



West Virginia 2019 Child and Family Services Plan



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

2020 West Virginia Child and Family Services Plan

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State Agency Administering Programs

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

The Bureau for Children and Families

Located within the Bureau for Children and Families (BCF) are individual offices which perform various functions for the Bureau. The offices are: The Office of Programs & Resource Development; the Office of Field Operations; Office of Planning; Research and Evaluation; Office of Operations/Safe at Home; and the Office of Field Support. Oversight of each office is by a Deputy Commissioner or Director who reports to the Commissioner of the Bureau, who, in turn, reports to the Cabinet Secretary of the Department. In addition, the Division of Training Director reports to the Commissioner, and is charged with the oversight, coordination, and delivery of training to BCF employees and foster parents statewide. This training includes New Worker Training, Supervisory Training, and Tenured Worker Training on new initiatives and professional development activities.

Office of Programs

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

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

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

For the most part, the staff within the Children and Adult Services (CAS) policy division is not involved in the direct provision of services. In some cases, however, staff does assist with the provision of services or is directly involved in service delivery. For example, staff in CAS operates the Adoption Resource Network

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and maintains financial responsibility for a case once an adoption subsidy has been approved. The Director position serves as both the IV-B and IV-E Coordinator. West Virginia's approved Child and Family Services Plan and any approved Annual Progress Services Report can be located at <http://www.wvdhhr.org/bcf/>.

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

The Division of Training is charged with the oversight, coordination, and delivery of training to BCF employees and foster parents statewide. This training includes New Worker Training, Supervisory Training, and Tenured Worker Training on new initiatives and professional development activities. This Division reports directly to the Commissioner.

State CAPTA Coordinator Alice N. Hamilton, LSW 350 Davis St. Princeton, WV 24739 304-425-8738 Alice.N.Hamilton@wv.gov	State IV-B and IV-E Coordinator Christina Bertelli-Coleman, Interim Director 350 Capitol Street, Room 691 Charleston, WV 25301 304-356-4570 christina.m.bertellicoleman@wv.gov
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The Office of Operations

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

The Division of Grants and Contracts; the Division of Finance; the Division of Personnel and Procurement report to the Chief Financial Officer, James Weekley. Major responsibilities of the Office of Operations are approving and monitoring sub-recipient grants and contracts; oversight of the bureau budget; oversight of personnel and procurement activities; and developing and producing research and analysis on the results of operations for the major programs operated by the Bureau.

Office of Planning, Research and Evaluation

The Office of Planning, Research and Evaluation, under the direction of Assistant Commissioner Keven Henson, has the responsibility Major activities of DPQI include conducting program and peer reviews; coordinating statewide quality councils; coordinating corrective action and program improvement plan; and accreditation activities.

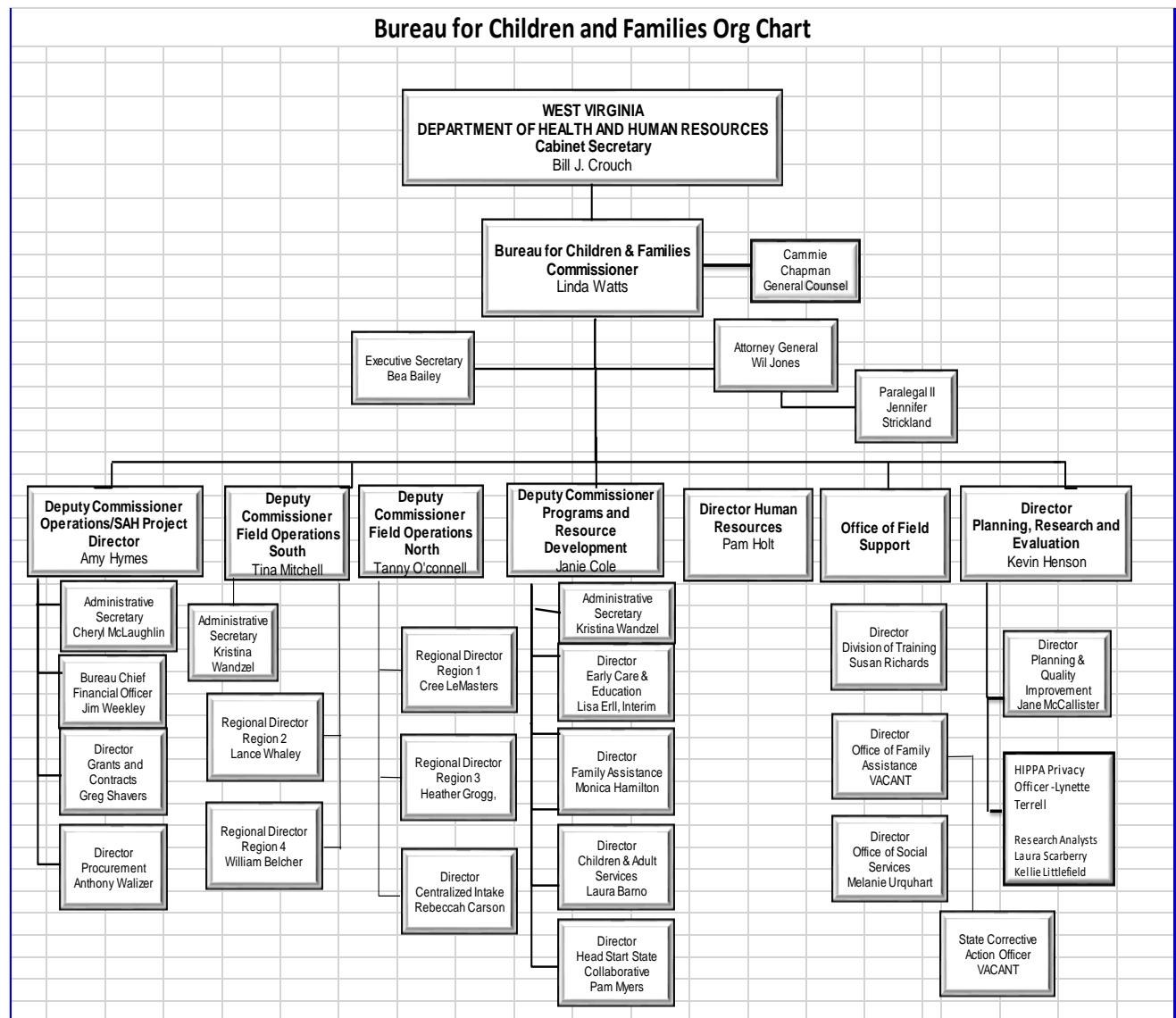
The Office of Field Operations

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

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

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



1. Collaboration and Vision

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

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

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

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

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

During the recent State Team Meeting in Washington, in late April 2019, members of The West Virginia Department of Health and Human Resources (WV DHHR), which includes both representatives from its Child Welfare System, as well as its Prevention Programs, and the Court Improvement Program (CIP),

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worked together to develop a vision statement for West Virginia that depicts the state's vision for the Child Welfare System for the next five years. This vision was shared and accepted by all the Bureau for Children and Families Leadership Team.

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

Vision Statement

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

Collaboration

The DHHR involves stakeholders from across the state and all child welfare systems. The diverse individuals representing the many facets of the system is a necessary step for meaningful improvement. Additionally, the DHHR obtain input from stakeholders by partnering with several high-level groups that together provide oversight and direction for child welfare in West Virginia. These oversight groups are:

- Commission to Study Residential Placement of Children;
- Safe at Home West Virginia;
- West Virginia Court Improvement Program;
- Education of Children in Out of Home Care Advisory Committee; and
- Child Welfare Collaboration

Commission to Study Residential Placement of Children

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

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

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

Safe at Home, West Virginia

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West Virginia's Title IV-E Waiver demonstration project, Safe at Home West Virginia, aims to provide wraparound behavioral health and social services to youth ages 12 to 17 years with specific identified behavioral health needs who are currently in congregate care or at risk of entering congregate care.

The Title IV-E Waiver allows the existing level of funding to be refocused on wraparound community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

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

West Virginia Court Improvement Program

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

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

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

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

West Virginia Regional Partnership Grants

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

Education of Children in Out of Home Care Advisory Committee

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

Child Welfare Collaborative

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

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

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

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

The increase of availability and accessibility and knowledge of existing services within communities will help provide wrap-around at a community level to prevent families coming to agencies attention. The goal

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is to develop a more family friendly, cohesive, community-based structure for the development and use of services. The Child Welfare System in West Virginia will concentrate on becoming more pro-active in its delivery of services. Department of Justice (DOJ) partnered with the West Virginia Department of Health and Human Resources in support of West Virginia's plan to expand statewide community-based services, such as, mobile crisis response, wrap-around services, in-home behavioral support services and Expanded School mental health services.

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

In addition to Family Treatment Drug Courts, West Virginia has been researching the Sobriety Treatment and Recovery Team (START) Model since 2016 and is again exploring the possibility of implementing this program in piloted areas. The program is designed to meet the needs of young children with substance-abusing parents involved with the child welfare system. It uses an intensive intervention model that integrates addiction services, family preservation, community partnerships, and best practices in child welfare and substance abuse treatment. The program aims to reduce recurrence of child abuse and neglect, improve substance abuse disorder (SUD) treatment rates, build protective parenting capacities, and increase the state's capacity to address co-occurring substance abuse and child maltreatment. It was adapted in 2006 from the START model developed in Cleveland, Ohio, and has been used successfully in Kentucky. For more information visit <https://www.zerotothree.org/resources/811-kentucky-sobriety-treatment-and-recovery-team-start-program-for-parents-involved-with-the-child-welfare-system>

2. Assessment of Performance

The most reliable data West Virginia has, to evaluate performance is the CFSR style reviews, Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS). West Virginia has a comprehensive quality assurance system in operation. The Department's QA system operates in all jurisdictions of the state and is part of an overall Continuous Quality Improvement (CQI) process. West Virginia's quality assurance system utilizes data from various sources to monitor the efficacy of program improvement measures. The State utilizes CFSR style social service review data in conjunction with the State's data profile (contextual data report), and data from the State's Statewide Automated Child Welfare Information System (SACWIS) in the development, planning, and monitoring of Child and Family Services Plan (CFSP) goals and other statewide child welfare initiatives. The Division of Planning and Quality Improvement (DPQI) utilizes the case review process and standards set forth by the US Department of Health and Human Services administration for Children and Families. This process is used for the continuous measurement of the State's performance in the areas of safety, permanency, and well-being. (Refer to-Quality Assurance Systemic Factor Section)

The DPQI social services case review data provides for continuous quality improvement through the identification of the district's strengths and areas for improvement. The review data is used at the district level to evaluate case practice and assist districts in making improvements in the provision of services to children and families. Following the social service review exit with the district management team DPQI completes a comprehensive report on the results of the review. DPQI provides this information to Children and Adult Services and the Program Manager for Community Partnerships for the identification of service needs and development of services. DPQI compiles the exit summary data report and corrective action

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plan for each district and distributes the findings to the district's management staff, the Regional Program Manager, Regional Director, Director of Training, Policy Program Specialists, and Department Leadership.

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

Child and Family Services Review Round 3

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

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

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

- Goal 1- Creating and supporting a Healthy Workforce
- Goal 2- Increase Family Support Services and Family Resource Homes to meet the needs of children and Families Community Support and Family Resources
- Goal 3- Transforming the culture of child welfare management to increase competency, skill and accountability of our child welfare practice

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- Goal 4- Increase effectiveness and efficiency and create a prevention-focused organizational culture in order to ensure the needs of children and families are addressed throughout the life of the case. Various strategies to reach the goals are being developed.

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

Measurement Period	Review Data Dates	Report Date
Baseline	December 1, 2017-November 30, 2018	December 2018
1 st Period	June 1, 2018-May 31, 2019 (125 cases, 60 in-home services, 65 foster care)	June 2019
2 nd Period	December 1, 2018-November 30, 2019	December 2019
3 rd Period	June 1, 2019-May 31, 2020	June 2020
4 th Period	December 1, 2019-November 30, 2020	December 2020
5 th Period	June 1, 2020-May 31, 2021	June 2121

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

Safety

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

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

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

Circumstances beyond the control of the agency may include:

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

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

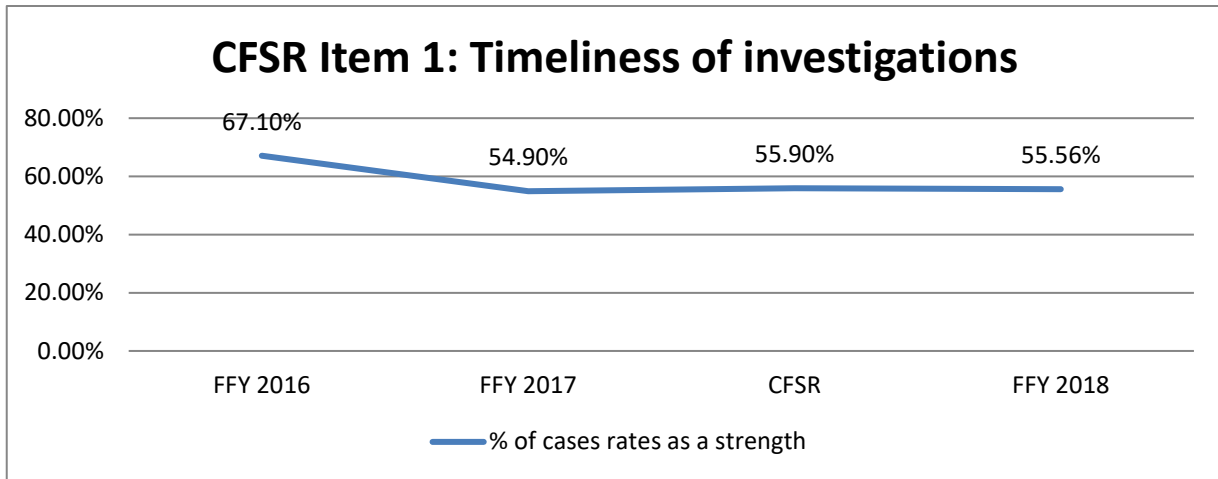
Goals and strategies to impact Safety Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 44-49, 51-53

DPQI Quality Assurance Case Review Data

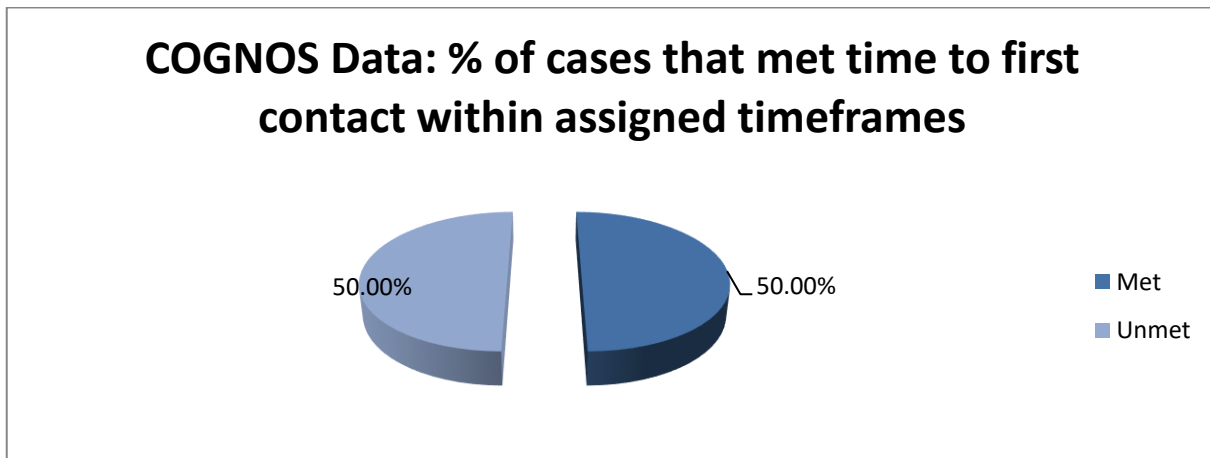
Baseline: 61.9%

PIP Goal: 69.7%

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

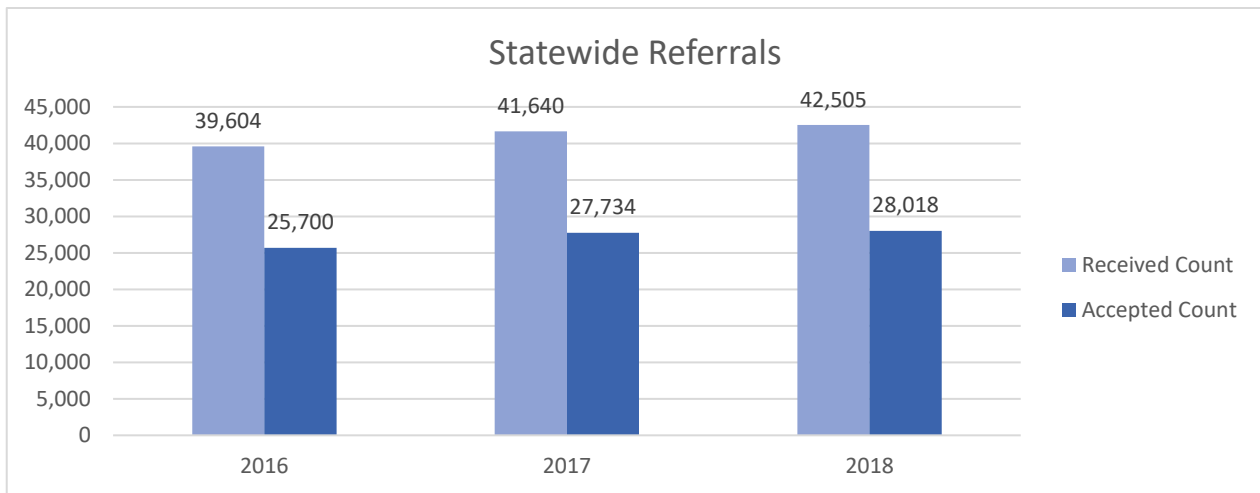


Source: DPQI Case Review Data



Source: COGNOS Time to First Contact Report FFY 2018

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Source: COGNOS Statewide Referrals Report Calendar Year 2018

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

COGNOS reports provide calendar year data regarding the time to first contact. The Time to First Contact Report is monitored by the District Community Services Managers, Regional Directors, and the Deputy Director of Field Operations on a regular basis. The COGNOS Statewide Referrals report continually shows an increase in the number of child maltreatment reports received and assigned for further assessment.

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

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

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

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

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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

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

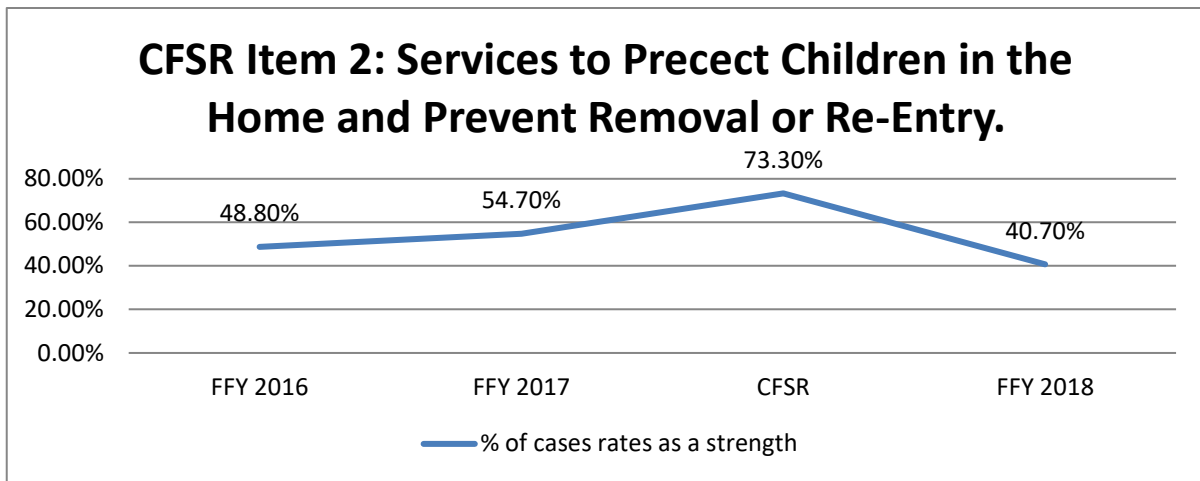
Goals and strategies to impact Safety Outcome 2 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49

DPQI Quality Assurance Case Review Data

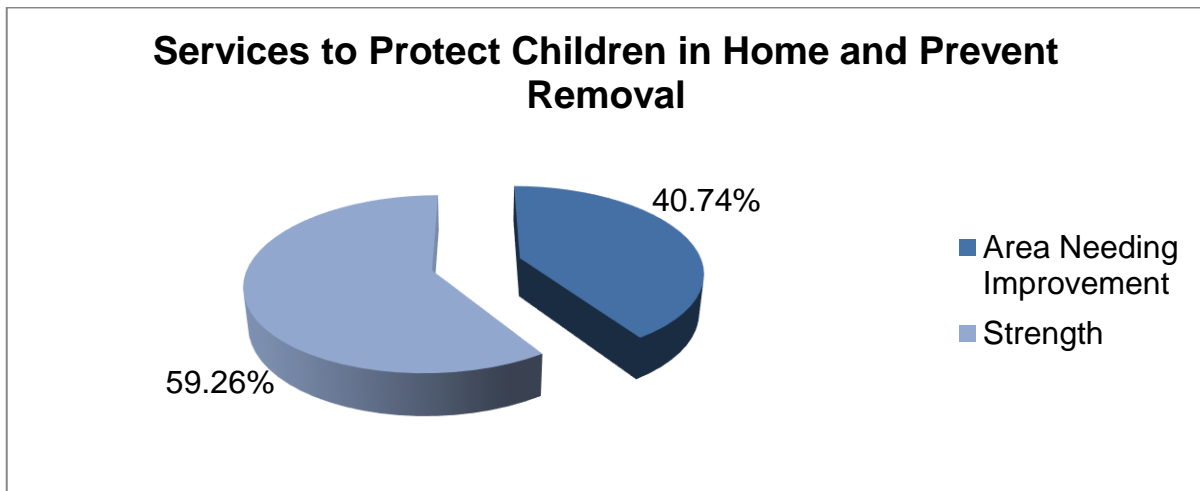
Baseline: 37.3%

PIP Goal: 45.9%

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

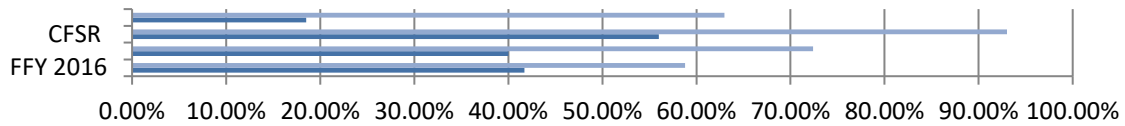


Source: DPQI Case Review Data



Source: DPQI Case Review Data 2018 FFY

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



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

Source: DPQI Case Review Data

Risk and Safety Assessment and Management (Item 3)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

Consider worker visitation practices (Caseworker Visits with Child [Item 14] and Caseworker Visits with Parents [Item 15]) when assessing this item. Although a rating on this item does not need to be

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consistent with the ratings on worker visits, reviewers should consider whether the frequency and quality of worker visits with children and/or parents supported quality assessments of risk and safety.

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

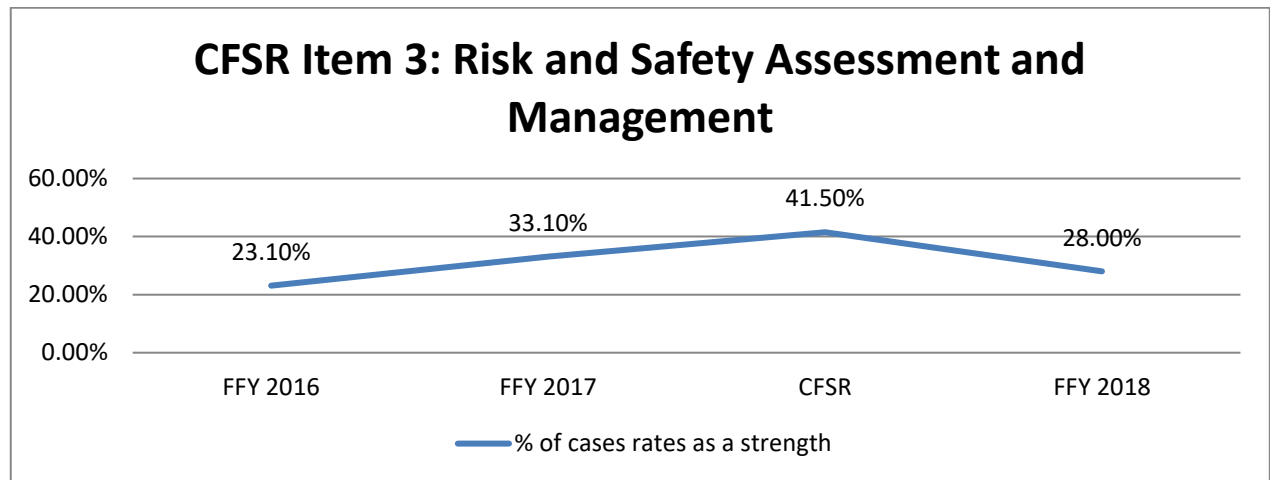
Goals and strategies to impact Safety Outcome 2 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49

DPQI Quality Assurance Case Review Data

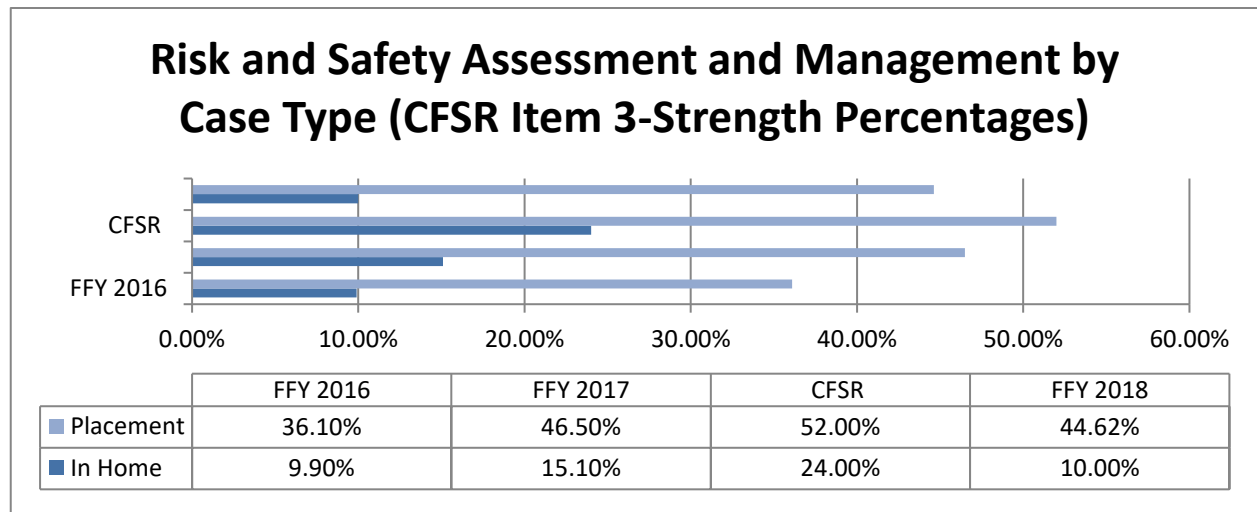
Baseline: 29.6%

PIP Goal: 34.8%

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



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Permanency

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

situations.

Stability of Foster Care Placement (Item 4)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

None.

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

DPQI Quality Assurance Case Review Data

Baseline: 73.8%

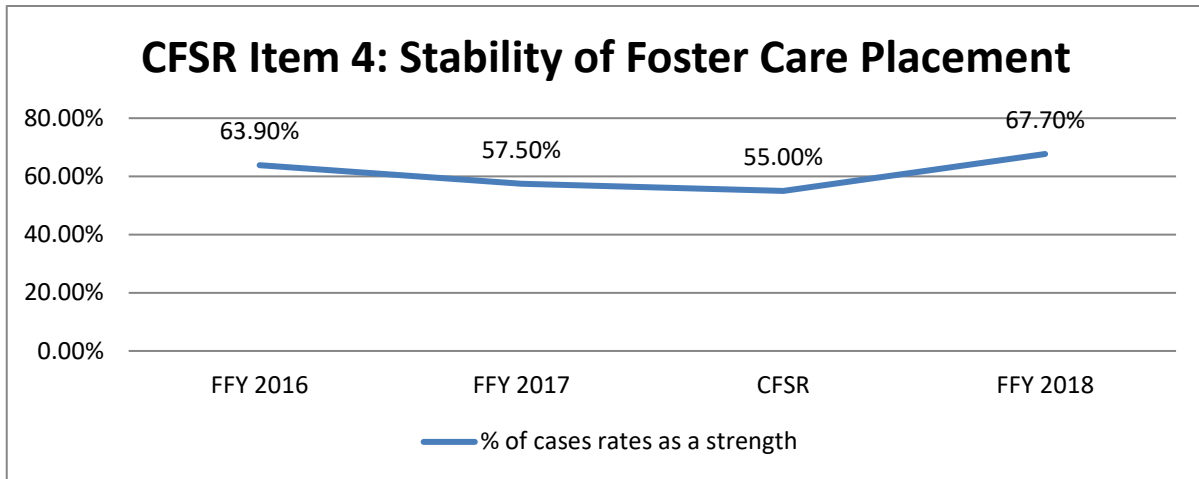
PIP Goal: 80.8%

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

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

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

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



Source: DPQI Case Review Data

Permanency Goal for Child (Item 5)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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

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

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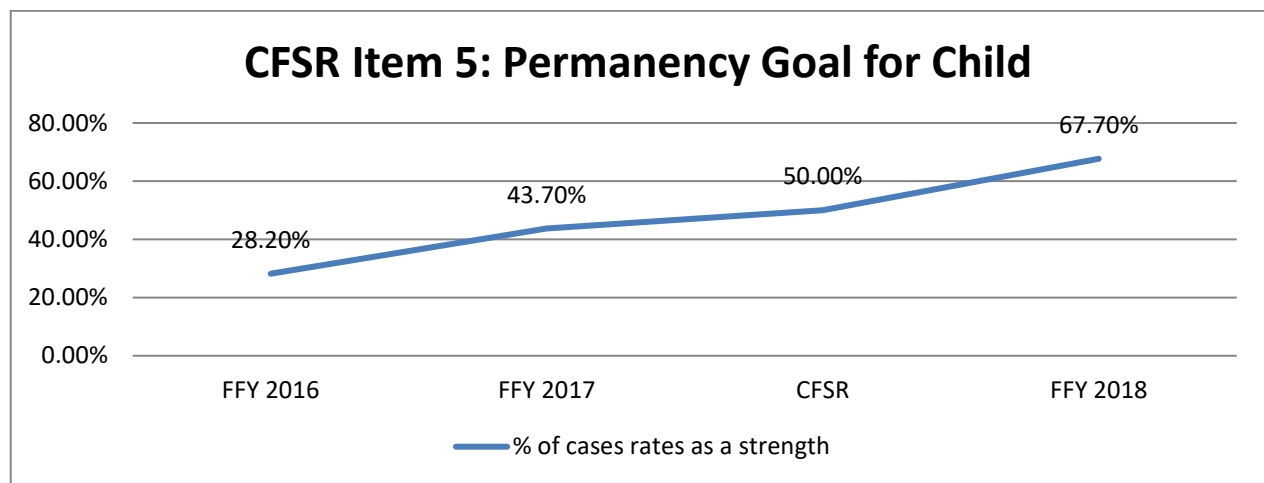
Goals and strategies to impact Permanency Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42

DPQI Quality Assurance Case Review Data

Baseline: 63.1%

PIP Goal: 70.7%

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



Source: DPQI Case Review Data

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

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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Generally, “timely achievement” is considered to have occurred within 12 months for the goal of reunification, within 18 months for the goal of guardianship, or within 24 months for the goal of adoption. However, the focus of this item is on assessing the efforts that were made to achieve permanency rather than on meeting the specific time frames noted for each goal. For example, if a child was reunified at the 12th month, but could have been reunified sooner had concerted efforts been made, the item could be rated as an Area Needing Improvement. Similarly, if a child did not achieve adoption within 24 months, but the agency and court had been making concerted efforts to achieve the goal of adoption despite circumstances beyond their control that caused a delay, the item could be rated as a Strength.

Concerted efforts toward achieving permanency may include:

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

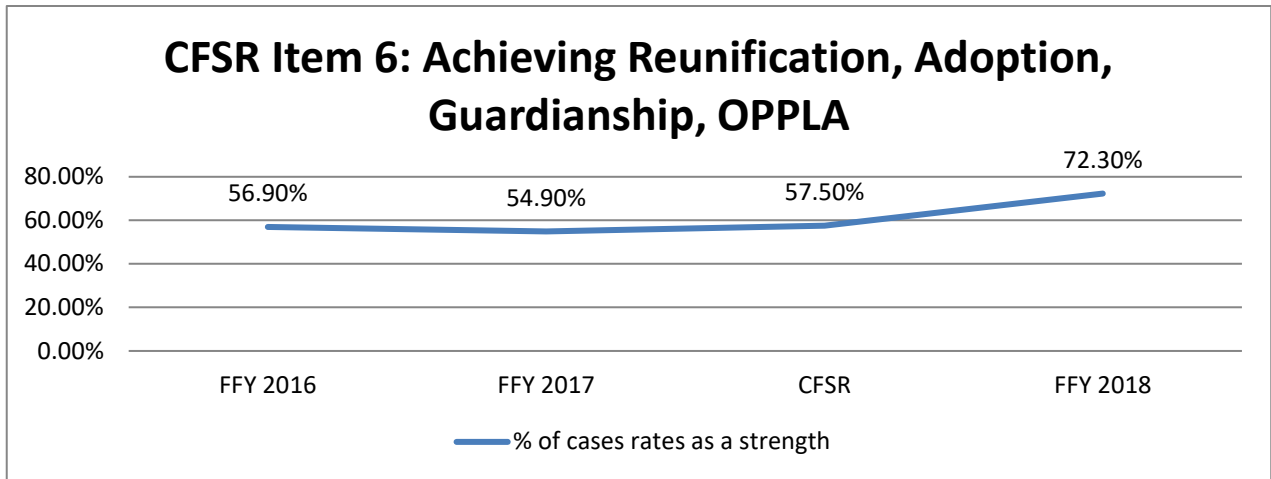
Goals and strategies to impact Permanency Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42

DPQI Quality Assurance Case Review Data

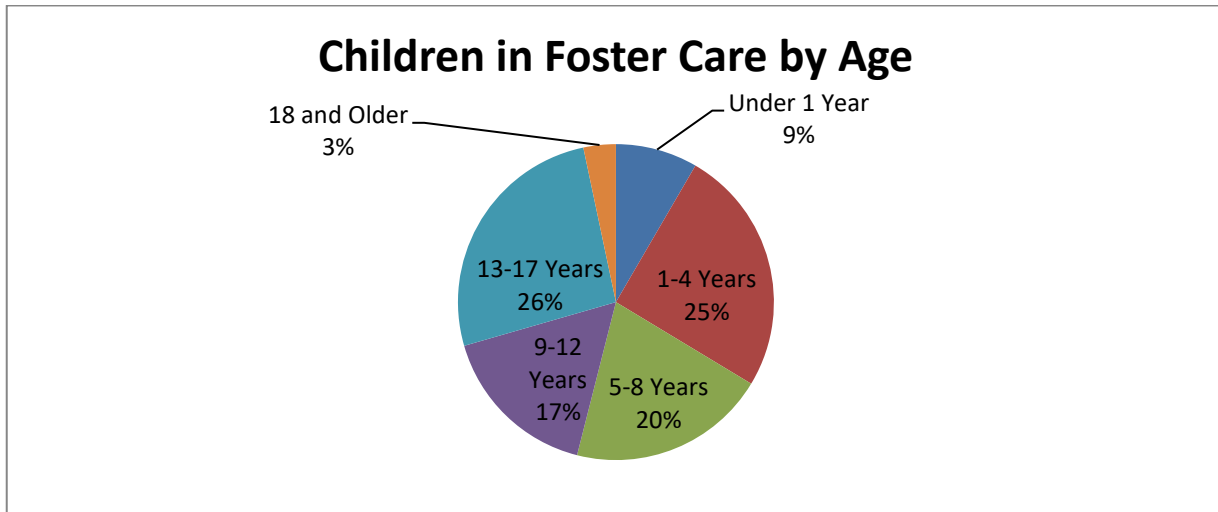
Baseline: 69.2%

PIP Goal: 76.6%

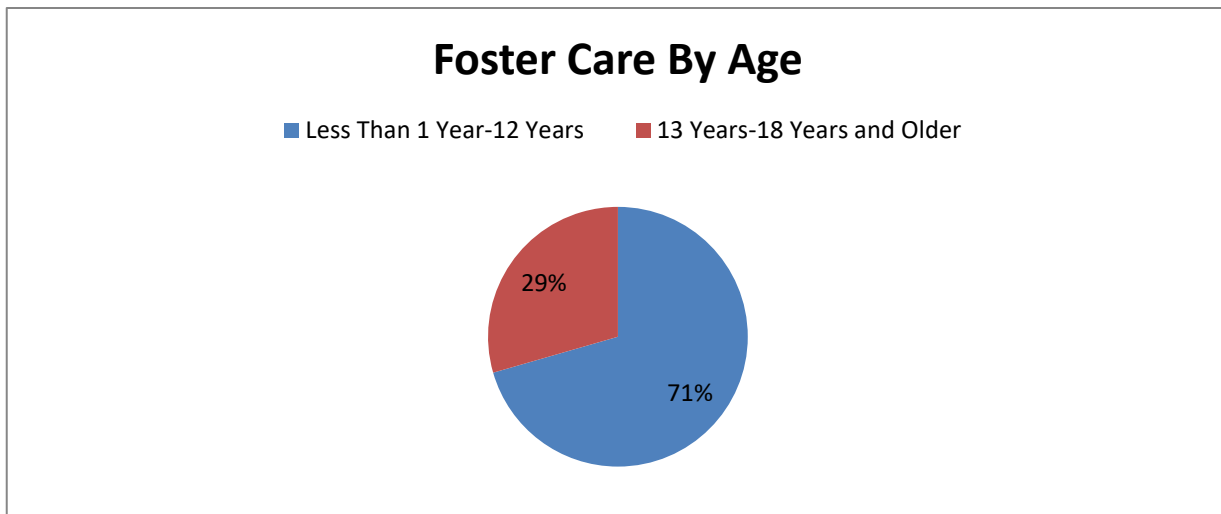
Reporting Period 6/2018-5/2019: 78.46%



Source: DPQI Case Review Data



COGNOS Point in Time Report 3/21/19



COGNOS Point in Time Report 3/21/19

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

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

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

Placement with Siblings (Item 7)

Purpose of Assessment: To determine whether, during the period under review, concerted efforts were made to ensure that siblings in foster care are placed together unless a separation was necessary to meet the needs of one of the siblings.

