



West Virginia 2022 Annual Progress and Services Review



*350 Capitol Street, Room 730
Charleston, WV 25301*

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State Agency Administering Programs

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, medical services, children’s health insurance, drug control policy, inspector general, health care authority 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 Linda Watts.

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 & Resource Development; the Office of Field Operations; Office of Planning; Research and Evaluation; Office of Operations/Safe at Home; and the Office of Field Support. Oversight of each office is by a Deputy Commissioner or Director who reports to the Commissioner of the Bureau, who, in turn, reports to the Cabinet Secretary of the Department. In addition, the Division of Training Director reports to the Commissioner, and 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.

Office of Programs

The Office of Programs and Resource Development, under the direction of Deputy Commissioner Janie Cole, 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

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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.

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 position serves as 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/>.

In addition, this office is responsible for the Division of Family Assistance, the Division of Early Care and Education.

The Division of Training 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. This Division reports directly to the Commissioner.

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The Office of Operations

The Deputy Commissioner of Operations, Amy Hymes, is responsible for oversight of West Virginia's Child Welfare Demonstration Project, Safe at Home as well as monitoring out of state placements.

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The Division of Grants and Contracts; the Division of Finance; the Division of Personnel and Procurement report to the Chief Financial Officer, James Weekley. 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.

Office of Planning, Research and Evaluation

The Office of Planning, Research and Evaluation, under the direction of Assistant Commissioner Kevin Henson, has the responsibility for major activities of the Child and Family services review (CFSR) and the Program Improvement Plan (PIP); Child Welfare Oversight and the statewide continuous quality improvement program; including conducting case reviews, as well as social service program review and peer reviews; assisting district offices in developing corrective action and program improvement plans and internal critical incident review. These activities reside in the Division of Planning and Quality Improvement (DPQI) under the direction of Jane McCallister. DPQI is also responsible for the management evaluation review of the SNAP program and TANF Quality Improvement review and corrective action.

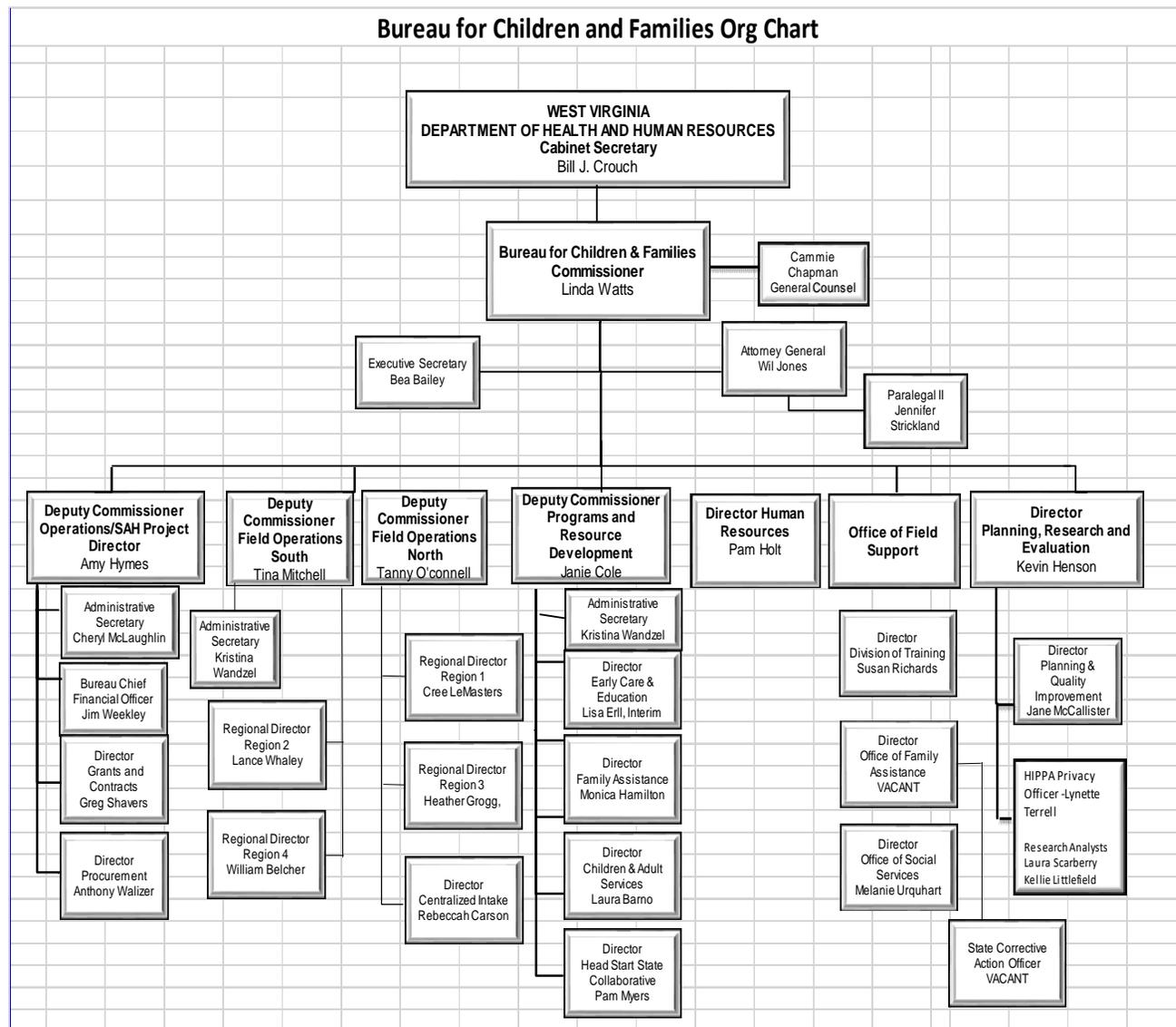
The Office of Field Operations

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, and Tanagra 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.

Field Operations' charge is the direct service delivery of all services within the Bureau, as well as Customer Services. There are two additional directors, one for Family Assistance Programs and one for Social Services Programs, that assist with supervision and direction for field staff.

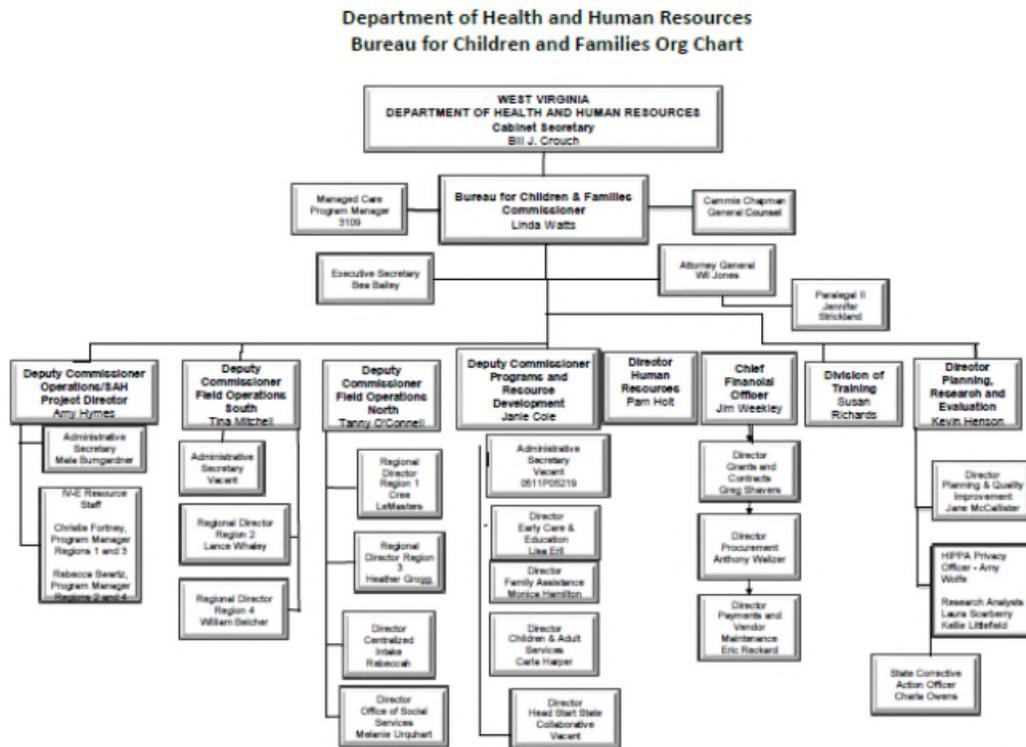
West Virginia is divided into four regions. Each region is supervised by a Regional Director (RD) who reports directly to the Deputy Commissioner. Various counties are grouped to create districts. If a county is large enough, it is considered its own District. Various districts are grouped into regions. 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.

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Update 2021:

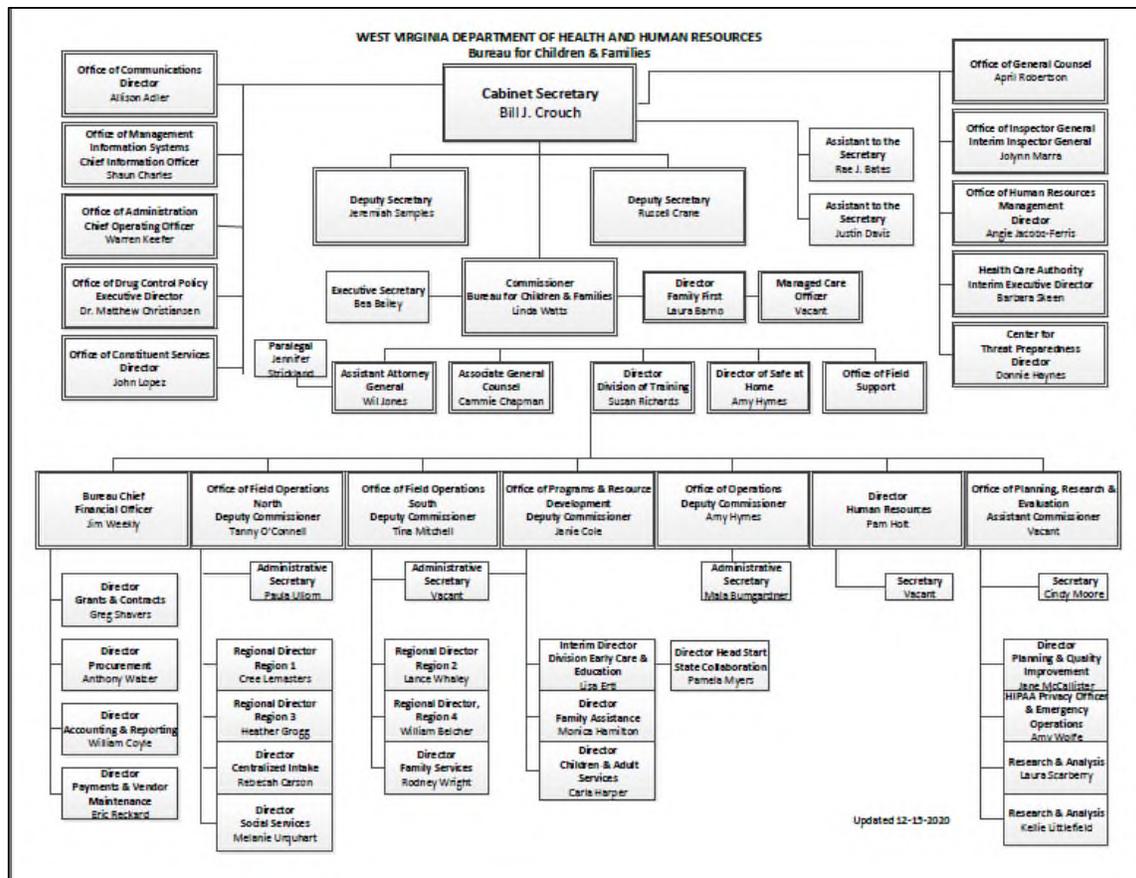
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10/25/2019

Update 2022:

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Update on Collaboration and Vision

West Virginia is a small rural state who is known to have a highly collaborative child welfare system, with multiple partnerships, but has struggled with the resources to provide services for children and families at the community level. The Family First Prevention Services Act (FFPSA) of 2019 has provided our state with the opportunity to implement model programs aimed at providing services to children and families in their homes and communities and to reduce the reliance on out of home care. Due to the state’s small size and lack of community-based resources the state has relied on out of home care and services that assist in the preservation and reunification of children and families. With the implementation of this legislation the door has been opened for the state to step-up its focus on community services and make use of its people who are willing to help others and for all its citizens to live their best lives possible.

The WV Department of Health and Human Resources shares a close relationship with several partnerships, which includes its Court Improvement Program and the state’s provider networks. Although these entities may not always agree, they have been able to come to a consensus on the importance of maintaining children and families together and providing services at the community level for those children and families who need the services. The Child Welfare System Reform, that includes sister Bureaus within the

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WV Department of Health and Human Resources, share their resources and a vision to develop a continuum of community based services.

There are many collaborative groups that have been in existence in the state for many years. These teams have designed and implemented initiatives to help accomplish goals outlined by the state and Congress. Many times, the collaborative groups utilize the same members, who provide a wealth of information to each group. Many of the members of these collaboratives participated in the CFSR and on many of the PIP groups. They received copies of the review and were involved in PIP discussions and planning sessions. It was apparent to all involved that West Virginia needs to focus on seeing families timely and developing case plans to address services needed by the families and youth who receive services from the Bureau for Children and Families.

During PIP discussions participants developed a root cause analysis which found WV rated 56% strength on meeting assigned time frames on accepted referrals. The data supports that caseworkers are much less likely to meet this time frame if the case is already open. Of the timeframes met, 73% were met on intakes on family's unknown to the agency versus 26% on referrals of already open cases. DPQI case review data indicates the measurement for CFSR Item 1 has steadily decreased over the last four FFYs. The FFY 2018 data indicates the agency is meeting the assigned timeframes for face-to-face contact with alleged child victims 50% of the time

The Department of Justice (DOJ) has also reviewed the states performance. They have found the state has an over-reliance on congregate care and has not provided services to prevent placement. Therefore, West Virginia has entered into an agreement with the DOJ to improve service delivery at a community level and reduce its number of children and youth placed in congregate care.

During the recent State Team Meeting in Washington, in late April 2019, members of The West Virginia Department of Health and Human Resources (WV DHHR), which includes both representatives from its Child Welfare System, as well as its Prevention Programs, and the Court Improvement Program (CIP), worked together to develop a vision statement for West Virginia that depicts the state's vision for the Child Welfare System for the next five years. This vision was shared and excepted by all the Bureau for Children and Families Leadership Team.

Although all agree that the state's vision must be much more proactive and preventative, the vision below is the team's realistic vision for where we envision the state in the next five years.

Vision Statement

West Virginia will develop a proactive system which preserves safe and healthy families.

Collaboration

The DHHR involves stakeholders from across the state and all child welfare systems. The diverse individuals representing the many facets of the system is a necessary step for meaningful improvement. Additionally, the DHHR obtain input from stakeholders 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 Court Improvement Program;
- Education of Children in Out of Home Care Advisory Committee; and
- Child Welfare Collaboration

Commission to Study Residential Placement of Children

The Commission to Study Residential Placement of Children tracks the goals and progress of the Commission's goals, the goals of the oversight groups and others. The progress is provided in the Annual Progress Report Advancing New Outcomes, Findings, Recommendations, and Actions. This report is provided to the Legislative Oversight Commission on Health and Human Resources Accountability, the Oversight Group members, and is available on the WV DHHR website at: http://www.wvdhhr.org/oos_comm/

The Commission's goal for the next five years is to be proactive rather than reactive when it comes to West Virginia's families. Rather than picking up the pieces when a family has been separated, the Commission would like the family to remain whole while fixing the issues with potential to pull them apart. Bringing together a diverse group of individuals representing the many facets of the system is a necessary step for meaningful improvement. The Commission carries out its work with strong collaborative participation from all of West Virginia's child and family serving systems. Open discussion, research and materials presented at quarterly meetings reflect the day-to-day experiences and voices of field staff members, families and youth from all areas.

The Commission works in collaboration with other projects/initiatives including Safe at Home West Virginia, Education of Children in Out-of-Home Care Advisory Committee, West Virginia Court Improvement Program and others to support its goals in the study of the residential placement of children.

Update 2021:

During 2019, the Commission examined the requirements established by W. Va. Code §49-2-125(d). In conjunction with responsibilities set forth by state code, the Commission continued to meet quarterly to discuss the following priority goals for 2019:

- *Transformational Collaborative Outcomes Management (TCOM)*
- *Provider input at Multidisciplinary Team (MDT) and court hearings*

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- *Implementation of Every Student Succeeds Act (ESSA) (focus on children in foster care)*
- *Transitioning youth aging out of foster care*

In addition to these goals, the 2019 quarterly Commission to Study Residential Placement for Children meetings continued to be a place for members and stakeholders to receive information and updates while making decisions and/or recommendations on pertinent information that affected the citizens of our State. The Commission continues to focus on sharing ideas and working to provide members and stakeholders with the most up-to-date information to improve the health and well-being of those we serve.

Update 2022:

The year 2020 presented the critical issue of a world-wide pandemic, the novel coronavirus disease (COVID-19). On January 21, 2020, the United States identified its first case of COVID-19, and on March 17, 2020, West Virginia's first case was diagnosed. Governor Jim Justice immediately responded by building a statewide team of experts to combat this deadly virus.

An initial "Stay-at-Home" executive order was issued in April, followed by a "Safer-at-Home" executive order issued in May; however, West Virginia's COVID-19 cases continued to rise. On July 6, 2020, Governor Justice issued an executive order establishing statewide indoor face covering requirements for all public places where social distancing could not be properly maintained. In December 2020, vaccines were approved for use in the United States, and West Virginia gained national recognition for its inoculation rate.

As in previous years, the opioid epidemic remains a critical issue affecting West Virginia, and drug overdoses have increased in the state throughout the COVID-19 pandemic. Although West Virginia faces a difficult road, the state's resiliency, resources, knowledge, and leadership will help residents succeed through these trying times.

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continues to focus on sharing ideas and working to provide members and stakeholders with the most up-to-date information to improve the health and well-being of those we serve.

Safe at Home, West Virginia

West Virginia's Title IV-E Waiver demonstration project, Safe at Home West Virginia, aims to provide wraparound behavioral health and social services to youth ages 12 to 17 years with specific identified behavioral health needs who are currently in congregate care or at risk of entering congregate care. The Title IV-E Waiver allows the existing level of funding to be refocused on wraparound community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

Safe at Home West Virginia seeks to increase permanency for all youth by reducing their time in foster care, increasing positive outcomes for youth and families in their homes and communities, and preventing child abuse and neglect and the re-entry of youth into foster care.

Update 2021:

Title IV-E Waiver demonstration projects ended September 2019. West Virginia remains committed to sustaining Safe at Home (SAH) West Virginia. West Virginia continues to provide wraparound services to youth ages 12 to 17 years with specific identified behavioral and mental health needs who are currently in congregate care or at risk of entering congregate care. SAH WV has also expanded utilization to children ages 9-11 that can successfully be returned to their home community from congregate care or a Bureau for Juvenile Services detention facility.

West Virginia's wraparound focuses on utilization of community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

Efforts within DHHR

Sister bureaus of the West Virginia Department of Health and Human Services, Bureau for Children and Families, Bureau for Behavioral Health and Bureau for Medical Services continue to collaborate efforts to provide a seamless wraparound to the children and families of West Virginia. Each bureau offers specialized wraparound programming to specific populations. The bureaus work to collaborate entry and programming for wraparound services through monthly meetings.

Collaboration with Lead Coordinating Agencies and Court Improvement Program

BCF began SAH redesign work in August 2019. Ongoing efforts are focused on redesign of the Waiver payment structure and model in order to sustain SAH WV, within the BCF budget, through the end of SFY2020; and, to adjust to operate within the SFY2021 budget allowance.

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In early 2020 an Accommodation Plan was developed for January 2020 through June 2020 utilizing the remaining SAH budget that resulted in a monthly rate payment to the ten Local Coordinating Agencies (LCAs). The Accommodation Plan incorporated LCA feedback and data, eased short-term financial pressure of LCAs, and kept BCF within the SFY20 budget requirements. This also allowed for further exploration and development of redesign for SFY 2021.

Currently WV SAH is partnering with the LCA providers and partners from WV Court Improvement Program to continue the work of redesign and sustainability. A Lead Coordinating Agencies Advisory Committee was formed in February to work with BCF and, project management contractor, Berry Dunn to develop recommendations for BCF to consider as we move forward. Initially these groups are meeting weekly through April 2020. They are expected to continue monthly through 2020.

- **SAH Transition**
 - *BCF's budget for the second half of SFY20 (January to June) is less than 35% of expenditures from July to December*
 - *January to June Accommodation Plan (SFY20)*
 - *Responsive to LCA feedback*
 - *Incorporates data from LCA budget workbook exercise*
 - *Leverages updated budget numbers*
 - *Eases short-term financial pressure on LCAs*
 - *Keeps BCF within SFY20 budget requirements*
 - *SFY21 SAH Transition Planning*
 - *BCFs strategic planning for SFY21 SAH Redesign is underway*
 - *Will adhere to the SFY21 budget authorized for SAH*
 - *This redesign will include new payment model and performance measures*
 - *Process will include collaboration with LCAs*
 - *Will meet with each LCA one-on-one*
 - *Convening of LCA Redesign Advisory Committee*

Partnership with Marshall University

BCF is currently working with Marshall University in work related to the CANS and FAST. SAH WV is exploring utilization of the services MU can provide in case review, fidelity monitoring, training, and TA. As this partnership develops in 2020 information will be updated.

Update 2022:

West Virginia remains committed to sustaining Safe at Home (SAH) West Virginia. West Virginia continues to provide wraparound services to youth ages 12 to 17 years who are currently in, or at risk of entering congregate care but has expanded to include children ages 9-11 who can successfully be returned to their home community from congregate care or a Bureau for Juvenile Services detention facility.

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West Virginia's wraparound focuses on utilization of community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

Efforts within DHHR

Sister bureaus of the West Virginia Department of Health and Human Resources, Bureau for Children and Families, Bureau for Behavioral Health and Bureau for Medical Services continue to collaborate efforts to fully develop and implement high-fidelity wraparound to serve children with complex high acuity needs identified through the agreement with Department of Justice. Although, Safe at Home will be carved out of the "no wrong door" approach to Children's Mental Health Wraparound, it will still work to ensure the same high-fidelity standards.

Collaboration with Lead Coordinating Agencies and Court Improvement Program

SAH WV continues to work regularly with the CIP to serve the children known to BCF through abuse and neglect and youth services court proceedings. SAH WV is utilized, when possible, with youth and families to prevent removals and to return children to their home and home communities from placements.

Partnership with Marshall University

BCF continues working with Marshall University related to the CANS and FAST. SAH WV is exploring utilization of the services MU can provide in case review, fidelity monitoring, training, and TA. As this partnership develops in 2022 information will be updated.

West Virginia Court Improvement Program

The West Virginia Court Improvement Program mission is to "advance practices, policies, and laws that improve the safety, timely permanency, and well-being of children and due process for families in child abuse/neglect and juvenile cases". To aid in that mission, the Bureau for Children and Families worked with the Court Improvement Board to enhance representation to parents and children.

Under West Virginia Code, the child welfare agency, parents, and children are represented by an attorney in child welfare proceedings. The Department of Health and Human Resources is represented by the county prosecuting attorney and the Attorney General's Office. Children and parents are represented by public defenders or private attorneys that are court-appointed and paid through Public Defender Services. The quality of the representation for all parties varies vastly. There is very little standardization of expectations of the attorney. West Virginia Code § 49-4-601(g) requires any attorney representing a party to receive a minimum of eight hours of continuing legal education training every two years on child abuse and neglect procedure and practice. Attorneys representing children must first complete training on representation of children that is approved by the administrative office of the Supreme Court of Appeals.

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West Virginia, in collaboration with the Prosecuting Attorneys' Institute, Public Defender Services, West Virginia State Bar, judges, Court Improvement Programs, and the administrative office of the Supreme Court of Appeals, will determine the level of training and qualifications that are required for attorneys representing the child welfare agency, parents, and children in child welfare proceedings. West Virginia will implement Standards of Practice for attorneys representing parties in child welfare proceedings to ensure that attorneys are competent in the relevant laws and litigation skills. Attorneys should be well versed in in-court advocacy, as well as out-of-court client counseling and advocacy to help clients navigate the child welfare system. Additionally, attorneys should receive training in relevant topics such as understanding substance use and recovery, trauma, available services to assist families, and disproportionality, disparity, and bias.

West Virginia will seek to draw down title IV-E funds to support and enhance legal representation for the child welfare agency, parents, and children. West Virginia will enter into memoranda of understanding with the appropriate legal agencies. These agreements will ensure that the child welfare agency is not involved in evaluating individual attorney performance or making decisions on individual attorney contracts for attorneys representing children or parents.

Update 2021:

West Virginia Court Improvement Program (WV CIP) accomplished the following in 2019:

- *Held three statewide cross training sessions with 546 participants total. Cross Training sessions provide up to date information on changes to the law and emphasizes emerging trends, topics, and best practices as well as provides instruction on topics related to ethics.*
- *Developed a new Stakeholder meeting that involved courts, local providers as well as DHHR staff to talk about issues pertaining to that area. These were held four times in 2019 with 302 participants total.*
- *Held a training in January 2019 for GALs that reached over 180 participants and have another planned in the late fall 2020.*

West Virginia Court Improvement Program will not be moving forward with seeking title IV-E funds to support and enhance legal representation for the child welfare agency, parents and children.

West Virginia DHHR has entered into preliminary discussion, regarding the Memoranda of Understanding, with Public Defender Services (PDS), a division of the Department of Administration, and the Court Improvement Program of the Supreme Court of Appeals of West Virginia. There is more work to be done before the memorandum can be finalized.

Update 2022:

Despite the reduction (inability to conduct) in-person committee meetings due to the COVID-19 pandemic, CIP staff continued to work on several projects designed to improve outcomes for children and families

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involved in child welfare proceedings. All projects are data driven, contain process and evaluation components, follow the continuous quality improvement cycle and are directly related to the CIP Strategic Plan. Completed work:

- *Received 1,022 survey responses for a project focused on MDTs and the quality of the subsequent hearings in abuse and neglect cases.*
- *Relaunched the New View Project in April 2020 as a judicial resource to examine cases wherein children may linger in state's custody. As of 3/1/21, and despite the pandemic, the project group reviewed 17 cases.*
- *Completed more than 150 surveys with youth who self-report running from out-of-home placements as part of a project to examine youth who run away. Interviews will continue through 2021.*
- *Continued work on the Juvenile Abuse and Neglect Information System (JANIS). This database houses court data on abuse and neglect cases. Released 16 updates to JANIS in 2020*

Community Outreach and education efforts looked differently due to the pandemic but continued during 2020. All trainings became virtual as of April 2020 and will continue to be virtual through 2021. 804 individuals received virtual training in 2020. A total of 13.4 free continuing education credits were provided during the year.

In response to HB 4092, The Division of Children and Juvenile Services re-organized training processes and requirements for GALs. CIP facilitated five webinars specifically targeted to Guardians ad Litem.

West Virginia DHHR has entered into a Memorandum of Understanding, with Public Defender Services (PDS), a division of the Department of Administration, and the Court Improvement Program of the Supreme Court of Appeals of West Virginia. DHHR has submitted an amended state plan. Once the state plan is approved, DHHR will begin requesting reimbursement. The parties are now working on a strategic plan.

West Virginia Regional Partnership Grants

West Virginia was awarded the Regional Partnership Grant (RPG) for Cabell, Wayne, and Lincoln Counties. RPG serves children that are involved with Child Protective Services due to substance abuse. The grant provides a wrap-around approach for the service delivery. The population served is ages 0-12. Marshall University, Prestera Center, and Children's Home Society have partnered with the Department of Health and Human Resources to provide these services. The referral for these services originates within the Bureau for Children and Families.

Update 2021:

During 2019, Prestera Center reports that the Regional Partnership Grant has served 171 adults and 149 children by providing these families with wraparound services that will assist them in overcoming their substance use disorder. The focus has been on providing the families with services that they will benefit from long after RPG services are removed from their home. The Program Director maintains office hours in each county's DHHR local office to staff current cases with CPS and Community Service Managers (CSM).

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The purpose of these meetings is to provide information, coordinate care, assure barriers to referrals are addressed, and discuss possible recruits for the program.

In calendar year 2020, the following goals for this program include the following:

- *Serve 200 children impacted by parental substance use and their families using wraparound processes resulting in improved well-being, safety, permanency for the child; recovery for the parent(s); and family strengthening.*
- *Establish improved processes and norms for confidential information sharing between all those involved in the family's plan.*
- *Establish practices for reunification services for children impacted by parental substance use and make recommendations for reunification services for West Virginia's children in out-of-home placements.*

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During 2021, Prester Center reports that the Regional Partnership Grant has served 208 adults and 179 children by providing these families with wraparound services that will assist them in overcoming their substance use disorder. The focus has been on providing the families with services that they will benefit from long after RPG services are removed from their home. The Program Director maintains office hours in each county's DHHR local office to staff current cases with CPS and Community Service Managers (CSM). The purpose of these meetings is to provide information, coordinate care, assure barriers to referrals are addressed, and discuss possible referrals for the program.

In calendar year 2021, the following goals for this program include the following:

- *Serve 200 children impacted by parental substance use and their families using wraparound processes resulting in improved well-being, safety, permanency for the child; recovery for the parent(s); and family strengthening.*
- *Establish improved processes and norms for confidential information sharing between all those involved in the family's plan.*
- *Establish practices for reunification services for children impacted by parental substance use and make recommendations for reunification services for West Virginia's children in out-of-home placements.*

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Education of Children in Out of Home Care Advisory Committee

The Education of Children in Out-of-Home Care Advisory Committee focused on the following major objectives during 2018: (1) Build a data sharing system between the West Virginia Department of Health and Human Resources and the West Virginia Department of Education to implement the provisions of the federal Every Student Succeeds Act, called ESSA, which requires the West Virginia Department of Education to annually report on the educational status and achievement of children in foster care; (2) Increase educational participation in multi-disciplinary teams; and (3) Monitor the educational programs of children placed out-of-state.

Update 2021:

During 2019, the Education of Children in Out-of-Home Care Advisory Committee the three focus areas remained key workgroup tasks. With the data exchange in place for West Virginia Department of Health and Human Resources to send data to the West Virginia Department of Education in compliance with Every Student Succeeds Act, called ESSA, the committee continued to work through development of the data use agreement for the bi-directional exchange of data with WVDHHR. With a desire to increase educational participation in multi-disciplinary teams, specific attention to requirements for notification to education and updatable tables of contact data from WVDE were included in the PATH system discussions. With the expansion of data provided to WVDE in the weekly file, out-of-state placements and exits are monitored to children and work to transition them back into community educational settings, as well as periodically inspect the out-of-state facilities. During 2019, the Department of Education began to match and analyze the data for school years 2017-18 and 2018-19.

For school years 2017-18 and 2018-19, the Department of Education matched 6,082 and 6,289 school records, respectively, for students in out-of-home care which were reported to the Department by the Department of Health and Human Resources. Of these records, 3,023 students were assessment eligible (included in grade levels in which students participate in the standardized testing program) in 2017-18 and 2,741 students were assessment eligible in 2018-19. A total of 369 assessment records were not found for students in 2017-18 and 193 were not found in 2018-19. Therefore, the total number of assessment records used in reporting the educational status and achievement information for children in out-of-home care for 2017-18 was 2,652 and for 2018-19, 2,616.

One of the objectives of the Education of Children in Out-of-Home Care Advisory Committee is to identify promising and best practices in education for children in out-of-home care. During 2019, the Advisory Committee endorsed an evidenced-based academic mentoring program for children who show warning signs of disengagement with school and who are at risk of dropping out. The program, based in Clay County, is called the Bridge and is operated by Mission West Virginia, Inc. Bridge serves students in Clay County schools, including children in foster care and uses a nationally validated program called Check & Connect, developed by the University of Minnesota. In Clay County, the results for the Bridge program in 2018-19 demonstrated a dramatic improvement in school behavior, academic performance, and promotion and graduation rates. The Advisory Committee plans to help disseminate information about the program and its effectiveness to other county school districts and stakeholders in 2020. Below is the

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updated information on the Bridge program. This information was erroneously reported in the Chaffe section in the CFSP. All updates regarding this program will now be located here.

April 2019 – December 2019

- *15 returning 2018-19 students and 19 new students*
- *33 of the 34 one on one students maintained or improving in academics*
- *April 1st-December 31st, 931 Connects with one on one students*
- *57 students had access to college campus visits in September and October 2020*
- *0 truancy with attendance*
- *4 students have had discipline (in school, out of school suspension or lunch detention)*

Partial year reporting is difficult due to typically reporting by school year. For the 2022 APSR the programs information will report the full 2019-2020 school year and continue to report by school year thereafter.

During 2020, the Education of Children in Out-of-Home Care Advisory Committee will continue to work on: (1) facilitating the implementation of the foster care provisions of the Every Student Succeeds Act (ESSA); (2) increasing educational participation in multi-disciplinary team meetings; (3) reporting on the educational status and achievement of children in out-of-home care; (4) improving and expanding transitional services; and, (5) identifying promising and best practices in the education of children in foster care.

Update 2022:

The Education of Children in Out-of-Home Care Advisory Committee continued its work on the following major objectives during 2020: (1) Increase educational participation in multi-disciplinary teams; (2) Monitor the educational programs of children placed out-of-state; (3) Identify promising and best practices with respect to the education of children in out-of-home care; and (4) Develop transition programs and services to assist out-of-home care students in returning to school, transitioning to work, or reunifying with their communities once they leave an institution or other out-of-home environment.

Under the Every Student Succeeds Act (ESSA), the West Virginia Department of Education is required to annually report on the educational status and achievements of children in foster care. However, due to the COVID-19 pandemic, the state testing program was cancelled for the 2019-20 and the 2020-21 school years. Therefore, the data normally reported in the Annual Report on the educational status and achievements of students in out-of-home care is unavailable.

During 2021, the Education of Children in Out-of-Home Care Advisory Committee will continue to work on: (1) Facilitating the implementation of the foster care provisions of the Every Student Succeeds Act (ESSA); (2) Increasing educational participation in multidisciplinary team meetings (MDTs); (3) Monitoring the education programs of children placed out-of-state; (4) Improving and expanding transitional services;

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and (5) Identifying and disseminating promising and best practices in the education of children in foster care.

Child Welfare Collaborative

The West Virginia Child Welfare Collaborative is an open and independent group of stakeholders, with meetings facilitated by WV DHHR for the purpose of sharing information, ideas, and feedback surrounding major child welfare reform initiatives throughout the state. Meetings are open to interested parties, and regular attendees include representatives of the Legislative, Judicial, and Executive branches of state government, foster and adoptive families, residential care providers, socially necessary service providers, educational institutions, social work organizations, advocacy organizations, law enforcement, and concerned citizens.

Child Welfare Community Collaboratives

In addition to these high-level collaborative groups, West Virginia has community collaboratives that combine several counties or districts together to review existing services and develop new services within the collaborative community. Members of these collaboratives include Family Resource Networks, DHHR Community Service Managers, local providers of community services as well as foster care services. These collaboratives meet routinely to identify gaps in services in their communities and their members take these service gaps to their Regional Summits. Regional Directors then relay the identified service gaps from the Regional Summits to Bureau for Children and Families Leadership.

Members of the Regional Summits as well as local collaboratives were involved in helping to develop the state's Program Improvement Plan. West Virginia received technical assistance from the Capacity Center for States to identify key issues that led to several areas needing improvement during the Child and Family Services Review. BCF staff as well as community stakeholders involved met numerous times to identify overarching themes that could be targeted to improve outcomes. From those meetings, goals were selected, and a PIP developed. Please see West Virginia's submitted PIP.

In the next five years, the state will improve its organization and operation of these community hubs. The expectation is that these community hubs will develop extensive resource directories through the Family Resource Networks and communities to front-line staff and families in need of assistance.

The increase of availability and accessibility and knowledge of existing services within communities will help provide wrap-around at a community level to prevent families coming to agencies attention. The goal is to develop a more family friendly, cohesive, community-based structure for the development and use of services. The Child Welfare System in West Virginia will concentrate on becoming more pro-active in its delivery of services. Department of Justice (DOJ) partnered with the West Virginia Department of Health and Human Resources in support of West Virginia's plan to expand statewide community-based services, such as, mobile crisis response, wrap-around services, in-home behavioral support services and Expanded School mental health services.

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The state is also exploring the use of Family Treatment Drug Courts and has selected a few counties in which to pilot this program. At this point, details have not been finalized. It will be based on the national model. For details please refer to <https://www.ndci.org/>

In addition to Family Treatment Drug Courts, West Virginia has been researching the Sobriety Treatment and Recovery Team (START) Model since 2016 and is again exploring the possibility of implementing this program in piloted areas. 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. For more information visit <https://www.zerotothree.org/resources/811-kentucky-sobriety-treatment-and-recovery-team-start-program-for-parents-involved-with-the-child-welfare-system>

Update 2021:

The Statement of Work for the Sobriety Treatment and Recovery Teams (START) project has been approved with an expected launch date of mid to late 2020. During 2020 Pretera center partnered with the Bureau for Children and Families and Kanawha County Child Protective Services (CPS) to implement the Sobriety Treatment and Recovery Teams (START). This pilot project is a new standard for addiction care, aimed at improving immediate and extended family unity and resiliency through wrap around substance use disorder (SUD) treatment. Participating families along with contracted social workers and family mentors will work together to develop specialized recovery plans. The goals of this project are to improve child safety, strengthen parenting skills, and increase the number of family members actively engaged in SUD treatment. Preliminary planning is underway to add an additional rural county to this pilot project.

Update 2022:

The Sobriety Treatment and Recovery Teams (START) project began with the Statement of Work (SOW) for implementation in Kanawha County, and has since expanded to include Putnam County in the pilot project. A new contract is in development to include Raleigh, Fayette, and Mercer Counties in the project. Fortunately, the implementation of START was not significantly impacted by COVID-19 and work was able to continue uninterrupted virtually. As part of the START project, a West Virginia Toolkit was developed in conjunction with The National START Training and Technical Assistance Program team and BCF staff. This toolkit outlines responsibilities and work guidelines as well as case work standards from the START model. Kanawha and Putnam counties have a START supervisor and caseworker hired and trained. The process for the Family Mentor to be hired for Kanawha and Putnam counties is currently underway. Once the family mentor is hired, they may begin taking cases for the program. An implementation date for Fayette, Raleigh, and Mercer counties has yet to be determined but is expected to occur before the end of 2021.

1. Update on Assessment of Performance

The most reliable data West Virginia has, to evaluate performance is the CFSR style reviews, Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS). West Virginia has a comprehensive quality assurance system in operation. The Department's QA system operates in all jurisdictions of the state and is part of an overall Continuous Quality Improvement (CQI) process. 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. The Division of Planning and Quality Improvement (DPQI) utilizes the case review process and standards set forth by the US Department of Health and Human Services administration for Children and Families. This process is used for the continuous measurement of the State's performance in the areas of safety, permanency, and well-being. (Refer to-Quality Assurance Systemic Factor Section)

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. Following the social service review exit with the district management team DPQI completes a comprehensive report on the results of the review. 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. DPQI compiles the exit summary data report 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.

The Child and Family Services Reviews (CFSRs) Onsite Review Instrument and Instructions (OSRI) is the only official instrument to be used in rating a case for CFSR determinations of substantial conformity. The OSRI contains the questions, applicability notes, instructions, and definitions, which provide more detailed information.

Child and Family Services Review Round 3

West Virginia began the round 3 Child and Family Services Review (CFSR) in January 2017 with the submission of the Statewide Assessment. The Administration for Children and Families (ACF) Children's Bureau approved the Department of Health and Human Resources Bureau for Children and Families (BCF) existing case review process, employing the federal onsite review instrument, for the purpose of the CFSR. The BCF Division of Planning and Quality Improvement (DPQI) staff reviewed 40 foster care cases and 25 in-home cases between April 2017 and September 2017; the Children's Bureau conducted secondary oversight of all 65 cases to ensure the accuracy of the ratings. Stakeholder interviews of BCF key partners were also completed by the Children's Bureau in April 2017; the results of those interviews, together with the stateside assessment, were used to determine substantial conformity of systemic factors rated by the CFSR (45 CFR 1355.34(c)).

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West Virginia's CFSR Final Report was received from the Children's Bureau in December 2017. West Virginia did not meet substantial conformity levels on the seven CFSR Outcomes and four of the seven CFSR Systemic Factors. West Virginia utilized the CFSR findings to begin a multi-faceted approach to gathering and analyzing information upon which to lay the foundation for systemic change within the child welfare system with the long-range goal of improving outcomes for WV children and families. The major factors impacting practice in West Virginia were identified through the review of the CFSR Final Report, through WV's CFSR style social service review data, data from the State's Statewide Automated Child Welfare Information System (SACWIS), the Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database, and consultation with external stakeholders. The cross-cutting barriers to higher outcome achievement identified include the inability to attract and retain qualified staff, failure to establish foster care resource homes at a rate sufficient to the rate of foster care entry, a lack of engagement with families to ensure child safety, identification of service needs, ensuring appropriate service provision, and the lack of services sufficient to address identified customer needs.

The PIP development process focused on addressing the underlying conditions that hold the highest potential to positively impact WV children and families while aligning with the current child welfare reform initiatives. The PIP addresses CFSR Items 1-6 and 12-15. (See WV Program Improvement Plan Pgs. 26-53) The WV Program Improvement Plan is not finalized and approved at this time, nonetheless the established goals are:

- Goal 1- Creating and supporting a Healthy Workforce
- Goal 2- Increase Family Support Services and Family Resource Homes to meet the needs of children and Families Community Support and Family Resources
- Goal 3- Transforming the culture of child welfare management to increase competency, skill and accountability of our child welfare practice
- Goal 4- Increase effectiveness and efficiency and create a prevention-focused organizational culture in order to ensure the needs of children and families are addressed throughout the life of the case. Various strategies to reach the goals are being developed.

The West Virginia CFSR Rd. 3 Measurement Plan was approved in 2018. West Virginia intends to use state generated data and information from its CQI process for PIP monitoring and measurement of performance. Measurement of systemic factors will be by completion of the key activities associated with each strategy associated with the factor. Measurement of CFSR items and associated outcomes will be measured by completion of social services case reviews completed by DPQI. West Virginia used state-conducted case review data from December 1, 2017 through November 30, 2018 to establish a baseline. This result was a review of twelve districts representing all four regions of the state. The baseline included the review of 125 cases separated as 65 placement and 60 in-home. The original reporting periods are listed in the chart below. Each reporting period data set will contain the same number of districts and at a minimum the same number of cases. West Virginia has been advised that although the PIP has not yet been approved the reporting period case review data can be used to show progress toward reaching PIP improvement goals.

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Measurement Period	Review Data Dates	Report Date
Baseline	December 1, 2017-November 30, 2018	December 2018
1 st Period	June 1, 2018-May 31, 2019 (125 cases, 60 in-home services, 65 foster care)	June 2019
2 nd Period	December 1, 2018-November 30, 2019	December 2019
3 rd Period	June 1, 2019-May 31, 2020	June 2020
4 th Period	December 1, 2019-November 30, 2020	December 2020
5 th Period	June 1, 2020-May 31, 2021	June 2021

Data gathered during the first reporting period of June 2018-May of 2019 indicate WV met the PIP goal established for CFSR Items 2, 6, 12, and 13.

Update 2021:

The WV Program Improvement Plan was approved by the Children’s Bureau, and the state provided notice of the same on 12/13/19. The WV PIP Implementation Period is 12/1/19-11/30/21. The established goals are:

- *Goal 1- Creating and supporting a healthy workforce (Safety Outcome 1, Safety Outcome 2, Permanency Outcome 1, Permanency Outcome 2, Well-Being outcome 1, Well-Being Outcome 2, Well-Being Outcome 3)*
- *Goal 2- Increase family support services and family resource homes to meet the needs of children and families through community support and family resources. (Safety Outcome 2, Permanency Outcome 1, Well-Being Outcome 2, Well-Being Outcome 3, Systemic Factors: Case Review, Notice to Caregivers, Array of Services, Individualizing Services, Diligent Recruitment of Foster and Adoptive Homes)*
- *Goal 3- Transforming the culture of child welfare management to increase competency, skill and accountability of our child welfare practice. (Safety Outcome 1, Safety Outcome 2, Permanency Outcome 1, Permanency Outcome 2, Well-Being Outcome 1, Systemic Factors: Statewide Information System, Case Review)*
- *Goal 4- Increase effectiveness and efficiency and create a prevention-focused organizational culture in order to ensure the needs of children and families are addressed throughout the life of the case. (Safety Outcome 1, Well-Being Outcome 1)*

The Federal Fiscal Year (FFY) 2019 social service case reviews were completed by the Division of Planning and Quality Improvement (DPQI). DPQI utilizes the January 2016 version of the Federal CFSR

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On-Site Review Instrument (OSRI) as the unit’s primary internal tool for evaluating the quality of services delivery to children and families. Case related information was entered into the Online Monitoring System (OMS) and reports generated from that system are used for evaluating continuous quality improvement efforts within BCF. Administrative data reports, information from stakeholders, and other data sources are also used to update the assessment of performance.

DPQI completed 129 CFSR style case reviews during the 2019 FFY. The FFY 2019 data is based upon the review of social services cases between October 1, 2018 to September 30, 2019. The review was comprised of 67 foster care and 62 in-home social service cases. DPQI staff conducted 684 interviews during FFY 2019. Of the interviews completed, 91 were with children, 151 were with parents, 57 were with foster parents, and 112 were judicial staff such as attorneys, guardian-ad-litem, juvenile probation officers, and Court Appointed Special Advocates, and the remainder were with other parties who may have information relative to the case review. Case reviews conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Barbour/Preston/Taylor, Lincoln/Boone, Nicholas/Webster, Mercer, Cabell, Logan, Hampshire/Mineral, Kanawha, Marshall/Wetzel/Tyler, Wayne, Harrison, and Raleigh.

Measurement Period	Review Data Dates	Report Date
<i>Baseline</i>	<i>December 1, 2017-November 30, 2018</i>	<i>December 2018</i>
<i>1st Period</i>	<i>June 1, 2018-May 31, 2019</i>	<i>Date of first PIP</i>
<i>2nd Period</i>	<i>December 1, 2018-November 30, 2019</i>	<i>Measurement Progress Report</i>
<i>3rd Period</i>	<i>June 1, 2019-May 31, 2020</i>	<i>June 2020</i>
<i>4th Period</i>	<i>December 1, 2019-November 30, 2020</i>	<i>December 2020</i>
<i>5th Period</i>	<i>June 1, 2020-May 31, 2021</i>	<i>June 2021</i>
<i>6th Period</i>	<i>December 1, 2020-November 30, 2021</i>	<i>December 2021</i>
<i>Non-Overlapping Period</i>	<i>December 1, 2021-March 31, 2023</i>	
<i>7th Period (Optional)</i>	<i>June 1, 2021-May 31, 2022</i>	<i>June 2022</i>
<i>8th Period (Optional)</i>	<i>December 1, 2021-November 30, 2022</i>	<i>December 2022</i>
<i>9th Period (Optional & Condensed)</i>	<i>June 2022-March 31, 2023</i>	<i>April 2023</i>

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Data related to Program Improvement Plan goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 1, 2020.

Update 2022:

The WV CFSR Rd. 3 Program Improvement Plan was approved by the Children's Bureau, and the state provided notice of the same on 12/13/19. The WV PIP Implementation Period is 12/1/19-11/30/21. The established goals are:

- *Goal 1- Creating and supporting a healthy workforce (Safety Outcome 1, Safety Outcome 2, Permanency Outcome 1, Permanency Outcome 2, Well-Being outcome 1, Well-Being Outcome 2, Well-Being Outcome 3)*
- *Goal 2- Increase family support services and family resource homes to meet the needs of children and families through community support and family resources. (Safety Outcome 2, Permanency Outcome 1, Well-Being Outcome 2, Well-Being Outcome 3, Systemic Factors: Case Review, Notice to Caregivers, Array of Services, Individualizing Services, Diligent Recruitment of Foster and Adoptive Homes)*
- *Goal 3- Transforming the culture of child welfare management to increase competency, skill and accountability of our child welfare practice. (Safety Outcome 1, Safety Outcome 2, Permanency Outcome 1, Permanency Outcome 2, Well-Being Outcome 1, Systemic Factors: Statewide Information System, Case Review)*
- *Goal 4- Increase effectiveness and efficiency and create a prevention-focused organizational culture in order to ensure the needs of children and families are addressed throughout the life of the case. (Safety Outcome 1, Well-Being Outcome 1)*

The Federal Fiscal Year (FFY) 2020 social service case reviews were completed by the Division of Planning and Quality Improvement (DPQI). 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 services delivery to children and families. Case related information was entered into the Online Monitoring System (OMS) and reports generated from that system are used for evaluating continuous quality improvement efforts within BCF. Administrative data reports, information from stakeholders, and other data sources are also used to update the assessment of performance.

DPQI completed 129 CFSR style case reviews during the 2020 FFY. The FFY 2020 data is based upon the review of social services cases between October 1, 2019 to September 30, 2020. The review was comprised of 67 foster care and 62 in-home social service cases. DPQI staff conducted 709 interviews during FFY 2020. Of the interviews completed, 88 were with children, 183 were with parents, 69 were with foster parents, and 119 were judicial staff such as attorneys, guardian-ad-litem, juvenile probation officers, and Court Appointed Special Advocates, and the remainder were with other parties who may have information relative to the case review. Case reviews conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. CFSR

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style case reviews were completed in each of the four regions of the state and included the following districts: Kanawha, Wyoming, McDowell, Mingo, Randolph/Tucker, Hardy/Grant/Pendleton, Lewis/Upshur/Braxton, Brooke/Hancock/Ohio, Calhoun/Gilmer/Wirt, Marion/Monongalia, Ritchie/Doddridge/Pleasants, and Berkeley/Jefferson/Morgan.

Measurement Period	Review Data Dates	Report Date
Baseline	December 1, 2017-November 30, 2018	December 2018
1 st Period	June 1, 2018-May 31, 2019	Date of first PIP
2 nd Period	December 1, 2018-November 30, 2019	Measurement Progress Report
3 rd Period	June 1, 2019-May 31, 2020	June 2020
4 th Period	December 1, 2019-November 30, 2020	December 2020
5 th Period	June 1, 2020-May 31, 2021	June 2021
6 th Period	December 1, 2020-November 30, 2021	December 2021
Non-Overlapping Period	December 1, 2021-March 31, 2023	
7 th Period (Optional)	June 1, 2021-May 31, 2022	June 2022
8 th Period (Optional)	December 1, 2021-November 30, 2022	December 2022
9 th Period (Optional & Condensed)	June 2022-March 31, 2023	April 2023

Data related to Program Improvement Plan goal achievement was reported out to the Children’s Bureau in electronically submitted reports in June and December of 2020. The next such data set will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report on June 1, 2021.

Safety

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

Timeliness of Initiating Investigations of Reports of Child Maltreatment (Item 1)

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Purpose of Assessment: To determine whether responses to all accepted child maltreatment reports received during the period under review were initiated, and face-to-face contact with the child(ren) made, within the time frames established by agency policies or state statutes.

Strength Rating Defined

- Timely face-to-face contact with children occurred on all investigations and/or assessments during the period under review (within state policy guidelines) AND
- All investigations and/or assessments during the period under review were initiated timely (within state policy guidelines).
- OR, if policy guidelines could not be met, it was due to circumstances beyond the control of the agency.

Concerted Efforts Required and/or Special Considerations in Rating

Circumstances beyond the control of the agency may include:

- Other agencies (such as law enforcement) causing delays
- Child/family not located despite documented efforts to locate them
- Lack of Community Resources

If the state has a policy that allows for exceptions to the face-to-face contact time frames when the child is in the hospital (or other specific circumstances), reviewers should rate the item based on the state's policy requirements.

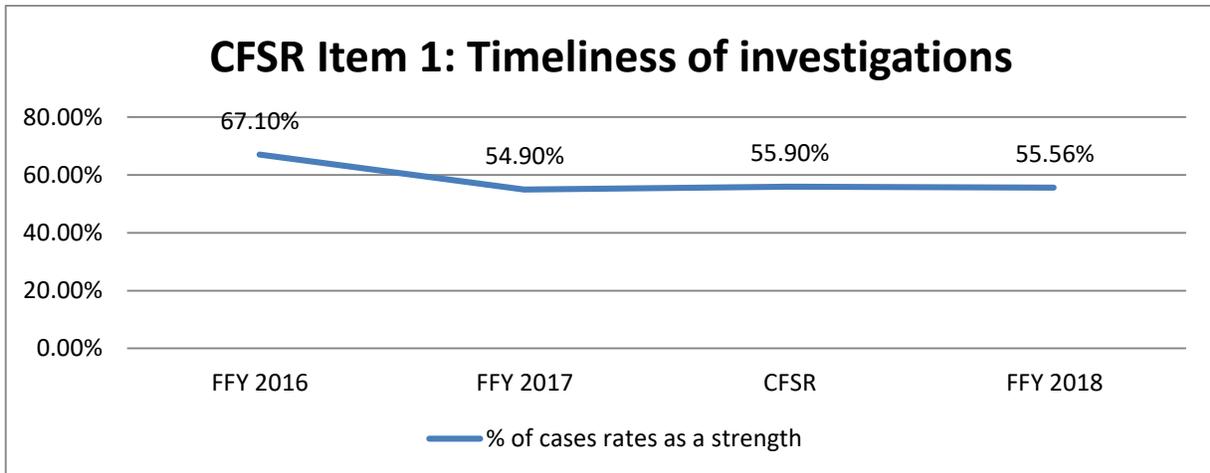
Goals and strategies to impact Safety Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 44-49, 51-53

DPQI Quality Assurance Case Review Data

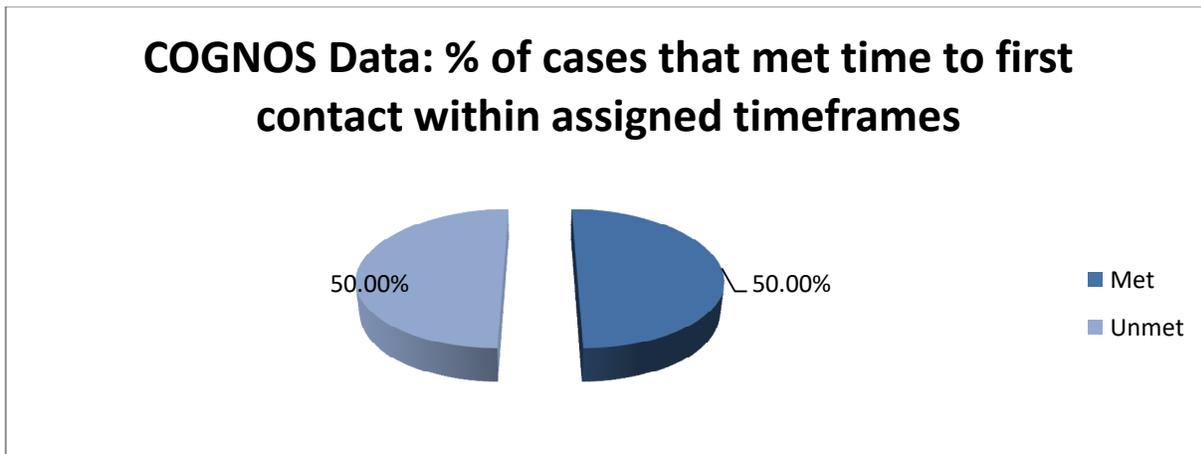
Baseline: 61.9%

PIP Goal: 69.7%

Reporting Period 6/2018-5/2019: 60.27%

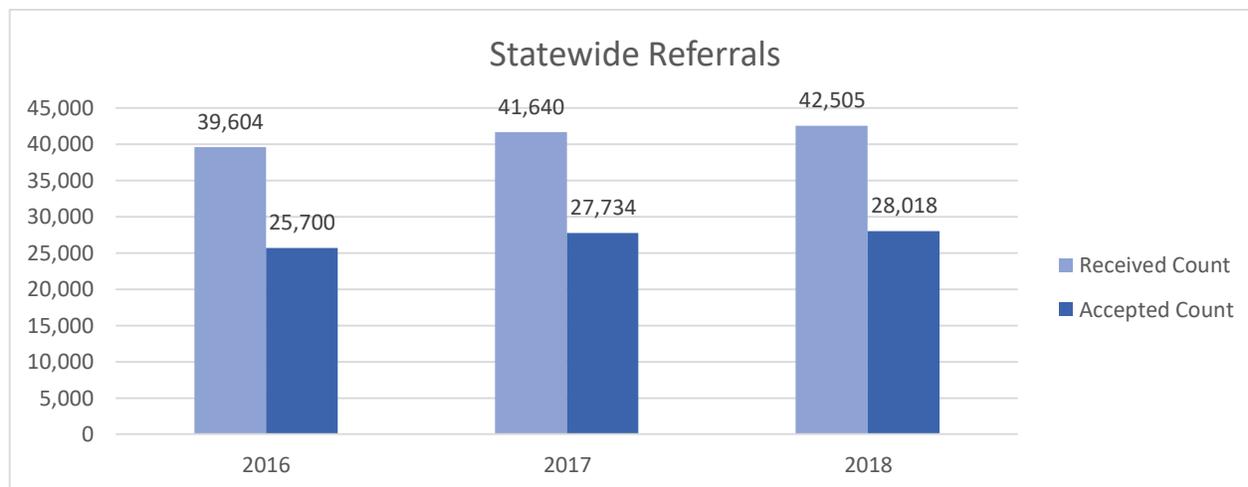


Source: DPQI Case Review Data



Source: COGNOS Time to First Contact Report FFY 2018

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Source: COGNOS Statewide Referrals Report Calendar Year 2018

The outcome rating for Safety 1 based on DPQI case reviews for federal fiscal year 2018 indicates safety outcome one was substantially achieved in 55.56% of the cases reviewed, and not achieved in 44.44% of the cases reviewed. FFY data is based on case reviews completed October 1, 2017 to September 30, 2018. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. The Child and Family Reviews Rd. 3 baseline indicated this measure as substantially achieved in 61.9% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 69.7%

COGNOS reports provide calendar year 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. The COGNOS Statewide Referrals report continually shows an increase in the number of child maltreatment reports received and assigned for further assessment.

West Virginia continues to perform substantially below the 95% compliance threshold. The state continues to utilize crisis teams to assist Districts experiencing a backlog in Family Functioning Assessments. The teams have been expanded to now include district level CPS staff who agree to work outside of their district for a brief period of time. These workers are given monetary incentives to assist in the FFA backlog reduction effort.

Further analysis is needed regarding the referral acceptance rate versus the substantiation rate of child maltreatment on new intakes. Therefore this issue is being addressed in the WV Program Improvement Plan through a threshold analysis conducted by the Capacity Center for States. This will examine the number of duplicate intakes on the same family/child accepted/assigned, percentage of intakes assigned versus maltreatment findings found, as well as other areas of the intake process to determine what corrective action is needed.

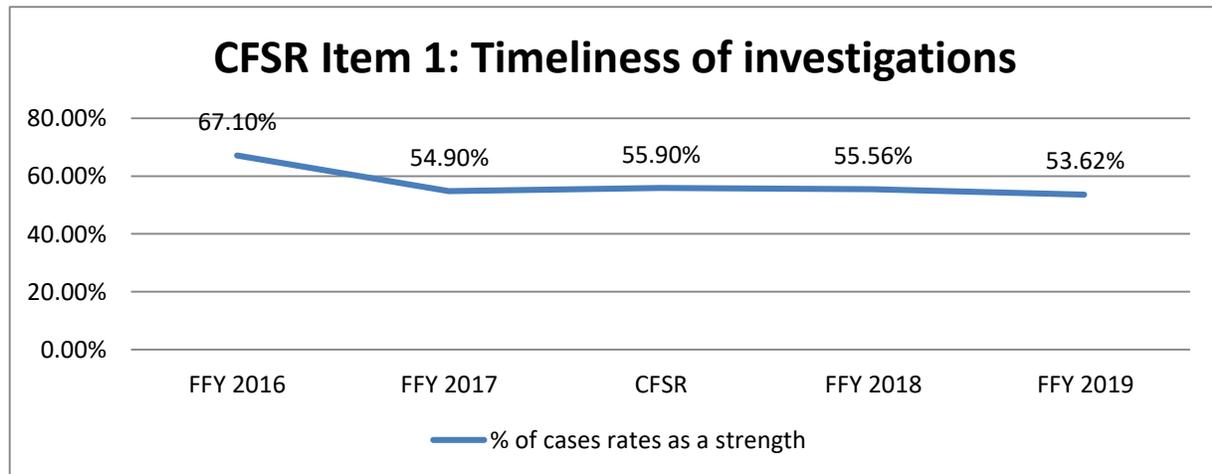
Update 2021:

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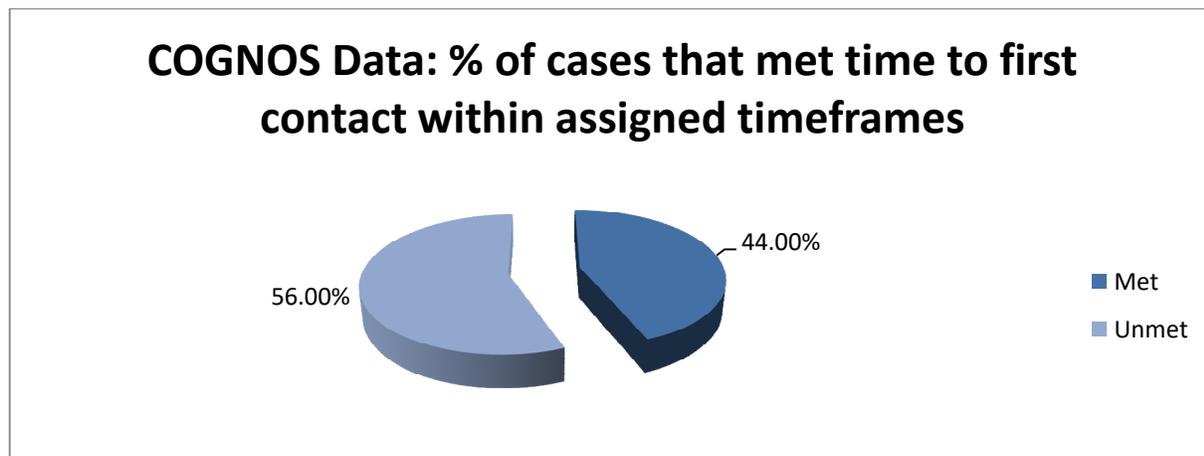
DPQI Quality Assurance Case Review Data

FFY 2018: 55.56%

FFY 2019: 53.62%

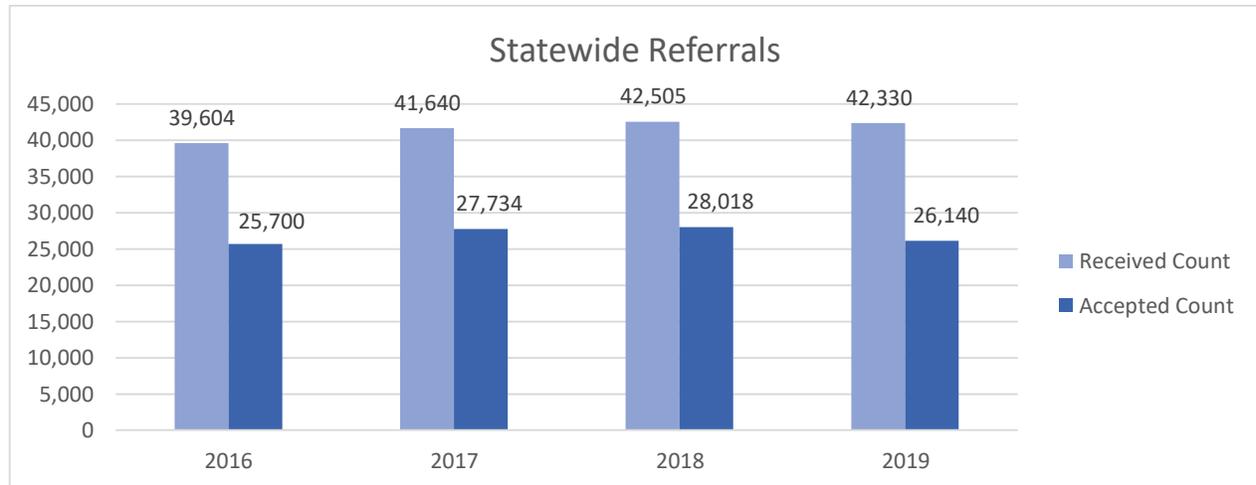


Source: DPQI Case Review Data



Source: COGNOS Time to First Contact Report FFY 2019

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Source: COGNOS Statewide Referrals Report Calendar Year 2019

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 9.5% or less.

CFSR Round 3 Data Profile February 2020

Observed Performance: FY16-17 is 3.5%

FY17-18 is 7.4%

Risk Standardized Performance: FY16-17 is 4.6%

FY17-18 is 9.4%

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 9.67 or less.

CFSR Round 3 Data Profile February 2020

Observed Performance: FY16 is 1.21

FY17 is 3.43

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Risk Standardized Performance: FY16 is 1.96

FY17 is 4.70

CFSR Outcome Safety 1 is comprised of one CFSR Item (Item 1). The outcome rating for Safety 1 based on DPQI case reviews for federal fiscal year 2019 indicates Safety Outcome 1 was substantially achieved in 53.62% of the cases reviewed, and not achieved in 46.38% of the cases reviewed. FFY data is based on case reviews completed October 1, 2018 to September 30, 2019. The outcome rating for Safety 1 based on DPQI case reviews for federal fiscal year 2018 indicates safety outcome one was substantially achieved in 55.56% of the cases reviewed, and not achieved in 44.44% of the cases reviewed. FFY data is based on case reviews completed October 1, 2017 to September 30, 2018. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

COGNOS reports provide calendar year data regarding the time to first contact. The Time to First Contact Report continues to be monitored by the District Community Services Managers, Regional Directors, and the Deputy Directors of Field Operations on a regular basis. During calendar year 2019 the COGNOS Statewide Referral report indicates the number of child maltreatment reports received and assigned for further assessment decreased when compared to prior years. There were 175 less referrals received during calendar year 2019, and the percentage of intakes assigned for further assessment declined from 65.92% to 61.75%.

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 9.5% 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 9.67 or less incidence of maltreatment in out-of-home care per 100,000 days in care.

Despite meeting the two CFSR safety data indicators, and receiving and accepting for further assessment, a lower number of child maltreatment reports during FFY 2019 than during FFY 2018, the agency was not able to increase the percentage of cases in which face to face contact with the alleged child victim was made within the assigned timeframe. The primary rationale for missed timeframes given by caseworkers is caseload size. Strategies to positively impact Outcome Safety 1 are included in the West Virginia Program Improvement Plan. These strategies include a threshold analysis of the Centralized Intake system, worker recruitment and retention activities, and the closure of ongoing cases in which child safety has been assured. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 1, 2020.

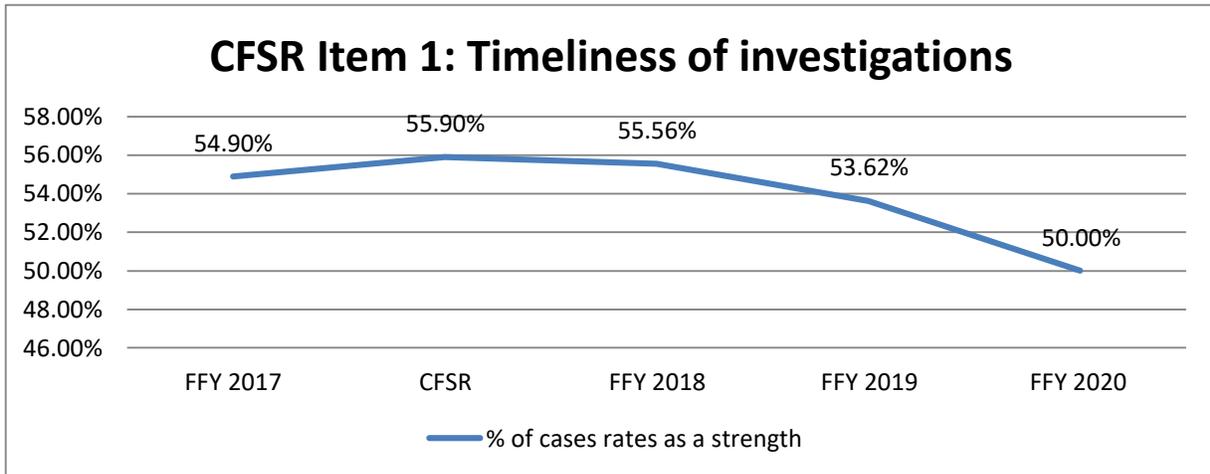
Update 2022:

DPQI Quality Assurance Case Review Data

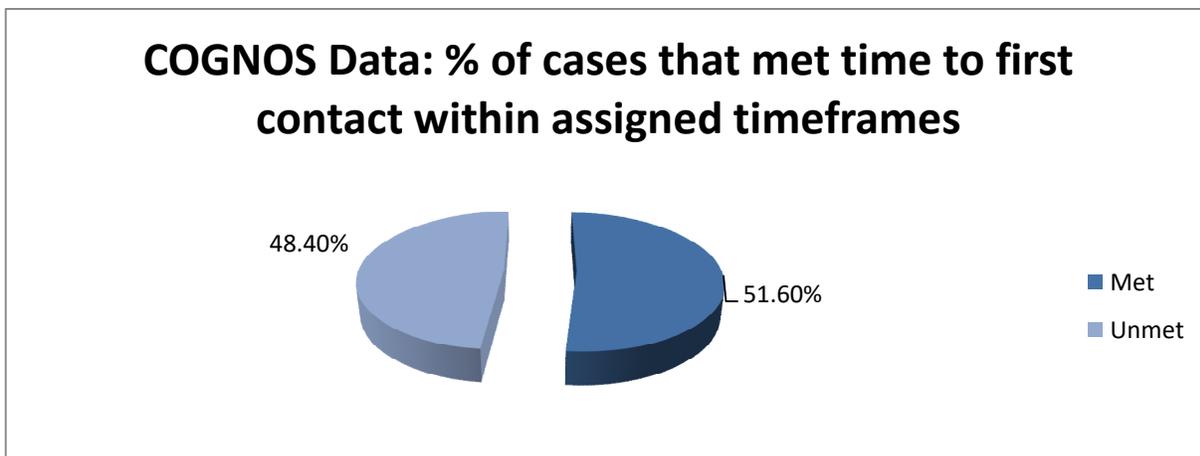
FFY 2019: 53.62%

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FFY 2020: 50%

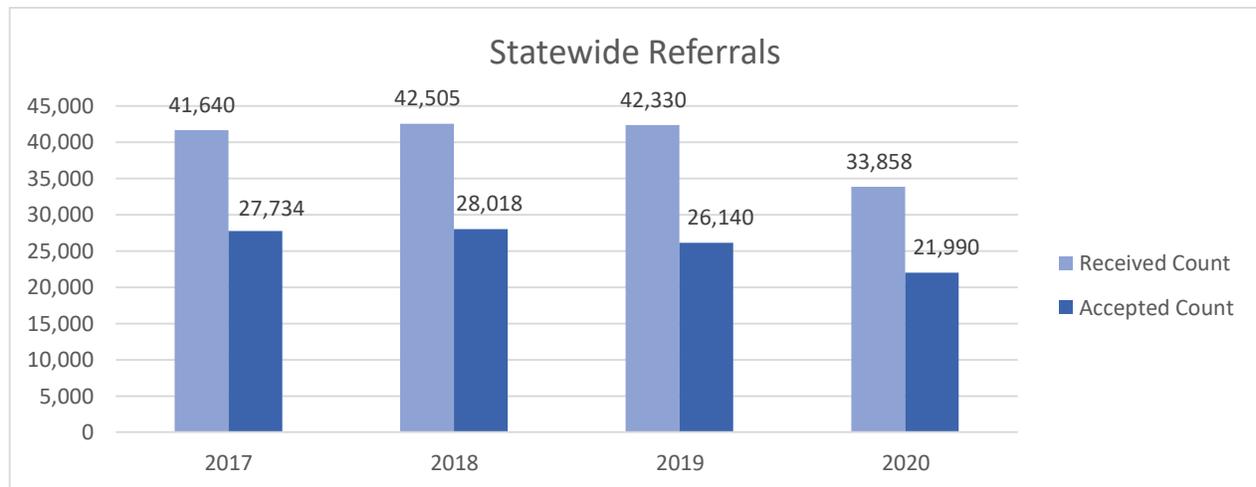


Source: DPQI Case Review Data



Source: COGNOS Time to First Contact Report FFY 2020

**WV Department of Health and Human Resources
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Source: COGNOS Statewide Referrals Report Calendar Year 2020

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 9.5% or less.

CFSR Round 3 Data Profile February 2021

Observed Performance: FY18-19 is 7%

FY17-18 is 7.4%

Risk Standardized Performance: FY16-17 is 4.6%

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 9.67 or less.

CFSR Round 3 Data Profile February 2021

Observed Performance: FY 18 is 3.12

FY17 is 3.43

Risk Standardized Performance: FY 18 is 4.59

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FY17 is 4.76

CFSR Outcome Safety 1 is comprised of one CFSR Item (Item 1). The outcome rating for Safety 1 based on DPQI case reviews for federal fiscal year 2020 indicates safety outcome one was substantially achieved in 50% of the cases reviewed, and not achieved in 50% of the cases reviewed. FFY data is based on case reviews completed October 1, 2019 to September 30, 2020. Case reviews are reflective of practice that occurred approximately 12 months prior to the date of the review. The outcome rating for Safety 1 based on DPQI case reviews for federal fiscal year 2019 indicates Safety Outcome 1 was substantially achieved in 53.62% of the cases reviewed, and not achieved in 46.38% of the cases reviewed. FFY data is based on case reviews completed October 1, 2018 to September 30, 2019.

COGNOS reports provide calendar year data regarding the time to first contact. The Time to First Contact Report continues to be monitored by the District Community Services Managers, Regional Directors, and the Deputy Directors of Field Operations on a regular basis. During calendar year 2020 the COGNOS Statewide Referral report indicates the number of child maltreatment reports received and assigned for further assessment decreased when compared to prior years. In example, there were 8,472 less referrals received during calendar year 2020 than in 2019. Although the percentage of intakes assigned for further assessment increase from 61.75% in 2019 to 64.95% in 2020, the actual number of intake assigned for further assessment decreased by 4,150.

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 9.5% 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 9.67 or less incidence of maltreatment in out-of-home care per 100,000 days in care.

The agency met the two CFSR safety data indicators and COGNOS data indicates that the percentage of cases in which face to face contact with the alleged child victim was made within the assigned timeframe increased from 44% in 2019 to 51.6% in 2020. DPQI social services case reviews show a slight decrease of 3.62% with a finding of 50% in FFY 2020 from 53.62% in FFY 2019. The primary rational for missed timeframes given by caseworkers is caseload size. Most district CAPS developed in 2020 include a strategy to increase meeting face to face timeframes with alleged child victims. Strategies to positively impact Outcome Safety 1 are also included in the West Virginia Program Improvement Plan. These strategies include a threshold analysis of the Centralized Intake system, worker recruitment and retention activities, and the closure of ongoing cases in which child safety has been assured. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 30, 2021.

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

Services to Family to Protect Children in the Home and Prevent Removal or Re-Entry into Foster Care (Item 2)

Purpose of Assessment: To determine whether, during the period under review, the agency made concerted efforts to provide services to the family to prevent children’s entry into foster care or re-entry after a reunification.

Strength Rating Defined

- In cases where safety issues were present, safety-related services were offered to families to prevent removal of children during the period under review.
- OR, if safety-related services were not offered, this was because the safety issues warranted immediate removal of the child.

Concerted Efforts Required and/or Special Considerations in Rating

This item is solely focused on rating the provision of appropriate safety-related services in response to safety concerns. If implementing a safety plan was the only provision needed to ensure the children’s safety rather than safety-related services, this item should be rated as Not Applicable (NA) and the safety plan should be assessed in Risk and Safety Assessment and Management (Item 3).

Concerted efforts include working to engage families in needed safety-related services and facilitating a family’s access to those services.

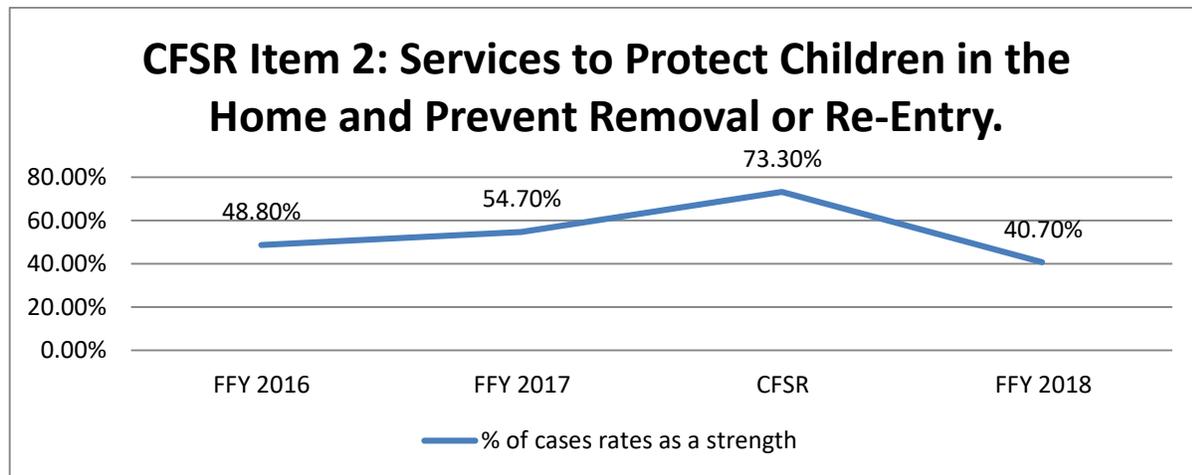
Goals and strategies to impact Safety Outcome 2 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49

DPQI Quality Assurance Case Review Data

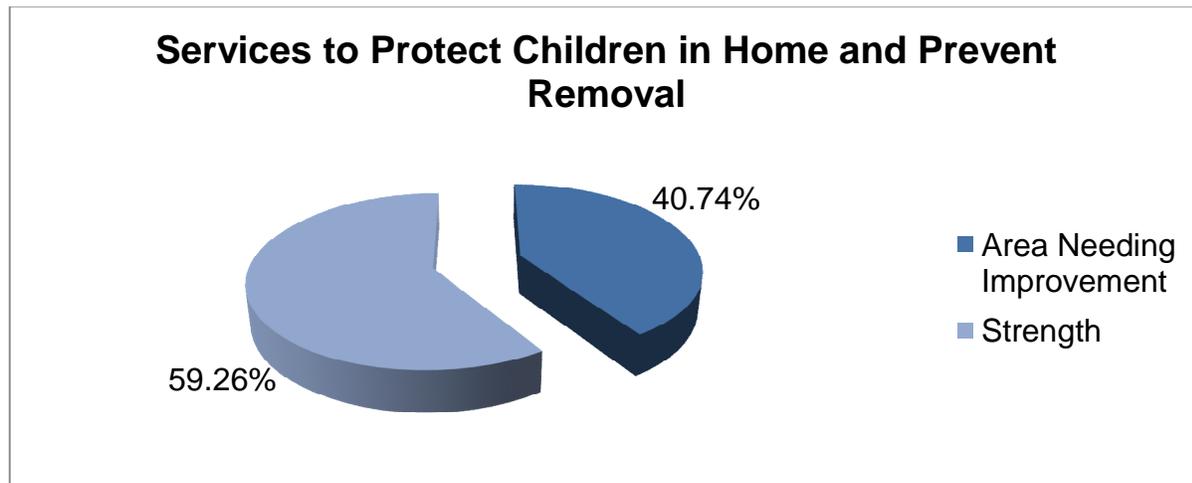
Baseline: 37.3%

PIP Goal: 45.9%

Reporting Period 6/2018-5/2019: 52.46%

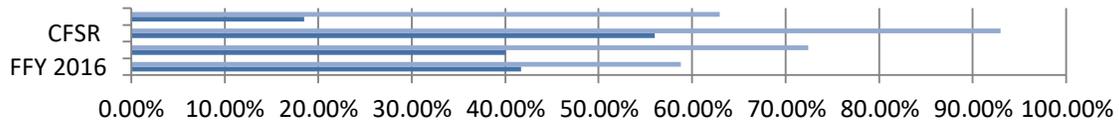


Source: DPQI Case Review Data



Source: DPQI Case Review Data 2018 FFY

Services to Protect Children and Prevent Removal by Case Type (CFSR Item 2-Strength Percentages)



	FFY 2016	FFY 2017	CFSR	FFY 2018
■ Placement	58.80%	72.40%	93.00%	62.96%
■ In Home	41.70%	40.00%	56.00%	18.52%

Source: DPQI Case Review Data

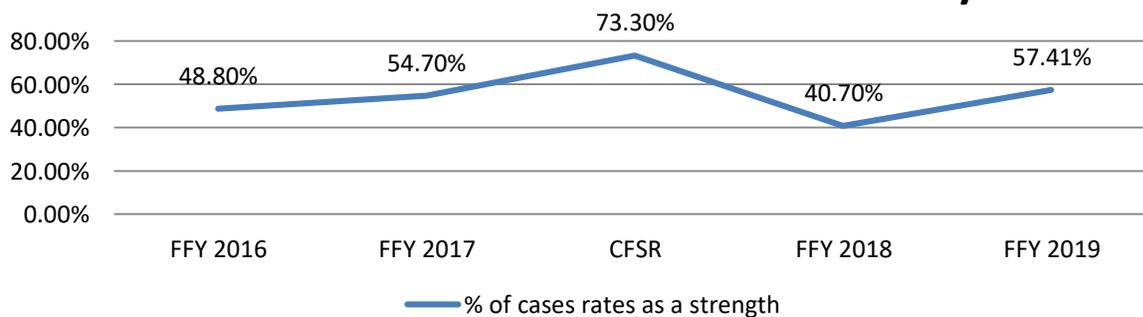
Update 2021:

DPQI Quality Assurance Case Review Data

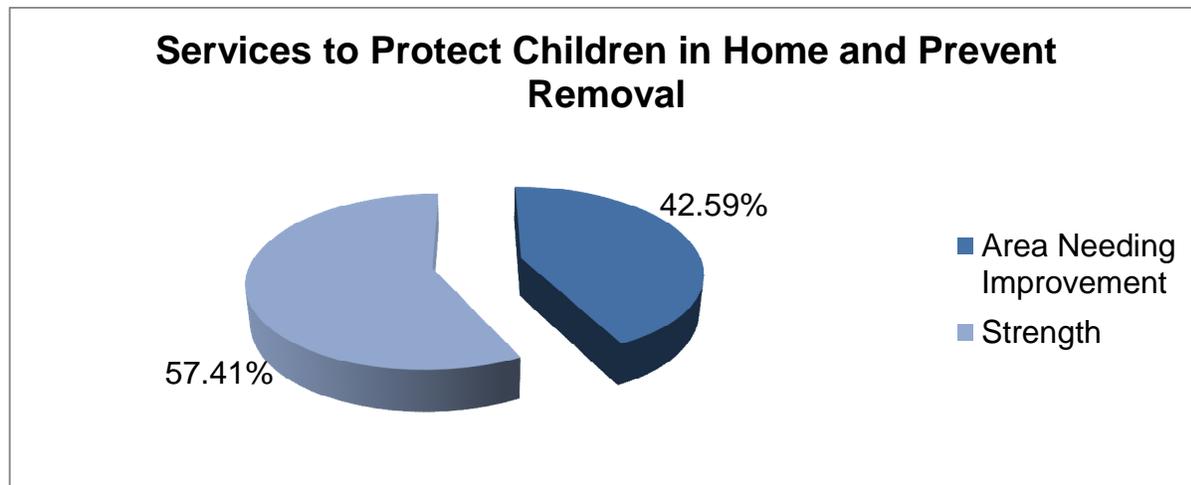
FFY 2018: 40.70%

FFY 2019: 57.41%

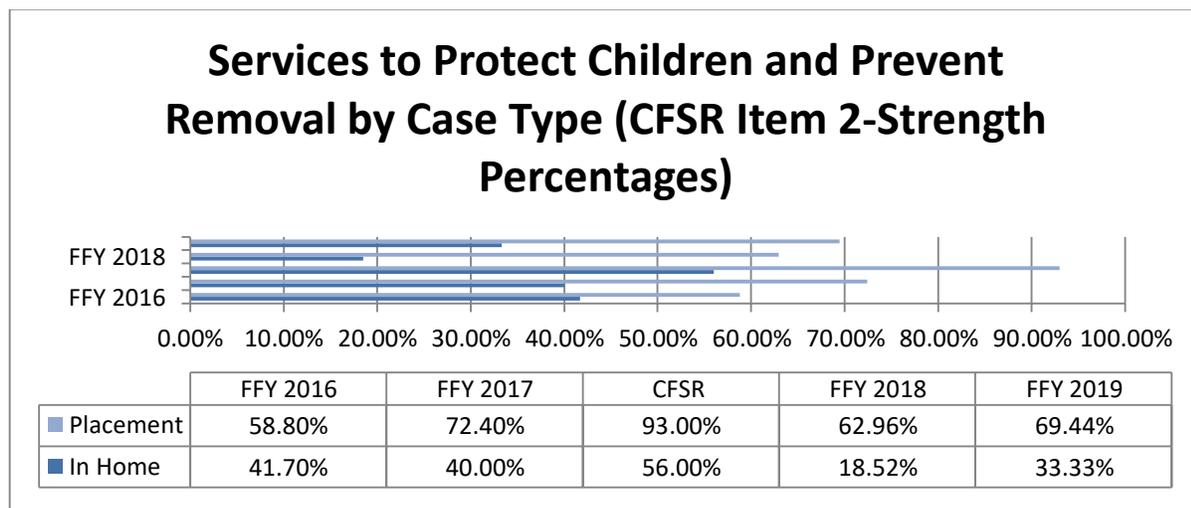
CFSR Item 2: Services to Protect Children in the Home and Prevent Removal or Re-Entry.



Source: DPQI Case Review Data



Source: DPQI Case Review Data 2019 FFY



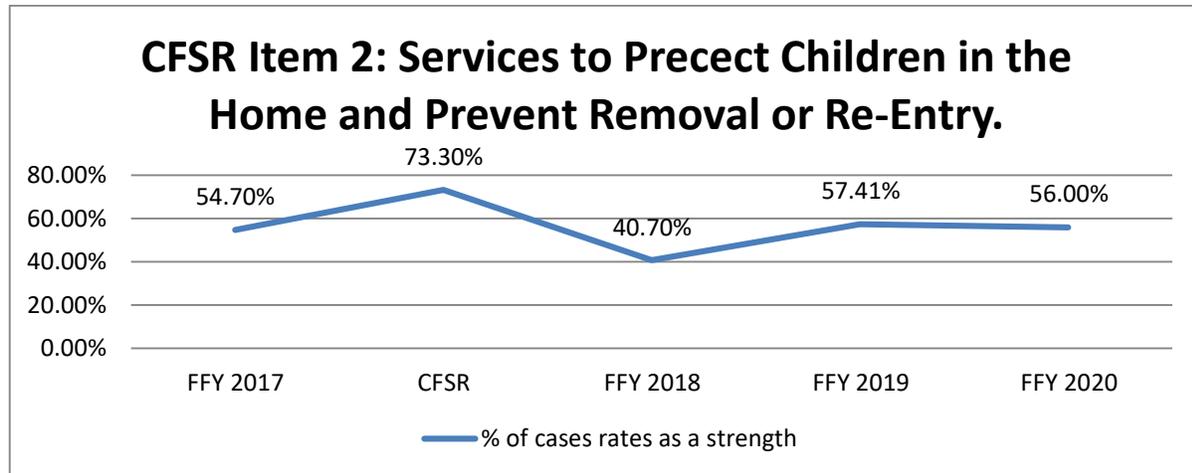
Source: DPQI Case Review Data

Update 2022:

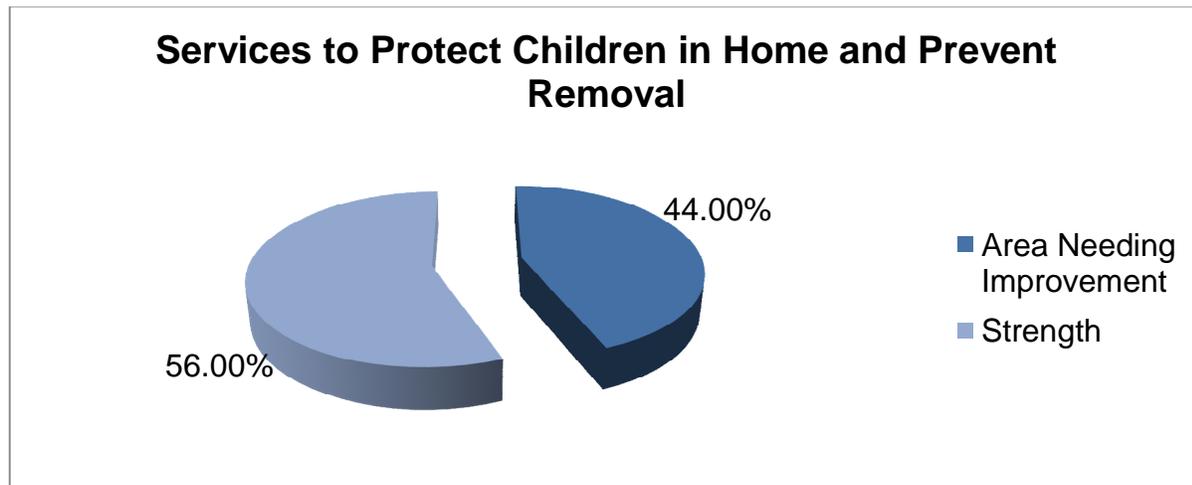
DPQI Quality Assurance Case Review Data

FFY 2019: 57.41%

FFY 2020: 56%

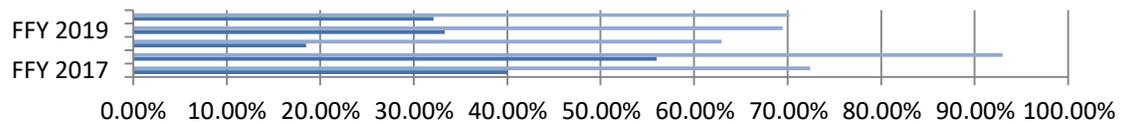


Source: DPQI Case Review Data



Source: DPQI Case Review Data FFY 2020

Services to Protect Children and Prevent Removal by Case Type (CFSR Item 2-Strength Percentages)



	FFY 2017	CFSR	FFY 2018	FFY 2019	FFY 2020
■ Placement	72.40%	93.00%	62.96%	69.44%	70.21%
■ In Home	40.00%	56.00%	18.52%	33.33%	32.14%

Source: DPQI Case Review Data

Risk and Safety Assessment and Management (Item 3)

Purpose of Assessment: To determine whether, during the period under review, the agency made concerted efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care.

Strength Rating Defined

- For cases with risk and/or safety concerns present during the period under review, the agency conducted initial and/or ongoing assessments of all children in the family during the period under review, unless the time frame and circumstances did not warrant ongoing assessments.
- The assessments were of good quality, accurately identifying risk and safety concerns, and they occurred at key junctures of the case.
- If safety concerns were identified during the period under review, the agency adequately addressed concerns and/or responded by developing and monitoring appropriate safety plans that ensured the children's safety.
- There were no repeat maltreatment and/or recurring safety concerns within 6 months of a report substantiated and/or accepted during the period under review.
- Additionally, for foster care cases, there were no safety concerns related to visitation with parents or family members during the period under review and there were no safety concerns related to the child's foster care placement during the period under review.

Concerted Efforts Required and/or Special Considerations in Rating

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Consider worker visitation practices (Caseworker Visits with Child [Item 14] and Caseworker Visits with Parents [Item 15]) when assessing this item. Although a rating on this item does not need to be consistent with the ratings on worker visits, reviewers should consider whether the frequency and quality of worker visits with children and/or parents supported quality assessments of risk and safety.

Documentation of completed assessments in a case record alone is not enough to decide that this item could be rated as a Strength. Reviewers must also determine the quality of assessments, assess whether there were any concerns present during the period under review, and evaluate whether the agency responded appropriately to any concerns.

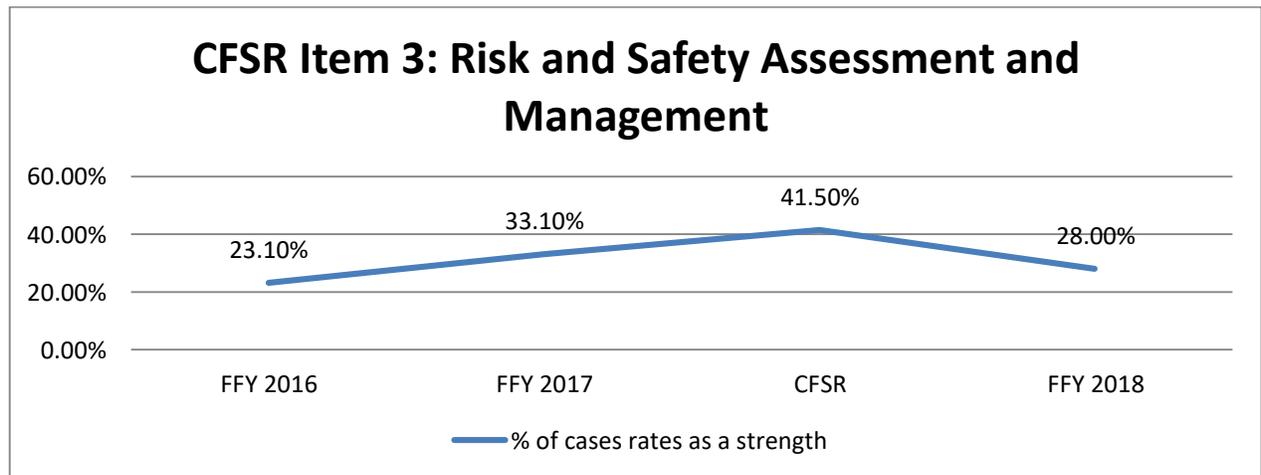
Goals and strategies to impact Safety Outcome 2 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49

DPQI Quality Assurance Case Review Data

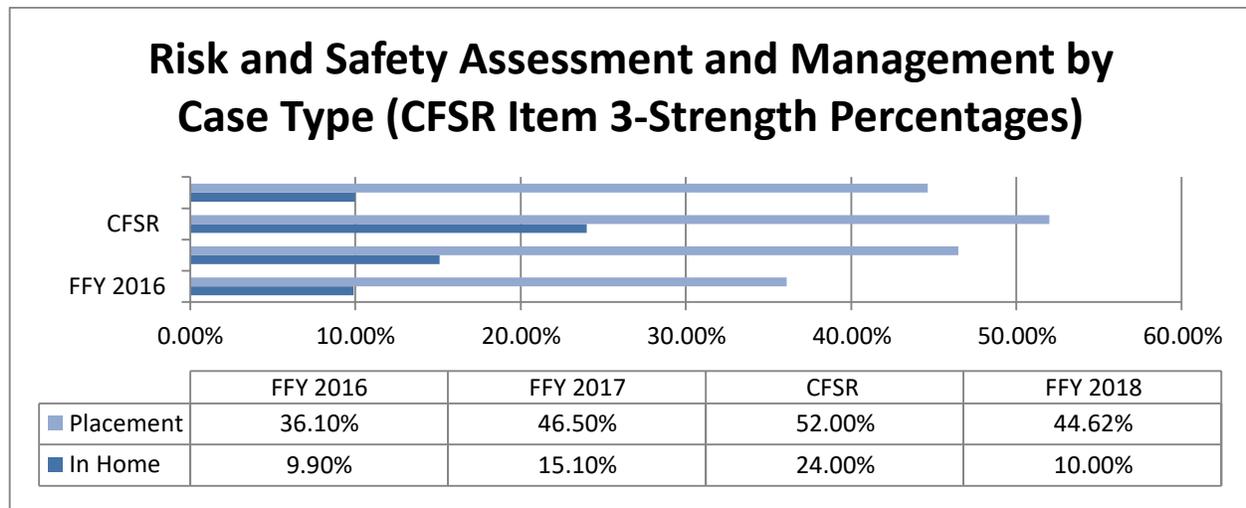
Baseline: 29.6%

PIP Goal: 34.8%

Reporting Period 6/2018-5/2019: 32.8%



Source: DPQI Case Review Data



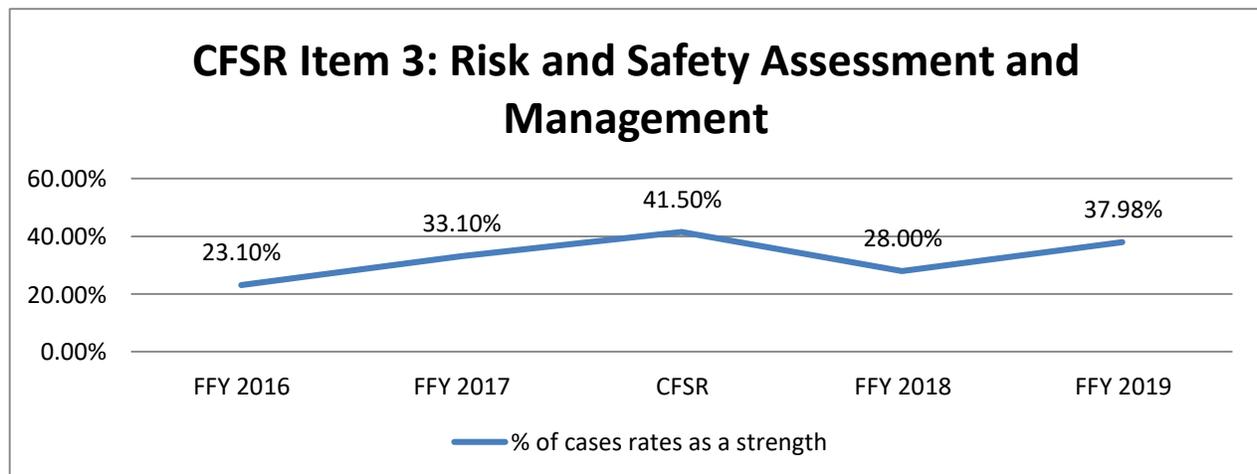
Source: DPQI Case Review Data

Update 2021:

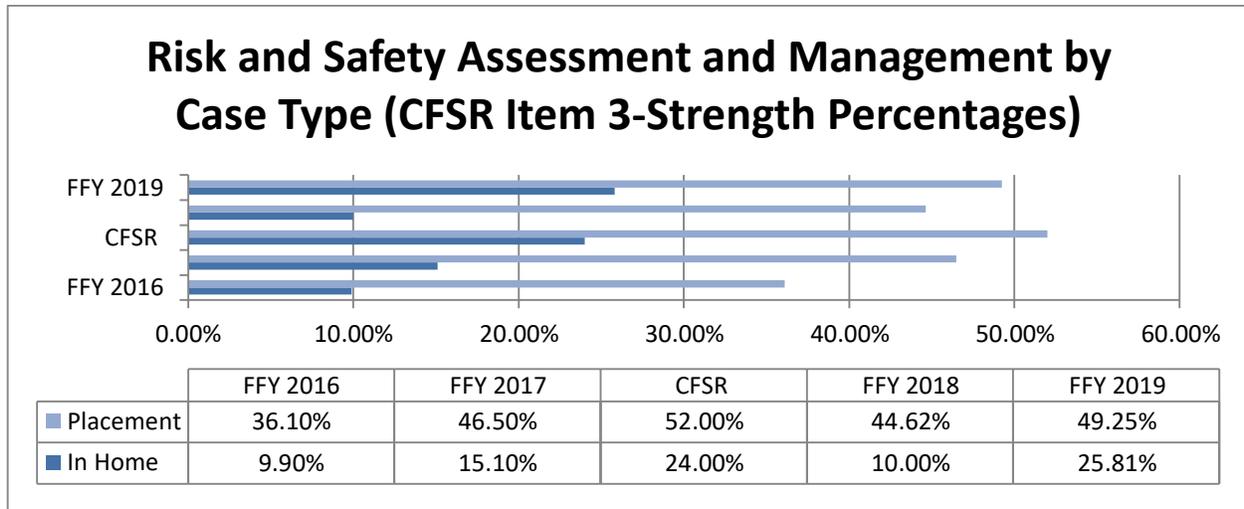
DPQI Quality Assurance Case Review Data

FFY 2018: 28%

FFY 2019: 37.98%



Source: DPQI Case Review Data



Source: DPQI Case Review Data

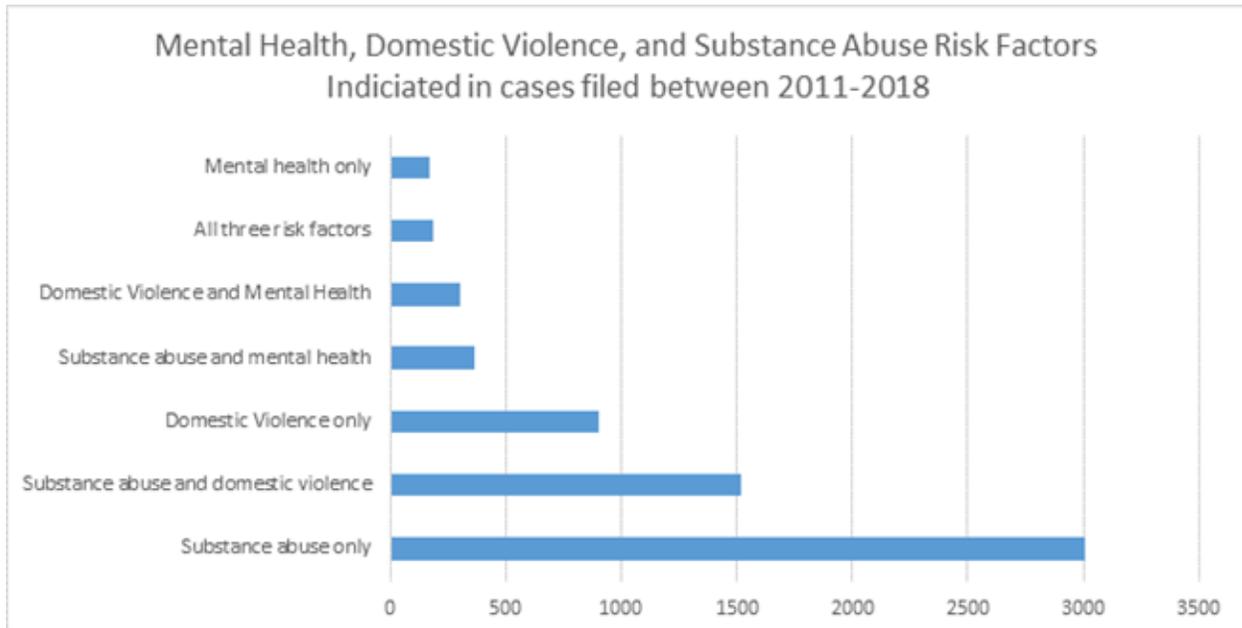
Outcome Safety 2 is measured by performance on Items 2-services to protect children in the home and prevent foster care entry or re-entry and 3-risk and safety assessment and management on the 2016 Federal CFSR Onsite Review Instrument. The outcome rating for Safety 2 based on case reviews for federal fiscal year 2019 indicates Safety Outcome 2 was substantially achieved in 35.66% of the cases reviewed, partially achieved in 17.05%, and not achieved in 47.29% of the cases reviewed during federal fiscal year 2019. FFY data is based on case reviews completed October 1, 2018 to September 30, 2019. FFY 2018 data shows Outcome Safety 2 was substantially achieved in 27.2% of the cases reviewed, partially achieved in 9.6%, and not achieved in 63.2% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

DPQI social services case reviews show an increase in the performance on both CFSR items 2 and 3. Despite this increase both items remain far below the 90% compliance threshold. Caseload size and the inability to ensure adequate staffing levels are observed as impacting the case review outcomes. Strategies to positively impact Outcome Safety 2 are included in the West Virginia Program Improvement Plan. These include efforts to recruit and retain staffing levels, activities to ensure quality contact between caseworkers and children and families occurs regularly, and that assessments of child safety are completed throughout the life of each case. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children’s Bureau by the due date of June 1, 2020.

Child abuse and neglect is often a symptom of larger social problems, such as substance abuse, which have no simple 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. This is demonstrated in the CAN database chart below. 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.

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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 child abuse and neglect cases. 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. The data presented in the following risk-factor analysis was pulled from the CANS Database



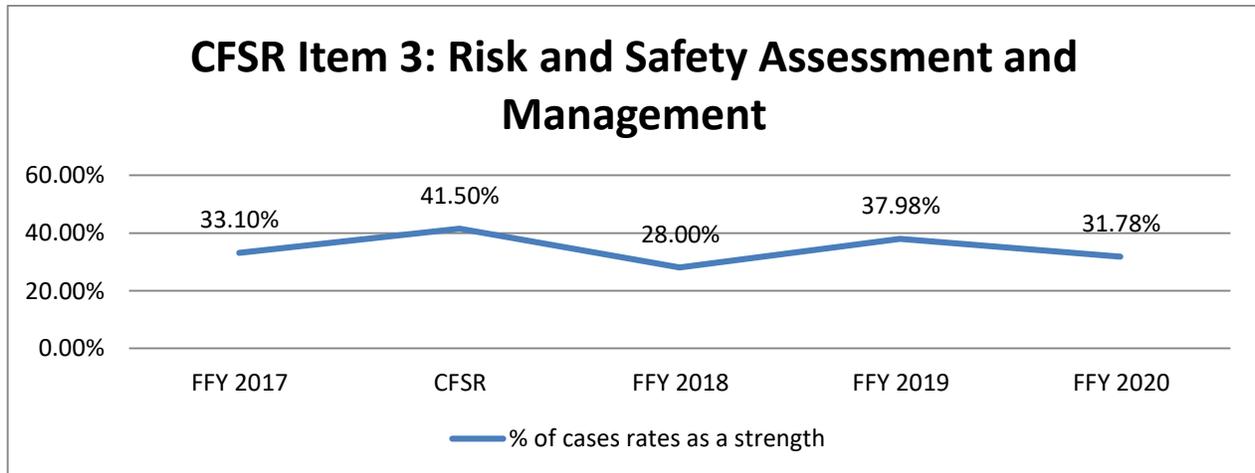
The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database

Update 2022:

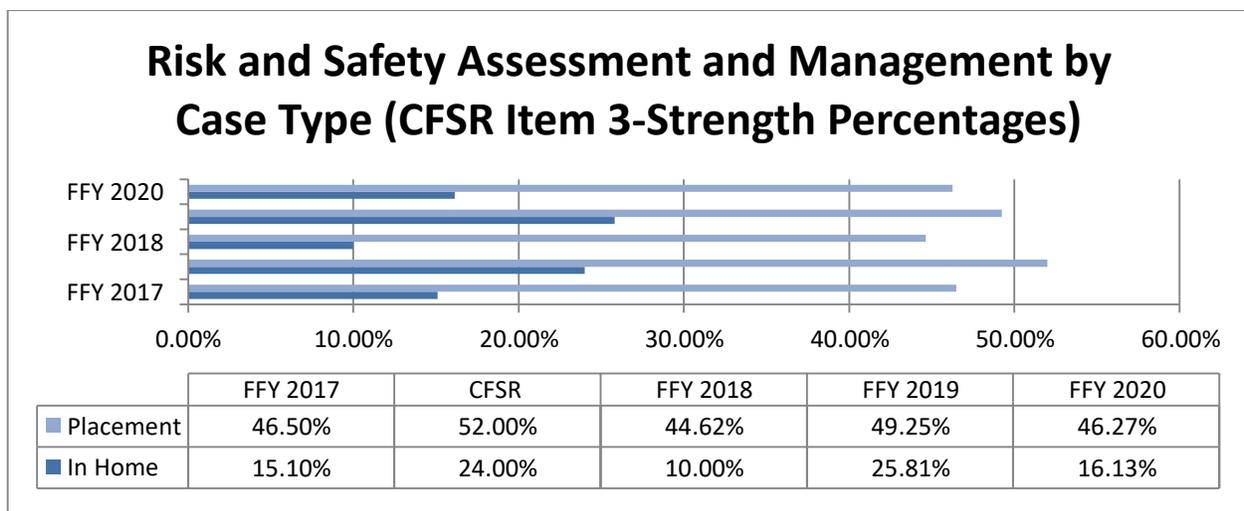
DPQI Quality Assurance Case Review Data

FFY 2019: 37.98%

FFY 2020: 31.78%



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Outcome Safety 2 is measured by performance on CFSR Items 2-services to protect children in the home and prevent foster care entry or re-entry and 3-risk and safety assessment and management on the 2016 Federal CFSR Onsite Review Instrument. FFY 2020 data shows Outcome Safety 2 was substantially achieved in 30.23% of the cases reviewed, partially achieved in 15.5%, and not achieved in 54.26% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. The outcome rating

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for Safety 2 based on case reviews for federal fiscal year 2019 indicates Safety Outcome 2 was substantially achieved in 35.66% of the cases reviewed, partially achieved in 17.05%, and not achieved in 47.29% of the cases reviewed during federal fiscal year 2019. FFY data is based on case reviews completed October 1, 2018 to September 30, 2019.

DPQI social services case reviews show a decrease in the performance on both CFSR items 2 and 3, and Outcome Safety 2, when FFY 2019 and 2020 are compared. Caseload size and the inability to ensure adequate staffing levels are observed as impacting the case review outcomes. Strategies to positively impact Outcome Safety 2 are included in the West Virginia Program Improvement Plan. These include efforts to recruit and retain staffing levels, activities to ensure quality contact between caseworkers and children and families occurs regularly, and that assessments of child safety are completed throughout the life of each case. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 30, 2021.

Unfortunately, the reasons why some parents or adults abuse children is complex and often difficult to clearly determine. The factors that lead to child abuse are often intertwined with other problems which are far more difficult to detect and successfully treat than the overt signs of abuse or neglect. As the Supreme Court of Appeals data below indicates, WV continues to have increasing numbers of new abuse and neglect petitions filed with most related to addiction.

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 child abuse and neglect cases. Data is collected and entered the Juvenile Abuse and Neglect Information System (JANIS) on abuse and neglect cases in West Virginia. Data on risk factors is entered by judicial staff. Data was retrieved from JANIS via Crystal Reports on March 3, 2021. Previously a trend report on risk factors in abuse and neglect cases was pulled and reported; however, the risk factors were changed in 2019 to include neglect factors and to specify types of substance abuse. This report reflects all cases filed in calendar years 2019 and 2020. It should be noted that Circuit Clerks reported 5,989 new abuse and neglect cases in 2019. Data for 2020 has not yet been finalized, but preliminary numbers estimate more than 5100 new abuse and neglect cases were filed. There were 6,550 cases from 2019 and 2020 entered into JANIS. Specifically, only 4044 cases (67%) from 2019 were entered into JANIS and 2,506 (est. 49%) were entered in 2020. In 2019, the Court Improvement Program began traveling to circuits to assist with data entry. The COVID 19 pandemic halted this assistance in March 2020. Once travelling restrictions are removed the CIP will resume this activity. Additionally, we are looking at ways to increase data integrity and completeness in JANIS. Therefore, this should be considered a 'snapshot' rather than a comprehensive overview.

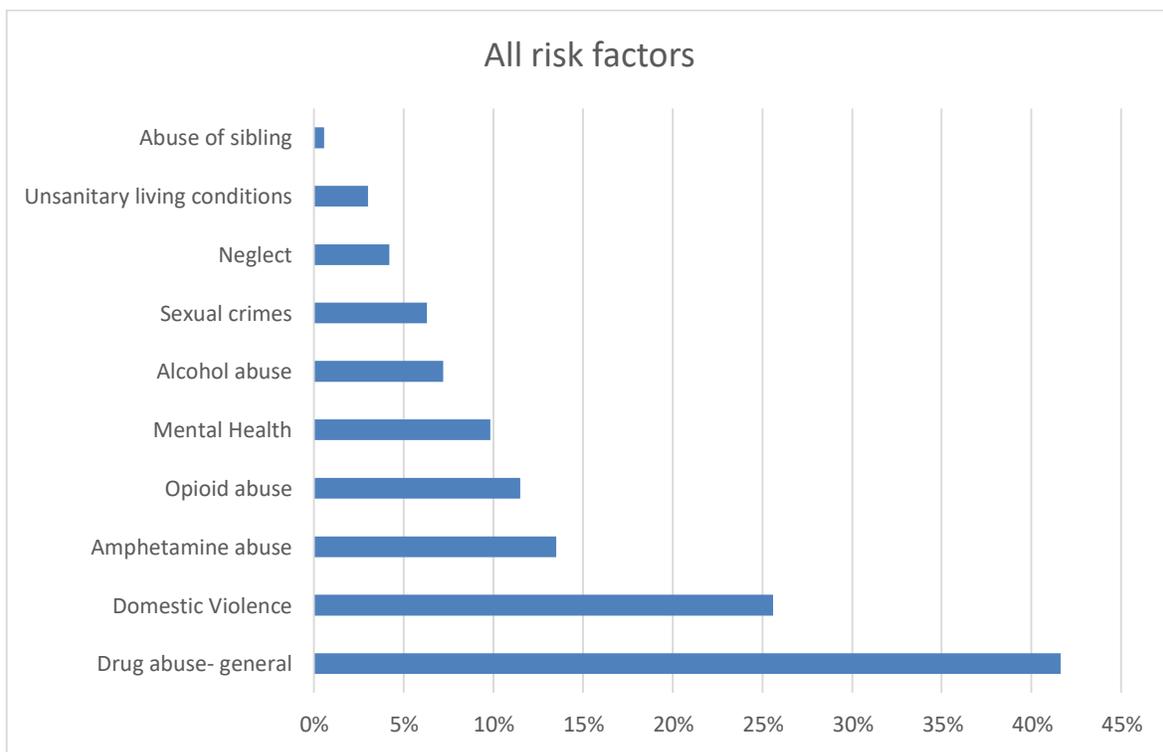
This chart represents all risk factors that are tracked, and the following definitions may be used for clarification. Note: The list of risk factors was expanded in 2019. The selection is manually entered into JANIS and is determined based on the subjectivity of the reviewer or the original petition.

Risk Factor	Definition
Abuse of Sibling	When a child in the home is removed due to the abuse of their sibling(s)

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<i>Unsanitary Living Conditions</i>	<i>Filthy, unsanitary living conditions which pose a threat to the child's safety</i>
<i>Sexual Crimes</i>	<i>Sexual assault, molestation, etc.</i>
<i>Alcohol Abuse</i>	<i>When alcohol abuse is specified in the petition</i>
<i>Opioid Abuse</i>	<i>When opioids is specified in the petition (Added 2019)</i>
<i>Amphetamine Abuse</i>	<i>When Amphetamine use is included in the petition (Added 2019)</i>
<i>Drug Abuse - General</i>	<i>Unspecified substances are included in the petition or the specified substance is something other than opioids, alcohol, or amphetamines</i>
<i>Mental Health</i>	<i>When the mental health of a parent is identified as a contributing factor to the abuse of a child in the petition</i>
<i>Domestic Violence</i>	<i>When domestic violence is specified in the petition between the parents or any party in the home</i>

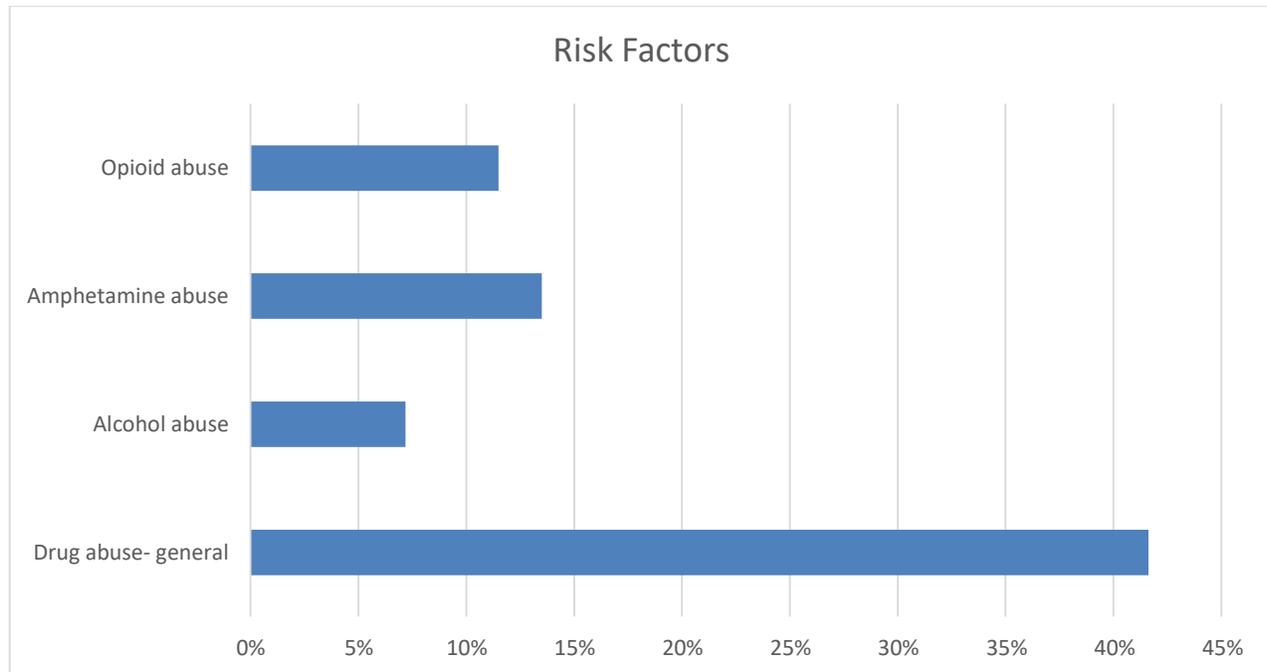
**Multiple risk factors may be selected for the same petition.*



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

Next to drug abuse, domestic violence was most often present. Just over 30% of cases where drug abuse – general was indicated, domestic violence was also cited.

This chart represents drug related risk factors identified. It should also be noted that a case can have multiple risk factors. Users can select all that apply.



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

Notice that amphetamine abuse was higher than opioid abuse. However, 27% of cases wherein either amphetamine or opioid abuse occurred (n=1637), both were present.

Permanency

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

situations.

Stability of Foster Care Placement (Item 4)

Purpose of Assessment: To determine whether the child in foster care is in a stable placement at the time of the onsite review and that any changes in placement that occurred during the period under review were in the best interests of the child and consistent with achieving the child's permanency goal(s).

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Strength Rating Defined

- A child only experienced one placement setting during the period under review, and that placement is stable.
- OR, the child's current placement is stable, and every placement made for the child during the period under review was based on the needs of the child and/or to promote the accomplishment of case goals.

Concerted Efforts Required and/or Special Considerations in Rating

None.

Goals and strategies to impact Permanency Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42

DPQI Quality Assurance Case Review Data

Baseline: 73.8%

PIP Goal: 80.8%

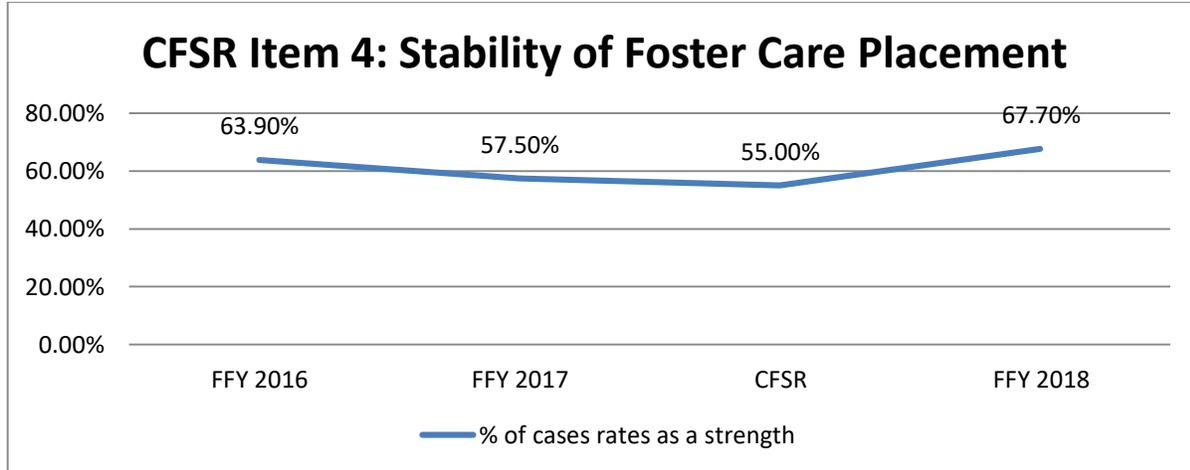
Reporting Period 6/2018-5/2019: 76.92%

Outcome Safety 2 is measured by performance on Items 2 and 3 on the 2016 Federal CFRS Onsite Review Instrument. The outcome rating for Safety 2 based on case reviews for federal fiscal year 2018 indicates Safety Outcome 2 was substantially achieved in 27.2% of the cases reviewed, partially achieved in 9.6%, and not achieved in 63.2% of the cases reviewed during federal fiscal year 2018. FFY data is based on case reviews completed October 1, 2017 to September 30, 2018. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. The Child and Family Reviews Rd. 3 baseline indicated Item 2 as a strength in 37.39% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 45.9%. Improvement was observed on the measurement for Item 2, services to families to protect children in the home and prevent removal or re-entry into foster care, during the first reporting period. The item rated 52.46% strength during this timeframe. Therefore, meeting the PIP goal for this item. The Child and Family Reviews Rd. 3 baseline indicated Item 3 as a strength in 29.6% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 34.8%

Barriers to higher levels of achievement on this outcome include, as reported by district staff, the lack of effective outpatient and in-patient treatment programs to address addiction along with an overall lack of quality mental health services for both adults and children. Districts also report a lack of quality in-home parenting services. The other important factor in monitoring safety in the home is worker contact with service providers and families. Caseworkers are not having regular contact with safety service providers according to DPQI case review interviewees, and case documentation.

