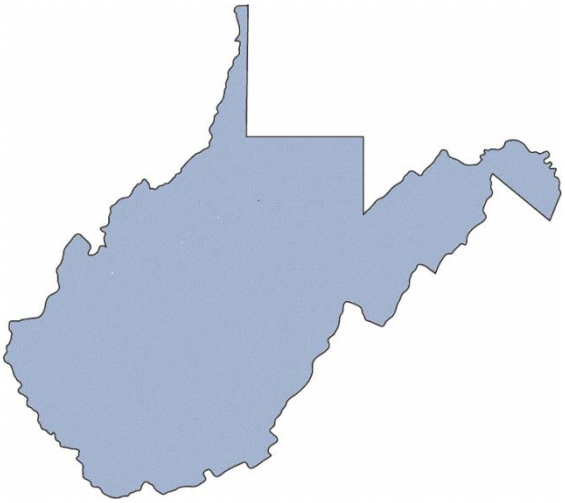
WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

April 1, 2015 – September 30, 2016



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I. Overview

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

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

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

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

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

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

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

Theory of Change

We implement CANS and NWI

So That

We have clear understanding of family strengths and needs

And

A framework/process to address those strengths and needs

So that

Families will receive the appropriate array of services and supports

And

Are more engaged and motivated to care for themselves

So that

Families become stabilized and/or have improved functioning

So that

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

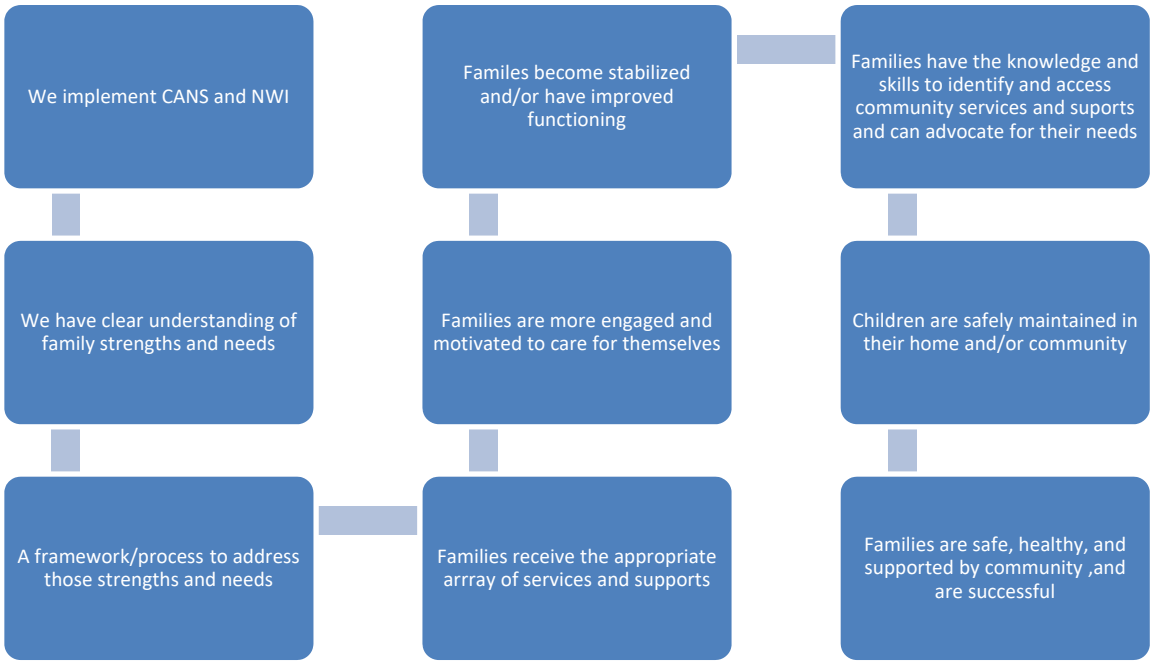
So that

Children are safely maintained in their home and/or community

And

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

Safe at Home West Virginia Theory of Change



Safe at Home West Virginia Logic Model

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

II. Demonstration Status, Activities, and Accomplishments

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

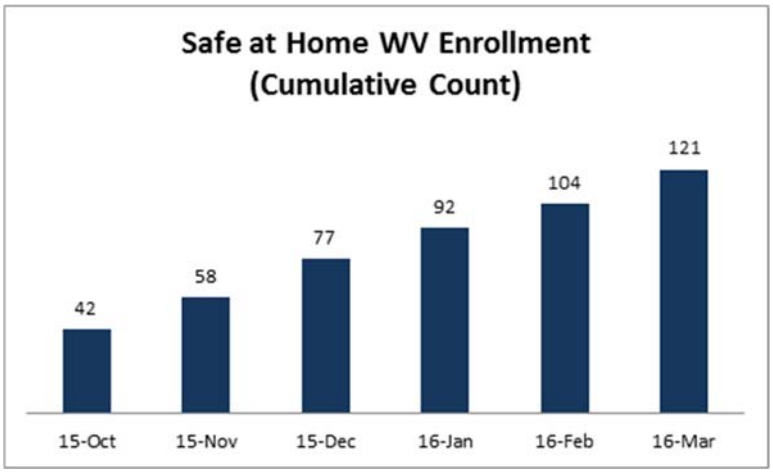
APRIL 2016

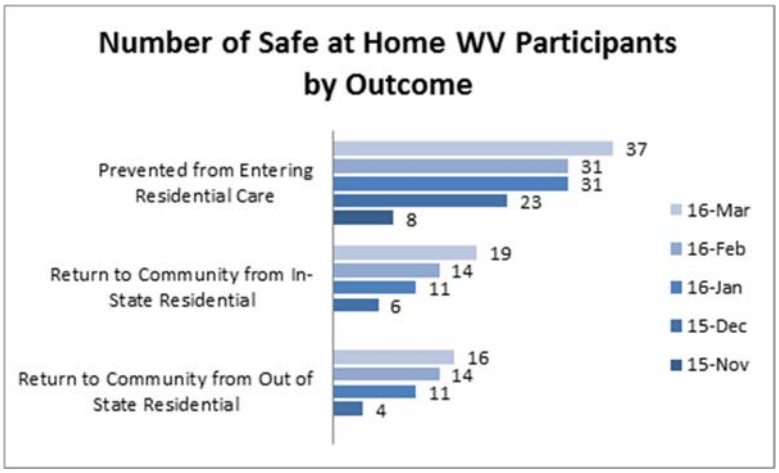
Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the 11 counties of Berkley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne with the first 21 youth being referred for Wraparound Facilitation. West Virginia also began the process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

As of March 31, 2016, 121 Youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 16 Youth from out-of-state residential placement back to West Virginia and 19 Youth have stepped down from in-state residential placement to their communities. We have been able to work with 37 at risk youth to prevent residential placement.

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

- 31 were or are in out-of-state residential placement
- 46 were or are in in-state residential placement
- 44 were or are prevention cases





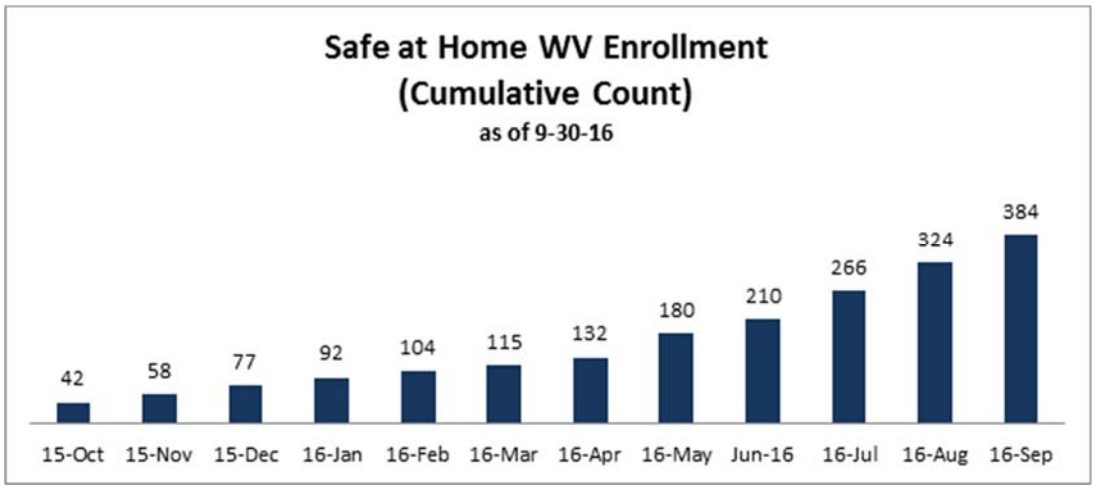
OCTOBER 2016

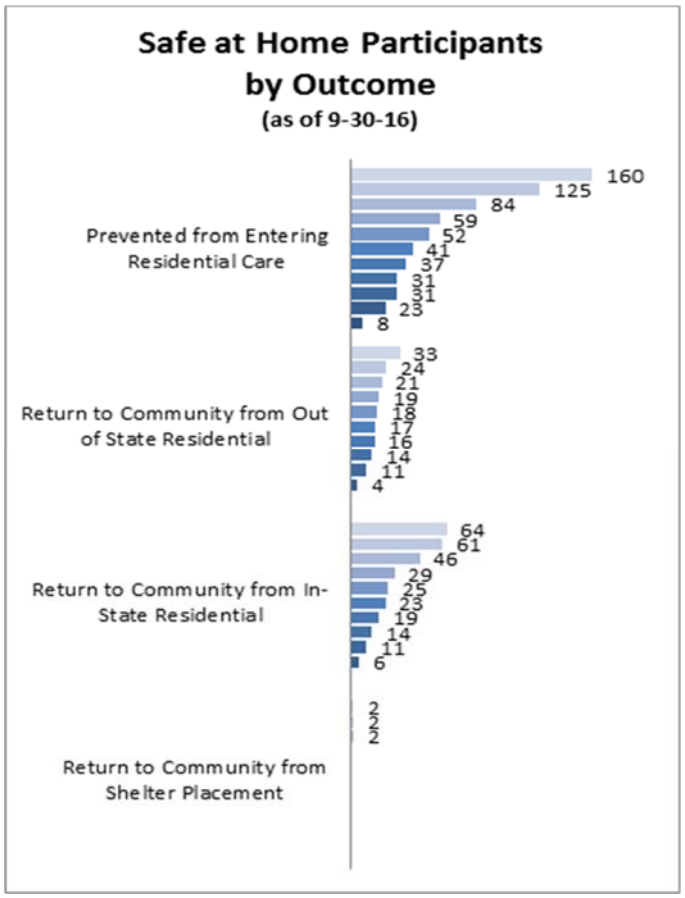
On August 1, 2016 West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker, and Upshur. At this time there are counties within each of the 4 BCF regions that have implemented.

As of September 30, 2016, 384 Youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 33 Youth from out-of-state residential placement back to West Virginia, 64 Youth have stepped down from in-state residential placement to their communities, 2 Youth have returned home from emergency shelter placement, and we have been able to prevent residential placement of 160 at risk youth.

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

- 52 were or are in out-of-state residential placement
- 128 were or are in in-state residential placement
- 181 were or are prevention cases
- 23 were or are in emergency shelter placement


Safe at Home WV Enrollment
(Cumulative Count)
as of 9-30-16
42
58
77
92
104
115
132
180
210
266
324
384
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep


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

APRIL 2016

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

On October 7 and 8, 2015 West Virginia Department of Health and Human Resources Secretary Karen Bowling hosted a Three Branch Conference to celebrate the kickoff of Safe at Home West Virginia. The conference focused on the launching of Safe at Home West Virginia and Trauma focused interventions. The conference was opened by West Virginia's First Lady Joanne Jaeger Tomblin with Trauma–informed care specialist Dr. Allison Sampson-Jackson conducting an engaging session on Trauma-informed interventions and care.

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

OCTOBER 2016

Within the first month of this reporting period West Virginia implemented the recommendations of our evaluator. Those included inclusion of Shelter care as one of the placement types at time of referral. The face to face meetings with the Judiciary was also

identified by our Home Team and our Local Coordinating Agencies as something they believed to be beneficial. The receipt of the recommendations from our evaluator served to reinforce this. The Home Team developed a plan for each Community Services Manager to partner with at least one of the Directors of a Local Coordinating Agency serving their area and schedule a meeting with the Judges. This was tracked and completed.

West Virginia has worked with the Capacity Building Center for States to develop a strategic plan to support the wavier as well as other BCF initiatives and needs. The Capacity Building Center for States provided a marketing consultant to assist with the development of a 1 page informational document about Safe at Home West Virginia. The document is written in layman terms and is being utilized by the department as well as any of our partners to inform and solicit community level support for the youth and families being served through Safe at Home West Virginia. This document is available for public use and may be accessed and printed from the Safe at Home West Virginia Website, safe.wvdhhr.org .

APRIL 2016

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

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

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

OCTOBER 2016

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

APRIL 2016 and OCTOBER 2016

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

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

OCTOBER 2016

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

CANS training and certification as well as Wraparound 101 training continue in the Phase 1 Counties to assure new staff hires have the required trainings while also moving to the Phase 2 and Phase 3 Counties.

From July-December 2015 West Virginia conducted 20 WV CANS training sessions. As of March 17, 2016, 505 BCF staff attended CANS training and 375 are certified. This continues as planned.

Between January 2016 and October 2016 West Virginia trained another 199 staff in CANS and certified 170. West Virginia also continues with the identification and certification of WV CANS Advanced CANS Experts (ACES) to provide ongoing training and technical assistance. West Virginia is finding that staff are having difficulty accessing advanced CANS experts to provide technical assistance. In order to address this Dr. Lyons came to West Virginia and spent a week with another 12 staff identified to go through the advanced CANS experts process. He will also be providing monthly technical assistance calls with the experts in order to continue the development process. The goal has always been to have the internal capacity within West Virginia to continue this process and the transferring of learning. We believe that with the assistance of the current experts and Dr. Lyons we will have no difficulty proceeding as planned.

There are no significant changes in the design of our interventions to date but there have been innovations. Within the first 2 months of implementation the Safe at Home West Virginia Advisory team began conducting “Barrier Busting” reviews aimed at assisting local staff and wraparound facilitators with problem cases that were not moving forward. These reviews included a case staffing with recommendations and ideas. Barrier Busting reviews and staffings only occurred for 3 months and then transitioned to the existing Advisory Team process. The Advisory Team has a written SOP that is undergoing changes. At present the Director of the

Division of Program Quality Improvement is chairing this group and is developing a tracking format for observations and trends. A feedback template is drafted for each case reviewed and provided to the Local Coordinating Agency director and supervisor as well as the local DHHR supervisor and Community Services Manager. The Advisory Team has been conducting reviews for several months and we are determining the most effective approach and use of this team. The Advisory Team will be discussed further in Section V.

During the first reporting period our evaluator also conducted process surveys. In order to address the issues identified through the process evaluation surveys and the "Barrier Busting" case reviews, West Virginia developed a 90 day intensive work plan. Updates were made to the DHHR Policy, training, referral review process, program manual, monthly progress report, wraparound plan, as well as training of content experts. As issues have become apparent West Virginia has developed plans to address them. The Program Manual, BCF Policy, and all pertinent documents and forms are updated and posted on the Safe at Home West Virginia website at safe.wvdhhr.org.

During this reporting period West Virginia has modified our individual wraparound plan format based on advice received from a consultant and our Local Coordinating Agency leads who are using the form. The changes may appear small but it allows for better focus on strengths and outcomes as well as making the form more user friendly and readable.

During this reporting period West Virginia also developed a plan for communication with the judiciary based on our observations and then the recommendations of our evaluator. The Safe at Home Home Team worked with the Directors of the Local Coordinating Agencies and Local Community Services Managers to develop a plan for individual meetings with each Judge that included both local DHHR staff and representation from the Local Coordinating Agency/ies that serve that area. A roundtable discussion was also held with a judicial district at the request of one of their Judges. The roundtable included the BCF Deputy Commissioners of field operations, a director of a Local Coordinating Agency, local community services managers and the circuit Judges. The purpose was to allow an open conversation about the implementation of Safe at Home in their area and to address questions or concerns. The goal is to replicate this process if it proves to be beneficial.

APRIL 2016

The plan for development of content experts as part of a training process was originally identified and mapped out in our implementation plan. As part of the intensive work plan to address identified innovations West Virginia has developed a white paper

overview of the experts and focused more specifically on their training and development. The home team determined that there was need for a larger group of individuals to be designated as content experts in order to meet the ongoing technical assistance need. More experts were identified and notified in February and March and received a one day overview of their expectations and then the Wraparound 101 overview. Further training is being developed and deployed and will be discussed in Section V.

OCTOBER 2016

The process for training and development of content experts has moved in a different direction. We have found that these individuals naturally emerge within their county and regional offices and the process has become more organic than we had originally planned. It has become clear that this isn't something that we needed to control but to allow to occur. Champions and experts have naturally developed among our 4 Regional Social Service Program Managers and their director. Under these individuals are 12 Child Welfare Consultant positions that are clearly necessary to have as experts due to their role in daily technical assistance within child welfare. We also have Community Services Managers, youth service workers, child protective service workers, youth services supervisors, and child protective services supervisors that have emerged and are available to newly implementing peers for support. Another interesting observation is the expertise that has developed among our Local Coordinating Agency directors and clinical supervisors and the role that they are playing in providing support not only to their staff and peers but also to the BCF staff. It truly demonstrates the need for partnership and collaboration on all levels. At present we are not pursuing the further training and development of content experts as originally conceptualized. The BCF Home Team will be making decisions as to the direction this should take.

Through this process and in partnership with the Bureau for Behavioral Health and Health Facilities (BHHF), we have identified the need for further wraparound training and consultation for our wraparound facilitators. Beginning in April, 2016 the Bureau for Children and Families partnered with the Bureau for Behavioral Health and Health Facilities and the West Virginia System of Care to access coaching and consultation with a nationally recognized wraparound expert. Mary Grealish visited West Virginia on 4 occasions to meet with Local Coordinating Agency staff, DHHR Staff, BHHF Staff, and other partners to discuss and coach on family and youth engagement strategies. Ms. Grealish also met with Family Teams to staff difficult cases and offer insight in planning and suggestions on wraparound planning

improvement, as well as conducting coaching calls with clinical supervisors regarding engagement strategies in supervision. Ms. Grealish completed her work with West Virginia in August and we are at this time determining the next steps for any coaching or training. This will be further explored in Section V.

APRIL 2016

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

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

OCTOBER 2016

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

every 90 days.

The system has proven to be very useful for the use of the CANS across systems. The ability for staff to quickly locate and use existing CANS is very helpful in treatment planning and the ability for administrative staff to access needed reports has proven to be very useful.

APRIL 2016 and OCTOBER 2016

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

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

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

With regard to analyses; the evaluator will separate them if the SACWIS system shows us whether the family got that service. If it does not, we can only obtain the information through our case readings and the prevalence of FFT will determine whether we get any meaningful information out of it.

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

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

In March, 2016 the Bureau for Behavioral Health and Health Facilities (BHHF) released a Request for Applications for Grants for Local Coordinating Agencies to hire Wraparound Facilitators to serve 4 pilot areas of West Virginia. The BHHF pilot project is to provide high fidelity wraparound modeled after Safe at Home West Virginia, to children in parental custody and no involvement with the child welfare system. BHHF has worked closely with BCF to assure that the two programs are as similar as possible without overlap. Several of the pilot areas are part of the Phase 1 of Safe at Home West Virginia and all but 1 of the grant awards were to Local Coordinating Agencies that are also serving Safe at Home West Virginia.

0CT0BER 2016

BHHF is preparing to implement their wraparound program within the next months. We continue to partner with them throughout this process. Our ongoing meetings with the Local Coordinating Agencies also include the BHHF director of Children's Mental Health Services and the Local Coordinating Agencies that will be serving under their grant. We have found this to be a very useful process that has assisted the agencies with the peer support they all desire.

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

III. Evaluation Status

APRIL 2016

During the past six months Hornby Zeller Associates, Inc. (HZA), the project evaluator, developed its data collection tools; performed baseline interviews, reviewed documents, automated the Child and Adolescent Strengths and Needs (CANS) tool, prepared data extract requests for FACTS, West Virginia's SACWIS, analyzed the first six-month extract of FACTS data, and analyzed the first set of CANS assessments.

Tool Development

Hornby Zeller Associates, Inc. (HZA), the project evaluator, developed many of the data collection tools which will be used throughout the evaluation during the first six months. These included a case review tool for determining how the project was implemented in individual cases (see Appendix A); four interview protocols for obtaining the perspectives and opinions of youth, parents, team members and wraparound facilitators (see Appendix B); and a staff survey to gather information on the program from the perspective of BCF staff in regions and counties where *Safe at Home* is being implemented (see Appendix C). A similar survey is being developed to gather information from the perspective of the wraparound facilitators.

Data Collection Activities

During this first six-month period HZA conducted interviews and completed a review of project documentation, while also arranging for and receiving the initial extracts from the State's SACWIS, called FACTS. The results from the first two activities will inform the process evaluation, while the analysis of FACTS data will focus primarily on the outcome evaluation but will also contribute to the process component.

In addition to the above data collection activities, HZA designed and implemented an automated version of the Child and Adolescent Strengths and Needs (CANS) tool which is being used by BCF and its contractors throughout the State. Some initial data have become available from this source, and ultimately the results of repeated CANS administrations to individual youth will provide a means of measuring clients' progress on well-being outcomes.

Baseline Interviews

The first round of interviews was completed during the week of November 16-20, 2015, to evaluate the planning and development of the program, and to assess early implementation. HZA conducted interviews in Phase I regions and counties, which included counties from Regions II and III, although not all counties within those two Regions were selected to participate in Phase I. Counties chosen for baseline interviews were randomly selected among Phase I implementation counties; counties which were not included in the first round of interviews will be included in subsequent rounds. HZA staff completed interviews with key stakeholders in the following Region II counties: Kanawha, Boone, Logan, Lincoln, and Cabell; in Region III interviews took place in Berkeley and Morgan counties.

HZA interviewed 50 stakeholders, including staff from West Virginia's Bureau for Children and Families, contracted community service providers, and members of the judicial community. Table 1 provides a full breakdown of stakeholders interviewed by staff type.

Table 1. Stakeholders Interviewed

Staff Category	Number Interviewed
Central Office Administrators	8

Regional Office Administrators	6
Direct Service Staff (includes Youth Services Workers and Supervisors)	11
Community Providers (includes Contracted Service Provider Administrators, Workers, and Supervisors)	13
Judges	8
Prosecutors	1
Probation Officers	1
Juvenile Justice Department Staff	2
Total	50

Documentation Review

Table 2 provides a list of documents HZA collected at the time of the interviews with key stakeholders. These documents are key to understanding the processes, policies, and conceptual framework guiding the program's implementation. The documents also exemplified how the state engages with their stakeholders and the public in regard to *Safe at Home* and provided insight into the program's progression. Additionally, the documentation review provided a solid context for the interview analysis.