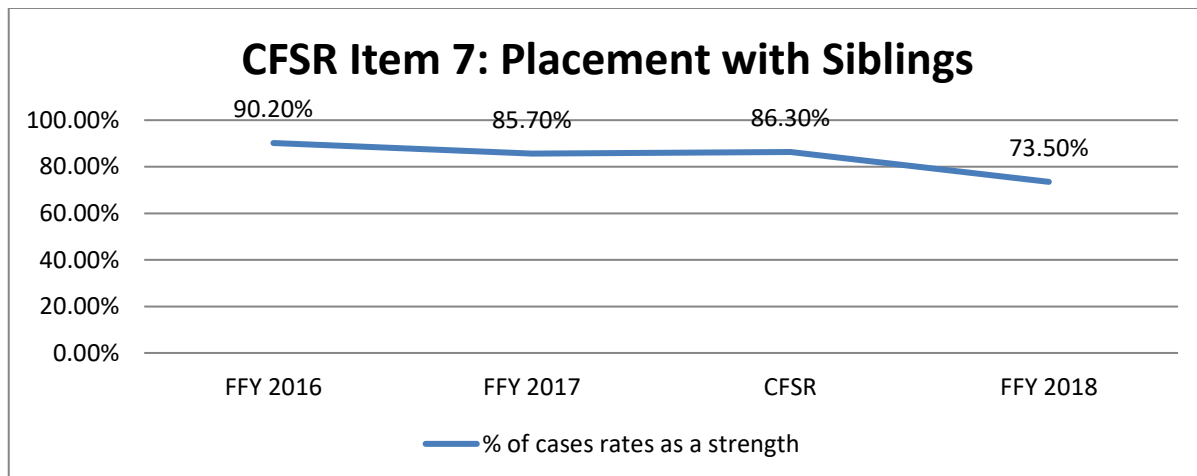
Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to place siblings together may include:

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



Source: DPQI Case Review Data

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

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

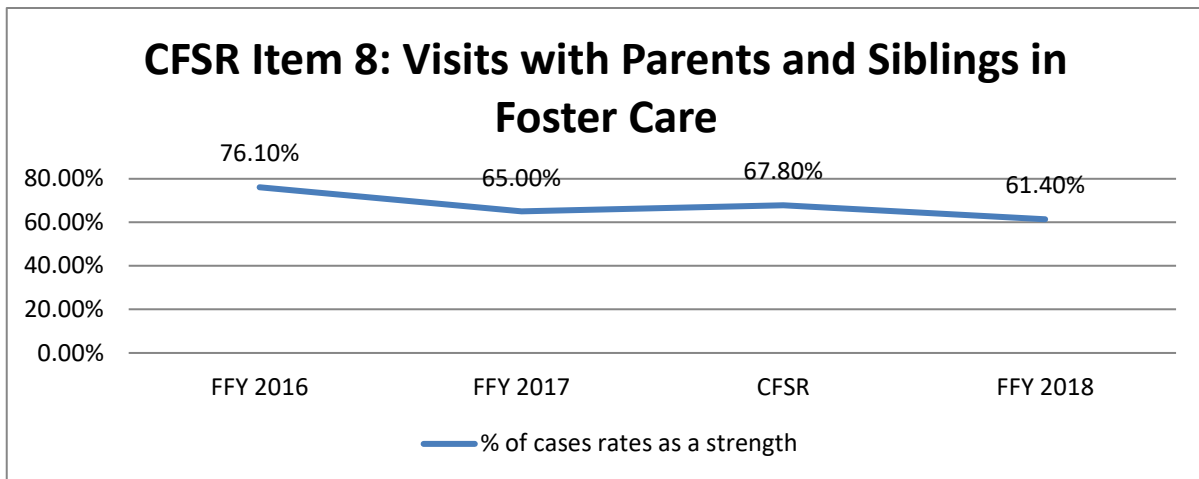
Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating Concerted

efforts to ensure frequent, quality visitation may include:

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



Source: DPQI Case Review Data

Preserving Connections (Item 9)

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

Strength Rating Defined

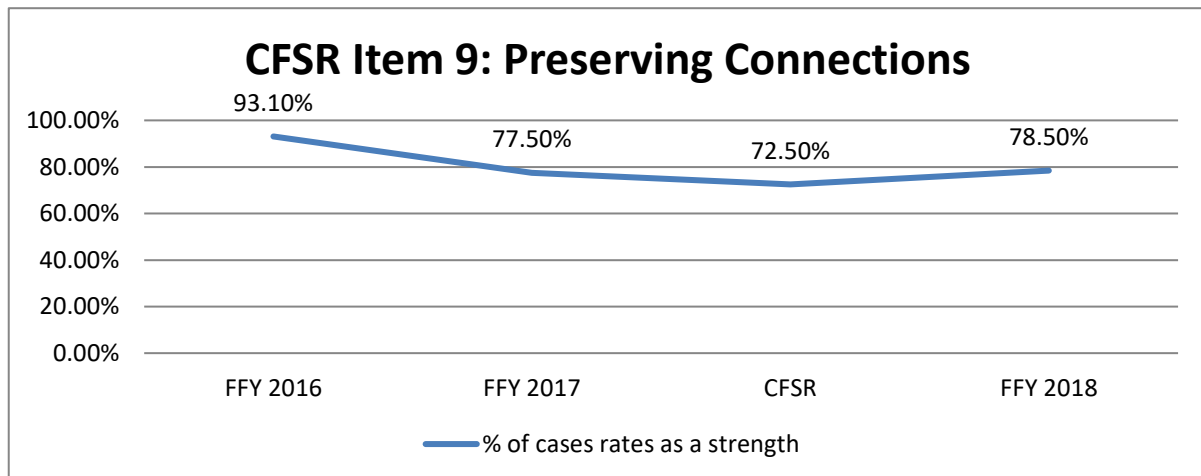
- During the period under review, the child’s important connections (neighborhood, community, faith, school, extended family, Tribe, and friends) that they had before entering care were identified and maintained.
- For a child who is a member of, or eligible for membership in, a federally recognized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

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to preserve connections may include:

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



Source: DPQI Case Review Data

Relative Placement (Item 10)

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

Strength Rating Defined

- Unless the child required a specialized placement that precluded placement with relatives, or the identity of relatives is unknown despite concerted efforts to locate them:

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- During the period under review, the child was placed with relatives and the placement was stable.
- OR, concerted efforts were made to identify, locate, inform, and evaluate paternal and maternal relatives as potential placement resources for the child, as appropriate, during the period under review.

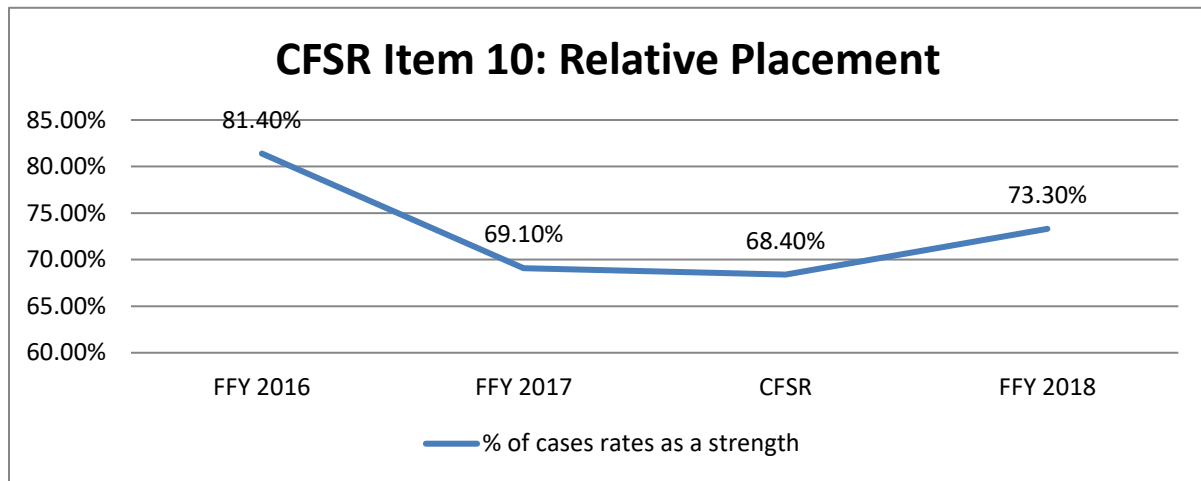
Concerted Efforts Required and/or Special Considerations in Rating

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

- Asking the child and parents/caretakers about relatives
- Sending letters to relatives to inform them of the child's status in foster care and need for placement
- Conducting home studies of relatives
- For cases where the whereabouts of the parents/caretakers are unknown and therefore relatives are unknown, evidence that the agency made a sufficient inquiry into the parents' identity, location, and status. Agencies are expected to use viable sources of

information such as parent locator services, case files, and central registries. In some situations, posting a legal advertisement in a newspaper might be the reasonable approach if lesser methods have failed to yield results, as would contacting the parents at the last known addresses or phone numbers.

- For cases that have been opened for some time, if concerted efforts were made before the period under review, evidence that any relatives who were previously ruled out were reconsidered (if appropriate) during the period under review



Source: DPQI Case Review Data

Relationship of Child in Care with Parents (Item 11)

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

Strength Rating Defined

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

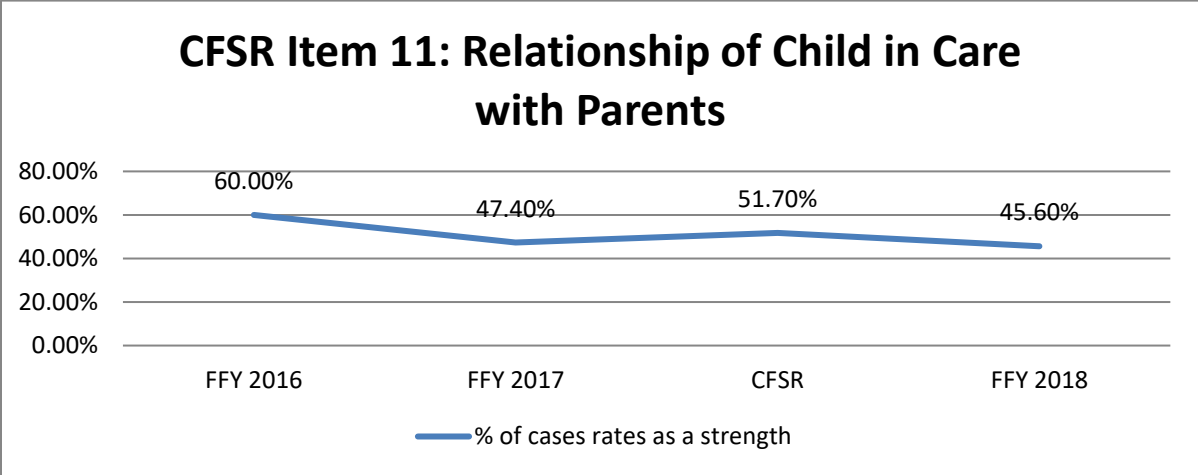
Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts may include:

- Encouraging a parent's participation in school-related activities, doctor's appointments for the child, or engagement in after-school activities

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- Providing or arranging transportation so that parents can participate in activities with the child
- Providing opportunities for therapeutic situations to strengthen the relationship
- Encouraging foster parents to serve as mentors/role models for parents
- Encouraging/facilitating communication with parents who do not live near the child and/or are unable to have frequent face-to-face visitation



Source: DPQI Case Review Data

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

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

Well-Being

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

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

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

Strength Rating Defined

- Concerted efforts were made during the period under review to accurately and comprehensively assess the needs of the children, parents, and foster parents initially (for cases that opened during the period under review) and periodically on an ongoing basis (as needed) to update assessment information relevant to ongoing case planning.
- Assessment of needs for the children does not include education, physical health, and mental/behavioral health (including substance abuse)
- Assessment of needs for parents refers to a determination of what the parents need to provide appropriate care and supervision and to ensure the safety and well-being of their children
- Assessment of needs for foster parents refers to a determination of what the foster parents need to provide appropriate care and supervision to the child in their home
- Concerted efforts were made during the period under review to provide appropriate services to the children, parents, and foster parents that were matched to needs identified in assessments.

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to locate parents may include:

- Contacting the parents at the last known addresses or phone numbers
- Using the federal parent locator service, reviewing case files/central registries

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- Asking about relatives and making efforts to contact any identified relatives
- Asking the children's current/previous schools for parent information
- Posting a legal advertisement in a newspaper (after all other search methods have been exhausted)

Concerted efforts to assess needs may include:

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

Concerted efforts to provide appropriate services may include:

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

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

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

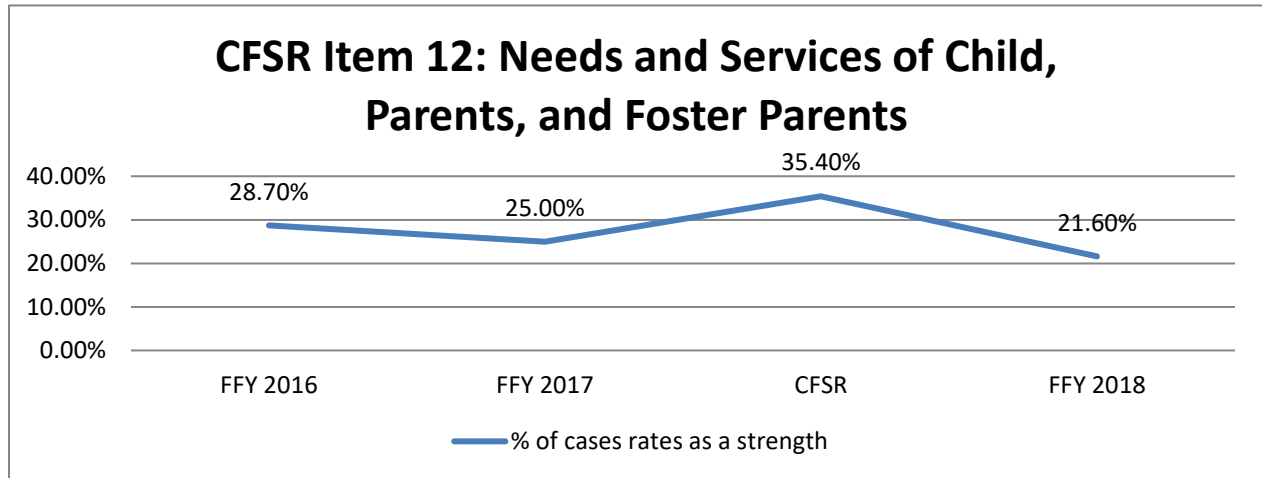
DPQI Quality Assurance Case Review Data

Baseline: 19.2%

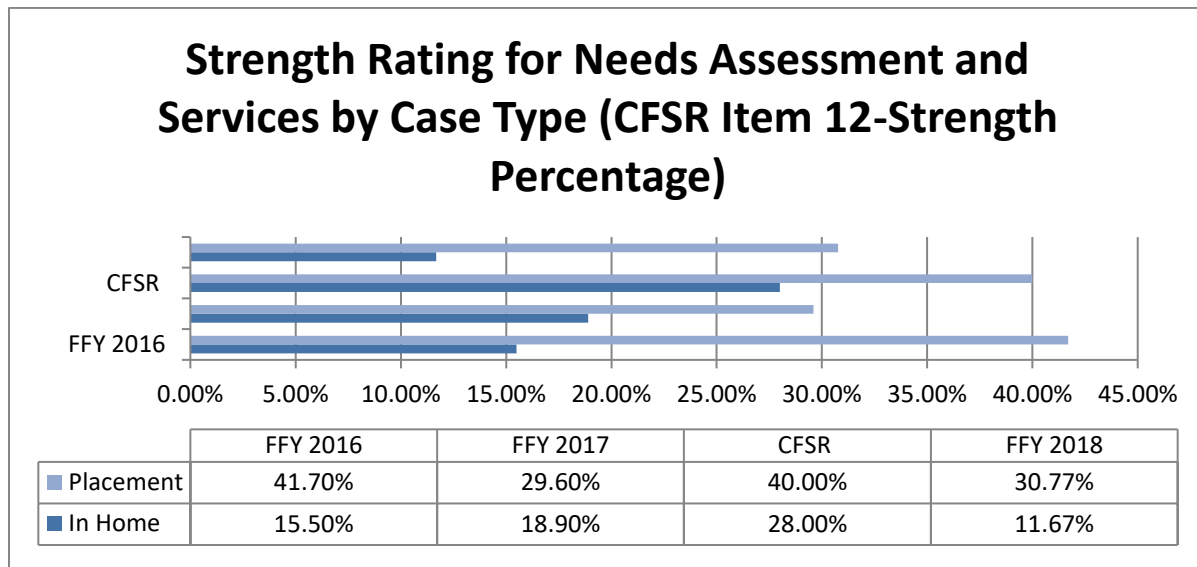
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PIP Goal: 23.7%

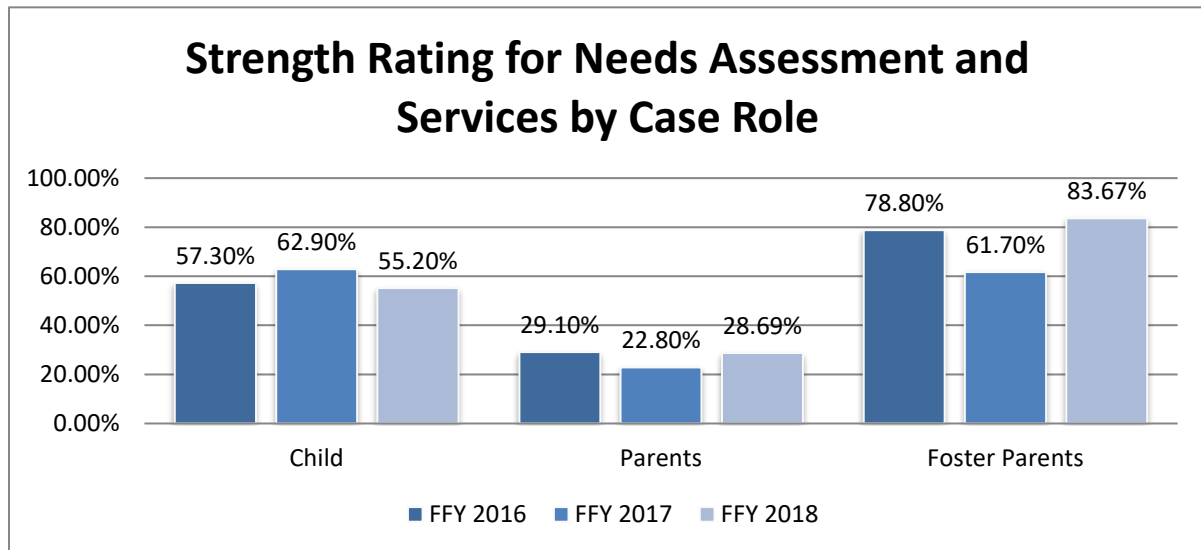
Reporting Period 6/2018-5/2019: 28%



Source: DPQI Case Review Data



DPQI Case Review Data



DPQI Case Review Data

Child and Family Involvement in Case Planning (Item 13)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

Concerted efforts to engage families in case planning may include:

- Having age-appropriate discussions with children and explaining case plans in language they understand
- Ensuring children understand permanency goals and changes made to goals

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- Discussing family strengths and needs with children and parents
- Evaluating other case plan goals and progress in services with both children and parents
- Ensuring that case planning meetings are arranged based on the family’s availability and are utilized to engage the family in case planning discussions

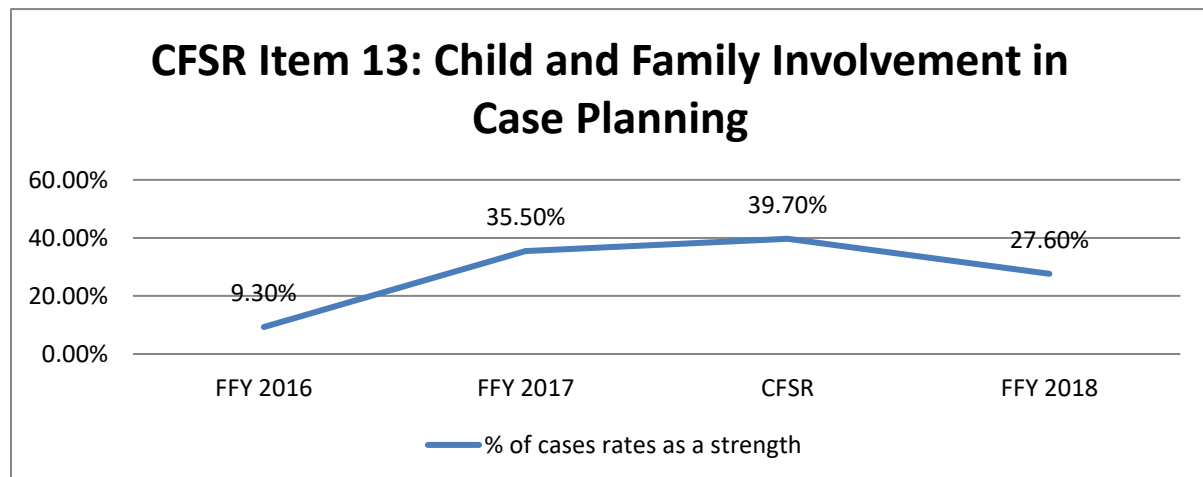
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

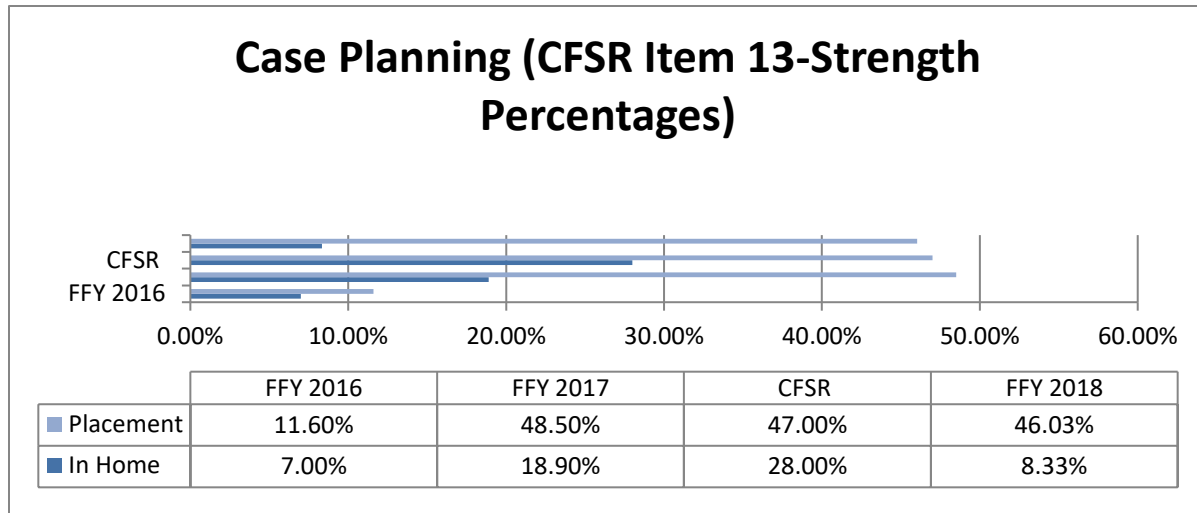
Baseline: 27.6%

PIP Goal: 32.8%

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



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Caseworker Visits with Child (Item 14)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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

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

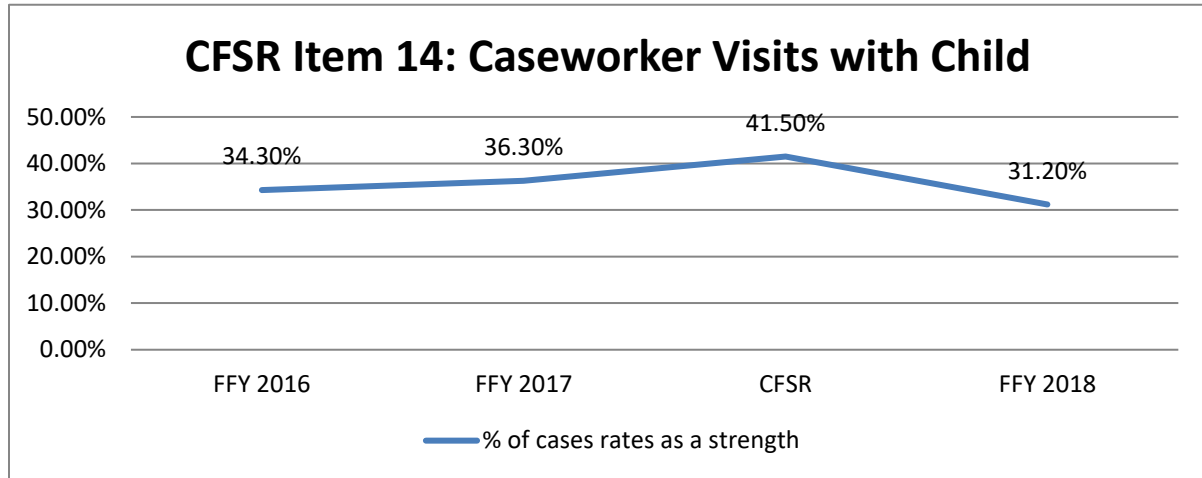
DPQI Quality Assurance Case Review Data

Baseline: 29.6%

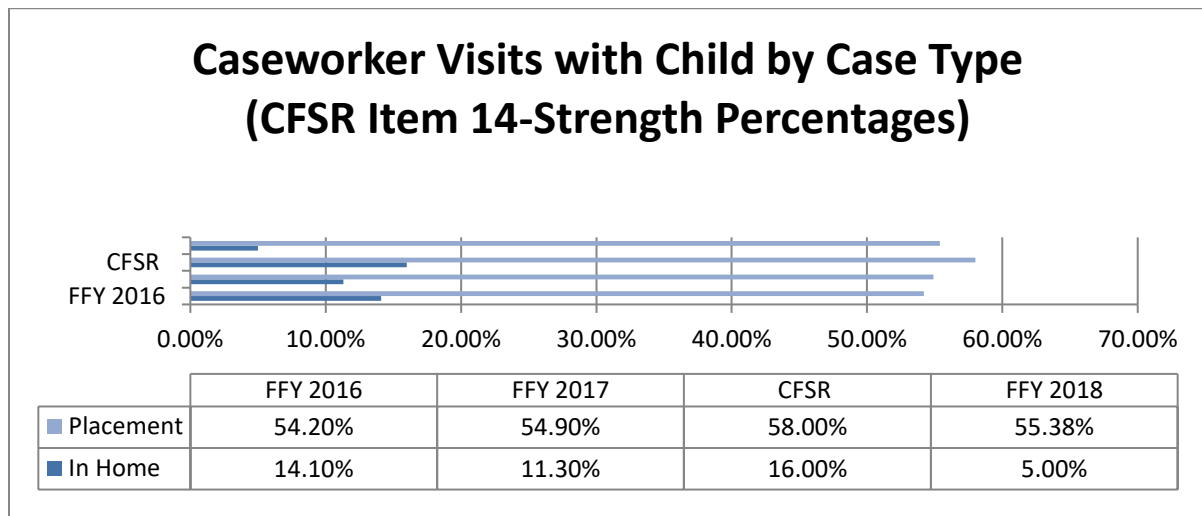
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PIP Goal: 34.8%

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



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Caseworker Visits with Parents (Item 15)

Purpose of Assessment: To determine whether, during the period under review, the frequency and quality of visits between caseworkers and the mothers and fathers of the child(ren) are sufficient to

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ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals.

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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

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

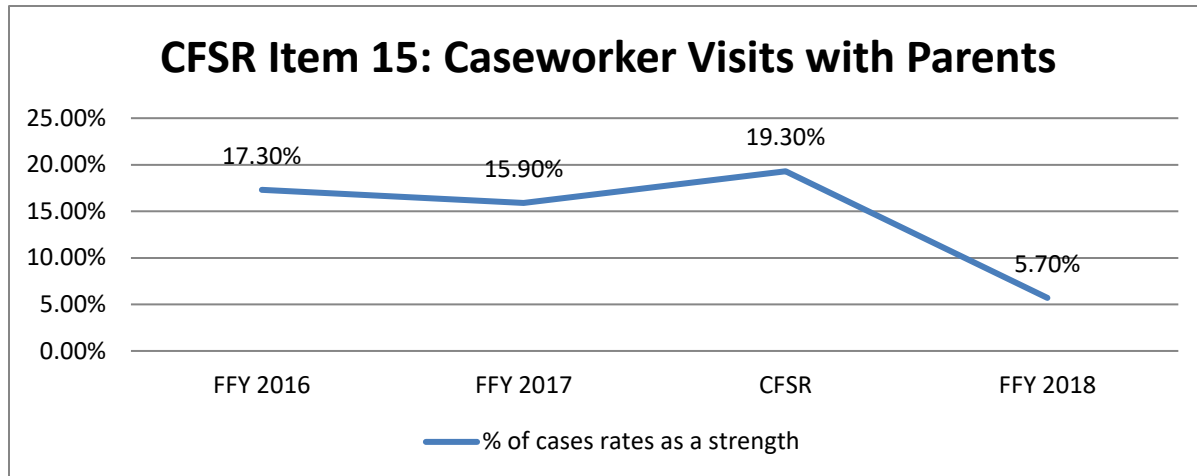
Goals and strategies to impact Well-Being Outcome 1 are in the WV Program Improvement Plan pgs. 26-29, 36-42, 44-49, 51-53

DPQI Quality Assurance Case Review Data

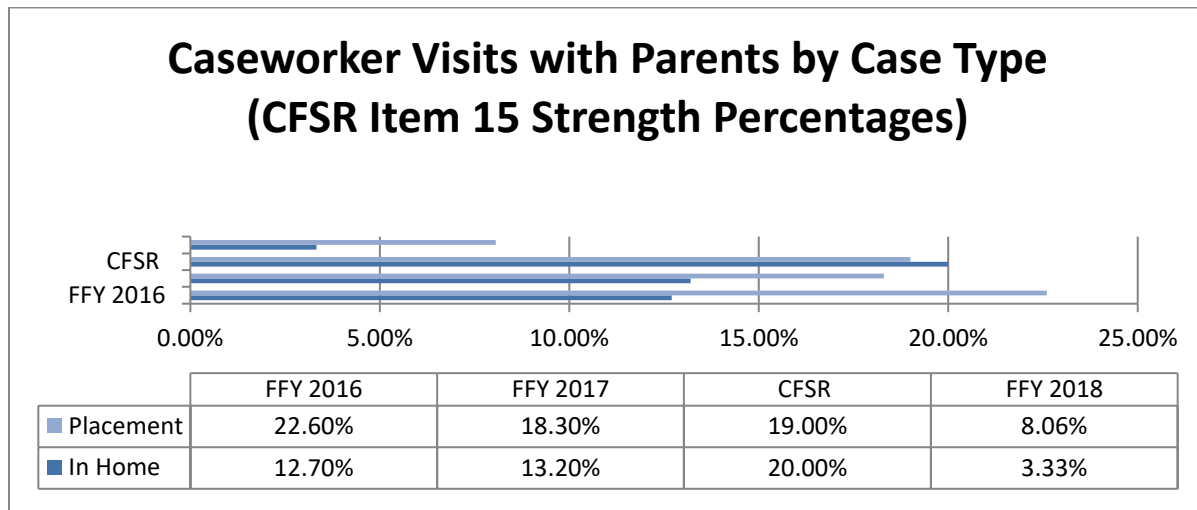
Baseline: 5.7%

PIP Goal: 8.4%

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



Source: DPQI Case Review Data



Source: DPQI Case Review Data

Well-Being Outcome 1 is measured by performance on Items 12, 13, 14, and 15 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal 2018 case review data indicates Well-Being Outcome 1 was substantially achieved in 12% of the cases reviewed, and partially achieved in 31.2% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review. The Child and Family Reviews Rd. 3 baseline indicated Permanency 1 as substantially achieved in 41.54% of the applicable cases reviewed. During this time period Item 12 rated as strength in 19.2% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 23.7%. The item rated 28% strength during the first PIP reporting period. Therefore, meeting the PIP goal for this item The Child and Family

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Reviews Rd. 3 baseline indicated Item 13 as rated strength in 27.6% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 32.8%. The item rated as strength in 35.25% of the applicable cases reviewed during the PIP first reporting period. Therefore, meeting the PIP goal for this item. The Child and Family Reviews Rd. 3 baseline indicated Item 14 as strength in 29.6% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 34.8%. The item rated as strength in 26.4% of the applicable cases reviewed during the PIP first reporting period. The Child and Family Reviews Rd. 3 baseline indicated Item 15 as strength in 5.7% of the applicable cases reviewed. The WV Program Improvement Goal for this item is 8.4%. The item rated as strength in 5.88% of the applicable cases reviewed during the PIP first reporting period.

Review data indicates placement cases scored higher on the measure than in-home cases. The inability to have frequent and quality contacts with children and parents by caseworkers had a direct impact on Well-Being Outcome 1. As the Practice Performance Report accurately indicates, neither the quality nor the quantity of caseworker contacts with children and parents is sufficient to ensure child safety and achieve case goals.

