STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Jim Justice
Governor

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Bill J. Crouch
Cabinet Secretary

June 30, 2017

Ms. Lisa Pearson
150 S. Independence Mall West - Suite 864
Philadelphia, PA 19106-3499

Dear Ms. Pearson;

Included with this submission please find West Virginia's required documentation for the Annual Progress Service Report. A signed original copy of the application, including all attachments is enclosed.

Included with this packet are:

The Second Annual Progress Services Report
The Training Plan
CFS-101 Part I
CFS-101 Part II
CFS-101 Part III

If you have any questions or comments, please feel free to contact Laura Barno, Director of Children and Adult Services at (304) 356-4586, Laura.S.Barno@wv.gov or Carla Harper, Program Manager at (304) 356-4571, Carla.J.Harper@wv.gov .

Sincerely,

Bill J. Crouch
Cabinet Secretary

BJC:bb

Attachments

West Virginia




Third Annual Progress Report

WEST VIRGINIA Department of Health & Human Resources

Bureau for Children and Families
350 Capitol Street, Room 730
Charleston, WV 25301
Jim Justice, Governor
Bill J. Crouch, Cabinet Secretary

Contents

1. General Information

The West Virginia Department of Health and Human Resources (the Department) is a cabinet level agency of state government, which was created by the Legislature and operates under the general direction of the Governor. This Department can be described as an umbrella agency with responsibility for several different programs and services including, but not limited to, Public Health, Behavioral Health, Child Support Enforcement, and services to Children and Families. The Department operates under the direction of a Cabinet Secretary, and the major programs are assigned to different Bureaus. Each Bureau operates under the direction of a Commissioner. The authority and responsibilities of the Commissioner vary from Bureau to Bureau. The Commissioner of the Bureau for Children and Families is Nancy N. Exline.

2017 Update

Effective April 3, 2017, Linda Watts is assuming the responsibilities of Interim Commissioner of the Bureau for Children and Families.

THE BUREAU FOR CHILDREN AND FAMILIES

Located within the Bureau for Children and Families (BCF) are individual offices which perform various functions for the Bureau. The offices are: The Office of Programs; the Office of Field Operations; and the Office of Operations. Oversight of each office is by a Deputy Commissioner who reports to the Commissioner of the Bureau who, in turn, reports to the Cabinet Secretary of the Department.

Office of Programs

The Office of Programs and Resource Development, under the direction of Deputy Commissioner Sue Hage, have primary responsibility for program planning and development related to child welfare. The staff formulates policy, develops programs, and produces appropriate state plans and manual materials to meet federal specifications and applicable binding court decisions. Such manual material is used as guidance for the implementation of applicable programs by field staff deployed throughout the state.

2016 Update

Effective December 1, 2015, The Office of Programs and Resource Development is under the direction of Deputy Commissioner Linda Watts.

The West Virginia Department of Health and Human Resources, through the Bureau of Children and Families (BCF), is responsible for administering child welfare services by WV Code §49-1-105. The administration of federal grants, such as Child Abuse Prevention Treatment Act funds, Chafee Independent Living funds, Title IV-E funds, and Title IV-B funds, is also a responsibility of this Bureau.

The staff within the Bureau for Children and Families is primarily responsible for initiating or participating in collaborative efforts with other Bureaus in the Department on initiatives that affect child welfare. The staff in the Bureau also joins with other interested groups and associations committed to improving the wellbeing of children and families.

For the most part, the staff within the Children and Adult Services (CAS) policy division is not involved in the direct provision of services. In some cases, however, staff does assist with the provision of services or is directly involved in service delivery. For example, staff in CAS operates the Adoption Resource Network and maintains financial responsibility for a case once an adoption subsidy has been approved. The Director, Jane McCallister is both the IV-B and IV-E Coordinator. West Virginia's approved Child and Family Services Plan and any approved Annual Progress Services Report can be located at http://www.wvdhhr.org/bcf/.

2016 Update

Effective March 1, 2016, Children and Adult Services is under the direction of Director Laura Barno. Barno now serves as both the IV-B and IV-E Coordinator as well. Upon approval, this year's APSR will be posted at http://www.wvdhhr.org/bcf/.

2017 Update

Upon approval, this year's Annual Progress Services Report will be posted at http://www.wvdhhr.org/bcf/.

In addition, this office is responsible for the Division of Family Assistance, the Division of Early Care and Education, and the Division of Training. This Division is charged with the oversight, coordination, and delivery of training to BCF employees and foster parents statewide.

This training includes New Worker Training, Supervisory Training, and Tenured Worker Training on new initiatives and professional development activities.

State CAPTA Coordinator Brandon Lewis 350 Capitol Street, Room 691 Charleston, WV 25301 304-356-4572 Brandon.S.Lewis@wv.gov	State IV-B and IV-E Coordinator Jane McCallister 350 Capitol Street, Room 691 Charleston, WV 25301 304-356-4575 Jane.B.McCallister@wv.gov
Effective March 1, 2016 Kristen Davis 350 Capitol Street, Room 691 Charleston, WV 25301 304-356-7980 Kristen.R.Davis@wv.gov	Effective March 1, 2016 Laura Barno 350 Capitol Street, Room 691 Charleston, WV 25301 304-356-4586 Laura.S.Barno@wv.gov

The Office of Operations

The Deputy Commissioner of Operations, Linda Adkins, is responsible for oversight of the Division of Grants and Contracts; the Division of Finance; the Division of Personnel and Procurement; the Division of Planning and Quality Improvement (DPQI); and the Division of Research and Analysis. Major responsibilities of the Office of Operations are: approving and monitoring sub-recipient grants and contracts; oversight of the bureau budget; oversight of personnel and procurement activities; and developing and producing research and analysis on the results of operations for the major programs operated by the Bureau. Major activities of DPQI include conducting program and peer reviews; coordinating statewide quality councils; coordinating corrective action and program improvement plan; and accreditation activities.

2015 Update

The Deputy Commissioner of Operations, Linda Adkins, is responsible for oversight of the Division of Grants and Contracts; the Division of Finance; and Procurement. Major responsibilities of the Office of Operations are: approving and monitoring sub-recipient grants and contracts; oversight of the bureau budget; and procurement activities. The Division of Personnel lead by Pam Holt and the Office of Research and Analysis lead by Kevin Henson, reports directly to the Commissioner, Nancy Exline. The Division of Planning and Quality Improvement (DPQI) falls under the Office of Research and Analysis. The Division of Personnel completes all the Human Resource functions for the Bureau and Research and Analysis does research and analyzes the results of the operations for the major programs operated by the Bureau. The major activities of DPQI

include conducting program and peer reviews and coordinating corrective action plans; coordinating the statewide quality councils; coordinating the state's Child and Family Services Review and developing and monitoring the Program Improvement Plan when implemented.

2017 Update

Effective October 1, 2016, Amy Lawson-Booth is now serving as Deputy Commissioner of Operations. Kevin Henson, Assistant Commissioner of the Office of Planning, Research, and Evaluation now reports to Interim Commissioner Linda Watts.

The Office of Field Operations

The Office of Field Operations is under the direction of Deputy Commissioner Tina Mitchell. Field Operations' charge is the direct service delivery of all services within the Bureau, as well as Customer Services. In January 2015, two additional directors, one for Family Assistance Programs and one for Social Services Programs, were hired to assist with supervision and direction for field staff.

West Virginia is divided into four regions. Each region is supervised by a Regional Director (RD) who reports directly to the Deputy Commissioner. Various counties are grouped within each Region. If a county is large enough, it is considered a District. The District is supervised by a Community Services Manager. All supervisory staff report directly to the Community Services Manager. Field staff is responsible for the service delivery of Child Protective Services (CPS), Youth Services (YS), Foster Care and Adoption.

2015 Update

Effective July 22, 2015, the Office of Field Operations is under the direction of two Deputy Commissioners. Tina Mitchell, Deputy Commissioner of Field Operations South oversees Region II and Region IV. Tanny O'Connell, Deputy Commissioner of Field Operations North oversees Region I and Region III. Together, the Deputy Commissioners of Field Operations coordinate their efforts to ensure staff and customers' needs are being addressed and resolved in a timely manner.

The Bureau has hired the two Directors that report directly to the Commissioner. The Director over Social Services, Patricia Vincent will provide direct field support to social services staff from the Commissioner's office. The Director for Family Support, Marilyn Trout will provide direct field support to the Family Support staff in the field offices.

Vision Statement

West Virginia is recognized for a collaborative, highly responsive quality child welfare system built on the safety, wellbeing, and permanency of every child. Its vision is guided by principles that are consistent with child and family services principles specified in Federal regulations [45 CFR 1355.25(a) through 1355.25(h)]. These practice model principles are:

- Our children and families will be safe
- Our children will have a strong, permanent connection with family and community. While reunification, adoption, and legal guardianship are ultimate goals, we need to make sure that all children have caring adults in their lives
- Our children and families will be successful in their lives and have enhanced well-being
- Our children and families will be mentally and physically healthy
- Our children and families will be supported, first and foremost, in their homes and home communities, and by receiving the correct services to meet their needs
- Our child-serving systems will be transformed to meet the needs of children and families

Collaboration

West Virginia Department of Health and Human Resources (DHHR) continues to collaborate with internal and external stakeholders to ensure that child welfare information and data is shared on a regular basis, agency strengths and areas needing improvement are assessed collectively, and goals and objectives for improvement are determined though a coordinated process.

West Virginia held joint planning meetings in preparation of the 2015-2019 Child and Family Services Plan (CFSP) that involved many stakeholders and will continue doing this to coordinate and collaborate for each of the Annual Progress and Services Reports (APSR).

To gain input for the 2015 APSR, the DHHR brought together an APSR Steering Committee that includes management from the DHHR, Bureau for Children and Families and a representative from the Court Improvement Program. Additional stakeholders came together on October 23, 2014 to discuss the progress that was made on the goals of the 2015-2019 CFSP. The participants were divided into 6 workgroups (and subcommittees). These workgroups and subgroups are:

1. Agency Responsiveness to the Community Assessment of Performance

    - Information Systems
    - Case Review System
    - Quality Assurance System
    - Agency Responsiveness to the Community
    - Foster Adoptive Parent Licensing, Recruitment, and Retention

2. Plan for Improvement – IV-E Waiver/Wraparound
3. Services
4. Chafee Foster Care Independence Program (CFCIP)
5. Health Care Oversight and Coordination Plan
6. Data and Evaluation Team

In addition, the DHHR can continuously obtain input from stakeholders across the state and all child welfare systems by partnering with several high-level groups that together provide oversight and direction for child welfare in West Virginia.

These oversight groups are: Commission to Study Residential Placement of Children; "Safe at Home West Virginia"; West Virginia Three Branch Institute; West Virginia Court Improvement Program; Juvenile Justice Reform Oversight Committee, and Education of Children in Out of Home Care Advisory Committee.

Commission to Study Residential Placement of Children

The Commission to Study Residential Placement of Children has leveraged its mandate (WV Code §49-2-125) to address both residential placements and their expanded focus on all children in out-of-home care. This Commission is chaired by the DHHR Cabinet Secretary. Members include all child-serving systems and the many volunteers that carry out the Commission's work, enabling the Commission to work collaboratively on making informed decisions.

Members of the Commission to Study Residential Placement of Children (serve as the Three Branch Institute Home Team) continues to work on the Safe at Home WV funding structure and addressing other needs for Safe at Home WV as they arise.

Title IV-E Assessment and Waiver Application "Safe at Home West Virginia"

In 2014, the WV DHHR, BCF submitted a Title IV-E application, and received a federal waiver, that would freeze the penetration rate at the current level and allow a full

continuum of supports, that begin with community-based solutions, to improve the lives of West Virginia children and families. West Virginia's waiver is referred to as Safe at Home West Virginia.

The goals of Safe at Home West Virginia are to:

- Ensure youth remain in their communities whenever safely possible.
- Reduce reliance on foster care/congregate care and prevent re-entries.
- Reduce the number of children in higher cost placements out-of-state.
- Step down youth in congregate care and/or reunify them with their families and home communities.

The IV-E Waiver, Safe at Home WV will provide wrap-around behavioral and human services to:

- Support and strengthen families to keep children in their homes;
- Return children currently in congregate care to their communities; and
- Reunite children in care with their families.

Safe at Home WV will measure its success with a Results Based Accountability (RBA) system.

During the development of Safe at Home West Virginia, the Bureau for Children and Families collaborated with all its community partners through our community collaboratives and regional children's summits to complete the community service needs assessments. This process allowed local partners to identify service gaps and to begin development of strategic plans in their communities to assist with the development of those needed services. Provider partners have also completed the Manager's Guide Implementation of Wraparound Readiness to Implement Self-Assessment to prepare for the initiative.

During the development of Safe at Home West Virginia, the Bureau for Children and Families collaborated with all its community partners through our Family Resource Networks, Community Collaborative groups and Regional Children's Summits.

During this review period, the WV Department of Health and Human Resources provided technical assistance for building the partnerships within each of the Family Resource Networks, Regional Summits and Community Collaborative groups. DHHR State Office Staff had been working with the Community Service Managers (CSMs) statewide and collectively the group of CSMs gave input on rebuilding the Community Collaborative

groups. The group decided to reduce the number of strategies for filling gaps in services down to between 3 to 5 strategies overall for each Community Collaborative group. The CSMs came up with plans to help the Community Collaborative groups build membership with the Courts, Education, Public Health, Local Government, Juvenile Justice, Partner Agencies, Businesses and Family Members and the information was shared statewide with the CSMs and Collaborative Chairs.

DHHR State Office Staff also met with the CSMs on May 18th, 2014 and reviewed the WV Comprehensive Assessment Planning System (WV CAPS) rollout, including giving recommendations on the strengths and weaknesses of the rollout plan. WV CAPS is the assessment and planning system model for children who are at risk of or placed in out of home care. DHHR State Office Staff took the suggestions from the CSMs into consideration in moving forward with the WV CAPS implementation.

The DHHR State Office Staff attended all the Regional Children's Summits including Region I Children's Summit on 7/01/14, Region II Children's Summit on 8/15/14, Region III Children's Summit on 10/01/14 and Region IV Children's Summit on 11/17/14 where the focus of the content was on building the WV CAPS providers capacity for each region. DHHR Central Office Staff created a training website for WV CAPS, created a training course and made it available for community stakeholders to access. The department trained over 1000 people in West Virginia on the WV CAPS. A WV CAPS Manual was created as well as development of Regional CAPS Task Teams to oversee Quality Assurance measures utilizing the DHHR Quality Assurance Process.

A Community Collaborative Conference was held on December 17th with CSMs, Family Resource Network Directors, and Community Collaborative chairs, to give technical assistance on the roles of the groups. The Family Resource Networks, Regional Summits and Community Collaborative groups were given direction by the Bureau for Children and Families (BCF) for moving forward with the Safe at Home WV Implementation Plan.

The Community Collaborative groups were also asked to complete the West Virginia *Safe at Home Services and Supports Survey* to assess what services were currently available, what were available in limited capacity and any gaps in services. This initial assessment allowed local partners to identify service gaps from a list of 17 core wraparound services. BCF identified services that are core to high fidelity wraparound and every county is completing a survey to show which of those services are available, which services are not, and which services may be available but in limited capacities and therefore needed further capacity building. The initial 11 counties were assessed as well as 19 other counties that have completed the survey so far. The results of this survey will need to be

reviewed and/or revised as community partners are included and services available and needed are identified.

During the next review period, we will continue providing technical to support expanding the partnerships of the Family Resource Networks, Regional Summits and Community Collaborative groups in expanding their membership, and increasing the availability of core wraparound services, including non-formal community supports.

Community Collaborative groups along with provider partners have begun completing the *Community Assessment of Strengths and Needs Survey*, a community readiness assessment for the implementation of wraparound services, which will determine the community's preparedness for the Safe at Home WV initiative. At the completion of the survey, collaborative groups will be expected to develop strategic plans to address identified gaps of service in their area. The DHHR Community Partnerships unit will monitor and provide communication pathways for these plans. The DHHR CSMs will be expected to provide oversight of these plans for their Community Collaborative group.

The information about Safe at Home WV is shared through various venues, such as the Safe at Home WV Network Newsletter and the Safe at Home WV website www.wvdhhr.org/bcf/safe that will be launched in early 2015.

Three Branch Institute

In 2013, West Virginia submitted a proposal and was again selected to participate in the National Governor's Association (NGA) Three Branch Institute. This institute focus is on the social and emotional wellbeing of children in foster care. West Virginia's proposal includes addressing the physical and mental health needs for children in foster care.

Governor Earl Ray Tomblin selected the following individuals to represent West Virginia's Core Team: Honorable Gary Johnson, Nicholas County Judge; Cindy Largent-Hill, Juvenile Justice Monitor; Karen L. Bowling, DHHR Cabinet Secretary; Cynthia Beane, Deputy Commissioner for Policy, Bureau for Medical Services; Susan C. Hage, DHHR Deputy Commissioner for Policy, Bureau for Children and Families; Senator John Unger, Berkeley County, District 16; and Delegate Don Perdue, Wayne County, District 19.

With this strong commitment by representatives from the three executive branches and with the Commission to Study Residential Placement of Children's members to serve as a "Home Team," West Virginia has a solid foundation for which collaborative changes can be made and sustained.

West Virginia Court Improvement Program

The Court Improvement Program is a collaborative effort administered by the WV Supreme Court with DHHR and the provider communities involved through funding from three federal grants with matching state funds. These are referred to as the "basic", "training" and "data collection" grants.

2016 Update

Juvenile Justice Reform Oversight Committee

In 2014, West Virginia partnered with the Pew Charitable Trust to evaluate the state's juvenile justice practices. The resulting information was published in a document titled Report of the West Virginia Intergovernmental Task Force on Juvenile Justice. This report found that between 2002 and 2012 referrals to court for status offenses rose nearly 124% and the number of status offenders placed outside of the home rose nearly 255%. "Three-quarters of juvenile justice youth placed in DHHR facilities in 2012 were status offenders or misdemeanants. Just fewer than 50% of these youths had no prior contact with the court" (Virginia, 2014). The result of these findings was legislative changes.

During legislative session of 2015, the West Virginia legislature passed Senate Bill 393. This bill was part of the Governor's initiative to reform juvenile justice practice and a response to the findings of the task force within. As part of this bill, many changes were implemented which include a restriction of placing first time offenders outside of the home into foster care, unless for abuse and neglect or other safety concerns; a restriction on the length of stay outside of the home, with a focus on community services; the prohibition of the utilization of detention facilities for status offenders, and the formation of the Juvenile Justice Reform Oversight Committee. The committee is a collaborative group of individuals from the Department of Health and Human Resources, the Supreme Court, the legislature, law-enforcement, the community, the Division of Juvenile Services, the Department of Education, and a crime victim advocate appointed by the Governor. The group's purpose is to provide oversight of the reform measures and improve the state's juvenile justice system.

2017 Update

Data Improvements and Exchanges between DHHR and the Courts

In the Fall of 2016, the chair of a Court Improvement Program workgroup, Judge Derek Swope of the state's Ninth Judicial Circuit, asked for the formation of an ad hoc group for

the purposes of ensuring that the court's data met the needs of both the Court Improvement Project and the Department of Health and Human Resources (DHHR). The courts have been collecting data through the Child Abuse Neglect (CAN) database for years. As states have moved away from merely providing numbers from counts and toward measurable outcomes capturing quality, Judge Swope felt that West Virginia's data should be able to assist in determining whether we are meeting our outcomes for both the Court Improvement grants, as well as the CFSR/APSR. Members of this ad hoc group include members of the Supreme Court's Administrative offices; DHHR's Division of Planning and Quality Improvement, Children and Adult Services; the SACWIS System; Child Support Enforcement; as well as members of the WV Coalition Against Domestic Violence.

The group identified two areas to begin their work. The first is determining if quality hearings are occurring. The group felt that the basic component of a quality hearing is having all parties of the case in attendance.

A survey of child protective service (CPS) workers yielded 154 complete responses. The survey was an exploratory, non-scientific instrument used to help the court and the department determine ways to increase the quality of hearings. Results of the survey have not been verified. CPS workers were specifically questioned about certain parties' attendance at typical adjudicatory hearings, disposition hearings, 90-day review hearings prior to termination of parental rights, and 90-day review hearings after termination of parental rights. The following are a couple highlights from the results.

The survey's results indicated that in the workers' practices guardian's ad litem are "always present" at hearings 95.45% of the time. Additionally, the survey revealed that foster parents were "always present" at hearings 5.36% of the time. The court and the department will conduct another exploratory survey to reach more professionals with the goal of expanding on the first survey's results and continuing to define areas in which quality can be improved.

Another survey is currently being developed for other parties of the case. As you will read in the systemic factors area of this document, a foster parent survey has been developed that will help identify the reasons for this and help both the courts and DHHR make improvements.

The other area of exploration is related to data that is captured for periodic case reviews. It is not specific to each child. In other words, the CAN database only captures the number of hearings for reviews but does not match it back up to the actual children involved. This will be one of the primary issues explored through the 2017-2018 fiscal years.

Education of Children in Out of Home Care Advisory Committee

The mission of the Education of Children in Out-of-Home Care Advisory Committee is to ensure that children placed in out-of-home care receive a free appropriate public education in accordance with federal and state laws, regulations and policies.

KEY ACCOMPLISHMENTS OF 2014

The following represent the 2014 key accomplishments for: the Commission's workgroups; the Three Branch Institute; Safe at Home WV; West Virginia Court Improvement Program; and the Education of Children in Out-of-Home Care Advisory Committee. The accomplishments may apply to more than one priority goal area.

1. Appropriate Diagnosis and Placement

a.) The new streamlined Comprehensive Assessment and Planning System (CAPS) that includes the Child and Adolescent Needs and Strengths (CANS) assessment continues to expand the target population and is being rolled out incrementally across the Department of Health and Human Resources regions.

- DHHR Region I could begin making referrals using the new process to service providers on October 10, 2014.
- DHHR Region III could begin making referrals using the new process to service providers on October 15, 2014.
- At the end of 2014 there were 425 certified users in the CANS in WV; 35 super users in West Virginia representing 29 different agencies; and 6 advanced CANS specialists.
  (Service Delivery & Development and Three Branch Institute)

b.) Dr. John S. Lyons, Chief Developer of the Child and Adolescent Needs and Strengths (CANS) Assessment provided a seminar in West Virginia on how the assessment can be utilized to design a strategy for Total Clinical Outcomes Management (TCOM). Dr. Lyons also reviewed and assessed sixty (60) children and youth using the CANS assessment. The draft report has been received and is being reviewed. (DHHR, Bureau for Children and Families, WV System of Care)

c.) In December 2013, the Commissioner for the Bureau for Children and Families decided to support a full review of West Virginia's children placed in out-of-state residential treatment facilities, and to use this information to develop short and long term strategies that will support the reduction of youth in congregate care. The report includes

children in residential group facilities, psychiatric residential treatment facilities, acute care hospitals, and specialized foster care out-of-state. It is important to note in this report that children are only counted one time in six years. However, there are several youths who are placed out-of-state numerous times, or remain in placement for numerous months. There was a total of 205 youth reviewed between April and October 2014. The report and findings will be distribution in February 2015. (WV System of Care)

d.) Regional clinical review teams continued to provide comprehensive, objective, clinical review for children at risk as a resource for the child's Multidisciplinary Treatment Team (MDT). (WV System of Care)

- A total of 58 regional clinical review team meetings took place between January and December 2014, to review 131 youth.
- Data show 21 youth who received a clinical review in 2014 were prevented from out-of-state placement.

e.) Participation in Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, known as HealthCheck in West Virginia, is a requirement for every child in foster care. All children who enter foster care are required to have an evaluation of their physical health within 72 hours. This is facilitated by the HealthCheck Program administered by our Bureau for Public Health Office of Maternal, Child, and Family Health. Overall the foster children are being scheduled for their exams more quickly. For example, 17% of foster children placed in September 2013 were scheduled for an exam within 1 day of placement. In June 2014, that increased to 63.5%. (Three Branch Institute)

f.) A plan for implementation of a trauma screening for physician residency clinics throughout the state is being developed. Physicians participating in the pilot will utilize a form that identifies trauma, in conjunction with a parent education handout. In April 2015, the HealthCheck Program will seek advice and guidance from the Office of Maternal, Child and Family Health Pediatric Advisory Board pertinent to HealthCheck psychosocial/behavioral screenings – specifically early toxic stress and trauma. (Three Branch Institute)

g.) In support of the WV Initiative for Foster Care Improvement (WV IFCI), that began as an American Academy of Pediatrics grant to improve health care of foster children, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Children with Special Health Care Needs (CSHCN) programs will work to identify at least one pediatric practice that sees a high volume of foster children in which to pilot the Visit Discharge and Referral Summary and accompanying Trauma-Specific Anticipatory Guidance. The

Office of Maternal, Child and Family Health (OMCFH) Database Management Unit will oversee data collection and analysis. (Three Branch Institute)

h.) To obtain a statistically relevant sample, 68 case records for foster children prescribed psychotropic medications from three or more classes were reviewed using a standardized tool in 2013. Nearly all (63/68; 93%) of these foster children had a hyperkinetic syndrome diagnosis, primarily ADD and ADHD (59/63; 94%) though it is not known if hyperkinetic syndrome diagnoses are appropriate or if this was a result of a trauma response. These prescriptions were primarily written by psychiatrists 98%) and did not exceed the recommended daily dosage (83%). There is evidence in the case record of therapy being used to help manage the majority of these conditions (90%). However, appropriate baseline and routine metabolic monitoring and follow-up are lacking. In 2015, the Three Branch Institute, Psychotropic Medication Workgroup would like to explore the use of prior authorization for these prescriptions that would help promote best practice for monitoring and follow-up, provided the correct criteria are in place. The workgroup would like to investigate the option of limiting the duration of these prescriptions to promote appropriate monitoring and follow-up. A plan will be developed to provide provider education on appropriate prescribing practices for psychotropic medications, best practice standards for baseline and routine metabolic monitoring and provider follow-up appointments, tardive dyskinesia assessments and clinical psychological exams.

2. Expanded Community Capacity

a.) On October 15, 2014, Governor Earl Ray Tomblin announced the award of a federal Title IV-E Waiver to support Safe at Home West Virginia Initiative, which will allow the Bureau for Children and Families to have more flexibility in delivering individualized services to children and their families. The Safe at Home project is expected to launch by the end of 2015 in Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam and Wayne counties and will focus on youth ages 12-17 currently in or at-risk of entering congregate placements. The Safe at Home WV will provide wrap-around behavioral and human services to:

- Support and strengthen families to keep children in their homes;
- Return children currently in congregate care to their communities; and
- Reunite children in care with their families.

b.) In November 2014, the Bureau for Children and Families approved a statewide Treatment Foster Care pilot with Pressley Ridge of West Virginia, to provide a holistic, strength-based individualized approach as an alternative to residential placement settings

for children ages 0-17, with priority given to children identified during out-of-state reviews, children at risk of out-of-state placement, and youth who are part of Safe at Home WV.

c.) A new level three residential facility, Old Fields, for children aged 5-10 with co-existing disorders (mental health and intellectual disabilities) operated by Burlington United Methodist Family Services was opened in Hardy County.

d.) Medicaid has implemented the Telehealth Policy and will continue to monitor the Behavioral Health and Health Facilities system redesigns which is starting with the comprehensive gap analysis. Medicaid will also monitor the new policies that were put in place in July to assure prioritized assessments for children in foster care. The group is working with the Casey Family Foundation and the Bureau for Behavioral Health to review how we can maximize our current resources to provide Behavioral Health Services to the children in our care. (Three Branch Institute)

e.) In 2014, the Division of Probation Services opened new Drug Courts in Marion, Wyoming, and Summers/Monroe Counties. A new Juvenile Drug Court was opened in Ohio County.

f.) Lily's Place, a treatment facility licensed for 12 neonatal beds in Cabell County, opened in partnership with DHHR/Child Protective Services, Prestera Center and Cabell Huntington Hospital, to serve the entire state of West Virginia. The treatment facility provides monitoring and treatment for newborns suffering from Neonatal Abstinence Syndrome (NAS) or drug exposure. The staff also provides one-on-one care to mothers and connects them with the resources they need including substance abuse programs, food, clothing, parenting, housing and other needed services.

g.) YALE Academy

Academy Programs, located in Fairmont, West Virginia submitted an application to the Bureau for Children and Families for the development of Youth Accelerated Learning Environment (YALE) Academy. This 24-bed, level II, staff secured residential treatment facility, will treat male and female adolescents between the ages of 12 and 17 and transitioning adults, with co-occurring substance abuse diagnosis and mental health or conduct disorder diagnosis. The YALE Academy is expected to open in 2015.

3. Best Practices Deployment

a.) Safe at Home West Virginia, approved for implementation by end of 2015, is based on the National Wraparound Initiative Model which focuses on a single service

coordination plan for the child and family. Elements of the service model will include assessments, care coordination, planning and implementation, and transitioning families to self-sufficiency. The Title IV-E Waiver program will require commitment of all stakeholders to transform the way we serve families. (Safe at Home WV)

b.) The New View was implemented in 2013. When the project started, West Virginia children ranked with the coldest temperatures (i.e., those predicted to be most likely to linger in care). The New View, modeled after Georgia's Cold Case project, assigns attorney "viewers" to conduct file reviews and interviews to make permanency and transitional recommendations to local courts, multidisciplinary treatment teams, and the Bureau for Children and Families (BCF) leadership, on the children identified as being at risk of lingering in care and/or aging out of the system. The New View Project involves some court observation, as local courts sometimes invite the attorney viewers to attend hearings regarding the children they are viewing, and the viewers often participate in the children's multidisciplinary treatment team (MDT) meetings. This year, the use of AFCARS data for the New View Project is in the implementation phase. The project used fall 2013 AFCARS data for a predictive model to identify children likely to linger in out-of-home care.

Approximately 100 were assigned to viewers in the past two years. Although the New View project provides a treasure trove of information, it represents a small segment of the whole state's cases. The New View, implemented in 2013, began incorporating use of AFCARS data.

c.) For the May 2014 circuit court judicial conference, the Court Improvement Program worked with Casey Family Programs to bring Judge Michael Nash of California to speak to the judges about monitoring psychotropic medications of children in care.

4. Workforce Development

a.) The Court Improvement Program (CIP) sponsored training that involved cross-system collaboration.

- In July 2014, the CIP held juvenile law training, "Building a Strong Education", that involved attorneys and the W.Va. Department of Education;
- In July 2014, the CIP with support from the Department of Health and Human Resources provided free cross-trainings for attorneys, social workers, counselors, and others involved in child abuse/neglect and juvenile cases. The theme of the July 2014 trainings was "From Impossible to I'm Possible: Empowering Children, Families, and Professionals to Realize Their Potential."

b.) Approximately 900 people have been trained on the Comprehensive Assessment and Planning System (CAPS) and the Child and Adolescent Needs and Strengths (CANS) assessment.

- A total of 202 people has attended the Comprehensive Assessment and Planning System (CAPS) Implementation Training; 24 CAPS providers trained and certified; online CAPS training was viewed by 424 DHHR employees and 258 people from other agencies/organizations; CAPS and CANS face-to-face training was provided to over 200 service provider staff in each DHHR region.
- Treatment providers utilized by the Juvenile Drug Court have also been trained in the use of the CANS.
- DHHR staff will be trained on using the CANS beginning with the Youth Services staff and their supervisors.
- A subgroup of the West Virginia super users began building the same sustainable Child and Adolescent Needs and Strengths (CANS) assessment training program for the Adult Needs and Strengths Assessment (ANSA).

c.) Training curriculum to support practical implementation of best practice principles, including Family Centered Practice, Family-Youth Engagement, and Cultural-Linguistic Competence, was delivered to 442 cross-systems direct care and management staff in 2014. Curriculum was launched in 2013 with support from a federal SAMHSA expansion grant and modules are approved for social work continuing education and delivered free of charge to stakeholders. (West Virginia System of Care)

d.) “Introduction to Serving Children with Co-Existing Disorders” training was revised and presented to 60 direct care staff and managers serving children with both mental health and intellectual/developmental disabilities. (Bureau for Behavioral Health & Health Facilities, Service Delivery and Development Work Group)

5. Education Standards

a.) To promote school stability, educational access and provide a seamless transition when school moves occur for children in out-of-home care, the West Virginia Department of Education and the Out-of-Home Care Education Advisory Committee worked on the following to promote positive outcomes:

- An additional Transition Specialist was hired in 2014 and participated in the out-of-state site visits to monitor regular educational programs of children in placement. They assisted students and the out-of-state host agency in developing individualized portfolios for the transitioning of students. The Transition Specialists

reconnect children returning from placement in juvenile institutions to their communities and public schools.

- The Reaching Every Child brochure was revised and a memorandum was sent out by the State Superintendent of Schools.

6. Provider Requirements

a.) The West Virginia Bureau for Children and Families has been working collaboratively with our Out of Home Provider partners to transform our child placing system. There have been numerous group meetings to allow activities of this group to focus on the development of proposals and plans to move from a system built on levels of care to a system built to meet the identified needs of individual children.

Meetings were held May 11, June 5, June 26, July 10, and August 18, 2015 with providers of the different types of agencies: shelters, specialized foster care, and group residential. The agencies were asked to develop standards of care across the placement types as well as outline a continuum of care for community based services. They were also encouraged to submit proposals (by out of home setting type and across types) to describe how they would assess the child to determine level of needs. By November 1, 2015 a plan will be developed outlining how the system will be transformed into a continuum of care by identifying each step that will need to be taken. Once the plan is developed, an implementation date will be determined.

Included in these systemic changes will be measurable outcomes and performance measures that will be included in all provider agreements. Draft provider agreements, including the newly developed outcomes and performance measures, are to be completed by August 31, 2015 to allow for updating agreements for finalization in September 2015.

b.) The West Virginia Interagency Consolidated Out-of-State Monitoring process continued to ensure children in foster care and placed outside of the state of West Virginia are in a safe environment and provided behavioral health treatment and educational services commensurate with WV DHHR and WVDE standards. In 2014, five on-site reviews and three remote assessments (facility self-assessment) were conducted on out-of-state facilities where WV children were placed. (West Virginia Interagency Consolidated Out-of-State Monitoring Team.

These are joint reviews done by staff from the Department of Education, Bureau for Medical Service (via APS Healthcare), and BCF’s Licensing unit. The teams do 5 on-site reviews a year, and the facilities that are reviewed are normally the OOS facilities that

provide services to the largest population of youth from WV. The three entities decide what facilities will be reviewed every year prior to Jan 1 of each year. The reviews normally take several weeks to complete, with the reviewers being onsite for about 2 to 3 days. Each entity decides how many staff they will send for each review. A sample (10%) of staff records and (10% of WV youth) youth's records are reviewed. Example: Timber Ridge in VA was reviewed recently and we had 2 staff from education, 1 staff from Licensing and 1 staff from APS HealthCare.

2017 Update

The West Virginia Interagency Consolidated Out-of-State Monitoring process continues to ensure children in foster care who are placed outside of the state of West Virginia are in a safe environment and provided behavioral health treatment and educational services commensurate with WV DHHR and WVDE standards. (West Virginia Interagency Consolidated Out-of-State Monitoring Team)

In FFY 2016, the following on-site reviews were completed:

- Barry Robinson - Psychiatric Residential Treatment Facility (VA)
- Gulf Coast – Group Residential (FL)
- New Hope Carolina - Psychiatric Residential Treatment Facility (SC)
- Coastal Harbor - Psychiatric Residential Treatment Facility (GA)
- Abraxas I – Group Residential (PA)

7. Multidisciplinary Team (MDT) Support

a.) Curriculum and training package for statutorily required Multidisciplinary Treatment (MDT) teams have been finalized. (Court Improvement Program)

b.) Regional Clinical Review teams continued to provide comprehensive, objective, clinical reviews for children at risk as a resource for the child's Multidisciplinary Treatment Team (MDT) (System of Care)

c.) The Court Improvement Program began sending an electronic survey to judges, attorneys, social workers, and others involved in child abuse/neglect and juvenile cases in the past year. The survey results may illuminate how MDT participation is going in practice, compared to policy and procedural rules. (Court Improvement Program)

8. Ongoing Communication and Effective Partnerships

a.) Members of the Commission, the Court Improvement Program and the West Virginia Department of Education/Education of Children in Out-of-Home Care Advisory Committee initiated an agreement to share data to compare educational outcomes for children in out-of-home care with all children in state public schools.

b.) Youth representative Jessica Richie-Gibson joined the Commission to Study Residential Placement of Children as a full member.

c.) Timeliness of the Health Screening (EPSDT) process overall has improved, a success that is a product of the Bureau for Children and Families and the Bureau for Public Health working together. (Three Branch Institute)

9. Performance Accountability

a.) The IV-E Waiver, Safe at Home West Virginia began its development and planning phase, including statewide training of Bureau for Children & Families staff and community providers on the Results Based Accountability (RBA) process. RBA uses a data-driven decision-making process to help communities and organizations take action to solve identified problems. It is a simple, common sense framework that everyone can understand. RBA starts with ends and works backward, towards means. Using RBA to guide the program means three core questions will inform the process: How much did we do? How well did we do it? Is anyone better off? Success is measured not simply by compliance to rules and regulations, but by the real-life impacts, or results, of the work completed. (Safe at Home WV).

b.) As part of Safe at Home WV, BCF has and will continue to award grants for Local Coordinating Agencies who will be responsible for hiring the Wraparound Facilitators. The grant Statement of Work was drafted by BCF and includes measurable outcomes that are included within the Demonstration Project. These Statements of work will also be discussed with our partners to allow for their input and additions. There is a meeting scheduled on September 16, 2015 with the lead agencies and BCF grants staff, program staff, and financial staff to discuss the statement of work and other requirements and to further assure the unity of our focus and purpose. The Waiver Demonstration Project Evaluation will measure identified outcomes. This information will be used to assist BCF and our partners in assuring quality performance. All grants and contacts will be revised to include RBA performance measures.

As outlined in the "Provider Requirements" section, West Virginia has worked collaboratively with our Out of Home Placement Providers to develop measurable outcomes and performance measures to include within their programs and our provider

agreements. West Virginia's Out of Home Placement partners have developed proposals for their program restructuring and outcome/performance measures. Because of our partnership of going through Results Based Accountability training together the outcome/performance measures are structured within the RBA framework. Most proposed outcomes also fit within West Virginia's Demonstration Project outcomes and therefore will be evaluated as part of the Demonstration Project program evaluation.

c.) Semi-annual evaluation reports prepared for the Commission by Marshall University, on both out-of-state youth and regional clinical review provide information to address systemic issues, service needs and gaps. (West Virginia System of Care)

Other Collaborative Efforts

Regional Summits and Community Collaboratives

In the Title IV-E demonstration project (Safe at Home, West Virginia); the Regional Summits and Collaborative Bodies have specific roles. The purpose of the Regional Summits is to help develop the appropriate linkages with courts, juvenile probation, agency providers, DHHR staff and county educations systems to meet the purpose of their identified specific service needs and gaps. The purpose of the Community Collaboratives is to share resources and identify service gaps to develop needed services with providers, service agencies and the community to ensure a timely, consistent and seamless response to the needs of children and families. Specifically, the Community Collaboratives will prevent children from being placed in congregate care and assist in returning children from out-of-state placements by identifying services or resources in their communities that can meet the needs of these children. They will also develop, link and implement services to assist youth transitioning into adulthood and prepare them for independent living. When the Collaborative Bodies have difficulty with filling gaps in services, the Collaborative is expected to forward the request to the Regional Summit to identify any resources in the area that lie outside the Community Collaborative body's scope. The regional Summit will communicate that need to the BCF Statewide Coordinator who can present the need to the Safe at Home West Virginia Advisory Team.

2016 Update

The West Virginia Department of Health and Human Resources (DHHR) continues to collaborate with internal and external stakeholders to ensure that child welfare information and data is shared on a regular basis, agency strengths and areas needing improvement are assessed collectively, and goals and objectives for improvement are determined though a coordinated process.

West Virginia held many joint planning meetings in preparation of the Annual Progress and Services Reports (APSR) that involved many stakeholders and will continue doing this to coordinate and collaborate for each of the Annual Progress and Services Reports (APSR).

Keeping the Commission's priority goals as the focus, these accomplishments represent the work for January 2015 through December 2015. The accomplishments may apply to more than one priority goal area.

1. Appropriate Diagnosis and Placement

Implement and maintain ways to effectively sustain accurate profile/defined needs (clinical) of children in out-of-home care, regardless of placement location, at the individual, agency, and system levels to include clinical review processes, standardized assessments, total clinical outcomes management models, etc., that result in the most appropriate placements.

- The WV System of Care worked through two processes to identify gaps in services, barriers to serving youth in the state, and returning youth to the state. These processes have also prevented youth from being placed in out-of-state services, identified services appropriate for the youth and assisted in the planning for youth returning to the state. These two processes are the Regional Clinical Review Team and the Out-of-State Review Team. The number of youth being placed out-of-state continues to decrease. Two years ago (2012-2013) 533 youth were placed out-of-state. Last year (2013-2014) 492 youth were placed out-of-state, and this year (2014-2015) 477 youth were placed out-of-state, an 11% decrease in 3 years. Regional clinical review teams continued to provide comprehensive, objective, clinical review for children at risk as a resource for the child's Multidisciplinary Treatment Team (MDT). A total of 58 regional clinical review team meetings took place between January and December 2015, to review 131 youth.
    - 21 youth who received a clinical review in 2015 were prevented from out-of-state placement.
- The Bureau for Children and Families is currently in the process of developing program standards for a request for applications to broaden the family foster care program statewide. This will create a three-tiered foster care program in West

Virginia that will serve children through traditional foster care, treatment foster care and intensive treatment foster care.

- The Universal Assessment, WV Child and Adolescent Needs and Strength (CANS) was cross walked with the National Child Traumatic Stress Network Trauma CANS version and CANS sub-modules and was approved by the Praed Foundation in May 2015.
- WV continues to move toward utilizing the Total Clinical Outcome Management (TCOM) framework to measure, report, and build system capacity, especially in community-based service delivery and supports.
- Hornby Zeller Associates, Safe at Home WV evaluators, has developed the Automation of the WVCANS 2.0. The site is complete and they have written a user guide that is being reviewed by a few of our WVCANS experts. All users are being set up in their system that went live in the middle of February.
- The Department of Health and Human Resources (DHHR), Bureau for Children and Families, provided grants for licensed behavioral health agencies with direct children's service experience to act as local coordinating agencies in the implementation of the high fidelity Wraparound Model, with supporting services, for West Virginia's Safe at Home WV Wraparound.
- A comprehensive and searchable Provider Directory was added to the Bureau of Medical Services website to allow members, parents or legal guardians of members, and field office staff to have access to a directory of a variety of behavioral health providers that are available in throughout our state. This is checked on a regular basis to ensure that true up to date information is available on this site: http://www.wvcca.org/directory.html.

2. Expanded Community Capacity

Expand in-state residential and community-based program and service capacity for out-of-home children through systematic and collaborative strategic planning to include statewide programs such as Building Bridges, System of Care, and systems such as the Automatic Placement and Referral System (APR), and greater emphasis on upfront prevention approaches.

- The Safe at Home WV Services and Supports survey and results were completed by the Family Resource Networks, Regional Children's Summits and Community Collaborative Group members in June 2015. The Safe at Home WV Services and

Supports included a listing of the core services within a wraparound model. The Family Resource Networks, Regional Children's Summits and Community Collaborative Group members were asked to determine if each of the 17 core services existed in their respective county. *(Safe at Home WV)*

- The Community Self-Assessment survey and results were completed by the Family Resource Networks, Regional Children's Summits and Community Collaborative Group members in July 2015. The Community Self-Assessment looks at the readiness (based on the member's knowledge) of communities to implement a wraparound model as prescribed from the National Wraparound Initiative. *(Safe at Home WV)*
- The Office of Maternal, Child and Family Health met with the Pediatric Medical Advisory Board on April 17, 2015, to form a workgroup to develop age-appropriate trauma screening questions for addition to the HealthCheck forms. *(The Three Branch Institute)*
- The Family Resource Networks, who are involved in county/community based prevention/tertiary initiatives, will continually assess the services available to community family members (community service array). As team members of the Community Collaborative Groups, who will be reviewing children's needs, this information will be shared and solutions will be identified. When Community Collaborative Groups identify systemic barriers, or need additional assistance, they will seek further assistance by forwarded their concerns to the Regional Summits.
- The Three Branch Committee for Substance Use in Pregnancy was created to "Safely reduce the reliance on out-of-home placement of children by reducing the incidence of substance exposed infants placed in out-of-home care". A collaborative planning approach was chosen to bring together existing programs and partnerships to promote consistency and achieve collective impact and to include ALL substances. Collaboratively, members have increased the number of treatment and recovery residences from 409 to 759; added Certified Recovery Coaches from 0 to 201; promoted Opioid Treatment Centers becoming licensed behavioral health programs; increased the number of physicians providing buprenorphine, 46 to 187 physicians waivered (164 Medicaid); and added Moms and Babies programs from 0 to 4.
- Governor's Advisory Council on Substance Abuse directed funding to support a START partnership pilot, a joint initiative between the Bureaus for Children and

Families and Behavioral Health and Health Facilities. (Three Branch Committee for Substance Use in Pregnancy)

- 1-844-HELP-4-WV 24/7 real-time call line clinical & recovery staff providing warm hand-offs, transportation and follow-up. *(Three Branch Committee for Substance Use in Pregnancy)*
- "As of December 31, 2015, 830 participants have successfully graduated from West Virginia's Adult Drug Courts (ADCs), which have a graduation rate of 52%. The recidivism rate for graduates over the past two years is 9.4%... One year post graduation recidivism rate is only 1.8%. As of the end of December 2015, there were 25 operating ADC programs comprising 31 individual courts covering 43 counties… and 448 active clients." (More information about the WV Adult Drug Courts can be found in Appendix H.)
- "As of December 31, 2015, there are 15 operational Juvenile Drug Courts (JDCs) programs comprised of individual courts covering 17 counties. On December 31, 2015, there are with 197 active JDC cases. 492 participants have successfully graduated from West Virginia's JDCs. The JDCs have a graduation rate of approximately 50.5%. The recidivism rate for graduates is 14.6% as compared to 55.1% in traditional juvenile probation." (More information about the WV Adult Drug Courts can be found in Appendix H.)

3. Best Practices Deployment

Support statewide awareness, sharing, and adoption of proven best practices in all aspects (e.g., treatment, education, well-being, safety, training, placement, support) regarding the Commission's targeted populations.

- Safe at Home WV revised plan was presented to the Children's Bureau in mid-January 2015. Hornby Zeller Associates was awarded the contract that began July 1, 2015. Safe at Home West Virginia was rolled out on October 1, 2015, in the counties of Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam and Wayne. These initial counties were chosen based upon areas of highest need as reflected by the number of children in out of home care and areas of most readily available services.
- The Safe at Home WV Wraparound Advisory Team was formed. By December 2015, 58 youth have been referred to Safe at Home WV for Wraparound Services (24 in out-of-state placements; 26 in in-state placements; and 8 cases were

prevented from residential placement). A total of 4 youth has returned to West Virginia, 5 youth have returned to their communities from in-state residential placements, and 8 youth were prevented from entering residential placement.

- Presentations have been provided to the members of the Community Collaborative Groups and Regional Children's Summits regarding Safe at Home WV and they have been asked to take the 10 Principles of Wraparound (that also align with the Commission priority goals) back to their agencies and offices and discuss thoroughly with their staff. They are also reviewing information regarding the youth in the Safe at Home WV target population and those in out-of-state placements.
- Development of the Wraparound Model work plan and products have been drafted. *(Service Delivery & Development Work Group)*

4. Workforce Development

Address staffing and development needs, including cross-systems training, that ensure a quality workforce with the knowledge, skills, and capacity required to provide the programs and services to meet the requirements (e.g., assessments, case management, adapt best practices, quality treatment, accountability) of those children in the Commission's targeted populations.

- In June 2015, direct service staff was surveyed to gage their level of knowledge of the Comprehensive Assessment Planning System (CAPS) Statewide Implementation and the Child Adolescent Needs and Strengths (CANS) assessment tool utilized by the CAPS and determine additional training and informational disbursement needed. *(Service Delivery & Development Work Group, CAPS Task Team)*
- A basic training entitled "Developmental Disabilities and Co-Existing Disorders: An Overview" along with a Training of Trainers curriculum was developed. This cross-sector training that also serves as relationship-building opportunities for providers in the mental health, IDD and child welfare systems. *(Service Delivery & Development Work Group, Silo Spanners)*
- HealthCheck operational policy was revised to include procedures that ensure continuity of operations when one or more Foster Care Liaison staff is absent. *(Three Branch Institute)*
- The Bureau for Public Health, Office of Maternal, Child and Family Health collaborated with the Bureau for Children and Families to improve quality and

timeliness of FACTS data. In September 2013, 17% EPSDTs were scheduled for an exam within the first day of placement. In May 2015, this percentage increased to 63.2%.

- The Wraparound Model Task Team developed and provided the Wraparound 101 training targeted stakeholders in June 2015.

5. Education Standards

Ensure education standards are in place and all out-of-home children are receiving appropriate quality education in all settings and that education-related programs and services are meeting the requirements of all out-of-home children, regardless of placement location.

- The West Virginia Department of Education and the Out-of-Home Care Education Advisory Committee will continue to study the educational growth of children in out-of-home care. Specifically, they wish to investigate why students are not included in the data; investigate the student growth data discrepancy; examine and study the proficient students and see why these students are doing better; obtain change of placement data and correlate with assessment data; and examine disciplinary infractions to see if the infractions made are accurate and consistent across the state.

6. Provider Requirements

Require placements in all locations be made only to providers meeting West Virginia standards of licensure, certifications and expected rules of operation to include demonstrated quality in all programs and services that meet West Virginia Standards of Care.

- The development of a retrospective review tool was initiated to capture expectations for quality Comprehensive Assessment and Planning System (CAPS) and Comprehensive Assessment Reports (CAR) that includes the Child and Adolescents Needs and Strengths (CANS). *(Service Delivery & Development Work Group, Comprehensive Assessment and Planning System Task Team)*
- The Bureau for Medical Services implemented prior authorizations for atypical psychotropics for all children receiving Medicaid between the ages of 6 and 18 years on August 1, 2015. Prior authorization for younger children is already a requirement. A key next step for the workgroup is to develop an evidence-based

professional education program that can be delivered to DHHR staff, practitioners and other professionals working with children in foster care.

- On August 1, 2015, the Bureau for Medical Services (BMS) implemented a prior authorization process for atypical psychotropic medications for foster children between the ages of 6 and 18 years. In addition, BMS is exploring a prior authorization process for stimulant medications, specifically for children in foster care. The workgroup is also continuing to develop a plan for provider education.
- To better understand prescribing practices, the Bureau for Public Health, Bureau for Medical Services and the Bureau for Children and Families undertook a case review of 68 case records for foster children prescribed psychotropic medications from three or more classes; nearly all (63/68; 93%) of these foster children had record of a hyperkinetic syndrome diagnosis, primarily Attention Deficient Disorder (ADD) and Attention Deficient Hyperactivity Disorder (ADHD) (59/63; 94%). These prescriptions were primarily written by psychiatrists (78%) and did not exceed the recommended daily dosage (83%).

7. Multidisciplinary Team (MDT) Support

Support the multidisciplinary treatment team (MDT) concept and assist enhancing present MDT processes statewide.

- To reduce the reliance of out-of-home placement of children by identifying needs of children when involvement begins, the Three Branch Institute, Out-of-Home Placement Workgroup coordinated cross system strategies with the IV-E Waiver process; conducted a survey to capture a snapshot of how MDTs are conducted; developed and released statutorily required Multidisciplinary Treatment (MDT) Team Curriculum and Training Package; revised and distributed a MDT Desk Guide; and supported the Implementation of Child and Adolescent Needs and Strengths (CANS) in WV.
- The statutorily required Multidisciplinary Treatment (MDT) team curriculum and training package was piloted on May 29, 2015. The training curriculum and training package will be maintained by the Court Improvement Program's newly joined Behavioral Health and Multidisciplinary Treatment (MDT) Team Committee chaired by Judge Bloom.

8. Ongoing Communication

Develop appropriate and timely cross-system and public communications regarding the work of the Commission that fosters awareness and the continued commitment of

stakeholders to reduce the placement of children outside of their community of residence and to enhance in-state service capacity to reduce the number of children in West Virginia requiring out-of-home care.

- The Commission members and guests traveled to Prestera Center at Pinecrest in Huntington, WV, on August 27, 2015, to hold their quarterly meeting and hear and see first-hand what is happening in the area regarding the out-of-home population. The goal of this meeting was to allow the community to communicate their actions and barriers they face when children need to be placed out-of-home, and gain support toward improving outcomes.

9. Effective Partnerships

Continue to seek strong partnerships with individuals, agencies, organizations, other Commissions and special initiatives that advance the overarching goals and strategies of the Commission.

- In February 2015, the Mentoring & Oversight for Developing Independence with Foster Youth launched a "We Still Care" project to provide care packages to youth throughout the year to show them that even as they transition out of foster care, there are those that do still care. Along with the care packages, sponsors will provide cards and letters of support. During the year, 440 packages were sent to youth ages 17 to 21 across the state that was identified in the National Youth in Transition Database cohorts. We Still Care received donations due to a partnership with the Taylor County Collaborative Family Resource Network. Donations are tax-deductible and are given by individuals and organizations across West Virginia.
- The West Virginia Interagency Consolidated Out-of-State Monitoring process continues to ensure children in foster care who are placed outside of the state of West Virginia are in a safe environment and provided behavioral health treatment and educational services commensurate with WV DHHR and WVDE standards. *(West Virginia Interagency Consolidated Out-of-State Monitoring Team)*

  In 2015, the following on-site reviews were completed:
  - George Junior Republic – Group Residential Level II Facility (PA)

    The Bureau for Children and Families terminated the placement agreement at the facility in April 2015 and all youth were to be moved from the facility as soon as appropriate placements were found;
  - Timber Ridge - Group Residential Level II Facility (VA)
  - Summit Academy - Psychiatric Residential Treatment Facility (PA)

- Liberty Point Behavioral Healthcare, UHS - Psychiatric Residential Treatment Facility (VA)
- Barry Robinson - Psychiatric Residential Treatment Facility (VA)

2017 Update

- The West Virginia Interagency Consolidated Out-of-State Monitoring process continues to ensure children in foster care who are placed outside of the state of West Virginia are in a safe environment and provided behavioral health treatment and educational services commensurate with WV DHHR and WVDE standards. *(West Virginia Interagency Consolidated Out-of-State Monitoring Team)*

  In FFY 2016, the following on-site reviews were completed:
  - Barry Robinson - Psychiatric Residential Treatment Facility (VA)
  - Gulf Coast – Group Residential (FL)
  - New Hope Carolina - Psychiatric Residential Treatment Facility (SC)
  - Coastal Harbor - Psychiatric Residential Treatment Facility (GA)
  - Abraxas I – Group Residential (PA)

10. Performance Accountability

Ensure accountability through monitoring performance outcomes, improving processes and sharing information with all stakeholders.

- West Virginia is one of six sites that was selected in November by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to receive an 18-month program of In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse and Child Welfare (NCSACW) to help us work collaboratively across multiple disciplines to improve outcomes related to the prevention, identification, intervention and provision of treatment and support services for Substance Exposed Infants (SEIs) and their families.
- Bureau for Children and Families initiated a new web-based reporting system to track babies with NAS and Fetal Alcohol Spectrum Disorder. (*Three Branch Committee for Substance Use in Pregnancy)*
- Bureau for Public Health has collected the first year of data for the new required birth certificate components that include substance exposed pregnancies. (*Three Branch Committee for Substance Use in Pregnancy*)

- Bureau of Medical Services has begun data collection on utilization of pregnant women to further analyze the origin of substance exposures, family planning and medication assisted treatment and implemented Medicaid Expansion, Telehealth and MAT Coverage improvements. (*Three Branch Committee for Substance Use in Pregnancy*)

2017 Update

West Virginia continues to collaborate with several high-level groups to develop and review progress on its Child and Family Services Plan as well as yearly progress reports. These oversight groups are: Commission to Study Residential Placement of Children; "Safe at Home West Virginia"; West Virginia Three Branch Institute; West Virginia Court Improvement Program; Juvenile Justice Reform Oversight Committee, and Education of Children in Out of Home Care Advisory Committee.

Bureau for Children and Families staff are assigned as representatives to offer input on various projects and plans initiated by each of these groups. In return, these groups offer input on the Child and Family Services Plan developed by the Bureau on a routine basis throughout the year.

For additional information, please see West Virginia's Statewide Self-Assessment.

2. Update on Assessment of Performance

Child and Family Outcomes

The most reliable data West Virginia has is our CFSR style reviews, AFCARS and NCANDS. The following information is from the reviews completed by the Division of Program and Quality Improvement. West Virginia also has many forms of data for the Systemic Factors but no clear concise way to calculate or analyze the data.

Additionally, during Contract Year 2013-2014, the Family Support Educator for APS Healthcare Inc. conducted eleven (11) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health Services.

The purpose of these focus groups is to provide youth who are receiving medically necessary behavioral health services in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the State of West Virginia to gain insight regarding the utilization and

impact of these services in the state. Each group may consist of youth receiving individualized and/ or group treatment in a residential facility and/or within the community.

This year seventy-three (73) youth receiving residential treatment participated.

The focus group questions were developed with input from the Bureau for Children and Families. The intent of these questions was to generate responses identifying systemic issues regarding consumer perceived problems and solutions regarding:

Access
Service delivery
Gaps in support systems
Engagement with system staff
Frequency/ duration of therapy
Treatment plan goals and outcomes
Consumer knowledge of services and supports

This information will be included to the assessment of performance as it assists the agency on gaining input from one of our key stakeholders.

2016 Updates

Federal Fiscal Year (FFY) Data is based on the case reviews completed from Oct 1, 2014 to September 30, 2015. Case reviews conducted in federal fiscal year 2015 are reflective of practice that occurred 12 months prior to the date of the review. During FFY 2015, the Division of Planning and Quality Improvement (DQPI) completed 142 Child and Family Services Reviews (CFSR). In 76 of the cases reviewed, the targeted Child was in a placement setting. Sixty-six of the cases reviewed were non-placement cases; hence the children remained in their home during the period under review. Twenty-four of the cases reviewed were reflective of practice in the State's largest metropolitan district, which represents 17.1% of the sample.

West Virginia completed its Child and Family Service Reviews (CFSR) style case reviews based on the July 2014 version of the Child and Family Services Review Instrument and instructions.

West Virginia 2015 FFY CFSR style case review data is based on the review of the following Districts: Mingo, Wyoming; Kanawha; Fayette; Lewis/Upshur; Harrison; Kanawha; Ohio/Brooke/Hancock; Greenbrier/Monroe/Pocahontas/Summers;

Berkley/Morgan/Jefferson; Ritchie/Pleasants/Doddridge; Calhoun/Gilmer/Wirt and Randolph/Tucker.

2017 Update

West Virginia completed its statewide self-assessment in January 2017 for its upcoming Child and Family Services Review which began with stakeholder interviews in March 2017. Please reference this assessment for current information. Any new information or data not reported on the assessment will be reported in its appropriate section.

Social service case reviews were completed by the Division of Planning and Quality Improvement (DPQI). DPQI is under the Office of Planning, Research, and Evaluation. DPQI utilizes the January 2016 version of the Federal CFSR On-Site Review Instrument (OSRI) as the unit's primary internal tool for evaluating the quality of delivery of services to children and families.

Federal Fiscal Year (FFY) 2016 data is based upon the review of 143 social services case reviews completed from October 1, 2015 to September 30, 2016. The review was comprised of 72 foster care and 71 in-home social service cases. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Wood, Kanawha, Jackson/Mason/Roane, Barbour/Preston/Taylor, McDowell, Raleigh, Hardy/Grant/Pendleton, Logan, Lincoln/Boone, Nicholas/Webster, Mercer, and Braxton/Clay. These 12 districts represent 40% of the districts in West Virginia. Case reviews conducted were reflective of practice that occurred 12 months prior to the date of the review.

Factors Contributing to Cases Ratings

One of the key indicators of how well Districts perform on the Child and Family Services case review process is the staffing pattern of the district. Districts that experience a staffing shortage due to staff turnover, rate significantly lower on all measures. All the districts reviewed in Federal Fiscal year 2014, indicated significant staffing issues at the time of the exit as a factor contributing to the area needing improvement.

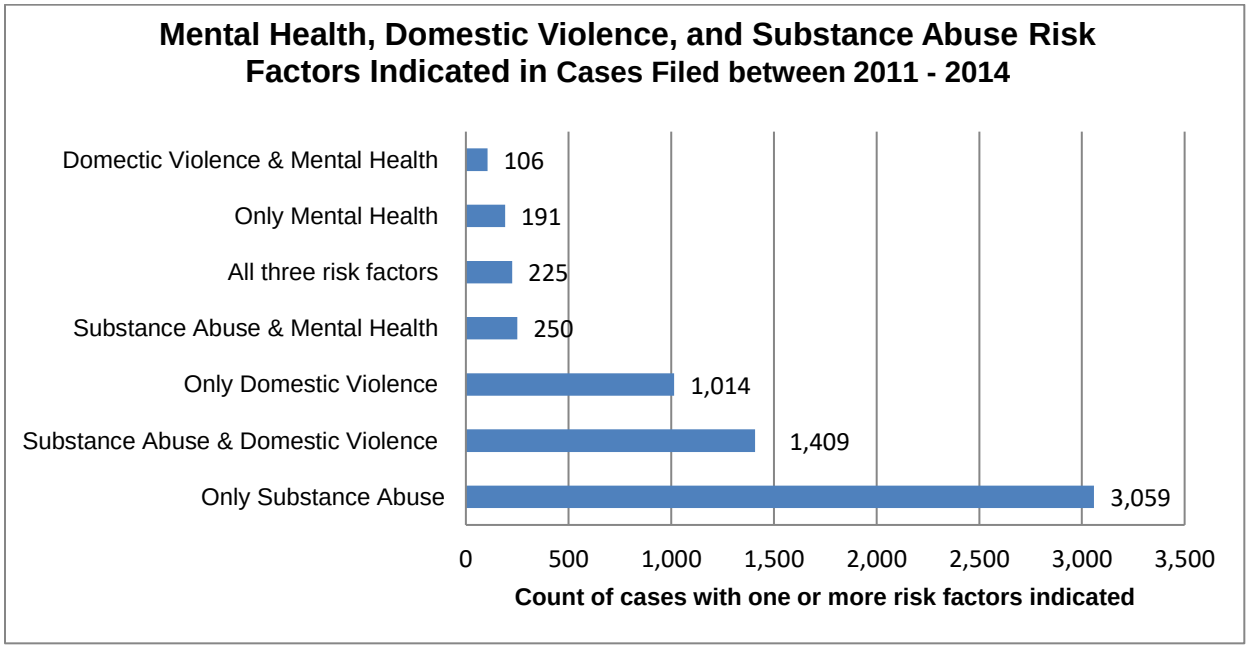
Districts indicate the limited availability of services including quality ASO providers, mental health services, domestic violence counseling for victims and batterers, and substance abuse treatment for both adults and youth as other barriers in meeting the needs of children and families. The lack of quality providers of services coupled with the lack of public transportation in many areas, results in social service clients not having

their treatment needs adequately addressed. Urban areas tend to have better resources than rural areas.

All Districts reviewed indicate the majority of the cases in which the Agency becomes involved deal with issues related to substance abuse. Districts report long wait lists for substance abuse treatment, both inpatient and outpatient services. Districts also note a lack of quality substance abuse treatment programs for youth, and the lack of ongoing community based support groups for those that remain in the community, or are returning home after treatment. West Virginia's case reviews indicate that 62.9% of the cases reviewed indicated substance use/abuse as a factor in the case.

WV Supreme Court of Appeals data further supports the Districts' findings regarding the prevalence of substance abuse and domestic violence in the case work process.

The data presented in this risk-factor analysis were pulled from the Supreme Court of Appeals of West Virginia's Child Abuse and Neglect (CAN) Database. The CAN database was created to collect and track the status and timeliness of all W.Va. child abuse and neglect cases. Each Circuit Court Judge's staff input data in each child abuse and neglect case assigned to the judge. The Court Services Division has trained staff to indicate which risk factors were present and mentioned in the original petition as a reason for filing the abuse and neglect petition. Cases may have more than one risk factor indicated.



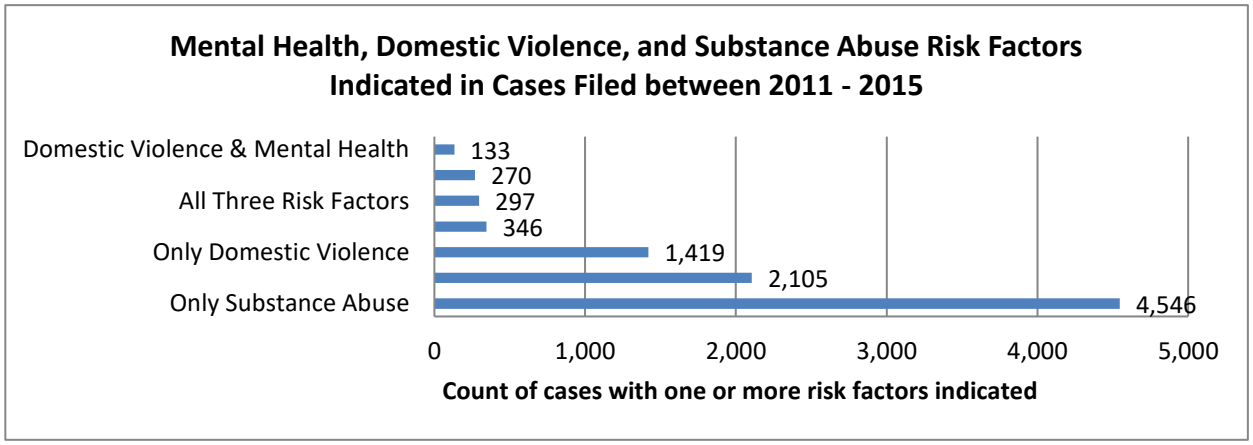
Between 2011 and 2014, there were 6,254 cases with one or more risk factors indicated. The above chart shows a breakdown of these cases and which risk factors were indicated in the original petition. This research assumes all cases include one or more risk factors; therefore, cases without an indicated risk factor are considered underreported.

2016 Updates

One of the key indicators of how well Districts perform on the Child and Family Services case review process is the staffing pattern of the district. Districts with a high staff turnover rate score significantly lower on all measures. All the districts reviewed in Federal Fiscal year 2015, indicated staffing issues as a key factor contributing to the area needing improvement.

Districts indicate the limited availability of services including quality ASO providers, mental health services, domestic violence counseling for victims and batterers, and substance abuse treatment for both adults and youth as other barriers in meeting the needs of children and families.

West Virginia continues to develop means to improve services to address the identified barriers, but is faced with many cases in which substance abuse is a factor lack substance abuse treatment and result in abuse and neglect petitions.



The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database was created to collect and track the status and timeliness of all W.Va. child abuse and neglect cases in the court system. The data presented in this risk-factor analysis was pulled from the CANS Database. Circuit court staff input data on each child abuse and

neglect case assigned to the judge. Court staff review petitions and enter the risk factors on each case. Cases may have more than one risk factor indicated.

Between 2011 and 2015, there were 9,116 cases with one or more risk factors indicated. The above chart shows a breakdown of these cases and which risk factors were indicated in the original petition. This research assumes all cases include one or more risk factors; therefore, cases without an indicated risk factor are considered underreported.

Out of the 9,116 cases that indicate one or more risk factors, 80.01% of the cases have indicated that substance abuse was at least one of the risk factors that led to the filing of a petition. Domestic Violence was indicated in 43.37% of the cases, and Mental Health in 11.47% of the cases.

Year	Total count of cases with one or more risk factors indicated	All cases with Substance Abuse indicated		All cases with Domestic Violence indicated		All cases with Mental Health indicated	
		Count	Percent	Count	Percent	Count	Percent
2011	1,025	807	78.73%	448	43.71%	94	9.17%
2012	1,556	1,231	79.11%	770	49.49%	220	14.14%
2013	1,767	1,392	78.78%	756	42.78%	350	19.81%
2014	2,478	1,976	79.74%	1,019	41.12%	285	11.50%
2015	2,290	1,888	82.45%	961	41.97%	197	8.60%
Total of All Years	**9,116**	**7,294**	**80.01%**	**3,954**	**43.37%**	**1,046**	**11.47%**

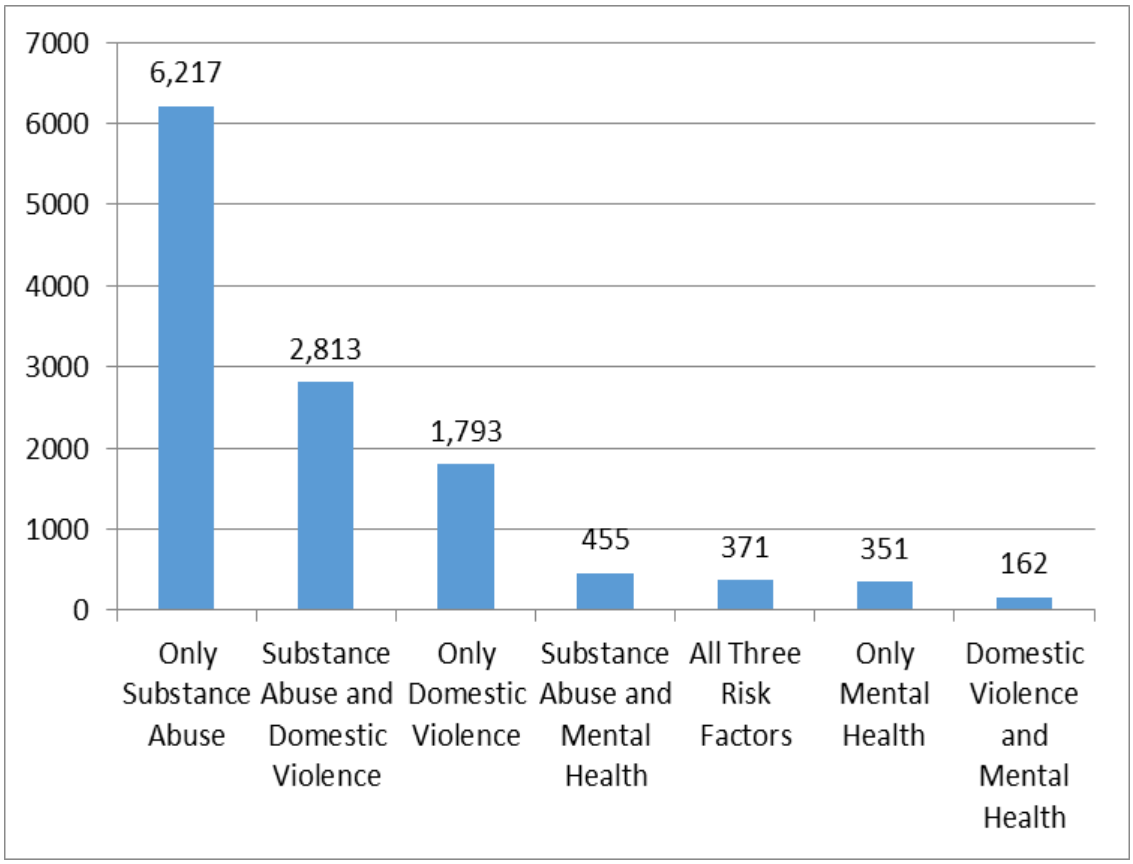
Between 2011 and 2014, there were 6,254 cases with one or more risk factors indicated. The above chart shows a breakdown of these cases and which risk factors were indicated in the original petition. This research assumes all cases include one or more risk factors; therefore, cases without an indicated risk factor are considered underreported.

2017 Update

Multiple factors impact the ability of West Virginia to improve positive outcomes for children and families. One major factor is the ever-increasing number of cases in which substance abuse is a risk factor. West Virginia also struggles to attract and retain qualified

staff. Performance on the Child and Family Services case reviews is directly linked to staffing levels in the district during the period under review. During both federal fiscal years 2015 and 2016, districts continue to list staff turnover as a barrier to achieving better outcomes for children and families. Districts also indicate the limited availability of services including quality ASO providers, mental health services, domestic violence counseling for victims and batterers, and substance abuse treatment for both adults and youth as other barriers in meeting the needs of children and families. West Virginia continues to work with community partners to increase services to address these barriers

The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database was created to collect and track the status and timeliness of all West Virginia. The data presented in the following risk-factor analysis was pulled from the CANS Database. Circuit court staff input data on each child abuse and neglect case assigned to the judge. Court staff review petitions and enter the risk factors on each case. Cases may have more than one risk factor indicated.

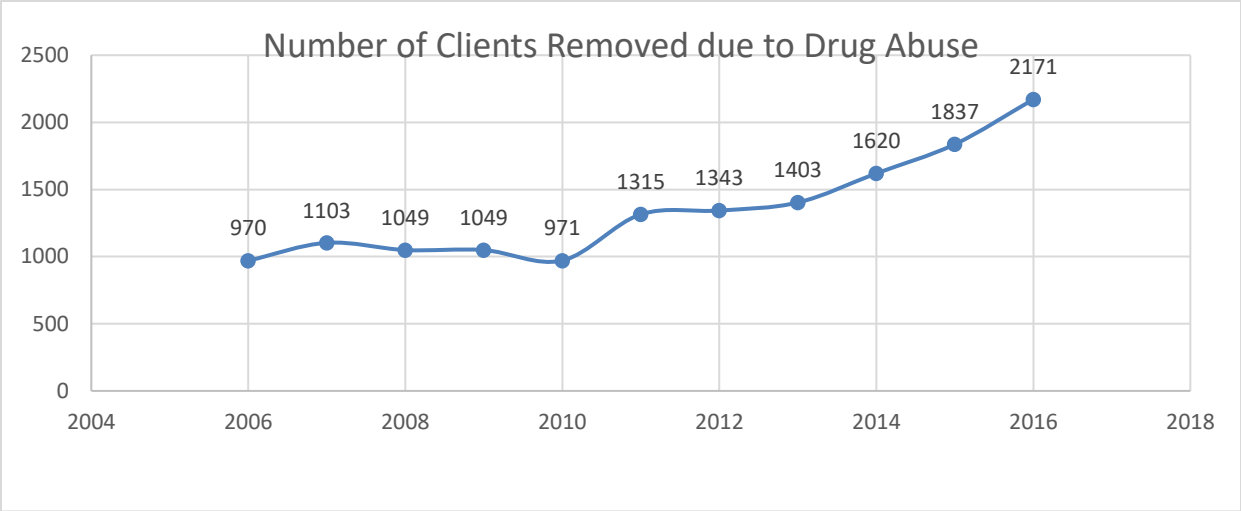


Staff members from each Circuit Court Judge's office submit data for each child abuse and neglect case assigned to their judge. The Court Services Division has trained staff to indicate which risk factors were present and mentioned in the original petition as a reason for filing the abuse and neglect petition. These cases may have more than one risk factor indicated.

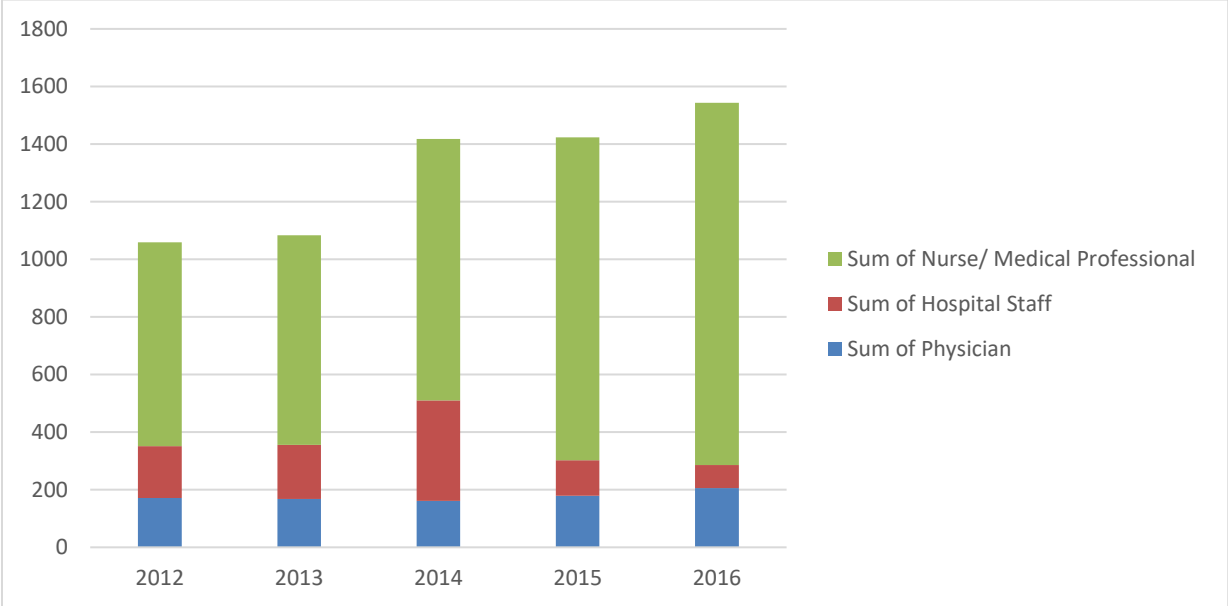
Between 2011 and 2016, there were 12,162 cases with one or more risk factors indicated. The above chart shows a breakdown of these cases and which risk factors were indicated in the original petition. This research assumes all cases include one or more risk factors; therefore, cases without an indicated risk factor are considered underreported.

Year	Total count of cases with one or more risk factors indicated	All cases with Substance Abuse indicated		All cases with Domestic Violence indicated		All cases with Mental Health indicated	
		Count	Percent	Count	Percent	Count	Percent
2011	1,025	807	78.73%	448	43.71%	94	9.17%
2012	1,559	1,234	79.15%	771	49.45%	220	14.11%
2013	1,775	1,399	78.82%	760	42.82%	254	14.31%
2014	2,495	1,996	80.00%	1,026	41.12%	289	11.58%
2015	2,557	2,102	82.21%	1,080	42.24%	223	8.72%
2016	2,751	2,318	84.26%	1,054	38.31%	259	9.41%
Total of All Years	**12,162**	**9,856**	**81.04%**	**5,139**	**42.25%**	**1,339**	**11.01%**

Out of the 12,162 cases that indicated one or more risk factors, 81.04% of the cases have indicated that substance abuse was at least one of the risk factors that led to the filing of a petition. Domestic Violence was indicated in 42.25% of the cases, and Mental Health was indicated in 11.01% of the cases.



West Virginia FACTS report on substance abuse related foster care entries



West Virginia FACTS report on increase in drug affected infant referrals received

Child abuse and neglect is often a symptom of larger social problems, such as substance abuse, which have no easy answers or quick fixes. West Virginia struggles with an ever-

increasing number of child welfare cases in which substance abuse is an identified risk factor. The nature of addiction, coupled with the inability to provide substance abuse treatment in a timely fashion, results in abuse and neglect petitions and negatively impacts outcomes in the West Virginia child welfare system.

Safety Outcomes 1 and 2

Safety outcome 1 incorporates two indicators. One indicator pertains to the timeliness of initiating a response to the report of child maltreatment, and the other related to the substantiation of recurrent reports of maltreatment.

The outcome rating for safety one based on case reviews for federal fiscal year 2014 indicate safety outcome one was substantially achieved in 52.2% of the cases reviewed, and partially achieved in 35.8. % of the cases reviewed.

Safety 1: Timeliness of initiating investigation of reports of maltreatment

Timeliness of initiating investigations of reports of maltreatment measures whether the assigned time frames were met on the Child Protective Services referrals received during the period under review.

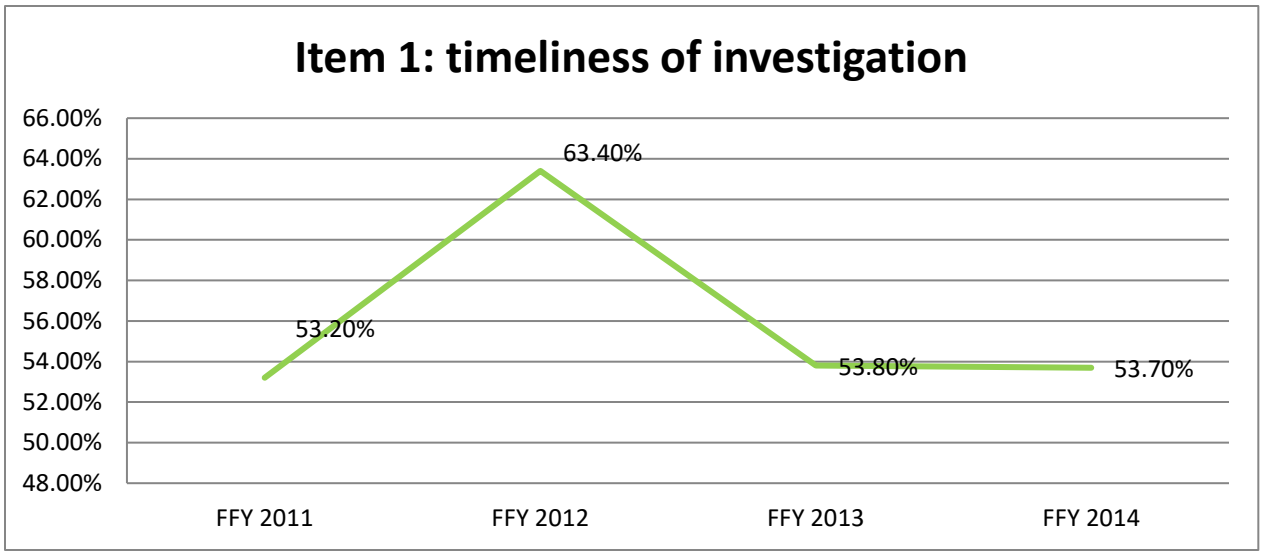
2017 Update

CFSR Item 1: Timeliness of initiating investigations of reports of child maltreatment.

DPQI Quality Assurance Case Review Data

FFY 2015: 70.2%

FFY 2016: 67.1%

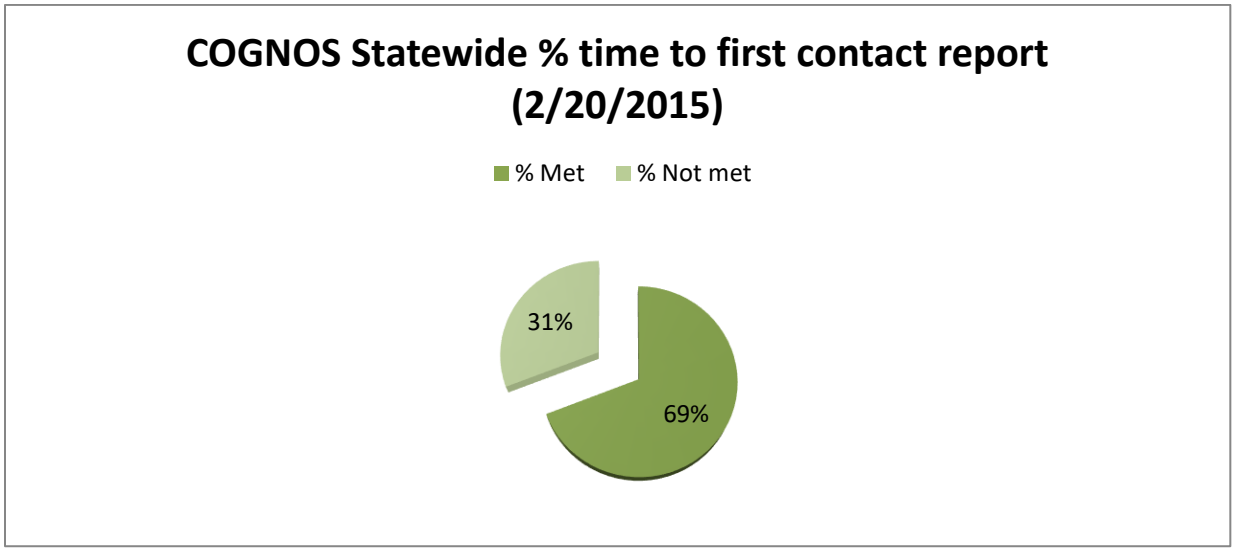


Federal Fiscal Year Data is based on the case reviews completed from Oct 1, 2013 to September 30, 2014. Case reviews conducted in federal fiscal year 2014 are reflective of practice that occurred 14 months prior to the date of the review; therefore, the data is indicative of practice that occurred in 2012 and 2013. Safety one case review data is not indicative of the current performance for initiating investigations of reports of maltreatment. Case review data for Federal Fiscal Year 2014, accounts for completed contacts. Attempted contacts are not reflected in the case review data. As of Federal Fiscal Year, 2015, attempted contacts made by workers to initiate investigations of reports of maltreatment will be included in the measurement.

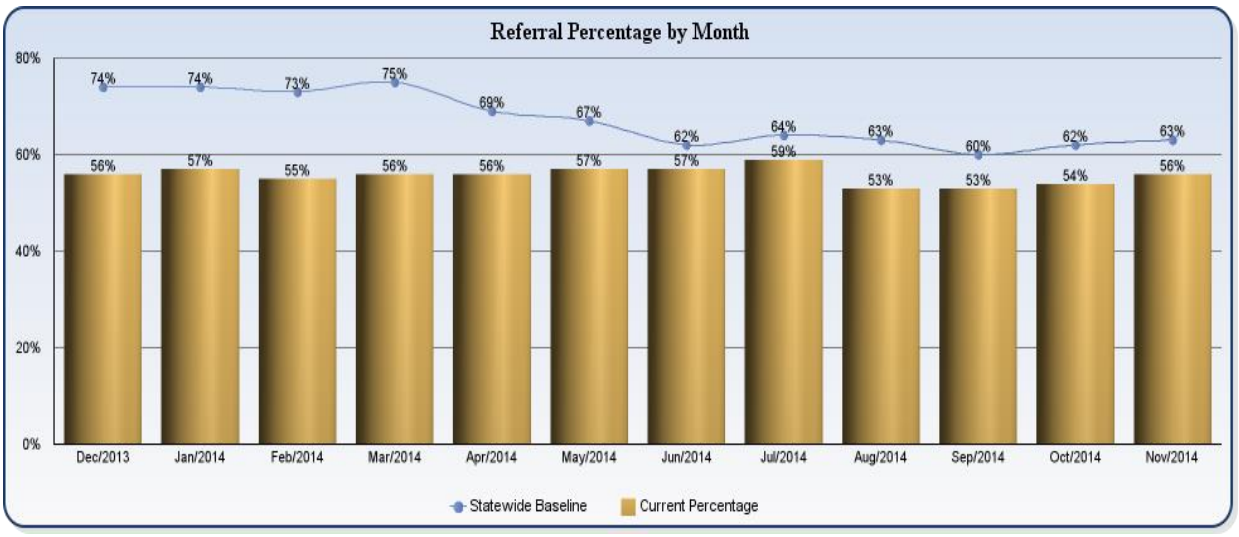
Districts' track and monitor the status of referrals through the COGNOS site. COGNOS data provides the Districts with point in time data regarding the time to first contact. This report is monitored by the District Community Services Managers and the Deputy Director of Field Operations. Currently, COGNOS data as of February 2015 indicates 69.1 % of intake assessments have been seen within the designated timeframes established by the Child Protective Services Supervisors. It should be noted the COGNOS system does not account for attempted contacts by workers.

Although Districts are more cognizant of their need to meet time frames, they are still struggling to resolve staffing issues that continue to impact this measure. All districts included in the Federal Fiscal Year 2014 reviews, indicated a shortage of staff. Lack of staffing creates a backlog of Family Functioning Assessments which in turns creates a reduction in the timeliness of investigations.

West Virginia is utilizing crisis teams to assist Districts experiencing a backlog of Family Functioning Assessments. Additionally, the Commissioner will pull staff from other districts to assist in the backlog reduction. Currently West Virginia is not experiencing a significant backlog of Family Functioning Assessments. It is anticipated that continued improvement in this measurement will occur as the result of the efforts of staff and management to address the backlog and move forward with initiatives to improve the timeliness of investigations.



It should also be noted that the number of referrals received and the number accepted for Family Functioning Assessments remain on the average at 55.7%.



2016 Update

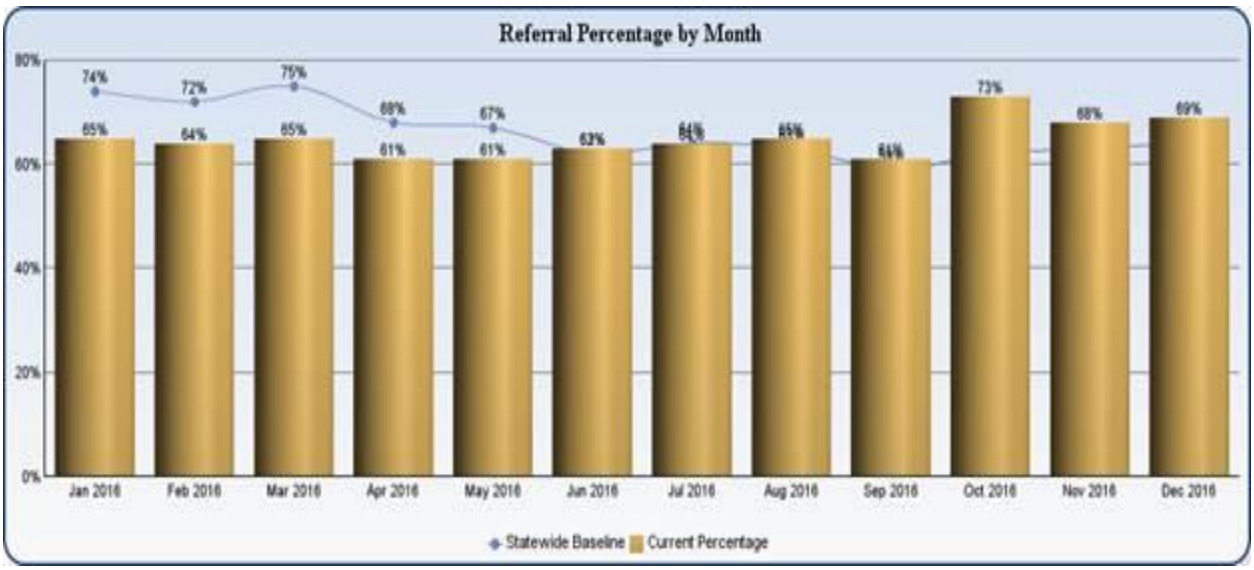
The outcome rating for safety one based on case reviews for federal fiscal year 2015 indicate safety outcome one was substantially achieved in 70.2% of the cases reviewed, and not achieved in 29.8. % of the cases reviewed.

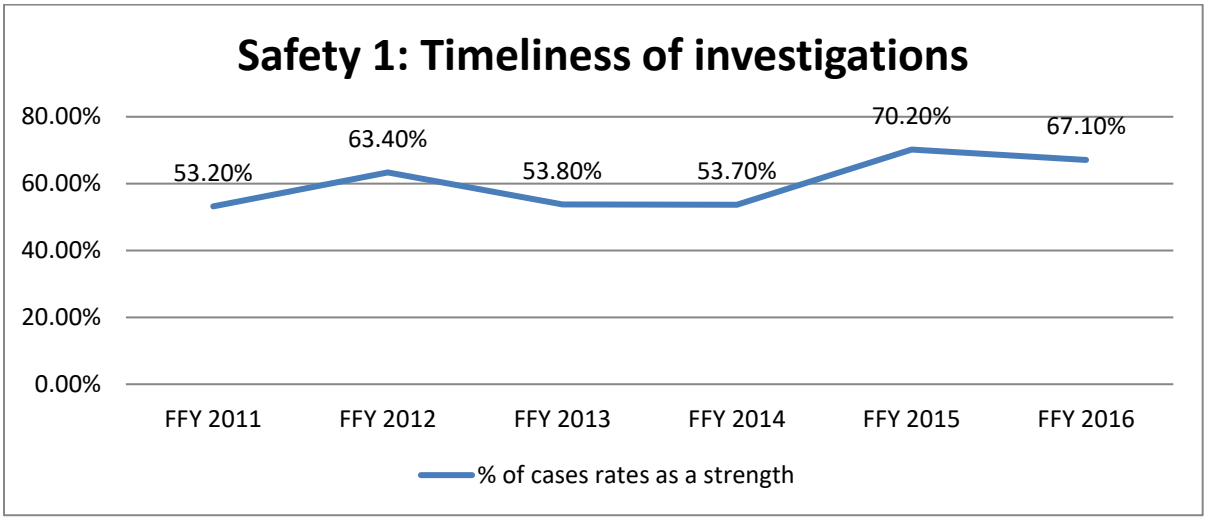
This measure continues to improve. “Timeliness to investigation” is consistently monitored by District Community Service Managers with oversight from the Deputy Commissioner’s over field operations. Districts management staff in conjunction with the Deputy Commissioners monitor this item daily using point in time data through WV’s COGNOS reporting system. West Virginia continues to make improvements in the time to first contact, a high priority in the efforts to improve the safety of children.

Case review data for Federal Fiscal Year 2015, reflects completed and attempted contacts.

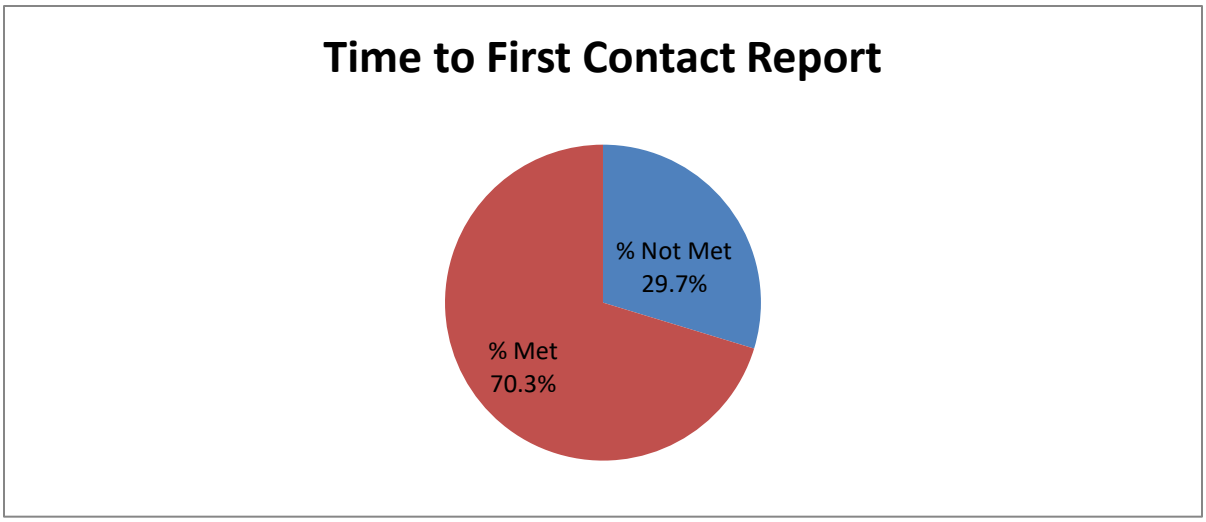
2017 Update

It should also be noted that the number of referrals received and the number accepted for Family Functioning Assessments remain on the average at 65.08%.

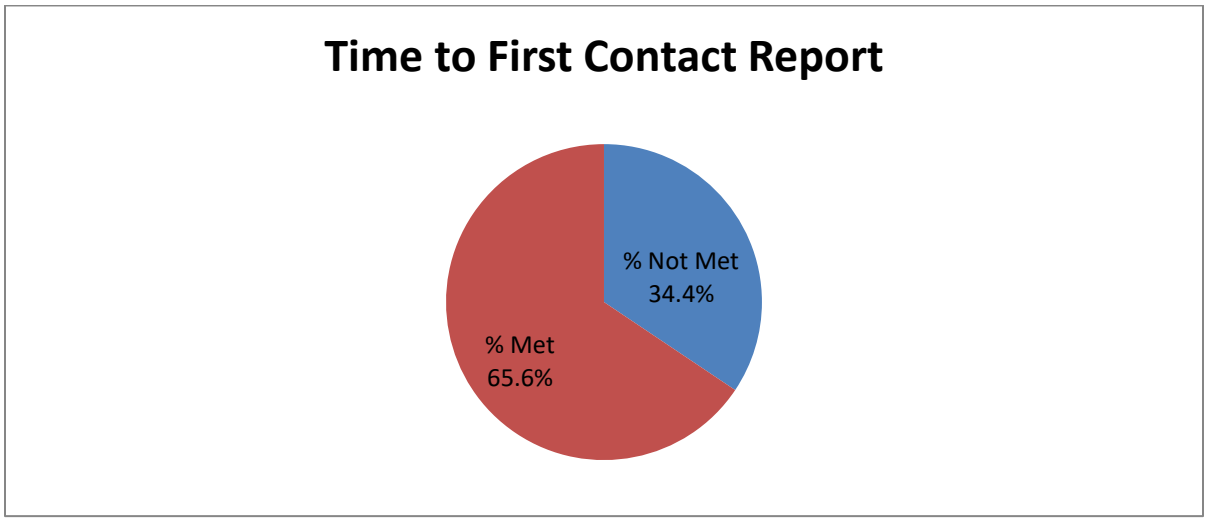




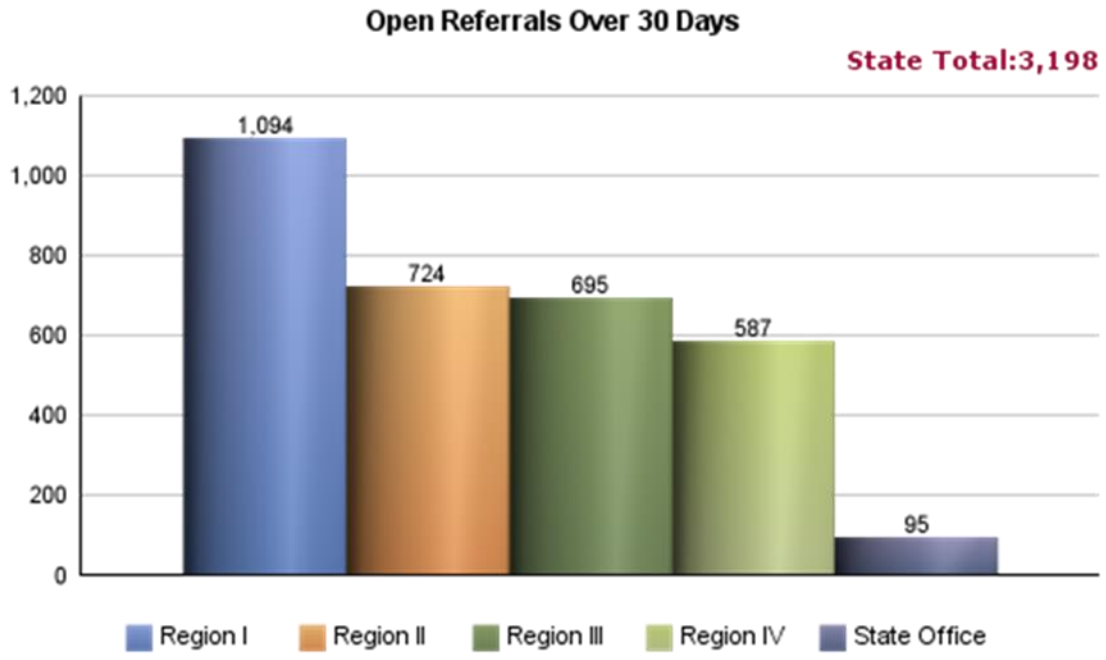
DPQI case review data



COGNOS Time to First Contact Report FFY 2015



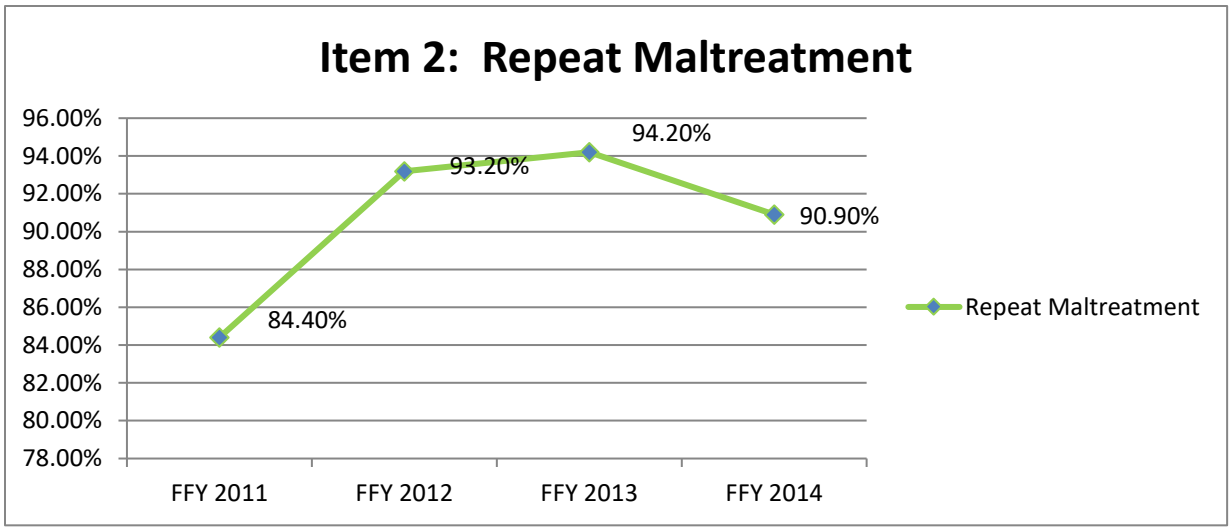
COGNOS Time to First Contact Report FFY 2016



COGNOS Point in Time Report 1/3/17

Safety 1: Repeat Maltreatment- the substantiation of recurrent reports of maltreatment

Repeat maltreatment indicator determines if any child in the family experiences substantiation of recurrent reports of maltreatment.



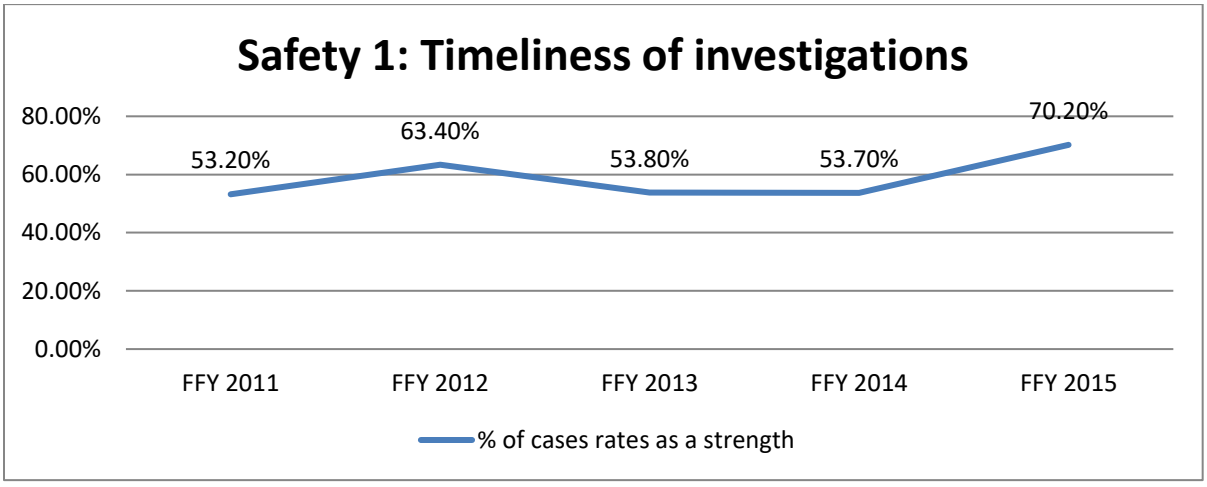
Based on the DPQI Child and Family Service Review data, the State appears to have a slight decline in the number of cases that rated as strength for Repeat Maltreatment.

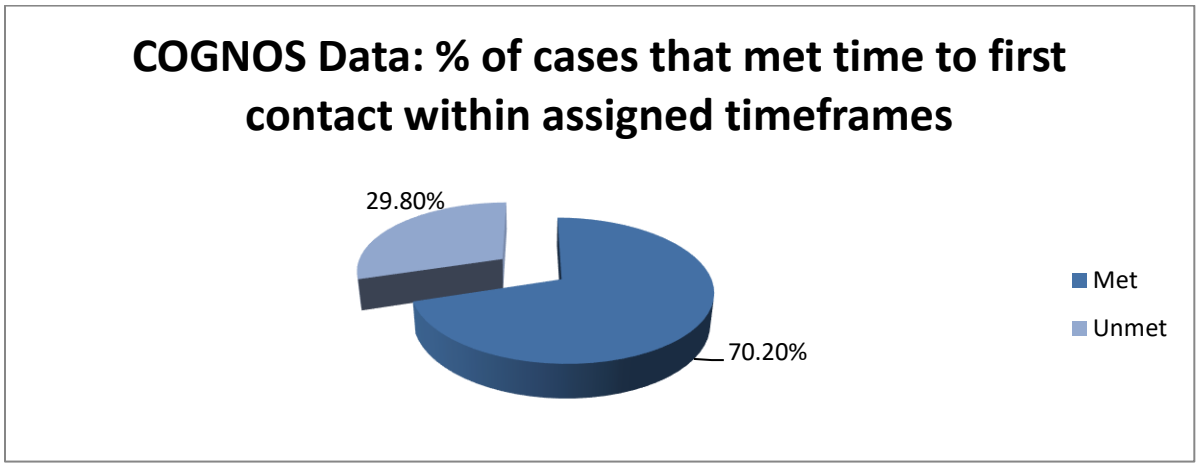
West Virginia's Contextual Data report indicates 97.7%. Measurement appears stable in the context of the larger sample.

1.1 Recurrence of Maltreatment Within 6 Months (%)				
	2010	**2011**	**2012**	**2013**
Children without a recurrence	95.6	97.6	97.6	97.7
Children with one or more recurrences	4.4	2.4	2.4	2.3
Number	**2,068**	**1,971**	**2,305**	**2,264**

2016 Update

Timeliness of initiating investigations of reports of maltreatment measures whether the assigned time frames were met on the Child Protective Service referrals received during the period under review. Data reflects the results of the CFSR style case reviews for FFY 2015. COGNOS reflects point in time data (2-8-2016).





2017 Update

CFSR Measure: Recurrence of Maltreatment

Of all children who were victims of a substantiated maltreatment report during a 12 month period, the percentages who were victims of another substantiated maltreatment report within 12 months will be 9.1% or less.

CFSR Round 3 Data Profile September 2016

FFY 2014-2015: 2.6% observed performance

FFY 2014-2015: 3.5% (risk standardized performance)

CFSR Measure: Maltreatment in Foster Care

Of all children in out-of-home care during a 12 month period, the victimization rate per 100,000 days of care will be 8.50 or less.

CFSR Round 3 Data Profile September 2016

FFY 2015: 1.7 observed performance

FFY 2015: 1.96 (risk standardized performance)

Assessment of Safety Outcome 1

The outcome rating for safety one based on DPQI case reviews for federal fiscal year 2015 indicate safety outcome one was substantially achieved in 70.2% of the cases reviewed, and not achieved in 29.8% of the cases reviewed. FFY data is based on case reviews completed from October 1, 2014 to September 30, 2015.

The outcome rating for safety one based on DPQI case reviews for federal fiscal year 2016 indicates safety outcome one was substantially achieved in 67.1% of the cases reviewed, and not achieved in 32.9% of the cases reviewed. FFY data is based on case reviews completed October 1, 2015 to September 30, 2016

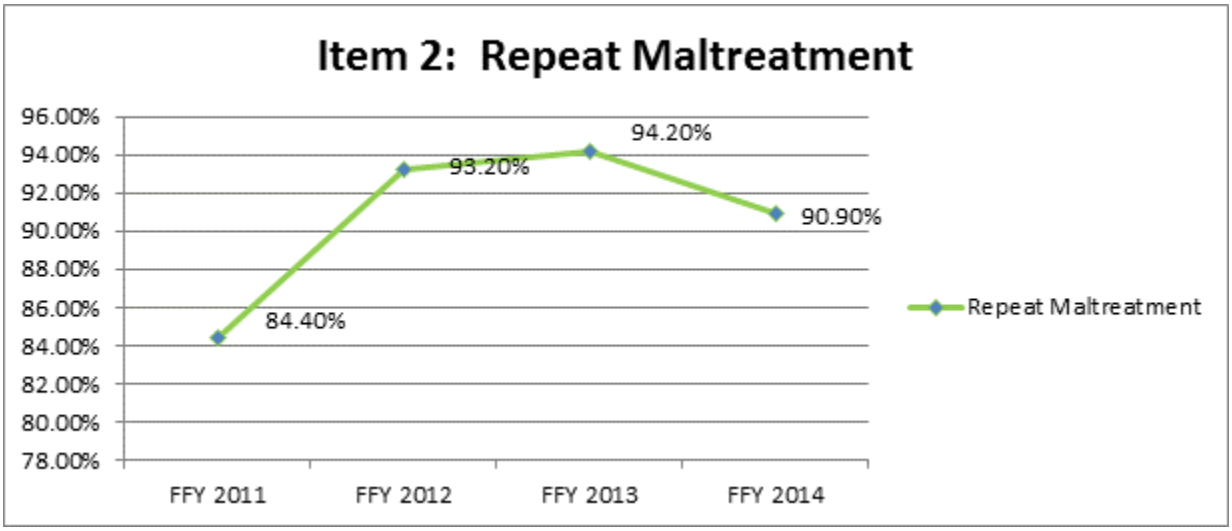
Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review. Case review data for Federal Fiscal Year 2015 and 2016 reflects completed and attempted contacts. COGNOS reports provide point in time data regarding the time to first contact. The Time to First Contact Report is monitored by the District Community Services Managers, Regional Directors, and the Deputy Director of Field Operations on a regular basis.

COGNOS report (Time to first contact report) indicates the number of assigned child maltreatment reports has increased each year between FFY 2013 and FFY 2016. The numbers of child maltreatment reports assigned for further assessment during the last three federal fiscal years were 17,538 in 2013; 19,115 in 2014; 21,620 in 2015; and

23,847 in 2016. There was a 36% increase in the number of child maltreatment reports assigned for further assessment between federal fiscal years 2013 and 2016.

Staffing levels during the period under review have a dramatic impact on how well districts perform on the DPQI case reviews. Districts with a high staff turnover rate score significantly lower on all measures. All of the districts reviewed in Federal Fiscal years 2015 and 2016 indicated staffing issues as a key factor contributing to the areas needing improvement. The lack of staff results in failure to initiate investigations of child maltreatment in a timely manner. It also creates a backlog of Family Functioning Assessments. COGNOS point in time data on 1/3/17 indicates a backlog of 3,198 referrals open over 30 days.

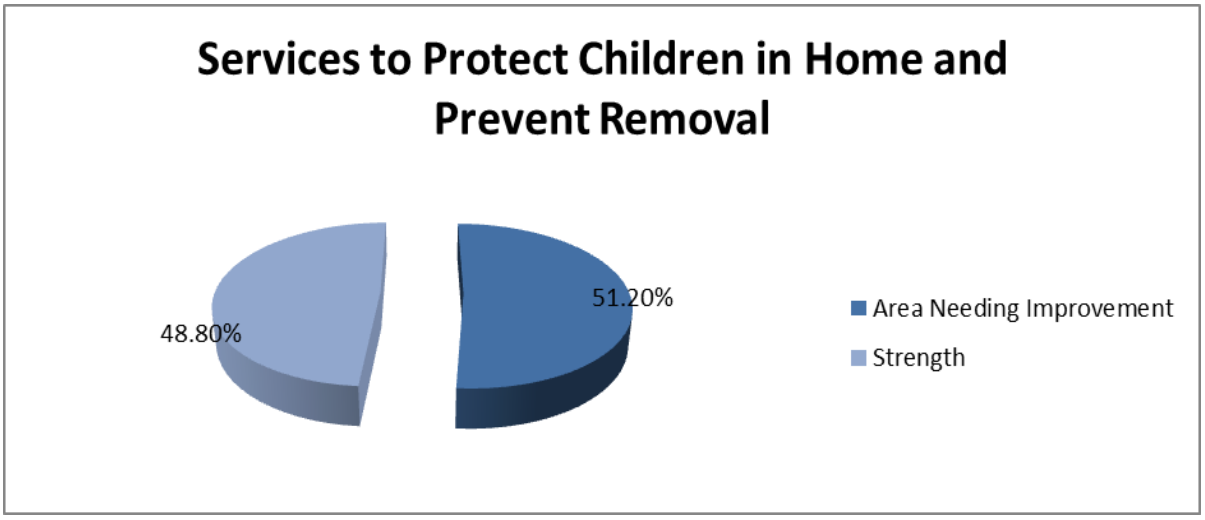
The West Virginia Department of Health and Human Resources (hereafter The Department) met the two CFSR safety data indicators. The Department met the national standard that 9.0% or less of children with a substantiated child maltreatment report had a second substantiated child maltreatment report within twelve months. The Department also met the national standard of 8.04 or less incidence of maltreatment in out-of-home care per 100,000 days in care. West Virginia's FFY 2015 risk standardized performance was 1.96, with an observed performance of 1.7.



Despite meeting the two CFSR safety data indicators, it appears from both the WV CFSR RD. 3 Data Profile and case review data that West Virginia is substantially below the 95% compliance threshold. To address this issue West Virginia has developed crisis teams. These CPS workers are not assigned to a district, but rather are available to assist districts experiencing a backlog of Family Functioning Assessments. The Commissioner

can also direct districts to provide additional staff to those experiencing a backlog. Some Regional Directors have initiated backlog reduction plans. These plans include a percentage backlog reduction goal. District managers develop plans to reach these goals. In addition, a Crisis Response Process and Crisis Response Worksheet

have been developed to support districts in addressing critical CPS workload situations. This process is designed to assist field staff in taking actions to identify and correct caseload issues that may generate a backlog. Features of the process include the ability to assess families using a shortened FFA format if no impending dangers are identified, and ensuring the timely documentation of all casework completed so it will not have to be redone if a staff member resigns from the agency. The Crisis Response Process and Worksheet were implemented in the fall of 2016. Therefore data on the efficacy of the process is unavailable.



Safety 2: Children are safely maintained in their homes whenever possible and appropriate.

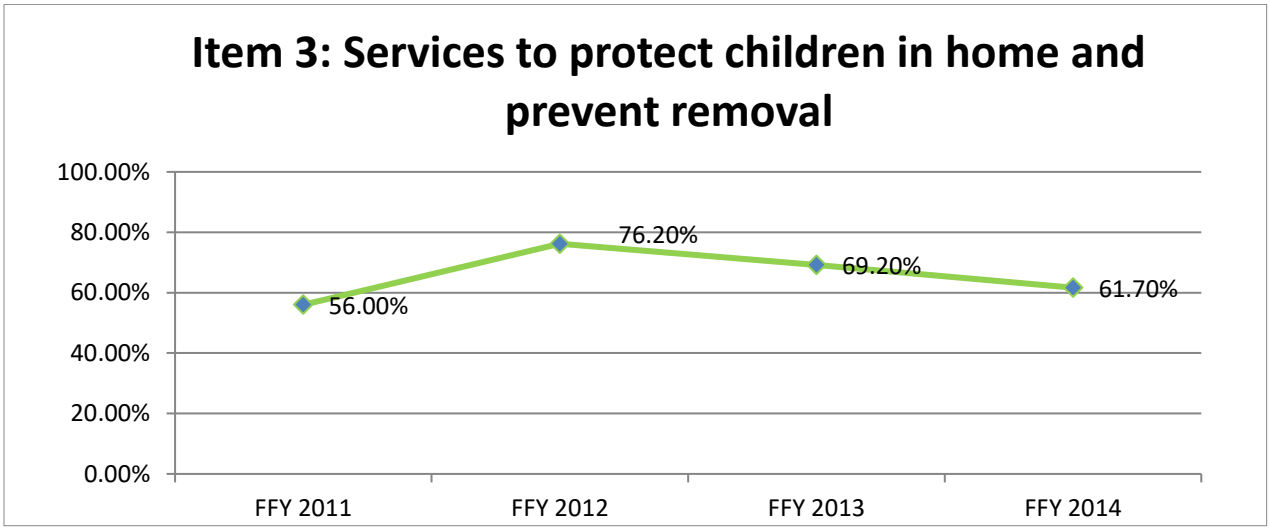
Outcome Safety 2 is measured by two measurement indicators: Items 3 and 4 of the 2008 CFSR measurement instrument. The outcome rating for safety 2 based on case reviews for federal fiscal year 2014 indicate safety outcome 1 was substantially achieved in 31.5% of the cases reviewed, and partially achieved in 21.8 % of the cases reviewed.

2016 Update

Outcome Safety 2 is measured by two measurement indicators: Items 2 and 3 on the 2014 Federal CFSR Onsite Review Instrument. The outcome rating for safety 2 based on case reviews for federal fiscal year 2015 indicate safety outcome 2 was substantially achieved in 33.8% of the cases reviewed, and partially achieved in 23.9% % of the cases reviewed. This item will not be compared to previous data as the measurement for this item has changed based on the revisions to the CFSR instrument and instructions.

Safety 2: Services to families to protect child(ren) in their homes and prevent removal.

Item 3 is a measurement of services to protect children in the home and prevent removal or reentry into foster care. It should be noted that if services would not have been able to ensure the child's safety and the only alternative was to place the child in care, then the measure would be rated strength.



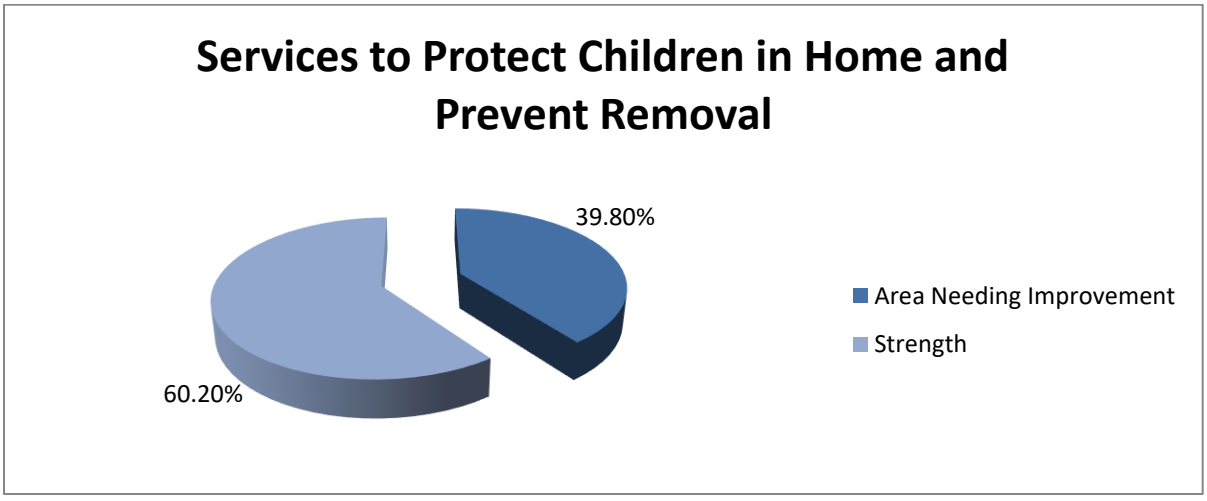
The social service reviewers found several factors contributing to the Areas Needing Improvement for this measure. Though there continues to be an increase in safety planning, the adequacies of the provision outlined in the plan fail to control for safety. Additionally, there was also a lack of contact with the family afterwards to ensure that the safety plan was effective. Safety services were often initiated but not continued in the ongoing work of the case. Services placed in the home do not match the issues identified in the assessment for safety, and/or services were not referred into the homes in a timely manner.

It should be noted domestic violence was often identified in safety plans but not addressed through services. This is also the case with the identification of parental substance abuse.

2016 Updates

Item 2 which entails the initial service provision for the family to protect child(ren) in the home and prevent removal or reentry into foster care after a reunification. The item assesses whether services were provided immediately to ensure safety in the home and/or whether the removals were necessary due to imminent danger. It should be noted that if this item is rated strength if the services provided would not have ensured the child's safety therefore requiring the child to be placed in care.

This item also assesses for repeat maltreatment. WV's CFSR style case reviews indicated this measurement was rated as strength in 60.2% of the cases reviewed in FFY2015.



The social service reviewers found several factors contributing to the areas needing improvement for this measure. In home safety plans continue to be inadequate as the provisions outlined in the plan fail to control for safety. Services placed in the home do not match the issues identified in the assessment for safety, and/or services were not referred into the homes in a timely manner. Furthermore, safety plans are not reviewed on a regular schedule and updated as needed when things change.

Domestic violence is often identified in safety plans but not addressed through services. Often ASO "parenting" is placed into the home as a catch all for addressing all identified

issues. The intent of the services is for parent education, and does not control for safety. There appears to be a wide spectrum on how this service in being implemented.

Districts note that limited services to address substance abuse issues are also a factor in controlling for safety. Lack of effective outpatient treatment programs paired with high rates of substance abuse impacts the Agency's ability to control for safety in the home. In 24 of the 129 cases applicable for this measure, the child was removed from the home as services could not control for safety.

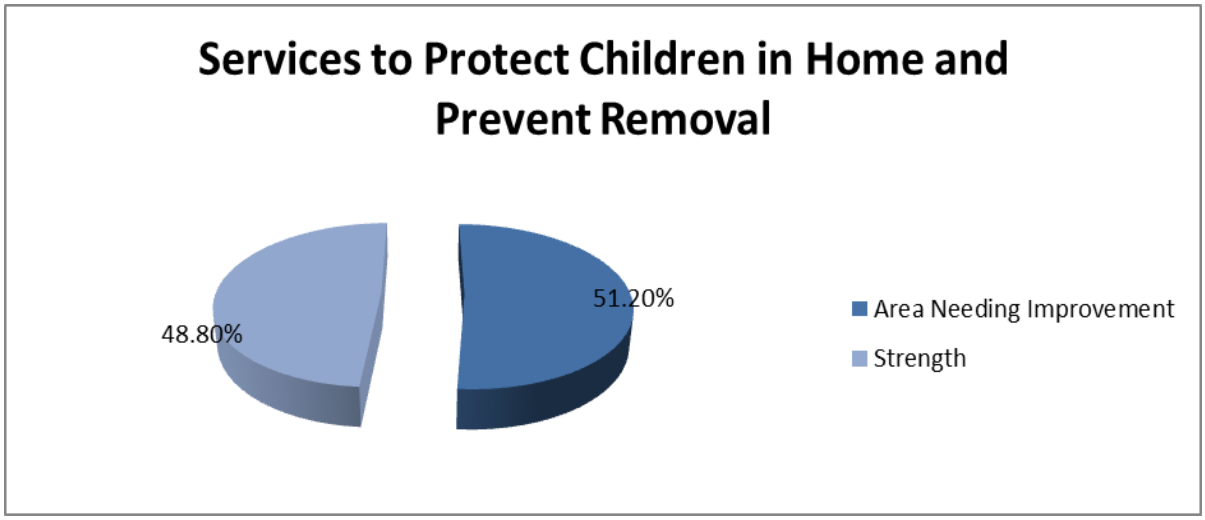
2017 Update

CFSR Item 2: Services to families to protect children in the home and prevent removal or re-entry into foster care.

DPQI Quality Assurance Case Review Data

FFY 2015: 60.2%

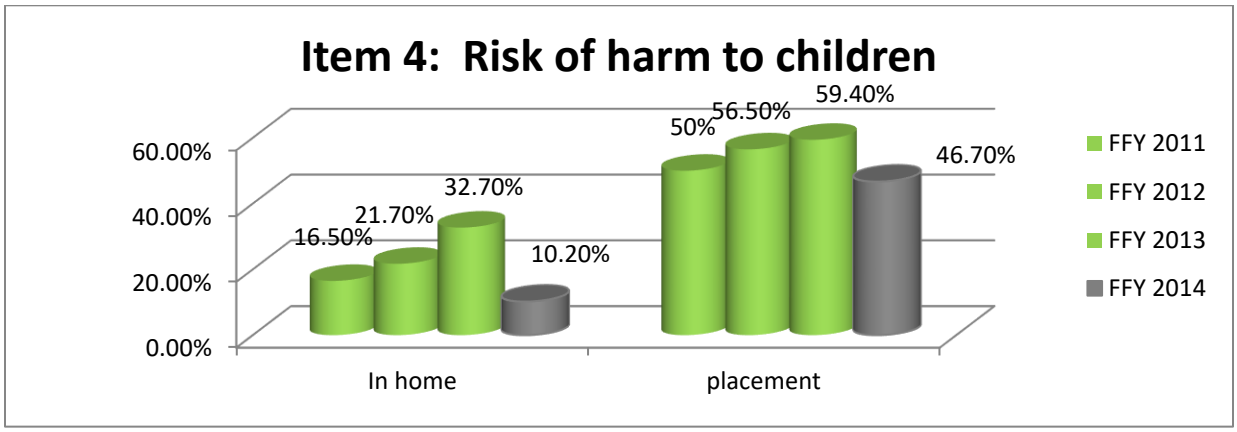
FFY 2016: 48.8%

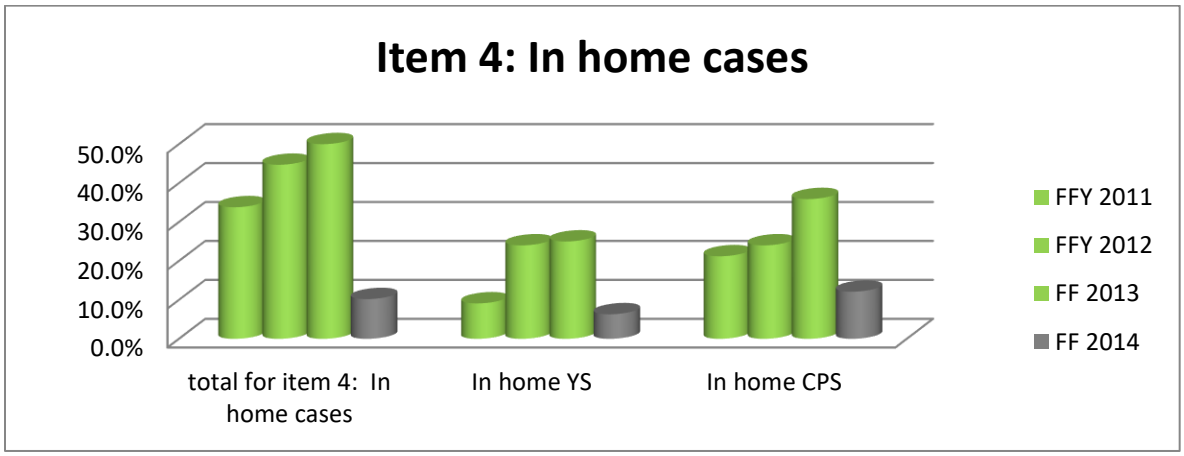


FFY 2016 DPQI case review data

Safety 2: Risk of harm to children

Item 4 is a measurement of risk assessment and safety management. This item addresses the Agency's concerted efforts to assess and address the risk and safety concerns to the child(ren) in their homes or while in foster care. Review of this measurement addresses what services were put into place to reduce or eliminate risk. Review of this measurement addresses ongoing risk assessment.





Data suggests that children in non-placement cases, both youth services and child protective service cases, are being continuously assessed for risk and safety at a low rate. This measure is impacted by the lack of visits to the home to assess all the children in the home. The lack of on-going assessments during the in-home portion of the cases is reflected in the rating of the placement cases. The period under review for federal fiscal year 2014 remained at 14 months prior to the date of the review. Children in placement are being seen on a regular basis and DPQI reviews indicate a continued improvement in workers' ability to assess the child's needs and safety.

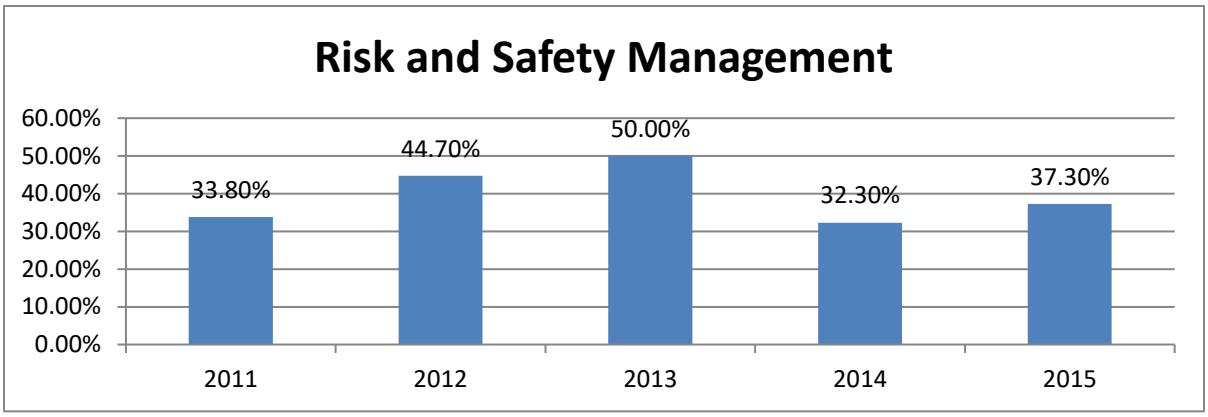
Risk to children in the home is not being formally or informally assessed in non-placement cases. This measure is also impacted by the lack of appropriate services put into the home to address the identified safety concerns. Primarily services to address domestic violence and parental substance abuse are inadequate. Cases reviewed also indicate that delays in initiating services and delays in filing petitions contributed to this measurement's decline. It should be noted that several of the districts reviewed in Federal Fiscal year 2014 had significant staffing shortages at the time of the reviews.

Social service reviewers identified several factors that contributed to the areas needing improvement in safety outcome measurement S2. There were more cases in which initial safety was assessed in a thorough manner; however, the practice was not carried into the ongoing casework. Although there are more cases where safety plans are developed, there continues to be a lack of contact made with the family afterwards to ensure that safety was continuing to be maintained. Social service reviewers also found that when visits do occur, the worker frequently fails to assess all the children in the home. Furthermore, workers experience difficulties in visiting with all the children on their caseloads as they are frequently traveling to visit with the children in placement. This limits the amount of time they have to make all their required contacts on in home cases.

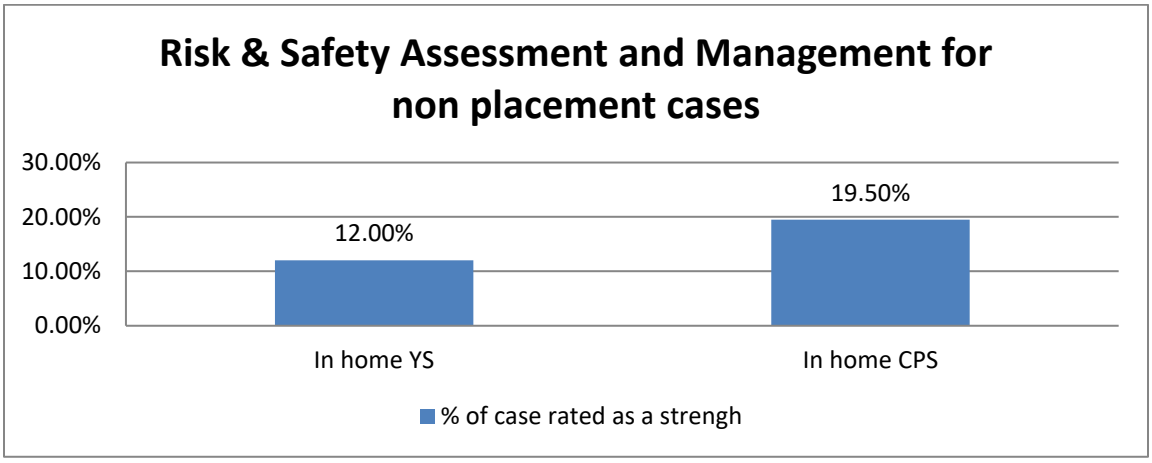
Risk and safety for child protective services placement cases are being assessed on a regular basis. This has greatly improved using the "dashboard" tracking system.

2016 Updates

Based on the July 2014 version of the Child and Family Services Review Instrument, Item 3 is a measurement of risk assessment and safety management. Item 3 evaluates the efforts to assess and address risk and safety concerns for children in their own homes or in foster care. Reviewers consider ongoing safety assessments, safety plans, and service provision throughout the course of the period under review. This item addresses the Agency's concerted efforts to assess and address the risk and safety concerns to the child(ren) in their homes or while in foster care. This item is comparable to item four from prior case review data.



Data suggests that children in non-placement cases, both youth services and child protective service cases, are being continuously assessed for risk and safety at a low rate. This measure is impacted by the lack of visits to the home to assess all the children in the home. Lack of on-going assessments during the in-home portion of the placement cases cause the cases to rate as an area needing improvement.



Risk to children in the home is not being assessed in non-placement cases. Due to lack of contact with families, cases are not being monitored to ensure safety plans are controlling safety. Social service reviewers found that worker rely heavily on the in-home service providers to keep them informed of the issues in the homes.

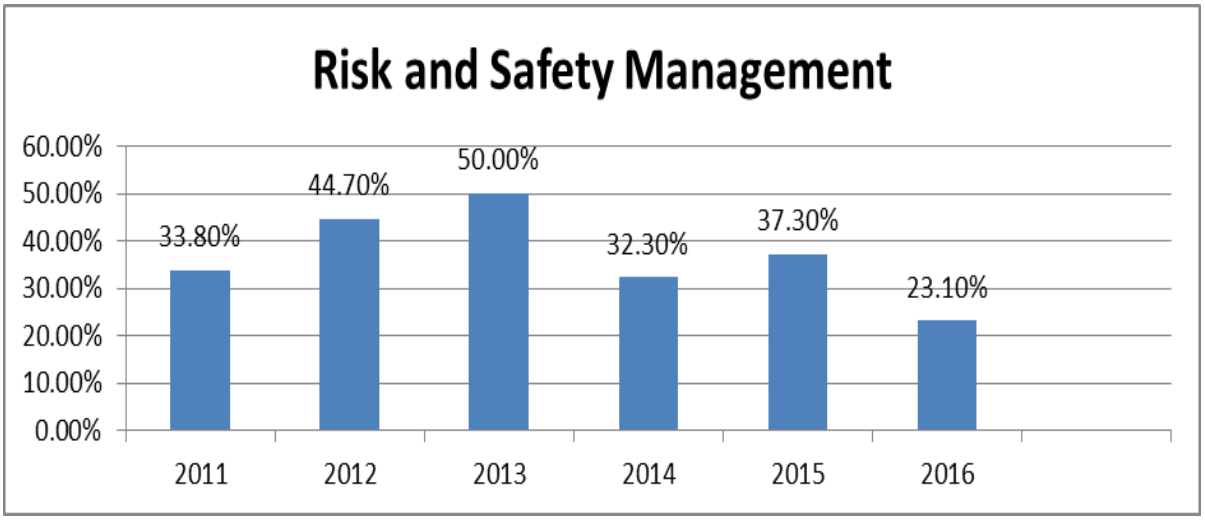
2017 Update

CFSR Item 3: Risk and Safety Assessment and Management

DPQI Quality Assurance Case Review Data

FFY 2015: 37.3%

FFY 2016: 23.1%



DPQI case review data

Assessment of Safety Outcome 2

Outcome Safety 2 is measured by performance on Items 2 and 3 on the 2016 Federal CFSR Onsite Review Instrument. The outcome rating for Safety 2 based on case reviews for federal fiscal year 2015 indicate Safety Outcome 2 was substantially achieved in 33.8% of the cases reviewed, and partially achieved in 23.9% of the cases reviewed. Federal fiscal year 2016 case reviews indicate Safety Outcome 2 was substantially achieved in 22.4% if the cases reviewed, and partially achieved in 16.8% of the cases reviewed respectively.

Most children in placement entered foster care to ensure their safety. However, DPQI case review findings indicate West Virginia is missing opportunities to impact family risks before they become safety threats necessitating removal, and to monitor child safety in

the home while the parents receive services to achieve behavioral change. Case reviewers found that in-home safety plans are often inadequate to control the factors impacting child safety. Case reviews also indicate that safety plans are not being reviewed regularly and updated as circumstances in the case warrant. In addition, safety related services placed in the home don't always match the identified safety threat, and/or services are not referred into the homes in a timely manner. An example, domestic violence is often identified in safety plans but not addressed through service provision. ASO "parenting" is placed into the home as a catch all for addressing all identified issues. The intent of the services is for parent education, and does not control for safety. There appears to be a wide spectrum on how this service is being implemented.

Districts note that substance abuse is a major factor impacting child safety and risk in most child abuse and neglect cases. Limited services to address substance abuse issues are a factor in controlling for safety. Lack of effective outpatient treatment programs paired with high rates of substance abuse impacts the Department's ability to control for safety in the home.

Permanency Outcomes 1 and 2

Permanency 1: Children have permanency and stability in their living situations

Permanency Outcome 1 incorporates six indicators into the assessment process. The indicators pertain to the child welfare agency's efforts to prevent foster care reentry; provide stability for children in foster care; and the development and establishment of appropriate permanency goals for children in foster care to ensure permanency. The remaining indicators focus on the agency's efforts to achieve the child's permanency goals.

The outcome rating for permanency 1 based on case reviews for federal fiscal year 2014 indicate permanency outcome 1 was substantially achieved in 46.7 % of the cases reviewed, and partially achieved in 52.0% of the cases reviewed. As reflected in the CFSR style case review data, West Virginia continues to make improvements to achieve permanency.

There are many factors that need to be considered when reviewing the data related to the achievement of permanency for West Virginia's children.

The Adoption and Safe Families Act established that the termination of parental rights should occur within a 22-month timeframe following placement. Barriers to achieving this measure are primarily the delays in the court process, such as extended improvement

periods and parents being adjudicated at separate times. WV State code allows for the Court to extend a parent's post-adjudicatory or post-dispositional improvement period for 90 days or longer after they have had two 90-day improvement periods in either or both the post-adjudicatory and post-dispositional time periods. These extensions may occur due to case circumstances such as: waiting for paternity testing, multiple fathers named, parents remaining in rehabilitation programs, parents who are incarcerated but are expected to be released during the court case, or even personal or weather related events that delay a hearing or hearings.

Additionally, if one or more parents are adjudicated at separate times due to case circumstances, such as paternity being established 6 months into the case, or an absent parent being located several months into the case, the parents will be on different timelines, and the case will last much longer. For example, Parent 1's case should end within the regular court dates, but the addition of 6 months for Parent 2 may add that much time to their court hearing timeline, and lengthen the child's time in custody and care. It is not unusual for the parents in the court case to be on separate timelines.

Despite these barriers West Virginia continues to make progress in achieving permanency for children. Data collected by the Supreme Court of Appeals of West Virginia also indicates an improvement in the time it takes for children involved in abuse and neglect proceedings to reach a permanent living placement.

2016 Updates

Permanency Outcome 1 incorporates three indicators into the assessment process. The indicators pertain to the stability of child(ren) in foster care placements, the timely establishment of permanency goals, and the achievement of the permanency goals.

The outcome rating for permanency 1 based on case reviews for federal fiscal year 2015 indicate permanency outcome 1 was substantially achieved in 40.8 % of the cases reviewed, and partially achieved in 52.6% of the cases reviewed. As reflected in the CFSR style case review data, West Virginia continues to make concerted efforts to achieve permanency in a timely manner.

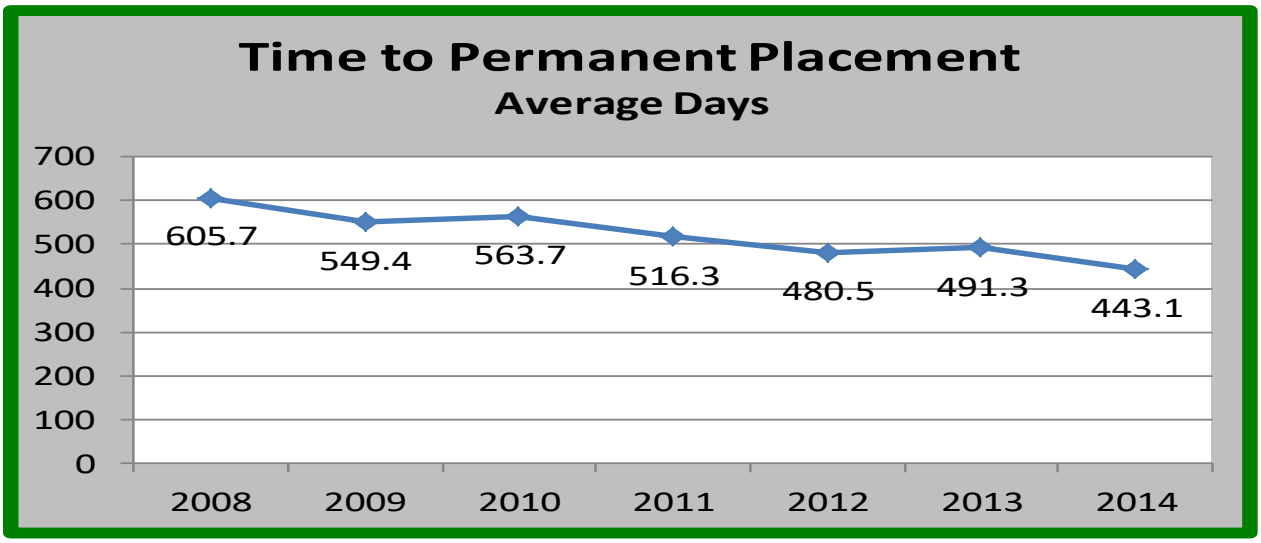
The time it takes for children involved in abuse and neglect proceedings to reach a permanent living placement has been reduced significantly over the last eight years based a review of the data.

2017 Updates

BCF has policy and homefinding staff that attend monthly Recruitment and Retention meetings with the specialized foster care agencies and Mission WV, to discuss recruitment updates and events.

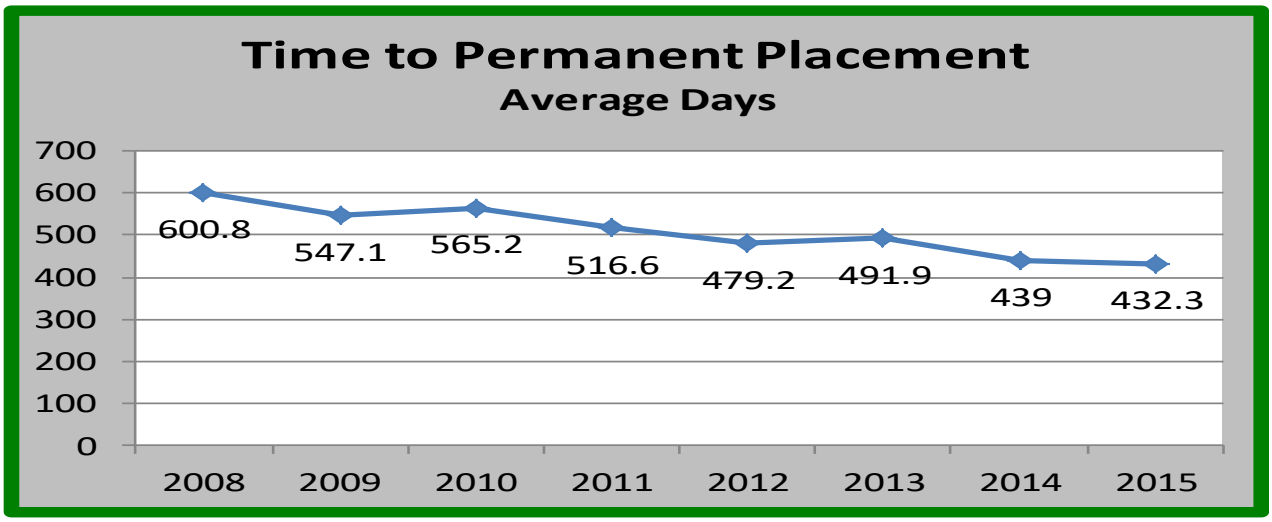
Judicial Performance Measure Trends

According to data collected by the Supreme Court of Appeals of West Virginia, the time it takes for children involved in abuse and neglect proceedings to reach a permanent living placement has been reduced significantly over the last seven years. For children who reached permanency through court proceedings during 2008, it took just over twenty months on average to complete judicial proceedings and find a sufficient permanent placement for the child. As demonstrated in the chart below, during 2014, the average was reduced by thirty three percent (approximately five months). With many children involved in such proceedings being placed away from home, a swifter process expedites access to a stable, permanent living arrangement. Permanency is considered to have been accomplished when a child has reached any one of the federally accepted permanency goals including: reunification with parents/guardians, adoption, legal guardianship, placement with a fit and willing relative, or emancipation.



2016 Updates

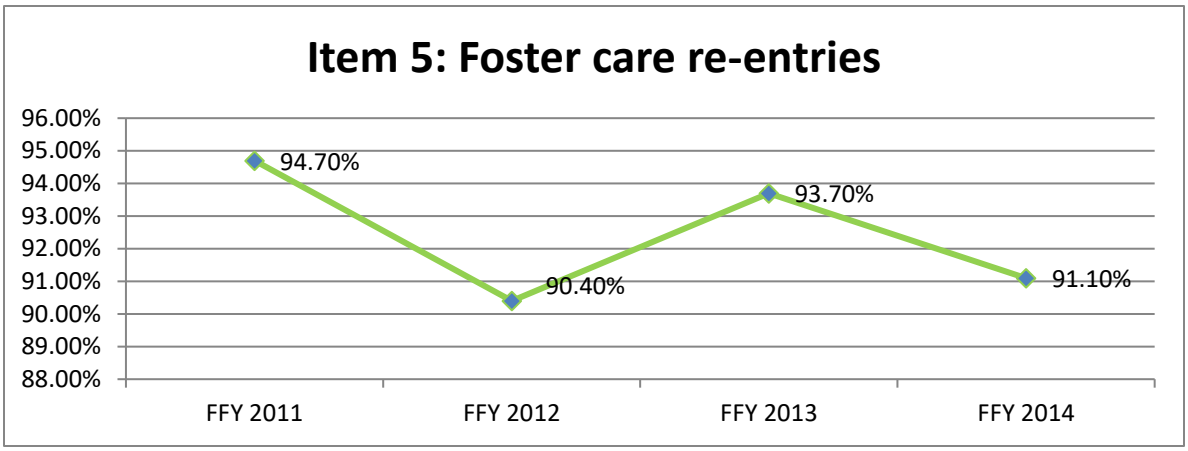
According to data collected by the Supreme Court of Appeals of West Virginia, the time it takes for children involved in abuse and neglect proceedings to reach a permanent living placement has been reduced significantly over the last eight years. For children who reached permanency through court proceedings during 2008, it took just over twenty months on average to find a permanent placement for the child. As demonstrated in the chart below, during 2015 the average was reduced by twenty eight percent (approximately six months). Permanency is considered to have been accomplished when a child has reached any one of the federally accepted permanency goals including: reunification with parents/guardians, adoption, legal guardianship, placement with a fit and willing relative, or emancipation.



Note: Chart obtained from data collected by the Supreme Court of Appeals of West Virginia

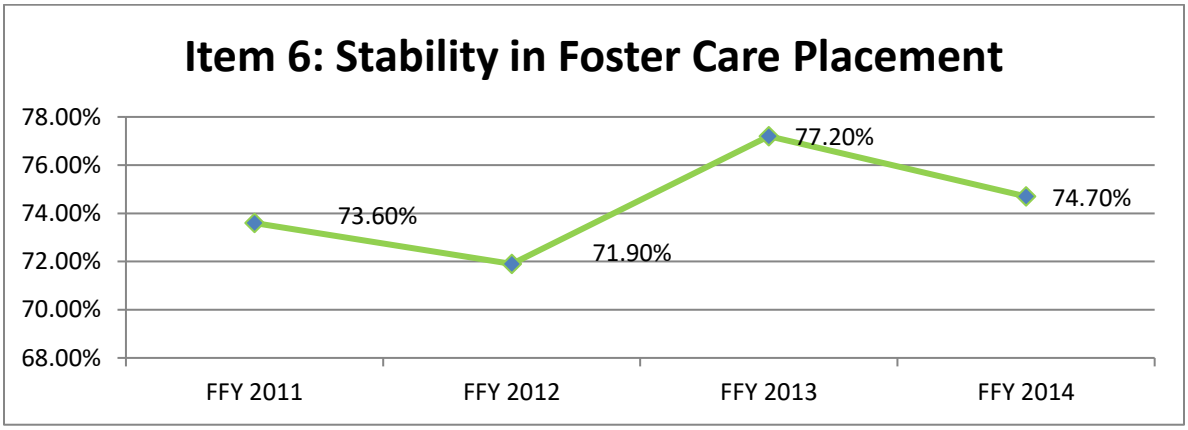
Permanency 1: Foster Care Reentries

Social service reviews indicate that WV is maintaining the foster care re-entry rate. In Federal Fiscal Year 2011, 94.7% of cases rated strength, in the Federal Fiscal Year 2014, 91.10% of the cases rated strength, indicating that the Agency continues to make concerted efforts to provide services to families to prevent the children's re-entry into foster care or re-entry after reunification within a 12-month period from the prior discharge.



