WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

October 1, 2016 – March 31, 2017

West Virginia Department of Health
and Human Resources

Bureau for Children and Families

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I. Overview

West Virginia was awarded our approval to proceed with our Demonstration Project, Safe at Home West Virginia, on October 14, 2014. Safe at Home West Virginia is high fidelity wraparound aimed at 12-17 year olds currently in congregate care settings in West Virginia or out-of-state and those at risk of entering a congregate care setting. West Virginia also plans to universalize the use of the WV CANS across child serving systems.

Recognizing the way we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

Safe at Home West Virginia Wraparound will help improve identification of a youth's and family's strengths and needs; reduce the reliance on congregate care and length of stay in congregate care; reduce the reliance on out-of-state residential care; improve the functioning of youth and families, including educational attainment goals for older youth; improve timelines for family reunification; and reduce re-entry into out-of-home care. The benefits of a wraparound approach to children and families include:

- One child and family team across all service environments;
- The family's wraparound plan unifies residential and community treatment;
- Wraparound helps families build long-term connections and supports in their communities;
- Provides concurrent community work while youth is in residential care for a smooth transition;
- Reduces the occurrence and negative impact of traumatic events in a child's life;
- Access to mobile crisis support, 24 hours per day, seven days per week; and

- Crisis stabilization without the need for the youth to enter/re-enter residential care.

As we begin to redirect funds from congregate care using a universal assessment and thresholds; changing our culture of relying on bricks and mortar approaches to treatment; and implementing wraparound to prevent, reduce, and support out-of-home care, we will free up funding to redirect into building our community-based interventions and supports. We will use the assessed target treatment needs from the WV CANS to guide our decision about the best evidence-informed treatment for the targeted needs at the community level and begin to develop a full array of proven interventions to meet the individual needs of children and families in their communities. This approach and model will lead to our children getting what they need, when they need it, and where they need it. It will also enhance our service delivery model to meet the needs and build on the strengths of the families of the children.

There are no significant changes in the design of our interventions to date.

Theory of Change

We implement CANS and NWI

So That

We have clear understanding of family strengths and needs

And

A framework/process to address those strengths and needs

So that

Families will receive the appropriate array of services and supports

And

Are more engaged and motivated to care for themselves

So that

Families become stabilized and/or have improved functioning

So that

Families have the knowledge and skills to identify and access community services and supports and can advocate for their needs

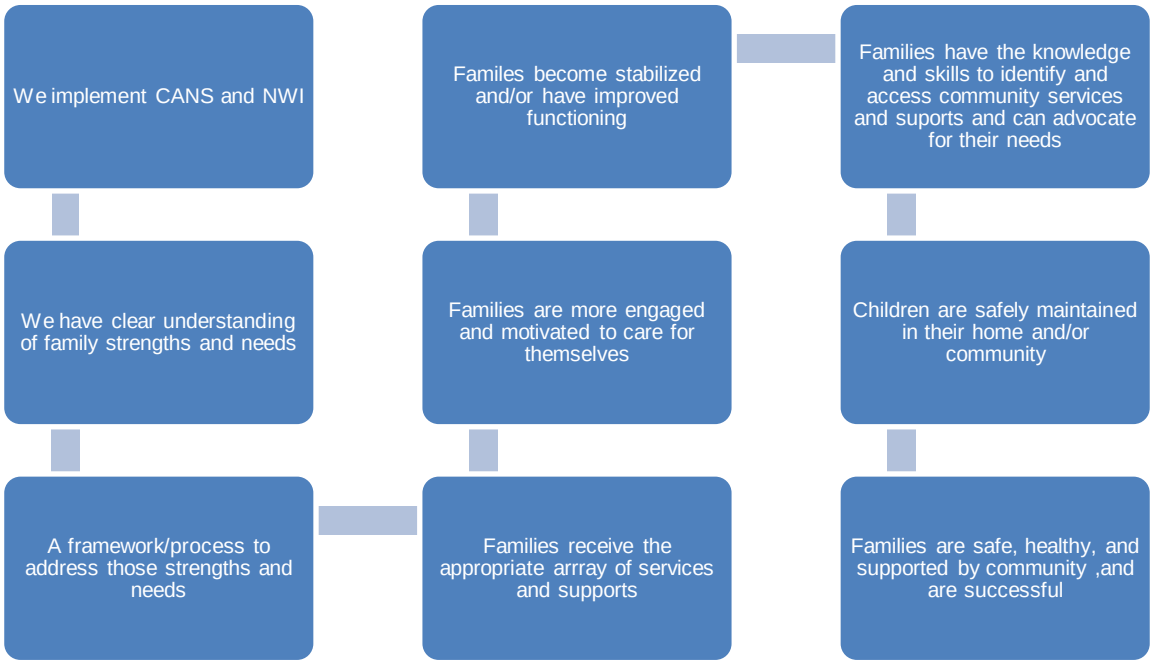
So that

Children are safely maintained in their home and/or community

And

Families are safe, healthy, supported by community, and are successful

Safe at Home West Virginia Theory of Change



Safe at Home West Virginia Logic Model

Inputs	Interventions	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
• Youth 12-17 in open cases • Flexible funding under Title IV-E waiver • CAPS/CANS tools • Caseworkers trained in wraparound service provision • Multi-disciplinary team • Courts • Coordinating agencies • Service providing agencies	• CAPS/CANS assessments to determine need for wraparound services • Intensive Care Coordination model of wraparound services • Next Steps model of wraparound services	• Number of youth[1] assessed with CAPS/CANS • Number of youth and families engaged in wraparound services while youth remains at home • Number of youth engaged in wraparound services while in non-congregate care out-of-home placement • Number of youth engaged in wraparound services while in congregate care	• Compre-hensive assessments lead to service plans better aligned to the needs of the youth and their families • Delivery of services tailored to the individual needs of the youth and families results in stronger families and youth with fewer intensive needs	• More youth leaving congregate care • Fewer youth in out-of-state placements on any given day • More youth return from out-of-state placements	• Fewer youth enter congregate care • The average time in congregate decreases • More youth remain in their home communities • Fewer youth enter foster care for the first time • Fewer youth re-enter foster care after discharge • Fewer youth experience a recurrence of maltreatment • Fewer youth experience physical or mental/ behavioral issues • More youth maintain or increase their academic performance

II. Demonstration Status, Activities, and Accomplishments

[1] All references to youth in the logic model refer to youth in open cases who are between 12 and 17.

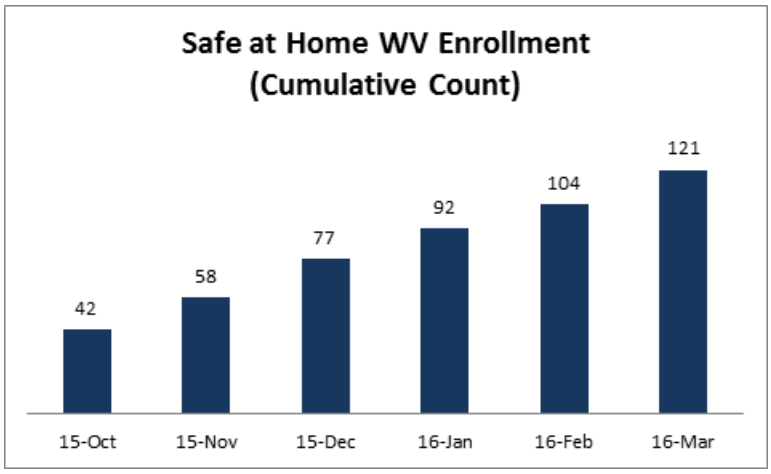
Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the 11 counties of Berkley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne with the first 21 youth being referred for Wraparound Facilitation. West Virginia also began the process of universalizing the CANS across child serving systems.

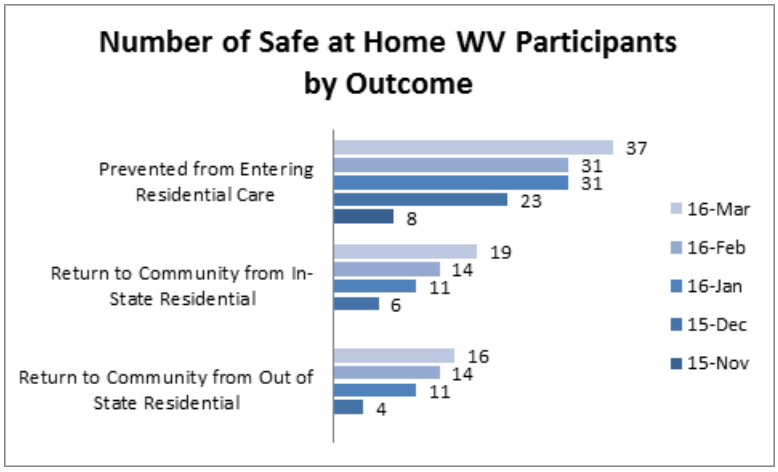
On August 1, 2016 West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker, and Upshur. This phase of implementation brought in counties from each of the 4 BCF regions.

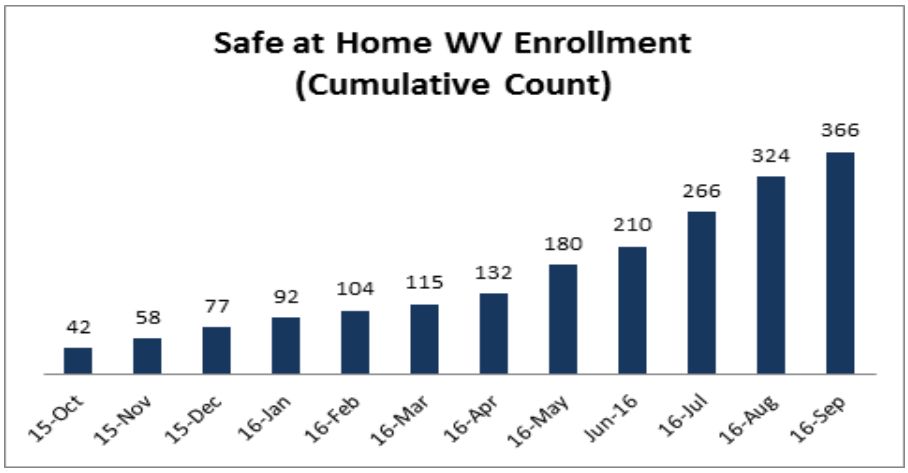
As of March 31, 2017, 662 Youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 41 Youth from out-of-state residential placement back to West Virginia, 114 Youth have stepped down from in-state residential placement to their communities, and 7 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 335 at risk youth. Please note that these numbers may differ from the outcome evaluation due to the tracking mechanisms. This information is reported by the local and Regional staff while the outcome evaluation pulls data from our SACWIS system which would be dependent upon data entry.

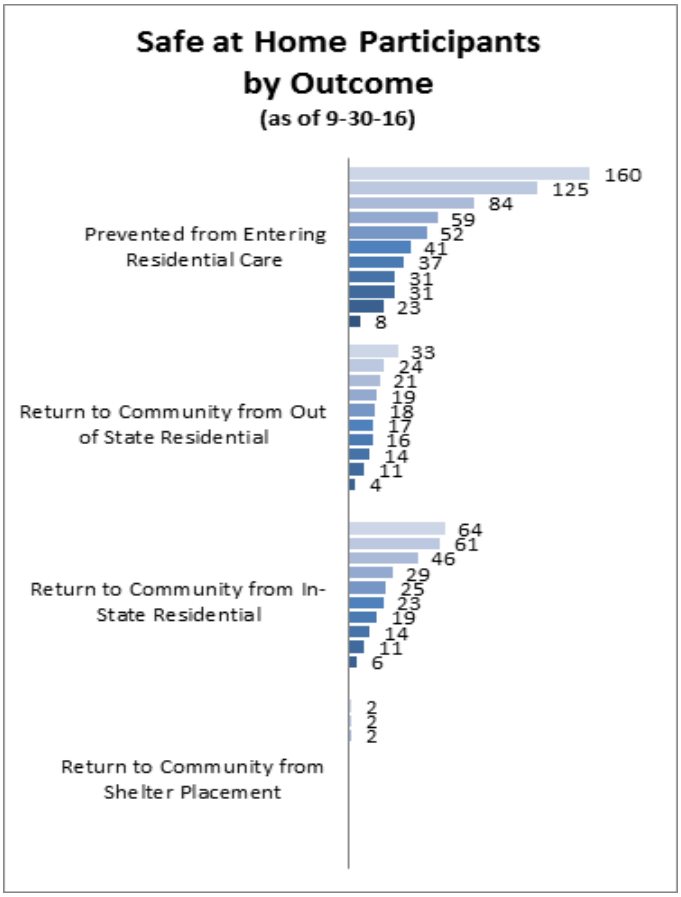
The breakdown of placement type at time of enrollment is as follows:

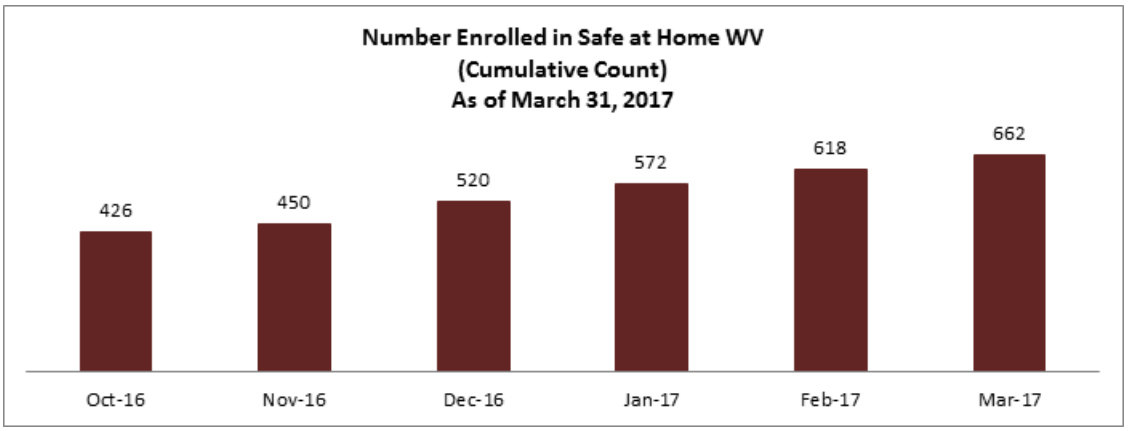
- 63 were or are in out-of-state residential placement
- 185 were or are in in-state residential placement
- 386 were or are prevention cases
- 28 were or are in an emergency shelter placement

