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**DIFFERENTIAL RESPONSE IN ILLINOIS:
2011 SITE VISIT REPORT
EXECUTIVE SUMMARY**

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Tamara Fuller, PhD
Judge Kathleen A. Kearney
Sandra Lyons, PhD

1010 W. Nevada, Suite 2080 Urbana, IL 61801
(217) 333-5837 | www.cfrc.illinois.edu | email: cfrc@illinois.edu

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Executive Summary

Introduction and Methods

This Illinois Differential Response Site Visit report summarizes findings on the implementation of Differential Response (DR) in the State of Illinois by the Department of Children and Family Services (DCFS, the Department) as of July 1, 2011. These findings are part of a larger evaluation of DR conducted by the Children and Family Research Center (CFRC, the Center) and sponsored by the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR), which is funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The State of Illinois is one of three sites selected by QIC-DR in December 2010 to implement and evaluate a DR program, and the only one of the three to implement DR statewide. The other sites are a consortium of five counties in Colorado and a consortium of six counties in Ohio. The Illinois Site Visit Report examines the exploration and adoption phases of DR implementation in Illinois; provides a detailed description of the DR program that was developed; presents findings on the fidelity of DR practice to the program described in policy and statute; and assesses the core competency and organizational drivers used in the first year of project development. The report will inform the cross-site evaluation being conducted by the QIC-DR, as well as the greater child welfare community about effective strategies for implementing large-scale system reform. The theoretical framework used for this report is that developed by Fixsen and colleagues (2005) following their review and synthesis of existing implementation evaluation literature.¹

Information for this report was collected through three primary methods: (1) document review, including legislation, rules, procedures, protocols, and contracts; (2) statewide focus groups with both workers and supervisors who provided DR services and conducted child protective investigations; and (3) individual interviews and a focus group with key informants critical to DR implementation and program development. All focus groups and interviews were recorded and transcribed for qualitative analysis.

Illinois DR Program Description

Illinois's DR program, known as *Pathways to Strengthening and Supporting Families (PSSF)*, was implemented throughout the state on November 1, 2010, to offer an intervention response for handling reported child maltreatment cases deemed moderate to low risk that is an alternative

¹ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

to the established investigative pathway that requires the gathering of forensic evidence and a formal determination whether child maltreatment occurred. Cases assigned to the DR pathway undergo an in-home assessment and families are offered short-term Strengthening and Supporting Families (SSF) services. The process is intended to be voluntary, non-adversarial, and non-accusatory. Family members are not labeled perpetrators or victims and DR cases are not entered into the State Central Register.

The Illinois DR program is unique in many ways. Unlike other child welfare systems, which locate DR within Child Protective Services (CPS), the State of Illinois administers DR as a separate unit. The DR program is staffed by both public-sector (DCFS) and private-sector (community-based social service agencies) employees who work together in paired teams.

Calls made to and accepted by the State Central Register (SCR, commonly referred to as the “hotline”) as meeting criteria for child abuse and/or neglect are screened to determine if they are eligible for the DR program by meeting all of the following criteria:

- Identifying information for the family members and their current address is known at the time of the report;
- The alleged perpetrators are birth or adoptive parents, legal guardians, or responsible relatives;
- The family has no pending or prior indicated reports of abuse and/or neglect, or prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations;
- The alleged victims, or other siblings or household members, are not currently in the care and custody of the Department or wards of the court;
- Protective custody of the children has not been taken or required in the current or any previous case; and
- The reported allegation or allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect.² The following circumstances prohibit the report from being assigned to DR and the case will be assigned an investigative pathway.
 - Allegations of Mental and Emotional Impairment reports taken as abuse (Allegation #17).
 - Inadequate Supervision reports involving a child or children under the age of 8, or a child older than 8 years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety.

² Substantial Risk of Physical Injuries due to neglect (Allegation #60) was added to this list in July 2011.

- Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated.

All other allegations are considered to involve substantial child abuse and neglect, and are ineligible for assignment to DR.

Families assigned to DR are contacted by telephone by the paired DCFS/SSF team to arrange for jointly conducted in-home assessment within 3 days of case assignment. The DCFS employee (called a DR specialist) is primarily responsible for assessing child safety through the use of the State's Child Endangerment Risk Assessment Protocol (CERAP). If the assessment finds no immediate safety concerns, the DCFS DR specialist hands over the case to the private agency SSF worker who then completes a family needs and strengths assessment and provides an array of services to the family. If a child is determined to be unsafe, DCFS DR supervisors have the authority to reassign (reprocess) the case to the traditional investigative pathway.

