Child and Family Services Reviews

Statewide Assessment Instrument

January 2017

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN & FAMILIES
Administration on Children, Youth and Families
Children's Bureau

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Introduction

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendments to the Social Security Act (SSA), are administered by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The goals of the CFSR are to:

- Ensure substantial conformity with title IV-B and IV-E child welfare requirements using a framework focused on assessing seven safety, permanency, and well-being outcomes and seven systemic factors;
- Determine what is happening to children and families as they are engaged in child welfare services; and
- Assist states in helping children and families achieve positive outcomes.

The CFSR Process

The CFSR is a two-phase process, as described in 45 CFR 1355.33. The first phase is a statewide assessment conducted by staff of the state child welfare agency, representatives selected by the agency who were consulted in the development of the Child and Family Services Plan (CFSP), and other individuals deemed appropriate and agreed upon by the state child welfare agency and the Children's Bureau.

The second phase of the review process is an onsite review. The onsite review process includes case record reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors. The onsite review instrument and instructions are used to rate cases, and the stakeholder interview guide is used to conduct stakeholder interviews.

Information from both the statewide assessment and the onsite review is used to determine whether the state is in substantial conformity with the seven outcomes and seven systemic factors. States found to be out of substantial conformity are required to develop a Program Improvement Plan (PIP) to address the identified areas out of substantial conformity. States participate in subsequent reviews at intervals related to their achievement of substantial conformity. (For more information about the CFSRs, see the *Child and Family Services Reviews* at http://www.acf.hhs.gov/programs/cb.)

Integration of the CFSP/APSR and CFSR Statewide Assessment

The CFSR process is intended to be coordinated with other federal child welfare requirements, such as the planning and monitoring of the CFSP. We are encouraging states to consider the statewide assessment as an update to their performance assessment in the state's most recent CFSP and/or Annual Progress and Services Report (APSR) rather than a separate assessment process and reporting document. Most of the content for the statewide assessment overlaps with the CFSP/APSR and the same expectations for collaboration with external partners and stakeholders exist across all planning processes. States can use the statewide assessment process to re-engage these partners and stakeholders in preparation for the CFSR.

The Statewide Assessment Instrument

The statewide assessment instrument is a documentation tool for states to use in capturing the most recent assessment information before their scheduled CFSR. Each section, as outlined below, is designed to enable states to gather and document information that is critical to analyzing their capacity and performance during the statewide assessment phase of the CFSR process.

- Section I of the statewide assessment instrument requests general information about the state agency and requires a list of the stakeholders that were involved in developing the statewide assessment.
- Section II contains data profiles for the safety and permanency outcomes. These include the data indicators, which are used, in part, to determine substantial conformity. The data profiles are developed by the Children's Bureau based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS), or on an alternate source of safety data submitted by the state.
- Section III requires an assessment of the seven outcome areas based on the most current information on the state's performance in these areas. The state will include an analysis and explanation of the state's performance in meeting the national standards as presented in section II. States are encouraged to refer to their most recent CFSP or APSR in completing this section.
- Section IV requires an assessment for each of the seven systemic factors. States develop these responses by analyzing data, to the extent that the data are available to the state, and using external stakeholders' and partners' input. States are encouraged to refer to their most recent CFSP or APSR in completing this section.

We encourage the state to use this document "as is" to complete the assessment, but the state may use another format as long as the state provides all required content. The statewide assessment instrument is available electronically on the Children's Bureau website at http://www.acf.hhs.gov/programs/cb/resource/round3-cfsr-statewide-assessment.

Completing the Statewide Assessment

The statewide assessment must be completed in collaboration with state representatives who are not staff of the state child welfare agency (external partners or stakeholders), pursuant to 45 CFR 1355.33 (b). Those individuals should represent the sources of consultation required of the state in developing its title IV-B state plan and may include, for example, Tribal representatives; court personnel; youth; staff of other state and social service agencies serving children and families; and birth, foster, and adoptive parents or representatives of foster/adoptive parent associations. States must include a list of the names and affiliations of external representatives participating in the statewide assessment in section I of this instrument.

We encourage states to use the same team of people who participate in the development of the CFSP to respond to the statewide assessment. We also encourage states to use this same team of people in developing the PIP. Members of the team who have the skills should be considered to serve as case reviewers during the onsite review.

How the Statewide Assessment Is Used

Information about the state child welfare agency compiled and analyzed through the statewide assessment process may be used to support the CFSR process in a range of ways. The statewide assessment is used to:

- Provide an overview of the state child welfare agency's performance for the onsite review team;
- Facilitate identification of issues that need additional clarification before or during the onsite review;
- Serve as a key source of information for rating the CFSR systemic factors; and
- Enable states and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach.

Statewide Assessment Instrument

Section I: General Information

Name of State Agency: The West Virginia Department of Health and Human Resources

CFSR Review Period

CFSR Sample Period: Initial April 1, 2016 through September 30, 2016 (November 15, 2016 for in-home cases), rolling forward one month per each month of the review.

Period of AFCARS Data: 2013B through 2016A

Period of NCANDS Data: FY 2014 through FY 2015

(Or other approved source; please specify if alternative data source is used):

Insert other approved data source

Case Review Period Under Review (PUR): April 1, 2016 through September 30, 2017, depending on sampling period. (From onset of Sampling Period to the Date of Case Review)

State Agency Contact Person for the Statewide Assessment

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Statewide Assessment Participants

Provide the names and affiliations of the individuals who participated in the statewide assessment process; please also note their roles in the process.

State Response:

Tabetha D. Blevins, Senior Analyst, Division of Court Services, West Virginia Supreme Court of Appeals
Laura Walsh, Special Project Analyst, West Virginia Supreme Court of Appeals
Caroline Duckworth, KEPRO, contracted administrative services organization previously known as APS Healthcare
James Jeffries, Bureau for Public Health, Office of Maternal, Child and Family Health
Christina Mullins, Bureau for Public Health, Office of Maternal, Child and Family Health
Michelle Dean, Program Manager, Bureau for Children and Families
Patty Vincent, Program Manager, Bureau for Children and Families
Terri Miller, Program Manager, Bureau for Children and Families
Christina Bertelli Coleman, Program Manager, Bureau for Children and Families
Kendra-Boley-Rodgers, Human Resource Specialist, Bureau for Children and Families
Linda Watts, Deputy Commissioner, Bureau for Children and Families
Rebeca Derenge, West Virginia Department of Education
Melanie Purkey, West Virginia Department of Education
Robert Crawford, West Virginia Department of Education
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Robert Crawford, West Virginia Department of Education
Michael D. Johnson, West Virginia DHHR/MIS, FACTS Director
Laura Barno, Director Division of Children and Adult Services, Bureau for Children and Families
Carla J. Harper, Program Manager, Bureau for Children and Families
Kevin Henson, Assistant Commissioner, Bureau for Children and Families
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Jeannette Welch, Health and Human Resources Specialist, Bureau for Children and Families
Tanya Landis, Health and Human Resources Specialist, Bureau for Children and Families
Jamie Whitlatch, Health and Human Resources Specialist, Bureau for Children and Families
Jeanie Hamilton, Health and Human Resources Specialist, Bureau for Children and Families

The individuals listed above provided information that is included in this Statewide Assessment. The individuals listed assisted in writing at least one item response or reviewed and commented on at least one item response. These individuals are primarily West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF), staff who engage in ongoing collaboration activities with stakeholder groups such as the courts, youth in foster care, foster and adoptive parents, service providing agencies, government agencies serving the same families, and others. The information and analysis provided for this report by BCF employees listed above includes information obtained from external stakeholders through their participation in workgroups, committees, surveys, focus groups, and other activities. Specific examples of information obtained through these interactions are included in item responses within this Statewide Assessment report.

Section II: Safety and Permanency Data

State Data Profile

State Data Profile deleted in its entirety

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

Instructions

Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance on each of the seven child and family outcomes. Review the information with the statewide assessment team and determine if more recent data are available that can be used to provide an updated assessment of each outcome. If more recent data are not available, simply refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each outcome. Analyze and explain the state's performance on the national standards in the context of the outcomes.

