



# West Virginia Families Come First

A Five-Year Plan for Title IV-E Prevention Services: 2019-2024

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## Introduction

The Family First Prevention Services Act (FFPSA) has come at a time when a solid foundation for prevention is a necessity and on track for reality. Since West Virginia became a Title IV-E state in 2014, substantial resources have been directed to diversifying the types of services available to families.

Implementation of the Title IV-E waiver allowed West Virginia to realize reductions in its reliance on residential care for youth aged 12-17. As of April 30, 2019, 3,146 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 97 youth from out-of-state residential placement back to West Virginia, 267 youth have stepped down from in-state residential placement to their communities, and 47 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 2,134 at-risk youth (PCG, 2019).

The work to increase alternatives to out-of-home care has not been an effort undertaken alone by the child welfare agency, the West Virginia Department of Health and Human Resources' (DHHR) Bureau for Children and Families. The collaboration between DHHR's Bureaus for Public Health, Behavioral Health, Medical Services and Children and Families has enabled community-based programming to grow, with plans to further utilize the opportunities under FFPSA to achieve common goals. Leadership provided by Cabinet Secretary Bill J. Crouch has been instrumental in the development of this shared vision.

## The Child Welfare Crisis in West Virginia

Despite efforts to build alternatives to out-of-home care over the past five years, West Virginia has seen an unprecedented burgeoning of the foster care numbers. As in many other states, this growth is mostly attributable to the opioid crisis. West Virginia's numbers reflect a growing and severe social crisis:

- 83% of open child abuse/neglect cases involve substance abuse as a factor in the home;
- Since 2014, the number of children in state custody has increased 46%;
- 22% increase in accepted child abuse/neglect referrals between 2014-2017;
- 34% increase in open Child Protective Services (CPS) cases between 2014-2017;
- West Virginia is #1 in child removal, nationally;
- West Virginia is #1 in congregate care usage, nationally;
- 63% of the children entering foster care are age 10 and younger.

There have been positive outcomes occurring simultaneously during this crisis:

- 43% of children in foster care are placed with relative/kin;
- 30% of foster children achieve permanency within 12 months of removal;
- Adoptions in West Virginia have increased 113% since 2005.

It isn't just DHHR that has been overwhelmed with responding to the human suffering of this crisis. It has impacted every organization whose mission is to serve the public, requiring partnerships to find solutions and bringing child welfare professionals into closer contact.

## Setting the Stage: Strengthening Prevention in West Virginia

Prevention is a concept that often requires the child welfare staff to do the nearly impossible in a crisis-driven system and think outside their child protection activities after maltreatment has already occurred. True primary prevention requires focus to be put on families who are not yet engaged with the child welfare agency due to abuse, neglect and/or juvenile justice issues.

In response to the U.S. Department of Health and Human Services' Administration for Children and Families' call to action, DHHR has been refining its prevention vision over the past year. DHHR's Bureau for Public Health and Bureau for Children and Families have been embedded in primary prevention for many years and will be instrumental in enhancing the prevention services opportunities that come with FFPSA.

Within the Bureau for Children and Families (BCF), the Division of Early Care and Education (ECE) has administered the Community-based Child Abuse Prevention grant for the past four years. While operationally part of West Virginia's child welfare organization, the child abuse prevention programs are often not seen as part of the child welfare service delivery system. Furthermore, the predominance of in-home visitation programming is funded through DHHR's Bureau for Public Health - Office of Maternal, Child and Family Health via the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program funding. Any expansion of primary prevention programming will require a new definition of child welfare for West Virginia, one which incorporates the concepts and services that move services "up-stream" to families not yet experiencing crises that require child removal.

In order to strengthen the foundation for primary prevention in preparation for FFPSA prevention opportunities, the ECE recently increased funding to Starting Points Family Resource Centers (SPFRC) through the utilization of Temporary Assistance to Needy Families (TANF) funds. SPFRCs target programs and services to families with children 0-18 years of age or through high school graduation age. SPFRCs serve their identified geographic regions and communities. Services are voluntary and available at no cost to families regardless of status with the child welfare agency. SPFRCs provide primary prevention services based on the protective factors and the family support approach. SPFRCs may offer:

- Parent education classes (which include Parents as Teachers)
- Child development activities
- Play groups
- Parent-to-parent support groups
- After school and academic enrichment
- High school equivalency diploma (TASC) and literacy instruction
- Health information
- Referrals to programs, activities and services in the community
- Specific services designed in accordance with the needs of the community
- Respite care for caregivers

SPFRCs will support the development and strengthening of the family's Protective Factors, which are strengths that can be built in all families that expand parental capacity and reduce the risk factors associated with abuse and neglect. This fits very well with the family support approach which embodies concept and practice to include (adapted from Standards for Prevention Programs: Building Success through Family Support/Family Support America):

- Services are responsive and adapt to family needs, involving family members in service planning, delivery, and evaluation.

- Programs are embedded in local communities to provide the best access to services and the development of partnerships within community. Services are integrated as a part of a continuum of services offered by the community and respond to specific community needs.
- Linkages to both formal (agencies and services) and informal (peer) support networks to provide support and reduce isolation are provided.
- Services are available to all families in the community and are voluntary.
- Services are targeted to families and children early to support the development of positive interactions and to intervene at the time of greatest brain development.
- Partnerships with parents as well as other community agencies are a primary focus of services.
- Parents are fully involved in decision making and guiding programs. Resources within the community work collaboratively to maximize and capitalize on available services.
- Program services are developmentally appropriate for the stages and developmental tasks of participants. Programing focuses on building on families' strengths.
- Programs are easily accessible and provide outreach to engage families and build relationships.

## Community Stakeholders Embracing Prevention - The Mountain Collaborative to Strengthen and Preserve Families in Mercer County

Jerry Milner, Associate Commissioner for the Children’s Bureau, has a motivational way of tying primary prevention to traditional child welfare philosophies. His presentation during the Children’s Bureau-sponsored State Team Planning Meeting July 17-18, 2018, in Washington, D.C., inspired a West Virginia circuit court judge to make an immediate change in his community.

Upon returning to West Virginia, the Honorable Judge Derek Swope of Mercer County called his local community collaborative together to share his excitement about what he heard in D.C. With his community connections, Judge Swope developed the Mercer County Families First (MCFF) Steering Committee. This committee boasts membership of many “movers and shakers” of the area: a professor from Bluefield State College, representatives from every branch of local government, the county commissioner, business leaders, child welfare leaders and many other community partners. From this group, the Empowering Appalachian Families in Mercer County initiative was formed.

West Virginia has the highest combined rate of deaths from drugs, alcohol, and suicide (in 2016, 83.1 deaths per 100,000 population) as well as the largest increase in deaths from these causes since 2005. The rate of drug overdose deaths in West Virginia more than quintupled between 2005 and 2016, while the state’s suicide rate increased by 46 percent and deaths from alcohol abuse rose by 41 percent. Within the state, Mercer County’s rates of suicide, drug overdose, and child and family poverty have

been significantly higher than the state average over the last five years. These factors combined with increased child abuse and neglect, domestic abuse, decline in family infrastructure, and pervasive hopelessness place Mercer County families at an increased risk for instability and impermanency.

The Mountain Collaborative to Strengthen and Preserve Families (MCSPF) applied for funding from the HHS-2019-ACF-ACYF-CA-1559 Community Collaborations to Strengthen and Preserve Families grant. These funds will enable Bluefield State College and the MCFE Steering Committee and Community Collaborative to promote child permanency, safety, and well-being in families at risk of being referred to Child Protective Services, Youth Services, and the juvenile justice system. This will be accomplished by: (1) establishing in-person outreach and a family mentoring program; (2) transformation of a promising existing wraparound service model to meet families' diverse needs (e.g., mental health, physical well-being, economic, financial, educational, and diversity-related); and (3) providing a Family Coach to facilitate family-centered service coordination promoting families' self-determination and independence.