DR services are voluntary. A family may refuse to accept services; in that event, if there are no safety concerns, the case is closed without a CPS investigation. If a family accepts services, the SSF worker can offer a wide array of strength-based and family-focused services to meet the their targeted needs. The SSF agencies must deliver most services in the home over the course of 90 days, the time allowed for service provision. However, up to three 30-day service extensions may be granted for good cause based on the family's needs and the availability of funds. Twice weekly in-home visits are required. Cash assistance of up to \$400 per family is available with approval at the regional level; expenditures above this amount must be approved by the DR Project Director.

Key Findings: Program Fidelity

Screening and Eligibility

All current allegations of maltreatment eligible for DR fall under the category of neglect. For the most part, DCFS DR specialists and DR supervisors as well as private agency SSF caseworkers and supervisors reported that the allegations currently referred to DR were appropriate, although a small number of workers voiced reservations about accepting severe medical neglect cases involving chronically or seriously ill children. Many workers and supervisors suggested that "risk of harm due to neglect" (Allegation #60) cases could be appropriate for DR, because it is often reported at the same time as other allegations currently eligible. However, they also expressed concerns about the catch-all nature of this category, which can include risk of harm due to domestic violence or parental substance abuse.

The evaluation uncovered worker concerns about the DR requirement that restricts eligibility to those families with no prior reports of abuse and neglect, since neglect tends to be a chronic condition for many of the families served by the Department. By restricting DR eligibility to

those families with no prior reports, many of the families that might benefit the most from DR are denied the opportunity. These findings indicate that the Department should consider expanding DR eligibility criteria to include prior maltreatment reports for neglect, especially those that are related to the same or similar incidents.

Reassignment of Cases from DR to Investigations

DR cases may be reassigned to an investigation for several reasons. Most DCFS DR specialists and SSF workers described situations in which cases were reprocessed due to safety concerns. But these cases occurred less frequently than those reprocessed because of inherent ineligibility, caused by the SSF worker's discovery after the initial contact of prior reports or an open case on a family member. Such discovery necessitates immediate reassignment to an investigation and was the most commonly reported reason for reassignment in Illinois. DR workers expressed frustration over the disruption the reassignment caused families after time had been spent in building rapport, assessing family needs, and providing necessary services.

SSF workers also expressed frustration with the requirement that a family assigned to a DR pathway must be reassigned to an investigation if the SCR receives a second call on that family (known as a Subsequent Oral Report or SOR), regardless of whether the SOR pertains to the same allegations and issues that the family is currently working with the SSF worker to alleviate. SCR workers have the discretion of taking subsequent calls as "related information" rather than an SOR, but SSF workers report that screeners do not always use this discretion consistently throughout the State. It is recommended that unless the information from the reporter involves new allegations, it seems less disruptive for the family if additional calls (while the case is open) are taken as information only.

Paired Team Approach

The overall opinion of both the public and private agency workers about the Illinois paired team approach was generally positive, although the DCFS DR specialists and the SSF workers differed on whether two people meeting with the family was necessary, or even beneficial. DCFS DR specialists were uniform in their assessment that the paired approach was "what makes DR work," because of the seamless transition from the initial safety assessment to the provision of services. Some private agency SSF workers appreciated the benefit of having two perspectives on family strengths and needs at the inception of a case, especially when the DCFS DR specialist assigned to work with them had more extensive child protection experience. Other SSF workers questioned the necessity of having two workers in the home at the same time, citing concerns that families may be intimidated, especially when one of the workers is identified as a DCFS employee. SSF workers and supervisors in two regions reported difficulties with DCFS DR specialists that they did not feel had a "family-friendly" approach.

Safety Assessment

The DR specialists, SSF workers, and their supervisors were asked if they felt that the safety assessment protocol used in DR cases was adequate. There was consensus among all DR staff that the CERAP was a useful tool for assessing the safety in the home. One DR specialist who used to be a DCFS investigator felt that even though the tool was the same, it was being used in a more strengths-based way

Service Provision

No one reported reassigning a family eligible for DR services to the investigative pathway on the sole basis of the family refusing services. SSF workers and supervisors reported that they were pressured to keep such refusals to a minimum. Three primary types of service were most often provided to families. *Instrumental* services, such as hands-on assistance in cleaning “dirty houses,” was often cited by SSF workers as a critical need of families with allegations of environmental neglect. Workers reported a need for *informational* services to help families both locate and obtain transportation to other community-based agencies to meet specific needs. Advocating on behalf of families to help them navigate or secure services from complex systems was frequently reported as a means by which *emotional* support was provided to families.