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

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

Educational Needs of the Child (Item 16)

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

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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

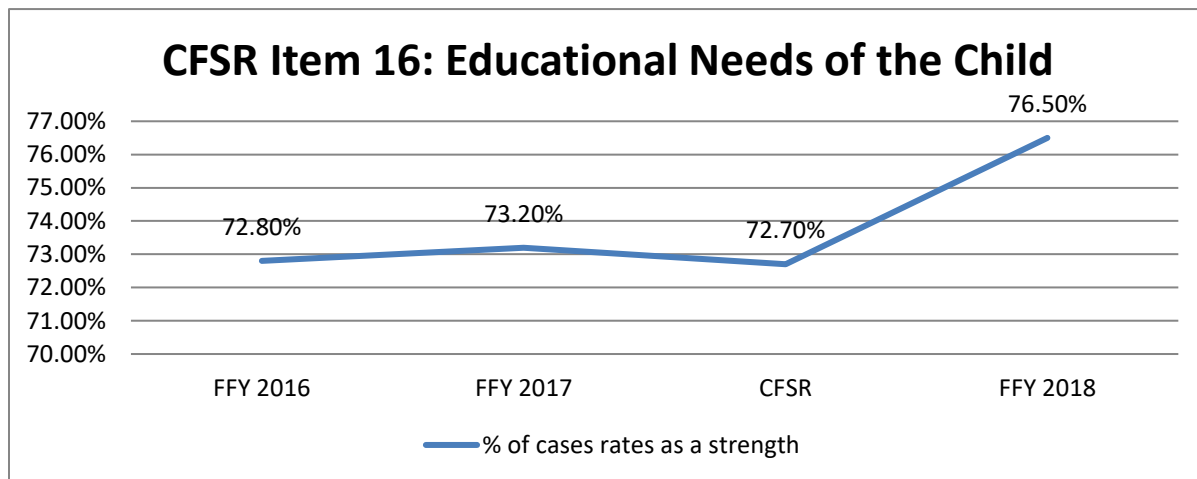
The focus of this item is on agency efforts, even if those efforts were not fully successful due to factors beyond the agency’s control.

Concerted efforts to assess needs may include:

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

Concerted efforts to provide services may include:

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



Source: DPQI Case Review Data

Well-Being Outcome 2 is measured by performance on Item 16 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2018 case review data indicates Well-Being Outcome 2 was substantially

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achieved in 76.54% of the cases reviewed. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

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

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

Physical Health of the Child (Item 17)

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

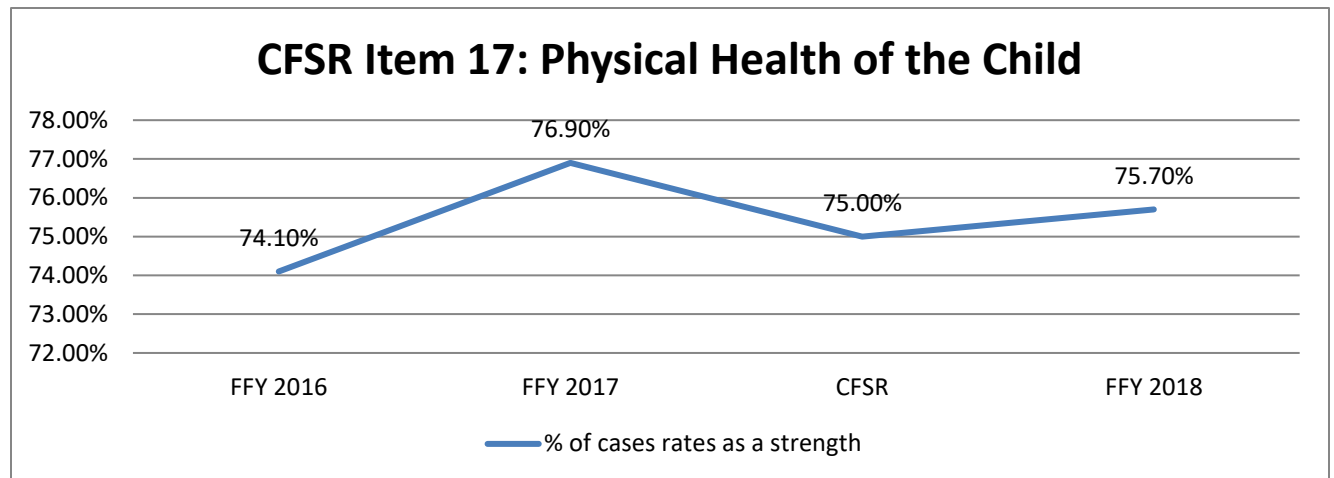
Strength Rating Defined

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

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

Concerted Efforts Required and/or Special Considerations in Rating

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



Source: DPQI Case Review Data

Mental/Behavioral Health of the Child (Item 18)

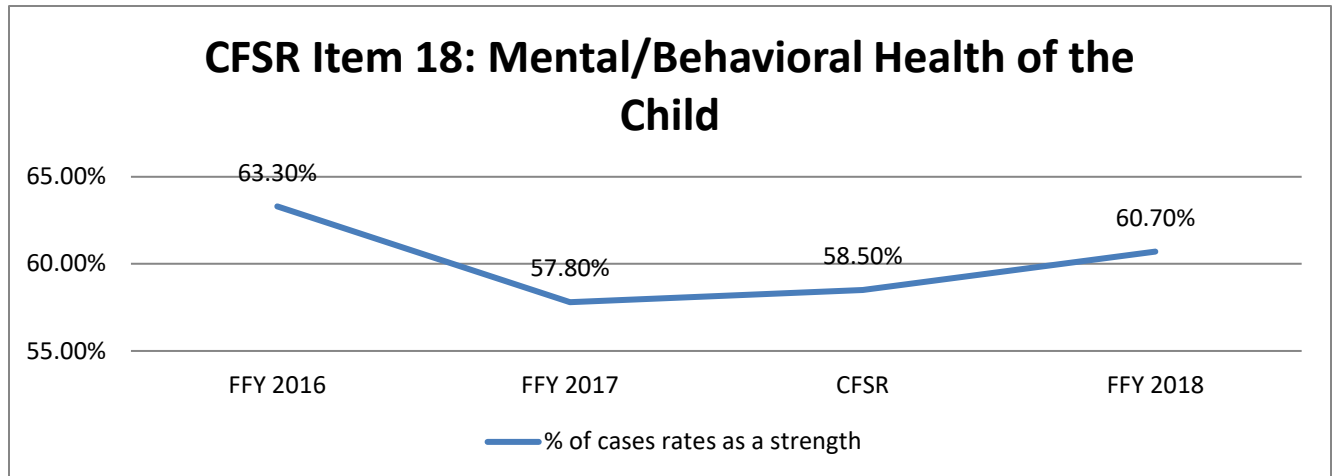
Purpose of Assessment: To determine whether, during the period under review, the agency addressed the mental/behavioral health needs of the children.

Strength Rating Defined

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

Concerted Efforts Required and/or Special Considerations in Rating

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



Source: DPQI Case Review Data

Well-Being Outcome 3 is measured by performance on Items 17 and 18 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2018 case review data indicates Well-Being Outcome 3 was substantially achieved in 67.69% of the cases reviewed, and partially achieved in 24.62% of the cases reviewed. The data reflects a 9.44% increase in the percentage of substantially achieved cases when compared to the prior FFY. Case reviews are reflective of practice that occurred 12 months prior to the date of the review.

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

Children in placement are more likely to have their behavioral health needs assessed and receive appropriate services to address identified needs than children involved in non-placement cases. Behavioral health assessments and services to address identified needs are provided or coordinated for children in placement by placement providers. The case review data indicates children in non-placement cases are less likely to have behavioral health assessments completed even when displaying overt behaviors that indicate such assessments are warranted. Barriers to children receiving behavioral health assessments and/or services are: lack of contact by agency staff with children in non-placement cases, lack of mental health providers within a district, the focus on one child and failing to assess all children in the home, and limited follow-up on behavioral health issues when a child is reunified. The WV PIP does

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not directly address WB 3, however many of the strategies within the PIP should positively impact the outcome.

Systemic Factors

Information Systems

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

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

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

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

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

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

FACTS has already begun data cleansing to prepare for conversion activities. FACTS is focusing on maintaining the accuracy and validity of the Title IV-E claiming data, demonstration waiver evaluation data and the IV-B, IV-E and Title XIX compliance reporting. The initial emphasis has been on resolving

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client duplication in the legacy data for a future push to the Master Client Index, which is central to the new system operations. In addition to surveillance and performance reporting around this initiative, we are planning on some extent of data corrections necessary to scrub the data of inaccuracies and inconsistencies

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

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

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

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

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

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

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

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

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

Case Review

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

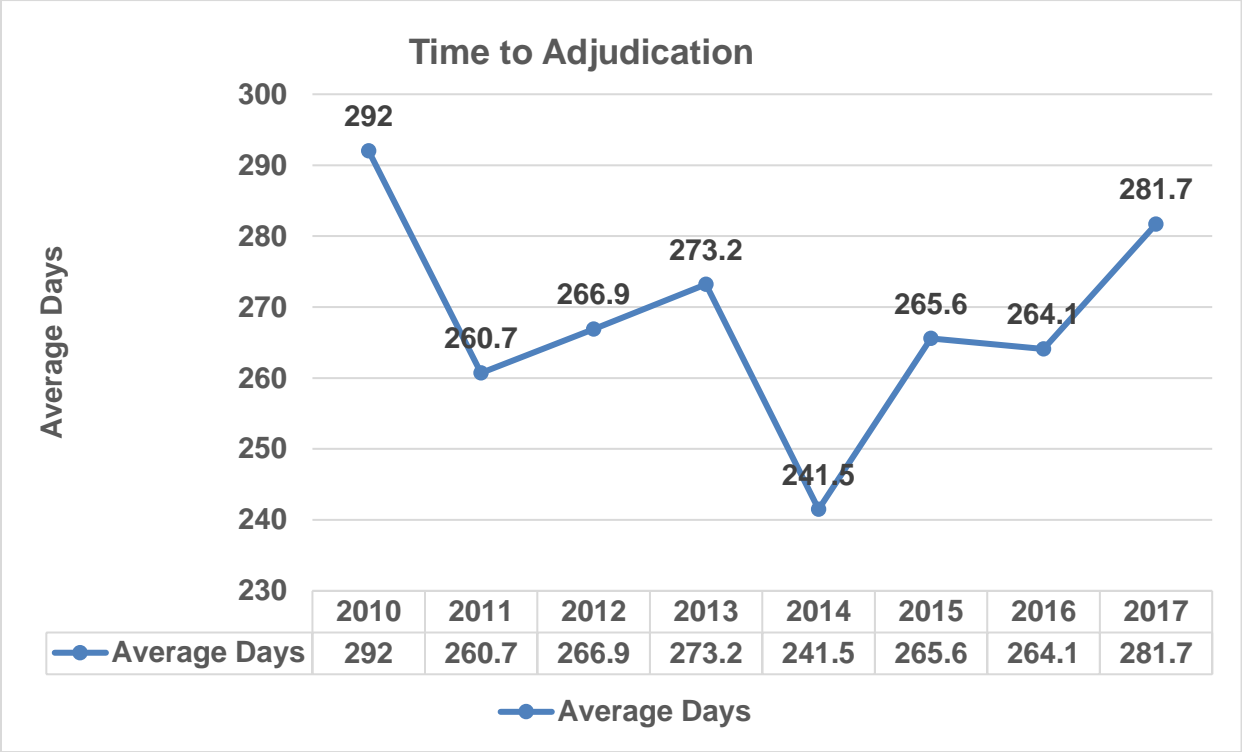
West Virginia does an excellent job of ensuring periodic reviews occur for each child no less than every 6 months, either by Court or Administrative Review. Review hearings are scheduled in all jurisdictions quarterly until permanency is achieved and the case is dismissed from the docket. An AFCARS report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

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

Time to Adjudication

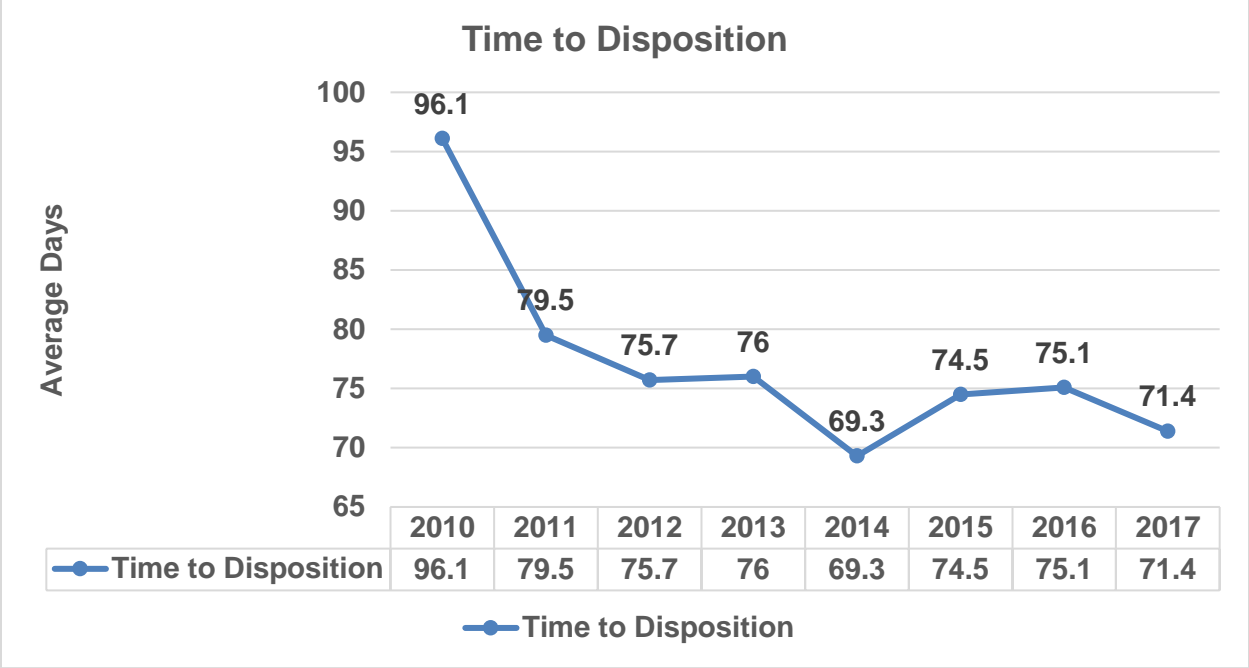
This measure will include calculating the average (mean) and median time from filing of the original petition to adjudication. The average will be calculated using all respondent records including original petition filing date and the beginning date of the adjudicatory hearing date for each respondent.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



Time to Disposition

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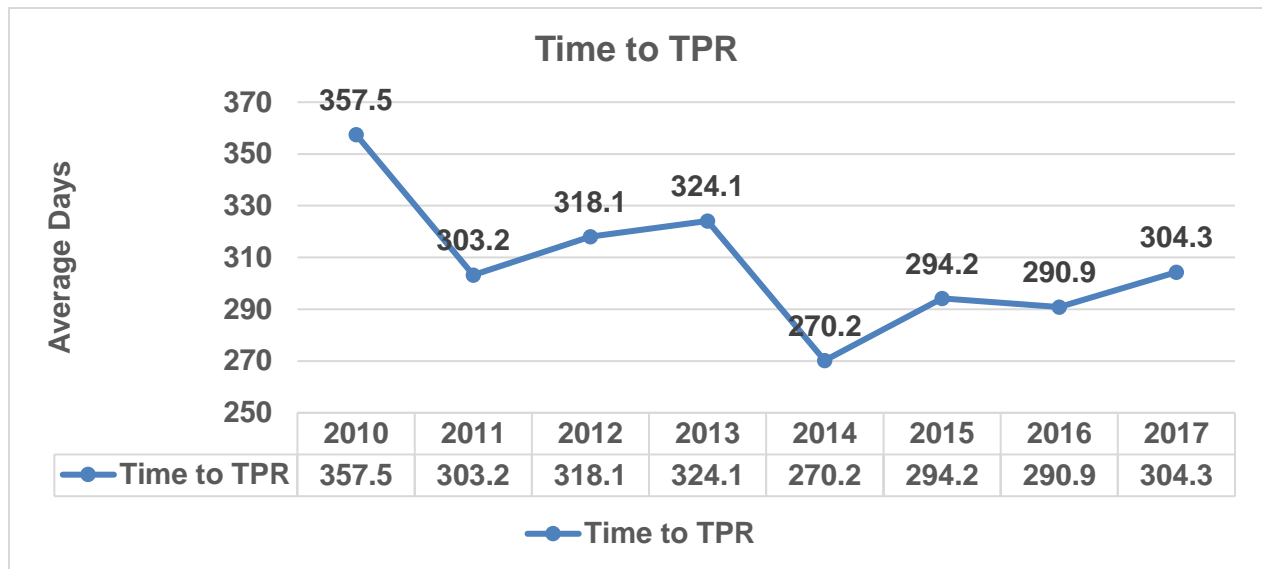
This measure will include calculating the average (mean) and median time from filing of the original petition to disposition. The average will be calculated using all respondent records including original petition filing date and the date of the earliest provided disposition date for each respondent.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



Time to Termination of Parental Rights (TPR)

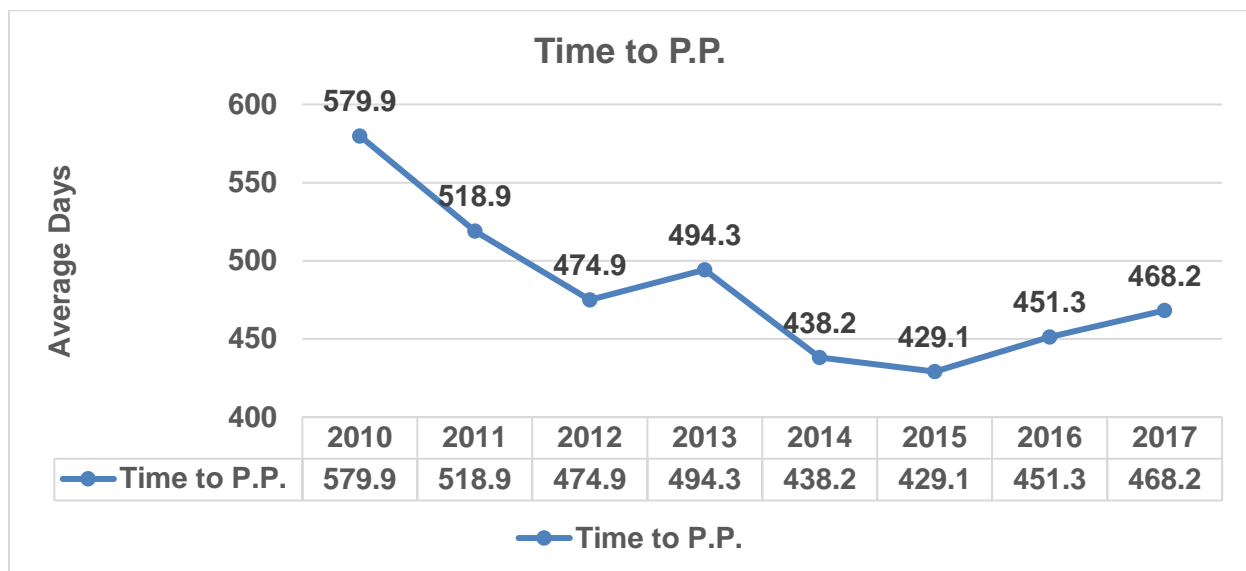
Court Improvement data indicates that time to Termination of Parental rights has fluctuated over the years but is currently at an average of less than twelve months.

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



Time to Permanent Placement

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



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

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

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

- **27%** foster/adoptive parents are **always** notified of court hearings.
- **20%** foster/adoptive parents **always** have their opinion heard at court hearings.
- **30%** foster children **always** attended MDTs when appropriate.
- **11%** foster children attending MDTs **always** had their opinion heard.
- It was felt MDTs **always** made the best decision for the foster child 24% of the time.
- **19%** of foster/adoptive parents were **always** asked to be involved in case planning.

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

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

The Bureau for Children and Families monitors the quality of service provision by social necessary service providers through a review process that requires a score of 80% or above during the provider's retrospective reviews for each service provided. When providers initially fall below 80%, they are given a six-month probation period wherein KEPRO (previously APS Healthcare) provides additional training and technical assistance. At the end of the six-month period, the service(s) falling below 80% is once again

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evaluated. If the service(s) still scores below 80%, it is closed, and the provider is no longer allowed to continue providing that service. In addition to the review process, in 2018 new agreements were developed with SNS providers that include new requirements and uniformity with monthly reports.

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

Training

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

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

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

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

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

Training Topic	Format	Hours
Orientation; Worker Safety; Introduction to Child Welfare Concepts	Online	12 hours
Interviewing, Interview Taping, and Transfer of Learning	Classroom Transfer of Learning	36 hours
Intake Assessment and Preparing for First Contact	Classroom Online	16 hours
Initial Assessment (by program area)	Classroom Transfer of Learning	36 hours
Family Assessment and Case Planning	Classroom, Online, Transfer of Learning	26 hours
The Court Process	Classroom, Online, Transfer of Learning	28 hours
Children in Care	Classroom Transfer of Learning	24 hours
Case Documentation	Classroom	42 hours
TOTAL HOURS:		220 hours

At the end of the ninth week, after it has been verified that the employee has completed all 220 hours of training, staff must successfully complete a competency test before assuming a caseload. The competency test contains three sections: a written knowledge examination, a skills-based interview based on the employees' program area, and a critical thinking examination to determine if the employee can make the correct decision based on information collected in the interview. The interview portion consists of actors role-playing a selected scenario with the employee interviewing the various members of the

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family. The employee must pass all three sections of the test with a score of 80% or above and may take the test up to three times. If the employee does not pass the test after three attempts, he/she must go back through new worker training from the beginning. Child welfare pre-service training must be completed before a caseload can be assigned according to law and for the purpose of Title IVE billing, and record checks are completed in FACTS every two weeks to ensure that no cases are assigned. If a caseload is found during the record check the trainer contacts the supervisor, CSM, and Regional Director to take action and have the caseload removed. The following table provides information on competency testing results in 2018.

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

The Division of Training starts two Child Welfare training rounds per month, one north and one south. Students are registered through a centralized onboarding process where the students’ names are identified when Oasis processing begins the new hire process. The supervisor or CSM is contacted to enroll the student in a training round and get the student enrolled in Blackboard. The employee can begin completing the initial online training starting on the first day of employment. The employee is scheduled to begin training within one to three weeks and may select either the next round or the closest round to the employee’s location. In 2018 the average time between start date and first day of training was 2.81 weeks, and the average time between start date and training completion (including competency testing) was 11.92 weeks.

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

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

In 2015 the West Virginia Legislature passed a law that allowed employees who are hired by the Department of Health & Human Resources to have a degree that was not in social work or a related field, provided they take a four-year training plan created and provided by the Department. This law was passed because of workforce shortages in various parts of the state. In 2018, 18% of staff hired by the Department had a degree in social work, 52% had a related degree, and 30% had an unrelated degree.

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The inclusion of staff without social work training in the workforce has caused the Division of Training to reevaluate each training it provides to ensure that all the information is included that an employee needs to perform child welfare jobs. Curriculum revisions and updates will continue over the next one to three years.

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

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

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

Question 27: Ongoing Staff Training

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

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

Feedback received from staff and supervisors has been that 100 hours of training after pre-service and within the first year of employment is too much. However, the 100 hours of training is currently written into the law that was passed for the restricted social work license and so cannot be reduced at this time. To compensate the Division of Training plans to incorporate an additional week of training prior to competency testing to complete 28 hours of this training, and parts of some trainings are being put online for better access.

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

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

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

There are several strategies related to training in the Program Improvement Plan and the new five-year plan. Statewide and regional trainings for managers, supervisors, and staff will be implemented and held twice per year. In addition, all supervisors and managers will be required to complete a shortened version of the new supervisor training that was implemented last year, and the Division of Training along with representatives from policy and DPQI will begin offering targeted training and technical assistance to district offices based on the results of their reviews. The training that has been developed for restricted license training will be opened to all staff and supervisors to meet the yearly 12-hour training requirement and for continuing education units.

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

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

Question 28: Foster Parent Training

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

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

The SWEC universities collect a large volume of data for each of their respective programs. Preservice training is evaluated after each session using a 10-point Likert scale, with 10 being the most positive score. The aggregate statewide mode for the training was over 9. Qualitative comments were almost uniformly positive, with the most frequent comments being, “the training was more helpful than I thought” and “I wish I had this training for my own kids”. Negative comments centered on facilities in which the training was held.

In addition to quantitative and qualitative continuous assessments, biannual surveys of foster parents are administered to assess the perception of foster parents of the efficacy of training longitudinally. The surveys found that after one and three years, the relevancy of the training mirrored the results of the training assessment immediately following the training. Furthermore, the surveys assessed what the foster parents perceived as content they needed to better address the needs of the foster children in their care. This data is juxtaposed with surveys of home finding specialists to assess gaps in needed content to more comprehensively discern future advanced in-service training.

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

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

Staff and Provider Training

The DHHR in conjunction with the states Court Improvement Program developed provider training for Child Placing Agencies and Residential Treatment Facilities and placed it on the DHHR/BCF website. The

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training includes a video titled “The Time is Now”, Away from Supervision Training and Normalcy and Prudent Parenting Training.

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

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

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

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

The Child Placing Agencies §78-2 requires:

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

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

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

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

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

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

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

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

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

- Basic medical needs and problems of the population served
- Basic first aid and medication reactions (updated every 3 years)
- CPR (every 2 years)
- Supervision of self-administration of medication as applicable, including typical medications prescribed, appropriate dosages & schedules and common side effects
- Basic de-escalation techniques and passive restraints
- Protocols for universal disease precautions and providing services to children with contagious and infectious diseases

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- Appropriate management of suicidal threats or behaviors
- Children's trauma stress experiences, to include impact on development, behavior and relationship; types of trauma; cultural factors; recognizing how on-going stressors impact child traumatic stress; responding to crises with interventions; strategies and interventions to promote resiliency & health
- Food handler's certification as necessary
- Agency's policy defining & prohibiting corporal & degrading punishment
- Procedures for maintaining a safe, hygienic and sanitary environment, including retarding the spread of infection and proper storage of cleaning supplies and hazardous materials

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

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

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

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

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

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

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

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

Quality Assurance System

Operating in the jurisdictions where the services included in the CFSP are provided

The West Virginia Department of Health and Human Resources (West Virginia DHHR) Bureau for Children and Families (BCF) has a comprehensive Quality Assurance System. The Department's QA system is centrally administered and operating in all jurisdictions of the state and is part of an overall Continuous Quality Improvement (CQI) process. Most QA functions are administered by the Division of Planning and Quality Improvement (DPQI). DPQI is under the Office of Planning, Research, and Evaluation. West Virginia has 12 designated DPQI staff for the purpose of providing quality assurance which includes three Program Managers, nine Health and Human Resource Specialist Seniors, and one DPQI Director. These staff members are stationed in various offices located across the Department's four regions.

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

DPQI completes Child and Family Services Review (CFSR) style social service case reviews for each of the West Virginia Department of Health and Human Resource's districts. One district level review is completed each month by DPQI staff. The review includes the examination of randomly selected cases consisting of in-home and placement cases. The largest metropolitan area is reviewed at least once each calendar year. The review cycle is continued until each district has been reviewed.

The Bureau for Children and Families is comprised of Community Services Districts that are divided into four regions. DPQI completed 125 CFSR style case reviews during the 2018 FFY. The FFY 2018 data is based upon the review of social services cases between October 1, 2017 to September 30, 2018. The review was comprised of 65 foster care and 60 in-home social service cases. Case reviews

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conducted were reflective of practice that occurred approximately 12 months prior to the date of the review. CFSR style case reviews were completed in each of the four regions of the state and included the following districts: Calhoun/Gilmer/Wirt, Fayette, Monongalia/Marion, Wood, Jackson/Roane/Clay, Cabell, Kanawha, Putnam/Mason, Berkeley/Morgan/Jefferson, Lewis/Upshur/Braxton, Wyoming, Greenbrier/Summers/Monroe/Pocahontas.

In July 2014, WV established a centralized intake system. Statewide implementation was phased in starting in July 2014 with full statewide implementation by February 2015. Centralized Intake call centers are in the northern and southern parts of the state. DPQI is responsible for the sampling and review of intake assessments. DPQI provides ongoing feedback to the Director of Centralized Intake as well as the Deputy Commissioner over Centralized Intake and the Commissioner. Each reviewer, in addition to other assignments, is randomly assigned ten Centralized Intakes to review each month. In addition to these ten, each review team also reviews any accepted intakes received on their monthly on-site case reviews. From May of 2018 to May of 2019 DPQI staff completed 618 reviews on intakes received by Centralized Intake.

West Virginia has established an internal child fatality review committee to review all child deaths due to child abuse and neglect and child near fatalities. Cases that are deemed by the internal review team to need an intensive level of review are reviewed by a member of DPQI in conjunction with two representatives from field staff. The results are reviewed by an internal review team quarterly. The objective is for the team to learn from these fatalities and near fatalities in order to prevent similar deaths in the future.

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

The DPQI unit also completes targeted reviews and related activities. For example, during FFY 2018 DPQI staff assisted in the merging of duplicate customers in the Family and Child Tracking System.

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This is being done to eliminate data quality errors and to prepare for conversion to the new automated child welfare reporting system.

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

Have standards to evaluate the quality of services

Standards to ensure that children and families are provided quality services that protect their safety and health, from referral intake to the achievement of permanency, are defined by federal and state laws and Department policy, at <http://www.dhhr.WestVirginia.gov/bcf/policy/Pages/default.aspx>. Department outcome measures are based on federal requirements and state policy. Department staff has access to an internal data dashboard that captures outcome data. This includes timeliness of initiating investigations of child maltreatment compared to the assigned timeframe.

Regulations and standards for West Virginia foster homes and institutions can be found in Systemic Factor G. Foster and Adoptive Parent Licensing, Recruitment, and Retention.

In order to evaluate the state's efforts to improve performance in the areas of safety, permanency, and wellbeing, DPQI utilizes the federal Child and Family Services Review process as a model to measure and evaluate the state's performance for the above-mentioned areas. DPQI utilizes the January 2016 version of the Federal CFSR On-Site Review Instrument (OSRI) as the unit's primary internal tool for evaluating the quality of delivery of services to children and families. The OSRI evaluates the quality of service delivery to children and families. Each review follows the guidelines established by the Federal Bureau for Children and Families. Pairs of DPQI reviewers complete a review of the paper and electronic records and conduct key case participant interviews in order to evaluate adherence to policy and practice standards. The goal of the reviews is to improve practice in order to achieve positive outcomes for the children and families being served. The period under review covers a 12month section of time going backwards from the start of the review date to 12 months prior. Preliminary case reviews to collect information are done related to FACTS records only. From this, reviewers develop a list of questions and information needed to complete the CFSR review. DPQI review teams then conduct interviews with designated stakeholders including the case worker, parents, service providers, placement providers, youth if age appropriate and any other parties who may have information relative to the case review. DPQI reviewers also review the paper file for additional information as part of the review process and include this information in review findings.

After the cases are rated each case is debriefed. At a minimum, case debriefings are comprised of two review teams and a DPQI program manager. During these debriefings case ratings are discussed in

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relation to CFSR instrument instructions and clarification guides to ensure fidelity to the tool. DPQI program managers then complete initial and secondary QA activities.

Identifies strengths and needs of the service delivery system

The DPQI social services case review data provides for continuous quality improvement through the identification of the district's strengths and areas for improvement. The review data is used at the district level to evaluate case practice and assist districts in making improvements in the provision of services to children and families. After completion of the CFSR style reviews, exit conferences are held at the district offices where DPQI staff assists the district in interpreting the results of the review. At the exit conference, the data indicators, based on the 18 items reviewed, are discussed with the district. The district is also provided with a comparison chart from their prior review. At that time, an exit interview is conducted by DPQI staff with the district's management staff. During the exit conference district management staff can comment on the factors that contributed to the strengths and areas needing improvement. Additionally, districts are asked to identify which services needed are not available or accessible in the area. DPQI creates a list of base questions to be asked at all the exits. The questions are based on the previous Federal Fiscal Year data and the overall issues impacting practice within the State.

The Critical Incident Field Review Team performs a detailed review of the facts and circumstances surrounding the critical incident involving a child alleged to have been critically injured or died as a result of abuse and/or neglect. This includes, but is not limited to, a review of current child protective services, child, and family history of abuse and/or neglect, and a review of Department interventions and services from external providers. Interviews are conducted with staff and external providers. A search of FACTS is conducted to identify the CPS or YS history of the family. All Intake Assessments are reviewed to determine if the screening decision follows code and policy. All assessments are read to determine if the findings are correct and procedures for completing the assessment adhere to policy. Case plans and safety plans are reviewed to determine if the plans appropriately address the identified problems in the home. All case contacts are read to determine the quantity and quality of caseworker interaction with the family. The team reviews all services to ensure requests were made in a timely manner and the provider delivered the requested services. Through the review process gaps in service availability and provision are identified. The findings are reviewed at the quarterly critical incident review meeting and the team determines if the child critical incident was due to abuse and neglect.

Provides relevant reports

DPQI staff utilizes the CFSR Online Monitoring System (OMS) developed by JBS International to complete case reviews and develop relevant reports. The OMS is available for states to use not only for the Federal CFSR, but also for continuous quality improvement (CQI) purposes. The OMS is a web-based application that provides DPQI staff the ability to complete case reviews and provide relevant district, regional, and state level reports. Because the OMS is automated it reduces the risk of reviewer error in completing the OSRI.

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Following the social service review exit with the district management team DPQI completes a comprehensive report on the results of the review. The exit summary report is provided to the district for review and comments. DPQI provides this information to Children and Adult Services and the Program Manager for Community Partnerships for the identification of service needs and development of services. Districts complete a corrective action plan based on the identified areas needing improvement outlined in the exit summary. DPQI compiles the exit summary, data and corrective action plan for each district and distributes the findings to the district's management staff, the Regional Program Manager, Regional Director, Director of Training, Policy Program Specialists, and Department Leadership.

DPQI provides ongoing feedback to the Director of Centralized Intake Unit and the training staff assigned to the unit. The Centralized Intake Unit utilized the results of the reviews to improve the quality of the intakes and adhere to the fidelity of the screening process.

The Critical Incident Review Team develops recommendations for modification of internal procedures, policies or programs of the Bureau for Children and Families; identifies programmatic or operational issues that point to the need for additional internal training or technical assistance; develops recommendations for external stakeholders to assist in the effort to reduce or eliminate future child fatalities through improved services to children and families; and identifies community resources for children and families that are needed but are currently unavailable or inaccessible. The Critical Incident Review Team submits an annual report to the Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: <http://www.dhhr.WestVirginia.gov/bcf/Reports/Pages/default.aspx>

Evaluates implemented program improvement measures

West Virginia's quality assurance system utilizes data from various sources to monitor the efficacy of program improvement measures. The State utilizes CFSR style social service review data in conjunction with the State's data profile (contextual data report), and data from the State's Statewide Automated Child Welfare Information System (SACWIS) in the development, planning, and monitoring of Child and Family Services Plan (CFSP) goals and other statewide child welfare initiatives.

As indicated earlier, results of the social services reviews are used by districts to develop corrective action plans. The comparison chart provided to the districts at the social services review exit conferences, and discussion of the corrective action plan developed at the conclusion of the prior review, allow management staff to evaluate the efficacy of the strategies for improvements that were implemented.

The Centralized Intake Unit utilizes the results of the DPQI intake assessment reviews, along with feedback from external stakeholders, to improve the quality of the intakes and improve fidelity to the

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Safety Assessment and Management System. The information is also used to ensure uniformity in screening decisions.

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

Service Array

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

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

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

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

During these meetings, and subsequent correspondence through e-mail, the Service Array workgroup determined that DHHR staff and stakeholders may not know where to find service availability for

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substance abuse and other services an individual or family might need. West Virginia has a 24-hour helpline (Help4WV) staff and other stakeholders may need to know specifically how to assist those needing help with addiction or mental illness. Help4WV provides free help securing a referral or placement for treatment <https://www.help4wv.com>. The members with the Bureau for Behavioral Health (BBH) and Bureau for Medical Services (BMS) stated that they have developed multiple new “Response for Application” (RFA) with a focus on substance abuse, over the past several months.