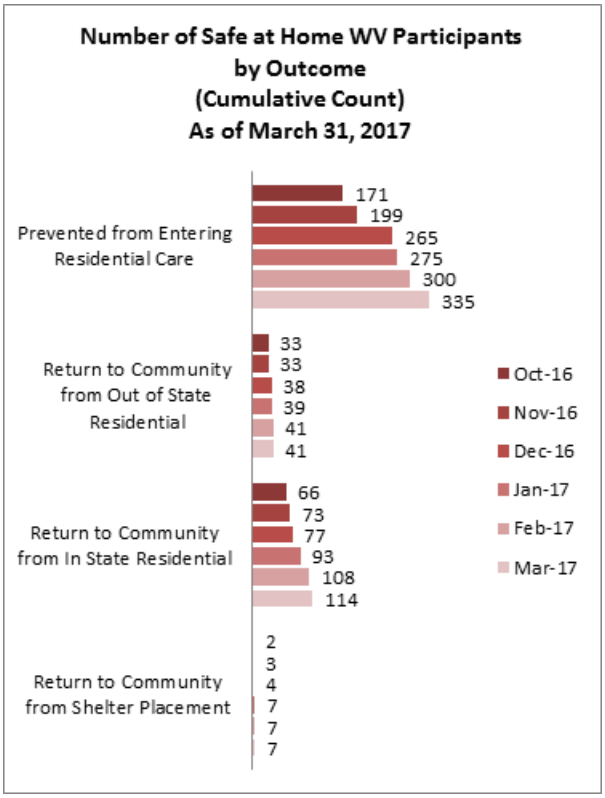

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
121
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar


Number of Safe at Home WV Participants by Outcome
Prevented from Entering Residential Care
37
31
31
23
8
Return to Community from In-State Residential
19
14
11
6
Return to Community from Out of State Residential
16
14
11
4
16-Mar
16-Feb
16-Jan
15-Dec
15-Nov


Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
115
132
180
210
266
324
366
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep


Safe at Home Participants
by Outcome
(as of 9-30-16)
Prevented from Entering Residential Care
160
125
84
59
52
41
37
31
31
23
8
Return to Community from Out of State Residential
33
24
21
19
18
17
16
14
11
4
Return to Community from In-State Residential
64
61
46
29
25
23
19
14
11
6
Return to Community from Shelter Placement
2
2
2


Number Enrolled in Safe at Home WV
(Cumulative Count)
As of March 31, 2017
426
450
520
572
618
662
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17


Number of Safe at Home WV Participants
by Outcome
(Cumulative Count)
As of March 31, 2017
Prevented from Entering Residential Care
171
199
265
275
300
335
Return to Community from Out of State Residential
33
33
38
39
41
41
Return to Community from In State Residential
66
73
77
93
108
114
Return to Community from Shelter Placement
2
3
4
7
7
7
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17

As part of our ongoing tracking and monitoring the Local Coordinating Agencies and the BCF Regional Social Service Program Managers turn in tracking forms that provide status updates on all cases. This also allows the identification of barriers to cases progressing.

Leading up to our first Safe at Home West Virginia referrals West Virginia developed a program manual and family guide as well as DHHR/BCF policies, desk guides and trainings. All staff and providers were provided with Wraparound 101 training, an overview of the wraparound process, Family and Youth engagement training that is part of our Family Centered Practice Curriculum, and CANS training. The West Virginia Department of Health and Human Resources (DHHR) instituted weekly email blasts that go out to all DHHR staff and our external partners. These email blasts focused on educating us on the 10 principles of Wraparound, family and youth engagement, and ongoing information regarding Safe at Home West Virginia. We also implemented a bi-monthly newsletter that reaches all of our staff and external partners, conducted presentations across the state as well as media interviews and private meetings with partners. These activities continue as specific to each phase of implementation and across the state. Our weekly email blasts and newsletters now reach over a 1,000 partners. All of our program materials, newsletters, as well as other pertinent information are posted on our website for public viewing and use.

During this reporting period West Virginia implemented the recommendations of our evaluator. This included the development of a professional white paper guiding the Local Coordinating Agency Clinical Supervisors in further professional development of the wraparound facilitators with regard to engagement. BCF developed a similar transfer of learning process for use by Child Protective Service Supervisors and Youth Service Supervisors to assist the professional development of BCF staff with regard to engagement. Our evaluator provided West Virginia with 4 case examples from the fidelity reviews they conducted during the previous reporting period. The 4 cases provided examples of successful case progression and outcomes that could be directly correlated to engagement. Those cases were used with staff during transfer of learning discussions.

West Virginia has worked with the Capacity Building Center for States to develop a strategic plan to support the wavier as well as other BCF initiatives and needs. The Capacity Building Center for States provided a marketing consultant to assist with the development of a 1 page informational document about Safe at Home West Virginia. The document is written in layman terms and is being utilized by the department as well as any of our partners to inform and solicit community level support for the youth and families being served through Safe at Home West Virginia. This document is available for public use and may be accessed and printed from the Safe at Home West Virginia Website, safe.wvdhhr.org. West Virginia took this learned skill and updated the one page flyer to be more current and also developed a one page flyer for use to guide the community on identifying youth in the target population and who to contact for possible referral to Safe at Home West Virginia.

During this reporting period West Virginia revised its concept of the Safe at Home West Virginia Advisory Team and their role and function. The Advisory Team is tasked with reviewing the Local Coordinating Agency Fidelity Review Summaries, provided by the independent evaluator, and request improvement plans as necessary, the tracking of improvement plans, reviewing of grant reports to monitor performance measures, as well as reviewing service invoices to assist with the identification of larger system gaps. The Advisory Team is also available for consultation with LCA's and DHHR staff to assist with barrier busting in difficult cases.

West Virginia's plan for implementation includes 3 phases with Phases 1 and 2 having begun on October 1, 2015 and September 1, 2016 respectively. Phase 3 is scheduled to implement on April 1, 2017.

In July 2015, in preparation for Phase 1 implementation, the Bureau for Children and Families released a request for applications for Local Coordinating Agencies to hire and provide Wraparound Facilitators. The grant awards were announced on August 25th. The grants provided startup funds for the hiring of wraparound facilitators and to assure a daily case rate for facilitation and flexible funds for providing the necessary wraparound services.

The Local Coordinating Agencies were allowed to hire their allotted wraparound facilitators in 3 cohorts. West Virginia believed this would be the best process to use to assure their ability to hire and train their staff as referrals began to flow.

For Phase 2 implementation the Bureau for Children and Families released a request for application for Local Coordinating Agencies to hire and provide Wraparound Facilitators on February 26, 2016. The grant awards were announced on March 28, 2106. West Virginia adjusted the grant awards based on lessons learned from Phase 1 implementation and required the Local Coordinating Agencies to hire their allotted positions prior to the implementation date. More time was allowed between the grant award date and the actual implementation of referrals in order to assure facilitators could receive required training.

This same process has been followed in preparation of Phase 3 implementation. At the time of this writing the grant awards have been made, all BCF and LCA staff trained and prepared for implementation. The same communication plan was implemented with staff and community partners. Case reviews and selection have followed the same process and referrals are prepared for implementation.

West Virginia held an "onboarding" meeting with the Phase 1 Local Coordinating Agencies on September 16, 2015, for the Phase 2 Local Coordinating Agencies on June 7, 2016, and for the Phase 3 Local Coordinating Agencies March 29, 2017 to assure consistency as we move forward. We then hold monthly meetings for the first 4 months and move to semi-monthly or quarterly. These meetings allow for open discussion and planning with regard to our processes and outcomes as well providing peer support and technical assistance among the agencies. Activities of this group include the updating of the wraparound plan form, updating the monthly progress summary, developing advanced training specific to the wraparound facilitation, working with our Grants division to update the quarterly grant report to simplify reflecting performance measures and outcomes, and implementation of evaluation recommendations.

In preparation for Phase 1 implementation the local DHHR staff began pulling possible cases for referral for review and staffing during the months of August and September so that the referral process could go smoothly and the first referrals sent to the Local Coordinating Agencies on October 1, 2015. For Phase 2 implementation this same process was used during the months of June and July to prepare for the first referrals that were sent on August 1, 2016. For Phase 3 implementation this same process was used during the months of February and March for the first referrals to be sent on April 1, 2017. We found this process to work well and it has been used in preparation for all implementation phases.

The Phase 1 initial startup grant period of 1 year expired on August 30, 2016. In preparation for this the Bureau for Children and Families prepared a provider agreement that includes all of the activities and requirements of the newest statement of work for Local Coordinating Agencies and Wraparound Facilitation as well as the Results Based Accountability outcomes and performance measures that are outlined in the grants. All 8 of the original Phase 1 provider agencies have signed the provider agreements to continue serving as Local Coordinating Agencies in the Phase 1 Counties.

CANS training and certification as well as Wraparound 101 training continue in the Phase 1 Counties to assure new staff hires have the required trainings while also moving to the Phase 2 and Phase 3 Counties. Wraparound 101 and CANS are now integrated into DHHR/BCF new worker training.

As of March 31, 2017 684 DHHR staff have been trained in CANS. Approximately 25 new Youth Service Workers have been trained since February 2017. This ongoing training continues as planned.

West Virginia also continues with the identification and certification of WV CANS Advanced CANS Experts (ACES) to provide ongoing training and technical assistance. West Virginia is finding that staff are having difficulty accessing advanced CANS experts to provide technical assistance. In order to address this Dr. Lyons came to West Virginia and spent a week with another 13 staff identified to go through the advanced CANS experts process. He will also be providing ongoing technical assistance calls with the experts in order to continue the development process. The goal has always been to have the internal capacity within West Virginia to continue this process and the transferring of learning. We believe that with the assistance of the current experts and Dr. Lyons we will have no difficulty proceeding as planned. At present we have 13 CANS experts with 7 providing certification training and the other 6 providing technical assistance.

West Virginia has also developed a plan for identifying all staff trained and certified, development of a training schedule based on identified need, technical assistance plan development based on identified need. Attached is the CANS Logic Model.

There are no significant changes in the design of our interventions to date but there have been innovations. During this reporting period a group of Local Coordinating Agency Directors and Clinical Supervisors with extensive experience with Wraparound have worked to develop an

advanced training for wraparound facilitators. We are referring to this training as "Applied Wraparound". At present the training is developed and ready to test. This training will address better engagement with families, how to problem solve and move a team forward, how to better write wraparound plans with measurable outcomes, as well as other identified needs. It is to be more focused on the actual application and practice of wraparound facilitation.

We are also working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and ongoing trainings in using the MAPs process. MAPs refers to Making Action Plans. The training helps facilitators understand the MAPs process and details and how to conduct a MAP and integrate it into a Wraparound Plan.

During this reporting period West Virginia has continued to follow the judiciary communication plan as developed last year. The plan simply calls for continued communication with our judiciary by combined teams of WV BCF management and LCA representation.

West Virginia also worked with our Evaluator, Hornby Zeller Associates, to create automated WV CANS. All Phase 1 DHHR and Local Coordinating Agency staff have been trained in the use of the automated WV CANS and have begun entering WV CANS and subsequent updates. West Virginia has been using the CANS since 2003. It has been updated to the WV CANS 2.0. WV CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the WV CANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; GLBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module. Staff continues to use the automated CANS and Local Coordinating Agencies continue to partner with the project director to assure that initial and subsequent CANS are complete on every youth enrolled in Safe at Home West Virginia.

Safe at Home West Virginia began implementation with the first referrals on October 1, 2015. The automated CANS data base did not become operational until February 12, 2016. During that time there would have been cases that already transitioned to closure for various reasons. There has been a learning curve with the wraparound facilitators navigating the system and remembering to save changes to the document. This explains any discrepancy regarding the number of youth enrolled and the number of initial CANS completed in the system. The Safe at home West Virginia project director continue to work with the Local Coordinating Agencies to monitor and assure CANS are completed on each child being served.

At present 572 CANS have been completed and entered into the automated system. This number represents initial and subsequent CANS. CANS are to be updated at minimum every 90 days.

The system has proven to be very useful for the use of the CANS across systems. The ability for staff to quickly locate and use existing CANS is very helpful in treatment planning and the ability for administrative staff to access needed reports has proven to be very useful. We foresee this becoming even more valuable as West Virginia moves forward with the use of CANS in treatment plan development.

Mentioned within West Virginia's Initial Design and Implementation reports is Senate Bill 393. This bill set forth very specific requirements regarding work with status offenders and diversion. West Virginia identified Evidence Based Functional Family Therapy (FFT) as a valuable service to the youth service population and their families as a diversion or treatment option. FFT is a short term (approximately four (4) months), high-intensity therapeutic family intervention. FFT focuses on the relationships and dynamics within the family unit. Therapists work with families to assess family behaviors that maintain delinquent behavior, modify dysfunctional family communication, teach family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. It is limited to youth 11-18 who have been charged or are at risk of being charged with either a status offense or a delinquent act.

West Virginia awarded a grant to a lead agency to facilitate service coverage and training throughout our state. Clinicians were trained throughout the month of March and are beginning to provide this valuable therapeutic service. FFT fits well within the wraparound process and has been identified as a very useful service for many of our families being served within Safe at Home West Virginia due to target population for FFT.

FFT is a well-established, evidence-based intervention model utilized in twelve (12) countries, including the United States. FFT has shown to reduce recidivism as much as 50%. It is one of the many therapeutic options that are available to youth and a family that may be served by the juvenile justice system, child welfare, and Safe at Home West Virginia.

With regard to analyses; the evaluator will separate them if the SACWIS system shows us whether the family got that service. If it does not, we can only obtain the information through

our case readings and the prevalence of FFT will determine whether we get any meaningful information out of it.

To further assist us with moving forward with Results Based Accountability, the outcomes included within the Local Coordinating Agency grant agreement statements of work are connected to the outcomes for Safe at Home West Virginia. All contracts and Provider agreements include provisions for training other wraparound team members with specialized roles, such as Peer Support Specialist, Parent or Youth Advocates, Mentors, and all wraparound team members outside of the Local Coordinating Agencies, and adherence to clear performance measures for families utilizing Safe at Home Wraparound. These performance measure outcomes will be linked to continuation of yearly contractual relationships between the Bureau and each Coordinating Local Agency. Responsibility for executing the duties of the contractual relationship with the Bureau rests with the Local Coordinating Agency, as well as development of an inclusive network of community providers in order to ensure youth and families receive services that are needed, when they are needed, and where they are needed. We continue to work with our Local Coordinating Agencies to assure that their workforce development meets West Virginia's needs.