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These barriers are being addressed in the WV PIP through efforts to support, recruit, and maintain agency staffing levels, and activities to improve knowledge about addiction and behavioral health services in the state. In addition, WV is addressing Safety Outcome 2 through the inclusion of more direct oversight by supervisors on casework practice through reflective supervision



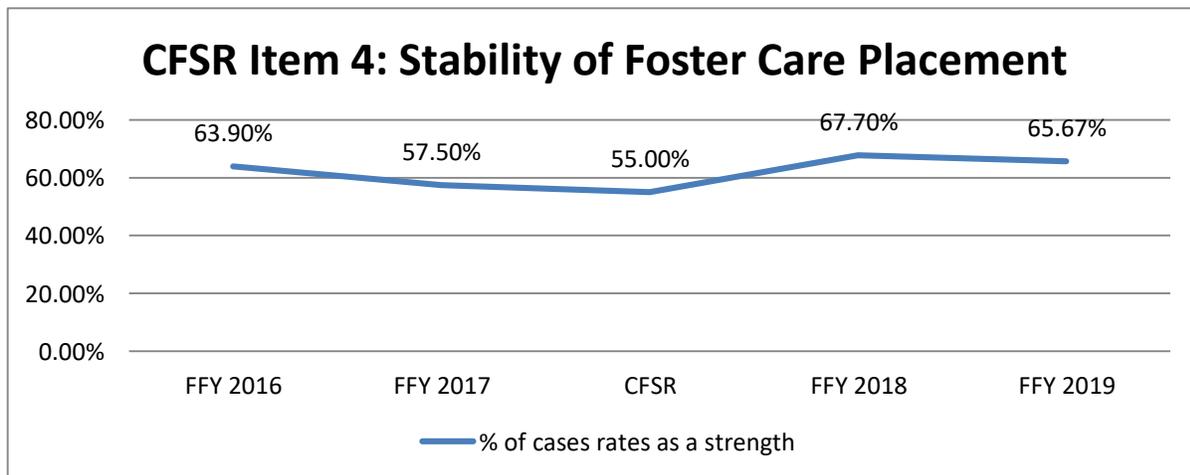
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 67.69%

FFY 2019: 65.67%



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Source: DPQI Case Review Data

CFSR Measure: Placement Stability

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 4.44 or fewer.

CFSR Round 3 Data Profile February 2020

Observed Performance: 19A19B is 2.62

18B19A is 2.52

18A18B is 2.82

Risk Standardized Performance: 19A19B is 2.59

18B19A is 2.54

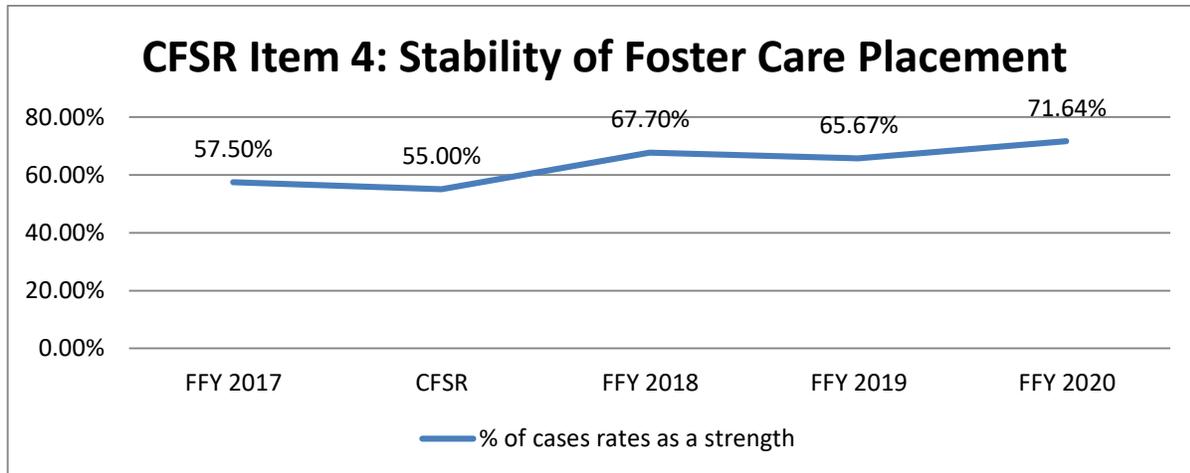
18A18B is 2.80

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 65.67%

FFY 2020: 71.64%



Source: DPQI Case Review Data

CFSR Measure: Placement Stability

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 4.44 or fewer.

CFSR Round 3 Data Profile February 2021

Observed Performance: 20A20B is 2.64

19B20A is 2.74

19A19B is 2.62

Risk Standardized Performance: 20A20B is 2.65

19B20A is 2.74

19A19B is 2.59

Permanency Goal for Child (Item 5)

Purpose of Assessment: To determine whether appropriate permanency goals were established for the child in a timely manner.

Strength Rating Defined

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- The child's permanency goal(s) was/were documented in the case file (unless case was opened for fewer than 60 days).
- Permanency goals during the period under review were established timely (assess timeliness by considering the length of time in foster care and the circumstances of the case).
- Permanency goals during the period under review were appropriate for the child's needs and considering the circumstances of the case.
- Requirements were met (as applicable) for termination of parental rights under the Adoption and Safe Families Act.

Concerted Efforts Required and/or Special Considerations in Rating

Although this item is not focused on *achievement* of permanency goals, it does require the reviewer to consider whether the agency was conducting appropriate permanency planning for the child *since he or she entered foster care* and to assess the impact of those efforts during the period under review. The item is rated based on goals in place during the period under review, but reviewers must also document and consider how long the child was in foster care before a goal was established in determining the timely establishment and appropriateness of the goals.

For example, in the case of a child who had been in foster care with a goal of reunification for several years before the period under review and the goal is changed to adoption at some point during the period under review, the agency's continuation of the reunification goal during the period under review would be considered not appropriate and the establishment of the adoption goal would not be considered timely.

Goals and strategies to impact Permanency Outcome 1 are in the WV Program Improvement Plan pgs.

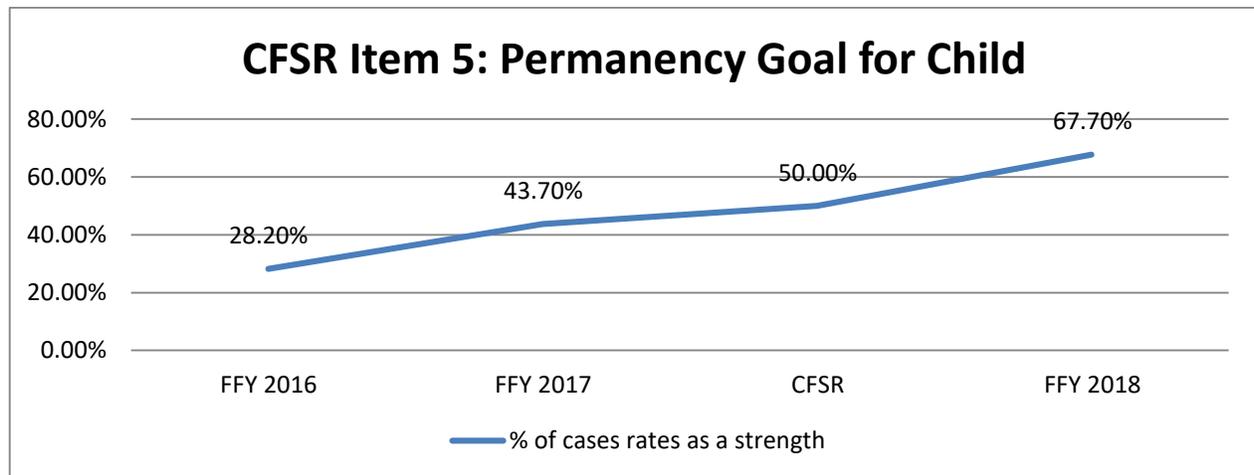
26-29, 36-42

DPQI Quality Assurance Case Review Data

Baseline: 63.1%

PIP Goal: 70.7%

Reporting Period 6/2018-5/2019: 64.62%



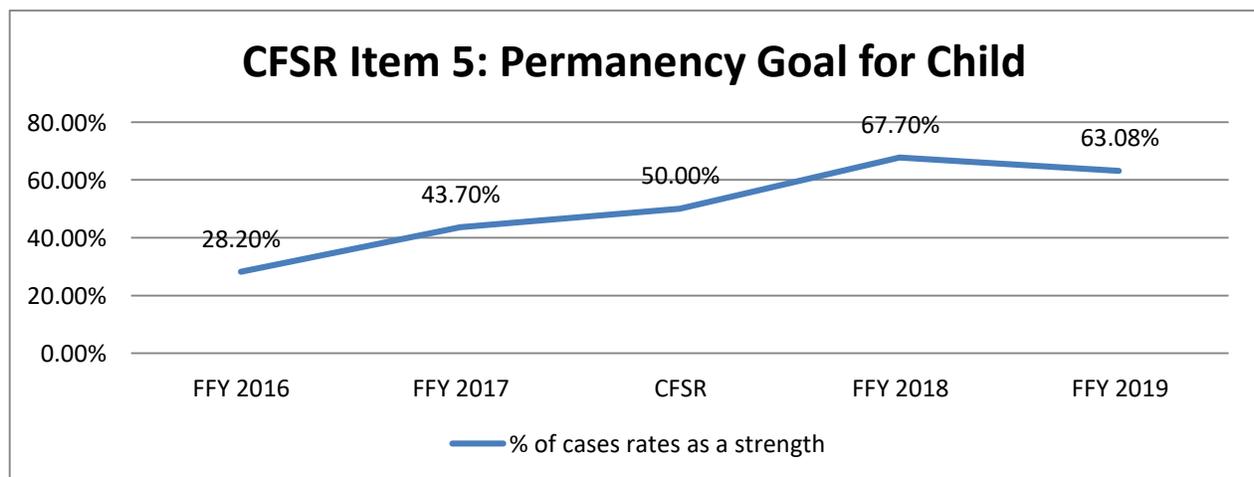
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 67.69%

FFY 2019: 63.08%



Source: DPQI Case Review Data

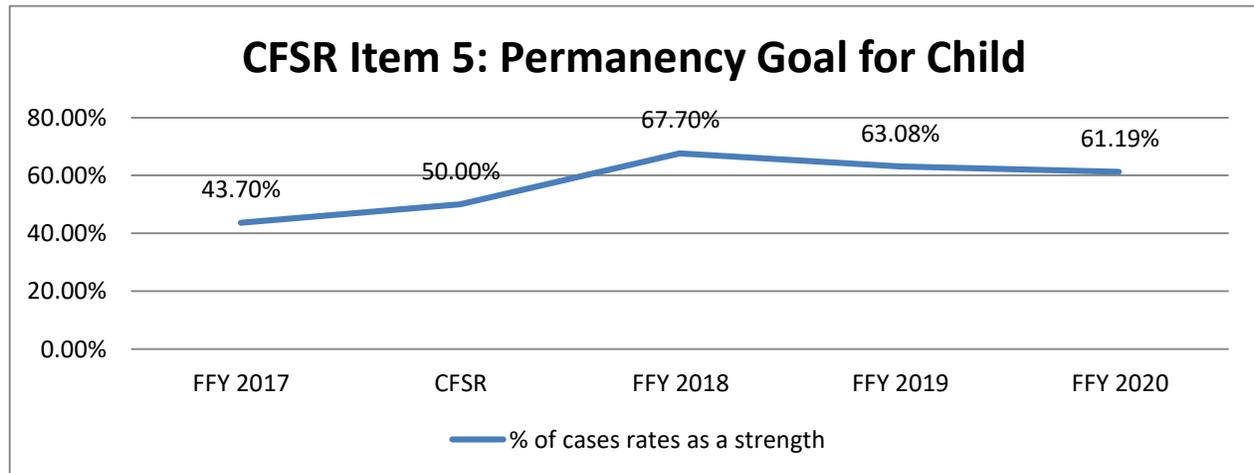
Update 2022:

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DPQI Quality Assurance Case Review Data

FFY 2019: 63.08%

FFY 2020: 61.19%



Source: DPQI Case Review Data

Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement (Item 6)

Purpose of Assessment: To determine whether concerted efforts were made, or are being made, during the period under review to achieve reunification, guardianship, adoption, or other planned permanent living arrangement.

Strength Rating Defined

- During the period under review, the agency made concerted efforts to achieve timely permanency for the child.
- OR, for children with the goal of other planned permanent living arrangement," during the period under review, the agency made concerted efforts to place the child in a living arrangement that could be considered permanent until discharge from foster care.

Concerted Efforts Required and/or Special Considerations in Rating

Generally, "timely achievement" is considered to have occurred within 12 months for the goal of reunification, within 18 months for the goal of guardianship, or within 24 months for the goal of

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adoption. However, the focus of this item is on assessing the efforts that were made to achieve permanency rather than on meeting the specific time frames noted for each goal. For example, if a child was reunified at the 12th month, but could have been reunified sooner had concerted efforts been made, the item could be rated as an Area Needing Improvement. Similarly, if a child did not achieve adoption within 24 months, but the agency and court had been making concerted efforts to achieve the goal of adoption despite circumstances beyond their control that caused a delay, the item could be rated as a Strength.

Concerted efforts toward achieving permanency may include:

- Actively and effectively implementing concurrent planning. Specifically, this means actively working on a second permanency goal simultaneously with the goal of reunification such that there is progress made to have that second goal for permanency achieved quickly should reunification not work out.
- Regularly assessing the safety of the home and family to which the child is to return. This includes utilizing appropriate safety plans and safety-related services to allow reunification to occur timely and safely rather than waiting until all risk and safety concerns are fully resolved before reunification occurs.
- Ensuring appropriate services are provided in a timely manner for parents seeking to achieve reunification
- In cases of adoption, conducting mediation with the child's parents, as appropriate, to work toward obtaining voluntary terminations and avoiding lengthy court trials
- Considering open adoptions, when in the child's best interest
- Addressing any concerns, a child, youth, or prospective adoptive family may have about adoption through specific discussions or counseling
- Conducting searches for absent parents and relatives early on and periodically throughout the case
- Establishing paternity early on in cases, as applicable
- Initiating child-specific recruitment efforts to identify permanent placements
- Ensuring that permanency hearings are held timely, and thoroughly address the issues in the case and the child's need for permanency
- Ensuring home studies or other legal processes required to finalize permanency happen timely
- Finalizing the permanency of a placement for youth with a goal of Other Planned Permanent Living Arrangement through written agreements

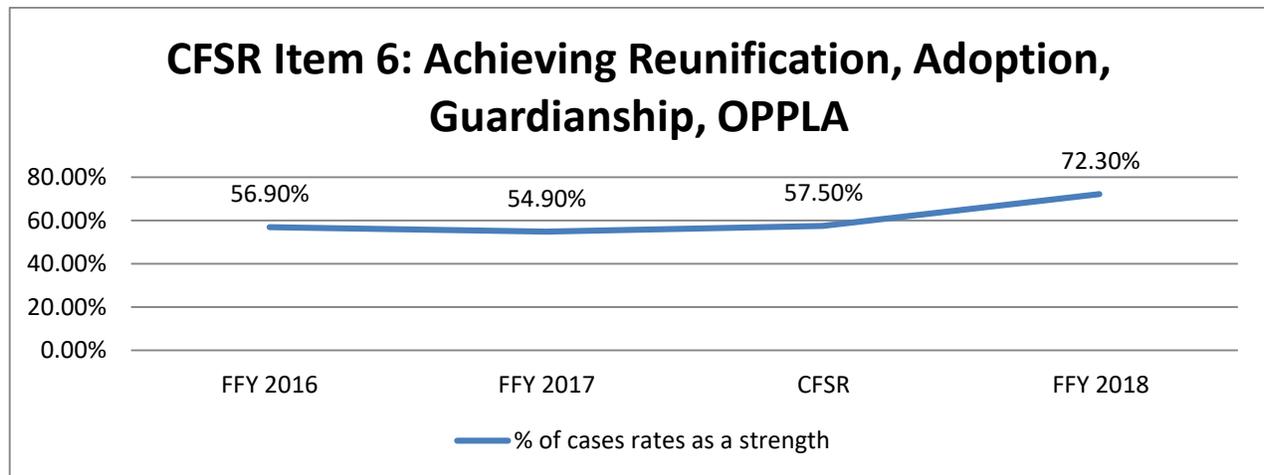
Goals and strategies to impact Permanency Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42

DPQI Quality Assurance Case Review Data

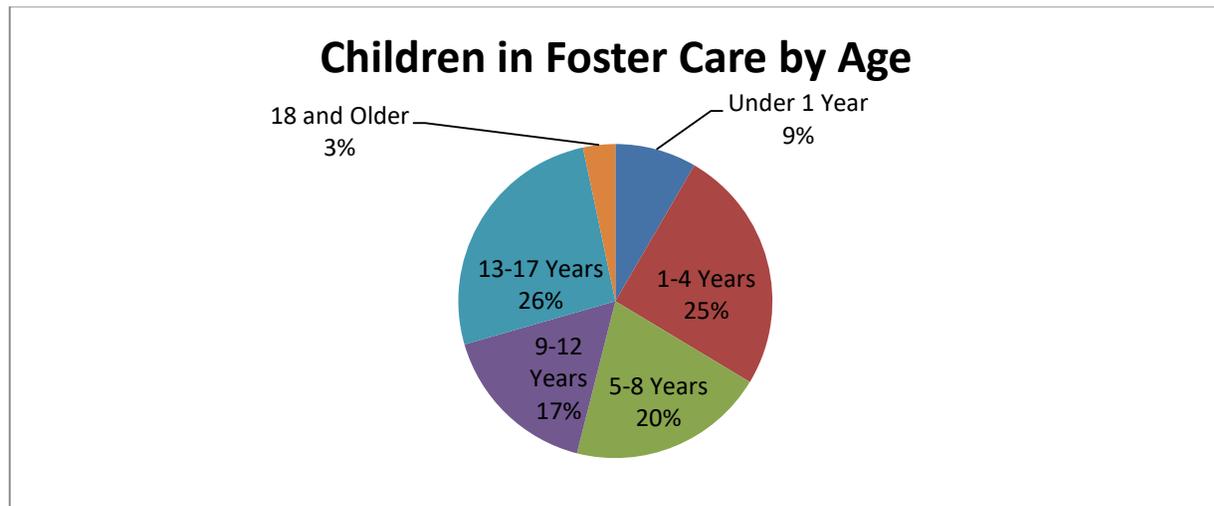
Baseline: 69.2%

PIP Goal: 76.6%

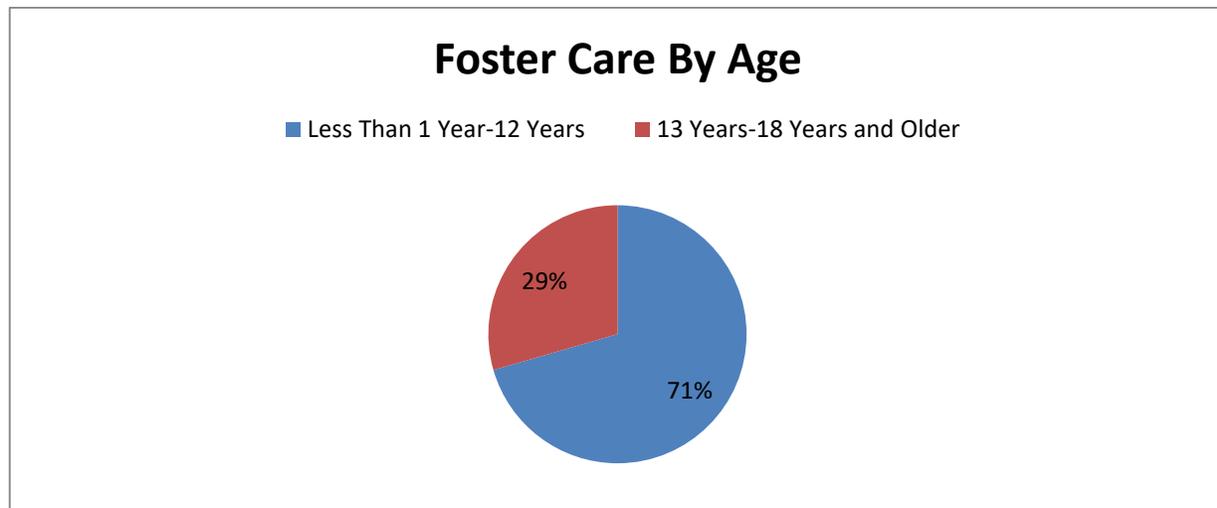
Reporting Period 6/2018-5/2019: 78.46%



Source: DPQI Case Review Data



COGNOS Point in Time Report 3/21/19



COGNOS Point in Time Report 3/21/19

Outcome Permanency 1 is measured by performance on Items 4, 5, and 6 of the 2016 Federal CFRS Onsite Review Instrument. During case reviews conducted during FFY 2018, Permanency 1 was substantially achieved in 35.38% of the cases reviewed, and partially achieved in 58.46% of the cases reviewed. Case reviews are reflective of practice that occurred approximately 12 months prior to the date of the review. The Child and Family Reviews Rd. 3 baseline indicated Permanency 1 as substantially achieved in 41.54% of the applicable cases reviewed. During this period Item 4 rated as strength in 73.8% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 80.8%. The item rated 76.92% strength during the first PIP reporting period. The Child and Family Reviews Rd. 3 baseline indicated Item 5 as rated strength in 63.1% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 70.7%. The item rated as strength in 64.62% of the applicable cases reviewed during the PIP first reporting period. The Child and Family Reviews Rd. 3 baseline indicated Item 6 as strength in 69.2% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 76.6%. Improvement was observed on the measurement for Item 6, efforts to achieve permanency, during the first PIP reporting period. The item rated 78.46% strength during this timeframe. Therefore, meeting the PIP goal for this item.

When Outcome Permanency 1 data is examined, improvement was observed in meeting the measure during FFYs 2017 and 2018. Agency leadership has taken steps to educate staff on the selection of appropriate permanency goals. The efforts appear to have been successful based upon the case review data for the last two federal fiscal years. The WV PIP will seek to further improve Outcome Permanency 1 by improving staffs' knowledge of available safety and treatment services and enhancing the current services array to address substance abuse and other identified needs to ensure appropriate and individualized services are available and accessible. The WV PIP will also address this outcome by creating and supporting a healthy workforce and creating a prevention-focused organizational culture in order to ensure the needs of children and families are addressed throughout the life of the case.

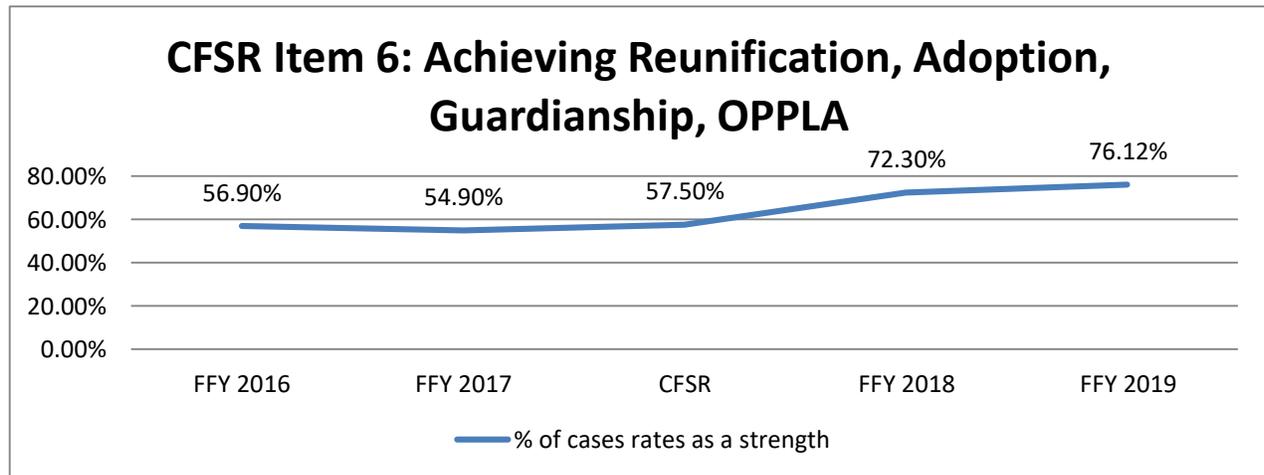
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Update 2021:

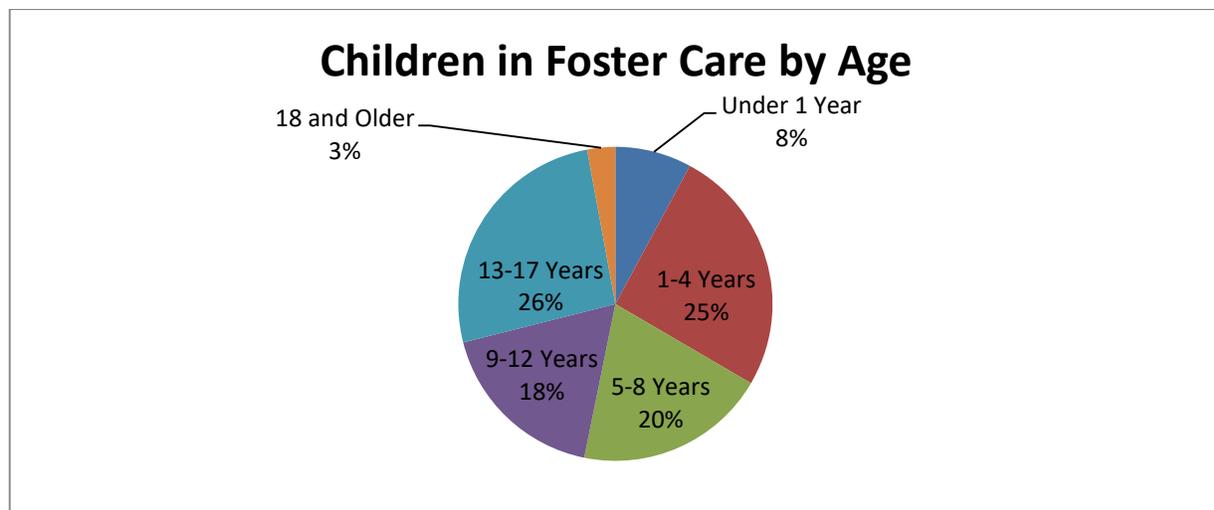
DPQI Quality Assurance Case Review Data

FFY 2018: 72.31%

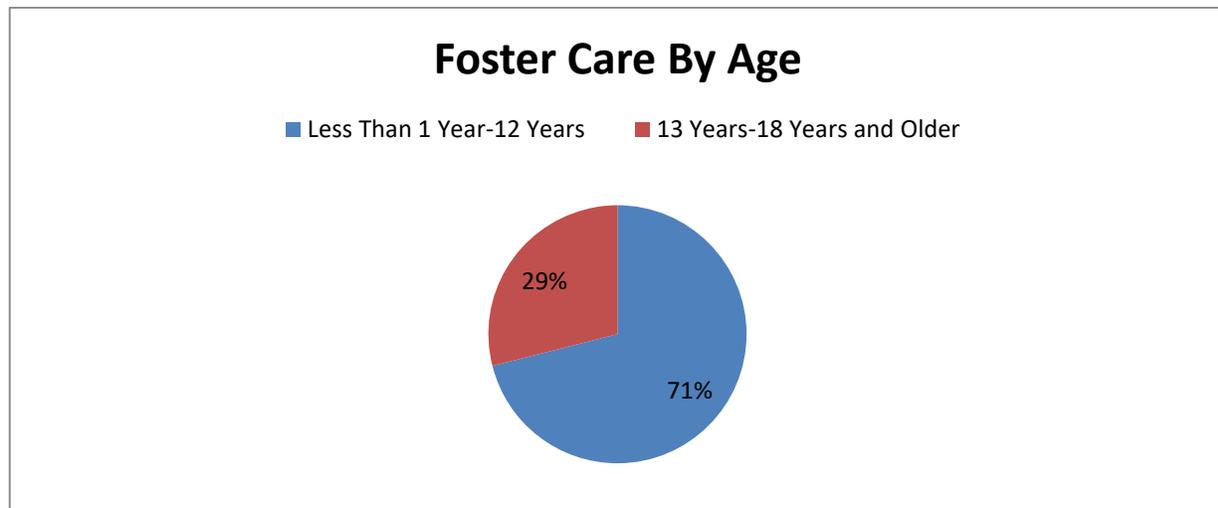
FFY 2019: 76.12%



Source: DPQI Case Review Data



COGNOS Point in Time Report 1/10/20



COGNOS Point in Time Report 1/10/19

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 42.7% or higher.

CFSR Round 3 Data Profile February 2020

Observed Performance: 17A17B is 37.5%

Due to data quality issues additional data sets are not available.

Risk Standardized Performance: 17A17B is 37.6%

Due to data quality issues additional data sets are not available.

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 8.1% or less.

CFSR Round 3 Data Profile February 2020

Observed Performance: 17A17B is 9.9%

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Due to data quality issues additional data sets are not available.

Risk Standardized Performance: 17A17B is 6.2%

Due to data quality issues additional data sets are not available.

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 45.9% or more.

CFSR Round 3 Data Profile February 2020

Observed Performance: 19A19B is 2.62

18B19A is 2.52

18A18B is 2.82

Risk Standardized Performance: 19A19B is 60.4%

18B19A is 59.3%

18A18B is 60.9%

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 31.8% or more.

CFSR Round 3 Data Profile February 2020

Observed Performance: 19A19B is 50.9%

18B19A is 54%

18A18B is 51.3%

Risk Standardized Performance: 19A19B is 44.8%

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18B19A is 47.2%

18A18B is 46.0%

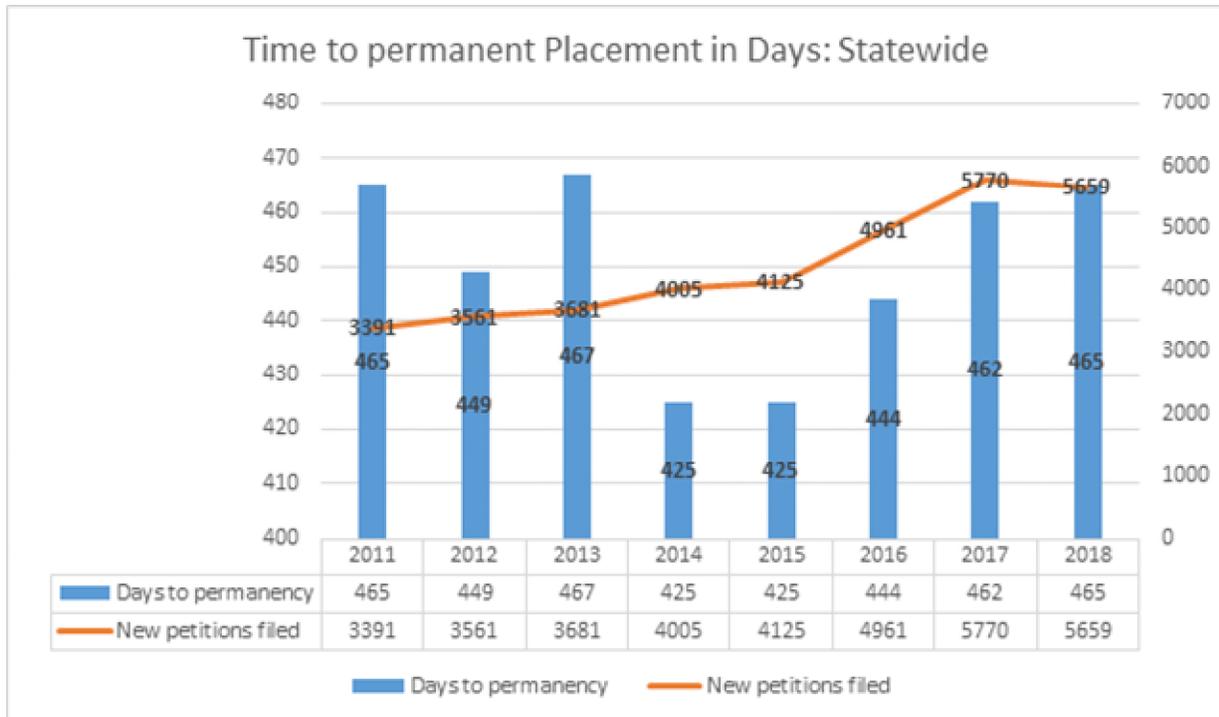
Outcome Permanency 1 is measured by performance on Items 4-stability of foster care placement, 5-permanency goal for the child, and 6-achieving reunification, guardianship, adoption, or other planned permanent living arrangement of the 2016 Federal CFSR Onsite Review Instrument. During case reviews conducted during FFY 2019, Permanency 1 was substantially achieved in 34.33% of the cases reviewed, and partially achieved in 58.21% of the cases reviewed. Case reviews are reflective of practice that occurred approximately 12 months prior to the date of the review. DPQI case review data for Outcome Permanency 1 shows a slight decrease in meeting the measure when FFYs 2018 and 2019 are compared. During FFY 2018 the Permanency Outcome 1 was 35.38% substantially achieved and 34.33% substantially achieved during FFY 2019. Slight decreases were observed in all three CFSR items that comprise the outcome.

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 did not meet the CFSR national standards for permanency within 12 months for children entering foster care. It should be noted that due to data quality issues only the 17A17B data set was available for this measure. The measure re-entry into foster care within 12 months of reunification, living with a relative, or guardianship being achieved likewise had data quality issues so only one data set is available.

Continually increasing caseloads and petitions, lack of resource homes, lack of services to address identified needs, and the inability to ensure adequate staffing levels are observed as impacting the case review outcomes. Strategies to positively impact Outcome Permanency 1 are included in the West Virginia Program Improvement Plan. These strategies include increasing the number of resource homes, ensuring resource families are engaged in the caseworker process, and building rapport between agency staff and judicial staff. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 1, 2020.

Despite the barriers, West Virginia continues to strive to make progress in achieving permanency for children. Data collected by the Supreme Court of Appeals of West Virginia also indicates an increase in the number of new petitions filed.

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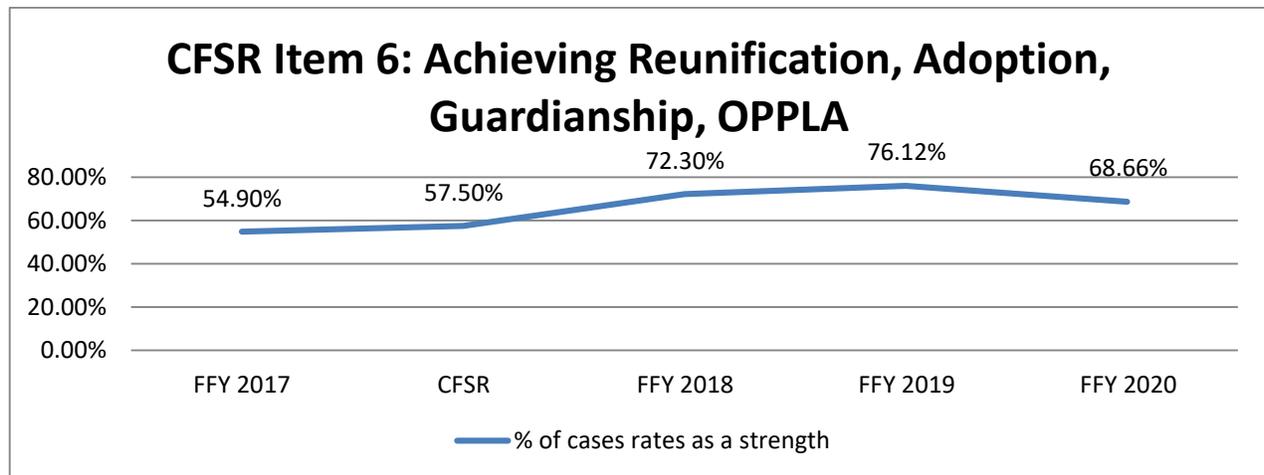
The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database

Update 2022:

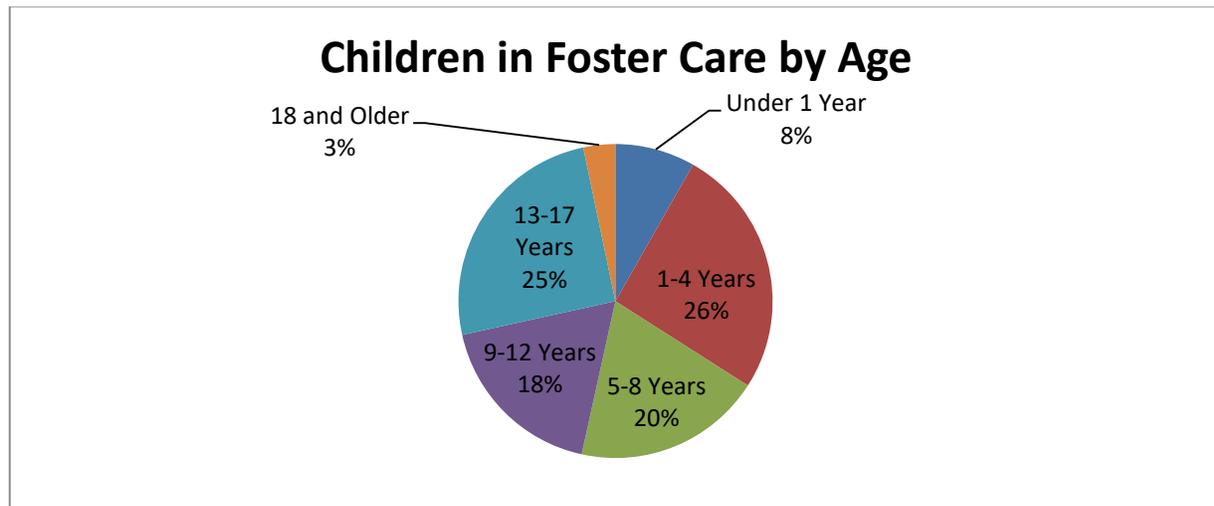
DPQI Quality Assurance Case Review Data

FFY 2019: 76.12%

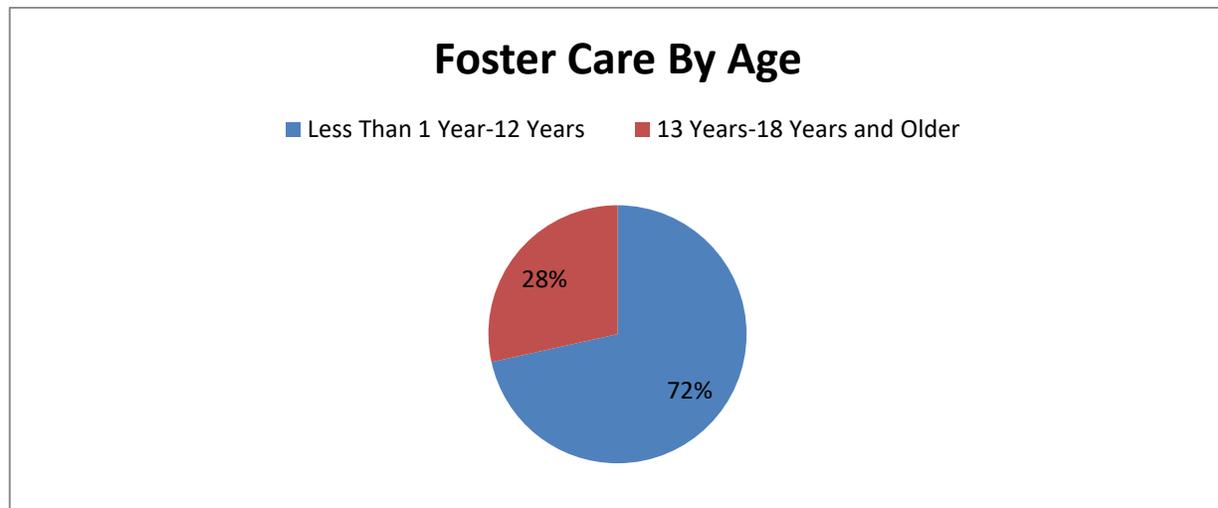
FFY2020: 68.66%



Source: DPQI Case Review Data



COGNOS Point in Time Report 1/4/2021



COGNOS Point in Time Report 1/4/2021

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 42.7% or higher.

CFSR Round 3 Data Profile February 2021

Observed Performance: 18A/18B is 36.4%

17B/18A is 37.4%

Risk Standardized Performance: 18A/18B is 37.2%

17B/18A is 37.7%

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 8.1% or less.

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CFSR Round 3 Data Profile February 2021

Observed Performance: 18A18B is 10.8%

17B18A is 9.9%

Risk Standardized Performance: 18A18B is 6.3%

17B18A is 6.1%

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 45.9% or more.

CFSR Round 3 Data Profile February 2021

Observed Performance: 20A20B is 60.6%

19B20A is 62%

19A19B is 62.1%

Risk Standardized Performance: 20A20B is 59.4%

19B20A is 60.5%

19A19B is 60.4%

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 31.8% or more.

CFSR Round 3 Data Profile February 2021

Observed Performance: 20A20B is 51.4%

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19B/20A is 48.6%

19A19B is 50.9%

Risk Standardized Performance: 20A20B is 44.3%

19B/20A is 43.3%

19A19B is 44.8%

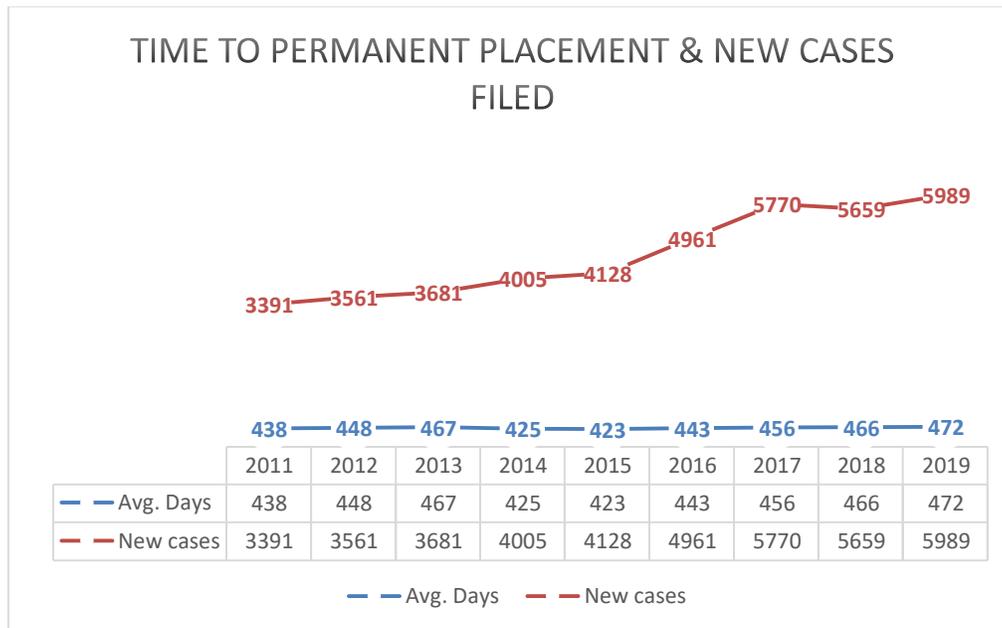
	2014		2015		2016		2017		2018		2019	
	Average Days	Percent Compliance	Average Days	Percent Compliance								
Time to Permanency Placement	439.5	None	427	None	437.8	None	465	None	440	None	472	None
Time to First Permanency Determination	265.2	None	254	None	251.7	None	121	None	206	None	Not available	
Judicial Permanent Placement Reviews												
(Compliance Limit 93 Days)	86.5	76.40%	83.1	78.00%	83.4	76.30%	82	77.06%	85	76.70%	119	73.20%
Disposition to Permanent Placement	144.4	93.80%	142.3	94.00%	150.2	87.30%	188	80.85%	156	82.91%	371	80.00%
Data pulled from the BenchView function in the Juvenile Abuse and Neglect information system on March 11, 2021												
For the measure Disposition to Permanent Placement- there were only 5 records in JANIS that contained enough information to make the calculation.												

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

This measures the average (mean) time from filing of the original petition to the permanency achieved date for each child. This is calculated using all records for all children, including both original petition filing date and the permanency achieved date.

With rare exception, permanency is addressed at every quarterly review hearing. This chart demonstrates the number of new cases filed each year with the number of children reaching permanent placement. Despite the increase in new cases, the Courts and child welfare system are moving children to permanency at rates close to those prior to the onset of the drug abuse epidemic in the state.

This is illustrated by the nearly flat blue line (average days to permanency) compared to the spike in the orange line (new cases filed).



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

Notes- Please note the numbers in the charts may be different – this is because some records have been updated causing the numbers to change.

Outcome Permanency 1 is measured by performance on three CFSR Items. These include: Item 4-stability of foster care placement, Item 5-permanency goal for the child, and Item 6-achieving reunification, guardianship, adoption, or other planned permanent living arrangement of the 2016 Federal CFSR Onsite Review Instrument. During FFY 2020, Permanency Outcome 1 was 31.34% substantially achieved and 34.33% substantially achieved during FFY 2019. Slight decreases were observed in CFSR items 5 and 6, while a slight increase was noted for CFSR Item 4. During case reviews conducted during FFY 2019, Permanency 1 was substantially achieved in 34.33% of the cases reviewed, and partially achieved in 58.21% of the cases reviewed. Case reviews are reflective of practice that occurred approximately 12 months prior to the date of the review. DPQI case review data for Outcome Permanency 1 shows a slight decrease in meeting the measure when FFYs 2019 and 2020 are compared. This is the second FFY in which the Permanency Outcome 1 has decreased.

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 CFSR national standards for permanency within 12 months for children entering foster care.

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Multiple factors negatively impact the ability of the agency to produce better Permanency 1 Outcomes. These factors include a lack of resource homes, the inability to ensure adequate staffing levels, and increasing caseloads and petitions being filed. Strategies to positively impact Outcome Permanency 1 are included in the West Virginia Program Improvement Plan. These strategies include increasing the number of resource homes, ensuring resource families are engaged in the caseworker process, and building rapport between agency staff and judicial staff. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children’s Bureau by the due date of June 30, 2021.

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 has steadily increased since 2015. (See charts above) It should be noted the number of new cases filed each year has also increased significantly during this same time period.

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

Placement with Siblings (Item 7)

Purpose of Assessment: To determine whether, during the period under review, 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.

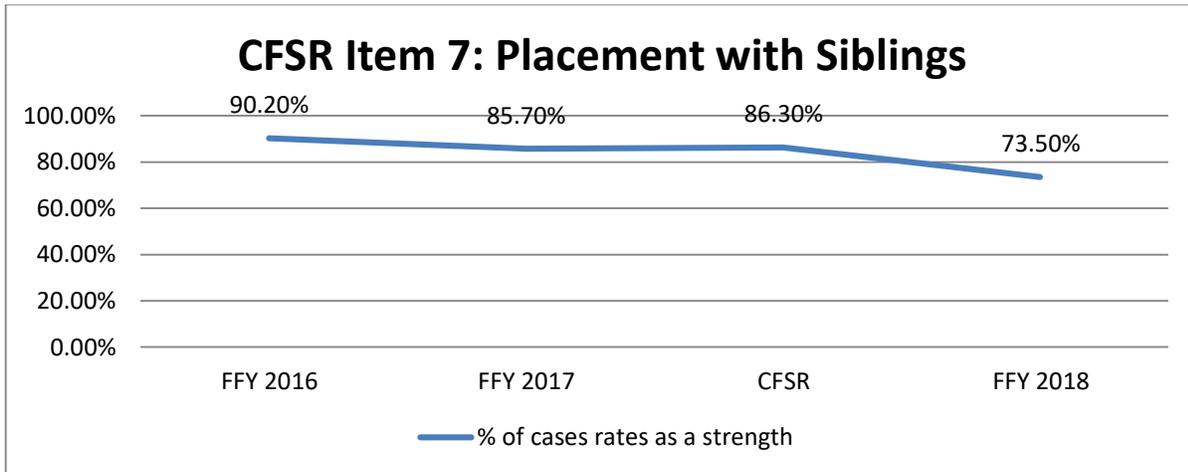
Strength Rating Defined

During the period under review, siblings in foster care are placed together unless separation was necessary to meet the needs of one of the siblings. If separation was necessary, the circumstances are reconsidered over time to determine whether separation needs to continue.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to place siblings together may include:

- Asking the children/family about potential placement resources who may accept a sibling group (e.g., relatives and/or fictive kin) and following up with searches and assessments
- Searching for resource homes that can accommodate the sibling group
- For cases where valid reasons for separation exist, providing any services or making arrangements to support the eventual placement of the siblings together



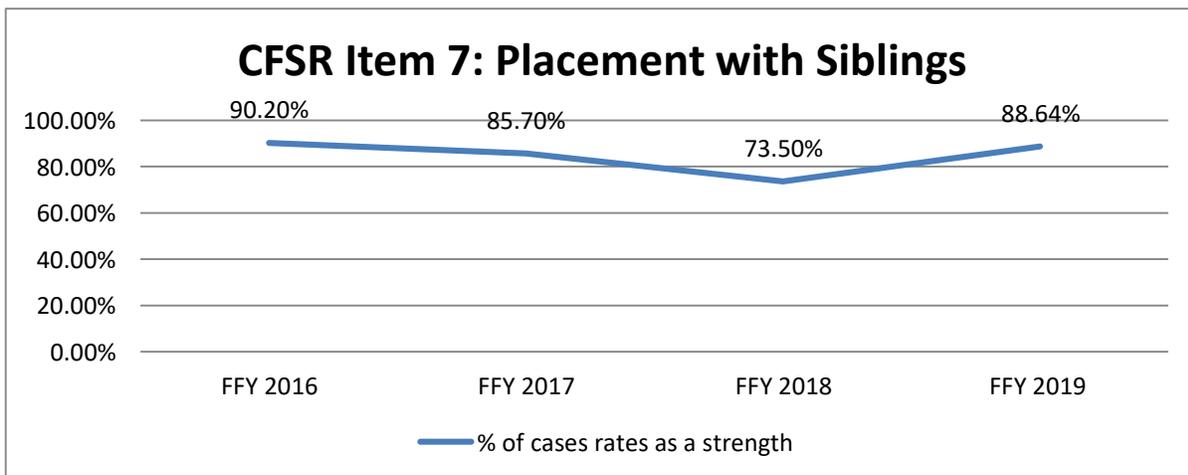
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 73.50%

FFY 2019: 88.64%



Source: DPQI Case Review Data

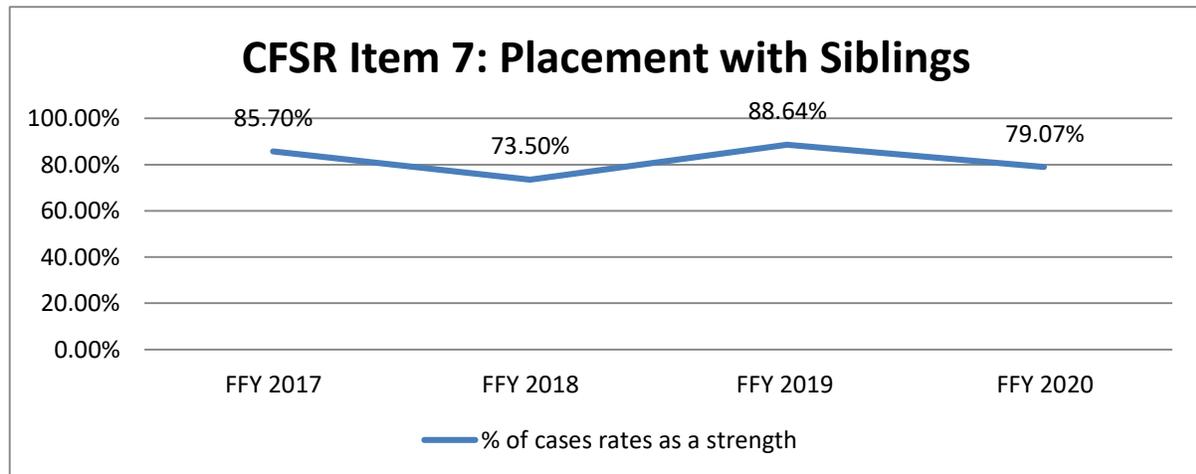
Update 2022:

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DPQI Quality Assurance Case Review Data

FFY 2019: 88.64%

FFY 2020: 79.07%



Source: DPQI Case Review Data

Visiting with Parents and Siblings in Foster Care (Item 8)

Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made to ensure that visitation between a child in foster care and his or her mother, father, and siblings is of sufficient frequency and quality to promote continuity in the child’s relationship with these close family members.

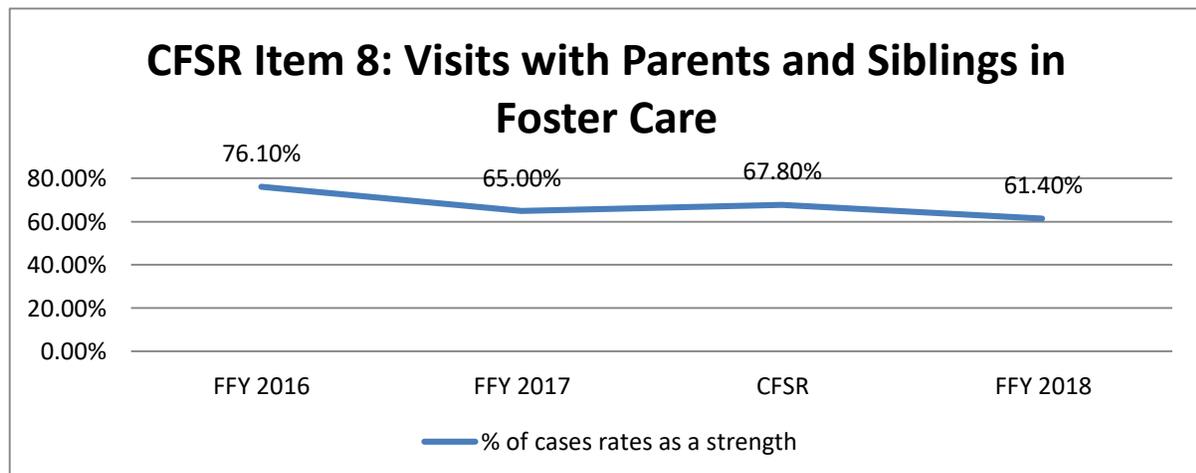
Strength Rating Defined

- During the period under review, the child had visitation with parents/caregivers and siblings (as applicable) that was of good quality and at a frequency that promoted continuity in their relationships.
- Frequency of visits is determined based on the child’s needs and the circumstances of the case and not on state policy or resource availability.
- Decisions about supervision during visits, location, length, etc., are made in such a way that supports a positive visitation experience for the child and ensures quality interactions with parents/siblings.

Concerted Efforts Required and/or Special Considerations in Rating Concerted efforts to ensure frequent, quality visitation may include:

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- Creating a visitation plan with the family that outlines details for frequency, location, duration, etc.
- Engaging relatives or kin in supporting visitation by providing transportation or assisting with supervision
- Providing transportation services for parents and children to attend visits
- Assessing the feasibility and appropriateness of visitation in prison facilities for incarcerated parents
- Discussing visitation with parents/child to assess whether frequency and quality are meeting their needs
- Facilitating the most frequent visitation possible while ensuring the child's safety



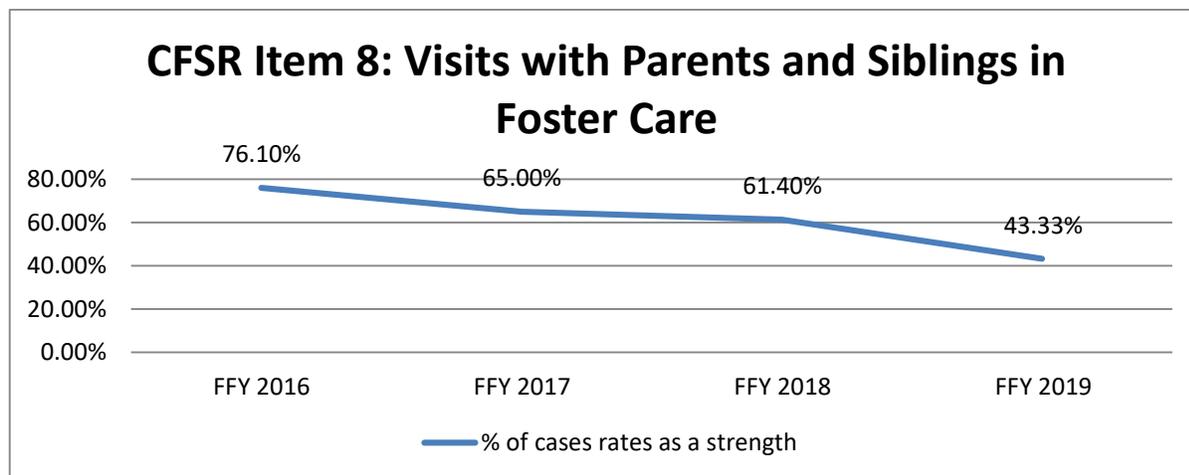
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 61.40%

FFY 2019: 43.33%



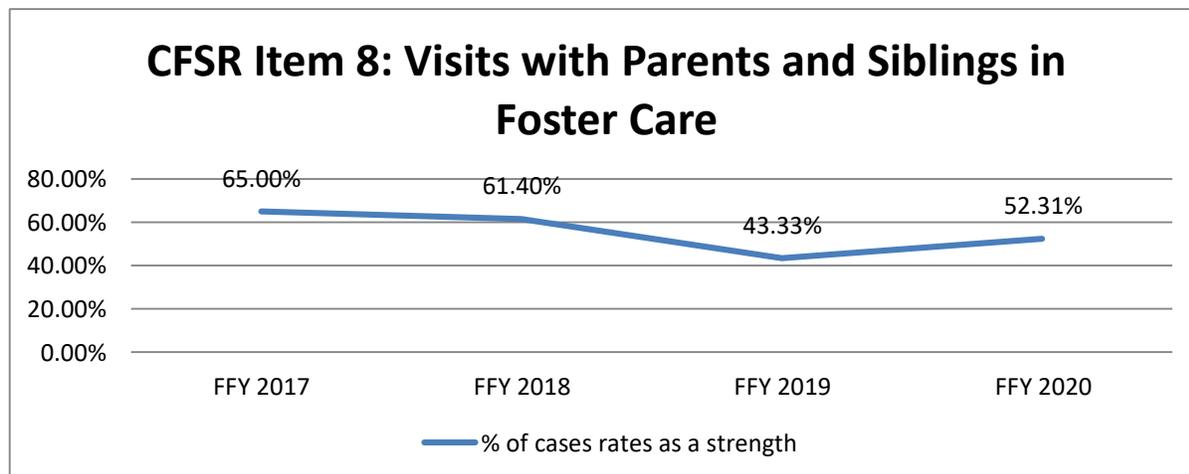
Source: DPQI Case Review Data

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 43.33%

FFY 2020: 52.34%



Source: DPQI Case Review Data

Preserving Connections (Item 9)

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Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made to maintain the child's connections to his or her neighborhood, community, faith, extended family, Tribe, school, and friends.

Strength Rating Defined

- During the period under review, the child's important connections (neighborhood, community, faith, school, extended family, Tribe, and friends) that they had before entering care were identified and maintained.
- For a child who is a member of, or eligible for membership in, a federally recognized Indian Tribe:
 - If the child entered foster care during the period under review and/or had a termination-of-parental-rights hearing during the period under review, the Tribe was provided timely notification of its right to intervene in any state court proceedings reviewing an involuntary foster care placement or termination of parental rights.
 - The child was placed in foster care in accordance with Indian Child Welfare Act placement preferences, or concerted efforts were made to do so.

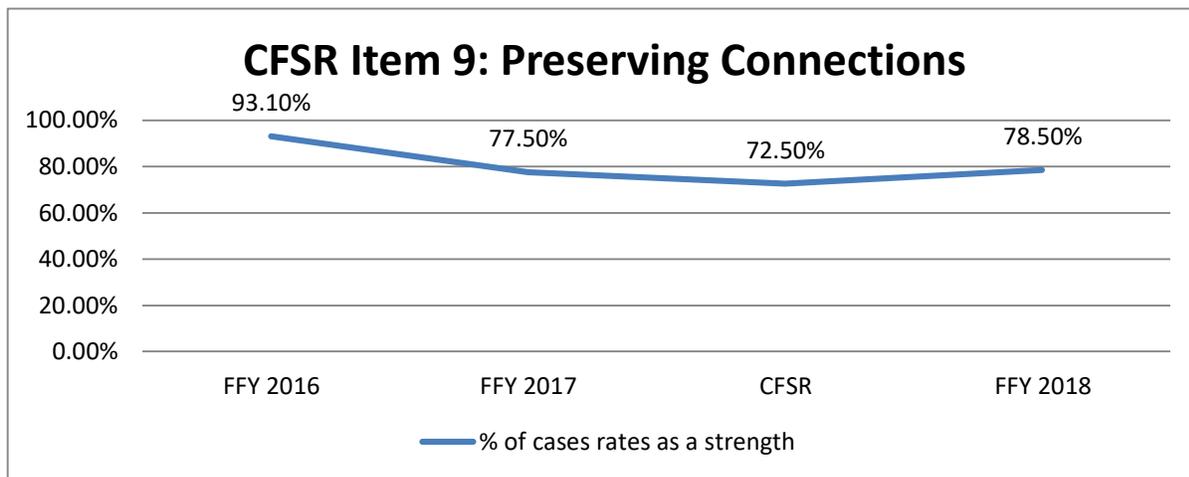
Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to preserve connections may include:

- Having discussions with the child and family, or others who are familiar with the child, in order to identify the child's most important connections
- Making efforts to maintain the child in the same school, if it is in the child's best interests to do so
- Ensuring the child has visits or contact with extended family members and siblings who are not in foster care
- Placing the child in a foster home that in the same community they lived in previously
- Taking the child to any religious activities he or she used to attend or connecting the child to a faith community with which he or she identifies
- For a child of Native American heritage, ensuring participation in tribal activities he or she had been involved in

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- Providing information to foster parents about the child’s cultural heritage and any cultural needs or preferences that should be maintained



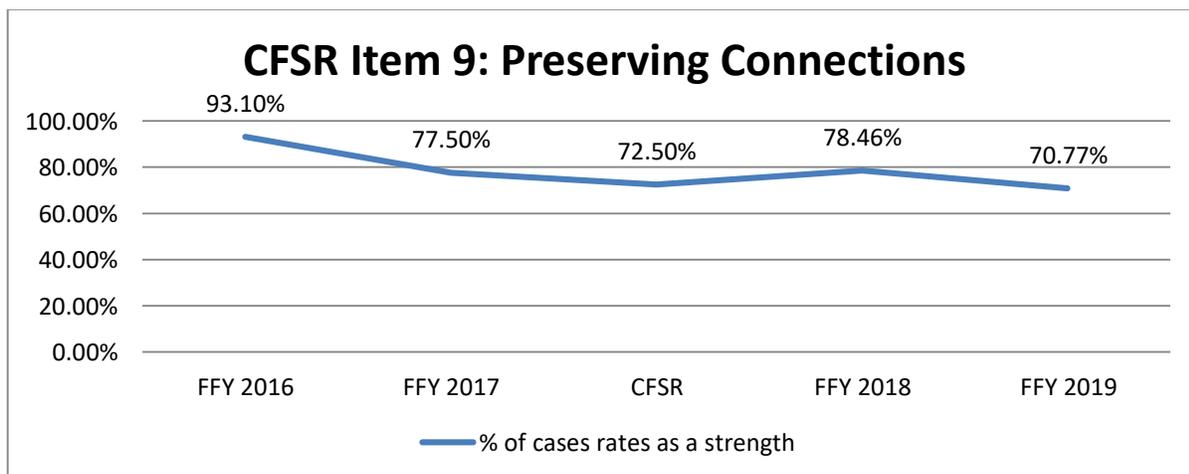
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 78.46%

FFY 2019: 70.77%



Source: DPQI Case Review Data

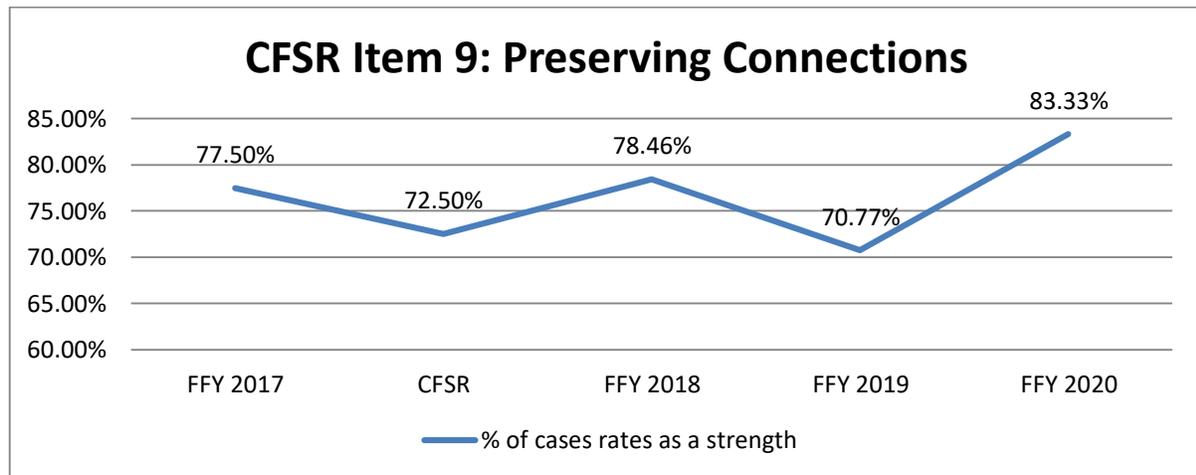
Update 2022:

**WV Department of Health and Human Resources
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DPQI Quality Assurance Case Review Data

FFY 2019: 70.77%

FFY 2020: 83.33%



Source: DOQI Case Review Data

Relative Placement (Item 10)

Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made to place the child with relatives when appropriate.

Strength Rating Defined

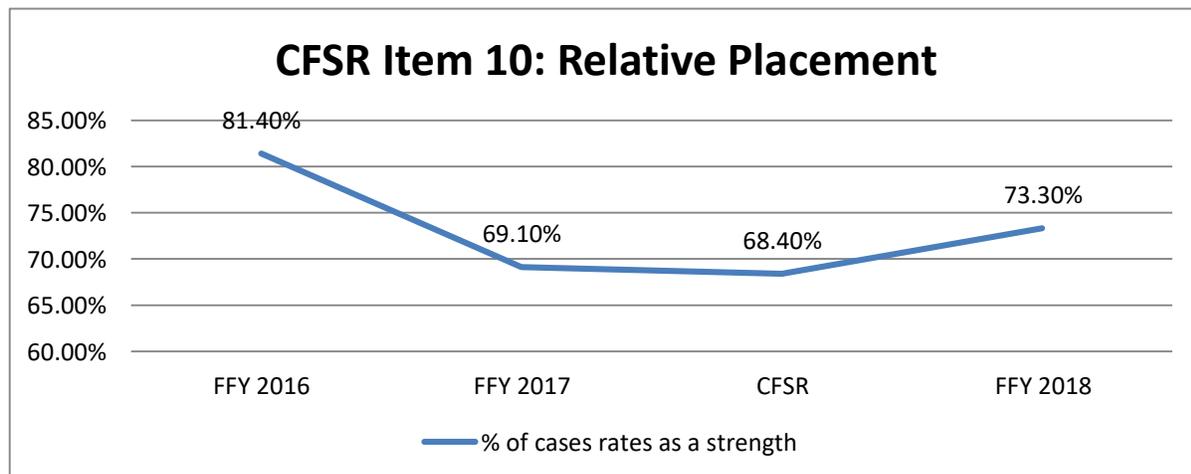
- Unless the child required a specialized placement that precluded placement with relatives, or the identity of relatives is unknown despite concerted efforts to locate them:
 - During the period under review, the child was placed with relatives and the placement was stable.
 - OR, concerted efforts were made to identify, locate, inform, and evaluate paternal and maternal relatives as potential placement resources for the child, as appropriate, during the period under review.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to identify, locate, inform, and evaluate relatives as placement resources may include:

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- Asking the child and parents/caretakers about relatives
- Sending letters to relatives to inform them of the child’s status in foster care and need for placement
- Conducting home studies of relatives
- For cases where the whereabouts of the parents/caretakers are unknown and therefore relatives are unknown, evidence that the agency made a sufficient inquiry into the parents’ identity, location, and status. Agencies are expected to use viable sources of information such as parent locator services, case files, and central registries. In some situations, posting a legal advertisement in a newspaper might be the reasonable approach if lesser methods have failed to yield results, as would contacting the parents at the last known addresses or phone numbers.
- For cases that have been opened for some time, if concerted efforts were made before the period under review, evidence that any relatives who were previously ruled out were reconsidered (if appropriate) during the period under review



Source: DPQI Case Review Data

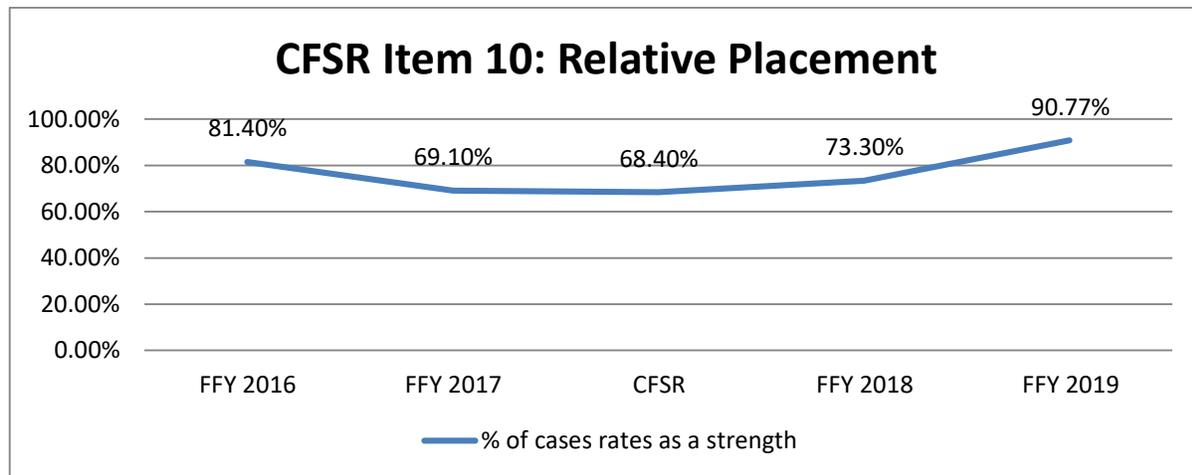
Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 73.30%

FFY 2019: 90.77%

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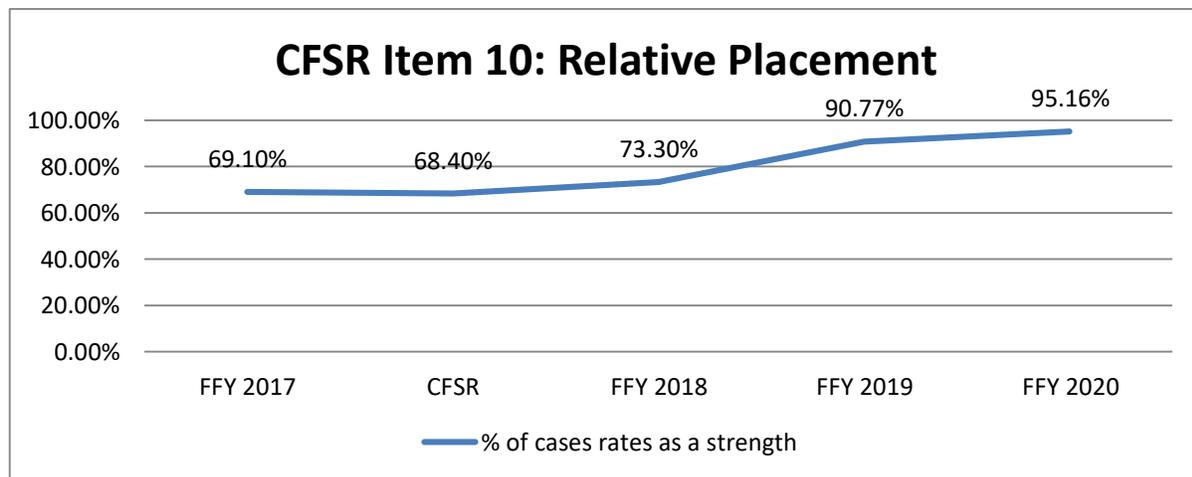
Source: DPQI Case Review Data

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 90.77%

FFY 2020: 95.16%



Source: DPQI Case Review Data

Relationship of Child in Care with Parents (Item 11)

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Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made to promote, support, and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregiver(s) from whom the child had been removed through activities other than just arranging for visitation.

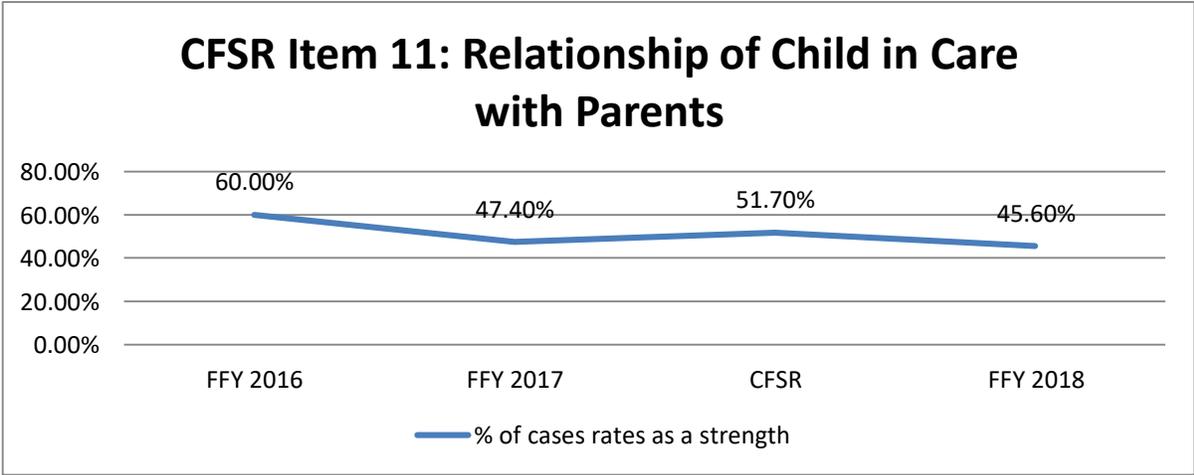
Strength Rating Defined

Concerted efforts were made during the period under review to promote, support, and otherwise maintain a positive and nurturing relationship between the child in foster care and the parents/caretakers from whom he or she was removed by encouraging and facilitating activities and interactions that go beyond just arranging for visitation.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts may include:

- Encouraging a parent’s participation in school-related activities, doctor’s appointments for the child, or engagement in after-school activities
- Providing or arranging transportation so that parents can participate in activities with the child
- Providing opportunities for therapeutic situations to strengthen the relationship
- Encouraging foster parents to serve as mentors/role models for parents
- Encouraging/facilitating communication with parents who do not live near the child and/or are unable to have frequent face-to-face visitation



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Source: DPQI Case Review Data

Outcome Permanency 2 is measured by performance on Items 7, 8, 9, 10, and 11 on the 2016 Federal CFSR Onsite Review Instrument. Case reviews conducted during federal fiscal year 2018 show Permanency 2 to be substantially achieved in 56.92% of the cases reviewed and partially achieved in 35.38% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. Permanency Outcome 2 is not measured on the WV Program Improvement Plan.

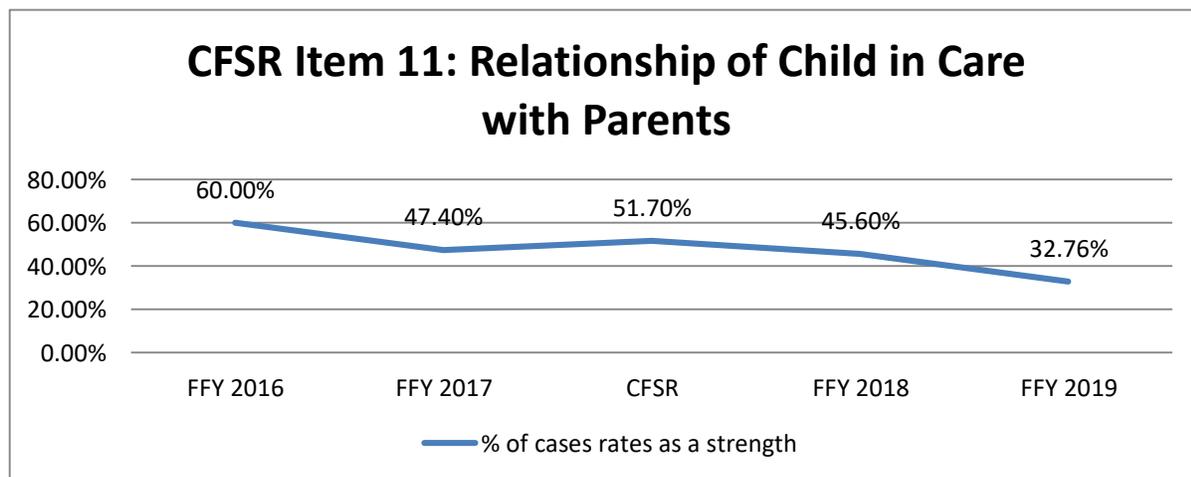
DPQI case review data has shown that CFSR Item performance on items 7, 8, 9, 10, and 11 has fluctuated over time. As is the case for most other outcomes, the co-occurrence of addiction and child maltreatment has impacted this outcome. Many districts report barriers created by the court to maintaining parent-child relationships and ensuring regular parent-child visitation as courts order no contact between the parents and child until addiction treatment has been completed or multiple drug screens return negative for substances. Other barriers to higher conformity on the outcome include inadequate number of resource homes within communities. This results in children being placed further from their home communities therefore resulting in connections not being preserved. The WV PIP does not directly address Outcome WB 3, however many of the strategies within the PIP should positively impact the outcome.

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 45.60%

FFY 2019: 32.76%



Source: DPQI Case Review Data

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Outcome Permanency 2 is measured by performance on Items 7, 8, 9, 10, and 11 on the 2016 Federal CFSR Onsite Review Instrument. Case reviews conducted during federal fiscal year 2019 show Permanency 2 to be substantially achieved in 46.27% of the cases reviewed and partially achieved in 47.76% of the cases reviewed. During FFY 2018 56.92% of the cases reviewed were substantially achieved and 35.38% of the cases reviewed were partially achieved. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

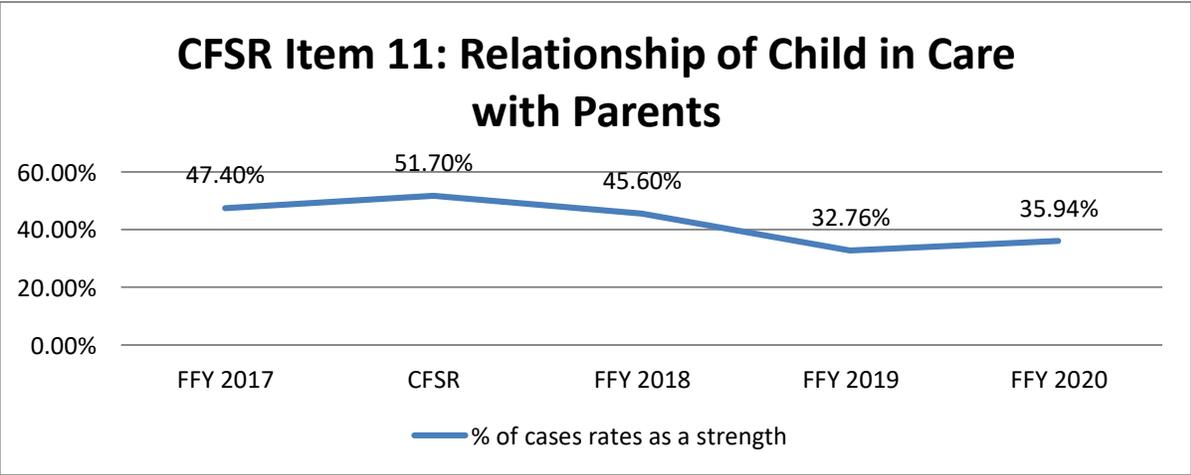
DPQI case review data has shown that CFSR Item performance on items 7-placement with siblings and item 10-relative placement showed significant improvement when FFY 2019 is compared with FFY 2018. However, CFSR items 8-visits with parents, item 9-preserving connections, and item 11-relationship of child in care with parents has decreased. District management staff continue to report barriers to higher levels of conformity are often created by the court due to mandates for completion of addiction treatment or clean drug screens prior to allowing parent-child contact. There continues to be a lack of resource homes within districts. This forces districts to place children outside of their communities, thus creating barriers to preserving existing connections for the child. Districts do utilize relative placements when available and appropriate. This is indicated in the higher performance on CFSR items 7 and 10. Although the WV PIP does not directly measure performance on Outcome WB 3, the strategies within the PIP should positively impact the outcome.

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 32.76%

FFY 2020: 35.94%



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Source: DPQI Case Review Data

Outcome Permanency 2 is measured by performance on Items 7, 8, 9, 10, and 11 on the 2016 Federal CFSR Onsite Review Instrument. During FFY 2020 52.24% of the cases reviewed were substantially achieved and 44.78% of the cases reviewed were partially achieved. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. Case reviews conducted during federal fiscal year 2019 show Permanency 2 to be substantially achieved in 46.27% of the cases reviewed and partially achieved in 47.76% of the cases reviewed.

DPQI case review data has shown that CFSR Item performance on items 8-visiting with parents and siblings in foster care, 9-preserving connections, and CFSR Item 10-relative placement showed significant improvement when FFY 2020 is compared with FFY 2019. CFSR items 7-placement with siblings, and 11-relationship of child in care with parents has decreased slightly. West Virginia continues to see an increase in the number of child maltreatment reports received and the rate of entry into foster care. The results of which have created a strain on the state's limited resources. District level management staff report utilizing relative placements when available and appropriate, and sometimes having difficulty placing siblings together if a relative placement is not available. A barrier to higher achievement on visitation between parents and children as well as supporting the parent-child relationship is the reluctance of courts to allow contact between parents and children due to the failure of parents to complete substance abuse treatment or achieve negative drug screens. Although the WV PIP does not directly measure performance on Outcome Well-Being 3, the strategies within the PIP should positively impact the outcome.

Well-Being

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

Needs and Services of Child, Parents, and Foster Parents (Item 12)

Purpose of Assessment: To determine whether, during the period under review, the agency (1) made concerted efforts to assess the needs of children, parents, and foster parents (both initially, if the child entered foster care or the case was opened during the period under review, and on an ongoing basis) to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family, and (2) provided the appropriate services.

Strength Rating Defined

- Concerted efforts were made during the period under review to accurately and comprehensively assess the needs of the children, parents, and foster parents initially (for cases that opened during the period under review) and periodically on an ongoing basis (as needed) to update assessment information relevant to ongoing case planning.

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- Assessment of needs for the children does not include education, physical health, and mental/behavioral health (including substance abuse)
- Assessment of needs for parents refers to a determination of what the parents need to provide appropriate care and supervision and to ensure the safety and well-being of their children
- Assessment of needs for foster parents refers to a determination of what the foster parents need to provide appropriate care and supervision to the child in their home
- Concerted efforts were made during the period under review to provide appropriate services to the children, parents, and foster parents that were matched to needs identified in assessments.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to locate parents may include:

- Contacting the parents at the last known addresses or phone numbers
- Using the federal parent locator service, reviewing case files/central registries
- Asking about relatives and making efforts to contact any identified relatives
- Asking the children's current/previous schools for parent information
- Posting a legal advertisement in a newspaper (after all other search methods have been exhausted)

Concerted efforts to assess needs may include:

- Conducting formal assessments through a contracted provider or another agency
- Conducting informal but thorough assessments using interviews with the child, family, and service providers
- Spending adequate time engaging with the child, parents, and foster parents to gain an in-depth understanding of their needs
- Using screening and assessment tools to assess specific issues such as domestic violence, substance abuse, cognitive abilities, or parenting skills

Concerted efforts to provide appropriate services may include:

- Ensuring accessibility of needed services by providing for transportation

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- Monitoring service participation to ensure that the services are meeting needs
- Ensuring availability of services by removing or addressing any barriers to participation, such as waitlists or scheduling conflicts
- Ensuring that services are matched to the parents needs and are culturally appropriate

Reviewers should not rate a parent for this item if, during the entire period under review, the case file documented that it was not in the child’s best interests to involve the parent in case planning. In such a situation, the item questions are not applicable. This would include cases in which there are ongoing safety threats that could emotionally or physically re-traumatize the child and that cannot be mitigated by the agency or other interventions. Typically, both the agency and court are involved in making this determination.

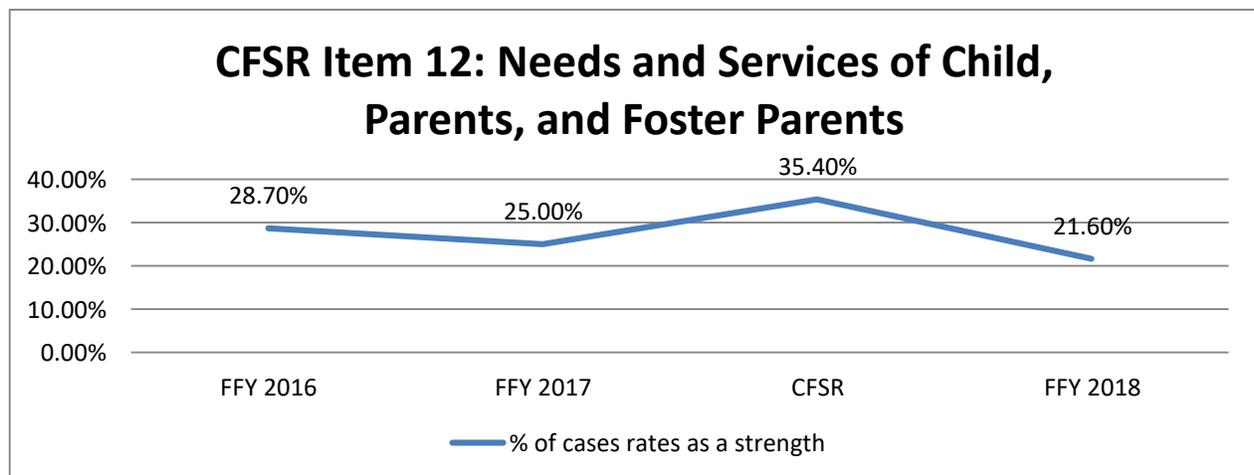
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

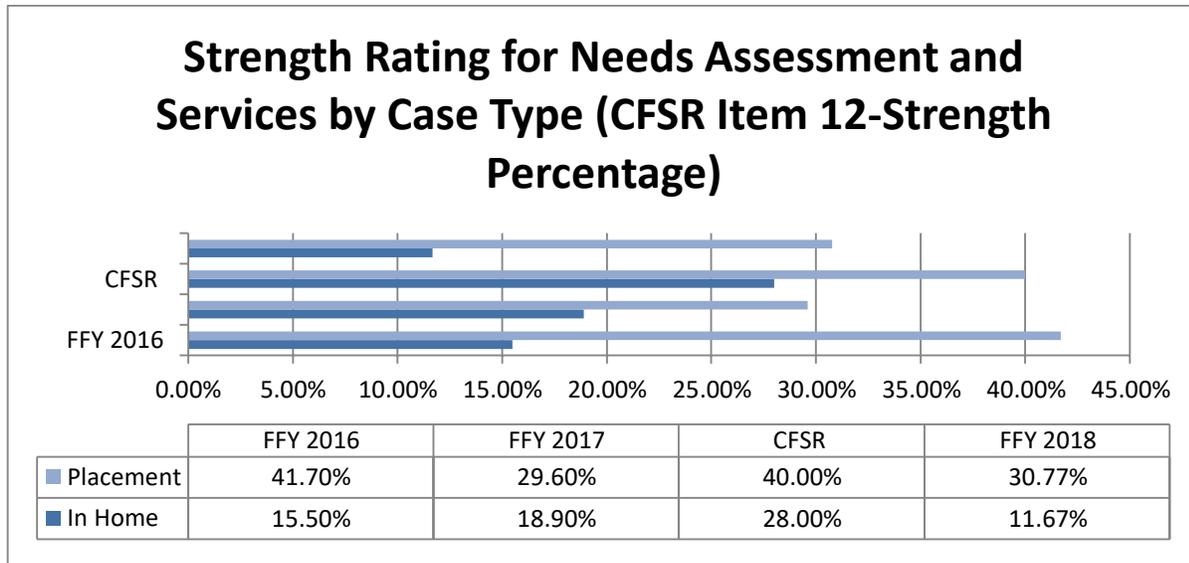
Baseline: 19.2%

PIP Goal: 23.7%

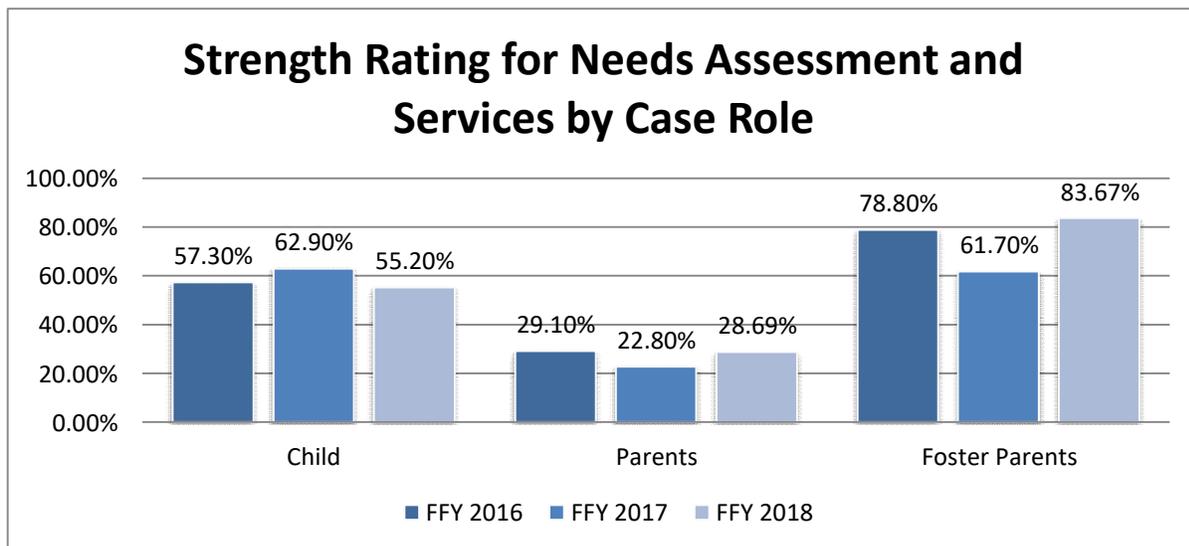
Reporting Period 6/2018-5/2019: 28%



Source: DPQI Case Review Data



DPQI Case Review Data



DPQI Case Review Data

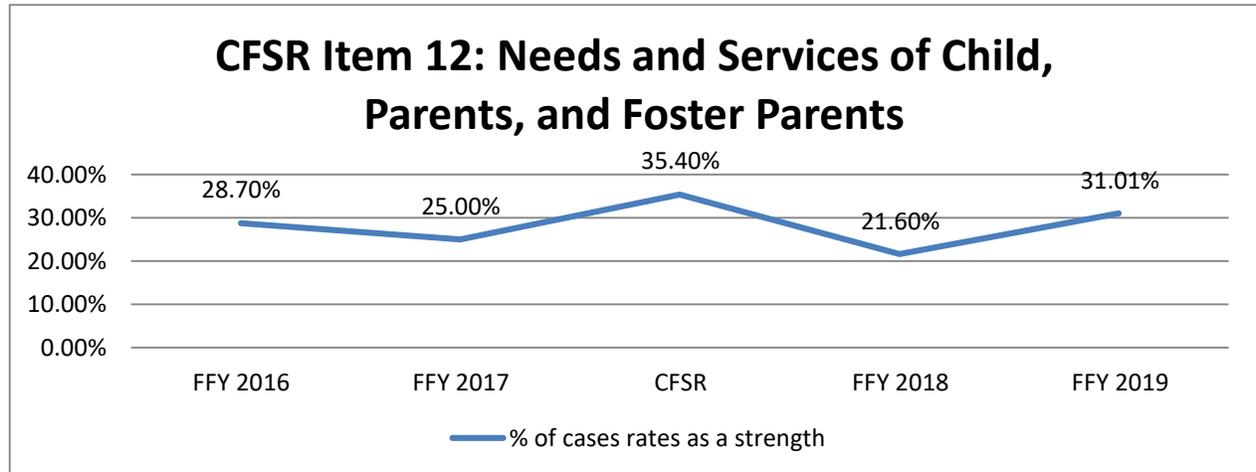
Update 2021:

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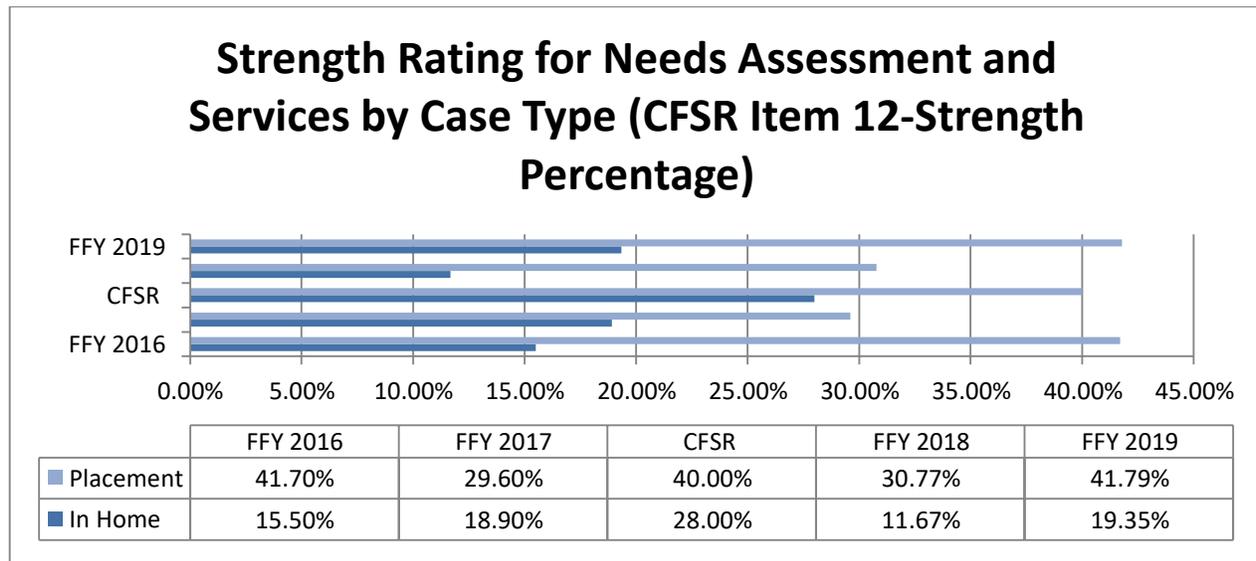
DPQI Quality Assurance Case Review Data

FFY 2018: 21.6%

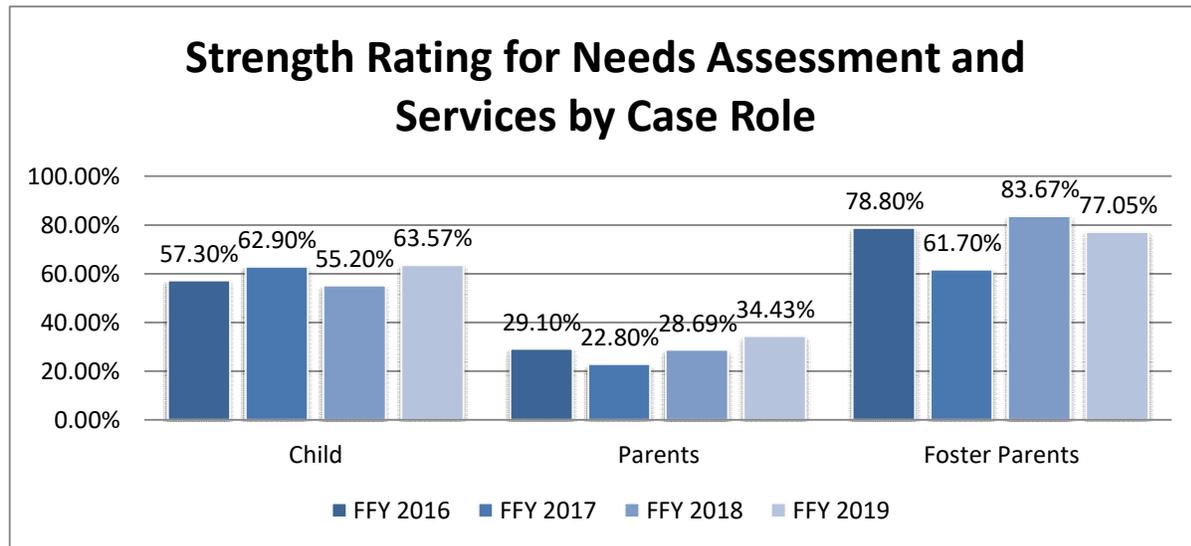
FFY 2019: 31.01%



Source: DPQI Case Review Data



Source: DPQI Case Review Data



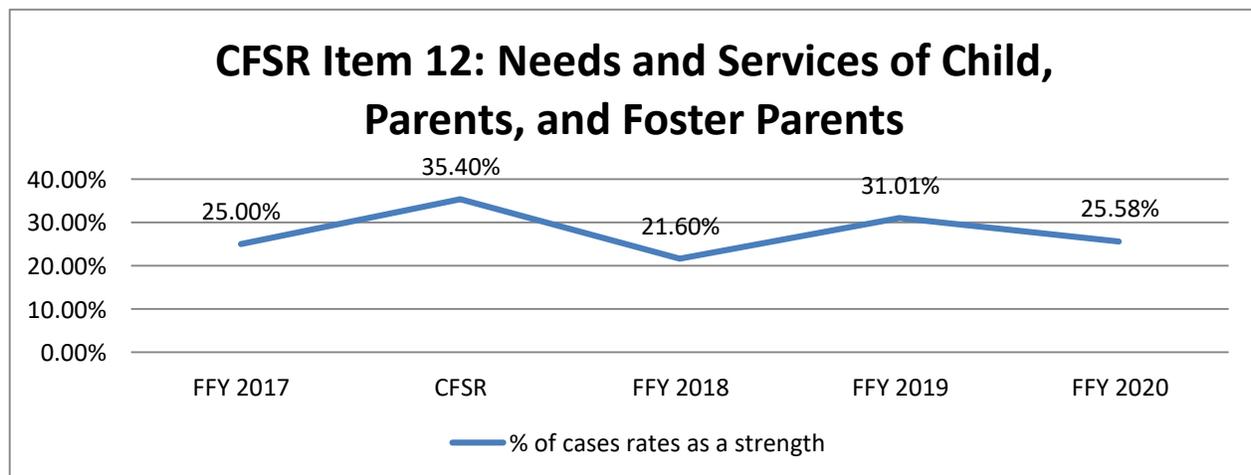
Source: DPQI Case Review Data

Update 2022:

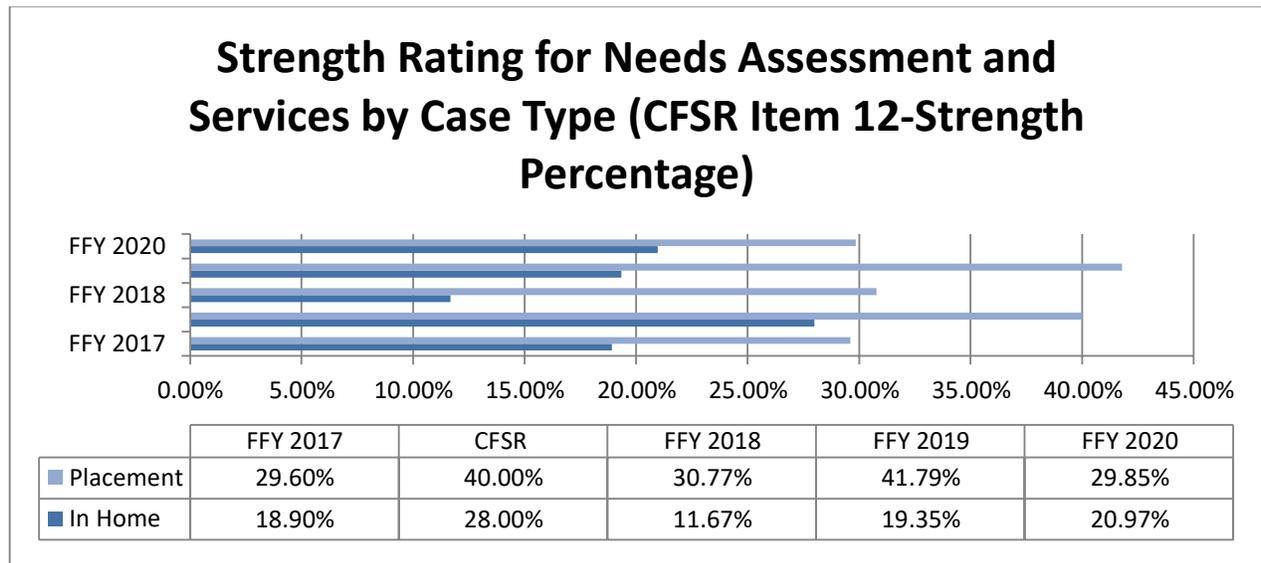
DPQI Quality Assurance Case Review Data

FFY 2019: 31.01%

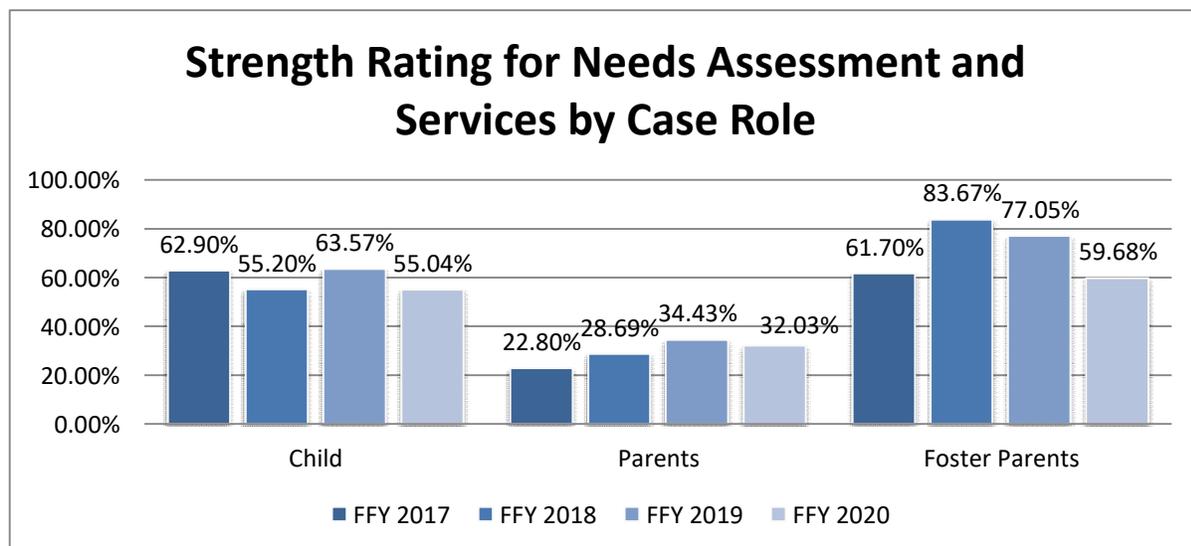
FFY 2020: 25.58



Source: DPQI Case Review Data



DPQI Case Review Data



DPQI Case Review Data

Child and Family Involvement in Case Planning (Item 13)

Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made (or are being made) to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis.

Strength Rating Defined

During the period under review, concerted efforts were made to actively involve the children (if developmentally appropriate) and parents/caretakers in case planning activities.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to engage families in case planning may include:

- Having age-appropriate discussions with children and explaining case plans in language they understand
- Ensuring children understand permanency goals and changes made to goals
- Discussing family strengths and needs with children and parents
- Evaluating other case plan goals and progress in services with both children and parents
- Ensuring that case planning meetings are arranged based on the family's availability and are utilized to engage the family in case planning discussions

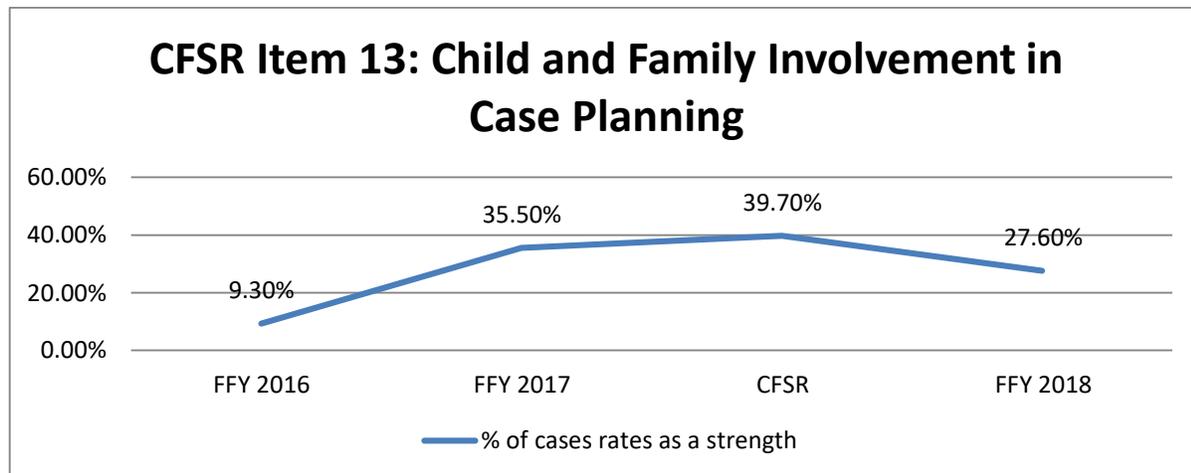
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

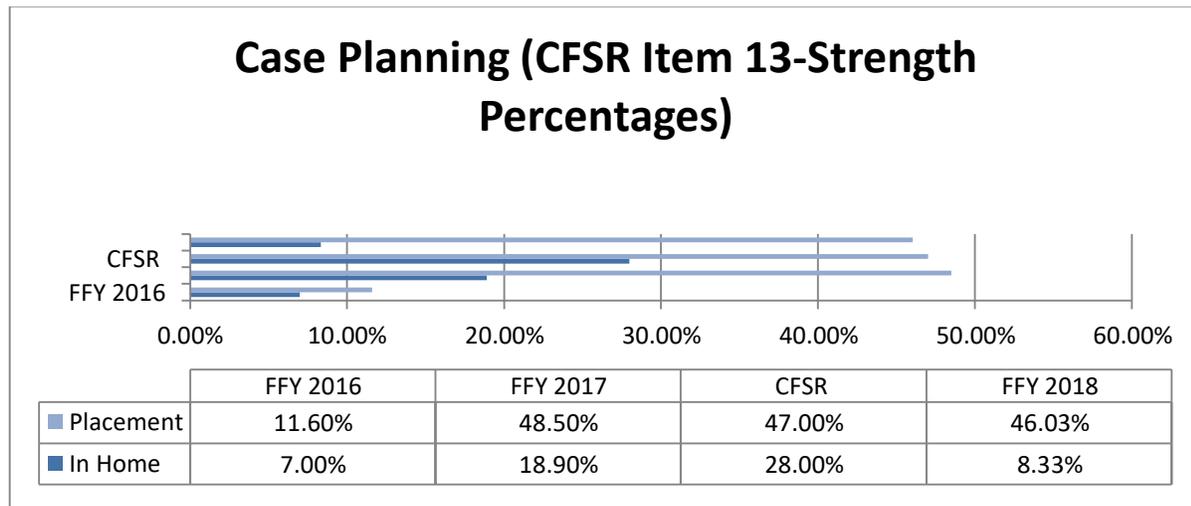
Baseline: 27.6%

PIP Goal: 32.8%

Reporting Period 6/2018-5/2019: 35.25%



Source: DPQI Case Review Data



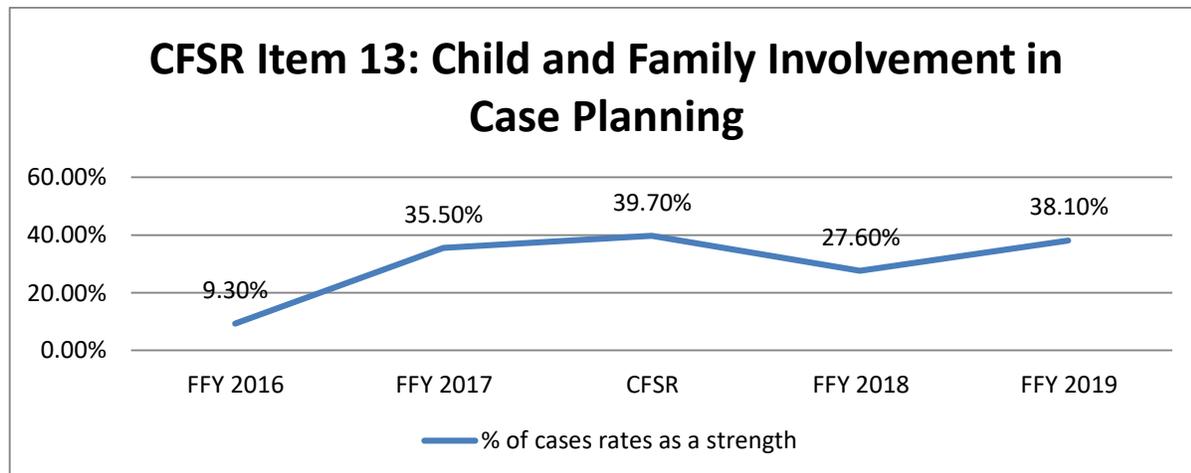
Source: DPQI Case Review Data

Update 2021:

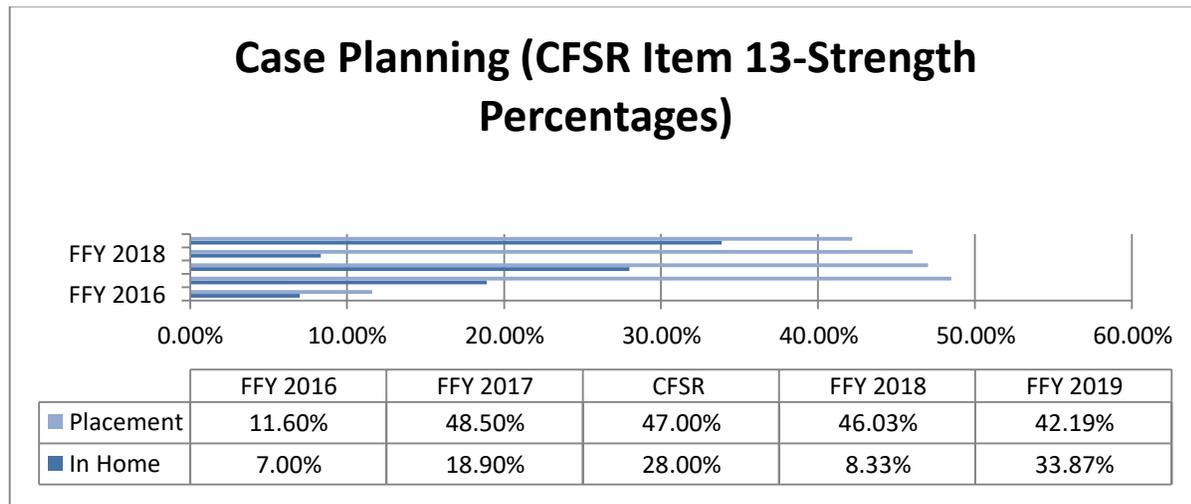
DPQI Quality Assurance Case Review Data

FFY 2018: 27.64%

FFY 2019: 38.1%



Source: DPQI Case Review Data



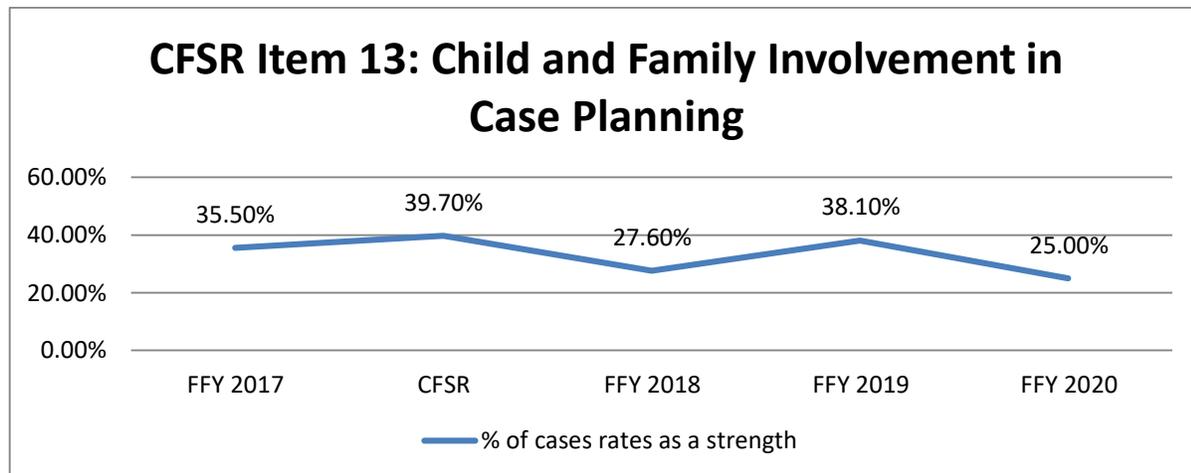
Source: DPQI Case Review Data

Update 2022:

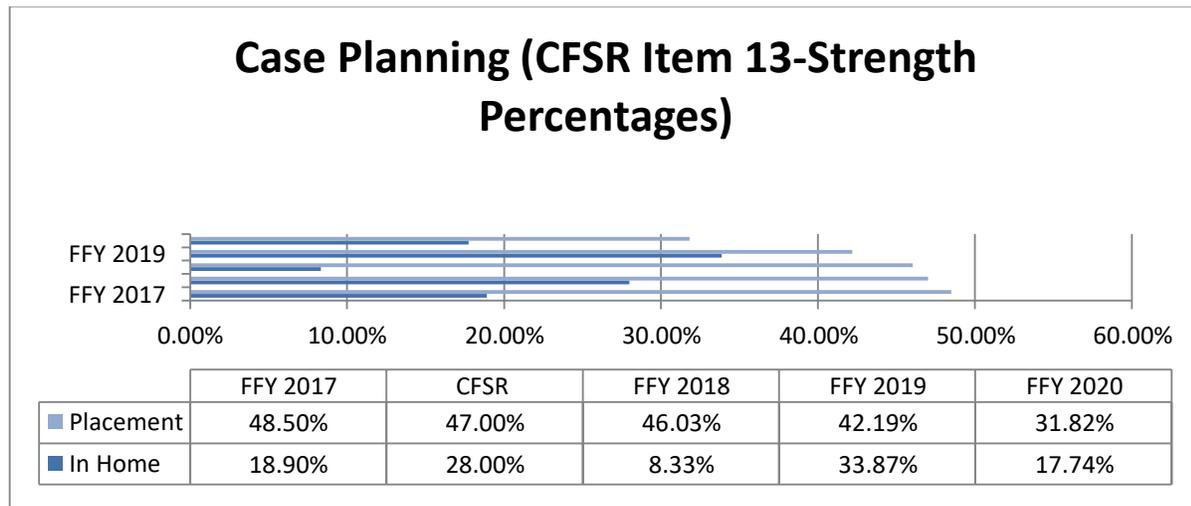
DPQI Quality Assurance Case Review Data

FFY 2019: 38.1%

FFY 2020: 25%



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Caseworker Visits with Child (Item 14)

Purpose of Assessment: To determine whether the frequency and quality of visits between caseworkers and the child(ren) in the case are sufficient to ensure the safety, permanency, and well-being of the child and promote achievement of case goals.

Strength Rating Defined

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During the period under review, the caseworker visited the children (for in-home cases, all children must be visited) frequently enough to adequately assess their safety, promote timely achievement of case goals, and support their well-being. The visits were of good quality, with discussions focusing on the children’s needs, services, and case plan goals. The children were visited alone, and the length and location of visits was conducive to open, honest, and thorough conversations.

Concerted Efforts Required and/or Special Considerations in Rating

Typically, visit frequency must be at least monthly for a Strength rating, unless there is substantial justification for less frequent visits.

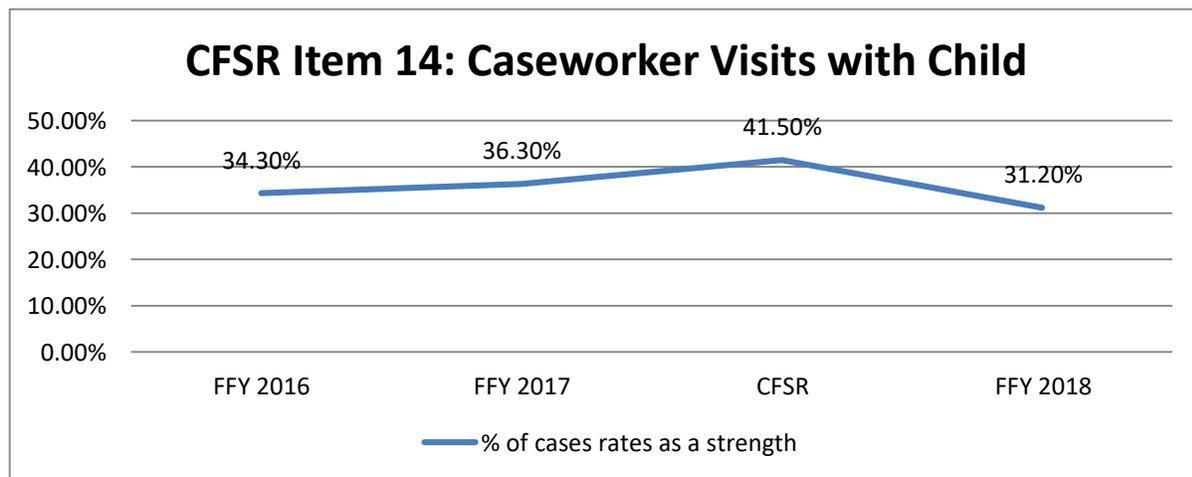
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

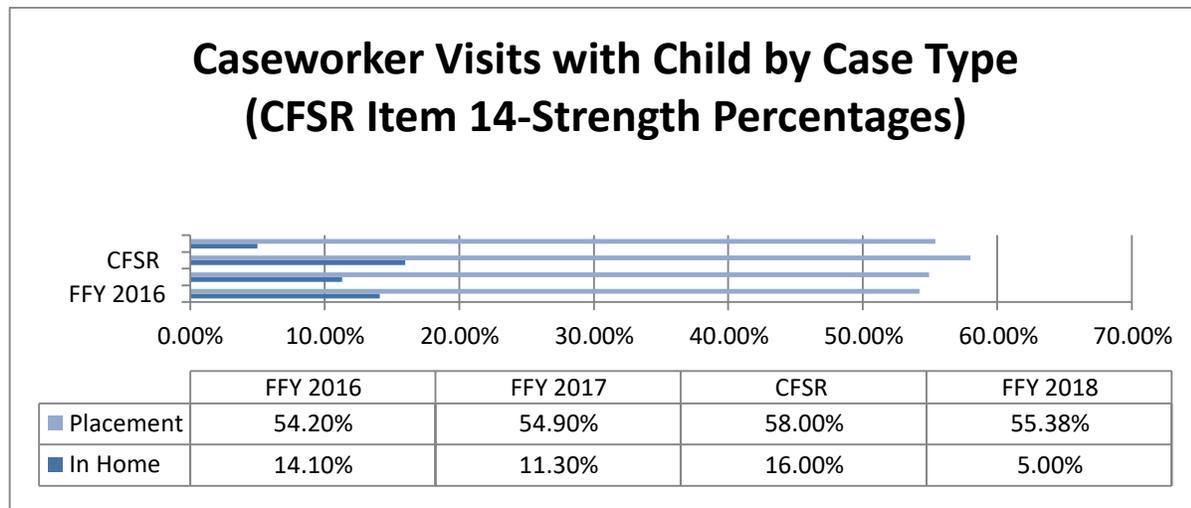
Baseline: 29.6%

PIP Goal: 34.8%

Reporting Period 6/2018-5/2019: 26.4%



Source: DPQI Case Review Data



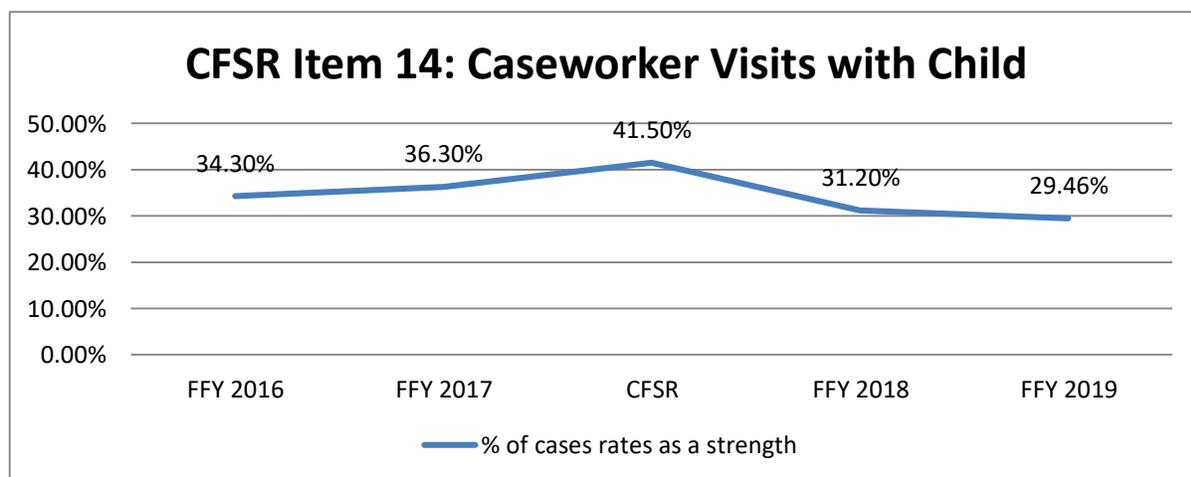
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

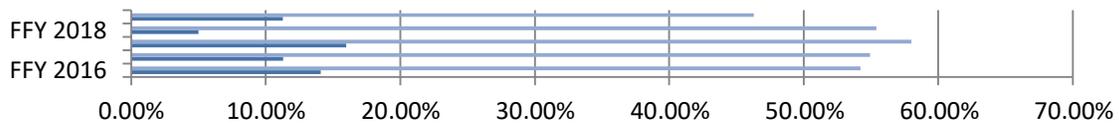
FFY 2018: 31.2%

FFY 2019: 29.46%



Source: DPQI Case Review Data

Caseworker Visits with Child by Case Type (CFSR Item 14-Strength Percentages)



	FFY 2016	FFY 2017	CFSR	FFY 2018	FFY 2019
■ Placement	54.20%	54.90%	58.00%	55.38%	46.27%
■ In Home	14.10%	11.30%	16.00%	5.00%	11.29%

Source: DPQI Case Review Data

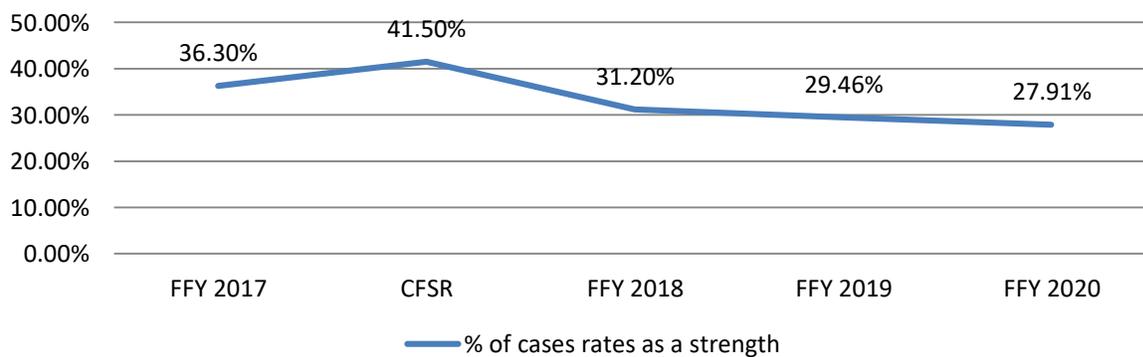
Update 2022:

DPQI Quality Assurance Case Review Data

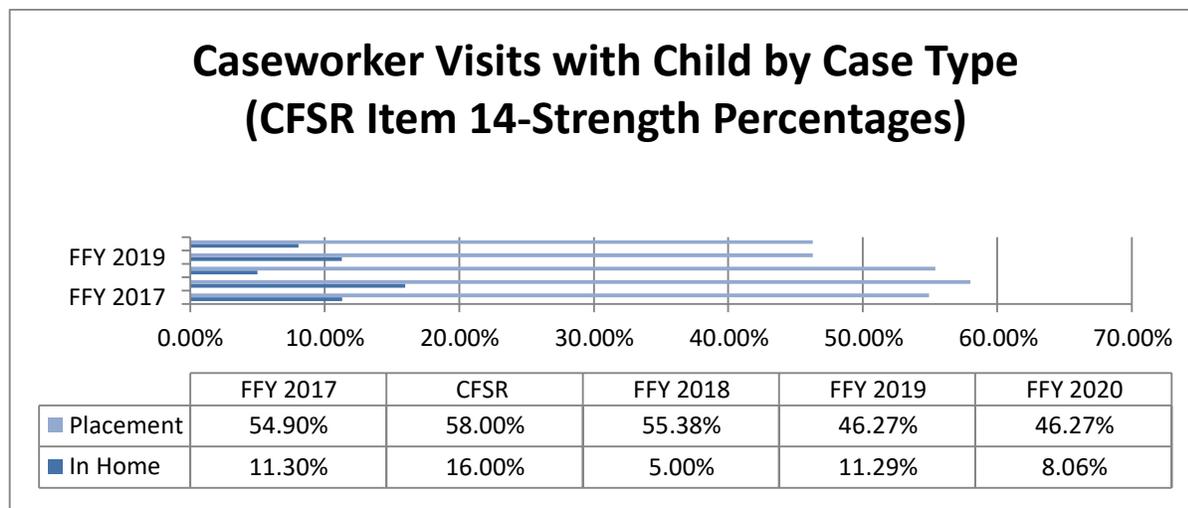
FFY 2019: 29.46%

FFY 2020: 27.91%

CFSR Item 14: Caseworker Visits with Child



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Caseworker Visits with Parents (Item 15)

Purpose of Assessment: To determine whether, during the period under review, the frequency and quality of visits between caseworkers and the mothers and fathers of the child(ren) are sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals.