DR Cash Assistance Program

SSF workers and supervisors expressed widespread frustration over the length of time it took to process their requests for cash assistance funds and the lack of clarity about what these funds could be used to purchase. The cash assistance application process should be simplified by giving SSF workers and supervisors clearer guidance on the types of family needs that will be approved and speeding up the process for getting the cash to the family.

Caseloads and Staffing

DCFS DR specialists have no maximum caseloads, due to their limited involvement in each case. Private agency SSF workers have a caseload capped at 12 cases per worker. During the period under review, SSF caseloads ranged from 1 to 9, with an average of 4 cases per worker, although there was considerable regional variability. The SSF workers and supervisors felt strongly that their current caseloads were about right, indicating that the number of hours workers spent with each family and the distances they traveled in most parts of the state to get to the families required such reduced caseloads.

This evaluation discovered that the caseloads of DR specialists were significantly lower than expected throughout the state. Most workers rarely handled more than one or two cases at a time. The significantly lower DCFS DR caseload affected DCFS staff negatively according to both DR specialists and investigators. DCFS investigators and supervisors reported that they understood from the beginning that a benefit of DR implementation would be a reduction in

investigative caseloads due to the diversion of cases. This has not materialized according to investigative supervisors, because too few cases are diverted and because positions vacated by investigators who transferred to the DR units were left unfilled. As a result, caseloads were higher for those who remained in investigations (e.g., 30 or more investigations in some regions). Additionally, the lower caseloads and the lower severity level of the types of cases being handled by the DCFS DR specialists were highly visible to the DCFS investigators, which often led to resentment.

Key Findings: Competency Drivers

Staff Selection

Staff selection is essential, since it is at this level that evidence-based practices and programs are actually carried out. The DCFS DR specialists and DR supervisors are governed by collective bargaining agreements between the Department and the union. Employee length of service is the prevailing and primary factor in determining who is selected to fill these positions. Private community-based agencies were selected to provide SSF program services and they were responsible for the hiring of SSF staff. SSF workers are required to have a bachelor's degree and be certified to use the CERAP. Documented experience working with youth and families also is required. Supervisors must have a master's degree and more extensive experience in working with families. The evaluation found little consistency in staff selection criteria across agencies. The primary means of recruiting SSF workers in two or three agencies was the loss of funding in other programs rather than a determination that the worker would have the requisite credentials, skill set, or temperament for DR.

Training

The inaugural group of DCFS DR specialists and supervisors and private agency SSF caseworkers and supervisors was trained together in a 4-week training program followed by a week of web-based training modules. All of the workers felt that joint training was beneficial, because it allowed them to establish rapport with one another prior to working together. Despite the opportunity for team-building that the 4-week training afforded them, they felt the training was too long and was not specific enough to prepare them for the actual work required of them. They were not provided the opportunity to work hands on with the automated data management system and were required to attend a week-long module on the safety assessment protocol, which most of the workers were already certified to use. SSF supervisors wished for specific training tailored to their needs as supervisors, which was lacking in the current training.

Although there are benefits to having one 4-week training curriculum that both DCFS DR specialists and private agency SSF workers and supervisors attend together, there are also disadvantages to a "one size fits all" training. Because of their seniority within the Department,

the DCFS DR specialists may not need to receive ALL of the modules currently included in the 4-week training, especially those that could be considered introductory. Since they are also CERAP-certified, they may not need to attend the week of training devoted to CERAP certification. Less experienced SSF workers or supervisors, however, may benefit from the more extensive training. Finally, separate modules dealing with supervision and coaching may be useful for DR and SSF supervisors.

Investigative staff were also required to attend a 1.5 hour web-based, instructor-led “control group” training on DR, which was intended to provide an overview of the purpose and rationale of the program, describe the evaluation components and the logistics of the randomization process, and provide instructions for each of the data collection activities required of them when they received a report that was randomly assigned to the control group. During the focus groups, investigative staff reported that the web-based training was not conducive to learning and that they often spent time multi-tasking instead of listening to the trainer. They also felt that the trainers did not have accurate information about the DR evaluation and were unable to answer any of the questions that were posed to them during the training. The widespread confusion about DR practice and the DR evaluation expressed by investigative staff suggests that the both the content and the method of administration of control group training may need revision. The control group training should emphasize to investigators that they will still get DR-eligible cases (in the control group) until the evaluation is over, and that DR will not affect their caseload immediately.