Prestera Center's Chief Executive Officer Karen Yost continues to provide Trauma-informed Care training to individuals representing all child serving systems and the community at large. This training provides an overview of the incidence and prevalence of childhood traumatic experiences and describes the impact that trauma can have on a child's physical, social, emotional, cognitive and behavioral development. Also discussed are trauma and the brain, the definition of trauma-informed care as a systemic framework around which services are developed and provided, and the six core components of a trauma informed system of care. Currently, Trauma-informed care is being redesigned to be required core training for all providers and BCF staff. Ms. Yost has also been conducting train the trainer sessions throughout the state to assist with expanding West Virginia's internal capacity to continue with this valuable training.

During this reporting period BHHF has fully implemented its Children's Behavioral Health Wraparound. In March, 2016 the Bureau for Behavioral Health and Health Facilities (BHHF) released a Request for Applications for Grants for Local Coordinating Agencies to hire Wraparound Facilitators to serve 4 pilot areas of West Virginia. The BHHF pilot project is to provide high fidelity wraparound modeled after Safe at Home West Virginia, to children in parental custody and no involvement with the child welfare system. BHHF has worked closely with BCF to assure that the two programs are as similar as possible without overlap.

Several of the pilot areas are part of the Phase 1 of Safe at Home West Virginia and all but 1 of the grant awards were to Local Coordinating Agencies that are also serving Safe at Home West Virginia. At present they have expanded to consider referrals from counties surrounding the original pilot areas.

As discussed in West Virginia's Initial Design and Implementation Report we have worked with our out-of-home partners to make changes to our continuum of care. All of our provider agreements are being written to include performance measures. The updated provider agreements were all completed during the months of July and August 2016.

During this reporting period West Virginia developed a request for applications for lead agencies to develop Treatment Foster Care homes throughout the state. These grants have been awarded to lead agencies in all 4 of the BCF Regions and homes are in the process of development. This is discussed further in Section IV.

III. Evaluation Status

Data Collection Activities

Over the third six-month evaluation period following implementation of *Safe at Home West Virginia,* Hornby Zeller Associates, Inc. (HZA), the evaluator, conducted a second round of staff interviews with key stakeholders, including individuals from West Virginia's Department of Health and Human Resources (DHHR) and contracted Local Coordinating Agencies (LCAs). HZA also administered a survey to DHHR caseworkers and supervisors from Phase II implementation counties. Both of these data collection efforts inform the process evaluation.

Data from DHHR's Statewide Automated Child Welfare Information System (SACWIS), FACTS, were used to inform the outcome evaluation, along with data from the automated Child and Adolescent Needs and Strengths (CANS) tool. CANS data were used to measure progress on well-being measures while data from FACTS were used to measure safety and permanency outcomes. All data collection activities are discussed in greater detail below.

Interviews

During the week of November 14, 2016 staff from HZA completed a site visit to Phase I and II counties. The counties selected for inclusion for this round included Kanawha, Putnam, Cabell, and Berkeley from Phase I and Nicholas, Marion, Mineral, and Hampshire from Phase II. These counties encompass all four of the State's regions. Administrative staff from DHHR central and regional offices and county-level staff were interviewed along with staff from the contracted LCAs. Table 1 provides a breakdown of staff interviewed by their position within either DHHR or the LCAs. A total of 51 interviews were completed and used in the analysis.

Table 1. Staff Interviewed by Position	
DHHR Central Office Administrators	6
DHHR Regional Office Administrators	5
DHHR Supervisors	3
DHHR Caseworkers	15
LCA Program Directors	4

Table 1. Staff Interviewed by Position	
LCA Wraparound Supervisors	3
LCA Wraparound Facilitators	15
Total	**51**

Staff were asked questions about their role in the planning process (when applicable), including what changes have occurred between Phases I and II as well as staff readiness to implement *Safe at Home*. Interviewees were encouraged to share their observations of successes and challenges with the program, as well as their expectations for the near future. Responses were summarized, with distinctions made across staff position or phase when significant differences were evident.

Surveys

A second round of surveys was administered to DHHR caseworkers and supervisors in November 2016, this time to staff from Phase II implementation counties. Results from the same survey administered to DHHR staff from Phase I counties were reported in the previous semi-annual evaluation report. Given the timing of the Phase II roll-out, i.e., at the start of August 2016, additional time was allowed to pass before asking staff from Phase II counties to respond. Respondents provided their perceptions of the quality and effectiveness of services, what can be done to enhance them, the frequency with which they complete associated program responsibilities, and the functionality of multi-agency collaboration.

On November 28, 2016 the survey link was sent to community services managers from 21 of the 24 Phase II implementation counties to forward on to all caseworkers and supervisors involved with *Safe at Home*. The deadline to complete the survey was December 13, 2016 and on December 6, 2016 a reminder was sent to all community services managers to further encourage their staff to participate. A total of 28 staff responded to the survey, inclusive of 19 caseworkers and nine supervisors.

FACTS Data

HZA uses data from West Virginia's SACWIS, FACTS, throughout the evaluation to measure outcomes, e.g., reduced placement in congregate care, and to compare those outcomes to an historical comparison group of youth matched to those referred to *Safe at Home*. The comparison group was selected from youth known to DHHR between State Fiscal

Years (SFYs) 2010 to 2015 with characteristics similar to the youth comprising each of the three treatment cohorts. Cohorts are used for the analysis of outcomes and are comprised of youth referred to the program within the six-month reporting timeframes (see Table 2 below). A total of 644 youth have been referred to *Safe at Home* as of March 31, 2017.

Table 2. Youth Cohorts		
Cohort	Referral Period	Number of Youth
Cohort I	October 1, 2015 – March 31, 2016	124
Cohort II	April 1, 2016 – September 30, 2016	231
Cohort III	October 1, 2016 – March 31, 2017	289
Total	-	**644**

Demographic data, case history, and qualifying characteristics, such as involvement in mental health and juvenile justice systems, were used to match youth to the treatment group cohorts. Youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state congregate care facilities and group care; in-state congregate care facilities and group care; emergency shelters; family foster care placements; and youth at home. Cases selected into the comparison groups are statistically similar to those in the corresponding treatment groups (Appendix A).

CANS Data

During the first few months of program implementation, HZA developed an online CANS tool for LCA and DHHR staff to use. Because CANS is an online tool, it allows for ease of access and information sharing across participating agencies. Each youth that enters *Safe at Home* is expected to have an initial CANS assessment within 14 days of referral, and subsequent CANS assessments are performed every 90 days thereafter to measure youth progress over time. The online CANS tool provides the evaluation team ready access to assessment data to measure progress on well-being measures.

IV. Significant Evaluation Findings to Date

Process Evaluation Results

The process evaluation focuses on how *Safe at Home* has progressed in its second year of implementation, the differences that have taken place between Phase I and Phase II roll outs, the successes or challenges of the program, and what staff hope to see happen with the program in the near future.

Planning Process

According to DHHR central office staff, there were some differences in the way Phase I and Phase II rolled out. Changes reflected the lessons learned in implementing Phase I. In the first three months of the initial phase, the State had halted the program, pulled together a work group, made a 90 day work plan, expanded policy, updated manuals, clarified staff roles, and retrained staff. Much of the change that occurred in Phase I was attributed to evaluation findings, which showed that there was role confusion between caseworkers and wraparound facilitators. Administrators and county-level managers from Phase I met with county-level managers from Phase II to share their feedback and the lessons learned as the program was implemented.

The Request for Applications (RFA), which was issued to procure wraparound service providers, was revised for the Phase II roll out. The most significant change was in the "Statement of Work" by tightening the reporting requirements for LCAs. One LCA program director noted that applications seemed to have a fast turnaround of only two weeks for Phase II and that more time to prepare the application would have been beneficial.

Stakeholder and public outreach for Phase II was reported as being similar to Phase I, though with less intensity since the program has now been implemented for over a year. DHHR still publishes weekly email blasts to key stakeholders as well as to anyone who chooses to subscribe. These email blasts provide information on wraparound services as well as program updates. The *Safe at Home* website is updated regularly with relevant information, including program manuals, semi-annual evaluation reports, and the quarterly newsletter. In addition to publishing quarterly newsletters on the *Safe at Home* website, the newsletters are directly

emailed to every State legislator and judge and are always sent in email blasts as well. Routinely the State has also issued press releases about the program. *Safe at Home* is integrated into DHHR's ongoing activities and is frequently presented in larger meetings with community partners, e.g., court improvement meetings.

Transparency is a key strategy used by DHHR to engage local communities for the Title IV-E Waiver initiative. DHHR central and regional office staff provide presentations on the program for any organization that asks. The State also distributes the semi-annual evaluation reports to legislators to ensure they remain informed. *Safe at Home* program leaders conduct outreach with local and State partners through Facebook and Twitter. Additionally, *Safe at Home* has its own email address where central office staff can answer any questions about the program directly.

LCAs regularly report on the program at regional summits, meetings, and collaborative efforts across systems. LCAs are required to submit weekly updates to DHHR describing how each youth in the program is progressing. These weekly updates enable higher-level DHHR staff to provide feedback to both LCAs and county-level workers. LCAs have been, and continue to be, an integral part of the planning and development of the program in collaboration with the State.

Readiness for Change

For each phase, the State puts together a committee to evaluate grant proposals submitted by LCAs to provide wraparound services for *Safe at Home*. The grant process for Phase II was highly competitive and only the most qualified applicants received contracts. Once contracts are awarded, LCAs are held accountable for reporting on key factors. The *Safe at Home* Advisory Team performs intense quarterly reviews of all LCA contracts and reports, including an analysis of the fidelity reviews provided by HZA on an annual basis. The *Safe at Home* Advisory Team monitors service gaps and looks to see how LCAs are working to build capacity in these areas. If issues with an LCA arise, the *Safe at Home* Advisory Team engages the LCA with corrective action planning. Currently, the *Safe at Home* Advisory Team is working in collaboration with the State's Bureau for Behavioral Health to develop an Excel spreadsheet that will make the reporting process easier for LCAs and more quantifiable for the State. The *Safe at Home* project director monitors the LCAs on an ongoing basis.

To examine the readiness of county DHHR and LCA staff, HZA asked questions about how

well the program's goals and mission were understood. All LCA and DHHR staff had a solid understanding about the program's focus, purpose, and goals. Additionally, nearly all county-level DHHR and LCA staff spoke positively about the communication they were receiving from higher-level DHHR staff. Most LCA program directors were ready for the change of *Safe at Home*, largely because many of them were involved in Phase I. DHHR and LCAs are able to hold each other accountable through the weekly reports/updates on youth.

The greatest concern relating to readiness for program implementation involved the State's capacity to provide the necessary services for youth. Eight interviewees across the LCAs and DHHR shared concern about the service capacity, or lack thereof, in the more rural parts of West Virginia. One central office staff member stated, "Services are not consistent across the state. While things are ready in one county, they may not be in another." The top five services interviewees reported as lacking were: mentoring; psychological/psychiatric services targeting youth; substance abuse services targeting youth; transportation for youth/families; and activities for youth/teenagers such as recreational centers. It is noteworthy that of the top five service concerns, three were specific to the lack of specialization of the service to the unique needs of youth.

Generally, most LCAs did not have to make significant organizational changes to accommodate *Safe at Home*. The biggest change for all LCAs was in hiring wraparound supervisors and facilitators. A couple of LCAs opened additional offices to accommodate the growth in staff. Some also recognized the need for services in the community, and thus expanded what they offer. Examples include mentors, therapists, and crisis specialists. One LCA created its own documentation system specific to the program so data could be monitored by the LCA for continuous quality improvement. All LCA staff agreed that their agencies' overarching missions coincided well with that of the program. One LCA program director stated, "Our agency has always been at the forefront of helping families and is very family centered, so it was really easy for us to do this work."

In contrast, about one third of LCA staff reported that their agencies have struggled with turnover in wraparound facilitators. One LCA program director stated, "I have noticed because our wraparound facilitators are out in the field a lot and they are engaging with other agencies and DHHR, they are getting lured by other providers. They all are called up and recruited for a job elsewhere. I know a couple of them said no for a while until they just kept upping the money. It's good for them for the opportunity but it is hard to lose good people."

Some staff have witnessed a positive organizational shift in the way DHHR and LCAs engage families. One regional office interviewee shared, "I think it has changed the overall way we do business and what it means to involve families in case planning. Informal supports are better understood. I tell staff that we should be using the same concepts and supports we have built through *Safe at Home* regardless of whether or not the child or youth is in the program."

Training

Training has been a collaborative effort between DHHR and the LCAs. Currently, the State is planning refresher trainings which will coincide with the scheduled training for Phase III LCAs. Wraparound facilitators and caseworkers receive training together to ensure that all staff hear the same message. Based on some of the confusion among staff about their roles following Phase I training, three matrices were developed to help clarify the roles among parties. Separate matrices were developed for DHHR staff and wraparound facilitators to outline their respective roles. The third matrix outlined how the preparation/initial phase (e.g. when the youth is referred and new to the program) should be coordinated between the two.

Of the interviewees targeted in the training (DHHR caseworkers/supervisors and LCA wraparound facilitators/supervisors), approximately half reported that the training sufficiently prepared them for their work with the program. LCA staff were more likely to report satisfaction with the training than DHHR staff. Of the staff who were dissatisfied, some found the training to be too basic, only scratching the surface of the necessary information. This sentiment was echoed by a few respondents in the Phase II DHHR staff survey. A couple of staff from Phase I reported that the follow up training was beneficial in clearing up role confusion.

Of the Phase II DHHR staff who participated in the survey, all of the supervisors as well as 83 percent of the caseworkers received training about *Safe at Home*. Of the caseworkers who received training, 93 percent rated it as preparing them "Somewhat" or "Very Well" for their role in the program, along with 67 percent of supervisors. Eighty-three percent of caseworkers had a CANS certification, and all of them rated the training as "Somewhat" or "Very Well" in preparing them to use the assessment tool.

Interviewees provided feedback on how training could be improved. The most common suggestions shared were to provide:

- more nuts and bolts level training on specific documentation such as referral forms, wraparound plans, and general reporting requirements;
- further hands-on training on wraparound facilitator and caseworker boundaries and responsibilities, possibly with scenarios and/or roleplay;
- more time for open-ended discussion in the training, and;
- more ongoing training since both DHHR and the LCAs experience varying degrees of turnover, to ensure the true message of the program does not get lost.