Strength Rating Defined

During the period under review, the caseworker visited the parents frequently enough to monitor their progress in services, promote timely achievement of case goals, and effectively address their children’s safety, permanency, and well-being needs. The visits were of good quality, with discussions focusing on the parent’s and children’s needs, services, and case plan goals. The length and location of visits were conducive to open, honest, and thorough conversations.

Concerted Efforts Required and/or Special Considerations in Rating

Typically, visit frequency must be at least monthly for a Strength rating, unless there is substantial justification for less frequent visits, which could vary depending on the circumstances of the case. For example, for parents who are incarcerated, efforts should be made to arrange face-to-face contact; however, this may not be permitted or viable in a facility that is out of state. A similar situation would be parents who live out of state. In lieu of face-to-face visits, the agency’s efforts to maintain monthly communication with the parent via phone calls and/or letters should be considered.

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If the case goal is not to place the child with that parent permanently, monthly face-to-face contact is not always required for a Strength rating, and frequency should be determined based on the circumstances of the case and needs of the children.

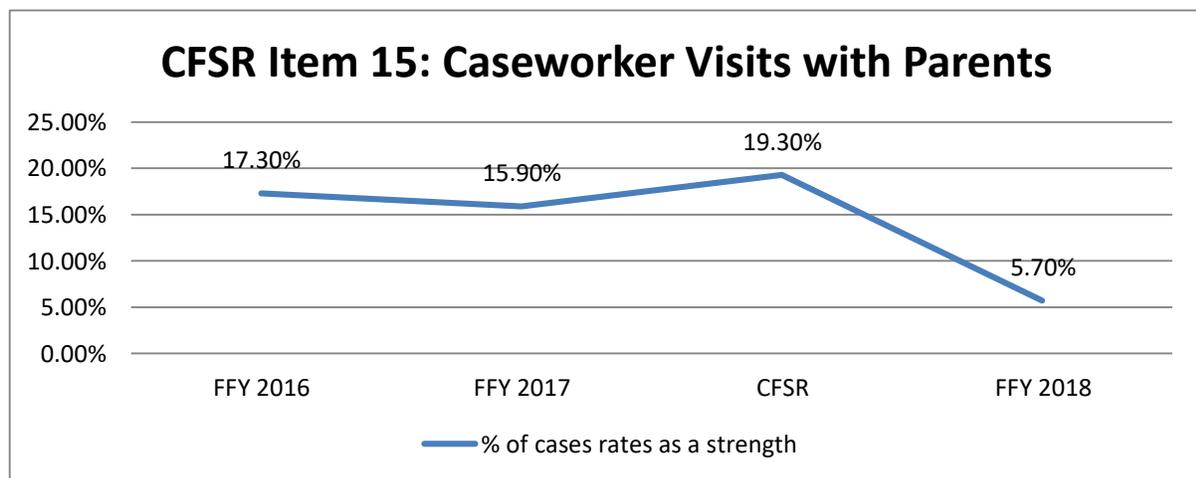
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

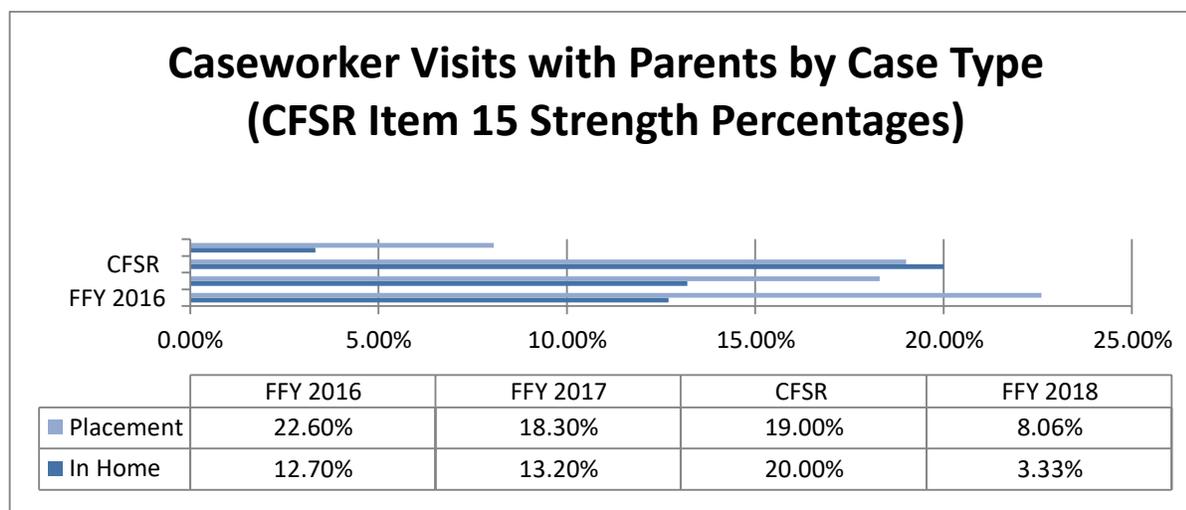
Baseline: 5.7%

PIP Goal: 8.4%

Reporting Period 6/2018-5/2019: 5.88%



Source: DPQI Case Review Data



Source: DPQI Case Review Data

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 2018 case review data indicates Well-Being Outcome 1 was substantially achieved in 12% of the cases reviewed, and partially achieved in 31.2% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. The Child and Family Reviews Rd. 3 baseline indicated Permanency 1 as substantially achieved in 41.54% of the applicable cases reviewed. During this time period Item 12 rated as strength in 19.2% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 23.7%. The item rated 28% strength during the first PIP reporting period. Therefore, meeting the PIP goal for this item The Child and Family Reviews Rd. 3 baseline indicated Item 13 as rated strength in 27.6% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 32.8%. The item rated as strength in 35.25% of the applicable cases reviewed during the PIP first reporting period. Therefore, meeting the PIP goal for this item. The Child and Family Reviews Rd. 3 baseline indicated Item 14 as strength in 29.6% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 34.8%. The item rated as strength in 26.4% of the applicable cases reviewed during the PIP first reporting period. The Child and Family Reviews Rd. 3 baseline indicated Item 15 as strength in 5.7% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 8.4%. The item rated as strength in 5.88% of the applicable cases reviewed during the PIP first reporting period.

Review data indicates 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. As the Practice Performance Report accurately indicates, neither the quality nor the quantity of caseworker contacts with children and parents is sufficient to ensure child safety and achieve case goals.

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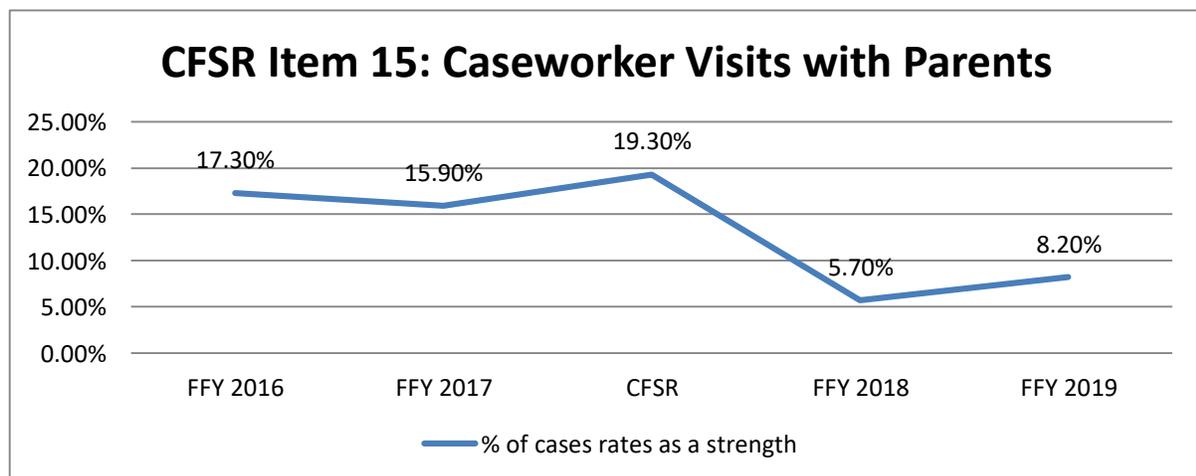
Well-Being Outcome 1 data has fluctuated somewhat over time, but overall has decreased since FFY 2015. Reviewed cases show concerning trends which include lack of regular quality contact with children and families, failure to regularly assess for child and family service needs throughout the life of the case, less than optimal service provision to address identified needs, lack of establishment of case plans/goals through engagement of family members, and failure to close cases timely. These barriers to higher outcome achievement are addressed in the WV PIP through closure of cases timely and when appropriate, stabilization of the workforce, more frequent and higher quality interactions between caseworkers and supervisors, improvement of staffs' knowledge of available treatment services, and enhancements to service array to address substance abuse and other identified needs to ensure appropriate and individualized services are available and accessible.

Update 2021:

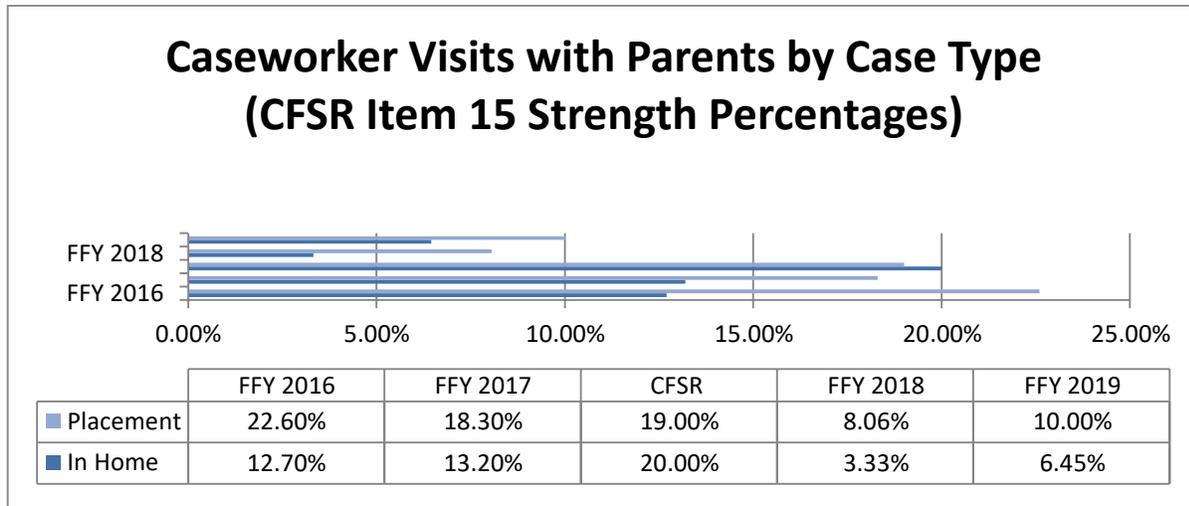
DPQI Quality Assurance Case Review Data

FFY 2018: 5.74%

FFY 2019: 8.2%



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Well-Being Outcome 1 is measured by performance on CFSR Items 12-needs and services of child, parents, and foster parents, 13-child and family involvement in case planning, 14-caseworker visits with child, and 15-caseworker visits with parents on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2019 case review data indicates Well-Being Outcome 1 was substantially achieved in 17.05% of the cases reviewed, and partially achieved in 36.43% of the cases reviewed. Federal fiscal year 2018 case review data indicates Well-Being Outcome 1 was substantially achieved in 12% of the cases reviewed, and partially achieved in 31.2% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. Court

DPQI social services case review data shows an overall increase of 5.05% for Well-Being Outcome 1 when FFYs 2018 and 2019 are compared. The data indicates an increase of 9.41% for Item 12, an increase of 10.5% for Item 13, a slight decrease of 1.74% for Item 14, and an increase of 2.46% for Item 15. While placement cases continue to perform higher on the measures, increases in all four of the CFSR items that make up the outcome were observed in relation to in-home cases during FFY 2019.

Despite the increases in performance observed for the CFSR items that comprise Well-Being Outcome 1 barriers to higher achievement remain. These barriers include the inability to retain sufficient staffing levels in the districts, the inability of caseworkers to have frequent and quality contacts with children and parents, the lack of quality assessments of needs for children and parents, and the lack of sufficient provision of services to address the identified needs. These barriers to higher measurement achievement are addressed in the WV CFSR Rd. 3 Program Improvement Plan. The WV PIP includes partnering with the Capacity Center for States to map available services and to identify service array gaps, increase the ability of supervisors to support staff and oversee casework activities, attract and retain qualified staff, ensure quality meaningful contact with children and parents occurs regularly regardless of case type, increase rapport between agency and judicial staff, and increase support and engagement of foster parents. Data

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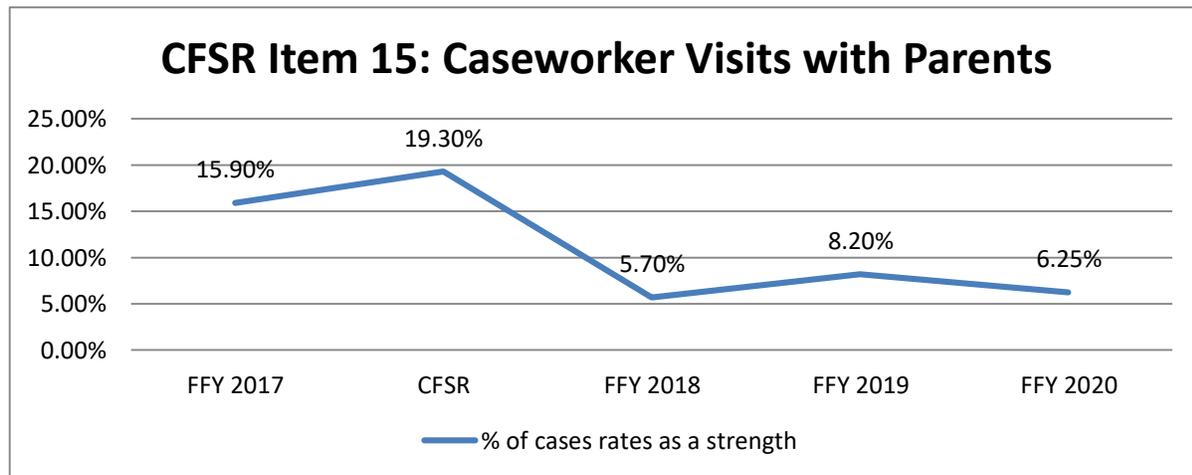
related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children’s Bureau by the due date of June 1, 2020.

Update 2022:

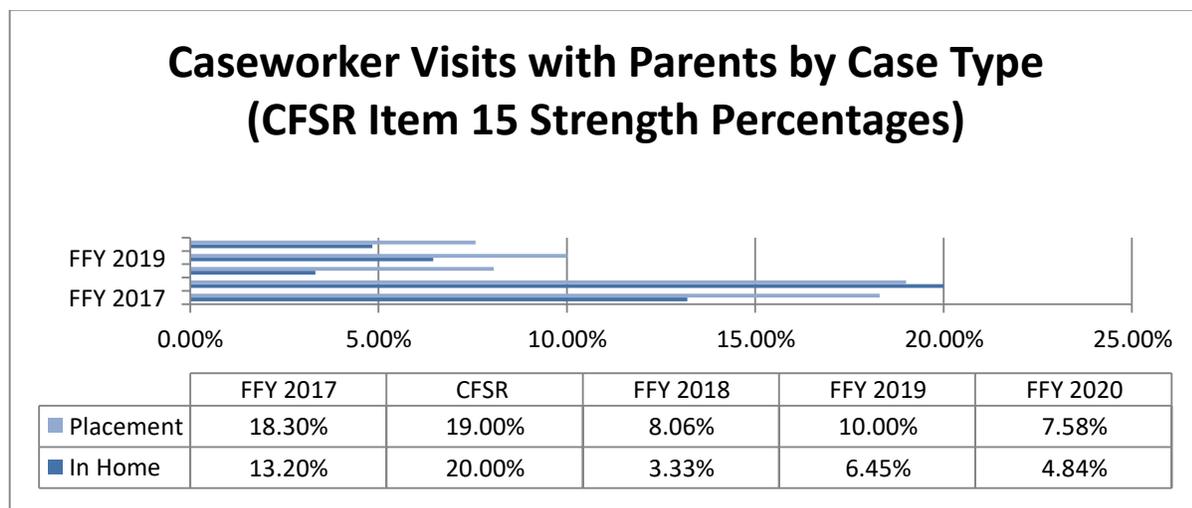
DPQI Quality Assurance Case Review Data

FFY 2019: 8.2%

FFY 2020: 6.25%



Source: DPQI Case Review Data



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Source: DPQI Case Review Data

Well-Being Outcome 1 is measured by performance on CFSR Items 12-needs and services of child, parents, and foster parents, 13-child and family involvement in case planning, 14-caseworker visits with child, and 15-caseworker visits with parents on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2020 case review data indicates Well-Being Outcome 1 was substantially achieved in 11.63% of the cases reviewed, and partially achieved in 33.33% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. Federal fiscal year 2019 case review data indicates Well-Being Outcome 1 was substantially achieved in 17.05% of the cases reviewed, and partially achieved in 36.43% of the cases reviewed.

DPQI social services case review data shows an overall increase of 5.42% for Well-Being Outcome 1 when FFYs 2020 and 2019 are compared. DPQI case reviews show a decrease in the four CFSR items measured in this outcome when the two FFY are compared. The decreases in performance include an overall decrease of 5.43% for CFSR Item 12, which includes a significant decrease of 17.37% for subitem 12C-assessments and services of foster parents. CFSR Item 13 shows a 13.1% decrease in performance, while CFSR Items 14 and 15 both show a 1.55% and 2% decrease, respectively.

Higher CFSR item and outcome ratings continue to be seen in placement cases when compared to in-home cases. Strikingly significant is the difference between the quantity and quality of contact between caseworkers and families when the two case types are compared. DPQI social services case review data for FFY 2019 and FFY 2020 indicate that a child in an in-home case is over five times less likely to have regular meaningful contact with an agency caseworker when compared to a child in a placement setting. Case review data indicates that the overall level of contact between caseworkers and children and parents, regardless of case type, is well below a standard which would allow for the ongoing assessment of child safety and ensuring appropriate service provision throughout the life of a case.

District staff often indicate barriers to high levels of achievement include the inability to retain sufficient staffing levels, inadequate quality and quantity of substance abuse services, and the continual need to prioritize intakes over ongoing casework. These barriers to higher measurement achievement are addressed in the WV CFSR Rd. 3 Program Improvement Plan. The WV PIP includes partnering with the Capacity Center for States to map available addiction services and to identify service array gaps, increase the ability of supervisors to support staff and oversee casework activities, attract and retain qualified staff, ensure meaningful contact with children and parents occurs regularly regardless of case type, increase rapport between agency and judicial staff, and increase support and engagement of foster parents. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 30, 2021.

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

Educational Needs of the Child (Item 16)

Purpose of Assessment: To assess whether, during the period under review, the agency made concerted efforts to assess children’s educational needs at the initial contact with the child (if the case was opened during the period under review) or on an ongoing basis (if the case was opened before the period under review), and whether identified needs were appropriately addressed in case planning and case management activities.

Strength Rating Defined

Concerted efforts were made during the period under review to assess the children’s educational needs initially (if the case was opened during the period under review) or on an ongoing basis and to provide appropriate services to address needs.

Concerted Efforts Required and/or Special Considerations in Rating

In-home cases are only applicable for this item if (1) educational issues are relevant to the reason for the agency’s involvement with the family and/or (2) it is reasonable to expect that the agency would address educational issues given the circumstances of the case.

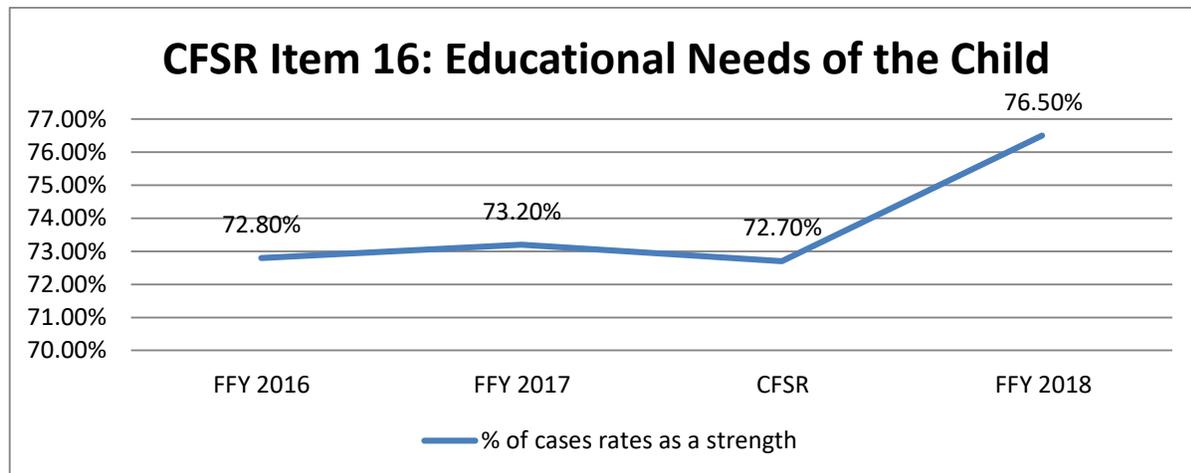
The focus of this item is on agency efforts, even if those efforts were not fully successful due to factors beyond the agency’s control.

Concerted efforts to assess needs may include:

- Having an educational assessment conducted by the school
- Conducting an informal assessment based on interviews with the child, parents/caretakers, and/or foster parents

Concerted efforts to provide services may include:

- Advocating for services on behalf of the child (by the caseworker and/or foster parents)



Source: DPQI Case Review Data

Well-Being Outcome 2 is measured by performance on Item 16 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2018 case review data indicates Well-Being Outcome 2 was substantially achieved in 76.54% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

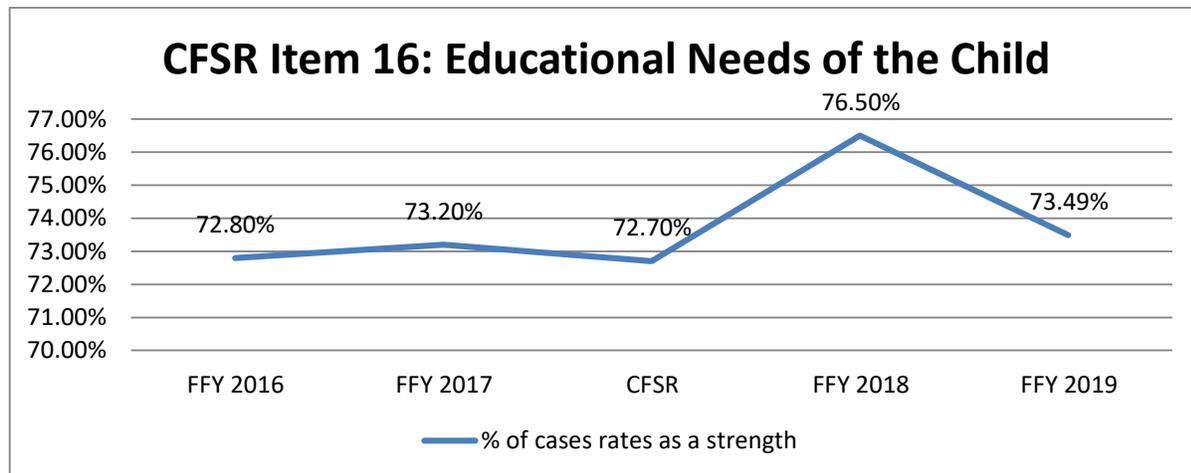
When examined over the prior CFSP time period of FFY 2015-FFY 2018, Well-Being Outcome 2 data indicated a general upward trend. Caseworkers are doing better at identifying educational needs of children and ensuring such needs are met through service provision. Case reviews indicate the Safe at Home West Virginia program has had a positive impact on this outcome. The WV PIP does not directly address WB 3, however many of the strategies within the PIP should positively impact the outcome.

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 76.54%

FFY 2019: 73.49%



Source: DPQI Case Review Data

Well-Being Outcome 2 is measured by performance on Item 16-educational needs of the child on the 2016 Federal CFSR Onsite Review Instrument. DPQI social services case reviews indicate Well-Being Outcome 2 was substantially achieved in 73.49% of the cases reviewed. Federal fiscal year 2018 case review data indicates Well-Being Outcome 2 was substantially achieved in 76.54% of the cases reviewed. This is a decrease of 3.05% when the two FFYs are compared. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

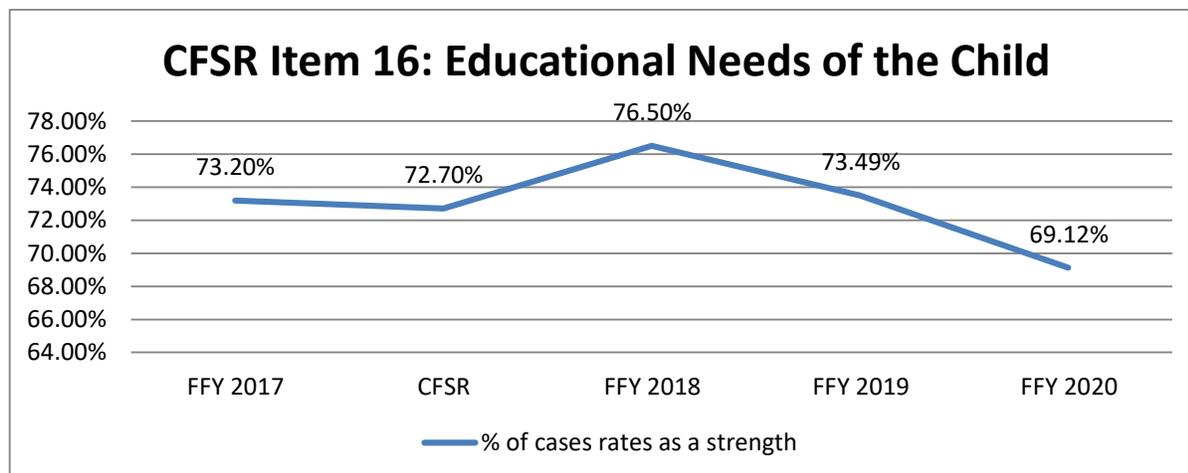
DPQI case reviews indicate the Safe at Home West Virginia program has had a positive impact on this outcome. The program is being expanded and this should result in higher performance on the measure in the upcoming review periods. The WV PIP does not directly address WB 3, however many of the strategies within the PIP should positively impact the outcome.

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 73.49%

FFY 2020: 69.12%



Source: DPQI Case Review Data

Well-Being Outcome 2 is measured by performance on Item 16-educational needs of the child on the 2016 Federal CFSR Onsite Review Instrument. DPQI social services case reviews indicate Well-Being Outcome 2 was substantially achieved in 69.12% of the cases reviewed. Federal fiscal year 2019 case review data indicates Well-Being Outcome 2 was substantially achieved in 73.49% of the cases reviewed. This is a decrease of 4.375% when the two FFYs are compared. This is the second FFY in which a decrease in this outcome has been observed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

A 29.55% difference was found between placement cases (79.55% Strength) and non-placement cases (50% Strength). This can be linked back to the inadequate frequency and quality of caseworker contacts with families involved in non-placement cases. The WV PIP does not directly address Well-Being 3, however many of the strategies within the PIP should positively impact the outcome.

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

Physical Health of the Child (Item 17)

Purpose of Assessment: To determine whether, during the period under review, the agency addressed the physical health needs of the children, including dental health needs.

Strength Rating Defined

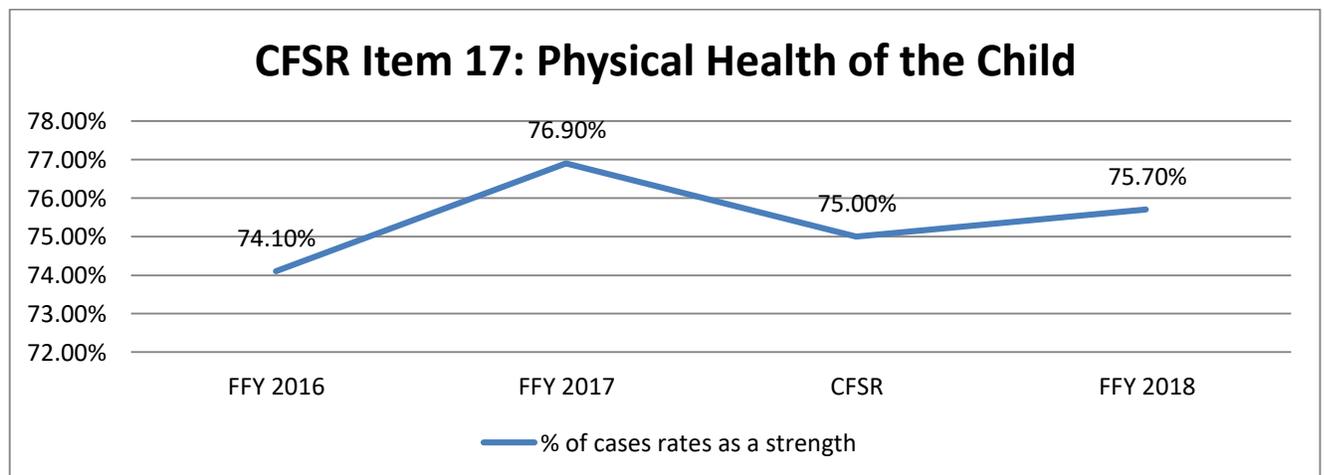
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During the period under review, the children’s physical health and dental needs were accurately assessed initially (if the case was opened during the period under review) and on an ongoing basis, and any needed services were provided.

In addition, for foster care cases, if the child was prescribed medication for physical health issues, the agency provided appropriate oversight for appropriate use and monitoring of medications.

Concerted Efforts Required and/or Special Considerations in Rating

In-home cases are only applicable for this item if (1) physical health issues were relevant to the reason for the agency’s involvement with the family, and/or (2) it is reasonable to expect that the agency would address physical health issues given the circumstances of the case.



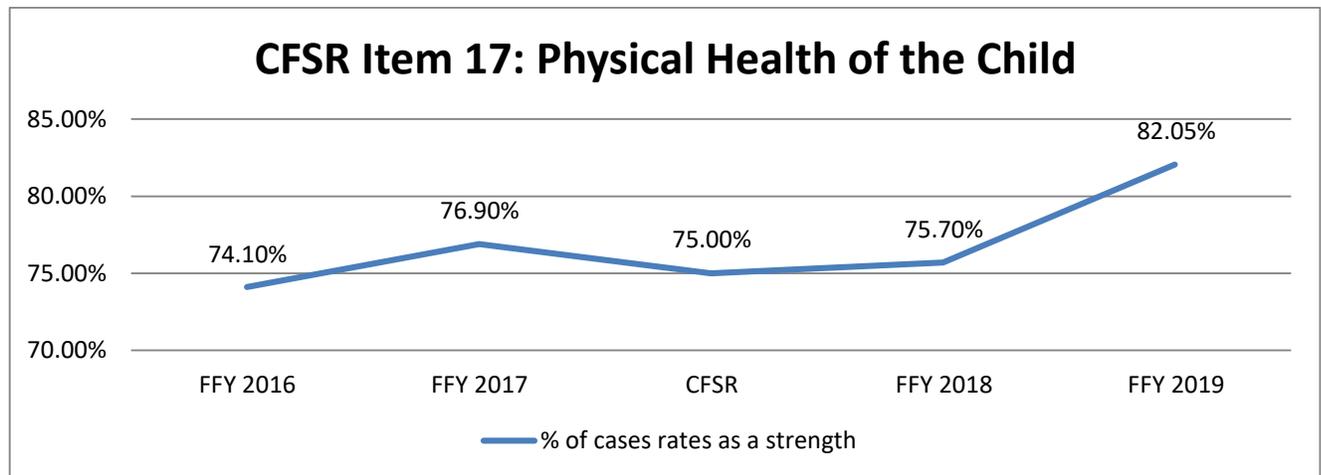
Source: DPQI Case Review Data

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 75.70%

FFY 2019: 82.05%



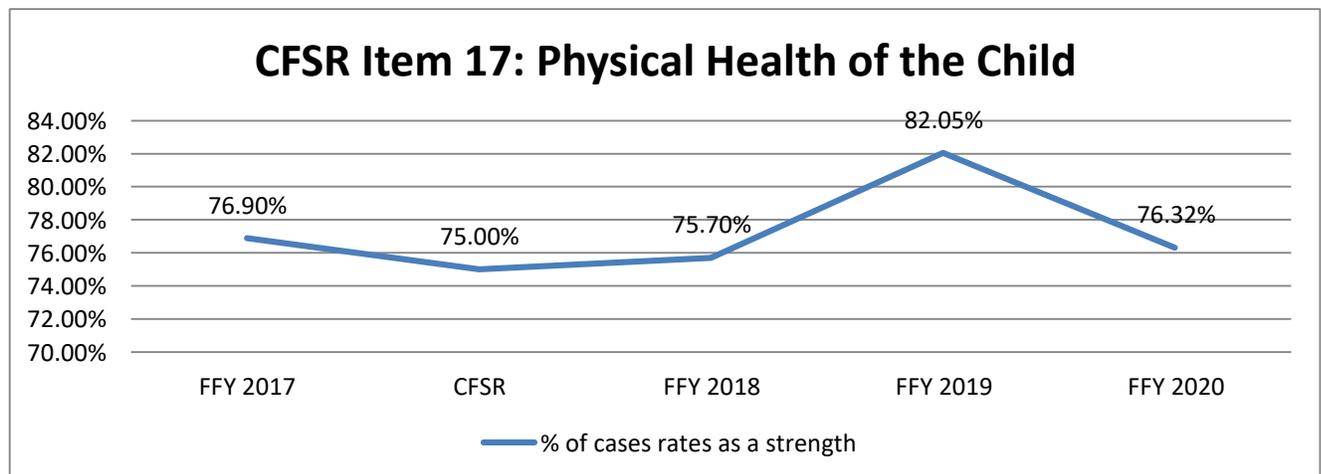
Source: DPQI Case Review Data

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 82.05%

FFY 2020: 76.32%



Source: DPQI Case Review Data

DPQI social services case reviews continued to find that children in placement are more likely to have their physical health needs assessed and receive appropriate services to address identified needs than children

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involved in non-placement cases. The item ratings indicate a 79.1% Strength for placement cases and a 55.56% Strength for non-placement cases.

Mental/Behavioral Health of the Child (Item 18)

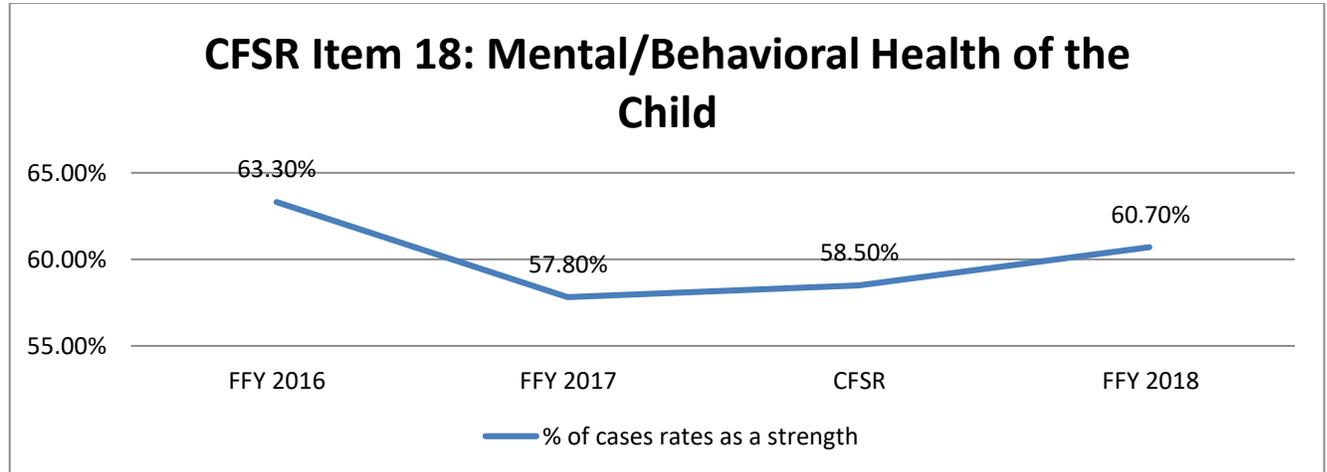
Purpose of Assessment: To determine whether, during the period under review, the agency addressed the mental/behavioral health needs of the children.

Strength Rating Defined

- During the period under review, the children’s mental and/or behavioral health needs were accurately assessed initially (if the case was opened during the period under review) and on an ongoing basis, and any needed services were provided.
- In addition, for foster care cases, if the child was prescribed medication for mental health issues, the agency provided appropriate oversight for appropriate use and monitoring of medications.

Concerted Efforts Required and/or Special Considerations in Rating

In-home cases are only applicable for this item if (1) mental/behavioral health issues were relevant to the reason for the agency’s involvement with the family, and/or (2) it is reasonable to expect that the agency would address mental/behavioral health issues given the circumstances of the case.



Source: DPQI Case Review Data

Well-Being Outcome 3 is measured by performance on Items 17 and 18 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2018 case review data indicates Well-Being Outcome 3 was substantially achieved in 67.69% of the cases reviewed, and partially achieved in 24.62% of the cases

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reviewed. The data reflects a 9.44% increase in the percentage of substantially achieved cases when compared to the prior FFY. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

Children in foster care receive medical care through a statewide, comprehensive managed care program known as West Virginia Health Check. Health Check is the name of West Virginia's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. This program employs Regional Program Specialists who assist families with scheduling EPSDT examinations, which include vision and oral health screenings, within three days of placement. The specialist can also link families with other needed medical services. The Regional Program Specialist helps ensure these medical assessments are completed annually and they provide the child welfare agency with copies of the completed health examinations. DPQI case reviewers find this information in the electronic case record.

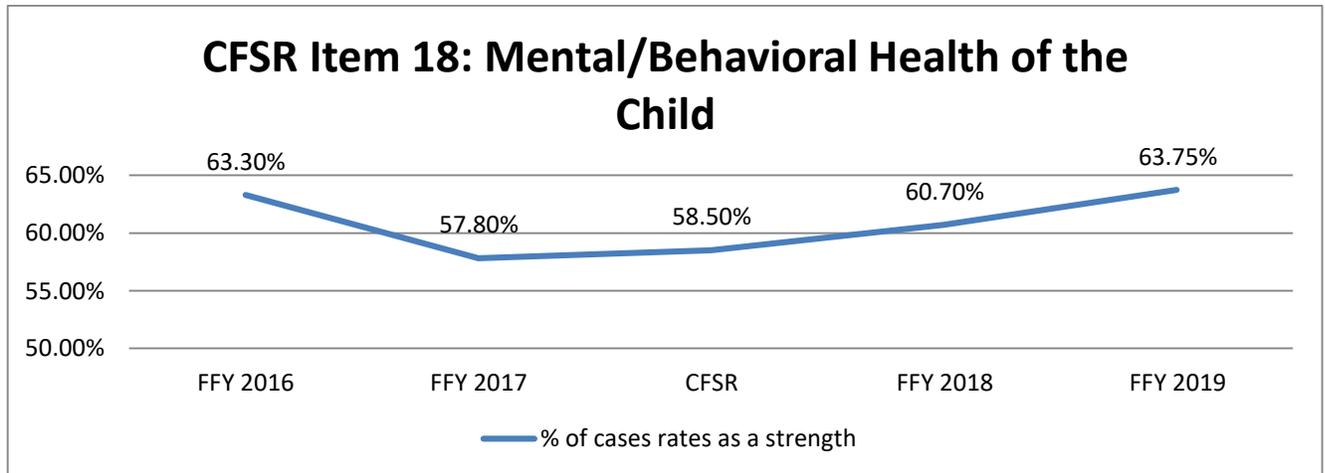
Children in placement are more likely to have their behavioral health needs assessed and receive appropriate services to address identified needs than children involved in non-placement cases. Behavioral health assessments and services to address identified needs are provided or coordinated for children in placement by placement providers. The case review data indicates children in non-placement cases are less likely to have behavioral health assessments completed even when displaying overt behaviors that indicate such assessments are warranted. Barriers to children receiving behavioral health assessments and/or services are: lack of contact by agency staff with children in non-placement cases, lack of mental health providers within a district, the focus on one child and failing to assess all children in the home, and limited follow-up on behavioral health issues when a child is reunified. The WV PIP does not directly address WB 3, however many of the strategies within the PIP should positively impact the outcome.

Update 2021:

DPQI Quality Assurance Case Review Data

FFY 2018: 60.70%

FFY 2019: 63.75%



Source: DPQI Case Review Data

Well-Being Outcome 3 is measured by performance on Items 17-physical health of the child and 18-mental/behavioral health of the child on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2019 case review data indicates Well-Being Outcome 3 was substantially achieved in 66.67% of the cases reviewed, and partially achieved in 9.65% of the cases reviewed. Federal fiscal year 2018 case review data indicates Well-Being Outcome 3 was substantially achieved in 56.6% of the cases reviewed, and partially achieved in 15.09% of the cases reviewed. The data reflects a 10.07% increase in the percentage of substantially achieved cases when compared to the prior FFY. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

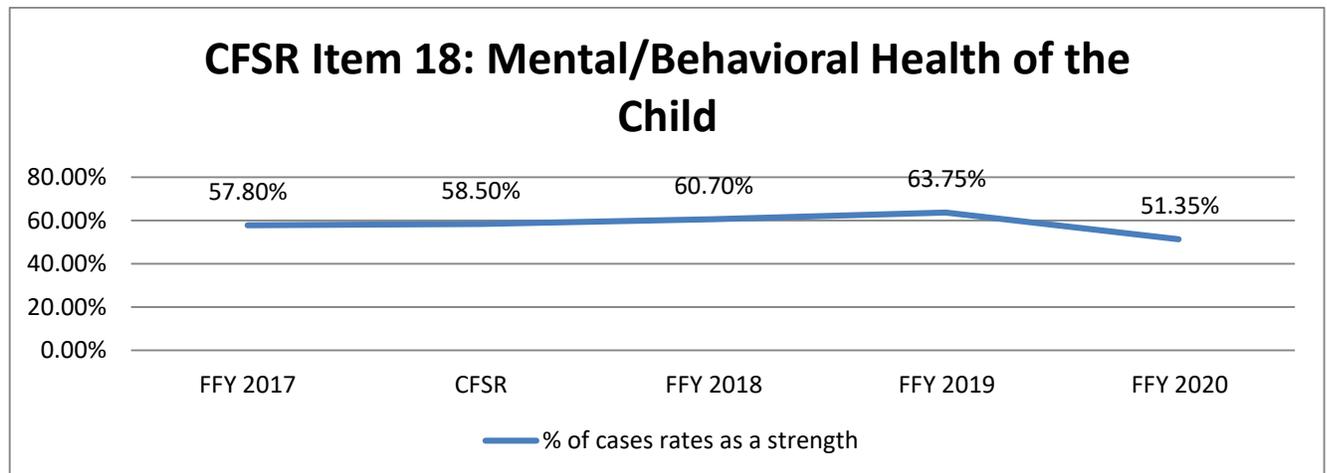
FFY 2019 DPQI social services case reviews continued to find that children in placement are more likely to have their behavioral health needs assessed and receive appropriate services to address identified needs than children involved in non-placement cases. Behavioral health assessments and services to address identified needs are provided or coordinated for children in placement by placement providers. DPQI case review findings show that even when displaying behaviors that would indicate the need for behavioral health assessment and service provision, children in non-placement cases are less likely to have behavioral health assessments completed or services provided. Although the WV CFSR Rd. 3 PIP does not directly address WB 3, many of the strategies within the PIP should positively impact the outcome. Also, the expansion of West Virginia Safe at Home should improve the identification and appropriate service provision for children with behavioral health needs receiving in-home services through the agency.

Update 2022:

DPQI Quality Assurance Case Review Data

FFY 2019: 63.75%

FFY 2020: 51.35%



Source: DPQI Case Review Data

Well-Being Outcome 3 is measured by performance on Items 17-physical health of the child and 18-mental/behavioral health of the child on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2020 case review data indicates Well-Being Outcome 3 was substantially achieved in 53.7% of the cases reviewed, and partially achieved in 14.81% of the cases reviewed. Federal fiscal year 2019 case review data indicates Well-Being Outcome 3 was substantially achieved in 66.67% of the cases reviewed, and partially achieved in 9.65% of the cases reviewed. The data reflects a 12.97% decrease in the percentage of substantially achieved cases when compared to the prior FFY. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

Children in placement continue to be much more likely to have their behavioral health needs assessed and receive appropriate services to address identified needs than children involved in non-placement cases. DPQI FFY 2020 data shows the behavioral health needs of children in placement is assessed and appropriate services provided in 62.5% of the cases reviewed. DPQI FFY 2020 data shows the behavioral health needs of children in non-placement cases is assessed and appropriate services provided in 38.24% of the cases reviewed. Children in placement also continue to be more likely to have their physical health needs assessed and have appropriate services provided to address their identified needs. This is typically found to be due to placement providers coordinating the assessments and service provision for these children. The West Virginia Safe at Home program has been expanded to include applicability for more children. This should improve the identification and appropriate service provision for children with behavioral health needs receiving in-home services through the agency. Although the WV CFSR Rd. 3 PIP does not directly address Well-Being 3, many of the strategies within the PIP should positively impact the outcome.

Systemic Factors

Information Systems

WV DHHR has opted to replace the current IV-A, IV-D, IV-B/E and Medicaid management systems with one single integrated eligibility system called PATH – Peoples Access to Help. The RFP closed last December 2017, and a contract was awarded, finalized and signed. The vendor, Optum Consulting, has completed system requirements and architecture planning, transferring hardware and software licensing and bringing up the PATH solution infrastructure. Detailed design requirements are underway with development activity starting soon after.

The focus is on creating an operational information system that readily identifies the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care. A robust data quality plan with management oversight tools (dashboards, reports, and quality alerts) is a key component of the schema for the IES.

The general expectation is that all common functions will be addressed in the IES. Requirements gathering with external stakeholders (the Courts, Education, and others) has begun to understand the types of data which can be gleaned from these other systems. The intent is to display information gathered through interfaces rather than capture and store that information in the CCWIS

Through the technical assistance of the Capacity Building Center for States, the ongoing work of the Court Improvement Program and West Virginia Department of Education, the CCWIS will utilize data exchanges to obtain source data to reduce errors

Using rolling wave planning with a spiral implementation, the child welfare components of the new PATH system are currently scheduled to be piloted in production November 30, 2020 with full system implementation expected by March 2021.

Since the new system will be developed and iteratively implemented, the SACWIS will operate concurrently until all development activity has been completed and all functionality to support child welfare operations, reporting and fund claiming has been successfully implemented. FACTS data will be used to guide conversion and current compliance reporting will be leveraged to verify and validate the conversion effort and data migration to the new system.

FACTS has already begun data cleansing to prepare for conversion activities. FACTS is focusing on maintaining the accuracy and validity of the Title IV-E claiming data, demonstration waiver evaluation data and the IV-B, IV-E and Title XIX compliance reporting. The initial emphasis has been on resolving client duplication in the legacy data for a future push to the Master Client Index, which is central to the new system operations. In addition to surveillance and performance reporting around this initiative, we are planning on some extent of data corrections necessary to scrub the data of inaccuracies and inconsistencies

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Since legacy FACTS will be operating concurrently it is important to note that there are no planned maintenance activities beyond updates required to meet federal and state mandates, data cleansing, pre-archival and data conversion preparation. New functionality, updates to business rules and new data outcomes will all be rendered in the new CCWIS with only minor configurations performed if necessary. The mandatory interfacing to the IV-A, IV-D and title XIX systems will remain in the legacy system until all necessary functions are implemented across the involved programs in the new integrated system. The mandated interfaces with education and the courts has been accounted for in the requirements and implemented in the new system.

The full legacy system retirement is planned to occur after all social service programs supported by the legacy system are integrated and implemented statewide in PATH.

Although modifications are being considered, a Standard Operating Procedure remains in place for districts to report monthly on each child in care. The report referred to as the “Kids in Care” is provided to each Regional Program Manager by the last day of each month. It includes pertinent information on each child including, but not limited to: Name, Client ID, Demographics, Removal Date, Placement Type and location. Districts maintain this report and use it for multiple purposes:

- As a printable document for use in emergency situations when there is no or limited access to electronic systems.
- A tracking tool to compare data entered into our FACTS system to verify correct entry of removals, placements, and reunifications.
- Compare and track boarding care payments to foster care parents
- Quick glance at the use of kinship versus other placement types.
- Verify date of last Multi-Disciplinary Team meeting.

In addition to the “Kids in Care” report, legacy FACTS has a monthly payment approval process for every child in placement. During this payment approval process, workers are to evaluate each child on their caseload and determine if the payment that will be authorized to providers is correct. Supervisors can see which providers will receive payments for placements of every child in foster care. This enables them to make corrections as needed regarding the current placement of children in foster care.

Once supervisors assure every child’s placement has been entered, the SACWIS system guides workers to enter the child’s location, visitation plan and permanency plan. These screens cannot be completed unless demographic information on each child has previously been entered.

A memo has been developed and will be released in September 2019, reminding staff of the mandate to complete this process.

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Currently, BCF only has data from Maternal Child and Family Health to confirm that placements are entered timely. This data measures the percentage of time Health Checks are completed within 30 days of placement. Each month, it captures children/youth from previous months.

Performance Measures	Completed Data
Percentage of foster children initially placed in January 2019 who were entered into FACTS within each timeframe after placement.	99.0%
Percentage of foster children initially placed in January 2019 who received a documented HealthCheck exam within each timeframe after placement.	95.3%

Update 2021:

Comparison of Date of Placement to Date Data Entered into FACTS			
Region / County with 7 or more days lag in entering placement into FACTS	April to June 2019	October to November 2019	* December 2019
Total Over 7 Days	240	65	51
Total Placements	526	252	143
Percentage Over 7 Days	46%	26%	36%

WV DHHR continues work to replace the current IV-A, IV-D, IV-B/E and Medicaid management systems with one single integrated eligibility system called PATH – Peoples Access to Help. In February 2020, the PATH Public Portal was brought online to allow citizens to apply for benefits. Detailed design, development, and unit testing is ongoing for the future PATH releases that will include the agency worker functionality.

The PATH system vendor, Optum, has been holding design sessions with internal and external stakeholders to validate the preliminary design for all components, including the Comprehensive Child Welfare

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Information System (CCWIS) requirements. This includes a walkthrough of the business processes and workflows associated with achieving the necessary child welfare business outcomes, meeting federal reporting requirements, and streamlining efficient services for our citizens. Using rolling wave planning, the child welfare components of the new PATH system are currently scheduled to be implemented over the course of the next two years.

While the new PATH system is in the process of being implemented, the legacy Families and Children Tracking System (FACTS) continues in operation. There are no planned enhancements to FACTS other than updates necessary to meet federal and state requirements such as the Family First Prevention Services Act and Foster Care Managed Care.

To improve timely data entry, a memo was released in September 2019, reminding staff of the mandate to complete this process. It gave workers step-by-step instructions on entering placements immediately and completing monthly payment approvals. The monthly payment approvals give workers the opportunity to correct any placement issues in the SACWIS system prior to payments being generated.

During weekly collaborative meetings to implement the MCO a report was developed to determine the length of time from placement to data entry (transaction date) of the placement. After the release of the memo in September, data entry of placements improved. Transaction dates tend to decline when no reminders are sent. As a result of a recommendation at the mid-February Managed Care collaborative meeting, weekly reminders to enter placements were “popped up” when workers logged into the SACWIS system.

Count of Placements Entered late (over 7, 24-hour-days)	Before memo to reduce delays			After memo & FACTS Communicator Message to Reduce Date Entry Delays					
	4/19	5/19	6/19	10/19	11/19	12/19	1/20	2/20	3/20
Region I	13	22	18	9	5	12	14	7	8
Region II	31	31	28	14	5	22	16	28	4
Region III	12	18	10	16	2	11	6	13	9
Region IV	19	22	17	9	4	7	20	10	16
Total Late	75	93	73	48	16	52	56	58	37
Total Placements	168	194	163	152	100	143	155	150	133
Percentage Late	45%	48%	45%	32%	16%	36%	36%	39%	28%

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Case Review

The case review system reveals WV continues to struggle with written case plans developed jointly with the child's parent(s). Efforts are underway to improve case planning outcomes by streamlining current policies and practices for both CPS and YS cases. The workgroup assigned to this project has made modification to policy and forms for the current CPS practice model to reduce duplication in work and simplify both processes and documentation. For youth services cases, the FAST is being utilized to assess family needs and move them toward change. At the present time, staff in each of the four regions are piloting the new forms and processes for both CPS and YS.

Update 2021:

See sections [Child Protective Services](#) and [Youth Services](#) for update.

Update 2022:

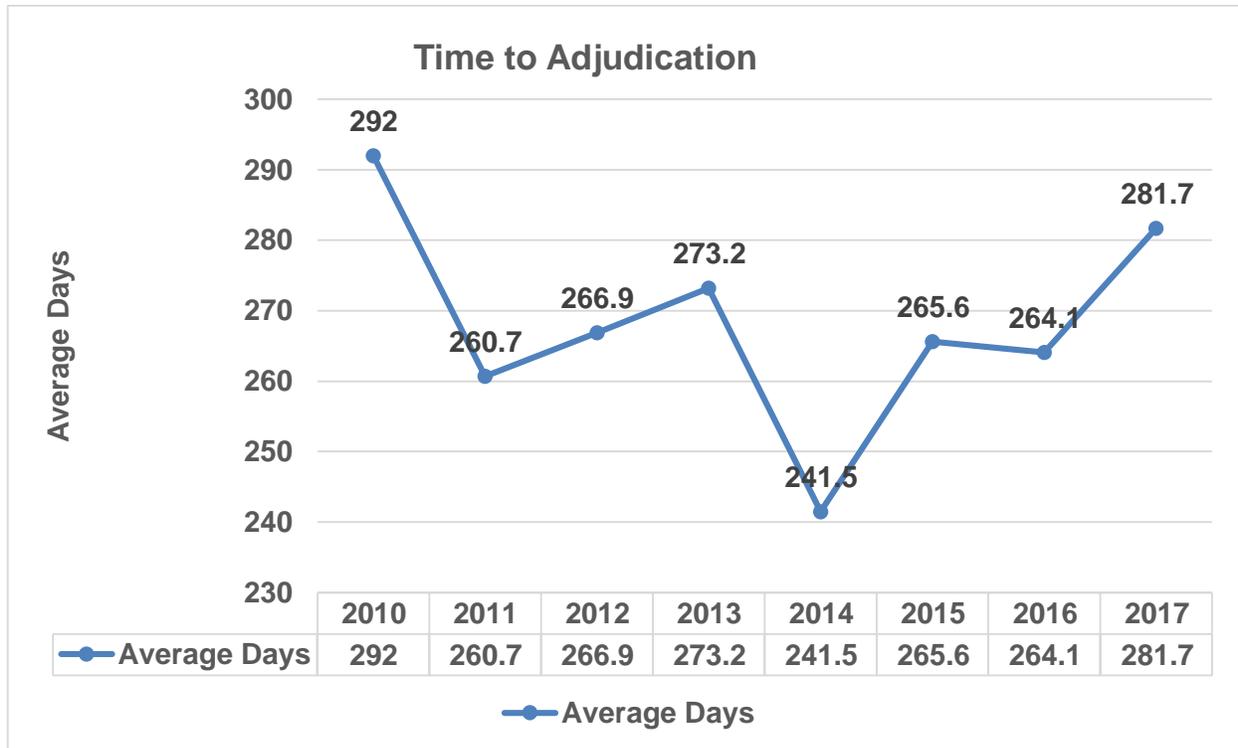
See sections [Child Protective Services](#) and [Youth Services](#) for update.

West Virginia does an excellent job of ensuring periodic reviews occur for each child no less than every 6 months, either by Court or Administrative Review. Review hearings are scheduled in all jurisdictions quarterly until permanency is achieved and the case is dismissed from the docket. An AFCARS report specific to this reporting element is generated from FACTS monthly that reflects every case with no review documented. This report is utilized by Regional Program Managers and Regional Directors to work with districts on getting these reviews documented in FACTS. In rare instances, the reviews have not been held and the report serves as a prompt for districts to request scheduling.

Effective February 2, 2018 data collection on review hearings in abuse and neglect cases moved to the Juvenile Abuse and Neglect Information System (JANIS). This merger created data integrity problems with respect to tracking two important measures 1) Days from Original Petition Date to First Review Hearing, and 2) Days Between Review Hearings. The Court Improvement Program along with the Supreme Court of Appeals of West Virginia IT department are working diligently to correct all and ensure accuracy of information in JANIS and will not release data until it is error free. To that end, data for these measures are not available as of April 30, 2019. Update data will not be available until summer 2019.

Time to Adjudication

This measure will include calculating the average (mean) and median time from filing of the original petition to adjudication. The average will be calculated using all respondent records including original petition filing date and the beginning date of the adjudicatory hearing date for each respondent. If a respondent was added after the preliminary hearing as a result of an Amended Petition, time to the Adjudicatory Hearing would be calculated from the date the respondent was added or served rather than the original petition date.

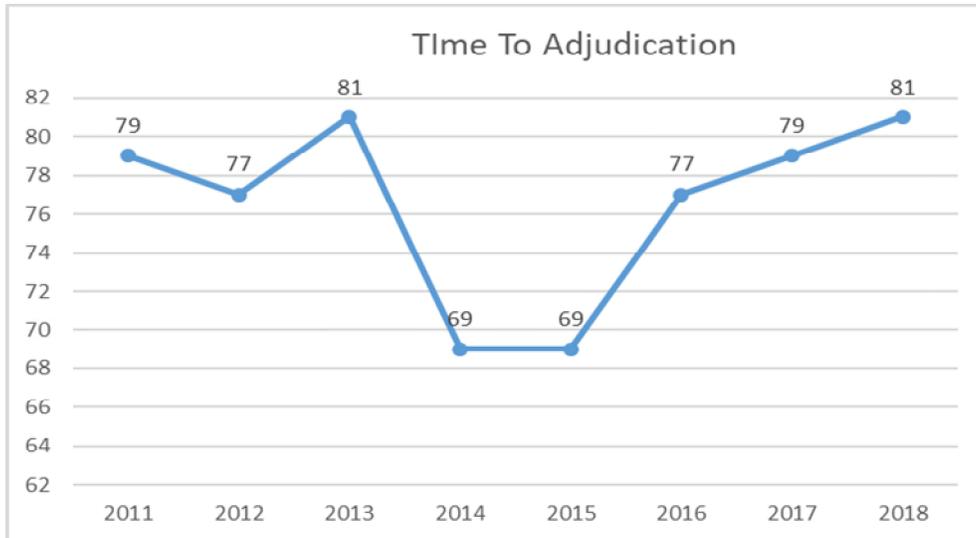


Update 2021:

Time to Adjudication and Disposition charts and information were inadvertently switched in the development of CFSP. The 2021 APSR corrects this problem and provides 2018 data.

This measure calculates the average time in days from the filing of the original petition to adjudication. The average is calculated using all respondent records, specifically the original petition filing date and the beginning date of the adjudicatory hearing date for each respondent. If an Amended Petition added a respondent after the preliminary hearing, the time to the Adjudicatory Hearing would be calculated from the date the respondent was added or served rather than the original petition date.

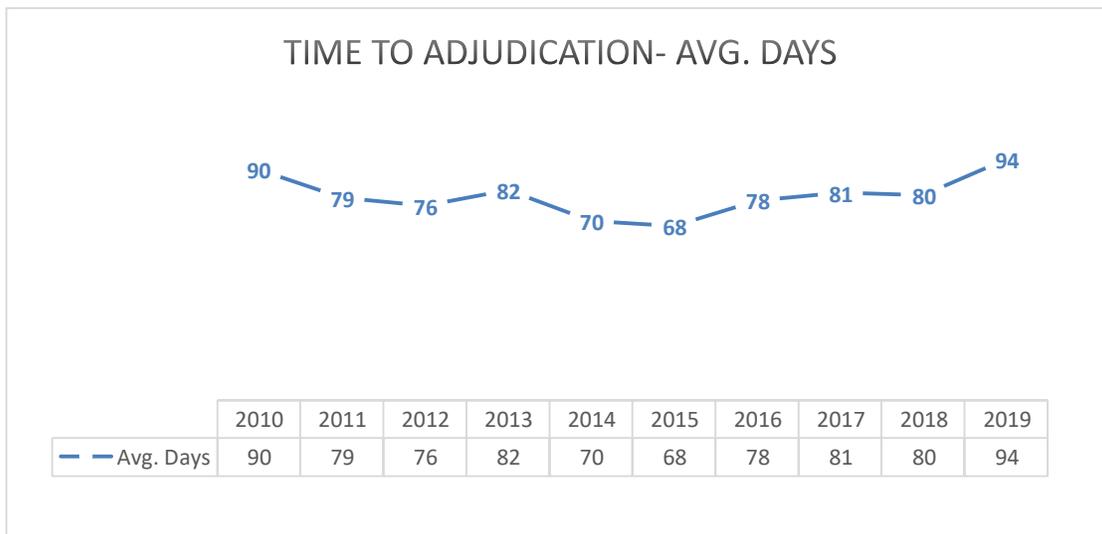
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Update 2022:

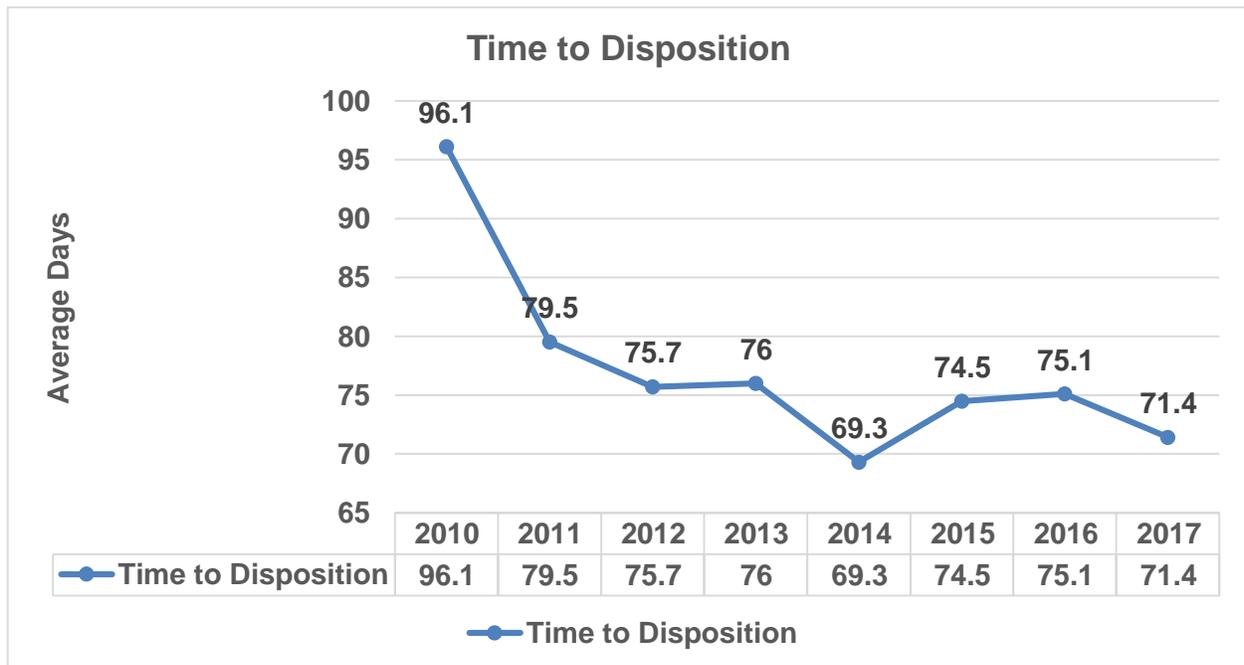
This measure calculates the average (mean) and median time from filing of the original petition to adjudication. The average is calculated using all applicable respondent records including original petition filing date and the beginning date of the adjudicatory hearing date for each respondent. Applicable records are those that have the required data needed to make the calculation included in the record. If a respondent was added after the preliminary hearing because of an Amended Petition, time to the Adjudicatory Hearing would be calculated from the date the respondent was added or served rather than the original petition date.

This chart shows the average time in days for 2010-2019.



Time to Disposition

This measure will include calculating the average (mean) and median time from filing of the original petition to disposition. The average will be calculated using all respondent records including original petition filing date and the date of the earliest provided disposition date for each respondent. If a respondent was added after the preliminary hearing as a result of an Amended Petition, or service was delayed to a respondent who was included in the original petition, time to the Disposition Hearing would be calculated from the date the respondent was added or served rather than the original petition date.

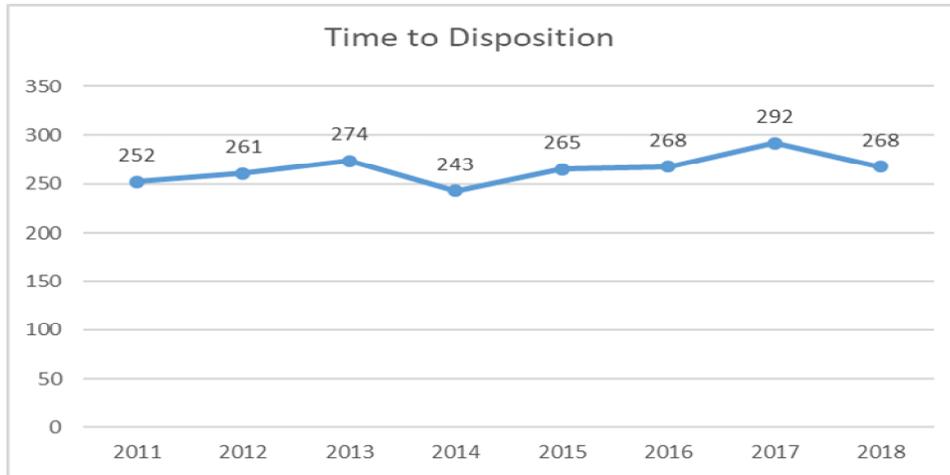


Update 2021:

Time to Adjudication and Disposition charts and information were inadvertently switched in the development of CFSP. The 2021 APSR corrects this problem and provides 2018 data.

This measure calculates the average time in days from the filing of the original petition to disposition. The average is calculated using all respondent records, specifically the original petition filing date and the date of the earliest provided disposition date for each respondent. If an Amended Petition added a respondent after the preliminary hearing or if service was delayed to a respondent, who was included in the original petition, the time to the Disposition Hearing is calculated from the date the respondent was added or served rather than the original petition date.

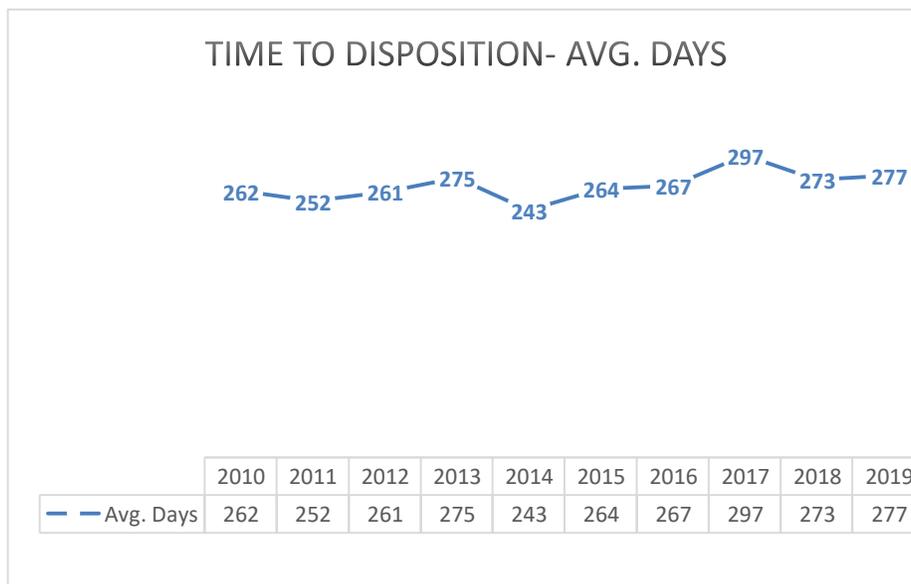
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Update 2022:

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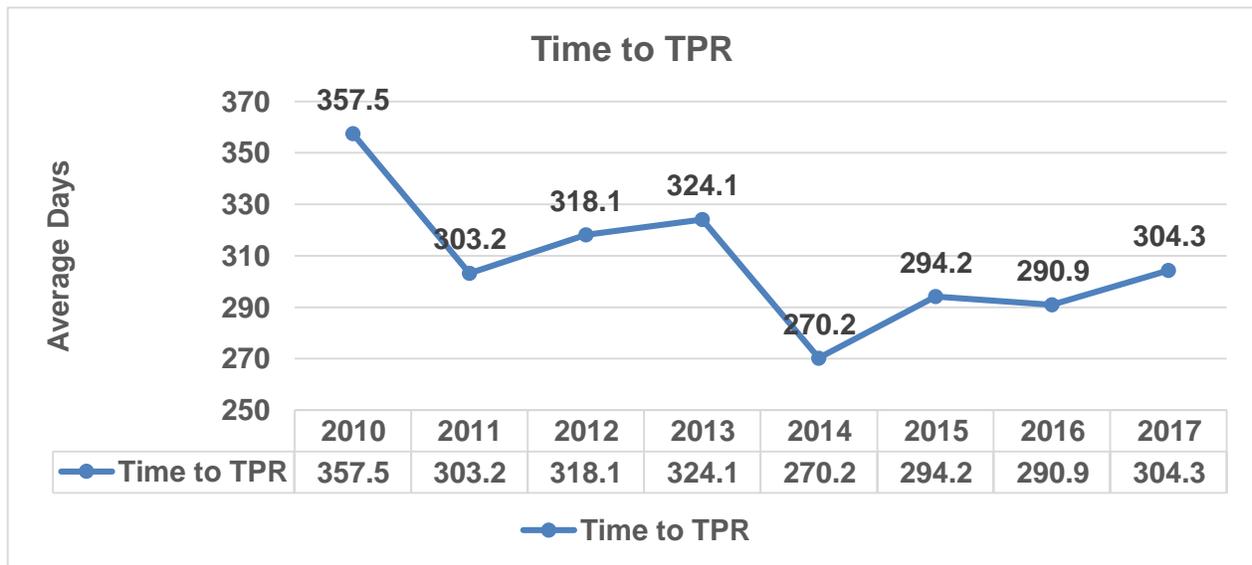
The chart below shows the average days from the filing of the original petition to disposition.



Time to Termination of Parental Rights (TPR)

Court Improvement data indicates that time to Termination of Parental rights has fluctuated over the years but is currently at an average of less than twelve months.

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 as a result of an Amended Petition, or service was delayed to a respondent who was included in the original petition, time to the Termination of Parental Rights would be calculated from the date the respondent was added or served rather than the original petition date.

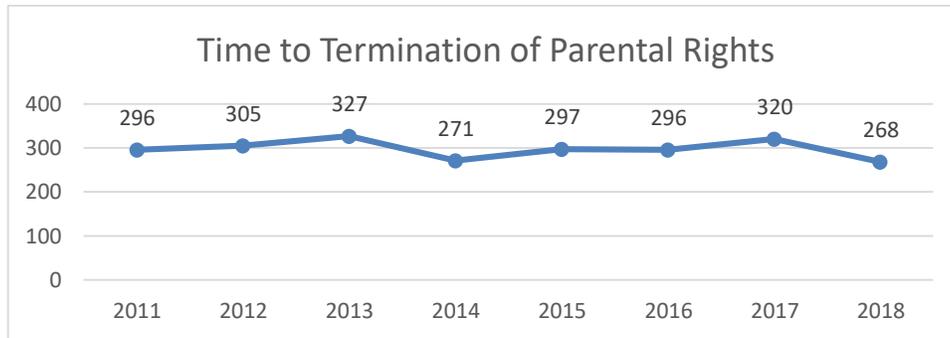


Update 2021:

Court Improvement Program (CIP) data indicates that the time to Termination of Parental rights has fluctuated over the years but is currently at an average of less than twelve months. It should be noted that in many cases it is the efforts to reunify the family that lead to longer times to termination of parental rights. These efforts include improvement periods and extending those improvement periods.

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

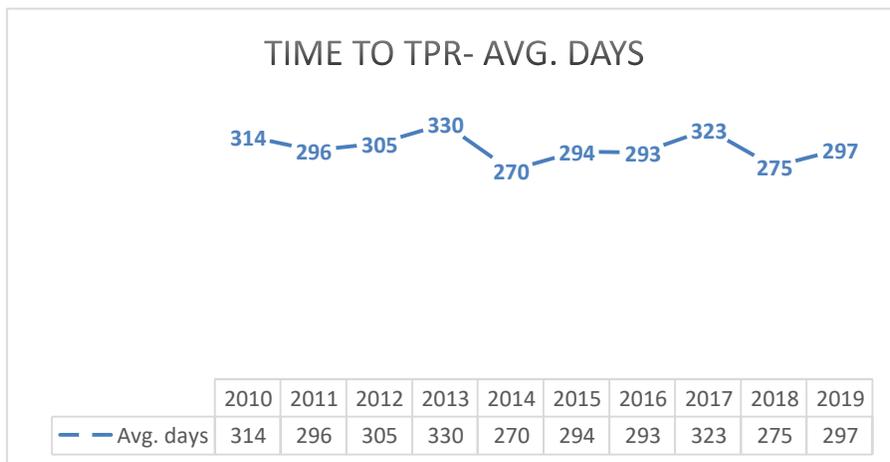
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Update 2022:

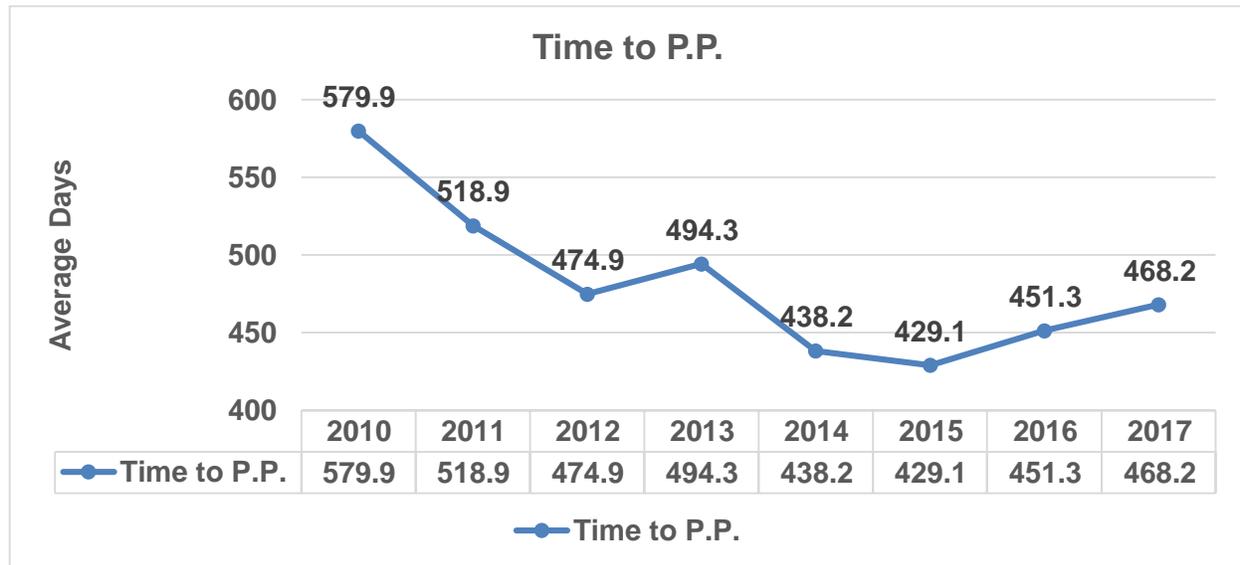
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This measure consists of the average time in days from the filing of the original petition to termination of parental rights for each respondent. All respondent items including applicable dates are included in the calculation. If a respondent was added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



Time to Permanent Placement

With rare exception, permanency is addressed at every review hearing held quarterly. Court Improvement data indicates that the time from removal to permanent placement is beginning to increase steadily but is still within the eighteen-month timeframe.

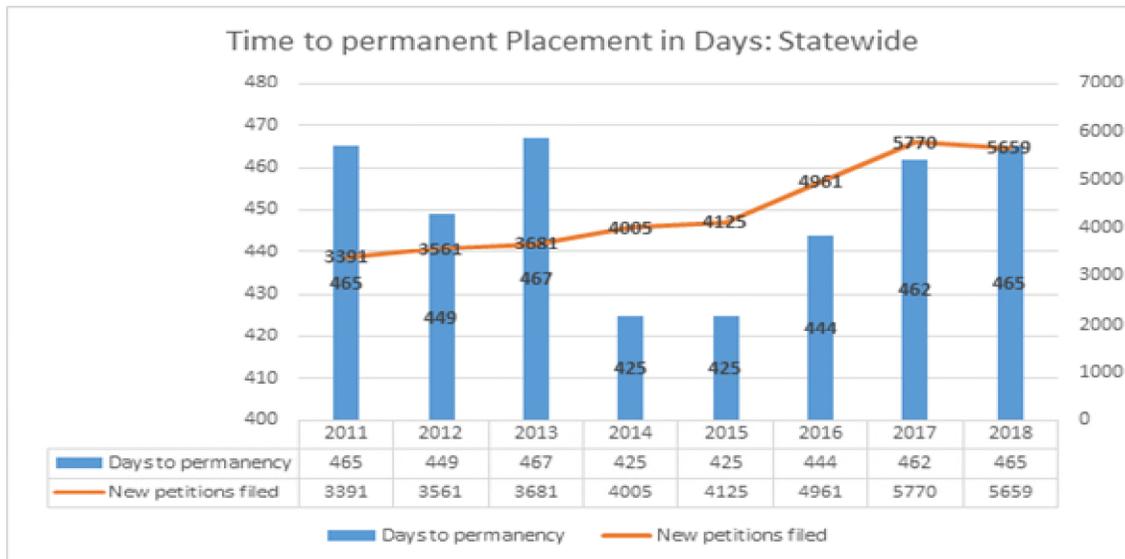


Update 2021:

The Time to Permanent Placement Chart has been modified for the 2021 APSR to provide a clear picture of the Time to Permanent Placement trending with the new petitions filed. This provides a historic look at the CFSP data back to 2011 and provides 2018 data as well.

With rare exception, permanency is addressed at every review hearing held quarterly. This chart demonstrates the number of new cases filed each year with the number of children reaching permanent placement. Despite the increase in new cases, the Courts and child welfare system are moving children to permanency at rates close to the onset of the drug abuse epidemic in the state.

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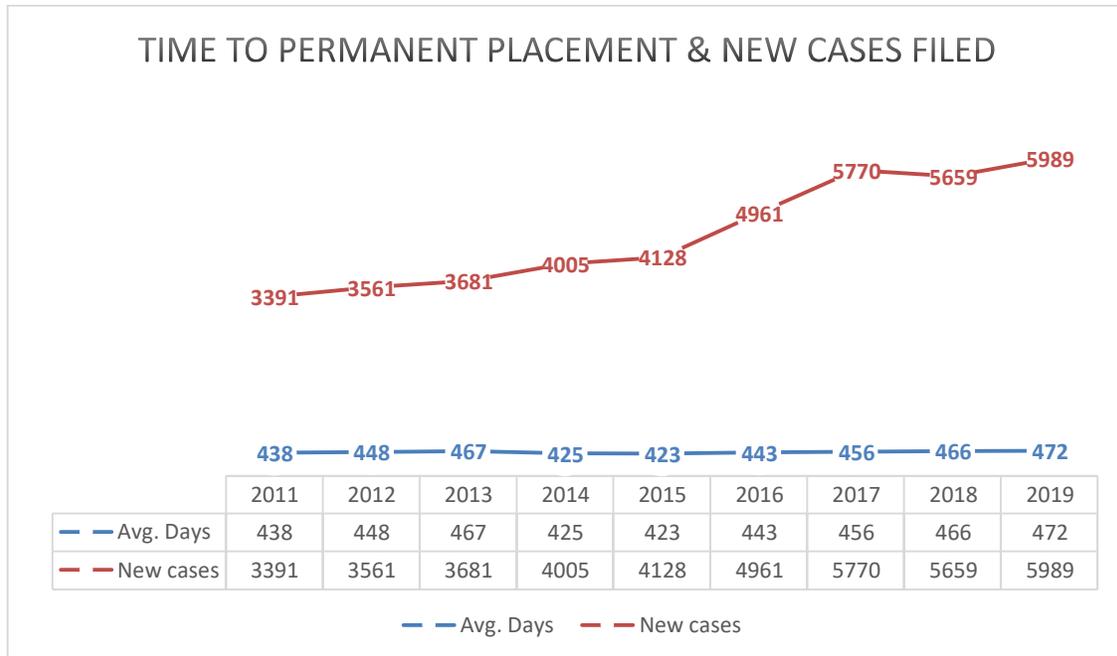


Update 2022:

This measures the average (mean) time from filing of the original petition to the permanency achieved date for each child. This is calculated using all records for all children, including both original petitions filing date and the permanency achieved date.

With rare exception, permanency is addressed at every quarterly review hearing. This chart demonstrates the number of new cases filed each year with the number of children reaching permanent placement. Despite the increase in new cases, the Courts and child welfare system are moving children to permanency at rates close to the onset of the drug abuse epidemic in the state.

This is illustrated by the nearly flat blue line (average days to permanency) compared to the spike in the orange line (new cases filed).



Some supervisors have their own tracking systems for knowing when youth have been in out of home care for 15 of the last 22 months, however, there is no statewide uniform tracking system. A statewide protocol that does exist is in relation to staffing cases for decisions as to disposition. Specifically, the standard operating procedure titled, “Dispositional Staffing”, contains information for an internal process that allows the Department to formulate a recommendation regarding termination of parental rights, legal guardianship, or an alternative disposition while facilitating concurrent planning, and the timely transfer of appropriate cases to the adoption unit.

During design sessions for the state’s new CCWIS, processes are being put in place both to prompt workers for action when youth have been in care for 15 of the last 22 months and to track decisions at this point in the case work process regarding TPR.

In June 2017, Children and Adult Services staff mailed 2,031 paper surveys to foster parents statewide to determine their rate of notification of hearings and whether they felt they were heard. Respondents had until August 31, 2017 to return the surveys. 651 respondents returned their survey yielding a **32%** response rate. The responses were as follows:

- 27%** foster/adoptive parents are **always** notified of court hearings.
- 20%** foster/adoptive parents **always** have their opinion heard at court hearings.
- 30%** foster children **always** attended MDTs when appropriate.
- 11%** foster children attending MDTs **always** had their opinion heard.
- It was felt MDTs **always** made the best decision for the foster child **24%** of the time.

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19% of foster/adoptive parents were **always** asked to be involved in case planning.

In February 2018 supervisors statewide were to address with staff as part of their monthly unit meeting topic the provision of support to foster care parents, including the need to ensure they are made aware of and invited to attend court proceedings. Specific policy and code sections were shared with supervisors to review with their staff on this important topic.

West Virginia currently has a dispositional tracking form for all cases in which children have been removed from the home and placed in foster care. The form tracks the removal date, date of each hearing and review, and a request to staff the case for termination of parental rights when children have been in care fifteen of the most recent twenty-two months. However, use of this form is sporadic. The state will incorporate the use of this form into periodic reviews completed by its Child Welfare Consultants and Regional Program Managers.

The Bureau for Children and Families monitors the quality of service provision by social necessary service providers through a review process that requires a score of 80% or above during the provider's retrospective reviews for each service provided. When providers initially fall below 80%, they are given a six-month probation period wherein KEPRO (previously APS Healthcare) provides additional training and technical assistance. At the end of the six-month period, the service(s) falling below 80% is once again evaluated. If the service(s) still scores below 80%, it is closed, and the provider is no longer allowed to continue providing that service. In addition to the review process, in 2018 new agreements were developed with SNS providers that include new requirements and uniformity with monthly reports.

An average of thirty Socially Necessary service providers are reviewed each year retrospectively to ensure they are providing IV-B Subpart II services as requested. Review rounds are 18-month cycles. Therefore, a provider scoring less than 80% on a specific service may not have reached the six-month re-review prior to this report. Providers who fell below 80% for a service, during their normal review period 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 falls below 80% on the services a second time, then the service will be closed for that provider. Providers may decide not to offer a specific service after receiving below 80%.

Training

The Bureau for Children & Families' (BCF) Division of Training is responsible for the oversight, development, coordination, and delivery of training and professional development for BCF staff, foster parents, prospective foster parents, and providers statewide. The Mission of the Division of Training is to provide timely, comprehensive, competency-based training to new and tenured staff in a professional and consistent manner to assure quality delivery of services that promote the health and well-being of West Virginia's families.

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The Division of Training is constructed of a central office in Charleston and staff trainers that are out stationed across the state. Staff trainers must have four years of experience in the program area they train and be licensed as social workers with a master’s degree preferred. The Division of Training provides most of its staff training, and training is also provided through contracts with The Social Work Education Consortium (SWEC) and the West Virginia Coalition Against Domestic Violence (CADV). The Division of Training is also responsible for developing curriculum; developing presentations for meetings and events; ensuring that training conforms with BCF policy and procedures; coordinating joint and cooperative training initiatives for BCF employees, providers, and community stakeholders; acting as a liaison between BCF and the State’s SACWIS system; administering the Title IV-E training grants, and serving as an approved provider of Social Work Continuing Education Units (CEUs) through the West Virginia Board of Social Work.

Child Welfare Initial Staff Training is provided through its pre-service training, consisting of 220 hours taken over a nine to ten-week period. The training is constructed of a combination of online training to learn basic concepts, classroom training to learn how to apply the concepts, and transfer of learning activities in their local offices to see the concepts in action and build skills. The following table demonstrates the employees who were trained in 2018 by classification. Note that contracted employees are required to complete the same training as staff employees.

Classification of Employee	Number
Child Protective Services	164
Youth Services	29
Contracted Youth Services	19
Adoption	5
Home-Finding	5
Centralized Intake	5
TOTAL NUMBER TRAINED:	238 Employees

Child Welfare pre-service training is designed to take the employee through the casework process. All Child Welfare employees are trained together in Interviewing, The Court Process, and Children in Care and are broken out by program area for Initial and Family Assessment. The following table outlines the training that is completed by topic area.

Training Topic	Format	Hours
Orientation; Worker Safety; Introduction to Child Welfare Concepts	Online	12 hours
Interviewing, Interview Taping, and Transfer of Learning	Classroom Transfer of Learning	36 hours
Intake Assessment and Preparing for First Contact	Classroom Online	16 hours

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Initial Assessment (by program area)	Classroom Transfer of Learning	36 hours
Family Assessment and Case Planning	Classroom, Online, Transfer of Learning	26 hours
The Court Process	Classroom, Online, Transfer of Learning	28 hours
Children in Care	Classroom Transfer of Learning	24 hours
Case Documentation	Classroom	42 hours
TOTAL HOURS:		220 hours

At the end of the ninth week, after it has been verified that the employee has completed all 220 hours of training, staff must successfully complete a competency test before assuming a caseload. The competency test contains three sections: a written knowledge examination, a skills-based interview based on the employees' program area, and a critical thinking examination to determine if the employee can make the correct decision based on information collected in the interview. The interview portion consists of actors role-playing a selected scenario with the employee interviewing the various members of the family. The employee must pass all three sections of the test with a score of 80% or above and may take the test up to three times. If the employee does not pass the test after three attempts, he/she must go back through new worker training from the beginning. Child welfare pre-service training must be completed before a caseload can be assigned according to law and for the purpose of Title IVE billing, and record checks are completed in FACTS every two weeks to ensure that no cases are assigned. If a caseload is found during the record check the trainer contacts the supervisor, CSM, and Regional Director to take action and have the caseload removed. The following table provides information on competency testing results in 2018.

Total Tested	Passed 1st Attempt	Passed 2nd Attempt	Passed 3rd Attempt	Did Not Pass
213	171	42	0	0

The Division of Training starts two Child Welfare training rounds per month, one north and one south. Students are registered through a centralized onboarding process where the students' names are identified when Oasis processing begins the new hire process. The supervisor or CSM is contacted to enroll the student in a training round and get the student enrolled in Blackboard. The employee can begin completing the initial online training starting on the first day of employment. The employee is scheduled to begin training within one to three weeks and may select either the next round or the closest round to the employee's location. In 2018 the average time between start date and first day of training was 2.81

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weeks, and the average time between start date and training completion (including competency testing) was 11.92 weeks.

The following data demonstrates the functioning of child welfare pre-service training in 2018.

Total number of Training Rounds	22 Rounds
Total Number of Students Trained	238 Students
Total Hours of Training Provided	7,025 Hours
Average Time from Start Date to Training Start	2.81 Weeks
Average Time from Start Date to Training End	11.92 Weeks
Average Time from Training Start to Training End	9.08 Weeks

In 2015 the West Virginia Legislature passed a law that allowed employees who are hired by the Department of Health & Human Resources to have a degree that was not in social work or a related field, provided they take a four-year training plan created and provided by the Department. This law was passed because of workforce shortages in various parts of the state. In 2018, 18% of staff hired by the Department had a degree in social work, 52% had a related degree, and 30% had an unrelated degree. The inclusion of staff without social work training in the workforce has caused the Division of Training to reevaluate each training it provides to ensure that all the information is included that an employee needs to perform child welfare jobs. Curriculum revisions and updates will continue over the next one to three years.

West Virginia has implemented a comprehensive training program for new supervisors in the past year that incorporates job-related training and management training provided by the West Virginia Division of Personnel and the WVDHHR Office of Human Resource Management. When new supervisors are hired, they are identified in the onboarding process and enrolled in the next series of “Putting the Pieces Together,” a nine-day curriculum for Child Welfare supervisors that was adapted from a training developed by the University of Colorado. The training consists of three three-day modules: Administrative Supervision, Supportive Supervision, and Educational Supervision and is directly related to their jobs as Child Welfare supervisors. West Virginia starts two new supervisor training rounds per year, and supervisors are required to complete the training in their first year as a supervisor. New supervisor training also consists of a Policy Review by the Child Welfare Consultants in the first 30 days of employment and an online training on documentation in the FACTS system. The following information demonstrates the functioning of supervisor training.

Total Child Welfare New Supervisor Training:	18 Students	6 Sessions	108 Total Hours
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West Virginia passed Initial Staff Training in the last Child and Family Services Review. There were some deficiencies identified in the area of supervisor training that were addressed by the development and implementation of the supervisor training plan in the last year. In the next five years the goals for Initial Staff Training are:

1. Revise and expand initial staff training to include information related to the implementation of the Family First Prevention Services Act, including providing a greater emphasis on candidacy and in-home case planning and services.
2. Develop and implement training for new positions in the CPS Career Ladder including CPS Senior and CPS Case Coordinator and training on mentoring (PIP).
3. Revise new worker training for the implementation of the new C-WIS system.
4. Develop and implement Child Welfare-specific training for new managers with an emphasis on those with a background in a program area other than Child Welfare.

Update 2021:

In 2020, training plans were developed for positions in the CPS Career Ladder including CPS Senior and CPS Case Coordinator. The first statewide training for this group was scheduled in March 2020 but was delayed due to the COVID crisis. Changes to the new worker training plan for Family First were developed and work began on implementation of the new curriculum in 2020 including expansion of training on in-home services, safety planning, and case management in addition to changes in policies that have been made from Family First.

In 2019 the following information demonstrates the functioning of initial staff training.

Staff Classifications:

<i>Classification of Employee</i>	<i>Number</i>
<i>Child Protective Services</i>	<i>175</i>
<i>Youth Services</i>	<i>37</i>
<i>Contracted Youth Services</i>	<i>20</i>
<i>Adoption</i>	<i>1</i>
<i>Home-Finding</i>	<i>11</i>
<i>Centralized Intake</i>	<i>3</i>
TOTAL NUMBER TRAINED:	247

New Worker Training Information:

<i>Month</i>	<i># Training Rounds</i>	<i># New Workers</i>	<i>Weeks Classroom Training</i>	<i>Hours Classroom Training</i>	<i>Hours Online Training</i>	<i>Hours TOL training</i>	<i>Total Training Hours</i>
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January	2	39	30	544	40	56	640
February	1	8	17	531	35	70	636
March	2	24	22	492	40	60	592
April	2	33	24	494	52	76	622
May	2	16	27	636	53	98	787
June	2	34	22	500	33	50	583
July	2	19	26	486	40	66	592
August	2	13	29	498	52	118	542
September	1	6	20	366	39	70	475
October	2	27	20	354	41	60	455
November	1	10	16	318	35	48	401
December	2	23	18	348	29	60	432
Yearly	21	247	271	5567	489	832	6762
Total CW Training	Rounds	Students	Classroom Weeks	Classroom Hours	Online Hours	TOL Hours	Total Hours

Summary:

Total number of Training Rounds	21
Total Number of Students Trained	247
Total Hours of Training Provided	6762
Average Time from Start Date to Training Start	23.23 calendar days
Average Time from Start Date to Training End	87.28 calendar days
Average Time from Training Start to Training End	64.05 calendar days

Competency Testing:

Total Tested	Passed 1 st Attempt	Passed 2 nd Attempt	Passed 3 rd Attempt	Did Not Pass
	198	20	0	0

Total Child Welfare New Supervisor Training:	18 Students	6 Sessions	108 Total Hours
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Update 2022:

In 2020 the BCF Division of Training went through many challenges and changes with Initial Staff Training to deal with the COVID-19 pandemic and stay-at-home order issued by the Governor of West Virginia. Staff were instructed to work from home beginning in March 2020 and all in-person training was halted. At the time of the stay-at-home order the Division of Training did not have the capability, neither knowledge or software, to train virtually, but it was clear that training had to continue because there was no way to predict when COVID-19 would be under control and the stay-at-home order would end.

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Working through the West Virginia Department of Health & Human Resources' Office of Human Resources Management and West Virginia Office of Technology, the State entered into an emergency contract with Blackboard, BCF's current learning management system for asynchronous online training, for use of Blackboard Collaborate Ultra, its live training platform. The contract was signed in April 2020, about three to four weeks after the stay-at-home order was issued. Once Collaborate was acquired training staff had to learn how to use the software and also how to train virtually, which is a completely different experience than live classroom training. Curriculum had to be modified so activities designed to be done in-person could be done virtually, especially small group activities and on-the-job transfer of learning activities. The Division of Training began providing its pre-service training in April 2020 for classes that had been interrupted by the stay-at-home order, then reorganized its new worker start dates and other administrative functions to align with virtual training and agency hire dates so it was completely functional. As the year progressed the State also obtained Zoom lines to use for virtual training in situations where Blackboard Collaborate did not function optimally due to differences in software features, although Zoom has primarily been used for ongoing training. New worker classes were back on schedule at full capacity by June 2020, held 100% on the virtual platform.

While the transition was taking place to virtual learning in 2020, the West Virginia Legislature passed legislation that necessitated revisions to new worker pre-service training. The new law created a "Social Services Registry" available to employees of the Bureau for Children and Families, which voided the previous legislation that had created the "restricted" social work license and training plan associated with that legislation. The new law required that new workers complete pre-service training including competency testing prior to obtaining a caseload and increased the number of pre-service hours from 220 hours to 240 hours. It also eliminated the requirement for the four-year training plan that had been attached to the previous legislation. The new law went into effect on 7/1/2020, requiring some significant changes to BCF's new worker training plan. The following is the revised new worker pre-service training plan with 240 hours.

Training Topic	Target Group	Number of Hours
Interviewing	Combined*	34
Intake Assessment & Casework Process	Combined	8
Preparing for First Contact	Combined	10
Initial Assessment	Job-Specific**	32
Safety Planning	Job-Specific	22
Family Assessment & In-Home Case Management	Job-Specific	32
Court	Combined	30
Out-of-Home Case Management	Combined	24
Case Plan Evaluation	Combined	6
Documentation	Combined	34
Review and Competency Test	Combined	8
Total Hours:		240

*Combined groups – all child welfare job classifications trained together

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***Job-Specific – child welfare job classifications are trained in separate groups that occur concurrently
The following information demonstrates the functioning of Initial Staff Training in 2020.*

Staff Classifications:

<i>Classification of Employee</i>	<i>Number</i>
<i>Child Protective Services</i>	<i>148</i>
<i>Contracted Child Protective Services</i>	<i>1</i>
<i>Youth Services</i>	<i>47</i>
<i>Contracted Youth Services</i>	<i>12</i>
<i>Adoption</i>	<i>7</i>
<i>Home-Finding</i>	<i>2</i>
<i>Centralized Intake</i>	<i>7</i>
TOTAL NUMBER TRAINED:	224

New Worker Training Information:

<i>Month</i>	<i># Training Rounds</i>	<i># New Workers</i>	<i>Hours Classroom Training</i>	<i>Hours Online Training</i>	<i>Hours TOL training</i>	<i>Total Training Hours</i>
<i>January</i>	<i>6</i>	<i>73</i>	<i>516</i>	<i>40</i>	<i>82</i>	<i>638</i>
<i>February</i>	<i>6</i>	<i>70</i>	<i>486</i>	<i>46</i>	<i>70</i>	<i>602</i>
<i>March</i>	<i>6</i>	<i>71</i>	<i>258</i>	<i>36</i>	<i>42</i>	<i>336</i>
<i>April</i>	<i>6</i>	<i>80</i>	<i>292</i>	<i>29</i>	<i>54</i>	<i>375</i>
<i>May</i>	<i>6</i>	<i>68</i>	<i>354</i>	<i>29</i>	<i>56</i>	<i>439</i>
<i>June</i>	<i>4</i>	<i>49</i>	<i>336</i>	<i>41</i>	<i>54</i>	<i>431</i>
<i>July</i>	<i>6</i>	<i>61</i>	<i>392</i>	<i>36</i>	<i>50</i>	<i>478</i>
<i>August</i>	<i>7</i>	<i>72</i>	<i>392</i>	<i>14</i>	<i>68</i>	<i>474</i>
<i>September</i>	<i>6</i>	<i>59</i>	<i>478</i>	<i>7</i>	<i>90</i>	<i>575</i>
<i>October</i>	<i>7</i>	<i>75</i>	<i>468</i>	<i>14</i>	<i>70</i>	<i>552</i>
<i>November</i>	<i>7</i>	<i>82</i>	<i>274</i>	<i>12</i>	<i>74</i>	<i>358</i>
<i>December</i>	<i>6</i>	<i>69</i>	<i>304</i>	<i>6</i>	<i>82</i>	<i>392</i>
Total CW Training	20 Training Rounds (Unduplicated)	224 Students (Unduplicated)	4,072 Classroom Hours	310 Online Hours	792 TOL Hours	5,174 Total Hours

Summary:

<i>Total number of Pre-service Training Rounds</i>	<i>20 rounds</i>
<i>Total Number of Students Trained (unduplicated)</i>	<i>224 students</i>
<i>Total Hours of Training Provided</i>	<i>5,174 hours</i>
<i>Average Time from Start Date to Training Start</i>	<i>calendar days</i>
<i>Average Time from Start Date to Training End</i>	<i>calendar days</i>

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Average Time from Training Start to Training End	calendar days
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Child Welfare Supervisor initial staff training was also temporarily halted due to the Governor’s stay-at-home order, with one training round that had been scheduled being cancelled in March and April 2020. New supervisor training was reimplemented in Fall 2020.

Total Child Welfare New Supervisor Training:	15 Students	3 Sessions/ 9 Days	36 Total Hours
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Ongoing Staff Training

West Virginia provides Ongoing Staff Training in two parts: In-service training, which takes place after pre-service training within the first year of employment; and professional development training, which is for tenured staff training after the first year of employment. Staff can register for training through GoSignMeUp, a software registration program. In in-service training staff must complete 100 hours of classroom and online training that expands on the knowledge and skills learned in pre-service training. The Social Work Education Consortium, which consists of the six public universities with accredited social work programs, provides part of the training to ensure that workers understand the concepts of social work. The following classes are required for Year One In-service Training:

Name of Training	Format	Hours	Provider
Introduction to Domestic Violence	Classroom	6	WVCADV
Substance Abuse	Class and Online	16	SWEC
Working with Foster Parents/Caregivers	Classroom	6	SWEC
Legal and Ethical Issues in Social Work Practice 1	Classroom	6	SWEC
Diversity and Cultural Factors 1	Classroom	12	Staff
Human Behavior in the Social Environment 1	Classroom	12	SWEC
Trauma-Informed Practice	Class and Online	9	SWEC
Family Centered Practice for Permanency	Classroom	6	Staff
Family Engagement Principles	Classroom	6	Staff
Meaningful Contacts	Classroom	6	Staff
Critical Incidents in CPS Practice	Classroom	6	Staff
Online Job-Specific Training	Online	13	Staff
TOTAL HOURS:		100	

Feedback received from staff and supervisors has been that 100 hours of training after pre-service and within the first year of employment is too much. However, the 100 hours of training is currently written into the law that was passed for the restricted social work license and so cannot be reduced at this time. To compensate the Division of Training plans to incorporate an additional week of training prior to

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competency testing to complete 28 hours of this training, and parts of some trainings are being put online for better access.

The restricted license legislation also requires tenured staff training for the second, third, and fourth year of licensure at 60 hours per year (total 180 hours). West Virginia has been developing and implementing this training at a fast pace since 2015 when the legislation was passed, and all four years of training will be completed in the next year. This training consists of classroom and online training provided by the West Virginia Coalition Against Domestic Violence, the West Virginia Social Work Education Consortium, and staff trainers. Training topics include yearly content on trauma-informed practice, culture and diversity, social work ethics, family engagement, and human behavior in the social environment (i.e., Systems Theory). The following information demonstrates the functioning of restricted license training in 2018.

Total Classroom Training: Year One	1,966 Students	117 Sessions	900 Total Hours
Total In-Service Online Training: Year One	2,486 Students	16 Hours	2,866 Total Hours
Total Classroom Training: Year Two	636 Students	30 Sessions	1,974 Total Hours
Total Online Training: Year Two	329 Students	18 Hours	3,866 Total Hours
Total Classroom Training: Year Three	56 Students	5 Sessions	30 Total Hours
Total Online Training: Year Three	85 Students	18 Hours	510 Total Hours
Total Online Training: Year Four	11 Students	6 Hours	66 Total Hours

The Division of Training tracks completion of this training to file a yearly report to the West Virginia Board of Social Work. To comply, staff must complete a minimum of 80% of the required training for their current year of licensure and 20 hours of CEUs each two years. Staff who fall below the 80% requirement must complete a corrective action plan with their supervisor and CSM to catch up with their training. Staff who have a regular license or regular provisional license must take ongoing training to maintain their licenses as well. Those with a regular license must take 40 hours of continuing education units each two years, and those with a regular provisional license must complete four college social work courses over four years and 20 hours of CEUs. In the past year BCF implemented a requirement for tenured staff and supervisors to complete 12 hours of job-specific training per year.

There are several strategies related to training in the Program Improvement Plan and the new five-year plan. Statewide and regional trainings for managers, supervisors, and staff will be implemented and held twice per year. In addition, all supervisors and managers will be required to complete a shortened version of the new supervisor training that was implemented last year, and the Division of Training along with representatives from policy and DPQI will begin offering targeted training and technical assistance to

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district offices based on the results of their reviews. The training that has been developed for restricted license training will be opened to all staff and supervisors to meet the yearly 12-hour training requirement and for continuing education units.

West Virginia did not pass the item for Ongoing Training in its last review, primarily because of a lack of supervisor training. The new supervisor training plan was implemented in the last year to address this issue, along with the requirement for 12 hours of job-specific training for supervisors and staff that will be tracked by their managers. The plan for ongoing training will include additional strategies to improve ongoing training for workers and supervisors. In the next five years the plan for Ongoing Staff Training includes:

1. Develop and implement training for staff, supervisors, and managers on the Family First Prevention and Services Act, including training on candidacy, prevention services, case planning, and in-home services.
2. Develop and implement trauma-informed training for supervisors and staff related to a) increasing the percentage of children who remain in their own homes safely, and b) increasing positive outcomes for youth aging out of foster care, through targeted trainings for regional, district, and unit meetings.
3. Develop and implement statewide and regional staff, supervisor, and manager meetings twice per year for training, skill development, and peer support (PIP)
4. Increase supervisor and manager skills through ongoing training and peer support to address their ability to support staff and provide direct supervision. (PIP)
5. Provide ongoing training and technical assistance for supervisors and managers on reflective supervision in conjunction with Casey Family Programs (PIP).
6. Provide a condensed version of new supervisor training for all managers and supervisors and a requirement for them to attend (PIP).
7. Develop and implement teams consisting of representatives from Training, Policy, CWCs, and DPQI to provide targeted training and technical assistance to districts based on the results of their reviews.
8. Develop and implement a plan to provide training and technical assistance to shift staff from a crisis orientation to a quality orientation as they come out of crisis, including the use of in-home services and case planning.
9. Provide training and technical assistance to tenured managers, supervisors, and staff on the new C-WIS system and the use of data.
10. Provide training and technical assistance for court personnel through the West Virginia Supreme Court/Court Improvement Program.

Update 2021:

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In 2020 the BCF Division of Training worked with the Division of Children, Adult, and Family Policy on the Candidacy committee to revise CPS Ongoing and Youth Services assessment and case management procedures around the provisions of the Family First Act. The new Youth Services assessment was implemented in December 2019, and the new CPS process is scheduled to begin in Summer 2020. Both focus on increasing prevention and in-home services for families. In Spring 2020 plans were developed to hold the first series of meetings for managers, supervisors, and workers for professional development and peer support. The meetings were postponed due to the COVID crisis. In 2019 Casey Family Programs sponsored two statewide trainings for supervisors and managers on the implementation of the reflective supervision model and the Standard Operating Procedure and forms were revised to reflect staff input and to make them more user friendly. The condensed version of new supervisor training for tenured managers and supervisors was developed but implementation was postponed due to the COVID crisis.

In 2019 the following training was provided to tenured child welfare staff:

<i>Total Classroom Training: Year One</i>	<i>2064 Students</i>	<i>119 Sessions</i>	<i>882 Total Hours</i>
<i>Total In-Service Online Training: Year One</i>	<i>2058 Students</i>	<i>22 Hours</i>	<i>3384 Total Hours</i>
<i>Total Classroom Training: Year Two</i>	<i>493 Students</i>	<i>35 Sessions</i>	<i>198 Total Hours</i>
<i>Total Online Training: Year Two</i>	<i>343 Students</i>	<i>18 Hours</i>	<i>2058 Total Hours</i>
<i>Total Classroom Training: Year Three</i>	<i>149 Students</i>	<i>9 Sessions</i>	<i>54 Total Hours</i>
<i>Total Online Training: Year Three</i>	<i>564 Students</i>	<i>48 Hours</i>	<i>3384 Total Hours</i>
<i>Total Online Training: Year Four</i>	<i>269 Students</i>	<i>60 Hours</i>	<i>1614 Total Hours</i>

The following training was provided for child welfare supervisors and managers:

<i>Reflective Supervision Skills Training</i>	<i>309</i>	<i>12</i>
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	Students	hours
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Update 2022:

In 2020 the Bureau for Children & Families experienced a wide variety of changes and challenges that impacted its ongoing training for tenured child welfare staff. The largest impact was COVID-19 and the stay-at-home order issued by the Governor. The stay-at-home order necessitated moving all training to a virtual platform, and to make that move the agency had to acquire the capability to train virtually by purchasing or contracting for software and training the trainers to use that software to train virtually. There was a two to three-month period (March to early May 2020) where ongoing training was not readily available to staff. DHHR did an emergency purchase of Blackboard Collaborate and acquired Zoom lines to use for training, and the BCF Division of Training received technical assistance from Aetna and Berry Dunn to begin offering ongoing training virtually until training staff were up to speed on using the programs.

While the stay-at-home order necessitated moving all training to a virtual platform, the need to provide training to meet legislative and federal mandates were still priorities. One of the largest initiatives that was impacted was the CFSR 2019 Program Improvement Plan (PIP). The CFSR PIP went into effect on 11/30/2019 and many of the activities were underway when the stay-at-home order went into effect in March 2020 were interrupted and delayed. Required PIP activities had to be redesigned and restructured to allow them to take place virtually or happen in a virtual world. Plans for training-related activities were revised to accommodate the virtual world and the status was made current by the end of Q5, with all activities occurring virtually. Training activities include:

- *Developed and implemented statewide and regional staff, supervisor, and manager meetings twice per year for professional development and peer support. Statewide manager meetings (two sessions, four hours each) and statewide supervisor meetings (four sessions, four hours each) were held in February and August 2020, and regional staff meeting implementation was planned for early 2021.*
- *Provided supervisor and manager skills training to address their ability to support staff and provide direct supervision through regional supervisor meetings. The Division of Training provided training to supervisors in their regional staff meetings in June and November 2021 (eight sessions, 1.5 hours each).*
- *Provided ongoing training and technical assistance for supervisors and managers on reflective supervision in conjunction with Casey Family Programs. Training was provided by Casey on “Reflective Supervision During a Global Pandemic” (12 sessions, 1.5 hours each), and peer-to-peer learning for supervisors on reflective supervision (eight sessions, 1.5 hours each).*
- *Provided a condensed version of new supervisor training (“Putting the Pieces Together”) for all tenured managers and supervisors (eight sessions, 12 hours each).*
- *Provided refresher training on consultation in safety planning for all supervisors (eight sessions, four hours each).*
- *Provided refresher training on safety planning for all CPS staff (13 sessions, four hours each).*

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- *Designed training plans and implemented training for the new positions in the CPS career ladder, CPS Senior (two sessions, 17 hours each) and CPS Case Coordinator (one session, 16 hours).*

West Virginia passed several pieces of legislation in the 2020 session related to foster care. Managed care for foster care was implemented in West Virginia, with Aetna selected as the provider. The BCF Division of Training worked closely with Aetna to provide training on how the managed care system would work and on ways to improve the foster care system, such as family-finding to locate potential kinship care homes. The West Virginia Legislature also created a foster care ombudsman to investigate complaints arising out of foster care, and training was provided related to the Federal Family First Act. The following chart shows the training that was provided in 2020.

Session Title	Number of Sessions	Session Hours	Number of Participants
<i>From Day One in Mountain Health Promise</i>	7	1.5	398
<i>Aetna/ Family Finding</i>	3	2	218
<i>Aetna/Family Finding Coaching Series Session 1</i>	4	1.5	104
<i>Aetna/Family Finding Coaching Series Session 2</i>	3	1.5	77
<i>Aetna/Family Finding Coaching Series Session 3</i>	4	1.5	88
<i>Aetna/Family Finding Coaching Series Session 4</i>	4	1.5	61
<i>Aetna/Connection for Life Technology Program</i>	4	1.0	124
<i>What is a Foster Care Ombudsman and Why Does it Matter?</i>	Online	1	426
<i>Foster Youth Initiative</i>	Online	1	42
<i>Assertive Community Treatment</i>	Online	1	358

West Virginia also worked with Casey Family Programs to provide training related to secondary trauma and working with clients during a global pandemic to help staff during the stay-at-home order. Training provided included:

Session Title	Number of Sessions	Session Length	Number of Participants
<i>Loss, Grief, and Self-Care During a Global Pandemic</i>	9	1.5	203
<i>Supporting Families in New Ways & Tips for Engaging Children</i>	24	1.5	442

The West Virginia Legislature passed a bill that changed the former “restricted” social work license to a social services registry program for BCF staff in critical positions. The social services registry requires a bachelor’s degree in any field, 240 hours of pre-service training, and 20 hours of CEUs every two years. The four-year training plan that was required for the restricted license went out of effect when the registry program was enacted on 7/1/2020. BCF leadership met to redesign the four-year training plan for restricted licenses into a five-year plan that outlines training for all social services staff including those

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with a regular license, those with a provisional license, and those placed on the social service registry using the training that had been developed for the restricted license. The requirements will go into effect in 2021. The BCF Division of Training in conjunction with the West Virginia Social Work Education Consortium continued to provide the training previously required for the restricted license virtually on a limited basis for all child welfare staff through the rest of 2020. Virtual classroom training included:

Session Title	Number of Sessions	Number of Participants
<i>Introduction to Domestic Violence</i>	4	75
<i>Substance Abuse 1</i>	10	104
<i>Working with Foster Parents/Caregivers</i>	7	76
<i>Legal and Ethical Issues in Social Work Practice 1</i>	9	81
<i>Diversity and Cultural Factors 1</i>	5	50
<i>Human Behavior in the Social Environment 1</i>	7	70
<i>Trauma-Informed Practice 1</i>	8	109
<i>Family Centered Practice for Permanency</i>	2	34
<i>Family Engagement Principles</i>	4	54
<i>Meaningful Contacts</i>	3	48
<i>Critical Incidents in CPS Practice</i>	4	58
<i>Working with Domestic Violence Offenders</i>	7	62
<i>Legal and Ethical Issues in Social Work Practice 2</i>	6	104
<i>Appalachian Culture</i>	3	28
<i>Human Behavior in the Social Environment 2</i>	4	37
<i>Trauma-Informed Practice 2: Secondary Trauma</i>	3	41
<i>Legal and Ethical Issues in Social Work Practice 3</i>	4	73
<i>Understanding Poverty</i>	3	44
<i>Rural Social Work Practice</i>	3	43
<i>Contemporary Issues in Social Work Practice</i>	6	31

Foster Parent Training

West Virginia contracts with the member schools of the West Virginia Social Work Education Consortium (SWEC) to provide most of its foster parent training. SWEC trains all Department and some provider foster and kinship homes through the Child Welfare League of America’s PRIDE model, including both pre-service and ongoing training. SWEC also trains some of the provider agency homes, although some agencies have chosen to become certified as PRIDE trainers and train their own foster parents. SWEC also provides trauma-informed practice training to foster families that is completed directly after pre-service training. In 2018, SWEC provided a total of 59 training rounds to 1,242 participants. Approximately 72% of the prospective foster parents who started the program completed the training. The schools also offer

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advanced Level II and Level III training to the foster/adoptive parents. In 2016/2017 there were 162 advanced trainings held with 2,133 participants.

The SWEC universities collect a large volume of data for each of their respective programs. Preservice training is 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 quantitative and qualitative continuous assessments, biannual surveys of foster parents are administered to assess the perception of foster parents of the efficacy of training longitudinally. 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.

West Virginia passed the systemic factor of Foster Parent Training in its last Child and Family Services Review. Plans are underway to further streamline and improve foster parent training in the state. Some of the provider agencies are currently piloting the new PRIDE blended model with positive results so far. In addition, BCF partnered with Casey Family Programs to assess its kinship care program and there will be recommendations from that related to training. The five-year plan for foster parent training includes the following.

1. Develop and implement training for foster families, staff, and providers on subjects related to the implementation of the Family First Prevention Services & Treatment Act.
2. Pilot the PRIDE blended model with provider agencies to assess if this model can be successful in West Virginia and implement statewide if it is successful.
3. Implement changes to training based on the recommendations of the kinship care report completed by Casey Family Programs.
4. Expand child-specific ongoing training opportunities for foster parents through a contract with the Foster Parent College and SWEC.

Update 2021:

In 2020 the PRIDE blended model was successfully piloted by three provider agencies. Plans are underway to make the PRIDE blended model training an option for all new foster parents statewide. The Title IV-E universities conducted research on kinship care-specific foster parent training models and developed

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recommendations on how to proceed once policy changes are made based on the final report. The Bureau for Children & Families is in discussions with the Foster Parent College on costs to the state to make its training available for all agency and provider foster parents statewide.

In 2019 the following foster parent training was provided:

2019 Pre-Service PRIDE Trainings	Number of Rounds	Number of Finishers
<i>Region I - West Virginia University</i>	13	206
<i>Region II - Marshall University</i>	16	293
<i>Region II - West Virginia State University</i>	15	378
<i>Region III - Shepherd University</i>	18	214
<i>Region IV - Concord University</i>	20	337
Total PRIDE Pre-Service Training	82 Rounds	1,428 Finishers

2019 In-Service PRIDE Trainings	Number of Sessions	Number of Participants
<i>Region I - West Virginia University</i>	60	942
<i>Region II - Marshall University</i>	19	66
<i>Region II - West Virginia State University</i>	1	24
<i>Region III - Shepherd University</i>	47	852
<i>Region IV - Concord University</i>	117	1,227
Total PRIDE Pre-Service Training	244 Sessions	3,111 Participants

Update 2022:

In 2020, foster parent training for new and prospective foster parents and in-service training for foster parents were also greatly impacted by the COVID-19 pandemic. Both foster parent pre-service and in-service training had to be halted temporarily due to the Governor's Stay-at-Home order in late March, April, and early May but was gradually reimplemented virtually by the schools as they each developed their ability to provide virtual training for these groups. The amount of training provided was back to its previous levels by July 2020. The universities in the West Virginia Social Work Education Consortium worked with the regional home-finding staff and Mission WV to identify new and prospective foster and kinship parents to complete the training and worked with individuals in their trainings to address internet access issues since broadband availability continues to be an issue in many parts of the state, especially rural areas. Some foster parents went to local libraries and schools to access wifi, and one school, Concord University, continued to provide some limited in-person sessions for foster parents who had no internet

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availability. Foster parent training continued to be provided almost 100% virtually through the end of 2020.