The MCSPF is centered on a theory of change that a wraparound family support system providing comprehensive, holistic, family-driven responses to needs will increase family stability and permanency and reduce the number of youth entering the child welfare system. This project's primary goals are to reduce the number of referrals to the child welfare system and the number of domestic violence court cases through systematic, family-centered wraparound services and the support of an integrated collaborative of diverse stakeholders.

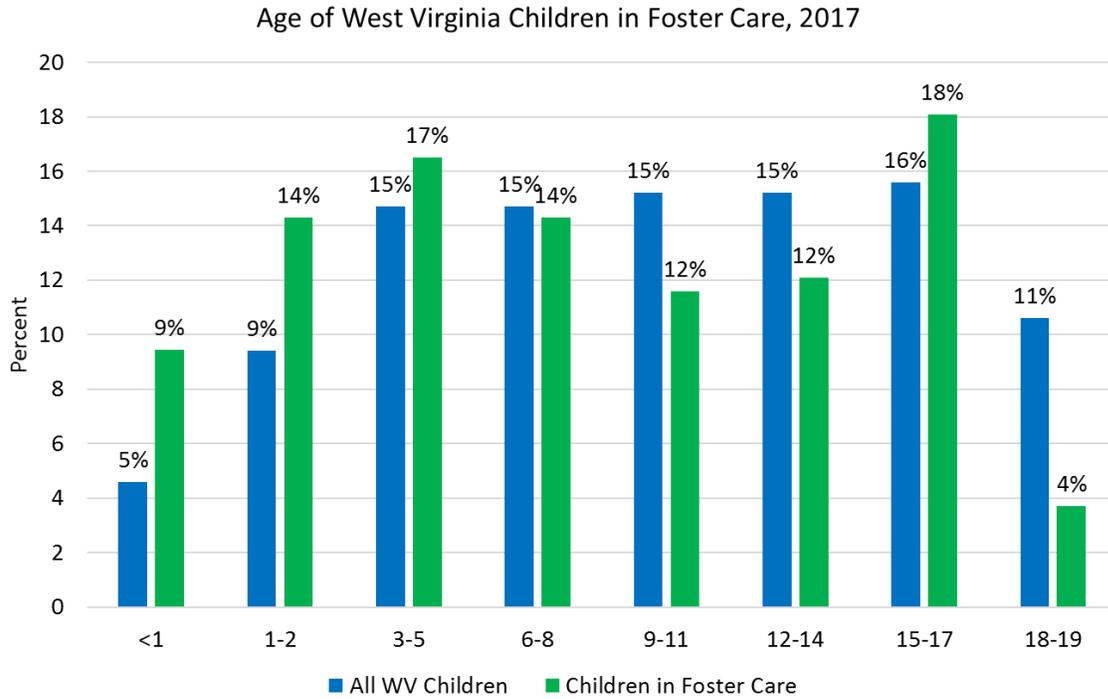
The measures used to assess the impact that MCSPF has on Mercer County families to enhance ongoing quality improvement will be tracked monthly by each consortium, reported quarterly to the Project Director, and evaluated annually by consortium members and the Project Director to ensure program success (Banks, 2019).

## Who is Coming into Foster Care? - West Virginia's Public Health Analysis of Foster Care

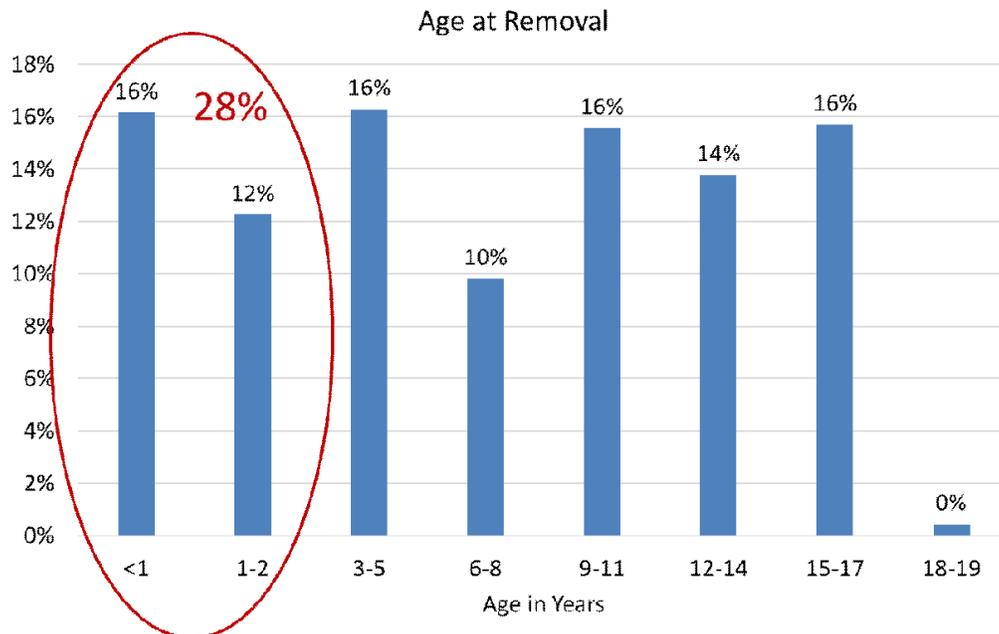
Earlier this year, DHHR's Bureaus for Public Health and Behavioral Health joined forces to review public health records for all children who entered foster care in 2017. The purpose of this comprehensive review was to:

- Determine patterns related to age at time of removal;
- Explore services offered to children prior to removal;
- Understand family dynamics for children at-risk of removal;
- Identify family needs to prevent removal; and
- Assist the Bureau for Children and Families in selecting Family First prevention services.

This data review included approximately 12,000 children. The data was obtained through matching records to birth and death certificates, Medicaid claims, public health records, the controlled substance monitoring program and emergency medical services.



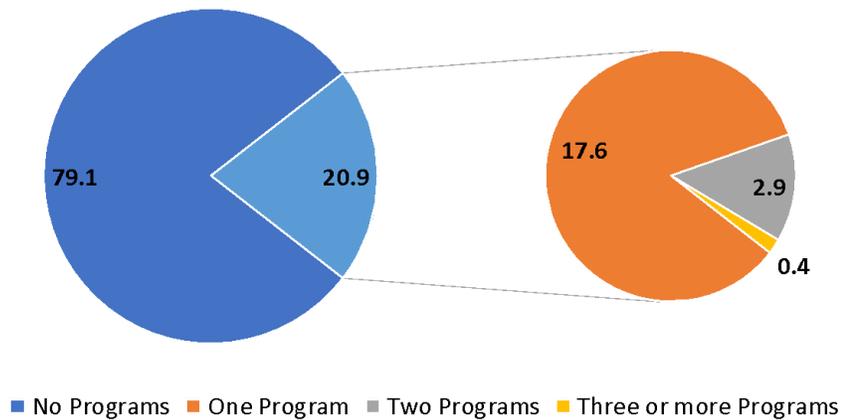
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The data collected show that 44%, nearly half, of children entering foster care are under the age of five, with 28% being age two or younger. Following behind at a close second for highest entry rate are youth aged 12-17, representing 30% of the total. Frequently, youth in this age group enter due to juvenile justice issues.