Implementation

Referral and Casework Process

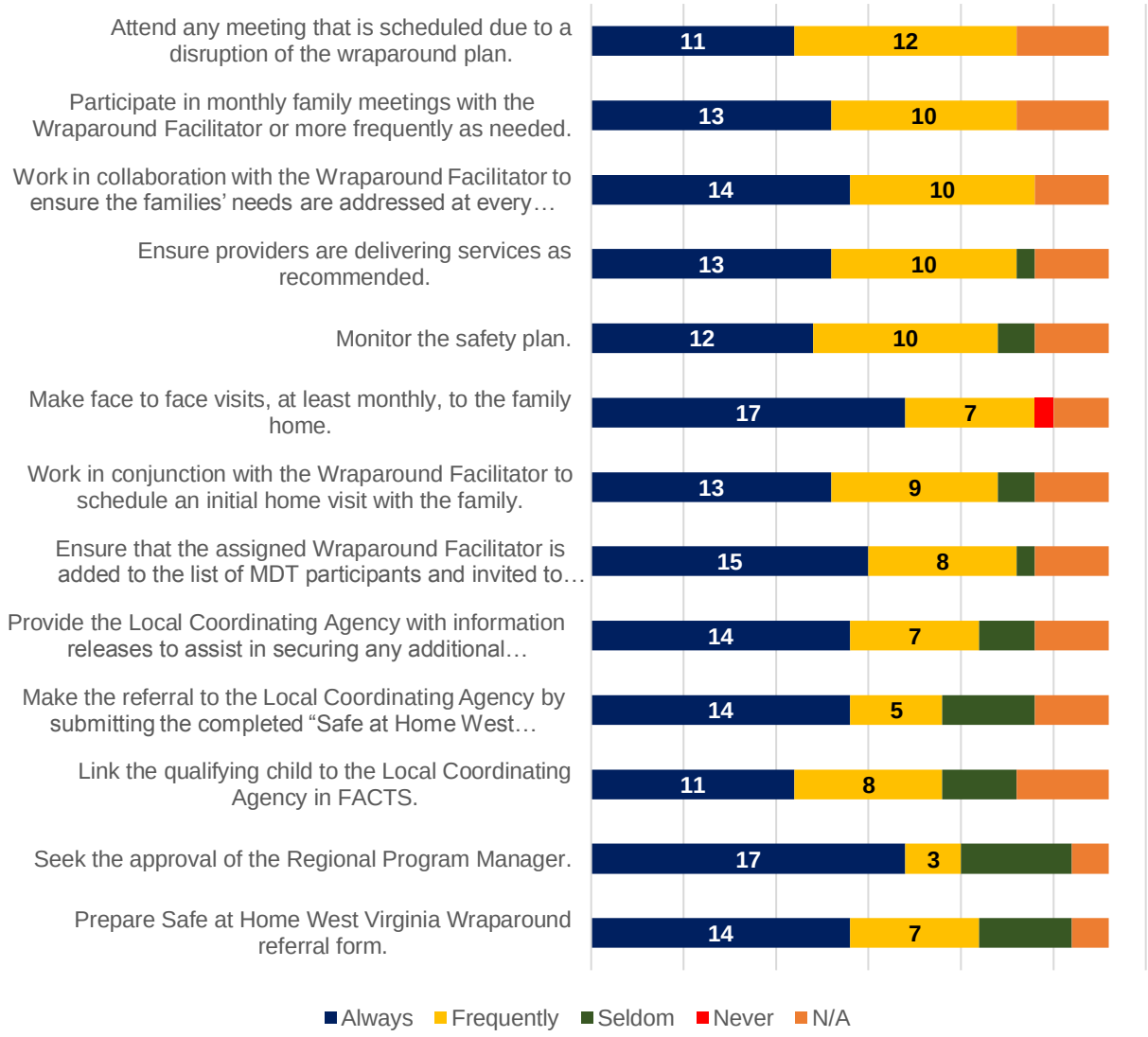
DHHR caseworkers are primarily responsible for referring youth to the program, so as one regional office staff member said, "It is critical to make sure staff understand the purpose of the program." DHHR caseworkers review the youth on their caseload to identify those who would best meet the criteria; those youth are then referred. The referral goes to the supervisor and then the region's program manager who makes the approval decision. Once the program manager approves the referral, it moves to a worker through the System of Care who assigns the youth to a LCA. The assignments are random, but done to ensure LCAs are receiving an equal amount of referrals. The referral process has not changed between Phase I and Phase II. One regional office interviewee stated that when s/he notices a slump in referrals, a reminder is sent to caseworkers in the Region to review all of their cases for potential program referrals.

Three DHHR caseworkers reported that it takes about two weeks to get the family approved for services, but that it seems to be taking a bit longer than two weeks lately. Three caseworkers also stated that the information on the referral form seems somewhat repetitive. One caseworker stated, "I think we could help to streamline the referral process so it could go a little faster, and maybe it would be useful to have an option to mark a referral as 'emergency' if there is a case that needs to be rushed through." A couple of LCA program directors and a couple of regional office staff noted that they have seen a decreased number of inappropriate referrals between Phase I and Phase II.

After the referral has been made, DHHR caseworkers have a variety of ongoing responsibilities as reflected in results of the staff survey. Figure 1 provides a breakdown of caseworker responsibilities for *Safe at Home* cases along with the frequency with which the 28

respondents (caseworkers and supervisors) reported completing them. Supervisors were asked to answer the questions in thinking about the work that their *Safe at Home* caseworkers conduct and caseworkers responded in reflection of their own *Safe at Home* casework practices. The N/A option is relevant when staff have not yet had any *Safe at Home* cases, case actions have not yet applied to their specific cases or the respondent chose not to answer the question. Desired responses, meaning the "Always" and "Frequently" survey options, have been emphasized for ease of reading.

Figure 1. Frequency of Caseworker Actions



The majority of staff reported that caseworkers "Always" or "Frequently" complete required *Safe at Home* casework tasks. It should be noted that some of these actions are conducted by supervisors, either because that is the way the process is designed or because the supervisor assumes responsibility for certain tasks to reduce the burden on caseworkers. Some of these tasks include: submitting the completed referral form, linking the youth to the LCA in FACTS, and seeking the approval of the Regional Program Manager.

The amount of time DHHR staff spent on *Safe at Home* cases varies from their non-*Safe at Home* cases: close to 75 percent of DHHR caseworkers and supervisors stated that more time is spent on *Safe at Home* cases which is due to weekly updates, more paperwork, more case consultation with LCAs, and more meetings to attend. However, some staff did state that *Safe at Home* cases would have required more time and attention regardless because these youth need a more intense level of involvement to be successful. Three caseworkers stated that they spend less time on *Safe at Home* cases because they have the assistance of the wraparound facilitator. One caseworker stated, "*Safe at Home* has really helped DHHR. Wraparound facilitators can have ten cases and can spend time with a kid and family. I have 50 cases and can only see a kid usually about once a month."

CANS assessments are used by wraparound facilitators to develop treatment plans to see what areas need improvement, what strengths can be built upon, and what services are most appropriate for the family. Five LCA staff reported that the CANS helps them to identify the youth's highest risk markers and it allows everyone involved in the case to monitor progress and remain updated. One LCA program director reported conflict with the CANS and *Safe at Home*, stating, "The CANS is used to identify high risk markers. This has been something I have been trying to grapple with myself. Usually if you hit those CANS' markers you work on it, but with the program, if the family doesn't want to work on it then you don't. So that has made it difficult for me to integrate the CANS into more of our work." A couple of LCA staff reported that the CANS provides a great opportunity to get to know the family better. However, one wraparound facilitator and two caseworkers reported that the assessments are not really used because the CANS tool is not helpful in case planning. One wraparound facilitator stated, "To be honest, I just use the same CANS on the subsequent one because it doesn't really change that much."

Most LCA staff reported no major issues in working with the CANS assessment itself or

the online tool. However, staff from one LCA stated they are required to enter the CANS into two reporting systems which can be quite time-consuming. Three people stated that the timeline of 14 days after referral to complete the initial CANS assessment was unrealistic. However, a central office staff member reported that the State is currently deciding whether or not the required timeframe should be changed to 30 days.

All caseworkers and wraparound facilitators reported that they are able to speak to their supervisor with ease. A few said they occasionally go up the chain and reach out to the county services manager or LCA program director. Interestingly, one caseworker shared that his/her county office has designated a staff person as an informal "*Safe at Home* expert" to whom all staff can use as a resource for questions or concerns. All LCA program directors reported that they reach out to the *Safe at Home* project director whenever issues arise. The vast majority of interviewees reported that issues have been resolved completely and in a timely manner. Only three wraparound facilitators reported that they have outstanding issues.

Safe at Home Youth

DHHR caseworkers believe about half their current caseloads would be a good fit for the program. Yet most caseworkers interviewed have only a couple to a few youth involved in *Safe at Home* despite fairly large caseloads. Of those youth currently in the program, DHHR caseworkers and supervisors and all LCA staff were asked to think about the systems with which youth were involved. A little over half of interviewees stated *Safe at Home* youth were involved in three systems simultaneously: child welfare, juvenile justice, and behavioral health.

Collaboration and Buy-In

Most DHHR supervisors and caseworkers expressed that they were well prepared to work with LCA staff, many due to their prior involvement with the LCAs. A few DHHR caseworkers and supervisors reported that working with the LCAs has been a "learn as you go" experience, which improves naturally as staff handle more *Safe at Home* cases. Most staff reported regular communication between DHHR caseworkers and wraparound facilitators, where the level was dependent on the needs of each particular case. In some cases, wraparound facilitators and caseworkers reported daily contact, in others a couple of times a week, and in some weekly. However, a small number of DHHR caseworkers reported that their involvement was dependent on the LCA and that some wraparound facilitators were not updating them on the case

frequently enough. One caseworker stated, “There is inconsistency among the agencies, such as, one agency gives constant updates and it feels like a team. Another agency doesn’t give a lot of updates, and with my third agency, you hear nothing.”

Six LCA staff reported that some caseworkers are great to work with, but that others can barely be reached and miss meetings or do not provide necessary information. While collaboration from the LCA staff perspective showed mixed results, nearly all interviewed stakeholders reported high levels of overall program buy-in and many believed the program would be able to achieve its goals, i.e., reduce the number of youth in congregate care as well as prevent youth from entering these placements.

DHHR caseworkers and supervisors were asked to gauge the extent to which they believe the program would be able to achieve its intended purpose. Other questions examine the effectiveness of wraparound services and multi-agency collaboration. Figure 2 displays responses of the 28 participants. Answers of “N/A” indicate staff do not have much experience with *Safe at Home* cases, the item has not been witnessed yet in practice, or the survey respondent chose not to answer. Desired responses, meaning the “Strongly Agree” and “Agree” options have been called out for ease of reading. Survey responses indicated that buy-in among caseworkers and supervisors is high due to the majority selecting “Strongly Agree” or “Agree” on every item.

Figure 2. Staff Perceptions of Safe at Home

Many stakeholders believe that the program's success is reliant upon the ability to have strong cross-systems partnerships. Central office staff spoke about how building those partnerships has been an ongoing process throughout implementation. DHHR central and regional office staff have put together presentations for stakeholders, such as faith based organizations, schools, and judicial partners, so they can have a general understanding of the program, what resources they can provide, and how they can help.

Interviewees reported that judges play a significant role in the ability to implement the program successfully because their decisions are vital to keeping youth in or returning them to their communities. Most stakeholders reported that some judges are huge supporters of the program, but that a few are highly resistant. One regional office staff member stated, "Judges are a tremendously important piece of the pie; they make all the final decisions. Their buy-in is hit and miss; there are judges who will ride the fence until we've sold them on the program, others that look for any opportunity to get the kids to stay in the community, and a few that get stuck on the extreme punitive actions and don't even look at our paperwork because they already think they know what's best for them."

Some stakeholders reported that judges have court-ordered youth into *Safe at Home*, and while this has been done with good intentions, it posed a concern since the program is supposed to be voluntary and based on youth/family voice and choice. One central office staff member stated, "I think *Safe at Home* is hard to grasp when you have been *telling* folks what needs to happen and now we are shifting to *asking* folks what needs to happen." Some staff were concerned about having even one or two judges openly opposing the program, because those judges preside over large geographic areas or areas densely populated with youth who could benefit from the program.

Successes, Challenges, and Hopes

Staff's perceptions of the program's most significant successes so far varied greatly, but the top ten have been synthesized in Table 3. Stakeholders highly revere the wraparound model as a chosen service for youth.

Table 3. Top 10 Successes Reported by Staff	
Success Sentiment	Respondents
The service as a whole has been working well and the overarching model of wraparound has been successful.	16
The program has created a changed/improved environment for working with families.	11
We are now actually looking for what youth want and allowing them to build their support system.	11
We have built great partnerships and there is a lot of cross-system collaboration that is working well.	10
There is great communication between DHHR and LCAs.	9
Families report that they have more support and have become more knowledgeable about available services.	9
The program allows us to think and spend outside the box.	8
The use of informal supports has been successful.	8
Youth have more services and options available to them.	7
Families are becoming empowered through the program.	7

Speaking generally about the program's success, one regional office administrator stated, "We have seen kids graduate who weren't even going to school before." A caseworker commented on a case that, "I have had one extremely successful case. This youth was suicidal and he's doing so well, he is now starting to take some college courses. He wouldn't be at this point if he had been put in residential care." When asked what they believed was working well with *Safe at Home*, the most common response among staff was that it has been especially beneficial to have "an extra set of eyes" in the home, making for better supervision of the case.

Interviewees were also asked to share the greatest challenges they have faced with the program; Table 4 provides a summation of the top ten responses. Interestingly, many were particularly worried about the impact new administrations could have on the program, especially as it related to funding. While one regional office administrator was concerned with the presidential election, s/he had hope stating, "I am anticipating with the new presidential election that we may lose a lot of programs, but I think *Safe at Home* leaves us in a better place for that because we are building capacity within the family to rely on atypical supports as opposed to the more formal ones that cost a lot of money."

Table 4. Top 10 Challenges Reported by Staff	
Challenge Sentiment	Respondents
There is insecurity about what impact newly elected officials at federal, state, and local levels, will have on the program.	20
Communication between DHHR and the LCAs could improve.	9
It has been hard to ensure that there are adequate services available, particularly in the more rural areas.	9
Staff are particularly worried about how the new President may impact the program, e.g., funding cuts.	8
It can be a challenge to coordinate everything (e.g. initial visit, monthly meetings, MDT, court, etc.) with so many different schedules.	6
The overall economy in West Virginia has been a struggle which could impact a variety of areas; such as losing staff at DHHR and LCAs, and seeing the closure of businesses and facilities.	6
Both LCAs and DHHR seem to struggle with turnover and hiring.	6
The substance abuse crisis makes it a challenge to keep youth in their homes and away from bad influences.	5
Families lack transportation and/or transportation services are hard to access.	5
Youth/family engagement needs improvement.	5

Regarding turnover, one caseworker stated, “Any social service job has that retention problem, but families may lose faith in the program with a rotating door of workers.” One wraparound facilitator on his/her last two weeks with the LCA stated, “My issue was I was working more than 40 hours and I have kids and was spending more time with my clients than my own children. As my children get older I would like to come back to this, but as of now I am leaving the company for this reason.”

