵ DHS later revised that decision and now only new staff are now required to take the new training.

Figure 10: Child Welfare Staffing Needs Compared to Budgeted and Actual



Source: DHS Workload Modeling and Consulting

DHS's latest estimate is that Child Welfare needs 2,689 active field positions to be fully staffed. However, that estimate does not account for centralized hotline staffing needs, and includes outdated numbers on paralegals required to support child welfare activities — numbers that DHS has not updated since 2008. Even the outdated estimate indicates the agency needs 117 more paralegal staff in the field. In contrast, they are currently budgeted for 21 and may actually employ even fewer. Paralegals in Child Welfare are not required to be certified, meaning that the number of certified paralegals that caseworkers have access to may be very limited.

When centralized screening, paralegal positions, and necessary field staff coverage are all factored into the workload model, the optimal staffing estimate increases from 2,689 positions to 2,961 positions. The field staffing deficit increases from roughly 497 positions to 769 positions. This does not include any central office support or operations positions that may be needed. Such positions are not factored into the workload model.

Excessive caseloads are not sustainable

DHS does not have accurate numbers on caseloads. Caseworker interviews, workload surveys, and child abuse and neglect hotline call increases all indicate caseloads have grown, with much of that growth in the last few years.

Reports of child abuse and neglect made to the hotline increased about 16% from 2014 to 2016, with an accompanying increase in the number of CPS investigations.

District 5 reported the average number of field investigations resulting from hotline calls ranged from 200 to 300 a month from 2002 to 2015, then increased to a range of 300 to 400 a month from 2015 to early 2017. Caseworkers in several other districts reported caseloads that far exceed the standard used in the workload model.

There can be over 450 distinct tasks in the life of a foster care case, with the tasks categorized into four different types of caseworkers: screening, CPS, permanency, and adoption.

Figure 11: Caseworker Caseloads Optimal vs Actual

Caseworkers	Optimal caseloads	Examples of reported caseloads
CPS	6.85 new investigations per month	21 new investigations per month (Salem)
Permanency & Adoption	11.5 cases (12.3 cases for adoption)	Up to 45 cases (Prineville)
Certification	21.6 homes	60-80 cases (Roseburg)
Screening	46.7 calls per month (closed at screening)	78 calls per month (Pendleton)

Source: DHS Workload Model and Staff Interviews

Actual caseloads reported by caseworkers and district managers far exceeded the optimal levels used in the workload model. According to CPS workers in Salem, they are assigned 21 investigations per month — more than three times the 6.85 investigations per month that the model supports. Permanency staff in Prineville reported having to cover as many as 45 cases at one time when they were short on staff, nearly four times the recommended 11.5 cases per worker, and permanency staff in Roseburg reported having roughly 20 cases each. Caseworkers who certify foster homes in Roseburg reported averaging 60 to 80 cases each, three to four times the 21.6 cases recommended in the workload model for certification staff.

A survey by state employee union SEIU Local 503 also adds evidence that caseloads are high. The 2016 survey of Child Welfare employees found 57% reported their caseloads are over the recommended allotment. Some reported nearly 28 cases for permanency workers.

The large caseloads create substantial demands on Child Welfare workers. Many individual tasks are time consuming and time sensitive. CPS workers shared that they sometimes work late into the night to prepare for a court hearing after removing a child from a home. At the same time, they are seeking out immediate foster placements for the children, contacting schools and family members, and compiling what information they can on the children for the foster placement. Permanency workers prepare lengthy case plans for Citizen Review boards, in addition to safety plans, court reports, action agreements, and permanency plans.

"When I first started, I was concerned about not being able to do everything as it should be done, and my supervisor sat me down and told me I couldn't expect to do consistent 'A' level work. 'C' at best. There was just too much to do to focus on the quality."

-Former CPS caseworker

On top of their administrative burdens, caseworkers are responsible for building and maintaining relationships with the children and families on their caseloads, foster families, school officials, health care providers, and many others.

Figure 12: Child Welfare Caseworkers Interact With Many Entities in Just One Case



Source: Created by DHS Foster Care and Youth Transition Program Manager

Management does not adequately monitor caseloads or use them to make informed staffing decisions

Central office management does not accurately monitor actual caseloads or staff allocations by county or district. This lack of oversight contributes to high caseloads that are not reflected in the available data, and inequitable staffing levels between counties and districts.

Caseload tracking is generally left to district managers. Despite having a district report that monitors turnover, training, and medical leave, central management does not have a standard statewide approach to caseload tracking that accounts for these factors, all of which have a substantial impact on caseloads and the capacity of field staff to perform their work. Caseload tracking through OR-Kids is often inaccurate, as cases may be assigned to a 'primary' worker in OR-Kids, but actually managed by a 'secondary' worker. As a result, the central office is unable to identify how many cases each caseworker is actually working on.

“The central office has limited to no involvement in staffing allocation meetings. Overall, there has been a loss of connection to the field and little accountability taken.”

-Program Manager

Several districts use staffing calculators with average monthly case numbers to determine appropriate staffing in their field offices. The calculations, however, do not account for critical staffing details, such as the district’s turnover rate, staff on medical leave, and staff in training.

This creates a gap between the average caseload per position captured in the calculators, and the actual caseloads reported by individual caseworkers. For example, the District 3 staffing calculator determined the average caseload for a CPS caseworker to be about 9 new investigations per month compared to the average of 21 per month reported to us by the district.

Factoring in the district turnover rate, the proportion of staff in training, and the number of staff out on family and medical leave increases the number of cases each available caseworker is responsible for. Other forms of staff leave, such as administrative leave and sick leave, may further impact caseloads and raise the average noted in the staffing calculator to more closely align with the average reported by the district.

The true burden of caseloads is not clearly represented in the data that is available and used to make staffing decisions.

Staffing allocations to counties and districts vary substantially, and need is not always driving allocation decisions. In the summer of 2017, Washington and Clackamas counties reported being staffed at or over 90%, some of the highest levels in the state. Lincoln County reported being staffed at 59% during the spring of 2017, far below the budgeted level.

According to District Managers and other staff we spoke with, staffing allocations sometimes went to “squeaky wheel” districts, those best able to advocate for their staffing needs to the central office. Staffing more heavily in one district or county means that staffing needs elsewhere in the state may be overlooked, which could impact that office’s ability to deliver timely and effective service. Rural counties also struggle to attract and retain qualified people to fill positions.

The central office’s involvement in staffing allocations has historically been limited. Some offices report growing resentment between districts and counties over what some perceive to be unfair and shortsighted staffing allocation practices that favor some districts over others.

Caseload and staffing allocation tracking methods were also highly variable and inconsistent from district to district, indicating that DHS may not be able to pinpoint the true caseload burden or true allocation needs in every district with existing data.

Facilities and office space are often inadequate. Prior to 2015, staff office space and tech needs were routinely monitored in an onboarding tracking report with direct input from the field services administration, workload modeling team, information technology staff, district staff, and DHS facilities management. When the field services administration was

dismantled in 2015, communication between the workload modeling team, district managers and other field staff, and DHS facilities was impacted and the onboarding tracking report was discontinued. The administration of field services was not formally reassigned until late 2017. Office capacity is currently tracked through staffing surveys and on-site inspections. DHS did not provide evidence that potential future staffing needs are considered when planning for and implementing facility expansions.

Even if Child Welfare were fully staffed, the agency may not have building and office capacity to house the additional staffing. Field staff also shared that they frequently did not have enough fleet vehicles available and often have to use their own cars for field work.

Lean processes have been used but have not been adequate to address the caseload burden. DHS has emphasized streamlining its processes and consolidating case steps since 2008 under the guidance of the Office of Continuous Improvement. Those efforts do not appear to have had the intended effect on caseworker workload. Many staff reported that their administrative burdens had only become greater in recent years and workload has grown, not diminished.

High caseloads and a negative work environment are overwhelming an inexperienced workforce

The high caseloads in Child Welfare are generating a continuous negative cycle throughout the Division.

Caseworkers and other field staff told us repeatedly that the demands placed upon them were unrealistic. Many workers put in considerable overtime to try to keep pace with their workload. About one quarter of Oregon's child welfare caseworkers left their caseworker positions in 2016, and were 60% more likely to resign and leave the agency entirely than other DHS staff, and reports from the field indicate that medical leave for stress and burnout is high. Management, workers told us, sometimes resorts to bullying and intimidation as field workers fall behind. Caseworkers told us 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.

"Each day I tape people back together. So, you are basically abusing your employees to get another day, another hour out of them, to get the work done."

CPS Supervisor, District Office

All of those factors may have increased turnover, adding to the workload for field staff who remain. Given the turnover, many of those staff are relatively new. These newer staff are taking on full caseloads, even though many have not been through the recommended 18-month training period. About a third of the system's caseworkers are still in their first 18 months on the job.

