Safe at Home West Virginia

West Virginia's Title IV-E Waiver Initiative

INTERIM EVALUATION REPORT

Produced by Hornby Zeller Associates, Inc.

May 2018

Contents

WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Executive Summary

Prior to the implementation of *Safe at Home* West Virginia, the State was facing a growing number of children and youth entering its foster care system, with a substantial portion being placed in congregate care. In fiscal year 2012, the entry rate in West Virginia was 8.6 per 1,000 children in the population, which was nearly three times the national rate (3.3).[1] Youth ages 12 to 17 were the hardest hit, making up nearly half (46%) of the children who entered care during fiscal year 2013.[2] Of the 1,488 youth between 12 and 17 years old, 71 percent were placed in congregate care.[3]

On October 1, 2015, the West Virginia Department of Health and Human Resources implemented the Title IV-E Waiver initiative *Safe at Home* West Virginia. The initiative is designed to accomplish a number of goals to address the safety, permanency and well-being of the State's youth.

- Increase the number of children staying in their home communities
- Reduce initial foster care entry rates
- Increase youth safety as demonstrated by decreased rates of maltreatment/repeat maltreatment
- Improve the well-being of children 12 to 17 years of age as demonstrated through educational achievement and increased numbers graduating high school
- Improve academic progress of children 12 to 17 years of age by keeping them in the same school
- Reduce the reliance on congregate care
- Decrease the length of stay in congregate care for children 12 to 17 years of age
- Improve family functioning to support reunification
- Reduce the number of children entering any form of foster care.

West Virginia contracted with Hornby Zeller Associates, Inc. (HZA), through a competitive bid process, to complete a process, outcome and cost evaluation of *Safe at Home*. HZA is using a mixed method approach to answer the evaluation questions. Qualitative data collected through interviews and surveys inform the results of the quantitative analyses. Quantitative data sources included extracts from West Virginia's statewide automated child welfare information system, FACTS, data from Child and Adolescent Needs and Strengths (CANS) assessments, and a manual review of case records and survey questions.

[1] West Virginia Department of Health and Human Resources, Initial Design and Implementation Report, August 2015, p.5.
[2] *Ibid,* p.3.
[3] *Ibid,* p.3.

Summary of Results

Process Evaluation Results

Initial planning for *Safe at Home* West Virginia focused on the development of guidance documents for the program, collaborating with Local Coordinating Agencies (LCAs) and communicating with community partners, including judges. Outreach and transparency represented continuous efforts throughout the implementation period. The first phase was implemented in October 2015 and the second phase in August of the following year; as of April 2017 the program has been fully implemented statewide. Administrative oversight has been provided at all levels of DHHR as well as internally by the LCAs themselves. Oversight has included holding LCAs accountable for assessing the strengths and needs of youth and their families and providing the services they families need to be successful. The program is running smoothly overall, so planning efforts have shifted toward program sustainability.

Safe at Home is based on the principles of the Wraparound model and fidelity to the model has been good overall. Both LCAs and DHHR have generally conformed to the requirements for each phase of wraparound. Fidelity scores improved as wraparound facilitators became more engaged with the youth and families. Youth and their families have been encouraged to be actively involved, building on their strengths in planning, and have reported progress on and/or achievement of goals from being involved in the program.

There have been some barriers encountered along the way that needed to be addressed. Initial confusion about the roles of DHHR and LCA staff was resolved through training and policy changes. An issue about the appropriateness of some referrals was also identified and resolved early in the implementation process. Barriers, including the lack of consistent motivation among youth and their families and available services in some areas, have remained challenging.

There have been a number of successes as well. Stakeholder buy-in has increased, including that of judges. This has been echoed by a change in how DHHR engages families, both within *Safe at Home* and more generally. Some staff have witnessed a positive organizational shift in the way DHHR and LCAs engage families. One regional office interviewee said, “I think it has changed the overall way we do business and what it means to involve families in case planning. Informal supports are better understood. I tell staff that we should be using the same concepts and supports we have built through *Safe at Home* regardless of whether or not the child or youth is in the program.”

Safety and Permanency Outcome Evaluation Results

The biggest success has been in returning many of the youth who had been in congregate care placements to their communities, leading to a policy change in program eligibility. Eligibility has now been extended from youth ages 12 to 17 with a behavioral or mental health diagnosis placed (or at risk of being placed) in congregate care to include at-risk youth who possibly have a behavioral or mental health diagnosis. This change is an indication of the program’s shift to a prevention focus of keeping youth safe at home.

Overall, *Safe at Home* outcomes follow an interesting pattern where treatment youth perform better than comparison groups for the first six months, but the successes dissipate by twelve months. As noted in the limitations section, there are no data for youth in the comparison group with a possible mental health diagnosis which may be influencing the result. Consequently, it is not possible to know if the severity of mental health issues explains the lack of difference in results a year after service begins.

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

Well-Being Outcome Evaluation Results

The well-being of youth in *Safe at Home* has shown dramatic improvement. Examination of the CANS assessments have shown that for youth with a six-month CANS follow-up, over half of the youth with at least one actionable item on the initial CANS had improved. Furthermore, for youth with a 12-month CANS follow-up, three-fourths show improvement from the initial CANS. This was true in the Child Behavioral/Emotional Needs, Child Risk Behaviors, Life Domain Functioning, and Trauma Stress Symptoms domains.

The exception is in the School Functioning domain, where improvement has not been as substantial. A quarter of Safe at Home youth showed improvement in school achievement, attendance and general behavior at school after six months. The proportion was less than ten percent at twelve months. Little impact was demonstrated for school violence in either timeframe.

There was also some improvement in the Family Functioning domain. While family stress and residential stability were reduced at twelve months from that at six months, the other measures were maintained between six and twelve months. Specifically, the same number of *Safe at Home* youth who showed improvement in physical health, mental health and substance use at six months showed improvement twelve months after the initial CANS assessment.

Cost Evaluation Results

The program has generated a cost savings of nearly $7,000 per child in foster care in room and board costs and a savings of nearly $750 per child receiving fee-for-services for *Safe at Home* youth referred in the first year and a half of implementation. The most significant portion of these savings can be attributed to the reduced time youth spend in congregate care facilities. As noted above, costs to contract with wraparound service providers averages $42,346 per youth. While the overall costs for treatment youth are greater than those in the comparison group, *Safe at Home* youth are receiving services which are beyond those which can normally be provided. Some of the additional costs should be offset by DHHR caseworkers spending less time on cases, which has yet to be examined.

Evaluation Lessons Learned and Recommendations

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

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

Next Steps

With West Virginia's *Safe at Home* program slated to end September 30, 2019, evaluation efforts will continue on a semi-annual basis. A third round of fidelity reviews is scheduled for the summer of 2018, with another round of surveys also to be administered close to the end of the calendar year. Data from FACTS will continue to be examined to measure outcomes and identify the types of youth for whom *Safe at Home* is most successful. Efforts are also being made to expand the cost evaluation to identify the funding sources which would have traditionally been used to support the services provided to youth, as a step toward identifying the fiscal impact of sustaining and even expanding *Safe at Home* to younger children across West Virginia. Costs which should be offset by DHHR caseworkers spending less time on cases will also be examined.

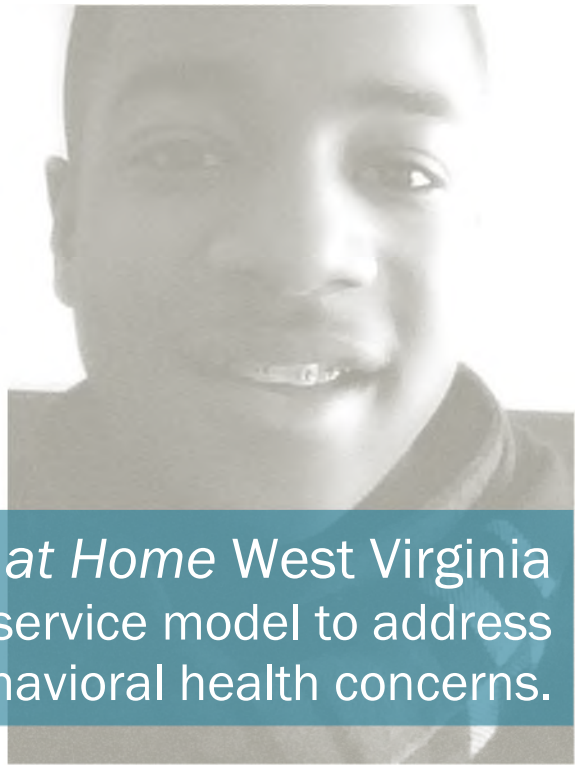
Introduction and Overview

Background and Context

Prior to the implementation of *Safe at Home* West Virginia, the State was facing a growing number of children and youth entering its foster care system, with a substantial portion being placed in congregate care. In fiscal year 2012, the entry rate in West Virginia was 8.6 per 1,000 children in the population, which was nearly three times the national rate (3.3).[4] Youth ages 12 to 17 were the hardest hit, making up nearly half (46%) of the children who entered care during fiscal year 2013.[5] Of the 1,488 youth between 12 and 17 years old, 71 percent were placed in congregate care.[6]

The West Virginia Department of Health and Human Resources (DHHR) received Title IV-E Waiver grant monies to implement a behavioral health approach, employing a wraparound service model to address the concern. *Safe at Home* West Virginia is designed to return youth who are placed outside of the State to West Virginia and to shorten the length of stay of youth in care. The initiative also encompasses the needs of youth who live in the community, with the idea that wraparound services would enable them to remain in their homes.

DHHR contracts with Local Coordinating Agencies (LCAs), which are licensed behavioral health care agencies, to provide these wraparound services to eligible youth and their families. The LCAs developed Memoranda of Understanding with other community service agencies to provide several of the services needed by youth and their families within their own communities. They are also responsible for hiring and maintaining wraparound facilitators who are responsible for leading child and family teams to develop individualized service plans through the wraparound process.



Safe at Home West Virginia employs a wraparound service model to address youths' behavioral health concerns.

[4] West Virginia Department of Health and Human Resources, Initial Design and Implementation Report, August 2015, p.5.
[5] *Ibid,* p.3.
[6] *Ibid,* p.3.

Purpose of the Waiver Demonstration

Implemented October 1, 2015, *Safe at Home* West Virginia is designed to accomplish a number of goals to address the safety, permanency and well-being of the State's youth.

- Increase the number of children staying in their home communities
- Reduce initial foster care entry rates
- Increase youth safety as demonstrated by decreased rates of maltreatment/repeat maltreatment
- Improve the well-being of children 12 to 17 years of age as demonstrated through educational achievement and increased numbers graduating high school
- Improve academic progress of children 12 to 17 years of age by keeping them in the same school
- Reduce the reliance on congregate care
- Decrease the length of stay in congregate care for children 12 to 17 years of age
- Improve family functioning to support reunification
- Reduce the number of children re-entering any form of foster care.

Evaluation Framework

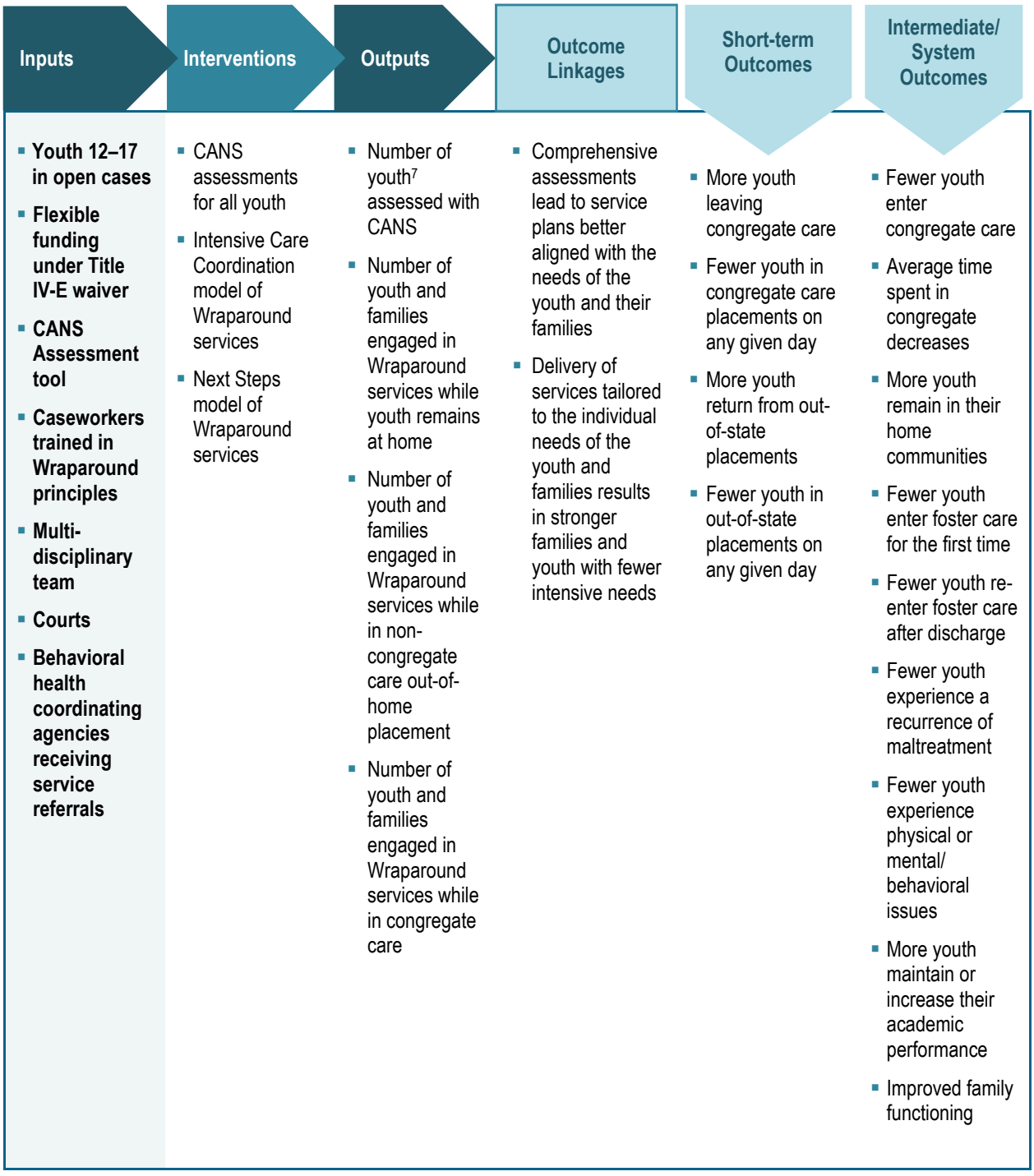
Evaluation Overview

Hornby Zeller Associates, Inc. (HZA) was contracted by DHHR to conduct the evaluation of *Safe at Home* West Virginia. The evaluation has three components: a process evaluation, an outcome evaluation and a cost evaluation. A comprehensive evaluation plan was provided to the Administration for Children and Families in September 2015, and subsequently approved. The plan was developed to determine the extent to which intended outcomes are achieved, determine the population(s) for which the interventions have been most effective, determine the cost effectiveness of the approach, and identify barriers which may have limited the success of the project in achieving the desired outcomes.