In speaking about the concern with service capacity, a LCA program director stated, “I think we kind of put the cart before the horse with this program because we started it before services were in place so there were rural areas that had no services and they now have to travel for services. I would have liked for the services to be in place before we rolled the program out; services in rural counties are a big concern.” This sentiment was echoed by a few DHHR staff in the survey who reported that an expansion of the service array would be essential to program

success, particularly in rural areas.

Staff were also asked what they hoped the initiative would achieve in the short-term, e.g., six months. Similar to Tables 3 and 4, Table 5 summarizes the most common responses. There was less commonality among the responses related to staff hopes for the program. However, many were hopeful that the program would prevent more youth from ever entering placement.

Table 5. Top 10 Hopes Reported by Staff	
Hope Sentiment	Respondents
It would be great to see more youth prevented from entering placement.	11
Judges will see more success stories and be more willing to buy in and work with the program.	9
There will be a greater reduction in congregate care usage.	8
There will be more youth living in their home communities.	6
The program will become available to younger children.	5
There will be an increase in youth returning directly home from congregate care placements.	5
There will be more success stories and program graduations.	5
There will be more qualified youth referred to the program.	3
More LCAs will become involved as time goes on.	3
Youth/family voice and choice will become the new culture among DHHR and LCAs regardless of whether a client is receiving the service.	2

In speaking about youth/family voice and choice becoming a shifting culture for DHHR and LCAs, one wraparound supervisor stated, "Voice and choice is working well. Sometimes families know what they need better than the agency does. I think we are now realizing that we should have simply been listening better all along."

Summary of Process Evaluation Results

There were not many changes in program implementation between Phase I and Phase II. This was due largely to the State making changes early on in Phase I which were replicated in Phase II to avoid similar pitfalls. The biggest concern among staff (as gathered from both the interviews and survey) regarding readiness was related to service capacity throughout the State, particularly in the more rural areas. Staff identified five services where capacity needs to be built:

mentoring, therapy/psychological/psychiatric services targeting youth, substance abuse targeting youth, transportation, and general activities or "hang out spots" where youth can gather to socialize. Turnover was also a concern for both DHHR caseworkers and LCA wraparound facilitators.

Staff see the beginning of a positive culture shift in the way both DHHR and LCAs "do business" throughout the State, regardless of whether or not clients are involved in *Safe at Home*. Youth and family input is becoming increasingly valued and prioritized, and creative solutions are often sought. Additionally, it was apparent in both interview and survey data that staff buy-in for the program was high.

About half of the staff reported that the training has been sufficient. The most common suggestion for future training is providing more "nuts and bolts" training related to the concrete requirements of the job for both caseworkers and wraparound facilitators. When asked to think about their caseloads, the majority of caseworkers and wraparound facilitators reported that youth are involved in three systems simultaneously: juvenile justice, child welfare, and behavioral health. Most DHHR caseworkers reported that they spend more time on *Safe at Home* cases in comparison to other case types. However, some staff did state that *Safe at Home* cases would have required more time and attention regardless of whether or not the program existed because these youth need a more intense level of involvement in order to be successful. Staff seem to be administering the CANS regularly and without significant issue, but a few did not see the value in the assessments.

Collaboration between DHHR and LCA staff appear to be a mixed bag, where it was often reported as a program strength as well as a challenge. Working with judges was also reported as either a strength or challenge. Staff frequently reported that because judges control placement, having even one or two not on board has been detrimental. Moving forward, staff are especially interested in seeing more successful prevention cases involved as well as an increased number of judges supporting the program; many staff observed that the two go hand in hand. Interestingly, many interviewees were concerned about how changing federal and state administrations may impact the program, particularly as it relates to funding.

Outcome Evaluation Results

Youth Population

Referrals to *Safe at Home* have been made for 644[2] youth statewide as of March 31, 2017. For the analysis of outcomes, youth are divided into six-month cohorts based on referral date. Cohort I is comprised of youth referred to the program between October 2015 and March 2016 and consists of 124 youth. Cohort II consists of youth referred to the program between April 2016 and September 2016 and is comprised of a total of 231[3] youth. Cohort III is comprised of 289 youth referred to the program between October 2016 and March 2017. Since youth in Cohorts I and II have been in the program for at least six months, greater emphasis is placed on these youth because sufficient time has passed to measure outcomes.

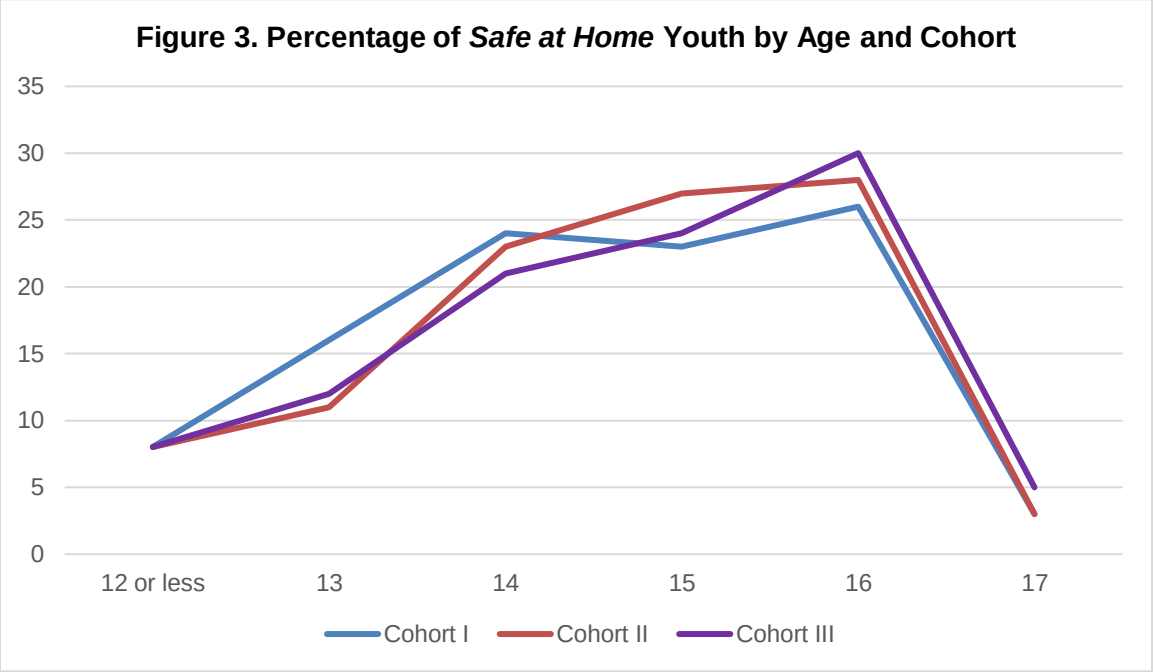
Table 6 below provides a breakdown of where youth were placed at the time of referral to *Safe at Home*, listed from the most restrictive to least restrictive setting for each cohort. Youth living at home who are at risk of congregate care placement are the most common among youth referred for all three cohorts. Preventive at home referrals comprise 55 percent of all *Safe at Home* referrals. With each cohort the percentage of youth in congregate care at referral is smaller; this includes 56 percent of Cohort I youth, 42 percent of Cohort II youth, and only 27 percent of Cohort III youth.

Table 6. Youth Placements at Referral			
Referral Placement	Cohort I	Cohort II	Cohort III
Out-of-state Congregate Care	30	20	13
In-state Congregate Care	39	76	61
Emergency Shelter	5	18	6
Family Foster Care	2	11	7
Home	48	106	202
Total	**124**	**231**	**289**

Figure 3 represents the percentage of youth referred by age within each of the three

[2] The numbers of youth reported by HZA and the State may differ slightly. This is because the State utilizes weekly tracking logs and HZA relies on FACTS extracts for data.
[3] There are 25 more youth in Cohort II in this evaluation report than there were in the previous report; this is likely due to delayed data entry.

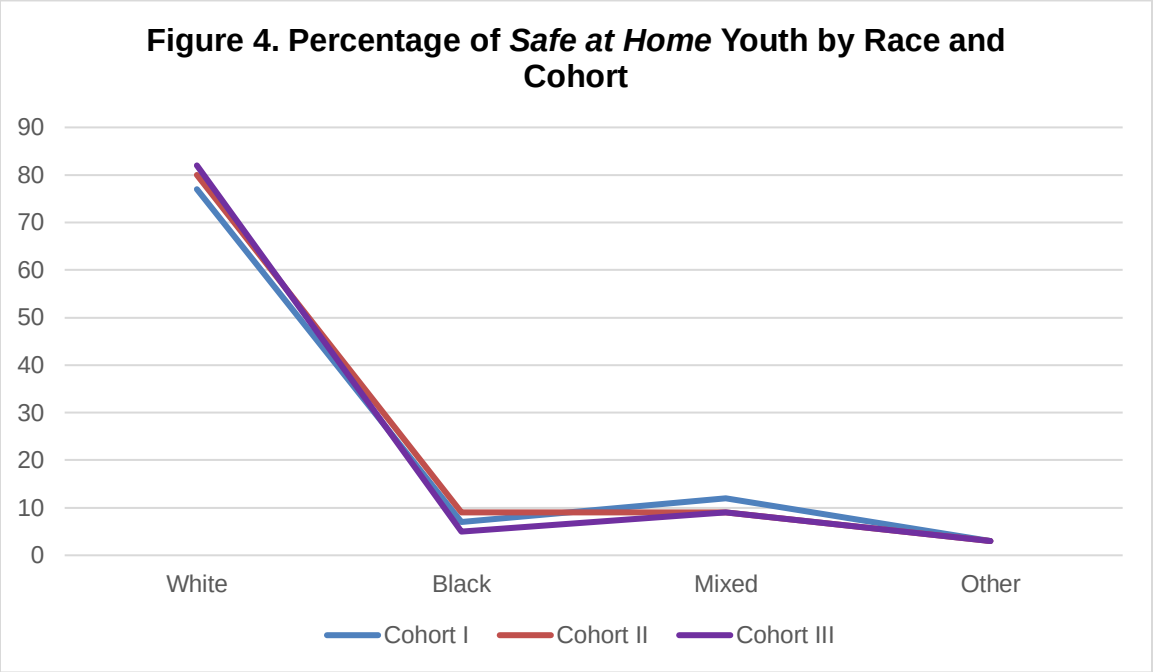
cohorts. Referrals can be made for youth between the ages of 12 and 17. As demonstrated below, 16 was the most common age of youth referred in all three cohorts, and there were no major differences among cohorts in regard to age at referral.



Sixty-two percent of youth referred in Cohorts I and III were male; 52 percent of the youth in Cohort II were male. Gender disproportions were highest among youth referred when placed in out-of-state congregate care, where males made up at least 80 percent of the population in each cohort.

Figure 4 provides the reported races of youth in *Safe at Home* by cohort. The majority

were white in all three cohorts.



Using data from FACTS, a matched comparison group was selected using a statistical technique called Propensity Score Matching (PSM). The comparison pool is drawn from youth who meet the Safe at Home referral criteria (age 12-17 with a mental health diagnosis in out-of-state or in-state congregate care or at risk of entering this type of placement) during SFYs 2010 through 2015. Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, count of years since the case opened, report allegation, number of prior placements, evidence of an axis one diagnosis, and if the youth was ever in a jail, psychiatric hospital, or group home. These scores were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to the treatment group (Appendix A). Six and twelve month outcomes were analyzed for youth in Cohort I; given the amount of time which has elapsed for youth in Cohort II, the analysis is limited to six month outcomes.

Youth Placements

This section of the report examines placement shifts of all *Safe at Home* youth from Cohorts I and II. Table 7 shows the placements of youth from Cohorts I and II at referral and six months[4] after referral.

Table 7. Youth Placements at Referral and Six Months							
		Placement at 6 Months					
		Out-of-state Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	Total at Referral
		Cohort I					
Placement at Referral	Out-of-state Congregate Care	10	4	1	2	13	**30**
	In-state Congregate Care	1	11	3	2	21	**38**
	Emergency Shelter	0	2	0	0	2	**4**
	Family Foster Care	0	2	0	0	0	**2**
	Home	6	6	3	0	32	**47**
	Total at Six Months	**17**	**25**	**7**	**4**	**68**	**121**
		Cohort II					
	Out-of-state Congregate Care	3	2	1	0	14	**20**
	In-state Congregate Care	3	26	4	2	41	**76**
	Emergency Shelter	0	6	4	3	5	**18**
	Family Foster Care	0	2	2	4	3	**11**
	Home	0	10	3	2	90	**105**
	Total at Six Months	**6**	**46**	**14**	**11**	**153**	**230**

Fewer youth were in an out-of-state or in-state congregate care placement and an increased number of youth were living at home six months following referral for both Cohorts I

[4] Three of the youth from Cohort I were rendered ineligible in FACTS at six months because they were placed in detention centers. This was also the case for one youth from Cohort II.

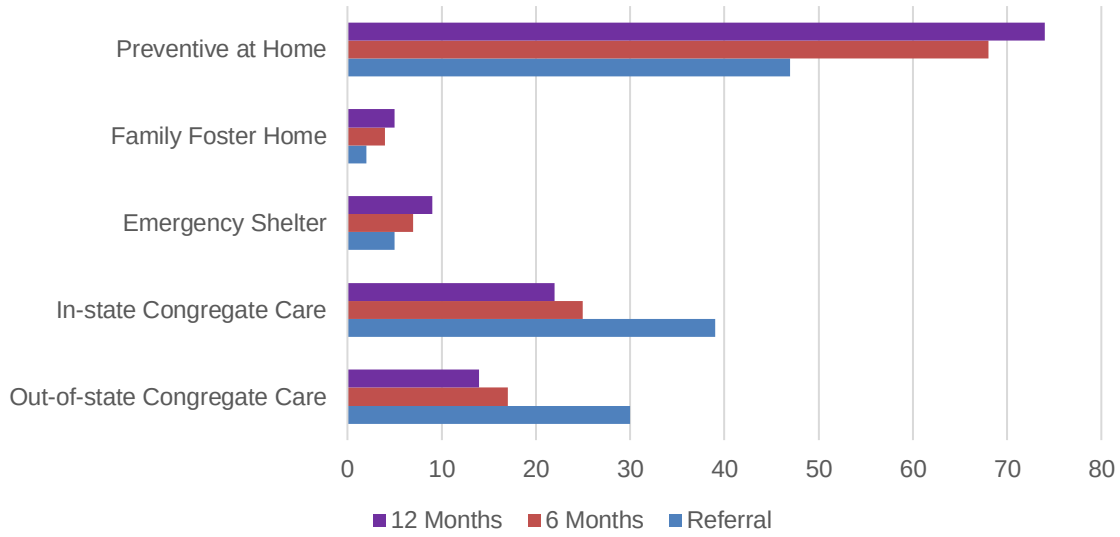
and II. Nearly half the number of youth referred to *Safe at Home* in Cohort I were in out-of-state congregate care six months following referral while the number of youth living at home increased by 45 percent. For Cohort II, there was a 70 percent reduction in the number of youth living in out-of-state congregate care at six months as well as a 39 percent reduction of youth living in in-state congregate care.