Table 2. *Safe at Home West Virginia* Documents Reviewed
Training Curriculum and Schedules
The 10 Principles of Wraparound
Safe at Home Training Schedule
Policies and Laws
Youth Transitioning Policy
Youth Services Policy
Governor Tomblin Signs Senate Bill 393, Juvenile Justice Reform
Safe at Home West Virginia BCF Policy
Child Protective Services Policy
Safe at Home West Virginia Policy Desk Guide
Guides, Manuals, and Handbooks
The National Wraparound Initiative's Wraparound Implementation Guide: A Handbook for Administrators and Managers
Safe at Home West Virginia: A Family's Guide to Wraparound
Safe at Home Fact Sheet
Safe at Home West Virginia FAQs

Table 2. *Safe at Home West Virginia* Documents Reviewed
Safe at Home West Virginia Program Manual
Community Collaborative Safe at Home Semi-Annual Report Form
Safe at Home WV Wraparound Planning Form
Safe at Home WV Referral Wraparound Form
Reports, Plans, and Organizational Charts
The Safe at Home West Virginia Implementation Work Plan
The Safe at Home West Virginia Initial Design and Implementation Report (IDIR)
The Department of Health and Human Resources Organizational Chart
BCF Organizational Chart
BCF Regional Map
The Safe at Home West Virginia Title IV-E Waiver Application
Public Announcements, Outreach, and Other Media
The Quarterly Newsletter (5)
Safe at Home Funding Announcement (Phase I)
Safe at Home Funding Announcement (Phase II)
WV Metro News: New program aimed at keeping more at-risk kids at home
Safe at Home West Virginia's Email Blasts (31)
Safe at Home West Virginia Speaking Points
WV Public Broadcasting: Investigation: W.Va.'s Mental Health Services for Children Not in Compliance with Federal Law
State Journal: WV DHHR cabinet Secretary Karen Bowling responds to DOJ criticism of state's handling of children with mental health needs
Governor Tomblin Announces Launch of Safe at Home Program
DHHR Press Release: DHHR Launches Safe at Home West Virginia (9/30/2015)
DHHR Press Release: DHHR's Safe at Home WV Project Continues to Progress (12/14/2015)
DHHR Press Release: Safe at Home Providing 100 Youths an Alternative to Institutional Care (2/16/2016)
DHHR Press Release: DHHR Seeking Applications for Phase Two of Safe at Home West Virginia (3/3/2016)
Safe at Home WV Printable Flyer

Child and Adolescent Strengths and Needs

During the first few months of implementing *Safe at Home*, HZA developed an online CANS tool for receiving agencies and caseworkers to use. The tool, which mirrors West Virginia's paper assessment tool, enables users to identify the strengths and needs of youth and allows for ease of access across participating agencies; it also provides the evaluative team with ready access to assessment data to measure progress on outcomes. Data are recorded in at least eight modules, with actionable items automatically identified when ratings of particular items reach specified values. The tool also prompts users to complete sub-modules or additional assessments when certain factors are identified within the main modules. In January,

HZA conducted a series of webinars to train staff in Phase I local coordinating agencies and BCF on how to navigate and use the tool. A User's Guide was developed and provided to users as a reference tool.

Of the 120 youth who participated in *Safe at Home* during the first six months of implementation, at least one CANS was completed for 69 youth. Twenty-five youth had one subsequent assessment completed and three had two subsequent assessments completed. A CANS is to be completed upon referral to wraparound, every 90 days thereafter and again at discharge.

Data from FACTS

HZA will use data from West Virginia's child welfare information system throughout the evaluation to measure outcomes, e.g., reduced length of stay or reduced number of youth re-entering foster care, and to compare those outcomes to an historical comparison group of youth matched to those referred to *Safe at Home*. A comparison group was selected from youth known to BCF between SFYs 2010 to 2015 with characteristics similar to the 120 youth who were referred to the program during the first six months. Demographic data, case history and qualifying characteristics such as mental health status and juvenile justice involvement were used to match youth to the treatment group. Because the kinds of data available vary between youth in substitute care and youth at home, and because placement at the time of referral is likely to be a strong influencing factor, youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state psychiatric facilities and group care; in-state psychiatric facilities and group care; emergency shelters; family foster care placements; and youth at home. Cases selected into the comparison groups are in the same placement types and are statistically similar to those in the corresponding treatment groups.

Tables provided in Appendix D illustrate the quality of the matches between youth in the treatment and comparison groups. There are no statistically significant differences between them.

OCTOBER 2016

Data Collection Activities

Over the course of this second six-month evaluation period HZA conducted case record reviews at DHHR County offices and at the local coordinating agencies (LCAs) as part of the

fidelity assessment. Additionally, for each case reviewed HZA staff conducted interviews with stakeholders willing to share their experiences; these included youth, parents, wraparound facilitators, and DHHR caseworkers.

HZA also administered surveys to wraparound facilitators from both Phase I and Phase II counties[2] and DHHR caseworkers from Phase I counties as part of the fidelity assessment. The fidelity assessment will be conducted on an annual basis, with results informing the process evaluation.

HZA received the second set of extracts from FACTS. The analysis of FACTS data generally informs the outcome component of the evaluation. Additionally, HZA has used extracts from the automated Child and Adolescent Needs and Strengths (CANS) tool, through repeat administrations, to measure clients' progress on well-being outcomes. Each of these is discussed below.

Case Reviews and Interviews

The first set of fidelity assessment case reviews and corresponding interviews were completed during the first two weeks of August 2016. Forty cases were selected at random in proportion to the population served by each LCA. For this baseline assessment randomly selected cases came from a total of eight LCAs in Regions II and III.[3] Selected Region II cases included youth from Kanawha, Cabell, Lincoln, Putnam, and Wayne counties; selected Region III cases included youth from Berkeley, Jefferson, and Morgan counties. Case review data was obtained from case records at DHHR County offices and LCAs; the majority of the data was provided by LCAs' case records.

HZA staff also interviewed 87 youth, parents, wraparound facilitators, and caseworkers from associated cases about their experience with wraparound service delivery. Some wraparound facilitators and caseworkers were interviewed about more than one case from the sample, because most wraparound facilitators and caseworkers carry multiple *Safe at Home* cases. Table 3 provides a breakdown of stakeholders interviewed by group.

[2] Surveys were administered to staff from both Phase I and II LCAs because most wraparound facilitators carry *Safe at Home* cases in multiple counties.
[3] Two of the LCAs had offices outfitted in both Regions II and III; cases were reviewed from both offices.

Table 3. Stakeholders Interviewed	
Interviewee Group	Number Interviewed
Youth	22
Parents	24
Wraparound Facilitators	17
BCF Caseworkers	24
Total	87

Surveys

Surveys were administered to wraparound facilitators from the LCAs and DHHR caseworkers. Survey respondent provided their perceptions of the quality and effectiveness of services, what can be done to enhance them, and multi-agency collaboration.

The survey deadline was October 3, 2016 for both the LCA staff and DHHR staff surveys. Out of the 102 LCA staff to whom the survey was sent, 27 it; this included 20 wraparound facilitators, five supervisors, and two respondents from other positions. For the DHHR staff survey, HZA emailed the survey link to all community services managers from Phase I implementation counties. The community services managers were asked to forward the link to caseworker staff involved with *Safe at Home*. Eighteen stakeholders completed the DHHR staff survey; this included 15 caseworkers and three supervisors. HZA does not know how many staff was asked to participate.

FACTS Data

HZA will continue to use data from West Virginia's SACWIS, FACTS, throughout the evaluation to measure outcomes, e.g., reduced length of stay and reduced number of youth re-entering foster care, and to compare those outcomes to a historical comparison group of youth matched to those referred to *Safe at Home*. A comparison group was selected from youth known to DHHR between SFYs 2010 to 2015 with characteristics similar to the 124 youth comprising Cohort I (i.e. those referred to the program between October 2015 and March 2016). Two-hundred and five youth comprise Cohort II (i.e. those referred to the program between April 2016 and September 2016). However not enough time has passed for youth in this cohort to look at outcomes. These data will be included in the next semi-annual report.

Demographic data, case history and qualifying characteristics such as mental health status and juvenile justice involvement were used to match youth to the treatment group. Youth in the treatment group were partitioned into five subgroups according to referral and

placement type: out-of-state psychiatric facilities and group care; in-state psychiatric facilities and group care; emergency shelters; family foster care placements; and youth at home. Cases selected into the comparison groups are in the same placement types and are statistically similar to those in the corresponding treatment groups.

Child and Adolescent Strengths and Needs

During the first few months of program implementation, HZA developed an online CANS tool for LCAs and DHHR caseworkers to use. The tool, which mirrors West Virginia's paper assessment tool, enables users to identify the strengths and needs of youth. Because the tool is online, it allows for ease of access across participating agencies. The online CANS tool also provides the evaluative team with ready access to assessment data to measure progress on outcomes. For this reporting period, HZA was able to measure progress with CANS data because youth have been in the program sufficiently long; 136 subsequent CANS assessments were available for analysis.

IV. Significant Evaluation Findings to Date

APRIL 2016

Process Evaluation Results

Answers to process evaluation research questions, presented below, help to identify the efforts being taken by West Virginia to implement *Safe at Home*.

How was the planning process conducted?

As reported in the *Safe at Home* West Virginia Initial Design and Implementation Report, the state utilized community Collaboratives to help identify service needs for *Safe at Home*. Community Collaboratives consist of Department of Health & Human Resources (DHHR) staff and community partners from a variety of fields (e.g., juvenile services, behavioral health, education, etc.), who work together to identify service gaps in their communities so plans can be made to address those gaps. Additionally, six *Safe at Home* work groups were created with specific goals and responsibilities, and consisted of team members with expertise in each particular area. The work groups were overseen by the DHHR *Safe at Home* Oversight Team and the BCF Home Team, and included the following:

- the Service Development Work Group (includes sub-groups for Service Implementation and Wraparound Design, Supports, and Services),
- the Practice Development Work Group,
- the Communications Work Group,
- the Evaluation Work Group,
- the Fiscal Accounting and Reporting Work Group,
- the IV-E Revitalization Work Group, and

  the Data Work Group.

In addition to the work groups and community Collaboratives, the State has made a substantial effort to educate key stakeholders and the general public on the program. Examples of public and stakeholder outreach include: personal meetings between DHHR staff and judges; weekly email blasts to over 1,000 recipients; quarterly newsletters; press releases; the development of a wraparound expert team; the creation of speaking points; a printable flyer; trainings; new policy and policy revision; a *Safe at Home* website and email; a program manual; and guides for families, DHHR staff, and service providers.

Ten of the thirteen community providers interviewed stated they were involved in the planning process in some capacity, and twelve of the thirteen believed that the planning process was inclusive. None of the judges interviewed were involved in the planning process and a couple of them stated that they would have liked more judicial representation during the planning period.

How was the demonstration organized, including staff structure, funding, administrative oversight, and problem resolution?

Contracted community providers are responsible for hiring wraparound facilitators who will play a key role in program implementation by developing and facilitating wraparound services for youth. All of the community providers interviewed reported they did not have to make any major organizational changes to successfully implement the program aside from hiring the wraparound facilitators or moving current staff into that position. According to the *Safe at Home* funding announcement, contracted agencies are to receive $70,000 in start-up grants for each wraparound facilitator and a daily rate of $136 for each child participating in *Safe at Home*; the daily rate excludes reimbursement for services which are billable to Medicaid.

Some community providers indicated they were enjoying the collaborative effort with DHHR. Similarly, some direct service, central, and regional office staff expressed relief about the collaboration with wraparound facilitators, because they believed it could result in lighter caseloads. On the other hand, some BCF caseworkers stated they were not confident in understanding their role in the program. The caseworker's role is defined in the *Safe at Home* policy, and it does require flexibility.

> In the wraparound process the worker will continue to facilitate the traditional roles of problem identifier, case manager, treatment provider, and permanency planner, but how the worker plays the role will shift from plan-to-plan. Some plans may require the worker to be more intensively involved in helping to identify informal supports, while another plan sees the worker taking a less involved presence and acting as an equal to
>
> the rest of the team. Workers should remain flexible in how, when, and where they contribute to the plan's success.

A *Safe at Home* West Virginia policy desk guide was created for caseworkers and

concisely outlines their role. One supervisor in Region II reported she holds meetings to ensure that her staff are aware of the hierarchy and structure between DHHR staff and community providers. Direct service staff from both Regions said they were comfortable asking their supervisor any questions they had about the program.

Regional office staff spoke about a wraparound expert team, responsible for educating stakeholders and answering any questions they may have about *Safe at Home* or wraparound services. Additionally, the *Safe at Home* website lists an email address which is available for anyone to submit questions and concerns about the program, or for subscription to the weekly email blasts. The state also includes a *Safe at Home* FAQs document on the website for troubleshooting common issues.

What number and type of staff were involved in implementation and how long were the implementation periods?

The wraparound facilitator is a new position created for the *Safe at Home* program, with contracted community providers responsible for hiring the facilitators. The wraparound facilitator plays a crucial role in maintaining fidelity to the wraparound model, and is responsible for:

- coordinating services among multiple agencies,
- engaging community partners and facilitating creative service delivery,
- ensuring the wraparound process remains family driven and strengths based,
- facilitating all team meetings and establishing ground rules and
- developing a crisis safety plan with the family.

Wraparound facilitators must ensure that family team meetings occur at a minimum of every 30 days, and they are to meet with families, face-to-face, at least once a week.

Contracted community providers in the Phase I implementation counties (Mason, Putnam, Kanawha, Cabell, Lincoln, Boone, Wayne, Logan, Berkeley, Jefferson, and Morgan) were required to have one third of their wraparound facilitators hired, trained, and ready to accept referrals by October 1, 2015. The following one third were to be hired and ready by February 1, 2016, and the final group of wraparound facilitators are to be ready by June 1, 2016. Eight community providers received contracts to serve as *Safe at Home* providers as part of Phase I. The number of wraparound facilitators which the providers were to hire ranged

between two and twelve, with a total of 42 wraparound facilitators to be hired in Region II and ten in Region III for Phase I. 40 of the 42 allotted positions were filled within the required timeframes.

Community providers claimed that it was difficult to find qualified applicants for the wraparound facilitator position because the entire State is experiencing workforce issues, e.g., there are not enough qualified workers throughout the State to meet workforce demands. Six of the 13 community providers interviewed reported there was not enough time between the receipt of their contracts in September and the October 1, 2015 roll-out to hire and train wraparound facilitators. BCF made adjustments to the next phase roll out based on this information.

Grants have been awarded to six licensed behavioral health providers to act as local coordinating agencies for Phase II. These local coordinating agencies are to hire and train staff to prepare to accept referrals by late summer to early fall.

How was the service delivery system for the Waiver defined?

The Child Protective Services policy was updated in July 2015 under section "4.17 Out-of-home Safety plan," and lists the following populations as eligible for the program.

Youth, ages 12 to 17 (up to the youth's 17th birthday), with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to a standardized diagnostic criteria) currently in out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by wrap-around.

Youth, ages 12 to 17 (up to the youth's 17th birthday), with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to a standardized diagnostic criteria) currently in in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by wrap-around.

Youth, ages 12 to 17 (up to the youth's 17th birthday), with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to a standardized diagnostic criteria) at risk of out-of-state residential placement and utilization of wrap-around can safely prevent the placement.

Youth, ages 12 to 17 (up to the age of the youth's 17th birthday), with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to a standardized diagnostic criteria) at risk of in-state level 1, 2, 3 or Psychiatric Residential

Treatment Facility residential placement and they can be safely served at home by utilizing wrap-around.

The referral process was described by many of the central and regional office staff, direct service staff, and community providers interviewed. The process from referral to assignment, as descried by the stakeholders, is displayed in Figure 1.

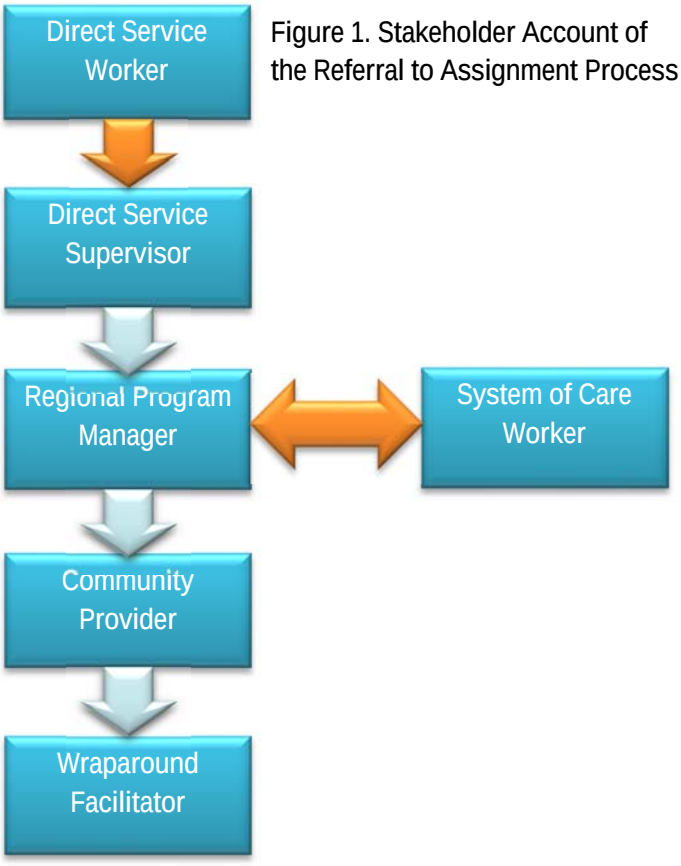


Figure 1. Stakeholder Account of the Referral to Assignment Process

Once the direct service worker identifies an eligible case, it is passed on to the supervisor for review, then to the Region's program manager who either approves or denies the referral. If the referral is approved, the program manager sends it to a System of Care worker who assigns the case to a community provider (assignment is based on a rotation), and the System of Care worker then sends the assignment back to the program manager, who notifies the assigned community provider. The community provider then assigns the case to a wraparound facilitator. Wraparound facilitators are permitted to have no more than ten *Safe at Home* cases at one time.

Regional office staff and community providers both reported that there was confusion at the beginning of implementation with direct service staff making some inappropriate referrals. However, both groups indicated that these issues were being resolved and improvements had already been made. Improvement was made by BCF clarifying the target population and referral process with their field staff and by the Regional Program Managers tightening the referral review process.

Stakeholders stated that wraparound services differ from traditional services because they are tailored to meet each individual youth's needs. Instead of mandating services, youth

and their families are integral participants in forming the plan for services, which is carefully monitored and changed when necessary. Services are both formal and informal, allowing the wraparound team to think creatively when developing a plan. The goal is to transition youth from reliance on formal supports to natural supports, which should sustain support for youth and their families after formal supports are no longer a part of their lives. Interviewees agreed that the wraparound approach could lead to success for youth.

The *Safe at Home* West Virginia program manual describes the wraparound process from beginning to end, with specific goals for each phase of wraparound. Table 3 displays the four phases of wraparound, along with the corresponding goals for each phase.

Table 3. Wraparound Phases and Service Provider Goals

Phase	Corresponding Goals
Engagement and Team Preparation	• Orientation to the wraparound process • Exploration of strengths, needs, culture, and vision • Stabilization of crises • Engagement of additional team members • Arrangement of meeting logistics
Initial Plan Development	• Development of an initial wraparound plan • Development of crisis/safety plan
Implementation	• Implementation of the initial wraparound plan • Revisiting and updating of the initial plan • Maintenance of team cohesiveness and trust
Transition	• Plan for cessation of formal wraparound • Create a "commencement" • Follow up with the family

Stakeholders across staff categories shared concern about the state's ability to meet the service demands of youth, particularly in the more rural areas. Seven of the eight judges, one prosecutor, one probation officer, and two staff from the juvenile justice department interviewed agreed with the goals and concepts of *Safe at Home*, but also thought that these goals were unrealistic. One of the main explanations given for those that shared this belief was the lack of community-based service options. Central office staff acknowledged this challenge and stated that the goal was to expand the services currently offered by providers, and to develop services where they are needed.

What role did the courts play in the demonstration; what is the relationship between BCF and the courts?

Stakeholders across staff categories agreed that the courts will play an integral role in the success of the program. Community providers, direct service staff, and regional and central office staff agreed that judges hold a powerful position in deciding placement for youth, and many stakeholders believe that judges have been too punitive, and currently use placement as a form of punishment. However, over half of the judges interviewed wanted the program to provide them with more options beyond out-of-community, residential placement. Some judges were defensive about their use of out-of-state placement. For example, one judge stated that the courts are often blamed for the high number of youth placed out of state, but they are not presented with enough community-based alternatives to keep youth home. Additionally, most judges agreed with the premise of *Safe at Home*, but were skeptical about the program's ability to accomplish anything.

A few of the judges, the probation officer and prosecutor said that, overall, they have a positive working relationship with DHHR, but some minor issues do exist. One judge stated that, "this is the best set of DHHR staff I have worked with in about ten years." A couple of judges reported problems with local DHHR workers, and argued that the position's high turnover rate causes inconsistencies in service recommendations. Another judge stated that, "there needs to be more direct interaction between DHHR and judges."

What contextual factors may impact the Waiver results?

Many stakeholders across staff categories stated that, overall; the State is very poor, which has resulted in a lack of community-based services. Many stakeholders noted that it will take a lot of time, effort, and money to develop needed services. Some community providers stated that poverty has created workforce issues, making it a challenge to attract qualified applicants for the wraparound facilitator position.

Many stakeholders also stated that there is a significant drug crisis throughout the State. According to data from the Center for Disease Control, in 2014 West Virginia had the highest rate of death from drug overdoses in the country.4 When judges were asked what they perceived as the greatest issues facing 12-17 year olds in their courts, the most common response was substance abuse among both youth and their parents. Additionally, some

[4] http://www.cdc.gov/drugoverdose/data/statedeaths.html

stakeholders argued that the drug problem made it difficult to recruit appropriate potential foster parents for youth.

Many stakeholders cited Senate Bill 393 as an element that could strengthen the program, since the Bill allows a juvenile with a status/misdemeanor offense to be referred to a truancy diversion specialist for informal resolution rather than being sent directly to congregate placement. Additionally, a few stakeholders reported that wraparound is not new to West Virginia. The state piloted a program called Next Step Community Based Treatment (CBT) through a grant in the late 1990s. The program experienced success in Region II, but was unsuccessful in its expansion throughout the rest of the state. Some stakeholders viewed this prior program as a strength, demonstrating that wraparound could be successful again. However, a couple of stakeholders feared that *Safe at Home* would run into the same issues that led to the demise of CBT.

Outcome Evaluation

The Population

Over the first six months of implementing *Safe at Home West Virginia*, Phase I counties, which are located in Regions II and III, referred 122 youth for wraparound services. Two of the referrals from the latter half of March 2016 were not yet recorded in FACTS yielding 120 referrals for the balance of this analysis. At the time of referral, 37 of those youth were placed in in-state congregate care facilities and 30 in out-of-state congregate care facilities. Of the 53 youth designated by the Bureau of Children and Families (BCF) as in a preventive placement at the time of referral, two were placed with relatives, six were in emergency shelters and 45 remained in their own homes.

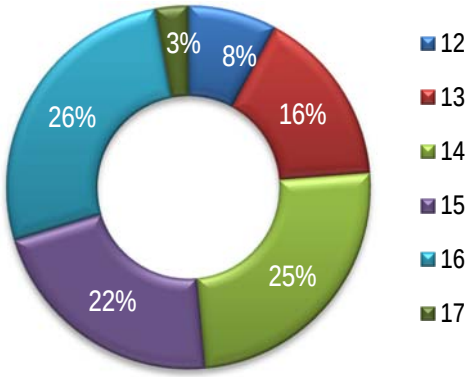
Table 4 displays the initial placement types of youth referred for inclusion in *Safe at Home*.

Table 4. Placement Types for Phase I Referrals				
	In-state	Out-of-state	Preventive	Totals
Group Residential Care	29	20	-	49
Psychiatric Hospital (short term)	1	-	-	1
Psychiatric Hospital (long term)	7	10	-	17
Kinship/relative	-	-	2	2
Agency emergency shelter	-	-	6	6
Remain at home	-	-	45	45
Totals	37	30	53	120

Seventy-two percent of the youth were between the ages of 14 and 16 at the time of referral, while nearly two-thirds (64%) were male. The disproportion of males was highest in out of state congregate care settings, where 88 percent of the youth were male. The two youth who were referred while placed in a detention center were both male.

The majority of youth were white (88%) while 19 percent were black.[5] The percentage of black youth referred to the program is substantially higher than the overall percentage of black youth in West Virginia (5%) and lower than the average percentage of black youth in foster care between 2010 and 2015, which ranged from 31 to 35 percent between calendar years 2010 to 2014.

Figure 2. Age of Youth at Referral



[5] The percentage of youth by race will total to more than 100 percent as youth may be categorized as a member of more than one racial group.

[6]Percentage of youth is based on the average percent of black youth in West Virginia between 2010 and 2014, as reported via the Office of Juvenile Justice and Delinquency Prevention Easy Access to Juvenile Populations website (www.ojjdp.gov/ojstatbb/ezapop/).

West Virginia's project includes both child welfare and juvenile justice referrals; however, it is not easy to distinguish cleanly between them because most *Safe at Home* youth have some evidence of juvenile justice involvement, but many had an open case with child welfare prior to that. For example, looking at the congregate care referrals from within the state (n = 37), 35 of them have some evidence of juvenile justice involvement, whether in an Axis IV diagnosis (indicating trouble with the law: n = 6), a detention placement prior to the referral (n = 9), or a juvenile justice-ordered removal (n = 33). Given the juvenile justice-ordered removal, 24 of them would be considered youth services cases rather than child welfare cases. Eleven of the youth's current cases had been open for more than a year prior to removal, while 21 were known to child welfare for less than six months prior to removal.