Permanency 1: Stability in Foster Care Placement

Social Service Reviews also indicate that West Virginia had a slight decline in the rate of stability of foster care placements as indicated below.



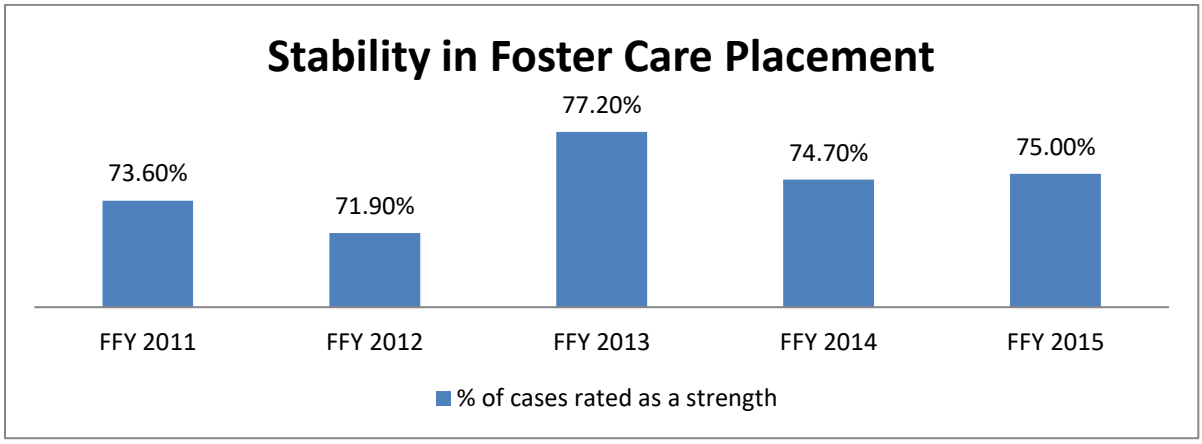
The decline in foster care placement stability is related to the use of shelter care and the unavailability of foster care beds at the time of placement. All regions reported a lack of foster homes. They noted a lack of homes that are willing to accept older children, children with severe behavioral issues, and large sibling groups. Furthermore, reviews indicate that when placement changes are needed, the moves are reflective of a planned move necessary to address the child's needs that may not have been evident at the time of initial placement.

Social Service reviews indicate that workers are making concerted efforts to place children in the homes of relatives when possible. This practice is believed to contribute to the stability of the placements.

West Virginia continues to have many children entering care; therefore, increasing the need for more foster care homes. West Virginia continues to work on the recruitment and retention of foster care homes.

2016 Updates

Social Service Reviews indicate that West Virginia has made improvements in stability of foster care placements as indicated below. (Note: data comparison over the last five FFY's utilized the 2008 version of the OSRI for FFYs 2011-2014 and the 2014 version of the OSRI for FFY 2015; item numbers vary based on the difference in the Onsite Review Instruments)



The stability in foster care placements is directly related to the availability of homes. Cases that rate as an area needing improvement for this measurement are due to the use of shelter care and the lack of foster care beds at the time of placement.

All regions reported a lack of foster homes. They noted a lack of homes that are willing to accept children with severe behavioral issues, developmental disabilities, or large sibling groups. Social Service reviews continue to indicate that workers are making concerted efforts to place children with relatives when possible.

West Virginia continues to work on the recruitment and retention of foster care homes. WV is working with the specialized foster care agencies to recruit families.

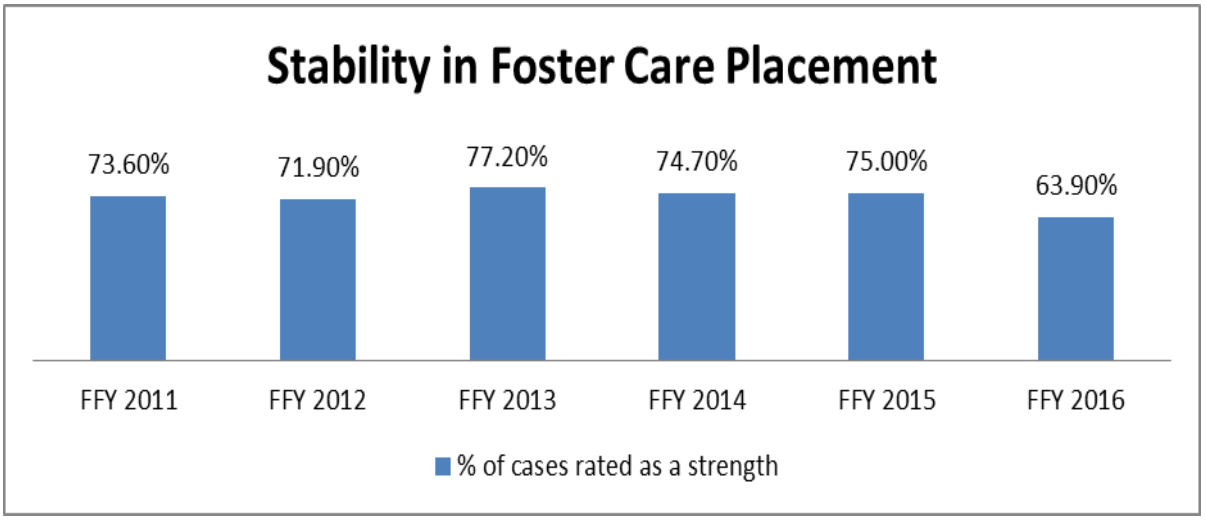
2017 Update

CFSR Item 4: Stability of Foster Care Placement.

DPQI Quality Assurance Case Review Data

FFY 2015: 75.0%

FFY 2016: 63.9%



DPQI case review data

<u>CFSR Measure: Placement Stability</u>

Of all children who enter care in a 12-month period, the rate of placement moves, per 1,000 days of out-of-home care will be 4.12 or fewer.

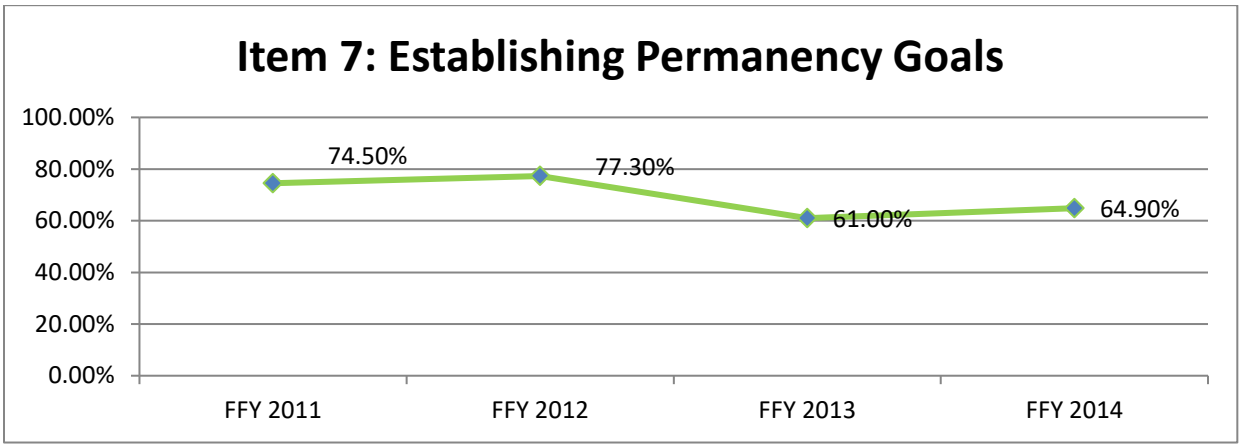
CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 3.34 observed performance

FFY 2015b2016a: 3.18 risk standardized performance

Permanency 1: Establishing Permanency Goals

West Virginia has made a gradual increase in establishing appropriate permanency goals in a timely manner. Data indicates a 3.9 % increase in the number of cases that rated as strength for establishing permanency goals in a timely manner.

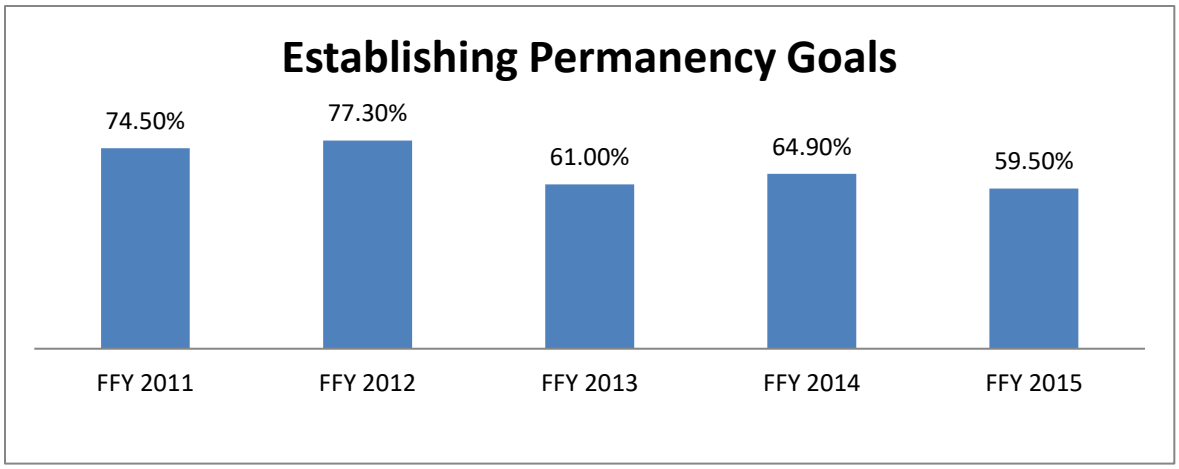


Field staff has made concerted efforts to review permanency goals and develop more appropriate goals. Districts with active Multidisciplinary Teams (MDTs) are more likely to address the continued need for permanency planning throughout the life of the case. Permanency planning is reflected in the uniform case plans.

Cases that rated as an area needing improvement are related to the goals not being documented in the case file in a timely manner, or goals that have not been changed to reflect the status of the case.

2016 Update

In FFY 2015, West Virginia has increased in the amount of time to establish permanency goals. Data indicates a 5.4% decrease in the number of cases that rated as strength for establishing permanency goals in a timely manner.



Cases that rated as an area needing improvement are related to the goals not being documented in the case file in a timely manner, or goals that have not been changed to reflect the status of the case.

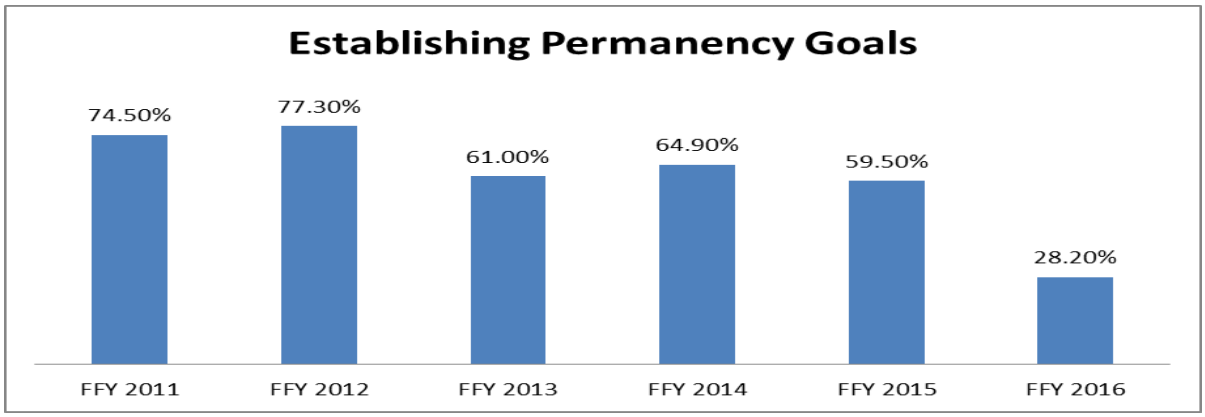
2017 Update

CFSR Item 5: Permanency goal for the child

DPQI Quality Assurance Case Review Data

FFY 2015: 59.5%

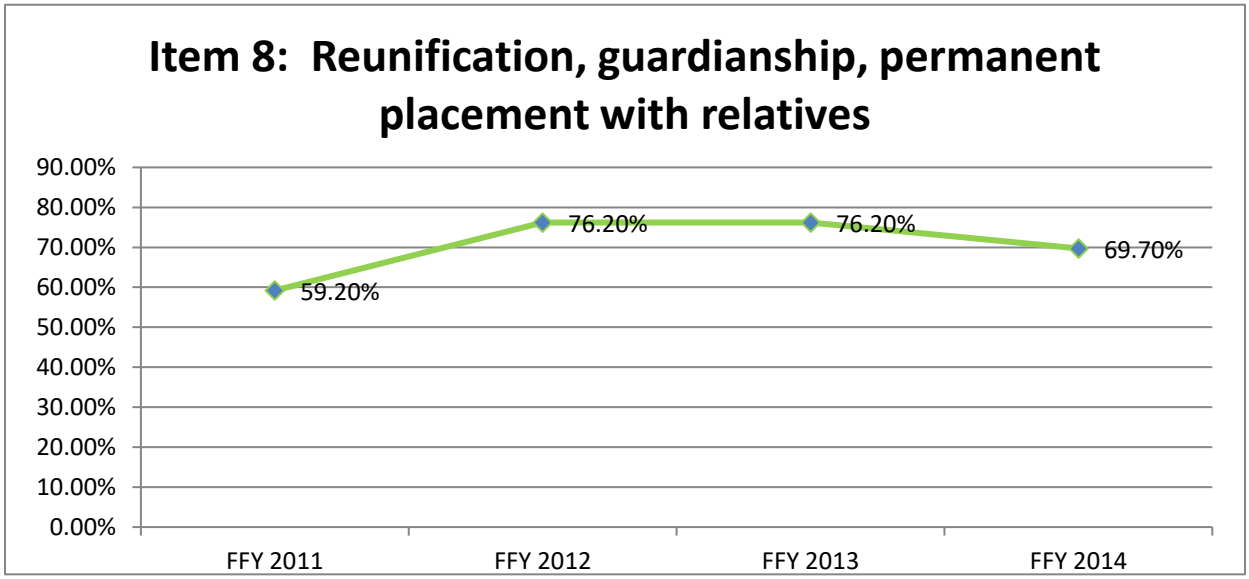
FFY 2016: 28.2%



DPQI case review data

Permanency 1: Permanency goal of reunification, guardianship, permanent placement with relatives.

Of the cases reviewed in federal fiscal year 2014, 69.70% indicated that acceptable progress was being made toward the achievement of permanency goals of reunification, permanent placement with a relative, or guardianship (Item 8). This measure looks at whether this permanency goal for the child has been achieved and/or effort by the agency/court within 12 months. It also addresses if efforts are being made to work the concurrent plan.



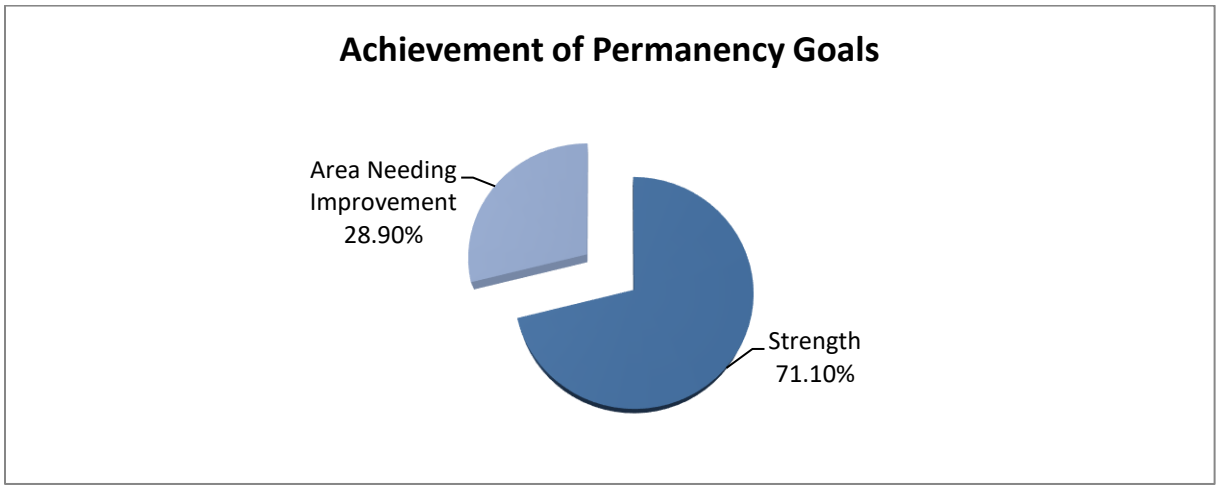
Case reviews indicate the decline in this measurement is related to the length of time in care without achieving permanency. Additionally, this measure is impacted by the lack of implementation of concurrent goals. Often concurrent goals are not being worked until after the primary permanency plan has failed.

WV foster care policy section 4.5 addresses the use of concurrent planning. As outlined in policy, “all children whose permanency plan is reunification must have a concurrent permanency plan. For other children, concurrent planning should be utilized to expedite the achievement of permanency for these children.” (WV BCF FC policy page 107). Unfortunately, concurrent plans are viewed too often as consecutive plans and are not pursued concurrently.

2016 Updates

Of the cases reviewed in federal fiscal year 2015, 71.1% indicated that acceptable progress was being made toward the achievement of permanency goals. This item will not be compared with prior federal fiscal years' data as the measurement has changed as the result of the changes in the OSRI.

Federal guidelines for permanency indicate reunification should occur within 12 months; guardianship within 18 months; and adoption within 24 months.



West Virginia's case review data indicates cases that rate as an area needing improvement are the result multiple factors. One factor that impacts this measure is the lack of implementation of concurrent goals. Often concurrent goals are not being worked until after the primary permanency plan has failed. Other factors include lack of working with both parent(s) creating delays in the termination of parental rights and extended lengths of time from termination of parental rights to finalization of adoption. Despite the delays West Virginia continues to make improvements to reduce the time to permanency for children.

Supreme Court of Appeals of West Virginia's data used in conjunction with WV's Social Services review data provides a more extensive data set when measuring the achievement of the permanency goals. The Supreme Court of appeals data indicates (on average) the amount of time it takes children to reach permanency over the course of the last eight years has dropped by 168.5 days.

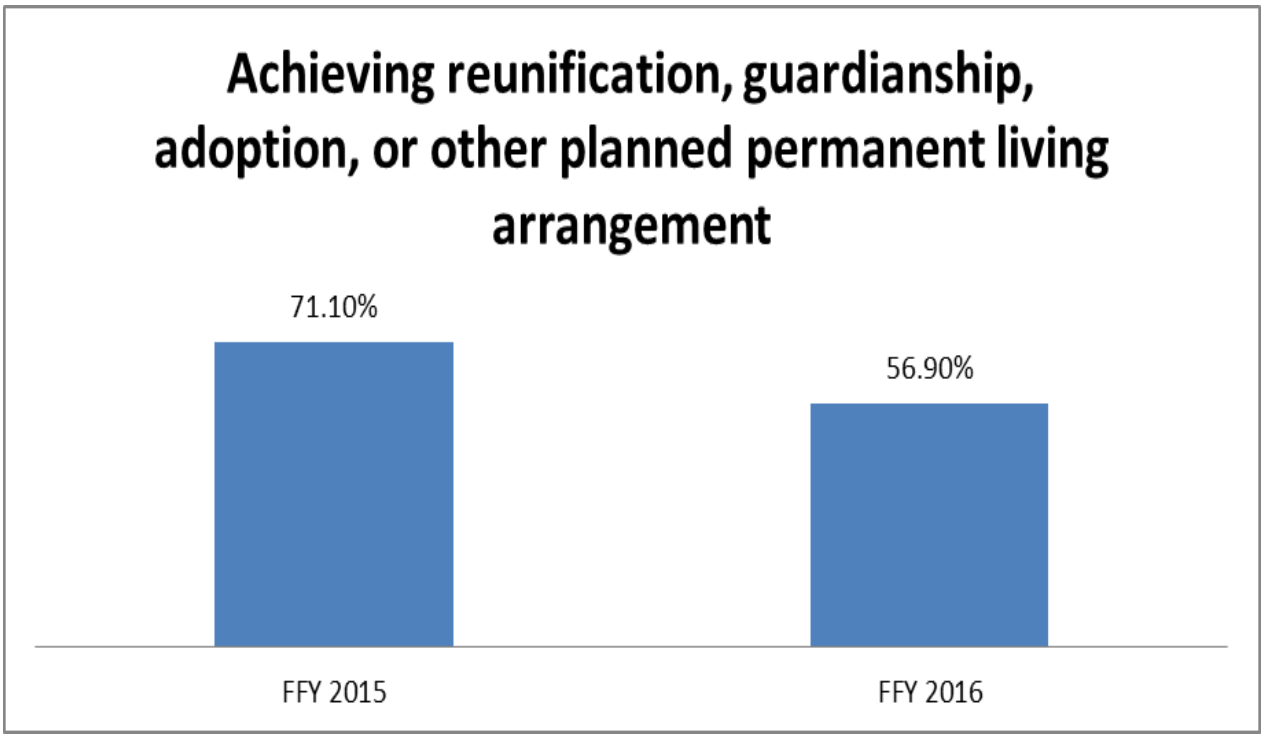
2017 Update

CFSR Item 6: Achieving reunification, guardianship, adoption, or other planned permanency living arrangement.

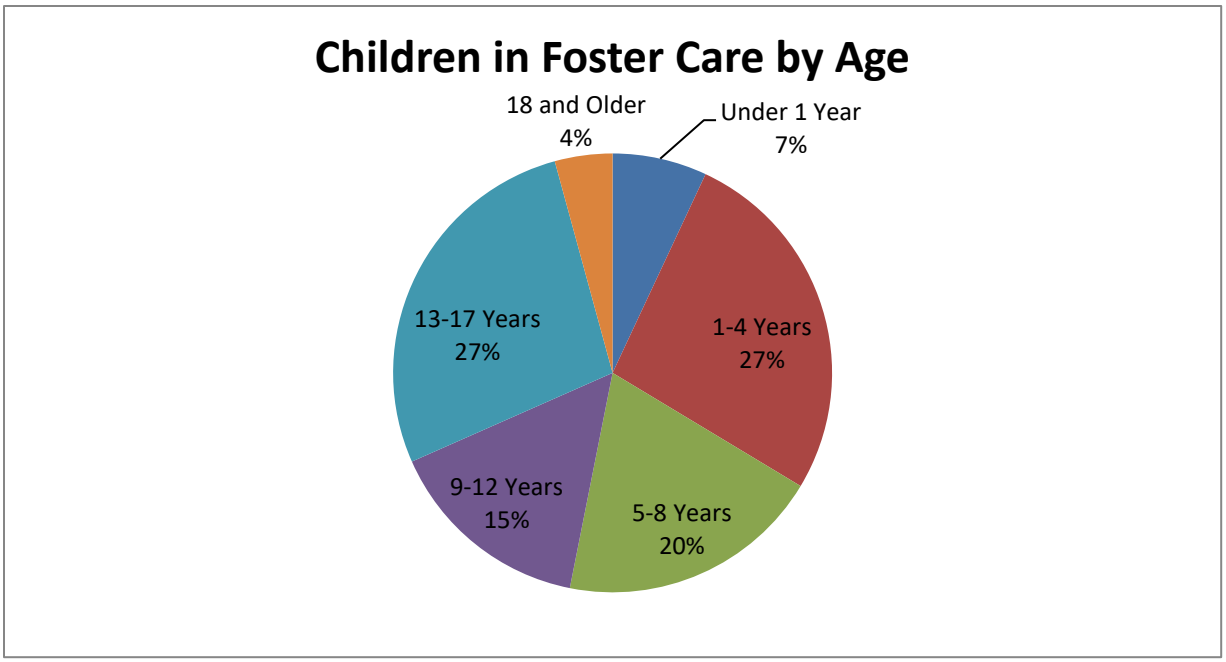
DPQI Quality Assurance Case Review Data

FFY 2015: 71.5%

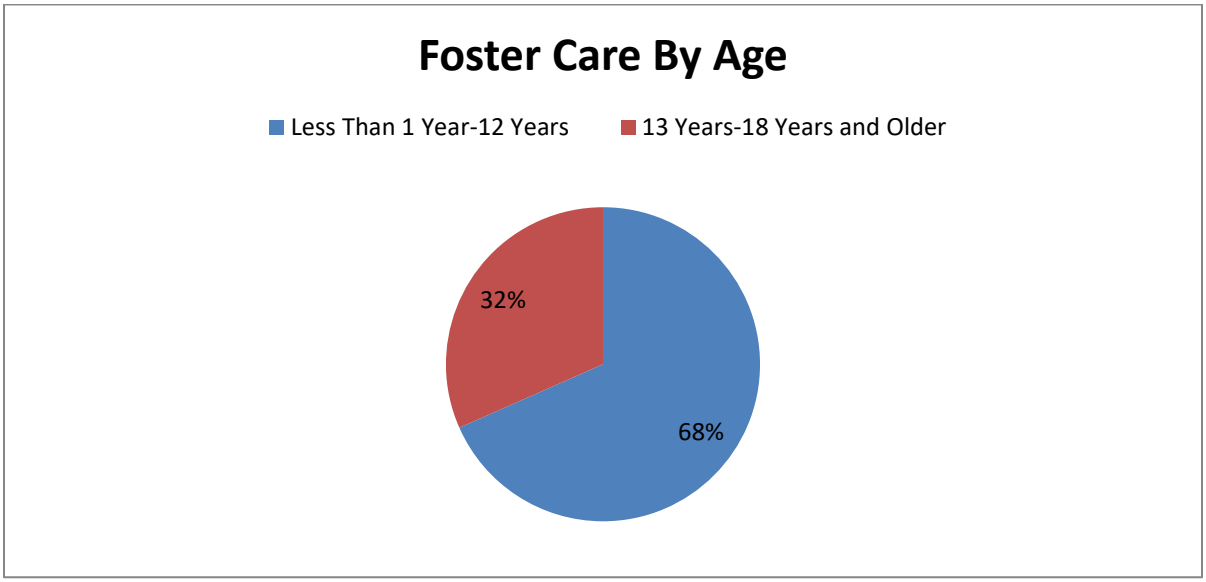
FFY 2016: 56.9%



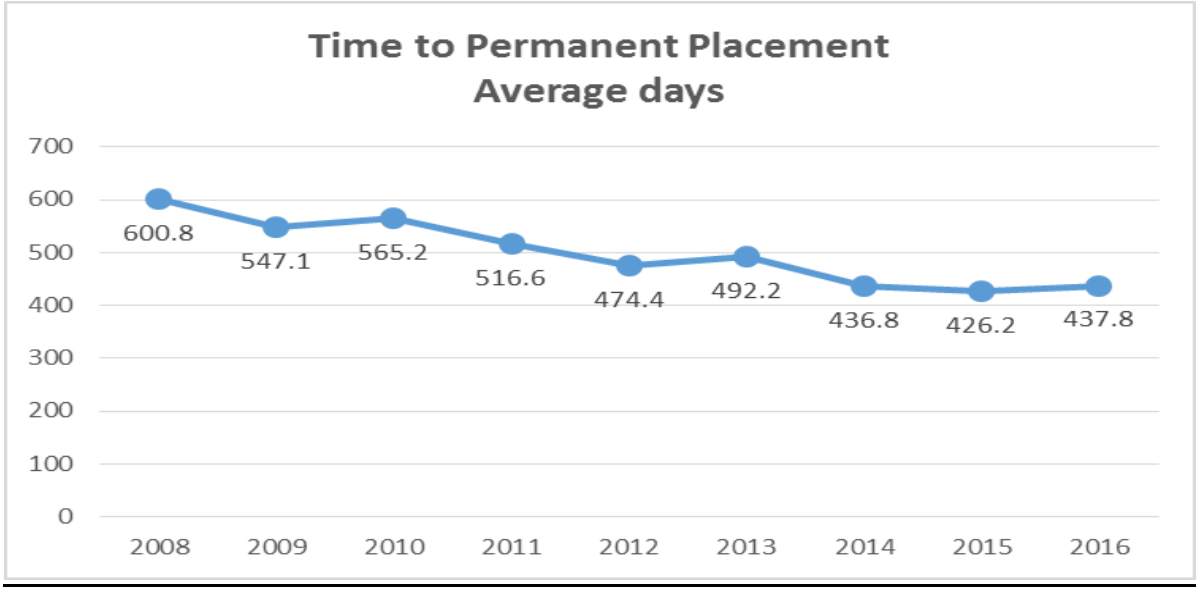
DPQI case review data



COGNOS Point in Time Report 1/3/17



COGNOS Point in Time Report 1/3/17



Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database

CFSR Measure: Permanency in 12 Months for Children Entering Foster Care

Of all children who enter care in a 12-month period and stay for eight days or more, the percentage who discharge to permanency within 12 months of entering care will be 40.5% or more

CFSR Round 3 Data Profile September 2016

FFY 2013b2014a: 44.2 observed performance

FFY 2013b2014a: 37.2% risk standardized performance

CFSR Measure: Re-entry to Foster Care in 12 Months

Of children who enter care in a 12-month period, who discharged within 12 months to reunification, live with relative, or guardianship, the percent who reenter care within 12 months of their discharge will be 8.3% or less.

CFSR Round 3 Data Profile September 2016

FFY 2013b2014a: 9.9% observed performance

FFY 2013b2014a: 6.8% risk standardized performance

CFSR Measure: Permanency in 12 Months for Children in Care 12 to 23 Months

Of children in care on the first day of the 12-month period who had been in care between 12 and 23 months, the percentage discharged to permanency within 12 months of the first day will be 43.6% or more.

CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 55.1% observed performance

FFY 2015b2016a: 55.0% risk standardized performance

CFSR Measure: Permanency for Children in Care 24 Months or Longer

Of children who enter care on the first day of the 12-month period who had been in care for 24 months or more, the percentage discharged to permanency within 12 months of the first day will be 30.3% or more.

CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 36.5% observed performance

FFY 2015b2016a: 35.2% risk standardized performance

Assessment of Permanency Outcome 1

Outcome Permanency 1 is measured by performance on Items 4, 5, and 6 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Permanency 1 was substantially achieved in 40.8% of the cases reviewed, and partially achieved in 52.6% of the cases reviewed. The outcome rating for Permanency 1 based on case reviews for federal fiscal year 2016 indicate Permanency 1 was substantially achieved in 18.3% of the cases reviewed, and partially achieved in 64.8% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

Slight declines in meeting the measure were observed in all three CFSR Items related to Permanency 1. District Management Staff often report a lack of foster homes within the district and difficulty in locating placement for children with severe behavioral issues,

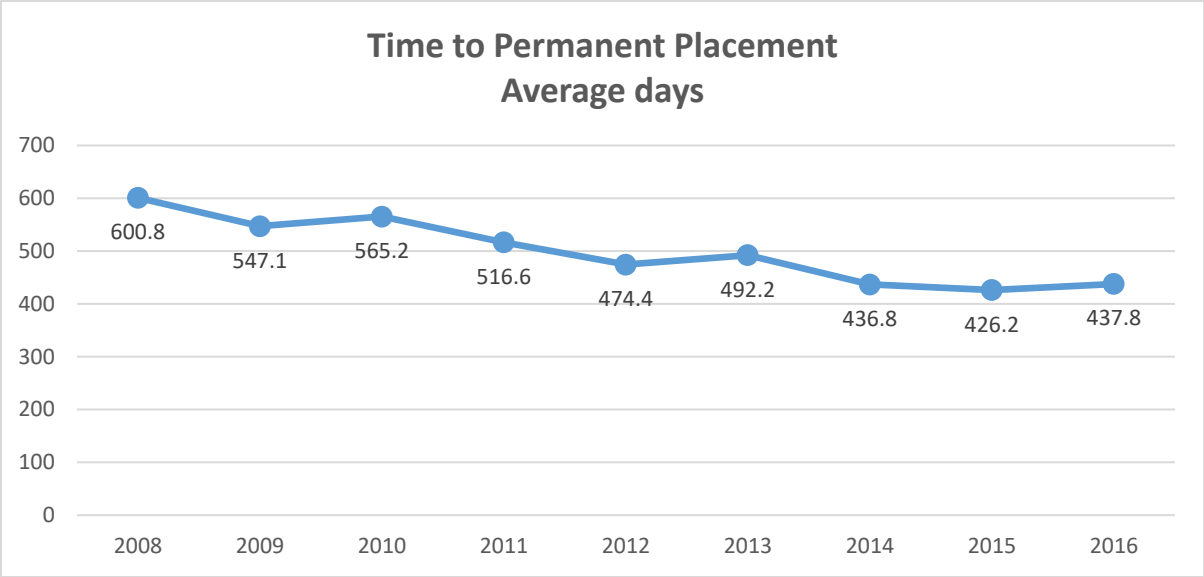
developmental disabilities, or large sibling groups. This contributes to instability of foster care placements. Despite these challenges, West Virginia met the national standard for placement stability.

The largest decline, based on DPQI case reviews, was observed in Item 5, permanency goal for the child. This is the second FFY in which the case review ratings for this item have decreased. DPQI case review data indicates a 31.3% decrease between FFY 2015 and FFY 2016 in the number of cases that rated as strength for establishing permanency goals in a timely manner. Issues contributing to the review findings include failure to document the goals in the case file in a timely manner, goals not being updated to reflect the status of the case, and the selection of inappropriate primary or concurrent permanency goals.

Reviewers found that workers often selected Relative Placement in the FACTS system when working to achieve adoption or guardianship by a relative caregiver. (It should be noted that court orders reflect the correct permanency goal) There are screens in the FACTS system for workers to select both a permanency goal and a placement goal. Department management staff has taken steps to address this issue by providing field level staff instruction on the selection of appropriate permanency goals. The issue has also been addressed in district level DPQI review exit conferences as well as in Statewide Management Team Meetings.

The measurement for Item 6 changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. DPQI case review data indicates the Department and courts were making concerted efforts to achieve permanency within designated timeframes in 56.9% of the cases reviewed. This is a 14.6% decrease from the FFY 2015 data of 71.5% strength. An issue which heavily impacts this item is failure to actively pursue achievement of concurrent permanency goals. Concurrent permanency planning requires both the identification of an alternative plan, and the implementation of active efforts toward achieving both plans simultaneously.

Supreme Court of Appeals of West Virginia data in conjunction with DPQI case review data provides a more extensive data set when measuring the achievement of the permanency goals. CANS data indicates (on average) the amount of time it takes children to reach permanency over the course of the last eight years has dropped by 168.5 days. This same data indicates the length of time for a child involved in abuse and neglect proceedings to reach permanency increased slightly in 2016. (See charts below) However the overall length of time for an abused or neglected child to reach permanency has been reduced over the last eight years.



Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database

Time to Permanent Placemet	
Year	**Average days**
2008	600.8
2009	547.1
2010	565.2
2011	516.6
2012	474.4
2013	492.2
2014	436.8
2015	426.2
2016	437.8

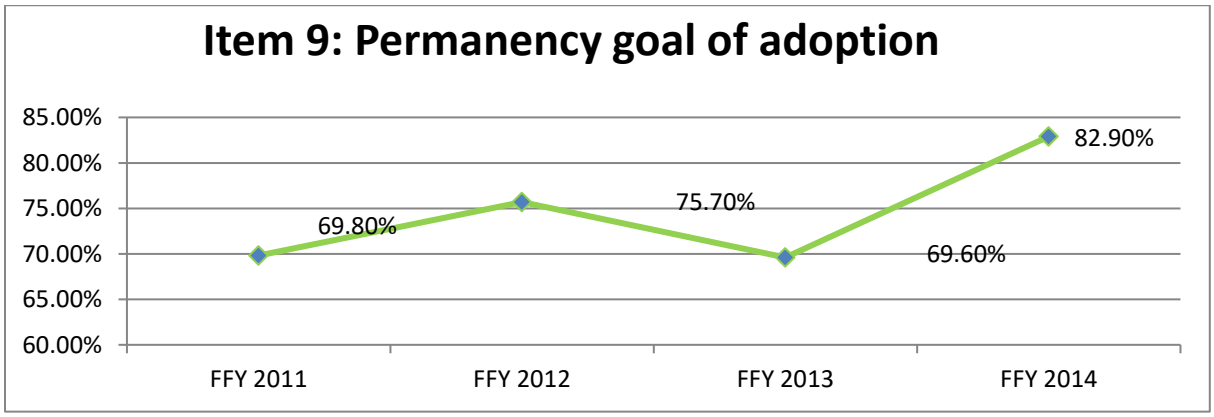
*Note: The CAN databas is fluid, therefore the average days can change slightly based on any work the staff has done to cases.

West Virginia is meeting or exceeding the CFSR national standards for permanency within 12 months for children in care 12 to 23 months, permanency within 12 months for children in care for 24 months or more, re-entry into foster care, and placement stability. West Virginia did not meet the national standard for permanency within 12 months of entry into out of home care.

West Virginia continues to make efforts to decrease the amount of time a child involved in court proceedings spends in out of home care. Examples of such efforts include West Virginia's IV-E demonstration project Safe at Home West Virginia and the 2014 evaluation of the state's juvenile justice practices completed by the state in conjunction with the Pew Charitable Trust.

Permanency 1: Permanency goal of Adoption

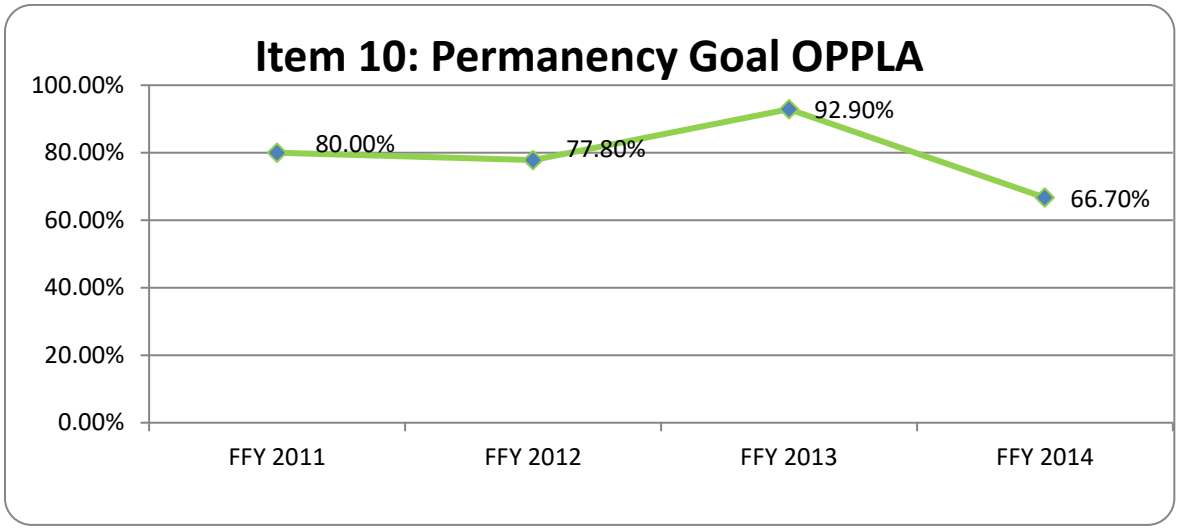
In the Federal Fiscal Year 2014, 82.90% of the cases reviewed with the permanency goal of adoption or a concurrent goal of adoption indicated that concerted efforts were made to achieve finalized adoptions. This measure determines if the child's adoption will be finalized within 24 months of the most recent foster care entry. There is a 13.3 % improvement from Federal Fiscal Year 2013 where 69.60% of the cases achieved this measure.



Permanency 1: Permanency goal of other planned permanent living arrangements.

The percentage of cases with the permanency goal of Other Planned Permanent Living Arrangement that demonstrated progress toward permanency was achieved in 66.7 % of the case sample. It should be noted that cases are chosen for review based on a random sample. Only nine cases reviewed during federal fiscal year 2014 had a primary goal or

a concurrent goal of independent living; therefore, six of the nine cases reviewed rated as strength.



Permanency 2: The continuity of family relationships and connections is preserved for children

Permanency Outcome 2 incorporates six indicators that assess the child welfare agency's performance in placing children in foster care in close proximity to their parents and close relatives (item 11); placing siblings together (item 12); ensuring frequent visitation among children and their parents and siblings in foster care (item 13); preserving connections of children in foster care with extended family, community, cultural heritage, religion, and schools (item 14); seeking relatives as potential placement resource (item15); and promoting the relationship between children and their parents while the children are in foster care (item 16). West Virginia's case review data indicates 94.7% of the cases reviewed substantially achieved, and 5.3% partially achieved. This is a significant improvement from 2008 Child and Family Services Review. The outcome was rated as substantially achieved in 77.5%.

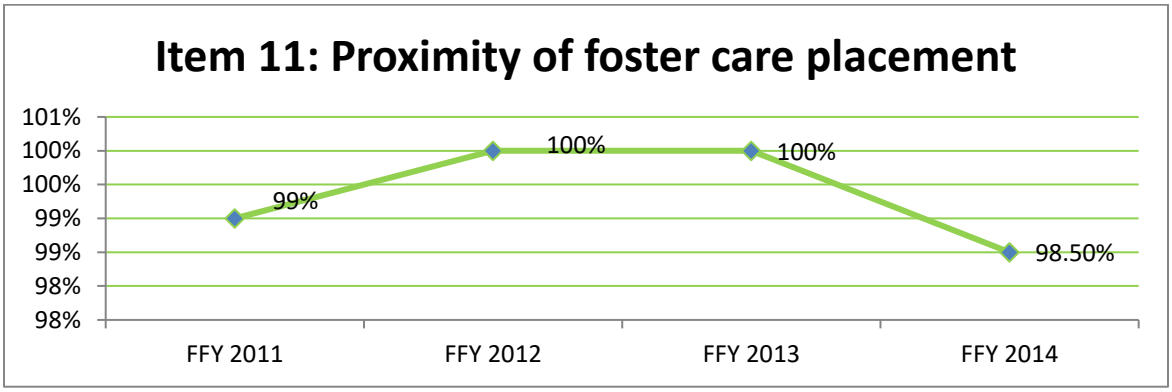
2016 Updates

The outcome rating for permanency 2 based on case reviews for FFY 2015 indicate permanency outcome 2 was substantially achieved in 73.7 % of the cases reviewed, and partially achieved in 22.4 % of the cases reviewed. As reflected in the CFSR style case review data, West Virginia continues to show strength in providing for the continuity of

family relationships and adhering to the value of ensuring children maintain their connections to their neighborhood, community, faith, extended family, school and friends.

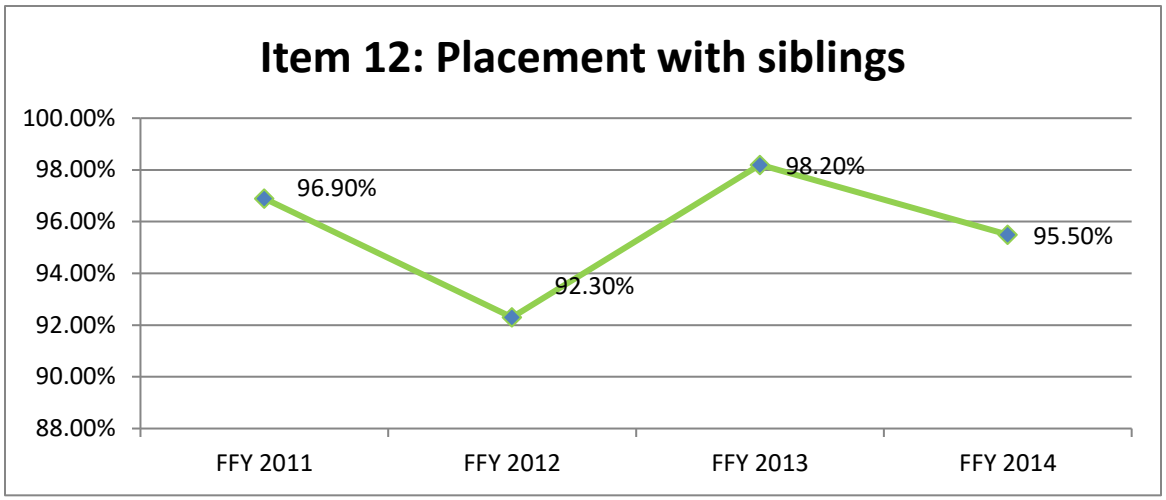
Permanency 2: Proximity of foster care placement

Permanency measures for the State appear to be improving. Based on the sampling of cases reviewed by the Division of Planning and Quality Improvement during Federal Fiscal Year 2014, 98.5% of the placement cases demonstrated that the Department made concerted efforts to ensure that the child's placement was close enough to the parents to facilitate visitation.



Permanency 2: Placement with siblings

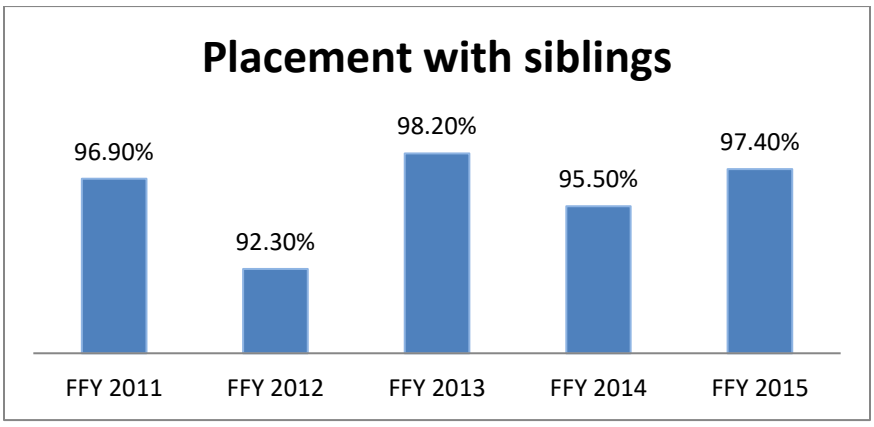
This measurement (Item 12) determines if concerted efforts were made to ensure that siblings in foster care are placed together unless a separation was necessary to meet the needs of one of the siblings. West Virginia saw a slight decline in this measure in FFY 2014.



Lack of available foster care homes makes placing large sibling groups together difficult and often requires the children to be separated based on the lack of foster homes. The children are often separated, placed in close proximity, and provided with ample visitation. All Districts interviewed over the course of the two-year period state that they struggle with the lack of foster care placement options. West Virginia continues to have a high rate of entry into placement.

2016 Update

This measurement (OSRI 2014; Item 7) determines if concerted efforts were made to ensure that siblings in foster care are placed together unless a separation was necessary to meet the needs of one of the siblings. Case review data indicates a 1.9% increase in the number of cases that rated as a strength for this measure.



The lack of available foster homes results in the inability of large sibling groups to be placed together.

The placement of children with relatives assists in the improvement of this measurement. All districts state that they struggle with the lack of foster care placement options.

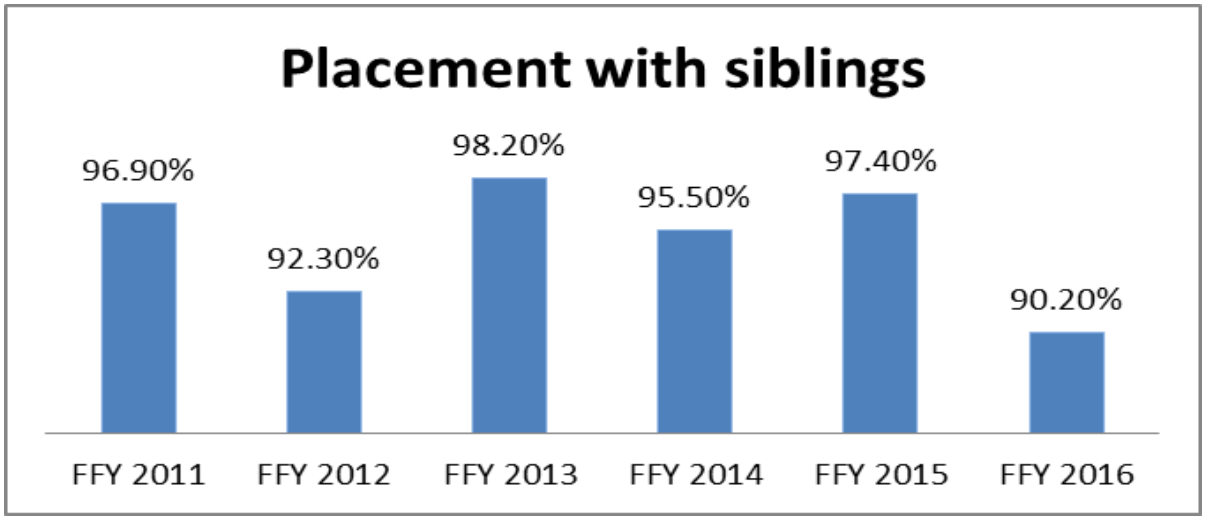
2017 Update

CFSR Item 7: Placement with Siblings

DPQI Quality Assurance Case Review Data

FFY 2015: 97.4%

FFY 2016: 90.2%

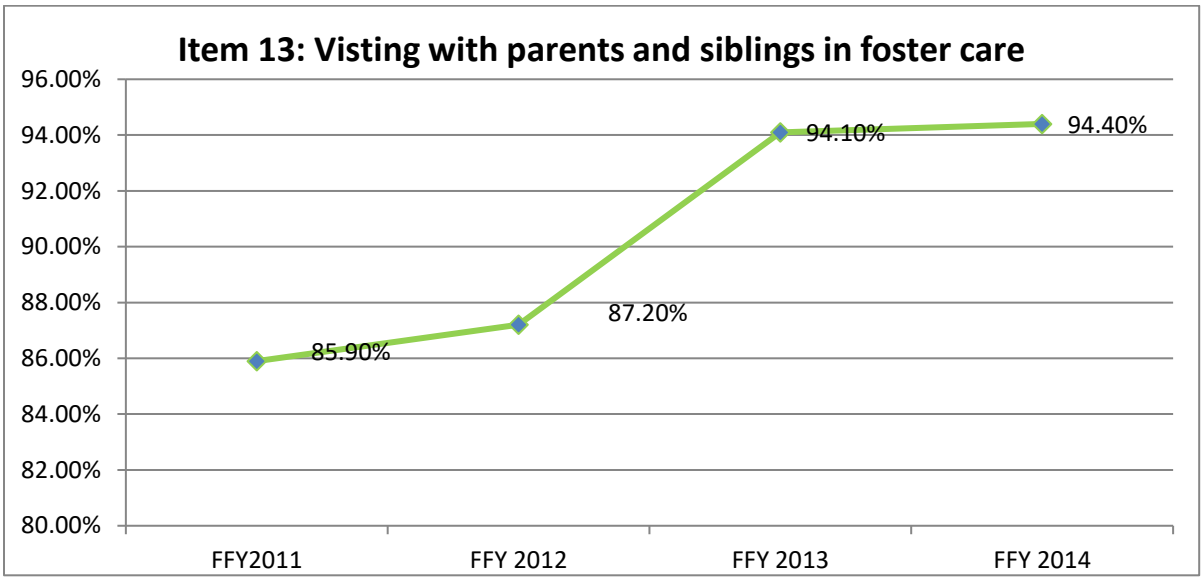


DPQI case review data

Permanency 2: Visiting with parents and siblings in foster care

Item 13 addresses the frequency and quality of visits between the parents and/or caregivers with the child and with the child and siblings who are in separate foster care placements. Frequency relates to whether the Department arranged sufficient contact to maintain or improve the existing relationship. Quality means that the visits were held in settings that were amenable to allow for children to interact with siblings and parents in a

safe and positive atmosphere. If the visits were determined by the Agency and courts not to be in the best interest of the child then the worker must provide documentation to support this decision.



This measure was rated strength in 94.40% of the cases reviewed in FFY 2014. West Virginia continues to make gradual improvements in this measure. Cases that did not meet the measure typically have failed to include the absent father(s).

2016 Update

Item 8 addresses the frequency and quality of visits between the parents and/or caregivers with the child and with the child and siblings who are in separate foster care placements. Frequency relates to whether the Agency arranged sufficient contact to maintain or improve the existing relationship. Quality means that the visits were held in settings that were amenable to allow for the children to interact with their siblings and parents in a safe and positive atmosphere. If the visits were determined by the Agency and courts not to be in the best interest of the child, then the worker must provide documentation to support this decision.

This measurement will not be compared to prior years as the directions for rating this item have changed based on the revisions to the OSRI and does not allow for a direct comparison of the measurements. For this item, the “mother” and “father” are defined as the “parents from whom the child was removed and with whom the agency is working toward reunification.” If the child is removed from a relative that is not the biological

"father" or "mother" and are relatives of the child and the agency is working toward reunification with the relative they are considered the "mother" and "father".

This measure was rated as strength in 77.6% of the cases reviewed in FFY 2015. Cases that did not meet the measure are due to the lack of, or delayed visitation with siblings, and/or biological fathers. Only two of the cases rated as an area needing improvement due to limited visitation based on the child not being placed in close proximity to the parent(s).

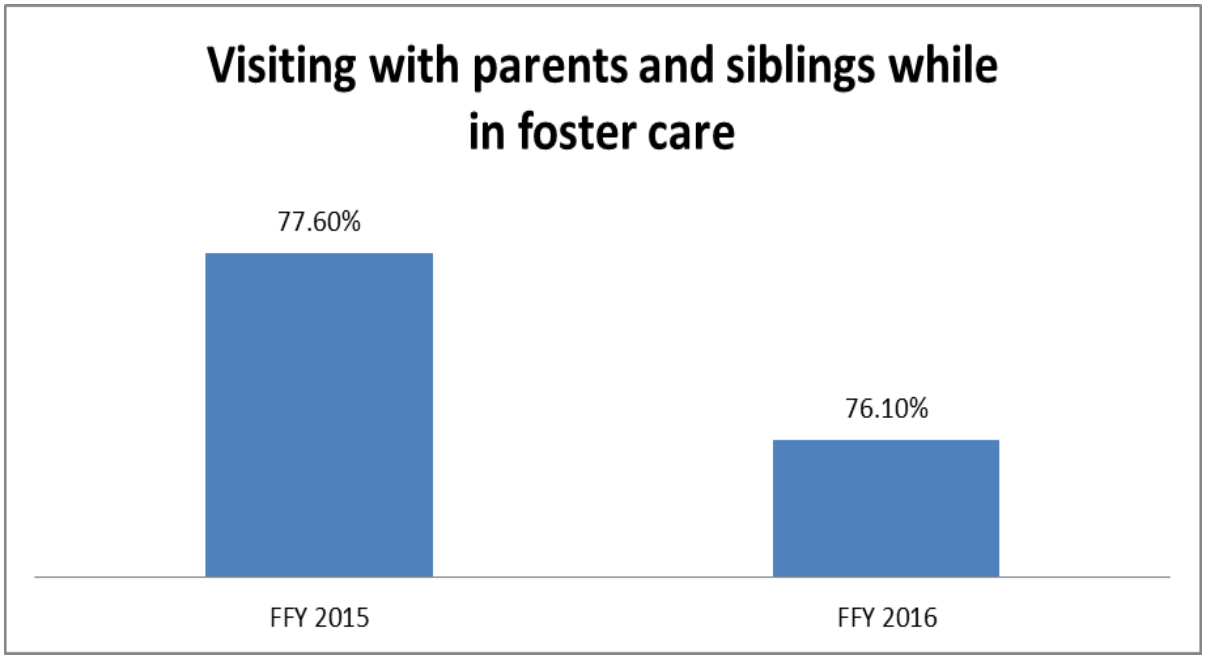
2017 Update

CFSR Item 8: Visiting with Parents and Siblings in Foster Care

DPQI Quality Assurance Case Review Data

FFY 2015: 77.6%

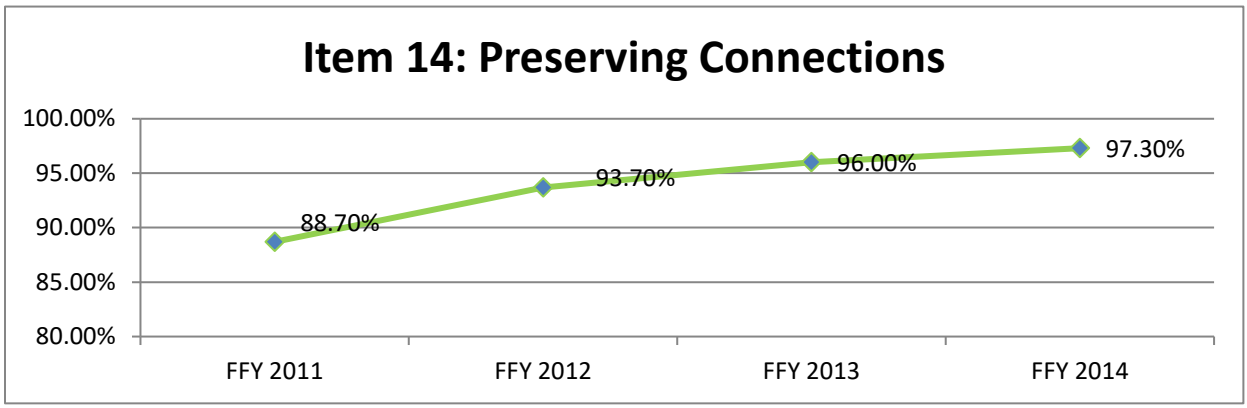
FFY 2016: 76.1%



FFY 2016 DPQI case review data

Permanency 2: Preserving Connections

Child and Family Service reviews determine if workers explore and maintain the primary connections for the child in care and document those efforts. This may include connections in the community, school, church, extended family members and siblings not in foster care. If a child is a member or eligible to be a member of an Indian Tribe the Tribe must be notified in a timely manner to advise them of their right to intervene in any State court proceedings seeking an involuntary foster care placement or termination of parental rights. The child must be placed in accordance with the Indian Child Welfare Act (ICWA). 97.3% of the cases reviewed in FFY 2014 indicated that the workers have made concerted efforts to maintain the child's important connections to their community, faith, extended family and siblings.

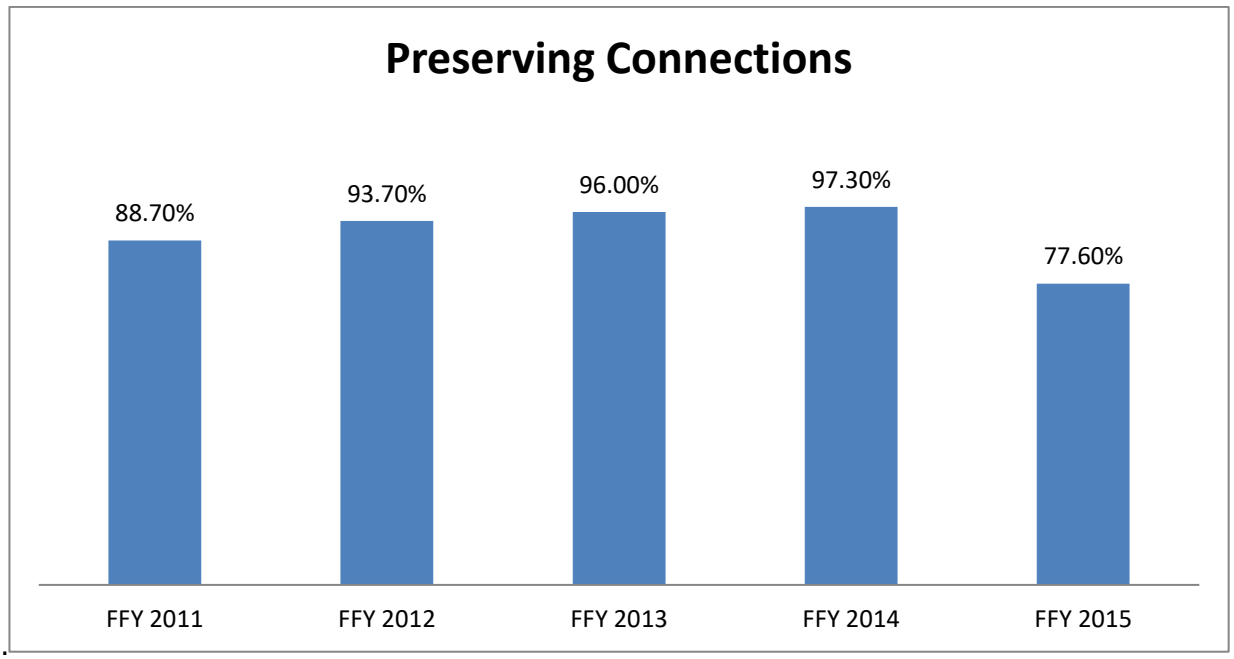


The use of relative placements is reflected in this measure. The cases reviewed indicated an increased involvement with extended family members because of placement with relatives.

2016 Update

Child and Family Service Reviews determine if workers explore and maintain the primary connections for the child in care and document those efforts. This may include connections in the community, school, church, extended family members and siblings not in foster care. If a child is a member or eligible to be a member of an Indian Tribe, the Tribe must be notified in a timely manner to advise them of their right to intervene. The child must be placed in accordance with the Indian Child Welfare Act (ICWA). 77.6% of the cases reviewed in FFY 2015, indicated that the workers have made concerted efforts

to maintain the child's connections to their community, faith, extended family and siblings. No case reviewed indicated a child belonged to a Tribe.



The cases reviewed indicated a decrease in this measure. The primary reason cases rated as an area needing improvement for this measure was due to grandparents or extended relatives being denied visitation with the targeted child.

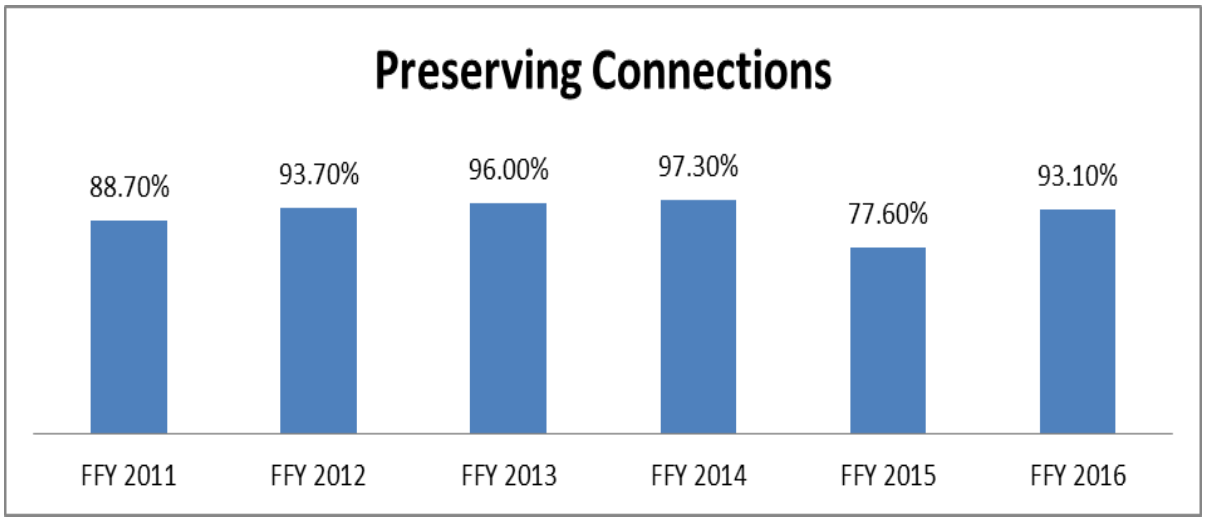
2017 Update

CFSR Item 9: Preserving Connections

DPQI Quality Assurance Case Review Data

FFY 2015: 77.6%

FFY 2016: 93.1%

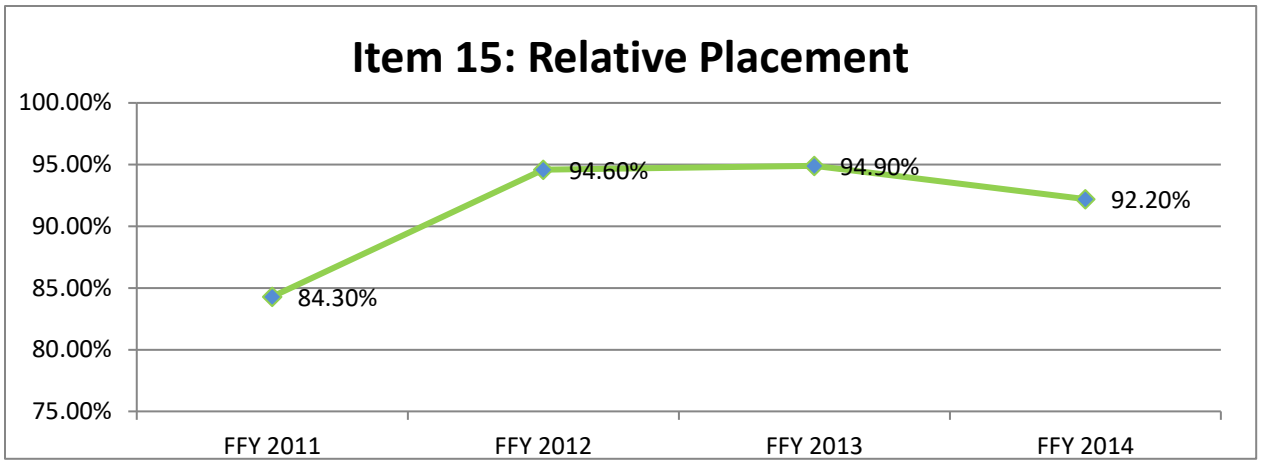


DPQI case review data

Permanency 2: Relative Placement

Workers continue to make efforts to explore relative/kinship care placements; this is often necessitated by the lack of other foster care homes. In cases where this measure has not been met, it is often paternal relatives that have not been considered. Although these measures declined by 2.7 %, case reviews indicate efforts to locate relatives are achieved in 92.2% of the cases reviewed during federal fiscal year 2014. Round two of the Child and Family Reviews indicate this measure as strength in 79% of the cases rated during the onsite reviewed.

West Virginia continues to distribute the diligent search tips guide developed during the last program improvement plan to staff on a regular basis to ensure continued use.

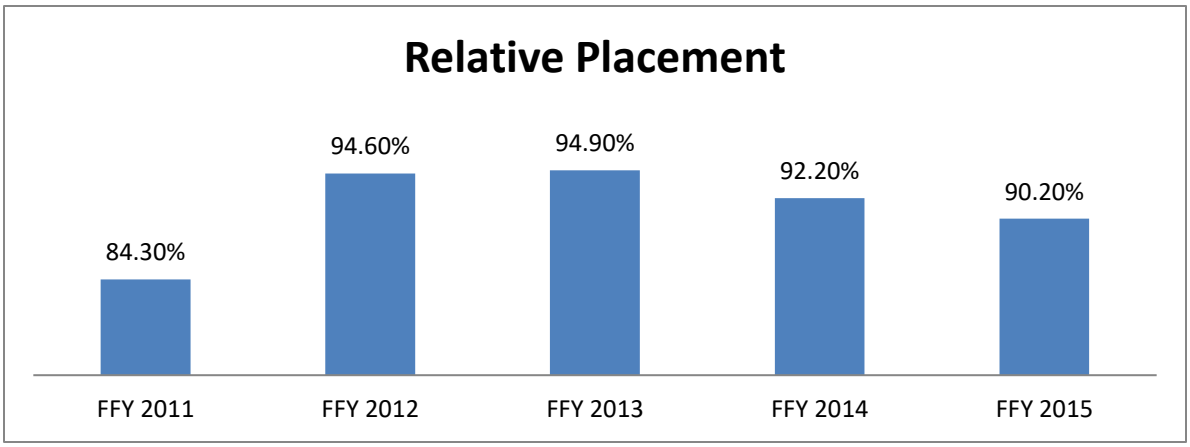


2016 Update

Workers continue to place children with relatives when appropriate to foster the continuity of the family relationship. In cases where this measure has not been met, it is often paternal relatives that have not been considered. Of the cases reviewed during federal fiscal year 2015 that were applicable for this measure, 90.2 % rated as strength. The slight decline represents six cases out of the 61 cases applicable for this measure. Review of cases rating as areas needing improvement indicated either maternal or paternal relatives were not considered. Exploration of both maternal and paternal relatives need to be considered when seeking relative placement for children; therefore, cases in which this did not occur rated this item as an area needing improvement.

It should be noted that fictive kinship placement can no longer be considered for rating in this item. Review of the data for FFY 2015 does not indicate this to be a factor in the reduction in the measurement of this item; however, does note the change in the instructions for the measurement of this item.

West Virginia's case review process will address the appropriateness of the Agency's decision to place child(ren) with fictive kin on a case-by-case basis to determine if the child's best interest was taken into consideration when placement decisions were made. For cases in which the fictive kin appear to be in the child's best interest and provides for continuity of care, WV will note the placement as an exception and override the measurement to rate as a strength.



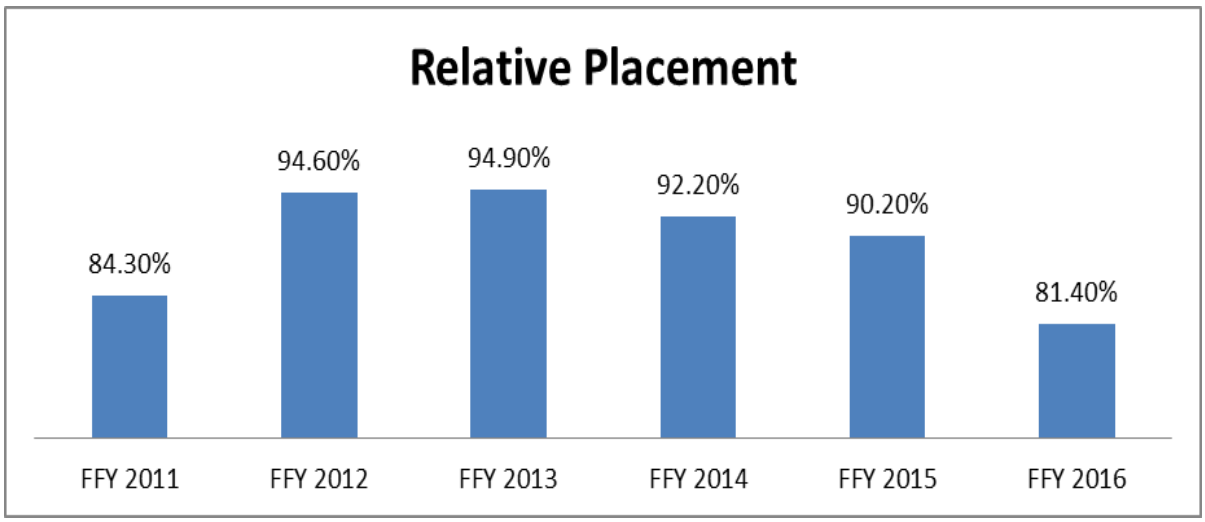
2017 Update

CFSR Item 10: Relative Placement

DPQI Quality Assurance Case Review Data

FFY 2015: 90.2%

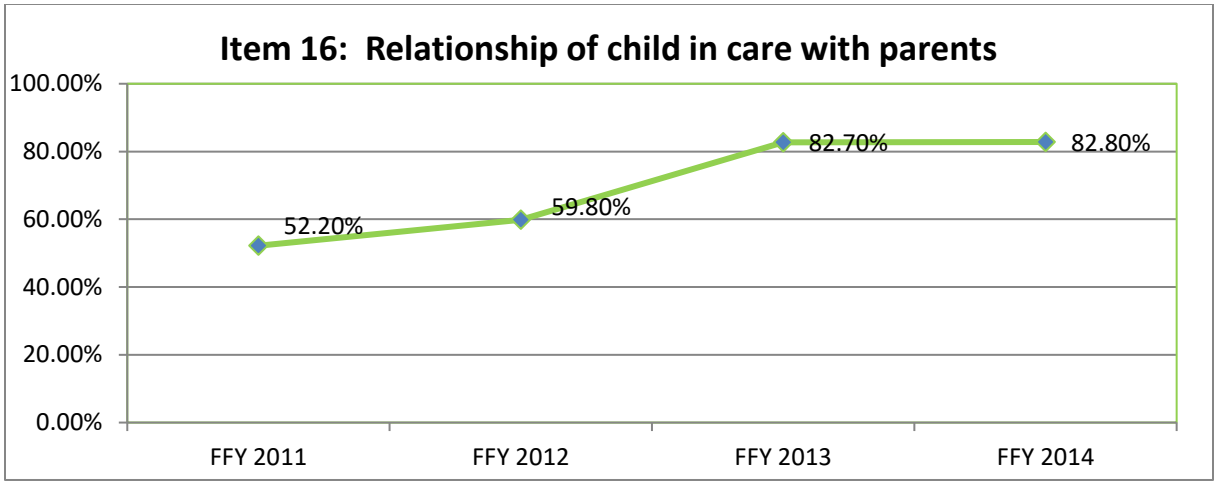
FFY 2016: 81.4%

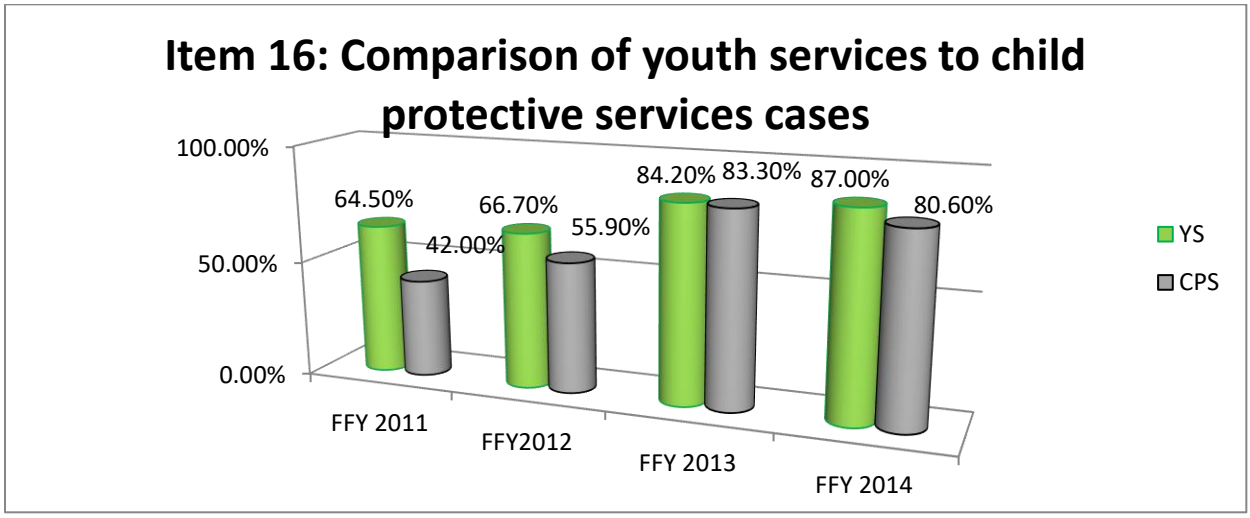


DPQI case review data

Permanency 2: Relationship of child in care with parents

Social service reviews also determine whether concerted efforts were made to promote, support and maintain positive relationships between the children in foster care and his or her parents or primary caregiver from whom the child had been removed through activities other than visitation.





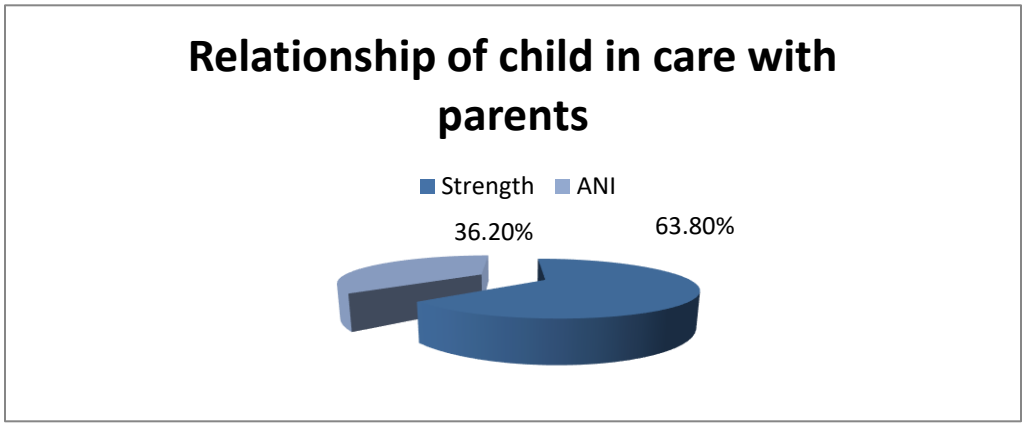
Reviews indicated that children placed in care through the youth services system are more likely to receive services to promote, support and maintain positive relationships between the child and his or her mother and father or primary caregiver from whom the child had been removed through activities other than visitation. This is achieved as the

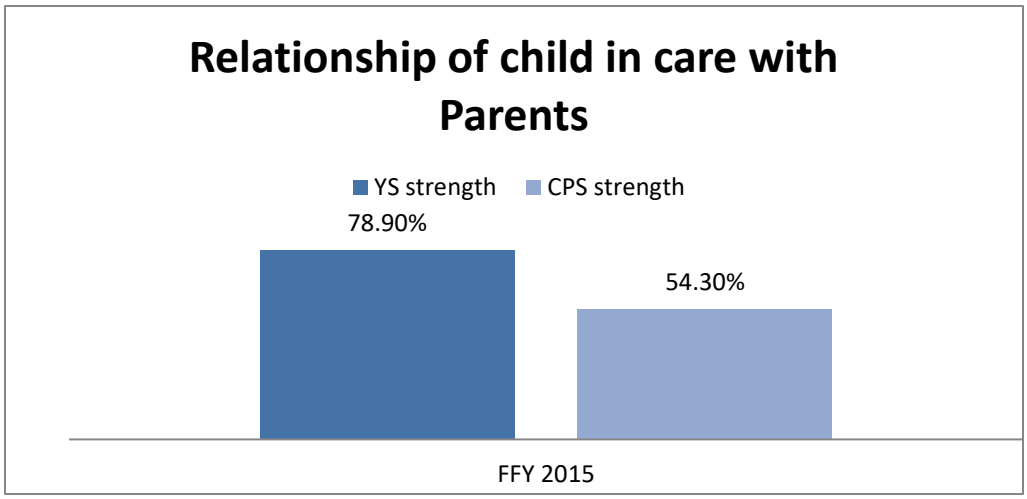
primary focus of treatment in most youth services cases involves working toward improving the parent child relationship to discover the underlying cause(s) for the child's behaviors. Older youth are typically placed in residential treatment centers that involve the caregivers in family therapy, treatment plan development and provide additional socially interactive activities. Many of the facilities encourage the youth to keep in touch with extended family through calls, emails, and visitation; whereas children in placement due to abuse and neglect are often unable to maintain contacts and relationships outside of supervised visitation without approval from the court system. It should also be noted that often in abuse/neglect cases, safety concerns prevent additional interaction or contact outside of the supervised visitation setting.

2016 Update

Social service reviews also determine whether concerted efforts were made to promote, support and maintain positive relationships between the children in foster care and his or her parents or primary caregiver from whom the child had been removed through activities other than visitation (OSRI 2014, item 11). This measurement will not be compared to prior years as the directions for rating this item has changed.

For this item, the "mother" and "father" are defined as the "parents from whom the child was removed and with whom the agency is working toward reunification." If the child is removed from a relative that is not the biological "father" or "mother" and are relatives of the child and the agency is working toward reunification with the relative they are considered the "mother" and "father". The same person(s) are rated in for OSRI 2014, items 8 and 11.





Reviews indicated that children placed in care through the youth services system are more likely to receive services to promote, support and maintain positive relationships between the child and his or her mother and father or primary caregivers. From the case review data, for CPS cases the involvement with the court and MDT plays a role in how much involvement a child has with their caregivers.

This is achieved as most youth service cases involve working toward improving the parent/child relationship to discover the underlying cause(s) for the child's behaviors. Most often children involved in youth services cases are placed in residential treatment centers. The residential treatment providers often involve the caregivers in family therapy, and provide additional socially interactive activities that include the youth's family. Parents are encouraged to attend recreational events and the youth's sporting events when possible.

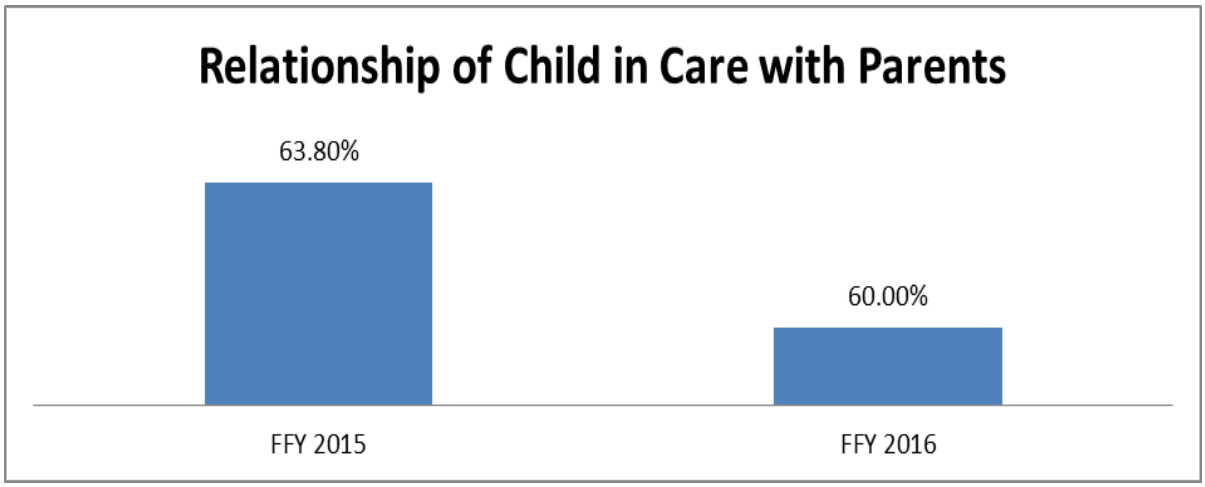
2017 Update

CFSR Item 11: Relationship of Child in Care with Parents

DPQI Quality Assurance Case Review Data

FFY 2015: 63.8%

FFY 2016: 60.0%

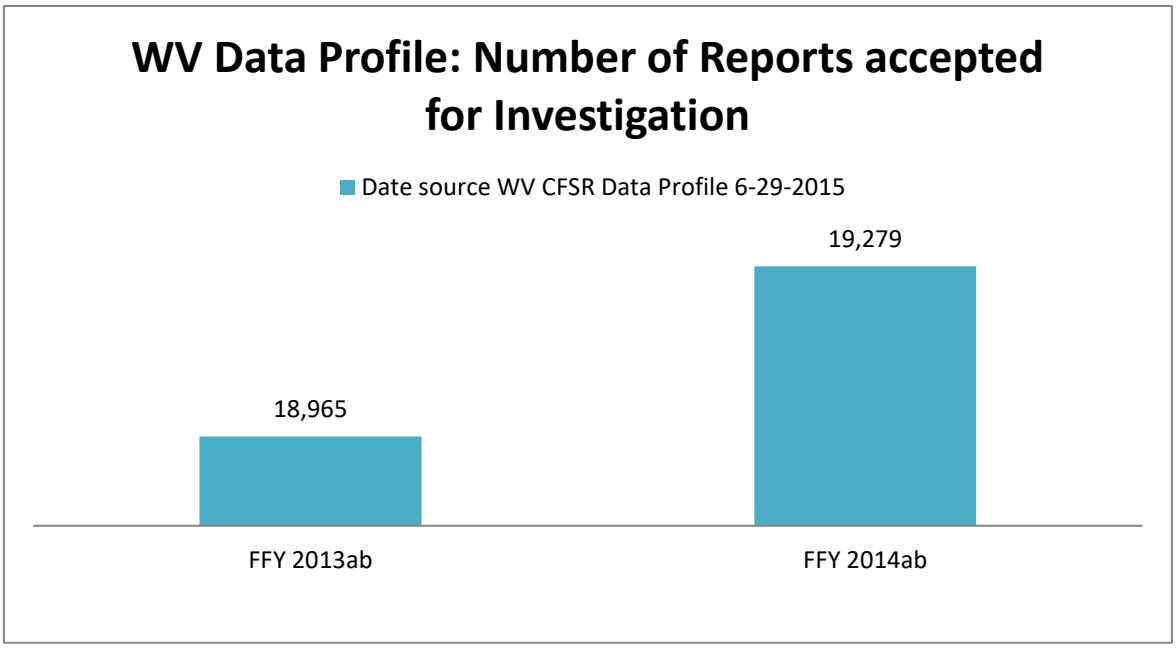


DPQI case review data

Assessment of Permanency Outcome 2

Outcome Permanency 2 is measured by performance on Items 7, 8, 9, 10, and 11 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Permanency 2 was substantially achieved in 73.7% of the cases reviewed, and partially achieved in 22.4% of the cases reviewed. The outcome rating for Permanency 2 based on case reviews for federal fiscal year 2016 indicate Permanency 2 was substantially achieved in 76.4% of the cases reviewed, and partially achieved in 22.2% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

The continuity of primary relationships and connections are being preserved for most children served in out of home care. DPQI case review data indicates strength ratings of 80% or more in three of the five items associated with this outcome. Despite these positive findings, DPQI data also indicates there are areas in which improvements can be made. Slight declines in item ratings were observed in all but one of the five CFSR Items associated with Outcome Permanency 2. The number of children entering out of home care in West Virginia has increased. West Virginia continues to see an increase in the number of child maltreatment victims, along with an increase in the rate of entry into foster care. This is likely due to the increase in the total number of child abuse and neglect reports received in WV that have a substantiated disposition in the reporting period under review (FFY 2014 ab).



Despite the increase in children entering foster care, Department staff and service providers continue to make concerted efforts to meet the ever-increasing need for transportation and supervision services associated with parent/family-child visitation.

DPQI case review data indicates the Department is making concerted efforts to ensure that siblings in foster care are placed together unless separation was necessary to meet the needs of one of the siblings. This item rated 90.2% strength during FFY 2016 case reviews. This item and Item 10 (Relative Placement) are often found to be linked during case reviews. The limited number of foster home placement options within most districts ensures that staff diligently seeks out relative placements. This practice often also ensures that sibling groups can be placed together.

The measurement for Item 8 (visits with parents and siblings in foster care) changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. Ensuring that the frequency and quality of visits between the parents and/or caregivers with the child, and the child with siblings placed in a different placement setting, are of sufficient quality and frequency to maintain the relationship was determined to be a strength in 76.1% of the cases reviewed by DPQI during FFY 2016. This is a 1.5% decrease from the strength rating found during case reviews during FFY 2015. DPQI reviewers frequently noted delays in initiating visitation with one or more parents/caregivers in cases that did not meet the measure. Addiction issues are often present in cases that do not meet this measure. Children in placement due to abuse and

neglect proceedings are often unable to maintain contacts and relationships without approval from the court system. Judges often do not permit contact between the child and the parent/s if the parent/s fails to complete substance abuse treatment or have positive drug screens due to safety concerns for the child.

DPQI case review data indicates workers are exploring and maintaining the primary connections for the child in care and document those efforts in most the cases reviewed. If a child is a member or eligible to be a member of an Indian Tribe, the Tribe must be notified in a timely manner to advise them of their right to intervene. The child must be placed in accordance with the Indian Child Welfare Act (ICWA). In 93.1% of the cases reviewed in FFY 2016 reviewers found evidence that workers had made concerted efforts to maintain the child's connections to their community, faith, tribe if applicable, extended family and siblings. This is a 15.5% increase from case review data collected in FFY 2015.

Case reviewers found that the child was placed in a stable relative placement, or that concerted efforts to identify and assess relatives, had been made in 81.4% of the cases reviewed during FFY 2016. In 13 of the 70 applicable cases reviewers did not find documentation or other evidence that the Department had made efforts to locate and assess relatives as possible placement resources. The searches for paternal relatives were more likely to have insufficient efforts than those for maternal relatives. No case reviewed in FFY 2016 involved a fictive kin placement. West Virginia's case review process will address the appropriateness of the Agency's decision to place child(ren) with fictive kin on a case-by-case basis to determine if the child's best interest was taken into consideration when placement decisions were made. For cases in which the fictive kin appear to be in the child's best interest and provides for continuity of care, WV will note the placement as an exception and override the measurement to rate as a strength.

The measurement for Item 11 (relationship of child in care with parents) changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. DPQI case review data indicates the Department and courts were making concerted efforts to promote, support and maintain positive relationships between the children in foster care and his or her parents or primary caregiver from whom the child had been removed through activities other than visitation in 60% of the cases reviewed. This is a 3.8% decrease from the ratings found on this same item during FFY 2015. Addiction issues are often present in cases that do not meet this measure. Contributing factors to the overall ratings on this item include courts not permitting contact between the child and his/her parent/s due to failure on the part of the parent to complete substance abuse treatment or have negative drug screens, and parents being incarcerated or transient.

Well-being Outcomes 1, 2 and 3

Well-being Being 1: Families have enhanced capacity to provide for their children's needs.

Well-being Outcome 1 incorporated four indicators. One pertains to the agency's efforts to ensure that the service needs of children, parent, and foster parents are assessed and that necessary services are provided to meet identified needs (item 17). A second indicator examines the agency's efforts to actively involve parents and children in the case planning process (item 18). The two remaining indicators examine the frequency and quality of the caseworkers' contacts with the children in their caseloads (item 19) and with the children's parent (item 20). Case reviews conducted in FFY 2014 indicate substantial conformity was met in 42.7% of the cases reviewed and partially achieved in 26.6%.

2016 Update

Well-being Outcome 1 incorporated four indicators. One pertains to the Agency's efforts to ensure that the service needs of children, parent, and foster parents are assessed and that necessary services are provided to meet identified needs. A second indicator examines the Agency's efforts to actively involve parents and children in the case planning process. The two remaining indicators examine the frequency and quality of the caseworker's contacts with the children in their caseloads and with the children's parents. Case reviews conducted in FFY 2015 indicate substantial conformity was met in 32.4 % of the cases reviewed and partially achieved in 37.3%.

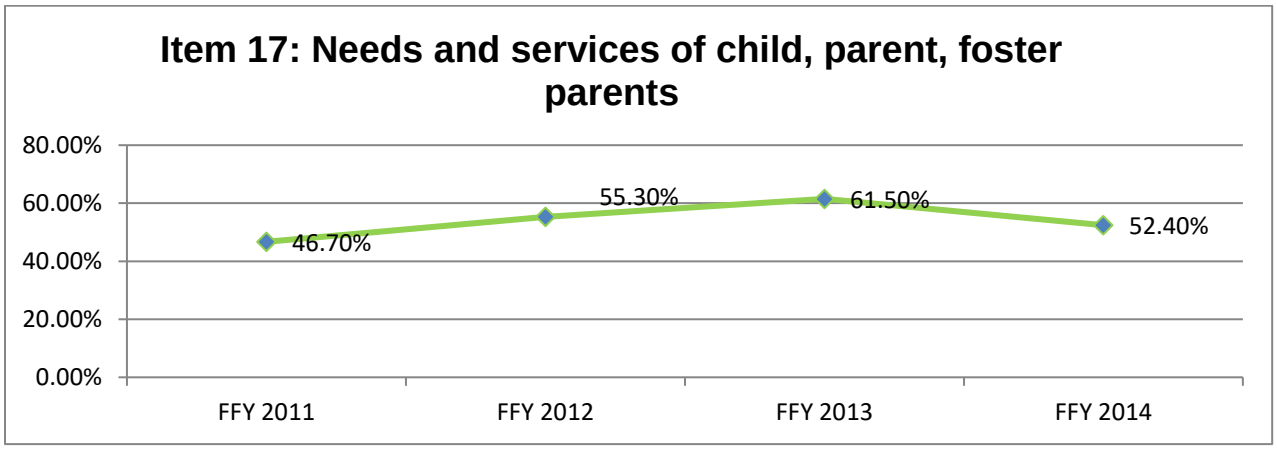
Well-being items 12B, 13, and 15 the terms "mother" and "father" are defined as the parents/caregivers with whom the children were living when the Agency became involved with the family and with whom the children will remain; biological parent(s) who were not the parents from whom the child was removed; and paramours to biological parents.

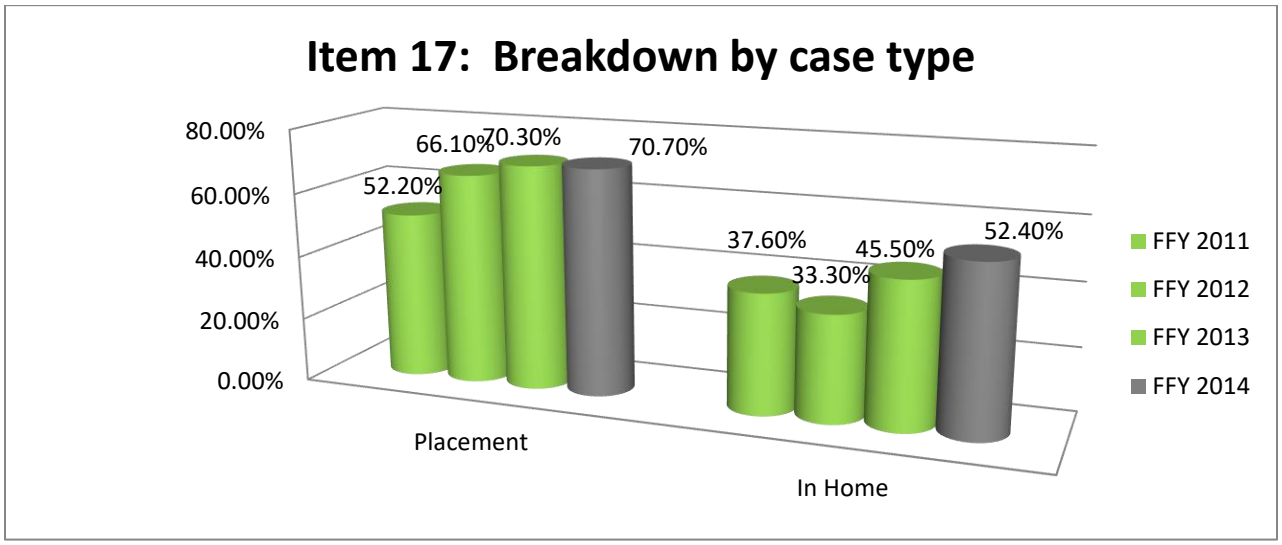
This measurement will not be compared to prior years' data as the directions for rating this item have been changed.

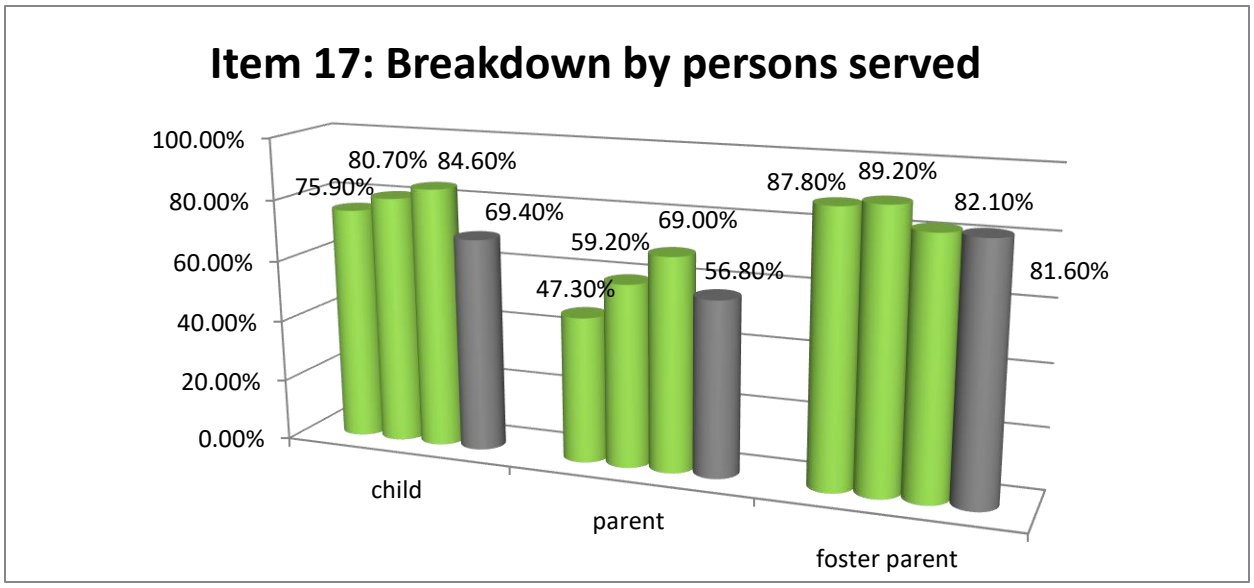
Well-being 1: Families have enhanced capacity to provide for their children's needs.

Cases were reviewed to determine whether concerted efforts were made to assess the needs of children, parents, and foster parents to determine or to identify the services necessary to achieve case goals and adequately address the issues relevant to the

agency's involvement with the family, and if appropriate services were provided. This measure is a composite of sub measurements that look separately at services to the children, fathers, mothers and foster parents.







The Agency continues to work towards improving their ability to assess the needs of children, parents and foster parents and to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family. The data indicates that this measure is only being met in 52.5% of the cases reviewed. The lack of on-going case work in non-placement cases and the lack of involvement with all identified fathers tend to hinder improvements.

The measure continues to fall short as identified needs are not always addressed in the on-going case work process. For example, domestic violence may be identified as a reason that the DHHR is involved with the family; however, no services are put into place to address the issue. Additionally, the data indicates a lack of ongoing assessment of children and parents to determine the efficacy of the services.

The provision of services is currently being redesigned to better meet the needs of those involved with the Agency.

Most Districts lack adequate substance abuse treatment services, both inpatient and outpatient for parents and youth; domestic violence services; and parent programs to address the issue of parenting older youth.

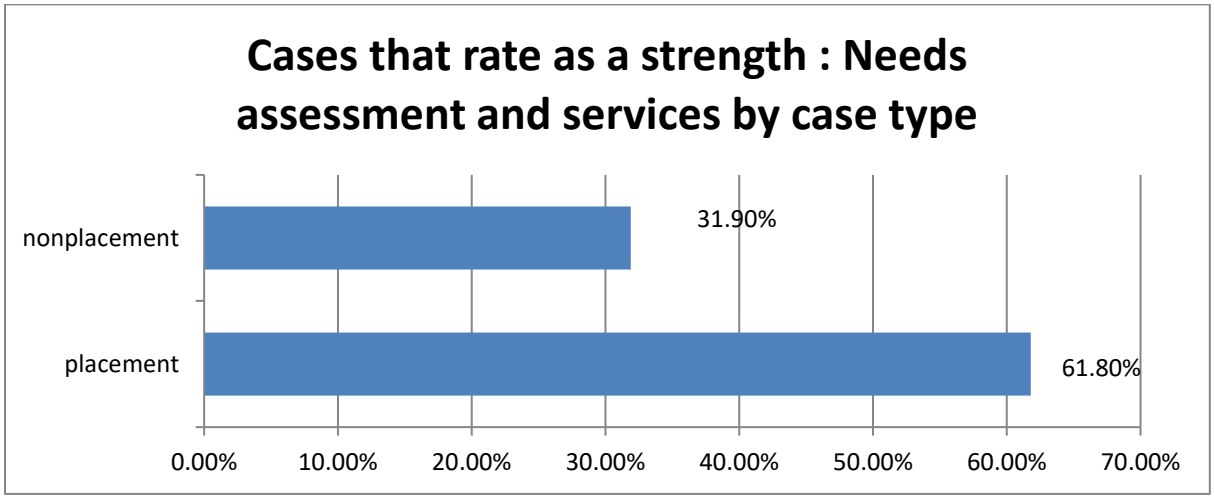
2016 Update

Cases were reviewed to determine whether concerted efforts were made to assess the needs of children, parents, and foster parents to determine or to identify the services

necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family, and if appropriate services were provided. This measure is a composite of sub-measurements that look separately at services to the children, fathers, mothers and foster parents (OSRI 2014; item 12; OSRI; 2004: item 17).

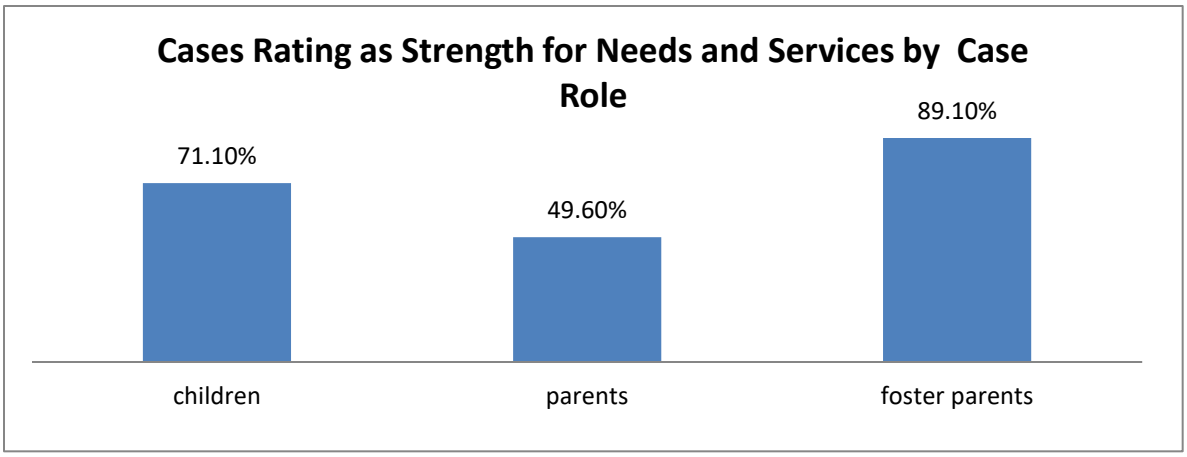
This measurement will not be compared to prior years for 12 B (needs and services for parents) as the directions for rating this item based on the revisions to the OSRI does not allow for a direct comparison of the measurements. This item defines "mother" and "father" as parents/caregivers with whom they were living when the agency became involved with the family and with whom the children will remain with and whom the agency is working toward reunification. This item also includes biological parents that indicate a desire to be involved with the child and it is in the child's best interest to do so. This item also includes biological parent(s) paramours.

Case review data indicates that this measure is being met in 47.9% of the cases reviewed.



Non-placement cases rate as an area needing improvement more often than placement cases. Cases rating as an area needing improvement are due to the lack of on-going case work. Case reviews indicate initial assessments are completed to identify area of need; however, ongoing assessments of the family are not occurring at the frequency needed to determine the effectiveness of treatment services.

When determining if concerted efforts were made to assess children, parents and foster parents, case reviews indicated the areas needing improvement for this item are related to gaps in assessing children and parents. As reflected in the break-down of this measurement into subsections for foster parents, parents, and children.



Of the cases that rated as an area needing improvement, 28.8% were due to the lack of ongoing assessments and services to the children. Of that 28.8%, 22% of the cases lacked the assessment of all children in the home, 61% rate as an area needing improvement as ongoing assessments were not frequent enough to continue to assess the children and determine the effectiveness of treatment services. In 1.7% of the cases needing improvement, the children were not referred to the Birth to Three Program as required by policy.

Data indicates the needs and services of parents were rated as strength in 49.6% of the cases reviewed. Reviews indicate a lack of ongoing assessments for parents, and a lack in the provision of services to address the identified needs.

Placement cases scored better with the measurement being met in 61.3% of the cases reviewed. Absent parent involvement impacted this measure in placement cases. Non-placement cases rated poorly for this measure with only 38.5 % of the cases rating as strength. All measurements for non-placement cases are highly impacted by the failure of Agency workers to have regular contact with the families.

Foster parents' needs and services were met in 91.0% of the cases reviewed. This represents five cases out of the 53 applicable cases. These cases rated as an area needing improvement due to the lack of ongoing assessments or provision of specific services.

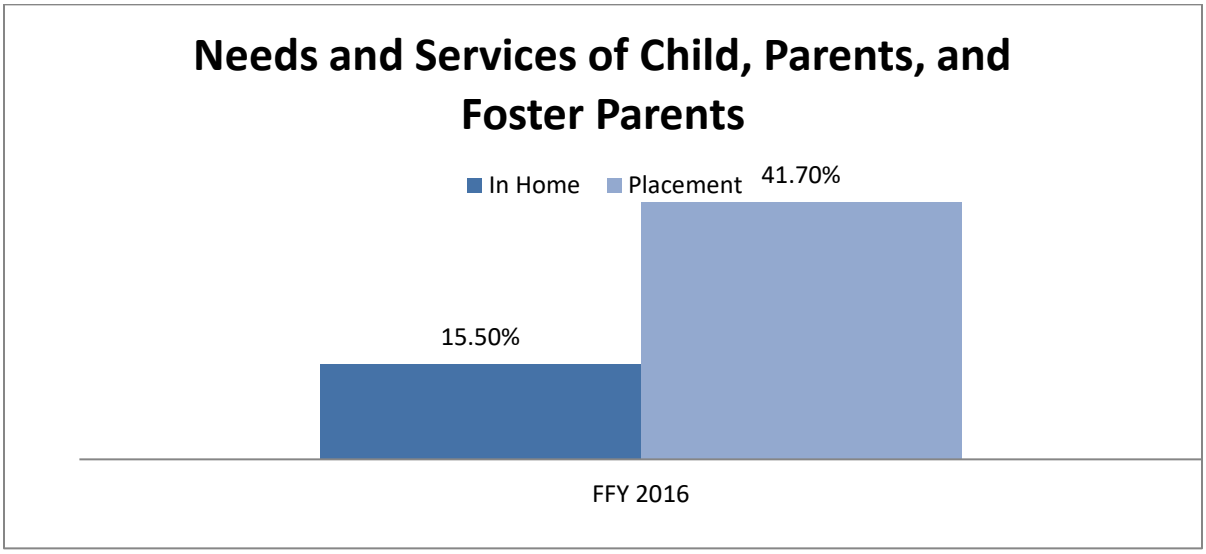
2017 Update

CFSR Item 12: Needs and Services of Child, Parents, and Foster Parents

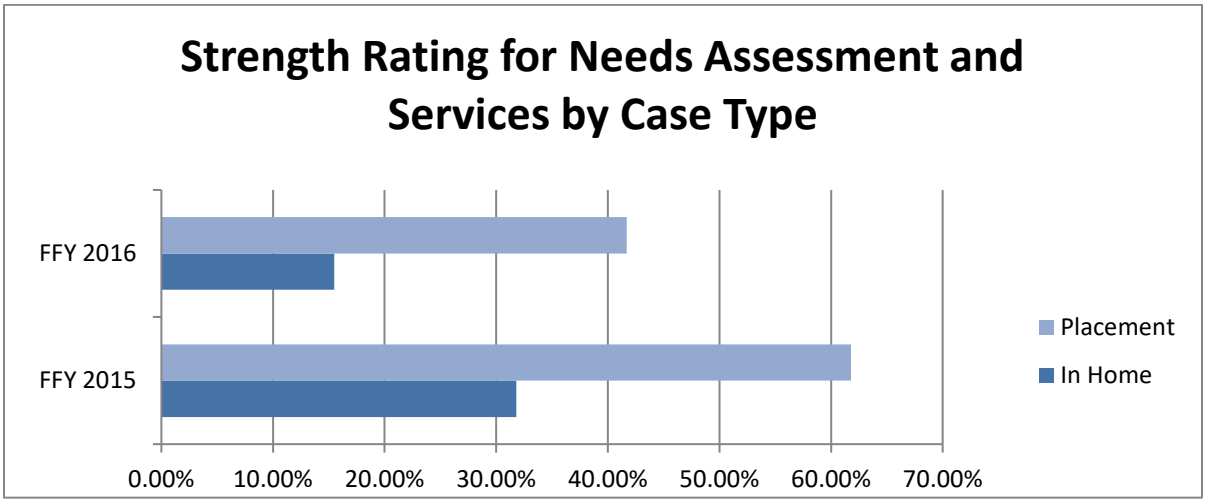
DPQI Quality Assurance Case Review Data

FFY 2015: 47.9%

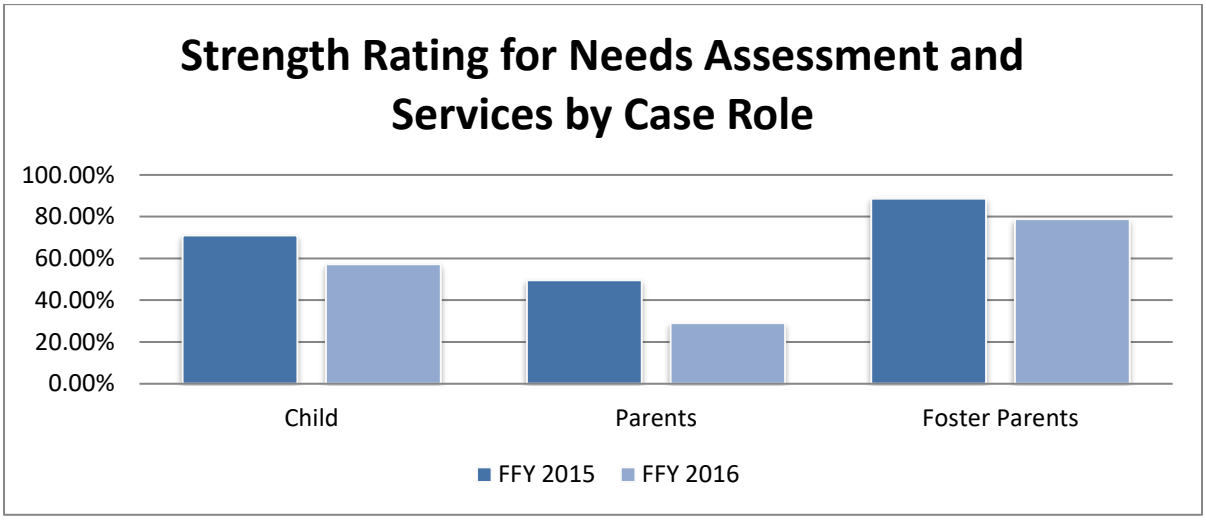
FFY 2016: 28.7%



FFY 2016 DPQI case review data



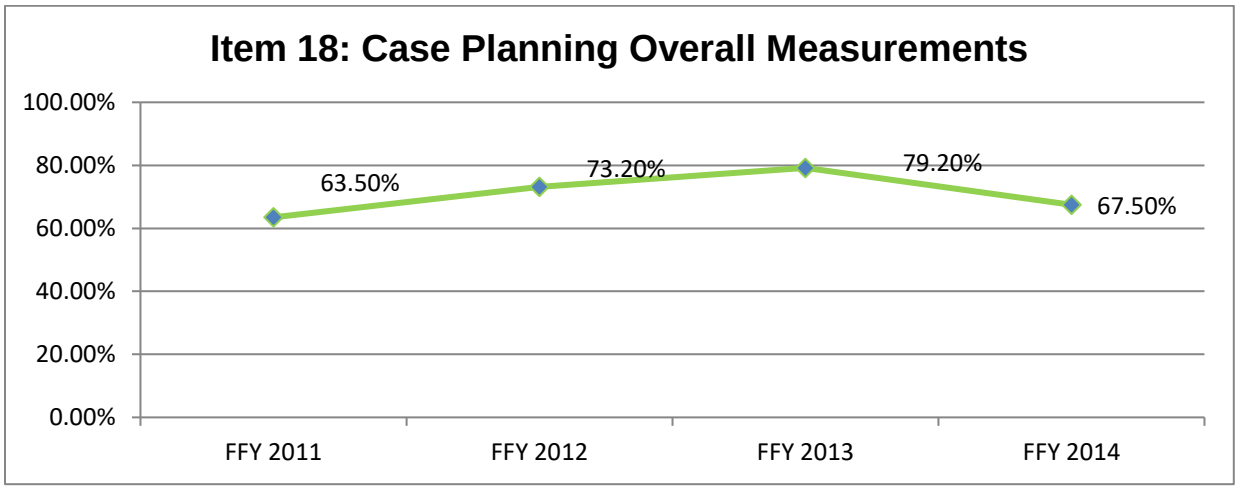
DPQI case review data

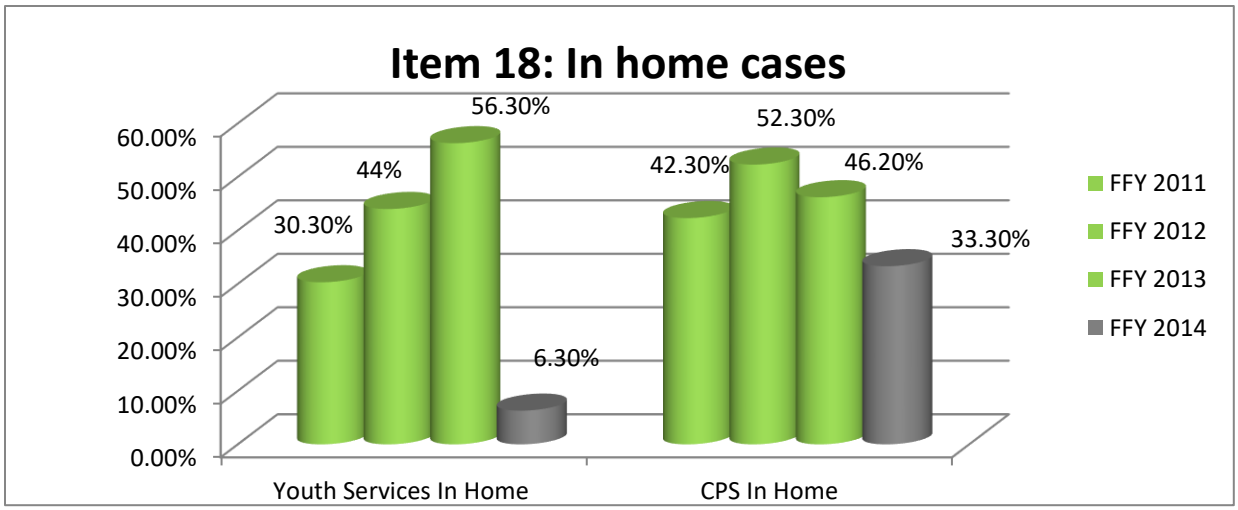


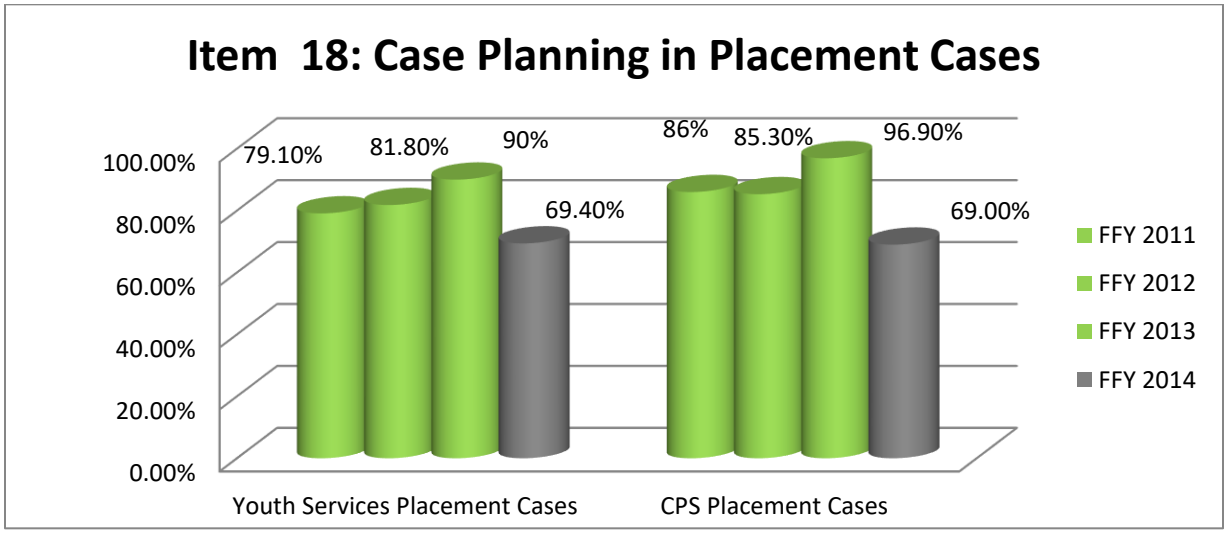
DPQI case review data

Well-being 1: Child and family involvement in case planning

Wellbeing Outcome 1 also measures child and family involvement in case planning on an ongoing basis. Reviews indicate an improvement in involving children and families in the case planning process.







Reviews indicated that family and child involvement in case planning when the child is in placement is significantly higher than for those involved in cases without placement. This can be attributed to court and MDT oversight.

Although case planning is occurring in youth services placement cases, Districts continue to struggle with the process. Staff feels case plans are often set forth by the court and juvenile probation system and they have little input into the process.

Case planning in CPS in-home cases is lacking. Many in-home cases are not receiving on-going casework, and many Districts have not been able to successfully implement the Protective Capacities Family Assessment (PCFA) and case planning process.

During Contract Year 2013-2014, the Family Support Educator for APS Healthcare Inc. conducted eleven (11) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health Services.

The purpose of these focus groups is to provide youth who are receiving medically necessary behavioral health services in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and impact of these services in the state. Each group may consist of youth receiving individualized and/ or group treatment in a residential facility and/or within the community.

This year seventy-three (73) youth receiving residential treatment participated. It should be noted youth were not limited to choosing a single response; therefore, a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number.

Youth that participated in the focus groups were asked several questions related to meeting their treatment needs and their participation in the treatment planning process. Many of these factors relate to the factors in well-being 1 measurement.

Youth were asked if their worker knows what they are working on in therapy. Forty-seven percent (47%) of participants agreed.

When youth were asked: “Do you understand your treatment plan?” 22% of the participants felt their input was considered. 69% of participants conveyed that they did not understand or agree on the plan. 7% could not remember their treatment plan and 3% of the participants stated they did not have a treatment plan.

Focus groups were also asked: “Was your input considered in the development of the plan”. The following responses were received, 36% responded in a positive affirmation, twelve percent (12%) of participants “Did not know.” Of this response, five (5%) percent of participants agreed with the response, “I don’t know what my treatment plan is. I can’t remember, it all runs together and they give you so much to sign when you get here. I just know what our daily goals are.” In addition, one percent (1%) added, “I didn’t even get to read it. They just rush you to sign everything because there is so much paper work to get through.” One percent (1%) stated, “I can’t remember. They said I had a bad attitude and

anti-social behaviors. It has improved as much as I want it to." One percent (1%) stated, "I'm not sure, I might have."

Focus groups were also asked "Has your outlook about yourself or situation changed since you came into the program"? 75% of the youth indicated yes.

Youth were asked follow-up questions to gain an understanding of what has helped change their outlook. Youth were asked what has helped change their outlook. Seventy-five percent (75%) of participants that stated, "Yes," expressed by achieving their goals, receiving therapy and attending school helped improve their outlook in the major areas tabled below. Twenty-nine percent (29%) of participants agreed being away from their family, home and communities made them appreciate their family and being in the community. Twenty-two percent (22%) felt a lack of freedom gave them respect for their home life and the things they had that they took for granted.

Data may not be reflective of the larger sample; however, the data does indicate further exploration is needed to understand the youth's treatment needs and means to improve on engaging the youth in the treatment planning process.

2016 Update

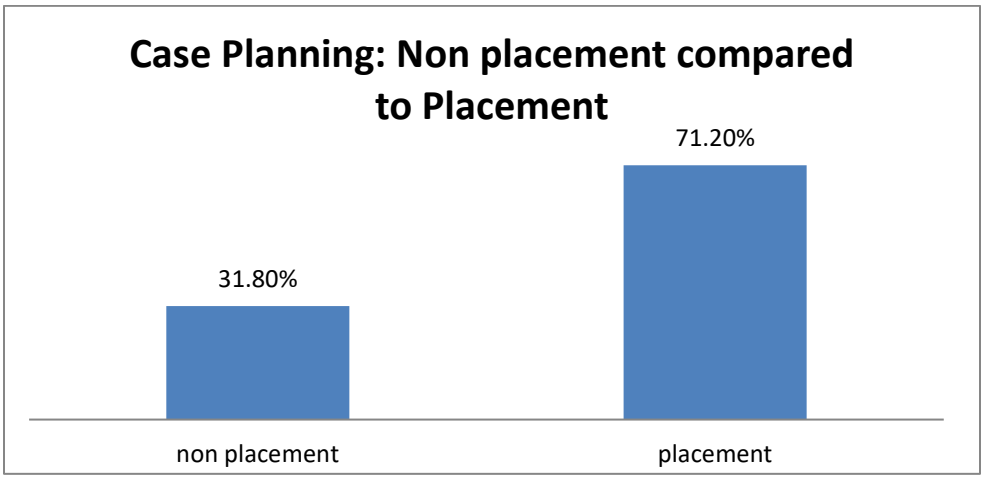
Wellbeing Outcome 1 also measures child and family involvement in case planning on an ongoing basis (OSRI 2014: item 13). For this item, the terms "mother" and "father" are defined as the caregivers with whom the children were living when the agency because involved with the family and with whom the children will remain.

This measurement cannot be compared to prior years for case planning due to a change in the way the DPQI unit assessed the item. In prior years, this item was rated based upon the level of engagement of the family in the case planning process. Based on consultation from the Children Bureau this item was not rated as a strength this year unless the case plan was signed; therefore, the overall decrease in the percentage of cases that rated as a strength for the item reflects a lack of signed case plans in the case records.

Case reviews indicate strength in 52.5 % of the case review for the measurement of case planning.

Reviews indicated that family and child involvement in case planning when the child is in placement is significantly higher than for those involved in cases without placement. This can be attributed to court and MDT oversight. Case planning in youth services placement

cases is often set forth by the court system and juvenile probation. Measurements for non-placement cases were impacted by the failure of the Agency workers to have regular contact with their families and a lack of signed case plans.



2017 Update

CFSR Item 13: Child and Family Involvement in Case Planning

DPQI Quality Assurance Case Review Data

FFY 2015: 52.5%

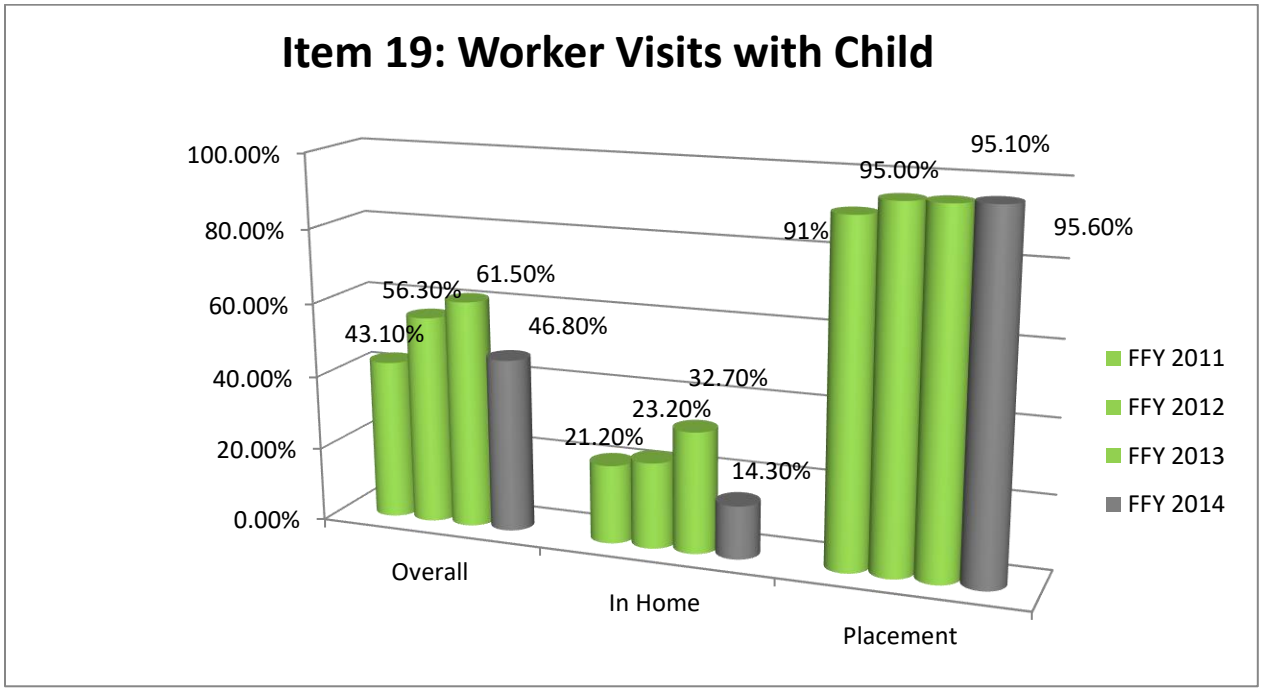
FFY 2016: 9.3%

Please note: This measurement cannot be compared to prior years due to a change in the way the DPQI case review unit assessed the item. In prior years, this item was rated based upon the level of engagement of the family in the case planning process, regardless of the presence of a written case plan. Based on consultation from the Children's Bureau in 2015, during FFY 2016 DPQI case reviews, reviewers only rated this item a strength if a written case plan was found in the case record and was signed by parents, and if age appropriate, the child. Later guidance by the CBRO in 2016 clarified that any type of "case plan" is acceptable, not just "written case plans." The change in rating criteria is the reason for the overall decrease in the percentage of cases that rated as strength for the item. Reviews often indicate that family and child involvement in case

planning when the child is in placement is significantly higher than for those involved in cases without placement. This can be attributed to court and MDT oversight. Case planning in youth services placement cases is often set forth by the court system and juvenile probation. Measurements for non-placement cases were impacted by the failure of the Agency workers to have regular contact with their families and a lack of signed case plans.

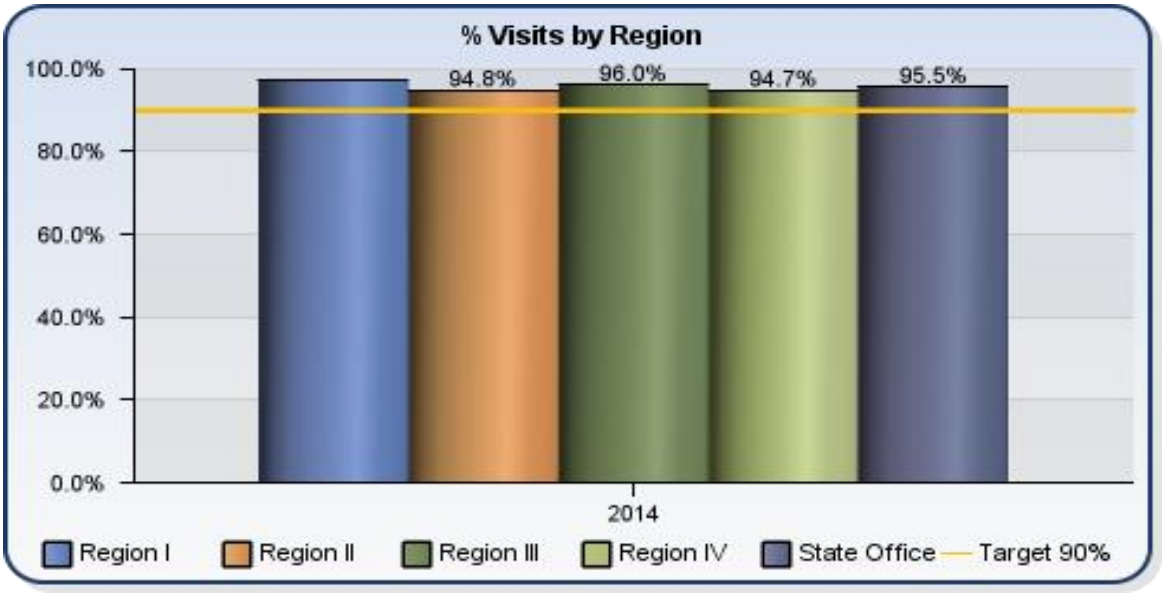
Well-being 1: Workers visits with child

Social service reviews also assess the caseworker visits with the child. Cases are reviewed to determine whether the frequency and quality of visits between caseworkers and the children in cases are sufficient to ensure the safety, permanency and wellbeing of the child and promote achievement of case goals. Case type is indicated by the placement of the child at the time of the review. In rating this measure, reviewers consider both the length of the visit and the location of the visit. Reviewers also consider whether the caseworker saw the child alone or whether the parent or foster parent was present. Reviewers must also consider the topics that were discussed during the visits to determine if the visit promoted the achievement of case goals. With the above mention contact characteristics in consideration, this measure is not congruent with COGNOS data that tracks only the frequency of visits.



As indicated there is a distinct gap in caseworker visits in non-placement cases. Data collected from the FFY 2014 review indicated that in only 14.30% of the non-placement cases the children were seen on a regular basis to monitor for their safety.

COGNOS Data Federal Fiscal Year 2014



Districts continue to monitor and track the intake portion of casework as the ongoing casework practice receives little attention. The monitoring of caseworker visits to children in placement has greatly improved the practice of visits with children in placement settings; however, in-home cases have significant gaps in contacts. Services are referred into the homes without follow up to ensure efficiency and cooperation with services. Reviews continue to indicate that in some districts there has been no contact by Agency workers in open in-home cases after the completion of family functioning assessments or youth behavior evaluations.

During Contract Year 2013-2014, the Family Support Educator for APS Healthcare Inc. conducted eleven (11) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health Services.

The purpose of these focus groups is to provide youth who are receiving medically necessary behavioral health services in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and

impact of these services in the state. Each group may consist of youth receiving individualized and/ or group treatment in a residential facility and/or within the community.

This year seventy-three (73) youth receiving residential treatment participated. It should be noted youth were not limited to choosing a single response; therefore, a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number. In addition, DPQI conducted focus groups with parents, youth, and stakeholders during case reviews.

Youth that participated in the focus groups were asked "how often do you see your DHHR case worker?" Their response fell into four main categories: 43% of those reporting satisfactions with the frequency of worker visits; 18% felt they were not seen enough; 30% reported not seeing their workers; 4% had recently entered custody and did not have enough experience to answer the question.

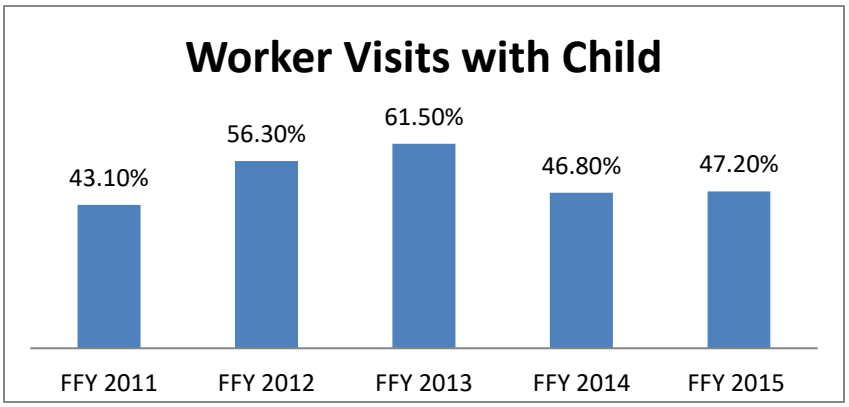
APS Healthcare also conducted focus groups with participants of service (youth and their families) and WV FAM members were asked to list their biggest concerns, of which most respondents replied, "sibling separation."

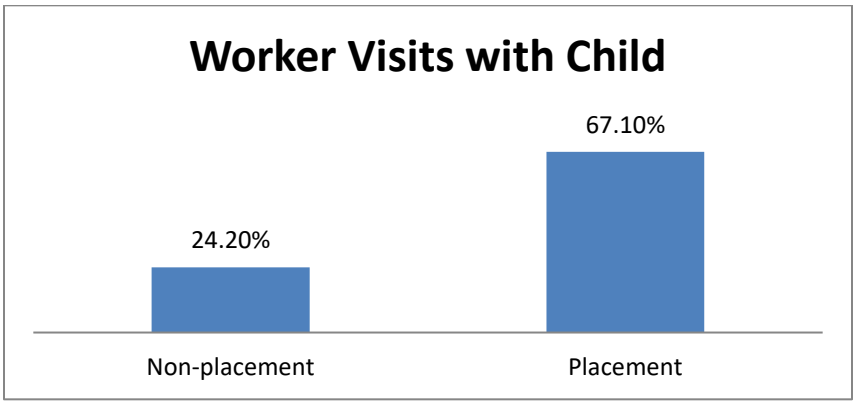
Data may not be reflective of the larger sample; however, the data does indicate further exploration is needed to understand the youth's treatment needs.

2016 Update

Cases are reviewed to determine whether the frequency and quality of visits between caseworkers and the children in cases are sufficient to ensure the safety, permanency and wellbeing of the child and promote achievement of case goals. Case type is indicated by the placement of the child at the time of the review. In rating this measure, reviewers consider both the length of the visit and the location of the visit. Reviewers also consider whether the caseworker saw the child alone or whether the parent or foster parent was present. Reviewers must also consider the topics that were discussed during the visits to determine if the visit promoted the achievement of case goals.

Since COGNOS is only able to measure that the visit occurred; data from the reviews also consider the quality of the visit. The two data sets should not be compared.

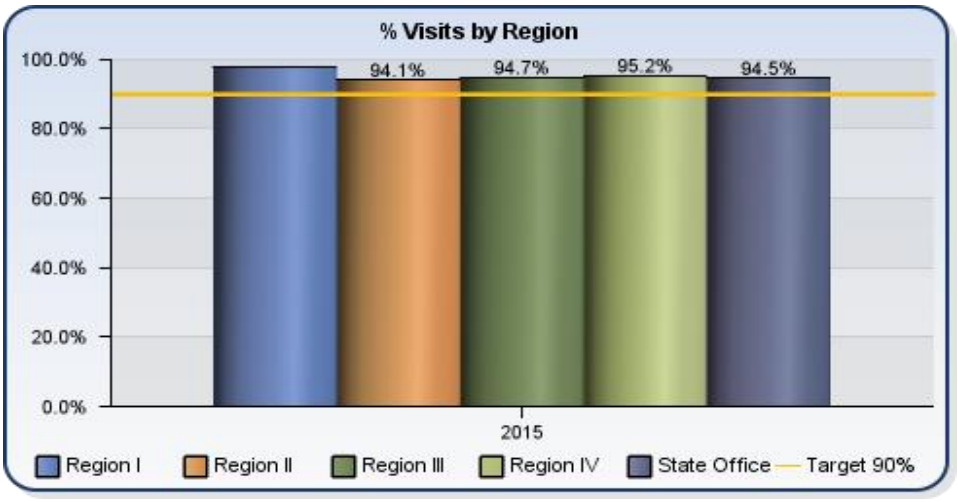




As indicated there is a distinct gap in caseworker visits in non-placement cases and placement cases. Data collected from the FFY 2015 review indicated that 24.30% of the non-placement cases have regular visits with children.

In placement cases, the children are seen on a regular basis to monitor safety. The frequency of case worker visits for children in placement is monitored in the State's COGNOS system. The focus on visits by management using COGNOS dashboard has increased the visits made to children in placement.

COGNOS Data point in time data 2/2016



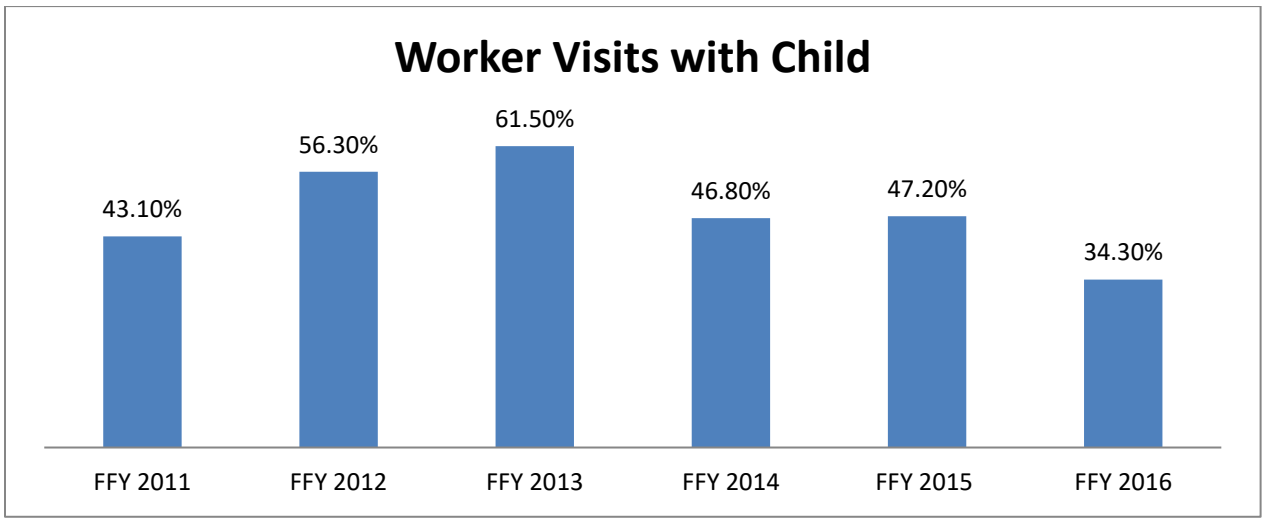
2017 Update

CFSR Item 14: Caseworker Visits with Child

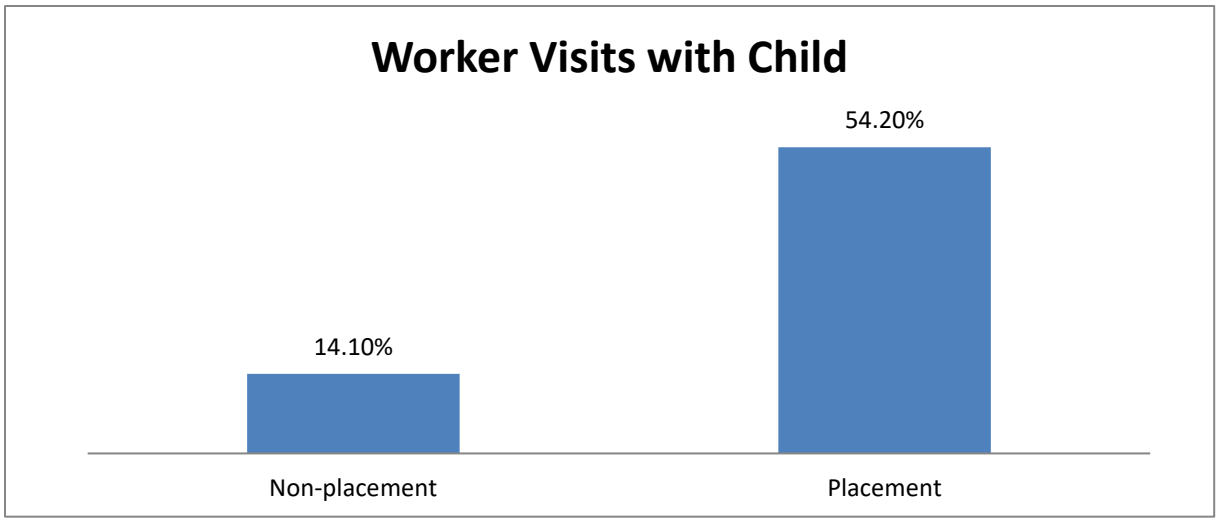
DPQI Quality Assurance Case Review Data

FFY 2015: 47.2%

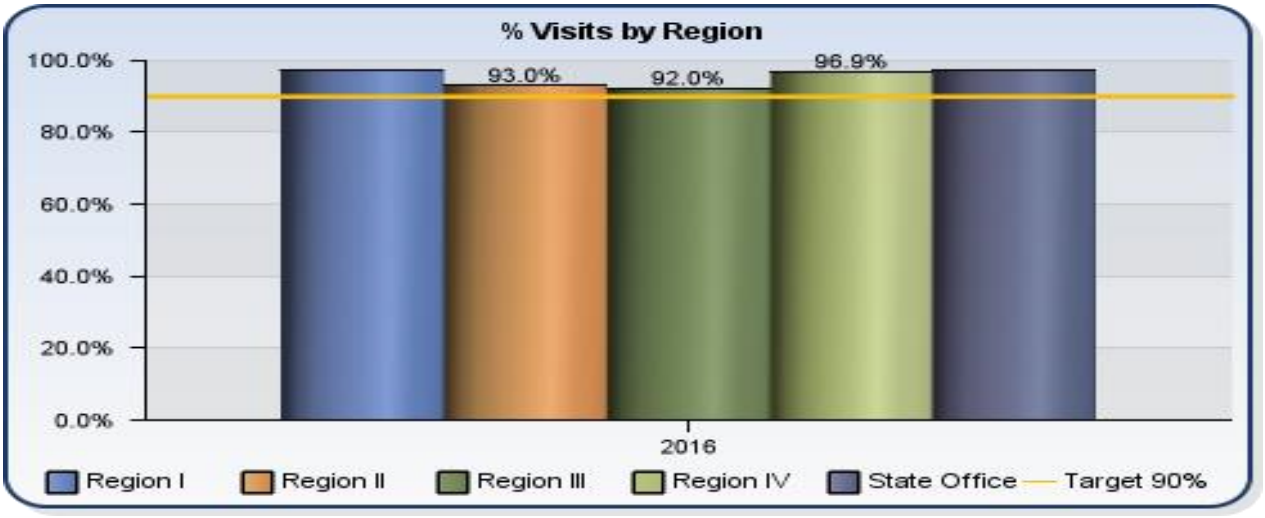
FFY 2016: 34.3%



DPQI case review data



FFY 2016 DPQI case review data

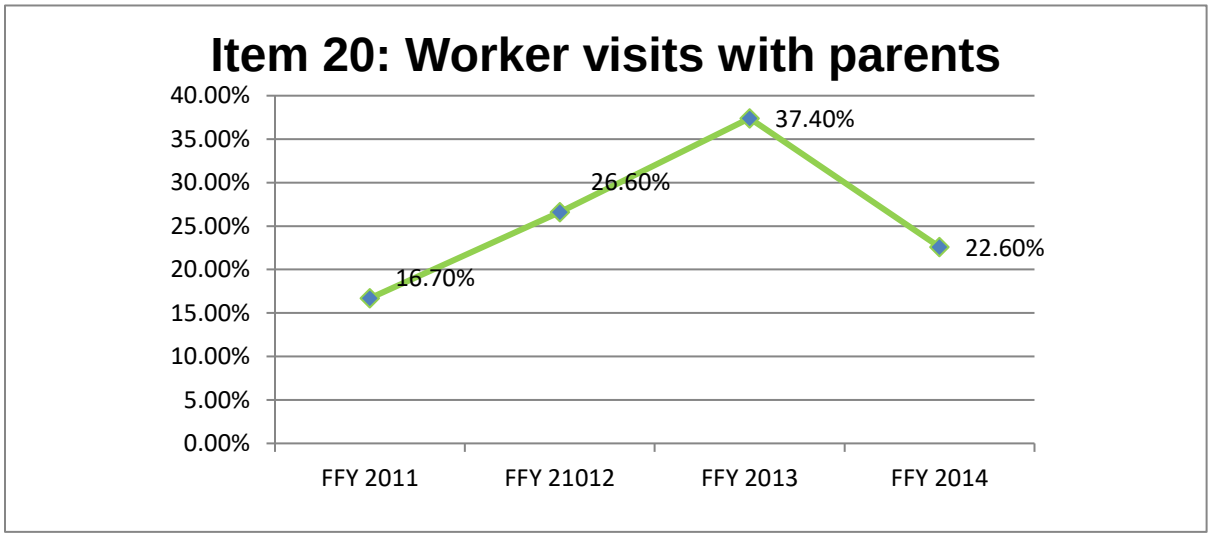


COGNOS Point in Time Report 12/22/16

(COGNOS does not evaluate the quality of the contact and therefore the two data sets cannot be compared.)

Well-being 1: Worker Visits with parents

Wellbeing Outcome 1 also assesses the case worker's visits with parents. Reviewers examine the visits that occurred during the 14-month period under review to determine whether the frequency and quality of visits between caseworkers and the mother and father(s) of the child(ren) are sufficient to ensure the safety, permanency, and wellbeing of the children and promote achievement of case goals. Reviews indicate a disturbingly low frequency of contact between caseworkers and parents.



Reviews indicated a low level of contact with parents. Cases reviewed in FFY 2014 showed a decline in worker visits with parent. Data suggests that WV needs significant improvement in this area.

Reviews indicate a lack of contact with biological fathers. Other barriers to achieving this measurement are related to the lack of contacts in the home; and involvement with the parent only at MDT meetings and court hearings. The frequency of visits between workers and parents in the family home is not sufficient to engage the parent(s) in the provision of services and ensure behavioral changes are occurring in the home environment.

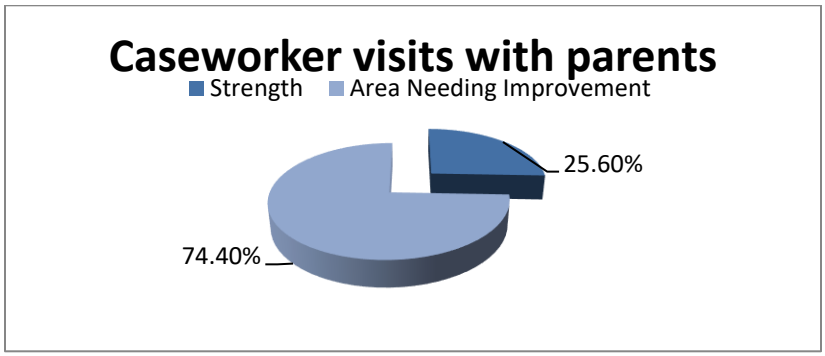
2016 Update

Wellbeing Outcome 1 also assesses the case worker's visits with parents. Reviewers examine the visits that occurred during the 12-month period under review to determine

whether the frequency and quality of visits between caseworkers and the mother, father and caretakers of the children are sufficient to ensure the safety, permanency, and wellbeing of the children and promote achievement of case goals.

This measurement will not be compared to prior years as the directions for rating this item based on the revisions to the OSRI does not allow for a direct comparison of the measurements.

Reviews indicate a low frequency of contact between caseworkers and parents. In placement cases, workers ensure compliance with court directed services but fail to engage the parent(s) in the treatment process.



Reviews indicate a lack of contact with all identified parents/caregivers. Other barriers to achieving this measurement are related to the lack of contacts in the home; and involvement with the parent only at MDT meetings and court hearings. The frequency of visits between workers and parents in the family home is not sufficient to engage the parents in the provision of services and ensure behavioral changes are occurring in the home environment. Base on case review interviews and APS Healthcare Focus Group surveys, family engagement is occurring between the service providers and the families, and Agency is seen more in the role as an overseer.

Focus Group Input Family Engagement (Welling-being 1):

Family Participant Response

The agency contracts with APS Healthcare to administer oversight to socially necessary services (SNS). As a part of the contract, APS Healthcare conducts focus groups to evaluate the quality of the services provided.

During Contract Year 2015, the Consumer Affairs for APS Healthcare Inc. conducted seven focus groups with 31 consumers receiving Socially Necessary Services (SNS) through Child Protective Services (CPS) and/or Youth Services (YS) to provide personal input. Although the sample size limits the generalization of the data to a large universe of cases, the data is promising in demonstrating family engagement.

The purpose of the focus group is to provide consumers who are receiving SNS in West Virginia the opportunity to candidly share their experiences and opinions regarding access, service delivery, the referral process and any other areas pertaining in CPS, YS and foster-adoptive cases. Youth and families receiving SNS and supports are in various regions across the state of West Virginia. The questions asked at the focus groups were developed by a workgroup of providers and agency staff in addition to APS HealthCare.

The responses from the focus group sheds additional insight into the dynamics related to family engagement.

Note: For the following focus group questions, the respondents were not limited to choosing a single response. Therefore, a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number.

When consumers were asked if they had regular contact with their agency worker and "if the worker was available when the consumer had a question", 74% of participants stated "Yes", 16% stated, "No. The remaining 10% indicated they have contact "sometimes" with their agency worker.

Family Participant Response	% of Participants
Yes	**74%**
No	**16%**
Sometimes	**10%**

All the focus group participants agreed that they are being seen monthly by their agency worker. They did note they did not feel the DHHR worker responded to them when they had an emergency, but did indicate their service provider addressed their needs in times of an "emergency".

Fifty-two percent of respondents stated that their agency worker was not in attendance when service plans were being developed with the provider agency.

The participants indicated, the provider and the members of the team developed the service plan and it was sent to the agency's caseworker for their signature.

Family Participant Response	% of Participants
Yes	**48%**
No	**52%**

The focus group participants were asked if the agency's caseworker meets with them, their family, and the provider as services are being carried out. Forty-two percent indicated "yes", their caseworker meet with them as services were carried out; 42% indicated "no" ongoing involvement by their caseworker and 16% indicate their caseworker participated "sometimes".

Family Participant Response	% of Participants
Yes	**42%**
No	**42%**
Sometimes	**16%**

The participants (31 consumers) were asked if they were actively involved in their service plan, 97% indicated yes. Participants indicated they felt engaged in the service planning process through the work of the provider.

Youth Participant Response

During Contract Year 2015, the Family Support Educator for APS Healthcare Inc. conducted eight focus groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues.