In Table 8, Cohort I offers an opportunity to examine the placement of youth one year following referral to *Safe at Home*.

Table 8. Cohort I Youth Placements at Referral and Twelve Months							
		Placement at 12 Months					
		Out-of-state Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	Total at Referral
Placement at Referral	Out-of-state Congregate Care	5	4	3	2	16	**30**
	In-state Congregate Care	3	8	3	2	23	**39**
	Emergency Shelter	0	2	0	0	3	**5**
	Family Foster Care	0	0	1	0	1	**2**
	Home	6	8	2	1	31	**48**
	Total at 12 Months	**14**	**22**	**9**	**5**	**74**	**124**

The number of youth in out-of-state or in-state congregate care continued to decrease, while those living at home continued to increase. At the time of referral, 39 percent of the youth from Cohort I were living at home, and at twelve months, 60 percent were living at home. Figure 5 provides a visual summation of the placement status of Cohort I youth at referral and six and twelve months following referral.

Figure 5. Cohort I Youth Placements at Referral and Six Months and Twelve Months following Referral



Congregate Care

Safe at Home has multiple objectives. In addition to avoiding out of state placement, *Safe at Home* is designed to prevent the placement of youth in higher levels of care and reduce the reliance on congregate care. To examine the impact the program has had on preventing placement into congregate care, the placement settings of youth placed in a lower levels of care for both the treatment and comparison groups were examined six and twelve months following referral. Larger percentages of youth in the treatment group for Cohort I were placed in congregate care six and twelve months following referral, while a smaller percentage of youth in the treatment group for Cohort II incurred a placement into congregate care six months following referral. However, none of the results shown in Table 9 is statistically significant

Table 9. Percentages of Youth from Lower Levels of Care to Congregate Care

Cohort	Group	Number Referred to a Lower Level	Percent in Congregate Care at 6 Months	Percent in Congregate Care at 12 Months
1	Treatment	55	36	47
	Comparison	55	**31**	**45**
2	Treatment	135	**22**	-
	Comparison	123	30	-

A rate of congregate care re-entry was calculated by looking at the percentage of youth

who were in congregate care and moved to a lower level of care and then subsequently moved back to congregate care within six or twelve months of moving to a lower level of care; this is displayed in Table 10. *Safe at Home* youth from Cohort I re-entered congregate at a higher rate than comparison youth at six and twelve months post-congregate care discharge. However, fewer *Safe at Home* youth from Cohort II re-entered congregate care within six months than did their comparison counterparts. None of these results were statistically significant.

Table 10. Rate of Congregate Care Re-Entry Within 6 and 12 Months			
Cohort	Group	Percent of Re-Entry at 6 Months	Percent of Re-Entry at 12 Months
1	Treatment	45	63
	Comparison	**32**	**36**
2	Treatment	**49**	-
	Comparison	59	-

Safe at Home has a concurrent goal of reducing the length of stay in congregate care. Table 11 identifies the average number of days youth spent in congregate care. *Safe at Home* youth from both cohorts spent fewer days in congregate care within six and twelve months of referral than youth from the comparison group at a statistically significant rate (all results at $p<.01$).

Table 11. Average Length of Stay in Congregate Care Within 6 and 12 Months			
Cohort	Group	Average Days in Congregate Care Within 6 Months	Average Days in Congregate Care Within 12 Months
1	Treatment	**100**	**168**
	Comparison	156	229
2	Treatment	**83**	-
	Comparison	129	-

Home Counties

One of *Safe at Home's* goals is to increase the number of youth living in their home communities. To measure the extent to which this goal has been achieved, movements of youth leaving their home counties and returning to them are examined. These results are provided in Table 12.

Table 12. Youth County Movements Within 6 and 12 Months			
Cohort	Group	Percent Within 6 Months	Percent Within 12 Months
From Home-County to Out-of-County			
1	Treatment	27	37
	Comparison	**20**	**33**
2	Treatment	**17**	-
	Comparison	20	-
From Out-of-County to Home-County			
1	Treatment	**39**	**44**
	Comparison	36	37
2	Treatment	**45**	-
	Comparison	28	-

While a smaller percentage of youth from the comparison group moved out-of-county from Cohort I, there were more *Safe at Home* youth from both cohorts returning to their home-counties at six and twelve months following referral, with 44 percent of the youth from Cohort I living in their home counties at twelve months and 45 percent of the youth from Cohort II doing so at six months. The results are statistically significant for Cohort II at six months ($p<.05$).

Foster Care

Safe at Home has a couple of goals related to foster care: first, reduce the percentage of youth who need placement outside the home; and second, reduce the percentage of youth who re-enter following discharge to their homes. Table 13 looks at initial foster care entries after referral. Between Cohort I and Cohort II, the percentage of youth placed into foster care within six months following referral decreased for both cohorts. The percentage of youth who were removed from their homes within twelve months was higher for the treatment and comparison

groups from Cohort I, although the percentage was smaller for the comparison group. The results are not statistically significant.

Table 13. Percent of Initial Foster Care Entries Within 6 and 12 Months				
Cohort	Group	Percent Home at Referral	Percent With Initial Foster Care Entry Within 6 Months	Percent With Initial Foster Care Entry Within 12 Months
1	Treatment	40	38	52
	Comparison	39	**30**	**45**
2	Treatment	46	**26**	-
	Comparison	41	33	-

Table 14 displays the rate at which youth re-entered out-of-home placement at six and twelve months following discharge. For both cohorts, the foster care re-entry rate is quite similar for the treatment and comparison groups at six months; however, at twelve months a statistically significant lower percentage of *Safe at Home* youth from Cohort I re-entered foster care ($p<.05$) when compared to youth in the comparison group.

Table 14. Rate of Re-Entry into Foster Care Within 6 and 12 Months			
Cohort	Group	Rate of Foster Care Re-Entry (%) Within 6 Months	Rate of Foster Care Re-Entry (%) Within 12 Months
1	Treatment	7	**8**
	Comparison	**10**	25
2	Treatment	**10**	-
	Comparison	11	-

Maltreatment

The initiative aims to increase youth safety by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 15 displays the number of youth with a maltreatment referral subsequent to referral to *Safe at Home* and the number for which an investigation was conducted, within six and twelve months of referral. This measure showed positive results for *Safe at Home* youth in both Cohorts I and II, with nearly all results found to be statistically significant (most at p<.01). For both cohorts, fewer *Safe at Home* youth had a maltreatment referral or an investigation than did youth in the comparison groups.

Table 15. Number of Youth with a New Referral or Investigation within 6 and 12 Months					
Cohort	Group	New Referral Within 6 Months	New Investigation Within 6 Months	New Referral Within 12 Months	New Investigation Within 12 Months
1	Treatment	2	2	2	2
	Comparison	9	6	14	11
2	Treatment	5	2	-	-
	Comparison	29	10	-	-

Youth Well-Being

The CANS tool provides an assessment of youth's strengths and needs which is used to support decision making, facilitate service referrals, and monitor the outcomes of services received. By utilizing a four level rating system (with scores ranging from 0 to 3) on a series of items used to assess specific domains, such as Child Risk Behaviors or Life Domain Functioning, the CANS helps wraparound facilitators and DHHR caseworkers identify needs/actionable items (e.g., those with a score of 2 or 3), which show where attention should be focused in planning with the family.

Wraparound facilitators from LCAs are primarily responsible for administering the CANS assessments to youth in the program. Once CANS assessments are completed by the wraparound facilitators, they are to be entered into the online WV CANS. Youth in the program are supposed to receive an initial CANS assessment within 14 days of referral and subsequent CANS are to be performed every 90 days thereafter.

A total of 309 *Safe at Home* youth had at least two CANS assessments completed, i.e., an initial CANS and at least one subsequent CANS. For purposes of this report, the results of initial CANS assessments for youth from Cohort I are compared to those at six and twelve months post-referral to determine progress while in the program, with the results limited to six months for youth from Cohort II. Progress is measured by the extent to which scores have improved, meaning needs/actionable items have been reduced over time. As shown in Table 16, CANS assessments available for analysis become more limited as time goes on. This is due to a variety of factors, including: inappropriate referral (for example, youth may not meet the age requirement), youth placements into a detention center, or cases close prior to six months because families decline participation or there is an inability to secure placements for youth.

Table 16. Youth With CANS Assessments Available for Analysis		
	Cohort I	Cohort II
Number of Youth with Initial CANS Assessment	85	169
Number of Youth with a 6 Month Follow-Up CANS	49	60
Number of Youth Discharged Before a 6 Month Follow-Up CANS can be Performed	26	24
Number of Youth Where Enough Time Has Passed & No 6 Month CANS Was Performed	8	0
Number of Youth with a 12 Month Follow-Up CANS	14	-
Number of Youth Discharged Before a 12 Month Follow-Up CANS can be Performed	53	-

Table 17 provides an overview of the percentage of youth with at least one need/item

selected in the domain at entry into the program. For a closer look at the needs on specific items within each domain, please see Appendix B.

Table 17. Percentage of Youth with an Actionable Item/Need in the Initial CANS Assessment		
CANS Domain	Cohort I (N=85)	Cohort II (N=169)
Behavioral/Emotional Needs	81	77
Child Risk Behaviors	48	43
Life Functioning Needs	96	91
Symptoms of Trauma	48	43

For both cohorts, 96 percent of youth had at least one actionable item in the Life Functioning Needs domain followed by 81 percent of youth in the Behavioral/Emotional Needs domain.

Table 18 shows the percentage of youth who had a six or twelve month follow up CANS and who also reduced at least one need in the domain (i.e., at least one item in the domain had gone from actionable to non-actionable or was no longer a need). Appendix C provides a breakdown of these results at the CANS item level.

Table 18. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6 or 12 Month Subsequent CANS		
CANS Domain	Youth with Improved Scores 6 Months Post-Initial CANS	Youth with Improved Scores 12 Months Post-Initial CANS
Cohort I		
Behavioral/Emotional Needs	51	92
Child Risk Behaviors	45	67
Life Functioning Needs	61	92
Symptoms of Trauma	40	75
Cohort II		
Behavioral/Emotional Needs	61	-
Child Risk Behaviors	68	-
Life Functioning Needs	69	-
Symptoms of Trauma	59	-

Looking at the domain which showed the most need upon initial assessment, i.e., Life

Functioning Needs, 61 percent of the youth from Cohort I showed a reduction in at least one item at six months; the same was true for 69 percent of youth in Cohort II. At twelve months, the reduction in need in the Life Functioning Needs domain for youth in Cohort I show a marked improvement with 92 percent of the youth having improved their scores within the domain. Interestingly, Life Functioning Needs seem to show the greatest reduction in needs overall for both cohorts; suggesting that while these are the most common needs identified, they are also the ones in which the program has been able to address most effectively.

Family Functioning

Progress in family functioning was analyzed by looking at the Family Functioning domain which is also broken down into specific items within the domain. Table 19 below displays the results.

Table 19. Number of Youth With Improved Scores in the Family Functioning Domain at 6 & 12 Months

CANS Items	Number of Youth With Need on Initial CANS	Number of Youth With a 6 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 6 Months After Initial CANS	Number of Youth With a 12 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 12 Months After Initial CANS
Cohort I					
Physical Health	5	1	1	1	1
Mental Health	2	2	0	1	1
Substance Use	1	1	1	1	1
Family Stress	23	17	10	4	4
Residential Stability	7	4	3	2	1
Total	**28**	**18**	**11**	**5**	**4**
Cohort II					
Physical Health	15	5	2	-	-
Mental Health	5	1	1	-	-

Table 19. Number of Youth With Improved Scores in the Family Functioning Domain at 6 & 12 Months					
CANS Items	Number of Youth With Need on Initial CANS	Number of Youth With a 6 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 6 Months After Initial CANS	Number of Youth With a 12 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 12 Months After Initial CANS
Substance Use	5	3	2	-	-
Family Stress	28	10	3	-	-
Residential Stability	10	3	2	-	-
Total	**44**	**15**	**6**	**-**	**-**

Family Stress was identified as the most common need item for youth in both cohorts on the initial CANS, followed by Residential Stability. By six months, 59 percent of the youth in Cohort I saw a reduction in Family Stress; the same was true for 30 percent of youth in Cohort II. At six months Residential Stability was reduced for three of the four youth in Cohort I with this need and the same was true for two of the three youth in Cohort II.

The numbers available at twelve months for youth in Cohort I are quite limited. However, of the four youth who had identified Family Stress as a need on the initial CANS and had a twelve month follow-up, none of them had Family Stress identified as a need at twelve months.

Summary of Outcome Evaluation Results

In looking at overall placement shifts for youth in *Safe at Home,* a smaller percentage of youth were in either out-of-state or in-state congregate care for both cohorts at six months post-referral; there was even a smaller percentage in such a setting for youth from Cohort I at twelve months. There were also a higher percentage of youth living at home six months after referral (for both cohorts) and this percentage continued to increase for youth in Cohort I at twelve months.

When looking at the placement of youth into congregate care, a slightly higher

percentage of youth from Cohort I's treatment group entered congregate care at both six and twelve months than those in the comparison group, although a smaller percentage of youth from Cohort II's treatment group entered congregate care within six months of referral; none of these results were statistically significant. *Safe at Home* youth from Cohort I re-entered congregate at a higher rate than comparison youth at six and twelve months. However, fewer *Safe at Home* youth from Cohort II re-entered congregate care at six months than did their comparison counterparts. None of these results were statistically significant. *Safe at Home* youth appear to be spending less time in congregate care than youth from the comparison groups. Youth from the treatment groups for both Cohorts I and II spent less time in congregate care at a statistically significant rate.