Theory of Change/Logic Model

To illustrate the conceptual linkages between the Waiver demonstration activities and the measurable short-term, intermediate and long-term outcomes, HZA developed the logic model displayed below to illustrate the theory of change.

Safe at Home West Virginia Logic Model



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

Data Sources and Data Collection Methods

HZA is using a mixed method approach to answer the process, outcome and cost evaluation questions. Qualitative data collected through interviews and surveys inform the results of the quantitative analyses. Quantitative data sources included extracts from West Virginia's statewide automated child welfare information system, FACTS, data from Child and Adolescent Needs and Strengths (CANS) assessments, a manual review of case records and survey questions.

A brief summary of the various data collection methods is provided below.

Stakeholder Interviews

HZA conducts interviews with DHHR staff, including central office administrators, regional office staff, community service managers (CSMs),[8] supervisors and caseworkers annually to learn about the successes and challenges of implementing *Safe at Home*. Yearly stakeholder interviews have also been conducted with LCA staff, including program directors, wraparound supervisors and wraparound facilitators, to gain their perspectives about the program. HZA interviewed judges as well. Protocols are tailored to each stakeholder group with open-ended questions used to prompt discussion about the implementation process and how well fidelity has been maintained to the Wraparound model and the *Safe at Home* program. While every attempt is made to conduct interviews in person, the evaluation team found that, following completion of the baseline interviews which all were conducted onsite, it was sometimes necessary to use telephone interviews to accommodate stakeholders' schedules.

Case Reviews

Data for the fidelity assessment have been gathered in part through onsite reviews for a sample of youth served by *Safe at Home* West Virginia. Forty *Safe at Home* cases are randomly selected each year as part of the fidelity assessment, with the number of cases selected for review within each contracted LCA proportional to the number of youth served by that agency. HZA conducts interviews with youth, caregivers, wraparound facilitators and caseworkers as part of the process of determining the extent to which the program has been implemented as intended. HZA developed a case record review tool to collect data on the timeliness and completeness of Wraparound model components. such as the wraparound plan and crisis safety plan. HZA developed interview protocols for each stakeholder group, including open-ended questions, to learn about how well fidelity has been maintained to the Wraparound model at the case level.

The case review tool assesses fidelity to specific requirements of the Wraparound plan. These include the consistency of service provision with a youth or family's needs and culture as well as youth and family strengths. Other plan requirements assessed are the inclusion of multiple strategies, opportunities for youth to engage in community activities, and maintenance and transition to the least restrictive environment. HZA also examines

[8] CSMs, who manage single and multi-county DHHR offices, report to regional directors and provide oversight to direct service supervisors and caseworkers.

measurable outcomes connected to the youth's long-term vision and multiple strategies linked to those outcomes to see how well they meet the requirements of the Wraparound model.

The crisis safety plan is assessed to determine if it includes the assignment of roles during a crisis, steps that will be taken if a crisis arises, behaviors that signal a crisis may be imminent, methods that can be used to de-escalate a crisis and strategies to prevent crises.

Fidelity assessment interviews are conducted onsite in person and by telephone when needed. Each case involves one youth, his or her caregiver(s), one wraparound facilitator and one caseworker. Wraparound facilitators and caseworkers have sometimes had more than one case in the sample, providing an opportunity to consolidate the number of interviews completed while still collecting data for each case.

Staff Surveys

HZA developed two fidelity survey protocols: one to gather data from the perspective of DHHR staff (including community service managers, supervisors and caseworkers), and the other from the perspective of LCA staff (such as LCA program directors, wraparound supervisors and wraparound facilitators).

The DHHR staff surveys were administered online. An email was sent to CSMs with a link to the survey and a request for them to participate as well as to forward the link to their caseworkers and supervisors. The survey addresses questions about staff's involvement in the implementation of *Safe at Home*, the adequacy of the training they have received, their engagement with wraparound service providers and judges, their perceptions of the quality and effectiveness of services and what can be done to enhance them.

Additionally, the survey asks DHHR staff about the extent to which they conduct their required work to align with the Wraparound and *Safe at Home* models. HZA initially staggered administration of the DHHR staff survey at the State's request to account for differences in staff training and time/experience working with the program. Since *Safe at Home* was fully implemented, the survey has been administered annually statewide.

Surveys of LCA staff also have been administered online. The survey link for the LCA staff survey was sent directly to the email addresses of all applicable LCA staff, using the online CANS database to identify applicable staff and their respective addresses. The LCA staff survey is tied to the four phases of the Wraparound model (engagement and team preparation, initial plan development, plan implementation, and transition), addressing questions about the quality and effectiveness of services, what can be done to enhance them, the frequency with which staff complete program responsibilities, their adherence to the Wraparound model, and the functionality of multi-agency collaboration.

FACTS Extracts

Characteristics of the youth involved in *Safe at Home* have been collected from FACTS. HZA receives FACTS extracts quarterly. Youth characteristics include demographic data, mental health status, youth involvement with juvenile justice, and placement type at time of referral

to the program. The five placement types used are: out-of-state congregate care facilities and group care, in-state congregate care facilities and group care, emergency shelter, family foster care placements, and youth at home. The data from FACTS are also used to measure outcomes, identifying the characteristics of youth which either contribute to or hinder the achievement of safety, permanency or well-being.

CANS

At the start of the evaluation, HZA developed an online Child and Adolescent Needs and Strengths assessment for wraparound facilitators to use. The online assessment tool enables wraparound facilitators to inform DHHR caseworkers of the results, doing so for the initial assessment as well as others to show progress over time. It also provides a source of information for the evaluation team to measure improved well-being and fidelity.

Data Analysis

HZA used both qualitative and quantitative analysis techniques to evaluate West Virginia's Title IV-E Waiver Program, *Safe at Home*. The qualitative analysis utilized content analysis to identify both common and disparate themes as reported by DHHR and LCA staff and other stakeholders. The quantitative analyses included descriptive statistics, outcome measures and cost calculations. Each of these is discussed in more detail below.

Content Analysis

Content analysis is a method of analyzing qualitative data. Content analysis was used to analyze open-ended questions in interviews as well as open-ended questions on staff surveys. Common threads and differences have been identified, including differences among various stakeholders. HZA reports not only on the themes that emerge but also on the prevalence and frequency among interview subjects. Data collected annually from stakeholder interviews to assess adherence to *Safe at Home* and the Wraparound model are compared over time to identify trends.

The content analysis was also employed to assess fidelity. While the results were summarized in the aggregate, they were also compiled for each LCA to help identify those which were struggling to complete the required practices as intended.

Descriptive Statistics

The process evaluation included completion of quantitative analyses. Data from FACTS were used to describe the characteristics of youth who were referred to *Safe at Home*. Fidelity data collected through the use of Likert scale questions in online surveys was also quantified to gain the perspective of DHHR and LCA stakeholders.

Outcome Measures

Data from West Virginia's case management system were used to measure the extent to which *Safe at Home* was successful at statistically significant levels in keeping youth safe and helping them to achieve permanency, while data from CANS were used to measure well-

being outcomes. Multivariate analyses of the FACTS data show with which populations the project is most successful.

Cost Calculations

HZA also used West Virginia's case management system to measure the fiscal impact of the program. Costs for placing youth outside the home were calculated in addition to the costs of providing auxiliary services, such as transportation, counseling and recreation, among others. The contracts between DHHR and the LCAs provided information on the costs of the wraparound services themselves.

Sampling Plan

Table 1 lists each source from which data are collected, the frequency of collection, and which populations are sampled. Data are collected annually from most sources with the exception of judges who are interviewed biennially. Data from FACTS are received semi-annually. Samples for interviews and case records are selected at random.

Table 1. Data Sampling Plan

Data Type	Source	Frequency	Sample
Document Review	DHHR	Annually	All relevant materials (*e.g.,* policies, federal waiver documentation like IDIRs, organizational charts, training manuals)
Interviews with Central and Regional Administrative Staff	Central and Regional Office Staff	Annually	Implementation Counties/Districts
Interviews with Direct Service Staff	Regional Office Staff	Annually	Implementation Counties/Districts
Interviews with Community Members and Providers	Community Members and Providers	Annually	Implementation Counties/Districts
Supervisor and Worker Survey	Regional Office Staff	Annually	Implementation Counties/Districts
Interviews with Judges	Judiciary	Years one, three, and five	*At least 10 per Cycle*
Fidelity Assessment	DHHR and Wraparound Providers	Annually	*100 per Year*
FACTS Analysis	DHHR	Semi-Annually	Treatment and Comparison Groups *All Relevant Cases*
Case Record Reviews	DHHR	Annually	Treatment and Comparison Groups *200 per Year*
Cost Analysis	DHHR	Annually	Treatment and Comparison Groups *All Relevant Cases*

Table 1. Data Sampling Plan			
Data Type	**Source**	**Frequency**	**Sample**
Standardized Assessment Review (CANS)	Wraparound Providers	Annually	Treatment Group Families; Others if Available
Secondary Data Analysis	Children's Bureau Report Data KIDS COUNT American Community Survey	Annually	N/A

Data Analysis Plan

Analyses were completed following completion of each data collection event, with the results presented in the semi-annual report following completion of those tasks. This report describes trends from the start of implementation to more recent practice. To measure the impact of *Safe at Home*, a matched comparison group was selected to demonstrate the impact of the program on *Safe at Home* youth, drawing comparisons between the two groups. The matched comparison group was selected using Propensity Score Matching, using data from FACTS. The comparison pool was drawn from youth who meet the *Safe at Home* referral criteria; *i.e.*, youth ages 12 to 17 in congregate care with a mental health diagnosis (or at risk of entering congregate care with a possible mental health diagnosis) during State Fiscal Years 2011 through 2015.

Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, report allegation, number of prior placements, evidence of an Axis 1 diagnosis, juvenile justice involvement and placement in a psychiatric hospital or group home. The scores for the treatment group were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to that of the treatment group (see Appendix A). Significance testing was used to quantify differences in outcomes between the two groups and highlights areas where *Safe at Home* is successful or needs improvement.

Limitations

Each data source was prone to unique forms of uncertainty. Analyses of each source were limited to both the quality and quantity of information contained in the data set. Below are limitations for each data source.

Stakeholder Interviews

While ideally each person involved in *Safe at Home* would be interviewed to gain every possible perspective, the time involved to collect interview data is limited. A random sample of staff at each position (*e.g.*, administrative staff, caseworkers, judges) and region were selected to produce an optimal and unbiased sample.

While HZA stresses anonymity, interviewees may still feel reserved and respond to the questions the way they believe their peers or superiors would want them to respond.

Case Reviews

Case reviews face a similar limitation to interviews where each review is a time-intensive process. Each year a random sample of 40 cases has been selected for the fidelity assessment, with an oversample also selected to account for cases where youth and caregivers were not able or willing to participate. Especially for the first case review, there were not enough youth who had completed *Safe at Home* to capture the practices that occurred as cases closed.

An additional limitation to the case reviews was the quality of the case notes. HZA identified specific questions to identify through case notes and, if this information was not contained within the case notes, there was no way to report on these data.

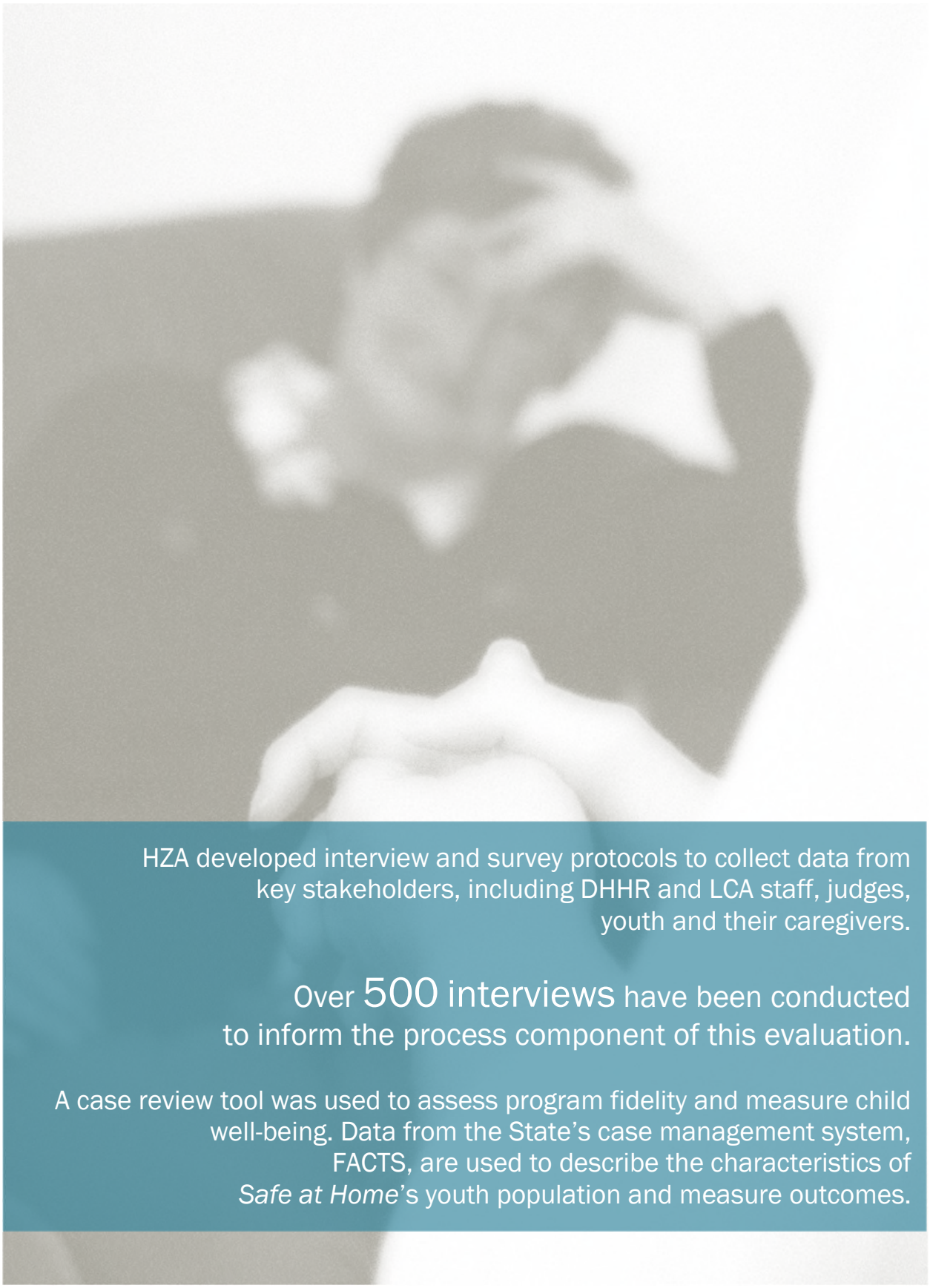
Staff Surveys

Survey data are inherently biased towards those who respond since participation in the survey is voluntary. This bias is mitigated as the response rate increases; therefore, HZA reminded staff several times during the survey window to complete the survey. Additionally, while HZA stresses anonymity, responses can be biased towards what staff think their peers or supervisors want to hear rather than what is taking place.