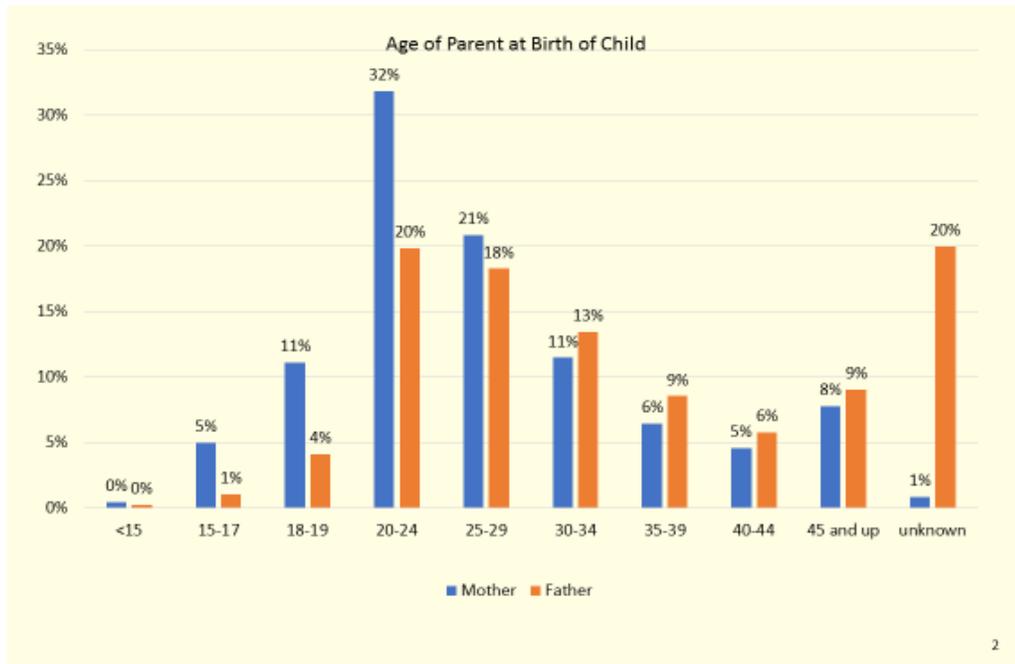
Percentage of Children that Participated in the Bureau for Public Health's Office of Maternal, Child, and Family Health Programs



Most children in foster care placement (79.1%) had no history of services from DHHR’s Bureau for Public Health’s Office of Maternal, Child and Family Health’s (OMCFH) prevention programs. For the purpose of this analysis, prevention programs included Birth to Three, Home Visitation (including Parents as Teachers, Healthy Families America and Right from The Start), and Children with Special Health Care Needs. Of the children enrolled in OMCFH programs, the majority utilized only one service. The most commonly utilized service is the Birth to Three Program. This is likely due to the Bureau for Children and Families’ requirement that all children with an open Child Protective Services case ages 0-3 years are referred to the Birth to Three Program as part of the compliance with the Child Abuse Prevention and Treatment Act requirements for drug-affected infants.

Utilization of OMCFH programs suggest that children are more likely to receive services when there is an identified developmental delay or medical condition that requires intervention. The data also suggests that policy requiring referral may positively impact utilization of services. While this population is less likely to receive prevention services from Home Visitation programs, this finding is expected since these programs have been demonstrated to reduce child abuse and neglect (Mullins and Sanders, 2019).

## Age of Parent at Birth of Child



In order to offer some description of the parent at the time of the child's birth, birth certificate data was analyzed. Mothers of children in foster care tended to be younger than expected with 48% of mothers less than 25 years of age, compared to 39% of the overall number of 2015 West Virginia births (Mullins and Sanders, 2019).

## Foster Care Candidate: West Virginia's Definition

For the provision of FFPSA prevention services, a **foster care candidate** is identified as follows: A foster care candidate is a child, under the age of 21, who is at imminent risk of foster care entry or re-entry, and who:

- Has not been removed from their home and placed in foster care; or
- Is not under the placement and care of the Title IV-E agency and is residing with a relative or an individual with whom the child has an emotionally significant relationship characteristic of a family relationship (fictive kin); or
- Has returned home on a trial home visit; or
- Has returned from a foster care placement and is residing with their parent or a non-paid kinship relative caregiver; or
- Has been adopted or is in a legal guardianship arrangement.

The child is considered at imminent risk of foster care entry, or re-entry, if at least one of the following conditions exist:

- Has been abused or neglected or has been identified as unsafe and, without intervention, is likely to be removed;
- Suffers a serious emotional, behavioral or mental disturbance and without intervention will be unable to reside in their home;
- Has committed a prosecutable offense in which the state has filed, or is considering filing, a juvenile petition and the planned out-of-home living arrangement is a foster care setting;
- Is a runaway or homeless youth;
- Is, or will be born to, a youth residing in foster care;
- Is an adopted child or in a legal guardianship arrangement at risk of disruption.

DHHR's Bureau for Children and Families will identify pregnant and parenting youth through enhancements that have been made to the state Administered Child Welfare Information System (SACWIS). Plans are also underway to incorporate documentation strategies into the state's CCWIS system, WV PATH (People's Access to Help), to assist with identification of pregnant and/or parenting youth.



## **Service Selection: Developing West Virginia's FFPSA Five-Year Prevention Plan**

While the public health analysis of foster care provided data to guide decisions on the needs of our most vulnerable populations, West Virginia's prevention strategies could not have been developed without the assistance of community stakeholders. Their engagement began in July 2018, when a statewide survey was circulated to query the types of evidence-based services that were being provided. Thirty-one unique providers responded. Thirty-three responses were received, with two agencies

sending two surveys due to the diversity of their programming. Of the 31 respondents, nine children’s residential and foster care agencies responded to the survey. Of those, three agencies responded that they are currently providing a significant number of evidence-based, in-home prevention services.

A formal workgroup was developed following the release of the *Title IV-E Prevention Services Clearinghouse*. Members of the workgroup were chosen from the providers of the services on the clearinghouse. Initial meetings have been related to information-gathering and determining how to phase the implementation strategies. Future workgroup meetings will be held to develop expansion strategies and examine fiscal implications. Budget projections are critical in determining the speed at which West Virginia will be able to expand existing services, as well as invite new services into the array. As services are added to the clearinghouse, this workgroup will be instrumental in assisting each other, and other stakeholders, in the education and assessment to determine which services work best for West Virginia families.

Prevention Workgroup/Sub-group Meeting	Meeting Description/Accomplishments
Sub-group Learning Collaborative In-Home Visitation Providers April 15, 2019	<ul style="list-style-type: none"> <li>● Education of Bureau for Children and Families’ staff about the in-home visitation programs available in WV</li> </ul>
Workgroup Meeting #1 In-home Visitation Providers, Functional Family Therapy (FFT), and Other Stakeholders June 19, 2019	<ul style="list-style-type: none"> <li>● Provider learning opportunity about FFPSA</li> <li>● Overview of preliminary public health analysis of foster care results</li> <li>● Discussion of services to meet the needs of the target population</li> </ul>
Workgroup Meeting #2 July 10, 2019	<ul style="list-style-type: none"> <li>● Review of Title IV-E Clearinghouse</li> <li>● Discussion of services unique to WV that research could support for inclusion in Clearinghouse</li> </ul>
Sub-group Meeting In-Home Visitation July 11, 2019	<ul style="list-style-type: none"> <li>● Budget overview</li> <li>● Preliminary review of expansion</li> </ul>
Sub-group Meeting FFT August 2, 2019	<ul style="list-style-type: none"> <li>● Budget overview</li> <li>● Preliminary review of expansion</li> </ul>
Sub-group Meeting Parents as Teachers (PAT) August 8, 2019	<ul style="list-style-type: none"> <li>● Discussion of pilot to complement the Family Treatment Courts</li> <li>● Budget overview for different phases of implementation</li> </ul>

Sub-group Meeting Healthy Families America (HFA) October 10, 2019	<ul style="list-style-type: none"> <li>● Program overview</li> <li>● Review of current WV catchment</li> <li>● Discussion of payment structure and outcomes measures</li> </ul>
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Several of the services included in the *Title IV-E Prevention Services Clearinghouse* are currently available in West Virginia. However, many are not available statewide or have waiting lists. For the first two years of the five-year planning period, West Virginia will place highest priority on the sustainability and expansion of services that have been shown to be meaningful for West Virginia families.