The West Virginia Department of Health and Human Resources (DHHR) Bureau for Children and Families (BCF) used data from the most recent Annual Progress and Services Report (APSR) submission, updating the information when possible, to assess the state's performance on the seven child and family outcomes. The updated information includes FFY 2016 CFSR style case review data. The Bureau for Children and Families is comprised of 29 Community Services Districts that are divided into four regions. During FFY 2016, DPQI completed 143 social services case reviews comprised of 72 foster care and 71 in-home cases. Reviews were completed in each of the four regions. Case reviews conducted in all federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review. Case reviews were completed in 12 different districts representing 40% of the districts in West Virginia. Social service case reviews were completed by the Division of Planning and Quality Improvement (DPQI). DPQI is under the Office of Planning, Research, and Evaluation. (Refer to Pgs. 3-9 of the DPQI CFSR Rd. 3 Policy Manual for additional information on DPQI and the case review process)

A. Safety

Safety Outcomes 1 and 2

Safety outcomes include: (A) children are first and foremost, protected from abuse and neglect; and (B) children are safely maintained in their own homes whenever possible and appropriate.

- For each of the two safety outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the two federal safety indicators, relevant case record review data, and key available data from the state information system (such as data on timeliness of investigation).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Safety Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the safety indicators.

State Response:

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

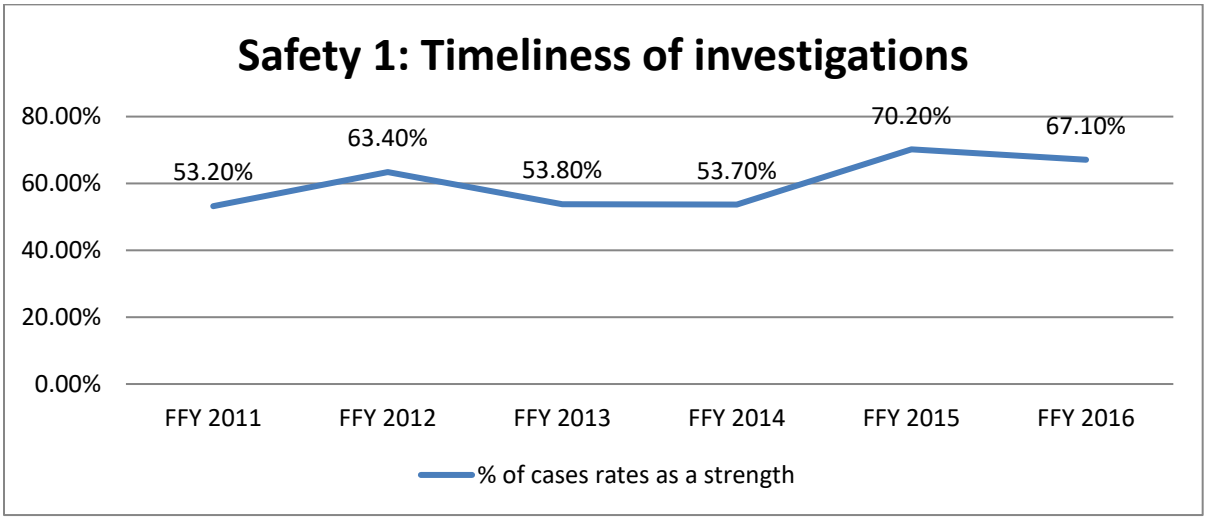
CFSR Item 1: Timeliness of initiating investigations of reports of child maltreatment.

The percentage of investigations initiated within state policy timeframes will be 95% or more.