In regard to the placement of youth within their home counties, the percentage of youth moving out of their home counties provided mixed results. However, a greater proportion of *Safe at Home* youth from both cohorts returned to their home-counties at six and twelve months than evidenced for those in the comparison groups. These results were statistically significant for Cohort II at six months.

While the rate at which Cohort I youth re-enter foster care is fairly similar among those from the treatment and comparison groups six months following discharge, by twelve months the foster care re-entry rate is significantly lower for youth in *Safe at Home* compared to those in the comparison group. *Safe at Home* youth from both cohorts had fewer maltreatment referrals and investigations at six and twelve months at a statistically significant rate than youth in the comparison groups.

In regard to youth well-being, the CANS domain exhibiting the highest percentage of need at initial assessment was Life Functioning Needs; it also showed the greatest reduction in need at six and twelve month follow-ups. While these needs are the most prevalent among *Safe at Home* youth, they are also the ones in which the program has been able to address most effectively.

Cost Evaluation Results

The primary objective of the cost evaluation is to determine if *Safe at Home West Virginia*

is more effective and more efficient from a cost perspective than traditional methods used in West Virginia's casework.

Four research questions are being used to guide the cost evaluation.

- Are the costs of providing the Waiver services to a youth and family less than those provided before the Waiver demonstration?
- How does *Safe at Home* alter the use of federal funding sources as well as state and local funds?
- What is the cost effectiveness of the program?
- Is the project cost neutral?

The focus of the preliminary cost analysis is on the first question, and more specifically on the costs of out-of-home care. Future reports will take into account new costs incurred by West Virginia, such as those for wraparound contracts, and differences in costs for other items incurred prior to and post implementation of *Safe at Home*, such as those for services and administrative expenditures.

The first step in analyzing differences in costs for maintenance payments incurred for youth removed from their homes is to develop an average rate for service, in this instance a daily rate. As described in the outcome evaluation discussion, a comparison group was selected among youth known to DHR between October 1, 2010 and September 30, 2015 with characteristics similar to *Safe at Home* youth from the first treatment group, providing an opportunity for at least twelve months to have passed since referral. The cost of providing out-of-home care to the youth in the comparison cohort was then calculated, limiting the cost to the first 365 days of substitute care for those who remained out of the home longer than one year following the date they qualified for inclusion in the comparison group. This limitation was applied to ensure the same amount of time eligible for review of costs for the treatment group was applied equally to the comparison group. Those costs were then used to compute an average daily rate which will be used for the cost evaluation going forward. With rates subject to change year to year, it is important that a standard rate be developed and applied to eliminate the impact of rate increases and thus avoid the inappropriate appearance of waiver costs being higher just because of rate increases.

Using the data from the comparison cohort of youth matched to youth in the first treatment group, the following daily rates were determined.

Out of State Residential Care	$242.24
In State Residential Care	$147.77
Shelter Care	$164.26
Therapeutic/Specialized Care	$54.49
Family Foster Care	$20.51

Those rates were next applied to the number of days youth in the first treatment cohort were in substitute care, again limiting the analysis to the first year following enrollment in *Safe at Home*. As illustrated in Table 20, the *Safe at Home West Virginia* initiative has generated a cost savings of over $740,000 in maintenance costs for youth in the first treatment cohort. The largest savings is the result of reducing the time youth spend in out of state residential care, followed by a reduction in in-state residential care.

Table 20. Cost of Maintenance Payments (Cohort I)		
	Comparison Group	Treatment Group
Out of State Residential Care	$1,520,061	$851,234
In State Residential Care	1,218,795	1,017,239
Shelter Care	257,073	342,983
Therapeutic/Specialized Care	14,712	73,942
Family Foster Care	26,832	9,683
Totals	**$3,037,473**	**$2,295,081**

Summary of Cost Evaluation Results

The program has generated a cost savings of over $740,000 in maintenance costs for youth in Cohort I. The most significant portion of this savings can be attributed to the reduced time youth spend in out-of-state congregate care.

Summary of Evaluation Findings

Staff shared concerns related to service capacity throughout the State, particularly in the more rural areas and they identified five service types which are currently lacking: mentoring, therapy/psychological/psychiatric services targeting youth, substance abuse targeting youth,

transportation, and general activities or "hang out spots" where youth can gather to socialize. Stakeholders also reported that the program has created a positive culture shift, where youth and family input is becoming increasingly valued and prioritized and creative solutions are often sought in case planning. Overall LCA and DHHR staff buy-in for the program was high.

About half of the staff reported that the training received has been sufficient and the most common suggestion for improving training was to provide greater detail. Most DHHR caseworkers reported that more time is spent on *Safe at Home* cases. However, some stated that more intense involvement may be necessary for these youth to be successful. Turnover was a concern for both DHHR caseworkers and LCA wraparound facilitators.

Collaboration between DHHR, LCAs, and judges was often reported with mixed views, as either a strength or challenge for the program. Moving forward, staff seemed especially interested in seeing more successful prevention cases as well as an increase in the number of judges supporting the program; many interviewees observed that the two go hand in hand. A high number of DHHR and LCA stakeholders were concerned about how changing federal and state administrations may impact the program.

In looking at the overall placement shifts for youth in *Safe at Home,* there was a smaller percentage of youth in out-of-state and in-state congregate care settings at six months post-referral; there was even a slightly smaller percentage of youth from Cohort I in this higher level of care at twelve months. There were also a higher proportion of youth living at home six months after referral (for both cohorts) and this percentage continued to increase slightly for youth in Cohort I at twelve months. Positive placement shifts were also evidenced with more *Safe at Home* youth from both cohorts returning to their home-counties at six and twelve months than their comparison counterparts.

Safe at Home youth from Cohort I re-entered congregate at a higher rate than comparison youth at six and twelve months. However, fewer *Safe at Home* youth from Cohort II re-entered congregate care at six months than did their comparison counterparts. None of these results were statistically significant. *Safe at Home* youth spent less time in congregate care placement settings than comparison youth at a statistically significant rate. This was evident in the cost savings found of over $740,000 in maintenance costs for youth in Cohort I which was largely impacted by the reduced time youth spent in out-of-state congregate care.

While the rate at which Cohort I youth re-enter foster care is fairly similar among those from the treatment and comparison groups six months following discharge, by twelve months the foster care re-entry rate is significantly lower for youth in *Safe at Home* compared to those in

the comparison group. *Safe at Home* youth from both cohorts had fewer maltreatment referrals and investigations at six and twelve months than youth in the comparison groups.

In regard to youth well-being, the CANS domain exhibiting the highest percentage of need at initial assessment was Life Functioning Needs; it also showed the greatest reduction in need at six and twelve month follow-ups. While these needs are the most prevalent among *Safe at Home* youth, they are also the ones in which the program has been able to address most effectively.

V. Recommendations & Activities Planned for Next Reporting Period

West Virginia's Evaluator's Recommendation:

Continue to work with LCAs to build service capacity. Some LCA staff reported that their agencies have worked internally to build capacity in order to meet the needs of *Safe at Home* youth. Some LCAs have added mentors, therapists, and transporters in response to the service needs of clients. It would be beneficial for the State to continue to work with LCAs to build this capacity wherever possible, particularly in the more rural areas.

West Virginia Activities Planned for Next Reporting Period:

West Virginia will implement in the final Phase 3 counties on April 1, 2017. This will complete a full statewide implementation.

Phase 2 Local Coordinating Agency grant periods end on April 30, 2017. Provider agreements will be created and submitted to the providers for agreement to continue to provide Wraparound services. This occurs as each grant period ends.

West Virginia has developed a strategic work plan for further training and development of BCF and Partner staff regarding the administration and use of the WV CANS and the further development of WV CANS Advance CANS Experts (ACES) for technical assistance. We are seeing that WV CANS are being administered but many do not yet understand how to use the results in the treatment or case planning process for youth and families. We have identified the continuing need to develop experts that can provide

technical assistance on an ongoing basis. Our goal is for WV CANS to be completed on all children with an open child welfare case and that the WV CANS will be used to determine the appropriateness of a referral to Safe at Home West Virginia and assist in guiding the intensity of services. Please refer to the attached Logic Model which is a fluid with changes being made as needed.

West Virginia will proceed with Applied Wraparound training for all wraparound facilitators and incorporate it as a normal part of facilitator training.

As mentioned previously, West Virginia is working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and ongoing trainings in using the MAPs process. "MAPs" refers to Making Action Plans. The training helps facilitators understand the MAPs process and details and how to conduct a MAP and integrate it into a Wraparound Plan. These training will occur during the next reporting period.

As part of West Virginia's ongoing work to improve our continuum of care we have created a Treatment Foster Care model that was mentioned in the previous section on status, activities, and accomplishments. As part of that process West Virginia is developing a Three-Tier Foster Family Care Continuum. This continuum will include Traditional Foster Care homes, Treatment Foster Care homes, and Intensive Treatment Foster Care homes. This is currently in development stages in partnership with the Licensed Child Placing Providers who currently hold the Treatment Foster Care grants.

West Virginia will continue with the combined meetings with Judges as well as community partners.

West Virginia will work with our evaluator and partners to plan for implementing recommendations as well as monitoring for any program or process improvements.

West Virginia will begin working on our sustainability plan as we prepare for transition out of the IVE Demonstration Waiver in 2019.

NEXT STEPS:

WEST VIRGINIA'S EVALUATOR:

HZA plans to conduct a site visit for the purpose of the second annual fidelity assessment in July 2017. A sample of 40 *Safe at Home* cases will be selected at random, in proportion to the number of youth served by each LCA. A case record review will be conducted of the 40 cases, relying primarily on LCA case records to answer questions pertaining to each phase of the wraparound process. In addition to the case reviews, each youth, parent, wraparound facilitator, and DHHR caseworker will be interviewed. Additionally, HZA will continue to utilize FACTS and CANS data for the outcome evaluation.

VI. Program Improvement Policies

- Title IV-E Guardianship Assistance Program (previously implemented): An amendment to the title IV-E plan that exercises the option to implement a kinship guardianship assistance program.

West Virginia amended its Adoption and Legal Guardianship Policies as well as its IV-E State Plan to accommodate claiming for Guardianship Assistance. This included kinship guardianship assistance. DHHR Office of Administration as well and the Office of Information Technology worked on the requirements for this expanded claiming. Although West Virginia is currently in the proposal process for the building of the new required CCWIS system the Office of Information Technology agreed to work with their current contractor to build a basic system within the existing SACWIS system to assist with this claiming. The build had a very tight timeframe and was completed and released on February 23, 2017. In conjunction to this activity was the preparation of the BCF IV-E eligibility staff for the necessary review and determinations and as well as work in the field offices with the pulling and identification of specific kinship guardianship cases. This work occurred concurrently with the build within the SACWIS system.

- Preparing Youth in Transition (new): The establishment of procedures designed to assist youth as they prepare to transition out of foster care, such as arranging for participation in age-appropriate extra-curricular activities; providing appropriate access to cell phones, computers and opportunities to obtain a driver's license; providing notification of all sibling placements if siblings are in care and sibling location if siblings are out of care; and providing counseling and financial support for post-secondary education.

West Virginia has made a conscious effort to "normalize" activities for all foster children. We have made a concerted effort to increase staff and stakeholder knowledge of youth transitioning by creating a Youth Transitioning Policy that outlines all activities and requirements for youth aging out of foster care. Several webinars and presentations have been presented across the state to increase awareness of services available to older youth. These presentation and webinars include information about allowing our youth to participate in everyday activities, completing transition plans that include giving them information about advance directives, Chafee funding, completing record checks and developing reasonable plans.

West Virginia provides every youth who graduate or obtains a GED wile in foster care a

computer and any needed software or accessories. We continue to work on advising them of their sibling's location. However, due to West Virginia's focus on relative/kinship placements, most of our foster youth are placed with siblings.

West Virginia continues to struggle with the issue of youth in care obtaining drivers licenses and continues to work on resolving this.

All necessary policies have been drafted and released to the field staff on September 17, 2015 with an effective date of September 28, 2015. The policy is also posted on the Bureau for Children and Families Website. A memo was sent releasing the policy to the field as well as explaining the policy update. A power point was also created for the use of Home Finding staff with foster parents. At present a webinar is in developed for all tenured staff and the new policy is being embedded into new worker training. West Virginia will continue to require all of our provider partners to assure that their staff are aware and trained in this area and that they provide information to their foster families.

This program improvement policy is complete. The policy may be accessed on the BCF website. http://www.dhhr.wv.gov/bcf

Attachments:

Appendix A - Hornby Zeller Associates, Inc.– Statistical Similarity of Treatment and Comparison Groups

Appendix B -Hornby Zeller Associates, Inc. - Number of Youth with an Actionable Item in the Initial CANS

Appendix C- Hornby Zeller Associates, Inc. – Number of Youth with a Need on Initial CANS Who Improved at 6 & 12 Months

Appendix D – WV CANS Logic Model

Appendix A. Statistical Similarity of Treatment and Comparison Groups

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Test
Gender	0.593	0.780	0.436	Chi-Squared
Hispanic	0.186	0.650	0.689	Chi-Squared
Black	0.583	0.708	0.630	Chi-Squared
UTD	1.000	1.000	1.000	Chi-Squared
White	0.883	0.765	0.763	Chi-Squared
NHOPI	0.969	0.156	0.317	Chi-Squared
Asian	0.956	1.000	0.317	Chi-Squared
AIAN	1.000	1.000	1.000	Chi-Squared
AsianPl	1.000	1.000	1.000	Chi-Squared
Unknown Race	0.530	1.000	0.476	Chi-Squared
Declined	1.000	1.000	1.000	Chi-Squared
Placement Type	0.999	0.814	0.326	Chi-Squared
Parent Jail	0.530	0.067	0.563	Chi-Squared
Abandonment	1.000	1.000	0.082	Chi-Squared
Child Alcohol	1.000	1.000	0.317	Chi-Squared
Parent Alcohol	0.594	0.703	1.000	Chi-Squared
Caretaker Unable to Cope	0.303	1.000	0.316	Chi-Squared
Child Behavior	0.454	0.926	0.739	Chi-Squared
Child Disability	0.340	1.000	1.000	Chi-Squared
Parent Death	1.000	1.000	0.563	Chi-Squared
Child Drugs	0.522	1.000	0.325	Chi-Squared
Parent Drugs	0.405	0.382	0.649	Chi-Squared
Housing	0.340	0.703	0.737	Chi-Squared
Neglect	0.524	0.563	0.862	Chi-Squared
Physical Abuse	0.854	0.413	1.000	Chi-Squared
Relinquishment	0.969	1.000	1.000	Chi-Squared
Sexual Abuse	0.608	0.587	1.000	Chi-Squared
Voluntary	0.340	0.154	1.000	Chi-Squared
Other	1.000	1.000	1.000	Chi-Squared
Number of Prior Placements	0.219	0.335	0.605	Chi-Squared
Axis 1 Diagnosis	0.804	0.847	0.677	Chi-Squared
Juvinal Justice Involved	0.839	0.86	0.253	Chi-Squared

