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Oregon Differential Response Initiative: Annual Interim Evaluation Report

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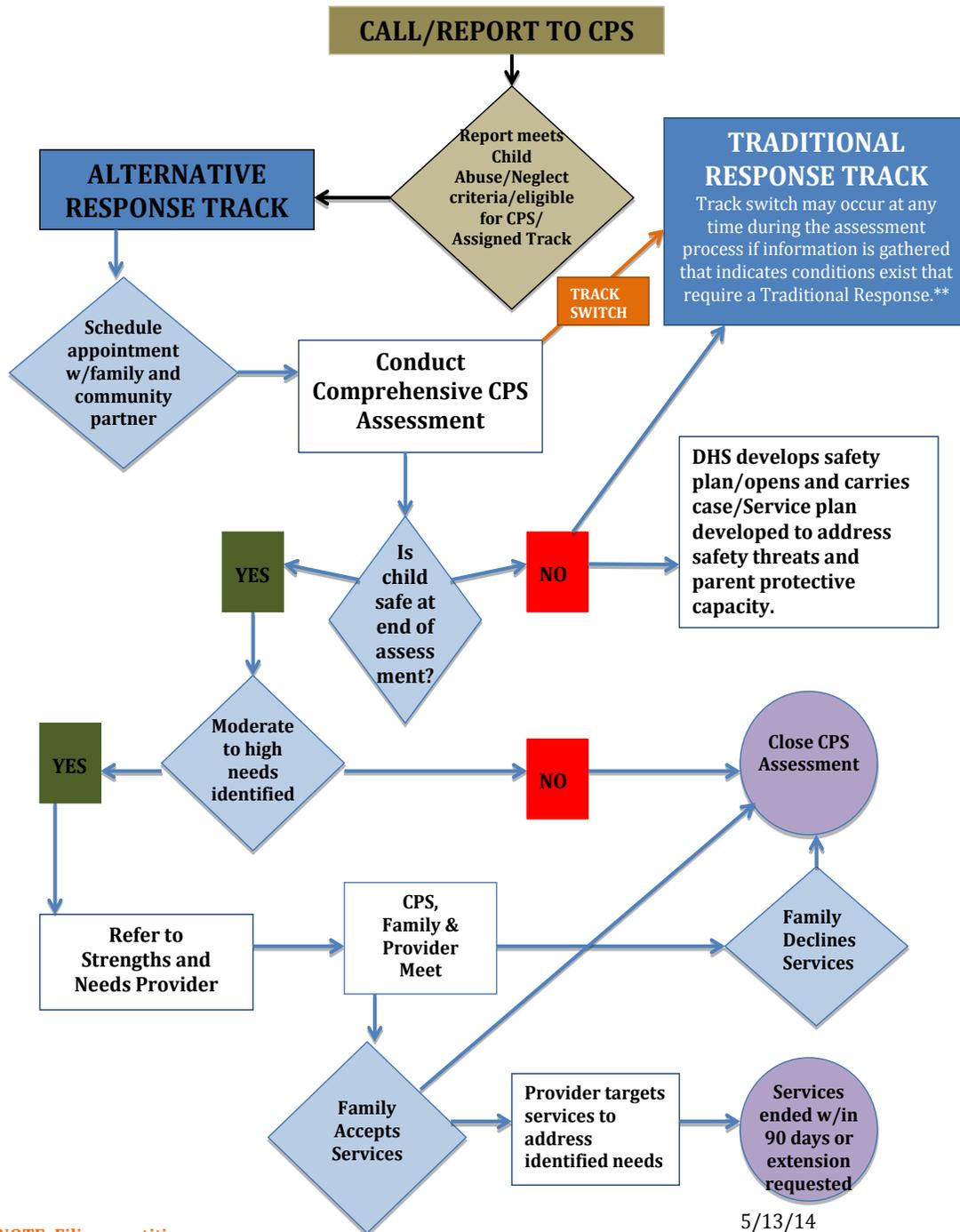
Chapter 1: Introduction and Background

Broadly speaking, Differential Response (DR) is an approach that allows child protective services (CPS) to respond differently to screened-in reports of child abuse and neglect. In Oregon, DR consists of two CPS response pathways: Traditional Response (TR) and Alternative Response (AR). Both TR and AR require a comprehensive Child Protective Services (CPS) Assessment using the Oregon Safety Model (OSM) to guide safety decision making. Traditional Response devotes substantial attention and resources to evaluating allegations of maltreatment and determining whether these allegations are substantiated. Alternative Response focuses on assessment of family needs through enhanced engagement strategies and deemphasizes forensic interviewing, and sets aside fault-finding, the substantiation of maltreatment allegations, and entries into the Central Registry. Both response types offer optional services to families identified with safe children and moderate to high needs. Table 1 highlights the differences between the TR and AR tracks in Oregon and Figures 1 and 2 show the process and decision flow charts for each response.

Table 1. Differences between Traditional Response and Alternative Response tracks

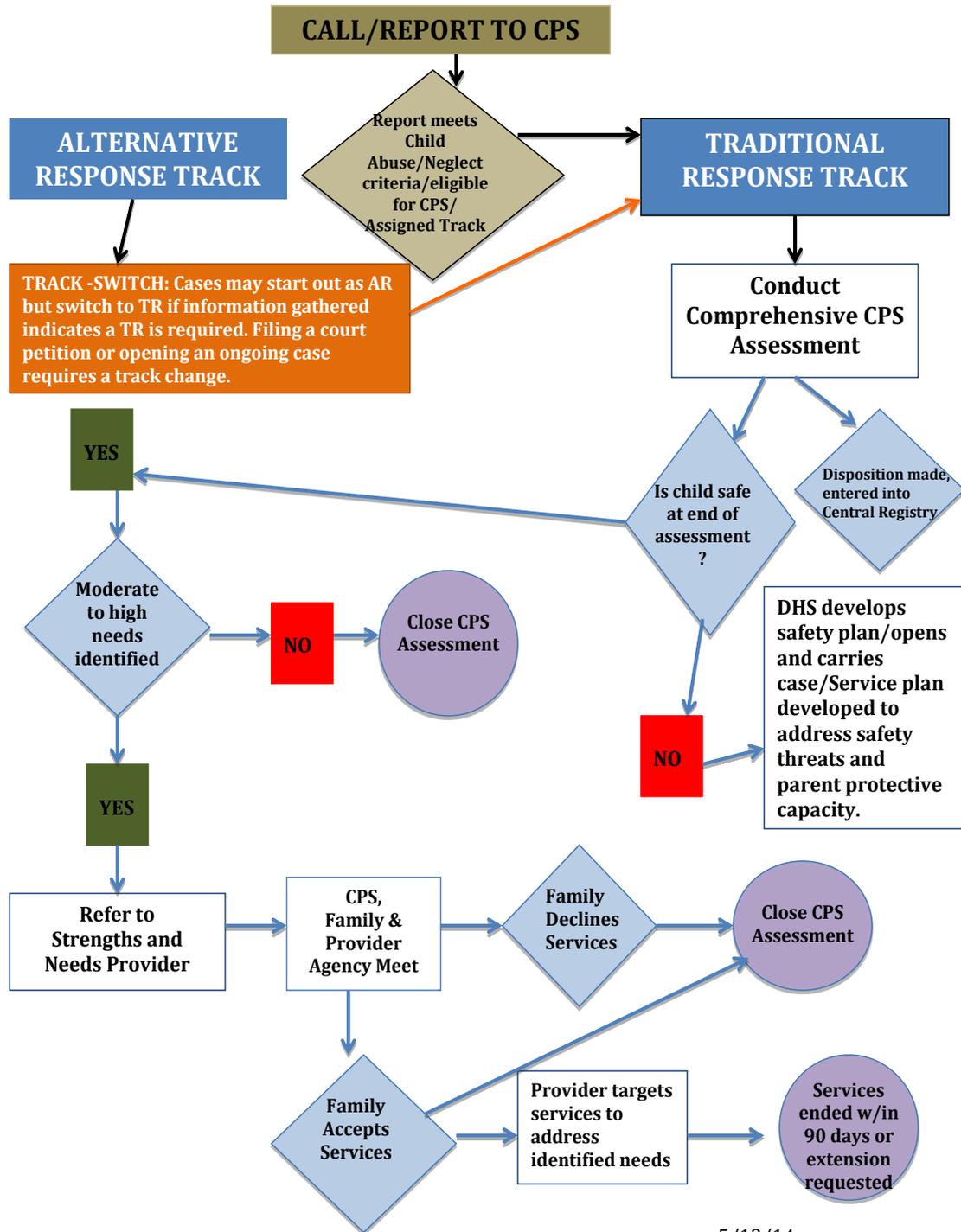
Traditional Response	Alternative Response
Comprehensive Safety Assessment on allegations of physical abuse, sexual abuse, and severe harm	Comprehensive Safety Assessment on allegations of neglect and no severe harm
Typically 24 hour response	Typically 5 day response
No scheduled joint first contact with community partner offered	Scheduled joint first contact with community partner offered
Agency driven	Family driven
Individual interviews	Family interviews
Disposition/finding required	No disposition/finding required
Central Registry entry as indicated	No entry in Central Registry

Figure 1. Alternative Response Process and Decision Flow



** NOTE: Filing a petition, on any case, also requires a track change.

Figure 2. Traditional Response Process and Decision Flow



The Oregon Department of Human Services (DHS) is using a staged roll-out to implement Differential Response (DR) throughout the state, beginning with two districts (District 5 and District 11) in May 2014, with statewide implementation expected to occur in 2017. In order to evaluate the effectiveness of their Differential Response Initiative, DHS issued a Request for Proposals (RFP) for evaluators and selected the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign (UIUC) to design and conduct a rigorous and comprehensive evaluation with three major components:

1. A process evaluation, which describes the program implementation process, examines fidelity to both the DR model and the Oregon Safety Model (OSM), and examines CPS practice throughout the state.
2. An outcome evaluation, which compares the outcomes of children and families in the treatment group, defined as those that receive a CPS assessment in counties that have implemented DR, with the outcomes of children and families in the comparison group, defined as those that receive a CPS assessment in selected counties that have not yet implemented DR.
3. A cost analysis, which examines the costs incurred by the system during the DR implementation process, and also compares the per-case costs associated with serving a family in the AR and TR tracks as well as those served in counties that have not yet implemented DR.