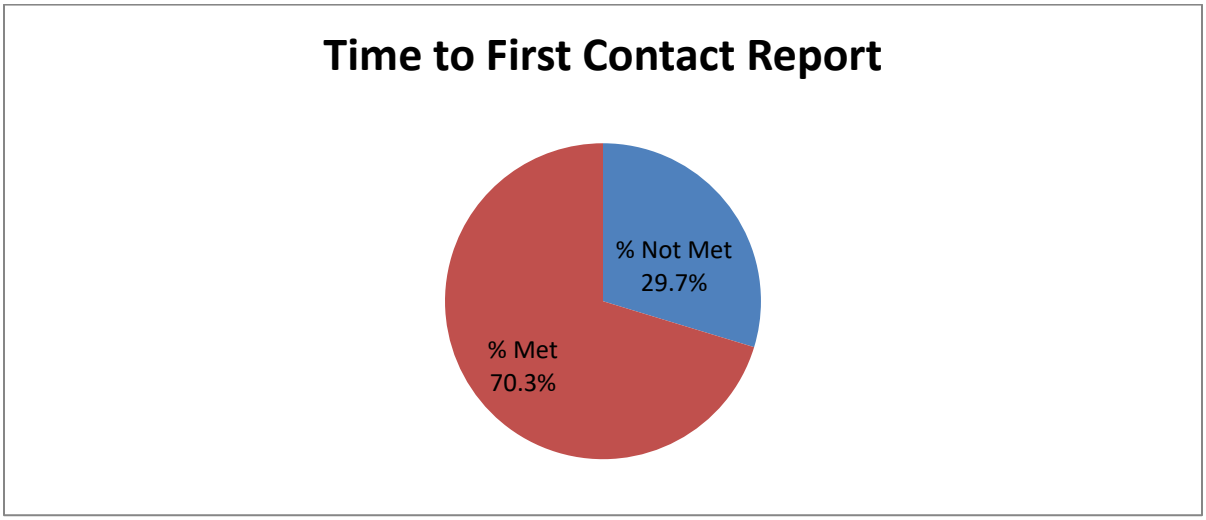
DPQI Quality Assurance Case Review Data

FFY 2015: 70.2%

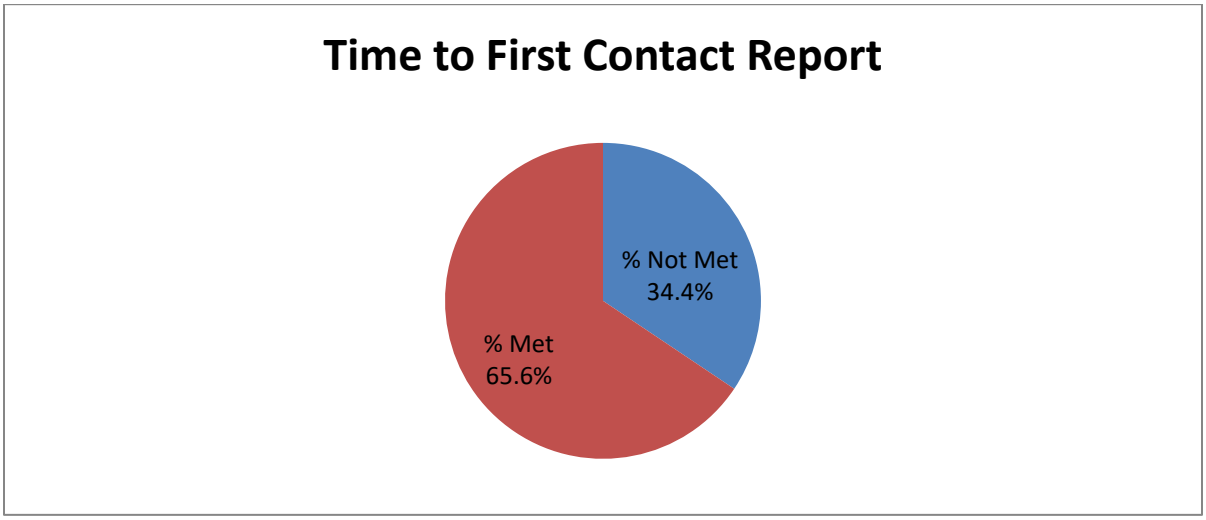
FFY 2016: 67.1%



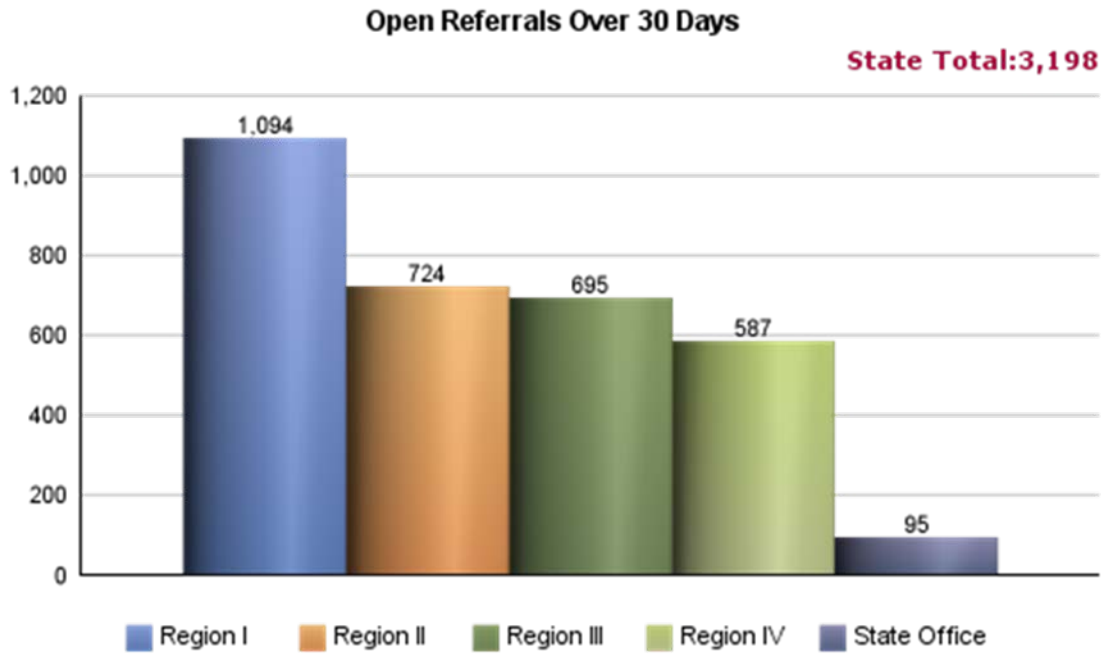
DPQI case review data



COGNOS Time to First Contact Report FFY 2015



COGNOS Time to First Contact Report FFY 2016



COGNOS Point in Time Report 1/3/17

CFSR Measure: Recurrence of Maltreatment

Of all children who were victims of a substantiated maltreatment report during a 12 month period, the percentages who were victims of another substantiated maltreatment report within 12 months will be 9.1% or less.

CFSR Round 3 Data Profile September 2016

FFY 2014-2015: 2.6% observed performance

FFY 2014-2015: 3.5% (risk standardized performance)

CFSR Measure: Maltreatment in Foster Care

Of all children in out-of-home care during a 12 month period, the victimization rate per 100,000 days of care will be 8.50 or less.

CFSR Round 3 Data Profile September 2016

FFY 2015: 1.7 observed performance

FFY 2015: 1.96 (risk standardized performance)

Assessment of Safety Outcome 1

The outcome rating for safety one based on DPQI case reviews for federal fiscal year 2015 indicate safety outcome one was substantially achieved in 70.2% of the cases reviewed, and not achieved in 29.8% of the cases reviewed. FFY data is based on case reviews completed from October 1, 2014 to September 30, 2015.

The outcome rating for safety one based on DPQI case reviews for federal fiscal year 2016 indicates safety outcome one was substantially achieved in 67.1% of the cases reviewed, and not achieved in 32.9% of the cases reviewed. FFY data is based on case reviews completed October 1, 2015 to September 30, 2016

Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review. Case review data for Federal Fiscal Year 2015 and 2016 reflects completed and attempted contacts. COGNOS reports provide point in time data regarding the time to first contact. The Time to First Contact Report is monitored by the District Community Services Managers, Regional Directors, and the Deputy Director of Field Operations on a regular basis.

COGNOS report (Time to first contact report) indicates the number of assigned child maltreatment reports has increased each year between FFY 2013 and FFY 2016. The numbers of child maltreatment reports assigned for further assessment during the last three federal fiscal years were 17,538 in 2013; 19,115 in 2014; 21,620 in 2015; and 23,847 in 2016. There was a 36% increase in the number of child maltreatment reports assigned for further assessment between federal fiscal years 2013 and 2016.

Staffing levels during the period under review have a dramatic impact on how well districts perform on the DPQI case reviews. Districts with a high staff turnover rate score significantly lower on all measures. All of the districts reviewed in Federal Fiscal years 2015 and 2016 indicated staffing issues as a key factor contributing to the areas needing improvement. The lack of staff results in failure to initiate investigations of child maltreatment in a timely manner. It also creates a backlog of Family Functioning Assessments. COGNOS point in time data on 1/3/17 indicates a backlog of 3,198 referrals open over 30 days.

The West Virginia Department of Health and Human Resources (hereafter The Department) met the two CFSR safety data indicators. The Department met the national standard that 9.0% or less of children with a substantiated child maltreatment report had a second substantiated child maltreatment report within twelve months. The Department also met the national standard of 8.04 or less incidence of maltreatment in out-of-home care per 100,000 days in care. West Virginia's FFY 2015 risk standardized performance was 1.96, with an observed performance of 1.7.

Despite meeting the two CFSR safety data indicators, it appears from both the WV CFSR RD. 3 Data Profile and case review data that West Virginia is substantially below the 95% compliance threshold. To address this issue West Virginia has developed crisis teams. These CPS workers are not assigned to a district, but rather are available to assist districts experiencing a backlog of Family Functioning Assessments. The Commissioner can also direct districts to provide additional staff to those experiencing a backlog. Some Regional Directors have initiated backlog reduction plans. These plans include a percentage backlog reduction goal. District managers develop plans to reach these goals. In addition, a Crisis Response Process and Crisis Response Worksheet have been developed to support districts in addressing critical CPS workload situations. This process is designed to assist field staff in taking actions to identify and correct caseload issues that may generate a backlog. Features of the process include the ability to assess families using a shortened FFA format if no impending dangers are identified, and ensuring the timely documentation of all casework completed so it will not have to be redone if a staff member resigns from the agency. The Crisis Response Process and Worksheet were implemented in the fall of 2016. Therefore data on the efficacy of the process is unavailable.

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

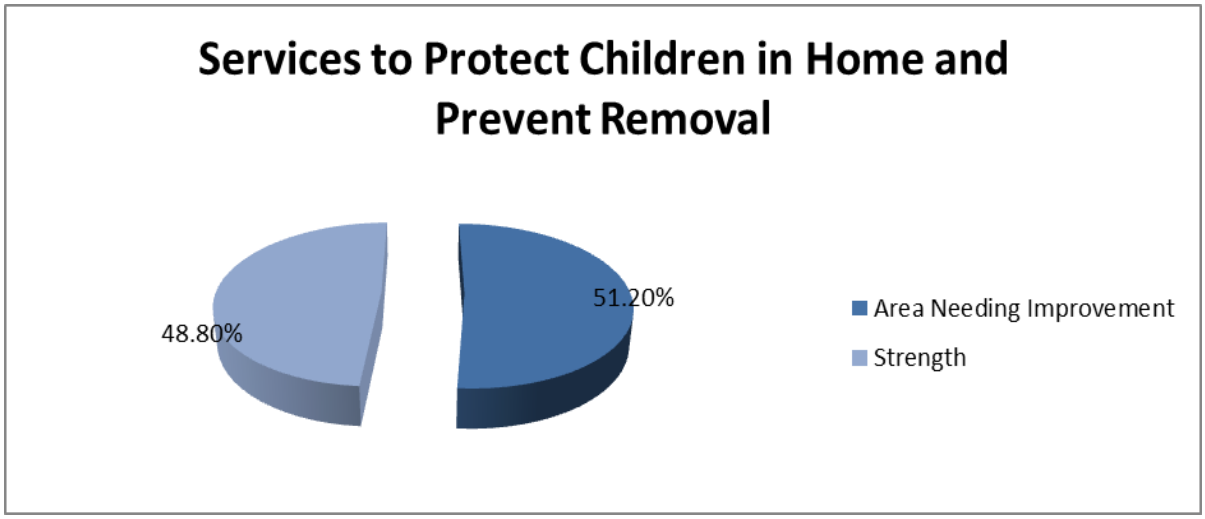
CFSR Item 2: Services to families to protect children in the home and prevent removal or re-entry into foster care.

The percentage of cases in which the agency took the least intrusive actions available to control present or impending dangers will be 95% or more.