FACTS Extracts

HZA receives semi-annual extracts to identify the characteristics of *Safe at Home* youth and measure outcomes. The data housed in the FACTS case management system are entered by DHHR workers and can be prone to data entry errors (*e.g.*, incorrect buttons pressed, misspellings, missing data). Additionally, data for a given case can be entered or altered after HZA receives the extract; consequently, outcomes are limited to the data included in the data extract received.

While youth who are referred to *Safe at Home* without a documented mental health diagnosis are presumed to have a possible mental health diagnosis, it is not possible to do the same for youth in the comparison group. While there are youth in the comparison group without a documented mental health diagnosis—some of whom may actually have a possible diagnosis—this limitation may be influencing the extent to which the comparison group shows better outcomes than the treatment group beyond six months.



HZA developed interview and survey protocols to collect data from key stakeholders, including DHHR and LCA staff, judges, youth and their caregivers.

Over 500 interviews have been conducted to inform the process component of this evaluation.

A case review tool was used to assess program fidelity and measure child well-being. Data from the State's case management system, FACTS, are used to describe the characteristics of *Safe at Home*'s youth population and measure outcomes.

Process Study

Key Questions

Research questions used to guide the process evaluation of West Virginia's Title IV-E Waiver program focus on the planning, organization and implementation of *Safe at Home*. They were formulated to examine the efforts employed by the State to plan for the program and the changes which have taken place over time; the staffing structure, service delivery and capacity of the initiative; and fidelity to the Wraparound model as implemented through the *Safe at Home* program as well as the contribution of stakeholders in achieving the program's success. The research questions explore not only programs successes but also ongoing challenges to implementing the program, the lessons learned and how those have been applied.

The eight questions used to guide the process evaluation are provided below.

Process Research Questions

1. **How was the planning process conducted?**
2. **How was the demonstration organized (including staff structure, funding, administrative oversight, and problem resolution)?**
3. **What number and type of staff were involved in implementation and how long were the implementation periods?**
4. **How was the service delivery system for the Waiver defined?**
5. **What role did the courts play in the demonstration; what is the relationship between DHHR and the court system?**
6. **What contextual factors may impact the Waiver results?**
7. **To what degree are the demonstration programs and services implemented with fidelity to their intended models?**
8. **What barriers were encountered during implementation, the steps taken to address them and any lessons learned?**

Data Sources and Data Collection

As described above, data have been collected annually from DHHR and LCA staff, youth and their caregivers, and biennially from judges. HZA developed tools to collect data from these key stakeholders, including interview and survey protocols. Over 500 interviews have been conducted since the start of the evaluation to inform the process component. A case review tool was also created to assist in assessing program fidelity and measure child well-being, which was used to collect data for 80 cases to date. Data from the State's case management system, FACTS, are used to describe the characteristics of *Safe at Home*'s youth population.

Results

How was the planning process conducted?

Planning activities for *Safe at Home* were accomplished by workgroups of team members with expertise in areas such as service development, practice development, fiscal accounting and reporting, Title IV-E maximization, communications, and data. Community partners participated in the initial planning activities, while judges later reported that they would have liked to have had a role during the initial planning stage. The State used community collaboratives, consisting of DHHR staff and community partners from a variety of fields (*e.g.*, juvenile justice, behavioral health, education), to help identify the service needs of eligible youth.

DHHR utilized transparency as a key strategy to engage local communities in planning for the Title IV- E Waiver initiative. While *Safe at Home* was integrated into DHHR's ongoing activities, it was frequently presented in larger meetings with community partners (*e.g.*, court improvement meetings) to gain their interest and involvement. DHHR central and regional office staff also provided presentations to organizations that were interested in learning about the program which helped to engage local stakeholders. The State distributes the semi-annual evaluation reports to legislators to ensure they remain informed while *Safe at Home* program leaders continue to conduct outreach with local and state partners, doing so through Facebook and Twitter. Additionally, *Safe at Home* has its own email address where central office staff can answer questions about the program directly.

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

As noted above, substantial effort was made to educate key stakeholders including the general public on the program. Examples of public and stakeholder outreach include: face-to-face meetings between DHHR staff and judges; weekly email blasts to over 1,000 recipients; quarterly newsletters; press releases; development of a wraparound expert team; creation of speaking points; a printable flyer; trainings; new policy and policy revision; a *Safe at Home* website that is updated regularly; a program manual; and guides for families, DHHR staff and service providers. DHHR reduced the intensity of outreach efforts once the program had been implemented for more than a year, though all outreach activities have continued.

Half of the central office staff interviewed reported that over time, as the program became fully implemented statewide, their involvement in the planning and development processes for *Safe at Home* has diminished. Central office staff who are involved in the more day-to-day work for *Safe at Home* stated their roles have not changed much. A couple of central office staff indicated that they are beginning to shift from implementation planning and direct

program oversight to program sustainability planning now that statewide implementation has been achieved and the program is, for the most part, running smoothly.

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

Staff Structure

Safe at Home West Virginia is structured as a collaborative program between DHHR, LCAs and community partners. DHHR has contracted with ten LCAs, which are responsible for hiring wraparound facilitators, a new position that was created specifically for *Safe at Home*. Wraparound facilitators work directly with youth and their families to develop service plans and facilitate access to wraparound services. DHHR caseworkers also play an important role in working with *Safe at Home* clients; caseworkers are members of the wraparound family teams which consist of formal and informal supports to help the youth and family meet their goals. Additionally, DHHR staff, particularly at the regional level, monitor LCA performance and provide direct oversight of the program. Community partners, including service providers and judges, also contribute to meeting the needs of youth.

LCA staff generally agreed during interviews that their agencies' overarching missions coincided well with that of *Safe at Home*; as a result, agencies did not have to make significant organizational changes to accommodate the program. One change made, however, was the hiring of wraparound supervisors and facilitators. Wraparound facilitators work directly with youth and their families, assessing their strengths and needs, developing plans to meet those needs, and providing support and guidance when needed. A couple of LCAs opened additional offices to accommodate the growth in staff.

Funding

As prescribed within the *Safe at Home* funding announcement, LCAs received $70,000 in start-up grants for each wraparound facilitator and are paid a daily rate of $136 for each youth participating in *Safe at Home*. The daily rate excludes reimbursement for services which are billable to Medicaid, as well as room and board.

Discretionary or "flexible" funds can be disbursed by LCAs, according to the *Safe at Home* Program Manual, and are intended for the purchase of a service or commodity that is needed to meet a specific client need. These funds are only to be accessed after all other funding sources have been explored and exhausted. Flexible funding is always meant to move clients toward the goal of child and family empowerment. It empowers families and children to navigate within their communities; it also enables wraparound facilitators to find creative solutions to accessing services for youth and their families. For instance, one youth with anger management issues was provided a membership to a local boxing club, enabling him to learn how to better channel his behavior. In other local communities where transportation services were not readily available, LCAs hired staff to provide transportation to youth and their families.

Administrative Oversight

The *Safe at Home* project director works with LCA staff on an ongoing basis to track cases at a regional level and monitor the amount and quality of referrals received. LCA staff reported that the *Safe at Home* project director holds primary responsibility for working directly with DHHR regional office staff to address major issues that might arise with the program. Wraparound facilitators receive guidance, oversight and support from their supervisors who, in turn, are supervised by program directors.

DHHR has a well-defined management structure and communication procedure which helped the implementation of *Safe at Home* to be relatively intuitive and straightforward for State staff. Central office staff do not regularly interact with county level staff beyond sending emails with policy or program updates. Interaction between regional office staff and central office staff is largely focused on the weekly tracking logs of *Safe at Home* cases submitted by regional staff. Regional staff receive updates about the program through statewide meetings (which are then disseminated to staff within each region's counties). Regional program managers reported that their role in *Safe at Home* is primarily being "the gatekeeper for referrals," where they approve or deny the referrals sent by supervisory and/or casework staff from the counties within the regions.[9]

Regional DHHR staff most often interact with counties, providing guidance, support and oversight through the supervision of CSMs. Some regional directors indicated that *Safe at Home* is regularly discussed with CSMs in their monthly management meetings and then the CSMs pass along any information to the supervisors and/or caseworkers within their county (or counties). CSMs reported that they provide direct oversight of supervisors and caseworkers and involve regional office staff only when problems cannot be resolved at the local level. Both regional office staff and CSMs agreed that over time, they have not needed to be as hands on in their involvement with subordinate staff regarding *Safe at Home*.

Accountability

The way central office staff monitor the work of LCAs did not change throughout the implementation phases. The *Safe at Home* project director, regional directors and regional program managers provide ongoing monitoring and oversight of the LCAs' work. The *Safe at Home* project director provides the most direct oversight, with communication with LCAs occurring on a near-daily basis. Weekly tracking logs are used to examine placement changes and to ensure, "LCAs are doing what they need to be doing."

Regional office and county-level staff reported that they have their own processes for holding LCA staff accountable. Examples include monitoring the weekly reports LCAs provide on all *Safe at Home* cases, hosting monthly meetings between themselves and LCAs to staff cases, and providing county staff with additional information whenever it is requested. A few DHHR staff also reported that judges will sometimes hold LCA staff accountable by expecting regular updates on the work being conducted and the progress being made on *Safe at Home* cases in their courts.

[9] Details of the referral process are discussed on pages 16–17.

Additional monitoring is provided by the evaluator, such as through the fidelity reviews, and the LCAs themselves, which are required to complete their own grant reports. When the State notices issues with an LCA, it works directly with the LCA to address concerns. The project director will sometimes request an LCA to submit a Program Improvement Plan (PIP) when corrective action is needed, *e.g.*, such as when required documentation for cases is not being completed on time or not at all. If the issues in the PIP are not resolved in a timely manner, then the State may terminate the contract with the LCA, although this has not occurred to date. The State can also perform additional audits on LCAs whenever deemed necessary.

Problem Resolution

All caseworkers and wraparound facilitators reported that they are able to speak to their supervisor with ease. Caseworkers and supervisors also reported that they follow the regular chain of command if they are having issues with *Safe at Home* cases and/or partners which they cannot resolve independently. Caseworkers start by trying to address issues with their direct supervisors, and then include LCA facilitators and wraparound supervisors as necessary. If issues cannot be resolved by these parties, then CSMs and LCA program directors become involved. If issues still cannot be resolved on a local/county level, then regional program managers and regional directors are engaged. The most severe issues are addressed in conjunction with the *Safe at Home* project director, and all LCA program directors reported that they reach out to the *Safe at Home* project director whenever issues arise. Most interviewees reported that issues have been resolved completely and in a timely manner. Interestingly, one caseworker reported that his/her county office has designated a staff person as an informal "*Safe at Home* expert" whom all staff can contact as a resource for questions or concerns.

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

Implementation of *Safe at Home* rolled out across three phases, beginning in October 2015. By the spring of 2017, the program was extended to all 55 counties in DHHR's four service regions (see Table 2). Phase I included most of the Region 2 counties and three counties in Region 3. The counties from Region 2 were selected because of their abundant resources and those in Region 3 were selected due to their high level of need. Phase II, which was rolled out on August 1, 2016, added 24 counties to the program, including the balance of Region 3 counties, several counties in Region 1 and the eastern counties in Region 4. On April 1, 2017, Phase III was implemented, adding the remaining three counties in Region 2, most of those in Region 1 and the western counties in Region 4, to complete implementation statewide.

Table 2. *Safe at Home* West Virginia Phased Rollout			
Phase	**Counties**		**Total**
I	Region 2:	Boone, Cabell, Kanawha, Lincoln, Logan, Mason, Putnam, Wayne	11
	Region 3:	Berkeley, Jefferson, Morgan	
II	Region 1:	Brooke, Hancock, Harrison, Marion, Monongalia, Ohio	24
	Region 3:	Barbour, Grant, Hampshire, Hardy, Lewis, Mineral, Pendleton, Preston, Randolph, Taylor, Tucker, Upshur	
	Region 4:	Greenbrier, Mercer, Monroe, Nicholas, Pocahontas, Summers	
III	Region 1:	Calhoun, Doddridge, Gilmer, Marshall, Pleasants, Ritchie, Tyler, Wetzel, Wirt, Wood	20
	Region 2:	Jackson, Mingo, Roane	
	Region 4:	Braxton, Clay, Fayette, McDowell, Raleigh, Webster, Wyoming	
		Total Counties in State	**55**

By March 2018 when the program was fully implemented statewide, there were a total of 182 wraparound facilitators and 58 administrators/supervisors from ten LCAs. Each of the LCAs, according to CANS data, had from one to twelve administrators/supervisors and from two to 38 facilitators on their staff at that time.

Contracted agencies in the Phase I implementation counties were required to have one-third of their wraparound facilitators hired, trained and ready to accept referrals by October 1, 2015. Six of the thirteen LCA staff 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 the wraparound facilitators. One central office staff person reported in later periods that a key difference in the Phase II and III implementations was that the preparation period was less rushed for staff than it was in Phase I, using the lessons learned in the first phase to better role out implementation in later phases.

How was the service delivery system for the Waiver defined?

Program Model

According to stakeholders, wraparound services differ from traditional services because they are tailored to meet each individual youth's needs. Instead of completing a prescribed set of mandated 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 the support needed by youth and their families after formal supports are no longer a part of their lives. Interviewees agree that the wraparound approach can lead to success for youth.

The *Safe at Home* West Virginia program manual describes the wraparound process from beginning to end, with specific goals specified for each phase of wraparound. Table 3 displays the four phases of wraparound, along with the corresponding goals for each phase while the specific tasks related to each phase are discussed later in this report in terms of model fidelity.

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

Eligibility Requirements

Initially, eligibility to participate in *Safe at Home* was limited to youth ages 12 to 17 with a behavioral or mental health diagnosis placed (or at risk of being placed) in congregate care. In practice, however, some of youth that were referred and participated in the program did not have a diagnosis. When the program manual was updated in July 2017, the eligibility requirements for *Safe at Home* were modified to include youth at risk of placement with a *possible* behavioral or mental health diagnosis. This brought the program manual in line with what was happening on the ground.

Referral Process

There are multiple steps involved in the *Safe at Home* referral process. Caseworkers begin by evaluating their cases to see if any meet the policy criteria for eligibility. Once a youth is identified as eligible, the caseworker must obtain the youth/family's consent to participate, because the program is intended to be voluntary. Sometimes caseworkers will run the idea of a referral by the Multi-Disciplinary Team (MDT), the court/judge or other involved stakeholders to see if all invested parties are on board.