The purpose of this 2015 Annual Evaluation Report is to describe the progress and findings of the evaluation as of December 2015. In order to accomplish this, the report is organized into several chapters:

- Chapter 2: Program Logic Model and Research Questions provides a description of the Oregon DR logic model and the research questions that are guiding the evaluation.
- Chapter 3: Research Design and Methodology describes the research design that is being employed in the outcome evaluation and the methods that are being used to collect data for the process, outcome, and cost evaluations.
- Chapter 4: Findings describes the findings of the evaluation as of December 2015, including results from the implementation evaluation and DR fidelity assessment. Findings from the outcome and cost evaluations will be included in the 2016 Annual Evaluation Report.
- Chapter 5: Conclusions provides some conclusions about Differential Response in Oregon, based on the evaluation findings to date.

Chapter 2: Logic Model and Research Questions

2.1 Oregon Differential Response Logic Model

A logic model clearly articulates how specific activities or services are expected to produce or influence their associated outcomes. It illustrates the conceptual linkages between the program components; expected outputs; and short-term, intermediate, and distal outcomes. The goals of the Oregon Differential Response initiative are to reduce repeat maltreatment and foster care entries; strengthen families and increase their functioning; reduce disproportionate representation of children of color in foster care; and strengthen the relationship between child welfare, families and the community. The logic model in Figure 3 presents the conceptual linkages between the Oregon Differential Response intervention components and expected outputs and outcomes.

Inputs and activities. The Oregon Department of Human Services (DHS) will invest numerous resources and engage in a range of activities (i.e., *inputs*) to develop Differential Response. Inputs include a supportive and inclusive leadership team; DR advisory workgroups and committees; child welfare staff; service providers; development of a DR practice model; development of screening and assessment tools to guide decision-making; development of rules, policies, and procedures; modification to existing IT systems; engagement with community partners; program evaluation; funding; staff training; and staff supervision and coaching.

Outputs. As a result of these inputs, the necessary components of the intervention will be implemented (*outputs*). Staff will be selected and adequately trained, supervised and coached so that they develop and maintain a high level of fidelity to the DR practice model that is specified in rules, policies, and procedures. Through the use of the track assignment tool, families will be assigned to the appropriate CPS response track (AR or TR). Initial meetings with the families will be timely, and families will be involved in the assessment and decision-making process. The Oregon Safety Model will be used to assess child safety and guide worker decision-making. If assessment reveals that families initially assigned to AR have ongoing safety threats, they will be reassigned to the TR track, a case will be opened by DHS, and appropriate services will be provided to the family. If no safety threats exist and the family is identified as having moderate to high needs, a service provider will engage them in a strengths and needs assessment to determine what services may be offered to improve family functioning. An array of services can be provided to address these needs and build on existing strengths.

Outcomes. The outputs of the intervention are expected to produce short-term, intermediate, and long-term changes in families', workers', community partners', and the child welfare system's *outcomes*. Within the short term, parents will feel fewer negative emotional responses and more positive emotional responses during the intervention, will feel respected during their interactions with the workers, and will be engaged in the assessment and decision-

making process. In addition, as a result of the assessment and services, formal and informal supports will be increased and family functioning will improve. These short-term changes will lead to intermediate changes: fewer families will be re-reported to DHS and fewer children will be removed from their homes and placed into foster care. In particular, the number of children removed from their homes who stay in foster care for short periods of time before being returned home may be reduced as more children are served safely in their own homes. The implementation of DR will also lead to distal outcomes, including a stronger relationship between child welfare and community partners, reduced disproportionate representation of children of color in foster care, fewer children who are taken into substitute care and decreased time to permanency for children taken into substitute care.

Figure 3. Oregon Differential Response program logic model

Inputs	Activities	Outputs	Outcomes		
			Short-Term	Intermediate	Distal
Leadership Advisory workgroups CW staff Service providers Practice model Assessment tools Policy, procedures, and legislation IT modification Community partners Evaluation Funding	Clear communication with staff, community partners Staff selection Staff training Supervision Coaching Screening and track assignment Comprehensive CPS assessment Strengths and needs assessment Service provision	Staff are assigned reasonable caseloads Staff are adequately trained Staff receive adequate supervision and coaching Agency leadership supports program Community partners are engaged Fidelity to practice model is developed and maintained Families are assigned to appropriate track Families change tracks when appropriate Initial meetings with families are timely The Oregon Safety Model is used with fidelity to assess child safety in the home Family strengths and needs are assessed as specified in rules and procedures Families with moderate to high needs are offered services Appropriate services are provided to strengthen family functioning	Parent negative emotions are reduced Parents feel respected Parents are engaged in planning and decisions Parents are satisfied with services Informal and formal supports are increased Family functioning is improved	Fewer repeat maltreatment reports Fewer substantiated maltreatment re-reports Fewer child removals	Reduced disproportionate representation of children of color in foster care Stronger relationship between child welfare and community partners Decreased time to permanency for children taken into foster care

2.2 Research Questions

In order to test the hypothesized relationships between Differential Response inputs, outputs, and outcomes, DHS is conducting a program evaluation that will include a process evaluation, an outcome evaluation and a cost analysis. The evaluation will attempt to answer the following research questions:

Research questions related to DR implementation:

1. How was each of the implementation components described in the framework developed by the National Implementation Research Network (NIRN)¹ addressed during the stages of the implementation process?
2. Is the coaching strategy effective in supporting staff in obtaining and maintaining fidelity to the DR model?
3. Is DHS adequately staffed to practice the DR model?
4. Are there differences in DR implementation across counties?
5. Are there differences in DR implementation across cultural and ethnic groups?
6. Are community and external partners involved in Differential Response implementation?
7. Are culturally responsive partners involved in the implementation of Differential Response?
8. Are the roles of DHS and community partners in keeping children safe clearly defined?
9. Is the coordination between DHS and community partners effective?
10. Do workers feel more supported by community partners?
11. How has Differential Response changed the nature of the relationships between DHS and community organizations?
12. Are service providers available for all families, including those in rural regions?
13. Are available services culturally responsive?
14. Are culturally responsive providers available for all families, including those in rural regions?
15. How is the service array, including Strengthening, Preserving, and Reunifying Families services, System of Care, In-Home Safety and Reunification, and other child welfare contracted services supporting the vision and goals of Differential Response?
16. Which implementation strategies were most effective? Least effective?

Research questions related to DR model fidelity:

1. What does Differential Response in Oregon look like?
2. How has worker practice changed in counties that have implemented DR?

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.

3. To what degree is each of the core components of the Differential Response Initiative implemented with fidelity to the practice model? Does fidelity vary across counties or districts?
 - a. Are families involved in decision-making about services?
 - b. Does the Strengths and Needs Assessment help identify families' needs?
 - c. Are identified strengths being utilized?
 - d. Are families utilizing available services?
 - e. Are the services offered consistent with the assessed needs and interests of the family?
4. Who are the families that decline services, and how do they differ from families that accept services?
5. What are the barriers to receiving and completing services?
6. What processes are being used to prevent entry into foster care?
7. What processes are being used to enhance permanency?
8. How has Differential Response influenced families' perceptions of the cultural responsiveness of DHS and child welfare?

Research questions related to Oregon Safety Model fidelity:

1. Are DHS staff using the Oregon Safety Model with fidelity?
2. Does fidelity to the Oregon Safety Model vary by county? By district?

Research questions related to CPS practice:

1. How satisfied are workers with the amount of training they have received? Are there areas in which they would like to receive additional training?
2. How satisfied are workers with the amount and type of supervision they currently receive?
3. How satisfied are workers with the amount and type of coaching they currently receive?
4. How do caseloads affect worker practice?
5. How satisfied are staff with their jobs overall? Do they intend to remain in their current positions or within their current agency?
6. Does CPS practice vary between counties and has it been affected by the implementation of Differential Response?
7. Does organizational culture vary between counties and has it been affected by the implementation of Differential Response?

Research questions related to outcomes:

1. Are there differences in engagement between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
2. Are there differences in satisfaction with CPS between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
3. Are there differences in formal and informal community supports between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?

4. Are there differences in family functioning between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
5. Are there differences in the rates of maltreatment re-reports between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
6. Are there differences in foster care entries and re-entries between children in families that receive an alternative response (AR) and children in similar families that receive a CPS assessment in a non-DR county?
7. Are there differences in engagement between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
8. Are there differences in satisfaction with CPS between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
9. Are there differences in formal and informal community supports between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
10. Are there differences in family functioning between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
11. Are there differences in the rates of maltreatment re-reports between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
12. Are there differences in foster care entries and re-entries between children in families that receive a traditional response (TR) in a DR county and children in similar families that receive a CPS assessment in a non-DR county?
13. Are there differences in the length of time to permanency for children who entered foster care following an alternative response (AR) compared to similar children who entered foster care following a CPS assessment in a non-DR county?
14. Are there differences in the length of time to permanency for children who entered foster care following a traditional response (TR) compared to similar children who entered foster care following a CPS assessment in a non-DR county?
15. Do child and family outcomes vary by geography? By racial or ethnic group?
16. Is family engagement related to outcomes (re-reports, removals)?
17. What services are most effective in achieving DR goals?
18. Is disproportionality in the system reduced following the implementation of DR?
19. How has the implementation of DR affected agency timeliness?
20. Has DR increased or decreased the number of families involved in the child welfare system?