For out-of-state congregate care referrals (n = 30), 24 had some evidence of juvenile justice including 17 with an Axis 4 diagnosis, 23 with a juvenile justice -ordered removal and seven with a prior detention placement. However, only three of those youth had been known to child welfare for more than a year prior to removal.

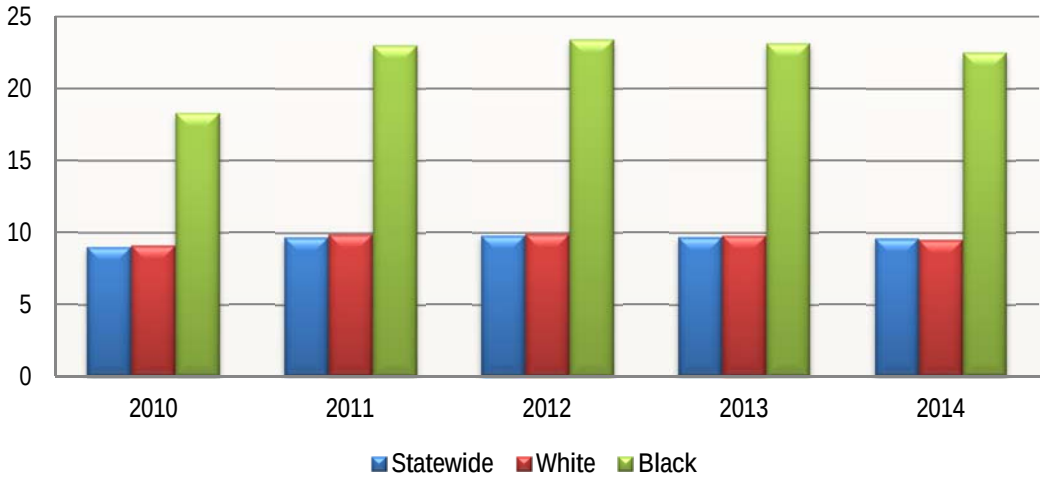
For the Preventive Referrals where the youth are in the home, the evidence of juvenile justice involvement is much less common: only two thirds of the 45 youth have evidence of juvenile justice involvement: 19 with an Axis 4 diagnosis, 26 with a previous (not current) juvenile justice -ordered removal, and two with a prior detention placement.

Broadly speaking, *Safe at Home* West Virginia is designed to improve the safety, permanency and well-being of youth, ages 12 to 17. When used preventively, the program is trying to have fewer children enter foster care in the first place or, when they do, to have fewer entering congregate care and more remaining in their own communities. Data from FACTS are used to inform many of the outcome measures with data for the few youth with a subsequent CANS assessment completed used to measure the extent to which the youth's functioning has improved.

Placement in Congregate Care and Outside the Home Community

Between 2010 and 2014, the placement rate of West Virginia's youth,[6] ages 12 to 17, who incurred an initial entry into foster care ranged from 9.0 to 9.6 per thousand. The placement rate is substantially higher for black youth while the rate for white youth is similar to the statewide rate, as shown in Figure 3.

Figure 3. Rate of First Entry into Foster Care per Thousand Youth



Males were slightly more likely to enter foster care than females. Placement rates for males ranged from 9.6 to 10.9 between 2010 and 2014, and 8.3 to 9.3 for females during those same years. Over time the evaluators will determine if *Safe at Home* has made an impact on placement rates in congregate care.

[7] Population counts for youth ages 12 to 17 were gathered from the Office of Juvenile Justice and Delinquency Prevention Easy Access to Juvenile Populations (www.ojjdp.gov/ojstatbb/ezapop/).

As can be surmised from Table 4, 67of the 120 youth referred to participate in *Safe at Home* during the first six months of the program were living in a congregate care setting at the time of referral, 30 of them in an out-of-state facility. By the end of March 2016, more than half of those out of state had been returned to West Virginia, with 14 youth (47 percent of the total) moving to a lower level of care. The comparison group shows very similar results.

Improvement was also evidenced for 22 of the 37 youth initially placed in an in-state congregate care facility. Of the youth first placed in a congregate care facility, regardless of where that facility was located, 39 percent were returned to their homes.

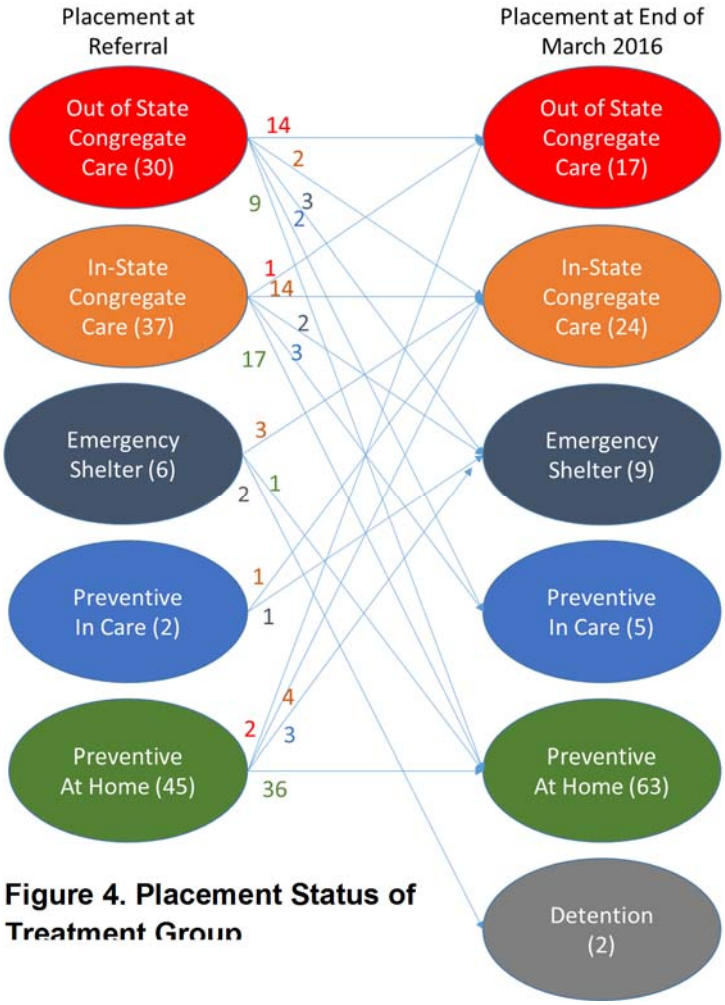


Figure 4. Placement Status of Treatment Group

As shown in Figure 4, success was also evidenced for youth who were in lower levels of care to start or remained with their families when referred to *Safe at Home*. Two of the 45 youth who were at home at the start of the program were placed in an out-of-state congregate care facility by the end of March. Five of the youth who began *Safe at Home* while in a family setting were placed in an in-state congregate care setting and two youth who had been in emergency shelters were placed in detention.

When the placement status of youth in the comparison group is examined six months following case opening or from the point in which the youth satisfy the *Safe at Home* referral criteria, the overall results are not substantially different from the treatment group. However, there is less movement from one setting to another among youth in the comparison group.

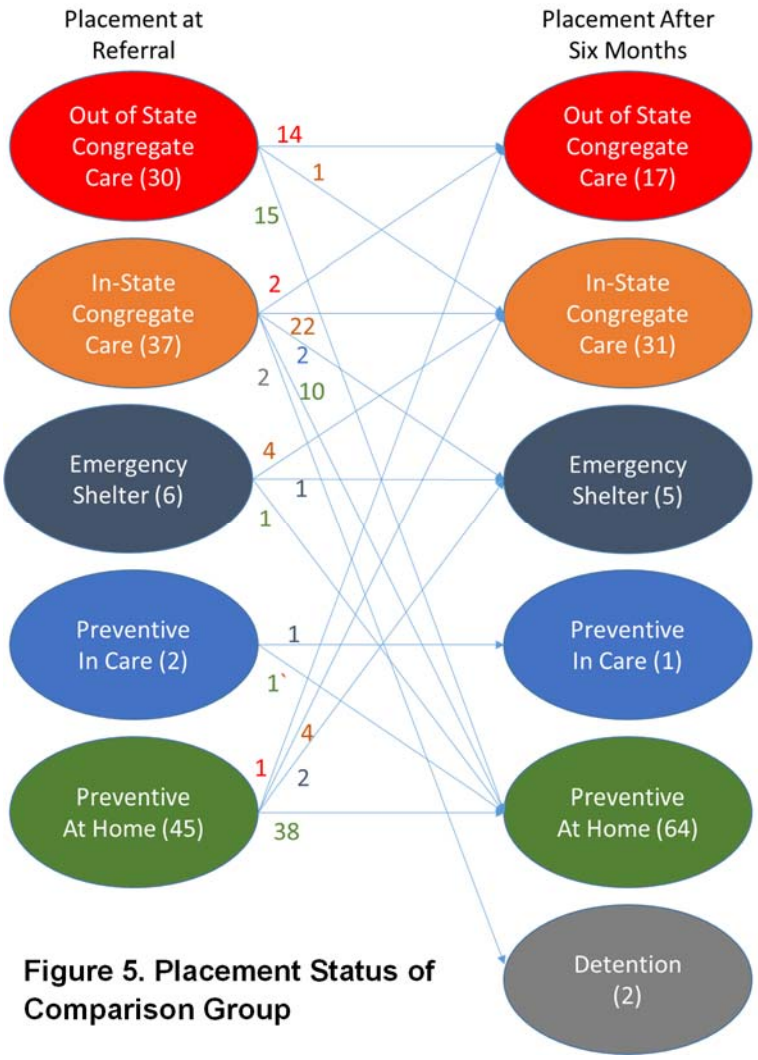


Figure 5. Placement Status of Comparison Group

As is illustrated in Figure 5, the outcomes are similar for the comparison group in this time period, with both groups ending up with similar distributions of youth in each placement type. The principal difference is a larger number of comparison youth (31) in in-state congregate care placements compared to Safe at Home youth (24). Safe at Home youth are slightly more likely to be in Emergency Shelters or family foster care.

Beyond the extent to which youth remained in their homes, data in FACTS were also used to measure the extent to which youth are remaining in their home communities. Among the 39 youth who were in substitute care at the time of referral to *Safe at Home* and incurred at least one placement change within the six months following referral to the wraparound program, nearly two-thirds (64 percent) of the placements were outside the youth's home county. Most of the out-of-county placements involved placement into an agency emergency shelter or group residential care setting. When the results are compared to a matched comparison group, within six months a smaller number of youth incurred more than one placement change. However, 75 percent of those placements were outside the youth's home county, half of which involved a stay in a group residential care facility.

A different picture emerges when examining the number of entries into congregate care during the first six months of implementation compared to a six-month interval for the comparison group. The 30 Safe at Home youth in out-of-state congregate care placements at referral had a total of 457 days outside of congregate care, and had a total of seven new

congregate care placements involving three youth. This gives a congregate care placement rate of 1.5 placements per 100 days of eligibility, with 0.7 distinct youth being placed in congregate care per 100 days of eligibility. In contrast, the comparison group had only 31 days outside of congregate care, and 14 congregate care placements involving 13 youth, for a congregate care placement rate of 45.2 placements per 100 days of eligibility, with 41.9 distinct youth per 100 days of eligibility.

Safe at Home youth in congregate care settings in West Virginia at the time of referral also had lower rates of subsequent congregate care placements than the comparison group, with eight placements in 582 days of eligibility, yielding a placement rate of 1.4 placements per 100 days. Since the placements involved eight youth, the rate is also 1.4 youth per 100 days. In contrast, comparison youth had 26 congregate care placements in the first six months, with only 114 days of eligibility, or a rate of 22.8 placements per 100 days of eligibility. Again, all placements involved distinct youth, so the same rate applies for youth.

Youth Functioning

The CANS tool is an assessment of children's strengths and needs which is used to support decision making, facilitate service referrals and monitor the outcomes of services. Using a four level rating system on a series of items used to assess specific domains such as trauma exposure or life domain functioning, needs or actionable items are identified, helping caseworkers and wraparound facilitators to determine where to focus their attention in planning with the family.

Analysis of the initial CANS completed for each of the 69 youth for whom an assessment was completed using the online tool shows that actionable items were most prevalent among the domains used to assess the caregiver's needs and strengths, followed by child strengths and life functioning. An average of nine actionable items resulted for the 61 youth for whom at least one actionable item was identified within the caregiver domain. Four actionable items, on average, were identified for the domains which assess youth's healthy development and their environments and three for those used to assess youth's behavioral and/or emotional needs.

When the average scores for each of the main modules are compared to the maximum score a youth could have, indicating immediate or intensive action is needed or no evidence of strength is exhibited, youth generally fell into the low spectrum of need. The highest average score (representing need) was evidenced for the module which examines the youth's strengths, which includes items such as his or her relationship to the family; psychological strengths,

coping and survival skills; or ties with the community.

Table 5. Initial CANS Scores and Actionable Items for Main Domains					
Main Module Domains	Maximum Score	Average Score	Maximum No. of Actionable Items	Average No. of Actionable Items	Youth with an Actionable Item
Exposure to potentially traumatic/ adverse childhood experiences	36	5.58	12	2	52
Symptoms related to traumatic/ adverse childhood experiences	21	5.04	7	1	35
Child strengths	30	13.33	10	4	62
Life domain functioning	57	7.42	19	4	61
Acculturation	9	0.45	3	1	2
Child behavioral/emotional needs	39	7.21	13	3	56
Child risk behaviors	39	3.40	13	1	30
Caregiver needs and strengths	108[7]	9.32	36	9	61

For several youth, ratings of relevant items within the main domains triggered at least one or more sub-modules to be completed. The delinquent behavior and sexual behaviors sub-modules triggered the highest average number of actionable items within the sub-module domains. Thirty-four youth (69%) triggered at least one actionable item within the delinquent behavior domain and six youth (9%) at least one actionable item within the sub-module used to assess the youth's sexual behaviors.

Table 6. Initial CANS Scores and Actionable Items for Sub-module Domains				
Sub-module Domains	Maximum Score	Average Score	Average No. of Actionable Items	Youth with an Actionable Item
Delinquent behavior	39	7.05	5	34
Substance abuse	21	7.41	2	9
Fire setting	15	-	0	-
Sexually abusive behavior	30	6.15	3	9
Intellectual and developmental disabilities	15	-	0	-
Lesbian, gay, bisexual, trans-sexual or questioning	27	5.56	1	3

[8] Youth with a placement into foster care may have a maximum score of 117.

Table 6. Initial CANS Scores and Actionable Items for Sub-module Domains				
Sub-module Domains	Maximum Score	Average Score	Average No. of Actionable Items	Youth with an Actionable Item
Expectant and parenting	87	-	0	-
Transitioning to adulthood	36	6.81	3	9
Commercial sexual exploitation	27	4.44	1	1
Sexual behaviors screener	30	6.15	5	6
Cognitive, communication, self-care daily living	30	4.08	1	8

The CANS assessment, which is to be completed every 90 days and again at discharge, is used to identify additional service needs and monitor outcomes. At least one subsequent assessment was completed for 26 of the 69 youth for whom an initial CANS was done. When the scores of the most recent assessment are compared to those of the first for each youth with at least one subsequent CANS, scores within the main domains tended to remain the same, indicating that service needs continue and at the same level as first assessed. When the scores do change, there seems to be a fairly even distribution between their getting higher or lower. With generally no more than three months going by between the first and subsequent assessment, it is not surprising that improvement is minimal and not surprising that additional needs or issues are surfacing as the facilitator has an opportunity to learn more about the youth and their families.

Table 7. Movement of Scores in Subsequent Assessments			
Main Module Domains	Higher Score	Same Score	Lower Score
Exposure to potentially traumatic/ adverse childhood experiences	3	20	3
Symptoms related to traumatic/ adverse childhood experiences	5	18	3
Child strengths	4	17	5
Life domain functioning	6	11	9
Acculturation	0	26	0
Child behavioral/emotional needs	5	16	5
Child risk behaviors	5	16	5
Caregiver needs and strengths	4	16	5

Summary of Significant Evaluation Findings

Among the successes registered within the first six months of the implementation of the *Safe at Home* effort are the return of 16 of the 30 *Safe at Home* youth who were in out-of-state congregate care back to West Virginia, the movement of 14 of those youth to lower levels of care including nine who returned home, the discharge of 17 youth from in-state congregate care to their own homes and of five more to lower levels of care and, finally, the placement of 36 percent of youth who were placed into out-of-home settings within their own communities, compared to only 19 percent of the comparison group. Another highlight is in the number of subsequent placements into congregate care, which show promising trends compared to the comparison group. The results suggest that youth are experiencing fewer moves from one congregate setting to another, and the larger number of days that Safe at Home youth are *not* in congregate care also suggests that their total time in congregate care may be found to be shorter than the comparison group's once enough time has passed to evaluate that objective.

The initial results have also brought disappointment. It is perhaps not surprising that among the 26 youth for whom multiple CANS assessments are recorded, there has been no significant movement in the levels of their functioning, given the relatively short period of time and the small number with multiple assessments. It is also disappointing that the placements of Safe at Home youth after six months do not compare more favorably with those of the comparison group, but of course, not all of the Safe at Home youth have had a full six months with the program.

Process Evaluation

Since HZA conducted the fidelity assessment for the process evaluation this reporting period, it is important to establish in a clear and concise manner, what exactly was being measured. West Virginia has chosen to utilize wraparound services as an intervention for youth in the program, and therefore, wraparound services became the primary focus of the fidelity assessment. The *Safe at Home West Virginia* program manual describes the wraparound process with specific goals for each of the four phases of wraparound. The four phases of wraparound, along with corresponding goals for each phase, are displayed below in Table 9.

Table 9. Wraparound Phases and Service Provider Goals

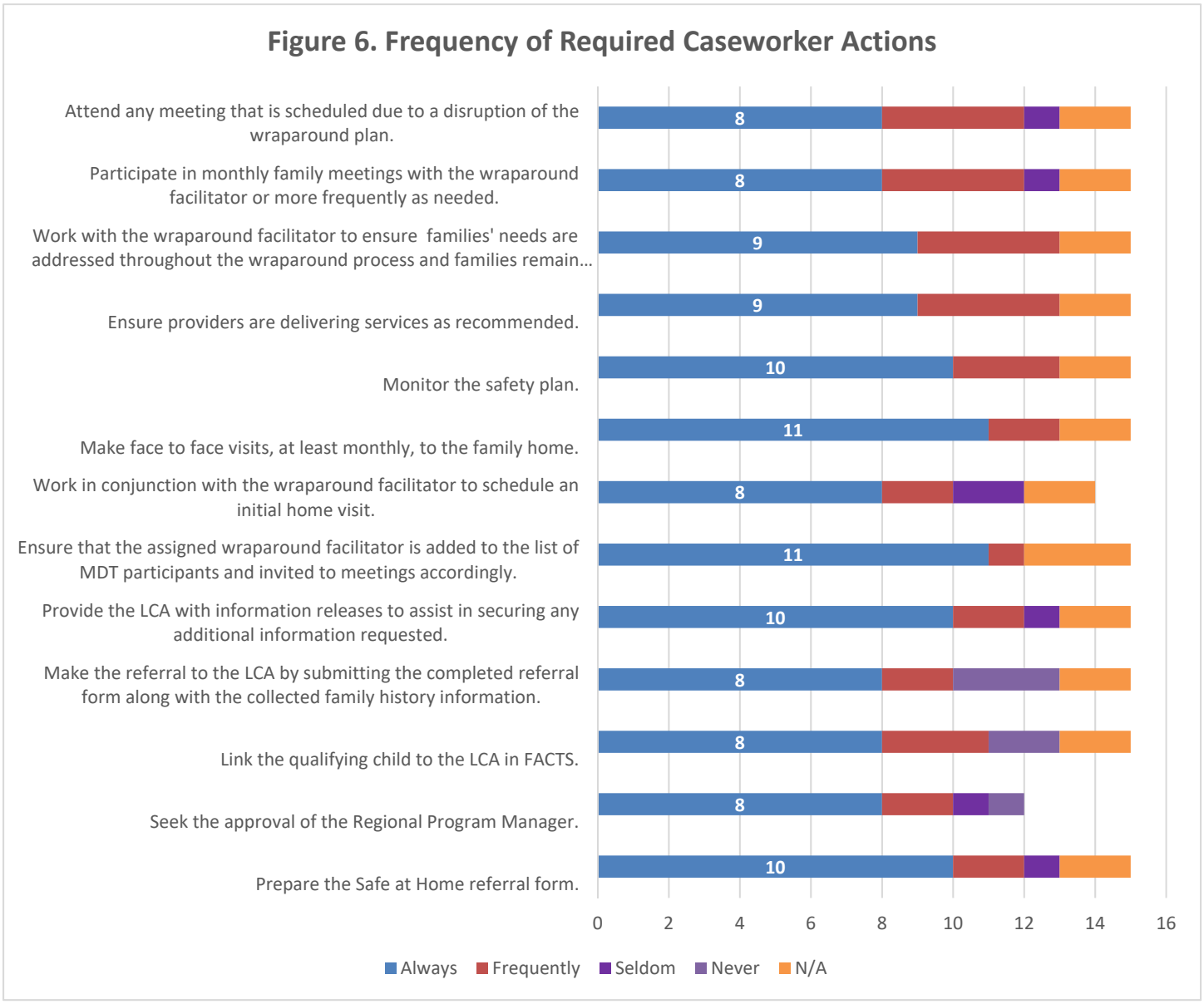
Phase	Corresponding Goals
Engagement and Team Preparation	• Orientation to the wraparound process • Exploration of strengths, needs, culture, and vision • Stabilization of crises • Engagement of additional team members • Arrangement of meeting logistics
Initial Plan Development	• Development of an initial wraparound plan • Development of crisis/safety plan
Implementation	• Implementation of the initial wraparound plan • Revisiting and updating of the initial plan • Maintenance of team cohesiveness and trust
Transition	• Plan for cessation of formal wraparound • Create a “commencement” • Follow up with the family

DHHR Caseworker Program Responsibilities

DHHR caseworkers are responsible for making appropriate referrals to the program. Appropriate referrals include youth ages 12-17 with a diagnosis of a severe emotional or behavioral disturbance that impedes daily functioning, and who are:

- currently in out-of-state residential placement and unable to return successfully without extra support, linkage, and services provided by wraparound;
- currently in in-state residential placement and cannot be reunified successfully without extra support, linkage, and services provided by wraparound;
- currently at risk of out-of-state residential placement, and utilization of wraparound can safely prevent placement; or
- currently at risk of in-state residential placement, and can be served safely at home by utilizing wraparound.

After the referral has been made, DHHR caseworkers have a variety of ongoing responsibilities with the case. The DHHR staff survey addressed caseworker responsibility by asking respondents with what frequency they perform required *Safe at Home* case actions. Figure 6 below provides a full breakdown of caseworker responsibilities for *Safe at Home* cases along with the frequency with which the 15 caseworkers who participated in the DHHR staff survey reported completing them. The N/A option is relevant to caseworkers who have not yet had any *Safe at Home* cases, or for case actions that have not yet applied to their specific cases. Responses from the "Always" survey option have been emphasized for ease of reading.



The majority of DHHR caseworkers reported that they "Always" or "Frequently" complete required *Safe at Home* case tasks. There were only three required case actions that some DHHR caseworkers stated they "Never" did with *Safe at Home* cases: three reported they never make the referral to the LCA by submitting the completed referral form along with the collected family history information; two reported they never link the child to the LCA in FACTS; and one reported never seeking the approval of the regional program manager. It should be

noted, however, that some of these functions are conducted by supervisors, either because that is the way the process is designed or because the supervisors assumes certain task to reduce the burden on the caseworkers.

Once the LCA receives the referral from DHHR, a wraparound facilitator is assigned to the case. The wraparound facilitators are primarily responsible for care coordination, facilitating family decision making, engaging youth/families by utilizing frequent face-to-face contact, guiding youth/families in the shift from professional to natural/informal supports, tailoring individualized needs/strengths based service plans and providing assessments for youth/families. Since wraparound facilitators are responsible for the actual delivery of wraparound services while DHHR caseworkers serve in more of a team member role, wraparound facilitator actions provided a larger focal point for the fidelity assessment than the work of DHHR caseworkers.