DPQI Quality Assurance Case Review Data

FFY 2015: 60.2%

FFY 2016: 48.8%



FFY 2016 DPQI case review data

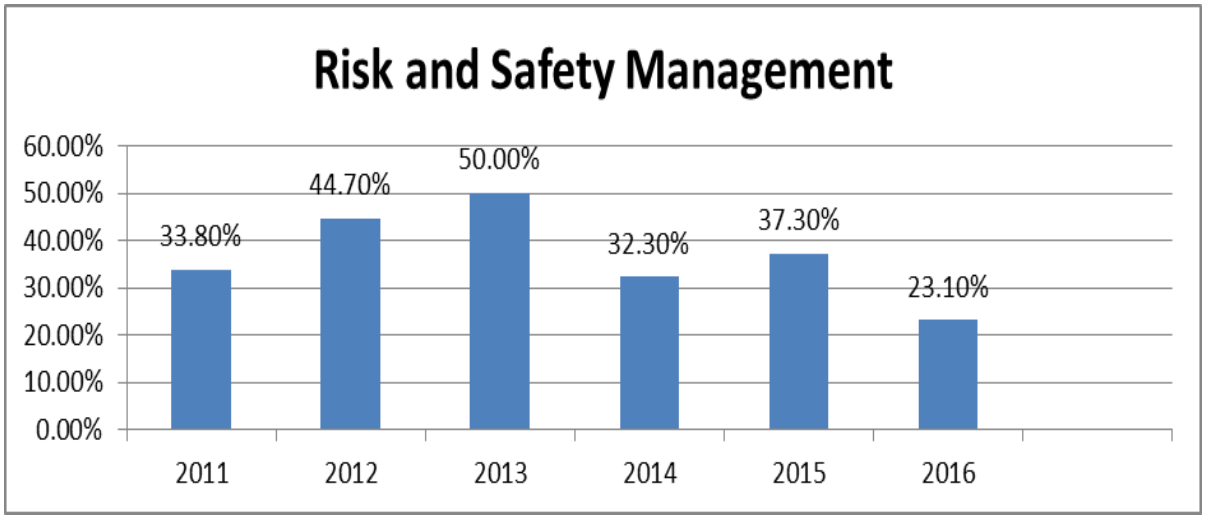
CFSR Item 3: Risk and Safety Assessment and Management

The percentage of cases in which the agency took appropriate actions to control present and impending dangers will be 95% or more.

DPQI Quality Assurance Case Review Data

FFY 2015: 37.3%

FFY 2016: 23.1%



DPQI case review data

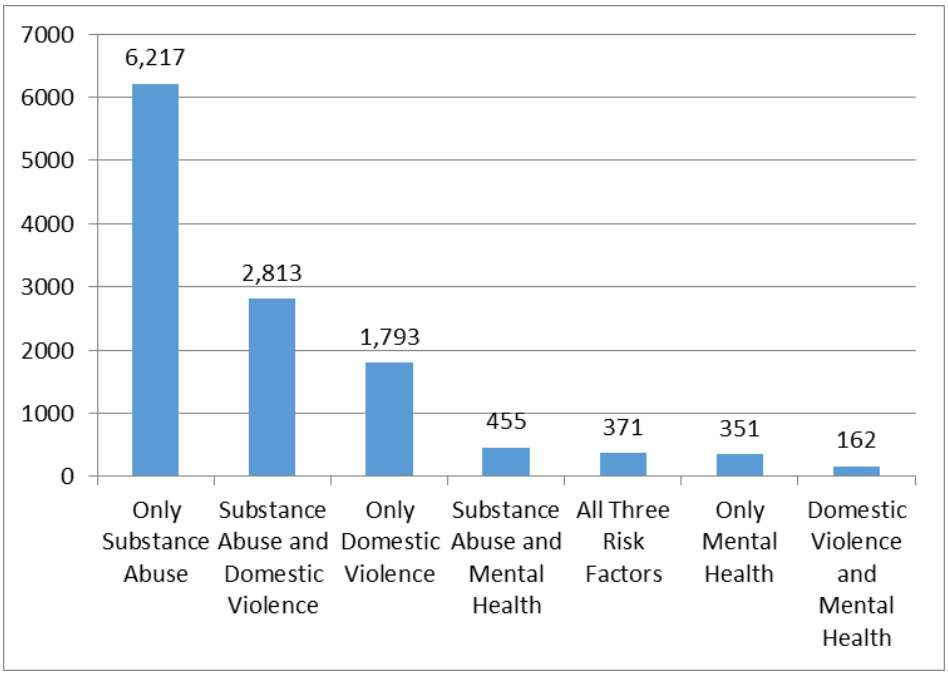
Assessment of Safety Outcome 2

Outcome Safety 2 is measured by performance on Items 2 and 3 on the 2016 Federal CFSR Onsite Review Instrument. The outcome rating for Safety 2 based on case reviews for federal fiscal year 2015 indicate Safety Outcome 2 was substantially achieved in 33.8% of the cases reviewed, and partially achieved in 23.9% of the cases reviewed. Federal fiscal year 2016 case reviews indicate Safety Outcome 2 was substantially achieved in 22.4% if the cases reviewed, and partially achieved in 16.8% of the cases reviewed respectively.

The majority of children in placement entered foster care to ensure their safety. However, DPQI case review findings indicate West Virginia is missing opportunities to impact family risks before they become safety threats necessitating removal, and to monitor child safety in the home while the parents receive services to achieve behavioral change. Case reviewers found that in-home safety plans are often inadequate to control the factors impacting child safety. Case reviews also indicate that safety plans are not being reviewed regularly and updated as circumstances in the case warrant. In addition, safety related services placed in the home don't always match the identified safety threat, and/or services are not referred into the homes in a timely manner. An example, domestic violence is often identified in safety plans but not addressed through service provision. ASO "parenting" is placed into the home as a catch all for addressing any and all identified issues. The intent of the services is for parent education, and does not control for safety. There appears to be a wide spectrum on how this service is being implemented.

Districts note that substance abuse is a major factor impacting child safety and risk in the majority of child abuse and neglect cases. Limited services to address substance abuse issues are a factor in controlling for safety. Lack of effective outpatient treatment programs paired with high rates of substance abuse impacts the Department's ability to control for safety in the home.

The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) database was created to collect and track the status and timeliness of all West Virginia. The data presented in the following risk-factor analysis was pulled from the CANS Database. Circuit court staff input data on each child abuse and neglect case assigned to the judge. Court staff review petitions and enter the risk factors on each case. Cases may have more than one risk factor indicated.



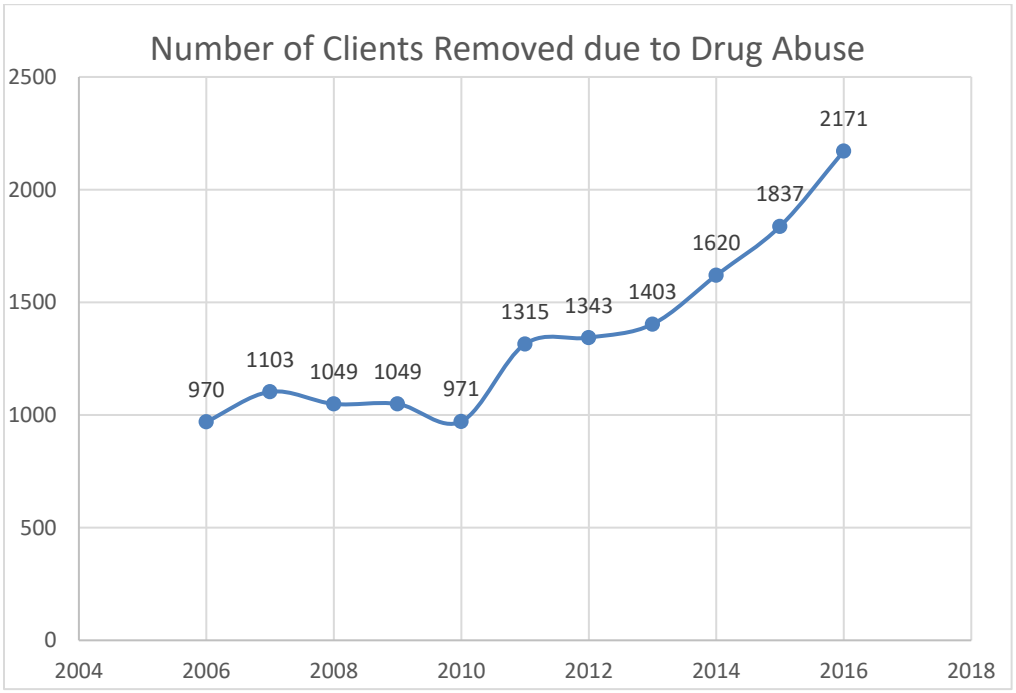
Staff members from each Circuit Court Judge's office submit data for each child abuse and neglect case assigned to their judge. The Court Services Division has trained staff to indicate which risk factors were present and mentioned in the original petition as a reason for filing the abuse and neglect petition. These cases may have more than one risk factor indicated.