The purpose of these focus groups is to provide youth who are receiving medically necessary behavioral health services in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and impact of these services. Each group may consist of youth receiving individualized and/ or group treatment in a residential facility and/or within the community. Sixty-one youth receiving residential treatment participated in the focus groups.

When youth were asked how often they saw their agency case worker, they provided the following responses.

Youth Participant Response	% of Participants
More than once a month	**>1%**
Monthly	**53%**
Every other month	**8%**
Every Three months/Quarterly	**13%**
3 times a year	**>1%**
Never	**5%**
Don't know	**3%**
Initial Court appearance only	**3%**
No response/ Other	**14%**

Youth also indicated they had a treatment/services plan. Eighty-four percent or *51* respondents reported having a treatment/service plan, while 15% or nine respondents replied "no". They stated that they had not been in the program long enough or just had goals to work towards. One participant didn't know.

Youth Participant Response	% of Participants
Yes	**84%**
No	**15%**
I don't know, can't remember	**>1%**

When the youth were asked if they had input into their service/treatment plan, 59% of participants replied, "yes"; 29% stated, "No." Less than 1% or one person did not have a treatment plan. Other responses are indicated in the chart below. Percentages were rounded up to the nearest whole number.

Youth Participant Response	% of Participants
Yes	**59%**
No	**29%**
Do not have a treatment plan	**>1%**
No response/Other reasons	**2%**
Don't know	**10%**

The youth also indicated an improvement in their well-being as indicated in their response regarding their outlook about themselves or their situation. Participants were asked if their outlook about themselves or their situation changed since they were placed into a residential program. Seventy-nine percent indicated "Yes".

Youth Participant Response	% of Participants
Yes	**79%**
No	**16%**
Unable to answer	**5%**

The youth were asked to indicate what has helped to change their outlook. The following chart reflects those 48 participants responding, "Yes" and what areas of change occurred in their outlook. This chart reflects the number of participants per response.

Youth Participant Response	Number of Participants
Coping/Life Skills	**27**
Educational performance	**15**
Sobriety	**13**
Change in overall outlook	**8**
Family dynamics	**3**
Spirituality	**1**

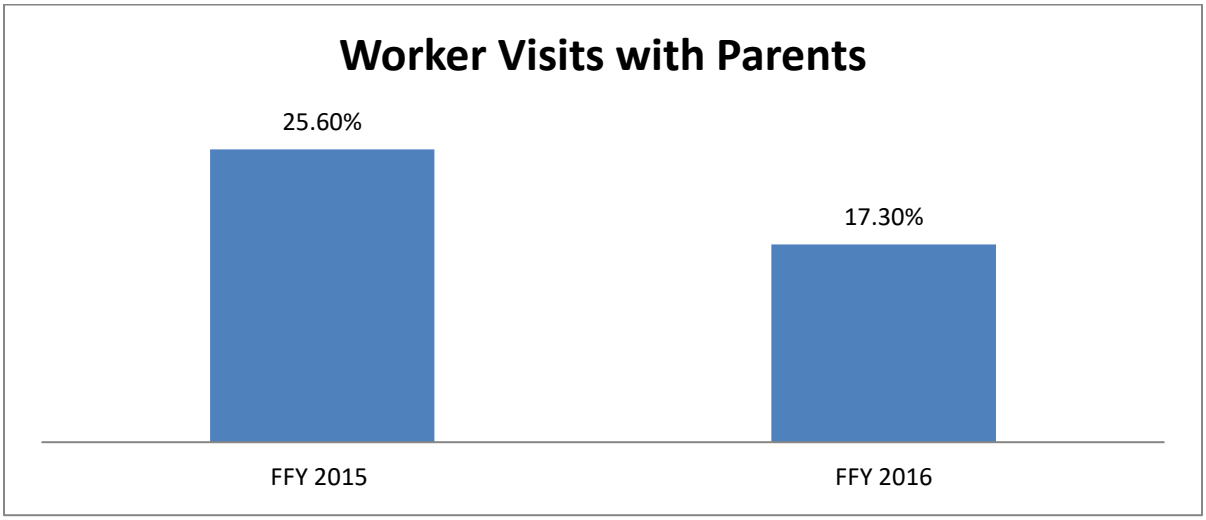
2017 Update

CFSR Item 15: Caseworker Visits with Parents

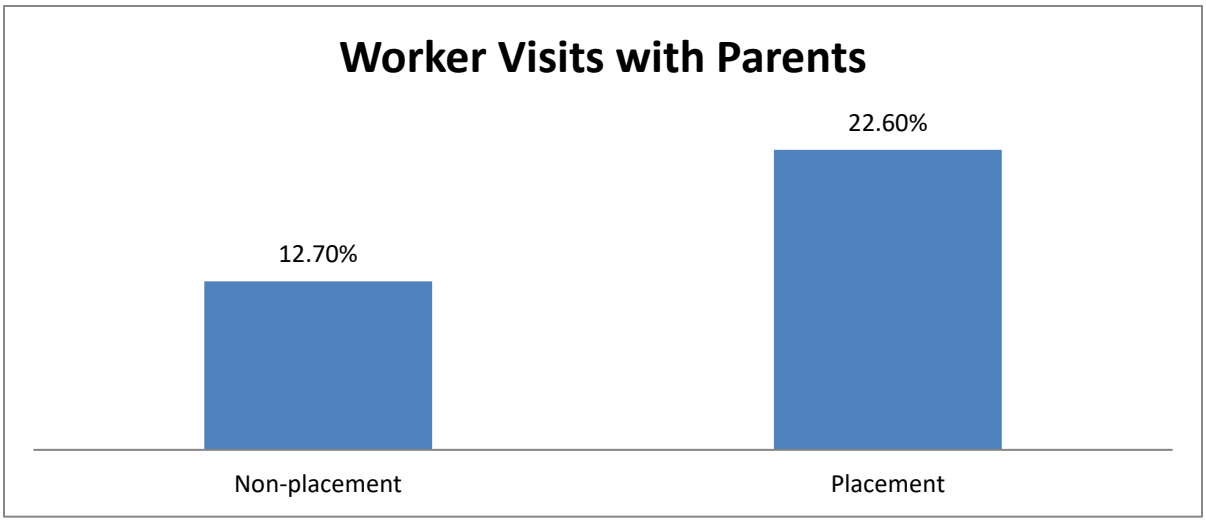
DPQI Quality Assurance Case Review Data

FFY 2015: 25.6%

FFY 2016: 17.3%



DPQI case review data



FFY 2016 DPQI case review data

Focus Groups

Focus groups are conducted with recipients of socially necessary services and children's residential services. The purpose of the focus groups is to provide consumers who are receiving socially necessary services the opportunity to share their experiences and opinions regarding access, the referral process, and service delivery. These focus groups are conducted by a contracted administrative services organization called KEPRO (previously known as APS Healthcare), as part of their overall contracted utilization management functions. One focus group consisted of 22 recipients of socially necessary services, with all but two of the participants being adults. The other focus group consisted of 14 youth between the ages of 12 and 18 receiving either medically necessary children's residential services or behavioral health services. Please refer to Item 30 for additional information on focus group participants and questions.

Results of the focus group add to the information available in relation to Permanency Outcome One regarding DHHR worker contact with families and agency engagement of families in the case planning process. Eleven out of the 14 youth who participated in the focus group comprised only of youth who indicated they see their DHHR worker one time per month. Two of the participants said they see their DHHR worker every three months. Regarding case planning activities, 11 of the 14-youth said they had a service/treatment plan. Four of the participants said they felt they had no input into the development of the plan. Of the 22 participants in the focus group comprised mainly of adults, 15 said they have "regular contact" with their DHHR worker. However, when asked what could be done

to improve service provision, five of the participants said that seeing the DHHR workers more frequently and two participants stated that meeting with a DHHR worker “period”, would assist with improved services. The majority indicated the DHHR worker did not meet jointly with them, their family, or the provider when the service plan was being developed. Fifteen of these participants said that although the DHHR worker completed monthly visits to their home the worker; never visited with the service providers; when services were being provided.

Assessment of Well-Being Outcome 1

Well-Being Outcome 1 is measured by performance on Items 12, 13, 14, and 15 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Well-Being Outcome 1 was substantially achieved in 32.4% of the cases reviewed, and partially achieved in 37.3% of the cases reviewed. Federal fiscal year 2016 case review data indicates Well-Being Outcome 1 was substantially achieved in 15.4% of the cases reviewed, and partially achieved in 30.1% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

Rating decreases were observed during FFY 2016 in all four CFSR items related to Well-Being Outcome 1. Overall, placement cases scored higher on the measure than in-home cases. The inability to have frequent and quality contacts with children and parents by caseworkers had a direct impact on Well-Being Outcome 1. Barriers to achieving this measurement include lack of contacts in the family home, having contact with parents only at MDT meetings and court hearings, and failure to have contact with all children in the home involved in YS cases.

Of the cases that did not meet the measure for assessments and service provision for children, parents, and foster parents, the majority were due to a lack of initial or ongoing assessments and service provision of the parent/s. Non-placement cases rate as an area needing improvement more often than placement cases. Cases rating as an area needing improvement are due to the lack of on-going case work. Ongoing assessments were not frequent enough to continue to assess the family and determine the effectiveness of treatment services. The Agency continues to work towards improving the ability to assess the needs of children, parents and foster parents and to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency’s involvement with the family. The lack of on-going case work in non-placement cases and the lack of involvement with all identified fathers tend to hinder improvements. The measure continues to fall short as identified needs are not always addressed in the on-going case work process. For example, domestic violence may be identified as a reason

that the DHHR is involved with the family; however, no services are put into place to address the issue. Additionally, the data indicates a lack of ongoing assessment of children and parents to determine the efficacy of the services.

Most Districts lack adequate substance abuse treatment services, both inpatient and outpatient for parents and youth; domestic violence services; and parent programs to address the issue of parenting older youth. Non-placement cases rate as an area needing improvement more often than placement cases. Cases rating as an area needing improvement are due to the lack of on-going case work. Case reviews indicate initial assessments are completed to identify areas of need; however, ongoing assessments of the family are not occurring at the frequency needed to determine the effectiveness of treatment services.

When determining if concerted efforts were made to assess children, parents and foster parents, case reviews indicated the areas needing improvement for this item are related to gaps in assessing children and parents.

As indicated earlier, there was a major difference in the way case planning actives were evaluated during case reviews during FFY2016. This lead to the significant decrease observed in the case review findings. Overall, older youth were more likely to be involved in the case planning process than younger children. Older youth in placement were often involved in case planning activities due to the activities being initiated by the placement provider. Older youth were also more likely to attend MDT meetings and court hearings.

Focus Group Input Family Engagement (Welling-being 1):

Family Participant Response

The agency contracts with APS Healthcare to administer oversight to socially necessary services (SNS). As a part of the contract, APS Healthcare conducts focus groups to evaluate the quality of the services provided.

During Contract Year 2015, the Consumer Affairs for APS Healthcare Inc. conducted seven focus groups with 31 consumers receiving Socially Necessary Services (SNS) through Child Protective Services (CPS) and/or Youth Services (YS) to provide personal input. Although the sample size limits the generalization of the data to a large universe of cases, the data is promising in demonstrating family engagement.

The purpose of the focus group is to provide consumers who are receiving SNS in West

Virginia the opportunity to candidly share their experiences and opinions regarding access, service delivery, the referral process and any other areas pertaining in CPS, YS and foster-adoptive cases. Youth and families receiving SNS and supports are in various regions across the state of West Virginia. The questions asked at the focus groups were developed by a workgroup of providers and agency staff in addition to APS HealthCare.

The responses from the focus group sheds additional insight into the dynamics related to family engagement.

Note: For the following focus group questions, the respondents were not limited to choosing a single response. Therefore, a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number.

When consumers were asked if they had regular contact with their agency worker and "if the worker was available when the consumer had a question", 74% of participants stated "Yes", 16% stated, "No. The remaining 10% indicated they have contact "sometimes" with their agency worker.

Family Participant Response	% of Participants
Yes	**74%**
No	**16%**
Sometimes	**10%**

All the focus group participants agreed that they are being seen monthly by their agency worker. They did note they did not feel the DHHR worker responded to them when they had an emergency, but did indicate their service provider addressed their needs in times of an "emergency".

Fifty-two percent of respondents stated that their agency worker was not in attendance when service plans were being developed with the provider agency.

The participants indicated, the provider and the members of the team developed the service plan and it was sent to the agency's caseworker for their signature.

Family Participant Response	% of Participants
Yes	**48%**
No	**52%**

The focus group participants were asked if the agency's caseworker meets with them, their family, and the provider as services are being carried out. Forty-two percent indicated "yes", their caseworker meet with them as services were carried out; 42% indicated "no" ongoing involvement by their caseworker and 16% indicate their caseworker participated "sometimes".

Family Participant Response	% of Participants
Yes	**42%**
No	**42%**
Sometimes	**16%**

The participants (31 consumers) were asked if they were actively involved in their service plan, 97% indicated yes. Participants indicated they felt engaged in the service planning process through the work of the provider.

Youth Participant Response

During Contract Year 2015, the Family Support Educator for APS Healthcare Inc. conducted eight focus groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues.

The purpose of these focus groups is to provide youth who are receiving medically necessary behavioral health services in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and impact of these services. Each group may consist of youth receiving individualized and/ or group treatment in a residential facility and/or within the community. Sixty-one youth receiving residential treatment participated in the focus groups.

When youth were asked how often they saw their agency case worker, they provided the following responses.

Youth Participant Response	% of Participants
More than once a month	**>1%**
Monthly	**53%**

Every other month	**8%**
Every Three months/Quarterly	**13%**
3 times a year	**>1%**
Never	**5%**
Don't know	**3%**
Initial Court appearance only	**3%**
No response/ Other	**14%**

Youth also indicated they had a treatment/services plan. Eighty-four percent or *51* respondents reported having a treatment/service plan, while 15% or nine respondents replied "no". They stated that they had not been in the program long enough or just had goals to work towards. One participant didn't know.

Youth Participant Response	% of Participants
Yes	**84%**
No	**15%**
I don't know, can't remember	**>1%**

When the youth were asked if they had input into their service/treatment plan, 59% of participants replied, "yes"; 29% stated, "No." Less than 1% or one person did not have a treatment plan. Other responses are indicated in the chart below. Percentages were rounded up to the nearest whole number.

Youth Participant Response	% of Participants
Yes	**59%**
No	**29%**

Do not have a treatment plan	**>1%**
No response/Other reasons	**2%**
Don't know	**10%**

The youth also indicated an improvement in their well-being as indicated in their response regarding their outlook about themselves or their situation. Participants were asked if their outlook about themselves or their situation changed since they were placed into a residential program. Seventy-nine percent indicated "Yes".

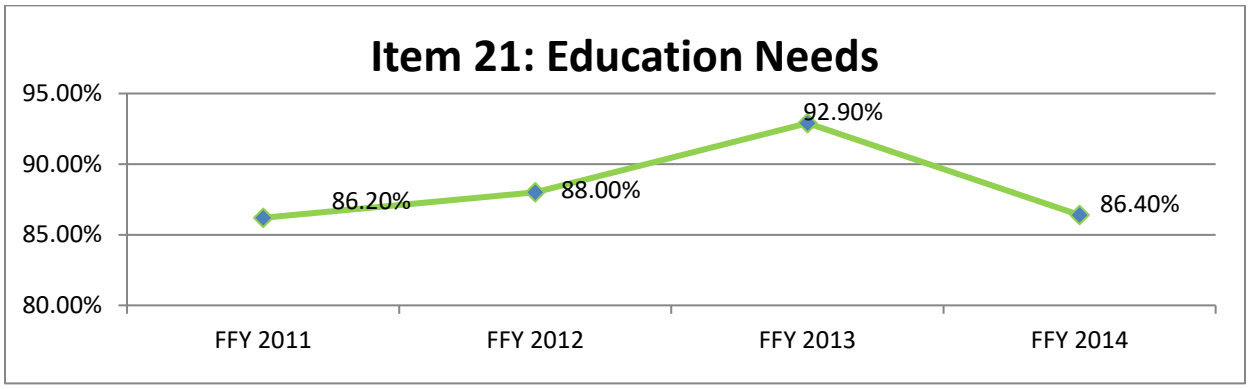
Youth Participant Response	% of Participants
Yes	**79%**
No	**16%**
Unable to answer	**5%**

The youth were asked to indicate what has helped to change their outlook. The following chart reflects those 48 participants responding, "Yes" and what areas of change occurred in their outlook. This chart reflects the number of participants per response.

Youth Participant Response	Number of Participants
Coping/Life Skills	**27**
Educational performance	**15**
Sobriety	**13**
Change in overall outlook	**8**
Family dynamics	**3**
Spirituality	**1**

Well-being Outcome 2: Children receive appropriate services to meet their educational needs

Well-being Outcome 2 has only one indicator; it pertains to the agency's efforts to address and meet the educational needs of children in both placement and in-home cases. In FFY 2014, this measure was substantially achieved in 86.4% of the cases reviewed.



Case reviews indicate that workers are making efforts to assess children's educational needs. In Federal Fiscal Year 2014, 86.4% of the cases reviewed rated strength.

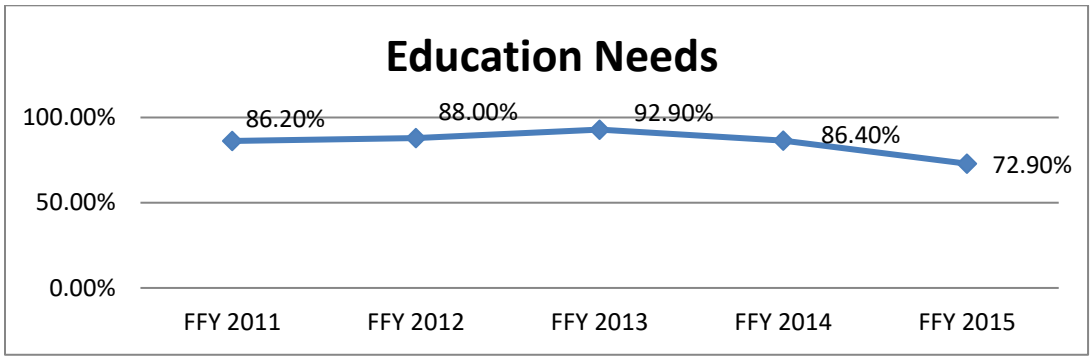
The decline is due to the lack of services to address the needs of children in non-placement cases. Educational issues that are identified are not being addressed. Case worker interviews indicate a lack of understanding of the Individual Education Plans (I.E.P.) process. Furthermore, case reviews indicate a lack of assessment in cases

referred to the Agency for truancy. Truancy cases in some districts are seen as "monitoring only". The caseworker monitors whether the youth attends school; however, fails to assess the causational factors that lead to the youth's lack of attendance. Collaboration with schools varies across the Districts, as does the process for handling truancy related cases.

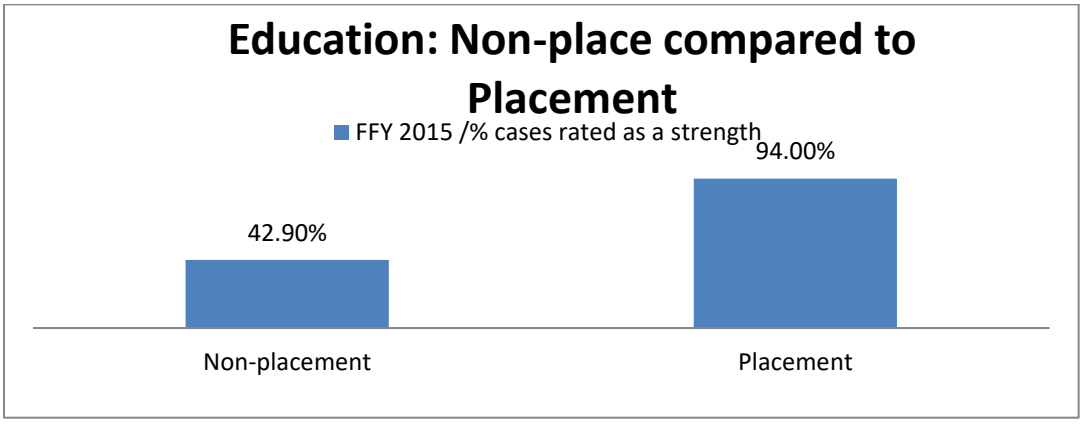
2016 Update

Well-being Outcome 2 has only one indicator; it pertains to the agency's efforts to address and meet the educational needs of children in both placement and in-home cases. In FFY 2015, this measure was substantially achieved in 72.90 % of the cases reviewed.

Well-being Outcome 2: Item 16



In FFY 2015, 72.3 % of the cases reviewed rated as strength, which is a 13.5% decline from 2014. The decline is due to the lack of services to address the educational needs of children in non-placement cases.



Educational issues that are identified are not being addressed. Case worker interviews indicate a lack of understanding of the Individualized Education Plans (I.E.P.) process. Furthermore, case reviews indicate a lack of assessment in cases referred to the agency for truancy. Truancy cases in some districts are "monitoring only". The caseworker monitors whether the youth attends school; however, fails to assess the causational factors that lead to the youth's lack of attendance. Collaboration with schools varies across the districts, as does the process for handling truancy-related cases.

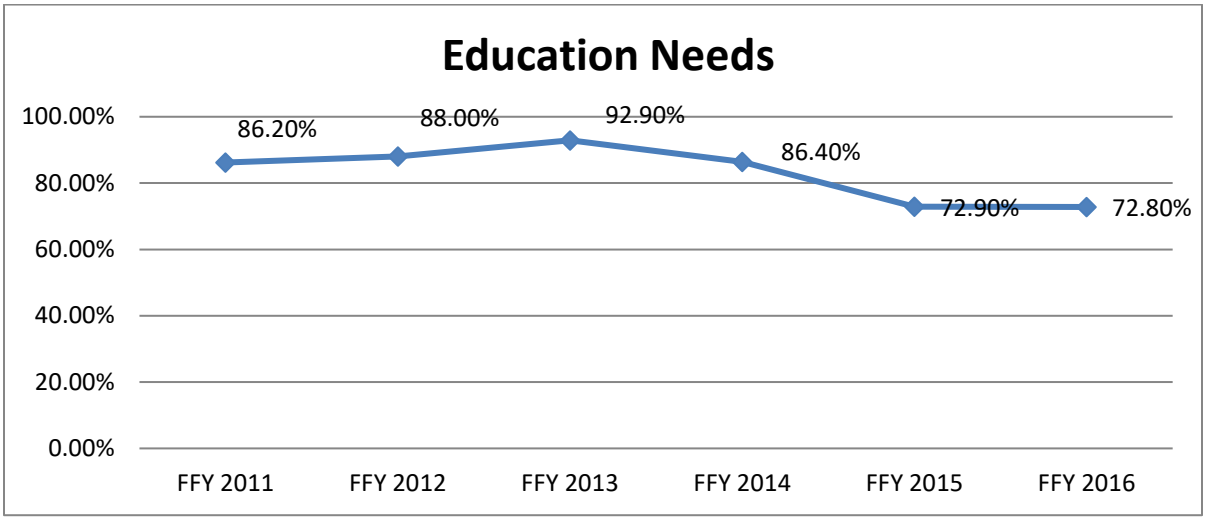
2017 Update

CFSR Item 16: Educational needs of the child.

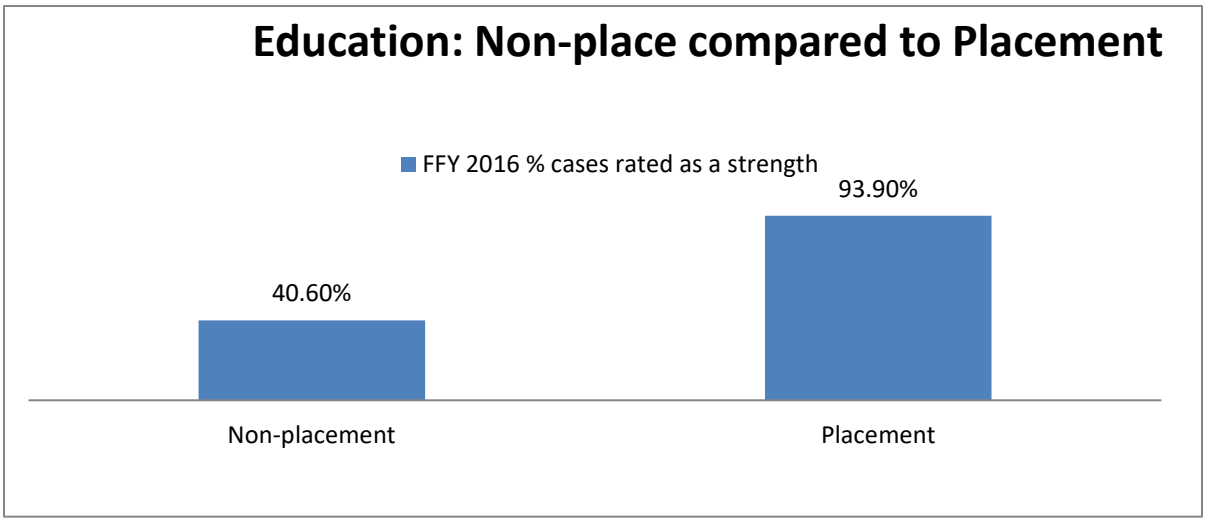
DPQI Quality Assurance Case Review Data

FFY 2015: 72.9%

FFY 2016: 72.8%



DPQI case review data



FFY 2016 DPQI case review data

Assessment of Well-Being Outcome 2

Well-Being Outcome 2 is measured by performance on Item 16 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Well-Being Outcome 2 was substantially achieved in 72.9% of the cases reviewed. The outcome rating for Well-Being Outcome 2 based on case reviews for federal fiscal year 2016 indicates Well-Being Outcome 2 was substantially achieved in 72.8% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review. Case reviews indicate minimal change in relation to the rating of this item between FFY 2015 and FFY 2016. Factors that contributed to the 2016 ratings include failure to assess all the children's educational needs in in-home Youth Services cases. There is often a focus on the child that came to the agency's attention, through formal or informal referrals for services, and other children residing in the home often are not assessed. Additionally, many districts within West Virginia have court systems that open truancy cases for monitoring purposes. The child welfare agency is often tasked with monitoring attendance, and service provision to address the issues contributing to the truancy are often only addressed when ordered by the court, or when the child is removed from the home due to the truancy. Over the past two years, West Virginia has seen an increase in these court-ordered monitoring cases.

Educational issues that are identified are not always being addressed. Case worker interviews indicate a lack of understanding of the Individualized Education Plans(IEP) process. Furthermore, case reviews indicate a lack of assessment in cases referred to

the agency for truancy. Truancy cases in some districts are "monitoring only". The caseworker monitors whether the youth attends school; however, fails to assess the causational factors that lead to the youth's lack of attendance. Collaboration with schools varies across the districts, as does the process for handling truancy-related cases.

Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

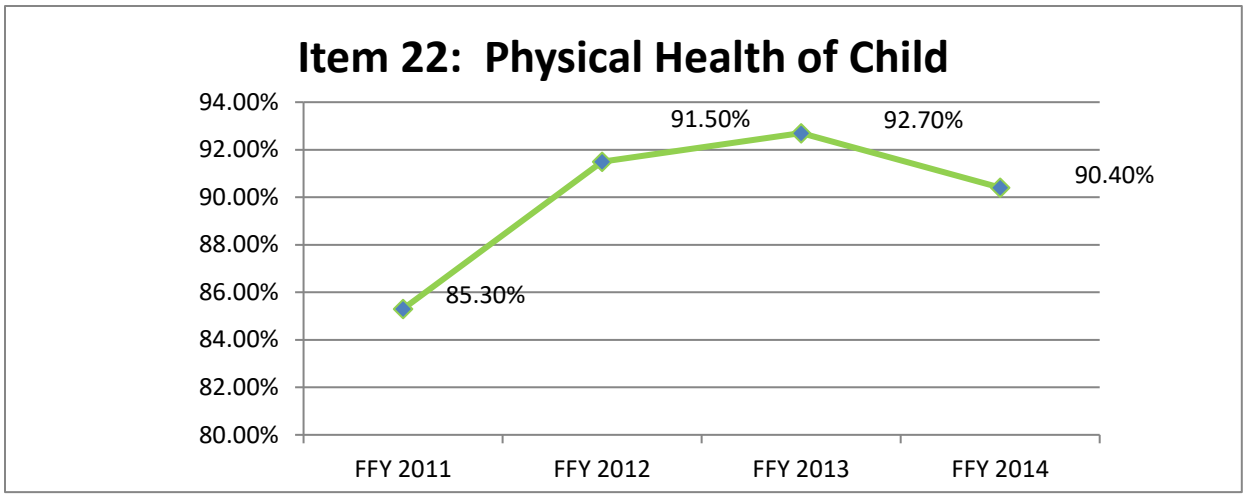
Well-being Outcome 3 incorporates two indicators that assess the child welfare agency's efforts to meet children's physical health needs and children's mental health needs. In FFY 2014, this measure was substantially achieved in 81.6% of the cases reviewed and partially achieved in 3.9% of the cases reviewed.

2016 Update

In FFY 2015, this measure was substantially achieved in 67.5% of the cases reviewed and partially achieved in 5.8% of the cases reviewed.

Well-being Outcome 3: Children receive adequate services to meet their physical health needs.

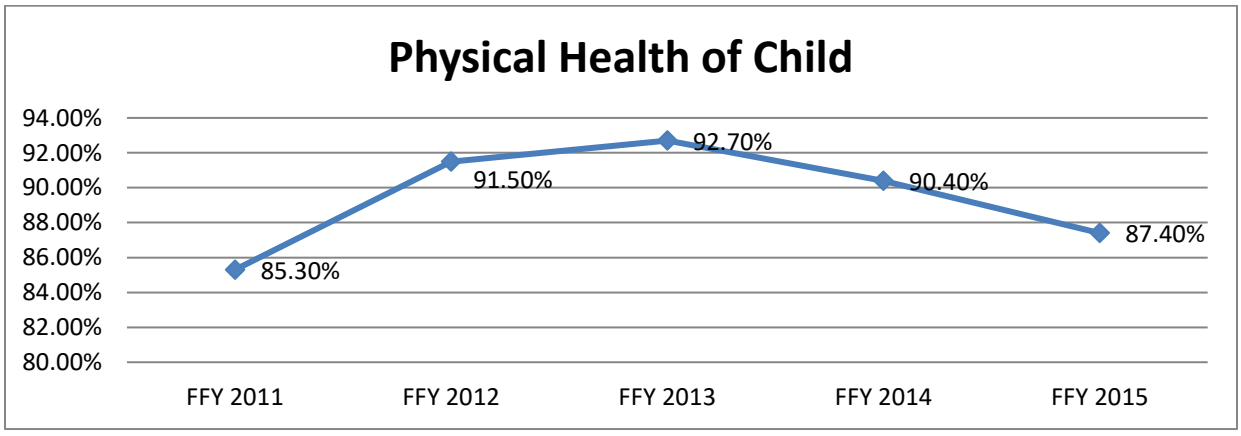
Cases are reviewed to determine if the Agency addressed the physical health needs of the child, including dental health. In-home cases are applicable to this measure if the health issues were relevant to the reason for the agency's involvement. All placement cases are reviewed for this measure.



During Federal Fiscal Year 2014, 86.3% of the cases applicable to this measure rated as a strength. 96.3% of the placement cases rated strength for this measure. The decline in this measure is related to the failure to address the child(ren) needs in in-home cases.

2016 Update

Cases are reviewed to determine if the agency addressed the physical health needs of the child, including dental health. In-home cases are applicable to this measure if the health issues were relevant to the reason for the agency's involvement. All placement cases are reviewed for this measure.



During FFY 2015, 86.3% of the cases applicable to this measure rated as a strength. Ninety-six-point three percent (96.3%) of the placement cases rated as a strength for this

measure. The decline in this measure is related to the failure to address the children's needs for in-home cases.

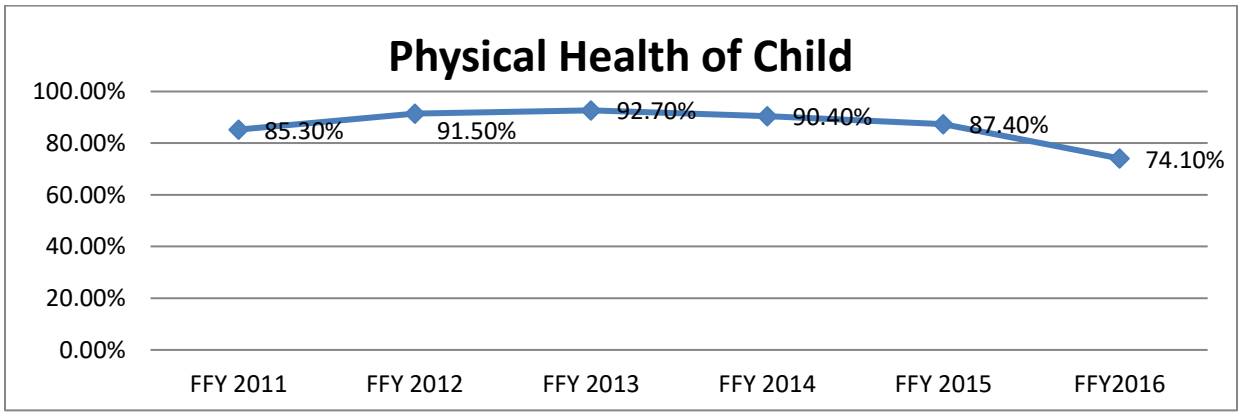
2017 Update

CFSR Item 17: Physical health of the child.

DPQI Quality Assurance Case Review Data

FFY 2015: 87.4%

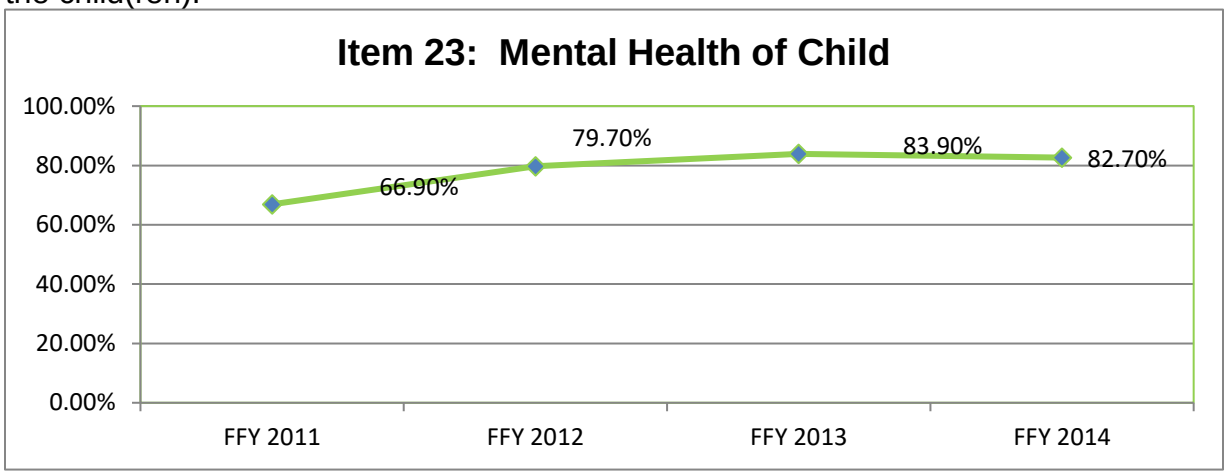
FFY 2016: 74.1%



DPQI case review data

Well-being Outcome 3: Children receive adequate services to meet their mental health needs.

Cases are reviewed to determine if the Agency addressed the mental health needs of the child(ren).



Data indicates that the Agency maintained with a slight decline in providing for the mental health needs of the child(ren). Data continues to indicate children in placement are more likely to have mental health assessments and services to address the identified need(s) of the child.

Children in residential placements have access to more mental health care services by the nature of the setting. Non-placement cases rated as strength less often due to several factors. Lack of transportation to mental health services is often a barrier in rural areas. Parents tend to fail to recognize the need for the treatment of mental health issues in child(ren). Districts continue to note that a lack of qualified providers and long waitlists as contributing factors to meeting the mental health needs of children.

Additionally, counseling services for children who have been sexually abused are not available in many areas. Districts also note a lack of programs and community support groups that can address issues related to addictions for both youth and parent(s).

In conclusion, the case review data from Federal Fiscal Year 2014 indicates West Virginia has made improvements in 4 of the 23 indicators based on the Child and Families Services reviews.

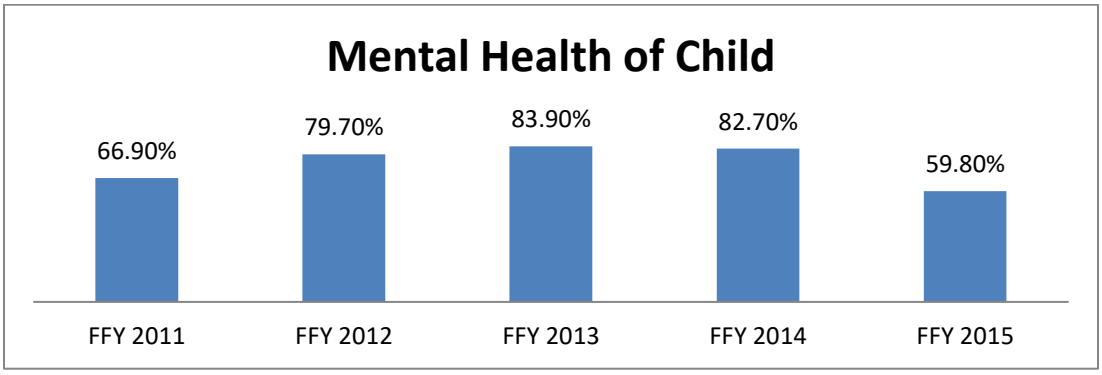
Based on Federal guidelines for achieving substantial conformity, West Virginia would not have met the 95% threshold for the seven performance outcomes.

October 1, 2013 - September 30, 2014 **All**
Cases Outcome or Performance Indicator

	Outcome Ratings		
	Substantially Achieved	Partially Achieved	Not Achieved
Outcome S1: Children are, first and foremost, protected from abuse and neglect	52.2%	35.8%	11.9%
Outcome S2: Children are safely maintained in their homes whenever possible and appropriate.	31.5%	21.8%	46.8%
Outcome P1: Children have permanency and stability in their living situation	46.7%	52.0%	1.3%
Outcome P2: The continuity of family relationships and connections is preserved for children.	94.7%	5.3%	0.0%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	42.7%	26.6%	30.6%
Outcome WB2: Children receive appropriate services to meet their educational needs.	86.4%	0.0%	13.6%
Outcome WB3: Children receive adequate services to meet their physical and mental health needs.	81.6%	3.9%	14.6%

2016 Update

Cases are reviewed to determine if the agency addressed the mental health needs of the children.



Data indicates that the agency declined in providing for the mental health needs of children. Services were not put into place to address the identified behavioral health

issues. Children exhibiting severely challenging behaviors were not assessed for mental health issues, or provided mental health services after the need for such was identified.

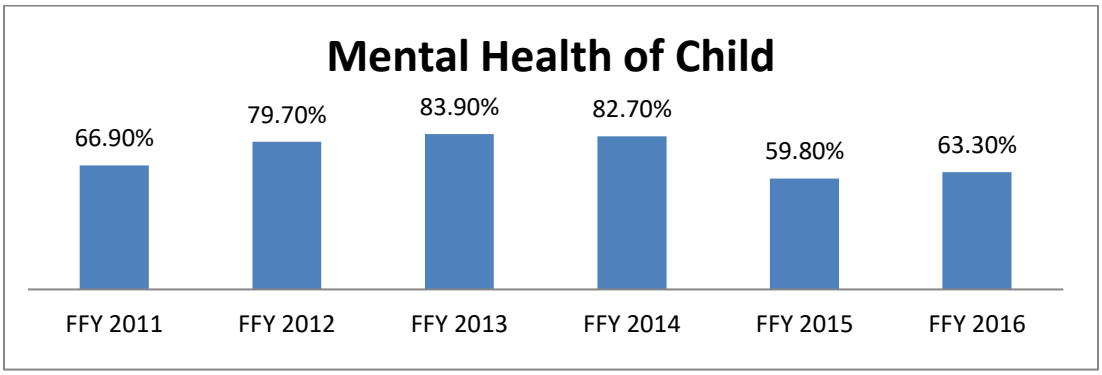
2017 Update

CFSR Item 18: Mental/behavioral health of the child.

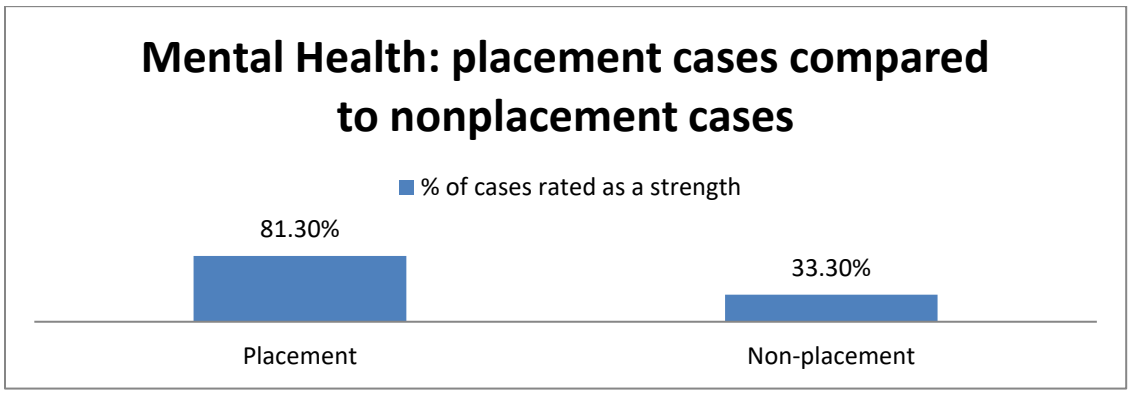
DPQI Quality Assurance Case Review Data

FFY 2015: 59.8%

FFY 2016: 63.3%

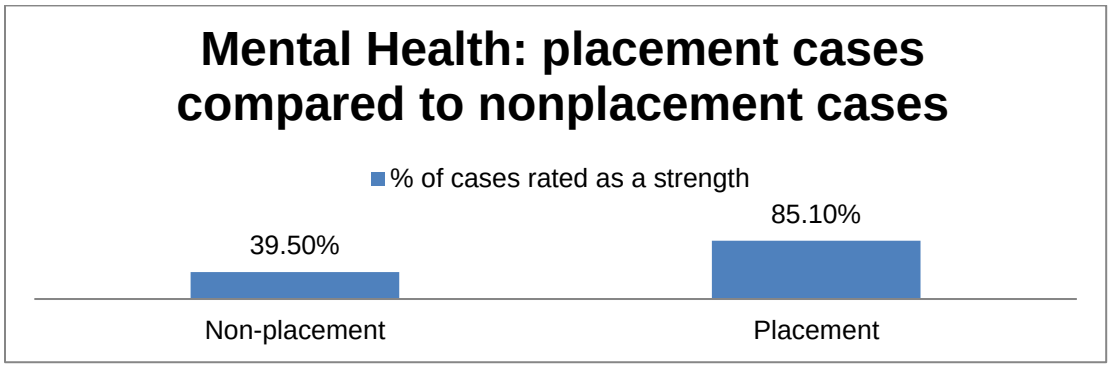


DPQI case review data



West Virginia's case data reviewed in conjunction with the outcomes of the residential youth focus groups indicate children in placement are more likely to have mental health assessments and services to address their identified needs. Children in residential placements have access to mental health services by the nature of the setting; however, the youth felt mental health services were available to them in their communities.

2017 Update



FFY 2016 DPQI case review data

Youth Participant Response Mental Health Services

During Contract Year 2015, the Family Support Educator for APS Healthcare Inc. conducted eight focus groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues. Sixty-one percent of youth receiving residential treatment participated in the focus groups.

Note: For the following focus group questions the respondents were not limited to choosing a single response. Therefore, a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number.

Participants were asked "Is your therapy dealing with matters and goals that are of concern to you?" Of the youth surveyed, 69% indicated a positive response indicating therapy was assisting them in dealing with matters and goals that were of concern to them.

Youth Participant Response	*% of Participants*
Yes	***69%***
No	***20%***
Sort of	***>1%***
Don't know	***>1%***
No response	***9%***

The youth indicated they felt they received therapy frequently enough to meet their goals and concerns.

Youth Participant Response	% of Participants
Yes	**68%**
No	**15%**
I don't know yet	**>1%**
No response	**17%**

The residential youth focus groups also provided insight into issues surrounding family participation in their treatment. The participants were asked, "*Do you feel your therapy is frequent enough?* Their responses are indicated in the chart below.

Youth Participant Response	% of Participants
No	**30%**
Yes	**43%**
Don't know	**24%**
No Comment	**3%**

The participants that indicated a positive response felt there were no issues, stating they had good visits and phone conversations with family members. The participants that felt there were issues surrounding family participation elaborated with comments such as "family doesn't care", or that they just didn't see family at all. One participant has a child but has not been allowed to have a visit.

Most the respondents indicated they feel confident about exiting the residential program. They indicated they had learned skills and were ready to enter dating relationships, have new friends and move forward with their lives. The participants that stated, "No," because of varying placement issues such as foster care placement vs. natural family, lack of

independence skills or aging out of the system. Ten percent of the participants stated they just wanted to go home.

Youth Participant Response	% of Participants
Yes	**68%**
No	**18%**
Just want to exit	**10%**
Don't know	**4%**

The focus group also identified they would know how to access activities and services within their community. Ninety-two percent or 56 respondents stated, "Yes", they would call or speak with their agency caseworker or family members if they had any questions. Three percent of participants stated, "No", they were unsure of future placements or communities.

Overall Case Outcomes or Performance Indicators

October 1, 2014 - September 30, 2015

All Cases Outcome or Performance Indicator

	Outcome Ratings

	Substantially Achieved	Partially Achieved	Not Achieved
Outcome S1: Children are, first and foremost, protected from abuse and neglect	70.2%	N/A	29.8%
Outcome S2: Children are safely maintained in their homes whenever possible and appropriate.	33.8%	23.9%	42.3%
Outcome P1: Children have permanency and stability in their living situation	40.8%	52.6%	6.6%
Outcome P2: The continuity of family relationships and connections is preserved for children.	73.7%	22.4%	3.9%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	32.4%	37.3%	30.3%
Outcome WB2: Children receive appropriate services to meet their educational needs.	72.9%	0%	27.1%
Outcome WB3: Children receive adequate services to meet their physical and mental health needs.	67.5%	5.8%	26.7%

West Virginia did not meet the 95% threshold as required by federal guidelines for achieving substantial conformity for the seven performance outcomes.

Case review data supports West Virginia's initiatives to improve community-based services and programming to better service children in their communities and reduce the dependence on residential services.

2017 Update

Summation of Performance

October 1, 2015 - September 30, 2016 All Cases Outcome or Performance Indicator	Outcome Ratings

	Substantially Achieved	Partially Achieved	Not Achieved
Outcome S1: Children are, first and foremost, protected from abuse and neglect	67.1%	N/A	32.9%
Outcome S2: Children are safely maintained in their homes whenever possible and appropriate.	22.4%	16.8%	60.8%
Outcome P1: Children have permanency and stability in their living situation	18.3%	64.8%	16.9%
Outcome P2: The continuity of family relationships and connections is preserved for children.	76.4%%	22.2%	1.4%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	15.4%	30.1%	54.5%
Outcome WB2: Children receive appropriate services to meet their educational needs.	72.8%	0%	27.2%
Outcome WB3: Children receive adequate services to meet their physical and mental health needs.	59.0%	9.8%	31.1%

DPQI case review data indicates that West Virginia did not meet the 95% threshold as required by federal guidelines for achieving substantial conformity for the seven performance outcomes. West Virginia did improve ratings on Outcome Permanency 2. The Child and Family Services Review (CFSR 3) Data Profile measuring West Virginia's performance on each of the Round 3 statewide data indicators, as measured against national standards and the results of the data quality checks, indicates that West Virginia met or exceeded the national standard in relation to six of the seven data indicators. West Virginia did not meet the indicator for permanency in 12 months for children entering care. Supreme Court of Appeals of West Virginia Child Abuse and Neglect data also indicates that children remain in placement longer than 12 months before achieving permanency in their living situation. West Virginia continues to work toward shortening the length of time children remain in care without permanency in their living situations. It should be noted that the overall length of time for an abused or neglected child to reach permanency has been reduced over the last eight years.

Multiple factors impact the ability of West Virginia to improve positive outcomes for children and families. One major factor is the ever-increasing number of cases in which substance abuse is a factor. West Virginia also struggles to attract and retain qualified

staff. As indicated earlier, performance on the Child and Family Services case reviews is directly linked to staffing levels in the district during the period under review. During both federal fiscal years 2015 and 2016, districts continue to list staff turnover as a barrier to achieving better outcomes for children and families. Districts also indicate the limited availability of services including quality ASO providers, mental health services, domestic violence counseling for victims and batterers, and substance abuse treatment for both adults and youth as other barriers in meeting the needs of children and families. West Virginia continues to work with community partners to increase services to address these barriers.

West Virginia Context Data Review and Child and Family Services Review Data Profile (June 29, 2015)

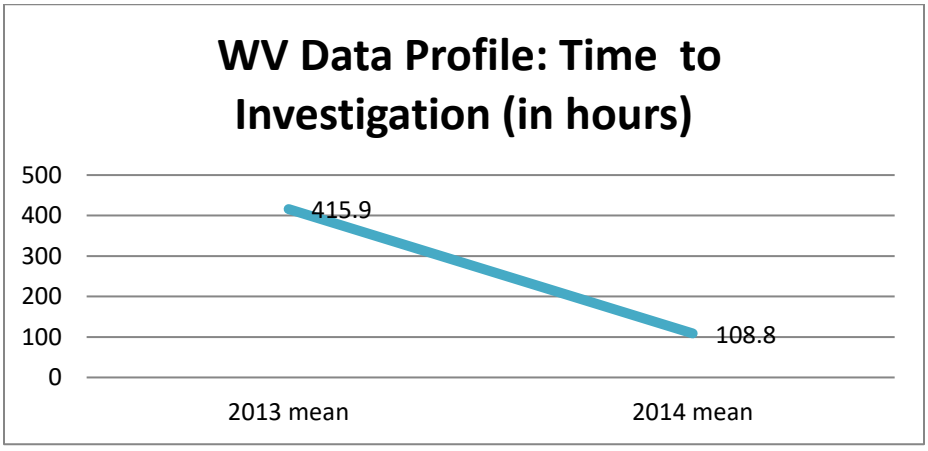
West Virginia utilizes the context data profile based on the AFCARS and NCANDS Federal report year 2014, as it is the most recent and available data to assist WV in the assessment of child welfare outcomes.

This data will be compared to the National Performance Outcomes as applicable.

Safety

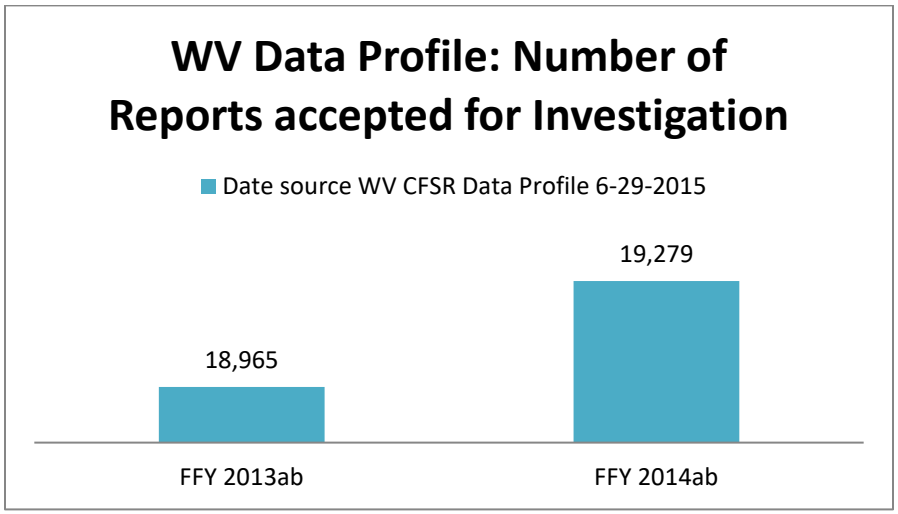
Data shown below are from the National Child Abuse and Neglect Data System (NCANDS) or the Adoption and Foster Care Analysis and Reporting System (AFCARS) and are based on the FFY, October 1 through September 30, 2014.

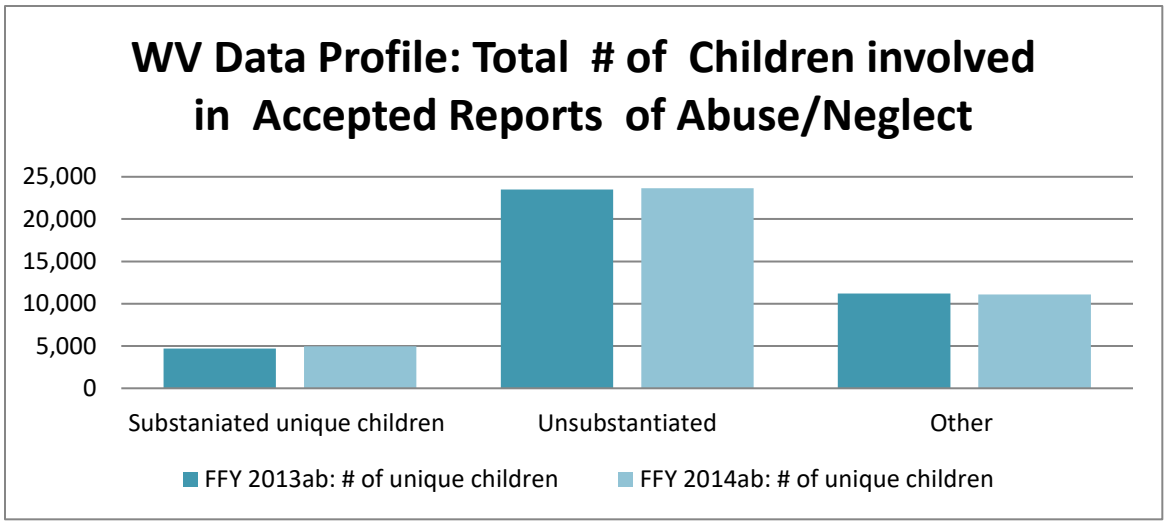
West Virginia continues to improve in the time to investigation.



In reviewing the data elements, West Virginia discovered that there is a discrepancy in the way the values for this element were being pulled. West Virginia was unable to get the values corrected to resubmit, but the errors are resolved within this submission. West Virginia submitted an agency file indicating the mean time to investigation in hours as 27.4. West Virginia notes the decrease in the response time in the agency file and contributes the decrease to the implementation of the Centralized Intake Unit. On July 1, 2014, WV began operating a Centralized Intake Unit for abuse and neglect complaints to improve consistency in the evaluation and decision related to reports of abuse and neglect. The Centralize Intake Unit operates seven days a week, 24 hours a day by staff employed by the agency, which replaced the former system of abuse and neglect reports being taken by staff at county offices and a contracted agency after regular business hours (WV Child and Family Review Data Profile; June 29, 2015; footnote D and E).

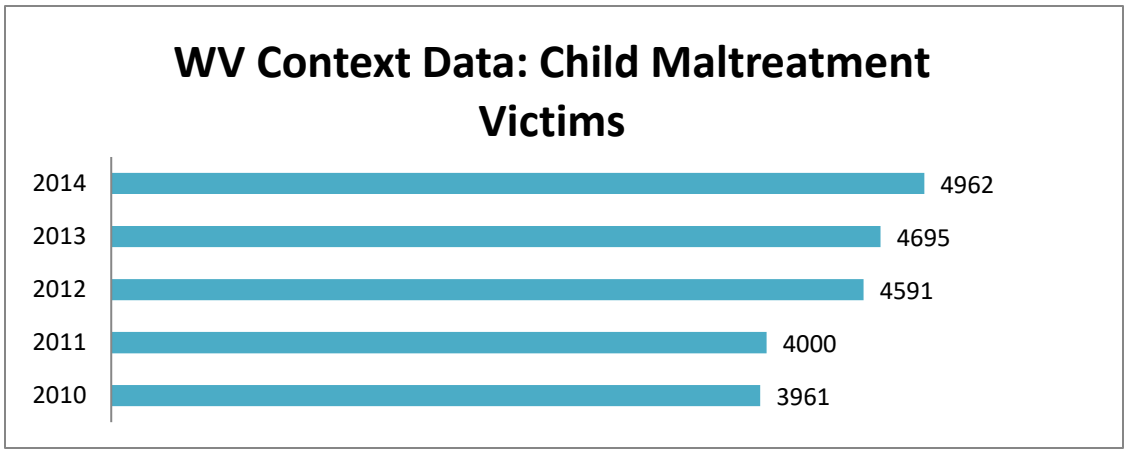
West Virginia continues to see an increase in the number of child maltreatment victims, along with an increase in the rate of entry into foster care. This is likely due to the increase in the total number of child abuse and neglect reports received in WV that have a substantiated disposition in the reporting period under review (FFY 2014 ab).





Each maltreatment allegation reported to NCANDS is associated with a disposition or finding that is used to derive the counts provided in this safety profile. The safety profile uses three categories. The various terms that are used in NCANDS reporting have been collapsed into these three groups. The unique count of children counts a child only once during the reporting period, regardless of how many times the child was reported.

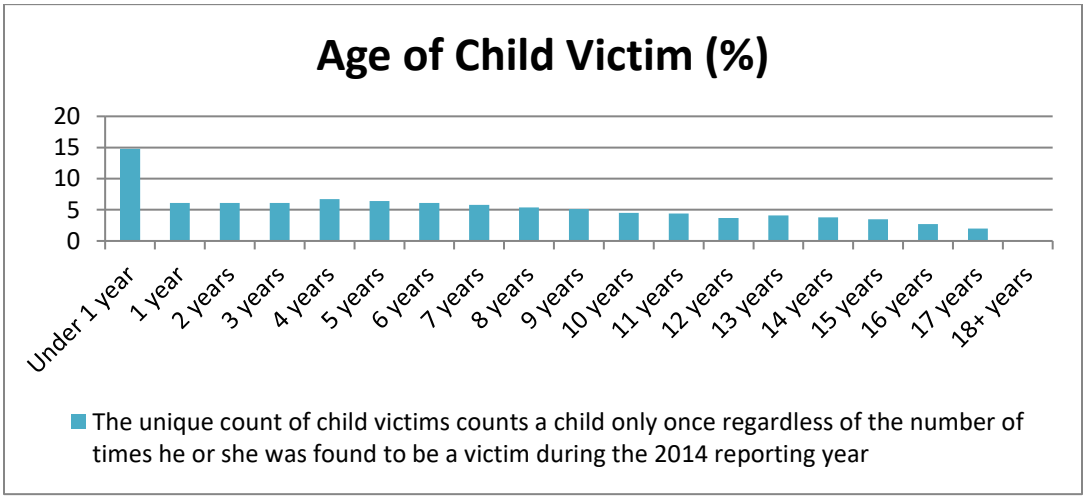
Substantiated or Indicated (Maltreatment Victim)	"Substantiated," "Indicated," and "Alternative Response Disposition Victim"
Unsubstantiated	"Unsubstantiated" and "Unsubstantiated Due to Intentionally False Reporting"
Other	"Closed-No Finding," "Alternative Response Disposition – Not a Victim," "Other," "No Alleged Maltreatment," and "Unknown or Missing"

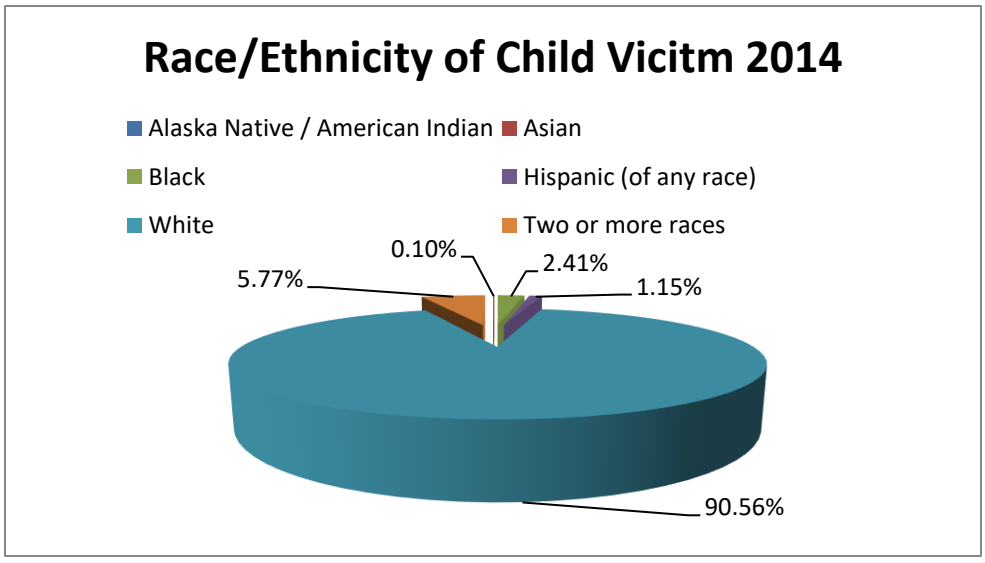


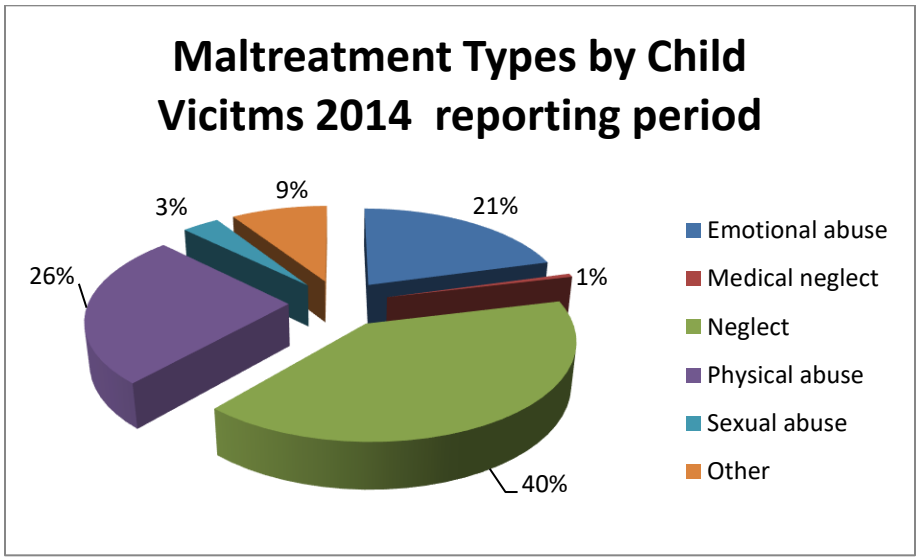
*Note: The definition is based on federal NCANDS definition: "*A child victim is defined as a child who is the subject of a maltreatment report for which the disposition is substantiated, indicated, or alternative response victim."*

Child Maltreatment Data (National Child Abuse and Neglect Data System (NCANDS) 2014: Profile of Victims of Maltreatment (Context Data)

West Virginia's most vulnerable children remain children from age birth to three years of age. 33.1 % of the victims of maltreatment are children ages birth to three.





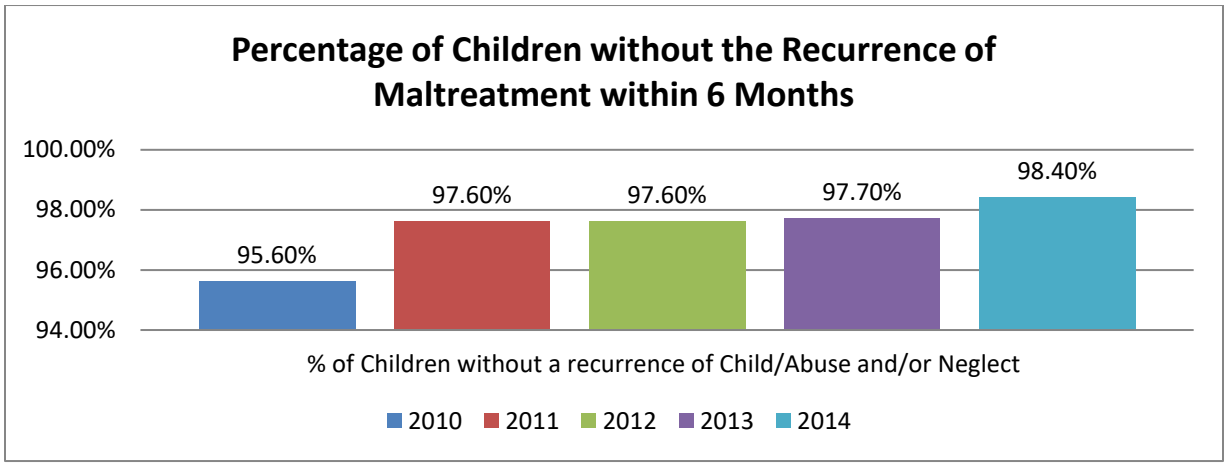


Percentage of Children without the Recurrence of Maltreatment within Six Months

West Virginia's data indicates a continued low rate in the recurrence of maltreatment. Based on the standards set forth by the U.S. Department of Health and Human Services Administration for Children and Families, WV achieved substantial conformity for this measure. West Virginia's data indicates of all children who were victims of substantiated or indicted child abuse and/or neglect during the first 6 months of the year, 1.6% had

another substantiated report within a six-month period. The National median for this measure is 4.9%.

(*for this measure, a lower number indicates better performance per NCANDS)

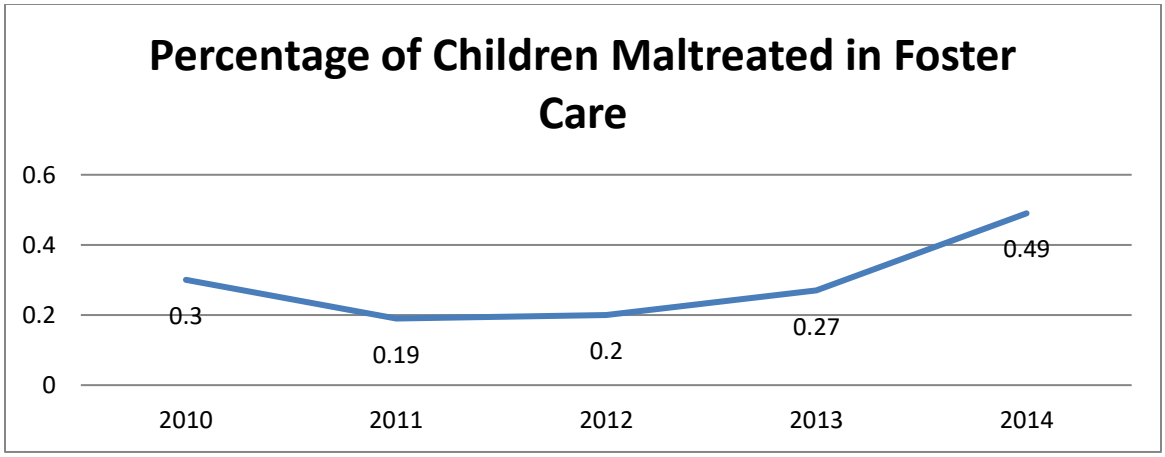


Children Maltreated in Foster Care

Data indicates that .49% of children in foster care were determined to be abused or neglected in foster care

West Virginia's data indicates that .49 % of children in foster care were determined to be abused or neglected in foster care. The National Median for this measurement is 4.9%.

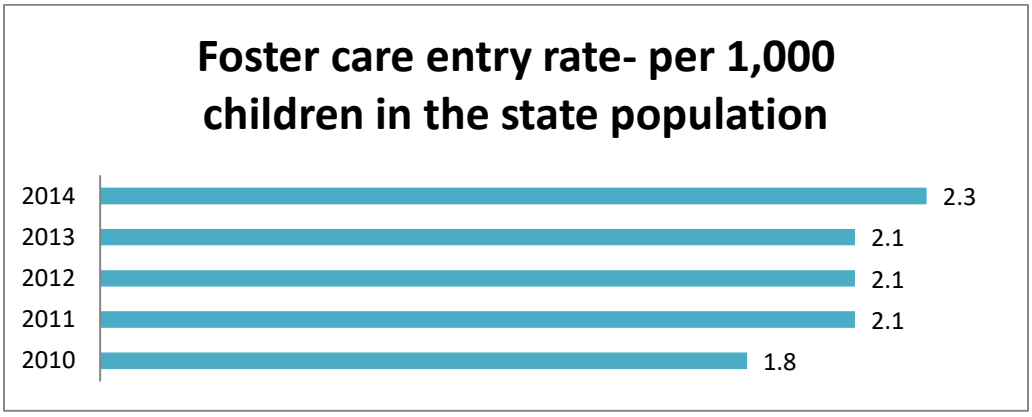
(*for this measure, a lower number indicates better performance per AFCARS).

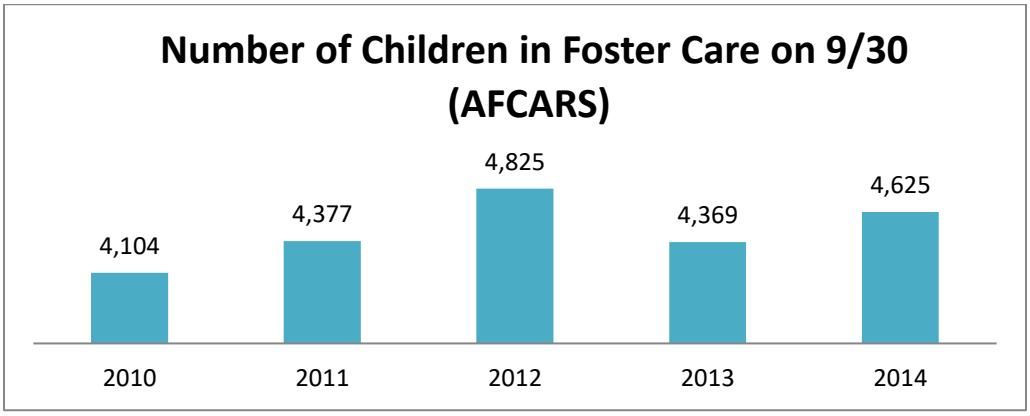


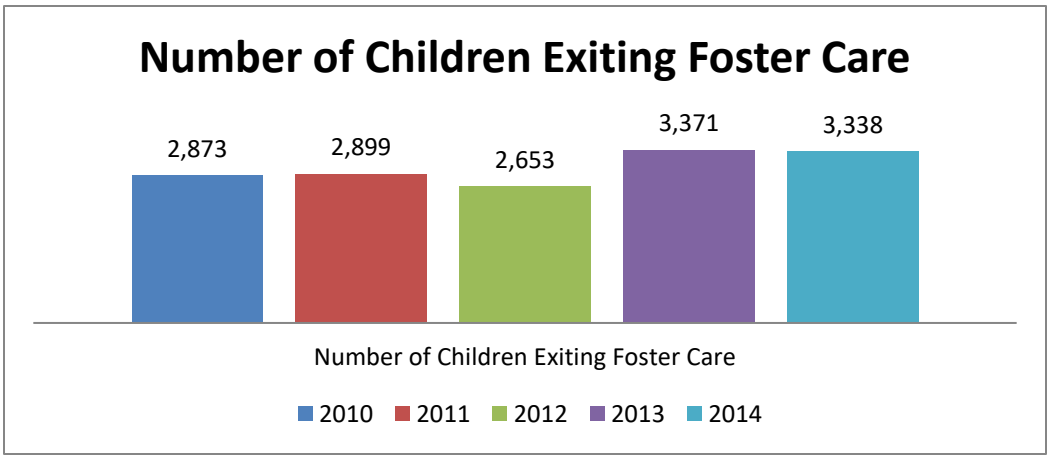
Permanency: Overview of the Characteristics of Children in Foster Care (Adoption and Foster Care Analysis and Reporting System (AFCARS) Foster Care Files) 2014

West Virginia's data indicated an increase in the number of children that have been maltreated. NCANDS indicate 4,695 children were maltreated in 2013, data for 2014 indicated 4,962.

West Virginia's rate of entry into foster care has also increased based on NCANDS data.

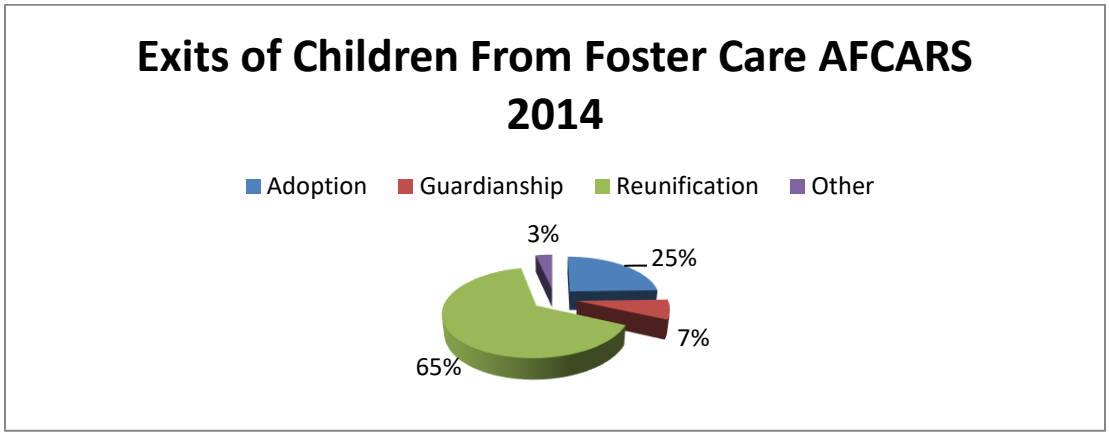






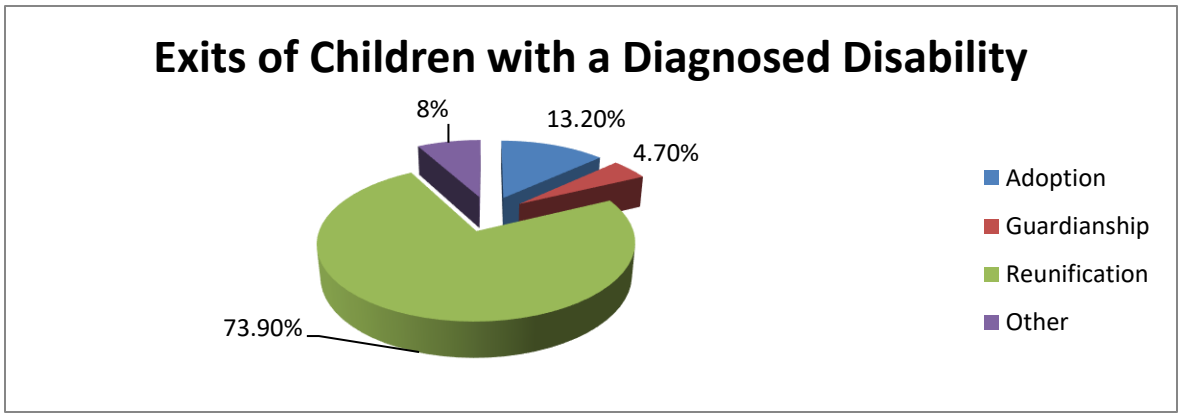
Children Exiting Foster Care

Of all the children who exited foster care during 2104, 98 % of West Virginia's children left to reunification, adoption, or legal guardianship. As indicated below, 64% of children exiting foster care are reunified with their families, 24 % were adopted, and 7% were placed in legal guardianship. Based on 2014 National Performance outcomes measures, WV would fall within the median range 89.0% when compared to other states.



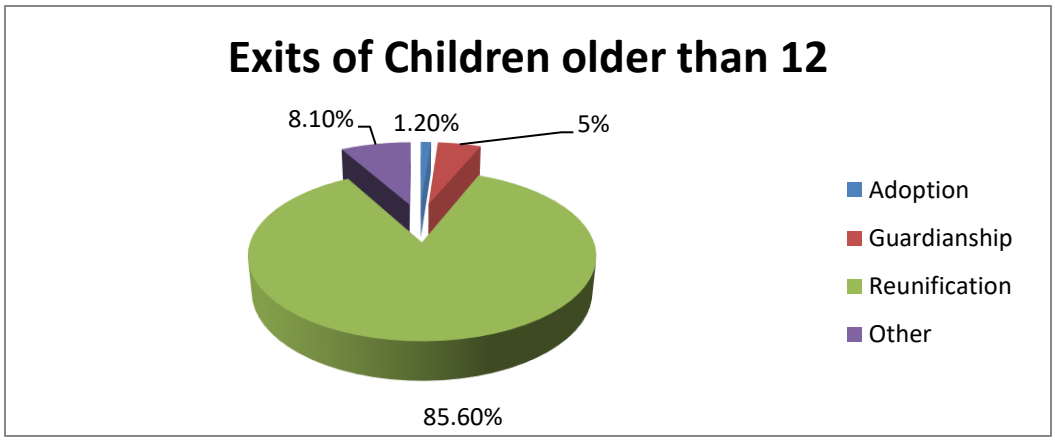
Exits of Children with a Diagnosed Disability

West Virginia's data indicates of all children who exited foster care during 2014 and were identified as having a diagnosed disability, 91.8 % left care to a permanent home. National performance on child welfare outcomes indicated the national median at 78.4%.



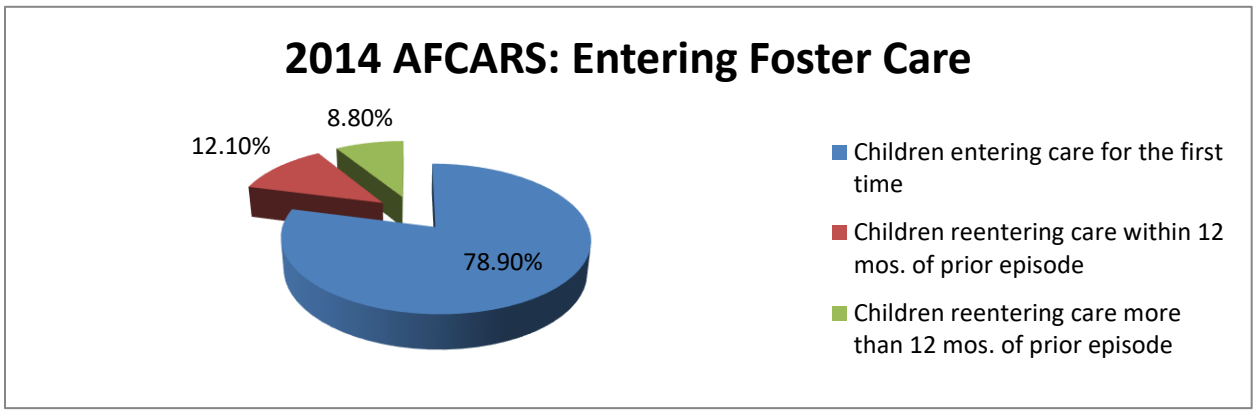
Exits of Children Older than 12

AFCARS data for 2014 indicates of all children who exited foster care and were older than age 12 at the time of their most recent entry into care, 91.8 % were discharge to a permanent home. National performance on child welfare outcomes indicated the national median at 63.9%.



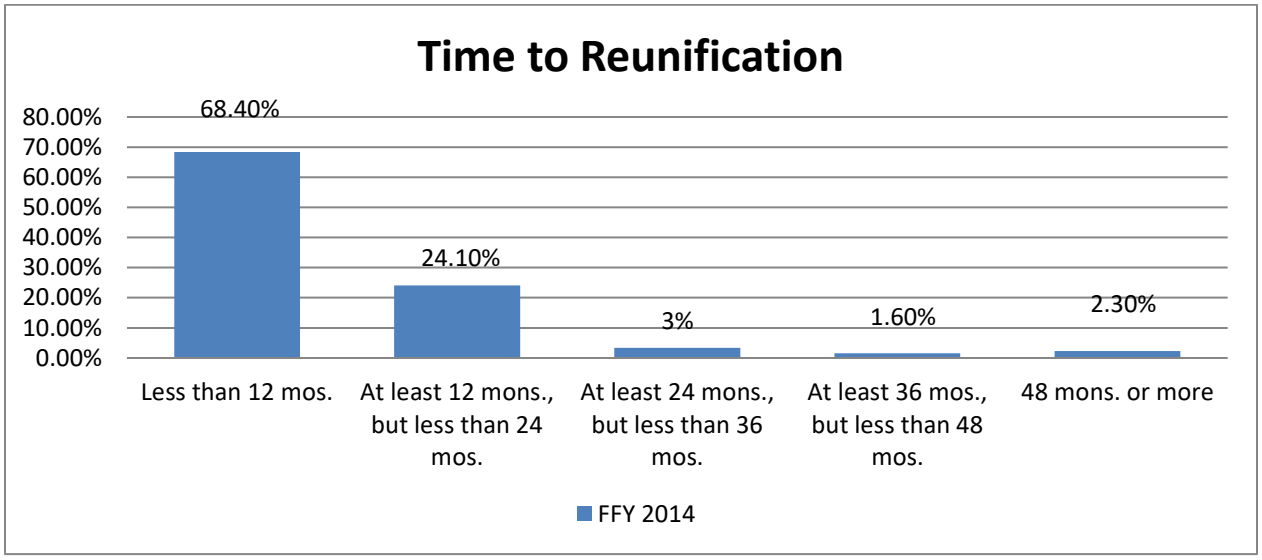
Foster Care Entry

AFARS data for 2014 indicates 3,710 children were included in the measurement addressing foster care entry. Of the 3,710 children, 80.2 % of the children entered foster care for the first time, 10.1% of the children reentered care within 12 months of a prior episode, and 9.3% reentered care more than 12 months after a prior removal episode.



Time to Reunification

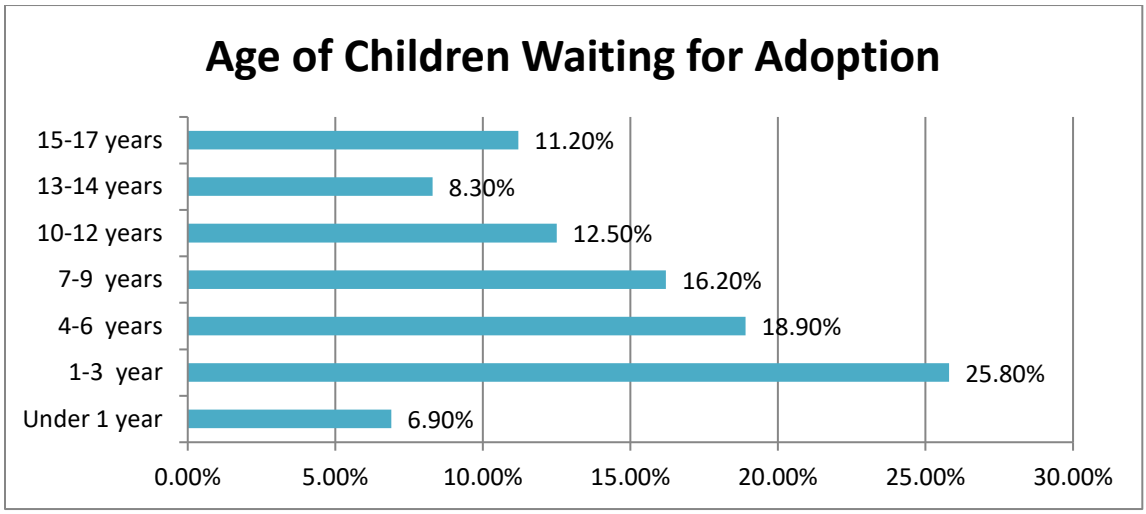
2014 AFCARS Data indicates 68.4 % of the 2,150 children achieved reunification within 12 months. Data indicates an improvement in this measurement by 6.1% from 2010 to 2014. The National performance outcome measure indicates the National median is 69.9 %.

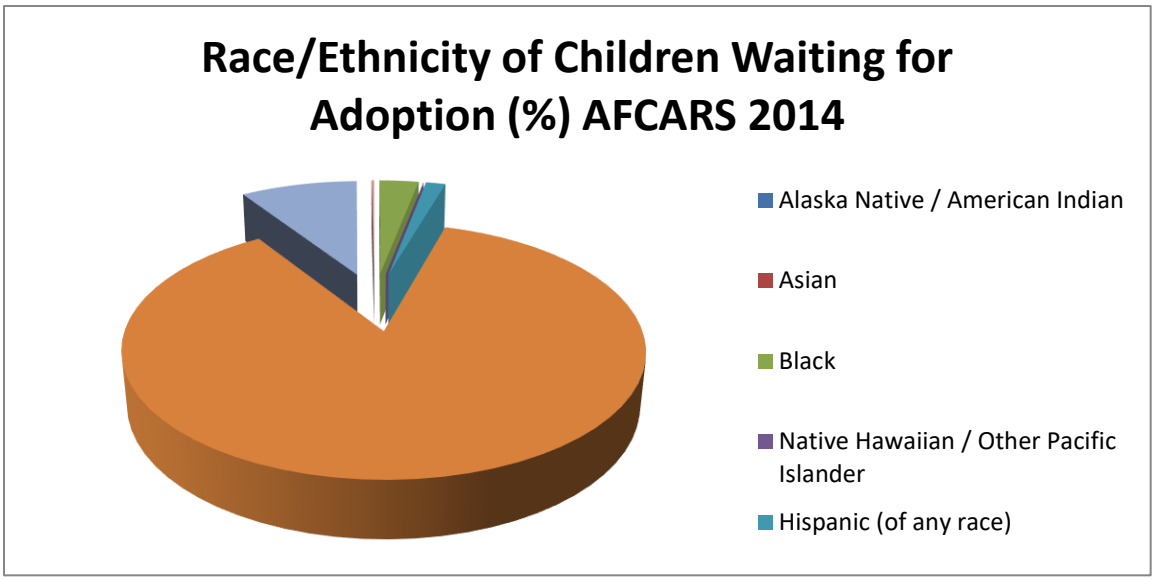


Permanency: Characteristics of Children "Waiting for Adoption" (AFCARS Foster Care File)

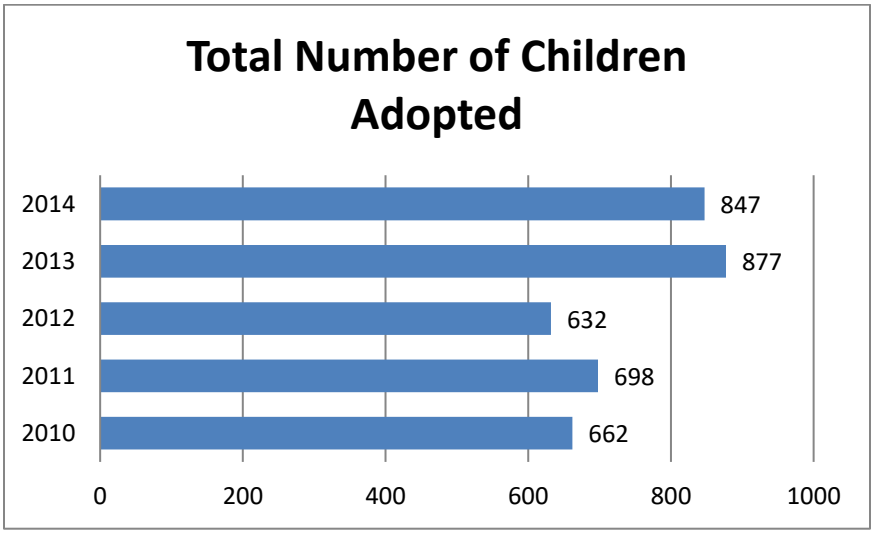
West Virginia's context data profile indicates the total number of children waiting for adoption based on 2014 AFCARS data is 1,446.

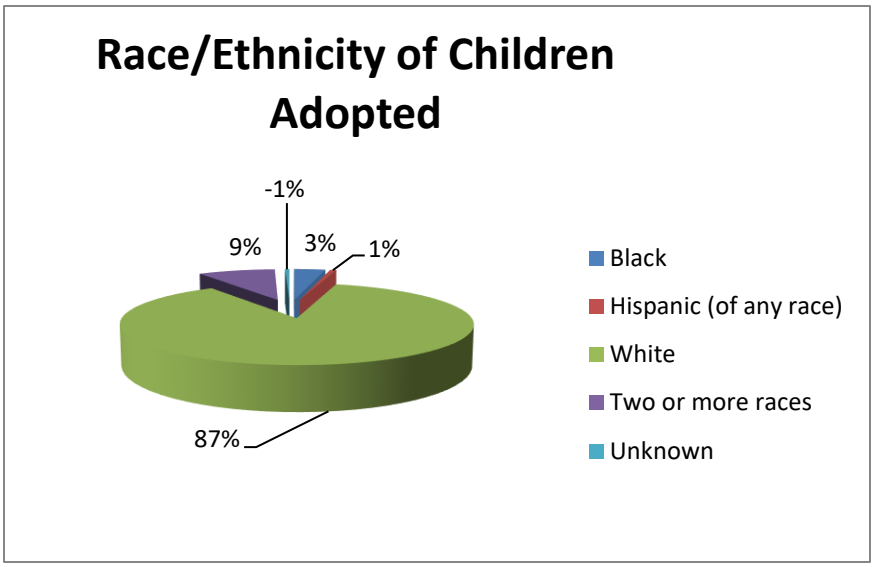
There is no federal definition for a child waiting to be adopted. The definition used in the charts include children and youth through age 17 who have a goal of adoption and/or whose parents' rights have been terminated. It excludes children 16 years old and older whose parents' rights have been terminated and who have a goal of emancipation. Children older than 17 years fall outside of the definition used to identify "waiting children" and are excluded from the data.





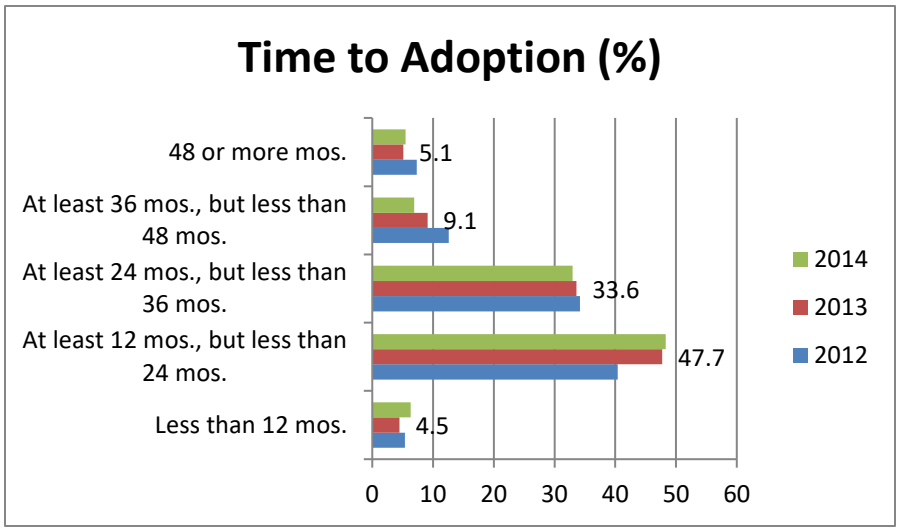
Permanency: Adoption Data (AFCARS Foster Care File)



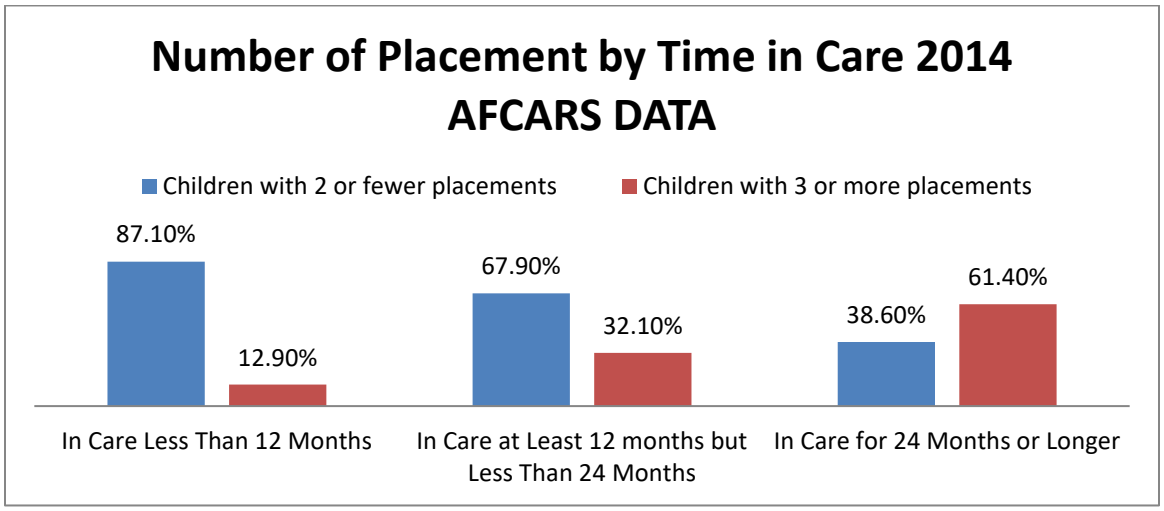


Time to Adoption

Based on 2014 AFCARS data, WV's data indicates a continued improvement in reducing the amount of time children remain in foster care before being adopted. AFCARS data for 2014, indicates that out of the 814 children included in this measure, 54% achieved the goals of adoption in less than 24 months. This is a 19.9 % improvement from 2010 AFCARS data, which indicated only 34.1% achieved reunification within 12 months. National performance outcome measures (5.1a) looks at the percentage of children discharged from care to a finalized adoption. West Virginia's data indicates 6.3 % of children in care were discharged to adoption in less than 12 months. The National Median is 4.1%.



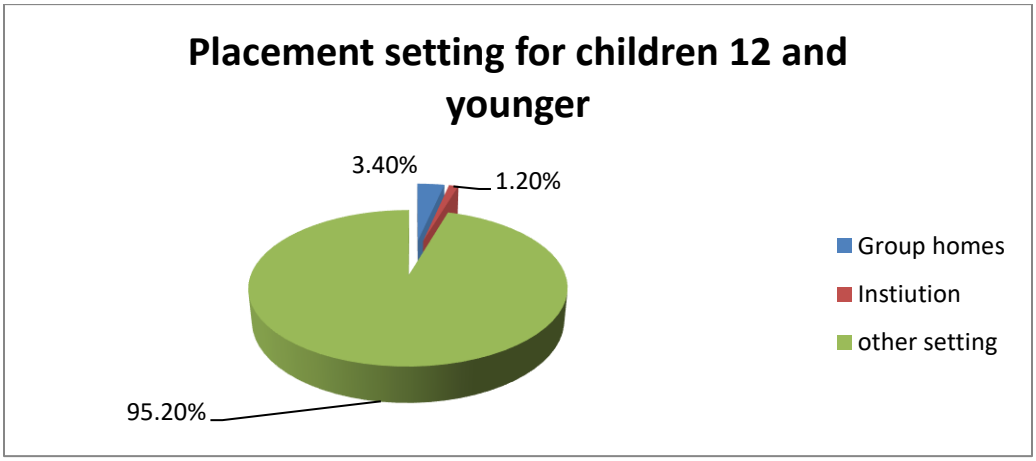
Number of Placements by Time in Care (%)



Placement Setting for Children 12 and Younger

Of all children who entered foster care during 2014 and were age12 or younger at the time of their most recent placement, 4.6 % of the 2,304-child included in this measure were placed in a group home or institution. The median for National performance on this outcome measure is 4.0%.

(*per AFCARS: for this measure, a lower number indicates a better performance).



Information Systems

The system has employed several strategies as part of a larger data quality plan to address data quality within the SACWIS. Additionally, Management Information Services has begun an awareness campaign by presenting specific data issues and common validation, verification approaches at the BCF statewide leadership conference.

Specific Data Quality Management Actions

- Monitoring – FACTS uses data quality utilities to check the status of the AFCARS, NCANDS and NYTD data elements throughout the submission period. Email blasts are used to keep management informed when any measure is approaching the tolerance threshold. Monthly exception reports are produced showing Medicaid eligibilities that are approaching the age 21 cutoffs, clients with invalid addresses and former foster care youths out of care with some period of extended eligibility remaining. Another example is a monthly report that shows all children with an open removal episode and no documented placement.
- Profiling – WV DHHR has implemented a Master Client Index (MCI) to better manage client identity attributes with an eye towards using the verified data to improve the data quality in FACTS and give a standard that could be used to improve the client duplication issue. FACTS has created numerous reports and dashboards that not only serve as compliance and outcome reporting but also can be used to identify data outliers such as the CPS response times, investigation timeframes, provider certifications, and payment reports. Detailed reporting is

done on a monthly or quarterly basis to identify problem cases in the IV-E determination process, coupled with specific case information these reports are used by the eligibility and finance units to address exceptional cases that are many times data anomalies. An example would be a report that shows IV-E determinations that have changed unexpectedly during the monthly review. More time than not a worker has changed case data. The daily, monthly and quarterly client merge reports are another example.

- System Design - The system contains a multitude of edit masks, validation checks and logical cross edits that aim to prevent bad data from being entered. Examples include a phone number data field only accepts numbers, a DOB field must have a full date, a client indicated as a child cannot be over the age of 21, etc. These edits do prevent data from being in a wrong format and add a level of scrutiny against logical errors. When the new CPS assessment/investigation was implemented, validation routines were built into the closure process that required a supervisor to review missing data or failed cross edits before closure could occur. FACTS uses a third-party address look up and validation tool called QAS that when invoked will only allow complete, valid and accurate addresses to be entered.
- Transformation – FACTS maintenance operations perform several data corrections through an established request process. Many of the requests are because of duplicated, merged or corrupted client identity attributes that the casework staff do not have the ability to fix themselves due to auditing or security level restrictions. The system has a formalized process of CPS/APS investigation corrections, where once a data issue has been discovered or upon supervisory or legal review the determination has been made by BCF management that the documentation must be changed, the system automatically keeps a backup of the original data and allows an override to make a change or enter new information.
- Data Governance – With the Master Data Management system now implemented DHHR leadership is building the capacity for data governance. A governance committee is being established at the cabinet secretary level to set rules, establish standards and address variances within the bureaus and for the benefit of the agency's data assets. As more systems are being brought into the enterprise data hub the more resources that are becoming available to survey data quality though the various data attributes of timeliness, accuracy, validity, completeness, conformity and integrity. FACTS is in the process of establishing a formalized change management process with BCF to help guide the decision-making process and prioritization of any SACWIS development and maintenance activity. Within that construct, a team of business and system personnel are charged with ensuring

adherence to standards of practice including data management within the client records.

2016 Updates

- Monitoring – FACTS is currently developing the data and reporting to support the APSR/CFSR activities of the quality assurance unit
- System Design – FACTS modified the system determination and a component of the quarterly IV-E fiscal reporting to clearly identify children in receipt of SSI benefits.
- Data Sharing – FACTS began sharing foster care data with the Department of Education to facilitate DOE cross-referencing school achievement and outcome data. In addition, FACTS developed data extraction and transfer processes for the Safe at Home WV independent evaluation contractor. Likewise, FACTS developed data and transfer to support state of WV's Three Branch and Juvenile Justice Task Force (JJTF) initiatives.
- Transition – The leadership of the Office of Management Information Systems has made the decision to transition the existing SACWIS to CCWIS model under the new proposed final rule. A Request for Proposals (RFP) is being developed to bring on contractors to staff and develop the requirements and perform the necessary technical work to change the system architecture, functionality, presentation layer and data collection/reporting processes. The plan is to continue operations in the present SACWIS with limited maintenance and operational work until the system can be transferred and or retired. The web based components of the current SACWIS can be leveraged for use in the new system so it still advantageous for the state to continue planned modifications up until the point that operations can be fully shifted over.
- Although the development is expected to be incremental and phased across the enterprise the RFP is expected to be published before the end of 2016, with the goal of having a vendor or vendors in place by late spring 2017.

The Kids in Care tracking report was implemented September 1, 2015 to create a uniform system to track vital information for all children in care. The report was initially developed as a means of tracking children for Safe at Home; however, it was determined that it would be used to track all children in care. The report originated from an August 2015 FREDI report title "Children in Placement with Level". This tracking report is kept by each District and is updated monthly concerning new placements and exits from placement. Information collected for this report includes but is not limited to the following:

Removal Date
Provider type, name, address
Placement date
Placement Exit
Permanency Plan

As information is updated on the spreadsheet, supervisors will be checking FACTS for matching documentation concerning start and end dates for placements. This spreadsheet is then provided to the Community Service Managers, Regional Program Manager and Director of Social Services. This report is also stored electronically and can be printed monthly for easy access in the event of a disaster that would impact our electronic records.

Foster care policy indicates that workers must enter the effective date of placement within 3 days of placement. The exit date should be entered within 3 days of discharge.

Supervisors and workers address children in placements and any changes in placements such as placements or disruptions during the worker conferences.

By using the Kids in Care spreadsheet and information obtained during worker conferences, the supervisor can compare them with monthly payment approvals for a checks and balance method of ensuring all children have been entered into care or have been discharged as appropriate.

2017 Updates

Foster care policy was changed to require workers enter the effective date of placement and exit the same day.
The four Regional Social Service Program Managers (RPM) along with eight child welfare consultants (CWC) are available to provide policy clarification, specific training related to policy, and to promote best practice. During 2016, the four RPMs and the eight CWCs worked as a team to review cases in the Kanawha District, Barbour/Taylor/Preston District, Braxton county, and Webster county. The items reviewed included the following: contacts with the family and the children, removals, placement entries, court hearings, dispositional staffing, MDTs, safety plans, permanency plans, diligent searches, education, medical, services to family and children.

We also review the COGNOS report which lists every child where termination of both parents has occurred. This report will indicate if a child has been assigned to an adoption

unit or not. We will review/staff with the District to determine if adoption is the appropriate permanency plan and then to help facilitate that assignment to the adoption unit with the District. In some cases, the RPMs and CWCs will work with the District to develop another appropriate plan for r the child.

In the next year, this group will keep information from which to pull statistics on the number of cases reviewed and of that number how many had accurate and appropriate information that indicates ***status*** (in foster care or not), ***demographic characteristics***, location (***placement***), and ***permanency goal.***

The West Virginia Department of Education (WVDE) and the West Virginia Department of Health and Human Resources (WV DHHR) both provide service and assistance to children and youth throughout the Mountain State. The agencies have a long history of cooperating and collaborating to ensure that the state's school-aged children are receiving the necessary support and resources to have safe, secure, and successful childhoods that will establish solid foundations for success as adults. The Elementary and Secondary Education Act of 1965 was reauthorized in 2015 as Every Student Succeeds Act, also called ESSA (20 U.S.C. § 6301 et seq.). Among the changes in the law are new requirements relating to the disaggregation of education data by student subgroups. Education agencies have long reported student performance data for subgroups based on student gender, race/ethnicity, socioeconomic status, disability status, and English language learner status. ESSA now requires that education agencies also report data for subgroups based on student homeless status, status as a child in foster care, and status as a student with a parent who is a member of the Armed Forces of the United States on active duty (see, e.g., Title I, Part A, Subpart 1, Section 1111. (h)(1)(C) of the ESSA statute). To comply with federal law, WVDE must collaborate with the West Virginia Department of Health and Human Resources (WV DHHR) to securely and systematically collect accurate information about students' statuses as children in foster care and to secure it within the West Virginia Education Information System (WVEIS).

The data exchange between WVDE and DHHR will also provide resiliency and well-being metrics. School stability, course completion, attendance, behaviors/discipline, are all data which when correlated to evidence-based practices become indicators of the success of wraparound and school interventions. Some of those evidence-based practices include Trauma-informed assessments for youth and their families to identify their needs, Functional Family Therapy, School-based mental health, and the development of formal and natural supports including tutoring, behavior rewards, and mentoring for both the children and adults in the family. The overall data exchange is targeted for completion for the requirements of the WVDE by the end of the Calendar

Year 2017, with the implementation of a web service for bidirectional exchange by Beginning of Federal Fiscal Year 2019 (10/01/2018).

The WV Department of Health and Human Resources has prepared a Request for Proposal outlining a modularized system the will incorporate the functionality of multiple system operations into combined blocks of common functionality shared by one or more systems. The various components of the current SACWIS will be moved into the combined system as new modules are brought up and implemented. Any distinct and non-sharable functionality will be addressed by migrating the last components of the legacy FACTS system to a browser based platform that can then be used to form additional modules. Additional interfaces with Education and the Courts are under discussion and pre-planning efforts underway. Also in development are the data and process quality efforts that will be imbedded within the new application. The agency is still waiting to review vendor responses to the RFP. With the projected date to select a vendor set in August, more details regarding prioritization and detailed CCWIS requirements can be given once the successful vendor has been chosen.

Case Review

Currently, the West Virginia Department of Health and Human Resources relies on individual workers and their supervisors to track future hearing and reviews. The Court generally sets the next hearing at the conclusion of the current hearing. Workers then make note of the next hearing on their calendars. Most circuit courts also have a plan to track upcoming hearings and send a docket list to Department workers in advance of the week's hearings.

In anticipation of the implementation of Safe at Home WV, a committee was formed to develop a tool to assist workers with tracking various stages of case management when children were placed in out of home care. A draft Standard Operating Procedural guide was developed to aid supervisors in tracking court hearing and reviews. Tracking right to be heard for foster care providers will be added.

The SOP will establish a protocol for districts to ensure workers are prepared for court and that court orders and court related issues are responded to in a timely manner. The overall goal is to establish a protocol that will assure workers are prepared for court, the orders of the court are followed and completed and that supervisors are closely monitoring all court cases by reviewing the information, tracking the cases and attending hearings with staff as needed. The following information will be tracked:

- Assure proper review of recommendations made to the MDT and Court

- Assure supervisors are aware of the MDT recommendations prior to the worker going to Court and prior to any report going to the Court
- Assure all Court orders are reviewed by management in a timely manner
- Assure that DHHR's practice follows the Court's directives
- Allow proactive planning to correct deficiencies in practice and/or non-compliance with Court Orders
- Prevent Contempt and Show Cause Orders from being issued.
- Assure all contempt or Show Cause orders are immediately reported through the appropriate chain of command.
- To assure proper response or compliance to Show Cause or Contempt orders issued by the Court.

2016 Update

A Court Standard Operating Procedure (SOP) draft was discussed and released in January 2015 at a Field Operations Management (FOMT) meeting. This meeting included Deputy Commissioner for Field Operation (one at that time) and four Regional Directors. The SOP and related tools had been developed by a statewide committee in 2014. In addition to the SOP a tracking form, court note sheet and desk guide were also released. The draft was updated into the final draft attached here and sent along with the other documents to the Deputy for Field Operations and the RD's in February 2015.

Many districts have implemented this recommended SOP and use some or all the tools – court note sheet, log, and desk guide.

Other than these draft releases and recommendations for use, there has been no other release of the Court SOP and related documents. BCF is presently reviewing the SOP and related documents – this review will include a legal review by newly hired counsel for BCF. BCF has a target timeframe for review and release of a revised SOP and the related tools of July 2016. The Bureau is already aware of the need to revise to better track foster parent notification, attendance at hearings and notation of their right to be heard.

Diligent Search

A random sample of cases was reviewed for the Diligent Search criteria for FFY 2014. There was a total of 75 placement cases reviewed to determine if diligent search for both maternal and paternal relatives was being conducted as part of the case work practice. Of the 75 cases, 53 cases were applicable for the diligent search criteria. Ninety-four-point three percent (94.3%) of the cases reviewed met the diligent search criteria while

5.7% did not. This will serve as baseline or comparison data for future reviews. DQPI will contact a targeted review of randomly selected cases will in FFY 2016.

The purpose of the New View Project is to identify cases in which children are at risk of lingering in out-of-home care; provide intensive review of those cases by an attorney (New Viewer), including file review and interviews with the child and others involved in the case; make recommendations for permanency solutions for the children; and make recommendations for systemic improvement.

Most the children's BCF files (82% in the first year and 65% in the second year) show no evidence of diligent search or use of the Federal Parental Locator Service. For the seven children, whose files show diligent search efforts in the first year, all the searches resulted in finding at least one family member with an average of 2.6 found family members. IN all, 18 family members were found for the seven children. Notations for the located family members include the following:

- 28% Relatives had criminal backgrounds
- 28% Relatives were not contacted or it is unknown if BCF and/or ICPC made contact
- 22% Resulted in a placement that failed
- 6% Led to completion of a home study;/home visits (no other noted actions occurred)
- 6% Relatives had inappropriate housing
- 6% Placement with biological mother
- 6% Relatives unable to take child due to age and illness

For the eleven children, whose files show diligent search efforts in the second year, all the searches resulted in finding at least one family member with an average of 2.9 found family members. In all, 32 family members were found for the eleven children. Notations for the located family members were found for the eleven children. Notations for the located family members include the following:

- 44% Unwilling/unable to take child
- 34% Not contacted or unknown if BCF and/or ICPC made contact
- 6% Placement with family member
- 3% Failed placement
- 3% Inappropriate housing
- 3% Visitation
- 3% Determined contact would be inappropriate
- 3% Child did not want to be placed with family member

Case Plan

In December 2015, Foster Care policy was revised to better describe the process of engagement with youth when developing their case plans. It reads as follows;

The case plan for each child, where appropriate for a child fourteen (14) years of age or over, must include a written description of the programs and services which will help the child prepare for the transition from foster care to successful adulthood. With respect to a child who has attained fourteen (14) years of age, any revision or addition to the plan must be developed in consultation with the child and, at the option of the child, with up to two (2) members of the case planning team who are chosen by the child and who are not a foster parent of, or caseworker for, the child. The case worker may reject an individual selected by the child to be a member of the case planning team at any time if the worker has good cause to believe that the individual would not act in the best interests of the child. One individual selected by the child to be a member of the child's case planning team may be designated to be the child's advisor and as necessary, advocate, with respect to the application of the reasonable and prudent parent standard to the child.

The FREDI report title "Client 14 and over in Care and in Open Case" is generated each month. This report lists each child over the age of 14 that has a completed Casey Assessment and Learning Plan. In addition, it also indicates any child over 14 that does not have a Learning Plan completed or does not have either a Casey Assessment or Learning Plan completed. This report reviewed by Regional Program Managers, Community Service Managers and Supervisors. This report identifies any child in custody over 14 that need a Learning Plan or Casey completed. Supervisors will discuss this report with workers during monthly worker conferences to help ensure the assessments have been completed either by staff or providers.

The Department will use current FREDI report data of 1489 children in care of which 600 (40%) do not have life skills assessments.

Permanency Reviews

The Court Improvement Program maintains the following data on case reviews.

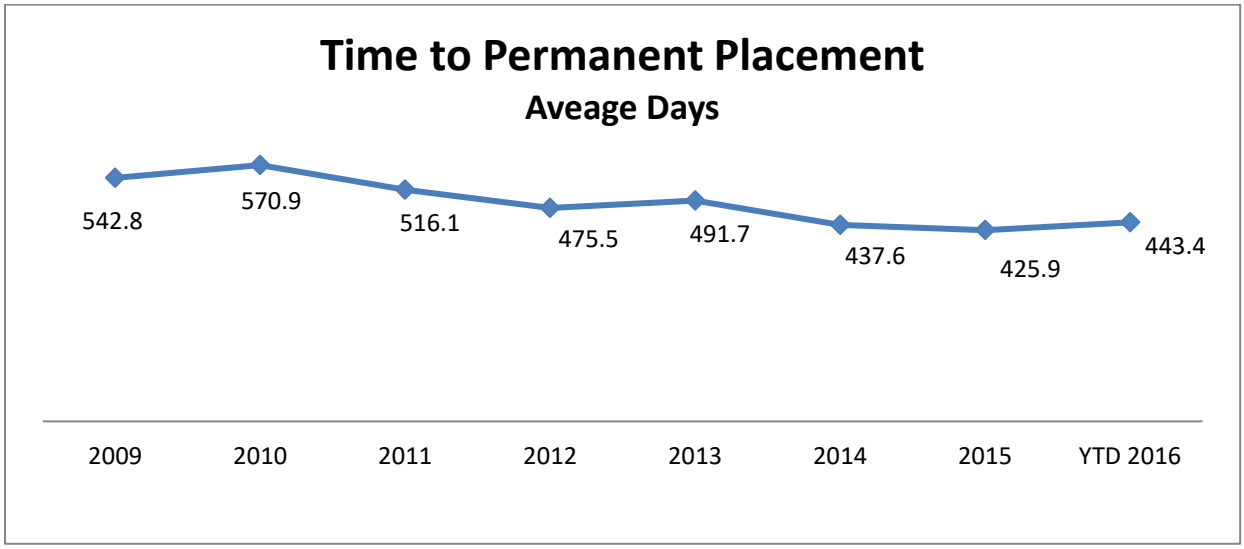
	2013		2014		2015	
	Average (days)	**Percent Compliance**	**Average** (days)	**Percent Compliance**	**Average** (days)	**Percent Compliance**

Time to Permanent Placement (Compliance Limit – none)	491.5	none	439.5	none	427.0	none
Time to First Permanency Planning Determination (Compliance Limit – none)	283.9	none	265.2	none	254.0	none
Judicial Permanent Placement Reviews (Compliance Limit – 93 days)	86.4	77.70%	86.5	76.40%	83.1	78.00%
Disposition to Permanent Placement (Compliance Limit – 543 days)	183.3	89.70%	144.4	93.80%	142.3	94.00%

In addition to the CIP data and tracking the Bureau for Children and Families distributes monthly trackers related to IV-E compliance – the Court Order Report & Pending Cases Report - are sent monthly to each CSM, the RD & Deputy Commissioner. Their use also helps districts to track Judicial & Periodic Reviews. The court order reports show where there are potential challenges to assuring proper review. The email that accompanies each set of reports give details of the report & outline needed action. The CSM or RD will involve Regional legal staff as districts attempt to address barriers with the courts. Generally, courts are meeting the periodic review timetable requirements and BCF has not had to use the Administrative Review process

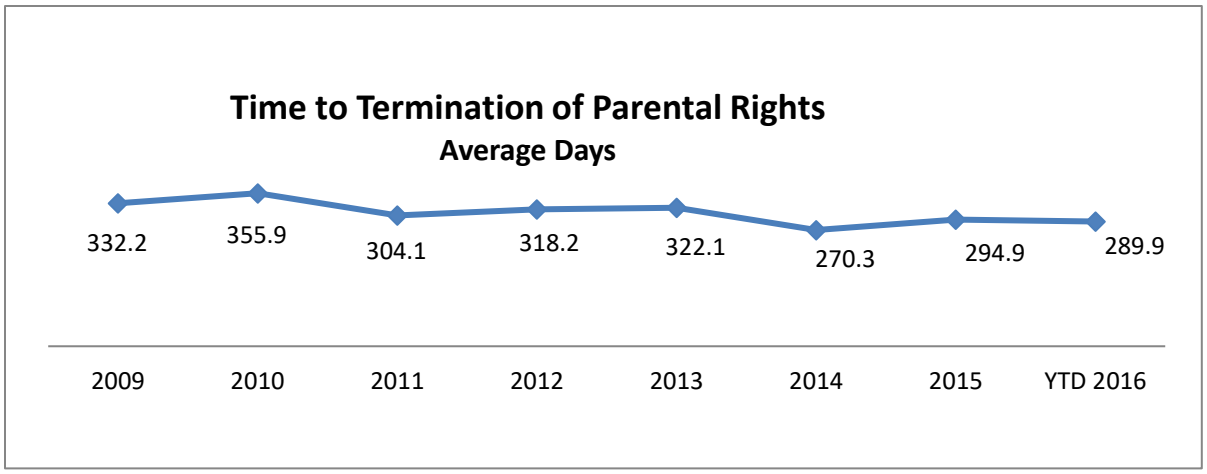
Permanency Hearings

Time to permanent placement is measured by the average (mean) and median time form filing of the original petition to permanent placement. This is calculated using all records, including both original petition filing date and the date of permanent placement.



Termination of Parental Rights

This measure consists of the average (mean) time from filing of the original petition to termination of parental rights for each respondent. All respondent items, including applicable dates for both items, will be included in the calculation. If a respondent was added because of an Amended Petition, or service was delayed to a respondent who was include in the original petition, time to the Termination of Parental Rights would be calculated form the date the respondent was added or served rather than the original petition.



Notice of Hearings

A random sample of cases was reviewed for the Right to Be Heard criteria for FFY 2014. There was a total of 75 placement cases reviewed to determine if foster parents were receiving notifications of hearings and MDT meetings as part of the Right to Be Heard mandate. Of the 75 cases, 48 cases were applicable for the notification of hearings and MDT meetings for foster parents. Of these 48 cases, 79.2% received notification for court hearing for every instance and 81.3% received notification for MDT meetings for every instance. In addition, 12.5% received notice for court hearing on at least one, if not most, instances for court hearings and 10.4% received notice for MDT meetings on most instances. Of the 48 cases, 8.3% never received notice for court hearings or MDT meetings. This will serve as baseline or comparison data for future reviews. Another targeted review of randomly selected cases will be conducted for FFY 2016.

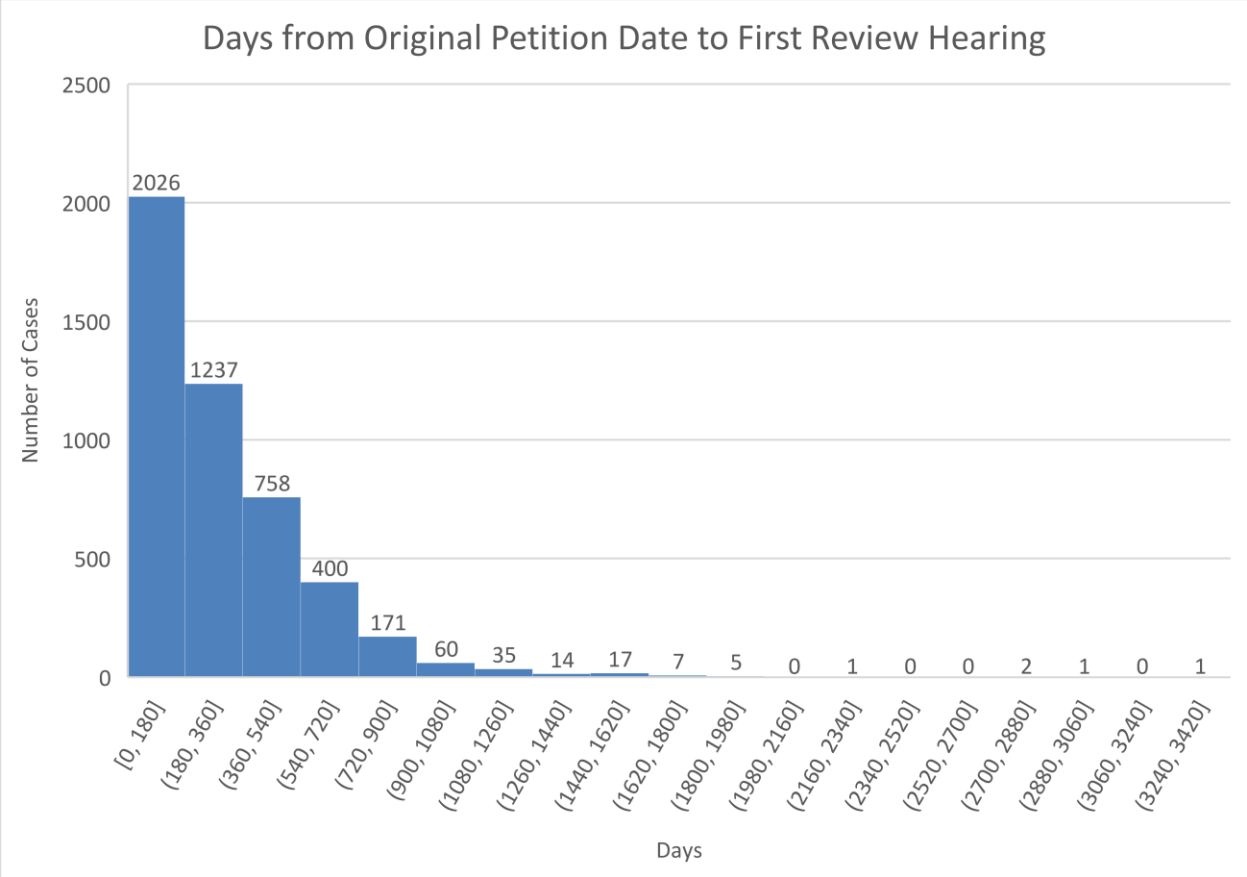
West Virginia will develop a survey to mail to foster parents to determine if they are noticed for hearings.

2017 Update

Two separate analyses were conducted of data contained within the West Virginia Child Abuse and Neglect Database. This datacase is maintained by the administrative offices of the West Virginia Supreme Court through the Court Improvement grant activities. The graphs below show (1) days between the original petition date and the first review hearing date, and (2) days between subsequent review hearings entered under a case.

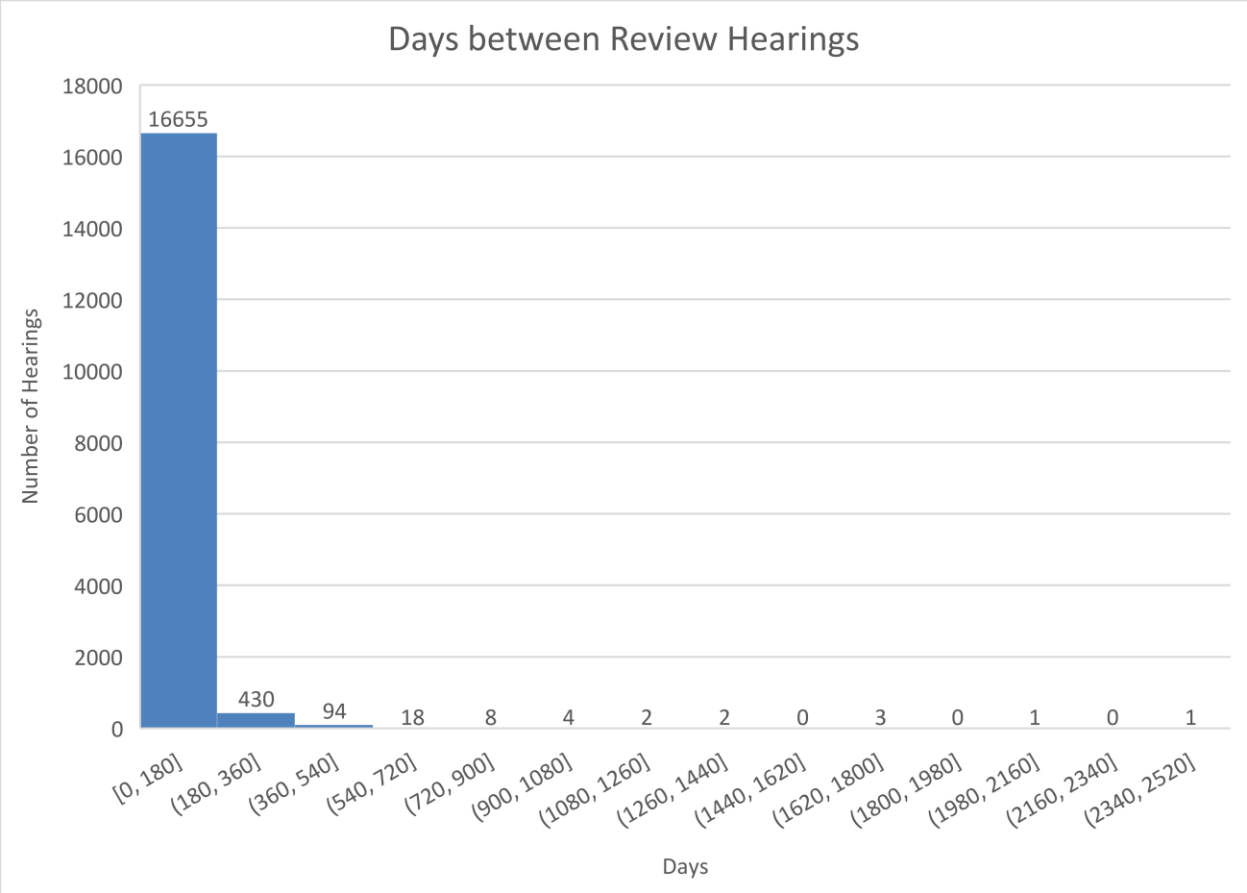
Graph One- 4,735 unique cases were used in the analysis. 22 unique cases were excluded from the analysis due to errors.

West Virginia developed a survey to gather data relating to notice of court hearings and MDTs, from a sample of foster parents, emergency shelters, and group residential facilities, statewide. Every survey will be mailed out to the chosen samples by the end of June 2017.



Graph Two- 3,765 unique cases were used in the analysis. Fewer cases were used in the second analysis than in the first because not all cases that had a first review hearing had subsequent review hearings. Two unique cases and 31 hearings were excluded from analysis due to errors. It is important to note that the CAN database maintained by the

CIP is not able to accurately match each hearing to each child within this data. Further exploration of this issue is occurring within the special workgroup charged with re-evaluating the data that is maintain by the courts.



A survey regarding MDT and court hearing notifications have been distributed out to all shelters and 49 groups residential facilities across West Virginia. Thus far, 40 surveys from the shelters have returned. There are 703 addresses for specialized foster care homes with current foster child placement and approximately 1330 kinship/relative and certified kinship/relative addresses. The MDT and court hearing notification survey will be sent to over 2000 foster homes, along with a survey regarding foster parent pre-service and in-service training and its effectiveness. These will be finalized and distributed to over 2000 foster homes by June 30, 2017.

Training

BCF Division of Training is responsible for the oversight, coordination, and delivery of training for BCF employees, including child welfare staff and foster parents statewide. This training consists of new worker training; professional development; supervisory and management training; and coordination of training for new, potential foster and adoptive parents. Goals for training are tied into the overall goals of the organization and include making continuous quality and process improvements to the training that is being provided. In addition, training activities are continuously being evaluated to ensure the transfer of learning and long-term retention and utilization of information, knowledge, and skills learned in training. A list of courses, course length, target audience and projected numbers of staff to be trained, and course syllabi (including all university trainings) are provided in the BCF Training Plan (separate document).

Systemic Functioning

West Virginia operates a statewide coordinated Training System to provide pre-service training and in-service training for new staff, and professional development training for tenured staff. This training is coordinated through the Central Office at the Diamond Building in Charleston, West Virginia, with staff trainers out-stationed across the state for provision of training activities. Training requirements are the same for both agency staff and contracted staff.

New worker pre-service training begins on the first day of employment. New workers are immediately placed into the first training class that is available after their first day of employment, usually occurring within one to three weeks of hire. New classes are started twice per month, for a total of 24 classes per year. The scheduled start dates for each training round are determined annually for the next calendar year each October. From the first day of employment to the first day of classroom training, new workers are required to complete an orientation and 18 hours of online training in the Blackboard learning management system (LMS). Once classroom training begins the new worker receives 144 hours of classroom training, 48 hours of structured transfer of learning, and 15 hours of online training over a six-week period. Pre-service training must be completed within the first three months of employment, and attendance/completion is tracked through daily sign-in sheets and Blackboard LMS reports as well as being documented in the SACWIS system. To be reported as complete new workers must attend a minimum of 95% of the required training. New workers are required not to carry a caseload during their pre-

service training period; however, to date this information has not been formally tracked. A mechanism will be developed to track this information so it can be reported in the next APSR.

Once pre-service training is completed, the in-service training period begins and continues during the remainder of the first year of employment. New workers are assigned a limited caseload that they carry over a period of four to 12 weeks (depending on the program area). The Division of Training is currently developing and implementing a coaching program for new workers that will be conducted during this time. New workers then return for an additional 48 hours of classroom training held over a three-week period, and an additional 42 hours of classroom training and 20 hours of online training during the remainder of their in-service training period. After that point, tenured workers are required to receive 40 hours of continuing education training every two years.

In 2014-2015, the BCF Division of Training trained 156 new child welfare workers. Of these, nine (six percent) left the agency prior to completing pre-service training. A small percentage of new workers completed their in-service training requirements, although the exact percentage could not be reported due to incomplete tracking information. A plan will be put in place to ensure that accurate data can be reported in the next APSR. Tenured worker training completion rates are much greater due to the continuing education requirements to maintain social work licensure. This training must be completed to remain licensed, which is a job requirement.

While the Division of Training does a very good job at tracking pre-service training, tracking methods for in-service training and professional development training must be improved to ensure accuracy of those numbers. This will become even more important in the next year as West Virginia implements a new social work licensure law that allows persons with a bachelor's degree in an unrelated field to be licensed as a social worker, and so be eligible for child welfare positions. The legislation requires an additional training plan for staff who are employed with this new restricted provisional license that will have to be tracked and reported, which will be implemented in the next year. A new competency test for will also be implemented in the next year, based on the HOT (hands-on testing) competency tests developed in Oklahoma, as well as competency testing for supervisors. This data can be tracked and reported to demonstrate the effectiveness of the training program to the Legislature and in the APSR.

In addition, while the Division of Training currently gathers qualitative data around its training programs, more efficient methods for standardized reporting of this information must be developed. The Division of Training holds a statewide Child Welfare Training Advisory Council meeting every other month to obtain feedback on training programs and to plan and implement training program improvements. Participant evaluations are done on each training session that is held, with the results summarized and entered into a database and reported to the trainer and his/her supervisor. New curricula are reviewed and approved by stakeholders including regional field staff, policy staff, and SACWIS system staff prior to the training being conducted and when any changes or updates are made. A formal tracking and reporting system for this information must be developed.

For provider training, West Virginia currently uses the PRIDE curriculum developed by the Child Welfare League of America. All prospective and new providers must attend 24 hours of pre-service training to be certified, although kinship families may be granted a waiver from the training. After certification foster parents must attend 12 hours of training each year to maintain certification. Tracking of pre-service training is done by the Social Work Education Consortium, who provide the training, and tracking of in-service training is done by the regional home-finders who are responsible for recertification of the homes.

In the next year, the Division of Training will implement a system for tracking and reporting the following information: in-service and professional development completion; qualitative evaluation data; competency test results for workers and supervisors; provider training; and training required by the new social work licensing requirements.

New Planned Activities

Child Fatality Review

The Division of Training is developing a course on Child Fatality to help reduce the number of child fatalities in West Virginia. This course provides participants with statistical data on child fatalities in WV and identifies trends in child welfare practices; factors related to child deaths; best practice standards; working with vulnerable children; supervisory consultation; safety planning; information gathering; co-sleeping; and substance abuse related child fatalities.

Safe at Home Project

The Division of Training will develop and implement training for Safe at Home initiative that will include training on wraparound values and principles, family and youth engagement, and the WV CANS.

Updates on Training Objectives

The BCF Division of Training continues to make steady progress towards meeting its training objectives outlined in the Child and Family Services Plan. Outstanding achievements include:

I. Implement and maintain training related to the Child and Family Services Review/Program Improvement Plan

The BCF Division of Training (DOT) provides program support for the West Virginia CFSR/Program Improvement Plan (PIP) through the completion of identified tasks and training-related activities included in the PIP.

For Goal 1, The Division of Training completed the statewide training of all CPS staff and supervisors in the documentation of the Protective Capacity Family Assessment in the SACWIS System and refresher training in Protective Capacity Family Assessment.

The following two training goals are included in one narrative, since both initiatives represent new child welfare staff development.

II. Restructure Mandatory Pre-Service Training Package

III. Restructure In-Service Training to be Completed Within the New Worker's First Year

The Pre-Service Child Welfare Training, Achieving Safety, Permanency and Wellbeing for West Virginia's Children has been restructured utilizing a blended learning approach that includes on-line training, classroom training, and structured transfer of learning activities. The pre-service curriculum was restructured to emphasize the acquisition of the skills and knowledge necessary to practice effective child welfare casework. The revised curriculum continues to strive to ensure workers have the required knowledge and skills necessary to provide quality service and promote safety, permanency, and wellbeing for

children and families. In 2014, pre-service training was provided to 152 new child welfare workers across the state.

The pre-service training consists of two component sections: Foundations and Job Specific Training. Foundation training is the underpinning of the knowledge and skills needed by the child welfare worker. These are built upon in successive components. Portions of the content of the Foundations' component were adapted from the curricula "Charting the Course towards Permanency for Children in Pennsylvania," developed by the Pennsylvania Child Welfare Training Program, University of Pennsylvania School of Social Work. Free use of this material is permitted for training and other educational purposes by public child welfare agencies and other not-for-profit child welfare agencies that properly attribute the material.

The second component of the New Worker Per-Service Training, Job Specific Training, provides four paths for new workers. The path the new worker follows is based on the worker's primary work assignment. This includes Child Protective Services, Youth Services, Homefinding, and Adoption. In the job specific training, the new worker is building on basic skills and knowledge introduced in the Foundations section of the training. Job specific training includes job specific procedures and policies required for the worker's position in child welfare. Systems and documentation training have been restructured to provide more individualized learning opportunities with the use of separate computer labs and desk guides to assist the worker with documentation.

Significant revisions have been made to the CPS and YS training tracks. Both are now set up to more closely follow the case work process and to be more experiential with additional classroom activities and participant involvement. This provides increased opportunity for skill building, practice, and feedback.

As part of the ongoing goal to provide effective knowledge based skill building training for all staff which promotes engagement with families and transfer of learning, the Homefinding Job specific training is being restructured to meet the current model of the pre-service training. The classroom training is being revised to provide more active learning opportunities for participants which are more skill based and experiential. Participants will be given greater opportunity to practice skills and receive feedback. Systems and documentation training will be held in computer labs and involve hands on practice.

This pre-service training for BCF child welfare staff is designed to provide participants with support and learning skills in the classroom while transferring those skills from the classroom to the job. The on-the-job training activities and skill building assignments are identified for both the new worker and the new worker's supervisor in the Transfer of Learning Notebook and the Supervisor Resource Guide, respectively. There are transfer of learning activities designed with adult learning styles in mind which are structured to assist participants in applying the knowledge and skills presented in the classroom to the field. Participants are encouraged to use the Self-Assessment tool provided to identify those skills and abilities in which they feel confident and those for which they require more training, assistance, or experience to fully develop.

New workers are encouraged to share this information with their supervisors. The Supervisor Resource Guide provided to all child welfare supervisors provides in-depth tools for the supervisor to use in coaching and effective utilization of skill-building assignments to promote transfer of learning.

IV. Implement Child Welfare Supervisory Training

The child welfare supervisory training developed by Colorado and available from the National Resource Center for Organizational Improvement is incorporated into BCF supervisory and management training. In total, 46 Child Welfare supervisors have completed supervisory training in FY 2014.

A multiple-level evaluation process will be incorporated to assess the efficacy of the training, including a Transfer of Learning component reflecting the restructured skills-based, pre-service child welfare training. Further, a Needs Assessment to identify topics for the professional development of tenured child welfare supervisory staff will be incorporated.

Family Functioning Supervisory Guide training will be incorporated into Child Protective Supervisory training. This training will provide CPS supervisors with the knowledge and skills to effectively consult with casework staff related to practice and decision making during the Family Functioning Assessment process. CPS supervisors will learn to help casework staff gather information; assess threats to child safety; promote proactive case consultation; delineate the fundamental supervisor responsibilities for facilitating effective

casework practice and establish criteria-based supervisor consultation related to the FFA; and assure that FFA standards are achieved.

The following three training goals are included in one narrative since they represent training initiatives with the partnership with the Social Work Education Consortium.

V. Partner with the Social Work Education Consortium

VI. Restructure Professional Development Training for Child Welfare Staff

VII. Provide Comprehensive Training to Foster Parents

The partnership with the Social Work Education Consortium (SWEC) has continued to strengthen in: 1) the provision of training opportunities for new workers and tenured staff; 2) foster parent training; and 3) educationally preparing the workforce for working in public child welfare.

- The BCF continues to utilize its partnership with the Consortium in planning and implementing several continuing education opportunities for tenured workers. The development of these courses has been based upon a regional needs assessment process facilitated by the DOT regional trainers with regional management staff and supervisors. Regional training staff and the Title IV-E Training Coordinator continue to meet quarterly with the participating university in the region to discuss identified training needs, make recommendations for new class development, and to schedule the classes.

The Consortium continues to offer a variety of professional development trainings developed in response to needs identified in the regions or anticipating noted trends in practice. The SWEC continues to provide three training modules for new workers as part of the in-service component of their first year of training, which includes, Substance Abuse, Legal and Advanced Ethical Issues for Child Welfare, and PRIDE for New Workers.

- The West Virginia Social Work Education Consortium (SWEC) provides 27 hours of pre-service training (referred to as a round of training) to all departmental prospective adoptive and foster parents. Utilizing the PRIDE curriculum developed by the Child Welfare League of America, SWEC works with the regional homefinders to schedule

pre-service training for foster/adoptive and kinship/relative parents in each region. Locations of training are prioritized based on need, but every effort is made to ensure the rural areas of the state have access to training as well. Each region utilizes quarterly meetings with the university in that region to identify training needs, challenges and opportunities to ensure quality services are being provided to the foster/adoptive and kinship/relative parents.

Foster parents are also required to complete 12 hours of additional in-service training annually. This training is available statewide, as all schools offer in -service training to foster parents. These modules build upon the competencies of the pre-service modules. Department Homefinding staff in the regions is active partners in topic selection, frequency, and location of course offerings.

The SWEC also continues to offer foster parent training on trauma as part of the in-service training component. Additionally, foster parents are given the opportunity to attend advanced in-service sessions, which vary from year-to-year, depending upon the needs identified by regional Homefinding staff. Topics may include Advanced Discipline, Psychotropic Medications, Sexually Reactive Children, etc. Both in-service and advanced in-service training are offered in a group setting.

An online training calendar for both pre-service and in-service training is maintained on a website for foster parents maintained by Concord University (www.wvfact.com). The training schedules are also on the Department's website as well.

- To enhance the social work workforce, SWEC recruits and provides educational stipends to qualified students who plan to work in public sector child welfare. These stipends are available for both undergraduate and graduate level course work. Two of the universities have developed a special Field Instruction manual for Departmental supervisors. Modeled along the lines of the Supervisor Resource Guide, it provides structured work activities for all field placement students placed in child welfare placements.

VII. Expand Technology-Based Training

Web-based training is a beneficial way to introduce staff to new concepts that can be reinforced in the classroom with skill-based training. The technology assistant is establishing a plan for regular, required maintenance and management of Blackboard

and other online courses for the Division of Training. The courses will be maintained and managed when course alterations are received from appropriate persons that determine the requirement for updates and course renewals to optimize learning through technology-based courses. The technology assistant is scheduled to complete required training to create and maintain a website and online calendar for the Division of Training and will post approved information to that site.

VIII. Develop a Multiple Level Evaluation Process for Child Welfare Training

Evaluation activities have been modestly expanded as part of ***Achieving Safety, Permanency and Wellbeing for WV's Children*** to assess the transfer of learning, to address long-term retention needs, and to reinforce practice skills acquired in training. Formative evaluation of the course content is ongoing.

Evaluation of transfer of learning has been delayed from what was originally anticipated, but is planned for the coming year as the Division prepares to assess trainee satisfaction and skill post-caseload acquisition (greater than six months after completion of training). The Division also plans to assess supervisor satisfaction with trainee transfer of learning and their satisfaction with the Supervisor Resource Guide.

2016 Update

Overview of West Virginia's Training System

West Virginia operates a statewide Training System that is responsible for oversight, coordination, and delivery of training for BCF employees and foster parents across the state. This includes pre-service training and in-service training for new staff; professional development training for tenured staff; supervisory and management training; and pre-service and in-service training for potential, new and tenured foster parents and kinship homes. This training is overseen and coordinated by the BCF Division of Training through the Central Office at the Diamond Building in Charleston, West Virginia, with staff trainers out-stationed across the state for provision of training activities for BCF staff and staff who are contracted to perform BCF casework activities (such as Youth Services contracted staff, who have the same training requirements). The West Virginia Social Work Education Consortium works closely with the Division of Training to provide designated training sessions for new and tenured workers under the Training Plan and

all foster and kinship home training, which is provided under their Title IVE training contracts.

Changes in the Last Year

West Virginia's training system has seen substantial changes in the past year. In early 2015, the West Virginia Legislature passed SB559, allowing DHHR to hire employees who do not have a degree related to social work into positions requiring a social work license and substituting the DHHR Training Plan for the training required by the West Virginia Board of Social Work for social workers with a regular provisional license. This new license type is referred to as a "restricted provisional license." During the Legislative rule-making process the BCF Training Plan was attached to the Legislative Rule, making the components of the Training Plan required by law. The major substantive changes required by the new law are the requirements for mandatory pre-service training (no caseload assignments), a New Worker Competency Test that must be passed at the end of pre-service training before assuming a caseload, and required training for each of four years for staff with a restricted license that must be taken as a condition of licensure.

As a result, West Virginia's training system has been systematically reviewed and modified to be incompliance with the new law. New training schedules were developed that follow the SB559 Training Plan, and procedures put in place to implement the new competency test. Written policies and procedures were developed in response to the Legislative Rule that outline the requirements for pre-service training (prior to assuming a caseload) and in-service training (after assuming a caseload, within the first year of employment) for all new workers, and ongoing training for workers holding the new "restricted" social work license for three additional years. Supervisors and managers were notified of the now mandatory pre-service training requirement and had to sign a form documenting that they had received and understood the requirements. Curriculum was reviewed and revised to follow the plan. The Title IVB/IVE Training Plan was also revised to follow the plan and the new schedules.

In the last year, the Division of Training made several additional changes to its training plans. The Division of Training, in conjunction with providers across the state, provided training related to the roll out of Safe at Home West Virginia, with nine hours of mandatory wraparound training and six hours of CANS training for all staff in districts as the roll out Safe at Home. As of May 2016, 559 CW staff were provided WV CANS training and 334 were provided WV Safe at Home training. Changes to Youth Services training

requirements were made as well with the passage of SB393 around juvenile justice reform. All Youth Services staff must be trained and certified on the YLS/CMI assessment, and additional procedures are will go into effect in July 2016 related to truancy diversion. The Division of Training is tracking training and certification requirements for the CANS for all child welfare staff, and the YLS/CMI for all Youth Services staff, and both are now included in the training plans for those program areas. Trauma training was also added as a requirement for all staff and foster care providers. For child welfare staff, all new workers are required to complete nine hours of trauma training as part of their in-service training requirements, and all foster parents are required to complete nine hours of trauma training in the first year as a foster parent. Training will be tracked and reported annually for the completion of Trauma training for staff and foster care providers.

A list of courses, course length, target audience and projected numbers of staff to be trained, and course syllabi (including all university trainings) are provided in the BCF Title IVB/IVE Training Plan (separate document).

2017 Update

West Virginia developed a survey to gather data relating to pre-service training and in-service training from a sample of foster parents statewide. The survey was developed to determine if foster parents believe the training was effectiveness in preparing them for placement. This survey will also gather data relating to the number of foster parents who have completed the entire module of pre-service training as well as those who have participate in the 12 hours of annual in-service training.

Initial Staff Training: Systemic Functioning

Pre-service Training

Initial staff training begins on the first day of employment in the worker's local office. Onboarding activities are conducted by the local office and Division of Training staff. New workers are immediately placed into the first available training class based on their job function, usually occurring within one to three weeks of hire. A total of 20 new worker classes, or one to two classes per month, are starting this year alternating between north and south. The number of classes provided during the year is based on the number of

new workers trained in the previous year, and scheduled start dates are determined annually for the next calendar year each October.

From the first day of employment to the first day of classroom training, new workers receive an orientation to the agency and the local office and complete 13 hours of online training in the Blackboard learning management system (LMS). Once classroom training begins the new worker completes 220 hours of classroom, blended, and online training and transfer of learning activities over the course of the next 11 weeks, following the training outlined in the Training Plan. In general workers attend two weeks of classroom training at 24 hours per week followed by one week of structured and unstructured transfer of learning in their local offices, such as shadowing workers on visits. Supervisors receive a transfer of learning handbook that reviews the information learned in class and provides a list of transfers of learning activities that is based on the classroom and online content for that training period. During each training round workers are tracked for completion of all the required training and must complete 95% of the required training before being certified to take the New Worker Competency Test. A total of 240 new workers completed pre-service training in 2015.

The New Worker Competency Test is taken during the 12th week of the training round, immediately following the 11 weeks of training and transfer of learning in the round, and the worker must pass each component of the competency test with a score of 80% or greater before being assigned a caseload. Components of the test include a written knowledge exam, two simulated interviews (one child and one adult), and a decision-making/documentation assessment. The competency test was implemented on January 1, 2016, and since that time a total of 53 new workers have taken the competency test, with 46 passing all components of the test on the first attempt. Workers who do not pass one or more components are provided with feedback on what they can do to improve with their supervisors. Workers must pass all components of the test in three attempts or must go back through new worker training. The worker, supervisor, Community Services Manager, and Regional Director are provided with the results of the competency test within three work days of its completion.

Pre-service training must be completed within the first six months of employment, and attendance/completion is tracked through daily sign-in sheets and Blackboard LMS reports as well as documentation in the training section of the SACWIS system. Workers are evaluated on progress after each two weeks of training, with results reported to the

supervisor and CSM. Workers also complete evaluations on the training they receive after each two weeks of training, and the results are compiled, distributed, and used to make improvements to the training or the trainer's performance. ***Ongoing***

Staff Training: Systemic Functioning

Ongoing training is divided into three components: in-service training, professional development training, and supervisory training.

In-Service Training

The in-service training period begins immediately upon successful completion of pre-service training and the competency test and continues for the first year of employment. It consists of a combination of classroom, blended, and online learning that expands on the information learned in pre-service training. Workers who hold a restricted or regular provisional license must take 100 hours of in-service training in the first year of employment. Workers with a BSW, MSW, or regular license are exempted from 30 of those hours and so must complete 70 hours of training.

While in-service training has always been a requirement for BCF staff, completion rates for in-service training have been an issue in the past. Completion rates have ranged from 30% to 40% for most classes, with rates being even lower for some. The passage of SB559 has placed additional emphasis on in-service training since completion of the training is a requirement for continued licensure for workers with a restricted provisional license. The Division of Training has put procedures in place to ensure that all new workers complete 100% of their required in-service training within the first year of employment, including pre-registering them for the required classes and sending out prompts to attend. Workers are encouraged to complete their in-service training as soon after completing pre-service training as possible because they have a graduated caseload assignment for the first two months, defined as the assignment of one to two cases per week until a full caseload is reached.

Professional Development Training and Provider Training

Professional development training is any training provided to tenured staff after the first year of employment that addresses the skill and knowledge needed to carry out their job duties. The baseline requirement for licensed staff is completion of 20 hours of training per year, which is required to maintain social work licensure. The amount of required

training could be higher based on BCF's current initiatives; for example, in the past year staff was required to attend 9 hours of training on Safe at Home and 6 hours of training on the CANS assessment, for a total of 15 additional hours of training. Staff were also required to take training and obtain certification in the YLS/CMI. As of May 2016, 194 Youth Services staff completed YLS/CMI training and 63 have completed and passed certification testing. Both the WV CANS and YLS/CMI requires recertification which will be tracked and reported by the Division of Training. In addition, staff with restricted licenses is now required to complete an additional 60 hours of training per year for years 2, 3, and 4 of employment as a condition of maintaining social work licensure through SB559.

While the Division of Training does a very good job at tracking pre-service training, tracking methods for professional development training must be improved to ensure accuracy of those numbers. This will become even more important in the next year as West Virginia continues to implement SB559 requirements. West Virginia's SACWIS system keeps individual training records based on training enrollment and attendance, but databases must be developed to track the total number of hours of training each staff person completed to ensure he/she met the training requirement. This data can be tracked and reported to demonstrate the effectiveness of the training program to the Legislature and in the APSR.

Supervisor and Manager Training

The BCF Division of Training provides and facilitates training for child welfare supervisors, along with training required by the WVDHHR Office of Employee Development and the West Virginia Division of Personnel Office of Organization and Human Resource Development (DOP). The Division of Training focuses on program specific training for child welfare supervisors. New supervisors are required to take three weeks or nine days of new supervisor training within their first year as a supervisor. The curriculum used for this training is "Putting the Pieces Together," based on curriculum developed by the National Resource Center for Organizational Improvement that has been adapted to West Virginia. This training covers Administrative Supervision (management and organizational theories; power; transitioning from worker to supervisor; supervisor as advocate, change agent, data analyst, recruiter, and performance monitor); Educational Supervision (adult learning; staff ability vs. performance; stages of worker development; balancing compliance with best practice; constructive feedback; coaching); and

Supportive Supervision (supervisor as motivator, counselor, team leader, conflict manager). The Division of Training tracks attendance at this training but although the training is mandatory, attendance has been sporadic. In the past year, 50 supervisors attended and completed this training, however, 84 supervisors were enrolled. The Division of Training plans to put procedures in place in the next year to ensure that all new supervisors take this training within the first year of their positions.

Along with program specific training, the DHHR Office of Employee Development requires supervisors to attend a week-long "management boot camp" that covers a variety of management and supervision topics. Their office tracks employees for compliance with the policy. The DOP requires supervisors to take 36 hours of training in their first 12 months on topics such as performance appraisal and supervising for success, then an additional 24 hours of training in the next 24 months including topics such as discipline and documentation and conflict management. After the first three years' supervisors are required to take 12 hours of additional training per year. The DOP tracks compliance and attendance with this policy.