Our visit to Roseburg was representative. The majority of the 19 caseworkers and supervisors interviewed averaged around 50 hours of overtime per month just to keep up with the caseload demands. Several said the district had experienced critically low staffing and a high degree of

staff turnover for several years. Caseworkers mentioned having to deal with unsafe situations and unsafe people when out in the field, and were more often than not left to handle these situations alone. Many felt that they did not receive enough training or enough support from supervisory staff, as their supervisors were as busy and overwhelmed as they were and unable to lend the level of support staff needed. Several shared that the job had taken a toll on their personal lives.

Over and over again, caseworkers, support staff, supervisors and district managers throughout the state stressed the increasing difficulty — and the importance — of the caseworkers' jobs.

Overtime use, turnover, and medical leave use are high

Overtime: The use of overtime is rampant and often happens in lieu of hiring more staff. High workloads and the increasing practice of hoteling children when caseworkers cannot find placements have caused many caseworkers to work substantial amounts of overtime. Caseworkers across the state told us they put in at least a few extra hours every week, and several reported putting in well over 100 hours of overtime per month during the spring and summer of 2017.

The agency pays over half a million dollars in overtime to Child Welfare caseworkers per month and that amount is growing. From November 2016 to October 2017 the agency spent almost \$8 million on caseworker overtime alone. Despite agency efforts to address the hoteling crisis that is contributing to increased overtime use, overtime costs were 34% higher in October 2017 than in October 2016.

Several supervisors and staff reported routinely working unpaid overtime (supervisors do not qualify, and some caseworkers can request five hours per week without the approval of the district manager). This indicates that overtime might cost significantly more if it were all paid out.

Overtime may be unavoidable with current caseloads. DHS's model for a CPS caseworker assumes 15.5 hours of work for an investigation that does not end in removing a child from their home. At the level reported to us in the Salem office — 21 investigations per month — it would take the caseworker 75 hours a week to handle those cases (barring any other non-case related work). That calculation assumes that none of the investigations resulted in removing a child, which would add still more time.

While overtime costs are a small piece of the overall child welfare budget, about five hours per month is considered normal. The excessive overtime use reported by staff (such as that used in hoteling) may contribute to the burnout and turnover of child welfare staff.

Turnover: Turnover for Child Welfare caseworkers in Oregon averaged 23% in 2016. Slightly less than half of those were resignations — turnover

"I worked 40 hours overtime a few weeks back. I was headed out one morning, and my four year old started crying because she 'never saw mommy.'"

CPS Caseworker, District Office

includes retirements, dismissal, and reassignments. At 13%, resignations among caseworkers in 2016 were double the state average of 6%.

Turnover varied among the districts. Three out of 16 districts were at or below 15%, and four districts were 40% or higher. One small district had a turnover rate of 75%, with about 12 out of 16 caseworkers leaving their positions. Turnover for all Child Welfare staff, including caseworkers, support staff, supervisors and central office program staff and management, increased from 15% in 2014 to 18% in 2016.

As all caseworkers are classified as Social Service Specialist 1 and turnover is tracked by classification, DHS cannot determine which caseworker positions are experiencing the highest turnover and where the greatest need for attention may be. Anecdotal evidence suggests that CPS workers experience unusually high turnover due to the high demands and emotionally taxing nature of the job, but DHS is not able to confirm this.

Turnover at the staff level also makes field supervisor positions more difficult to fill because it reduces the pool of workers experienced enough to be supervisors. Supervisors oversee a team of caseworkers, and work with large caseloads, overwhelming demands, and little ongoing training. Supervisors do not qualify for overtime pay, although many supervisory staff interviewed said they worked extra hours anyway. One District Manager mentioned having difficulty finding qualified candidates for open supervisor positions, and that members of their own staff were reluctant to apply given the high demands and unpaid overtime.

Caseworkers do not have interim promotional steps before supervisor. That lack of a “career ladder” may increase turnover.

When staff leave, it may take several months, or even up to a year, to fill the vacant position. In the meantime, other caseworkers and support staff must shoulder the additional workload, further reducing the time they have to work directly with children.

Turnover also increases costs. According to the National Child Welfare Workforce Institute, training costs alone total \$54,000 for each new social worker. DHS spends an estimated \$28 million per year on training and onboarding new caseworkers, due in part to the high turnover rate.³⁶

Family Medical Leave: This leave is reportedly often used by caseworkers for stress and burnout. At any given time, multiple Child Welfare field staff are out on medical leave under the Family and Medical Leave Act (FMLA). FMLA has multiple use restrictions, and is typically granted to staff in need of leave time for personal or family health conditions, pregnancy, or military family leave. A qualifying reason is one that renders the employee temporarily unable to perform the functions of the job. Staff in Portland reported that six caseworkers were out on stress-related family medical

³⁶ The cost of turnover, training and onboarding was calculated by multiplying the SSS1 staff turnover by estimated total compensation for a new caseworker for one year.

leave in July alone, and that it was a very common occurrence. Other districts indicated a similar trend in their offices.

In 2017, Child Welfare caseworkers used roughly 4,234 hours of FMLA per month, which reduced total available staffing by 24 FTE per month. That loss is about 2% of total caseworkers but it transfers more cases to the already overburdened caseworkers who remain.

Given the high-stakes interactions with families, a caseworker's job would be stressful even with normal caseloads. The high workload and difficulty staying on top of it further increase that stress. We were told caseworkers who experience unusually violent or traumatic events, such as witnessing a parent's suicide or having to inform a parent or family member of a child's death, are sometimes expected to return to the field the following day and make decisions on other cases.

Sustaining a large workforce requires a substantial resource investment and a certain amount of staff turnover, FMLA use, and sometimes overtime use are to be expected. However, DHS may benefit from exploring ways to reduce caseworker turnover and retain skilled staff, reduce excessive overtime use, and address the causes of medical leave for stress and burnout.

Caseworkers with limited field experience are taking on full caseloads

Given the turnover, many staff are relatively new. About a third of front line Child Welfare staff are in their first 18 months on the job. Many of these newer staff are taking on full caseloads, even though they have not been through the recommended 18-month training period.

Navigating even relatively straightforward cases requires a high degree of familiarity with DHS policy and practice, local courts, local and regional public services, schools, and mental health and health care providers. Due to understaffing, newer and less experienced caseworkers may be assigned to complex cases. Supervisors, also facing high caseloads, may not be able to help them handle those cases.

For example, one caseworker who had been employed for less than a year had one case with eight siblings, some with disabilities, and biological family members with ties to a violent motorcycle gang. Another caseworker mentioned having to sit with toddlers and school-age children as they went through withdrawals for drug addiction.

After years of discussion, DHS has developed an improved four- to six-week preliminary training for new caseworkers with the help of Portland State University. The new training began in September 2017. However, ongoing training options and expectations for caseworkers, supervisors, and support staff are still unclear, and there is limited tracking and monitoring of staff participation in the training.

In 2017, the Legislature set aside \$2 million dollars to develop new supervisor training. While funding is ensured, the new training is not scheduled to roll out until August 2018.

Workers report disrespectful management practices and fear for their personal safety on the job

Staff at all levels of the Office of Child Welfare Division reported incidents of bullying, intimidation of caseworkers by senior staff, and management efforts to suppress information. Some staff shared that management threatened to take away scheduled leave time from field staff unless monthly case goals are met. Several central office staff mentioned specific instances of bullying in meetings, including being shouted at and verbally abused. Some told us that they had been instructed not to talk to the state audit team.

In one example, a manager was told if they testified in front of the legislature on a failing program they would lose their job. In another example, management told an employee to respond to a Senator that the information they needed was not available, when it was. A third manager told us that they and their team were treated ‘as saboteurs’ for sharing information about a child safety review with management, and that the report was essentially dismissed and ignored.

Caseworkers also reported concerns about personal safety. Given high caseloads, caseworkers are typically alone when visiting homes or following up on a report. On a ride along we took part in, a young female caseworker had to drive to a remote area to find an alleged abuser. The caseworker indicated this is a normal part of the job and that she is often alone hoping nothing goes wrong.

In districts that lack a sufficient number of fleet vehicles, caseworkers may also have to use their own vehicles in the field, which could make them personally identifiable when off duty.

Staff working night shifts to supervise children staying at hotels reported feeling unsafe, and several shared stories of them or their coworkers being physically assaulted by some children while on duty. Staff also shared that they felt coerced into taking hoteling shifts.

Similar concerns were reflected in a 2016 Oregon Audits Division work environment survey of DHS staff.³⁷ Numerous Child Welfare field staff who responded shared concerns about a lack of empathy about the excessive workload, examples of bullying, personal safety and fears of retaliation for speaking up about problems to managers.

“From the top down in child welfare...an unhealthy and even toxic workplace where disrespect, favoritism, harassment, intimidation, and retaliation are allowed has been and continues to be nurtured. As a result, this same culture is seen as acceptable at all levels of child welfare. The first step is to make sure people are treated humanely.”

-Respondent to the Work Environment Survey Conducted by Audits Division in 2016

³⁷ Secretary of State audit, Report No. 2016-24

The negative work environment could be both a cause and an effect of high caseloads and high turnover, with both staff and management reacting poorly to overwhelming workloads and increasing demands on their time.