When an eligible case is identified and the youth, caregiver and other stakeholders agree to participate, the caseworker passes a referral to his or her supervisor for review; the case is then referred 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 an LCA which is contracted to provide wraparound services within the county (assignment is based on a rotation); the System of Care worker notifies the program manager of the assignment, who in turn notifies the assigned community provider. The community provider then assigns the case to a wraparound facilitator, all of whom are permitted to have no more than ten *Safe at Home* cases at one time. Caseworkers have reported that the referral process takes about two weeks.

Cross-System Collaboration and Communication

Many stakeholders believe that the program's success is reliant upon the ability to have strong cross-system partnerships (*i.e.*, county DHHR staff, wraparound facilitators, the courts, and other partners when appropriate, including schools and probation officers) work as a team. Most DHHR supervisors and caseworkers expressed that they were well prepared to work with LCA staff, many due to their prior involvement with the LCAs. A few DHHR caseworkers and supervisors reported that working with the LCAs has been a "learn as you go" experience, improving naturally as staff handle more *Safe at Home* cases. LCA staff have reported that some caseworkers are great to work with, but that others can barely be reached and miss meetings or do not provide necessary information.

Most staff reported regular communication between DHHR caseworkers and wraparound facilitators, where the level was dependent on the needs of each particular case. In some cases, wraparound facilitators and caseworkers reported daily contact, in others a couple of times a week; some reported weekly contact. Regular collaborative and regional summit meetings also offer opportunities for community partners to come together and share their ideas on how to meet client needs and address the current service gaps throughout the State.

Staff Training

Training has been a collaborative effort between DHHR and the LCAs. Approximately half of the DHHR caseworkers/supervisors and LCA wraparound facilitators/supervisors report that the training sufficiently prepared them for their work with the program. LCA staff were more likely to report satisfaction with the training than were DHHR staff. Of the staff who were dissatisfied, some found the training to be too basic, only scratching the surface of the information needed. This sentiment was echoed by a few respondents in the Phase II DHHR staff survey. A couple of staff from Phase I reported that the follow-up training they received was beneficial in clearing up role confusion.

DHHR staff training needs are identified by DHHR central office staff in a couple of ways, one of which is through the feedback received from county-level staff. All staff are given surveys following participation in *Safe at Home* trainings, where they are asked to share their opinion as to what they did not understand or would have liked to have learned more about. For example, in Phase I staff were reporting role confusion between caseworkers and wraparound facilitators on the follow up surveys so a half day of training was added to the

curriculum to address this specific topic. Another way training needs are identified by central office staff (for both DHHR and LCAs) is by looking at the quality of work being conducted with *Safe at Home* clients through the State's tracking logs, and recognizing problems in how *Safe at Home* is being implemented.

While DHHR staff must complete Wraparound 101 and CANS training for *Safe at Home*, LCA staff have a much more in-depth and intense level of training because they are the ones providing the direct *Safe at Home*/wraparound service to clients. Most recently, the Applied Wraparound training for LCA staff was adjusted to add more advanced material. Training for LCA staff include the following:

- System of Care "Ladder of Learning" for Core Competencies,
- Child and Family Team Building,
- Family Centered Practice,
- Family and Youth Engagement,
- Effects of Trauma on Children and Youth,
- The 10 Wraparound Key Principles,
- *Safe at Home* West Virginia Model and
- BCF Policy Cross Training.

In addition to the training required of LCA staff by the State, LCA staff report that they also identify individual training needs within their agency and will often add more trainings for their staff to what is minimally required. The amount and type of additional trainings added by LCAs varied by each agency according to their particular staff needs.

Responses to the survey administered to LCA staff were mixed as to how well the training prepared them for their role in *Safe at Home* with more staff agreeing that the training was adequate than not. LCA staff were more satisfied with the training offered internally than that provided by the State.

Interview data were consistent with survey data regarding DHHR staff satisfaction with *Safe at Home* training. The vast majority of DHHR supervisors and caseworkers reported that the training for *Safe at Home* prepared them sufficiently for their role in the program. Referring to an initial survey administered to DHHR staff who participated in the Phase II roll-out, all the supervisors as well as 83 percent of the caseworkers reported receiving training about *Safe at Home*. Ninety-three percent of the caseworkers and two-thirds of the supervisors rated the training as preparing them "Somewhat" or "Very Well" for their roles. Of the 85 DHHR caseworkers, supervisors and CSMs who responded to a second survey, 82 percent reported that they had received training for *Safe at Home*. Respondents noted the Wraparound 101 and CANS trainings prepared them "Somewhat" or "Very Well" for their roles in the program. DHHR staff satisfaction with training was a bit higher with the Wraparound 101 training.

What role did the courts play in the demonstration, and what is the relationship between DHHR and the court system?

Courts play an integral role in the success of the program. Community providers, direct service staff, and regional and central office staff agree that judges hold a powerful position in deciding placement for youth, and many stakeholders believe that judges have been too punitive and use placement as a form of punishment. However, over half of the judges interviewed at baseline wanted the program to provide them with more options beyond out-of-community, residential placement. Judges have reported looking to the program for community-based alternatives to keep youth home.

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

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

DHHR and LCA staff further elaborated on the specific role of judges, stating that when judges help to make *Safe at Home* cases successful it is because they hold LCA and DHHR staff accountable for their work and they ensure that youth and families cooperate and participate in services.

Judges involved with *Safe at Home* along with LCA and DHHR staff reported that judges value and follow provider recommendations. In fact, judges who had direct experience with *Safe at Home* cases in their court reported that they almost always were on board with youth/families trying *Safe at Home* whenever it is recommended. Many regional office staff and CSMs reported that judges have been helpful when they have taken on a more active role with *Safe at Home* cases. One CSM shared, "[The judge] helps. [S/he] explains the program well to families and makes sure they understand it. [S/he] monitors the cases closely and is supportive of us and families."

What contextual factors may impact the Waiver results?

Stakeholders across staff categories shared concern about the State's ability to meet the service needs 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.

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.

The top five services interviewees reported as lacking are: mentoring, psychological/ psychiatric services targeting youth, substance abuse services targeting youth, transportation for youth/families and activities for youth/teenagers such as recreational centers and after school program options. It is interesting to note that three of the services which are available in limited supply are intended to address the unique needs of youth. Regarding informal supports, one caseworker survey respondent wrote, "Informal supports [outside the family itself] appear to be nonexistent within the area. It appears that the plans thus consist of only the family members who live in the home and formal supports."

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.[10] When judges were asked what they perceived as the greatest issues facing 12 to 17 year-olds in their courts, the most common response was substance abuse among both youth and their parents.

Additionally, some stakeholders argued that the drug problem has made it difficult to recruit appropriate potential foster parents for youth even as the need for foster homes is increasing.

When judges were asked what they perceived as the greatest issues facing 12 to 17 year-olds in their courts, the most common response was substance abuse among both youth and their parents.

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

Many stakeholders cited Senate Bill 393 as an element that could strengthen the program, since the Bill allows a juvenile with a status or 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 State. Some stakeholders viewed this prior program as a strength, demonstrating that wraparound could indeed be successful. However, a couple of stakeholders feared that *Safe at Home* would run into the same issues that led to the demise of CBT.

To what degree are the demonstration programs and services implemented with fidelity to their intended models?

The vast majority of wraparound facilitators meet the State's requirements to have a Bachelor's Degree in social work, sociology, psychology or another human service-related field and two years of work experience serving a youth population similar to that of *Safe at Home*'s (*i.e.*, ages 12 to 17 with a possible mental health diagnosis in congregate care or at risk of congregate care entry). Facilitators also by and large met the State's expectations to have a general knowledge of mental illness diagnoses and behavioral disorders in children, and more than half have personal family experience with mental illness, which is considered helpful.

The State can make an exception to one or more of these requirements if the applicant has extensive knowledge and/or experience in the field; most facilitators have substantial experience. The percentage of wraparound facilitators with at least two years of experience in the field increased from 60 percent at the time of the first fidelity assessment to 91 percent at the time of the second assessment. LCA staff are more experienced than caseworkers, with 60 percent of caseworkers involved in *Safe at Home* having less than two years of experience in their current role. The remainder of this section discusses fidelity to the Wraparound model by the phases previously summarized in the "Program Model" section.

Phase 1: Engagement and Team Preparation

The first wraparound phase, Engagement and Team Preparation, is used to orient the family to the program and to begin engaging with the family and youth to explore their strengths, needs and goals; identify any pressing issues or concerns that the family has; and to build the wraparound team with an emphasis on family identified supports.

Most DHHR caseworkers and supervisors have reported always or frequently completing tasks related to *Safe at Home*. For instance, figures 1 and 2 show that 80 percent of DHHR staff participating in the staff surveys reported that program tasks "always" or "frequently" are completed. This was true at the end of both the first and second years of program implementation.

Figure 1. DHHR Staff Frequency of Fidelity Item Performance, End of Year 1

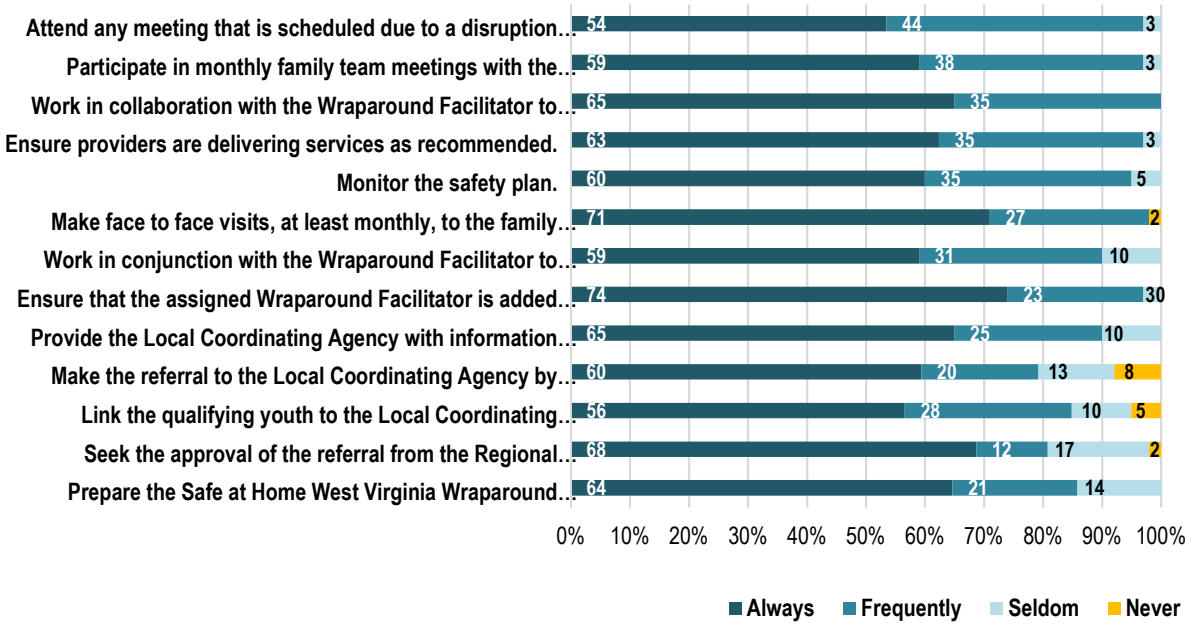
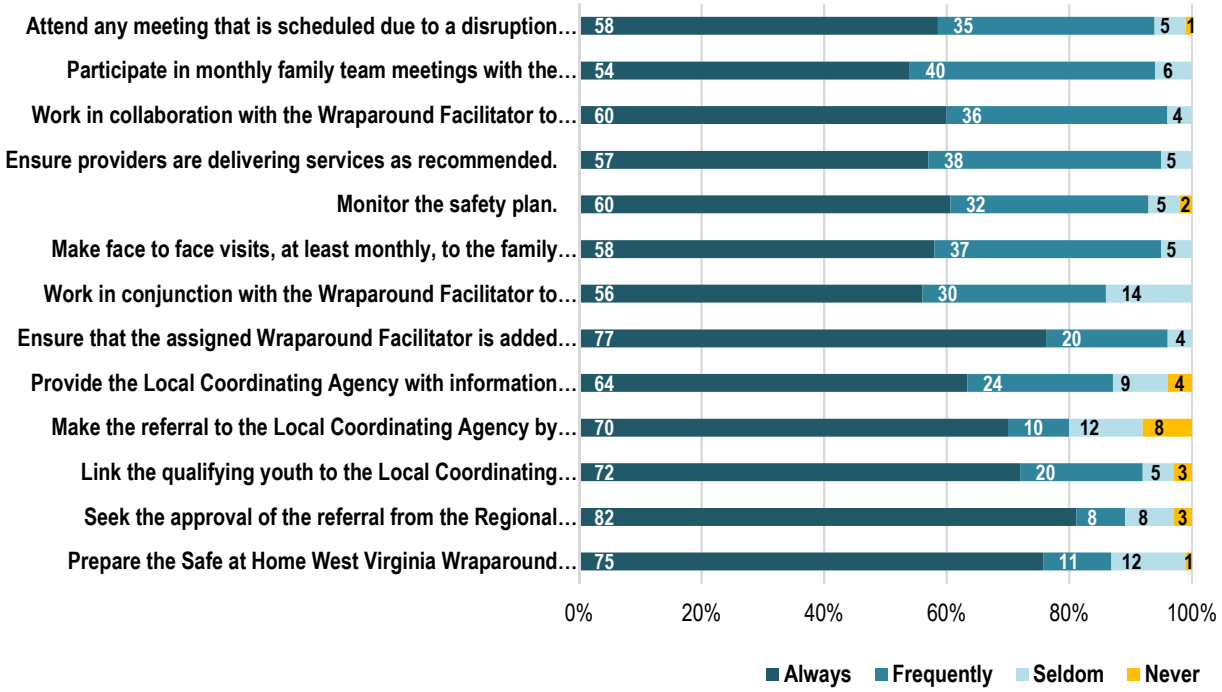


Figure 2. DHHR Staff Frequency of Fidelity Item Performance, End of Year 2



LCA staff have also reported always or frequently completing *Safe at Home* tasks, although one agency fell short of completing initial CANS assessments and crisis safety plans within required timeframes. Overall, LCAs did well with conforming to the Phase 1 requirements of the Wraparound model through *Safe at Home*.

Interviewees reported that in most cases youth and their families initially learned about *Safe at Home* through their DHHR caseworkers. Typically, caseworkers provided a brief overview of the program to the families and their youth and how it may help to meet their needs. Following this introduction, wraparound facilitators provided a more in-depth explanation of what *Safe at Home* entails.