Data Collection

The Division of Training currently gathers qualitative data around its training programs, but more efficient methods for standardized reporting of this information must be developed. The Division of Training holds a statewide Child Welfare Training Advisory Council meeting quarterly to obtain feedback on training programs and to plan and implement training program improvements, although these meetings have been cancelled in recent months due to budget and travel issues. Participant evaluations are done on each training session that is held, with the results summarized and entered into a database and reported to the trainer and his/her supervisor. A formal tracking system to compile data from all training evaluations to identify trends and areas of improvement is being development. New curricula are reviewed and approved by stakeholders including regional field staff, policy staff, and SACWIS system staff prior to the training being conducted and when any changes or updates are made. A formal tracking and reporting system for this information must be developed and maintained.

In the next year, the Division of Training will implement a system for tracking and reporting the following information: in-service and professional development completion; qualitative evaluation data; competency test results for workers and supervisors; provider training; and training required by the new social work licensing requirements.

Foster Parent and Provider Training: Systemic Functioning

Foster parent training is currently provided by members of the West Virginia Social Work Education Consortium, consisting of the six public accredited social work programs in the state including West Virginia University, Marshall University, Concord University, West Virginia State University, Shepard University, and West Liberty State University. The schools pay for foster parent training under their IVE university training contracts. Requirements for the number of training rounds, scheduling, and reporting are included in the grant agreements with each university and are monitored through quarterly reports from the universities.

West Virginia currently uses the PRIDE curriculum developed by the Child Welfare League of America for foster parent pre-service training. All prospective and new foster parents must attend 21 hours of pre-service training and a three-hour agency orientation to be certified, although kinship families may be granted a waiver from the training. Each school holds an average of six PRIDE rounds per year in their respective geographic locations, and works with the regional home finders to identify and enroll prospective foster parents in the training. Training records are turned in to the Division of Training for each round, including sign-in sheets and participant evaluations. The schools track training completion, and participants who complete the training are awarded certificates to document completion that is kept in their home study records.

After certification foster parents must attend 12 hours of training each year to maintain certification. Training is tracked by the regional home-finders as part of the recertification process and records are maintained in the FACTS system. BCF contracts with Concord University to provide in-service foster parent training across the state, and Concord subcontracts with the other universities so the training can be provided locally for foster parents. In the past year trauma training was added as a requirement for all foster parents and Concord is in the process of scheduling and conducting trauma informed practice training across the state. The curriculum is based on the National Child Traumatic Stress Network trauma informed practice curriculum. Tracking of in-service training is done by the regional home-finders who are responsible for recertification of the homes.

Because of the implementation of the New Worker Competency Test at the end of pre-service training, which requires that workers pass the test prior to assuming a caseload, completion scores for pre-service training within the first six months of employment have been near 100%. In WVFY2016, the average amount of time between the first day of

employment and the first day of classroom training was three weeks. Since January 1, 2016, when the training schedule changed to accommodate SB559, all training rounds and competency tests have been completed within 12 weeks of the first day of classroom training. Therefore, since January 2016 there has been an average of 15 weeks between the first day of employment and the first day of classroom training.

Training requirements for providers are outlined in their contracts with the state and are monitored by Grants & Contracts. Contracted staff with casework responsibilities, such as Youth Services contracted staff, is required to complete the same training and competency test as workers who work for BCF. They are trained with the agency new workers and their numbers are included in the data provided for new workers.

Ongoing Staff Training

The Division of Training requires completion of a class evaluation for each class/session it trains and the data is compiled at the State Office. In the last fiscal year, 88% of training participants rated their training as good or excellent on class evaluations for ongoing staff training.

With the implementation of SB559 in-service training requirements for new workers have increased substantially. This is due in part to the requirement that workers with a provisional license that is restricted to DHHR must complete these requirements to maintain their social work licenses. Since the new requirements were just implemented in January 2016 and the SB559 Legislative Rule just went into effect on July 1, 2016, complete data about this issue is not yet available but will be reported in next year's APSR.

In West Virginia child welfare workers are required to hold a social work license issued by the West Virginia Board of Social Work. There are continuing education requirements for each type of license issued by the Board ranging in 20 hours/2 years to 80 hours/2 years. A regular social work license requires 40 hours of CEUs every two years. These continuing education requirements are in addition to any training provided by DHHR. If workers fail to obtain the required number of CEUs in the specified time they will lose their licenses and their positions with DHHR. These requirements are the same for DHHR staff, contracted staff, and provider staff who hold a license.

Supervisory training is an area that needs to be improved. Supervisors are required by West Virginia Division of Personnel Policy 18 to take 36 hours of supervisor/management training in the first year of their positions and 12 hours each year after. However, in recent months this training has not been provided often enough or in locations that are accessible to supervisors without overnight travel. The Division of Training is working with the Division of Personnel to make this training more available to supervisors, since it is very good supervisor/manager training. The Division of Training will also begin providing the nine hours of child welfare-specific supervisor training quarterly in the next year with the requirement that all supervisors attend. Attendance will be monitored, tracked, and reported.

Foster and Adoptive Parent Training

Foster and adoptive parent training is provided by the universities in the West Virginia Social Work Education Consortium (SWEC) and requirements for this training are specified and tracked in their Title IVE contracts with the state. Compliance is tracked through quarterly reports that are submitted by each school. Contractual requirements include providing PRIDE training rounds across the state based on regionally identified needs, schedule and attend quarterly regional foster parent planning meetings that include all stakeholders, providing all relevant documentation of each training round to the Regional Homefinders including the names of each person who completed the training, providing certificates of attendance to each participant, making the training schedules for each session available no less than two months prior to the start date and publishing schedules to the public through the internet, developing an acceptable level of competency for each training team, and obtaining written approval in advance prior to making any changes to the curriculum. Each school is also required to do class evaluations for each session and they report results of these evaluations in their quarterly reports. In FY2016, 62 rounds of PRIDE pre-service training were provided to 915 participants.

Foster and adoptive parents must complete their pre-service training prior to becoming certified as a foster home, and must complete 12 hours of continuing education each year to maintain certification. The foster parent must provide documentation of this training to maintain certification. Any foster parent that does not provide this documentation will lose certification and will not be allowed to continue as a foster home. This information is tracked and reported in FACTS by the Home-finding staff, which is responsible for

certification and recertification of foster homes. SWEC provides in-service training hours free of charge that are open to both agency and private provider foster parents. In FY2016, 131 in-service trainings were provided to 1,313 foster parents.

Private foster care agencies are required by contract to provide the same training as the state, which is the CWLA PRIDE model. Any agency that wishes to provide training other than PRIDE must have the curriculum reviewed and approved by the Division of Training. Currently only one agency has received approval to provide a different curriculum that has been reviewed to ensure that the content is the same. Private agencies may also choose to send their foster parents to the PRIDE training provided by SWEC at no cost to them.

There is currently no method in place to track the number of agency/private foster parents who should have been through the initial and ongoing training and the number who completed the training. The Division of Training will develop and implement a tracking methodology in the next year.

2017 Update

BCF has been working with the Capacity Center for States on workforce recruitment and retention because of the high volume of turnover in the agency. In March 2017, the Bureau for Children & Families formed a Child Welfare Supervisor Training Committee out of its Recruitment and Retention Initiative since supervisor training was identified as one of the leading workforce retention factors for the agency. The Supervisor Training Committee met in April 2017 to develop a new child welfare supervisor training plan and a work plan to implement it over the next year. The committee decided that all new supervisors must complete the training plan within their first 12 months of employment, and will begin providing the new supervisor training in June 2017 with the goal of training all supervisors with less than one year of tenure by September 2017 then moving on to the next group. The “Putting the Pieces Together” training curriculum will be used with modifications to add information about trauma and reflective supervision. Implementation of the supervisor training plan includes writing policy around expectations for supervisor training, including best practice on how and when supervisor responsibilities are assigned and an overview of federal requirements for staff and supervisor training.

The new supervisor training plan includes the following components:

Activity	Time Frame	Explanation
Kronos Time-Keeper Training	Within first 14 days	New supervisors must immediately become familiar with the process of approving timesheets in the Kronos system, effective immediately.
FACTS Supervisor Functions Training	Within first 14 days	BCF will develop and implement an online class that reviews supervisory functions in the FACTS SACWIS system. This training will be implemented in September 2017.
WV Division of Personnel Policy 18 Mandatory Class Enrollment	Within first 30 days	BCF will require new supervisors to begin the process of enrolling in required DOP classes within 30 days of employment, based on availability of the classes. BCF Division of Training will conduct a short survey on Survey Monkey on current supervisor's compliance with DOP training and barriers to the training.
Assign Mentor	Within first 30 days	BCF will review, revise, and re-release its current policy on mentoring. Mentoring assignments will be made outside of the new supervisor's district and will be monitored by management.
Develop a program policy overview on using policy to supervise.	Within first 30 days.	This training will be done by the Regional Program Managers with all new supervisors. It will include information on structure of unit meetings and all the SOPs.
Reflective Supervision	Within first 30 days	This training will be based on information received from Connecticut and includes a form to document what occurred in supervisor meetings with employees. There will be a short Blackboard course implemented by September 2017 and the

		information will be integrated into the new supervisor training.
Overview of Administrative Rules and the BCF Manager's Handbook	Within first 90 days	This will be a pre-training activity to "Putting the Pieces Together, providing an overview of administrative policy, where it's located, and how to use it.
Putting the Pieces Together	First module within first six months, finish all three modules within first year	This training consists of three-three day modules for a total of nine days and is based on curriculum obtained from Colorado. This training is specific to supervising in child welfare. Additional information on secondary trauma, using data, and reflective supervision will be added to the training. All supervisors with less than one year tenure will receive this training between June and December 2017. The training will be provided in the north and in the south in Harrison and Kanawha.
Resiliency Alliance/Trauma Informed Care for Supervisors	Within first year	This training will provide an overview of the Resiliency Alliance project on trauma informed practice for child welfare workers, including information on dealing with secondary trauma.
Ongoing training	Each year	Supervisors will be required to take 12 hours of program-specific supervisor training each year, with training completion tracked in an online Access database that can be viewed by supervisors and management staff.
Intranet website for new supervisors	As needed	BCF plans to set up an intranet page with resources and information for new supervisors, including links to important policies and information, a section on

		how to have effective consultation meetings with workers, and short training videos on relevant topics.

All components of the Child Welfare Supervisor Training Plan will be implemented by December 2017, with initial data to be reported in the 2018 APSR.

Since the submission of the Systemic Factors report in January 2017 the West Virginia Social Work Education Consortium has developed a process to aggregate data on foster parent training from each of the six participating universities and a process to report to BCF quarterly. The SWEC universities collect a large volume of data for each of their respective programs but previously did not put all the information into one format and one report.

Each SWEC school provided training for new foster and adoptive parents through preservice modules, modules on trauma, and in-service modules designed for existing or continuing foster parents. The preservice is evidenced-based utilizing a Child Welfare League of America, hybrid training. The schools delivered 61 sessions of preservice training, with 1,148 starters and 1,025 finishers. The training was evaluated after each session using a 10 point Likert scale, with 10 being the most positive score. The aggregate statewide mode for the training was over 9. Qualitative comments were almost uniformly positive, with the most frequent comments being, “the training was more helpful than I thought” and “I wish I had this training for my own kids”. Negative comments centered on facilities in which the training was held. In addition to preservice training and in concert with Training, the schools offered trauma training modules throughout the state. Each school offered at least three trauma sessions at each of the three levels of trauma training. Building on the preservice and trauma training, foster parents attend in-service training based on their needs as assessed by the home finding specialist and the family development plan. The schools scheduled 79 sessions, with 68 sessions held. In addition to quantitative and qualitative continuous assessments, biannual surveys of foster parents were administered to assess the perception of foster parents of the efficacy of training longitudinally. In summary, the surveys found that after one and three years, the relevancy of the training mirrored the results of the training assessment immediately following the training. Furthermore, the surveys assessed what the foster parents perceived as content they needed to better address the needs of the foster children in

their care. This data is juxtaposed with surveys of home finding specialists to assess gaps in needed content to more comprehensively discern future advanced in-service training.

The 2016 outcome data in the three expressed areas serve as a working beginning baseline relative to the continuing improvements corresponding to reliability and utility. The data and process will continually be assessed during the coming year to be consistent with the changing training needs and resultant training plans.

Quality Assurance System

West Virginia Department of Health and Human Resources Bureau for Children and Families (BCF) have a developed Quality Assurance System. The review system evaluates social services case activities and decisions in the following program areas:

- Intake Assessments
- Social Services case reviews (includes child protective services and youth services)
- Child Fatality reviews

The data from the review process is used to guide State planning and development efforts to improve the quality of services to children and families. The State utilizes the data from the social service reviews to develop and monitor items within the State's Child and Family Service Plan. The annual plan utilizes CFSR style case review data in conjunction with the State's data profile (contextual data report), and data from the State's COGNOS and "FREDI" systems in the development, planning and monitoring of CFSP goals and other Statewide Initiatives. Goals are modified based on the available data. Additionally, the social services case reviews track prevalence of substance abuse and domestic violence in the case review sampling for use in the development of services.

West Virginia has designated staff for providing quality assurance. The Division of Planning and Quality Improvement is under the umbrella of the Office for Planning and Research and Evaluation. The Division of Planning and Quality Improvement includes a Director of Planning and Quality Improvement, three Program Managers, and nine reviewers (Health and Human Resource Specialists Senior).

Social Services CFSR style reviews:

The Division of Planning and Quality Improvement (DPQI) utilizes Child and Family Service (CFSR) style reviews to evaluate case practice with children and families. Utilizing the Federal Children and Family Services Review process allows for the

continuous measurement of the State's performance in the areas of safety, permanency, and well-being.

The Division of Planning and Quality Improvement, Social Services Review Unit, completes biennial Child and Family Services Reviews (CFSR) style reviews for each of the West Virginia Department of Health and Human Resource's districts. The Division of Planning and Quality Improvement (DPQI) continues its efforts to further enhance the State's performance in the areas of safety, permanency, and well-being by utilizing the Federal Child and Family Services Review (CFSR) process as a model to measure and evaluate the State's performance for the above-mentioned areas.

The CFSR review instrument (OSRI) is and will continue to be the unit's primary internal tool for evaluating the quality of service delivery to children and families. Each reviewed case must follow the guidelines established by the Federal Bureau for Children and Families.

The CFSR style review provides meaningful data to the districts to assist them in improving services to children and families. All cases reviewed are completed by pairs of reviewers, per federal guidelines. In addition to completing a review of the paper record and FACTS, client and stakeholder interviews are conducted for each case reviewed.

After completion of the CFSR style reviews, exit conferences are held at the district offices where DPQI Staff assist the district in interpreting the results of the review. At the exit conference, the data indicators, based on the 18 items reviewed, are discussed with the District. The District is also provided with a comparison chart from their prior review. At this time, an exit interview is conducted by DPQI staff with the District's Management staff. Following the exit with the District Management Team and DPQI staff, DPQI completes a comprehensive report on the results of the review. The exit summary report is provided to the District for review and comments. Districts complete a corrective action plan based on the identified areas needing improvement outlined in the exit summary. DPQI compiles the exit summary, data and corrective action plan for each district and distributes the findings to the District's Management staff, the Regional Program Manager, Regional Director, Director of Training, Policy Program Specialists and the Executive Team.

West Virginia's Division of Planning and Quality Improvement includes in their District exit summaries a means for the District's staff to outline the services commonly needed to address the needs of the person(s) being served. Additionally, Districts are asked to identify which services are not available or accessible. DPQI provides this information to

the Director of Children and Adult Services and the Program Manager for Community Partnerships for the identification of service needs and development of services.

During the last fiscal year, WV requested the Administration for Children and Families (ACF) to provide technical assistance to assure that DPQI was applying the new instrument correctly. ACF along with JBS International Incorporated visited in April 2015 and provided technical assistance. This assistance was very helpful and clarified many questions DPQI had concerning the instrument. WV will continue to rely on ACF for further clarification during the CFSR process. Additional technical assistance/consultation will be needed for the implementation of the revised statewide assessment process for CFSR round three. Technical assistance/consultation may be needed regarding the development of West Virginia's continuous quality improvement site on the JBS web based site.

Results of CFSR style case reviews are indicated below.

Performance Indicator FFY 2013 - FFY 2014Comparison	FFY 2013	FFY 2014
Item 1: Timeliness of initiating investigations of reports of maltreatment	53.8%	53.7%
Item 2: Repeat maltreatment	94.2%	90.9%
Item 3: Services to family to protect child(ren) in home and prevent removal	69.2%	61.7%
Item 4: Risk of harm to child(ren)	50.0%	32.3%
Item 5: Foster care re-entries	93.7%	91.1%
Item 6: Stability of foster care placement	77.2%	74.7%
Item 7: Permanency goal for child	61.0%	64.9%
Item 8: Reunification, guardianship, or permanent placement with relatives	76.2%	69.7%
Item 9: Adoption	69.6%	82.9%
Item 10: Permanency goal of other planned permanent living arrangement	92.9%	66.7%
Item 11: Proximity of foster care placement	100.0%	98.5%
Item 12: Placement with siblings	98.2%	95.5%
Item 13: Visiting with parents and siblings in foster care	94.1%	94.4%
Item 14: Preserving connections	96.0%	97.3%

Item 15: Relative placement	94.9%	92.2%
Item 16: Relationship of child in care with parents	82.7%	82.8%
Item 17A: Needs and services of child	84.6%	69.4%
Item 17B: Needs and services of parents	69.0%	56.8%
Item 17C: Needs and services of foster parents	82.1%	81.6%
Item 17: Needs and services of child, parents, foster parents	61.5%	52.4%
Item 18: Child and family involvement in case planning	79.2%	67.5%
Item 19: Worker visits with child	61.5%	46.8%
Item 20: Worker visits with parents	37.4%	22.6%
Item 21: Educational needs of the child	92.9%	86.4%
Item 22: Physical health of the child	92.7%	90.4%
Item 23: Mental health of the child	83.9%	82.7%

BCF has established a separate internal child fatality review committee to review all child deaths due to child abuse and neglect and near child fatalities. Cases are reviewed by a member of DPQI in conjunction with representatives from Field and Policy. The results are reviewed by an internal review team for recommendations.

The objective is for the team to learn from these deaths to prevent similar deaths in the future. The team develops recommendations for modification of internal procedures, policies or programs of the Bureau for Children and Families; identifies programmatic or operational issues that point to the need for additional internal training or technical assistance; develops recommendations for external stakeholders to assist in the effort to reduce or eliminate future child fatalities through improved services to children and families; and identify community resources for children and families that are needed but are currently unavailable or inaccessible**.**

A comprehensive report is developed at the end of the Fiscal Year by BCF's Division of Research and Analysis and Division of Policy. The report is made available to the WV Legislature and other stakeholders. The results of the reviews were utilized in the development of the CFSP, and monitoring through the APSR.

WV has established a centralized intake system. DPQI is responsible for the sampling and review of intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake and the Training staff assigned to the unit. The results of the intake assessment reviews are used to improve fidelity to the Safety Assessment and Management System and the uniformity in screening decisions. Currently, the

Centralized Intake unit has established uniformity in its screening decisions and thus the acceptance rate is consistent Statewide.
West Virginia will be using COGNOS data. This is a developed, current report, real-time, already available. It measures number of hours to face-to-face contact with the identified victim.

The Statewide data, from case review and child fatality reviews indicated a need for improvement in the development of safety plans, as indicated in the CFSP. Data suggests a 7% improvement in the completion of safety plans from FFY 2013 to FFY 2014.

WV continues to utilize the COGNOS data to ensure continuous quality improvement related to the timely completion of Family Functioning Assessments, time to first contact, open referrals over 30 days, caseworker visits with children in placement, and NYTD.

WV has continued to utilize the Quality Councils as part of its CQI process. CQI is a management concept built upon employee empowerment which promotes increased efficiency, higher levels of professionalism, and enhanced job satisfaction. CQI is different from traditional quality assurance in that the focus is self-directed, self-determined change rather than change imposed by an external entity. To implement this process and provide a continuous information flow, the Bureau for Children and Families has established a statewide Quality Improvement Council system. This system consists of three council levels: Local, Regional and State.

The Local Level Quality Improvement Council (QIC) is used to improve processes and systems within the districts and to make recommendations for improvements to the Regional and Statewide Quality Improvement Councils. The Local (District) Level councils are comprised of representatives from Economic Services, WV Works, Adult Services, Children Services, Operations staff, and Administration. The program groups will be facilitated by the Regional Program Managers or a designated Community Service Manager. The Local Level QIC's utilize relevant data to make informed decisions regarding case practice. The Local Level QIC also reviews their District's Program Improvement Plans (PIP) that was developed based on the findings of the District's Social Services review. Progress is reported to the council as well as barriers to achieving the goals of the plan. Improvements are measured based on relevant data such as COGNOS, FREDI, dashboards, and case review data. The results are documented on the program improvement plan quarterly summary and forwarded to DPQI and the Regional QIC.

The local councils also provide a means for the district to self-monitor the Quality Council Activity Summary and report on progress or adjust the plans to improve services to

families and children. This allows the districts to focus on issues relevant to them while remaining focused on key national standards and measurements that impact the State.

During the last year, the Local and Regional Quality Councils have dealt with many issues. Many involved the flow of work, which were resolved at the lowest level. Each Council reviewed and monitored targeted data, identified by the DPQI reviews and COGNOS reports as areas needing improvement. At the local and regional level plans were put into place to improve the indicators of face to face contact with parents and time to first contact. As a result, there has been an improvement in the time to first contact and a slight increase in face to face contact with parents.

Issues which rose to the level of the State Quality Council in the past year tended to be more systemic. Examples of these issues are:

- Formatting of forms is too difficult and entering data is time consuming for workers. As a result, the State Team assigned a group to redesign forms so that entering data would be simplified.
- The length of time to get new staff hired is too long. As a result, the Commissioner worked with the Director of Personnel and staff to rectify the situation. The length of time was shortened.
- New worker training needs to be shortened. As a result, the new worker training was redeveloped to include more online training and on-the-job training with shadowing and mentoring.
- It is difficult to hire staff qualifying for Child Protective Services or Youth Services jobs due to the current law requiring a Social Work license. As a result, DHHR worked with the legislature to pass a bill this past session which would reinstate those who had previously had a temporary Social Work license and expand the field of candidates with qualifying degrees to obtain a temporary Social Work license. The intent of this legislation is to assist the Bureau in recruiting more staff and negate the problem of recurrent vacancies.

All the Quality Councils at each level provide a feedback loop. Each Council is comprised of peer representation who then takes the information back to staff in each local site. At the Regional level, representatives from the local councils meet to discuss issues that have arisen from the local level which cannot be resolved there. Feedback is given to each staff member via of minutes of the Council. The State level provides feedback to each Regional Director, who is a member of the State Council. Each is provided with a spreadsheet with the issues and results. This is shared with all staff. In addition, minutes of the meeting are provided to all staff.

West Virginia will continue to improve its already existing Continuous Quality Improvement Councils to include the use of a broader set of data including data from external sources.

West Virginia Is in the process of developing a Web site to allow for data sharing with stakeholders.

West Virginia continues to improve its already existing CFSR style case reviews in preparation for round three of the CFSR. DPQI has developed a policy and procedures manual to ensure the case review process is accurate and consistent. DPQI has revised the existing training manual to adhere to the requirements outlined for CFSR round three. DPQI with assistance from the Division of Training has established a training plan for new reviewers.

West Virginia has created a Data Subcommittee to review data and develop strategies related to the resolution of the data quality issues. The committee also identified other data needs for the improvement in case practice. Additionally, the committee has reviewed existing data sources to determine relevance and usefulness.

Goals for Improvement:

Goal 1

West Virginia will begin to incorporate a variety of sources of data, including input from partners/stakeholders to provide a complete picture and fuller understanding of trends and practices in the child welfare system.

Tasks:

1. Data subcommittee will identify available external data sources and determines its application in the overall CQI process.
   Measurement of completion for the utilization of stakeholder data will be documented in the Continuous Quality Improvement Council's minutes. This item will be completed by September 30, 2016.
2. Data subcommittee will develop a statewide communication plan for sharing and distribution of data for CQI processes. This item will be completed by September 30, 2016.
3. The Director of Planning and Quality Improvement will communicate with external stakeholders to begin to process of data sharing. This item will be completed September 30, 2017.

4. West Virginia will expand it focus groups to gain input from various stakeholders. Data from the Focus Groups will be incorporated into State's initiatives for improvements in child welfare. This item will be initiated by September 30, 2016.

Goal 2

West Virginia will continue to improve its already existing Continuous Quality Improvement Councils to include a more comprehensive use of internal and external data to make improvement in child welfare practices.

Tasks:

1. Local/District councils will report out the progress or changes to the DPQI CAPS. The Regional Continuous Quality Improvement Council will review Districts monitoring of CAPS, and provide the Districts with feedback to assistance them in improving child welfare practices. Quarterly updates will be provided to the Deputy Commissioner of Field Operations, Regional Director, Director of Social Services for Field Operation and the Director of Planning and Quality Improvement. This item will be initiated by September 30, 2016.

2. Improve utilization of ASO data in the make improvements in the interactions between Districts and service providers to enhance the quality of services to children and families, through the dissemination and analysis of ASO data to the District councils. The measure of completion will be the documentation of the utilization of the ASO data in the Quality Improvement Council minutes. This item will be initiated by September 30, 2017.

2016 Update

Social Services CFSR style reviews:

The Division of Planning and Quality Improvement (DPQI) utilizes the case review process set forth by the US Department of Health and Human Services administration for Children and Families for the continuous measurement of the State's performance in the areas of safety, permanency, and well-being. Furthermore, review data is used at the district level to evaluate case practice and assist districts in making improvements in the provision of services to children and families.

DPQI completes biennial reviews for each of the West Virginia Department of Health and Human Resource's districts. The CFSR review instrument (On Site Review Instrument,

2014) is and will continue to be the unit's primary internal tool for evaluating the quality of service delivery to children and families. All cases reviewed are completed by pairs of reviewers, per federal guidelines. In addition to completing a review of the paper record and FACTS, client and stakeholder interviews are conducted for each case reviewed.

After completion of the CFSR style reviews, exit conferences are held at the district offices with the management. DPQI Staff assist the district in interpreting the results of the review. At the exit conference, the data indicators, based on the 18 items reviewed, are discussed with the District. The District is also provided with a comparison chart from their prior review. At this time, an exit interview is conducted by DPQI staff with the District's Management staff, to gather additional information on the functioning of the districts. Following the exit with the District Management Team and DPQI staff, DPQI completes a comprehensive report on the results of the review. The exit summary report is provided to the District for review and comments. Districts complete a corrective action plan based on the identified areas needing improvement outlined in the exit summary. DPQI compiles the exit summary, data and corrective action plan for each district and distributes the findings to the District's Management staff, the Regional Program Manager, Regional Director, Director of Training, Policy Program Specialists, and Leadership.

West Virginia's DPQI include in their District exit summaries a means for the District's staff to outline the services commonly needed to address the needs of the person(s) being served. As part of the district review exit, staff is asked to discuss services available in their area and service needs. DPQI provides this information to Children and Adult Services and the Program Manager for Community Partnerships for the identification of service needs and development of services.

West Virginia continues to improve its already existing case reviews in preparation for round three of the Child and Family Services Review (CFSR). DPQI has developed a policy and procedures manual to be consistent with the requirements outlined in *Child and Family Services Review Procedures Manual (Office Management and Budget control number 0970-0214)* and the *Criteria for Using State Case Review Process for CFSR Purposes.*

DPQI has developed a manual for round three CFSR reviews as outlined in Child and Family Services Review Technical Bulletin seven and is pending approval.

Results of CFSR style case reviews are indicated below.

FFY 2015 All Cases Outcome or Performance Indicator	Performance Indicator Ratings		Outcome Ratings		
	Strength	Area Needing Improvement	Substantially Achieved	Partially Achieved	Not Achieved
Outcome S1:			70.2%		29.8%
Item 1: Timeliness of initiating investigations	70.2%	29.8%			
Outcome S2:			33.8%	23.9%	42.3%
Item 2: Services to family to protect child(ren) in the home and prevent removal or re-entry into foster care	60.2%	39.8%			
Item 3: Risk and safety assessment and management	37.3%	62.7%			
Outcome P1:			40.8%	52.6%	6.6%
Item 4: Stability of foster care placement	75.0%	25.0%			
Item 5: Permanency goal for child	59.5%	40.5%			
Item 6: Achieving reunification, guardianship, adoption, or other planned permanent living arrangement	71.1%	28.9%			

Outcome P2:			73.7%	22.4%	3.9%
Item 7: Placement with siblings	97.4%	2.6%			
Item 8: Visiting with parents and siblings in foster care	77.6%	22.4%			
Item 9: Preserving connections	77.6%	22.4%			
Item 10: Relative placement	90.2%	9.8%			
Item 11: Relationship of child in care with parents	63.8%	36.2%			
Outcome WB1:			32.4%	37.3%	30.3%
Item 12: Needs and services of child, parents, and foster parents	47.9%	52.1%			
Item 13: Child and family involvement in case planning	52.5%	47.5%			
Item 14: Caseworker visits with child	47.2%	52.8%			
Item 15: Caseworker visits with parents	25.6%	74.4%			
Outcome WB2:			72.9%	0.0%	27.1%

Item 16: Educational needs of the child	72.9%	27.1%			
Outcome WB3:			67.5%	5.8%	26.7%
Item 17: Physical health of the child	87.4%	12.6%			
Item 18: Mental/behavioral health of the child	59.8%	40.2%			

Data from the CFSR style reviews is used to evaluate the child and family outcomes in the Annual Progress Services Report.

During the last fiscal year, WV requested the Administration for Children and Families (ACF) to provide technical assistance to assure that DPQI was applying the new instrument correctly. ACF along with JBS International Incorporated visited in April 2015 and provided technical assistance. West Virginia will continue to rely on ACF for further clarification during the CFSR process. Additional technical assistance/consultation will be needed for the implementation of the revised statewide assessment process for CFSR round three. Technical assistance/consultation may be needed regarding the use of the JBS OSRI case review online system.

Critical Incident Reviews:

The Bureau for Children and Families has established an internal Critical Incident Review Team for the systematic review of critical incidences. The purpose of the Critical Incident Review process is to review cases to determine if something could have been done differently to prevent the fatality or near fatality of a child. The review process focuses on children that are “known” to our Child Welfare system, this means any child or family that we have had prior contact with, either through a Child Protective Services or Youth Services intake assessment or open case within the last 60 months. The review process looks at practice, policy and training to see if there are areas that, if improved, could have prevented the death or severe injury to the child.

The critical incident review team is chaired by the Director for of Planning and Quality Improvement and consists of the Commissioner of the Bureau for Children and Families, the Deputy Commissioner over Programs and Resource Development, the Deputy Commissioners over Field Operations and the Assistant Commissioner over Planning, Research and Evaluation. Additional State level staff include; the Director of Training

and the Director of Children and Adult Services. The staff representing field practice in each region includes the four Regional Directors, and the four Regional Program Managers.

A field review team is determined by the Director of Social Services Programs (SSP), Director of Children and Adult Services (CAS), and the Director of Planning and Quality Improvement (DPQI). The Field Review Team is led by a DPQI staff member. The Team involves the Child Protective Services (CPS) or Youth Services (YS) worker; the CPS or YS Supervisor and the Community Services Manager (CSM).

The Field Review Team performs a detailed review of the facts and circumstances surrounding the critical incident involving a child alleged to have been critically injured or died because of abuse and/or neglect. This includes, but is not limited to, a review of current child protective services, child, and family history of abuse and/or neglect, and a review of Department interventions and services from external providers. Interviews are conducted with staff and external providers. A search of FACTS is conducted to identify the CPS or YS history of the family. All Intake Assessments are reviewed to determine if the screening decision follows code and policy. All assessments are read to determine if the findings are correct and procedures for completing the assessment adhere to policy. Case plans and safety plans are reviewed to determine if the plans appropriately address the identified problems in the home. All case contacts are read to determine Caseworker interaction with the family. The Team reviews all services to be sure requests were made in a timely manner and the provider delivered the requested services. The findings are reviewed at the quarterly critical incident review meeting. The review team makes recommendations for the development of a Plan of Action.

The critical incident review team submits an annual report to the Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: http://www.dhhr.wv.gov/bcf/Reports/Documents/FFY2015.

Centralized Intake Reviews:

In July 2014, WV established a centralized intake system. Statewide implementation was phased in starting in July 2014 with full statewide implementation by February 2015. The DPQI is responsible for the sampling and review of intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake and the Training staff assigned to the unit. The results of the intake assessment reviews are used to improve fidelity to the Safety Assessment and Management System and the uniformity in screening decisions. Currently, the Centralized Intake unit has established uniformity in its screening decisions and thus the acceptance rate is consistent Statewide. The acceptance rate for WV for FFY 2015 was within a consistent range of the overall national average.

From October 2014 to August 2015, there were a total of 5,139 intakes reviewed based on the sampling percentage of 12% of accepted intakes and 25% of the screened-out intakes being reviewed on a weekly basis. Samples were drawn from weekly supervisory logs for all screened intakes received statewide.

Intake assessment reviews consisted of areas related to the sufficiency of information collection for maltreatment, nature and functioning; identification of absent parents and collaterals; identification of present and impending dangers; agreement with screening decisions; and assigned response times. Based on the completed reviews, the overall agreement with the screening decisions of the centralized intake unit was at 98.88%. Overall agreement with present danger identification was 95.31% and impending danger identification was 91.02%. Agreement with assigned timeframes was as follows: 0-2-hour response time was 90.63%; 0-72-hour response was 99.30% and 14-day response was 93.02%.

In addition to feedback related to above mentioned areas, information was provided to centralized intake director and staff regarding more specific findings for any area of strength or identified area needing improvement.

Management by Data

West Virginia continues to utilize the COGNOS data to ensure continuous quality improvement related to the timely completion of Family Functioning Assessments, time to first contact, referrals open over 30 days, caseworker visits with children in placement, and NYTD.

West Virginia will expand its focus groups to gain input from various stakeholders. Data from the focus groups will be collected using surveys. Data will be used to improve services to children and families.

Quality Councils

To improve outcomes, DPQI has recommended to the Commissioner of the Bureau for Children and Families to institute a quality assurance process that incorporates local, regional, and state level Quality Councils. Each district would submit their corrective action plan to the local Quality Council. If issues are not resolved at the local level they would move to the Regional Quality Councils. Local Quality Councils consist of district field staff, supervisors, coordinators, community services managers and local stake holders. Regional Quality Councils should meet on quarterly basis and should have staff

that represents each district and each level of management including: child protective worker, supervisors, coordinators, youth service workers, community services managers, and child welfare consultants. The Quality Councils activities should include:

- A review of each districts corrective action plan
- A review of the current data for each district and for the region
- A discussion on trends within the region
- A plan on items that need to be addressed as a regional issue
- Monitoring of each districts plan
- Update of regional and district plans as needed based upon the data
- A list of items that need to be forwarded to the Child Welfare Oversight (CWO) team for the development of a statewide plan
- A review of the feedback from the CWO
- A report to the CWO team after each QC meeting on achievement of outcomes on their regional and district plans.

The chair of the regional Quality Councils should do the following activities:

- Prepare the agenda;
- Provide copies of each districts corrective action plan;
- Provide copies of the data for each team member at each meeting;
- Ensure the team has all required members;
- Assist the team with the development of the regional plan;
- Provide quarterly updated to the CWO;
- Provide feedback from the CWO back to the regional QC.

Child Welfare Oversight Team

As part of the continuous quality improvement process, the Child Welfare Oversight Team activities should include:

- Reviewing the Regional Quality Council Plans;
- Monitoring child welfare data by state, region, and district;
- Provide resources to the regions as needed;
- Provide feedback for the regional plans and the outcomes.

The Child Welfare Oversight team is comprised of individuals on the state level that have the ability to impact child welfare in a way that the district and regions may not be able to achieve. The list below is an example of some ways the CWO can have an impact but is not all-inclusive:

- Court system;
- Policy changes;

- Changes to the training;
- Ability to pull statewide resources;
- Impact other bureaus services;
- Development of services.

The Child Welfare Oversight Team will also be the team that reviews and provides feedback on stakeholder surveys. The team will review the surveys for statewide trends and provide feedback to the regions and/or divisions. This data will be given to the regional Quality Councils to process and incorporate into their regional plans as needed.

Goals for Improvement

West Virginia has created a Data Subcommittee to review data and develop strategies related to the resolution of the data quality issues. The committee has reviewed existing data sources to determine relevance and usefulness. The committee has identified other data needs that would be helpful in the monitoring of case practice.

West Virginia recognizes the need to build staff skills and expertise in how to strategically select and appropriately use data for meaningful, targeted decision making and to extend such expertise to a broader range of staff. West Virginia is working with the Capacity Building Center for States with the goal of “enhancing the knowledge and skills among managers in using management reports to guide action planning, monitoring, and continuous quality improvement”. The Data Subcommittee has conducted a gap analysis of its existing data sources, and has begun formulating strategies to improve existing data reports. Additionally, the Data Subcommittee has begun a discussion on a statewide communication plan that would utilize a “data hub” for sharing and distribution of data.

2017 Update

Operating in the jurisdictions where the services included in the CFSP are provided

The West Virginia Department of Health and Human Resources (West Virginia DHHR) Bureau for Children and Families (BCF) has a comprehensive Quality Assurance System. The Department’s QA system is centrally administered and operating in all jurisdictions of the state, and is part of an overall Continuous Quality Improvement (CQI) process. Most QA functions are administered by the Division of Planning and Quality Improvement (DPQI). DPQI is under the Office of Planning, Research, and Evaluation. West Virginia has 12 designated DPQI staff for the purposes of providing quality assurance which includes three Program Managers, nine Health and Human Resource Specialist Seniors,

and one DPQI Director. These staff members are stationed in various offices located across the Department's four regions.

West Virginia' s quality assurance system evaluates social services case management activities and decisions in the areas of Child Protective Services from initial abuse/neglect report to case closure, Youth Services cases with and without judicial oversight, Critical Incidents, and Intake Assessments as received by West Virginia Centralized Intake.

DPQI completes biennial Child and Family Services Review (CFSR) style social service case reviews for each of the West Virginia Department of Health and Human Resource's districts. One district level review is completed each month by DPQI staff. The review includes the examination of 12 randomly selected cases consisting of six in-home and six placement cases. The largest metropolitan area is reviewed at least once each calendar year. The review cycle is continued until each district has been reviewed.

The Bureau for Children and Families is comprised of 29 Community Services Districts that are divided into four regions. During FFY 2016 DPQI completed 143 social services case reviews comprised of 72 foster care and 71 in-home cases. Reviews were completed in each of the four regions. The reviews occurred in 12 different districts representing 40% of the districts in West Virginia. DPQI staff completed approximately 516 interviews during FFY 2016. Of this number, 209 were children, parents, foster parents, or other relatives and/or caregivers of the children involved in the cases being reviewed.

In July 2014, WV established a centralized intake system. Statewide implementation was phased in starting in July 2014 with full statewide implementation by February 2015. A centralized intake call center is in the northern and southern part of the state. DPQI is responsible for the sampling and review of intake assessments. The reviews evaluate the quality of intake assessments. The Centralized Intake unit utilizes the results of the reviews to improve the quality of the intakes and adhere to the fidelity of the screening process.

During FFY 2016 DPQI staff reduced the number of Centralized Intake reviews from 40% of all accepted and screened out reports received to 20%. DPQI reviewed 2,273 intakes as received by the Centralized Intake Unit during FFY 2016. Intakes as approved by each Centralized Intake supervisor were reviewed. Reviewers agreed with the screening decisions made by Centralized Intake supervisors in over 95% of the intakes reviewed. Centralized Intake staff will be completing peer reviews of intakes during FFY 2017. During FFY 2017 DPQI will not be completing Centralized Intake reviews. The Centralized Intake Unit has implemented their own system of peer reviews to measure uniformity.

West Virginia has established an internal child fatality review committee to review all child deaths due to child abuse and neglect and child near fatalities. Refer to prior updates for detailed information on the Critical Incident Review Team. Cases that are deemed by the internal review team to need an intensive level of review are reviewed by a member of DPQI in conjunction with two representatives from field staff. The results are reviewed by an internal review team quarterly. The objective is for the team to learn from these deaths to prevent similar deaths in the future. DPQI staff reviewed 62 critical incidents in 2016.

As part of CQI efforts, BCF has created a Data Subcommittee to review data and develop strategies related to the resolution of data quality issues. The committee also identified other data needs for the improvement in case practice. Additionally, the committee has reviewed existing data sources to determine relevance and usefulness. In late November 2016, with assistance from the Capacity Building Center for States, the subcommittee conducted focus groups designed to determine the data needs of field level staff. The goal of the focus groups was to gain a better understanding of how data is used by field staff and what changes in the way data is collected and disseminated would be most useful for the improvement of practice. The group is working toward analyzing the information gained from these groups.

West Virginia has been approved to conduct Round Three of the Child and Family Services Reviews using the State Conducted Case Review process to complete the onsite review. DPQI staff will conduct reviews of 65 social service cases representative of statewide practice in six districts. The six districts selected are representative of the dichotomy of the State from urban to rural practice and will include the largest metropolitan area in West Virginia, Kanawha County. Reviews will be conducted in each of the designated districts with a staggered schedule over the course of the six-month review period. The sample will include 40 foster care cases and 25 in-home cases for a total of 65 cases. WV will utilize the US Department of Health and Human Services Administration on Children and Families, Children Bureau's Child and Family Services Review Onsite Review Instrument and Instructions (OSRI) when reviewing cases. Case information will be entered into the Online Monitoring System per requirement of the Children's Bureau.

To improve outcomes DPQI has recommended to the Commissioner of the Bureau for Children and Families to institute a quality assurance process that incorporates local, regional, and state level Quality Councils. The Quality Councils process in place includes DPQI case review of districts, development of a district corrective action plan (CAP) based upon review results, and submission of the CAPS to agency leadership. See prior submissions for additional information on quality councils.

The DPQI unit also completes targeted reviews. For example, during federal fiscal year 2017, as part of the Juvenile Justice Reform Bill (Senate Bill 393), Aggressive Replacement Therapy will be piloted by Children's Home Society of West Virginia. As part of the implementation of this project the Department must have Model Fidelity Coordinators to conduct fidelity reviews of the program and sessions with the children. DPQI staff will be trained to complete these reviews.

Have standards to evaluate the quality of services

Standards to ensure that children and families are provided quality services that protect their safety and health, from referral intake to the achievement of permanency, are defined through federal and state laws and Department policy, available at http://www.dhhr.West_Virginia.gov/bcf/policy/Pages/default.aspx. Department outcome measures are based on federal requirements and state policy. Department staff has access to an internal data dashboard that captures outcome data. This includes timeliness of initiating investigations of child maltreatment compared to the assigned timeframe.

Regulations and standards for West Virginia foster homes and institutions can be found in Systemic Factor G. Foster and Adoptive Parent Licensing, Recruitment, and Retention.

To evaluate the state's efforts to improve performance in the areas of safety, permanency, and wellbeing, DPQI utilizes the federal Child and Family Services Review process as a model to measure and evaluate the state's performance for the above-mentioned areas. DPQI utilizes the January 2016 version of the Federal CFSR On-Site Review Instrument (OSRI) as the unit's primary internal tool for evaluating the quality of delivery of services to children and families. The OSRI evaluates the quality of service delivery to children and families. Each review follows the guidelines established by the Federal Bureau for Children and Families. Pairs of DPQI reviewers complete a review of the paper and electronic records, and conduct client and key case participant interviews to evaluate adherence to policy and practice standards. The goal of the reviews is to improve practice to achieve positive outcomes for the children and families being served. The period under review covers a 12-month section of time going backwards from the start of the review date to 12 months prior. Preliminary case reviews to collect information are done related to FACTS records only. From this, reviewers develop a list of questions and information needed to complete the CFSR review. DPQI review teams then conduct interviews with designated stakeholders including the case worker, parents, service providers, placement providers, youth if age appropriate and any other parties who may have information relative to the case review. DPQI reviewers also review the paper file for additional information as part of the review process and include this information in review findings.

After the cases are rated each case is debriefed. At a minimum, case debriefings are comprised of two review teams and a DPQI program manager. During these debriefings case ratings are discussed in relation to CFSR instrument instructions and clarification guides to ensure accuracy with instrument instructions. A different DPQI Program Manager completes QA activities.

Identifies strengths and needs of the service delivery system

The DPQI social services case review data provides for continuous quality improvement through the identification of the district's strengths and areas for improvement. The review data is used at the district level to evaluate case practice and assist districts in making improvements in the provision of services to children and families. After completion of the CFSR style reviews, exit conferences are held at the district offices where DPQI staff assists the district in interpreting the results of the review. At the exit conference, the data indicators, based on the 18 items reviewed, are discussed with the district. The district is also provided with a comparison chart from their prior review. At that time, an exit interview is conducted by DPQI staff with the district's management staff. During the exit conference district management staff can comment on the factors that contributed to the strengths and areas needing improvement. Additionally, districts are asked to identify which services needed are not available or accessible in the area. DPQI creates a list of base questions to be asked at all the exits. The questions are based on the previous Federal Fiscal Year data and the overall issues impacting practice within the State.

The Critical Incident Field Review Team performs a detailed review of the facts and circumstances surrounding the critical incident involving a child alleged to have been critically injured or died because of abuse and/or neglect. This includes, but is not limited to, a review of current child protective services, child, and family history of abuse and/or neglect, and a review of Department interventions and services from external providers. Interviews are conducted with staff and external providers. A search of FACTS is conducted to identify the CPS or YS history of the family. All Intake Assessments are reviewed to determine if the screening decision follows code and policy. All assessments are read to determine if the findings are correct and procedures for completing the assessment adhere to policy. Case plans and safety plans are reviewed to determine if the plans appropriately address the identified problems in the home. All case contacts are read to determine the quantity and quality of caseworker interaction with the family. The team reviews all services to ensure requests were made in a timely manner and the provider delivered the requested services. Through the review process gaps in service availability and provision are identified. The findings are reviewed at the quarterly critical incident review meeting.

Provides relevant reports

DPQI staff utilizes the CFSR Online Monitoring System (OMS) developed by JBS International to complete case reviews and develop relevant reports. The OMS is available for states to use not only for the Federal CFSR, but also for continuous quality improvement (CQI) purposes. The OMS is a web-based application that provides DPQI staff the ability to complete case reviews and provide relevant district, regional, and state level reports. Because the OMS is automated it reduces the risk of reviewer error in completing the OSRI.

Following the social service review exit with the district management team DPQI completes a comprehensive report on the results of the review. The exit summary report is provided to the district for review and comments. DPQI provides this information to Children and Adult Services and the Program Manager for Community Partnerships for the identification of service needs and development of services. Districts complete a corrective action plan based on the identified areas needing improvement outlined in the exit summary. DPQI compiles the exit summary, data and corrective action plan for each district and distributes the findings to the district's management staff, the Regional Program Manager, Regional Director, Director of Training, Policy Program Specialists, and Department Leadership.

DPQI provided ongoing feedback to the Director of Centralized Intake Unit and the Training staff assigned to the unit. The Centralized Intake Unit utilized the results of the reviews to improve the quality of the intakes and adhere to the fidelity of the screening process.

The Critical Incident Review Team develops recommendations for modification of internal procedures, policies or programs of the Bureau for Children and Families; identifies programmatic or operational issues that point to the need for additional internal training or technical assistance; develops recommendations for external stakeholders to assist in the effort to reduce or eliminate future child fatalities through improved services to children and families; and identifies community resources for children and families that are needed but are currently unavailable or inaccessible. The Critical Incident Review Team submits an annual report to the Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: http://www.dhhr.WestVirginia.gov/bcf/Reports/Pages/default.aspx

Evaluates implemented program improvement measures

West Virginia's quality assurance system utilizes data from various sources to monitor the efficacy of program improvement measures. The State utilizes CFSR style social service review data in conjunction with the State's data profile (contextual data report), and data from the State's Statewide Automated Child Welfare Information System (SACWIS) in the development, planning, and monitoring of Child and Family Services Plan (CFSP) goals and other statewide child welfare initiatives.

As indicated earlier, results of the social services reviews are used by districts to develop corrective action plans. The comparison chart provided to the districts at the social services review exit conferences, and discussion of the corrective action plan developed after the prior review, allow management staff to evaluate the efficacy of the strategies for improvements that were implemented.

The Centralized Intake Unit utilizes the results of the DPQI intake assessment reviews, along with feedback from external stakeholders, to improve the quality of the intakes and improve fidelity to the Safety Assessment and Management System. The information is also used to ensure uniformity in screening decisions.

Service Array

The Safe at Home Service Development Workgroup, the workgroup that is in the process of developing new services to support the Title IV-E demonstration project. This workgroup has created two new services: **Peer Support** and **Youth Coaching**. These services are promising practices and are used across the country to support wraparound programs. Both utilize paraprofessional staff members who are employed and supervised by a behavioral health organization.

Peer Support is a service designed to help adults with addiction and/or mental/behavioral health disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice, with the least amount of ongoing professional intervention. Peer Support focuses on skill and resource development related to life in the community and to increasing the participant's ability to live as independently as possible, and to participate in community opportunities related to functional, social, educational and vocational goals.

The service is based on the principles of recovery, including equipping the client with skills, emphasizing self-determination, using natural and community supports, providing individualized intervention, emphasizing employment, emphasizing the "here and now", providing early intervention, providing a care environment, practicing dignity and respect,

providing consumer choice and involvement in the process, emphasizing functioning and support in the real world and allowing time for interventions to work over the long-term.

2016 Update

Peer Support, the new service designed to help adults with addiction and/or mental/behavioral health disabilities, is in the final stages of preparation. The service definition and criteria have been developed and the managed care organization has completed the programming necessary for its inclusion in their authorization and review procedures. At this time, the service awaits the SACWIS enhancements that will allow workers to link it to specific clients and to interface with the managed care organization's data system. It is anticipated that this enhancement can occur by Fall 2016.

Youth Coaching is a structured relationship or partnership that focuses on the needs of the identified youth. The purpose of youth coaching is to acquire new behaviors or skills, alter existing nonproductive skills and connect children with safe places and structured activities through encouragement, reinforcement, counseling and role modeling. Youth Coaching is a strength-based model that requires an outlined, well-defined plan with established goals and objectives. The Youth Coaching intervention is guided by many of the "evidence based essentials" identified and described Dr. Larry K. Brendtro, Martin L. Mitchell, EdD and Herman J. McCall, EdD, in their book titled Deep Brain Learning ®: evidence-based essentials in education, treatment, and youth development. Youth Coaching must focus on interpersonal skills, educational goals and self-management. A person who is not related to the family and is at least a paraprofessional provides mentoring. Youth Coaching may occur individually or in a dyad/triad when the identified children have similar needs. Youth Coaching will be guided by the youth's Asset Development Plan. This plan is approved by the Family Team, is individualized and will focus on building targeted assets specific to the youth's identified needs. These needs will be identified by WV CANS which will identify centerpiece strengths to build upon, as well as opportunities for strength development.

The Safe at Home Service Development Workgroup has also been charged with the redesign of the Bureau's current structure for providing Community-based Supportive Services, currently known as Socially Necessary Services. The work of this team over the past year has involved the evaluation of current payment structures, service availability and provider accountability. Several recommendations have been approved by the Bureau's Executive Team, which include:

1. Structural changes to service categories: The service categories are now broken down into the four federally requires categories of Family Support, Family Preservation, Time-limited Reunification and Post-Adoptive Services.
2. Development of Performance Measures for Each Service Category: The current compliance-based methodology of measuring provider performance will be changed to results-based accountability. This will enable the Bureau for Children and Families to begin gathering qualitative and quantitative data about the effect these services have on our families.

   The performance measures for Family Support funds, which are allocated to grant-funded prevention programs, will be included in the statements of work for those organizations and are not part of the current structure for Socially Necessary Services. The performance measures for Family Preservation, Time-limited Reunification and Post-Adoptive Services are as follows:

a. Family Preservation

How much did we do?

# of referrals received
# of referrals accepted for service provision
# of services delivered
# of customers served

How well did we do it?

% of staff with required training and certification
% of staff with tenure of two years or more
% of families contacted within 24 hours of referral acceptance
Staff/case ratio

Is anyone better off?

and % of families who remained intact during service provision and at six-months follow-up;
and % of families served with no repeat maltreatment;
and % of youth served with no new incidences of status or criminal activity during services provision and six-months after returning home;
and % of youth who enjoyed improved academic achievement;
and % of parents who express improved ability to provide care to their children;
and % of families and youth with improved ties to the community.

b. Time-limited Reunification

How much did we do?

# of referrals received
# of referrals accepted for service provision
# of services delivered
# of customers served

How well did we do it?

% of staff with required training and certification
% of staff with tenure of two years or more
% of families contacted within 72 hours of referral acceptance
Staff/case ratio

Is anyone better off?

and % of families who were reunified within 12 months from service start date;
and % of children experiencing re-removal within six-months of returning home;
and % of youth served with no new incidences of status or criminal activity during service provision and six-months after returning home;
and % of youth who enjoyed improved academic achievement;
and % of parents who express improved ability to provide care to their children;
and % of families and youth with improved ties to the community.

c. Post-adoptive Services

How much did we do?

# of referrals received

# of referrals accepted for service provision

# of services delivered

# of customers served

How well did we do it?

% of staff with required training and certification

% of staff with tenure of two years or more

% of families contacted within five days of referral acceptance

Staff/case ratio

Is anyone better off?

and % of children participating in supportive services will maintain their adoptive placement in a safe, family environment;

and % of adoptive families that have connected with and maintained community resources and support;

and % of adoptive families participating in recommended supportive services;

and % of adoptive parents who express improved ability to provide care to their adopted children.

3. Restructuring of payment methodology: Currently, Socially Necessary Services utilizes a fee for service-based reimbursement process. The workgroup recommends that that instead of payment for each individual service on a unit-by-unit basis, case rates be established for each service category. The family would be referred for services under one of the service categories and the provider agency would assign an array of services to meet the specific needs of each member. The case rate would be based on the intensity of each case type. For example, Family Preservation would be paid a higher case rate (due to intensity of need when families are experiencing crises and efforts are being made to keep children in the home) than time-limited reunification, where children may be out-of-the home and the service provision would entail supervised visitations to reintegrate the family. Several of the current services that are paid individually, such as transportation, will be factored into the case rates and will no longer be considered a separate service.

2016 Update

The development of the **Youth Coaching** service that was mentioned in the 2015 updated has been delayed. During the latter developmental phases, the workgroup

learned that the evidence-basis for our new service, the published works of Larry K. Brentro, et. al., had been sold to Star Commonwealth and now had proprietary restrictions on its usage. The workgroup, through partnership with our sister Bureau, the Bureau for Behavioral Health and Health Facilities (BBHHF), had to find other experts in the field of youth mentoring/re-education models. Several conversations have occurred with Mark Freado and Mary Grealish, mentioned throughout this document in relation to our IV-E demonstration project. The group, through funding from BBHHF, is examining the possibility of Mr. Freado, Ms. Grealish and several other "experts" coming to West Virginia to conduct "train the trainer" workshops with our mutual providers and Departmental staff to help develop a youth mentoring service that fits West Virginia.

The **redesign of the Bureau's current structure for providing community-based supportive services**, currently known as **Socially Necessary Services**, has been delayed. During the past year, the contract for the managed care organization that manages the State's Medicaid and Socially Necessary Services programs was up for renewal, which initiated a competitive rebidding process. The current provider, who has been the contract awardee since 2004, was successful in their re-application for the contract. However, this process has taken longer than anticipated due to West Virginia's adoption of a new payment system for both providers and employees. This new system, West Virginia Oasis, has experienced technological delays, as well as delays due to political unpopularity of the new system. An anticipated approval date for this new contract has tentatively been announced for June 1, 2016. The reason the contract rebidding process delayed forward movement with the redesign of our socially necessary service system is because making significant changes to payment and oversight structures is not part of the current contract, and had been specifically added to the request for proposals when the rebid announcement was published. Once the new contract has been finalized, movement can occur with design of the new structures discussed in the 2015 update. However, realizing that necessary services needed a better mechanism for improving quality of services, the Bureau for Children and Families adopted the "80% Rule" in November 2015.

The "80% Rule", which was effective on November 4, 2015, requires that socially necessary services providers score at least 80% during their retrospective review. The retrospective review is conducted by the managed care organization at least every 18 months. If the provider scores less than 80% on any service they provide, the provider received written notice that a six-month probationary period is in effect. Training and technical assistance will be offered. After 6 months, the managed care organization will conduct another review on the services scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider's record and they will no longer be able to receive referrals to provide that service. If, during the retrospective

review process, a provider scores zero on any safety-related service, that service will be automatically closed from the provider's record. There will not be a six-month probationary period when a safety service scores zero. In the four months since implementation of this new quality assurance process, no provider has scored zero on their safety services. We have seen four agencies whose scores have dramatically increased since the rule was effective.

Continuum of Care Redesign

Community-based Service Expansion

West Virginia is one of several states that control the development of medical and behavioral health care services through a certificate of need process.

In West Virginia, the Health Care Authority provides oversight and staffing for the certificate of need process. The Health Care Authority's goals are to control health care costs, improve the quality and efficiency of the health care system, encourage collaboration and develop a system of health care delivery which makes health services available to all residents of the State. The Certificate of Need program is a regulatory element used to achieve these goals. The program was originally enacted in 1977 and became part of the Authority in 1983. The language outlining the program is found in W.Va. Code §16-2D.

Housed within West Virginia State Code Chapter 49 is a provision to become exempt from the full certificate of need process. Summary Review process is outlined in section § 49-2-124. This section of code allows providers of behavioral health services to bypass the full certificate of need process if certain criteria are met. These criteria are:

- Criterion 1: The proposed facility or service is consistent with the State Health Plan. (See attachment "West Virginia State Health" Plan 11-13-95)
- Criterion 2: The proposed service/facility is consistent with the Department's programmatic and fiscal plan for behavioral health services for children with mental health and addiction disorders.
- Criterion 3: The proposed facility or service contributes to providing services that are child and family driven, with priority given to keeping children in their own homes.
- Criteria 4: The proposed facility or service will contribute to reducing the number of child placements in out-of-state facilities by making placements available in in-state facilities.

- Criterion 5: The proposed facility or service contributes to reducing the number of child placements in in-state or out-of-state facilities by returning children to their families, placing them in foster care programs, or making available school-based and outpatient services.
- Criterion 6: If applicable, the proposed facility or service will be community-based, locally accessible, and provided in an appropriate setting consistent with the unique needs and potential of each child and family.

Since these criteria are housed in Chapter 49, the child welfare statutes, the Bureau for Children and Families has acted as the liaison with the Healthcare Authority in processing requests for a summary review.

The certificate of need, and thus the summary review, is required for all new service development, as well as any changes in current services provided, population served or county of location. Due to the multiple initiatives that are geared toward reducing the use of congregate care, many of the children's residential and child placing agencies are seeking summary review to expand the services they provide, the population they serve and the areas where their business are located. The agencies are seeking to provide more community-based, in-home behavioral health services to a broader range of clientele. Instead of serving only the youth and families who have become involved in the child welfare system, the agencies are now becoming focused on providing preventive services to off-set crises that bring children and their families into the system.

During the past two years, summary review has been approved for eight children's residential providers and two child placing foster care agencies to expand their service array to include community-based, in-home behavioral health services. This represents 30% of our current licensed child welfare providers. There have also been four other community-based organizations that have started the process to become licensed behavioral health centers. This totals 16 new summary review approvals for the provision of an expanded array of trauma-focused, in-home behavioral health services in what were often previously underserved counties, aimed at keeping families together.

The areas in the state that have seen the most benefit from this expansion is in the Martinsburg and the southern coal fields communities surrounding Princeton. These areas have traditionally been underserved, but for different reasons. In Martinsburg, the area continually must compete with the Washington D.C. job market which can pay substantially higher wages. The Martinsburg area, over the past 10 years, has gone from a farming community to a metropolitan hub of dramatically increased population. The

service provider volume has not kept pace with the growth in population. For many years, the only behavioral health provider was the state funded comprehensive behavioral health center and a couple of private practice therapists. Due to the summary review process, Martinsburg now has four new providers of behavioral health services, specifically geared to serving children at-risk of being removed from their homes, and their families.

Princeton, West Virginia, and its surrounding communities, has a lack of services due to not having a nearby comprehensive behavioral health center. The closest center is in Beckley. Due to the more rural nature of southern West Virginia, many customers are unable to travel the distance to Beckley. Also, the volume of need, and the limited population that can be served, resulted in long waiting lists at the Beckley comprehensive center. Princeton and surrounding areas have added three new behavioral health centers over the past two years.

The Bureau for Children and Families began collaborating with its sister Bureaus, the Bureau for Medical Services and the Bureau for Behavioral Health and Health Facilities during the Summer of 2016 to begin work on a Medicaid Section 1115 Waiver to help expand service availability for substance use disorders (SUD). Since substance abuse is the leading reason for child abuse and neglect removals, the expansion of services that will be realized with the Medicaid waiver will focus primarily on the population most in need.

Addressing the Substance Use Disorders crisis has been a priority for Governor Earl Ray Tomblin throughout his administration. In September 2011, he established the Governor's Advisory Council on Substance Abuse (GACSA) and six Regional Task Forces to combat the substance use crisis. The GACSA is composed of cabinet-level positions across the West Virginia Departments, behavioral health experts, and community leaders. These groups are charged with providing guidance on implementation of the Comprehensive Statewide Substance Abuse Strategic Action Plan. The Task Force is also recommending priorities for the improvement of the statewide substance abuse continuum of care, identifying planning opportunities with interrelated systems, and providing recommendations to the Governor on enhancing substance abuse education; collecting, sharing, and utilizing data; and supporting policy and legislative action.

The Comprehensive Statewide Substance Abuse Strategic Action Plan includes the following overarching strategic goals for prevention, early intervention, treatment, and recovery:

- Assessment and Planning: Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation, and monitoring of the West Virginia substance abuse service delivery system (data).
- Capacity: Promote and maintain a competent and diverse workforce specializing in prevention, early identification, treatment and recovery of SUDs and promotion of mental health (workforce).
- Implementation: Increase access to effective substance abuse prevention, early identification, treatment and recovery management that is high quality and person-centered (access).
- Sustainability: Manage resources effectively by promoting further development of the West Virginia substance abuse service delivery system (resource management).

The Governor's Advisory Council and the Regional Task Forces have been meeting regularly, and in October 2015, put forth the following recommendations:

Statewide Implementation - The recommendations include increasing dissemination and education of Naloxone, improving access to licensed Medication Assisted Treatment (MAT) Centers, establishing standards of care and providing education, expanding school-based behavioral health services, and ensuring consistent public outreach and education.

Regional Capacity - To fill some of the identified gaps in service delivery, the Council is working to promote SUD treatment capacity by region across the state. The recommendations also include developing an infrastructure for recovery housing.

Legislative and Policy - The recommendations for legislative and policy change include developing/supporting "Second Chance for Employment Act" legislation to help remove barriers to obtaining employment, assessing an Alcohol and Tobacco User Fee with a percentage set aside for SUD services, reviewing Certificate of Need process for behavioral health services to recommend ways to reduce barriers for new and existing program expansions, shifting Benzodiazepines from Schedule 4 to Schedule 3, and increasing usage of and accountability measures for the Prescription Drug Monitoring Program.

Over the past five years West Virginia has implemented several pieces of legislation (including West Virginia Senate Bills 335, 437 and 523) to address prescription drug abuse and opioid overuse. Senate Bill 437, passed on March 10, 2012, takes a

comprehensive approach to address prescription drug diversion and substance abuse issues. The law increases regulation of opioid treatment centers; establishes licensing and regulation of chronic pain clinics; creates mechanisms to flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners; implements requirements for continued education for physicians and others who administer controlled substances; and establishes a system for tracking sales of pseudoephedrine, limiting the amount that can be legally purchased daily (3.6g), monthly (7.3g), and annually (48g).

Building on the foundation of both legislative and operational efforts to combat substance abuse in West Virginia, this proposed Medicaid section 1115 waiver will permit the state to increase the availability of SUD prevention and treatment services and create a continuum of care that will improve overall health and health outcomes, while at the same time promoting economic stability across the state. Given that managed care plans are already responsible for providing the full continuum of care to meet beneficiaries' physical health and behavioral health needs, this waiver presents a tremendous opportunity to improve care for beneficiaries with chronic conditions. This integration will also move West Virginia toward value-based purchasing for both physical and behavioral health services.

Current Delivery System - The West Virginia Medicaid program currently provides health coverage to 596,450 residents (cite) nearly 70 percent of whom are served through a managed care delivery system. By the end of calendar year 2016, 85 percent of Medicaid beneficiaries are expected to have transitioned from fee-for-service to managed care. The only populations who will remain in fee-for-service are individuals receiving long-term care services and supports, home and community-based waiver services, dual eligible, and foster care children. In addition, in July 2015, West Virginia incorporated behavioral health services into managed care to improve integration of physical and behavioral health services.

The Bureau for Medical Services (BMS) is the state agency that administers the Medicaid program. The Bureau for Behavioral Health and Health Facilities (BBHHF) is the federally-designated state authority for mental health, substance abuse, and intellectual and developmental disabilities. BBHHF provides funding for community-based behavioral health services for individuals with behavioral health needs. These two Bureaus work closely together to deliver SUD services to vulnerable populations (such as Medicaid beneficiaries and the uninsured).

In addition to incorporating behavioral health services into managed care, the state has been actively taking additional steps to integrate its behavioral and physical health systems and services. Currently, BMS provides a range of SUD services under Medicaid, and BBHHF funds SUD services and programs targeted to specific populations through federal grants and charity care programs. West Virginia's publicly-funded community based behavioral health system is anchored by 13 Comprehensive Behavioral Health Centers (CBHCs), operating full-service and/or satellite offices in each of the counties located in the center's catchment area. Federally Qualified Health Centers (FQHCs) also play a major role in providing SUD services – 19 of the state's 34 FQHCs across 108 sites employ a behavioral health provider. Five of the state's largest CBHCs offer coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through co-location and integration agreements.

Transforming West Virginia's Behavioral Health Delivery System - West Virginia is submitting this Medicaid Section 1115 waiver proposal to gain federal support to provide a more cohesive approach to SUD prevention and treatment services to Medicaid beneficiaries by developing a comprehensive SUD continuum of care across the state. Upon approval, the state plans to have a six-month planning period, with an initial launch of the of the waiver in July 2017 and a goal of having all four MCOs achieve certification for network adequacy by January 2018.

"West Virginia Legislature Enacts Comprehensive Substance Abuse Laws," Health Law Monitor, 2012.

These comprehensive and coordinated set of SUD services and supports will be available to all Medicaid managed care enrollees in West Virginia. West Virginia is also planning to develop initiatives that would specifically target high-need populations including babies born with NAS and individuals recently released from incarceration.

Individuals who are not enrolled in a managed care plan will continue to receive services in the same way they do today (through the Medicaid state plan), including individuals receiving long-term services and supports, home and community-based services, and certain children and adolescents. All enrollees under the age of 21 receive the services available under Early Periodic Screening, Diagnostic and Treatment (EPSDT), which includes appropriate services needed to address behavioral health issues. The state will ensure that any SUD related services provided to individuals under age 21 also meet the ASAM criteria.

Under this proposal, Medicaid managed care organizations (MCOs) will be responsible for contracting with providers to deliver the SUD services, for conducting provider recruitment and credentialing, and for working with the state to ensure network adequacy. The MCOs will receive a financial incentive in the form of increased capitation rates for facilitating this effort, as well as additional incentives for providing high-quality care and meeting required reporting and performance metrics. Since managed care plans will be responsible for providing the full continuum of care for physical health and behavioral health, this waiver presents a tremendous opportunity to improve the health of beneficiaries with chronic conditions.

The 1115 waiver will provide a critical vehicle for enhancing the scope of SUD services that are available to Medicaid beneficiaries in West Virginia, including coverage of SUD services provided in residential treatment settings coupled with an enhancement of outpatient SUD services and MAT. West Virginia proposes to add Medicaid coverage of methadone and to design and implement an initiative that will make Naloxone widely available and increase awareness of it across the state. West Virginia will enhance the availability of detoxification and withdrawal management in more settings, propose adding a comprehensive set of peer recovery support strategies, and coverage of recovery housing supports that will help promote successful transitions.

One of the key goals of the waiver is to ensure that individuals have access to the approach to achieving recovery that is most appropriate based on their circumstances – to meet people where they are. Building on the delivery system integration efforts that are already underway and working to establish a seamless continuum of care will enable West Virginia to move toward value-based purchasing for SUD services and facilitate meeting the goals of the Triple Aim of improved quality of care, improved population health, and decreased costs

Excerpts are provided from West Virginia Medicaid Section 1115 Waiver Proposal: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders, 2016.

Expansion of Foster Care - Therapeutic Foster Care

To support West Virginia's IV-E demonstration project Safe at Home West Virginia, the West Virginia Department of Health and Human Resources, Bureau for Children and Families is looking to broaden its continuum of care by developing a Therapeutic Foster Care program. This program will serve children in foster care that may require additional services to allow them to remain in a family setting. The Therapeutic Foster Care program

would provide a continuum of foster care services that would best meet the needs of the children in the state.

Therapeutic Foster Care is a family-based, service delivery approach providing individualized treatment for children and their families. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by Treatment Foster Parents. Treatment Foster Parents are trained, supervised and supported by qualified program staff. The values and principles of Treatment Foster Care are as follows:

- Normalization is a treatment principle and the power of family living as a normalizing influence;

- Kinship plays an important role in the formation of identity and self-worth;

- Kinship relationships impart a sense of family belonging to the child;

- The inherent need and right of all children to have a permanent family. Family reunification, adoption, kinship care or other long-term, stable family living arrangements are critical;

- Cultural diversity and the importance of developing competence in dealing with issues of diversity;

- Doing “whatever it takes” to maximize a young person’s opportunity to live successfully in a family and community;

- The fundamental importance of documentation and the systemic evaluation of services and their effects.

A Therapeutic Foster Care program would allow for a continuum of care for the children within the program through an individualized approach to treatment. A child within the Therapeutic Foster Care program could experience a movement within the continuum based upon need, but this would not necessarily constitute a transfer to a different Treatment Foster Care home. Depending on the child’s individual plan, it may be possible they could step down in the continuum or step up the continuum without experiencing placement disruption. The Bureau believes that such a continuum of care within the foster care system will provide for more flexibility in serving children with complex needs and will allow more children to be served successfully in a foster home setting when out-of-home care is needed. The Bureau further believes that a continuum within the foster care

system would allow the ability for children, who need out-of-home care, to receive foster care services in a foster home setting would maximize the child's well-being and would also be less costly than a residential care/facility program.

A request for applications (RFA) will be released in June 2016, with awards being issued to successful candidates by July 1, 2016. Therapeutic Foster Care will be a program that will be available state-wide across West Virginia to include all fifty-five (55) counties. The RFA will seek one licensed child placing agency per geographical region whose focus will be the development of a full foster care continuum, including the three components of therapeutic foster care program, in each of the counties within that region. Successful candidates will describe the methods that will be used to recruit and train foster parents within each county in their respective region, including population and cultural issues that may factor into successful recruitment.

The children who will be served by the Therapeutic Foster Care program are those who are determined to need more intensive services than a traditional foster care home could provide. Three levels of foster care will exist: Traditional Foster Care; Treatment Foster Care; and Intensive Foster Care. The level of care that the child receives will be determined by their specific needs. These needs and level of care will be re-evaluated every 90 days using the CANS.

Traditional Foster Care is the system that West Virginia has historically provided. This level of care is ideal for children who have no significant indicators of trauma, behavioral or emotional issues, and difficulty in school, home, and community. These children do not exhibit any high-risk behaviors; have any significant medical issues, and no assessed needs for mental or behavioral health treatment. Children will receive the CANS assessment within thirty days to determine the appropriate level of care. This level of care supports normalization as part of a daily living. Crisis support will be available twenty-four hours a day as needed, and crisis response training must be part of pre-service training for the foster family. Staff will have up to fifteen children on their caseload at any given time and must visit with each child at least twice monthly unless otherwise specified by the Department caseworker. Traditional Foster Care homes can use respite as needed.

Treatment Foster Care is the level of care to be used for children who exhibit a mild to moderate level of trauma/behavioral or emotional issues as identified through the CANS assessment. These children may present with moderate risk behaviors and have moderate difficulty in school, home and community. This level would include pregnant/teen mothers and other children who have medical needs that exceed preventative measures. This level will be used for all children entering care on an

emergency basis. Children will receive the CANS assessment within thirty days to determine the appropriate level of care. Normalcy activities are encouraged to provide opportunities to practice life skills for these children. Crisis support will be available twenty-four hours a day as needed. These foster families will receive crisis response and trauma training as well as child-specific training related to potential crisis due to history and current issues, as well as consultation and response to the setting. Staff will be permitted to work with up to eight children at this level and must visit with each child at least weekly unless the Department caseworker requests that visits occur more often. Treatment Foster Care homes are strongly encouraged to use respite as needed.

Intensive Treatment Foster Care will be the level of care used for children who exhibit significant indicators of trauma/behavioral or emotional issues on the CANS. These children present with high risk behaviors and have significant difficulty in school, home and community. This level will be used for children who are stepping down from a higher level of care, are at risk for out-of-state placement, can be supported in the community as an alternative to residential care, are drug exposed infants with additional medical needs, and children who are medically fragile as diagnosed by a physician. Normalcy at this level is encouraged, but may take a lot of effort to safely and securely expose these children to experiences and activities in their community. Crisis support will be available twenty-four hours a day as needed, and these foster families will receive crisis response and trauma training as well as child-specific training related to potential crisis due to history and current issues, as well as staff consultation, staff response to these homes or other settings, aide support, modeling and coaching to assist with skill acquisition, emergency respite and reintegration to the home. Staff will only be permitted to work with six or less children at this level and must visit each child as often as necessary but no less than once a week to meet individual needs. Intensive Treatment Foster Care homes are mandated to use planned respite.

Successful agencies must be able to meet the components of all three levels of foster care.

We currently have 49 children featured on our WV Adoption site and eight (8) children waiting to be released. 27 children registered in the past year and 27 placed “on hold” or finalized. They are placed on “hold” once they have achieved permanency or moved into their Trial Adoptive home.

These figures are only for the children who are registered on the adoption site. Most of West Virginia’s children are placed in kinship or relative homes or already have an adoptive resource identified are not registered on the site.

2017 Update

In November 2016, two agencies for each of the four regions in West Virginia were selected to implement the grant funded therapeutic foster care homes. Some agencies were awarded more than one region. They were given a six-month period to recruit and train their Tier II and Tier III homes. An MOU will be released June 2017, to the BCF field staff that these homes are now ready to receive referrals for foster children who have been identified as requiring treatment foster care for moderate risk behaviors or intensive treatment foster care for high risk behaviors.

Please see Item 29 of the Statewide Self-Assessment for West Virginia for additional information.

Safe at Home West Virginia Services and Supports

In 2014, the Department of Health and Human Resources, Bureau for Children and Families leadership developed the Safe at Home West Virginia Services and Supports survey to identify in each county of West Virginia the Supports and Services we have in place using 17 identified services/supports that were determined to be highly effective services in Wraparound. The survey responses were categorized by adequate amount of available services, inadequate amount of services and services not available at all. This survey would then be sent to the Community Collaborative groups (that include service providers, Family Resource Network members, and others) with input from the Regional Children's Summits, to identify service gaps.

The information gathered would be used as a benchmark to develop strategic plans in their communities to assist with the development of those needed services.

In June 2015, the survey was distributed. The following is a copy of the survey and the results:

West Virginia Safe at Home Services and Supports

County Name	Name of Service	Currently Available Y/N	Service Gap Y/N
	Assessment and evaluation (CANS/CAPS and supporting assessments)		

	Outpatient therapy – individual		
	Outpatient therapy-family		
	Medication Management		
	Behavior Management Skills Training		
	Intensive Home-based Mental Health Services		
	School-based Behavioral Health Services		
	Substance Abuse Intensive Outpatient		
	Crisis Services-In home		
	Mobile Crisis Response		
	Youth Transition Coach (Youth Advocacy)		
	Peer Support (Youth)		
	Peer Support (Family)		
	Respite		
	Peer Support (Recovery Support)		
	Therapeutic Mentoring		
	Therapeutic Foster Care (medically necessary)		

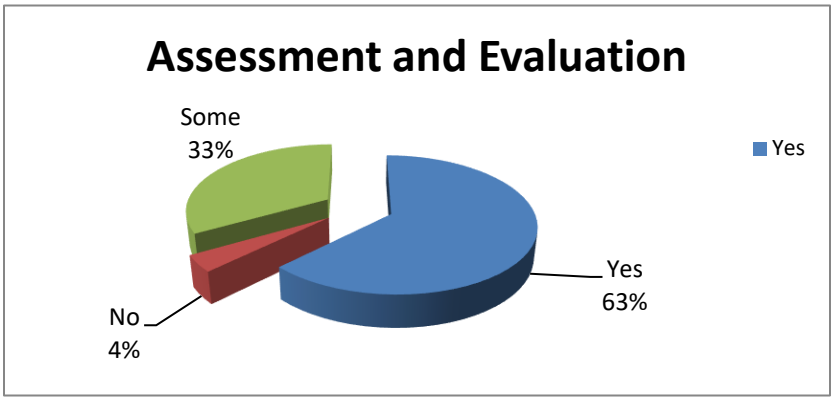
Safe at Home Services and Supports Survey

Purpose of the Report:

This report covers the results from the 2015 Safe at Home Services and Supports Survey. Respondents were asked about what services were available in their individual counties. This report summarizes the results of that survey. Questions were geared toward discovering the capacity and availability of certain services. The intent of the survey was to gauge the resources and capacity development of our communities. In this report, you will get a picture of what the community members determined to be the areas that need

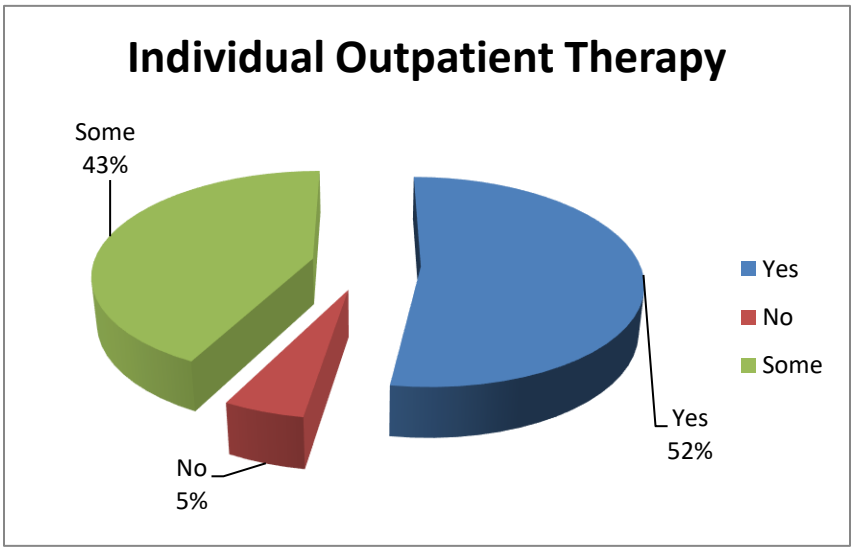
to further develop services. Fifty-two of the fifty-five counties participated in the survey. The following are the results of the survey.

Are Assessment and Evaluation (CANS/CAPS and supporting assessments) currently available?



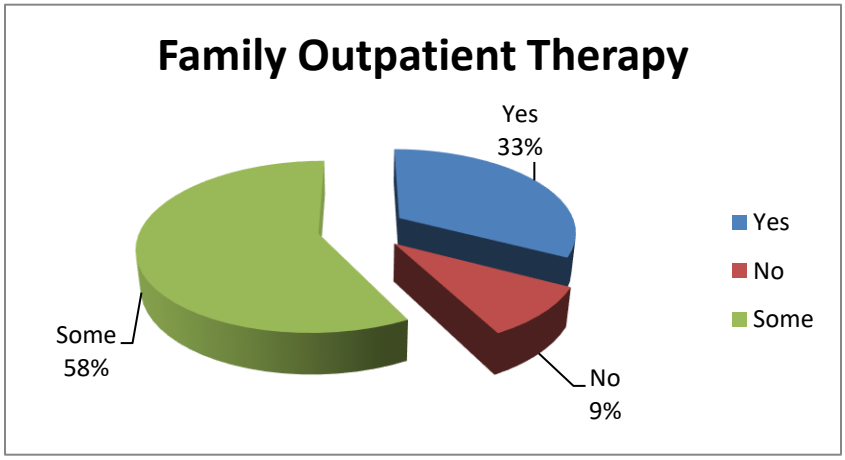
63% of the counties reported they had sufficient Assessment and Evaluation Services (CAPS/CANS and supporting assessments) currently available. 33% has some but not enough, and 4% had none at all. Overall service gap was at 37%.

1. Is Individual Outpatient Therapy available?



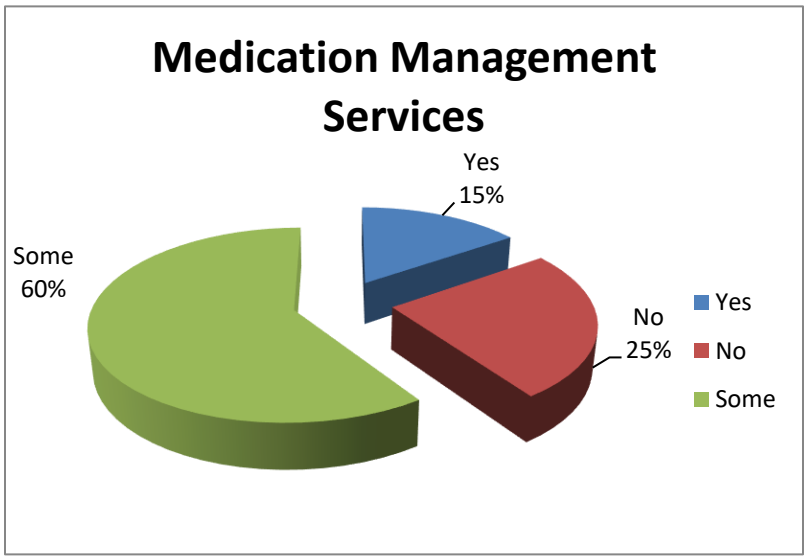
52% of the counties reported they had sufficient Individual Outpatient Therapy Services available, while 43% some but not enough and 5% had none at all. Overall service gap was at 48%.

2. Is Family Outpatient Therapy available?



33% of the counties reported they had sufficient Family Outpatient Therapy Services available, while 58% had some but not enough and 9% had none at all. Overall service gap was 67%.

3. Are Medication Management Services available?

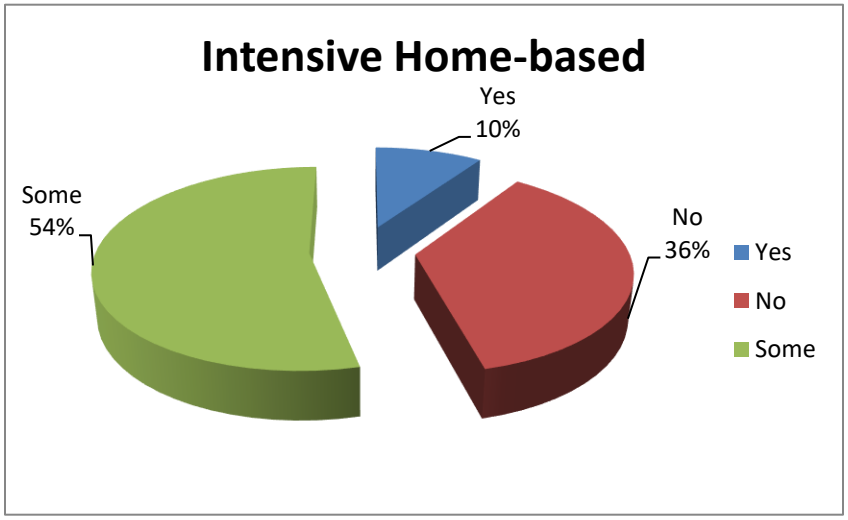


15% of the counties reported they had sufficient Medication Management Services available while 60% had some but not enough and 24% had none at all. Overall service gap was 84%.

4. Are Behavior Management Skills available?

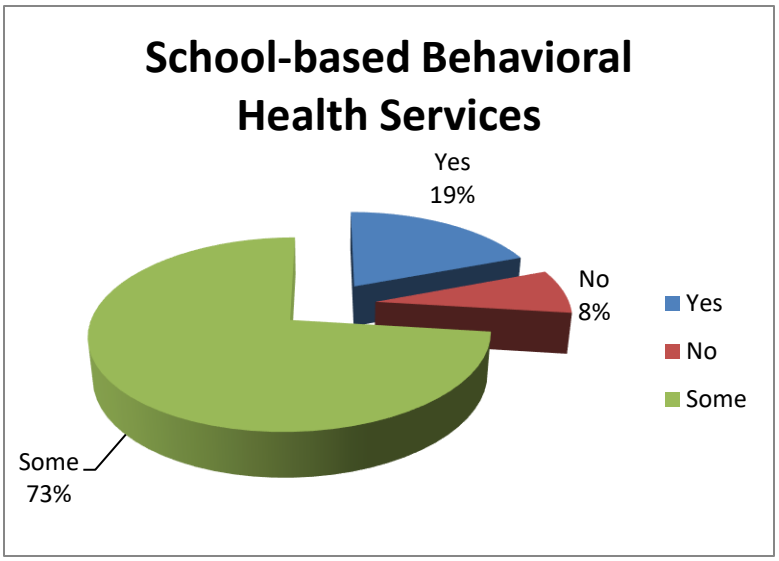
16% of the counties reported they had sufficient Behavior Management Skills Training available while 42% had some but not enough and 42% had none at all. Overall service gap was 84%.

5. Are Intensive Home-based Mental Health Services available?



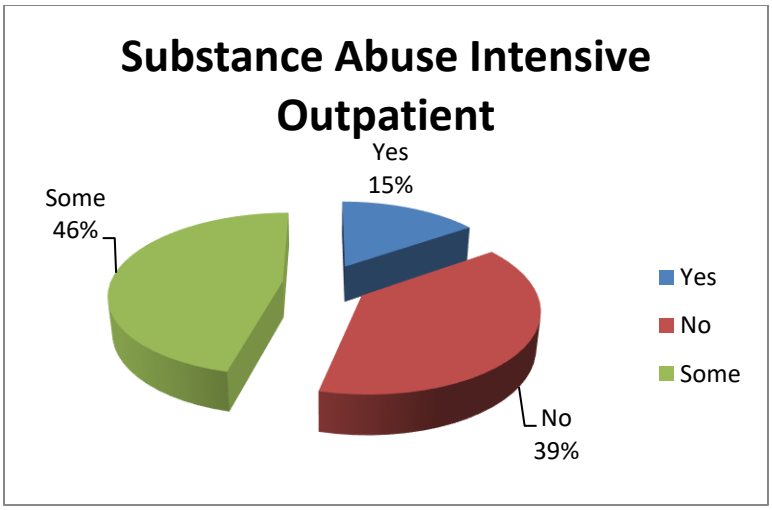
10% of the counties reported they had sufficient Intensive Home-Based Services available while 54% reported having some but not enough and 36% had none at all. Overall service gap was at 90%.

6. Are School-based Behavioral Health Services available?



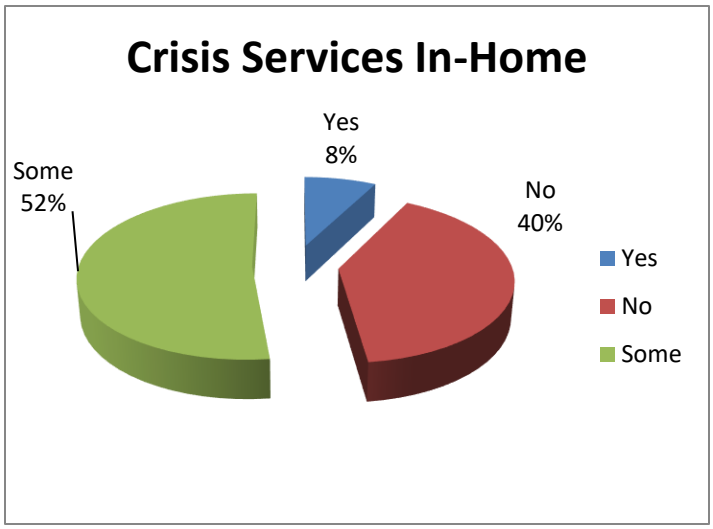
19% of the counties reported having sufficient School-based Behavioral Health Services available, while 73% reported having some but not enough and 8% reported having none at all. Overall service gap was at 81%.

7. Are Substance Abuse Intensive Outpatient Services available?



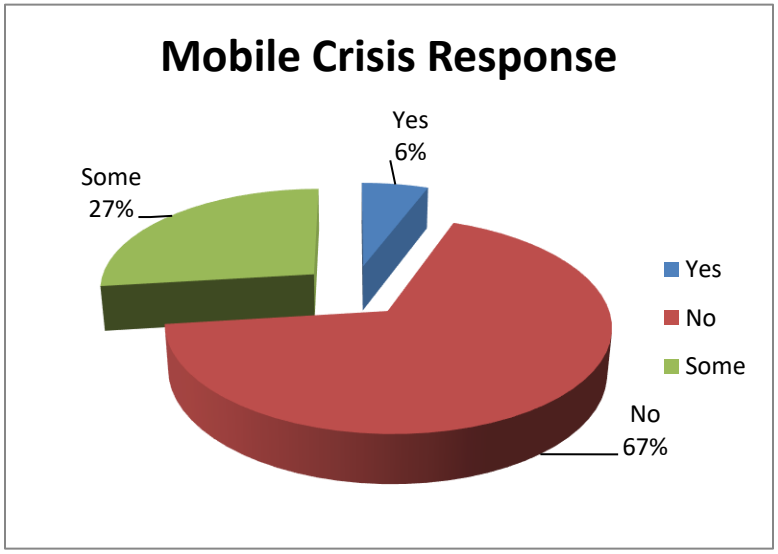
15% of the counties reported having sufficient Substance Abuse Intensive Outpatient Services available. 46% had some but not enough and 39% had none at all. Overall service gap was at 85%.

8. Are In-home Crisis Services available?



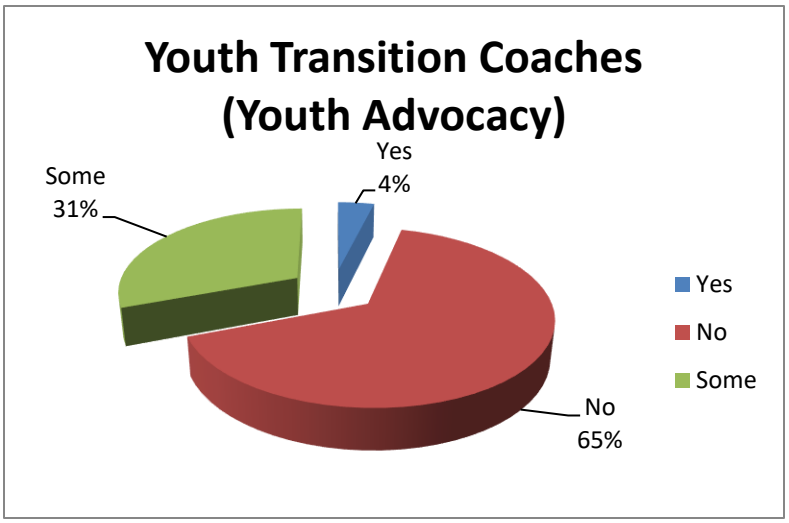
8% of the counties reported having sufficient In-Home Crisis Services available. 52% reported having some but not enough and 40% reported having none at all. Overall service gap was at 92%.

9. Are Mobile Crisis Response Services available?



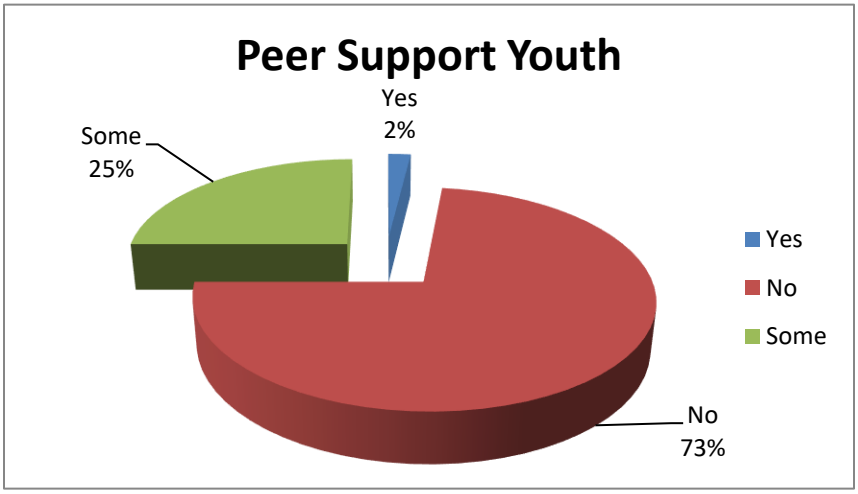
6% of the counties reported having sufficient Mobile Crisis Response Services available. 27% reported having some but not enough and 67% reported having none at all. Overall service gap was at 94%.

10. Are Youth Transition Coaches (Youth Advocacy) available?



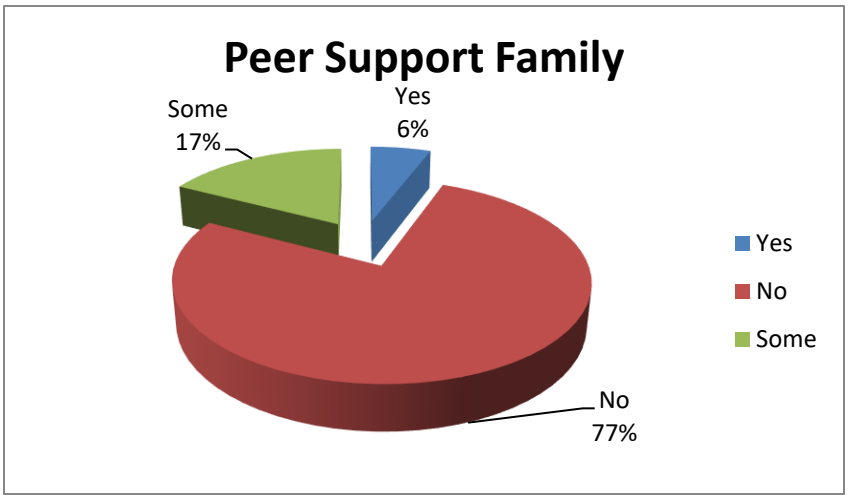
4% of the counties reported having sufficient Youth Transition Coaches (Youth Advocacy) available. 31% had some but not enough and 65% reported having none at all. Overall service gap was at 86%.

11. Is Peer Support available for the youth?



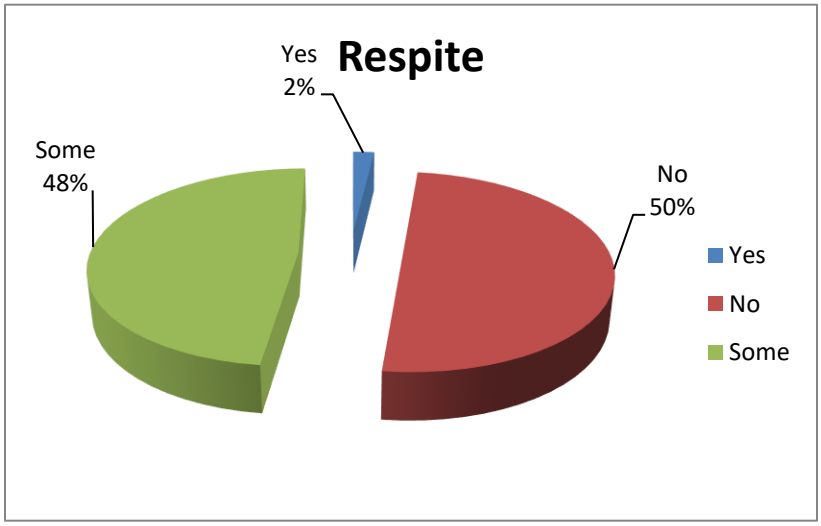
2% of the counties reported having sufficient Peer Support available for the youth. 25% had some but not enough and 73% reported having none at all. Overall service gap was at 98%.

12. Is Peer Support available for the family?



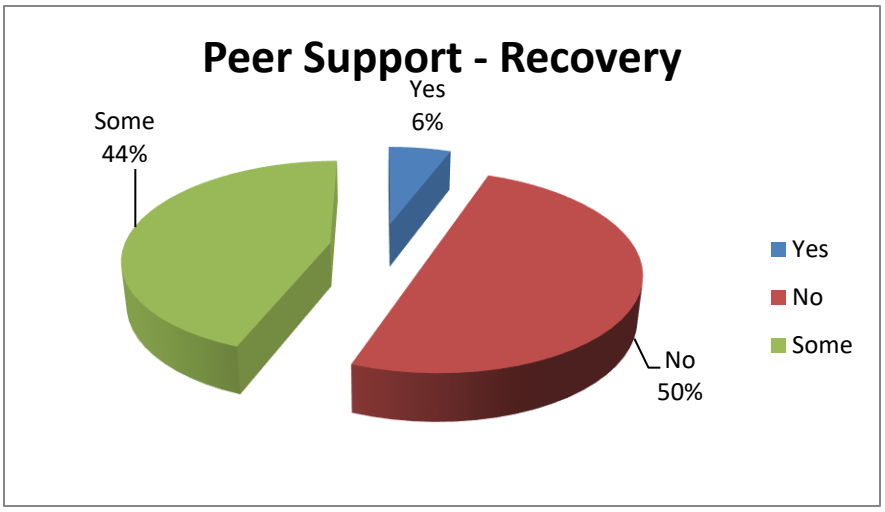
6% of the counties reported having sufficient Peer Support available for the family. 17% had some but not enough and 77% reported having none at all. Overall service gap was at 23%.

13. Is Respite Care available?



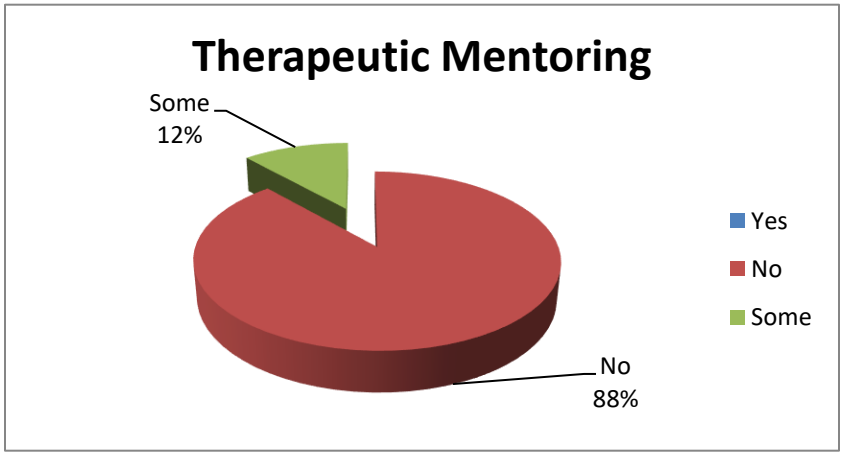
2% of the counties reported having sufficient Respite Care available. 48% had some but not enough and 50% had none at all. Overall service gap was at 98%.

14. Is Peer Support-Recovery Support available?



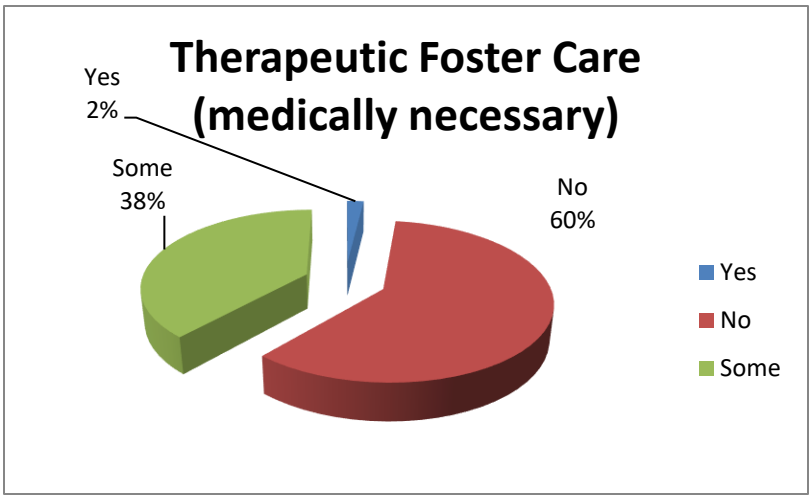
6% of the counties reported having sufficient Peer Support – Recovery available. 44% had some but not enough and 50 Percent reported having none at all. Overall service gap was at 94%.

15. Are Therapeutic Mentoring Services available?



12% of the counties reported having some but not enough Therapeutic Mentoring Services available while 88% reported having none at all. Overall service gap was at 100%

16. Is Therapeutic Foster Care available? (medically necessary)



2% of the counties reported having adequate Therapeutic Foster Care (medically necessary) available. 38% reported having some while 60% reported having none at all. Overall service gap was at 98%.

Community Self-Assessment of Strengths and Needs Survey

In 2015, the Department of Health and Human Resources, Bureau for Children and Families distributed the Community Self-Assessment of Strengths and Needs, which looks at the readiness of communities to implement a wraparound model as prescribed by the National Wraparound Initiative to the Community Collaborative groups (that include service providers, Family Resource Network members, and others) with input from the Regional Children's Summits. The survey was broken down into six Themes or areas of wraparound implementation: The Themes were: Community Partnership; Collaborative Activity; Fiscal Policies and Sustainability; Access to Needed Services; Human Resource Development and Support; and Accountability. For each theme, information was provided regarding key considerations to keep in mind, the most critical things to accomplish, and the biggest dangers or pitfalls to avoid.

The information gathered would be used as a benchmark to develop strategic plans in their communities to assist with the development of those needed services. The DHHR Community Service Managers (CSMs) are expected to provide oversight of these plans for their Community Collaborative group.

Ten of the fourteen Community Collaborative groups participated in the survey.

The following is a copy of the survey and the results:

Community

Self-Assessment of Strengths and Needs

Theme 1: Community Partnership	Is this happening?
An initial group of stakeholders has come together and made a firm commitment to moving forward with wraparound implementation	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
This group currently includes or is actively reaching out to…	
…family members and youth and/or young adults who are "system experienced" including any family or youth support/advocacy organizations in the community	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…representative of key funders and key child- and family-serving organizations	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…agency and organization leaders who are able to commit resources and lead efforts to change policies	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Theme total (sum of four items):	
Theme 2: Collaborative Activity	**Is this happening?**
The people who are planning for wraparound implementation…	

…have solid understanding of—and commitment to—wraparound principles and practice	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…are committed to making changes in their own organizations and in the larger system	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…have reached a decision regarding who will be eligible for wraparound	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…are clear about the desired outcomes they hope to achieve	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Theme total (sum of four items):	
Theme 3: Fiscal Policies and Sustainability	**Is this happening?**
The people who are planning wraparound implementation have a basic understanding of what will need to be funded and approximately how much it will cost to fund the following core wraparound needs:	
Key staff roles, including facilitators, family partners, youth partners, supervisors and administrators	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Training, coaching and supervision for key staff roles	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
IT or data management systems to track utilization, administrative data, and wraparound plans, progress and outcomes	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
People who are planning wraparound implementation understand the basic models and options for achieving	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT

adequate, stable funding for the wraparound effort	
Theme total (sum of four items):	
Theme 4: Access to Needed Services and Supports	**Is this happening?**
The people who are planning for wraparound implementation…	
…have knowledge about the array of services that is typically needed for wraparound programs, including non-traditional services and supports and are actively strategizing about how to fill gaps in the array	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…understand the role that informal and community supports play in wraparound, and are actively strategizing about how to increase community capacity to build and use such supports	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…understand the importance of peer support in wraparound, and are actively strategizing about how to ensure access to peer support	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…are actively strategizing about how to build community capacity to create completely individualized supports for youth, caregivers, and family members	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Theme total (sum of four items):	
Theme 5: Human Resource Development and Support	**Is this happening?**
The people who are planning for wraparound implementation…	

…have a realistic understanding of what it takes to provide adequate training and coaching for key roles (facilitators, family/youth partners, supervisors), and are actively strategizing about how to ensure this for the wraparound project	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
… have a realistic understanding of typical staffing plans (including caseload sizes) that allow people in key roles (facilitators, family/youth partners, supervisors) sufficient time to provide high quality wraparound, and are actively strategizing about how to ensure this for the wraparound project	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
… have a realistic understanding of the structures and processes that are needed to ensure that people in key roles offer high quality supervision, and are actively strategizing about how to ensure this for the wraparound project	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
…understand the need to get service providers and community partners "on board" with wraparound, and are actively strategizing about how to do this	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Theme total (sum of four items):	
Theme 6: Accountability	**Is this happening?**
The people who are planning for wraparound implementation…	
…are exploring options for assessing progress and success in overall implementation of the wraparound project	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
… are exploring options for measuring wraparound quality and other process outcomes	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT

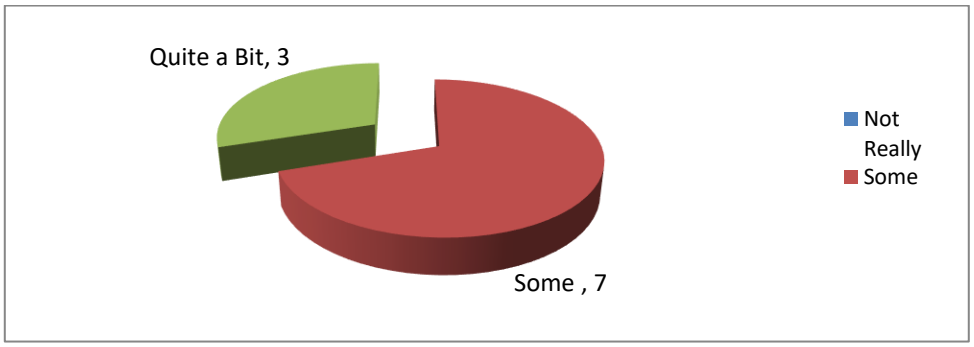
… are exploring options for measuring utilization, costs and expenditures	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
… are exploring options for measuring child/youth and family outcomes, including child/youth and family satisfaction and other outcomes that families and youth care about	☐ 1=NOT REALLY ☐ 2=SOME ☐ 3=QUITE A BIT
Theme total (sum of four items):	

Safe at Home WV Self-Assessment of Strengths and Needs

Purpose of the Report:

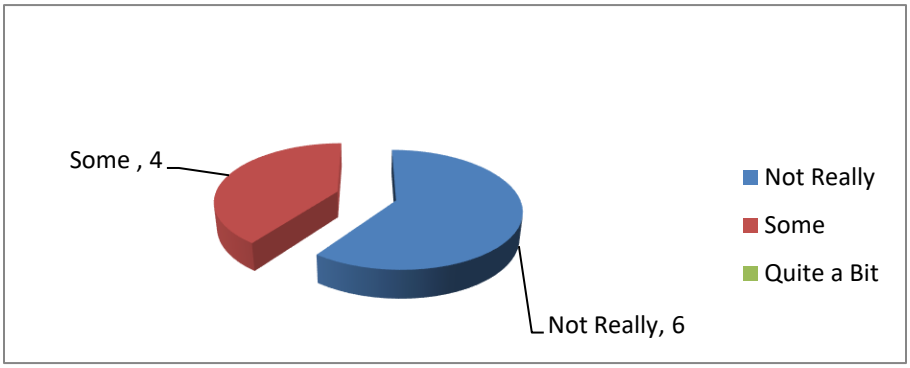
This report covers the results from the 2015 Safe at Home WV Self-Assessment of Strength and Needs Survey. Respondents were asked about Community Readiness and Stakeholder Commitment. This report summarizes the results of that survey. Questions were geared toward Community Partnerships, Collaborative Activity, Fiscal Policies and Sustainability, Access to Needed Services, Human Resource Development and Support and Accountability. The intent of the survey was to gauge the Strengths and Needs of each community and the readiness of the community to implement Safe at Home WV. In this report, you will get a picture of what the community members determined to be the areas that need to further develop services. 10 of the 14 Community Collaborative Groups completed the survey. The following are the results of the survey:

17. An Initial group of stakeholders has come together and made a firm commitment to moving forward with wraparound implementation.



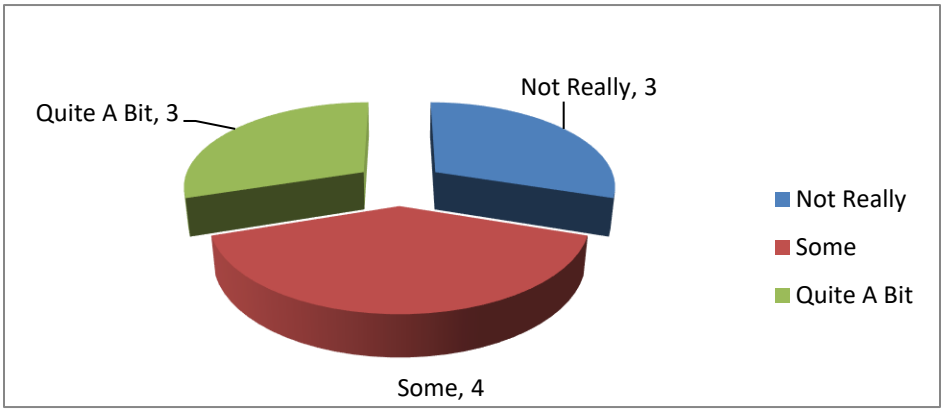
In total, 100% had come together and made a firm commitment to moving forward with Wraparound. 30% had quite a bit, 70% had at least some.

18. This group currently includes or is actively reaching out to family members and youth and/or young adults who are "system experienced" including any family or youth support/advocacy organizations in the community.



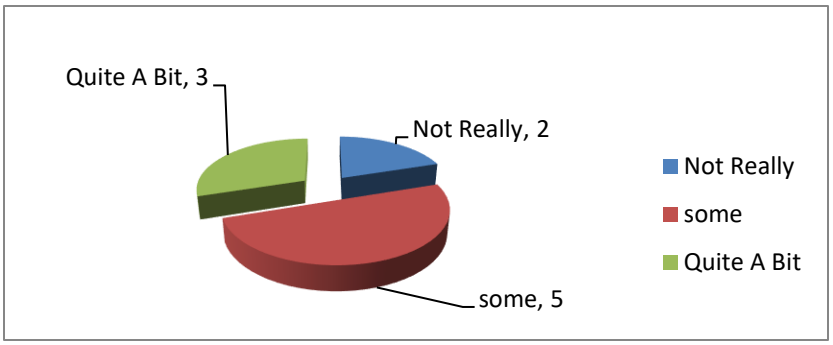
40% were including or actively reaching out to family members and youth and/or young adults. 60% were not.

19. This group currently includes or is actively reaching out to representatives of key funders and key child and family serving organizations.



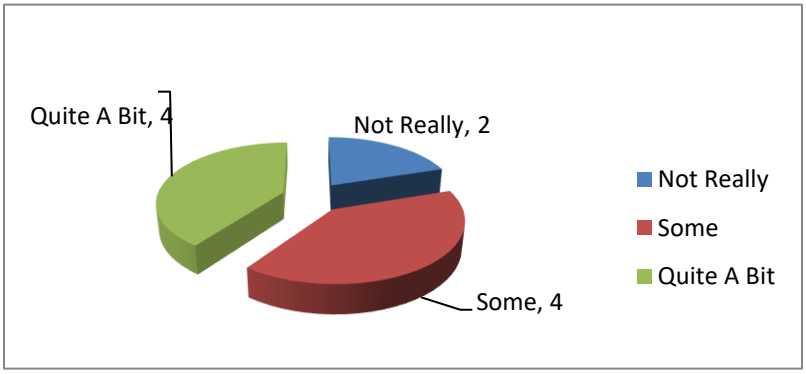
70% were including or actively reaching out to representatives of key funders and key child and family serving organizations. 40% were quite a bit, 30% were some, and 30% were not. In total, 70% were.

20. This group currently includes or is actively reaching out to agency and organization leaders who are able to commit resources and lead efforts to change policies.



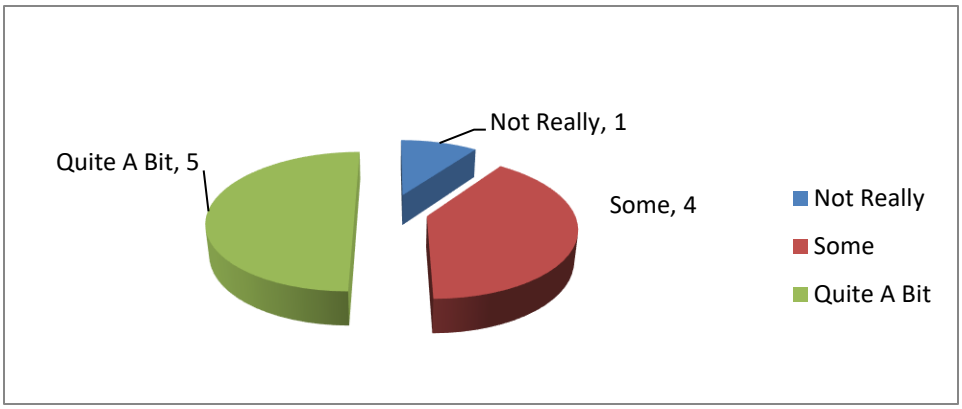
80% of the groups have included or are actively reaching out to agency and organization leaders able to commit resources.

21. The people who are planning for wraparound implementation have a solid understanding of, and commitment to wraparound principles and practice.



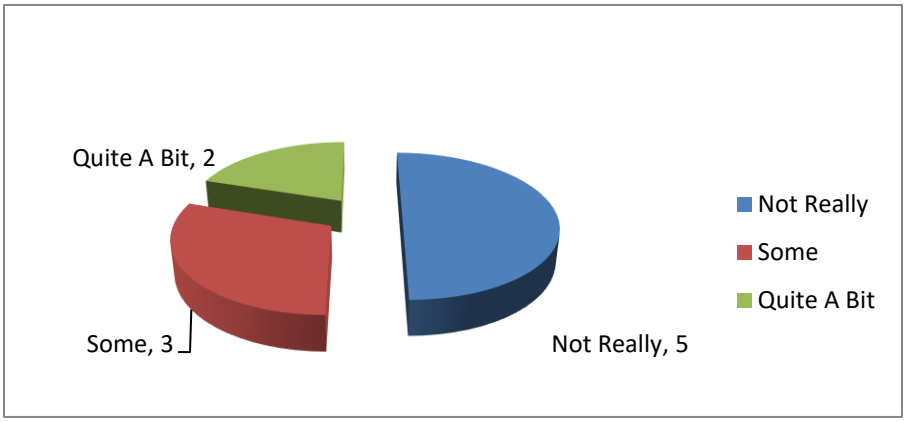
80% of the people planning for wraparound have an understanding and commitment to wraparound principles.

22. The people who are planning for wraparound implementation are committed to making changes in their own organizations and in the larger system.



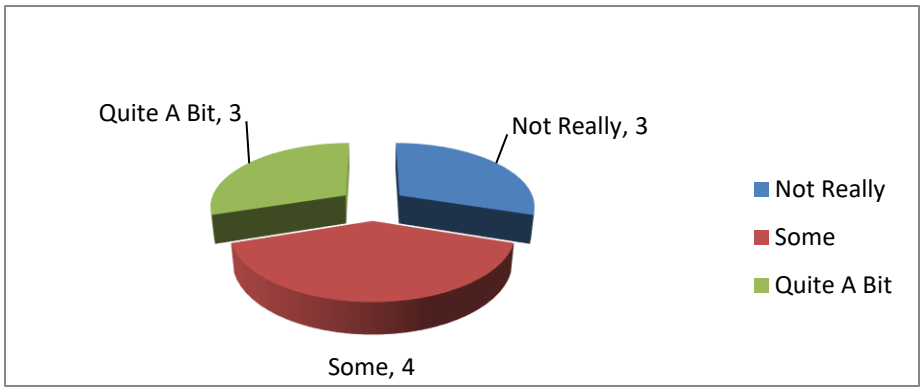
90% of the people planning for wraparound implementation are committed to making changes.

23. The people who are planning for wraparound implementation have reached a decision regarding who will be eligible for wraparound.



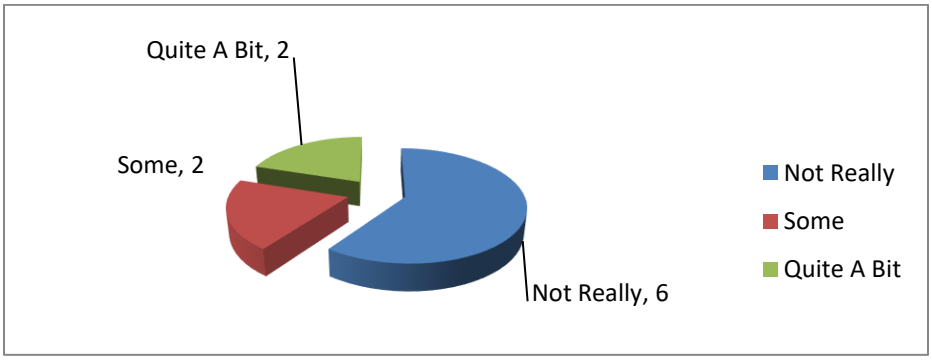
50% of the people planning for wraparound reached a decision on who will be eligible.

24. The people who are planning for wraparound implementation are clear about the desired outcomes they hope to achieve.



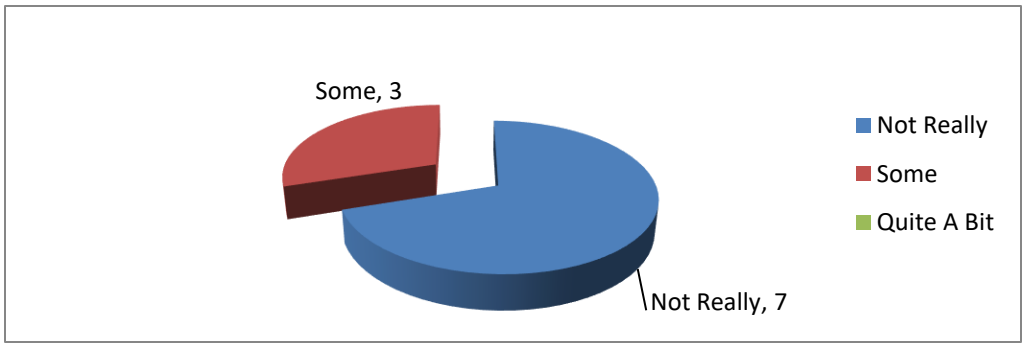
70% of the people planning for wraparound are clear about the desired outcomes.

25. Key Staff Roles, including facilitators, family partners, youth partners, supervisors and administrators who are planning wraparound implementation have a basic understanding for what will need to be funded and approximately how much it will cost to fund the following core wraparound needs.



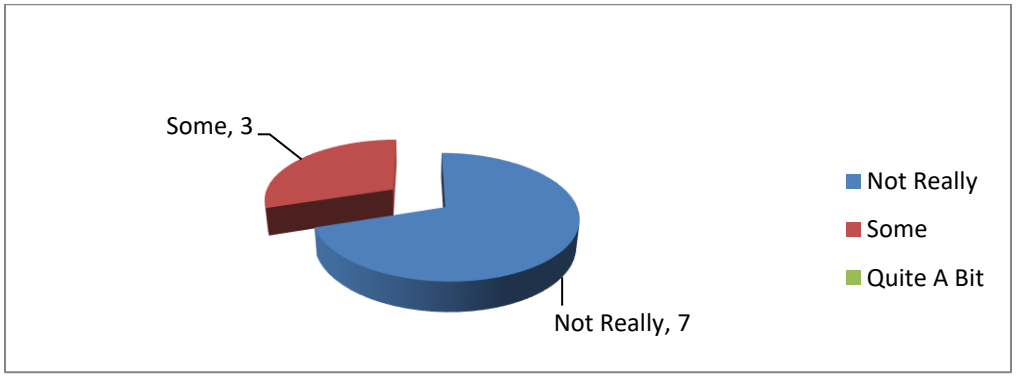
40% of the key staff had quite a bit or some basic understanding for what will need to be funded and how much it will cost to fund core wraparound needs. 60% did not.

26. The people who are planning wraparound implementation have a basic understanding of what will need to be funded and approximately how much it will cost to fund training, coaching and supervision for key staff roles.



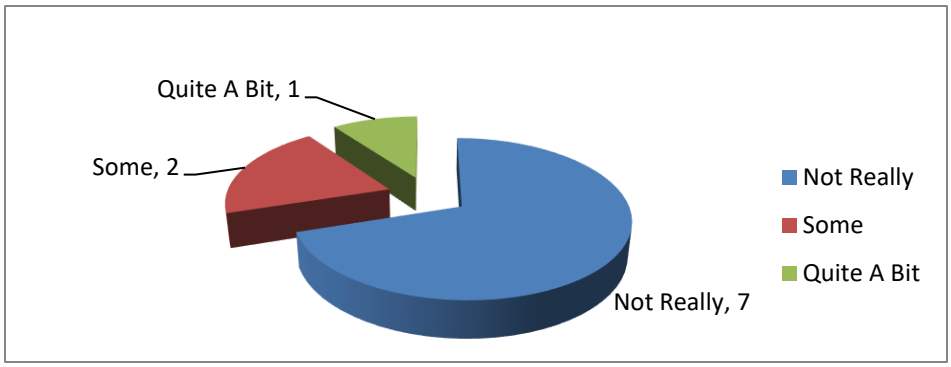
30% of the key staff had some basic understanding for what will need to be funded and how much it will cost to fund training, coaching and supervision. 70% did not.

11. The people who are planning wraparound implementation have a basic understanding of what will need to be funded and approximately how much it will cost to fund data managements systems to track utilization, administrative data and wraparound plans, progress and outcomes?



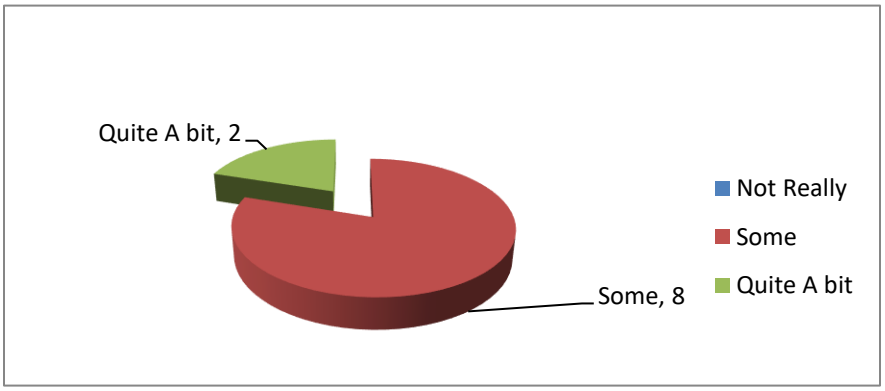
30% of the key staff had quite a bit or some basic understanding for what will need to be funded and how much it will cost to fund data management systems to track utilization, administrative data and wraparound plans, progress and outcomes. 70% did not.

12. People who are planning wraparound implementation understand the basic models and options for achieving adequate, stable funding for the wraparound effort?



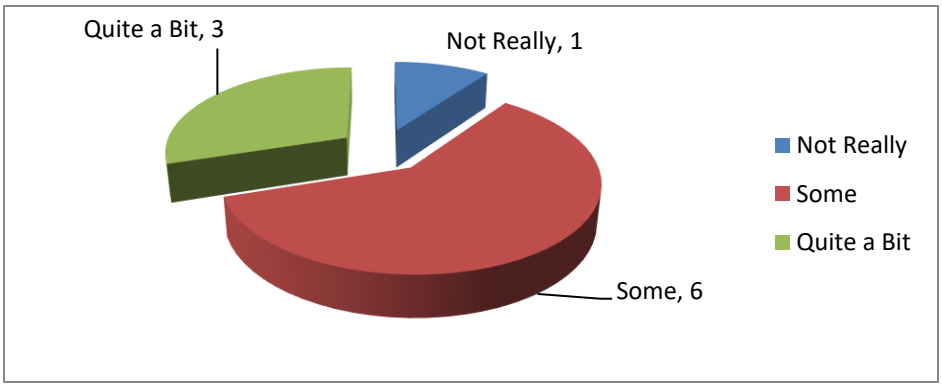
30% of the people planning wraparound implementation understand the basic models and options for achieving adequate, stable funding for wraparound. 70% do not.

13. **The people who are planning or wraparound implementation have knowledge about the array of services that are typically needed for wraparound programs, including non-traditional services and supports and are actively strategizing about how to fill gaps in the array of services.**



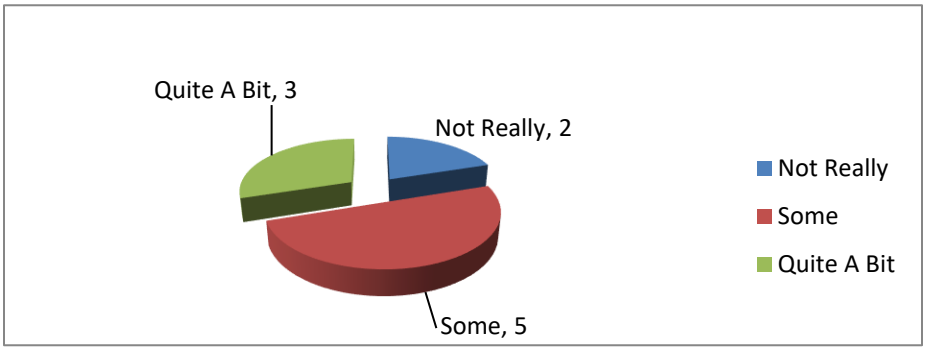
100% of the people planning wraparound implementation have knowledge about the array of services that are typically needed and actively strategizing how to fill the gaps in services.

14. **The people who are planning for wraparound implementation have knowledge about the array of services that are typically needed for wraparound programs, including non-traditional services and supports and are actively strategizing about how to increase community capacity to build and use such supports.**



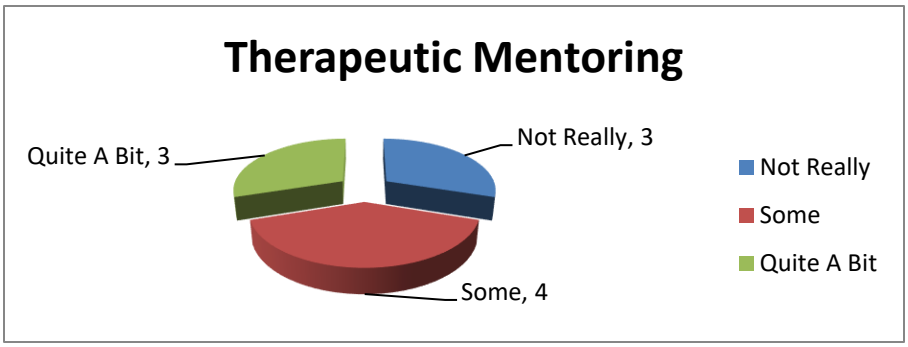
90% of the people planning wraparound implementation have knowledge about the array of services that are typically needed and actively strategizing how to fill the gaps in services.

15. The people who are planning for wraparound implementation understand the importance of peer support in wraparound and are actively strategizing about how to ensure access to peer support.



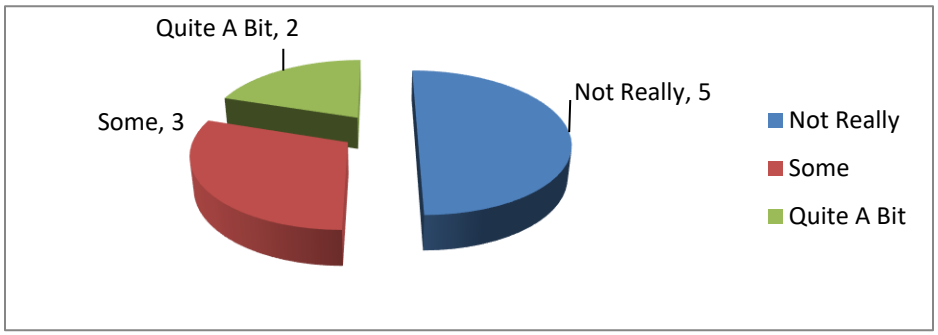
80% of the people who are planning for wraparound implementation understand the importance of peer support and are actively strategizing how to ensure access.

15. The people who are planning the wraparound implementation are actively strategizing about how to build community capacity to create completely individualized supports for youth, caregivers and family members.



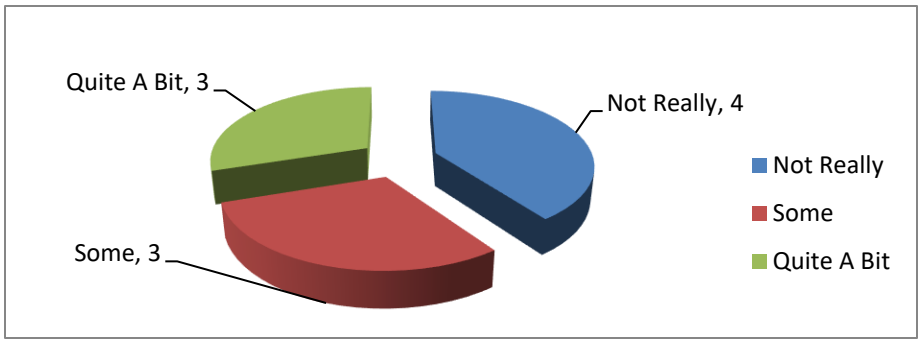
70% of the people planning wraparound implementation have quite a bit or some knowledge about the array of services that are typically needed and actively strategizing how to fill the gaps in services. 30% did not.

16. **The people who are planning for wraparound implementation have a realistic understanding of what it takes to provide adequate training and coaching for key roles (facilitator, family/youth partners, supervisors) and are actively strategizing about how to ensure this for the wraparound project.**



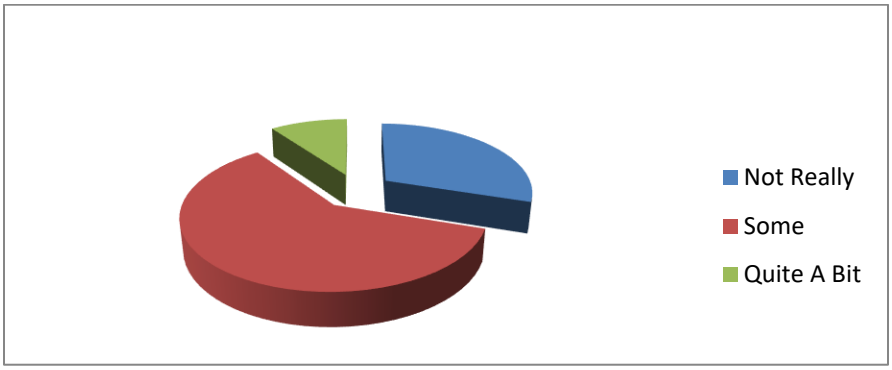
50% of the people who are planning for wraparound implementation have a realistic understanding of what it takes to provide adequate training and coaching for key roles. 50% do not.

17. **The people who are planning for wraparound implementation have a realistic understanding of typical staffing plans (including caseload sizes) that allow people in key roles (facilitators, family/youth partners, supervisors) sufficient time to provide high quality wraparound and are actively strategizing about how to ensure this for the wraparound project.**



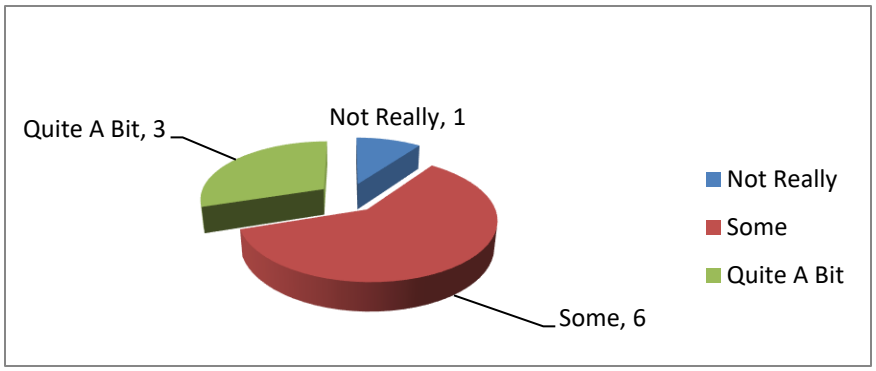
60% of the people who are planning for wraparound implementation have a realistic understanding of typical staffing that allow people in key roles sufficient time to provide high quality wraparound. 40% do not.

18. **The people who are planning for wraparound implementation have a realistic understanding of the structures and processes that are needed to ensure that people in key roles offer high quality supervision, and are actively strategizing about how to ensure this for the wraparound project.**



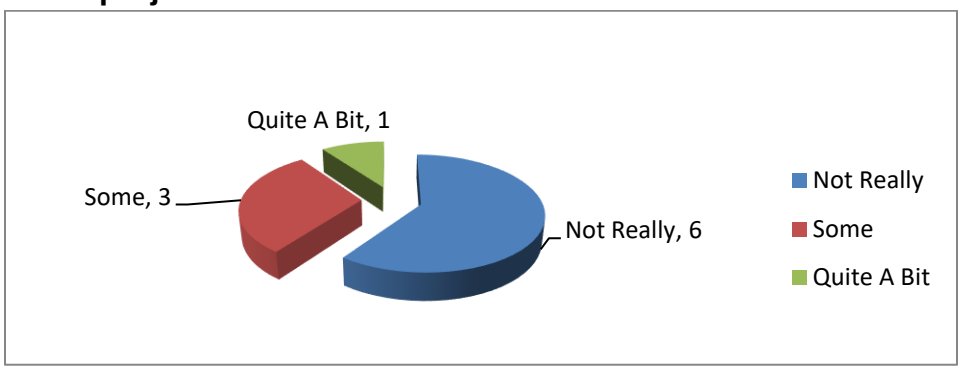
70% of the people who are planning for wraparound implementation have a realistic understanding of the structures and processes that are needed to ensure that people in key roles offer high quality supervision.

19. **The people who are planning the wraparound implementation understand the need to get service providers and community partners "on board" with wraparound and are actively strategizing about how to do this.**



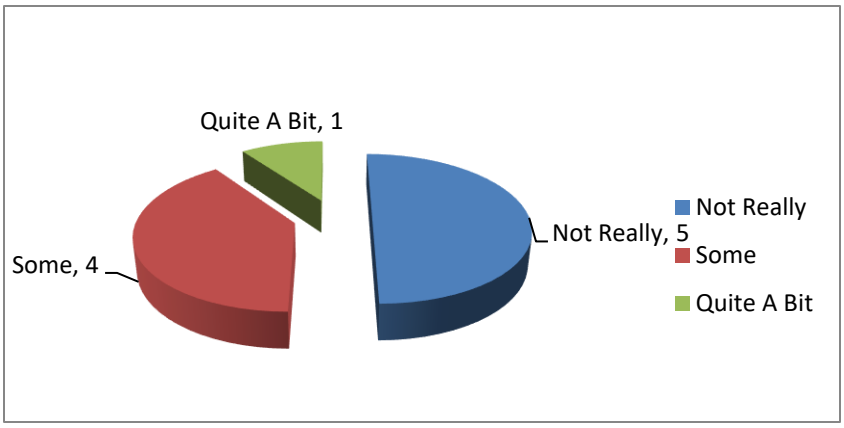
90% of the people who are planning the wraparound implementation understand the need to get service providers and community partners "on board" with wraparound.

20. The people who are planning for wraparound implementation are exploring options for assessing progress and success in overall implementation of the wraparound project.



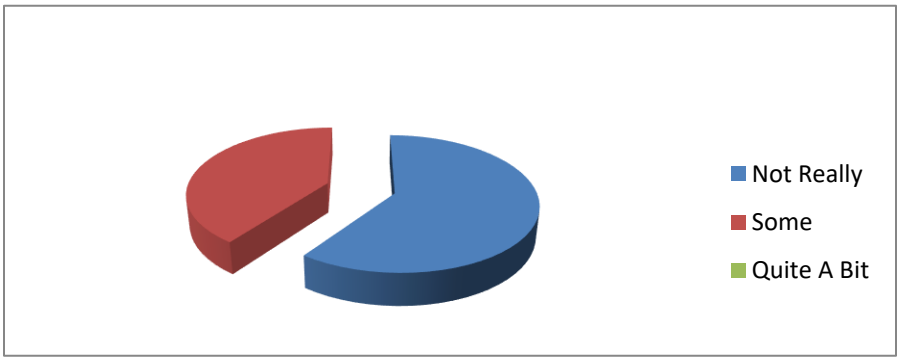
40% of the people who are planning for wraparound implementation are exploring options for assessing progress and success in overall implementation of the wraparound project.

21. The people who are planning for wraparound implementation are exploring options for measuring wraparound quality and other process outcomes.



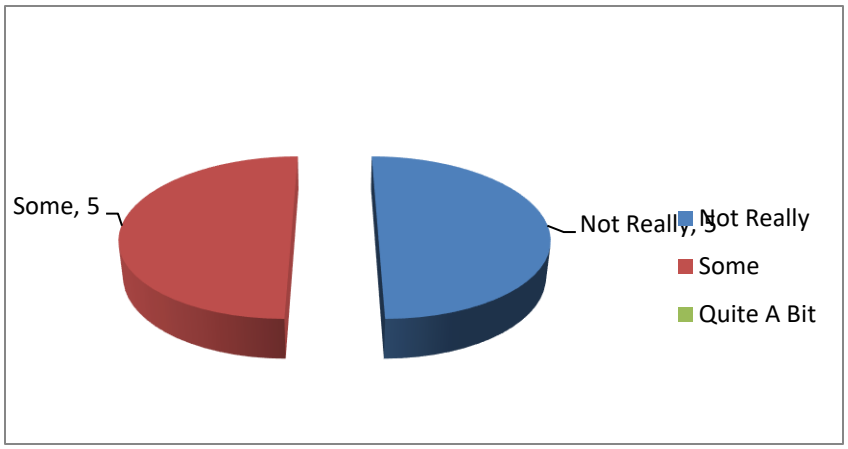
50% of the people who are planning for wraparound implementation are exploring options for measuring wraparound quality and other process outcomes.

22. The people who are planning for wraparound implementation are exploring options for measuring utilization, costs and expenditures.



40% of the people who are planning for wraparound implementation are exploring options for measuring utilization, costs and expenditures. 60% are not.

23. The people who are planning for wraparound implementation are exploring options for measuring child/youth and family outcomes, including child/youth and family satisfaction and other outcomes that families and youth care about.



Conclusion:

There is still some confusion and uncertainty when it comes to implementing wraparound. While most understand the Wraparound Process itself, implementation is still confusing to many. As implementation continues throughout WV, we should have more of an understanding on how implementation works, and what we have to have in place in each community to be successful. This survey was completed in the very early stages of Safe at Home WV.

STATEWIDE FRN 2016 CQI SURVEY RESULTS

Purpose of the Survey:

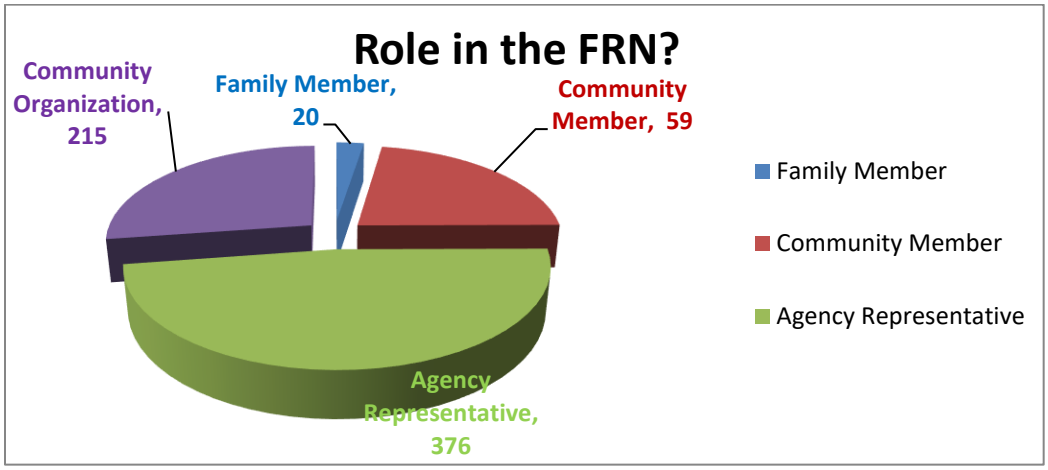
In a response to Results Based Accountability and to foster a culture of Continuous Quality Improvement (CQI), the Department of Health and Human Resources, Bureau for Children and Families, Division of Children and Adult Services began conversations with Family Resource Networks (FRNs) in late 2011. In an effort to assist and meet the desires of the FRNs to be accountable with data rather than anecdotal stories, the Bureau adapted the community collaboration portion of the 2012 Peer Review[1] in CBCAP process that Family Resource Centers currently undergo. For more information on the CQI process, please visit http://friendsnrc.org/continuous-quality-improvement.

Because the FRNs are provided with planning and coordination grants from the WVDHHR, community collaboration should be a key cornerstone of every FRN. This can

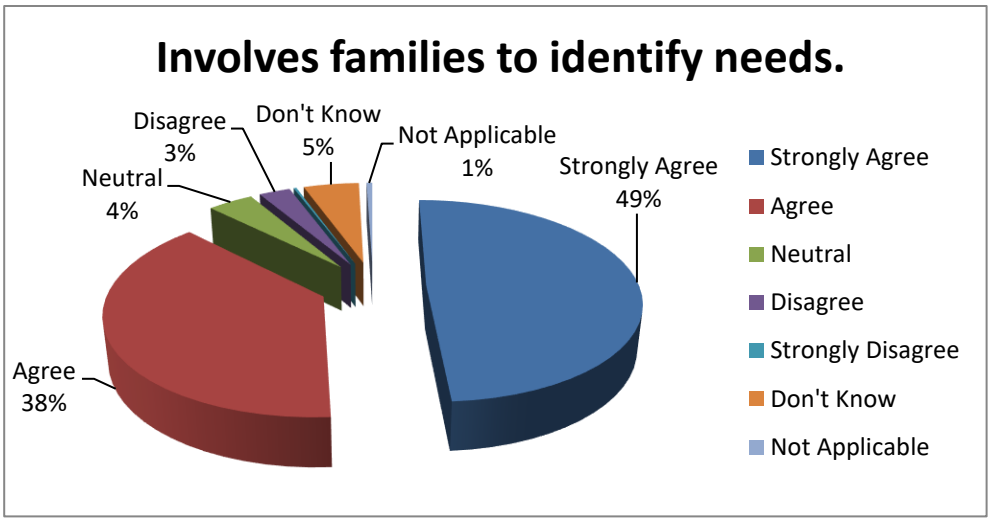
[1] http://friendsnrc.org/peer-review

be universally measured across all FRNs regardless of the way they function or the diversity of outcomes they are working toward. During FY'12, DHHR program staff met with the FRNs to review the instrument, take comments, and revise the instrument for distribution. WVDHHR developed a process where FRNs submitted their list of community networks. The survey was distributed electronically or by paper to a list of community stakeholders the FRN provided. Using SurveyNet software, responses were recorded electronically or entered when the paper survey was returned to the WVDHHR. The following is a statewide report based on the responses received from the community network of Your FRN for fiscal year 2016.

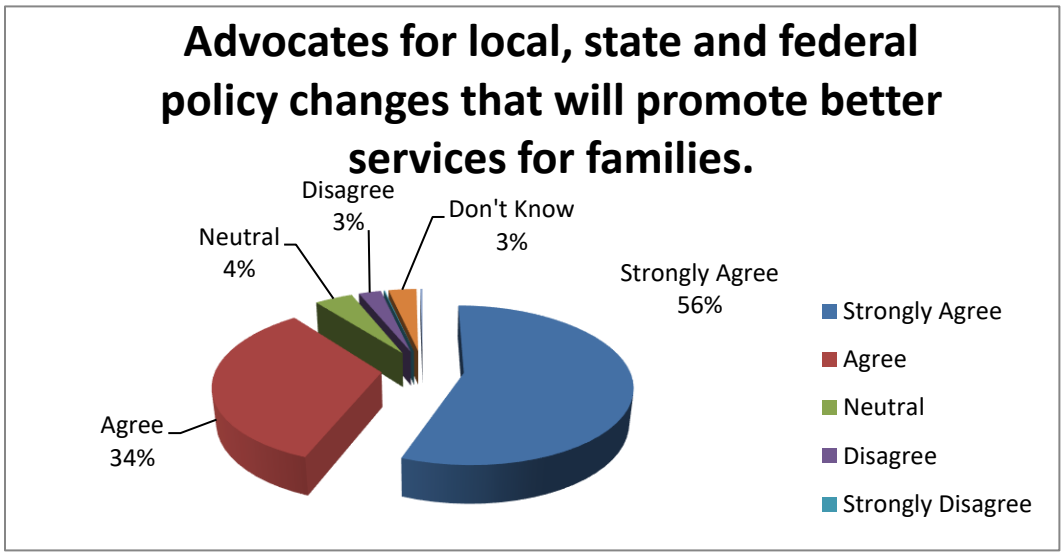
1. Which answer best describes your role in your FRN?



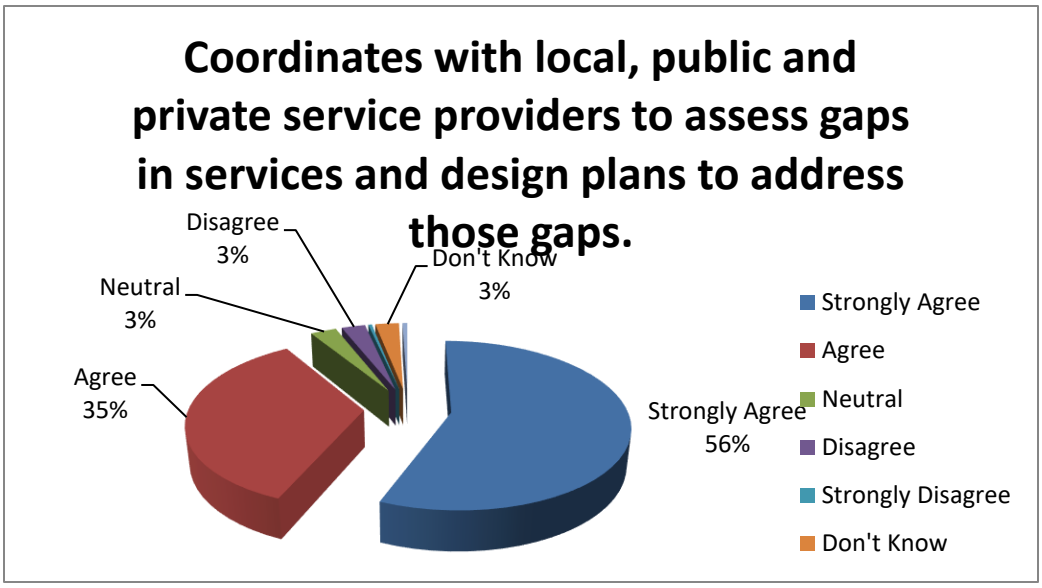
2. Your FRN involves families to identify needs.



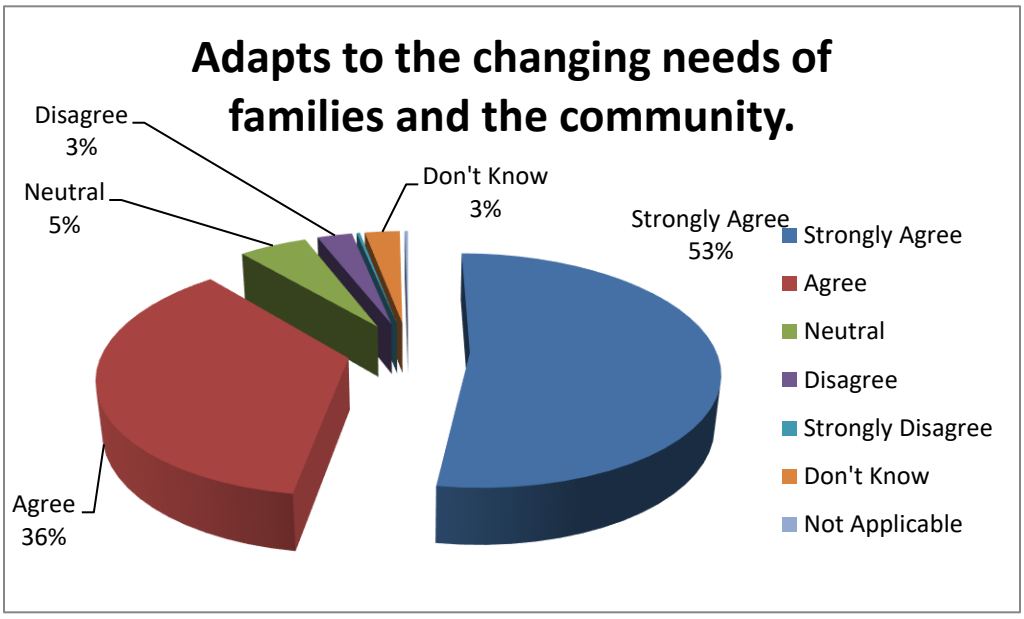
3. Your FRN advocates for local, state and federal policy changes that will promote better services for families.