Staff Backgrounds and Training

DHHR and LCA surveys asked staff background questions about education and experience. According to *Safe at Home* funding announcements, wraparound facilitators should have a: bachelor's degree in social work, sociology, psychology, or another human service related field; experience working with older youth and their families; and a prior knowledge base of mental illness diagnoses and behavioral disorders in children (family experience with mental illness is considered helpful).

Wraparound facilitators held either a bachelor's (80%) or master's degree (20%). Although degree fields varied, 75 percent of wraparound facilitators held a degree in either social work or psychology. Waivers to education requirements have been made when particular applicants have demonstrated an extraordinary amount of relevant experience in the field.

Eighty percent of wraparound facilitators reported prior experience working directly with older youth and their families. Eighty-five percent had a knowledge base of mental illness diagnoses and behavioral disorders in children prior to their current role. Just over half (55%) reported personal family experience with mental illness.

Time spent in the field varied greatly among wraparound facilitators surveyed. Thirty percent reported less than a year, ten percent reported one to two years, ten percent reported two to four years, 25 percent reported four to six years, and 25 percent reported over six years.

Caseworkers reported less experience, with 60 percent reporting less than a year to two years spent in their current role.

All respondents to the LCA staff survey reported familiarity with the state's *Safe at Home* policies. All respondents, with the exclusion of one wraparound facilitator reported that they had received training on wraparound services/*Safe at Home*. All respondents to the DHHR staff survey had received training on wraparound services/*Safe at Home*. Of the 26 respondents from the LCA staff survey who received training, 15 percent received one training, 46 percent received two to three trainings, and 38 percent received four or more trainings. Wraparound facilitators received the most training, with 45 percent reporting four or more trainings.

Survey respondents from both the LCA and DHHR staff surveys were asked to what degree the training prepared them for their role in the program with the options of "Very Well," "Somewhat," and "Not Well." Fifty-three percent of respondents from both surveys who received training selected "Somewhat," 28 percent selected "Very Well," and 19 percent selected "Not Well." The two most common suggestions made by wraparound facilitators and their supervisors to improve future training were to provide information on how to complete the required paperwork and documentation, and include more real-life case scenarios. One wraparound facilitator stated, "There is a lot of paperwork that goes with this program and there is no clear training regarding all of the different forms. This makes the documentation portion of this position extremely confusing." Caseworkers and their supervisors most commonly suggested incorporating more specific information about what should be expected of caseworkers and wraparound facilitators and more explicit information on the case process.

The LCA staff survey also asked questions specific to CANS training. All respondents from the LCA staff survey had received CANS training, and all but one wraparound facilitator had received certification. Wraparound facilitators are responsible for entering the CANS into the online system, and 74 percent of them received training on how to do so. Wraparound facilitators were evenly split in rating the online CANS training in preparing them for their role in the program as "Somewhat" or "Very Well." When asked what more was needed to improve CANS training, responses varied to the extent that no two were similar. A couple of examples included, "knowledge on writing recommendations," and, "dealing with special circumstances, i.e., foster care, when the youth refuses to participate, etc."

Placements of Youth from the Fidelity Assessment Sample

HZA staff established through case reviews and stakeholder interviews where the 40 selected youth were placed at the time of referral and where those youth were placed at the time of data collection in August 2016. Of the 11 youth who had an out-of-state congregate care referral, four had moved home, three were placed in foster care, two were placed in in-state congregate care, and two were still in an out-of-state congregate care. Of the 14 youth with an in-state congregate care referral, nine returned home, three were placed in in-state congregate care, one was placed in an emergency shelter, and one was currently missing/runaway. Of the two youth with an emergency shelter referral, one was placed in a foster home and the other had returned home. The remaining 13 youth had a prevention at home referral and 11 of them remained home, one was placed in in-state congregate care, and one was placed in an emergency shelter.

In discussing youth placement, one parent expressed gratitude for the program by saying, "I am very thankful for them because if it wasn't for [the wraparound facilitator] [the youth] wouldn't be home with us." One youth also stated, "I've been in placement a lot and now I think I might not have to be." Buy-in for the program's ability to improve youth placement was high among wraparound facilitators and DHHR caseworkers surveyed. Eighty-five percent of wraparound facilitators who completed the survey and 75 percent of caseworkers who completed the survey and had *Safe at Home* cases reported that the program helps to reduce the number of youth living in out-of-state facilities; 80 percent of wraparound facilitators and 67 percent of caseworkers agreed that the program helps to reduce the number of youth living in in-state facilities; and 90 percent of wraparound facilitators and 83 percent of caseworkers agreed that the program helps to increase the number of youth able to remain safely in their homes and communities.

Phase 1: Engagement and Team Preparation

Interviewees from each case reported that the program was initially explained to the youth/family by either the wraparound facilitator, DHHR caseworker, or both, with most interviewees reporting that the program explanation was provided by the wraparound facilitator. Of the caseworkers who completed the survey and had *Safe at Home* cases, 92 percent believed that referrals adhere to the eligibility criteria. Wraparound facilitators from over half of the cases reported that *Safe at Home* materials were shared with youth/families. Overall, wraparound facilitators and caseworkers from the majority of cases reported that youth/families received a good overview of the program and that youth/families had a good

understanding of the program; however, only about half of youth and parents echoed these sentiments.

Most stakeholders agreed that youth/families have been encouraged to discuss concerns, hopes, dreams, and strengths with the wraparound facilitator; this was reported by 64 percent of youth, 75 percent of parents, wraparound facilitators in 85 percent of the cases, and caseworkers in 73 percent of the cases. All of the wraparound facilitators surveyed either agreed or strongly agreed that the wraparound process is designed to be family driven, and family perspectives are prioritized in planning for youth. Seventy-five percent of caseworkers surveyed reported that family perspectives are elicited and prioritized in planning for youth. One youth spoke about the family decision-making process by stating, "I like the program because it makes me feel like I can do things on my own for once and my voice is actually being heard. It gives me hope."

Additionally, caseworkers and wraparound facilitators from most of the cases agreed that youth/families were encouraged to invite individuals to join the wraparound team; this was reported by approximately half of youth and parents. Ninety-five percent of wraparound facilitators and 92 percent of caseworkers surveyed agreed or strongly agreed that wraparound teams consist of individuals agreed upon by the family. All caseworkers surveyed who carry *Safe at Home* cases agreed that despite challenges, the wraparound team persists in helping families to meet their goals.

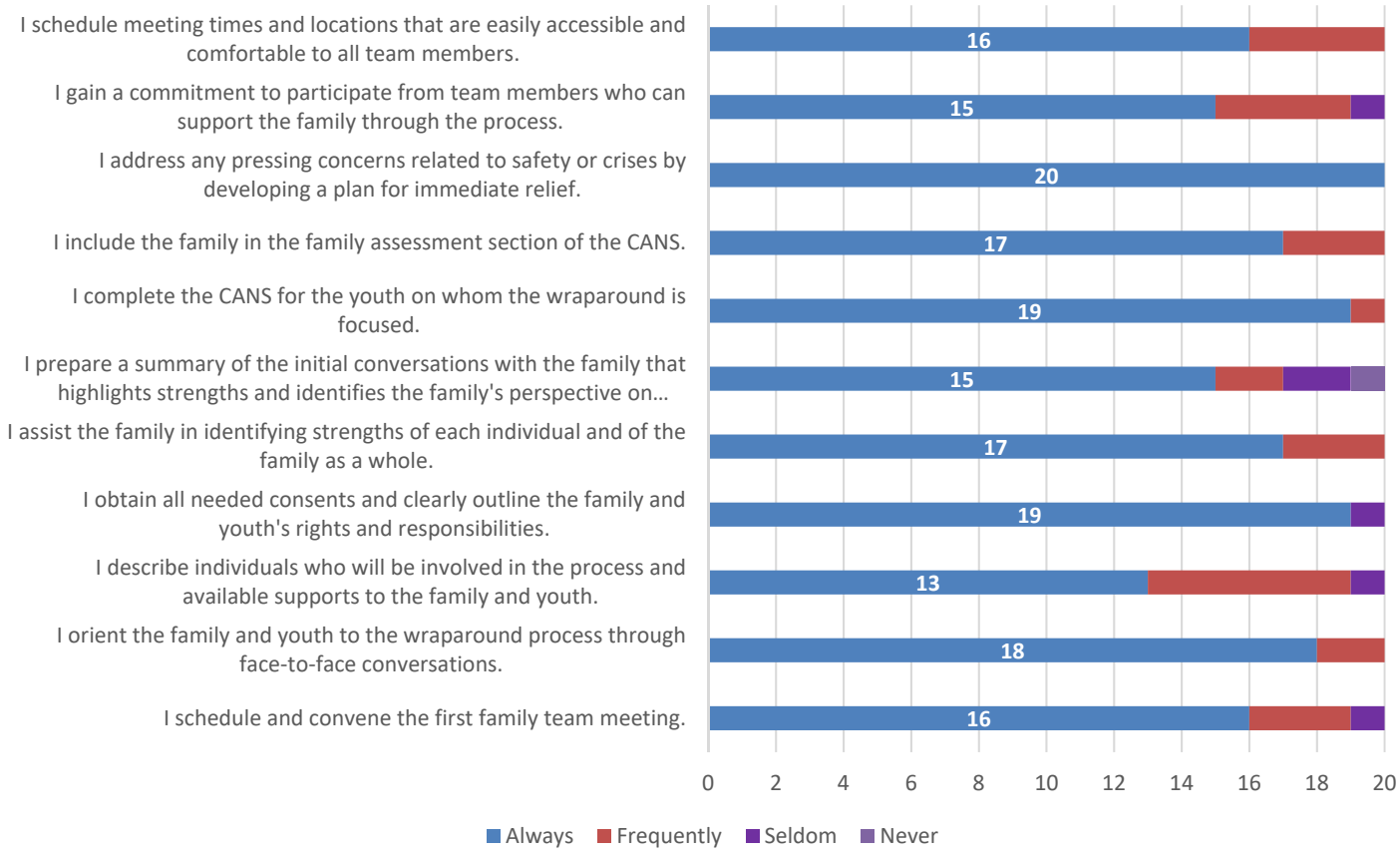
According to the *Safe at Home* program manual, during the engagement and team preparation phase, the wraparound facilitator will use the CANS to determine the needs and strengths of the youth/family so the initial planning process can move forward. The LCA staff survey asked respondents about the ease of use of the CANS assessment itself, as well as of the online CANS tool. Respondents rated the ease of the assessment and the online tool on a scale of one to ten, with one being the easiest and ten being the most difficult. Sixty percent of wraparound facilitators reported the ease of the CANS assessment to be a six or higher. Wraparound facilitators were completely split when rating the ease of use of the online CANS tool, with half rating this item between one and five, and the other half rating this item between six and ten.

However, even though challenges with the CANS assessment were reported by wraparound facilitators, the tool was rated as "Effective" and "Somewhat Effective" by nearly all of them. A couple of wraparound facilitators reported that the tool could be more effective if there was more time available to get to know the client prior to the initial assessment. A couple of wraparound facilitators also shared concerns about obtaining accurate information

from youth/families, with one wraparound facilitator stating, “I feel often times, especially if the court system is involved, the family will over exaggerate or under exaggerate depending on the desire or fear of placement.”

As part of the LCA staff survey, wraparound facilitators were asked to think about their cases and provide responses on the frequency in which they completed activities for each phase of wraparound. Wraparound facilitators were presented with a case action/task and asked whether or not they complete the task “Always,” “Frequently,” “Seldom,” or “Never” with their cases. Figure 7 displays case actions taken by wraparound facilitators during this first phase of wraparound: Engagement and Team Preparation. The “Always” response option has been emphasize

Figure 7. Frequency of Wraparound Facilitator Case Actions during Engagement and Team Preparation Phase



Phase 2: Initial Plan Development

All wraparound facilitators from each case, with the exclusion of wraparound facilitators at one agency, reported that the CANS assessment tool was used in the development of the initial wraparound plan. The majority of stakeholders from all four groups (youth, parents, wraparound facilitators, and caseworkers) reported that youth and family voice has been integral in developing wraparound plans. All caseworkers surveyed who carry *Safe at Home* cases agreed that planning is customized to the strengths and needs of children.

Initial wraparound plans were reviewed by HZA staff and the content was rated for the extent to which the required items were included in the plan. Items were rated on a five point Likert scale, with one meaning the item was "Not at All" a part of the plan and five meaning the item was "Thoroughly" included in the plan; below, Table 10 displays the results with the most frequent answers bolded. Initial wraparound plans were rated highly by HZA case reviewers, with nearly all items falling under a rating of "Thoroughly" included in the plan.

Table 10. Initial Wraparound Plan Content

Plan Item	5	4	3	2	1	N/A
Youth's Long Term Vision	20	7	7	1	3	2
Mission Statement for the Team	21	9	3	2	4	1
Outcomes Clearly Connected to the Vision	25	8	4	0	2	1
Measurable Outcomes/Objectives	20	10	6	1	2	1
Multiple Strategies	17	11	7	2	2	1
Clear Relationship between Outcomes and Strategies	20	14	2	0	2	2
Plan for Maintenance in or Transition to Least Restrictive Environment	8	11	5	0	4	11
Opportunities for Youth to Engage in Community Activities	17	8	9	2	2	2
Services/Supports Consistent with Youth's/Family's Culture	18	15	4	1	1	1
Services/Supports Consistent with Youth's/Family's Primary Needs	23	9	5	1	1	1
Services/Supports Take Account of and Use Youth's/Family's Strengths	23	10	4	1	1	1

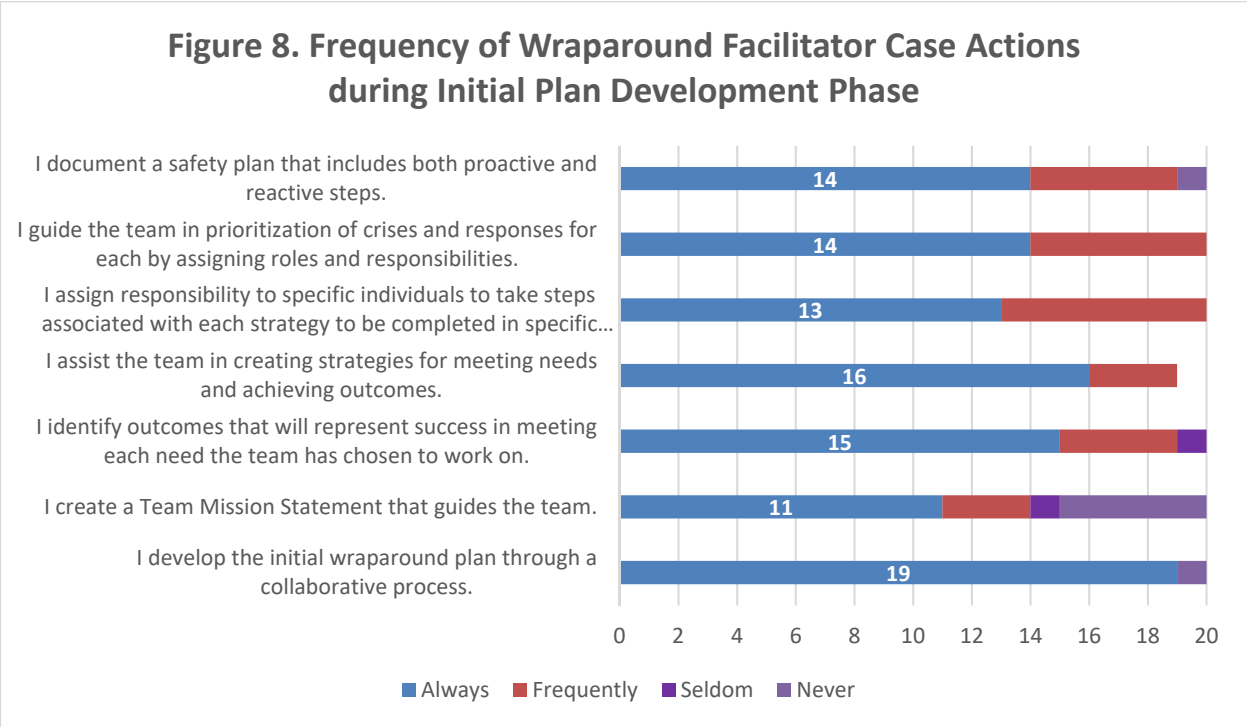
The majority of interviewees stated that youth/families were involved in creating crisis safety plans. Youth and parents reported that crisis safety plans have been useful in meeting the needs of the youth/family most frequently, at 68 and 79 percent respectively. Wraparound facilitators reported that crisis safety plans have been useful in 64 percent of the cases and caseworkers reported this in 46 percent of cases. When asked about the crisis safety plan one youth stated, "Talking to [the wraparound facilitator] was a huge part of it. I would retreat to my room to read, draw, or listen to music. I would think about my options and future actions and then I would talk to my mom about it and we would work it out."

Similar to the initial wraparound plans, crisis safety plans were also reviewed by HZA staff using a five point Likert scale, with one meaning the item was "Not at All" included and five meaning the item was "Thoroughly" included in the plan; Table 11 below displays the results. All but one of the crisis safety plan items fell under the rating of "Thoroughly" included in the plan. "Identification of Behaviors Signaling Coming Crisis" was rated as "Mostly" included in the plan.

Table 11. Crisis Safety Plan Content

Plan Item	5	4	3	2	1
Strategy for Crisis Prevention	24	8	4	1	3
Identification of Behaviors Signaling Coming Crisis	10	16	7	1	6
Methods for De-escalating Crises	18	11	7	1	3
Steps to be Taken During Crisis	27	4	4	1	4
Assignment of Roles During Crisis	27	5	3	1	4

Like Figure 7 (above), Figure 8 (below) displays the case actions reported by wraparound facilitators from the LCA staff survey during the second wraparound phase: Initial Plan Development. Initial Plan Development phase required case actions were "Always" completed by the majority of wraparound facilitators.



Seventy-five percent of caseworkers surveyed agreed that the wraparound team supports the family through formal, informal, and community relationships. Sixty-seven percent of caseworkers surveyed who carry *Safe at Home* cases reported that team members work cooperatively, sharing in the responsibility for plan implementation and success. One caseworker had a mixed view on collaboration, stating, "With the right facilitator, some of the burden is lifted from the worker and more services can be implemented. However, some facilitators do little; and thus refer the family back to the [case]worker for everything." Ninety-two percent of caseworkers surveyed who carry *Safe at Home* cases reported that goals and strategies are tied to observable or measurable indicators of success.

Phase 3: Implementation

Wraparound plans are to be updated on an as needed basis when successes or challenges are identified. On average, wraparound plans for the 40 cases were updated every 47 days. According to the *Safe at Home* funding announcement, wraparound facilitators are required to have a minimum of one face-to-face meeting with the youth/family per week.

Most interviewees reported that the wraparound facilitator has, on average, weekly face-to-face contact with the youth/family. There were three cases where the wraparound facilitator had biweekly contact with the youth/family: in two of the cases, the youth were close to the Transition Phase and in the process of slowly reducing the frequency of visits; in the third case, the youth lived over three hours away from the wraparound facilitator.

The majority of stakeholders reported that the amount of contact between the wraparound facilitator and the youth/family is adequate; this was most apparent with 92 percent of parents reporting this sentiment. One wraparound facilitator stated, "I have so much contact with the family, so we meet every barrier and challenge as it comes." However, while most stakeholders spoke highly about the frequent visits between the wraparound facilitator and the family, a couple of wraparound facilitators and one caseworker reported that the frequency of visits sometimes detracted from the program. One caseworker from the survey stated, "It seems like many of our families find the program invasive. I have noticed that families will get burned out on the weekly face-to-face visits and lengthy wraparound plan meetings."

The majority of stakeholders reported that the wraparound facilitator identifies or rewards the success the youth achieves. One youth stated, "[The wraparound facilitator] always tells me what I am good at and [he/she] rewards me with small things and says [he/she] is proud of me. [The wraparound facilitator] is the only person in my life to ever do that and it is super encouraging when I feel down." Below, Table 12 outlines youth successes as reported by stakeholders, denoting which interviewees expressed the sentiments.

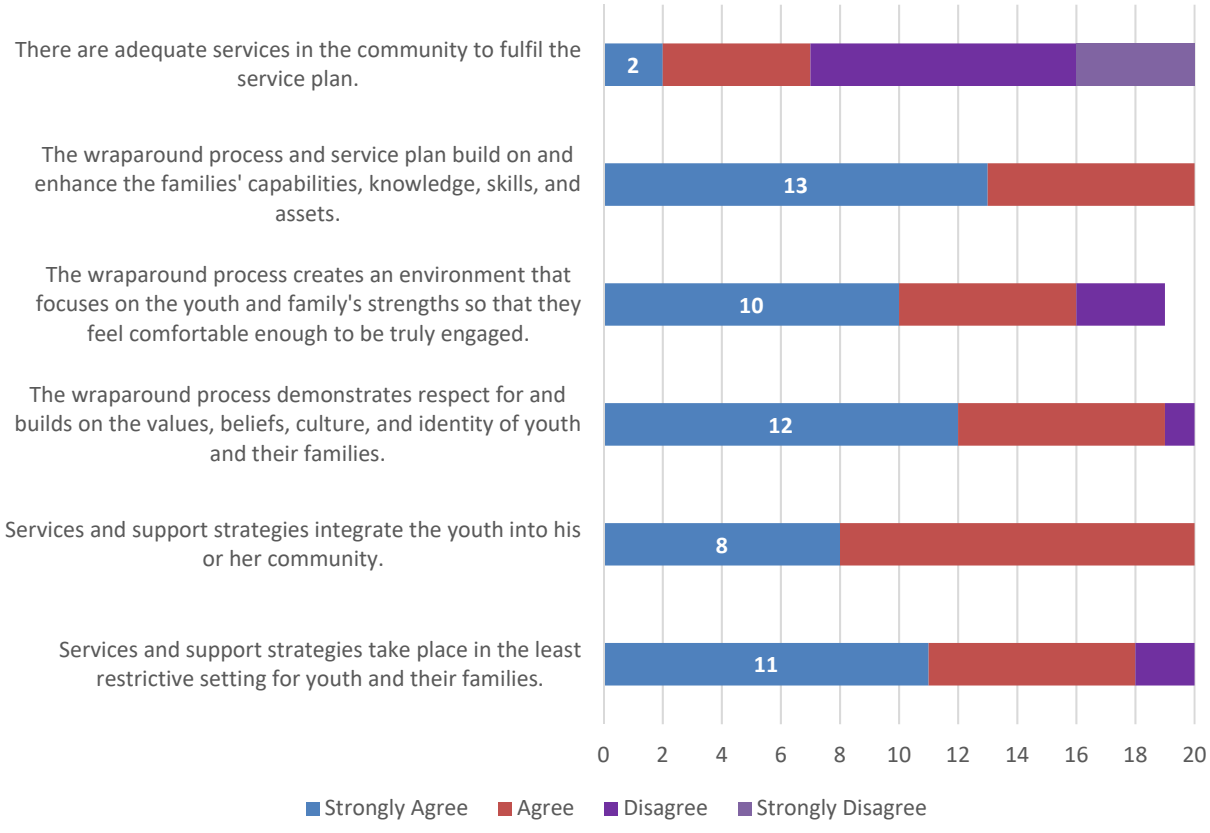
Table 12. Youth Successes Reported by Stakeholders

Successes Youth Have Achieved	Stakeholder Reports
No probation violations	Youth
Learning coping skills	
Less emotional breakdowns	
Understanding how anxiety impacts behavior	
Being respectful	
Becoming involved in art	
Moving closer to home	
Better attitude	
Improved school attendance	
Adjusting to peers	
Losing weight	
No more police contact	Parents

Table 12. Youth Successes Reported by Stakeholders	
Successes Youth Have Achieved	Stakeholder Reports
Transitioning home	Wraparound Facilitators
Transitioning to foster home	
Transitioning to public school	
Helping to care for/mentor siblings	
Improved behavior at home	
Feeling loved at home	
No longer having to be restrained	
Improved hygiene	
Improved verbal skills	
Improved public safety skills	
Compliance with medication	
Compliance with therapy	
Stopped smoking marijuana	
Participation in sports	Caseworkers
Improved confidence	
More accountability for themselves	
Making better overall choices	
Opening up to people	Youth and Wraparound Facilitators
Got a job	
Better communication	
Handling crisis situations	Youth and Caseworkers
Active participation on the case	Parents and Wraparound Facilitators
Staying home	
Improved self-esteem	Wraparound Facilitators and Caseworkers
Stopped from running away	
Staying out of trouble	Youth, Parents, and Wraparound Facilitators
Following ground rules/listening to directions	
Improved family relationships	
Improved behavior at school	Youth, Parents, and Caseworkers
Ditched negative peer influences	Youth, Wraparound Facilitators, and Caseworkers
Decreased aggression	
Improved overall behavior	
Building new/positive friendships	Youth, Parents, Wraparound Facilitators, and Caseworkers
Improved anger control	
Improved grades	

Wraparound facilitators who completed the LCA staff survey answered questions about services and the wraparound process in general. Figure 9 displays the number of wraparound facilitators who agreed or disagreed with statements regarding the wraparound process and services, with the "Strongly Agree" response option called out. Most wraparound facilitators "Agreed or Strongly Disagreed" with these statements. All caseworkers surveyed who carry *Safe at Home* cases reported that services and support strategies take place in the least restrictive setting, and that they also integrate the youth into his or her community. However, 65 percent of wraparound facilitators either "Disagreed" or Strongly Disagreed" that there are adequate services in the community to fulfill the service plan.