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

West Virginia’s Service Array includes:

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

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

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

The WV DHHR funds and supports several child abuse prevention initiatives that use a combination of CBCAP, Temporary Assistance for Needy Families (TANF), and MIECHV funds, state appropriations, and private funds. These initiatives include In Home Family Education Programs (IHFE), Family Resource Centers (FRC), and Partners in Prevention grants to communities. These programs are considered an

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integral part of the child welfare continuum by building and increasing protective factors that enable parents and families to nurture and parent appropriately and connect them to concrete supports that help keep families out of the child welfare system. Programs are community based and driven, with advisory boards made up of program participants, service providers, and local leaders. Services are available to any member of the community, regardless of income, and are voluntary.

Family Resource Centers

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

Maternal Infant Early Childhood Home Visiting program (MIECHV)

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

Partners in Prevention

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

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

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

Birth to Three

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

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

Cognitive - thinking and learning

Physical - moving, seeing and hearing

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

Adaptive - doing things for him/herself

Communication - understanding and communicating with others

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

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

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

Right from The Start

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

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social worker or registered dietician. These services have the combined purpose to improve birth outcomes and reduce infant mortality and morbidity in a high-risk population with a medically focused approach.

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

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

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

Maternity Services

Maternity Services is limited funding of prenatal, delivery, postpartum and routine newborn hospital care for low-income, medically indigent pregnant women who are determined to be ineligible for Medicaid, have not insurance to cover obstetrical care, and have monthly income below 185% FPL. This includes minors and income eligible non-citizens. Maternity Services require prenatal care is provided in the standards outlined in the American College of Obstetricians and Gynecologist guidelines.

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

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

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

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Key Project Aspects

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

Family Resource Networks

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

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

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

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

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

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

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

- ***Child and Family Safety and Wellbeing***

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

- ***Economic and Poverty***

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

Expanded School Mental Health Approach (ESMHA)

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

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Trauma Informed Elementary Schools (TIES)

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

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

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

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

Transformational Collaborative Outcomes Management (TCOM)

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

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

In 2018, the following was continued:

- Experts Training (training-the-trainers);
- Automated certification process;
- All DHHR Youth Service Workers trained on the use of the WV CANS and received annual certification/recertification;

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- The CANS Algorithms used for decisions for placement and treatment in the Safe at Home West Virginia wraparound program, the Regional Clinical Reviews and the Out-of-State Clinical Reviews; and
- Promoted the Family First Prevention Services Act (FFPSA), the TCOM model for Youth Service staff that include a Family Assessment (WV FAST) and the Case Plan to identify both the child as a "candidate" and specified services as required by FFPSA.

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

Safe at Home West Virginia

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

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

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

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

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

Socially Necessary Services

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

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

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

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

Socially Necessary Services Retrospective Reviews

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

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

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

Providers who fall below 80% for a service, during their normal review period are placed on probation for each service category that did not meet the 80% rule. At the end of the probation period, each provider goes through a follow-up review on the service (s) not meeting the 80% rule. If a provider falls below 80% on the services a second time, then the service is closed for that provider.

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

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

Office of Drug Control Policy

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

Project Hope for Women and Children

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

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

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

Bureau for Behavior Health, Children's Wraparound

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

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Currently, Children's Mental Health Wraparound services are provided in six counties (Cabell, Kanawha, Raleigh, Marion, Harrison, and Berkeley) by five agencies (Braley and Thompson/ResCare, National Youth Advocate Program, Necco, Prestera, and FMRS). In the State Fiscal Year 2018, the BBH Children's Mental Health Wraparound Program had 118 referrals. Of these, 43 were accepted into the Children's Wraparound Program. Of the 75 not accepted, 39 did not meet eligibility requirements, 18 were unable to be contacted after numerous attempts, 12 of the parents declined the voluntary services, and four were not accepted during a brief period of funding transition. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

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

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

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

Children's Mobile Crisis Response

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

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

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

Services that help children in foster and adoptive placements achieve permanency

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

The Regional Clinical Review Process is a coordinated effort to provide a comprehensive and coordinated clinical review of designated youth. The process has several steps to assure that the review is objective, thorough, and includes a standardized assessment tool utilized in all reviews. The role of the review process is to identify what the youth's current treatment and permanency needs are and serve as a resource to the youth's individual Multidisciplinary Team (MDT).

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

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

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

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

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treatment plans. RCC services are available to children and families regardless of the child's custodial status.

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

Bureau for Juvenile Services (BJS) Conference Call-Meetings

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

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

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

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

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

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

Provider Input at MDT and Court Hearings

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

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

Educational Input at Multidisciplinary Treatment (MDT) Teams

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

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

Child Placement Network

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

The West Virginia Adult Behavioral Health Placement Network

The West Virginia Adult Behavioral Health Placement Network is a centralized resource for identifying daily availability of residential crisis, group home and treatment services across West Virginia for adults

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

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

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

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

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

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

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

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- Attendance Rates: OOH students were equal to Low SES and SPED at 92%. Whereas, all other students reflected 93% and ELL 95% participation rate.

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

The West Virginia Adult Drug Courts Program

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

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

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

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

As of June 30, 2018, there were 28 operating ADC programs comprising 34 individual courts covering 46 counties.

The West Virginia Juvenile Drug Court Program

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The West Virginia Juvenile Drug Court (JDC) Program is a cooperative effort of the juvenile justice, social service, substance abuse treatment, law enforcement and education systems.

JDCs are established in accordance with West Virginia Code §49-4-703 and are designed and operated consistent with the developmental and rehabilitative needs of the juveniles and operate under uniform protocol and procedures established by the Supreme Court of Appeals of West Virginia.

The program seeks to divert non-violent, juvenile offenders engaging substance abuse from the traditional juvenile court process to a non-adversarial, intensive, individualized outpatient substance abuse treatment process which includes parental involvement and cooperation. All JDCs use evidence-based treatment approaches and assessments and are evaluated annually.

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

For State Fiscal Year 2018, the average cost per youth was \$1,057. This cost includes intensive supervision and individualized treatment services and includes services to the family. This contrasts with the approximately \$110,000 annually in a residential or correctional facility placement. There were 291 participants served by the JDC programs for State Fiscal Year 2018.

As of June 30, 2018, there were 16 operational JDC programs.

Family Treatment Court

West Virginia is going to use the Family Treatment Court model to address cases entering the child welfare system that allege child abuse or neglect involving parental use of alcohol or other drugs. The family treatment court's mission is to ensure the safety and well-being of children and to offer parents a viable option to reunify with their children. A family treatment court does this by providing children and parents with the skills and services necessary to live productively and establish a safe environment for their families. The court partners with child protective services and an array of service providers for parents, children, and families. The Family Treatment Court includes an interdisciplinary team working together to address the complex issues facing families affected by substance use disorders. Family treatment court draws on best practices from the treatment court model, dependency court, and child welfare services to effectively manage cases within ASFA mandates. In this way, family treatment court ensures the best interests of children while providing necessary services to parents.

Transitioning Youth from Foster Care

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In 2018, the Commission to Study Residential Placement of Children, Service Delivery and Development (SDD) Workgroup updated the It's My Move wallet cards to include a scan code that links directly to the It's My Move website. The It's My Move website is a program that assists youth in gaining life skills to support them as they transition to adulthood. The website includes the Readily at Hand checklist of key documents and experiences needed as youth transition to adulthood. Youth can set up their own account, track their own progress, add notes, and save their information as they move through the checklist.

The following related goals are underway or have been achieved:

- Readily at Hand, <http://www.itsmymove.org/rah.php>, is an online and printable checklist of essential skills and experiences and links to information about needed documents. Updates to the website are currently underway.
- Youth who are transitioning to adulthood are provided the desk guide and wallet card for the It's My Move website, www.ItsMyMove.org/raf.php. The wallet cards have been updated to include a scan code that links to It's My Move and Readily at Hand.

West Virginia Interagency Consolidated Out-of-State Monitoring

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

The following summary outlines the 2018 out-of-state monitoring visits. While violations are noted, each facility also had positive programming aspects and is working on weaknesses through corrective action plans:

- Hermitage Hall, Nashville, TN – This was a return visit completed in January 2018. The facility was previously reviewed in November 2016 and since that time had four requests for investigations. Educational weaknesses identified included teacher certification issues; wide spans of grade levels in elementary and middle grade classrooms; lack of Career Technical Education (CTE) options; lack of structure leading to excessive restraints; no continuum of services for students with disabilities; expired IEPs; scheduling issues; and confusion about the rights of parents who retain educational rights.
- Devereux, Viera, FL – The review was completed in March 2018. No major violations were found – Devereux has a very low turnover rate of employees with many in the school and on the treatment, team employed for more than 20 years. Strengths identified include teachers are certified in special education; classrooms are observed four times per week through observation rooms; excellent technology availability and use; lesson plans are standard-based and contain quality instruction; educational field trips are provided monthly; and outdoor recreation

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opportunities are provided for students. A change in Florida State Standards no longer requires CTE coursework to graduate. Therefore, Devereux currently has no CTE programming in place where formerly they had an on-site cosmetology program. The facility administration was encouraged to develop partnerships for students to participate in community-based opportunities for work experience and career planning.

- George Junior Republic, Grove City, PA – A follow-up visit was conducted in March 2018. A DHHR team along with one WVDE representative visited George Junior to determine progress since the placements to this facility were suspended in January 2015. The team had the same concerns after the visit regarding treatment of WV youth, details of programming and attitude towards feedback and discussion regarding changes that should be considered.
- Timber Ridge, Winchester, Virginia – A review was completed in May 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, Transition Services, including a focus on the lack of CTE offerings, and Notification to Transition Specialist of Upcoming Discharges to provide support and planning with the home county in West Virginia.
- Natchez Trace, Waverly, TN – A review was completed in September 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, provision of FERPA training to school staff, and Notification to Transition Specialist of Upcoming Discharges.
- Foundations for Living, Mansfield, Ohio – A review was completed November 2018 (reports pending). Weaknesses identified include no CTE programs offered due to acute care in self-harm, trafficking, drug and alcohol treatment, and mental health concerns.

Agency Responsiveness to the Community

The Division of Planning and Quality Improvement (DPQI) utilizes Child and Family Service (CFSR) style reviews to evaluate case practice with children and families. Specifically, to the WV Service Array, the DPQI identify service gaps through the reviews and focus groups with parents, youth, and stakeholders.

In addition to the Division of Planning and Quality Improvement (DPQI) process, the West Virginia Community Collaborative Groups (Collaboratives) identify and address service gaps in their communities. The Collaboratives were originally formed in the late 90's with the purpose of continuous community assessment over specified geographical areas. In 2014, West Virginia was federally approved by the Administration for Children and Families to develop the IV-E demonstration project (known as Safe at Home WV). As part of Safe at Home WV, Community Collaborative groups play a key role in identifying these community-based services and, if needed, assist in developing services based on the needs of the children and families in their community. The Collaboratives have a sense of "community ownership" for children at-risk of being placed in out-of-home care and keeping children closer to their families and home communities when they must be placed out-of-home.

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The Collaboratives are expected to provide bi-annual reports to the Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF). However, not all Collaboratives provide these reports, they are not always provided consistently, the reports are not reviewed through a formal service development plan, the DHHR, BCF does not have a Memorandum of Understanding that formalized this relationship, and the information is not included in a formal service delivery and development plan for identifying service needs and gaps.

Although the Collaboratives continue to meet, some Collaboratives do not consistently provide community data reports on the service needs and gaps. The needs and gaps are reported to the four Regional Summits as well as the Regional CQI team. Community Service Managers are mandated members of each of these teams. They are to notify their Regional Director of these gaps in service and the Regional Director is to report the information to Bureau for Children and Families Leadership.

The Bureau for Children and Families has notified newer Community Services Managers of their responsibility to participate in each of these groups and their responsibility to make their Regional Director aware of any information shared at the Summits.

Communication and Dissemination Process

The Family Resource Networks (FRNs), currently develop the Family Resource Directories for each of the fifty-five counties in West Virginia annually. The FRNs support and promote the collaboration of all citizens in order to develop strategies for communities to succeed. Recently, the FRNs began putting their directories on a central website. This website was possible because a Benedum grant that was awarded to the Marshall County FRN. The Bureau for Children and Families recently required, as a part of the FRN Contract, the FRNs to utilize the central website as their resource directory. WV does need to develop a standardized process for the FRN's that will address how the information is to be gathered and how often the website needs to be updated and monitored.

In January 1, 2018 through June 30, 2018, seven (7) of the thirteen (13) Community Collaboratives (Family Central; Family Southern; Family Ways; Little Kanawha; Nicholas-Webster; Fayette/Raleigh; and Upper Potomac) reported for the **January 1, 2018 through June 30, 2018** biannual report. Of the seven (7) Collaboratives that reported, five (5) reported that they were addressing substance abuse issues and five (5) reported addressing foster parent recruitment/retention.

In July 1, 2018 through December 31, 2018, nine (9) of the thirteen (13) Community Collaboratives (Family Central; North Central; Nicholas-Webster; Family Ways; Upper Potomac; Family Southern; South Central; Raleigh/Fayette; and Greenbrier) reported for the **July 1, 2018 through December 31, 2018** biannual report. Of the nine (9) Collaboratives that reported, eight (8) reported that they were addressing substance abuse issues and four reported addressing foster parent recruitment/retention.

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Other issues that were being addressed by the Collaboratives during the 2018 calendar year were: Respite/Wraparound; Increasing Collaborative Membership/Key Partners; School Based Behavioral Health; Family Support/Basic Needs; Family/Youth Mentoring and Support; Support for Safe at Home WV program; Youth Transitioning; Recruitment and Retention of DHHR staff; Expanding Court Appointed Special Advocates (CASA); Multidisciplinary Treatment Teams; Truancy Diversion; and School Education on Mental Health Services for Children and Families.

Program Plan to be Implemented:

<p>1.1 Partner with the Capacity Building Center to develop a Service Array map of available substance abuse services throughout the state (utilizing work of the DHHR, Bureau for Behavioral Health (ranking)), and what barriers exist. Map development completed and will include:</p> <ul style="list-style-type: none"> • Identify type of services needed • Barriers for substance abuse services are identified
<p>1.2 Service Array Workgroup will meet at least monthly to collect information to develop map of service availability.</p>
<p>2.1 West Virginia will partner with the Family Resource Networks to provide Service Directories of available services on the FRN website that can be accessed by all DHHR staff and stakeholders.</p>
<p>2.2 Staff will be notified of the website and Resource Directories through short blackboard training</p>
<p>2.3 Staff will be notified quarterly through PSA blasts that highlight new services</p>
<p>2.4 Provide information on WV DHHR Facebook on FRN website and Resource Directories.</p>
<p>2.5 Service Array Workgroup will meet at least monthly to collect information to develop map of service availability.</p>
<p>2.6 WV DHHR will develop and execute a formal statewide communication plan that will include all DHHR Bureaus (and others as needed) to improve cross-system service provision (identifying service availability, accessibility, barriers, and service development).</p> <p>2.6.1 Memorandum of Understanding between all DHHR Bureaus</p> <ul style="list-style-type: none"> • Memorandum of Understanding between DHHR and Community Collaborative Groups completed (July 1, 2019)

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- Standardize communication process completed that:
- Applies the Service Array map and Community Collaborative Group reports for evaluation of service development and expansion.
- Formal Communication Plan utilized for service development

All information about progress or the lack of progress to West Virginia's goals are shared at Statewide ESSA, Trafficking, Drug Affected Infants group and CIP Data Statute and Rules committee meetings on a regular basis. Goals for each program area are discussed at length and cross training within the meetings occurs to ensure the state is maximizing all its resources to achieve safety, permanency and well-being for its children and families.

2018 Annual Youth Stakeholder Focus Group Summary
Socially Necessary Services/Community Behavioral Health Services

During Contract Year 18-19, the Consumer & Community Affairs Liaison facilitated twelve (12) Focus Groups with youth, families and foster parents that reside in the community and utilize Socially Necessary Services (SNS) and Community Behavioral Health Services.

The purpose of these focus groups is to provide youth in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and impact of these services in the state. Information is gathered throughout the year with a minimum of twelve (12) focus groups that reflect consumers' voices regarding access, service delivery, cultural competency and outcomes.

Total: Ninety-six (96) youth, family and foster parents utilizing Socially Necessary Services/Community BH Services

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

- Access
- Service delivery
- Gaps in support systems
- Engagement with system staff
- Cultural competency

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- Consumer knowledge of services and supports
1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
One hundred percent (100%) or 96 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs.
 2. Are intake forms or materials available in different languages?
One hundred percent (100%) or 96 respondents stated that materials were available in different languages.
 3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
One hundred percent (100%) or 96 participants agreed that their agencies offered assistance for those with disabilities.
 4. Does the agency have trained interpreters readily available for various languages, including sign language?
One hundred percent (100%) or 96 participants stated that the agencies had access to trained interpreters for various languages and sign language.
 5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
One hundred percent (100%) or 96 participants agreed that the agencies had established connections to serve diverse groups.
 6. In the past six months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?
One hundred percent (100%) or 96 participants agreed that the agencies had established connections to serve diverse groups.
 7. Do you have the opportunity to attend racial group holidays or functions within diverse communities?
What was it?
One hundred percent (100%) of those responding stated that they had attended one or more group holidays or community functions within diverse communities.
They were as follows:

Passover services

Easter services

Various protestant church groups

Catholic services

Christmas parties

Holiday cook outs

ethnic dining/meal prep

Cultural Art Festival

Italian Festival

Hanukkah services

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8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
One hundred percent (100%) of participants or 96 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues.
9. Do you have access to religious services in which you affiliate?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
10. Does your care provider (Family) alter your programming or care based on your values or culture?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
11. Do you feel your services are tailored to your needs?
Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?
One hundred percent (100%) or 96 participants agreed that visits were comfortable, both physically and emotionally.
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?
One hundred percent (100%) or 96 participants stated that they were allowed to stay in touch with extended family, kin and friend from home.
14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snap chat?
One hundred percent (100%) or 96 participants stated that they were able to contact family and friends via email, skype, face time, Facebook, etc. with supervision and timelines.
15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
* To both questions
16. Do you have access to personal care items or services that match your needs? (Haircuts dye...)
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
17. Do you feel you get to express your personal style in clothing and appearance?
One hundred percent (100%) of participants or 96 respondents stated, "Yes."
18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?
Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."

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19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles?
Ninety-four percent (94%) of participants or 90 respondents stated, "Yes." Another Six percent (6%) or 6 participants said, "No."
20. Do you feel isolated or separated/segregated due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth would receive?
Eighty-two percent (82%) or 79 participants said, "No." Another eighteen percent (18%) or 17 participants said, "Yes."
21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
One hundred percent (100%) or 96 participants said, "Yes."
22. Have caregivers identified support groups, places, and people for you outside of the family setting?
One hundred percent (100%) or 96 participants said, "Yes."

**2018 Annual Youth Stakeholder Focus Group Summary
Medically Necessary Services - Behavioral Health/Residential Facilities**

The Kepro Consumer & Community Affairs Liaison facilitated twelve (12) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities.

The purpose of these focus groups is to provide youth in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various regions across the state of West Virginia to gain insight regarding the utilization and impact of these services in the state. Information is gathered throughout the year with a minimum of twelve (12) focus groups that reflect consumers' voices regarding access, service delivery, treatment plan goals, cultural competency and outcomes.

One hundred thirty-six (136) youth receiving behavioral health treatment placed in residential settings. The focus group questions were developed with input from the Bureau for Children and Families. The intent of these questions was to generate responses identifying systemic issues regarding consumer perceived problems and solutions regarding:

- Access
- Service delivery

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- Gaps in support systems
 - Engagement with system staff
 - Cultural competency
 - Consumer knowledge of services and supports
1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
Seventy-six percent (76%) or 103 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs, while twenty-four percent (24%) or 33 participants were unsure.
 2. Are intake forms or materials available in different languages?
Seventy-eight percent (78%) or 106 respondents were unsure if materials were available in different languages, while eighteen percent (18%) or 24 participants stated that the agencies did provide alternative language formats. Four percent (4%) or 6 respondents stated that forms were available in different formats.
 3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
Eighty-four percent (84%) or 114 participants agreed that their agencies offered assistance for those with disabilities, while sixteen percent (16%) or 22 participants weren't sure.
 4. Does the agency have trained interpreters readily available for various languages, including sign language?
Ninety-five percent (95%) or 129 participants stated that the agencies had access to trained interpreters for various languages and sign language. Five percent (5%) or 7 respondents did not know.
 5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
Sixty-seven percent (67%) or 91 participants agreed that the agencies had established connections to serve diverse groups, while twenty percent (20%) or 27 participants said, "No." Thirteen percent (13%) or 18 participants didn't know or had had no response.
 6. In the past six months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?
Sixty-nine percent (69%) or 94 of those responding agreed that the agencies had sponsored at least one activity that promoted teamwork and communication between cultural and ethnic groups. Thirty-one percent (31%) or 42 participants said, "No."

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7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?
Sixty-seven percent (67%) or 91 of those responding stated that they had not attended group holidays or community functions within diverse communities. While Thirty-three percent (33%) or 45 had and they were as follows:
- | | |
|-------------------|-------------------------|
| Passover services | Holiday cook outs |
| Easter services | Ethnic dining/meal prep |
| Christmas parties | |
8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
Thirty-three percent (33%) of participants or 45 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues, while sixty-three percent (63%) or 85 participants had not. Four percent (4%) or 6 participants gave no response.
9. Do you have access to religious services in which you affiliate?
Seventy-six percent (76%) of participants or 104 respondents stated, "Yes." While twenty-three percent (23%) or 31 respondents said no. One (1) person did not respond.
10. Does your care provider (Family) alter your programming or care based on your values or culture?
Seventy-two percent (72%) of participants or 98 respondents stated, "Yes." While twenty-eight percent (28%) or 38 respondents said, "No."
11. Do you feel your services are tailored to your needs?
Sixty-eight percent (68%) of participants or 92 respondents stated, "Yes." While thirty-two percent (32%) or 44 participants said, "No."
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?
Eighty-five percent (85%) or 115 participants agreed that visits were comfortable, both physically and emotionally, while fifteen percent (15%) or 21 participants had no family visits due to parental rights being terminated.
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?
Eighty-five percent (85%) or 115 participants agreed that visits were comfortable, both physically and emotionally, while fifteen percent (15%) or 21 participants had no family visits due to parental rights being terminated.
14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snap chat?
Seven percent (7%) or 9 participants stated that they were able to contact family and friends via email, skype, face time, Facebook, etc. with supervision and timelines; while ninety-three percent

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(93%) or 127 respondents agreed that other than face-face visitation they were only allowed to use the phone.

15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?

Seventy-four percent (74%) of participants or 100 respondents stated, "Yes." While twenty-six percent (26%) or 36 participants said, "No."

To both questions

16. Do you have access to personal care items or services that match your needs? (Haircuts dye...)

Eighty percent (80%) of participants or 109 respondents stated, "Yes." Twenty percent (20%) or 27 participants said their personal care needs weren't met.

17. Do you feel you get to express your personal style in clothing and appearance?

Eighty-five percent (85%) of participants or 115 respondents stated, "Yes." While fifteen percent (15%) or 21 respondents said, "No."

18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?

Seventy-two percent (72%) or 98 participants said, "Yes of the three questions." Twenty-six percent (28%) or 38 respondents answered no to all three questions.

19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles?

Seventy-two percent (72%) or 98 participants said, "Yes." Twenty-six percent (28%) or 38 respondents answered no.

20. Do you feel isolated or separated/segreated due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth would receive?

Forty-eight percent (48%) or 66 participants gave no response to both questions, while forty-five percent (45%) or 61 respondents answered no to both questions. Seven percent (7%) or 9 participants said, "Yes."

21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?

Sixty-eight percent (68%) or 92 participants gave no in response to both questions, while thirty-two percent (32%) or 44 respondents answered no to both questions.

22. Have caregivers identified support groups, places, and people for you outside of the family setting?

Forty-five percent (45%) of participants or 61 respondents stated, "Yes." There were identified supports outside the facilities, while another forty-five percent (45%) or 62 participants said, "No." Ten percent (10%) or 13 participants had no comment.

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2018 Annual Youth Stakeholder Focus Group Summary
Medically Necessary Services – Out of State Residential Facilities

The Kepro Consumer & Community Affairs Liaison facilitated six (6) Focus Groups with youth receiving Medically Necessary Services (MNS) for Behavioral Health issues who are currently in crisis /residential treatment facilities out of state.

The purpose of these focus groups is to provide youth in out of state placement the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis in various states to gain insight regarding the utilization and impact of these services in each state. Information is gathered throughout the year with a minimum of six (6) focus groups that reflect consumers' voices with regard to access, service delivery, treatment plan goals, cultural competency and outcomes.

Total: Fifty-two (52) youth receiving behavioral health treatment placed in out of state residential settings. The focus group questions were developed with input from the Bureau for Children and Families. The intent of these questions was to generate responses identifying systemic issues regarding consumer perceived problems and solutions in regard to:

- Access
 - Service delivery
 - Gaps in support systems
 - Engagement with system staff
 - Cultural competency
 - Consumer knowledge of services and supports
1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
Eighty-six percent (86%) or 45 participants agreed that the agencies were committed to providing pertinent materials that addressed their individual needs, while ten percent (10%) or 5 participants said, "No." Four percent (4%) or 2 participants had no response.
 2. Are intake forms or materials available in different languages?
Seventy-one percent (71%) or 37 respondents were unsure if materials were available in different languages, while twenty-three percent (23%) or 12 participants stated that the agencies did provide alternative language formats. Six percent (6%) or 3 respondent's N/A.

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3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
Eighty-six percent (86%) or 45 participants agreed that their agencies offered assistance for those with disabilities, while eleven percent (12%) or 6 participants weren't sure. Three percent (2%) or 1 participant did not respond.
4. Does the agency have trained interpreters readily available for various languages, including sign language?
Eighty-one percent (81%) or 42 participants stated that the agencies had access to trained interpreters for various languages and sign language. Eleven percent (12%) or 6 respondents did not know. Eight percent (7%) or 4 respondents did not respond.
5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
Fifty-two percent (52%) or 27 participants agreed that the agencies had established connections to serve diverse groups, while thirty five percent (35%) or 18 participants said, "No." Eleven percent (11%) or 6 participants didn't know and two percent (2%) or 1 participant had no response.
6. In the past six months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?
Seventy-three percent (73%) or 38 of those responding agreed that the agencies had sponsored at least one activity that promoted teamwork and communication between cultural and ethnic groups. Twenty-five percent (25%) or 13 participants said, "No." Two percent (2%) or 1 respondent did not reply.
7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?
Forty-six percent (46%) or 24 of those responding stated that they had not attended group holidays or community functions within diverse communities. While Forty percent (40%) or 21; another fourteen percent (14%) or 7 participants had no response.
Holiday cook outs
Easter services
Christmas parties
8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
Thirty-one percent (31%) of participants or 16 of those responding agreed that they were provided linkages to advocates regarding diverse and important issues, while forty percent (40%) or 21 participants had not. Twenty-nine percent (29%) or 15 participants gave no response.

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9. Do you have access to religious services in which you affiliate?
Ninety-eight percent (98%) of participants or 51 respondents stated, "Yes." While two percent (2%) or 1 respondent did not respond.
10. Does your care provider (Family) alter your programming or care based on your values or culture?
Eighty-three percent (83%) of participants or 43 respondents stated, "Yes." "While fifteen percent (15%) or 8 respondents said, "No." Two percent (2%) or 1 respondent did not reply.
11. Do you feel your services are tailored to your needs?
Seventy-seven percent (77%) of participants or 40 respondents stated, "Yes." While fifteen percent (15%) or 8 participants said, "No." Two percent (2%) or 2 respondents did not reply.
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?
Ninety-six percent (96%) or 50 participants agreed that visits were comfortable, both physically and emotionally, while two percent (2%) or 1 participant said, "No." Another two percent (2%) or 1 participant did not respond.
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?
Ninety-eight percent (98%) or 51 participants agreed that visits were comfortable, both physically and emotionally, while two percent (2%) or 1 participant had no response.
14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snap chat?
Ninety-eight percent (98%) or 51 participants said, "No." While two percent (2%) or 1 participant had no response.
15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?
Fifty-two percent (52%) of participants or 27 respondents stated, "Yes." While forty-six percent (46%) or 24 participants said, "No." Two percent (2%) or 1 participant did not respond.
* To both questions
16. Do you have access to personal care items or services that match your needs? (Haircuts dye...)
Ninety-eight (98%) of participants or 51 respondents stated, "Yes." Two percent (2%) or 1 participant did not respond.
17. Do you feel you get to express your personal style in clothing and appearance?
Sixty-seven percent (67%) of participants or 35 respondents stated, "Yes." While thirty-one percent (31%) or 16 respondents said, "No." Two percent (2%) or 1 participant did not respond.
18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?

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Thirty-nine percent (39%) or 20 participants said, “Yes of the three questions.” Forty-six percent (46%) or 24 respondents had no response to all three questions. Another fifteen percent (15%) or 8 participants were not asked the questions due to the specifics of the population.

19. Do you feel that caregivers’ uses inclusive language rather than identifying activities based on stereotyped gender roles?

Thirty-nine percent (39%) or 20 respondents said, “yes.”; while thirty-one percent (31%) or 16 participants stated they didn’t know. Fifteen percent (15%) or 8 respondents had no response and another fifteen percent (15%) or 8 participants were N/A.

20. Do you feel isolated or separated/segregated due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth would receive?

Forty-eight percent (48%) or 25 participants gave no response to both questions, while fifty-two percent (52%) or 27 respondents stated the questions weren’t applicable.

21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?

Twenty-eight percent (28%) or 15 participants said, “Yes, in response to both questions,” while thirty-one percent (31%) or 16 respondents answered no to both questions. Another thirty-one percent (31%) or 16 respondents did not reply to both questions’ Ten percent (10%) or 5 participants the question did not apply.

22. Have caregivers identified support groups, places, and people for you outside of the family setting?

Fifty-two percent (52%) of participants or 27 respondents stated, “Yes.” There were identified supports outside the facilities, while another forty-six percent (46%) or 24 participants said, “No.” two percent (2%) or 1 participant had no comment.

Client Services

The WV Department of Health and Human Resources maintains a unit of staff that handles calls from the public when issues arise. These staff research each case individually and report back findings to the individual who reported the issue. The following is statistical information regarding those calls. The state will use this data for comparison purposes over the next five years.

**Total and Monthly Calls for CSRC
and Client Services from January
1, 2019 through June 30, 2019**

Unit	January	February	March	April	May	June	Total
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CSRC	16,522	14,650	16,357	16,043	15,486	13,106	92,164
Client Services	3,609	3,176	3,273	3,135	2,983	2,674	18,850

Total and Monthly CPS and Foster Care calls and inquiries from January 1, 2019 through June 30, 2019

CPS/FC	January	February	March	April	May	June	Total
CPS Calls	89	81	87	88	120	89	554
CPS Inquiries	40	26	21	34	40	25	186
Foster Care Calls	0	0	2	1	0	3	6
Foster Care Inquiries	9	9	4	9	3	6	40

Court Improvement Program

The Program Manager of Residential Licensing attends the Shelter Care Network and Youth and Family Services meetings. The meeting is facilitated/sponsored by the Court Improvement Program (CIP). The meeting is attended by the Bureau for Families and Children (BCF), Emergency Shelter Providers, Judges and the CIP. The Shelter Care Network meets to discuss emergency shelter care in West Virginia. The Youth and Family Services meeting is also facilitated/sponsored by the CIP. The meeting is attended by BCF, Residential and Emergency Shelter Providers, West Virginia Department of Education, Bureau for Juvenile Services, Probation, Judges and the CIP. The focus of this committee is on the services and treatment of youth in state's custody. The Away from Supervision data that is collected from providers on a monthly basis is shared at this meeting,

NYTD data collected through the CCWIS system, as well as NYTD data collected through age 17, 19, and 21-year-old surveys are and will continue to be distributed to various entities, agencies, and workgroups. The Court Improvement Program (CIP) conducts permanency reviews and NYTD data is provided to them on a regular or as needed basis and is the avenue in which NYTD data is provided to West Virginia's court systems. NYTD data is also provided to workgroups such as the Service Development and Delivery Workgroup (SDDW), and the Transitional Living Workgroup (TLW), and to other state oversight entities such as the Bureau for Health Facilities (BHF). The SDDW, TLW, and other workgroups contain members of the Department of Health and Human Resources (DHHR), service providers, IL coordinators, and members of the public and use NYTD data to identify gaps in services, needs, and trends.

Additionally, through coordination with the DHHR, the WV MODIFY program is developing a youth council as part of the West Virginia Foster Advocacy Movement (WVFAM). This group will be youth led and made of current and former foster youth and Chafee fund recipients. While the youth of this council will have

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final say over which agencies and non-former or current foster youth can participate, and what subjects would be discussed, the NYTD data will be provided to them so that their discussions and desired outcomes can be as data informed as possible. Through this method, youth most affected by this data are included. It is anticipated the WVFAM youth councils will begin in early 2020 and be split with one occurring for the northern counties and one occurring for the southern counties.

Foster and Adoptive Parent Licensing/Recruitment

Foster care is an intricate service within the child welfare system. Foster care requires a partnership between the foster care providers, whether traditional, therapeutic, kinship/relative providers. This partnership is necessary for children to appropriately achieve permanency, primarily reunification, with adoption and legal guardianship as necessary for permanency. The partnership should exist between the foster care provider, child welfare staff, the Courts, attorneys, and service providers, as well as a key partner, the biological parents, or family of origin. This congruent partnership is crucial to achieving permanency and enhancing their well-being outcomes.

Foster care providers have reported through implemented Bureau for Children and Family surveys in 2017, that they do not feel as though they are included in the process and their opinion does not matter. Of the 31% response rate to the surveys, 28% of foster parents indicated that they were always notified of MDTs, and 27% indicated that they were always notified of court hearings; with 19% reporting that they participate with the development of case planning. Additional information provided by Marissa Sanders, the Director of the WV Foster, Adoptive, & Kinship Parents Network, has indicated that this continues to be a prevalent issue for foster care providers. This results in a struggle and has frequently resulted in the loss of foster care providers through the process.

West Virginia's child welfare system, the Bureau for Children and Families and the Court Improvement Program have begun to recognize that a true partnership with foster care providers is significantly lacking. Initiatives are being developed to address the identified barriers in communication and partnership with foster care providers and ensuring their right to be heard is recognized and shown the consideration they are entitled to have. West Virginia's Program Improvement Plan addresses these initiatives and strategies that will be continued through the next five years.

Child welfare staff with the Bureau for Children and Families strives to place foster children with kinship/relative care providers, currently having 48% of all foster children placed in a kinship/relative care placement. With the Kinship Navigator grant awarded, services to kinship/relative care providers will be ensured through the regional navigators. Additional needs have been identified specific to kinship/relative care providers. These needs include inconsistency with caregiver payments, the lack of needs of the family and/or children being met, and the lack of linkage to services. West Virginia's plan to address the needs of kinship/relative care providers is through the Kinship Navigator grant award. The Bureau for Children

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and Families has sub-granted the Kinship Navigator grant to Mission West Virginia for implementation. This will allow for regional Kinship Navigators to be placed locally within the regions and assist all new kinship/relative caregivers assigned to their caseloads. An assessment of needs form has been developed that will be utilized by the Kinship Navigators at three stages of placement; the initial placement, between three and six months after placement, and permanency achievement.

West Virginia will monitor the success of the Kinship Navigator program within the first two years of implementation through surveys provided to kinship/relatives at the onset of placement and at the achievement of permanency. If the program is successful, West Virginia will examine the structure of the program to determine a system of sustainability for continued improvement of kinship/relative care.

West Virginia has revised the Foster and Adoptive Parent Diligent Recruitment Plan to include missing components identified through technical assistance from the Capacity Building Center for States. The Foster and Adoptive Parent Diligent Recruitment Plan is attached. West Virginia currently contracts with 12 specialized/private family foster care agencies. Each agency performs their own recruitment in collaboration with Mission West Virginia. The 12 agencies have focused targeted recruitment efforts for address challenges with placing older children and youth. Targeted recruitment efforts include targeting recruitment for older children and youth, large sibling groups, and fostering only. Additional efforts are being made in counties where greatest needs are shown. The Bureau for Children and Families develops data reports comprised of the number of children in care for each of the 55 counties, and the number of family foster homes through any of the 12 contracted specialized/private agencies. This data is shared with Mission West Virginia, who develops recruitment plans based on the identified areas/counties of need revealed in the data. The Bureau for Children and Families is committed to continuing the recruitment effort and is currently in a Program Improvement Plan to implement strategies in order to achieve goals and outcomes for increased foster parent recruitment. *West Virginia's Statewide Recruitment Plan is attached.