Caseworkers lack full legal representation and support

Despite recent efforts to ensure that all child welfare caseworkers in Oregon have access to adequate legal representation and support while conducting agency business,³⁸ many caseworkers in Oregon continue to have neither. Oregon is one of two states in the country that does not require that caseworkers have access to full legal representation in dependency hearings for foster children. Some caseworkers reported that they were expected to write their own petitions and present arguments with no legal representation.

Though District Attorneys often support CPS workers in initial court hearings, they do not always agree with the agency's decisions, hindering the CPS worker's ability to ensure children are safe. CPS workers were particularly concerned about 'practicing law,' as generally only permanency staff have any access to representation by the Department of Justice.

The lack of legal representation may also contribute to safety issues for children, since all parties except the child welfare caseworker are granted representation in court. One example shared was that a young child could choose to return to an abusive parent. Since the child's lawyer is legally bound to represent the child's interest *as stated* (which may not necessarily be in that child's best interest), some children could potentially be returned to unsafe situations, even if the caseworker disagrees with the decision.

Caseworkers also shared that some counties have courts and Citizen Review Boards³⁹ that can be very difficult to work with. The Department of Justice has also coordinated meetings with some judges in recent years to compel them to treat caseworkers less harshly.

High caseload and turnover compromise child safety and outcomes

High caseloads and high turnover can negatively affect children during initial investigations and as caseworkers try to build relationships with parents, children, and foster care providers.

³⁸ HB2345 would have funded staffing needed for the Department of Justice (DOJ) to cover caseworker representation in court, but that bill died in committee in 2017. With the sunset of 2015 SB222 in June 2018, DOJ will be required to provide coverage, but may not have the staffing necessary to ensure adequate statewide coverage for DHS staff needing support in dependency hearings.

³⁹ The Citizen Review Board (CRB) is a program within Oregon's state court system that allows volunteer boards made up of community members to review the cases of children in foster care. Currently, there are 62 boards in 33 of Oregon's 36 counties.

When investigating a report of abuse or neglect and deciding what to do next, caseworkers must quickly make critical decisions. Miscalculations can lead to children being left in dangerous home situations, removed inappropriately, or placed in inappropriate foster homes or residential centers. The wrong decision can lead to further trauma for the children, and in some cases, endanger their lives.

Finding an appropriate placement also requires caseworkers to consider multiple factors, including the child's cultural background, sexual orientation, religion, family dynamics, and relationships with extended family.

Making appropriate decisions in this early stage requires time and a thoughtful approach. In Oregon's system, high caseloads reduce the amount and quality of time caseworkers can spend evaluating their cases. This increases the risk of making wrong decisions.

Once a child is through the initial stage, caseworkers are required to check in with them regularly, with the intent that they will build a stable relationship and be a constant in their lives. Federal law requires caseworkers to have face-to-face contact with a child at least every 30 days, for 95% of their cases.

DHS says its caseworkers meet that requirement 90% of the time, despite the high caseloads. That still leaves 700 children not receiving face-to-face contact in a month and results in a 1% reduction in federal funding for the Child Welfare program per biennium — a loss of about \$4.9 million that could go to support increased staffing. In addition, many caseworkers told us that they are unable to spend the time needed to build and maintain relationships with the children in their caseload.

While they might technically meet the face-to-face contact requirement, many of the meetings take place in passing, such as waiting for a court appointment or having a casual conversation in the hallway between other meetings. Caseworkers stated that these meetings were often inadequate.

High caseworker turnover can also damage relationships and reduce the chance a child will end up in a permanent, stable home. One well-known study⁴⁰ found that a child with just one caseworker in a year had a 74% chance of ending up in a stable home. A child with three caseworkers in a year had just a 5% chance. The stability of the caseworker/child relationship supports effective case management and positive outcomes for foster children. Caseworkers are a key resource for children in the foster system; permanency caseworkers may carry one case for several years and be intimately familiar with the needs of the children on their caseload.

In our interviews with current and former foster children, several reported having multiple caseworkers throughout their time in the foster care

⁴⁰ Review of Turnover in Milwaukee County Private Agency Child Welfare Case Management, January 2005.

system. When asked what adults they would consider turning to when they had needs or questions, children mentioned independent living workers, counselors, and foster parents. Few included their caseworker.



BRIDGET RAYBURN

Age: 24
Time with CPS: About one year
Number of open assessments: 51 as of November 3rd
Average number of new assessments: About 21 per month
Average overtime: 20+ hours per month

DISTRICT 3

Yamhill, Polk, and Marion counties

Caseworkers: 149 allocated as of July 2017 (including screeners)
CPS Caseworkers: 56 allocated as of July 2017
2016 Turnover rate for D3 caseworkers: 25%
Average monthly cost of D3 overtime: \$49,241
Number of children in foster care for at least one day (2016): 1,211
2016 foster care entries/foster care exits: 454/481 (decline in total of 2%)
Number of certified foster homes (as of Sept. 2016): 348
Change in number of foster homes in 2016: net loss of 37 homes (11% capacity lost)

As of June 2017, District 3 lost 3 caseworkers a month to FMLA and 2 per month to turnover.

"I feel like I'm burning out."

In February of 2017, a member of the audit team rode along with CPS caseworker Bridget Rayburn as she responded to reports of abuse and neglect. We checked back in with her in November of 2017, after she had been on the job a little over one year. She provided the following comments:

There are aspects of the job that are awesome. If I can take a kid out of a truly dangerous situation, then I am helping. But right now, half of my CPS unit is looking for other jobs. You don't do this for the money. You do it because you love kids. I love my job, but I feel like it's not sustainable.

Right now me and everyone in my unit is getting a new assessment every day, and averaging 21 per month. Some people got 23 assessments last month. We're supposed to be getting 6 new assessments in a month.

I understand that it's never going to be easy. It's a hard and emotional job, but things could be done to improve it. It's not the work that makes you want to leave. It's not the families, or the trauma, that make you want to leave. It's the workload. You can't even keep track of it all. I've gotten calls from people that I should have recognized from a case, but I couldn't remember who they were. Because there is too much.

I am here because of the kids and the feeling of helping. I wish that I could spend more time with the kids on my caseload because I love working with kids, but I can't do this because my caseload is so high. Removing kids from their family home and placing them in stranger foster care is always hard. A lot of our foster homes are overfilled. It feels good when we can certify a family so the kids can stay with someone familiar. Getting a hand drawn picture from a kid makes this job worth it. At the end of the day, the job is about keeping kids safe and it's rewarding to know that I play a part in that.

I really love my job. If the workload were manageable, I think that I could do it forever.

I've become a more jaded person. My whole perspective on what constitutes abuse and neglect has shifted. I've become desensitized. That's just normal. I'm so discouraged by DHS, though. They have so many great workers, and they're just throwing them away.

This job has taken a toll on my personal life. I feel like I'm burning out. It's hard to leave work at work. I still go out and see friends, but I have this constant anxious feeling. Sometimes I'll wake up in the middle of the night because I forgot to call a parent back, or some form didn't get completed. I'm always afraid of having missed something, or something going wrong. And it's my responsibility. Sometimes it's just overwhelming.

The turnover is unreal. I've been in CPS for a little over a year, and in my unit I'm one of two people that have been there longer than a year. Someone cries at their desk every day. Not because of trauma. Because they're overwhelmed with work.

Approaches used in other states may help DHS more effectively address staffing challenges.

Some states and cities facing high caseloads and caseworker turnover in their own foster programs have taken steps to address their problems. Their strategies, ranging from hiring more caseworkers to upgrading technology used by caseworkers, could help improve Oregon's Child Welfare program.

Reduce caseloads and turnover

Other states, including New Jersey, Michigan, and Arizona, mandate caseload limits for child welfare caseworkers. In all three states, lawsuits led to the caps.

In New Jersey, under court order to reduce caseloads since 2004, the state increased caseworker salaries and took other measures, such as emphasizing caseworker professional development and career progression. The state has reduced caseworker turnover from 18% to 7%.

In Texas, a caseworker turnover crisis resulted in emergency funding for 829 workers to reduce unmanageable workloads and better ensure caseworkers meet guidelines for face-to-face contact with children. In addition, front line workers received a \$12,000 salary increase to bring their compensation in line with similar professions. Other vital positions that support caseworkers will also receive a salary increase.

Provide incentives for social work education

Some states have developed university-agency partnerships to encourage bachelor's and master's degrees in social work. Measures include loan forgiveness and specialized child welfare service coursework. Evidence indicates that professionally educated social workers are better prepared for child welfare work, stay longer, and influence organizations to support best practices. Child welfare workers in New York, for example, can receive loan forgiveness awards up to \$10,000 per year of service, up to five years and not to exceed the total amount of the worker's student loan debt.

Provide realistic job previews

At least twenty other states develop realistic job previews that present the unique aspects of their child welfare agency, available positions, geography, and client populations. These job previews are designed to present a balanced view of the rewards and demands of child welfare positions in order to align the goals and expectations of applicants with the requirements of child welfare work. The goal is to improve the fit between the applicant and the job.