2020 Pre-Service PRIDE Trainings January-October 2020	Number of Sessions	Number of Participants	Number of Finishers
<i>Region I - West Virginia University</i>	100	261	114
<i>Region II - Marshall University West Virginia State University</i>	68	353	165
<i>Region III - Shepherd University</i>	81	288	175
<i>Region IV - Concord University</i>	116	322	194
Total PRIDE Pre-Service Training	365	1,224	648
	Rounds	Participants	Finishers

2020 In-Service PRIDE Trainings	Number of Sessions	Number of Participants
<i>Region I - West Virginia University</i>	18	149
<i>Region II - Marshall University West Virginia State University</i>	4	56
<i>Region III - Shepherd University</i>	30	410
<i>Region IV - Concord University</i>	26	233
Total PRIDE Pre-Service Training	78	848
	Sessions	Participants

Staff and Provider Training

The DHHR in conjunction with the states Court Improvement Program developed provider training for Child Placing Agencies and Residential Treatment Facilities and placed it on the DHHR/BCF website. The training includes a video titled “The Time is Now”, Away from Supervision Training and Normalcy and Prudent Parenting Training.

The video titled “The Time is Now” is for parents in West Virginia child abuse and neglect proceedings that explains the procedure for child abuse and neglect cases. This training is a great resource for providers to be informed about the process for parents and children.

The Away from Supervision Training includes the Child Abuse Prevention and Treatment Act requirements for state agency staff as well as provider staff caring for youth in foster care. This training includes policy and procedures for guidance in the event a child runs away while in out of home care.

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The Normalcy and Prudent Training includes requirements for the IV-E agency and provides training to help ensure staff are following a reasonable and prudent parenting standard of care which includes activities normal for children. Following these requirements allows for youth in foster care to lead a normal life as possible and thereby reduces the risk of running away and falling prey to the risk of trafficking.

In addition to the training developed and provided on the DHHR website the West Virginia Rules for Child Placing Agencies §78-2 and Residential Child Care and Treatment Facilities §78-3 require specific training.

The Child Placing Agencies §78-2 requires:

Child placing agencies require that all employees involved in child placing services, within three (3) months of employment, complete a minimum of forty (40) hours of orientation training in areas including:

- Agency philosophy and goals
- Agency operations overview
- Protocol for emergencies and incidents
- Confidentiality
- Universal precautions
- Infectious and communicable disease
- The risks of exposure to infectious agents, materials and instruments, and the control and disposal of them
- Licensing rules and legal aspects of substitute care
- Service planning
- Interviewing
- Conflict resolution
- Crisis intervention and passive restraint
- Mandatory abuse/ neglect reporting
- First Aid
- CPR

Child placing agencies require that all employees providing direct services to clients receive at least twenty (20) hours of ongoing training within six (6) months of employment in areas including:

- assessment of family dynamics
- human growth and development
- values and cultural diversity
- ethics
- child abuse and neglect issues
- behavior management

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Child placing agencies require that after the first year of employment, all employees providing direct services to clients, complete a minimum of twenty-five (25) hours of training per year, fifteen (15) hours of which shall be directly related to the employee's responsibilities.

Residential Child Care and Treatment Facilities §78-3 requires:

Residential providers are to orient all new employee to the following topics within the first 10 days of employment:

- Agency mission, philosophy and goals
- Agency services, policies and procedures
- Agency's CQI program
- Confidentiality and disclosure of information, including federal confidentiality requirements and penalties for violation
- Legal rights of the person served
- Mandatory reporting procedures for suspected abuse/ neglect
- Identifying and documentation of incidents
- Responsibility to abide by professional ethics
- Fire drills
- Procedures for medical and psychiatric emergencies, including notification of guardians

Residential providers are required to train all clinical and direct care employees on the following topics within 30 days of employment:

- Basic medical needs and problems of the population served
- Basic first aid and medication reactions (updated every 3 years)
- CPR (every 2 years)
- Supervision of self-administration of medication as applicable, including typical medications prescribed, appropriate dosages & schedules and common side effects
- Basic de-escalation techniques and passive restraints
- Protocols for universal disease precautions and providing services to children with contagious and infectious diseases
- Appropriate management of suicidal threats or behaviors
- Children's trauma stress experiences, to include impact on development, behavior and relationship; types of trauma; cultural factors; recognizing how on-going stressors impact child traumatic stress; responding to crises with interventions; strategies and interventions to promote resiliency & health
- Food handler's certification as necessary
- Agency's policy defining & prohibiting corporal & degrading punishment
- Procedures for maintaining a safe, hygienic and sanitary environment, including retarding the spread of infection and proper storage of cleaning supplies and hazardous materials

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Residential providers are required to train all program employees with direct care responsibilities on the following topics within 90 days of employment:

- Sensitivity to differences in cultural norms& values
- Management of children attempting to escape supervision
- Sensitivity to sexual identity (LGBTQ)
- Family dynamics, including human growth and development
- Proper documentation techniques
- Basic therapeutic or behavior management techniques

Residential providers are required to provide annual training to employees on the following topics throughout employment:

- Supervision of self-administration of medication as applicable, including typical medications prescribed, appropriate dosages & schedules and common side effects
- Basic de-escalation techniques and passive restraints
- Protocols for universal disease precautions and providing services to children with contagious and infectious diseases
- First Aid certification to be renewed every three years
- CPR certification to be renewed every two years

The Child Placing Agency and Residential Child Care and Treatment Facilities have an annual on-site visit and a licensing review every two years. To ensure that training is occurring statewide for current foster parents, adoptive parents, and staff of state licensed facilities the Licensing Specialist reviews employee/foster parent files, training records and interviews current employees and foster parents.

To ensure that the training the foster/adoptive parents and Residential Treatment employees receive adequately prepares them to care for the needs of West Virginia foster children, BCF is developing a survey. A survey allows for the collection of valuable data and to gain information in real time. Agencies will be able to learn from the results and be able to turn the data into useful content to further engage and train foster/adoptive parents and residential staff.

The survey will be provided to West Virginia Child Placing Agencies and Residential Child Care and Treatment Facilities. The agency/facility will administer the survey quarterly. The agencies will be required to compile and maintain the quarterly data and provide the data to BCF annually. After the quarterly survey is given, the Child Placing and Residential Treatment agencies must address any training needs the survey identifies as lacking.

As part of the review process, the licensing specialist will review the survey data to ensure identified training needs are being addressed by the agency/facility. The Specialist will interview 10% of foster/adoptive parents or Residential Treatment employees. The interview will address agency provided training to determine if the training meets their needs and prepares them to do their job duties effectively and adequately care for West Virginia foster children.

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Update 2021:

The Residential Child Care and Treatment Facilities and Child Placing Agencies have an annual on-site visit and a licensing review every two years. The Licensing Specialist reviews employee/foster parent files, training records and interviews current employees and foster parents to ensure that training is occurring as directed.

BCF developed surveys to ensure that the training the foster/adoptive parents, Child Placing employees and Residential Treatment employees receive adequately prepares them to care for the needs of West Virginia foster children. Three surveys were developed: one for Residential Treatment employees, one for Child Placing employees and one for foster/adoptive parents. A survey for each provider group allows for the collection of valuable data relevant to each provider type. Agencies will be able to learn from the results of the survey and be able to turn the data into useful content to further engage and train foster/adoptive parents and staff.

The surveys were provided to West Virginia Child Placing Agencies and Residential Child Care and Treatment Facilities. The agency/facility will administer the survey quarterly to employees hired and trained during the quarter. All new staff hired January – March will be surveyed in April to provide first quarter data. When surveys are completed, each agency will tally scores to determine an average for each individual survey item. Agencies are expected to respond to each quarterly administration of the survey by retraining staff and modifying delivery or curriculums for any survey items rating less than 80% average.

The compiled survey results and responsive training modifications will be available to BCF licensing specialists upon request and will be incorporated into the licensing review process. Survey data will be reviewed to ensure identified training needs are being addressed by the agency/facility. The Specialist's interviews with residential and child placing employees and foster/adoptive parents will be used to assess participants' experiences with agency provided training and to determine if the training meets their needs and prepares them to effectively and adequately care for West Virginia foster children.

Update 2022:

The Residential Child Care and Treatment Facilities and Child Placing Agencies have an annual on-site visit and a licensing review every two years. The Licensing Specialist reviews employee/foster parent files, training records and interviews current employees and foster parents to ensure that training is occurring as directed.

BCF developed and distributed surveys to the Residential Treatment Providers and the Child Placing Agencies to ensure staff are being adequately trained to care for the needs of West Virginia foster children. The providers are surveying their staff and foster parents quarterly and providing additional training when needed. The BCF licensing specialists have incorporated this into the review process.

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The Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia §78-3 is being updated during the 2021 Legislative Session to include the survey requirement for staff. The Child Placing Agency survey requirement will be incorporated into their contract.

Rule §78-3 was updated during the 2020 Legislative Session to include training for all employees on interacting with victims of sex trafficking.

Quality Assurance System

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 purpose 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 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 randomly selected cases consisting of in-home and 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 Community Services Districts that are divided into four regions. DPQI completed 125 CFSR style case reviews during the 2018 FFY. The FFY 2018 data is based upon the review of social services cases between October 1, 2017 to September 30, 2018. The review was comprised of 65 foster care and 60 in-home social service cases. Case reviews conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Calhoun/Gilmer/Wirt, Fayette, Monongalia/Marion, Wood, Jackson/Roane/Clay, Cabell, Kanawha, Putnam/Mason, Berkeley/Morgan/Jefferson, Lewis/Upshur/Braxton, Wyoming, Greenbrier/Summers/Monroe/Pocahontas.

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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. Centralized Intake call centers are in the northern and southern parts of the state. DPQI is responsible for the sampling and review of intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake as well as the Deputy Commissioner over Centralized Intake and the Commissioner. Each reviewer, in addition to other assignments, is randomly assigned ten Centralized Intakes to review each month. In addition to these ten, each review team also reviews any accepted intakes received on their monthly on-site case reviews. From May of 2018 to May of 2019 DPQI staff completed 618 reviews on intakes received by Centralized Intake.

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. 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 fatalities and near fatalities in order to prevent similar deaths in the future.

In order to improve outcomes DPQI 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. The DPQI Case Review and resulting exit report begin the CQI process at the district and regional levels. This process continues through the state level utilizing the Child Welfare Oversight Team (CWO) to monitor child welfare data by state, region and district. Each district has a corrective action plan, which is sent to the regional Quality Council for review and monitoring. The regional Quality Councils meet on a quarterly bases and have staff that represent each district and each level of management including; child protective workers, supervisors, coordinators, youth service workers, community services managers, and child welfare consultants. The Child Welfare Oversight team is comprised of individuals on the state level, and key stakeholders, that can impact child welfare in a way that the district and regions may not. The CWO team reviews and provides feedback on stakeholder surveys. The team also reviews surveys for statewide trends and provides the feedback to the regions and/or divisions. This data is given to the regional Quality Councils to process and incorporate into their regional plans as needed.

The DPQI unit also completes targeted reviews and related activities. For example, during FFY 2018 DPQI staff assisted in the merging of duplicate customers in the Family and Child Tracking System. This is being done to eliminate data quality errors and to prepare for conversion to the new automated child welfare reporting system.

In addition to the data and information collected through the CFSR style case review process, DPQI staff also collect additional information during the onsite reviews. This information includes such things as if foster parents are notified of court hearings and MDTs, if domestic violence is indicated in the case, if services were needed in the case but not provided due to not being available in the area. This information is provided in the exit summary reports and used for state planning purposes.

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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 by federal and state laws and Department policy, at <http://www.dhhr.WestVirginia.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.

In order 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 key case participant interviews in order to evaluate adherence to policy and practice standards. The goal of the reviews is to improve practice in order to achieve positive outcomes for the children and families being served. The period under review covers a 12month 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 fidelity to the tool. DPQI program managers then complete initial and secondary 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

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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 as a result 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 and the team determines if the child critical incident was due to abuse and neglect.

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 provides 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.

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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 at the conclusion of 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.

West Virginia intends to use state generated data and information from its CQI process for PIP monitoring and measurement of performance. Measurement of systemic factors will be by completion of the key activities associated with each strategy associated with the factor. Measurement of CFSR items and associated outcomes will be measured by completion of social services case reviews completed by the Division of Planning and Quality Improvement.

Update 2021:

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) continues to have 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

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Planning and Quality Improvement (DPQI). DPQI is under the Office of Planning, Research, and Evaluation. West Virginia has 12 designated DPQI staff for the purpose 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.

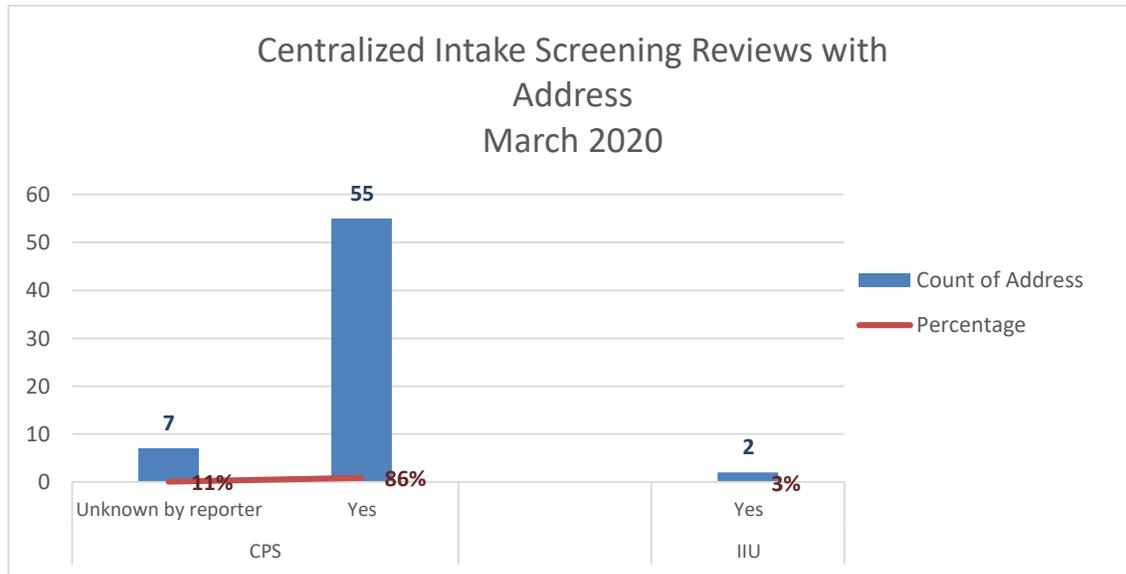
West Virginia's quality assurance system evaluates social services case management activities and decisions in the areas of Child Protective Services from initial abuse/neglect report to case closure, Youth Services cases with and without judicial oversight, Critical Incidents, and Intake Assessments as received by West Virginia Centralized Intake.

DPQI completes 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 randomly selected cases consisting of in-home and 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. Additional data and information is collected through the CFSR style case review process. This information is provided in the exit summary reports and used for state planning purposes.

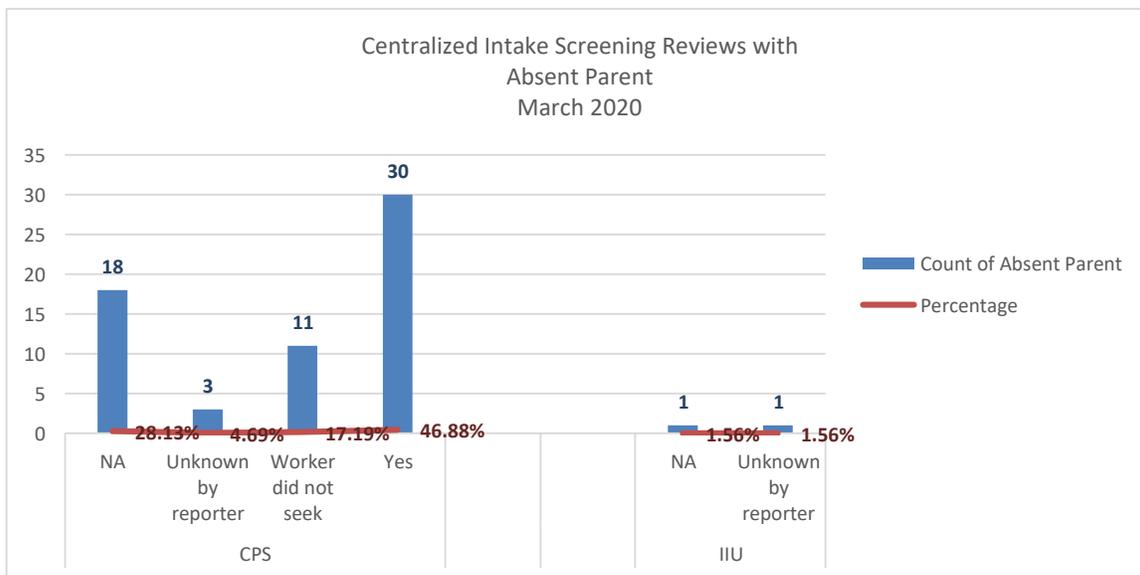
The Bureau for Children and Families is comprised of Community Services Districts that are divided into four regions. DPQI completed 129 CFSR style case reviews during FFY 2019. Case reviews conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. The FFY 2019 data is based upon the review of social services cases between October 1, 2018 to September 30, 2019. The review was comprised of 67 foster care and 62 in-home social service cases. DPQI staff conducted 684 interviews during FFY 2019. Of the interviews completed, 91 were with children, 151 were with parents, and 57 were with foster parents. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Marshall/Wetzel/Tyler, Boone/Lincoln, Cabell, Kanawha, Logan, Wayne, Hampshire/Mineral, Taylor/Preston/Barbour, Harrison, Mercer, Nicholas/Webster, and Raleigh.

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. Centralized Intake call centers are in the northern and southern parts of the state. DPQI is responsible for the sampling and review of accepted intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake as well as the Deputy Commissioner over Centralized Intake and the Commissioner. During FFY 2019, DPQI staff completed 668 reviews on intakes received by Centralized Intake. An example of the monthly report regarding family location information is listed below.

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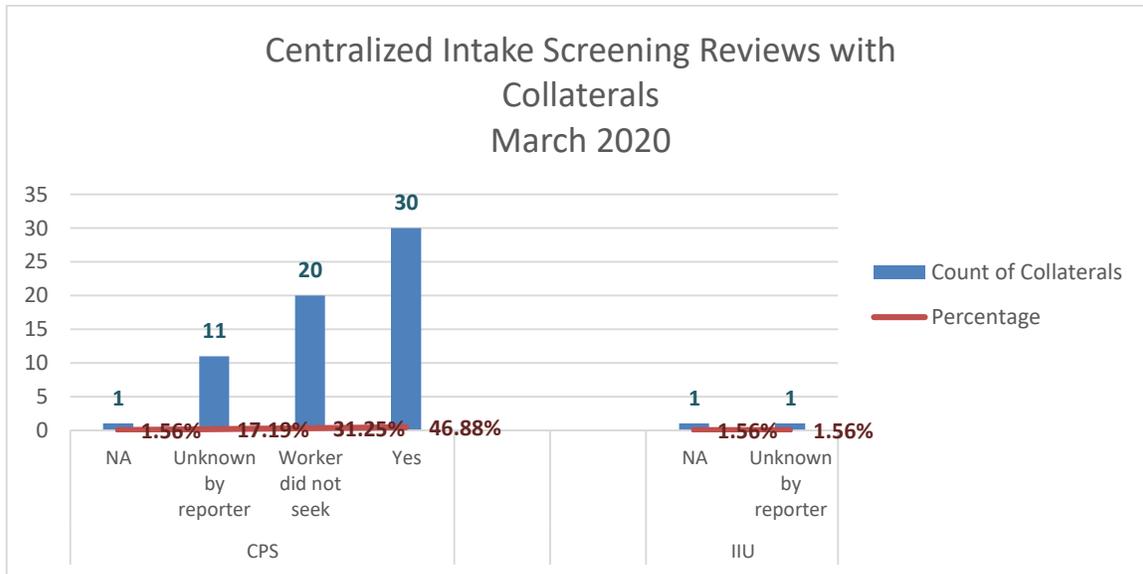


Source: DPQI Centralized Intake Review Data March 2020

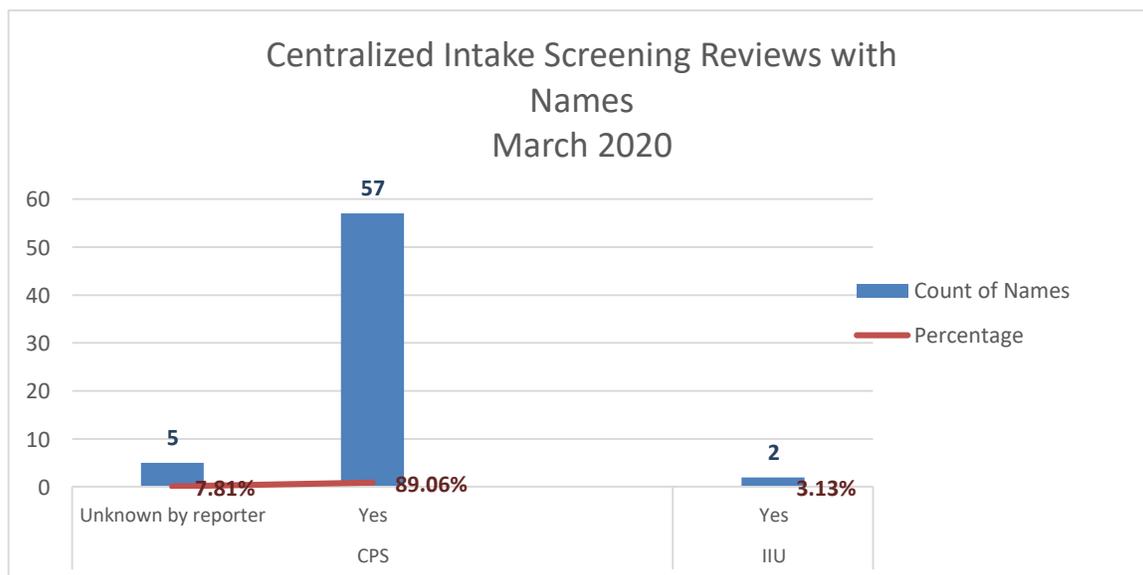


Source: DPQI Centralized Intake Review Data March 2020

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Source: DPQI Centralized Intake Review Data March 2020



Source: DPQI Centralized Intake Review Data March 2020

West Virginia has established an internal child critical incident review team to review all child deaths due to child abuse and neglect and child near fatalities. Cases that are deemed by the internal review team to

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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 fatalities and near fatalities in order to prevent similar deaths in the future. Please see the Critical Incident Review Team 2020 Update for details of these reviews.

West Virginia has instituted 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. The DPQI Case Review and resulting exit report begin the CQI process at the district and regional levels. This process continues through the state level utilizing the Child Welfare Oversight Team (CWO) to monitor child welfare data by state, region and district. 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.

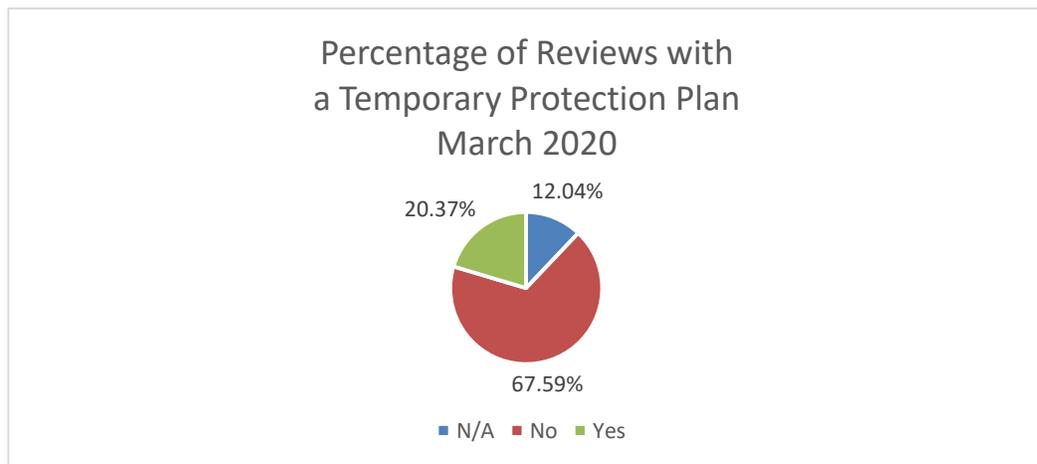
In late 2019 a decision was made to include key stakeholders outside the Bureau for inclusion in the Child Welfare Oversight Team to offer input on proposed initiatives within the Bureau to improve outcomes and address systemic issues identified during reviews. The Oversight Team currently invites members of the Court Improvement Program but will also invite providers of foster care and socially necessary services as well as a representative from Mission WV.

The DPQI unit also completes targeted reviews and related activities. For example, during FFY 2019 DPQI staff reviewed cases in which no contact was listed in Family and Child Tracking System (FACTS) for sixty or more consecutive days. DPQI staff completed 565 of these no-contact reviews. The results are used to validate information in FACTS regarding frequency of contact and to determine the presence of active/updated protection and safety plans.

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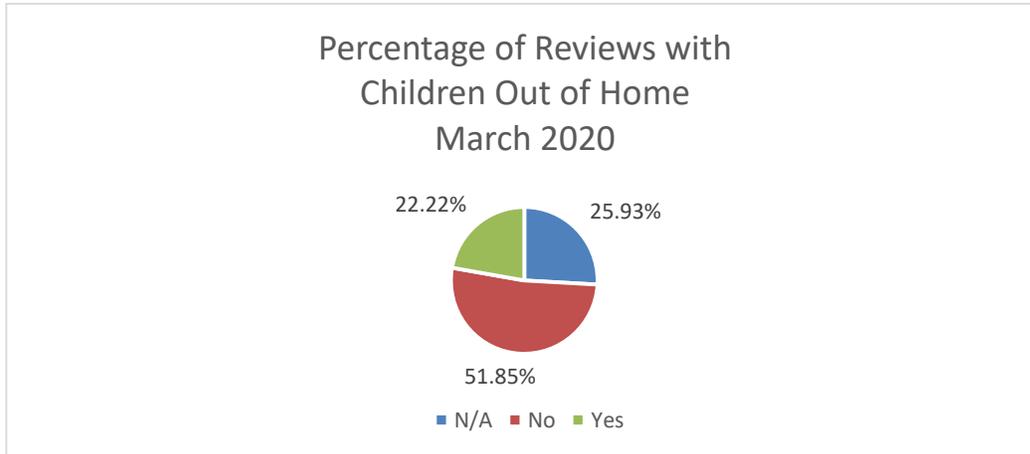


Source: DPQI No Contact Review Data March 2020

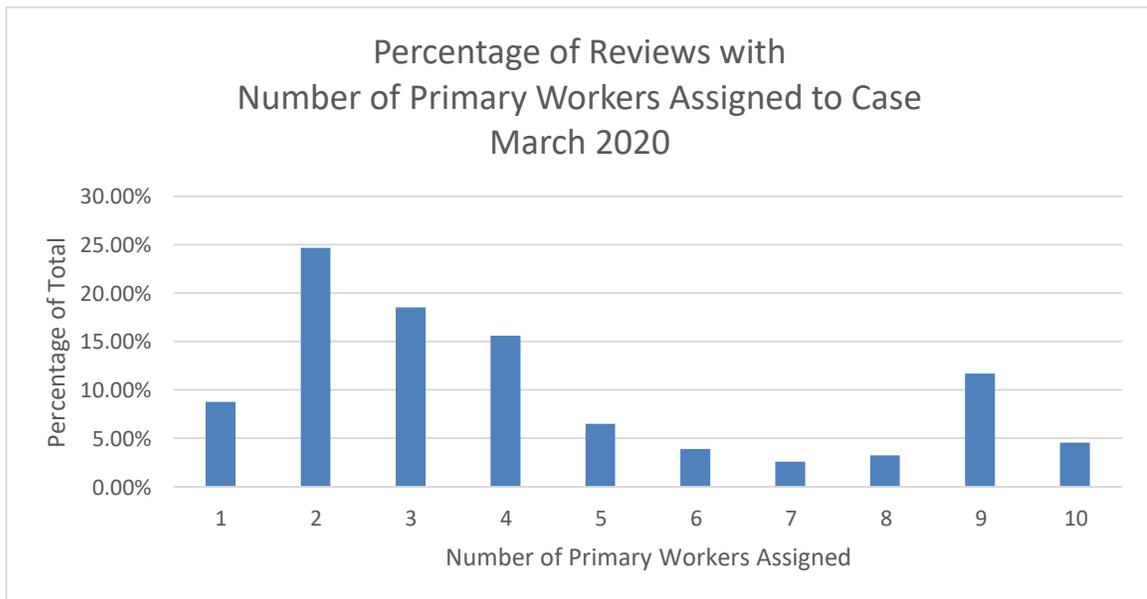


Source: DPQI No Contact Review Data March 2020

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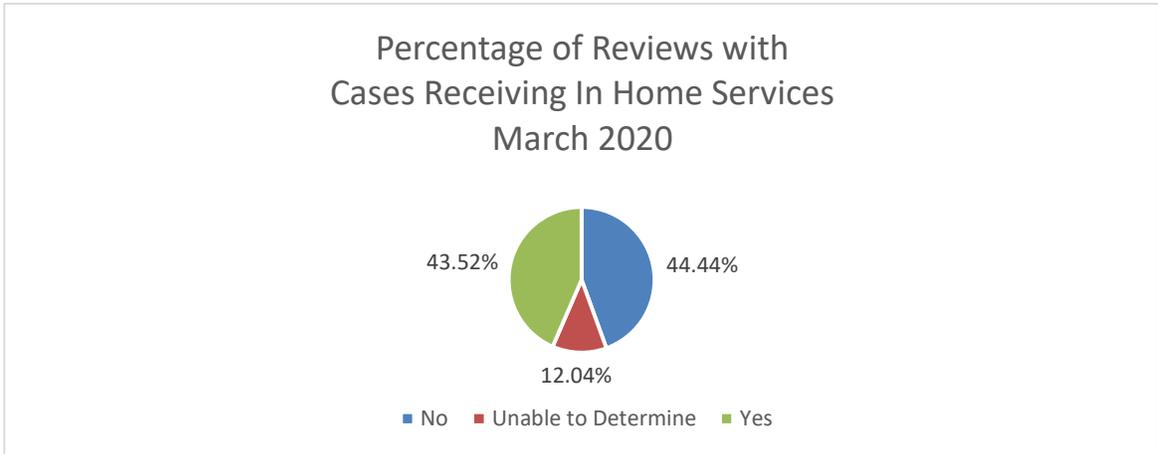


Source: DPQI No Contact Review Data March 2020

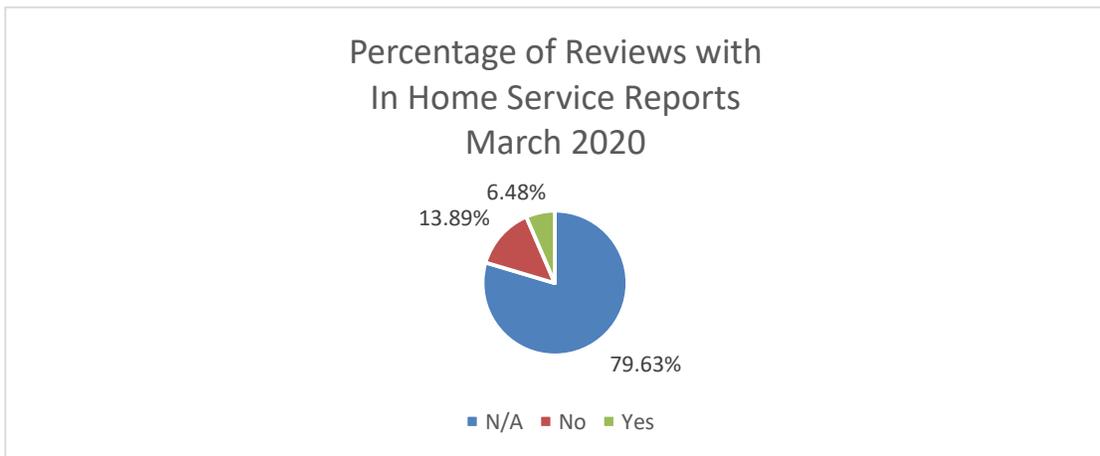


Source: DPQI No Contact Review Data March 2020

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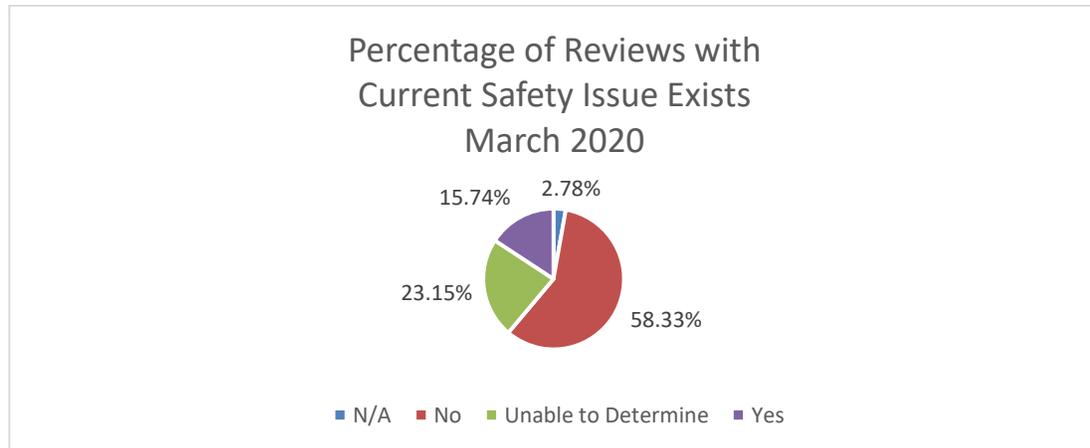


Source: DPQI No Contact Review Data March 2020



Source: DPQI No Contact Review Data March 2020

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Source: DPQI No Contact Review Data March 2020

Have standards to evaluate the quality of services

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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.

In order 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 key case participant interviews in order to evaluate adherence to policy and practice standards. The goal of the reviews is to improve practice in order to achieve positive outcomes for the children and families being served. The period under review covers a 12month 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

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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 fidelity to the tool. DPQI program managers then complete initial and secondary QA activities. During CFSR Rd. 3 case reviews, and PIP implementation measurement periods, the Children's Bureau provides secondary oversight on a percentage of the cases reviewed by DPQI.

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. During the exit DPQI staff discuss the prior CAP activities and if they appear to have been impactful in relation to improving outcomes for children and families.

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 as a result of abuse and/or neglect who has a previous child welfare history within the last twelve months. This review 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 team meeting. This team reviews all critical incidents resulting in a fatality or near fatality of a child as stated above, in order to make improvements to the process in which critical incidents are reviewed with the intent of reducing the number of fatalities and near fatalities that were

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the result of abuse and neglect. The Critical Incident Review utilizes a quality assurance process to look at practice, policy and training and to make needed program improvements. The review process will look 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.

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 provides 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. This information leads to the CQI process provided by the state Child Welfare Oversight Team. The Critical Incident Review Team submits an annual report which includes a Plan for Action that contains activities designed to increase awareness, support practice and improve outcomes in child welfare cases. This report is submitted to the Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: <https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.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

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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 at the conclusion of 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.

West Virginia will use state generated data and information from its CQI process for PIP monitoring and measurement of performance. Measurement of systemic factors will be by completion of the key activities associated with each strategy associated with the factor. Measurement of CFSR items and associated outcomes will be measured by completion of social services case reviews completed by the Division of Planning and Quality Improvement. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 1, 2020.

Update 2022:

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) continues to have 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 13 designated DPQI staff for the purpose 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 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

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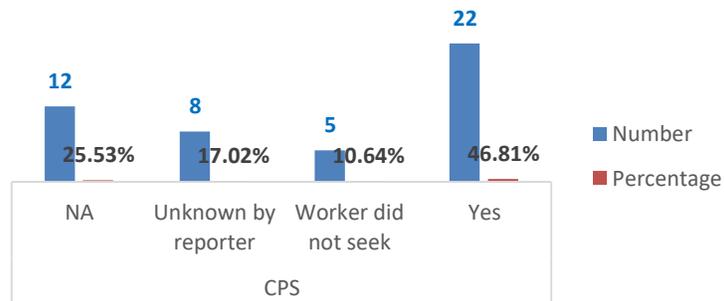
each month by DPQI staff. The review includes the examination of randomly selected cases consisting of in-home and placement cases. The largest metropolitan area is reviewed once each calendar year. The review cycle is continued until each district has been reviewed. Additional data and information is collected through the CFSR style case review process. This information is provided in the exit summary reports and used for state planning purposes.

The Bureau for Children and Families is comprised of Community Services Districts that are divided into four regions. The Federal Fiscal Year (FFY) 2020 social service case reviews were completed utilizing 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 services delivery to children and families. Case related information was entered into the Online Monitoring System (OMS) and reports generated from that system are used for evaluating continuous quality improvement efforts within BCF. Administrative data reports, information from stakeholders, and other data sources are also used to update the assessment of performance.

DPQI completed 129 CFSR style case reviews during the 2020 FFY. The FFY 2020 data is based upon the review of social services cases between October 1, 2019 to September 30, 2020. The review was comprised of 67 foster care and 62 in-home social service cases. DPQI staff conducted 709 interviews during FFY 2020. Of the interviews completed, 88 were with children, 183 were with parents, 69 were with foster parents, and 119 were judicial staff such as attorneys, guardians-ad-litem, juvenile probation officers, and Court Appointed Special Advocates, and the remainder were with other parties who may have information relative to the case review. Case reviews conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Kanawha, Wyoming, McDowell, Mingo, Randolph/Tucker, Hardy/Grant/Pendleton, Lewis/Upshur/Braxton, Brooke/Hancock/Ohio, Calhoun/Gilmer/Wirt, Marion/Monongalia, Ritchie/Doddridge/Pleasants, and Berkeley/Jefferson/Morgan.

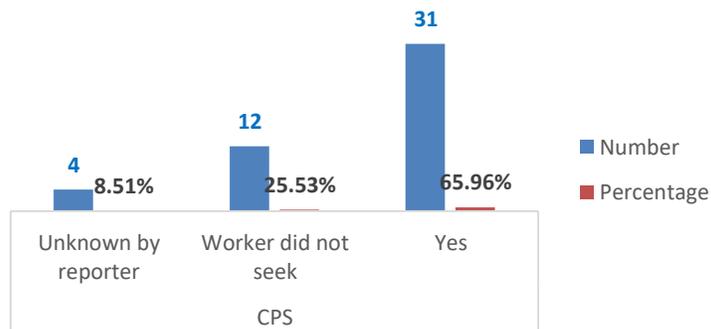
In July 2014, WV established a centralized intake system. Statewide implementation was phased in starting in July 2014 with statewide implementation by February 2015. Centralized Intake call centers are in the northern and southern parts of the state. DPQI is responsible for the sampling and review of accepted intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake as well as the Deputy Commissioner over Centralized Intake and the Commissioner. Through December of 2020 DPQI conducted approximately 90 reviews of maltreatment intake reports monthly. The reviews were conducted from a random sample pull and primarily assessed the sufficiency of the information gathered during the intake process. The areas assessed included demographic information that would help identify and locate the family, such as names and addresses. DPQI also assessed the inclusion of absent parents, collateral sources of information, and current locations of household members for immediate and timely responses. DPQI staff also assessed whether the Centralized Intake worker had searched the FACTS system to ascertain a history or any open assessments and/or cases on the family. Examples of data collected by DPQI during the Centralized Intake reviews and provided to the Director of Centralized Intake and the Deputy Commissioner over CI are presented below.

**Centralized Intake Screening Reviews
with Absent Parent
December 2020**



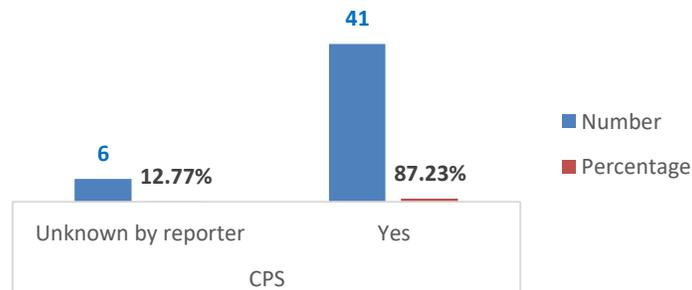
Source: DPQI Centralized Intake Review Data December 2020

**Centralized Intake Screening Reviews
with Collaterals
December 2020**



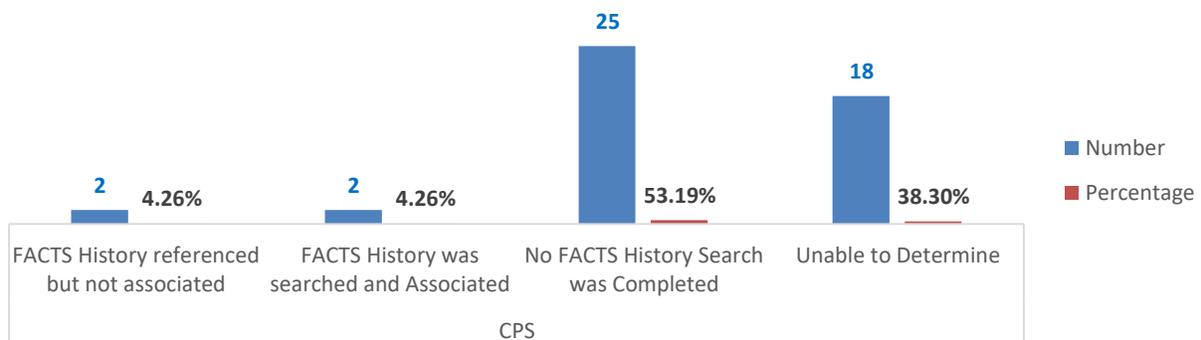
Source: DPQI Centralized Intake Review Data December 2020

**Centralized Intake Screening Reviews
with Names
December 2020**



Source: DPQI Centralized Intake Review Data December 2020

**Centralized Intake Screening Reviews
with FACTS History
December 2020**



Source: DPQI Centralized Intake Review Data December 2020

West Virginia has established an internal child critical incident review team to review all child deaths due to child abuse and neglect and child near fatalities. 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 representative field staff. The results are reviewed by an internal review team quarterly. The objective is for the team to learn from these fatalities and near fatalities to prevent similar deaths in the future. Please see the Critical Incident Review Team 2020 Update for details of these reviews.

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West Virginia has instituted a continuous quality assurance process that incorporates three levels of continuous quality improvement oversight councils. They are the district level, the regional level and the state level. The state level continuous quality improvement council is the Child Welfare Oversight Team (CWO) which meets on a quarterly basis. The Continuous Quality Improvement Council process currently 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. The DPQI case review and resulting exit report begin the CQI process at the district and regional levels. This process continues through the state level utilizing the Child Welfare Oversight Team (CWO) to monitor child welfare data by state, region, and district. 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 office. 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. They also review corrective action plans and goals currently in place to determine if progress is being made or if goal changes need to occur. The regional council also reviews and discusses regional trends and issues as they relate to service delivery. Feedback is given to each staff member via minutes of the Council meeting. The State level council provides feedback to each Regional Director, who is a member of the State Council. Each is provided with a spreadsheet containing the issues and results. This spreadsheet along with minutes of the Child Welfare Oversight Team are to be shared with all staff. The state level team utilizes case review data, stakeholder surveys, AFCARS, NCANDS and NYTD data to drive change within the organization to improve outcomes for children and families.

The DPQI unit also completes targeted reviews and related activities. The focus in 2021 has been to conduct a threshold analysis on the screening decisions by Centralized Intake and the correlating assessment outcomes. DPQI conducted 400 intake reviews from a random sample pull to be used for this analysis. During this process, the unit followed the intakes out 120 days to determine whether repeat reports of maltreatment were received and whether any intakes received during that timeframe resulted in an open maltreatment case. The information was compiled and provided to the Capacity Center for States for data analysis. The threshold analysis workgroup will continue to meet to review the outcome of these reviews and to make recommendations regarding our intake process and screening decisions.

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 by federal and state laws and Department policy, at <https://dhhr.wv.gov/bcf/policy/Pages/default.aspx>. Department outcome measures are based on federal requirements and state policy. Department staff have 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.

In order 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

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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. 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 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 fidelity to the tool. DPQI program managers then complete initial and secondary QA activities. During CFSR Rd. 3 case reviews, and PIP implementation measurement periods, the Children's Bureau provides secondary oversight on a percentage of the cases reviewed by DPQI.

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 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 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. During the exit, DPQI staff discuss the prior CAP activities and if they appear to have been impactful in relation to improving outcomes for children and families.

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 as a result of abuse and/or neglect who has a previous child welfare history within the last twelve months. This review includes, but is not limited to, a review of current child protective services, child, and family history of abuse

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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. In FFY 2020 the review of Internal Investigative Unit (IIU) cases was added to the Critical Incident SOP. These cases involve children who are in foster care at the time of the critical incident. These cases are reviewed through the same process as the regular critical incident reviews. The findings are reviewed at the quarterly critical incident review team meeting. This team reviews all critical incidents resulting in a fatality or near fatality of a child as stated above, in order to make improvements to the process in which critical incidents are reviewed with the intent of reducing the number of fatalities and near fatalities that were the result of abuse and neglect. The Critical Incident Review utilizes a quality assurance process to look at practice, policy and training and to make needed program improvements. The review process will look 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.

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 and logical 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 provides ongoing feedback to the Director of Centralized Intake Unit and the training staff assigned to that 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

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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. This information leads to the CQI process provided by the state Child Welfare Oversight Team. The Critical Incident Review Team submits an annual report which includes a Plan for Action that contains activities designed to increase awareness, support practice and improve outcomes in child welfare cases. This report is submitted to the Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: <https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.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 at the conclusion of the prior review, allow management staff to evaluate the efficacy of the strategies for improvements that were implemented. Beginning in January of 2020, DPQI also began providing a report at district exits which compares the review findings with the ten CFSR items being evaluated on the WV CFSR PIP data measures. This report allows districts to view their data in comparison to the WV CFSR Rd. 3 item data goals.

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.

West Virginia uses state generated data and information from its CQI process for PIP monitoring and measurement of performance. Measurement of systemic factors will be by completion of the key activities associated with each strategy associated with the factor. Measurement of CFSR items and associated outcomes will be measured by completion of social services case reviews completed by the Division of Planning and Quality Improvement. Data related to PIP goal achievement will be reported out in the West Virginia Child and Family Services Review Round 3 Program Improvement Plan Progress Report. The report will be sent electronically to the Children's Bureau by the due date of June 30, 2021.

Service Array

The Child and Family Services Review (CFSR) in 2017 found that the West Virginia service array lacked services to address substance abuse. The lack of adequate substance abuse services negatively impacts child and family outcomes in the state. It was also found that providers of addiction services often have wait lists and limited service availability in more rural portions of the state.

Other necessary services for children and families that were also noted as lacking included mental health services for children, sex offender treatment, batterer offender treatment, autism support services, post-adoption services, kinship family support services, and housing.

The Service Array workgroup met several times in early 2018 to review data and information related to the CFSR findings and to discuss the current status of services in West Virginia. During the meetings, the group discussed several issues related to the determination of the availability of substance abuse services, including the perceptions of stakeholders interviewed during the CFSR reporting that substance abuse services were not available, when there was evidence that the development of substance abuse services had been developed prior to and after the CFSR in 2017.

In March 2017, the DHHR, Bureau for Behavior Health developed “Need” maps and “Treatment/Recovery” maps using 2016 data. The Need maps provide the ranking of the county (from 1 to 55) for Drug Exposed Infants; Children Removed Due to Substance Abuse; Overdose Deaths; EMS Runs with Naloxone Administration; and Opioid Prescriptions. The “Treatment/Recovery” maps show the rates (beds per 100,000 population) per GASCA Region (which is also the BBH Regions) for Detoxification, Treatment Beds; Recovery Beds; and Doctors That Prescribe Buprenorphine to Medicaid Patients.

During these meetings, and subsequent correspondence through e-mail, the Service Array workgroup determined that DHHR staff and stakeholders may not know where to find service availability for substance abuse and other services an individual or family might need. West Virginia has a 24-hour helpline (Help4WV) staff and other stakeholders may need to know specifically how to assist those needing help with addiction or mental illness. Help4WV provides free help securing a referral or placement for treatment <https://www.help4wv.com>. The members with the Bureau for Behavioral Health (BBH) and Bureau for Medical Services (BMS) stated that they have developed multiple new “Response for Application” (RFA) with a focus on substance abuse, over the past several months.

Update 2021:

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The Child and Family Services Review Program Improvement Plan (PIP) was developed and approved in December 2019. The Program Improvement Plan's goal is identifying service gaps, barriers and needs across the state. Strategies to obtain this goal include working with sister agencies, service providers, and additional stakeholders to create a service communication plan as well a service gap identification and development process. The state is currently focusing on substance abuse services. Building a map of available substance abuse services throughout the state will help identify gaps, barriers and needs. The Capacity Building Center has partnered with the Service Array workgroup to bring these entities together in efforts to collect information to develop this map. See attached capacity center workplan for activities and timelines.

During 2020, WV DHHR will develop and execute a formal statewide communication plan that will included all DHHR bureaus and additional stakeholders. This communication plan will improve cross-system service provision such as identifying service availability, accessibility and barriers. It will be crucial to service development in all areas of service array as we move forward.

In 2021 the Service Array Workgroup will continue to meet at least monthly to identify service array gaps and needs throughout the state and how these issues can be addressed to better serve our children and families.

The Child and Family Services Review, Program Improvement Plan – Service Array has been submitted.

Update 2022:

During FFY 2020, Bureau for Children and Families Community Partnership Program continued to work with the Capacity Building Center for States as designated in the Child and Family Services Review Program Improvement Plan (PIP). The Capacity Building Center developed a work plan on 12/27/19. The plan is to assist the state with data gathering, research, facilitating team meetings, and data analysis. The theory of change stated in the work plan is to explore what substance abuse services are needed so that Bureau for Children and Families can create a substance abuse service map.

The Service Array Workgroup was developed to help identify service needs throughout the state and barriers or gaps in services that might exist. The workgroup consists of members from Bureau of Children and Families, Bureau of Behavioral Health, Bureau for Public Health, community partners, WV Court, and stakeholders. The workgroup is organized and facilitated by Bureau for Children and Families Community Partnership Program. The Service Array Workgroup, in partnership with the Capacity Building Center for States, began the work of developing a substance misuse disorder service array map in April 2020. Through workgroup meetings, it was pointed out that similar maps exist. The WV Office of Drug Control Policy (ODCP) developed an interactive substance use disorder treatment map for adults that was released in July 2020. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA) also has a treatment locator map. In discussions with the WV ODCP and after reviewing the SAMHSA map, the workgroup felt like youth substance use disorder services were not well

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developed on either map. The workgroup met to develop a list of established youth substance use disorder services in West Virginia. These services were added to the ODCP interactive map in November 2020.

In addition to the gathering of resources, the workgroup started the process of identifying substance use disorder services that are needed, any gaps and barriers. There is an understanding that to know what services are needed, we would have to identify numerical and anecdotal data on how we are currently serving the population with substance use disorders. The anecdotal data was found through past case reviews. There have been several different avenues to collecting numerical data. The workgroup reached out to several different bureaus and community partners to capture this data. An internal review of our current SACWIS showed that the data we needed is not captured. As a result of the lack in needed numerical data, the workgroup concluded that a survey to caseworkers and supervisors statewide would be the way to get the data so we can move forward.

A Case Review Survey was administered and completed in the months of July and August 2020. The workgroup was able to identify a few gaps and barriers to substance use disorder services throughout WV after reviewing the data. It should be noted that a lack of data on child welfare cases that involve substance misuse disorders and services provided to individuals in the case, was a barrier to determining service gaps for the workgroup.

A service gap identified through the case survey data is that not all child welfare staff (around 9%) are offering treatment services to clients. Although this is a small percentage of staff, it is still notable as a concern in relation to service gaps. The case survey did not capture the why on this subject. There is an understanding through anecdotal information that child welfare workers lack the ability or knowledge to locate resources.

During FFY 2021 the workgroup plans to look at ways to strengthen worker engagement on existing service array maps. Over the last year the workgroup identified many resources but was unable to verify that child welfare staff are aware of these resources and services. The workgroup has discussed a potential online course on how to locate already existing service array maps for the State of West Virginia. This could be a useful tool for child welfare staff and external stakeholders. It can also be a way to obtain feedback from the individuals that take the course.

West Virginia Service Communication Plan

The Service Communication Plan Standard Operating Procedure (SOP) was developed in November 2020. The SOP includes Regional Summits, Community Collaboratives, Community Partnership, Community Service Managers, Child Welfare Collaborative, and the Child Welfare Reform Oversight Team roles and responsibilities. It details the individuals to be involved as well. The Community Partnership Program will offer technical assistance to these entities through the Service Array Coordinator and the Program Manager to ensure this plan is followed.

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The Community Partnership Program is working with chairs of the Regional Summits, Chairs and CSMs involved in the Community Collaborative and Family Resource Network directors to help strengthen their infrastructure. The Service Array Coordinator is working to ensure these entities understand the importance their role will play in this plan and the goal to communicate on service availability, service gaps, and how to build service capacity.

Twice a year (State Fiscal Year), the Community Collaborative Group will submit the Semi-Annual Report on service gaps to the Bureau for Children and Families Community Partnership Unit. The Semi-Annual Report from the Community Collaborative Groups will include service gaps, actions to be taken to remedy the gap identified, and the challenges the Community Collaborative Group face.

During 2021 this Service Communication Plan will be implemented and monitored to ensure appropriate feedback is obtained by all parties involved in the plan.

West Virginia's Service Array includes:

- Family Support Services;
- Community-Based/Prevention Services;
- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.

The West Virginia Department of Health and Human Resources (WVDHHR), is the designated lead agency for Community-Based Child Abuse Prevention (CBCAP) activities. The Division of Early Care and Education (ECE) within the Bureau for Children and Families (BCF) in the WV DHHR manages the activities funded by the CBCAP grant. ECE is also responsible for coordination and administration of the Child Care and Development Fund and the Head Start State Collaboration Office. ECE staff work closely with the Bureau for Public Health, which includes Birth to Three and the state's Maternal Infant Early Childhood Home Visiting program (MIECHV). Activities and initiatives that touch all aspects of children's lives and wellbeing are coordinated through the state Early Childhood Advisory Council (ECAC).

Through CBCAP activities, WV DHHR works closely with Prevent Child Abuse West Virginia to coordinate prevention efforts across the state to give children good beginnings by strengthening families and communities. They work collaboratively to build awareness, provide education, and strive to keep children free from abuse and neglect.

The WV DHHR funds and supports several child abuse prevention initiatives that use a combination of CBCAP, Temporary Assistance for Needy Families (TANF), and MIECHV funds, state appropriations, and

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private funds. These initiatives include In Home Family Education Programs (IHFEF), Family Resource Centers (FRC), and Partners in Prevention grants to communities. These programs are considered an integral part of the child welfare continuum by building and increasing protective factors that enable parents and families to nurture and parent appropriately and connect them to concrete supports that help keep families out of the child welfare system. Programs are community based and driven, with advisory boards made up of program participants, service providers, and local leaders. Services are available to any member of the community, regardless of income, and are voluntary.

Family Resource Centers

Twenty-three Family Resource Centers across the state aid families and communities based upon their community's needs and gaps in service. FRC staff are connected to local resources and provide referrals and concrete assistance through food, baby, and hygiene pantries. Depending upon community need, they also offer childcare, support groups, parenting education, and play groups. Services are offered to any family with children from prenatal through eighteen years of age. In State Fiscal Year 2020, the funding allocation to the FRCs was increased to allow them to expand into unserved communities in their catchment areas and serve more families. This was made possible through TANF funds, and the programs now have oversight from both ECE and Family Assistance staff.

Update 2021:

During 2019, the Family Resource Centers have served the following individuals statewide:

- *2,110 families with children with disabilities*
- *1,870 parents with disabilities*
- *Total number children who received preventative direct services- 31,595*
- *Total number of parents/caregivers who received preventative direct services- 46,781*
- *Total number families who received preventative direct services- 20,629*

Update 2022:

During 2020, the Family Resource Centers have served the following individuals statewide:

- *917 families with children with disabilities*
- *1,331 parents with disabilities*
- *Total number children who received preventative direct services- 28,280*
- *Total number of parents/caregivers who received preventative direct services- 16,059*
- *Total number families who received preventative direct services- 22,227*

Maternal Infant Early Childhood Home Visiting program (MIECHV)

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While MIECHV funds the majority of In-Home Family Education Programs in the state, thirteen IHFEs are jointly funded through CBCAP and MIECHV funds. Programs may choose from two evidence-based models, Parents as Teachers or Healthy Families America. These programs systematically assess family strengths and needs, and enhance family functioning through trusting relationships, teaching problem solving skills, and promoting positive parent-child interactions. They also educate parents and caregivers on child development and connect them to referrals and resources.

Update 2021:

During FY 2019, The MIECHV program served 4,034 participants. This program reached 1,811 households and involved 20,128 home visits.

MIECHV program awardees serve high-risk populations. Awardees tailor their programs to serve populations of need within their state. WV reported the following data:

- *62.1% of households were low income.*
- *30.5% of households included someone who used tobacco products in the home.*
- *20.5% of households included a child with developmental delays or disabilities.*

West Virginia performance highlights include a continuity of insurance coverage and depression screening. 97.1% of caregivers enrolled in home visiting had continuous health insurance coverage for at least six consecutive months. 90.8% of caregivers enrolled in home visiting were screened for depression within three months of enrollment or within three months of delivery.

Update 2022:

During FY 2020, The MIECHV program served 3615 participants. This program reached 1,573 households and involved 19,796 home visits.

MIECHV program awardees serve high-risk populations. Awardees tailor their programs to serve populations of need within their state. WV reported the following data:

- *58.8% of households were low income.*
- *27.5% of households included someone who used tobacco products in the home.*
- *21.7% of households included a child with developmental delays or disabilities.*

West Virginia performance highlights include a continuity of insurance coverage and depression screening. 96.0% of caregivers enrolled in home visiting had continuous health insurance coverage for at least six consecutive months. 92.5% of caregivers enrolled in home visiting were screened for depression within three months of enrollment or within three months of delivery.

Partners in Prevention

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Partners in Prevention (PIP) is a community grant and networking program that focuses on preventing child abuse and neglect. Forty-four PIP teams work to build protective factors within communities and families by promoting local needs-based activities with the cooperation of community members, local organizations, policy makers, and parents.

WV DHHR's various Bureaus have a commitment to collaboration. All Bureaus and Divisions maintain linkages to one another and communicate frequently on joint programs and projects to reduce child maltreatment and strengthen families and communities.

Also, the Bureau for Children and Families refers families to the Bureau of Medical Services for many preventative services such as Birth to Three and Right from the Start. Workers make referrals to these programs at the time of assessment.

Update 2021:

During FY 2019, Partners in Prevention teams across the state of West Virginia:

- *Provided Public Education and/or Services to 100,624 individuals and organizations;*
- *Distributed 72,624 pieces of educational materials and/or resource packets to caregivers and community members;*
- *Trained 5,663 individuals and/or organizations through locally based workshops and a variety of prevention curricula;*
- *Coordinated 395 public events in their communities; and,*
- *Generated 418 public messages (via print articles, radio, and television) about the importance of supporting and nurturing children & families, as well as public engagement activities to help families thrive.*

Update 2022:

During FY 2019, Partners in Prevention teams across the state of West Virginia:

- *Provided Public Education and/or Services to 47,390 individuals and organizations;*
- *Distributed 170,870 pieces of educational materials and/or resource packets to caregivers and community members;*
- *Trained 8,292 individuals and/or organizations through locally based workshops and a variety of prevention curricula;*
- *Coordinated 538 public events in their communities; and,*

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- *Generated 8,657 public messages (via print articles, radio, and television) about the importance of supporting and nurturing children & families, as well as public engagement activities to help families thrive.*

Birth to Three

WV Birth to Three is a statewide system of services and supports for children under age three who have a delay in their development, or may be at risk of having a delay, and their family. The Department of Health and Human Resources, through the Bureau for Public Health and the Office of Maternal, Child and Family Health, WV Birth to Three, is the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA), assures that family centered, community-based services are available to all eligible children and families. WV Birth to Three partners with families and caregivers to build upon their strengths by offering coordination, supports, and resources to enhance children's learning and development.

To be eligible for WV Birth to Three services, an infant or toddler under the age of three can either have a delay in one or more areas of their development or be at risk of possibly having delays in the future. A child may have delays in one or more of the following areas:

Cognitive - thinking and learning

Physical - moving, seeing and hearing

Social/emotional - feeling, coping, getting along with others

Adaptive - doing things for him/herself

Communication - understanding and communicating with others

A child may also have risk factors such as a condition which is typically associated with a developmental delay such as Down Syndrome or a combination of biological and other risk factors. Some of these factors may include family stressors.

As a result of individualized supports and services families will know their rights, effectively communicate their child's needs, and help their child develop and learn. The child will demonstrate improved social emotional skills and relationships, acquisition of knowledge of skills including language

and communication and use of appropriate behaviors to meet their needs.

Update 2021:

WV Birth to Three reports during the time period of November 30th, 2018 through December 1st, 2019 they served 7,512 children through an Individualized Family Service Plan (IFSP). The IFSP identifies the child's current developmental levels and helps determine what services will be provided.

Update 2022:

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WV Birth to Three reports during the time period of December 2nd, 2019 through December 1st, 2020 they served 7,213 children through an Individualized Family Service Plan (IFSP). The IFSP identifies the child's current developmental levels and helps determine what services will be provided.

Right from The Start

The Right from The Start (RFTS) Program is a home visitation program which provides targeted case management and/or the provision of enhanced prenatal care services for Medicaid pregnant women up to 60 days postpartum and infants through one year of age. Targeted case management in the RFTS Program includes an Initial Assessment for prenatal or infant clients, development of an individualized Service Care Plan reassessed on an ongoing basis, depression screening, domestic violence screening, tobacco/substance use screening, assistance with locating needed resources, education and counseling programs for the mother, transportation assistance to medical appointments and referrals as needed. Enhanced prenatal care services include childbirth education, parenting education, health education and nutritional evaluation/counseling. All services are provided by a registered nurse, licensed social worker or registered dietician. These services have the combined purpose to improve birth outcomes and reduce infant mortality and morbidity in a high-risk population with a medically focused approach.

The Right from the Start (RFTS) Program has been delivering services, providing health care for low-income mothers and infants at-risk of adverse health outcomes for over two decades. The services are FREE and support mothers, their new babies and their families by helping create a safe, nurturing home.

The Designated Care Coordinator provides professional, individualized, and comprehensive care that empowers families to achieve the healthiest possible outcomes during pregnancy and infancy. The program empowers participants to choose lifestyles resulting in healthy families.

The RFTS is a carefully crafted and highly interdependent partnership with tertiary care centers, primary care centers, local health departments, private practitioners and community agencies working with the West Virginia. Its focus is the continuum of care model. The RFTS coordinates services provided to high risk, low income pregnant women through the second postpartum month and to Medicaid eligible high-risk infants through age one. The RFTS also helps provide access to other enhanced services, such as parenting classes, transportation to medical appointments, smoking cessation programs and health and nutrition programs.

Maternity Services

Maternity Services is limited funding of prenatal, delivery, postpartum and routine newborn hospital care for low-income, medically indigent pregnant women who are determined to be ineligible for Medicaid, have not insurance to cover obstetrical care, and have monthly income below 185% FPL. This includes

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minors and income eligible non-citizens. Maternity Services require prenatal care is provided in the standards outlined in the American College of Obstetricians and Gynecologist guidelines.

Maternity Services also acts as a guarantor of payment for initial prenatal exams and associated laboratory/diagnostic test. Maternity Services is the payer of last resort. If the client is approved for Medicaid or another third-party source, the practitioner is paid by that source.

The Drug Free Moms and Babies (DFMB) Project is a comprehensive and integrative medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services.

This project is supported through funding from West Virginia Department of Health and Human Resources, Division of Behavioral Health and Health Facilities, the WV Office of Maternal, Child, and Family Health, and the Claude Worthington Benedum Foundation.

Key Project Aspects

- **Screening, Brief Intervention, Referral and Treatment (SBIRT)** services integrated in maternity care clinics
- **Collaboration with community partners** for the provision of comprehensive medical, behavioral health, and social services
- **Long term follow-up** for two years after the birth of the baby provided by a recovery coach. In addition, home visits and other services to help women maintain sobriety and access needed resources are provided.
- **Program evaluation** of effective strategies for identifying women in need, preventing addiction and abuse, treating women with substance abuse problems, and delivering recovery coaching services.
- **Provider outreach education** to other maternity care clinics in West Virginia to facilitate the duplication of successful model programs.

Family Resource Networks

The Family Resource Networks (FRNs) are organizations that are responsive to the needs and opportunities in West Virginia communities. Partnering with citizens and local organizations, the FRNs provide indirect services, including managing, supervising, and coordinating a variety of programs and initiatives in their respective community. The FRNs work with the Family Resource Centers where direct services are provided.

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In 1995, the office of the Governor's Cabinet on Children and Families negotiated a federal-state partnership agreement whereby a small portion of federal Medicaid administrative funds, and other federal funding sources would be made available to help support local assessment of needs, planning, and resource development by West Virginia's Family Resource Networks (FRNs).

The forty-seven (47) Family Resource Networks (FRNs), representing all West Virginia's fifty-five (55) counties are organizations that understand and are responsive to the needs and opportunities in West Virginia communities. Partnering with citizens and local organizations, the FRNs organize and mobilize activities that support innovative projects and provide needed resources on upfront prevention and intervention approaches that contribute directly or indirectly to the health and safety of the Medicaid eligible population.

The FRNs have a resource directory for each county in West Virginia. Through a Benedum Foundation grant, the Alliance of Family Resource Networks (WVAFRN) and Marshall County FRN has developed a central website. The website will include a link to each of the FRNs that will include their resource directories and current events. The West Virginia Alliance of Family Resource Networks (WVAFRN) website is: <http://wvfrn.org/> and a quick directory can be found on this same website at: <http://wvfrn.org/quick-directory/>.

The three key quantitative indicators below document the benefits of local FRN activity to the state's Medicaid program. These indicators are: 1) Strategies to address alcohol, tobacco and other drug prevention and intervention; 2) Strategies to address child and family safety and wellbeing prevention and intervention; and 3) Strategies to address economic and poverty prevention and intervention.

- **Alcohol, Tobacco and other drug prevention and intervention activities**

Forty (40) of the forty-seven (47) Family Resource Networks (representing West Virginia's fifty-five counties) were involved in alcohol, tobacco and other drug prevention and intervention activities. During the fiscal year, July 1, 2017 through June 30, 2018, the Family Resource Networks were involved in approximately two hundred forty-eight (248) activities related to alcohol, tobacco and other drug prevention and intervention.

Update 2021:

- **Alcohol, Tobacco and other drug prevention and intervention activities**

46 of 47 Family Resource Networks (representing West Virginia's fifty-five counties) were involved in alcohol, tobacco and other drug prevention and intervention activities. During the state fiscal year, July 1, 2018 through June 30, 2019, the Family Resource Networks were involved in

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approximately 931 activities related to alcohol, tobacco and other drug prevention and intervention.

Update 2022:

- **Alcohol, Tobacco and other drug prevention and intervention activities**

46 of forty-seven 47 Family Resource Networks (representing West Virginia's fifty-five counties) were involved in alcohol, tobacco and other drug prevention and intervention activities. During the state fiscal year, July 1, 2019 through June 30, 2020, the Family Resource Networks were involved in approximately 766 activities related to alcohol, tobacco and other drug prevention and intervention.

- **Child and Family Safety and Wellbeing**

All forty-seven (47) Family Resource Networks (representing West Virginia's 55 counties) were involved in child and family safety activities. During the fiscal year, July 1, 2017 through June 30, 2018, the Family Resource Networks were involved in approximately nine hundred, sixty (960) activities related to child and family safety.

Update 2021:

- **Child and Family Safety and Wellbeing**

46 of 47 Family Resource Networks (representing West Virginia's 55 counties) were involved in child and family safety activities. During the fiscal year, July 1, 2018 through June 30, 2019, the Family Resource Networks were involved in approximately 1,012 activities related to child and family safety.

Update 2022:

- **Child and Family Safety and Wellbeing**

46 of the forty seven 47 Family Resource Networks (representing West Virginia's 55 counties) were involved in child and family safety activities. During the fiscal year, July 1, 2019 through June 30, 2020, the Family Resource Networks were involved in approximately 1,076 activities related to child and family safety.

- **Economic and Poverty**

Forty-five (45) of the forty-seven (47) Family Resource Networks (representing West Virginia's fifty-five counties) were involved in economic and poverty activities. During the fiscal year, July 1, 2017 through June 30, 2018, the Family Resource Networks were involved in approximately three hundred, sixteen (316) activities related to economic and poverty activities.

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Update 2021:

- **Economic and Poverty**

46 of the 47 Family Resource Networks (representing West Virginia's fifty-five counties) were involved in economic and poverty activities. During the fiscal year, July 1, 2018 through June 30, 2019, the Family Resource Networks were involved in approximately 799 activities related to economic and poverty activities.

Update 2022:

- **Economic and Poverty**

46 of the 47 Family Resource Networks (representing West Virginia's fifty-five counties) were involved in economic and poverty activities. During the fiscal year, July 1, 2019 through June 30, 2020, the Family Resource Networks were involved in approximately 898 activities related to economic and poverty activities.

The West Virginia Family Resource Networks documented a total of 2,749 events for the public serving over 408,000 family members. 37,526 (9.18%) of those family members completed surveys showing that 36,116 (96.24%) of the families stated the event was beneficial. 30,934 (82.43%) people who filled out surveys had families who lived under the 300% of the Federal Poverty Level.

Update 2022:

The West Virginia Family Resource Networks documented a total of 2,540 events for the public during the fiscal year, July 1, 2019 through June 30, 202. These events served over 387,000 family members. 27,558 (14.07%) of those family members completed surveys showing 27,268 (98.9%) of the families stated the event was beneficial. Due to COVID-19 restrictions, written surveys were not completed at all events. Reports state 38,269 potential Medicaid eligible recipients attended the events.

Expanded School Mental Health Approach (ESMHA)

The Expanded School Mental Health Approach (ESMHA) is an integrated approach that builds on core services typically provided by schools. It is a three-tiered framework that includes the full continuum of mental health prevention, early intervention and treatment services. The four expected outcomes of this approach are reduced barriers to learning; improved academic performance; improved attendance; and improved school functioning/behavior. Currently there are 40 ESMH sites in 20 counties.

Update 2021:

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Expanded School Mental Health (ESMH) is a comprehensive system of behavioral health services and programs that builds on core services provided by schools. ESMH includes the full continuum of prevention, early intervention, and treatment. Prevention strategies work by either increasing protective factors (e.g., resiliency, social involvement, recognition of positive behavior) or decreasing risk factors (e.g., preventing early initiation of substance use, rebelliousness, low socioeconomic status). The ESMH model emphasizes shared responsibility and funding, services for all students, meaningful involvement of parents and youth, evidence-based programs, and continuous quality improvement.

In 2006, the West Virginia Department of Education (WVDE) and Department of Health and Human Resources (DHHR), Bureau for Behavioral Health established a formal agreement to work together to improve and expand school-based mental health services. A state level interagency steering team of subject matter experts recommended adoption of the ESMH Model with Marshall University School Health Center providing technical assistance, consultation, and maintaining a website devoted to ESMH.

ESMH services include three tiers of programming that engage both the academic and behavioral health system.

- *Tier One, Universal Prevention Programming, is preventive, proactive, includes all students and offers school-wide academic assessments and primary prevention programs (e.g., safe school, suicide prevention, substance misuse, bullying prevention, study skills and other academic skill builders). Tier 1 is provided in the everyday learning environment in classroom or large group settings.*
- *Tier Two, Targeted Group and Early Intervention, embraces at risk students and includes referral services, rapid response capability, study groups, tutoring, mentoring, after school programs, small group interventions to address anger, social skills, substance misuse and other needs, as well as some individual supportive services.*
- *Tier Three, Intensive Intervention, is intended for students who have involved needs and intensive individual, group or family therapy interventions.*

ESMH is currently implemented in 40 schools and 20 counties throughout West Virginia. An additional 6 sites have been added through a collaboration with Reclaim WV and are in the beginning stages of ESMH. This will bring the total to 46 by the end of FY20 Fiscal Year. DHHR financially supports ESMH using State funds. Schools also braid funding from other sources to help create and sustain ESMH.

Tier 1 and Tier 2 utilize evidence-based programs (EBPs) that are selected utilizing the Strategic Prevention Framework which is a five-step planning process to guide prevention activities that is endorsed by the Substance Abuse Mental Health Services Administration (SAMHSA).

- *Step 1 Assess population needs, resources required to address needs, and readiness to act*

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- *Step 2 Build capacity to address needs*
- *Step 3 Develop a comprehensive strategic plan*
- *Step 4 Implement the evidence-based programs identified in Step 3*
- *Step 5 Monitor implementation and evaluate effectiveness.*

In FY19 the following numbers were reported for Tier 1, Tier 2 and Tier 3.

- *Tier 1 a total of 130,449 doses of prevention were provided,*
- *Tier 2 a total of 11,525 does of prevention were provided, and*
- *Tier 3 a total of 698 students received treatment services.*

These numbers are in line with what is projected for Tiers 1-3 services. Tier 1 is projected to impact 80-90% of student population. Tier 2 is projected to impact 5-15% of students. Tier 3 is projected to impact 1-5% of students. The overall goal of ESMH is to reduce the number of students who would need Tier 3 services through the implementation of Tiers 1 and 2.

Update 2022:

During FFY 2020, Expanded School Mental Health was established in 46 schools in total. Below is a list of school levels reached:

- *Elementary Schools: 18*
- *Middle Schools: 12*
- *High Schools: 9*
- *Elem/Middle: 3*
- *Middle/High: 2*
- *All Grades: 2*

In FY20 the following numbers were reported for Tier 1, Tier 2, and Tier 3.

- *Tier 1 a total of 126,917 doses of prevention were provided,*
- *Tier 2 a total of 12,527 doses of prevention were provided, and*
- *Tier 3 a total of 7,373 doses of treatment services were provided to nearly 800 high-risk students.*

Tier 1 is projected to impact 80-90% of the student population. Tier 2 is projected to impact 5-15% of students. Tier 3 is projected to impact 1-5% of students. The overall goal of ESMH is to reduce the number of students who would need Tier 3 services through the implementation of Tiers 1 and 2.

Although the number of total encounters decreased by 19% from FY 2019 to 2020 due to COVID-19 restrictions and school closings, prevention services were still maintained at all three tiers. ESMH providers used creative measures to provide these critical services during unprecedented times such as telehealth, virtual mechanisms, and through home visitation encounters for the most vulnerable children.

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This change in services had to be implemented quickly to meet student needs; so, it is suspected that additional encounters may have been provided that were not reported due to sudden changes and urgency. BBH has continued to work with ESMH providers to ensure accuracy in reporting despite rapid changes to accommodate the importance of providing mental health related prevention activities while safely mitigating the spread of COVID-19. Remarkably, providers have been able to sustain services for the most high risk students via these alternative means, despite pandemic barriers, with only a 5% decrease in the number of students in need, benefitting from intensive ESMH services from FY '19 to '20.

Evidenced Based Practices used:

<i>Second Step</i>	<i>Signs of Suicide</i>	<i>Like skills by Botvin</i>	<i>Too Good for Drugs</i>
<i>Too Good for Violence</i>	<i>Green Dot</i>	<i>Mind Up</i>	<i>Body Safety</i>
<i>Strong Kids</i>	<i>PBIS</i>	<i>Positive Action</i>	<i>Body Positive/Child Protection Unit</i>
<i>Catch a Breath</i>	<i>Headspace</i>	<i>Dinosaur School</i>	<i>Lifelines</i>
<i>PATH</i>	<i>OWLEUS</i>	<i>Coping Cat</i>	<i>Stanford Harmony</i>
<i>Change Journals</i>	<i>Mind Yeti</i>	<i>Toolbox</i>	<i>7 Habits for Healthy Kids</i>
<i>Classroom Dojo</i>	<i>Resilience Builder</i>	<i>Restorative Justice</i>	
<i>STARS</i>	<i>THINK</i>	<i>Journey of Hope</i>	

Other activities due to COVID since March 2020- June 2020

<i>Classroom Guidance</i>	<i>Nutritional Support</i>	<i>“All In” (Scott High School, school culture/reward program)</i>	<i>Goal 2.0 (Scott High School, school culture/reward program)</i>
<i>Conflict Resolution packets</i>	<i>Anxiety coping packets</i>	<i>Friendship/bonding packets</i>	<i>Peer pressure/safety activities</i>
<i>Getting along and Keeping Cool</i>	<i>Ted Talks on Mental Health</i>	<i>Rapport building for small groups</i>	<i>Social respect and cultural competency (racism)</i>
<i>Communities in Schools</i>	<i>Jamie’s Law</i>	<i>Life management skills</i>	<i>Opioid awareness</i>
<i>Truth about Drugs</i>	<i>Colorful Mindset</i>	<i>Zoom platforms to meet with students with teachers</i>	

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Home visits	Food distribution with resources materials included	Clothing drives to include activities for families	
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Trauma Informed Elementary Schools (TIES)

Trauma-Informed Elementary Schools (TIES) is a program designed to bring trauma-informed services to early elementary school classes, pre-K through grade 1. TIES is nationally recognized, and research driven. The TIES program is funded by the Claude Worthington Benedum Foundation and DHHR’s Bureau for Behavioral Health for the 2018-19 school year.

The goal of TIES is to bring early intervention to children who exhibit symptoms of chronic stress, or trauma, in the classroom, symptoms that interfere with the child's ability to learn, such as disruptive, defensive, or withdrawn behavior. Schools receive training; have a resource liaison available for consultation and parent education; and receive a therapeutic toolbox for the classroom.

For children in need of treatment, Crittenton can work collaboratively with the school and the child's family to build an integrated environment that helps the child develop self-regulation skills. Crittenton is currently partnering with elementary schools in Hancock, Ohio, Tyler and Wood counties. Sustainability planning is underway to extend TIES beyond the 2018-19 school year.

Update 2021:

The TIES program is funded by the Claude Worthington Benedum Foundation and DHHR’s Bureau for Behavioral Health for the 2019-20 school year. Crittenton is currently partnering with elementary schools in Hancock and Ohio counties. BBH reports that the TIES program has worked with 9021 students in the school year 2018-2019.

Update 2022:

The TIES program is not statewide. It is only in Hancock and Ohio Counties. Trauma-Informed Elementary Schools (TIES) is a prevention and early-intervention program that is designed to bring trauma-informed principles into the classroom and, for children that are referred for treatment, to provide an integrated approach for the school and home environments. Providers shall serve as trauma-informed agencies and seek to improve outcomes for children by providing trauma-informed practices for teachers and by strengthening family functioning with interventions.

In this Bureau for Behavioral Health (BBH) program, the expanded TIES project will serve eight elementary schools in Pre-Kindergarten, Kindergarten and 1st Grade classrooms. TIES includes teacher training in the principals of the attachment, regulation and competency (ARC), trauma treatment framework,

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incorporation of trauma-informed practices in the classroom, a bachelor level staff to act as a resource liaison for the school, and referral to professional, licensed, trauma-focused therapeutic services.

TIES is currently in Weirton Elementary, Bethlehem Elementary, Elm Grove Elementary, Madison Elementary, Middle Creek Elementary, Ritchie Elementary, Woodsdale Elementary and West Liberty Elementary.

In FY 20 there were 4,654 children served and a total of 1,011 (22%) received individual therapy services.

Services that assess the strengths and needs of children and families and determine other service needs

Transformational Collaborative Outcomes Management (TCOM)

Transformational Collaborative Outcomes Management (TCOM) is a framework that includes the philosophy, strategies and tools to address the needs of children and families, including those served by youth placed in out-of-state facilities or returning from existing out-of-state placements. TCOM includes a structured assessment that directly informs service/intervention planning which includes the Family Advocacy and Support Tool (FAST), the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA). The TCOM tools provide effective decision-making at every level of the system because it involves a shared understanding of the current needs and strengths of children, youth, and caregivers.

The WV FAST will support effective interventions with the entire family and be utilized by the DHHR Youth Service Workers who are involved with the Youth Services Program. The WV CANS will be utilized when a child is being placed out-of-home and utilized typically by service providers.

In 2018, the following was continued:

- Experts Training (training-the-trainers);
- Automated certification process;
- All DHHR Youth Service Workers trained on the use of the WV CANS and received annual certification/recertification;
- The CANS Algorithms used for decisions for placement and treatment in the Safe at Home West Virginia wraparound program, the Regional Clinical Reviews and the Out-of-State Clinical Reviews; and
- Promoted the Family First Prevention Services Act (FFPSA), the TCOM model for Youth Service staff that include a Family Assessment (WV FAST) and the Case Plan to identify both the child as a "candidate" and specified services as required by FFPSA.

Update 2021:

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West Virginia continues in its implementation efforts of the TCOM model. On December 1st, 2019 the BCF implemented the WV FAST statewide within the Youth Services framework. This assessment tool is utilized throughout the life of the case to inform case planning, safety planning, and service delivery needs. The BCF continues in its partnership with Marshall University to act as the center for excellence in the TCOM tools and provide training and ongoing technical assistance to Youth Service staff to continuously improve their assessment of and planning for families. The BCF intends to continue in its collaboration with Marshall University to develop algorithms during the 2020 calendar year to ensure children receive the proper level of care indicated by their needs.

Update 2022:

West Virginia has continued working with Marshall University to develop pathways to appropriate treatment for children who receive a CANS assessment. In August 2020, WV had over 700 youth who were in a group residential or psychiatric residential treatment facility. Amongst those, over 300 youth were in an out-of-state facility. The state partnered with Marshall University's Center of Excellence for Recovery and Dr. John Lyons from the University of Kentucky's Center of Innovation in Population Health to identify the similarities of these youth and their needs through a latent class analysis. This will assist the state in determining what level of intervention is necessary amongst existing community-based services that can be utilized to keep the youth in a home-like setting and what new services may need to be developed. This cluster analysis will be used to further understand the demographics and treatment needs of youth who are in residential mental health treatment. The demographic information will help DHHR understand trends and barriers to serving those children in their home communities.

The cases selected had been in the placement for at least three months. This allowed for at least two data time-points to be reviewed. Marshall University provided the state with a list of cases to be reviewed both in-state and out-of-state. Of those cases, 372 were selected for the latent class analysis.

Demographic information was collected, and the major findings are as follows:

- The majority (67%) of youth that were reviewed in group residential and psychiatric residential treatment facilities were in state.
- The majority (84%) of youth were in a group residential setting no matter if in-state or out-of-state.
- The majority (52%) of the cases were Youth Service Cases.
- The majority (57%) of youth served were ages 15-17 years old.
- The majority (63%) of youth are males.
- The majority (86%) of youth are Caucasian.
- 91% of the youth had at least 1 trauma experience.
- 27% or 100 youth had an intellectual disability, which included autism spectrum disorder, borderline intellectual functioning, and mild to severe intellectual disabilities. The longest lengths of stay were with youth who had an intellectual disability.

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- *20% of the youth have substance use issues.*
- *24% of the youth are wards of the state. This often makes placement difficult and extends lengths of stay in group residential and psychiatric residential treatment facilities. 20% of the youth are adjudicate delinquents but many more simply had charges.*

There were 372 case reviewed in the latent class analysis (LCA). The four-model class fit WV's data the best. Youth were divided into four classes through the LCA. The classes are:

- *Class 1-Youth with Low Needs*
- *Class 2-Youth with Legal and Conduct Issues*
- *Class 3-Youth in Special Populations*
- *Class 4-Youth with Trauma and/or Mental Health Issues*

CANS items that are common to three or more classes include:

- *Family*
- *Living Situation*
- *Social Functioning*
- *Anger*
- *Oppositional*
- *Impulsivity*

Services that address the needs of families in addition to individual children in order to create a safe home environment:

Safe at Home West Virginia

West Virginia's Title IV-E Waiver demonstration project, Safe at Home West Virginia, aims to provide wraparound behavioral health and social services to 12 to 17-year-olds with specific identified behavioral health needs who are currently in congregate care or at risk of entering congregate care. The Title IV-E Waiver allows the existing level of funding to be refocused on wraparound community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

Some of the most common successes achieved by youth and families as reported by stakeholders in interviews in August 2018 were improved grades and school attendance, improved behavior or emotional regulation, youth sobriety, youth taking responsibility for themselves, healthier family and peer relationships, living in a safer location, increased parenting skills, and achieving permanency.

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Local Coordinating Agencies did particularly well in developing high quality Wraparound and Crisis Safety Plans, where the content of those plans demonstrated a strong adherence to the wraparound model.

At twelve months, Safe at Home youth were more likely to have returned home from congregate care than youth from the historical comparison group; spend less amount of time in congregate care than do the matched comparison youth, and at a statistically significant rate; and more likely to return to their home county than youth in the historical matched comparison group.

When youth do need to enter foster care, Safe at Home youth are more likely to be placed in a relative home, and at a statistically significant rate. Safe at Home youth are also more likely to reunify as compared to cohorts at a statistically significant rate.

Update 2021: See Safe at Home update in [Collaboration](#) section

Update 2022: See Safe at Home update in [Collaboration](#) section

Socially Necessary Services

Socially Necessary Services (SNS) are services provided to children and families which are necessary to provide for the child's safety, permanency and well-being, but are not covered through Medicaid. To build in accountability and control cost, the SNS program is being revised. The SNS Redesign will deliver the following:

- The most appropriate services to meet the needs of our children and families;
- Reunification and family preservation services are targeted;
- The cost of the services is controlled to only meet the needs of children and families; and
- Ensure appropriate monitoring and oversight of services and providers.

In 2018, the following was initiated as part of the SNS Redesign:

- DHHR entered into agreements with active SNS providers;
- A Gap Analysis was conducted of all SNS providers to gather information on what SNS services are being provided and where these services are located;
- A Request to Become an SNS Provider process was developed to ensure that potential SNS providers are providing services in locations where they are needed based on the gap analysis and recommended by the county Community Service Manager and Community Collaborated. The information/documentation will be sent to the DHHR's Bureau for Children and Families, Office of Children and Adult Services, Regulatory Management Unit for approval.
- The process is being piloted with a potential agency to ensure the process, that will include the gap analysis/data works well (Project Hope).

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Socially Necessary Services Retrospective Reviews

Each provider chooses which individual services they want to provide so the number of agencies differs per service.

Providers may decide not to offer a specific service after receiving below 80% and/or may not have received a referral to provide a specific service that scored below 80% by the next scheduled review.

Review rounds are 18-month cycles. Therefore, a provider scoring less than 80% on a specific service may not have reached the six-month re-review prior to this report.

Providers who fall below 80% for a service, during their normal review period are 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 falls below 80% on the services a second time, then the service is closed for that provider.

Of significant need is *Safety Services*. The Service Array Workgroup will assess the issues why providers are having difficulty providing these services promptly and appropriately. This array of services will be unbundled in the new Comprehensive Child Welfare System.

Update 2021:

During the FFY 2019, there were 56 retrospective reviews conducted on SNS providers. Ten of the reviews were re-reviews of providers who scored under 80% on some services during the FFY 2017-2018.

During the review, 35 of the SNS providers scored above 80% for each service they provided; but, 11 of the SNS providers had at least one service fall below the 80% threshold. All 11 of the providers were re-reviewed.

During the review in FFY 2018-2019, a total of 15 services fell below the 80% threshold. Specifically, the following number of services fell below 80%:

- *Two providers had one service score below 80%*
- *Three providers had two services score below 80%*
- *Four providers had three services score below 80%*
- *One provider had five services score below 80%*
- *One provider had seven services score below 80%*
- *One provider had eight services score below 80%*

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The following table shows the services that fell below 80% and the total number of providers for each service for FFY 2017, FFY 2018 and FFY2019:

Service Name	FFY 2017	FFY 2017	FFY 2018	FFY 2018	FFY 2019	FFY 2019
	# services of this type below 80%	# providers for this service *	# services of this type below 80%	# providers for this service *	# services of this type below 80%	# providers for this service *
Agency Transportation	0	19	0	16	1	19
Case Management	0	2	1	5	0	1
Connection Visit	0	3	0	1	0	0
Family Crisis Response	1	1	1	2	0	1
General Parenting	0	0	0	1	0	0
Homemaker Services	0	0	1	2	1	1
Needs Assessment/Service Plan	0	2	1	8	0	2
Pre-Reunification Support	0	4	1	5	3	7
CAPS Review	1	5	1	4	2	6
Private Transportation 1	0	0	0	3	0	2
Private Transportation 2	0	1	0	3	0	3
Private Transportation 3	0	0	0	1	0	0
Transport Time	1	6	4	8	6	12
Intervention Travel Time	0	15	0	13	1	19

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<i>Supervised Visitation 2</i>	3	13	3	14	7	22
<i>Supervised Visitation 1</i>	1	17	1	18	2	22
<i>Adult Life Skills</i>	6	22	12	19	14	29
<i>Agency Transportation 1</i>	0	20	0	20	2	34
<i>Agency Transportation 2</i>	3	19	1	19	1	19
<i>Supervision</i>	4	20	5	16	2	17
<i>Individualized Parenting</i>	8	25	1	18	7	23
<i>Safety Services</i>	9	22	11	18	6	17
<i>MDT</i>	1	12	0	15	0	13
<i>Chaffee Preplacement</i>					0	1
<i>Chafee Phase 2 Part 1</i>					1	1

**Each provider chooses which individual services they want to provide so the number of agencies differs per service.*

Providers may have decided not to offer a specific service after receiving below 80% and/or may not have received a referral to provide a specific service that scored below 80% by the next scheduled review.

Review rounds are 18-month cycles. Therefore, a provider scoring less than 80% on a specific service may not have reached the six-month re-review prior to this report.

Providers who fell below 80% for a service, during their normal review period 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 falls below 80% on the services a second time, then the service will be closed for that provider.

During the FFY 2018 - 2019, zero providers had services closed after the initial review, due to a zero-compliance score. Three providers, who were placed on probation, during FFY 2018 - 2019, for falling below the 80% rule, had a follow-up review on a total of five service categories, during FFY 2018 - 2019. All of the services scored above 80% during the re-review and the providers were taken off of probation.

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During the FFY 2018 – 2019, 11 providers were placed on probation for those services that fell below 80% and received a follow-up review during the FFY 2018 – 2019. Eight of these providers improved their scores, but three of the providers had five services remain below 80% and those services were closed.

The review of the data provided above for FFY 2018 and FFY 2019, shows a slight increase in the number of services reviewed that fell below an 80% compliance rule. In FFY 2018, 15% of the services reviewed fell below 80%, and in FFY 2019 18% of the services reviewed fell below 80%. In FFY 2019, 90% of reviewed socially necessary service providers scored above 80% for all of the services they provide. Only 10% of the reviewed socially necessary service providers had one or more services fall below 80%. This indicates that during the past FFY year of 2019, the providers of socially necessary services have improved their service provision. The following data reflects the number of family cases and individuals that received Family Preservation and Reunification services through Socially Necessary Services during FFY 2019:

- *Family Preservation- 5953 Unique Individuals and 4188 Unique Cases*
- *Reunification- 1025 Unique Individual and 631 Unique Cases*

Update 2022:

WV DHHR Bureau for Children and Families convened virtual meetings with Socially Necessary Services providers starting in May 2020 in response to the COVID 19 pandemic. These meetings were held bi-weekly to discuss service provisions to comply with the Center of Disease Control guidelines on safety during the pandemic. In July 2020, the meetings were changed to monthly after receiving feedback from the providers requesting a change in frequency. This will continue in FFY 2021 as providers have deemed it beneficial to have the opportunity to voice concerns.

During FFY 2019-2020 the in-person review process was suspended due to the COVID 19 Pandemic. Reviews switched from on site and desk audit format to desk audits only and slowly started transitioning to some on site reviews being completed. As providers transitioned to virtual services for those allowed to be rendered and slowly returned to in-home service provision, the review process also had to adapt. Review times, sample sizes, and service array were all affected including issues such as working through provider out breaks, their geographic coverage areas, their record keeping systems, “stay-at-home orders,” and the color-coded system set up by the Governor’s office.

During the FFY 2020, there were 16 retrospective reviews conducted on SNS providers. None of the reviews were re-reviews of providers who scored under 80% on services during the previous review.

During the review, 11 of the SNS providers scored above 80% for each service they provided; but five of the SNS providers had at least one service fall below the 80% threshold. All five of the providers will be reviewed in the coming months.

During the review period, a total of seven services fell below the 80% threshold. Specifically, the following number of services fell below 80%:

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- Four providers had one service score below 80%
- One provider had two services score below 80%

The following table shows the services that fell below 80% and the total number of providers for each service for FFY 2019 and FFY 2020:

Service Name	FFY 2019	FFY 2019	FFY 2020	FFY 2020
	# services of this type below 80%	# providers for this service *	# services of this type below 80%	# providers for this service *
Agency Transportation	1	19	0	12
Case Management	0	1	1	1
Connection Visit	0	0	0	1
Family Crisis Response	0	1	0	1
General Parenting	0	0	0	0
Homemaker Services	1	1	1	1
Needs Assessment/Service Plan	0	2	0	1
Pre-Reunification Support	3	7	0	5
CAPS Review	2	6	0	1
Private Transportation 1	0	2	0	2
Private Transportation 2	0	3	0	2

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Private Transportation 3	0	0	0	0
Transport Time	6	12	1	6
Intervention Travel Time	1	19	0	9
Supervised Visitation 2	7	22	0	8
Supervised Visitation 1	2	22	0	13
Adult Life Skills	14	29	3	9
Agency Transportation 1	2	34	1	16
Agency Transportation 2	1	19	0	11
Supervision	2	17	0	9
Individualized Parenting	7	23	0	11
Safety Services	6	17	1	5
MDT	0	13	0	9
Chaffee Preplacement	0	1	0	0
Chafee Phase 2 Part 1	1	1	1	1

**Each provider chooses which individual services they want to provide so the number of agencies differs per service.*

Providers may have decided not to offer a specific service after receiving below 80% or may not have received a referral to provide a specific service that scored below 80% by the next scheduled review.

Review rounds are 18-month cycles. Therefore, a provider scoring less than 80% on a specific service may not have reached the six-month re-review prior to this report.

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Providers who fell below 80% for a service, during their normal review period 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 falls below 80% on the services a second time, then the service will be closed for that provider.

During the FFY 2019 - 2020, zero providers had services closed after the initial review, due to a zero-compliance score.

During the FFY 2019-2020 five providers were placed on probation for those services that fell below 80% and none have received a follow-up review yet.

The review of the data provided above for FFY 2019 and FFY 2020, shows an 11% increase in the number of services reviewed that fell below an 80% compliance rule. In FFY 2018, 15% of the services reviewed fell below 80%, in FFY 2019 18% of the services reviewed fell below 80% and in this period 29% fell below 80%. In FFY 2019-20, 69% of reviewed socially necessary service providers scored above 80% for all of the services they provide. 31% of the reviewed socially necessary service providers had one or more services fall below 80%. This indicates that during the past FFY year of 2019, the providers of socially necessary services have improved their service provision. The following data reflects the number of family cases and individuals that received Family Preservation and Reunification services through Socially Necessary Services during FFY 2019:

- *Family Preservation- 5048 Unique Individuals and 3536 Unique Cases*
- *Reunification- 918 Unique Individual and 586 Unique Cases*

Services that enable children to remain safely with their parents when reasonable

Office of Drug Control Policy

In 2017, House Bill 2620 was signed into law creating the Office of Drug Control Policy (ODCP). Under the direction of DHHR Cabinet Secretary Bill J. Crouch, the ODCP leads development of all programs and services related to the prevention, treatment and reduction of substance use disorder, in coordination with DHHR's Bureaus and other state agencies. The goal of the ODCP is to maximize funds to fight substance and opioid abuse. The ODCP wishes to expand neonatal centers (i.e., Lily's Place) to support mothers and babies born addicted to substances and opioids and develop treatment beds for substance use disorder through the Medicaid waiver.

Update 2021:

From October 1, 2018 through September 30, 2019 Lily's Place reports that they have had 57 admissions with an average length of stay of 27 days. They have successfully discharged 36 infants to parents, 7 infants to relatives and 14 infants to foster care.

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A second Neonatal Abstinence Syndrome Center at Thomas Memorial Hospital in South Charleston opened Baby STEPS, an eight-bed unit for babies withdrawing from maternal drug use, in the spring of 2019. St. Thomas reported 18 admissions, with an average length of stay of 24.68 days. 16 of these children discharged to a parent or relative and only two resulted in a foster care placement.

Update 2022:

From October 1, 2019 through September 30, 2020 Lily's Place reports that they have had 41 admissions with an average length of stay of 28 days. They have successfully discharged 25 infants to parents; 3 infants to grandparents and 12 infants to foster care. They further report that 1 infant was adopted immediately at the hospital before being admitted to Lily's Place.

Thomas Memorial Hospital's Baby STEPS program in South Charleston reports that from October 1, 2019 through September 30, 2020, there were 47 admissions for an average length of stay for 21 days. They have successfully discharged 30 infants to parents, 7 infants to relatives, and 8 infants to foster care. The 2 other infants were discharged from Baby STEPS and admitted to the hospital's NICU due to complications.

Project Hope for Women and Children

Project Hope offers a safe living environment for new or expectant mothers suffering from substance use disorder and their children. The project provides women with the treatment and recovery resources necessary to facilitate long-term well-being. Other services include mediation-assisted treatment, job placement and training, and spiritual counseling.

The project offers 18 single-family apartments that include two or three bedrooms, one bathroom, a living room and kitchenette with laundry facilities on site and support staff available 27/7.

This recovery initiative complements existing projects, such as Health Connections, Cabell Hospitals Maternal Opioid Medication Support (MOMS), Marshall Health's maternal Addiction Recovery Center (MARC) and Lily's Place.

Bureau for Behavior Health, Children's Wraparound

The Children's Mental Health Wraparound initiative of DHHR's Bureau for Behavioral Health (BBH) is modeled after the National Children's Wraparound Model and philosophy. The purpose of Children's Mental Health Wraparound is to prevent out-of-home placement of children with serious emotional disturbances and have them thrive at home with their families and in their schools and communities.

Currently, Children's Mental Health Wraparound services are provided in six counties (Cabell, Kanawha, Raleigh, Marion, Harrison, and Berkeley) by five agencies (Braley and Thompson/ResCare, National Youth

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Advocate Program, Necco, Prestera, and FMRS). In the State Fiscal Year 2018, the BBH Children's Mental Health Wraparound Program had 118 referrals. Of these, 43 were accepted into the Children's Wraparound Program. Of the 75 not accepted, 39 did not meet eligibility requirements, 18 were unable to be contacted after numerous attempts, 12 of the parents declined the voluntary services, and four were not accepted during a brief period of funding transition. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

The following are findings for Children's Mental Health Wraparound accepted cases:

- 24 or 52% are male;
- 16 or 35% are age 11 or younger;
- 4 or 9% have been adopted;
- 8 or 17% are in the care of a relative/guardian;
- 23 or 50 % of these accepted referrals were involved with DHHR's Child Protective Services;
- 11 or 24% of accepted referrals are children who have an intellectual/developmental disability (IDD) diagnosis in addition to a serious emotional disturbance (SED) diagnosis and are not eligible for IDD Waiver or have not applied for IDD Waiver;
- 6 or 13% have a diagnosis of Autism;
- 39 or 85% receive Medicaid; and
- 12 or 26% have a parent incarcerated or a parent with a history of incarceration.

The Children's Wraparound successfully maintained 41 or 89% of accepted children/youth who were at risk of placement in their homes and communities by providing individualized, strength-based, trauma-focused, community-based planning and intensive intervention that safely preserves family relationships and empowers children and families to help meet their own needs.

Update 2021:

In the State Fiscal Year 2019, the BBH Children's Mental Health Wraparound Program had 103 referrals. Of these, 77 were accepted into the Children's Wraparound Program. Of the 46 not accepted, 29 did not meet eligibility requirements, 12 were unable to be contacted after numerous attempts, three of the parents declined the voluntary services, and two were not accepted during a brief period of funding transition. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

The following are findings for Children's Mental Health Wraparound accepted cases:

- 50 or 64.9% are male;
- 41 or 53.25% are age 11 or younger;

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- 12 or 15.58% have been adopted;
- Eight or 10.39% are in the care of a relative/guardian;
- Ten or 12.99 % of these accepted referrals were involved with DHHR's Child Protective Services;
- 26 or 33.77% of accepted referrals are children who have an intellectual/developmental disability (IDD) diagnosis in addition to a serious emotional disturbance (SED) diagnosis and are not eligible for IDD Waiver or have not applied for IDD Waiver;
- Nine or 11.69% have a diagnosis of Autism; and,
- 19 or 24.68% have a parent incarcerated or a parent with a history of incarceration.

The Children's Wraparound successfully maintained 54 or 70.13% of accepted children/youth who were at risk of placement in their homes and communities by providing individualized, strength-based, trauma-focused, community-based planning and intensive intervention that safely preserves family relationships and empowers children and families to help meet their own needs.

SFY2020 includes an expansion of the Children's Mental Health Wraparound to include all 55 counties in WV. This change included adding up to 15 Wraparound Facilitators statewide. BBH has six regional Children's Mental Health Wraparound agencies: Braley & Thompson, Region one; Board of Childcare, Region two; NYAP, Region three; Braley & Thompson, Region four; Prester Center, Region five; FMRS, Region six. New data for this change will be available in July 2020.

Update 2022:

Currently, Children's Mental Health Wraparound services are provided by five agencies (Board of Child Care, Braley and Thompson, National Youth Advocate Program (NYAP), Prester Center, and Fayette, Monroe, Raleigh, Summers (FMRS). In State Fiscal Year 2020, the BBH Children's Mental Health Wraparound Program had 199 referrals. Of these, 121 were accepted into the Children's Wraparound Program. Of the 78 not accepted, 36 did not meet eligibility requirements, 26 were unable to be contacted after numerous attempts, 16 of the parents declined the voluntary services. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

The following are findings for Children's Mental Health Wraparound accepted cases for FY 2020:

- 79 are male;
- 55 were age 11 or younger;
- 23 have been adopted;
- 13 are in the care of a relative/guardian;
- 15 of these accepted referrals were involved with DHHR's Child Protective Services/Youth Services;
- 33 of accepted referrals are children who have an intellectual/developmental disability (I/DD) diagnosis in addition to a serious emotional disturbance (SED) diagnosis and are not eligible for I/DD Waiver or have not applied for I/DD Waiver;
- 20 have a diagnosis of Autism; and

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- 8 have a parent incarcerated or a parent with a history of incarceration.

The Children's Mental Health Wraparound seeks to maintain those children/youth accepted into the program who were at risk of placement in their homes and communities by providing individualized, strength-based, trauma focused, community-based planning, and intensive intervention that safely preserves family relationships and empowers children and families to help meet their own needs.

Children's Mobile Crisis Response

Children's Mobile Crisis Response is currently in two pilot areas. United Summit Center serves Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur counties. FMRS serves Raleigh County and surrounding area in West Virginia.

The program links children and their families/caregivers to services in the community, involves families in treatment, and avoids unnecessary hospitalization or residential placement. The Children's Mobile Crisis Response has served 445 children/youth. Of the 928 crisis calls taken, 345 were managed by phone, 566 required an in-person response, 335 crisis plans were completed.

The Mobile Crisis Program will continue for another year through DHHR's Office of Drug Control Policy.

Update 2021:

In 2019 Children's Mobile Crisis Response was serving children through four agencies covering the following counties: United Summit Center serves Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, and Taylor; Appalachian Community Mental Health serves Barbour, Randolph, Tucker, and Upshur counties; FMRS serves Raleigh County and the surrounding area in West Virginia and Prester Center serves Cabell, Wayne and Boone.

The program links children and their families/caregivers to services in the community, involves families in treatment, and avoids unnecessary hospitalization or residential placement. The Children's Mobile Crisis Response has served 493 children/youth. Children's Mobile Crisis changed service provision to all in person response, allowing all calls to be responded to in person. 380 crisis plans were completed.

FY2020 includes an expansion of the Children's Mobile Crisis Response & Stabilization to all BBH regions except Region two which covers, Berkeley, Jefferson, Morgan, Pendleton, Mineral, Grant, Hardy and Hampshire Counties. It is expected that services will be statewide by October 2020. BBH's current services: Region one, Genesis Youth Crisis Center; Region two, TBD; Region three, Westbrook Health Services; Region four, Appalachian Community Mental Health covering Barbour, Upshur, Tucker and Randolph and United Summit Center covering Marion, Monongalia, Preston, Harrison, Taylor, Gilmer, Lewis, Doddridge, Braxton; Region five, Prester Center; Region six, FMRS. Data for this expansion will be available for SFY2020 in July 2020. Crisis Respite Services were also added to the services which are available to families and will be offering 80 hours (96 hours if there is an unforeseen emergency requiring extra care) of Crisis Respite Services to give parents a break.

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FY 2021 will include further expansion of services for Children's Mobile Crisis with the opening of a statewide crisis line through First Choice Services. This will include a Children's Mobile Crisis Statewide Hotline that will allow individuals and families statewide to be able to access crisis services through one centralized number.

Regional Family Coordinators – State Opioid Response (SOR)

Federal FY 2020, the State Opioid Response (SOR) Regional Family Coordinators are housed in the six Youth Service Centers. The SOR Regional Family Coordinators serve all counties in West Virginia. The SOR Family Coordinators facilitate the needs of family members of the youth or young adults involved in treatment and recovery at the Regional Youth Service Centers through screening, referrals, engagement and connecting the family to treatment and recovery service available through the community partners in the region and the state. An outreach event is scheduled in May at the Moorefield Ballfield with activities for families and referral/service information.

Regional Family Coordinators – System of Care (SOC)

Federal FY 2020, the System of Care (SOC) Regional Family Coordinators promotes coordination and integration of family-centered care, facilitate participation and involvement of the entire family in a child, youth and/or young adult's treatment and recovery, and connect families affected by mental health and/or co-occurring disorder with support and resources. The Family Coordinator facilitates the needs of family members of the children, youth and young adults involved in services at the Regional Youth Service Center and those who have been referred by other community agencies through referral, engagement, and connecting the family to treatment and recovery services available through the community partners in the region and state. The SOC Family Coordinators assist families in system navigation, including connecting them with resources to meet their basic living, social and emotional, educational, behavioral and mental health service needs.

Update 2022:

In FY 2020, Children's Mobile Crisis Response was serving children through six agencies within the following counties:

- *Genesis Youth Crisis Center – Brooke, Hancock, Marshall, Ohio and Wetzel counties*
- *Westbrook Health Systems – Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt and Wood counties*
- *United Summit Center served Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston,*
- *and Taylor counties*
- *Appalachian Community Mental Health served Barbour, Randolph, Tucker, and Upshur counties*
- *Fayette, Monroe, Raleigh, Summers (FMRS) - Nicholas, Webster, Pocahontas, Greenbrier, Fayette, Raleigh, Summers, Monroe, Mercer, Wyoming, and McDowell counties*

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- *Prester Center- Boone, Cabell, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam and Wayne counties*

The program continues to link children and their families/caregivers to community services. It involves families in treatment and avoids unnecessary hospitalization or residential placement. In FY 2020, the Children's Mobile Crisis Response served 584 children/youth through these six agencies.

The Mobile Crisis Program will continue through DHHR's Bureau for Behavioral Health.

In Federal FY 2021, which is still ongoing until September 2021, the Regional Family Coordinators (SOR and SOC) added a Family Advisory Board, completed a family survey which surveyed family needs and wants as related to how services are accessed, received and how families which to contacted or notified. The Bureau developed and published a family newsletter called Family Connections which is issued quarterly. The Regional Family Coordinators served 104 families since October 2020 and currently are still offering 2 parenting classes.

Children's Crisis and Referral Line and Warm Peer Line

On October 1, 2020, the Bureau for Behavioral Health launched a statewide, 24/7 Children's Crisis and Referral Line which seeks to connect families in crisis immediately with regional Mobile Crisis Response and Stabilization Teams through warm transfer referrals. It will also connect professionals and families not in crisis with appropriate community-based behavioral health services and supports.

A companion to the Crisis and Referral Line is a statewide, 24/7 Peer Warm Line utilizing peer, including peer recovery support specialists (PRSS) employed by First Choice Services. The Warm Line is for young adults and adults experiencing life challenges or recovering from SMI or co-occurring substance use disorder (SUD) and their families. The Warm Line will give any individuals experiencing life challenges, but not in crisis, the option to talk with peers who will listen actively and nonjudgmentally and link them with resources as needed, including referrals to other PRSS and regional Family Coordinators in the state.

First Choice Services manages the Children's Crisis and Referral Line and Warm Peer Line – Statewide Services CALL 1-844-HELP4WV

Services that help children in foster and adoptive placements achieve permanency

Regional Clinical Review Teams, Out-of-State Review Teams, and Conference Calls

The Regional Clinical Review Process is a coordinated effort to provide a comprehensive and coordinated clinical review of designated youth. The process has several steps to assure that the review is objective, thorough, and includes a standardized assessment tool utilized in all reviews. The role of the review

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process is to identify what the youth's current treatment and permanency needs are and serve as a resource to the youth's individual Multidisciplinary Team (MDT).

The goal is to determine that the type and level of services matches the treatment and permanency needs by evaluating that:

- The care being provided meets the youth's assessed need;
- The facility where the youth is placed has the program in place to meet the youth's need;
- The youth and family/legal guardian are involved in the treatment and their input is being considered in the treatment and discharge planning process;
- Discharge planning is occurring from the time of admission throughout the youth's treatment; and
- The identified discharge plan is detailed and specific and addresses continued treatment and permanency needs.

Each DHHR Region has one team consisting of community members that represent group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children's Mental Health Wraparound (WRAP), community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally. This team participates in Regional Clinical Review Teams, Out-of-State Review Teams and conference calls.

Regional Clinical Coordinators (RCC) assist and coordinate the activities of the Clinical Review Team/Process by establishing working relationships with community partners and ensuring that the Clinical Review Process is completed as outlined in the established protocols and timeframes. The RCCs also provide resource awareness and system navigation to families, probation staff, therapists, social workers, and other service providers responsible for developing individualized, person-centered treatment plans. RCC services are available to children and families regardless of the child's custodial status.

In 2017-18, there were 16 children reviewed by Regional Clinical Review Teams, 148 reviewed by Out-of-State Review Teams, and 98 reviewed via Conference Calls.

Update 2021:

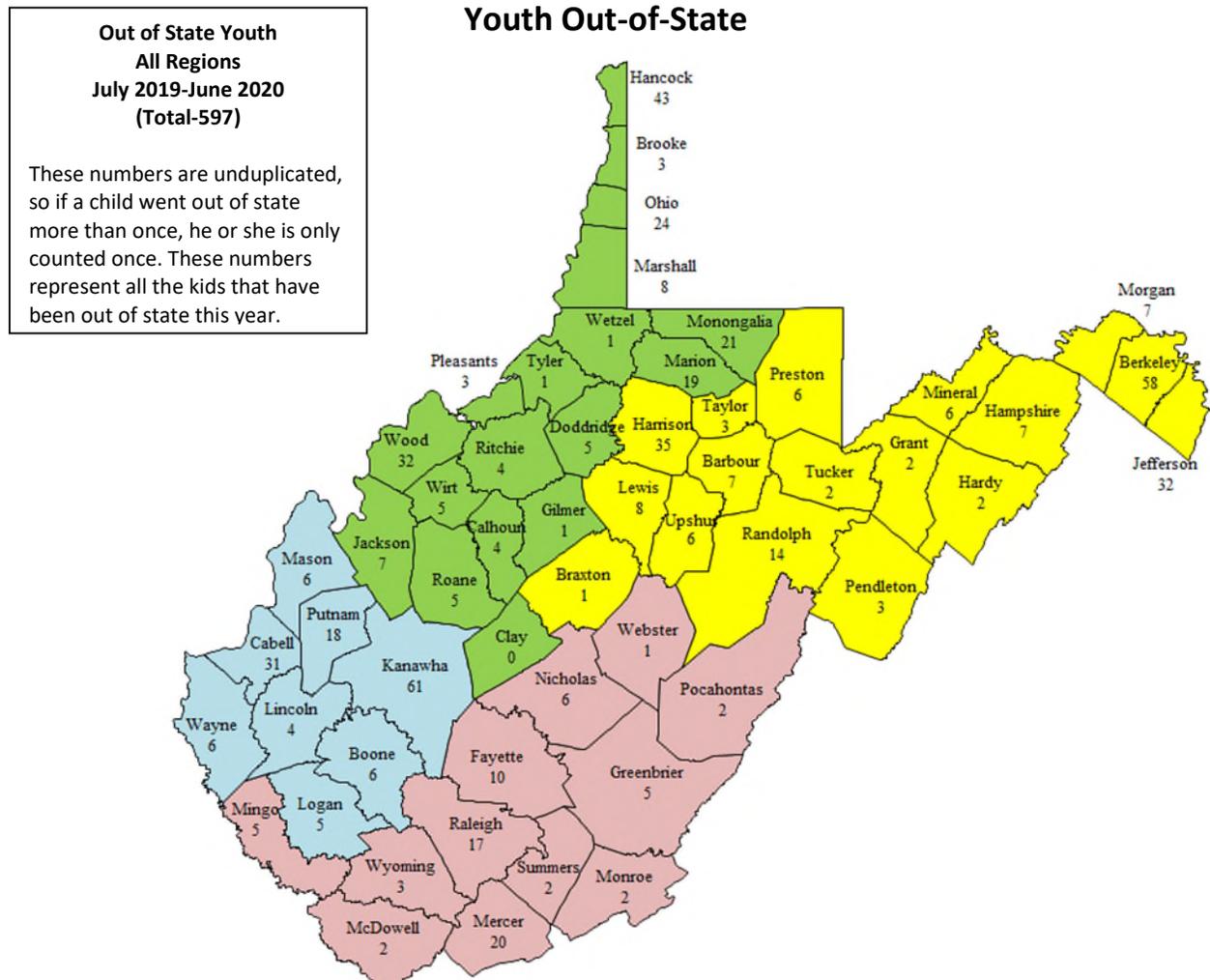
The following chart provides for the Regional Clinical Review Teams for SFY 2019.

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In 2018-19, there were 2 youth reviewed by Regional Clinical Review Teams, 168 reviewed by Out-of-State Review Teams, and 47 reviewed via Conference Calls. Note: in FY 2019-2020, the “conference calls” have been replaced by Clinical Staffings and are performed either face to face or virtually.

The following chart provides for the Regional Clinical Review Teams for SFY 2020.

# of Kids Reviewed in 2019-2020	Regional Clinical Review Teams	Out-of-State Review Teams	Clinical Staffings
Region I	0	23	1
Region II	1	37	38
Region III	0	79	6
Region IV	0	39	3
State Total	1	178	48



Bureau for Juvenile Services (BJS) Conference Call-Meetings

Senate Bill 393 required DHHR to establish non-secure facilities for the rehabilitation of youth status offenders. Therefore, all youth who were status offenders at Robert Shell (a secured facility) had to be transitioned to an alternative placement. After a meeting regarding a youth whose IQ was 44, and in need of a specialized placement, the West Virginia Division of Corrections and Rehabilitation, Bureau for Juvenile Services (BJS) and other stakeholders began having conference call meetings on June 29, 2017, to discuss alternative placements for vulnerable children who have special needs and who have been placed within the Bureau for Juvenile Services. These calls have continued through 2018.

A total of 181 youth has been staffed. Thirteen of the 181 youth had duplicated reviews for a total of 168 unduplicated youth being reviewed. Currently there are 21 youth on the review list.

The ages of the youth are: youth 12 years and under (62); youth 13 to 14 years (64); youth 15 to 17 (54); and youth 18 years and older (1).

Placements: youth in-state (66); youth out-of-state (46); youth remaining in their own home with services (39); youth committed to Bureau (8).

A total of 106 youth was identified Intellectually/Developmentally Disabled. Forty-three were below an Intelligence Quotient (IQ) of 70; 41 were Borderline (70-85 IQ); and 22 were within the Autism Spectrum. The weekly conference call participants include staff and administrators from Bureau for Juvenile Services; DHHR's Bureau for Children and Families Regional Directors (4); DHHR's Bureau for Behavioral Health; DHHR's Interstate Compact Placement of Children (ICPC) Central Office; DHHR's Bureau for Medical Services; PSIMED (mental health provider); Supreme Court of Appeals of West Virginia, Division of Probation and Division of Children and Juvenile Services; West Virginia Department of Education, Diversion and Transition Programs; child's probation officer; and child's primary DHHR worker.

Update 2021:

A total of 298 unduplicated youth have been staffed to date. Of the 298 unduplicated youth, 50 of them have been staffed twice, 16 have been staffed three times and seven have been staffed four times. Currently there are 19 youth on the review list. The ages of the youth are: youth age nine (13); youth age ten (19); youth age 11 (56); youth age 12 (95); youth 13 to 14 years (106); youth 15 to 17 (108); and youth 18 years and older (7). Placements: placed in a shelter (31); youth in-state (83); youth out-of-state (116); youth remaining in their own home with services (88); youth committed to Bureau (21).

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A total of 173 youth was identified Intellectually/Developmentally Disabled. 69 were below an Intelligence Quotient (IQ) of 70; 59 were Borderline (70-85 IQ); and 45 were within the Autism Spectrum. An Intelligence Quotient (IQ) was not available to BJS for 157 of the youth staffed.

Update 2022:

A total of 387 unduplicated youth has been staffed to date. Of the 387 unduplicated youth, 78 of them have been staffed twice, 20 have been staffed three times and seven have been staffed four times. Currently there are 23 youth on the review list. The ages of the youth are youth age eight (1); youth age nine (4); youth age ten (14); youth age 11 (56); youth age 12 (111); youth age 13 (80); youth age 14 (62); youth 15 to 17 (154); and youth 18 years and older (8). All youth which have been staffed to date through the BJS calls and have discharged have been discharged to the following types of foster care placements: shelter (39); youth in-state (110); youth out-of-state (155); youth remaining in their own home with services (122); youth committed to Bureau of Juvenile Services commitment (25).

A total of 235 youth has been identified Intellectually/Developmentally Disabled. 101 were below an Intelligence Quotient (IQ) of 70; 76 were Borderline (70-85 IQ); and 58 were within the Autism Spectrum. An Intelligence Quotient (IQ) was not available to BJS for 216 of the youth staffed.

Court Improvement Program: Support for Multidisciplinary Treatment (MDT) Teams

Provider Input at MDT and Court Hearings

During 2018, DHHR's Bureau for Children and Families (BCF), and the Court Improvement Program (CIP) began addressing a concern regarding service providers not receiving notifications/having input at Multidisciplinary Treatment (MDT) meetings and Court Hearings. Although the lack of notifications to providers for MDT and Court Hearings appear to be isolated, BCF and CIP took the following steps:

- The DHHR staff were notified that notification to MDTs and Court are required and that when a provider cannot attend, the monthly reports by providers can be shared at MDT and Court Hearings to allow the provider to have input.
- The CIP and DHHR managers will develop a survey for DHHR staff to identify where MDTs are working well and where improvements are needed.

Update 2021:

During the 2019 calendar year the CIP workgroup surveyed Regional Directors, Community Services Managers, Child Protective and Youth Services Supervisors from the department. The CIP was also able to survey Juvenile Probation Officers about their experience with the MDT process. The group has yet to review the collected data and we will wait until all groups have been surveyed. The CIP plans to survey Guardians Ad Litem, prosecuting attorneys, and public defenders for the 2020 calendar year.

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Update 2022:

CIP's quality hearing project continues. It remains in Change Management Phase 1- Needs Assessment. The project seeks to examine the correlation between MDTs and the quality of the succeeding hearing. During 2020, the CIP received 1022 completed surveys from a variety of professionals on their perceptions, attendance, and participation in MDTs. Education will be surveyed in 2021. In late 2020, CIP staff began observing MDTs and the succeeding hearing to gather data and will continue to do so through 2021.

Educational Input at Multidisciplinary Treatment (MDT) Teams

On May 2, 2018, a Memorandum signed by Honorable Gary Johnson, Administrative Director, Supreme Court of Appeals of West Virginia, Steven Paine, West Virginia State Superintendent of Schools, and Bill J. Crouch, Cabinet Secretary, West Virginia Department of Health and Human Resources (DHHR) and sent to West Virginia County Superintendents of Schools and DHHR Community Services Managers.

The Memorandum recognized the legal mandates and the importance for educators at the MDT meetings and a commitment for the notification and participation of school officials at Multidisciplinary Treatment Team meeting.

Update 2021:

The CIP workgroup developed a survey specific to educators in the 2019 calendar year with the intention of releasing during the 2020 calendar year. Unfortunately, due to school cancellations due to the COVID-19 pandemic, the survey will be put on hold until the school system reopens.

Update 2022:

No 2022 Update

Child Placement Network

The West Virginia Child Placement Network (WVCPN) was launched in 2005 as a centralized resource for identifying daily placement availability for children when they cannot remain in their own homes. In August 2006, the WVCPN was awarded the 2006 State Information Technology Award in the Government to Government category. In January 2008, the "Facility Detail" screen added the placement criteria for IQ Range(s); accepted ages; mental; physical; and court involved. In July 2010, the WVCPN "Daily Report" began featuring real-time data, export options, and the ability to refresh the data contained in the report to the current second. In February 2012, the provider type, "Transitional Living" was added. Currently, the WVCPN has 76 participating facilities. The WVCPN website address is <http://www.wvdhhr.org/wvcpn/>.

The West Virginia Adult Behavioral Health Placement Network

The West Virginia Adult Behavioral Health Placement Network is a centralized resource for identifying daily availability of residential crisis, group home and treatment services across West Virginia for adults with mental health and/or substance abuse issues. There are currently 94 licensed service agencies that provide regular updates about bed vacancies, with additional detail about accepted ages, gender, and type of behavioral health challenge. The website also provides updates on new facilities or expansions in services as available. The website is intended to be a source of information for those seeking available resources throughout West Virginia. To access the West Virginia Adult Behavioral Health Placement Network, visit <http://www.wvdhhr.org/wvabhpn/>.

Update 2021:

The West Virginia Adult Behavioral Health Placement Network is expected to retire within the next year. The current functionality is limited and the increase in available substance use treatment beds will not be supported. Another solution is being evaluated and will be purchased. The solution will begin with assisting individuals in finding placement at substance use facilities and will expand over time to include placements for individuals with intellectual or developmental disabilities.