Figure 9. Wraparound Facilitator Perceptions of Services and the Wraparound Process



The majority of stakeholders reported that youth/families have actively made decisions about services and also that their input has been heard and incorporated into plans; parents

and wraparound facilitators interviewed reported this most frequently at 79 percent for both groups.

One parent stated, "[The wraparound facilitator] has not made us do anything we don't want to do. [He/she] always listens to what [the youth] has to say and [the wraparound facilitator] lets [the youth] be [his/her] own person. A wraparound facilitator similarly stated, "Basically I told [the youth] that this is [his/hers] and [he/she] has to want this for [him/herself] and [him/her] knowing that [he/she] has that level of control and that [his/her] input is used and heard is enough for [him/her] to participate willingly." Table 13 below provides the formal and informal services stakeholders reported youth/families have received. Informal services were utilized more often than formal services. Since a goal of the program is to transition the youth/family to a reliance on more informal services/supports, i.e., those they will still be able to access after formal services have ended, it is not surprising that a wider range of informal services were reported. Only a couple of wraparound facilitators reported difficulty in obtaining formal services, or in getting the youth/family motivated to participate in formal services. While informal services were more common, there were also more reports of a need for further service development in this area.

Table 13. Youth/Family Services Received

Formal/Professional Services	Informal Services

• Behavioral Management/Specialists
• Classes on
  - Hoarding
  - Job Skills
  - Parenting Skills
• County/School Transition Specialists
• Crisis Intervention
• Department of Rehabilitation Services
• Legal Aid
• Life Skills Coaching
• Medication Management
• Narcotics Anonymous
• Physical Therapy
• Probation
• Professional Family Support
• Psychiatric Services
• Respite
	• Advocacy by the wraparound facilitator
	• Art classes
	• Attending transitional student-teacher meetings
	• Babysitting younger siblings
	• Boy Scouts
	• Choir
	• Church activities
	  - Bible Study
	• Civil Air Patrol
	• Clubs
	  - Boys and Girls Club
	  - Pep Club
	  - Robotics Club
	• Going to the
	  - Park
	  - Public pool
	• Groups
	  - Female Support Group
	  - Peer Support Group

Table 13. Youth/Family Services Received	
Formal/Professional Services	Informal Services

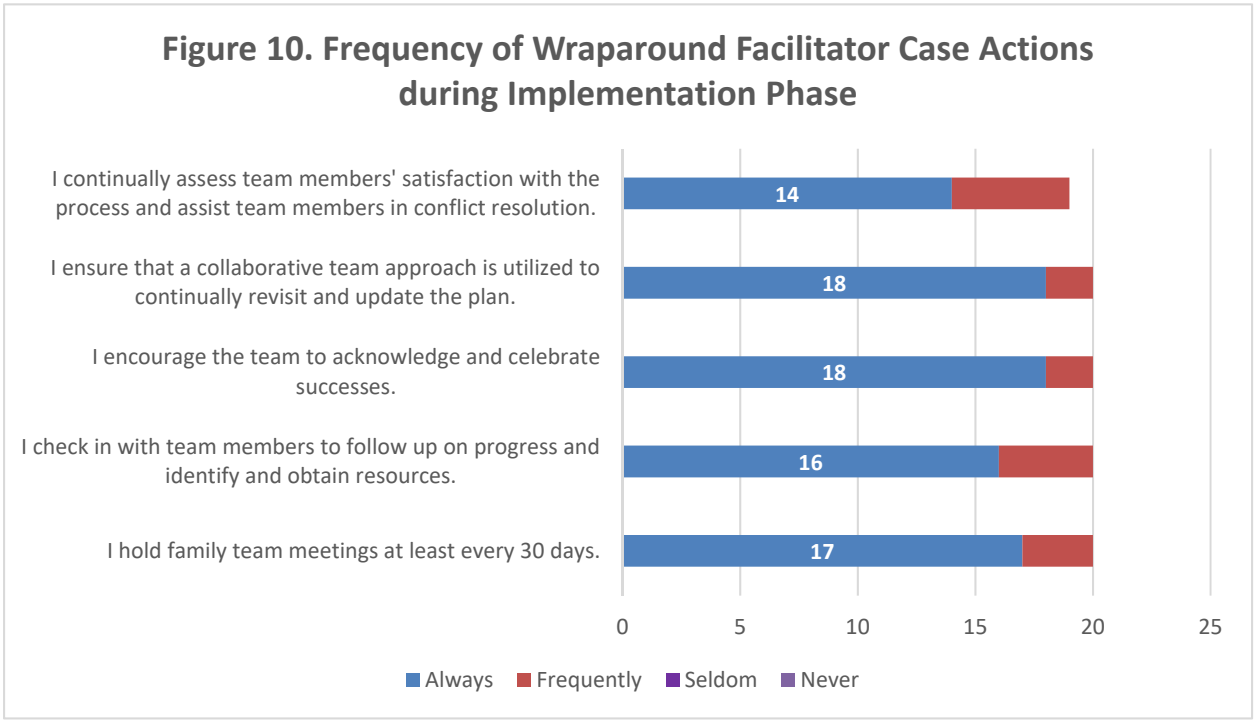
• Therapy/Counseling
  - Individual Therapy
  - Interchange Program
  - Family Therapy
  - Functional Family Therapy
• Youth Coaching
	• Hanging out with the wraparound facilitator
	• Historical reenactments
	• Help with
	  - Beauty School portfolio
	  - Court documentation
	  - Developing a college plan
	  - Enrolling in public school
	  - Filling out the Free Application for Federal Student Aid form (FAFSA)
	  - Finding housing for the parent
	  - Finding the youth a job
	  - Getting the family food stamps
	  - Getting the family Medicaid
	  - Getting the family Supplemental Security Income (SSI)
	  - Getting the parent a driver's license
	  - Keeping the apartment clean
	  - Modifying an Individualized Education Plan (IEP)
	  - Setting up homeschooling
	  - Transitioning the youth in a new school
	• Hunting
	• Mentoring
	• Overnight summer camp
	• Paying for
	  - An air conditioner for the family
	  - Back to school supplies
	  - The deposit on an apartment for the family
	  - The family's rent
	• Planning outings for youth with extended family
	• Rewards for meeting goals, including
	  - A bicycle
	  - Art supplies
	  - Bowling parties
	  - Candy
	  - Coloring books
	  - Go-kart racing
	  - Going out for ice cream
	  - Going out to dinner
	  - Going to a barber shop

Table 13. Youth/Family Services Received	
Formal/Professional Services	Informal Services
	- Going to McDonalds - Going to Walmart - Gym membership - Pokémon cards - Pottery classes - Verbal praise • Sports - Basketball - Cheerleading - Cross-Country - CrossFit - Dance - Football - Gymnastics - Swimming - Tennis - Volleyball • Teaching the youth how to - Budget - Build a grocery list - Create resumes - File taxes - Read a pay stub - Use a checking account - Use good communication skills • Transportation, including - Parent to visit youth - Youth to doctor's visits - Youth to probation officer meetings • Tutoring • Visits to grandparents • Voice lessons • Volunteering - At a daycare - At a horse farm - At an animal shelter • Weekly ice cream trips • West Virginia Military Academy

While stakeholders reported high levels of inclusion in the service decision-making process, it was clear that not all youth have been able to receive all the planned services. Forty-five percent of youth, 71 percent of parents, wraparound facilitators from 56 percent of cases, and caseworkers from 43 percent of cases reported that youth have been able to receive all services according to plan.

Stakeholders described various barriers to service provision. Mentoring was listed most frequently by stakeholders as a service gap; both in interviews and in survey responses. Some interviewees also reported that while youth were motivated and interested in obtaining jobs, it has been a challenge in finding establishments willing to hire them. Some interviewees stated that resources and local services were limited in a more general sense. In fact, 65 percent of wraparound facilitators and 58 percent of caseworkers surveyed either disagreed or strongly disagreed with the statement, "There are adequate services in the community to fulfill the service plan." A few stakeholders also reported it can be difficult to motivate some youth and families to participate in services. Additionally, wraparound facilitators and caseworkers from a couple of cases reported that when youth change placements frequently, it is difficult to get services set up. One caseworker stated, "[The LCA] works to the best of their ability. [The youth] bounces. [He/she] can't stay put long enough before they have to change the plan because [he/she] gets kicked out of [his/her] placement. They are doing the best they can."

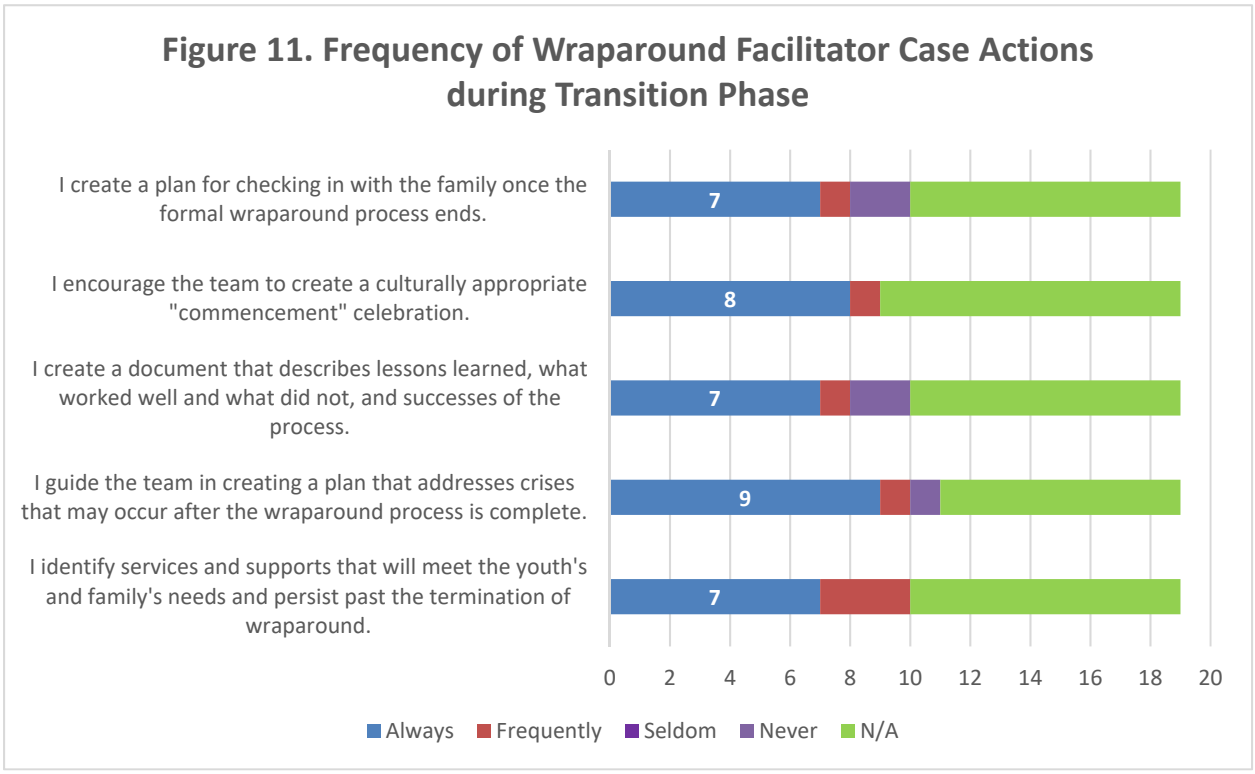
Figure 10 displays data from the LCA staff survey illustrating the case actions taken by wraparound facilitators during the third phase: Implementation. The "Always" response option has been called out for emphasis. Wraparound facilitator reported that all of the required case actions during the Implementation phase were completed either "Always" or "Frequently."



Phase 4: Transition

Although a couple of the cases were reported as close to reaching the Transition Phase, none had quite made it there yet. This was to be expected since the program only began in October 2015. While ten cases from the sample had already closed, they had closed before the case moved to the Transition phase, i.e., they were cases that had closed unsuccessfully. In the couple of cases where transition was near, stakeholders reported that face-to-face visits have become further spaced apart and discussions have already begun about graduation ceremonies and what to expect post-*Safe at Home*. Next year, the fidelity assessment will likely include cases that have transitioned.

Figure 11 displays the case actions taken by wraparound facilitators during the final phase: Transition. This figure differs from those on the other wraparound phases because an "N/A" option was added to reflect those cases which have not reached this phase.



Successes and Challenges

Interestingly, areas that some stakeholders regarded as a strength others found to be a challenge. For example, wraparound facilitators and caseworkers from approximately half of the cases reported positive collaboration between DHHR and the LCAs with caseworkers from 25 percent of the cases reporting that wraparound facilitators helped to ease their overall workload. One caseworker stated, "[The wraparound facilitator] is very effective and the problem with [the youth] is that [he/she] has so many issues and I couldn't have given [him/her] all the attention [he/she] needed, so it's been a lifesaver to have this wraparound facilitator."

Caseworkers who responded to the staff survey were asked if they provide more, less, or the same amount of supervision to *Safe at Home* cases in comparison to their other cases: 33 percent reported that they provide more supervision, 40 percent reported that they provide the same amount of supervision, 13 percent reported that they provide less supervision and 13 percent have not yet had a *Safe at Home* case.

Caseworkers from approximately 25 percent of the cases reviewed and wraparound facilitators from a few of the cases reported that there is not positive collaboration between DHHR and the LCAs. One wraparound facilitator stated, "I have had two DHHR workers attend meetings with the family." Wraparound facilitators from just over 25 percent of the cases reported that there was not enough information given to them from DHHR at the beginning of the case, nor was there enough information in the referral to complete a high quality initial CANS assessment. It should be noted, however, that the referral should only provide preliminary information, because the CANS assessment should be built primarily on the wraparound facilitator's interaction with the family. Additionally, 40 percent of wraparound facilitators reporting that the *Safe at Home* referral process does not run smoothly. One wraparound facilitator stated, "There is a lot of information left out of the referrals, which makes it difficult for the facilitator to proceed." In four cases, wraparound facilitators reported that there was never a warm hand-off from DHHR at the beginning of the case. A wraparound facilitator expressed confusion about this process, stating, "It is still unclear who contacts the family first… it often depends on the DHHR [case]worker."

Timelines were reported as a challenge by wraparound facilitators from a couple of cases, particularly as they pertained to youth placed out-of-state. The timeframe for completing the initial CANS with youth was particularly considered a challenge. One wraparound facilitator suggested, "Make the initial CANS due within the first 30-60 days because 14 days is not enough time to establish rapport and expect accurate information." Wraparound facilitators from a few cases also stated that while caseloads were currently low, they needed to remain so. One wraparound facilitator stated, "I have only six right now… This is an intensive program. With my six cases, keeping up with team members, court stuff, and basically every aspect of their life; you can't do that for ten kids." Another wraparound facilitator echoed these sentiments, stating, "The caseloads need to be small for the amount of intensive case management that goes into being a facilitator. It's impossible to meet the demands of this job without burning out." A caseworker also worried about the potential for wraparound facilitator burn out, stating, "I don't think it's realistic for facilitators to be on call 24/7."

Documentation was reported as a challenge both in interviews and in the LCA staff survey. Wraparound facilitators and caseworkers from a few cases reported that program documents could use streamlining, because there is often duplicative information. Some wraparound facilitators who participated in the survey suggested future training on required documentation. Another wraparound facilitator stated that having so many documents has

been overwhelming for some youth/families. A couple of wraparound facilitators reported that there is simply too much to document. One wraparound facilitator stated, "We document every single thing, inclusive of a weekly report, a monthly report with every contact, and our quarterly reports, yet as a facilitator, I am supposed to be available for crisis at any time, which is almost every day in many cases."

Youth and family engagement was another area with polarizing reports. Sixty-eight percent of youth, 71 percent of parents, wraparound facilitators from 64 percent of the cases, and caseworkers from 59 percent of the cases reported that youth and family engagement was adequate. Similar percentages of stakeholders reported that wraparound facilitators had become key supports for youth/families, with one parent stating, "I really like how involved [the wraparound facilitator] is. It is like having another family member." However, youth from four cases reported that engagement was poor, along with parents from five cases, and wraparound facilitators and caseworkers from almost 25 percent of the cases. Since the principals of the program rely so heavily on youth/family engagement, when engagement was reported as poor, it was one of the greatest barriers to success in these cases. A parent who reported poor engagement stated, "I am not really kept in the loop." One wraparound facilitator stated, "It's not DHHR, it's not the family. We have worked so hard for [the youth] to be successful. [The youth] does not want help. [The youth] will do what [he/she] wants to do." A caseworker stated, "I think some of the facilitators need to be trained on how to truly engage the family."

Youth from three cases and parents from two cases reported that there is a lack of services to get youth involved with. Interestingly, a lack of available services was reported by wraparound facilitators from only 18 percent of the cases, but caseworkers from 46 percent of the cases. However, 65 percent of wraparound facilitators from the LCA survey did not believe there were enough services available in the community to fulfil service plans. One wraparound facilitator stated, "As for informal services, because of the lack of services in our community, it blurs the lines of what my position is. I should be doing more facilitating, but I do the actual work." Wraparound facilitators and caseworkers from a couple of cases stated that LCA and DHHR staff could use training on available community resources to maximize the services that are currently available.

Additionally, a few stakeholders reported that the courts (judges, attorneys, and probation officers) contributed to case success. There was only one case where stakeholders reported that the courts created a significant hindrance. However, a few wraparound facilitators and LCA supervisors who participated in the LCA staff survey reported challenges with the courts.

One LCA supervisor stated, "Other systems have to get on board with the project. It does not work if other stakeholders, such as probation, are able to overturn the plan and place a kid out of home." However, 92 percent of caseworkers who completed the survey and had *Safe at Home* cases reported that judges have been on board with the program.

Fidelity Summary

For the most part, the program has been performed with fidelity. It was apparent through survey, case review, and interview data that wraparound facilitators were completing required *Safe at Home* activities regularly. However, while DHHR caseworkers seemed to be adhering to their roles and responsibilities with the program most of the time, issues were reported through wraparound facilitator accounts. For example, 40 percent of wraparound facilitators surveyed reported that the referral process does not run smoothly and wraparound facilitators from 25 percent of cases reviewed reported that caseworkers did not give them enough information at the beginning of the case nor was there enough quality information in referrals to complete high quality initial CANS assessment. Overall collaboration between DHHR and the LCAs seems to be an area that could be improved.

Interestingly, what many stakeholders reported as a strength others found to be a challenge. This was apparent with youth/family engagement, which is a cornerstone of the *Safe at Home* program. While most stakeholders reported positive youth/family engagement, poor youth/family engagement was reported in 25 percent of cases. While this is clearly not the majority of cases, it is still worth addressing because it appeared that whenever engagement was an issue, it had a profound impact on overall case success.

Outcome Evaluation

The Population

Referrals to *Safe at Home* have been made for 329[8] youth statewide as of September 30, 2016. For the analysis of outcomes, youth are divided into cohorts. Cohort I is comprised of youth referred to the program between October 2015 and March 2016 and consists of 124 youth. Cohort II consists of youth referred to the program between April 2016 and September

[9] It should be noted that the numbers of youth reported by HZA and the State may differ slightly. This is because the State utilizes weekly tracking logs and HZA relies on FACTS extracts for data.

2016 and is comprised of a total of 205 youth. Since Cohort I youth have been in the program for a longer period of time, more data have become available for them. However, it should also be understood that overall numbers for Cohort I are relatively small since this cohort only includes youth referred in the earliest stage of the program (between October 1, 2015 and March 31, 2016). Additionally, the State prioritized congregate care referrals when the program initially rolled out, therefore, the low numbers of youth with family foster care referrals were expected.

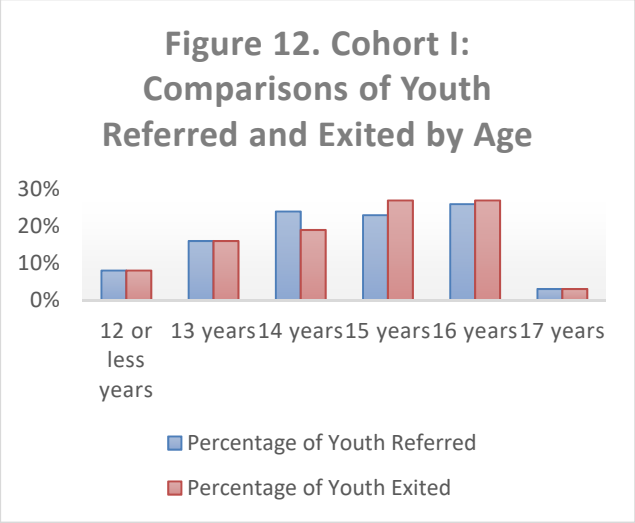
The majority of the outcome evaluation for this semi-annual report will focus on youth in Cohort I. Table 14 provides a breakdown of youth referral types by cohort. The majority of referrals for both Cohorts I and II were for preventive at home cases (38% and 44%, respectively).

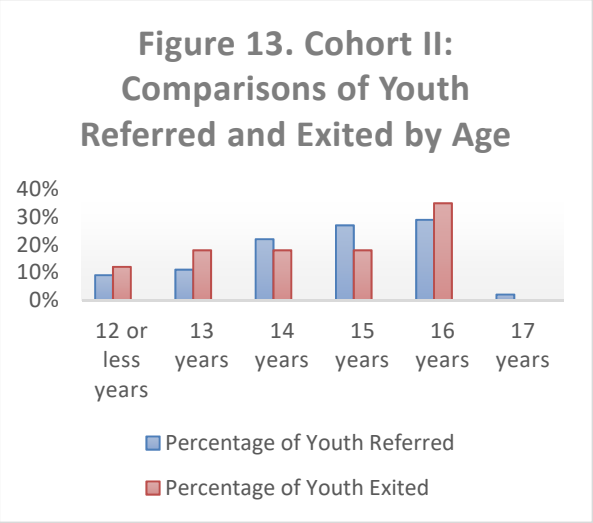
Table 14. Youth Referral Types by Cohort

Referral Type	Cohort I	Cohort II
Out-of-state Congregate Care	30	17
In-state Congregate Care	39	72
Emergency Shelter	6	18
Family Foster Care[8]	2	8
Preventive at Home	47	90

Figure 12 displays the percentages of youth referred by age. This figure additionally looks at the total youth who have exited the program thus far and provides percentages for each age in Cohort I. Figure 13 serves the same purpose as Figure 12, but provides the results for Cohort II. Overall, the results for Cohorts I and II look fairly similar. Youth ages 15 to 16 make up the highest percentage of referrals and youth age 16 are the highest percentage of those who have left the program thus far.

[10] DHHR includes family foster care cases under its "preventive" category, but they are treated separately for purposes of the evaluation to allow exploration of differing outcomes from the rest of the prevention group.





Sixty-two percent of youth referred were male in Cohort I and 51 percent in Cohort II. Gender disproportions were highest in out-of-state congregate care referral types, where 80 percent of youth were male in Cohort I. This seems to have increased with Cohort II, where 88 percent of out-of-state congregate care referrals were for male youth. The majority of youth were white in both cohorts (77% in Cohort I; 78% in Cohort II) while seven percent were black in Cohort I and nine percent were black in Cohort II. Fifteen percent in Cohort I were reported as "Mixed" or "Other" race; this was the case for 13 percent of youth in Cohort II.