One county in North Carolina has used job preview videos in part to deter prospective applicants who may not be ready for the challenges of the job. County officials also check in with new caseworkers in their first 30, 60 and

"Right now its sink or swim, and everyone's drowning."

- Caseworker discussing the lack of a support structure and the need for an appropriate training period for new staff.

90 days to find out if they are facing any difficulties. In the last decade, the county reduced caseworker turnover from a high of 39% to 12%.

Increase caseworker teaming

New York has developed a caseworker teaming model, with casework functions shared among multiple staff and group supervision. These teams collaborate to make case decisions and decide how to meet client needs. The team model is designed to reduce caseworker isolation and workload, improve workforce retention, and strengthen casework decision making.

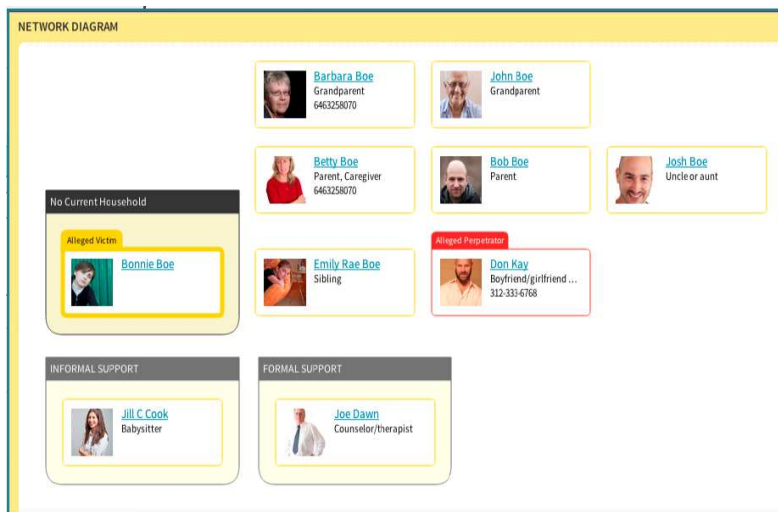
Improve Technology

Effective case management in Indiana's child welfare agency was thwarted by poor data and paper recordkeeping. In 2012, the agency implemented new casework software from a non-profit that shadowed caseworkers to develop the system.

With the new system, caseworkers immediately see critical information, including the number of days since their last visit with a child and how many days it has been since each child visited with their biological parents. The system also includes relationship diagrams to help caseworkers understand family networks and manage complex relationships. Other key

components include alerts, notifications and progress status indicators that help keep case management efforts on track and includes a placement-matching tool that helps caseworkers place children in care in the most appropriate setting and family.

By contrast, Oregon's OR-Kids software provides caseworkers with little useful data. During our field visits, we found caseworkers tracking child visits by posting handwritten notes on their cubicle walls.



Indiana's Casebook: A state of the art tool designed to help child welfare workers track and improve results for children in their care.

Recommendations: DHS Should Address Chronic Management Failures and High Caseloads

The numerous problems facing DHS and the Office of Child Welfare are serious and demand thoughtful and thorough attention.

Management of child welfare and foster care are disorganized, inconsistent and constantly in a state of flux. There are too few foster placements to meet the needs of children, and the agency lacks a robust foster parent recruitment plan. Chronic understaffing, excessive caseloads, high turnover, and a large proportion of inexperienced staff compromise the division's ability to perform basic and essential child welfare functions.

Recent changes to agency leadership set the stage for the agency to address these challenges. The recommendations below will help DHS ensure child safety and bring stability to an unstable foster care system.

To improve management in DHS and Child Welfare, the agency should:

1. Review and address the four foundational recommendations outlined in the Public Knowledge report:
 - a) Improve the DHS culture;
 - b) Focus the whole DHS Agency and Child Welfare on Safety
 - c) Adopt data-driven decision making; and
 - d) Increase staffing resources for Child Protective Services and other DHS entities.
2. Cultivate a culture of transparency, responsibility, respectful communication, and professionalism using an array of leadership tools and measurable through an independent work environment survey.
3. Review the structure and organization of key child welfare programs to identify and understand long-standing issues and system weaknesses; set policy and communicate expectations to ensure appropriate implementation of changes; and ensure changes are not simply reorganizations or movement of employees, but help management to address root problems.
4. To advocate more effectively for program and staffing needs to the Legislature, use clear and accurate data to support budget requests and show the effects of under budgeting on program stability.
5. Implement a thorough and ongoing evaluation process for agency programs and initiatives, including the following actions:
 - e) consider overhauling or replacing the OR-Kids case management system, and continue to apply lessons learned from this and other projects to future information systems projects;

- f) review the Oregon Safety Model to ensure that staff fully understand and can apply key concepts and more effectively safeguard child safety;
 - g) assess the true impact of the move to centralized screening on statewide staffing resources and the consistency of the screening function; and
 - h) assess the two-track investigative model used by CPS and OAPPI to ensure all identified gaps are addressed and consistency of response to reports of child abuse and neglect.
6. Establish safe mechanisms for staff to provide input, and develop a transparent process for reporting concerns, tracking them, and ensuring top management takes action to resolve them.

To improve management of foster care and recruitment and retention of foster parents, the agency should:

- 7. Develop and implement a statewide strategic plan to increase foster care capacity that includes using data analytics and tracking to target the recruitment of foster care placements for every district in the state. The strategy should include targeted recruitment of specific types of placements (career foster parents, therapeutic foster beds and culturally appropriate placements).
- 8. Collect and use data to improve the foster care system, including:
 - a) the availability of foster homes and the true capacity of available beds in the system;
 - b) the rate of foster parent turnover and the number of foster parents trained per year; and
 - c) a statewide dashboard to compare district performance on key metrics.
- 9. Remove unnecessary barriers that impede timely recruitment of foster families. Track certification of career foster parents, from inquiry through certification, and keep foster parents engaged during the entire process to increase the likelihood of certification.
- 10. Build a robust support system to retain career foster parents and reduce placement instability. This should include a foster care payment that fully covers the cost of caring for a foster child, options for respite care providers and encouraging foster families to use respite care, and ongoing training and support to foster parents so they can continue to meet the challenges of fostering.
- 11. Create and maintain a culture of respectful communication between foster parents and DHS caseworkers, and allow staff time for caseworkers to build relationships with foster parents. Use foster parent satisfaction and exit surveys to measure the quality of the program over time to understand and address foster parents' concerns.

12. Design a robust internal policy to reduce the risks of hoteling children by providing district caseworkers and office staff with clear protocols and operational support.
13. Commit to building foster placement capacity across the whole system for children with a range of behavioral, health-related, and cultural needs.
14. Develop a strategy for ending the practice of placing children in hotels.

To improve chronic understaffing, overwhelming caseloads and high turnover, the agency should:

15. Understand and clearly communicate child welfare field staffing needs to the legislature.
16. Review, revise, and update the current workload model to reflect recent policy and procedure changes, and field staffing needs.
17. Work with the legislature to increase child welfare field staffing according to the revised workload model and reduce the number of field positions held vacant to balance the budget, in order to reduce child welfare caseloads to manageable levels.
18. Monitor caseworker caseloads, district staffing allocations, and the impact of turnover, overtime use, lack of experience, and FMLA use on caseloads to support equitable staffing allocations across the state.
19. Develop and implement strategies to reduce and mitigate workload stress factors, reduce staff turnover, and reduce the use of paid and unpaid overtime by child welfare field staff.
20. Take the following actions to improve caseworker staffing and training:
 - a) work with DAS to review the Social Service Specialist 1 classification and consider separating casework positions into separate classes;
 - b) consider developing a career ladder for skilled caseworkers, supervisors, and support staff; and
 - c) Continue to develop and review training and professional development of casework staff and supervisors in conjunction with community partners.
21. Ensure adequate facility space and technological support throughout the state to absorb needed child welfare staffing increases and support quality casework.
22. Work with the Department of Justice and the Legislature to improve caseworker access to legal representation and legal case management support.
23. Consider implementing casework teams for responding to potentially dangerous calls and managing unusually complex or difficult cases.

24. Ensure that the central and district offices are in regular communication with field offices throughout the state and provide the necessary support and resources to field offices when requested.



Embargoed until 10:00 am, Wednesday, January 31

Oregon

Kate Brown, Governor

Department of Human Services

Office of the Director

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January 29, 2018

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310



Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled Foster Care in Oregon: Chronic management failures and high caseloads jeopardize the safety of the state's most vulnerable children.

I appreciate the audit and the attention it helps bring to such important issues. DHS embraces the recommendations and is already moving forward on most of them, working to improve outcomes for Oregon's children.

The report highlights the impact of chronic understaffing, which has led to high turnover and other problems in the agency. It also emphasizes the need to improve management practices and change our agency culture to one of empowerment to do our best for our children and our communities.

We need to tackle the root cause of these issues, not just the symptoms. That means focusing on recruiting and retaining foster parents and case workers, leveraging data and analytics in our strategic planning, and continuing our efforts to better partner with communities and support our existing foster parents.

When I started in my role as DHS director in September, the Governor made it clear to me that she expects results and outcomes within a reasonable timeframe. While we are responding to many crises articulated in the audit report, we are also building the capacity to deliver sustained outcomes and results according to our vision of safety, independence and health for all Oregonians.