Research questions related to the costs associated with DR:

1. What are the short-term and long-term costs and benefits of a DR approach?
2. What resources are needed to establish DR as a sustainable practice in Oregon?
3. Does resource need and availability vary by region (urban versus rural)?

Chapter 3: Research Design and Methodology

3.1 Research Design

The outcome evaluation employs a quasi-experimental research design that assesses the impact of the program on a range of outcomes by comparing client groups from Differential Response (DR) counties with client groups from non-DR counties. In order to rule out the possibility that differences in outcomes between the DR and non-DR groups could be explained by pre-existing differences between the groups, the research design also uses a propensity score matching (PSM) procedure to create equivalent DR and non-DR groups. This is one of the strongest research designs when pre-tests on outcomes are impractical or impossible (as in the Oregon DR program), because it provides a counterfactual to show the difference between DR and non-DR counties while making sure that the samples from these counties are comparable.²

The specific groups to be studied follow from the nature of the DR program. CPS practice in counties that have implemented DR will be different in a variety of ways from practice in counties that have not implemented DR. Families in DR counties are assigned either to the Alternative Response (AR) pathway or the Traditional Response (TR) pathway. Although the practice changes associated with the AR track are more comprehensive, practice in the TR track will also differ from CPS practice in counties that have not implemented DR, including an enhanced emphasis on family engagement and additional service provision. This suggested the need for two separate treatment groups: families in DR counties that are assigned to the AR track and families in DR counties that are assigned to the TR track.

Propensity score matching is being used to create matched comparison groups for both the AR and TR groups. In this method, families who do not receive the intervention (i.e., those in non-DR counties) are statistically matched with families who receive the intervention (i.e., those in DR counties) to produce intervention and comparison groups that are equivalent on all key characteristics. PSM is a two-step procedure. First, propensity scores are calculated for all eligible families in the population (both in the treatment and comparison groups) – these are scores that indicate the likelihood that families would receive the treatment, regardless of whether or not they actually did. In the second step, each family in the treatment group is matched with another family with a similar propensity score who did not receive the treatment. This produces matched pairs. Propensity score matching typically produces groups that are statistically indistinguishable on most or all variables that relate to outcomes. It is reasonable then to attribute differences in outcomes between the groups to the impact of the treatment intervention.

² Shadish, W.R., Cook, T.D. & Campbell, D.T. (2002). *Experimental and Quasi-Experimental Designs for Generalized Causal Inference*. Belmont, CA: Wadsworth.

Propensity scores will be calculated for each family in the AR group and the TR group in the DR counties included in the evaluation³ and for each family in selected non-DR counties. Each family in the AR group in the DR counties will be matched with a family with a similar propensity score in the non-DR counties. Likewise, each family in the TR group in the DR counties will be matched with a family with a similar propensity score in the non-DR counties. Once the two-step matching process is completed, there will be four groups in the outcome evaluation:

1. AR families
2. AR-matched families from non-DR counties
3. TR families
4. TR-matched families from non-DR counties

	DR County	Non-DR county
AR Matching	Families assigned to Alternative Response	Families who received CPS assessment and have similar propensity score to AR families
TR Matching	Families assigned to Traditional Response	Families who received CPS assessment and have similar propensity score to TR families

The outcome evaluation will compare the outcomes of the AR families (group 1) with the AR-matched families in non-DR counties (group 2), and the TR families (group 3) with the TR-matched families in non-DR counties (group 4). These comparisons will test the hypothesis that introducing DR to a county leads to improved outcomes for families in that county.

3.2 Process Evaluation Methodology

The process evaluation has four components, including: 1) an implementation evaluation that describes the program implementation process, 2) a fidelity assessment of the DR model, 3) a fidelity assessment of the Oregon Safety Model within counties that have implemented DR, and 4) an assessment of CPS practice throughout the state. By describing or measuring the inputs and outputs in the logic model, the process evaluation will provide information that will help explain the results of the outcome evaluation. In addition, collecting and reporting information on program implementation and functioning will allow program managers and administrators to make mid-course modifications if early feedback suggests that things are not working as anticipated. The process evaluation will use a mixed-methods approach that will combine analysis of administrative data, qualitative interviews and focus groups, and survey data from a variety of informants.

³ The PSM matching includes the first 4 districts to implement DR during the staged roll-out (D5, D11, D4, and D16) and four districts that are not scheduled to implement DR until the latter stages of implementation.

3.2.1 Implementation evaluation

The implementation evaluation is guided by the implementation science framework developed by the National Implementation Research Network (NIRN). The purpose of the implementation evaluation is to examine the Oregon Differential Response Initiative through each stage of implementation. The program will be described by paying attention to the seven core drivers (or components) that influence the effective use of evidence-based programs by practitioners in human services: staff selection, staff training, ongoing supervision and coaching, staff performance evaluation, decision-support data systems (e.g., quality improvement information), facilitative administration (e.g., leadership), and systems intervention (e.g., financial, organizational, and human resources).

Data for the implementation evaluation will be collected through a series of site visits in the counties that have implemented DR. During the site visits, data will be collected through several methods:

- Document review of relevant materials
- Focus groups with child welfare staff
- Focus groups with other key stakeholders, such as community partners, service providers, advisory groups, or legislators
- Interviews with key DHS staff and external consultants who were involved in DR implementation

Participants in the interviews and focus groups will be asked about a variety of topics, as applicable:

- Training
- Supervision
- Coaching
- Performance evaluation
- Aspects of practice such as engagement, assessment, service effectiveness
- Service provision, including how the existing service array supports the implementation of the Differential Response Initiative
- Collaboration between child welfare and other child and family-serving community organizations
- Contextual factors impacting implementation (other child welfare initiatives, worker caseloads)

Two rounds of site visits will be conducted in each of the first four districts to implement DR in Oregon. The interviews and focus groups will be transcribed by a transcription service, and content analysis will be used to identify common themes that appear in the data across respondents. The results of the analyses can be compared across counties and by type of respondent to determine if there are differences.

3.2.2 Differential Response fidelity assessment

In any program evaluation, it is critical to assess whether the programs, services, and activities were implemented with fidelity, that is, as originally designed or intended. Core components of the Oregon Differential Response model include:

- Screening and track assignment/re-assignment
- Timely worker contact with families
- CPS safety assessment (Oregon Safety Model)
- Family Strengths and Needs Assessment
- Family involvement in assessment and decision making
- Targeted services to address identified needs
- Partnership between DHS, private agencies, and community organizations

Data for the fidelity assessment will be collected from several sources and through several different methods, including:

- administrative data;
- focus groups with CW staff in the counties that have implemented DR; and
- staff surveys.

If administrative data are reliably available, fidelity indicators can be developed to measure certain areas of practice fidelity:

- Timeliness of initial CPS worker contacts with families
- Timely completion of the comprehensive CPS assessment
- Percentage and types of children who are redirected from the AR track to the TR track
- Percentage of families with moderate to high needs who are referred for a Strengths and Needs Assessment
- Percentage of families with moderate to high needs who receive a Strengths and Needs Assessment
- Timely completion of the Strengths and Needs Assessment
- Number of face-to-face worker contacts
- Percentage of families that accept or decline services
- Length of case (in days) for cases opened as “admin only”

Site visits will be conducted in the counties that have implemented DR as part of the implementation evaluation. During these site visits, information on DR practice (at both the micro and macro level) will be obtained from CW staff and community stakeholders. CW staff will be asked (when appropriate) about each of the different components of DR practice described in the list above:

- Screening and track assignment
- Contact with families
- Family engagement
- Safety assessment (Oregon Safety Model)
- Family Strengths and Needs Assessment

- Redirecting families from AR to TR
- Family involvement in assessment and decision making
- Service provision
- Partnership between DHS, private agencies, and community organizations

3.2.3 Oregon Safety Model fidelity assessment

A third component of the process evaluation will be an assessment of staff fidelity to the Oregon Safety Model. The CFRC will assess staff fidelity to the Oregon Safety Model through several data collection methods:

- Interview questions will be asked during site visits about fidelity to the Oregon Safety Model.
- Questions related to the Oregon Safety Model can be included on the annual statewide survey.
- A case review will be used to gather information about model fidelity from a representative sample of cases.

For the case review, random samples of cases will be selected for review in each of the DR counties. Sampling strategies will be put in place to ensure that the samples include cases with in-home and out-of-home safety plans. A case review tool will be developed (in close consultation with DHS) that will guide case reviewers in gathering information on several domains including: 1) the six domains of safety, 2) precision in safety decision-making, 3) identifying moderate to high need families, 4) safety planning, and 5) conditions for return home, and 6) expected outcomes.

3.2.4 Process evaluation of state CPS practice

As part of the process evaluation, DHS is interested in an assessment of “the state overall.” Thus, in addition to the qualitative data collection that will occur in the counties that have implemented DR, an online survey will be developed and administered to collect information on CPS processes throughout the entire state.

Child welfare staff throughout the state will be included in the survey sample. Participants will be sent a recruitment letter that contains information about the purpose of the survey and a link to the online survey, which will contain several sections to assess:

- opinions and knowledge of the DR Initiative
- readiness for practice change
- organizational culture and climate
- staff caseloads
- use of family-centered practice
- overall satisfaction with work and intentions to remain in their current positions
- satisfaction with training
- satisfaction with supervision

- service coordination between DHS and community partners
- service availability

Results will be compared by county, by district, and by worker characteristics such as age, gender, tenure on the job, and type of worker. In order to assess change over time, the same survey will be administered in early 2016 and 2017.