Update 2022:

The West Virginia Adult Behavioral Health Placement Network is still operating but is expected to retire in the next few months. In March 2021 Wv DHHR's Bureau for Behavioral Health released a Request for Qualifications (RFQ) to select a new vendor for a variety of data needs. This RFQ includes a solution that will assist individuals in finding placement at substance use facilities and will expand over time to include placements for individuals with intellectual or developmental disabilities.

Implementation of Every Students Succeeds Act (ESSA): Focus on Foster Care Children

A memorandum was provided to West Virginia County School Superintendents and DHHR Community Services Managers from the Honorable Gary Johnson, State Superintendent of Schools Steven L. Paine, and DHHR Cabinet Secretary Bill Crouch which stated, "It is imperative that school districts develop a protocol that works best for each county in adhering to ESSA, West Virginia law, and this commitment to our state's children."

The Education of Children in Out-of-Care Advisory Committee developed a guiding tool on conducting MDTs. Additionally, the agreement for the exchange of data as required by ESSA was finalized.

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The West Virginia Department of Education (WVDE) is reviewing exemplary programs to close the gap for children in foster care.

In the 2017-18 school year, the WVDE, Office of Diversion and Transition Programs collected data from the following:

- 6,109 educational records with the DHHR, FACTS database for children in out-of-home (OOH) care
- 6,082 children had attendance records in WVEIS
- 3,023 children of the matches are assessment eligible (grades 3-8 and grade 11)
- 2,652 children had assessment records
- There were 369 missing assessment from eligible students
- General Summative Assessment Results for grades 3-8 and grade 11 are measured by five categories: Exceeds Standard; Meets Standard; Partially Meets Standard; and Does Not Meet Standard.
- OOH student scores were lower in English/Language Arts and Mathematics for all grade levels (3-5th grade, 6-8th grade, and 11th grade).
- Proficiency Breakdown: Although most children in OOH care did not meet expectations, data indicated that some students did not take tests in English/Language Arts or Mathematics.
- The participation Rates for children in OOH care was lower in each area than English Language Learners (ELL), Low Socio-Economic Status (SES) and Special Education (SPED).
- Attendance Rates: OOH students were equal to Low SES and SPED at 92%. Whereas all other students reflected 93% and ELL 95% participation rate.

In addition, the role of the local schools and the DHHR county offices, ensures collaboration, communication, and implementation of Every Students Succeeds Acts (ESSA). This is the responsibility of the DHHR Community Services Manager (CSM) and/or designee to ensure these partnerships are made and maintained.

Update 2021:

The Education of Children in Out-of-Home Care Advisory Committee (ESSA) continued its work on the following major objectives during 2019: (1) Implement the provisions of the federal Every Student Succeeds Act (ESSA) which requires the West Virginia Department of Education to annually report on the educational status and achievement of children in foster care; (2) Identify promising and best practices with respect to the education of children in out-of-home care; (3) Increase educational participation in multi-disciplinary teams; (4) Monitor the educational programs of children placed out-of-state; and (5) Develop transition programs and services to assist out-of-home care students in returning to school, transitioning to work, or reunifying with their communities once they leave an institution of other out-of-home environment.

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In the 2018-19 school year, the WV Department of Education's (WVDE) Office of Diversion and Transition Programs collected the following data:

- *WVDE matched 6,082 and 6,289 school records, respectively, for students in out-of-home care which were reported to DHHR.*
- *Of these records, 3,023 students were assessment eligible (included in grade levels in which students participate in the standardized testing program) in 2017-18, and 2,741 students were assessment eligible in 2018-19.*
- *A total of 369 assessment records were not found for students in 2017-18, and 193 were not found in 2018-19.*
- *The total number of assessment records used in reporting the educational status and achievement information for children in out-of-home care for 2017-18 was 2,652, and for 2018-19 was 2,616.*

During 2020, the Education of Children in Out-of-Home Care Advisory Committee will continue to work on: (1) Facilitating the implementation of the foster care provisions of the Every Student Succeeds Act (ESSA); (2) Increasing educational participation in multi-disciplinary team meetings; (3) Reporting on the educational status and achievement of children in out-of-home care; (4) Improving and expanding transitional services; and (5) Identifying promising and best practices in the education of children in foster care.

Update 2022:

The Education of Children in Out-of-Home Care Advisory Committee continued its work on the following major objectives during 2020: (1) Increase educational participation in multi-disciplinary teams; (2) Monitor the educational programs of children placed out-of-state; (3) Identify promising and best practices with respect to the education of children in out-of-home care; and (4) Develop transition programs and services to assist out-of-home care students in returning to school, transitioning to work, or reunifying with their communities once they leave an institution or other out-of-home environment.

Under Every Student Succeeds Act (ESSA), the West Virginia Department of Education is required to annually report on the educational status and achievements of children in foster care. However, due to the COVID-19 pandemic, the state testing program was cancelled for the 2019-20 and the 2020-21 school years. Therefore, the data normally reported in the Annual Report on the educational status and achievements of students in out-of-home care is unavailable.

During 2021, the Education of Children in Out-of-Home Care Advisory Committee will continue to work on: (1) Facilitating the implementation of the foster care provisions of the Every Student Succeeds Act (ESSA); (2) Increasing educational participation in multidisciplinary team meetings (MDTs); (3) Monitoring the education programs of children placed out-of-state; (4) Improving and expanding transitional services;

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and (5) Identifying and disseminating promising and best practices in the education of children in foster care.

The West Virginia Adult Drug Courts Program

The West Virginia Adult Drug Courts (ADC) Program is a cooperative effort of the criminal justice, social service, substance abuse treatment, and law enforcement systems. The ADCs are established in accordance with the West Virginia Drug Offender Accountability and Treatment Act (West Virginia Code § 62-15-1, et seq.) and are designed and operated consistent with the National Association of Drug Court Professionals, key ingredients of the Drug Court model (known as the Ten Key Components (NADCP, 1997) which became the core framework not only for Drug Courts but for most types of problem-solving court programs. The West Virginia ADC is operated under policies and procedures established in consultation with the Supreme Court of Appeals of West Virginia. All ADCs use evidence-based treatment approaches and assessments and are to be evaluated annually.

Program components include intensive supervision; frequent, random, and observed drug testing; meetings between participants and their probation officer; counseling sessions for participants; court appearances for participants; and community service.

The program seeks to achieve a reduction in recidivism and substance abuse among offenders and to increase the likelihood of successful rehabilitation through early, continuous, and intense treatment; mandatory periodic drug testing; community supervision; appropriate sanctions and incentives; and other rehabilitation services, all of which is supervised by a judicial officer.

For State Fiscal Year 2018 the average annual cost per drug court participant was \$3,814 as compared to \$19,425 in the Regional Jail or \$26,081 in a Division of Corrections and Rehabilitation prison. These costs include intensive supervision, treatment, case management, and drug testing.

As of June 30, 2018, there were 28 operating ADC programs comprising 34 individual courts covering 46 counties.

Update 2021:

For State Fiscal Year 2019, the average annual cost per drug court participant was \$3,794 as compared to approximately \$19,425 in a regional jail or \$26,081 in a Division of Corrections and Rehabilitation prison. These costs include intensive supervision, treatment, case management, and drug testing. There were 909 participants served by the West Virginia ADC Program in State Fiscal Year 2019.

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As of June 30, 2019, there were 28 operating ADC programs comprising 34 individual courts covering 46 counties.

Update 2022:

For State Fiscal Year 2020, the average annual cost per drug court participant was \$5,045 as compared to approximately \$19,425 in a regional jail or \$26,081 in a Division of Corrections and Rehabilitation prison. These costs include intensive supervision, treatment, case management, and drug testing. There were 897 participants served by the West Virginia ADC Program in State Fiscal Year 2019. As of June 30, 2020, there were 28 operating ADC programs comprising 34 individual courts that cover 46 counties.

The West Virginia Juvenile Drug Court Program

The West Virginia Juvenile Drug Court (JDC) Program is a cooperative effort of the juvenile justice, social service, substance abuse treatment, law enforcement and education systems.

JDCs are established in accordance with West Virginia Code §49-4-703 and are designed and operated consistent with the developmental and rehabilitative needs of the juveniles and operate under uniform protocol and procedures established by the Supreme Court of Appeals of West Virginia.

The program seeks to divert non-violent, juvenile offenders engaging substance abuse from the traditional juvenile court process to a non-adversarial, intensive, individualized outpatient substance abuse treatment process which includes parental involvement and cooperation. All JDCs use evidence-based treatment approaches and assessments and are evaluated annually.

Program components include intensive supervision; frequent, random, and observed drug testing; meetings between juveniles and probation officer and parents and probation officer; counseling sessions for juveniles and for families; court appearances for juvenile and parents; and community service.

For State Fiscal Year 2018, the average cost per youth was \$1,057. This cost includes intensive supervision and individualized treatment services and includes services to the family. This contrasts with the approximately \$110,000 annually in a residential or correctional facility placement. There were 291 participants served by the JDC programs for State Fiscal Year 2018.

As of June 30, 2018, there were 16 operational JDC programs.

Update 2021:

For State Fiscal Year 2019, the average cost per youth was \$3,113. This cost includes intensive supervision and individualized treatment services and includes services to the family. This contrasts with the minimum

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\$100,000 annually in a residential or correctional facility placement. There were 375 participants served by the JDC programs for State Fiscal Year 2019.

As of June 30, 2019, there were 117 operational JDC programs.

Update 2022:

For State Fiscal Year 2020, the average cost per youth was \$3,522. This cost is primarily for the intensive supervision, contingency management, and drug testing. The cost contrasts with the minimum \$100,000 annually in a residential or correctional facility placement. There were 331 participants served by the JDC programs for State Fiscal Year 2020.

As of June 30, 2020, there were 17 operational JDC programs in the state.

Family Treatment Court

West Virginia is going to use the Family Treatment Court model to address cases entering the child welfare system that allege child abuse or neglect involving parental use of alcohol or other drugs. The family treatment court's mission is to ensure the safety and well-being of children and to offer parents a viable option to reunify with their children. A family treatment court does this by providing children and parents with the skills and services necessary to live productively and establish a safe environment for their families. The court partners with child protective services and an array of service providers for parents, children, and families. The Family Treatment Court includes an interdisciplinary team working together to address the complex issues facing families affected by substance use disorders. Family treatment court draws on best practices from the treatment court model, dependency court, and child welfare services to effectively manage cases within ASFA mandates. In this way, family treatment court ensures the best interests of children while providing necessary services to parents.

Update 2021:

The Family Drug Treatment Court established a State Family Treatment Court Advisory Committee. The State Committee membership includes members from the DHHR, service providers and other stakeholders. The State committee met on three different occasions in 2019.

In 2019, Boone and Ohio counties had fully functioning Family Treatment Courts. Boone county served 12 parents and 22 children. Ohio county served six parents and 12 children. Randolph, Roane, and Nicholas Counties were at the beginning stages of operation.

Update 2022:

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As of June 30, 2020, Family Treatment Courts were in Boone, Nicholas, Ohio, Randolph, and Roane counties and were serving approximately 50 participants.

Transitioning Youth from Foster Care

In 2018, the Commission to Study Residential Placement of Children, Service Delivery and Development (SDD) Workgroup updated the It's My Move wallet cards to include a scan code that links directly to the It's My Move website. The It's My Move website is a program that assists youth in gaining life skills to support them as they transition to adulthood. The website includes the Readily at Hand checklist of key documents and experiences needed as youth transition to adulthood. Youth can set up their own account, track their own progress, add notes, and save their information as they move through the checklist.

The following related goals are underway or have been achieved:

- Readily at Hand, <http://www.itsmymove.org/rah.php>, is an online and printable checklist of essential skills and experiences and links to information about needed documents. Updates to the website are currently underway.
- Youth who are transitioning to adulthood are provided the desk guide and wallet card for the It's My Move website, www.ItsMyMove.org/raf.php. The wallet cards have been updated to include a scan code that links to It's My Move and Readily at Hand.

Update 2021:

Any further updates regarding Transitioning Youth from Foster Care will be located in the John H. Chafee section.

Update 2022:

Any further updates regarding Transitioning Youth from Foster Care will be located in the John H. Chafee section.

West Virginia Interagency Consolidated Out-of-State Monitoring

The West Virginia Interagency Consolidated Out-of-State Monitoring process continues 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 DHHR and WVDE standards.

The following summary outlines the 2018 out-of-state monitoring visits. While violations are noted, each facility also had positive programming aspects and is working on weaknesses through corrective action plans:

- Hermitage Hall, Nashville, TN – This was a return visit completed in January 2018. The facility was previously reviewed in November 2016 and since that time had four requests for investigations. Educational weaknesses identified included teacher certification issues; wide spans of grade levels

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in elementary and middle grade classrooms; lack of Career Technical Education (CTE) options; lack of structure leading to excessive restraints; no continuum of services for students with disabilities; expired IEPs; scheduling issues; and confusion about the rights of parents who retain educational rights.

- Devereux, Viera, FL – The review was completed in March 2018. No major violations were found – Devereux has a very low turnover rate of employees with many in the school and on the treatment, team employed for more than 20 years. Strengths identified include teachers are certified in special education; classrooms are observed four times per week through observation rooms; excellent technology availability and use; lesson plans are standard-based and contain quality instruction; educational field trips are provided monthly; and outdoor recreation opportunities are provided for students. A change in Florida State Standards no longer requires CTE coursework to graduate. Therefore, Devereux currently has no CTE programming in place where formerly they had an on-site cosmetology program. The facility administration was encouraged to develop partnerships for students to participate in community-based opportunities for work experience and career planning.
- George Junior Republic, Grove City, PA – A follow-up visit was conducted in March 2018. A DHHR team along with one WVDE representative visited George Junior to determine progress since the placements to this facility were suspended in January 2015. The team had the same concerns after the visit regarding treatment of WV youth, details of programming and attitude towards feedback and discussion regarding changes that should be considered.
- Timber Ridge, Winchester, Virginia – A review was completed in May 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, Transition Services, including a focus on the lack of CTE offerings, and Notification to Transition Specialist of Upcoming Discharges to provide support and planning with the home county in West Virginia.
- Natchez Trace, Waverly, TN – A review was completed in September 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, provision of FERPA training to school staff, and Notification to Transition Specialist of Upcoming Discharges.
- Foundations for Living, Mansfield, Ohio – A review was completed November 2018 (reports pending). Weaknesses identified include no CTE programs offered due to acute care in self-harm, trafficking, drug and alcohol treatment, and mental health concerns.

Update 2021:

The West Virginia Interagency Consolidated Out-of-State Monitoring process continues 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 DHHR and WVDE standards.

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The following summary outlines the 2019 out-of-state monitoring visits. While violations are noted, each facility also had positive programming aspects and is working on weaknesses through corrective action plans:

- ***New Hope Carolinas, South Carolina*** – *The review was completed in January 2019 and since that time has not had any requests for investigations. Educational weaknesses identified; the IEPs are not always completed timely when students arrive from West Virginia and the school schedules do not consistently reflect the services stipulated in the IEP. However, the classrooms were bright, inviting and had productive and positive interactions with student engagement. Another minor issue is that leave forms from home visits were rarely completed by parents (or responsible person) so it was difficult to determine if the visit was successful. On a positive note, treatment planning meetings are scheduled when the guardian is available, and youth get substance abuse education group on a 12-week rotation. The living units within the facility continue to appear dirty in some areas. However, there was definite improvement in the overall appearance of the units since the team’s last visit in August 2018.*
- ***Hughes Center Danville, Virginia*** – *The review was completed in April 2019. There were two requests for investigation in 2019. The school environment is strong. Teachers work collaboratively with the treatment team and use relevant data from the treatment teams to update IEPs and provide feedback to parents. Students can earn rewards and privileges based on their progress. There were zero restraints reported in the six months leading up to the review. Students were engaged in the classroom. One weakness identified in the school setting is that some students are in a classroom where a wide range of ages, grade levels and ability are served. There were significant issues with the physical plant of the Hughes Center. Directions were given for immediate changes. A cleaning crew was at the facility within an hour. A time limited corrective action plan was directed to address the issues. The reviewer returned to the Hughes Center in June 2019 to ensure all physical plant issues were corrected as directed. There were no issues identified at this visit.*
- ***Harbor Point, Portsmouth, Virginia*** – *A review was completed in May 2019. One request for investigation occurred in 2019. Overall Harbor Point had a positive review. The employee files had all necessary information and the background materials were 100% compliant. The youth were satisfied with the placement and can contact family in a timely manner. The incident reports were well written and contacts to parents and guardians were completed timely. EPSDT’s were completed within the required timelines. One noted improvement would be that the parents/guardians and youth do not consistently sign the treatment plans. One educational issue identified is the IEP and the students schedule do not always reflect the appropriate amount of time of special education. There were many positives in the area of education. Student material is well organized, there are varied instructional strategies implemented, good student to teacher ratio and students are actively engaged.*
- ***Liberty Point, Staunton, Virginia*** – *A review was completed in September 2019. Two requests for investigation were received in 2019. Educationally, students are treated with respect and report*

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being satisfied with education and feel safe. Liberty Point staff members, including teachers, are trained every six months in verbal de-escalation and Handle with Care procedures. IEP stipulated service minutes and schedule are not always consistent. Treatment plans had a few deficiencies. The treatment plans are not being consistently signed or reviewed for progress nor updated as needed. However, 100% of the policy/procedures met criteria required for facilities providing services to West Virginia children. Some employee records lacked the appropriate training documentation. Liberty point has strong programing strengths. They maintain detailed policies geared toward positive and pro-active staff interactions with residents. Supervision policies provide specificity to staff for supervision expectations in nearly every environment that could be anticipated for residents. Residents report a sense that staff is invested in their success and that there is always support available to them when needed.

Gulf Coast, Ft. Walton, Florida – A review was completed December 2019 (reports pending). No major issues were reported during the review.

Update 2022:

The West Virginia Interagency Consolidated Out-of-State Monitoring process continues 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 DHHR and WVDE standards.

Due to the COVID 19 pandemic, out-of-state monitoring visits were placed on hold. One out-of-state monitoring visit occurred in January 2020 prior to the pandemic.

▪ **The Children’s Center of Ohio, Ohio** - The review was completed in January 2019. As a result of the monitoring review, the West Virginia Bureau for Children and Families (BCF) suspended placements with The Children’s Center of Ohio. The suspension of placements remains at this time.

Agency Responsiveness to the Community

The Division of Planning and Quality Improvement (DPQI) utilizes Child and Family Service (CFSR) style reviews to evaluate case practice with children and families. Specifically, to the WV Service Array, the DPQI identify service gaps through the reviews and focus groups with parents, youth, and stakeholders.

In addition to the Division of Planning and Quality Improvement (DPQI) process, the West Virginia Community Collaborative Groups (Collaboratives) identify and address service gaps in their communities. The Collaboratives were originally formed in the late 90’s with the purpose of continuous community assessment over specified geographical areas. In 2014, West Virginia was federally approved by the Administration for Children and Families to develop the IV-E demonstration project (known as Safe at Home WV). As part of Safe at Home WV, Community Collaborative groups play a key role in identifying these community-based services and, if needed, assist in developing services based on the needs of the children and families in their community. The Collaboratives have a sense of “community ownership” for

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children at-risk of being placed in out-of-home care and keeping children closer to their families and home communities when they must be placed out-of-home.

The Collaboratives are expected to provide bi-annual reports to the Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF). However, not all Collaboratives provide these reports, they are not always provided consistently, the reports are not reviewed through a formal service development plan, the DHHR, BCF does not have a Memorandum of Understanding that formalized this relationship, and the information is not included in a formal service delivery and development plan for identifying service needs and gaps.

Although the Collaboratives continue to meet, some Collaboratives do not consistently provide community data reports on the service needs and gaps. The needs and gaps are reported to the four Regional Summits as well as the Regional CQI team. Community Service Managers are mandated members of each of these teams. They are to notify their Regional Director of these gaps in service and the Regional Director is to report the information to Bureau for Children and Families Leadership.

The Bureau for Children and Families has notified newer Community Services Managers of their responsibility to participate in each of these groups and their responsibility to make their Regional Director aware of any information shared at the Summits.

Update 2021:

The West Virginia Children and Families Service Review, Program Improvement Plan (PIP) was approved in December of 2019. As a strategy in the PIP, WV DHHR will develop a Service Communication Plan to standardize and strengthen communications between the DHHR and Community Collaborative Groups. This communication plan will assist in identifying service needs and gaps. The development of this communication plan started in 2020 and currently being worked on.

Additional PIP activities include the development of A Memorandum of Understanding (MOU) between the DHHR and the Community Collaborative Group to establish the responsibilities of each party as they relate to the West Virginia Semi-Annual Service Gaps Reports. During 2020, a MOU was drafted and will be revised, as needed, to form a final version.

Update 2022:

Bi-annually (State Fiscal Year), the Community Collaborative Group submits the Semi-Annual Report on service gaps to the Bureau for Children and Families Community Partnership Unit. The Semi-Annual Report from the Community Collaborative Groups includes service gaps, actions to be taken to remedy the gap identified, and the challenges the Community Collaborative Group face.

During 2021 this Service Communication Plan will be implemented and monitored to ensure appropriate feedback is obtained by all parties involved in the plan.

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For more information on the Communication Plan for Collaboratives, please see the Service Array section of this report.

During 2020, due to the COVID pandemic, DHHR initialized individual weekly meetings with several groups of providers: Child Placing Agencies, Residential Providers and Socially Necessary Service providers. These meetings were held weekly during the first few months of the pandemic to discuss any guidance that may have been released as well as issues the providers were having delivering services or obtaining PPE.

The meetings with each individual group have continued but were changed to bi-weekly meetings in the summer of 2020. Topics have included obtaining PPE, new CDC guidance, new state directives and vaccination information.

In addition, in March 2021, bi-weekly meetings with Child Placing agencies have been initiated to discuss developing new contracts that focus less on quantitative reporting data and more on performance-based outcomes. These will continue until the end of May 2021 when new contracts will be developed.

To send information out to kinship/relative providers quickly in 2020, Mission West Virginia developed a website <https://www.missionwv.org/kinship>. The website lists standard information for formal and informal relative caregivers: legal, financial, kinship navigators, homestudy process, CPS/court process, etc. Additionally, there is a section for posting current updates and announcements from DHHR. When a new announcement is posted MWV conducts an automated call to DHHR providers, using a contact list provided by DHHR. The call directs families to the website so that they can view the full announcement. Many families also contact MWV after receiving the call, either by calling back or filling out an assistance form on the website. For each call, MWV generally talks to 30-40 families, who either have questions about the call or many who just have questions about their individual cases.

The announcements made in 2020 were as follows:

- *June: A posting was made on a DHHR directive regarding COVID and travel to “hotspots”*
- *July: A call was made to introduce families to the website and suggest that they bookmark the site and check it regularly for news and announcements.*
- *September: A call and posting focused on the change in foster care payment rates.*
- *October: A call and posting advised families of a survey by the Court Improvement Board, seeking input from foster and kinship/relative families.*
- *November: A call and posting were made concerning a change to payment rates and an additional demand payment.*
- *December: A posting was made concerning the Child Crisis and Referral line for behavioral health emergencies.*

Communication and Dissemination Process

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The Family Resource Networks (FRNs), currently develop the Family Resource Directories for each of the fifty-five counties in West Virginia annually. The FRNs support and promote the collaboration of all citizens in order to develop strategies for communities to succeed. Recently, the FRNs began putting their directories on a central website. This website was possible because a Benedum grant that was awarded to the Marshall County FRN. The Bureau for Children and Families recently required, as a part of the FRN Contract, the FRNs to utilize the central website as their resource directory. WV does need to develop a standardized process for the FRN's that will address how the information is to be gathered and how often the website needs to be updated and monitored.

In January 1, 2018 through June 30, 2018, seven (7) of the thirteen (13) Community Collaboratives (Family Central; Family Southern; Family Ways; Little Kanawha; Nicholas-Webster; Fayette/Raleigh; and Upper Potomac) reported for the **January 1, 2018 through June 30, 2018** biannual report. Of the seven (7) Collaboratives that reported, five (5) reported that they were addressing substance abuse issues and five (5) reported addressing foster parent recruitment/retention.

In July 1, 2018 through December 31, 2018, nine (9) of the thirteen (13) Community Collaboratives (Family Central; North Central; Nicholas-Webster; Family Ways; Upper Potomac; Family Southern; South Central; Raleigh/Fayette; and Greenbrier) reported for the **July 1, 2018 through December 31, 2018** biannual report. Of the nine (9) Collaboratives that reported, eight (8) reported that they were addressing substance abuse issues and four reported addressing foster parent recruitment/retention.

Other issues that were being addressed by the Collaboratives during the 2018 calendar year were: Respite/Wraparound; Increasing Collaborative Membership/Key Partners; School Based Behavioral Health; Family Support/Basic Needs; Family/Youth Mentoring and Support; Support for Safe at Home WV program; Youth Transitioning; Recruitment and Retention of DHHR staff; Expanding Court Appointed Special Advocates (CASA); Multidisciplinary Treatment Teams; Truancy Diversion; and School Education on Mental Health Services for Children and Families.

Program Plan to be Implemented:

<p>1.1 Partner with the Capacity Building Center to develop a Service Array map of available substance abuse services throughout the state (utilizing work of the DHHR, Bureau for Behavioral Health (ranking)), and what barriers exist. Map development completed and will include:</p> <ul style="list-style-type: none">• Identify type of services needed• Barriers for substance abuse services are identified
<p>1.2 Service Array Workgroup will meet at least monthly to collect information to develop map of service availability.</p>
<p>2.1 West Virginia will partner with the Family Resource Networks to provide Service Directories of available services on the FRN website that can be accessed by all DHHR staff and stakeholders.</p>

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2.2 Staff will be notified of the website and Resource Directories through short blackboard training
2.3 Staff will be notified quarterly through PSA blasts that highlight new services
2.4 Provide information on WV DHHR Facebook on FRN website and Resource Directories.
2.5 Service Array Workgroup will meet at least monthly to collect information to develop map of service availability.
2.6 WV DHHR will develop and execute a formal statewide communication plan that will include all DHHR Bureaus (and others as needed) to improve cross-system service provision (identifying service availability, accessibility, barriers, and service development).
2.6.1 Memorandum of Understanding between all DHHR Bureaus <ul style="list-style-type: none">• Memorandum of Understanding between DHHR and Community Collaborative Groups completed (July 1, 2019)• Standardize communication process completed that:• Applies the Service Array map and Community Collaborative Group reports for evaluation of service development and expansion.• Formal Communication Plan utilized for service development

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.

Stakeholder Focus Group

As of March 2020, KEPRO is no longer the contracted entity with the WV DHHR that manages Socially Necessary Services and Medically Necessary Services. While some functions remained subcontracted to the new vender, Aetna Better Health, focus groups are not. The contractual change occurred during this rating period. Therefore, the number of focus groups completed overall will be less than previous years.

KEPRO conducted focus groups with families, foster parents, and youth to assist the department in identifying systemic issues including gaps in service and general practice. Below are summaries of the information that was discovered during these groups.

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In March 2020, a new contract was initiated between the WV DHHR and Aetna Better Health of WV (ABHWV) to bring all children currently in foster care and children with completed adoptions and legal guardianship cases under managed care. This contract included the members receiving Socially Necessary Services. As part of the contract, ABHWV assumed control of the SNS focus groups from KEPRO, the previous vendor.

When ABHWV assumed control of the SNS focus groups, the process was changed from having new members for each focus group to a group that maintained the same members for a year. Also, due to COVID-19 restrictions, the meetings were held virtually with no in-person option from June 2020 to June 2021. The first focus group for SNS was held on June 29, 2020 and was comprised of biological parents of children who had been removed and put into WV DHHR custody. The parents and the children received SNS during the removal episodes. One family received SNS before the removal episode as well. Due to having the same members for the next year, all focus group questions were not asked at the first meeting or at subsequent meetings. The questions were split out and covered over the course of a year.

The first meeting introduced the focus group members to the purpose of the group, the ground rules, ABHWV facilitation staff, and each other. The members explained their reasons for wanting to participate in the focus group. One member said she wanted to improve the system and remove some of the barriers she encountered. Another member stated that she was not pleased with the SNS she received, especially the service of Supervision while she was still in the Family Preservation section of her case. She found the service to be disruptive and “creepy”. She stated that the SNS provider did not give her any reason for why the service was provided, what he/she was looking for while in the home. She stated that the CPS worker on the case also did not elaborate what purpose the service served. She said that once her children were removed, her visitation times and locations were constantly changing. She said that lack of communication led to service disruption and cancelled visitation.

One member said that if she would have had a service navigator or a peer support specialist that specialized in CPS, she would have made more progress. She said she felt “lost” all the time. She never really understood the court process, the seriousness of her situation, and what the next steps should be. She said that at the second hearing, the judge told her that he was going to terminate her parental rights and that she would never see her child again. That was the first time she understood the seriousness of the situation and began really participating in an improvement period.

2018 Annual Youth Stakeholder Focus Group Summary
Socially Necessary Services/Community Behavioral Health Services

During Contract Year 18-19, the Consumer & Community Affairs Liaison facilitated twelve (12) Focus Groups with youth, families and foster parents that reside in the community and utilize Socially Necessary Services (SNS) and Community Behavioral Health Services.

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The purpose of these focus groups is to provide youth 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. Information is gathered throughout the year with a minimum of twelve (12) focus groups that reflect consumers' voices regarding access, service delivery, cultural competency, and outcomes.

Total: Ninety-six (96) youth, family and foster parents utilizing Socially Necessary Services/Community BH Services

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
- Cultural competency
- Consumer knowledge of services and supports

1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural, and special needs groups?
One hundred percent (100%) or 96 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs.
2. Are intake forms or materials available in different languages?
One hundred percent (100%) or 96 respondents stated that materials were available in different languages.
3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
One hundred percent (100%) or 96 participants agreed that their agencies offered assistance for those with disabilities.
4. Does the agency have trained interpreters readily available for various languages, including sign language?
One hundred percent (100%) or 96 participants stated that the agencies had access to trained interpreters for various languages and sign language.
5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?

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One hundred percent (100%) or 96 participants agreed that the agencies had established connections to 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?

One hundred percent (100%) or 96 participants agreed that the agencies had established connections to serve diverse groups.

7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?

One hundred percent (100%) of those responding stated that they had attended one or more group holidays or community functions within diverse communities.

They were as follows:

Passover services	Holiday cook outs
Easter services	ethnic dining/meal prep
Various protestant church groups	Cultural Art Festival
Catholic services	Italian Festival
Christmas parties	Hanukkah services

8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?

One hundred percent (100%) of participants or 96 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues.

9. Do you have access to religious services in which you affiliate?

One hundred percent (100%) of participants or 96 respondents stated, "Yes."

10. Does your care provider (Family) alter your programming or care based on your values or culture?

One hundred percent (100%) of participants or 96 respondents stated, "Yes."

11. Do you feel your services are tailored to your needs?

Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."

12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?

One hundred percent (100%) or 96 participants agreed that visits were comfortable, both 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?

One hundred percent (100%) or 96 participants stated that they were allowed to stay in touch with extended family, kin and friend from home.

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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?
One hundred percent (100%) or 96 participants stated that they were able to contact family and friends via email, skype, face time, Facebook, etc. with supervision and timelines.
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?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
* To both questions
16. Do you have access to personal care items or services that match your needs? (Haircuts dye...)
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
17. Do you feel you get to express your personal style in clothing and appearance?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?
Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."
19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles?
Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."
20. Do you feel isolated or separated/segregated 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?
Eighty-two percent (82%) or 79 participants said, "No." Another eighteen percent (18%) or 17 participants said, "Yes."
21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
One hundred percent (100%) or 96 participants said, "Yes."
22. Have caregivers identified support groups, places, and people for you outside of the family setting?
One hundred percent (100%) or 96 participants said, "Yes."

Update 2021:

During Contract Year 2019, the Consumer & Community Affairs Liaison facilitated twelve Focus Groups with youth, families and foster parents that reside in the community and utilize Socially Necessary Services (SNS) and Community Behavioral Health Services.

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The purpose of these focus groups is to provide youth 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. Information is gathered throughout the year with a minimum of six focus groups that reflect consumers' voices regarding access, service delivery, cultural competency and outcomes.

Total: One hundred one youth, family and foster parents utilizing Socially Necessary Services/Community Behavioral Health Services

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*
- *Cultural competency*
- *Consumer knowledge of services and supports*

1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups? 100% or 101 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs.

2. Are intake forms or materials available in different languages? 55% or 56 respondents stated that materials were available in different languages; 45 % or 45 participants stated that they "did not know".

3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology. 92% or 93 participants agreed that their agencies offered assistance for those with disabilities; 8% or 8 participants were not sure.

4. Does the agency have trained interpreters readily available for various languages, including sign language? 100% or 101 participants stated that the agencies had access to trained interpreters for various languages and sign language.

5. Does the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups? 100% or 101 participants agreed that the agencies had established connections to 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? 54%

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or 55 participants agreed that the agencies had established connections to serve diverse groups; 46% or 46 participants stated “no”.

7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it? 100% of those responding stated that they had attended one or more group holidays or community functions within diverse communities.

They were as follows:

- Passover services
- Holiday cook outs
- Easter services
- Ethnic dining/meal prep
- Various protestant church groups
- Cultural Art Festival
- Catholic services
- Italian Festival
- Christmas parties
- Hanukkah services

8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues? 100% of participants or 101 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues.

9. Do you have access to religious services in which you affiliate? 100% of participants or 101 respondents stated, “Yes.”

10. Does your care provider (Family) alter your programming or care based on your values or culture? 100% of participants or 101 respondents stated, “Yes.”

11. Do you feel your services are tailored to your needs? 100% of participants or 101 respondents stated, “Yes.”

12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally? 100% or 101 participants agreed that visits were comfortable, both 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? 100% or 101 participants stated that they were allowed to stay in touch with extended family, kin and friend from home.

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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? 100% or 101 participants stated that they were able to contact family and friends via email, skype, face time, Facebook, etc. with supervision and timelines.*
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? 100% of participants or 101 respondents stated, "Yes," in regard to both questions.*
16. *Do you have access to personal care items or services that match your needs? (Haircuts dye...) 100% of participants or 101 respondents stated, "Yes."*
17. *Do you feel you get to express your personal style in clothing and appearance? 100% of participants or 101 respondents stated, "Yes."*
18. *Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues? 93% of participants or 94 respondents stated, "Yes"; another 6% or six participants said, "No."*
19. *Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles? 93% of participants or 94 respondents stated, "Yes"; another 7% or eight participants said, "No."*
20. *Do you feel isolated or separated/segregated 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? 92% or 93 participants said, "No"; 8% or eight participants said, "Yes."*
21. *Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex? 81% or 82 participants said no in response to both questions, while 11% or 11 participants had said it wasn't applicable; 8% or eight participants answered yes to both questions.*
22. *Have caregivers identified support groups, places, and people for you outside of the family setting? 100% or 101 participants said, "Yes."*

Update 2022:

2020 Annual People Stakeholder Focus Group Summary

Socially Necessary Services/Community Behavioral Health Services

Kepro facilitated six focus groups with 61 youth and families receiving Socially Necessary Services. The purpose of these focus groups is to provide those receiving services from BCF in West Virginia the

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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. Information is gathered throughout the period regarding access, service delivery, treatment plan goals, cultural competency and outcomes. The focus group questions were developed with input from the Bureau for Children and Families.

The intent of these questions is to generate responses identifying systemic issues regarding consumer perceived problems and solutions regarding:

- *Access*
- *Service delivery*
- *Gaps in support systems*
- *Engagement with system staff*
- *Cultural competency*
- *Consumer knowledge of services and supports*

Please note that at various times during this period, COVID 19 restrictions were in place. Face-to-face focus groups were suspended. The Aetna MCO contract took over the SNS focus groups in March 2020 so Kepro's time-period was shortened to nine months.

In March 2020, a new contract was initiated between the WV DHHR and Aetna Better Health of WV (ABHWV) to bring all children currently in foster care and children with completed adoptions and legal guardianship cases under managed care. This contract included all children in in-state Residential Treatment Facility (RTF) care. As part of the contract, ABHWV assumed control of the RTF focus groups from KEPRO, the previous vendor.

The format for RTF focus groups under Aetna changed to a virtual format due to COVID-19 restrictions. Meetings were held with the children in the facilities every other month. Then meetings were held with the parents of some of the children in alternating months. This format allows ABHWV staff to gather information from the parents and the children interacting with the in-state residential treatment facilities. The first RTF focus group was held on 7/30/2020 so it will be covered in the next APSR.

1. *Is your current agency committed to providing health and educational materials that appeal to various social, cultural and special needs groups?*

84% or 51 people responded "yes." 11% or 7 people responded "no." 3% or two people did not know and one person or 2% did not respond.

2. *Are intake forms or materials available in different languages?*

21% or 13 people said "yes". 21% or 13 people said "no". 58% or 35 people did not know.

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3. *Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.*

75% or 46 people responded "yes". 23% or 14 people responded "no". 2% or one person did not know.

4. *Does the agency have trained interpreters readily available for various languages, including sign language?*

58% or 35 people responded "yes". 21% or 13 people did not know.

5. *Does the agency have established connections with various community, cultural, ethnic and religious groups to help better serve diverse groups?*

87% or 53 people responded "yes". 10% or 6 people responded "no". 3% or two people did not know.

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?*

69% or 42 people responded "yes". 23% people responded "no". 8% or five people did not know.

7. *Do you have the opportunity to attend racial group holidays or functions within diverse communities?*

67% or 41 people did have opportunities. 31% or 19 people responded "no". 2% or one person did not know.

8. *Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?*

67% or 41 people responded "yes". 33% responded "no".

9. *Do you have access to religious services in which you affiliate?*

90% or responded "yes". 8% or five people responded "no". 2% did not know.

10. *Does your provider alter your programming or care based on your values or culture?*

67% or 41 people responded "yes". 33% or 20 people responded "no".

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11. *Do you feel your services are tailored to your needs?*

62% or 38 people responded "yes". 38% or 23 responded "no".

12. *Are visitations arranged in situations you and your family are comfortable- physically and emotionally?*

85% or 52 people responded "yes". 3% responded "no". 12% or seven people did not know.

13. *Are you allowed visits with siblings, extended family, kin, or your friends you want to keep in touch with from home?*

77% responded "yes". 5% or 3 people responded "no". 18% or 11 people did not know.

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?*

62% or 38 people responded "yes". 36% responded "no". 2% did not know.

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?*

62% or 38 people responded "yes". 36% or 22 people responded "no". 2% or one person did not know.

16. *Do you have access to personal care items or services that match your needs? (haircuts, dye...)*

87% or 53 people responded "yes". 13% or 8 people responded "no".

17. *Do you feel you get to express your personal style in clothing and appearance?*

69% or 42 people responded "yes". 29% responded "no". 2% or one person did not know.

18. *Does staff understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?*

46% or 28 people responded "yes". 50% people responded "no". 2% did not know and 2% did not answer.

19. *Do you feel that staff uses inclusive language rather than identifying activities based on stereotyped gender roles?*

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46% or 28 people responded “yes”. 52% responded “no”. 2% or one person did not respond.

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 people would receive?*

23% or 14 people responded “yes”. 72% responded “no”. 5% or three people did not know.

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?*

23% or 14 people responded “yes”. 59% or 36 people responded “no”. 18% or 11 people did not know.

22. *Has staff identified support groups, places, and people for you outside of the facility?*

52% or 32 people responded “yes”. 41% or 25 people responded “no”. 7% or 4 people did not know.

2018 Annual Youth Stakeholder Focus Group Summary

Medically Necessary Services - Behavioral Health/Residential Facilities

The Kepro Consumer & Community Affairs Liaison facilitated twelve (12) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities.

The purpose of these focus groups is to provide youth 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. Information is gathered throughout the year with a minimum of twelve (12) focus groups that reflect consumers’ voices regarding access, service delivery, treatment plan goals, cultural competency and outcomes.

One hundred thirty-six (136) youth receiving behavioral health treatment placed in residential settings. 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

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- Service delivery
 - Gaps in support systems
 - Engagement with system staff
 - Cultural competency
 - Consumer knowledge of services and supports
1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
Seventy-six percent (76%) or 103 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs, while twenty-four percent (24%) or 33 participants were unsure.
 2. Are intake forms or materials available in different languages?
Seventy-eight percent (78%) or 106 respondents were unsure if materials were available in different languages, while eighteen percent (18%) or 24 participants stated that the agencies did provide alternative language formats. Four percent (4%) or 6 respondents stated that forms were available in different formats.
 3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
Eighty-four percent (84%) or 114 participants agreed that their agencies offered assistance for those with disabilities, while sixteen percent (16%) or 22 participants weren't sure.
 4. Does the agency have trained interpreters readily available for various languages, including sign language?
Ninety-five percent (95%) or 129 participants stated that the agencies had access to trained interpreters for various languages and sign language. Five percent (5%) or 7 respondents did not know.
 5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
Sixty-seven percent (67%) or 91 participants agreed that the agencies had established connections to serve diverse groups, while twenty percent (20%) or 27 participants said, "No." Thirteen percent (13%) or 18 participants didn't know or had had no response.
 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?
Sixty-nine percent (69%) or 94 of those responding agreed that the agencies had sponsored at least one activity that promoted teamwork and communication between cultural and ethnic groups. Thirty-one percent (31%) or 42 participants said, "No."

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7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?
Sixty-seven percent (67%) or 91 of those responding stated that they had not attended group holidays or community functions within diverse communities. While Thirty-three percent (33%) or 45 had and they were as follows:
- | | |
|-------------------|-------------------------|
| Passover services | Holiday cook outs |
| Easter services | Ethnic dining/meal prep |
| Christmas parties | |
8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
Thirty-three percent (33%) of participants or 45 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues, while sixty-three percent (63%) or 85 participants had not. Four percent (4%) or 6 participants gave no response.
9. Do you have access to religious services in which you affiliate?
Seventy-six percent (76%) of participants or 104 respondents stated, "Yes." While twenty-three percent (23%) or 31 respondents said no. One (1) person did not respond.
10. Does your care provider (Family) alter your programming or care based on your values or culture?
Seventy-two percent (72%) of participants or 98 respondents stated, "Yes." While twenty-eight percent (28%) or 38 respondents said, "No."
11. Do you feel your services are tailored to your needs?
Sixty-eight percent (68%) of participants or 92 respondents stated, "Yes." While thirty-two percent (32%) or 44 participants said, "No."
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?
Eighty-five percent (85%) or 115 participants agreed that visits were comfortable, both physically and emotionally, while fifteen percent (15%) or 21 participants had no family visits due to parental rights being terminated.
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?
Eighty-five percent (85%) or 115 participants agreed that visits were comfortable, both physically and emotionally, while fifteen percent (15%) or 21 participants had no family visits due to parental rights being terminated.
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?
Seven percent (7%) or 9 participants stated that they were able to contact family and friends via email, skype, face time, Facebook, etc. with supervision and timelines; while ninety-three percent (93%) or 127 respondents agreed that other than face-face visitation they were only allowed to use the phone.

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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?
Seventy-four percent (74%) of participants or 100 respondents stated, “Yes.” While twenty-six percent (26%) or 36 participants said, “No.”
To both questions
16. Do you have access to personal care items or services that match your needs? (Haircuts dye...)
Eighty percent (80%) of participants or 109 respondents stated, “Yes.” Twenty percent (20%) or 27 participants said their personal care needs weren’t met.
17. Do you feel you get to express your personal style in clothing and appearance?
Eighty-five percent (85%) of participants or 115 respondents stated, “Yes.” While fifteen percent (15%) or 21 respondents said, “No.”
18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?
Seventy-two percent (72%) or 98 participants said, “Yes of the three questions.” Twenty-six percent (28%) or 38 respondents answered no to all three questions.
19. Do you feel that caregivers’ uses inclusive language rather than identifying activities based on stereotyped gender roles?
Seventy-two percent (72%) or 98 participants said, “Yes.” Twenty-six percent (28%) or 38 respondents answered no.
20. Do you feel isolated or separated/segregated 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?
Forty-eight percent (48%) or 66 participants gave no response to both questions, while forty-five percent (45%) or 61 respondents answered no to both questions. Seven percent (7%) or 9 participants said, “Yes.”
21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
Sixty-eight percent (68%) or 92 participants gave no in response to both questions, while thirty-two percent (32%) or 44 respondents answered no to both questions.
22. Have caregivers identified support groups, places, and people for you outside of the family setting?
Forty-five percent (45%) of participants or 61 respondents stated, “Yes.” There were identified supports outside the facilities, while another forty-five percent (45%) or 62 participants said, “No.” Ten percent (10%) or 13 participants had no comment.

Update 2021:

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The KEPRO Consumer & Community Affairs Liaison facilitated six Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities.

The purpose of these focus groups is to provide youth 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. Information is gathered throughout the year with a minimum of six focus groups that reflect consumers' voices regarding access, service delivery, treatment plan goals, cultural competency and outcomes.

Total: 61 youth receiving behavioral health treatment placed in residential settings.

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*
- *Cultural competency*
- *Consumer knowledge of services and supports*

Is your current agency committed to providing health and educational materials that appeal to various social, cultural and special needs groups? 84% or 51 youth responded "yes"; 11% or seven youth responded "no"; 3% or two youth did not know; and, one youth or 2% did not respond.

Are intake forms or materials available in different languages? 21% or 13 youth said "yes"; 21% or 13 youth said "no"; and, 58% or 35 youth did not know.

Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology. 75% or 46 youth responded "yes"; 23% or 14 youth responded "no"; and, 2% or one youth did not know.

Does the agency have trained interpreters readily available for various languages, including sign language? 58% or 35 youth responded "yes"; 21% or 13 youth did not know.

Does the agency have established connections with various community, cultural, ethnic and religious groups to help better serve diverse groups? 87% or 53 youth responded "yes"; 10% or six youth responded "no"; and, 3% or two youth did not know.

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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? 69% or 42 youth responded “yes”; 23% youth responded “no”; and, 8% or five youth did not know.

Do you have the opportunity to attend racial group holidays or functions within diverse communities? 67% or 41 youth did have opportunities; 31% or 19 youth responded “no”; 2% or one youth did not know.

Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues? 67% or 41 youth responded “yes”; 33% responded “no”.

Do you have access to religious services in which you affiliate? 90% or responded “yes”; 8% or five youth responded “no”; and, 2% did not know.

Does your provider alter your programming or care based on your values or culture? 67% or 41 youth responded “yes”; 3% or 20 youth responded “no”.

Do you feel your services are tailored to your needs? 62% or 38 youth responded “yes”; 38% or 23 responded “no”.

Are visitations arranged in situations you and your family are comfortable- physically and emotionally? 85% or 52 youth responded “yes”; 3% responded “no”; and, 12% or seven youth did not know.

Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home? 77% responded “yes”; 5% or 3 youth responded “no”; and, 18% or 11 youth did not know.

Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, Skype, FaceTime, texting, Twitter, Facebook, Instagram, Snap Chat? 62% or 38 youth responded “yes”; 36% responded “no”; and, 2% did not know.

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? 62% or 38 youth responded “yes”; 36% or 22 youth responded “no”; and, 2% or one youth did not know.

Do you have access to personal care items or services that match your needs? (haircuts, dye...) 87% or 53 youth responded “yes”; 13% or eight youth responded “no”.

Do you feel you get to express your personal style in clothing and appearance? 69% or 42 youth responded “yes”; 29% responded “no”; and, 2% or one youth did not know.

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Does staff understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues? 46% or 28 youth responded “yes”; 50% youth responded “no”; and, 2% did not know and 2% did not answer.

Do you feel that staff uses inclusive language rather than identifying activities based on stereotyped gender roles? 46% or 28 youth responded “yes”; 52% responded “no”; and 2% or one youth did not respond.

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? 23% or 14 youth responded “yes”; 72% responded “no”; and 5% or three youth did not know.

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? 23% or 14 youth responded “yes”; 59% or 36 youth responded “no”; and 18% or 11 youth did not know.

Has staff identified support groups, places, and people for you outside of the facility? 52% or 32 youth responded “yes”; 41% or 25 youth responded “no”; and 7% or four youth did not know.

Update 2022:

2020 Annual Youth Stakeholder Focus Group Summary

Medically Necessary Services - Behavioral Health/Residential Facilities

Kepro completed focus groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities.

The purpose of these focus groups is to provide youth 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.

45 youth receiving behavioral health treatment placed in residential settings 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

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- *Engagement with system staff*
- *Cultural competency*
- *Consumer knowledge of services and supports*

1. *Is your current agency committed to providing health and educational materials that appeal to various social, cultural, and special needs groups?*

84% or 51 youth responded “yes.” 11% or 7 youth responded “no.” 3% or two youth did not know and one youth or 2% did not respond.

2. *Are intake forms or materials available in different languages?*

21% or 13 youth said “yes”. 21% or 13 youth said “no”. 58% or 35 youth did not know.

3. *Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.*

75% or 46 youth responded “yes”. 23% or 14 youth responded “no”. 2%, or one youth did not know.

4. *Does the agency have trained interpreters readily available for various languages, including sign language?*

58% or 35 youth responded “yes”. 21% or 13 youth did not know.

5. *Does the agency have established connections with various community, cultural, ethnic and religious groups to help better serve diverse groups?*

87% or 53 youth responded “yes”. 10% or 6 youth responded “no”. 3% or two youth did not know.

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?*

69% or 42 youth responded “yes”. 23% youth responded “no”. 8% or five youth did not know.

7. *Do you have the opportunity to attend racial group holidays or functions within diverse communities?*

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67% or 41 youth did have opportunities. 31% or 19 youth responded “no”. 2% or one youth did not know.

8. *Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?*

67% or 41 youth responded “yes”. 33% responded “no”.

9. *Do you have access to religious services in which you affiliate?*

90% or responded “yes”. 8% or five youth responded “no”. 2% did not know.

10. *Does your provider alter your programming or care based on your values or culture?*

67% or 41 youth responded “yes”. 33% or 20 youth responded “no”.

11. *Do you feel your services are tailored to your needs?*

62% or 38 youth responded “yes”. 38% or 23 responded “no”.

12. *Are visitations arranged in situations you and your family are comfortable- physically and emotionally?*

85% or 52 youth responded “yes”. 3% responded “no”. 12% or seven youth did not know.

13. *Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?*

77% responded “yes”. 5% or 3 youth responded “no”. 18% or 11 youth did not know.

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?*

62% or 38 youth responded “yes”. 36% responded “no”. 2% did not know.

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?*

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62% or 38 youth responded “yes”. 36% or 22 youth responded “no”. 2% or one youth did not know.

16. *Do you have access to personal care items or services that match your needs? (haircuts, dye...)*

87% or 53 youth responded “yes”. 13% or 8 youth responded “no”.

17. *Do you feel you get to express your personal style in clothing and appearance?*

69% or 42 youth responded “yes”. 29% responded “no”. 2% or one youth did not know.

18. *Does staff understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?*

46% or 28 youth responded “yes”. 50% youth responded “no”. 2% did not know and 2% did not answer.

19. *Do you feel that staff uses inclusive language rather than identifying activities based on stereotyped gender roles?*

46% or 28 youth responded “yes”. 52% responded “no”. 2% or one youth did not respond.

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?*

23% or 14 youth responded “yes”. 72% responded “no”. 5% or three youth did not know.

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?*

23% or 14 youth responded “yes”. 59% or 36 youth responded “no”. 18% or 11 youth did not know.

22. *Has staff identified support groups, places, and people for you outside of the facility?*

52% or 32 youth responded “yes”. 41% or 25 youth responded “no”. 7% or 4 youth did not know.

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Medically Necessary Services – Out of State Residential Facilities

The Kepro Consumer & Community Affairs Liaison facilitated six (6) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities out of state.

The purpose of these focus groups is to provide youth in out of state placement the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various states to gain insight regarding the utilization and impact of these services in each state. Information is gathered throughout the year with a minimum of six (6) focus groups that reflect consumers' voices with regard to access, service delivery, treatment plan goals, cultural competency and outcomes.

Total: Fifty-two (52) youth receiving behavioral health treatment placed in out of state residential settings. 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 in regard to:

- Access
 - Service delivery
 - Gaps in support systems
 - Engagement with system staff
 - Cultural competency
 - Consumer knowledge of services and supports
1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
Eighty-six percent (86%) or 45 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs, while ten percent (10%) or 5 participants said, "No." Four percent (4%) or 2 participants had no response.
 2. Are intake forms or materials available in different languages?
Seventy-one percent (71%) or 37 respondents were unsure if materials were available in different languages, while twenty-three percent (23%) or 12 participants stated that the agencies did provide alternative language formats. Six percent (6%) or 3 respondent's N/A.
 3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.

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- Eighty-six percent (86%) or 45 participants agreed that their agencies offered assistance for those with disabilities, while eleven percent (12%) or 6 participants weren't sure. Three percent (2%) or 1 participant did not respond.
4. Does the agency have trained interpreters readily available for various languages, including sign language?
Eighty-one percent (81%) or 42 participants stated that the agencies had access to trained interpreters for various languages and sign language. Eleven percent (12%) or 6 respondents did not know. Eight percent (7%) or 4 respondents did not respond.
5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
Fifty-two percent (52%) or 27 participants agreed that the agencies had established connections to serve diverse groups, while thirty five percent (35%) or 18 participants said, "No." Eleven percent (11%) or 6 participants didn't know and two percent (2%) or 1 participant had no response.
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?
Seventy-three percent (73%) or 38 of those responding agreed that the agencies had sponsored at least one activity that promoted teamwork and communication between cultural and ethnic groups. Twenty-five percent (25%) or 13 participants said, "No." Two percent (2%) or 1 respondent did not reply.
7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?
Forty-six percent (46%) or 24 of those responding stated that they had not attended group holidays or community functions within diverse communities. While Forty percent (40%) or 21; another fourteen percent (14%) or 7 participants had no response.
Holiday cook outs
Easter services
Christmas parties
8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
Thirty-one percent (31%) of participants or 16 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues, while forty percent (40%) or 21 participants had not. Twenty-nine percent (29%) or 15 participants gave no response.
9. Do you have access to religious services in which you affiliate?
Ninety-eight percent (98%) of participants or 51 respondents stated, "Yes." While two percent (2%) or 1 respondent did not respond.

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10. Does your care provider (Family) alter your programming or care based on your values or culture? Eighty-three percent (83%) of participants or 43 respondents stated, "Yes." While fifteen percent (15%) or 8 respondents said, "No." Two percent (2%) or 1 respondent did not reply.
11. Do you feel your services are tailored to your needs? Seventy-seven percent (77%) of participants or 40 respondents stated, "Yes." While fifteen percent (15%) or 8 participants said, "No." Two percent (2%) or 2 respondents did not reply.
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally? Ninety-six percent (96%) or 50 participants agreed that visits were comfortable, both physically and emotionally, while two percent (2%) or 1 participant said, "No." Another two percent (2%) or 1 participant did not respond.
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home? Ninety-eight percent (98%) or 51 participants agreed that visits were comfortable, both physically and emotionally, while two percent (2%) or 1 participant had no response.
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? Ninety-eight percent (98%) or 51 participants said, "No." While two percent (2%) or 1 participant had no response.
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? Fifty-two percent (52%) of participants or 27 respondents stated, "Yes." While forty-six percent (46%) or 24 participants said, "No." Two percent (2%) or 1 participant did not respond.
* To both questions
16. Do you have access to personal care items or services that match your needs? (Haircuts dye...) Ninety-eight (98%) of participants or 51 respondents stated, "Yes." Two percent (2%) or 1 participant did not respond.
17. Do you feel you get to express your personal style in clothing and appearance? Sixty-seven percent (67%) of participants or 35 respondents stated, "Yes." While thirty-one percent (31%) or 16 respondents said, "No." Two percent (2%) or 1 participant did not respond.
18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues? Thirty-nine percent (39%) or 20 participants said, "Yes of the three questions." Forty-six percent (46%) or 24 respondents had no response to all three questions. Another fifteen percent (15%) or 8 participants were not asked the questions due to the specifics of the population.
19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles?

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- Thirty-nine percent (39%) or 20 respondents said, “yes.”; while thirty-one percent (31%) or 16 participants stated they didn’t know. Fifteen percent (15%) or 8 respondents had no response and another fifteen percent (15%) or 8 participants were N/A.
20. Do you feel isolated or separated/segregated 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?
Forty-eight percent (48%) or 25 participants gave no response to both questions, while fifty-two percent (52%) or 27 respondents stated the questions weren’t applicable.
21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
Twenty-eight percent (28%) or 15 participants said, “Yes, in response to both questions,” while thirty-one percent (31%) or 16 respondents answered no to both questions. Another thirty-one percent (31%) or 16 respondents did not reply to both questions’ Ten percent (10%) or 5 participants the question did not apply.
22. Have caregivers identified support groups, places, and people for you outside of the family setting?
Fifty-two percent (52%) of participants or 27 respondents stated, “Yes.” There were identified supports outside the facilities, while another forty-six percent (46%) or 24 participants said, “No.” two percent (2%) or 1 participant had no comment.

Update 2021:

The KEPRO Consumer & Community Affairs Liaison facilitated six focus groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities.

The purpose of these focus groups is to provide youth 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. Information is gathered throughout the year with a minimum of six focus groups that reflect consumers’ voices regarding access, service delivery, treatment plan goals, cultural competency and outcomes.

Total: 37 youth receiving behavioral health treatment placed in residential settings.

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

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- *Gaps in support systems*
- *Engagement with system staff*
- *Cultural competency*
- *Consumer knowledge of services and supports*

Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups? 100% of youth responded “yes.”

Are intake forms or materials available in different languages? 54% or 20 youth stated “yes”; 46% or 17 youth did not know.

Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology. 92% or 34 youth responded “yes”; 8% or three youth did not know.

Does the agency have trained interpreters readily available for various languages, including sign language? 70% or 26 youth responded “yes”; 11% or four youth said “no”; and, 19% or seven youth did not know.

Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups? 100% of youth responded “yes.”

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? 100% of youth responded “yes.”

Do you have the opportunity to attend racial group holidays or functions within diverse communities? 68% or 25 of those responding stated that they had attended group holidays or community functions within diverse communities; 32% or 12 had not.

Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues? 86% or 32 youth said “yes”; 24% or five youth did not.

Do you have access to religious services in which you affiliate? 100% of youth responded “yes.”

Does your care provider (Family) alter your programming or care based on your values or culture? 100% of youth responded “yes.”

Do you feel your services are tailored to your needs? 100% of youth responded “yes.”

Are visitations arranged in situations you and your family are comfortable- physically and emotionally? 100% of youth responded “yes.”

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Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home? 100% of youth responded "yes."

Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, Skype, FaceTime, texting, Twitter, Facebook, Instagram, SnapChat? 24% or nine participants stated that they were able to contact family and friends with supervision and timelines; 76% or 28 respondents agreed that other than face-face visitation they were only allowed to use the phone.

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? 90% of participants or 33 respondents stated, "Yes"; 10% or four participants said "No" to both questions.

Do you have access to personal care items or services that match your needs? (Haircuts dye...) 100% of youth responded "yes."

Do you feel you get to express your personal style in clothing and appearance? 100% of youth responded "yes."

Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues? 100% of youth responded "yes."

Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles? 100% of youth responded "yes."

*Do you feel isolated or separated/segregated due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth receive?
24% or nine participants gave no response to both questions; 76% or 28 respondents answered "no" to both questions.*

*Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
57% or 21 participants said "yes"; 43% or 16 participants responded "no" in response to both questions.*

Have caregivers identified support groups, places, and people for you outside of the family setting? 100% of youth responded "yes."

Update 2022:

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During Contract Year, KEPRO staff facilitated six Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis and residential treatment facilities out-of-state.

The purpose of these focus groups is to provide youth in out-of-state placement the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various states to gain insight regarding the utilization and impact of these services in each state. Information is gathered throughout the year with a minimum of six focus groups that reflect consumers' voices with regard to access, service delivery, treatment plan goals, cultural competency and outcomes.

Please note that at various times during this period, Covid-19 restrictions were in place. These varied by state. Therefore, the means of gathering the information was by face-to-face as well as virtual groups.

Total: 32 youth receiving behavioral health treatment placed in out-of-state residential settings.

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 in regards to:

- *Access*
- *Service delivery*
- *Gaps in support systems*
- *Engagement with system staff*
- *Cultural competency*
- *Consumer knowledge of services and supports*

1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups? 100% responded yes.

2. Are intake forms or materials available in different languages? 59% responded yes. 41% did not know.

3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology. 100% responded yes.

4. Does the agency have trained interpreters readily available for various languages, including sign language? 75% responded yes. 25% responded no.

5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups? 84% responded yes. 16% responded no.

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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? 97% said yes. 3% said no.*
7. *Do you have the opportunity to attend racial group holidays or functions within diverse communities? 50% said yes. 50% said no.*
8. *Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues? 84% said yes. 13% said no.*
9. *Do you have access to religious services in which you affiliate? 66% said yes. 34% said no.*
10. *Does your care provider (Family) alter your programming or care based on your values or culture? 97% said yes. 3% said no.*
11. *Do you feel your services are tailored to your needs? 97% said yes. 3% said no.*
12. *Are visitations arranged in situations you and your family are comfortable- physically and emotionally? 72% said yes. 28% said no.*
13. *Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home? 72% said yes. 28%*
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? 19% said yes. 81% said no.*
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? 100% said yes.*
16. *Do you have access to personal care items or services that match your needs? (Haircuts dye...) 100% percent said yes.*
17. *Do you feel you get to express your personal style in clothing and appearance? 78% said yes. 22% said no.*
18. *Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues? 91% said yes. 3% said no. 6% did not know.*

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19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles? 100% said yes.

20. Do you feel isolated or separated/segregated 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? 100% said yes.

21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex? 81% said yes. 19% said no.

22. Have caregivers identified support groups, places, and people for you outside of the family setting? 69% said yes. 31% said no.

Client Services

The WV Department of Health and Human Resources maintains a unit of staff that handles calls from the public when issues arise. These staff research each case individually and report back findings to the individual who reported the issue. The following is statistical information regarding those calls.

**Total and Monthly Calls for CSRC
and Client Services from January
1, 2019 through June 30, 2019**

Unit	January	February	March	April	May	June	Total
CSRC	16,522	14,650	16,357	16,043	15,486	13,106	92,164
Client Services	3,609	3,176	3,273	3,135	2,983	2,674	18,850

Update 2021:

**Total and Monthly Calls for CSRC
and Client Services from July 1,
2019 through December 31, 2019**

Unit	July	August	September	October	November	December	Total
CSRC	18,384	19,501	17,122	18,411	15,479	15,072	104,019
Client Services	2,997	3,206	2,778	3,219	2,717	2,676	17,593

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Update 2022:

Total and Monthly Calls for CSRC and Client Services from January 1, 2020 through December 31,

Unit	January	February	March	April	May	June	July
CSRC	21,690	19,929	19,726	23,963	19,364	17,696	25,431
Client Services	3,632	3,502	3,895	5,604	4,229	5,204	6,976
Unit	August	September	October	November	December	Total	
CSRC	26,984	26,544	24,277	20,219	24,944	270,767	
Client Services	6,698	4,888	4,986	4,193	5,113	58,920	

Total and Monthly CPS and Foster Care calls and inquiries from January 1, 2019 through June 30, 2019

CPS/FC	January	February	March	April	May	June	Total
CPS Calls	89	81	87	88	120	89	554
CPS Inquiries	40	26	21	34	40	25	186
Foster Care Calls	0	0	2	1	0	3	6
Foster Care Inquiries	9	9	4	9	3	6	40

Update 2021:

Total and Monthly CPS and Foster Care calls and inquiries from July 1, 2019 through December 31, 2019

CPS/FC	July	August	September	October	November	December	Total
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<i>CPS Calls</i>	99	80	43	89	90	77	478
<i>CPS Inquiries</i>	35	36	34	57	68	77	307
<i>Foster Care Calls</i>	2	1	7	11	19	12	52
<i>Foster Care Inquiries</i>	10	6	8	10	13	12	59

Update 2022:

Total and Monthly CPS and Foster Care calls and inquiries from January 1, 2020 through December 31, 2020

CPS/FC	January	February	March	April	May	June	July
<i>CPS Calls</i>	30	107	113	81	127	159	167
<i>CPS Inquiries</i>	101	179	163	133	165	221	228
<i>Foster Care Calls</i>	10	20	26	12	20	27	45
<i>Foster Care Inquiries</i>	27	31	37	21	32	48	65
CPS/FC	August	September	October	November	December	Total	
<i>CPS Calls</i>	136	95	103	76	91	1,285	
<i>CPS Inquiries</i>	187	175	180	137	165	2,034	
<i>Foster Care Calls</i>	68	38	41	13	30	350	
<i>Foster Care Inquiries</i>	87	54	53	21	43	519	

Court Improvement Program

The Program Manager of Residential Licensing attends the Shelter Care Network and Youth and Family Services meetings. The meeting is facilitated/sponsored by the Court Improvement Program (CIP). The meeting is attended by the Bureau for Families and Children (BCF), Emergency Shelter Providers, Judges and the CIP. The Shelter Care Network meets to discuss emergency shelter care in West Virginia. The Youth and Family Services meeting is also facilitated/sponsored by the CIP. The meeting is attended by BCF, Residential and Emergency Shelter Providers, West Virginia Department of Education, Bureau for Juvenile Services, Probation, Judges and the CIP. The focus of this committee is on the services and treatment of youth in state's custody. The Away from Supervision data that is collected from providers on a monthly basis is shared at this meeting.

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NYTD data collected through the CCWIS system, as well as NYTD data collected through age 17, 19, and 21-year-old surveys are and will continue to be distributed to various entities, agencies, and workgroups. The Court Improvement Program (CIP) conducts permanency reviews and NYTD data is provided to them on a regular or as needed basis and is the avenue in which NYTD data is provided to West Virginia's court systems. NYTD data is also provided to workgroups such as the Service Development and Delivery Workgroup (SDDW), and the Transitional Living Workgroup (TLW), and to other state oversight entities such as the Bureau for Health Facilities (BHF). The SDDW, TLW, and other workgroups contain members of the Department of Health and Human Resources (DHHR), service providers, IL coordinators, and members of the public and use NYTD data to identify gaps in services, needs, and trends.

Additionally, through coordination with the DHHR, the WV MODIFY program is developing a youth council as part of the West Virginia Foster Advocacy Movement (WVFAM). This group will be youth led and made of current and former foster youth and Chafee fund recipients. While the youth of this council will have final say over which agencies and non-former or current foster youth can participate, and what subjects would be discussed, the NYTD data will be provided to them so that their discussions and desired outcomes can be as data informed as possible. Through this method, youth most affected by this data are included. It is anticipated the WVFAM youth councils will begin in early 2020 and be split with one occurring for the northern counties and one occurring for the southern counties.

Foster and Adoptive Parent Licensing/Recruitment

Foster care is an intricate service within the child welfare system. Foster care requires a partnership between the foster care providers, whether traditional, therapeutic, kinship/relative providers. This partnership is necessary for children to appropriately achieve permanency, primarily reunification, with adoption and legal guardianship as necessary for permanency. The partnership should exist between the foster care provider, child welfare staff, the Courts, attorneys, and service providers, as well as a key partner, the biological parents, or family of origin. This congruent partnership is crucial to achieving permanency and enhancing their well-being outcomes.

Foster care providers have reported through implemented Bureau for Children and Family surveys in 2017, that they do not feel as though they are included in the process and their opinion does not matter. Of the 31% response rate to the surveys, 28% of foster parents indicated that they were always notified of MDTs, and 27% indicated that they were always notified of court hearings; with 19% reporting that they participate with the development of case planning. Additional information provided by Marissa Sanders, the Director of the WV Foster, Adoptive, & Kinship Parents Network, has indicated that this continues to be a prevalent issue for foster care providers. This results in a struggle and has frequently resulted in the loss of foster care providers through the process.

West Virginia's child welfare system, the Bureau for Children and Families and the Court Improvement Program have begun to recognize that a true partnership with foster care providers is significantly lacking. Initiatives are being developed to address the identified barriers in communication and partnership with

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foster care providers and ensuring their right to be heard is recognized and shown the consideration they are entitled to have. West Virginia's Program Improvement Plan addresses these initiatives and strategies that will be continued through the next five years.

Child welfare staff with the Bureau for Children and Families strives to place foster children with kinship/relative care providers, currently having 48% of all foster children placed in a kinship/relative care placement. With the Kinship Navigator grant awarded, services to kinship/relative care providers will be ensured through the regional navigators. Additional needs have been identified specific to kinship/relative care providers. These needs include inconsistency with caregiver payments, the lack of needs of the family and/or children being met, and the lack of linkage to services. West Virginia's plan to address the needs of kinship/relative care providers is through the Kinship Navigator grant award. The Bureau for Children and Families has sub-granted the Kinship Navigator grant to Mission West Virginia for implementation. This will allow for regional Kinship Navigators to be placed locally within the regions and assist all new kinship/relative caregivers assigned to their caseloads. An assessment of needs form has been developed that will be utilized by the Kinship Navigators at three stages of placement; the initial placement, between three and six months after placement, and permanency achievement.

West Virginia will monitor the success of the Kinship Navigator program within the first two years of implementation through surveys provided to kinship/relatives at the onset of placement and at the achievement of permanency. If the program is successful, West Virginia will examine the structure of the program to determine a system of sustainability for continued improvement of kinship/relative care.

West Virginia has revised the Foster and Adoptive Parent Diligent Recruitment Plan to include missing components identified through technical assistance from the Capacity Building Center for States. The Foster and Adoptive Parent Diligent Recruitment Plan is attached. West Virginia currently contracts with 12 specialized/private family foster care agencies. Each agency performs their own recruitment in collaboration with Mission West Virginia. The 12 agencies have focused targeted recruitment efforts for address challenges with placing older children and youth. Targeted recruitment efforts include targeting recruitment for older children and youth, large sibling groups, and fostering only. Additional efforts are being made in counties where greatest needs are shown. The Bureau for Children and Families develops data reports comprised of the number of children in care for each of the 55 counties, and the number of family foster homes through any of the 12 contracted specialized/private agencies. This data is shared with Mission West Virginia, who develops recruitment plans based on the identified areas/counties of need revealed in the data. The Bureau for Children and Families is committed to continuing the recruitment effort and is currently in a Program Improvement Plan to implement strategies in order to achieve goals and outcomes for increased foster parent recruitment. *West Virginia's Statewide Recruitment Plan is attached.

Over the next five years, the Bureau for Children and Families will be using a workgroup that will pull monthly samples of foster care cases from each county in order to determine the appropriateness of child removals to ensure that the children coming into care are removed due to uncontrollable safety threats.

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A recent study was conducted on the number of removed West Virginia children. This study broke down the number of children in foster care from each of West Virginia's 55 counties. The number of children in foster care was compared to overall population of the county to determine which counties had the highest number of children in foster care per capita. The study was broken down further and the number of children in foster care in each county was compared to the number of minors, 18 and under in each of the corresponding counties. The 10 counties with the highest number of children in foster care, based on the comparison of the number of minors 18 and under in each county, were then compared to the national average of children in foster care. Some West Virginia counties are nine times the national average, while the entire state of West Virginia is approximately three times the national average. This workgroup's primary goal is to determine whether children being placed into foster care should be there, whether children can be maintained in the home with appropriate safety planning, and whether child welfare staff are exhausting all available resources in order to prevent child removals and ensure safety within the homes.

Through the 2017 West Virginia on-site CFSR findings, the Bureau for Children and Families began working on the Program Improvement Plan, which lead to deeper data dives. Through the deeper data analyses, it was discovered that the Bureau for Children and Families do not complete effective safety plans that would prevent children from being placed into foster care. Focus must begin to shift from removing children and placing them into foster care, onto appropriate safety planning to allow children to remain in their homes. Safety planning factors will be looked at by the workgroup charged with monthly reviews of random foster care cases in each county.

The Bureau for Children and Families contracts with 12 specialized/private foster care agencies, as well Mission West Virginia to recruit and train foster care providers. Mission West Virginia, in addition, partners with each agency to implement recruitment efforts within each region. The specialized/private foster care providers continually host events and activities to recruit new foster care providers. Efforts among all 12 contracted agencies include the following:

- Social media,
- Public service announcements,
- Church and faith-based partnerships for recruitment (singing events, youth events, and special services,
- Marketing through newspapers, radio, television, billboards, flyers, door hangers, return mail cards, and yard signs,
- Collaborating with other placing agencies through jointed events and activities,
- Attending community and county events,
- Utilizing current foster parents as recruiters,
- Fairs, festivals, and parades,
- Speaking engagements through local clubs such as Rotary, Lions, and Women's Clubs,
- Foster parent recruitment bonuses,
- Attending regional or county Collaboratives and Regional Summit meetings,
- Orphan Sunday, Adoption and Foster Care month activities, and
- Monthly informational sessions.

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These types of events have proven to be effective for the contacted specialized agencies, as specialized/private agency foster homes have nearly doubled between March 2016 and March 2019. The table below reflects the tracked increase since March of 2016.

Month	Mar 16	Sept 16	Jun 17	Sept 17	Dec 17	Mar 18	Jun 18	Sept 18	Dec 18	Mar 19
Total Increase	692	779	987	955	1,052	1,066	1,093	1161	1,251	1,288

Update 2021:

Month	Mar 2016	Sept 2016	Jun 2017	Sept 2017	Dec 2017	Mar 2018	Jun 2018	Sept 2018	Dec 2018	Mar 2019	Jun 2019	Sept 2019	Dec 2019
Increased Totals	692	779	987	955	1,052	1,066	1,093	1161	1,251	1,288	1,287	1,306	1,371

Update 2022:

The child placing agencies, contracted by the DHHR, continue to make efforts to recruit and train resource and adoptive homes across the state. New contracts with the child placing agencies will take effect before the end of 2021. These new contracts are performance-based and will incorporate CFSR outcome components. The contracts will emphasize working with families of origin as a resource to reunify more children. Additionally, there will be outcomes regarding targeted recruitment in counties where there are few foster care providers but high rates of removal and placement. The chart below shows the progressive increase of foster home recruitment throughout West Virginia by the child placing agencies. Through the COVID-19 pandemic, child placing agencies were able to complete more training virtually and reported seeing an increase in interest to foster since the training in its entirety has been made available virtually.

Month	Mar 2016	Sept 2016	Jun 2017	Sept 2017	Dec 2017	Mar 2018	Jun 2018	Sept 2018	Dec 2018	Mar 2019	Jun 2019	Sept 2019	Dec 2019
Increased Totals	692	779	987	955	1,052	1,066	1,161	1,251	1,251	1,288	1,287	1,306	1,371

Month	Mar 2020	Jun 2020	Sept 2020	Dec 2020

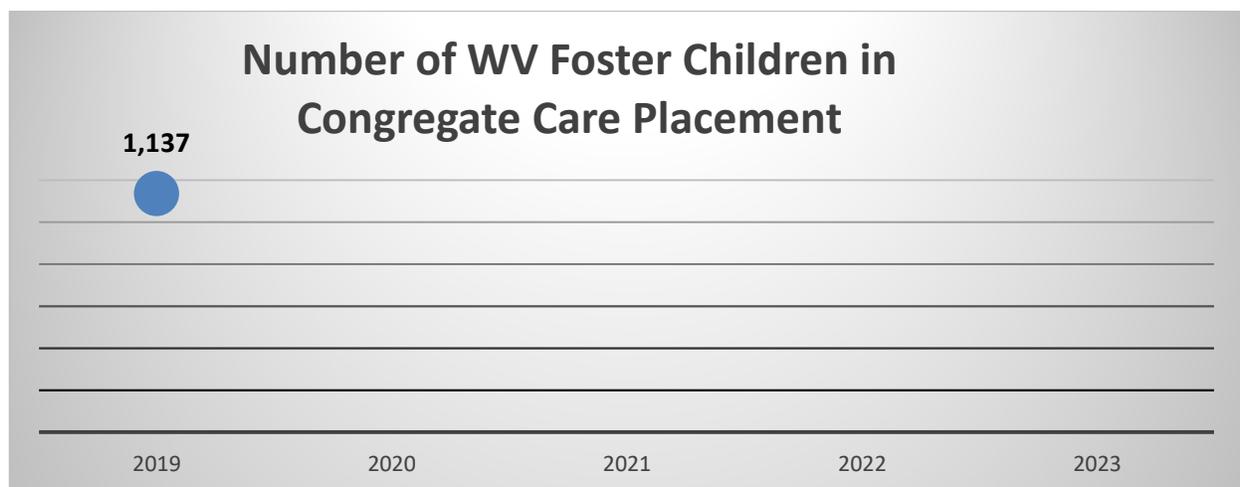
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Increased Totals Continued	1,415	1,490	1,529	1,548
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The Bureau for Children and Families will provide monthly and quarterly data to Mission West Virginia relating to the number of children in foster care for each of the 55 counties, as well as the number of foster homes in each of the 55 counties. Mission West Virginia will compile the data to focus targeted recruitment efforts in counties with the greatest need of foster care providers based on the number of children placed in foster care per county. Mission West Virginia will collaborate with the child placing agencies within those counties to increase the number of foster homes through targeted recruitment.

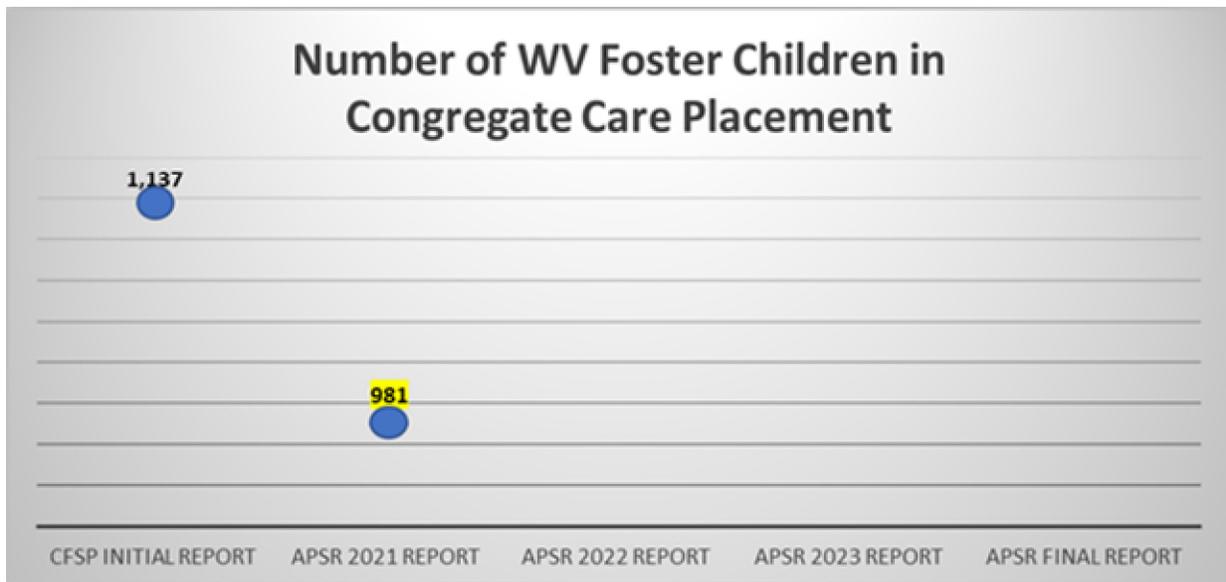
Additional efforts are also underway and will continue over the next five years to convert certified kinship/relative providers to traditional foster parents. Currently region IV is in the beginning stages of bridging relationships between kinship/relative providers and specialized/private foster care agencies to aid with the transition from the Bureau for Children and Families to a specialized/private agency. The success of this effort will allow for expansion into the other three regions and will allow for an increase in certified foster parents.

Moreover, West Virginia envisions over the next five years to partner with foster care providers and promote them as resource homes to support biological parents or family of origin, in being reunified with their children. West Virginia envisions increasing reunification support efforts by encouraging foster care providers to mentor biological parents or family of origin, become a resource and/or respite for biological parents or family of origin, and support the goal of reunification by working directly with biological parents or family of origin to increase reunification of foster children with their families.

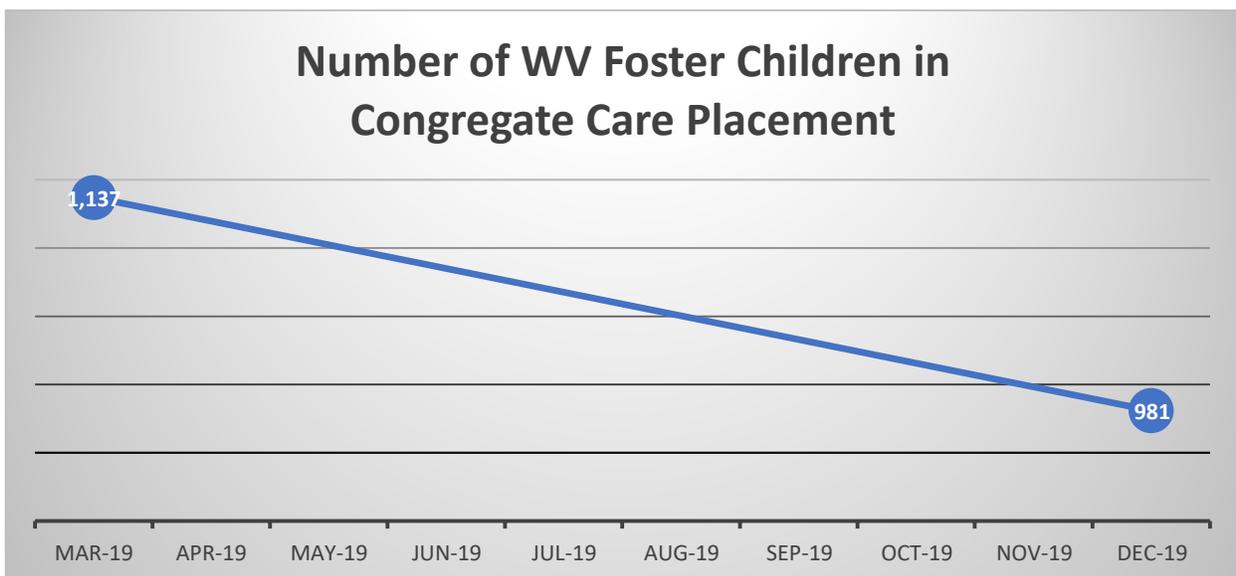


Source: FREDI PLC-0700 Point in Time 3/31/2019

Update 2021:



Source: FREDI PLC-0700 Point in Time 3/31/2019; FREDI PLC-0700 Point in Time 12/31/2019



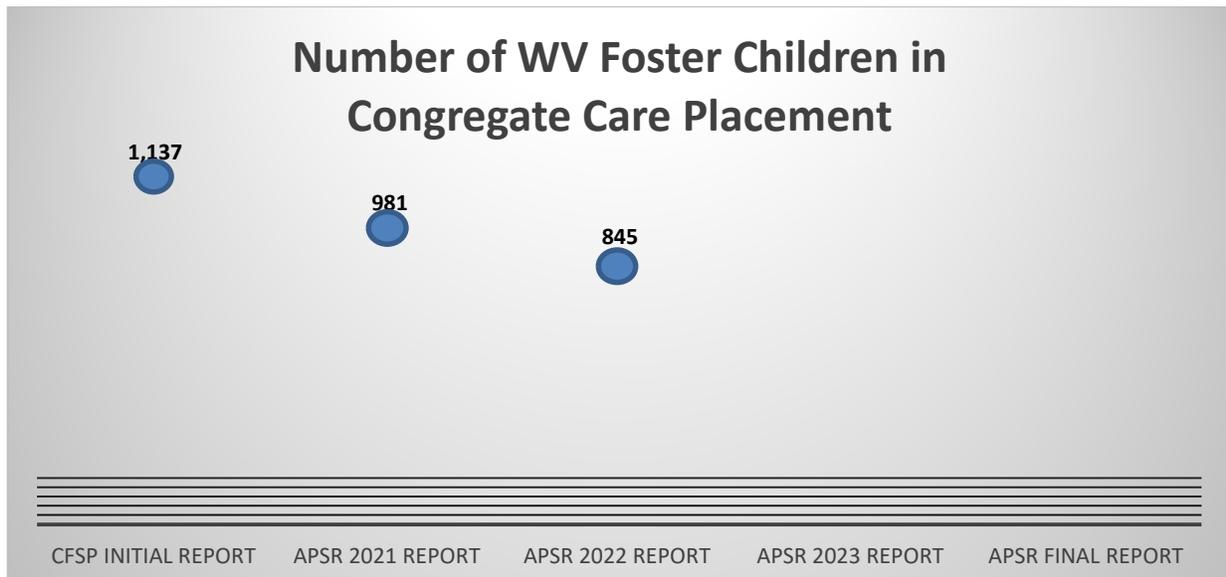
Update 2021:

West Virginia continues to work toward the reduction of foster children placed in congregate care settings. Between March 31, 2019 and December 31, 2019, the Bureau for Children and Families reduced the

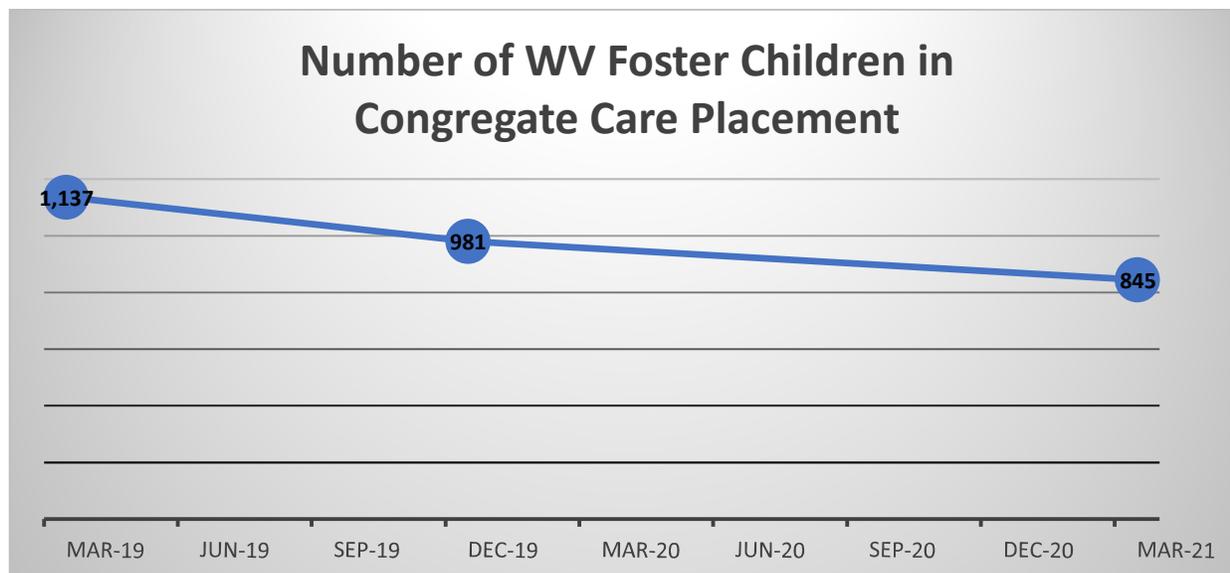
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number of foster children in congregate care settings by 156 children, approximately 8.6%. The West Virginia Department of Health and Human Resources has entered an agreement with the US Department of Justice to reduce the number of children in congregate care by 25% by December 31, 2022. The Bureau for Children and Families is working with five of the 13 child placing agencies who are contracted to provide tier foster care, to improve the tier system for the purpose of placing more children with severe behavioral needs in home settings rather than congregate care. The Bureau for Children and Families plans to release another RFA for the tier foster care program in order to increase the number of Child Placing Agencies, beyond the original five, who will provide the tier foster care placements. The goal of increasing the tier homes is to continue in the reduction of congregate care placements.

Update 2022:



Source: FREDI PLC-0700 Point in Time 3/31/2019; FREDI PLC-0700 Point in Time 12/31/2019; FREDI PLC-0700 Point in Time 3/31/2021



Source: FREDI PLC-0700 Point in Time 3/31/2019; FREDI PLC-0700 Point in Time 12/31/2019; FREDI PLC-0700 Point in Time 3/31/2021

West Virginia continues to work toward the reduction of foster children and youth placed in congregate care settings. Between December 31, 2019 and December 31, 2020, the Bureau for Children and Families reduced the number of foster children in congregate care settings by 136 children, approximately 13.8%. The West Virginia Department of Health and Human Resources has entered into an agreement with the US Department of Justice to reduce the number of children in congregate care by 25% by December 31, 2022. Since March 2019, BCF has already reduced the number of children in congregate care by 25.6%. West Virginia must stay on this track through December 2022. The Bureau for Children and Families works with five of the 11 child placing agencies who are contracted to provide tiered foster care, to improve the tier system for the purpose of placing more children with severe behavioral needs in home settings rather than congregate care. The Bureau for Children and Families will release an RFA for the tier foster care program and open it to all child placing agencies in the state. The goal of increasing the tier homes is to continue the reduction of congregate care placements.

Cross-Jurisdictional Placements and Requests for Placements, Interstate Compact on the Placement of Children (ICPC)

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 302 incoming requests for FFY 2018. Out of the 302 requests, WV completed 86 or 28% of the home studies within the 60-day timeframe. This is a decrease from the previous year, but it is a significant increase in the number of home study requests for the year. The most documented reason for the home

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studies not being completed within the 60-day timeframe is due to the lack staffing resources and other staff duties, 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 continues to monitor a tracking spreadsheet of requests and send reminders to the local staff, prior to the home study being due.

The State ICPC Office continues to enter the home study requests in the FACTS System as a referral for services, when the request is received in the State Office. The referral is then be transferred to the local office electronically, which should assist in timeliness.

The ICPC Standard Operating Procedure (SOP) was revised to give a more step by step guidance to all field staff on completing the paperwork for an out of state request, completing and submitting an in-state home study, and the workers role throughout the ICPC case to ensure timely progression to permanency. The ICPC SOP was released to staff and can be re-released to ensure that everyone has reviewed it. The following activities have already been completed to improve these outcomes;

- The state ICPC Office will track all ICPC home study requests and send reminder to staff prior to the due date.
- Review the current website to determine if it is user friendly and staff are aware of the resources available on the site.

Additional activities not yet completed include;

- Work with BCF's Training Unit on developing or enhancing training on concurrent planning to achieve permanency while using cross-jurisdictional resources for staff.
- Determine if the development of online training for field staff to complete on cross-jurisdictional resources if feasible and needed.
- Work with the Policy Unit to determine if the Home Finding Policy can be revised to address the following: How to handle an ICPC home study when the placement resource is non-compliant, and the completion of the study is delayed.
- Review current field practices regionally to find a more streamline process in completing the home studies
- The ICPC Office will work with the Regional Managers in Homefinding, to develop a monitoring mechanism/process for field management, that will assist in monitoring the ICPC home studies, timeframes, overdue ICPC studies and the barriers to the studies being done timely.

Update 2021:

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In FFY 2019, there were 199 incoming requests. WV completed 62 or 31% of these requests within the 60-day timeframe. There has been a decrease in cases and a small increase in timeliness. The State ICPC office continues to track cases through a spreadsheet.

The ICPC Standard Operating Procedure (SOP) was revised to give step-by-step guidance to all field staff on completing the paperwork for an out of state request; completing and submitting an in-state home study; and, the workers role throughout the ICPC case to ensure timely progression to permanency. The ICPC SOP was released to staff and will be re-released to ensure that everyone has reviewed it. The ICPC office will continue in its efforts to implement enhance training and policies and to streamline processes for front line field staff.

Additionally, WV DHHR has decided to join the national electronic system (NEICE) for ICPC. NEICE will allow WV to increase timeliness of placements through ICPC as well as provide different tools for tracking data.

National Electronic Interstate Compact Enterprise (NEICE)

The National Electronic Interstate Compact Enterprise (NEICE) is a national electronic system for quickly and securely exchanging the data and documents required by the Interstate Compact on the Placement of Children (ICPC) to place children across state lines.

The American Public Human Services Association (APHSA), in conjunction with the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC), has developed and implemented the NEICE.

The NEICE was launched in November 2013 with pilot funding from the Office of Management and Budget through the Partnership Fund for Program Integrity Innovation. Recognizing the success of the pilot and the potential for nationwide, electronic data exchange, in June 2015, the Children's Bureau awarded a cooperative agreement to APHSA and AAICPC to rollout NEICE to every state and jurisdiction.

The NEICE (National Electronic Interstate Compact Enterprise) grant (\$403,895.00) was awarded to the West Virginia DHHR in September 2019. The purpose of this grant is to support the interstate placement through electronic systems in West Virginia. West Virginia has proposed a project design that includes the following components: develop an electronic exchange through NEICE for the first time and fund the ongoing operating fees associated with NEICE. The plan of action for this project design includes system enhancements, NEICE fees and training.

NEICE will interface with the statewide automated child welfare information system and components around the interfacing will need to be developed. NEICE handles sensitive client data, and WV is committed to ensuring confidentiality and reliable system performance. To ensure there are funds available to make any needed enhancements or implement new technology to support the interface after the initial deployment, funds will be allocated for system enhancements in the project budget. Over the course of the project, WV will utilize the award funding to provide for the one-time connection fee and three (3) Annual Service Fee payments to the APHSA to be part of NEICE. The initial connection and licensing fee will

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be paid in the fourth quarter of year one to allow for connection. WV is currently in the processing of switching from a Statewide Automated Child Welfare Information System called FACTS to a Comprehensive Child Welfare Information System called PATH. PATH is projected to go live in late 2021. WV DHHR is working to ensure that NEICE will interphase with WV PATH.

WV plans to deliver extensive NEICE training. Funds awarded under this project will be used to deliver business redesign training to its child welfare workforce, stakeholders (including Judges and Attorneys), and outside entities. To complete this task, the development of an ICPC-NEICE specific workforce training curriculum will be needed. WV DHHR will contract with a public university to develop specific curriculum, evaluation and training of the trainer's components based on Federal ICPC and NEICE guidelines. The WV ICPC unit will participate in National ICPC and NEICE trainings or conferences. These training usually entail out of state travel and overnight stays.

Update 2022:

In FFY 2020, there were 219 incoming requests. WV completed 33 or 15% of these requests within the 60-day timeframe. There has been an increase in cases and a small decrease in timeliness. The decrease in timeliness can be attributed to the restrictions that were set in place for in-person visits, due to the COVID-19 pandemic. Many states across the nation, set guidelines and enforced restrictions specific to their state that limited the movement of children across state lines. The National Association of Administrators for the Interstate Compact on the Placement of Children provided monthly updates on restrictions other members of the Compact had in place.

National Electronic Interstate Compact Enterprise (NEICE)

WV DHHR BCF was awarded the NEICE grant on 9/30/19 and moved forward with development of an MOU with APHSA regarding NEICE. This MOU was signed by WV DHHR BCF Commissioner Watts on 1/6/2020. WV DHHR has chosen the clearinghouse as it is connection method between the child welfare system and NEICE. WV is currently in the Design, Development and Implementation phase of a new Comprehensive Child Welfare Information System called WV PATH. Designated WV DHHR BCF staff members attend ongoing meetings regarding the system design. ICPC staff have been included in these meetings since 2018.

Due to the impact of COVID, the one-time connection fee was not paid until 6/2/2020 which is outside of the projected time frame. WV DHHR BCF was unable to start the processing of contracting with an outside entity to develop ICPC-NEICE training. This delay was due to the state mandates set in place regarding stay-at-home orders and travel bans. The 2020 AA ICPC National Conference and Annual Business meeting was canceled due to COVID.

During FFY 2020 WV DHHR BCF worked with state project management office, BerryDunn to start the facilitation of technical calls regarding the NEICE interface to WV PATH. These calls started in June 2020 and have been held monthly since then. Additional members on the call includes the NEICE team, APHSA, WV DHHR MIS, Optum and Tetras. The purpose of these calls is to keep all parties informed on the progress

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of the interfacing of NIECE and WV PATH. During this reporting period, WV DHHR MIS has requested interface codes from the State of Ohio since Ohio's system is similar.

In FFY 2021, West Virginia will continue to work on onboarding with NEICE as we get closer to the rollout of WV PATH.

2. Update on Plan for Enacting the States Vision

West Virginia will be implementing the Family First Prevention Services Act (FFPSA) on October 1, 2019. Our state views this as an exciting opportunity to leverage these changes with existing initiatives in order to create lasting change in our child welfare system. Our state sees Family First as a tool to help us realize our vision to develop a proactive system which preserves safe and healthy families and correct a decades-old reliance on out-of-home care. Through the restructuring requirements, the focus on keeping children in the least restrictive setting, as well as the focus on primary prevention services, we believe FFPSA to be the much-needed missing piece of the puzzle.

Primary Prevention is a concept that often requires the child welfare staff to do the nearly impossible, in our crisis driven system, and think outside their child protection activities after maltreatment has already occurred. Associate Commissioner of Health and Human Services' Administration for Children and Families, Jerry Milner, honored West Virginia by addressing some of our state leaders and stakeholders December 11, 2018, during a meeting hosted by Casey Family Programs. During his presentation Mr. Milner urged states to remember that FFPSA will be a helpful first step in re-visioning child welfare but it must be viewed as only one of many tools that states will need. The funding allowances under FFPSA are revolutionary but they will not get us as far upstream as we need to go to effect real change.

In response to the Administration for Children and Families' call to action, the Department of Health and Human Resources has been refining its prevention vision over the past year, preparing for the development of the State's Family First Five-Year Prevention Plan. The goal of the prevention plan will be to expand existing prevention services, as well as enhance the array of services from which families may choose. Family engagement and family voice will be two important components of prevention service provision, much like Safe at Home.

Over the next five years, providers, foster parents, the courts, private citizens and DHHR staff will be involved at every step as we begin to plan, develop and utilize a broader range of in-home community-based services. The primary goal being to increase children served safety in their homes and decrease the number of children served in out-of-home care.

Please see the attached Family First Five-Year Implementation Plan.

On December 10, 2017, the Children's Bureau released the WV CFSR Final Report and the CFSR financial penalty estimates. On December 21, 2017, the Children's Bureau conducted an exit conference during which the results of the CFSR case reviews and the Statewide Assessment and interviews with

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stakeholders conducted by Children's Bureau staff to determine conformity on the seven systemic factors was discussed. WV did not meet substantial conformity on the seven CFSR Outcomes and four of the seven CFSR Systemic Factors.

After each review round no state was found to be in substantial conformity in all the seven outcome areas and seven systemic factors. States developed and implemented Program Improvement Plans (PIP) after each review to correct those areas not found in substantial conformity. Since WV was determined not to be in substantial conformity with the seven outcomes and four of the systemic factors, a PIP must be developed to address areas of nonconformity. Following the CFSR exit conference workgroups were formed to address areas thought to impact the outcomes. These groups are: Worker Recruitment and Retention, Information Systems, Foster Parent Recruitment and Retention, Field Support-Meaningful Contact, Court Improvement Program-Data Group, and Service Array group. The Children's Bureau and DPQI will monitor the plan's implementation and the state's progress toward plan-specified goals. If WV is unable to demonstrate the agreed-upon level of improvement, the Administration for Children and Families must take a financial penalty from a portion of the state's title IV-B and IV-E federal child welfare funds.

It should be noted that to be considered in substantial conformity on a CFSR Outcome the state must achieve a rating of 95% on the applicable cases reviewed. For each of the 18 items that make up the outcomes a state must be found to have a strength rating of 90% on the applicable cases reviewed. This is an intentionally high conformity level which no state has ever attained. Therefore, all states following each CFSR round have developed a PIP.

DPQI staff completed onsite reviews of 65 cases (all finalized) and the data compiled. The case review data indicates WV has substantially achieved a rating of 56% on the cases applicable for Safety Outcome 1, 42% substantially achieved rating on cases applicable for Safety Outcome 2, 20% substantially achieved rating on cases applicable for Permanency Outcome 1, 65% substantially achieved rating on cases applicable for Permanency Outcome 2, 26% substantially achieved rating on cases applicable for Well-Being Outcome 1, 73% substantially achieved rating on cases applicable for Well-Being Outcome 2, and 59% substantially achieved rating on cases applicable for Well-Being Outcome 3. (Please see attached chart for additional information on item specific data)

West Virginia had multiple meetings with its stakeholders to review the Child and Family Services Plan and developed five groups to develop its Program Improvement Plan. This plan developed strategies to improve five over-arching areas which, if improved, would improve multiple CFSR outcomes. These include meaningful contact with children and families, service array, recruitment and retention of foster parents, workforce recruitment and improving safety.

West Virginia's Program Improvement Plan has not been approved.

In June 2015 an article in the Washington Times reported West Virginia had the highest rate of overdose deaths in the U.S. West Virginia's drug overdose death rate was more than double the national average.

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Citing statistics from the CDC, it found that West Virginia's rate far surpassed the second-highest state, New Mexico, which was at 28.2 deaths per 100,000. The national average was 13.4.

West Virginia's number of children in foster care rose rapidly and the states data suggests that most of these children were younger and were removed predominately for substance abuse by their caretakers. The tenure and skill set of workers as well as community-based services could not keep up with the rate of the crisis.

That same year, West Virginia was reviewed by the Department of Justice and the following recommendations (summarized) were made;

- West Virginia should expand in-home and community-based mental health service capacity throughout the state to minimize or eliminate unnecessary institutionalization
- West Virginia should eliminate the unnecessary use of public and private segregated residential treatment facilities, both within the state and outside of the state. The State should ensure the availability of voluntary, comprehensive services and supports in the community to divert children from segregated residential placement.
- West Virginia should ensure that all Comprehensive Centers provide for (directly or indirectly) in-home and community-based mental health services across the
- West Virginia policy, practice, and regulations should ensure that a single Intensive Care Coordinator has ultimate responsibility and accountability in cases where a child is involved in multiple child-serving systems (such as child welfare, juvenile justice, Medicaid, and special education). The State should charge this Intensive Care Coordinator with ensuring the planning, delivery and monitoring of services and supports consistent with State and federal law. This entity should coordinate the provision of services using a high-fidelity Wraparound model pursuant to the National Wraparound Initiative's published guidance.
- West Virginia should develop an interagency decision making and oversight entity to improve coordination of and access to intensive mental health services.

The Office of Drug Control Policy was established to identify strategies to address the Substance Use issues within WV. The goal of the ODCP is to work with stakeholders and identify service gaps and needs in communities across WV and to reduce the drug overdose fatalities while working toward the development of a continuum of services and supports for those addicted to drugs.

The Department of Justice has developed a partnership with WV to provide support as the state develops a continuum of community services and supports for children with serious mental health disorders. West Virginia has committed to developing statewide Assertive Community Treatment for youth between the ages of 18-21, Expanded School-Based Mental Health Services, Behavioral Support Services, Children's Mobile Crisis Response Program, Wraparound, and a Children Serious Emotional Disorder Waiver that includes Therapeutic Foster Care services.

Update 2021:

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In order to improve the availability and quality of services to children and families in West Virginia, the state has implemented several initiatives including the expansion of Family Drug Treatment Courts, codifying and hiring an Ombudsman and establishing several workgroups to improve services for Seriously Emotionally Disturbed children.

House Bill 3057 in 2019, codified as §62-15B-1(d)(4), permitted the Supreme Court of Appeals of West Virginia to create and implement a Family Treatment Court (FTC) pilot program in at least four counties to serve individuals with substance use disorders who are also involved in a child abuse and neglect case. The Supreme Court provides oversight, technical assistance, and training. The Court established a State Family Treatment Court Advisory Committee, as called for in the law, and local family treatment court advisory committees in the counties where there are Family Treatment Courts. Each local advisory committee sets criteria for the eligibility and participation of adults who have a substance use disorder and have been adjudicated to be abusive or neglectful parents and who have been granted a post-adjudicatory improvement period. Family Treatment Courts are designed to return children to a safer home environment and achieve permanency faster and more effectively than traditional methods.

The Office of Drug Control Policy, under the direction of Robert Hanson, provided the initial grant funding to implement three Family Drug Courts in the state in 2019. Another Family Drug Court is expected to open in early 2020. Additional funding was provided by the Office of Juvenile Justice and Delinquency Prevention.

Currently, there are three Family Treatment Courts established in Boone, Randolph and Ohio counties. There are plans to open FTC's in Nicholas and Roane counties in 2020.

The Foster Care Ombudsman (FCO) is a new role and function, established to perform a variety of dispute-resolution, data collection, and systemic improvement duties as set forth in applicable West Virginia law. The office is organizationally positioned within the Office of the Inspector General, West Virginia Department of Health and Human Resources. The FCO conforms to generally accepted professional practice standards and was adapted to serve designated populations and priorities as identified by the West Virginia Legislature. Enabled by W. Va. Code §9-5-27 in 2019, the first FCO was hired on October 28, 2019. Although the enabling legislation was deliberately general, the 2020 legislative session further established W. Va. Code §§ 49-9-101, et. seq. The amended language, informed by the United States Ombudsman Association, the International Ombudsman Association, and the American Bar Association, significantly elaborated, expanded, and clarified the duties, responsibilities, and authority of the role. These statutes incorporate the four pillars of the ombudsman profession: independence, impartiality, credibility, and confidentiality.

The FCO is directed to perform a variety of duties, including:

- To advocate for the rights of foster children and foster parents and provide all callers with information and resource assistance. Advocacy endorses for fair, equitable, lawful and just treatment, but does not takes sides with any party in the process of resolving disputes.*

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- *To investigate and resolve complaints filed on behalf of a foster child or foster parent, relating to agency actions, inactions, or decisions. Entities include managed care providers, public agencies, social service agencies, child placing agencies, and residential care facilities.*
- *To monitor and review federal, state, and local legislation, regulations, policies, and procedures relating to the system of providing foster care and treatment and make recommendations for improvement.*
- *To undertake legislative advocacy and make proposals for systemic reforms.*
- *To conduct programs of public education regarding the availability and services of the Foster Care Ombudsman.*
- *To prepare and submit periodic reports to the Governor, legislative commissions, and the Bureau of Children and Families within the West Virginia Department of Health and Human Resources.*
- *To investigate violations of the newly established Foster Children’s Bill of Rights (W. VA. Code §49-2-126) and the Foster Parents’ and Kinship Bill of Rights (W. Va. Code §49-2-127).*

The Code further defines the Foster Care Ombudsman’s access to foster care children, access to records, subpoena powers, confidentiality of complainants and investigations, limitations on liability, and the consequences to individuals for willful interference or retaliation as it pertains to the FCO lawfully performing his/her duties. Funding for the program is appropriated by the West Virginia Legislature.

The priorities for the first several months of the Foster Care Ombudsman’s tenure have been to design an organizational structure including the budget and human resources plan, create policy and procedures, engage vigorous community and stakeholder relations, and procure necessary technology for case management, data tracking, and reporting. The first Foster Care Ombudsman, Pamela Woodman-Kaehler, is a certified and tenured foster parent, with experience as a child protective services worker, a citizen review panel coordinator, a PRIDE pre-service co-trainer, a federal compliance auditor, an industry association executive and a health care administrator for multi-state outpatient operations. She received her master’s degrees in business administration and social work and is a licensed graduate social worker in West Virginia.

In order to decrease its reliance on placement of children in congregate care, the WV Department of Health and Human Resources is working in conjunction with the Department of Justice. Several key areas have been targeted to integrate services to children and families to improve their functioning at home and in community-based settings. These include an integrated Wraparound program, Children’s Mobile Crisis Response, Positive Behavioral Support Services, Therapeutic Foster Care, Assertive Community Treatment, Mental Health Screening tools and processes, a quality assurance performance system and outreach and education for stakeholders.

West Virginia Wraparound

West Virginia currently has two mental health programs for children using a wraparound facilitation model (commonly referred to as “wraparound”): Safe at Home West Virginia and West Virginia Children’s Mental Health Wraparound (Children’s Mental Health Wraparound). DHHR has applied for a Children’s Serious Emotional Disorder (CSED) waiver which uses a wraparound facilitation model. Each program targets a

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different population and is funded by different sources. The programs provide similar services, with the goal of operating with high fidelity to the National Wraparound Initiative's (NWI) model.

Children's Mobile Crisis Response Program

Children's Mobile Crisis Response and Stabilization Teams help children and youth who are experiencing emotional or behavioral crises by interrupting the immediate crisis and ensuring youth and their families in crisis are safe and supported. The program provides the support and skills needed to return youth and families to routine functioning and maintain children in their homes or current living arrangements, schools, and communities whenever possible. The Children's Mobile Crisis Response and Stabilization model is part of a continuum of community-based services designed to provide evaluation and assessment; crisis intervention and stabilization; and transition planning and follow-up.

Positive Behavioral Support Services

Positive Behavioral Support (PBS) focuses on providing prevention and intervention supports for individuals who are demonstrating significant maladaptive behaviors, are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or Psychiatric Residential Treatment Facility (PRTF), or are transitioning to the community from an out-of-home placement. PBS is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life of individuals who are experiencing significant maladaptive behavioral challenges.

Therapeutic Foster Family Care

In July 2017, West Virginia formally launched a three-tiered foster family service model. The model is a family-based, therapeutic, trauma-informed service delivery approach. The three-tiered model provides individual services for children and their families. The model is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and on-going training provides the foster parents the knowledge and skills needed to care for children that meet the criteria. The service is provided by five child placing agencies statewide.

Assertive Community Treatment

ACT is an inclusive array of community-based rehabilitative mental health services for Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and integrated package of services provided over an extended duration to live successfully in the community of their choice.

Mental Health Screening Tools and Processes

The Office of Maternal, Child and Family Health (OMCFH) is West Virginia's Title V Maternal and Child Health Agency and is responsible for the utilization of funds provided by the Maternal and Child Health Block grant of title V of the Social Security Act of 1935, 42 U.S.C. § 701 et seq. Federal policy requires state Medicaid agencies to coordinate with title V grantees, especially regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The OMCFH provides administrative oversight for West Virginia's EPSDT program, also known as HealthCheck. Consequently, the OMCFH has a major role in establishing standards, policies, and procedures for health care services, interpreting standards to

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providers, providing education to enhance implementation, promoting quality of care, and assessing progress.

Quality Assurance and Performance Improvement System

West Virginia currently relies on accessing data across multiple non-integrated systems. Work is underway to create an integrated system across the bureaus of DHHR. It is anticipated that this system will be operational across all bureaus by November 2021.

Outreach and Education for Stakeholders

DHHR is seeking to institute a more unified, department-wide approach to engaging stakeholders in its services and programming for children. Currently, a variety of stakeholder groups interact individually with DHHR's bureaus on areas of concern, while the Office of Communications globally coordinates DHHR's releases to and interactions with the press.

Update 2022:

Family Treatment Courts were established in West Virginia in 2019 with three pilot sites in Boone, Ohio, and Randolph Counties. The first expansion occurred early in 2020 with Nicholas County and Roane County. A request was made to the Courts and DHHR to allow the Roane County FTC to also accept participants from Calhoun County in late Spring and this was approved. The fall of 2020 saw three more FTC's in Braxton, Logan, and McDowell County. In the summer of 2021 three more Counties will have FTC's in Fayette, Wetzel, and Wood Counties.

Family Treatment Courts in West Virginia are a non-adversarial treatment court that focuses on families suffering from the effects of addiction issues. Parents that have been adjudicated in Circuit Court with child abuse/neglect charges are eligible for FTC. Participation is voluntary and serves as the improvement period for the abuse and neglect case. One of the goals of FTC is for parents and children to have more frequent and meaningful contact with one another if safety can be maintained. FTC participants are afforded the ability to have a collaborative treatment team that can meet the needs of not only the children but the parents as well. Providing them with a safe and stable home to return to with a parent recovery is purpose of FTC.

**To date we have 83 participants active in FTC with 24 that have graduated. We are currently serving 101 children. At the end of January 2021 FTC's time to reunification was an average of 313 days and time to permanency yielded an average of 392 days.*

Foster Care Ombudsman Report

The Foster Care Ombudsman (FCO), a legislatively created unit of state government in 2019 (§W. Va.9-5-27 and §§W. Va. 49-9-101 et. seq.), is positioned within the DHHR Office of Inspector General. The FCO advocates for the rights of foster children and foster/kinship parents, investigates and resolves complaints, monitors and reviews policy and law relating to the foster care system, proposes systemwide reforms, and conducts programs of public education. This independent, impartial, and confidential unit is developing

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the human resources, technology supports, structures/processes, and stakeholder relationships to effectively deploy its duties statewide.

The FCO distributed its first public-facing report, encompassing its activities from November 2019 through January 2021, in April 2021. In addition to reporting on program development and the complaint-handling process, the initial report provides an array of complaint statistics and categorizes complaints received into several themes. Future reporting will provide additional statistical analysis of complaint trends and patterns as well as recommendations for improvements to the provision of child welfare services. In addition to assisting individuals who may be struggling with the foster care system, the intent of the FCO is to provide unique and meaningful information to leaders, lawmakers, and other stakeholders so that the experiences and perspectives of those served, can be incorporated into systemwide improvement. The report is located at the following link.

https://www.wvlegislature.gov/legisdocs/reports/agency/H01_CY_2020_15152.pdf

West Virginia Wraparound

The Children's Mental Health Wraparound initiative of DHHR's Bureau for Behavioral Health (BBH) is modeled after the national children's wraparound model and philosophy. The purpose of Children's Mental Health Wraparound is to prevent the out-of-home placement of children with serious emotional disturbances and have them thrive at home with their families and in their schools and communities.

Currently, Children's Mental Health Wraparound services are provided by five agencies (Board of Child Care, Braley and Thompson, National Youth Advocate Program (NYAP), Pretera Center, and Fayette, Monroe, Raleigh, Summers (FMRS)). In State Fiscal Year 2020, the BBH Children's Mental Health Wraparound Program had 199 referrals. Of these, 121 were accepted into the Children's Wraparound Program. Of the 78 not accepted, 36 did not meet eligibility requirements, 26 were unable to be contacted after numerous attempts, 16 of the parents declined the voluntary services. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

- *The following are findings for Children's Mental Health Wraparound accepted cases for FY 2020:*
- *79 are male.*
- *55 were age 11 or younger.*
- *23 have been adopted.*
- *13 are in the care of a relative/guardian.*
- *15 of these accepted referrals were involved with DHHR's Child Protective Services/YPS.*
- *33 of accepted referrals are children who have an intellectual/developmental disability
 - *(I/DD) diagnosis in addition to a serious emotional disturbance (SED) diagnosis and are not eligible for I/DD Waiver or have not applied for I/DD Waiver.**
- *20 have a diagnosis of Autism; and*
- *8 have a parent incarcerated or a parent with a history of incarceration.*

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The Children's Mental Health Wraparound seeks to maintain those children/youth accepted into the program who were at-risk of placement outside their homes and communities by providing individualized, strength-based, trauma focused, community-based planning, and intensive intervention that safely preserves family relationships and empowers children and families to help meet their own needs.

Children's Mobile Crisis Response Program

FY2020 includes an expansion of the Children's Mobile Crisis Response & Stabilization to all BBH regions except region two which covers, Berkeley, Jefferson, Morgan, Pendleton, Mineral, Grant, Hardy and Hampshire Counties. It is expected that services will be statewide by October 2020. BBH's current services: region one, Genesis Youth Crisis Center; region two, TBD; region three, Westbrook Health Services; region four, Appalachian Community Mental Health covering Barbour, Upshur, Tucker and Randolph and United Summit Center covering Marion, Monongalia, Preston, Harrison, Taylor, Gilmer, Lewis, Doddridge, Braxton; region five, Prestera Center; region six, FMRS. Data for this expansion will be available for SFY2020 in July 2021. Crisis Respite Services were also added to the services which are available to families and will be offering 80 hours (96 hours if there is an unforeseen emergency requiring extra care) of respite.

In FY 2020, Children's Mobile Crisis Response was serving children through six agencies within the following counties:

- *Genesis Youth Crisis Center – Brooke, Hancock, Marshall, Ohio and Wetzel counties*
- *Westbrook Health Systems – Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt and Wood counties*
- *United Summit Center - Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston,*
- *and Taylor counties*
- *Appalachian Community Mental Health - Barbour, Randolph, Tucker, and Upshur counties*
- *Fayette, Monroe, Raleigh, Summers (FMRS) - Nicholas, Webster, Pocahontas, Greenbrier, Fayette, Raleigh, Summers, Monroe, Mercer, Wyoming, and McDowell counties*
- *Prestera Center- Boone, Cabell, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, and Wayne counties*

The program continues to link children and their families or caregivers to community services. It involves families in treatment and avoids unnecessary hospitalization or residential placement. In FY 2020, the Children's Mobile Crisis Response served 584 children/youth through these six agencies.

The Mobile Crisis Program will continue through DHHR's Bureau for Behavioral Health.

FY 2021 will include further expansion of services for Children's Mobile Crisis with the opening of a statewide crisis line through First Choice Services. This will include a Children's Mobile Crisis Statewide Hotline that will allow individuals and families statewide to be able to access crisis services through one centralized number.

Children’s Crisis and Referral Line and Warm Peer Line

On October 1, 2020, the Bureau for Behavioral Health launched a statewide, 24/7 Children’s Crisis and Referral Line which seeks to connect families in crisis immediately with regional Mobile Crisis Response and Stabilization Teams through warm transfer referrals. It will also connect professionals and families not in crisis with appropriate community-based behavioral health services and supports.

A companion to the Crisis and Referral Line is a statewide, 24/7 Peer Warm Line utilizing peer, including peer recovery, support specialists (PRSS) employed by First Choice Services. The Warm Line is for young adults and adults experiencing life challenges or recovering from SMI or co-occurring substance use disorder (SUD) and their families. The Warm Line will give any individuals experiencing life challenges, but not in crisis, the option to talk with peers who will listen actively and nonjudgmentally and link them with resources as needed, including referrals to other PRSS and regional Family Coordinators in the state.

First Choice Services manages the Children’s Crisis and Referral Line and Warm Peer Line – Statewide Services CALL 1-844-HELP4WV

Regional Family Coordinators – State Opioid Response (SOR)

Federal FY 2020, the State Opioid Response (SOR) Regional Family Coordinators are housed in the six Youth Service Centers. The SOR Regional Family Coordinators serve all counties in West Virginia. The SOR Family Coordinators facilitate the needs of family members of the youth or young adults involved in treatment and recovery at the Regional Youth Service Centers through screening, referrals, engagement and connecting the family to treatment and recovery service available through the community partners in the region and the state. An outreach event is scheduled in May at the Moorefield Ballfield with activities for families and referral/service information.

Regional Family Coordinators – System of Care (SOC)

Federal FY 2020, the System of Care (SOC) Regional Family Coordinators promote coordination and integration of family-centered care, facilitate participation and involvement of the entire family in a child, youth and/or young adult’s treatment and recovery, and connect families affected by mental health and/or co-occurring disorder with support and resources. The Family Coordinator facilitates the needs of family members of the children, youth and young adults involved in services at the Regional Youth Service Center and those who have been referred by other community agencies through referral, engagement, and connecting the family to treatment and recovery services available through the community partners in the region and state. The SOC Family Coordinators assist families in system navigation, including connecting them with resources to meet their basic living, social and emotional, educational, behavioral, and mental health service needs.

During Federal FY 2021, the Regional Family Coordinators (SOR and SOC) added a Family Advisory Board, completed a family survey which surveyed family needs and wants as related to how services are accessed,

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received and how families should be contacted or notified. The Bureau developed and published a family newsletter called *Family Connections* which is issued quarterly. The Regional Family Coordinators served 104 families since October 2020 and currently are still offering two parenting classes.

Positive Behavioral Support Services

Positive Behavioral Support (PBS) services focus on providing prevention and intervention supports for individuals who are demonstrating significant maladaptive behaviors, are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or Psychiatric Residential Treatment Facility (PRTF) or are transitioning to the community from an out-of-home placement. PBS is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve the overall quality-of-life of individuals who are experiencing significant maladaptive behavioral challenges. PBS embraces the conceptual approaches of wraparound or person-centered planning for individuals who have challenging behavioral needs requiring intensive support to help them demonstrate competencies to participate in community life, develop satisfying relationships, make choices, and gain personal dignity and respect. Services are designed to assist individuals to remain in or return to their homes or communities from residential treatment programs, psychiatric hospitals, or residential Crisis Response Units.

The current PBS program coordinator is the West Virginia University's Center for Excellence in Disabilities. The purpose of this program is to build both workforce capacity and systemic capacity to serve individual clients.

Therapeutic Foster Family Care

West Virginia's Therapeutic Foster Care (TFC) program is a family-based, therapeutic, trauma-informed service delivery approach. The program provides individual services for children and their families. The program is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and on-going training provides the foster parents the knowledge and skills needed to care for children that meet the criteria. The service is currently provided by five child placing agencies statewide however, new agencies will be added by July 1, 2021. West Virginia seeks to improve its program through development of model standards that clearly define services and activities that are to be provided to support the therapeutic foster parents, the child and his or her family and clarify the role of the child placing agency's case manager.

The West Virginia Therapeutic Foster Family Home model will be accessible statewide for all eligible children, will ensure that children are placed timely in a home in their own community with specially trained treatment foster parents who act as resource parents to the child's family of origin, and will provide children with high quality treatment services in a foster family home setting.

The TFC workgroup received technical assistance on three occasions which focused different TFC models and how different states implemented TFC. The State met with representatives from the states of Oklahoma and New Jersey for peer-to-peer learning.

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TFC will be provided for children who meet Wraparound or CSED Waiver eligibility and need placement through the Child Welfare system. Providers will recruit, train, and support these families at a more intense level than traditional foster care and the foster families will receive additional training to meet the more intensive emotional and behavioral health needs of the children placed with them.

Assertive Community Treatment

Children’s Mobile Crisis Response and Stabilization Teams help children and youth who are experiencing emotional or behavioral crises by interrupting the immediate crisis and ensuring youth and their families in crisis are safe and supported. The program is initiated by calling the crisis hotline, which went live on October 1, 2020, and provides the support and skills needed to return youth and families to routine functioning and maintain children in their homes or current living arrangements, schools, and communities whenever possible. The Children’s Mobile Crisis Response and Stabilization model is part of a continuum of community-based services designed to provide a toll-free crisis line, crisis intervention and stabilization, evaluation and assessment, and transition planning and follow-up. The service is provided in family homes, schools, group care, and other settings where immediate evaluations can be conducted that accurately assess the child and his or her living environment. Staff are available 24 hours per day, seven days per week to respond within an hour and offer intensive support and stabilization for up to 72 hours. The Children’s Mobile Crisis Response and Stabilization model links children and their families or caregivers to services in the community, involves families in treatment, and avoids unnecessary hospitalization or residential placement. Specifically, the target population for Children’s Mobile Crisis Response and Stabilization are children with the following characteristics:

- *Current symptoms or behaviors indicating the need for a crisis intervention;*
- *Symptoms and behaviors that are unmanageable at home, school, or in other community settings;*
or,
- *At risk of placement, or currently placed, in a psychiatric treatment facility or acute care psychiatric hospital and who cannot return without extra support.*

Mental Health Screening Tools and Processes

DHHR’s Office of Maternal, Child and Family Health (OMCFH), located within the Bureau for Public Health (BPH), is West Virginia’s Title V Maternal and Child Health Agency and is responsible for the utilization of funds provided by the Maternal and Child Health Block grant of title V of the Social Security Act of 1935, 42 U.S.C. § 701 et seq. Federal policy requires state Medicaid agencies to coordinate with title V grantees, especially regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. OMCFH provides administrative oversight for West Virginia’s EPSDT program, also known as HealthCheck. Consequently, OMCFH has a major role in establishing standards, policies, and procedures for health care services, interpreting standards to providers, providing education to enhance implementation, promoting quality of care, and assessing progress.