RECOMMENDATION 1

Review and address the four foundational recommendations outlined in the Public Knowledge report:

- a. Improve the DHS culture;
- b. Focus the whole DHS Agency and Child Welfare on Safety;
- c. Adopt data-driven decision making; and
- d. Increase staffing resources for Child Protective Services and other DHS entities.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Marilyn Jones 503-945-6627 Paul Bellatty 503-569-9700

Narrative for Recommendation 1

a. Improve the DHS Culture

We are making positive movement toward changing the DHS culture. My first step was hiring a new Child Welfare Director, Marilyn Jones, in October 2017. Under Marilyn's leadership Child Welfare has established the following:

New Vision, Mission and Action Statements

Vision: Every child and family has a safe and positive environment in which to live and develop.

Mission: Every child and family is empowered to live independent, safe and healthy lives.

Action: Promote exceptional and equitable service by embracing opportunity for growth and providing innovative resources and support to our staff.

A Clearly Defined Action Plan

Many of the efforts underway through the Unified Child and Youth Safety Implementation Plan, The Child and Family Services Review/Program Improvement Plan, The Governor's Foster Care Commission and the Three Branch Initiative, have been pulled together in one clear Child Welfare Action Plan which describes how DHS is aligning the child safety system's vision, mission and goals with the project work.

The Action Plan identifies the 'Keys to Success' as Data-Informed Decisions, Valued Professional Discretion, Implementation with a Focus on Service to Children and Families, and Leadership Commitment to Positive Personal Development.

The Statewide Goals are Child/Family Safety and Well-Being, System Alignment, Service Intervention Effectiveness and Community Engagement; and key elements of the Action Plan include:

- Children are safe and healthy in their own families and communities.
- The child and family serving system is "right-sized" and operates effectively, efficiently, and uses data and research to inform decision-making.
- A competent, engaged, supported and valued workforce further strengthens DHS as a caring and supportive organization.
- DHS employs a connected and collective community-based approach to ensure children and families receive the best services.

Statewide Community Forums

Marilyn and I are visiting areas throughout the state during the months of January, February and March 2018. During these visits, we are engaging with stakeholders about what can be done better in Child Welfare. Stakeholders include local Child Welfare staff, foster/adoptive parents, youth who have experienced foster care, attorneys, elected officials, CASAs, Tribal representatives, law enforcement, service providers, educators, and interested community members.

Employee Suggestions

We are asking staff to engage and work together to improve the Child Welfare system. An email address was recently established (CW-Staff.Suggestions@dhsosha.state.or.us) for staff to submit ideas for follow up by agency leadership.

Process Mapping

We are currently working to develop a mapping process that will help describe the work we do, how we do it, and how we know we are doing it well. This will help everyone in the program clearly see how they contribute to the overall work of Child Welfare and will help inform the program's quality assurance efforts.

b. Focus the Whole DHS Agency and Child Welfare on Safety

In the fall of 2016, following the release of the *Final Assessment & Review Report for the Child Safety in Substitute Care Independent Review* from Public Knowledge, Nathan Rix, Director of Executive Projects, and his team of six project managers, were hired by the DHS Director's Office to help assure DHS as a whole is focused on safety. The Executive Projects Team developed the Unified Child and Youth Safety Implementation Plan focused on the safety of children across DHS divisions. The Plan can be found at: <http://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Pages/index.aspx>.

The Unified Child and Youth Safety Implementation Plan aims to achieve five strategic goals:

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

The Plan is advised and directed by a community-based steering team. The steering team prioritized ten projects to make safety-focused system improvements across the department. All ten projects focus on responsibility for child and youth safety, and over 100 community members are involved in these projects.

Each of the projects is listed below as Tasks A-J, and we have also provided a link to more information about each specific project.

<http://www.oregon.gov/DHS/ABOUTDHS/Child-Safety-Plan/Pages/projects.aspx>

- Task A. Enhancing Community Engagement
- Task B. Recruitment and Retention of Child Welfare Caseworkers
- Task C. Supervisor Training
- Task D. Fidelity to the Oregon Safety Model (OSM): Quality Review, Accountability, and Training
- Task E. Continuum of Care
- Task F. Coordinated Child Safety-Centered Response to Abuse
- Task G. Centralize Hotline Operations
- Task H. Aligning Policy, Procedure and Best Practice for Caseworkers and Supervisors
- Task I. Certification Safety and Well-Being Review Standardization (formerly Foster Home Reviews)
- Task J. Foster Parent Recruitment, Retention Support and Training

c. Adopt Data-Driven Decision Making

In the fall of 2017, we created the Office of Reporting, Research, Analytics, and Implementation (ORRAI) under the leadership of Dr. Paul Bellatty. This office will use the work from reporting and research to inform decision making and improve outcomes while ensuring the support of the field to improve outcomes for children and families.

d. Increase Staffing Resources for Child Protective Services and Other DHS Entities

The department's workload modeling has been recently moved under ORRAI. Our Office of Child Welfare Programs commits to working closely with this team to develop a workload model that accurately reflects the tasks and time required to do the work. We will present our findings to the Legislature and will seek their consideration in aligning resources and staffing with workload.

RECOMMENDATION 2

Cultivate a culture of transparency, responsibility, respectful communication, and professionalism using an array of leadership tools and measurable through an independent work environment survey.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019 and ongoing	Marilyn Jones 503-945-6627

Narrative for Recommendation 2

Child Welfare Director, Marilyn Jones, will use an array of tools to build high-functioning Child Welfare leadership teams. Casey Family Program consultants are working closely with her to build a team who understand that high-functioning leaders make stronger decisions together to create a successful organization. These teams will understand the need for transparency, strong and open communication, and offering high levels of support while asking for high levels of accountability. This work has already begun with the listening tours across the state (as described in narrative for

Recommendation 1) to identify areas of improvement. ORRAI is helping to establish baseline data and creating the optimal measuring tools for success.

In addition, beginning this year, 16 hours of professional development training will be provided to district and program managers to continue building a high-functioning leadership team.

RECOMMENDATION 3

Review the structure and organization of key child welfare programs to identify and understand long-standing issues and system weaknesses; set policy and communicate expectations to ensure appropriate implementation of changes; and ensure that changes are not simply reorganizations or movement of employees, but help management to address root problems.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 3

Stabilizing Leadership Changes Made

- Child Welfare Director Jones started on October 9, 2017. This provided stability for Child Welfare.
- Stabilized the district structure by filling vacant district manager positions across the state. We established a quality assurance function to help streamline Child Welfare QA efforts and align existing/future improvement plans into one focused plan moving forward. This position is also responsible for managing the federally required Program Improvement Plan, Child and Family Services Plan, and the Annual Progress and Service Reports.
- Rebuilt the field support structure to help better bridge the gap between central and field staff that was left with the elimination of 'Field Operations' in late Spring of 2016. This will ensure communication of expectations to ensure appropriate implementation of changes.
- In addition, Tim Sinatra has been hired as Director of Transformational Change to complete an assessment of the field and central office structures of all DHS programs to assure that our structures support the best service delivery model to meet our clients' needs. Final recommendations will be reviewed in May 2018 and will help inform additional improvements.

Structural Changes Currently Underway

- A mobile Certification and Training Team is being developed. The supervisor has been hired, and we are in the process of hiring five certification and training specialists to provide assistance wherever there is a backlog throughout the State. This will help stabilize the foster care program by assuring that foster care certification and training are completed timely.

Structural Changes Approved but Not Yet Fully Implemented

- Centralization of referrals for behavioral rehabilitation services. This central team will be responsible for securing appropriate placements for children and youth with high needs and assuring timely discharge. This will reduce workload for caseworkers during times of crisis. This work will be centralized effective May 1, 2018.
- Centralization of federal program eligibility determinations (Title IV-E, TANF and Title XIX). Eligibility determinations must be completed on every child that enters foster care to maximize federal reimbursement to the state. This process currently occurs at the branch level throughout Oregon. By centralizing eligibility determinations, we expect to improve accuracy and gain efficiencies. The centralization has already begun and positions are being brought to Central Office through attrition to minimize impact to staff currently working in the Child Welfare field offices.
- Centralized screening for child abuse and neglect reports. There are currently 15 child abuse hotlines throughout the state. They will be centralized to assure that all reports of abuse and neglect receive the same level of response and are screened the same way. This project will begin phasing the 15 hotlines into one centralized location in December 2018.

RECOMMENDATION 4 To advocate more effectively for program and staffing needs to the Legislature, use clear and accurate data to support budget requests and show the effects of under budgeting on program stability.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019	Marilyn Jones 503-945-6627 Paul Bellatty 503-569-9700

Narrative for Recommendation 4

DHS Child Welfare will work with the Office of Reporting, Research, Analytics and Implementation (ORRAI) to establish an effective workload model and actively apply it to better understand staffing needs. This, along with the information gained through the Child Welfare Research Priorities (outlined under Audit Recommendation 1.c), will be used to develop a data-informed request to the Legislature for adequate program staffing and funding.