3.3 Outcome Evaluation

The outcome evaluation will compare the short-term, intermediate, and distal outcomes that are listed in the logic model between the treatment and comparison groups described earlier in this chapter:

- Families assigned to AR in DR counties will be compared to matched families who received a CPS assessment in non-DR counties
- Families assigned to TR in DR counties will be compared to matched families who received a CPS assessment in non-DR counties

The short-term outcomes that will be compared include:

- parent emotional responses
- parent feeling of respect
- parent engagement in assessment and decision making
- parent satisfaction with their caseworker and services
- parent informal and formal supports
- family functioning

The intermediate outcomes that will be compared include:

- screened in maltreatment reports (re-reports)
- substantiated maltreatment reports (re-abuse)
- child removals

The distal outcomes that will be compared include:

- disproportionate representation of child of color in child welfare
- relationships between community partners and child welfare
- time to permanency for children taken into foster care

Administrative data will be used to measure some of these outcomes, including maltreatment re-reports, child placements into substitute care, and length of time to permanency. Subgroup analysis of these rates among children of different racial and ethnic groups can determine the effects of DR on disproportionality. Data on other outcomes will be collected from parents through a parent survey and parent interviews. The parent survey contains measures of: 1) emotional responses following the initial in-person meeting with CPS, 2) satisfaction with their caseworker and the services received,

3) engagement with their worker, 4) experience of family-centered practice (parent involvement in planning and services, joint decision-making, cultural competence), 5) informal and formal supports and services, 6) family functioning, and 7) socio-demographic information such as income and education level. Paper copies of the survey will be distributed to the parents by CW staff in the DR and matched non-DR counties. Once parents complete the surveys, they will be mailed to the CFRC and the data will be entered into a database. Parents will also be given the option of completing an online version of the survey or calling a toll-free number to have the questions administered to them over the phone by a CFRC researcher. All parents who complete the survey through any method will receive an incentive (a gift card to a retail store).

In addition to the parent survey, qualitative interviews will be conducted with parents in each of the four groups (AR and matched comparison group, TR and matched comparison group) who completed the parent survey and indicated that they would be interested in participating in additional research activities. The sample will be stratified by county. Because DHS is interested in examining the implementation of DR across different cultural groups, the sample will also be stratified by race and ethnicity to ensure that the perceptions of all parents are represented in the results. The interviews will be conducted by telephone and will gather in-depth information from parents about their perceptions of their service experience, including their relationship with their worker(s) and the services they received or did not receive. The interview protocol will be adapted from the one that was utilized in the Illinois Differential Response evaluation. The parent interviews will take approximately 45 minutes to complete and parents who participate will receive a retail gift card.

3.4 Cost Evaluation

A cost evaluation will be conducted that includes:

- an analysis of the resources (types and amounts) necessary to implement and maintain DR in each of the three Round 1 counties and four Round 2 counties,
- a comparison of the average total cost-per-family of serving a family through AR and a similar family in a non-DR county, and
- a comparison of the average total cost per-family of serving a family through TR and a similar family in a non-DR county.

3.4.1 DR start-up and maintenance costs

CFRC will gather information from DHS staff to estimate the level of effort and resources that were spent to implement DR in each of the seven counties. Through interviews with key personnel, document review, and administrative data (if available), information will be gathered on the amount of money, number of people, type of people, and time spent on each of the following implementation activities:

- exploring DR models in other states
- designing the DR program and developing program guidelines

- developing screening and eligibility tools and assessment tools
- developing training modules and training workers
- updating policy and procedure manuals
- updating IT systems
- enhancing the service array
- community outreach
- communication

The results will be compiled to estimate the total level of effort and cost to implement DR.

3.4.2 Per-case cost analysis

The evaluation will compare the average total cost of serving a family through AR, TR, and a CPS assessment in a non-DR county, both during the initial case and during a standard follow-up period. Due to the difficulty of obtaining cost data, a sample of cases will be randomly selected for the cost analysis from the larger population of AR, TR, and matched comparison cases in the outcome evaluation. Costs will be calculated for two mutually exclusive time periods: initial costs are those that occur between the initial report date through the date the case is closed by DHS or the community provider, and follow-up costs are those that occur starting the day after the initial case closes through 365 days after the initial report.

Two types of costs during the initial case will be examined: the costs of the *worker's time* spent on direct services to the family and the costs of *services* provided to the families that are paid for by the DHS.

- The costs of worker time will be computed by multiplying the number of hours spent during the initial case by the worker's hourly rate. If the amount of time that workers spend during the case is not available in administrative data, it can be estimated by developing standardized multipliers for each type of worker activity and applying these multipliers to the number of times the worker completes each activity with a family. Similarly, if hourly rates are not available for each worker, an average hourly rate can be computed for each types of worker.
- Data on service costs will be gathered from administrative data.

For each family in the sample, the costs of worker time and service costs will be added to determine the total costs to serve the family during the initial case.

Several types of costs can occur during the follow-up period:

- the family may be re-reported and an additional CPS assessment may occur,
- the family may have moderate to high needs and receive services through a contracted provider, or
- a child may be placed into substitute care and receive foster care services.

Administrative data will be used to track which families in the sample experience any of these outcomes. Then, using methodology similar to that used in calculating initial case costs, the costs of worker time and direct services to families will be computed from the day after the initial case closes through 365 days of the initial report date. This will be done for each family that is randomly selected into the cost analysis samples. This methodology will allow us to report on the following cost outcomes:

- Range and average of total costs for initial AR and TR assessments and similar assessments in non-DR counties
- Range and average of follow-up costs for AR and TR assessments and similar assessments in non-DR counties
- Range and average of total costs for AR and TR assessments and similar assessments in non-DR counties

3.5 Data Collection and Reporting Schedule

To complete the process, outcome, and cost evaluations, data are being collected from several sources and through multiple methods. Data collection began in May 2015 and will conclude around February 2017. Table 3 lists each of the data collection activities that will occur, their anticipated collection timeframes, and reporting schedules. The final report will be cumulative, and will contain information from the two prior reports, as well as findings from additional analyses completed during 2017.

Table 3. Data collection and reporting schedule

Data collection	Timeline	Reporting		
		2015 Annual Report	2016 Annual Report	2017 Final Report
Site visits in DR counties (interviews and focus groups)	May 2015 (D5, D11) Feb 2016 (D4, D16) Sep 2016 (D5, D11) Jan 2017 (D4, D16)	✓	✓	✓ ✓
Administrative data	Ongoing	✓	✓	✓
Parent survey	Feb – June 2016		✓	✓
Staff survey	Feb 2016 Feb 2017		✓	✓
OSM case review	June 2016*		✓	✓
Parent interviews	June 2016*		✓	✓
Cost data collection	Sep – Dec 2016*			✓

*estimated

Chapter 4: Findings

This chapter reports findings related to the implementation evaluation and the DR practice fidelity assessment. As of December 2015, site visits have been conducted in the first two districts that implemented DR (D5 and D11). The findings from the site visits were used to answer research questions related both to the implementation evaluation and the DR fidelity assessment, and were reported in the *Oregon Differential Response Year 1 Site Visit Report*.⁴ Highlights from this report are presented below, but readers wishing additional information should refer to this report.

In addition to the results from the year 1 site visits, this chapter contains several findings related to DR practice fidelity that were obtained from the analysis of administrative data, including: initial track assignment (AR or TR), initial response time assignment (24-hour or 5-day), initial response time compliance, track changes from AR to TR, number and percentage of families that receive a Family Strengths and Needs Assessment (FSNA), and the number and percentage of families that accept services following the FSNA.

4.1 Implementation Evaluation Findings

The implementation evaluation uses a framework developed by the National Implementation Research Network (NIRN)⁵ to describe the efforts to implement Differential Response in Oregon. This conceptual framework suggests that program implementation is a lengthy process that is driven by several core components, known as *implementation drivers*, that are essential to successful human service change efforts. *Competency drivers* are mechanisms that help to develop, improve, and sustain the practitioner's ability to implement the intervention and include *staff selection, training, supervision and coaching, and performance evaluation*. *Organization drivers* are mechanisms that help to create and sustain hospitable organizational environments to support those practitioners in the delivery of the intervention, and include *data systems* that support decision-making, *facilitative administration, and systems interventions*. According to this framework, leadership must attend to both competency and organization drivers to bring evidence-informed practices successfully from concept to reality. These interactive processes are both integrated and compensatory, in that a weakness in one component can be overcome by strengths in other components, but each one is critical and should be aligned to ensure the increased likelihood of implementation success.⁶

⁴ Pacific Research and Evaluation. (November 2015). *Oregon Differential Response: Year 1 Site Visit Report*. Portland, OR: Pacific Research and Evaluation.

⁵ <http://nirn.fpg.unc.edu/about-nirn>

⁶ Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

4.1.1 Staff selection

The overall staffing structure of an organization can have a significant effect on the capacity to implement and sustain change. It is imperative for any organization to address specific questions regarding who is qualified for a given set of tasks and which roles they will assume during a shift. When DR was introduced, staffing configurations at the state and district levels changed for several reasons. Some of the restructuring was initiated to accommodate the needs associated with DR, such as the hiring of experienced supervisors from district offices for DR consulting roles at central office.

A staffing-related challenge encountered at the district level was estimating how many caseworkers to assign as AR workers and how many to assign as TR workers. Initially, District 5 and District 11 assigned caseworkers to either an AR team or to a TR team. However, citing difficulty with finding the right balance of AR and TR caseworkers, as well as internal conflict arising from the belief among workers that AR cases were “fluff” compared with TR cases, district administrators moved toward blended teams with caseworkers trained to take cases from both tracks. Caseworkers in District 5 and District 11 ultimately seemed to prefer having mixed caseloads.

Although most caseworkers seemed to favor having mixed caseloads, interviewees reported that some workers had more difficulty adjusting to the new structure than did others. Specifically, caseworkers who had been on staff for longer sometimes had more difficulty adjusting to AR than less experienced caseworkers. Community providers noticed that some TR caseworkers had not adjusted their practices when dealing with AR cases. Conversely, newer caseworkers who had only known DR sometimes had difficulty not calling ahead for TR cases such as those involving a severe abuse allegation.