Developed in coordination with the OMCFH Pediatric Medical Advisory Board and BMS, HealthCheck preventive health screening forms and health history forms aid the determination of trauma history and

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any current trauma-related symptoms. These forms integrate socio-behavioral factors examined in the Adverse Childhood Experiences (ACEs) study and beginning at age nine, an abbreviated Post-Traumatic Stress Disorder (PTSD) Checklist – Civilian Version (PCL-C). This tool will be used for an initial screening of eligibility for Children’s Wraparound and Children with Serious Emotional Disorders Waiver. Further screening may be required.

Quality Assurance and Performance Improvement System

DHHR is developing a Quality Assurance and Performance System, including a data dashboard, which provides data and analytic capability necessary to assist with the assessment of service delivery and support the development of semi-annual reports in alignment with the goals and objectives of the Agreement.

To support quality assurance and performance improvement of the Agreement goals, West Virginia will focus on the collection, synthesis, and analysis of various DHHR data sources in the following areas:

- Examination of the quality of mental health services funded by the state, measured by improved positive outcomes, including remaining with or returning to the family home; and decreased negative outcomes, including disrupted foster home placement, institutionalization, arrest or involvement with law enforcement and the juvenile or criminal courts, suspension or expulsion from school, commitment to the custody of the Bureau of Juvenile Services or DHHR, or being prescribed three or more anti-psychotic medications.
- All children receiving services under the Agreement, including the type and amount of services they are receiving.
- All children screened pursuant to the Agreement, including the dates of screening and the dates of engagement in services.
- All children living in a RMHTF, including admission dates, length of stay, and number of prior placements in RMHTFs.
- Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment and the quality sampling review process.
- The fidelity of child and family teams to the NWI’s model.
- Data from the Crisis Response Team encounters, including timelines of response and data on connection to services.

Outreach and Education for Stakeholders

DHHR has instituted a more unified, department-wide approach to engaging stakeholders in its services and programming for children.

DHHR hosts an open stakeholder association, the West Virginia Child Welfare Reform Collaborative (the Collaborative). The Collaborative is a broad group of independent stakeholders, with meetings facilitated

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by DHHR, with participation from the DOJ and the SME, to share information, ideas, and feedback surrounding major child welfare reform initiatives throughout the state. Meetings are open to the public, and regular attendees include representatives of the legislative, judicial, and executive branches of state government, foster and adoptive families, residential care providers, socially necessary service providers, educational institutions, social work organizations, advocacy organizations, law enforcement, and concerned citizens. Representatives of press organizations have also attended the Collaborative meetings.

The most critical stakeholder, and often overlooked, is the child and his or her family. DHHR continues to work with the MCOs that serve the target population and those at risk of becoming part of the target population to identify and provide program-specific educational materials regarding the in-home and community-based mental health services available to the child and his or her family.

West Virginia believes that in addition to its Family First Five-Year Implementation plan and the states Program Improvement Plan, focusing on two main performance goals for the next five years will help set the stage for enacting its true vision for Child Welfare as well as bring the state closer to the vision of the Family First Prevention and Services Act. These two goals are extensions of the state's current PIP outcomes. They can be accomplished by simplifying our message to our front-line workers, Courts, providers and communities. They include; Increasing the percentage of West Virginia children who remain safe in their own homes, and, increase the number of youths experiencing positive outcomes as demonstrated through National Youth Transitional Database outcomes.

Several objectives under each goal will improve the quality of safety and case planning and improve the quality of both Child Protective and Youth Services intervention in the state. These activities include improving the frequency and quality of monthly contact by caseworkers, decreasing child fatalities, improving safety planning and case planning, decreasing repeat maltreatment and utilizing family preservation services more.

Update 2021:

In 2019 the Bureau for Children and Families began implementation of a streamlined policy and practice model focusing on clear direction for staff in investigating and assessing the needs of families. It began with training for our Youth Services caseworkers using the Family Assessment Support Tool (FAST) in assessing youth and families in youth services cases. Training was provided to a few selected counties and technical assistance was available to insure proper implementation. The focus was on guided intervention and teaming with families to improve areas identified as needing improvement.

Case Plans were developed to focus on those targeted areas and services delivered to reduce the likelihood they would need further intervention. This model was rolled out statewide December 1, 2019. There are plans to roll out a similar model in Child Protective Services in the summer of 2020. This streamlined intervention focuses on identifying areas of family functioning that are diminished and targeting services and interventions to improve those areas.

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Training and Technical Assistance teams will provide support and targeted training to individual counties based on their areas identified as needing improvement through quality assurance reviews and monitoring of statewide data in the areas of safety identification and planning and treatment planning. Counties may also request additional Training and Technical Assistance in areas they feel their staff need support.

An emphasis was also placed on family assessments and treatment planning in the managed care implementation process. With the help of the new managed care organization, Mountain Health Promise, and their on-staff clinicians and psychologists, the focus for 2020 will be on targeting appropriate services to address identified issues. Case planning has improved throughout the state and upper-level child welfare consultants and regional program managers will be monitoring cases within their counties, districts and regions to identify areas struggling in order to request additional training early on.

Update 2022:

Implementation of the changes to the Child Protective Services assessment and case planning process have been delayed to the COVID-19 pandemic. The pandemic consumed the time, resources, and ability of staff at all levels of the bureau. The streamlining group that developed the tools and planned implementation began meeting again in January 2021 to realign its focus. The training plan and webinar are in development with completion and implementation expected no later than June 2021. Regional field staff will work with the bureau's policy and training staff to ensure CPS workers are supported through this implementation and technical assistance is provided as needed.

In support of West Virginia's second goal of improving outcomes of youth transitioning from foster care, the state will improve its frequency and quality of services provided to older youth in foster care. This, in turn, will benefit children born of previous foster children. Activities to accomplish this goal include increasing the number of youths in foster care who receive prevention and transitioning services, increasing the number of youths who receive supervised independent living services and increasing the number of youths in foster care who have and maintain permanent connections.

Update 2021:

The BCF has initiated several projects in an effort to meet its goal of improving outcomes for transitioning youth. The creation of a "permanency unit" to focus solely on this group of foster children, a workgroup focused on implementation of the Foster Youth Initiative and expansion of the Family Unification Program, the redesign of our transitional living model, and innovative programs to serve and assist youth. The state anticipates the modifications and creation of a permanency unit with a dedicated manager and staff will be the link to improve the outcomes outlined in Goal 2; however, the state recognizes improvements to the data will not be seen until 2021, due to the timing of cohort surveys. All data will be shared with CIP, Child Welfare Oversight, WVFAM and Citizens Review Panel. The permanency program manager position is expected to be filled by May 2020.

One Program, Stepping Stones, is developing a community of tiny homes for transitional living clients. They currently have two tiny homes completed. One was designed by engineering students at Wayne High

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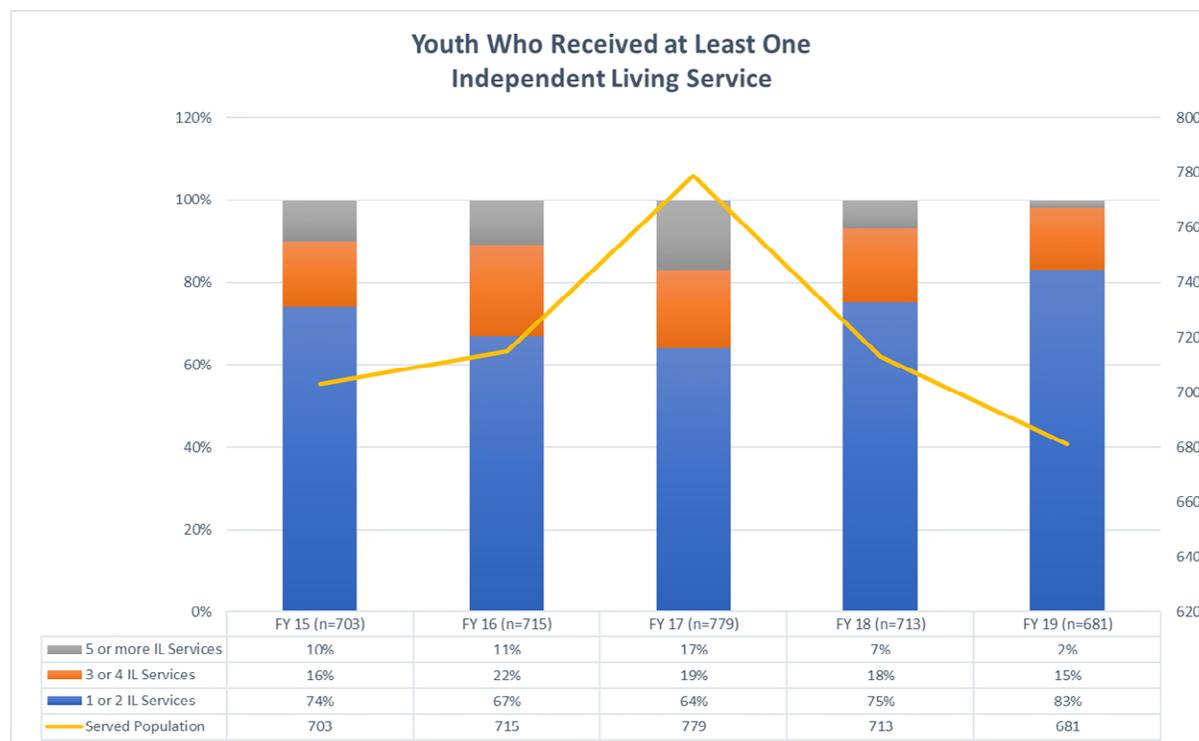
School and built by students at Tolsia High School. The other was built by inmates at Prunytown in adult education and certification classes. The first home was funded by Cabell Huntington Hospital and Toyota and the second one funded by the WV Department of Education Office of Diversion and Transition.

When the weather improves, they will be moving them on-site. They obtained funding for the septic system, moving, furniture and foundations through private funding. A ribbon cutting ceremony is planned for summer 2020, however due to the COVID-19 pandemic, this may be delayed. Engineering students are currently designing the entire village and they will be working with the Robert C. Byrd Institute to 3D Print a model of the tiny home village.

They will be providing an on-ground adult education and Options Pathway program in partnership with WV Department of Education Office of Diversion and Transition Programs, WVDOTP, (first certification in agriculture followed by building and construction and hospitality), Greenhouse and outdoor agriculture program providing training, therapy and employment as well as food security, evidence based substance treatment (Seven Challenges), evidence based trauma treatment (Seeking Safety), life skills, job training, employment, mentoring, food pantry, clothing closet, transportation, housing, social skills, transition coaching, integrated healthcare and community integration and support to residents of the village.

Update 2022:

In support of West Virginia's second goal of improving outcomes of youth transitioning from foster care, the state will improve its frequency and quality of services provided to older youth in foster care. This, in turn, will benefit children born of previous foster children. Activities to accomplish this goal include increasing the number of youths in foster care who receive prevention and transitioning services, increasing the number of youths who receive supervised independent living services and increasing the number of youths in foster care who have and maintain permanent connections. Data from NYTD indicates continued upward trends for Independent Living Services.



BCF recognizes supervisors and workers throughout the state that share a passion and dedication to providing our youth the best services possible. The Regions work closely with foster families to continue placement after age 18 while the youth are finishing high school. Foster and Kinship families have opened their doors to youth who return for services after they have aged out of care.

Several private agencies have also built-out their existing programs and services. As mentioned last year, Stepping Stones continues to build their Tiny Village on campus. Golden Girls on-site apartments continues to serve transitioning youth, especially prior to their entry into campus living at Marshall University. Youth Service Systems offers support, training and housing at the Tuel Transitional Living Training Center in New Martinsville serving youth 18 to 21. McCrary Center is an apartment complex in Wheeling, and Youth Service Systems obtained accreditation through CARF International as Community Housing. This supported housing option allows youth to live independently with assistance available 24/7.

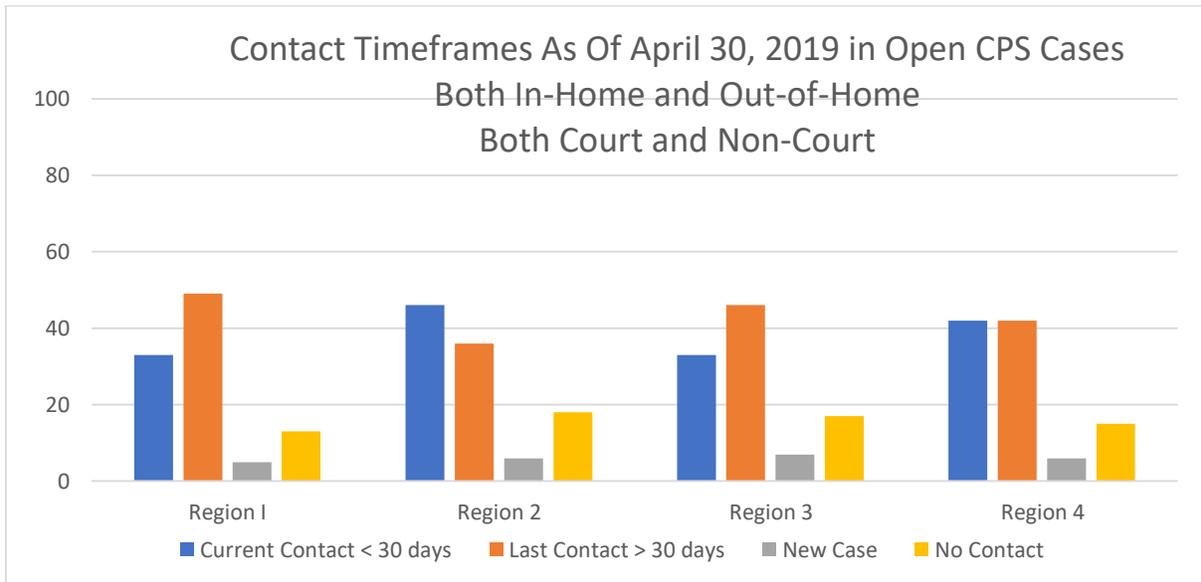
Goal 1. Ensure children receiving services, through Child Protective Services and Youth Services, remain in their own homes safely whenever possible.

The ability of the State to maintain children who are Candidates for Foster Care Placement due to Safety Concerns hinges upon quality Family Preservation Services provided to families. The percentage of Foster Care Candidates who remain in their homes until case closure will measure the success of prevention

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interventions. Trends in Socially Necessary Services track the number and duration of CPS and YS Family Preservation Services provided to families in their homes¹. Progress will be determined by increased percentages of the baseline, not on the state’s progress or lack thereof.

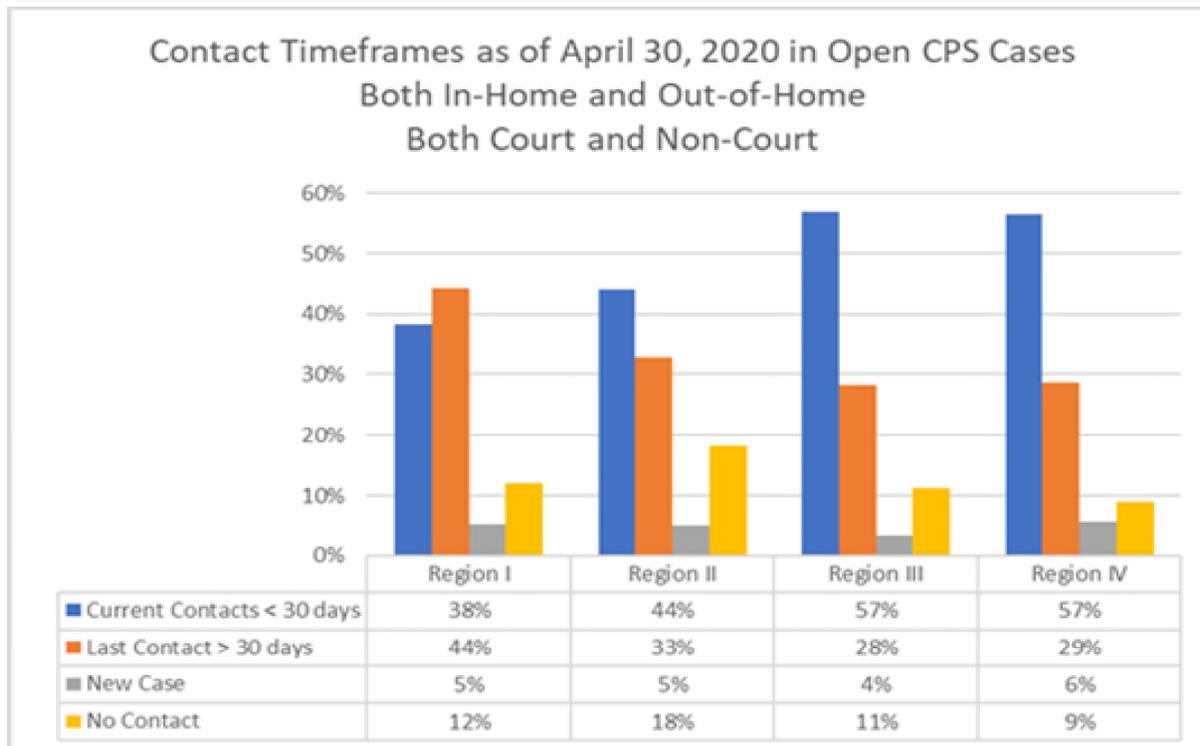
Objective 1.1 Increase the percentage of open cases with monthly contact by 2% the first year and 5% each additional year.



Current Contact < 30 Days	33%	46%	33%	42%
Last Contact > 30 Days	49%	36%	46%	42%
New Case	5%	6%	7%	6%
No Contact	13%	18%	17%	15%

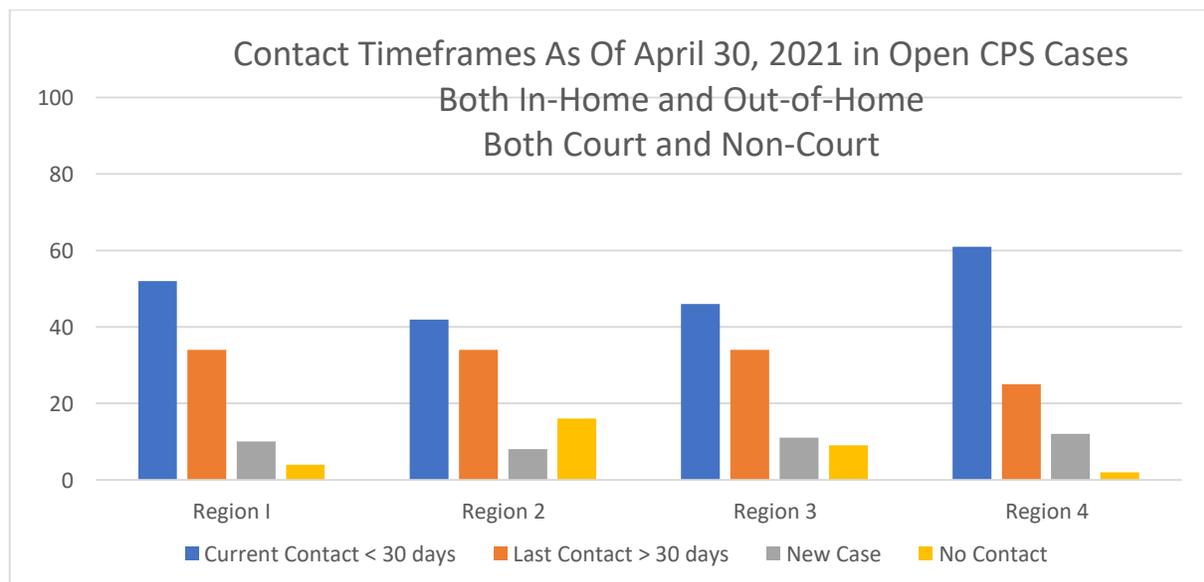
Source: FREDI CPS-8801 and CPS-5140 As Of 4/30/2019

Update 2021



Source: FREDI CPS-8801 and CPS-5140 As Of 4/30/2020

Update 2022:



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Current Contact < 30 Days	52%	42%	46%	61%
Last Contact > 30 Days	34%	34%	34%	25%
New Case	10%	8%	11%	12%
No Contact	4%	16%	9%	2%

Baseline 38.5%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	40.5%	45.5%	50.5%	
	Actual	49%	50.25%		

During the past year, the COVID-19 pandemic created an environment that required staff to alter monthly face-to-face contact with children and families as authorized by the Stafford Act. West Virginia has worked with staff to ensure that contact with families and children has continued to occur and work towards improvement despite any barriers resulting from the pandemic. In June 2020, the Meaningful Contact guide was released to staff to provide guidance and support for the contacts made with children and families. This guide was discussed at Social Services Supervisor meetings to reinforce its importance and continued use in support of field staff. The topic of using the Meaningful Contacts guide, was added to district unit meetings around the state. Supervisors were also reinforcing meaningful contacts with children and families, with child welfare workers during monthly consultations. Each supervisor is doing a monthly case review that includes looking for meaningful contacts within the case documentation. Finally, Customer Service Managers are monitoring face-to-face first contacts with victim child reports, monthly face-to-face contacts with children in placement reports and case reviews completed by supervisors. They are reporting their findings to the Regional Directors.

Due to COVID-19 restrictions with conducting face-to-face contact during much of the past year, virtual face-to-face contacts began occurring with child welfare workers and the children and youth they serve in specific circumstances. There were varied experiences with virtual visits that workers described:

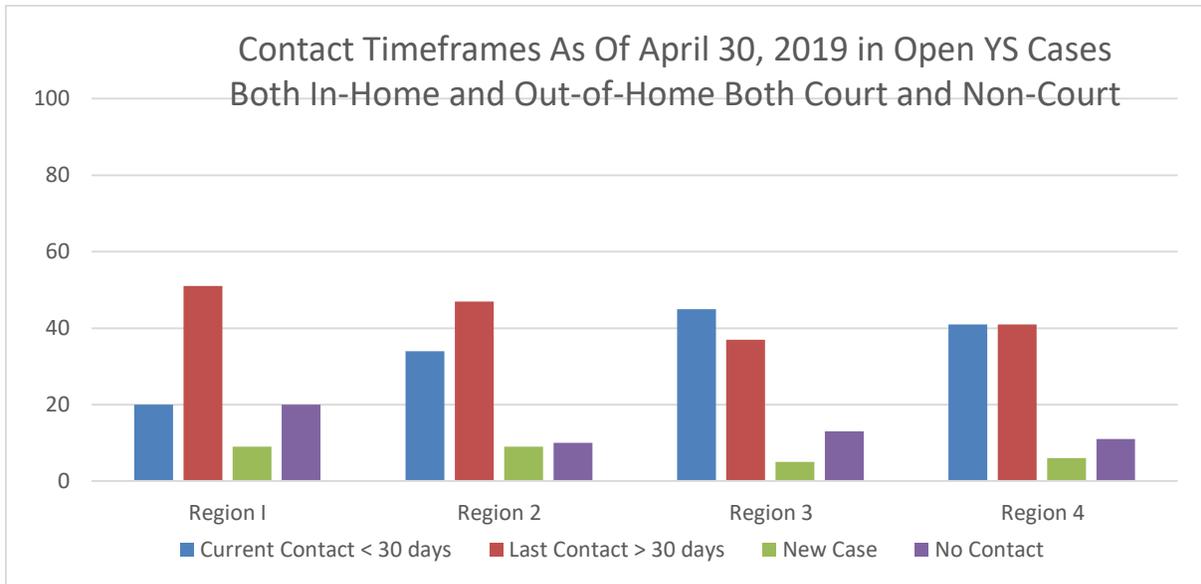
- “I liked doing the virtual visits. I have to admit it was a hard adjustment at first, but I came to like how it kept everyone safe. I have had several clients to tell me they like doing virtual better because it keeps everyone at a distance. I had a couple of my youth to speak to me more virtually than they do face to face. Not really sure why, but I think it is because they felt more comfortable virtually than in person. Most teens are in the virtual thing anyways, so in many ways we were getting on their level. Just my thoughts.” -D.G.*
- “The Virtual Visits were fine for the most part. However, as you know, real safety concerns cannot be seen or addressed over a video. We see what they want us to see. Also, most of the time when we are speaking with a child who doesn’t really want to talk to us-we look at the ceiling. Another concern is the inability to make and maintain rapport via video. It has also been a challenge to get the children to answer the Zoom calls, etc., and see the parents via virtual visitation-as well. I understand that the situation made it the safest way possible to conduct visits, but I am glad that we are back to seeing our children and their families face to face.” -P.W.*
- “The virtual visits were good with parents and older children who can talk and directly answer questions when asked. It was a great tool to keep us safe and the clients safe from the virus.*

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However, many clients did not have access to internet services or their phone signal was nonexistent so it was extremely difficult to meet with families. Young children were extremely hard to interview and assess for safety concerns considering that parents were usually around and were unable to disclose. There was also the human aspect that was lacking. We as workers were unable to play with the children or hug them so it seemed very disheartening for the children as us workers get close with our families we work with.”-M.C.

- *“I completed a monthly face to face with a youth this month that is in a treatment facility. Due to a covid-19 outbreak all of their face to face had to be done virtually for the month. The visit went really well with the youth, he was more open to talk and did not appear to be as nervous talking to the worker via zoom than he was in person the previous month. The virtual visit with this youth went smoothly and also provided extra time for me to talk with his case manager more in detail without the youth being present.”-C.M.*

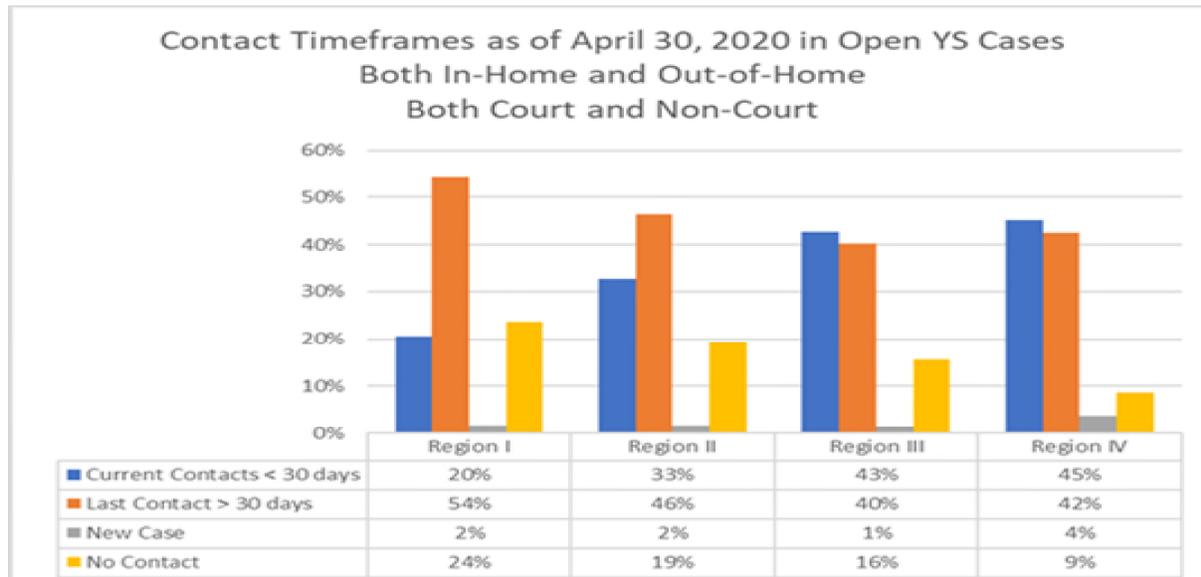
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Current Contact < 30 Days	20%	34%	45%	41%
Last Contact > 30 Days	51%	47%	37%	41%
New Case	9%	9%	5%	6%
No Contact	20%	10%	13%	11%

Source: FREDI YSS-5020 As Of 4/30/2019

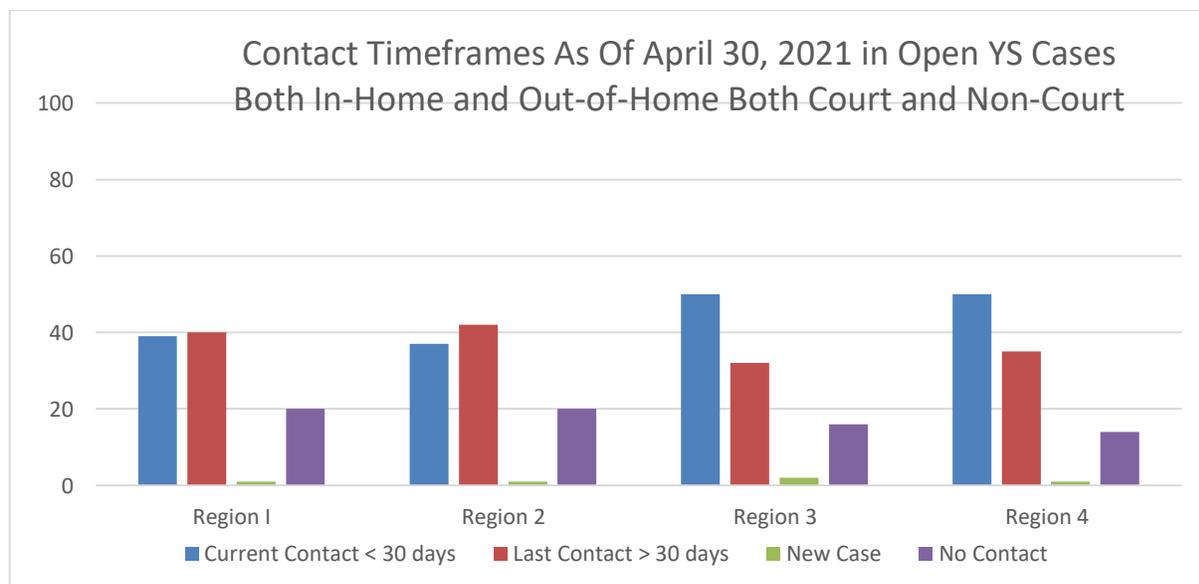
Update 2021:



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Source: FREDI YSS-5020 As Of 4/30/2020

Update 2022:



Current Contact < 30 Days	39%	37%	50%	50%
Last Contact > 30 Days	40%	42%	32%	35%
New Case	1%	1%	2%	1%
No Contact	20%	20%	16%	14%

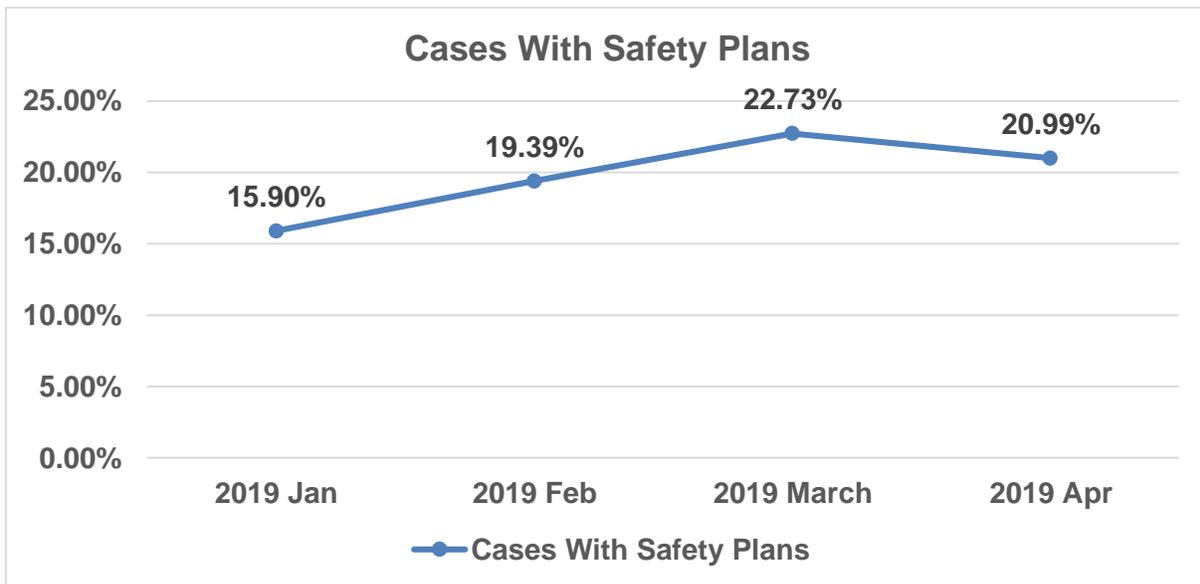
Baseline 35%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	37%	42%		
	Actual	35.25%	44%		

Youth Services cases are usually derived from court involved youth. These youth are often referred to the court system due to problems in the education system. Youth Services staff will often make face-to-face contact with their children either at court or at the child's school. On March 22nd, the West Virginia Supreme Court of Appeals issued a judicial emergency, cancelling all hearings through April the 10th. On March 24th, 2020 Governor Justice issued a Stay at Home order. The Stay at Home Order closed schools for a three-week period and prevented staff from making face-to-face visits with their children. During this time the state began planning its response to the pandemic and how it would continue to ensure children and families continued to receive the vital services provided by the BCF while maintaining their safety and the safety of our staff. The state, like much of the country, struggled with obtaining the proper cleaning and sanitation supplies, as well as personal protective equipment. Considering this limited supply,

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the state prioritized child abuse and neglect referrals for continued face-to-face visitations. Then on April 3rd the West Virginia Supreme Court of Appeals entered an amended judicial emergency order canceling all hearings through May 1st and then on April 21st Governor Justice closed schools for the remainder of the year. This rapid change in circumstance limited Youth Services' staff ability to make the necessary in person visitation through much of March and all of April. This undoubtedly impacted Youth Services ability to meet its targeted goals.

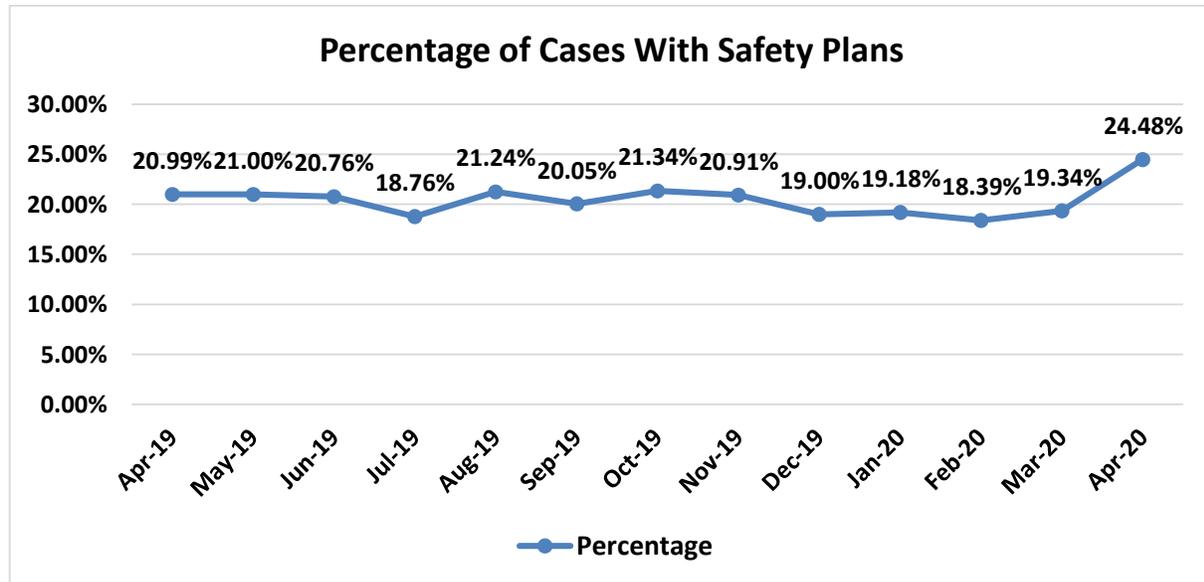
Objective 1.2 Increase the percentage of CPS cases open with safety plans by 2% in year one and 5% each additional year.



Source: End of Month CPS Case Counts and FREDI CPS-5170

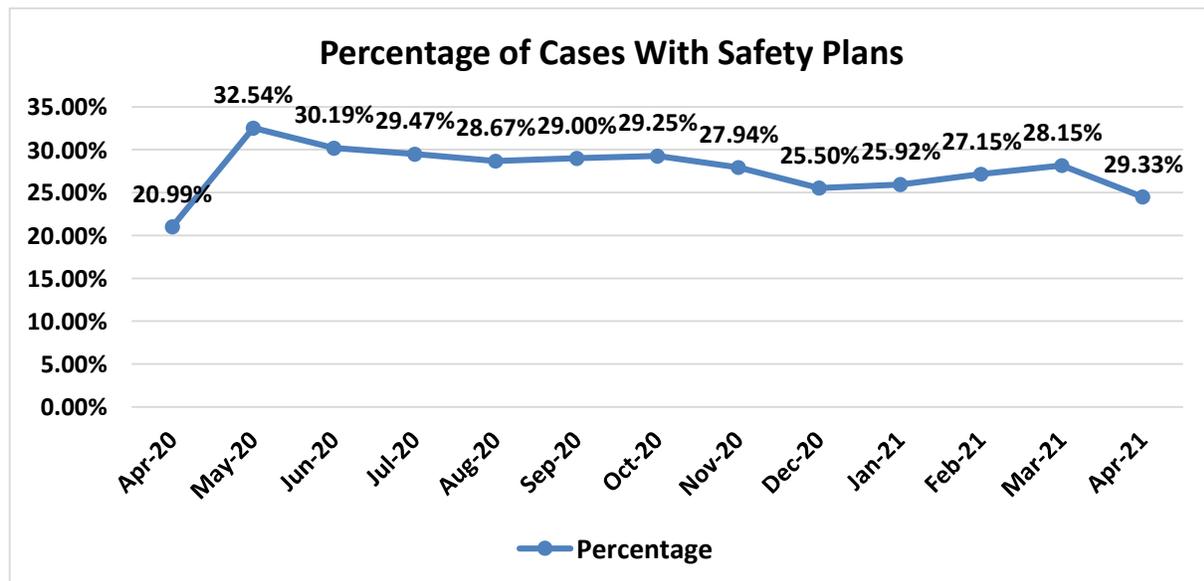
Update 2021:

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Source: End of Month CPS Case Counts and FREDI CPS-5170

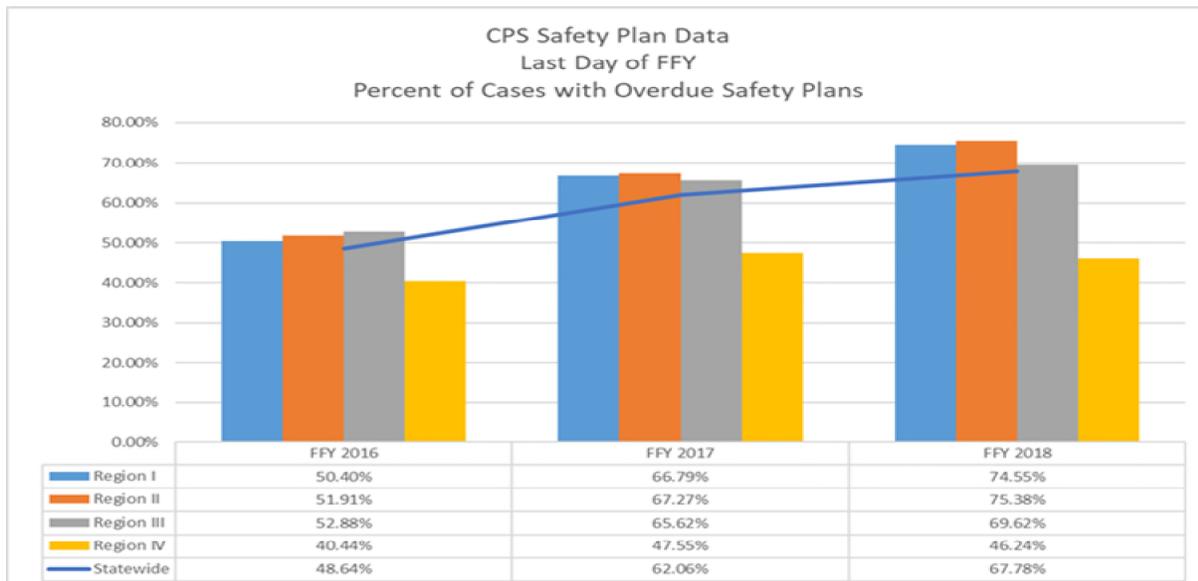
Update 2022:



Source: End of Month CPS Case Counts and FREDI CPS-5170

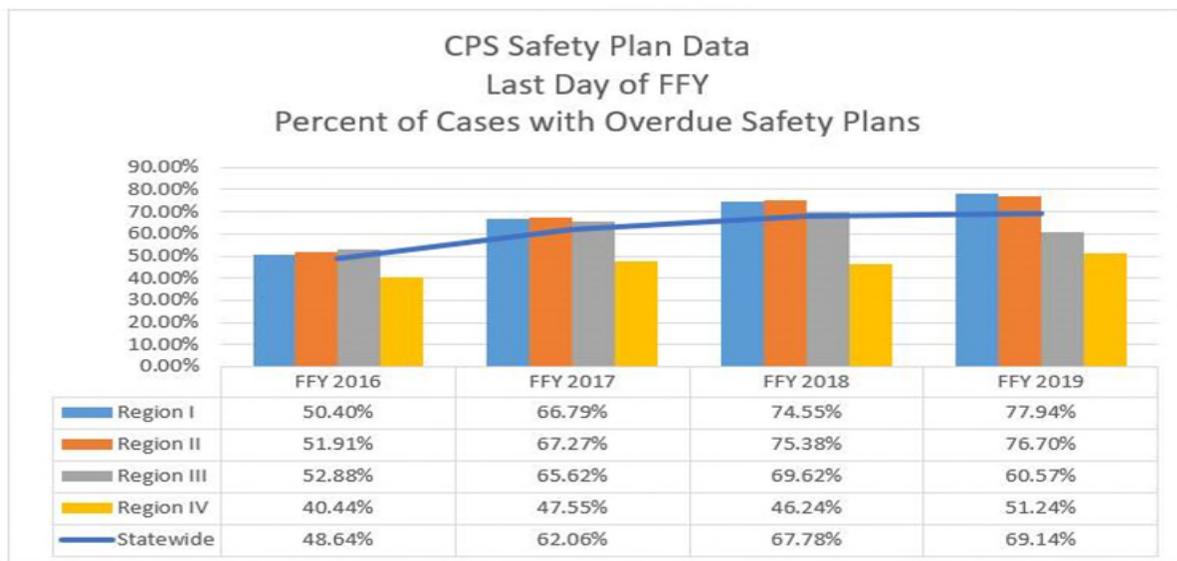
	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
Baseline 20.99	Projected	22.99%	27.99%	32.99%	
	Actual	24.48%	29.33%		

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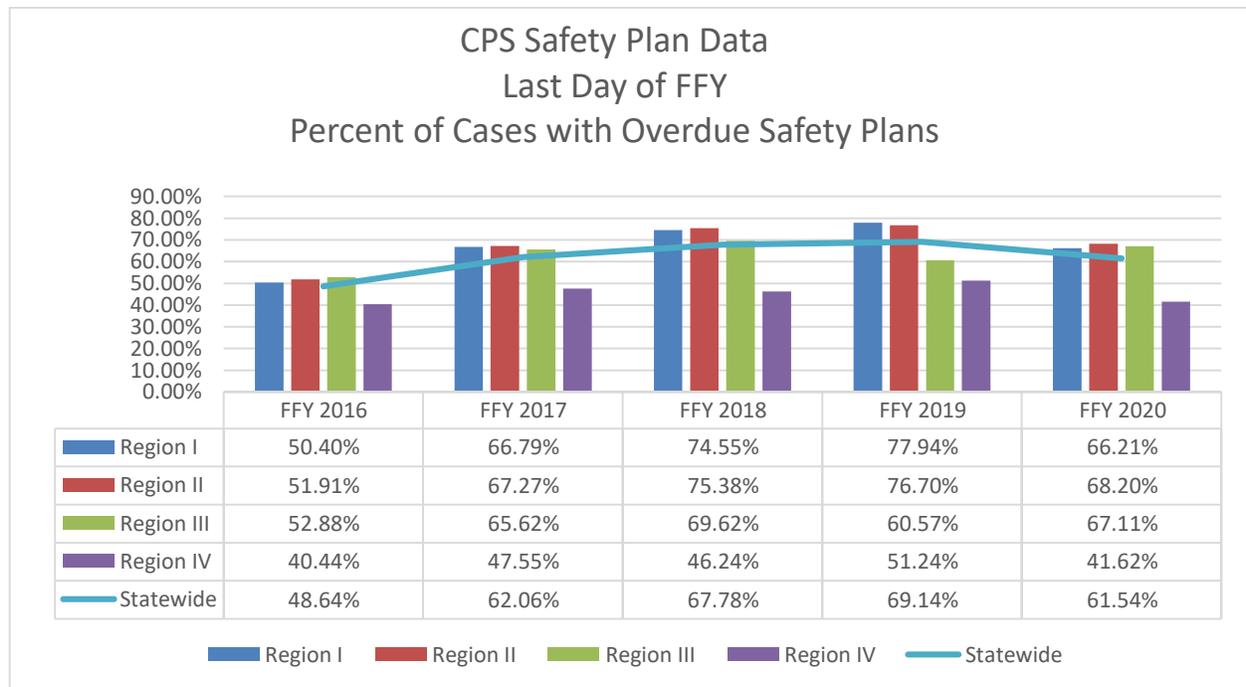
Source: FREDI CPS-5170 9/30 of each FFY

Update 2021



Source: FREDI CPS-5170 9/30 of each FFY

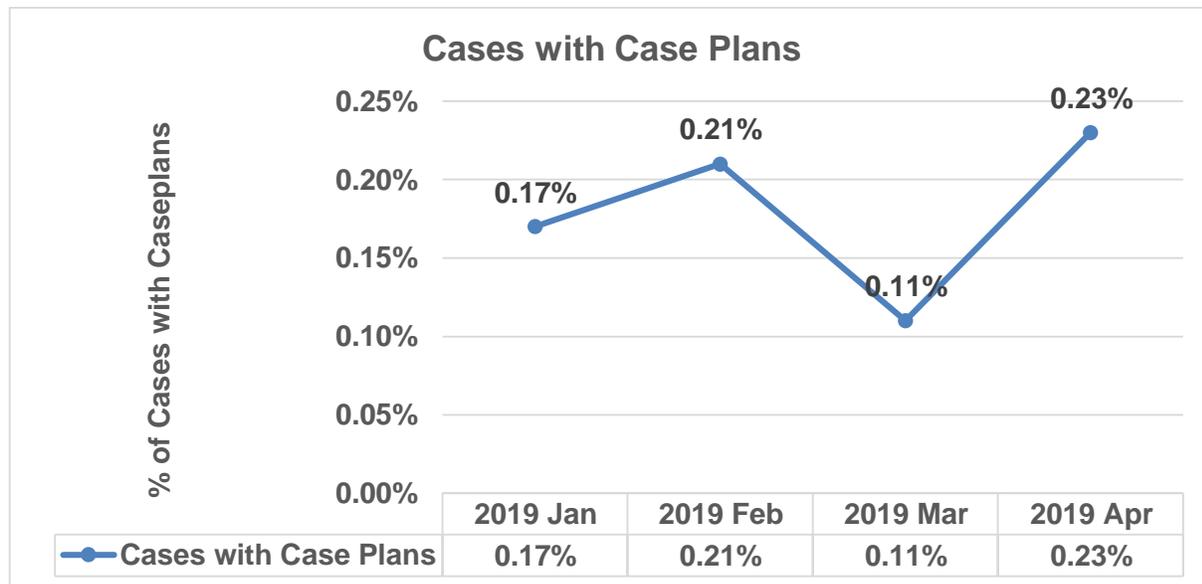
Update 2022:



Source: FREDI CPS-5170 9/30 of each FFY

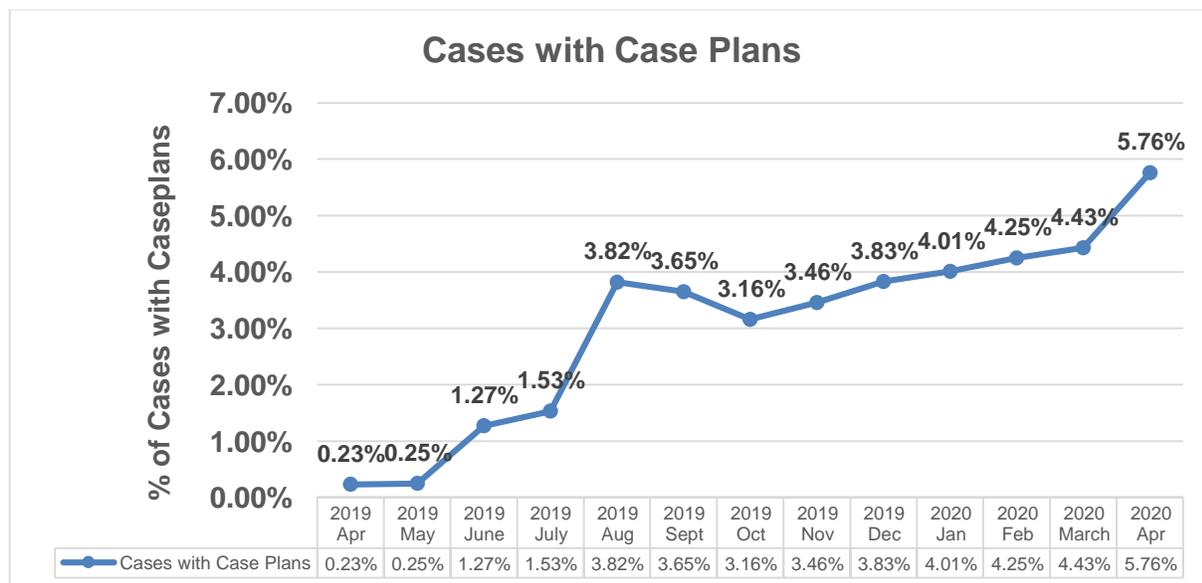
Objective 1.3 Increase the percentage of cases that have a case plan by 2% in year one and 5% each additional year.

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Source: FREDI reports CPS5260 and CPS8802

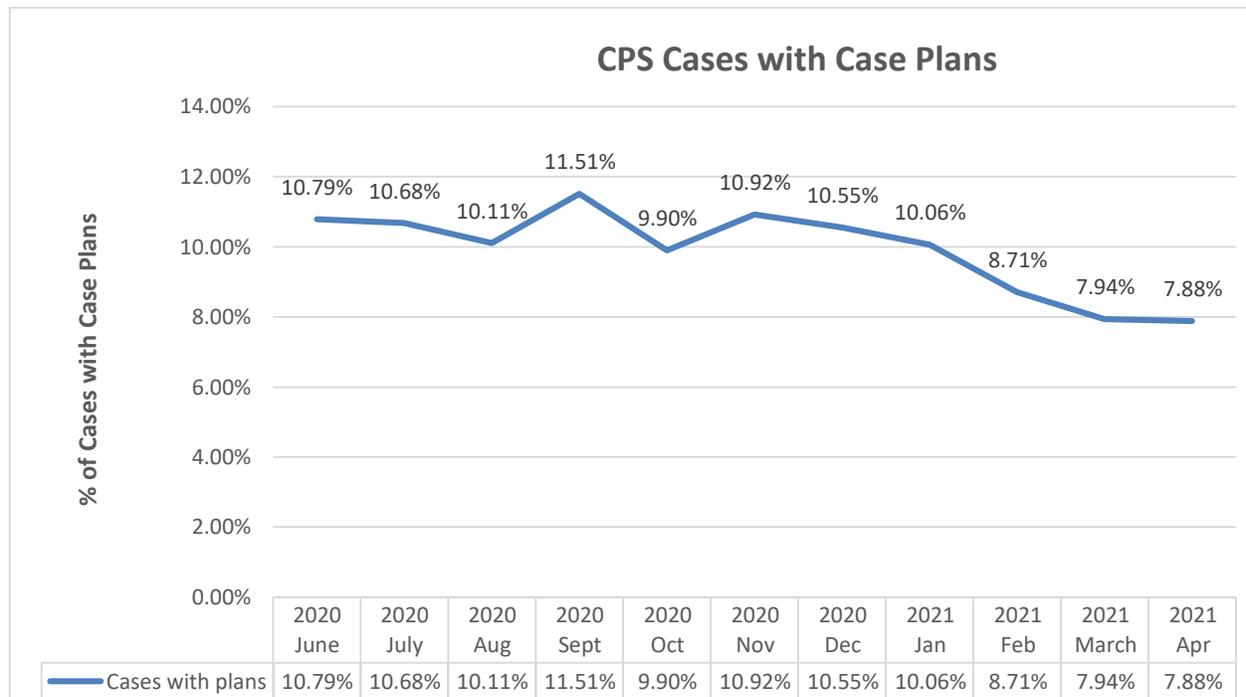
Update 2021:



Source: FREDI reports CPS5260 and CPS8802

Update 2022:

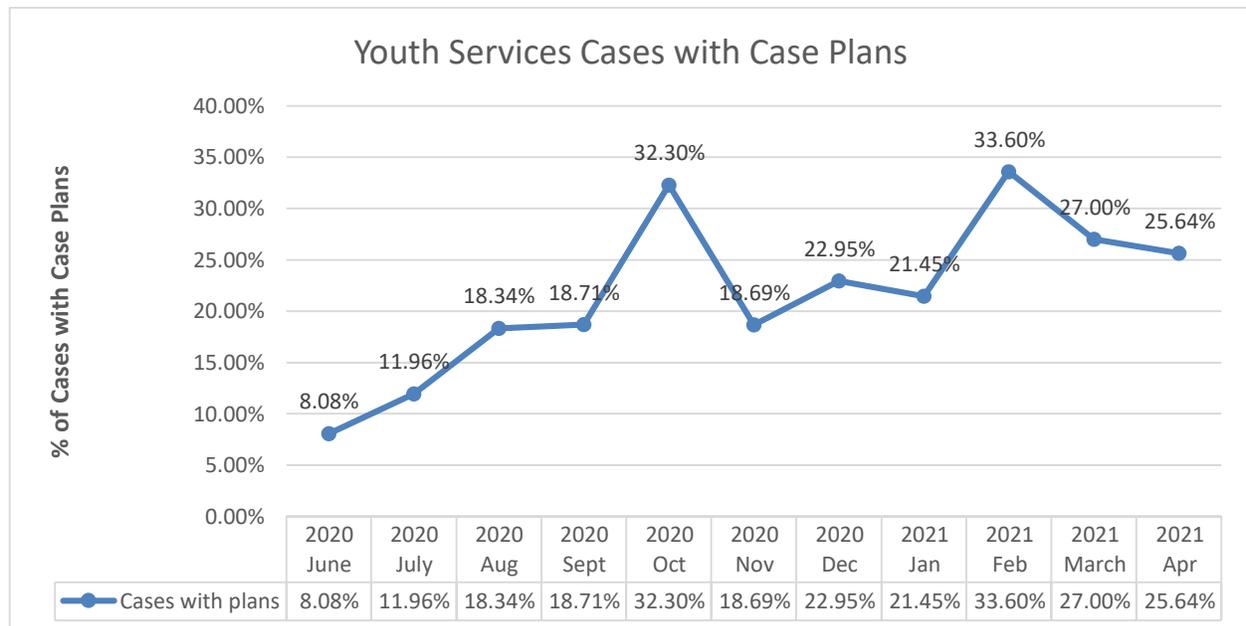
**WV Department of Health and Human Resources
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Source: Hand counts

Although this goal is specific to abuse and neglect cases, the agency is placing the same emphasis on case planning within the Youth Services program. The concept of case planning is well-established as an intervention necessary to move families towards success and prevent reentry into the child welfare or juvenile justice system. Below is the percentage of Youth Services cases with a case plan. This data will not be reflected in the case planning goals benchmarks and will not be counted towards progress.

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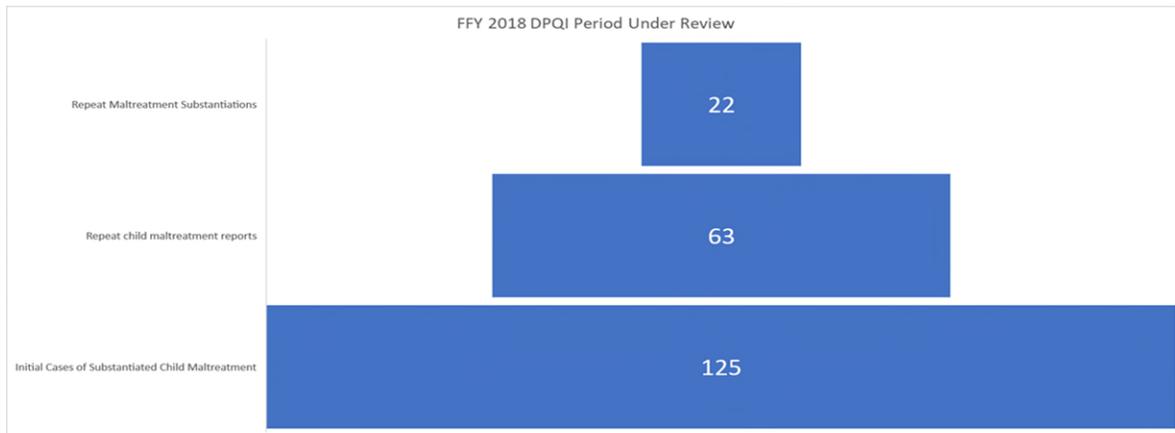
Source: Hand Counts

The agency began gathering data regarding cases with case plans by doing hand counts in June 2020. Ongoing technical assistance was provided to supervisors to help determine how best to gather and report the information as well as regarding the necessity for each case to have a case plan. Initially, there was a spike in the number of completed case plans because staff were considering court case plans in the data until assistance was provided to the field to only include data about case plans done through the Protective Capacities Family Assessment case plan. By initiating this process, the staff began reevaluating cases for closure, which will further help with conversion to PATH. This will also help provide more accurate data once the conversion to PATH has been completed.

Baseline .23%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	2.23%	7.23%	12.23%	17.23%
	Actual	5.76%	7.88%		

Objective 1.4 Decrease the percentage of cases with repeat maltreatment by 2 % the first two years and 5% each additional year.

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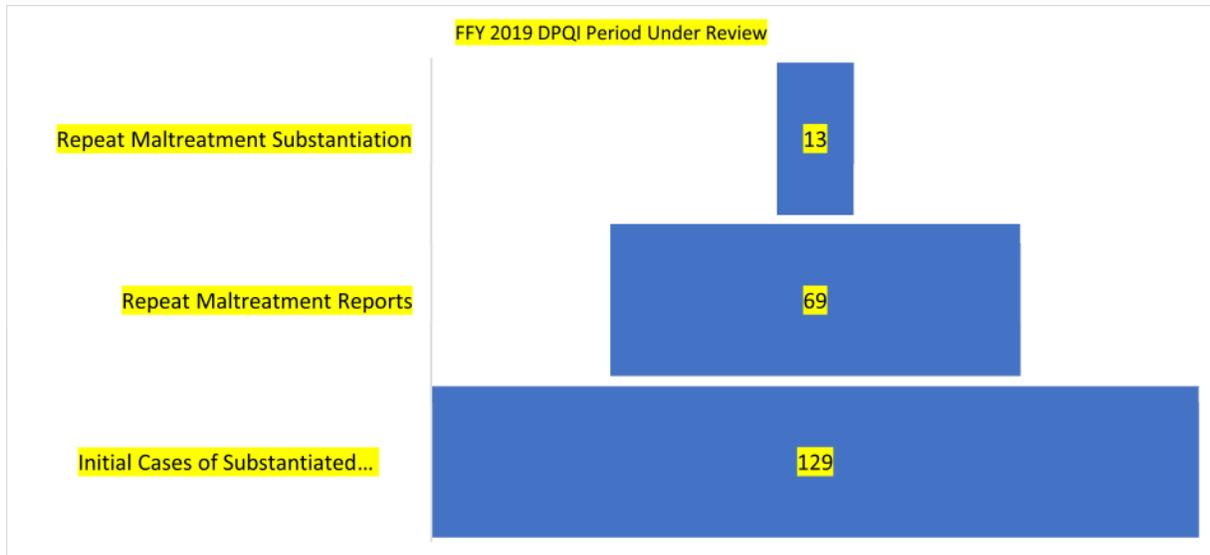
Source: DPQI Review Data

- FFY 2018 reviewed cases which had at least one substantiated child maltreatment intake during the period under review (PUR-12 months from date of the review) is 125 cases.
- Of the 125 cases reviewed during the FFY, 63 cases were rated for CFSR Item 1 indicating a received, accepted, and assigned child maltreatment report during the PUR.
- Of those 63 cases, child maltreatment was substantiated in 22 cases or 17.6%

Update 2021:

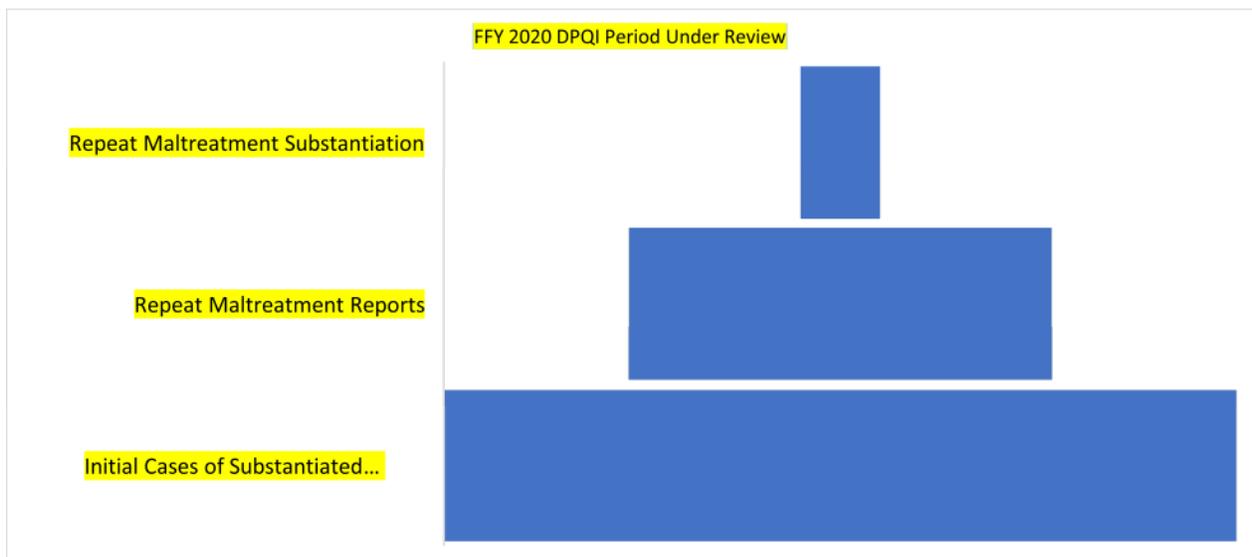
The chart above indicates those cases that had more than one substantiated referral during the period under review. For this year's APSR and each subsequent year, West Virginia will be reporting the number of cases reviewed that had a substantiated maltreatment after a case was opened and services were provided. See chart below.

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Source: DPQI Review Data

Update 2022:

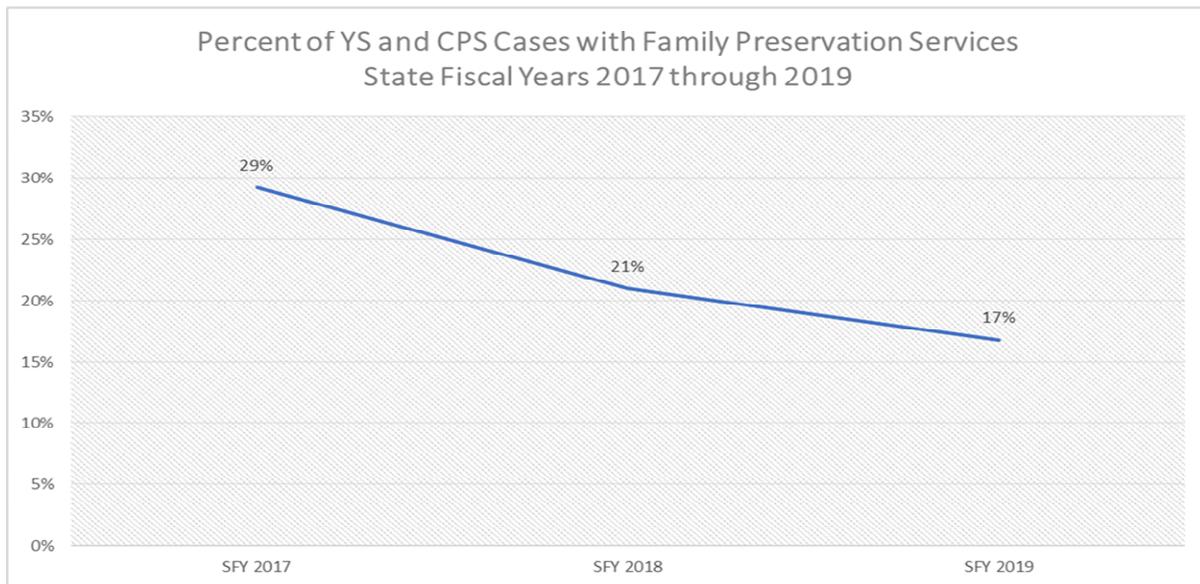


Source: DPQI Review Data

	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
Baseline 17.6%	Projected	15.6%	10.6%	5.6%	.6
	Actual	14.7%	6.9%		

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Objective 1.5 Increase the percentage of open cases that receive Family Preservation Services by 2% in the first year and 5% each additional year.

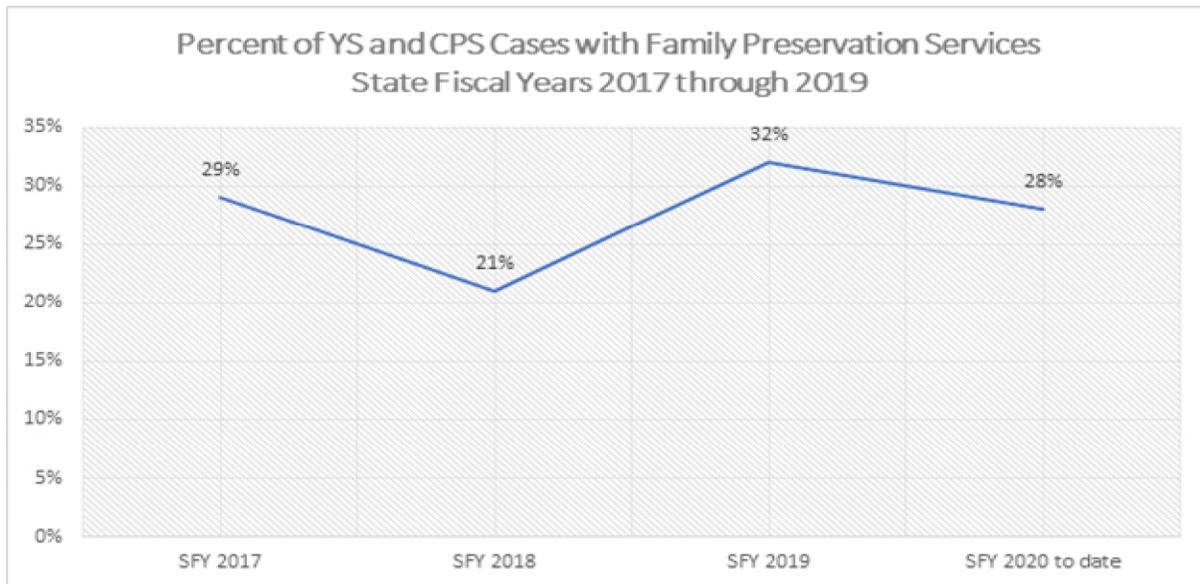


Source Data: COGNOS ASO Payments

Update 2021:

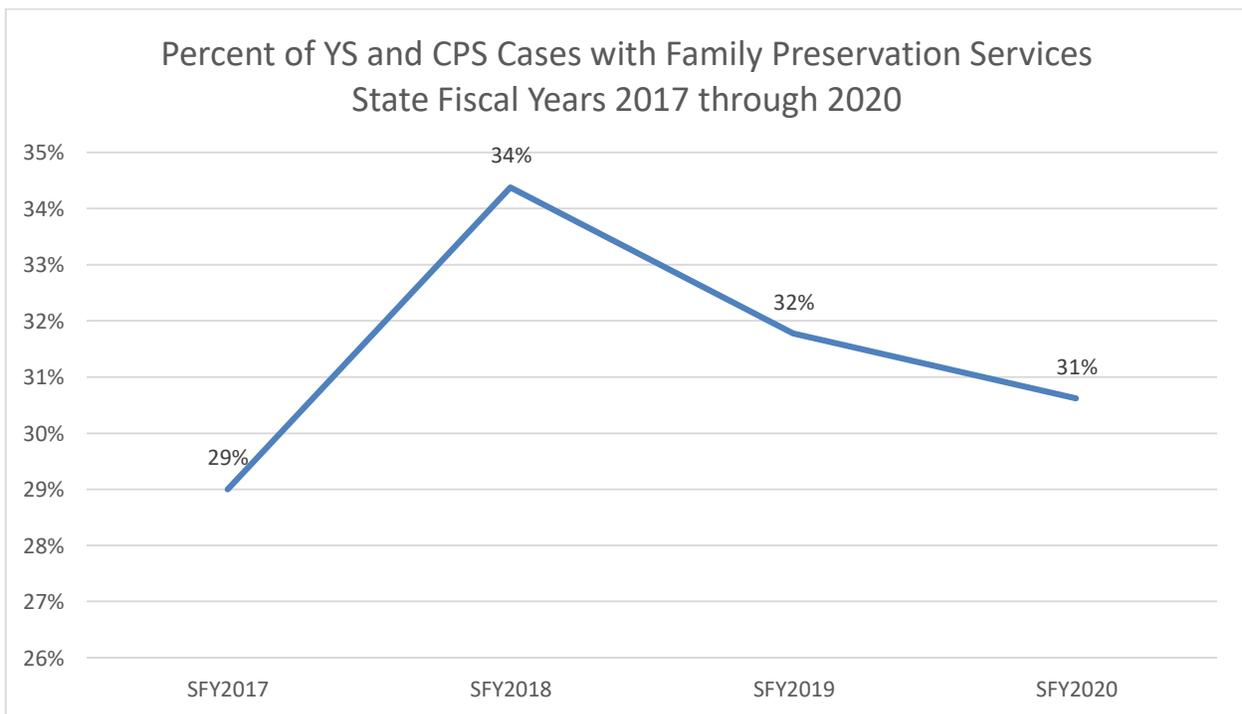
The chart below includes the entire year of 2019 which showed a positive increase in the percentage of cases that received Family Preservation services through the remainder of the year. This APSR is using the full year of SFY 2018 as its baseline and the SFY for all updates.

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Source Data: COGNOS ASO Payments

Update 2022:



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	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
Baseline 21%	Projected	23%	28%	33%	38%
	Annual	32%	31%		

Though BCF met its 2022 goal, we did see a marginal drop in cases with preservation services. This is predominantly due to COVID-19 restrictions and the temporary suspension of use and limitations on specific services immediately preceding the state’s stay-at-home order.

Goal 2. Increase positive outcomes for youth aging out of foster care.

Goal 2 utilizes NYTD survey data to measure objectives’ progress. Due to the availability of the data source progress reporting will be delayed by one reporting year. Cohort 3 A is the baseline percentage utilized to measure the state’s ongoing progress. This group of youth represents the first cohort that the state can actualize positive change. Cohorts 1 A and B, and Cohorts 2 A and B are illustrated in the charts for each objective. This allows the state to infer the progress which should be reflected when Cohort 3 B data is available in calendar year 2021. Progress will be determined by increased percentages of the baseline, not on the state’s progress or lack thereof.

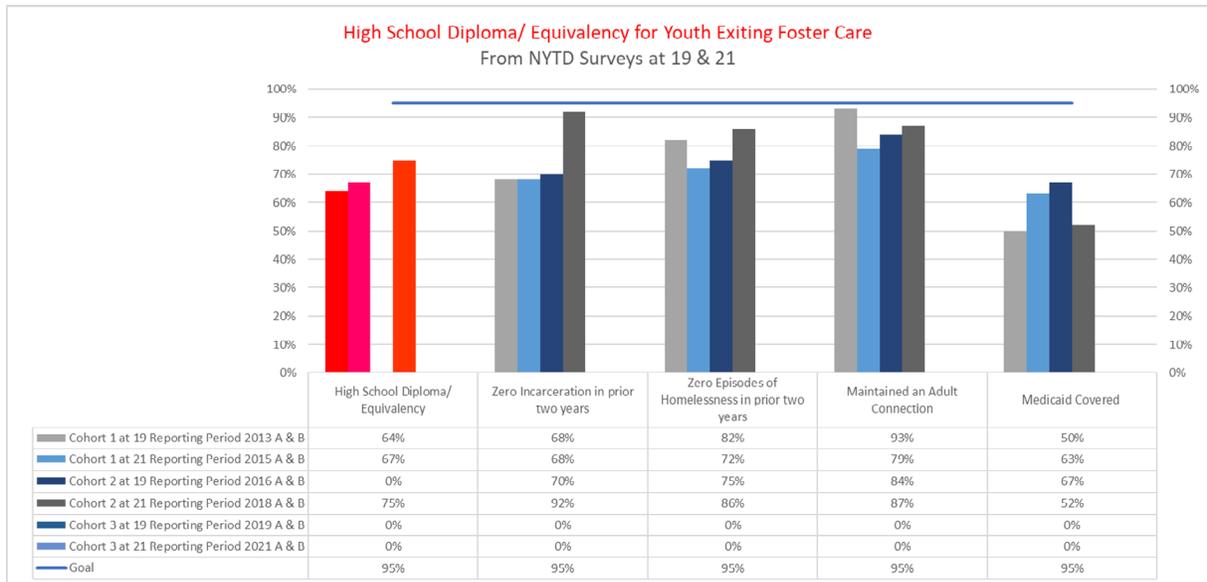
Update 2022:

West Virginia sought technical assistance for NYTD Cohort 3 period 10/1/20 through 3/31/21. Telisa Burt at the Children’s Bureau was very helpful to assist when it was discovered that the NYTD Survey Specialist contacted a list of 17-year-old youth rather than the 21-year-old follow-up population. The Served Population data was submitted timely for 2021A. A corrected file will be resubmitted of 2021A by September 30, 2021. Thus, our progress reporting for 2022 is delayed.

Another area of technical assistance was received from Andrea Grimaldi, Technical Specialist. The data submission for FFY14 and FFY16 indicated zero high school graduates. This data was reviewed and revealed 21 youth finished high school or GED in the Baseline FFY14 period and 138 youth finished high school or GED in the 19-year-old follow-up FFY16 period. We have revised this chart below.

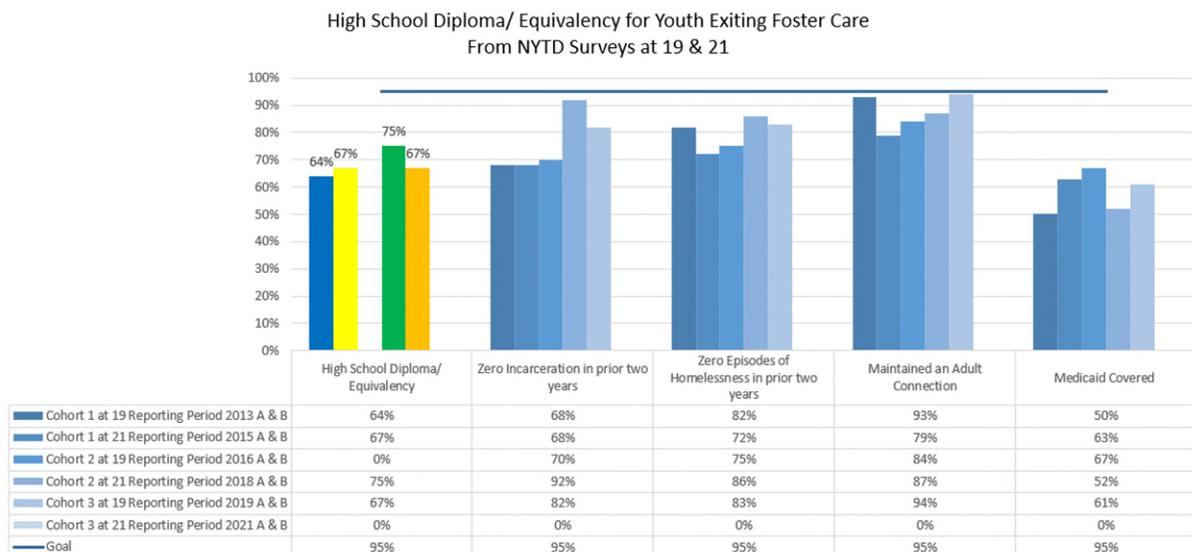
Objective 2.1 Increase the percentage of foster youth who, when surveyed at 21, completed high school or obtained high school equivalency by 5% each additional year.

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Source: NYTD Snapshots for West Virginia from ACF

Update 2021:



Source: NYTD Snapshots for West Virginia from ACF

Objective 2.1 is to increase high school or equivalency completion by ages 19 & 21. Based upon the result from Cohort 1 at 17 this measure is 5% and increases to 64% at 19 with 67% of youth at 21 reporting

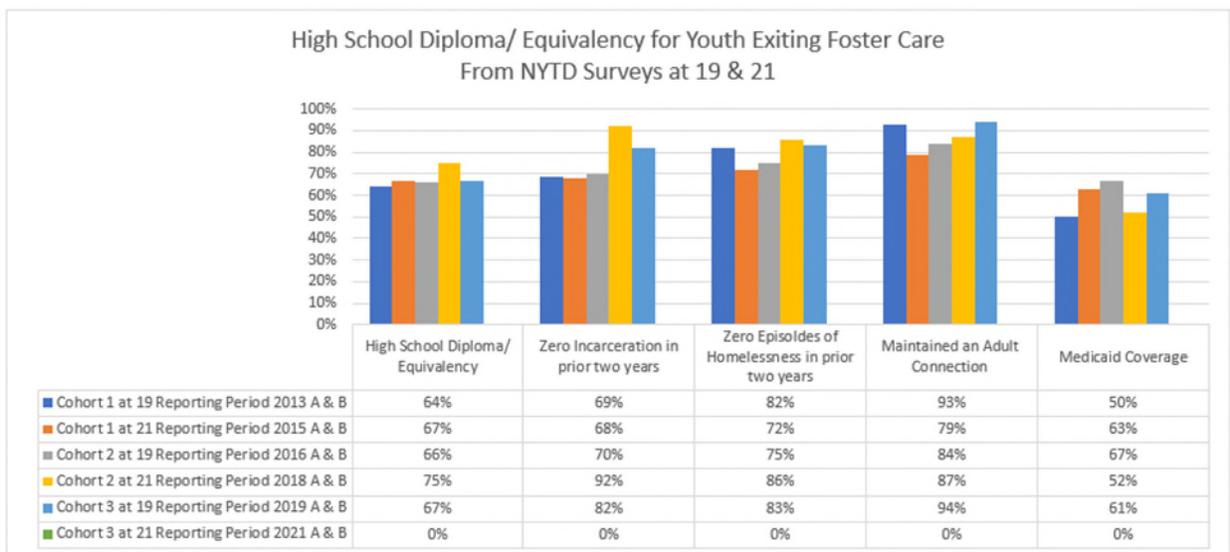
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completion of high school or equivalency. 67% of youth in Cohort 3 at 19 report completion of high school or equivalency. When data is available for Cohort 3 at 21 the trend should continue upward toward the goal of 72%.

Update 2022:

Another area of technical assistance was received from Andrea Grimaldi, Technical Specialist. The data submission for FFY14 and FFY16 indicated zero high school graduates. This data was reviewed and revealed 21 youth finished high school or GED in the Baseline FFY14 period and 138 youth finished high school or GED in the 19-year-old follow-up FFY16 period. We have revised this chart below.

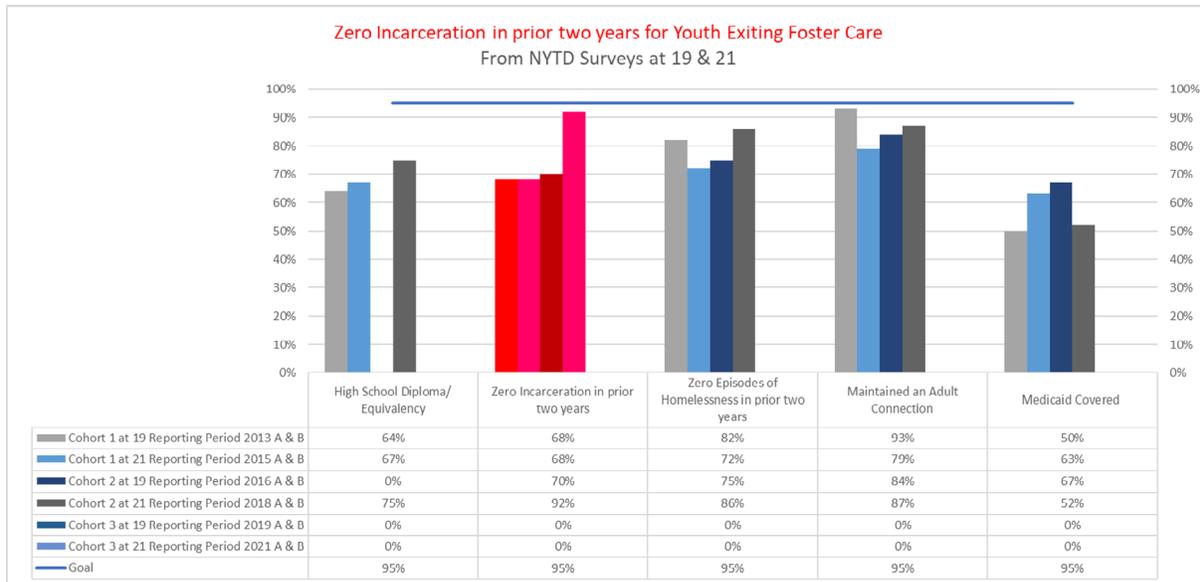
Revised Chart based upon data review by ACF Children’s Bureau:



Baseline 67%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	72%	77%	82%	87%
	Actual				

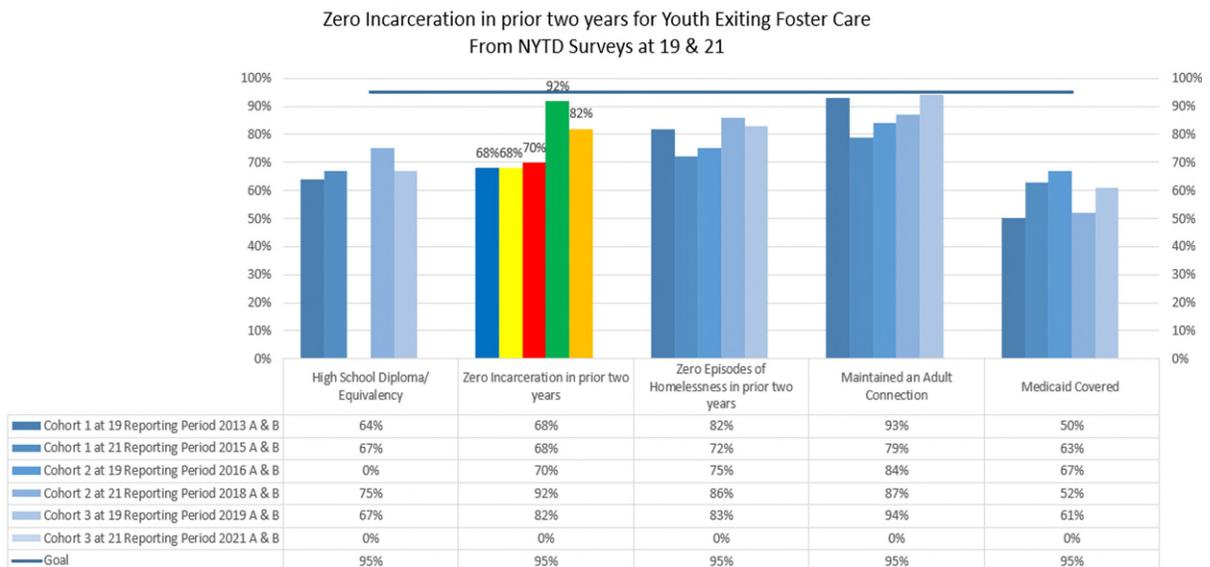
Objective 2.2 Increase the percentage of foster youths, by 5% each year who, when surveyed at 21, had not been incarcerated.

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Source: NYTD Snapshots for West Virginia from ACF

Update 2021:



Source: NYTD Snapshots for West Virginia from ACF

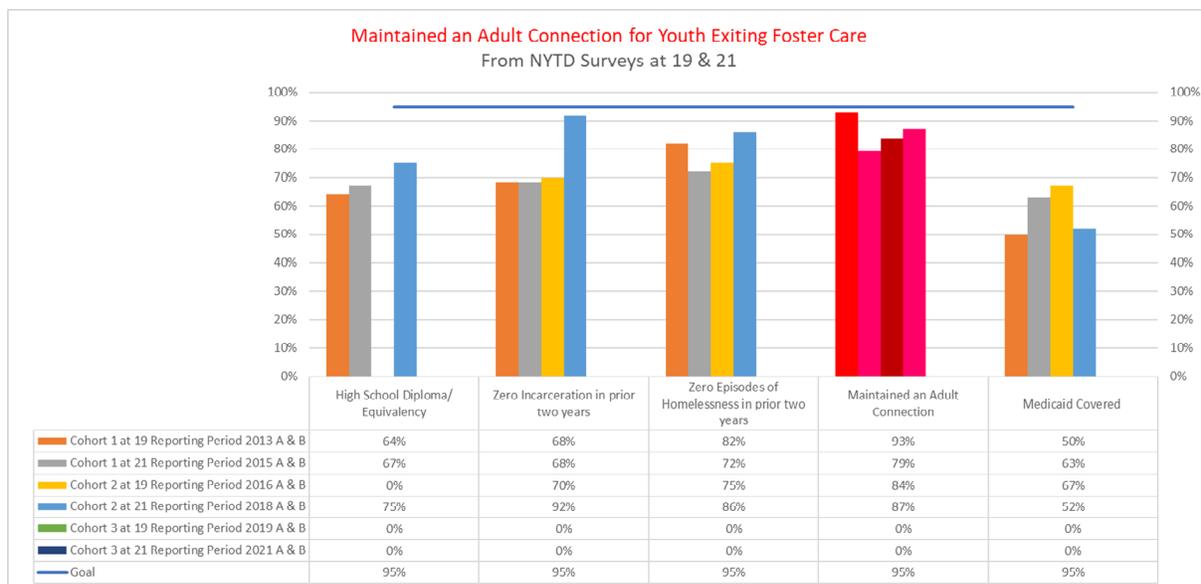
While NYTD data will not be available until the next reporting year, we see that in the past 2 cohorts and up to Cohort 3 A a positive increase in the number of youths who report never being incarcerated. From

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Cohort 1 A to the current cohort we see a 14% positive increase. The difference between Cohort 2 A and B is staggering. This group of children saw a 22% positive increase in the number of youth reporting zero incarcerations. We expect to see our Cohort 3 B group to follow in the same positive trend when the data is available.

Baseline 82%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	87%	92%	97%	100%
	Actual				

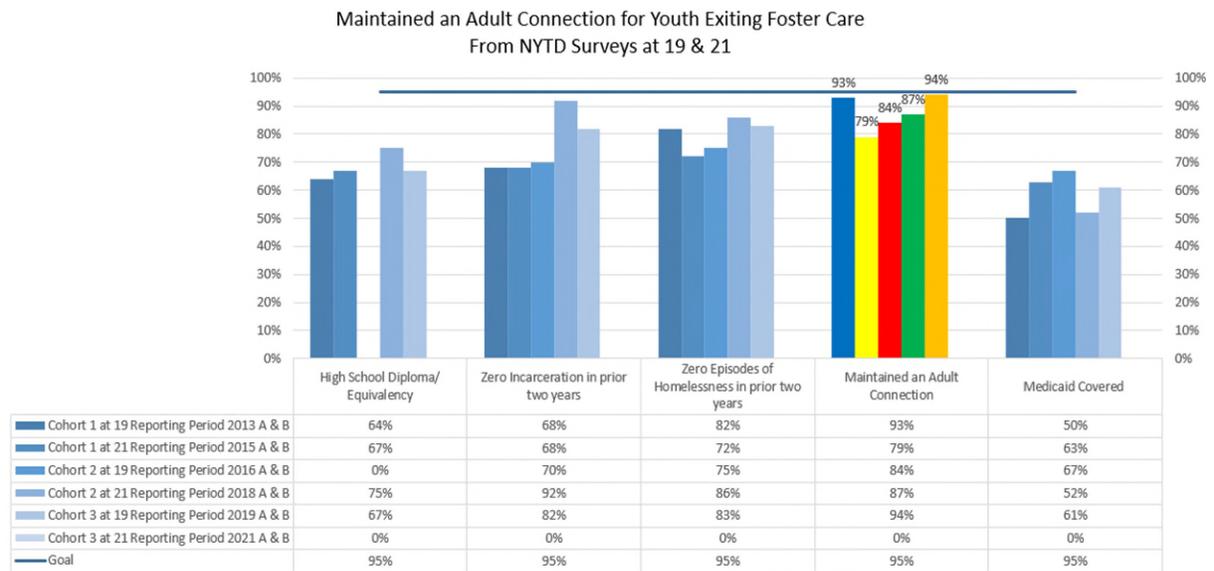
Objective 2.3 Maintain the percentage of older youth in care who have a permanent connection identified at 17, 19 & 21 at or above 95%



Source: NYTD Snapshots for West Virginia from ACF

Update 2021:

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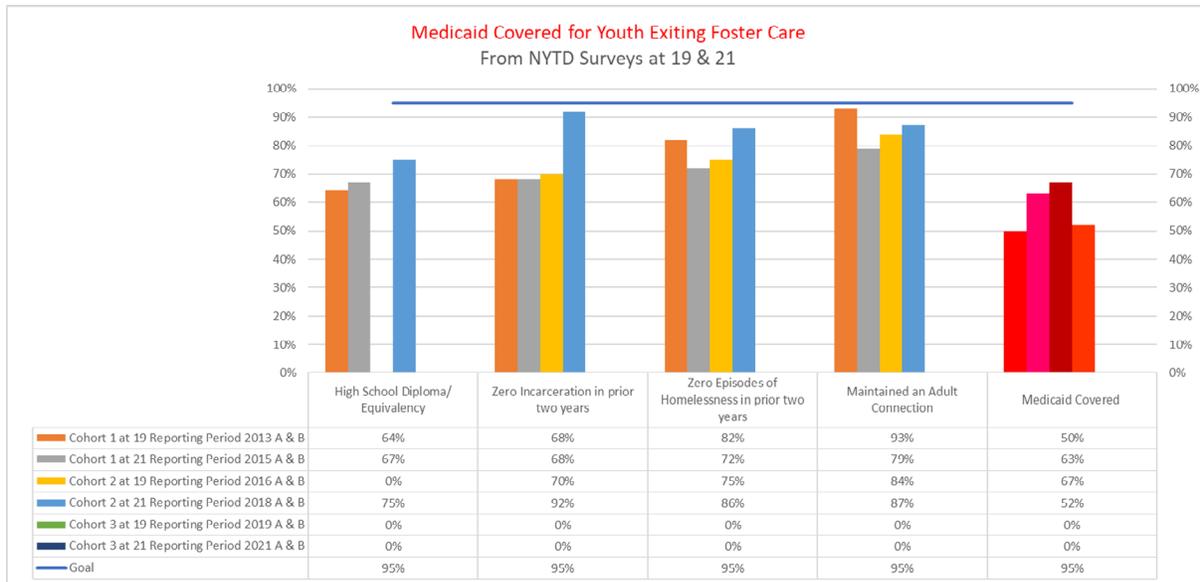
Source: NYTD Snapshots for West Virginia from ACF

Baseline 94%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	95%	95%	95%	95%
	Actual				

Connections to positive adults after foster care is an important indicator of stability and resilience. While youth report having an adult connection at 17, while in foster care, this number often dips at 19 and 21. The dip between 19 and 21 in cohort 1 was 14%, yet by cohort 2 the dip lessened to just 3%, thus the goal for this measure is attainable at 95%. Some of the success in this measure is the increased use by youth and adults of technology: video chatting and social media.

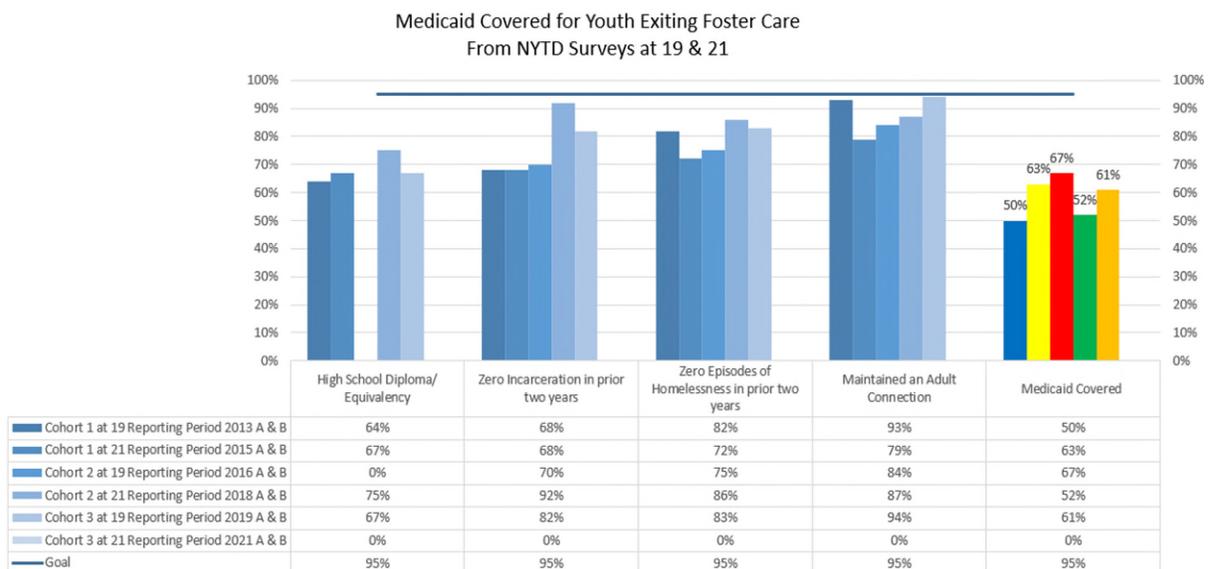
Objective 2.4 Increase by 5% each year, the percentage of foster youth who, when surveyed at 21, had Medicaid.

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Source: NYTD Snapshots for West Virginia from ACF

Update 2021:



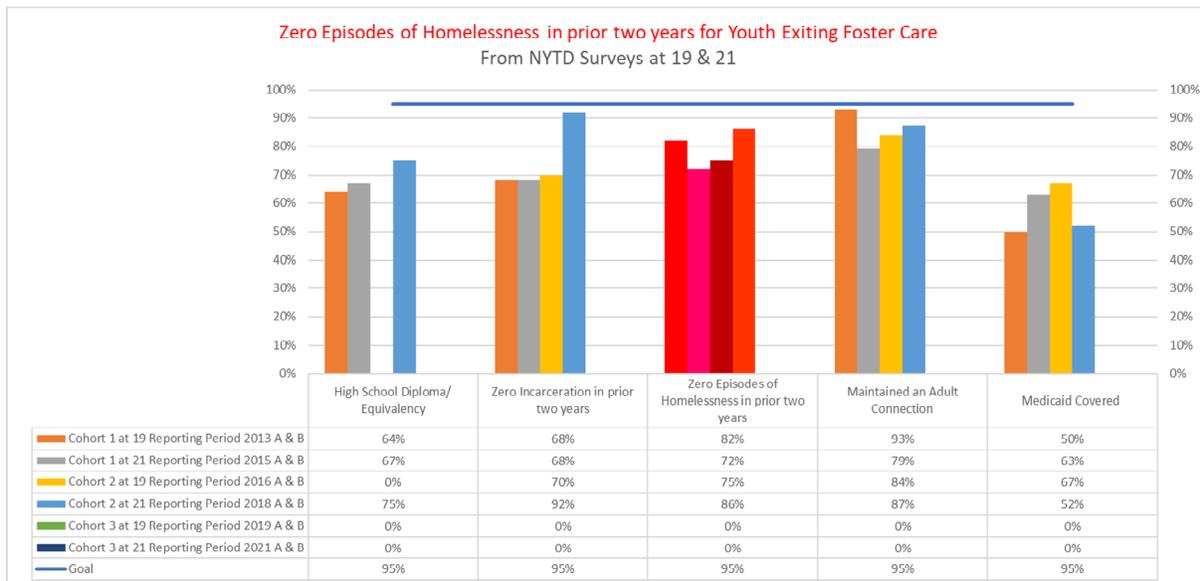
Source: NYTD Snapshots for West Virginia from ACF

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Baseline 61%	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
	Projected	66%	71%	76%	81%
	Actual				

Access and utilization of health care continues to be a challenge for youth in West Virginia. Medicaid is fully available to youth who exit Foster Care through age 25. To obtain this continuation of coverage the young person must apply at the local DHHR office, which may be a barrier. A higher application rate occurred after a statewide notification effort during the roll-out of expanded Medicaid in calendar year 2014, indicated by the 17% increase from cohort 1 to 2 at 19 in reported Medicaid coverage. This measure is impacted by “getting the word out” to youth of availability of coverage and what Medicaid does cover. MODIFY Survey Specialists have commented that youth often know they have a Medicaid card, but do not know all of the services available to them. Through the MCO and advertising the ifoster.org portal, more youth will learn of the expansive benefits available.

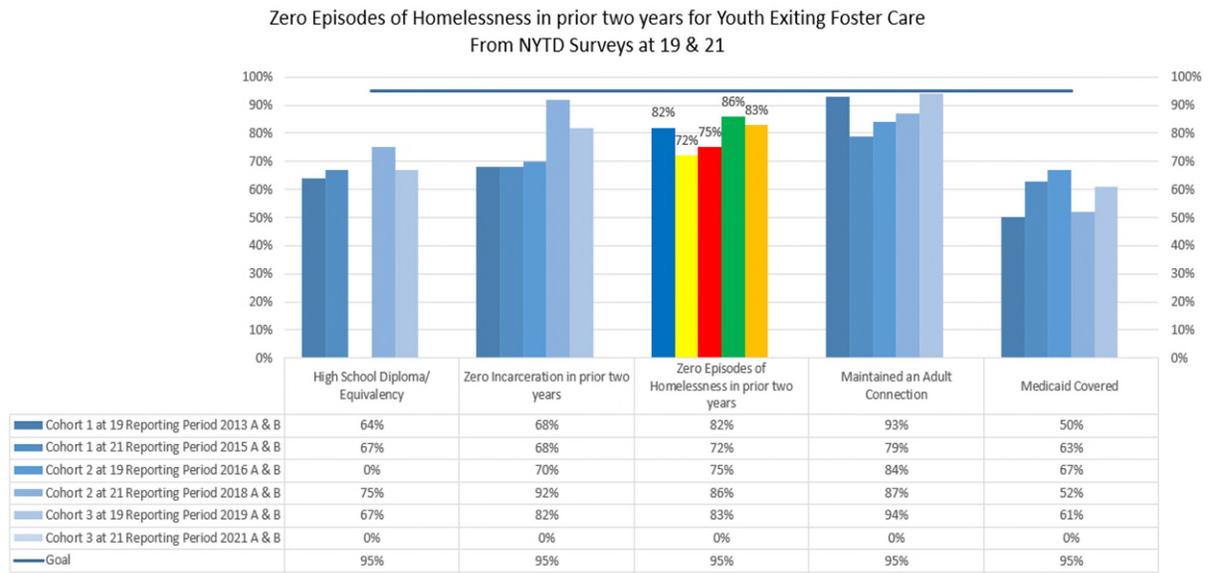
Objective 2.5 Increase by 5% each year the percentage of foster youth who, when surveyed at 21, had not experienced Homelessness.



Source: NYTD Snapshots for West Virginia from ACF

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Source: NYTD Snapshots for West Virginia from ACF

Baseline	Reporting Year	2021 Goal	2022 Goal	2023 Goal	2024 Goal
83%	Projected	88%	93%	98%	100%
	Actual				

West Virginia has seen a steady decrease in the number of youths who experience homelessness. The state anticipates this trend to continue. The expansion of Chafee services to youths until 23 and other programs such as the Fostering Youth Initiative are expected to positively impact this number even further. The state expects to meet its 2021 goal.

Staff Training, Technical Assistance and Evaluation

Please reference the Training Plan for staff development and training in support of the goals and objectives of the Child and Family Services Plan.

To help districts move towards the outcomes identified, DHHR will assemble Training and Technical Assistance Teams consisting of Quality Assurance staff, Policy staff, Training staff and local district supervisors to provide intensive training and mentoring to district staff on the areas needing improvement identified during their local Quality Assurance reviews.

These teams will also be available to aid individual districts on selected topics when they are identified as having a decrease in performance outcomes or their individual supervisors notice a decrease in performance during their monthly supervisory reviews.

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Update 2021:

During the 2019 calendar year, the Bureau for Children and Families worked to develop the framework for its Training and Technical Assistance (T and TA) teams. The T and TA framework will consist of a steering team and regional teams. The steering team is anticipated to be a static group of individuals who are considered experts in their field. The core team will consist of:

- *Regional Program Managers;*
- *Policy Program Managers;*
- *Training Program Managers;*
- *IV-E Program Managers; and,*
- *DPQI Program Managers*

The steering team will meet monthly, or more frequently as needed, to review data, DPQI exit reports, district corrective action plans, and T and TA requests.

The regional teams will consist of individuals considered specialists in their field that work directly with staff. Regional T and TA teams core group includes:

- *Trainers;*
- *Policy specialists;*
- *DPQI reviewers;*
- *IV-E specialists;*
- *Regional Program Manager; and,*
- *Child Welfare Consultants.*

Additional members may include:

- *Tenured Peer Staff (non-district);*
- *Tenured Peer Supervisors (non-district);*
- *Select Social Service Coordinators; and,*
- *Community subject matter experts*

Upon a finding that a district has identified weaknesses or assistance has been requested, the steering team will identify the appropriate regional T and TA team to be deployed. The individuals selected for the regional team will be dependent upon the specialized training needs of the district. Regional teams will include community subject matter experts whenever possible and reasonable.

T and TA teams will provide:

- *Training, which includes in person training on specialized topics; and,*

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- *Technical assistance, which includes answering staff questions, providing information needed to understand staff mandates, implementation of best practices, and accessing needed resources.*
 - *These services may be delivered in small group discussions, through email and telephone consultations, or Q and A sessions with staff and supervisors.*

Several events may trigger the deployment of the T and TA teams, these include:

1. *A district completes a DPQI review and problematic increases or decreases of tracked percentages are identified, such as falling below CFSP baseline performance and mandatory objective increases;*

Monitored CFSP percentages include:

- *Case plans completed;*
 - *Safety plans completed;*
 - *Assessments completed timely;*
 - *Cases without a monthly contact;*
 - *Open cases with family preservation (IV B or IVE prevention) services;*
 - *Repeat Maltreatments.*
2. *Major federal or state initiatives and programs which may need additional support to facilitate full implementation;*
 3. *Grant programs targeting specific catchment areas which affect day-to-day worker actions or knowledge-base; and,*
 4. *Child Welfare Oversight identification of problem areas.*
 5. *Additional requests may be made by district or regional staff to assist in specific topic areas.*

The established process:

1. *When a district completes a DPQI review, the exit report will be submitted by the DPQI Regional Program Manager to the Training and Technical Assistance steering team for review. These reports will be reviewed and discussed by the steering team and will consider the need to deploy a T and TA team to assist in improving on areas of possible weakness. Districts which have areas in need of improvement which require a Corrective Action Plan (CAP) will require deployment of a T and TA team.*
 - a. *The district will develop their CAP and submit to DPQI. The DPQI Regional Program Manager will submit the CAP to the steering team and the steering team will approve or reject the districts CAP. If the steering team rejects the CAP, they will provide technical assistance in the modification of the CAP. A regional team will be deployed to assist in implementing the CAP.*

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the request and develop a plan for regional team deployment following the protocol established under # 2 above.

- 4. A formal request for training and technical assistance may be requested by any district staff through the chain of command protocol. Once the CSM and RD agrees, the requesting district employee will utilize a Training and Technical Assistance Request Form and email it to DHHRBCFCPSPolicy@wv.gov. The policy specialist will reply to the request to inform staff the request has been received and a regional team is being assembled. The request will be forwarded to the steering team who will follow the process outlined in #2 to identify and deploy the T and TA team. The identified regional team leader will notify the district management and requesting employee of the status of their request.*

Update 2022:

The implementation of the Training and Technical Assistance teams has been delayed due to the COVID-19 pandemic. As the state begins to resume in-person visits, and increase gathering sizes, the T and TA teams will work towards resuming implementation efforts.

The Bureau for Children and Families will continue to utilize in depth technical assistance from Casey Family Programs to assist with the implementation of several on-going initiatives including but not limited to our kinship navigator program, foster care reform, reflective supervision and Family First Prevention Services Act implementation.

The Capacity for States will continue to assistance to the state as referenced in the Program Improvement Plan.

Casey Family Programs and Marshall University will continue to assist the state with data collection and analytics surrounding our Kinship Navigator Program and Case Assessment and treatment model respectively.

Update 2021:

The Bureau for Children & Families received technical assistance from Casey Family Programs on the implementation of reflective supervision in 2019. Activities included assistance with revising the Standard Operating Procedures and reflective supervision forms and training for all supervisors statewide in June 2019 and December 2019 to build on supervisors' and managers' skills in the application of reflective supervision in practice. A total of 309 supervisors and managers attended 12 hours of training.

Update 2022:

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Casey Family Programs worked closely with West Virginia in 2020 on implementation activities related to Family First, kinship care, and workforce retention. West Virginia's contract with Casey Family Programs included the following goals:

- 1. Support Leadership connect and build working relationships with like jurisdictions to facilitate ongoing learning, sharing, and partnership.*
- 2. Continue to support and assist West Virginia with Family First Prevention Services Act, including predictive analytics and performance-based contracting.*
- 3. Support and coordination of implementing next steps based on the 2018 analysis of West Virginia's Kin program.*
- 4. Support the continued implementation of policies and practices that will reduce front line turnover to allow West Virginia to maintain a consistent and competent workforce that will make the best decisions possible on behalf of the children and families they serve.*

In working towards those goals, West Virginia attended Casey Family Programs peer-to-peer sessions and used many of the materials provided to develop guidance documents for staff in West Virginia. Casey Family Programs sponsored web-based live training sessions for workers and supervisors on Supporting Families During a Global Pandemic and on trauma and self-care and provided ongoing coaching and mentoring for supervisors on those issues with selected districts. Casey consultants worked with the Project Lead for the Family First Initiative on the development of staff and infrastructure; communication with state and community stakeholders; development of policies, protocols, and program evaluation tools; and revamping existing home/settings for more challenging youth. Casey Family Programs also provided support to field staff on using reflective supervision, including providing peer-to-peer sessions for supervisors on effective use of reflective supervision and working with Social Services Coordinators in Kanawha, Marion, Cabell, Harrison, and Mercer counties to address worker reflection and use of reflective supervision.

Implementation Supports

Leadership members identified needing more staff and a standard operating procedure to outline the process to close out their backlogged referrals and cases with no activity. However, the DHHR is in the process of obtaining Technical Assistance with determining if the state is accepting the right referrals for assessment and if staff are following policy to make correct determinations at case opening. It is believed this TA may eliminate the need for more staff.

Centralized Intake recently received approval for their own Trainer. This person will provide specific training for CI staff covering position responsibilities, policy updates, and will provide feedback in real time on active calls, and then go over any problem areas.

The Director of Social Services will continue to identify statewide issues and provide district supervisors with targeted tools to use for re-training their staff during monthly unit meetings.

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Leadership also identified the need for a Standard Operating Procedure for assignment of investigations in active cases. This item is addressed in the Program Improvement Plan.

West Virginia will collaborate with its other bureaus to Geo-map its array of services.

Update 2021:

Leadership has a budget request in for more CPS staff to assist in reducing backlogged referrals. A standard operating procedure has been drafted and any further updates will be identified in the PIP update. The Centralized Intake hired a Health and Human Resources Specialist, Senior position which started in November 2019. She provides one-on-one support to workers, monitors calls and provides verbal and written feedback, and provides on the job orientation to new employees at both sites. A Social Services Coordinator will start at CI on 3/28/20. Monthly unit meetings continued through 2019 and included the following topics:

- *July - Reports to the court and court order processing*
- *August - Runaways*
- *September - Support for foster parents including kinship navigators*
- *October - Foster care and homefinding policy changes due Families First Prevention Services Act*
- *November - Staff and agency roles and responsibilities with focus on interactions with clients*
- *December - Placement and payment approval.*

West Virginia has also teamed with the Capacity Building Center for States to evaluate the state's child abuse and neglect hotline, Centralized Intake. The workgroup is currently defining the criteria that will be used to evaluate all of the child abuse and neglect referrals taken by Centralized Intake within a specific time frame and the screening decisions made about each of those referrals. The evaluation will include if the screening decision was appropriate based on information gathered from the CCWIS system and whether another referral was later received that indicated maltreatment had or had not occurred. Agreements are being made between BCF, OMIS, and the Capacity Center, including confidentiality agreements, so that the data can be pulled for the evaluation to be done.

Second Chance Inc., the Bureau for Children and Families plans to redesign the Homefinding unit, conduct a work and time study to determine caseload and practice standards, develop a Gold Standard Process for best practice with kinship/relative providers, and explore and review kinship/relative specific training models for the eventual development and/or adoption of the identified model.

A Second Chance Inc. is a non-profit organization that provides kinship care programs in Pittsburgh and Philadelphia. The model is nationally recognized for its success in kinship practice. They provide technical assistance to other states regarding their kinship practice and model. Through Casey Family Programs, a grant was provided to A Second Chance Inc., in August 2018, to work with WV on assessing BCF kinship practice to develop recommendations and implementation to improve kinship practice. In June 2019 additional grant funding provided by the Benedum Foundation, distributed to a Second Chance to further

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the work on kinship/relative care for the purpose of improvement, including completing the Kinship Study mandated by West Virginia House Bill 2010 of legislative session 2019.

The study revealed recommendations for improvement to standardize throughout the state how the BCF works with kinship/relative providers. Additional funds through the Benedum Foundation are in the process of being awarded to A Second Chance, to continue this work through the second phase which includes the implementation of the recommendations from the Kinship Study. This work will continue through June 2021.

Update 2022:

Work with the Capacity Center to review Centralized Intake has continued in spite of the COVID-19 pandemic. The criteria which will be used to analyze abuse and neglect referrals has been finalized and the time frame was set. The data sample is from 2018 to allow WV to be sure all open assessments, during the sample period, had time to be closed.

The criteria that will be used in determining screening accuracy are:

- **True positives** – initial intakes screened in where the result of the investigation was that maltreatment occurred, services were needed, or safety concerns were noted.
- **True negatives** – initial intakes screened out where no subsequent referral was made within 121 days where maltreatment occurred, services were needed, or safety concerns were noted.
- **False Positives** - initial intakes screened in where the result of the investigation was that no maltreatment occurred and no services were needed and no safety concerns were noted (all three criteria were no) and that no subsequent referral was made within 121 days where maltreatment occurred, services were needed, or safety concerns were noted.
- **False Negatives** - - initial intakes screened out where at least one subsequent referral was made within 121 days where maltreatment occurred, services were needed, or safety concerns were noted.

A report was developed in the state’s CCWIS system and a sample has been selected and reviewed by Division of Planning and Quality Improvement to test the criteria. The review data has been sent to the Capacity Center data experts and is currently being evaluated. The group will meet again mid-April to review and discuss the preliminary results. This will allow a further refinement of the process based on how the criteria and process is working in obtaining the results that were intended. Additionally, monthly unit meetings with supervisors and staff continued through 2020. Below is a list of topics by month:

January	<i>Timely Placement Entry and Exit</i>
February	<i>ROSA</i>
March	<i>SAH Sustainability</i>
April	<i>BCF COVID-19 Response</i>
May	<i>Guidance for COVID-19 Response</i>

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June	<i>SOPs and Memos (PIP) - Supervisory Intake Tracking, Peer Reviews, Meaningful Contact, Preparing for Court and Court Procedures, Supervisory Reviews</i>
July	<i>Face to Face Visitation with Families and Children/Proper Document</i>
August	<i>Diligent Search</i>
September	<i>Foster and Kinship Parent Bill of Rights & Foster Child Bill of Rights</i>
October	<i>Multidisciplinary Treatment Teams</i>
November	<i>Preparing for PATH Conversion</i>
December	<i>Meaningful Contact with Parents</i>

Work with A Second Chance

The Bureau for Children and Families is continuing work with A Second Chance Inc., through June 2021, to standardize and simplify the kinship/relative caregiver process statewide. This work is a result of West Virginia's 2019 legislative session, House Bill 2010 that required a kinship study and recommendations for improvement. The kinship/relative redesign committee is working to standardize the process to become a certified kinship/relative caregiver that will allow for simplified expectations, decrease in approval times, and adopt a kinship/relative specific certification training that focus on how to care for relative or kinship foster children while supporting the kinship/relative caregiver.

West Virginia's 2020 legislative session passed House Bill 4092 that outlines the requirement for child welfare workers to submit a list of all known kinship/relatives within seven days after the filing of an abuse and neglect petition to be reviewed by the court. At the 45-day juncture, after the petition alleging abuse and neglect has been filed, the child welfare worker is required to file with the court, placement preference of those named on the original submission within seven days. Memos, forms, and other documents have been developed for child welfare staff to ensure that such reports are being submitted to the Courts within seven days of filing and abuse and neglect petition and placement preference if being given to grandparents and other relatives.

Update on Services

Child and Family Service Continuum

Prevention

The West Virginia Department of Health and Human Resources (WVDHHR), is the designated lead agency for Community-Based Child Abuse Prevention (CBCAP) activities. The Division of Early Care and Education (ECE) within the Bureau for Children and Families (BCF) in the WV DHHR manages the activities funded by the CBCAP grant. ECE is also responsible for coordination and administration of the Child Care and Development Fund and the Head Start State Collaboration Office. ECE staff work closely with the Bureau for Public Health, which includes Birth to Three and the state's Maternal Infant Early Childhood Home Visiting program (MIECHV). Activities and initiatives that touch all aspects of children's lives and wellbeing are coordinated through the state Early Childhood Advisory Council (ECAC).

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Through CBCAP activities, WV DHHR works closely with Prevent Child Abuse West Virginia to coordinate prevention efforts across the state to give children good beginnings by strengthening families and communities. They work collaboratively to build awareness, provide education, and strive to keep children free from abuse and neglect.

The WV DHHR funds and supports several child abuse prevention initiatives that use a combination of CBCAP, Temporary Assistance for Needy Families (TANF), and MIECHV funds, state appropriations, and private funds. These initiatives include In Home Family Education Programs (IHFE), Family Resource Centers (FRC), and Partners in Prevention grants to communities. These programs are considered an integral part of the child welfare continuum by building and increasing protective factors that enable parents and families to nurture and parent appropriately and connect them to concrete supports that help keep families out of the child welfare system. Programs are community based and driven, with advisory boards made up of program participants, service providers, and local leaders. Services are available to any member of the community, regardless of income, and are voluntary.

Twenty-three Family Resource Centers across the state aid families and communities based upon their community's needs and gaps in service. FRC staff are connected to local resources and provide referrals and concrete assistance through food, baby, and hygiene pantries. Depending upon community need, they also offer childcare, support groups, parenting education, and play groups. Services are offered to any family with children from prenatal through eighteen years of age. In State Fiscal Year 2020, the funding allocation to the FRCs was increased to allow them to expand into unserved communities in their catchment areas and serve more families. This was made possible through TANF funds, and the programs now have oversight from both ECE and Family Assistance staff.

While MIECHV funds the majority of In-Home Family Education Programs in the state, thirteen IHFEs are jointly funded through CBCAP and MIECHV funds. Programs may choose from two evidence-based models, Parents as Teachers or Healthy Families America. These programs systematically assess family strengths and needs, and enhance family functioning through trusting relationships, teaching problem solving skills, and promoting positive parent-child interactions. They also educate parents and caregivers on child development and connect them to referrals and resources. Bureau for Children and Families continues service coordination with Bureau for Public Health through the In-Home Family Education (IHFE) programs. WVDHHR plans to continue this partnership with additional IHFE programs being created in counties not served by an IHFE program as resources permit.

Partners in Prevention (PIP) is a community grant and networking program that focuses on preventing child abuse and neglect. Forty-four PIP teams work to build protective factors within communities and families by promoting local needs-based activities with the cooperation of community members, local organizations, policy makers, and parents.

WV DHHR's various Bureaus have a commitment to collaboration. All Bureaus and Divisions maintain linkages to one another and communicate frequently on joint programs and projects to reduce child maltreatment and strengthen families and communities.

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Also, the Bureau for Children and Families refers families to the Bureau of Medical Services for many preventative services such as Birth to Three and Right from the Start. Workers make referrals to these programs at the time of assessment.

Update 2021:

Bureaus within the WV DHHR continue collaboration efforts in prevention services. Most of the statistical data for these prevention services are listed above in the [Service Array](#) section.

Update 2022:

Bureaus within the WV DHHR continue collaboration efforts in prevention services. Most of the statistical data for these prevention services are listed above in the [Service Array](#) section.

Birth to Three

WV Birth to Three is a statewide system of services and supports for children under age three who have a delay in their development, or may be at risk of having a delay, and their family. The Department of Health and Human Resources, through the Bureau for Public Health and the Office of Maternal, Child and Family Health, WV Birth to Three, is the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA), assures that family centered, community-based services are available to all eligible children and families. WV Birth to Three partners with families and caregivers to build upon their strengths by offering coordination, supports, and resources to enhance children's learning and development.

To be eligible for WV Birth to Three services, an infant or toddler under the age of three can either have a delay in one or more areas of their development or be at risk of possibly having delays in the future. A child may have delays in one or more of the following areas:

Cognitive - thinking and learning

Physical - moving, seeing and hearing

Social/emotional - feeling, coping, getting along with others

Adaptive - doing things for him/herself

Communication - understanding and communicating with others

A child may also have risk factors such as a condition which is typically associated with a developmental delay such as Down Syndrome or a combination of biological and other risk factors. Some of these factors may include family stressors.

As a result of individualized supports and services families will know their rights, effectively communicate their child's needs, and help their child develop and learn. The child will demonstrate improved social emotional skills and relationships, acquisition of knowledge of skills including language and communication and use of appropriate behaviors to meet their needs.

Right from The Start

The Right from The Start (RFTS) Program is a home visitation program which provides targeted case management and/or the provision of enhanced prenatal care services for Medicaid pregnant women up to 60 days postpartum and infants through one year of age. Targeted case management in the RFTS Program includes an Initial Assessment for prenatal or infant clients, development of an individualized Service Care Plan reassessed on an ongoing basis, depression screening, domestic violence screening, tobacco/substance use screening, assistance with locating needed resources, education and counseling programs for the mother, transportation assistance to medical appointments and referrals as needed. Enhanced prenatal care services include childbirth education, parenting education, health education and nutritional evaluation/counseling. All services are provided by a registered nurse, licensed social worker or registered dietician. These services have the combined purpose to improve birth outcomes and reduce infant mortality and morbidity in a high-risk population with a medically focused approach.

The Right from the Start (RFTS) Program has been delivering services, providing health care for low-income mothers and infants at-risk of adverse health outcomes for over two decades. The services are FREE and support mothers, their new babies and their families by helping create a safe, nurturing home. The Designated Care Coordinator provides professional, individualized, and comprehensive care that empowers families to achieve the healthiest possible outcomes during pregnancy and infancy. The program empowers participants to choose lifestyles resulting in healthy families.

The RFTS is a carefully crafted and highly interdependent partnership with tertiary care centers, primary care centers, local health departments, private practitioners and community agencies working with the West Virginia. Its focus is the continuum of care model. The RFTS coordinates services provided to high risk, low income pregnant women through the second postpartum month and to Medicaid eligible high-risk infants through age one. The RFTS also helps provide access to other enhanced services, such as parenting classes, transportation to medical appointments, smoking cessation programs and health and nutrition programs.

Maternity Services

Maternity Services is limited funding of prenatal, delivery, postpartum and routine newborn hospital care for low-income, medically indigent pregnant women who are determined to be ineligible for Medicaid, have not insurance to cover obstetrical care, and have monthly income below 185% FPL. This includes minors and income eligible non-citizens. Maternity Services require prenatal care is provided in the standards outlined in the American College of Obstetricians and Gynecologist guidelines.

Maternity Services also acts as a guarantor of payment for initial prenatal exams and associated laboratory/diagnostic test. Maternity Services is the payer of last resort. If the client is approved for Medicaid or another third-party source, the practitioner is paid by that source.

The Drug Free Moms and Babies (DFMB) Project is a comprehensive and integrative medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby

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outcomes by providing prevention, early intervention, addiction treatment, and recovery support services.