RECOMMENDATION 5

Implement a thorough and ongoing evaluation process for agency programs and initiatives, including the following actions:

- a. Consider overhauling or replacing the OR-Kids case management system and continue to apply lessons learned from this and other projects to future information systems projects;
- b. Review the Oregon Safety Model to ensure that staff fully understand and can apply key concepts and more effectively safeguard child safety;
- c. Assess the true impact of the move to centralized screening on statewide staffing resources and the consistency of the screening function; and
- d. Assess the two-track investigative model used by CPS and OAPPI to ensure all identified gaps are addressed and consistency of response to reports of child abuse and neglect.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019	Kristen Duus 503-947-2594 Marilyn Jones 503-945-6627 Kris Skaro 971-599-9454

Narrative for Recommendation 5

a. Consider overhauling or replacing the OR-Kids case management system.

Recently, federal rules changed child welfare data systems from statewide automated child welfare information systems (SACWIS) to comprehensive child welfare information systems (CCWIS). Under the new CCWIS rules, states are required to share their system 'code' with other states. We feel strongly that waiting to review other state's CCWIS systems, seeing how successful they are and benefiting from their lessons learned, will inform Oregon's decision on whether to overhaul or replace OR-Kids.

Our OR-Kids business analyst team will work closely with the Department's Office of Information Systems (OIS) technical team to establish a shared team that includes OR-Kids business analysts, OIS technicians, and field end users to prioritize changes that will improve the end-user experience with OR-Kids. This team will conduct branch visits and interviews with end users to help guide decisions to make OR-Kids more user friendly and to help improve data quality.

Continue to apply lessons learned from this and other projects to future information systems projects.

Over the past three years, OIS has had a focus on improving processes for delivering IT projects. Changes made have incorporated lessons learned from previous projects, including the implementation of Child Welfare's statewide automated child welfare information system, OR-Kids.

b. Review the Oregon Safety Model to ensure that staff fully understand and can apply key concepts and more effectively safeguard child safety.

We have made significant efforts over the past year to provide child safety consultant support in all 16 districts to improve practice and fidelity to Oregon's Safety Model (OSM). The Child Safety Program is leading efforts to complete OSM Model fidelity reviews in all 16 districts with a goal of full completion by December 2018. Approximately fifty-percent of the state has already received the first level review and is in line for the six-month follow-up review to measure progress.

- The Child Safety Program works in collaboration with each district to develop branch level action plans following each fidelity review to identify goals and areas needing heightened focus. These plans are monitored and adjusted as needed by the Child Safety Program coordinators.
- Child safety consultants currently provide ongoing case reviews, training and coaching in all 16 districts. In addition, the consultants hold monthly debriefing meetings with district leadership to discuss data elements, practice concerns and goals.
- A quality assurance manager has been hired to assist in streamlining Child Welfare's QA efforts, including those of the Child Safety Program.
- Newly redesigned caseworker training started for all new caseworkers in September 2017. The practice model is incorporated throughout the training courses and new caseworkers are required to complete computer based training on the Oregon Safety Model as a prerequisite to entering their new worker Essential Elements training co-hort.

c. Assess the true impact of the move to centralized screening on statewide staffing resources and the consistency of the screening function.

The centralized screening project team is currently assessing the impact of centralizing screening functions on statewide staffing resources, and the consistency of the screening function as part of the staged implementation plan. A subcommittee kick-off meeting was held January 17, 2018, with approximately 75 staff and community partners from across the state attending, to help plan for issues related to: workforce; continuity of operations; quality assurance and continuous quality improvement; communication and community engagement; rules and procedures; training and coaching, and technology. In addition, Action for Child Protection and Casey Family Programs are providing consultation and support. The research reviewed thus far and discussions with several other states indicates that centralizing screening positively affects consistency in screening decisions.

d. Assess the two-track investigative model used by CPS and OAPPI to ensure all identified gaps are addressed and consistency of response to reports of child abuse and neglect.

We agree that safety assessments should center on the child and the child's setting. We are reviewing how best to do this. Programs within the department that are involved in the oversight of licensed child caring agencies (CCA's) have each undergone significant leadership and personnel changes since this audit was completed. New leadership in these program areas used the internal audit findings to guide process improvement efforts, including, but not limited to, establishing regular opportunities to share child safety information, increasing oversight requirements in Oregon administrative rules and procedures, and aligning rules and procedures between different child abuse investigatory units within the department. Department leadership has directed the Office of Adult Abuse Prevention and Investigations (OAAPPI) to provide

documentation that all previously identified gaps have been addressed by December 31, 2018. The Child Safety Program and OAAPI have increased communication efforts and partnership to ensure consistency of response to reports of child abuse and neglect. In addition, a monthly Licensing and Safety Review meeting takes place and includes representatives from every division in the department, to escalate concerns related to licensed CCA's.

RECOMMENDATION 6

Establish safe mechanisms for staff to provide input, and develop a transparent process for reporting concerns, tracking them, and ensuring top management takes action to resolve them.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	March 1, 2018	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 6

We recently established (CW-Staff.Suggestions@dhsosha.state.or.us) for staff to submit ideas for follow up by agency leadership. A tracking mechanism will be established to assure appropriate action is taken on all input received. In addition, the Executive Projects Office established an email box for staff and community partners to submit ideas to improve child safety: child.safety@state.or.us.

RECOMMENDATION 7

Develop and implement a statewide strategic plan to increase foster care capacity that includes using data analytics and tracking to target the recruitment of foster care placements for every district in the state. The strategy should include targeted recruitment of specific types of placements (career foster parents, therapeutic foster beds and culturally appropriate placements).

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 30, 2019	Kevin George 503-945-5897

Narrative for Recommendation 7

We acknowledge the need to develop a statewide strategic plan to increase family foster care capacity, and agree that a statewide strategic plan is necessary to improve the recruitment, retention and support of foster families caring for children in Oregon. DHS Child Welfare worked closely with the Administration for Children and Families throughout the summer and fall of 2017 to include

strategies in the Program Improvement Plan to address these very issues. A proposal outlining those needs will be submitted to the Child Welfare Director by March 31, 2018.

As the statewide strategic plan is developed, it will incorporate the statewide plan for expansion of the *Every Child* model. In addition, the Oregon Foster Family Recruitment Retention and Support Diligent Recruitment planning tool (developed through the GRACE project) will be utilized to create recruitment and retention plans at the statewide level.

The statewide strategic plan which will be complete by June 30, 2018, will be informed by strong data analytics. We will strategically place staff with the knowledge, skills and abilities to bring families forward and review various other states strategies as part of this planning.

RECOMMENDATION 8		
Collect and use data to improve the foster care system, including		
a. the availability of foster home and the true capacity of available beds in the system; b. the rate of foster parent turnover and the number of foster parents trained per year; and c. a statewide dashboard to compare district performance on key metrics.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	October 31, 2018	Kevin George 503-945-5897 Paul Bellatty 503-569-9700

Narrative for Recommendation 8

a. Collect and use data to improve the foster care system, including the availability of foster home beds and the true capacity of the system.

We are continuously making efforts to right-size the capacity of care to help assure safety, wellbeing and permanency for children/youth experiencing foster care. Data analytics is an essential tool in the effective utilization and development of foster care and other substitute care resources. The department gathers a tremendous amount of data through its information systems but has not had an effective way to assure the accuracy of data entered, or had access to timely and effective analysis of the data. Timely, accurate, and appropriately analyzed data is critical to making good data-informed decisions. The newly formed Office of Reporting, Research, Analytics, and Implementation (ORRAI) will play a critical role in our ability to use data to improve the foster care system.

As discussed above in recommendation 1. c, ORRAI is working on the development of data-informed tools including capacity and service matching. The placement of children/youth in Oregon has been primarily dictated by bed availability, with limited recognition of a child's specific needs and/or foster parent capabilities. Knowing the number and type of placements needed (foster care, kinship care, treatment/proctor foster care, behavioral rehabilitation services,

psychiatric residential treatment services, sub-acute, etc.), and which child/youth should be placed into what type of setting will help improve outcomes for children and families.

The placement capacity research will estimate the number and type of placements needed to optimally serve children's needs through a two-step process. First, an ideal service level will be determined using a random sample of children/youth, then statistical analysis will be used to identify the best outcomes of similar individuals placed in various service levels. The differences in these two results will refine estimates of what capacity is needed to create an optimal continuum of care.

Through a Federal grant opportunity DHS Child Welfare created the GRACE (Growing Resources and Alliances through Collaborative Efforts) project in Oregon. This program developed a Diligent Recruitment Practice Model informed by data and using a customer service approach, to recruit and retain resource/foster families who reflect the culture and characteristics of the children in foster care and to develop and sustain thriving community partnerships. We are currently evaluating how to sustain the positive impacts of GRACE as the grant funding ends in the fall 2018.

b. Collect and use data to improve the foster care system, including the rate of foster parent turnover and the number of foster parents trained per year.