Nearly all stakeholders interviewed reported that wraparound facilitators encouraged youth/families to share their concerns, hopes, goals or strengths in the very early stages of the case. Wraparound facilitators reported that in many cases it took time to build a rapport and get youth/families to fully engage and feel comfortable enough to share their concerns and goals.

One of the key tenets of the Wraparound model is in building and maintaining a strong natural support system so that when *Safe at Home*, DHHR, and other formal supports leave, the youth/family will still be able to maintain their success without reliance on formal supports and systems. In spite of wraparound facilitators' consistent efforts to get youth/families to identify natural supports, the vast majority did not want others involved or did not feel as though they had any natural supports available to involve. In the few cases where supports were identified, half of them included only a formal support system.

Phase 2: Initial Plan Development

The purpose of the Initial Plan Development phase is to create the initial wraparound and crisis safety plans through a collaborative team process. Youth/families are to play an active and integral role in safety and service planning, where their feedback is elicited and incorporated into plans wherever possible. This section of the report discusses who participates in the planning process, what resources are used and how quickly it happens.

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 while caseworkers reported taking a more supportive role. Caseworkers reported using their legal authority to sign off on service referrals and follow up with providers to ensure that plans were being implemented.

DHHR staff also reported providing input into crisis safety planning while the wraparound facilitators took the lead in the actual planning. Interestingly, half of the youth interviewed during the second fidelity assessment could not remember anything about crisis safety planning including a few parents as well. The remaining youth and most parents reported that they had been involved in crisis safety planning. Facilitators reported that youth/families were always involved in crisis safety plan development and refinement, but that plans were sometimes not implemented because youth never experienced a crisis.

All caseworkers surveyed who carry *Safe at Home* cases agreed that planning is customized to the strengths and needs of youth. Stakeholders listed the goals established through the *Safe at Home* planning process. While the goals varied, the most common included improvement in grades, behavior, school attendance, social skills and family relationships, and to achieve permanency when youth were placed out of the home. Most youth and their parents reported witnessing progress and/or goal achievement through their involvement with the program.

Initial wraparound and crisis safety plans are to be completed within 30 days of program referral. On average, LCAs completed initial wraparound plans within 45 days of referral, falling short of the time requirement by 15 days. On average, all LCAs completed the initial crisis plans within 39 days of referral, again falling short of meeting the required timeframe. However, the average time to complete the initial crisis safety plans satisfies the 30-day requirement when the one agency, which stood out as not meeting the required timeframe, is excluded from the analysis.

Phase 3: Implementation

The third phase of wraparound, Plan Implementation, is when the wraparound plan is put into action. It also offers an opportunity to revisit and update plans whenever necessary, to ensure that the youth/family and team members remain engaged, to continually monitor progress and address challenges as they arise and to celebrate successes.

Wraparound and crisis safety plans are to be updated and refined as necessary and, on average, HZA found they were revised every 50 days. The plans as well as the CANS are updated as goals are met and the needs of the youth and family change. The majority of stakeholders reported that a combination of formal and informal services were tailored to meet the needs of youth and family and that the wraparound facilitator identifies or rewards the success the youth achieves. The ten most common services received included:

- individual therapy
- tutoring
- school advocacy
- family therapy
- life skills
- youth coaching
- medication management
- community outings
- mentoring
- parenting classes

Caseworkers, youth and parents reported that in most cases wraparound facilitators were diligent and, for the most part, successful in getting youth to make active decisions in ongoing planning activities. In the few cases where youth were not active in planning, caseworkers reported that facilitators made substantial efforts to engage the youth in service planning, but engagement was a challenge due to parental issues, lack of motivation or interest from the youth, and youth's serious mental health issues.

As part of the fidelity case reviews, HZA reviewed the initial and most recent wraparound plans and rated the content for the extent to which required items were included. Reviewers used a five-point Likert scale to document their findings, with one meaning the item was "Not at All" a part of the plan and five meaning the item was "Thoroughly" included. Similar to its review of the wraparound plans, HZA reviewed the initial and most recent crisis safety plans to assess their thoroughness, again using a five-point Likert scale to assess their completeness.

Scores generally improved when the most recent wraparound and crisis plans are compared to the initial ones. As LCAs learned more about the youth and their families and built a rapport with team members, they were better able to conform to the requirements of the *Safe at Home* model. It should be noted, however, that HZA reviewers found that it was difficult to identify data on the families' cultural needs in the record. Fidelity to the model also increased from the first assessment to the second as wraparound facilitators gained more experience throughout the program implementation.

Phase 4: Transition

The purposes of the Transition phase are to plan for the end of wraparound services when the team's goals and objectives have been met, to conduct a commencement or some type of ritual to celebrate success, and to formally discuss where the family can go for help in the future.

Wraparound facilitators are required to have weekly contact with youth/families at the start of program involvement and then gradually reduce contact as progress is being made and youth/families get closer toward transition. Although a couple of the cases were reported as close to reaching the Transition phase at the time of the first fidelity assessment, none had quite made it there yet. 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.

The second fidelity assessment demonstrated promising practices in terms of transitioning youth out of the program. In cases where youth had graduated from the program, stakeholders reported the visits were gradually reduced from weekly to biweekly and then to monthly contact. Most interviewees agreed that the amount of contact between wraparound facilitators and youth/families was adequate. However, in a couple of cases stakeholders across the board believed that the frequent contact was too overwhelming/invasive for the youth/family. In two cases, facilitators stated that the contact was not frequent enough but that the youth/families consistently cancelled meetings.

Of the 14 closed *Safe at Home* cases included in the second fidelity assessment, eight youth had successfully graduated the program, and thus, completed the Transition Phase. Stakeholders from the eight completed cases reported that the team knew the youth were ready to graduate because all the goals set forth had been achieved.

All interviewees stated that facilitators held some sort of celebration for youth/families to symbolize graduation. Often, gifts were given to the youth and in a couple of cases scrapbooks with pictures of the journey were also given. In five of the eight cases, wraparound facilitators gave youth a diploma/certificate, and in a sixth case the facilitator provided the youth a closing letter listing his/her successes.

Youth, parents and facilitators stated that at the celebration the group discussed the youths' achievements and the progress they made throughout the life of the case. Stakeholders also reported that wraparound facilitators provided the youth/family with information on where to go for help in the future should it be necessary. In most of the cases, the wraparound facilitators offered themselves as a resource should any issues arise.

Despite the results of the fidelity reviews, the survey administered to facilitators produced less positive responses, indicating required activities were not being completed regularly for the Transition Phase. For example, just over half (51 percent) of the facilitators responded that they "Always" or "Frequently" create a document that describes lessons learned, what worked well and what did not, and the successes of the process. It is particularly concerning that only 57 percent of the facilitators "Always" or "Frequently" created a plan for checking in with the family after services end.

What barriers were encountered during implementation, the steps taken to address them, and any lessons learned?

Training

The first phase of *Safe at Home* rolled out in eleven counties on October 1, 2015, as expected. Feedback received by the State from those who participated in the early training indicated a need to clarify the roles of DHHR and LCA staff. The State responded quickly, putting together a workgroup and a 90-day work plan, expanding policy, updating the program manual and retraining staff. Another early change tightened the reporting requirements for LCAs starting in Phase II, which rolled out on August 1, 2016, adding 24 additional counties. Statewide implementation was achieved without any other substantial changes on April 1, 2017, when the remaining 20 counties were brought in.

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 have since indicated that these issues were resolved. A couple of LCA staff reported that the quality of information provided with referrals has improved over time.

Safe at Home's Wraparound 101 and CANS trainings are now incorporated into DHHR's standardized new worker training, ensuring that all new DHHR staff are trained on *Safe at Home* through the regular employee onboarding processes.

Staff provided feedback during interviews on how training could be improved. The most common suggestions shared were for the training to include:

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

Suggestions made by LCA staff to improve training included refreshers, more training on writing wraparound plans, training on documentation requirements and spending expectations and continued training on youth and family engagement.

Communication

Regional office staff reported that their involvement in the planning process was mainly to prepare the region's staff and stakeholders for the implementation of *Safe at Home*. They reported that over time they learned the importance of keeping the lines of communication open, the need to educate stakeholders on an ongoing basis and the importance of actively working to keep community partners (*e.g.*, courts, schools, other service providers) engaged.

As part of the early communication efforts for *Safe at Home*, program leaders worked to establish communication with judges and other court staff in order to educate them about the program and obtain their buy-in. However, central office staff reported they learned after Phase I that their initial outreach efforts were insufficient. A combined communication plan was created for CSMs and LCA program directors to use with the judges in their areas. The *Safe at Home* project director sent out preparation materials to CSMs two and a half months prior to roll out. Meeting with judges was already a regular part of CSMs' work and the addition of LCA program directors to some of these meetings offered the opportunity to provide judges with more detail about *Safe at Home*.

In addition to the outreach provided by CSMs and LCA program directors regarding the program, sometimes the *Safe at Home* project director and regional office staff held private meetings with judges, particularly if concerns about the program had been voiced. However, there are a few judges who continue to voice concerns about *Safe at Home*. While central office staff have reached out to these judges several times, they have continuously declined invitations to meet.

Despite the judges who remain resistant, central and regional office staff and CSMs reported during year two of the implementation that more judges demonstrated their support for *Safe at Home* than not. CSMs, supervisors and caseworkers echoed these sentiments, with 89 percent of survey respondents agreeing that "Judges are on board with *Safe at Home*."

Nearly all judges interviewed agreed with the goals and premise of *Safe at Home*, with one stating, “If they’re safe at home, then leave them home!”

Central office staff stated that the increased buy-in of judges has been largely attributed to them being able to see the success of *Safe at Home* cases over time; they are even sharing success stories within their own professional circles. However, buy-in has not been universal. One regional office staff person and a few central office staff reported that a few particular judges have created a major hindrance with *Safe at Home* cases. According to caseworkers, supervisors and LCA staff, when non-supportive judges hinder success, it is because they do not recognize progress/small victories, they court order participation, they hold unrealistic expectations of youth and families and they expect *Safe at Home* to be a “quick fix” or “magic bullet.”

Case Involvement

When staff were surveyed at the start of the evaluation, about three-quarters of the caseworkers and supervisors stated that more time is spent on *Safe at Home* cases due to weekly updates, more paperwork, more case consultation with LCAs and more meetings to attend. This changed as staff became more familiar with the program and less than one-quarter of DHHR staff are still reporting *Safe at Home* cases taking longer. More than half of the caseworkers and supervisors recently surveyed report spending about the same amount of time on *Safe at Home* cases as they do on traditional cases, with several also noting the amount of time is more but about the same they would have spent on these cases anyway since these youth require a more intense level of involvement.

One-third of the LCAs reported struggling with the turnover of wraparound facilitators in the early stages of implementation. After year two, all but one LCA staff reported that there have not been turnover issues with *Safe at Home* facilitators and supervisors. One wraparound supervisor stated, “I've seen a lot less turnover with *Safe at Home* than any other job in this field. I think it's because the job is more rewarding. You're working with families on a totally different level.”

Services

While stakeholders who participated in the fidelity case reviews reported high levels of inclusion in the service decision-making process, stakeholders have also noted that not all youth have been able to receive all the services which were planned and needed. Caseworkers and facilitators cite two barriers to accessing services. One barrier was the lack of consistency by the youth/families and follow through or motivation to succeed. In a few cases placement changes/disruptions resulted in services stopping and starting, which can be a challenge as well. Despite the emphasis of using family voice to establish service need, in two cases disputes between the caseworker and facilitator made it difficult to come to an agreement about what services would be best for the youth.

The other barrier involves a lack of services, including placements for teenagers with mental health needs, mentoring programs, medication management, adolescent psychiatry and services for youth with special needs. Some stakeholders also reported that while youth were

motivated and interested in obtaining jobs, it has been a challenge to find establishments willing to hire them.

Facilitators provided examples on ways they have worked to overcome the challenges caused by service barriers; efforts include: making lots of calls; physically being there to make sure youth/families follow through; staffing the case with LCA supervisors, DHHR staff and school staff; rewarding youth for participation; working to keep placements stable; identifying informal mentors; and teleconferencing with doctors or getting them to prescribe medications or services for multiple months. LCAs have also used their flexible funding to purchase non-traditional services, such as tutoring, gym memberships, computers, phones, housing and car repairs, among others.

Summary of Process Evaluation Results

Initial planning for *Safe at Home* West Virginia focused on the development of guidance documents for the program, collaborating with LCAs and communicating with community partners, including judges. Outreach and transparency represented continuous efforts throughout the implementation period. The first phase was implemented in October 2015, the second phase in August of the following year and, as of April 2017, the program has been fully implemented statewide. Administrative oversight has been provided at all levels of DHHR as well as internally by the LCAs themselves. Oversight has included holding LCAs accountable for assessing the strengths and needs of youth and their families and providing the services they families need to be successful. The program is running smoothly overall, so planning efforts have shifted toward program sustainability.

Safe at Home is based on the principles of the Wraparound model and fidelity to the model has been good overall. Both LCAs and DHHR have generally conformed to the requirements for each phase of wraparound. Fidelity scores improved as wraparound facilitators became more engaged with the youth and families. Youth and their families have been encouraged to be actively involved, building on their strengths in planning, and have reported progress on and/or achievement of goals from being involved in the program.

There have been some barriers encountered along the way that needed to be addressed. Initial confusion about the roles of DHHR and LCA staff was resolved through training and policy changes. An issue about the appropriateness of some referrals was also identified and resolved early in the implementation process. Barriers, including the lack of consistent motivation among youth and their families and available services in some areas, have remained challenging. There have been a number of successes as well. Stakeholder buy-in has increased, including that of judges. This has been echoed by a change in how DHHR engages families both within *Safe at Home* and more generally. Some staff have witnessed a positive organizational shift in the way DHHR and LCAs engage families. One regional office interviewee said, “I think it has changed the overall way we do business and what it means to involve families in case planning. Informal supports are better understood. I tell staff that we should be using the same concepts and supports we have built through *Safe at Home* regardless of whether or not the child or youth is in the program.”

Outcome Study

Key Questions

The following questions are designed to determine the effectiveness of *Safe at Home* in achieving safety and permanency and whether the well-being of the child is improving.

1) To what extent has the project reduced the number of youth placed in congregate care?
2) To what extent has the project reduced the length of stay in congregate care and what impact did that have on the overall length of time in care for the foster care population?
3) To what extent has the project increased the number of youth remaining in their own communities?
4) To what extent has the project reduced the rates of initial and repeat foster care entry?
5) To what extent has the project improved youth safety/ maltreatment recidivism?
6) To what extent has the project improved the well-being, educational achievement, and family functioning of youth?

Sample

From the first day of program implementation, October 1, 2015, to March 31, 2018, 1,544[11] total youth have been referred to *Safe at Home* and remained in the program for at least three days. For the analysis of outcomes in this interim report, all youth are combined into one treatment group regardless of the date of referral to *Safe at Home* (Table 4). This is a change from the six-month progress reports which break the treatment group into cohorts based on when the youth entered the program. Combining all *Safe at Home* youth into one group displays the overall effectiveness of the program and provides a larger sample to draw conclusions.