Over the next five years, the Bureau for Children and Families will be using a workgroup that will pull monthly samples of foster care cases from each county in order to determine the appropriateness of child removals to ensure that the children coming into care are removed due to uncontrollable safety threats. A recent study was conducted on the number of removed West Virginia children. This study broke down the number of children in foster care from each of West Virginia's 55 counties. The number of children in foster care was compared to overall population of the county to determine which counties had the highest number of children in foster care per capita. The study was broken down further and the number of children in foster care in each county was compared to the number of minors, 18 and under in each of the corresponding counties. The 10 counties with the highest number of children in foster care, based on the comparison of the number of minors 18 and under in each county, were then compared to the national average of children in foster care. Some West Virginia counties are nine times the national average, while the entire state of West Virginia is approximately three times the national average. This workgroup's primary goal is to determine whether children being placed into foster care should be there, whether children can be maintained in the home with appropriate safety planning, and whether child welfare staff

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are exhausting all available resources in order to prevent child removals and ensure safety within the homes.

Through the 2017 West Virginia on-site CFSR findings, the Bureau for Children and Families began working on the Program Improvement Plan, which lead to deeper data dives. Through the deeper data analyses, it was discovered that the Bureau for Children and Families do not complete effective safety plans that would prevent children from being placed into foster care. Focus must begin to shift from removing children and placing them into foster care, onto appropriate safety planning to allow children to remain in their homes. Safety planning factors will be looked at by the workgroup charged with monthly reviews of random foster care cases in each county.

The Bureau for Children and Families contracts with 12 specialized/private foster care agencies, as well Mission West Virginia to recruit and train foster care providers. Mission West Virginia, in addition, partners with each agency to implement recruitment efforts within each region. The specialized/private foster care providers continually host events and activities to recruit new foster care providers. Efforts among all 12 contracted agencies include the following:

- Social media,
- Public service announcements,
- Church and faith-based partnerships for recruitment (singing events, youth events, and special services,
- Marketing through newspapers, radio, television, billboards, flyers, door hangers, return mail cards, and yard signs,
- Collaborating with other placing agencies through jointed events and activities,
- Attending community and county events,
- Utilizing current foster parents as recruiters,
- Fairs, festivals, and parades,
- Speaking engagements through local clubs such as Rotary, Lions, and Women’s Clubs,
- Foster parent recruitment bonuses,
- Attending regional or county Collaboratives and Regional Summit meetings,
- Orphan Sunday, Adoption and Foster Care month activities, and
- Monthly informational sessions.

These types of events have proven to be effective for the contacted specialized agencies, as specialized/private agency foster homes have nearly doubled between March 2016 and March 2019. The table below reflects the tracked increase since March of 2016.

Month	Mar 16	Sept 16	Jun 17	Sept 17	Dec 17	Mar 18	Jun 18	Sept 18	Dec 18	Mar 19

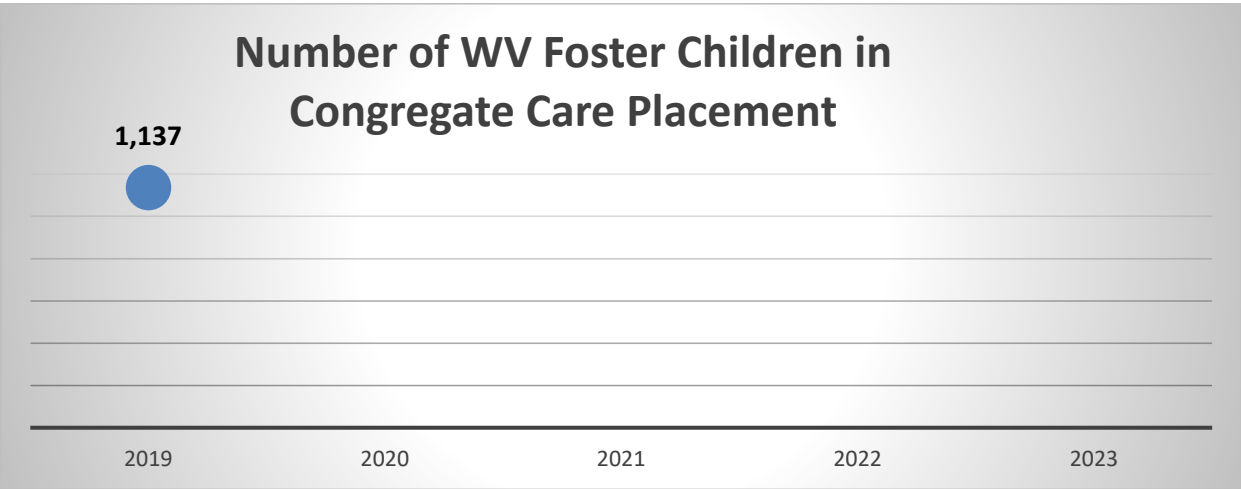
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Total Increase	692	779	987	955	1,052	1,066	1,093	1161	1,251	1,288
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The Bureau for Children and Families will provide monthly and quarterly data to Mission West Virginia relating to the number of children in foster care for each of the 55 counties, as well as the number of foster homes in each of the 55 counties. Mission West Virginia will compile the data to focus targeted recruitment efforts in counties with the greatest need of foster care providers based on the number of children placed in foster care per county. Mission West Virginia will collaborate with the child placing agencies within those counties to increase the number of foster homes through targeted recruitment.

Additional efforts are also underway and will continue over the next five years to convert certified kinship/relative providers to traditional foster parents. Currently region IV is in the beginning stages of bridging relationships between kinship/relative providers and specialized/private foster care agencies to aid with the transition from the Bureau for Children and Families to a specialized/private agency. The success of this effort will allow for expansion into the other three regions and will allow for an increase in certified foster parents.

Moreover, West Virginia envisions over the next five years to partner with foster care providers and promote them as resource homes to support biological parents or family of origin, in being reunified with their children. West Virginia envisions increasing reunification support efforts by encouraging foster care providers to mentor biological parents or family of origin, become a resource and/or respite for biological parents or family of origin, and support the goal of reunification by working directly with biological parents or family of origin to increase reunification of foster children with their families.



Source: FREDI PLC-0700 Point in Time 3/31/2019

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West Virginia has a process for tracking some data in relation to Cross-Jurisdictional Placements and Requests for Placements, but we do not have a “monitoring” system to track the progress of home study requests from other states.

There were 302 incoming requests for FFY 2018. Out of the 302 requests, WV completed 86 or 28% of the home studies within the 60-day timeframe. This is a decrease from the previous year, but it is a significant increase in the number of home study requests for the year. The most documented reason for the home studies not being completed within the 60-day timeframe is due to the lack staffing resources and other staff duties, but staff have been very inconsistent in their reporting reasons for delays.

The State ICPC Office has developed a new process to track home study requests. State Office ICPC staff continues to monitor a tracking spreadsheet of requests and send reminders to the local staff, prior to the home study being due.

The State ICPC Office continues to enter the home study requests in the FACTS System as a referral for services, when the request is received in the State Office. The referral is then be transferred to the local office electronically, which should assist in timeliness.

The ICPC Standard Operating Procedure (SOP) was revised to give a more step by step guidance to all field staff on completing the paperwork for an out of state request, completing and submitting an in-state home study, and the workers role throughout the ICPC case to ensure timely progression to permanency. The ICPC SOP was released to staff and can be re-released to ensure that everyone has reviewed it. The following activities have already been completed to improve these outcomes;

- The state ICPC Office will track all ICPC home study requests and send reminder to staff prior to the due date.
- Review the current website to determine if it is user friendly and staff are aware of the resources available on the site.

Additional activities not yet completed include;

- Work with BCF’s Training Unit on developing or enhancing training on concurrent planning to achieve permanency while using cross-jurisdictional resources for staff.
- Determine if the development of online training for field staff to complete on cross-jurisdictional resources if feasible and needed.
- Work with the Policy Unit to determine if the Home Finding Policy can be revised to address the following: How to handle an ICPC home study when the placement resource is non-compliant, and the completion of the study is delayed.

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- Review current field practices regionally to find a more streamline process in completing the home studies
- The ICPC Office will work with the Regional Managers in Homefinding, to develop a monitoring mechanism/process for field management, that will assist in monitoring the ICPC home studies, timeframes, overdue ICPC studies and the barriers to the studies being done timely.

3. Plan for Enacting the States Vision

West Virginia will be implementing the Family First Prevention Services Act (FFPSA) on October 1, 2019. Our state views this as an exciting opportunity to leverage these changes with existing initiatives in order to create lasting change in our child welfare system. Our state sees Family First as a tool to help us realize our vision to develop a proactive system which preserves safe and healthy families and correct a decades-old reliance on out-of-home care. Through the restructuring requirements, the focus on keeping children in the least restrictive setting, as well as the focus on primary prevention services, we believe FFPSA to be the much-needed missing piece of the puzzle.

Primary Prevention is a concept that often requires the child welfare staff to do the nearly impossible, in our crisis driven system, and think outside their child protection activities after maltreatment has already occurred. Associate Commissioner of Health and Human Services' Administration for Children and Families, Jerry Milner, honored West Virginia by addressing some of our state leaders and stakeholders December 11, 2018, during a meeting hosted by Casey Family Programs. During his presentation Mr. Milner urged states to remember that FFPSA will be a helpful first step in re-visioning child welfare but it must be viewed as only one of many tools that states will need. The funding allowances under FFPSA are revolutionary but they will not get us as far upstream as we need to go to effect real change.

In response to the Administration for Children and Families' call to action, the Department of Health and Human Resources has been refining its prevention vision over the past year, preparing for the development of the State's Family First Five-Year Prevention Plan. The goal of the prevention plan will be to expand existing prevention services, as well as enhance the array of services from which families may choose. Family engagement and family voice will be two important components of prevention service provision, much like Safe at Home.

Over the next five years, providers, foster parents, the courts, private citizens and DHHR staff will be involved at every step as we begin to plan, develop and utilize a broader range of in-home community-based services. The primary goal being to increase children served safety in their homes and decrease the number of children served in out-of-home care.

Please see the attached Family First Five-Year Implementation Plan.

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On December 10, 2017, the Children's Bureau released the WV CFSR Final Report and the CFSR financial penalty estimates. On December 21, 2017, the Children's Bureau conducted an exit conference during which the results of the CFSR case reviews and the Statewide Assessment and interviews with stakeholders conducted by Children's Bureau staff to determine conformity on the seven systemic factors was discussed. WV did not meet substantial conformity on the seven CFSR Outcomes and four of the seven CFSR Systemic Factors.

After each review round no state was found to be in substantial conformity in all the seven outcome areas and seven systemic factors. States developed and implemented Program Improvement Plans (PIP) after each review to correct those areas not found in substantial conformity. Since WV was determined not to be in substantial conformity with the seven outcomes and four of the systemic factors, a PIP must be developed to address areas of nonconformity. Following the CFSR exit conference workgroups were formed to address areas thought to impact the outcomes. These groups are: Worker Recruitment and Retention, Information Systems, Foster Parent Recruitment and Retention, Field Support-Meaningful Contact, Court Improvement Program-Data Group, and Service Array group. The Children's Bureau and DPQI will monitor the plan's implementation and the state's progress toward plan-specified goals. If WV is unable to demonstrate the agreed-upon level of improvement, the Administration for Children and Families must take a financial penalty from a portion of the state's title IV-B and IV-E federal child welfare funds.

It should be noted that to be considered in substantial conformity on a CFSR Outcome the state must achieve a rating of 95% on the applicable cases reviewed. For each of the 18 items that make up the outcomes a state must be found to have a strength rating of 90% on the applicable cases reviewed. This is an intentionally high conformity level which no state has ever attained. Therefore, all states following each CFSR round have developed a PIP.

DPQI staff completed onsite reviews of 65 cases (all finalized) and the data compiled. The case review data indicates WV has substantially achieved a rating of 56% on the cases applicable for Safety Outcome 1, 42% substantially achieved rating on cases applicable for Safety Outcome 2, 20% substantially achieved rating on cases applicable for Permanency Outcome 1, 65% substantially achieved rating on cases applicable for Permanency Outcome 2, 26% substantially achieved rating on cases applicable for Well-Being Outcome 1, 73% substantially achieved rating on cases applicable for Well-Being Outcome 2, and 59% substantially achieved rating on cases applicable for Well-Being Outcome 3. (Please see attached chart for additional information on item specific data)

West Virginia had multiple meetings with its stakeholders to review the Child and Family Services Plan and developed five groups to develop its Program Improvement Plan. This plan developed strategies to improve five over-arching areas which, if improved, would improve multiple CFSR outcomes. These include meaningful contact with children and families, service array, recruitment and retention of foster parents, workforce recruitment and improving safety.

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West Virginia's Program Improvement Plan has not been approved.

In June 2015 an article in the Washington Times reported West Virginia had the highest rate of overdose deaths in the U.S. West Virginia's drug overdose death rate was more than double the national average. Citing statistics from the CDC, it found that West Virginia's rate far surpassed the second-highest state, New Mexico, which was at 28.2 deaths per 100,000. The national average was 13.4.

West Virginia's number of children in foster care rose rapidly and the states data suggests that most of these children were younger and were removed predominately for substance abuse by their caretakers. The tenure and skill set of workers as well as community-based services could not keep up with the rate of the crisis.

That same year, West Virginia was reviewed by the Department of Justice and the following recommendations (summarized) were made;

- West Virginia should expand in-home and community-based mental health service capacity throughout the state to minimize or eliminate unnecessary institutionalization
- West Virginia should eliminate the unnecessary use of public and private segregated residential treatment facilities, both within the state and outside of the state. The State should ensure the availability of voluntary, comprehensive services and supports in the community to divert children from segregated residential placement.
- West Virginia should ensure that all Comprehensive Centers provide for (directly or indirectly) in-home and community-based mental health services across the
- West Virginia policy, practice, and regulations should ensure that a single Intensive Care Coordinator has ultimate responsibility and accountability in cases where a child is involved in multiple child-serving systems (such as child welfare, juvenile justice, Medicaid, and special education). The State should charge this Intensive Care Coordinator with ensuring the planning, delivery and monitoring of services and supports consistent with State and federal law. This entity should coordinate the provision of services using a high-fidelity Wraparound model pursuant to the National Wraparound Initiative's published guidance.
- West Virginia should develop an interagency decision making and oversight entity to improve coordination of and access to intensive mental health services.

The Office of Drug Control Policy was established to identify strategies to address the Substance Use issues within WV. The goal of the ODCP is to work with stakeholders and identify service gaps and needs in communities across WV and to reduce the drug overdose fatalities while working toward the development of a continuum of services and supports for those addicted to drugs.

The Department of Justice has developed a partnership with WV to provide support as the state develops a continuum of community services and supports for children with serious mental health disorders. West

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Virginia has committed to developing statewide Assertive Community Treatment for youth between the ages of 18-21, Expanded School-Based Mental Health Services, Behavioral Support Services, Children's Mobile Crisis Response Program, Wraparound, and a Children Serious Emotional Disorder Waiver that includes Therapeutic Foster Care services.

West Virginia believes that in addition to its Family First Five-Year Implementation plan and the states Program Improvement Plan, focusing on two main performance goals for the next five years will help set the stage for enacting its true vision for Child Welfare as well as bring the state closer to the vision of the Family First Prevention and Services Act. These two goals are extensions of the state's current PIP outcomes. They can be accomplished by simplifying our message to our front-line workers, Courts, providers and communities. They include; Increasing the percentage of West Virginia children who remain safe in their own homes, and, increase the number of youths experiencing positive outcomes as demonstrated through National Youth Transitional Database outcomes.

Several objectives under each goal will improve the quality of safety and case planning and improve the quality of both Child Protective and Youth Services intervention in the state. These activities include improving the frequency and quality of monthly contact by caseworkers, decreasing child fatalities, improving safety planning and case planning, decreasing repeat maltreatment and utilizing family preservation services more.

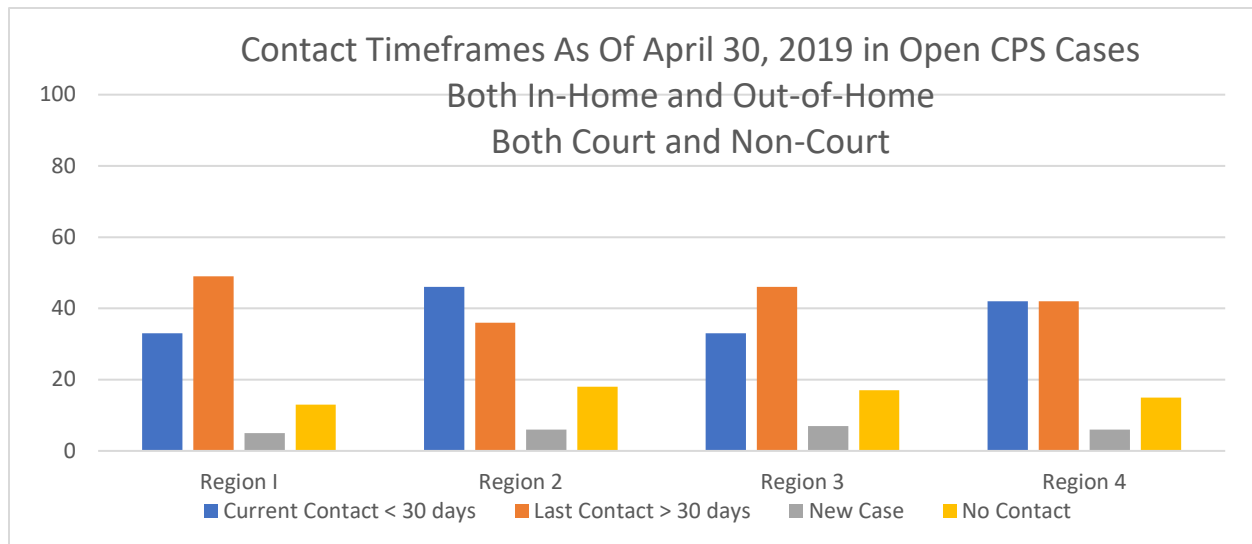
In support of West Virginia's second goal of improving outcomes of youth transitioning from foster care, the state will improve its frequency and quality of services provided to older youth in foster care. This, in turn, will benefit children born of previous foster children. Activities to accomplish this goal include increasing the number of youths in foster care who receive prevention and transitioning services, increasing the number of youths who receive supervised independent living services and increasing the number of youths in foster care who have and maintain permanent connections.

Goal 1. Ensure children receiving services, through Child Protective Services and Youth Services, remain in their own homes safely whenever possible.

The ability of the State to maintain children who are Candidates for Foster Care Placement due to Safety Concerns hinges upon quality Family Preservation Services provided to families. The percentage of Foster Care Candidates who remain in their homes until case closure will measure the success of prevention interventions. Trends in Socially Necessary Services track the number and duration of CPS and YS Family Preservation Services provided to families in their homesⁱ.

Objective 1.1 Increase the percentage of open cases with monthly contact by 2% the first year and 5% each additional year.

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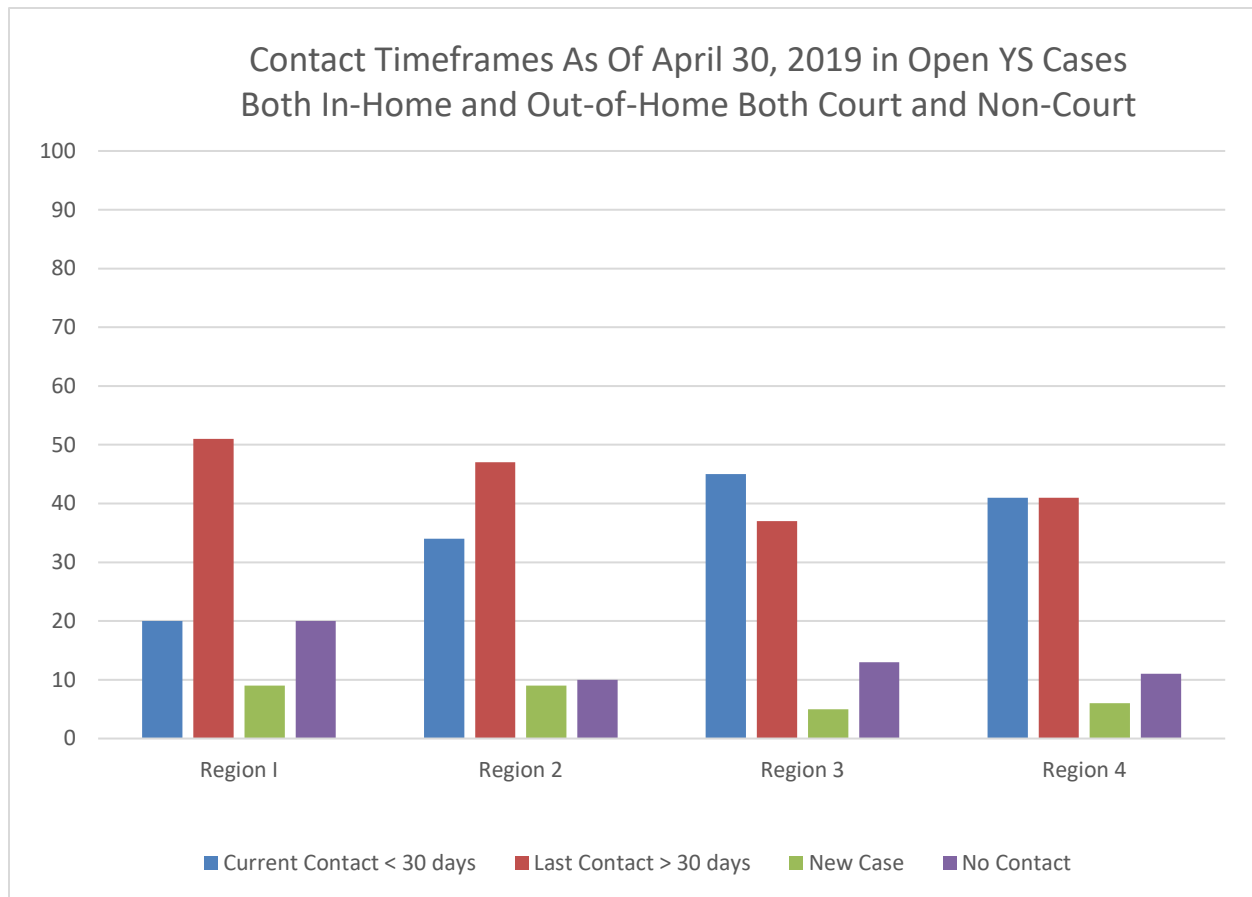


Current Contact < 30 Days	33%	46%	33%	42%
Last Contact > 30 Days	49%	36%	46%	42%
New Case	5%	6%	7%	6%
No Contact	13%	18%	17%	15%

Source: FREDI CPS-8801 and CPS-5140 As Of 4/30/2019

Year	Baseline	2020	2021	2022	2023
Performance	38.5%	40.5%	45.5%	50.5%	55.5%

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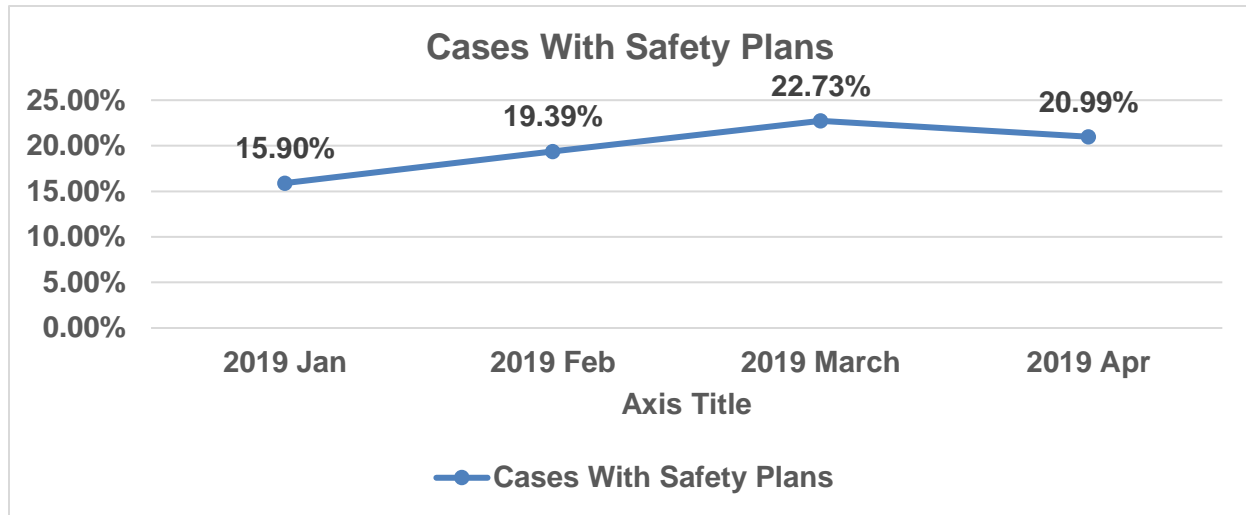
Current Contact < 30 Days	20%	34%	45%	41%
Last Contact > 30 Days	51%	47%	37%	41%
New Case	9%	9%	5%	6%
No Contact	20%	10%	13%	11%

Source: FREDI YSS-5020 As Of 4/30/2019

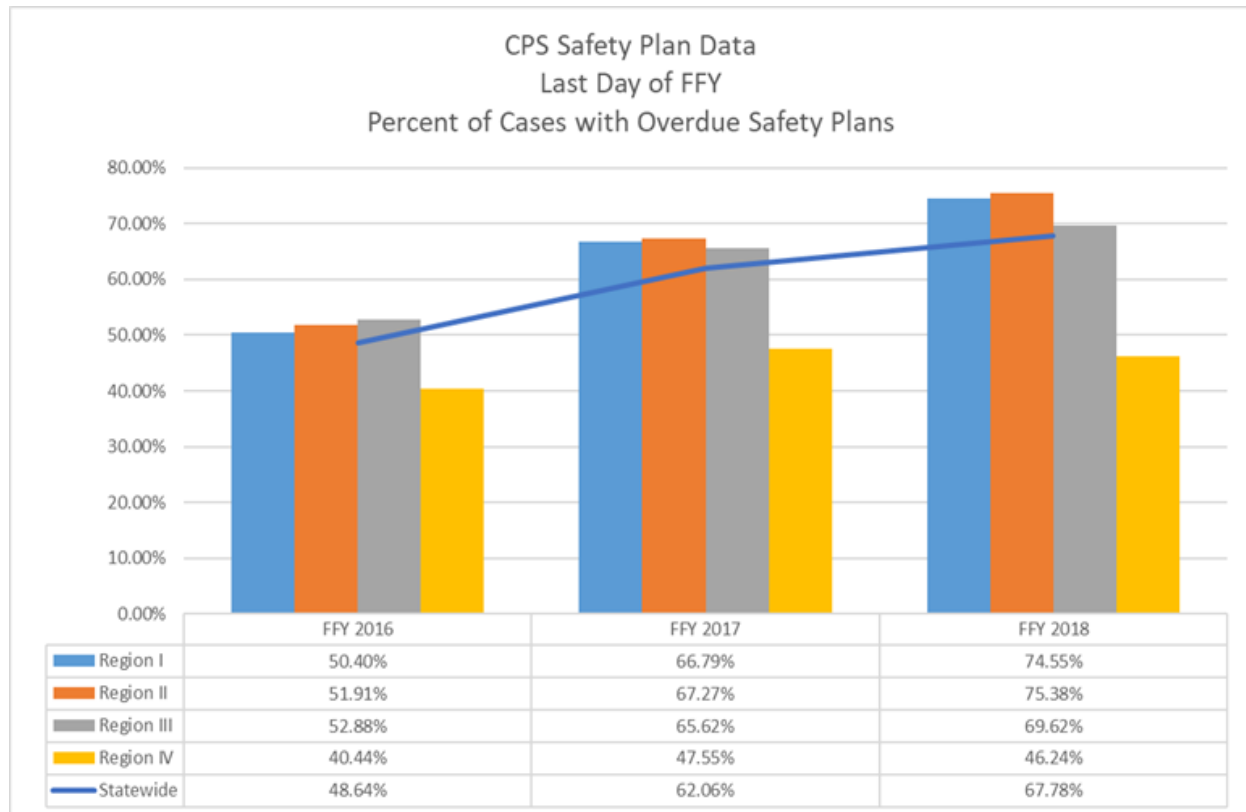
Year	Baseline	2020	2021	2022	2023
Performance	35%	37%	42%	47%	52%

Objective 1.2 Increase the percentage of CPS cases open with safety plans by 2% in year one and 5% additional year.

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Source: End of Month CPS Case Counts and FREDI CPS-5170

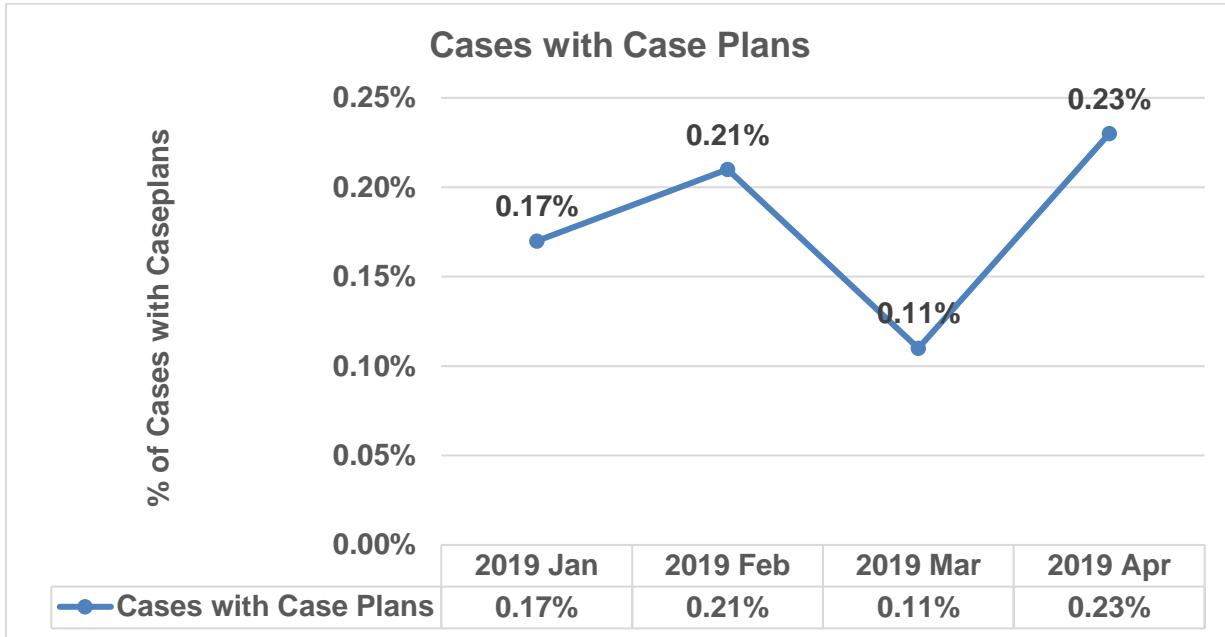


Source: FREDI CPS-5170 9/30 of each FFY

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Year	Baseline	2020	2021	2022	2023
Performance	67.78%	69.78%	74.78%	79.78%	84.78%

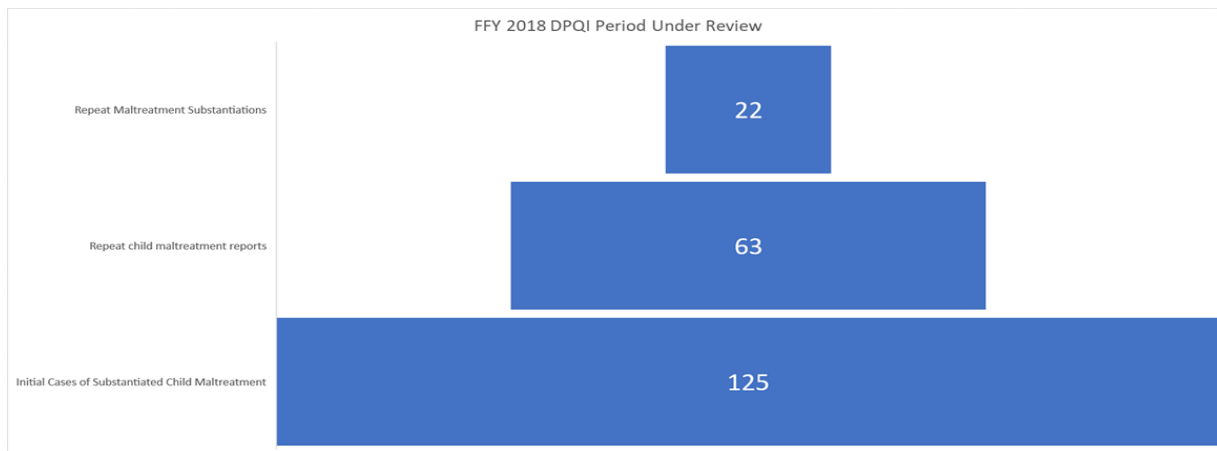
Objective 1.3 Increase the percentage of cases that have a case plan by 2% in year one and 5% each additional year.



Year	Baseline	2020	2021	2022	2023
Performance	<1%	3%	8%	13%	18%

Objective 1.4 Decrease the percentage of cases with repeat maltreatment by 2 % the first two years and 5% each additional year.

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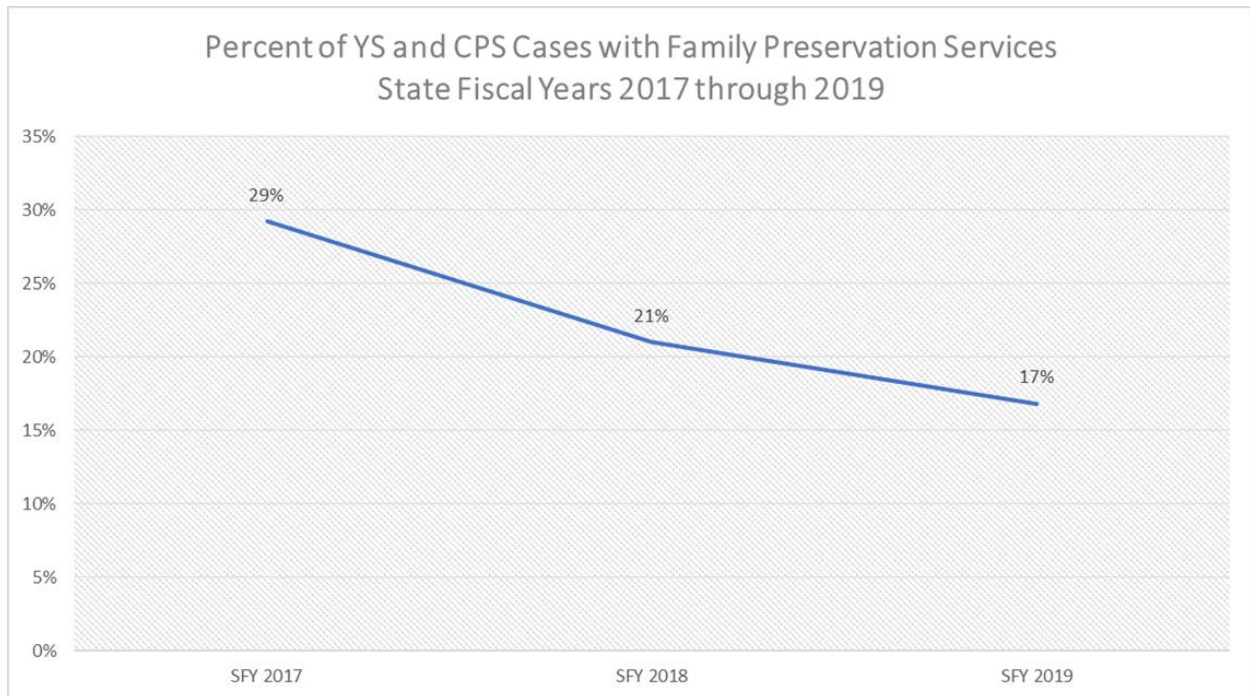
Source: DPQI Review Data

- FFY 2018 reviewed cases which had at least one substantiated child maltreatment intake during the period under review (PUR-12 months from date of the review) is 125 cases.
- Of the 125 cases reviewed during the FFY, 63 cases were rated for CFSR Item 1 indicating a received, accepted, and assigned child maltreatment report during the PUR.
- Of those 63 cases, child maltreatment was substantiated in 21 cases.