The department will conduct a review of the historic turnover rate of foster parents in Oregon, along with a scan of literature and national surveys to assist in creating a baseline turnover rate for foster parents in Oregon. This review will be completed by June 30, 2018, and the results will help inform the Statewide Strategic Plan for Recruitment, Retention and Support at the district level.

The department will address the need to track foster parent training. By the end of April 2018, the Foster Care and Youth Transitions program area will add a foster care coordinator focused solely on caregiver training for both foster parents and relative caregivers, and will have a caregiver training strategic plan developed by October 2018.

c. Collect and use data to improve the foster care system, including statewide dashboard to compare district performance on key metrics.

ORRAI is currently using geographic information systems technology to create mapping statewide that will provide data about how many children are in care by county/community, including demographic information, and how many current foster homes are certified by county/community, identifying which are kith/kin and which are general applicants. This information will inform the statewide strategic plan and help track performance across districts.

RECOMMENDATION 9

Remove unnecessary barriers that impede timely recruitment of foster families. Track certification of career foster parents from inquiry through certification, and keep foster parents engaged during the entire process to increase the likelihood of certification.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 30, 2018 and ongoing	Kevin George 503-945-5897 Paul Bellatty 503-569-9700

Narrative for Recommendation 9

We will work to remove unnecessary barriers that impede timely recruitment and to improve the retention of good foster families. Utilization of data analytics is one necessary element to help identify the specific barriers.

DHS Child Welfare has identified the need for a workload model analysis to be completed for all staff identified as Foster Care Certification workers. This is one area that has not received a thorough workload analysis in the past, and with the number of significant changes over the past 5-7 years (see below), a workload analysis is necessary.

The foster care program began using a Structured Analysis Family Evaluation (SAFE) approach to completing home studies as a critical piece of the certification process of foster families. While this tool has been identified as very thorough and helpful, it is also time consuming and was not considered in the existing workload model. We will consider this as we develop our new workload model.

The department will initiate a relative caregiver review utilizing national standards, literature and other state's models to learn how other states work with and/or certify relatives who care for children being served by Child Welfare in those states. This review will include recommendations to the Child Welfare Director by June 30, 2018 for consideration regarding modifying and continuing the current model or movement toward a new model.

DHS Child Welfare is currently developing a Mobile Certification and Training Team to test a model that will allow more flexibility of staff to meet the needs of potential foster families within communities throughout the state. This team is not dedicated to any one county, but will be deployed according to need. This is a small team—three foster home certifiers and two trainers to test the intervention. This team is projected to be up and running by March 2018.

RECOMMENDATION 10

Build a robust support system to retain career foster parents and reduce placement instability. This should include a foster care payment that fully covers the cost of caring for a foster child,

options for respite care providers and encouraging foster families to use respite care, and ongoing training and support to foster parents so they can continue to meet the challenges of fostering.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	September 30, 2019	Kevin George 503-945-5897

Narrative for Recommendation 10

During the last legislative session, the Legislature authorized increased reimbursement rates for family foster care effective January 1, 2018.

The Legislature also set aside \$750,000 for Foster Parent Supports. The department worked with the Legislative Fiscal Office during the fall of 2017 to prepare the legislative request which was submitted on January 12, 2018. This plan includes developing the following programs to support foster parents:

- **Respite Care** – Approximately 65% of the funding (\$487,500) will be used to provide two conservative models of respite care for foster parents—a ‘general respite’ model and a ‘child specific’ model;
- **Mentoring** – Approximately 20% of the funding (\$150,000) will be used to develop mentoring programs to help support new foster parents; and
- **Immediate Needs** – Approximately 15% of the funding (\$112,500) will be used flexibly to meet the immediate needs of foster parents (i.e., purchasing a crib, car seat, etc.) so they are able to more immediately care for a child or sibling group.

In addition, we have prioritized providing a child care stipend to offset the cost of child care for working foster parents. This will be achieved by reinvesting general funds ‘saved’ through the Federal Adoption and Safe Families Act of 2008 (Public Law 110-351). This law changed Title IV-E adoption assistance eligibility requirements to allow federal funds to be claimed where they couldn’t be before. In return, the state is required to reinvest the ‘savings’ into Child Welfare services not currently offered (i.e., supplement not supplant existing services). A letter was submitted on January 12, 2018, to the Interim Joint Ways and Means Committee requesting permission to implement a Child Care Stipend Program that would allow a \$375 per child/per month stipend to be provided to working foster parents who care for children 0 through 5 years of age.

Both requests – for the foster parent supports and the child care stipend – require action by the Legislature during the February session before we can move forward. Program development for foster parent supports will begin approximately 30 days following legislative approval, and the Child Care Stipend Program is ready to begin within 60 days of legislative approval.

A sustainability proposal supported by data showing the successful work conducted through the GRACE project will be submitted to the Child Welfare director by March 30, 2018. This sustainability proposal will identify staffing resources necessary to help increase recruitment,

retention, and support of caregivers through a customer service, data-informed approach. The GRACE project is currently supported by a federal grant, set to expire in the fall, and is only available in 5 districts throughout the state. More information can be found at:

http://www.nrcdr.org/diligent-recruitment/dr-grantees/story?k=dr_grace

RECOMMENDATION 11

Create and maintain a culture of respectful communication between foster parents and DHS caseworkers and allow staff time for caseworkers to build relationships with foster parents. Use foster parent satisfaction and exit surveys to measure the quality of the program over time to understand and address foster parents' concerns.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2018	Kevin George 503-945-5897

Narrative for Recommendation 11

The audit has identified significant staffing needs for Child Welfare caseworkers. Addressing the staffing needs is essential to providing capacity for workers to engage in more quality time with children and foster parents. This will allow caseworkers to build necessary relationships. Meanwhile, the new leadership in Child Welfare is communicating a set of expectations for respectful communications and interactions.

RECOMMENDATION 12

Design a robust internal policy to reduce the risks of hoteling children by providing district caseworkers and office staff with clear protocols and operational support.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	Completed August 1, 2017	Peter Rosenblatt 503-945-5732

Narrative for Recommendation 12

DHS worked with the Service Employees International Union (SEIU) to develop the Oregon DHS Statewide Protocol for Children in Need of Placement. In addition to the development of this protocol, a supplemental training was developed and posted on iLearn, the state's on-line employee education system. All Child Welfare employees providing supervision of a child in a hotel setting were required to read this protocol and take the online training, prior to August 1,

2017. Thereafter, all new Child Welfare employees providing supervision of children in a hotel must read the protocol and complete the training prior to supervising a child.

RECOMMENDATION 13 Commit to building foster placement capacity across the whole system for children with a range of behavioral, health-related, and cultural needs.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Kevin George 503-945-5897 Peter Rosenblatt 503-945-5732

Narrative for Recommendation 13

Audit Recommendation 7 identified the need for a statewide strategic plan to increase foster care capacity. This will help address one area of need in a continuum of care. Developing a comprehensive continuum of care model in Oregon will require a public/private solution-based approach. DHS Child Welfare cannot create the solution alone.

In July 2017, DHS Child Welfare made a significant investment to expand capacity in the DHS Behavioral Rehabilitation Services system (BRS). This investment is projected to yield an increase of 90 BRS Shelter/Basic Residential/Intensive Residential placements and an additional 150 BRS treatment foster care placements in the 17-19 biennium.

To help address the gaps in other child-serving systems and assist in the development of a true continuum of care model, the DHS Unified Child and Youth Safety Implementation Plan –Continuum of Care Project was created.

Continuum of Care Project Status and Updates

Task E, listed in Audit Recommendation 1.b, creates a service array and placement structure based on the individual needs of the child/youth, aligns policies and procedures across state agencies, and improves state agency coordination and service delivery. OHA Director Allen and I (DHS Director Pakseresht) gave this group a joint mandate to work cooperatively and to propose solutions directly to them. This service array will be developed by the end of December 2018.

DHS and OHA are co-sponsoring a youth system improvement effort.

A small group of subject matter experts from both agencies, including representatives from Child Welfare, I/DD and OHA's children's mental health system, have been working on a proposal for the directors to review. The timeline for completion of the proposal is January 31, 2018.

DHS commits to continuing to work with its partners to develop a sustainable, full continuum of care that begins with the availability of comprehensive supports to help children remain in their own

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homes whenever possible. With an effective continuum of care model, many of the children currently requiring care by DHS Child Welfare would instead receive care and support within their communities with or without DHS Child Welfare involvement.

In January 2018, Child Welfare Director Jones called together a team, including representatives from OHA, Coordinated Care Organizations, and DHS, to discuss developing a strong continuum of care for Oregon's children. Several partners have committed to work with us to address providing comprehensive services for behavioral, medical and cultural needs of our children.

RECOMMENDATION 14 Develop a strategy for ending the practice of placing children in hotels.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Peter Rosenblatt 503-945-5732

Narrative for Recommendation 14

Most often, children placed temporarily in hotel settings are not there due to a lack of family foster homes, but rather due to a lack of appropriate services and supports that should be available through other child-serving systems. DHS is addressing this recommendation directly by focusing on what we can be doing differently in the short term and partnering with system partners for long-term solutions. This is a child-serving systems problem that will only be resolved through the development of a true continuum of care that can meet the needs of children requiring high-level services to address extreme mental health or I/DD issues. Please refer to the information provided above, under Audit Recommendation 13, for a description of the efforts of DHS Child Welfare in helping to develop a true continuum of care for Oregon's children.