This project is supported through funding from West Virginia Department of Health and Human Resources, Division of Behavioral Health and Health Facilities, the WV Office of Maternal, Child, and Family Health, and the Claude Worthington Benedum Foundation.

Key Project Aspects

- **Screening, Brief Intervention, Referral and Treatment (SBIRT)** services integrated in maternity care clinics
- **Collaboration with community partners** for the provision of comprehensive medical, behavioral health, and social services
- **Long term follow-up** for two years after the birth of the baby provided by a recovery coach. In addition, home visits and other services to help women maintain sobriety and access needed resources are provided.
- **Program evaluation** of effective strategies for identifying women in need, preventing addiction and abuse, treating women with substance abuse problems, and delivering recovery coaching services.
- **Provider outreach education** to other maternity care clinics in West Virginia to facilitate the duplication of successful model programs.

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. WV follows the Safety Assessment and Management System or SAMS model. The SAMS model includes 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.

The SAMS model is a very detailed and time-consuming model. A combination of an opioid crisis, lack of tenured workers, and a very high turnover rate has led to a large backlog of assessments. To counteract this backlog, the Department has allowed workers to complete a very short version of the SAMS model. The state has also begun work on a streamlined process for both CPS and Youth Services. The streamline workgroup has successfully edited most of the two policies to become easier to navigate. Case plans and safety plans have also been streamlined for both programs to use. The new case plan process has been piloted statewide and was praised by the staff selected to use them. Child welfare staff stated the forms used are much easier to understand and families felt they were included in the process. Safety plans have been reduced to one document, instead of three that were previously used. The plan can be altered to address immediate safety concerns, and in and out-of-home safety plans as well.

Further, CPS has a shortened documentation process for completing the Functional Family Assessments. That form is Crisis Response Worksheet CRW. The CRW mandates CPS staff to narrate the allegations of

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child abuse or neglect, and maltreatment and nature portions of the assessment on the form. This form has allowed staff to quickly document their interactions with the family.

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.

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.

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

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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.

2021 Update:

During 2019 Child Protective Services worked on implementing a pilot project for a comprehensive approach to Plans of Safe Care in two pilot counties, Ohio and Greenbrier Counties. This is in response to the overwhelming substance use related cases in West Virginia contributing to a child welfare crisis. The Department's request for technical assistance through the Substance Exposed Infants In-Depth Technical Assistance (SEI IDTA) team brought together a committee solely focused on addressing this project. The pilot project expanded in 2019 to improve policy language that more clearly defines individual roles and activities within the plans. Concern arose among the project developers that certain roles and activities were not clear within the plans of safe care. The primary roles that were of concern were: who was responsible for facilitating the development of the Plan of Safe Care and what entity or entities would be responsible for monitoring the plan throughout the life of the plan. The policy for the pilot project has continued to be evaluated by the committee and will then be brought before the Department's internal directors and management for final approval. The projected implementation for the project has been moved to the Summer of 2020 at this time.

The WV Coalition Against Domestic Violence (WVCADV) collaborated with Child Protective Services to better define areas regarding addressing domestic violence in cases. These revisions were added to child welfare policy that included adding the definition of D-LAG (Dangerous: Lethality Assessment Guide) to assist child welfare workers in identifying and addressing factors that may increase the lethality indicators in domestic violence cases. There was also a need to change the wording of "spouse abuse" to "family

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violence”, due to the variation in the makeup of families in WV. The Coalition found that many victims also needed the protection of their location during child welfare involvement. Guidance was added to child welfare policy to aid with the citation of legislation regarding the “Address Confidentiality Program” in WV. Finally, the Department co-petitioning with a parent/guardian who is considered “non-offending” and does not live with the “offending” parent/guardian was updated in policy. This included adding to policy that child welfare workers should not request custody of the child(ren) in these situations and that the child(ren) should be placed in the care, control and custody of the “non-offending” parent/guardian at the initial request for removal of the child(ren).

As a result of recommendations of the Child Protection Across County Systems (CPACS) committee, child welfare policy was updated to reflect that child welfare workers will communicate with the family court if there is a material change of circumstances as well as any time there is family court involvement with a family involved in the child welfare system, whether the family court judge is the reporter or not. The policy was further updated to reflect that child welfare workers will provide a written report, regardless of whether it was requested, and the report will be sent to the jurisdictional family court judge, circuit court judge, as well as the prosecuting attorney. Additions were also made to reflect that the timeframes for the reports may be less than the 45 days previously stated in policy, depending on the timeframe that the judge orders the reports to be completed.

Child Protective Services is moving towards a universal language change throughout policy and practice. This would include using common terms that would be interchangeable between both child protective services (CPS) and Youth Services (YS) to form a more fluid interaction between programs. Families often interact with both programs and common language is important to limit confusion regarding information that can often seem technical or specific to only one program. Having universal language also allows for flexibility if the Bureau for Children and Families chooses to adopt new and changing practice models in their approach to assessing families for abuse and/or neglect. This would not require a full rewrite of child welfare policies if a model change does occur with universal language in place.

These revisions and additions to child protective services will aid West Virginia’s child welfare workers in preventing child removals by strengthening preservation practices and improving interdisciplinary relationships. West Virginia will continue to improve relationships with all agencies, organizations, and stakeholders involved in the child welfare process to better serve our children and families by ensuring child safety and preserving families.

Update 2022:

The implementation of practice model changes in CPS was delayed due to the COVID19 Pandemic. Planning resumed in January 2021 and an implementation date of changes is tentatively set for statewide implementation in May 2021. The state is exploring opportunities for outside technical support and training to improve the child welfare worker’s understanding of assessing and case planning but has to-date been unsuccessful in identifying an entity or organization to provide such support.

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Other changes in the CPS program have been focused on enhancing policy and training to ensure staff are able to identify individuals in need of reasonable accommodations or modifications to enjoy the full and equitable participation in Child welfare programs. These changes have been implemented and training for nearly 1100 staff was completed between February and March of 2021.

Youth Services

West Virginia's Youth Service program serves youth and their families who are involved or are at risk of being involved in the Juvenile Justice System through courts and/or probation. While ensuring the safety and protection of the child is paramount, Youth Services also aims to strengthen the functioning of the family unit through coordinated, multi-disciplinary efforts which involve community agencies and resources.

Case Planning

Case planning continues to be an essential part of the Youth Services process. A standardized case plan document titled 'Family Service Plan' has been developed and approved and will continue to be utilized on all open Youth Service cases. Included in this case plan document are the reasons for DHHR involvement, what must happen for DHHR to no longer be involved, individual strengths and needs, prioritized goals, services, and a section identifying foster care candidates and an explanation of what qualifies a youth as a foster care candidate. The Family Service Plan document was created with CANS and FAST assessments in mind. WV Youth Service workers will use the CANS and FAST as their standardized screening tool on all open YS cases and use this data to help case plan accordingly.

CANS/FAST

A critical component of West Virginia's Youth Service program is the assessment of the youth and families which it serves. Youth Services presently uses the Child and Adolescent Needs and Strengths (CANS) tool as its standardized assessment tool. However, the Department has recently begun a pilot program in which the CANS is replaced by the Family Advocacy Support Tool (FAST). While the CANS and FAST are both developed by John Lyons PhD and the Praed Foundation, and require the same level of training and recertification, the FAST is a more condensed assessment and focus on the wellbeing and safety of the entire family. If the pilot program for the FAST is a success and leads to better case planning and outcomes, then the Department will replace the CANS with the FAST as its standardized assessment tool.

The Youth Level Service Case Management Inventory or (Y)LS-CMI was previously used as a standardized assessment tool. However, due to wording changes in WV Code, the (Y)LS-CMI will no longer be a necessary tool and its role will be filled by the CANS assessment and eventually the FAST assessment.

Update 2021:

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The FAST has been fully implemented in the Youth Services model. The FAST will assist staff in clearly identifying youth needs and strengths as they relate to case planning. The full implementation occurred on December 1, 2019. Training and technical assistance in the quality of use of the tool is provided by Marshall University on a regular basis. This is expected to continue through the calendar year 2020, with additional case reviews to help identify training and technical assistance needs, occurring through BCF.

Update 2022:

The BCF continues with its training and technical assistance with the FAST tool. BCF and Marshall University have implemented a process to ensure staff who are not trained, do not maintain the certification status annually, or fail to participate in the three mandatory technical assistance sessions are centrally reported to the bureau. This information is then shared internally and plans to rectify the problems are provided to Marshall University. The FAST tool has also been designed into the bureau's new CCWIS system, PATH. Once live, PATH will send periodic batch files to Marshall university to receive FAST data and assess assessment quality to assist in identifying specific technical assistance needs of staff.

Programs

West Virginia's Youth Service Program has recently assisted in implementing two evidence-based programs, Victim Offender Mediation (VOM) and Family Functional Therapy (FFT). VOM is a program in which an opportunity is provided for the victim of a crime and the perpetrator to meet face to face with a mediator to help victims heal, the offender to learn, and to reduce the cost for the Juvenile Justice System. The VOM program presently serves thirteen (13) counties and has plans to expand given the opportunity. FFT is a high intensity short term family therapy program intended for youth between the ages of 11-18 which are experiencing family dysfunction. There is presently one FFT provider in West Virginia which serves six (6) total counties. The Department will seek to expand FFT on a continual basis to help prevent children removal. Additionally, the Youth Services Division will continue to review additional programs and determine if their implementation can benefit the youth of West Virginia.

Juvenile Justice and Collaboration with The Bureau of Juvenile Services

WV tracks and reports the number of youths who are transferred from the Department to the custody of the Bureau of Juvenile Services (BJS). The tracking methodology is to use reports from the SACWIS system of youth in custody of the Department who were court ordered to another placement. A hand count is then used on the custody transfer list to determine the number of those transfers who were placed with BJS.

The Department also collaborates with BJS when necessary on youth who are adjudicated or are at risk of court involvement. This collaboration continues to evolve and change to meet the needs of WV Youth and their families. It is anticipated that the Department and BJS will work together on solutions and programs to address truancy and other issues related to the treatment of the Youth Services population.

Gaps in Service: Fostering older youth/teens

An area of concern for the population served by Youth Services is the lack of foster homes available for, or unwilling to take, older youth. The most recent placement report for Youth Services was for the month of April 2019 and notes 643 total Youth Services cases had youth in placement. Of these 643 cases, the majority, 346, were placed in Group Residential Care instead of a Foster Care setting. Of the youth placed in a type of Foster Care, 30 were placed with a certified kinship/relative home, 41 were placed with a kinship/relative, 2 were placed with in Agency Foster Family Care, and 29 were placed in Therapeutic Foster Care. All other placements were through Psychiatric Hospitals, Detention Centers, Transitional living, or Emergency Shelters.

A survey completed in February of 2019 by the WV Foster, Adoptive, and Kinship Parents Network regarding the barriers for fostering teens was conducted. These barriers include; fear of teens influence on younger children in the home, negative behaviors, fear of incomplete or honest data and background information from the Department or foster agencies, and lack of training on how to meet a teen's needs. Also included on the survey were possible solutions to these barriers which included marketing parents who already have older youth, ensuring that a teens needs are met prior to placement, ensuring that youths case history is shared prior to placement, helping potential foster parents receive the necessary training, skills, and support prior to placement. The Department will continue to review policies, the needs of WV foster parents and youth, and will continue to work with placement agencies to help fill this gap in services.

Another way to reduce the amount of older youth placement in Group Residential Care is to reduce the number of youths removed from their home in the first place. In many cases, removal from the home is necessary for the safety of the youth and their family or is required by court order. However, thorough and thoughtful case planning and safety planning measures by Youth Service workers and the Department can help reduce the amount youth removals by ensuring that safety in the home is maintained and that the youth and family are receiving the proper services. The Department will monitor the number cases that do not have a case plan and/or safety plan and with this data make efforts to ensure case plans and safety plans are completed.

Foster Care

West Virginia's foster care system is comprised of kinship/relative care providers, private/specialized family foster care providers, and residential treatment facilities. West Virginia provides an array of services to all foster children. Services offered to foster children include but not limited to medical services, including eye and dental, mental health services, clothing, food, shelter, support, education services, independent and transitional living services, legal services, and community supports.

West Virginia continues to provide every foster child a Journey Placement Notebook when they enter care. This notebook follows each foster child through their entire foster care placement and provides forms or records of information including:

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- The Outcome Observation Report which includes outcomes relating to:
 - developmental
 - relationships
 - protection and nurturing
- Application for SAFEKIDS PIX identification card
- Information check list
- Wardrobe and personal item inventory checklist
- Child's daily schedule
- Behavior observation chart
- Medication side effect checklist
- Therapist/Health Care/Service Providers
- Equipment/supplies inventory
- Foster care/adoption terms to know
- Foster care tuition waiver facts sheet

Journey Notebooks

Journey Placement Notebook forms are accessible through the Bureau for Children and Families webpage; <https://dhhr.wv.gov/bcf/policy/Pages/default.aspx> This accessibility allows foster care providers as well as private/specialized agencies, and facilities to access the forms whenever necessary if one or more forms have been lost or additional information that exceeds the current provided forms need added. The Bureau for Children and Families will continue to make the Journey Placement Notebooks accessible for the next five years to ensure each foster child has to appropriate forms and documentation necessary through their foster care placement.

2021 Update:

West Virginia continues to provide every foster child with a Journey Placement Notebook. The forms are located on the Bureau for Children and Families website, under the child welfare policy section, for easy access for child welfare staff, child placing agencies, residential placement facilities, and foster care providers.

2022 Update:

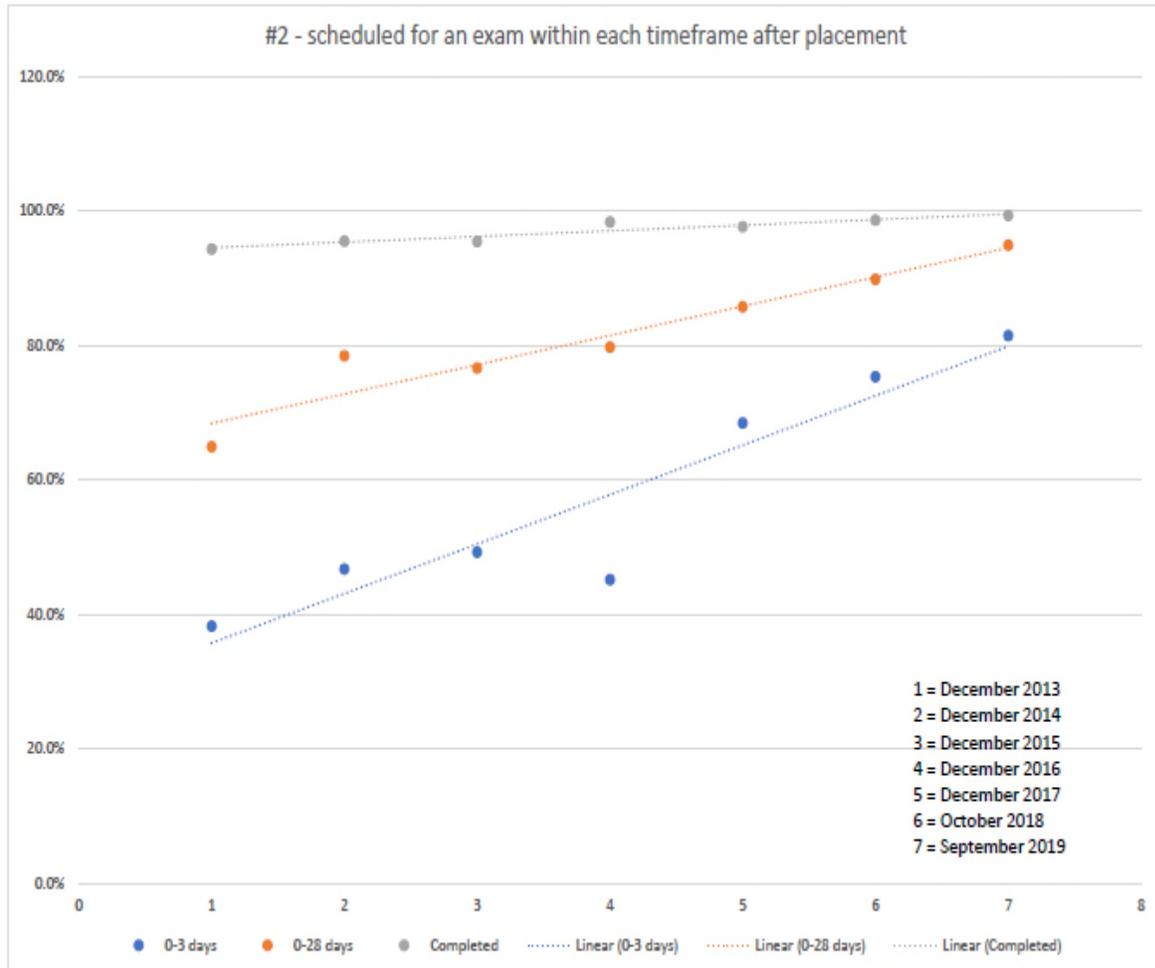
There is no update concerning Journey Placement Notebooks

Early, Periodic, Screening, Diagnostic and Treatment

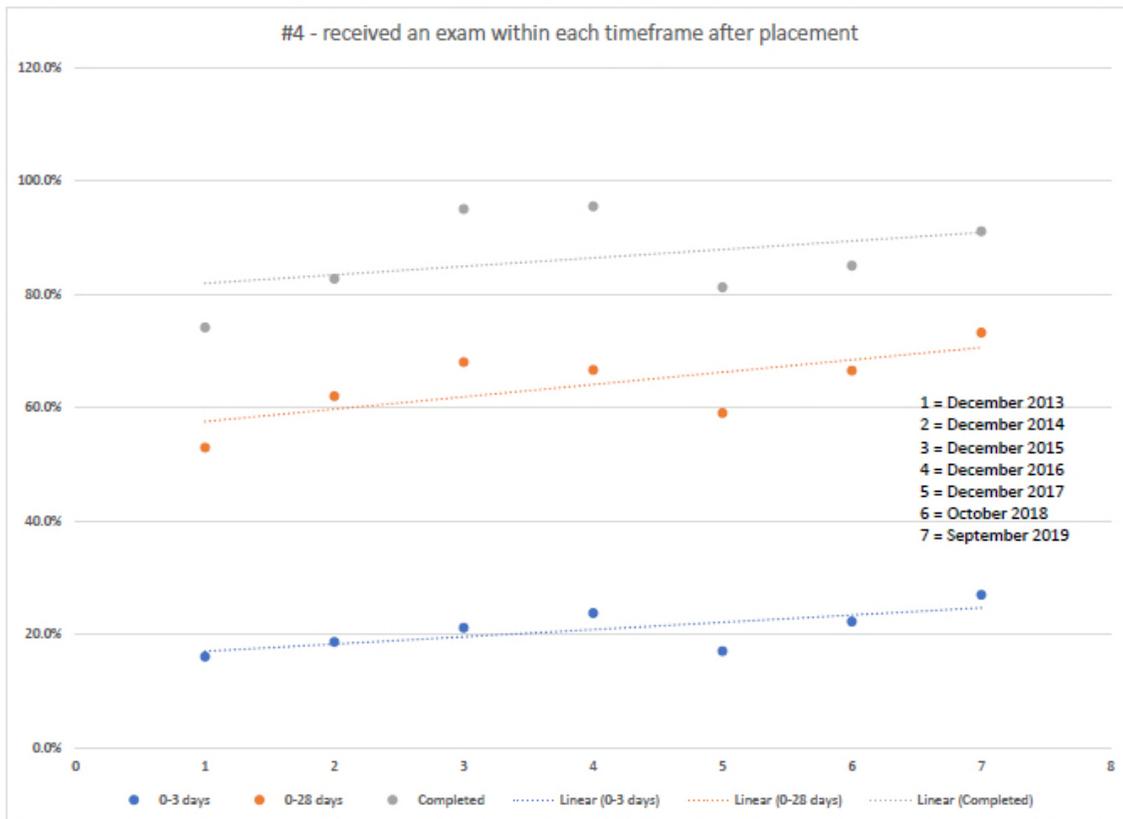
The Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) will continue to be performed for each child who enters foster care. The Bureau for Children and Families partners with the Bureau for Medical Services to ensure that each child is linked with a Sander's Liaison and receives their EPSDT screening within 30 days of entering foster care. This will continue into the next five years and will be tracked through the database system as documentation is entered by the Sander's Liaison.

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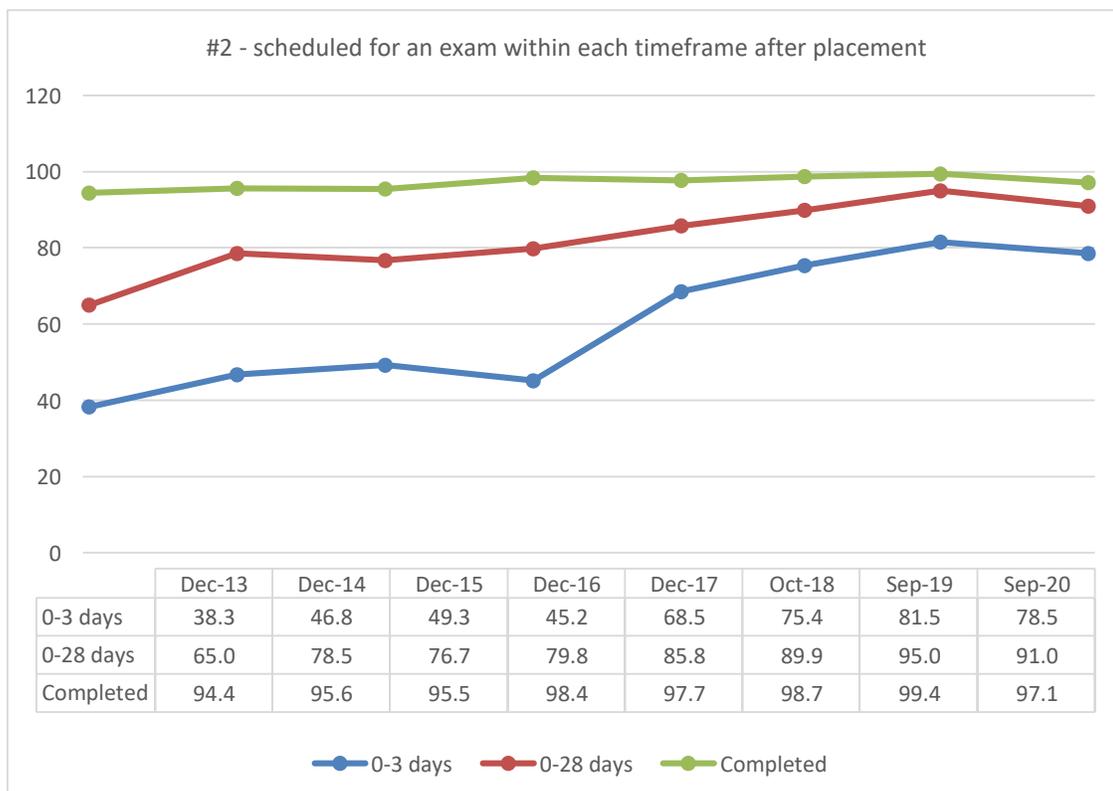
Update 2021:

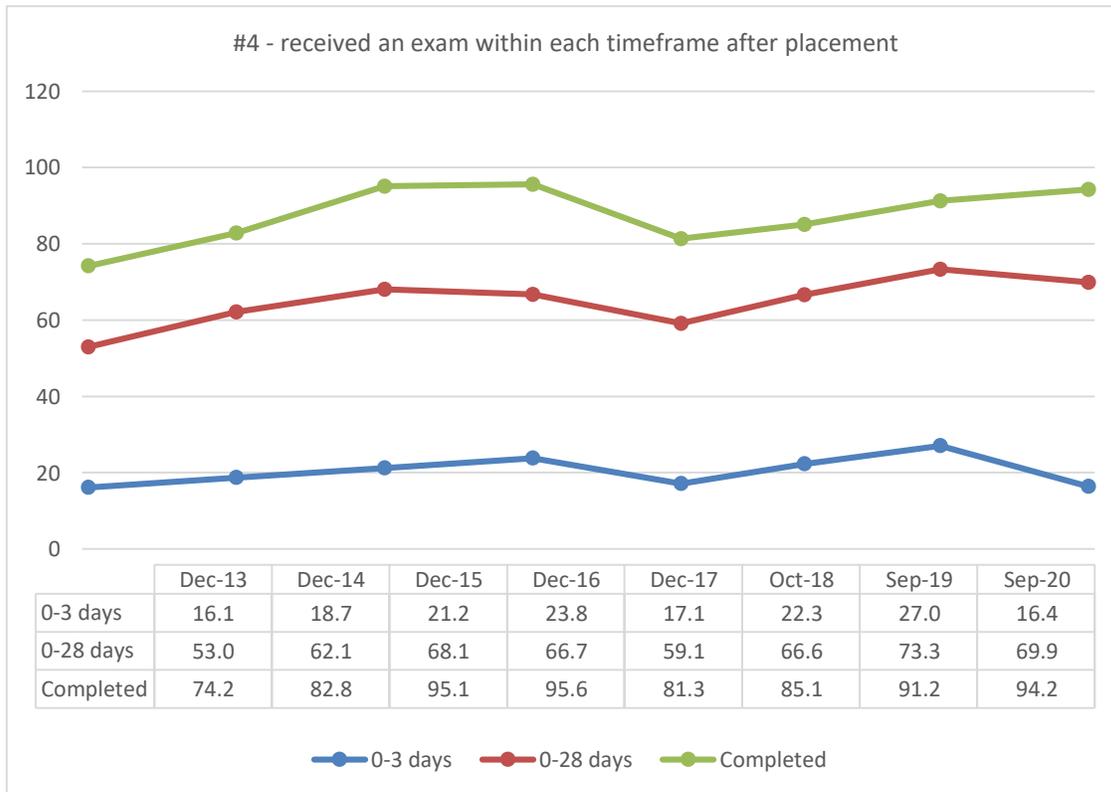


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Update 2022:





Multidisciplinary Treatment Team

Multidisciplinary treatment team meetings (MDT) are required for all foster care cases as set forth by West Virginia State Code §49-4-403. Multidisciplinary treatment teams consist of child welfare staff, biological parents or family of origin, other necessary family members, the child or youth if deemed in the child’s best interest, service providers, and foster care providers. Many foster care providers are not permitted to participate in the multidisciplinary treatment team meeting; therefore it is difficult for foster care providers to understand or be aware of particular case and child goals. Often biological parent goals and foster care provider goals fail to align due to their exclusion from the process. West Virginia will continue to improve relationships with foster care providers and child welfare staff and will enlist the

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assistance of the Court Improvement Program to improve the court relationship between child welfare staff and foster parents as well. The Director of Child and Youth Services through the Supreme Court is committed to improving judicial and child welfare staff relationships for the betterment of West Virginia children and families.

Foster Care Redesign

Treatment Foster Care Program

In July 2017, West Virginia formally launched a treatment foster family service model. The model is family-based, therapeutic, trauma-informed service delivery approach. The tiered model provides individual services for children and their families. The model is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and ongoing training provides the foster parents the knowledge and skills needed to care for the children that meet the criteria.

The Treatment Foster Care Program is being provided statewide by five specialized foster care provider agencies. As of June 2019, there have been 256 treatment foster care homes developed across the state. The State plans to increase the provider base within the next few years so treatment/therapeutic foster homes will be available and accessible statewide for the population of youth coming into care.

Treatment Foster Care Program tiers:

1. Tier II - Treatment Foster Care-serves children who exhibit mild to moderate levels of trauma/behavioral or emotional dysregulation. There may be mild or moderate difficulty in settings such as school, home and/or community. This level may be used for emergency placements, pregnant/teen moms that require special medical care or children with chronic medical conditions.
2. Tier III - Intensive Treatment Foster Care or Therapeutic Foster Care serves children who currently exhibit moderate to significant indicators of trauma/behavioral or emotional dysregulation. High-risk behaviors are present. Significant support is needed. This level may be used for children stepping down from a higher level of care, are at risk of out of state placement or residential placement, infants who are drug exposed with additional medical needs beyond initial medical withdraw or children considered medically fragile as diagnosed by a physician.

Update 2021:

In an effort to reduce the States' over reliance on congregate care, The West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF), engaged in a competitive bid process to solicit providers to establish a Treatment Foster Care Program, a multi-tiered Foster Family Care

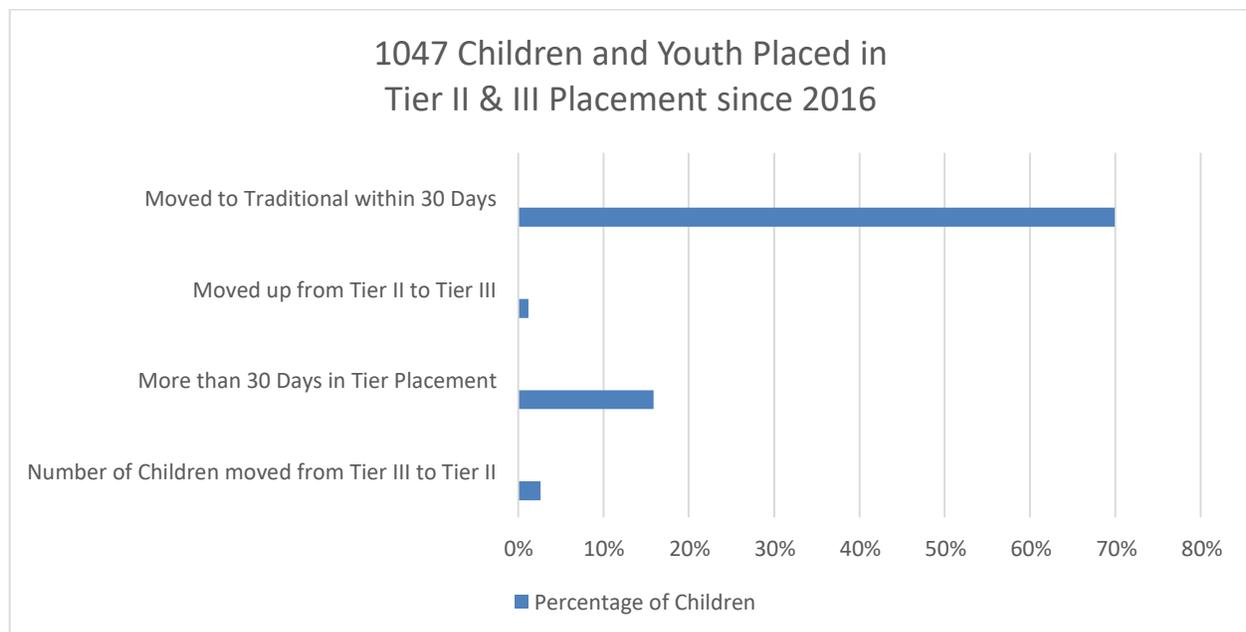
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Model which would broaden the continuum of foster care services for youth ages 5-17 in the legal custody of DHHR in August 2016.

The children served within the Foster Family Care Model are children between the ages of 5 and 17 in the legal custody of the Department of Health and Human Resources who require an out-of-home setting as well as treatment and/or supportive services. Children eligible to receive treatment or intensive treatment foster family care are identified during the initial assessment process and supported by the Child and Adolescent Needs and Strength (CANS) tool and Care Connection form. The level of care that the child receives is determined by the child's individualized treatment/service needs. The daily rate paid by BCF is based on the child's needs. These needs and level of care are re-evaluated every 90 days.

Currently, children placed with one of the five agencies offering Treatment Foster Care enter at Tier II (for 30 days) and are assessed. At the end of the assessment, a determination is made as to whether they can step down to traditional foster care, remain in Treatment Foster Care or step up to Intensive Treatment Foster Care.

The following is an analysis of the children's movement between tiers. It was found that most children placed in tier II at intake stepped down to traditional foster care after their initial 30 days.



Update 2022:

In the fall of 2020, BCF met virtually with the child placing agencies not currently providing Therapeutic Foster Care regarding expansion of treatment foster care beds. BCF asked any agency interested in

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providing this service to submit an implementation plan by December 15, 2020. These proposals were reviewed, and additional contracts were awarded.

The additional contracts will provide an additional seventy-eight (78) Therapeutic Foster Care Homes. Each home could have more than one TFC bed. These additional beds will be available by July 1, 2021.

During the last year, West Virginia has worked on developing a model of Therapeutic Foster Care for its agreement with the Department of Justice. After reviewing data from the previous year, the state determined the best use of this model of foster care is for those youth who meet the eligibility of its Children with Emotional Disorders (CSED) Waiver or Wraparound.

In March 2021, a second review of children in Therapeutic Foster Care with the same agencies was completed. During this review, the state reviewed all children in Therapeutic Foster Care with those same five agencies to determine the number of children who met the newly developed criteria. Of the 556 children that entered family foster care with the same initial five agencies, only 48 or 8.6% met the newly established criteria.

If the state uses all family foster care placements with these five agencies to represent the universe of family foster care placements, we can surmise that approximately 8.6% of our family foster care placements may need TFC level of care. Using this data, the state determined a list of counties to target for development of additional TFC homes.

Staff from Children and Adult Services continue to meet to refine its model of Therapeutic Foster Care and will be meeting with the Child Placing Agencies in the summer of 2021 to refine the final model. The goal is to have the updated model and refined contracts with agencies in place by October 1, with a transition period of ninety days for TFC agencies who are not CSED waiver providers.

A cluster analysis of youth in residential was conducted by Marshall University to determine the needs of the youth in those settings. It was found that a high percentage will not meet TFC eligibility due to a lack of serious emotional or behavioral disorder. West Virginia is currently conducting a similar analysis of youth in residential as the one described above using data from the Marshall University sample. It is expected that a slightly higher percentage of those youth will be eligible for TFC.

Performance based contracting

The West Virginia State Legislature passed House Bill 2010 in 2019 which requires the Department of Health and Human Resources to enter performance-based contracting with the child placing agencies who provide foster care services. As part of the procurement process under this requirement, the Department will be issuing a request for proposals by July 1, 2020.

Update 2021:

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During the 2020 legislative session, HB 4092 was passed which, in part, requires the WV DHHR to enter performance-based contracting with Child Placing Agencies in the state by no later than December 1, 2020. The bill defined performance-based contracting as; structuring all aspects of the procurement of services around the purpose of the work to be performed and the desired results with the contract requirements set forth in clear, specific, and objective terms with measurable outcomes and linking payment for services to contractor performance.

The contracts must include adequate capacity to meet the anticipated service needs in the contracted service area of the child placing agency; The use of evidence-based, research-based, and promising practices, where appropriate, including fidelity and quality assurance provisions; Child placing agency data reporting, including data on performance and service 33 outcomes, including, but not limited to:

- *Safety outcomes;*
- *Permanency outcomes;*
- *Well-being outcomes;*
- *Incentives earned;*
- *Placement of older children;*
- *Placement of children with special needs;*
- *Recruitment and retention of foster parents; and,*
- *A hold harmless period to determine a baseline for evaluation.*

As part of the procurement process under this section, the department shall issue the request for proposals no later than July 1, 2020. The department shall notify the apparently successful bidders no later than September 1, 2020.

Performance-based payment methodologies must be used in child placing agency contracting. Performance measures should relate to successful engagement by a child or parent in services included in their case plan and resulting improvement in identified problem behaviors and interactions.

Staff from Children and Adult Services have begun outlining required outcomes of performance expected from Child Placing agencies as well as an incentive-based payment schedule to meet those outcomes. Once this is completed, a Request for Application will be released publicly.

Update 2022:

In fall 2020, the Bureau for Children and Families received applications to provide foster care from each of its Child Placing Agencies. However, it was immediately apparent that the Request for Proposal process used initially would not accomplish the states goal of reforming foster care and the RFP was withdrawn. A Request for Information (RFI) process was initiated. Since then, the Bureau for Children and Families has held bi-weekly meetings with its Child Placing Agencies to develop performance-based contracts for family foster care. These meetings are to solicit feedback from the agencies as well to establish outcomes for our foster care contracts.

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During the meetings with our providers, they put forth performance measures as well as a process to determine their success at meeting the performance-based outcomes developed. BCF staff are meeting to refine the proposed outcomes, incentives, and penalties. The meetings will continue through May of 2021. Simultaneously, staff from the Bureau of Children and Families have met frequently to revise the language in existing contracts. The new, performance-based expectations will be added, and the new contracts released by July 2021. It is expected the meetings will continue through 2021 to refine these contracts and a final contract, with all outcomes, will be completed by January 2022.

Kinship Navigator

The navigator program will assist with monitoring kinship/relative placements to ensure their entry into FACTS, monthly demand payments have been entered, and foster care subsidy begins upon certification approval. The Kinship Navigators will assist kinship/families by completing a brief needs assessment and linking families with necessary services and supports to ensure their needs are met. The program is intended to provide added resources for kinship/relative families and assist child welfare workers when kinship/relative families have extra needs that require time and assistance.

Update 2021:

Mission West Virginia, the subgrantee of the Kinship Navigator grant, has employed four kinship navigators, which includes a coordinator who oversees the additional three navigators. One navigator is placed in each of the four child welfare regions. The Bureau for Children and Families has put protocol in place to ensure each navigator receives information regarding the kinship/relative families who have taken placement. Child welfare supervisors are to notify the coordinator when a removal of a child and placement with a kinship/relative has occurred. According to the region in which the removal and placement occurs, the appropriate navigator will contact the kinship/relative caregiver within 24 hours and begin the "DHHR/BCF Kinship/Relative Needs Assessment". The navigator ensures that timely placement entry occurs in the child welfare case, necessary demand payments are made, initial clothing vouchers are issued, and links the kinship/relative to necessary Federal, State, local, and community resources. West Virginia just completed the grant application for the third year of funding and will continue to improve the Navigator program as additional funding is granted for the program.

Update 2022:

The goals of the Kinship Navigator program:

- Serve relative and kinship providers in the first 90 days after placement of children*
- Ensure that they have needed resources to care for the children in their home and to pass a home study*
- Reduce the task-load for CPS and Home finding workers*
- Help relatives feel supported and confident in their ability to care for the children in their home*
- Reduce placement disruptions*

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The Navigator program has filled a service gap that existed in relative/kinship cases. Now, there is a worker who is dedicated to supporting the relative/kinship family. They are a non-threatening neutral party, without ability to disrupt the placement or to “fail” the home study. Navigators are often able to resolve issues that the family is hesitant to bring up to the CPS worker or home finder. The program acknowledges and addresses the service gap that exists between child placement and resource procurement. For instance, the Navigator will help ensure that the family has food, baby supplies, beds, bedding, etc., during the time before TANF and WIC are provided. The Navigators also function beyond the basic services provided by and information and referral service. Rather than simply identifying a resource for the family, the Navigators contact the resource, ensure that they can serve the family and they have the items they need, and complete a warm hand-off between the family and resource. They also ensure that the families are accessing all appropriate DHHR services and that they apply for and are provided with them in a timely manner. When a need is identified the Navigators explore various options through DHHR and community resources to address the need. They may also create resources to meet ongoing needs in a specific community, such as a foster closet or food pantry. Families served by the Navigators have expressed gratitude for the service. They appear to be more confident in their ability to meet the children’s’ needs and to maintain the placement. They also demonstrate increased understanding of how a CPS case works and the elements involved in a home study. The family is also more likely to have in place the requirements for a home study, which should shorten the time frame required for certification and for receiving a boarding care check. The program continued to help families through the Covid-19 pandemic. There was no indication that the pandemic affected the Kinship Navigator program in helping to meet the needs of kinship/relative caregivers.

Case Referrals

	Region I	Region II	Region III	Region IV	Total
October 2019- Dec 2019*					40
January	1	8	8	0	17
February	6	21	18	2	47
March	4	20	4	0	28
April	12	3	3	0	18
May	19	4	7	0	30
June	27	7	3	11	48
July	29	13	7	18	67
August	26	8	8	9	51
September	10	4	4	12	30
October	21	8	4	10	43
November	24	4	4	2	34
December	22	5	0	0	27
Totals	201	105	70	64	480

October -December 2019: 40 referrals were received but tracking was not broken down by region at the time.

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- 480 Referrals were received by the program between October 2019 and December 2020.
- 373 Initial Assessments were completed.
- 93 cases were unable to be opened due to lack of complete contact information or lack of response by family (most often due to lack of family response).
- 197 6-week assessments were completed.
- 122 3-month assessments were completed.

Funds for the Kinship Navigator Program for FFY 2020:

Personnel	\$120,539
Fringe Benefits	\$42,955
Supplies	\$2,628.18
Phones	\$285.08
Postage	\$274.20
Travel/Mileage	\$1,000
Professional Development/Trainings	\$1,000
Caregiver Needs	\$3,863.93
Legal Aid/Contract Services	\$5,391.93

Residential

West Virginia intends to maximize the provisions for the qualified residential treatment programs (QRTP) and its 30-day assessment requirements to more thoroughly screen youth who are being identified to need residential mental health services. This will also help flag existing diagnoses that must be taken under consideration and help ensure unnecessary mental health diagnoses are not being made for youth to access non-family care.

West Virginia intends to slowly on-board QRTP providers through a targeted, purposeful process utilizing requests for applications (RFA) and population-specific contracting. The RFA strategy aligns with the Bureau’s need to mitigate compliance and financial risk to the State if the federal QRTP requirements are not met.

By soliciting applications from existing contracted providers, the Bureau will be able to clearly define the population for this restrictive category of congregate care. The first RFA was released on April 19, 2019 and defined the target population as youth who require an intensive, non-family residential setting and who have traditionally been served in out-of-state facilities. These youth have demonstrated an inability to function in foster homes or less restrictive forms of residential care due to significant lack of behavioral control and have been diagnosed with one or more significant behavioral, intellectual, developmental, and/or emotional disorder. Once assurances can be made that the system supporting QRTP is in place, data will be gathered to determine the extent of further QRTP on-boarding and will be focused on

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populations that require a higher level of care. The on-boarding of QRTP will not be through the development of new beds but the re-configuration of existing beds. There will be 42 of the existing beds converted to QRTP between January 2019 and March 2020.

The current residential structure (excluding the Medicaid categories of residential treatment psychiatric residential treatment facilities and Intermediate Care Facilities for Mental Retardation as well as one pregnant/parenting program) is being modified to fulfill the requirements of the at-risk of sex trafficking category. These programs are all in the process of training staff on new programming that will address risk factors for youth that meet this population. Until the QRTP beds are converted in January 2020, all programs will be licensed as a “vulnerable youth” program. Emergency legislative rules were filed on August 16, 2019, that will become effective on October 1, 2019. These will be included with the IV-E state plan amendment. The licensing specialists are currently in the process of making visits to each program to evaluate the curricula that the agencies will be using, how it will be trained and any new services the program requires. They will also be evaluating the new requirements for trauma-focused organizational structures.

Update 2021:

Qualified Residential Treatment Programs (QRTP)

The RFA was released in the Spring of 2019 asking for applications requesting. Five current residential treatment providers submitted applications and all five were selected to provide one of more QRTP sites. Several meetings with the providers were held to discuss the requirements, transition plans and rates. During those meetings, four of the providers decided it was not financially feasible for their agencies to continue developing a QRTP site. One provider decided to move through the process of opening two QRTP sites. One of those sites would have ten beds for females and be in the northern part of the state. The second site would have ten beds for males and be in the southern part of the state. The licensing reviews were conducted on the sites, and both were approved and are ready for licensure. The southern site was slated to begin transition/onboarding of children in March 2020. The second site was slated to begin transition/onboarding of children in April 2020. However, due to the COVID-19 pandemic and the impact of the pandemic on the facilities being transitioned, these dates have been postponed.

The Bureau for Children and Families was successful in expanding the existing contract with Kepro in January 2020, for their qualified staff to conduct the 30-day independent assessment for QRTP.

The Bureau for Children and Families pursued new legislative licensure rules to support FFPSA residential categories through the emergency rule process. Those rules were passed and became effective on October 1, 2019. During the 2020 legislative session, the Bureau for Children and Families formally codified the rules into WV Code §49-2-121, §27-17-3, §27-1A-4(g), §27-1A-6(6) and §27-1A-7 and they become effective July 1, 2020.

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The CIP's Data, Statutes and Rules Committee was successful in its efforts to revise the Judicial Rules of Procedure for both child abuse/neglect and juvenile justice to incorporate the 60-day court review process for circuit court judges that supports QRTP. The approval occurred in September 2019.

Youth at Risk of Sex Trafficking Programs (Vulnerable Youth)

During 2019, the Residential Treatment Licensing Unit of the Bureau for Children and Families, developed a condensed licensing tool that would be used to review residential programs for compliance with the new requirements for Vulnerable Youth Programs. Specifically, the review consisted of:

- *Review of the provider's curriculum on sex trafficking for youth and staff*
- *Review of training provided to staff and youth*
- *Interview with trainers on the curriculum*
- *Interviews with staff on the training they received*

The reviews were completed prior to October 1, 2019 and all facilities were re-licensed as Vulnerable Youth Programs on October 1, 2019.

Re-structuring Residential Care

During 2019 and into 2020, the Bureau for Children and Families worked with Level I Residential Treatment Facility Providers to re-structure their programs into transitioning programs for youth and to move away from licensing them as behavioral health facilities.

A new series of legislative licensure rules is currently being developed for legislative session 2021 through a public/private partnership between the Bureau for Children and Families and the child residential programs that would support transitioning services for older youth. The services and supports for transitioning youth include modernized residential programs, as well as options for youth to be in scattered site placements and would meet the unique needs of foster youth becoming adults. The residential programs would not be licensed as behavioral health facilities, but as transitional living homes.

Update 2022:

Qualified Residential Treatment Programs (QRTP)

There is no update for QRTP placements. West Virginia has no facilities that are classified as Qualified Residential Treatment Programs at this time. There is currently a residential redesign underway.

Youth at Risk of Sex Trafficking Programs (Vulnerable Youth)

The Residential Providers have incorporated sex trafficking curriculum for youth and staff into their programming. The Legislative rule requires the residential facility to provide sex trafficking prevention

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programming that includes education about sex trafficking including what it is and the prevalence of it; education about understanding one's vulnerabilities and how to protect self from traffickers; education about how to enhance the child's existing support system of family, friends, and community; education about services for housing, homelessness prevention, and educational support; and education to prevent running away.

Re-structuring Residential Care

During the 2021 Legislative Session the new series of legislative rules passed both Houses and is awaiting the Governor's signature. The Bureau for Children and Families continues to work with Level I Residential Treatment Providers as we move forward with transitional living programs, services and supports for this population. A new model of residential care is being designed for West Virginia youth in care. As part of the work toward this goal, a cluster analysis of youth in residential care was conducted by Marshall University. The analysis looked at youth in care and their treatment needs. The model of care workgroup is utilizing this data and inputs from partners and shareholders to design residential settings that meets the needs of our youth including transitional living settings and nontreatment group facilities.

Adoption/Legal Guardianship

Adoption and Legal Guardianship services provided by the DHHR are provided state wide. These services include recruitment of foster and adoptive families, the home-finding process, case management, the adoption resource network (ARN), and the contract with specialized private foster and adoption agencies.

Adoption/Legal Guardianship subsidy, medical assistance, and non-recurring adoption expenses are provided to all eligible children adopted or placed in Legal Guardianship through foster care through the age of twenty-one (21) if they meet eligibility criteria.

Adoption Resource Network

Children from West Virginia who are legally available for adoption and have no adoption resource identified are placed on the Adoption Resource Network at www.adoptawvchild.org

Mutual Consent Registry

The purpose of the Registry is to provide a centralized location wherein adult adoptees who were born in West Virginia and the birth parents of such adoptees may register their willingness to have their identity and whereabouts disclosed to each other and to provide for the release of this information once each party has voluntarily registered.

The Registry can also provide non-identifying background information to birth parents, adoptive parents, and adult adoptees upon request if WVDHHR was the agency that facilitated the adoption.

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The DHHR utilizes home-finding specialists throughout the state to certify homes for kinship relative providers. Specialized agencies are contracted by the Department to certify traditional foster and adoptive homes. The DHHR assigns adoption specialist to manage the cases of children who have been placed with kinship relative providers. Specialized agencies assign their agencies case workers to manage cases for children who have been placed in traditional foster and adoptive homes for whom no appropriate kinship/relative provider could be found. Department adoption specialist as well as specialized agency case managers have the responsibilities of completing monthly face to face contact with children, making assessments of services that children and families need, and assisting the foster/adoptive family with completing necessary documents throughout the adoption process. Once the adoption process is complete, cases are transferred to the state office for management of post adoption case records.

Service Coordination

The ultimate responsibility for service coordination is the case worker for all cases opened for services, with the help of the Multi-disciplinary team in cases where children have been removed from the home.

Managed Care Organization (MCO)

The West Virginia Department of Health and Human Resources is in the process of procuring a vendor to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance. Additionally, the successful vendor will provide statewide administrative services for all individuals accessing socially necessary services (SNS). Per House Bill (HB) 2010, this program seeks to reduce fragmentation and offer a seamless approach to participants' needs, deliver needed supports and services in the most integrated and cost-effective way possible, provide a continuum of acute care services, and implement a comprehensive quality approach across the continuum of care services. Services include, but are not limited to, the following:

- Coordination of physical health services, behavioral health services, and SNS
- Financial management and claims management for physical and behavioral health services
- Establishing and managing a credentialed provider network for physical and behavioral health services
- Utilization management, quality management, member and provider services, reporting, and analytics for all services under the contract
- Maintaining information systems to support delivery of services to the member population and the terms of the contract
- Assisting in reducing the number of children entering the child welfare system

There is currently a fragmented system of care for West Virginia's children and youth in foster care, as well as those children at risk of entering the foster care system and their families. West Virginia's foster

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care population has continued to increase over the past several years due to the opioid epidemic facing our state, with 85% of cases involving Substance Use Disorder (SUD). The Department has identified a significant need to better help those families in crisis and reduce the number of children removed from their homes. For those who have already been subjected to this event, it is imperative that the Department implement a strategy to help better coordinate the care of those members and make sure they are receiving all of the necessary services available, in hopes that reunification may occur.

A single vendor will be selected to oversee and coordinate both health and social services, with physical health and behavioral health services provided through an MCO model and SNS provided through an Administrative Services Organization (ASO) model.

The following goals and objectives support the Department's vision for this procurement:

1. Enhance coordination of care and access to services, including physical health, behavioral health, dental care, and SNS.
2. Improve communication and training among stakeholders.
3. Enhance quality of care.
4. Reduce fragmentation and offer seamless continuity of care.
5. Deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible.
6. Improve health and social outcomes for youth and impacts on families.
7. Develop and utilize meaningful and complete electronic health records (EHRs) for each member and other IT supports to improve data sharing.
8. Help reduce the number of children removed from the home through increased family-centered care that provides necessary and coordinated services to all members of the family.
9. Include a comprehensive quality approach across the entire continuum of care services.

The State will automatically enroll beneficiaries into an MCO in order to provide specialized and coordinated care in the most seamless and cost-effective way possible.

Members included in the MCO will receive specialized care coordination that incorporates trauma-informed practice and adverse childhood experiences (ACEs) guidelines. The MCO will be responsible for coordinating continuity of care and developing an integrated care plan with healthcare providers, child welfare providers, behavioral health providers, and the member and their family or caregiver(s). The MCO will also provide specialized support when a member leaves a residential facility or changes levels of care. The care coordinator can monitor quality and quantity of services, which will decrease duplication of services and/or prescription medications. Care coordinators will also conduct outreach to their assigned members in order to establish relationships and respond to changes in members' needs over time.

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Update 2021:

In May 2019 the Bureau for Children and Families, Bureau for Behavioral Health and Bureau for Medical Services began working on an outline that would clearly define the roles and responsibilities for the Managed Care Organization (MCO) once selected. It was agreed the MCO would manage all health and behavioral health needs of Medicaid recipients including foster and adoptive children as well as Socially Necessary Service selection and provision.

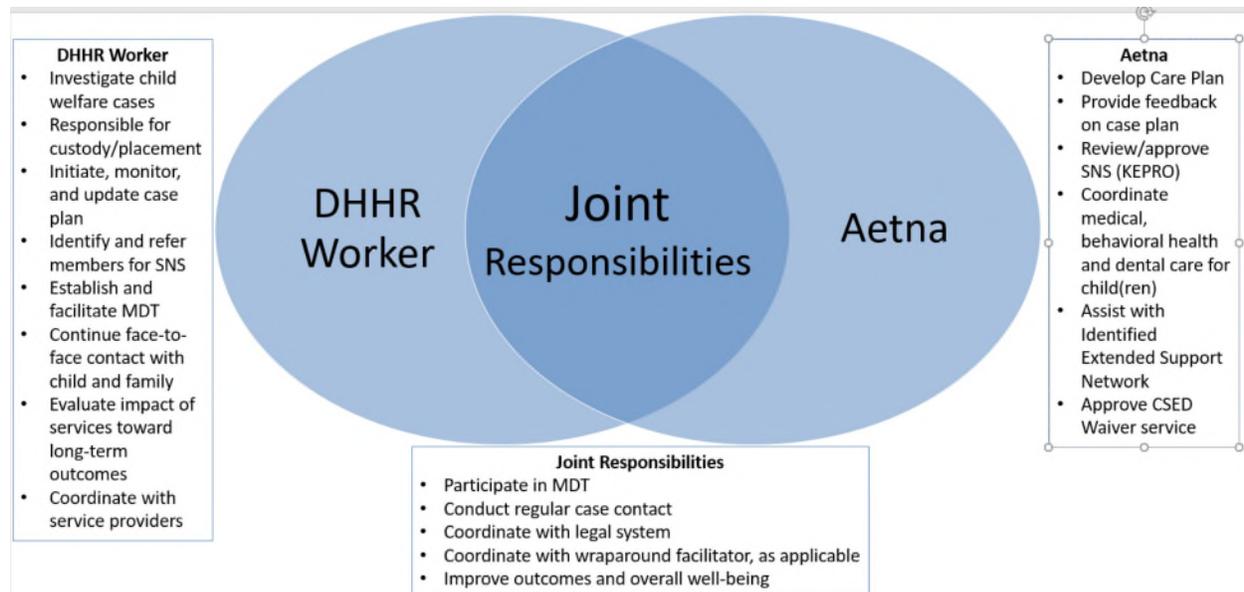
In October 2019, Aetna was selected as the Managed Care Organization for West Virginia and the program was named Mountain Health Promise. Joint meetings have been held two to three times per week since that time to clearly define roles, outline access to recipients and caretakers and develop compatible data bases.

On March 1, 2020, Mountain Health Promise will be rolling out their care coordination for foster children. The process is not fully implemented, and all three bureaus continue to meet with Aetna several times per week to delineate roles and identify and eliminate barriers. The most important goal for everyone involved is to ensure recipients and their caretakers receive the services and care they need without being bombarded by workers gathering the same information and developing multiple plans.

The added benefits of Aetna managing care of health and behavioral health services to foster children include consistent care coordination, review of services identified for families by clinicians, doctor's and psychiatrists, the availability of [lfoster](#) to foster children, medical homes for all foster children and an added layer of accountability for foster children and their families to receive needed services. It is hoped that all families will receive the appropriate services at the appropriate time to reduce their length of stay in foster care. Cross training on the MCO is expected to occur with courts and child welfare staff regarding service coordination during calendar year 2020-2021.

Below is a diagram that begins to outline the roles and responsibilities of each entity.

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Update 2022:

On March 1, 2020, Aetna Better Health of West Virginia (ABHWV), launched the Mountain Health Promise (MHP), a specialized single MCO contract to provide statewide physical and behavioral health services for children and youth in the foster care system and individuals receiving adoption assistance. This also includes Socially Necessary Services (SNS) and Children with Serious Emotional Disorder Waiver (CSED). Aetna continues to focus on quality care management, outstanding clinical leadership, stakeholder engagement and training to support the wellbeing of vulnerable WV children. MHP assists WVDHHR, families, stakeholders and providers towards commonly held goals: Healing families, returning children to communities (home or kinship), reducing the number of children in care and the time they spend in care (getting them the right services at the right time) and increasing connections for all kids in care. Aetna knows connections help heal kids more than anything else.

The MHP program is a total approach to coverage that cares for the youth, which includes access to a care coordination team that consists of:

- Aetna Case Managers
- Aetna System of Care team (Justice SoC Administrator, Adult SoC Administrator, Child SoC Administrator, Recovery and Resiliency SoC Administrator)
- Clinical team
- CSEDW Project Manager
- SNS Liaison

ABHWV case managers are nurses, social workers, and other behavioral health specialists. All MHP members are assigned to an Aetna case manager. They are managing the physical, behavioral, and emotional health care needs of foster children. The Aetna case managers reach out initially to enroll the

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member in MHP and obtain necessary assessment information. This information determines the level of case management Aetna will provide.

Acuity levels:

- *Population Health (tier 1)* – for children currently residing in a family-based setting with no current indication of possible placement disruption.
- *Supportive case management (tier 2)* – for children exhibiting some disruptive behavior with physical and/or behavior health diagnoses.
- *Intensive case management (tier 3)* – for children at imminent risk of placement disruption including residential placement, for children with significant unmet needs and exhibiting severe behavior/trauma or with identified chronic medical needs.

As of March 2021, ABHWV has enrolled 22,500 members in Care Management with Mountain Health Promise. Enrollees in acuity level tier 3/intensive care management are currently 694, tier 2/supportive CM are 1165 and tier 1/population health 20,741 respectively.

Reporting for 3/2020 to current:

- *CM Case Rounds – (members reviewed in weekly case rounds) – 698 intensive and/or supportive cases reviewed*
- *CM Contact: Successful and unsuccessful CM outreaches – (68673+127018=) total of 195,691*

Reporting 7/1/20 to current:

- *Condition specific assessments completed –
Assessments include but are not limited to anxiety, safety questionnaire, asthma, adverse childhood experience, CPI – clinical/ functional/ living environment/ medication/ self-care, depression, diabetes, GAD7 screener, HTN, interval, lead, pain, perinatal, SF10, sickle cell, trauma screening questionnaire, UNCOPE, weight, K6 screener 7/1/20 to current = 41,731 completed
- *Current Timely Initial Outreach for MHP members–
= 100%*
- *Initial Person -Centered Care plans completed–
= 92.31%*

Deep Dive and specialized reviews:

Over the past six months the ABHWV team have selected 25 members that have been in their current residential placements for extended amounts of time, to discuss in a Deep Dive meeting. The ABHWV team has come together with BCF from each member's home region, to develop a viable discharge plan. Fifteen

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of the twenty- five have not yet moved. Seven have moved to a lower level of care and three to a higher or lateral level of care.

Aetna has also developed a “Special Review Team” which can be initiated by anyone due to an abrupt disruption of care with any member. This team has met regarding twenty- six youth, usually within 24 hours of receiving the request. For particularly difficult placement issues, the team has met multiple times.

They plan to continue doing specialized reviews collaboratively with the WVSoC.

Child youth program descriptions:

Aetna’s System of Care (SoC)Team has spearheaded family engagement practices of Family Finding and H.E.E.R.O. workshops all within the restrictions of the new virtual meeting world. These initiatives help children and youth build a supportive network of adults around our foster youth that can love them and help them heal from their early lived adversities. They have offered over 80 hours of virtual training during year one and are planning an additional 80 hours over the summer of 2021.

Family Finding – practice model that offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. The goal of Family Finding is to connect each child with a family. We are building a network of support for the child that could result in placement, but placement is not the primary goal if treatment is the immediate need. Children fail in placements because they are isolated and lonely. Core beliefs inherent in this approach are:

- Every child has a family, and they can be found if we try
- Loneliness can be devastating, even dangerous, and is experienced by most children in out-of-home care
- A meaningful connection to family helps a child develop a sense of belonging.
- The single factor most closely associated with positive outcomes for children is meaningful, lifelong connections to family.

Connect our Kids® - a Family Finding tool developed to assist social workers in locating family members for children in need. The tool uses several search engines that are compiled together and FREE to use. Every person has a minimum of 20 immediate connections and engaging all family is vital to the healing process.

HEERO (Helping Everyone and Each other Reach Out) – These are workshops that help transitional aged youth build their own lifelong unconditional support networks and connection in preparation for life beyond emancipation from formal services. HEERO is not about finding the youth a place to live after aging out, although that may happen during the process. It is not about who the youth is placed with, or what agency/program would best serve this youth or even who is safe for this youth. HEERO is about allowing the youth to have a say in what their life after the system looks like. It allows them the chance to make mistakes in a controlled safe environment while they are still in care so that they can deal with any rejection or eye-opening moments with support.

FamilyConnect® Portal – an Aetna Better Health of WV (ABHWV) secure portal for members and state case workers to enhance continuity of care through its functions. Functions include:

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- Member appointments
- ABHWV case manager assignment and CM enrollment level
- ABHWV care plans and communication with CM to add to care plan
- State case workers can message the member's assigned ABHWV case manager
- View member authorizations for services

The **CSEDW** (Children with Serious Emotional Disorder Waiver) is a Medicaid Home and Community Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. The CSEDW provides services that are additions to Medicaid State Plan coverage for members ages three through 20 who are enrolled in the CSEDW program. The CSEDW permits WV to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities.

This waiver prioritizes children/youth with serious emotional disorders (SED) who are:

- In Psychiatric Rehabilitation Treatment Facilities (PRTF's) or other residential treatment providers either out-of-state or in-state; and
- Other Medicaid-eligible children with SED who are at risk of institutionalization.

CSED will reduce the number of children housed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTF's) and shorten the lengths of stay for children who require acute care in PRTF's. West Virginia defines the term "children with a serious emotional disorder" (CSED) as children with an SED who are ages three through 20 and who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

For children who are placed in both in and out of state facilities, BCF can pursue application to the CSEDW program to serve as step-down treatment for individuals placed in such facilities and who, upon discharge will be placed in a home setting. Home setting is defined as a natural family home, kinship placement and/or foster care placement. The CSEDW program offers intensive services within the home and community where the child will be residing to assist with a successful transition from a facility back into the community.

Aetna can make recommendations and assist the child's legal guardian with making application when necessary for both in and out of state kids. Aetna case managers ensure that services are provided according to the policy.

- To date, we have had 153 individuals approved for CSEDW
- Of those 153, 19 have discharged with a current total of 134
- Of these 134 there are 37 on hold due to being currently in residential placement

Service Description

For an analysis on gaps in services please see the Service Array section of this plan.

Services to Homeless Youth

To prevent homelessness for youth in WV, BCF utilizes several approaches throughout the state. BCF policy requires workers working with children 14 years and older to develop a transition plan. This plan is informed by a multitude of information, including a life skills assessment. The life skills assessment is used to determine which areas, important to successful independent living, need improvement. The plan also includes the youth's self-identified skills and needs and requires the youth to identify areas of improvement she/he would like to focus on every 90 days. Youth who attain the age of 16 and have demonstrated a substantial ability to support themselves are provided the opportunity to test their knowledge and skills with placement into semi-independent living programs. These programs are often housing on group residential grounds in which one or more youths live together and take responsibility for self-care under the supervision of a program worker. This allows the youth and social worker the opportunity to visualize the reality of the identified skills and needs, to further work on areas needing improvement. Once a youth has successfully demonstrated their ability to succeed in an environment of limited supervision, the youth has the option of transitioning into scattered site apartments or similar independent living units. In these units the youth will receive a subsidy for essentials, will further their education or job training, and will continue to improve on important areas of self-sufficiency such as job readiness and interviewing skills. These options remain open to foster youth and former foster youth until the age of 23, with education and training voucher to youth up to the age of 26.

When youth who aged of foster care do become homeless, they are provided the opportunity to return to the department for a voluntary removal and placement into a foster care setting to attain needed services. Youth who do not wish to return to a foster care setting may apply for Independent living or homeless services, which includes the ability to be obtain food, shelter, and medical care. BCF will be moving to partner with one of our state's Continuum of Care associations to improve homeless services and access for children and families. Currently, WV homeless shelters are funded through a variety of funding sources which only fragments the system, making requirements different for each shelter. The varying requirements effect everything from the training of shelter staff, the referral process, and the point of eligibility.

The U.S. Department of Housing and Urban Development funds state homeless coalitions across the country through two primary funding streams. The Emergency Solutions Grant (ESG) program and the Continuum of Care (CoC) program fund each community's homeless system. The ESG grant funds street

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outreach, homelessness prevention and diversion, emergency shelter, and rapid re-housing. The CoC program funds permanent supportive housing, rapid re-housing, transitional housing, coordinated entry, and pilots like the Youth Homelessness Demonstration Program. HUD provides funding based on a state's population statistics and provides some regulation. These populations are counted through the mandatory use of a Homeless Management Information System (HMIS). In addition, to these federal sources the WV Department of Health and Human Resources also funds shelters' through two different Bureaus; the BCF and The Bureau of Behavioral Health. This allows shelters flexibility in how they deliver services and which requirements they wish to follow. The BCF intends to release a funding announcement for one of the four CoC's to manage the BCF's homeless program. This will enable the CoC to include the state's data in homeless counts as it will require the use of the HMIS, it will require the use of the centralized intake line for service access, ensure system-wide training requirements and the access of services prior to ever becoming homeless through the rapid re-housing program and prevention work.

Additionally, BCF partners with several agencies to provide services and opportunities for at-risk youth. The Human Resource Development Foundation provides valuable programs and education to youth who are at high-risk of future homelessness due to being in foster care and/or having juvenile justice involvement. Job Corp is another program BCF Social workers rely on and regularly refer to for foster youth interested in pursuing on-the-job training. Particularly helpful, are Job Corp sites which include supportive housing. These programs often offer youth who wish to end their involvement with the foster care system a stable and safe living environment in which they can focus on their education and job-training.

Update 2021:

In February of 2019, the BCF began participating in the West Virginia Coalition to End Homelessness (WVCEH) Youth Homelessness Demonstration Program (YHDP). This collaboration of representatives from the BCF, Department of Education, CoCs, Housing and Urban Development and other agencies gather to discuss gaps in services, new initiatives, potential data sharing within the parameters of HIPPA, and garner feedback on local, regional, and statewide levels of what is working and not working. The BCF has provided data to the YHDP in the form of NYTD survey information and legislative foster care reports. It has also provided background and updates to the foster youth transitioning process.

In the fall of 2019, the YHDP began collaboration with the Rapid Results Institute to undertake that programs' '100 Day Challenge'. This program aims to target a specific catchment area and significantly reduce youth homelessness therein. The YHDP has selected the counties of Monongalia, Harrison, and Marion as the catchment area. Representatives from multiple disciplines will receive a workshop training on the '100 Day Challenge' and, with assistance from the BCF, will attempt to find stable housing for at least 60 homeless or at-risk youth ages 18-24.

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2019 also had the introduction of the Foster Youth Initiative (FYI) program. This program is funded by HUD and provides vouchers to landlords who can provide housing for transitioning foster youth at risk of homelessness and would provide priority housing to at-risk transitioning youth. The BCF has begun preliminary meetings with representatives from HUD, BJS, MODIFY, and WVCEH to discuss a potential roll out of the FYI program in WV. In 2020, the BCF will continue its collaboration on this project and, if the program is deemed viable, will pilot in a selected catchment area with hopes of statewide expansion.

Finally, the Huntington PHA began issuing Family Unification Program (FUP) vouchers in July 2019. FUP vouchers are to be on families for whom the lack of adequate housing is a primary factor for youth returning from placement, and for youth who have left foster care at age 16 or older and who are homeless and at risk of being homeless. As of December 2019, there have been nine FUP referrals, of which seven vouchers have been issued. The BCF will continue to evaluate the success of the FUP program within the Huntington WV PHA to determine if other PHAs would benefit from the program.

Update 2022:

BCF continues its collaboration with Youth Homelessness Demonstration Project (YDHP) and has assisted in forming the Youth Action Board (YAB), a collaboration of former and current foster youth, with representatives from WVCEH, BCF, and other agencies. Beginning in December 2020, the YAB holds Zoom calls to identify housing barriers and discuss youth homelessness initiatives. These meetings are youth lead and occur on the last Wednesday of every month.

Another function of the YDHP was to facilitate the Rapid Results Institute's 100-day challenge of housing youth. Due to the onset of the COVID-19 pandemic, the YDHP was forced to reduce its 100 days to 75. In that timeframe, it successfully housed 17 homeless youth.

The BCF continued its collaboration with HUD, local Public Housing Authorities, CoC's, and other agencies in launching the FYI program. A pilot of the FYI began in November 2020 for three counties served by the Charleston/Kanawha Housing Authority (CKHA), and the Kanawha Valley Collective (KVC), the CoC provider for the pilot counties. To date, the FYI Pilot has served three youth identified to be at-risk of homelessness. In March 2021, a second group of counties served by the Fairmont/Morgantown Housing Authority (FMHA), and the WVCEH, launched the FYI program. In 2021, the BCF and those collaborating on the FYI program will launch an FYI awareness campaign to bring public attention to the program. The HUD office will continue to evaluate WV PHAs and determine which of these are ready for FYI implementation.

The Huntington Housing Authority continues to provide the FUP program. This program provided vouchers to 3 individuals in 2020 and has provided 6 total vouchers overall. HUD has announced the FYI program and FUP program can exist in the same housing authority, a stipulation that was previously not allowed. The BCF and HUD will collaborate in 2021 to see if FUP expansion is viable in other regions of WV.

Services to LGBTQ youth

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The Bureau for Children and Families 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 us 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 missing element is a similar training to be required of foster parents. 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 are fundamental in the healthy development of these youth and the families they live with must be able to provide this invaluable experience.

The BCF also recognizes that state agencies are not often viewed as "safe spaces" for the LGBT communities, and as a result 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. BCF recognizes this as an area that needs improvement. BCF desires to develop 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. BCF also wishes to develop educational literature for use with our social service staff and for distribution in our local office waiting areas. The state 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.

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.

Transgender youth reported the highest levels of victimization, disproportionate to their representation. These staggering statistics, coupled with a Williams Institute report citing West Virginia having the nation's highest percentage of youth identifying as transgender, made it evident the BCF had to ensure these youth receive services in a welcoming, culturally competent environment. To accomplish this BCF undertook several key activities.

The BCF has partnered with the Aspiring Allies for Equity (AAE) to work on addressing issues of systemic oppression of marginalized communities. AAE works with the Rainbow Justice League, specifically, to help

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identify issues of equality and service accessibility for the LGBTQ population. The BCF has required domestic violence shelter decision makers to attend the AAE group to ensure they hear firsthand some of the accessibility and bias the LGBTQ population experience when attempting to access safety and how their services can be improved. Additionally, the BCF also required that shelters allow interested staff in joining the Rainbow Justice League protected time to participate.

The state has also piloted a new needs tool for use with our youth population. This tool will begin the full implementation process in FFY19. The West Virginia version of the Family Advocacy and Support Tool (FAST) was developed jointly with the PRAED foundation to meet West Virginia's needs. As part of this new tool, workers will be working to identify youth who may be victims of Intimate Partner Violence and working to address those needs specifically.

No 2021 Update

No 2022 Update

Services to Victims of Human Trafficking

West Virginia is committed to providing necessary services for all minor trafficking victims. and has been part of the West Virginia Human Trafficking Task Force for approximately three years. Bureau for Children and Families has representatives as part of the task force, subcommittees within the task force, as well as the leadership or steering committee that guide the task forces' activities and responsibilities. The Bureau for Children and Families representatives have aided in education at statewide conferences and trainings to child welfare staff as well as other professionals who work in the child welfare system regarding the response of the Bureau for Children and Families to minor trafficking victims. The bureau will continue to work and collaborate with West Virginia's Human Trafficking Task Force for the continued improvement of West Virginia's response to human trafficking victims and available services. The task force will be applying for numerous available grants after their release, over the course of the next five years. The Bureau is devoted to assisting with all grant applications and providing any necessary data, information, statistics, etc., as West Virginia's child welfare agency, that may be necessary or required for the application of any grants. The Bureau for Children and Families will aid the state task force in improving West Virginia's response and service for minor victims of human trafficking.

The Bureau for Children and Families developed a report through the SACWIS database system to track all human trafficking referrals in 2018. However, the report is not functioning and has not been able to capture all trafficking referrals for FFY 2018. A manual report will be created, and regional social service program managers and directors will be tasked with disseminating information to all county supervisors requesting that all human trafficking referral numbers be sent to a Children and Adults Services' program specialists who will track all human trafficking referrals and corresponding information including gender, age, maltreater type, action taken, and services offered. This report will be maintained and updated monthly until the state's new Comprehensive Child Welfare Information System (CCWIS) is operating and can capture this information.

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Update 2021:

The Bureau for Children and Families continues to have an active involvement in the West Virginia Human Trafficking Task Force. Between October 2019 and December 2019, members of the task force participated in six regional trainings throughout the state to educate and trained various professionals, including child welfare staff, in human trafficking, available services for victims/survivors, and appropriate reporting protocol. A program specialist with the Bureau for Children and Families aided with the trainings to educate individuals on the Bureau's role in addressing and dealing with human trafficking referrals and identified victims/survivors.

In order to stay ahead of the statewide demand for human trafficking training for various professionals, members of the task force have gathered various curriculum from relevant disciplines to host a "train the trainer" session in the 2020 calendar year. This training will allow additional professionals to become subject matter experts relating to West Virginia's response to human trafficking. The is training was originally scheduled for May 2020 but has been pushed back to a later date.

Additionally, with the Family First Prevention Services Act, the Bureau for Children and Families has implemented required human trafficking components and training curriculum for all residential and congregate care facility staff to address the needs of human trafficking victims/survivors. The Bureau for Children and Families will continue to work with other disciplines for the improvement and maintained service delivery to human trafficking victims/survivors.

Update 2022:

The Bureau for Children and Families continues to offer services to minor victims of human trafficking as required by Chapter 49 of the W. Va. Code, though West Virginia received fewer than five trafficking related referrals during the calendar year 2020. During the 2021 legislative session House Bill 2830 requires that services offered to victims of trafficking as abused and neglected children and minors through the Bureau for Children and Families include more comprehensive trauma-informed services that are specialized to the needs of child victims of sexual abuse and exploitation and child sex trafficking victims. The Bureau for Children and Families continues to have representation through staff who are active members of the West Virginia Human Trafficking Task Force and various subs-committees and steering committee of the task force. The task force met virtually throughout most of the 2020 year and continue to meet virtually through the first part of 2021. Virtual trainings continue to occur as well, to increase education and awareness about human trafficking and prevention. The task force recently reapplied for the funding grant through The Sisters of St. Josephs. This grant award would allow the task force to continue to work together to develop new training opportunities for BCF staff as well as other disciplines and professions. Staff from BCF have assisted in human trafficking trainings throughout the state to educate child welfare staff, service providers, law enforcement, and other disciplines about the dangers and risks of sex trafficking for children and youth involved in the child welfare system.

Services to Children in Disasters

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In the event of any natural disaster, the West Virginia Department of Health and Human Resources will assist in community efforts, when needed, to assure unaccompanied children remain safe. For those children who do not have family, friends or community resources to assure their safety, the Department of Health and Human will assume custody in order to provide services and will use the following procedures.

- If the emergency custody is granted then the worker will initiate placement of the child in emergency family care, foster/adopt care or emergency shelter care.
- If placement with family members, foster care or emergency shelter is not possible during a natural disaster or emergency, the child/children will be taken to an established disaster relief site by the worker.
- Workers will provide supervision to the unaccompanied children at the disaster relief site as needed.
- The worker will see that the children's basic needs are met during the disaster or emergency to the best of their ability.

- If the child's parents or family members are located before the end of the two judicial days, the child may be returned to the family at that time.
- If the family cannot be located, the worker will file the petition requesting temporary custody.
- If the family is located after the DHHR has requested and received custody of the child/children, the worker can return the child/children to the parent or family members and then request that the petition requesting custody be dismissed at the first court hearing.

Update 2021:

In June 2019, severe thunderstorms hit Grant, Pendleton, Preston, Tucker and Randolph counties leading to flooding and evacuations. Homes, bridges and roads were destroyed including parts of four-lane U.S. Route 33.

Gov. Jim Justice declared an emergency and the West Virginia National Guard was deployed to help with some of the cleanup.

Due to this natural disaster, West Virginia was eligible for funding to improve services to the people of those counties.

In order to provide relief, the Bureau for Children and Families will use the funding from CWS Disaster Relief Funding to provide grants to local Family Resource Networks in those counties. The funding would be used to help families, affected by flooding, protect and support their children.

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Most of the funding would be used to purchase needed items lost due to the disaster such as beds, bedding, clothes, food, appliances and supplies. These goods and services would be distributed by the Family Resource Networks directly or through local Family Resource Centers if there is one located in the county. Services provided by Family Resource Centers fall under the State's Title IV-B Subpart I Prevention services.

The COVID crisis has forced the state to develop crisis response plans for all its social services programs. Services such as visitation between children in care with their biological families have been limited to provision by Skype, Facetime, Zoom and other technical programs unless safety of children is an issue.

All safety services in safety plans and the investigation of abuse and neglect referrals must be provided face to face.

Plans have been implemented to address our runaway and homeless youth as well as foster care plans for a virus outbreak in foster homes or facilities.

Update 2022:

When a stay-at-home order was issued by West Virginia's Governor, Jim Justice, in March 2020 due to COVID, the Bureau for Children and Families immediately went to work on a plan for foster children to assure their safety and well-being.

Each foster family was asked to prepare a plan to implement in the event they or their children contracted COVID. All families had no issues developing plans to care for the children in the event the children became ill. The response was, "I'll take care of them like I always do". However, it became a bit more challenging to develop backup plans for some families if it was the caretakers who became ill. Our Child Placing Agencies developed respite plans for the families in their agencies. Our Kinship Navigator program worked with kinship and relative providers to assure they also had backup plans for the children in their care.

The Bureau for Children and Families issued a series of memos for staff and letters for providers with each new developing situation. Initially all visits and contacts were put on hold. All service provision was also placed on hold unless it was a direct safety service. Alternative means for visits were developed using technology such as Skype or Facetime visits with parents and siblings.

Additionally, supplemental funding was sent to foster parents on two occasions during 2020 to help offset additional costs of lunch as well as any additional personal hygiene products that may be needed due to COVID such as masks and hand sanitizer.

BCF staff worked with MODIFY staff to ensure that older youth in transitional living placements such as their own apartments or college dorms had appropriate housing when schools shut down. Work and school requirements were waived in order to allow these youth to remain or secure appropriate housing.

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In April 2021, Bureau for Children and Families staff released guidance for obtaining consents for vaccination of youth in care sixteen (16) and over. Child Welfare workers are required to meet with these youth and determine their desire to obtain the vaccine as well as that of their parents. An Excel spreadsheet was developed to track all youth in care that have consented and received the vaccine.

New means of communicating with families were developed. A COVID website was developed by the Governor's Office to spread the word of any closures or actions taken by the state. Mission WV developed a website specific to kinship and relative families to give the Bureau for Children and Families a means to notify that population of providers of any new guidance or news. Additional payments to foster families to offset costs of providing food to children in their care was announced on this site as well as the release of PEBT benefits. These websites are still operational and are now used to announce any openings or closings of services in the state.

Stephanie Tubbs Jones Child Welfare Services Program (title IV-B, subpart 1)

Prevention Services, Child Protective Services, Youth Services, Foster Care Services, Adoption and Legal Guardianship Services are available to all children 0-18 in West Virginia if they meet eligibility criteria. For a complete list, please reference the Services section of this plan.

Services for Children Adopted from Other Countries

All children in West Virginia are eligible for the same array of prevention services. This includes children with no child welfare intervention as well as children adopted from other countries. Services provided under sub-part I are available to children adopted from other countries however, accessing these services may require a request to receive services.

The states array of post-adoptive services not covered by traditional insurance or Medicaid are minimal. A Request for Proposal (RFP) was developed for these services several years ago but was never released. The Bureau for Children and Families intends to revisit this RFP for possible release in the upcoming year. This contract would make accessing these services easier for all adopted children and their families. West Virginia has had no children adopted from other countries come into foster care in the last year.

Update 2021:

West Virginia has not released the RFP for post adoptive services. The state had one child previously adopted from China through a private agency. The child was re-adopted privately through the same agency and West Virginia provided a conditional medical card.

Update 2022:

No 2022 Update. There were no children adopted from other countries in the reporting year.

Services for Children under the Age of Five

When children are placed in foster care, the families they are placed with have already been certified and received training to be their adoptive home. This minimizes the amount of time after termination of parental rights (TPR) to adoption. This applies to kinship/relative providers as well. This practice has reduced the time it takes to move from TPR to adoption.

Focusing efforts to place children with kinship/relative providers has also helped reduce the time to adoption. West Virginia places children with relatives/kin 48% of the time. Relative/kin providers are more likely to adopt and there are fewer disruptions.

Birth to Three and Right from the Start services are available to all children in the state. Both services focus on the developmental needs of newborns to three. Child Protective Services Policy mandates that all children with substantiated maltreatment must be referred to the Birth to Three Program. The Bureau for Behavioral Health offers children's mental health services to children and youth ages newborn to twenty-one. For more detailed information about mental health services and programs for children please visit the following website.

<https://dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/ChildandAdolescent/Pages/ChildAdolescentBehavioralHealth.aspx>

Lily's Place, a *Neonatal Abstinence Syndrome Center*, provides medical care to infants suffering from Neonatal Abstinence Syndrome (NAS) and offers support, education and counseling services to families and caregivers to create healthier families and help end the cycle of addiction. West Virginia has utilized services at Lily's Place since 2014.

From Oct. 1, 2017 thru Sept. 30, 2018 Lily's place reports the following statistical information;

Admits- 48
Length of stay- 28-day average
Discharge to parents- 29
Discharge to relatives- 5
Discharge to foster care- 14

Update 2021:

From October 1, 2018 through September 30, 2019 Lily's Place reports the following statistical information:

*Admissions – 57
Length of stay – 27-day average
Infants discharged to parents – 36*

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*Infants discharged to relatives – 7
Infants discharged to foster care – 14*

Update 2022:

From October 1, 2019 through September 30, 2019 Lily's Place reports the following statistical information:

*Admission – 41
Length of stay – 28-day average
Infants discharged to parents – 25
Infants discharged to grandparents – 3
Infants discharged to foster care – 12
And 1 infant was adopted immediately at the hospital before being admitted to Lily's Place*

A second Neonatal Abstinence Syndrome Center at Thomas Memorial Hospital in South Charleston opened Baby STEPS, an eight-bed unit for babies withdrawing from maternal drug use, in the spring of 2019.

West Virginia University Center for Excellence in Disabilities offers many services to address the developmental needs of children zero (0) to five (5). They include but are not limited to Behavior and Learning Intervention Services (BLIS), Feeding & Swallowing Clinics, and Next Steps Clinics. For a complete list of available services please visit; <http://cedwvu.org/media/3286/programsservicesflyer101918.pdf>

Marshall University in Huntington, West Virginia houses the Autism Training Center. They provide training, information and support to West Virginians with autism, their families, educators, and other persons. For more information please visit; <https://www.marshall.edu/atc/about-autism-training-center/>.

Update 2021:

Saint Thomas Hospital reports the following statistical information:

*Admissions – 18
Length of stay – 24.68-day average
Discharge to parent – 13
Discharge to relative – 3
Discharge to foster care – 2*

Update 2022:

Saint Thomas Hospital reports the following statistical information:

*Admissions – 47
Length of stay – 21.05-day average*

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Discharge to parent – 30

Discharge to relative – 7

Discharge to foster care – 8

And 2 infants had to be discharged and admitted to the hospital's NICU due to complications.

Efforts to Track and Prevent Child Maltreatment Deaths

In the state of West Virginia there is currently a WV Child fatality Review Panel (WVCFRP) which is operated under the Bureau for Public Health, Office of the Medical Examiner and a review team with the Bureau for Children and Families named the Critical Incident Review Team (CIRT). Both teams function differently and for different purposes but also intersect. The WVCFRP is sanctioned through the Code of Rules and the section of code is listed below.

§61-12A-1. Fatality and Mortality Review Team.

(a) The Fatality and Mortality Review Team is created under the Bureau for Public Health. The Fatality and Mortality Review Team is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of:

- (1) The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses;
- (2) The deaths of children under the age of eighteen years;
- (3) The deaths resulting from suspected domestic violence; and
- (4) The deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child.

(b) The Fatality and Mortality Review Team shall consist of the following members:

- (1) The Chief Medical Examiner in the Bureau for Public Health or his or her designee, who is to serve as the chairperson and who is responsible for calling and coordinating meetings of the Fatality and Mortality Review Team and meetings of any advisory panel created by the Fatality and Mortality Review Team;
- (2) The Commissioner of the Bureau for Public Health or his or her designee;
- (3) The Superintendent of the West Virginia State Police or his or her designee; and
- (4) A prosecuting attorney, as appointed by the Governor, who shall serve for a term of three years unless otherwise reappointed to a second or subsequent term. A prosecuting attorney appointed to the team shall continue to serve until his or her term expires or until his or her successor has been appointed.

(c) Each member shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

§61-12A-2. Responsibilities of the Fatality and Mortality Review Team and Advisory Panels.

(a) The Fatality and Mortality Review Team shall establish the following advisory panels to carry out the purposes of this article including:

- (1) An unintentional pharmaceutical drug overdose fatality review panel to examine, analyze and review deaths resulting from unintentional prescription or pharmaceutical drug overdose;
- (2) A child fatality review panel to examine, analyze and review deaths of children under the age of eighteen years;

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- (3) A domestic violence fatality review panel to examine, analyze and review deaths resulting from suspected domestic violence;
- (4) An infant and maternal mortality review panel to examine, analyze and review the deaths of infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child.
- (b) The members of the Fatality and Mortality Review Team shall serve as members of each of the advisory panels established pursuant to this article.
- (c) The Commissioner of the Bureau for Public Health, in consultation with the Fatality and Mortality Review Team, shall propose rules for legislative approval in accordance with article three, chapter twenty-nine-a of this code that the advisory panels shall follow. Those rules shall include, at a minimum:
 - (1) The representatives that shall be included on each advisory panel;
 - (2) The responsibilities of each of the advisory panels, including but not limited to, each advisory panel's responsibility to:
 - (A) Review and analyze all deaths as required by this article;
 - (B) Ascertain and document the trends, patterns and risk factors; and
 - (C) Provide statistical information and analysis regarding the causes of certain fatalities;
 - (3) The standard procedures for the conduct of the advisory panels;
 - (4) The processes and protocols for the review and analysis of fatalities and mortalities of those who were not suffering from mortal diseases shortly before death;
 - (5) The processes and protocols to ensure confidentiality of records obtained by the advisory panel;
 - (6) That the advisory panels must submit a report to the Fatality and Mortality Review Team annually, the date the annual report must be submitted and the contents of the annual report;
 - (7) That the advisory panel may include any additional persons with expertise or knowledge in a field that it determines are needed in the review and consideration of a particular case as a result of a death in subsection (a), section one of this article;
 - (8) That the advisory panel may provide training for state agencies and local multidisciplinary teams on the matters examined, reviewed and analyzed by the advisory panel;
 - (9) The advisory panel's responsibility to promote public awareness on the matters examined, reviewed and analyzed by the advisory panel;
 - (10) Actions the advisory panel may not take or engage in including:
 - (A) Call witnesses or take testimony from individuals involved in the investigation of a fatality;
 - (B) Contact a family member of the deceased;
 - (C) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or
 - (D) Otherwise take any action which, in the determination of a prosecuting attorney or his or her assistants, impairs the ability of the prosecuting attorney, his or her assistants or any law-enforcement officer to perform his or her statutory duties; and
 - (11) Other rules as may be deemed necessary to effectuate the purposes of this article.
- (d) The Fatality and Mortality Review Team shall submit an annual report to the Governor and to the Legislative Oversight Commission on Health and Human Resources Accountability concerning its activities within the state and the activities of the advisory panels. The report is due annually on December 1. The report is to include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases and the team's recommendations to reduce the number of fatalities and mortalities that occur in the state.

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The Critical Incident Review Team which functions under the Bureau for Children and Families is an internal team which reviews cases that are known to our bureau in which the child died or was critically injured as a result of abuse and neglect. The purpose of this team is for quality assurance purposes to look at policy, practice and training to see if improvements could be made to reduce critical incidents.

In order to ensure that the Bureau is aware of all child deaths due to abuse and neglect, the chair of the WVCFRP is notified by WV Vital Statistics of all child deaths. The chair of the WVCFRP then reports all deaths to the chair of the CIRT via a form developed by the WVCFRP (See attachment A). While not all children will be reviewed by the CIRT, at the end of the year the Chair of the CIRT which is also the Director of the Division of Planning and Quality Improvement, the Director of Social Services and the Director of Children and Adult Services review the NCANDS data file to ensure all children that need to be reported are reported.

The CIRT completes an annual report to the WV Legislature which we maintain on our Bureau website at <https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx>. The numbers reported on this report and the NCANDS reporting are different, the numbers reported here are only cases known to our department not all children that have died as a result of abuse and/or neglect. The NCANDS data includes all children that died as a result of abuse/and or neglect in the state and should be reported. In 2015 the state changed policy to accept and investigate all cases of child fatality even if there are no other children in the home at the time of the death. This change allows us to capture all children who died as a result of abuse and/or neglect because they are assessed, and a determination is made in the SACWIS system.

Plans of Improvement to Prevent Child Fatalities

The WV Child Fatality Review Team Panel makes recommendations for system improvements and submits those recommendations to the legislature annually. If those recommendations include Child Protective Services, the CIRT reviews those recommendations and provides a response back to the Chair of the WVCFRP, the Chief Medical Examiner in the Office of the Chief Medical Examiner from the Commissioner of Children and Families.

The CIRT has a current Plan for Action which is maintained within the CIRT process. The plan is also included in the annual report to the legislature and can be found within that report. Since the CIRT process is a quality assurance process, information learned during the reviews is used to improve areas identified as deficiencies. An example of an action taken is safe sleep. The report shows a decline in unsafe sleep and therefore the number of fatalities as a result of unsafe sleep practices since the start of our reviews in 2014 has decreased.

Involvement of Partners to Prevent Child Fatalities

The Child Fatality Review Team Panel is required to have specific members on its panel including law enforcement, a prosecutor and several staff from the Bureau for Public Health including the Medical Examiner's office, vital statistics, Injury Prevention and Emergency Medical personnel. The team also includes a person from the Bureau for Behavioral Health and Health Facilities, the Fire Marshall's Office,

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state and local law enforcement and local and state child protective services. In the state of West Virginia these entities are all mandated reporters to child protective services.

The Child Welfare Oversight Team is the state level team for the CQI process in WV. Critical Incident data is a standing agenda item for this team to review and discuss the data and recommendations from the reviews. The Child Welfare Oversight Team is currently in the process of expanding the membership of the team to include the court, service providers, behavioral health. We are currently expanding a state team to include our court partners, behavioral health, mental health and service providers.

§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. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(c) Any school teacher or other school personnel who receives a disclosure from a witness, which a reasonable prudent person would deem credible, or personally observes any sexual contact, sexual

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intercourse or sexual intrusion, as those terms are defined in article eight-b, chapter sixty-one, of a child on school premises or on school buses or on transportation used in furtherance of a school purpose shall immediately, but not more than 24 hours, report the circumstances or cause a report to be made to the State Police or other law-enforcement agency having jurisdiction to investigate the report: Provided, That this subsection will not impose any reporting duty upon school teachers or other school personnel who observe, or receive a disclosure of any consensual sexual contact, intercourse, or intrusion occurring between students who would not otherwise be subject to section three, five, seven or nine of article eight-8, chapter sixty-one of this code: Provided, however, That any teacher or other school personnel shall not be in violation of this section if he or she makes known immediately, but not more than 24 hours. to the principal, assistant principal or similar person in charge, a disclosure from a witness, which a reasonable prudent person would deem credible, or personal observation of conduct described in this section: Provided further, That a principal, assistant principal or similar person in charge made aware of such disclosure or observation from a teacher or other school personnel shall be responsible for immediately, but not more than 24 hours, reporting such conduct to law enforcement.

(d) County boards of education and private school administrators shall provide all employees with a written statement setting forth the requirement contained in this subsection and shall obtain and preserve a signed acknowledgment from school employees that they have received and understand the reporting requirement.

(e) The reporting requirements contained in this section specifically include reported, disclosed or observed conduct involving or between students enrolled in a public or private institution of education, or involving a student and school teacher or personnel. When the alleged conduct is between two students or between a student and school teacher or personnel, the law enforcement body that received the report under this section is required to make such a report under this section shall additionally immediately, but not more than 24 hours, notify the students' parents, guardians, and custodians about the allegations.

(f) Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect. In addition to changes in reporting laws, one of the Plan for Action items included standardizing and conducting training for mandated reporters to ensure all suspected cases of child abuse are reported to child protective services in a timely fashion. The team through reviews had determined that mandated reporters sometimes know about cases prior to the deaths but did not make a child protective services report until the child was severely injured.

CAPTA Requirements

The child's name is not included in the report we submit to the legislature, however if a request is made, information allowed by CAPTA will be provided.

Comprehensive Statewide Plan

The Child Fatality Review Team chaired by the Chief Medical Examiner for the state is required to submit a report annually on how to prevent fatalities. The report is reviewed by the Critical Incident Review Team

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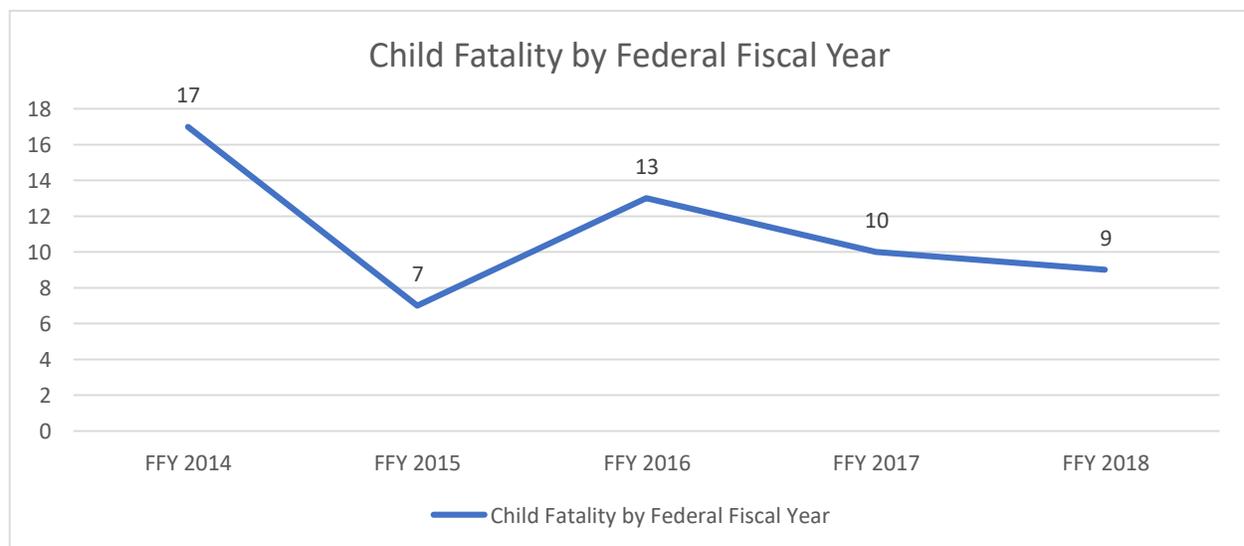
and a response is provided to the Chief Medical Examiner on actions either taken or that will be taken based on the recommendations in the report. Since the Child Fatality Review Team reviews cases at least a year behind the reviews conducted by the Critical Incident Team, many times these issues have already been addressed. Collaboration is maintained throughout the year between the two teams.

The Critical Incident Review Team has developed a Plan for Action to address critical incidents. The Plan for Action is updated at each review meeting and recommendations on each case are discussed and a decision is made on the actions to be taken. The Plan for Action is updated annually for the legislature but as recommendations are made, it is updated and put into action as needed. The plan for action and the data from the critical incident reviews are shared and discussed at the child welfare oversight team, our state team for our CQI process. We are currently expanding a state team to include our court partners, behavioral health, mental health and service providers.

New Plan for Action Activities 2019:

- Coordinate training for staff with local law enforcement on the drugs most prevalent in their area of the state.

To review the annual report including the detailed Plan for Action for FFY-2018 go to: <https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx>



Source: Child Fatality Review Annual Reports

2021 Update:

The Child Welfare Oversight team currently includes our court partners, behavioral health, mental health and service providers.

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§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. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(c) Any school teacher or other school personnel who receives a disclosure from a witness, which a reasonable prudent person would deem credible, or personally observes any sexual contact, sexual intercourse or sexual intrusion, as those terms are defined in article eight-b, chapter sixty-one, of a child on school premises or on school buses or on transportation used in furtherance of a school purpose shall immediately, but not more than 24 hours, report the circumstances or cause a report to be made to the State Police or other law-enforcement agency having jurisdiction to investigate the report: Provided, That this subsection will not impose any reporting duty upon school teachers or other school personnel who observe, or receive a disclosure of any consensual sexual contact, intercourse, or intrusion occurring between students who would not otherwise be subject to section three, five, seven or nine of article eight-

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8, chapter sixty-one of this code: Provided, however, That any teacher or other school personnel shall not be in violation of this section if he or she makes known immediately, but not more than 24 hours. to the principal, assistant principal or similar person in charge, a disclosure from a witness, which a reasonable prudent person would deem credible, or personal observation of conduct described in this section: Provided further, That a principal, assistant principal or similar person in charge made aware of such disclosure or observation from a teacher or other school personnel shall be responsible for immediately, but not more than 24 hours, reporting such conduct to law enforcement.

(d) County boards of education and private school administrators shall provide all employees with a written statement setting forth the requirement contained in this subsection and shall obtain and preserve a signed acknowledgment from school employees that they have received and understand the reporting requirement.

(e) The reporting requirements contained in this section specifically include reported, disclosed or observed conduct involving or between students enrolled in a public or private institution of education, or involving a student and school teacher or personnel. When the alleged conduct is between two students or between a student and school teacher or personnel, the law enforcement body that received the report under this section is required to make such a report under this section shall additionally immediately, but not more than 24 hours, notify the students' parents, guardians, and custodians about the allegations.

(f) Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

In addition to changes in reporting laws, one of the Plan for Action items included standardizing and conducting training for mandated reporters to ensure all suspected cases of child abuse are reported to child protective services in a timely fashion. The team through reviews had determined that mandated reporters sometimes know about cases prior to the deaths but did not make a child protective services report until the child was severely injured.

CAPTA Requirements

The child's name is not included in the report we submit to the legislature, however if a request is made, information allowed by CAPTA will be provided.

Comprehensive Statewide Plan

The Child Fatality Review Team chaired by the Chief Medical Examiner for the state is required to submit a report annually on how to prevent fatalities. The report is reviewed by the Critical Incident Review Team and a response is provided to the Chief Medical Examiner on actions either taken or that will be taken

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based on the recommendations in the report. Since the Child Fatality Review Team reviews cases at least a year behind the reviews conducted by the Critical Incident Team, many times these issues have already been addressed. Collaboration is maintained throughout the year between the two teams.

The Critical Incident Review Team has developed a Plan for Action to address critical incidents. The Plan for Action is updated at each review meeting and recommendations on each case are discussed and a decision is made on the actions to be taken. The Plan for Action is updated annually for the legislature but as recommendations are made, it is updated and put into action as needed. The plan for action and the data from the critical incident reviews are shared and discussed at the child welfare oversight team, our state team for our CQI process.

New Plan for Action Activities 2019:

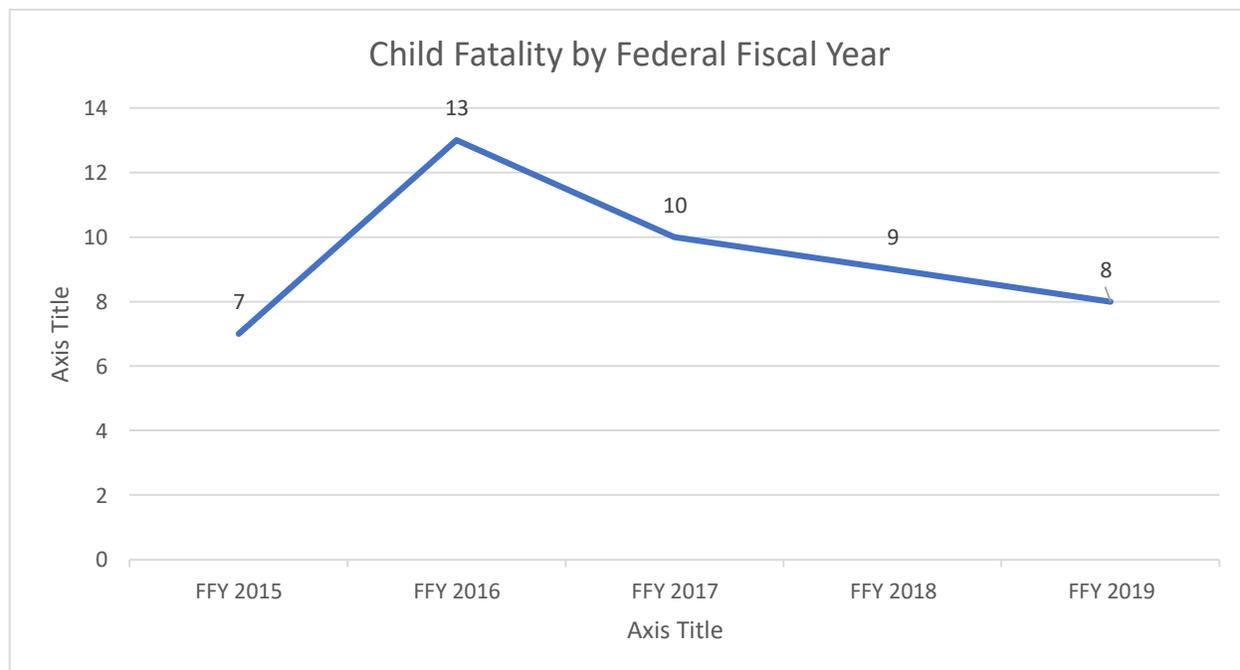
Coordinate training for staff with local law enforcement on the drugs most prevalent in their area of the state.

New Plan for Action Activities 2020:

- Critical Incident refresher training in a blackboard course.**
- Critical Incident SOP for field staff**
- Plan of Safe Care Pilot Program**

To review the annual report including the detailed Plan for Action for FFY-2018 go to:
<https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx>

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Source: Child Fatality Review Annual Reports

Update 2022:

§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. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

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(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(c) Any school teacher or other school personnel who receives a disclosure from a witness, which a reasonable prudent person would deem credible, or personally observes any sexual contact, sexual intercourse or sexual intrusion, as those terms are defined in article eight-b, chapter sixty-one, of a child on school premises or on school buses or on transportation used in furtherance of a school purpose shall immediately, but not more than 24 hours, report the circumstances or cause a report to be made to the State Police or other law-enforcement agency having jurisdiction to investigate the report: Provided, That this subsection will not impose any reporting duty upon school teachers or other school personnel who observe, or receive a disclosure of any consensual sexual contact, intercourse, or intrusion occurring between students who would not otherwise be subject to section three, five, seven or nine of article eight-8, chapter sixty-one of this code: Provided, however, That any teacher or other school personnel shall not be in violation of this section if he or she makes known immediately, but not more than 24 hours. to the principal, assistant principal or similar person in charge, a disclosure from a witness, which a reasonable prudent person would deem credible, or personal observation of conduct described in this section: Provided further, that a principal, assistant principal or similar person in charge made aware of such disclosure or observation from a teacher or other school personnel shall be responsible for immediately, but not more than 24 hours, reporting such conduct to law enforcement.

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In addition to changes in reporting laws, one of the Plan for Action items included standardizing and conducting training for mandated reporters to ensure all suspected cases of child abuse are reported to child protective services in a timely fashion. The team through reviews had determined that mandated reporters sometimes know about cases prior to the deaths but did not make a child protective services report until the child was severely injured.

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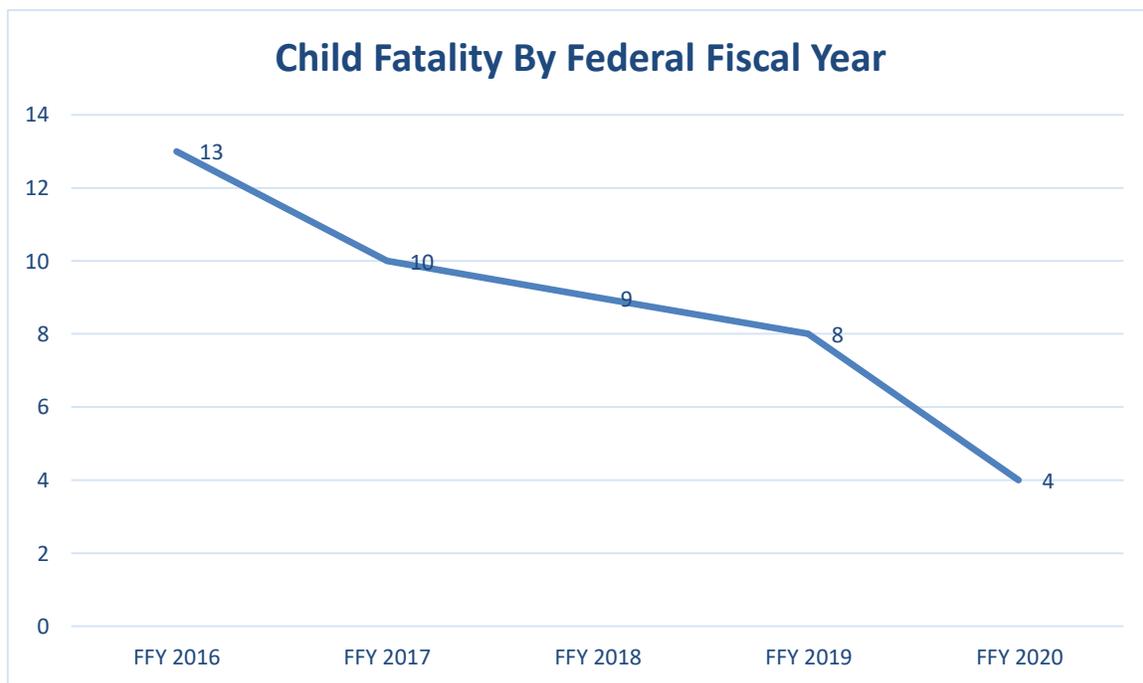
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Source: Child Fatality Review Annual Reports

Disaster Relief Act

Disaster Act funds were used to reimburse Family Resource Networks for the cost of assisting families with the purchase of items destroyed due to severe flooding in six West Virginia counties. These items included beds and bedding, clothing, food, and appliances.

Coronavirus Aide, Relief, and Economic Security (CARES) Act

CARES funds were used to assist in covering administrative costs in the office and in the field setting.

Promoting Safe and Stable Families (title IV-B, subpart 2)

Since July 2004, West Virginia has utilized a managed care system of sorts for Socially Necessary Services. These are services provided to children and families for Family Support, Family Preservation, Time-Limited Reunification and Adoption Support which are necessary to provide for the child's safety, permanency,

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and wellbeing and are not covered through Medicaid. Workers are expected to use existing, community services when available.

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. 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.

With the development of this system and Socially Necessary Services, the Department developed uniform definitions for services, standard/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. The IV-B subpart two money was equally divided among the four categories of service and administration. The state supplements all the different categories with state funds. The Internet site is <http://wvaso.kepro.com/resources/manuals-reference-materials/>

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. The ASO continues to encourage providers to administer services in more rural areas by compensating them for traveling longer distances.

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 Proposal (RFP) 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.

Socially Necessary Services are currently provided under Family Preservation, Time-Limited Reunification, and Adoption Preservation categories for children receiving services through both Child Protective Services and Youth Services. They are currently being provided in all geographical areas of the state and are funded equally with Subpart II money.

Update 2021:

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Specializing in serving children and youth involved in the child welfare system requires a coordinated system, an understanding of available resources, and the ability to access care. All these capabilities are necessary, so each child has a single, integrated, individualized service plan. Members of Aetna's Care Management team and KEPRO's teamwork with the CPS and YS caseworkers in identifying services available for a full continuum of medical, behavioral, and SNS support based upon the identified needs of the child. To assure effective access to SNS, Aetna continuously monitors the utilization of SNS and provides monthly reports highlighting key metrics identified by BCF such as geographic areas in which there is a high utilization of services required with low provider enrollment. This monitoring encompasses analysis of provider capacity by routinely reviewing provider reports to assure members are effectively accessing SNS provider services.

In 2020, Aetna Better Health of West Virginia, became the provider of medical service for children in the foster care system. Aetna has provided Medicaid managed care services in West Virginia for over 23 years and currently serves approximately 138,000 Medicaid beneficiaries statewide. Socially Necessary Service (SNS) is a tool that WV uses to improve the welfare of children in foster care. Providers across the state are engaged to ensure that every child and family has the support they need to be successful. For the last 17 years, KEPRO has been serving as the administrative service organization managing socially necessary services. The partnership of Aetna and KEPRO, will allow children and families in the foster care system to receive a holistic approach to health. Care managers in both organizations work together to provide a care plan that coordinates the medical needs of the child with the socially necessary services that are necessary to improve the success of both the child and their family.

Update 2022:

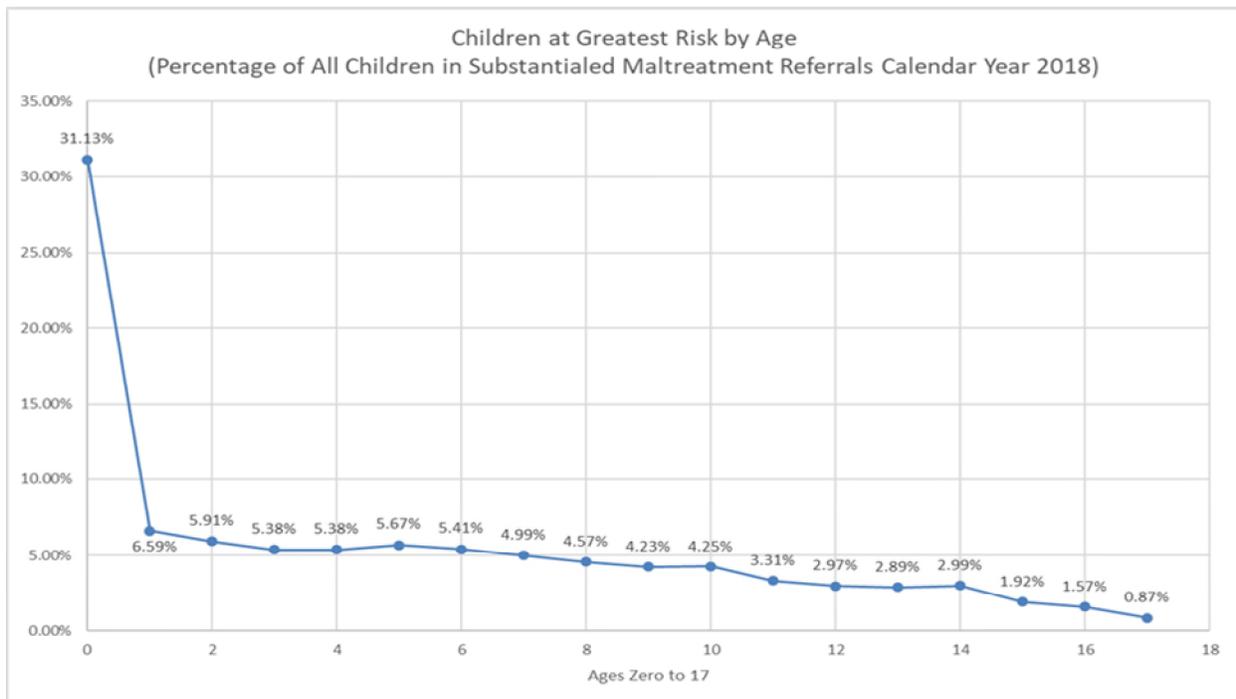
Services under Title IV-B Subpart II continued to be managed by Kepro and are available statewide. West Virginia continues to divert all its Family Support money into community-based programs for all families in the state. Families opened for child welfare and youth services have an array of services available to them through Family Preservation and Time Limited Reunification services.

The Bureau for Children and Families has had a more difficult time expending Adoption Support money to Post Adoptive Families. The system in place was cumbersome and not easily understood. Bureau for Children and Families has had two meetings with First Choice to develop a warm line for adoptive families to call to access services for their adoptive children. It will be a one call service for any needs adoptive families may have. Most calls received from Post-Adoptive family's center around minor technical needs such as subsidy changes or direct deposit corrections. These calls will continue to be routed to the Adoption Specialist at the state office. First Choice is currently being used to triage needed behavioral health services in the state and can easily take the calls of adoptive families and route them to appropriate community-based services or start them on the Assessment Pathway to determine if more complex service delivery is needed such as Wraparound or CSED waiver.

Populations at Greatest Risk

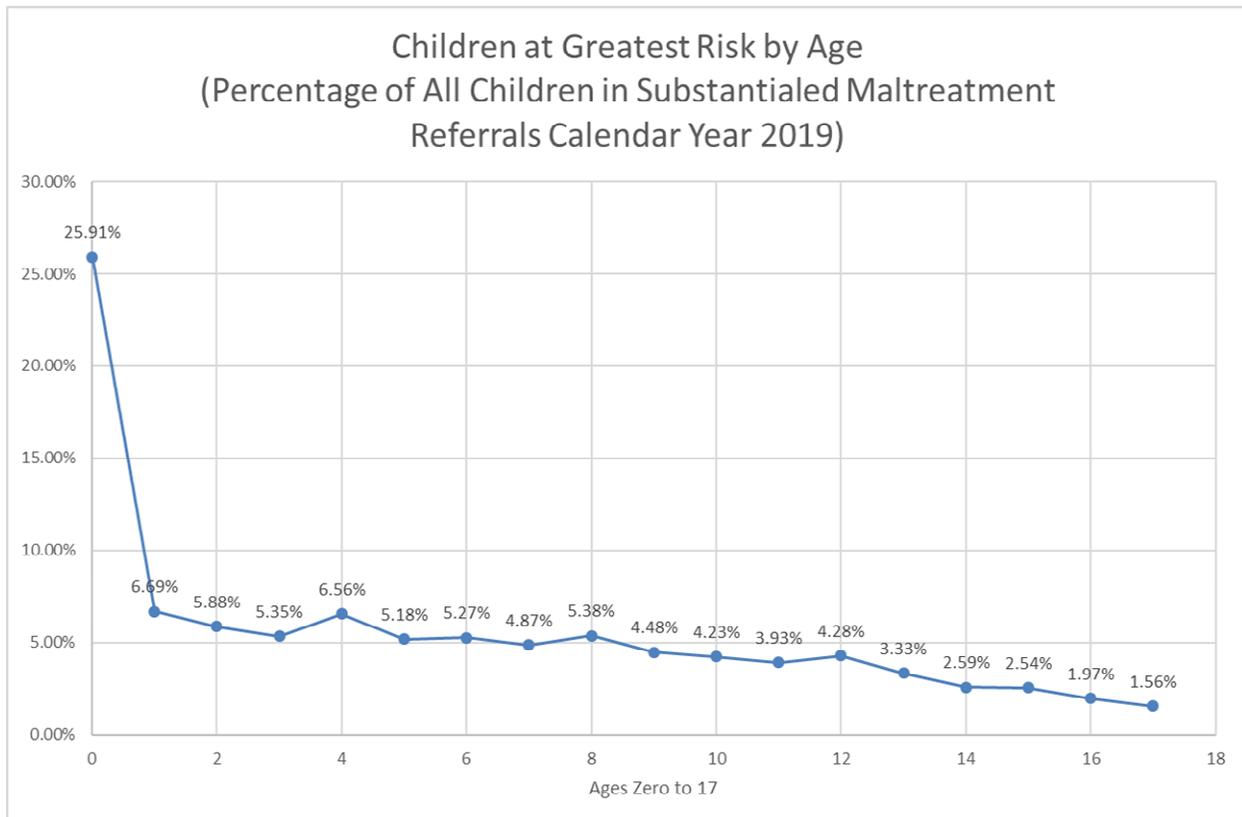
For the last five years, West Virginia has consistently identified children zero (0) to three (3) as being at greatest risk of maltreatment, specifically, children zero (0) to one (1). These numbers were derived from those children most consistently being removed from their homes to ensure safety.

West Virginia's population at greatest risk of maltreatment continues to be infants, zero (0) to one (1) year of age. Based on referral data it's believed this is due to the state's substance use epidemic. In the last five years the drug of choice has been opioids, but the state is seeing a return to methamphetamines.



Source: Cognos CPS-5232 Maltreatment by Age Calendar Year 2018

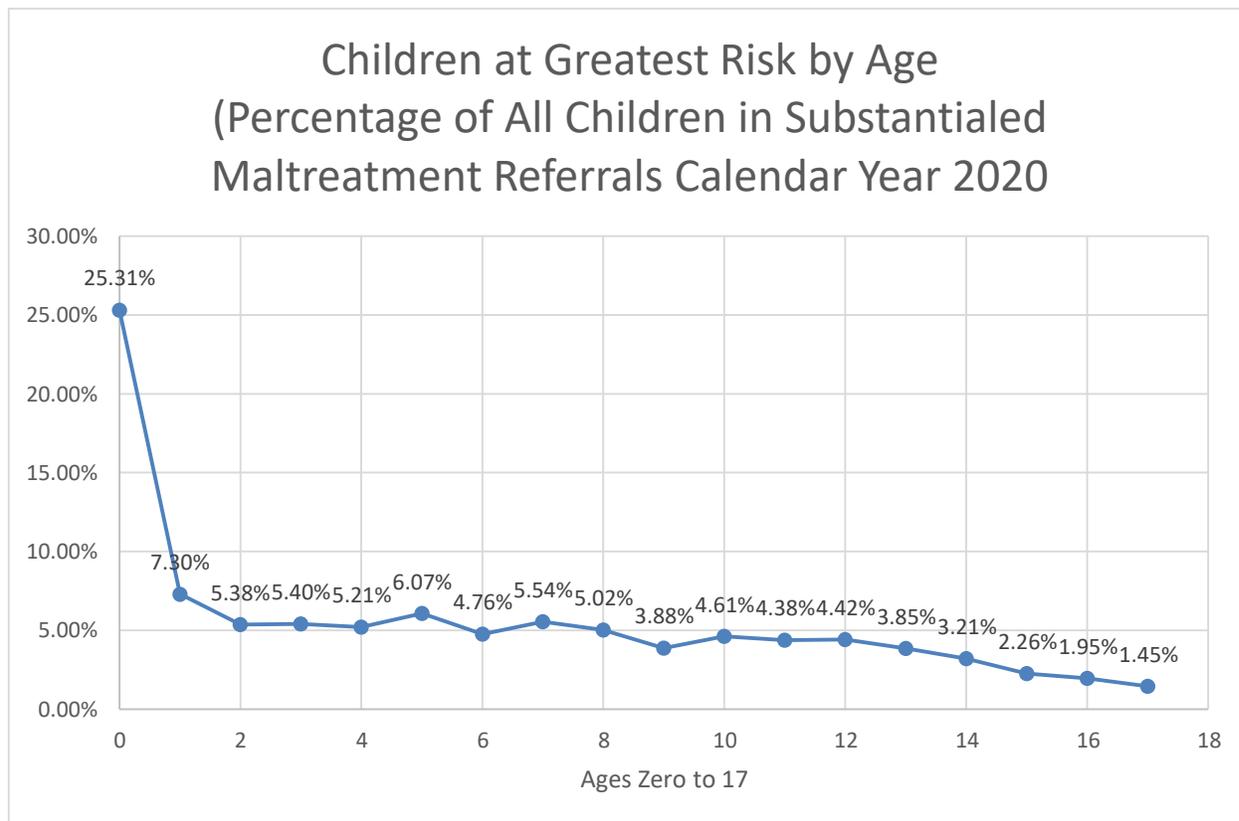
Update 2021:



Source: Cognos CPS-5232 Maltreatment by Age Calendar Year 2019

West Virginia’s population at greatest risk of maltreatment continues to be infants, zero (0) to one (1) year of age. West Virginia will continue to offer neo-natal abstinence programs. Further, the state anticipates an expansion in Family Treatment Courts and the launch of Sobriety Treatment and Recovery Teams (START). This pilot project is a new standard for addiction care, aimed at improving immediate and extended family unity and resiliency through wrap around substance use disorder (SUD) treatment. These services are expected to launch mid to late 2020.

Update 2022:



West Virginia’s population at greatest risk of maltreatment continues to be infants, zero (0) to one (1) year of age. West Virginia will continue to offer neo-natal abstinence programs. Further, the state anticipates an expansion in Family Treatment Courts and the launch of Sobriety Treatment and Recovery Teams (START).

Emergency Funding for the MaryLee Allen Promoting Safe and Stable Families (PSSF) Funding

The Bureau for Children and Families has identified a gap in service provision for parents with Intellectual or Developmental Disorders. The state seeks to implement Step-by-Step Parenting Program to incorporate into its Socially Necessary Services milieu. The main goals of the Step-by-Step Parenting Program is to reduce risk for child neglect due to parenting skills deficits and to promote family preservation. It is one of the few evidence-based programs in the world that focuses on teaching skills to parents with learning differences, including parents who have intellectual disabilities, fetal alcohol spectrum disorder, autism spectrum disorder, acquired brain injury, slow learners, learning disabilities, and low reading skills.

BCF seeks to implement the new service in four selected pilot counties. These counties include Wood, Cabell, Harrison, and Mercer. Agencies already approved to provide Socially Necessary Services in those counties can apply to be selected as a pilot agency. Selection of agencies will be completed by a Request

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for Funding Announcement Application process. Applicants will need to be able to execute a plan to ensure staff are trained on the program. The agency will need to detail their plan of fidelity and outcome measurements as part of the application. Agencies that are selected will in return accept referrals from DHHR staff located in those specific pilot counties.

The state anticipates utilizing PSSF supplemental funding to support start-up costs and reimbursement of services costs for this new program model.

Monthly Caseworker Visit Formula Grants and Standards for Caseworker Visits

All staff have access to a face to face dashboard to track their monthly visits with each child in care on their workload. Similarly, supervisors and managers have access to the dashboard to track progress for all staff for whom they have responsibility. This tool is of great assistance in measuring compliance but does not ensure quality. Case review is the only true measure of quality and is being implemented as an action for the state's Program Improvement Plan to improve meaningful contact.

Face to face visits with children and their families is also an objective in the states Program Improvement Plan as well as outlined goals for the next five years. This data measurement will be tracked on a monthly basis by county and will be addressed in training and technical assistance to be provided to counties who have been identified as needing improvement in this area.