4.1.2 Staff training

To develop the DR training, DHS contracted with a curriculum writer with DR experience in other states. DR consultants and other content experts at the central office worked with the writer to develop the curriculum for Oregon. A special effort was made to make the training *flexible*; as workers in Districts 5 and 11 went through training, their feedback helped make adjustments to make future training more effective. The training has also been modified when there have been enhancements to the model, new tools, and useful experiences to include as case examples. An additional strength of the training was that its content varied depending on staff roles, as opposed to one standardized training for everyone.

Despite the specificity of the training modules, some caseworkers in D5 and D11, who took the training *before* any adaptations were made, noted it was not always a productive use of their time. CPS workers attended three days of DR training, which they described as highly repetitive.

We had to do three days of DR training. The first day was the exact same as the second day, except the second day we had some community providers there, but even half the PowerPoints were the exact same slides, and so it was just a lot of wasted time. I don't

know if they had to have so many hours of training to justify the funding or what.
(District caseworker)

A lot of the training went over stuff that we've been doing, so it was kind of like, ugh, why are we doing this again? Like OSM training; I get doing an overview, but we've done it a million times. (District caseworker)

The timing of training may have contributed to this. In Districts 5 and 11, DR training occurred around the same time as the OSM Refresh and the establishment of SPRF services. There seemed to be a “saturation” of trainings, as well as overlap with the ongoing meetings and discussions about DR before the rollout began.

Focus group participants also noted instances in which trainers gave conflicting messages. A district caseworker discussed trying to resolve these discrepancies: “In having different trainers, one would say one thing and then another would say another thing. We were just pulled in so many different directions, and you had to call somebody to check to see whose information was correct.” This may have occurred because trainers themselves were learning about DR.

Not all focus group participants wanted less training. Some DR consultants and screeners requested more time for training to help them understand how to use the track assignment tool for cases in the “gray areas” between AR and TR.

4.1.3 Staff coaching

To augment training and support staff after training, DR consultants served as coaches and helped facilitate the transition from training to practice. Focus group participants expressed high satisfaction with the DR consultants and praised them for their availability and time spent with staff. The consultants’ hands-on approach eased doubts and gave encouragement to workers. Focus group participants described the DR consultants as highly engaged at multiple levels; consultants would go out into the field with caseworkers and join meetings with staff.

Although there was an overall high level of satisfaction with the coaching provided, staff also raised minor concerns during the initial implementation period. For instance, some screeners reported receiving inconsistent advice from consultants, perhaps because consultants were also learning about how to use the new track assignment screening tools. Second, participants expressed uncertainty regarding when and how consultants would transition out of offices. And finally, participants raised concerns about the workload of the consultants; because consultants were so heavily involved, participants wondered what was being done to avoid consultant burnout. In sum, staff found the help of the consultants invaluable, but also showed understanding that such commitment would not (and could not) last forever.

4.1.4 Staff supervision and performance assessment

In general, focus group participants reported that district supervisors are readily available to assist caseworkers. Caseworkers frequently depicted scenarios in which they would simply walk

over to a supervisor and immediately receive assistance with questions regarding their cases. Supervisors were also available during lunch and would fill in for each other as needed.

Staff performance evaluations received mixed feedback from focus group participants. Caseworkers from both districts indicated that most of their overall performance assessment came from informal meetings with supervisory staff. This appeared to be a welcome practice, as caseworkers appreciated regular suggestions for areas of improvement, rather than only learning this information during their annual reviews. Participants generally disliked the more formalized evaluations, however, and described the Employee Development Plans (EDPs) as generally not useful and too frequently administered.

Supervisors themselves noted some challenges with staff evaluations. Many concurred with worker judgments about the usefulness of the EDPs. Additionally, some supervisors reported that they had struggled to provide expertise on the new model and felt challenged because they had to learn the new system at the same time as their staff.

4.1.5 Leadership and facilitative administration

Project leadership occurred at both the state and district levels. At the state level, all members of the DHS leadership team were recognized for their advocacy and work during the exploration and implementation stages. In particular, the DR program manager was named as a leader for the advancement of DR. Other individuals named as advocates of DR included the DHS child welfare director and the DR consultants. Casey Family Programs was also named as a partner providing vital consulting services and other resources.

At the district level, participants in almost every focus group identified their coworkers as champions, including consultants, screeners, caseworkers, and supervisors. Additionally, participants recognized community partners as important champions for DR; their support changed the minds of many initial skeptics.

4.1.6 External systems intervention and community engagement

The support of community partners and service providers was also important as much of DR's success depends on their work. The effort to build this support began before DR was implemented. District administrators forwarded DR-related emails from the DHS child welfare director to community partners to inform these groups about the coming changes. This helped create support for DR and address any misunderstandings.

Because one motivating factor for DR implementation was the need to reduce disproportionality, DHS worked to include the tribal perspective. DHS invited representatives from the tribal community to participate in DR committee work, presented at Oregon's Indian Child Welfare Act (ICWA) advisory board meetings, and conducted a series of focus groups with Oregon tribes about the DR planning process.

SPRF funding also improved relationships between DHS and community partners. With more resources available to help families, district offices have communicated more with community partners, strengthened old relationships, and created new ones. Focus group participants

reported that families are better supported because of SPRF funding and the closer collaboration with service providers and community partners. Additionally, participants said these closer relationships increased community support for DR as a whole and helped resolve questions. Overall, communication, efforts to reduce disproportionality, and the availability of more funding created closer ties between DHS central and district offices and community partners.

4.1.7 Decision-support data systems

System intervention and facilitative administration depend heavily upon data to help inform decisions during implementation. These decisions often drive change and shape the ultimate success of the implementation. A systematic evaluation of an intervention uses multiple measures to analyze the effectiveness and potential areas for improvement of the intervention, helping to maintain alignment with expected outcomes. Organizations use these measures to understand overall intervention performance and to gather data to support decision making.

Data from various metrics regarding workload and staff performance have been used to improve DR practice. Statewide metrics attempt to capture key data points pertaining to the effectiveness of DR practice. One member of the DHS leadership team outlined some of the measurements used in the data gathering process: “We have a whole dashboard of the statewide metrics we look at: number of kids in care, timeliness to investigation, length of stay, those sort of things to track as we're looking at how the DR counties are doing, and then anxiously awaiting the evaluation.”

To complement the data gathered by the DHS leadership, district administrators used ongoing measurements on overdue assessments, timeliness to investigations, and in-person visits, among other measurements, to monitor the implementation of DR practice. District administrators gathered these data multiple times per month in an attempt to determine and address areas where caseworkers were experiencing difficulty. Identifying the right types of measurements to examine, however, appeared to be challenging.

At the district level, efforts were made to engage in continuous quality improvement of DR practice. Such exercises included examining the screening reports for a given period of time and then reviewing them to determine whether these reports were being assigned correctly; closed cases were also examined. These efforts served to monitor fidelity to DR screening and to provide a means of tracking with DR practice. Data on how many cases were assigned to each track were used to inform staffing decisions and improve upon existing training and screening practices.

Although information gathered through these varied methods has thus far proven useful in the evolution and improvement of DR implementation, supervisors raised concerns about the reliability and utility of these data, especially concerning overdue assessments. In commenting on the lack of confidence in the overdue assessment numbers, one district supervisor described

the process as “punitive,” given that staff were held to numbers that seemingly nobody knew how to correctly interpret. Other district supervisors in the same focus group elaborated that there was a disconnect between enforcing the disparities revealed in the data and the real-world lack of resources that workers encountered, such as colleagues who became sick or went on vacation. This, supervisors argued, often substantially decreased the number of available workers to handle the workload, which could lead to a skewing of the data’s interpretation. Supervisors in one district expressed frustration that the district administrators examined the data without a realistic understanding of the context and fluctuations that occurred in daily practice because the administrators were more focused on wanting to see “that numbers go down.”

4.1.8 Implementation effects on workload

DHS leadership was aware of the possibility that DR implementation would impact workloads and therefore developed methods to monitor them. At the state level, administrators have access to a variety of metrics related to workload and staff performance, which can be used to monitor and improve DR practice. At the district level, administrators can gather data on multiple measures, although some line staff and supervisors raised concerns in interviews about the degree to which these data sources accurately reflect the context and fluctuations of day-to-day child welfare practice.

At the practice level, many district staff discussed DR’s effect on their individual workload. In the focus groups, caseworkers reported their workload increased when DR was implemented; the extent to which DR caused this change is unclear. Part of this perception may have come from initial efforts to give staff only AR or only TR cases. This practice was changed, and now staff are assigned both types of cases. Focus group participants also observed that more experienced staff had more difficulty adjusting to the new system than less experienced staff.

Screeners have seen their role change the most because of the implementation of DR, and they expressed frustration with their increased workload during the focus groups. Screeners described how DR increased their responsibilities when handling a report of child abuse or maltreatment. To determine whether a case is eligible for AR or TR, screeners need to make more collateral calls, research a family’s history with child welfare, and complete the track assignment tool. Focus group participants reported that current staffing levels are not adequate to cover the additional screening responsibilities.

4.2 DR Fidelity Assessment Findings

At the conclusion of the evaluation, several sources of information about DR practice will be available, including qualitative descriptions of practice from CPS workers in DR counties, quantitative data from CPS workers throughout the entire state, quantitative and qualitative data from parents about their experiences with CPS, and administrative data. Currently, data from two of these sources is available: qualitative descriptions of DR practice from CPS workers in the first two districts that implemented DR, and administrative data on system performance. The following segments of practice are described:

- CPS reports assigned to assessment
- Initial track assignments
- Initial contacts with families
- Track re-assignments
- Family engagement
- Safety assessment
- Family Strengths and Needs Assessments
- Service provision

4.2.1 CPS reports assigned to assessment

When a report is received by a screener, it can either be assigned for an assessment or closed at screening. The percentage of CPS reports assigned for an assessment in each of the four districts that implemented DR prior to September 2015 is shown in Table 4. Statewide percentages are shown for comparison. Statewide, there has been a slight increase in both the number of CPS reports received and the percentage of those reports that are assigned for assessments in the two most recent years (2014 and 2015). The pattern for the districts examined shows some variation across the districts as well as in comparison to the statewide numbers.