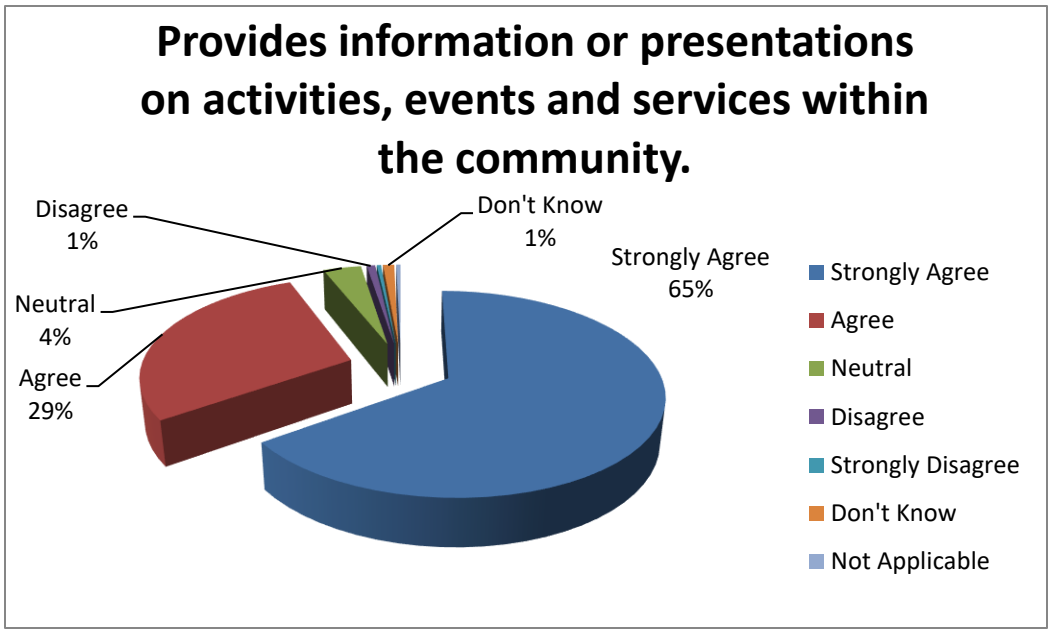
4. Your FRN Coordinates with local, public and private service providers to assess gaps in services and design plans to address those gaps.



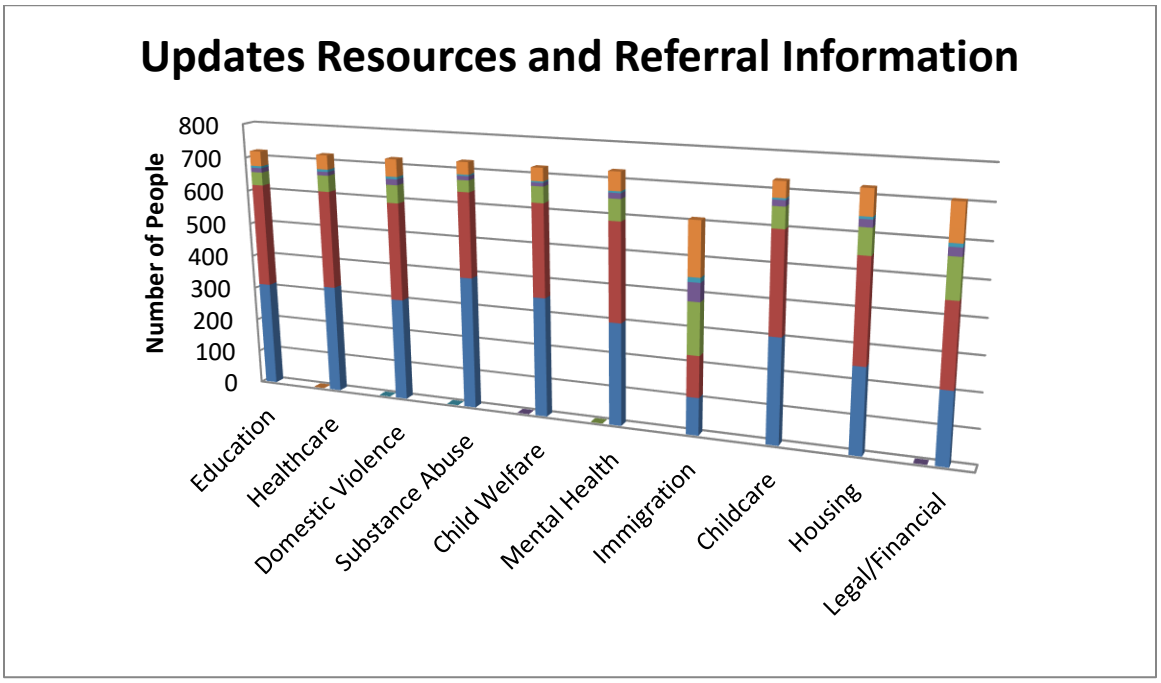
5. Your FRN adapts to the changing needs of families and the community.



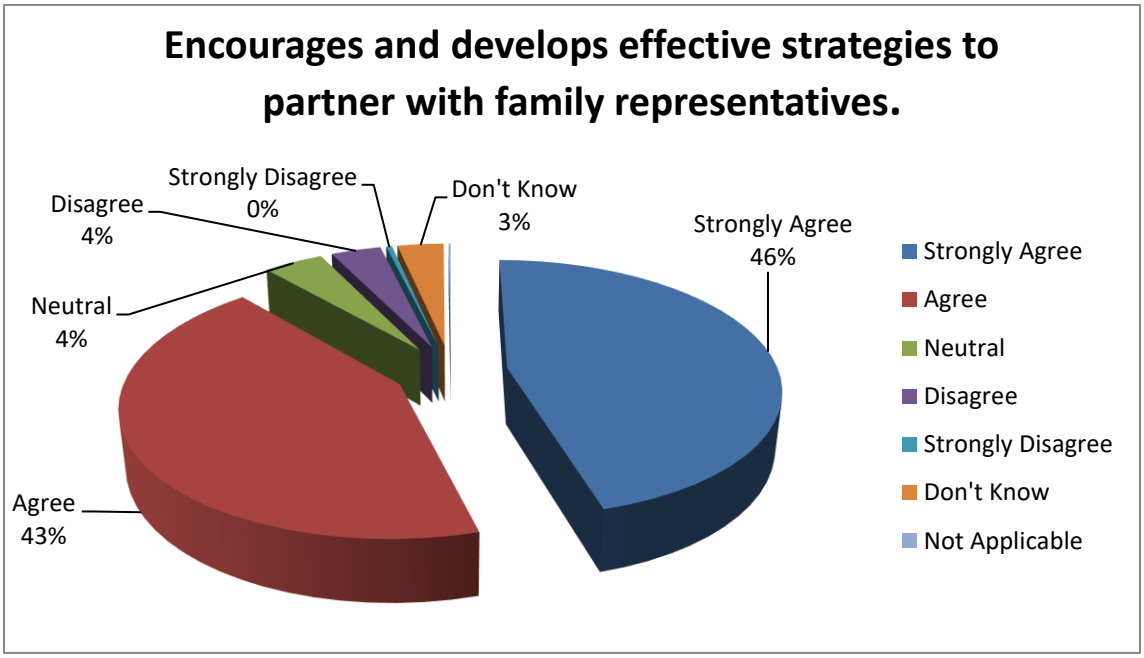
6. Your FRN provides information or presentations on activities, events and services within the community.



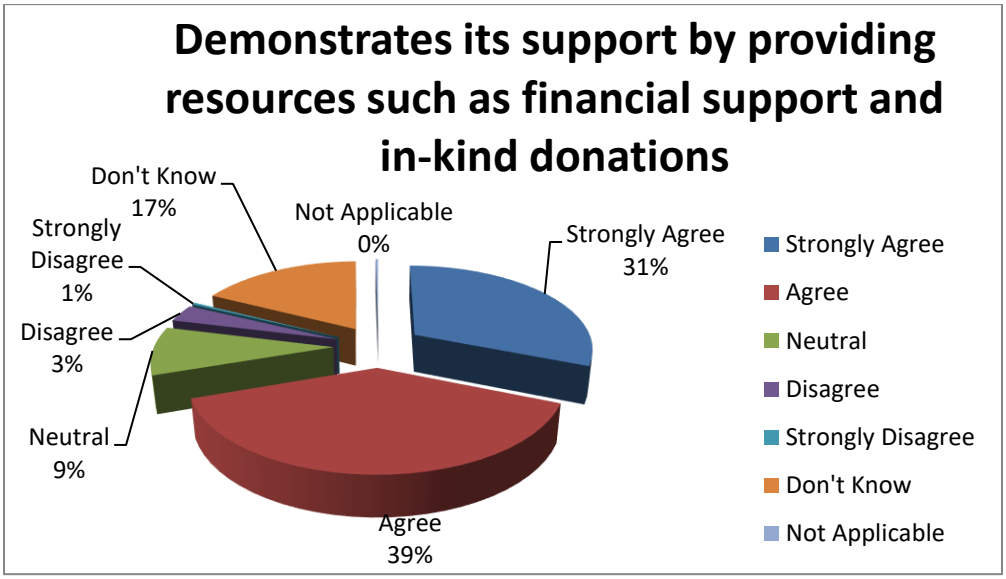
7. Your FRN consistently updates resources and referral information on the following:



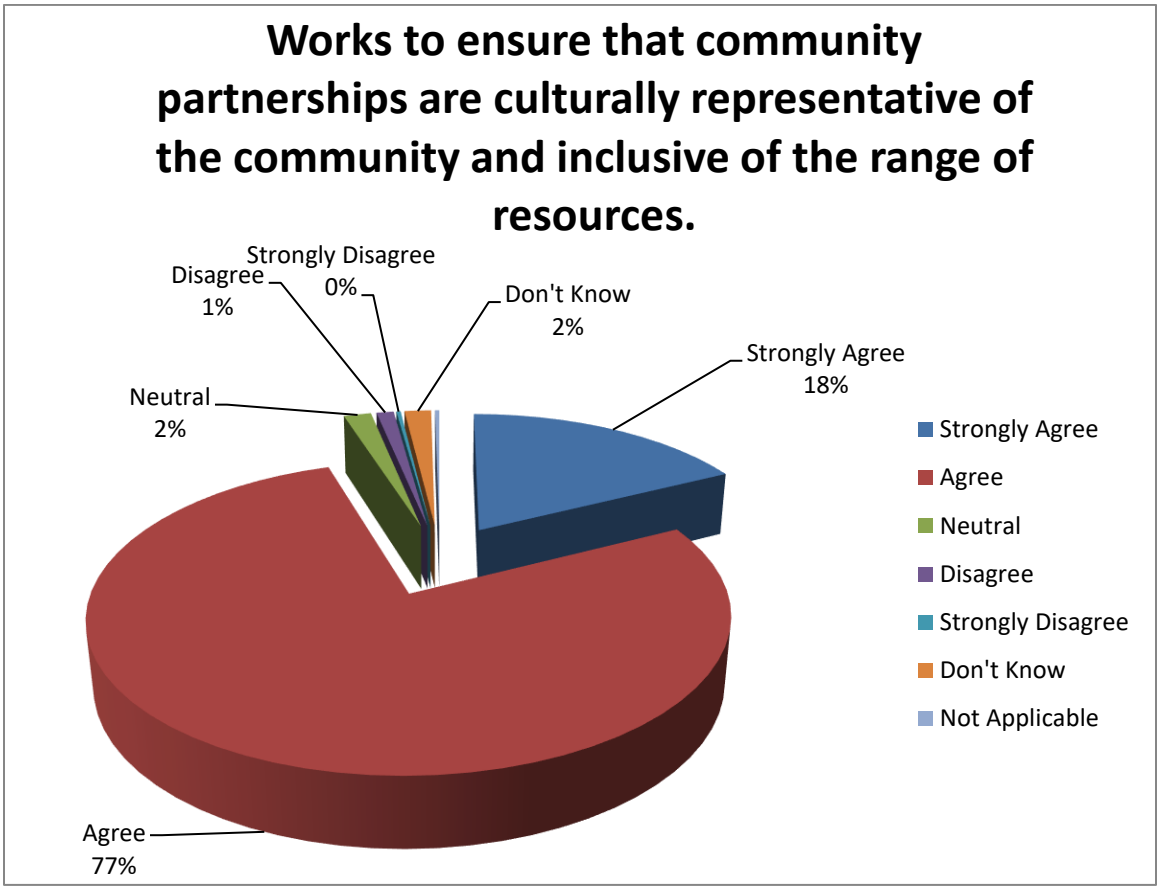
8. Your FRN encourages and develops effective strategies to partner with family representatives.



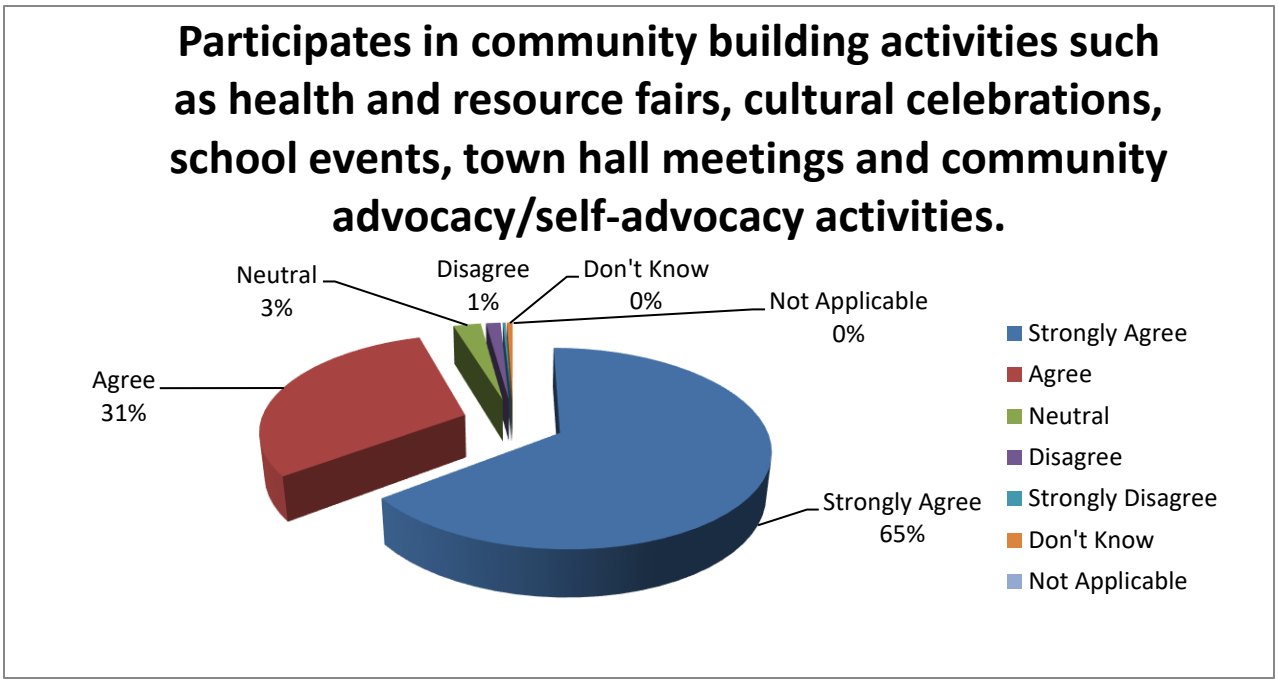
9. The Community demonstrates its support of your FRN by providing resources such as financial support and in-kind donations.



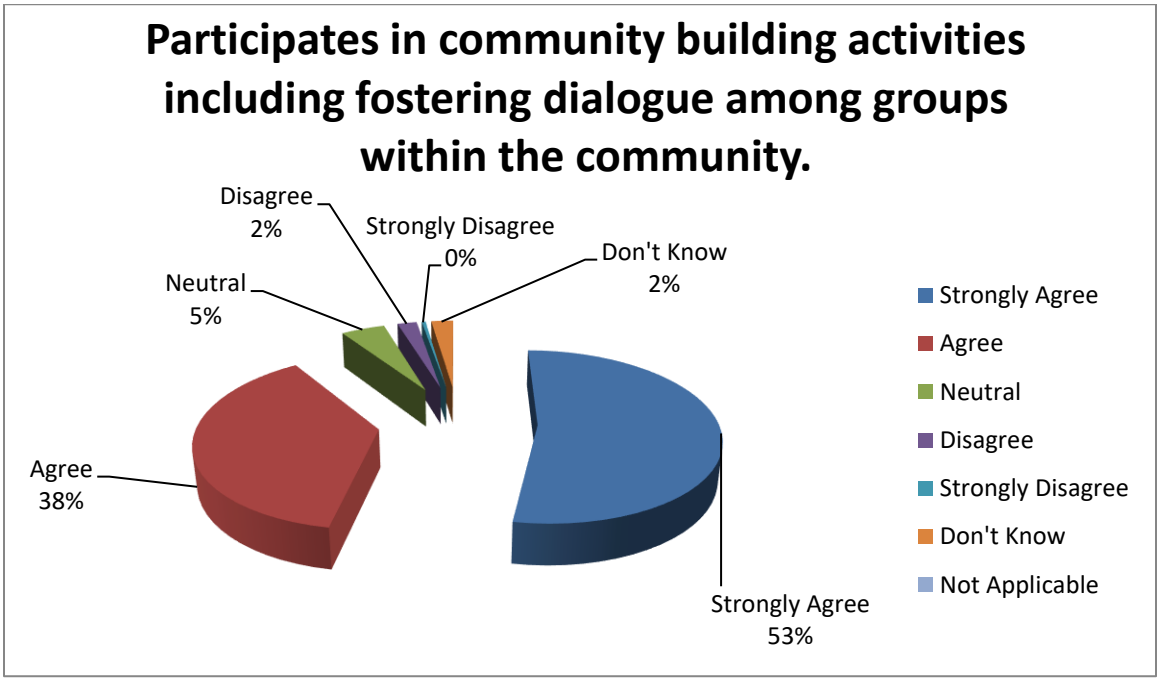
10. Your FRN works to ensure that community partnerships are culturally representative of the community and inclusive of the range of resources.



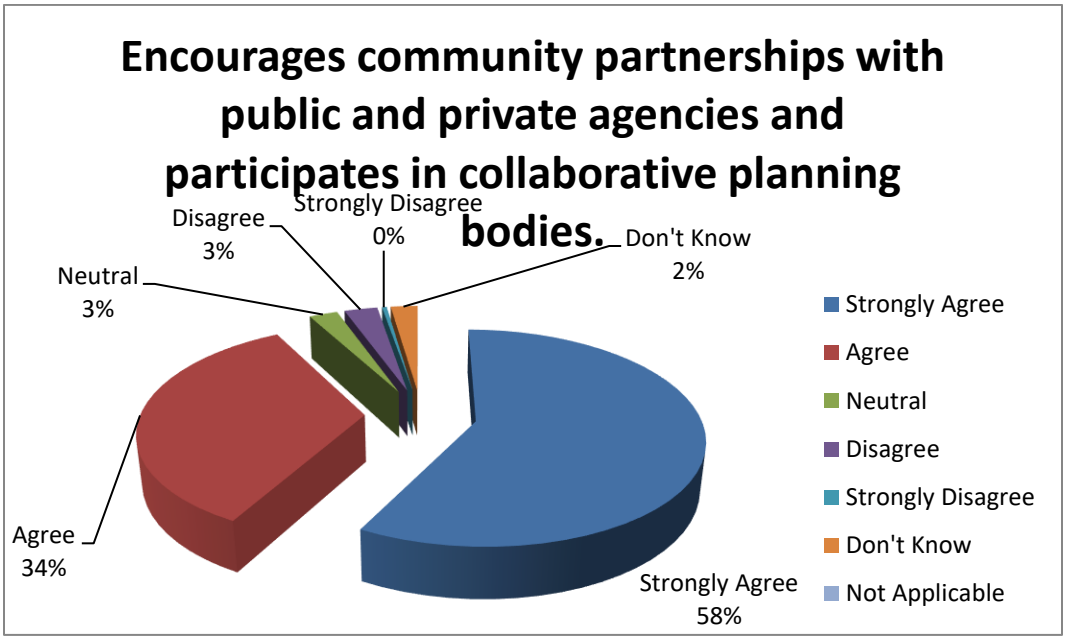
11. Your FRN participates in community-building activities such as health and resource fairs, cultural celebrations, school events, town hall meetings and community advocacy/self-advocacy activities.



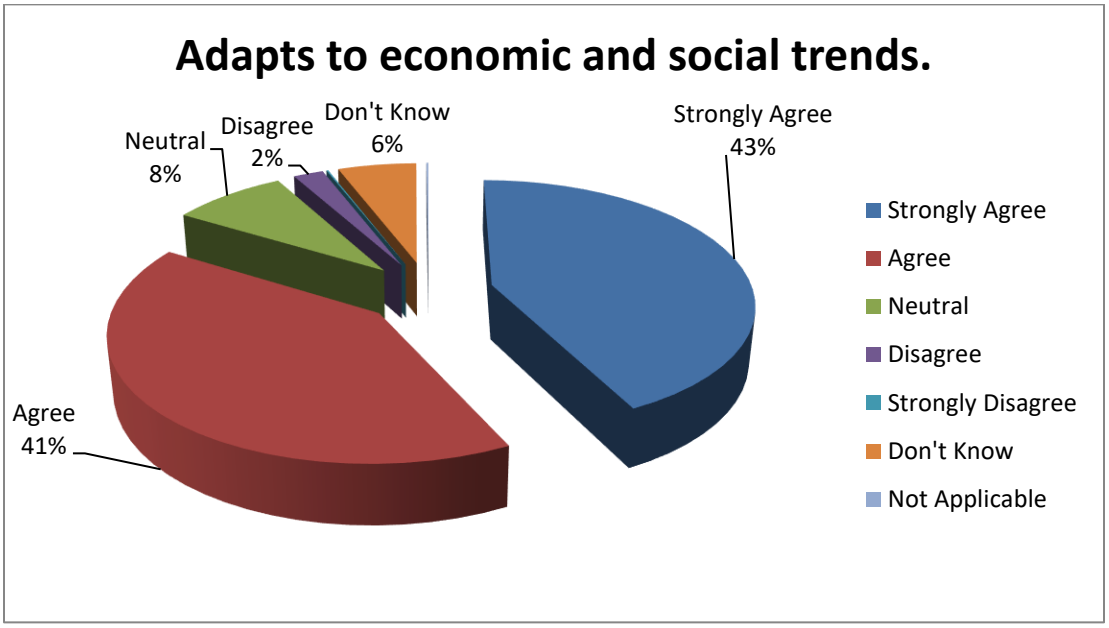
12. Your FRN participates in community building activities including fostering dialogue among groups within the community.



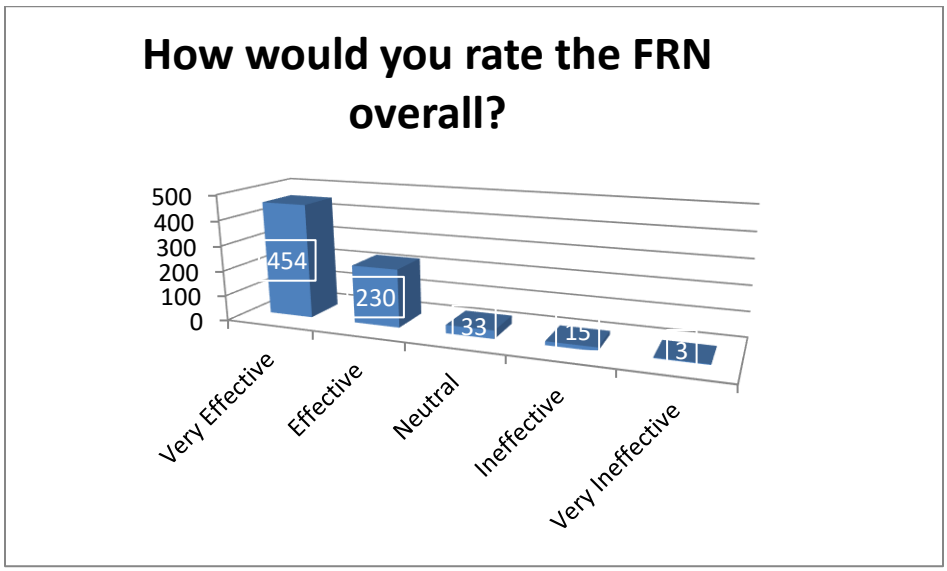
13. Your FRN encourages community partnerships with public and private agencies and participates in collaborative planning bodies.



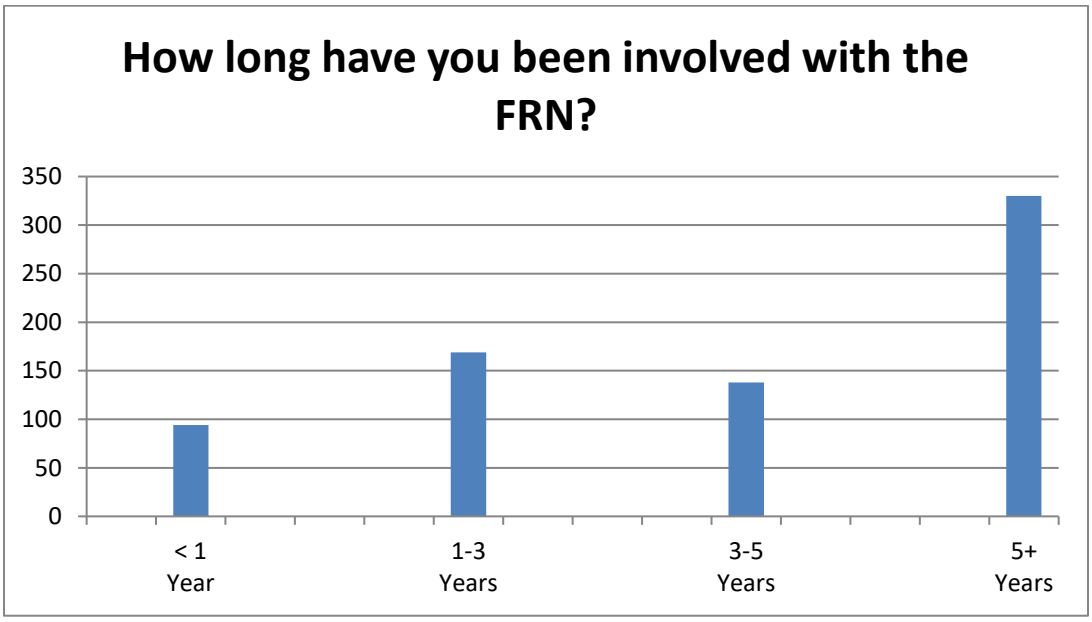
14. Your FRN adapts to economic and social trends.



15. How would you rate your FRN overall?



16. How long have you been involved with your FRN?



Over 670 people completed the survey given through the FRN Network. The following information shows the percentage of respondents and their answers:
87% of the people surveyed agreed that the FRNs involve families to identify needs.

90% of the people surveyed agreed that the FRNs advocate for local, state and federal policy changes that will promote better services for families.

91% Percent of the people surveyed agreed that the FRNs coordinate with local, public and private service providers to assess gaps in services and design plans to address those gaps.

89% of the people surveyed agreed the FRNs adapt to the changing needs of families and the community.

94% the people surveyed agreed the FRNs provide information or presentations on activities, events and services within the community.

89% of the people surveyed agree the FRNs encourage and develop effective strategies to partner with family representatives.

70% of the people surveyed agree the FRNs demonstrate their support by providing resources such as financial support and in-kind donations.

95% of the people surveyed agree the FRNs work to ensure that community partnerships are culturally representative of the community and inclusive of the range of resources.

96% of the people surveyed agree the FRNs participate in community building activities such as health and resource fairs, cultural celebrations, school events, town hall meetings and community advocacy/self-advocacy activities.

91% of the people surveyed agree the FRNs participate in community building activities including fostering dialogue among groups within the community.

92% of the people surveyed agree the FRNs encourage community partnerships with public and private agencies and participate in collaborative planning bodies.

84% of the people surveyed agree the FRNs adapts to economic and social trends.

93% of the people surveyed agree the FRNs are effective overall.

Over 600 people taking the survey have been involved with the FRN for over a year with nearly 150 involved more than 3 years, and over 300 who have been involved 5 years or more.

WV currently does not need additional training or technical assistance.

The Bureau for Children and Families currently determines customer satisfaction with two categories of services through client focus groups. These focus groups are conducted with recipients of socially necessary services and children's residential services. These focus groups are conducted by a contracted administrative services organization called Kepro (previously known as APS Healthcare), as part of their overall contracted utilization management functions.

A workgroup was convened in February 2017 to revise the focus group questions to better capture specific information about cultural differences, specific disabilities or special needs. The new questions are listed below and will be implemented in the second quarter of 2017.

1. Is your current agency committed to providing health and educational materials that appeal to various social, cultural and special needs groups?

2. Are intake forms or materials available in different languages?

3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.

4. Does the agency have trained interpreters readily available for various languages, including sign language?

5. Does the agency have established connections with various community, cultural, ethnic and religious groups to help better serve diverse groups?

6. In the past six months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?

7. Do you have the opportunity to attend racial group holidays or functions within diverse communities?

8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?

9. Do you have access to religious services in which you affiliate?

10. Does your provider alter your programming or care based on your values or culture?

11. Do you feel your services are tailored to your needs?

12. Are visitations arranged in situations you and your family are comfortable-physically and emotionally?

13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?

14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snap chat?

15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?

16. Do you have access to personal care items or services that match your needs? (haircuts, dye…)

17. Do you feel you get to express your personal style in clothing and appearance?

18. Do staff understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Do staff initiate discussions related to LGBTQ issues?

19. Do you feel that staff use inclusive language rather than identifying activities based on stereotyped gender roles?

20. Do you feel isolated or separated/segregated from the population at the facility due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth would receive?

21. Did staff ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?

22. Have staff identified support groups, places, and people for you outside of the facility?

Agency Responsiveness to the Community

Family Resource Networks, Community Collaborative Groups and Summits

The Family Resource Networks (FRNs) are organizations that understand and are responsive to the needs and opportunities in West Virginia (WV) communities. Partnering with citizens and local organizations, the FRNs develop, coordinate, and administer innovative projects and provide needed resources. FRNs provide indirect services, including managing, supervising, and coordinating a variety of programs and initiatives in their respective community. They also provide services to those dealing directly with children and families, specifically organizations and groups.

The FRNs Service Agreement include attending and participating in the (multi-county) Community Collaborative and Regional Summits to identify existing services and service gaps in the community.

The FRNs, who have a larger focus of what is needed in their communities, will assist the Community Collaborative Groups in tracking service needs and when those services are not available.

Community Collaborative Groups play a key role in the Safe at Home West Virginia (Title IV-E demonstration project). The Safe at Home WV will include “wrapping” services in the community around the child and family. This wrap around model is intended to prevent removal or reduce the length of time a child spends in out-of-home care (residential care).

Community Collaborative Groups (along with representation of the FRNs) will identify community based services and, if needed, developing services based on the needs of the children and families in their community. When a need is identified, the Community

Collaborative will first seek to meet that need within their community and in partnership with community providers and service agencies. If a service or group of services is not available to meet the identified need, the Collaborative group is expected to forward the request to the Regional Summit to identify any resources in the area that lie outside the Community Collaborative Group's scope. If, after collaborating with the Regional Summit, a true gap in services is identified, the Regional Summit will communicate that need to the BCF Statewide Coordinator who will present the need to the Safe at Home West Virginia Advisory Team.

Communication is essential for service identification and development. When a Community Collaborative communicates a service gap to the Regional Summit, the needed service should be accompanied by a brief summary of the situation and need the service is trying to fill. Likewise, if the gap cannot be filled at the Regional level, the Regional Summit will also be expected to provide this information when sending the request to the Safe at Home Advisory Team. This will communicate a clear understanding of the service gap and allow for consideration of different solutions. Family Resource Network members will attend, participate and provide support both the Community Collaborative Groups and Regional Summits.

From October 2013 through September 2014

A Service Delivery Coordinator with DHHR was hired to provide technical assistance for Community Collaborative Groups. Technical assistance can include data sharing with the Community Collaborative Groups on the identified needs and characteristics of the children from their community placed in care. The Coordinator will also assist with the statewide Community Collaborative meetings and foster relationships between providers and the Bureau for Children and Families staff.

Resource Development and Capacity Plans are being completed by the Community Collaborative Groups and submitted semi-annually (July and January) to the BCF Statewide Coordinator. This report will track the strategies, actions and challenges the Community Collaborative Groups are following.

The Safe at Home West Virginia (Title IV-E Waiver) will support the provision of a full continuum of supports to strengthen West Virginia children and families. Identifying and building community based services, focused on reducing youth currently in congregate care and those children at risk of going into out of home care so that they can safely remain in their home community.

In June 2014, the WV Department of Health and Human Resources, Bureau for Children and Families provided a quality improvement survey to those involved with the FRNs. The purpose of the survey was to examine the FRN within the community, analyze their ability to work cooperatively with other organizations and assess their knowledge of available community resources and their ability to access those resources.

A statewide Community Collaborative meeting was held on December 17, 2014 to discuss Safe at Home West Virginia, the goals of the Child Family Services Plan, using the Child Adolescent Needs & Strengths (CANS) to identify gaps and needed services that will build on the child's strengths and needs. This meeting was attended by Community Collaborative members, Family Resource Network Directors, DHHR Managers (local and statewide), Bureau for Health and Health Facilities staff, and service providers.

New View report – The draft of the New View Report is being reviewed and is expected to be finalized by the Court Improvement Program (CIP) Board on November 6, 2015.

2016 Update

The WV DHHR Office of Communications serves as the point of contact for the DHHR Cabinet Secretary's office for internal and external communications efforts, and manages the Department's reputation through the production and distribution of messages surrounding its activities. The Office of Communications serves as DHHR's voice to the media and helps keep employees informed.

Additionally, Communications at DHHR is a strategic management tool, integrating and linking marketing and branding strategies with public relations. DHHR utilizes two-way communication to effectively develop trusting relationships with clients, employees, legislators, the media and the public.

The staff for the Office of Communications consists of the Director, who serves as media spokesperson for the Secretary and as the department's liaison with the staff of the Governor's Communications Office; Deputy Director; Assistant to the Director; Communications Specialist; and Communications Assistant.

The following communications protocol is followed:

- Media inquiries are referred to the Director of Communications upon initial contact/request for information.
- News releases must be approved by the Office of Communications prior to release.

- The Office of Communications provides internal design services and professionally developed templates.
- Social media is a coordinated effort through the Office of Communications. All programs and services of the Department may be promoted or shared on the Department's official Facebook page by submitting information and ideas to dhhrcommunications@wv.gov.
- The Office of Communications approves all promotional items before purchase and distribution.

The Field Operations Management Team, consisting of two Deputy Commissioners, four Regional Directors, one Director of Client Services and the Change Center North and South, one Director of Centralized Intake and 30 Community Service Managers (CSM) who cover the 55 counties is tasked with interacting with the communities. Based upon a job analysis – Position Description Form (PDF) - done by a representative group of CSMs they determined that they spend 20% of their time responding to and interacting with the communities they serve. Please see attached PDF. This PDF was developed for use with the WV Division of Personnel as a supporting document in the hiring process for managers. Examples of tasks and activities that are included in this 20% of CSMs' jobs would be:

- Mandated Abuse & Neglect Reporter training done for Hospitals, Schools and other groups, such as churches, camps, youth community groups. CSMs would conduct or arrange for others to conduct such training;
- Quarterly Meetings with judges and prosecuting attorneys;
- Serving on Family Resource Networks (FRN) that are established by WV Code in every county. FRNs meet monthly;
- Serving on Community Collaboratives, which bring together FRNs, CSMs, service providers and community members from across two or three districts each. Community Collaboratives meet monthly;
- Serving on Regional Children's Summits, of which one exists in each of the four BCF regions, and brings together all the Collaboratives noted above. Summits work to identify community needs, service gaps and work towards solutions for communities on a regional level. Most Summits meet monthly.

The process for when complaints are received regarding work at the field level:

- Complaints may be received at and addressed at any level of the agency;
- The chain of command is often employed to respond to complaints. Complainants who call are referred to a supervisor or someone of a higher level, or to Client Services. Written complaints received are handled similarly;

- Client Services is a unit dedicated to responding to client complaints. The staff works with the district staff to evaluate the complaint and issue proper responses;
- Client Services is under the purview of a Director and one of the Deputy Commissioners for Field Operations, thus affording opportunity for more neutral oversight regarding the nature of complaints and practice. Client Services tracks some statistical information regarding complaints – program type and county;
- Field staff may be redirected by their chain of command, if practice issues are discovered, as a result of a client complaint. Most complaints do not involve this sort of redirection;
- Clients are often reminded about program requirements and policy as a result of complaints;
- Many complaints do involve lack of return phone calls by field staff to clients. Handling client issues at the lowest level and returning a call has been a mandate for district staff. This BCF initiative – One & Done- first came about due to overflow calls related to Affordable Care Act, it has been in place since 2014 and a new version is set to be released in May 2016 and will also be an expectation of Social Service as well as Family Assistance Staff.

Community Outreach

The Department recognizes data collection and using that data to identify trends that have been a deficit in the past. We have data and information from many resources such as New View Reports, Client Services complaints, Court Improvement Board, Citizen's Review Panel, focus groups reports and other sources. Part of the problem has been not having one data source that reviews and analyzes that data to identify issues and trends. A Data Collection committee will begin gathering and evaluating all data to identify trends that will be forwarded to the Leadership Team each month and will be reviewed at the monthly leadership meeting. They will discuss and then share trends with Child Welfare Oversight to develop plans to address issues and perform an assessment of strengths and concerns.

In each District, local Community Services Managers will continue to be responsive to needs within the community by working with various resources within the community to address local concerns. The Customer Service Centers and County Offices will continue to offer customers prompt, efficient, and accurate service. The Centralized Intake Centers are now functioning at full capacity and will be able to address all CPS issues and provide assistance to clients as needed. The county offices will begin to show videos that explain the CPS process on a more regular basis. These efforts will help the bureau address deficiencies and identify strengths that will enable us to better serve our customers in a more efficient and timely manner.

A workgroup was developed in response to the needs of the communities we serve. The workgroup gathered to determine the goals and objectives of the DHHR/BCF response to the community we serve. In dissecting the overall mission of the workgroup, it was agreed BCF should look at the community as a whole and survey the community to ascertain data on strengths as well as weaknesses. The group has developed two surveys which encompass the community as a whole. The first survey will explore the professional aspect of responsiveness, seeking feedback from the Judicial/Legal Branch, Law Enforcement, Collaborative, Family Resource Networks, and any other professional organization. The second survey seeks feedback from individuals who serve in the capacity of a foster parent, inclusive of kinship relative providers.

It has been decided Survey Monkey will be the most adequate mechanism to not only collect data, but also disseminate the data to determine future actions. Based on the various disciplines involved in the collection process, distribution of the survey would most likely work on the local level utilizing both current professional relationships and stored foster parent email addresses for the online survey process.

Upon completion of the data dissemination process, recommendations as well as future goals and objectives can be established from information received from the community at large. This process will be fluid, constantly subject to updates and changes as the needs of the citizens are determined to be stable or changing.

The Bureau for Children and Families continues to participate on the Citizen's Review Panel. A copy of the Citizen's Review Panel Recommendations as well as the Commissioners response are attached to this report.

The Bureau for Children and Families regularly collaborates and coordinates its services with federal programs to assist families served. Some of the federal programs include TANF, Medicaid, Social Security, the Office of Maternal, Child, and Family Health, and Birth to Three. BCF works with these programs to ensure our families are served in the most efficient and effective manner.

When a child is removed by BCF, whether through Child Protective Services or through Youth Services, and placed in kinship/relative care, BCF will work to provide a state paid subsidy consistent with TANF rates until the kinship/relative guardian can have a TANF application completed and approved and/ or a home study can be completed. Another way we collaborate with federal programs is through Medicaid. When a child or family comes to the attention of BCF as needing some service, BCF may be able to provide a Special Medical card to ensure that families needing medically necessary services

receive them while the family works to apply and receive approval for a state medical or chip card. BCF also collaborates with social security to ensure that when a child is removed from care, BCF becomes the representative payee of the child's social security income. BCF manages the youth's account to ensure funds do not exceed the federal limit of $2,000. BCF utilizes these funds to purchase items for the youth that will be helpful to the youth in transitioning to adulthood or personal items the youth may request.

Over the last six years, the Office of Maternal, Child and Family Health (OMCFH, the State's Title V agency) have collaborated with the Bureau for Children and Families to assure adequate health care services to children in foster care. The two agencies worked to establish a project entitled Fostering Healthy Kids (FHK). The FHK Project is a collaborative effort between the Bureau for Children and Families and the OMCFH to improve healthcare coordination for children placed in relative/kinship care and/or WVDHHR foster family homes. This Project ensures that all children in foster care receive a timely EPSDT screen and assistance with accessing medically necessary treatment. In addition to this healthcare initiative, Child Protective Services is required to refer all children of appropriate age to the Birth to Three programs to ensure children within this age range receive assistance with possible developmental delays. The state's SACWIS system also generates an automatic referral for all children who are identified under CAPTA as drug exposed.

The state has not identified an adequate data reporting system to determine if these collaborative systems are functioning. This item is one in which the state relies heavily on the narrative between programs and staff to determine areas that need improvement. When problem areas are identified, the appropriate program area works to remedy identified issues as quickly as possible to ensure a streamlined approach is used to serve our children and families.

In the next year, the Bureau for Children and Families will have its Child Protective Services, Youth Services and Foster Care policies reviewed again by NAIF.

2017 Update

Please see West Virginia's Statewide Self-Assessment.

Foster and Adoptive Parent Licensing/Recruitment

With Safe At Home West Virginia starting in October, the West Virginia Department of Health and Human Resources has been looking at caseloads across the state, as well as the number of inquiries that each region is receiving regarding individuals interested in

becoming foster care providers. Due to the volume of both, as well as the increased focus on kinship/relative care providers, the Department has determined that it does not have the number of staff required to adequately handle foster care inquiries without additional positions being granted. The Commissioner has asked for an increase in Homefinding Specialist positions, but was denied that request. Therefore, the Department has decided that potential foster care providers will be referred to private foster care agencies for certification.

At this time, the Department is referring all new inquiries to become foster parents to Mission WV to be sent to the private sector. The Department will, however, continue to work with new and existing kinship/relative provider homes. When an individual contacts the Department to show interest in possibly becoming a certified provider, the Department employee who receives the inquiry will provide the caller with the contact information for Mission West Virginia, informing them that they need to call Mission West Virginia for further assistance. Mission West Virginia will then send out an inquiry packet to the caller with information on all the private foster care agencies, and will also continue to follow up with the caller to help them through the process of deciding which agency will best meet their needs.

The Department currently has 1,338 inquiries to provide foster care that have not been addressed.

2016 UPDATES

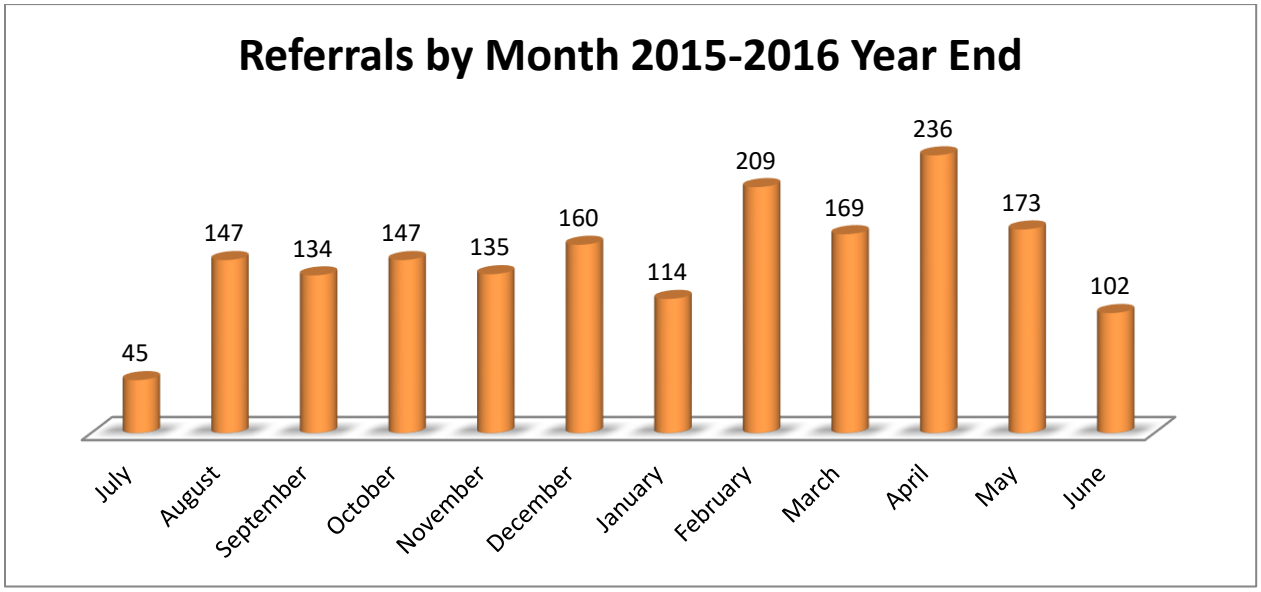
Foster and Adoptive Parent Licensing, Recruitment and Retention

In February 2015, WV was approved for Training and Technical Assistance from the National Resource Center for Diligent Recruitment (NRD-DR). The NRC team came to West Virginia and began gathering data from staff interviews and data reports. Just as a plan was about to be developed, Bureau for Children and Families Leadership notified staff that the Recruitment and Retention of new foster homes was going to be given to private agencies. BCF staff would continue to develop kinship and relative homes.

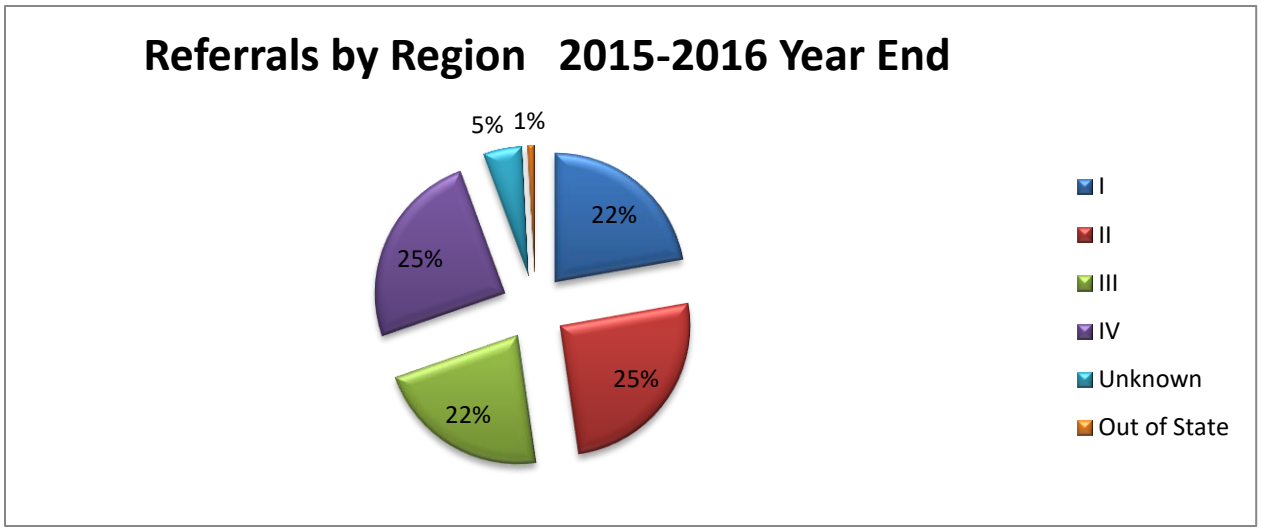
A hold was put on the technical assistance in August of 2015 and resumed in late October 2015. Over the next few months, NRC staff as well as a diverse group of BCF staff and stakeholders met to develop a new plan and process for general foster/adoptive inquiries.

West Virginia executed a change order to increase the grant currently given to Mission, WV. Mission will handle all inquiries from the general public requesting to become foster and adoptive parents. When someone inquires through Mission, they will receive a packet

of information including general information about the process, contact information for private agencies serving their county and a calendar of scheduled PRIDE training. Mission continues to follow up with these families at regular intervals until they select and are contacted by their chosen agency or the request not to be contacted again. After they have selected an agency, Mission will continue to contact them, less frequently, to insure they are not lost in the process. A breakdown of inquiry information is as follows;



West Virginia is also working on an interactive map that will allow the general public to access county specific information. It is hoped when families inquire, they will be able to choose their county on this map and only agencies that serve their county will pop up with information about their program, requirements and contact information.



West Virginia is currently investigating different avenues of documenting the inquiry information in our SACWIS system so that it can be matched to our SACWIS data of receiving the packet from prospective foster/adoptive parents. Documentation of a received packet from a family will begin the timeframe for tracking how long it takes to certify our resource homes.

When families select an agency, the agency will mail them a foster/adoptive home packet which includes and application as well as notify Mission that the family is beginning the process. At the conclusion of the process, the specialized agency that certified the home documents the required information in the SACWIS system. The SACWIS system tracks the number of certified homes within the state.

All foster homes, both kinship/relative, traditional or specialized, medical, and therapeutic homes are expected to adhere to the same standards statewide. There are no additional training requirements for specialized foster homes. There are however, additional training requirements for Specialized Family Care medical homes (medley). These homes receive their additional training through West Virginia University's Center for Excellence in Disabilities. These homes are for our medically fragile youth in care. Additionally, West Virginia plans to expand services to include Therapeutic Foster Care homes which will require additional training in crisis response, trauma training and child-specific training related to potential crisis due to the child's history or current issues. See the 2016 update on Expansion of Foster Care: Therapeutic Foster Care.

The current training curriculum used is the West Virginia modified PRIDE model and sessions are scheduled jointly for all kinship/relative, traditional or specialized homes,

medley, and therapeutic homes. These sessions are developed and scheduled jointly by the West Virginia Social Work Educational Consortium staff and BCF homefinding staff in each region.

Currently there is no data to support the effectiveness of the West Virginia modified PRIDE training model. However, placement stability for the year 2015 is at 75 percent. Noted in the review is a shortage of foster homes within the entire state which sometimes requires a short-term placement in emergency shelters. The shelter placement could easily account for the below 95% stability. 75% in this measure indicates there is high effectiveness in foster parent preparation. West Virginia continues to seek kinship/relative placement first when appropriate. A short survey will be developed in the next year to be mailed out annually to all approved foster homes to better determine the effectiveness of the West Virginia modified PRIDE training model.

West Virginia does not currently monitor/track the pre-service or in-service trainings. However, within the next year, a report will be developed that monitors/tracks the number of homes that complete both pre-service and in-service trainings. This report will include training data from all certified foster homes and will be developed from information in the FACTS system. The report will determine if the training system is routinely functioning statewide.

To facilitate timely adoptive and/or permanent placements for waiting children statewide West Virginia's licensing, recruitment and retention system has determined a baseline of 19%.

For the 2015 year, West Virginia completed 194 ICPC home study requests. Of those 194 requests, 19% (37) were completed within the 60-day requirement. Additionally, there were 200 ICPC home study requests made to other states by West Virginia. Of those 200 requests, 17% (33) were completed within the 60-day requirement.

2017 Update

West Virginia has a process for tracking some data in relation to Cross-Jurisdictional Placements and Requests for Placements, but we do not have a "monitoring" system to track the progress of home study requests from other states.

There were 188 incoming requests for FFY 2016. Out of the 197 requests, WV completed 65 or 33% of the home studies within the 60-day timeframe. The most documented reason for the home studies not being completed within the 60-day timeframe is due to the

fingerprint results not being back in that 60 days, but staff have been very inconsistent in their reporting reasons for delays.

The State ICPC Office has developed a new process to track home study requests. State Office ICPC staff will monitor a tracking spreadsheet of requests and send reminders to the local staff, prior to the home study being due.

The State ICPC Office will begin entering the home study request in the FACTS System as a referral for services, when the request is received in the State Office. The referral will then be transferred to the local office electronically, which will assist in timeliness.

West Virginia currently has 49 children featured on the West Virginia Adoption Network, with an additional eight children waiting to be released to the network. There were 27 children registered on the network within the last year and there are currently 27 children placed on hold due to achieving permanency or moving into their Trial Adoptive Homes.

A workgroup of BCF policy, BCF regulatory and child placing provider staff have been working on revisions to the Legislative Rules “Licensing Requirements for Child Placing Agencies” 78-CSR-2. These rules provide minimal standards for regulating specialized agency foster homes. The revised rules will incorporate requirements from the Fostering Connections to Success and Increasing Adoptions Act and the Preventing Sex Trafficking and Strengthening Families Act. The revisions will also include most standards from the “Model Family Foster Home Licensing Standards” from the National Association for Regulatory Administration (NARA).

Some of the standards that have been added to the licensing requirements are around prudent parenting, normalcy for youth in foster care, away from supervision and runway events, trafficking of foster youth and many of the NARA standards for foster homes.

The revised “Licensing Standards for Child Placing Agencies” will be completed by the end of 2016 and submitted to the Legislature in 2017 for approval in the 2018 Legislative session.

BCF policy staff will also align the Foster Care and Home Finding Policy with these “Licensing Standards”, so all foster homes in West Virginia will meet the new requirements.

Additional information can be found in the update on Foster and Adoptive Parent Diligent Recruitment Plan.

2017 Update

In August 2016, all private foster care agencies partnered with the Bureau for Children and Families to revise the provider agreements. The revisions were done for several reasons, but two of the main reasons were to (1) strengthen language related to on-going foster parent recruitment expectations, and (2) incorporate results-based outcomes aimed at improving the quality of services from private agencies and their foster homes. These private agencies have always had case management responsibility for the children placed in their homes but the specific responsibilities such as family engagement with the biological parents, prudent parenting and permanency planning were more specifically outlined.

Even though the Bureau made a significant change in late 2015 to place all traditional foster parent recruitment with the private agencies (while the Bureau maintained sole responsibility of kinship/relative providers), the agreements had not undergone significant revisions to reflect these changes. Also, the outcome measures were based solely on superficial counts that did not reveal any qualitative data.

Below are the outcomes that are now required for each private foster care agency. No specific benchmarks have been incorporated yet. The agreement now requires that the outcomes be reviewed annually. Once basic data is gathered during the first year or two, specific benchmarks will be added to each set of measures to further develop the qualitative expectations.

How much do we do?	How well did we do it?
# of referrals received # of referrals accepted for placement #of foster homes	% of children placed with siblings; % of children discharged to residential programs; % of children with regular family visits; % of children reunited with parents or other family members; % of foster homes with yearly re-certifications.

Is anyone better off?

and % of children in care have 2 or fewer placements in foster care;

and % of children age 6 and older will maintain attendance at the same school they attended prior to removal;

and % of children who experience improved academic achievement;

and % of youth who experience a decrease in his or her CANS score;

and % of children who achieve permanency within 15 months.

4. Update to the Plan for Improvement and Progress Made to Improve Outcomes

Due to West Virginia's ongoing drug epidemic and the Child Protective Services crisis in the state, some of the following goals, objectives, and interventions have no new data for year 2017. The states focus in the last year has required a major re-distribution of staff to crisis counties as well as using any staff with Child Protective Services experience to manage backlogs of referrals as well as supervision of re-assigned staff to work the backlog. Goals related to anything other than safety of children in their homes or safety, permanency and well-being of children in foster care have not been addressed.

All information about progress or the lack of progress to West Virginia's goals are shared at Statewide ESSA, Trafficking, Drug Affected Infants group and CIP Data Statute and Rules committee meetings on a regular basis. Goals for each program area are discussed at length and cross training within the meetings occurs to ensure the state is maximizing all its resources to achieve safety, permanency and well-being for its children and families.

Revision to Goals, Objectives and Interventions

Goal 1: West Virginia's children will be safe.

1.1 Improve the time to initial face-to-face contact with families when a Child Protective Services referral is accepted by July 2015.

Based on West Virginia's Context Data Report

	2011	2012
Mean	356.9	395.9
Median	>48 but <72	>72 but <96

West Virginia will be using COGNOS to monitor the rate of face-to-face contact with children in care. COGNOS data includes the entire foster care universe as opposed to a sample and is real-time data.

Rationale

Based on the Child Data Profile, West Virginia recognizes the need for improvement in response time to initiate the Family Functioning Assessment for abuse and neglect cases. Faster response times will improve West Virginia's ability to ensure safety.

Measurement Plan:

West Virginia will reduce the mean rate for response time as indicated on West Virginia's Data Context report to monitor progress for the goal 1.1.

West Virginia's current baseline measurement indicates the mean rate for response time as 395.9 hours based on the NCANDS data for 2012.

Benchmarks:

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
2012	**2015**	**2016**	**2017**	**2018**	**2019**
395.9 hrs.	335.9 hrs.	273.9 hrs.	215.9 hrs.	155.9 hrs.	95.6 hrs.

Updated:

2013	2014	2015	2016	2017	2018	2019

283.9	97.2	101.6	179.2			

Again, West Virginia will be using COGNOS data. This is a developed, current report, real-time, already available. It measures percentage of cases, with face-to-face contact with the identified victim within the specified response time. West Virginia will increase its percentages by 5% each of the next four years.

Tasks

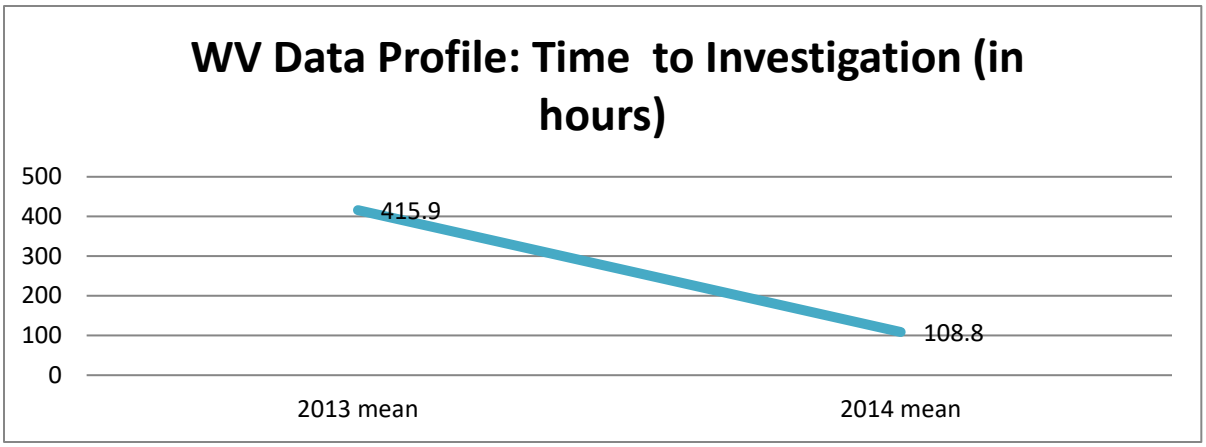
- Improve the time to initial face-to-face contact with families when a Child Protective Services referral is accepted by July 2015.
- The Field Operations Management Team will monitor COGNOS monthly for real time reports of response times on accepted referrals by October 2014.
- Develop and immediately implement district-specific plans for improvement when deficiencies are identified to assure that abuse and neglect assessments are initiated on time beginning December 2014.
- Develop a methodology to distinguish between actual missed face-to-face contacts and attempted contacts by tracking through case reviews by October 2014. Current case review data will now include attempted contacts evidenced by diligent efforts as defined in policy.
- Analysis of FACTS data to determine the causation factors for median time to first contact by Sept. 2015. Develop plan to address causational factors based on the data analysis by *October 1, 2015.*
- Complete research to determine if WV's interpretation of incomplete assessments and blatantly false reports is consistent with NCANDS definitions.

2015 Updates

CSMs will review COGNOS reports concerning response times for referrals. Supervisors will track contacts on each referral to ensure timely response times.

2016 Updates

West Virginia continues to improve in the time to investigation.



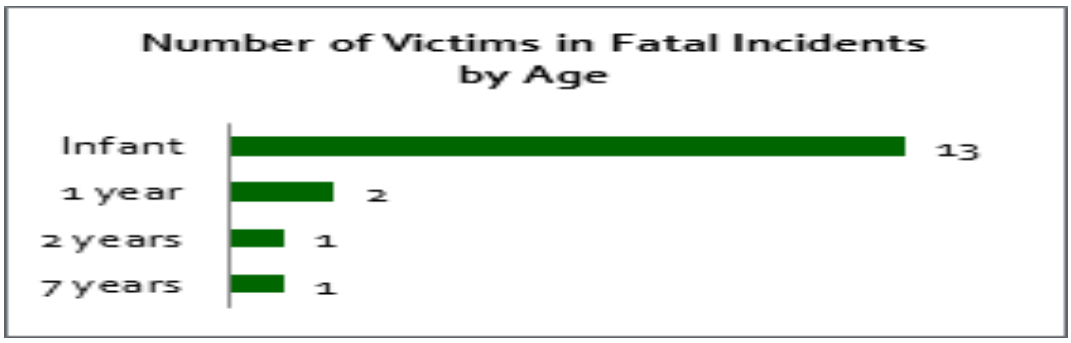
In reviewing the data elements, WV discovered that there is a discrepancy in the way the values for this element were being pulled. West Virginia was unable to get the values corrected in order to resubmit, but will have the errors resolved by the 2015 submission. WV submitted an "agency file' indicating the mean time to investigation in hours as 27.4. WV notes the decrease in the response time in the agency file and contributes the decrease to the implementation of the Centralized Intake Unit. On July 1, 2014, WV began operating a Centralized Intake Unit for abuse and neglect complaints to improve consistency in the evaluation and decision related to reports of abuse and neglect. The Centralize Intake Unit operates seven days a week, 24 hours a day by staff employed by the agency, which replaced the former system of abuse and neglect reports being taken by staff at county offices and a contract agency after regular business hours **(WV Child and Family Review Data Profile; June 29, 2015; footnote D and E).**

Based on West Virginia's Context Data Report Data on child maltreatment victims are from NCANDS.

2017 Update

During FFY 2016 Centralized Intake was understaffed. To accept and assign referrals quickly a decision was made to assign most referrals a 24-hour contact. This has created a backlog of referrals. In a Child Welfare Oversight meeting in May 2017, screening policy was reviewed and a decision was made to return to the original Bureau for Children and Families policy. This will allow for referrals in which children are not in immediate danger to be given a 72-hour contact timeframe.

1.2 Decrease the number of children who die because of abuse and neglect that are known to the Department by October 2017.



Rationale

West Virginia has established an Internal Child Fatality Review committee to review all critical incidents. The committee notes a sharp incline in the number of deaths as the result of child abuse and neglect. The above data is based on the NCANDS submissions for FFYs 2008 to 2012. Data for FFY 2013 is based on the internal team review of critical incident reports from Oct 1, 2012 to June 2013.

Between October 1, 2013 and July 30, 2014, 14 children in West Virginia died because of abuse and neglect. Of these 14 children, eight children were known to the child welfare system. In addition, we have identified that safety planning and review is only being done on a statewide level approximately 30% of the time.

West Virginia determined through the review process that safety planning did not always prevent child fatalities. Analysis of identified trends in child fatality cases known to the Department determined a need for further training, such as the effects of drugs on the safety of children and more effective Family Functioning Assessments.

Measurement Plan:

West Virginia will utilize the review of critical incidents to determine the rate of child fatalities when the child(ren) was known to the child welfare system.

West Virginia's current baseline measure indicates between October 1, 2013 and July 30, 2014, 14 children in West Virginia died because of abuse and neglect. Of these 14 children, eight children were known to the child welfare system. Before the end of the FFY 2014 there were three additional child fatalities in the state.

Benchmarks:

Reduction in Child Fatalities (Data will be measured from Intake Critical Incident COGNOS report)

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
Partial FFY 2014	**2015**	**2016**	**2017**	**2018**	**2019**
14	0	0	0	0	0

Update:

2013	2014	2015	2016	2017	2018	2019
14	17	7	13			

Tasks

- Review all child fatalities and critical incidents at least quarterly through the BCF Child Fatality Review panel beginning October 2014. Division of Planning and Quality Improvement will complete quarterly reports on the review of all critical incident received within the quarter. Reports will be provided to the BCF Internal Review Team at quarterly review meeting. Quarterly data on child fatalities will be tracked by the Office of Planning, Research and Evaluation.
- Compile and analyze identified trends of fatalities known to the Department each year beginning October 2014.
- Develop and implement plans to address current trends related to children known to the Department by March of each year.
- Develop and implement training for all Child Welfare staff that will focus on the current trends in child fatalities and will be updated quarterly with the analysis of the reviews by the fall of 2015.
- Increase the percentage of CPS cases with current safety plans by April 2016.

Update

West Virginia continues to review all child fatalities and critical incidents on a quarterly basis. Reviews of all fatalities are presented to the Internal Child Fatality Review Team.

The CPS Policy Specialist track the finding of all the cases reviewed. The Internal Team makes continuous quality improvements based on the reviews. The Team also compiles all the data for determination of case trends and the development of annual plans to address issues. The annual plan for 2014 is listed below.

West Virginia has developed training to educate workers in the investigative process for cases in which there is a child fatality. Implementation of the training is projected to begin in the fall of 2015. Additionally, West Virginia has issued a memorandum to all staff addressing the importance of education of safe sleep issues. All offices received flyers outlining infant sleeping practices that cause concerns and appropriate safe sleep alternatives. Per directive of BCF Commissioner, all programs under the umbrella of BCF are expected to identify and address families that may have safe sleep issues with infants.

Under the direction of the HHR Office Director of Social Service Programs, Child Welfare Consultants have begun attending unit meetings to provide case consultation on Safety plans. Regions 2 and 4 have begun this process across their respective Regions. Regions 1 and 3 are anticipated to phase this process into their consultation model by December 2015.

Benchmarks:

Increase in completion of Safety Plans (Data will be measured through FREDI report CPS5170)

Increase the percentage of CPS cases with current safety plans by April 2016.

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
Point in time 2014	**2015**	**2016**	**2017**	**2018**	**2019**
30%	60%	70%	80%	90%	100%

Update:

2013	2014	2015	2016	2017	2018	2019

30%	37%	71.13%	45%			

2016 Updates

West Virginia will utilize the Critical Incident Review Team to determine the rate of child fatalities when the child(ren) was known to the child welfare system and to develop and monitor a plan for action.

Reduction in Child Fatalities:

2013	2014	2015	2016	2017	2018	2019
14	17	7	0	0	0	0

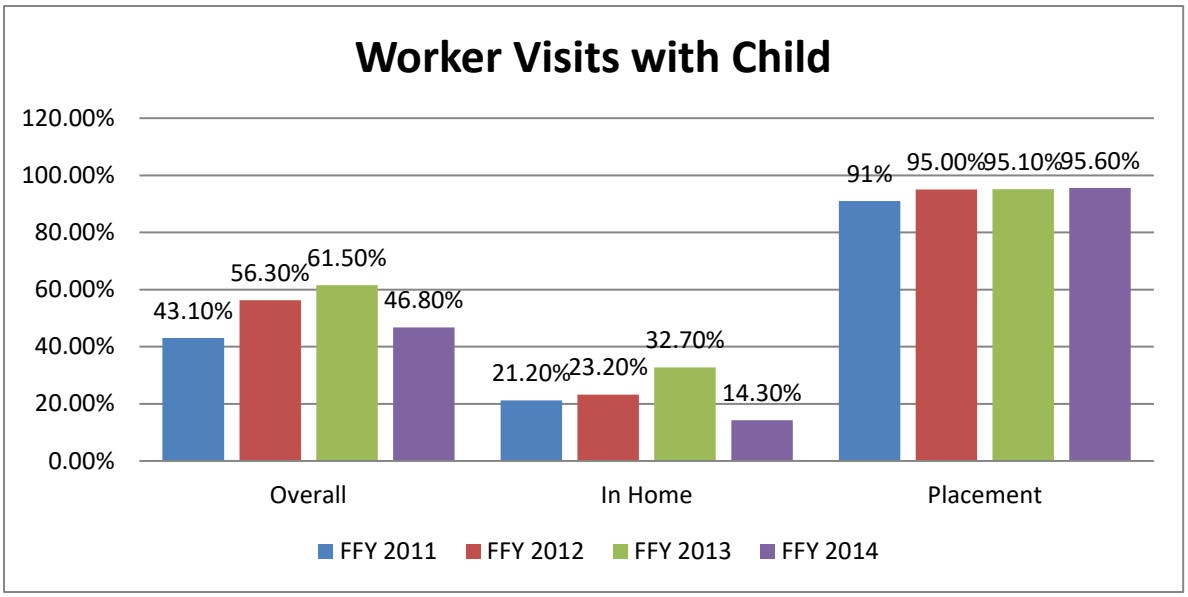
Tasks:

- Review all critical incidents quarterly.
- Compile and analyze trends.
- Develop a plan for action at each quarterly review meeting as needed.
- Monitor the plan for action on a regular basis.
- Increase the completion of safety plans as identified in the plan for action.
- Implement the use of the safe sleep check sheet and monitor use.
- Increase the use of safe sleep videos to all hospitals.
- Continue to provide training to mandated reporters.

2017 Update

See the link to the 2016 Critical Incident Report located at the following website; http://www.dhhr.wv.gov/bcf/Reports/Documents/BCF%20Critical%20Incident%20Report%202016.pdf

1.3 Improve safety of in-home cases by increasing caseworker involvement with the family by October 2019.



Rationale:

West Virginia case review data indicates a low rate of contact with children and families with open child welfare non-placement cases. By increasing caseworker involvement with these families, outcomes will be improved.

Measurement Plan:

West Virginia will utilize the Child and Family Service style case reviews to monitor the increase in the caseworker involvement with the family. 2014 Child and Family Review instrument will be utilized for ongoing measurement. Applicable item numbers 14 and 15.

Baseline measurement indicates 32.7% of in home case were rated as a strength for case worker visits with child(ren) in non-placement cases reviewed in Federal Fiscal Year 2013. Baseline measurement indicates 37.4 % of all case (placement and non-placement) rated as strength for worker visits with parents in Federal Fiscal Year 2013. *2008 CFSR instrument utilized for case review data.

Benchmarks:

Increase in worker visits with child (non-placement case)

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
32.7%	-	-	-	50%	60%

Update:

2013	2014	2015	2016	2017	2018	2019
32.7%	14.3%	24.3%	14.1%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2017. Case review should begin to demonstrate improvement by 2018.

Tasks

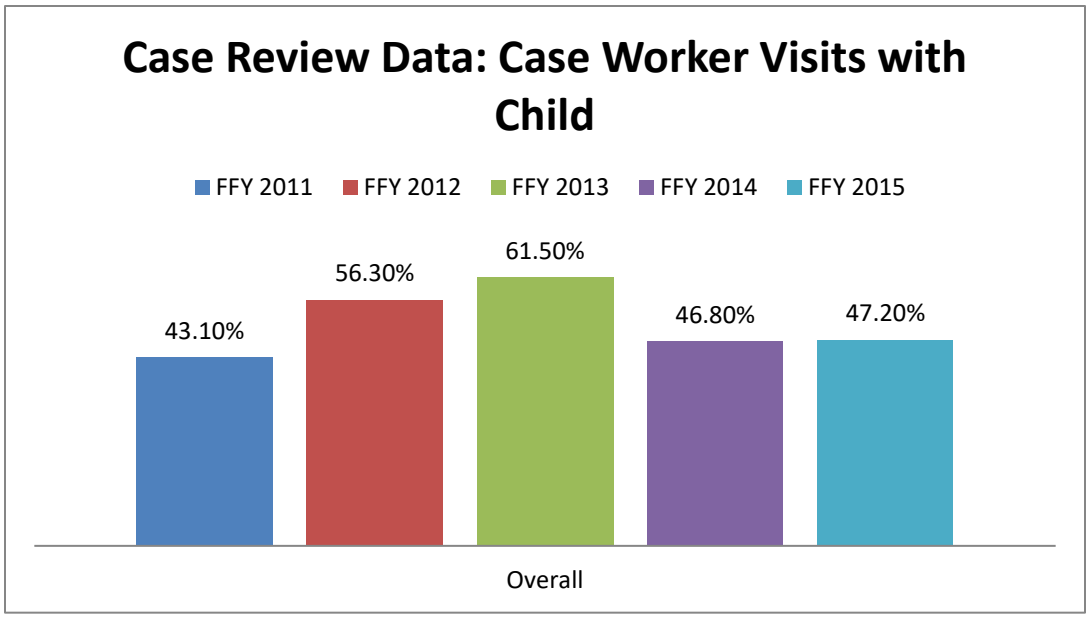
- Improve the quality and quantity of caseworker visits as evidenced by results of case review process and FREDI reports by July 2015.
- Develop and implement a tool for caseworkers to identify what a quality visit looks like by July 2015.
- Develop a mechanism on the Dashboard for tracking face-to-face contact with non-placement cases by September 30, 2016.

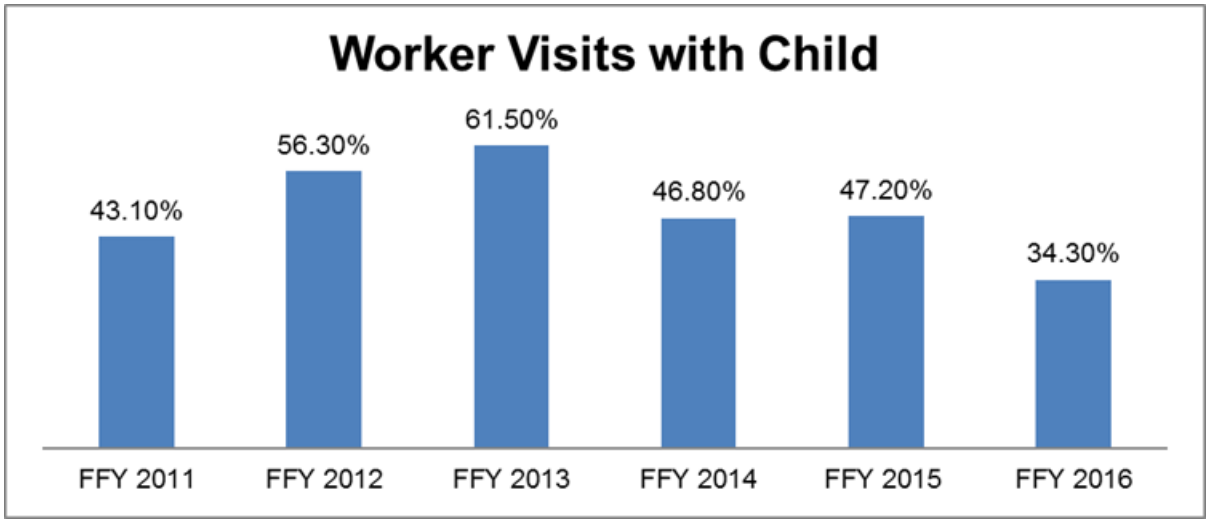
Updates

Regional staff will work with the Field to ensure families are seen on a regular basis and continued safety evaluations occur every ninety days per policy.

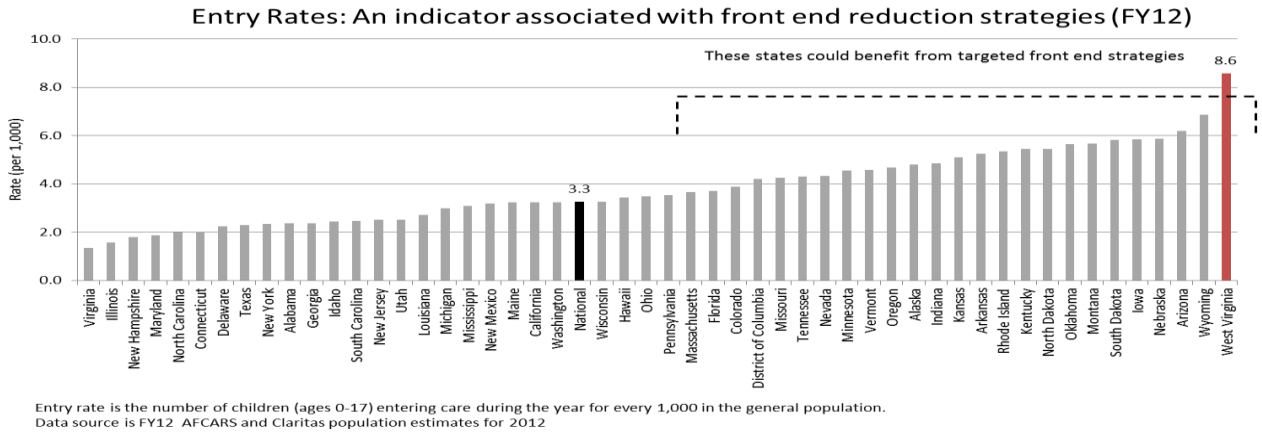
In anticipation of the CFSR, a group has been developed to revise a Meaningful Contact Guide for workers to improve the quality of caseworker visits. This group has been established, however, the anticipated completion date will be revised by January 2016.

The BCF Data Committee has requested FACTS to develop a dashboard for tracking face-to-face contact with non-placement cases by September 30, 2016.





1.4 Increase the percent of children who can be safely maintained at home by October 2019.



Entry rate is the number of children (ages 0-17) entering care during the year for every 1,000 in the general population.
Data source is FY12 AFCARS and Claritas population estimates for 2012

Rationale

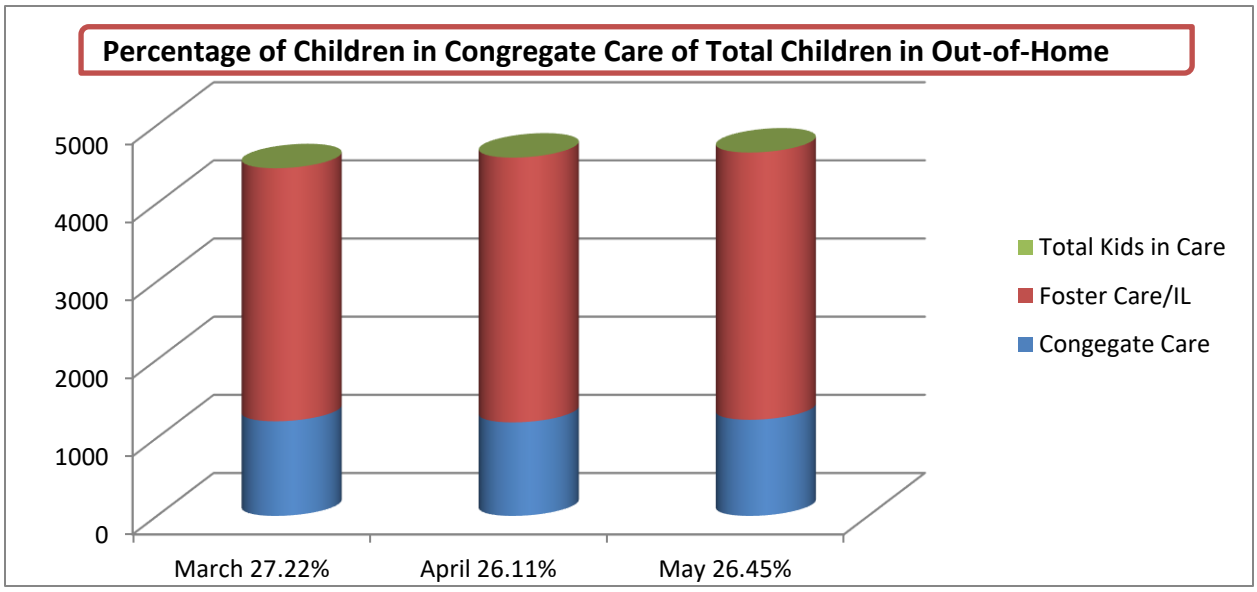
West Virginia has the highest entry rate per capita of children entering care in the United States. West Virginia recognizes the need to safely reduce the number of children entering care. Upon analysis of the case review data, West Virginia has determined the need for improvement in the development and implementation of safety plans with families.

Measurement Plan:

West Virginia will measure the reduction in the percentage of children in congregant care through FREDI report. Baseline measurement indicated by FREDI reports 4,818 total children in care as of March 31, 2014. Of those, 29.16% were in congregant care.

Updated Benchmarks:

Data is pulled from Children in Placement Report as of 3/31 each year.



Data is pulled from FREDI as of the last day of each calendar month

Tasks

- Develop a method in FACTS to better distinguish the reason for entry, including children entering care for Truancy, by October 2017.
- Develop a plan based on the point in time data by July 2018.
- In preparation for Safe At Home West Virginia, training will be rolled out in the pilot counties regarding more proficient safety planning in conjunction with the implementation. The training will then go state-wide as the program extends to other counties.
- Develop a plan for re-educating Supervisors in Safety Planning Coaching with emphasis on appropriate use of both formal and informal providers to control safety in cases with domestic violence and substance abuse by January 2017.
- Training will be completed for all CPS staff and supervisors by January 2016.
- Monitor the improvement in the quantity of safety planning through the *Child Welfare Oversight Committee* beginning January 2016.

2015 Updates

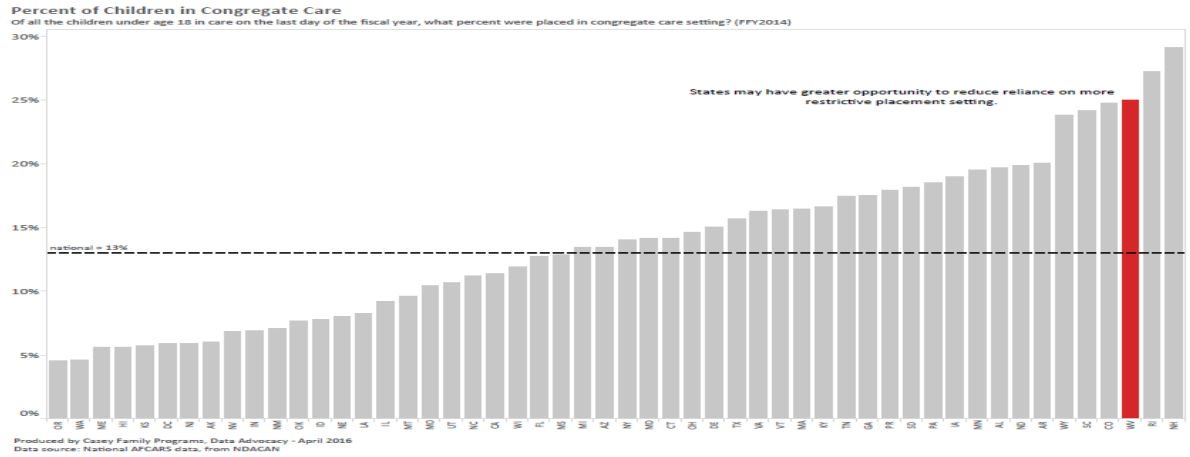
- August 27, 2014: Sample of cases was finalized. Sample included 200 cases, 160 CPS, 40 YS.
- September 4, 2014: Final version of case review form was completed.
- October 2014: Final version of the desk guide for case review was completed.

- November 12, 2014: Training for case reviews.
- November 15, 2014 through February 20, 2015: Case reviews were conducted
- May 4, 2015: Data results from the reviews were compiled.

The Removal Review Teams were established in July 2014 to determine the reason that West Virginia had the highest out out-of-home rate. The Removal Review team sampled 200 cases for review. A case review form and desk guide was developed for the reviews, and staff conducting the reviews was trained in November 2014. Between November 2014 and February 2015, the case reviews were completed and the data is being compiled. The next step it to complete the initial identification of data by October 2015.

The reviewer's submitted information collected from January 2015 through April 2015. Of the 200 cases randomly picked 134 had reviews completed by the time of the data summary. This resulted in 67% of the total cases being reviewed. We are currently in the process of analyzing the data and determining next steps.

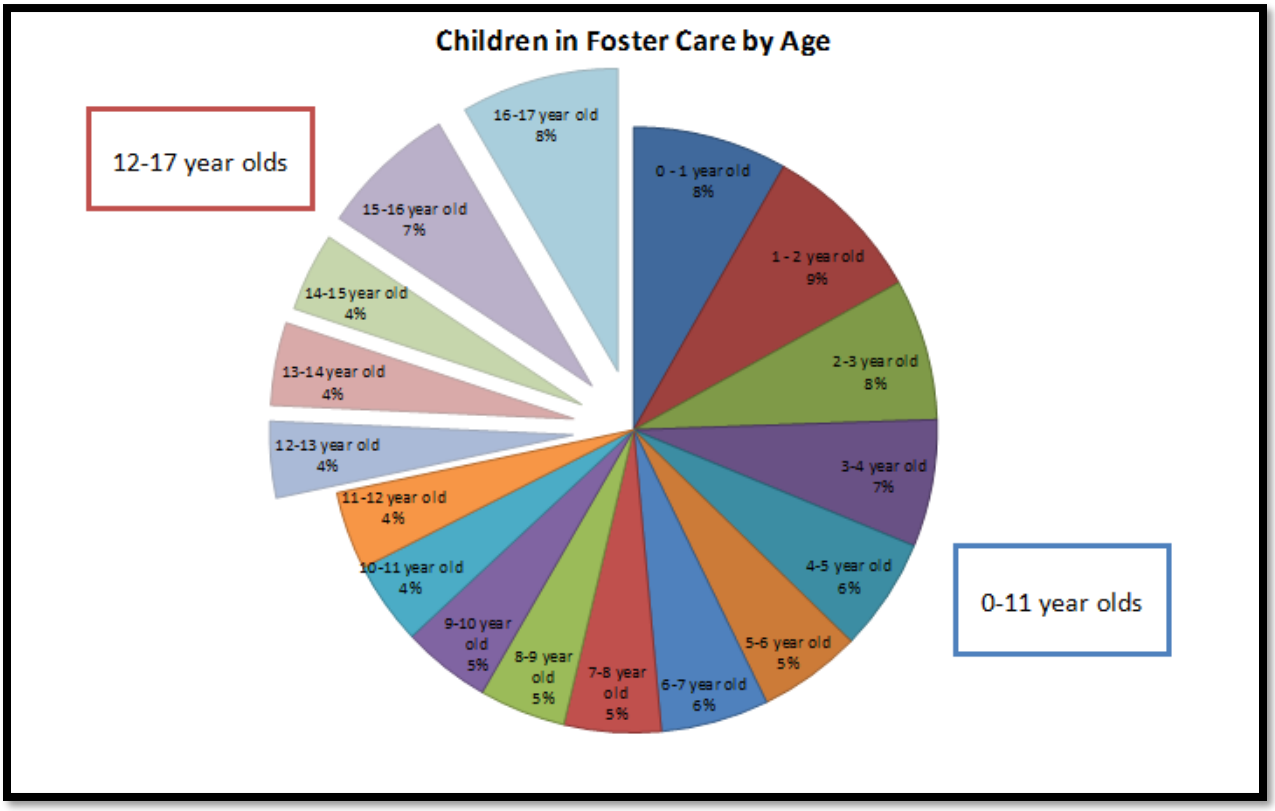
2016 Updates



According to a June 2015 article in the Washington Times, West Virginia has the highest rate of overdose deaths in the U.S. West Virginia's drug overdose death rate was more than double the national average, the report says. Citing statistics from the CDC, it found that West Virginia's rate far surpasses the second-highest state, New Mexico, which was at 28.2 deaths per 100,000. The national average was 13.4. This is probably the most important contributing factor to the high rate of termination of parental rights in West Virginia.

Dr. Rahul Gupta, West Virginia's state health officer, said the reasons why vary, but they are intertwined. He cited the impoverished region's history of poor education, along with the isolation of people and communities in its rugged mountainous terrain. There's a limited offering of substance abuse programs, though it's growing, but services may be far away and hard to reach.

Although West Virginia's number of children in foster care is on the rise, data suggests that the majority of these children are younger and are removed due to abuse and neglect, predominately substance abuse by their caretakers.



When children are removed from their homes, each parent and child are assigned attorneys to represent their best interests. Each family is also reviewed no less often than every 90 days by a Multi-Disciplinary Team (MDT) which includes the parents, their attorney's, the children's attorney and the caseworker. This team meets continually throughout the life of the case to assist the parents in finding solutions to the issues that are making their children unsafe. Parents can be granted Improvement Periods by the Court. During these Improvement Periods, they must cooperate with their plan and

complete services identified to help make their children safe. At the end of the time allotted by the Court, all parties reconvene in front of the judge and present evidence. The judge can then make the decision to terminate parental rights if they don't feel enough change has been made to keep the children safe.

Due to extreme substance abuse issues and a lack of available treatment, many times the conditions listed above are present. The Adoption and Safe Families Act requires that termination of parental rights be considered when children have been in foster care 15 of the last 22 months.

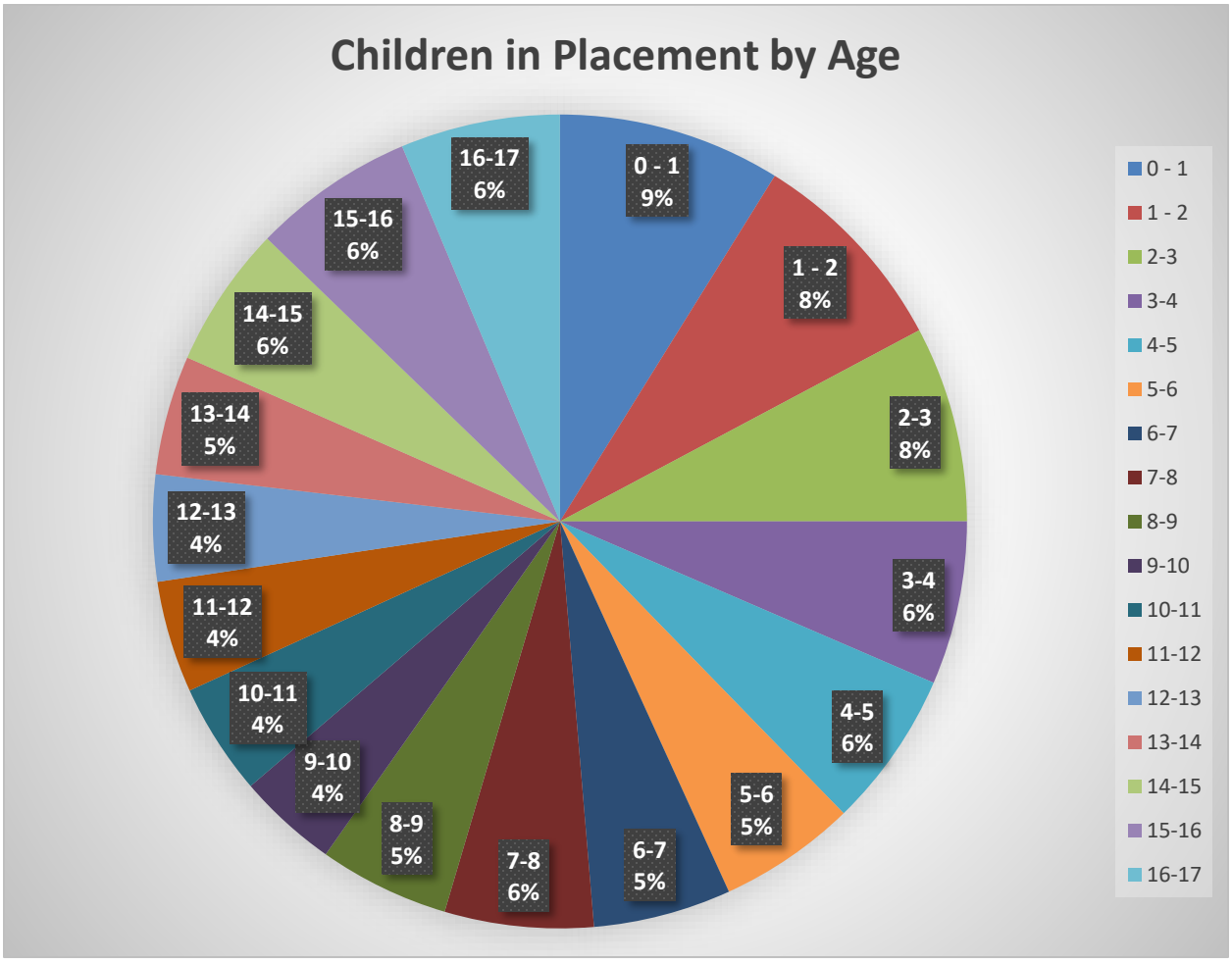
The WV Department of Health and Human Resources (DHHR) is not comfortable with the rate of parent's rights being terminated in this state. The Department submitted a Title IV-E waiver application with the hope that by re-allocating existing funding, we can develop a model that will eventually allow financial and service resources be moved to preventative measures with all West Virginia children and families that come to the attention of the Bureau for Children and Families.

The Department believes that if targeted, trauma informed, and comprehensive community services are wrapped around youth and their families, we can reunify them, prevent an initial placement and most importantly, keep youth in their communities. The West Virginia waiver demonstration project has focused on youth 12-17 years of age in state and out-of-state congregate care. The demonstration started in the 11 counties in Region II and the identified counties of Berkeley, Jefferson, and Morgan in Region III. These two identified areas were selected due to their readiness and need. Region II has been identified as an area that has extensive partnerships and a wealth of services. The three counties located in the Eastern Panhandle of Region III have a large number of children in congregate care and a lack of services. Service development was necessary in those counties. The Bureau for Children and Families believed that if we developed the necessary services and demonstrated success in in those areas that we will be able to systemically replicate successfully throughout the state. The DHHR expects to roll out Safe at Home to additional counties in June 2016.

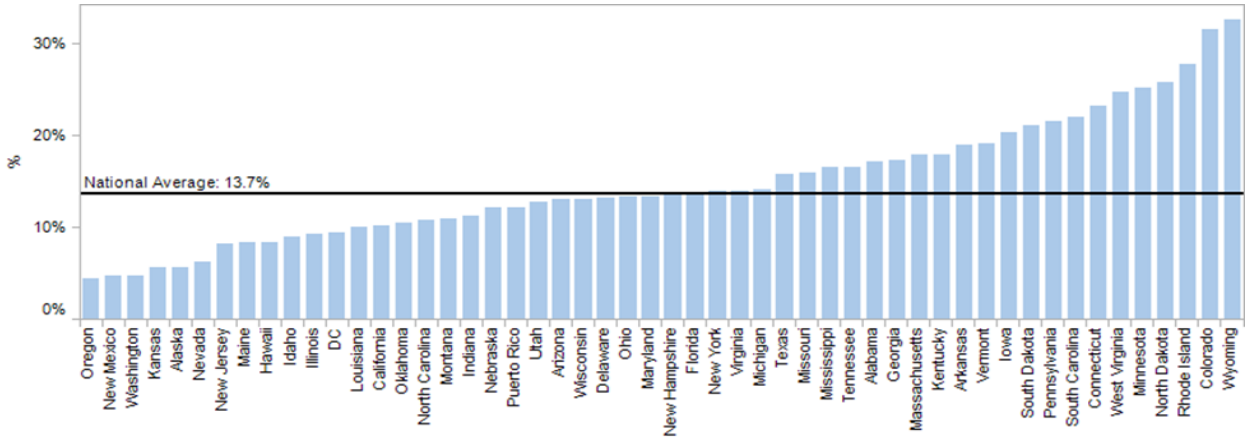
Along the same lines, WV has been researching the Sobriety Treatment and Recovery Team (START) Model and plans to implement this program in piloted areas in the near future. The program is designed to meet the needs of young children with substance-abusing parents involved with the child welfare system. It uses an intensive intervention model that integrates addiction services, family preservation, community partnerships, and best practices in child welfare and substance abuse treatment. The program aims to reduce recurrence of child abuse and neglect, improve substance abuse disorder (SUD) treatment rates, build protective parenting capacities, and increase the state's capacity to

address co-occurring substance abuse and child maltreatment. It was adapted in 2006 from the START model developed in Cleveland, Ohio, and has been used successfully in Kentucky.

2017 Update



1.5 Reduce the percentage of children in congregate care through the Safe at Home WV Project by October 2019.



Rationale

West Virginia's data indicate that a large portion of youths in out-of-home placements are in congregate care, ranking in the top six in the country. West Virginia data indicates that 61% of youth ages 12-17 who were in care on September 30, 2013, were in congregate care. This is an increase from the proportion in group care in FY12, and is considerably higher than the national indicator.

Tasks

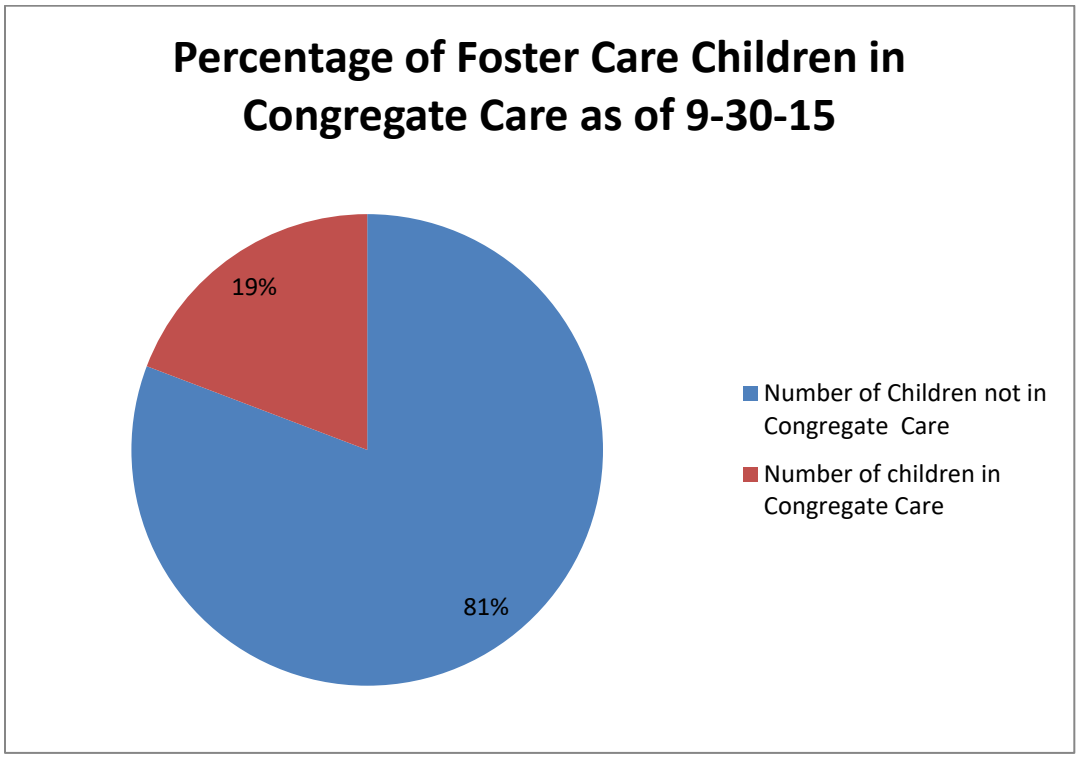
The West Virginia Department of Health and Human Resources has submitted a IV-E Demonstration Waiver application due to our high percentage of children in congregate care. Our goal is to develop a trauma-informed and evidence-informed Wrap-around model based on the national Wrap-around initiative. As a result, we will increase the available services to our families and youth within their communities, both formal and informal. Through this we will increase the number of families and youth served within their communities (reference service array section for plan). If the waiver is received, implement the plan according to the timeframes in the waiver.

Update

IV-E waiver has been approved. Measurement and benchmarks are to be established through IV-E demonstration project. Implementation begins October 1, 2015. See IDIR for more details.

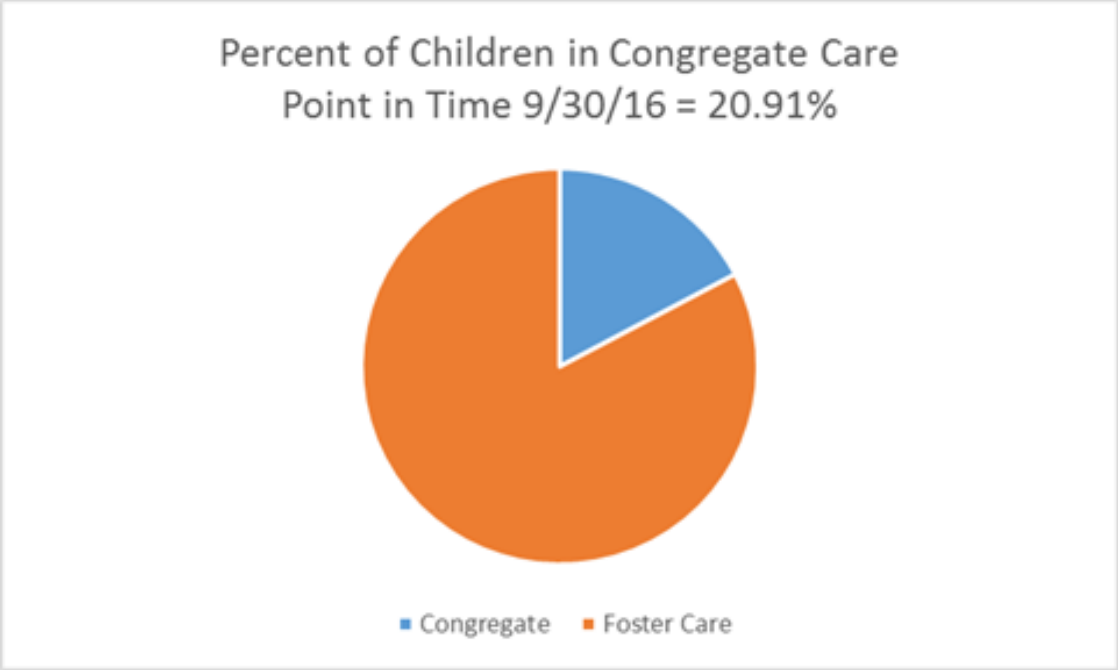
2016 Update

Current Casey Date indicates that although West Virginia currently has more children in care, the percentage of children ages 12 through 17 in congregate care has remained the same.



2017 Update

The West Virginia Department of Health and Human Resources is approved to run a Title IV-E Demonstration Waiver Demonstration Project. We have developed a trauma-informed and evidence-informed Wraparound model based on the national Wraparound initiative. As a result, we have increased the available services to our families and youth within their communities, both formal and informal. Please refer to section 9 regarding the Waiver Demonstration Project and West Virginia's Semi-Annual Progress Report.



1.6 All children in West Virginia will be safe from trafficking.

West Virginia will be using data from the Office of Research and Strategic.

Rationale

West Virginia recognizes the need for policies or procedures to ensure that victims of sex trafficking are considered victims of child abuse and neglect and sexual abuse. The **West Virginia Human Trafficking/Civil Rights Task Force** is currently in its early stages of working to improve the WV response to Human Trafficking. The membership of the task force already includes representatives from each discipline recommended by the document collaborating with Youth-Serving Agencies to respond to and Prevent Sex Trafficking of Youth, developed by the Capacity Building Center for States. We have recently hired a Human Trafficking Coordinator. The individual serving in this role comes to us with experience working with survivors and an intense passion to end human trafficking. One of the initial responsibilities will be to coordinate the communication loop with statewide task force membership, as well as assigning parties to the task force sub-committees specific to each individual item on the work plan. One of the key tasks on the work plan will be cross-system coordination of services delivery for victims.

Measurement Plan: Track the number of referrals which were accepted due to trafficking.

The Bureau for Children and Families will develop intra-agency screening and response tools to assist in the identification and servicing of youth and young adults not in foster care, who may be victims of human trafficking. This screening tool will be used across multiple programmatic areas, including customers who may be applying for TANF, SNAP or Medicaid benefits. Once a victim of human trafficking is identified, despite which avenue of entry, a referral will be made to child protective services for assessment of service needs.

Benchmarks:

Baseline: West Virginia currently has no baseline for victims of trafficking. In the next year, the Bureau for Children and Families in collaboration with other members of the West Virginia Human Trafficking/Civil Rights Task Force will develop a tool to track victims of trafficking.

Tasks

- Ensure all children assessed by the Department are assessed for history of possible trafficking.
- Provide every child in foster care age 14 and up a document that describes the rights of the child with respect to education, health, visitation and court participation, the right to be provided with the documents specified in section 475(5)(1) and the right to stay safe and avoid exploitation;
- Establish or designate a state authority responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards including those related to admission policies, safety, sanitation and protection of civil rights and which permit the use of reasonable and prudent parenting standards.
- Develop policies and procedures for identifying, documenting and determining appropriate services for any youth for whom the agency has responsibility for placement, care, or supervision or youth who are not in foster care but are receiving services when there is reasonable cause to believe that youth is, or is at risk of being a victim of sex trafficking;

2017 Update

West Virginia has an existing Human Trafficking and Civil Rights Task Force, comprised of federal, state, and local agencies. The Bureau for Children and Families has staff members who are part of this statewide task force. This task force meets at least quarterly and more often when necessary. The task force is grant funded by The Sisters of Saint Joseph's, out of Wheeling, West Virginia. The task forces purpose is to raise awareness, develop statewide protocols and screening tools regarding potential human trafficking survivors, and develop and provide statewide trainings to the necessary disciplines that will likely encounter human trafficked victims.

A survey was developed by the West Virginia State Human Trafficking Task Force coordinator and members of the services subcommittee. The results of this survey show the specific services that are provided by several individual service providers across the state and the populations that they serve. Those served by these providers include: minors, females, males and transgender. The services range widely and include: shelter, case management, 24-hour response, transportation, and medical, case management, legal, translation, advocacy, education, and screening. Many of the service providers are either human trafficking specific or human trafficking informed. The service providers include medical centers and hospitals, emergency shelters, child advocacy centers, domestic violence resource centers, and victim's services within certain prosecuting attorney offices.

The task force is also working to recognize service deficits and barriers to address and work to correct those issues. There will be a statewide human trafficking training during the second half of 2017. This training will focus on a uniform statewide protocol for individual disciplines as well as screening tools specific to those disciplines.

Foster care policy has been updated to include signs of sex trafficking and labor trafficking as well as examples of both forms of trafficking. Updates also include protocol for field staff should they identify a trafficking victim. Protocol requires an assessment and notifying law enforcement immediately but not later than 24 hours of receiving a referral or suspecting trafficking of a minor youth.

The passage of House Bill 2318 amended Chapter 49: Child Welfare, of the West Virginia State Code, terms any minor victim of human trafficking an abused and neglected child who is eligible to receive services.

http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=HB2318%20SUB%20ENR.htm&yr=2017&sesstype=RS&i=2318

Goal 2: West Virginia's children will achieve permanency timely.

2.1. Improve timeliness to permanency by more timely and effective use of family assessment and case planning by December 2017.

Rationale

One of the key indicators of how well districts perform on the Child and Family Services case review process is the staffing pattern of the district. Districts that experience a staffing shortage due to staff turnover, rate significantly lower on all measures. All the districts reviewed in Federal Fiscal Year 2014, indicated significant staffing issues at the time of the exit as a factor contributing to the area needing improving.

Overall measurements indicate case planning in occurring in 79.20% of the cases. The cases reviews indicate that this measure is being achieved in placement cases with court oversight and the case planning process is governed by court involvement. When interviewed parents and youth indicate they feel they have had involvement in their case plan; however, data suggests that non-placement cases without court oversight do not. Data also indicates although the planning and development of the case plan may involve the youth and family there appears to be a breakdown in the implementation and engagement of families after the development of the case goals, as indicated in the frequency of caseworker visits with non-placement youth and parents.

WV recognizes the importance of family engagement to achieve the permanency goal of reunification, or to identify the necessity of moving on to a different permanency goal. 2008 CFSR indicated parent contact as an area needing improvement, and WV developed a PIP to address the areas needing improvement. PIP strategies included the implementation of PCFA as a model for improving family engagement in CPS cases. WV met its negotiated PIP improvement goal at 16.60% of cases reviewed showed parent contact as strength. WV implemented the PCFA process statewide; however, current case reviews indicate a lack of consistent use and family engagement in case planning, demonstrating the need for WV to refocus on the implementation of the PCFA process.

Measurement Plan:

West Virginia will utilize the Child and Family Service style case reviews to monitor the improvement in time to permanency. 2014 Child and Family Review instrument will be utilized for ongoing measurement. Permanency Outcome 1, 2, and Wellbeing Outcome1 will be used to monitor improvements.

Baseline measurement indicates Permanency Outcome 1 was achieved in 50.5 % of the cases reviewed. Permanency Outcome 2 was achieved in 94.1% of the cases reviewed. Wellbeing Outcome 1 was achieved in 51.9 % of the cases reviewed.

****Baseline measurement indicates all case (placement and non-placement) rated as strength in Federal Fiscal Year 2013. *2008 CFSR instrument utilized for case review data.*

Benchmarks:

Permanency Outcome 1

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
50.5 %			-	60%	65%

Update:

2013	2014	2015	2016	2017	2018	2019
50.5%	52.0%	40.88%	18.3%			

**West Virginia utilizes a 14-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2017. Case review should begin to demonstrate improvement by 2018.

Benchmarks:

Permanency Outcome 2

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
94.1%		-	-	95%	97%

Update:

2013	2014	2015	2016	2017	2018	2019
94.1%	91.1%	73.7%	76.4%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2017. Case review should begin to demonstrate improvement by 2018.

Benchmarks:

Wellbeing Outcome 1

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal

FFY 2013	2015	2016	2017	2018	2019
51.9%		-	-	50%	60%

Update:

2013	2014	2015	2016	2017	2018	2019
51.9%	42.6%	32.4%	15.4%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2017. Case review should begin to demonstrate improvement by 2018.

Tasks

- Identify districts that are successfully utilizing the Protective Capacities Family Assessment (PCFA), analyze why they are successful, and identify the barriers. Develop a plan to improve performance and address barriers in other districts based on the information by December 2014.
- Provide refresher training to staff on the PCFA and case planning process, as well as activities to re-engage staff to the PCFA process, by December 2015.
- Re-implement the PCFA supervisor proficiency assessment process and track completion of staff consultation on all stages of the PCFA by March *2019*.
- Monitor quality of casework through the DPQI case review process and implement corrective action plans when there are identified deficiencies by December 2017.

2015 Updates

West Virginia completed an analysis of all districts to determine why some were successfully implementing the PCFA process and others were not. The following counties have successfully implemented the use of the PCFA: Wood, Monongalia, Cabell, Putnam, Logan, Randolph/Tucker, Lewis/Upshur, Fayette, Greenbrier/Monroe/Pocahontas/Summers, McDowell, Mercer, Nicholas/Webster, Raleigh, and Wyoming. These counties have had refresher training and now have the ability to complete these assessments in our Families and Children Tracking System (FACTS). Full implementation of the PCFA will be completed by March 31, 2016.

It was determined that districts that completed quality PCFA's within the time frames did so due to lower staff turnover and smaller caseloads. Commissioner Exline requested additional staff during the last Legislative Session.

The Division of Planning and Quality Improvement continued to identify Districts that need additional supports to make improvements in family engagement. DPQI, in conjunction with the District's management staff, developed a plan to address the barriers to successful family engagement. The Division of Training has provided refresher training to the identified Districts.

West Virginia continues to develop strategies for improving family engagement. West Virginia's 2015 Legislative session passed of Senate Bill 393 which will utilize court oversight to monitor plans to transition youth placed out-of-home back into their home setting with community services within 90 days of placement. West Virginia is in the process of implementing the Safe at Home IVE waiver grant, which utilizes a family-centered approach to working with children and families.

In the last 6 months, BCF/Division of Training has completed PCFA refresher training for tenured staff in 17 counties around the state and will continue to provide the training as requested. Protective Capacity Family Functioning Assessment training is incorporated into Child Protective Service Worker new worker training.

2016 Updates

The four Child Welfare Consultants that are responsible for each of the four Regional Adoption and Homefinding units have developed a resource to present to all child welfare workers and supervisors during unit meetings that explains the process to permanency. It is anticipated that having the Consultants work directly with the supervisors and workers to provide assistance that we will be able to more timely bridge the gap to permanency for youth in our care. The Consultants will review the process from diligent search to permanency with the workers and supervisors. This includes the homestudy process, diligent search for kinship/relatives, Multi-Disciplinary teams, dispositional staffing, and timely adoption case transfers. The four Child Welfare Consultants that are responsible for each of the four Regional Adoption and Homefinding units have developed a resource to present to all child welfare workers and supervisors during unit meetings that explains the process to permanency. It is anticipated that having the Consultants work directly with the supervisors and workers to provide assistance that we will be able to more timely bridge the gap to permanency for youth in our care. The Consultants will review the process from diligent search to permanency with the workers and supervisors. This

includes the homestudy process, diligent search for kinship/relatives, Multi-Disciplinary teams, dispositional staffing, and timely adoption case transfers.

West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2017. Case review should begin to demonstrate improvement by 2018.

October 1, 2014 - September 30, 2015

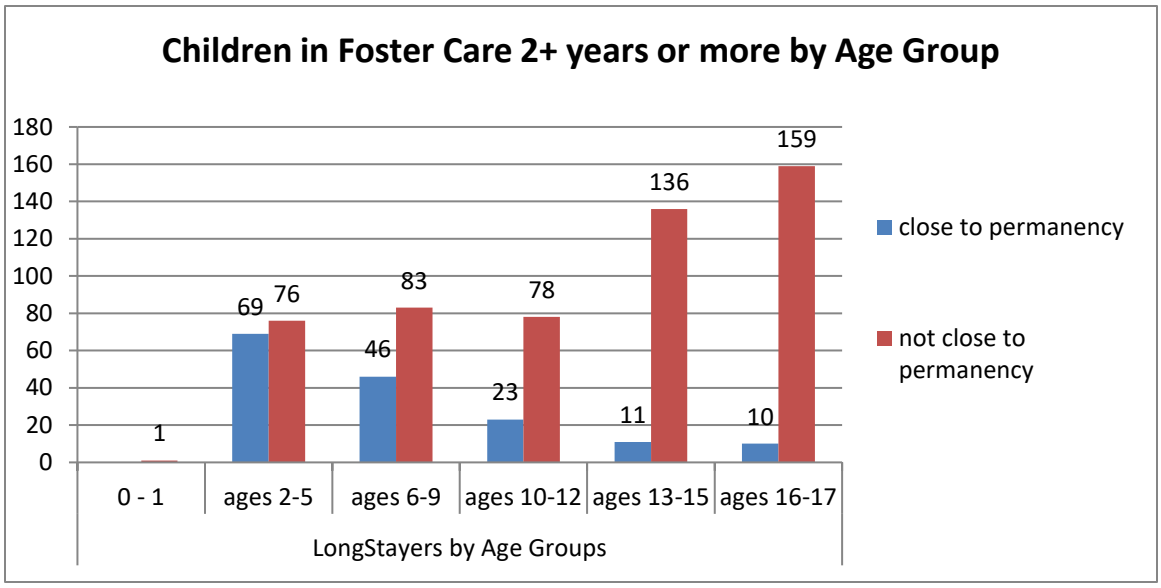
All Cases Outcome or Performance Indicator

	Outcome Ratings		
	Substantially Achieved	**Partially Achieved**	**Not Achieved**
Outcome P1: Children have permanency and stability in their living situation	40.8%	52.6%	6.6%
Outcome P2: The continuity of family relationships and connections is preserved for children.	73.7%	22.4%	3.9%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	32.4%	37.3%	30.3%

2017 Update

Outcome P1: Children have permanency and stability in their living situation	18.3%	64.8%	16.9%
Outcome P2: The continuity of family relationships and connections is preserved for children.	76.4%%	22.2%	1.4%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	15.4%%	30.1%	54.5%

2.2 Reduce the number of children in foster care 24 months or longer by 25% by October 2019.



Rationale

Recent emphasis has been placed on reviewing cases of children and youth who have been in foster care for a long period of time. Recent data reveals there are 692 children and youth who have been in foster care for two or more years, or 15% of the children in care. The percentage increases as the age of the child increases, with 20 of children 13 to 15 and 23% of children 15-17 in placement for two or more years. West Virginia must analyze this data to determine the causes of children being in lengthy placements and take appropriate steps to reduce the amount of time children are in care.

Measurement Plan:

West Virginia will utilize AFCARS data to measure the length in time of care.

Baseline data indicates there are 692 children and youth who have been in foster care for two or more years, or 15% of the children in care. The percentage increases as the age of the child increases, with 20% of children 13 to 15 and 23% of children 15-17 in placement for two or more years.

Benchmarks:

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
March 2014	**2015**	**2016**	**2017**	**2018**	**2019**
692	658	624	590	556	522

Update:

2013	2014	2015	2016	2017	2018	2019
692	658	633	661			

Tasks

- Develop a review tool for children in foster care 24 months or longer to identify and better understand the issues related to delays in achieving permanency and a plan developed to address the issues by December 31, 2015.
- Work with the Court Improvement Program to review children in foster care 24 months or longer through the New View project, including analyzing results and developing a plan to address identified trends a minimum of two times per year by December 2016.
- Work with the Court Improvement Committee Data, Statute and Rules committee to identify and address issues identified related to the court system by December 2017.
- Expand the use of Regional Clinical Reviews to identify barriers in the permanency process with all cases of children in care for two or more years by October 2019.
- Establish a process to monitor the regularity of judicial reviews and permanency hearing and the establishment and reevaluation of placement plans.

Update

West Virginia continues to work with the Court Improvement Program to review children in foster care 24 months or longer. The New View project has identified barriers to permanency on a case by case basis. The report should be available in the fall of 2015.

The benchmark date for the first task, developing a review tool, is being changed due to Safe at Home implementation. The new target date will be June 2016.

The purpose of the out-of-state reviews is to identify treatment and services needs and assist the DHHR case worker with discharge planning. The process is standardized and was conducted in each DHHR region. There have been two out-of-state reviews completed to date.

The first review was from April – July 2014. A total of 205 children/youth were reviewed. Thirty-one percent were child protective services cases and sixty-nine percent were youth services cases

The second review was from March – April 2015. A total of 117 children/youth were reviewed (unduplicated from previous year). Twenty-one percent were child protective service cases and seventy-nine percent were youth service cases.

Since the second review, the oversight team has reviewed and revised the forms and will be implementing this process statewide on a regular basis to provide assistance and support to DHHR staff and track system changes and improved outcomes.

2016 Update

The passing of Senate Bill 393 in the 2015 legislative session included an amendment to code section 49-4-403. The amendment to this section requests the DHHR to coordinate with the court to establish, at least, one day per month in which MDTs are to occur. This effort is to ensure every child who has an MDT can enjoy maximum participation by attorneys, family members, and school personnel who often find it difficult to attend.

A Court SOP draft was discussed and released in January 2015 at a Field Operations Management (FOMT) meeting. This meeting included the Deputy Commissioner for Field Operations (one at that time) and four Regional Directors. The SOP and related tools had been developed by a statewide committee in 2014. In addition to the SOP a tracking form, court note sheet and desk guide were also released. The draft was updated into the final draft attached here and sent along with the other documents to the Deputy for Field Operations and the RDs in February 2015.

Many districts have implemented this recommended SOP and use some or all the tools – court note sheet, log, and desk guide.

Other than these draft releases and recommendations for use, there has been no other release of the Court SOP and related documents. BCF is presently reviewing the SOP and related documents. This this review will include a legal review by newly hired counsel for BCF. BCF has a target timeframe for review and release of a revised SOP and the

related tools of July 2016. BCF is already of aware of the need to revise to better track foster parent notification, attendance at hearings and notation of their right to be heard.

State Review Team

A State Clinical Review Team will be operational by June 2016. The State Clinical Review Team will review children/adolescents that have been in congregate care in-state or out-of-state and are no longer progressing, are unable to transition due to lack of a biological, adoptive or foster family, or have a diagnosis that is preventing them from a less restrictive level of care. The team members include but are not limited to Bureau for Children and Families (adult services as needed); Bureau for Behavioral Health and Health Facilities (IDD Division, Adult MH Services, Children MH and Substance Abuse); Bureau for Medical Services ; Policy Representative; DHHR Program Manager (based on the child reviewed); Experts in the areas of Trauma, Substance Abuse/Use, Traumatic Brain Injury and Intellectual and Developmental Disabilities, Severe Mental Health Disorders, and Sexual Abuse and Abuse/Reactive issues.

Out-of-State Review Team

The purpose of the Out-of-State Review team is to identify gaps in services, system issues and barriers to keeping youth in-state for services or returning the youth to West Virginia from out-of-state services. The process also assists the DHHR worker in discharge planning.

- From April 2015-March 2016, 191 Out-of-State Reviews were completed.

Regional Clinical Review Team

- From April 2015-March 2016, 68 youth were reviewed through a Regional Clinical Review Team.
- 66 of the youth were at risk of going out of state for services.
- The team recommended that 39 youth remain in-state and 7 youth were recommended to remain in-state but if services could not be secured, then they were to be placed out of state.
- A youth must remain in state at least 4 months after the team makes the recommendation in order for the recommendation to be considered as being followed. 31 kids fall within the guidelines.
- Out of those 31 kids, 25 or 81% were prevented from going out of state.

	2013		2014		2015	
	Average (days)	**Percent Compliance**	**Average** (days)	**Percent Compliance**	**Average** (days)	**Percent Compliance**
Time to Permanent Placement (Compliance Limit – none)	491.5	none	439.5	None	427.0	none
Time to First Permanency Planning Determination (Compliance Limit – none)	283.9	none	265.2	None	254.0	none
Judicial Permanent Placement Reviews (Compliance Limit – 93 days)	86.4	77.70%	86.5	76.40%	83.1	78.00%
Disposition to Permanent Placement (Compliance Limit – 543 days)	183.3	89.70%	144.4	93.80%	142.3	94.00%

Goal 2.3 Increase foster care and kinship care homes to reduce the number of children placed in residential treatment centers and address the needs of children entering placement.

Rationale

West Virginia leads the nation in the number of children placed in congregate care per capita. Research has shown that children in congregate care do not have as good outcomes as children placed in family based care.

Measurement Plan

Please refer to West Virginia's Initial Design and Implementation Report located on our website; http://www.wvdhhr.org/bcf/safe/ .

Tasks

- Work with CIP to establish plans to address delays in finalizing adoptions. – check original CFSP
- Consult with the National Resource Center for Diligent Recruitment to develop strategies to improve agency's response to Foster care and adoption inquiries.
- Reduce the delays in providing training for foster care families by developing an online training.
- Expand the use of Morpho Trust CIB machine to allow potential foster parents to receive CIB printing in a timelier manner by January 2018.
- Develop protocol for the collection of data related to the timeliness of the completion of home studies by January 2016.

2015 Updates

The West Virginia Department of Health and Human Resources has been looking at caseloads across the state, as well as the number of inquiries that each region is receiving regarding individuals interested in becoming foster care providers. Due to the volume of both, as well as the increased focus on kinship/relative care providers, the Department has determined that it does not have the number of staff required to adequately handle foster care inquiries without additional positions being granted. At this time, the Department is no longer accepting new inquiries for foster care providers. All new foster care providers must go through the private foster care providing agencies for certification. The Department will, however, continue to work with new and existing kinship/relative provider homes.

When an individual contacts the Department to show interest in possibly becoming a certified provider, the Department employee who receives the inquiry will provide the caller with the contact information for Mission West Virginia, informing them that they need to call Mission West Virginia for further assistance. Mission West Virginia will then send out an inquiry packet to the caller with information on all the private foster care agencies, and will also continue to follow up with the caller to help them through the process of deciding which agency will best meet their needs.

When the applicant chooses an individual agency, the application packet will be sent to the selected agency to begin the certification process.

West Virginia has met with the National Resource Center for Diligent Recruitment to develop strategies to improve agency's response to Foster care and adoption inquiries. The Department currently has 1,338 inquiries to provide foster care that have not been

addressed. The state will modify its request to the NRC-DR to address studies being forwarded to the private agencies.

2016 Updates

In the spring of 2015, West Virginia enlisted the help of the National Resource Center for Diligent Recruitment (NRC-DR) to help develop a plan to address over 1300 inquiries for resource homes that had gone unattended. By the summer of 2015, BCF Leadership made the decision to send those inquiries to private agencies so that agency staff could focus their attention on the growing number of Kinship and Relative homes. Later in the fall of 2015 the NRC-DR was contacted again for help in initiating this process.

After several on-site meetings, a plan was developed that includes inquiries be handled through increasing the state's contract with Mission, WV and referring those interested in foster care to private agencies.

The process calls for Mission, WV to receive all calls from the public requesting to become foster parents, send those families information packets, and make the referral to the agency selected. This process allows all inquiries to be tracked and insures follow up until an agency is selected.

After an agency is selected, Mission, WV will continue to follow up with the family to insure the private agencies have the resources to meet the needs of the families. BCF is currently working to develop a process to track the inquiries received by Mission, WV through to certification by the private agency.

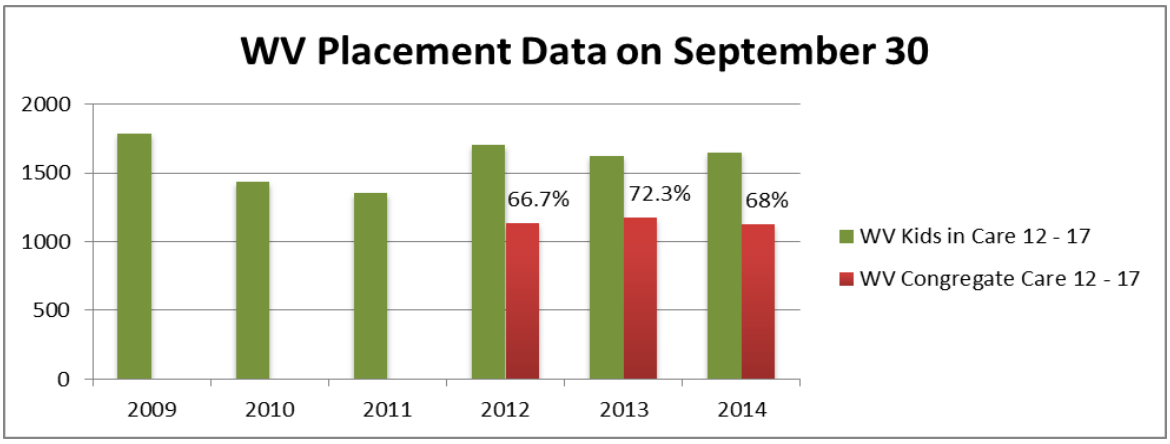
Sending inquires to private agencies will also help alleviate delays in foster parent training. Private agencies can utilize the states Social Work Education Consortium training but currently can provide training one on one with potential foster parents who must miss a session due to unforeseen circumstances. Due to the volume, this was never a viable option for home finders employed by the state.

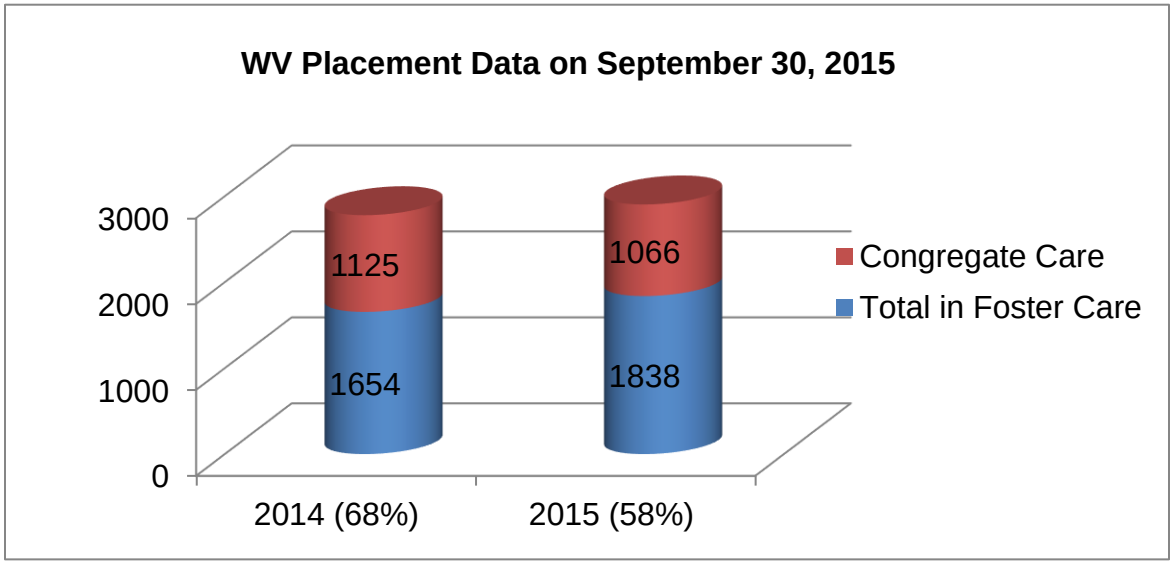
Between 4/1/16 and 3/31/17, 1759 inquiries were received by Mission WV. 36 were certified as of June 8, 2017. Over those same dates, a total of 130 families were certified. Their inquiry dates span from 2/2/10 to 9/22/16.

Goal 3: West Virginia's older youth will have more coordinated, integrated services that will maintain them safely in their communities by 2019.

3.1 WV will provide alternative services to youth and families that will allow youth to be maintained in their communities by 2019.

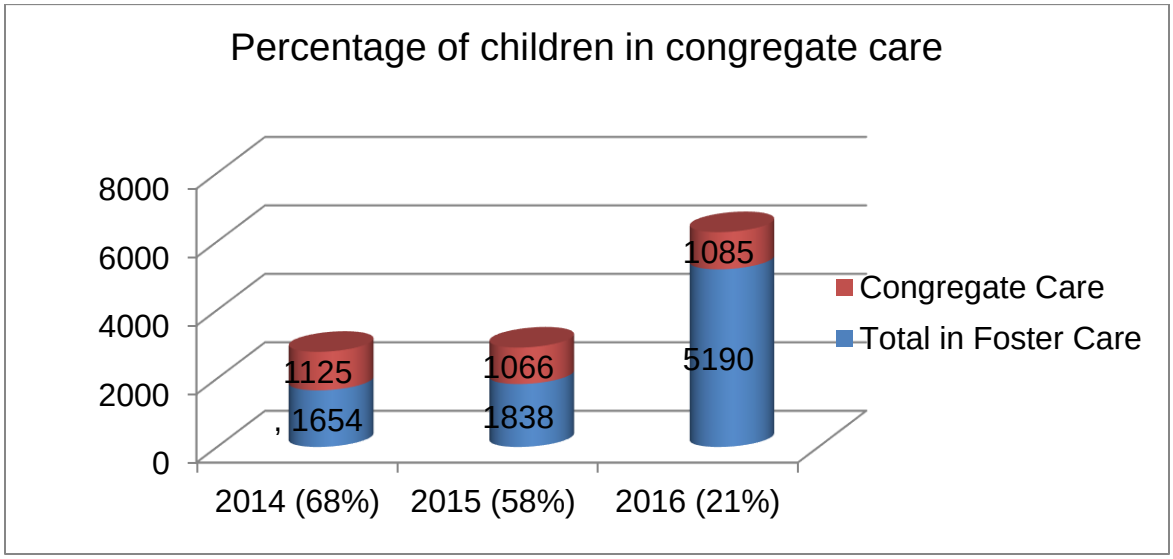
Based on the FREDI Placement Reports of Children in care at point in time (9/30) the following charts of data were created. In 2014, the number of youth in Foster Care on the 30th of September was 1,654, and of that number 1,125 were in congregate care, representing a decrease of 4.3% over 2013.

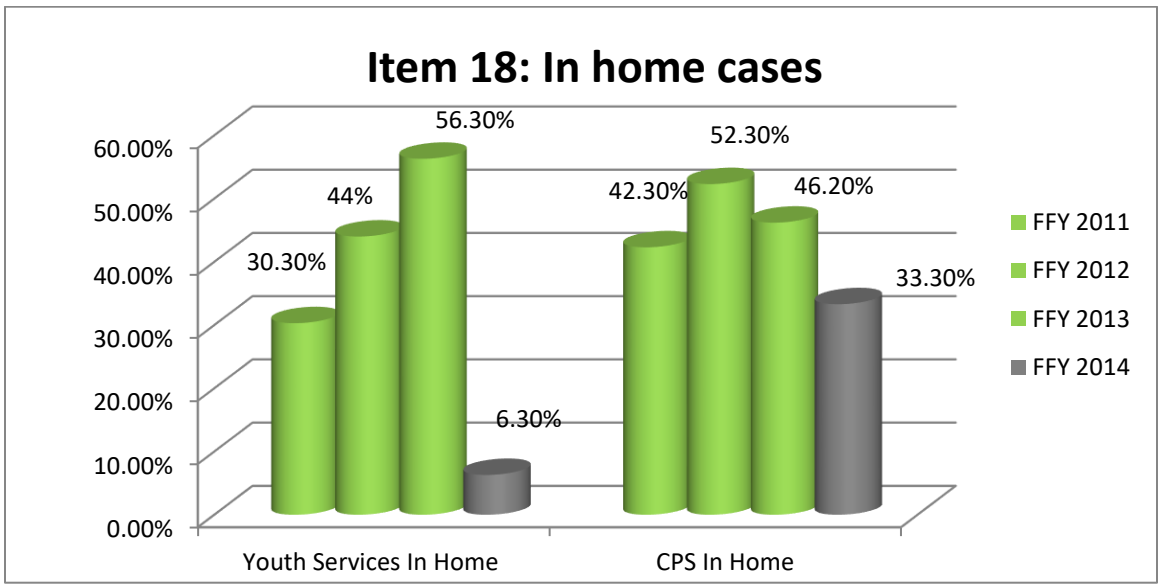


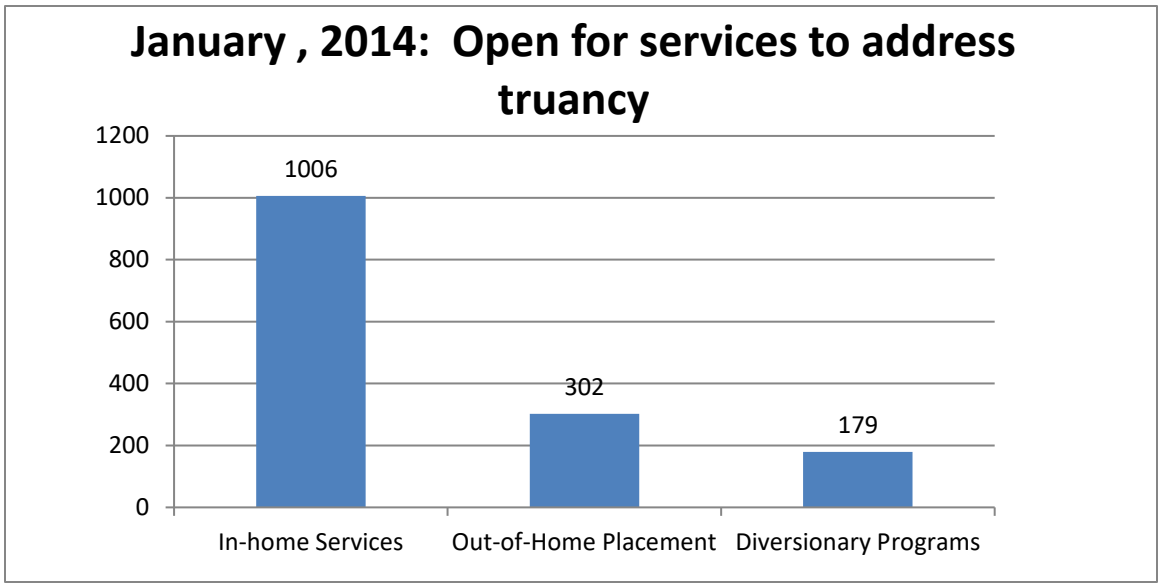


2017 Update

In the past year, the percentage of children in congregate care decreased to 21%.







Rationale

Data suggests a need to improve the practices related to the treatment and provision of services in non-placement youth services cases. Furthermore, the number of youth in congregate care ages 12-17 is well over the national average. This suggests that youth are being placed in congregate care as their needs cannot be meet within the community setting. Data collected by WV case review process indicates the need for improved services.

West Virginia recognizes the need to improve services and create services based on the needs of those served. Case reviews indicate a need for services related to substance abuse and treatment as a key area needing improvement.

West Virginia does not have an accurate data collection system to identify the reason the youth entered care through the youth services system. West Virginia has seen an increase in the number of youth involved in youth services because of truancy. West Virginia has no formalized method to track the number of children entering care because of truancy; however, informal “hand counts” and case reviews suggest a significant percentage of the youth involved with youth services come to the attention of the Department because of habitual truancy.

Point in time hand count data suggest only 179 youth involved in truancy diversion programs (13.69%). In January of 2014, hand count data indicates 1,006 Youth Services cases were opened on families to provide in-home services to address identified truancy

issues. Placements into the custody and care of the Department due to truancy issues numbered 302. Through the work and technical assistance of PEW, SAMHSA, the MacArthur Foundation and Casey Family Programs, West Virginia has identified Substance Use Disorder among youth 12-17 years of age as a primary need where truancy issues are also indicated. An appropriation of new funding was made in the Governor's budget bill for Expansion of Community-based Evidenced-based services and pilot programs for services relating to substance abuse, mental health, family functional therapies, and programs such as restorative justice. West Virginia plans to release grants to implement Evidence Based Curricula (Prime for Life, SMART for Teens or Creating Lasting Family Connections). Additionally, West Virginia's Bureau for Behavioral Health and Health Facilities has identified and funded grantees to expand school-based mental health, and Regional Behavioral Health Youth Services Network to serve families in their communities.

Measurement Plan:

West Virginia will utilize AFCARS point in time data pull to measure the reduction of youth in congregate care. Baseline data indicates 61.1% all youth ages 12-17 in out of home care on the last day of the fiscal year are in congregate care.

West Virginia will utilize "hand count data" to indicate a reduction of youth placed in care due to truancy issues. Baseline point in time data indicates as of January of 2014, 302 youth were placed in the custody and care of the Department due to truancy issues.

West Virginia will develop methodologies for data exchange with courts and probation information systems to track the number of youth services cases where truancy petitions have been filed.

Benchmarks:

Point in time data- AFCARS

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
2012	**2015**	**2016**	**2017**	**2018**	**2019**

46.1%	42%	38%	34%	30%	26%

Update:

2013	2014	2015	2016	2017	2018	2019
61.1%	56.1%	58%				

Benchmarks:

Reduction of youth in custody due to truancy issues (5% reduction)

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
1/2014	**2015**	**2016**	**2017**	**2018**	**2019**
302	287	272	257	242	227

Update:

Point in time data- “hand count”

2013	2014	2015	2016	2017	2018	2019
	302	279				

Tasks

- Develop a framework of programs and services that address the needs of youth entering because of status offences through grant funded community-based evidence based programs for youth by July 2016.
- Through technical assistance from National Center for Mental Health and Juvenile Justice (Policy Research Associates Inc.) and collaboration with West Virginia Department of Education, Division of Juvenile Justice, and the Department implement a School-based Diversion model with a community-based behavioral health responder for screening and subsequent assessment and treatment by October 2017.

- Work with community partnerships to increase substance use disorder treatment and peer-support evidence based programs specific to youth by December 2016.

Updates

In June 2014, the West Virginia Intergovernmental Task Force on Juvenile Justice was established under the leadership of Governor Earl Ray Tomblin, Chief Justice of the Supreme Court of Appeals Robin Jean Davis, Senate President Jeffrey Kessler, House of Delegates Speaker Tim Miley, Senate Minority Leader Mike Hall, and Supreme Court of Appeals Administrative Director Steve Canterbury. The charge of the Task Force was to conduct a comprehensive analysis of the state's juvenile justice system and make recommendations that focus on protecting public safety by improving outcomes for youth, families and communities; enhancing accountability for juvenile offenders and the system; and containing taxpayer costs by focusing resources on the most serious offenders (State of West Virginia). The Task Force extensively reviewed juvenile justice data and produced a set of policy recommendations, which resulted in the writing, passage, and signing of Senate Bill 393. This comprehensive juvenile reform bill focused on reducing the number of youth and the amount of time youth spend in congregate care, requires the redistribution of funds used by the Department of Health and Human Resources (WV DHHR) and the Division of Juvenile Services to the use of evidence-based community services, and requires the use of diversion and restorative justice programs and to reduce the number of youth coming into contact with the juvenile justice system.

The understanding that many youth who come into contact with the juvenile justice system are first-time, low-level offenders, exemplifies the necessity for more diversion and restorative justice programming in the state. As a result, the WV DHHR, Bureau for Children and Families (BCF) was provided with a line-item one-million-dollar budget to provide for the establishment of two new evidence-based programs. These programs are to be provided to pilot counties experiencing high numbers of juvenile petitions, to further the mission of Senate Bill 393; to reduce the numbers of juveniles coming into contact with the justice system.

The WV DHHR will be announcing a grant to provide evidence-based programming that has been researched as a sustainable method to address our specified problems. The WV DHHR is currently reviewing two such evidence-based programs for possible implementation, Functional Family Therapy and Victim-Offender Mediation. These two programs offer substantial outcomes for juveniles, focusing on engagement of not only the youth, but their families and their communities. The DHHR will continue its efforts to identify the best programming to fund to ensure juvenile justice reform is not only successful, but sustainable.

2016 Update

The limitations on placement time and occurrences in 393 are assured by requiring evidence of specific need to remain in placement longer than 90 days for juveniles in residential care and restricting first time status offending youth from being placed in group residential care. These changes emphasize serving our youth in their communities whenever possible and limit residential to high-need youth.

In winter of 2015, the Bureau for Children and Families (BCF) received a line item budget of one million dollars to expand community based mental health services and programs for juveniles. The programs the Bureau was asked to implement were Functional Family Therapy (FFT) and Victim Offender Mediation (VOM). The Bureau solicited proposals from entities interested in providing these services. The result was FFT being offered by 9 providers serving 33 of 55 counties and 2 additional victim offender mediation programs in the state. While FFT is still in its infancy, it has currently served 14 families in need.

Public and private agencies across various service delivery systems, which historically have been “siloed”, have come together to foster communication and education. Brainstorming opportunities strengthen and develop expertise, and enhance workforce capacity. Networking effectively serves all of WV’s children who experience intellectual/developmental disabilities (I/DD) and co-existing mental illness who require complex multi-tiered supports.

Some examples of this effort are the cross-systems work products. In 2013, the first Integrated Behavioral Health Conference occurred. The conference was held to educate providers I relevant topics related to behavioral health. In 2015, the conference focused on “Building Trauma Informed Systems of Care.” A year-long Technical Assistance grant from SAMHSA’s National Center for Trauma Informed Care (NCTIC)

Silo Spanners is subcommittee of the Service Development and Delivery Work Group. Silo Spanners brings together a diverse group of entities representing Child Welfare Residential and Foster Care providers, I/DD Home and Community Based Waiver and ICF/IID providers, DHHR Bureau for Behavioral Health and Health Facilities, Bureau for Children and Families, Comprehensive Community Mental Health Centers, WV Developmental Disabilities Council, WV Autism Training Center, WVU Center for Excellence in Disabilities, Association for Positive Behavior Support Network, Mental Health therapists, & Division of Juvenile Services.

Accomplishments to date:

- Cross-systems and cross-disability awareness and recognition of service needs and gaps for this population;

- Catalogue of areas of expertise and experience of each member, geographical location and contact information for purposes of technical assistance and integrated service planning/delivery;

- Development of basic training entitled “Developmental Disabilities and Co-Existing Disorders: An Overview” along with a Training of Trainers curriculum. It is cross-sector training that also serves as relationship-building opportunities for providers in the mental health, IDD and child welfare systems;

- Planned and presented workshops at BBHHF Integrated Behavioral Health Conference, e.g., Developing Therapeutic Relationships with Individuals on the Autism Spectrum; Trauma Informed Treatment for Children with IDD.

2017 Update

The BCF has lost several providers of FFT and VOM. FFT currently maintains three (3) teams and provides service to sixteen (16) counties, while VOM maintains two (2) VOM sites in the state and provides service to twelve (12) counties.

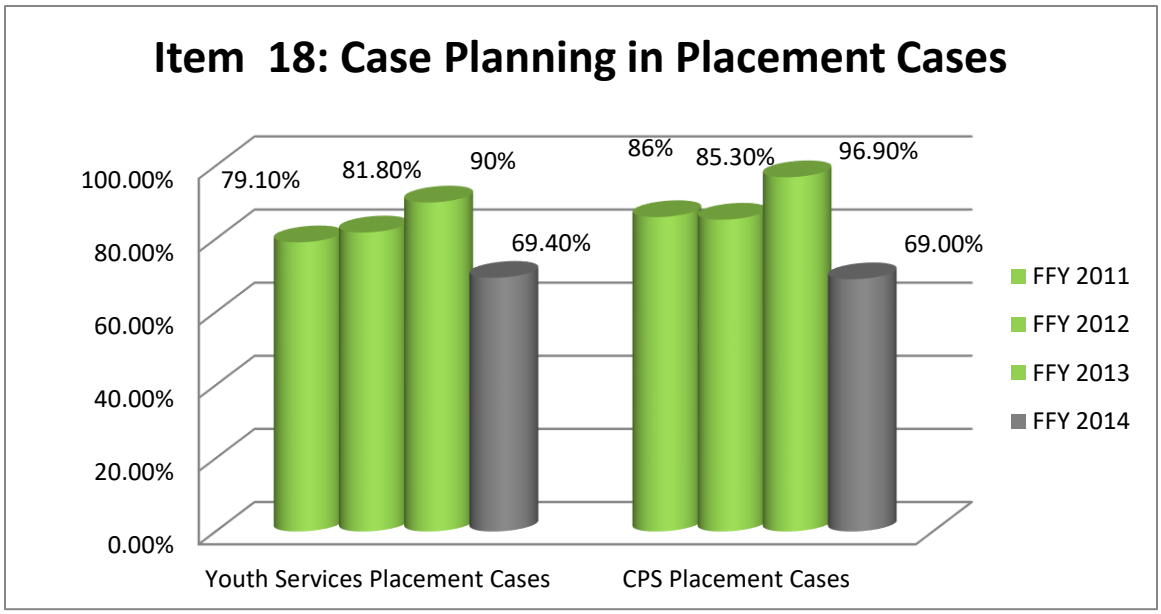
West Virginia recently identified the extraordinary need to reduce the number of children ages 12-17 coming into congregate care. West Virginia maintained the highest number of youth residing in congregate care in the nation, explicitly pointing to the need to increase community service accessibility and capacity. West Virginia needs our service array to become more coordinated and integrated into the fabric of our youth’s communities from which they are so frequently removed. In reviewing data to determine our primary system-entry point leading to removal, we determined that juvenile petitions for truancy were the number one factor causing placement. We began a structure of district level hand counts to collect data on truancy to establish our baseline and measure our yearly reductions.

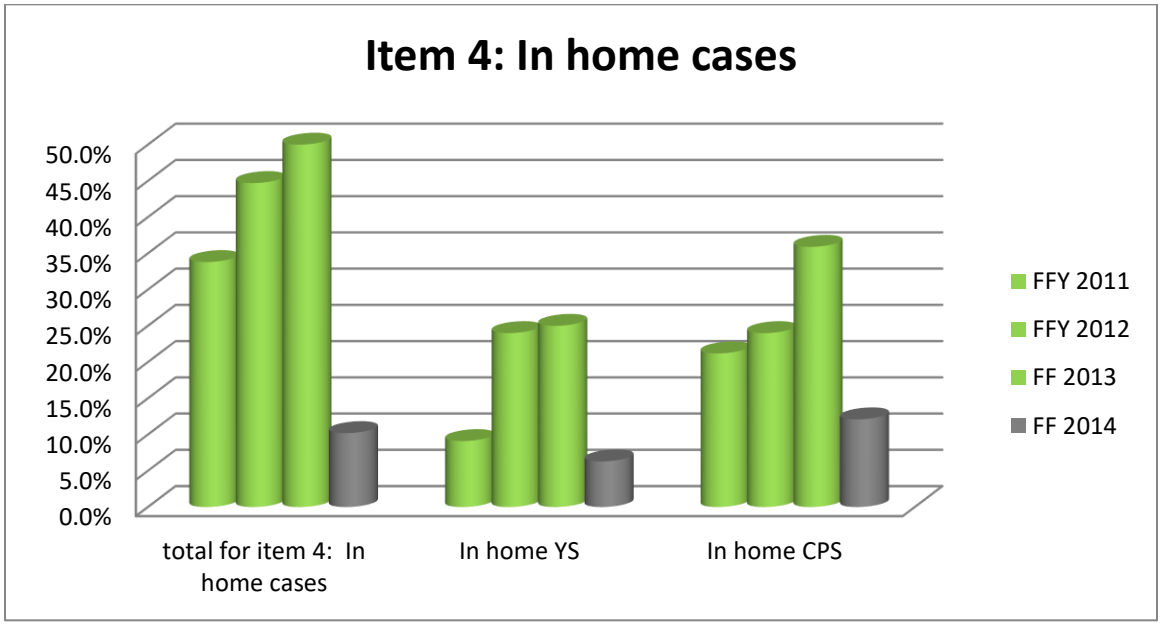
Since the inception of this goal West Virginia has passed legislation which has required our education system to improve its response to truancy in our state thereby lessening many of the unnecessary referrals to the court. Some examples include, funding to the Department of Education for truancy specialists, a tiered system of notifications to the family that truancy is becoming a problem, a mandate that the parents of truant youth are

petitioned against instead of the child, the mandate that all first-time status offenders be diverted from the court to a truancy diversion specialist, probation officer, or department worker. These changes in conjunction with the department's Safe at Home program will inevitably continue to reduce congregate numbers for truancy related offenses. West Virginia, however has identified a larger problem, the opioid epidemic. While West Virginia will continue in its goal to improve service integration and coordination in the community, we will no longer be measuring success by tracking a reduction in truancy cases.