Supervision and Coaching

Both DCFS DR specialists and private agency SSF workers noted uniform satisfaction with their supervision. Reasons for satisfaction included the supervisors’ fostering of a good working relationship leading to a cohesive team approach; demonstrating flexibility to meet the individual needs of their workers; providing constructive feedback; being readily available to answer questions; and having the subject matter expertise and the willingness to share knowledge.

Performance Evaluation

DCFS DR specialists’ performance evaluations are governed by the master contract with the union and are therefore limited to what is agreed on through negotiation. Although the current MOU encourages “periodic informal evaluation conferences” between the DCFS DR specialists and their supervisors, and the DCFS DR supervisors and the DR Project Director, it restricts written employee evaluation to DR work performance only and must acknowledge that the assignment is voluntary and the performance evaluated is not reflective of the employee’s permanent job assignment. The DCFS Project Director reports that she had the DR supervisors and the DR specialists develop DR-specific performance objectives. The performance objectives

for the supervisors are set annually by the supervisors themselves in partnership with the DR Project Director. According to the Project Director, if performance is deemed not acceptable, they will jointly identify training needs and develop a corrective action plan. No evaluations had taken place when the focus groups were conducted, so the public agency workers had limited information to share on this topic. In the private agencies, most SSF workers reported that they had yet to be evaluated and that they expected that the evaluation would be general in nature and not targeted to DR-specific competencies.

Key Findings: Organization Drivers

Decision Support Data Systems

Significant and intensive work was done to the Department's Statewide Automated Child Welfare Information System (SACWIS) to accommodate implementation of DR. Three DCFS divisions are responsible for DR program oversight. The Department's Division of Quality Assurance is responsible for determining fidelity of programs and services provided by the DCFS directly. The Division of Monitoring is responsible for programmatic oversight of private agencies under contract with DCFS; and the Division of Budget and Finance monitors fiscal compliance. The focus groups did not produce much information related to the use of data to drive practice improvement or to help frontline staff in the SSF agencies.

Facilitative Administration

The DR program is led by the DR project director, who is primarily responsible for ongoing development of and modifications made to DR program goals and the practice model. Wide differences in sentiment existed between the public agency (DCFS) and private agency (SSF) workers about whether their suggestions and opinions were taken into consideration by DR administration: DCFS DR staff felt a strong sense of ownership of and involvement in program planning, while the private agency SSF staff felt much less involved.

The site visit also revealed some confusion and frustration about the lack of clarity of the role of the DR Project Steering Committee, which was formed to ensure proper oversight of the preparation and planning process for DR. It is recommended that project administration create opportunities for meaningful dialogue between all DR stakeholders to support the work of the frontline staff. Task-related workgroups should be established within the steering committee to examine each implementation driver and the supports needed to improve and sustain the project over time.

External Systems Intervention

Systems interventions are strategies to work with external systems and stakeholders to ensure the availability of the financial, organizational, and human resources required to support the intervention. Other than the CWAC DR Project Steering Committee, external stakeholder

groups and community members were not invited to participate in focus groups or interviews during the 2011 site visit. Thus, the information that is available about systems intervention related to DR in Illinois is very limited at this time and reflects only the views of those steering committee members who participated in the focus group. The next DR site visit, set to occur in late 2012, will collect more detailed information about the influence of external systems on the implementation of DR.

DCFS Organizational Culture and Resistance to Differential Response

The evaluation found that a certain amount of friction, or resistance, existed at all levels (administrative, supervisory, and frontline) between the Division of Child Protection (DCP) and DR. One source of this friction at the worker and supervisor levels is the difference in workload between DCFS DR specialists and DCFS investigators. Based on the Department's representation of DR to them, investigative staff believed that DR would result in a decreased workload. Unclear training regarding the need for random assignment of DR cases to a control group left investigators confused about why they were still responsible for cases they believed should have been assigned to the DR pathway. Many focus group participants described the prevailing DCFS organizational culture as one that is punitive toward workers; filled with burdensome paperwork; and overly concerned with negative outcomes, leading to bureaucratic redundancy in decision making.

Another finding relates to a perceived climate of secrecy created by the DR program, caused by the lack of information available to investigators either when DR cases are reprocessed to the investigative track or when new reports of abuse or neglect on a closed DR case are made to the hotline. Current policy requires that all information related to DR cases be sealed, meaning that it cannot be shared with investigators or other Department workers. Many workers saw this requirement as detrimental both to effective child protection efforts and to family engagement.