For the interim report, outcomes are reported for youth where sufficient time has passed to measure outcomes, with youth included in the six-month analysis different from those included in the 12-month analysis of outcomes. Unless otherwise specified, outcome measures are examined at or within six and twelve months post-referral to *Safe at Home*. Results for the matched comparison group are also provided to examine the impact of the Wraparound model as compared to traditional case practice.

[11] The numbers of youth reported by HZA and the State differ slightly because the State utilizes weekly tracking logs (*i.e.*, real-time data) to count the number of youth in the program and HZA relies on quarterly FACTS extracts for data (*i.e.,* slightly delayed data). HZA's counts are lower due to delayed data entry into FACTS which results in small differences in the total numbers of youth and the number of youth reported for some of the cohorts.

Table 4. Outcome Analysis Cohorts		
Group	**Referral Period**	**Number of Youth**
Treatment	October 1, 2015 – September 30, 2017	1087
Comparison	SFY 2011 – 2015	1087

While the program targets certain kinds of youth with specific problems, there is also some diversity in the characteristics of the *Safe at Home* population. Table 5 shows both the similarities and the differences.

Table 5. *Safe at Home* Youth Population Description at Referral		
	Number of Youth	**Percentage of Youth**
Placement		
Total	**1544**	**100%**
Out-of-state Congregate Care	86	6%
In-state Congregate Care	283	18%
Emergency Shelter	62	4%
Family Foster Care	82	5%
Home	1031	67%
Age		
12 or less	146	9%
13	216	14%
14	324	21%
15	394	26%
16	396	26%
17	68	4%
Gender		
Male	918	59%
Female	626	41%
Race		
White	1317	85%
Black	78	5%
Mixed	119	8%
Other	30	2%
Systems Involvement		
Juvenile Justice	104	7%
Substance Abuse		
Yes	71	5%
No	1473	95%

Table 5. *Safe at Home* Youth Population Description at Referral		
	Number of Youth	Percentage of Youth
Mental Health		
Behavioral Disorders[12]	521	34%
Psychiatric Disorders[13]	189	12%
Youth with Possible Mental Health Diagnoses[14]	970	63%

Youth referred to *Safe at Home* are typically between the ages of 14 and 16, male and white. The goal of *Safe at Home* shifted to a prevention focus soon after the start of the initiative; therefore, the initial placement setting of youth is predominately in the youth's home. Roughly one-third of the *Safe at Home* population has a behavioral disorder and two-thirds have a possible mental health diagnosis. Because one of the eligibility criteria for *Safe at Home* is that youth should have a "possible" mental health diagnosis, youth participating in *Safe at Home* without a behavioral or psychiatric disorder identified in FACTS are deemed to have a possible diagnosis.

Data Analysis

Stepwise Regression Analysis

To gain a better understanding of which populations *Safe at Home* best serves, HZA performed a stepwise regression analysis for most of the outcome measures. A linear regression is first run using a complete list of independent variables against the outcome measure. The programming then determines if removing or adding variables, if they were removed, in a stepped fashion produces a stronger correlation to the outcome. The stepwise regression is complete once no change in independent variables produces a stronger correlation, resulting in the variables which are most strongly correlated to the outcome. The variables examined are:

- county,
- referral date,
- gender,
- race,
- placement at referral,

[12] Includes diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit and Hyperactivity Disorder, among others.
[13] Includes diagnoses such as Anxiety Disorder, Bipolar I and II Disorder, Major Depressive Disorder, Schizophrenia, among others.
[14] According to the State's Program Manual, referral criteria has been updated stating that youth in the prevention category now only need, "a *possible* [emphasis added] diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning." Originally, all youth needed an official mental health diagnosis in order to participate in the program.

- length of time out-of-state prior to referral,
- age,
- length of DHHR case activity prior to referral,
- presence of a mental health diagnosis,[15]
- juvenile justice involvement,
- substance abuse and
- if formal services have been received.

Each of the factors listed above have been run against all the following outcome measures:

- initial congregate care entries,
- congregate care re-entries,
- length of stay in congregate care,
- county movement (*e.g.*, home-county to out-of-county and out-of-county to home-county),
- initial foster care entries,
- foster care re-entries and
- new referrals.

Whenever any of the factors from the stepwise regression analysis are found to have a notable impact (which may or may not be statistically significant) on any of the outcome measures, it will be described in greater detail while discussing the specific outcome measure. To determine the extent to which the *Safe at Home* program is effective for certain populations, an identical regression analysis was performed for youth in the comparison group taking into account the youth's characteristics.

Results

Before the results of the outcome measures are examined, it is beneficial to see how the population of *Safe at Home* youth changed over time. The number of youth who were referred while in out-of-state congregate care decreased from the start of the program. The most substantial change involved the count of youth who were referred while in their own homes, increasing from 46 youth referred between October 2015 and March 2016 to 457 two years later. Table 6 identifies the placement of youth at the time of referral to *Safe at Home*.

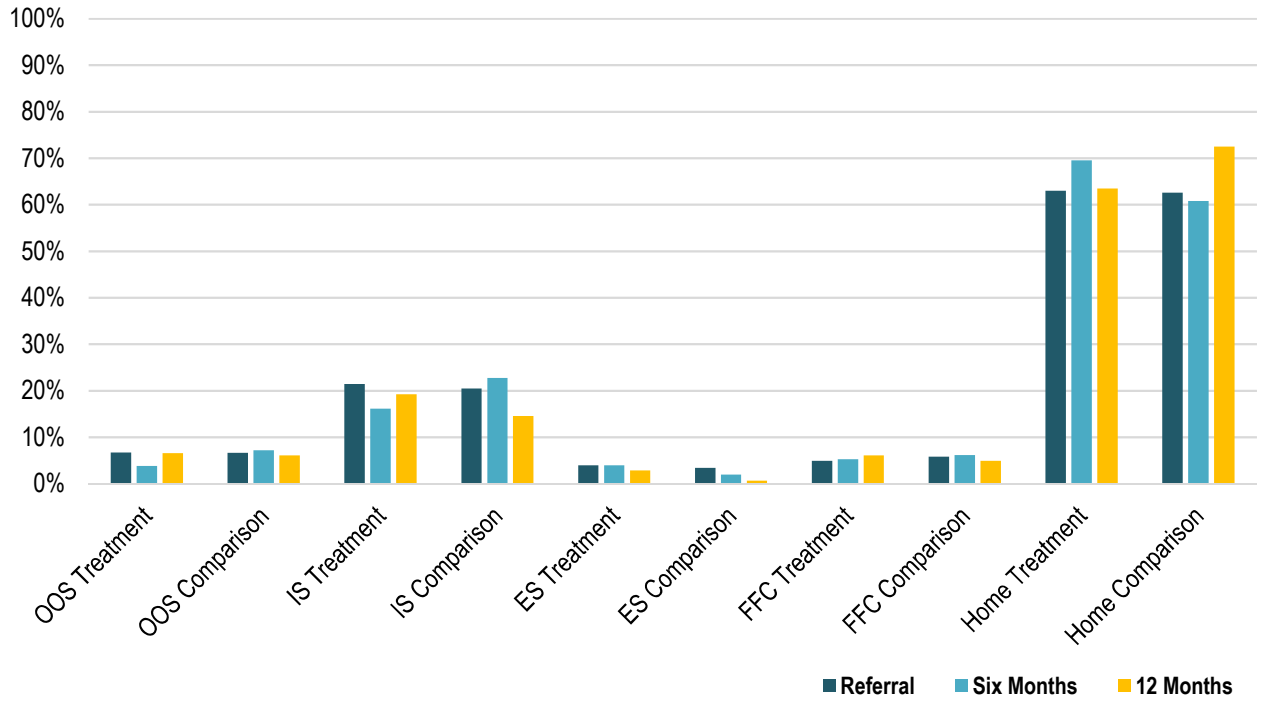
[15] This analysis will be further broken down by the date of diagnosis; looking separately at those youth who received a diagnosis prior to congregate care entry, and those who received a diagnosis following entry.

Table 6. Placement of Youth at Referral to *Safe at Home*					
Placement Setting	**10/15 – 3/16**	**4/16 – 9/16**	**10/16 – 3/17**	**4/17 – 9/17**	**10/17 – 3/18**
Out-of-state Congregate Care	31	18	12	12	13
In-state Congregate Care	39	73	61	60	50
Emergency Shelter	6	18	6	13	19
Family Foster Care	2	11	13	27	29
Home	46	101	205	333	346
Total	**124**	**221**	**297**	**445**	**457**

Youth Placement Changes

Figure 3 contrasts the placement changes of youth at six and 12 months following referral for the treatment and comparison groups. Youth in *Safe at Home* show a significantly ($p < 0.001$) higher percentage of youth in their home at six months and a lower percentage of youth in both out-of-state (OOS) and in-state (IS) congregate care facilities. This trend reverses at 12 months, where a significantly ($p < 0.05$) higher percentage of *Safe at Home* youth are placed in OOS or IS facilities rather than at home. Throughout the remainder of the report, this same theme appears across many of the outcomes, suggesting *Safe at Home* works well for the first six months after referral but does not keep up that momentum through a full year.

Figure 3. Percentage of Youth Placement Type at Referral and Six and 12 Months Post Referral



Congregate Care

Safe at Home has multiple goals related to out-of-state and in-state congregate care, including the prevention of initial placements into this higher level of care, returning youth to lower level settings and reducing the time spent in these types of settings.

One way to evaluate the impact of preventing placement into congregate care is to compare the results for youth in the treatment group to those in the comparison group who were in a lower level of care at the time of referral. Youth placed initially in lower levels of care, *i.e.*, their own homes, family foster care or an emergency shelter, were examined at six and twelve months following referral (Table 7) to determine the extent to which those youth moved to congregate care. *Safe at Home* youth referred to lower levels show similar results to comparison group youth at six months. However, at 12 months there is a significantly ($p < 0.01$) higher percentage of *Safe at Home* youth in congregate than comparison group youth.

Table 7. Percentages of Youth from Lower Levels of Care to Congregate Care

Group	Number Referred at a Lower Level with 6 Months Possible	Percent in Congregate Care at 6 Months	Number Referred at a Lower Level with 12 Months Possible	Percent in Congregate Care at 12 Months
Treatment	781	17%	408	24%
Comparison	788	17%	788	14%

The results from the stepwise regression analysis show that *Safe at Home* youth who have an Axis 1 diagnosis are at higher risk to move to a congregate care facility from a lower level within six and 12 months of referral. Interestingly, treatment group youth with juvenile justice involvement have a lower risk of being placed in congregate care at 12 months. Additionally, treatment group youth referred earlier in *Safe at Home* implementation showed a higher risk of being placed in congregate care at six months, and a lower risk of placement in congregate care facilities at 12 months. The comparison group regression did not show any significance for juvenile justice youth but did show youth receiving formal services are at higher risk of entering congregate care. This is suggestive that *Safe at Home* is more effective at keeping juvenile justice-involved youth and those who receive formal services out of congregate care.

Table 8 displays the results for youth who exited congregate care to a lower level of care within 12 months of referral and ultimately returned to congregate care at six or twelve months later. Results displayed below are for youth where sufficient time has passed to measure outcomes. A lower percentage of *Safe at Home* youth re-entered congregate care within six months than comparison group members. Like the previous outcome, the opposite occurs at 12 months where a higher percentage of *Safe at Home* youth re-enter congregate care than comparison group youth. However, none of the results is statistically significant.

Table 8. Rate of Congregate Care Re-Entry				
Group	Number of Youth Moved to Lower Level of Care from Congregate Care within 12 Months with 6 Months Possible	Percent of Re-Entry 6 Months After Congregate Care Discharge	Number of Youth Moved to Lower Level of Care from Congregate Care within 12 Months with 12 Months Possible	Percent of Re-Entry 12 Months After Congregate Care Discharge
Treatment	121	34%	78	37%
Comparison	136	41%	136	28%

The stepwise regression reveals *Safe at Home* youth referred earlier in the program's implementation are at a lower risk to re-enter congregate care within six months. Youth who were referred in Morgan County are at significantly higher risk to re-enter congregate care at 12 months than those in other counties. Additionally, the older the youth are when referred to *Safe at Home*, the lower the risk to re-enter congregate care at 12 months. The regression analysis of the comparison group also shows older youth are at slightly less risk of re-entering congregate care, suggesting this population is less likely to re-enter these facilities in general.

Table 9 identifies the average number of days youth spent in congregate care. While *Safe at Home* youth seem more likely to enter congregate care than their historical counterparts, they spend much less time in those settings. Results for the average length of time in congregate care within six and 12 months are significant at the $p < 0.01$ level.

Table 9. Average Length of Stay in Congregate Care Within 6 and 12 Months		
Group	Average Days in Congregate Care Within 6 Months	Average Days in Congregate Care Within 12 Months
Treatment	78	143
Comparison	126	211

Not surprisingly, the regression analysis showed that treatment youth referred while in a congregate care facility or with an Axis 1 diagnosis are at significantly higher risk of spending more time in congregate care than those that begin *Safe at Home* when placed in another placement setting or without a diagnosis. Participants who were referred later in the program's implementation (*e.g.*, the second year of implementation) and who are older spend less time in congregate care. The regression analysis completed for the comparison group also shows youth referred in congregate care facilities or with an Axis 1 diagnosis are at significantly higher risk of spending more time in congregate care. However, the comparison group shows males have a higher risk of spending more time in care while *Safe at Home* males do not, suggesting *Safe at Home* is more effective at keeping males from spending more time in congregate care than the comparison group.

Detention

Since a proportion of *Safe at Home* youth are juvenile justice involved, HZA added initial detention entries and re-entries to the outcome measures. As shown in the "Youth Placement Changes" section of the report (above), the overall number of youth in detention is low and therefore a regression analysis will not provide meaningful insights to the population entering detention. However, the ramifications of this level of placement are serious enough to warrant further investigation. Youth cannot be referred to *Safe at Home* from a detention facility; therefore, none of them start at this particulate placement setting. Additionally, once youth enter a detention facility they are no longer eligible for *Safe at Home* and are subsequently discharged from the program (though they may be re-referred following their exit from detention).

Table 10 reveals fewer *Safe at Home* youth are in a detention facility both six and 12 months after referral than comparison group youth. However, neither result is statistically significant.

Table 10. Initial Detention Entries at 6 and 12 Months Post-Referral

Group	Number of Youth in Detention at 6 Months	Number of Youth in Detention at 12 Months
Treatment	8	4
Comparison	11	8

Table 11 displays the results for youth in which sufficient time has passed since exiting detention to measure the extent to which they re-enter detention within six and 12 months after leaving and being referred to *Safe at Home*. Both treatment and comparison groups have only one youth who was in detention six months after leaving a previous detention facility. At 12 months, the treatment group shows no youth in a detention facility while the comparison group has three youth in such a facility. Here too, the results are not significant.