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Test
GAF	0.389	0.449	0.304	Chi-Squared
Removal	0.844	0.114	0.318	Chi-Squared
Jail	0.847	0.843	0.53	Chi-Squared
Psychiatric Hospital	0.408	0.568	0.157	Chi-Squared
Group Home	0.882	0.576	0.933	Chi-Squared
Age at Referral	0.823	0.085	0.534	One Way ANOVA
Years since Case Open	0.481	0.205	0.169	One Way ANOVA

Appendix B. Number of Youth with an Actionable Item in the Initial CANS

CANS Domain	CANS Item	Cohort I (N=85)	Cohort II (N=169)
Behavioral/Emotional Needs	Psychosis	2	6
	Attention/Concentration	42	65
	Impulsivity	33	52
	Depression	18	48
	Anxiety	13	36
	Oppositional Behavior	35	67
	Conduct	21	30
	Substance Use	9	16
	Attachment Difficulties	10	16
	Eating Disturbances	2	5
	Affective/Physiological Dysregulation	10	16
	Somatization	-	2
	Anger Control	47	55
	Total	**69**	**130**
Child Risk Behaviors	Suicide Risk	4	13
	Non-Suicidal Self Injury	8	11
	Other Self Harm	5	10
	Exploitation	1	-
	Danger to Others	15	25
	Cruelty to Animals	-	3
	Fire Setting	1	2
	Sexually Abusive	1	2
	Sexualized Behaviors	8	11
	Bullying	6	12
	Delinquency	2	8
	Runaway	5	22
	Intentional Misbehavior	13	17
	Total	**41**	**72**
Life Functioning Needs	Family	33	72
	Living Situation	18	48
	Social Functioning	29	47
	Developmental/Intellectual	17	26
	Brain Injury	2	-
	Substance Exposure	10	17
	Recreational	18	36
	Legal	50	84
	Medical	7	10
	Physical	2	1
	Medication Compliance	9	9
	Sleep	16	22
	Sexual Development	5	8
	Child Involvement With Care	15	25
	Daily Functioning	8	6

CANS Domain	CANS Item	Cohort I (N=85)	Cohort II (N=169)
	Natural Supports	42	88
	School Behavior	31	53
	School Achievement	20	45
	School Attendance	14	31
	Total	**78**	**153**
Symptoms of Trauma	Adjustment to Trauma	29	55
	Traumatic Grief	8	22
	Re-experiencing	5	15
	Hyperarousal	17	34
	Avoidance	7	10
	Numbing	5	1
	Dissociation	2	7
	Total	**41**	**73**

Appendix C. Number of Youth with a Need on Initial CANS Who Improved at 6 & 12 Months

		Cohort I				Cohort II	
CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS
Behavioral/ Emotional Needs	Psychosis	1	1	-	-	1	0
	Attention/ Concentration	25	6	10	5	28	8
	Impulsivity	19	1	5	1	17	7
	Depression	11	4	2	1	21	6
	Anxiety	11	6	5	3	20	8
	Oppositional Behavior	21	4	7	3	26	10
	Conduct	10	3	2	1	9	3
	Substance Use	4	3	-	-	7	5
	Attachment Difficulties	4	1	1	1	5	3
	Eating Disturbances	1	0	1	1	2	1
	Affective/ Physiological Dysregulation	4	0	-	-	7	2
	Somatization	-	-	-	-	-	-
	Anger Control	26	5	8	4	19	6
	Total	**43**	**22**	**13**	**12**	**51**	**31**
Child Risk Behaviors	Suicide Risk	2	1	1	1	2	2
	Non-Suicidal Self Injury	5	4	3	1	3	2
	Other Self Harm	4	2	2	2	3	3
	Exploitation	-	-	-	-	-	-
	Danger to Others	6	2	1	0	9	3
	Cruelty to Animals	-	-	-	-	1	1
	Fire Setting	1	0	-	-	-	-
	Sexually Abusive	-	-	-	-	-	-
	Sexualized Behaviors	4	2	1	1	4	3
	Bullying	4	1	1	1	4	1

		Cohort I				Cohort II	
CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS
	Delinquency	-	-	-	-	4	3
	Runaway	3	0	-	-	9	6
	Intentional Misbehavior	8	4	1	0	3	0
	Total	**22**	**10**	**6**	**4**	**25**	**17**
Life Functioning Needs	Family	21	5	6	4	26	10
	Living Situation	11	4	2	1	17	12
	Social Functioning	17	5	3	1	19	12
	Developmental/ Intellectual	12	4	4	2	13	3
	Brain Injury	1	0	1	1	-	-
	Substance Exposure	3	0	1	0	7	1
	Recreational	11	4	3	3	15	8
	Legal	24	3	5	4	32	6
	Medical	4	2	-	-	4	1
	Physical	1	0	-	-	-	-
	Medication Compliance	5	2	2	2	5	1
	Sleep	7	4	1	1	10	4
	Sexual Development	2	2	-	-	4	2
	Child Involvement With Care	8	2	1	1	6	5
	Daily Functioning	4	1	-	-		
	Natural Supports	24	5	9	5	31	11
	School Behavior	18	6	3	2	21	13
	School Achievement	10	5	1	1	17	11
	School Attendance	5	5	1	1	14	10
	Total	**44**	**27**	**13**	**12**	**55**	**38**
Symptoms of Trauma	Adjustment to Trauma	17	2	7	3	19	9
	Traumatic Grief	6	3	1	1	11	8
	Re-experiencing	4	2	2	1	7	5

		Cohort I				Cohort II	
CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS
	Hyperarousal	10	5	5	3	9	5
	Avoidance	4	0	2	1	5	4
	Numbing	2	1	2	1	1	1
	Dissociation	-	-	-	-	1	1
	Total	**25**	**10**	**8**	**6**	**29**	**17**

Appendix D

CHILDREN AND ADOLESCENTS NEEDS AND STRENGHS (CANS)

Logic Model

Working Draft 04-19-2017

Goal 1: West Virginia will develop policy and protocols that support CANS implementation				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Develop and Implement Youth Services (YS) Policy to include CANS	* *CANS will replace the YBE immediately* * *YS Policy regarding CANS completed* **June 1, 2016 COMPLETED**	▪ Professional staff that can identify a child's needs and develop or recommend appropriate treatment ▪ Reduce unnecessary requirements/tools	Michelle Dean BCF Leadership	
Objective 2: Develop and Implement Child Protective Services (CPS) Policy to include CANS	1. Determine if the CANS and/or FAST will be used for CPS cases and what other tools will be needed. 2. Map the FFA and PCFA to the CANS using FAST **DUE:**	▪ Professional staff that can identify a child's needs and develop or recommend appropriate treatment ▪ Reduce unnecessary requirements/tools	Streamline Committee Michelle Dean BCF Leadership	* *Tennessee and Washington State both use the FAST as their safety assessment.*
	2. Develop CPS policy regarding CANs **DUE:**	▪ Provides clear expectations		

Goal 2: **West Virginia will have 100% of DHHR Staff trained and certified in the CANS.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: All Youth Services (YS) staff will be trained and certified at .70 in the CANS.	1. Identify and track YS staff that need trained, certified and/or recertified. **DUE: 05/2017**	▪ YS supervisors will identify staff that have not been trained, those that have trained and need certification and those that require TA.	Linda Dalyai Tammy Pearson Gary Keen YS Supervisors	**YS staff was trained through Safe at Home rollout*
	2. Identify Training and Type Needed (New Worker or	▪ Training will be delivered by:	Linda Dalyai Tammy Pearson	* *CANS Youth Services*

	Ongoing) and provide training notices to Supervisors and Regional Managers. **DUE: 05/2017**	1. DHHR CANS Trainers (Experts); 2. CANS-ACES; 3. DHHR Regional/State CANS Expert	Elva Strickland	*tenure staff will be given training preference.* *** ***Training and Technical Assistance is planned for staff that did not receive training during rollout.*** ** YS staff will receive CANS training and certification through new worker training.*
Objective 2: All Child Protection Services (CPS) staff will be trained and certified in the CANS.	1. Identify and track CPS staff that need trained, certified and/or recertified.	▪ CPS supervisors will identify staff that have not been trained, those that have trained and need certification and those that require TA.	Linda Dalyai Tammy Pearson YS Supervisors	** CPS staff was trained when Safe at Home was rolled out.* **CPS staff will receive*
	2. Identify Training and Type Needed (New Worker or Ongoing) and provide training	▪ Training will be delivered by: 1. DHHR CANS Trainers (Experts); 2. CANS-ACES;	Linda Dalyai Tammy Pearson Elva Strickland	

	notices to Supervisors and Regional Managers **DUE:**	3. DHHR Regional/State CANS Expert		*CANS training and certification through new worker training after decisions are made regarding recommendations from the Streamline Committee (Goal1-Objective 2)*
Objective 3: Ensure all YS and CPS staff are certified & Recertified	1. Determine who will monitor certification and recertification **DUE: 05/2017**	▪ State Office will monitor certification and recertification until all staff have had an opportunity to certify or recertify	BCF Leadership	* *The Praed Foundation sends those that have certified in CANS a notification 1 month prior to their certification expiration date.*
	2. Monitor certification and recertification **DUE:**	▪ Identify 1 Regional Coordinator per each DHHR Region to continue to monitor staff certification	?	
	3. Determine the consequences for failure to meet .75 certification standards.	▪ After multiple attempts, staff may need re-assigned	BCF Leadership	

Goal 3: **West Virginia will build BCF Internal Capacity Statewide.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Provide ongoing technical assistance Regionally and statewide.	1. Identify and train/certify internal CANS Experts. **DUE: Completed/Ongoing**	▪ Ongoing technical assistance offered by Regional CANS Experts will allow Supervisors and staff to feel supported.	Linda Dalyai Tammy Pearson	* *Criteria for CANS Experts has been developed.* * *CANS Experts must certify at .80* * *Only CANS Experts can provide TA*
	2. Develop short-term and long-term Technical Assistance goals and protocol (expectation, cost, dates, locations, etc.) ▪ Identify those that will provide TA ▪ Identify and support DHHR staff that meet the criteria as CANS Experts	▪ This will support sustainability and allow staff to be supported within their own Regions	Linda Dalyai Tammy Pearson BCF Management	
	3. TA will include supporting staff by reviewing completed CANS and provide ongoing quality assurance. **DUE: Completed/Ongoing**	▪ Reliable and valid CANS	Linda Dalyai Tammy Pearson	
Objective 2 Explore Higher Education Support of CANS in Curriculum and Certification Process	1. Discuss with Universities the need for students to be trained and certified in the CANS prior to employment **DUE: 05/2017**	▪ A workforce that is competent in using the CANS ▪ Priority given to those with current certification in the hiring process	Linda Dalyai Tammy Pearson Elva Strickland BCF Management Div. of Training	

Goal 4: **West Virginia will have a fully automated CANS system.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Utilize or develop software to capture the CANS information across participating agencies and DHHR staff	1. Determine if: a) Software is designed only for Safe at Home cases; b) Can software be expanded to include all cases	▪ Promotes the full use of the CANS	Hornsby/Zeller FACTS BCF Management Linda Dalyai Tammy Pearson Elva Strickland	* *A mechanism that allow the CANS scores (initial and ongoing) to be documented, tracked and data to be obtained and distributed.*
	1. Determine if software belongs to the DHHR, BCF, and if so, contract with a University to: a) Maintain CANS information across participating agencies b) Evaluation and Reports	▪ The DHHR will have available information on a child or family so the diagnostic process can be minimized		
	1. FACTS Redesign will include slight modification of the YBE screens that mirror CANS items and additional screens added for CANS that are needed. 2. FACTS to interface with external partners	▪ Documentation for workers will match policy		

Goal 5: **West Virginia will establish threshold (algorithms)/Total Communication Outcome Management (TCOM)**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Algorithms and automated feedback are specified for each key decision-point in service / support process	1. Determine when algorithms will be used and who will use them.	▪ At a practice level, algorithms guide decisions toward the level of care or intensity of service needed.	BCF Management Linda Dalyai Tammy Pearson	* *Dr. Lyons identified Algorithms based on a WV case record study* * *Algorithms are indicators that guide decisions at multiple levels.* * *Algorithms are to be considered along with other information when making service decisions for a child and family.*
	2. Determine what tool can be used to guide decision making	▪ This will allow consistent results		

OUTCOMES:

Benefit to children, youth and families from the utilization of CANS

1. Safety, Permanency and Well-being outcomes are met when needs and strengths are identified.
2. Identified strengths in the area of talents/interests and spiritual/religious are strong predictors for placement stability and positive outcomes.
3. The CANS is completed as a shared visioning activity rather than the opinion of one person.
4. The CANS is used to support placement, level of care, or intensity of intervention decisions that it is also used for other work as well (i.e. creating the permanency plan).
5. Engaging youth and families in actively collaborating on the assessment process is helpful to staring personal change. The appropriate use of the CANS is an engagement strategy.

Benefit to Professional DHHR Staff

1. Youth Services and Child Protective Services staff will expand their competence in intervention techniques and approaches. These enhanced professional skills will help them to work with families to overcome life's most difficult challenges.
2. With ongoing support, staff will value the performance of their work and view their documentation as part of their work rather than as a paperwork activity. ** Key to creating that support is the use in supervision.*
3. The CANS is replacing other documentation not simply adding documentation burden.
4. Creates a model that informs effective case planning and linking children and family needs to specific strategies and placements.
5. Having an organized way of communication about children and families facilitates (professionalizes) case worker communications with other partners, in particular, the courts and mental health professionals.

Benefits at Program Level

1. At the program level, provides supervisors with a way for their case workers to organize themselves so that supervision is more targeted and efficient.
2. Reveals training needs and opportunities for practice development
3. Allows the monitoring of effectiveness of interventions

Benefits at the System Level

1. Significant savings for re-investment from better management of expensive interventions
2. Improved resource mapping for system right-sizing.
3. Re-structuring payment and rate setting systems to better match children and families and encourage improvement.

Excerpts from, John S. Lyons, Ph.D. Chapin Hall at the University of Chicago Praed Foundation. *Use of the Child and Adolescent Needs and Strengths (CANS) in Child Welfare in the United States*. Report prepared for the Ohio Association of Child Caring Agencies, Inc. (March 23, 2014)