Year	Baseline	2020	2021	2022	2023
Performance	33%	31%	29%	24%	19%

Objective 1.5 Increase the percentage of open cases that receive Family Preservation Services by 2% in the first year and 5% each year after.

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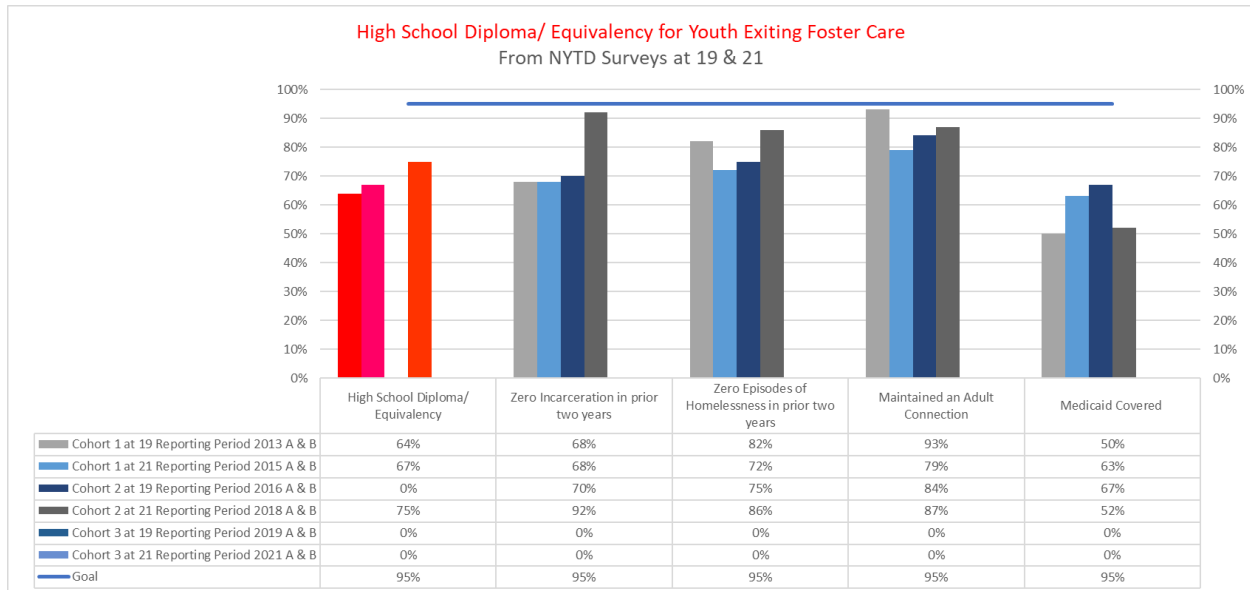
Source Data: COGNOS ASO Payments

Year	Baseline	2020	2021	2022	2023
Performance	17%	19%	24%	29%	34%

Goal 2. Increase positive outcomes for youth aging out of foster care.

Objective 2.1 Increase the percentage of foster youth who, when surveyed at 21, completed high school or obtained high school equivalency by 5% each year.

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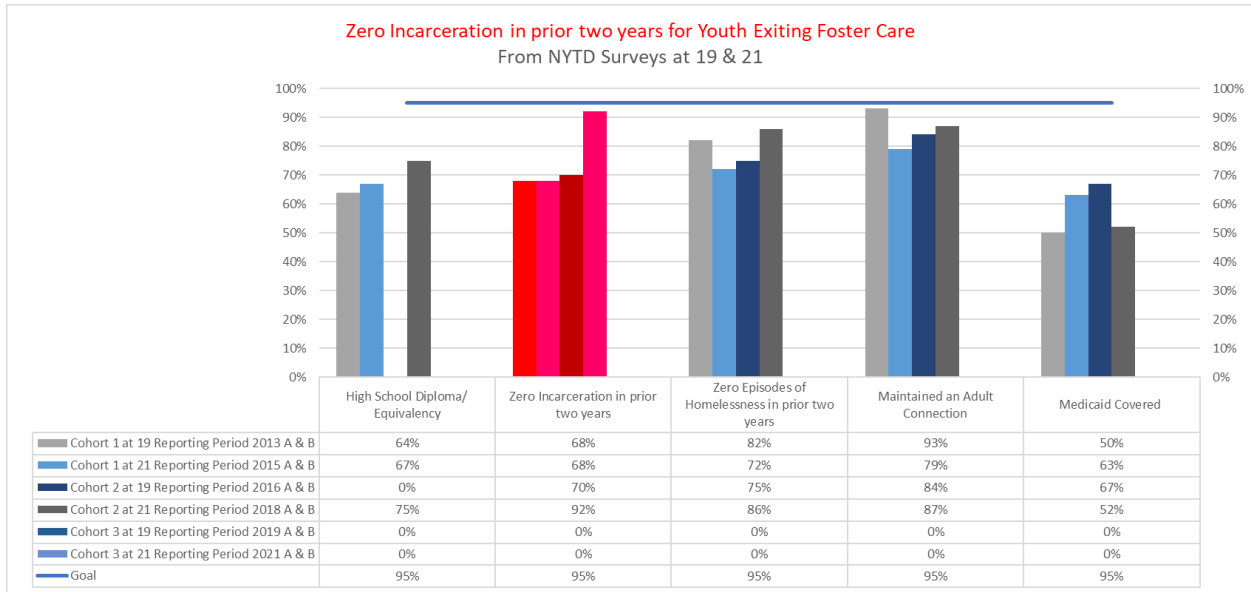


Source: NYTD Snapshots for West Virginia from ACF

Year	Baseline	2020	2021	2022	2023
Performance	69%	74%	79%	84%	89%

Objective 2.2 Increase the percentage of foster youths who, when surveyed at 21, had not been incarcerated.

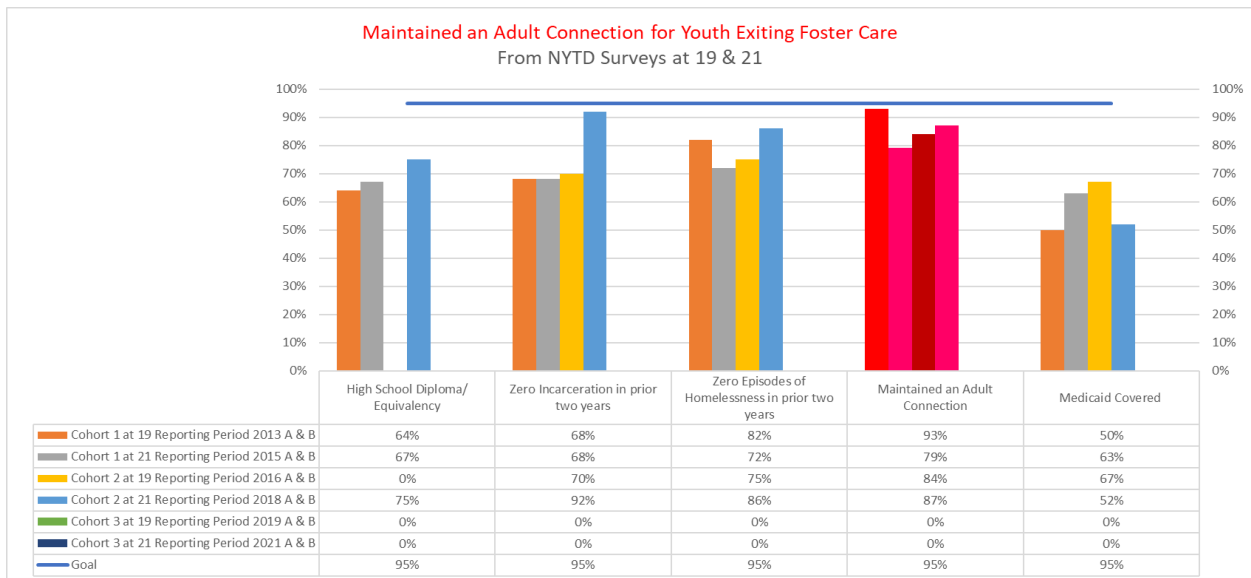
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Source: NYTD Snapshots for West Virginia from ACF

Year	Baseline	2020	2021	2022	2023
Performance	74.5%	79.5%	84.5%	89.5%	95%

Objective 2.3 Increase the percentage of older youth in care who have a permanent connection identified at 17, 19 & 21 at or above 95%

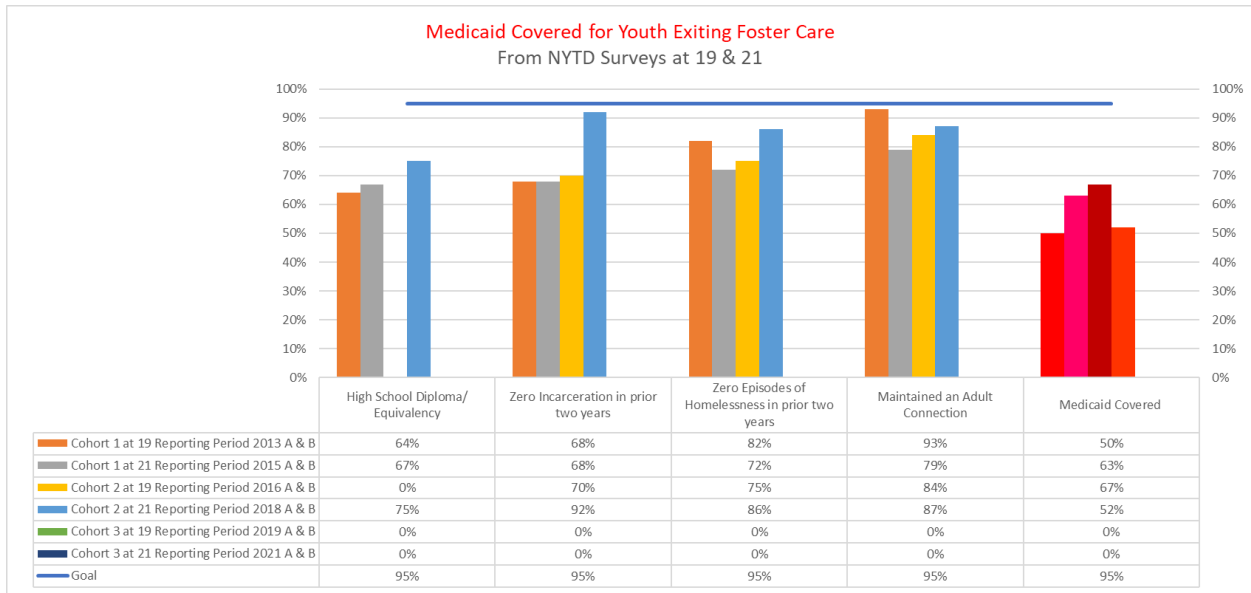


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Source: NYTD Snapshots for West Virginia from ACF

Year	Baseline	2020	2021	2022	2023
Performance	85.75%	90.75%	95.75%	100%	100%

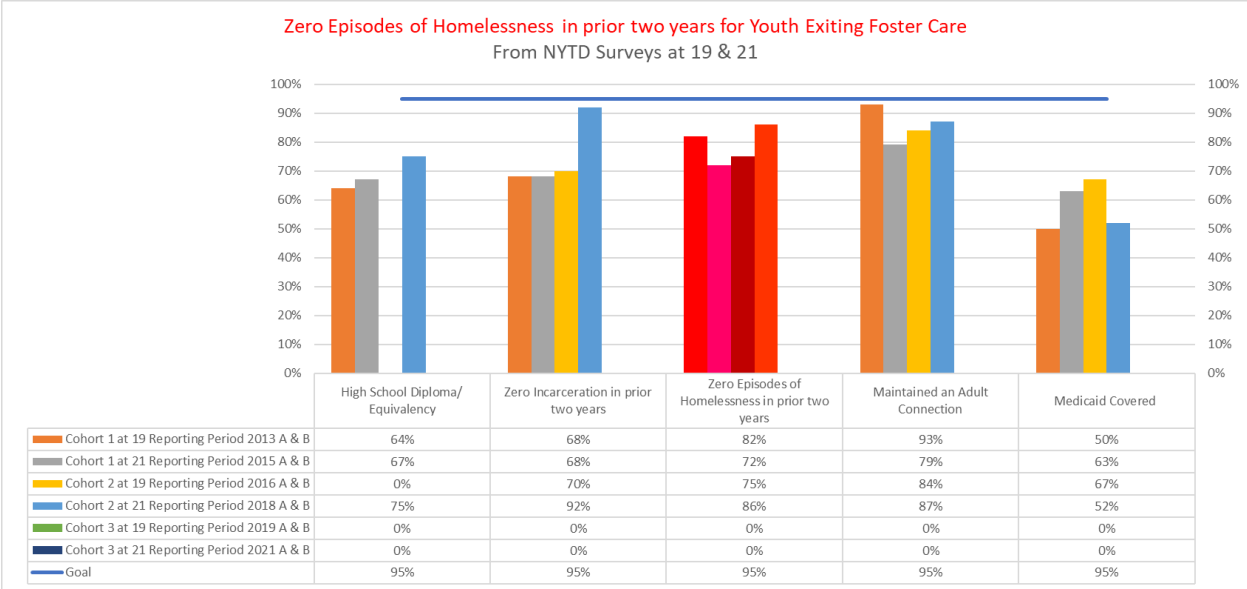
Objective 2.4 Increase by 5% each year the percentage of foster youth who, when surveyed at 21, had Medicaid.



Year	Baseline	2020	2021	2022	2023
Performance	58%	63%	68%	73%	78%

Objective 2.5 Increase by 5% each year the percentage of foster youth who, when surveyed at 21, had not experienced Homelessness.

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Year	Baseline	2020	2021	2022	2023
Performance	78.75%	83.75%	88.75%	93.75%	98.75%

Staff Training, Technical Assistance and Evaluation

Please reference the Training Plan for staff development and training in support of the goals and objectives of the Child and Family Services Plan.

To help districts move towards the outcomes identified, DHHR will assemble Training and Technical Assistance Teams consisting of Quality Assurance staff, Policy staff, Training staff and local district supervisors to provide intensive training and mentoring to district staff on the areas needing improvement identified during their local Quality Assurance reviews.

These teams will also be available to aid individual districts on selected topics when they are identified as having a decrease in performance outcomes or their individual supervisors notice a decrease in performance during their monthly supervisory reviews.

The Bureau for Children and Families will continue to utilize in depth technical assistance from Casey Family Programs to assist with the implementation of several on-going initiatives including but not limited to our kinship navigator program, foster care reform, reflective supervision and Family First Prevention Services Act implementation.

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The Capacity for States will continue to assistance to the state as referenced in the Program Improvement Plan.

Casey Family Programs and Marshall University will continue to assist the state with data collection and analytics surrounding our Kinship Navigator Program and Case Assessment and treatment model respectively.

Implementation Supports

Leadership members identified needing more staff and a standard operating procedure to outline the process to close out their backlogged referrals and cases with no activity. However, the DHHR is in the process of obtaining Technical Assistance with determining if the state is accepting the right referrals for assessment and if staff are following policy to make correct determinations at case opening. It is believed this TA may eliminate the need for more staff.

Centralized Intake recently received approval for their own Trainor. This person will provide specific training for CI staff covering position responsibilities, policy updates, and will provide feedback in real time on active calls, and then go over any problem areas.

The Director of Social Services will continue to identify statewide issues and provide district supervisors with targeted tools to use for re-training their staff during monthly unit meetings.

Leadership also identified the need for a Standard Operating Procedure for assignment of investigations in active cases. This item is addressed in the Program Improvement Plan.

West Virginia will collaborate with its other bureaus to Geo-map its array of services.

4. Services

Child and Family Service Continuum

Prevention

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

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

The WV DHHR funds and supports several child abuse prevention initiatives that use a combination of CBCAP, Temporary Assistance for Needy Families (TANF), and MIECHV funds, state appropriations, and private funds. These initiatives include In Home Family Education Programs (IHFE), Family Resource Centers (FRC), and Partners in Prevention grants to communities. These programs are considered an integral part of the child welfare continuum by building and increasing protective factors that enable parents and families to nurture and parent appropriately and connect them to concrete supports that help keep families out of the child welfare system. Programs are community based and driven, with advisory boards made up of program participants, service providers, and local leaders. Services are available to any member of the community, regardless of income, and are voluntary.

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

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

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

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

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

Birth to Three

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

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

Cognitive - thinking and learning

Physical - moving, seeing and hearing

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

Adaptive - doing things for him/herself

Communication - understanding and communicating with others

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

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

Right from The Start

The Right from The Start (RFTS) Program is a home visitation program which provides targeted case management and/or the provision of enhanced prenatal care services for Medicaid pregnant women up to 60 days postpartum and infants through one year of age. Targeted case management in the RFTS Program includes an Initial Assessment for prenatal or infant clients, development of an individualized Service Care Plan reassessed on an ongoing basis, depression screening, domestic violence screening, tobacco/substance use screening, assistance with locating needed resources, education and counseling programs for the mother, transportation assistance to medical appointments and referrals as needed. Enhanced prenatal care services include childbirth education, parenting education, health education and

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nutritional evaluation/counseling. All services are provided by a registered nurse, licensed social worker or registered dietician. These services have the combined purpose to improve birth outcomes and reduce infant mortality and morbidity in a high-risk population with a medically focused approach.

The Right from the Start (RFTS) Program has been delivering services, providing health care for low-income mothers and infants at-risk of adverse health outcomes for over two decades. The services are FREE and support mothers, their new babies and their families by helping create a safe, nurturing home. The Designated Care Coordinator provides professional, individualized, and comprehensive care that empowers families to achieve the healthiest possible outcomes during pregnancy and infancy. The program empowers participants to choose lifestyles resulting in healthy families.

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

Maternity Services

Maternity Services is limited funding of prenatal, delivery, postpartum and routine newborn hospital care for low-income, medically indigent pregnant women who are determined to be ineligible for Medicaid, have not insurance to cover obstetrical care, and have monthly income below 185% FPL. This includes minors and income eligible non-citizens. Maternity Services require prenatal care is provided in the standards outlined in the American College of Obstetricians and Gynecologist guidelines.

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

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

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

Key Project Aspects

- **Screening, Brief Intervention, Referral and Treatment (SBIRT)** services integrated in maternity care clinics

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

Child Protective Services

Child Protective Services (CPS) operates under the authority of West Virginia State Statute. There are two primary purposes for CPS intervention in West Virginia: (1) to protect children who are unsafe, and (2) to provide services to alter the conditions which created the threat to child safety. WV follows the Safety Assessment and Management System or SAMS model. The SAMS model includes CPS Intake Assessment; CPS Family Functioning Assessment (FFA); CPS Protective Capacities Family Assessment and Family Case Plan (PCFA); and Family Case Plan Evaluation/Case Closure.

The SAMS model is a very detailed and time-consuming model. A combination of an opioid crisis, lack of tenured workers, and a very high turnover rate has led to a large backlog of assessments. To counteract this backlog, the Department has allowed workers to complete a very short version of the SAMS model. The state has also begun work on a streamlined process for both CPS and Youth Services. The streamline workgroup has successfully edited most of the two policies to become easier to navigate. Case plans and safety plans have also been streamlined for both programs to use. The new case plan process has been piloted state wide and was praised by the staff selected to use them. Child welfare staff stated the forms used are much easier to understand and families felt they were included in the process. Safety plans have been reduced to one document, instead of three that were previously used. The plan can be altered to address immediate safety concerns, and in and out-of-home safety plans as well.

Further, CPS has a shortened documentation process for completing the Functional Family Assessments. That form is Crisis Response Worksheet CRW. The CRW mandates CPS staff to narrate the allegations of child abuse or neglect, and maltreatment and nature portions of the assessment on the form. This form has allowed staff to quickly document their interactions with the family.

Intake Assessment: The Department receives reports of child abuse or neglect through phone calls to the local office, emails, letters, and when referents visit the local office. These reports are routed through our Centralized Intake Unit via a 24-hour hotline. The report is accepted if the allegations meet the statutory definitions of abuse or neglect, which include if the children are in a situation where abuse or neglect is likely to occur. All mandated reporters are required to be notified in writing whether the report was

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accepted for assessment. When reports are not accepted, the family may be referred to other more appropriate state agencies or community resources to assist the family. If accepted for Family Functioning Assessment, the report is assigned a time frame for response. The time frames are immediate response, 72-hour response, or 14-day response. The response times are assigned based on requirements in state statute and policy.

Family Functioning Assessment: The assessment of a report of child abuse or neglect sets the stage for the problem validation, service provision, and the establishment of a helping relationship in CPS. The primary purposes of the family functioning assessment are to gather information for decision making; to explain a community concern to the family; to explain the agency's purpose; to assess the family for possible safety threats; to reduce trauma to the child; to secure safety as indicated; to promote family preservation and expend reasonable efforts; and to offer help.

During the family functioning assessment, the CPS Social Worker collects information through interviews, observations, and written materials provided by knowledgeable individuals using a family-centered approach. This approach seeks to support and involve children, caregivers/parents, and other individuals in CPS intervention. The CPS Social Worker uses the information to determine if the children are abused, neglected, or unsafe and in need of protection. If the children are unsafe, the family must be open for Ongoing Child Protective Services. A safety plan is then developed with the family, in the least intrusive manner possible, to provide a safe environment while CPS attempts to alter the safety threats discovered. The safety plan can include paid and non-paid safety services. If possible, the assessment should be completed within 30 days of the receipt of the referral.

Protective Capacities Family Assessment: The Protective Capacities Family Assessment is a structured interactive process that is intended to build partnerships with caregivers to identify and seek agreement regarding what must change related to child safety as well as to develop family case plans that will effectively address caregiver protective capacities and meet the child's needs.

The Safety Assessment and Management System (SAMS) Protective Capacities Family Assessment and Family Case Plan Evaluation focuses on diminished caregiver protective capacities and the safety threats identified during family functioning assessment which may or may not involve court intervention. The Protective Capacities Family Assessment and Family Case Plan Evaluation is a structured, interactive intervention intended to build partnerships with caregivers to identify and seek agreement regarding what must change related to child safety and to develop family case plans that will effectively address caregiver protective capacities and meet the child's needs. The CPS Social Worker translates diminished caregiver protective capacities into client goals, and those goals are used to develop the family case plan. Services are then put in place to assist the caregiver in meeting the goals. The Protective Capacities Family Assessment and Family Case Plan must be completed within 45 days of the case being opened for ongoing CPS services.

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Family Case Plan Evaluation/Case Closure: The family's case plan will receive ongoing evaluation by the CPS Social Worker. This process is called the SAMS Family Case Plan Evaluation. The Family Case Plan Evaluation is a formal decision-making point in the safety intervention process that occurs minimally every 90 days, which requires involvement from caregivers and children; Family Case Plan service providers; and safety service providers. The purpose of the Family Case Plan Evaluation is to measure progress toward achieving the goals in the Family Case Plan associated with enhancing diminished caregiver protective capacities. The Family Case Plan Evaluation is also the decision point when the case may be closed for CPS Services. In addition, the family's case is closed when the parents can provide a safe home for their child, without CPS intervention, or their child is in another permanent living situation such as adoption or legal guardianship.

Service Population: Child Protective Services are provided statewide to families in which a child (ages 0-17) has been suspected to be abused or neglected or subject to conditions that are likely to result in abuse or neglect (as defined in WV Code §49-1-201 Definitions section and DHHR operational definitions) by their parent, guardian, or custodian. There are approximately 20,000 families who receive Child Protective Service each year.

Youth Services

West Virginia's Youth Service program serves youth and their families who are involved or are at risk of being involved in the Juvenile Justice System through courts and/or probation. While ensuring the safety and protection of the child is paramount, Youth Services also aims to strengthen the functioning of the family unit through coordinated, multi-disciplinary efforts which involve community agencies and resources.

Case Planning

Case planning continues to be an essential part of the Youth Services process. A standardized case plan document titled 'Family Service Plan' has been developed and approved and will continue to be utilized on all open Youth Service cases. Included in this case plan document are the reasons for DHHR involvement, what must happen for DHHR to no longer be involved, individual strengths and needs, prioritized goals, services, and a section identifying foster care candidates and an explanation of what qualifies a youth as a foster care candidate. The Family Service Plan document was created with CANS and FAST assessments in mind. WV Youth Service workers will use the CANS and FAST as their standardized screening tool on all open YS cases and use this data to help case plan accordingly.

CANS/FAST

A critical component of West Virginia's Youth Service program is the assessment of the youth and families which it serves. Youth Services presently uses the Child and Adolescent Needs and Strengths (CANS) tool as its standardized assessment tool. However, the Department has recently begun a pilot program in

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which the CANS is replaced by the Family Advocacy Support Tool (FAST). While the CANS and FAST are both developed by John Lyons PhD and the Praed Foundation, and require the same level of training and recertification, the FAST is a more condensed assessment and focus on the wellbeing and safety of the entire family. If the pilot program for the FAST is a success and leads to better case planning and outcomes, then the Department will replace the CANS with the FAST as its standardized assessment tool.

The Youth Level Service Case Management Inventory or (Y)LS-CMI was previously used as a standardized assessment tool. However, due to wording changes in WV Code, the (Y)LS-CMI will no longer be a necessary tool and its role will be filled by the CANS assessment and eventually the FAST assessment.

Programs

West Virginia's Youth Service Program has recently assisted in implementing two evidence-based programs, Victim Offender Mediation (VOM) and Family Functional Therapy (FFT). VOM is a program in which an opportunity is provided for the victim of a crime and the perpetrator to meet face to face with a mediator to help victims heal, the offender to learn, and to reduce the cost for the Juvenile Justice System. The VOM program presently serves thirteen (13) counties and has plans to expand given the opportunity. FFT is a high intensity short term family therapy program intended for youth between the ages of 11-18 which are experiencing family dysfunction. There is presently one FFT provider in West Virginia which serves six (6) total counties. The Department will seek to expand FFT on a continual basis to help prevent children removal. Additionally, the Youth Services Division will continue to review additional programs and determine if their implementation can benefit the youth of West Virginia.

Juvenile Justice and Collaboration with The Bureau of Juvenile Services

WV tracks and reports the number of youths who are transferred from the Department to the custody of the Bureau of Juvenile Services (BJS). The tracking methodology is to use reports from the SACWIS system of youth in custody of the Department who were court ordered to another placement. A hand count is then used on the custody transfer list to determine the number of those transfers who were placed with BJS.

The Department also collaborates with BJS when necessary on youth who are adjudicated or are at risk of court involvement. This collaboration continues to evolve and change to meet the needs of WV Youth and their families. It is anticipated that the Department and BJS will work together on solutions and programs to address truancy and other issues related to the treatment of the Youth Services population.

Gaps in Service: Fostering older youth/teens

An area of concern for the population served by Youth Services is the lack of foster homes available for, or unwilling to take, older youth. The most recent placement report for Youth Services was for the month of April 2019 and notes 643 total Youth Services cases had youth in placement. Of these 643 cases, the

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majority, 346, were placed in Group Residential Care instead of a Foster Care setting. Of the youth placed in a type of Foster Care, 30 were placed with a certified kinship/relative home, 41 were placed with a kinship/relative, 2 were placed with in Agency Foster Family Care, and 29 were placed in Therapeutic Foster Care. All other placements were through Psychiatric Hospitals, Detention Centers, Transitional living, or Emergency Shelters.

A survey completed in February of 2019 by the WV Foster, Adoptive, and Kinship Parents Network regarding the barriers for fostering teens was conducted. These barriers include; fear of teens influence on younger children in the home, negative behaviors, fear of incomplete or honest data and background information from the Department or foster agencies, and lack of training on how to meet a teen's needs. Also included on the survey were possible solutions to these barriers which included marketing parents who already have older youth, ensuring that a teens needs are met prior to placement, ensuring that youths case history is shared prior to placement, helping potential foster parents receive the necessary training, skills, and support prior to placement. The Department will continue to review policies, the needs of WV foster parents and youth, and will continue to work with placement agencies to help fill this gap in services.

Another way to reduce the amount of older youth placement in Group Residential Care is to reduce the number of youths removed from their home in the first place. In many cases, removal from the home is necessary for the safety of the youth and their family or is required by court order. However, thorough and thoughtful case planning and safety planning measures by Youth Service workers and the Department can help reduce the amount youth removals by ensuring that safety in the home is maintained and that the youth and family are receiving the proper services. The Department will monitor the number cases that do not have a case plan and/or safety plan and with this data make efforts to ensure case plans and safety plans are completed.

Foster Care

West Virginia's foster care system is comprised of kinship/relative care providers, private/specialized family foster care providers, and residential treatment facilities. West Virginia provides an array of services to all foster children. Services offered to foster children include but not limited to medical services, including eye and dental, mental health services, clothing, food, shelter, support, education services, independent and transitional living services, legal services, and community supports.

West Virginia continues to provide every foster child a Journey Placement Notebook when they enter care. This notebook follows each foster child through their entire foster care placement and provides forms or records of information including:

- The Outcome Observation Report which includes outcomes relating to:
 - developmental
 - relationships

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- protection and nurturing
- Application for SAFEKIDS PIX identification card
- Information check list
- Wardrobe and personal item inventory checklist
- Child's daily schedule
- Behavior observation chart
- Medication side effect checklist
- Therapist/Health Care/Service Providers
- Equipment/supplies inventory
- Foster care/adoption terms to know
- Foster care tuition waiver facts sheet

Journey Notebooks

Journey Placement Notebook forms are accessible through the Bureau for Children and Families webpage; <https://dhhr.wv.gov/bcf/policy/Pages/default.aspx> This accessibility allows foster care providers as well as private/specialized agencies, and facilities to access the forms whenever necessary if one or more forms have been lost or additional information that exceeds the current provided forms need added. The Bureau for Children and Families will continue to make the Journey Placement Notebooks accessible for the next five years to ensure each foster child has to appropriate forms and documentation necessary through their foster care placement.

Early, Periodic, Screening, Diagnostic and Treatment

The Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) will continue to be performed for each child who enters foster care. The Bureau for Children and Families partners with the Bureau for Medical Services to ensure that each child is linked with a Sander's Liaison and receives their EPSDT screening within 30 days of entering foster care. This will continue into the next five years and will be tracked through the database system as documentation is entered by the Sander's Liaison.

Multidisciplinary Treatment Team

Multidisciplinary treatment team meetings (MDT) are required for all foster care cases as set forth by West Virginia State Code §49-4-403. Multidisciplinary treatment teams consist of child welfare staff, biological parents or family of origin, other necessary family members, the child or youth if deemed in the child's best interest, service providers, and foster care providers. Many foster care providers are not permitted to be participate in the multidisciplinary treatment team meeting, therefore it is difficult for foster care providers to understand or be aware of particular case and child goals. Often biological parent goals and foster care provider goals fail to align due to their exclusion from the process. West Virginia will continue to improve relationships with foster care providers and child welfare staff and will enlist the assistance of the Court Improvement Program to improve the court relationship between child welfare

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staff and foster parents as well. The Director of Child and Youth Services through the Supreme Court is committed to improving judicial and child welfare staff relationships for the betterment of West Virginia children and families.

Foster Care Redesign

Treatment Foster Care Program

In July 2017, West Virginia formally launched a treatment foster family service model. The model is family-based, therapeutic, trauma-informed service delivery approach. The tiered model provides individual services for children and their families. The model is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and ongoing training provides the foster parents the knowledge and skills needed to care for the children that meet the criteria.

The Treatment Foster Care Program is being provided statewide by five specialized foster care provider agencies. As of June 2019, there have been 256 treatment foster care homes developed across the state. The State plans to increase the provider base within the next few years so treatment/therapeutic foster homes will be available and accessible statewide for the population of youth coming into care.

Treatment Foster Care Program tiers:

1. Tier II - Treatment Foster Care-serves children who exhibit mild to moderate levels of trauma/behavioral or emotional dysregulation. There may be mild or moderate difficulty in settings such as school, home and/or community. This level may be used for emergency placements, pregnant/teen moms that require special medical care or children with chronic medical conditions.
2. Tier III - Intensive Treatment Foster Care or Therapeutic Foster Care serves children who currently exhibit moderate to significant indicators of trauma/behavioral or emotional dysregulation. High-risk behaviors are present. Significant support is needed. This level may be used for children stepping down from a higher level of care, are at risk of out of state placement or residential placement, infants who are drug exposed with additional medical needs beyond initial medical withdraw or children considered medically fragile as diagnosed by a physician.

Performance based contracting

The West Virginia State Legislature passed House Bill 2010 in 2019 which requires the Department of Health and Human Resources to enter performance-based contracting with the child placing agencies who provide foster care services. As part of the procurement process under this requirement, the Department will be issuing a request for proposals by July 1, 2020.

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Kinship Navigator

The navigator program will assist with monitoring kinship/relative placements to ensure their entry into FACTS, monthly demand payments have been entered, and foster care subsidy begins upon certification approval. The Kinship Navigators will assist kinship/families by completing a brief needs assessment and linking families with necessary services and supports to ensure their needs are met. The program is intended to provide added resources for kinship/relative families and assist child welfare workers when kinship/relative families have extra needs that require time and assistance.

Residential

West Virginia intends to maximize the provisions for the qualified residential treatment programs (QRTP) and its 30-day assessment requirements to more thoroughly screen youth who are being identified to need residential mental health services. This will also help flag existing diagnoses that must be taken under consideration and help ensure unnecessary mental health diagnoses are not being made for youth to access non-family care.

West Virginia intends to slowly on-board QRTP providers through a targeted, purposeful process utilizing requests for applications (RFA) and population-specific contracting. The RFA strategy aligns with the Bureau's need to mitigate compliance and financial risk to the State if the federal QRTP requirements are not met.

By soliciting applications from existing contracted providers, the Bureau will be able to clearly define the population for this restrictive category of congregate care. The first RFA was released on April 19, 2019 and defined the target population as youth who require an intensive, non-family residential setting and who have traditionally been served in out-of-state facilities. These youth have demonstrated an inability to function in foster homes or less restrictive forms of residential care due to significant lack of behavioral control and have been diagnosed with one or more significant behavioral, intellectual, developmental, and/or emotional disorder. Once assurances can be made that the system supporting QRTP is in place, data will be gathered to determine the extent of further QRTP on-boarding and will be focused on populations that require a higher level of care. The on-boarding of QRTP will not be through the development of new beds but the re-configuration of existing beds. There will be 42 of the existing beds converted to QRTP between January 2019 and March 2020.

The current residential structure (excluding the Medicaid categories of residential treatment psychiatric residential treatment facilities and Intermediate Care Facilities for Mental Retardation as well as one pregnant/parenting program) is being modified to fulfill the requirements of the at-risk of sex trafficking category. These programs are all in the process of training staff on new programming that will address risk factors for youth that meet this population. Until the QRTP beds are converted in January 2020, all programs will be licensed as a "vulnerable youth" program. Emergency legislative rules were filed on

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August 16, 2019, that will become effective on October 1, 2019. These will be included with the IV-E state plan amendment. The licensing specialists are currently in the process of making visits to each program to evaluate the curricula that the agencies will be using, how it will be trained and any new services the program requires. They will also be evaluating the new requirements for trauma-focused organizational structures.

Adoption/Legal Guardianship

Adoption and Legal Guardianship services provided by the DHHR are provided state wide. These services include recruitment of foster and adoptive families, the home-finding process, case management, the adoption resource network (ARN), and the contract with specialized private foster and adoption agencies.

Adoption/Legal Guardianship subsidy, medical assistance, and non-recurring adoption expenses are provided to all eligible children adopted or placed in Legal Guardianship through foster care through the age of twenty-one (21) if they meet eligibility criteria.

Adoption Resource Network

Children from West Virginia who are legally available for adoption and have no adoption resource identified are placed on the Adoption Resource Network at www.adoptawvchild.org

Mutual Consent Registry

The purpose of the Registry is to provide a centralized location wherein adult adoptees who were born in West Virginia and the birth parents of such adoptees may register their willingness to have their identity and whereabouts disclosed to each other and to provide for the release of this information once each party has voluntarily registered.