Table 4. Percentage of CPS reports assigned to assessment (2011-2015)

	D5		D11		D4		D16		Statewide	
	# reports	% assigned								
2011	5,423	51%	2,251	48%	4,787	41%	5,371	44%	71,360	43%
2012	4,638	61%	1,855	50%	4,808	36%	5,278	38%	67,471	43%
2013	3,922	56%	2,047	47%	4,475	40%	5,095	37%	64,544	42%
2014^a	4,622	56%	2,305	47%	4,621	42%	4,834	35%	69,127	44%
2015^b	5,840	55%	2,086	60%	4,321	53%	5,352	40%	70,583	47%

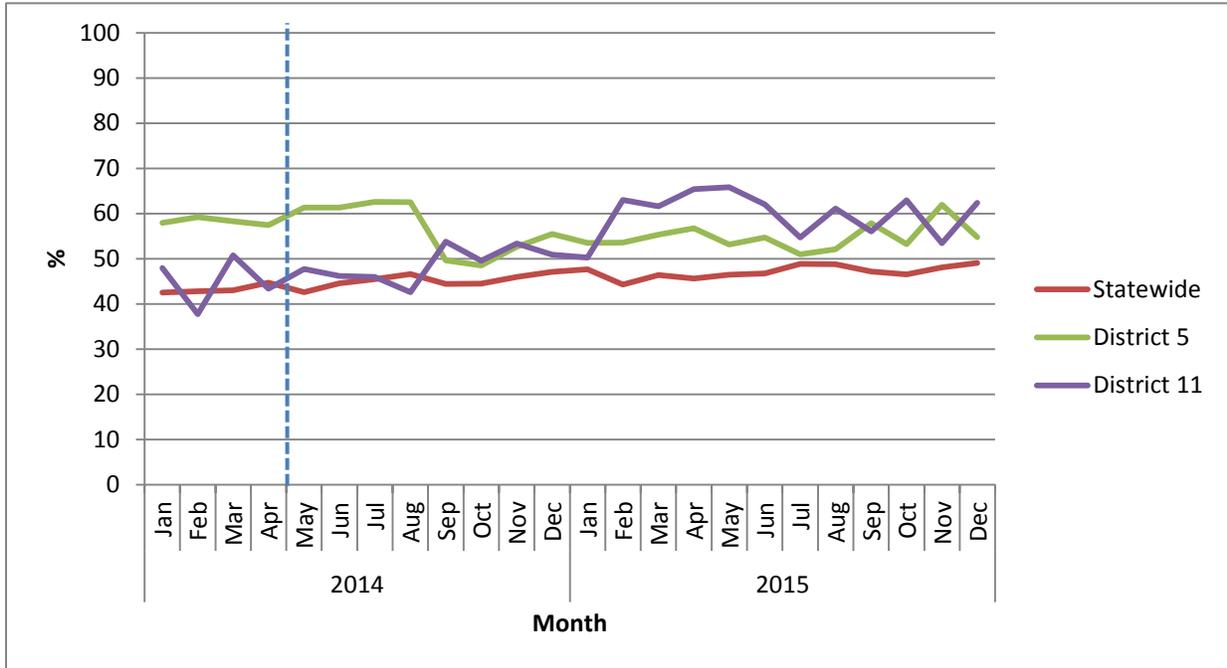
^a D5 and D11 implemented DR in May 2014

^b D4 and D16 implemented DR in April 2015

The percentage of reports assigned for assessment during the months before and after DR implementation was examined to determine whether changes occurred following the DR implementation date. The results for D5 and D11, which implemented in May 2014, are presented in Figure 4 and compared to the percentage of reports assigned to assessment statewide. The percentage of assigned reports in D5 was much higher than the statewide percentage prior to DR implementation in May 2014 and for several months following implementation. Around September 2014, the percentage declined to a level closer to the statewide rate. Conversely, the percentage of reports assigned to assessment in D11 has

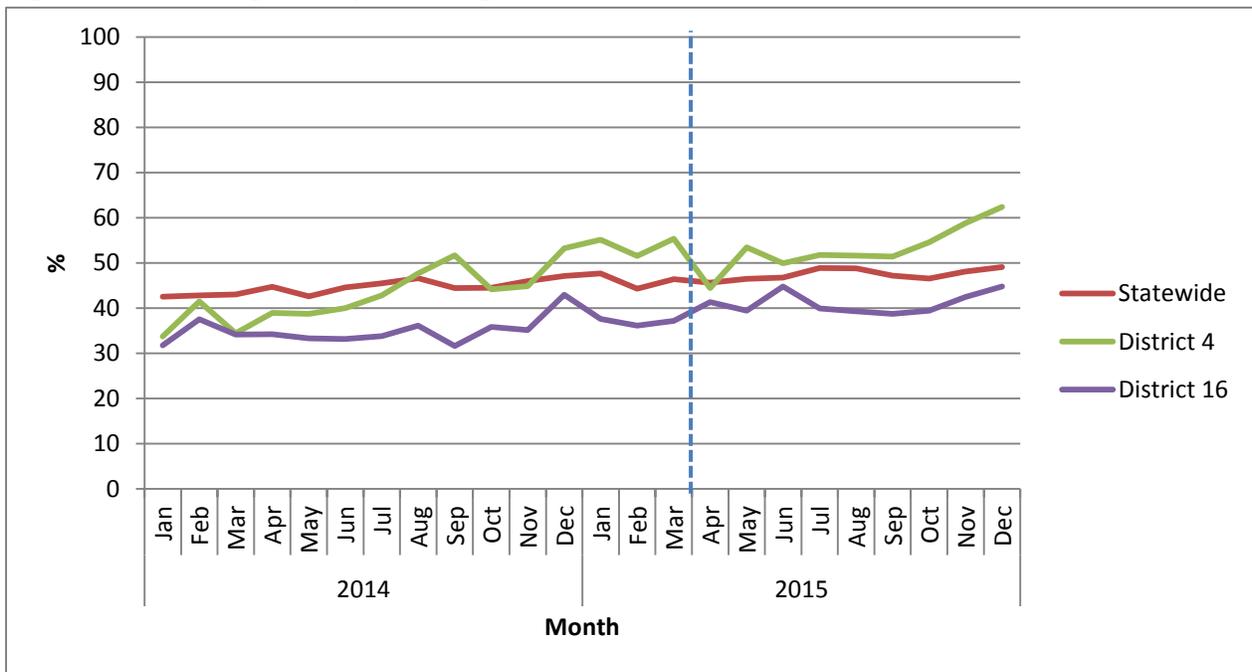
increased since DR implementation. At the district level, percentages show a great deal of month to month variation.

Figure 4. Percentage of Reports Assigned to Assessment in D5, D11, and Statewide



The percentage of reports assigned to assessments before and after DR implementation in D4 and D16, which occurred in April 2015, is shown in Figure 5. The percentages in D4 began to increase around October 2015, approximately 5 months following implementation.

Figure 5. Percentage of Reports Assigned to Assessment in D4, D16, and Statewide



4.2.2 Track assignment

Focus group participants from Districts 5 and 11 described how the child welfare screening process changed after the implementation of DR. To determine if a screened-in maltreatment report should be assigned to the TR or AR track, screeners use Oregon’s track assignment tool. Participants reported that knowledge of and practice with this tool is a vital component of DR trainings. Because the process can be so complicated, participants noted they often rely on each other for help making the decisions. Participants spoke highly of these collaborative efforts; they provided opportunities for group learning about how reports should be assigned.

The percentage of screened-in reports initially assigned as AR and TR for CPS assessment was examined using administrative data (see Table 5). In 2014, screeners in District 5 assigned 60% of the screened-in reports to AR for CPS assessment, while screeners in District 11 assigned 52% to AR. In 2015, those percentages decreased to 53% in District 5 and 47% in District 11. Since implementing DR in April 2015, screeners in Districts 4 and 16 have been assigning approximately equal percentages of reports to AR and TR for CPS assessment.

Table 5. Percentage of Assessments Initially Assigned to AR and TR

	D5		D11		D4		D16	
	AR	TR	AR	TR	AR	TR	AR	TR
2014^a	60%	40%	52%	48%	-	-	-	-
2015^b	53%	47%	47%	53%	47%	53%	54%	46%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

4.2.3 Initial contact with families

In addition to assigning an assessment to AR or TR, screeners also assign a response time to each assessment.⁷ Response time is an important element of Oregon CPS assessment to ensure child safety in a prompt manner. According to the Oregon DHS Differential Response Procedure Manual,⁸ every CPS assessment is assigned one of two possible response timelines at screening: within 24 hours and within 5 calendar days. The timeline refers to “the amount of time between when the report is received at screening and when the CPS worker is required to make an initial contact.” In 2014 and 2015, 75% of all reports in the state were assigned a response time of “within 24 hours.”

The primary response time for AR assessments is 5 days; a 24-hour response is only required when there is an indication that a child may be in danger right now, or a child has a current injury as a result of the alleged abuse or neglect. Conversely, a 24-hour response time applies to TR assessments unless “a screener can clearly document how the information indicates child safety will not be compromised”⁹ to allow a 5-day response time.¹⁰

Analysis of administrative data indicates that most AR assessments are assigned a 5-day response time, although the percentage of assessments assigned to this response timeline varied significantly across districts (Table 6). District 4 had the lowest percentage of AR assessments with a 5-day response time (59%) and District 11 had the highest (86%). In District

⁷ Response time assignment also occurs in non-DR districts.

⁸ Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 3 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.

⁹ Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 3 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.

¹⁰ Regarding the procedure of CPS assessment response time in non-DR districts, see Oregon Department of Human Services. (May, 2014.). *DHS Child welfare Procedure Manual. Chapter 2: Assessment-section 2 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.

11, the percentage of AR assessments assigned to the 5-day response time increased from 76% in 2014 to 86% in 2015.