The substance abuse and opioid epidemic that is ravaging our communities has created a situation in which our district office can no longer focus on hand counting truancy cases. We understand that many of the truancy related problems youth face is symptomatic of a much larger problem. We recognize that opioid addiction is often a direct feeder to the problem of truancy. As we continue to fight the opioid crisis, we have determined that by measuring the reduction of congregate care, as opposed to a focus on truancy cases, relief will be provided to district offices allowing them to focus more on the major crisis'. We also realize that the overall tracking of congregate care reduction will provide insight in to the larger picture of service development and coordination. We believe that by showing an overall reduction in congregate care totals for youth ages 12-17 we will show an overall growth in our service array.

3.2 WV will increase the involvement of youth and families in the provision of treatment and services through the restructuring of West Virginia's youth services program by 2019.





Rationale:

Case review data indicates a significant need to improve youth and family involvement in the case planning process. Data also indicates a need for improvement related to the continued assessment for safety in non-placement youth services home cases.

Measurement Plan:

West Virginia will utilize the Child and Family Service style case reviews to monitor the improvement in the involvement of youth and families in the provision of treatment and services. Applicable items based on 2008 CFSR instrument are 4, 18, 19 and 20.

2014 Child and Family Review instrument will be utilized for ongoing measurement applicable items 3, 13, 14, 15.

Baseline measurements indicate the following for Federal Fiscal Year 2013.

25% of the youth services cases reviewed rated as a strength for item 4, risk assessment and safety management. 56.3 % of the youth services cases reviewed rated as strength for item 18, child and family involvement in case planning. 25% of the youth services cases reviewed rated as strength for work visits with the child. 37.5 % of the youth services cases reviewed rated as strength for worker visits with parents. **2008 CFSR instrument utilized for case review data*.

Benchmarks:

Risk assessment and safety management in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Data	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
25%	46.8%	30%	35%	40%	45%	50%

**West Virginia utilizes a 14-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Child and family involvement in case planning in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Data	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
56.3%	67.5%	61.3%	66.3%	71.3%	76.3%	81.3%

West Virginia utilizes a 14-month period under review for case reviews. **Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Worker visits with the child in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Data	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
25%	46.8%	55%				

**West Virginia utilizes a 14-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Worker visits with parents in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Data	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
37.5 %	12.5%	30%				

**West Virginia utilizes a 14-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Tasks:

Restructure the Youth Services casework practice model to more closely parallel the casework model for abuse and neglect cases by October 2019.

The Department began a data-sharing project with the West Virginia Department of Education in September of 2014. The project includes data on children in out-of-home care such as attendance and the number of schools attended (school stability measure). The Department will develop a method to expand these data-sharing initiatives among cross-system partners by July 2016.

Develop and implement a methodology to improve the continued assessment for safety for all the children in the home when a case is opened for Youth Services by October 2016.

2016 Update

Streamlining
In late 2015, BCF created a formal group to evaluate the Child Protective and Youth Service programs. The group will provide a recommendation to the BCF executive team in how best to “streamline” Child Protective and Youth Services to more closely align the two programs. Through this effort, the Department hopes to increase family engagement and involvement within the Youth Services program.

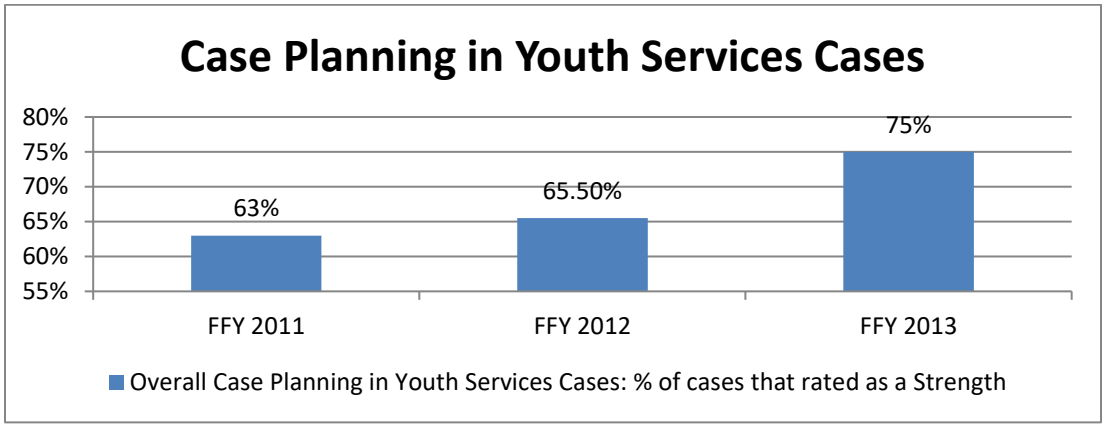
Juvenile Justice Reform
During Fiscal Year 2015, the Department began working collaboratively with major system stakeholders to develop a comprehensive data sharing agreement. The Department, the Division of Juvenile Services, The Supreme Court, The Department of Education, and Probation Services, are working with the Division of Justice and Community Services to develop a framework for data collection and sharing. The Division of Justice and Community Services intends to provide the Juvenile Justice Reform Oversight Commission with an annual report which will inform on the state of the Youth Services population. The outcome measurements provided will help to identify key areas needing improvement cross-systems and allow for more targeted changes to be made.

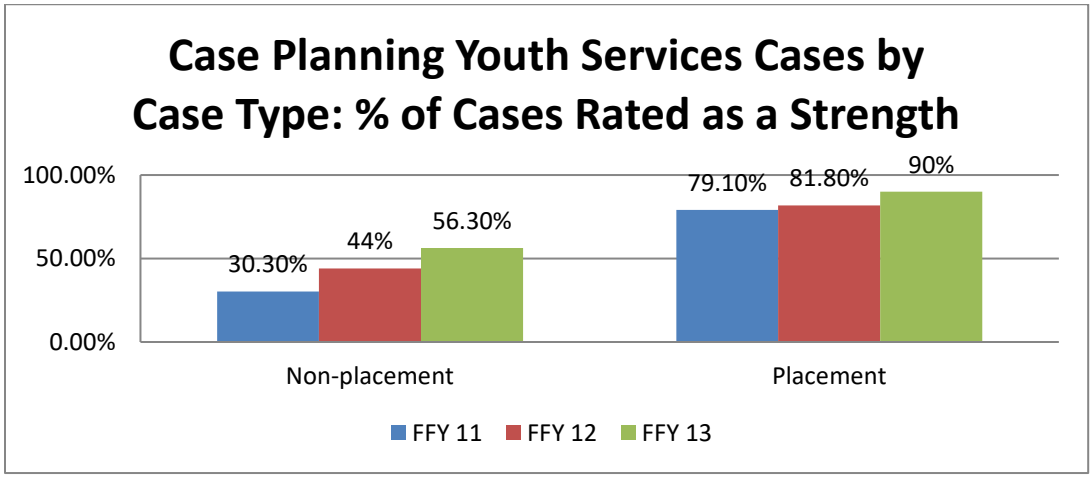
Additionally, the Department will begin diversion programming in July 2016. As part of Diversion the youth service worker will be expected to involve the family in service planning. The code allows for workers to obtain an order from the court to enforce the service plan and involvement of those members. This will hopefully encourage the participation of family in rehabilitating the youth.

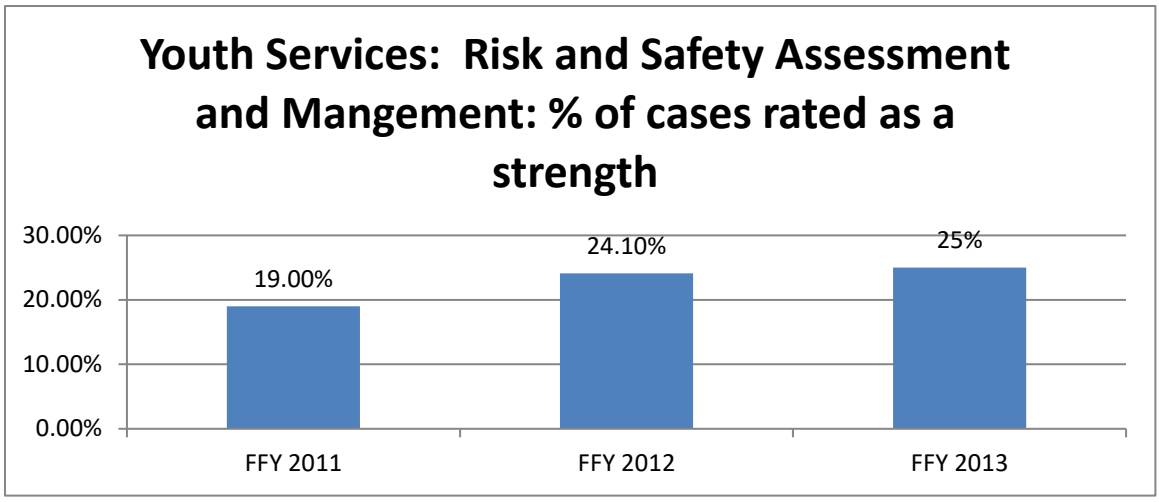
The information below related to case planning has been updated due to erroneous information being reported during the 2015 APSR Report.

Rationale:

Case review data indicates a significant need to improve youth and family involvement in the case planning process. Data also indicates a need for improvement related to the continued assessment for safety in youth services home cases.







Measurement Plan:

West Virginia will utilize the Child and Family Service style case reviews to monitor the improvement in the involvement of youth and families in the provision of treatment and services. Applicable items based on 2008 CFSR instrument are 4, 18, 19 and 20.

2014 Child and Family Review instrument will be utilized for ongoing measurement applicable items 3, 13, 14, 15, with a 12-month period under review.

Baseline measurements indicate the following for Federal Fiscal Year 2013.

25% of the youth services cases reviewed rated as a strength for item 4, risk assessment and safety management. Fifty-six-point three percent (56.3 %) of the non-placement youth services cases reviewed rated as strength for item 18, child and family involvement in case planning. Twenty-five percent of the youth services cases reviewed rated as strength for work visits with the child. Thirty-seven-point five percent (37.5 %) of the youth services cases reviewed rated as strength for worker visits with parents. **2008 CFSR instrument utilized for case review data*.

Benchmarks:

Risk assessment and safety management in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
19%	30%	35%	40%	45%	50%

Update:

Risk assessment and safety management in Youth Services Cases

2014	**2015**	**2016**	**2017**	**2018**	**2019**
20.5%	24.4%	XXX			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Child and family involvement in case planning in non-placement Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
56.3%	61.3%	66.3%	71.3%	76.3%	81.3%

Update: **Child and family involvement in case planning in Youth Services Cases for <u>non-placement cases</u>.**

2014	**2015**	**2016**	**2017**	**2018**	**2019**
18.8%	32.0%	XXX			

Update: **Child and family involvement in case planning in Youth Services Cases for both placement and non-placement cases.**

2014	2015	2016	2017	2018	2019
61.5%	46.7%	XXX			

**West Virginia utilizes a 12-month period under review for case reviews.

***** *This measurement cannot be compared to prior years for case planning due to a change in the way the DPQI unit assessed the item. In prior years, this item was rated based upon the level of engagement of the family in the case planning process. Based on consultation from the Children Bureau this item was not rated as a strength this year unless the case plan was signed; therefore, the overall decrease in the percentage of cases that rated as a strength for the item reflects a lack of signed case plans in the case records, not necessarily the lack of family engagement in the case planning process.*

Benchmarks:

Worker visits with the child in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
25%					

Update**: Worker visits with the child in Youth Services Cases**

2014	2015	2016	2017	2018	2019
46.8%	42.2%	XXX			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Worker visits with parents in Youth Services Cases

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
37.5 %					

Update: **Worker visits with parents in Youth Services Cases**

2014	**2015**	**2016**	**2017**	**2018**	**2019**
12.5%	11.4 %	XXX			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

2017 Update

Risk assessment and safety management in Youth Services Cases

2014	**2015**	**2016**	**2017**	**2018**	**2019**
20.5%	24.4%	15.9%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Child and family involvement in case planning in non-placement Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
56.3%	61.3%	66.3%	71.3%	76.3%	81.3%

Update: **Child and family involvement in case planning in Youth Services Cases for non-placement cases.**

2014	2015	2016	2017	2018	2019
18.8%	32.0%	7.7%			

Update: **Child and family involvement in case planning in Youth Services Cases for both placement and non-placement cases.**

2014	2015	2016	2017	2018	2019
61.5%	46.7%	4.5%			

**West Virginia utilizes a 12-month period under review for case reviews.

***** *This measurement cannot be compared to prior years for case planning due to a change in the way the DPQI unit assessed the item. In prior years this item was rated based upon the level of engagement of the family in the case planning process. Based on consultation from the Children Bureau this item was not rated as a strength this year unless the case plan was signed; therefore, the overall decrease in the percentage of cases that rated as a strength for the item reflects a lack of signed case plans in the case records, not necessarily the lack of family engagement in the case planning process.*

Benchmarks:

Worker visits with the child in Youth Services Cases

Data will be measured through CFSR style reviews

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
25%					

Update**: Worker visits with the child in Youth Services Cases**

2014	2015	2016	2017	2018	2019

46.8%	42.2%	27.3%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

Benchmarks:

Worker visits with parents in Youth Services Cases

Data will be measured through CFSR style reviews

Original:

Baseline	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal	Targeted Goal
FFY 2013	**2015**	**2016**	**2017**	**2018**	**2019**
37.5 %					

Update: **Worker visits with parents in Youth Services Cases**

2014	**2015**	**2016**	**2017**	**2018**	**2019**
12.5%	11.4 %	14.0%			

**West Virginia utilizes a 12-month period under review for case reviews. Implementation of objective will occur during FFY 2015-2019. Case reviews may not show marked improvement until 2021.

2017 Update:

BCF has outlined the framework for its “streamlining” project. The group has identified a self-modified version of the Family Advocacy and Support Tool (FAST) to be utilized in all cases that come to the attention of the department. The FAST not only readily identifies strengths and needs each member of the family may have, it helps to paint a picture of the family unit, as opposed to the focus on only one member. This should help to improve family engagement through the requirement of needs identification and strength planning for all family members. This should prove to be especially helpful in those cases that are identified as “Youth Service” as it will help remove the focus of treatment as solely a juvenile issue, and provide a framework for family improvement.

The department has already developed some reports to share information with the Juvenile Justice Reform Oversight Commission on the data measures required due to the passage of SB 393. Though no agency is yet able to provide all the information requested, the agencies involved have made some advancement on data they are able to provide. The department should be able to provide information related to the number of juveniles ordered to remain outside of the home for longer than 90 days, the number of cases which are referred for pre-petition diversion, the number of active Youth Services cases, and the number of youth who are adjudicated as either a status offender or delinquent.

Goal 4: West Virginia will have a standardized process to address gaps in services and the availability of services for children and families in their communities by 2019.

4.1 Identify current needs and gaps in services to develop the availability, quality, accessibility and provision of services to children and families serviced by the Child Welfare System by 2017.

Rationale

West Virginia has no current data to indicate the need and availability of services for children and families in their communities.

Measurement Plan:

Through the Title IV-E Demonstration Project implementation activities, West Virginia will establish a baseline of existing service availability and needs. The initial focus will be the 11 demonstration counties, with a planned statewide implementation target of 2019. Benchmarks cannot be determined until a baseline has been established.

Tasks

- Explore the ability of the FACTS system to develop a report to collect and analyze Safe at Home West Virginia data.
- Integrate and analyze data collected through the multiple case review processes and stakeholder surveys to identify service gaps, beginning in the Safe at Home counties, by October 2015.
- Completion of an Initial Needs Assessment, coordinated with stakeholders through Regional Summits and Community Collaboratives, of the level of community and work-force readiness and “ownership” for a wrap-around service model, using the

Self-Assessment of Strengths and Needs from the National Wrap-around Initiative's (NWI) Wrap-around Implementation Guide, Community Groundwork for Wrap-around Implementation (Appendix A), which includes an assessment of the services, supports and workforce development needs by October 2015.

- Develop detailed plans, coordinated with stakeholders through the Regional Summits and Community Collaboratives, regarding methodology in developing needed workforce, services, and supports identified in the NWI needs assessment by October 2016.
- Develop an interdepartmental team consisting of the Bureau for Medical Services, the Bureau for Behavioral Health and Health Facilities and the Bureau for Children and Families to garner resources for new services and the expansion and sustainability of existing services.
- Explore the use of an existing screen in our SACWIS system to collect data on unmet needs and develop a report.
- Analyze the data from these reports and share the data with collaboratives.

2015 Updates

West Virginia continues to work on the development and expansion of services and supports in preparation for the implementation of Safe at Home, Title IV-E Demonstration Project. Tasks for this objective will be reported out in 2015 APSR.

West Virginia is utilizing the community collaboratives to assist in the development and identification of needed services.

The Bureau for Children and Families continues to collaborate with the Bureau for Health and Health Facilities, Bureau for Medical Services, and Bureau for Public Health to support this initiative.

2016 Updates

West Virginia developed detailed plans, coordinated with stakeholders through the Regional Summits and Community Collaboratives, regarding methodology in developing needed workforce, services, and supports identified in the National Wraparound Initiative's (NWI) needs assessment by October 2016.

The state developed an interdepartmental team consisting of the Bureau for Medical Services, the Bureau for Behavioral Health and Health Facilities and the Bureau for Children and Families to garner resources for new services and the expansion and sustainability of existing services.

West Virginia has worked in partnership with the four Regional Children's Summits and the local Community Collaboratives. All Collaboratives, statewide, have completed a cursory needs assessment, as well as the agency assessment of readiness within the *NWI's Wraparound Guide to Implementation for Managers*. Once the assessments were completed, the Collaboratives were to develop strategic plans. Any service gaps that they cannot meet will be pushed up to the attention of the Regional Children's Summit to assist.

The Bureau for Behavioral Health and Health Facilities Updates
West Virginia's Mental Health Block Grant 10% percent set aside devoted to First Episode Psychosis (FEP) was initiated this year. The Bureau is piloting an integrated response to individuals with First Episode Psychosis that uses a person-centered, multiagency intervention strategy coordinated through case management, family awareness/outreach/support, and innovative psychiatric treatment.

The Bureau has funded additional sites for Expanded School Mental Health: school-based supports and services that address the full continuum of mental health services: Tier one Universal Supports for all students; Tier two - early intervention for students at risk for truancy and/or poor academic performance due to behavioral health challenges; Tier three - intervention and treatment services for youth with intensive support needs. Schools partner with licensed behavioral health providers, a variety of community resources and families to create an environment that promotes student well-being and academic success. ESMH services were approved for funding during the current year.

The Bureau has funded one new Substance Use Transitional Youth Residential Program: Resident capacity is up to 16 beds/individuals; length of stay is up to 3 months. Service areas to be provided at the facility include: Prevention, Health Promotion and Wellness, Engagement Services, Outpatient and Intensive Support, Medication Services, Community and Recovery Support. The program also collaborates with community-based, primary care/public health entities to coordinate physical health needs. Serves males and females aged 18-24 with a substance use disorder and/or co-occurring substance use and mental health disorder; priority is given to intravenous (IV) drug users, individuals being transitioned from a higher level of care (psychiatric hospital and/or detoxification-crisis stabilization) and/or women who are pregnant.

The Bureau has awarded funding for six pilot projects for High Fidelity Wraparound for children in parental custody placed in out of state psychiatric residential treatment facilities: intensive case management and individualized, strengths-based, trauma-focused service planning for youth with serious emotional disturbances, substance use disorders, or co-occurring disorders, with services delivered in an environment that safely

preserves family relationships and empowers families to help meet their own needs. Programs are operating in the counties with the highest rates of youth placed in acute psychiatric care and out-of-state psychiatric residential treatment facilities: Berkeley, Cabell, Harrison, Kanawha, Marion and Raleigh Counties.

The Bureau has funded Regional Youth Service Centers. The purpose of having a network of Regional Youth Service Centers is to implement a consistent and collaborative approach to serving youth ages 12-24 with mental health, substance abuse, and co-occurring disorders across systems. The RYSCs will become "centers of excellence" that:

- Identify and coordinate a full spectrum of community based services to provide meaningful partnerships with families and youth with the goal of improving the youth's functioning in the home, school and community;
- Create a unique and identified regional presence (including physical locations) that improves awareness of and access to "close to home" prevention, early intervention, treatment, and recovery services to meet the needs of the target population;
- Incorporate individualized, strength-based out-patient behavioral health services in an integrated environment that offers face to face and telehealth options for evidence based practice and program implementation; and
- Serve as a "no wrong door" point of service access and information for youth, families, and providers in need of resources, particularly those related to intensive, community-based wraparound services;
- Integrate the work of regional children's behavioral health staff as the core of the Regional Youth Service Centers, including but not limited to: Regional Director; Children's Clinical Liaison; Suicide Intervention Specialist; Peer Outreach Specialist; Regional Clinical Coordinators, and System of Care Coordinator.

The Bureau expanded the Family Engagement and Parent Peer Support component of the Family Advocacy, Support and Training (FAST) program: The purpose of the FAST program is to develop a statewide parent and youth support network that will empower families of children with behavioral health needs to participate in the planning, management, and evaluation of their child's treatment and service needs. FAST empowers parents to advocate for themselves and their children, and empowers parents to build support networks in which they can educate other families with similar circumstances. BBHHF plans to hire two additional Family Engagement and Parent Peer Support Coordinators to develop regional parent/family support services across disabilities and to assure families served by the Children's Wraparound pilots and Safe At Home have access to peer support services.

Funding is proposed for six regional mobile teams that provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis.

- Assure 24/7 access to crisis response services in the child's home, school, other living arrangement, or other location in the community.
- Assess and evaluate the presenting crisis to include an assessment of child and community safety, caregiver capability, and clinical risk.
- Provide clinical interventions to stabilize the presenting crisis.
- Refer, link, and connect the child to appropriate services to help the child stay at home, stay in school, and stay out of trouble.
- Collaborate with local and state community stakeholders to remove barriers to treatment and ensure a system-wide approach to addressing youth and family needs and supports.

Workforce Development: The Bureau has resources to provide sustainable professional education strategies for child and family therapists/clinicians to improve professional competence and the adoption of evidence based, evidence informed and promising behavioral health practices, and to expand capacity to serve children with identified but unmet treatment needs:

- Dialectical Behavior Therapy;
- Parent/Child Interaction Therapy;
- Positive Behavioral Support;
- Trauma-Focused Cognitive Behavior Therapy and/or Seeking Safety;
- Clinical Interventions for Victims of Trauma with Autism Spectrum Disorder, Fetal Alcohol Syndrome, Traumatic Brain Injury, or Mild Intellectual Disability;
- Clinical Interventions for Children with Sexual Trauma and Sexual Aggression/Acting Out.

As a result of creative partnerships with the higher education community, the Higher Education Policy Commission, and the Expanded School Mental Health initiative, internships for students pursuing counseling degrees in higher education will be made available in school-based settings. This emerging project will help with the professional workforce needed in the state and improve outcomes for youth with SED and their families.

The Bureau's staff provides perspective, clinical expertise and resource knowledge/access regarding youth with developmental disabilities and traumatic brain

injury on a variety of cross-system teams: Regional Clinical Review Teams, Out of State Review Team, Regional Children's Summits, and individual case consultations to brainstorm solutions for children with complex support needs.

The Bureau for Behavioral Health and Health Facilities funds two pilot projects for serving youth ages 18 – 21 with significant behavioral health needs. We are working with BCF and the providers to evolve that service into one that more closely resembles, in terms of language and outcomes, services these youths will access through the adult behavioral health system, with greater access to supported housing and peer supports.\

The Bureau recently submitted an application for a four-year SAMHSA Children's System of Care (SOC) Expansion and Sustainability Cooperative Agreement grant, which proposes to expand and sustain the current WV System of Care framework for children's behavioral health services at the state and local level.

- At the state level, efforts will focus on integrating SOC principles across the child serving systems and coordinating plans into one comprehensive approach to serve youth with SED and their families;
- At the regional level, we will use the Regional Youth Service Centers as "hubs" to: infuse the SOC principles and values into the culture and practices of providers; engage youth and families; break down barriers; expand partnerships across child-serving systems; expand wraparound models into service planning for youth in parental custody; and grow the array of community-based services to reduce reliance on residential services are laudable and achievable goals;
- At the community level, the Bureau proposes further expansion of the wraparound model for service planning and development, mobile crisis services, intensive home-based services, parent peer support and system navigation; and workforce development.

West Virginia continues to utilize the Community Collaborative Groups (that include members from the Family Resource Networks) to assist in the development and identification of needed services.

From October 2014 through September 2015, the DHHR, Bureau for Children and Families (BCF), Community Partnership's unit provided ongoing technical support to the Family Resource Networks and the Community Collaborative groups:

- Technical assistance was provided in developing Strategic Plans to address the service needs and gaps using the data collected from the Safe at Home West Virginia Services and Supports survey

- Technical assistance was provided in developing Strategic Plans to address the satisfaction of the Family Resource Networks using the data collected from the Continuing Quality Improvement survey.
- Development of Family Resource Networks Quarterly Reports to capture the services/supports that are provided to community members.

Safe at Home Service Development

Peer Support, the new service designed to help adults with addiction and/or mental/behavioral health disabilities, is in the final stages of preparation. The service definition and criteria have been developed and the managed care organization has completed the programming necessary for its inclusion in their authorization and review procedures. At this time, the service awaits the SACWIS enhancements that will allow workers to link it to specific clients and to interface with the managed care organization's data system. It is anticipated that this enhancement can occur by Fall 2016.

The development of the Youth Coaching service that was mentioned in the 2015 updated has been delayed. During the latter developmental phases, the workgroup learned that the evidence-basis for our new service, the published works of Larry K. Brentro, et. al., had been sold to Star Commonwealth and now had proprietary restrictions on its usage. The workgroup, through partnership with our sister Bureau, the Bureau for Behavioral Health and Health Facilities (BBHHF), had to find other experts in the field of youth mentoring/re-education models. Several conversations have occurred with Mark Freado and Mary Grealish, mentioned throughout this document in relation to our IV-E demonstration project. The group, through funding from BBHHF, is examining the possibility of Mr. Freado, Ms. Grealish and several other "experts" coming to West Virginia to conduct "train the trainer" workshops with our mutual providers and Departmental staff to help develop a youth mentoring service that fits West Virginia.

The redesign of the Bureau's current structure for providing community-based supportive services, currently known as Socially Necessary Services, has been delayed. During the past year, the contract for the managed care organization that manages the State's Medicaid and Socially Necessary Services programs was up for renewal, which initiated a competitive rebidding process. The current provider, who has been the contract awardee since 2004, was successful in their re-application for the contract. However, this process has taken longer than anticipated due to West Virginia's adoption of a new payment system for both providers and employees. This new system, West Virginia Oasis, has experienced technological delays, as well as delays due to political unpopularity of the new system. An anticipated approval date for this new contract has tentatively been announced for June 1, 2016. The reason the contract rebidding process

delayed forward movement with the redesign of our socially necessary service system is because making significant changes to payment and oversight structures is not part of the current contract, and had been specifically added to the request for proposals when the rebid announcement was published. Once the new contract has been finalized, movement can occur with design of the new structures discussed in the 2015 update. However, realizing that necessary services needed a better mechanism for improving quality of services, the Bureau for Children and Families adopted the “80% Rule” in November 2015.

The “80% Rule”, which was effective on November 4, 2015, requires that socially necessary services providers score at least 80% during their retrospective review. The retrospective review is conducted by the managed care organization at least every 18 months. If the provider scores less than 80% on any service they provide, the provider received written notice that a six-month probationary period is in effect. Training and technical assistance will be offered. After 6 months, the managed care organization will conduct another review on the services scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider’s record and they will no longer be able to receive referrals to provide that service. If, during the retrospective review process, a provider scores zero on any safety-related service, that service will be automatically closed from the provider’s record. There will not be a six-month probationary period when a safety service scores zero. In the four months since implementation of this new quality assurance process, no provider has scored zero on their safety services. We have seen four agencies whose scores have dramatically increased since the rule was effective.

Continuum of Care Redesign –Community-based Service Expansion

West Virginia is one of several states that control the development of medical and behavioral health care services through a certificate of need process. In West Virginia, the Health Care Authority provides oversight and staffing for the certificate of need process. The Health Care Authority's goals are to control health care costs, improve the quality and efficiency of the health care system, encourage collaboration and develop a system of health care delivery which makes health services available to all residents of the State. The Certificate of Need program is a regulatory element used to achieve these goals. The program was originally enacted in 1977 and became part of the Authority in 1983. The language outlining the program is found in W.Va. Code §16-2D.

Housed within West Virginia State Code Chapter 49 is a provision to become exempt from the full certificate of need process. Summary Review process is outlined in section

§ 49-2-124. This section of code allows providers of behavioral health services to bypass the full certificate of need process if certain criteria are met. These criteria are:

- Criterion 1: The proposed facility or service is consistent with the State Health Plan. (See attachment “West Virginia State Health” Plan 11-13-95)
- Criterion 2: The proposed service/facility is consistent with the Department's programmatic and fiscal plan for behavioral health services for children with mental health and addiction disorders.
- Criterion 3: The proposed facility or service contributes to providing services that are child and family driven, with priority given to keeping children in their own homes.
- Criteria 4: The proposed facility or service will contribute to reducing the number of child placements in out-of-state facilities by making placements available in in-state facilities.
- Criterion 5: The proposed facility or service contributes to reducing the number of child placements in in-state or out-of-state facilities by returning children to their families, placing them in foster care programs, or making available school-based and outpatient services.
- Criterion 6: If applicable, the proposed facility or service will be community-based, locally accessible, and provided in an appropriate setting consistent with the unique needs and potential of each child and her family.

Due to the fact that these criteria are housed in Chapter 49, the child welfare statutes, the Bureau for Children and Families has acted as the liaison with the Healthcare Authority in processing requests for a summary review.

The certificate of need, and thus the summary review, is required for all new service development, as well as any changes in current services provided, population served or county of location. Due to the multiple initiatives that are geared toward reducing the use of congregate care, many of the children’s residential and child placing agencies are seeking summary review to expand the services they provide, the population they serve and the areas where their business are located. The agencies are seeking to provide more community-based, in-home behavioral health services to a broader range of clientele. Instead of serving only the youth and families who have become involved in the child welfare system, the agencies are now becoming focused on providing preventive services to off-set crises that bring children and their families into the system.

During the past two years, summary review has been approved for eight children’s residential providers and two child placing foster care agencies to expand their service

array to include community-based, in-home behavioral health services. This represents 30% of our current licensed child welfare providers. There have also been four other community-based organizations that have started the process to become licensed behavioral health centers. This totals 16 new summary review approvals for the provision of an expanded array of trauma-focused, in-home behavioral health services in what were often previously underserved counties, aimed at keeping families together.

West Virginia completed research on the Sobriety Treatment and Recovery Teams (START) Program modelled after Kentucky's program, to develop services to assist families with vulnerable infants and young children affected by parental substance use. This project is in its infancy at this time. The following is a list of activities and timelines associated with the research needed to move forward.

October 2015 -BCF & BHHF begin joint investigative meetings;

November 2015 -BCF Deputies for Field Operations tasked with START initiative for BCF and conduct a literature review, as the BCF internal team was formed;

December 2015 –Joint Bureau's Team meets and established goals of the project;

January 2016 - Talking Points and formal goals were developed; The position description process was developed to establish the Director /Manager and Coordinator roles which go to Division of Personnel for review and approval; BCF internal Team has conference call with Kentucky START Team; Positions identified to use for the Program Director or Manger & the Program Coordinator; WV-BCF START Organizational Chart developed; Received several "chapters" from Kentucky START program manual for use in developing a START program. Kentucky reports that not all chapters are available yet; BCF and BHHF explore options regarding hiring of peer mentors; BCF considers budget options for year three of START, possibly using TANF. Years one and two have dedicated funding through BHHF.

February 2016 - BCF connects with the director of WV Perinatal Partnership as a possible resource for peer mentors. West Virginia Perinatal Partnership, in turn, attempts to connect with Kentucky START providers to get further information regarding how peer mentors are used; BHHF attempts to clarify roles and responsibilities between bureaus, as well as those in relation to provider agencies that may be used to support the peer mentors; The WV Division of Personnel (DOP) determines proper allocation of the START Coordinator Position and BCF Human Resources Director is to post the position; BCF Deputy Commissioner, Training Director and CPS Policy Specialist attend START 101 training in Kentucky.

March 2016 – West Virginia DOP determines proper allocation of the START Director /Manager Position;

April 2016- The Bureau for Children and Families places START development on hold while BCF evaluates other options such as the use of Recovery Coaches.

The "80% Rule", which was effective on November 4, 2015, requires that socially necessary services providers score at least 80% during their retrospective review for each service.

During the FFY 2016, there were 36 retrospective reviews conducted on providers. 15 providers scored above 80% for each service they provided. 21 providers had at least one service fall below the 80% threshold.

Out of the 21 providers the following number of services fell below 80%:

- 3 providers had 1 service score below 80%
- 5 providers had 2 service score below 80%
- 5 providers had 3 service score below 80%
- 5 providers had 4 service score below 80%
- 2 providers had 8 service score below 80%
- 1 providers had 9 service score below 80%

The following table shows the services that fell below 80% and the total number of providers for each service:

Service Name	**# of Providers of this service scoring below 80%**	**Total # of Providers of this specific service***
Private Transportation 1	1	5
Private Transportation 2	1	4
Transport Time	1	11
Intervention Travel Time	4	21
Supervised Visitation 2	4	16
Supervised Visitation 1	2	21

Adult Life Skills	14	23
Agency Transportation 1	4	28
Agency Transportation 2	7	19
Supervision	6	18
Individualized Parenting	14	26
Safety Services	14	18
MDT	2	19

*Each provider chooses which individual services they want to provide so the number of agencies differs per service

All providers who fell below 80% for a service, were placed on probation for each service category that did not meet the 80% rule. At the end of the probation period, each provider goes through a follow-up review on the service (s) not meeting the 80% rule. If a provider fall below 80% on the services a second time, then the service will be closed for that provider.

No services were closed during the period, since probation status for providers was not implemented until June 2016.

During the FFY 2016, one service category was closed for one provider, due to the provider scoring a 0% compliance for that service.

Implementation Supports

Implementation Supports Goal 1:

In preparation for application for Title IV-E waiver, West Virginia worked with Casey Family Programs to pull relevant data and analyze said data to determine the focus of our demonstration project.

- Casey Family Programs, along with the Federal Children's Bureau, provided guidance and technical assistance in the development of West Virginia's IV-E waiver application.

- James Bell Associates, in partnership with The Federal Children's Bureau, has provided technical assistance in West Virginia's development of our theory of change pertaining to Safe at Home West Virginia.
- West Virginia has received assistance from Casey Family Programs in the collaborative work with our Out of Home Placement providers and West Virginia's transformation of our child placing system.
- James Bell Associates is currently assisting West Virginia and our independent evaluator in the development of our evaluation plan for Safe at Home West Virginia.
- Research was completed regarding diligent efforts to make initial face to face contact with the identified victim on a Family Functioning Assessment. Policy indicates what is considered a diligent effort and DPQI considers these efforts in their assessments.
- Policy staff is now researching appropriate use of blatantly false reports as well as incomplete assessments.
- Division of Training developed training for all Child Welfare staff that will focus on the current trends in child fatalities that will be implemented by the fall of 2015.
- Provided training to 520 law enforcement officers in 2013.
- Training will be developed and delivered in pilot counties to address more proficient safety planning in conjunction with Safe at Home Implementation.
- Training will be developed and delivered to other counties as the Safe at Home extends statewide.
- Division of Training will develop and deliver a more detailed training on safety planning for supervisors with a focus on using both informal and formal supports.

2016 Updates

- WV CANS and Automation:
- West Virginia also worked with our Evaluator, Hornby Zeller Associates, to create automated WV CANS. All Phase One DHHR and Local Coordinating Agency staff have been trained in the use of the automated WV CANS and have begun entering WV CANS and subsequent updates. West Virginia has been using the CANS since 2003. It has been updated to the WV CANS 2.0. WV CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the WV CANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; LGBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-

module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module.

- Phase Two – Safe at Home West Virginia:
- West Virginia continues to move forward with Phase Two implementation which will include the addition of 24 counties. This is projected to begin sometime late summer to early fall 2016. The grants to local coordinating agencies to hire wraparound facilitators have been awarded and the hiring process has begun. The date that referrals begin will be determine in consultation with the Local Coordinating Agencies and our Evaluator.
- Phase Two implementation includes the 24 counties of Brooke Hancock Monongalia, Marion, Ohio, Barbour, Grant, Hardy, Hampshire, Harrison, Lewis, Mineral, Pendleton, Preston, Randolph, Taylor, Tucker, Upshur, Greenbrier, Mercer, Monroe, Nicholas, Pocahontas, Summers. Through data review WV identified 430 youth in the target population that could be referred to Safe at Home West Virginia for wraparound. Based on the identified population, West Virginia awarded 43 wraparound facilitator positions to 6 Local Coordinating Agency Grantees.
- The Phase Two counties were selected due to their current out-of–state placement data, location, and readiness to implement.
- Phase Three of implementation is slated to begin in the Spring of 2017 and will include the final 20 counties bringing all West Virginia into full implementation.
- Wraparound 101 training is being conducted throughout the next phase Counties beginning in March and running through May. This is always a cross-training so BCF staff and Facilitators attend together.
- WV CANS training for the Phase Two areas is also scheduled throughout the months of April and May to assure that all BCF staff and partners have the opportunity to attend this training prior to implementation.
- West Virginia has developed a strategic work plan for further training and development of BCF and Partner staff regarding the administration and use of the WV CANS and the further development of WV CANS Advance CANS Experts (ACES) for technical assistance. We are seeing that WV CANS are being administered but many do not yet understand how to use the results in the treatment or case planning process for youth and families. We have identified the continuing need to develop experts that can provide technical assistance on an ongoing basis. Our goal is for WV CANS to be completed on all children with an open child welfare case and that the WV CANS will be used to determine the appropriateness of a referral to Safe at Home West Virginia and assist in guiding the intensity of services. Please refer to the attached work plan which is a fluid plan with changes being made as needed.

- West Virginia continues the development of Safe at Home West Virginia content experts. The further training includes new blackboard training and an advanced classroom training that will be delivered during the month of May. The goal is to have a content expert in every community service district for BCF and that they are available to assist with questions and needed technical assistance as well as future training. The Experts have met together and assisted in identifying what knowledge they believe they need to be comfortable in this role as well as what the home team identified as necessary for their development. The advanced training curriculum has been developed to meet those identified needs.
- Mary Grealish – further wraparound training and certification:
- Through the barrier busting and review process, we have identified the need for further wraparound training and consultation for our wraparound facilitators and supervisors. We recognize that we are all in a learning curve when it comes to wraparound planning, crisis planning, intensity of services and the quality of written plans and monthly reports. To address this and to prepare for further expansion BCF and the Bureau for Behavioral Health and Health Facilities (BHHF) have worked through the system of care to enter into an agreement with Mary Grealish of Wraparound Solutions to assist West Virginia to further consult and coach with our wraparound facilitators and supervisors. Eileen Mary Grealish, M.Ed., designs and implements individualized, strengths-based strategies that have a direct impact on young people and families. She is a recognized expert in functional strengths-based strategies that have direct impact on young people and families. She is a recognized expert in functional strengths and needs assessment, crisis planning, and staff supervision in Wraparound and family/person-centered practice. As president of Community Partners, Inc., Grealish focuses on writing and teaching about delivery of comprehensive community-based services including Wraparound and the development of innovative treatment behavior plans.
- Capacity Building Center for States:
- West Virginia has been working with the Capacity Building Center for states to develop a strategic plan to support the implementation and sustaining of West Virginia's Demonstration Project. West Virginia's strategic plan focuses on the 3 main goals of DATA collection and use, Truancy and YS diversion, and Workforce Recruitment and Retention. At present, there are 3 focused workgroups developing their logic models and plans moving forward.
- The Capacity Building Center for States also assisted West Virginia with a "Brief Service" in the development of a one page informational document regarding Safe at Home West Virginia. The DHHR and Local Coordinating Agencies were looking for a smaller document that would be written in layman terms that could be used

within our communities to garner support and to develop more informal support systems to assist families in their communities. The consultants worked with the Waiver Project Director and Lead on the Communication team to take the existing fact sheet and reduce it to a one page document. This document may be downloaded from our website at http://safe.wvdhhr.org.

Implementation Supports Goal 2:

- West Virginia is currently receiving technical assistance from the NRC for Diligent Recruitment. This T/TA will continue through 2015 focusing on developing a comprehensive system assessment and work plan development to address multiple issues affecting recruitment and retention of foster/adoptive family's efforts. This will include developing a multi-faceted recruitment and retention plan, evaluation and improvement of customer service provided to new and existing families and assess whether the preparation of families is sufficient for high needs children entering care.
- Apply for a Legislative improvement package to hire additional home finding staff by April 2015.
- Continued development of an Interface between the Departments SACWIS system and the Board of Education's WEVISS will need to be completed to share educational records of foster children.

2016 Updates

- A workgroup of BCF policy, BCF regulatory and child placing provider staff have been working on revisions to the Legislative Rules "Licensing Requirements for Child Placing Agencies". These rules provide minimal standards for regulating specialized agency foster homes. The revised rules will incorporate requirements from the Fostering Connections to Success and Increasing Adoptions Act and the Preventing Sex Trafficking and Strengthening Families Act. The revisions will also include most standards from the "Model Family Foster Home Licensing Standards" from the National Association for Regulatory Administration (NARA).
- Some of the standards that have been added to the licensing requirements are around prudent parenting, normalcy for youth in foster care, away from supervision and runway events, trafficking of foster youth and many of the NARA standards for foster homes.
- The revised "Licensing Standards for Child Placing Agencies" will be completed by the end of 2016 and submitted to the Legislature for in 2017 for approval in the 2018 Legislative session.

- BCF policy staff will also align the Foster Care and Home Finding Policy with these "Licensing Standards", so all foster homes in West Virginia will meet the new requirements.

2017 Update

MWV submitted their information guide to staff from the National Resource Center after they provided technical assistance to DHHR in 2016. Professionals from the NRC reviewed the guide and made suggestion/revisions to ensure that the guide was helpful and clear for prospective parents.

Implementation Supports Goal 3:

- FACTS will develop screens to better distinguish the reason for entry, including children entering care for Truancy, by October 2017.
- Develop training to educate workers on using new screens
- Develop training on a tool for supervisors to use to track worker's compliance with entering information.
- Develop a mechanism on a dashboard to track face to face contacts with non-placement cases by September 30, 2016.

2016 Updates

- The leadership of the Office of Management Information Systems has made the decision to transition the existing SACWIS to CCWIS model under the new proposed final rule. A Request for Proposals (RFP) is being developed to bring on contractors to staff and develop the requirements and perform the necessary technical work to change the system architecture, functionality, presentation layer and data collection/reporting processes. The plan is to continue operations in the present SACWIS with limited maintenance and operational work until the system can be transferred and or retired. The web based components of the current SACWIS can be leveraged for use in the new system so it still advantageous for the state to continue planned modifications up until the point that operations can be fully shifted over.
- Although the development is expected to be incremental and phased across the enterprise the RFP is expected to be published before the end of 2016, with the goal of having a vendor or vendors in place by late spring 2017.

2017 Update

The WV Department of Health and Human Resources has prepared a Request for Proposal outlining a modularized system the will incorporate the functionality of multiple system operations into combined blocks of common functionality shared by one or more systems. The various components of the current SACWIS will be moved into the combined system as new modules are brought up and implemented. Any distinct and non-sharable functionality will be addressed by migrating the last components of the legacy FACTS system to a browser based platform that can then be used to form additional modules. Additional interfaces with Education and the Courts are under discussion and pre-planning efforts underway. Also in development are the data and process quality efforts that will be imbedded within the new application. The agency is still waiting to review vendor responses to the RFP. With the projected date to select a vendor set in August, more details regarding prioritization and detailed CCWIS requirements can be given once the successful vendor has been chosen.

Implementation Supports Goal 4:

- Training and technical assistance from The National Capacity Building Center for Public Child Welfare Agencies to redesign the current service, payment rate and referral structure for Socially Necessary Services may be needed.

2016 Update

- Has not been initiated.

West Virginia does not need additional technical assistance now.

Service Description

Child and Family Service Continuum

(Stephanie Tubbs Jones Child Welfare Services Program)

Prevention

The goal of allocating Title IV-B funds to Starting Point groups was to enable the community to have easier access to family support services. In the past, services required could only be provided to those who opened a DHHR case file for family support services. A desire for programs to be community-focused led DHHR to utilize the already

existing Starting Points model, making available Title-IV-B PSSF federal dollars to 15 grantees to fund these resource centers. Not all Starting Points programs applied for the federal funding; however, six existing Starting Points were awarded this grant. This created a partnership between Starting Points and Family Resource Centers, which are known today as "Starting Point Family Resource Centers." The other nine grants were awarded to newly created Family Resource Centers. Subsequent Family Resource Centers have been created, without Title IV-B funding, for a total of 26 Family Resource Centers currently in operation, performing family support services around the state.

The expansion with Title IV-B funds also moved services from primary prevention to early intervention services and extended them beyond the scope that programs were limited to providing. Additional early intervention services included linkages to respite care, child care, and transportation as well as coordination of optional/flexible services depending on community needs such as:

- Early childhood education such as play groups and before/after school or summer programs.
- Self-sufficiency and life management skills training.
- Education services, such as tutoring, literacy, and general education.
- Job and career readiness training.
- Family support counseling/clinical mental health services.
- Health services/nutrition education.
- Peer counseling.
- Emergency assistance.

The expanded funds provided Starting Points FRCs the resources and the staff to expand services for many families in their community. With this funding, some Staring Points have been able to offer, for example, respite care during the school year, twice a week, to over 40 families. The funding has allowed one county to utilize FRC staff and AmeriCorps members to operate this program.

Newly developed programs for dads are also a result of the additional Title IV-B funding. One program has enlisted the assistance of two fathers who meet weekly with dads during the school year. Another program was a co-sponsored father's event at one of the target schools and had over 30 dads with their children attend.

Some of the resources and staff time are used to work with middle school children after school and during the summer, as well as a yearly transition dinner for fifth graders and their families heading to local middle schools. In addition, work with high school students

on their Free Application for Federal Student Aid (FAFSA) and some specialized tutoring is also available.

Also, important about this funding is that it increases a programs ability to develop subsequent programs, to partner with other groups, and to be responsive to community and family needs because the programs have a core staff that can spend time developing relationships and listening to what families need.

With the additional funding became the ability to expand the Starting Points population served from ages 0-8 to ages 0-18. With this age population expanded, Starting Point Family Resource Centers have been able to expand our services into the high school and include older siblings in their current programs. For an example, one county has a community health and information fair that serves families with children from the prenatal stage of life to 18 years of age. They have developed peer-to-peer parent mentoring groups, such as Circle of Parents, which is inclusive of parents with children of all ages. They also have the Energy Express Program which is a summer reading program.

While Energy Express is primarily for elementary aged children, with the additional Title IV-B funding, Starting Points FRCs use older kids and teaches them how to volunteer and to do community service which empowers them to become more involved in the community and eventually become leaders in their communities and their schools.

Ongoing work around infusion of the Protective Factors framework continues to take place. West Virginia now has a new website, a guide to the Protective Factors for in-home family educators, and a guide on how to explain the Protective Factors. More information can be found at http://www.strengtheningfamilieswv.org/.

Concerns include worker retention in programs as turnover and worker caseloads continue to increase. Other concerns are the budget available to these programs to maintain staff to administer the survey; continued trainings on the strengths approach to service delivery utilizing the results for the West Virginia Survey; and support administrative costs.

Collaboration continues to occur with BCF and the WV Home Visitation Program jointly managing the Parents as Teachers State office. They also provide trainings and technical assistance to In-Home Family Education programs.

The involvement of Maternal Infant Early Childhood Home Visitation (MIECHV) has allowed CBCAP funded In-Home Family Education (IHFE) grantees to receive numerous trainings and programmatic support.

In 2012, MIECHV funded $20,000 dollars for nine IHFE programs: (1) Upper Kanawha Valley: (2) Brooke-Hancock PAT; (3) Marshall County PAT; (4) Rainelle Medical Center; (5) Doddridge County Starting Points; (6) Northern Panhandle Head Start (Ohio County MIHOW); (7) Tucker County Family Resource Center, (8) Preston County Caring Council; and (9) Wetzel. This award was not for personnel areas but for development of programs, trainings, equipment, and other related service delivery.

MIECHV has also allowed for the development of trainings on data collected regarding child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits. Parent educator resources, parent handouts focusing on safety, childproofing, and prevention of injuries are in the PAT curriculum and have been provided by the WV Home Visitation Program. Parents as Teachers screens for domestic violence through the WV Home Visitation Program produced HITS tool (which stands for "**H**its you, **I**nsults you, **T**hreatens you, or **S**creams at you.") Comprehensive developmental screening is a required component of PAT. One of the preferred developmental screening tools is the ASQ-3.

Trainings for Ages and Stages, Depression Screening, Birth Spacing, Life Skills Progression, Home Visitor Safety, Healthy Families America core training, and Home Inventory training have been either paid for by WV Home Visitation or jointly by the Bureau for Children and Families and WV Home Visitation.

In 2006, the state organized efforts to standardize the 13 Community Collaboratives and the four Children Regional Summits. Activities to strengthen the existing community and regional Collaboratives included: formalized vision and mission statements; defining membership; and clarifying roles and functions of each collaborative group. Since then, two additional Collaboratives were created to an already existing Collaborative.

A team was created at the state level because of Service Array. The Service Array Steering Committee, also known as a SIT (System of Care Implementation Team), was developed to help pursue changes required at the state level so that the community and regional Resource and Capacity Development Plans (RCDPs) could be implemented.

The Collaboratives prioritized the 66 needed services by which services were needed in most areas of the state. The most needed services became the Year One Strategies. Those services included:

- School based Family Resource Workers
- Substance Abuse Services
- Adoption and Post Adoption Services

- Enhanced MDT Process
- Peer Support Groups
- Independent Living Services

The final strategy was to develop a plan to assess the quality of services being provided to families and children.

This strategy has not been achieved due to the lack of implementation of the plan to address the gaps in service availability. There are Administrative Services Organization (ASO) services being utilized throughout the state. These ASO services are subject to retrospective reviews through the contracted agency, APS Healthcare, Inc. This retrospective review is done through a review of case records based upon what the Department has determined to be outcome measures.

APS Healthcare also conducts Socially Necessary Focus Group Summaries. This process is conducted with recipients of each Socially Necessary Service. It is a ten-question process intended to provide the consumers of the service the opportunity to candidly share their experiences and opinions. They are conducted on a regular basis to gain insight regarding the utilization and impact of these services in the state.

Child Protective Services

Child Protective Services (CPS) operates under the authority of West Virginia State Statute. There are two primary purposes for CPS intervention in West Virginia: (1) to protect children who are unsafe, and (2) to provide services to alter the conditions which created the threat to child safety. CPS consists of CPS Intake Assessment; CPS Family Functioning Assessment (FFA); CPS Protective Capacities Family Assessment and Family Case Plan (PCFA); and Family Case Plan Evaluation/Case Closure. Due to West Virginia implementing a new Child Protective Services Decision-making model, some counties are still using the previous Ongoing CPS Process. Each step is described below.

Intake Assessment: The Department receives reports of child abuse or neglect through phone calls to the local office, emails, letters, and when referents visit the local office. These reports are routed through our Centralized Intake Unit via a 24-hour hotline. The report is accepted if the allegations meet the statutory definitions of abuse or neglect, which include if the children are in a situation where abuse or neglect is likely to occur. All mandated reporters are required to be notified in writing whether the report was accepted for assessment. When reports are not accepted, the family may be referred to other more appropriate state agencies or community resources to assist the family. If accepted for Family Functioning Assessment, the report is assigned a time frame for

response. The time frames are immediate response, 72-hour response, or 14-day response. The response times are assigned based on requirements in state statute and policy.

2016 Update

To meet CAPTA requirements, the Department has changed the response time for infants born drug or alcohol exposed to “immediate”.

A new definition of “immediate” was added to read as follows: Immediate response- A CPS Social Worker must respond as soon as the report of abuse or neglect is received unless there is a protective caregiver is identified. If there is a protective caregiver clearly documented in the report, contact must be made within the same day while the child is still under the care of that protective caregiver.

Due to the Child Abuse and Prevention and Treatment Act requirement that children born exposed to drugs or alcohol must have a plan of care prior to discharge and the misunderstanding of policy in this area, Child Protective Services policy was changed to reflect that all referrals alleging that a child has been born exposed to drugs or alcohol will be marked as an immediate response.

The definition of immediate response was changed to: must respond as soon as possible to the report of abuse or neglect unless there is a protective caregiver identified. If there is a protective caregiver clearly documented in the record, and a same day response will in no way jeopardize child safety, face to face contact must be made no later than same day of the referral, while the child is still with the protective caregiver.

2017 Update

To meet CAPTA requirements and WV Code passed during the 2017 legislative session, the Department has updated intake assessment policy to include reports involving Human Trafficking. The update includes identifying the trafficker as the maltreater and entering the report on the home of the trafficker, whether the maltreater is a parent or a third-party perpetrator. If human trafficking is suspected at intake, the report will be accepted and assigned an immediate response. The supervisor will contact law enforcement to report the suspicion of human trafficking within twenty-four (24) hours of receipt of the referral.

Family Functioning Assessment: The assessment of a report of child abuse or neglect sets the stage for the problem validation, service provision, and the establishment of a helping relationship in CPS. The primary purposes of the family functioning assessment are to gather information for decision making; to explain a community concern to the family; to explain the agency's purpose; to assess the family for possible safety threats; to reduce trauma to the child; to secure safety as indicated; to promote family preservation and expend reasonable efforts; and to offer help.

During the family functioning assessment, the CPS Social Worker collects information through interviews, observations, and written materials provided by knowledgeable individuals using a family-centered approach. This approach seeks to support and involve children, caregivers/parents, and other individuals in CPS intervention. The CPS Social Worker uses the information to determine if the children are abused, neglected, or unsafe and in need of protection. If the children are unsafe, the family must be open for Ongoing Child Protective Services. A safety plan is then developed with the family, in the least intrusive manner possible, to provide a safe environment while CPS attempts to alter the safety threats discovered. The safety plan can include paid and non-paid safety services. If possible, the assessment should be completed within 30 days of the receipt of the referral.

2016 Update

The Department adopted a Crisis Response/Reduced Documentation assessment. The purpose of this assessment was to create a uniform system statewide for districts experiencing a crisis in CPS due to backlog in overdue Family Functioning Assessments and to standardize the usage of reduced documentation.

Protocol was established for the appropriate use of Crisis Response/Reduced Documentation. This protocol is intended for all districts experiencing a backlog in overdue Family Functioning Assessments and to establish clear expectations for those counties approved to utilize reduced documentation. This protocol replaces all former standard operating procedures, documents, and instructions related to crisis response or reduced documentation. Districts must demonstrate correct application of this protocol to use it.

Backlog – A district is considered to have a backlog when they have CPS referrals pending over 30 days.

Backlog Crisis - A backlog is to the point of crisis when the number of overdue referrals is equal to or exceeds 100% of the district's average monthly acceptance rate.

Documentation is required for each impending danger threat identified with a narrative that focuses on the existence of protective capacities that help to rule out the threat. It must be family specific with examples and not a restatement of the impending danger.

There have been no changes to other sections.

2017 Update

The Department added Family Functioning Assessments involving Human Trafficking. An assessment tool, The Comprehensive Human Trafficking Assessment, was also added. The tool can be completed with the child/youth by the worker to determine possible trafficking victimization and may be found at the following website; https://humantraffickinghotline.org/sites/default/files/Comprehensive%20Trafficking%20Assessment.pdf.

The substantiation of maltreatment will be assigned to trafficker or parent/caregiver.
If a petition for custody is filed, the petition must indicate that the child/youth is a victim of trafficking. Law Enforcement must be notified within 24 hours of the Department becoming aware of the trafficking.

Protective Capacities Family Assessment: The Protective Capacities Family Assessment is a structured interactive process that is intended to build partnerships with caregivers to identify and seek agreement regarding what must change related to child safety as well as to develop family case plans that will effectively address caregiver protective capacities and meet the child's needs.

The Safety Assessment and Management System (SAMS) Protective Capacities Family Assessment and Family Case Plan Evaluation focuses on diminished caregiver protective capacities and the safety threats identified during family functioning assessment which may or may not involve court intervention. The Protective Capacities Family Assessment and Family Case Plan Evaluation is a structured, interactive intervention intended to build partnerships with caregivers to identify and seek agreement regarding what must change related to child safety and to develop family case plans that will effectively address caregiver protective capacities and meet the child's needs. The CPS Social Worker translates diminished caregiver protective capacities into client goals, and those goals are used to develop the family case plan. Services are then put in place to assist the caregiver in meeting the goals. The Protective Capacities Family Assessment and Family Case Plan must be completed within 45 days of the case being opened for ongoing CPS services.

Family Case Plan Evaluation/Case Closure: The family's case plan will receive ongoing evaluation by the CPS Social Worker. This process is called the SAMS Family Case Plan Evaluation. The Family Case Plan Evaluation is a formal decision making point in the safety intervention process that occurs minimally every 90 days, which requires involvement from caregivers and children; Family Case Plan service providers; and safety service providers. The purpose of the Family Case Plan Evaluation is to measure progress toward achieving the goals in the Family Case Plan associated with enhancing diminished caregiver protective capacities. The Family Case Plan Evaluation is also the decision point when the case may be closed for CPS Services. In addition, the family's case is closed when the parents can provide a safe home for their child, without CPS intervention, or their child is in another permanent living situation such as adoption or legal guardianship.

Service Population: Child Protective Services are provided statewide to families in which a child (ages 0-17) has been suspected to be abused or neglected or subject to conditions that are likely to result in abuse or neglect (as defined in WV Code §49-1-201 Definitions section and DHHR operational definitions) by their parent, guardian, or custodian. There are approximately 20,000 families who receive Child Protective Service each year.

Youth Services

West Virginia's Bureau for Children and Families Youth Services has been dedicated to helping families thrive. Our mission is to provide programs and services statewide that promote the healthy development of youth and families and help them gain the skills necessary to lead constructive lives within the community.

Assisting individuals living in West Virginia, Youth Services may help with problems ranging from the challenges associated with adolescent behaviors to homelessness to substance abuse or trouble with the law. The Department works with Community Partners to implement prevention programs, truancy diversion efforts, and in-home services to families so that youth do not become involved with the courts. However, when court involvement occurs, the Department may provide services or out-of-home placement. When the youth and family have worked through problems, reunification and permanency planning services are available to support everyone in the family.

Youth with court involvement receive case management from dedicated social workers who utilize family centered practice methodology, including Engaging Families through Motivational Interviewing. Current Youth Services policies and procedures emphasize the need for meeting with the family and youth and working collaboratively with other

agencies and professionals in the community to provide supports and linkages to overcome the behavioral control influences which led to court involvement.

Youth Services operates under the authority of West Virginia State Statute and consists of several basic steps. The steps can vary depending on whether there is involvement of the court. In general, the process is as follows: Intake; a Youth Behavior Evaluation; the Comprehensive Assessment and Planning System process for court involved youth; a Family Service Plan; Service Provisioning; and Case Plan Evaluation/Case Closure. Each step is described below.

Intake: Intake is a distinct step in the Youth Services decision-making process. Intake involves all the activities and functions which lead to a decision to either complete the Youth Behavior Evaluation or make a referral to appropriate Community Resources which are better suited to meet the families identified needs.

Youth Behavioral Evaluation (YBE): A Youth Behavioral Evaluation is used to assess the presence of or absence of risk and behavioral control influences. Behavioral control influences are those conditions which are currently present in the home and pose a threat to the safety of the juvenile, the juvenile's family, or the community.

Behavioral Control Plan (BCP): _Table_of_ContentsA Behavioral Control Plan is a Protection Plan developed whenever Behavioral Control Influences are identified, and immediate action is needed to ensure the safety of the child and/or the family. The Plan can involve informal, non-paid services such as temporary placement with friends or relatives. The Plan can also involve other services such as Behavioral Health intervention.

Completion of the Behavioral Control Plan and the In-Home Behavioral Control Plan is a short-term plan that is developed to control those Behavioral Control Influences which pose a threat to the safety of the juvenile, the juvenile's family, or the community. The Plan should consider each identified Influence and specifically address how these Influences will be controlled. The family should be engaged in the casework process to understand how the influences pose a threat so that they can gain acceptance and ownership of the Plan. In some cases, the worker will identify Behavioral Control influences and the conditions in the home are such that an In-Home Behavioral Control Plan is not feasible, and out-of-home placement must be provided.

Comprehensive Assessment Planning System (CAPS): WV Code requires that individualized assessments be completed for every adjudicated status offender and juvenile delinquent served by the Department. The Comprehensive Assessment and

Planning System (CAPS) was created and adopted by the Department to meet the requirements of the statute. The assessments are compiled into a summary titled the Comprehensive Assessment Report (CAR). The CAR is used as a guide for multidisciplinary treatment teams (MDTs) in making better, more objective decisions about the treatment needs of youthful offenders.

2016 Update

During legislative session 2015, the legislature revised the code section requiring a comprehensive individualized assessment, to include a validated assessment of risk and needs. The Supreme Court was asked to adopt the Comprehensive risk and needs assessment to be utilized across systems. The Supreme Court chose the (Youth) Level of Service Case Management Inventory ((Y)LS/CMI). The Bureau for Children and Families expects to have full implementation of the assessment by May 2016.

2017 Update

The YLS CMI has been fully implemented into the Youth Services case work process. However, the Supreme Court Administrative Director, Gary Johnson, along with Chief Justice Allen H. Loughry II, issued an administrative order revoking the requirement for the use of the YLS CMI. Though the department will continue to use it until a replacement option may be determined, we recognize this as a valuable opportunity to again shift the focus to family engagement and planning, and away from youth focused criminality.

Multidisciplinary Treatment Teams (MDT): There are requirements in state statute and federal regulations requiring the regular review of juveniles who are the subject of an MDT and may or may not be in an out-of-home placement. For youth involved with the court, state statute requires that an MDT report is made to the court prior to the hearing. The court must also review the individualized service plan for the child and family, developed by the MDT, to determine if implementation of the plan is in the child's best interest. MDT meetings must be held at least once every 90 days to review and revise, if needed, service and treatment plans until permanency has been achieved for the child.

2016 Update

To increase the participation of MDT members, the WV legislature made changes to code section 49-4-403 concerning the MDT process. The changes included a requirement for the Department to coordinate with the court to dedicate at least one day in which MDT's are regularly to occur. The intent is to provide at least on day each participant can dedicate solely to participating in these meetings.

2017 Update

Since May of 2015, the state has worked collaboratively with our judicial and legal partners to select at least one day per month, in each county, as an MDT day. The selected day is a day in which only MDT meetings are held ensure maximum participation of all codified members of the MDT and reducing unnecessary barriers to families. As of September 2016, 44 of the state's 55 counties had determined a date for MDTs to be held.

Youth Service Family Service Plan/Case Closure: The Youth Behavioral Evaluation process involves interviews of all the family members and assesses either the presence or absence of risk and behavioral control influences. Working with the family assures that the parent/caregiver understands the Department's role in providing services to address issues relating to troubled youth. In facilitating the discussion of the plan, the worker assists the family to address their strengths, needs, and prioritized goals related to the conditions which are the basis for Youth Services involvement. Services are provisioned to assist the family and youth achieve the goals which will lead to disengagement of Youth Services from family involvement.

Service Population: Each year, with the help of DHHR Direct Services Staff, hundreds of volunteers and community-based treatment partners, Youth Services works with an average of 3,000 families. The target population for Youth Services includes juveniles under the age of 18 years of age or between the ages of 18 and 21 if under the jurisdiction of the court beyond age of 18.

Family Engagement in Youth Services

West Virginia's families are served statewide by district offices. The Bureau's Division of Planning and Quality Improvement (DPQI) provides case analysis to help focus Youth Service social workers on areas that need attention in the casework process. Youth Services has used this data and tools available through the training department to significantly impact family engagement. Collaboration with community partners, private agencies, and public entities across systems continues to drive improved services for families, especially those with youth at risk of involvement in the Juvenile Justice System or with youth who are actively involved with the courts. Diversion efforts continue through expansion of Juvenile Drug Courts, Teen Courts, and partnerships with Juvenile Probation where the Department can provide in-home services to prevent out-of-home placements.

West Virginia Rules of Juvenile Procedure

In February 2005**,** members of the Court Improvement Project (CIP), Division of Juvenile Services (DJS), and the DHHR began writing new rules for Juvenile Court. Those rules were completed in late 2009 and approved in early 2010 after scrutiny by the West Virginia State Supreme Court. The rules for Juvenile Court are a standardized, fair, and consistent way of processing juvenile delinquency and status offense cases statewide. Judges have a better understanding of the services available to youthful offenders and the role of the Department in the treatment process because of the Rules of Juvenile Procedure. It is believed that increased cooperation between the Court and the Department will benefit youth and their families statewide. These rules continue to be monitored quarterly by the CIP juvenile court rules group. The Bureau for Children and Families has representation on this group. With the passage of Senate Bill 393, work has already begun to update these rules.

Truancy Diversion

Delinquency Prevention, as noted by Supreme Court Justice Robin Jean Davis, should begin with Truancy Diversion. "The truancy habit can lead students to drop out of school before graduation. That is usually the beginning of a lifetime of trouble that can include unemployment, drug dependency, crime, and incarceration," Justice Davis said. In 2010, a new state law reduced the number of absences needed to be considered truant from ten to five. This past year, the law reverted to ten absences.

Comprehensive Assessments

In 2002, the Bureau for Children and Families (BCF) began formulating a program improvement plan (PIP) to address issues identified in the Child and Family Services Review (CFSR). This included developing a comprehensive assessment of needs and strengths for children and families. To address comprehensive assessment and planning for youth and families, BCF, in partnership with private providers, developed and implemented the Comprehensive Assessment Planning System (CAPS). The CAPS process is the assessment protocol which is used to meet the treatment planning requirements established in WV Code §49-4-406(a).

2017 Update

In 2016, the department implemented new Youth Services policy changes to include:

1. The mandatory case management for all youth who are referred by the prosecuting attorney and are alleged to have committed a prosecutable status offense. The mandatory case management is applicable to all first-time status offenders and

any other non-violent status or misdemeanant youth which the prosecutor believes should be provided the opportunity to have informal resolution to the alleged incidents. The policy changes reflect the requirement for the youth services child welfare worker to complete a needs and strengths assessment of the youth and caregiver, the development of a family-driven service plan to address the family strengths and needs, and the referral to a child and family review team if the developed service plan is not successful in assisting the family through the issues which have brought them to the attention of the department.

2. Policy on the 1964 Title IV Discrimination Law and Title II Americans with Disability Act (ADA) laws to ensure Child Welfare Systems know about their responsibilities to protect the civil rights of children and families and ensure compliance with federal non-discrimination laws. The policy change reflects the requirement for youth services child welfare workers, and any other agency contracted through DHHR to make all case management decisions without intentional or unintentional discrimination. This includes discriminating on basis of age, race, color, sex, mental or physical disability, religious creed, national origin, sexual orientation, political beliefs, and limited proficiency in speaking, reading, writing or understanding the English language. The policy change also reflects ensuring children and families are receiving appropriate accommodations to address their disability to ensure they are receiving the best services that are available.

Foster Care

Health and Wellness

The physical and mental health of children in foster care continues to be an important contributing factor in the stability and wellbeing of our foster children. To ensure foster children receive this basic right and necessity, the Department's foster care policy requires all foster children receive health evaluations through our HealthCheck Program. HealthCheck is a collaborative effort between the Bureau for Children and Families and the Bureau of Public Health's Office of Maternal, Child and Family Health. HealthCheck requires children entering care receive an initial examination within 72 hours of placement. During the initial appointment, it may be determined that a child needs additional follow-up appointments, specialized appointments, or dental and eye care. If these medical services are needed, the child's worker is responsible for assuring that the child receives these medical services. The HealthCheck program also requires children

receive health care throughout their placement in foster care according to the child's individual needs and age based on a schedule provided in foster care policy. The Department utilizes a DHHR position known as the Sanders Field Liaison to assist the child's worker, foster parents, and health facilities to coordinate and ensure proper evaluations and examinations are completed on each child as they enter care. Assigned primary workers follow up with periodicity.

In addition, to ensure a child's health after discharge from foster care and an attempt to alleviate re-entry into foster care, the Department provides continued Medicaid eligibility to all children exiting foster care. Children are eligible for continued Medicaid coverage from the date of placement for a continuous period of 12 months, whether they remain in placement. Eligibility is re-determined during the child's one-year anniversary month, which is the child's initial placement month. For a child to be eligible for another 12-month episode, they must be in a foster care placement and in the custody of the Department. With the passage of the Affordable Care Act, all children who have aged out of foster care at age 18 are eligible for continued Medicaid coverage until the age of 26.

2016 Update

HealthCheck Foster Care Liaisons continue to ensure that health supervision plans for all foster children are established in FACTS, but the CSHCN Program has not yet implemented FHK statewide. However, the plans to implement FHK statewide have not changed, however. This means that all children who enter any foster care have a Sanders Liaison through Maternal, Child and Family Health, who screen them the following day, arrange their first well child visit and document the results of the screen. For those children who meet the criteria of Children with Special Health Care needs, Maternal and Child Health will continue to coordinate their care. Children with acute medical conditions will be followed as well if they are placed in a state agency homes. Children placed in Specialized Foster Care Homes will continue to have their health care coordinated by that agency.

Journey Placement Notebook

To ensure children receive adequate services to meet their physical and mental health needs, as well as their educational needs, the Department continues to utilize the Journey Placement Notebook. The Journey Placement Notebook is intended to provide foster/adoptive parents with a mechanism to receive and maintain information about a child they care for and to provide a central entity that contains all information from each placement. The notebooks are supplied to foster/adoptive parents when a child/youth enters foster care and is placed in a foster/adoptive home. There may be times when the

child/youth's worker may not have all the information about a child at the time of placement. Therefore, the Journey Placement Notebook serves as a continuous record in that information is entered throughout the child's placement in foster care.

2016 Update

The Bureau for Children and Families decided in the last year to make Journey Notebooks a requirement for all children in a foster care setting, including congregate care. In meetings with providers, it was decided that shipments of these notebooks will be drop shipped to the local providers as opposed to being given to them by the caseworker. All the forms included in the Journey Notebook are in the process of being updated and will be hyperlinked in the revised foster care policy which is posted on the Bureau for Children and Families website. The revision will be posted in July 2016.

Foster/Adopt Concept

The stability of a child's foster care placement is paramount and directly affects a child's wellbeing. To demonstrate continual improvement in the outcome stability of children's foster care living arrangements, the Department continues to practice a foster/adopt concept. In practice, all resource homes for children in foster care are initially approved as a foster home and an adoptive home. This practice concept was initiated to eliminate a change of placement from a licensed foster home to a new licensed adoptive home after Termination of Parental Rights and to alleviate lengthened time frames to adoption.

In addition to the foster/adopt practice concept, the Department continues to provide the Parent Resources for Information, Development, and Education (PRIDE) training curriculum statewide for foster/adoptive parents. PRIDE training is designed to equip foster/adopt families with the skills and information necessary to provide care to foster children and to encourage mentoring and active engagement between the foster parents and the child's biological family. Active engagement with the child's biological family improves the continuity of family relationships and ensures those connections are preserved for children. In addition, PRIDE training was initiated to aid child welfare staff to properly evaluate foster parents' strengths and needs on a regular basis. Policy requires all resource families to participate in 27 hours of PRIDE training curriculum Implementing PRIDE training statewide has eliminated the variation in foster/adopt training curriculum throughout the state that may have existed prior to this initiative. West Virginia is currently evaluating other foster/adoptive training models as well as making some of this training available on-line.

BCF plans to change its foster parent training requirements beginning July 1, 2015. The pre-service training requirement will be reduced to 21 hours, with an additional nine hours of trauma training required within the first year for all resource homes. We are also investigating the use of the new PRIDE online training utilizing the Foster Parent College website.

2016 Update

Expansion of Foster Care - Therapeutic Foster Care

To support West Virginia's IV-E demonstration project Safe at Home West Virginia, the West Virginia Department of Health and Human Resources, Bureau for Children and Families is looking to broaden its continuum of care by developing a Therapeutic Foster Care program. This program will serve children in foster care that may require additional services to allow them to remain in a family setting. The Therapeutic Foster Care program would provide a continuum of foster care services that would best meet the needs of the children in the state.

Therapeutic Foster Care is a family-based, service delivery approach providing individualized treatment for children and their families. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by Treatment Foster Parents. Treatment Foster Parents are trained, supervised and supported by qualified program staff. The values and principles of Treatment Foster Care are as follows:

- Normalization is a treatment principle and the power of family living as a normalizing influence;
- Kinship plays an important role in the formation of identity and self-worth;
- Kinship relationships impart a sense of family belonging to the child;
- The inherent need and right of all children to have a permanent family. Family reunification, adoption, kinship care or other long-term, stable family living arrangements are critical;
- Cultural diversity and the importance of developing competence in dealing with issues of diversity;
- Doing "whatever it takes" to maximize a young person's opportunity to live successfully in a family and community;

- The fundamental importance of documentation and the systemic evaluation of services and their effects.

A Therapeutic Foster Care program would allow for a continuum of care for the children within the program through an individualized approach to treatment. A child within the Therapeutic Foster Care program could experience a movement within the continuum based upon need, but this would not necessarily constitute a transfer to a different Treatment Foster Care home. Depending on the child's individual plan, it may be possible they could step down in the continuum or step up the continuum without experiencing placement disruption. The Bureau believes that such a continuum of care within the foster care system will provide for more flexibility in serving children with complex needs and will allow more children to be served successfully in a foster home setting when out-of-home care is needed. The Bureau further believes that a continuum within the foster care system would allow the ability for children, who need out-of-home care, to receive foster care services in a foster home setting would maximize the child's well-being and would also be less costly than a residential care/facility program.

A request for applications (RFA) will be released in May 2016, with awards being issued to successful candidates by July 1, 2016. Therapeutic Foster Care will be a program that will be available state-wide across West Virginia to include all fifty-five (55) counties. The RFA will seek one licensed child placing agency per geographical region whose focus will be the development of a full foster care continuum, including the three components of therapeutic foster care program, in each of the counties within that region. Successful candidates will describe the methods that will be used to recruit and train foster parents within each county in their respective region, including population and cultural issues that may factor into successful recruitment.

The children who will be served by the Therapeutic Foster Care program are those who are determined to need more intensive services than a traditional foster care home could provide. Three levels of foster care will exist: Traditional Foster Care; Treatment Foster Care; and Intensive Foster Care. The level of care that the child receives will be determined by their specific needs. These needs and level of care will be re-evaluated every 90 days using the CANS.

Traditional Foster Care is the system that West Virginia has historically provided. This level of care is ideal for children who have no significant indicators of trauma, behavioral or emotional issues, and difficulty in school, home, and community. These children do not exhibit any high-risk behaviors; have any significant medical issues, and no assessed needs for mental or behavioral health treatment. Children will receive the CANS assessment within thirty days to determine the appropriate level of care. This level of care supports normalization as part of a daily living. Crisis support will be available twenty-four hours a day as needed, and crisis response training must be part of pre-service

training for the foster family. Staff will have up to fifteen children on their caseload at any given time and must visit with each child at least twice monthly unless otherwise specified by the Department caseworker. Traditional Foster Care homes can use respite as needed.

Treatment Foster Care is the level of care to be used for children who exhibit a mild to moderate level of trauma/behavioral or emotional issues as identified through the CANS assessment. These children may present with moderate risk behaviors and have moderate difficulty in school, home and community. This level would include pregnant/teen mothers and other children who have medical needs that exceed preventative measures. This level will be used for all children entering care on an emergency basis. Children will receive the CANS assessment within thirty days to determine the appropriate level of care. Normalcy activities are encouraged to provide opportunities to practice life skills for these children. Crisis support will be available twenty-four hours a day as needed. These foster families will receive crisis response and trauma training as well as child-specific training related to potential crisis due to history and current issues, as well as consultation and response to the setting. Staff will be permitted to work with up to eight children at this level and must visit with each child at least weekly unless the Department caseworker requests that visits occur more often. Treatment Foster Care homes are strongly encouraged to use respite as needed.

Intensive Treatment Foster Care will be the level of care used for children who exhibit significant indicators of trauma/behavioral or emotional issues on the CANS. These children present with high risk behaviors and have significant difficulty in school, home and community. This level will be used for children who are stepping down from a higher level of care, are at risk for out-of-state placement, can be supported in the community as an alternative to residential care, are drug exposed infants with additional medical needs, and children who are medically fragile as diagnosed by a physician. Normalcy at this level is encouraged, but may take a lot of effort to safely and securely expose these children to experiences and activities in their community. Crisis support will be available twenty-four hours a day as needed, and these foster families will receive crisis response and trauma training as well as child-specific training related to potential crisis due to history and current issues, as well as staff consultation, staff response to these homes or other settings, aide support, modeling and coaching to assist with skill acquisition, emergency respite and reintegration to the home. Staff will only be permitted to work with six or less children at this level and must visit each child as often as necessary but no less than once a week to meet individual needs. Intensive Treatment Foster Care homes are mandated to use planned respite.

Successful agencies must be able to meet the components of all three levels of foster care.

West Virginia continues to require the PRIDE model.

2017 Update

In November 2016, two agencies for each of the four regions in West Virginia were selected to implement the grant funded therapeutic foster care homes. Some agencies were awarded more than one region. They were given a six-month period to recruit and train their Tier II and Tier III homes. An MOU will be released June 2017, to the BCF field staff that these homes are now ready to receive referrals for foster children who have been identified as requiring treatment foster care for moderate risk behaviors or intensive treatment foster care for high risk behaviors.

Kinship/Relative Care

In addition to utilizing the CAPS process to identify relatives as soon as children enter foster care, the Department continues to process kinship/relative home studies in an expedited manner as required by policy when at all possible. Foster Care Policy requires all kinship/relative home studies be completed within 45 days. To assist with this process the Department now has seven live scan machines which allow providers to use their sites for electronic fingerprinting for both state and federal background checks.

Also, the Department developed a Diligent Search Desk Guide for staff to utilize in practice that requires caseworkers to conduct a "diligent search" for the purpose of placing children with potential kin/relatives. The purpose of this guide is to assist the staff in their efforts. The search will be conducted for all child welfare cases, including Youth Services cases. Diligent Search is the efforts by the caseworker to use all "due diligence" in locating kin/relatives of a child placed into foster care. The diligent search does not end at identifying and notifying kin/relatives of the child's situation, but requires the caseworker to discuss their interest in being a placement option or an on-going connection for the child. Foster Care Policy section 13.21 Absent/Unknown Parent and Relative Search requires that the "search for an absent or unknown parent must occur within the first thirty (30) days of the child entering placement, so the parent can be involved in the court process, MDT, case planning process, visitation plan, and any other aspect of the case." This is applicable not just for absent/unknown parents but for all kin/relatives. This search is not limited to the first 30 days and can be on-going throughout the life of the case.

2016 Update

In August 2015, the Bureau for Children and Families made the decision to send all general inquiries to become foster/adoptive parents to private agencies. This decision has not only given more immediate attention to those who inquire to provide traditional foster care but it has allowed the state agency to focus on our growing number of kinship/relative studies and handle those studies in a more timely fashion.

MDT Process

WV Code §49-4-405 and 49-4-406 requires Multidisciplinary Treatment Team (MDT) meetings to be held on all children in child welfare custody cases in which children have been removed from their parents or caretakers. The department continues to utilize the MDT process as the central point for decision making in the life of a child welfare custody case. All parties involved in a case, including children in care and the family should participate in the MDT process. MDT activities include coordinating services; developing a case plan; evaluation and review of all aspects of the case including the child's permanency plan; and efforts to achieve the identified appropriate permanency goal in a timely manner. MDTs can be held in non-custody cases as well.

Active MDT participation is vital to making case decisions and achieving safety, permanency, and wellbeing. To improve the involvement of children, families, and individuals from all disciplines involved in case planning, the Department developed several handbooks for families to utilize.

The WV DHHR, with the help of Channing Bête Company, Inc., has prepared booklets for families involved with Child Welfare in several different areas including MDT's, Foster care, Youth Transitioning and Right to Be Heard.

The "Multidisciplinary Treatment Team" brochure was developed as a tool to be given to families, foster care providers, and individuals from many disciplines to educate on the policy and practice of MDT meetings as well as to encourage participation in such.

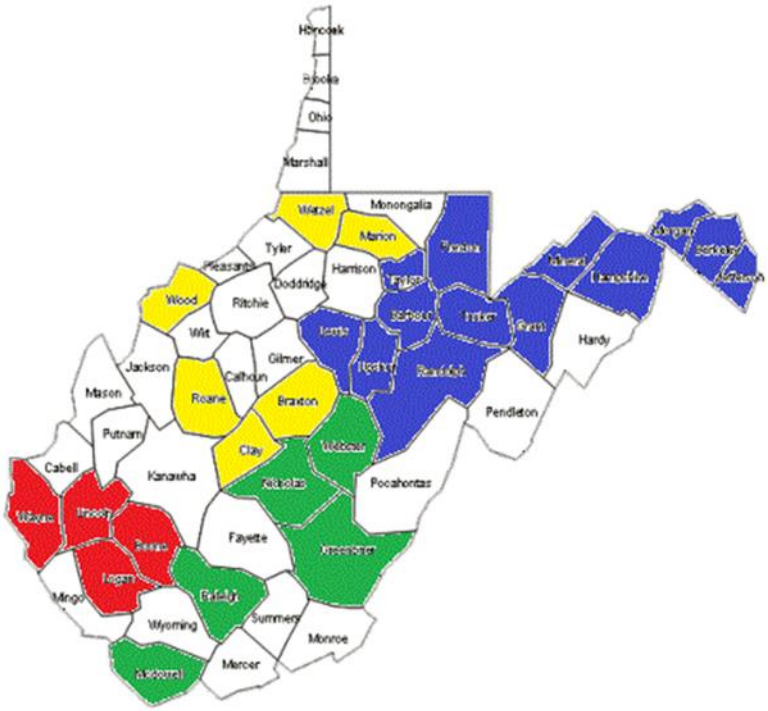
The "Foster/Adoptive Parents or Kinship Care Providers" booklet is given to all foster care providers to inform them of the child welfare process and their expected involvement in case planning.

The "What's Next" booklet is intended for youth to encourage them to participate in case planning, inform them of the MDT process, and educate them on how to navigate the child welfare system.

The "Right to Be Heard Letter" has been distributed to all foster parents, pre-adoptive parents, and relative caretakers to inform them of their right to be involved in the case planning for the child(ren) in their care. A memorandum was also sent to child welfare staff regarding the same to explain that they are required to give notice to any of these providers in a timely manner of any MDT meetings or court proceedings that take place via a letter, and they must document the notice within the FACTS contact screen for that case.

2016 Update

West Virginia passed legislation, §49-4-403 Multidisciplinary treatment planning process; coordination; access to information in the 2015 session that requires all counties to designate a day for team meetings. Many counties have established a day for these meetings but it continues to be an on-going process.



Region 1 (Yellow) Braxton, Clay, Marion, Roane, Wetzel, Wood
Region 2 (Red) Boone, Lincoln, Logan Wayne
Region 3 (Blue) Barbour, Berkeley, Grant, Hampshire, Jefferson, Mineral, Morgan, Preston, Randolph, Taylor, Tucker, Upshur
Region 4 (Green) Greenbrier, McDowell, Nicholas, Raleigh, Webster

Court Improvement Program (CIP) Multidisciplinary Treatment (MDT) Team Study Committee

Multidisciplinary Treatment Team (MDT) Desk Guide

The original MDT Desk Guide was developed in 2006 by a MDT Task Team, which is made up of Department of Health and Human Resources (DHHR) field and central office staff, private agency staff, and other State agency staff. The desk guide was developed to be utilized as a tool to assist staff in the MDT process.

In 2014, the MDT Desk Guide was updated by members of the Court Improvement Program (CIP) MDT Study Committee. The purpose of the updated Desk Guide was to assist both staff and other stakeholders in the MDT process.

The MDT CIP Study Committee has begun distribution of the MDT Desk Guide.

Standard MDT Curriculum/Package

A standard (statutorily required) MDT training curriculum package that will meet the needs of numerous stakeholders (e.g., objectives of the MDT, roles and responsibilities of team members, best practices, and educational stability and slide templates) was developed in 2014.

The Standard MDT Curriculum/Package included information to be shared with potential trainers/presenters wishing to provide training workshops on the West Virginia statutorily required Multidisciplinary Treatment Teams. Information includes sample slides and handouts.

The training curriculum package was piloted on May 29, 2015 in Braxton County (a central location in West Virginia). Sixteen DHHR caseworkers and supervisors and 15 caseworkers and supervisors from the Division of Juvenile Services attended the training.

The training evaluations confirmed that the training will be effective. However, the information regarding participation by school personnel will be revised to clarify their role in the MDT team process.

The Court Improvement Program (CIP) Multidisciplinary Treatment (MDT) Team Study Committee will determine in September 2015 who will retain the Standard MDT Curriculum/Package and the process for the annual review and/or revisions.

Effectiveness of Multidisciplinary Treatment (MDT) Teams Study, Summary of MDT Survey Results

In 2014, Judge Gary Johnson, Chairperson of the Court Improvement Program, requested that a survey be conducted to gauge the effectiveness of multidisciplinary treatment teams (MDTs) in West Virginia. The survey was designed to obtain a "snapshot" of how MDTs are conducted. The survey addressed MDTs in abuse and neglect cases conducted by the DHHR. In addition, the survey elicited information about MDTs in juvenile cases. The survey results concerning juvenile cases appeared to reflect DHHR MDTs as opposed to those conducted by the Division of Juvenile services.

The initial survey was distributed in the latter part of 2014. The BCF also sent the survey to their staff in January of 2015. The results of these two different survey distributions have not been combined. For that reason, we refer to the CIP and BCF surveys in this summary. When relevant, we also refer to abuse and neglect (A&N) and youth services (Y.S.) surveys. Most persons responding to the survey included, CPS workers, youth service workers, guardian’s ad litem and respondents' counsel.

Overall, 73.41% of the CIP survey respondents indicated that MDTs were conducted. MDTs are most often conducted every three months in abuse and neglect cases (42.21% CIP survey; 55% BCF survey), but a sizeable majority indicated that their counties conducted them monthly (29.22% CIP survey; 26% BCF survey). In youth services cases, the survey respondents indicated that they met every three months (45.45% CIP survey; 41% BCF survey), but a sizeable minority (37% BCF) indicated that they met at varying times every one to three months. Only 15.15% of the CIP survey respondents indicated that youth services MDTs met monthly. They did not have the response option of meeting at varying times every one to three months.

Most survey respondents indicated that MDTs met often enough to be effective (52.73% CIP A&N; 51.55% CIP Y.S.; 72% BCF A&N; 73% BCF Y.S.). It should be noted that the BCF survey respondents indicated that they met often enough to be effective at a much higher rate than CIP survey respondents.

A high percentage of the participants, although less than a majority, thought that neutral facilitation in abuse and neglect cases would make MDTs more effective (46.95% CIP A&N; 40% BCF A&N). However, 42% of the BCF A&N respondents indicated that neutral facilitation would not make MDTs more effective. Only 33.54% of the CIP respondents thought that neutral facilitation would not make MDTs more effective. In youth services cases, the CIP respondents were almost evenly split on this issue (37.50% indicating yes and 38.82% responding no). The BCF respondents had a slightly more varied response (41% responding no and 36% responding yes).

Other issues addressed by the survey included typical attendees at MDTs (primarily BCF workers, guardian's ad litem, respondents' attorneys, and probation officers in youth services cases), methods of participation (predominantly in-person and by phone), person that provides notice of the MDT (BCF personnel), length of MDTs (typically between 30 minutes to an hour), methods for the MDT to report to the court (most often a written report) and information that MDTs should provide to the court.

In addition to the specific questions, survey respondents could include open-ended comments on specific questions. These comments provide insight into ways that MDTs could be improved: better attitudes on the part of participants, accurately reflecting MDT decisions and recommendations and noting minority opinions in a written report to the court, better scheduling practices, set scheduling (i.e., set MDTs on specific days of the month), more visitation of child clients by guardian's ad litem and more participation by prosecutors in MDTs.

In May 2015, S.B. 393 (§49 4-403) passed, "In each circuit, the department shall coordinate with the prosecutor's office, the public defender's office or other counsel representing juveniles to designate, with the approval of the court, at least one day per month on which multidisciplinary team meetings for that circuit shall be held: Provided, that multidisciplinary team meetings may be held on days other than the designated day or days when necessary. The Division of Juvenile Services shall establish a similar treatment planning process for delinquency cases in which the juvenile has been committed to its custody, including those cases in which the juvenile has been committed for examination and diagnosis."

Annual Credit Report

Each child in foster care under the responsibility of the state who has attained 16 years of age receives without cost a copy of any consumer report (as defined in section 603(d) of the Fair Credit Reporting Act) pertaining to the child each year until the child is discharged from care, and receives assistance (including, when feasible, from any court-appointed advocate for the child) in interpreting and resolving any inaccuracies in the report. The consumer credit report must be provided to the youth without cost. Since credit reporting agencies do not knowingly maintain credit files on minor children, if a file is found, it must be interpreted and all issues resolved prior to the youth leaving care.

2016 Update

Foster Care Policy has been revised to reflect annual credit checks are required for youth in foster care beginning at age fourteen (14).

NYTD and Transition Planning Template

During the process of developing the SACWIS System's policy and program changes required by National Youth in Transition Database (NYTD), the state took the opportunity to revisit the way services were being provided to older youth. The policy was revised to reflect services being provided to "Youth Transitioning" from foster care, rather than the independent living services that were being provided to older youth.

The state has implemented a new requirement for the youth's Transition Plan, which is as follows:

A youth's Transition Plan must be personalized for the youth, developed by the youth, and contain specific information to assist the youth in their transition to adulthood.

90 days prior to the youth turning 18 years old, the Transition Plan must be revised or updated by the youth's worker and youth.

The plan must be personalized by the youth and must contain as much detailed information as the youth decides to incorporate into the plan.

The plan must contain the following specific information:

- Housing options and services;
- Employment services;
- Health insurance options;
- Mentor options;
- Workforce options;
- Continuing support services;
- Health care directives and how to complete an "advance directive," when requested; and
- Any other information that the youth deems important.

The state has implemented the Casey life skills assessment and curriculum process, and SACWIS changes have been made to incorporate this process. Through collaboration with the Service Delivery and Development Workgroup, a Transition Plan template has been adopted by the Department. A desk guide was developed to walk workers through using the template and entering critical data into the SACWIS system. The Transition Plan template is also posted on the Department's web page so that foster care agencies, guardian ad litem attorneys, and others can also use the tool with youth.

The state has made SACWIS changes to meet the reporting requirements for NYTD, including the outcome survey portion of NYTD. The changes to the SACWIS, as well as the data to be reported, have been tested, and NYTD data will be reported this period.

Youth assisted in the development of how the survey would be presented and explained to youth, prior to the survey section being developed in the SACWIS system.

2016 Update

West Virginia participated in the NAR review from May 17 – 19, 2016.

2017 Update

West Virginia's NYTD Snapshot

NYTD
National Youth in Transition Database

Data Snapshot

West Virginia

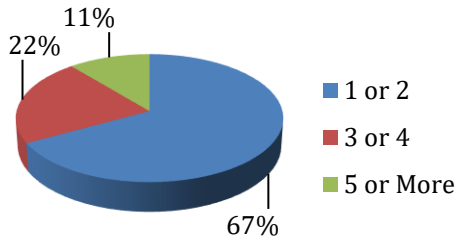
Youth Services
(FY 16 total served: 715 youth)

Includes information about all youth who received at least one independent living service paid for or provided by the state CFCIP agency.

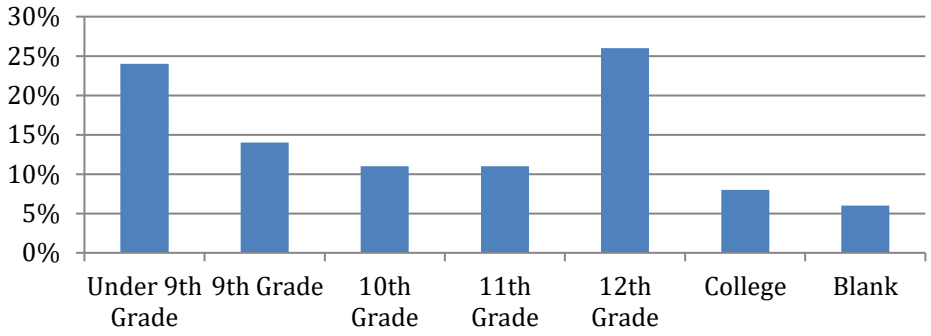
Characteristics of youth receiving services (FY 16)

Male	45%	In foster care	59%
Female	55%	In federally recognized tribe	<1%
White	94%	Adjudicated delinquent	16%
Black	13%	Receiving special education	1%
American Indian	<1%	Age range	14-23
Other Race	1%	Mean age	18
Hispanic	3%		

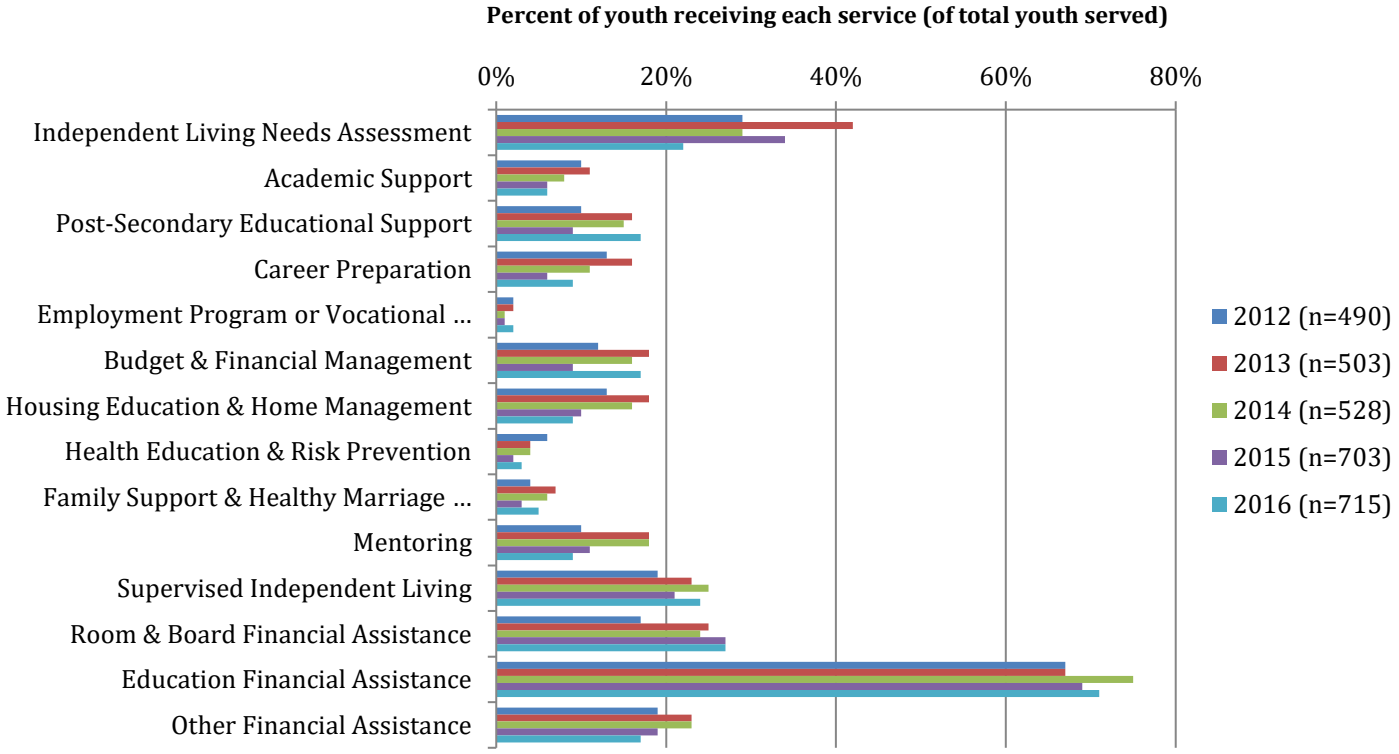
Number of services received (FY16)



Education level of youth receiving (FY 16)



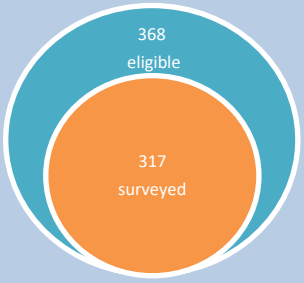
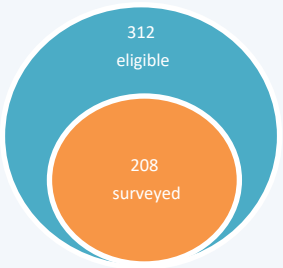
Type of services received (FY 12-16)



This snapshot was prepared by the Children's Bureau and contains a summary of highlights from NYTD data reported by states between Fiscal Year (FY) 2012 and 2016. The data are currentas as of March 2017. Please contact NYTDinfo@acf.hhs.gov if you have any questions about information in this data snapshot.

Youth Outcomes

Includes information about all youth who were eligible to take the NYTD survey at ages 17 and 19

	Baseline Population (17-year-olds in foster care, FY 14)	**Follow-Up Population** (19-year-olds, FY 16)
Survey participation, FY 14-16		
	86% surveyed	**67% surveyed**
Characteristics of survey participants		
Male	56%	54%
Female	44%	46%
White	94%	95%
Black	10%	10%
American Indian	<1%	1%
Hispanic	2%	3%
In foster care	100%	13%
Reasons for non-participation		
Youth declined	2%	32%
Parent declined	0%	<1%
Incapacitated	1%	0%
Incarcerated	1%	1%
Runaway/missing	2%	0%

Unable to locate	0%	1%
Invalid participant	8%	0%
Outcomes reported		
Employed full- or part-time	**7%**	**30%**
Receiving public assistance	**N/A**	**30%**
Finished high school or GED	**0%**	**0%**
Attending school	**95%**	**27%**
Referred for substance abuse treatment	**31%** (in lifetime)	**19%** (in past 2 years)
Incarcerated	**29%** (in lifetime)	**30%** (in past 2 years)
Had children	**4%** (in lifetime)	**10%** (in past 2 years)
Homeless	**11%** (in lifetime)	**25%** (in past 2 years)
Connection to adult	**99%**	**84%**
Medicaid coverage	**86%**	**67%**

Homelessness Prevention

2016 Update

Two programs have been awarded grants from the United States Department of Health and Human Services to provide shelters for Runaway and Homeless Youth. The programs provide crisis shelter for runaway and homeless youth ages 11-18 in Parkersburg and Wheeling. Any youth in the community may call or come to Children's Home Society or YSS-Wheeling anytime day or night. Two counselors are always on shift to provide crisis counseling, food, clothing, shelter, security, and individual, group and family counseling.

Youth and parents are welcome to call or stop by the programs anytime for advice or referrals to other services in the community. The DHHR-BCF does not provide any funding or oversight of these Runaway and Homeless Youth Programs.

YSS- Wheeling program reported for the SFY 2015 consultation with 47 youth who had or were considering running away from home. YSS shows that only three of the youth

counseled resulted in a referral to the Department of Health and Human Resources for an out-of-home placement. No reporting information was made available to the Department by Children Home Society.
In addition to YSS- Wheeling and CHS runaway and homeless youth shelters, Daymark center in Charleston, WV provides transitional living programming to homeless and runaway youth with the assistance of RHYA funding.

BCF partners with these provider agencies to ensure that youth who need housing receive it. Homeless youth who have aged out of foster care have the additional option of signing a contract with the Department in return for housing options. Options may include housing in a transitional living program, traditional foster care, or a housing subsidy for independent living. Youth may access these services through any of the 55 county offices. Temporary housing in shelter care may also be utilized until more permanent solution can be achieved. Youth who enter through the contract must agree to pursue higher education or job training, in addition to receiving services tailored to their transitional needs, as identified through life skills assessment and the youth's self-identified needs.

For youth who come to the Department who are experiencing homelessness and do not wish to engage in a contract or do not have a history of foster care, BCF will provide referral to YSS, CHS, Daymark, and referrals may include those to adult homeless shelters, when appropriate. Additionally, BCF will help to facilitate transportation to an appropriate placement.

2017 Update

Two programs have been awarded grants from the United States Department of Health and Human Services to provide shelters for Runaway and Homeless Youth. The programs provide crisis shelter for runaway and homeless youth ages 11-18 in Parkersburg and Wheeling. Any youth in the community may call or come to Children's Home Society (CHS) or Youth Services System (YSS)-Wheeling anytime day or night. Two counselors are always on shift to provide crisis counseling, food, clothing, shelter, security, and individual, group and family counseling.

Youth and parents are welcome to call or stop by the programs anytime for advice or referrals to other services in the community. The DHHR-BCF does not provide any funding or oversight of these Runaway and Homeless Youth Programs.

Youth Services System (YSS) admits homeless youth into its two emergency shelters, and for older youth into its Transitional Living venues in New Martinsville (Tuel Center)

and Wheeling (McCrary Center). YSS also meets homeless youth at its Winter Freeze Shelter which operates annually from December 15th – March 15th.

During this time, there were 14 admissions to the emergency shelters (12 females, 2 males) of youth 17 and younger. Ten (10) were discharged to home or relatives, 2 to the Transitional Living Program, 2 to Residential Treatment.

Eight (8) youth, ages 18-21, were served in the Transitional Living Programs. These older youths were enrolled in WIB Program that prepares, supports and sustains employment opportunities.

All youth in our care are afforded needed physical, emotional and treatment planning services.

During this time period's Winter Freeze Shelter 12 youth (18-21), 6 males, 6 females were offered services. Five (5) were helped with housing, 2 were admitted to our Transitional Living Program, 1 admitted to Substance Abuse Treatment; four (4) to other destinations.

YSS met two youth under 18. They put them and their parents in a hotel because they do not permit minors in the Winter Freeze Shelter. One of these youths was flown to a relative in Alabama, the other returned her to her mom to Morgantown.

Children's Home Society has a Basic Center Program at their Parkersburg site, which is a federally funded runaway and homeless youth program. This program serves youth ages 12-17 who have run away from home, are at risk of running away, or are otherwise in a homeless situation. This is a voluntary program, and parent / guardian permission is required for CHS to house youth when necessary. CHS utilizes a host home model (like foster homes), versus a shelter model. The aim is to stabilize the crisis within the home, and return that youth to a safe home with their guardian(s). In total, CHS served 57 youth through the Basic Center Program from July 1, 2015 – June 30, 2016. Some of these youths were served only briefly (23), some were only served by receiving the BCP "Let's Talk" curriculum at the Youth Day Report Center (12), and a few received services only by coming to our Teen Drop-In Center (14). Eight (8) additional youth received services for a longer period, though none were served residentially. None of these youths served during the SFY 2016 resulted in a referral to DHHR for out of home placement.

Pregnancy Prevention

2016 Update

West Virginia's adolescent pregnancy prevention programs are administered by the Bureau for Children and Families' sister agency, the Bureau for Public Health. The division directly overseeing the programs is the Office of Maternal, Child and Family Health. Historically, there has not been a close working relationship between the Bureau for Children and Families and the Office of Maternal, Child and Family Health related to adolescent pregnancy prevention. Therefore, in the upcoming year, collaborative efforts will begin to develop protocols for outreach to foster children regarding pregnancy and STI prevention.

2017 Update

THINK is an initiative of Mission West Virginia, Inc. (MWV) that focuses on adolescents and their health. The program is funded through federal and state dollars to provide education to adolescents across the state of West Virginia on issues related to teen pregnancy prevention, making healthy decisions, and positive relationship development. Currently, THINK is managing three federal grants, Teen Pregnancy Prevention (TPP), Competitive Abstinence Education (CAE), Sexual Risk Avoidance Education (SRAE) and two state grants, the PREP grant, and Title V.

Over the past ten years, THINK has provided over 85,000 students across 25 counties in West Virginia with pregnancy prevention education and positive youth development services. To accomplish their goals, Mission West Virginia, Inc. (MWV) has three partner organizations which include, Community Action of Southeast West Virginia (CASE), Rainelle Medical Center (RMC), and Regeneration, Inc. During the last grant cycle with the Teen Pregnancy Prevention Program, MWV and partners, served over 15,900 youth with evidence based curriculum and provided additional educational opportunities to 1,600 youth through teen expos.

Educational Stability

Child welfare agencies are required to assure educational stability for children in care. At the initial time of removal of the child from their home, the Department makes diligent efforts to maintain the child in the school that they are currently enrolled in unless it is not in the child's best interest. WV makes a concerted effort to place the child with relatives and fictive kin as often as possible who generally reside in the same communities as the child, which helps in providing educational stability.

Federal funding to cover education related transportation costs for children in foster care is utilized whenever possible. However, since WV is such a rural state, if placement is not

with relative/kin or local foster parents, the distance to maintain the child in the same school is great and usually not in their best interest.

The Out of Home Education Committee has embraced the Blueprint for Change. Subcommittees have been formed to address each of the Blueprints goals such as a seamless transition between schools and young children entering school ready to learn. There have occasionally been some minor issues in getting foster children into school if they must change schools; however, these are being addressed. Overall, this process has gone well.

2017 Update

On December 10, 2016, the new federal provisions to ESSA, Every Student Succeeds Act, went into effect, relating to best interest determination and immediate enrollment of foster children. Each state education department was required to submit their plan of implementation to the Department of Education. ESSA implementation is the responsibility of the state and local education departments. However, to achieve successful implementation of the new provisions, a collaboration effort with the Child Welfare Agency is required.

The Bureau for Children and Families created a team of to ensure that the Child Welfare field staff are aware and understand these new provisions. Meetings were set up regionally, with the regional directors, regional program managers, community service managers (CSM), social service coordinators, social service supervisors, and child welfare consults. Some meetings were completed through conference calls and others were conducted at quarterly social service supervisor meetings. The process and expectation for BCF field staff was introduced and explained during these meetings and guidance documents were provided.

It has been determined that the CSMs for each county or district of the Child Welfare Agency, will be the point of contact (POC) and the county or district Attendance Directors would be the POCs for the education department. CSMs were given the flexibility to choose a designee, (social service coordinators or supervisors) to work with the education agency POC on decision making and best interest determination. The CSM designees can handle all matters apart from any financial decisions that may draw out county funds.

Members of the BCF, ESSA team, came together to determine how transportation costs for foster children would be shared with the Education Departments and where BCF would pull these funds from. The final determination on cost sharing has not been determined and is still in the process. Data has been collected from each county or district,

Child Welfare Agency, to have a better understanding of how many children are placed outside of their county or district of origin. If the child is determined to be IV-E eligible, those funds can be used to share the cost of transportation for children placed in a county or district outside of their school or origin but the determined that it is in their best interest to remain in that school.

The data that was collected from each county or district on out of county or district placements has been given to the BCF financial department. This data is being used to estimate the state dollars that will be needed to share these transportation costs if the child is determined not to be IV-E eligible. This information must then be reported to the West Virginia legislature for a final estimate of cost. This data will be reported in August or September of 2017. Cost sharing and means of payment, other than IV-E eligible children, are pending at this time.

Uniform Child or Family Case Plan

The Uniform Child or Family Case Plan was developed and implemented across the state during the latter part of 2009. When a child is placed in the care, custody, and control of the state because of child abuse and neglect proceedings, various federal and state statutory requirements go into effect. The purpose of the requirements is to assure the child is safe, has a permanent placement, and has his or her emotional, physical, and educational needs met.

The Uniform Child or Family Case Plan is an automated report (Case Plan Report or CPR) in FACTS. The report contains all of the information necessary to fulfill the federal requirements for foster care programs and case plans SEC. 475 (42U.S.C. 675) of the Social Security Act and WV Code §49-4-408 state requirements for a unified child and family case planhttp://www.legis.state.wv.us/WVCODE/ChapterEntire.cfm?chap=49&art=6&section=5A - 06, Rules, 23,28 and 29 of the Rules of Procedure for Child Abuse and Neglect. **It is one document that fulfills the requirements for one federal statute and state statutes.** The Case Plan Report can be printed whenever needed. The Case Plan Report may be found in FACTS under “CPR” in the New Court location. FACTS will automatically populate some of the information to the report while some information must be added manually.

Recently, the Uniform Child or Family Case Plan was modified to include all the major provisions identified in the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351). The purpose of this law is to amend parts B and E of Title IV of the Social Security Act to connect and support relative caregivers; improve

outcomes for children in foster care; provide for tribal foster care and adoption access; improve incentives for adoption; and for other purposes. West Virginia's Uniform Child or Family Case Plan currently meets those needs.

The Department is currently revising all their Child Welfare Policies into one Policy. This policy will include a casework process for Child Protective Services, Youth Services, Foster Care and Youth Transitioning. It is hoped that by combining the philosophy of Family Engagement at all steps of the process to all who enter through the door there will be a more consistent practice of individualized case planning in all phases of child welfare.

2016 Update

Due to the amount of resources involved in implementing the requirements of Senate Bill 393 passed in the 2015 legislative, Child Welfare policy for the state of West Virginia remains separated into Child Protective Services, Youth Services, Foster Care (which includes Youth Transitioning) and Adoption. Although these have not yet been combined, a group has been convened to streamline assessments required by all the above program areas. The goal of this group is to establish one assessment process to use across program areas.

2017 Update

A small group of policy and field staff have continued to meet to develop an assessment and treatment planning process to use with both Child Protective Services and Youth Services case types. The intake process for each system will remain as they were. The group has determined a model, safety plan and treatment plan template. The policy is currently being developed and should be completed and forwarded to the training division by the end of July 2017.

4 Update on Service Description

The Preventing Sex Trafficking and Strengthening Families Act amended title IV-B and IV-E requirements to address domestic sex trafficking, limit use of another planned permanency living arrangement (APPLA) as a permanency plan for youth age 16 and older and requires agencies to modify their case review system to;

- Provide youth with certain documents when they age out of foster care
- Include youth age 14 and over more fully in case planning
- Limit APPLA as a permanency plan for youth age 16 and older
- Defined sibling

Progress on other requirements of this legislation will be reported in their appropriate sections.

WV Foster Care Policy was amended in 2012 to provide an additional policy for Youth Transitioning from foster care. Our Youth Transitioning Policy separated those activities specific to older youth in foster care who were planning to remain in care at age 18 or discharge to either home, on their own or post-secondary settings. These activities included transition planning with the youth, discussing advanced directives, credit checks and a Personal Exchange Document Discharge List (PEDDL). The PEDDL list is those documents that must be given to youth upon discharge from foster care and includes the following;

- the youth's social security card;
- certified original birth certificate;
- health records including immunization history;
- education records;
- life book;
- completed journey placement notebook;
- state photo ID;
- SSI application (copy), and;
- other information the youth may find helpful or important

WV Child Protective Services, Youth Services and Foster Care Policies have historically been based on intensive family engagement practice and youth involvement in their case planning was already an intrinsic value in all policies.

The limitation of Another Planned Permanent Living Arrangement (APPLA) to those youth ages sixteen and older required statutory changes that were codified this past legislative session. Policy as well as our IV-E state plan was revised in December to accommodate these changes.

Finally, WV revised its policies to incorporate the Federal definition of sibling. Our IV-E plan was also amended to reflect this change specifically. However, it should be noted that WV policies are much broader when considering sibling and kinship. In this state, kinship is defined as anyone a child views as a relative and sibling is anyone a child considers being a brother or sister. So, although policy was strengthened to include specific relationships, our practice of recognizing these groups has been much more accommodating.

In July 2004, the Department implemented the concept of a managed care system of sorts for Socially Necessary Services. These are services provided to children and families which are necessary to provide for the child's safety, permanency, and wellbeing and are not covered through Medicaid. Workers are expected to use existing, community services when available. Twenty percent (20%) of Subpart II dollars are used in each category. However, West Virginia typically must augment both the Family Preservation and Time-Limited Reunification cases with several hundred thousand dollars of state funding.

An Internet website section was developed and linked to the DHHR home page to assist interested parties in communities in determining whether they wanted to enroll as a provider of Socially Necessary Services. The website contains the following information:

- Overview of the ASO process and Socially Necessary Services;
- Overview of the ASO Process and CAPS;
- Enrollment materials;
- Utilization Management Guidelines;
- A Service Matrix;
- Information on payment rates; and
- Samples of the letters sent to providers.

Interested parties may review the material before deciding to enroll as a provider. They can also choose which services they can provide and the geographic area they can cover. The material also describes the qualifications for providers for each service. The enrollment process provides an opportunity for all interested parties to consider what they wish to provide and where they want to provide it.

With the development of the Socially Necessary Services system, the Department developed uniform definitions for services, standards and consistent credentialing for staff providing services, service criteria to help provide consistent client outcomes, a standardized authorization process for the initial approval of services, reauthorization of service continuation when warranted, and a process to review the services that were provided and uniform rates of reimbursement for services. All services are provided in every geographic region of the state. Due to West Virginia being such a rural state, incentives were built into the funding of the services to encourage providers to cover the more mountainous and sparsely populated areas. Services are outlined for each case type at the following website is http://www.wvdhhr.org/bcf/aso/.

As of May 28, 2015, the following recommendations have been made for the redesign of what was once referred to as Socially Necessary Services, which will be known as Community Support Services with the roll-out of Safe at Home:

1. Structural Changes to Service categories- Instead of the case designations being broken down into CPS and Youth Services, with the multiple sub-categories (See utilization report dated July 2014-April 2015), the services will be categorized into the federally required categories of Family Support, Family Preservation, Time-limited Reunification and Adoption Preservation.

2. Development of Performance Measures for Each Service Category- The current compliance-based methodology of measuring provider performance will be changed to results-based accountability. This will allow us to determine how much providers do, how well they do it and if our families are better off. Three to five performance measures will be developed for each of the four service categories;

3. Removal of the fee-for-service payment structure- Instead of payment for each individual service on a unit-by-unit basis, the recommendation is to develop case rates for each service category mentioned above. The family would be referred for, as an example, Family Preservation and the provider agency would assign an array of services within Family Preservation that addresses the family's specific needs. The case rate would be based upon the intensity of the specific case type: Family Preservation would be paid a higher case rate (due to intensity of need when families are experiencing crises and efforts are being made to keep children in the home) than time-limited reunification, where the children may be out of the home, and the main service may be supervised visits to reunify the children.

4. Removal of the following services from the utilization matrix:

    a. Child-oriented Activity will be completely removed (was previously removed from CPS cases but remained available for Youth Services cases);

    b. Child-oriented Group Activity;

    c. General Parenting;

    d. Family Crisis Response for Jacob's Law;

    e. CBT (This will become the Wraparound Facilitator through the local coordinating agencies)

f. Pre-reunification Support- This service is available to specialized foster care agencies now. However, those agencies receive case management payments which should include the provision of reunification activities with families;

g. Tutoring- Has not been accessed for authorization in one year;

h. Homemaker Services- Only three authorizations within the past year

5. Changes to the eligibility, service definition and provider criteria of existing services-

a. Under Family Support, require the CANS tool be used for Needs Assessment/Service Plan;

b. Case Management would not be available as a service option for families enrolled in Safe at Home, as the local coordinating agency would be receiving a case rate for the care coordination;

c. Family Crisis Response-Remove the requirement for a social work license;

d. Respite- Evaluate the four types of respite to determine if all are needed. Only one, emergency respite, has been utilized in the past year.

6. New Service Development-

a. Peer Support- For adults with substance abuse and/or mental health issue for which they are either undergoing treatment or recently completed treatment. The service providers a paraprofessional peer for recovery support;

b. Youth Coaching- Based on the Circle of Courage model, provides education and youth development skills that have evidence-basis for success.

c. Recreational Activities - Is a treatment service designed for all youth to be engaged in meeting their basic personal and social needs to be safe, feel cared for, valued, useful, and to build skills and competencies that allow them to function and contribute in their daily lives.

APS Healthcare continues to monitor the operation of the authorization process, the provision of training to service providers and Department staff, and the operation of the retrospective review process. The Bureau for Children and Families convened an oversight workgroup. The workgroup is composed of Bureau staff, staff from the ASO, and representatives of the provider agencies.

West Virginia continues to use a managed care approach to service delivery. Twenty percent (20%) of Subpart II dollars are used in each category. Family Support dollars are provided as grants to community providers. West Virginia typically must augment both the Family Preservation and Time-Limited Reunification cases with several hundred thousand dollars of state fFunding.

Family Support

After bringing together a cross section group to look at the Family Support category of ASO in late 2010, the Department decided to close this category of services in ASO and develop a Request for Applications (RFA) for Family Resource Centers. Family support services are now available to anyone in the state who needs the services without having to have an open Child Welfare Case. All West Virginia's IV-B Family Support money was diverted into community-based services and were outlined previously in the Prevention section of this report. As with all other grants, these will be evaluated yearly to determine if they continue to meet RBA outcomes established this year.

West Virginia redirected Family Support money to Starting Points to ensure this money was spent on preventing families from coming to the attention of the DHHR. It is difficult to determine how many families have been diverted.

Family Preservation

Currently, the Department offers Family Preservation Services to recipients of Child Protective Services, Youth Services and Adoption under the categories of Family Preservation, Time Limited Family Reunification and Adoption Promotion and Support. These services range from Individualized Parenting, Adult Life Skills, Supervised Visitation, Transportation and many other Services. Providers receive a referral from the family's worker to provide a distinct service. This referral allows the identified service to be provided for up to one year before a review of the service is completed.

During planning for the Title IV-E Waiver Demonstration Project, several groups were formed to look at different pieces of implementation. The Safe at Home Service Model Development Workgroup believes that services could be bundled for Family Preservation

under the current Infrastructure of Socially Necessary Services to include the current services available in this array of services. There would need to be additional services included like peer support and mentoring like those offered in the National Wrap-Around Model. This may require changes to our current CIB Policy. The bundle would be capped at either a length of provision or dollar amount.

2016 Update

During the 2015, legislative session the Governor's budget bill included a line item budget for the provision of evidence-based community services for juvenile justice involved youth. The result was the issuance of a grant announcement for interested entities to provide Functional Family Therapy (FFT) and Victim Offender Mediation (VOM). These services are intended to keep families together and provide alternative sanctions to youth involved in the court system.

2017 Update

The Bureau for Children and Families (BCF) structured Functional Family Therapy's (FFT) target population to be youth at-risk of involvement with the juvenile justice system and youth currently in out-of-home placement who may need an intensive family therapy program to more readily transition them back to their home and community. Currently, BCF funds three FFT teams providing service to sixteen (16) counties throughout the state. Our three FFT sites have served a total of 186 youth with 44 of these cases currently open and a 51% success rate, since the program's inception in March of 2016. The BCF continues to work with system stakeholders and providers to increase knowledge and awareness of the FFT program to increase the reach and effectiveness this service has to the community.

Victim Offender Mediation (VOM) has the capacity to serve both high and low level offenders in the community. The BCF has structured the VOM programs to include youth who cannot (status offenders) or will not participate in mediation receive case management with an array of service options. Our two sites were trained by the international authority on evidence based victim-sensitive mediation programs, Dr. Mark Umbreit of the University of Minnesota's School of Social Work. JVOM is currently available in in twelve (12) counties within the state and have served a total of 248 cases since March of 2016.

Time-Limited Family Reunification

Services offered under Time-Limited Family Reunification are sometimes the same as in Family Preservation. However, there is also a service bundle in this category known as Pre-Reunification Support. This service is for children who are still placed in foster care settings, but are beginning transitional overnight visits to the home from which they were removed. The purpose is to observe the interactions of the family as they adjust to being re-united in their own home and report to the DHHR worker and/or court regarding the family dynamics and give recommendations regarding the children being reunified. These observations are to be scheduled as well as random as determined by the MDT. The provider must be available to the family if assistance/modeling is needed including Saturday and Sunday. If a crisis arises that would require the possible removal of the child(ren) the DHHR worker must be notified immediately. Behavioral health services, preferably family therapy, should also be arranged for the family to support their adjustment to the re-unification. If possible, the same agency/individual that is providing services to the parents should be used to support the transition.

The Safe at Home Service Development Workgroup is considering both grants and fee for service type payment methods to deliver a similar, all-inclusive array of services under this service category. Like Family Preservation, these services would be either capped at length of service or dollar amount.

Adoption Promotion and Support Service

Foster/Adoptive family recruitment is an ongoing process because the foster care population is in constant flux as foster/adoptive families leave the system for various reasons, such as adopting children or ceasing to be foster/adoptive parents. Another factor for the need of constant recruitment is the existence of a special needs group of children for whom it is difficult to find permanent placements.

To aid in maintaining this effort, West Virginia previously enlisted technical assistance from AdoptUSKids, during which a strategic recruitment plan was developed. The recruitment plan provides for the Department to collaborate with stakeholders including Mission WV, private child-placing agencies, the family resource networks, and our foster/adoptive parent networks. Representatives from these stakeholders participated in developing the recruitment plan. The recruitment plan is the blueprint for the recruitment efforts in West Virginia and continues being utilized as a resource.

Drawing on the motivated and growing community of stakeholders brought together by the Department through the recruitment plan, a collaborative committee was formed to work on and coordinate recruitment and retention activities statewide and to explore both

public and private funding sources for recruitment efforts. This group, the Recruitment and Retention Collaborative, meets monthly.

The Recruitment and Retention Collaborative is comprised of DHHR state office and field staff from all four regions, Mission WV, CASA, the Prosecuting Attorney's Institute, private Specialized Foster Care Agencies, foster/adoptive parents, and others who are interested in recruitment and retention of foster/adoptive parents. The goals of this group are to not only recruit and retain foster/adoptive parents but to share information about emerging topics and best practices in the state. This group has had great success in raising awareness of foster care and adoption which is done through activities such as an annual foster care walk held during Foster Care Month, continuing education events for foster/adoptive parents and staff, and a retention activity for families each year during National Adoption Month.

Because of the extensive and statewide scope of the plan, priorities were developed to maximize the groups' efforts. Priorities included tailoring the recruitment message to coordinate information being disseminated, working together to compare recruitment activities, and finding innovative ways to leverage activities and resources already in place. Goals arising from these early meetings specifically targeted the need for additional outside (non-governmental) resources and the need to increase the number of recruitment events statewide.

The regional recruitment activities by DHHR staff include social activities and recruitment events for foster/adoptive families. Many of the DHHR staff has been interviewed by local newspapers and TV news stations. These staff host open houses and have become quite innovative in partnering with businesses in their communities to disseminate information about becoming a foster/adoptive family. Staff often speaks at local churches and community groups about becoming foster/adoptive parents as well as setting up booths at community fairs. DHHR staff participate in the Recruitment and Retention Collaborative and the events organized by that group.

The West Virginia Department of Health and Human Resources continues its formal partnership with Mission West Virginia, Inc. (MWV). The organization, a private nonprofit created in 1997, is contracted to provide recruitment services for both adoption and foster care. MWV has worked to promote adoption and foster care since 2001 and provides a comprehensive recruitment approach, employing all levels of recruitment statewide. They serve as a neutral information and referral source – referring prospective families to both the WV DHHR and all appropriate specialized child-placing agencies in the state. They also employ an in-depth, follow-up process providing prospective families assistance from initial inquiry to placement or adoption.

On staff, MWV has one Recruitment Specialist who is an adoptive parent designated to follow-up on inquiries. They employ three foster/adoptive parents total who use word-of-mouth to recruit new families. Data tracking progress and successes are recorded both through an internal database created by MWV and through the AdoptUSKids online database. Data collected includes the inquiry date, city, county, referral source, and basic family information. By tracking the referral source and following up with families in their internal database, MWV is better able to track the success of their recruitment efforts and determine which efforts have been most effective during a specified period. Additionally, MWV can track and report on benchmarks throughout the process (family certification, adoption, etc.) by looking at inquiry dates and follow-ups. Reports are provided quarterly to the WV DHHR. Outlined below are some of the recruitment services provided directly by MWV.

General Recruitment

During FFY 13, MWV provided general recruitment activities throughout the state, but the bulk of recruitment methods they employed fell into more targeted or micro levels of recruitment. Through research of similar demographic locations, MWV contacted Northeast Ohio Adoption Services, an organization that received a federal demonstration grant (Lessons from Rural Targeted Community Outreach, Federal Adoption Opportunities), that employed general recruitment in the State of Ohio. This resulted in MWV engaging in a direct mail campaign to a targeted demographic audience in communities throughout the state. The Direct Mail campaigns have two goals – the first is to recruit more families to provide foster care and/or adopt, and the second is to provide information about the myths and facts of foster care with the goal of changing the public's perception of foster care and the children who are in foster care. MWV also solicits free and donated media for promotion. They also keep web materials up-to-date and track the penetration of web outreach efforts. Finally, they are very active on social media pages, even purchasing ads on Facebook as well as the more traditional methods including billboards, brochures, materials with marketing message, etc.

MWV utilizes successful adoptive and foster parent stories to recruit families throughout the state. Their quarterly newsletter titled "Open Your Life" provides a platform for sharing personal stories and advice from foster and adoptive families in WV. Each year, MWV works with the Recruitment and Retention Collaborative of WV to organize an Adoption Celebration in recognition of National Adoption Month. At this event, there is a program that features the personal stories of adoptive families told by the families themselves. Through well-organized and strategic follow-up with families in their database, they maintain and nurture relationships with successful families who often volunteer to help with ongoing campaigns, special projects and speaking engagements. They encourage

their successful foster and adoptive families to promote foster care via word-of-mouth and keep brochures and handouts available for distribution. Sharing personal and positive stories about youth in foster care helps mitigate the public's poor perceptions of foster care.

Targeted Recruitment

In West Virginia, there is a strong faith community throughout the state. Churches are often interested in helping recruit families for waiting children, and MWV utilizes child-specific strategies to work within these communities. "Sunday's Child" is a bi-weekly column that features the profile and photo of children waiting for permanent placement. This column is sent to several churches throughout the state; these churches display the column in their bulletins or on an overhead projector during the Sunday service. MWV also presents information about waiting children and their programming to churches interested in learning more about foster care and adoption in WV. Whenever an adoption/foster care event is planned, MWV sends an information bulletin insert to churches that surround the area of the event. "The Heart Gallery of West Virginia" is also often on display at different churches in various areas of the state.

"The Heart Gallery of West Virginia" is a traveling photography exhibit that features portraits of WV's children in foster care who are legally eligible for adoption. MWV hosts "Heart Gallery Dinners" at restaurants in towns in each region of the state and invites certified and interested families to attend an informative evening that features the Heart Gallery. At each dinner, an adoption recruiter speaks about the children on the gallery, shares details about the adoption process, and answers questions from attending families.

MWV's FrameWorks initiative has for years primarily focused on working with children who are older; in sibling groups; are minorities in a state where roughly 95 percent of residents are Caucasian; or have other physical/mental/emotional challenges that have made adoption and/or foster care difficult. Through the direct mail campaign, they can segment the targeted population to best fit the children who are waiting and their needs. Specifically, MWV focuses their recruitment efforts to serve the entire special needs adoption population in the state. Additionally, the agency makes a special effort to show diversity in their promotional materials and respond to non-English speaking families who inquire. This concentrated effort has allowed the organization to best utilize limited resources to promote a population that needs the most support.

Child-Specific Recruitment

As previously mentioned, the Heart Gallery of West Virginia is a display that features photos and profiles of waiting children. This display is a great tool for creating awareness about the need for more families, specifically for older children who are waiting to be matched with a family. All children featured on the Heart Gallery fit the category of "special needs adoption" per WV law. This display is set up in locations with high foot traffic such as large churches, shopping centers, and bank lobbies.

MWV has partnered with many different news stations over the years to feature children through child-specific news segments. Since 2011, MWV has partnered with WBOY, a news station in central WV, to feature children on their "Finding a Family" segment. Through this segment, waiting children are given the opportunity to reach out to a large general audience. A special activity is arranged to give the child a special day and allow the audience to learn about the individual child. These segments often help audiences connect an actual child to the abstract need for adoptive families. MWV's toll-free number is included in all broadcasts, and the organization handles all inquiry calls and follow-ups.

Child-Focused Recruitment

WWK Mission West Virginia employs two full-time Wendy's Wonderful Kids recruiters through the Dave Thomas Foundation for Adoption who provide direct recruitment for approximately 40 children in the state who have been identified as special needs. Recruiters follow a child-focused recruitment model which involves establishing a relationship with the child; a complete case record review; adoption readiness assessment and adoption preparation; network building; recruitment planning; and diligent search. Independent research released in 2011 showed that children served through the Wendy's Wonderful Kids program were three times more likely to be adopted. Each recruiter covers one-half of the state and serves 15-20 children annually.

The WV Adoption Resource Network (ARN) is the state's online photo-listing. Although operated by the DHHR, MWV works closely with the ARN. All children served by MWV's recruitment efforts must be featured on the ARN, and often a referral to MWV leads to the ARN referral, which staff can assist with. Additionally, Heart Gallery portraits are used on the ARN, either when the child is first listed or to replace an out-of-date or poor quality photo. Certified families may register on the website and express interest in individual children. Encouraging families to use the ARN is a standard part of MWV's response to inquiring families.

Additional Awareness/Recruitment Techniques

Not all families are open to the idea of providing foster care or adopting but want to reach out to youth in foster care. MWV provides volunteer opportunities for communities to volunteer their time and services to brightening the lives of kids. The Carry-On Campaign is an ongoing effort with the goal of eliminating garbage bags as luggage for youth in foster care. This campaign is in partnership with the U.S. Attorney's Office (USAO) for the Southern District of WV and was able to easily become a statewide campaign with the support of the USAO and county DHHR offices. Over 2,000 pieces of new or gently used luggage and hundreds of toiletry items have been donated since 2010. Community members can also donate to the Celebrations! project, which is designed to create positive memories for children in the foster care system. For example, Celebrations! has funded adoption parties; a choir trip for a youth in foster care; a trip for a foster youth to attend a science camp; and many other enriching and meaningful events. Both projects have also generated several media and partnership opportunities and have led to adoption/foster parenting inquiries.

Through the Relatives as Parents Program (RAPP), an experienced foster/adoptive father and experienced PRIDE class trainer are available to answer questions and provide resources for relative providers. MWV updated their resource guide entitled "Kinship Care Support, Relatives as Parents Program Resource Guide" which has been widely distributed throughout the state and is available for download on their website. There are an increasing number of children in the U.S. who are living with relative caregivers who may or may not have formal custody or legal guardianship. This guide acts as a central source of basic information regarding the assistance and resources available to families raising their relative's children. The RAPP program also provides workshops in different regions of the state that focus on relative caregiving issues.

2017 Update

MWV submitted their information guide to staff from the National Resource Center after they provide technical assistance to DHHR in 2016. Professionals from the NRC reviewed the guide and made suggestion/revisions to ensure that the guide was helpful and clear for prospective parents.

After over 10 years the Recruitment and Retention Collaborative has shifted to focus more on retention events over recruitment activities. Statewide collaborative recruitment events have proven to be difficult because they are hard to plan on a statewide level and they often duplicate efforts already conducted by the individual agencies. The R&R has most recently been focusing on awareness/retention events tied to National Foster Care month and National Adoption Day. Recruitment is evolving to be conducted on a more regional basis- there are currently regional recruitment groups in each of the 4 DHHR

regions. These groups plan to focus their recruitment efforts on specific counties and areas that have been identified as having need for foster families, with messaging focusing on regional and county population numbers. Although DHHR will no longer be recruiting foster/adoptive homes, DHHR staff continue to participate in R&R and regional recruitment groups.

MWV has created a custom database (using a Microsoft Customer Relationship Management system) with increased tracking capabilities. MWV now tracks the following additional information related to foster/adopt inquiries: type of interest, stage of process, closure reason.

MWV continues to utilize all types of recruitment (media, direct mail, social media) but upcoming recruitment efforts will have more regional and county-based messaging as well as more hands-on work in specifically identified areas as opposed to efforts with statewide reach.

MWV continues to participate in child-specific recruitment (Heart Gallery, Sunday's Child, news segments) and child-focused recruitment (Wendy's Wonderful Kids). With the increased need for foster families, MWV recruitment efforts will shift to put more focus on general foster parent recruitment with less emphasis on recruiting families for specific children. The goal is that an increased pool of foster/adoptive parents will still result in resources for specific waiting children, especially considering that most adoptive matches occur within foster placements. The WWK program will continue to be utilized as one of the most effective resources for specific waiting children.

The above-mentioned recruitment activities are funded by IV-B Part 2 monies, the Dave Thomas Foundation, and the WV Bureau of Senior Services.

During the FFY 2013, West Virginia finalized 875 adoptions, 137 of these were completed by Specialized Foster Care Agencies.

2016 Updates

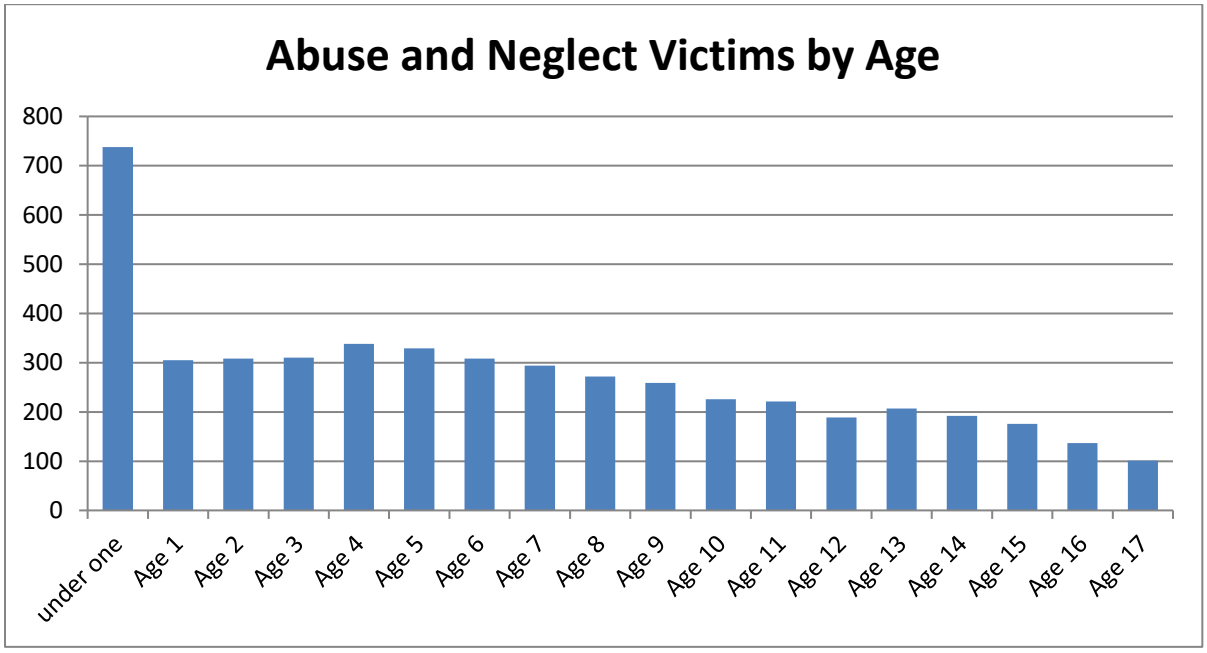
There were 893 adoptions in FFY 2014-2015, of those, 218 were specialized adoptions.

2017 Updates

There were 937 adoptions in FFY 2015-2016. Of those, 258 were specialized adoptions.

Populations at Greatest Risk of Maltreatment

Children three years of age and under have the highest rate of maltreatment in West Virginia. That age group accounts for approximately 33% of the victims in West Virginia according to data derived from our Statewide Automated Child Welfare Information System (SACWIS); up from 31% last year. More specifically, children under the age of one are most likely to be abused or neglected in West Virginia and be the victims of child fatality due to abuse and neglect in the state.



Child vulnerability is a key component in the Safety Assessment and Management System (SAMS). Child Vulnerability in the Safety Assessment and Management System refers to a child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size; dependence; and susceptibility. By focusing on vulnerability in the CPS Casework Process, the most vulnerable children will be better protected.

Early intervention services are provided to any child under the age of three who has been abused or neglected. West Virginia offers Right from the Start, Birth to Three, and Lilly's Place, which is a Neonatal Abstinence Syndrome Program for infants that are drug exposed. Safety Services are provided to ensure the most vulnerable population is safe,

and repeat maltreatment has been steadily declining in West Virginia. There are 40 Partners in Prevention community teams in West Virginia who provide services to vulnerable children and their families.

2015 Updates

The state has focused most of its resources in the last year on services to children under the age of one. As stated earlier, this demographic represents West Virginia's largest population of child fatalities, almost always due to co-sleeping and substance abuse.

The West Virginia Department of Health and Human Resources has convened of team leadership from both the Bureau for Children and Families as well as The Bureau of Health and Health Facilities to begin the process of modeling the Sobriety Treatment and Recovery Team (START) program implemented in Kentucky. We plan to implement two sites in Regions I and IV. The START program is an intensive intervention model for substance abusing parents and families involved with the child welfare system. The program integrates addiction and recovery services, family preservation, community partnerships and best practices in child welfare and substance use disorder treatment. It will provide substance abusing parents and families involved with the child welfare system a Family Team including a Mentor who has at least three years of sobriety and previous involvement with CPS.

West Virginia has also developed a Safe Sleep flier for workers to hand out to any families with newborns. This flier describes the hazards of co-sleeping and gives parents information on healthy, accepted safe sleep arrangements. The Department of Health and Human Services has also placed an emphasis on training for both new and tenured workers on assuring safe sleep in any referrals that involve newborns.

Safe Sleep is a topic of discussion at every Supervisor and Leadership meeting as well as a training topic for law enforcement as well as other Bureaus within the West Virginia Department of Health and Human Resources.

Training has been developed and will be rolled out in the fall of 2015 based on trends that have been seen in our critical incident reviews. Training will focus on adequately assessing substance abuse in the homes, assessing children under the age of three and adequate safety planning.

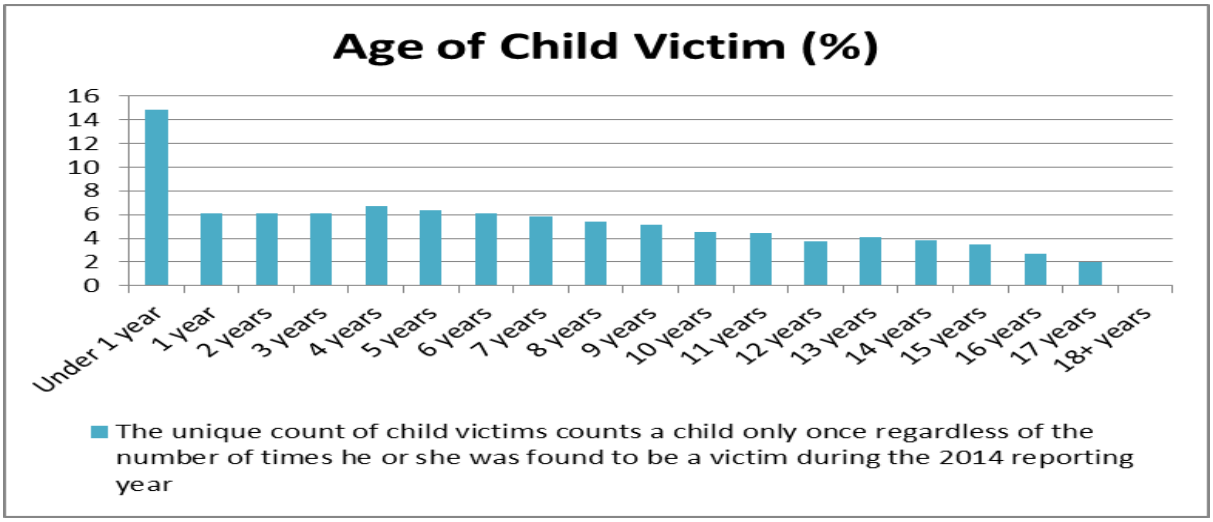
2016 Updates

To clear up confusion regarding the CAPTA requirement of a plan of safe care for infants born drug exposed, the Bureau for Children and Families revised Child Protective Services Policy, the Department has changed the response time for infants born drug or alcohol exposed to immediate.

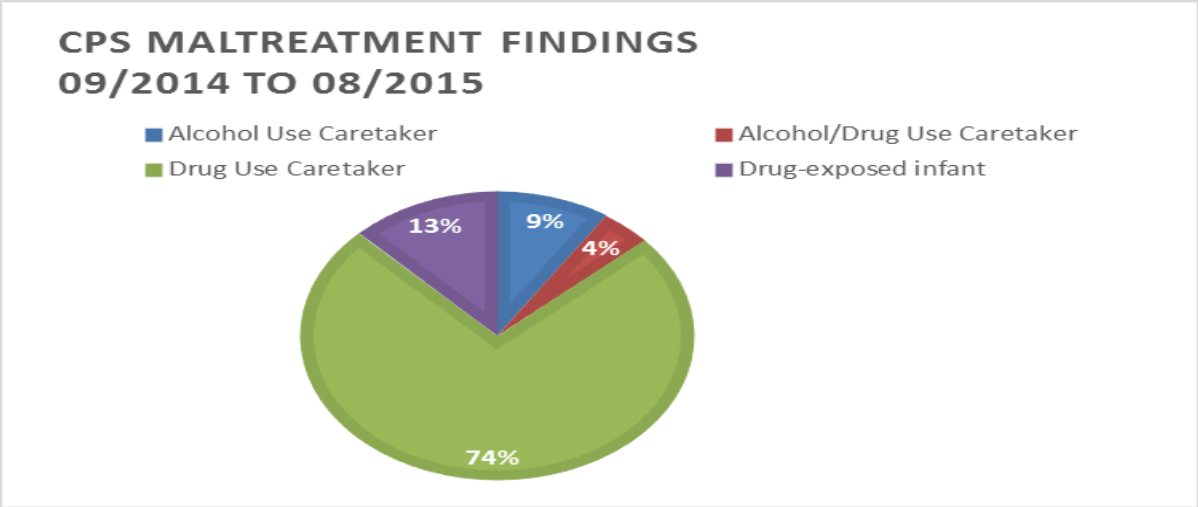
A new definition of immediate was added which says CPS Social Worker must respond as soon as the report of abuse or neglect is received unless there is a protective caregiver. If there is a protective caregiver clearly documented in the report, contact must be made within the same day while the child is still under the care of that protective caregiver.

The Department developed and implemented new training on critical incidents and appropriate safety planning training.

The population at Greatest Risk in West Virginia continues to be our 0 to 1 year olds.



The chart below gives specific data regarding our maltreatment findings.



West Virginia completed research on the Sobriety Treatment and Recovery Teams (START) Program modelled after Kentucky's program, to develop services to assist families with vulnerable infants and young children affected by parental substance use. This project is in its infancy now. The following is a list of activities and timelines associated with the research needed to move forward.

October 2015 -BCF & BHHF begin joint investigative meetings;

November 2015 -BCF Deputies for Field Operations tasked with START initiative for BCF and conduct a literature review, as the BCF internal team was formed;

December 2015 –Joint Bureau's Team meets and established goals of the project;

January 2016 - Talking Points and formal goals were developed; The position description process was developed to establish the Director /Manager and Coordinator roles which go to Division of Personnel for review and approval; BCF internal Team has conference call with Kentucky START Team; Positions identified to use for the Program Director or Manger & the Program Coordinator; WV-BCF START Organizational Chart developed; Received several "chapters" from Kentucky START program manual for use in developing a START program. Kentucky reports that not all chapters are available yet; BCF and BHHF explore options regarding hiring of peer mentors; BCF considers budget options for year three of START, possibly using TANF. Years one and two have dedicated funding through BHHF.

February 2016 - BCF connects with the director of WV Perinatal Partnership as a possible resource for peer mentors. West Virginia Perinatal Partnership, in turn, attempts to

connect with Kentucky START providers to get further information regarding how peer mentors are used; BHHF attempts to clarify roles and responsibilities between bureaus, as well as those in relation to provider agencies that may be used to support the peer mentors; The WV Division of Personnel (DOP) determines proper allocation of the START Coordinator Position and BCF Human Resources Director is to post the position; BCF Deputy Commissioner, Training Director and CPS Policy Specialist attend START 101 training in Kentucky.

March 2016 – West Virginia DOP determines proper allocation of the START Director /Manager Position;

April 2016- The Bureau for Children and Families places START development on hold while BCF evaluates other options such as the use of Recovery Coaches.

Pediatric Recovery Center

West Virginia's first "Pediatric Recovery Center", Lily's Place provides residential treatment for infants suffering from neonatal abstinence syndrome (NAS). Infants placed at Lily's Place may or may not be in the custody of the DHHR. The facility has developed contracts with the Managed Care Organizations in West Virginia, so they can provide services to infants who remain in the custody of their parent(s).

Since opening the doors at Lily's Place, infants exposed to cocaine, opiates, methamphetamines, prescription drugs, benzodiazepines and psychotropic drugs have been admitted for treatment. West Virginia has seen an increase in the births of infants who have been exposed to drugs. While most communities average 7 babies per 1000 births with drug exposure, the Cabell Huntington community has seen 137 babies per 1000 births with drug exposure in the past year.

During an infant's treatment at Lily's Place, parental involvement is required. The biological parents are provided with an addictions counselor, who assists them with their own substance abuse treatment issues. Lily's Place provides education and training to biological parents, foster parents, and relative caretakers so they will be prepared to provide care for the infant's special needs after the infant is discharged. This treatment, education and training will assist in the reduction of repeat maltreatment, including child fatalities, and minimizes placement disruptions that would have occurred without treatment, education and training to ameliorate the symptoms of NAS.

The facility has monthly follow up clinics for the infants that discharge from their program. The infants are scheduled to attend a clinic on average every 3 months. The clinic doctor

will see an infant more often, if there are any concerns found. They did not have specific participation rates, but indicate that they do have a very high rate of participation. At the last clinic, they had 20 infants in attendance. The facility also has a social worker, who is employed through the mental health agency, Prestera. She does follow up home visits with families and checks on the infant's care and progress. They have continued to follow up with infants that were in their program from the day of opening.