The Registry can also provide non-identifying background information to birth parents, adoptive parents, and adult adoptees upon request if WVDHHR was the agency that facilitated the adoption.

The DHHR utilizes home-finding specialists throughout the state to certify homes for kinship relative providers. Specialized agencies are contracted by the Department to certify traditional foster and adoptive homes. The DHHR assigns adoption specialist to manage the cases of children who have been placed with kinship relative providers. Specialized agencies assign their agencies case workers to manage cases for children who have been placed in traditional foster and adoptive homes for whom no appropriate kinship/relative provider could be found. Department adoption specialist as well as specialized agency case managers have the responsibilities of completing monthly face to face contact with children, making assessments of services that children and families need, and assisting the foster/adoptive family with completing necessary documents throughout the adoption process. Once the adoption process is complete, cases are transferred to the state office for management of post adoption case records.

Service Coordination

The ultimate responsibility for service coordination is the case worker for all cases opened for services, with the help of the Multi-disciplinary team in cases where children have been removed from the home.

Managed Care Organization (MCO)

The West Virginia Department of Health and Human Resources is in the process of procuring a vendor to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance. Additionally, the successful vendor will provide statewide administrative services for all individuals accessing socially necessary services (SNS). Per House Bill (HB) 2010, this program seeks to reduce fragmentation and offer a seamless approach to participants' needs, deliver needed supports and services in the most integrated and cost-effective way possible, provide a continuum of acute care services, and implement a comprehensive quality approach across the continuum of care services. Services include, but are not limited to, the following:

- Coordination of physical health services, behavioral health services, and SNS
- Financial management and claims management for physical and behavioral health services
- Establishing and managing a credentialed provider network for physical and behavioral health services
- Utilization management, quality management, member and provider services, reporting, and analytics for all services under the contract
- Maintaining information systems to support delivery of services to the member population and the terms of the contract
- Assisting in reducing the number of children entering the child welfare system

There is currently a fragmented system of care for West Virginia's children and youth in foster care, as well as those children at risk of entering the foster care system and their families. West Virginia's foster care population has continued to increase over the past several years due to the opioid epidemic facing our state, with 85% of cases involving Substance Use Disorder (SUD). The Department has identified a significant need to better help those families in crisis and reduce the number of children removed from their homes. For those who have already been subjected to this event, it is imperative that the Department implement a strategy to help better coordinate the care of those members and make sure they are receiving all of the necessary services available, in hopes that reunification may occur.

A single vendor will be selected to oversee and coordinate both health and social services, with physical health and behavioral health services provided through an MCO model and SNS provided through an Administrative Services Organization (ASO) model.

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The following goals and objectives support the Department's vision for this procurement:

1. Enhance coordination of care and access to services, including physical health, behavioral health, dental care, and SNS.
2. Improve communication and training among stakeholders.
3. Enhance quality of care.
4. Reduce fragmentation and offer seamless continuity of care.
5. Deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible.
6. Improve health and social outcomes for youth and impacts on families.
7. Develop and utilize meaningful and complete electronic health records (EHRs) for each member and other IT supports to improve data sharing.
8. Help reduce the number of children removed from the home through increased family-centered care that provides necessary and coordinated services to all members of the family.
9. Include a comprehensive quality approach across the entire continuum of care services.

The State will automatically enroll beneficiaries into an MCO in order to provide specialized and coordinated care in the most seamless and cost-effective way possible.

Members included in the MCO will receive specialized care coordination that incorporates trauma-informed practice and adverse childhood experiences (ACEs) guidelines. The MCO will be responsible for coordinating continuity of care and developing an integrated care plan with healthcare providers, child welfare providers, behavioral health providers, and the member and their family or caregiver(s). The MCO will also provide specialized support when a member leaves a residential facility or changes levels of care. The care coordinator can monitor quality and quantity of services, which will decrease duplication of services and/or prescription medications. Care coordinators will also conduct outreach to their assigned members in order to establish relationships and respond to changes in members' needs over time.

Service Description

For an analysis on gaps in services please see the Service Array section of this plan.

Services to Homeless Youth

To prevent homelessness for youth in WV, BCF utilizes several approaches throughout the state. BCF policy requires workers working with children 14 years and older to develop a transition plan. This plan is informed by a multitude of information, including a life skills assessment. The life skills assessment is

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used to determine which areas, important to successful independent living, need improvement. The plan also includes the youth's self-identified skills and needs and requires the youth to identify areas of improvement she/he would like to focus on every 90 days. Youth who attain the age of 16 and have demonstrated a substantial ability to support themselves are provided the opportunity to test their knowledge and skills with placement into semi-independent living programs. These programs are often housing on group residential grounds in which one or more youths live together and take responsibility for self-care under the supervision of a program worker. This allows the youth and social worker the opportunity to visualize the reality of the identified skills and needs, to further work on areas needing improvement. Once a youth has successfully demonstrated their ability to succeed in an environment of limited supervision, the youth has the option of transitioning into scattered site apartments or similar independent living units. In these units the youth will receive a subsidy for essentials, will further their education or job training, and will continue to improve on important areas of self-sufficiency such as job readiness and interviewing skills. These options remain open to foster youth and former foster youth until the age of 23, with education and training voucher to youth up to the age of 26.

When youth who aged of foster care do become homeless, they are provided the opportunity to return to the department for a voluntary removal and placement into a foster care setting to attain needed services. Youth who do not wish to return to a foster care setting may apply for Independent living or homeless services, which includes the ability to be obtain food, shelter, and medical care. BCF will be moving to partner with one of our state's Continuum of Care associations to improve homeless services and access for children and families. Currently, WV homeless shelters are funded through a variety of funding sources which only fragments the system, making requirements different for each shelter. The varying requirements effect everything from the training of shelter staff, the referral process, and the point of eligibility.

The U.S. Department of Housing and Urban Development funds state homeless coalitions across the country through two primary funding streams. The Emergency Solutions Grant (ESG) program and the Continuum of Care (CoC) program fund each community's homeless system. The ESG grant funds street outreach, homelessness prevention and diversion, emergency shelter, and rapid re-housing. The CoC program funds permanent supportive housing, rapid re-housing, transitional housing, coordinated entry, and pilots like the Youth Homelessness Demonstration Program. HUD provides funding based on a state's population statistics and provides some regulation. These populations are counted through the mandatory use of a Homeless Management Information System (HMIS). In addition, to these federal sources the WV Department of Health and Human Resources also funds shelters' through two different Bureaus; the BCF and The Bureau of Behavioral Health. This allows shelters flexibility in how they deliver services and which requirements they wish to follow. The BCF intends to release a funding announcement for one of the four CoC's to manage the BCF's homeless program. This will enable the CoC

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to include the state's data in homeless counts as it will require the use of the HMIS, it will require the use of the centralized intake line for service access, ensure system-wide training requirements and the access of services prior to ever becoming homeless through the rapid re-housing program and prevention work.

Additionally, BCF partners with several agencies to provide services and opportunities for at-risk youth. The Human Resource Development Foundation provides valuable programs and education to youth who are at high-risk of future homelessness due to being in foster care and/or having juvenile justice involvement. Job Corp is another program BCF Social workers rely on and regularly refer to for foster youth interested in pursuing on-the-job training. Particularly helpful, are Job Corp sites which include supportive housing. These programs often offer youth who wish to end their involvement with the foster care system a stable and safe living environment in which they can focus on their education and job-training.

Services to LGBTQ youth

The Bureau for Children and Families has begun a collaborate relationship with the Huntington/Charleston chapter of the national organization PFLAG. PFLAG is the nation's largest family and ally support organization. Through this collaboration BCF intends to connect with other LGBT specific groups to help us establish a system that provides support and advocacy for the LGBT community. BCF intends to enhance training efforts for foster parents specific to this issue. In 2013, BCF required all residential congregate care providers to include LGBTQ specific training to their staff. A missing element is a similar training to be required of foster parents. As our state continues in its efforts to normalize foster care for our children and youth, we must work to ensure our foster parents are equipped with the knowledge and skills to appropriately respond to children who identify as being LGBT or Q. Acceptance and support are fundamental in the healthy development of these youth and the families they live with must be able to provide this invaluable experience.

The BCF also recognizes that state agencies are not often viewed as "safe spaces" for the LGBT communities, and as a result of this perception gay and lesbian couples who are willing to provide loving and supportive homes for children and youth often seek out private adoption agencies unaffiliated with the state. BCF recognizes this as an area that needs improvement. BCF desires to develop targeted recruitment efforts for LGBT foster parents to encourage their application with the state or state affiliated agencies to foster/adopt children and youth who have been removed through social services. BCF also wishes to develop educational literature for use with our social service staff and for distribution in our local office waiting areas. The state recognizes the importance of bringing awareness to the truths about the LGBT community and work to dispel common myths. BCF will develop specific policies and procedures pertaining to the service development of youth who identify as LGBT or Q and identify agencies or organizations who can provide support and advocacy to both our children and youth and our families.

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Youth identifying as LGBT are at a higher risk to experience homelessness, violence, and at a higher risk to attempt or commit suicide than their heterosexual counterparts. The CDC identifies safe and supportive learning environments and caring and accepting parents as essential to the health and well-being, both mentally and physically, of youth who identify as LGBT or Q. BCF is committed to ensuring our LGBT youth experience safety, permanency, and well-being at rates consistent with their heterosexual counterparts and believes this requires a multi-faceted approach.

Transgender youth reported the highest levels of victimization, disproportionate to their representation. These staggering statistics, coupled with a Williams Institute report citing West Virginia having the nation's highest percentage of youth identifying as transgender, made it evident the BCF had to ensure these youth receive services in a welcoming, culturally competent environment. To accomplish this BCF undertook several key activities.

The BCF has partnered with the Aspiring Allies for Equity (AAE) to work on addressing issues of systemic oppression of marginalized communities. AAE works with the Rainbow Justice League, specifically, to help identify issues of equality and service accessibility for the LGBTQ population. The BCF has required domestic violence shelter decision makers to attend the AAE group to ensure they hear firsthand some of the accessibility and bias the LGBTQ population experience when attempting to access safety and how their services can be improved. Additionally, the BCF also required that shelters allow interested staff in joining the Rainbow Justice League protected time to participate.

The state has also piloted a new needs tool for use with our youth population. This tool will begin the full implementation process in FFY19. The West Virginia version of the Family Advocacy and Support Tool (FAST) was developed jointly with the PRAED foundation to meet West Virginia's needs. As part of this new tool, workers will be working to identify youth who may be victims of Intimate Partner Violence and working to address those needs specifically.

Services to Victims of Human Trafficking

West Virginia is committed to providing necessary services for all minor trafficking victims. and has been part of the West Virginia Human Trafficking Task Force for approximately three years. Bureau for Children and Families has representatives as part of the task force, subcommittees within the task force, as well as the leadership or steering committee that guide the task forces' activities and responsibilities. The Bureau for Children and Families representatives have aided in education at statewide conferences and trainings to child welfare staff as well as other professionals who work in the child welfare system regarding the response of the Bureau for Children and Families to minor trafficking victims. The bureau will continue to work and collaborate with West Virginia's Human Trafficking Task Force for the continued improvement of West Virginia's response to human trafficking victims and available services. The task force will be applying for numerous available grants after their release, over the course of the next five years. The

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Bureau is devoted to assisting with all grant applications and providing any necessary data, information, statistics, etc., as West Virginia's child welfare agency, that may be necessary or required for the application of any grants. The Bureau for Children and Families will aid the state task force in improving West Virginia's response and service for minor victims of human trafficking.

The Bureau for Children and Families developed a report through the SACWIS database system to track all human trafficking referrals in 2018. However, the report is not functioning and has not been able to capture all trafficking referrals for FFY 2018. A manual report will be created, and regional social service program managers and directors will be tasked with disseminating information to all county supervisors requesting that all human trafficking referral numbers be sent to a Children and Adults Services' program specialists who will track all human trafficking referrals and corresponding information including gender, age, maltreater type, action taken, and services offered. This report will be maintained and updated monthly until the state's new Comprehensive Child Welfare Information System (CCWIS) is operating and can capture this information.

Services to Children in Disasters

In the event of any natural disaster, the West Virginia Department of Health and Human Resources will assist in community efforts, when needed, to assure unaccompanied children remain safe. For those children who do not have family, friends or community resources to assure their safety, the Department of Health and Human will assume custody in order to provide services and will use the following procedures.

- If the emergency custody is granted then the worker will initiate placement of the child in emergency family care, foster/adopt care or emergency shelter care.
- If placement with family members, foster care or emergency shelter is not possible during a natural disaster or emergency, the child/children will be taken to an established disaster relief site by the worker.
- Workers will provide supervision to the unaccompanied children at the disaster relief site as needed.
- The worker will see that the children's basic needs are met during the disaster or emergency to the best of their ability.

- If the child's parents or family members are located before the end of the two judicial days, the child may be returned to the family at that time.
- If the family cannot be located, the worker will file the petition requesting temporary custody.
- If the family is located after the DHHR has requested and received custody of the child/children, the worker can return the child/children to the parent or family members

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and then request that the petition requesting custody be dismissed at the first court hearing.

Stephanie Tubbs Jones Child Welfare Services Program (title IV-B, subpart 1)

Prevention Services, Child Protective Services, Youth Services, Foster Care Services, Adoption and Legal Guardianship Services are available to all children 0-18 in West Virginia if they meet eligibility criteria. For a complete list, please reference the Services section of this plan.

Services for Children Adopted from Other Countries

All children in West Virginia are eligible for the same array of prevention services. This includes children with no child welfare intervention as well as children adopted from other countries. Services provided under sub-part I are available to children adopted from other countries however, accessing these services may require a request to receive services.

The states array of post-adoptive services not covered by traditional insurance or Medicaid are minimal. A Request for Proposal (RFP) was developed for these services several years ago but was never released. The Bureau for Children and Families intends to revisit this RFP for possible release in the up-coming year. This contract would make accessing these services easier for all adopted children and their families. West Virginia has had no children adopted from other countries come into foster care in the last year.

Services for Children under the Age of Five

When children are placed in foster care, the families they are placed with have already been certified and received training to be their adoptive home. This minimizes the amount of time after termination of parental rights (TPR) to adoption. This applies to kinship/relative providers as well. This practice has reduced the time it takes to move from TPR to adoption.

Focusing efforts to place children with kinship/relative providers has also helped reduce the time to adoption. West Virginia places children with relatives/kin 48% of the time. Relative/kin providers are more likely to adopt and there are fewer disruptions.

Birth to Three and Right from the Start services are available to all children in the state. Both services focus on the developmental needs of newborns to three. Child Protective Services Policy mandates that all children with substantiated maltreatment must be referred to the Birth to Three Program. The Bureau for Behavioral Health offers children's mental health services to children and youth ages newborn to twenty-one. For more detailed information about mental health services and programs for children please visit the following website.

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<https://dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/ChildandAdolescent/Pages/ChildAdolescentBehavioralHealth.aspx>

Lily's Place, a *Neonatal Abstinence Syndrome Center*, provides medical care to infants suffering from Neonatal Abstinence Syndrome (NAS) and offers support, education and counseling services to families and caregivers to create healthier families and help end the cycle of addiction. West Virginia has utilized services at Lily's Place since 2014.

From Oct. 1, 2017 thru Sept. 30, 2018 Lily's place reports the following statistical information;

Admits- 48
Length of stay- 28-day average
Discharge to parents- 29
Discharge to relatives- 5
Discharge to foster care- 14

A second Neonatal Abstinence Syndrome Center at Thomas Memorial Hospital in South Charleston opened Baby STEPS, an eight-bed unit for babies withdrawing from maternal drug use, in the spring of 2019.

West Virginia University Center for Excellence in Disabilities offers many services to address the developmental needs of children zero (0) to five (5). They include but are not limited to Behavior and Learning Intervention Services (BLIS), Feeding & Swallowing Clinics, and Next Steps Clinics. For a complete list of available services please visit; <http://cedwvu.org/media/3286/programsservicesflyer101918.pdf>

Marshall University in Huntington, West Virginia houses the Autism Training Center. They provide training, information and support to West Virginians with autism, their families, educators, and other persons. For more information please visit; <https://www.marshall.edu/atc/about-autism-training-center/>

Efforts to Track and Prevent Child Maltreatment Deaths

In the state of West Virginia there is currently a WV Child fatality Review Panel (WVCFRP) which is operated under the Bureau for Public Health, Office of the Medical Examiner and a review team with the Bureau for Children and Families named the Critical Incident Review Team (CIRT). Both teams function differently and for different purposes but also intersect. The WVCFRP is sanctioned through the Code of Rules and the section of code is listed below.

§61-12A-1. Fatality and Mortality Review Team.

(a) The Fatality and Mortality Review Team is created under the Bureau for Public Health. The Fatality and Mortality Review Team is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of:

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- (1) The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses;
 - (2) The deaths of children under the age of eighteen years;
 - (3) The deaths resulting from suspected domestic violence; and
 - (4) The deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child.
- (b) The Fatality and Mortality Review Team shall consist of the following members:
- (1) The Chief Medical Examiner in the Bureau for Public Health or his or her designee, who is to serve as the chairperson and who is responsible for calling and coordinating meetings of the Fatality and Mortality Review Team and meetings of any advisory panel created by the Fatality and Mortality Review Team;
 - (2) The Commissioner of the Bureau for Public Health or his or her designee;
 - (3) The Superintendent of the West Virginia State Police or his or her designee; and
 - (4) A prosecuting attorney, as appointed by the Governor, who shall serve for a term of three years unless otherwise reappointed to a second or subsequent term. A prosecuting attorney appointed to the team shall continue to serve until his or her term expires or until his or her successor has been appointed.
- (c) Each member shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

§61-12A-2. Responsibilities of the Fatality and Mortality Review Team and Advisory Panels.

- (a) The Fatality and Mortality Review Team shall establish the following advisory panels to carry out the purposes of this article including:
- (1) An unintentional pharmaceutical drug overdose fatality review panel to examine, analyze and review deaths resulting from unintentional prescription or pharmaceutical drug overdose;
 - (2) A child fatality review panel to examine, analyze and review deaths of children under the age of eighteen years;
 - (3) A domestic violence fatality review panel to examine, analyze and review deaths resulting from suspected domestic violence;
 - (4) An infant and maternal mortality review panel to examine, analyze and review the deaths of infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child.
- (b) The members of the Fatality and Mortality Review Team shall serve as members of each of the advisory panels established pursuant to this article.
- (c) The Commissioner of the Bureau for Public Health, in consultation with the Fatality and Mortality Review Team, shall propose rules for legislative approval in accordance with article three, chapter twenty-nine-a of this code that the advisory panels shall follow. Those rules shall include, at a minimum:
- (1) The representatives that shall be included on each advisory panel;
 - (2) The responsibilities of each of the advisory panels, including but not limited to, each advisory panel's responsibility to:
 - (A) Review and analyze all deaths as required by this article;
 - (B) Ascertain and document the trends, patterns and risk factors; and
 - (C) Provide statistical information and analysis regarding the causes of certain fatalities;
 - (3) The standard procedures for the conduct of the advisory panels;
 - (4) The processes and protocols for the review and analysis of fatalities and mortalities of those who were not suffering from mortal diseases shortly before death;

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- (5) The processes and protocols to ensure confidentiality of records obtained by the advisory panel;
 - (6) That the advisory panels must submit a report to the Fatality and Mortality Review Team annually, the date the annual report must be submitted and the contents of the annual report;
 - (7) That the advisory panel may include any additional persons with expertise or knowledge in a field that it determines are needed in the review and consideration of a particular case as a result of a death in subsection (a), section one of this article;
 - (8) That the advisory panel may provide training for state agencies and local multidisciplinary teams on the matters examined, reviewed and analyzed by the advisory panel;
 - (9) The advisory panel's responsibility to promote public awareness on the matters examined, reviewed and analyzed by the advisory panel;
 - (10) Actions the advisory panel may not take or engage in including:
 - (A) Call witnesses or take testimony from individuals involved in the investigation of a fatality;
 - (B) Contact a family member of the deceased;
 - (C) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or
 - (D) Otherwise take any action which, in the determination of a prosecuting attorney or his or her assistants, impairs the ability of the prosecuting attorney, his or her assistants or any law-enforcement officer to perform his or her statutory duties; and
 - (11) Other rules as may be deemed necessary to effectuate the purposes of this article.
- (d) The Fatality and Mortality Review Team shall submit an annual report to the Governor and to the Legislative Oversight Commission on Health and Human Resources Accountability concerning its activities within the state and the activities of the advisory panels. The report is due annually on December 1. The report is to include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases and the team's recommendations to reduce the number of fatalities and mortalities that occur in the state.

The Critical Incident Review Team which functions under the Bureau for Children and Families is an internal team which reviews cases that are known to our bureau in which the child died or was critically injured as a result of abuse and neglect. The purpose of this team is for quality assurance purposes to look at policy, practice and training to see if improvements could be made to reduce critical incidents.

In order to ensure that the Bureau is aware of all child deaths due to abuse and neglect, the chair of the WVCFRP is notified by WV Vital Statistics of all child deaths. The chair of the WVCFRP then reports all deaths to the chair of the CIRT via a form developed by the WVCFRP (See attachment A). While not all children will be reviewed by the CIRT, at the end of the year the Chair of the CIRT which is also the Director of the Division of Planning and Quality Improvement, the Director of Social Services and the Director of Children and Adult Services review the NCANDS data file to ensure all children that need to be reported are reported.

The CIRT completes an annual report to the WV Legislature which we maintain on our Bureau website at <https://dhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx>. The numbers reported on this report and the NCANDS reporting are different, the numbers reported here are only cases known to our department not all children that have died as a result of abuse and/or neglect. The NCANDS data includes

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all children that died as a result of abuse/and or neglect in the state and should be reported. In 2015 the state changed policy to accept and investigate all cases of child fatality even if there are no other children in the home at the time of the death. This change allows us to capture all children who died as a result of abuse and/or neglect because they are assessed, and a determination is made in the SACWIS system.

Plans of Improvement to Prevent Child Fatalities

The WV Child Fatality Review Team Panel makes recommendations for system improvements and submits those recommendations to the legislature annually. If those recommendations include Child Protective Services, the CIRT reviews those recommendations and provides a response back to the Chair of the WVCFRP, the Chief Medical Examiner in the Office of the Chief Medical Examiner from the Commissioner of Children and Families.

The CIRT has a current Plan for Action which is maintained within the CIRT process. The plan is also included in the annual report to the legislature and can be found within that report. Since the CIRT process is a quality assurance process, information learned during the reviews is used to improve areas identified as deficiencies. An example of an action taken is safe sleep. The report shows a decline in unsafe sleep and therefore the number of fatalities as a result of unsafe sleep practices since the start of our reviews in 2014 has decreased.

Involvement of Partners to Prevent Child Fatalities

The Child Fatality Review Team Panel is required to have specific members on its panel including law enforcement, a prosecutor and several staff from the Bureau for Public Health including the Medical Examiner's office, vital statistics, Injury Prevention and Emergency Medical personnel. The team also includes a person from the Bureau for Behavioral Health and Health Facilities, the Fire Marshall's Office, state and local law enforcement and local and state child protective services. In the state of West Virginia these entities are all mandated reporters to child protective services.

The Child Welfare Oversight Team is the state level team for the CQI process in WV. Critical Incident data is a standing agenda item for this team to review and discuss the data and recommendations from the reviews. The Child Welfare Oversight Team is currently in the process of expanding the membership of the team to include the court, service providers, behavioral health We are currently expanding a state team to include our court partners, behavioral health, mental health and service providers.

§49-2-803. Persons mandated to report suspected abuse and neglect; requirements.

(a) Any medical, dental or mental health professional, Christian Science practitioner, religious healer, school teacher or other school personnel, social service worker, child care or foster care worker, emergency medical services personnel, peace officer or law-enforcement official, humane officer, member of the clergy, circuit court judge, family court judge, employee of the Division of Juvenile Services, magistrate, youth camp administrator or counselor, employee, coach or volunteer of an entity that provides organized activities for children, or commercial film or photographic print processor who has

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reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(c) Any school teacher or other school personnel who receives a disclosure from a witness, which a reasonable prudent person would deem credible, or personally observes any sexual contact, sexual intercourse or sexual intrusion, as those terms are defined in article eight-b, chapter sixty-one, of a child on school premises or on school buses or on transportation used in furtherance of a school purpose shall immediately, but not more than 24 hours, report the circumstances or cause a report to be made to the State Police or other law-enforcement agency having jurisdiction to investigate the report: Provided, That this subsection will not impose any reporting duty upon school teachers or other school personnel who observe, or receive a disclosure of any consensual sexual contact, intercourse, or intrusion occurring between students who would not otherwise be subject to section three, five, seven or nine of article eight-8, chapter sixty-one of this code: Provided, however, That any teacher or other school personnel shall not be in violation of this section if he or she makes known immediately, but not more than 24 hours. to the principal, assistant principal or similar person in charge, a disclosure from a witness, which a reasonable prudent person would deem credible, or personal observation of conduct described in this section: Provided further, That a principal, assistant principal or similar person in charge made aware of such disclosure or observation from a teacher or other school personnel shall be responsible for immediately, but not more than 24 hours, reporting such conduct to law enforcement.

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(d) County boards of education and private school administrators shall provide all employees with a written statement setting forth the requirement contained in this subsection and shall obtain and preserve a signed acknowledgment from school employees that they have received and understand the reporting requirement.

(e) The reporting requirements contained in this section specifically include reported, disclosed or observed conduct involving or between students enrolled in a public or private institution of education, or involving a student and school teacher or personnel. When the alleged conduct is between two students or between a student and school teacher or personnel, the law enforcement body that received the report under this section is required to make such a report under this section shall additionally immediately, but not more than 24 hours, notify the students' parents, guardians, and custodians about the allegations.

(f) Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect. In addition to changes in reporting laws, one of the Plan for Action items included standardizing and conducting training for mandated reporters to ensure all suspected cases of child abuse are reported to child protective services in a timely fashion. The team through reviews had determined that mandated reporters sometimes know about cases prior to the deaths but did not make a child protective services report until the child was severely injured.

CAPTA Requirements

The child's name is not included in the report we submit to the legislature, however if a request is made, information allowed by CAPTA will be provided.

Comprehensive Statewide Plan

The Child Fatality Review Team chaired by the Chief Medical Examiner for the state is required to submit a report annually on how to prevent fatalities. The report is reviewed by the Critical Incident Review Team and a response is provided to the Chief Medical Examiner on actions either taken or that will be taken based on the recommendations in the report. Since the Child Fatality Review Team reviews cases at least a year behind the reviews conducted by the Critical Incident Team, many times these issues have already been addressed. Collaboration is maintained throughout the year between the two teams.

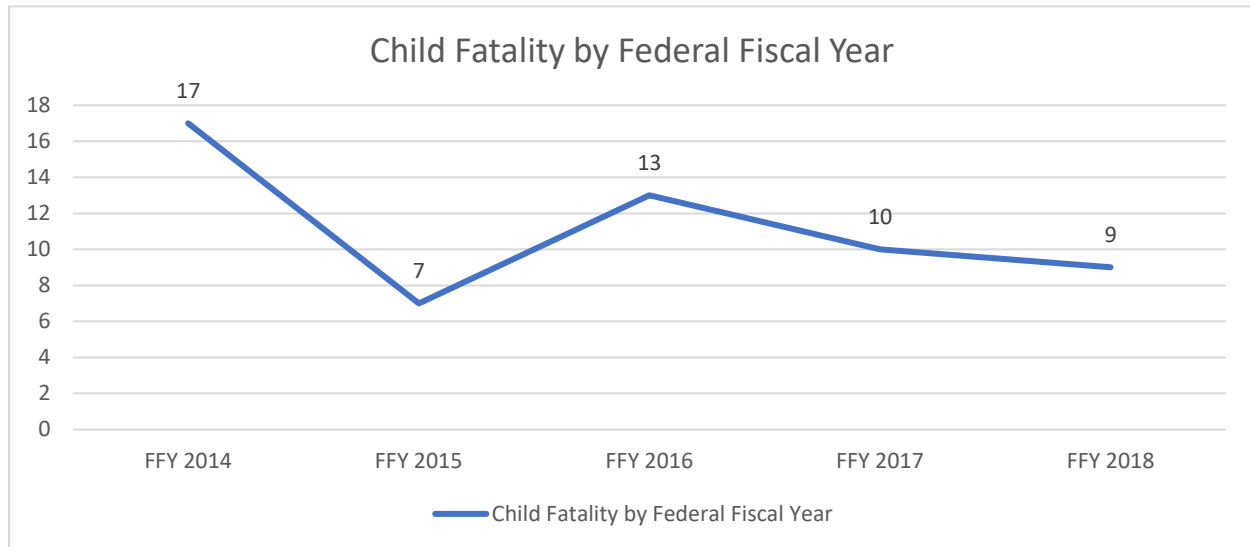
The Critical Incident Review Team has developed a Plan for Action to address critical incidents. The Plan for Action is updated at each review meeting and recommendations on each case are discussed and a decision is made on the actions to be taken. The Plan for Action is updated annually for the legislature but as recommendations are made, it is updated and put into action as needed. The plan for action and the data from the critical incident reviews are shared and discussed at the child welfare oversight team, our state team for our CQI process. We are currently expanding a state team to include our court partners, behavioral health, mental health and service providers.

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New Plan for Action Activities 2019:

- Coordinate training for staff with local law enforcement on the drugs most prevalent in their area of the state.

To review the annual report including the detailed Plan for Action for FFY-2018 go to: <https://dhhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx>



Source: Child Fatality Review Annual Reports

Promoting Safe and Stable Families (title IV-B, subpart 2)

Since July 2004, West Virginia has utilized a managed care system of sorts for Socially Necessary Services. These are services provided to children and families for Family Support, Family Preservation, Time-Limited Reunification and Adoption Support which are necessary to provide for the child's safety, permanency, and wellbeing and are not covered through Medicaid. Workers are expected to use existing, community services when available.

An Internet website section was developed and linked to the DHHR home page to assist interested parties in communities in determining whether they wanted to enroll as a provider of Socially Necessary Services. They can also choose which services they can provide and the geographic area they can cover. The material also describes the qualifications for providers for each service.

With the development of this system and Socially Necessary Services, the Department developed uniform definitions for services, standard/consistent credentialing for staff providing services, service criteria to help provide consistent client outcomes, a standardized authorization process for the initial approval of services, reauthorization of service continuation when warranted, and a process to review the services

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that were provided and uniform rates of reimbursement for services. The IV-B subpart two money was equally divided among the four categories of service and administration. The state supplements all the different categories with state funds. The Internet site is <http://wvaso.kepro.com/resources/manuals-reference-materials/>

APS Healthcare continues to monitor the operation of the authorization process, the provision of training to service providers and Department staff, and the operation of the retrospective review process. The Bureau for Children and Families convened an oversight workgroup. The workgroup is composed of Bureau staff, staff from the ASO, and representatives of the provider agencies. The ASO continues to encourage providers to administer services in more rural areas by compensating them for traveling longer distances.

After bringing together a cross section group to look at the Family Support category of ASO in late 2010, the Department decided to close this category of services in ASO and develop a Request for Proposal (RFP) for Family Resource Centers. Family support services are now available to anyone in the state who needs the services without having to have an open Child Welfare Case. All West Virginia's IV-B Family Support money was diverted into community-based services.

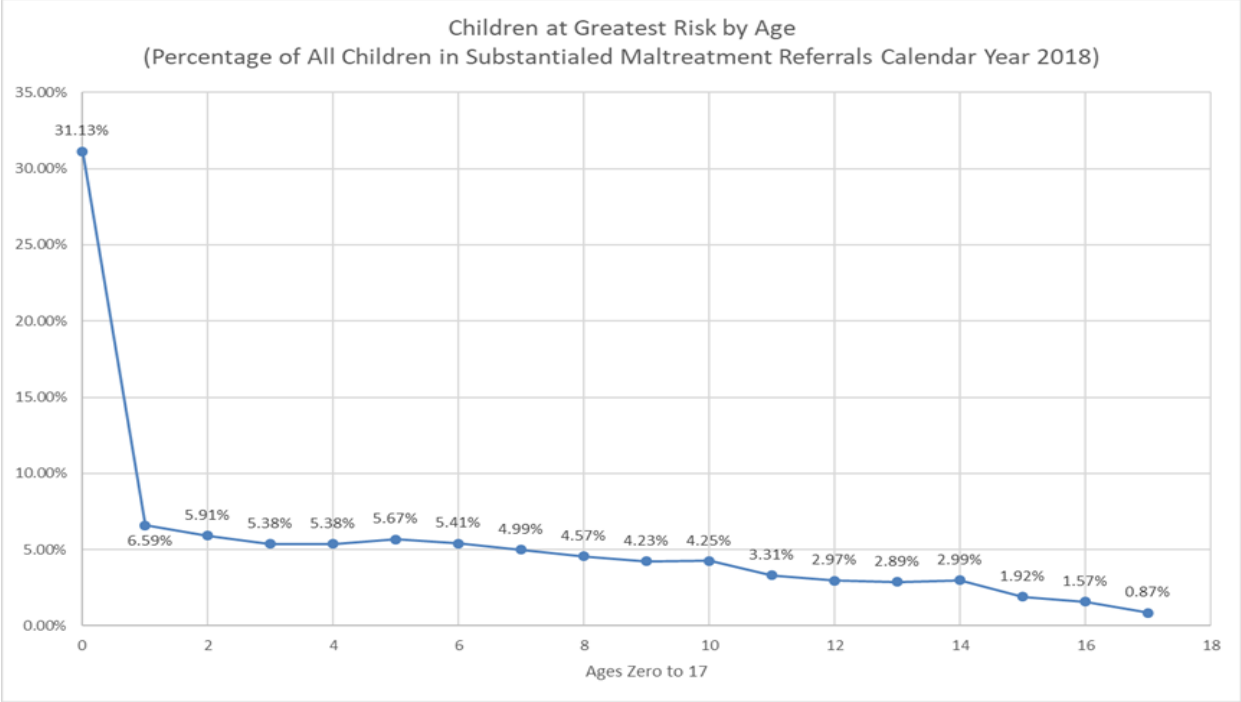
Socially Necessary Services are currently provided under Family Preservation, Time-Limited Reunification, and Adoption Preservation categories for children receiving services through both Child Protective Services and Youth Services. They are currently being provided in all geographical areas of the state and are funded equally with Subpart II money.

Populations at Greatest Risk

For the last five years, West Virginia has consistently identified children zero (0) to three (3) as being at greatest risk of maltreatment, specifically, children zero (0) to one (1). These numbers were derived from those children most consistently being removed from their homes to ensure safety.

West Virginia's population at greatest risk of maltreatment continues to be infants, zero (0) to one (1) year of age. Based on referral data it's believed this is due to the state's substance use epidemic. In the last five years the drug of choice has been opioids, but the state is seeing a return to methamphetamines.

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Source: Cognos CPS-5232 Maltreatment by Age Calendar Year 2018

Monthly Caseworker Visit Formula Grants and Standards for Caseworker Visits

All staff have access to a face to face dashboard to track their monthly visits with each child in care on their workload. Similarly, supervisors and managers have access to the dashboard to track progress for all staff for whom they have responsibility. This tool is of great assistance in measuring compliance but does not ensure quality. Case review is the only true measure of quality and is being implemented as an action for the state’s Program Improvement Plan to improve meaningful contact.

Face to face visits with children and their families is also an objective in the states Program Improvement Plan as well as outlined goals for the next five years. This data measurement will be tracked on a monthly basis by county and will be addressed in training and technical assistance to be provided to counties who have been identified as needing improvement in this area.

Monthly Caseworker grant money will be used to support Training and Technical Assistance Teams in providing specific, targeted training to individual districts on safety planning, treatment planning and meaningful contacts with children and families receiving child welfare services. This in depth assistance is aimed at improving West Virginia’s outcomes in Safety, Permanency and Well-being.

Additional Service Information

Child Welfare Waiver Demonstration Activities

West Virginia Department of Health and Human Resources implemented its Title IV-E Waiver program, *Safe at Home*, to address the growing number of children entering its foster care system, with a substantial portion of those children and youth being placed in congregate care. *Safe at Home* employs a wraparound service model for youth ages 12 to 17 with a mental health diagnosis or at risk of entering congregate care with a possible mental health diagnosis.