Youth referral types in Cohort I (see Table 14 above) comprise the treatment groups for this report. An historical matched case design was employed to create the comparison group. Matched groups varied depending upon the question that needed to be addressed. For example, not all *Safe at Home* youth have had a substantiated maltreatment report to start with; therefore questions about repeat maltreatment only use youth from the sample and comparison youth who had at least one confirmed maltreatment. Similarly, this constraint would not apply to a question about length of time in care, but only youth who have ever been in care are examined on that question.

Comparison groups were drawn from federal fiscal years (FFY) 2011 through 2015. Cases were selected from FACTS for youth that became eligible for inclusion in a specific treatment group during a given half year. Propensity score matching variables included, at a minimum, demographic factors, reasons for removal, length of time since removal, number of removals, and number of prior placements during a removal episode. The remainder of this outcome evaluation examines Cohort I and its corresponding comparison groups.

Youth Placements

Tables 15 and 16 provide an in-depth view of where youth in Cohort I were placed at referral, March 31, 2016, and again six months later, as of September 30, 2016.

Table 15. Youth Placement at Referral and March 31, 2016[9]

		Placement March 31, 2016					
		Out-of-state Congregate Care	In-state Congregate Care	Emergency Shelter	Family Foster Care	Preventive at Home	Total
Placement at Referral	Out-of-state Congregate Care	14	2	2	2	10	30
	In-state Congregate Care	1	15	2	3	18	39
	Emergency Shelter	-	3	-	-	1	4
	Family Foster Care	-	1	-	1	-	2
	Preventive at Home	2	4	3	-	37	46
	Total	17	25	8	6	66	122

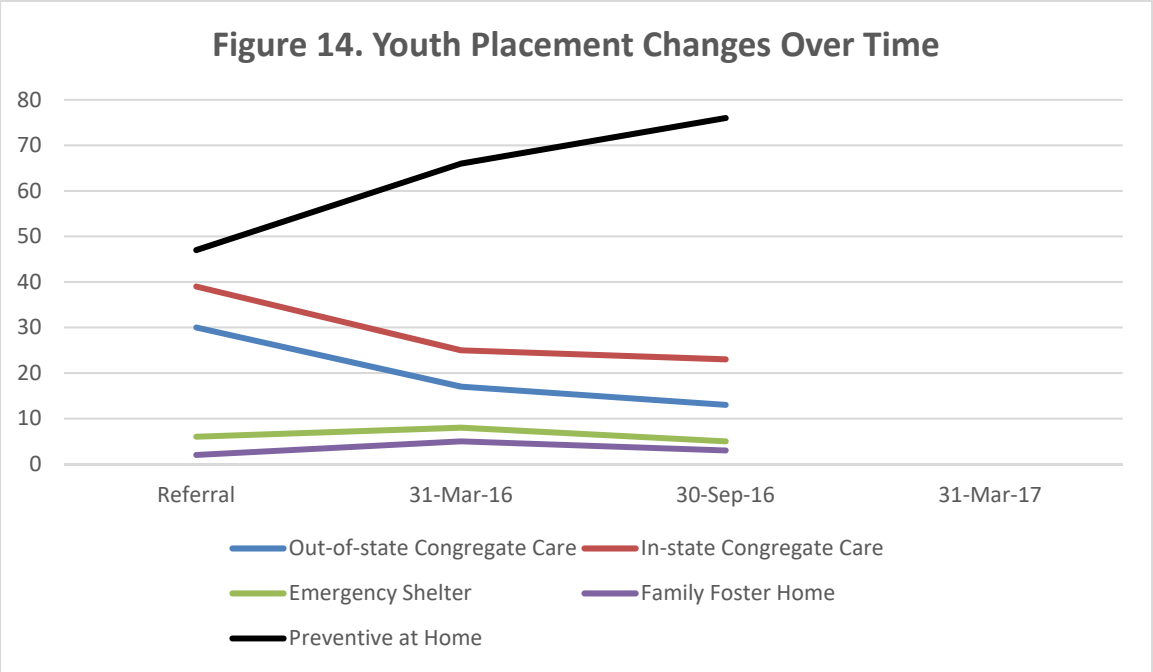
Table 16. Youth Placement at Referral and March 31, 2016

		Placement at Referral					
		Out-of-state Congregate Care	In-state Congregate Care	Emergency Shelter	Family Foster Care	Preventive at Home	Total
Placement September 30, 2016	Out-of-state Congregate Care	5	4	4	2	15	30
	In-state Congregate Care	2	11	4	-	22	39
	Emergency Shelter	1	2	-	-	3	6

[11] Three youth were designated as "Ineligible" in FACTS in March 31, 2016 because they were placed in detention centers.

Table 16. Youth Placement at Referral and March 31, 2016							
		Placement at Referral					
		Out-of-state Congregate Care	In-state Congregate Care	Emergency Shelter	Family Foster Care	Preventive at Home	Total
	Family Foster Care	-	1	-	-	1	2
	Preventive at Home	5	5	1	1	35	47
	Total	13	23	9	3	76	124

Figure 14 provides a visual display of placement changes over time. This figure will be updated as the program progresses as a way to track youth placement change.



When comparing the placements of youth in Cohort I at referral, March 2016, and September 2016, congregate care placements illustrate promising results. Youth placements decreased in both out-of-state and in-state congregate care from referral to March 2016 and again from March 2016 to September 2016. By September 30, 2016 there were 33 fewer youth in congregate care than there were at referral.

Additionally, the number of youth at home continued to rise steadily from referral to March 2016 and again in September 2016. By September 2016, there were 29 more youth at home than there were at referral. Seventy-four percent of youth who were at home at referral were at home in September 2016. However, 21 percent of youth with a preventive at home referral were placed in congregate care settings (half in in-state, and half in out-of-state) in September 2016.

Youth from Cohort I were matched with youth from a comparison group to look at the rate of entry into congregate care. A daily rate of entry into congregate care was calculated by dividing the total number of entries by the number of days that youth were eligible to enter congregate care (that is, the number of days that the youth was *not* in congregate care). Daily congregate care entry rates are illustrated in Table 17, below from Cohort I and the matched comparison group. The lower entry rates have been bolded for emphasis. Statistical significance was calculated for all referral types except for family foster care and emergency shelter, because the numbers for those two populations were too small to permit valid calculations. The level of statistical significance is shown, where it is applicable.

Table 17. Daily Congregate Care Entry Rate

Referral Type	Treatment Group/Cohort I	Comparison Group	Statistical Significance
Out-of-state Congregate Care	0.003199	0.008381	p<.05
In-state Congregate Care	0.003868	0.010286	p<.01
Emergency Shelter	0.004845	0.00464	-
Family Foster Care	0.012448	0.003058	-
Preventive at Home	0.002094	0.001495	p>.05

Table 17 shows that youth referred while in out-of-state or in-state congregate settings are more likely to leave congregate care, and less likely to return than those in the comparison group at a statistically significant rate. On the other hand youth who started at home showed the opposite (although this was not statistically significant).

In addition to the calculation of daily entry rates into congregate care for youth and comparison groups, an average length of time in congregate care was calculated for the treatment and comparison groups. This is illustrated below in Table 18.

Table 18. Average Number of Days Spent in Congregate Care			
Referral Type	Treatment Group/Cohort I	Comparison Group	Statistical Significance
Out-of-state Congregate Care	68.4	119.4	p<.01
In-state Congregate Care	63.7	125.7	p<.01
Emergency Shelter	11.0	39.3	-
Family Foster Care	62.5	19.5	-
Preventive at Home	30.6	26.5	p>.05

Youth with in-state and out-of-state congregate care referrals are spending less time in congregate care settings than those of the comparison group at a statistically significant rate. Though statistical significance could not be calculated this also seems to be the case for youth with an emergency shelter referral.

A comparison was also done of the amount of time youth have spent out of their home counties. As shown in Table 19, youth starting in congregate care, whether in-state or out-of-state less time (at a statistically significant rate) out of their home counties than the comparison group. This was also the case for youth starting as preventive at home, though the results were not statistically significant.

Table 19. Average Days Spent Out of County			
Referral Type	Treatment Group/Cohort I	Comparison Group	Statistical Significance
Out-of-state Congregate Care	80.7	117.7	p<.05
In-state Congregate Care	90.2	128.2	p<.05
Emergency Shelter	18.8	159.0	-
Family Foster Care	84.0	42.0	-
Preventive at Home	24.8	26.8	p>.05

Similar to Tables 17 and 18, Table 19 shows positive results for youth with in-state and out-of-state congregate care referrals. Youth who began in in-state and out-of-state congregate care settings as well as youth in emergency shelters are returning to their home counties in a shorter period of time than youth from the comparison group. While the differences between preventive at home youth and the comparison group are not substantial, differences between family foster care youth and the comparison group are, with family foster care youth spending twice as much time out-of-county than youth in the comparison group.

Youth in Care and Repeat Maltreatment

The next analysis addresses the average days spent in care by referral type for Cohort 1 cases, since sufficient time has elapsed to make the results more meaningful. Table 20 displays the results, with statistical significance noted.

Table 20. Average Days Spent in Care

Referral Type	Treatment Group/Cohort I	Comparison Group	Statistical Significance
Out-of-state Congregate Care	91.0	120.1	p>.05
In-state Congregate Care	96.3	128.2	p<.05
Emergency Shelter	118.7	172.5	-
Family Foster Care	183.0	152.5	-
Preventive at Home	30.8	30.7	p>.05

Youth with referrals from out-of-state congregate care, in-state congregate care and emergency shelters spent less time in care than their matched counterparts in the comparison group. However, statistical significance was only achieved for youth with in-state congregate care referrals. Youth with a preventive at home referral spent an almost equal amount of time in care as youth in the comparison group.

The last analysis looks at abuse recidivism. In the six months following referral to *Safe at Home*, only one youth had a maltreatment referral. In the six months following an imputed referral date, the comparison group had eight referrals for maltreatment, involving eight different youth. Therefore Safe at Home did better on referral recidivism. The next report will address the results of the referral.

FACTS Outcomes Measures Summary

Youth placement outcomes were very positive for Cohort I youth with in or out-of-state congregate care referrals. When looking at congregate care youth and their comparison groups, youth from Cohort I spent less time in care, fewer days out of their home county, less time in congregate care, and had fewer congregate care entries. Nearly all of these measures (excluding out-of-state congregate care for days in care) were statistically significant as well. However, youth with family foster care and preventive at home referrals did uniformly worse than youth in the comparison groups (though not at a statistically significant rate). As the

evaluation proceeds it will be of particular interest to see if these measures improve, and if they do not, to hone in on possible explanations.

Youth Functioning

The CANS tool is an assessment of youth's strengths and needs which is used to support decision making, facilitate service referrals and monitor the outcomes of services. Using a four level rating system on a series of items used to assess specific domains such as trauma exposure or life domain functioning, the CANS tool helps facilitators and caseworkers identify actionable items, to determine where to focus their attention in planning with the family.

The first win is the use of the tool itself. Wraparound facilitators are primarily responsible for administering CANS assessments to youth in the program. Once CANS assessments are completed by the facilitators, they are to be entered into the online WV CANS database created by HZA. Great improvement has been shown in the number of initial assessments entered in the database between youth from Cohorts I and II. While there were 82 initial CANS assessments entered for youth in Cohort I (those referred between October 2015 and March 2016), there are 216 initial CANS assessments for youth in Cohort II (those referred between April 2016 and September 2016). For the analysis of the CANS assessment data, youth from Cohorts I and II will be combined unless stated otherwise.

The first analysis asks the question, does it take longer to have a completed CANS by referral type? The time to initial CANS entry into the online system is noted below in Table 21. While there is a policy that initial CANS assessments are to be completed within 14 days of the referral, there is not a policy on the timeframe for which the assessment should be entered into the online CANS database.

Table 21. Time to Initial CANS Assessment Entries		
Referral Type	Days	Percentage
Out-of-State	0-30	44
	31-60	25
	61-90	14
	91+	17
In-State	0-30	67
	31-60	22
	61-90	6
	91+	6
Emergency Shelters	0-30	36
	31-60	43
	61-90	14
	91+	7
Family Foster Care	0-30	63
	31-60	-
	61-90	25
	91+	13
Preventive at Home	0-30	63
	31-60	26
	61-90	5
	91+	5

Needs Reduced at Six and Twelve Months

HZA examined the CANS domains as a way to measure the well-being of youth. Table 22 displays the percentage of needs reduced at six months and 12 months within the CANS domains by each specific item. The table also provides more specific information on the reduction of needs within the CANS domains themselves by item.

Table 22. Percentage of Youth with Reduced Needs at Six and Twelve Months			
CANS Domain	CANS Items	6 Months (%)	12 Months (%)
Behavioral/Emotional Needs	Psychosis	-	-
	Attention/Concentration	3	8.2
	Impulsivity	4.5	5.2
	Depression	3.7	4.5
	Anxiety	3.7	4.5
	Oppositional Behavior	8.2	9
	Conduct	2.2	3.7
	Substance Use	6	6
	Attachment Difficulties	0.7	2.2
	Eating Disturbances	-	-
	Affective/Physiological Dysregulation	-	-
	Somatization	-	-
	Anger Control	9	10.4
	Total	17.2	21.6
Child Risk Behaviors	Suicide Risk	0.7	0.7
	Non-Suicidal Self Injury	2.2	4.5
	Other Self Harm	3	3.7
	Exploitation	-	-
	Danger to Others	3	2.2
	Cruelty to Animals	-	-
	Fire Setting	-	-
	Sexually Abusive	-	0.7
	Sexualized Behaviors	0.7	1.5
	Bullying	1.5	1.5
	Delinquency	0.7	0.7
	Runaway	2.2	3
	Intentional Misbehavior	3.7	4.5
	Total	8.2	9.7
Life Functioning	Family	6	8.2
	Living Situation	4.5	4.5
	Social Functioning	6.7	9
	Developmental/Intellectual	1.5	3
	Brain Injury	-	0.7
	Substance Exposure	1.5	1.5
	Recreational	6	8.2
	Legal	3.7	4.5
	Medical	1.5	2.2
	Physical	-	-

Table 22. Percentage of Youth with Reduced Needs at Six and Twelve Months			
CANS Domain	CANS Items	6 Months (%)	12 Months (%)
	Medication Compliance	1.5	3.7
	Sleep	5.2	6
	Sexual Development	1.5	2.2
	Child Involvement with Care	3.7	5.2
	Daily Functioning	0.7	0.7
	Natural Supports	6.7	10.4
	School Behavior	14.2	18.7
	School Achievement	6.7	8.2
	School Attendance	9	10.4
	Total	14.9	18.7
Symptoms of Trauma	Adjustment to Trauma	5.2	6
	Traumatic Grief	2.2	2.2
	Re-experiencing	2.2	2.2
	Hyperarousal	6	6.7
	Avoidance	2.2	2.2
	Numbing	-	1.5
	Dissociation	0.7	0.7
	Total	21.6	22.4

Overall, needs have been reduced in all CANS domains at six and 12 months. Additionally, overall domain needs have been further reduced at the 12-month mark in comparison to the six-month mark. The CANS domain with the most reduced needs at 12 months is “Symptoms of Trauma.” The specific CANS item with the greatest reduction of needs at six and 12 months is “School Behavior,” which falls within the “Life Functioning” domain.

Strengths at Baseline, Six, and Twelve Months

Table 23 displays the percentage of youth with strengths in the CANS domain, incorporating the specific items.

Table 23. Percentage of Youth with Strengths or Centerpiece Strengths at Baseline, Six Months, and Twelve Months			
Child Strengths Items	Baseline (%)	6 Months (%)	12 Months (%)
Family	67	69	72
Interpersonal	53	60	64
Educational Setting	55	62	66
Coping and Survival Skills	53	58	57
Optimism	68	72	76
Talents/Interests	55	63	66
Spiritual/Religious	33	37	37
Community Life	28	39	43
Relationship Permanence	63	67	66
Resilience	58	60	63

Strengths were rated generally high at baseline, with over half of youth rated as exhibiting the strength in all but two items. Nearly all strength items were rated highest at the 12 month period, showing improvement over time. “Coping and Survival Skills” and

“Relationship Permanence” strengths saw very slight decreases between the six and 12 month marks. “Spiritual/Religious” strengths remained the same between six and 12 months.

Family Functioning at Baseline, Six, and Twelve Months

Family functioning was assessed using the CANS domain for “Family Well-Being.” Table 24 displays the percentage of youth with non-actionable item scores (e.g. scores of 0 or 1 that do not require worker support) within the Family Well-Being domain at baseline, six months, and 12 months.

Table 24. Percentage of Youth with Nonactionable Family Well-Being Items at Baseline, Six Months, and Twelve Months			
Well-Being Items	Baseline (%)	6 Months (%)	12 Months (%)
Physical Health	74	78	82
Mental Health	77	81	84
Substance Use	77	81	84
Family Stress	34	43	49
Residential Stability	73	75	80

All of the "Family Well-Being" items improved over time, reaching their peak, thus far at the 12 month mark. This appears most substantial with the "Family Stress" item which yielded a 50 percent improvement in the percent of youth with "nonactionable" items over 12 months.

V. Recommendations & Activities Planned for Next Reporting Period

APRIL 2016

West Virginia continues to move forward with Phase 2 implementation which will include the addition of 24 counties. This is projected to begin sometime late summer to early fall 2016. The grants to local coordinating agencies to hire wraparound facilitators have been awarded and the hiring process has begun. The date that referrals begin will be determine in consultation with the Local Coordinating Agencies and our Evaluator.

Wraparound 101 training is being conducted throughout the next phase Counties beginning in March and running through May. This is always a cross-training so BCF staff and Facilitators attend together.

WV CANS training for the Phase 2 areas is also scheduled throughout the months of April and May to assure that all BCF staff and partners have the opportunity to attend this training prior to implementation.

West Virginia has developed a strategic work plan for further training and development of BCF and Partner staff regarding the administration and use of the WV CANS and the further development of WV CANS Advance CANS Experts (ACES) for technical assistance. We are seeing that WV CANS are being administered but many do not yet understand how to use the results in the treatment or case planning process for youth and families. We have identified the continuing need to develop experts that can provide technical assistance on an ongoing basis. Our goal is for WV CANS to be completed on all children with an open child welfare case and that the WV CANS will be used to determine the appropriateness of a referral to Safe at Home West Virginia and assist in guiding the intensity of services. Please refer to the attached work plan which is a fluid plan with changes being made as needed.

West Virginia continues the development of Safe at Home West Virginia content experts. The further training includes a new blackboard training and an advanced classroom training that will be delivered during the month of May. The goal is to have a content expert in every community service district for BCF and that they are available to assist with questions and needed technical assistance as well as future training. The Experts have met

together and assisted in identifying what knowledge they believe they need to be comfortable in this role as well as what the home team identified as necessary for their development. The advanced training curriculum has been developed to meet those identified needs.

Through the barrier busting and review process, we have identified the need for further wraparound training and consultation for our wraparound facilitators and supervisors. We recognize that we are all in a learning curve when it comes to wraparound planning, crisis planning, intensity of services and the quality of written plans and monthly reports. To address this and to prepare for further expansion BCF and the Bureau for Behavioral Health and Health Facilities (BHHF) have worked through the system of care to enter into an agreement with Mary Grealish of Wraparound Solutions to assist West Virginia to further consult and coach with our wraparound facilitators and supervisors. Eileen Mary Grealish, M.Ed., designs and implements individualized, strengths-based strategies that have direct impact on young people and families. She is a recognized expert in functional strengths-based strategies that have direct impact on young people and families. She is a recognized expert in functional strengths and needs assessment, crisis planning, and staff supervision in Wraparound and family/person-centered practice. As president of Community Partners, Inc., Grealish focuses on writing and teaching about delivery of comprehensive community-based services including Wraparound and the development of innovative treatment behavior plans.

West Virginia has planned meetings with the Directors and Leads from the Local Coordinating Agencies to discuss provider network training moving forward and how to best approach issues that are identified. One of the identified issues that this group is now focusing on is the planned coordination of combined meetings with Judges.

With the implementation of Phase 2 West Virginia will again hold an onboarding meeting with the new Local Coordinating Agencies. Those meetings will include the existing Local Coordinating Agencies and we the new Local Coordinating Agencies working within the Behavioral Health Pilot. We are planning combined meetings that include the wraparound facilitators to assist with moving forward with our skill development in the art of wraparound. Meetings with the Local Coordinating Agency directors will be held separately.

West Virginia will work with our evaluator to plan for implementing recommendations.

OCTOBER 2016

As previously mentioned in the status, activities, and accomplishments section, West Virginia is currently reassessing the original construct of the content experts. The Safe at Home West Virginia Home Team will be determining how to best proceed with regard to this strategy.

West Virginia continues to move forward with Phase 3 implementation which will include the addition of the final 20 counties. This will complete initial implementation statewide. Phase 3 implementation is scheduled for April 2017. The grants announcement for local coordinating agencies to hire wraparound facilitators is scheduled for release in December.

Wraparound 101 training will be conducted throughout the next phase counties as well as in the previously implemented counties to allow for the ongoing training of newly hired staff both within BCF and the Local Coordinating Agencies. This is always a cross-training to allow for the combined attendance of those staff. Both the BCF Training Division and leads from our Local Coordinating Agencies conduct this training and the invitations and scheduling is coordinated between them.

The Local Coordinating Agency directors and clinical supervisors are currently developing a plan for ongoing coaching and development of wraparound facilitators. Through lengthy discussions West Virginia has identified internal strengths and knowledge that is being used to develop an advanced wraparound training that is to be provided to facilitators once they have been on the job for a month or two. This training will address better engagement with families, how to problem solve and move a team forward, how to better write wraparound plans with measurable outcomes, as well as other identified needs. It is to be more focused on the actual application and practice of wraparound facilitation. The development of this advanced training will occur during the next reporting period with the hope that the training will also roll out during that time.

As mentioned previously West Virginia is working with Dr. Lyons to build our internal capacity to identify and train CANS experts. This is in process and will continue.

West Virginia is in the process of updating the monthly progress summary to compliment the changes made to the wraparound plan form. There will also be an update to the summary guidance document. This will then involve an update to the program manual and forms. This will all take place during the next reporting period.

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

West Virginia is re-defining the purpose and function of the Safe at Home Advisory team. The team members have been in discussion regarding the effectiveness of the current process and what innovations might need to occur. As West Virginia is receiving information from our evaluators regarding the first fidelity assessments it is becoming clearer that this Advisory team would be the appropriate place for the review the fidelity assessments and then the monitoring of improvement or progress of the local coordinating agencies. This group would also be the appropriate place for the ongoing review of quarterly grant reports to assure adherence to the statement of work as well as monitoring performance measures. The overview and function of the group is being revised and will be included within the next semi-annual progress report.

West Virginia will work with our evaluator and partners to plan for implementing recommendations.

Recommendations & Activities Planned for Next Reporting Period For West Virginia's Evaluator:

APRIL 2016

Recommendations

Overall, there appears to be general optimism among stakeholders for the *Safe at Home* program. Almost all of the stakeholders interviewed want the same things: to reduce the number of youth living in congregate care settings, to bring youth back to West Virginia, and to keep youth home whenever safely possible.

Recommendation 1: Make efforts to improve buy-in among judges.

Many stakeholders agreed that judges will be crucial to the program's success, and since many judges were doubtful that the program could be successful, this is an issue that needs to be addressed. One way to do this would be to expand the personal meetings between DHHR staff and judges to ensure all judges receive personal outreach from DHHR, especially since this

form of outreach was appreciated by a couple of the judges who had received it. Other suggestions are to offer judges more formal training on the program; invite more judicial representation in the decision-making process; include more probation officers, attorneys, and guardians ad litem; and issue a point of contact from DHHR specifically tasked with addressing the questions and concerns of judges and legal staff. Additionally, one judge stated that he would like to read and distribute evaluation reports so that the judicial community can be kept abreast on how the program is progressing; this would be an excellent opportunity for DHHR staff to keep judges engaged, strengthen that relationship and demonstrate any program success.

Recommendation 2: Increase use of the CANS tool.

An initial CANS assessment was missing for one-third of the 120 youth initially referred to the wraparound program. While it is possible a CANS may have been completed for the youth missing an initial assessment in the online tool, it is important for wraparound facilitators to remember the broader value of documenting completion of the tool. While the CANS is designed to help wraparound facilitators identify the strengths and needs of youth and support decision making and facilitate service referrals, it is also used by BCF caseworkers to help them manage their cases and provide support to facilitators, for BCF as a whole to identify systemic service needs and for the project to gauge progress in improving child well-being.