Data from DHHR’s public health analysis of foster care supports prioritizing expansion of the in-home visitation programs, Parents as Teachers and Healthy Families America. Since nearly 70% of West Virginia’s foster care population is eligible for Medicaid or the Children’s Health Insurance Program (CHIP) prior to entering care, the services chosen for initial consideration should be those with insecure and/or inadequate funding streams. The predominance of mental health and substance abuse services on the *Title IV-E Prevention Services Clearinghouse* currently available in West Virginia are funded by Medicaid, CHIP, and private insurance. This justified the selection of Functional Family Therapy and Motivational Interviewing, neither of which have sufficient funding but result in positive outcomes for the families who have received these services.

## In-Home Visitation Programs – Parents as Teachers and Healthy Families America

The in-home parenting education program, Parents as Teachers (PAT), is currently available in 49 of West Virginia’s 55 counties. Most of the counties have waiting lists. The in-home parenting education program, Healthy Families America (HFA), is located in six counties along the south-eastern portion of the state. Both programs have the infrastructure to expand services with additional home visitation staff to meet increased needs. DHHR’s Office of Maternal, Child and Family Health, housed within the Bureau for Public Health, has worked strategically over the past five years to develop leadership and resource/referral partners in counties to more readily add staff as needed (based upon funding availability). In addition, West Virginia now has a state-level PAT training team, which has reduced staff training costs. Both programs have demonstrated positive outcomes for West Virginia’s families and children.

Attachment B provides infographics related to the outcomes for PAT. These in-home visitation programs can offer life-changing opportunities for the young mothers of West Virginia’s foster care population. Program staff help schedule regular doctor’s visits, improve diets, reduce stress levels, and

provide supports to quit smoking or substance use (University of Texas at Austin 2015). These benefits could be the path to reducing poverty and increasing economic stability over the mother's lifetime.

Currently, the Maternal, Infant and Early Childhood Home Visitation funds (MIECHV) and a small amount of Community-Based Child Abuse Prevention (CBCAP) funding, and the required state match, are the only funding streams for in-home visitation programs. This causes limited availability despite positive outcomes.

## Target Population of In-Home Visitation Programs

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will implement Healthy Families America to families with increased risk of child maltreatment or those who have already experienced abuse/neglect within the home, who have an active Child Protective Services case, are pregnant, and/or with young children up to 24 months of age. This service will also be available to pregnant and/or parenting foster children as they will be eligible as foster care candidates.

Parents as Teachers will be implemented for families expecting a new infant, have increased risk of child maltreatment or have already experienced abuse/neglect in the home with a child kindergarten age or younger and have an active child protective services case, and meet the criteria to be defined as a foster care candidate. This service will also be available to pregnant and/or parenting foster youth.

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment F.

## Phased-in Implementation

A two-phased approach is planned for the utilization of IV-E funding for these in-home visitation programs.

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to DHHR's Office of Maternal, Child and Family Health (OMCFH) for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include CPS families and pregnant and/or parenting youth in foster care. The utilization process would include tailored guidelines that have the same look and feel that all other social necessary services possess.

The second phase includes efforts to expand services beyond their current localities of coverage as well as increase service capacity in areas where services are located but have waiting lists. Service

expansion will require budgetary appropriation from the West Virginia Legislature and proposals will be drafted for the 2021 legislative session.

## Caseloads

For newly hired home visitors, the recommended caseload is no more than 10 families with higher risks. After the first year, the home visitor can carry an average of around 20 cases. Cases are assigned to the home visitors by their supervisors, and reports are frequently generated to track the number of families per home visitor. If a home visitor is at capacity, families can still participate in other parenting programs. Many families are referred to Help Me Grow West Virginia. Help Me Grow is a free referral service that connects families with critical developmental resources for their children, from birth through five years. The goal of Help Me Grow is to successfully identify children at-risk and link them to the supports they need.

OMCFH also works with community in-home parenting education providers to evaluate if additional home visitors are needed. Additional home visitors are hired as funding is available.

## Monitoring Child Safety

All in-home visitation program staff are considered mandated reporters, as per West Virginia Code §49-2-803. The mandated reporter training curricula used was developed by TEAM for West Virginia Children, the West Virginia Chapter of Prevent Child Abuse America. This organization is a grant recipient of DHHR's Bureau for Children and Families, whose statement of work requires conducting statewide stakeholder trainings and events related to child abuse recognition and reporting, as well as maintaining a website for mandated reporter resources. TEAM for West Virginia Children provides mandated reporter training to all in-home visitation program staff statewide to enable them to recognize and respond properly to signs of child abuse and neglect that they may encounter in their work with families. During every home visit, the provider is informally assessing the environment for indicators of child well-being or threats to safety. Formal screenings include:

- Developmental screenings (ASQ-3 and ASQ:SE2)
- Depression screenings (PHQ-9)
- Intimate Partner Violence screenings (Relationship Assessment Tool or HITS)
- Parent-Child Interaction screenings, such as CHEERS Check-In which was developed by HFA National

Additional components of the TEAM for West Virginia Children training curriculum focus on safety, stress, anger management, and other topics that are related to abuse/neglect potential.

## Outcome Measures-Evaluation Waiver Justification

West Virginia is submitting evaluation waiver requests for Healthy Families America and Parents as Teachers as part of this plan submission (see attachment II). Both programs, as implemented in West Virginia, are required to adhere to federally defined outcome measures and model fidelity measures. Attachment A outlines the measures used to determine outcomes for the in-home visitation programs. While the population of recipients under IV-E will not be funded using MIECHV dollars, the same measures will be utilized. The IV-E funded recipients will be tracked independently from the recipients utilizing MIECHV funds.

West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and Families' *Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia*, the socially necessary services program will be transferred to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for PAT and HFA will be incorporated into the retrospective review process. These reviews are described in more detail below in the section *Quality Matters- Continuous Quality Improvement*.

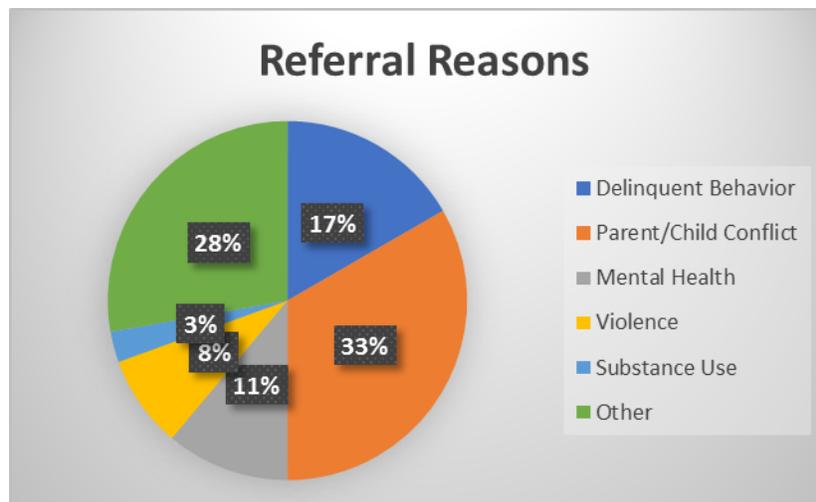
## Functional Family Therapy as a Mental Health Service in West Virginia

The Functional Family Therapy (FFT) program was implemented in West Virginia following a 2015 legislative bill that required development of community-based mental health services for youth engaged with the juvenile justice system. Funding has been the primary issue for FFT not being available statewide. When adopted by the Juvenile Justice Commission to meet the requirements of West Virginia Code §49-4-712, a legislative appropriation was provided in the amount of \$1,000,000 yearly. With training and administrative costs, this amount was not enough to fund expansion to more than a few providers.