Between 2011 and 2016, there were 12,162 cases with one or more risk factors indicated. The above chart shows a breakdown of these cases and which risk factors were indicated in the

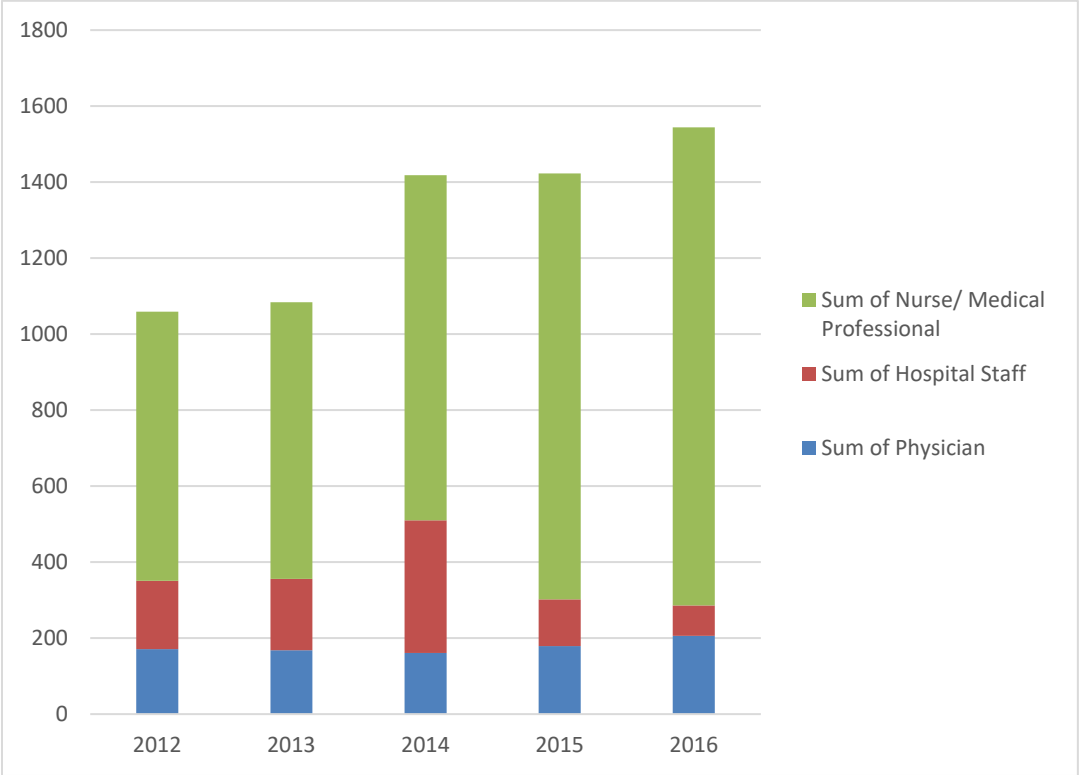
original petition. This research assumes all cases include one or more risk factors; therefore, cases without an indicated risk factor are considered underreported.

Year	Total count of cases with one or more risk factors indicated	All cases with Substance Abuse indicated		All cases with Domestic Violence indicated		All cases with Mental Health indicated	
		Count	Percent	Count	Percent	Count	Percent
2011	1,025	807	78.73%	448	43.71%	94	9.17%
2012	1,559	1,234	79.15%	771	49.45%	220	14.11%
2013	1,775	1,399	78.82%	760	42.82%	254	14.31%
2014	2,495	1,996	80.00%	1,026	41.12%	289	11.58%
2015	2,557	2,102	82.21%	1,080	42.24%	223	8.72%
2016	2,751	2,318	84.26%	1,054	38.31%	259	9.41%
Total of All Years	**12,162**	**9,856**	**81.04%**	**5,139**	**42.25%**	**1,339**	**11.01%**

Out of the 12,162 cases that indicated one or more risk factors, 81.04% of the cases have indicated that substance abuse was at least one of the risk factors that led to the filing of a petition. Domestic Violence was indicated in 42.25% of the cases, and Mental Health was indicated in 11.01% of the cases.



West Virginia FACTS report on substance abuse related foster care entries



West Virginia FACTS report on increase in drug affected infant referrals received

Child abuse and neglect is often a symptom of larger social problems, such as substance abuse, which have no easy answers or quick fixes. West Virginia struggles with an ever

increasing number of child welfare cases in which substance abuse is an identified risk factor. The nature of addiction, coupled with the inability to provide substance abuse treatment in a timely fashion, results in abuse and neglect petitions and negatively impacts outcomes in the West Virginia child welfare system.

B. Permanency

Permanency Outcomes 1 and 2

Permanency outcomes include: (A) children have permanency and stability in their living situations; and (B) the continuity of family relationships is preserved for children.

- For each of the two permanency outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the four federal permanency indicators and relevant available case record review data.
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Permanency Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the permanency indicators.

State Response:

Permanency Outcomes 1: Children have permanency and stability in their living situations.

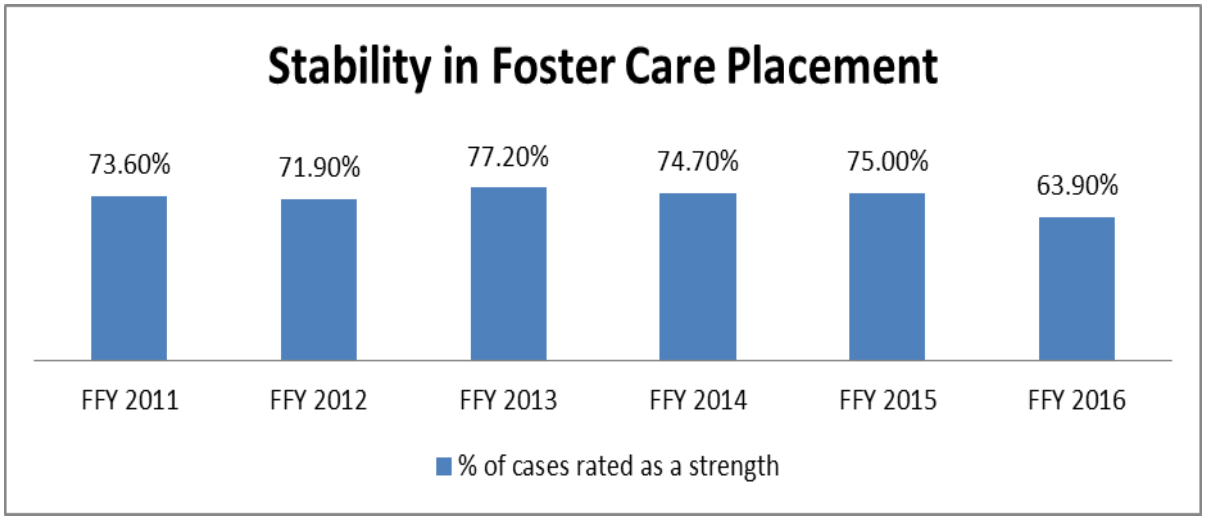
CFSR Item 4: Stability of Foster Care Placement.

The percentage of cases in which placement moves occurring during the period under review are in the best interests of the child and consistent with achieving the child's permanency goals will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 75.0%

FFY 2016: 63.9%



DPQI case review data

CFSR Measure: Placement Stability

Of all children who enter care in a 12 month period, the rate of placement moves, per 1,000 days of out-of-home care will be 4.12 or fewer.

CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 3.34 observed performance

FFY 2015b2016a: 3.18 risk standardized performance

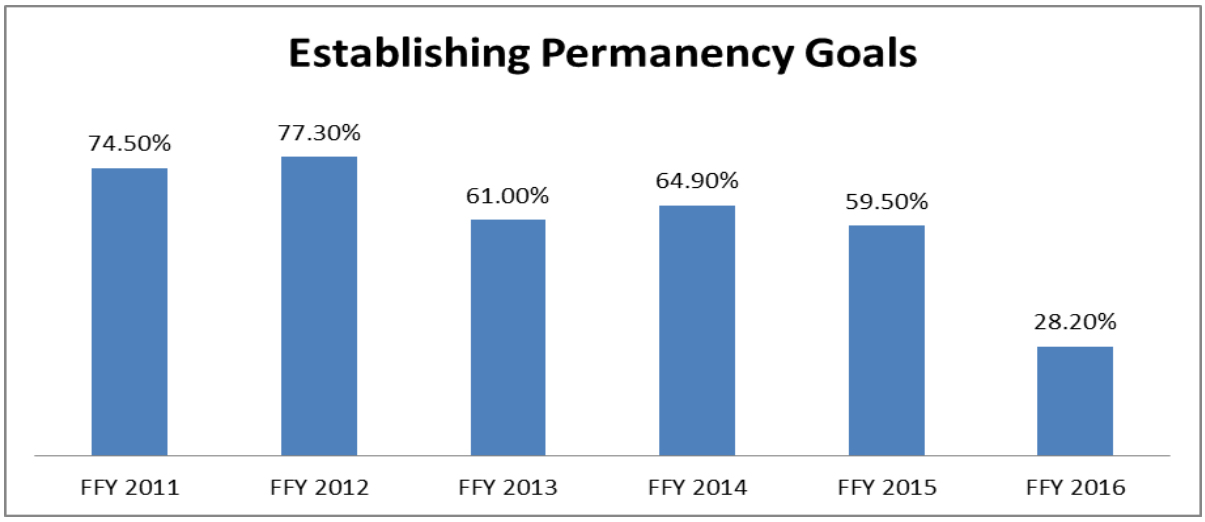
CFSR Item 5: Permanency goal for the child

The percentage of cases where the child's permanency goal matches the child's needs and is established in a timely manner, and Termination of Parental Rights (TPR) requirements according to the Adoption and Safe Families Act (ASFA) are met, will be 95% or more.

DPQI Quality Assurance Case Review Data

FFY 2015: 59.5%

FFY 2016: 28.2%



DPQI case review data

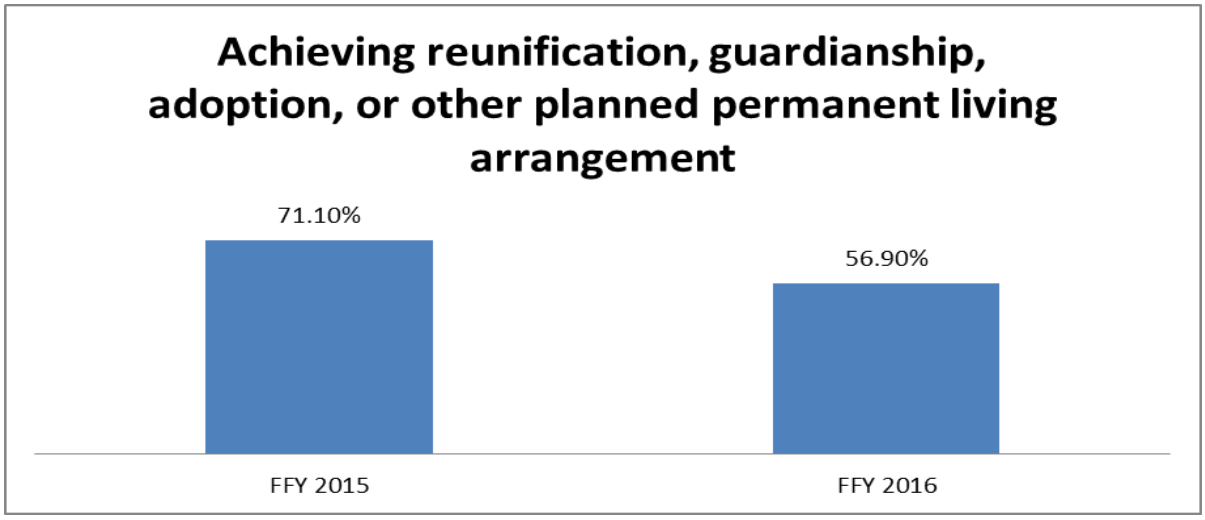
CFSR Item 6: Achieving reunification, guardianship, adoption, or other planned permanency living arrangement.

The percentage of cases in which permanency is achieved for the child within the designated timeframes will be 95% or more.