Table 6. Response Times Assigned to AR Assessments

	D5		D11		D4		D16	
	24 hours	5 days						
2014^a	29%	71%	24%	76%	-	-	-	-
2015^b	31%	69%	14%	86%	41%	59%	22%	78%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

Most TR cases are assigned a 24-hour response time; rates ranged between 82% and 93% in the four districts (see Table 7).

Table 7. Response Times Assigned to TR Assessments

	D5		D11		D4		D16	
	24 hours	5 days						
2014^a	83%	17%	93%	7%	-	-	-	-
2015^b	89%	11%	92%	8%	82%	18%	82%	18%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

We examined compliance with the assigned response time, which was measured by calculating the percentage of assessments that had initial contact within the assigned response time. For comparison, statewide¹¹ compliance for assessments assigned a 24-hour response time was 69% in 2014 and 67% in 2015; response time compliance for assessments assigned a 5-day response time was much lower – 20% in both 2014 and 2015 (see Table 8).

When compliance rates were examined in the districts that implemented DR, the results revealed that rates vary considerably across districts and were much higher among assessments assigned a 24-hour response time compared to those assigned a 5-day response time (see Table 8). Among AR assessments that were assigned a 24-hour response time, the percentage that received an initial contact within the timeline ranged from a low of 62% in D4 in 2015 to a high

¹¹ Statewide calculations include all districts, regardless of whether they have implemented DR or not.

of 85% in D11 in 2015. Compliance among AR assessments assigned a 5-day response time ranged from 17% in D5 in 2015 to 34% in D11 in 2015.

A similar analysis of initial response time compliance among TR assessments is also shown in Table 8. Of the TR assessments that were assigned a 24-hour response time, the percentage that received an initial visit within 24 hours ranged from 58% (D5 in both 2014 and 2015) to 85% (D11 in 2014). Compared to those assigned a 24-hour response time, compliance was much lower among TR assessments assigned an initial response time of 5 days, ranging from 17% (D5 in 2014) to 44% (D11 in 2014).

A comparison of compliance rates between DR districts and the state as a whole suggests that the introduction of DR did not negatively impact response time compliance rates. For assessments assigned a 24-hour response time, compliance in DR counties was similar to that for the state, with the exception of D11, which has compliance rates much higher than the state, and D5, which has compliance rates that are slightly lower than the state. For assessments assigned a 5-day response time, compliance in DR districts was similar to or higher than that for the state as a whole.

Table 8. Compliance within Assigned Response Times

AR Assessments								
	Within 24 hours				Within 5 days			
	D5	D11	D4	D16	D5	D11	D4	D16
2014^a	68%	79%	-	-	24%	28%	-	-
2015^b	65%	85%	62%	63%	17%	35%	18%	21%
TR Assessments								
	Within 24 hours				Within 5 days			
	D5	D11	D4	D16	D5	D11	D4	D16
2014^a	58%	84%	-	-	17%	44%	-	-
2015^b	58%	85%	62%	68%	19%	38%	26%	41%
Statewide Assessments								
	Within 24 hours				Within 5 days			
2014^a	69%				20%			
2015^b	67%				20%			

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

A major difference in practice between AR and TR assessments is that families assigned to AR should receive a phone call from caseworkers prior to the initial in-person meeting, where TR assessments traditionally receive an unannounced initial visit from the worker. When a caseworker calls a family assigned to AR, the caseworker asks for their scheduling preferences for the initial meeting and whether they would like to have a support person at the initial meeting. During the site visits, CPS workers were asked about initial contacts with families and how it differed for AR and TR assessments. Although several caseworkers mentioned that the initial phone call helped decrease hostility and establish a better relationship with the family, others indicated that it is sometimes difficult to schedule a time for the initial meeting because of the client's availability, which can lead to increases in initial response times.

4.2.4 Track changes

The conditions and procedures for changing an AR assessment to a TR assessment are clearly defined in Oregon DHS Differential Response Procedure Manual. The procedure manual states that “if during the initial contact or in the course of gathering information throughout the CPS assessment, the worker obtains information that meets the Traditional Response Assessment criteria, a change in the type of CPS assessment is required.”¹² Additionally, if an AR assessment becomes court-involved, a track change to TR is automatically required.

We examined the administrative data to see how often a track change occurred for AR assessments between the initial report date and assessment close date (see Table 9). In 2014, around one-fifth of assessments were switched from AR to TR (19% in District 5 and 22% in District 11). The percentage of track changes in District 11 decreased to 17% in 2015. The percentage of AR assessments that were switched to TR was lower in the second cohort of districts to implement DR (Districts 4 and 16) than in D5 and D11.

Table 9. Percentage of AR Assessments that Change Tracks from AR to TR^a

	D5	D11	D4	D16
2014^b	19%	22%	-	-
2015^c	19%	17%	11%	11%

^a Track change: If an assessment initially assigned to AR have a track change date it was counted as having a track change.

^b Includes assessments from May 1, 2014 to December 31, 2014.

^c Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^d Data extracted January 8, 2016.

¹²Oregon Department of Human Services. (May, 2014). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 10 change from alternative response assessment to traditional response assessment*. Salem: Oregon Department of Human Services.

4.2.5 Family engagement

A key element of DR practice is the caseworker's ability to engage the family and work collaboratively to identify and address the family's needs. To this end, one of the initial DR implementation subcommittees developed a family engagement training module and toolkit for caseworkers. Focus group participants spoke about how these efforts translate to handling AR assessments and even influence TR assessments. Caseworkers are more likely to ask families to contribute to safety plans, and caseworkers also reported using simpler language in their assessments so that families can fully understand what the reports say. Overall, participants perceived more positive interactions with families because of these changes, and in both AR and TR assessments.

4.2.6 Safety assessment

Undergirding all DR changes is Oregon's effort to increase fidelity to the Oregon Safety Model, a comprehensive practice model used to evaluate child safety at multiple points throughout the life of a case, from initial assessment to case closure. Most of supervisors and consultants spoke positively about the improvements in fidelity to the OSM practice model that were observed after the OSM Refresh in 2013. Specifically, they felt that the OSM Refresh modules have helped caseworkers understand the six domains of the OSM in greater depth. In addition, since the assessment and case notes are no longer recorded in chronological order but instead are more of a summary, it provides a better understanding and quicker review of each assessment.¹³ Although a few workers expressed concerns about the clarity of the model, most of the focus group participants were generally positive about the possibility of achieving a high level of fidelity to the OSM.

4.2.7 Family Strengths and Needs Assessment (FSNA)

The Family Strengths and Needs Assessment (FSNA) is, as its name implies, the instrument used to assess family strengths and needs. Both AR and TR assessments can receive an FSNA if the children are determined to be safe and the family has moderate to high needs. If these criteria are met, the family's assigned caseworker will offer the family the optional FSNA and, if the family accepts, refer the family to a local service provider to complete the FSNA. These service providers are selected based on family need and are often people caseworkers know have worked with the family already or believe will work with the family in the future. One caseworker described selecting someone to do the FSNA: "[W]hen I'm going to do a referral for a strengths and needs, in my mind, I'm just going to send it to the person who I want to do the service and ask them to do the strengths and needs." Service providers have 15 days to complete the assessment. Once completed, families are offered services to help address their needs.

¹³ Pacific Research and Evaluation. (November 2015). *Oregon Differential Response: Year 1 Site Visit Report*. Portland, OR: Pacific Research and Evaluation, p. 62.

Focus group participants raised some concerns about the FSNA process. When the FSNA process first began, caseworkers estimated that they were referring approximately 70% of cases for the FSNA “because it was a good idea in theory.”¹⁴ As of June 2015, however, caseworkers estimated that only about 5% to 10% of cases were being referred for an assessment.

Caseworkers offered several explanations for why they are referring families for FSNA at lower than expected rates. First, some caseworkers felt the FSNA was unnecessary because caseworkers are able to identify family needs without the assessment. Second, caseworkers expressed concern that the FSNA process was inefficient. Many caseworkers reported that service providers often took longer than 15 days to complete the assessment; this delayed the delivery of services such that, sometimes, families reported no longer needing them. Finally, caseworkers suggested service providers were not properly trained to conduct the FSNA; some seemed resentful that others were asked to do a job caseworkers felt was theirs.¹⁵ Though caseworkers felt the FSNA were not useful, some district supervisors and service providers viewed the process more favorably. Overall, however, the FSNA process has been a source of frustration among workers and supervisors.

4.2.8 Service availability and service receipt

Focus group participants noted that the introduction of SPRF funding has greatly improved service availability by providing access to more services and encouraging community partnerships that did not exist before funding was available. In particular, SPRF funding has given families access to an array of services that were not available in the past: housing services, mental health services, family navigators, and a relationship-building program. Not all services are readily available, however. Participants noted obstacles to service access including long waitlists, lack of sustained services, and distance, especially for families living in rural areas. Additionally, some services like child care and transportation were not available as often as families needed them.

Administrative data were used to examine the number and percentage of families who were offered and received services following DR implementation. If the child is determined to be safe and the family has moderate to high needs, they may be offered services through a strengths and needs provider. Prior to September 2015, administrative data on the families who did or did not have moderate to high needs were unavailable for analysis. Therefore, in order to get an indication of the percentage of families who were offered services, Table 10 shows the percentage of families who have children who were determined to be safe and who were offered services, including those with and without moderate to high needs. The percentage of AR families who were offered services ranged from 9% in D16 in 2015 to 21% in D11 in 2014.

¹⁴ Pacific Research and Evaluation. (November 2015). *Oregon Differential Response: Year 1 Site Visit Report*. Portland, OR: Pacific Research and Evaluation, p. 65.

¹⁵ Pacific Research and Evaluation. (November 2015). *Oregon Differential Response: Year 1 Site Visit Report*. Portland, OR: Pacific Research and Evaluation, p. 66.

The percentage of TR families who were offered services ranged from 6% in D16 in 2015 to 16% in D4 in 2015. In general, the percentage of TR families who were offered services was lower than the corresponding percentage of AR assessments in each district.