FFT is a well-established, well-supported evidence-based intervention model utilized in 12 countries, including the United States. FFT has shown to reduce recidivism as much as 50%. It also has

the added benefit of cost savings allowing West Virginia to reinvest dollars saved to fund additional preventative community-based programs. West Virginia currently has one FFT team, consisting of three master’s level therapists, with the ability to add five more therapists to their team. FFT is available in six counties in the northern half of the state. FFT is primarily utilized to prevent removal of children from the home but may also be utilized to help reunify families when youth have been living in a foster care setting.

Functional Family Therapy, LLC, the proprietors of the FFT model, provides internal fidelity controls for the one existing FFT team in West Virginia. This is primarily accomplished through the required use of the Client Services System (CSS), which monitors therapist contacts with families, diagnosis, demographic information, and referral reasons. The CSS identifies primary and secondary reasons for referrals to the program. These range from youth delinquency behaviors to mental health and substance use problems. The chart below represents referral reasons for active cases in FFY18. The most common referral reason is parent/youth conflict in the home.



Families are more likely to voluntarily accept FFT services than be required to participate through a court order. Those who are mandated to participate in FFT do not typically see positive outcomes; the 12% of cases which were court ordered during FFY18 all experienced treatment failure.

Functional Family Therapy is most often successful when utilized as a voluntary prevention strategy to keep children and families from being separated due to abuse and neglect or juvenile justice involvement. Fifty percent of families who voluntarily participated in services completed the program, and of those none of the youth were placed outside of the home. This makes FFT ideal for youth who are at-risk of removal but can be diverted through the utilization of a well-supported service.

## Target Population for Functional Family Therapy

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will be implementing FFT for 11 to 18-year-old youth who experience behavioral or emotional problems that bring them into contact with the juvenile justice system and meet the criteria to be defined as a foster care candidate. These children will be assessed for eligibility through the completion of the FAST (Family Advocacy and Support Tool).

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment F.

## Phased-in Implementation for Functional Family Therapy

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to current providers for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include children who interface with the juvenile justice system and pregnant and/or parenting youth in foster care.

Expansion of FFT will require appropriation from the West Virginia Legislature and budget proposals will be drafted for the 2021 legislative session. Future phases will include onboarding new FFT providers and extending geographic coverage.

## Caseloads

The full-time FFT practitioner carries a caseload of 10-12 cases, depending on the acuity of the family. A part-time practitioner carries a caseload of 5-7 cases. All team supervisors must carry a caseload of 5-7 cases. The team supervisor monitors caseloads to ensure adherence to caseload standards. Functional Family Therapy, LLC also monitors caseloads as part of the fidelity monitoring process. Teams can be decertified by Functional Family Therapy, LLC at any time for failing to maintain the appropriate caseloads. If patterns and trends emerge for providers, Functional Family Therapy, LLC, contacts the contract oversight staff within DHHR's Bureau for Children and Families.

## Monitoring Child Safety

Functional Family Therapy program staff are considered mandated reporters, as per West Virginia Code §49-2-803. All FFT staff are trained on child abuse and neglect recognition and how to make a referral to the child abuse/neglect hotline. They are also trained on indicators of self-harm and

risks a youth may pose to family or community members. The therapists screen for child and community safety as part of the initial assessment process. If there are any concerns, more specialized assessments, such as those to determine suicide, homicide and/or self-harm, are conducted. An FFT therapist will implement a crisis plan for a family if needed.

## Outcome Measures – Well-Supported Services Evaluation Waiver

West Virginia is submitting an evaluation waiver request for FFT since it is rated as a well-supported service on the *Title IV-E Prevention Services Clearinghouse*. Participation in FFT requires that program fidelity be paramount to the process. Functional Family Therapy, LLC, has embedded quality into its services.

Functional Family Therapy, LLC's web-based Client Services System (CSS) is the primary tool used to monitor program fidelity. Clinicians are required to document cases using the CSS, which is designed to ensure that goals and interventions at each session are consistent with the family's phase of treatment and the FFT model. Supervisors and consultants review documentation in the CSS as one way to monitor therapists' adherence to the FFT model. Therapist alliance with family members, which is emphasized from the start of treatment and is critical to the model, is monitored by the Family Self Report (FSR) and Therapist Self Report (TSR), rating scales completed by the therapist and every family member after the first and second sessions. FSR and TSR scores help therapists identify when an alliance is not developing as it should.

In addition, specific adherence measures are collected in the CSS and monitored by the site supervisor and Functional Family Therapy, LLC, the consultant assigned to West Virginia. The supervisor or consultant rates each therapist weekly on several factors based on cases he/she discussed during supervision. At least three times per year these ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model. The Global Therapist Rating includes two scales: 1) Dissemination Adherence, which is the degree to which the therapist adheres to FFT protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, responsiveness to community partners, etc.; and 2) Fidelity, which considers both therapist competence (e.g., sophistication of interventions, tailoring treatment to the family) and adherence (e.g., applying the model as intended and doing the "right thing at the right time").

Cut-off scores indicate whether the therapist demonstrates satisfactory dissemination adherence and model fidelity, and each therapist has a Learning and Growth Plan to facilitate adherence and competence. (Alexander, et. al., 2013)

West Virginia currently only has one provider for FFT. In addition to the fidelity monitoring that Functional Family Therapy, LLC., conducts as detailed above, this provider has developed an outcomes data collection and monitoring process for FFT, among other services they provide. The outcome data process is provided with this plan as Attachment C.

West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and Families' *Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia*, the socially necessary services program will be transferred to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for FFT will be incorporated into the retrospective review process. These reviews are described in more detail below in *Quality Matters: Continuous Quality Improvement*.

## Motivational Interviewing – A Complement to West Virginia's Substance Use Disorder Strategies

As outlined, an extraordinarily high number of children are removed due to substance use disorders of their parents or guardians. State Opioid Response grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Ryan Brown Act (passed by the West Virginia Legislature in 2017) and DHHR's Bureau for Medicaid Services have provided West Virginia with significant funding opportunities related to substance use prevention and treatment. The Ryan Brown Act allowed DHHR to provide more than \$20.8 million in funding to nine substance use disorder programs to expand residential treatment services across West Virginia. This funding is supported by the Ryan Brown Addiction Prevention and Recovery Fund as part of a comprehensive statewide plan to combat the opioid epidemic.

Motivational Interviewing will be an important complementary service due to its ability to enhance client motivation for behavior change. Motivational Interviewing will be utilized by the providers who deliver prevention services, as well as BCF staff. A more detailed plan for West Virginia's intentions for using Motivational Interviewing will be provided in a prevention plan modification, once its presence on the *Title IV-E Prevention Services Clearinghouse* has been established.