Data on Infants Served

Lily's Place began accepting infants for placement in early October 2014. Below is the data for the infants served, discharged and discharge placement:

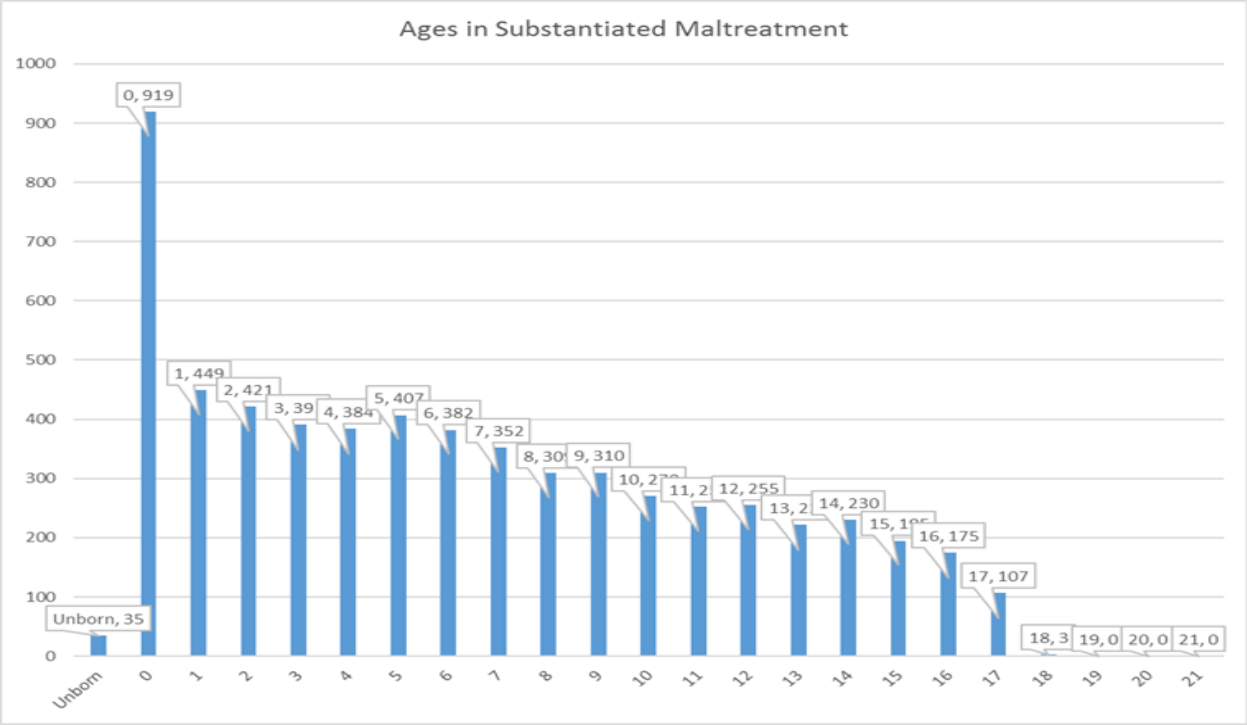
October 1, 2014 to September 30, 2015

- 57 infants admitted for treatment
- 4 weeks was the average length of stay for an infant
- 47 infants discharged
    - 22 discharged to parent(s)
    - 9 discharged to relative caretaker
    - 16 discharged to foster care

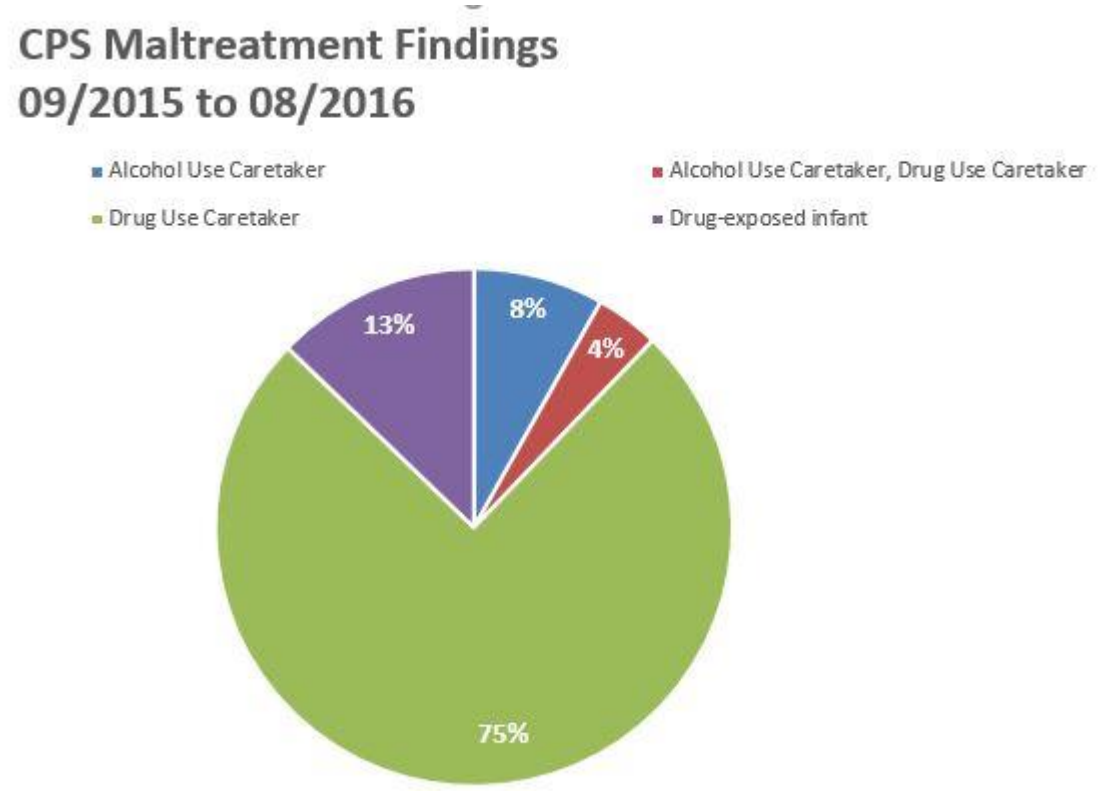
October 1, 2015 to April 15, 2016

- 43 infants admitted for treatment
- 4 weeks was the average length of stay for an infant
- 47 infants discharged
    - 32 discharged to parent(s)
    - 4 discharged to relative caretaker
    - 11 discharged to foster care

2017 Update



West Virginia's population at greatest risk continues to be our 0 -1-year-old. Again, this is due to the states drug epidemic.



Lily's Place began accepting infants for placement in early October 2014. Below is the data for the infants served, discharged and discharge placement, with updated data for FFY 2016 and for data for FFY 2017, up to May1, 2017:

October 1, 2014 to September 30, 2015

- 57 infants admitted for treatment
- 4 weeks was the average length of stay for an infant
- 47 infants discharged
    - 22 discharged to parent(s)
    - 9 discharged to relative caretaker
    - 16 discharged to foster care

October 1, 2015 to September 30, 2016

- 77 infants admitted for treatment
- 4.9 weeks was the average length of stay for an infant
- 72 infants discharged
    - 50 discharged to parent(s)
    - 21 discharged to relative caretaker
    - 6 discharged to foster care

October 1, 2016 to May 1, 2017

- 36 infants admitted for treatment
- 4.9 weeks was the average length of stay for an infant
- 32 infants discharged
    - 21 discharged to parents
    - 5 discharged to relative caretaker
    - 6 discharged to foster care

Lily's Place continues to provide monthly follow up clinics for infants who discharge from their facility. The follow up rate of the infants who attend the follow up clinics is currently at 59%.

Community Services and Outreach

Lily's Place provides community services and outreach for several counties in West Virginia. They maintain a "diaper bank", which supplies selected food and clothing pantries in the Tri-State area with emergency diapers to serve the needy families in the community. The facility provides community education on substance abuse issues, education and training for families caring for NAS infants and referral services for families in need of another type of service in the community.

To educate the community and surrounding counties on their unique services, they have done outreach to several county DHHR offices, county court systems, prosecutors and judges over the past year. They provided presentations on the program for staff in the following DHHR County offices: Kanawha, Cabell, Mason, Boone, Lincoln, Putnam, and Wayne. They sent packets of information concerning their program and held meetings with the judges, to the following county courts: Cabell, Wayne, Putnam, Lincoln, Logan, Mingo, and Mason. They sent packets of information concerning their program to the following county prosecuting attorney: Davitan (Wirt), Johnson (Calhoun), Skeen (Jackson), Downey (Roane), Samples (Clay), Milam (Nicholas), Tatterson (Mason),

Sorsaia (Putnam), Hammers (Cabell), Plymale (Wayne), Gabehart (Lincoln), Randolph (Boone), Harris (Fayette), Keller (Raleigh), Mann (Summers), StClair (Monroe), Ash (Mercer), Kornish (McDowell), Cochrane (Wyoming), Bennett (Logan), Teresa (Mingo), and Rocky (Kanawha).

2017 Update

Substance-Exposed Infants and Their Families workgroup has been organized and include the Bureau for Children and Families, Bureau for Health and Health Facilities, and Bureau for Public Health. This workgroup is developing a multi-agency response to families affected by substance use. It's apparent that all the bureaus are duplicating services in working with the same families. The group is trying to develop a protocol to determine which bureau best meets the needs of the family and develop an assessment tool that will identify this. A map will be created that will show both child fatalities and drug affected infants by county. This will allow us to the information necessary to target specific areas and/or counties in need of services. Working with hospitals and birthing centers regarding reporting drug affected infants is one step in identifying service need. The goal is to target limited resources affectively. The group is attempting to identify resources, including gaps and duplication, and using "Policy and Practice Framework 5 Points of Intervention Goals" that include:

Pre-pregnancy:

WV Perinatal Partnership is developing an informational brochure that discusses effects of drugs and other substances in pregnancy. It includes information on effects on fetus and on newborn.

WV Perinatal Partnership piloted a comprehensive women's health program to Day Report programs in 2015. The evidence-based curriculum that the program was based on ("Time out for Me" developed by TCU's Institute of Behavior Research) was shared with Judge Keller in Cabell County. As part of the health education, they emphasize reproductive health and effective contraception. Ideally, the program helps facilitate access to long acting reversible contraception (LARC) and other family planning services. They've proposed expanding the program to women of childbearing age who are at-risk for giving birth to substance exposed infant, including those in substance abuse treatment, judicial system for drug related charges and those who are identified as having previously given birth to an affected infant.

Prenatal - Screening and Assessment

The Prenatal Risk Screening Instrument is required to be completed at the initial prenatal visit for all pregnant women in the state. Questions include the 4Ps on substance use to screen for risk: patient's history of use; patient's previous use; parents' use, and partner's use.

Many obstetrical providers in WV also conduct urine drug screen at the initial prenatal visit – some are universally done as part of lab workup; others may do it if patient is determined to be at-risk.

The Drug Free Moms and Babies pilot project sites are required to provide SBIRT (screening, brief intervention, and referral for treatment). The pilot project sites are located at Shenandoah Valley Medical Systems (Martinsburg), Thomas Memorial Hospital (South Charleston), Greenbrier Physicians (Ronceverte, outside of Lewisburg), and WVU (Morgantown). Wheeling Hospital and Weirton Medical Center have recently added programs.

Identification at Birth

Most delivery hospitals have a policy in place for conducting urine drug screens upon admission to Labor & Delivery – either on every admission or if mom meets certain criteria. (WV Perinatal Partnership is currently conducting a statewide survey to get most current information on testing of moms and babies at the hospital). Confirmation of newborn's exposure is done by testing umbilical cord tissue, meconium or urine. (Policies vary by hospital and even sometimes within hospital by pediatricians.)

West Virginia Perinatal Partnership developed a standardized definition for diagnosing neonatal abstinence syndrome (NAS). All delivery hospitals have been trained on using this criterion. Training included the American Academy of Pediatrics' screening recommendations, NAS definition, medical coding on intrauterine exposure and NAS, etc. West Virginia Perinatal Partnership has provided (and continues to offer) training to nurses on assessing the signs and symptoms of neonatal withdrawal to improve consistency and accuracy. The Partnership also worked with OMCFH to have intrauterine exposure and NAS surveillance questions added to Birth Score data collection tool.

Enhanced Prenatal and Post-Partum Services:

The Drug Free Moms and Babies program follows women for up to two years postpartum. Marshall University's Maternal Addiction Recovery Center (MARC) provides Medication Assisted Therapy (MAT) and addiction counseling in their high-risk OB clinic. FamilyCare Health Center (in Charleston area) also provides services to pregnant women. CAMC also has a program. (Post-partum services are limited.)

Infancy and Beyond:

The Drug Free Moms and Babies programs follow families for up to two years and help link families to home visitation programs, Birth to Three, and other services for infants.

A spinoff group of the Substance-Exposed Infants and Their Families workgroup has also been organized focusing on families with substance use disorders interacting with the Bureau for Children and Families (BCF), with these goals:

- Engaging mothers and families in supportive ways;
- Developing consistent referral protocols across systems;
- Identifying appropriate treatment services and any gaps, especially for pregnant women and substance-exposed infants; and
- Workforce training on evidence-based addiction treatment, including medication-assisted treatment (MAT).

Healthy Connections

Healthy Connections is a collaborative community response to the treatment of mothers struggling with addiction and the well-being of their families. It undertakes the challenge of finding solutions to our region's high rate of neonatal abstinence syndrome, substance abuse, and the resulting consequences for child development and family stability by better integrating the existing programs and services in the community and building upon them. It seeks to increase inter-agency efficiency through research, education, and collaboration for patients, students, and providers. Participating agencies are committed to utilizing and improving upon evidence-based practices. West Virginia Office of Technology consists of over 20 community organizations including representatives from the City of Huntington, the Department of Health and Human Resources, several departments from Marshall University, Marshall Health and Cabell Huntington Hospital.

The Healthy Connections Coalition partners with the Marshall University Substance Abuse Coalition to provide a solution to the effects of opiate addiction in our region.

Treatment and Intervention

Support Services will include case navigators and peer recovery coaches.

Treatment of Prenatal Exposure

One in five babies born in Cabell Huntington Hospital (CHH) have been prenatally exposed to drugs. The Neonatal Therapeutic Unit in CHH and Lily's Place are uniquely equipped to provide the best and most innovative care to these newborns. Babies receive treatment in a quiet environment with therapeutic handling, with a volume driven feeding protocol, medicine to manage withdrawal symptoms if necessary, and general medical care. Parents are educated about the needs of their infant and available transition services.

Medication Assisted Treatment Programs

Medication assisted treatment (MAT) programs have been established as best practice for the treatment of opiate addition by the American Society of Addiction Medicine (ASAM) and the Substance Abuse and Mental Health Services Administration (SAMHSA). All participating MAT programs in the Healthy Connections coalition are committed to ASAM and SAMSHA best practice guidelines and adhere to requirements of the West Virginia Office of Health Facility Licensure & Certification. MAT includes medication management, group and individual therapy, education, and peer support groups. Psychosocial treatment focuses on helping mothers understand, learn, and practice living a drug free life by improving emotion regulation, decision making skills, and the ability to engage in healthy goal directed behavior.

<u>Enterprise Child Development Center</u>

Through a partnership with River Valley Child Development, Healthy Connections proposes to establish birth-to-two child-care services for infants with neonatal exposure. Staff will maintain best-practices to improve the development of these infants, integrate Marshall students into training and research programs, and then disseminate best-

practices and research outcomes around the state. By housing the daycare and other services in the same location, we aim to remove the transportation barrier and improve retention in the programs. This center will also be a location for the community to come together and support these families by providing a “one-stop-shop” for families and providers by reducing common barriers to treatment and improving service retention.

Services will include: Evidence based care-giver/child dyadic therapies addressing attachment, trauma, and substance abuse; Individual, Couple, and Family therapy; Recovery Groups; Community engagement services: GRE/education, legal services, vocational training, nutrition and cooking classes, exercise, gardening, support groups and skill building, organized fun social activities, education and resources related to child development.

Education

Healthy Connections’ strategic plan includes a strong three-fold focus on education. First, mothers who struggle with opiate addiction are educated about addiction, treatment rationale, local resources and the effects of drug exposure on their children. They are also educated about treatment options and interventions that may alleviate the adverse results of drug addiction. Second, the community and professionals will be educated about the biopsychosocial aspects of addiction and treatment related to Neonatal Abstinence Syndrome (NAS), the long-term effects of drug exposure, and the resulting challenges in the development of a secure attachment with caregivers. Third, Healthy Connections is committed to researching all aspects of this complex problem. Both the research process and resulting outcomes will educate students and scholars, develop local specialized providers, establish Healthy Connections and Marshall as a center of excellence in the treatment of this substance abuse, ensure the highest quality of treatment, and provide guidance to other communities who may struggle with similar concerns.

The Healthy Connections will engage Marshall students, from a variety of disciplines. They will be provided hands-on training opportunities to learn from professionals and experts in the field while engaging first-hand with struggling families. This approach will have a twofold benefit: one, students will become invested in the community, which will reduce the stigma associated with substance abuse as they build empathy by working with these families; second, this approach will reduce the mental health shortage as

students will be trained as the next group of experts on best-practices, innovative research, and community collaboration.

Prevention

Treating the negative effects of addiction are much harder and far costlier than providing prevention services in advance. Many groups are working to provide preventative services, and Healthy Connections is supporting collaborations between these groups to support their outreach. Prevention of neonatal exposure includes partnering with other groups within the Marshall Substance Abuse Coalition to support programs such as VLARC (long-acting birth control education and services), SBIRT screening services for providers, and drug-education throughout the school system.

Research

Process research, or research that not only seeks to understand the outcomes but rather understand the change mechanisms that occur throughout the entire process, is an essential part of the Health Connections objectives. Huntington currently imports its best practices from other communities who are not experiencing even half of the substance use epidemic and neonatal exposure rates. It is time for Huntington to take the lead and conduct research from pre-conception through the lifespan on infants and individuals who are substance use exposed. The systemic framework that Health Connections is working within will make this uniquely possible. We will be able to determine effective education and prevention efforts, potential differences in infants and mothers who experience different withdrawal symptoms, and identify interventions that are most effective for infants, toddlers, and school-age children with NAS. The outcomes of the research in Huntington can propel the nation towards fiscally responsible, truly-effective interventions, to stop the intergenerational effects of the substance use disorder epidemic.

Advocacy

Lily's Place advocated and supported a Bill that was introduced in the West Virginia Legislature in 2015, which would establish rules for Neonatal Abstinence Centers in the State. The bill passed during the 2015 Legislative Session. During the Legislative Session in 2016, the rules were passed for Neonatal Abstinence Centers and are effective now.

The new rules will now allow for the development of other Neonatal Abstinence Centers across the State.

Our Babies: Safe & Sound *(co-funded with OMCFH and Benedum)*
With support from the Bureau for Children and Families, Office of Maternal, Child and Family Health (OMCFH) and the Claude Worthington Benedum Foundation, we had a very successful quarter promoting infant safe sleep and efforts to prevent Shaken Baby Syndrome.
Highlights from the quarter include the following:

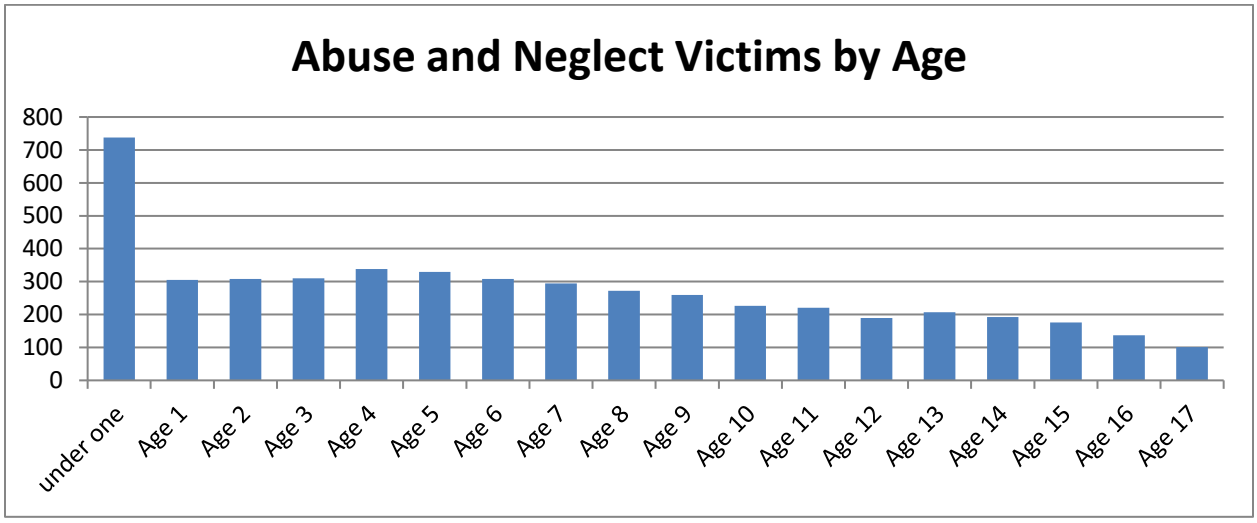
- Recruitment and expansion of hospital and home visitation partners for 2016 was a key focus for this quarter, resulting in 5 new hospital partners agreeing to join the program, including: Grant Memorial Hospital, Logan Regional Medical Center, Mon General Hospital, Weirton Medical Center, and WVU Medicine Children's Hospital. With the addition of these five hospitals, the program will be reaching 81% of West Virginia's birthing population. Activities related to outreach and recruitment included:

    - Introductory and outreach calls and emails
    - A briefing session with potential new hospitals in conjunction with the WV Perinatal Partnership Summit held on November 5-6, 2015;
    - Follow-up correspondence and hosting of an orientation call and follow-up calls and visits with potential new sites;
        - Development of revised participation agreements and overview materials;
        - Identification of corresponding home visitation programs through WV Birth Score data and planning calls with Partners in Community Outreach;

- Partnered with the WV Perinatal Partnership, the Office of the First Lady, and Cribs for Kids to co-host hospital safe sleep awards at the Governor's Mansion on November 5, 2015. Five hospitals received *Say YES To Safe Sleep for Babies* leadership awards, and 6 hospitals received national safe sleep certification awards through Cribs for Kids;
- Planned a plenary session on infant safe sleep at the WV Perinatal Partnership Summit. Presented by Dr. Rachel Moon, leading infant safe sleep expert and researcher, the presentation, *Infant Safe Sleep: What Parents Believe,* was well received;
- Planned and convened an additional regional training for home visitation staff, *The ABCs of Infant Safety* on October 22nd in Charleston, which was attended by over 30 participants;

- Made preliminary plans for annual competency training for hospital and home visitation partners to be kicked off in March 2016;
- Responded to technical assistance requests from home visitation staff and hospitals through regular peer-to-peer calls regarding readiness and implementation of *Say YES To Safe Sleep,* and addressed issues related to infant safety products on the market, timing of infant safe sleep audits and assessments, face-to-face education of parents, safe sleep education and NAS babies, and data collection;
- Finalized the new *Say YES to Safe Sleep* and *Keep Your Cool* PSAs;
- Responded to over 34 requests for educational materials (25,240 pieces of materials) for distribution to families this quarter;
- Made preliminary plans to revise portions of the safe sleep DVD;
- Reviewed the first set of quarterly benchmark data submitted by hospitals and home visitation partners on a trial basis. Collected copies of hospitals' and home visitation programs' safe sleep policies as well as forms used for nursery audits and in-home assessments to monitor practices;
- Convened meetings with partner organizations: WV Child Fatality Review Team, Birth-To-Three, and Right From the Start, to outline future directions; and
- Worked on sustainability plans and proposed ideas for private foundation funding, and development of staff operational plans.

Services for Children under the Age of Five



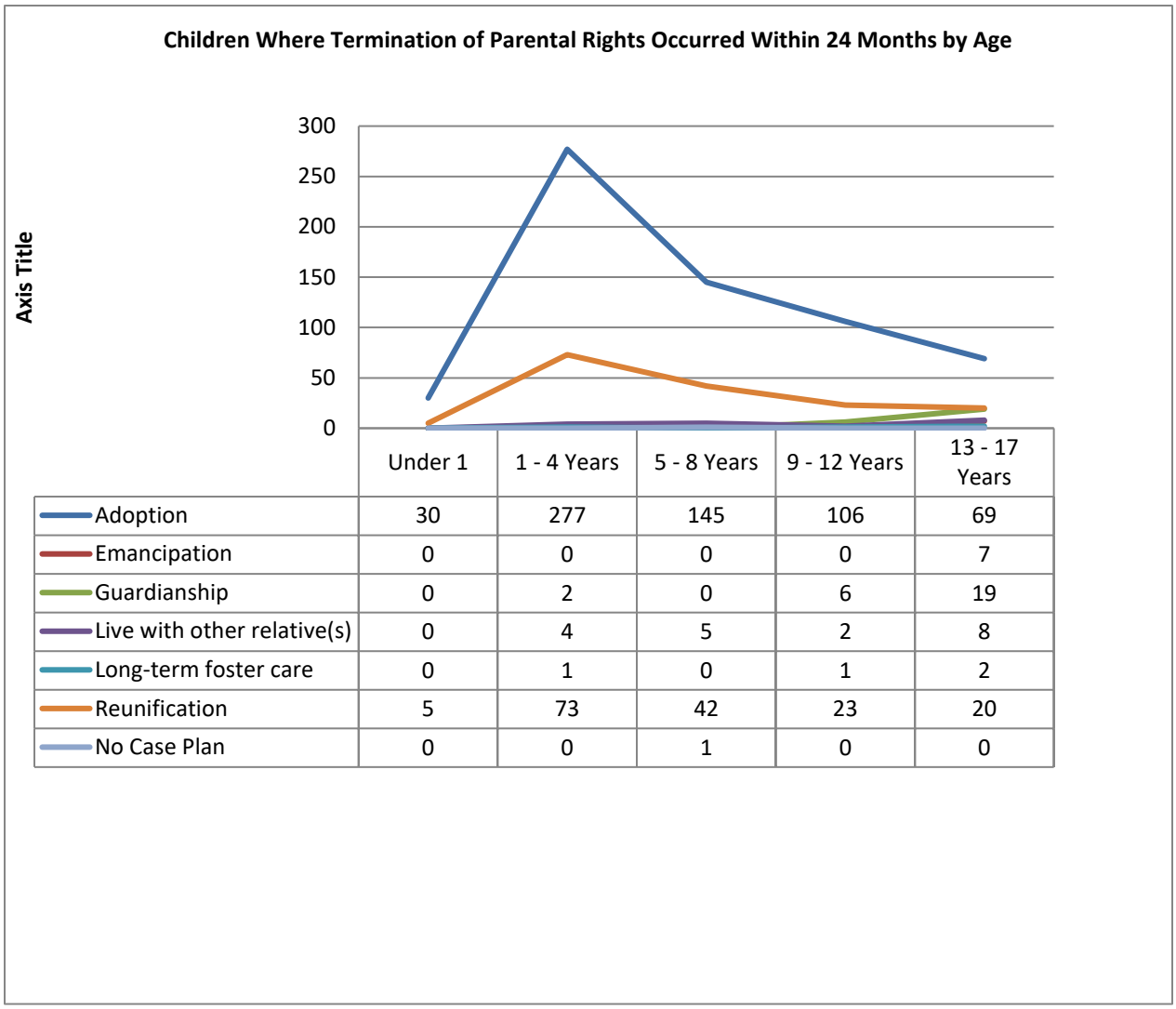
WV has requested and is receiving technical assistance from the NRC for Diligent Recruitment to aid in our issue of addressing completing timely Homestudies on kinship/relative homes as well as processing and certifying inquiries for foster and

adoptive parents. This will enable us to have a wider selection of available homes for children who come into foster care and will improve our matching abilities.

Also, during the last legislative session, a bill was passed relating to neonatal abstinence centers; authorizing neonatal abstinence centers; requiring the Secretary of the West Virginia Department of Health and Human Resources to establish rules to set minimum standards of operation for neonatal abstinence centers. It also required the state agency to consider neonatal abstinence care as a unique service.

Update:

West Virginia has placed a focus on moving children out of foster care for several years. This focus has worked extremely well for younger children. Most are either returned home within 12 months of removal or find permanent homes within 12 months of termination of parental rights, usually adoption by foster parents or relatives.



	Under 1	1 - 4 Years	5 - 8 Years	9 - 12 Years	13 - 17 Years
Adoption	30	277	145	106	69
Emancipation	0	0	0	0	7
Guardianship	0	2	0	6	19
Live with other relative(s)	0	4	5	2	8
Long-term foster care	0	1	0	1	2
Reunification	5	73	42	23	20
No Case Plan	0	0	1	0	0

West Virginia has recently made the decision to handle all inquiries from prospective foster parents through our existing grant with Mission WV. Mission WV will receive all calls from citizens interested in becoming foster parents and will help guide those inquirers to private Specialized Foster Care agencies. This will enable Department workers to focus their attention on completing kinship/relative studies timelier as well as allowing the private sector to focus more attention on recruitment of resource homes.

West Virginia will be refocusing their training and technical assistance from the NRC for Diligent Recruitment towards the private providers.

2016 Update

West Virginia START

West Virginia completed research on the Sobriety Treatment and Recovery Teams (START) Program modelled after Kentucky's program, to develop services to assist families with vulnerable infants and young children affected by parental substance use. This project is in its infancy now. The following is a list of activities and timelines associated with the research needed to move forward.

October 2015 -BCF & BHHF begin joint investigative meetings;

November 2015 -BCF Deputies for Field Operations tasked with START initiative for BCF and conduct a literature review, as the BCF internal team was formed;

December 2015 –Joint Bureau's Team meets and established goals of the project;

January 2016 - Talking Points and formal goals were developed; The position description process was developed to establish the Director /Manager and Coordinator roles which go to Division of Personnel for review and approval; BCF internal Team has conference call with Kentucky START Team; Positions identified to use for the Program Director or Manger & the Program Coordinator; WV-BCF START Organizational Chart developed; Received several "chapters" from Kentucky START program manual for use in developing a START program. Kentucky reports that not all chapters are available yet; BCF and BHHF explore options regarding hiring of peer mentors; BCF considers budget options for year three of START, possibly using TANF. Years one and two have dedicated funding through BHHF.

February 2016 - BCF connects with the director of WV Perinatal Partnership as a possible resource for peer mentors. West Virginia Perinatal Partnership, in turn, attempts to connect with Kentucky START providers to get further information regarding how peer mentors are used; BHHF attempts to clarify roles and responsibilities between bureaus, as well as those in relation to provider agencies that may be used to support the peer mentors; The WV Division of Personnel (DOP) determines proper allocation of the START Coordinator Position and BCF Human Resources Director is to post the position; BCF Deputy Commissioner, Training Director and CPS Policy Specialist attend START 101 training in Kentucky.

March 2016 – West Virginia DOP determines proper allocation of the START Director /Manager Position;

April 2016- The Bureau for Children and Families places START development on hold while BCF evaluates other options such as the use of Recovery Coaches.

The Division of Early Care and Education serves children under the age of five through programs supported with the Child Care and Development Block Grant (CCDBG), Community Based Child Abuse Prevention (CBCAP) funds, and federal Head Start through the State Collaboration Grant. The Division works with the child welfare system to offer a supportive continuum of services for West Virginia's most vulnerable population, our young children. Through training and technical assistance regarding understanding of early childhood socio-emotional development as well as the need for family engagement, all West Virginia's early childhood programs are being supported regarding the effects of trauma and poverty. Programs are learning to effectively support children and families who might have been impacted by either factor or are at risk for involvement with child protective services. The increased focus on a two-generation approach helps guide the work from the CCDBG and CBCAP programs and creates linkages with Head Start to support vulnerable children and their families.

Children in the foster care system in West Virginia are categorically eligible for Early Head Start and Head Start Services. These services include case management, mental health support and home visiting in addition to early childhood education. Child care subsidies have been available to foster families to support their child care needs without regard to income. The recent provision of federal funding to Early Head Start/Child Care Partnerships has increased the opportunities for families to receive Early Head Start Services, including family engagement, in settings that previously had limited capability of supporting vulnerable families. Now, child care programs can implement Head Start Standards in their infant and toddler classrooms, increasing access to the supports that families eligible for Head Start services typically receive. The current number of infant/toddler child care slots that are receiving funding in West Virginia is 175.

West Virginia leads the nation in children involved in state funded preschool services. West Virginia has implemented a strong collaboration with the Department of Education, child care programs and Head Start Programs. This collaboration has evolved over the last decade and a half to create a Universal Pre-K program that meets outstanding criteria for service. All West Virginia four year olds and three year olds with special needs are eligible for these programs which provide early childhood education to prepare children to be ready for Kindergarten.

Through West Virginia's Early Childhood Advisory Committee, the Division of Early Care and Education as well as the Division of Children and Adult Services, work with partners in the early childhood system to ensure a supportive continuum of services for all West

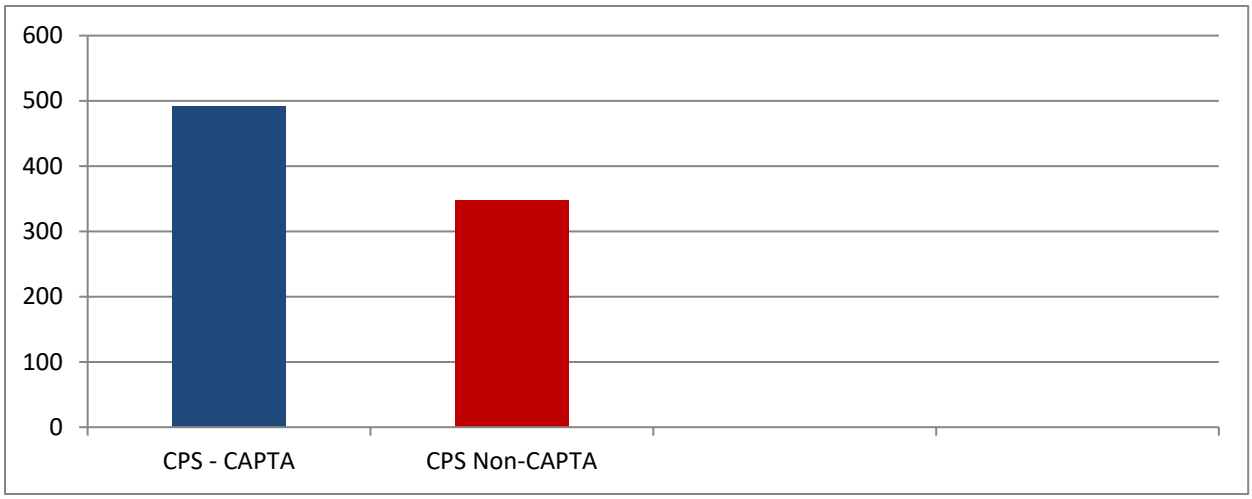
Virginia's children. One example of this work is the Family Engagement Committee. This committee has begun work to crosswalk the Head Start Parent, Family and Community Engagement Framework with the Five Protective Factors from Strengthening Families and work to integrate the principles into all early childhood settings. Starting Points Family Resource Centers, child care providers, Head Start agencies, home visitation programs, early intervention service providers, pediatricians, as well as state level government representatives and advocates comprise this group.

In West Virginia, enrollment was 16,622, down by 212 children in 2014-2015. However, the state serves 70 percent of 4-year-olds in the state and ranks 5th in the nation in access for 4-year-olds. West Virginia also saw gains in terms of quality standards – meeting all 10 of NIEER's minimum quality standards benchmarks with the new requirement for assistant teachers to have at least a Child Development Associate credential. Only 5 other states meet all 10. The passage of SB 146 (2016) helps move West Virginia forward in the provision of equitable services for all children, serving as a model for other states by requiring a minimum of 25 hours of weekly instruction.

Birth to Three services

West Virginia does capture referral source information for all children referred to WV Birth to Three. Previously, the system only captured the primary referral source. If a child was already receiving Birth to Three services and was referred by another referral source, (which could have been the case with a mandatory referral under CAPTA) the data system would not have captured that second referral. As of 2016 the data system was enhanced to capture later referrals for an active child. In the future, West Virginia will have better data for all CAPTA referrals.

Our local system point of entry grantees (Regional Administrative Units – RAUs) tries to determine at referral whether the CPS referral is a CAPTA referral, or Non CAPTA CPS referral. We have both CPS-CAPTA and CPS Non-CAPTA as referral sources. It is sometimes difficult for the RAUs to distinguish whether the referral is coming as a CAPTA referral unless the CPS worker informs them. This data can be broken down by county.



Report period of 5/22/15 - 5/23/16

Right from the Start

At-Risk for Developmental Delays for Calendar years 2012 and 2013

The 2012 Annual Report indicated the following findings;

309 (1.6%) infants scored were at-risk for developmental delay
60 (2.2%) of those at-risk for developmental delay were out of state residents

The 2013 Annual Report indicated the following findings;

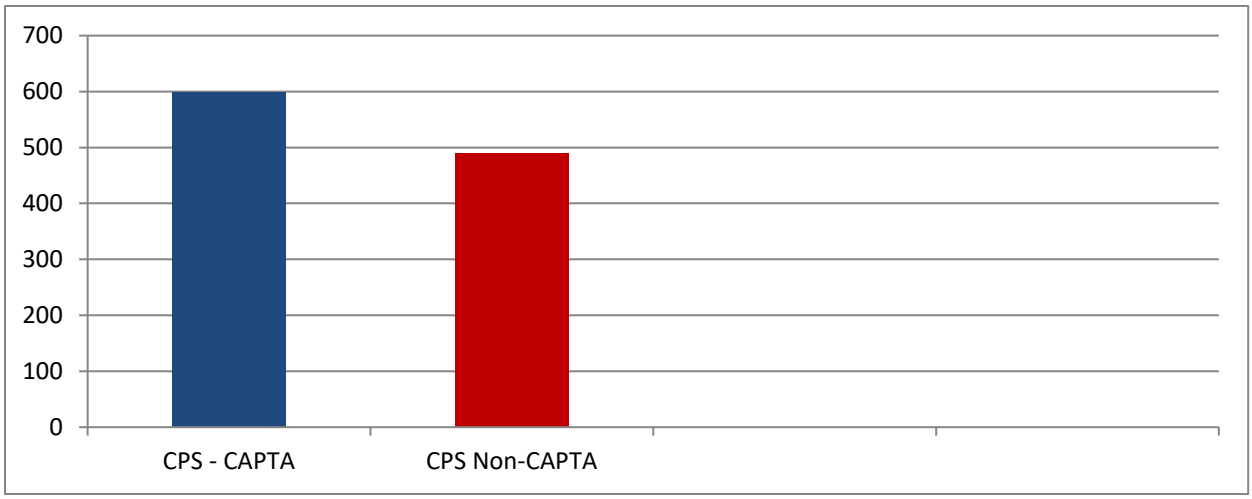
307 (1.4%) infants scored were at-risk for developmental delay

68 (2.4%) of those at-risk for developmental delay were out of state residents

Information and statistics about West Virginia's Right from the Start Program can be found at http://www.wvdhhr.org/rfts/

2017 Update

Report period is 4/1/2016 - 6/7/17



Services for Children Adopted from Other Countries

Children and Adult Services has recommended to the Executive Leadership team within the Bureau for Children and Families to contract all post-adoptive services in the state. The Department of Health and Human Resources has approved a recommendation to contract all post-adoptive services in the state of West Virginia and to remove them from Socially Necessary Services. As part of the contract, the contractor will provide post-adoptive services to all post adoptees, including international and private adoptions and their families statewide.

The Department of Health and Human Resources completed a survey of all foster and adoptive parents of both Department of Health and Human Resources and private adoption agencies to determine the services that are needed. The following services were identified and will be required as part of the contract:

- Provide all adoption competent services needed for a family within the contract funding.
- Provide case management for all services, including appropriate Medicaid funded services, ensuring they are adoption competent providers.
- Ensure that all providers of services are adoption-competent trained and certified.
- Increase the number of post-adoption providers of service that are adoption competent.
- Maintain a toll-free 24-7 warm-line.

- Develop resources for information dissemination, including regular newsletters providing topic-specific information.
- Training specific to child needs for both the providers and adoptive parents.
- Remove all post-adoption services from socially necessary services and make them a requirement of the contract.
- Aid adoptive families navigating the special education system.

As part of the recommendation we have identified the following outcomes:

- Reduce the number of adoption disruptions, including international adoptions.
- Reduce the number of children entering or re-entering foster care.
- Reduce the number of exploited children by preventing the inappropriate re-homing or abandonment of youth.
- Increase the number of adoption-competent providers statewide.
- Reduce the number of children entering PRTF level facilities both in-state and out of state.

We will continue to work with our SACWIS system to collect data on disrupted adoptions, including international adoptions. We do have a mechanism in our SACWIS system to collect the data, but need to continue to educate staff on the importance of this data. There are discussions with FACTS to make this information mandatory so we can begin collecting reliable data on both domestic and international adoption disruptions/dissolutions. In the interim, a memo will be distributed by November 1, 2015 reminding field staff of the importance of completing this 'pop-up' box. A request has been made to the Adoption/Homefinding Child Welfare Consultants (CWCs) for a hand count of any international adoption disruption/dissolutions. Once our Contract for post-adoptive services is operational, we will also be able to gather data on disrupted adoptions from the monthly reports.

2016 Update

West Virginia had no children adopted from other countries placed in state's custody in FFY 2015.

2017 Update

West Virginia had no children adopted from other countries placed in state's custody in FFY 2016.

5. Program Support

West Virginia is receiving Training and Technical assistance from the National Center for Diligent Recruitment to develop a plan for recruitment and retention of foster families. There have been two on-site visits with the NRC-DR, both for two days each. There have been multiple phone calls with the NRC and at least one more on-site visit is planned. The goals of the plan include:

- A comprehensive system assessment of issues effecting WV recruitment and retention efforts of foster/adoptive families.
- Assess the training and preparation of foster/adoptive families and determine if it meets the high needs of our youth in care particularly the older youth and sibling groups and children with very high needs.
- Assess the customer service provided to new and existing foster/adoptive families.
- Because of the comprehensive statewide assessments, develop a recruitment and retention plan to ensure the state has a sufficient pool of qualified foster/adoptive families that can meet the needs of the children coming into care as well as to sufficiently support the IV-E Waiver “Safe at Home WV” and its goal of reducing the use of congregate care both in and out of state.
- West Virginia Bureau for Children and Families has been working with the Capacity Building Center for States. We have completed our assessment, met to prioritize our needs and activities, and a plan is being developed to addresses the identified needs. The Primary focus on technical assistance will be activities that support Safe at Home West Virginia.

West Virginia will also have an independent evaluator with our Safe at Home Title IV-E Waiver Demonstration Project that will focus analysis of data on:

- Number of youth placed in congregate care
- Length of stay in congregate care
- Number of youth remaining in their home communities
- Rates of initial foster care entry
- Number of youth re-entering any form of foster care
- Youth safety (e.g., rates of maltreatment and recidivism
- Well-being of youth
- Educational achievement (e.g., number/proportion of youth graduating high school)
- Educational stability (e.g., number/proportion of youth remaining in the same school throughout BCF involvement

- Family Functioning

As part of implementation of Safe at Home West Virginia began has begun to work with our independent evaluator, system upgrades to West Virginia's SAWCIS are being developed. Changes and modifications to West Virginia's CQI process will be made to better facilitate evaluation and fidelity of Safe at Home West Virginia's Wraparound model. As part of the design of the Safe at Home West Virginia's is the creation of a Wraparound oversight team whose responsibility will be to provide technical assistance, guidance, and assure fidelity.

2016 Update

DHHR Bureau for Children and Families has forged a decade long partnership with Casey Family Programs as past WV State DHHR Secretary Joan Ohl, serving as the states representative. During the period of July 2015 to present, Casey Family Programs has provided three major project areas for WV.

In September 2015, Tricia Mouser trainer for Strength Based Leadership provided a two-day course for all managers in child welfare. Workshops around community engagement for the roll out of Safe at Home were the foundation of the two days. Role playing for each group of stakeholders associated with Safe at Home were used to help every local manger know and understand the value of individual conversations outside of group presentations. BCF has twenty-nine districts serving our fifty-five counties, of those Community Service Mangers sixteen have two years or less experience as mangers many without child welfare experience these types of activities assist in leadership capacity building within the Bureau. On June 1-3, 2016, a follow-up session has been planned to assist new managers since our fall session to understand the concepts of strength based leadership and then to continue a higher-level workshop concerning community and stakeholder engagement with all managers in BCF. It is our hope that these workshops will provide additional assistance as the Bureau continues to work on our systemic factor for the 2017 CFSR.

In October 2015, Casey provided invitations to stakeholders across the state to hear presentations about Safe at Home WV at the Embassy Suites in Charleston. The event brought a specialist in Trauma Based Therapy to the state that Casey and BCF are currently discussing a fall 2016 training event or spring 2017 in the state. A Virginia Judge who refuses to use residential providers and a team from this jurisdiction discussed community based resources both formal and informal with the group and a specialist on data collection. The two days were very well received by those who attend by the department, providers, and a member of court administrative staff. Unfortunately, only two judges and one legislator attended the meeting. One of the judges took a federal

magistrate job two months later and the second lost his bid for election on May 10th. The turn out from the judicial and legislative branches of government was disappointing.

Starting in January 2016, ongoing calls and a two-day face to face meeting were scheduled and completed with Don Winstead of Casey Family Programs to assist both the DHHR and BCF finance staff with the reporting and daily financial activities surrounding the Title IV-E Waiver Demonstration Project. The importance of key accounting, reporting structures, and understanding of the Terms and Conditions were major themes for the events.

On September 29-30, 2015 BCF held a project launch meeting with the Capacity Building Center for States. A work group was formed to work with CBCS to leverage existing reports to enhance the use of data, assess needs and develop reports for the worker and supervisor levels to enable continuous improvement, create and develop usable management reports, and enhance the ability of supervisors and management staff to use and interpret data appropriately to inform decision making. To date a plan has been finalized and a logic model has been developed.

The following are dates and activities that occurred;

September 29 - 30, 2015 – Capacity Center Meetings with BCF, Deputy Commissioners for Field Operations select *Collaboration with Schools* as a Strategic Goal for Project Planning with Capacity Center

State's Need Statement: Implementing and sustaining practice changes being tested in the IV-E Waiver Demonstration Project requires creating an enabling context both internally and in relationships with key external partners as well as the ongoing use of performance management reports to continuously improve practice and reduce the current over-use of congregate care.

Strategic Goal 3: BCF will leverage Senate Bill 393 to engage community partners in safely maintaining and supporting youth in their homes and communities. Initial work will target four counties with high truancy petitions and will eventually inform work statewide.

November 10, 2015- Deputy Commissioners for Field Operations Meet with Capacity Center. Project Plan developed for Collaboration with Schools.

November – December 2015 Deputies collect data and information regarding counties for project selection. Selected Counties: Wood in Region I, Cabell in Region II, Harrison in Region III and Mercer in Region IV

January 5, 2016 Formalized Project Plan received from Capacity Center

January 15, 2016 Deputies for Field meet with Capacity Center discuss selected counties, develop logic model, set target dates for work plan and discuss evaluation plans. Also discussed was a concern of potential impact and overlay of SB 393 with this initiative.

January – February 2016 Deputies collect Truancy Initiatives in process from across the state. Review of results indicates all initiatives involve court processes. Deputies receive recommended & subject related literature for review from CC.

February 4, 2016 Deputies convene with CSMs & RD's from selected counties for project introduction, review of Truancy Initiative collection results, planning, assignment of tasks & time frames

February 23, 2016 Deputies have check-in conference call with Capacity Center – discussed development of MOU's for this project, WV requests additional information from CC regarding Seattle WA JJ Demonstration project. Planning for update of logic model, review of reports and evaluation to include benchmarks for success, discussed using truancy rates to evaluate model – discussed code change that resulted in redefining truancy in WV and need to study how BCF policies will change due to SB 393 and impact this project.

February – April 2016 – selected counties continue to implement work plan for districts, broiler plate MOU and literature review results done by the BCF group are shared with the selected counties. One JJ Demonstration Project from Seattle WA (2007) may be a promising practice type of lead for this WV Strategic goal. Request made to Capacity Center for additional information regarding this resource. BCF Research will be asked to help follow up on possible leads to get additional information about the WA program.

April 12, 2016 – BCF internal Meeting to discuss SB 393 implementation – included in the discussion is its overlay with the Collaboration with Schools Strategic Goal Project – Field, Policy, Legal & Training in attendance. Decision made to evaluate status of selected counties with the Collaboration with Schools Strategy and decide county by county of the effectiveness of continuing with the collaboration strategy considering the 393 Diversion piece to become effective July 2016.

May 3, 2016 – Field Deputies meet with Capacity Center Lead to revise Logic Model and Work Plan. Update of the 393 issue and impact to this initiative is discussed. Deputies will evaluate continuing with this strategy with the team of selected counties and advise CC of result of that evaluation.

May 12, 2016 Field Deputies meet with CC evaluator, reviewed changes to the Logic Model, discussed evaluation plan considering extending the time frame for implementation of the Strategic Goal of Collaboration with Schools until after the July 2016 date for the Diversion section of SB 393. Truancy Tracking will start with revised

reporting in Oct 2016. CC evaluator will revise evaluation plan to reflect these and related time frame changes

May 12, 2016 – To date two of four project counties have reported in on project status.

One county – Harrison - reports some progress – although the work was initiated prior to the task related the strategic planning. Appears the county is building some initiative related to the 393 Diversion piece and has included some planning for truancy related cases.

Mercer County is reporting lack of progress but is planning to initiate in coming months.

Wood & Cabell – have not yet reported in. Deputies will be following up.

Target date to evaluate progress and plan next steps for this Strategic Goal – June 2016

West Virginia also worked with our Evaluator, Hornby Zeller Associates, to create automated WV CANS. All Phase 1 DHHR and Local Coordinating Agency staff have been trained in the use of the automated WV CANS and have begun entering WV CANS and subsequent updates. West Virginia has been using the CANS since 2003. It has been updated to the WV CANS 2.0. WV CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the WV CANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; GLBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module.

In February 2015, WV was approved for Training and Technical Assistance from the National Resource Center for Diligent Recruitment (NRD-DR). The NRC team came to West Virginia and began gathering data from staff interviews and data reports. Just as a plan was about to be developed, Bureau for Children and Families Leadership notified staff that the Recruitment and Retention of new foster homes was going to be given to private agencies. BCF staff would continue to develop kinship and relative homes.

A hold was put on the technical assistance in August of 2015 and resumed in late October 2015. Over the next few months, NRC staff as well as a diverse group of BCF staff and stakeholders met and developed a new plan and process for general foster/adoptive inquiries.

The Bureau for Children and Families currently is not in need of additional technical assistance.

2017 Update

With the passage of Senate Bill 393 in 2015, relevant agencies were provided the opportunity to receive technical assistance from the Crime and Justice Institute (CJI). The Bureau for Children and Families has worked with CJI to develop policies related to mandatory pre-petition diversion for all first-time status offending youth and optional diversion for all non-violent misdemeanant delinquents. Further technical assistance has been provided to pilot an evidence based program for aggressive youth called Aggression Replacement Training (ART). CJI will help to coordinate the training of ART facilitators and fidelity review monitors within the early months of 2017 year. ART is expected to roll out with its first cohort in late February, early March of 2017.

The Bureau continues to engage the Capacity Building Center for States to work on improving the Bureau's ability to interpret and use data to inform decision making.

In October of 2016 the team completed cataloging the existing system generated reports and completed both a gap analysis and data quality analysis.

In November of 2016 the Capacity Center held focus groups with Bureau staff to assess the use of data in managing work activities and to identify reporting needs. The Center provided a report of their findings to the Bureau in January of 2017.

The Bureau's data team and consultants from the Center for States identified a list of users consisting of CQI staff, managers, CSMs, supervisors and frontline staff to engage with MIS in User Group's to help identify data needs at various levels and to determine data analysis priorities.

Current activities include exploring new resources for building agency capacity for analyzing and reporting data to all levels of staff with a planned implementation of August 31, 2017.

Tasks included are:

- Exploring open source reporting tools that will allow the Bureau to create ad hoc dash boards and reports viewable at all staff levels.

- Developing internal capacity through instruction to increase pool of report developers

- Develop capacity to access data and develop mechanisms for optimal report distribution to all staff levels

- Development of standards for data collection, data validation and reporting.

The Bureau's data team with the help of the Capacity Center will develop a training plan with training and coaching materials on understanding and utilizing reports, using and interpreting various types of data, and using data in decision making to improve practice and outcomes. Completion date for this Plan is September 30, 2017.

The Bureau working with the Office of Management Information Systems and with technical assistance from the Capacity Center will develop a long-term strategy for creating a culture within the Bureau for using data to support its program of Continuous Quality Improvement to achieve the desired outcomes for children and families. This strategy will be from the ideal perspective and will leverage COGNOS to create data visualizations for use by all levels of management and staff based on the data measures for federal outcomes.

Recruitment & Retention - WV Bureau for Children and Families began to work in depth with the Capacity Center in early 2016 around a plan for Staff Recruitment & Retention. The initial plan involved 7 factors:

1. Develop a plan to Calculate Turnover
2. Develop a plan to Calculate Cost of Turnover
3 and 4. *Develop a plan to Diagnose Causes of Turnover and Identify Solutions*
5 and 7. *Develop a plan to Prioritize and Implement Solutions and Adjust Course, as Needed*
*6. Develop a plan Evaluate Success of Solutions (*CQI – Fidelity*)*

The Capacity Center and BCF continued to work jointly on these efforts through most of 2016. In early 2017 WV BCF, along with a representative from the Capacity Center, met and reviewed identified causes and tentative solutions. WV BCF selected it's top four action items as priorities to address recruitment & retention:

1. Supervisory Training
2. Mentoring Workers
3. *Recruitment Planning*
4. *Crisis Teams*

The WV BCF has established chartered work groups for each action item. All groups are proceeding with their tasks. Now, the WV BCF is not actively engaged on a routine basis with the Capacity Center for these action items – however, the Center remains available to the Bureau as a resource.

The four Regional Social Service Program Managers schedule Regional Social Service Supervisor meetings at least quarterly with their supervisors in their Regions. These supervisors include all Child Protective Services Supervisors and all Social Service Supervisor in Child Welfare and Adult Services. The purpose of these meetings is to provide update/clarifications on policy, provide information on specific topics related to children and families, and to discuss any issues concerning social services regarding Regional or statewide issues.

Region I –

- June 8, 2016
- September 14, 2016
- December 14, 2016
- March 8, 2017

Region II-

- May 26, 2016
- July 13, 2016
- October 5, 2016
- January 25, 2017

Region III –

- May 24, 2016
- July 27, 2016
- September 21, 2016
- February 9. 2017

Region IV –

- April 26, 2016
- July 26, 2016

- January 20, 2017
- April 21, 2017

Some of the common topics that were presented at the Social Services Supervisors meetings include the following:

- Our Babies: Safe and Sound – infant Safety Education in WV
- Substance Abuse – Prevention Specialist, Kim Walsh
- Drug Affected Infants
- Safe at Home
- Title IV-E
- Critical Incidents
- Fostering Connections
- Foster Care Candidacy
- Length of Stay for children in Shelters and Residential programs
- Medically Fragile Children
- ROSA
- Youth Services Updates
- Permanency – Adoption/Legal Guardianship/APPLA
- CPS updates
- ICPC – updates/clarifications
- ESSA – Every Student Succeeds ACT
- Diligent Searches
- Kinship/relative homes
- Dispositional Staffing/terminations
- APS updates
- Home finding policy updates
- Adoption updates

In addition to the Social Services Supervisor meetings, Regional Program Managers (RPMs) and Child Welfare Consultants (CWCs) will go to specific Districts and provide training to social service workers and supervisors concerning specific topics.

Between April 2016 and including the present time, the RPMs and CWCs have been training Districts on “Bridging the Gap” which describes the process for achieving permanency for our youth. They provide training/information on Permanency Plans, termination of parental rights, legal guardianship vs. adoption, and best interest. Training also includes FACTS screens.

Some of the other training provided by RPMs and CWCs include the following: Safety Planning, Policy refreshers concerning Child Protective Services, Foster Care, and Youth

Services. Documentation, meaningful contacts, present and impending dangers, pre-division for truancy cases, CANS, Safe at Home.

WV RESILIENCE Alliance

Subject: Requested material for APSR Feedback- Training Report 2016-2017

The WV RESILIENCE Alliance resides within the WVDHHR/BCF and has a two-fold function:

- Promoting **RESILIENCE** and Reducing Secondary Trauma Among Child Welfare Staff
- Providing an in-person response to any/all staff, unit or Regional Office which has experienced a work-related **TRAUMATIC EVENT**

The following is a summary of WVRA activities from April 1, 2016 thru March 31, 2017

I. WV RESILIENCE Alliance Curriculum Delivery in Region IV

TITLE/SESSION	DATE	HOURS
Pre-Intervention/Impact of Trauma on	5/18/2016	3.0
Child Welfare Staff and Implementing Resilience		
Resilience & Survival Mode	6/8/2016	2.0
Reactivity	6/8/2016	2.0
Collaboration	6/15/2016	2.0
Optimism	6/15/2016	2.0
Positive Thinking & Self-Talk	6/21/2016	2.0
Reactivity & Optimism in a	6/21/2016	2.0
Staff/Supervisor Interaction		
Mastery	6/29/2016	2.0
Self-Care	6/29/2016	2.0
Self-Awareness	7/13/2016	2.0
Self-Awareness & Resilience	7/13/2016	2.0

Self-Reflection	7/20/2016	2.0
Integrating Resilience into Practice	7/20/2016	2.0
Supervisory Training: Modeling	9/20/2016	2.0
Supervisory Training: Support	9/20/2016	2.0
Supervisory Training: Authority	11/1/2016	2.0
Collaboration & Optimism	10/11/2016	2.0
Positive Reframing	10/11/2016	2.0
Collaboration & Mastery of Job Related Skills	10/11/2016	2.0
Self-Awareness: Mastery of Negative Emotions & Reactivity	10/18/2016	2.0
Collaboration & Conflict Resolution	10/18/2016	2.0
Integrating Resilience Skills Into Practice	10/18/2016	2.0

II. WV RESILIENCE Alliance Curriculum Delivery in Region II

TITLE/SESSION	**DATE**	**HOURS**
Supervisory Kick-Off Session	3/22/2017	3.0
Supervisory Module 1 – MODELING	3/29/2017	2.0
Supervisory Module 2 – SUPPORT	4/5/2017	2.0
Supervisory Module 3 – AUTHORITY	4/19/2017	2.0
Supervisory Module 4 – TRAUMA-AWARE, REFLECTIVE SURPERVISION	4/26/2017	2.0

III. WV RESILIENCE Alliance TRAUMATICE EVENT RESPONSE

Traumatic Event Definition: A traumatic event is an incident that causes physical, emotional, spiritual, or psychological harm. The person(s) experiencing the distressing event may feel threatened, anxious, or

frightened as a result. In some cases, they may not know how to respond, or may be in denial about the effect such an event has had. The person(s) will need support and time to recover from the traumatic event and regain emotional and mental stability.
http://www.healthline.com/health/traumatic-events#Overview1

From 4/1/2016 thru 3/31/2017 the **WV RESILIENCE Alliance** responded to **TRAUMATIC EVENTS** utilizing the SAFER-R intervention model in the following counties:

11/18/2016	**Jackson**
xx/xx/2016	**Boone**
03/03/2017	**Barbour**
03/27/2017	**Calhoun**

6. Consultation and Coordination between States and Tribes

There are currently no federally recognized tribes in the state of West Virginia. Current Foster Care Policy states that if a child is recognized as a member of a tribe, the child's social worker is to contact the U. S. Department of Interiors Bureau for Indian Affairs to determine if the tribe has child welfare jurisdiction.

West Virginia is currently working to strengthen its child welfare policies regarding ICWA. Child welfare staff will be expected to determine tribal affiliation much earlier in the case to provide a more seamless process for the family. If the tribe does not have jurisdiction over the child or family, our staff will ensure that they are contacting the tribe continuously throughout the life of the case to ensure that all the child and family's rights are being respected regarding their tribal affiliation.

Foster Care Policy states that children of families that have American Indian ancestry are to be referred to the tribe in which ancestry is claimed for child welfare services. If a child is placed in the custody of the Department and the child or his family is claiming American Indian heritage the worker must do the following:

- Review the record and discuss the child's background with the parents to try to discover the child's heritage.
- Determine if the child is a member of that tribe or eligible for membership in the tribe.
- If a Tribe is identified, the worker must refer the child to the tribe for membership determination or membership eligibility.
- If several tribes are suspected, contact must be made with each tribe. The child's worker must document that a tribe has been contacted to determine tribal membership.
- If a tribe determines the child is not a member nor eligible for membership, the worker will document the response.
- If a tribe responds the child is eligible for membership, the child's worker must request application forms. The child's parents must be contacted and the membership in the tribe explained to them.
- If the parent enrolls the child in the tribe's membership, the child's worker must refer the case to the tribe's tribal court if the tribe has exclusive jurisdiction over child welfare matters.
- The child's worker must contact the U. S. Department of Interiors Bureau for Indian Affairs to determine if the tribe has child welfare jurisdiction.

The West Virginia Department of Health and Human Resources plans to revise an existing tool to use with the entire foster care population designed by the Service Delivery and Development Workgroup for Youth Transitioning to monitor all youth in foster care. This form was designed to insure workers covered all aspects of case management, including tribal affiliation. This is completed every ninety days prior to case reviews

The State will run reports to determine which three counties have the highest completion rates of the use of this form in the next six months and, subsequently, pilot the use of this instrument within one year. By the APSR due in 2017, the state will have analyzed the data to determine if this process should be implemented statewide. If the process captures the information required, the state will develop a plan to integrate this process into SACWIS by June 2018.

2016 Updates

West Virginia currently has no federally recognized tribes. However, West Virginia is home to members of several tribes. Foster Care Policy was reviewed by the Bureau for Indian Affairs just prior to completion 2009 – 2014 Child and Family Services Plan. All recommendations for changes were made to appropriate policies. West Virginia will again submit its policies to the Bureau for Indian Affairs during SFY 2017. • Provide an update

to the state's plan for ongoing coordination and collaboration with tribes in the implementation and assessment of the CFSP/ APSR. Describe any barriers to this coordination and the state's plans to address these barriers.

West Virginia has no arrangements made with tribes as to who is responsible for providing the child welfare services and protections for tribal children. However, foster care policy in West Virginia directs staff to do everything possible to determine tribal affiliation for children whose families indicate Native American ancestry and to contact the identified tribe. Services and protections afforded all children in West Virginia are afforded to children with Native American ancestry equally.

The following protections are afforded to all children in foster care in West Virginia, including those with Native American ancestry.

APPLA as a permanency plan is limited to only youth age 16 and older;

Documenting at each permanency hearing the efforts to return a child home or to secure a placement for a child with a relative, or with guardianship or adoptive parent;

Implementing procedures to ensure that the court or administrative body conducting the permanency hearing asks the child about his/her desired permanency outcome and makes a judicial determination at each permanency hearing that APPLA is the best permanency plan for the child and specifies compelling reasons why it's not in the best interest of the child to be returned home, placed with a relative or legal guardian, or placed for adoption;

Documenting at the permanency hearing and the 6-month periodic review the steps the agency is taking to ensure that the foster family or child care institution follows the "reasonable and prudent parent standard" and whether the child has regular opportunities to engage in "age or developmentally-appropriate activities";

For children age 14 and older, the agency documents in the case plan the child's education, health, visitation, and court participation rights, the right to receive a credit report annually beginning at age 16;

That the child's case plan is developed in consultation with the child, and at the option of the child, two members of the case planning team, who are not the caseworker or foster parent;

Describe in the case plan and at the permanency hearing the services to help the youth transition to successful adulthood; and

If Native American ancestry is found and supported by the tribe, caseworkers notify Indian parents and tribes of state proceedings involving Indian children and their right to intervene.

2017 Update

West Virginia has had a difficult time finding federal entities to review its policies. The Children's Bureau has been contacted and they are currently researching avenues for consultation for the state. One possibility is the Capacity Center for Tribes. Although West Virginia has no federally recognized tribes the state does have tribal children. The states policy regarding services to tribal children was determined to comply with federal requirements when reviewed by NAIF several years ago.

7. Monthly Caseworker Visit Formula Grants

During FFY 14, West Virginia used 99% of caseworker visitation funding for transportation costs associated with visiting children in foster care and 1% for computer supplies. The same is planned for FFY15.

West Virginia continues to focus on every child in placement having a face-to-face contact with their worker each month to review treatment needs and to ensure safety. Some of the steps taken to ensure that a face to face contact occurs each month are as follows:

- Supervisors maintain a list of all children in placement that is utilized with the development of scheduled visits
- Workers schedule visits during the first 3 weeks of each month – this allows an extra week in the event of unforeseen circumstances that would require rescheduling.
- Supervisors and workers will track their visits for each month
- Supervisors and workers review the Dashboard in FACTS each month to review the face to face contacts with child in placement
- If the Dashboard does not indicate a visit completed – supervisor will review to determine if this was a data error.

2016 Updates

During FFY 2015, West Virginia used 100% of caseworker visitation funding for transportation costs associated with visiting children in foster care.

2017 Update

During FFY 2016, West Virginia used 100% of caseworker visitation funding for transportation costs associated with visiting children in foster care.

8. Adoption and Legal Guardianship Incentive Payments

FY 2014 funds were spent as follows:

- Adoption Promotion and Support Services - $268,805.98
- Adoption Promotion and Support Grants - $773,041.00
- The contracting of all post adoptive services will use the additional incentive funds as part of the contract to cover the services.

West Virginia is considering the following activities to be paid for with Adoption Incentive Funds:

- Statewide Adoption/Homefinding Conference re-instated
- Regional Foster/Adoptive family conference/training
- Expand contract with those agencies providing Homefinding staff to DHHR, increasing staff will increase positive customer service to our families
- Expanding or developing contracts to:
    - provide response to all inquiries about becoming a foster/adoptive family
    - expand targeted recruitment campaign efforts
    - be responsible for all recruitment for foster/adoptive families in the state freeing up DHHR Homefinding staff to focus on Homestudies
- Purchase "Foster Parent College" to be utilized by all foster/adoptive parents so there is no cost to them

2016 Update

Adoption Promo & Support:	**Fund**	**Unit**	**Total**	**Federal**	**State**
Services			385,148	288,861	96,287
Subrecipient Grants			667,501	500,626	166,875
Total Adoption Promo & Support			1,052,650	789,487	263,162

Adoption Promo & Support Admin:			
Travel	5,828	4,371	1,457
Training & Development - In State	533	400	133
Computer Equip & Supplies	4,196	3,147	1,049
Total Adoption Promo & Support	10,557	7,918	2,639
Caseworker Visitation:			
Travel	164,751	123,563	41,188
Total Caseworker Visitation	164,751	123,563	41,188

BCF intends to release an RFA for post adoptive services. Applicants interested in applying for this grant must be capable of providing all-inclusive post-adoptive services to all children (Birth to 18 years of age) from West Virginia Department of Health and Human Resources foster care, private adoptions and international adoptions, in all regions within West Virginia.

Applicants must be capable of providing high quality post-adoptive services to include, but not limited to:

- Provide consistent service and reimbursement to all regions.
- Assist the Bureau for Children and Families (BCF) to increase efficiency and quality of services.
- Assure consistent application of BCF policies in service delivery.
- Identify service gaps and availability
- Training and education for adoptive parents regarding the special needs of adopted children, including adjustment and attachment issues. (Adopted children most often required services for these needs within the first six months of adoption.)
- Continuing education for both adoptive parents and providers regarding adoption issues.
- Counseling services for family/individual.
- Respite services
- Case management services for both individual and families.
- Educational / school's advocacy and support.
- Information and referral/warm Line.

2017 Update

Adoption Promo & Support:					
Services	5074	2776	385,148	288,861	96,287
Sub recipient Grants	5074	3590	667,501	500,626	166,875
Total Adoption Promo & Support			1,052,650	789,487	263,162
Adoption Promo & Support Admin:	5362	2776			
Travel			5,828	4,371	1,457
Training & Development - In State			533	400	133
Computer Equip & Supplies			4,196	3,147	1,049
Total Adoption Promo & Support			10,557	7,918	2,639
Caseworker Visitation:					
Travel	5362	2588	164,751	123,563	41,188
Total Caseworker Visitation			164,751	123,563	41,188

Due to budget concerns for the state of West Virginia, an RFA for post-adoptive services has been held indefinitely. These services continue to be provided on a case by case basis by the Bureau for Children and Families.

9. Child Welfare Waiver Demonstration Activities

In October 2014, BCF was granted a federal Title IV-E Waiver by the U.S. Department of Health and Human Services Administration for Children and Families to conduct a child welfare demonstration project.

West Virginia's Title IV-E Waiver demonstration project, Safe at Home West Virginia, aims to provide wrap-around behavioral health and social services to 12-17 year olds with specific identified behavioral health needs who are currently in congregate care or at risk of entering congregate care.

The State is authorized to implement a demonstration project under which the West Virginia Bureau for Children and Families (BCF) will implement a Wraparound service model and enhanced service array to reduce the frequency and duration of congregate care placements.

The granting of the IV-E Waiver allows WV to use federal dollars in a more flexible manner to pay for services that will assist in attaining the APSR and IV-E waiver demonstration goals. You will note that the Waiver goals are aligned with the APSR goals as well as extending further. Although the demonstration project focuses on 12-17 year olds, WV plans to incorporate the wraparound principles into all child welfare practice. An integral part of wraparound, but not listed in the goals below, is the guiding principle of Family Engagement thus fulfilling the goals of increasing worker involvement as well as increased involvement of youth and families in the provision of treatment and services.

The State's demonstration will seek to accomplish the following goal(s):

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth.
- Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth.
- Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

More detailed goals within the waiver's main goals include:

- Reduce the reliance on congregate care
- Decrease the length of stay in congregate care for children 12-17 years of age
- Improve family functioning to support reunification
- Reduce the number of children re-entering any form of foster care
- Reduce initial foster care entry rates
- Increase the number of children staying in their home community
- Improve well-being of children 12-17 as demonstrated through educational achievement and increased numbers graduating high school
- Improve academic progress of children 12-17 by keeping them in the same school

The demonstration, titled Safe at Home West Virginia, will initially be implemented in BCF child welfare Regions II and III, with plans to expand statewide over the duration of the demonstration. The demonstration will target youth ages 12–17 that are in or at risk of

entering congregate care placement. Approximately 400 children could be served in the first year; more may be served when including those at-risk of entering congregate care. The specific timeframes for expanding the demonstration interventions to this target population statewide is still being determined.

The State's demonstration will implement a Wraparound service model as the core component of Safe at Home West Virginia. Based on the National Wraparound Initiative Model, the demonstration will incorporate evidence-based, evidence-informed, and promising practices to coordinating services for eligible youth and their families. Under this model, eligible youth and families will receive a combination of services and supports that are uniquely tailored to their strengths, needs, and placement risk level, as determined by trauma-informed assessments. Family Team Conferencing will be utilized to develop or revise youth and family treatment plans. Wraparound services will be provided by contracted service providers, including Care Coordinators, who will implement and manage treatment plans and provide community-based services and supports.

Under the demonstration, the State will implement the West Virginia Child and Adolescent Needs and Strengths Assessment (WVCANS) universally across child-serving systems at early points of youths' involvement in the child welfare system, develop thresholds to guide decision making about levels of care, and educate system partners to base decision making on the assessed needs and strengths of youth using a common assessment language. The assessed treatment needs indicated by the WVCANS will guide the State's development of a full array of interventions to meet the individual needs of youth and families in their communities.

The State believes that conducting a comprehensive assessment of youth and families' strengths and needs, and providing intensive community services using a Wraparound service model, will reduce congregate care placements, and improve youth and family functioning and well-being.

The State is working closely with our partners in the development of the service model, community assessment of needs, development of community based services, and in restructuring our payment process. All BCF's grants and contracts are being re-written to become outcome based. BCF's provider agreements with our residential providers are being changed to become more time limited with focused discharge planning beginning the day of admittance. We are meeting and having conversations with our stakeholders as we move through this process. We are also involving technical assistance, not only for the Bureau but also for our partners.

The State believes that all the focused activity for the IV-E Waiver Demonstration as well as other initiatives support the goals of our APSR and will assist in the forward transformation of the State's Child Welfare System.

2016 Update

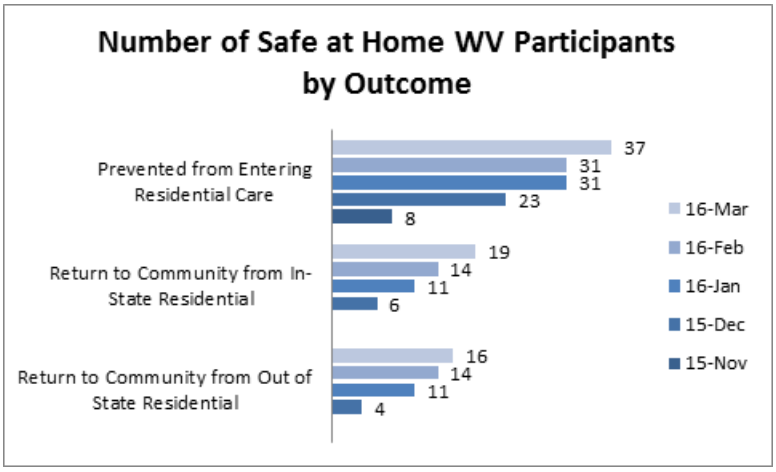
West Virginia was awarded our approval to initiate our Demonstration Project, Safe at Home West Virginia, on October 14, 2014. Safe at Home West Virginia is high fidelity wraparound aimed at 12-17 year olds currently in congregate care settings in West Virginia or out-of-state and those at risk of entering a congregate care setting. West Virginia also plans to universalize the use of the WV CANS across child serving systems.

Recognizing the way we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

Safe at Home West Virginia Wraparound will help improve identification of a youth's and family's strengths and needs; reduce the reliance on congregate care and length of stay in congregate care; reduce the reliance on out-of-state residential care; improve the functioning of youth and families, including educational attainment goals for older youth; improve timelines for family reunification; and reduce re-entry into out-of-home care.

Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the 11 counties of Berkley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne with the first 21 youth being referred for Wraparound Facilitation. West Virginia also began the process of universalizing the CANS across child serving systems.

As of March 31, 2016, 121 Youth have been referred to Safe at Home West Virginia. West Virginia has returned 16 Youth from out-of-state residential placement back to West Virginia and 19 Youth have stepped down from in-state residential placement to their communities. We have been able to work with 37 at risk youth to prevent residential placement.



During the past six months Hornby Zeller Associates, Inc. (HZA), the project evaluator, developed its data collection tools; performed baseline interviews, reviewed documents, automated the Child and Adolescent Strengths and Needs (CANS) tool, prepared data extract requests for FACTS, West Virginia's SACWIS, analyzed the first six-month extract of FACTS data, and analyzed the first set of CANS assessments.

During this first six-month period HZA conducted interviews and completed a review of project documentation, while also arranging for and receiving the initial extracts from the State's SACWIS, called FACTS. The results from the first two activities will inform the process evaluation, while the analysis of FACTS data will focus primarily on the outcome evaluation but will also contribute to the process component.

In addition to the above data collection activities, HZA designed and implemented an automated version of the Child and Adolescent Strengths and Needs (CANS) tool which is being used by BCF and its contractors throughout the State. Some initial data have become available from this source, and ultimately the results of repeated CANS administrations to individual youth will provide a means of measuring clients' progress on well-being outcomes.

Baseline Interviews

The first round of interviews was completed during the week of November 16-20, 2015, to evaluate the planning and development of the program, and to assess early implementation. HZA conducted interviews in Phase I regions and counties, which

included counties from Regions II and III, although not all counties within those two Regions were selected to participate in Phase I. Counties chosen for baseline interviews were randomly selected among Phase I implementation counties; counties which were not included in the first round of interviews will be included in subsequent rounds. HZA staff completed interviews with key stakeholders in the following Region II counties: Kanawha, Boone, Logan, Lincoln, and Cabell; in Region III interviews took place in Berkeley and Morgan counties.

HZA interviewed 50 stakeholders, including staff from West Virginia's Bureau for Children and Families, contracted community service providers, and members of the judicial community. Table 1 provides a full breakdown of stakeholders interviewed by staff type.

Documentation Review

Table 2 provides a list of documents HZA collected at the time of the interviews with key stakeholders. These documents are key to understanding the processes, policies, and conceptual framework guiding the program's implementation. The documents also exemplified how the state engages with their stakeholders and the public in regard to *Safe at Home* and provided insight into the program's progression. Additionally, the documentation review provided a solid context for the interview analysis.

Table 2. *Safe at Home West Virginia* Documents Reviewed
Training Curriculum and Schedules
The 10 Principles of Wraparound
Safe at Home Training Schedule
Policies and Laws
Youth Transitioning Policy
Youth Services Policy
Governor Tomblin Signs Senate Bill 393, Juvenile Justice Reform
Safe at Home West Virginia BCF Policy
Child Protective Services Policy
Safe at Home West Virginia Policy Desk Guide
Guides, Manuals, and Handbooks
The National Wraparound Initiative's Wraparound Implementation Guide: A Handbook for Administrators and Managers
Safe at Home West Virginia: A Family's Guide to Wraparound
Safe at Home Fact Sheet
Safe at Home West Virginia FAQs

Table 2. *Safe at Home West Virginia* Documents Reviewed
Safe at Home West Virginia Program Manual
Community Collaborative Safe at Home Semi-Annual Report Form
Safe at Home WV Wraparound Planning Form
Safe at Home WV Referral Wraparound Form
Reports, Plans, and Organizational Charts
The Safe at Home West Virginia Implementation Work Plan
The Safe at Home West Virginia Initial Design and Implementation Report (IDIR)
The Department of Health and Human Resources Organizational Chart
BCF Organizational Chart
BCF Regional Map
The Safe at Home West Virginia Title IV-E Waiver Application
Public Announcements, Outreach, and Other Media
The Quarterly Newsletter (5)
Safe at Home Funding Announcement (Phase I)
Safe at Home Funding Announcement (Phase II)
WV Metro News: New program aimed at keeping more at-risk kids at home
Safe at Home West Virginia's Email Blasts (31)
Safe at Home West Virginia Speaking Points
WV Public Broadcasting: Investigation: W.Va.'s Mental Health Services for Children Not in Compliance with Federal Law
State Journal: WV DHHR cabinet Secretary Karen Bowling responds to DOJ criticism of state's handling of children with mental health needs
Governor Tomblin Announces Launch of Safe at Home Program
DHHR Press Release: DHHR Launches Safe at Home West Virginia (9/30/2015)
DHHR Press Release: DHHR's Safe at Home WV Project Continues to Progress (12/14/2015)
DHHR Press Release: Safe at Home Providing 100 Youths an Alternative to Institutional Care (2/16/2016)
DHHR Press Release: DHHR Seeking Applications for Phase Two of Safe at Home West Virginia (3/3/2016)
Safe at Home WV Printable Flyer

HZA will use data from West Virginia's child welfare information system throughout the evaluation to measure outcomes, e.g., reduced length of stay or reduced number of youth re-entering foster care, and to compare those outcomes to an historical comparison group of youth matched to those referred to *Safe at Home*. A comparison group was selected from youth known to BCF between SFYs 2010 to 2015 with characteristics similar to the 120 youth who were referred to the program during the first six months. Demographic

data, case history and qualifying characteristics such as mental health status and juvenile justice involvement were used to match youth to the treatment group. Because the kinds of data available vary between youth in substitute care and youth at home, and because placement at the time of referral is likely to be a strong influencing factor, youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state psychiatric facilities and group care; in-state psychiatric facilities and group care; emergency shelters; family foster care placements; and youth at home. Cases selected into the comparison groups are in the same placement types and are statistically similar to those in the corresponding treatment groups.

Over the first six months of implementing *Safe at Home West Virginia*, Phase I counties, which are located in Regions II and III, referred 122 youth for wraparound services. Two of the referrals from the latter half of March 2016 were not yet recorded in FACTS yielding 120 referrals for the balance of this analysis. At the time of referral, 37 of those youth were placed in in-state congregate care facilities and 30 in out-of-state congregate care facilities. Of the 53 youth designated by the Bureau of Children and Families (BCF) as in a preventive placement at the time of referral, two were placed with relatives, six were in emergency shelters and 45 remained in their own homes.

Table 4 displays the initial placement types of youth referred for inclusion in *Safe at Home*.

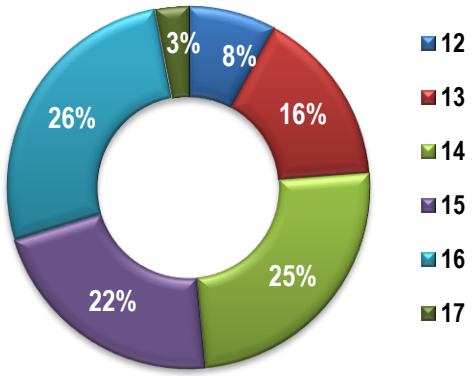
Table 4. Placement Types for Phase I Referrals

	In-state	Out-of-state	Preventive	Totals
Group Residential Care	29	20	-	49
Psychiatric Hospital (short term)	1	-	-	1
Psychiatric Hospital (long term)	7	10	-	17
Kinship/relative	-	-	2	2
Agency emergency shelter	-	-	6	6
Remain at home	-	-	45	45
Totals	**37**	**30**	**53**	**120**

Seventy-two percent of the youth were between the ages of 14 and 16 at the time of referral, while nearly two-thirds (64%) were male. The disproportion of males was highest in out of state congregate care settings, where 88 percent of the youth were male. The two youth who were referred while placed in a detention center were both male.

The majority of youth were white (88%) while 19 percent were black.[2] The percentage of black youth referred to the program is substantially higher than the overall percentage of black youth in West Virginia (5%3) and lower than the average percentage of black youth in foster care between 2010 and 2015, which ranged from 31 to 35 percent between calendar years 2010 to 2014.

Figure 2. Age of Youth at Referral



West Virginia's project includes both child welfare and juvenile justice referrals; however, it is not easy to distinguish cleanly between them because most *Safe at Home* youth have some evidence of juvenile justice involvement, but many had an open case with child welfare prior to that. For example, looking at the congregate care referrals from within the state (n = 37), 35 of them have some evidence of juvenile justice involvement, whether in an Axis IV diagnosis (indicating trouble with the law: n = 6), a detention placement prior to the referral (n = 9), or a juvenile justice-ordered removal (n = 33). Given the juvenile justice-ordered removal, 24 of them would be considered youth services cases rather than child welfare cases. Eleven of the youth's current cases had been open for more than a year prior to removal, while 21 were known to child welfare for less than six months prior to removal.

For out-of-state congregate care referrals (n = 30), 24 had some evidence of juvenile justice including 17 with an Axis 4 diagnosis, 23 with a juvenile justice -ordered removal and seven with a prior detention placement. However, only three of those youth had been known to child welfare for more than a year prior to removal.

For the Preventive Referrals where the youth are in the home, the evidence of juvenile justice involvement is much less common: only two thirds of the 45 youth have evidence of juvenile justice involvement: 19 with an Axis 4 diagnosis, 26 with a previous (not current) juvenile justice -ordered removal, and two with a prior detention placement.

Broadly speaking, *Safe at Home* West Virginia is designed to improve the safety,

[2] The percentage of youth by race will total to more than 100 percent as youth may be categorized as a member of more than one racial group.

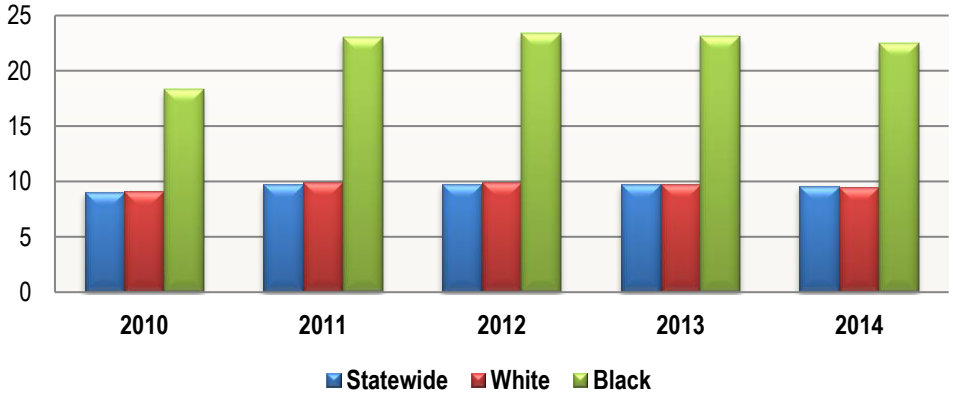
[3] Percentage of youth is based on the average percent of black youth in West Virginia between 2010 and 2014, as reported via the Office of Juvenile Justice and Delinquency Prevention Easy Access to Juvenile Populations website (www.ojjdp.gov/ojstatbb/ezapop/).

permanency and well-being of youth, ages 12 to 17. When used preventively, the program is trying to have fewer children enter foster care in the first place or, when they do, to have fewer entering congregate care and more remaining in their own communities. Data from FACTS are used to inform many of the outcome measures with data for the few youth with a subsequent CANS assessment completed used to measure the extent to which the youth's functioning has improved.

Placement in Congregate Care and Outside the Home Community

Between 2010 and 2014, the placement rate of West Virginia's youth, ages 12 to 17, who incurred an initial entry into foster care ranged from 9.0 to 9.6 per thousand. The placement rate is substantially higher for black youth while the rate for white youth is similar to the statewide rate, as shown in Figure 3.

Figure 3. Rate of First Entry into Foster Care per Thousand Youth



Males were slightly more likely to enter foster care than females. Placement rates for males ranged from 9.6 to 10.9 between 2010 and 2014, and 8.3 to 9.3 for females during those same years. Over time the evaluators will determine if *Safe at Home* has made an impact on placement rates in congregate care.

As can be surmised from Table 4, 67of the 120 youth referred to participate in *Safe at Home* during the first six months of the program were living in a congregate care setting at the time of referral, 30 of them in an out-of-state facility. By the end of March 2016, more than half of those out of state had been returned to West Virginia, with 14 youth (47 percent of the total) moving to a lower level of care. The comparison group shows very similar results.

Improvement was also evidenced for 22 of the 37 youth initially placed in an in-state congregate care facility. Of the youth first placed in a congregate care facility, regardless of where that facility was located, 39 percent were returned to their homes.

As shown in Figure 4, success was also evidenced for youth who were in lower levels of care to start or remained with their families when referred to *Safe at Home*. Two of the 45 youth who were at home at the start of the program were placed in an out-of-state congregate care facility by the end of March. Five of the youth who began *Safe at Home* while in a family setting were placed in an in-state congregate care setting and two youth who had been in emergency shelters were placed in detention.

When the placement status of youth in the comparison group is examined six months following case opening or from the point in which the youth satisfy the *Safe at Home* referral criteria, the overall results are not substantially different from the treatment group. However, there is less movement from one setting to another among youth in the comparison group.

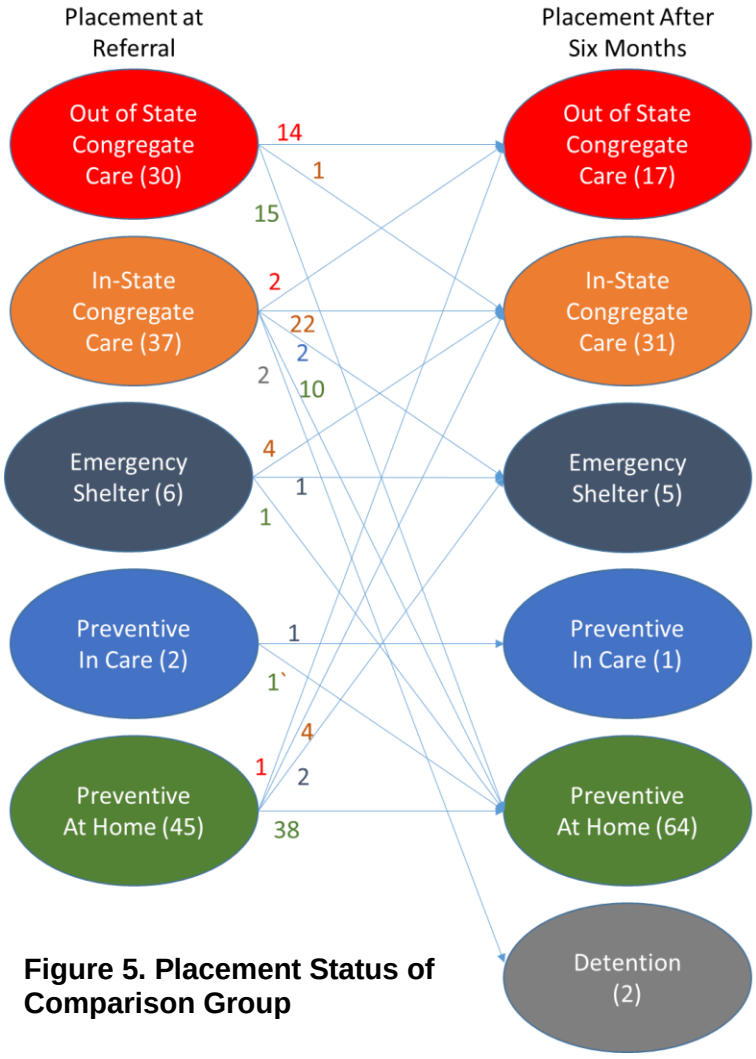


Figure 5. Placement Status of Comparison Group

As is illustrated in Figure 5, the outcomes are similar for the comparison group in this time period, with both groups ending up with similar distributions of youth in each placement type. The principal difference is a larger number of comparison youth (31) in in-state congregate care placements compared to Safe at Home youth (24). Safe at Home youth are slightly more likely to be in Emergency Shelters or family foster care.

Beyond the extent to which youth remained in their homes, data in FACTS were also used to measure the extent to which youth are remaining in their home communities. Among the 39 youth who were in substitute care at the time of referral to *Safe at Home* and incurred at least one placement change within the six months following referral to the wraparound program, nearly two-thirds (64 percent) of the placements were outside the youth's home county. Most of the out-of-county placements involved placement into an agency emergency shelter or group residential care setting. When the results are compared to a matched comparison group, within six months a smaller number of youth incurred more than one placement change. However, 75 percent of those placements were outside the youth's home county, half of which involved a stay in a group residential care facility.

A different picture emerges when examining the number of entries into congregate care during the first six months of implementation compared to a six-month interval for the comparison group. The 30 Safe at Home youth in out-of-state congregate care placements at referral had a total of 457 days outside of congregate care, and had a total

of seven new congregate care placements involving three youth. This gives a congregate care placement rate of 1.5 placements per 100 days of eligibility, with 0.7 distinct youth being placed in congregate care per 100 days of eligibility. In contrast, the comparison group had only 31 days outside of congregate care, and 14 congregate care placements involving 13 youth, for a congregate care placement rate of 45.2 placements per 100 days of eligibility, with 41.9 distinct youth per 100 days of eligibility.
Safe at Home youth in congregate care settings in West Virginia at the time of referral also had lower rates of subsequent congregate care placements than the comparison group, with eight placements in 582 days of eligibility, yielding a placement rate of 1.4 placements per 100 days. Since the placements involved eight youth, the rate is also 1.4 youth per 100 days. In contrast, comparison youth had 26 congregate care placements in the first six months, with only 114 days of eligibility, or a rate of 22.8 placements per 100 days of eligibility. Again, all placements involved distinct youth, so the same rate applies for youth.

Among the successes registered within the first six months of the implementation of the *Safe at Home* effort are the return of 16 of the 30 *Safe at Home* youth who were in out-of-state congregate care back to West Virginia, the movement of 14 of those youth to lower levels of care including nine who returned home, the discharge of 17 youth from in-state congregate care to their own homes and of five more to lower levels of care and, finally, the placement of 36 percent of youth who were placed into out-of-home settings within their own communities, compared to only 19 percent of the comparison group. Another highlight is in the number of subsequent placements into congregate care, which show promising trends compared to the comparison group. The results suggest that youth are experiencing fewer moves from one congregate setting to another, and the larger number of days that Safe at Home youth are *not* in congregate care also suggests that their total time in congregate care may be found to be shorter than the comparison group's once enough time has passed to evaluate that objective.

Recognizing the way we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

West Virginia continues to move forward with Phase Two implementation which will include the addition of 24 counties. This is projected to begin sometime late summer to early fall 2016. The grants to local coordinating agencies to hire wraparound facilitators have been awarded and the hiring process has begun. The date that referrals begin will be determine in consultation with the Local Coordinating Agencies and our Evaluator.

Phase Two implementation includes the 24 counties of Brooke Hancock Monongalia, Marion, Ohio, Barbour, Grant, Hardy, Hampshire, Harrison, Lewis, Mineral, Pendleton, Preston, Randolph, Taylor, Tucker, Upshur, Greenbrier, Mercer, Monroe, Nicholas, Pocahontas, Summers. Through data review WV identified 430 youth in the target population that could be referred to Safe at Home West Virginia for wraparound. Based on the identified population, West Virginia awarded 43 wraparound facilitator positions to six Local Coordinating Agency Grantees.

The Phase Two counties were selected due to their current out-of–state placement data, location, and readiness to implement.

Phase Three of implementation is slated to begin in the spring of 2017 and will include the final 20 counties bringing all of West Virginia into full implementation.

Wraparound 101 training was conducted throughout the next phase Counties beginning in March and running through May. This is always a cross-training so BCF staff and Facilitators attend together.

WV CANS training for the Phase Two areas was also scheduled throughout the months of April and May to assure that all BCF staff and partners have the opportunity to attend this training prior to implementation.

West Virginia has developed a strategic work plan for further training and development of BCF and Partner staff regarding the administration and use of the WV CANS and the further development of WV CANS Advance CANS Experts (ACES) for technical assistance. We are seeing that WV CANS are being administered but many do not yet understand how to use the results in the treatment or case planning process for youth and families. We have identified the continuing need to develop experts that can provide technical assistance on an ongoing basis. Our goal is for WV CANS to be completed on all children with an open child welfare case and that the WV CANS will be used to determine the appropriateness of a referral to Safe at Home West Virginia and assist in guiding the intensity of services. Please refer to the attached work plan which is a fluid plan with changes being made as needed.

West Virginia continues the development of Safe at Home West Virginia content experts. The further training includes a new blackboard training and an advanced classroom training that will be delivered during the month of May. The goal is to have a content expert in every community service district for BCF and that they are available to assist with questions and needed technical assistance as well as future training. The Experts have met together and assisted in identifying what knowledge they believe they need to be comfortable in this role as well as what the home team identified as necessary for their development. The advanced training curriculum has been developed to meet those identified needs.

2017 Update

West Virginia was awarded our approval to proceed with our Demonstration Project, Safe at Home West Virginia, on October 14, 2014. Safe at Home West Virginia is high fidelity wraparound aimed at 12-17 year olds currently in congregate care settings in West Virginia or out-of-state and those at risk of entering a congregate care setting. West Virginia also plans to universalize the use of the WV CANS across child serving systems.

Recognizing how we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

Safe at Home West Virginia Wraparound will help improve identification of a youth's and family's strengths and needs; reduce the reliance on congregate care and length of stay in congregate care; reduce the reliance on out-of-state residential care; improve the functioning of youth and families, including educational attainment goals for older youth; improve timelines for family reunification; and reduce re-entry into out-of-home care.

Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the first 11 counties. Phase 2 of implementation began on August 1, 2016 by rolling in an additional 24 counties. The final phase of implementation occurred on April 1, 2017 rolling in the final 20 counties bringing the entire state into the implementation. West Virginia also began the process of universalizing the CANS across child serving systems.

As of March 31, 2017, 662 Youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 41 Youth from out-of-state residential placement back to West Virginia, 114 Youth have stepped down from in-state residential placement to their communities, and 7 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 335 at risk youth. Please note that these numbers may differ from the outcome evaluation due to the tracking mechanisms. This information is reported by the local and Regional staff while the outcome evaluation pulls data from our SACWIS system which would be dependent upon data entry.

The breakdown of placement type at time of enrollment is as follows:

- 63 were or are in out-of-state residential placement
- 185 were or are in in-state residential placement
- 386 were or are prevention cases
- 28 were or are in an emergency shelter placement

The following are highlights from the evaluation sections of the September 30, 2016 and March 31, 2017 Semi-Annual Progress reports as reported by West Virginia's Independent Evaluator, Hornby Zeller Associates.

Fidelity Summary

For the most part, the program has been performed with fidelity. It was apparent through survey, case review, and interview data that wraparound facilitators were completing required Safe at Home activities regularly.

Outcome Evaluation Summary

September 30, 2016

When comparing the placements of youth in Cohort I at referral, March 2016, and September 2016, congregate care placements illustrate promising results. Youth placements decreased in both out-of-state and in-state congregate care from referral to

March 2016 and again from March 2016 to September 2016. By September 30, 2016 there were 33 fewer youth in congregate care than there were at referral.

Additionally, the number of youth at home continued to rise steadily from referral to March 2016 and again in September 2016. By September 2016, there were 29 more youth at home than there were at referral. Seventy-four percent of youth who were at home at referral were at home in September 2016. However, 21 percent of youth with a preventive at home referral were placed in congregate care settings (half in in-state, and half in out-of-state) in September 2016.

Youth referred while in out-of-state or in-state congregate settings are more likely to leave congregate care, and less likely to return than those in the comparison group at a statistically significant rate. On the other hand, youth who started at home showed the opposite (although this was not statistically significant).

Youth with in-state and out-of-state congregate care referrals are spending less time in congregate care settings than those of the comparison group at a statistically significant rate. Though statistical significance could not be calculated this also seems to be the case for youth with an emergency shelter referral.

Youth with referrals from out-of-state congregate care, in-state congregate care and emergency shelters spent less time in care than their matched counterparts in the comparison group. However, statistical significance was only achieved for youth with in-state congregate care referrals. Youth with a preventive at home referral spent an almost equal amount of time in care as youth in the comparison group.

The last analysis looks at abuse recidivism. In the six months following referral to Safe at Home, only one youth had a maltreatment referral. In the six months following an imputed referral date, the comparison group had eight referrals for maltreatment, involving eight different youth. Therefore, Safe at Home did better on referral recidivism.

HZA examined the CANS domains to measure the well-being of youth. Table 22 displays the percentage of needs reduced at six months and 12 months within the CANS domains by each specific item. The table also provides more specific information on the reduction of needs within the CANS domains themselves by item.

Overall, needs have been reduced in all CANS domains at six and 12 months. Additionally, overall domain needs have been further reduced at the 12-month mark in comparison to the six-month mark. The CANS domain with the most reduced needs at 12 months is “Symptoms of Trauma.” The specific CANS item with the greatest reduction

of needs at six and 12 months is “School Behavior,” which falls within the “Life Functioning” domain.

Strengths were rated generally high at baseline, with over half of youth rated as exhibiting the strength in all but two items. Nearly all strength items were rated highest at the 12-month period, showing improvement over time. “Coping and Survival Skills” and

“Relationship Permanence” strengths saw very slight decreases between the six and 12 month marks. “Spiritual/Religious” strengths remained the same between six and 12 months.

All the “Family Well-Being” items improved over time, reaching their peak, thus far at the 12-month mark. This appears most substantial with the “Family Stress” item which yielded a 50 percent improvement in the percent of youth with “nonactionable” items over 12 months.

March 31, 2017

Youth Placements

Fewer youth were in an out-of-state or in-state congregate care placement and an increased number of youth were living at home six months following referral for both Cohorts I and II. Nearly half the number of youth referred to Safe at Home in Cohort I were in out-of-state congregate care six months following referral while the number of youth living at home increased by 45 percent. For Cohort II, there was a 70 percent reduction in the number of youth living in out-of-state congregate care at six months as well as a 39 percent reduction of youth living in in-state congregate care.

Youth Well-Being

The CANS tool provides an assessment of youth’s strengths and needs which is used to support decision making, facilitate service referrals, and monitor the outcomes of services received. By utilizing a four-level rating system (with scores ranging from 0 to 3) on a series of items used to assess specific domains, such as Child Risk Behaviors or Life Domain Functioning, the CANS helps wraparound facilitators and DHHR caseworkers identify needs/actionable items (e.g., those with a score of 2 or 3), which show where attention should be focused in planning with the family.

Wraparound facilitators from LCAs are primarily responsible for administering the CANS assessments to youth in the program. Once CANS assessments are completed by the

wraparound facilitators, they are to be entered into the online WV CANS. Youth in the program are supposed to receive an initial CANS assessment within 14 days of referral and subsequent CANS are to be performed every 90 days thereafter.

A total of 309 Safe at Home youth had at least two CANS assessments completed, i.e., an initial CANS and at least one subsequent CANS. For purposes of this report, the results of initial CANS assessments for youth from Cohort I are compared to those at six and twelve months' post-referral to determine progress while in the program, with the results limited to six months for youth from Cohort II. Progress is measured by the extent to which scores have improved, meaning needs/actionable items have been reduced over time. As shown in Table 16, CANS assessments available for analysis become more limited as time goes on. This is due to a variety of factors, including: inappropriate referral (for example, youth may not meet the age requirement), youth placements into a detention center, or cases close prior to six months because families decline participation or there is an inability to secure placements for youth.

Looking at the domain which showed the most need upon initial assessment, i.e., Life Functioning Needs, 61 percent of the youth from Cohort I showed a reduction in at least one item at six months; the same was true for 69 percent of youth in Cohort II. At twelve months, the reduction in need in the Life Functioning Needs domain for youth in Cohort I show a marked improvement with 92 percent of the youth having improved their scores within the domain. Interestingly, Life Functioning Needs seem to show the greatest reduction in needs overall for both cohorts; suggesting that while these are the most common needs identified, they are also the ones in which the program has been able to address most effectively.

Family Stress was identified as the most common need item for youth in both cohorts on the initial CANS, followed by Residential Stability. By six months, 59 percent of the youth in Cohort I saw a reduction in Family Stress; the same was true for 30 percent of youth in Cohort II. At six months, Residential Stability was reduced for three of the four youth in Cohort I with this need and the same was true for two of the three youth in Cohort II.

The numbers available at twelve months for youth in Cohort I are quite limited. However, of the four youth who had identified Family Stress as a need on the initial CANS and had a twelve-month follow-up, none of them had Family Stress identified as a need at twelve months.

Summary of Outcome Evaluation Results

In looking at overall placement shifts for youth in Safe at Home, a smaller percentage of youth were in either out-of-state or in-state congregate care for both cohorts at six months' post-referral; there was even a smaller percentage in such a setting for youth from Cohort I at twelve months. There were also a higher percentage of youth living at home six months after referral (for both cohorts) and this percentage continued to increase for youth in Cohort I at twelve months.

When looking at the placement of youth into congregate care, a slightly higher percentage of youth from Cohort I's treatment group entered congregate care at both six and twelve months than those in the comparison group, although a smaller percentage of youth from Cohort II's treatment group entered congregate care within six months of referral; none of these results were statistically significant. Safe at Home youth from Cohort I re-entered congregate at a higher rate than comparison youth at six and twelve months. However, fewer Safe at Home youth from Cohort II re-entered congregate care at six months than did their comparison counterparts. None of these results were statistically significant. Safe at Home youth appear to be spending less time in congregate care than youth from the comparison groups. Youth from the treatment groups for both Cohorts I and II spent less time in congregate care at a statistically significant rate.

Regarding the placement of youth within their home counties, the percentage of youth moving out of their home counties provided mixed results. However, a greater proportion of Safe at Home youth from both cohorts returned to their home-counties at six and twelve months than evidenced for those in the comparison groups. These results were statistically significant for Cohort II at six months.

While the rate at which Cohort I youth re-enter foster care is similar among those from the treatment and comparison groups six months following discharge, by twelve months the foster care re-entry rate is significantly lower for youth in Safe at Home compared to those in the comparison group. Safe at Home youth from both cohorts had fewer maltreatment referrals and investigations at six and twelve months at a statistically significant rate than youth in the comparison groups.

Regarding youth well-being, the CANS domain exhibiting the highest percentage of need at initial assessment was Life Functioning Needs; it also showed the greatest reduction in need at six and twelve month follow-ups. While these needs are the most prevalent among Safe at Home youth, they are also the ones in which the program has been able to address most effectively.

Safe at Home youth from Cohort I re-entered congregate at a higher rate than comparison youth at six and twelve months. However, fewer Safe at Home youth from Cohort II re-

entered congregate care at six months than did their comparison counterparts. None of these results were statistically significant. Safe at Home youth spent less time in congregate care placement settings than comparison youth at a statistically significant rate. This was evident in the cost savings found of over $740,000 in maintenance costs for youth in Cohort I which was largely impacted by the reduced time youth spent in out-of-state congregate care.

While the rate at which Cohort I youth re-enter foster care is similar among those from the treatment and comparison groups six months following discharge, by twelve months the foster care re-entry rate is significantly lower for youth in Safe at Home compared to those in the comparison group. Safe at Home youth from both cohorts had fewer maltreatment referrals and investigations at six and twelve months than youth in the comparison groups.

For detailed DATA and evaluation information please refer to the attached Semi-Annual Progress Reports.

Waiver Sustainability and Transition Planning:

As part of the planning for the ending of Waivers in 2019, West Virginia has begun planning for sustainability. The sister Bureaus of BCF and BMS have been meeting to discuss possible funding mechanisms as we move forward. This planning is in its infancy and will be ongoing.

The West Virginia BCF Executive Team is in the early stages of discussions about transitioning out of the waiver and sustainability. These discussions are very early in their processes while West Virginia awaits the preliminary cost evaluation being conducted by our independent evaluator. The first cost evaluation will be conducted during the reporting period of April 1, 2017 to September 30, 2017. Information from our evaluator and this preliminary cost evaluation will assist us with the needed information for further planning.

10. Quality Assurance System

West Virginia's quality assurance system utilizes data from various sources to make improvements in case practice and services for West Virginia's children and families. The Division of Planning and Quality Improvement, Social Services Review Unit, completes Child and Family Services Reviews (CFSR) style reviews for each of the West Virginia Department of Health and Human Resources districts. The Division of Planning and Quality Improvement (DPQI) continues its efforts to further enhance the state's

performance in the areas of safety, permanency, and wellbeing by utilizing the federal Child and Family Services Review (CFSR) process as a model to measure and evaluate the state's performance for the above-mentioned areas.

West Virginia utilizes the July 2014 version of the Federal Child and Family Services Review On-Site Review Instrument as the unit's primary internal tool for evaluating the quality of delivery of services to children and families. Each reviewed case is reviewed following the guideline established by the Federal Bureau for Children and Families.

The CFSR style review provides meaningful data to the districts to assist them in improving services to children and families. All cases reviewed are completed by pairs of reviewers, by federal guidelines. In addition to completing a review of the record and FACTS, client and stakeholder interviews are conducted for each case reviewed.

DPQI review team members review cases related to the 18 items of the Federal CFSR style review instrument. The period under review covers a 12-month section of time going backwards from the start of the review date to 12 months prior. Preliminary case reviews to collect information are done related to the FACTS records only. Reviewers develop a list questions and information needed to complete the CFSR review. DPQI review teams then conduct interviews with designated stakeholders including the case worker, parents, service providers, placement providers, youth if age appropriate and any other parties who may have information relative to the case review. DPQI reviewers also review the paper file for additional information as part of the review process and include this information in review findings.

After the completion of the review, all cases are debriefed based on the Federal Child and Family Services Review model. Case debriefing are comprised of two teams and a DPQI program manager at minimum. All applicable items are discussed and consensus is reached in the rating of the items. This provides for better inter-rater reliability. The teams upload their completed instruments into a SharePoint site. Quality Assurance reviews are conducted on all cases reviewed by the Division of Planning and Quality Assurance program management staff. Data is compiled as a result of the CFSR style reviews and utilized in the development of district specific of corrective action plans.

Exit conferences are held at the district offices where DPQI Staff assist the district in interpreting the results of the review. At the exit conference, the data indicators based on the 18 items reviewed are discussed with the District. The District is also provided with a comparison from their prior review to review improvements and areas needing improvements. At this time, an exit interview is conducted by DPQI staff with the District's Management staff. District Management staff can comment on the factors that contributed to the areas needing improvement, and strengths. Additionally, DPQI creates a list of base questions to be asked at all the exits. The questions are based on the

previous Federal Fiscal Year data and the overall issues impacting practice within the State.

Following the exit with the district management team and DPQI staff, DPQI completes a comprehensive report on the results of the review. The exit summary report is provided to the District for review and comments. Districts complete a corrective action plan based on the identified areas needing improvement outlined in the exit summary.

DPQI compiles the exit summary, data and corrective action plans for each district and distributes the findings to the District's Management staff, the Regional Program Manager, Regional Director, Director of Training, Director of Policy and the Executive Team.

CFSR Round Three:

West Virginia is currently in the process of developing a plan for the implementation of Round Three of the Child and Family Services Reviews. West Virginia's sampling plan is currently being developed with assistance from the Regional Children's Bureau and the Measurement and Sampling Committee. No plan has been finalized.

West Virginia has proposed the sampling of 65 social services cases representative of statewide practice. Case reviews will be conducted over a period of six months. West Virginia will utilize a 12-month period under review when reviewing cases.

The sample will include 40 foster care cases and 25 in-home cases for a total of 65 cases. West Virginia has a high rate of children in placement. West Virginia believes this should be reflected in the number of placement cases included in the sample. The types of cases reviewed during the District monitoring reviews include open Child Protective Services (CPS) cases, with and without placement, open Youth Services cases, with and without placement, Foster Care cases and Adoption cases where the adoptions have not been finalized. The sampling for the state foster care population will be a consistent of the listing of children served by jurisdiction strata in accordance with WV's AFCARS defined reportable cases.

WV will utilize the US Department of Health and Human Services Administration on Children and Families, Children Bureau's Child and Family Services Review Onsite Review Instrument and Instructions (OSRI) when reviewing cases. Case information will be entered into the OSRI on line system provided by JBS international per requirement of the Children's Bureau.

West Virginia's current CFSR style case review process will be applied to Round Three of the CFSR. Once the sample is screened to meet the identified case types, case lists will be distributed to the lead reviewer for identification of interview participants. All case reviews are conducted in pairs. Preliminary case reviews to collect information are done

related to the FACTS records only. Reviewers then develop a list questions and information needed to complete the CFSR review. This phase enhances the reviewer's ability to collect relevant and/or clarifying information during the interviews related to rating the CFSR items. DPQI review teams then conduct interviews with designated case participants to include the case worker, parents, service providers, placement providers, youth if age appropriate and any other parties who may have information relative to the case review. Interviews are conducted jointly by the team of reviewers. Interviews will be conducted either in person or by telephone as the discretion of the interviewee. DPQI reviewers also review the paper file for additional information as part of the review process and include this information in review findings. Reviewers will jointly complete the US Department of Health and Human Services Administration on Children and Families, Children Bureau's Child and Family Services Review Onsite Review Instrument and Instructions (OSRI) when reviewing cases.

Upon the completion of the review process, all cases will be "debriefed". At a minimum, two teams of reviewers and a program manager must attend the debriefing. The debriefing allows an opportunity for the case review to be discussed and a consensus on case rating to be reached. The debriefing exercise allows for inter-rater reliability between the teams of reviewers. After the debriefing, the teams will enter the rated instrument into the on-line rating system. Program Mangers will provide quality assurance after the instrument is uploaded to the on-line site to ensure items were rated correctly, justifications are complete and the information is consistent with the debriefings.

2016 Update

West Virginia is in the process of finalizing a plan for the implementation of Round Three of the Child and Family Services Reviews. West Virginia has proposed using the State Conducted Case Review process to complete the onsite review. West Virginia's sampling plan is being developed with assistance from the Regional Children's Bureau and the Measurement and Sampling Committee. No plan has been finalized now. West Virginia proposes the review of 65 social service cases representative of statewide practice in six districts. The reviews will occur between April 1, 2017 and September 30, 2017, and will be conducted as part of the regular DPQI district review process.

The six Districts selected are representative of the dichotomy of the State from urban to rural practice and will include the largest metropolitan area in West Virginia, Kanawha County. The review will include at least one district from each of the four regions. The additional proposed districts include: McDowell, Ohio/Brook/Hancock, Randolph/Tucker, Doddridge/Ritchie/Pleasants, and Mingo.

Reviews will be conducted in each of the designated Districts with a staggered schedule over the course of the six-month review period. This means that as indicated permissible in the Child and Family Services Reviews Procedures Manual (November 2015), the

sample period used will be a rolling 6-month sample plan that begins on April 1, 2016 and adjusts forward one month per each month of the review period. This will provide for a period under review of approximately twelve months.

Reviews will be conducted by pairs of DPQI reviewers. Review teams will conduct interviews with key case participants. Reviewers will jointly complete the US Department of Health and Human Services Administration on Children and Families Children Bureau's Child and Family Services Reviews Onsite Review Instrument and Instructions (January 2016 version) when reviewing cases. Reviewers will be prohibited from reviewing cases in which they have been directly involved or provided direction. Each reviewed case will be debriefed with a minimum of one DPQI program manager and two review teams. After the debriefing is completed a DPQI program manager will review the completed instrument to ensure accuracy of ratings in accordance with instrument instructions. There will be a designated Lead Reviewer for each District reviewed.

The sample will include 40 foster care cases and 25 in-home cases. The types of cases reviewed will include open Child Protective Services (CPS) cases, with and without placement, open Youth Services (YS) cases, with and without placement, Foster Care cases and Adoption cases where the adoptions have not been finalized prior to the start of the sampling period. Safe At Home WV cases will be reviewed if they appear in the random sample. WV does not propose to stratify the sample by CPS/YS case type. Elimination criteria will be applied if a case type appears to be overrepresented in the sample.

The population, from which the placement sampling frame will be created, will comply with ACF standards as they apply to the CFSR Round 3 Placement case criteria. The population data source will be an abridged AFCARS file sorted by district. Data set details will include the Child ID number, age, date of birth, date of most recent home removal, permanency goals and FIPS code for the county. Initial data set will include all cases in which a child was in Bureau for Children and Families' custody and out-of-home care a minimum of 24 hours. Initial sampling period will begin on 4/1/16. Subsequent case sampling will occur monthly to allow for a consistent period under review of approximately 12 months. The sample will be separated into county of assignment and then into districts.

West Virginia's SACWIS system Family and Children Tracking System (FACTS) will generate the data set for the sampling of the non-placement cases. Included in the data set will be the case number which is by family served, case type, case open date, and if applicable date of case closure, FIPS code, and assigned caseworker. The data set will include all cases with at least 45 days in an "open" status, during the period of 04/01/16-11/15/16. Initial sampling period will begin on 4/1/16. Subsequent case sampling will occur monthly to allow for a consistent period under review of approximately 12 months. The sample will be separated into county of assignment and then into districts. Random

sample will be extracted monthly for the 12-month period under review using the Excel Data Analysis TookPak.

As per ACF standards for CFSR Round 3, all in-home cases will be pre-screened to ensure that no children in the family were in placement for 24 hours or longer during any portion of the sampling period. In-home cases will also be pre-screened to ensure they have been open at least 45 days at the time of review.

West Virginia's current CFSR style case review process will be applied to Round Three of the CFSR. The samples for both placement and in-home cases will be separated into county of assignment and then into districts. Once the samples are screened for elimination criteria they will be distributed to the district lead reviewer. The lead reviewer will develop the district review schedule and identify interview participants. All case reviews will be conducted in pairs. Preliminary case reviews to collect information will be done related to the FACTS records. Reviewers will then develop a list questions and information needed to complete the CFSR review. This phase enhances the reviewer's ability to collect relevant and/or clarifying information during the interviews related to rating the CFSR items. DPQI review teams will then conduct interviews with designated case participants that include the case worker, parents, service providers, placement providers, youth if age appropriate and any other parties who may have information relative to the case review. Interviews are conducted jointly by the team of reviewers. Every effort will be made to conduct the interviews in person; however, interviews may occur by telephone at the discretion of the interviewee. DPQI reviewers will also review the paper file for additional information as part of the review process and include this information in the review findings. Reviewers will jointly complete the US Department of Health and Human Services Administration on Children and Families, Children Bureau's Child and Family Services Review Onsite Review Instrument and Instructions (OSRI) when reviewing cases. Case information will be entered into the OSRI on line system provided by JBS international per requirement of the Children's Bureau.

Upon the completion of the review process, all cases will be "debriefed". At a minimum, two teams of reviewers and a DPQI program manager must attend the debriefing. The debriefing allows an opportunity for the case under review to be discussed and a consensus on case ratings to be reached. The debriefing exercise allows for inter-rater reliability between the teams of reviewers. After the debriefing, the teams will enter the rated instrument into the on-line rating system. DPQI management staff will provide quality assurance after the instrument is uploaded to the on-line site to ensure items were rated correctly, justifications are complete, and the information is consistent with the debriefings.

2017 Update

Please refer to the Statewide Self-Assessment.

CAPTA

The CAPTA State Grant, under the direction of state coordinator Brandon Lewis has been used to support and improve the child protective services system in the following program areas, as required in the Child Abuse Prevention and Treatment Act:

Conducting and improving intake, assessment, screening, and investigation of reports of abuse and neglect.

2016 Update

Effective April 1, 2016, the new CAPTA state coordinator is Kristen Davis.

The Department has provided a statewide system for receiving, investigating, and assessing referrals of child abuse and neglect since the last reporting period. Within the reporting period, CAPTA funds were used to train CPS Social Workers and stakeholders on the SAMS Intake, Investigation, and Ongoing CPS Services Process.

The Department has initiated a statewide Centralized Intake Unit responsible for receiving reports of child abuse and/or neglect during the reporting period. The Centralized Intake Unit provides consistency among West Virginia counties regarding reports of child abuse and/or neglect.

A part-time Citizens Review Panel Coordinator was hired using CAPTA funds during the reporting period. The part-time Citizens Review Panel Coordinator completed many of the tasks volunteers have been required to do, and this has allowed the Citizens Review Panel to continue to thrive. The Citizens Review Coordinator makes all arrangements for meetings; making copies, taking notes, providing minutes, and creating agendas. The results of the Citizens Review Panel will be used to improve the CPS System in West Virginia.

2016 Update

The part-time Citizens Review Panel Coordinator hired using CAPTA funding, has since taken a position with the Department as a Child Protective Services Worker. There continues to be discussions at CRP meetings as to whether she should continue as the coordinator as part of her agency responsibility or if the position should be posted for the public.

Within the last year, the Department has changed the response time for infants born drug or alcohol exposed to immediate.

A new definition of immediate was added. Immediate response: CPS Social Worker must respond as soon as the report of abuse or neglect is received unless there is a protective caregiver. If there is a protective caregiver **clearly** documented in the report, contact must be made within the same day while the child is still under the care of that protective caregiver.

Policy surrounding drug affected infants has been revised several times in the last year. Currently, the Department requires all referrals involving substances are accepted for assessment, assigned to a worker for investigation and an assessment completed. Further revisions may be needed requiring that cases be opened if recent substance abuse is found.

Mandated Abuse & Neglect Reporter training for hospitals, schools and other groups, such as churches, camps, and youth community groups is arranged for by district Community Services Managers.

West Virginia currently has state law §49-2-805 that requires all hospital personnel to report any suspected abuse and neglect or observes the child being subjected to conditions that are likely to result in abuse or neglect to the Department. The Department has policy that directs staff to accept, assign, assess and determine if services are needed for these families. WV law also allows that parental rights of parents be terminated if the abusing parent or parents have habitually abused or are addicted to alcohol, controlled substances or drugs, to the extent that proper parenting skills have been seriously impaired and the person or persons have not responded to or followed through the recommended and appropriate treatment which could have improved the capacity for adequate parental functioning;

WV Code §49-2-803; Persons mandated to report suspected abuse and neglect; requirements.

(a) Any medical, dental or mental health professional, Christian Science practitioner, religious healer, school teacher or other school personnel, social service worker, child care or foster care worker, emergency medical services personnel, peace officer or law-enforcement official, humane officer, member of the clergy, circuit court judge, family court judge, employee of the Division of Juvenile Services, magistrate, youth camp administrator or counselor, employee, coach or volunteer of an entity that provides organized activities for

> children, or commercial film or photographic print processor who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources.

A small multi-agency group has been established to update mandated reporting statute. The goal will be to make it more specific to infants who are drug exposed, drug affected, involve parents who are using or abusing drugs including illegal, legal and prescribed medication for substance abuse treatment and maintenance.

CPS Policy 3.19 Reports Involving Caregiver Substance Abuse currently reads in part as follows;

When a report is received alleging caregiver substance abuse, a thorough interview must be conducted with the reporter to determine if there is reason to suspect that the child is abused or neglected in any way, or subject to conditions or circumstances that would likely result in abuse or neglect due to any use or abuse of substances (legal or illegal) by the parents, the report must be accepted and assigned.

3.20 Reports Involving Drug-affected Infants or Infants/Children suffering from Fetal Alcohol Spectrum Disorder

The Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation that guides child protective services. This legislation requires that child protective services and other community service providers address the needs of new-born infants who have been identified as being affected by illegal drug abuse or experiencing withdrawal symptoms resulting from prenatal drug exposure. Health care providers who are involved in the delivery or care of such infants are required to make a report to child protective services.

Infants who test positive for prescribed, non-prescribed or illegal drugs; present with withdrawal symptoms; or are diagnosed with fetal alcohol spectrum disorder, are even more vulnerable due to their medical condition. When a child is born with prescribed or non-prescribed drugs in their system, it is often impossible to know based upon the intake assessment if the parent is actively involved in a treatment program or if the parent is abusing the prescribed drugs, such as suboxone or methadone, and unable to properly care for a newborn.

• The referral is accepted anytime a newborn child tests positive for drugs or has been diagnosed with fetal alcohol spectrum disorder.

Due to the Departments percentage of new staff and the complexity of substance abuse Children and Adult Service staff would propose to change the above policy to the following;

3.21 Reports Involving Substance Use or Abuse

Caregiver substance abuse in and of itself does not constitute child maltreatment; however, caregiver substance abuse is often present when child maltreatment occurs. When a report is received alleging caregiver substance abuse, a thorough interview must be conducted with the reporter to determine if there is reason to suspect that the child is abused or neglected in any way, or subject to conditions or circumstances that would likely result in abuse or neglect due to any use or abuse of substances (legal or illegal) by the parents, the report must be accepted and assigned.

For reports of suspected child abuse or neglect involving parental substance abuse, the worker and the supervisor will:

• Follow the same rules and procedures for intake as other reports of suspected child abuse or neglect.

The Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation that guides child protective services. This legislation requires that child protective services and other community service providers address the needs of new-born infants who have been identified as being affected by illegal drug abuse or experiencing withdrawal symptoms resulting from prenatal drug exposure. Health care providers who are involved in the delivery or care of such infants are required to make a report to child protective services. The facility or hospital where the mother and exposed infant are being cared for is not considered a protective caregiver.

All newborns are extremely vulnerable as 100% of their livelihood is dependent upon their care givers. Infants who test positive for prescribed, non-prescribed or illegal drugs; present with withdrawal symptoms; or are diagnosed with fetal alcohol spectrum disorder, are even more vulnerable due to their medical condition. When a child is born with prescribed or non-prescribed drugs in their system, it is often impossible to know based upon the intake assessment if the parent is actively involved in a treatment program or if the parent is abusing the prescribed drugs, such as Suboxone or Methadone, and unable to properly care for a newborn.

For reports of drug-affected infants and/or infants born exposed to illegal substances or alcohol or prescribed medication used inappropriately or Methadone, Suboxone, Subutex or any other medication used to treat addiction, the Intake Assessment Worker will gather the following information:

- The name and address of the medical facility where the child was delivered;
- The infant's drug results if applicable, including type of drug for which the infant tested positive;
- The birth mother's drug test results if applicable, including type of drug for which she tested positive;
- Information from the delivering obstetrician, nurse practitioner, mid-wife or other qualified medical personnel as to the condition of the infant upon birth. The statement should include specific data as to how the in-utero drug or alcohol exposure has affected the infant (e.g., withdrawal, physical and/or neurological birth defects);
- The infant's birth weight and gestational age;
- The extent of prenatal care received by the birth mother;
- The names and ages of any siblings the infant may have, including any abuse, neglect or safety concerns regarding the siblings.

Following the information gathering process with the reporter, the worker will:

- Follow the same rules and procedures for entering intakes as other reports of suspected child abuse and neglect into FACTS, indicating that the allegations of maltreatment are "Abuse" and the type is "Physical injury";
- The referral is accepted anytime a newborn child has been exposed to substances in utero, if the infant tests positive for substances or has been diagnosed with fetal alcohol spectrum disorder or if the mother discloses drug use or tests positive for substances during pregnancy or during delivery.

The supervisor will:

- Follow the same rules and procedures for intake as other reports of suspected child abuse or neglect by a caregiver.

Current Assessment policy is as follows;

4.40 Family Functioning Assessments Involving Drug-affected Infants and/or Infants/Children suffering from Fetal Alcohol Spectrum Disorder

Substance abuse may be identified at various stages throughout a Child Protective Service case process and can affect safety in a various ways. However, the purpose of this section will focus on infants born with effects of illegal substances as well as infants suffering from fetal alcohol spectrum disorder.
Once the referral is assigned to the district, the Child Protective Services Worker will review the family's available records and history of past involvement with the Department of Health and Human Resources, this includes other adults that would be considered caregivers and residing in the household.

- The Child Protective Services Worker will conduct a face to face with the family based on the assigned time frame.
- Child Protective Service Worker should obtain identifying information about the father. Hospital Staff should be asked if paternity declaration was established.
- The Child Protective Services Worker should thoroughly assess the family, gathering information from the parents, and other pertinent collaterals. Suggested collaterals are, but should not be limited to; hospital staff, social worker, pediatrician, drug counselors, therapist and teachers. Both, mother and child(ren) records from the hospital should be obtained. This could include toxicology reports and withdrawal scores of the infant, and nurses/doctors progress notes. Infants whose mothers self-report drug use and/or test positive for drugs while pregnant should be identified as a "Drug Affected Infant" and a protection plan or safety plan initiated before the child(ren) is discharged from the hospital after consultation with a supervisor.

It is important for the worker to obtain information about the parent's interaction with the infant and any relevant statements the parents revealed to staff about the ability to properly care for the child(ren).
- Upon the child(ren) discharge from the hospital the Child Protective Services Worker should visit the family's home assessing the total home environment and what safety concerns if any are in the home. The Child Protective Service Worker should assess the parent's preparedness for the child(ren) as evidenced by the presence of adequate baby supplies. Sleeping arrangements and what intentions/beliefs the parents have regarding sleeping arrangements should also be discussed with all caregivers.
- Child Protective Service Worker should assess the parent's ability to parent the infant and any other children in the home identifying any safety concerns in the home.
- During the assessment process, it is important to assess the caretakers/parent's ability to parent the child(ren), and if the caretakers/parents have made strides to correct the substance abuse issues. This could include what methods of treatment intervention the parent chose, and compliance with those treatments.
- In situations where the mother has been prescribed medication due to a physical illness it is very important for the Child Protective Service Worker to:

- Obtain documentation from the prescribing physician about the mother's illness and maintenance of the medication.
- Obtain records from the Obstetrician to determine the mother's cooperation with pre-natal appointments and to determine if the mother consulted about the effects of the medications. This will help to determine if the mother did what was in the best interest of her child.

It is important to assess if the mother has taken the medication as advised by a physician. For Example: A mother is in a severe car wreck while pregnant and has several surgeries due to injuries. She takes medication as prescribed by her physician. Upon delivery, a safety plan/protection plan may not need to be developed. A full assessment should be completed to determine her ability to parent is not compromised.
In situations where the Department has knowledge of drug affected/exposed infants a referral to Birth to Three must be initiated and clearly documented. This is regardless of a maltreatment finding of whether the case will be opened.
Children and Adult Service Staff propose the following change;

4.40 Family Functioning Assessments Involving Substance Use or Abuse.

Substance abuse may be identified at various stages throughout a Child Protective Service case process and can affect safety in a various way. However, the purpose of this section will include a focus on infants born exposed to illegal substances or alcohol or prescribed medication used inappropriately or Methadone, Suboxone, Subutex or any other medication used to treat addiction.

For family assessments and safety evaluations involving parents who are using or abusing illegal substances or alcohol or prescribed medication used inappropriately or Methadone, Suboxone, Subutex or any other medication used to treat addiction the worker will:

- Once the referral is assigned to the district, the Child Protective Services Worker will review the family's available records and history of past involvement with the Department of Health and Human Resources, this includes other adults that would be considered caregivers and residing in the household;
- CAPTA requires that if a child is born testing positive it may not leave the hospital without a plan of care, which begins with a Protection Plan or Safety Plan put in place by the worker. Since most children are released within 24 hours of birth, the Child Protective Services Worker must conduct a face to face with the family immediately;
- CPS Social Worker must respond as soon as the report of abuse or neglect is received unless there is a protective caregiver. If there is a protective caregiver clearly documented in the report, contact must be made within the same day while the child is

still under the care of that protective caregiver. The hospital or facility should not be considered a protective caregiver;

• Child Protective Service Worker should obtain identifying information about the father. Hospital Staff should be asked if paternity declaration was established;

• The Child Protective Services Worker should thoroughly assess the family, gathering information from the parents, and other pertinent collaterals. Suggested collaterals are, but should not be limited to; hospital staff, social worker, pediatrician, drug counselors, therapist and teachers. Both, mother and child(ren) records from the hospital should be obtained. This could include toxicology reports and withdrawal scores of the infant, and nurses/doctors progress notes. Infants whose mothers self-report drug use and/or test positive for drugs while pregnant should be identified as a "Drug Affected Infant", an abuse finding will be made and a protection plan or safety plan initiated before the child(ren) is discharged from the hospital after consultation with a supervisor. A case will be opened and services put in place to address the drug use and/or any other contributing factors;

- The West Virginia Department of Health and Human Resources (WVDHHR) will work to create a public service announcement spot to be broadcasted on all state/local radio and television stations about substance use/abuse during pregnancy; the negative effects of substances use/abuse on the fetus, the infant child and the parent/parents. The announcement will cover WVDHHR's responsibility of keeping children safe who are exposed to drug use. The public service announcement will also cover state law surrounding mandated reporting by birthing centers and hospitals, and CAPTA requirements. The public service announcement can be played in the waiting areas of WVDHHR district offices, health departments, doctor's offices, pediatrician offices, WIC offices and hospitals. We can pair with the Bureau for Public Health, Bureau for Medical Services and the Bureau for Behavior Health for funding.

- WVDHHR is going to work diligently with the WV legislature to implement a law that requires hospitals to follow CAPTA reporting procedures for Drug Affected infants and substance use/abuse by parents/caregivers. The WVDHHR will also do a mass mailing to all hospitals and birthing centers in the state to remind them of their role as mandated reporters.

- WVDHHR will create a telephone recording to be played as an introduction and while you're on hold when calling all WVDHHR district offices, Centralized Intake, and the Call Center to educate customers, the public as well as mandated reporters about substance use/abuse and Drug Affected infants.

- WVDHHR will create a separate plan of care to use explicitly with infants who have been identified as being affected by illegal drug abuse or experiencing withdrawal symptoms resulting from prenatal drug exposure.

- Critical Incident Training which was held from October 2015 through December 2015 and was mandatory for all child welfare and adult service staff. The training addressed better safety planning, better assessments around drug use specifically when there are small children in the home, and more frequent contact with the children in cases. The training has been incorporated into new worker training and will be updated as issues are identified in the critical incident review team meetings.

On June 30, 2016, West Virginia submitted a revised IV-E PIP to address items not included in the previous submission. Specially, West Virginia was asked to address the following:

- Ensure foster parents and child care institutions are following the reasonable and prudent parenting standard, including youth whose permanency plan is APPLA;
- Provide every child in foster care age 14 and up a document that describes the rights of the child with respect to education, health, visitation and court participation, the right to be provided with the documents specified in section 475(5)(1) and the right to stay safe and avoid exploitation;
- Establish or designate a state authority responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards including those related to admission policies, safety, sanitation and protection of civil rights and which permit the use of reasonable and prudent parenting standards.
- Develop policies and procedures for identifying, documenting and determining appropriate services for any youth for whom the agency has responsibility for placement, care, or supervision or youth who are not in foster care but are receiving services when there is reasonable cause to believe that youth is, or is at risk of being a victim of sex trafficking;

Further feedback was provided by ACF on July 22, 2016, requesting further documentation on the array of services provided to victims of sex/human trafficking, protocols for serving victimized youth not in foster care and further exploration about the sustainability of the collaborative task force should legislation fail to pass again in the 2017 session to codifying the activities of this group.

The West Virginia Human Trafficking/Civil Rights Task Force is currently in its early stages of working to improve the WV response to Human Trafficking. The membership of the task force already includes representatives from each discipline recommended by the document ***Collaborating with Youth-Serving Agencies to Respond to and Prevent Sex Trafficking of Youth***, developed by the Capacity Building Center for States. We have recently hired a Human Trafficking Coordinator. The individual serving in this role comes to us with experience working with survivors and an intense passion to end human trafficking. One of the initial responsibilities will be to coordinate the communication loop with statewide task force membership, as well as assigning parties to the task force sub-committees specific to each individual item on the work plan. One of the key tasks on the work plan will be cross-system coordination of services delivery for victims.

The Bureau for Children and Families will develop intra-agency screening and response tools to assist in the identification and servicing of youth and young adults not in foster care who may be victims of human trafficking. This screening tool will be used across multiple programmatic areas, including customers who may be applying for TANF, SNAP or Medicaid benefits. Once a victim of human trafficking is identified, despite which avenue of entry, a referral will be made to child protective services for assessment of service needs. (See attached PIP)

The Bureau for Children and Families continues to seek codification of its proposed Trafficking legislation but should not need the legislation passed to carry out the requirements related to CAPTA.

Currently, the only data West Virginia has available is from The National Human Trafficking Resource Network.

Between 12/7/07 and 6/30/16 there have been **214 calls** and **57 cases**.

High – **43**

Moderate – **34**

Cases categorized as "**High**" contain a high level of indicators of human trafficking. Cases coded as "**Moderate**" contain several indicators of human trafficking, or resemble common trafficking scenarios but lack core details of force, fraud, or coercion.

So far, this year there have been **23 calls** and **8 reported cases.** Of the 8 reported cases, **7** were **sex trafficking**. Also of the 8 cases, **7** were **female** and **5** were **adults**, which relates to almost **half** of the cases being **underage youth.**

2017 Update

During federal fiscal year 2017 CPS policy was revised to include CARA standards. These standards include all infants born ***exposed*** to legal or illegal substances or alcohol or prescribed medication used inappropriately or Methadone, Suboxone, Subutex or any other medication used to treat addiction to all legal, illegal, prescribed substances used inappropriately. These referrals will be accepted and assessed. The immediate response that was implemented in 2016 will be changed to require the Child Protective Service Worker making face-to-face contact with the infant and family prior to the infant's discharge from the hospital to develop a Plan of Safe Care.

West Virginia's reporting of infants born testing positive for substances or showing withdrawal symptoms will be changed in the fall of 2017. During requirements for NCANDS changes it was discovered the Centralized Intake Unit reported that referrals received from hospital social workers were being coded as social workers instead of hospital staff. Policy and training will correct this issue to ensure all referrals are being coded correctly. Centralized Intake handles all referrals statewide.

West Virginia has an interagency collaborative group working on all issues of prenatal drug use. This group has developed and delivered training to all hospitals and birthing centers on the subject of reporting all babies born testing positive for any substances or born showing symptoms of withdrawal or Fetal Alcohol must be reported to DHHR.

Please refer to West Virginia's CAPTA Program Improvement Plan.

In 2017, West Virginia had 19 victims of trafficking, five of those were minors.

Creating and improving the use of multidisciplinary and interagency, intra-agency, interstate and intrastate protocols to enhance investigations; and improving legal preparation and representation, including procedures for appealing and

responding to appeals of substantiated reports of child abuse or neglect; and provisions for the appointment of an individual appointed to represent a child in judicial proceedings.

To assist parents and other caretakers to better understand the Child Protective Services and their rights in the Child Protective Services Process, the Department developed the publication "A Parent's Guide to Working with Child Protective Services" several years ago, and CAPTA funds were used to purchase this publication. This publication provides the parents/caretakers with information on:

The Child Protective Services process beginning with the receipt of a referral and proceeding through investigation and the filing of a petition if necessary;

- The court process including the parents' rights;
- The process for resolving disagreements/appeals with the Department;
- A section on services that the family can explore;
- A section (glossary) of terms;
- A section concerning the appellant process.

Child Protective Services has state statute and policy on the use of multidisciplinary investigation. Child Protective Services staff receives multidisciplinary training, and the MDIT (Multidisciplinary Investigative Team) process is included in Child Welfare Policy. Other disciplines are also trained on multidisciplinary investigations. Children's Justice Act (CJA) funds have been utilized to fund training for the investigation and resolution of child abuse and neglect cases. CJA funds were again used during the reporting period to conduct regional multidisciplinary trainings with attendees from law enforcement, child protective services, children's advocacy centers, and judicial staff attending. The Children's Justice Task Force conference has been held each year with the focus of multidisciplinary investigations.

CJA funds were used to establish the new West Virginia Center for Children's Justice to coordinate and oversee the Children's Justice Task Force, The Alliance for Drug Endangered Children, West Virginia Defending Childhood Initiative Task Force (Handle with Care), as well as, Human Trafficking Task Force. The Center is charged with improving the investigation, prosecution and judicial handling of child abuse and neglect cases, strengthening prevention and intervention efforts, and promoting school-community partnerships aimed at ensuring that children who are exposed to trauma in their home, school or community receive appropriate interventions to help them achieve academically at their highest levels despite whatever traumatic circumstances they may have endured.

A protocol for reporting suspected crimes against children to the West Virginia State Police Child Abuse and Neglect Investigation Unit has been developed and implemented. The protocol allows more effective collaboration between Child Protection Services, State Police, and Local Law Enforcement to reduce child fatalities and aid in the prosecution of perpetrators of child abuse and neglect.

2016 Update

To increase the participation of MDT members, the WV legislature made changes to code section 49-4-403 concerning the MDT process. The changes included a requirement for the Department to coordinate with the court to dedicate at least one day in which MDT's are regularly to occur. The intent is to provide at least one day each participant can dedicate solely to participating in these meetings.

The Court Improvement Program's MDT Study Committee revised and updated the MDT Desk Guide to provide case workers with a better understanding of the MDT process. The Desk Guide outlines who should be included in the meetings, when the meetings should occur, what should be occurring during the meetings, and the responsibilities of each member of the team. This Desk Guide should be used as a reference by all case workers to provide a best practice model for conducting MDT meetings.

2017 Update

Since May of 2015, the state has worked collaboratively with our judicial and legal partners to select at least one day per month, in each county, as an MDT day. The selected day is a day in which only MDT meetings are held ensure maximum participation of all codified members of the MDT and reducing unnecessary barriers to families. As of September 2016, 44 of the state's 55 counties had determined a date for MDTs to be held.

Providing case management, including ongoing case monitoring and delivery of services and treatment provided to children and their families.

The Department continues to provide case management and services to families whose children are threatened with child abuse and neglect. Case Management Services are provided by Department staff and are enhanced through Socially Necessary Services funding, which is a managed care program operated by the Department for services to clients and families.

The Department provides medically necessary services to families and children through the Medicaid system. If the family does not qualify for Medicaid due to their children being in care, the Department pays for medically necessary services to attempt to reunify the family if appropriate.

2016 Update

West Virginia has initiated a Title IV-E Demonstration Project, Safe at Home West Virginia, in the 11 phase 1 counties. Safe at Home West Virginia is a high fidelity wraparound model. For more information, please see the Child Welfare Demonstration section of the Annual Progress Services Report

2017 Update

See Waiver Demonstration project section for update.

Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response.

Within the reporting period, the Intake Assessment and Family Functioning Assessment portion of a new decision-making model titled the Safety Assessment and Management System (SAMS) was implemented statewide, and portions of the SAMS Ongoing Child Protective Services Process were implemented.

CAPTA funds were used to purchase training materials as well as purchase classroom training and consultation from Action for Child Protection. Training materials purchased using CAPTA funds will be utilized for years to enhance child protective services for years.

2016 Updates

The West Virginia Child Abuse Needs and Strengths Assessment (WV CANS) have been implemented and training was provided to staff statewide. The Bureau for Children and Families currently has initiated two workgroups. One group is meeting to determine if the WV CANS and/or FAST should be integrated into or replace, in part or whole, the current SAMS model. A second group is meeting to research if the state should implement differential response.

2017 Update

For the past eighteen months, a small group was formed to begin to develop a streamlined assessment process for both Children's Protective Services and Youth Services in West Virginia. The FAST model by the Praed Foundation has be selected. This development was recently sent to the Bureau for Children and Families Policy unit for completion. A final policy should be sent to the Division of Training by August 2017 for curriculum development.

Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange.

The WV SACWIS System (FACTS) continues to track all reports of child abuse and neglect from intake through final disposition and has done so since prior to the reporting period. The FACTS system is available to all Child Welfare staff throughout the state and can be accessed at any District office.

2016 Update

The Department has contracted with Berry Dunn to develop requirements for a Request for Quotes (RFP) to develop a new Statewide Automated Child Welfare Information System (SACWIS). Several staff met with Berry Dunn the last week of March 2016 to develop requirement for this RFP.

2017 Update

The WV Department of Health and Human Resources has prepared a Request for Proposal outlining a modularized system the will incorporate the functionality of multiple system operations into combined blocks of common functionality shared by one or more systems. The various components of the current SACWIS will be moved into the combined system as new modules are brought up and implemented. Any distinct and non-sharable functionality will be addressed by migrating the last components of the legacy FACTS system to a browser based platform that can then be used to form additional modules. Additional interfaces with Education and the Courts are under discussion and pre-planning efforts underway. Also in development are the data and process quality efforts that will be imbedded within the new application. The agency is still waiting to review vendor responses to the RFP. With the projected date to select a vendor set in August, more details regarding prioritization and detailed CCWIS requirements can be given once the successful vendor has been chosen.

Developing, strengthening, and facilitating training including training regarding research-based strategies, including the use of differential response, to promote collaboration with families; training regarding the legal duties of such individuals, personal safety training for case workers, and training in early childhood, child and adolescent development.

Within the reporting period, CAPTA funds were used to provide continued training to CPS staff concerning the new CPS decision-making model, the Safety Assessment and Management System.

The SAMS Ongoing Case Management Process was implemented throughout the entire state during the reporting period. The training focuses on family collaboration and engagement during the Ongoing Case Management Process.

Extensive training is provided for CPS staff by the Department of Health and Human Resources Training Division. This training includes worker safety. Staff receives training from other avenues. A Multidisciplinary Conference on Child Abuse and Neglect is held annually for professionals who work with child abuse and neglect cases and is supported with CJA funds.

The Court Improvement Board continues their training on legal issues and case law in child welfare. The training is available to attorneys, CASA volunteers, and Departmental staff, among others. The content of the training sessions includes the Keeping Families and Children Safe Act of 2003; The Adoption and Safe Families Act of 1997 (ASFA); state statutes; information on Title IV-E regulations; and key state court decisions. CPS staff attends Sexual Abuse Finding Words Trainings which are conducted by the Prosecuting Attorney's Institute and Children's Advocacy Centers.

Protective Services staff attended a variety of child welfare trainings including but not limited to: Identifying Abuse and Neglect/Worker Safety; Fundamentals of Child Welfare; Human Growth and Development in the Social Environment; Culturally Sensitive Practice/Special Populations; Basic Interviewing Techniques and the Child Welfare Process; CPSS Initial Assessment and Safety; Domestic Violence; Substance Abuse; Permanency and Concurrent Planning; CPSS Family Assessment and Treatment; Foster Care/Policy and Systems; Preserving Connections; Sexual Abuse Initial Assessments; Advanced Interviewing; Sexual Abuse Interventions; Family Centered Practice; PRIDE Training for Child Welfare Workers; Social Work Ethics I and II; Advanced MDTs: An Experiential Approach; and Meaningful Contacts.

<u>2016 Update</u>

West Virginia made a concerted refocus effort regarding the importance of Family and Youth Engagement. Family and Youth engagement training was conducted statewide, not just for DHHR staff but also for our partners and stakeholders. West Virginia has included Family and Youth Engagement training as part of the required training for the Safe at Home Local Coordinating Agency grants as well as incorporating it into the system of care learning ladder as core training necessary for all those who serve with in the West Virginia System of Care.

There were legislative changes made to Chapter 49 of the West Virginia State Code allowing the Department to hire persons with an unrelated four (4) year degree through a restricted social license. This change came with a requirement that workers hired and holding this restricted license must complete a four-year training plan. See training plan changes for details.

Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers.

Within the reporting period, CAPTA funds were utilized during the reporting period to provide classroom training on Safety Assessment and Management System supervisory guides. This training was provided by the Division of Training to assist supervisors in engaging staff, mentoring, and ensuring that the SAMS decision-making model is appropriately applied.

Protective Services staff attended a variety of child welfare trainings including but not limited to: Identifying Abuse and Neglect/Worker Safety; Fundamentals of Child Welfare; Human Growth and Development in the Social Environment; Culturally Sensitive Practice/Special Populations; Basic Interviewing Techniques and the Child Welfare Process; the Safety Assessment and Management System; Domestic Violence; Substance Abuse; Permanency and Concurrent Planning; Foster Care/Policy and Systems; Preserving Connections; Sexual Abuse Initial Assessments; Advanced Interviewing; Sexual Abuse Interventions; Family Centered Practice; PRIDE Training for Child Welfare Workers; Social Work Ethics I and II; Advanced MDTs: An Experiential Approach; and Meaningful Contacts.

<u>2016 Update</u>

The WV RESILIENCE Alliance (WVRA) is a trauma-informed, resilience-resource curriculum which is being provided to WV's professional child welfare staff to assist them

in 'recovery' from the trauma and the secondary traumatic stress that they encounter daily.

Through the WVRA work we are, with the knowledge & permission of the source, using curriculum developed by the ACS-NYU Children's Trauma Institute titled *The Resilience Alliance: Promoting Resilience and Reducing Secondary Trauma Among Welfare Staff* made available through the National Child Trauma Stress Network . BCF has – with permission from the source- adapted the model for use within BCF. The ACE study is used & discussed with staff as a part of the WVRA sessions.

The WVRA curriculum has been delivered to workers, supervisors and administrators in 27 WV counties since beginning in April of 2013 in the northern Panhandle of West Virginia. It has also been delivered to the Centralized Intake Unit Supervisors, with plans to bring the curriculum to the entire CIU staff in early June 2016. Currently, new 'waves' of the WVRA curriculum are being implemented in all four Regions. The four Regional WVRA Facilitators are also responding and providing intervention to child welfare staff that have participated in or experienced a traumatic event.

2017 Update

CAPTA funds were used to provide non-employee travel for these services.

Developing and facilitating the use of, and implementing research-based strategies, and developing training protocols for individuals mandated to report child abuse or neglect.

Within the reporting period, the Department and West Virginia Partners for Prevention provided mandated reporter training throughout West Virginia. The training is a comprehensive training session for mandated reporters of suspected child abuse and neglect including child care workers, educators, law enforcement, clergy, medical professionals, and others who are legally mandated to report suspected abuse or neglect. Train-the-trainer sessions were conducted, and more than 100 individuals are now able to train the curriculum.

2016 Update

There have been no updates to this requirement this year.

Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions.

The Department of Health and Human Resources Children with Special Healthcare Needs program provides specialized medical care for children who have or might have chronic, disabling, medical conditions. Registered nurses and licensed social workers are available to coordinate and facilitate children's participation in healthcare services. A Care Coordinator is assigned to each enrolled child at the time the Patient/Family Assessment and Patient Care Plan is completed. The program supports the family and community in the care of children with special health problems by providing:

- Arrangements for early care
- Medical exams and tests to identify problems
- Medical treatment
- Planning to make sure all needed care is arranged
- Medical services are provided through clinics located in different areas throughout the state, or are arranged with medical specialists who work with the program. Treatment Services include, but are not limited to:
- Doctor visits
- Laboratory tests
- X-Rays
- Medicine
- Physical, occupational and/or speech therapy
- Equipment
- Hospital stays
- Surgery
- Laboratory tests and X-rays
- Medications
- Physical therapy
- Hearing aids
- Medical equipment and supplies
- Surgery/anesthesia
- Hospitalization
- Physician visits

<u>2016 Update</u>

See Health Care Coordination Oversight Plan update in this APSR.

Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response.

The Department provided training during the reporting period on reporting suspected incidents of child abuse and neglect. This training was provided to mandated reporters as well as others who may have regular contact with children. Train-the-trainer sessions were held during the reporting period. There are more than 100 trainers certified to train the community on child abuse and neglect as well as the role of Child Protective Services. The training is also being developed into a Web Course that can be taken by mandatory reporters and other interested parties.

The Department collaborated with the Children's Justice Task Force on known issues with individuals failing to report suspected child abuse or neglect. The West Virginia Children's Justice Task Force distributed information concerning the Child Protection System throughout the state. Each year, the National Association of Social Workers (NASW) hosts a conference in the capitol city of Charleston during April gathering thousands of social work professionals together. The task force had a booth presenting a myriad of packets of information and answering questions. The task force sponsored a booth at Children's Day at the Legislature to inform the public and legislators about issues regarding children and child abuse and neglect. The task force has participated in other conferences and fairs distributing child welfare information.

2016 Update

West Virginia has a detailed communication plan focused on engaging our partners at every level about serving our families and youth with in our IV-E demonstration project and beyond. As part of the Safe at Home West Virginia implementation plan, West Virginia has sent weekly e-mail blasts to all DHHR employees and external stakeholders, we produce a bi-monthly newsletter that is sent to the same audience and posted on our website, we conducted numerous community presentations to small civic groups as well as larger professional organizations, we have held personal meetings with Judges and attorneys, released news articles, been featured on several statewide news networks, radio broadcasts, newspapers, and periodicals. In partnership with our Local Coordinating Agencies and our Community Collaborative partners we have participated in local level community forums focused on engaging community members to partner with families as informal supports.

An important tool that is accessible by any of our partners is our one page flyer that was developed through a partnership with the Capacity Building Center for States.

2017 Update

The West Virginia Department of Health and Human Resources (WVDHHR) will work to create a public service announcement spot to be broadcasted on all state/local radio and television stations about substance use/abuse during pregnancy; the negative effects of substances use/abuse on the fetus, the infant child and the parent/parents. The announcement will cover WVDHHR's responsibility of keeping children safe who are exposed to drug use. The public service announcement will also cover state law surrounding mandated reporting by birthing centers and hospitals, and CAPTA requirements. The public service announcement can be played in the waiting areas of WVDHHR district offices, health departments, doctor's offices, pediatrician offices, WIC offices and hospitals. We can pair with the Bureau for Public Health, Bureau for Medical Services and the Bureau for Behavior Health for funding.

Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

Since 2004, the number of Partners in Prevention community teams has grown from 22 to 40 and currently operates with the assistance of CAPTA funds. The team leaders meet three times a year to learn about effective prevention strategies from state as well as national experts and from each other. The program ultimately seeks to tap the expertise of the people who are doing this work in communities and to provide ways to share that knowledge with others.

Local projects are designed and implemented by the community teams using research on successful programs in West Virginia and across the country. Participating Community Teams are encouraged to review Emerging Trends in the Prevention of Child Abuse, published by the U.S. Department of Health and Human Services, for guidance on various prevention programs and their effectiveness. Examples include:

- Community baby showers
- Offering useful items and information to new and expecting parents
- Parenting education and information on strengthening families
- Enhancing and supporting home visiting programs
- Family literacy programs
- Family fun nights to promote healthy relationships

- Sponsoring community forums on issues impacting families
- Presentations for professionals and the public on promoting child well-being and preventing maltreatment before it occurs
- Awareness sessions for children on protection from abusive situations
- Public awareness and educational programs on child abuse prevention
- Respite care services to provide relief from child-caring responsibilities for a period of time for families who require a significant amount of support to maintain family stability

Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems.

The Child Protection System and the Juvenile Justice System are members of the Commission to Study the Residential Placement of Children and the West Virginia System of Care Implementation Team. Those collaborations focus on seamless service delivery to children transitioning between the two systems and continued their work during the reporting period.

2016 Update

During the 2016 Legislative Session, the Legislature removed the Sunset Provision of the Commission to Study Residential Placement of Children. This group will continue to meet indefinitely.