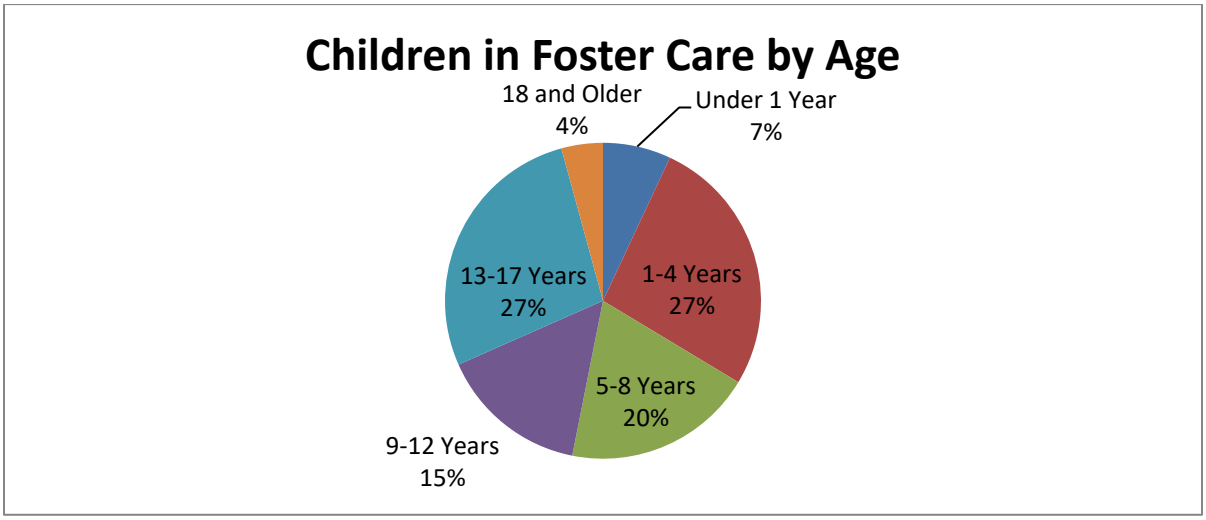
DPQI Quality Assurance Case Review Data

FFY 2015: 71.5%

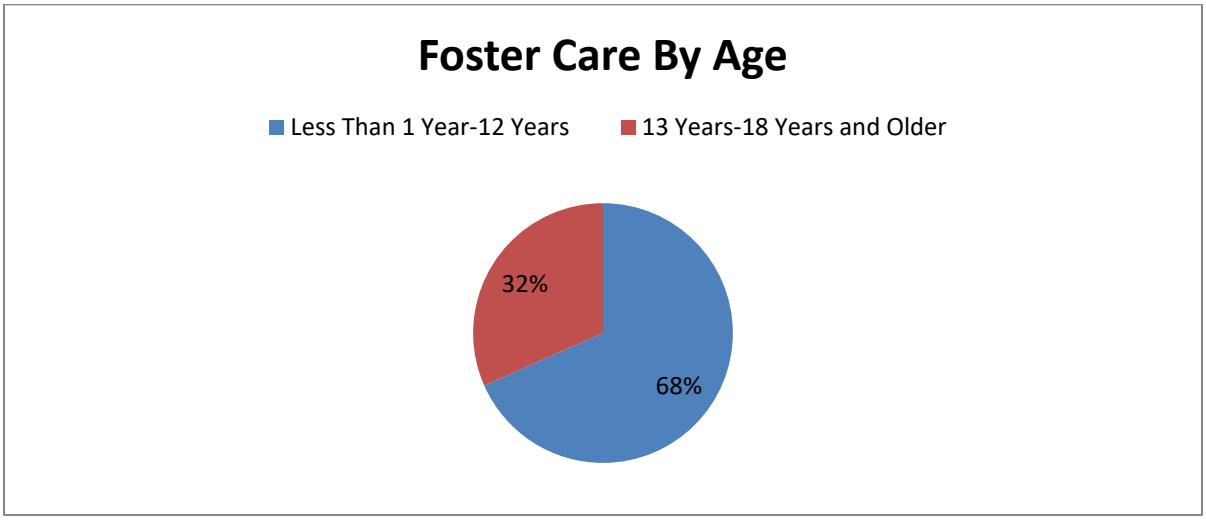
FFY 2016: 56.9%



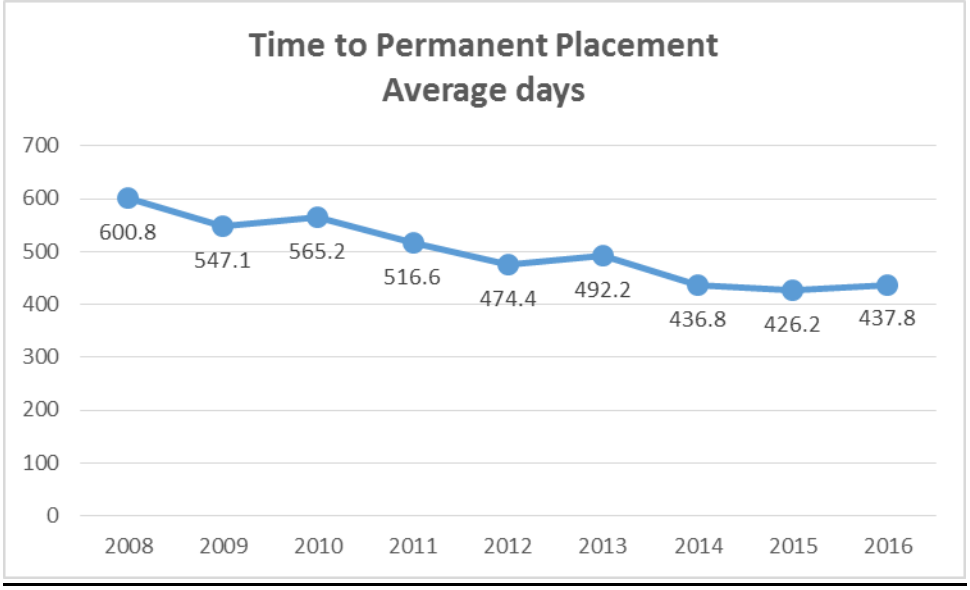
DPQI case review data



COGNOS Point in Time Report 1/3/17



COGNOS Point in Time Report 1/3/17



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

CFSR Measure: Permanency in 12 Months for Children Entering Foster Care

Of all children who enter care in a 12 month period and stay for eight days or more, the percentage who discharge to permanency within 12 months of entering care will be 40.5% or more

CFSR Round 3 Data Profile September 2016

FFY 2013b2014a: 44.2 observed performance

FFY 2013b2014a: 37.2% risk standardized performance

CFSR Measure: Re-entry to Foster Care in 12 Months

Of children who enter care in a 12 month period, who discharged within 12 months to reunification, live with relative, or guardianship, the percent who reenter care within 12 months of their discharge will be 8.3% or less.

CFSR Round 3 Data Profile September 2016

FFY 2013b2014a: 9.9% observed performance

FFY 2013b2014a: 6.8% risk standardized performance

CFSR Measure: Permanency in 12 Months for Children in Care 12 to 23 Months

Of children in care on the first day of the 12 month period who had been in care between 12 and 23 months, the percentage discharged to permanency within 12 months of the first day will be 43.6% or more.

CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 55.1% observed performance

FFY 2015b2016a: 55.0% risk standardized performance

CFSR Measure: Permanency for Children in Care 24 Months or Longer

Of children who enter care on the first day of the 12 month period who had been in care for 24 months or more, the percentage discharged to permanency within 12 months of the first day will be 30.3% or more.

CFSR Round 3 Data Profile September 2016

FFY 2015b2016a: 36.5% observed performance

FFY 2015b2016a: 35.2% risk standardized performance

Assessment of Permanency Outcome 1

Outcome Permanency 1 is measured by performance on Items 4, 5, and 6 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Permanency 1 was substantially achieved in 40.8% of the cases reviewed, and partially achieved in 52.6% of the cases reviewed. The outcome rating for Permanency 1 based on case reviews for federal fiscal year 2016 indicate Permanency 1 was substantially achieved in 18.3% of the cases reviewed, and partially achieved in 64.8% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

Slight declines in meeting the measure were observed in all three CFSR Items related to Permanency 1. As indicated in the 2017 APSR in relation to Item 4, District Management Staff often report a lack of foster homes within the district and difficulty in locating placement for children with severe behavioral issues, developmental disabilities, or large sibling groups. This contributes to instability of foster care placements. Despite these challenges West Virginia met the national standard for placement stability.

The largest decline, based on DPQI case reviews, was observed in Item 5, permanency goal for the child. This is the second FFY in which the case review ratings for this item have decreased.

DPQI case review data indicates a 31.3% decrease between FFY 2015 and FFY 2016 in the number of cases that rated as strength for establishing permanency goals in a timely manner. Issues contributing to the review findings include failure to document the goals in the case file in a timely manner, goals not being updated to reflect the current status of the case, and the selection of inappropriate primary or concurrent permanency goals.

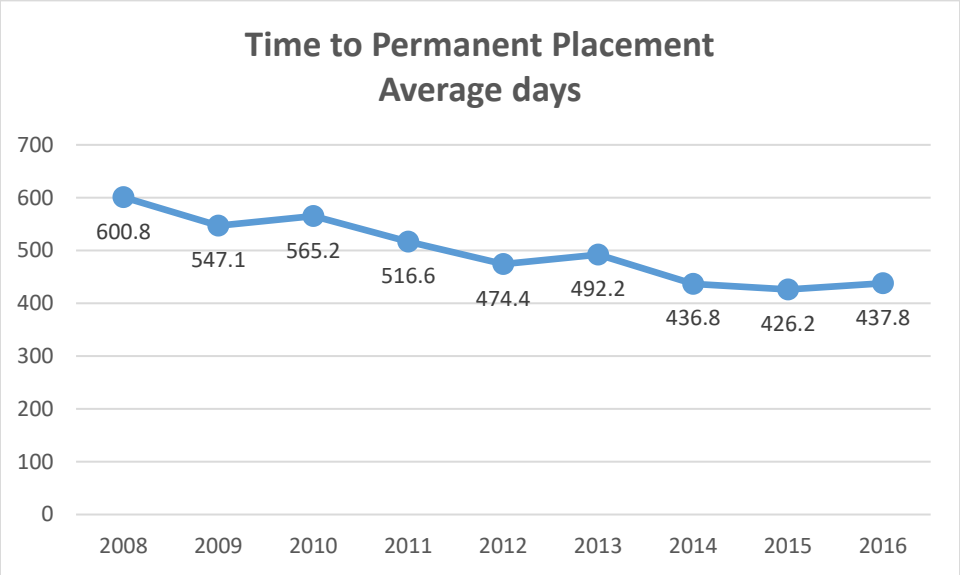
Reviewers found that workers often selected Relative Placement in the FACTS system when working to achieve adoption or guardianship by a relative caregiver. (It should be noted that court orders reflect the correct permanency goal) There are screens in the FACTS system for workers to select both a permanency goal and a placement goal. Department management staff has taken steps to address this issue by providing field level staff instruction on the selection of appropriate permanency goals. The issue has also been addressed in district level DPQI review exit conferences as well as in Statewide Management Team Meetings.

The measurement for Item 6 changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. DPQI case review data indicates the Department and courts were making concerted efforts to achieve permanency within designated timeframes in 56.9% of the cases reviewed. This is a 14.6% decrease from the FFY 2015 data of 71.5% strength. An issue which heavily impacts this item is failure to actively pursue achievement of concurrent permanency goals. Concurrent permanency planning requires both the identification of an alternative plan, and the implementation of active efforts toward achieving both plans simultaneously.

Refer to the most recent West Virginia APSR (Pgs. 55-57) for historic information on the time it takes for West Virginia children involved in abuse and neglect proceedings to reach a permanent living situation.