Monthly Caseworker grant money will be used to support Training and Technical Assistance Teams in providing specific, targeted training to individual districts on safety planning, treatment planning and meaningful contacts with children and families receiving child welfare services. This in-depth assistance is aimed at improving West Virginia's outcomes in Safety, Permanency and Well-being.

Update 2021:

This funding continued to be utilized to pay for caseworkers' travel costs associated with visiting children and families. It is unclear whether the funds may be utilized to pay for travel associated with T and TA team deployment, however these teams will be operational regardless of funding availability. Monthly caseworker visitation is a PIP item. One strategy to improve the quality of caseworker visitations, includes a monthly review by supervisors and Child Welfare Coordinators. This data will be reviewed at Child Welfare Oversight and adjustments made as needed.

Update 2022:

The funding continued to be utilized to pay costs associated with caseworker travel in relation to face to face contact with children and families. Due to the Covid-19 pandemic, T and TA teams were not deployed to county or district offices due to social distance and capacity restrictions. As restrictions begin to ease and capacity for meetings increases, it will be determined if the funding can be used for T and TA team

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deployment. Meaningful contact continues to be a PIP item, and a focus for BCF to improve outcomes for children and families.

Additional Service Information

Child Welfare Waiver Demonstration Activities

West Virginia Department of Health and Human Resources implemented its Title IV-E Waiver program, *Safe at Home*, to address the growing number of children entering its foster care system, with a substantial portion of those children and youth being placed in congregate care. *Safe at Home* employs a wraparound service model for youth ages 12 to 17 with a mental health diagnosis or at risk of entering congregate care with a possible mental health diagnosis.

While some challenges were encountered during the first phase of implementation, changes were quickly implemented to remedy those issues. Those changes allowed for easier implementation of *Safe at Home* during the final two phases. In April 2017, *Safe at Home* began operating on a statewide basis.

The focus of the program has shifted over time, focusing less on youth who are placed in congregate care (including those placed into out-of-state facilities) and more on those who remain in their homes. This shift is largely the result of reduced numbers of youth being placed into congregate care, both in and out of state.

When safety, permanency and well-being outcomes for treatment youth are compared to a matched comparison group, *Safe at Home* youth tend to have a higher degree of success within six months of the start of service delivery or referral to the program, but the success appears to dissipate by 12 months.

The stepwise regression analyses highlighted which populations of youth the program did and did not work well. Youth with an Axis 1 diagnosis are at higher risk of not achieving favorable outcomes than youth without a diagnosis. Conversely, *Safe at Home* appears to be working well for youth with juvenile justice involvement and those who receive formal services. Additionally, treatment youth referred while placed in congregate care show more favorable outcomes than comparison group youth referred while in such a setting.

The overall costs for *Safe at Home* youth are greater than youth in the comparison group. However, *Safe at Home* youth are receiving services that are beyond those which can normally be provided. The provision of additional services yielded positive results, especially in relation to the youths' well-being and overall functioning.

Programmatic/Implementation Lessons Learned and Recommendations

As noted in the discussion above, West Virginia encountered a few challenges at the start of implementation. One of those challenges involved the training which DHHR and Licensed Coordinating

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Agency (LCA) staff were provided. Once identified, the State responded quickly, putting together a work group and a 90-day work plan, expanding policy, updating the program manual and retraining staff. In fact, West Virginia incorporated *Safe at Home's* Wraparound 101 and CANS training into its new worker training, ensuring that all DHHR staff are trained on the program. In addition, LCAs have expanded their own training materials to address the needs of wraparound facilitators.

While communication with key stakeholders was an important element of implementing *Safe at Home*, central office staff recognized, after the implementation of Phase I, that their initial outreach efforts, especially to judges, were inefficient. A combined communication plan was created for Community Services Managers (CSM) and LCA program directors to use with the judges in their areas. Materials were sent out by CSMs two and a half months prior to roll out in later implementation phases which were helpful. Meeting with judges became a regular part of CSMs' work and the addition of LCA program directors to attend some of these meetings offered the opportunity to provide judges with more detail about *Safe at Home*.

Access to services, especially in the early phases of implementation, was a challenge. One barrier, as reported by caseworkers and facilitators, was the lack of consistency by the youth/families and follow through to participate in services. While several services were not readily available, especially in more rural areas of the state, LCAs took creative steps to address the lack of services. For example, transportation to services is limited in several areas of the state. LCAs hired individuals to transport youth and their families, thus addressing that shortage.

Evaluation Lessons Learned and Recommendations

Two primary issues have been encountered over the term of the evaluation, with steps taken to remedy them as they were identified. The first involves obtaining a sufficient level of response to the online surveys administered to DHHR staff. An email message was sent to CSMs, asking each to complete the annual survey and send the link to the *Safe at Home*-involved staff to also complete the survey. This process was used in lieu of asking CSMs to provide a list of email addresses for all *Safe at Home* caseworkers to the evaluator. Because the request to complete the survey was sent to the group of CSMs via a list serve, DHHR's mail system identified the message as spam. Many CSMs did not receive the request. The process was changed to send individual email messages to CSMs which yielded a higher rate of response.

The second issue involves understanding the full range of data contained within DHHR's case management system, FACTS, and how the data tables are applied. Over time, additional data have been requested to be included within the data extracts received. This has provided a more robust ability to identify the populations or characteristics of youth for whom *Safe at Home* has been successful.

The work and efforts of the Demonstration project align with the larger initiative of WVDHHR of the WV Child Welfare Reform. As we move toward the completion of the demonstration project, WV continues

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to work on sustaining Safe at Home WV by incorporating the successful efforts of the project into current initiatives and work throughout out child welfare system.

While initially focused on reducing and preventing congregate care placement of youth with a behavioral health issue, the program was quickly expanded to focus on preventing any foster care placement for youth with known or possible behavioral health issues. The waiver project was successful at preventing the re-entry of youth into congregate care, reducing the length of stay when placed in congregate care, returning youth to their communities, placing youth with relatives, increasing their rate of reunification, reducing repeat maltreatment and improving youth's educational and family functioning. The demonstration project however was not as successful, when results are compared to an historical group of comparison youth, in preventing removal.

From a fiscal perspective, the wraparound model was successful in reducing the costs of out-of-home placement expenditures and payments for fee-for-service items. However, when the monies paid to local coordinating agencies to provide assessments, case management, supervision and services are factored in, the costs for treatment youth are more than those for comparison youth; the difference does not take into account the reduction in time caseworkers spend on waiver youth with wraparound facilitators providing intensive services to youth and their families. Based on the overall success of the program, West Virginia intends to expand its wraparound program to serve children and families under the age of twelve (12).

Family First Prevention Services Act FFPSA

As part of our ongoing sustainability efforts WV continues to work with the upcoming changes through FFPSA to incorporate appropriate utilization of wraparound moving forward.

WV will also continue efforts Foster Care Candidacy Claiming to assist potentially in financial support for sustainability of wraparound.

Seriously Emotionally Disorder Waiver Application

Bureau of Medical Services, one of our sister bureaus within the DHHR, has been working on a SED 1915C Waiver for wraparound of children with severe emotional disorders. The application is currently under public comment period. WV believes that approval of this waiver will provide continued coverage of services to the portion SAH WV wraparound children that meet the criteria.

Behavioral Health Wrap Around Pilot Expansion

Bureau of Behavioral Health previously ran a pilot for children in parental custody that meet the criteria for wraparound. After the successful pilot they have been granted additional funding to expand the service statewide. WV believes this too, will serve a portion of children in parental custody that need wraparound.

Wraparound Continuum of Care Post Waiver

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The entire DHHR and the involved agencies have begun working together to align all WV Wraparound into a single continuum of wraparound service for the children and families of WV. As the work continues, more updates will be provided.

Licensed Coordinating Agencies

LCA meetings have been increased during the reporting period to provide the opportunity for better communication in monthly conference calls and face to face LCA meetings. In the next review period LCA face to face meetings and sub workgroup meeting continue to work collaboratively on enhancements to improve practice during the move to post waiver SAH work.

Marshall University

Collaborative work began with Marshall University to continue the expansion of the Child and Adolescence Needs and Strengths (CANS) Automated System to gather data and continue work post waiver. Marshall will begin oversight of the CANS Training and hopes to become a center of excellence to carry on the valuable work and utilization during our Demonstration Project.

Update 2021:

Although our Title IV-E waiver has officially ended the Bureau continues in its delivery of wraparound services. These services are working in conjunction with our sister bureaus to create a “no wrong door” entryway for families, and to expand eligibility. See section [Safe at Home](#) for more information.

Update 2022:

See section [Safe at Home](#) for more information.

Adoption and Legal Guardianship Incentive Payments

The Bureau of Children and Families will use adoption and legal guardianship incentive payments during the next five years to improve post adoption and legal guardianship services offered to West Virginia’s children and families. Incentive funds will be used to decrease the amount of time it takes for foster children to achieve permanency through adoption or legal guardianship and for post adoption services and post legal guardianship services.

Thirty percent of incentive funds will be used by the Bureau of Children and Families toward post adoption and post legal guardianship services. The Bureau of Children and Families will release a Request for Application (RFA) for applicants to implement plans to provide prevention, post adoption, and post legal guardianship services to West Virginia’s children and families. These funds will be used to strengthen Socially Necessary Services offered through Title IV-B funding and prevention services offered through Title IV-E funding. The Bureau of Children and Families will use incentive payments to provide the necessary services to keep adoptive and legal guardianship families together that are at risk of disruption.

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Incentive payments will be used by the Bureau of Children and Families to provide services to help decrease disruption before permanency and to decrease the amount of time before permanency is achieved through adoption or legal guardianship. Kinship providers as well as foster care providers will receive services that will help them manage tasks of transporting children to medical and mental health appointments, school activities, and extracurricular activities. Incentive payments will be used to strengthen services in order to meet the needs of West Virginia's children and families, so that disruptions will decrease and time to permanency will increase.

Update 2021:

During the 2020 legislative session HB 4092 was passed which gives Specialized Foster Care agencies a \$1,000 incentive for each adoption completed. These funds will be used by the agencies to recruit new foster/adoptive homes. The state had previously attempted to release a Request for Proposals to provide specific post adoptive services to promote permanency. The state will no longer pursue this venture and will focus on strengthening provider contracts and the use of incentive payments required under HB4092. It is anticipated that the payments made under the approved legislation will require the use of all adoption incentive funds and will require additional funding of state dollars to fill in the gaps.

Update 2022:

The Bureau for Children and Families is currently working on a process to distribute \$1,000 payments for each adoption completed by the agency. BCF staff will review all required documentation and send an approved invoice to finance for payment. From December 1, 2020 to April 30, 2021, Child Placing agencies completed 14 adoptions for a total of \$14,000.

Adoption Savings

The calculated savings must be spent on title IV-B and IV-E programs; 30 percent of which must be spent on post-adoption services, post-guardianship services and services to support positive permanent outcomes for children at risk of entering foster care. Two-thirds of the 30 percent must be spent on post-adoption and post-guardianship services. (In other words, title IV-E agencies must spend at least 20 percent of calculated savings on post-adoption and post-guardianship services. If at least 20 percent, but less than 30

Please see attached FORM CB-496: TITLE IV-E PROGRAMS QUARTERLY FINANCIAL REPORT
PART 4: ANNUAL ADOPTION SAVINGS CALCULATION AND ACCOUNTING
REPORT

Adoption Savings Methodology

No Update

Adoption Savings Expenditures

The Bureau for Children and Families will pursue the release of a Request for Applications designed at providing post-adoptive services statewide to adoptive families. The services will include;

- training and education for adoptive parents regarding the special needs of the adopted children, including adjustment and attachment issues.
- Providing or referring families to counseling services for both families and individuals.
- Providing educational advocacy and support.
- Respite care.
- Facilitating support groups or referrals to support groups for parents and children.
- Family crisis response team – including crisis respite.
- Case management services, including introduction to the family prior to finalization
- Financial services, including transportation, lodging and meals.
- Completing assessments to determine which services would benefit the family

Update 2021:

The RFA is in the process of being updated and revised for release in late 2020. West Virginia has calculated approximately \$13 million in adoption savings and plans to spend these funds through contract(s) with service provider(s) to provide the post-adoptive services outlined in the CFSP and the RFA. The following is the anticipated timeline for the release of the RFA:

- *November 27, 2020, the RFA will be finalized for release.*
- *December 4, 2020, the RFA will post to the WV DHHR website and the first newspaper ad will run.*
- *December 8 & 9, 2020, additional newspaper ads will run.*
- *December 11, 2020, questions regarding the RFA are due to the agency via electronically.*
- *December 17, 2020, answers will be posted the DHHR website.*
- *December 22, 2020, the letters of intent from applicants are due.*
- *January 12, 2021, applications are due to the DHHR.*
- *January 29, 2021, all applications will be evaluated.*
- *February 15, 2021, grant(s) will be awarded to selected applicant(s).*
- *April 15, 2021, service provider(s) will begin coordinating and providing services statewide.*

The RFA will also include performance measures to determine the effectiveness of the services provided to families to adjust and/or alter services as necessary to support children and families and preserve placements to prevent permanency placement disruptions.

Barriers to spending these funds in the past have been associated with obtaining approval for the posting of the RFA. This was primarily a barrier due to concern over how much in funding we actually had available for contract and what portion of the current funding could be utilized on current expenses encountered. Unfortunately, the state was unable to isolate expenses specific to eligible services to appropriate the

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funding. Therefore, the state will continue to seek approval of the RFA and begin spending down these funds.

Update 2022:

The state finalized its RFP for post-adoptive services but decided to temporarily hold the release of the RFP while other opportunities unfolded. The agreement between the Department of Justice and BCF required the state to create a “no wrong door” approach to access, what would be deemed, Children’s Mental Health Wraparound. This program was intended to unify BCF’s Safe at Home program with our sister bureaus’ Children with Serious Emotional Disturbances (CSED) and West Virginia Wraparound programs to create a seamless system to providing these high-intensity services to all children of need in the state. However, after review of the program’s referrals and outcomes, the department decided to carve out Safe at Home to create a standalone program for children with complex needs but are not considered to have Serious Emotional Disturbances. This created an opportunity to develop a service array for post adoptive families that can meet all levels of need. The state began having weekly meetings on the design of post-adoptive services in early 2021.

In 2011 a survey was developed and sent to adoptive families which BCF has utilized this information to identify follow up inquiries to stakeholders and staff who regularly answer calls concerning post adoptive services. The state anticipates learning about important services gaps, such as family support groups, training, and case management services for more complex cases as readily absent and in high need. Once complete, BCF will begin identifying where services do exist, services that need created, and a service structure which supports a seamless access point to help.

BCF is currently working with sister bureau, Bureau for Behavioral Health, to determine if a current warm-line grantee could be expanded to serve this population. Current talks appear promising; however, more information is needed from our stakeholdes before a final decision can be made. BCF envisions the warm line receiving calls, identifying service providers when needed, or referring for more intense services when the family needs appear more complex or present as in crisis. Currently, the anticipated plan is to have children who present with the possible presence of a mental health condition be referred to Children’s Mental Health Wraparound and children with other complex issues such as family conflict, oppositional defiant disorders, etc. be referred to Safe at Home.

Family First Act Transition Grants

The state has yet to submit its cost allocation plan to begin implementing Family First Prevention Services Act Plan services. West Virginia received feedback on its initial submission in February 2021, but has yet to submit the revised plan. As the state awaits the cost allocation plan to be revised, submitted, and approved, it will move forward with supporting the implementation of services through the use of transition grants. Funding will be used to expand the availability of Parents as Teachers across the state and provide ongoing cost support to expanding the use of Functional Family Therapy (FFT).

Consultation and Coordination Between State 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.

The state continues to work with the Children's Bureau to find a resource for this review.

Update 2021:

House Bill 4471, titled "West Virginia Native American Tribes Unique Recognition, Authentication and Listing Act" which was introduced during the 2020 West Virginia Legislative session, sought to officially recognize Native American tribes and tribal organizations in WV. The bill did not pass out of committee but will likely be revisited in the 2021 session.

The BCF, however, has engaged in a process to strengthen its child welfare policies regarding ICWA. A workgroup consisting of policy specialists, child welfare consultants, a community service manager, CPS supervisor, and CPS senior worker with experience or knowledge working with tribes and ICWA. This group's focus is to not only strengthen existing policies but develop a comprehensive guide for staff on working with ICWA cases.

Update 2022:

House Bill 2107, titled "West Virginia Native American Tribes Unique Recognition, Authentication and Listing Act" which was introduced during the 2021 West Virginia Legislative session, again sought to officially recognize Native American tribes and tribal organizations in WV. The bill did not pass out of committee.

The BCF began strengthening its child welfare policies regarding ICWA. A workgroup was formed in 2020 consisting of a policy specialist, child welfare consultants, a community service manager, CPS Supervisor, and a CPS senior worker with experience and knowledge working with tribes and ICWA. Due to restrictions regarding COVID-19 and in person meetings, the workgroup met virtually. The workgroup determined that policies relating to ICWA would be a separate policy from other child welfare policies in efforts to

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ensure staff would have access to the specific requirements of ICWA. The state consulted with the Bureau of Indian Affairs to assist in the drafting of its new policy. A draft policy has been written and is under review. The workgroup further recommended a Blackboard training would be designed for staff once the final ICWA policy has been implemented.

3. Update on John H. Chafee Foster Care Program for Successful Transition to Adulthood

Agency Administering Chafee

The West Virginia Department of Health and Human Resources is responsible for assisting youth transitioning to adulthood into safe, healthy, self-sufficient adults. In meeting this responsibility West Virginia contracts with other agencies to provide transitioning services.

Currently, West Virginia provides some direct services to youth fourteen and up through our casework process and relies heavily on contracts with a few community agencies to provide monitoring, oversight, and some direct services for youth transitioning.

The Department has established and sustained a relationship over the past 30 years with West Virginia University (WVU) and the Center for Excellence in Disabilities (WVU CED). The Mentoring and Oversight for Developing Independence for Foster Youth (MODIFY) Program within the WVU CED has collaborated closely with the Department to provide: 1) services to youth who are 17.5 years and aging out of the foster care system and those who are adopted or placed in legal guardianship after the age of 16 years; 2) technical assistance to the Department on subject matter pertaining to youth transition; and 3) support and oversight for youth councils throughout West Virginia (WV).

This relationship will continue over the next five years with the MODIFY program taking on more of a consultant role with youth transitioning and transitional living agencies. Due to their lengthy involvement with older youth in foster care, their expertise will be invaluable in developing our continuum of care for youth transitioning.

Description of Program Design and Delivery

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:

1. Help youth transition to self-sufficiency.
2. Help youth receive the education, training, and services necessary to obtain employment.

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3. Help youth prepare for and enter post-secondary training and educational institutions.
4. Provide personal and emotional support to youth aging out of foster care through mentors and the promotion of interactions with dedicated adults.
5. Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 23 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.
6. Make available vouchers for education and training, including post-secondary education, to youth who have aged out of foster care.
7. Provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption.

The Bureau for Children and Families (BCF) has incorporated Positive Youth Development (PYD) practices into its policy and procedures, and through the MODIFY program that serves Chafee eligible transitioning youth. Prudent Parent Standard has been defined and informs workers and children and youth in foster care on parental decisions that should encourage emotional and developmental growth. In Foster Care Policy, the completion of a Life Skills Assessment has been mandated which begins for youth age 14 and assesses and educates youth on a variety of necessary life skills. Youth Services (YS) requires youth participation within the Multidisciplinary Treatment Team (MDT) process both as an invitee and a participant. Through this, the youth involved with YS and the MDT has an opportunity to lead and discuss what they would like to see happen with their case plan.

Additionally, the WV MODIFY program has incorporated PYD into their process. MODIFY promotes youth skills in self-directed decisions regarding educational goals, living arrangements and establishing independent decision making in activities of daily living. Youth are presented options for education and are encouraged to determine what kind of degree or certification they are interested in obtaining based on their interest, beliefs and what they want to pursue for employment. Living arrangements are individualized and based on the youth's preference, strengths and limitations. Budget and money management, establishing of dorm or apartment living management, productivity management, social interaction and self-care skills are an intricate part of the MODIFY program in reinforcing the youth establishing independence. As needed and requested per the youth, MODIFY serves as a coordinator of services and support to strengthen a successful outcome. MODIFY age eligibility has been expanded to better meet the needs of the youth while increasing the opportunity to succeed. MODIFY focuses on the ideology that the youth is now an adult and can make their own decisions. Additionally, MODIFY has begun establishing two youth led councils, one for the northern portion of the state, and one for the southern. These councils will be composed of, and lead by current and former foster youth and will provide recommendations for service improvement to the MODIFY program and the DHHR.

NYTD data collected through the CCWIS system, as well as NYTD data collected through age 17, 19, and 21-year-old surveys are and will continue to be distributed to various entities, agencies, and workgroups.

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The Court Improvement Program (CIP) conducts permanency reviews and NYTD data is provided to them on a regular or as needed basis and is the avenue in which NYTD data is provided to West Virginia's court systems. NYTD data is also provided to workgroups such as the Service Development and Delivery Workgroup (SDDW), and the Transitional Living Workgroup (TLW), and to other state oversight entities such as the Bureau for Health Facilities (BHF). The SDDW, TLW, and other workgroups contain members of the Department of Health and Human Resources (DHHR), service providers, IL coordinators, and members of the public and use NYTD data to identify gaps in services, needs, and trends.

- **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. In order 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 caseworker. 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.

- **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.).

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The Department recently updated the transition plan 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.

- **Transitional Living Placement with Subsidy:**

Currently, 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, or is employed or seeking employment. West Virginia plans to expand this opportunity to all youth transitioning to adulthood to include different living situations and support from a transitional living provider regardless of placement setting.

- **Employment Programs:**

The employability project will continue 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 and is provided statewide. 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, agency site, within the community, or at Sponsored Employment sites.

Youth participating in this project are provided the opportunity 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; and
- Gain/Maintain employment.

In the next five year, the state expects to expand these services by increasing the number of Transitional Living providers as well as the services and supports they provide to youth transitioning.

Some unique and promising programs offered to youth transitioning in West Virginia by various agencies, coordinated with MODIFY, include the following:

- **Helping our Undergraduates Succeed in Education (H.O.U.S.E.) Project:**

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Some transitioning youth who are first-time freshman at West Virginia State University (WVSU) 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 and support services.

- **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 the purpose of attending one of the public colleges/universities in West Virginia.

- **Computers for Graduates Program:**

Access to technology is a necessity and no longer a luxury in today's post-secondary education environment. Each year, the Department makes funds 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.

- **Mentoring:**

The Department has developed close working relationships with transitional living providers to address the issues that youth face when transitioning out of foster care. The Department has also encouraged the use of the Foster Club Permanency Pact in several regions in the state.

Youth councils will also continue to be a priority in the next five years as leadership skills continue to be important to this increasing cohort of youth who are transitioning to vocational and/or educational phases in their lives. West Virginia helped to establish a youth group, West Virginia Foster Youth Advocacy Movement (WV FAM). There are currently several members of this group in the state, but they've lost their infrastructure and organization. Several planning sessions with youth have occurred to get youth councils up and running again in the state. The state plans to continue to support the reorganization and functioning of WV FAM.

- **Conferences:**

In the past, several conferences were held which provided opportunities for youth in foster care to interact with positive adult role models. Youth were given the opportunity to interact with adult role models during statewide conferences. The state has hosted transitioning youth conferences. The conference provided opportunities to interact socially with foster parents (their own and others), staff (their own and others), and adult volunteers.

During development of the Transitional Living continuum, the state will add regional conferences for transitioning youth to be part of the program. These conferences will provide life skills training, networking for WV FAM, the opportunity to interact with positive role models, development of

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positive peer to peer relationships and the opportunity for youth to offer input on the states program and design.

Update 2021:

WVFAM is currently recruiting new members by meeting with foster and former foster youth. Meetings have been held in MODIFY Regions I and III. Meetings were scheduled for the three remaining regions in March and April of 2020 however, due to COVID-19 the meetings have been cancelled but will be rescheduled. Upon completion of the meetings the youth council will be reestablished. Youth from all five regions will be represented.

- **Post-Secondary Education Student Support Services:**

Youth in a post-secondary educational program will be 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, and 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:**

Youth can receive additional community supports, as indicated on their transition plan. Transitional Living providers will assist youth under their responsibility with receiving any community supports that the youth may need. Additionally, the MODIFY program staff will refer youth to community services for extra support. Some of the community resources that are utilized are: Workforce; HRDF; WV Housing; Community Mental Health Centers; Legal Aid of WV; Social Security Offices; Division of Rehabilitation Services; Housing Urban Development; Community Pregnancy Support groups or prevention groups; DHHR Economic Services; Transportation Agencies; WV Higher Education Commission and Bureau for Medical Services or Community Medical Assistance Programs.

- **Transition from High School to Post-Secondary Education Support Programs:**

Youth in high school or obtaining their GED will be 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 which includes eight programs targeted to serve and assist low-income individuals, first-generation college students, and individuals with disabilities to progress through the academic pipeline from middle school to post-baccalaureate programs. TRiO was originally given its name after the first three programs (Upward Bound, Talent Search, Student Support Services) were

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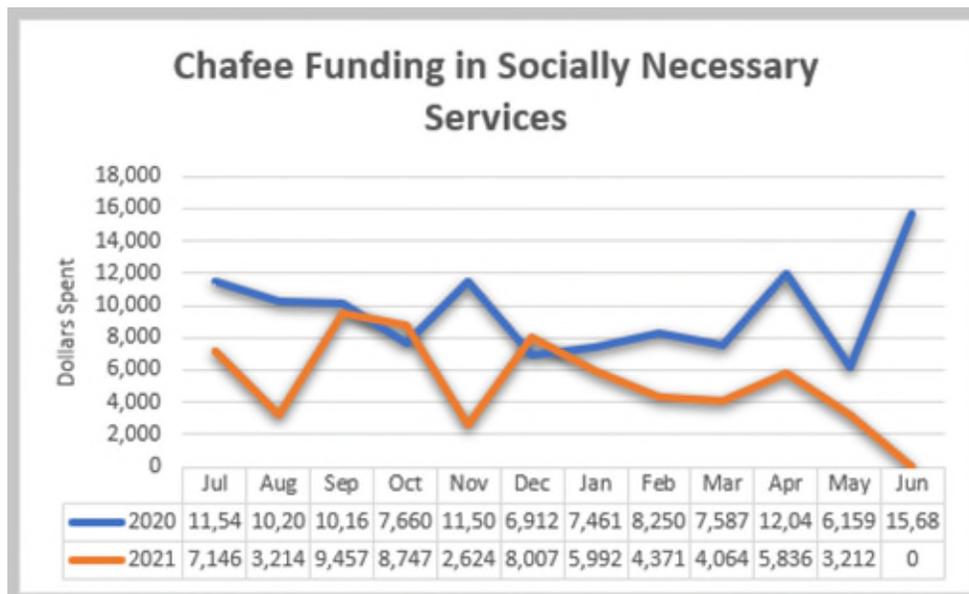
implemented. Currently it encompasses these programs: Upward Bound, Talent Search, Student Support Services, Educational Opportunities Centers, Veteran’s Upward Bound, Training Program for Federal TRiO Programs, Ronald E. McNair Post-Baccalaureate Achievement Program, and the Upward Bound Math-Science Program.

Update 2022:

The HOUSE program at West Virginia State University has been reimagined into the Office of Retention and Student Success (ORSS) is committed to the success of all West Virginia State University students. ORSS is responsible for the coordination of academic, financial, health, and social services to assist our students in overcoming unforeseen obstacles, getting back on track, and continue their path to degree attainment. These services and supports are available to all students, not just former foster youth.

Through the Aetna Mountain Health Promise managed care organization in collaboration with iFoster.org’s connections for life technology is available to youth in Foster Care. Youth enrolled with Aetna for Medicaid ages 13-17 qualify for tablets and youth 18 and older qualify for laptops. Thus, we are better able to meet the needs of children and provide them the tools for academic and social success.

Better utilization of Chafee socially necessary services has been seen in the past several years. This trend provides supports from ASO Agencies directly to youth. However, comparing State Fiscal Year spending in this area 2020 to 2021 there is a significant drop in service delivery.



Serving Youth Across the State

West Virginia provides Chafee funded services through its general casework practice as well as, targeted transitioning services to its older youth in all areas of the state. Although the state does provide services through its general casework practice and its MODIFY program, there is a very limited number of transitional providers that provide the more intensive transitional services.

West Virginia has developed a plan to increase the number of transitional providers across the state to promote a more flexible diverse continuum of care to youth in all communities. We would like every youth transitioning from foster care to have the opportunity to receive quality services to help them become safe, healthy, self-sufficient adults.

Mentoring and Oversight for Developing Independence for Foster Youth (MODIFY) with CED Program:

A referral to the MODIFY Program becomes appropriate when a youth is 17.5 years or six months prior to graduating or obtaining a high school equivalency. Once eligibility is confirmed and the youth is enrolled for services, the MODIFY Project specialists assist youth within two large domains: independent living services and/or postsecondary education attainment. As noted earlier, the MODIFY Program is maintained through a cooperative agreement with the Department. The relationship between the MODIFY Program and the Department has been sustained and strengthened over the past thirty years. The program is one of eight programs and 11 initiatives within the WVU CED (www.wvuced.org) designed to provide at least one of the following services to youth, families, and/or providers where applicable: training, direct services and technical assistance, information dissemination, and research/evaluation. The WVU CED is one of 62 centers within a national network of university-based centers of excellence coordinated by the Association of University Centers for Excellence in Developmental Disabilities (AUCD; www.aucd.org).

Within the areas of independent living and postsecondary education services, the MODIFY Program team works closely with the youth and other providers to:

- Ensure that youth who are likely to remain in foster care until 18 years of age are provided education, training, financial support, and other needed transitioning services (e.g., start-up funds, independent living subsidies);
- Support and serve recipients between 18-20 years of age in a way that compliments their own efforts toward self-sufficiency; and
- Provide youth who exit foster care at 18 years or older with education and training vouchers with the purpose of attending a post-secondary educational program. These funds may be used for the costs of attending college or vocational training.

Initiated in the past plan and continued in this plan, the MODIFY Program team also supports opportunities and trainings for youth to develop their leadership skills within their local communities and national events, where applicable.

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twenty-three (23) for transitional living and twenty-six (26) for Educational Training Vouchers for transition living.

Some of the services/training that will be provided to youth in a transitional living program:

- Supervision/Monitoring and Support
- Transition Planning & Life Coaching
- Life Skills
- Educational Support and Planning
- Job Prep & Support
- Career & Interest Inventories
- Financial Literacy
- Community Linkage & Support
- Support & Crisis Response
- Peer to Peer Relationships
- Adolescent Brain Development
- Normalcy/Prudent Parent Standard

Update 2021:

Currently there has been no change to services provided under Chaffee. A proposal was submitted regarding a redesign of our transitional living programs in August of 2019. The programs redesign would allow more flexibility in where and how youth could be served. The proposal would “pair” a transition living provider with a youth to provide services and assistance. The model intends to allow a youth to live in a setting they choose, as opposed to a foster care or residential setting, to obtain the necessary services. Services would be tiered into three separate levels, distinguished by the level of supervision and support required, as well as by age. The program will be suitable to serve youth from age 17 through age 26. A list of barriers to implementation was then compiled and provided to management. These barriers ranged in complication from legislative rules requiring changes to simply, identifying the appropriate staff to carry the caseloads. Certain barriers will not be easily overcome. As such, Children and Adult Services unit determined an additional position may be necessary to manage the redesign efforts. This position will be a program manager that will focus on foster youth permanency. They will oversee and direct the efforts to move transitional living redesign efforts forward. Additionally, the position will manage our John H. Chafee grant, NYTD survey and data, adoption and legal guardianship subsidy, and the Adoption Resource Network. An additional specialist position was also requested for that unit to handle Legal Guardianship cases.

Currently, there is no designated unit to manage permanency options for youth across West Virginia. With the addition of these two positions, adoption, legal guardianship and transitional living clients will be managed within one unit creating a focus on providing services to youth who have obtained permanency.

Update 2022:

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The Transitional Living and Permanency Support Program Manager position has been filled, and a redesign of Transitional Living is underway in 2021. Several private agencies have requested opportunities to serve youth with programs proven in other states. NECCO is an organization with Independent Living programs in Georgia, Kentucky, and Ohio. Their model works with youth from referral, to moving into an apartment, to on-going future building and then transition to productive citizenship. NECCO’s success in 2020 includes serving 413 youth. The NECCO model does include post-secondary support, but in West Virginia, the MODIFY program will continue to work with college-bound youth.

MODIFY compiles data quarterly for youth served in the calendar year. The program served an average of 230 youth per quarter in 2020.

<i>Performance Measures</i>	<i>January 1 to March 31, 2020</i>	<i>April 1 to June 30, 2020</i>	<i>July 1 to September 30, 2020</i>	<i>October 1 to December 31, 2020</i>
<i>Number of youth who completed post-secondary education</i>	0	5	2	3
<i>Number of youth who are enrolled in post-secondary education</i>	107	126	192	187
<i>Number of youth who obtained employment</i>	9	18	26	23

West Virginia’s Transitional Living and Permanency Support unit and MODIFY staff also participated in the Children’s Bureau Virtual Roundtables and the Jim Casey Youth Opportunity Initiative Activating Youth Engagement Summit and Action Plans. The group was pleased that West Virginia youth representative, Sarah Rose a student at Fairmont State, was one of the youths that spoke of their experiences. Also participating virtually were Kaley Limer and Guillermina Lopez. During the Youth Engagement Summit, our youth noted: “we don't want to be a token Foster kid”.

The group came away from those events with a desire to re-establish and grow the regional youth councils and assure cohesiveness before entering other state meetings like the CIP. The unit will continue to link youth representatives from WV with those from nearby states. Their discussions will reveal both gaps and solutions. It will also be empowering for them to know that their voice is lending to progress.

Collaboration with Other Private and Public Agencies

The Department and MODIFY program have established and sustained strong partnerships with public and private partners throughout the state and in surrounding areas that serve youth in West Virginia (WV). For example, MODIFY, Youth Services System, and Human Resource Development Foundation partners, Bureau of Juvenile Services, Bureau for Mental Health, Community and Technical Colleges, Mission WV, Administrative Services Organization, Court Improvement Board, and multiple Community Collaborative groups have worked closely for more than two decades to coordinate youth services around such needs as independent living, substance use prevention, and job skills training. Additionally, partners who provide new services are routinely identified throughout the year and meet with Departmental team members to learn more about youth services and to identify potential roles and collaborations. Once a partnership is established, team members touch base with one another regularly (e.g., team meetings, workshop sponsorships) to sustain global awareness of the various programs that are available to youth, eligibility criteria if applicable, and referral procedures. Working closely together ensures continuation of services, unique contributions to youth service provisions (rather than duplication of services), and smoother transitions. New youth initiatives are often coordinated by the Department and sent to all youth service providers. Project materials are also shared across partners on a regular basis to increase dissemination among eligible youth. Results of our NYTD profile are shared with partners, including the Court Improvement Program, to help determine services to be developed and processes and training to be refined. Finally, social media postings and shared information have become more common among the partners as a means of disseminating information among team members but also directly to youth.

Update 2021:

The BCF and MODIFY have begun a partnership with the U.S. Department of Housing and Urban Development and the West Virginia Coalition to End Homelessness. This partnership will focus on reducing homelessness of youth who age out of foster care, through use of the FYI initiative. See “Services to Homeless Youth” in the Services section for more information.

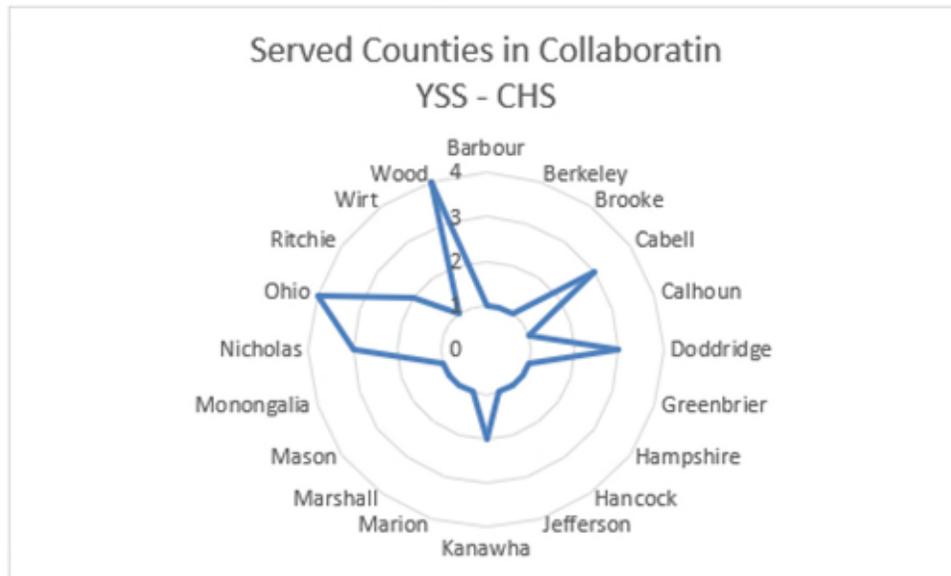
Update 2022:

BCF has begun to look at our private agencies’ successes in other states. Noted above is the successful model from NECCO. Pressley Ridge’s model in Baltimore County Maryland includes services to youth from 16 to 24 through customer-centered workforce development options that support our young adults and employer partners. Using a personalized approach that takes into account a student’s unique profile, we provide comprehensive experiential learning options, including career readiness, essential skill building, vocational planning, college preparation, career placement support and case management. Apartment-based services for foster youth ages 17-21. This includes life skills education, career development and

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physical and mental health care. Our Second Generations program mirrors these services for young parents who attend school or work and also provides parenting and day care services.

Children's Home Society of West Virginia and Youth Service System have collaborated to utilize the Chafee Socially Necessary Services to prepare youth for independence in the community. This collaboration has served 30 youth during the period June 1, 2020 through May 25, 2021. The service area spans 20 counties. The opportunity to expand this kind of collaboration among the private agencies can be replicated from the early success of this endeavor.



In addition to exploration of these successful models, Legislative Rules were passed in the 2021 session which will permit current group residential agencies to serve youth with transitioning services without the Medicaid placement requirements. Utilization of previous treatment beds as supervised independent living settings, moving toward supported settings like the Tiny Village and McCrary Center, finally transitioning to productive citizenship will be the most beneficial program for our youth.

Determining Eligibility for Benefits and Services

All youth in foster care will be eligible for age appropriate services as described within the John H. Chafee Foster Care Program for Successful Transition to Adulthood section. Services will be determined by age and developmental level and may be provided by newly developed Transitional Living agencies. The services will be available to all current and former foster youth as described in [Foster Care Policy](#), but the frequency and intensity will be delivered according to the level of the youth.

Update 2021:

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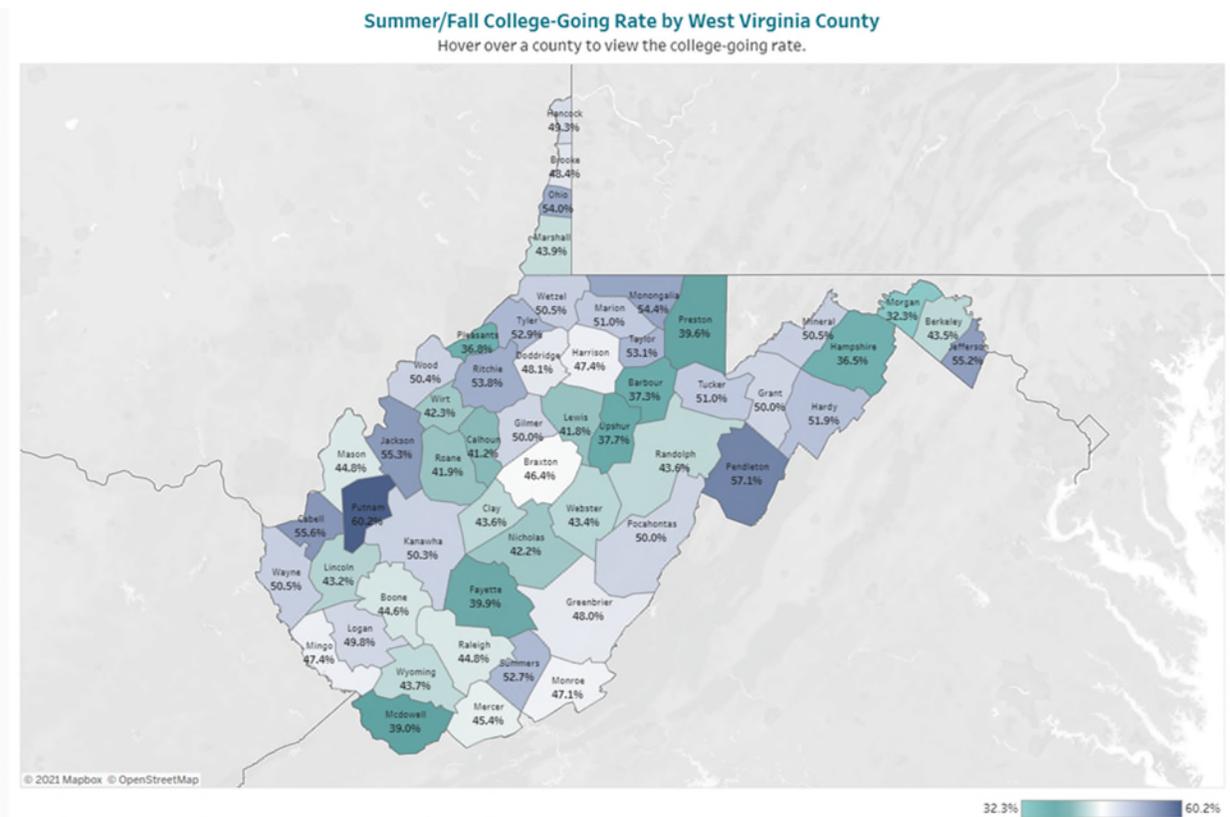
The BCF has begun the process of updating its foster care policy to expand eligibility for youth to receive Chafee services. The changes sought will also provide clarity to staff on providing Transitional Living services to children beginning at 14. Some of the current eligibility requirements include the youth be enrolled in a post-secondary institution prior to 25 to receive ETV, have aged out of foster care to receive Independent Living subsidy, and provides restrictive access to services through work requirements. The BCF seeks to change these restrictive policies to encourage more transitioning services be provided to children who need them. It is expected these changes will occur in several stages to account for current Comprehensive Child Welfare Information System (CCWIS) system limitations until implementation of our integrated PATH CCWIS system.

Update 2022:

The MODIFY program does not serve youth along the full spectrum of transitional living from 14 to 25. Rather than fitting all youth into a college-bound mold or forcing a college-centric program outside of their expertise, the new Transitional Living and Permanency Support Program Manager is looking for new solutions to meet the needs of children along the full spectrum.

First, the MODIFY program will be scaled down to meet the demographic of college-bound foster youth. A collaboration with the Higher Education Policy Commission will promote use of the Foster Care Tuition Waiver and better utilization by MODIFY of the supports on West Virginia's campuses. The coverage area will align to enrollment rather than DHHR Regions.

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Second, moving funds from the grant to WVU CED to create pilots based on successful models will permit the state to serve youth who are not college-bound. These pilots will permit private agencies to prove out the models they utilize in other states here in West Virginia. The pilots will yield program models which can be replicated within the state.

Third, BCF will support collaborations like YSS/ CHS and the supported housing programs like the Tiny Village, McCrary Center and Golden Girls. Utilizing the new Legislative Rules to utilize beds for transitional living will permit these programs to serve more youth.

Cooperation in National Evaluation

In May 2016, the WV DHHR/ BCF participated in a 3-day voluntary onsite NYTD Pilot Assessment Review. While there were findings, and areas needing to be improved upon, since this assessment was voluntary, no financial penalties were imposed. During the 3-day review, a system demonstration was provided, the NYTD Survey was reviewed, a case review completed, and stakeholder interviews held.

At the conclusion, of the review, several findings were noted and a NYTD- Quality Improvement Plan (N-QIP) created. Findings included; but are not limited to, the general requirements and the reporting of various elements within the client demographics, services, and the NYTD Outcome Survey. In addition, it

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was found that for a few of the youth reviewed, what was reported in the 2015B submission was not actually what the youth had reported.

At this time, West Virginia is in the process of replacing the current legacy system (FACTS) with functional modules which will comprise the new Comprehensive Child Welfare Information System. Due to this endeavor, it was determined making changes in the current legacy system was not feasible due to scope and complexity of work to be done. To date, most findings have been completed, however, some findings which remain pending, in the N-QIP, and are to be completed in the new WV PATH System. The 2015B file has been corrected and a subsequent file was submitted in January 2017 to correct the 2015B submission. A Quality Assurance tool has been created and shared in our latest NYTD-QIP quarterly submission. In addition, updated Foster Care policy has been developed and implemented. The state continues to address outstanding items on the NYTD-QIP.

Update 2021:

The new Comprehensive Child Welfare Information System (CCWIS) is tentatively expected to go live in August of 2021 and no further updates will be provide until this date.

Update 2022:

See 2021 update.

Chafee Training

West Virginia is planning to develop regional teams to target specific training and technical assistance to individual counties or districts in areas needing improvement. Chafee services to youth fourteen to seventeen will be one area addressed in all fifty-five counties. The state will explore expanding a service currently offered in only one county that provides mentoring and advocacy services to foster youth to help improve educational outcomes. The program currently offers the following services.

Academic Success Coaching - The program is guided by the concept of ABC model (Attendance, Behavior, and Course Completion). The program ensures that the student has the highest level of support possible. Our Mentor will track attendance, behavior and course completion and respond to any areas of concern.

Educational Advocacy –Ensuring that the students' rights are upheld in the school setting; helping students access education-related support services; minimizing the effects of disciplinary actions that keep students out of school; assisting high school youth in making up credits when necessary and possible; and facilitating participation in extracurricular activities.

Student Enrichment Opportunities - Students need opportunities to flourish outside of the classroom. These experiences bring classroom concepts to life and establish a new future horizon on which students

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in foster care may focus. The program and county school provide student enrichment workshops, college visit field trips, and educational experiences.

Post-Secondary Education Planning - The goal is to build the confidence, skills and supports youth impacted by foster care need to take charge of their lives and future. The program and county school work with youth to create a personal plan to graduate high school and pursue their dreams. The program uses Check & Connect along with other research-based methods to give students the necessary tools to first understand and use their individual strengths and interests.

Group Counseling – In the grade school setting, the Mentor works with the elementary school counselor to co-facilitate Journey of Hope, a trauma informed program through Save the Children that teaches students how to deal and cope with circumstances they may face.

The most recent data available for the school months of August 2018– April 2019 yielded the following results:

- 33 Students were enrolled in the program
- Since the 2018-19 school year started in mid-August the Mentor has made 750 “Connects” or encounters with 33 students.
- 0 of the 33 students have had behavior incidents this 18-19 school year.
- Graduating Seniors – There are seven seniors enrolled in the program currently and all are on target for graduation in May. **Five of the seniors will be attending college in the fall, one has plans to join the military and get a college degree as well and one will be F**
- 100% of seniors in the program have a post-secondary education plan.
- 53 Youth have been involved in post-secondary education field trips.
- 100% of youth participating in field trips reported on a survey college trips as beneficial to their post-secondary plans.
- 28 of 29 middle and high school youth receiving one-on-one mentoring show improvement in core subject areas than prior year (before being served.)
- 28 of 29 middle and high school-youth receiving one-on-one mentoring have maintained or shown improvement on their report card with services than without.
- All students in the program follow the attendance policy
- All students in the program are on target for graduation with their class and no discipline issues causing expulsion or ALC.

The above information was erroneously reported here. Updated data will be located in the Collaboration section under **Education of Children in Out of Home Care Advisory Committee*

Update 2021:

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No additional training needed at this time however training will be required based on the redesign of our TL program and corresponding policy changes.

Update 2022:

No 2022 Update

Additional Chafee Funding Division X

Planned enhancement of the current HRDF and YSS/CHS grants with Chafee IL Pandemic Funds during July 1, 2021 to Sept 30, 2022 to achieve housing, employment or stable income, food security, transportation and monthly utilization of Medical/ Mental health and Driver's License attainment. The HRDF enhancement would serve Mason, Putnam, Kanawha, Raleigh, and Fayette. The YSS/ CHS enhancement would serve Jackson, Wood, Wetzel, Marshall, Ohio and Brooke.

Youth served by these programs, and by DHHR field staff will receive IL Subsidies, start-up funding, driver's program funding, and other financial supports as necessary. Youth will also be connected for Medicaid to meet their medical and mental health needs.

Education and Training Vouchers (ETV)

The education and training vouchers are supported using money provided to the state as a part of the reauthorization of the independent living program. Education Training Voucher (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: a) youth adopted or placed in legal guardianship from foster care after the age of 16 years old; and b) foster/ former foster care youth through 26 years old, who aged out of care at 18 or older. If an eligible youth is enrolled, attending, and making satisfactory progress in a post-secondary educational program on their 25st Birthday, then they may be eligible to continue to receive ETV funds until their 26th 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.

To meet the guidelines of satisfactory standing and receive ETV funds, youth must meet the following: 1) a 2.0 GPA; an 80% course completion rate; and maintain regular attendance and provide monthly progress reports to the MODIFY Community Support Specialist.

MODIFY specialists monitor each case individually through both FACTS and WVU CED CODA system. The student and payment allotment are kept on an excel spread sheet which is checked each time a payment is rendered. Youth enrolled in education is counted only once as a new enrollee no matter the number

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semesters attended per year. All new youth who officially receive an intake and are opened as a MODIFY client are an unduplicated client. Through case management and data collection system MODIFY specialists verify individual counts and numbers. Specialists send their requested payments to the MODIFY director each month who enters it for payment. Those payments are then approved by a DHHR specialists who checks the payments against an Excel spreadsheet.

The Department, through the MODIFY program, produces materials and training sessions designed to sustain awareness about the ETV funds and other support services among higher educational staff, advisors, and families throughout the network. This collaboration is bidirectional in that higher education institutions, state scholarship programs, noted tuition waiver programs also provide information to the Department teams to inform youth and families of changes in fiscal support and procedures. Youth assessments, case modifications, and other updates are shared through similar tracking methods to identify strengths and areas of improvements for youth enrolled in the program. Students placed on probation are provided resources across Department partners and higher education institutions. Attempts to resolve challenges prior to issues with fiscal support, scholarships, and other concerns are made collectively by teams and institutions when possible.

The state provides Chafee Services to youth who have been adopted or who were placed in legal guardianship. Some of the services that youth are provided include Educational and Training Voucher (ETV) funds, case management oversight, community referral services, mentoring services, and other transitioning services as needed as indicated above.

West Virginia provides the same MODIFY services to youth adopted or placed in Subsidized Legal Guardianship.

Update 2021:

There were no changes or updates to services for calendar year 2019; however, changes are expected for calendar year 2020. Policy updates will be made during calendar year 2020. These updates will expand eligibility to ensure eligible youth are permitted a payment until the last day of the month in which they turn 26. A waiver process will also be implemented to ensure youth who may not have met BCF established thresholds pertaining to satisfactory progress in an academic setting, but have extraordinary circumstances may continue to receive, or have ETV vouchers reestablished. There has been no change to the states system to ensure that the total amount of educational assistance to youth under this and any other federal assistance program does not exceed the total cost of attendance.

To maximize ETV funding and in coordination with AETNA-iFoster.org, previously paid services will be made available at no-cost to youth in the MODIFY program beginning Spring semester 2021. iFoster's various programs have been evaluated by Children's Bureau, USC and Chapin Hall. An example is one-on-one tutoring which was previously paid with ETV dollars (Marshall's HELP Program) will now be available such

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resources as free online SAT and ACT test prep, as well as free homework help with college professors and tutors.

Update 2022:

The state worked collaboratively with the MODIFY program to address issues of post-secondary school completion for children receiving such services. Through the collaborative partnership, the state monitored children who were at-risk of being displaced, issuing emergency funds when necessary to ensure housing. The state provided funding to secure needed devices to move towards virtual school platforms when possible and provided ongoing education to youth about the dangers of COVID-19 and recommended precautions to prevent its spread. Further the state has continued to provide eligibility waivers to allow children who were unable to meet continued eligibility for MODIFY due to the pandemic reenroll in the program.

For information on Consultation and Coordination with tribes, please refer to Section 5 of this Child and Family Services Plan.

Additional Funding ETV Division X

MODIFY program specialist are directed to provide up to an additional \$7000 to each current youth on caseloads (current caseload is 250), for payment of educational expenses, housing, meal plans, or other expenses, exercising leniency towards educational progress. The additional funding will supplement the \$5000 allocation to each of the students on the current caseloads.

New enrollees (up to 30 youth) for the academic year Fall 2021 through Summer 2022 shall receive \$12000 in educational expenses, housing, meal plans, or other expenses exercising leniency towards educational progress. These youth will likely be housed off-campus to ensure stable housing and food security should another campus shut-down occur.

4. Update on CAPTA

Update 2021:

The Victims of Child Abuse Act Reauthorization Act of 2018 was enacted on January 7, 2019. Amendments to the act expanded assurances to include civil and legal immunity for good faith reports of child abuse and neglect to professionals who may be consulted with or provide medical diagnosis and report abuse and neglect.

During West Virginia's 2020 regular legislative session, the BCF sought introduction of House Bill 4585. This House Bill mirrored the modifications to immunity provisions specific in The Victims of Child Abuse Act Reauthorization Act of 2018. The bill passed both chambers and was signed into law on March 25, 2020. Though West Virginia was already in compliance with the requirement and provided an assurance in 2019,

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it required the Bureau for Children and Families to utilize multiple sections of code to ensure compliance. This assurance is now located in W. Va. Code §49-2-810.

Update 2022:

No 2022 Update

Program Areas

Intake, assessment, screening, and investigation of reports of child abuse or neglect

2021 Update:

A new part-time Citizens Review Panel (CRP) Coordinator was hired during the calendar year 2019. This individual has extensive knowledge and experiences working in the child welfare field and in child welfare policy and programs. The state will continue to work in collaboration with the CRP and coordinator to improve the child welfare system. This individual's stipend, and necessary travel costs, are paid utilizing CAPTA funding.

Update 2022:

During 2020, the Citizen Review Panel (CRP) adjusted to the pandemic by holding quarterly meetings via a virtual platform. The CRP is continuing its efforts to recruit members as well as focus on issues within child welfare, specifically concerns for foster care and children deemed unsafe and remain in their natural homes. The part time CRP Coordinator resigned in December 2020 and the part-time position has been posted. The individual's stipend, and necessary travel costs, will be paid utilizing CAPTA funding.

Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; 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

Update 2022:

No 2022 update

Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families

Update 2021:

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The BCF has worked on a process to improve its assessment, planning, and monitoring for families involved in the child protective system. This process includes a new assessment protocol, new case plan, and a new case review protocol. The process will be rolled out to the state in phases. First phase districts were expected to begin June 1st, 2020; however due to the COVID-19 pandemic this is likely to be delayed until later summer 2020. The BCF will provide a six-month waiting period before the first phase roll out and the second phase. During this waiting period the BCF will work with districts to identify any process improvements which may be needed, as well as, deliver training and technical assistance to ensure proper implementation.

Update 2022:

The state will implement this new process in May of 2021. See further updates in [Child Protective Services](#) section.

Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response

Update 2021:

The BCF has been piloting in several districts, variant “tracks” to assess child abuse and neglect referrals. The pilot was approved for implementation on May 24th, 2018 and is being utilized in 21 counties residing in two of the four DHHR regions.

Update 2022:

BCF began soliciting feedback from child welfare staff regarding their use of variant tracks. Once collected, the agency will use this information, combined with available outcome data, to determine whether procedural modifications are needed and whether expansion towards statewide implementation should be pursued.

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

Update 2021:

The state continues to develop a new SACWIS system. This system, which will be known as Peoples Access to Help (PATH) will be a department-wide integrated eligibility system. Once the system’s development and testing phases are complete, it will be released in waves and will ultimately replace the use of FACTS. Child welfare implementation is currently scheduled to occur in August of 2021.

Update 2022:

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Implementation of PATH has been delayed and a current implementation timeline is being negotiated.

Developing, strengthening, and facilitating training including training regarding research-based strategies, including the use of differential response, to promote collaboration with the families; training regarding the legal duties of such individuals; personal safety training for case workers; and training in early childhood, child, and adolescent development

Update 2021:

See [Training](#) section for updates.

Update 2022:

See [Training](#) section for any updates.

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

Update 2021:

See update in [Staff Training, Technical Assistance, and Evaluation](#) section

Update 2022:

See update in [Staff Training, Technical Assistance, and Evaluation](#) section

Developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect

APSR 2022:

There is no 2022 update

Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions, including existing social and health services; financial assistance; services necessary to facilitate adoptive placement of any such infants who have been relinquished for adoption; and the use of differential response in preventing child abuse and neglect

Update 2021:

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On February 15, 2017, the Bureau for Children and Families and Bureau for Public Health/Office of Maternal, Child and Family Health (OMCFH) 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. The West Virginia Children with Special Health Care Needs (CSHCN) Program located within the OMCFH works 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. Per the West Virginia CSHCN Program Policy, at minimum, children will be automatically deemed eligible for care coordination when the child:

- *Receives 100% nutritional intake through the gastrointestinal tract via a tube, catheter or stoma that delivers sustenance distal to the oral cavity, as confirmed by the CSHCN Program's Eligibility Unit;*
- *Is a member of the Children with Disabilities Community Services Program (CDCSP);*
- *Is in foster care, as defined by 45 CFR 1355.20.*
- *Was in foster care, as defined by 45 CFR 1355.20 and now qualifies for federal Title IV-E adoption assistance.*
- *Diagnosed with Neonatal Abstinence Syndrome (NAS; ICD-19 code: P96.1).*

Per the memorandum of understanding, the West Virginia 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, is completed 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 who meet are categorically eligible or are identified as having a special health care need according to the MCHB definition¹ with low service utilization and mild or few functional limitations;*
- *Tier 2 – CSHCN with a special physical health care need (defined as an organ dysfunction and/or a neuromotor or musculoskeletal chronic condition that must have lasted, or is certain to last, for at least one year and is not behavioral or emotional in origin) 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*

¹ **Children** and youth with special health care needs (**CSHCN**) "have or are at increased risk for **chronic** physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by **children** generally." (<https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs>)

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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 communication;*
- *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.*

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. Based on the eligibility criteria, these children may be found eligible for Title V funded medical nutrition foods. In calendar year 2019, the CSHCN Program completed care plans for 68 children diagnosed with NAS or neonatal drug exposure and provided medical foods for 21 of these children. In addition, the CSHCN Program funded medical foods for 269 children, and facilitated the authorization for medical foods through the child’s EPSDT Medicaid benefit for 80 children and the MCO for 14 children.

FFY 2020-2021: Being that foster care children are categorically eligible for CSHCN services, children referred will be screened and identified as a child with a special health care need, their service needs will be assessed and CSHCN Care Coordinators will continue to ensure services and document in FACTS. The CSHCN Services Program will ensure that children and adolescents in foster care receive health care through a medical home and will work to ensure that the medical home remain the same despite changes in foster placement to maximize access and continuity of care. The CSHCN Services Program agrees to strengthen their collaboration with all agencies in order to integrate and optimize services while avoiding duplication. The CSHCN Services Program agrees to work to clarify the roles and responsibilities of each agency in regards to the processes for healthcare information and early intervention for children under the age of 3 and to work to create a statewide system to ensure that BCF Child Protective Service and Foster Care Workers are informed with the most relevant and up to date healthcare information and records.

Update 2022:

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.

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In calendar year 2020, the CSHCN Program completed care plans for 211 children diagnosed with NAS or neonatal drug exposure and provided medical foods for seven of these children. In addition, the CSHCN Program funded medical foods for 282 children and facilitated the authorization for medical foods through the child's EPSDT Medicaid benefit for 94 children and the managed care organization (MCO) for eight children. In calendar year 2020: 1,715 children were screened to identify the appropriate care coordination tier level. Of the 1,715 children screened, 239 children were enrolled for services and 1, 476 were found ineligible due to leaving foster care. CSHCN Care Coordinators provided Tier 1 services to 213 foster children, Tier 2 services to 84 foster children and foster 20 children received Tier 3 services. Of the eligible children, 91% received a care plan and services received by all children were documented in FACTS. The CSHCN Program will ensure that 100% of all children and adolescents in foster care received health care through a medical home and ensured that the medical home remained the same despite changes in foster placement to maximize access and continuity of care.

The CSHCN Program Director of Nursing collaborates monthly with the specialized managed care organization to integrate and optimize services while avoiding duplication. The WV Children with Special Health Care Needs (CSHCN) Program and Mountain Health Promise Aetna Better Health have developed a partnership to address the interrelated complex medical needs of the foster care population. The CSHCN Program provides comprehensive care coordination to the child with complex chronic conditions, enhancing the caregiving capabilities of families by ensuring the medical home, pediatric specialists and community resources are aligned. The CSHCN Program's Plan of Care reflects the goals and outcomes developed by the multidisciplinary team through assessment and continuous monitoring of medical/clinical records and collaboration with the client's medical home. The Plan of Care is distinctive in that the compilation of information is obtained from hard copy medical/clinical reports such as the annual EPSDT well child exam, electronic health records (EHR), specialist reports, specialized children hospitals discharge orders, educational records and/or other state program records. The CSHCN Program staff has access to various highly protected state electronic data systems that allows the Care Coordination Team Registered Nurse or Social Worker to view records/history specific to the enrolled CSHCN Program Foster Child. The information obtained from the data systems and medical records provides the foundation for building the Plan of Care that is specific to that child who is enrolled in the CSHCN Program.

The WV CSHCN Program and AETNA Better Health manage the WV foster populations from different aspects of the care continuum, it is mutually beneficial for the foster child and families to have both entities involved. There is daily communication between the CSHCN Program staff and the Aetna Case Managers to collaborate on CSHCN Program enrolled foster children. The relationship between the CSHCN Program and AETNA Better Health can provide the best standard of care for the WV foster child.

Additionally, the CSHCN Program is regionally located with teams in several of the BCF local offices. The WV CSHCN Program teams have developed a statewide system to ensure that BCF Child Protective Service and Foster Care Workers are informed with the most relevant and up to date healthcare information and records. All healthcare information is entered into the FACTS system and the CSHCN Program teams are available locally.

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To ensure the use of early mental health screening and assessment, a clinical strategy utilized to enable the implementation of tailored mental health services and the safe reduction in congregate care the OMCFH was charged with evaluating the extent to which mental health screening is taking place during EPSDT exams for Medicaid members ages 6-18. To accomplish this task, claims data and clinical data from individual medical records were employed to quantify results.

To ensure that early and periodic screening, diagnosis, and treatment (EPSDT) services are provided in accordance with reasonable standards of medical practice, West Virginia's EPSDT Program, WV HealthCheck, applies the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents to inform the development of policy, procedures, and age-appropriate preventive health screening (PHS) forms made available (free of charge) to all health care providers who see children/youth 0-20 years of age. The HealthCheck standard compels psychosocial and behavioral (i.e., mental health) screening during each EPSDT exam from birth through age 20. A chart review was completed to determine the rate of mental health screening at EPSDT encounters for Medicaid members aged 6-18. The analysis involved standardized medical record reviews of an age and geographically representative sample of 713 EPSDT exam records. A mental health screening was determined to have been completed if responses were recorded from standard trauma screening, i.e., the abbreviated (two question) Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C); if the provider addressed two or more social determinants of health; or if responses were recorded from a depression screening, i.e., the Patient Health Questionnaire-2 (PHQ-2). In this sample, 82.3% of EPSDT exam records included mental health screening. The prevalence of mental health screening varied by HealthCheck Region and according to documentation format. A higher prevalence of mental health screening among providers using age appropriate HealthCheck PHS forms suggests that increasing utilization of these forms could enhance statewide mental health screening in this critical population.

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

Update 2021:

CAPTA funds continue to be utilized to support the TEAM grant. The TEAM grant's local projects are designed and implemented by the community teams using research on successful programs in West Virginia and across the country. 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*

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- *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*

Update 2022:

The WV DHHR funds and supports several child abuse prevention initiatives that use a combination of Community Based Child Abuse Prevention (CBCAP), Temporary Assistance for Needy Families (TANF), and Maternal Infant Early Child Home Visiting (MIECHV) funds, state appropriations, and private funds. These initiatives include In Home Family Education Programs (IHFEP), Family Resource Centers (FRC), and Partners in Prevention grants to communities. There are also other prevention programs utilizing CAPTA funds throughout the state to target child abuse and neglect such as:

- *Parenting education and information on strengthening families*
- *Public awareness and educational programs on child abuse prevention*
- *Presentations for professionals and the public on promoting child well-being and preventing maltreatment before it occurs*
- *Sponsoring community forums on issues impacting families*

The Family Resource Networks (FRN) also completed food, clothing and back to school drives over the last year. Many activities were accomplished this year within Center for Disease Control (CDC) guidelines and guidance from the Governor's office regarding social distancing and wearing appropriate personal protective equipment (PPE). Many fun family events that would normally be held in person, were adapted per the current guidance.

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

Update 2021:

The Bureau for Children and Families (BCF) continues to have weekly meetings with the Bureau for Juvenile Services (BJS) to help facilitate the transfer of youth inappropriately placed in BJS facilities back into a child welfare setting. Additionally, the BCF and BJS continue as participating members of the Commission to Study the Residential Treatment of Children and the West Virginia System of Care Implementation Team, focused on the seamless delivery of services to these populations between systems. Further, the BCF will begin a collaboration with BJS concerning former foster youth transitioning out of detention to adulthood. This collaboration will connect youth to the local Public Housing Authority to issue a Family Youth Initiative Voucher for housing when needed and provide 18 months of supportive after care services.

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Update 2022:

BCF has started a collaboration with BJS concerning former foster youth transitioning out of detention to adulthood. This collaboration will connect youth to the local Public Housing Authority to issue a Family Youth Initiative Voucher (FYI) for housing when needed and provide 18 months of supportive after care services. Referrals for FYI must come from the DHHR within that catchment area, therefore BJS will send referrals to local DHHRs who will verify eligibility and send a referral form to the Public Housing Authority. Due to the COVID 19 pandemic, this program's start date was delayed. No youth in the Balance of State Continuum of Care have been enrolled in the FYI program through FMHA yet, since the program launched April 1, 2021. The only other FYI program in the state is in Charleston which is outside of the Balance of State's jurisdiction. Charleston-Kanawha Housing Authority has received zero referrals from BJS but has received one referral from another agency for the program.

Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and, to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect; including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports

Update 2021:

In addition to the implementation of the Managed Care Organization (MCO) (See MCO update in Service Coordination section), the BCF has worked to identify a system to ensure children who become involved in the child welfare system have an appropriate mental health screening. Children who are identified as having a possible mental health diagnosis must be referred for a clinical assessment and be referred for resulting recommended services.

BCF also continued to fund the State Police's Drug Endangered Children's Alliance (DECA) grant with CAPTA funds. The DECA program is a collaboration of state, federal, and community agencies that are committed to rescuing, defending, sheltering, and supporting drug endangered children. The Alliance provides training and support to local multidisciplinary teams that coordinate services and support for Drug Endangered Children. Additionally, they provide education and awareness to law enforcement, child welfare agencies, other professionals, and the general public regarding activities of DECA.

BCF continues to work with the National Center on Substance Abuse and Child Welfare (NCSACW) to finalize a statewide coordinated response to children born affected by substances. Over the last two years the policy has been finalized and a process outlined to use our Drug Free Mom's and Babies program to work with pregnant women who use substances. This program will notify Child Protective Services when a child is born testing positive for any legal or illegal substances or indications of fetal alcohol syndrome or shows signs of withdrawal from substances.

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Staff with Drug Free Mom's and Babies programs will help the mothers develop a plan of safe care for their infants and themselves and notify Child Protective Services of the plan. If no signs of abuse or neglect are present, community agencies will monitor the families progress.

The current process for monitoring plans of safe care, is carried out by Child Protective Services workers. All referral for substance exposed infants requires an assessment be completed to determine if maltreatment has occurred. If maltreatment has occurred a CPS worker will complete an ongoing assessment and case plan and refer to community support services. These plans are monitored monthly and formally revisited every 90 days, until the situation is rectified. If the assessment concludes maltreatment has not occurred the worker will open a case and develop or document an existing plan of safe care, identify the services being provided, refer for needed services, and close the case. This process has not proven to be the most effective and changes are in process.

Currently, the state is working with two pilot areas, Wheeling and Greenbriar programs, to implement a pilot of this program. Concerns have been identified by the Mom's and Babies programs about being responsible for these families. Therefore, Children and Adult Services is proposing to secure two additional positions to monitor these plans and complete the documentation. These workers will enter all documentation and work with community agencies to secure appropriate services.

Update 2022:

As a continued effort to identify mental health needs of children and youth, mental health screening tools are being developed to assist child welfare workers with identifying children and youth who may require additional supports or referrals for assessment or treatment. Training to use the screening tools and identify the children and youth's needs to make appropriate referrals will also be provided.

The state continues to work on the pilot regarding plans of safe care, but the roll out was delayed due to COVID-19 restrictions on meeting in person, which would be necessary to train staff and stakeholders. The BCF utilized this time to update the pilot policy to align with current practice in working with infants and mothers who are experiencing substance use, misuse or substance use disorders.

Drug endangered children are those children who suffer physical or psychological harm or neglect resulting from exposure to an environment where adults are manufacturing, selling, or using drugs. These harms may include: physical abuse; sexual abuse; medical neglect and; lack of basic care including failure to provide meals, sanitary and safe living conditions, or schooling. It is estimated that 90% of the child maltreatment cases in WV involve a substance abuse component. Unless first responders understand addiction issues, treatment options, and long and short-term safety in a drug endangered environment; first responders will be unable to work a case effectively. The State Police's Drug Endangered Children's Alliance continued to provide training and support to local multidisciplinary teams that coordinate services and support for drug endangered children over this past year. The Alliance also provided education and awareness to law enforcement, child welfare agencies, other professionals, and the general public regarding their activities.

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Activity

Provide training where needed or upon request on emerging drug issues.

2020

September 23 - Breaking the Cycle of Addiction: Hope in Recovery with Judge William Thompson, 25th Judicial Circuit at the 2020 WV Center for Children's Justice Virtual Handle with Care Conference

Promote and support efforts to create Family Treatment Courts. Family Treatment Courts work to protect children and help parents found guilty of abuse and neglect overcome substance abuse disorders before they permanently lose custody of their children.

Activity

Participate in the Family Treatment Court State Advisory Committee Meetings:

Outcome

2020: August 11

Activities during the Pandemic

- *Facilitated the Virtual Handle with Care Brainstorming sessions which were developed to brainstorm ways children in hard places due to the Pandemic could be reached.*
 - *April 8*
 - *April 22*
 - *May 6*
 - *May 20*
 - *June 3*
 - *June 17*
 - *July 22*

Developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in investigations, 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 caregiving role of their non-abusing parents

Update 2021:

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Child Protective Services (CPS) has been working closely with the West Virginia Coalition Against Domestic Violence (WVCADV) and its 14 programs in a cross systems collaboration during 2019. The Coalition was recently re-awarded the Office on Violence Against Women Rural Grant, by the US Department of Justice for an additional four years. Under the previous awarded Rural Grant, the Coalition worked with the DHHR to pilot co-located "Domestic Violence Specialists" (DV Specialists) in four counties within the DHHR offices. The DV Specialists provided specialized assessment, services and referrals to survivors of domestic violence. They have started work with the first four counties approved in the initial grant award. The DV Specialists can work in partnership to build and maintain a support network while focusing on the safety, permanency, and well-being of the adult survivor and the child. In October 2019 the award was granted again to the Coalition and they have been able to add 5 additional counties to the pilot. Those counties include Morgan, Mason, Pocahontas, Randolph and Taylor counties. In early 2020 they will have a Rural Grant conference and invite Customer Service Managers, CPS Supervisors, Social Service Coordinators and CPS staff to, along with DV Specialist and their programs to come together to understand the history of the Rural Grant, the future of the grant and what the expectations are for DV Specialists when working within the DHHR alongside staff.

The SAFeR (Screen, Assess, Focus and Respond) model is being used as a tool to assist the DV specialists in their role in assessing domestic violence and providing assistance to victims of domestic violence. This assessment can also play a key role in a DV specialist's communication and participation in CPS cases with a victim. The SAFeR model has four components. It first screens for intimate partner violence (IPV). Second, it assesses for the nature and content of IPV. Next, the assessment focuses on the effects of IPV. Finally, the DV Specialist considers responses to the intimate partner violence with the victim. The pilot is designed so that DV Specialists and CPS have a unique opportunity to collaborate if so allowed by the victim. DV Specialists may also assist victims through their attorneys, Income Maintenance Workers or Child Support Specialists. This collaboration is important and could be crucial in developing safety plans that effectively enhance safety not only for victims, but primarily for the children. The DV Specialist can assist in providing advanced assessments and provide recommendations for safety planning for the adult victim and the child as well as assessing for offender accountability and recommendations of services.

The DV Specialists are not employed by the DHHR, but rather by local domestic violence programs in their service areas. The DV Specialists are also providing services to victims of domestic violence referred from other programs within the DHHR if needed since they are located either full-time or part-time at the local DHHR offices.

Another important tool that West Virginia uses as a collaborative effort with many different systems is the Dangerousness Lethality Assessment Guide (D-LAG), which brings together a coordinated response for each entity listed in the guide and a specified response for their role when working with domestic violence. Currently the guide includes information for Law Enforcement, Advocates, Magistrates, Family Court, Circuit Court, Prosecutors, CPS, Victim's Attorney/GALs and Batterer Intervention Programs. This guide assists in recognizing highly dangerous and potentially lethal behaviors of domestic violence offenders. During 2020 the Coalition will be working to add additional professions to the D-LAG guidebook so that more collaboration can occur with systems that CPS has frequent interaction with during our work with domestic violence victims, abusers and their children.

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*There is a continued effort to bring together all of these systems to encourage accountability for the offender. CPS Policy has moved to work with the Coalition to enhance the policies surrounding domestic violence for the upcoming year. These changes include adding the definition of D-LAG and how to assess for indicators of D-LAG for CPS staff **and further clarifying and updating terminology**. The Address Confidentiality Program legislation information for victims of domestic violence was added for staff to ensure that victim's rights continued to be protected by law. Understanding the role of substance use and how it may impact domestic violence and how fear by a parent of their abuser may appear as condoning abuse and/or neglect of a child(ren). Also, when assessing domestic violence, more guidance was suggested from the Coalition and a fundamental question to consider being, "who is doing what to whom and with what impact?". Finally, additional information regarding co-petitioning with non-offending parents who do not reside with offending parents was added. The information included that after confirming with the non-offending parent that they are agreeable to co-petitioning with Department, that the Department shall not request custody of the child(ren), but rather request that legal and physical custody remain or be placed with the non-offending parent.*

The Department has coordinated with the WVCADV to provide domestic violence trainings not only to new child welfare workers, but to provide on-going continued training regarding domestic violence for all child welfare staff throughout year 2020. These trainings include topics of Working with Families Experiencing Domestic Violence and Working with the Offender in the Child Welfare System.

Update 2022:

The DHHR has continued working closely with the WVCADV this past year. During the second year of the Rural Grant, the DHHR continued the efforts of the pilot that co-located Domestic Violence Specialists, "DV Specialists" in nine DHHR county offices. The Domestic Violence specialists are continuing to collaborate with child welfare workers to ensure both disciplines have a strong working relationship and a clear working knowledge of how to best serve adult and child victims of domestic violence while maintaining confidentiality. In February 2021, the annual Rural Grant conference was held virtually. Customer Service Managers, CPS Supervisors, Social Service Coordinators, and CPS staff, along with DV Specialists and others, came together to understand the history of the Rural Grant, the future of the projects and what the expectations and goals are for DV Specialists when working alongside DHHR staff. Over the past year, due to COVID-19 guidelines, DV Specialists did much of their work virtually or by phone. Since February 2021, many have been able to start returning to working in their offices. They adapted their services and no services stopped at any time.

The SAFeR model continued to be utilized by DV Specialists. There are sustained efforts to educate both child welfare workers and supervisors regarding the referral, use and applicability of the tool.

Since the D-LAG model was introduced into child welfare, there has been a dedicated effort to train the model to child welfare workers and supervisors. The training is in the use of the model and how it applies to child welfare cases. There are additional trainings being scheduled for the upcoming year with supervisors and Centralized Intake workers as well. All of the trainings also include how to incorporate D-LAG into safety planning.

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Throughout the past year the WVCADV has provided approximately 20 trainings for child welfare on domestic violence. Most of the training was held virtually due to COVID-19 guidelines. The training includes new child welfare worker training on domestic violence in child welfare cases. There are also trainings open to all child welfare workers on topics of domestic violence in CPS Policy, how to be supportive of adult and child victims of domestic violence, WV State Code regarding “Knowingly Allow” and the use of the “Battered Parent” adjudication. Training further addresses working with the maltreater of domestic violence, as well as how to hold a maltreater accountable and providing services that promote a behavioral change. Planned upcoming training will include co-occurring domestic violence and substance use disorders.

Supplemental CAPTA Funding American Rescue Plan

The state intends to utilize supplemental CAPTA funds to support enhancement grants to the state Family Resource Networks (FRN). FRNs are a linkage between services and resources for families and individuals in need. They often refer families to other agencies such as in Health Care, Community-Based Supports Agencies, and Governmental Services. This requires having an expanded knowledge of their community. To assist additional agencies in the community, the FRNs develop resource guides specific to their service area. These resource guides are updated annually and monitored by the DHHR.

Grant funds from CAPTA will allow the FRNs to enhance their ability to coordinate events and activities that promote prevention awareness. While being able to network more, the FRNs will make connections throughout their community to broaden their knowledge of service and resources. Connection of services for basic needs of the community can lessen burdens on families that can lead to child abuse and neglect.

The state has also engaged the Capacity Building Center for States to determine what supports may be available to support enhanced case planning and technical assistance regarding assessment and case planning in child welfare cases.

5. Update on Targeted Plans within the 2020-2024 CFSP

Foster and Adoptive Parent Diligent Recruitment Plan

The Foster and Adoptive Parent Diligent Recruitment Plan was developed with the states Regional Recruitment and Retention teams, Mission WV, the Foster and Adoptive Diligent Recruitment Program Improvement Plan team and West Virginia’s Specialized foster care agencies. Please see attached.

Update 2021:

There are no updates for the Foster and Adoptive Parent Diligent Recruitment Plan for the current period.

Between July 1, 2019 and December 31, 2019 Mission WV responded to 999 inquiries, with over 99% of families receiving responses within 2 business days. Main sources of inquiries included: Internet, DHHR

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via phone, and word of mouth. Other inquiry sources included media, special events, publications, billboards, AdoptUSKids, etc. Approximately 1,500 to 2,000 families who are actively considering or pursuing certification are served by Mission West Virginia at any given point in time. During this period 8,119 contacts were made to these families. Contacts are made to provide information and assistance, to resolve issues between the families and providers, to track families' progress toward certification, etc. During this period the following progress was tracked: 189 families connected with an agency, 105 families received training and 95 families were certified. (*Data only applies to families that stayed engaged in the process with Mission West Virginia. It is known that a percentage of families do complete steps toward certification without reporting back to the agency).

Mission West Virginia has developed new tracking to measure how many families "engage" in the follow up protocol. Families are counted as engaged when they respond to or initiate contact past the initial inquiry. During this period over 60% of families "engaged" in the process. We believe that tracking this figure will allow us to better measure the success rate of our protocol by separating out the families who only wanted to receive information but did not actively begin any steps in the process and/or engage in our follow-up protocol.

- Mission West Virginia engages in General, Targeted, Child-specific and Child-focused recruitment. Current recruitment methods include:
 - General: website optimization, google adwords, social media, awareness events, print media, PSAs, business partnerships,
 - Targeted: presentations, work with faith communities, newsletters, direct mail, targeted social media, video success stories, use of experienced foster/adoptive parents for messaging
 - Child-specific recruitment- Heart Gallery, Sunday's Child, website and newsletter features
 - Child-focused recruitment- individual meetings with children, case file review
- In partnership with the DHHR, we are targeting certified relative/kinship parents who may be appropriate to convert to resource foster homes. DHHR generally initiates the initial outreach and then directs families to Mission West Virginia for information and response. They are then referred to private foster care and adoption agencies for certification.
- Recruitment messaging is intended to recruit families interested in fostering or adopting from the foster care system. Messaging and images focus on older youth, sibling groups and racially diverse families.
- Additionally, Mission West Virginia provides technical assistance and leadership for regional and community-based recruitment efforts. Activities are based on county or regional data identifying need and county-specific messaging is used in recruitment efforts. Efforts are also based on input from regional DHHR staff.

Upcoming and recent changes:

Mission West Virginia received a Google Adwords grant which will allow them to expand their current use of this platform at no cost. Web-based searches are one of their consistently highest referral sources.

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Mission West Virginia now has a monthly public access television show that will focus on topics related to foster care and adoption as well as teen health. Each show airs multiple times per month across different platforms.

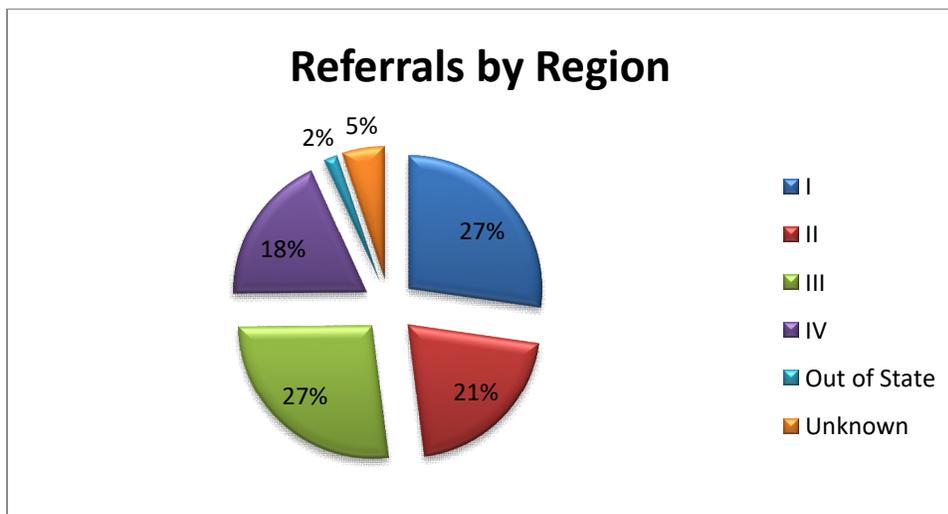
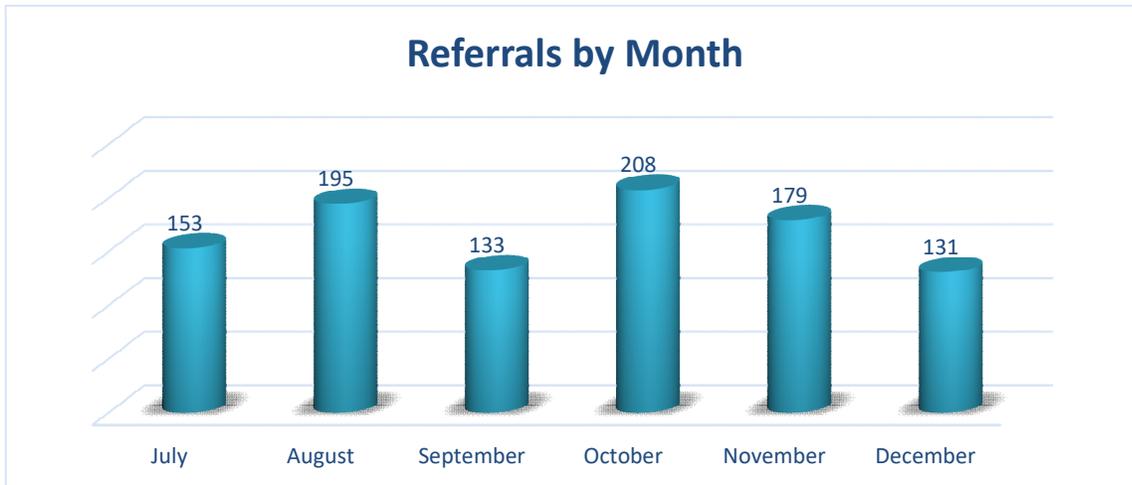
A major focus of the January Adoption Call to action conference in Washington D.C., was shifting much of the effort of the child welfare agencies to really emphasize foster child reunification with birth families. The focus was on shifting the message of recruitment to focus on recruiting resource parents to work with birth parents or families of origin to accomplish successful reunifications. As part of this shift to focus on resource parents working with birth families on reunification, the achievement of this goal will ultimately limit the number of children who are lingering in foster care, awaiting adoption. West Virginia's Recruitment and Retention plan. In recent years recruitment messaging has shifted from adoption (with focus on older youth) to promoting a need for foster parents. Staff have always provided inquiring families with a data-informed perspective on the realities of foster care, reunification and adoption. In the future the state will be providing more messaging focused on reunification, including statistical data on case outcomes as well as positive stories illustrating the foster parent's role in successful reunifications.

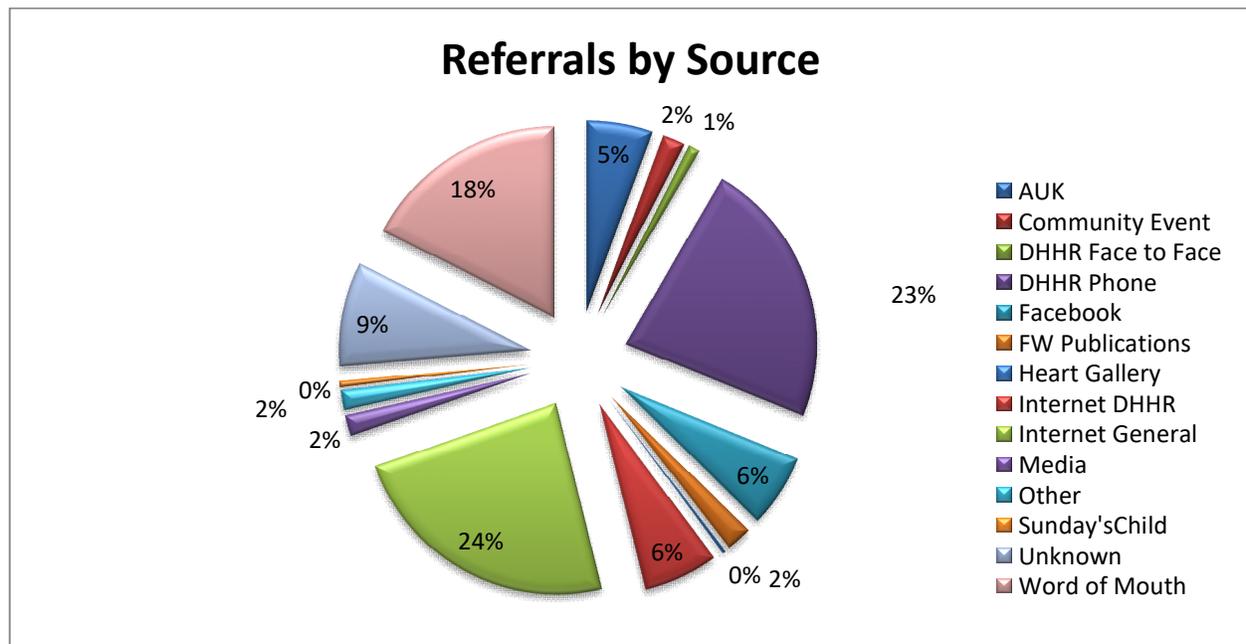
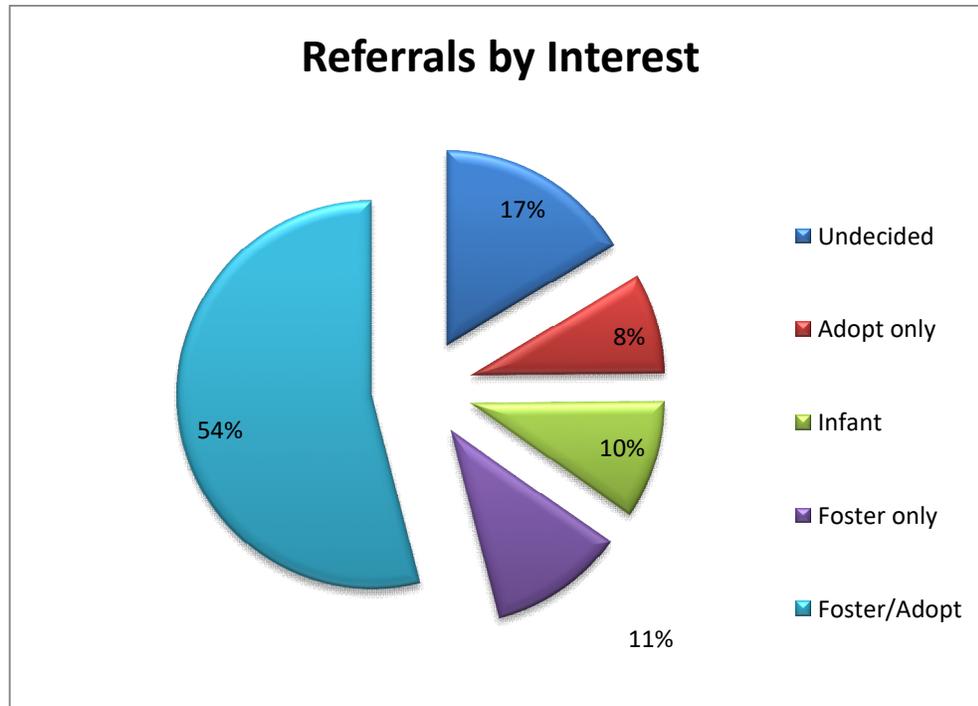
Mission West Virginia is currently utilizing business partnerships to promote recruitment messaging to new audiences and across different platforms, such as business websites and social media accounts. Additional business and service organizations partnerships have allowed us to meet needs and provide extra resources for relative/kinship and foster/adoptive families. This includes giveaway of 26 bed sets (frame, mattress, bedding) as well as fundraised money that is used for the purchase necessities for relative and kinship families and for foster youth.

Videos produced by Mission West Virginia and released in Fall 2019 highlighted former foster youth, highlighting their successes and illustrating the struggles of older youth in the foster care system. Videos planned for fall 2020 will focus on the theme of reunification and relationships with biological families. If appropriate families can be found the videos will highlight: a foster family who helped a family achieve reunification, an adoptive family with an open adoption/ongoing relationship with their adopted child's birth families. Again this focus aligns with the Adoption Call to Action, with an emphasized focus on reunification and eliminating children lingering in foster care, awaiting adoption.

A survey will be conducted before the end of the current grant year to obtain feedback from families who did not maintain contact with Mission West Virginia. Results will be used to inform practice, adjust our protocols and to identify service gaps and barriers.

For the time period July 1, 2019- December 31, 2019.





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AUK	32
Heart Gallery	2
Other	4
Sunday's Child	5
DHHR Face to Face	6
FW Publications	15
Community Event	8
Media	9
Facebook	22
Unknown	32
Internet DHHR	33
Word of Mouth	83
DHHR Phone	114
Internet General	117

As part of West Virginia's Program Improvement Plan, several initiatives are currently in process to improve foster parent recruitment and retention. These initiatives include sending letters to kinship/relative providers six months into their certification process to inform them of their qualification to transition to traditional foster care, if they are interested. This letter provides information on contacting Mission West Virginia to discuss their process. Mission West Virginia tracks these providers for reporting purposes to demonstrate the interest and increase in traditional foster care providers. Additional strategies include training and assistance from the child placing agencies for child welfare staff regarding working collaboratively with foster care providers and building strong supportive relationships. Providing open house type meetings to initiate a "warm handoff" of kinship/relative providers to child placing agencies for the purpose of converting to traditional foster care providers. West Virginia is continued to work on the approved strategies and goals to improve foster parent recruitment and retention.

Update 2022:

Between January 1, 2020 and December 31, 2020 Mission WV responded to 1,843 inquiries, with over 99% of families receiving responses within 2 business days. Main sources of inquiries included: Internet, DHHR via phone, and word of mouth. Other inquiry sources included media, special events, publications, billboards, AdoptUSKids, etc. Approximately 1,500 to 2,000 families who are actively considering or pursuing certification are served by Mission West Virginia at any given point in time. During this period 16,583 contacts were made to these families. Contacts are made to provide information and assistance, to resolve issues between the families and providers, to track families' progress toward certification, etc. During this period, the following progress was tracked:

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*418 families connected with an agency, 219 families received training and 190 families were certified. (*Data only applies to families that stayed engaged in the process with Mission West Virginia. It is known that a percentage of families do complete steps toward certification without reporting back to the agency).*

Mission West Virginia has developed tracking to measure how many families “engage” in the follow up protocol. Families are counted as engaged when they respond to or initiate contact past the initial inquiry. During this period over 70% of families “engaged” in the process. We believe that tracking this figure will allow us to better measure the success rate of our protocol by separating out the families who only wanted to receive information but did not actively begin any steps in the process and/or engage in our follow-up protocol.

- *Mission West Virginia engages in General, Targeted, Child-specific and Child-focused recruitment. Current recruitment methods include:*
 - *General: website optimization, google adwords, social media, awareness events, print media, PSAs, business partnerships, etc.*
 - *Targeted: presentations, work with faith communities, newsletters, direct mail, targeted social media, video success stories, use of experienced foster/adoptive parents for messaging*
 - *Child-specific recruitment- Heart Gallery, Sunday’s Child, website and newsletter features*
 - *Child-focused recruitment- individual meetings with children, case file review*
- *In partnership with the DHHR, we are targeting certified relative/kinship parents who may be appropriate to convert to resource foster homes. DHHR generally initiates the initial outreach and then directs families to Mission West Virginia for information and response. They are then referred to private foster care and adoption agencies for certification.*
- *Recruitment messaging is intended to recruit families interested in fostering or adopting from the foster care system. Messaging and images focus on older youth, sibling groups and racially diverse families.*
- *Additionally, Mission West Virginia provides technical assistance and leadership for regional and community-based recruitment efforts. Activities are based on county or regional data identifying need and county-specific messaging is used in recruitment efforts. Efforts are also based on input from regional DHHR staff.*

During 2020 Mission West Virginia engaged in the following additions to the standard recruitment plan:

Webinars: Webinars were held in place of trainings and community events that could not be held in person due to COVID. Webinars topics were selected that could be helpful to both current and prospective foster adoptive parents and including topics on: communication between birth and foster families, transracial hair and skin care and a former foster youth who shared their story. Some of the webinars are being offered in partnership with the Court Improvement Board. The recruitment piece is the hope that families will feel more confident to pursue certification if they feel that they are educated on issues before starting the process.

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Pandemic Response: All recruitment planning required adaptation for COVID restrictions. These included:

- *Announcement on the Mission West Virginia website that families may still pursue certification.*
- *Call-forwarding to employees based at home. Continued timely response to family inquiries including phone calls, e-mail packets and mailed packets.*
- *Increased communication with private agencies and DHHR to stay abreast of any changes to policy and practice.*
- *Increase social media content regarding recruitment, clarifying that foster parents are still needed, and that recruitment and certification are continuing.*
- *Website article was written titled, 'Can I still pursue fostering during COVID-19?'*
- *Social media sharing of private agency messaging regarding virtual events and training opportunities.*
- *Communication with the DHHR Communications office and Governor's office regarding recruitment and certification and a slide with recruitment information shared at every Governor's press briefing.*

Media: Worked with various media including national and state to coordinate response to pieces involving foster care/adoption. Mission West Virginia educated the media on how foster care certification works and served as the response team to inquiries. Additionally, Mission West Virginia ran a "Say Yes" themed digital media campaign focusing on foster parent recruitment. Ads featured diverse families with focus older and minority youth.

Closed Case survey: Mission West Virginia maintains foster parent inquiry data in a secure database covering 20 years of recruitment. They engaged in a data exploration project that looked at records going back 3 years for families with "Closed, Not Pursing" status. Families were re-contact if their circumstances could have changed with time and several families were able to be re-opened to pursue certification.

Social Media: Use of Facebook Live for readings of children's books focused on foster care and adoption themes

For the time period January 1, 2020- December 31, 2020.

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Chart provided by Mission West Virginia

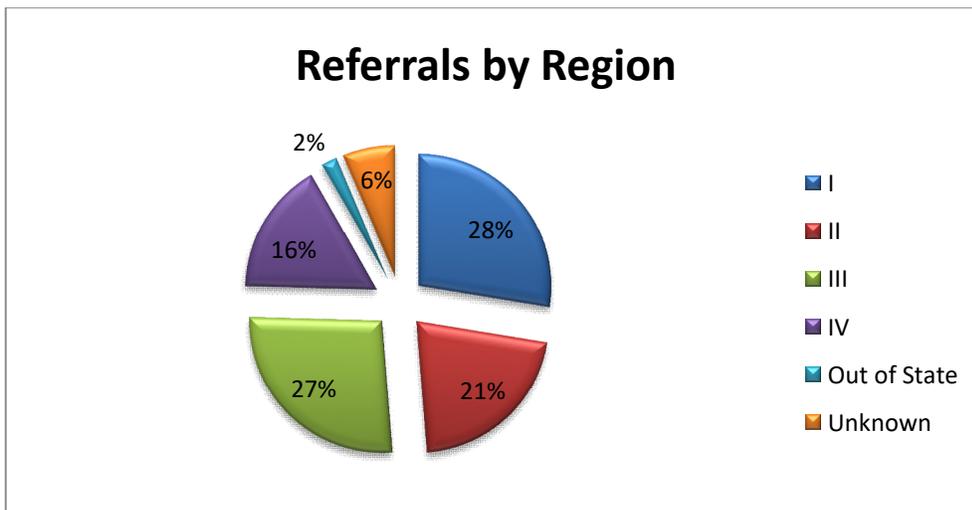


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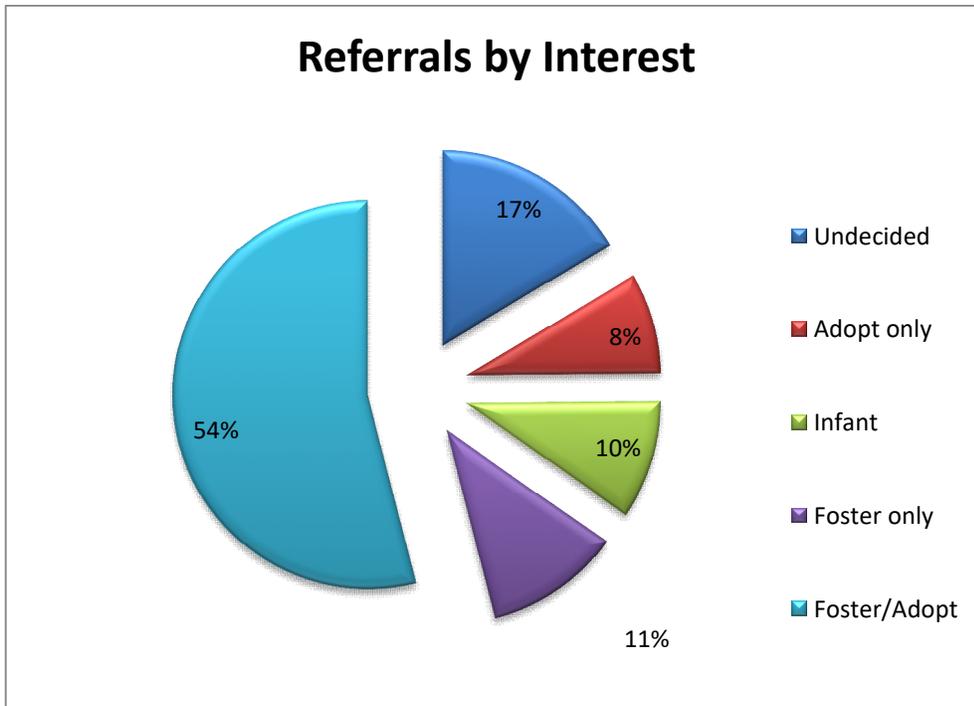


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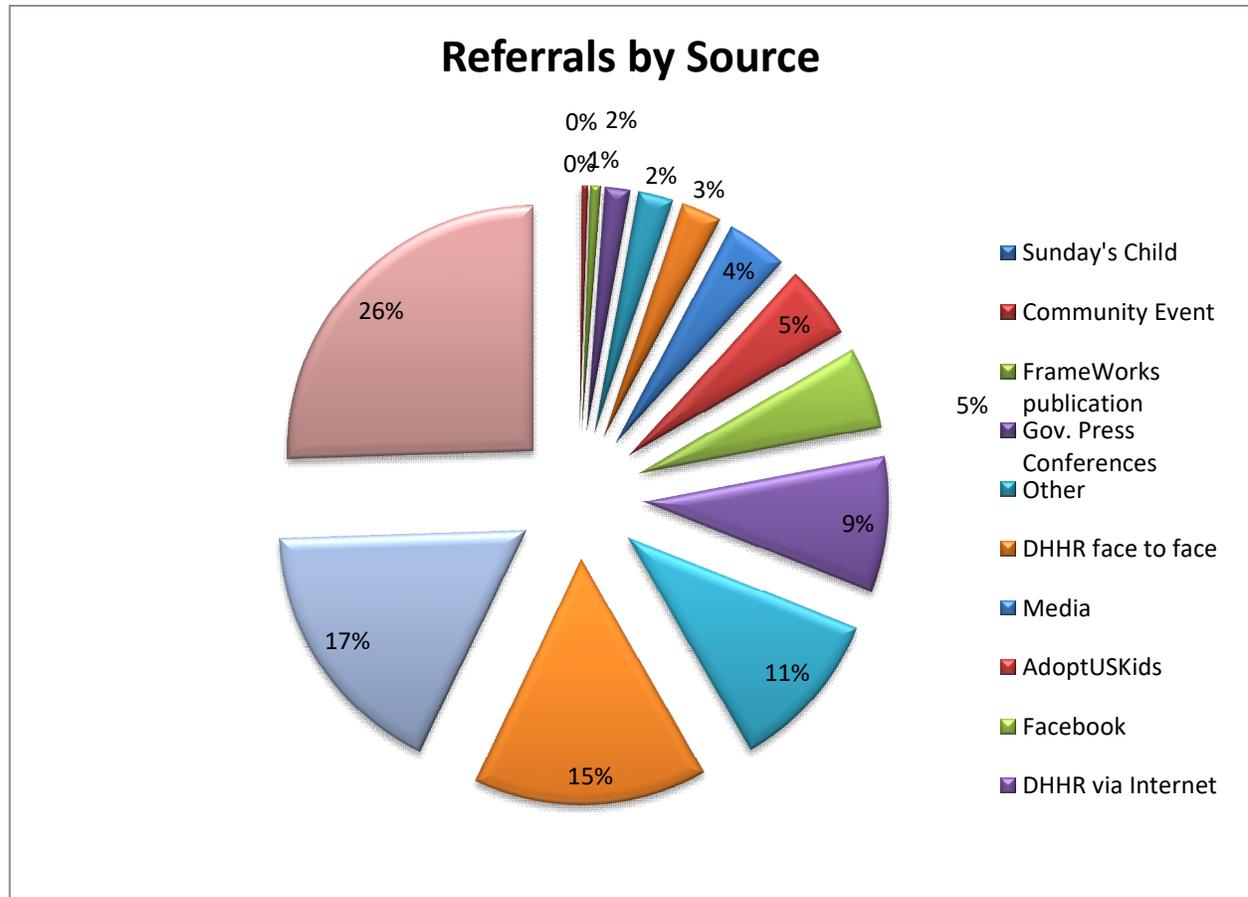


Chart provided by Mission West Virginia

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Sunday's Child	2
Community Even	7
FrameWorks pub	12
Gov. Press Confe	30
Other	42
DHHR face to fac	48
Media	73
AdoptUSKids	87
Facebook	98
DHHR via Interne	162
Unknown	194
DHHR via phone	279
Word of Mouth	315
Internet- Genera	462

Upcoming:

The webinar series will continue throughout 2021 focusing on topics with appeal to both current and potential foster parents.

Foster Care Month: 2021 will feature an outdoor exhibit of self-portraits of foster youth that will travel through the state. Focus will be on awareness of the need for foster parents and to help the public gain a more complex understanding of foster youth.

Public Access Show: Mission West Virginia will resume tapings of their Public Access show (previously delayed due to COVID). Shows will tape and air monthly with regular focus on foster care and adoption topics.

As part of West Virginia's Program Improvement Plan, several initiatives are currently in process to improve foster parent recruitment and retention. These initiatives include sending letters to kinship/relative providers six months into their certification process to inform them of their qualification to transition to traditional foster care, if they are interested. This letter provides information on contacting Mission West Virginia to discuss their process. Mission West Virginia tracks these providers for reporting purposes to demonstrate the interest and increase in traditional foster care providers. Additional strategies include training and assistance from the child placing agencies for child welfare staff regarding working collaboratively with foster care providers and building strong supportive relationships. Providing open house type meetings to initiate a "warm handoff" of kinship/relative providers to child placing agencies for the purpose of converting to traditional foster care providers. West Virginia is continued to work on the approved strategies and goals to improve foster parent recruitment and retention.

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The workgroup has taken AFCARS data relating to children and youth who have not yet achieved permanency and identified children and youth where termination of parental rights has occurred but permanency has not been achieved and children and youth are eligible for adoption but are lingering in foster care. The workgroup meets periodically to discuss progress and to complete deeper dives into case records to determine possible common themes with the children and youth lingering in foster care to determine what, if any, systemic factors may be contributing to the failure to achieve permanency and address appropriately any contributing factors to increase permanency for lingering foster children and youth.

Health Care Oversight and Coordination Plan

The Health Care Oversight and Coordination Plan was developed with the Office of Maternal Child and Family Health, Bureau for Medical Services and the Bureau for Children and Adult Services. Please see attached.

Update 2021:

See MCO update in [Service Coordination](#) section.

There are no changes to the Health Care Coordination Plan for the current period.

Update 2022:

See MCO update in [Service Coordination](#) section.

Disaster Plan

Update 2021:

On September 12, 2019, Boggs Environmental Consultants finalized a report detailing their findings of mold issues in the Wood County DHHR office. As a result of their findings and recommended remediation, on September 16, 2019 staff on the first and second floors were informed of the issue and relocated to an alternate location. All work to the building has been completed; however, staff have not been placed back on those floors as of this date due to the COVID-19 situation.

On January 23, 2020 the Marshal County DHHR temporarily closed due to a heating issue in the building and reopened on January 24, 2020.

As a result of the COVID-19 virus, the Governor called a state of Emergency in all 55 counties on March 16, 2020.

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The bureau activated the COOP on March 19, 2020 and all staff began teleworking from home and/or rotating working from the office according to the plan. Teleworking and office coverage allowed services to the public remain fully operational. The local offices remained open to the public for emergency walk-in customers. All other customers were directed to call the office, leave documentation in available drop boxes, or mail documentation to the office. Signs with detailed information for customers were posted at each location.

On March 23, 2020 the Governor signed a Stay-at-Home Order to be effective at 8:00 pm on March 24, 2020 and will remain in effect until terminated by subsequent executive order. Only essential personnel can report to work and travel outside the home is limited to essential needs.

The Disaster Plan was updated June 2020. Please see attached.

Update 2022:

On May 4, 2020, the Governor announced that the “Safer-at-Home” order replaced the “Stay-at-Home” order that was issued on March 23, 2020. Government office buildings were scheduled to be reopened in weeks three through six.

On June 11, 2021, the Governor announced the reopening of government office buildings and provided safety guidelines. The governor allowed Cabinet Secretaries to have flexibility to bring back employees. The governor urged the use of telework when full services can be maintained with remote work. As of today, telework continues to be utilized by most employees.

There were no revisions to the Disaster Plan.

Training Plan

See attached.

6. Update on Statistical Information

CAPTA Annual State Data Report:

Update 2021:

Child Protective Services Workforce FFY2019	Region I	Region II	Region III	Region IV	Statewide
Total CPS Cases ¹	21,297	29,147	16,701	21,095	88,240
Monthly Average CPS Cases ²	1,775	2,429	1,392	1,758	7,353
Staff Needed @ Action Standard ³	178	243	139	176	735

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Total CPS Staff Allocated Positions ⁴	122	151	100	117	490
% of Allocated Positions Meeting Action Standard ⁵	69%	62%	72%	66%	67%
Average CPS Caseload for Allocated Positions ⁶	15	16	14	15	15
Caseload Difference(allocated to action standard) ⁷	-56	-92	-39	-59	-245

¹Obtained 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 FFY2019(October 2018-September 2019)

²Total CPS cases divided by 12 (months) rounded to nearest integer

³Monthly average of CPS cases divided by 10(action standard for CPS cases)rounded to nearest integer

⁴Obtained from monthly "Position Vacancy Report" submitted by each region rounded to nearest integer

⁵Total CPS allocated positions divided by staff needed at action standard (10) multiplied by 100 rounded to nearest integer

⁶Monthly average CPS cases divided by total CPS staff allocated positions rounded to nearest integer

⁷Staff needed at action standard (10) subtract CPS allocated positions rounded to nearest integer (positive numbers mean above action standard, negative numbers mean below action standard)

Youth Services Workforce FFY2019	Region I	Region II	Region III	Region IV	Statewide
Total YS Cases ¹	7,760	9,680	6,042	4,572	28,054
Monthly Average YS Cases ²	647	807	504	381	2,338
Staff Needed @ Action Standard ³	54	67	42	32	195
Total YS Staff Allocated Positions ⁴	31	48	34	26	139
% of Allocated Positions Meeting Caseload Standard ⁵	57%	72%	81%	81%	71%
Average YS Caseload for Allocated Positions ⁶	21	17	15	15	17
Caseload Difference (Allocated Action Standard) ⁷	-23	-19	-8	-6	-56

¹Obtained by adding the monthly case total of Youth Services staff (FREDI-0010) each month during FFY2019 (October 2018-September 2019)

²Total Youth Services Cases divided by 12 (number of months)rounded to nearest integer

³Monthly average of Youth Services Cases divided by 12 (action standard for Youth Services cases) rounded to nearest integer

⁴Obtained from the "Position Vacancy Report" as reported by each region

⁵Total Youth Services staff allocated positions divided by the staff needed at action standard multiplied by 100 rounded to nearest integer

⁶Monthly average of Youth Services cases divided by total allocated Youth Services positions rounded to nearest integer

⁷Youth 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)

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Information related to Child Protective Services education, qualifications, and training requirements, as well as advancement criteria can be found at the following links:

[Child Protective Services Case Coordinator](#)

[Child Protective Services Worker Trainee](#)

[Child Protective Services Worker](#)

[Child Protective Worker Senior](#)

[Child Protective Services Supervisor](#)

[Social Service Coordinator](#)

Demographic information, as well as, information pertaining to the education and qualifications of child welfare personnel is unavailable for FY21. Information related to training of such personnel can be found in the Training section of the APSR. This information is expected to be readily available with PATH CCWIS implementation and will be made available in FY 22 through a staff survey which will be completed in December 2020.

Update 2022:

Child Protective Services Workforce FFY2020	Region I	Region II	Region III	Region IV	Statewide
Total CPS Cases ¹	19,533	25,904	18,265	18,957	82,659
Monthly Average CPS Cases ²	1,628	2,159	1,522	1,580	6,888
Staff Needed @ Action Standard ³	163	216	152	158	689
Total CPS Staff Allocated Positions ⁴	130	163	111	129	533
% of Allocated Positions Meeting Action Standard ⁵	80%	75%	73%	82%	77%
Average CPS Caseload for Allocated Positions ⁶	13	13	14	12	13
Caseload Difference(allocated to action standard) ⁷	-33	-53	-41	-29	-156

¹Obtained 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 FFY2020(October 2019-September 2020)

²Total CPS cases divided by 12 (months) rounded to nearest integer

³Monthly average of CPS cases divided by 10(action standard for CPS cases)rounded to nearest integer

⁴Obtained from monthly "Position Vacancy Report" as of 9/30/20 submitted by each region rounded to nearest integer. Positions included in count are CPSW/T, CPSW FTDC and CPSW Senior.

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⁵Total CPS allocated positions divided by staff needed at action standard (10) multiplied by 100 rounded to nearest integer

⁶Monthly average CPS cases divided by total CPS staff allocated positions rounded to nearest integer

⁷Staff needed at action standard (10) subtract CPS allocated positions rounded to nearest integer (positive numbers mean above action standard, negative numbers mean below action standard)

Youth Services Workforce FFY2020	Region I	Region II	Region III	Region IV	Statewide Total
Total YS Cases ¹	8,503	12,059	6,934	4,962	32,458
Monthly Average YS Cases ²	709	1005	578	414	2,705
Staff Needed @ Action Standard ³	59	84	48	35	225
Total YS Staff Allocated Positions ⁴	32	49	32	25	138
% of Allocated Positions Meeting Caseload Standard ⁵	54%	58%	67%	71%	61%
Average YS Caseload for Allocated Positions ⁶	22	21	18	17	20
Caseload Difference (Allocated Action Standard) ⁷	-27	-35	-16	-10	-87

¹Obtained by adding the monthly case total of Youth Services staff (FREDI-0010) each month during FFY2020 (October 2019-September 2020)

²Total Youth Services Cases divided by 12 (number of months)rounded to nearest integer

³Monthly average of Youth Services Cases divided by 12 (action standard for Youth Services cases) rounded to nearest integer

⁴Obtained from the "Position Vacancy Report" as reported by each region as of September 2020

⁵Total Youth Services staff allocated positions divided by the staff needed at action standard multiplied by 100 rounded to nearest integer

⁶Monthly average of Youth Services cases divided by total allocated Youth Services positions rounded to nearest integer

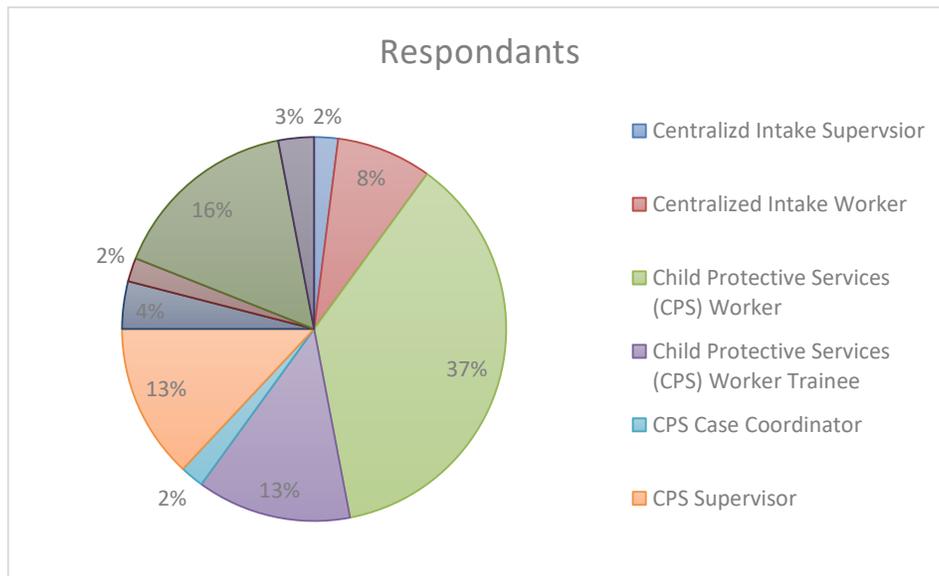
⁷Youth Services allocated positions subtract Youth Services staff needed at action standard rounded to nearest integer

(positive numbers mean above action standard, negative numbers mean below action standard)

While all other programs experienced a decline in cases during the pandemic, Youth Services cases rose. Data reviews indicate that some data may have been in accurate and a review continues to occur to determine if there are data quality issues.

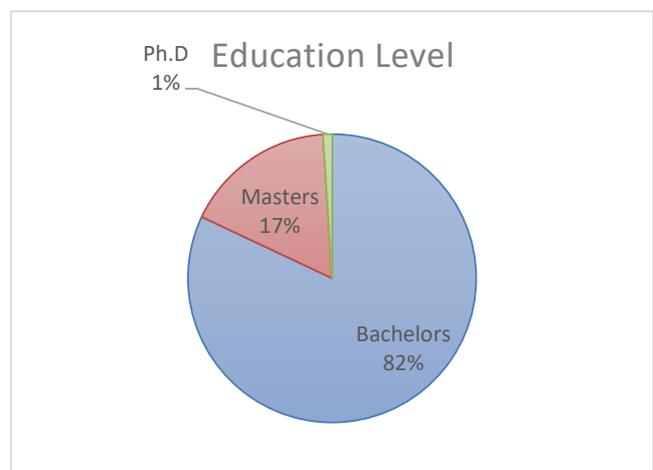
A survey was conducted in December 2020 to obtain the demographics, education, and qualifications of child welfare personnel. As previously mentioned however, the state envisions full reporting capabilities with its new SACWIS system implementation.

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This chart provides the survey participation of personnel by position type. 78% of the respondent workforce were females and 21% were male, while a combined 1% identified as either transgender male, preferred not to answer, or identified with a non-represented gender. Child Welfare personnel primarily identified as white, making up 90% of respondents; while 8% identified as African American or Black, and Native Hawaiian/Pacific Islanders, Asian, Hispanic/Latino, and American Indian/Alaskan Native representing a combined 2% of participants. Nearly 48% of participants had been with the agency less than three years, 21% had more than 10 years of tenure, and 31% had between three and 10 years of experience.

Participants by Field of Study	
Behavioral Science	17%
Board of Regents	3%
Business Management	4%
Counseling	3%
Criminal Justice	18%
Criminology	1%
Education	4%
Health Service and Social Welfare	1%
Political Science	2%
Psychology	17%
Social Work	23%
Sociology	5%
Not Listed/Other	15%



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License Type					
<i>Social Service Registry</i>	<i>Provisional License</i>	<i>Licensed Social Worker</i>	<i>Licensed Certified Social Worker</i>	<i>Licensed Graduate Social Worker</i>	<i>Licensed Independent Clinical Social Worker</i>
32%	28%	37%	1%	2%	>1%

Information related to Child Protective Services education, qualifications, and training requirements, as well as advancement criteria can be found at the following links:

[Child Protective Services Case Coordinator](#)

[Child Protective Services Worker Trainee](#)

[Child Protective Services Worker](#)

[Child Protective Worker Senior](#)

[Child Protective Services Supervisor](#)

[Social Service Coordinator](#)

Juvenile Justice Transfers:

Update 2021:

To capture the total number of individuals transferred from the Departments custody to BJS, from January 2019 to December 2019, monthly COGNOS reports for these 12 months were used. COGNOS reports list transfers as 'Exit from Foster Care'. These numbers are then vetted to collect only the transfers to BJS. For the calendar year 2019, the total number of Juvenile Justice Transfers is 61.

Update 2022:

The methodology for obtaining juveniles transfer numbers has not changed. During the current reporting period of FFY2020 there were 19 transfers. Since 2012 there have been 770 total transfers.

Education and Training Vouchers:

See Attachment D

Inter-Country Adoptions:

2021 Update:

West Virginia had no children adopted from other countries that entered state custody in FY 2019 as a result of the disruption of a placement for adoption or the dissolution of an adoption.

Update 2022:

West Virginia had no children adopted from other countries that entered state custody in FY 2020 as a result of the disruption of a placement for adoption or the dissolution of an adoption.

Monthly Case Worker Visit Data:

2021 Update:

In FFY 2019, 92.7% of the children in foster care in West Virginia were visited during each and every month, with 56.4% of those visits occurring in the child's place of residence.



CASE WORKER VISIT REPORT

Report start date: Oct 1, 2018
Report end date : Sep 30, 2019

Creation date: Oct 15, 2019
Report ID: 53

Sequence	Description	Count
1	The aggregate number of children served in foster care	10,763
2	The total number of monthly case worker visits made to children in reporting population.	73,049
3	The total number of complete calendar months children in the reporting population spent in care	78,743
4	The total number of monthly visits made to children in the reporting population that occurred in the child's residence.	44,416
5	The percentage of visits made on a monthly basis by caseworker to children in foster care	93
6	The percentage of visits that occurred in the residence of the child	61
7	Total Number of AFCARS Children IN Daily Process	12,198

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Update 2022:

In FFY 2020, 93.09% of the children in foster care in West Virginia were visited during each and every month, with 77.6% of those visits occurring in the child’s place of residence. West Virginia did not meet the required 95 percentile range for visitation with each child in foster care during FFY 2020. West Virginia is currently in a PIP agreement that includes goals around meaningful contact with children in foster care. However, West Virginia did exceed the required 50 percentile range for visits occurring within the placement. The demonstration of increased visits within the child’s placement residence is due to the COVID-19 pandemic and the ability to complete the monthly face-to-face visits virtually. Though the pandemic created great challenges for child welfare staff in the beginning months, they were able to adapt to the virtual visits with the foster children and youth. Guidance, protocol, and memos were drafted for child welfare staff regarding virtual visits and screening for COVID when in-person visits could resume, to ensure the safety of children and the process in placement and treatment. Alteration was required for data reporting elements due the already existing reported designed to catch “in placement” visits not including the “other” category for which the virtual visits were categories. A new report build was required to filter out the “other” category in order to capture an accurate percentage of visitations occurring within the foster child’s placement.



CASEWORKER VISIT REPORT

Report start date: Oct 1, 2019
Report end date : Sep 30, 2020

Creation date: Mar 3, 2021
Report ID: 54

Sequence	Description	Count
1	The aggregate number of children served in foster care	10,741
2	The total number of monthly case worker visits made to children in reporting population.	76,023
3	The total number of complete calendar months children in the reporting population spent in care	81,662
4	The total number of monthly visits made to children in the reporting population that occurred in the child's residence.	59,057
5	The percentage of visits made on a monthly basis by caseworker to children in foster care	93
6	The percentage of visits that occurred in the residence of the child	78
7	Total Number of AFCARS Children IN Daily Process	13,755

Source: Cognos Monthly Visitation Report pulled March 3, 2021 for FFY 2020

7. Financial Information

2021 Update:

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West Virginia's estimated f) administration expenditures for IV-B subpart 2 at 2% and estimated e) planning activities at 18% for FFY 2016 and years prior. Historically, administration costs have been significantly less than 2% and no planning activities occurring. The lack of activity in these two categories for FFY 2015 resulted in additional expenditures being claimed under the four service categories of which most of additional costs were claim under b) family support services.

Please see attached CFS-101 parts I, II and III.

Update 2022:

Please see attached CFS-101 parts I, II and III.