Recommendation 3: Revisit the nomenclature used to identify preventive cases.

It is useful to separate the youth who are in their own homes and possess the eligibility criteria for *Safe at Home* from those who are in emergency shelters or who have already been adjudicated and are awaiting an opening in congregate care. While the early stages of the project make it appear that wraparound is not as effective with preventive cases, the classification of the cases may be interfering with a true assessment of effectiveness. Some of those may already have been ordered into care with little chance of changing the outcome without actually being placed. It is also possible that preventive cases are not being treated with the same sense of urgency or require a different suite of services, perhaps heavier on the support of the caregiver. These ideas will be explored in subsequent reports.

Within the first month of the reporting period West Virginia implemented the

recommendations of our evaluator. The addition of Shelter care as one of the placement types at time of referral is based on evaluator recommendation. The face to face meetings with the Judiciary was also identified by our Home Team and our Local Coordinating Agencies as something they believed to be beneficial. The receipt of the recommendations from our evaluator served to reinforce this. The Home Team developed a plan for each Community Services Manager to partner with at least one of the Directors of a Local Coordinating Agency serving their area and schedule a meeting with the Judges. This was tracked and completed.

Judge Swope of Mercer County requested that the Commissioner and the Deputy Commissioners meet with all of the Judges within that judicial circuit to have a round table discussion. This was scheduled with the thought that the format may be replicated in other circuits.

For the coming period, HZA has only 1 recommendation, and it relates to family and youth engagement.

OCTOBER 2016

Recommendation: Improve Youth/Family Engagement

Since youth/family engagement provides a cornerstone for the *Safe at Home* program, cases cannot function successfully without it. Where youth/family engagement was reported as a barrier, the case seemed to struggle enormously. While more stakeholders reported adequate engagement than not, the lack of quality engagement reported in almost 25 percent of cases should not be taken lightly. During the next six months HZA recommends that DHHS consider additional training or other mechanisms for improving family and youth engagement among both wraparound facilitators and caseworkers.

NEXT STEPS

APRIL 2016

During the next review period, between April 1 and September 30, 2016 *Safe at Home West Virginia* will be implemented in another 24 counties. Along with the baseline interviews which will be conducted in a sample of those counties, located in Regions 1, 111, and IV, additional evaluation activities will also take place.

Case review. Between late spring and early summer, a case review will be completed for a sample of 40 cases to assess the extent to which *Safe at Home* has been implemented with fidelity, i.e., as intended, in Phase I regions and counties. Data will be collected from BCF case files as well as those of wraparound service providers, with interviews also conducted with key stakeholders to inform the review.

Staff survey. A survey will be administered to Phase 1 supervisors and caseworkers in the summer of 2016 to gain insight about the program from their perspective. Staff will receive an email inviting them to complete the survey online. Fixed answer questions, including Likert scales, will be used to determine how well staff were prepared to carry out the initiative and what successes and barriers they have encountered during implementation.

Outcome measures. Using data from FACTS and CANS, outcomes of youth and their families will continue to be measured. FACTS will be used to measure safety and permanency for youth who have been referred to *Safe at Home* West Virginia. CANS will be used to measure the youth's well-being. Similar to the first evaluation report, the characteristics of youth who are referred during Phase II will be examined, although here only three months of referrals will be examined, because Phase II is not scheduled for implementation until July 1. Much of the outcome analyses will instead focus on youth who were referred during the first six months of the program, providing more time to have passed to measure the impact of the program.

Dashboard development. The evaluator will work closely with BCF during the next six-month period to develop a web-based dashboard. The dashboard will provide BCF and its contracted wraparound service providers with information about the youth referred for inclusion in the program and as well as the impact of the program. A draft plan of items to be included in the dashboard will be provided to BCF by July 1. Upon approval, using data from FACTS, steps will be taken to implement the dashboard for quarterly reporting to commence October 1.

CANS online training. Phase II of the program is scheduled for implementation effective July 1. Staff from the three regions, comprised of 24 counties, will be trained on how to use the online

CANS assessment tool.

Interviews. During the summer of 2016, interviews will be conducted with staff from the Phase II regions and counties. The interviews will be used to identify steps which were taken to engage them and prepare them to participate in *Safe at Home* West Virginia.

Cost analysis. Using data from FACTS, the costs of out-of-home care will be calculated for youth referred to *Safe at Home* during Phase I who incurred an out-of-home placement, comparing the maintenance costs for those youth to the comparison group. Program costs, such as start-up costs for wraparound facilitators and payments to the local coordinating agencies, will also be measured.

OCTOBER 2016

During the next review period, between October 1, 2016 and March 31, 2017 *Safe at Home* West Virginia will prepare to implement in the final 20 counties. Along with the baseline interviews which will be conducted in a sample of those counties, located in Regions I, III and IV, additional evaluation activities will also take place.

West Virginia has continued to move forward with Phase II implementation, which rolled out on August 1, 2016 and included the addition of 24 counties. HZA staff will travel to West Virginia in November 2016 to obtain interviews with stakeholders, including: DHHR central and regional office administrative staff, DHHR caseworkers, and staff from the contracted LCAs. Interviews will be obtained from stakeholders in both Phase I and Phase II counties; the first providing perspective on the program one year post-implementation, and the second allowing HZA to examine the successes and/or challenges of the Phase II roll out.

VI. Program Improvement Policies

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

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

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

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

West Virginia provides every youth who graduate or obtains a GED wile in foster care a computer and any needed software or accessories. We continue to work on advising them of their sibling's location. However, due to West Virginia's focus on relative/kinship placements, most of our foster youth are placed with siblings.

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

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

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

Attachments:

Hornby Zeller Associates, Inc. Case Review Tool
WV CANS work plan

Appendix A. Case Review Tool

WEST VIRGINIA TITLE IV-E WAIVER

WRAP-AROUND FIDELITY ASSESSMENT

CASE RECORD REVIEW INSTRUMENT

Case Number:	Family Name:
Child Client Number:	County: Region:
Reviewer:	Review Date:

FAMILY INFORMATION

1. Please describe the household members involved in the case, beginning with the child of primary concern.

Name	Role in Family	Date of Birth	Race/Ethnicity	Gender

Role Codes: 1 = Parent 2 = Child 3 = Other Relative 4 = Non-relative
Race Codes: 1 = Asian 2 = Black 3 = Hispanic 4 = White
5 = Mixed/Other
Gender Codes: 1 = Female 2 = Male

WRAP-AROUND CHRONOLOGY

Please provide dates of relevant activities; if the activity has not occurred indicate 05/05/1955.

2. Case opening date: _ _ / _ _ / _ _ _ _
3. Removal date (for primary child): _ _ / _ _ / _ _ _ _
4. Date of referral to wrap-around services: _ _ / _ _ / _ _ _ _
5. Date of initial family contact with wrap-around representative: _ _ / _ _ / _ _ _ _
6. Date of needs and strength assessment: _ _ / _ _ / _ _ _ _
7. Date of initial wrap-around plan: _ _ / _ _ / _ _ _ _
8. Dates of subsequent wrap-around plans (earliest to latest): _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
9. Date of initial crisis safety plan: _ _ / _ _ / _ _ _ _
10. Date of wrap-around closure/transition: _ _ / _ _ / _ _ _ _
11. Date of return home (of primary child): _ _ / _ _ / _ _ _ _
12. Case closing date: _ _ / _ _ / _ _ _ _

ENGAGEMENT AND TEAM PREPARATION PHASE

PREPARATION

13. Based on the information in the case record, please indicate the extent to which the engagement and team preparation included the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Care Coordinator Met with Family to Discuss Wraparound Process					
Care Coordinator Listened to Family's Concerns, Hopes, Dreams and Strengths					
Care Coordinator Made Provisional Crisis Plan if Needed					
Family Identified People to Attend Meeting to Develop Plan					

STRENGTHS AND NEEDS ASSESSMENT

14. Based on the information in the case record, please indicate the extent to which the assessment of the youth's and family's strengths and needs included the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Exposure to Potentially Traumatic/Adverse Childhood Experiences					
Symptoms Related to Traumatic/Adverse Childhood Experiences					
Child Strengths					
Life Domain Functioning					
Acculturation					
Child Behavioral/Emotional Needs					
Child Risk Behaviors					
Caregiver Needs and Strengths					

INITIAL PLAN DEVELOPMENT PHASE

INITIAL WRAP-AROUND PLAN DEVELOPMENT

15. Based on the information in the case record, please indicate the extent to which the development of the initial wrap-around plan included the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Active Participation of Child					
Active Participation of Immediate Family					
Active Participation of Extended Family/Relatives					
Active Participation of Friends/Neighbors					
Active Participation of Other Supports (e.g., Teacher, Clergy)					

Evidence of Family Voice and Choice					
Evidence of Child Voice and Choice					

INITIAL WRAP-AROUND PLAN CONTENT

16. Based on the information in the case record, please indicate the extent to which the initial wrap-around plan contains the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Family's Long Term Vision					
Mission Statement for the Team					
Goals Clearly Connected to the Vision					
Measurable Goals/Objectives					
Multiple Strategies					
Clear Relationship between Goals and Strategies					
Plan for Maintenance in or Transition to Least Restrictive Environment					
Opportunities for Youth to Engage in Community Activities					
Services/Supports Consistent with Youth's/Family's Culture					
Services/Supports Consistent with Youth's/Family's Primary Needs					
Services/Supports Take Account of and Use Youth's/Family's Strengths					

CRISIS SAFETY PLAN

17. Based on the information in the case record, please indicate the extent to which the ***latest*** crisis safety plan contains the following. Responses are:

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1	NA
Strategy for Crisis Prevention						
Identification of Behaviors Signaling Coming Crisis						
Methods for De-escalating Crises						
Steps to Be Taken during Crisis						
Assignment of Roles during Crisis						

PLAN IMPLEMENTATION PHASE

MOST RECENT WRAP-AROUND PLAN DEVELOPMENT

18. Based on the information in the case record, please indicate the extent to which the development of the most recent wrap-around plan or plan amendment included the following. Responses are:

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Active Participation of Child					
Active Participation of Family					
Active Participation of Extended Family/Relatives					
Active Participation of Friends/Neighbors					
Active Participation of Other Supports (e.g., Teacher, Clergy)					

MOST RECENT WRAP-AROUND PLAN CONTENT

19. Based on the information in the case record, please indicate the extent to which the most recent wrap-around plan or plan amendment contains the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Family's Long Term Vision					
Mission Statement for the Team					
Goals Clearly Connected to the Vision					
Measurable Goals/Objectives					
Multiple Strategies					
Clear Relationships among Strategies					
Plan for Maintenance in or Transition to Least Restrictive Environment					
Opportunities for Youth to Engage in Community Activities					
Services/Supports Consistent with Youth's/Family's Culture					
Services/Supports Consistent with Youth's/Family's Primary Needs					
Services/Supports Take Account of and Use Youth's/Family's Strengths					
Identification of Needs/Supports to Be Required after Termination of Wrap-around					

WRAP-AROUND SERVICE PROGRESS

20. Based on the information in the case record, please indicate the extent to which the following has occurred. Responses are:

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Family/Youth Successes Are Identified					
Natural Supports (Family/Friends/Others) Are Actually Providing Support					
Family and/or Youth Participate Actively in Decisions about Service/Support Direction and Methods					
Service Providers and/or Natural Supports Are Working Together					
Progress towards Goals/Action Steps Are Being Monitored					

TRANSITION PHASE

WRAP-AROUND SERVICE TRANSITION

21. Based on the information in the case record, please indicate the extent to which the following has occurred for youth/families terminating services. Responses are:

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Final Meeting, Celebration or Acknowledgement of Completion Takes Place					
Family Receives Record of Work Completed and Accomplishments					
Family Receives Information on Where to Go for Future Help					

Appendix B. Interview Protocols

WEST VIRGINIA TITLE IV-E WAIVER

PARENT INTERVIEW PROTOCOL

Interviewee Name:	Interviewer Name:
Date of Interview:	County:

ENGAGEMENT AND TEAM PREPARATION PHASE

1. Who explained the wraparound process to you?

    a. What kind of information did they share with you?

    b. Do you have a good understanding of how services will be coordinated? If no, why not?

2. To what extent are you and your youth encouraged to discuss your concerns, hopes, dreams, and strengths with the care coordinator?
    a. Did the care coordinator respond to what you were saying?
    b. Do other team members play a role in encouraging you and your youth to be active participants? If yes, how do they engage you to participate?

3. Did you tell the care coordinator about people you wanted to invite to attend the meeting to develop the wraparound plan?
    a. If yes, did those people participate?
    b. How did the care coordinator respond to your suggestions?

INITIAL PLAN DEVELOPMENT PHASE

4. What was your level of involvement in creating the wraparound plan? Do you feel that you should have had more input in the planning process?
    a. What types of things did you discuss when creating the plan?

5. To what extent has the wraparound plan been helpful in meeting the goals created for your youth and your family?
    a. If it has not been helpful, why do you think that is?

6. Were you involved in the creation of a crisis safety plan?
    a. If yes, did the care coordinator explain why it was created and what it entails?
    b. How helpful was the crisis safety plan in meeting your family's needs?

PLAN IMPLEMENTATION PHASE

7. Did the care coordinator help you to identify the successes your youth and your family have achieved?
    a. If yes, what are the successes?
    b. What steps are being taken to overcome barriers and challenges you and your youth face?

8. Are relatives, friends, and/or others providing support to you and your youth?
    a. If yes, what type of support are they providing?
    b. If no, what is impacting their ability to provide support?

9. Has your youth been an active participant in making decisions about services being offered and delivered through the wraparound plan?
    a. If yes, has his/her input been heard and incorporated into the plan?
    b. If no, why do you think that is?

TRANSITION PHASE

10. Was there a final meeting to acknowledge service completion for you and your youth?
    a. If yes, what took place during the final meeting?
    b. If yes, what kind of information was shared?

11. Did your youth receive a record of work completed and accomplishments that he/she has made?
    a. If yes, what did the record contain?
    b. If no, do you feel this would have been beneficial for your youth to receive?

12. Did you and your youth receive information on where to go for help in the future?
    a. If yes, what information was given to you?
    b. If no, was any transition information given to you?

WEST VIRGINIA TITLE IV-E WAIVER

TEAM MEMBER INTERVIEW PROTOCOL

Interviewee Name:	Interviewer Name:
Date of Interview	County:

RELATIONSHIP TO YOUTH

1. What is your role in developing and/or monitoring the wraparound plan?

ENGAGEMENT AND TEAM PREPARATION PHASE

2. How was the wraparound process explained to the youth and his/her family?
    a. Who was responsible for explaining the wraparound process to the youth and his/her family?
    b. What information was shared with them?
    c. Did they seem to have a good understanding of how services will be coordinated? If no, why?

3. To what extent are the youth and his/her family encouraged to discuss their concerns, hopes, dreams, and strengths?
    a. Did the care coordinator respond to what they were saying?
    b. Do other team members play a role in encouraging the youth and his/her family to be active participants? If yes, how do they engage family members to participate?

4. Did the youth and his/her family identify people they wanted to attend the meeting to help develop the wraparound plan?
    a. If yes, did those people participate?
    b. What efforts were made to ensure those people would participate?

5. How was the strengths and needs assessment used to develop a wraparound plan?

INITIAL PLAN DEVELOPMENT PHASE

6. What was your level of involvement in the creation of the wraparound plan?
    a. How involved was the family in the creation of the plan?

7. To what extent has the wraparound plan helped in meeting the goals of the youth and his/her family?
    a. If it has not been helpful, why do you think that is?

8. What was your level of involvement in the creation of a crisis safety plan?
    a. If a crisis safety plan was created, how helpful has it been in meeting the needs of the youth and his/her family?

9. Are there any ways to improve family involvement in the planning phase?

PLAN IMPLEMENTATION PHASE

10. Did the care coordinator help identify successes the youth and his/her family have achieved?
    a. If yes, what are the successes?
    b. What steps are being taken to overcome barriers and challenges the youth and family face?

11. How do you help to ensure that relatives, friends, and others are providing support to the youth and his/her family?

12. Is the care coordinator ensuring that the youth is actively participating in making decisions about services being offered and delivered through the wraparound plan?
    a. If yes, is his/her input being heard and incorporated into the plan?
    b. If the youth is not actively participating, why do you think that is?

13. Is the care coordinator monitoring the progress being made toward reaching the youth's and family's goals?
    a. How does the care coordinator help to ensure progress is being made?
    b. How do you help to ensure progress is being made?

TRANSITION PHASE

14. How did the care coordinator determine that the youth and his/her family were ready to end services?

15. Did the care coordinator hold a final meeting to acknowledge service completion for the youth and his/her family?
    a. If yes, what took place during the final meeting?
    b. If yes, what kind of information was shared?

16. Did the care coordinator present a record of work completed and accomplishments the youth has made?
    a. If yes, what did the record contain?
    b. If no, do you feel this would have been beneficial for the youth to receive?

17. Did the care coordinator present information on where the youth and his/her family can go for help in the future?
    a. If yes, what information was given to them?
    b. If no, was any transition information given to them?

WEST VIRGINIA TITLE IV-E WAIVER

WRAPAROUND FACILITATOR INTERVIEW PROTOCOL

Interviewee Name:	Interviewer Name:
Date of Interview:	County:

ENGAGEMENT AND PREPARATION PHASE

1. How was the wraparound program explained to the youth and his/her family?

    a. Who was responsible for explaining the wraparound program to the youth and his/her family?
    b. What information was shared with them?
    c. Did they seem to have a good understanding of how services will be coordinated? If no, why?

2. To what extent are the youth and his/her family encouraged to discuss their concerns, hopes, dreams, and strengths?
    c. Did you respond to what they were saying?
    d. Do other team members play a role in encouraging the youth and his/her family to be active participants? If yes, how do they engage family members to participate?

3. Did the youth and his/her family identify people they wanted to attend the meeting to develop the wraparound plan?
    a. If yes, did those people participate?

    b. What efforts were made to ensure that they would participate?

4. How did you use the strengths and needs assessment to develop a wraparound plan?
    a. Did you face any challenges in conducting the strengths and needs assessment? If yes, what were they and how did you address them?

INITIAL PLAN DEVELOPMENT PHASE

5. When you created the wraparound plan, did the youth and his/her family seem willing and interested to be involved?
    a. If yes, what types of things did you discuss with them?
    b. If no, how did you attempt to engage them?

6. To what extent has the wraparound plan been helpful in meeting goals for the youth and his/her family?
    a. If it has not been helpful, why do you think that is?

7. What was the family's level of involvement in the creation of the crisis safety plan?
    a. If a crisis safety plan was created, how helpful has it been in meeting the needs of the youth and his/her family?

8. Are there any ways to improve family involvement in the planning phase?

PLAN IMPLEMENTATION PHASE

9. How did you help identify successes the youth and his/her family have achieved?
    a. If yes, what are the successes?
    b. What steps are being taken to overcome barriers and challenges the youth and family face?

10. How do you help to ensure that relatives, friends, and others are providing support to the youth and his/her family?

11. How do you get the youth to be an active participant in decisions about services being offered and delivered though the wraparound plan?
    a. How do you use his/her input and incorporate it into the plan?
    b. If the youth is not actively participating, why do you think that is?

12. How are you monitoring the progress being made towards reaching the youth's and family's goals?
    a. How do you help to ensure that progress is being made?

TRANSITION PHASE

13. How did you determine that the youth and his/her family were ready to end services?

14. Did you hold a final meeting to acknowledge service completion for the youth and his/her family?
    a. If yes, what took place during the final meeting?
    b. If yes, what kind of information was shared?

15. Did you present a record of work completed and accomplishments that the youth has made?
    a. If yes, what did the record contain?
    b. If no, do you feel this would have been beneficial for the youth to receive?

16. Did you present information on where the youth and his/her family can go for help in the future?
    a. If yes, what information was given to them?
    b. If no, was any transition information given to them?

WEST VIRGINIA TITLE IV-E WAIVER

YOUTH INTERVIEW PROTOCOL

Interviewee Name:	Interviewer Name:
Date of Interview:	County:

ENGAGEMENT AND TEAM PREPARATION PHASE

1. Who explained the wraparound program to you?
    a. What kind of information did they share with you?
    b. Do you have a good understanding of how services will be coordinated? If no, what is missing?

2. To what extent are you and your family encouraged to discuss your concerns, hopes, dreams, and strengths with the care coordinator?
    c. Did the care coordinator respond to what you were saying?
    d. Do other team members play a role in encouraging you and your family to be active participants? If yes, how do they engage you to participate?

3. Did you tell your care coordinator about people you wanted to be at the meeting to develop your wraparound plan?
    a. If yes, did those people participate?
    b. How did the care coordinator respond to your suggestions?

INITIAL PLAN DEVELOPMENT PHASE

4. When your care coordinator created your wraparound plan, did you feel like he/she included you enough in the process?
    a. If yes, what types of things did you discuss?
    b. If no, what was missing?

5. To what extent has the wraparound plan helped you in meeting the goals that were created for you and your family?
    a. If it has not been helpful, why do you think that is?

6. Were you involved in the creation of a crisis safety plan?
    a. If yes, did the care coordinator explain why it was created and what it involves?
    b. How helpful was the crisis safety plan in meeting your family's needs?

PLAN IMPLEMENTATION PHASE

7. Did your care coordinator help you to identify successes you and your family have achieved?
    a. If yes, what are the successes?
    b. What steps are being taken to overcome barriers and challenges you and your family face?

8. Are relatives, friends, and others providing support to you and your family?
    a. If yes, what kind of support are they providing to you?
    b. If not, why do you think that is?

9. Are you actively helping to make decisions about the services you are receiving?
    a. If yes, do you feel that you have been heard and that your suggestions have been included in the plan?
    b. If no, why do you think that is?

TRANSITION PHASE

10. Was there a final meeting for you and your family to acknowledge service completion?
    a. If yes, what took place during the final meeting?
    b. If yes, what kind of information was shared?

11. Did you receive a record of the work you have completed and the accomplishments you have made?
    a. If yes, what did the record contain?
    b. If no, do you think it would have been beneficial for you to receive something like this?

12. Did you and your family receive information about where you could go for help in the future?
    a. If yes, what information was given to you?
    b. If no, did you receive any kind of information about what to do when services are finished?

Appendix C. Staff Survey

Safe at Home West Virginia

Staff Survey

Thank you for participating in this survey regarding *Safe at Home West Virginia*.

This survey is being conducted by Hornby Zeller Associates, Inc. (HZA), the contracted evaluator for West Virginia's Title IV-E Demonstration Project, to learn about your experiences with *Safe at Home* processes and services and your impressions of their effectiveness.

Your answers are confidential and will be shared only in aggregate form.

1. **Which position most closely represents your job title?**

   ☐ Caseworker
   ☐ Supervisor

2. **How long have you been in this position?**

   ☐ Less than a year
   ☐ 1-2 years
   ☐ 3-5 years
   ☐ More than 5 years

3. **Have long have you been with BCF?**

   ☐ Less than a year
   ☐ 1-2 years

- ☐ 3-5 years
- ☐ More than 5 years

4. **In what county do you work?** (drop down list)

5. **What is the highest level of education you completed?**

- ☐ High School or GED
- ☐ Associates
- ☐ Some College
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Higher than a Master's Degree

6. **In what field was your degree obtained?**

- ☐ Social Welfare
- ☐ Criminal Justice
- ☐ Public Health
- ☐ Education
- ☐ Child Care
- ☐ Other (*specify*): _____
- ☐ Not applicable

7. **Did you receive any type of training to prepare you for Wraparound or *Safe at Home West Virginia*?**

- ☐ Yes
- ☐ No

8. **To what degree did the training prepare you for your role in the program?**

- ☐ Very Well
- ☐ Somewhat
- ☐ Not Well

☐ Did not receive training

8a. If Somewhat or Not Well, what more was needed?

9. Did you receive certification to use the CANS?

☐ Yes
☐ No

10. How well did the CANS training prepare you to use the assessment tool?

☐ Very Well
☐ Somewhat
☐ Not Well
☐ Did not receive training

11. Did you participate in the training on how to use the online CANS tool?

☐ Yes
☐ No

12. How well did the training prepare you to use the online CANS tool?

☐ Very Well
☐ Somewhat
☐ Not Well
☐ Did not receive training

12a. If Somewhat or Not Well, what more was needed?

13. Do you receive or provide more or less supervision for *Safe at Home West Virginia* cases?

☐ More
☐ Same

☐ Less
☐ Not applicable. My caseload or my workers' caseload does not include qualifying cases.