## Trauma-Informed Delivery of Prevention Services

The organizations providing Title IV-E evidence-based services will be required to contractually attest to their adherence to a trauma-informed organizational structure. The MCO will incorporate

measures into the retrospective review process to determine the organizations understanding and ability to recognize and respond to the effects of all types of trauma. The evidence that the MCO will require is as follows:

- Sufficient workforce development in understanding trauma and staff support in sustaining trauma-informed treatment;
- Residents and their families are part of care planning and decision-making;
- Use of data as a driving force with quality improvement; and
- Systemic reviews conducted within the organization.

## Title IV-E Claiming-Prevention Services

In order to provide direction to the BCF's IV-E specialists, the IV-E unit program managers developed a new policy specific to Title IV-E claiming. This policy was submitted to the Administration for Children and Families as part of the Title IV-E state plan amendment. Attachment D provides further details related to Title IV-E claiming. Section 6.3 of Attachment D provides a detailed guide of components that are required for Title IV-E claiming for foster care candidates.

## **Child Welfare Workforce Training and Support: Worker Readiness Initiatives for FFPSA and Prevention Planning**

One of the most important components of West Virginia's Prevention Plan will be to ensure that the public and private child welfare workforce is well-trained and prepared to implement the provisions of the FFPSA. The child welfare workforce must be proficient in conducting strengths-based, trauma-informed assessments; connecting families to appropriate and timely services; and overseeing and evaluating the continuing appropriateness of services for the families. They must be able to recognize, understand, and respond to the effects of trauma using the principles of a trauma-informed approach to address the consequences of past trauma, and must understand why and how evidence-based practices will be used to prevent children from being removed from their families and to improve outcomes for children and families.

To ensure that the child welfare workforce is ready to implement the provisions of FFPSA, initial training and technical assistance will be focused on conducting high quality, strengths-based assessments; identifying goals and objectives for the family; and monitoring and evaluating the families' progress toward meeting their goals with an emphasis on working with foster care candidates and in-home cases. In September 2018, an existing workgroup was repurposed to develop a plan to integrate the new prevention planning/foster care candidacy requirements into policy, training and case work practice. The workgroup members represented multiple programs within DHHR's Bureau for

Children and Families. Part of the scope of work included defining foster care candidacy for West Virginia, streamlining some of the safety planning requirements and policies, developing a total-family assessment process for youth services and incorporating a prevention planning process for both Child Protective Services (CPS) and Youth Services. The new tools that were developed were piloted from February through May 2019 with Youth Services workers from four districts across the state. The response to the new policies and tools was favorable, with several staff requesting to continue using the tools post-pilot. A great deal of emphasis has been placed, both in training and in policy, on the importance of case planning for foster care candidates.

In August 2019, new policies, tools and training were released that focus more on prevention planning and in-home service provision. The first round of changes will be for Youth Services workers on changes to the Youth Services model. These changes include a new assessment tool, the Family Advocacy and Support Tool (FAST), which will take replace the Child and Adolescent Needs and Strengths (CANS) as the initial assessment and ongoing assessment for all Youth Services cases. The training and tools will also provide skill-building opportunities for Youth Services workers on identifying casework goals and objectives. In November and December 2019, the focus will shift to CPS, concentrating on completion of the revised family assessment tool along with identifying casework goals and objectives emphasizing the provision of in-home prevention services and keeping children from entering the system. After the initial training, staff from Marshall University will provide ongoing technical assistance for Youth Services workers and supervisors in their local offices with a monthly regional training for skills development in each region that will include evaluating the continuing appropriateness of services.

FFPSA training will also focus on recognizing and responding to the effects of trauma using the principles of a trauma-informed approach. The principles of a trauma-informed approach are already infused into new worker and foster parent pre-service training, and both new CPS and Youth Services workers and foster parents must take nine additional hours of trauma training in the first year of employment or first year as a foster parent. Trauma training will be provided to tenured staff through a variety of methods including providing trauma content in all scheduled regional and statewide training sessions and meetings for CPS and Youth Services workers, supervisors, and managers; releasing short video clips and online trainings on trauma; providing training outlines for supervisors to use at unit meetings with their staff; and implementing an online library of readily available content that can be accessed and used whenever a caseworker needs additional information on trauma or other FFPSA provisions. The Bureau for Children and Families is exploring ways to ensure that providers and staff have the same opportunities for ongoing training on trauma-informed care through joint training opportunities and yearly requirements for both public and private providers. The Bureau for Children and Families is also working with colleges and universities in West Virginia to ensure that their degree programs are geared towards a trauma-informed approaches and other FFPSA principles, and that

information on trauma and other FFPSA provisions is included in foster parent training so that foster parents are knowledgeable and informed.

As the provisions of FFPSA are implemented, training will also be provided so that staff and providers have the knowledge and skills necessary to access and deliver evidence-based services to children and families. Staff will be trained to ensure they understand the components of evidence-based services and the specific requirements of those services as they are used in West Virginia so that they can make appropriate referrals and understand how to monitor and evaluate the services that families receive. Targeted training/technical assistance teams will be deployed to local DHHR offices identified as struggling through data and quality assurance reviews completed by the Division of Planning and Quality Improvement. Ongoing training will be provided to DHHR staff through web-based and face-to-face trainings designed to educate staff on the evidence-based services along with the referral process to each service to ensure families have access. Providers will be required to be trained on specific evidence-based models selected for use by the state, and their contracts will require they are appropriately certified in the models they administer. Compliance with these requirements will be addressed through contract monitoring activities and other technical assistance and support.

## **Consultation and Coordination: Family First Isn't Being Implemented in a Bubble**

***“Committing to a broader continuum of prevention services that emphasizes primary prevention is contingent on a change of mindset and reorientation of what child welfare is intended to accomplish.”***

***- Jerry Milner, Associate Commissioner, Office of the Administration for Children and Families (ACF), U.S. Department of Health and Human Services***

ACF Associate Commissioner Jerry Milner honored West Virginia by addressing some of the state's most influential leaders on December 11, 2018, during a meeting hosted by Casey Family Programs. During his presentation, Mr. Milner urged West Virginia to remember that FFPSA will be a helpful first step in re-visioning child welfare but must be viewed as only one of many tools that states will need. Funding allowances under FFPSA are revolutionary, but additional supports and funding streams will be necessary to affect real change.

The timing of the FFPSA comes when West Virginia was already deeply engaged in several initiatives to reform its child welfare system and sustain the advancements brought about by the Title

IV-E waiver, Safe at Home West Virginia. FFPSA is a much-needed bridge for families who may not qualify for other support sources.

## The Children with Serious Emotional Disorders Medicaid Waiver

The sustainability planning for West Virginia's Title IV-E waiver project, Safe at Home West Virginia, has been an on-going project and efforts are underway to fund expansion of the project. While the FFPSA funding will help support important service provision, immediate federal funding for Safe at Home West Virginia cannot be anticipated due to the selection of initial services to be reviewed for the clearinghouse.