Table 10. Percentage of Families With Safe Children Who Were Offered Services

	AR				TR			
	D5	D11	D4	D16	D5	D11	D4	D16
2014^a	14%	21%	-	-	7%	13%	-	-
2015^b	16%	19%	19%	9%	11%	12%	16%	6%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

Families in both the AR and TR tracks may choose to either accept or decline the offered services. Administrative data were analyzed to determine the number and percentage of families who accepted services. When the percentage of families that accept services out of those who were offered services is examined, the percentage ranges from 41%-55% for AR families (Table 11) and 39%-71% for TR families (Table 12). When the percentage of families that accept services is examined as a portion of all CPS assessments, however, it is clear that a relatively small percentage of families are receiving services following a CPS assessment, ranging from 4% to 14% depending on district.

Table 11. AR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% accepting services of those offered ^c	% accepting services of all families with safe children ^d
2014^a	D5	757	108	59	55%	8%
	D11	251	52	22	42%	9%
2015^b	D5	585	91	45	49%	8%
	D11	313	59	32	54%	10%
	D4	283	54	28	52%	10%
	D16	499	46	19	41%	4%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)

^d % accepting services of all safe families = (# Families Accepted Services/# Families With Safe Children)

^e Data extracted January 8, 2016.

Table 12. TR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% accepting services of those offered ^c	% accepting services of all families with safe children ^d
2014 ^a	D5	471	31	22	71%	5%
	D11	190	24	14	58%	7%
2015 ^b	D5	517	55	26	47%	5%
	D11	299	36	14	39%	5%
	D4	312	51	23	45%	7%
	D16	409	24	15	63%	14%

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)

^d % accepting services of all safe families = (# Families Accepted Services/# Families With Safe Children)

^e Data extracted January 8, 2016.

In DR counties, if a family accepts services, these services can be paid for by DHS through contracts with local service providers in what are called “Admin-Only” cases. Alternatively, the CPS worker can refer families to local non-contracted service providers but not open an Admin-Only case. Table 13 shows the number of families that received services following a CPS assessment and whether or not the services were paid for by DHS in an Admin-Only case.

Table 13. Percentage of Admin-Only Services

Year	District	AR		TR	
		# Families Who Accepted Services	Admin-Only	# Families Who Accepted Services	Admin-Only
2014 ^a	D5	59	23 (39%)	22	13 (59%)
	D11	22	2 (9%)	14	3 (21%)
2015 ^b	D5	45	15 (33%)	26	6 (23%)
	D11	32	5 (16%)	14	2 (14%)
	D4	28	6 (21%)	23	8 (35%)
	D16	19	9 (47%)	15	6 (40%)

^a Includes assessments from May 1, 2014 to December 31, 2014.

^b Data for D5 and D11 includes assessments from January 1, 2015 to September 30, 2015.

Data for D4 and D16 include assessments from April 1, 2015 to September 30, 2015

^c Data extracted January 8, 2016.

Chapter 5: Conclusions and Recommendations

The Oregon Department of Human Services (DHS) began implementing Differential Response in 2014, using a carefully planned and staged roll-out strategy that began with implementation in two districts (D5 and D11) in May 2014 and two additional districts (D4 and D16) in April 2015. Site visits were conducted in May 2015 in the first two districts to implement DR, and a comprehensive report has been written¹⁶ that describes the processes that were used to implement DR in those counties and offers recommendations to enhance the implementation process in districts that are implementing DR in 2016 and 2017. The first section of conclusions and recommendations are taken from the *Oregon Differential Response: Year 1 Site Visit Report*. For a full list of recommendations related to implementation, please refer to the report. It should be noted that any practice or policy changes that occurred subsequent to May 2015 (when the site visit data collection occurred) will not be reflected in these recommendations, and many of them will have already been implemented. Site visits in D4 and D16 will occur in February 2016; the data collected in these districts will document the effects of any policy or practice changes that were made after May 2015 and changes made in the 2nd round of implementation.

5.1 Recommendations Related to DR Implementation

5.1.1 Communication

DHS leadership articulated its overarching vision of a new approach to child welfare practice for Oregon. DHS central office was open to adaptations and appreciated the feedback provided by state stakeholders and district staff as the model continued to evolve. Local district offices viewed (and continue to view) central office as a vital and committed partner to child welfare in Oregon and generally understand and support the practice changes. DR expansion will be aided by DHS central office's continued communication with district staff and community partners.

5.1.2 Staff training

Staff training, by design, was flexible to evolve as DHS learned more about what was most useful for workers and supervisors. After each round of DR training, DHS central office used feedback from training evaluations to enhance the training materials (adding scenarios and new tools). From the central office's perspective, this evolution created an improved training process. Conversely, district staff expressed frustration about the DR trainings as the information from different trainers was inconsistent. Moreover, many supervisors struggled to provide expertise because they were learning a new model alongside their staff.

¹⁶ Pacific Research and Evaluation. (November 2015). *Oregon Differential Response: Year 1 Site Visit Report*. Portland, OR: Pacific Research and Evaluation.

To address the concerns of supervisors, several adjustments in training schedule and module may be helpful. It may be beneficial for district managers and supervisors to attend DR training before caseworkers. Adding additional topics tailored to DR—like managing conflict, motivational techniques, and coaching—may help district staff feel more competent as DR is implemented.

5.1.3 Staff coaching

Focus group participants and members of the DHS central office all viewed DR consultants as important assets for DR implementation in Oregon. The consultants provided expertise to frontline staff and supervisors, and they were willing and able to participate in all stages of DR practice. As DR implementation continues, new districts are likely to have significant need for consultants. DHS central office should carefully consider the needs of the consultants to make sure they stay motivated and available.

The focus groups did generate a few suggestions for how consultants can be used most effectively. First, it is important to define how consultants will continue to support districts. One district manager recommended the development of a timeline and exit strategy so that everyone is clear on the availability of DR consultation. Second, as consultants move on to other districts or divide their time between multiple districts, DHS could establish a peer-support network among districts to supplement the support the consultants provide. Lastly, it is important to be aware of consultant's workload (e.g., amount of travel and burnout) and provide support as needed.

5.1.4 Staffing and workload

The initial staffing configurations in Districts 5 and 11 during the initial stages of DR implementation were not successful. Both districts adopted a staffing model of AR- and TR-specific caseworkers. Managers and supervisors found it difficult to maintain evenly distributed caseloads for AR and TR caseworkers, and some staff members were resentful that other workers carried what was perceived as easier caseloads. As a result, both District 5 and District 11 changed their staffing model to assign caseworkers both AR and TR assessments. Mixed caseloads eased the staffing tensions. Therefore, we recommend this staffing configuration for districts implementing DR.

Caseworkers and screeners both felt their workloads increased after DR implementation. Caseworkers reported they were spending more time with families because of the DR practice model, which they viewed as beneficial, but expressed concern about the adequacy of staffing resources. Screeners reported they were spending more time with each report, and that pre-DR staffing levels were not adequate based on their post-DR responsibilities. Managers in all districts should carefully monitor workloads and be prepared to make adjustments as needed.

5.2 Conclusions Related to DR Practice

The site visits also offered a preliminary examination of DR practice in the first two districts that implemented DR. Qualitative data from CPS workers and supervisors was supplemented with some administrative data analyses that examined several aspects of DR practice such as initial

track assignment, initial contacts with families, track changes, Family Strengths and Needs Assessments, and service provision. Although it is too early in the evaluation timeline to draw definitive conclusions or make recommendations about DR practice, these early analyses suggest areas that need additional exploration in future analyses.

5.2.1 Screening and track assignment

Across the entire population of families served, just over half of families were assigned to the AR track. This percentage decreased substantially in District 5 from 2014 to 2015; in every other district, the proportion was consistently close to half.

In addition to assigning screened-in reports to a response track (AR or TR), screeners also assign a response timeline to each report (24-hour or 5-day), and CPS workers should make initial contact with families during this timeline. The typical response time for AR assessments was 5 days, although about a quarter to a third were assigned a 24-hour response time. Conversely, a large majority (around 80-90%) of TR assessments were assigned a response time of 24-hours.

CPS worker compliance with the assigned response time (i.e., the percentage of assessments that received an initial contact within the assigned timeline) was considerably higher for assessments with a 24-hour response time compared to those with a 5-day response time; this was true for both the state as a whole and in those districts that have implemented DR. Statewide, around 68% of the assessments assigned a 24-hour response time had an initial contact within that time, compared to 20% of the assessments assigned a 5-day response time. Compliance with the 24-hour timeframe in districts that have implemented DR ranged from 58% (D5) to 85% (D11) and compliance with the 5-day timeframe in these districts ranged from 17% (D5) to 44% (D11). These comparisons suggest that the introduction of DR did not negatively impact response times.

5.2.2 Track changes

Analysis of administrative data revealed that in the first two districts to implement DR (D5 and D11), about 20% of assessments that were initially assigned to AR switched tracks to TR. In the districts that implemented DR the following year (D4 and D16), 11% of the assessments that were initially assigned to AR were switched to TR.

Findings from the site visit report suggest that regular, on-the-job training may help enhance understanding of the track assignment tool. In addition, group decision making was viewed as especially useful for making track decision in complex reports. This was especially helpful when DR was first implemented because it provided an opportunity for group learning.

5.2.3 Family Strengths and Needs Assessment (FSNA) and service provision

Most focus group participants viewed the FSNA as a challenge. Caseworkers and supervisors questioned the utility and value of the assessment. They described it as an unnecessary and duplicative step for families with a negative effect on family engagement. Additionally, they noted it was difficult to complete the FSNA within the prescribed 15 day window.

Results from the administrative data analysis suggest that between 6-21% of families with safe children and moderate to high needs in DR counties were offered services. Of these, about 40-60% accepted services. Future analyses will more closely examine which families are offered and accept services.