13a. How frequently do you receive or provide supervision for *Safe at Home West Virginia* cases?

☐ Never
☐ Weekly
☐ Monthly
☐ Not applicable. My caseload or my workers' caseload does not include qualifying cases.

14. How many *Safe at Home* provider agencies have you worked with?

15. In thinking about your cases, or your worker's cases if you are a supervisor, to what extent do you agree with the following statements?

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
Safe at Home helps to reduce the number of children living out-of-state in congregate care facilities.	❍	❍	❍	❍	❍
Safe at Home helps to reduce the number of children living in West Virginia's congregate care facilities, whether in-state or out-of-state..	❍	❍	❍	❍	❍
Safe at Home helps to increase the number of children who can remain safely in their homes and communities.	❍	❍	❍	❍	❍
Referrals to *Safe at Home* adhere to the eligibility criteria.	❍	❍	❍	❍	❍
Family perspectives are elicited and prioritized in planning for children.	❍	❍	❍	❍	❍
The wraparound team consists of individuals	❍	❍	❍	❍	❍

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
agreed upon by the family.					
The wraparound team supports the family through formal, informal and community relationship.	❍	❍	❍	❍	❍
The team members work cooperatively, sharing in the responsibility for implementation and success.	❍	❍	❍	❍	❍
Services and support strategies take place in the least restrictive setting.	❍	❍	❍	❍	❍
Services and support strategies integrate the youth into his or her community.	❍	❍	❍	❍	❍
The wraparound process demonstrates respect for and builds on the values, presence, beliefs, culture, and identity of the children and their families.	❍	❍	❍	❍	❍
Planning is customized to strengths and needs of the children.	❍	❍	❍	❍	❍
The wraparound process and service plan build on and enhance the families' capabilities, knowledge, skills, and assets.	❍	❍	❍	❍	❍
Despite challenges, the team persists in helping the families to meet their goals.	❍	❍	❍	❍	❍
Goals and strategies are tied to observable or measurable indicators of success.	❍	❍	❍	❍	❍

16. In thinking about your cases, or your workers' cases, that qualify for the program, to what extent do you or your workers complete the following actions?

Referral Process	Always	Frequently	Seldom	Never	Not Applicable
Prepare *Safe at Home* West Virginia Wraparound referral form.	❍	❍	❍	❍	❍
Seek the approval of the Regional Program Manager.	❍	❍	❍	❍	❍
Link the qualifying child to the Local Coordinating Agency in FACTS.	❍	❍	❍	❍	❍

Make the referral to the Local Coordinating Agency by submitting the completed "*Safe at Home* West Virginia Wraparound Referral Form" along with the collected family history information.	❍	❍	❍	❍	❍
Provide the Local Coordinating Agency with information releases to assist in securing any additional information requested.	❍	❍	❍	❍	❍
Ensure that the assigned Wraparound Facilitator is added to the list of MDT participants and invited to meetings accordingly.	❍	❍	❍	❍	❍
Work in conjunction with the Wraparound Facilitator to schedule an initial home visit with the family.	❍	❍	❍	❍	❍
Ongoing Responsibilities	**Always**	**Frequently**	**Seldom**	**Never**	**Not Applicable**
Make face to face visits, at least monthly, to the family home.	❍	❍	❍	❍	❍
Monitor the safety plan.	❍	❍	❍	❍	❍
Ensure providers are delivering services as recommended.	❍	❍	❍	❍	❍
Work in collaboration with the Wraparound Facilitator to ensure the families' needs are addressed at every phase of the wraparound process and that the families remain engaged throughout.	❍	❍	❍	❍	❍
Participate in monthly family meetings with the Wraparound Facilitator or more frequently as needed.	❍	❍	❍	❍	❍
Attend any meeting that is scheduled due to a disruption of the wraparound plan.	❍	❍	❍	❍	❍

17. What do you see as working well with the *Safe at Home* initiative?

18. Do you have any suggestions for changes or improvements?

19. What other services, if any, are needed to increase the effectiveness of *Safe at Home West Virginia*?

20. Do you have any other thoughts about *Safe at Home*?

Thank you for participating in the survey. Your input is very valuable.

SUBMIT

Appendix D. Quality of Treatment and Comparison Group Match

Table D-1. Quality of Match for Out-of-State Congregate Care Referrals (*n* = 30)					
Category	**Characteristic**	**Treatment Group**	**Comparison Group**	**Test Statistic**	**Significance (two-tailed)**
Age	Age at Referral	14.9	14.7	0.515	0.476
Gender	Percent Male	80.0	80.0	*	1.000
Race	Percent White	83.3	80.0	*	1.000
	Percent Black	26.7	30.0	*	1.000
Placement	Percent in Group Residential	66.7	83.3	*	0.233
Case History	Yrs Since Case Open	1.9	1.3	2.374	0.129
	Yrs Since Removal	1.7	1.1	2.050	0.158
	# Prior Removals	0.13	0.13	0.000	1.000
	# Placements (current removal)	3.6	2.6	1.448	0.234
	Yrs in Congregate Care	1.2	0.9	1.160	0.286
	Yrs Out of State	1.1	0.9	1.796	0.185
Removal Reasons	Parent Incarcerated	6.7	3.3	*	1.000
	Parent Alcohol	3.3	0.0	*	1.000
	Child Behavior	76.7	83.3	*	0.748
	Parent Drugs	10.0	6.7	*	1.000
	Neglect	6.7	3.3	*	1.000
	Physical Abuse	16.7	13.3	*	1.000
	Sexual Abuse	6.7	0.0	*	0.492
Mental Health Indicators	Axis I Diagnosis	93.3	86.7	*	0.671
	GAF	56.7	53.3	*	1.000
	Psych Facility	36.7	20.0	*	0.252
	Group Care	80.0	90.0	*	0.472
Juvenile Justice Indicators	Axis IV JJ Mention	56.7	56.7	*	1.000
	JJ Removal	76.7	80.0	*	1.000
	Detention	23.3	20	*	1.000

Table D-2. Quality of Match for In-State Congregate Care Referrals (*n* = 37)					
Category	**Characteristic**	**Treatment Group**	**Comparison Group**	**Test Statistic**	**Significance (two-tailed)**
Age	Age at Referral	15.2	15.1	0.080	0.778
Gender	Percent Male	59.5	62.2	*	1.000
Race	Percent White	91.9	91.9	*	1.000
	Percent Black	18.9	8.1	*	0.308
Placement	Short Term Psychiatric	2.7	2.7	0.321	0.852
	Long Term Psychiatric	18.9	24.3		
	Group Care	78.4	73.0		
Case History	Yrs Since Case Open	1.7	1.8	0.145	0.704
	Yrs Since Removal	0.9	0.9	0.000	0.991
	# Prior Removals	0.6	0.4	1.409	0.239
	# Placements (current removal)	2.5	2.7	0.063	0.802
	Yrs in Congregate Care	0.7	0.7	0.043	0.837
	Yrs Out of State	0.0	0.0	-	-
Removal Reasons	Caretaker Ill/Unable to Cope	2.7	5.4	*	1.000
	Child Behavior	86.5	75.7	*	0.374
	Child Disability	2.7	0.0	*	1.000
	Child Drugs	5.4	5.4	*	1.000
	Parent Drugs	2.7	5.4	*	1.000
	Inadequate Housing	2.7	0.0	*	1.000
	Neglect	5.4	5.4	*	1.000
	Voluntary	2.7	5.4	*	1.000
Mental Health Indicators	Axis I Diagnosis	89.2	91.9	*	1.000
	GAF	51.4	37.8	*	0.350
	Psych Facility	37.8	29.7	*	0.624
	Group Care	89.2	89.2	*	1.000
Juvenile Justice Indicators	Axis IV JJ Mention	16.2	16.2	*	1.000
	JJ Removal	89.2	94.6	*	0.674
	Detention	24.3	21.6	*	1.000

Table D-3. Quality of Match for Emergency Shelter Referrals (*n* = 6)					
Category	**Characteristic**	**Treatment Group**	**Comparison Group**	**Test Statistic**	**Significance (two-tailed)**
Age	Age at Referral	14.1	14.2	0.010	0.923
Gender	Percent Male	50.0	33.3	*	1.000
Race	Percent White	100.0	100.0	-	-
	Percent Black	16.7	16.7	*	1.000
Placement	Short Term Psychiatric	2.7	2.7	0.321	0.852
	Long Term Psychiatric	18.9	24.3		
	Group Care	78.4	73.0		
Case History	Yrs Since Case Open	0.9	0.5	0.404	0.539
	Yrs Since Removal	0.5	0.3	0.354	0.565
	# Prior Removals	0.5	0.5	0.000	1.000
	# Placements (current removal)	2.8	2.2	0.354	0.565
	Yrs in Congregate Care	0.3	0.2	0.053	0.822
	Yrs Out of State	0.0	0.0	-	-
Removal Reasons	Child Behavior	83.3	66.7	*	1.000
	Neglect	16.7	33.3	*	1.000
Mental Health Indicators	Axis I Diagnosis	100.0	100.0	-	-
	GAF	50.0	33.3	*	0.350
	Psych Facility	33.3	16.7	*	1.000
	Group Care	33.3	16.7	*	1.000
Juvenile Justice Indicators	Axis IV JJ Mention	0.0	0.0	-	-
	JJ Removal	83.3	66.7	*	1.000
	Detention	16.7	16.7	*	1.000

Table D-4. Quality of Match for Preventive/FC Referrals (*n* = 2)					
Category	**Characteristic**	**Treatment Group**	**Comparison Group**	**Test Statistic**	**Significance (two-tailed)**
Age	Age at Referral	15.0	14.8	0.004	0.957
Gender	Percent Male	50.0	50.0	*	1.000
Race	Percent White	100.0	100.0	-	-
	Percent Black	0.0	0.0	-	-
Case History	Yrs Since Case Open	1.9	1.5	0.083	0.800
	Yrs Since Removal	1.8	7.0	0.606	0.518
	# Prior Removals	0.0	0.0	-	-
	# Placements (current removal)	10.5	3.5	0.421	0.583
	Yrs in Congregate Care	1.1	0.3	0.468	0.534
	Yrs Out of State	0.0	0.0	-	-
Removal Reasons	Child Behavior	50.0	50.0	*	1.000
	Relinquish	50.0	50.0	*	1.000
Mental Health Indicators	Axis I Diagnosis	100.0	100.0	-	-
	GAF	50.0	100.0	*	1.00
	Psych Facility	50.0	0.0	*	1.000
	Group Care	50.0	50.0	*	1.000
Juvenile Justice Indicators	Axis IV JJ Mention	50.0	0.0	*	1.000
	JJ Removal	50.0	50.0	*	1.000
	Detention	50.0	0.0	*	1.000

Table D-5. Quality of Match for Preventive/IH Referrals (n = 45)					
Category	**Characteristic**	**Treatment Group**	**Comparison Group**	**Test Statistic**	**Significance (two-tailed)**
Age	Age at Referral	15.1	15.2	0.309	0.580
Gender	Percent Male	57.8	55.6	*	1.000
Race	Percent White	86.7	93.3	*	0.485
	Percent Black	15.6	4.4	*	0.157
Case History	Yrs Since Case Open	0.8	0.8	0.004	0.949
	Ever Removed	51.1	46.7	*	0.833
	# Prior Removals	0.67	0.51	1.104	0.307
	# Placements	1.3	1.3	0.003	0.957
	Ever in Congregate Care	33.3	31.1	*	1.000
	Ever Placed Out of State	20.0	22.2	*	1.000
Mental Health Indicators	Axis I Diagnosis	73.3	71.1	*	1.000
	GAF	20.0	17.8	*	1.000
	Psych Facility	17.8	15.6	*	1.000
	Group Care	26.7	26.7	*	1.000
Juvenile Justice Indicators	Axis IV JJ Mention	42.2	40.0	*	1.000
	JJ Removal (ever)	57.8	53.3	*	0.832
	Detention	4.4	6.7	*	1.000

West Virginia CANS Strategic Plan

OUTCOMES AND STRATEGIES	Lead		2RD QUARTER Jan. 2016- Mar. 2016	3RD QUARTER Apr. 2016- Jun. 2016	4th QUARTER Jul. 2016- Sept. 2016	Looking Forward Oct. 2016 - June 2018	NOTES
GOAL 1: 100% OF YOUTH SERVICES STAFF TRAINED AND CERTIFIED ON CANS BY SEPTEMBER 2016							
OBJECTIVE 1: Youth Service Staff will be implementing CANS by 9/30/16							
1. Identify the number of Youth Services staff that will need to receive training and certification.	E. Strickland		**Feb 28, 2016**				Create and maintain a list of those that must attend training and certification, AND those that Attend/Certify
2. Establish Training Dates	E. Strickland T. Pearson		**Mar 15, 2016**				
3. Establish Training Commitment from ACEs	T. Pearson		**Mar 15, 2016**				Plan for developing the TA for DHHR is completed.
4. Set up and Provide FACTS Registration and Notification to Staff	E. Strickland		**Mar 15, 2016**				
5. Coordinate Logistics/Training/ Materials/Equipment	Elva Strickland		**Mar 15, 2016**				
6. Provide Weekly Notification of Training Registration	T. Pearson E. Strickland		Ongoing				
7. Provide bi-weekly notifications of trainees certification to RD's/Training Division	T. Pearson E. Strickland		On-going				

8. Summarize the Training Evaluations	Jennifer Lane		On-going				Completed within 5 days of receipt
OBJECTIVE 2: Provide Technical Assistance and support needed to build internal expertise and capacity within youth services by 9/30/16							
1. Develop Letter of Understanding (LOA) Between ACEs and SOC for Training/Technical Assistance	T. Pearson S. Fry L. Dalyai BCF Manag.			May 15, 2016			Final approval by BCF Management ACEs to serve 1-2 counties * Policy needs implemented/Staff can start using CANS.
2. Develop Technical Assistance Protocol (Expectation, Cost, dates, locations etc.)	Tammy Pearson Susan Fry Linda Dalyai			May 15, 2016			
3. Identify ACEs willing to provide Technical Assistance	Tammy Pearson Susan Fry			May 15, 2016			
4. Develop criteria for CANS Experts to assist in TA efforts if they meet certain criteria.				May 15, 2016			
5. Secure Commitment of ACEs	Tammy Pearson Susan Fry			May 15, 2016			
6. Present Technical Assistance Plan to RDs, CWCs, PMs, and DCs.	Linda Watts			May 15, 2016			
7. Roll Out and Monitor Technical Assistance	Linda Dalyai				July 2016		
8. Re-Evaluate Every 60 Days	Linda Watts/ CANS Planning Committee			June 30, 2016	August 30, 2016	Nov 30, 2016	
GOAL 2: 100% OF ALL CHILD PROTECTIVE SERVICES STAFF TRAINED AND CERTIFIED BY DECEMBER 2016							
OBJECTIVE 1: CPS Staff will be implementing CANS and/or FAST by 12/31/165							

1. Identify the number of CPS staff that will need to receive training and certification.	Elva Strickland			June 15, 2016			Create and Maintain a list of those that must attend training and certification, AND those that Attend/Certify
2. Establish Training Dates	E. Strickland T. Pearson			June15 , 2016			
3. Establish Commitment of ACEs	Tammy Pearson			June 15, 2016			**SEE GOAL 1: OBJECTIVE 1 FOR COMPLETION DATE**
4. Set up and Provide FACTS Registration and Notification to Staff	Elva Strickland			June 15, 2016			
5. Develop Letter of Understanding (LOA) Between ACEs and SOC for Training/Technical Assistance	T. Pearson S. Fry L. Dalyai BCF Manag.			June 15, 2016			**SEE GOAL 1: OBJECTIVE 1 FOR COMPLETION DATE**
6. Coordinate Logistics/Training/ Materials/Equipment	Elva Strickland			June 15, 2016			
7. Provide Weekly Notification of Training Registration	Tammy Pearson			On-going			
8. Provide bi-weekly notifications of trainees certification to RD's/Training Division	Tammy Pearson			On-going			
9. Summarize the Training Evaluations	Jennifer			On-going			Within 5 days of receipt
OBJECTIVE 2: TECHNICAL ASSISTANCE PROTOCOL TO BUILD BCF INTERNAL CAPACITY FOR CHILD PROTECTIVE SERVICES							
1. Develop Technical Assistance Protocol (Expectation,	T. Pearson S. Fry L. Dalyai				July 1, 2016		**SEE GOAL 1: OBJECTIVE 2 FOR COMPLETION DATE**

Cost, dates, locations etc.)							
2. Identify ACEs willing to provide Technical Assistance	T. Pearson S. Fry				July 1, 2016		
3. Develop criteria for CANS Experts to assist in TA efforts if they meet certain criteria.	T. Pearson S. Fry				July 1, 2016		
4. Secure Commitment of ACEs	L. Watts				July 1, 2016		
5. Present Technical Assistance Plan to RDs, CWCs, PMs, and DCs.	L. Dalyai				July 1, 2016		
6. Roll Out and Monitor Technical Assistance	L. Dalyai CANS Planning Committee				Augus t 2016		
7. Re-Evaluate Every 60 Days	L. Watts CANS Planning Committee				On-going		
GOAL 3: : IDENTIFY AND INTEGRATE ASSESSMENT TOOLS FOR SCREENING MENTAL HEALTH SERVICES AND ADULT SERVICES BY SEPTEMBER 2016							
OBJECTIVE 1: IDENTIFY AND INTEGRATE ASSESSMENT TOOLS FOR SCREENING MENTAL HEALTH SERVICES AND ADULT SERVICES BY 9/30/16							
1. OBTAIN AND STUDY ANSA TOOL AND PROVIDE RECOMMENDATIO N TO BCF MANAGEMENT TEAM	Internal DHHR Committee (Tools)				July 2016		
2. Develop a CANS Screener for identification for MH Services	S. Fry CANS Planning Committee				Augus t 30, 2016		

GOAL 4: DEVELOP CERTIFICATION AND RECERTIFICATION PROCESS FOR BCF STAFF BY DECEMBER 2016							
OBJECTIVE 1: DEVELOP CERTIFICATION AND RECERTIFICATION PROCESS FOR BCF STAFF							
1. Develop Expectations for Certification/ Recertification	CANS Planning Team		**March 31, 2016**				Use Best Practice standard. Determine what happens if staff do not meet standard established.
2. Cross Walk personnel lists to those that have trained and certified and identify if they met the 70% reliability to be eligible to utilize the CANS.	Elva Strickland		April 29, 2016				Certification is on the Praed Foundation Website.
3. Identify how we will track/monitor those that need to certify/re-certify.	Tammy Pearson		April 29, 2016				Identify 1 Regional Coordinator per each DHHR Region; Using coupons for certification/recertificatio n
4. Establish Ongoing Technical Assistance for 2016 and beyond	CANS Planning Team			June 30, 2016			Work jointly with DHHR Regional Directors.
5. Develop a plan to sustain the Certification /Recertification Process within WV.	CANS Planning Team					Dec 31, 2016	To sustain CANS Certification
6. Integrate CANS Training into BCF New Worker Training Protocol.	S. Richards E. Strickland; T. Pearson;				July 31, 2016		
GOAL 5: BCF WILL HAVE 15 DHHR CANS EXPERTS TRAINED AND PROVIDING TECHNICAL ASSISTANCE BY March 2017							
OBJECTIVE 1: BUILD CAPACITY FOR DHHR CANS EXPERTS							
1. Identify those that trained and received the 75% reliability to consider eligibility	Elva Strickland		**March 31, 2016**				Initially consider 4 Regional (one person from each region; 2 from state office; 3 from training division; and 2 DPQI.

as CANS Advanced Experts							** Every Supervisor will be required to become a CANS Expert*
2. Prepare for the CANS Experts Training – homework, website review, etc.	Advance CANS Experts		**March 31, 2016**				
3. Identify DHHR staff those that trained and received the 75% reliability	Elva Strickland		**March 31, 2016**				
4. Identify Current Advanced Cans Experts (Aces) Willing To Support And Provide Technical Assistance to DHHR	Susan Fry		**March 31, 2016**				
5. Attend the May 2016 CANS Training for New CANS Advanced Experts	Susan Fry DHHR ACEs			May 2016			
6. Explore Higher Education Support of CANS in Curriculum and Certification Process	Susan Richards Elva Strickland Linda Dalyai					Dec 1, 2016	This conversation should also include Trauma Awareness and Informed Practice and Interviewing Skill Development
GOAL 6: BCF WILL ESTABLISH THRESHOLDS (ALGORITHMS)/TOTAL COMMUNICATION OUTCOME MANAGEMENT (TCOM) BY JUNE 2017							
OBJECTIVE 1: ESTABLISH THRESHOLDS (ALGORITHMS)/TOTAL COMMUNICATION OUTCOME MANAGEMENT (TCOM)							
1. Initial Comparison (Cross Walk) of the WV CANS Algorithms to SAH cases.	Susan Fry			May 1, 2016			Algorithms and automated feedback are specified for each key decision-point in service/support process
2. Discuss CANS Algorithms with Key Stakeholders	Planning Team FACTS Hornsby/Zeller			June 30, 2016			TCOM – look at Washington State and what they've done
3. Review Scoring for Comparison Cases	Susan Fry			May 1, 2016			

and Develop a Subjective Decision Tree							
GOAL 7: BCF WILL STREAMLINE YOUTH SERVICES TOOLS by SEPTEMBER 2016							
OBJECTIVE 1:							
1. BCF will Review/Recommend Tools to be used in Youth Services Cases	Internal DHHR Tool Committee		Apr 29, 2016				* Need Safety Checklist
GOAL 8: BCF WILL STREAMLINE CHILD PROTECTIVE SERVICES TOOLS BY DECEMBER 2016							
OBJECTIVE 1:							
1. BCF will Review/Recommend Tools to be used in Child Protective Services Cases	Internal DHHR Tool Committee						Map the FFA and PCFA to the CANS using FAST. NOTE – Tennessee and Washington State both use the FAST as their safety assessment.
GOAL 9: BCF WILL DEVELOP POLICY AND PROTOCALS THAT SUPPORT CANS IMPLEMENTATION BY							
OBJECTIVE 1:							
1. Develop and Distribute policy and Memorandums that Support CANS Implementation	Linda D, Elva S, Carla Harper (Policy Staff)			May 15, 2016			Complete YLS-CMI first, use results to inform the CANS. NOTE – Tennessee implemented YLS and CANS also.
2. Develop Standard Operating Procedures, Training Manual.	CANS Planning Team			June 30, 2016			Include Certification/Recertification and use of coupons.
3. Develop a training curriculum that will guide workers on how to use CANS into case work planning	Susan Fry – sub committee			June 30, 2016			
GOAL 10: CANS WILL BE FULLY AUTOMATED INTO THE FACTS SYSTEM BY JUNE 2017							
OBJECTIVE 1:							
1. Hornby Zeller Associates, Inc. develops CANS software to capture the CANS information across participating agencies and DHHR staff.	Hornsby/Zeller CANS Planning Team						The Software will have built-in security based on level of use/administrative duties. The software will include the ability to generate Data Reports.
2. FACTS Redesign will include re-	FACTS						Change language in YBE FACTS screens

design of YBE screens	CANS Planning Team						
3. FACTS Redesign will include new screens to fully capture CANS Tool/Information	FACTS CANS Planning Team						Build in Sub-modules
4. FACTS Redesign will include an interface with FACTS that those external to BCF can inter and extract CANS information	FACTS CANS Planning Team CANS ACEs						
5. Collaborative assessment and treatment planning documentation integrated with FACTS system; reports available with test/simulated data	Internal DHHR FACTS CANS Planning Team						
GOAL 11: IMPLEMENT SUSTAINABILITY PLAN BY							
OBJECTIVE 1:							
1. Develop Sustainability Plan	CANS Planning Team				July 2016		Build Internal Capacity
2. Identify and develop CANS Experts						June 2018	
3. Identify and develop Advanced CANS Experts						June 2018	
GOAL 12: ALL CLIENTS WILL HAVE OPPORTUNITY TO EVALUATE FAMILY ENGAGEMENT USING CANS BY ….							
OBJECTIVE 1: FAMILY ENGAGEMENT USING THE CANS TOOL WILL BE BUILT INTO THE BCF DPQI PROCESS							
1. DPQI WILL EVALUATE FAMILY ENGAGEMENT USING CANS	Susan Richards Jane McCallister					On-going	