In April 2019, DHHR's Bureau for Medical Services, the agency that manages the state's Medicaid program, applied for a 1915 (c) waiver. The Children with Serious Emotional Disorders Waiver (CSEDW) is part of DHHR's child welfare reform effort and will provide an array of services that enable children who would otherwise require institutionalization to remain in their homes and communities. The services to be offered under the waiver were chosen due to their compatibility with a wraparound approach:

- Case Management
- In-Home Family Therapy
- Independent Living/Skill Building
- Job Development
- Respite Care, In-Home
- Supported Employment
- Assistive Equipment
- Community Transition
- In-Home Family Support
- Mobile Response
- Non-Medical Transportation
- Peer Parent Support
- Respite Care, Out-of-Home
- Specialized Therapy

In order to truly embed and sustain the Safe at Home wraparound into West Virginia's service lexicon in a meaningful way, DHHR is developing a longer-term funding solution. In order to accomplish this, the wraparound service model, upon which Safe at Home was designed, needs to be placed on the *Title IV-E Prevention Services Clearinghouse*. Conversations are occurring between consultants from Casey Family Programs, Marshall University, BerryDunn (a national accounting and management

consulting firm), and the BCF leadership team related to engaging the provisions allowable under the *Transitional Payments for the Title IV-E Prevention and Family Services and Programs* program instructions memorandum, released on July 18, 2019.

## Managed Care for Foster and Post-Adoptive Children

West Virginia Code §9-5-27, effective January 1, 2020, requires that medical, pharmacy, dental and behavioral health services for foster children and children adopted through the state's child welfare agency be transferred to an MCO. Additionally, DHHR is incorporating socially necessary services into the MCO. Traditionally, medical and social needs of foster and adopted children have been managed by the case worker, in conjunction with the Multidisciplinary Team (MDT). This process has proven ineffective in ensuring the child receives wholistic care or preventing adoption dissolution. Often, the worker is unaware of medical histories, having to rely on family members to provide necessary information. The goal with an MCO is to engage the family and the case worker in service planning and provision, creating more efficiency and preventing delays in children receiving medical care. The role of the MCO will be to track down medical history and coordinate care to prevent duplication, creating greater opportunities for CPS and Youth Services workers and the MDT to receive complete information for planning purposes. The MCO will also be instrumental in developing services to assist in keeping families in the home when possible, as it will be financially beneficial to create a continuum of in-home, community-based care.

The MCO procurement process began in July 2019, with on-boarding of the MCO occurring during fall 2019. The MCO will be instrumental in partnering with the providers and DHHR in transforming the behavioral health and socially necessary systems and identifying service gaps to enhance West Virginia's service array. This organization will also be required to serve recipients of socially necessary services who are not in foster care. More information can be found in *Quality Matters-Continuous Quality Improvement*.

## Ensuring Child Safety-Children and Families are Served Safely in the Home

Over the past two years, a team of Bureau for Children and Families' subject matter experts have been working on a process to streamline and enhance efficiency of decision making and safety planning for Child Protective Services and Youth Services.

## Youth Services

The primary goal for youth services was to implement a decision-making model that assessed the family and not just the child. Traditionally, this population of youth have been served in somewhat of a vacuum. Services offered were often only directed toward the youth, isolating him/her from the family unit.

West Virginia's Family Advocacy and Support Tool (FAST) is a product developed in collaboration with Chapin Hall and the Praed Foundation. This tool will allow a Youth Services worker to better understand family dynamics that are impacting not only the youth's behaviors but also factors that influence the safety of the youth and community.

Safety and case planning for Youth Services will take on a much broader perspective, not focusing solely on the isolated behaviors that led the youth to the juvenile justice system. Having a full picture of the needs and strengths of the entire family will allow the worker to develop case plans that address behaviors and influences. Youth Services families will receive wholistic services geared to build upon each member's strengths and provide services to mitigate conditions that make children and communities unsafe.

FAST will also be instrumental in assisting Youth Services workers with monitoring outcomes, quickly identifying where a family may be losing ground. FAST and its plans will be revisited with the family every 90 days, at a minimum, to track a family's success. However, re-visitation of a safety plan will be done at any time there is an indication of crisis. Youth Services workers began the process for utilizing FAST on September 13, 2019.

There is a formal safety plan for families accessing the Youth Services system. This plan's purpose is to neutralize identified safety threats using safety resources such as service providers and extended family. This concept will allow Youth Services workers and other stakeholders to reframe how they have historically served youth. It is important for Youth Services workers to understand that many youth who commit status offenses, and other low-risk crimes, achieve better outcomes if served at home. The Youth Services worker will evaluate for safety during each home visit. At any time the youth is unsafe, the Youth Services worker will understand the next course of action to take.

A new case plan was developed to support the information that would be gathered with FAST. Prior Youth Services assessment models focused only on the functioning of the young person who committed the status or criminal offense; there was minimal insight into the family dynamic that may be contributing to the unsafe behaviors of the youth. FAST allows the worker to assess each family member individually and as part of the family until to determine service needs to reduce risk of harm to the youth

and/or his community. The Youth Services policy has also been updated to create more guidance to staff about the importance of family engagement.

The new Youth Services policy has been provided with this plan as Attachment E.

## Child Protective Services

Modifications to the Child Protective Services (CPS) process are being developed to reduce duplicative activities and to enhance a family's participation. Instead of assessments occurring at specific points in time, CPS workers will engage families through ongoing assessment. This is an interactive process intended to build partnerships with a child's caregivers. It involves the family identifying what must change and agreeing on strategies to make those changes. A key component of child safety is understanding a family's protective factors and using them to control safety so services can happen in the home. CPS workers are currently required to assess for safety during every contact with the family. The policy guides staff through the casework process, helping to ensure that safety is of paramount concern from the beginning of contacts with the family until the case is closed.

The revised version of Child Protective Services policy will also contain enhanced safety and protection planning components for in-home, non-custody cases, which includes a formal process fostering more communication between CPS workers when case transfers occur to bring the gap between the CPS workers who conduct initial assessments and those who carry cases that have been opened for on-going services. This case transfer process is vital to ensure that families receive prompt delivery of services so that children remain safe. The revised policy will be completed and released to CPS workers in late December 2019.

## Prevention Caseloads

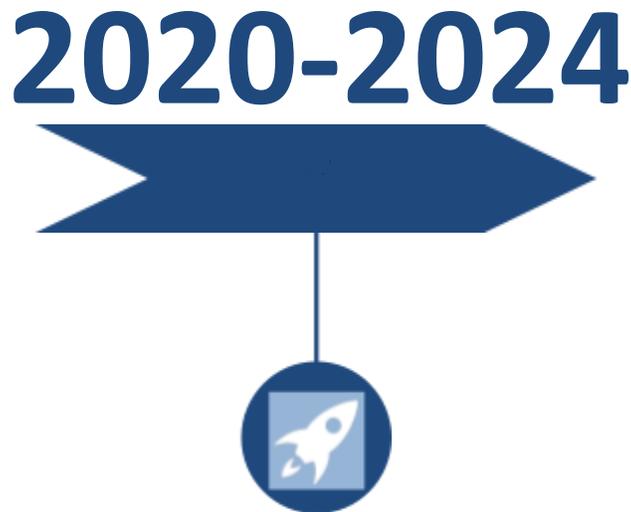
Youth Services workers carry a mixed caseload of both prevention and court-involved families. The prevention cases are comprised of youth (and their families) who are working with the child welfare agency to remediate the issues that resulted in the youth committing a status or juvenile delinquency offense. These youth may have court oversight and receive Title IV-E prevention services to divert the need for placement or have been in a court-ordered placement and are returning home. The targeted mixed caseload for Youth Services workers is 1:12.

The Bureau for Children and Families uses a caseload ratio calculation when allocating Youth Services worker positions to the district offices. When one district's caseloads tip over the caseload

standard, they become eligible for position allocations when vacancies arise in counties that do not have critical caseload overages.

Child Protective Services caseloads are separated into initial assessments/investigations and on-going services. The on-going caseload is a mix between prevention and court-involved families. The prevention cases will be comprised of children who have come to the attention of the child welfare agency through an abuse/neglect referral and who have been identified as unsafe and at imminent risk of removal; children who are returning home from a court-ordered placement; and children who were adopted through the child welfare system and are experiencing risk to the stability of the adoptive relationship. The targeted in-home caseload for CPS workers is 1:10.