RECOMMENDATION 15 Understand and clearly communicate child welfare field staffing needs to the legislature.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019	Marilyn Jones 503-945-6627 Paul Bellatty 503-569-9700

Narrative for Recommendation 15

DHS' Office of Child Welfare Programs is working closely with the Office of Reporting, Research, Analytics and Implementation (ORRAI) team to develop a workload model that accurately reflects the work associated with practicing the Oregon Safety Model to fidelity and building strong relationships with children and families to improve outcomes. Please see the responses included in Audit Recommendation 1.c., 1.d, and 4. This information will be collected and used to present the 2019 Legislature with a well-informed request to increase staffing to what the workload model indicates is needed to do the work properly, with manageable caseloads, and necessary Central Office supports.

RECOMMENDATION 16 Review, revise, and update the current workload model to reflect recent policy and procedure changes and field staffing needs.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 1, 2018	Marilyn Jones 503-945-6627 Paul Bellatty 503 569-9700

Narrative for Recommendation 16

Our Office of Child Welfare Programs is working closely with the ORRAI team to develop a workload model that accurately reflects the work associated with practicing the Oregon Safety Model to fidelity and building strong relationships with children and families to improve outcomes. Please see the responses included in Audit Recommendation 1.c., 1.d, and 4.

RECOMMENDATION 17 Work with the legislature to increase child welfare field staffing according to the revised workload model and reduce the number of field positions held vacant to balance the budget, in order to reduce child welfare caseloads to manageable levels.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 17

DHS Child Welfare commits to being transparent and having open communication with the Legislature about the need to be fully staffed to improve outcomes for Oregon's children and families, and to ask for relief from the legislatively required position vacancy hold.

RECOMMENDATION 18 Monitor caseworker caseloads, district staffing allocations, and the impact of turnover, overtime use, lack of experience, and FMLA use on caseloads to support equitable staffing allocations across the state.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 30, 2018	Marilyn Jones 503-945-6627 Paul Bellatty 503-569-9700

Narrative for Recommendation 18

Caseload and workload will be measured by the ORRIA as described in Audit Response 1.c.3. District staffing allocations will be determined using caseload and workload information in conjunction with the number of positions allocated by the Legislature, and will take into consideration turnover, overtime needs, lack of experienced staff and FMLA.

We have a number of initiatives aimed at improving the quality and quantity of training to increase the knowledge, skills, and abilities of the Child Welfare workforce, please see the responses under Audit Recommendation 1.b, Task C, Audit Recommendation 2 and 5.b.

RECOMMENDATION 19 Develop and implement strategies to reduce and mitigate workload stress factors, reduce staff turnover, and reduce the use of paid and unpaid overtime by child welfare field staff.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 19

Appropriate staffing levels will assist the department in mitigating and reducing workload stress factors, reduce staff turnover, and the use of overtime. We commit to working with the Legislature to reach the level of staffing required to do the work.

A true continuum of care is necessary to meet children's needs and reduce the need for overtime to provide the direct supervision of children and youth. Please see the responses under Audit Recommendations 1.b Task E and Recommendation 13 for activities the department is currently taking to help develop a true continuum of care for children across child serving systems.

Placing youth in optimal settings increases the probability of success in placement which directly impacts workload and overtime. To accomplish this, research will estimate the number of service level beds needed to optimally serve the substitute care population through a two-step process. An ideal service level will be identified using a random sample of children/youth, then statistical analysis will be used to identify the best outcomes of individuals with similar attributes in various service levels. The differences between the two results will refine the estimates of what capacity is needed to create an optimal continuum of care.

The Legislature provided the department with 50 positions to assist with the retention and support of front-line staff. These positions have been allocated and are currently being on boarded throughout the state.

RECOMMENDATION 20

Take the following actions to improve caseworker staffing and training:

- a. Work with DAS to review the Social Service Specialist 1 classification and consider separating casework positions into separate classes;
- b. Consider developing a career ladder for skilled caseworkers, supervisors, and support staff; and
- c. Continue to develop and review training and professional development of casework staff and supervisors in conjunction with community partners.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019	Marilyn Jones 503-945-6627 Becky Daniels 503-945-6470

Narrative for Recommendation 20

- a. **Work with DAS to review the Social Service Specialist 1 classification and consider separating casework positions into separate classes.**

DHS commits to working with DAS to review the Social Service Specialist 1 classification and will consider separating casework positions into separate classifications.

- b. **Consider developing a career ladder for skilled caseworkers, supervisors, and support staff.**

DHS commits to considering developing a career ladder for skilled caseworkers, supervisors and support staff and taking an associated request to the Legislature if appropriate.

c. Continue to develop and review training and professional development of casework staff and supervisors in conjunction with community partners.

The department currently uses employee development plans, allows people to shadow positions across divisions, and allows for job rotations to give employees the opportunity to try different jobs. In addition, we have a number of initiatives aimed at improving the quality and quantity of training to increase the knowledge, skills, and abilities of Child Welfare workforce.

RECOMMENDATION 21		
Ensure adequate facility space and technological support throughout the state to absorb needed child welfare staffing increases and support quality casework.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	January 1, 2019 and ongoing	Kristen Duus 503-947-2954 Don Erickson 503-884-8774

Narrative for Recommendation 21

The Office of Child Welfare Programs commits to working closely with the Office of Information Systems (OIS) and Facilities to assure adequate facility space and technological support to support quality casework. This is contingent upon receiving additional staffing allocation from the Legislature.

RECOMMENDATION 22		
Work with the department of Justice and the Legislature to improve caseworker access to legal representation and legal case management support.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 30, 2020	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 22

The Legislature prioritized statewide legal representation for Child Welfare caseworkers, and DHS was awarded \$6.9 million in its budget for this purpose. An associated budget note (in HB 5006)

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requires the of Justice (DOJ), DHS, Oregon Judicial Department (OJD) and the Oregon state office of Public Defense Services (OPDS) to work together to ensure system efficiencies and effectiveness, and requires reports to the Legislature on progress, with the first report due October 2018.

In addition, HB 3470 extended the sunset for caseworkers appearing in court without representation to June 30, 2020.

As a result, DHS and DOJ have been working together over the past several months to develop a statewide, phased roll-out plan for legal representation of Child Welfare caseworkers in each county. Phase 1, which included legal representation by DOJ in 15 counties, was completed January 1, 2018. Phase 2, which includes hiring additional attorneys by DOJ, communications with staff and stakeholders, and legal representation by DOJ in 12 additional counties, will be complete July 1, 2018; and Phase 3 which includes legal representation by DOJ in the remaining nine counties, is currently scheduled to be completed by the end of June 2019.

In addition to the above-mentioned legislation, HB 2500 passed during the 2017 session mandating updated legal representation training for caseworkers every four years regarding their legal role in juvenile cases. DHS Child Welfare is currently planning with DOJ regarding the ongoing training they will provide as part of their 'technical legal assistance and contact' with Child Welfare staff. We are also working together to assure that legal representation training in the new worker training, and a more advanced five-day legal training, stay in alignment with the legal representation phase-in schedule.

RECOMMENDATION 23 Consider implementing casework teams for responding to potentially dangerous calls and managing unusually complex or difficult cases.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	July 1, 2019	Marilyn Jones 503-945-6627 Laurie Price 503-945-6953

Narrative for Recommendation 23

We agree that this is best practice, and having casework teams would be ideal. Currently, supervisors support their caseworkers by going out on calls, caseworkers partnering with law enforcement, and in some cases two caseworkers going out together. The department commits to considering what it would take to implement casework teams across all disciplines. Additional staffing will be required to implement this recommendation.

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RECOMMENDATION 24

Ensure that the central and district offices are in regular communication with field offices throughout the state and provide the necessary support and resources to field offices when requested.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 2018 and ongoing	Shannon Biteng 503-602-9871 Laurie Price 503-945-6953

Narrative for Recommendation 24

In addition to the efforts outlined above, effective January 2018, we rebuilt the field support structure to help better bridge the gap between central and field staff that was left with the elimination of 'Field Operations' in late Spring of 2016. This will ensure communication of expectations to ensure appropriate implementation of changes.

I would like to thank you and your Audit Team for your efforts on this audit. The department values the objective and independent evaluation that audits such as these provide. We look forward to implementing these recommendations to enhance the quality of services provided to Oregonians.

As we move forward, we will report to the Governor, the Legislature and the public with timelines and expectations for our performance.

Our staff is dedicated, hardworking and eager to help find solutions to the problems that affect our ability to serve children and families. DHS leadership is increasing our support for our staff by improving our systems and management of those systems.

Please contact Marilyn Jones at 503-945-6627 if you have any questions.

Sincerely,



Fariborz Pakseresht
Director

EC: Marilyn Jones, Child Welfare Director
David Lyda, Chief Audit Officer