Table 11. Number of Youth Re-Entering Detention at 6 and 12 Months

Group	Number of Youth Moved Out of a Detention Center 12 Months After Referral	Number Re-Entering Detention 6 Months After Leaving	Number Re-Entering Detention 12 Months After Leaving
Treatment	22	1	0
Comparison	44	1	3

County Movement

Another goal of *Safe at Home* is to increase the number of youth living in their home community. To measure the extent to which this goal has been achieved, the movement of youth both leaving their home county and those returning are examined at six and twelve

months post-referral; the results are provided in Table 12.[16] A similar percentage of *Safe at Home* youth were placed out of their home county as was evidenced for the comparison group at six months. This trend does not hold at 12 months where the treatment group shows a significantly ($p < 0.01$) higher percentage of youth in the treatment group who were placed outside their home county than the comparison group.

A significantly ($p < 0.05$) higher percentage of youth who were referred to *Safe at Home* while outside their home community moved back to their home county at six and 12 months than comparison group youth. Interestingly, there is a slightly lower percentage of *Safe at Home* youth who remained in their home county at both the six and 12 month marks.

Table 12. Youth County Movements

Group	Number Referred at a Lower Level with 6 Months Possible	Percent in Congregate Care at 6 Months	Number Referred at a Lower Level with 12 Months Possible	Percent in Congregate Care at 12 Months
From Home-County to Out-of-County				
Treatment	782	17%	417	23%
Comparison	759	16%	759	13%
From Out-of-County to Home-County				
Treatment	326	69%	237	65%
Comparison	331	31%	331	55%

The regression analysis reveals *Safe at Home* youth are at higher risk of being moved out of their home county if they have an Axis 1 diagnosis, were placed in a shelter or psychiatric facility at the time of referral, or were referred later in the program's implementation. In addition to these variables, the comparison group shows youth receiving formal services are at higher risk of being moved out of their home county, suggesting the services received in *Safe at Home* are more successful at keeping youth in their community. Treatment group youth who are older at the time of referral or are juvenile justice involved have a higher chance of returning to their home county while youth who received formal services have a lower chance of returning to their home county. These populations are not seen in the comparison group regression, suggesting *Safe at Home* is successful at returning juvenile justice and older youth to their home county.

Additionally, the comparison group shows that youth referred while in a psychiatric or out-of-state group home facility are less likely to return home. Because these populations are not seen in the *Safe at Home* regression, it implies the program is more effectively returning youth in these placement settings to their home county.

[16] Instances where youth move out-of-county because of placement with a parent or relative foster placement are not included in the analysis, as these are more ideal settings for youth to achieve permanency than merely living within their home-counties.

Foster Care

Safe at Home has two goals related to foster care, understood as any out-of-home placement. The first is to reduce the percentage of youth who need placement outside the home, and the second is to reduce the percentage of youth who re-enter care following discharge to their home. Table 13 examines the initial entry into foster care following referral for youth who were referred while living in their own homes. Treatment group members show similar results to the comparison group at six months. Following the trend for six- and 12-month congregate care outcomes, *Safe at Home* shows significantly ($p < 0.01$) more youth with initial foster care placements at 12 months than comparison group youth.

Table 13. Initial Foster Care Entries

Group	Number of Youth Home at Referral with 6 Months Possible	Percent with Initial Foster Care Entry at 6 Months	Number of Youth Home at Referral with 12 Months Possible	Percent with Initial Foster Care Entry at 12 Months
Treatment	685	20%	352	26%
Comparison	687	18%	687	15%

The regression analysis shows that treatment youth who were referred later in the program's implementation or have an Axis 1 diagnosis are at higher risk of being placed into foster care. Additionally, juvenile justice involved youth have a slightly lower risk of entry into foster care at 12 months, though the results are not significant. Finally, youth who received formal services prior to *Safe at Home* are at a slightly higher risk of entering foster care within 12 months of referral.
]
The comparison group regression does not show youth with juvenile justice involvement as having reduced risk to enter foster care, suggesting *Safe at Home* is more effective at keeping this population out of foster care. Furthermore, the comparison group regression shows a significantly higher risk for youth receiving formal services to enter foster care, suggesting the formal services youth are receiving in *Safe at Home* are slightly more effective at keeping youth out of foster care.

Table 14 displays the results for youth who exited foster care within 12 months of referral to live with their parents or a relative and ultimately returned to foster care at six or twelve months following discharge. Results presented below include youth where sufficient time has passed to measure outcomes. *Safe at Home* shows a higher percentage of youth re-entering foster care at both timeframes than comparison group youth. This outcome is significant at the $p < 0.05$ level at six months.

Table 14. Rate of Re-Entry into Foster Care				
Group	Number of Youth Discharged from Foster Care within 12 Months of Referral with 6 Months Possible	Rate of Foster Care Re-Entry (%) at 6 Months	Number of Youth Discharged from Foster Care within 12 Months of Referral with 12 Months Possible	Rate of Foster Care Re-Entry (%)
Treatment	253	22%	156	20%
Comparison	273	12%	273	14%

The stepwise regression shows youth who received formal services during *Safe at Home* are at significantly higher risk of re-entering foster care than those who did not. Additionally, the longer the case was open prior to the *Safe at Home* referral, the less risk the youth has of re-entering foster care at both timeframes. The comparison group regression showed youth referred in congregate care facilities and youth in Clay and Ritchie counties are significantly more likely to re-enter foster care. These results suggest the formal services youth received in *Safe at Home* are less effective in preventing youth from re-entering congregate care, but are more effective at keeping youth referred while in congregate care from re-entering care.

Maltreatment

The *Safe at Home* initiative aims to increase youth safety by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 15 displays the number of youth with a maltreatment referral subsequent to referral to *Safe at Home* and the number for which that referral led to a substantiated maltreatment determination. Youth in *Safe at Home* experienced fewer subsequent referrals of maltreatment within six and 12 months from referral to the program than their comparison group counterparts. Results are statistically significantly across both timeframes at the $p < 0.01$ level.

Table 15. Number of Youth with a New Referral or Substantiation				
Group	Referral Within 6 Months	Substantiation Within 6 Months	Referral Within 12 Months	Substantiation Within 12 Months
Treatment	72	1	59	1
Comparison	118	0	171	0

Due to the limited number of new substantiations, the regression discussion will focus on new referrals. Youth referred in Brooke, Hampshire, Mercer and Wetzel counties are at significantly higher risk to have a new referral than those in other counties. The risk to have a new referral decreases as youth become older and later after the program's implementation. Additionally, males are significantly less likely to have a new referral at 12 months than females. The comparison group regression shows youth with an Axis 1 diagnosis or who were referred while placed in a shelter or in their own home are at higher risk of a referral while males are at lower risk. The county from which youth were referred to the program is not a factor for a maltreatment referral in the comparison group; however,

new referrals of maltreatment are dependent on the youth's home county for *Safe at Home* participants.

Summary of Safety and Permanency Outcome Evaluation Results

The biggest success has been in returning many of the youth who had been in congregate care placements to their communities, leading to a policy change in program eligibility. Eligibility has now been extended from youth ages 12 to 17 with a behavioral or mental health diagnosis placed or at-risk of being placed in congregate care to include at-risk youth who possibly have a behavioral or mental health diagnosis. This change is an indication of the program's shift to a prevention focus of keeping youth safe at home.

Overall, *Safe at Home* outcomes follow an interesting pattern where treatment youth perform better than comparison groups for the first six months, but the successes dissipate by twelve months. As noted in the limitations section, there are no data for youth in the comparison group with possible mental health diagnoses which may be influencing the result. Consequently, it is not possible to know if the severity of mental health issues explains the lack of difference in results a year after service begins.

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

Well-Being

The CANS tool provides an assessment of youth's strengths and needs which is used to support decision-making, facilitate service referrals and monitor the outcomes of services received. By utilizing a four-level rating system (with scores ranging from 0 to 3) on a series of items used to assess specific domains, such as Child Risk Behaviors or Life Domain Functioning, the CANS helps LCA wraparound facilitators and DHHR caseworkers to identify needs/actionable items (*i.e.*, those with a score of 2 or 3), indicating where attention should be focused in planning with the youth and family. Some items in the CANS will trigger further modules for questioning if a need is discovered in that area, such as substance use and GLBTQ (Gay, Lesbian, Bi-Sexual, Transgender, and/or Questioning).

Wraparound facilitators from the LCAs are responsible for administering CANS assessments to youth in the program. Once the assessments are completed, they are to be entered into the online WV CANS system. Youth in the program are supposed to receive an initial CANS assessment within 30 days of referral and subsequent CANS are to be performed every 90 days thereafter.

A total of 720 *Safe at Home* youth have at least two CANS assessments completed (*i.e.*, an initial CANS and at least one subsequent CANS). There are no CANS available to compare to youth in the comparison groups; thus, the analysis is limited to youth in *Safe at Home*.

For this report, the results of the initial CANS assessments are compared to those completed for youth at six and twelve months post the initial CANS (where time allows) to measure progress while in the program. Progress is measured by the improvement in scores reflecting a reduction in needs/actionable items. As shown in Table 16, CANS assessments available for analysis become more limited as more time elapses after the youth's entry into *Safe at Home*. This is due to a variety of factors, including: placement into a detention center, case closure within six months because families decline participation or the State cannot secure a placement for youth.

Table 16. Number of Youth with CANS Assessments Available for Analysis	
Number of Youth with an Initial CANS Assessment	761
Number of Youth with a 6-Month Follow-Up CANS	319
Number of Youth Discharged Before a 6-Month Follow-Up CANS can be Performed	246
Number of Youth Where Not Enough Time Has Passed Before a 6-Month CANS can be Performed	35
Number of Youth Where Enough Time Has Passed & No 6-Month CANS was Performed	161
Number of Youth with a 12-Month Follow-Up CANS	87
Number of Youth Discharged Before a 12-Month Follow-Up CANS can be Performed	434
Number of Youth Where Not Enough Time Has Passed Before a 12-Month CANS can be Performed	180
Number of Youth Where Enough Time Has Passed & No 12 Month CANS was Performed	359

Table 17 provides an overview of the percentage of youth with at least one need item selected as actionable in the main CANS domains on the initial assessment. For a closer look at the specific items identified with a need within each of the main domains, please see Appendix B. The most common CANS domain with an actionable item is Life Domain Functioning followed by Child Behavioral / Emotional Needs. Roughly 50 percent of the youth are actionable in the "Legal" item of the Life Domain Functioning domain.

Table 17. Percentage of Youth with an Actionable Item/Need on the Initial CANS Assessment	
CANS Domain	**Percentage Actionable**
Child Behavioral/Emotional Needs (13 Items)	72.5%
Child Risk Behaviors (13 Items)	40.5%
Life Domain Functioning (19 Items)	91.2%
Trauma Stress Symptoms (12 Items)	34.6%

Table 18 shows the percentage of youth who had a six or twelve month follow up CANS and who also had at least one need in a domain with a decreased score (*i.e.*, at least one item in the domain had gone from actionable to non-actionable because it was no longer considered a need). Over half of the youth for whom a second CANS was completed showed improvement from the initial CANS in each domain listed.

The Life Domain Functioning domain, which describes how children and adolescents are doing in their various environments (*e.g.*, home, school, legal, recreation), shows the largest percentage of youth with improved scores at six months. Further improvement is evidenced for youth with a 12-month CANS with roughly 75 percent of youth showing improved scores from the initial CANS assessment in each domain.

Table 18. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6- or 12-Month Subsequent CANS		
CANS Domain	**Youth with Improved Scores 6 Months Post-Initial CANS**	**Youth with Improved Scores 12 Months Post-Initial CANS**
Child Behavioral/Emotional Needs	54.4%	72.1%
Child Risk Behaviors	59.1%	75.0%
Life Domain Functioning	66.4%	75.3%
Trauma Stress Symptoms	53.3%	72.2%

As noted earlier, there are triggered sub-modules which delve deeper into specific questions on specific topics where youth have identified needs. Table 19 provides the results of youth who triggered sub-modules in the initial CANS assessment. The most commonly triggered submodule is Delinquent Behavior followed by Substance Use while the least commonly triggered submodules are Commercial Sexual Exploitation and Fire Setting.

Table 19. Percentage of Youth with Triggered Submodules on Initial CANS Assessment	
Submodule Triggered	**Percentage**
Adolescent Suicide	7%
Commercial Sexual Exploitation	1%
Children's Sexual Behaviors Screen	11%
Delinquent Behavior	49%
Fire-Setting	1%
LGBTQ	4%
Sexually Abusive	14%
Substance Use	27%

When a sub-module is triggered it is likely to remain triggered unless evidence is found that the youth was not honest when first triggered or the wraparound facilitator incorrectly entered information in the CANS tool. However, there is some opportunity to determine if a subsequent CANS continues to trigger the sub-module. When the 26 youth whose initial assessment triggered the adolescent suicide submodule are considered, 25 youth continued to have that submodule triggered when the six-month CANS was completed. Additionally, a total of 40 youth triggered the adolescent suicide submodule at the time of their six-month assessment. The increase is likely based on youth being more open with the facilitator as the two build a rapport. This pattern exists for each submodule.

Educational Functioning

Similar to the analysis of family functioning, an analysis of educational functioning draws on the use of CANS data to identify the areas of challenge and improvement for youth in *Safe at Home*. Educational functioning items fall within the Life Domain Functioning and Trauma Exposure CANS domains and are inclusive of four specific items:

- School Achievement
- School Attendance
- School Behavior
- School Violence

Results for Educational Functioning are displayed in Table 20. The most common Educational Functioning need on the initial assessment is School Achievement followed by School Behavior. Overall, 60 percent of the youth show improvement on the six-month follow-up CANS assessment when compared to the initial CANS. The most improved

Educational Functioning item at both the six- and 12-month follow-up is School Attendance while School Violence shows the least improvement at both follow-up assessments.

Table 20. Number of Youth with Improved Scores on Educational Functioning Items at 6 & 12 Months

CANS Items	Number of Youth with Need on Initial CANS	Number of Youth with a 6 Month CANS & Need on Initial CANS	Number of Youth with Improved Scores 6 Months After Initial CANS	Number of Youth with a 12 Month CANS & Need on Initial CANS	Number of Youth with Improved Scores 12 Months After Initial CANS
School Achievement	238	105	54	25	16
School Attendance	174	73	55	14	10
School Behavior	224	108	61	24	15
School Violence	66	25	6	6	2
Total	**447**	**191**	**115**	**45**	**29**

Family Functioning

Progress in family functioning was analyzed by looking at CANS items that make up the Family Functioning domain (Table 21). The most common Family Functioning need on the initial assessment is Family Stress followed by Residential Stability. Of those with a CANS assessment at six months, roughly 45 percent showed improved Family Stress and Residential Stability scores. Though the number of 12-month assessments is limited, roughly two-thirds of the youth showed improved Family Functioning from the initial CANS to the 12-month follow-up.