The Bureau for Children and Families uses a caseload ratio calculation when allocating Child Protective Services worker positions to the district offices. When one district's caseloads tip over the caseload standard, they become eligible for position allocations when vacancies arise in counties that do not have critical caseload overages.



## **Maintenance of Effort**

In August 2019, Casey Family Programs sponsored a two-day collaborative session with Dennis Blazey, an independent contractor who provides financial consultation to state child welfare agencies as part of the technical assistance services offered by Casey Family Programs. Mr. Blazey provided consultation on key policy and finance projects related to FFPSA and other social services initiatives. The consultation services helped West Virginia determine the maintenance of effort calculation, which is zero. These calculations are detailed in Attachment IV.

## Quality Matters – Continuous Quality Improvement

West Virginia has partnered with an administrative services organization since 2004 to provide continuous quality monitoring and improvement strategies for West Virginia’s socially necessary services program. West Virginia’s new MCO will be contractually required to perform administration services organization management services not only for all medical and dental services but also for all socially necessary services for foster children, post-adoptive children and foster care candidates beginning January 1, 2020. The Title IV-E prevention services that West Virginia will be providing will be embedded into the current utilization management structure as all other socially necessary services. Contracts outlining performance requirements for providers of socially necessary services were implemented in July 2018, which require providers to achieve a score of 80% or higher during retrospective quality assurance reviews.

The “80% Rule,” which has been in effect since 2015, requires that socially necessary services providers score at least 80% during their retrospective on-site review. The retrospective review is conducted by the ASO at least every 12 months. If the provider scores less than 80% on any service they provide, the provider receives written notice that a six-month probationary period is in effect. Training and technical assistance is offered during the probationary period. After the six-month probationary period ends, the administrative services organization conducts another on-site review on the service(s) scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider’s service offerings 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 array of services. There will not be a six-month probationary period when a safety service scores zero.

The Bureau for Children and Families currently determines qualitative data and customer satisfaction for socially necessary services through client focus groups. These focus groups are conducted with recipients of all services offered through the socially necessary services program. The results from the focus groups are shared with Bureau for Children and Families managers and the socially necessary services providers for improvements to be made to services. These focus groups will continue with the new MCO, as part of their continuous quality improvement processes.

## Additional Outcomes Monitoring

An important provision of the MCO contract will be the enhanced outcomes monitoring of socially necessary services for all foster care candidates. DHHR will use the established outcome

measures that have been demonstrated by research and have been embedded into each evidence-based service. The outcomes developed for West Virginia with Functional Family Therapy, LLC, will continue to be used as outlined in Attachment C.

DHHR's Bureau for Children and Families will partner with DHHR's OMCFH to utilize the established federal outcome measures for the two in-home visitation programs through MIECHV, as mentioned above and outlined in Attachment A.

## **Prevention Program Reporting**

The Bureau for Children and Families has developed a new statement of work with Optum, the organization under contract for development of WV PATH, a comprehensive child welfare information system (CCWIS) to add the FFPSA minimum data/reporting requirements into FACTS, West Virginia's SACWIS. The first round of data is due to the Administration for Children and Families in 2021. The release date for this provision was October 1, 2019. These data sets are also being imbedded into WV PATH which will replace DHHR's FACTS in 2021. The minimum data requirements are:

- The specific prevention services provided to the child and family;
- The total expenditures for each of the services provided to the child and/or family;
- The duration of the services provided;
- If the child was identified in the prevention plan as a child who is a candidate for foster care:
  - The child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a child who is a candidate for foster care in a prevention plan; and
  - Whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period; and
  - Basic demographic information (e.g. age, sex, race/Hispanic Latino ethnicity).

*See Attachment I: State Title IV-E Prevention Program Reporting Assurance*

## **Workforce Support: Now and Into the Future**

### **Technical Assistance: Casey Family Programs**

During West Virginia's planning for the reforms to its child welfare system, it became evident that the impact on Child Protective Services and Youth Services staff could be devastating if the supervisors were not prepared for the implementation of these initiatives. Casey Family Programs has

been instrumental in responding to the technical assistance needs that have created barriers in West Virginia for many years. For that reason, BCF's Commissioner Linda Watts reached out to Casey Family Programs to help determine the best approaches to prevent chaos in the field during the roll-out of changes.

One of the first initiatives was supervisory skill-building workshops to front-line supervisors to strengthen their understanding of the importance of case planning and meaningful supervisor/worker interactions. Reflective supervision skills were taught to all front-line supervisors over several multi-day workshops beginning in late 2018 and lasting through summer 2019. Casey Family Programs brought Sue Badeau, a national child welfare speaker and author, to West Virginia for each workshop. Ms. Badeau has targeted specific counties that experience crisis-level turnover rates for additional supports for their supervisory staff that will continue over the next year.

Casey Family Programs also sponsored two day-long workshops to assist the financial planning efforts as West Virginia plans for evidence-based practice spending, exits the Title IV-E waiver and transitions back to traditional IV-E claiming. These workshops helped key leaders within the Bureau for Children and Families develop tools and theories to assist with budget planning.

Casey Family Programs will continue to provide access to national experts on topics such as front-line worker support, evidence-based programming, IV-E claiming, asset allocation and other topics as they are identified.

## Court and Stakeholder Education: Child Welfare Partners with the Court Improvement Project

As part of DHHR's partnership with the Supreme Court of Appeals, which holds West Virginia's court improvement program (CIP) grants, there have been multiple, targeted engagement activities related to FFPSA in place since summer 2018. These activities included community engagement forums and trainings across the state for a broad child welfare audience, as well as targeted judicial training on the provisions of FFPSA for the state's circuit court judges. The training collaboration included a more intense workshop in September 2019 for recently elected as well as tenured judges that utilized case scenarios. Participants were led step-by-step through the prevention services and explored how the new non-family placement options could be used as a complement to community-based treatment.

One of the paradigm shifts West Virginia will need to make is only utilizing congregate care to meet specific treatment needs or short-term homelessness. CIP cross-training sessions for spring 2020 are currently being planned, and there will be presentations on FFPSA and the CSED Waiver. These

presentations will be delivered in conjunction with the new MCO to help participants learn how the MCO will be utilized to support the expansion of community-based services in West Virginia.

The intent over the next five years is to provide opportunities for circuit court judge engagement at their bi-annual conferences and statewide child welfare trainings about FFPSA prevention services and how they support the ongoing child welfare reforms. CIP and DHHR are also in the beginning stages of planning a judicial workshop for March 2020, with support from Casey Family Programs, that will utilize national judicial experts to further engage the judicial community. The hope is that utilizing external credible sources, especially those viewed as peers, will go a long way in assisting West Virginia meet its goals.

## **Looking Ahead-Increasing Evidence-Based Programming in WV**

In realizing the vision to develop a proactive system which preserves safe and healthy families, West Virginia is committed to showing meaningful and measurable improvement in increasing its reliance on in-home community-based services and reducing its usage of out-of-home care, especially congregate care. The expected goal is to meet national standards for congregate care usage by mid-2024.

The five-year prevention plan will be a dynamic, ever-evolving document. West Virginia anticipates making regular amendments which will occur as future waves of evidence-based programs are added to the *Title IV-E Prevention Services Clearinghouse*. West Virginia will embrace services that meet target population needs as they become available instead of waiting for annual progress and services report to make changes. High-quality, in-home programming will enable West Virginia to experience sustained improvement in its child welfare system to benefit the state's families and children.

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