While some challenges were encountered during the first phase of implementation, changes were quickly implemented to remedy those issues. Those changes allowed for easier implementation of *Safe at Home* during the final two phases. In April 2017, *Safe at Home* began operating on a statewide basis.

The focus of the program has shifted over time, focusing less on youth who are placed in congregate care (including those placed into out-of-state facilities) and more on those who remain in their homes. This shift is largely the result of reduced numbers of youth being placed into congregate care, both in and out of state.

When safety, permanency and well-being outcomes for treatment youth are compared to a matched comparison group, *Safe at Home* youth tend to have a higher degree of success within six months of the start of service delivery or referral to the program, but the success appears to dissipate by 12 months.

The stepwise regression analyses highlighted which populations of youth the program did and did not work well. Youth with an Axis 1 diagnosis are at higher risk of not achieving favorable outcomes than youth without a diagnosis. Conversely, *Safe at Home* appears to be working well for youth with juvenile justice involvement and those who receive formal services. Additionally, treatment youth referred while placed in congregate care show more favorable outcomes than comparison group youth referred while in such a setting.

The overall costs for *Safe at Home* youth are greater than youth in the comparison group. However, *Safe at Home* youth are receiving services that are beyond those which can normally be provided. The provision of additional services yielded positive results, especially in relation to the youths' well-being and overall functioning.

Programmatic/Implementation Lessons Learned and Recommendations

As noted in the discussion above, West Virginia encountered a few challenges at the start of implementation. One of those challenges involved the training which DHHR and Licensed Coordinating Agency (LCA) staff were provided. Once identified, the State responded quickly, putting together a work group and a 90-day work plan, expanding policy, updating the program manual and retraining staff. In

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fact, West Virginia incorporated *Safe at Home's* Wraparound 101 and CANS training into its new worker training, ensuring that all DHHR staff are trained on the program. In addition, LCAs have expanded their own training materials to address the needs of wraparound facilitators.

While communication with key stakeholders was an important element of implementing *Safe at Home*, central office staff recognized, after the implementation of Phase I, that their initial outreach efforts, especially to judges, were inefficient. A combined communication plan was created for Community Services Managers (CSM) and LCA program directors to use with the judges in their areas. Materials were sent out by CSMs two and a half months prior to roll out in later implementation phases which were helpful. Meeting with judges became a regular part of CSMs' work and the addition of LCA program directors to attend some of these meetings offered the opportunity to provide judges with more detail about *Safe at Home*.

Access to services, especially in the early phases of implementation, was a challenge. One barrier, as reported by caseworkers and facilitators, was the lack of consistency by the youth/families and follow through to participate in services. While several services were not readily available, especially in more rural areas of the state, LCAs took creative steps to address the lack of services. For example, transportation to services is limited in several areas of the state. LCAs hired individuals to transport youth and their families, thus addressing that shortage.

Evaluation Lessons Learned and Recommendations

Two primary issues have been encountered over the term of the evaluation, with steps taken to remedy them as they were identified. The first involves obtaining a sufficient level of response to the online surveys administered to DHHR staff. An email message was sent to CSMs, asking each to complete the annual survey and send the link to the *Safe at Home*-involved staff to also complete the survey. This process was used in lieu of asking CSMs to provide a list of email addresses for all *Safe at Home* caseworkers to the evaluator. Because the request to complete the survey was sent to the group of CSMs via a list serve, DHHR's mail system identified the message as spam. Many CSMs did not receive the request. The process was changed to send individual email messages to CSMs which yielded a higher rate of response.

The second issue involves understanding the full range of data contained within DHHR's case management system, FACTS, and how the data tables are applied. Over time, additional data have been requested to be included within the data extracts received. This has provided a more robust ability to identify the populations or characteristics of youth for whom *Safe at Home* has been successful.

The work and efforts of the Demonstration project align with the larger initiative of WVDHHR of the WV Child Welfare Reform. As we move toward the completion of the demonstration project, WV continues to work on sustaining *Safe at Home* WV by incorporating the successful efforts of the project into current initiatives and work throughout out child welfare system.

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While initially focused on reducing and preventing congregate care placement of youth with a behavioral health issue, the program was quickly expanded to focus on preventing any foster care placement for youth with known or possible behavioral health issues. The waiver project was successful at preventing the re-entry of youth into congregate care, reducing the length of stay when placed in congregate care, returning youth to their communities, placing youth with relatives, increasing their rate of reunification, reducing repeat maltreatment and improving youth's educational and family functioning. The demonstration project however was not as successful, when results are compared to an historical group of comparison youth, in preventing removal.

From a fiscal perspective, the wraparound model was successful in reducing the costs of out-of-home placement expenditures and payments for fee-for-service items. However, when the monies paid to local coordinating agencies to provide assessments, case management, supervision and services are factored in, the costs for treatment youth are more than those for comparison youth; the difference does not take into account the reduction in time caseworkers spend on waiver youth with wraparound facilitators providing intensive services to youth and their families. Based on the overall success of the program, West Virginia intends to expand its wraparound program to serve children and families under the age of twelve (12).

Family First Prevention Services Act FFPSA

As part of our ongoing sustainability efforts WV continues to work with the upcoming changes through FFPSA to incorporate appropriate utilization of wraparound moving forward.

WV will also continue efforts Foster Care Candidacy Claiming to assist potentially in financial support for sustainability of wraparound.

Seriously Emotionally Disorder Waiver Application

Bureau of Medical Services, one of our sister bureaus within the DHHR, has been working on a SED 1915C Waiver for wraparound of children with severe emotional disorders. The application is currently under public comment period. WV believes that approval of this waiver will provide continued coverage of services to the portion SAH WV wraparound children that meet the criteria.

Behavioral Health Wrap Around Pilot Expansion

Bureau of Behavioral Health previously ran a pilot for children in parental custody that meet the criteria for wraparound. After the successful pilot they have been granted additional funding to expand the service statewide. WV believes this too, will serve a portion of children in parental custody that need wraparound.

Wraparound Continuum of Care Post Waiver

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The entire DHHR and the involved agencies have begun working together to align all WV Wraparound into a single continuum of wraparound service for the children and families of WV. As the work continues, more updates will be provided.

Licensed Coordinating Agencies

LCA meetings have been increased during the reporting period to provide the opportunity for better communication in monthly conference calls and face to face LCA meetings. In the next review period LCA face to face meetings and sub workgroup meeting continue to work collaboratively on enhancements to improve practice during the move to post waiver SAH work.

Marshall University

Collaborative work began with Marshall University to continue the expansion of the Child and Adolescence Needs and Strengths (CANS) Automated System to gather data and continue work post waiver. Marshall will begin oversight of the CANS Training and hopes to become a center of excellence to carry on the valuable work and utilization during our Demonstration Project.

Adoption and Legal Guardianship Incentive Payments

The Bureau of Children and Families will use adoption and legal guardianship incentive payments during the next five years to improve post adoption and legal guardianship services offered to West Virginia's children and families. Incentive funds will be used to decrease the amount of time it takes for foster children to achieve permanency through adoption or legal guardianship and for post adoption services and post legal guardianship services.

Thirty percent of incentive funds will be used by the Bureau of Children and Families toward post adoption and post legal guardianship services. The Bureau of Children and Families will release a Request for Application (RFA) for applicants to implement plans to provide prevention, post adoption, and post legal guardianship services to West Virginia's children and families. These funds will be used to strengthen Socially Necessary Services offered through Title IV-B funding and prevention services offered through Title IV-E funding. The Bureau of Children and Families will use incentive payments to provide the necessary services to keep adoptive and legal guardianship families together that are at risk of disruption.

Incentive payments will be used by the Bureau of Children and Families to provide services to help decrease disruption before permanency and to decrease the amount of time before permanency is achieved through adoption or legal guardianship. Kinship providers as well as foster care providers will receive services that will help them manage tasks of transporting children to medical and mental health appointments, school activities, and extracurricular activities. Incentive payments will be used to strengthen services in order to meet the needs of West Virginia's children and families, so that disruptions will decrease and time to permanency will increase.

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Adoption Savings

The calculated savings must be spent on title IV-B and IV-E programs; 30 percent of which must be spent on post-adoption services, post-guardianship services and services to support positive permanent outcomes for children at risk of entering foster care. Two-thirds of the 30 percent must be spent on post-adoption and post-guardianship services. (In other words, title IV-E agencies must spend at least 20 percent of calculated savings on post-adoption and post-guardianship services. If at least 20 percent, but less than 30

Please see attached FORM CB-496: TITLE IV-E PROGRAMS QUARTERLY FINANCIAL REPORT
PART 4: ANNUAL ADOPTION SAVINGS CALCULATION AND ACCOUNTING
REPORT

Adoption Savings Methodology

Please see Attachment E

Adoption Savings Expenditures

The Bureau for Children and Families will pursue the release of a Request for Applications designed at providing post-adoptive services statewide to adoptive families. The services will include;

- training and education for adoptive parents regarding the special needs of the adopted children, including adjustment and attachment issues.
- Providing or referring families to counseling services for both families and individuals.
- Providing educational advocacy and support.
- Respite care.
- Facilitating support groups or referrals to support groups for parents and children.
- Family crisis response team – including crisis respite.
- Case management services, including introduction to the family prior to finalization
- Financial services, including transportation, lodging and meals.
- Completing assessments to determine which services would benefit the family

Consultation and Coordination Between State and Tribes

There are currently no federally recognized tribes in the state of West Virginia. Current Foster Care Policy states that if a child is recognized as a member of a tribe, the child's social worker is to contact the U. S. Department of Interiors Bureau for Indian Affairs to determine if the tribe has child welfare jurisdiction.

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West Virginia is currently working to strengthen its child welfare policies regarding ICWA. Child welfare staff will be expected to determine tribal affiliation much earlier in the case to provide a more seamless process for the family. If the tribe does not have jurisdiction over the child or family, our staff will ensure that they are contacting the tribe continuously throughout the life of the case to ensure that all the child and family's rights are being respected regarding their tribal affiliation.

Foster Care Policy states that children of families that have American Indian ancestry are to be referred to the tribe in which ancestry is claimed for child welfare services.

The state continues to work with the Children's Bureau to find a resource for this review.

5. John H. Chafee Foster Care Program for Successful Transition to Adulthood

Agency Administering Chafee

The West Virginia Department of Health and Human Resources is responsible for assisting youth transitioning to adulthood into safe, healthy, self-sufficient adults. In meeting this responsibility West Virginia contracts with other agencies to provide transitioning services.

Currently, West Virginia provides some direct services to youth fourteen and up through our casework process and relies heavily on contracts with a few community agencies to provide monitoring, oversight, and some direct services for youth transitioning.

The Department has established and sustained a relationship over the past 30 years with West Virginia University (WVU) and the Center for Excellence in Disabilities (WVU CED). The Mentoring and Oversight for Developing Independence for Foster Youth (MODIFY) Program within the WVU CED has collaborated closely with the Department to provide: 1) services to youth who are 17.5 years and aging out of the foster care system and those who are adopted or placed in legal guardianship after the age of 16 years; 2) technical assistance to the Department on subject matter pertaining to youth transition; and 3) support and oversight for youth councils throughout West Virginia (WV).

This relationship will continue over the next five years with the MODIFY program taking on more of a consultant role with youth transitioning and transitional living agencies. Due to their lengthy involvement with older youth in foster care, their expertise will be invaluable in developing our continuum of care for youth transitioning.

Description of Program Design and Delivery

The purpose of the Chafee Foster Care Independence Act was to provide states with flexible funding to develop and design services and activities to meet the needs of youth transitioning from foster care. The Act provides guidance for seven specific purposes listed below:

1. Help youth transition to self-sufficiency.
2. Help youth receive the education, training, and services necessary to obtain employment.
3. Help youth prepare for and enter post-secondary training and educational institutions.
4. Provide personal and emotional support to youth aging out of foster care through mentors and the promotion of interactions with dedicated adults.
5. Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 23 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition to adulthood.
6. Make available vouchers for education and training, including post-secondary education, to youth who have aged out of foster care.
7. Provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption.

The Bureau for Children and Families (BCF) has incorporated Positive Youth Development (PYD) practices into its policy and procedures, and through the MODIFY program that serves Chafee eligible transitioning youth. Prudent Parent Standard has been defined and informs workers and children and youth in foster care on parental decisions that should encourage emotional and developmental growth. In Foster Care Policy, the completion of a Life Skills Assessment has been mandated which begins for youth age 14 and assesses and educates youth on a variety of necessary life skills. Youth Services (YS) requires youth participation within the Multidisciplinary Treatment Team (MDT) process both as an invitee and a participant. Through this, the youth involved with YS and the MDT has an opportunity to lead and discuss what they would like to see happen with their case plan.

Additionally, the WV MODIFY program has incorporated PYD into their process. MODIFY promotes youth skills in self-directed decisions regarding educational goals, living arrangements and establishing independent decision making in activities of daily living. Youth are presented options for education and are encouraged to determine what kind of degree or certification they are interested in obtaining based on their interest, beliefs and what they want to pursue for employment. Living arrangements are individualized and based on the youth's preference, strengths and limitations. Budget and money management, establishing of dorm or apartment living management, productivity management, social interaction and self-care skills are an intricate part of the MODIFY program in reinforcing the youth

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establishing independence. As needed and requested per the youth, MODIFY serves as a coordinator of services and support to strengthen a successful outcome. MODIFY age eligibility has been expanded to better meet the needs of the youth while increasing the opportunity to succeed. MODIFY focuses on the ideology that the youth is now an adult and can make their own decisions. Additionally, MODIFY has begun establishing two youth led councils, one for the northern portion of the state, and one for the southern. These councils will be composed of, and lead by current and former foster youth and will provide recommendations for service improvement to the MODIFY program and the DHHR.

NYTD data collected through the CCWIS system, as well as NYTD data collected through age 17, 19, and 21-year-old surveys are and will continue to be distributed to various entities, agencies, and workgroups. The Court Improvement Program (CIP) conducts permanency reviews and NYTD data is provided to them on a regular or as needed basis and is the avenue in which NYTD data is provided to West Virginia's court systems. NYTD data is also provided to workgroups such as the Service Development and Delivery Workgroup (SDDW), and the Transitional Living Workgroup (TLW), and to other state oversight entities such as the Bureau for Health Facilities (BHF). The SDDW, TLW, and other workgroups contain members of the Department of Health and Human Resources (DHHR), service providers, IL coordinators, and members of the public and use NYTD data to identify gaps in services, needs, and trends.

- **Life Skills Assessment Process:**

At age 14 or older (if a youth enters care at an older age), each child in foster care completes their Casey life skills assessment. The assessment is completed within 30 days following the youth's 14th birthday or entrance into care if the youth is already age 14. The assessment helps determine the child's level of functioning in several areas including but not limited to personal hygiene, food management, housekeeping, employability, education planning, and so forth. The results of the assessment provide critical information regarding strengths and weaknesses in various life skills areas. In order to ensure that foster care youth are gaining necessary skills to prepare them for independence, the life skills curriculum provides foster care youth in all out-of-home placements in West Virginia the opportunity to learn these valuable skills. The learning objectives of the life skills curriculum are taught to the foster child by the foster parents, by staff in group residential settings/specialized foster care, or by the child's Department caseworker. The life skills assessment is completed on youth in care annually.

The Department has continued to implement the new life skills assessment and curriculum process. West Virginia continues utilizing the Casey Life Skills Assessment and Curriculum. When the Casey Assessment process and website changed, provider agencies and staff were provided with information on the new process and how to access the site and assessment. The utilization of the Casey Assessment and Curriculum process is being used statewide.

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- **Transition Plan and Services:**

At the age of 14 or older (if a youth enters care at an older age), each child in foster care develops their individualized transition plan, which will help the youth move towards independence and self-sufficiency. The transition plan is to be developed within 60 days following the youth's 14th birthday or entrance into care if the youth is already age 14. The transition plan is reviewed every 90 days and revised as necessary. Some areas that are addressed in the transition plan are housing options, insurance options, community supports, educational plans and supports, employment plans and supports, workforce supports, mentoring services, healthy relationships, family planning, supportive counseling, life skill curriculum, and benefits available (SSI, SS, ETV, Food Stamps, etc.). The Department recently updated the transition plan with the input of the older youth transitioning task team. The new format has been shared with partners at the Court Improvement Program and at various supervisor meetings across the state.

- **Transitional Living Placement with Subsidy:**

Currently, when a youth reaches the age of 17 or older, he or she has an option to move into a community setting in his or her own apartment if they meet the eligibility criteria. The purpose of this placement type is to allow the youth an opportunity to use the life skills acquired while in foster care and continue to receive support from the state. In this setting, the youth is pursuing an educational/vocational goal, learning job skills, or is employed or seeking employment. West Virginia plans to expand this opportunity to all youth transitioning to adulthood to include different living situations and support from a transitional living provider regardless of placement setting.

- **Employment Programs:**

The employability project will continue to help youth obtain employment. The employability services are available to youth currently in foster care and to the 18-20-year-old population who have aged out of foster care and is provided statewide. The services and activities provided are designed to not just place youth into employment but also provide them with the skills, guidance, and ongoing support necessary to sustain employment and succeed in the workplace. Services are provided at the youth's place of residence, agency site, within the community, or at Sponsored Employment sites.

Youth participating in this project are provided the opportunity to:

- Develop Job Seeking Skills;
- Develop an employment history;
- Receive cash for attendance;
- Receive assistance with job placement, on the job training, and job shadowing; and

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- Gain/Maintain employment.

In the next five year, the state expects to expand these services by increasing the number of Transitional Living providers as well as the services and supports they provide to youth transitioning.

Some unique and promising programs offered to youth transitioning in West Virginia by various agencies, coordinated with MODIFY, include the following:

- **Helping our Undergraduates Succeed in Education (H.O.U.S.E.) Project:**
Some transitioning youth who are first-time freshman at West Virginia State University (WVSU) live in the H.O.U.S.E. project. This initiative provides a small, staff supervised house on the WVSU campus for students who may need a gradual introduction to college life and support services.
- **Foster Care Tuition Waiver:**
House Bill 4787 was passed in 2000 and provides for youth in foster care and former foster care youth to receive tuition waivers for the purpose of attending one of the public colleges/universities in West Virginia.
- **Computers for Graduates Program:**
Access to technology is a necessity and no longer a luxury in today's post-secondary education environment. Each year, the Department makes funds available for the purchase of a computer to youth who graduate from high school or complete the High School Equivalency exam while in foster care.
- **Mentoring:**
The Department has developed close working relationships with transitional living providers to address the issues that youth face when transitioning out of foster care. The Department has also encouraged the use of the Foster Club Permanency Pact in several regions in the state. Youth councils will also continue to be a priority in the next five years as leadership skills continue to be important to this increasing cohort of youth who are transitioning to vocational and/or educational phases in their lives. West Virginia helped to establish a youth group, West Virginia Foster Youth Advocacy Movement (WV FAM). There are currently several members of this group in the state, but they've lost their infrastructure and organization. Several planning sessions with youth have occurred to get youth councils up and running again in the state. The state plans to continue to support the reorganization and functioning of WV FAM.
- **Conferences:**

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In the past, several conferences were held which provided opportunities for youth in foster care to interact with positive adult role models. Youth were given the opportunity to interact with adult role models during statewide conferences. The state has hosted transitioning youth conferences. The conference provided opportunities to interact socially with foster parents (their own and others), staff (their own and others), and adult volunteers.

During development of the Transitional Living continuum, the state will add regional conferences for transitioning youth to be part of the program. These conferences will provide life skills training, networking for WV FAM, the opportunity to interact with positive role models, development of positive peer to peer relationships and the opportunity for youth to offer input on the states program and design.

- **Post-Secondary Education Student Support Services:**

Youth in a post-secondary educational program will be linked to supportive services within the educational system they are attending. These supportive services often assist the youth in maintaining their grades, advocating for their own rights, staying connected to other youth, and receiving other supports as needed. Some of the services that are utilized are student tutoring services, college career centers, college help centers, and student groups.

- **Community Support Services:**

Youth can receive additional community supports, as indicated on their transition plan. Transitional Living providers will assist youth under their responsibility with receiving any community supports that the youth may need. Additionally, the MODIFY program staff will refer youth to community services for extra support. Some of the community resources that are utilized are: Workforce; HRDF; WV Housing; Community Mental Health Centers; Legal Aid of WV; Social Security Offices; Division of Rehabilitation Services; Housing Urban Development; Community Pregnancy Support groups or prevention groups; DHHR Economic Services; Transportation Agencies; WV Higher Education Commission and Bureau for Medical Services or Community Medical Assistance Programs.

- **Transition from High School to Post-Secondary Education Support Programs:**

Youth in high school or obtaining their GED will be referred to supportive programs to assist them in making the transition from high school to a post-secondary educational program, when needed. Some of the programs utilized are the Heart of Appalachia (HAT) Program and the Federal TRiO Programs which includes eight programs targeted to serve and assist low-income individuals, first-generation college students, and individuals with disabilities to progress through the academic

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pipeline from middle school to post-baccalaureate programs. TRiO was originally given its name after the first three programs (Upward Bound, Talent Search, Student Support Services) were implemented. Currently it encompasses these programs: Upward Bound, Talent Search, Student Support Services, Educational Opportunities Centers, Veteran's Upward Bound, Training Program for Federal TRiO Programs, Ronald E. McNair Post-Baccalaureate Achievement Program, and the Upward Bound Math-Science Program.

Serving Youth Across the State

West Virginia provides Chafee funded services through its general casework practice as well as, targeted transitioning services to its older youth in all areas of the state. Although the state does provide services through its general casework practice and its MODIFY program, there is a very limited number of transitional providers that provide the more intensive transitional services.

West Virginia has developed a plan to increase the number of transitional providers across the state to promote a more flexible diverse continuum of care to youth in all communities. We would like every youth transitioning from foster care to have the opportunity to receive quality services to help them become safe, healthy, self-sufficient adults.

Mentoring and Oversight for Developing Independence for Foster Youth (MODIFY) with CED Program:

A referral to the MODIFY Program becomes appropriate when a youth is 17.5 years or six months prior to graduating or obtaining a high school equivalency. Once eligibility is confirmed and the youth is enrolled for services, the MODIFY Project specialists assist youth within two large domains: independent living services and/or postsecondary education attainment. As noted earlier, the MODIFY Program is maintained through a cooperative agreement with the Department. The relationship between the MODIFY Program and the Department has been sustained and strengthened over the past thirty years. The program is one of eight programs and 11 initiatives within the WVU CED (www.wvuced.org) designed to provide at least one of the following services to youth, families, and/or providers where applicable: training, direct services and technical assistance, information dissemination, and research/evaluation. The WVU CED is one of 62 centers within a national network of university-based centers of excellence coordinated by the Association of University Centers for Excellence in Developmental Disabilities (AUCD; www.aucd.org).

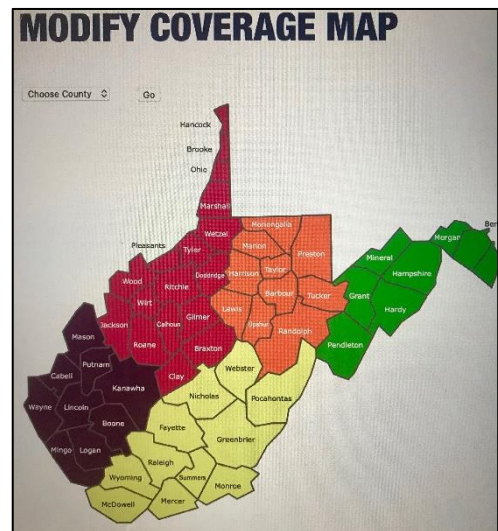
Within the areas of independent living and postsecondary education services, the MODIFY Program team works closely with the youth and other providers to:

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- Ensure that youth who are likely to remain in foster care until 18 years of age are provided education, training, financial support, and other needed transitioning services (e.g., start-up funds, independent living subsidies);
- Support and serve recipients between 18-20 years of age in a way that compliments their own efforts toward self-sufficiency; and
- Provide youth who exit foster care at 18 years or older with education and training vouchers with the purpose of attending a post-secondary educational program. These funds may be used for the costs of attending college or vocational training.

Initiated in the past plan and continued in this plan, the MODIFY Program team also supports opportunities and trainings for youth to develop their leadership skills within their local communities and national events, where applicable.

The MODIFY Program is fully staffed with five Youth Specialists who serve youth across five regions within WV (see map). Two additional specialists additionally refer eligible youth to the program while also collecting important information from youth about the transition, their ongoing needs, and the services they need to address those needs. Led by a Program Manager and Program Assistant, the MODIFY Program is fully able to reach youth throughout the state within these service domains. The Department and the MODIFY Program team will continue to focus on increased utilization of services, training, and professional education opportunities in the next period. The Department will continue to monitor the utilization of services and work within the MODIFY Program to promote and recruit eligible youth over the next five years.



The continued increase in the number of youths within the foster care system is a significant factor in service efficiency and effectiveness over the next five years. Discussions about this increased number have been conducted in the past year to identify supports for the youth, providers, and the MODIFY Program directly, as number of eligible youths for MODIFY services continues to increase perhaps beyond the current size of the MODIFY team. MODIFY will continue to examine the characteristics of youth cohorts each year and needs of cohorts to better address needed services and trainings over time. Additional partners may be identified to provide additional services to these larger cohorts. MODIFY Program team members will expand efforts to reach out and work closely with these providers for training and educational opportunities as well as continuation of services and communication of care.

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Serving Youth of Various Ages and Stages of Achieving Independence

Beginning at age fourteen, all youth in foster care are eligible for transitioning services up to the age of twenty-three. These services are provided, contracted and/or monitored by agency workers and foster care providers. One area to be targeted for improvement are services to youth placed in kinship or relative homes. Currently, these youth are not as well served, and case management and oversight are sporadic. The services that are being provided to youth in kinship homes successfully are educational support as well as employment services to youth seventeen and older and are provided by the MODIFY program.

West Virginia is currently working on a transitional living program model that will provide a continuum of services for youth transitioning out of foster care. These services will be provided in a tiered manner so youth can receive the level of services that best meets their needs. The program will operate under a trauma informed structure and will be flexible, so youth can move from one tier to another without a disruption in services. The WV CANS and Casey Life Skills Assessment will help workers determine which level of services will best meet their needs. West Virginia will be working towards increasing the number of transitional living providers across that state in order to provide this continuum of services up to age twenty-three (23) for transitional living and twenty-six (26) for Educational Training Vouchers for transition living.

Some of the services/training that will be provided to youth in a transitional living program:

- Supervision/Monitoring and Support
- Transition Planning & Life Coaching
- Life Skills
- Educational Support and Planning
- Job Prep & Support
- Career & Interest Inventories
- Financial Literacy
- Community Linkage & Support
- Support & Crisis Response
- Peer to Peer Relationships
- Adolescent Brain Development
- Normalcy/Prudent Parent Standard

Collaboration with Other Private and Public Agencies

The Department and MODIFY program have established and sustained strong partnerships with public and private partners throughout the state and in surrounding areas that serve youth in West Virginia (WV). For example, MODIFY, Youth Services System, and Human Resource Development Foundation partners, Bureau of Juvenile Services, Bureau for Mental Health, Community and Technical Colleges, Mission WV,

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Administrative Services Organization, Court Improvement Board, and multiple Community Collaborative groups have worked closely for more than two decades to coordinate youth services around such needs as independent living, substance use prevention, and job skills training. Additionally, partners who provide new services are routinely identified throughout the year and meet with Departmental team members to learn more about youth services and to identify potential roles and collaborations. Once a partnership is established, team members touch base with one another regularly (e.g., team meetings, workshop sponsorships) to sustain global awareness of the various programs that are available to youth, eligibility criteria if applicable, and referral procedures. Working closely together ensures continuation of services, unique contributions to youth service provisions (rather than duplication of services), and smoother transitions. New youth initiatives are often coordinated by the Department and sent to all youth service providers. Project materials are also shared across partners on a regular basis to increase dissemination among eligible youth. Results of our NYTD profile are shared with partners, including the Court Improvement Program, to help determine services to be developed and processes and training to be refined. Finally, social media postings and shared information have become more common among the partners as a means of disseminating information among team members but also directly to youth.

Determining Eligibility for Benefits and Services

All youth in foster care will be eligible for age appropriate services as described within the John H. Chafee Foster Care Program for Successful Transition to Adulthood section. Services will be determined by age and developmental level and may be provided by newly developed Transitional Living agencies. The services will be available to all current and former foster youth as described in [Foster Care Policy](#), but the frequency and intensity will be delivered according to the level of the youth.

Cooperation in National Evaluation

In May 2016, the WV DHHR/ BCF participated in a 3-day voluntary onsite NYTD Pilot Assessment Review. While there were findings, and areas needing to be improved upon, since this assessment was voluntary, no financial penalties were imposed. During the 3-day review, a system demonstration was provided, the NYTD Survey was reviewed, a case review completed, and stakeholder interviews held.

At the conclusion, of the review, several findings were noted and a NYTD- Quality Improvement Plan (N-QIP) created. Findings included; but are not limited to, the general requirements and the reporting of various elements within the client demographics, services, and the NYTD Outcome Survey. In addition, it was found that for a few of the youth reviewed, what was reported in the 2015B submission was not actually what the youth had reported.

At this time, West Virginia is in the process of replacing the current legacy system (FACTS) with functional modules which will comprise the new Comprehensive Child Welfare Information System. Due to this

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endeavor, it was determined making changes in the current legacy system was not feasible due to scope and complexity of work to be done. To date, most findings have been completed, however, some findings which remain pending, in the N-QIP, and are to be completed in the new WV PATH System. The 2015B file has been corrected and a subsequent file was submitted in January 2017 to correct the 2015B submission. A Quality Assurance tool has been created and shared in our latest NYTD-QIP quarterly submission. In addition, updated Foster Care policy has been developed and implemented. The state continues to address outstanding items on the NYTD-QIP.

Chafee Training

West Virginia is planning to develop regional teams to target specific training and technical assistance to individual counties or districts in areas needing improvement. Chafee services to youth fourteen to seventeen will be one area addressed in all fifty-five counties. The state will explore expanding a service currently offered in only one county that provides mentoring and advocacy services to foster youth to help improve educational outcomes. The program currently offers the following services;

Academic Success Coaching - The program is guided by the concept of ABC model (Attendance, Behavior, and Course Completion). The program ensures that the student has the highest level of support possible. Our Mentor will track attendance, behavior and course completion and respond to any areas of concern.

Educational Advocacy –Ensuring that the students' rights are upheld in the school setting; helping students access education-related support services; minimizing the effects of disciplinary actions that keep students out of school; assisting high school youth in making up credits when necessary and possible; and facilitating participation in extracurricular activities.

Student Enrichment Opportunities - Students need opportunities to flourish outside of the classroom. These experiences bring classroom concepts to life and establish a new future horizon on which students in foster care may focus. The program and county school provide student enrichment workshops, college visit field trips, and educational experiences.

Post-Secondary Education Planning - The goal is to build the confidence, skills and supports youth impacted by foster care need to take charge of their lives and future. The program and county school work with youth to create a personal plan to graduate high school and pursue their dreams. The program uses Check & Connect along with other research-based methods to give students the necessary tools to first understand and use their individual strengths and interests.

Group Counseling – In the grade school setting, the Mentor works with the elementary school counselor to co-facilitate Journey of Hope, a trauma informed program through Save the Children that teaches students how to deal and cope with circumstances they may face.

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The most recent data available for the school months of August 2018– April 2019 yielded the following results:

- 33 Students were enrolled in the program
- Since the 2018-19 school year started in mid-August the Mentor has made 750 “Connects” or encounters with 33 students.
- 0 of the 33 students have had behavior incidents this 18-19 school year.
- Graduating Seniors – There are seven seniors enrolled in the program currently and all are on target for graduation in May. **Five of the seniors will be attending college in the fall, one has plans to join the military and get a college degree as well and one will be F**
- 100% of seniors in the program have a post-secondary education plan.
- 53 Youth have been involved in post-secondary education field trips.
- 100% of youth participating in field trips reported on a survey college trips as beneficial to their post-secondary plans.
- 28 of 29 middle and high school youth receiving one-on-one mentoring show improvement in core subject areas than prior year (before being served.)
- 28 of 29 middle and high school-youth receiving one-on-one mentoring have maintained or shown improvement on their report card with services than without.
- All students in the program follow the attendance policy
- All students in the program are on target for graduation with their class and no discipline issues causing expulsion or ALC.

Education and Training Vouchers (ETV)

The education and training vouchers are supported using money provided to the state as a part of the reauthorization of the independent living program. Education Training Voucher (ETV) funds are State administered funds provided to foster care and former foster care youth by the MODIFY Community Support Specialists as well as DHHR caseworkers, through the WV DHHR State Office of Finance and Administration. Youth eligible for Chafee ETV funds include the following: a) youth adopted or placed in legal guardianship from foster care after the age of 16 years old; and b) foster/ former foster care youth through 26 years old, who aged out of care at 18 or older. If an eligible youth is enrolled, attending, and making satisfactory progress in a post-secondary educational program on their 25st Birthday, then they may be eligible to continue to receive ETV funds until their 26th birthday.

ETV funds may not exceed \$5000 per FFY (10/01 – 09/30). ETV funds may be used to cover educational expenses as outlined by the Higher Education Act which may include tuition/fees, books/supplies, room/board, transportation, tutoring, etc. A student must reapply **each year** to receive ETV funds and must maintain **satisfactory standing** within the guidelines of the ETV program.

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To meet the guidelines of satisfactory standing and receive ETV funds, youth must meet the following: 1) a 2.0 GPA; an 80% course completion rate; and maintain regular attendance and provide monthly progress reports to the MODIFY Community Support Specialist.

MODIFY specialists monitor each case individually through both FACTS and WVU CED CODA system. The student and payment allotment are kept on an excel spread sheet which is checked each time a payment is rendered. Youth enrolled in education is counted only once as a new enrollee no matter the number semesters attended per year. All new youth who officially receive an intake and are opened as a MODIFY client are an unduplicated client. Through case management and data collection system MODIFY specialists verify individual counts and numbers. Specialists send their requested payments to the MODIFY director each month who enters it for payment. Those payments are then approved by a DHHR specialists who checks the payments against an Excel spreadsheet.

The Department, through the MODIFY program, produces materials and training sessions designed to sustain awareness about the ETV funds and other support services among higher educational staff, advisors, and families throughout the network. This collaboration is bidirectional in that higher education institutions, state scholarship programs, noted tuition waiver programs also provide information to the Department teams to inform youth and families of changes in fiscal support and procedures. Youth assessments, case modifications, and other updates are shared through similar tracking methods to identify strengths and areas of improvements for youth enrolled in the program. Students placed on probation are provided resources across Department partners and higher education institutions. Attempts to resolve challenges prior to issues with fiscal support, scholarships, and other concerns are made collectively by teams and institutions when possible.

The state provides Chafee Services to youth who have been adopted or who were placed in legal guardianship. Some of the services that youth are provided include Educational and Training Voucher (ETV) funds, case management oversight, community referral services, mentoring services, and other transitioning services as needed as indicated above.

West Virginia provides the same MODIFY services to youth adopted or placed in Subsidized Legal Guardianship.

Consultation with Tribes

For information on Consultation and Coordination with tribes, please refer to Section 5 of this Child and Family Services Plan.

6. Targeted Plans within the 2020-2024 CFSP

Foster and Adoptive Parent Diligent Recruitment Plan

The Foster and Adoptive Parent Diligent Recruitment Plan was developed with the states Regional Recruitment and Retention teams, Mission WV, the Foster and Adoptive Diligent Recruitment Program Improvement Plan team and West Virginia's Specialized foster care agencies. Please see attached.

Health Care Oversight and Coordination Plan

The Health Care Oversight and Coordination Plan was developed with the Office of Maternal Child and Family Health, Bureau for Medical Services and the Bureau for Children and Adult Services. Please see attached.

Disaster Plan

It has not been necessary for the Bureau for Children and Families (BCF) to activate its COOP during the 5-year review period. Although various BCF offices closed and alternative locations were used in some instances, none of those facilities activated their COOP. When offices closed, essential staff remained available. Emergency events were handled by the local emergency management officials.

The Bureau for Children and Families was on stand-by, as needed, at the Center for Threat Preparedness during events for which Health Command was activated.

See attached

Training Plan

See attached.