Table 21. Number of Youth with Improved Scores in the Family Functioning Domain at 6 & 12 Months

CANS Items	Number of Youth with Need on Initial CANS	Number of Youth with a 6 Month CANS & Need on Initial CANS	Number of Youth with Improved Scores 6 Months After Initial CANS	Number of Youth with a 12 Month CANS & Need on Initial CANS	Number of Youth with Improved Scores 12 Months After Initial CANS
Physical Health	33	12	4	8	4
Mental Health	21	7	3	3	3
Substance Use	12	7	3	5	3
Family Stress	127	57	25	20	15
Residential Stability	48	21	10	9	7
Total	**172**	**75**	**30**	**28**	**18**

Summary of Well-Being Outcome Evaluation Results

The well-being of youth in *Safe at Home* has shown dramatic improvement. Examination of the CANS assessments have shown that for youth with a six-month CANS follow-up over half of the youth with at least one actionable item on the initial CANS had improved. Furthermore, for youth with a 12-month CANS follow-up, three-fourths show improvement from the initial CANS. This was true in the Child Behavioral/Emotional Needs, Child Risk Behaviors, Life Domain Functioning and Trauma Stress Symptoms domains.

The exception is in the School Functioning domain, where improvement has not been as substantial. A quarter of *Safe at Home* youth showed improvement in school achievement, attendance and general behavior at school after six months. The proportion was less than ten percent at twelve months. Little impact was demonstrated for school violence in either timeframe.

There was also some improvement in the Family Functioning domain. While family stress and residential stability were reduced at twelve months from that at six months, the other measures were maintained between six and twelve months. Specifically, the same number of *Safe at Home* youth who showed improvement in physical health, mental health and substance use at six months showed improvement twelve months after the initial CANS assessment.

The well-being of youth in *Safe at Home*

has shown dramatic improvement

in almost every domain measured.

Cost Evaluation

The cost evaluation is used to determine whether *Safe at Home* West Virginia is more effective and efficient from a cost perspective than traditional methods used in West Virginia's casework.

Key Questions

Four research questions guide the evaluation of costs.

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

Data Sources and Data Collection

The cost analysis for the interim report focuses on answering the first and third research questions by comparing the costs of out-of-home care and fee-for-services for those incurred for youth in the treatment group to those in the comparison group for youth who have been in the program for at least one year. It also provides a glimpse of the contracted costs for services provided by the wraparound providers.

Due to the nature of how the comparison group was selected (*i.e.*, propensity score matching), the comparison group will have more youth with one measurable year than the treatment group because at least 12 months will have passed for youth in the comparison group as opposed to some of the youth in the treatment group where only six months have passed. Therefore, only costs per case are appropriate to report.

Data Analysis

For consistency with the semi-annual reports, daily rates for room and board expenditures are developed using costs incurred by youth in the comparison group of *Safe at Home* youth referred in the first six months of implementation (*i.e.*, October 1, 2015 through March 31, 2016). With rates subject to change year to year, it is important that a standard rate be developed and applied to eliminate the impact of rate increases and thus avoid the inappropriate appearance of waiver costs being higher just because of rate increases.

The cost of providing out-of-home care to the youth in the comparison cohort was calculated, limiting the cost to the first 365 days of substitute care for those who remained out of the home longer than one year following the date they qualified for inclusion in the comparison group. This limitation was applied to ensure that the same amount of time eligible for review of the costs for treatment youth was applied equally to the comparison group. Those costs were then used to compute an average daily rate which will continue to be used for the cost evaluation going forward.

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

Out of State Residential Care	**$239.91**
In-State Residential Care	**$161.95**
Shelter Care	**$150.17**
Therapeutic/Specialized Care	**$57.29**
Preventive Care	**$21.47**

Results

The rates were first applied to the number of days youth in the treatment and comparison groups were in substitute care, again limiting the analysis to the first year following enrollment in *Safe at Home*. Table 22 lists the average cost spent in each out of home placement location per case. In total, *Safe at Home* costs nearly $7,000 less per case annually than for youth in the comparison group.

Table 22. Average Cost per Youth Receiving Room and Board Payments

Type of Care	Comparison Group	Treatment Group
Out-of-state Residential Care	$45,593.45	$28,028.81
In-state Residential Care	$29,405.99	$19,875.52
Shelter Care	$7,206.61	$9,807.10
Therapeutic/Specialized Care	$9,569.51	$6,151.71
Preventive Care	$5,136.52	$3,748.78
Totals	**$29,927.69**	**$23,102.65**

Fee-for-services costs (*e.g.*, case management, maintenance, services) were also examined to determine if *Safe at Home* was having a positive impact in reducing expenditures incurred by West Virginia to meet the needs of youth. Several service categories (*e.g.*, assessment, transportation) are not reported for *Safe at Home* youth since they are Administrative Services Organization (ASO) payments which are now funded by the LCAs through wraparound services. As shown in Table 23, per-case amounts for fee-for-services paid through FACTS for *Safe at Home* youth is nearly $750 less than the comparison group.

Table 23. Average Cost per Youth Receiving Fee-for-Service Payment		
Service Category	**Comparison Group**	**Treatment Group**
Assessment	$661.10	–
Case Management	$446.04	–
Clothing	$305.34	$259.44
Education	$10,745.17	$11,635.40
Independent Living	$926.27	$1,154.04
Legal	$299.07	$283.78
Maintenance	$288.21	–
Other	$820.70	$959.09
Services	$1,451.02	$468.96
Supervised Visitation	$778.99	–
Transportation	$459.30	–
Totals	**$1,745.23**	**$1,006.90**

HZA also examined contracted costs to provide wraparound services, again limiting the analysis to the first 12 months of enrollment in *Safe at Home*. A cost of $136 per day is paid to wraparound providers to provide assessments, case management, supervision and flex services, *i.e.*, those which are not commonly acquired to meet the needs of youth. For example, flex funds were used to pay for car repairs, furniture, YMCA membership, uniforms, driver's education classes and a bike and helmet, among other items and services.

Using the number of days youth were enrolled in *Safe at Home* West Virginia, between October 1, 2015 and March 31, 2017, nearly $27.2 million was incurred to provide services to enrolled youth. The costs equate to an average cost of $42,346 per youth annually.

Table 24. Cost for Wraparound Services			
Group	**Days in Wraparound Care (First 12 Months)**	**Cost Per Day**	**Average Annual Cost per Youth**
Treatment	$199,897	$136	$42,346

Summary of Cost Evaluation Results

The program has generated a cost savings of nearly $7,000 per child in foster care in room and board costs and a savings of nearly $750 per child receiving fee-for-services for *Safe at Home* youth referred in the first year and a half of implementation. The most significant portion of these savings can be attributed to the reduced time youth spend in congregate care facilities.

As noted above, costs to contract with wraparound service providers averages $42,346 per youth. While the overall costs for treatment youth are greater than those in the comparison group, *Safe at Home* youth are receiving services which are beyond those which can normally be provided. Some of the additional costs should be offset by DHHR caseworkers spending less time on cases, which has yet to be examined.

Summary, Lessons Learned and Next Steps

Summary

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

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

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

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

The stepwise regression analyses highlighted for which populations of youth the program is and is not working well. Youth with an Axis 1 diagnosis are at higher risk of not achieving favorable outcomes than youth without a diagnosis. Conversely, *Safe at Home* appears to be working well for youth with juvenile justice involvement and those who receive formal services. Additionally, treatment youth referred while placed in congregate care show more favorable outcomes than comparison group youth referred while in such a setting.
The overall costs for *Safe at Home* youth are greater than youth in the comparison group. However, *Safe at Home* youth are receiving services that are beyond those which can normally be provided which are yielding positive results, especially in relation to the youths' well-being and overall functioning.

Programmatic/Implementation Lessons Learned and Recommendations

As noted in the discussion above, West Virginia encountered a few challenges at the start of implementation. One of those challenges involved the training which DHHR and LCA staff were provided. Once identified, the State responded quickly, putting together a work group and a 90-day work plan, expanding policy, updating the program manual and retraining staff. In fact, West Virginia went so far as to incorporate *Safe at Home*'s Wraparound 101 and CANS training into its new worker training, ensuring that all DHHR staff are trained on

the program. In addition, LCAs have expanded their own training materials to address the needs of wraparound facilitators.

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

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

Evaluation Lessons Learned and Recommendations

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

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

Next Steps

With West Virginia's *Safe at Home* program slated to end September 30, 2019, evaluation efforts will continue on a semi-annual basis. A third round of fidelity reviews is scheduled for the summer of 2018, with another round of surveys also to be administered close to the end of the calendar year. Data from FACTS will continue to be examined to measure outcomes and identify the types of youth for whom *Safe at Home* is most successful. Efforts are also being taken to expand the cost evaluation to identify the funding sources which would have

traditionally been used to support the services provided to youth as a step toward identifying the fiscal impact of sustaining and even expanding *Safe at Home* to younger children across West Virginia. Costs which should be offset by DHHR caseworkers spending less time on cases will also be examined.

Appendix A. Statistical Similarity of Treatment and Comparison Groups

Measure	Significance	Test
Gender	0.60	Chi-Squared
Hispanic	0.38	Chi-Squared
Black	0.62	Chi-Squared
UTD	1.00	Chi-Squared
White	0.30	Chi-Squared
NHOPI	0.65	Chi-Squared
Asian	0.71	Chi-Squared
AIAN	1.00	Chi-Squared
Asian PI	1.00	Chi-Squared
Unknown Race	1.00	Chi-Squared
Declined	1.00	Chi-Squared
Placement Type	0.87	Chi-Squared
Parent Jail	0.50	Chi-Squared
Abandonment	0.48	Chi-Squared
Child Alcohol	0.71	Chi-Squared
Parent Alcohol	0.69	Chi-Squared
Caretaker Unable to Cope	0.35	Chi-Squared
Child Behavior	1.00	Chi-Squared
Child Disability	0.32	Chi-Squared
Parent Death	0.71	Chi-Squared
Child Drugs	0.44	Chi-Squared
Parent Drugs	0.51	Chi-Squared
Housing	0.26	Chi-Squared
Neglect	0.28	Chi-Squared
Physical Abuse	0.82	Chi-Squared
Relinquishment	0.65	Chi-Squared
Sexual Abuse	0.43	Chi-Squared
Voluntary	0.49	Chi-Squared
Other	1.00	Chi-Squared
Number of Prior Placements	0.22	Chi-Squared
Axis 1 Diagnosis	0.83	Chi-Squared
Juvenile Justice Involved	0.65	Chi-Squared
Psychiatric Hospital	0.4	Chi-Squared
Group Home	0.54	Chi-Squared
Age at Referral	0.05	One Way ANOVA

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

CANS Domain	CANS Item	Youth with Actionable Item (N=761)
Behavioral / Emotional Needs	Affective and/or Physiological Dysregulation	71
	Anger Control	271
	Anxiety	150
	Attachment Difficulties	65
	Attention/Concentration	252
	Conduct	132
	Depression	189
	Eating Disturbances	9
	Impulsivity	206
	Oppositional Behavior	261
	Psychosis	16
	Somatization	7
	Substance Use	49
	Total	**552**
Child Risk Behaviors	Bullying	58
	Cruelty to Animals	6
	Danger to Others	119
	Delinquency	37
	Exploitation	12
	Fire Setting	12
	Intentional Misbehavior	78
	Non-Suicidal Self Injury	41
	Other Self Harm	28
	Runaway	87
	Sexualized Behaviors	31
	Sexually Abusive	11
	Suicide Risk	34
	Total	**308**
Life Functioning Needs	Brain Injury	7
	Child Involvement with Care	119
	Daily Functioning	40
	Developmental/Intellectual	110
	Family	269
	Legal	413
	Living Situation	166
	Medical	44
	Medication Compliance	61
	Natural Supports	303
	Physical	7
	Recreational	186
	School Achievement	238
	School Attendance	174
	School Behavior	224

CANS Domain	CANS Item	Youth with Actionable Item (N=761)
	Sexual Development	47
	Sleep	104
	Social Functioning	187
	Substance Exposure	72
	Total	**694**
Symptoms of Trauma	Adjustment to Trauma	189
	Avoidance	51
	Dissociation	21
	Hyperarousal	124
	Numbing	30
	Re-experiencing	42
	Traumatic Grief	72
	Total	**263**

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

CANS Domain	CANS Item	Youth With a 6-Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12-Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Behavioral/ Emotional Needs	Affective and/or Physiological Dysregulation	29	10	2	1
	Anger Control	113	42	29	14
	Anxiety	75	31	26	13
	Attachment Difficulties	26	11	9	3
	Attention/Concentration	120	34	35	15
	Conduct	53	15	10	5
	Depression	83	25	21	10
	Eating Disturbances	5	2	4	2
	Impulsivity	81	24	20	4
	Oppositional Behavior	109	37	28	17
	Psychosis	6	5	2	2
	Somatization	3	1	1	1
	Substance Use	22	14	8	4
	Total	**241**	**131**	**68**	**49**
Child Risk Behaviors	Bullying	27	12	3	1
	Cruelty to Animals	2	1	0	0
	Danger to Others	48	25	11	8
	Delinquency	12	4	4	3
	Exploitation	2	0	0	0
	Fire Setting	6	3	0	0
	Intentional Misbehavior	34	12	8	4
	Non-Suicidal Self Injury	19	13	7	3
	Other Self Harm	12	8	5	3
	Runaway	31	15	7	5
	Sexualized Behaviors	14	8	3	3
	Sexually Abusive	1	0	0	0
	Suicide Risk	9	8	2	2
	Total	**127**	**75**	**32**	**24**
Life Functioning Needs	Brain Injury	2	0	1	1
	Child Involvement with Care	44	19	7	4
	Daily Functioning	13	5	2	2
	Developmental/Intellectual	57	12	17	5
	Family	124	56	36	17
	Legal	166	33	38	12
	Living Situation	74	43	20	17
	Medical	18	6	6	3
	Medication Compliance	23	10	9	8
	Natural Supports	124	37	43	20

CANS Domain	CANS Item	Youth With a 6-Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12-Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Physical	5	0	1	0
	Recreational	82	38	14	9
	School Achievement	105	54	25	16
	School Attendance	73	55	14	10
	School Behavior	108	61	24	15
	Sexual Development	19	9	3	3
	Sleep	45	22	8	6
	Social Functioning	86	38	18	10
	Substance Exposure	23	4	6	1
	Total	**289**	**192**	**77**	**58**
Symptoms of Trauma	Adjustment to Trauma	87	31	28	15
	Avoidance	24	10	8	3
	Dissociation	7	4	4	2
	Hyperarousal	53	25	18	13
	Numbing	11	5	5	3
	Re-experiencing	22	12	9	7
	Traumatic Grief	41	27	14	10
	Total	**122**	**65**	**36**	**26**