Recommendations

This site visit report provides a snapshot of how the DR program looked as of June 2011, approximately 8 months into the implementation process. Program implementation is a dynamic process and the DR program model in Illinois has already changed in several significant ways since the data for this report were collected:

1. The DR case eligibility criteria have been expanded to include the additional allegation of risk of harm due to neglect (Allegation #60). Although it is too soon to know how big of an impact this will have on the number of cases assigned to the DR pathway, this change will most likely increase the caseloads of both DR specialists and SSF caseworkers.

2. The 4-week training curriculum for DR specialists and SSF workers and their supervisors has been updated to include additional hands-on instruction related to SACWIS and the specifics of DR policy.
3. As of July 1, 2012, the requirement of twice weekly in-home visits from SSF workers may be reduce to once a week at the family's request. This request must be discussed between the family and the SSF supervisor, and this discussion must be documented in SACWIS. It should be noted that this request must come from the family rather than the SSF worker.

Based on the data collected during the site visit and the growing empirical literature on the factors that affect successful implementation of human services programs, some additional recommendations can be made regarding both the Illinois DR program and the competency and organizational components that support DR practice.

1. Some of the cases that are being randomly assigned to the DR pathway are actually ineligible (under the current eligibility criteria) to receive DR services, because they have prior reports that the SCR is not identifying at the time of the initial acceptance of the call. SSF workers report a tremendous amount of frustration when these cases get flipped back to investigations because a prior report is discovered after the case is opened. Two potential solutions exist to this problem. The first would be to improve the screening process employed by SCR workers so that fewer ineligible reports are put into the randomizer and sent to the DR pathway. A second solution would be to expand the DR eligibility criteria to include those families with prior maltreatment reports related to neglect, which tends to be a chronic condition. Ruling out all families with prior neglect reports excludes a significant number of the families that could potentially benefit from DR.
2. There seems to be some inconsistency at the SCR about how additional calls that come in on a family assigned to the DR pathway are handled: whether they are taken as "information only" or as an SOR, a subsequent oral report, which automatically causes the DR case to be reassigned to an investigation. Unless the information from the reporter involves new allegations, it seems less disruptive for the family if additional calls (while the case is open) are taken as information only.

3. Simplify the cash assistance process by giving SSF workers and supervisors clearer guidance on the types of family needs that will be approved and speeding up the process for getting the cash to the family.
4. Create more opportunities for meaningful dialogue between the DR workers. DCFS DR specialists and SSF workers expressed a desire to meet more often with their colleagues to exchange ideas and information. Geographic barriers may impede the ability to get together often—even within a region—but this is important, especially since new workers will not have the benefit of spending 4 weeks together in training like the inaugural group of workers did.
5. Increase the flow of information about DR to DCFS investigators, supervisors, and managers. Many of the investigation staff expressed an interest in learning more about how the implementation of DR is proceeding but had no informal or formal venues for obtaining current information. A webpage on the DCFS intranet with brief updates from the DR Project Director would be one method for communicating about DR implementation with all DCFS employees in an efficient manner. Another possible method of increasing the flow of information to the investigation staff would be to have the regional DR supervisors attend the regional supervisory forum that are attended by investigation supervisors and give period updates on DR implementation. Investigation supervisors can then pass the information along to the investigators that they supervise.
6. Review the “control group” training module on DR that is now part of the new employee training for DCFS employees. The widespread confusion among investigators about DR practice and the DR evaluation indicates that the current module may not be effective. It seems important to emphasize to investigators that they will still get DR-eligible cases (in the control group) until the evaluation is over, and that DR will not affect their caseload immediately.
7. Although there are benefits to having one 4-week training curriculum that both DCFS DR specialists and private agency SSF workers and supervisors attend together, there are also disadvantages to a “one size fits all” training. Because of their seniority within the Department, the DCFS DR specialists may not need to receive ALL of the modules currently included in the 4-week training, especially those that could be considered introductory. Since they are also CERAP-certified, they may not need to attend the week of training devoted to CERAP certification. Less experienced SSF workers or supervisors, however, may benefit from the more extensive training. Finally, separate

modules dealing with supervision and coaching may be useful for DR and SSF supervisors.

8. The role of the CWAC Project Steering Committee should be clarified. A facilitator should lead a discussion on the role of the steering committee going forward, and develop shared goals for the DR project once their role has been clearly established. A long-range strategic plan should be developed with particular attention paid to how external stakeholders will be engaged to support and champion the DR project. In addition, task-related workgroups within the steering committee should be structured to examine each of the implementation drivers as they relate to DR.