In 2014, West Virginia partnered with the Pew Charitable Trust to evaluate the state's juvenile justice practices. The resulting information was published in a document titled Report of the West Virginia Intergovernmental Task Force on Juvenile Justice. This report found that between 2002 and 2012 referrals to court for status offenses rose nearly 124% and the number of status offenders placed outside of the home rose nearly 255%. "Three-quarters of juvenile justice youth placed in DHHR facilities in 2012 were status offenders or misdemeanants. Just under 50% of these youths had no prior contact with the court" (Virginia, 2014). The result of these findings was legislative changes.

During legislative session of 2015, the West Virginia legislature passed Senate Bill 393. This bill was part of the Governor's initiative to reform juvenile justice practice and a response to the findings of the task force within. As part of this bill, many changes were implemented which include a restriction of placing first time offenders outside of the home into foster care, unless for abuse and neglect or other safety concerns; a restriction on

the length of stay outside of the home, with a focus on community services; the prohibition of the utilization of detention facilities for status offenders, and the formation of the Juvenile Justice Reform Oversight Committee. The committee is a collaborative group of individuals from the Department of Health and Human Resources, the Supreme Court, the legislature, law-enforcement, the community, the Division of Juvenile Services, the Department of Education, and a crime victim advocate appointed by the Governor. The group's purpose is to provide oversight of the reform measures and improve the state's juvenile justice system.

2017 Update

CAPTA funds were used primarily for the State Police and TEAM grants.

Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protection system, and agencies carrying out private community-based programs to provide child abuse and neglect prevention and treatment services and to address the health needs of children identified as abused or neglected, including supporting prompt evaluations for children who are the subject of substantiated child maltreatment reports.

West Virginia Child Protective Services Policy requires that all children who have been identified as abused or neglected under the age of three receive a referral for Early Intervention Services. Child Protective Services Policy also requires children to be referred to Early Intervention Services when other risk factors are identified. Due to collaborative efforts within the Department and public health agencies, each child who enters foster care receives an Early and Periodic Screening and Diagnosis Treatment (EPSDT) within 72 hours of placement.

2016 Update

West Virginia's screening tools for EPSDT have been revised to include screeners for trauma. See Health Care Coordination and Oversight Plan.

2017 Update

See the Health Care Coordination and Oversight Plan Update

Developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in investigation, interventions, and the delivery of services and treatment provided to children and

families, including the use of differential response, where appropriate; and the provision of services that assist children exposed to domestic violence, and that also support the care-giving role of their non-abusing parents.

West Virginia Department of Health and Human Resources has a longstanding, productive relationship with the West Virginia Coalition against Domestic Violence (WVCADV). During the reporting period the WVCADV provided training to Child Protective Services Workers and Supervisors to assure child protection. The WVCADV and Department Trainers train CPS staff on power and control and how it can impact the non-abusing parent and children. The WVCADV trains CPS Staff on Co-Petitioning. Co-Petitioning allows the non-abusing parent and Child Protective Services to partner together and file a child abuse petition against the perpetrator. This supports the non-offending parent and allows them to continue to care for their child yet receive protective services from the court and permanency for their child. CPS staff can work with local Domestic Violence Advocates to assure child protection.

Due to the Child Abuse and Prevention and Treatment Act requirement that children born exposed to drugs or alcohol must have a plan of care prior to discharge and the misunderstanding of policy in this area, Child Protective Services policy was changed to reflect that all referrals alleging that a child has been born exposed to drugs or alcohol will be marked as an immediate response.

The definition of immediate response was changed to: must respond as soon as possible to the report of abuse or neglect unless there is a protective caregiver. If there is a protective caregiver clearly documented in the record, and a same day response will in no way jeopardize child safety, face to face contact must be made no later than same day of the referral, while the child is still with the protective caregiver.

H.B. 4489, which almost passed during the regular 2016 session, would add “commercial sexual exploitation” to the definition of an “abused child” in 49-1-201. There is effort to have the bill be part of a special legislative session this year, or it will be reintroduced in the 2017 session. The bill version on which there is consensus is available here:

http://www.legis.state.wv.us/legisdocs/chamber/2016/RS/floor_amends/HB4489%20HFA%20COWLES%20_1.htm.

2017 Update

In 2017, CPS policy was updated to include the definitions of a *Child Exposed to Domestic Violence.* The update will provide workers with needed information to help identify victims

of Domestic Violence and aid in assessment, referral, case planning and treatment for child victims of Domestic Violence.

Following the 2017 Legislative Session, the definition of Abused Child was amended to include a *Child Born of Sexual Assault.* The update the WV Code definition and WVDHHR's CPS Policy of Abused Child allows victims of sexual assault resulting in pregnancy to petition the court to terminate the parental rights of their abuser without the involvement of the DHHR. They may contact the prosecuting attorney to initiate a petition for Termination of Parental Rights (TPR) on their own.

State Law

There have been no changes in state law which would affect eligibility for CAPTA.

CAPTA State Plan

There have been no significant changes to the CAPTA State Plan or how funds will be used to support the 14 program areas found in Section 106(b) of CAPTA.

Requirements for Criminal Background Checks for Prospective Foster Parents, Adoptive Parents, and other Adult Relatives. WV Code §49-2-114 requires a check of personal criminal records for foster/adoptive parents. The Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248) requires states to complete a fingerprint-based criminal background check on all prospective foster/adoptive parents through the National Crime Information Database (NCID) prior to placement, whether a maintenance payment will be made to the family or not. All applicants and other adults in the home will authorize the release of criminal records through the State Policy and FBI National Database to the Department by completing the FD-258 record check request form. All applicants and other adults in the home must complete a signed Statement of Criminal Record, which provides for a disclosure and authorization statement. If the prospective foster/adoptive parent or any adult member of the household refuses to authorize the check, the home will not be approved. If the applicant or other adult in the home indicate a conviction for which there is no waiver permitted, the home will not be approved.

2016 Updates

The West Virginia Court Improvement Program has a runaway workgroup, as well as a collaborative group working to secure funding for a human trafficking task force that would inventory services available to victims and work on training and public awareness of human trafficking.

In the last year, West Virginia has collaborated with both its residential and child placing agencies to update both contracts/agreements and licensing rules to include a comprehensive process to identify assess and report runaway youth who may have been trafficked. The Division of Training is in the process of developing training for staff and providers on the updated policy and use of forms developed to track and report runaway and homeless youth as well as those who may have been victims of trafficking.

In October 2015, West Virginia increased staff processing NCID information from one to two and a half positions. This increase in staff has allowed the state to stay current processing this information. All prints completed by our contractor, Morpho Trust, are completed within 14 days and Department electronic prints hard print cards are completed in 4 weeks.

The Citizens Review Report was received by the Bureau for Children and Families in December 2014. The report is attached to the APSR. The response from the Commissioner is also attached to this report. The 2016 APSR including the CAPTA plan and updates will be posted to http://www.wvdhhr.org/bcf/ upon approval.

2017 Update

The Runaway Event Survey was revised to be used as a tool to identify youth, who are in foster care and who are “away from supervision” (AFS) or run away from their placement for a period, who have been a victim of trafficking. The Runaway Event Survey is currently being used by the Residential Treatment Facility providers when a youth returns from an AFS or runaway event. The provider is required to complete a monthly data report on all AFS or runaway events, with data on the number of youth identified as being a victim of trafficking. This report is submitted to BCF, who documents the data in a tracking spreadsheet. Quarterly reports are pulled on the AFS/Runaway data.

In 2017, there have been 5 youth identified as being a victim of trafficking. Please refer to West Virginia’s CAPTA Program Improvement Plan.

In March 2017, BCF implemented the same process for Child Placing Agency providers. The agencies have started utilizing the Runaway Event Survey for youth who are “absent from supervision” or run away from a foster home. Data has just started to come into the BCF office and is being put into a tracking spreadsheet. No reports are available now, since the process has just begun.

During FFY 2017, both the coordinator and Bureau for Children and Families policy specialist resigned from the Citizen’s Review Panel. They have not met since December

2016 but have submitted their report. The Bureau for Children and Families Policy specialist will be re-hired in her former position in late June 2017 and will be reassigned to this panel. The annual report is attached. The Commissioner's response will be forwarded to the Administration for Children and Families before the end of the year.

Chafee Foster Care to Independence Program

The West Virginia Department of Health and Human Resources has the responsibility to help older youth, in their care, develop into self-sufficient adults. In addition, all agencies and individuals who provide substitute parental care for older youth, in their care, are charged with helping to ensure that their social, emotional, and intellectual development is achieved to each youth(s) highest potential.

The Department should ensure that all adults entrusted with the care of older youth demonstrate appropriate social behavior; respond properly to stressful situations; and promote good physical, emotional, and intellectual well-being. It is through the observation of positive adult behavior and through interaction with positive adult role models that youth develop and demonstrate positive attributes.

All youth in out of home care, at age 14 or older, are provided with transitioning services to assist them with their transition from foster care as well as their transition to adulthood. Youth are provided with a life skills assessment on an annual basis, and a transition plan, which is reviewed and revised every 90 days. Transitioning services are provided when indicated through the life skills assessment and transition plan.

Since November 2014, West Virginia has been making changes to its child welfare policies to comply with the Preventing Sex Trafficking and Strengthening Families Act. We are strengthening our policies and practices to hopefully reduce the amount of West Virginia children in foster care who run away from placement, which ultimately leaves them with a higher probability of becoming victims of human and/or sex trafficking.

Our goal is to provide the children in foster care with a more stable and flexible environment, which will ultimately decrease the likelihood that they will run away. We have expanded our definition of a sibling to include any individual that the child considers to be a sibling with the hopes of broadening the chances for a kinship or relative placement wherein the child will already feel welcome and familiar. We have also added an entire section on prudent parenting, which requires our placement providers and case workers to allow the children to lead a more "normal" lifestyle and will provide them with more typical childhood experiences with family and friends. We are encouraging our providers to allow the children to spend the night with their friends, get involved with extra-

curricular activities, play sports, attend birthday parties, go on vacations, and anything else that the child is interested in doing. By allowing the children to have more freedom, our hope is that they will not feel the pressure to leave their placement as strongly as before.

Beginning in January 2015, the Bureau for Children and Families has had briefings with their Child Welfare Supervisors. These briefings have included information about appropriate use of Chafee funding, transition plans, learning plans, and discharge plans. Supervisors have been instructed to assure their workers are revisiting learning plans and transition plans monthly to determine any services their youth may need to transition.

West Virginia has also expanded the process for case workers and placement providers to follow in the instance that a child does run away or goes missing. They have always been required to report a missing child to law enforcement and to work diligently and cooperatively with them to locate the child. We are in the process of adding a survey to be completed by the caretaker (once a child is located) to assess the child to determine if they ran away willingly, why they ran away, what experiences they had while they were gone, and determine the likelihood of them running again. If it is found that they could have possibly been a victim of human and/or sex trafficking, the case worker is to report such information to the officials immediately, and then determine if there are any available services or other resources that could help the child process and recover from their experiences. West Virginia currently has a committee made up of private providers and DHHR staff to evaluate and revise forms and training to determine services needed by runaway youth. This group has met twice and should be able to finalize these documents in the next three months.

The Bureau for Children and Families has a representative participating in statewide committees regarding human and sex trafficking, as well. The Human Trafficking Subcommittee is a part of the West Virginia Children's Justice Taskforce. This subcommittee consists of members of the West Virginia State Police, West Virginia Supreme Court of Appeals, West Virginia Court Appointed Special Advocates, and various other entities that play a large role in child welfare. The subcommittee was created to establish a protocol on working with children in West Virginia who have gone missing or run away and to determine if they have been a victim of human or sex trafficking. The various players within the subcommittee already have certain policies in place and are now working together to create a network of resources and contacts to assist in these cases. The Court Improvement Program Human Trafficking Subcommittee is slated to begin in September 2015. This subcommittee will comprise of many of the same players as the West Virginia Children's Justice Taskforce Human Trafficking Subcommittee, but will be working together to create a bill to present to the

legislature in January 2016 to update West Virginia State Code in accordance with the Preventing Sex Trafficking and Strengthening Families Act.

For FFY 2016 the Department plans to hire transition specialists in each Region. These positions:

- Will be assigned as a secondary worker for every youth involved with child welfare in the Region ages 14 and older.
- Will assure that transitioning plans for all youth involved with Child Welfare are appropriate and updated as needed.
- Interacts with a variety of professional practitioners in the areas of social work, mental health, developmental disabilities, education, juvenile delinquency, and counseling and guidance to assess client's needs and provide appropriate services.
- Helps the primary worker develop a client transition plan designed to accomplish and to provide Child Welfare youth in attaining social, educational and vocational goals.
- Cooperates with the court system for child protective services, foster care, adoption, juvenile delinquency and Medley program services by helping primary worker to prepare or complete Life Skills assessments, Learning plans and transition plans.
- Provides technical assistance to primary workers and providers in effectively developing required plans and services; conducts periodic evaluations of facilities and services.
- Counsels clients/families in achieving goals of client transition plan.
- Counsel’s youth to help primary worker develop appropriate transition plans.
- Speaks before educational and community organizations and groups regarding services available and to develop community resources.

By creating these positions the Department will be able to ensure that all youth in foster care of transitioning age will have staff whose sole purpose is to see that youth transitioning have their needs met.

Training

Training on “Understanding Youth Transitioning” was provided to BCF staff in the fall of 2014 via webinar. There were 10 webinars scheduled to make the training available to staff statewide. In July 2015, cross training on “Youth Transitioning” was provided at the Court Improvement Program Conference held in Bridgeport and Charleston. Over 250 participants from a variety of disciplines attended, including judicial, private providers, education, social workers, probation officers, BCF staff and juvenile services.

The Bureau for Children and Families/ Division of Training is currently working on developing training on the topic of youth transitioning from foster care to independent living. This course is design to help BCF case managers, foster parents, relative guardians, and adoption parents develop the skills and knowledge they need to help youth transition from foster care to successfully live independently and self-sufficiently. This course will be included in the IV-E/IV-B training plan.

Purpose

The purpose of the Chafee Foster Care Independence Act was to provide states with flexible funding to develop and design services and activities to meet the needs of youth transitioning from foster care. The Act provides guidance for seven specific purposes listed below:

Help youth transition to self-sufficiency;

Help youth receive the education, training, and services necessary to obtain employment;

Help youth prepare for and enter post-secondary training and educational institutions;

Provide personal and emotional support to youth aging out of foster care through mentors and the promotion of interactions with dedicated adults;

Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition to adulthood;

Make available vouchers for education and training, including post-secondary education, to youth who have aged out of foster care; and

Provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption.

There have been several new initiatives developed to carry out the purposes of the Chafee Act as well as the carryover of initiatives previously developed. The following are available initiatives and activities conducted in FFY 2014 as they relate to the seven purposes of the Act.

Programs/policies to help youth transition to self-sufficiency

2016 Update

The purpose of the Chafee Foster Care Independence Act was to provide states with flexible funding to develop and design services and activities to meet the needs of youth transitioning from foster care. The Act provides guidance for eight specific purposes listed below:

Help youth transition to self-sufficiency;

Help youth receive the education, training, and services necessary to obtain employment;

Help youth prepare for and enter post-secondary training and educational institutions;

Provide personal and emotional support to youth aging out of foster care through mentors and the promotion of interactions with dedicated adults;

Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition to adulthood;

Make available vouchers for education and training, including post-secondary education, to youth who have aged out of foster care;

Provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption; and

Ensure that youth served have regular, ongoing opportunities to engage in age or developmentally appropriate activities

There have been several new initiatives developed to carry out the purposes of the Chafee Act as well as the carryover of initiatives previously developed. The following are available initiatives and activities conducted in FFY 2015 as they relate to the seven purposes of the Act.

Programs/policies to help youth transition to self-sufficiency

As part of the MODIFY Strategic Plan WVU CED are developing, they are creating a course about youth protective factors that will be available to case managers and others who have an interest in youth transitioning. This course will introduce the Youth Thrive Protective Factors Framework and the benefits of the MODIFY with CED Program

West Virginia has already begun working with PFLAG and intends to reach out to further institutions to expand upon available resources. Youth identifying as LGBT are at a higher

risk to experience homelessness, violence, and at a higher risk to attempt or commit suicide than their heterosexual counterparts. The CDC identifies safe and supportive learning environments and caring and accepting parents as essential to the health and well-being, both mentally and physically, of youth who identify as LGBT or Q. BCF is committed to ensuring our LGBT youth experience safety, permanency, and well-being at rates consistent with their heterosexual counterparts and believes this requires a multi-faceted approach.

2017 Update

MODIFY and HRDF will continue to provide services for the upcoming year. MODIFY has been working on a strategic plan that includes looking at retention rates and bringing the Youth Thrive framework to West Virginia.

Life Skills Assessment Process: At age 14 or older (if a youth enters care at an older age), each child in foster care completes their Casey life skills assessment. The assessment is completed within 30 days following the youth's 14th birthday or entrance into care if the youth is already age 14. The assessment helps determine the child's level of functioning in several areas including but not limited to personal hygiene, food management, housekeeping, employability, education planning, and so forth. The results of the assessment provide critical information regarding strengths and weaknesses in various life skills areas. To ensure that foster care youth are gaining necessary skills to prepare them for independence, the life skills curriculum provides foster care youth in all out of home placements in West Virginia the opportunity to learn these valuable skills. The learning objectives of the life skills curriculum are taught to the foster child by the foster parents, by staff in group residential settings/specialized foster care, or by the child's Department case worker. The life skills assessment is completed on youth in care annually.

The Department has continued to implement the new life skills assessment and curriculum process. West Virginia continues utilizing the Casey Life Skills Assessment and Curriculum. When the Casey Assessment process and website changed, provider agencies, and staff were provided with information on the new process and how to access the site and assessment. The utilization of the Casey Assessment and Curriculum process is being used statewide.

2016 Update

West Virginia continues utilizing the Casey Life Skills Assessment and Curriculum. When the Casey Assessment process and website changed, provider agencies, and staff were

provided with information on the new process and how to access the site and assessment. The utilization of the Casey Assessment and Curriculum process is being used statewide.

Transition Plan and Services: At the age of 14 or older (if a youth enters care at an older age), each child in foster care develops their individualized transition plan, which will help the youth move towards independence and self-sufficiency. The transition plan is to be developed within 60 days following the youth's 14th birthday or entrance into care if the youth is already age 14. The transition plan is reviewed every 90 days and revised as necessary. Some areas that are addressed in the transition plan are, housing options, insurance options, community supports, educational plans and supports, employment plans and supports, workforce supports, mentoring services, healthy relationships, family planning, supportive counseling, life skill curriculum, and benefits available (SSI, SS, ETV, Food Stamps…etc.). In March 2014, the Department released an updated transition plan and transition plan desk guide that was developed with the input of the older youth transitioning task team. The new format has been shared with partners at the Court Improvement Program and at various supervisor meetings across the state. Webinars were held in October and November of 2014 to further provide clarification and training on the required youth transition planning process.

2016 Update

In some situations, for youth who are over the age of 18, the youth may choose to live in an apartment, with community services. The youth's placement is supported by the Department's caseworker or a MODIFY Community Support Specialist. Life skills are provided to the youth through community services or through the caseworker.

Transitional Living Placement with Subsidy: When a youth reaches the age of 17 or older, he or she has an option to move into a community setting in his or her own apartment, if they meet the eligibility criteria. The purpose of this placement type is to allow the youth an opportunity to use the life skills acquired while in foster care and continue to receive support from the State. In this setting the youth is pursuing an educational/vocational goal, learning job skills, is employed or seeking employment.

If a placement is unavailable or the youth shows signs of advanced progress towards independence, youth can choose to rent an apartment in the community. If the youth are placed in a transitional living program under a specialized foster care agency, and they are living in their own apartment, the youth will have contact with staff from a transitional living agency at least five hours per week. They may choose to live in one of the staff supervised transitional living programs currently available. In these programs, youth live in an apartment within an apartment building or complex and a staff person is on the premises frequently or available 24/7.

In some situations, for youth who are over the age of 18, the youth may choose to live in an apartment, with community services. The youth's placement is supported by the Department's caseworker or MODIFIES Community Support Specialist. Life skills are provided to the youth through community services or through the caseworker.

2016 Update

In some situations, for youth who are over the age of 18, the youth may choose to live in an apartment, with community services. The youth's placement is supported by the Department's caseworker or a MODIFY Community Support Specialist. Life skills are provided to the youth through community services or through the caseworker.

2017 Update

Foster care policy has updated transitional living to require field staff to educate their transitional living youth case about being self-aware and personal safety to prevent becoming victims of human trafficking.

Transitioning Youth Grant Program: The Bureau of Behavioral Health and Health Facilities (BHHF) has continued to provide two grants to agencies to provide independent living services to foster care and former foster care youth with mental health and/or behavioral health issues. The Department has partnered with BHHF to assist with these programs and to assure their sustainability. These transitional living programs are designed to have three phases, with different level of staff supervision in each phase. Phase I consists of basic residential care, with complete supervision. Phase II, graduate's youth to living in an apartment building, with staff supervision available 24/7. Phase III, transitions youth to living in scattered apartments, with limited supervision. The MODIFY program assists with the provision of the services for Phase II and III.

Outcomes

Outcome 1: There were approximately 19 youth that participated in Transitional Living (TL) placements during FFY 2014. These youths may have been in a TL placement under a private agency or in a TL placement supervised by the Department.

2017 Update

During the FFY 2015, Burlington United Methodist has provided transitional living services to 1 youth, under their BHHF grant program

Outcome 2: During the FFY 2014, Burlington United Methodist has provided transitional living services to 13 youth, under their grant program. Number of youth who participated in the following Phases:

Phase I - 5 youth

Phase II - 4 youth

Phase III - 4 youth

2016 Update

During the FFY 2015, Burlington United Methodist has provided transitional living services to 38 youth, under their grant program. Number of youth who participated in the following Phases:

Phase I - 19 youth

Phase II - 13 youth

Phase III - 6 youth

Outcome 3: During the FFY 2014, Stepping Stones has provided transitional living services to 6 youth, under their grant program.

Achievements of FFY 2014

2016 Update

Outcome 3: During the FFY 2015, Stepping Stones has provided transitional living services to 24 youth, under their grant program.

2017 Update

During the FFY 2015, Stepping Stones has provided transitional living services to no youth, under their BHHF grant program.

BHHF will no longer be funding these programs.

West Virginia continues to work through issues related to the Casey Assessment process changing. The State has had an increased focus on completing the Casey Life Skills Assessment on all youth in care and in developing appropriate transition plans for youth in care.

The Department continues to maintain two transitional living programs for youth who need extra supports as they transition out of foster care. These transitional living programs can be duplicated and established in any part of the State.

The State continues to work in partnership with private agencies, which develop or continue to provide programs for youth transitioning from foster care. The State continues work with an Older Youth Transitioning Work Group, consisting of all TL Providers and Department management, to look at transitioning services for older youth. This group is in the process of developing a two-year strategic plan to address the needs of youth who

are transitioning out of foster care. The work group had developed a transition plan document for older youth. The transition plan document was piloted by a few provider agencies and DHHR staff. After considerable consultation with groups the Department works with, the document was finalized and rolled out in March 2014. The group is focusing on life skills curriculum choices and looking at strategies to prevent the exploitation of foster children, including human trafficking. This group also worked collaboratively together, with Stepping Stones taking the lead, to expand and improve the "It's My Move" website and checklist for youth. New modules look at pregnancy and parenting youth.

Help youth receive the education, training, and services necessary to obtain employment.

Employment Programs: The employability project was developed to help youth obtain employment. The employability services are available to youth currently in foster care and to the 18-20-year-old population who have aged out of foster care. The project began as a pilot but quickly went state wide. Youth Services System Inc., (YSS) in Wheeling provides this service in Hancock, Brooke, Ohio, Marshall, Wetzel, counties in region I. The services and activities provided are designed to not just place youth into employment, but also provide them with the skills, guidance, and ongoing support necessary to sustain employment and succeed in the workplace. Services are provided at the youth's place of residence, YSS site, within the community, or at Sponsored Employment sites. The second grantee, Human Resource Development Foundation Inc. (HRDF), covers regions II, III, and IV, and all counties in Region I not covered by YSS.

Youth participating in this project are expected to:

● Develop Job Seeking Skills

● Develop an employment history

● Receive Cash for attendance

● Receive assistance with job placement, on the job training, and job shadowing

● Gain/Maintain employment

Outcomes of Employment Programs

Outcome 1: During the FFY 2014, HRDF provided 238 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills. Youth gained employment; youth completed job mentoring, and completed an orientation/assessment.

2016 Update

During the FFY 2015, HRDF provided 154 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills. Youth gained employment; youth completed job mentoring, and completed an orientation/assessment.

2017 Updates

During the FFY 2016, HRDF provided 211 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills. 23 youth gained employment; 161 youth completed job mentoring, and 99 youth completed an orientation/assessment. 102 youth maintained employment for 90 days and 91 youth maintained employment for 180 days. 9 youth had jobs with benefits.

Outcome 2: During the FFY 2014, YSS provided 74 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills.

2016 Update

During the FFY 2015, YSS provided 39 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills.

2017 Update

During the FFY 2016, YSS provided 155 foster care/former foster care youth with employment services, to obtain employment, retain employment and gain employment skills.

Through continued collaboration with the HRDF and YSS, the State has been able to assist more youth into obtaining employment and into receiving employment services within their own communities. The State plans to continue to work with these employment programs as well as other community employment programs, such as WorkForce West Virginia.

Human Resource Development Foundation, Inc. (HRDF) provides Youth Job Development and Placement services in selected counties of WV Department of Health and Human Resources (WVDHHR) Bureau for Children and Families (BCF) Operating Regions I, II, III, and IV. The services provided assist youth aging out of foster care to gain independence by promoting job preparation and work.

The purpose of the program is to offer youth aging out of foster care an opportunity to develop job-seeking skills, acquire employment, develop an employment history, learn regular work habits, develop basic skills needed to succeed in the workplace, and retain employment.

The services and activities provided through the Employment for Independent Living Program are designed to not just place customers into employment, but also provide them with the skills, guidance, and ongoing support necessary to sustain employment and succeed in the workplace.

In addition to the services provided through the program components, the Employment for Independent Living Program (EFILP) provides customers bonuses for superior attendance during Job Search, bonuses for retaining employment, stipends to assist the customer with the cost associated with attending training, and travel payments to assist the customer with the expense of getting to work for the first 30 days of employment.

The curriculum to be used for Job Search Instruction is suitable for individuals with low reading levels; however, individuals who cannot read at all would not be able to handle the program. Materials are geared to an adult interest level and are suitable for average and above-average readers, so the program serves customers functioning at nearly every academic level.

Employment for Independent Living Program Performance Objectives look at entire section

To provide opportunities for all older foster care youth to increase and improve job seeking and job keeping skills. The Employment for Independent Living Program serves youth 16-21 who are currently in foster care or who have aged out of foster care.

To provide opportunities for older foster care youth to gain work experience.

EFILP services are available to other eligible youth in the priority counties, as well as, the remaining counties depending on the number of referrals received from the priority counties and the availability of staff time.

There are key elements, which are embodied throughout the program. These elements include: Personal Empowerment (through the discovery of skills, motivation, and goals); Hands-On Skill Development (through practical application of skills being taught and in field activity); and, Ongoing Support (initiated during Job Search Instruction and sustained throughout program participation and for 12 months after the attainment of customers' employment is obtained).

Job Search Instruction is designed to be dynamic with lively exchanges between the Service Placement Specialist/Job Developer and customer along with small group activities (when possible) and multi-media/instructional techniques. Job Shadowing experiences, if utilized, will be relevant to the customer's interest and/or occupational goals and skillfully selected and shaped to fit the customer through cooperation with the employer/site supervisor and the Service Placement Specialist/Job Developer.

Recordkeeping materials will be clear and easy to complete while allowing for efficient tracking of activity.

While Employment for Independent Living Program staff will be actively involved in case management issues, HRDF recognizes the role of DHHR as the primary Case Manager. HRDF will notify childcare agencies, foster care agencies, and Social Service Supervisors of the date, time, and locations of all program intakes/Job Search Workshops. If sufficient numbers of referrals are unavailable, program services will be provided on an individual basis and coordinated with the aforementioned agencies.

2016 Update

HRDF staff work closely with collaborating partners. HRDF operates Workforce Innovation and Opportunity Act (WIOA) Programs, funded by three Regional Workforce Development Boards (WDB), and collaborates with all of the other WDB's in the state. Under WIOA, priority of service includes foster youth and as a result, HRDF makes sure that youth take advantage of services being provided by HRDF and others youth providers funded by WIOA.

2017 Update

HRDF staff work closely with collaborating partners. HRDF operates Workforce Innovation and Opportunity Act (WIOA) Programs funded by three Regional Workforce Development Boards (WDB) and collaborates with all the other WDB's in the state. Under WIOA, priority of service includes foster youth and as a result, HRDF makes sure that youth take advantage of services being provided by HRDF and other youth providers funded by WIOA.

Help youth prepare for and enter post-secondary training and educational institutions.

Helping our Undergraduates Succeed in Education (HOUSE) Project: Some TL youth who are first-time freshman at West Virginia State University live in the H.O.U.S.E. project. This initiative provides a small staff supervised house on the WVSU campus for students who may need a gradual introduction to college life. H.O.U.S.E. stands for Helping Our Undergraduates Succeed in Education.

Foster Care Tuition Waiver: House Bill 4787 was passed in 2000 and provides for youth in foster care and former foster care youth to receive tuition waivers for attending one of the public colleges/universities in West Virginia.

Computers for Graduates Program: Since the early 2000s, the Department has recognized that education plays a vital role in youth growth and development and the transition to adulthood. The Computer for Graduates Program was established to encourage and reward youth to stay in school and get a high school diploma or GED and

to assist them in post-secondary education or employment. A memorandum to staff is released each spring which outlines the process and dollar amounts for purchasing these electronic devices. Each year, the Department determines a dollar amount that will be available for the purchase of a computer to youth who graduate from high school or complete the High School Equivalency exam while in foster care. Vouchers are issues to the youth by the Department worker to purchase the equipment. We also look at supplying printers and other electronic devices and accessories because we realize only a computer is not sufficient.

2016 Update

Vouchers to Wal-Mart are issues to the youth by the Department worker to purchase the equipment. The MODIFY Program facilitated a new partnership with the national IFoster Computers for Foster Children program to get more reliable computers at a reduced cost as Wal-Mart computers wear out or fail more often. Youth have the option of a voucher or an IFoster computer shipped to them.

2017 Update

Access to technology is a necessity and no longer a luxury in today's post-secondary education environment. Each year the Department determines a dollar amount that will be available for the purchase of a computer to youth who graduate from high school or complete the High School Equivalency exam while in foster care. Vouchers are issues to the youth by the Department worker to purchase the equipment.

Outcomes of Post-Secondary Preparation

Outcome 1: West Virginia had approximately 185 foster care and former foster care youth attending post-secondary educational or some type of educational training during the FFY 2014.

2017 Update

West Virginia had approximately 271 foster care and former foster care youth attending post-secondary educational or some type of educational training during the FFY 2016.

The Department, in collaboration with the MODIFY Program and higher educational institutions, has steadily increased the enrollment of youth exiting foster care, into post-secondary educational programs over the past several years. The WV tuition waiver provides youth with additional financial aid, so their educational costs are reduced.

2017 Update

Due to budget cuts at both the federal and state level for higher education programs and the subsequent increases in tuition and fees, the Department and the MODIFY Program

will be considering changes to the program, including limitations on costs for the upcoming fiscal year.

The Department plans to continue to work with the higher educational institutions to increase the number of youth attending post-secondary educational programs. The tuition waiver opportunity will continue to assist youth with educational expenses. The Department and other partners continue to work with the community and technical colleges of WV to improve the services that youth are receiving through the education system.

The Department will continue to work with the H.O.U.S.E project at West Virginia State University and increase the number of youth, exiting foster care, that are served by this program.

The computers for graduate's program has been a successful program for youth in foster care who obtain their high school diploma or GED while in foster care, for several years. The computer program is an excellent incentive for youth to complete their high school education. These computers are often utilized by the youth as they pursue their higher educational goals. The computer for graduate's program will continue.

Provide personal and emotional support to youth aging out of foster care, through mentors and the promotion of interactions with dedicated adults.

2016 Update

West Virginia had approximately 199 foster care and former foster care youth attending post-secondary educational or some type of educational training during the FFY 2015.

The computers for graduate's program has been a successful program for youth in foster care who obtain their high school diploma or High School Equivalency while in foster care, for several years.

Mentoring: The Department has developed close working relationships with transitional living providers to address the issues that youth transitioning out of foster care face. The Department has also encouraged the use of the Foster Club Permanency Pact in several regions in the state. Youth involved in the West Virginia Foster Advocacy Movement (WVFAM) initiative supported by the MODIFY with CED Program participate in group mentoring and individual mentoring activities at local meetings and activities. The Stepping Stones Program and the MODIFY with CED Program provide local training activities for current and former foster youth that included a local "Game Called Life" event in Huntington WV. Other transitional living providers, MODIFY staff, and Chafee funded grantees encourage the interaction with caring adults through informal mentoring and group meetings.

The MODIFY with CED Program has developed training called “This Yard Called Life,” that will seek to involve the community and professionals that are not traditionally involved with foster youth to participate in local life skills trainings, host events at local workplaces, and invite WVFAM members to share the issues important to them in the community. The MODIFY with CED Program hopes that this non-traditional approach to life skills training will result in the development of informal mentoring and personal relationships to benefit the youth.

Through the hiring and development of the WV NYTD Survey team, the MODIFY with CED Program has begun and will continue to undertake a project called “We Still Care.” Adopted during research to engage and improve support of former foster youth who age out, the MODIFY with CED Program adopted the idea from the state of Maine. Utilizing a public-private partnership with the Taylor County Collaborative FRN, donations are accepted for care packages to youth identified in the 17-21-year-old population. Donors are encouraged to create care packages specific to kids in their community or to make donations of products and items to be put together for youth anywhere in the state. Donors are encouraged to put together cards and letters that will demonstrate caring and compassion for these youth that may have little to no support.

West Virginia Foster Advocacy Movement and the Taylor County Collaborative Family Resource Network Breaking the Cycle Youth Group have teamed up to provide mentoring and peer sharing between the two youth groups. Breaking the Cycle is a group of middle through college age students who work on the issues of teen stigma and stereotyping of destructive decisions. The Breaking the Cycle youth work on prevention related issues such as drug, alcohol, and tobacco in their own community. Initial Christmas meetings was held in December of 2014 where the groups had the opportunity to share the issues each was working on and brainstorm how they can work together. Activities are on-going. Youth are supporting one another in the issues each group has identified and sharing strategies and resources such as influential connections.

2016 Update

West Virginia Foster Advocacy Movement and the Taylor County Collaborative Family Resource Network Breaking the Cycle Youth Group have teamed up to provide mentoring and peer sharing between the two youth groups. The groups come together at least once a year, usually during Christmas, to share resources and leadership skills. Youth are supporting one another in the issues each group has identified and sharing strategies and resources such as influential connections.

Youth Councils: Through the re-invigorated West Virginia Foster Advocacy Movement, youth are provided opportunities to participate in meetings with peers, interaction with other youth from other areas, and interaction with the community through participation in

speaking engagements and panels. Youth will continue to be provided leadership and mentoring opportunities in the coming year.

2016 Update

Through the West Virginia Foster Advocacy Movement (WVFAM), youth are provided opportunities to participate in meetings with peers, interaction with other youth from other areas, and interaction with the community through participation in speaking engagements and panels. Youth will continue to be provided leadership and mentoring opportunities in the coming year.

Post-Secondary Education Student Support Services: Youth in post-secondary educational program are linked to supportive services within the educational system they are attending. These supportive services often assist the youth in maintaining their grades, advocating for their own rights, staying connected to other youth, receiving other supports as needed. Some of the services that are utilized are student tutoring services, college career centers, college help centers, and student groups.

Community Support Services: Using the recently formatted youth transition plans, youth can receive additional community supports. Additionally, youth enrolled in the MODIFY program are often referred to community services for extra support. Some of the community resources that are utilized are: Workforce or HRDF, WV Housing, Community Mental Health Centers, Legal Aid of WV, SSI Offices, DRS Offices, HUD, Community Pregnancy Support groups or prevention groups, DHHR economic Services and Community medical assistance programs.

Transition from High School to Post-Secondary Education Support Programs: Youth in high school or obtaining their GED are referred to supportive programs to assist them in making the transition from high school to a post-secondary educational program, when needed. Some of the programs utilized are the Heart of Appalachia (HAT) Program, and the Federal TRIO Programs.

2016 Update

Youth in high school or obtaining their High School Equivalency are referred to supportive programs to assist them in making the transition from high school to a post-secondary educational program, when needed. Some of the programs utilized are the Heart of Appalachia (HAT) Program, and the Federal TRIO Programs.

Outcomes of Supporting Youth Aging Out of Foster Care

Outcome 1: Approximately 70 youth are engaged throughout the state in the West Virginia Foster Advocacy Movement. Youth participate in local meetings and a statewide meeting in June of 2014. Youth identified the top four issues they want to focus on.

Sibling separation, the overuse of prescription medication, adequate information for and about foster parents, and proper involvement in their own cases was identified.

2016 Update

Approximately 50 youth are engaged throughout the state in the West Virginia Foster Advocacy Movement. Youth participate in local meetings and a statewide meeting in June of 2014. Youth identified the top four issues they want to focus on. Sibling separation, the overuse of prescription medication, adequate information for and about foster parents, and proper involvement in their own cases was identified. The youth maintained the same issues at a June 2015 statewide meeting.

2017 Update

Approximately 15 youth are engaged throughout the state in the West Virginia Foster Advocacy Movement. Youth participate in local meetings and a statewide Retreat in June of 2016. Youth gave input on the NYTD Project and IL Skills notebooks for MODIFY clients.

Outcome 2: Approximately $150 in cash donations and $300 in in-kind donations for We Still Care Packages has been collected through March of 2015.

2016 Update

Approximately $900 in cash donations and $3000 in in-kind donations for the We Still Care Packages has been collected through April of 2016. 80 Christmas backpacks were distributed to MODIFY and WVNYTD youth in December of 2015.

2017 Update

Approximately $200 in cash donations and $350 in in-kind donations for the We Still Care Packages has been collected through March of 2016.

Outcome 3: During the FFY 2014 youth were referred to educational supportive services within their educational program on a consistent basis. Approximately 90 youth were referred to educational supportive services, such as tutoring, network groups, student support groups, and college career centers.

2016 Update

During the FFY 2015 youth were referred to educational supportive services within their educational program on a consistent basis. Approximately 93 youth were referred to educational supportive services, such as tutoring, network groups, student support groups and college career centers.

2017 Update

During the FFY 2016 youth were referred to educational supportive services within their educational program on a consistent basis. Approximately 75 youth were referred to educational supportive services, such as tutoring, network groups, student support groups, and college career centers.

Outcome 4: Youth are referred to HAT, and the TRIO program on a continuous basis as needed during the intake process for the MODIFY with CED Program. Three youth were referred to these programs.

2016 Update

Youth are referred to HAT, and the TRIO program on a continuous basis as needed during the intake process for the MODIFY with CED Program. Two youth were referred to these programs.

2017 Update

Two youth were referred to these programs.

West Virginia Foster Advocacy Movement, with the support of the MODIFY with CED Program, has gained a strong presence this past year. In addition to the identification of the issues, youth are excited about local meetings, the partnership with the Taylor County Collaborative Family Resource Network Breaking the Cycle Youth Group and the We Still Care packages.

Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age.

Transitional Living Program Grantee: Youth Services System provides support to young adults ages 17 – 21 through their Transitional Living Program and services. A 2010 study of former foster care youth found that at the age of 23-24 years old, compared to their peers of the same age:

The foster care alumni had only half the annual income of their peers (52% were unemployed, average income $8000/year);

They were much more likely to be parents (2/3 of the women reported being pregnant since leaving foster care at age 18);

They used public benefits, like food stamps, at a much higher rate than their peers;

Nearly 25% had not completed high school or received a GED;

Source: http://www.chapinhall.org/sites/default/files/Midwest_Study_ES_Age_23_24.pdf

At Youth Services System, each youth is provided safe, stable living accommodations during their time in the program. Supportive services are made available to youth. Youth Services System assures access to health, mental health, social services, law enforcement, education, welfare and legal aid. Additional referrals for specialized help are made when needed.

Each youth is assessed using the Casey Life Skills, a nationally recognized instrument that indicates the individual's readiness for independent living. For insight into trauma, they use the Adverse Childhood Experience Screening (ACEs) tool. Staff works in partnership with each youth to create a unique plan of practical life skills training to build on youth strengths, to complete their basic education and to continue their education through vocational or higher education. Youth learn job readiness skills and seek employment. Participants work toward living in community apartments to demonstrate their independent living skills in the real world with regular ongoing staff support and supervision with increasing levels of independence from this support.

Youth are involved in developing and revising their Individual Service Plan, in group and house meetings, in developing program materials, in program evaluation, and in supporting new youth entering TL. Staff address trauma, and work with each youth in a way that is respectful of their individuality, their own culture and their identity. Where possible mentors help youth improve interpersonal skills and relationships. Youth engage in community service and participate in activities and events that give them permanent connections to helpful adults.

The goal is for each young person to be safe, healthy, to achieve a sense of well-being, confidence, and develop the skills they will need as adults, to have connections to caring adults and relationships that will lead to independence and self-sufficiency.

Mentoring and Oversight for Developing Independence for Foster Youth (MODIFY) with CED Program: MODIFY provides transitional services to youth 18 through 21 years of age to enhance their own efforts toward self-sufficiency. To be eligible for MODIFY, youth must have aged out of foster care or group care on or after their 18th birthday. If a youth was in State's care at the time they were incarcerated and subsequently aged out while incarcerated, the youth is eligible for services once released from incarceration and until their 21st Birthday. These services include, but are not limited to, short term financial assistance, employment assistance/support, educational assistance/support, transportation, housing assistance/support, supportive counseling, independent living skills training, assistance with application for benefits, and linkages to necessary community supports and resources.

MODIFY Community Support Specialists offers assistance to Chafee eligible youth six months prior to discharge, or earlier when necessary, from custody. MODIFY Specialists also provide technical assistance daily to staff within the DHHR on youth transitioning

issues, as well as the provider community and the public. They attend Multidisciplinary Treatment Team (MDT) meeting for youth needing transitioning services. MODIFY has also begun notifying youth who are age 17 ½ and in foster care, of MODIFY services, the eligibility criteria and how to contact the program. Additionally, MODIFY sends letters to all the residential agencies and local Departments reminding them to refer high school seniors in January.

West Virginia NYTD Team: The Department provided resources to WVU Research Corporation beginning December 2014 to hire four specialists to administer the NYTD Survey and to follow youth from ages 17 – 21. The WV NYTD Survey Team is a part of the MODIFY with CED Program. The specialists contact the youth before the 17-year-old survey is due and maintain quarterly contact with youth until they are 21, administering the 19 and 21-year-old surveys during the relationship. The Specialists will provide information and resources on Chafee funded programs as well as resources in the local community that the youth can access. The program is gathering information on health topics, programs, and other resources that will be of use to the youth throughout the life of the supportive relationship. The WVNYTD Team also encourages the youth to access supportive resources such as WVFAM. While the project is relatively new, there has been a positive response to resource information and the assistance being given by the WV NYTD team.

2016 Update

The Department provided resources to WVU Research Corporation beginning December 2014 to hire four specialists to administer the NYTD Survey and to follow youth from ages 17 – 21. The West Virginia NYTD Team has been instrumental in developing strong supportive relationships with youth in and out of foster care. Several youth report the NYTD Specialist as a person of influence in their life and have reached out during times of crisis or need. The NYTD Team uses incentives to get youth to complete the survey and care packages as a support mechanism.

2017 Update

During May 2016, the Department underwent the NYTD Assessment Review. The Department developed an improvement plan and is currently working on the goals and objectives contained within it. These activities will continue in the upcoming year.

Collaboration with Other Programs/Agencies: The Department continues to work with many collaborative groups and other agencies that provide services to youth transitioning. Agencies/committees who are involved in these meetings are Division of Juvenile Services, Bureau Behavioral Health and Health Facilities, Community and Technical Colleges, Mission WV, Administrative Services Organization, Court Improvement Board, multiple Community Collaborative groups.

Outcomes of Transitioning Supports:

Outcome 1: During FFY 2014, Human Resource Development Foundation (HRDF) and the MODIFY Program improved its relationship and agreed to promote on another's programs. As a result, HRDF developed a fact sheet like the MODIFY Program fact sheet to aid Department workers and others in understanding services available to Chafee eligible youth.

2016 Update

During FFY 2015, MODIFY and HRDF met to cement the working relationship and problem solve on ways to assist mutual clients.

2017 Update

During FFY 2016, 327 referrals were received for the MODIFY program.

Outcome 2: During FFY 2014, the Older Youth Transitioning Workgroup developed goals and plans to establish a choice of life skills curriculums for providers and foster parents.

2016 Update

During FFY 2015, the Older Youth Transitioning Workgroup developed goals and plans to establish a choice of life skills curriculums for providers and foster parents.

2017 Update

During FFY 2016, MODIFY with CED provided services to an average of 276 foster care youth and former foster care youth.

Not all the services provided by the MODIFY Program involve financial services. Many of these youths were provided information and referral services, linkage with community resources, and advocacy on their behalf in obtaining SSI, medical cards and other benefits.

Outcome 3: During FFY 2014, the Stepping Stones program and the residential facilities of River Park and Golden Girls worked together to improve services to transitioning youth and to make a smoother transition.

2016 Update

During FFY 2015, 337 referrals were received for the MODIFY program.

2017 Update

During FFY 2016, MODIFY Community Support Specialists attended approximately 47 MDT's for youth in foster care. Staff provided information of the youth and other members

of the MDT on transitioning services that are available for youth as well as information on programs that can assist the youth when they transition from foster care.

Outcome 4: During FFY 2014, 249 referrals were received for the MODIFY program.

2016 Update

During FFY 2015, MODIFY with CED provided services to an average of 200 foster care youth and former foster care youth.

Not all the services provided by the MODIFY Program involve financial services. Many of these youths were provided information and referral services, linkage with community resources, and advocacy on their behalf in obtaining SSI, medical cards and other benefits.

Outcome 5: During FFY 2014, MODIFY with CED provided services to an average of 183 foster care youth and former foster care youth.

Outcome 6: During FFY 2014, MODIFY Community Support Specialists attended approximately 40 MDT's for youth in foster care. Staff provided information of the youth and other members of the MDT on transitioning services that are available for youth as well as information on programs that can assist the youth when they transition from foster care.

2016 Update

During FFY 2015, MODIFY Community Support Specialists attended approximately 35 MDT's for youth in foster care.

Chafee funded grantees of the Department have either established or re-established close working relationships with one another and multiple partners in the community. Each grantee works hard to promote their program as well as the programs of others to provide youth with the best transition services possible. Each provides technical assistance to the Department and the community about issues facing transitioning youth and ways we can all improve the system.

Provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption.

The State provides Chafee Services to youth who have been adopted or who had been placed in legal guardianship. Some of the services that youth are provided include Educational and training Voucher funds, case management oversight, community referral services, mentoring services and other transitioning services as needed as indicated above.

*See ETV Section for eligibility criteria and outcomes for ETV services.

Chaffee Outreach Activities/Specific Training FFY 2014

Several of the Chafee services and activities have been previously reported by individual type of service or activity. By arranging some of those services and activities under the category of outreach, focuses the attention to the various ways potential Chafee clients are identified and encouraged to seek services.

The Department released the revised Youth Transition Plan in March 2014 and provided a series of webinars for Department staff during October and November.

The MODIFY with CED Community Support Specialists provided training and technical assistance and special topic workshops on the MODIFY Program and other youth transitioning topics. MODIFY developed the Youth Transition checklist as a technical assistance product for the Department.

The MODIFY Program continued to assist the Department with the dissemination of program posters, fact sheets, and brochures. Program brochures are provided to community groups such as homeless shelters and child welfare agencies. In addition, MODIFY program staff developed good working relationships with college admissions staff. Informational brochures, posters, fact sheets and referral forms were provided to these staff as needed.

The MODIFY with CED Program has a webpage located on the WVU-CED Website, where individuals can find information about services for the program. Staff contact information is located on the website and a referral for MODIFY services may also be made through the website. It is located at http://modify.cedwvu.org/.

2016 Update

Ensure that youth have regular, ongoing opportunities to engage in age or developmentally-appropriate activities

Chaffee Outreach Activities/Specific Training FFY 2015

The MODIFY with CED Program provided training to the Department of Juvenile Services in FFY 15 to clarify the limited eligibility and provide information on Chafee services to incarcerated youth.

Outcomes of Outreach and Training

Outcome 1: During FFY 2014 MODIFY with CED staff conducted approximately 15 informational trainings to professional and paraprofessional staff.

Presentations about Chafee funded services were made to many professional and community agencies, throughout the State, including but not limited to, State/County WV Department of Health and Human Resources, Department of Juvenile Justice Services, Family Resource Networks, Child Care Agencies, Independent Living Agencies, Court Appointed Special Advocates (CASA), Colleges/Universities, WV Tribal Group, Faith based organizations, Human Resource Development Foundation, Job Corp., Psychiatric Hospitals, and Emergency Youth/Adult Homeless Shelters.

2016 Update

During FFY 2015 MODIFY with CED staff conducted approximately 15 informational trainings to professional and paraprofessional staff.

2017 Update

During FFY 2016 MODIFY with CED staff conducted approximately 13 informational trainings to professional and paraprofessional staff.

Outcome 2: During this reporting period, the MODIFY with CED webpage has been available for individuals to quickly locate the services that are available through the MODIFY program. The website was updated with fact sheets to assist individuals with clear eligibility criteria. Referrals for the MODIFY program can also be made through the website. The program also maintains a universal e-mail address for inquiries, modifyced@hsc.wvu.edu.

2016 Update

The MODIFY with CED webpage has been available for individuals to quickly locate the services that are available through the MODIFY program. The website was updated with fact sheets to assist individuals with clear eligibility criteria. Referrals for the MODIFY program can also be made through the website. The program also maintains a universal e-mail address for inquiries, modifyced@hsc.wvu.edu.

Outcome 3: During the reporting period, the It's My Move website was updated.

Outcome 4: During the reporting period, individuals were trained on the BHHF model of transitioning, the TIPS model.

2016 Update

During the reporting period, individuals were trained on the BHHF model of transitioning, the TIPS model.

The Department plans to develop a list of activities that are age appropriate for older youth and revise policy in a manner that demands workers use prudent parenting

standards as well as allow children under their supervision to have normal child and youth experiences.

Service Collaboration Activities Achieved in FFY 2014

The Department, MODIFY Community Support Specialists, Transitional Living Providers, and other Chafee funded programs collaborated with many agencies to provide foster care and former foster care youth services necessary for effective transitioning to adulthood. Some of these collaborative efforts included the following:

The Employment for Independent Living Program and WorkForce West Virginia collaborate on summer employment programs for youth in foster care.

The West Virginia Department of Education, in conjunction with the Education of Children in Out-of-Home Care Advisory Committee, hired Transition Specialists to support children placed out-of-state as they prepare and transition back to their school setting in West Virginia.

The MODIFY with CED Program and WV Bureau for Health and Health Facilities continue to work together to develop and support two Independent Living Programs to provide services to foster care and former foster care youth with mental and behavioral health issues.

MODIFY and Human Resource Development Foundation (HRDF) and Youth Service System (YSS) continue to work together to ensure foster care and former foster care youth received employment skills training. MODIFY Community Support Specialists, YSS and HRDF work together to improve efforts to get former foster care youth employed and to ensure job maintenance skills were developed and utilized.

The MODIFY Program and WV universities/colleges established a collaborative partnership on various levels to provide educational and financial support/assistance to eligible youth. MODIFY program staff continue to build relationships with various university/college financial aid offices, bursar offices, student affair offices, Trio Program Offices, and Tutoring Centers to assist eligible youth make a successful transition into a Post-Secondary Educational program.

The MODIFY Program continued collaborative efforts with WV State University's H.O.U.S.E. Project to provide a supportive living environment on WV State's campus to assist eligible youth transition into college life successfully.

The MODIFY Program utilized the resources available through the WV University Centers for Excellence in Disabilities (WVU CED) to provide services to eligible youth with a variety of disabilities to assist in their transition from youth disability services to adult disability services. Because MODIFY is housed within the CED, education of these young

people on their rights, self-advocacy skills, and the provision of service linkages and applications for benefits to this population were available.

Transitional Living Providers and the MODIFY Program continued to work with various housing projects to provide temporary and long term housing to former foster care youth. Some of these agencies include: WV Housing Authority, HUD, WV Centers for Independent Living, WV Adult Homeless Shelters, Adult Independent Living Programs, Community Action Councils, United Way, and other faith based organizations that assist in prevention of homelessness.

MODIFY Program staff and other Chafee funded service providers attend local Family Resource Network and community collaborative meetings to provide input youth with the most recent resources available to them.

The Department and the MODIFY Program collaborated with DJS which provides after care services to individuals discharged from Juvenile Justice Facilities. The MODIFY Program continues to provide services/supports to eligible youth exiting DJS care to assist in an effective transition from incarceration to independence.

The Department, MODIFY, transitional living providers, and others continues to work with the Commission to Study out of Home Placements to improve services to youth transitioning from care. A noteworthy accomplishment of this team was the development of a comprehensive youth transition and learning plan that was implemented in March 2014.

The Taylor County Collaborative Family Resource Network and the MODIFY with CED Program developed a public private partnership to support the WVFAM initiative and the We Still Care Project.

The MODIFY with CED Program and two Guardian Ad Litems teamed up to provide training to lawyers, foster parents, and providers.

2016 Update

The West Virginia Department of Education, in conjunction with the Education of Children in Out-of-Home Care Advisory Committee, hired Transition Specialists to support children placed out-of-state as they prepare and transition back to their school setting in West Virginia. MODIFY with CED works closely with these Transition Specialists on shared cases.

The Department, MODIFY, transitional living providers, and others continues to work with the Commission to Study out of Home Placements to improve services to youth transitioning from care.

The Taylor County Collaborative Family Resource Network and the MODIFY with CED Program continue a public private partnership to support the WVFAM initiative and the We Still Care Project.

The MODIFY with CED Program worked with Mission West Virginia to get information about the program and benefits to foster parents and the community through newsletters and attendance at the Recruitment and Retention Collaborative.

Youth Engagement FFY 2014

In March and April of 2014, with the support of the MODIFY with CED Program, kick-off cafes were held across the state to re-establish and re-invigorate the West Virginia Foster Advocacy movement. Youth were provided information on the idea and asked to participate in local and state meetings. A statewide meeting was held in June of 2014 where youth representing original local youth and all geographic areas of the state came together to plan and discuss issues that they want to work on as a state and locally.

Youth identified four issues - Sibling Separation, the over prescription of psychotropic medications and lack of alternative therapies, the need for information for and about foster families, and involvement in their own cases.

Youth continued to meet locally throughout the year. In November, youth gave input on a Foster Youth Bill of Rights. Youth also participated in panels at several court improvement program conferences and other events. Youth reviewed and gave feedback thru social media, phone conversations, and at local meetings on policies, NYTD activities, and the CFSP. MODIFY with CED has also provided support to Youth to develop videos and offers to attend committee meetings such as the Older Youth Transitioning Workgroup.

Jessica Gibson, a former foster youth, was elected in 2014 to serve on the Commission to Study the Residential Placement of Children. Samantha Sixma, a former foster youth, serves on the WV Court Improvement Program's training committee. Other youth have attended various meetings as their schedules allow, including the Older Youth Transitioning Workgroup.

WVFAM youth provided input and agreement on the We Still Care Packages. Youth provided the items that they would like to have placed in the packages and suggested that donors include individual notes to let youth know they are cared about. We Still Care packages are sent to youth being tracked in the NYTD co-horts as an engagement tool.

Other states have offered incentives for youth who complete their NYTD survey. These incentives have greatly improved their percentage of completion rates. By January 1,

2016, West Virginia will explore those incentives and develop a plan to implement a similar process in West Virginia.

The State continues to work in partnership with private agencies, which develop or continue to provide programs for youth transitioning from foster care. The State continues work with an Older Youth Transitioning Workgroup, consisting of all TL Providers and Department management, to look at transitioning services for older youth. This group is in the process of developing a two-year strategic plan to address the needs of youth who are transitioning out of foster care. The work group had developed a transition plan document for older youth. The transition plan document was piloted by a few provider agencies and DHHR staff. After considerable consultation with groups the Department works with, the document was finalized and rolled out in March 2014. The group is focusing on life skills curriculum choices and looking at strategies to prevent the exploitation of foster children, including human trafficking. This group also worked collaboratively together, with Stepping Stones (under the direction of Susan Frye) taking the lead, to expand and improve the “It’s My Move” website and checklist for youth. New modules look at pregnancy and parenting youth. Although this group has been very active in the past improving services to older adolescents in foster care and transitioning out of foster care, recent activity has been minimal due to their assistance in implementing Safe at Home West Virginia.

In December 2014, WVFAM established a peer relationship with the Taylor County Collaborative Family Resource Network Breaking the Cycle Group which will result in opportunities to have input with legislative bodies and contacts that group has already established.

2016 Update

In June 2015, the youth had a statewide retreat of members who participated in at least two WVFAM meetings the year before or had spoken on a panel. The youth kept the issues the same as they continue to be at the forefront of West Virginia’s foster youth concerns.

Youth continued to meet locally throughout the year. Work and collaboration in the spring of 2015 was halted on the Bill of Rights after the Department implemented Goals for Children in Foster Care in their internal policy

Jessica Gibson, a former foster youth, was elected in 2014 to serve on the Commission to Study the Residential Placement of Children. Other youth have attended various meetings as their schedules allow, including the Older Youth Transitioning Workgroup.

WVFAM continues the peer relationship with the Taylor County Collaborative Family Resource Network Breaking the Cycle Group which will result in opportunities to have input with legislative bodies and contacts that group has already established.

2017 Update

Youth continue to meet locally throughout the year. Youth have been given the opportunity to design Independent Living Skills notebooks for MODIFY youth to help aid in the transition to independence. Youth also participated in the NYTD Assessment Review and other events. Youth review and give feedback thru social media, phone conversations, and at local meetings on policies, NYTD activities, and the CFSP. MODIFY with CED has also provided support to youth to participate in grant committees through the WV Housing Assistance Fund. These activities will continue in the upcoming year.

State Trust Fund Program:

West Virginia has not established a trust fund program for Chafee eligible youth.

Indian Tribe Consultation:

For information on Indian Tribe Consultation, please refer to Section B, number four of the Annual Progress and Services Report.

National Youth Transition Database

See the NYTD section under Chafee. West Virginia will be sharing NYTD data with the Court Improvement Program, Citizen's Review Panel, WV FAM and Commission to Study Residential Placement of Children on a quarterly basis

2016 Update

West Virginia participated in the Administration on Children and Families' NYTD Assessment Review (NAR) during FFY 16. The Onsite review was held May 17-19, 2016.

2017 Update

In May 2016, the NYTD Assessment Review was held. Assessment findings were provided to WV in September 2017. Even prior to receiving the official findings, West Virginia's Bureau for Children and Families and the DHHR – OMIS – FACTS formed a task team to draft a plan to address the preliminary findings. The WV NYTD QIP Quality Improvement Plan (NQIP) was submitted February 28, 2017 and on April 3, 2017, the NQIP was approved by the Children's Bureau. Various changes must be made to accommodate the Assessment findings. While some changes will be implemented in current FACTS, other changes are planned to be implemented in the proposed CCWIS.

Some of the changes planned for implementation in FACTS; include, but are not limited to: revisions to collection of data surrounding client demographics, placement, education, and survey information. Implementation, of the various changes, is planned by the end of 2018.

Homelessness Prevention

Two programs have been awarded grants from the United States Department of Health and Human Services to provide shelters for Runaway and Homeless Youth. The programs provide crisis shelter for runaway and homeless youth ages 11-18 in Parkersburg and Wheeling. Any youth in the community may call or come to Children's Home Society or YSS-Wheeling anytime day or night. Two counselors are always on shift to provide crisis counseling, food, clothing, shelter, security, and individual, group and family counseling.

Youth and parents are welcome to call or stop by the programs anytime for advice or referrals to other services in the community. The DHHR-BCF does not provide any funding or oversight of these Runaway and Homeless Youth Programs.

YSS- Wheeling program reported for the SFY 2015 consultation with 47 youth who had or were considering running away from home. YSS shows that only three of the youth counseled resulted in a referral to the Department of Health and Human Resources for an out-of-home placement. No reporting information was made available to the Department by Children Home Society.

Youth Services System in Wheeling and Children's Home Society in Parkersburg, the former grantees, and do fundraising to continue efforts to support a portion of their former programming. They coordinate "Sleep Out" fundraisers in November of each year to get businesses and individuals involved in the issue of youth homelessness.

Pregnancy Prevention

The state partners with Mission WV and Children's Home Society who have adolescent pregnancy prevention program grants. MODIFY will invite the program coordinators to speak at WVFAM events and provide pregnancy prevention education. MODIFY also gets information from the state's public health agency on pregnancy prevention and distributes it to MODIFY and NYTD youth. MODIFY also partners with the state's MIECHV grantees to make referrals for pregnant and parenting teens.

Educational Training Vouchers

The education and training vouchers are supported using money provided to the state as a part of the reauthorization of the independent living program. ETV funds are State

administered funds provided to foster care and former foster care youth by the MODIFY Community Support Specialists as well as DHHR caseworkers, through the WV DHHR State Office of Finance and Administration.

- Youth eligible for Chafee ETV funds include the following;
- Youth adopted from foster care after the age of 16 years old.
- Foster/ former foster care youth age 18 through 20 years old, who aged out of care at 18 or older.
- Youth placed in legal guardianship. Policy changed to reflect a IV-E Plan amendment and youth after 2014 must have a finalized legal guardianship after the age of 16.

**If an eligible youth is enrolled, attending, and making satisfactory progress in a post-secondary educational program on their 21st Birthday, then they may be eligible to continue to receive ETV funds until their 23rd Birthday.

ETV funds may not exceed $5000 per FFY (10/01 – 09/30). ETV funds may be used to cover educational expenses as outlined by the Higher Education Act which may include tuition/fees, books/supplies, room/board, transportation, tutoring, etc.

A student must reapply each year to receive ETV funds and must maintain satisfactory standing within the guidelines of the ETV program. These guidelines include the following:

- Student must maintain a 2.0 GPA.
- Student must maintain an 80% completion rate.
- Student must attend school on a regular basis and provide monthly progress reports to the MODIFY Community Support Specialist.
- If a student experiences some problems maintaining satisfactory progress, the student must contact their MODIFY Specialist to develop an improvement plan as soon as problems arise.
- If placed on probation with the MODIFY Specialist for failing to meet minimum expectations, students must comply with and complete the probation improvement plan to continue to receive ETV services and funds.

ETV Accomplishments for 2014

The state has made some progress in expanding the use of ETV funding over the past few years as well as the enrollment of youth in post-secondary educational programs.

Although enrollment has increased, retention in educational programs has been an issue for the State agency.

2017 Update

The state has made progress in expanding the use of ETV funding over the past few years as well as the enrollment of youth in post-secondary educational programs. In fact, the state may run short on education and training voucher funds in the upcoming year as well as the current year. The Department and the MODIFY program will continue to look at usage and make program adjustments as needed.

The MODIFY Program developed a user-friendly database that records the demographics of youth, their ETV utilization, and grades.

Over the past few years, higher education institutions have continued to raise the cost of their programs. With the rise in educational costs, the State has made efforts to maximize the use of all funding available to youth for the purposes of obtaining a post-secondary education. WV has a foster care tuition waiver that is available to youth who complete high school or obtain their High School Equivalency while in foster care. The Department and the MODIFY Program have made great strides in assuring that youth are provided with this waiver. There continues to be a push to ensure youth complete their Free Application for Federal Student Aid (FAFSA) before March 1, so they will obtain the maximum amount of funding available to them.

Outcomes of Education and Training Vouchers

Outcome1: For the FFY 2014 (October 1, 2013 to September 30, 2014) the State provided ETV funding to approximately 152 youth; 45 of these were new to the program.

2016 Update

For the FFY 2015 (October 1, 2014 to September 30, 2015) the State provided ETV funding to approximately 196 youth; 154 of these were new to the program.

2017 Update

For the FFY 2016 (October 1, 2015 to September 30, 2016) the State provided ETV funding to approximately 271 youth; 72 of these were new to the program.

Outcome 2: For the recent partial year (October 1, 2014 to March 30, 2015) the State provided ETV funding to approximately 137 youth; 33 of these are new to the program since October 2014.

2016 Update

For the recent partial year (October 1, 2015 to March 30, 2016) the State provided ETV funding to approximately 156 youth; 29 of these are new to the program.

2017 Update

For the recent partial year (July 1, 2016 to May 24, 2017) the State provided ETV funding to approximately 221 youth; 66 of these are new to the program since October 2015.

During the Spring 2016 semester, 41 students obtained a GPA of 3.0 or above with 7 students obtaining a 4.0 GPA. 40 students obtained a GPA of 2.0 or above. During the Summer 2016 semester, 4 students obtained a 3.0 GPA or better with one student obtaining a 4.0 GPA. Two students obtained a 2.0 GPA or better. During the Fall 2016 semester, 56 students obtained a 3.0 GPA or better with 9 students obtaining a 4.0 GPA. 45 students obtained a 2.0 GPA or better.

Updates to Targeted Plans within the 2015-2019 CFSP

Foster and Adoptive Parent Diligent Recruitment Plan

Planned activities for FFY 2017

The Bureau for Children and Families (BCF) has begun a collaborate relationship with the Huntington/Charleston chapter of the national organization PFLAG. PFLAG is the nation's largest family and ally support organization. Through this collaboration BCF intends to connect with other LGBT specific groups to help establish a system that provides support and advocacy for the LGBT community. BCF intends to enhance training efforts for foster parents specific to this issue. In 2013, BCF required all residential congregate care providers to include LGBTQ specific training to their staff. A similar training for foster parents was not completed. In October of 2014 BCF revised all policies to reflect changes regarding revisions required by the Supreme Court No. 12 – 307. As our state continues in its efforts to normalize foster care for our children and youth, we must work to ensure our foster parents are equipped with the knowledge and skills to appropriately respond to children who identify as being LGBT or Q. Acceptance and

support is fundamental in the healthy development of these youth and the families they live with must be able to provide this invaluable experience.

BCF recognizes that state agencies are not always viewed as “safe places” for the LGBT communities. Because of this perception gay and lesbian couples who are willing to provide loving and supportive homes for children and youth often seek out private adoption agencies unaffiliated with the state to complete private adoptions. Although West Virginia has many gay and lesbian foster/adoptive homes we believe targeted recruitment efforts for LGBT foster parents to encourage their application with the state or state affiliated agencies to foster/adopt children and youth who have been removed through social services would be beneficial. BCF also wishes to develop educational literature for use with our social service staff and for distribution in our local office waiting areas. BCF recognizes the importance of bringing awareness to the truths about the LGBT community and work to dispel common myths. BCF will develop specific policies and procedures pertaining to the service development of youth who identify as LGBT or Q, and identify agencies or organizations who can provide support and advocacy to both our children and youth and our families.

BCF does not intend to complete all the identified tasks within FFY 2017 but rather considers this an on-going process that needs to be continuously refined.

See attached Foster and Adoptive Parent Licensing/Recruitment Plan for updated plan.

2017 Update

The Bureau for Children and Families provided an in-depth training for Child Protective Services, Adoption, Homefinding and private agency workers on LBGTQ issues at its permanency conference held in May 2017. Issues focused on identifying providers that were LBGTQ friendly and inclusiveness while in foster care. The Bureau for Children and Families continues to support recruitment of LBGTQ foster parents.

The same philosophy in recruitment of LBGTQ foster parents applies to recruitment efforts of families of similar race and culture of its foster care population. West Virginia has made an extensive effort over the last few years to place children with relatives and kinship providers which helps maintain children with their own race, culture and community.

Due to the drug epidemic in this state it has become more difficult to recruit appropriate foster and adoptive parents. The Bureau for Children and Families has worked closely with our private providers to develop strategies to recruit and train additional foster parents. For more information, please see the Addendum to our Foster and Adoptive Diligent Recruitment Plan attached to this submission.

Health Care Oversight and Coordination Plan

2016 Update

West Virginia continues to implement the Fostering Healthy Kids Program. This program ensures that every child that enters foster care has their initial Early Periodic Screening, Diagnostic and Treatment (EPSDT) completed. The following data represents data on Health Checks completed on children entering foster care.

Fostering Health Kids Monthly Data Summary	October	November	December	January	February	March
Percentage of active foster children assigned to a primary care physician	98.2%	99.8%	97.5%	97.5%	97.5%	97.3%
Percentage of active foster children initially placed in foster care and have been scheduled for an initial HealthCheck exam	91.3%	90.1%	88.3%	91.6%	84.7%	91.3%
Percentage of active foster children initially placed in foster care and kept their initial HealthCheck exam appointment	96.8%	97.8%	97.8%	92.1%	97.3%	95.8%
Percentage of active foster children initially placed in foster care and whose initial HealthCheck exam results have been received	100%	99%	100%	100%	100%	100%

The Office of Maternal, Child and Family Health (OMCFH) Pediatric Medical Advisory Board has endorsed the integrated use of trauma-focused screening into the regular screening activities taking place under EPSDT. Precisely, all age-appropriate preventive health screening and health history forms have been revised to facilitate the determination of trauma history and any current trauma-related symptoms. West Virginia HealthCheck age-appropriate preventive health screening forms now integrate socio-behavioral factors examined in the Adverse Childhood Experiences (ACEs) Study & beginning at age 9, an abbreviated Post-Traumatic Stress Disorder (PTSD) Checklist – Civilian Version (PCL-C).[1] By integrating trauma screening into the regular screening activities taking place

under EPSDT, West Virginia now conclusively meets the requirements of the Child and Family Services Improvement and Innovation Act of 2011, which obliges States to include in their health care oversight plans a description of how they will screen for and treat emotional trauma associated with maltreatment and removal (for children in foster care).

Since the Health Care Oversight and Coordination Plan must be developed in consultation with pediatricians and other experts in health care [2], input from the OMCFH Pediatric Medical Advisory Board – which is comprised of 10 pediatricians, 2 family practitioners, an otolaryngologist, a licensed psychologist, a dentist and an optometrist has been requested. The OMCFH Pediatric Medical Advisory Board provided the following feedback.

- The attached American Academy of Pediatrics Policy Statement [3] calls for increased coordination and collaboration with team members from many sectors. Any future evolution of the Health Care Oversight and Coordination Plan should utilize this policy framework to shape and grow the child health infrastructure that is needed in West Virginia.
- The task team charged with developing a plan to monitor psychotropic medications of each individual foster child should include physicians.
- The task team recommendation for prior authorization of psychotropic medication may not be conducive to promoting best practice.
- Limiting the duration of prescriptions (by re-evaluating the continued necessity and tolerance) is the responsibility of the prescriber. If such a limit is mandated, said limit should be on a reasonable timeline.
- Rather than the task team, it is the responsibility of each prescriber to maintain his/her professional skills through continuing medical education.

See attached Health Care Coordination and Oversight Plan for additional information.

2017 Update

Trauma screening has been integrated into the regular screening activities taking place under EPSDT. Through its network of nine (9) community-based HealthCheck Program Specialists, the HealthCheck Program equips West Virginia's medical providers with the necessary tools and knowledge to carry out EPSDT services that meet reasonable standards of medical practice, i.e. the American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, and provides ongoing technical assistance regarding the EPSDT benefit.

On February 15, 2017, the Bureau for Children and Families and Bureau for Public Health/Office of Maternal, Child and Family Health formally agreed (via signed memorandum of understanding) to establish roles and responsibilities between the parties for the purposes of addressing the issues of interface in the delivery of health care services to children and youth in foster care, and providing coordination to promote prompt access to comprehensive, coordinated services and supports in a patient-centered medical home.[4]

Per the memorandum of understanding, HealthCheck Foster Care Liaisons now facilitate the completion of the West Virginia Children with Special Health Care Needs (CSHCN) Screener©, a parent-reported tool designed to mirror the federal Maternal and Child Health Bureau's consequences-based definition of children with special health care needs, for all foster care placements. West Virginia CSHCN Program Registered Nurses then authenticate Screener© responses and assign each foster child a care coordination tier level. Care coordination tier levels vary:

- Tier 1 – CSHCN identified with low service utilization and mild or few functional limitations;
- Tier 2 – CSHCN with a special physical health care need in addition to high service utilization and moderate to severe functional limitations; or
- Tier 3 – CSHCN with a special physical health care need in addition to high service utilization and moderate to severe functional limitations and requires facilitation of the child's EPSDT benefit and substantiating the medical necessity of a requested "non-covered" service (i.e. medical nutrition foods prescribed by a physician).

For children and youth in foster care with Tier 2 and Tier 3 care coordination levels, West Virginia CSHCN Program Care Coordinators (Registered Nurses and Social Workers) afford the following care coordination functions:

- Advocate patient-centered, coordinated, ongoing comprehensive care within a medical home;
- Ensure an appropriate written (shared) care plan;
- Promote communications within the medical home and ensure defined minimal intervals between said communications;

[4] The patient-centered medical home is both an approach to providing comprehensive primary care for children, youth and adults, and a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association).

- Support and/or facilitate (as appropriate) care transitions from practice to practice and from the pediatric to adult systems of care;
- Support medical homes' capacity for electronic health information and exchange; and
- Facilitate access to comprehensive home and community-based supports.

The HealthCheck and CSHCN programs work to facilitate a team approach to health care, with coordination across multiple services and settings, in accordance with the National Standards for Systems of Care for Children and Youth with Special Health Care Needs.[5] For foster children with Tier 2 or Tier 3 care coordination levels, a shared plan of care contains input from multidisciplinary providers and services, including primary, subspecialty and behavioral health professionals. As such, the shared plan of care plays a critical role in monitoring the appropriate use of psychotropic medications.

The following data represents data on Health Checks completed on children entering foster care.

Fostering Healthy Kids Monthly Data Summary	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of active foster children assigned to a primary care physician	97.4%	98.0%	98.9%	98.9%
Percentage of active foster children initially placed in foster care and have been scheduled for an initial HealthCheck exam	88.0%	86.2%	90.0%	91.67%
Percentage of active foster children initially placed in foster care and kept their initial	96.5%	94.9%	97.2%	97.0%

[5] VanLandeghem K, Sloyer P, Gabor V, Helms V. 2014. *Standards for systems of care for children and youth with special health care needs*. [Washington, DC]: Association of Maternal and Child Health Programs; [Palo Alto, CA]: Lucile Packard Foundation for Children's Health, 37 pp.

HealthCheck exam appointment				
Percentage of active foster children initially placed in foster care and whose initial HealthCheck exam results have been received	100%	100%	100%	99.8%

Disaster Plan

During the 2013-2014 federal fiscal year, West Virginia had two winter weather events, one federal disaster declaration and a chemical spill.

January 6, 2014 the West Virginia Department of Health and Human Resources issued a warning to West Virginia residents about the dangers posed by freezing temperatures over the next several days because of a severe winter storm. Residents who did not have a heating source in their home were advised to contact the county emergency operations centers or the local health department to locate the nearest shelter or warming station. There was no disruption of services.

On January 9, 2014, approximately 10,000 gallons of Crude MCHM/PPH blend leaked from a storage tank at the Freedom Industries Elk River facility in Charleston. The spill shut down the drinking water supply for citizens across nine West Virginia counties until January 17. State emergency management officials coordinated the distribution of bottled water to those areas affected. The bureau continued to provide services without interruption.

March 2, 2014 the West Virginia Bureau for Public Health alerted residents to be aware of an approaching winter storm that impacted many counties across the state. A couple of local offices were closed for a day due to road conditions and power outages. Staff reported to alternate work locations and the impact on the delivery of services was minimal.

The Bureau for Children and Families did not activate its COOP for any of these events. All offices remained open to provide services to the states citizens. The emergency

response for these events was handled by the county and local emergency management officials.

2016 Update

During the 2015-2016 plan reporting year, West Virginia had several severe weather events, two of which required a state of emergency declaration. The Bureau for Children and Families was not officially present at the Center for Threat Preparedness, but was on stand-by as needed.

7/13/15 A State of Emergency was declared in three WV counties due to heavy flooding and rainfall in the areas. Some local BCF offices closed for up to two days and worked from alternate locations, but no facilities activated their COOP.

1/22/16 A statewide State of Emergency was declared in WV due to severe winter weather. Most local BCF offices closed and no facilities activated their COOP.

The Bureau for Children and Families did not activate its COOP for any of these events. When the offices closed, essential staff remained available. On each occasion, emergency events were handled by the local emergency management officials.

2017 Update

During the 2016-2017 plan reporting year, West Virginia had several weather events, with one requiring a state of emergency declaration. The Bureau for Children and Families was not officially present at the Center for Threat Preparedness, but was on stand-by as needed.

6/24/16 - A State of Emergency was declared for 44 West Virginia counties due to consistent, heavy rainfall and flooding in the areas. Several local BCF offices closed, many without access to alternative locations as they were also affected by flood waters and weather related power outages. No facilities activated their COOP.

The Bureau for Children and Families did not activate its COOP for this event. When the offices closed, essential staff remained available. Emergency events were handled by the local emergency management officials.

Training Plan

2016 Update

PRE-SERVICE

IN-HOUSE PRE-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Personal Safety in Health & Human Resources	New Worker Pre-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	50%	FC
DHHR Orientation for New Employees	New Worker Pre-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	50%	FC
DHHR & WV Executive Branch Privacy Policies	New Worker Pre-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	50%	FC
Mandated to Report-Responsibility to Prevent Child Abuse & Neglect	New Worker Pre-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
ROSA Time Studies	New Worker Pre-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	Blended
Foundations 100	New Worker Pre-Service	Online	Short-term	BCF e-Learning	6 hours	CW Staff	240	75%	FC
The Interviewing Process	New Worker Pre-Service	Classroom	Short-term	Staff Trainer	24 hours	CW Staff	240	75%	FC
Intake Assessment	New Worker Pre-Service	Classroom	Short-term	Staff Trainer	12 hours	CW Staff	240	0%	FC
Case Documentation	New Worker Pre-Service	Computer Lab	Short-term	Staff Trainer	12 hours	CW Staff	240	50%	FC
Foundations 101	New Worker Pre-Service	Online	Short-term	BCF e-Learning	4 hours	CW Staff	240	75%	FC

IN-HOUSE PRE-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Interviewing Process/ Intake Assessment Transfer of Learning	New Worker Pre-Service	Local Office	Short-term	Supervisor	24 hours	CW Staff	240	0%	FC
Initial Case Assessment: Child Protective Services	New Worker Pre-Service: CPS; Adopt; HF	Classroom	Short-term	Staff Trainer	42 hours	All CPS, Adopt. Home Finding Staff	180	0%	FC
Initial Case Assessment Documentation: CPS	New Worker Pre-Service: CPS; Adopt; HF	Classroom	Short-term	Staff Trainer	6 hours	All CPS, Adopt. Home Finding Staff	180	0%	FC
Initial Case Assessment: Child Protective Services Transfer of Learning	New Worker Pre-Service: CPS; Adopt; HF Structured OJT	Local Office	Short-term	Supervisor	24 hours	All CPS, Adopt. Home Finding Staff	180	0%	FC
Initial Case Assessment: Youth Services	New Worker Pre-Service: YS	Classroom	Short-term	Staff Trainer	42 hours	YS Staff	60	75%	FC
Initial Case Assessment Documentation Youth Services	New Worker Pre-Service: YS	Classroom	Short-term		6 hours	YS Staff	60	50%	FC
Initial Case Assessment: Youth Services Transfer of Learning	New Worker Pre-Service Structured OJT: YS	Local Office	Short-term	Supervisor	24 hours	YS Staff	60	0%	FC
Foundations 102	New Worker Pre-Service	Online	Short-term	BCF e-Learning	4 hours	CW Staff	240	75%	FC
Children in Care	New Worker Pre-Service	Classroom	Short-term	BCF Trainer	12 hours	CW Staff	240	75%	FC
Children in Care Documentation	New Worker	Computer Lab	Short-term	BCF Trainer	12 hours	CW Staff	240	50%	FC

IN-HOUSE PRE-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
	Pre-Service								
The Court Process	New Worker Pre-Service	Classroom	Short-term	BCF Trainer	12 hours	CW Staff	240	75%	FC
The Court Process Documentation	New Worker Pre-Service	Computer Lab	Short-term	Staff Trainer	12 hours	CW Staff	240	50%	FC
Children in Care/Court Process Transfer of Learning	New Worker Pre-Service Structured OJT	Local Office	Short-term	Supervisor	24 hours	CW Staff	240	50%	FC
Family Assessment/ Case Planning: CPS	New Worker Pre-Service: CPS	Classroom	Short-term	Staff Trainer	42 hours	CPS Staff	150	75%	FC
Family Assessment/Case Planning Documentation: CPS	New Worker Pre-Service: CPS	Classroom	Short-term	Staff Trainer	6 hours	CPS Staff	150	50%	FC
Family Assessment/Case Planning: CPS Transfer of Learning	New Worker Pre-Service: CPS Structured OJT	Local Office	Short-term	Staff Trainer	12 hours	CPS Staff	150	0%	FC
CPS Competency Test	New Worker Pre-Service: CPS	Classroom	Short-term	Staff Trainer	7 hours	All CPS Staff	150	0%	FC
Family Assessment/Case Planning: Youth Services	New Worker Pre-Service: YS	Classroom	Short-term	Staff Trainer	42 hours	YS Staff	60	75%	FC

IN-HOUSE PRE-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Family Assessment/Case Planning Documentation: Youth Services	New Worker Pre-Service YS	Classroom	Short-term	Staff Trainer	6 hours	YS Staff	60	75%	FC
Family Assessment/Case Planning: Youth Services Transfer of Learning	New Worker Pre-Service Youth Services Structured OJT	Local Office	Short-term	Supervisor	12 hours	All Youth Services Staff	60	0%	FC
Competency Test: Youth Services	New Worker Pre-Service YS	Classroom	Short-term	Staff trainer	7 hours	All Youth Services Staff	60	0%	FC
Family Assessment/ Case Planning: Adoption	New Worker Pre-Service: Adoption	Classroom	Short-term	Staff Trainer	42 hours	All Adoption Staff	15	75%	AA
Family Assessment/ Case Planning Documentation: Adoption	New Worker Pre-Service: Adoption	Classroom	Short-term	Staff Trainer	6 hours	All Adoption Staff	15	50%	AA
Family Assessment/ Case Planning: Adoption Transfer of Learning	New Worker Pre-Service: Adoption Structured OJT	Local Office	Short-term	Supervisor	12 hours	All Adoption Staff	15	0%	`AA
Competency Test: Adoption	New Worker Pre-Service: Adoption	Classroom	Short-term	Staff Trainer	7 hours	All Adoption Staff	15	0%	AA

IN-HOUSE PRE-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Family Assessment/ Case Planning: Home Finding	New Worker Pre-Service: Home Finding	Classroom	Short-term	Staff Trainer	42 hours	All Home Finding Staff	15	75%	Blended
Family Assessment/ Case Planning Documentation: Home Finding	New Worker Pre-Service: Home Finding	Classroom	Short-term	Staff Trainer	6 hours	All Home Finding Staff	15	50%	Blended
Family Assessment/ Case Planning: Home Finding Transfer of Learning	New Worker Pre-Service: Home Finding Structured OJT	Local Office	Short-term	Supervisor	12 hours	All Home Finding Staff	15	0%	Blended
Competency Test: Home Finding	New Worker Pre-Service: Home Finding	Classroom	Short-term	Staff trainer	7 hours	All Home Finding Staff	15	0%	Blended

IN-SERVICE

IN-HOUSE IN-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Family Engagement	New Worker In-Service	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	240	75%	FC
Meaningful Contacts	New Worker In-Service	Classroom	Short-term	Staff Trainer	12 hours	CW Staff	240	75%	FC

IN-HOUSE IN-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Title IV-E Reimbursement	New Worker In-Service	Online	Short-term	Staff Trainer	1 hour	CW Staff	240	75%	FC
Introduction to Domestic Violence	New Worker In-Service	Classroom	Short-term	Staff Trainer & DV Advocate	6 hours	CW Staff	240	75%	FC
Socially Necessary Services	New Worker In-Service	Online	Short-term	BCF e-Learning	2 hours	Child Welfare Staff/ Providers	500	75%	FC
Automated Placement Referral	New worker In-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
Critical Incidents	New Worker In-Service	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	240	0%	FC
Adoption Subsidy Process	New Worker In-Service	Online	1 hour	BCF e-Learning	1 hour	CW Staff	240	75%	AA
National Youth Transitioning Database (NYTD)	New Worker In-Service	Online	Short-term	BCF e-learning	2 hours	Staff	240	75%	FC
Youth Transitioning to Adult Services	New Worker In-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
McKinney-Vinto Act	New Worker In-Service	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC

IN-HOUSE IN-SERVICE TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Family Centered Practice	New Worker In-Service	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	240	75%	FC

PROFESSIONAL DEVELOPMENT

IN-HOUSE PROFESSIONAL DEVELOPMENT TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Youth Leveling System Case Management Inventory	Professional Development	Classroom	Short-term	Staff Trainer	18 hours	Youth Services Staff	300	0%	FC
WV Child and Adolescent Needs and Strengths Assessment	Professional Development	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	1000	75%	FC
West Virginia Safe at Home	Professional Development	Classroom	Short-term	Staff Trainer	9 hours	CW Staff	1000	75%	FC
Sexual Abuse Initial Assessments	Professional Development	Classroom	Short-term	Staff Trainer	24 hours	CW Staff	240	0%	FC
Case Aide Skills and Documentation	New Worker Professional Development	Classroom	Short-term	Staff Trainer	18 hours	Case Aides	20	50%	FC
AFCARS	New Worker Professional Development	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC

IN-HOUSE PROFESSIONAL DEVELOPMENT TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Uniform Child & Family Case Plan	New Worker Professional Development	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
Working with Families Experiencing Domestic Violence	Professional Development	Classroom	Short-term	DV Advocate/ Staff Trainer	12 hours	CW Staff	240	75%	FC
Out-Of-Home Investigations (IIU)	Professional Development	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	240	0%	FC
Psychological Evaluation Referrals for CPS/YS Families	Professional Development	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
Child & Family Services Review	Professional Development	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC
Diligent Search	Professional Development	Online	Short-term	BCF e-Learning	2 hours	CW Staff	240	75%	FC

SUPERVISORY

IN-HOUSE SUPERVISORY TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Supervisory Training: Putting the Pieces Together Module 1: Administrative Supervision	Supervisory Training	Classroom	Short-term	Staff Trainer	18 hours	Child Welfare Supervisors	50	50%	FC
Supervisory Training: Putting the Pieces Together Module 2: Educational Supervision	Supervisory Training	Classroom	Short-term	Staff Trainer	18 hours	Child Welfare Supervisors	50	50%	FC
Supervisory Training: Putting the Pieces Together Module 3: Supportive Supervision	Supervisory Training	Classroom	Short-term	Staff Trainer	18 hours	Child Welfare Supervisors	50	50%	FC
Orientation to Supervision	Supervisory Training	Online	Short-term	BCF e-Learning	1 hour	Child Welfare Supervisors	50	50%	FC
Practical Aspects of Supervision	Supervisory Training	Classroom	Short-term	Staff Trainer	6 hours	Child Welfare Supervisors	50	50%	FC
Transfer of Learning	Supervisory Training	Classroom	Short-term	Staff trainer	4 hours	Child Welfare Supervisors	50	50%	FC
Competency Based Interviewing Skills	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC

IN-HOUSE SUPERVISORY TRAINING	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	FC AA Blended
Recruitment of Qualified Staff	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC
Retention of Qualified Staff	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC
Coaching Skills for Supervisors	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC
Working in Small Groups	Supervisory Training	Classroom	Short-term	Supervisory Staff trainer	3 hrs.	Child Welfare Supervisors	50	50%	FC
Persuasion: Influencing Others for Effective Change	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC
FFA Supervisory Consultation Guide	Supervisory Training	Classroom	Short-term	Staff trainer	12 hours	Child Welfare Supervisors	50	0%	FC
Enhancing Your Nonverbal Communication Skills for Work	Supervisory Training	Classroom	Short-term	Staff trainer	3 hours	Child Welfare Supervisors	50	50%	FC

West Virginia Court Improvement Program Training

TRAINING	Setting	Duration	Provider	Length	Audience	Projected Number Attending	Rate	FC AA Blended
Child Protective Services Issues	Classroom	Short-term	W.Va. Supreme Court	50 minutes	All magistrates	160	75%	FC

TRAINING	Setting	Duration	Provider	Length	Audience	Projected Number Attending	Rate	FC AA Blended
Child Welfare Legislative Updates	Classroom	Short-term	W.Va. Supreme Court	1 hour	All magistrates	160	75%	FC
Animal Cruelty Issues	Classroom	Short-term	W.Va. Supreme Court	50 minutes	All magistrates	160	75%	FC
Human Trafficking and Crimes Against Children	Classroom	Short-term	W.Va. Supreme Court	1 hour 30 minutes	All magistrates	160	75%	FC
We Are Shelter Providers and We Are Here to Help	Classroom	Short-term	W.Va. Supreme Court	1 hour	Circuit Court Judges, Senior Status Judges, Justices	100	75%	FC
Update on Child Abuse and Neglect Law	Classroom	Short-term	W.Va. Supreme Court	30 minutes	Circuit Court Judges, Senior Status Judges, Justices	100	75%	FC
What to Expect from Your GAL	Classroom	Short-term	W.Va. Supreme Court	30 minutes	Circuit Court Judges, Senior Status Judges, Justices	100	75%	FC
Trauma-What We Need to Know and Where We Need to Go	Classroom	Short-term	W.Va. Supreme Court	30 minutes	Circuit Court Judges, Senior Status Judges, Justices	100	75%	Blended
Webinars	Online	Short-term	W.Va. CIP	1 hour	Attorneys, caseworkers, judicial staff, others	100	75%	FC
New Law Clerk Training	Classroom	Short-term	W.Va. Supreme Court	2 hours	Judicial law clerks	20	75%	FC
Judicial Assistant CAN Database Training	Online as group, in person individually for new assistants	Short-term	W.Va. CIP	4 hours	Circuit Court assistants and law clerks	70	75%	FC
CAN Guardian *ad Litem* (GAL) Training	Classroom (also recorded/ posted online)	Short-term	W.Va. CIP	8 hours	Attorney GALs	100	75%	FC

Child Welfare In-Service and Professional Development Courses: University (SWEC) Classes

These classes are provided by the five public universities in West Virginia that have

accredited social work programs through the Title IV-E University contracts. The Schools provide the match for their grants and are reimbursed directly for the expenses.

The following changes were made to In-Service Training for Child Welfare Workers and provided by BCF staff trainers

Family Engagement 2	Online	Short-term	Staff Trainer	6 hours	CW Staff	240	75%	FC	10.2
Domestic Violence 2	Classroom	Short-term	DV Advocate/ Staff Trainer	6 hours	CW Staff	240	75%	FC	10.2
SAMSHA Substance Abuse Online	Online	Short-term	BCF e-Learning	4 hours	CW Staff	240	75%	FC	10.2
Diversity & Cultural Factors 1	Classroom	Short-term	Staff Trainer	12 hours	CW Staff	240	75%	FC	10.2
Diversity & Cultural Factors 2	Classroom	Short-term	Staff Trainer	6 hours	CW Staff	240	75%	FC	10.2

The following changes were made to In-Service Training for Child Welfare Workers provided by the Social Work Education Consortium

Human Growth & Development in the Social Environment 1	Classroom	Short-term	SWEC	12 hours	CW Staff	240	75%	FC
Human Growth & Development in the Social Environment 2	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Trauma-Informed Child Welfare Practice 1	Classroom / Online	Short-term	SWEC	9 hours	CW Staff	240	75%	FC

Trauma-Informed Child Welfare Practice 2	Classroom / Online	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Understanding Poverty	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Rural Social Work Practice	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Childhood/Adult Mental Health Issues	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC

SWEC Professional Development Course	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	Blended FC or AA
Adolescent Behavior and Development	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Confidentiality in the Age of Technology	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Ethics in Action	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Self Determination and Confidentiality in Practice	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Professionalism in Child Welfare Practice	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Family Centered Multidisciplinary Treatment Teams	Professional Development	Classroom	Short-term	SWEC	1 day/6 hours	CW Staff	240	75%	FC
Using Nonverbal Communication Effectively in Child Welfare Casework	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Interviewing Children with Disabilities	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Engaging Absent Fathers	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC
Write it Right: Casework Documentation	Professional Development	Classroom	Short-term	SWEC	3 hours	CW Staff	240	75%	FC

SWEC Professional Development Course	Section	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	Blended FC or AA
Lesbian, Gay, Bisexual, Transgender Issues in Casework	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Child Welfare Trauma Toolkit	Professional Development	Classroom	Short-term	SWEC	12 hours	CW Staff	240	75%	FC
Common Childhood Mental Health Disorders and Implications for Service Planning	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Common Childhood Mental Health Disorders and Implications for Service Planning	Professional Development	Classroom	Short-term	SWEC	12 hours	CW Staff	240	75%	FC
Dual Relationships in Child Welfare Practice	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Engaging Hostile Clients	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Working with Resistant Families	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Culturally Competent Practice with Hispanic Families	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Adult Mental Health Issues	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Childhood Mental Health Issues	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Sexually Reactive Children	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC
Preserving Connections	Professional Development	Classroom	Short-term	SWEC	6 hours	CW Staff	240	75%	FC

PRIDE Foster/Adoptive Parent Pre-service Training (Level 1)
West Virginia Social Work Education Consortium (SWEC) Classes

These classes are provided by the five public universities in West Virginia that have accredited social work programs through the Title IV-E University contracts. The Schools provide the match for their grants and are reimbursed directly for the expenses.

Foster/Adopt/ Kinship Care Pre-Service Training	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	Blended FC or AA
Orientation	Classroom	Short-term	Home finder	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Connecting with PRIDE	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Teamwork Toward Permanence	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Meeting Developmental Needs-Attachment	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Meeting Developmental Needs-Loss	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Strengthening Family Relationships	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Meeting Developmental Needs-Discipline	Classroom	Short-term	SWEC / Home finder	3hours	Foster/ Adoptive Parents	600	75%	Blended
Continuing Family Relationships	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Planning for Change	Classroom	Short-term	SWEC	3 hours	Foster/ Adoptive Parents	600	75%	Blended
Taking PRIDE-Making an Informed Decision	Discussion Panel	Short-term	SWEC / Home finder / CW staff	3 hours	Foster/ Adoptive Parents	600	75%	Blended

2017 Update

There were no changes in PRIDE Pre-Service Training

PRIDE Foster/Adoptive Parent In Service Training (Level 2)

(Caring for Children Who Have Experienced Trauma was moved to Level 2 required In-service training for resource families)

West Virginia Social Work Education Consortium (SWEC) Classes

These classes are also provided by the five public universities in West Virginia that have accredited social work programs through the Title IV-E University contracts. The Schools provide the match for their grants and are reimbursed directly for the expenses.

Course	Setting	Duration	Provider	Hours	Audience	Projected Number Attending	Rate	Blended FC or AA
Caring for Children Who Have Experienced Trauma	Classroom	Short-term	SWEC	9 hours	Foster/Adoptive Providers	600	75%	Blended

There were no other changes made to PRIDE Foster/Adoptive Parent Advanced Training (Level 3)

Child Welfare Pre-Service Training: Child Protective Services

Initial Case Assessment Child Protective Services (Classroom, 42 hours))

This workshop focuses on interviewing techniques for engaging families in the assessment process. Participants are introduced to the philosophy of family centered practice in Child Protective Services (CPS) and the Family Systems Theory. It familiarizes the new worker with the policies and procedures of the Department of Health and Human Resources concerning the provision of Child Protective Services. Workers are taught how to use the Safety Assessment and Management System model to assess safety and plan for intervention throughout the problem-solving process, from intake to case evaluation and closure. Participants will learn how to assess reports of child abuse and neglect by using the Safety Assessment and Management System Instruments; use appropriate interviewing skills; navigate through the intake and family functioning assessment practice protocols and assess for safety. An experiential practicum

concludes the training in which a worker simulates a Family Functioning Assessment interview, assesses for safety and documents their findings. *Instructional Methods: Blended learning that includes online training, structured TOL activities, lecture, class room discussion, practice simulation, video, and individual activity and reading.*

Initial Case Assessment Documentation, CPS (Computer lab, 6 hours)

This training is designed to teach new workers how to navigate and document the Family Functioning Assessment into the FACTS system. New workers will learn how to document the assessment onto the template and save it to the file cabinet in FACTS as well as complete the necessary FACTS screens. New workers will have the opportunity to document practice FFA cases into the FACTS system. *Instructional Methods: Blended learning that includes online training, structured TOL activities, lecture, class room discussion, and demonstration. Participants practice entering case information in the FACTS Training Database.*

Initial Case Assessment Transfer of Learning, CPS (Local Office, 24 hours)

Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the FFA Transfer of Learning period include: shadowing tenured CPS workers; observing family engagement techniques; reviewing FFA Assessments in the SACWIS system; secondary case worker assignments; attend MDT's; attend court hearings; documentation; making referrals for services; and supervisor consultation. *Instructional Methods: Structured TOL activities, individual activity, and reading.*

<u>Child Welfare Pre-Service Training: Youth Services</u>

Initial Case Assessment: Youth Services (Classroom, 42 hours)

This course familiarizes the new worker with procedures to use the Youth Services model of risk to assess and plan for intervention throughout the assessment and treatment planning process, from intake to case evaluation and closure. Training topics include the role and responsibilities of a Youth Service Worker; using the family centered practice approach in working with Youth Services cases; the Youth Behavior Evaluation; information collection; protocol for interviewing families and documenting the information. The emphasis of this training is to work with the family as a whole and not just the

identified youth. *Instructional Methods: Blended learning that includes online training, structured TOL activities, lecture, computer practice, small group activity, practice simulation, and group discussion.*

Initial Case Assessment Documentation, YS (Computer lab, 6 hours)

This training is designed to teach new workers how to navigate and document the Youth Behavioral Evaluation and Behavior Control Plans into the FACTS system. New workers will learn how to document the assessment onto the template and save it to the file cabinet in FACTS as well as complete the necessary FACTS screens. New workers will have the opportunity to document practice Youth Services cases into the FACTS system. *Instructional Methods: Blended learning that includes online training, structured TOL activities, lecture, class room discussion, and demonstration. Participants practice entering case information in the FACTS Training Database.*

Initial Case Assessment Transfer of Learning: YS (Local Office, 24 hours)

Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the Youth Services Transfer of Learning period include: shadowing tenured YS workers; observing family engagement techniques; reviewing YBE and Behavioral Control Plans in the SACWIS system; BCP, intake and court documentation; making referrals for services; and supervisor consultation. *Instructional Methods: Structured TOL activities, individual activity, and reading.*

Family Assessment/ Case Planning: CPS (Classroom, 42 hours)

This course familiarizes the new worker with the Protective Capacities Family Assessment, including the purposes of Protective Capacities Assessment and Treatment Planning; decisions associated with protective capacities assessment and treatment; how treatment fits in the Child Protective Services process; how to conduct a family assessment and develop a treatment plan; principles of individual and family change; motivation and change with involuntary clients; client involvement in treatment planning; use of outcomes in treatment planning; decisions associated with and completion of a case evaluation and closure; reunification; and notification of providers. *Instructional Methods: Lecture, small group activity, practice simulation, group discussion, individual activity and reading.*

Family Assessment/Case Planning Documentation: CPS, (Computer Lab, 6 hours)
This workshop will, in conjunction with Protective Capacities Family Assessment and Treatment Planning training, provide practice experience on how to document a Protective Capacities Family Assessment and Family Case Plan in the FACTS system. *Instructional Methods: Lecture, computer practice, practice simulation and individual activity.*

Family Assessment/Case Planning Transfer of Learning: CPS (Local Office, 12 hours)
Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the Transfer of Learning period include: shadowing tenured CPS workers; observing family engagement techniques during the PCFA process; reviewing PCFA in the SACWIS system; practice and observe interviewing with tenured staff; review case evaluations SACWIS system Instructional *Methods: Structured TOL activities, individual activity, and reading.*

New Worker Competency Test: CPS (Classroom/Online, 7 hours)
The New Worker Competency Test will include a written CPS knowledge test, a simulated adult interview, a simulated child interview, and a documentation assessment.
Instructional Methods: computer practice, practice simulation and individual activity.

Child Welfare Pre-Service Training: Youth Services
Family Assessment/Case Planning: YS (Classroom, 42 hours)
This course focuses on gathering sufficient information to develop Protection Plans and Behavioral Control Plans. Participants will learn how reasonable efforts correlate with the behavior control planning and the difference between in-home and out-of-home plans. Participants will learn how to accurately document Protection Plans and Behavioral Control Plans. It assists them to understand their role in the case planning process as well as how to motivate families and youth to participate in the case planning process to promote change. Workers are given demonstrations of interviewing and goal writing then are given an opportunity to demonstrate writing a case plan including goal development. *Instructional Methods: Blended learning that includes online training, structured TOL activities, computer practice, small group activity, role play, practice interviewing, individual activities and group activities.*

Family Assessment/Case Planning Documentation: YS (Computer Lab, 6 hours
This course provides instruction for documenting Youth Services Intakes; client demographics; Youth Behavioral Evaluations; Behavioral Control Plans; Family Service Plans and Family Service Plan Reviews. *Instructional Methods: Blended learning that includes online training, structured TOL activities, class room discussion, demonstration, and computer-based activities.*

Family Assessment/Case Planning Transfer of Learning: YS (Local Office, 12 hours)
Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the Youth Services Transfer of Learning period include: shadowing tenured YS workers; observing family engagement techniques; reviewing Behavioral Control Plans in the SACWIS system; BCP, intake and court documentation; making referrals for services; and supervisor consultation. *Instructional Methods: Structured TOL activities, individual activity, and reading.*

New Worker Competency Test: Youth Services (Classroom/Online, 7 hours)
The New Worker Competency Test will include a written Youth Services knowledge test, a simulated adult interview, a simulated child interview, and a documentation assessment.
Instructional Methods: computer practice, practice simulation and individual activity.

Child Welfare Pre-Service Training: Adoption

Family Assessment/Case Planning: Adoption (Classroom, 42 hours)
This course addresses Title IV of the Civil Rights Act of 1964; Multiethnic Placement Act (MEPA) of 1994; Interethnic Adoption Provisions (IEP) of 1996; the Indian Child Welfare Act (ICWA) of 1978; the Adoption and Safe Families Act (ASFA) of 1997; and a discussion of concurrent planning in the context of the Child and Family Services review process. In addition, deals with the Safe and Timely Interstate Placement of Foster Children Act; the Adam Walsh Child Protection and Safety Act; the Child and Family Services Improvement Act of 2006; the Deficit Reduction Act of 2006; and Fostering Connections to Success

and Increasing Adoptions Act of 2008, as related to safe, timely placements for children in foster care and adoption. This course focuses on Child Assessment and Preparation. It reviews WV policies, procedures and protocols for completing a child assessment and preparation of the child for adoption. Participants will discuss issues of transitioning children/youth from foster care; issues specific to adoption assessment and preparation of older children and youth; and issues of sibling placements. The course stresses the importance of using team meetings and engaging prospective, adoptive families in assessing their ability to parent a specific child/youth. In addition, it fosters discussion in engaging the older child/youth in selecting the adoptive family. This course covers: the history of adoption subsidy in the United States; federal laws, policies and eligibility requirements for Title-IV-E Adoption Assistance; core components of negotiating and discussing adoption assistance; and discussion of adoption assistance with older children/youth and prospective adoptive families. *Instructional methods: Lecture, individual activity, group discussion, group activity, and video.*

Family Assessment/Case Planning Documentation: Adoption (Computer lab, 6 hours)

This course covers the documentation process in adoption. This includes the importance of thoroughly reviewing the case record, case transfer of the state ward case to the adoption unit, documentation of placement and adoption information in the FACTS system, documenting the finalized adoption including subsidy information when appropriate, and preparing the case for transfer to the Division of Children and Adult Services after the consummation of the adoption. The adoption specialist will learn the importance of thorough documentation, completing all related adoption screens, and preparing the case record for transfer and archiving. *Instructional Methods: Computer lab, reviewing FACTS adoption screens, documenting practice case information in FACTS.*

Family Assessment/Case Planning Transfer of Learning: Adoption (Local Office, 12 hours)

Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the Transfer of Learning period include: shadowing tenured Adoption workers; observing family engagement techniques during the adoption process; reviewing child summaries in the SACWIS system; practice and observe interviewing with tenured adoption staff; attend MDT meetings and permanency hearing

for adoption; review adoption screens in the SACWIS system Instructional *Methods: Structured TOL activities, individual activity, and reading.*

New Worker Competency Test: Adoption (Classroom/Online, 7 hours)
The New Worker Competency Test will include a written Adoption knowledge test, a simulated adult interview, a simulated child interview, and a documentation assessment. *Instructional Methods: computer practice, practice simulation and individual activity.*

Family Assessment /Case Planning: Home Finding (Classroom, 42 hours)
This course prepares child welfare workers who are Home Finding Specialists to work with families who are providing substitute care for children in state custody who are in out of home care. The training covers the role of the home finder in the child welfare system, recruiting foster/adoptive parents, eligibility criteria, PRIDE training for prospective parents, the assessment process, compiling the actual home study, making decisions with the family regarding certification and the Family Development Plan. The importance of supporting certified foster/adopt families, retaining families and the annual recertification process is also covered in this course. In addition, the training participant's review and practice documentation in the FACTS system as it relates to foster/adopt providers and placements. *Instructional Methods: Lecture, role play, practice interviewing, individual activities, group activities and video*

Family Assessment/Case Planning Documentation: Home-Finding (Computer Lab, 6 hours)
This workshop teaches participants to enter required documentation in the FACTS system as it relates to foster/adopt providers and placements. Participants learn application of the FACTS system; entering new provider records and maintaining current provider records; provider documentation: and IV-E documentation. Lecture; small group activity; practice simulation; group discussion. Instructional *Methods: Lecture, small group activities, practice simulation, and group discussion.*

Family Assessment/Case Planning Transfer of Learning: Home Finding (Local Office, 12 hours)
Transfer of Learning periods provide the opportunity to practice skills learned in the classroom or online through structured activities that are a critical piece of learning and skill development. Assignments for the Transfer of Learning period include: shadowing

tenured Home Finding workers; observing family engagement techniques during the Home Study process; reviewing Home Studies in the SACWIS system; practice and observe interviewing with tenured Home Finding staff; review Home Finding screens in the SACWIS system Instructional *Methods: Structured TOL activities, individual activity, and reading.*

New Worker Competency Test: Homefinder (Classroom/Online, 7 hours)
The New Worker Competency Test will include a written Home Finding knowledge test, a simulated adult interview, a simulated child interview, and a documentation assessment.
Instructional Methods: computer practice, practice simulation and individual activity.

Child Welfare In-Service Training Provided by BCF Staff Trainer For Child Welfare Staff

Family Engagement (Classroom, 6 hours
This course will help participants learn the definition of Family & Youth Engagement, as a core competency of community-based Systems of Care. Participants will learn benefits of engaging families and youth in service planning and delivery, as well as challenges to engagement within various child and youth-serving systems. This course will focus on the six components of effective parent engagement that were rated as most important by West Virginia families of children with behavioral challenges and other needs. Participants will review key concepts and develop practical skills for each of the six family engagement components and develop personalized plans of action to improve family and youth engagement in day-to-day practice. *Instructional Methods: Lecture, small group activities, practice simulation, and group discussion.*

Critical Incidents (Classroom, 6 hours)
This course provides participants with statistical data on child fatalities in WV and identifies trends in child welfare practices; factors related to child deaths; best practice standards; working with vulnerable children; supervisory consultation; safety planning; information gathering; co-sleeping; and substance abuse related child fatalities. *Instructional Methods: Lecture, small group activity, practice simulation, and group discussion.*

Family Centered Practice (Classroom, 6 hours)

This workshop provides workers with an understanding of the concept of "Family Centered Practice" as it relates to Child Welfare practice, including the advantages of this approach to working with children and families and how to apply the concepts to practice. Workers engage in a variety of activities that encourage them to understand the importance of the key elements of Family Centered Practice. *Instructional Methods: Lecture, small group activity, practice simulation, and group discussion.*

SAMSHA Substance Abuse (Online, 4 hours)

This course is designed to provide participants with knowledge and skills needed to understand the impact of substance abuse for clients who are involved in the child welfare system, highlighting the key considerations and effective strategies for working with these families to achieve reunification and recovery. This curriculum will provide child welfare professionals with knowledge and skills spans: Knowledge of substance use disorders, treatment, and family recovery, and their relationship to parenting. How to build and enhance partnerships, and coordinate case planning and management with substance use disorder treatment professionals. How to identify and carry out key responsibilities that arise if the investigation or screening indicates that alcohol or drug use may be a factor in the abuse or neglect: Instructional Methods: Online presentation (internet) Online presentation (internet) that includes videos and activity exercises to aid in transfer of learning.

Family Engagement 2 (Online Course 6 hours)

This course is four module course that is designed to provide participants with knowledge and skills need to understand how to effectively engage with family. The curriculum of this course will provide the learns the knowledge of what engagement skills are necessary skills are required for engagement. How family engagement effects the social work practice including the importance of family finding in terms of engagement. What some potential challenges of family engagement including challenges for absent fathers. Also, provided for the learner are involvement strategies for social workers to aid in encouraging engagement of absent fathers. Required course for staff with restricted licensure. Instructional Methods: Online presentation (internet) that includes videos and activity exercises to aid in transfer of learning.

Domestic Violence 2 (Domestic Violence Contract, 6 hours)

This course presents a continuation of the Basic Domestic Violence course and provides a more in-depth look at the role of and procedures for domestic violence in child welfare cases, service options, and working with the court. It also explores changes and additions to Family and Circuit Court rules, statutes, and policies related to domestic violence involving child abuse and neglect; explains the difference between protective order proceedings and Chapter 49 proceedings in cases of domestic violence and the advantages and disadvantages of each. Required course for staff with restricted licensure. Instructional Methods: Lecture, small group activities, practice simulation, and group discussion.

Diversity and Cultural Factors 2 (Classroom, 6 hours)

This course provides the worker with an understanding of Appalachian culture and diversity, including prevalence and the role that prejudice and stereotypes can have on services to clients. The course also examines diversity in the child welfare system, including disproportionate representation in out of home care, relationship between poverty and race and impact on child welfare outcomes. Required course for staff with a restricted provisional license. Instructional Methods: Lecture, videos, group activities and group discussion.

In-Service Training Provided by Social Work Education Consortium for Child Welfare Staff

Substance Abuse 2 (SWEC Contract, 6 hours)

*This course is designed to give participants a better understanding of how drug and alcohol negatively affects child development and family systems**;** examines strategies and effective interventions for drug affected infants and their caregivers; collaboration efforts across service delivery systems that are more child centered and family focused, comprehensive, culturally/ethnically competent; linkage of drug and alcohol and drug prevention, treatment and aftercare services. Required course for staff with restricted licensure. Instructional Methods: Lecture, small group activity, practice simulation, video, and group discussion.*

Legal and Ethical Issues in Social Work Practice 2 (SWEC Contract, 6 hours)

This workshop will address a practical application of ethical dilemmas encountered in

child welfare and is open to all child welfare staff; however, those who attend must bring specific, case related ethical dilemmas to be discussed during this workshop. Required course for restricted licensure. Instructional Methods: Lecture, guided group discussion, and group activity.

Human Development in the Social Environment 2 (SWEC Contract, 6 hours)

This workshop provides a framework for studying the person in environment from an ecological perspective and examines human development and social functioning within the context of transactional influences and the significance of ethnicity, gender, culture and class. Required for staff with a restricted provisional license. Instructional methods: Lecture, small group activities, video, and group discussion.

Trauma Informed Practice 2 (SWEC Contract, 6 hours)

This workshop was developed by the National Child Traumatic Stress Network and is designed to educate case workers about the impact of trauma on the development and behavior of children in foster care and to provide knowledge and skills necessary to assess and appropriately identify the behavioral and emotional challenges of traumatized children. Instructional Methods: Lecture, video, small group activity, practice simulation, and group discussion.

Understanding Poverty (SWEC Contract, 6 hours)

The Understanding Poverty workshop provides an operational definition of poverty and examines how poverty is measured in our national context. The workshop highlights magnitude of poverty in the United states and the implications for children and families. Participants will examine their own personal stereotypes and biases in regards to individuals and families living in poverty and analyze causation from the perspectives of poverty as an individual failure versus poverty as a structural, social problem. The workshop emphasizes poverty's impact on the physio-psycho-emotional development of children and indicates policies that have been effective in countering poverty's negative effects. Finally, participants will be able to identify the link between poverty and child welfare involvement and be able to discern between child neglect and issues of impoverishment. Required course for staff with restricted provisional license. Instructional Method: Lecture, video, group activities and group discussion.

Rural Social Work Practice (SWEC Contract, 6 hours)

This workshop will explore the complexity of dual relationships, particularly as it relates to child welfare practice in rural areas. Relevant sections of the NASW Code of Ethics will be discussed, as well as their application to practice. Required course for staff with a restricted provisional license. Instructional Methods: Lecture, group discussion, case examples, and group activity.

Common Childhood/Adult Mental Health Disorders (SWEC Contract, 6 hours)
This workshop explores common emotional and behavioral disorders commonly encountered in child welfare, and what a child welfare professional should expect to see in treatment plans from the professionals he/she refers his/her clients to. Required course for restricted licensure. Methods of presentation: lecture, group discussion, video, and group discussion.

Professional Development *Provided by BCF Staff Trainer*

Youth Leveling System and Case Management Inventory (Classroom, 18 hours)
The Youth Level of Service/Case Management Inventory 2.0 is a gender-informed, culturally-informed, strengths-focused risk/needs tool that reliably and accurately classifies and predicts re-offending within male and female juvenile populations. Participants will learn how to utilize the assessment, score assessment and integrate results into the case planning process and service provision. *Instructional Methods: Lecture, small group activities, group discussion, videos, and demonstration.*

WV Child and Adolescent Needs and Strengths Assessment (Classroom, 6 hours)
This course focuses on the use of the CANS information integration tool that will help child welfare workers to assess and identify the needs and strengths of children and families. The CANS assist workers in identifying service needs of the child and family, prioritizing such needs and providing rationale for service planning and decision making. The CANS is designed for use at two levels—for the individual child and family and for the system of care. The CANS utilizes current, relevant information gathered and compiled from all available resources to better serve the individual child and their family as well as helping child welfare workers and service providers in service planning and/or

quality assurance monitoring. *Instructional Methods: Lecture, small group activities, group discussion, videos, and demonstration.*

Safe At Home West Virginia (Classroom, 9 hours)

This course will help participants gain knowledge and skills about the wraparound model and learn techniques that are essential in identifying and utilizing child and family strengths in the case planning. Workers learn about the importance of engaging the family; coordination of community services; family decision making and the effectiveness of family driven case plans. *Instructional Methods: Blended learning that includes online training, structured TOL activities, classroom discussion, demonstration, and small group activities.*

Pre-Service Training for Foster/Adopt Resource Families

Level I: Pre-service

The PRIDE pre-service training consists of nine modules (21 hours of classes) required by all potential foster/adoptive providers.

LEVEL II: INSERVICE FOSTER/ADOPTIVE TRAINING

Caring for Children Who Have Experienced Trauma: (Moved from Level III advanced training to Level II required in-service training for Resource Parents and Relative Care Givers)

This 9-hour workshop was developed by the National Child Traumatic Stress Network and is designed to educate resource parents and relative care givers about the impact of trauma on the development and behavior of children in foster care and to provide parents with the necessary knowledge and skills necessary to respond appropriately to the behavioral and emotional challenges of traumatized children. *Instructional Methods: Lecture, video, small group activity, practice simulation, and group discussion.*

Statistical and Supporting Information

Statistical and Supporting Information

Information on Child Protective Service Workforce:

Child Protective Services FFY2014 (Revised)	Region I	Region II	Region III	Region IV	Statewide Total
Total CPS Case[1]	12,557	18,487	8,179	18,048	57,271
Monthly Average CPS Cases[2]	1,046	1,541	682	1,504	4,772
Staff Needed @ Action Standard[3]	105	154	68	150	477
Total CPS Staff Allocated Positions[4]	109	127	57	133	426
% of Allocated Positions Meeting Caseload Standard[5]	104%	82%	84%	89%	89%
Average CPS Caseload for Allocated Positions[6]	10	12	12	11	11
Caseload Difference (Allocated to Action Standard)[7]	4	-27	-11	-17	-51

[1]Obtained by adding the monthly case totals of On-going CPS staff (FREDI CPS 8802) to the Intake CPS staff (FREDI CPS 8801) each month during FFY2014 (October 2013-Spetember 2014)
[2]Total CPS cases divided by 12 (months) rounded to nearest integer
[3]Monthly average of CPS cases divided by 10 (action standard for CPS cases) rounded to nearest integer
[4]Obtained from monthly regional reports in FFY2014
[5] Total CPS allocated positions divided by the total staff needed according to action standard rounded to nearest integer
[6]Monthly average CPS cases divided by total allocated CPS positions rounded to nearest integer
[7]CPS allocated positions subtract staff needed at action standard and rounded to nearest integer (positive numbers mean above standard, negative numbers mean below standard)

Information on Youth Service Workforce:

Youth Services FFY2014 (Revised)	Region I	Region II	Region III	Region IV	Statewide Total
Total YS Case[1]	9,329	11,163	6,543	6,261	33,296
Monthly Average YS Cases[2]	777	930	545	521	2,773
Staff Needed @ Action Standard[3]	65	78	45	43	231
Total YS Staff Allocated Positions[4]	40	56	44	34	174
% of Allocated Positions Meeting Caseload Standard[5]	62%	72%	98%	79%	53%
Average YS Caseload for Allocated Positions[6]	19	17	12	15	15
Caseload Difference (Allocated to Action Standard)[7]	-25	-22	-1	-9	-57

[1]Obtained by adding the monthly case total of Youth Service staff (FREDI YSS-0010) each month during FFY2014 (October 2013-September 2014)
[2]Total YS cases divided by 12 (months) rounded to nearest integer

[3]Monthly average of YS cases divided by 12 (action standard for YS cases)
[4]Obtained from monthly peer allocation reports in FFY2014
[5]Total YS allocated positions staff needed according to action standard divided by the total staff needed according to action standard rounded to nearest integer
[6]Monthly average of YS cases divided by total allocated YS positions rounded to nearest integer
[7]YS allocated positions subtract staff needed at action standard rounded to nearest integer (positive numbers mean above standard, negative numbers mean below standard)

2016 Update

Youth Services Workforce FFY2015	Region I	Region II	Region III	Region IV	Statewide Total
Total YS Cases[1]	6,729	8,824	6,618	7,593	29,764
Monthly Average YS Cases[2]	561	735	552	633	2,480
Staff Needed @ Action Standard[3]	47	61	46	53	207
Total YS Staff Allocated Positions[4]	30	51	31	47	159
% of Allocated Positions Meeting Caseload Standard[5]	64%	84%	67%	89%	77%
Average YS Caseload for Allocated Positions[6]	19	14	18	13	16
Caseload Difference (Allocated Action Standard)[7]	-17	-10	-15	-6	-48

*Numbers reflect new region alignment as of November 2014
[1]Obtained by adding the monthly case total of Youth Services staff (FREDI-0010) each month during FFY2015 (October 2014-September 2015)
[2]Total Youth Services Cases divided by 12(number of months) rounded to nearest integer
[3]Monthly average of Youth Services Cases divided by 12 (action standard for Youth Services cases) rounded to nearest integer
[4]Obtained from the "Position Vacancy Report" as reported by each region
[5]Total Youth Services staff allocated positions divided by the staff needed at action standard multiplied by 100 rounded to nearest integer
[6]Monthly average of Youth Services cases divided by total allocated Youth Services positions rounded to nearest integer
[7]Youth Services allocated positions subtract Youth Services staff needed at action standard rounded to nearest integer (positive numbers mean above action standard; negative numbers mean below action standard)

Child Protective Services FFY2015	Region I	Region II	Region III	Region IV	Statewide Total
Total CPS Case[1]	12,727	16,823	10,730	18,245	58,525
Monthly Average CPS Cases[2]	1,061	1,402	894	1,520	4,877
Staff Needed @ Action Standard[3]	106	140	89	152	487
Total CPS Staff Allocated Positions[4]	111	114	73	129	427
% of Allocated Positions Meeting Caseload Standard[5]	105%	81%	82%	85%	88%
Average CPS Caseload for Allocated Positions[6]	10	12	12	12	11
Caseload Difference (Allocated to Action Standard)[7]	5	-26	-16	-23	-61

*Numbers reflect new region alignment as of November 2014
[1]Obtained by adding the monthly case totals of On-going Child Protective Services staff (FREDI CPS-8802) to the number of referrals accepted for the month (Cognos-Referrals Accepted) for FFY2015(October 2014-September 2015)
[2]Total CPS cases divided by 12 (months) rounded to nearest integer
[3]Monthly average of CPS cases divided by 10(action standard for CPS cases) rounded to nearest integer
[4]Obtained from monthly "Position Vacancy Report" submitted by each region rounded to nearest integer
[5]Total CPS allocated positions divided by staff needed at action standard multiplied by 100 rounded to nearest integer
[6]Monthly average CPS cases divided by total CPS staff allocated positions rounded to nearest integer
[7]Staff needed at action standard subtract CPS allocated positions rounded to nearest integer (positive numbers mean above action standard; negative numbers mean below action standard)

Youth Services Workforce FFY2016	Region I	Region II	Region III	Region IV	Statewide Total
Total YS Cases[1]	7,331	10,002	7,616	7,270	32,219
Monthly Average YS Cases[2]	611	834	635	606	2,685
Staff Needed @ Action Standard[3]	51	69	53	50	224

*Numbers reflect new region alignment as of November 2014
[1]Obtained by adding the monthly case total of Youth Services staff (FREDI-0010) each month during FFY2016 (October 2015-September 2016)
[2]Total Youth Services Cases divided by 12(number of months) rounded to nearest integer
[3]Monthly average of Youth Services Cases divided by 12 (action standard for Youth Services cases) rounded to nearest integer

Child Protective Services FFY2016	Region I	Region II	Region III	Region IV	Statewide Total
Total CPS Case[1]	17,399	22,378	11,575	19,212	70,564
Monthly Average CPS Cases[2]	1,450	1,865	965	1,601	5,880
Staff Needed @ Action Standard[3]	145	186	96	160	588

Numbers reflect new region alignment as of November 2014
[1]Obtained by adding the monthly case totals of On-going Child Protective Services staff (FREDI CPS-8802) to the number of referrals accepted for the month (Cognos-Referrals Accepted) for FFY2016(October 2015-September 2016)
[2]Total CPS cases divided by 12 (months) rounded to nearest integer
[3]Monthly average of CPS cases divided by 10(action standard for CPS cases) rounded to nearest integer

Staffing for YS – there is only a total of 139 allocated YS SSWIII's – that includes the additional 29 we got last year. There are an additional 50 contract positions.

Here is the breakdown:
Reg I – 33 allocated
Reg II - 43 allocated
Reg III -32 allocated
Reg IV- 31 allocated
Total – 139
Total in 2016 was 110 – add 29 additional positions =139

Contracted YS workers

Reg I 10
Reg II 15
Reg III 13
Reg IV 12
Total 50
Total in 2016 was also 50

Grand total for 2017 – allocated positions & contracted = 189

Recruitment:

The Division of Personnel provides for the announcement of vacancies to current and former employees of the classified service via its website at:

http://www.state.wv.us/admin/personnel/jobs/default.htm.

The Division of Personnel provides for the continuous announcement of positions for the State of West Virginia at:

http://www.state.wv.us/admin/personnel/jobs/default.htm.

The Division of Personnel provides for general recruitment through the announcement of job and career fairs via its website at:

http://www.state.wv.us/admin/personnel/jobs/default.htm.

Local DHHR Community Services Managers and Supervisory staff is invited to participate at Division of Personnel sponsored job and career fairs to showcase BCF openings and to respond to potential applicant's questions.

Local DHHR Community Services Managers are also responsible for recruitment of staff using a variety of methods that include: hosting local job fairs at our offices and at colleges and universities; identifying potential candidates through college and university placement offices; and posting advertisements in local newspapers. Many DHHR Community Services Managers participate in the State's Schools of Social Work IV-E supported undergraduate programs that provide for tuition and stipend payments, educational placements at local DHHR offices, and the offer of employment upon graduation.

The Office of Human Resources Management's Recruitment and Retention unit will work in partnership with BCF to establish a candidate pool for its vacancies, which will be done through several different efforts. DHHR's Recruitment Manager will be working to establish working relationships with several colleges and other higher education

institutions to inform their students of the opportunities BCF has available and will work to create internships for the different Bureaus' positions. We will also continue to offer to partner with BCF's staff on planning job fairs specifically designed for BCF's titles/positions.

Selection:

BCF is responsible for requesting the posting of each vacancy. The Division of Personnel in turns posts vacancies allowing potential qualified applicants, who are current or former covered employees, to apply. At the same time, BCF local offices request civil service registers from the Division of Personnel, which in turn certifies the names of the top ten available candidates who have tested and meet the minimum qualifications for the vacancy. It is from these two sources (present/former employees and names of candidates who have tested for vacancies) that the candidate pool is made.

Interview Panels consisting of three individuals conduct interviews and make selections based upon the policy found in DHHR Policy Memorandum 2106 and 2106-A. These polices can be located at:

http://intranet.wvdhhr.org/ops/Policies/WordPolicies/POLICY.2106.pdf and at:

http://intranet.wvdhhr.org/ops/Policies/WordPolicies/POLICY.2106-A.pdf

Degrees and Certifications required:

Information related to degrees and certifications required can be found online for each classified position:

Child Protective Service Worker Trainee

http://www.state.wv.us/admin/personnel/clascomp/spec/9684.pdf

Salary range: $27,732.00 - $51,312.00

Child Protective Service Worker

http://www.state.wv.us/admin/personnel/clascomp/spec/9685.pdf

Salary Range: $31,164.00 - $57,660.00

Social Service Worker III

http://www.state.wv.us/admin/personnel/clascomp/spec/9588.pdf

Salary Range: $26,160.00 - $48,396.00

Social Service Worker II

http://www.state.wv.us/admin/personnel/clascomp/spec/9587.pdf

Salary Range: $24,912.00 - $46,092.00

Social Service Supervisor

http://www.state.wv.us/admin/personnel/clascomp/spec/9584.pdf

Salary Range: $29,400.00 - $54,396.00

Social Service Coordinator

http://www.state.wv.us/admin/personnel/clascomp/spec/9585.pdf

Salary Range: $37,140.00 - $68,712.00

Child Protective Service Supervisor

http://www.state.wv.us/admin/personnel/clascomp/spec/9579.pdf

Salary Range: $35,028.00 - $64,812.00

West Virginia currently relies on various reports that are maintained in the Regional Offices and at the State Office for workforce demographic information. This information is useful in providing a snapshot of the workforce demographics. This includes information about the current type of social work license and level of education. DHHR maintains some information in the HRIS system but this system is dependent on the accurate reporting of changes to a worker's education and licensure status.

The state of West Virginia is currently deploying a statewide Enterprise Resource Planning (ERP) system to integrate administrative business functions and thus transform how the State manages its financial, human resources, procurement and other administrative business processes. The system will capture information and make it readily accessible, as appropriate, to State decision-makers and managers by:

Creating a business intelligence data warehouse with effective reporting tools and predefined reports;

Providing agencies, and specifically system users and business managers, with the necessary technology, tools, and training to enable them to extract the data they require to meet their daily business needs;

Improving the State's ability to conduct business, human resources, and technology planning based on reliable, timely financial and human resources data;

This system known as WV OASIS is scheduled to have the human resource functionality available in January of 2015. Additional information about the system is available at http://www.wvoasis.gov/

The following are the demographics of the child welfare workforce.

Education Level	# of Staff
Bachelor's Degree	311
Master's Degree	25
Ph.D. Degree	1
Education not listed	11

Type of License	# of Staff
Licensed Clinical Social Worker (LCSW)	3
Licensed Graduate Social Worker (LGSW)	5
Licensed Social Worker (LSW)	190
Social Worker (SW)	78
Provisional Social Worker	58
License not listed	5

Type of License by Educational Degree of Child Protective Service Workers		
Education Degree	**Type of License**	**# of Staff**
Bachelor's Degree	Certified Social Worker (LCSW)	3
	Not Listed	3
	Provisional Social Worker	159
	Social Worker (LSW)	173
	Temporary Permit (SW)	76
Master's Degree	Graduate Social Worker (LGSW)	5
	Provisional Social Worker	4
	Social Worker (LSW)	14
	Temporary Permit (SW)	2
Ph. D Degree	Provisional Social Worker	1
Not Listed	Not Listed	2

	Provisional Social Worker	2
	Social Worker (LSW)	3

Educational Degree and Discipline Type of Child Protective Services Workers		
Education Degree	**Discipline**	**# of Staff**
Bachelor's Degree	Behavioral Science	26
	Board of Regents	15
	Business Management	2
	Counseling	2
	Criminal Justice	71
	Criminology	34
	Education	11
	Health Services and Social Welfare	2
	Human Services Management	4
	Not Listed	1
	Other	8
	Psychology	56
	Psychology/Criminal Justice	4
	Psychology/Sociology	12
	Social Science	10
	Social Work	68
	Sociology	11
	Specialized Studies	1
Master's Degree	Counseling	5
	Criminal Justice	3
	Education	1
	Human Services Management	1
	Other	1
	Psychology	4
	Social Science	1
	Social Work	11
	Special Education	1
Ph. D Degree	Sociology	1
Not Listed	Not Listed	4

	Other	3

Juvenile Justice Transfers

West Virginia had 52 children under the care of the state child protection system who were transferred into the custody of the state juvenile justice system in FFY 2014. We began with a report from the SACWIS system of youth in the custody of DHHR who were court ordered to another placement and sorted this report by provider numbers associated with DJS facilities.

2016 Update

For the 2015 APSR, a similar methodology was utilized for counting the number of juveniles transferred into the DJS custody. A "hand count" was used to count the number of youth with an "exit placement type" in our state SACWIS system as "Other, specify" and "transferred to another agency" and a comment specifying the transfer to DJS. For the current reporting period, there were 37 youth documented to have transferred to the custody of the Division of Juvenile Services.

2017 Update

For the 2017 APSR, the same methodology was utilized for counting the number of juveniles transferred into the DJS custody. A "hand count" was used to count the number of youth with an "exit placement type" in our state SACWIS system as "Other, specify" and "transferred to another agency" and a comment specifying the transfer to DJS. For the current reporting period, there were 50 youth transferred to DJS custody.

Child Maltreatment Deaths

West Virginia utilizes various information sources to accurately report child maltreatment deaths to National Child Abuse and Neglect Data System (NCANDS). Information is collected from the internal Bureau for Children and Families Critical Incident Review Team, The Child Fatality Review Team operated under the State Medical Examiner's Office, as well as information from West Virginia's SACWIS system to assure that all child deaths because of abuse or neglect is captured in the NCANDS. Once the information is obtained, a review of that data is completed to ensure there is no duplication of cases. The Child Fatality Review Team operates under the Medical Examiner's Office is a team that is required under West Virginia State Code to review all child fatalities in the state of West Virginia. The code requires certain members to be on the team; of those, law enforcement and a person from vital statistics are required members. The State

Coordinator of the Child Fatality Review Team works with vital statistics to get all records of deaths for children under the age of eighteen. In the state of West Virginia, the Medical Examiner's Office has investigators that are assigned to each child death; they coordinate with law enforcement to conduct the investigation of the death. When other children are in the home, this team coordinates with the local DHHR office to ensure the safety of the other children in the home. Jane McCallister, Director of Children's and Adult Services, is an active member of the Child Fatality Review Team and the chair of the Critical Incident Review Team and has been instrumental in assuring that children who died because of abuse or neglect are accurately identified and reported. In FFY 2014, West Virginia had 14 deaths due to abuse and neglect.

2016 Update

In FFY 2015, West Virginia had 7 deaths due to abuse and/or neglect.

2017 Update

West Virginia continues to collect information from the internal Bureau for Children and Families Critical Incident Review Team, The Child Fatality Review Team operated under the State Medical Examiner's Office, as well as information from West Virginia's SACWIS system to assure that all child deaths because of abuse or neglect is captured in the NCANDS.

See the link to the 2016 Critical Incident Report located at the following website; http://www.dhhr.wv.gov/bcf/Reports/Documents/BCF%20Critical%20Incident%20Report%202016.pdf

Education and Training Vouchers

In the federal school year 2014, (July 1, 2013 – June 30, 2014) there were 152 youth who received education and training vouchers, with 45 being new recipients. In the time period July 1, 2014 – June 30, 2015, 137 youth have received ETV vouchers, with 33 being new recipients.

2016 Updates

For the academic year 2015 (July 1, 2014 – June 30, 3015) the State provided ETV funding to approximately 130 youth; 83 of these are new to the program.

For the recent partial year (October 1, 2015 to March 30, 2016) the State provided ETV funding to approximately 156 youth; 29 of these are new to the program.

2017 Update

For the academic year **2015-2016 School Year** (July 1, 2015 to June 30, 2016) the state provided funding to approximately 218; 64 of these are new to the program.

For the recent partial year **2016-2017 School Year** (July 1, 2016 to June 30, 2017) the state provided ETV funding to approximately 221 youth; 66 of these are new to the program.

Inter-Country Adoptions

West Virginia had no children adopted from other countries that entered state custody in FY 2014 because of the disruption of a placement for adoption or the dissolution of an adoption.

2016 Updates

West Virginia had no children adopted from other countries who entered state custody in FFY 2015.

2017 Update

West Virginia had no children adopted from other countries that entered state custody in 2016.

Monthly Caseworker Visit Data

In FFY 2013, West Virginia's percentage of visits with children in foster care monthly was 95.1%. Of those visits, 75.3% occurred in the child's place of residence. For FFY 2014 West Virginia's percentage of visits with children in foster care monthly was 95.6%, of those visits, 72% occurred in the child's place of residence. This continues to be monitored daily by management through COGNOS. West Virginia continues to exceed the national average.

West Virginia continues to focus on every child in placement having a face-to-face contact with their worker each month to review treatment needs and to ensure safety. Some of the steps taken to ensure that a face to face contact occurs each month are as follows:

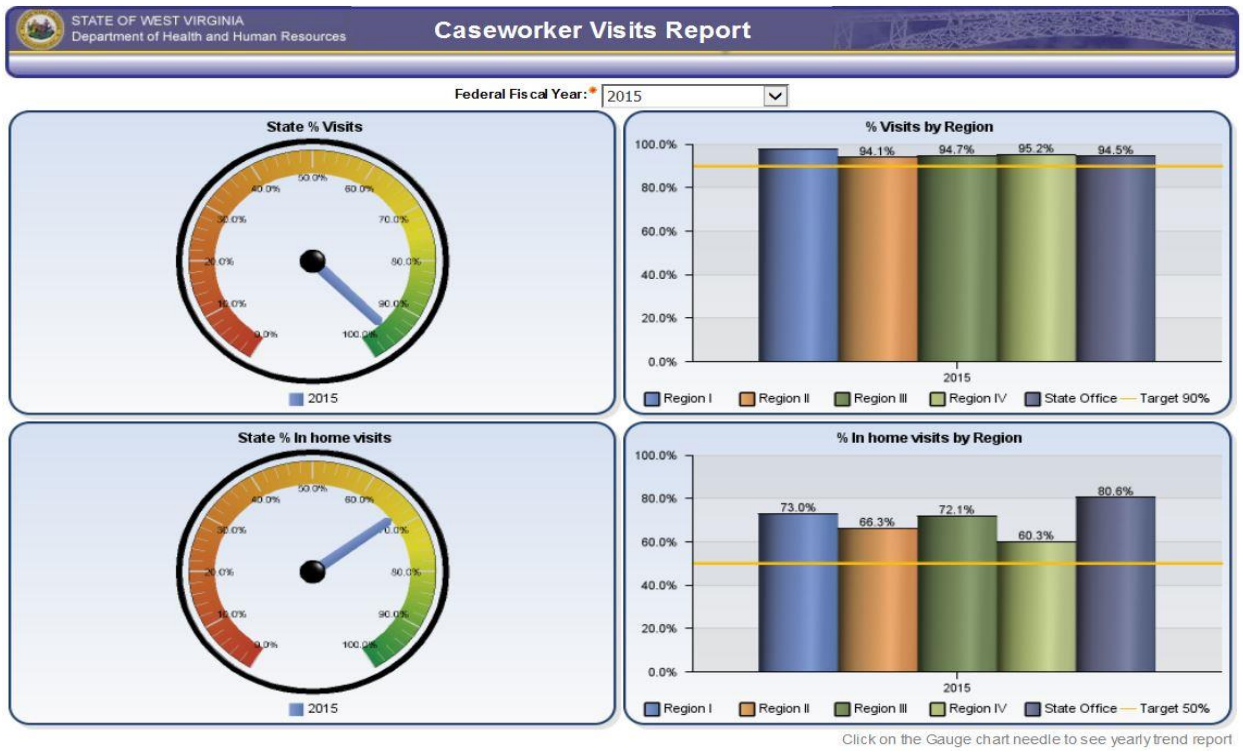
- Supervisors maintain a list of all children in placement that is utilized with the

development of scheduled visits

- Workers schedule visits during the first 3 weeks of each month – this allows an extra week in the event of unforeseen circumstances that would require rescheduling.
- Supervisors and workers will track their visits for each month
- Supervisors and workers review the Dashboard in FACTS each month to review the face to face contacts with child in placement
- If the Dashboard does not indicate a visit completed – supervisor will review to determine if this was a data error.

2016 Updates

For FFY 2015 West Virginia's percentage of visits with children in foster care monthly was 95.2%, of those visits, 67.7% occurred in the child's place of residence.



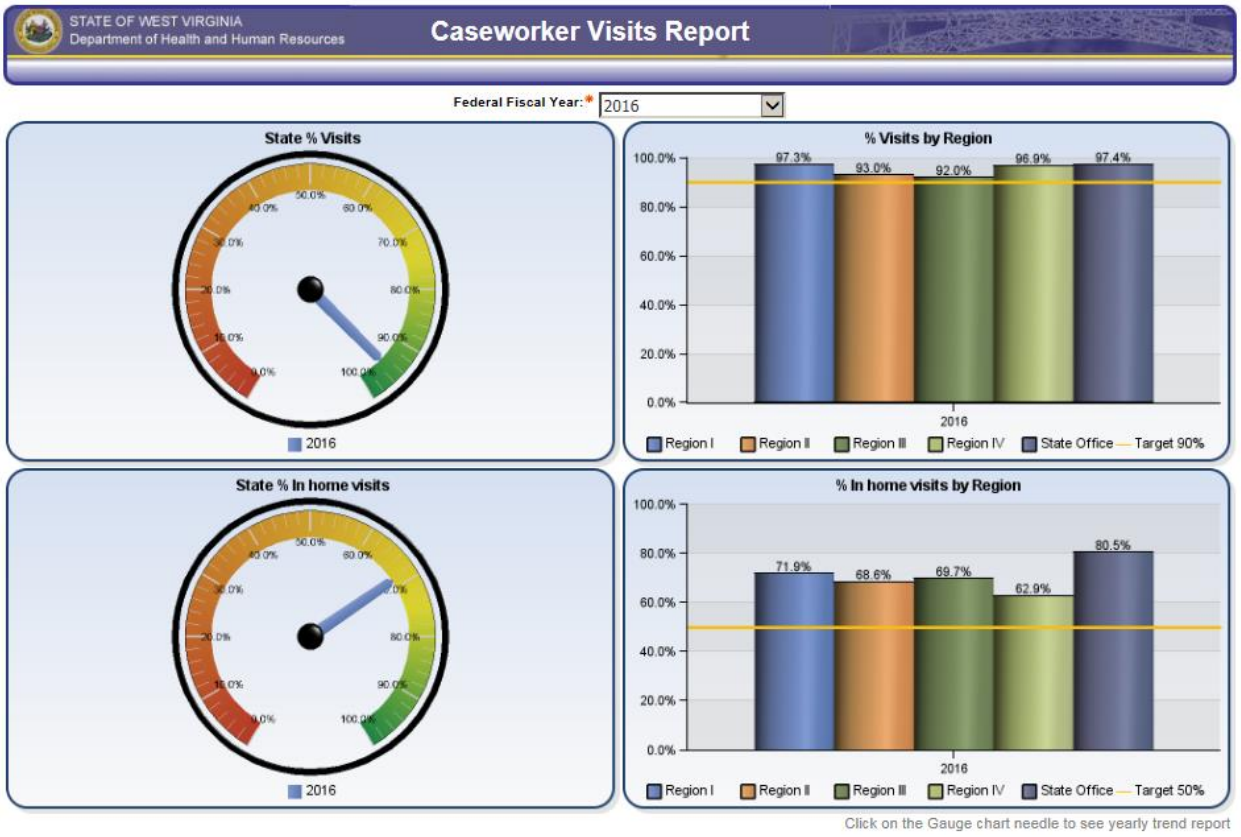
99% of caseworker visit funds were spent on transportation costs to visit children in out of home care and 1% was spent on computer supplies. West Virginia will use most the funding over the next year for travel.

2016 Update

100% of caseworker visit funds were spent on transportation costs to visit children in out of home care.

2017 update

For FFY 2016 West Virginia's percentage of visits with children in foster care monthly was 95.6%, of those visits, 68.6% occurred in the child's place of residence. 100% of caseworker visit funds were spent on transportation costs to visit children in out of home care.



Financial Information

West Virginia Citizen Review Panel

Annual Summary Report

December 2015 – September 2016

August 20, 2017

Linda Watts, Acting Commissioner

WV Department of Health and Human Resources

Bureau for Children and Families

350 Capitol Street, Room 713

Charleston, WV 25301-3711

Dear Acting Commissioner Watts:

On behalf of the members of the West Virginia Citizen Review Panel (CRP), I present to you the 2016 Annual Summary of the CRP. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that we prepare and make available to the state and to the public, a report summarizing the activities of the panel and making both observations and recommendations to improve the child protective services system. In accordance with that requirement, this summary is provided for your review.

The CRP is a multidisciplinary group that meets quarterly, and is committed to the effective functioning and continuous improvement of the comprehensive child welfare system in West Virginia. However, after several years of organizational stability and increasingly productive annual reports, the most recent year was exceptionally challenging. The organization experienced turnover at the chair level, then operated for much of the year without a coordinator. It was necessary for the CRP coordinator, having obtained full time employment with the DHHR, to submit requests to the West Virginia Office of Human Resource Management then the West Virginia Ethics Commission, to ensure no conflicts of interest were present. Although the decision(s) revealed no concerns regarding conflicts of interest, the process took several months, during which the coordinator took no role in CRP meeting business. The interruptions took a toll during the report year and the present calendar year, but the membership remains committed to is purpose and obligations on behalf of West Virginia's children and families. This year's report is thus in summary fashion representing meetings occurring between December 2015 and December 2016. It meets the requirements set forth by CAPTA.

I am grateful for a diverse group of CRP members who bring perspective, dedication, and professionalism. Our members hold the Bureau for Children and Families (BCF) in high regard and desire to assist continuous improvement toward the best outcomes for children and families in West Virginia. If you have questions or comments regarding this report, please do not hesitate to contact me.

Very truly yours,

Pamela M. Kaehler, CRP Coordinator

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Citizen Review Panel Focus Areas

Centralized Intake

Assessing the centralized intake function and processes has been a standing agenda item at all CRP meetings. The CRP received detailed, in-person updates at each meeting by the director of this unit. The CRP members were informed about and provided input to several key topics.

- The CRP advocated the implementation of customer/caller satisfaction survey efforts. The surveying process initiated with mandated reporters using a short, online form. The goal would be to expand the survey to additional identified groups, improving the survey and corresponding process with each subsequent rollout. The CRP maintains that feedback regarding Centralized Intake is most meaningful when it is of sufficient quantity to be statistically valid, is standardized, and is obtained from a range of stakeholders: They include units receiving Centralized Intake referrals at the district level, mandated reporters and community callers to the Child Abuse & Neglect Hotline, and representatives from law enforcement, the judicial system, and the medical community.
- The Centralized Intake director shared a Monthly Progress Report, providing answers to questions regarding the data and statistics contained therein. The CRP members have been impressed by the reporting and analytics functions of the call management technology, particularly the capacity for Centralized Intake to research negative variances or outliers. The CRP questioned conclusions regarding wait times, hang ups, and internal call transfers when those conclusions were based on certain mean averages or ratios. Centralized Intake has been particularly responsive to questions, concerns, and input from the CRP members and considered input from them regarding the queue system, the narrative presentation of automated options to callers, and the satisfaction survey process.
- The CRP receives updates regarding other Centralized Intake issues, including staffing levels and quality assurance (i.e., screen in/out decision consistency and accuracy). This is a busy, 24/7 call center with near-constant personnel and scheduling challenges.

Initially, the CRP added Centralized Intake to its standing agenda because the unit was a new, important consolidating initiative. The intent was to monitor the rollout of the program, making both observations and recommendations so that community input was assured. However, effective, ongoing performance of Centralized Intake is mission-critical to improving child welfare in West Virginia. For this reason, the CRP will continue Centralized Intake as a standing agenda topic for at least the next year.

Safe at Home

Safe at Home West Virginia (SAH) is a Title IV-E waiver demonstration project for child welfare reform. According to the website http://www.dhhr.wv.gov/bcf/Services/Pages/Safe-At-Home-West-Virginia.aspx, Safe at Home is designed to ensure that youth remain in their own homes and communities, avoiding foster care, congregate care, and high cost out of state placements whenever possible. The program is a wraparound model that incorporates system of care principles. The CRP received updates from the project director during the year.

The CRP takes great interest in the Safe at Home program and although initial rollout process, statistics, and challenges had been the focus of standing agenda updates this past year, the CRP will closely examine SAH Semi-Annual Progress Reports, the Program Evaluation Plan, and any forthcoming Evaluation Reports and audits (internal and external) going forward. The CRP is encouraged by the potential of the SAH program, realizing that it has many parts and differing community and clinical resources from county to county across the state. The CRP members were informed about the strategy and direction of the program and the timing/effectiveness of its implementation during this report year.

- A thrust of SAH is the capacity for creative, "out of the box" solutions, informal supports, and use of community resources. However, the CRP members observe that awareness and utilization of non-traditional providers seems limited. As the local coordinating agencies gain community relationships, experience, and confidence in this innovative process, it is anticipated that this aspect will improve.

Case Reviews

The CRP continued to perform case reviews throughout the year. Of particular interest to the CRP are the cases that are not associated with the circuit court system in West Virginia. A layperson is unlikely to realize that child protective services (CPS) open cases may or may not involve the circuit court. Those involving the court, many of which include children who are in the temporary legal and physical custody of West Virginia, are subject to progress reviews, timeliness standards, and other multi-disciplinary measures of accountability. Those not involving the court may lack visibility, continuity, or both. General CRP observations of non-court case reviews include issues as follows:

- Case reviews reveal a pattern whereby all people in the home, and absent parents outside of the home, are not addressed during the investigatory or subsequent case work processes. The root cause of this issue is not clear to CRP members, so this is relayed as an observation only.
- Case reviews reveal that safety planning and case planning for substance abuse-related issues does not follow consistent protocols, perhaps due to the varied availability of substance abuse resources and services throughout the state. However,

this may also be a casework/education issue, an issue of "local custom," or a deficiency of policy. Given the escalating and pervasive nature of substance abuse in West Virginia, the CRP recommends continuing focus on strengthening worker knowledge and best-practice interventions for substance-affected families.

- Case reviews reveal that safety planning and case planning for chronic mental illness, similarly, does not follow consistent protocols. Documentation reveals regular references to "low functioning" parents and caregivers yet worker knowledge and best-practice interventions for this challenging population appears scant. Accordingly, the CRP recommends strengthening worker knowledge and best-practice policy guidance regarding CPS response to situations of chronic mental illness or apparent "low functioning" of parents and caregivers.
- Case reviews reveal the vital yet variable involvement and performance of supervisors. The CRP will request additional information from BCF regarding its efforts to standardize and strengthen supervisor performance, given the critical impact of supervisory behavior on the quality of decisions and the satisfaction/retention of social services staff. The CRP recommends that the agency be diligent to develop and monitor, longitudinally, quantitative and qualitative measures by which to assess the effectiveness of supervisor training.

Home Studies/Foster Care Recruiting

The CRP shares the agency's concern for the effectiveness and timeliness of home studies. Over the last two years, the process and accountability has changed. The processes of recruiting, approving, training, and monitoring resource homes now involves several entities and agencies.

- The CRP has asked, "how does the old process compare to the new, from a results/expectations standpoint?" The members recommend that the BCF and its partners in these processes develop a means to measure and monitor the effectiveness of systemic changes so that we know and can duplicate what works, and change what does not.
- The CRP observes that the marketing, media, and public relations effort to recruit foster families appears fragmented, and recommends greater coordination among stakeholders to strengthen the message, increase interest, and reduce barriers. Recognizing that this is not a BCF function, the CRP encourages all entities involved to join forces, using marketing intelligence, toward compelling, targeted messaging around this topic.
- The CRP observes that the background checking process itself creates inordinate delays to the home study process, and recommends continuing all organizational efforts to make this key set of steps as efficient and user-friendly as possible.