Supreme Court of Appeals of West Virginia data in conjunction with DPQI case review data provides a more extensive data set when measuring the achievement of the permanency goals. CANS data indicates (on average) the amount of time it takes children to reach permanency over the course of the last eight years has dropped by 168.5 days. This same data indicates the length of time for a child involved in abuse and neglect proceedings to reach permanency increased slightly in 2016. (See charts below) However, as indicated in the most recent West

Virginia APSR, the overall length of time for an abused or neglected child to reach permanency has been reduced over the last eight years.



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

Time to Permanent Placemet	
Year	Average days
2008	600.8
2009	547.1
2010	565.2
2011	516.6
2012	474.4
2013	492.2
2014	436.8
2015	426.2
2016	437.8

*Note: The CAN databas is fluid, therefore the average days can change slightly based on any work the staff has done to cases.

West Virginia is meeting or exceeding the CFSR national standards for permanency within 12 months for children in care 12 to 23 months, permanency within 12 months for children in care for 24 months or more, re-entry into foster care, and placement stability. West Virginia did not meet the national standard for permanency within 12 months of entry into out of home care.

West Virginia continues to make efforts to decrease the amount of time a child involved in court proceedings spends in out of home care. Examples of such efforts include West Virginia's IV-E demonstration project Safe at Home West Virginia and the 2014 evaluation of the state's juvenile justice practices completed by the state in conjunction with the Pew Charitable Trust. Please refer to APSR 2017 for additional information on Safe at Home West Virginia and Senate Bill 393 that resulted from the evaluation of the state's juvenile justice practices.

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

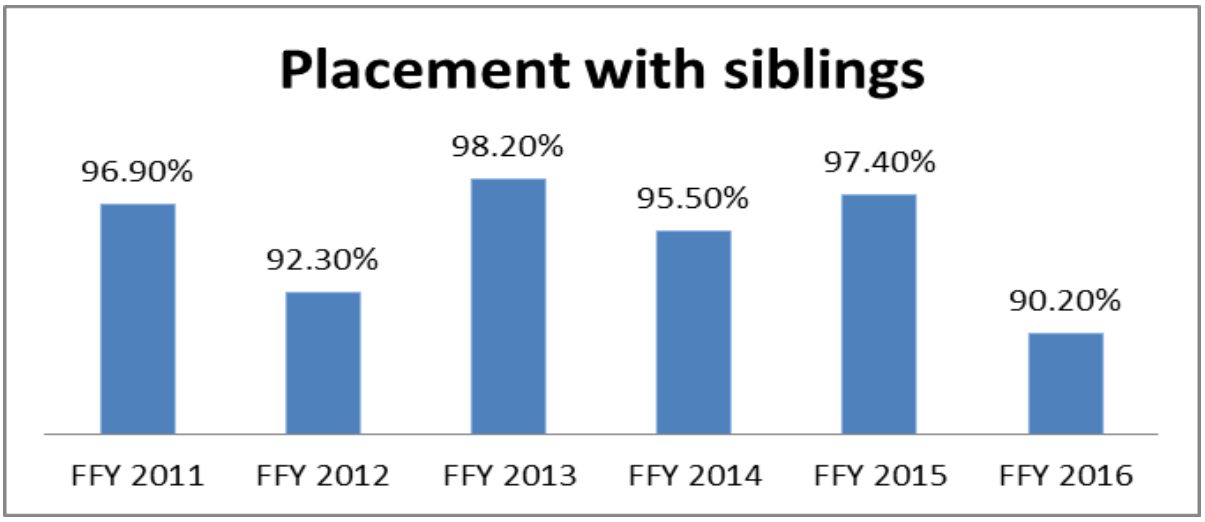
CFSR Item 7: Placement with Siblings

The percentage of cases in which concerted efforts were made to ensure that siblings in foster care are placed together unless a separation was necessary to meet the needs of one of the siblings will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 97.4%

FFY 2016: 90.2%



DPQI case review data

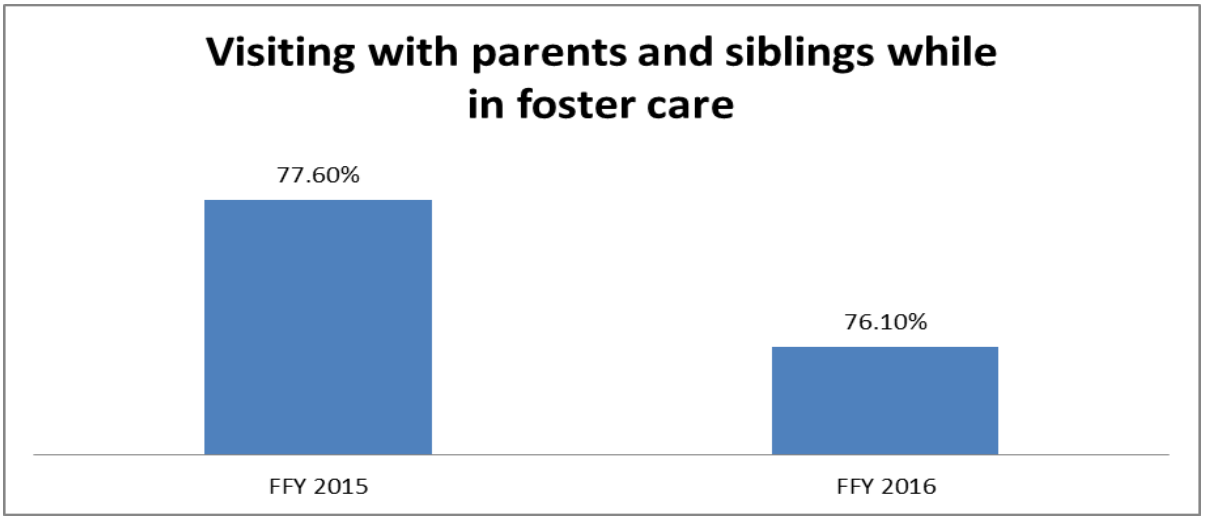
CFSR Item 8: Visiting with Parents and Siblings in Foster Care

The percentage of cases in which children in out of home care have visitation with their parents and siblings that is of sufficient frequency and quality to promote continuity of the relationships will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 77.6%

FFY 2016: 76.1%



FFY 2016 DPQI case review data

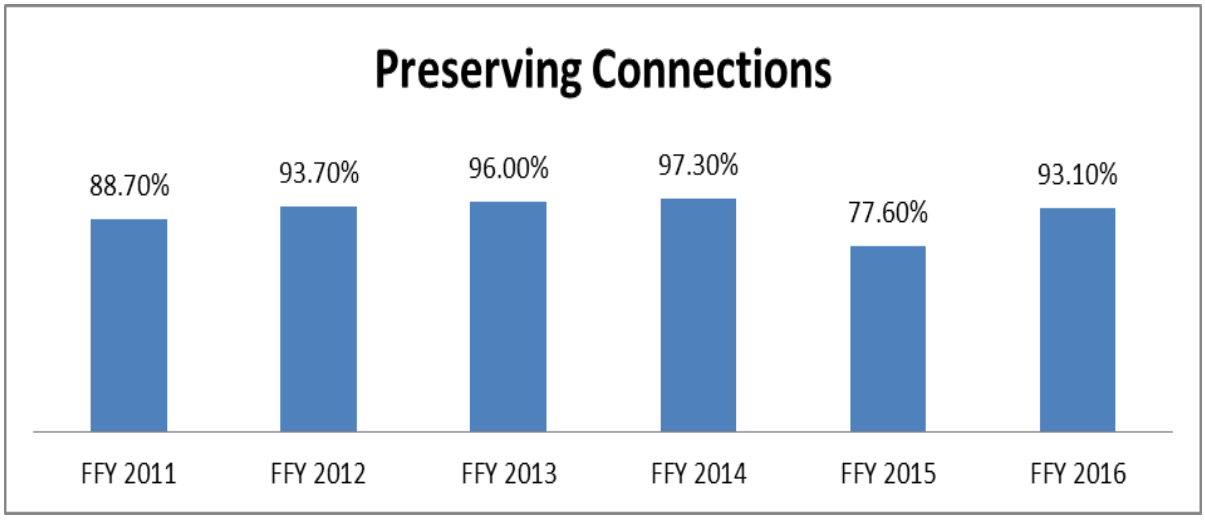
CFSR Item 9: Preserving Connections

The percentage of cases in which concerted efforts were made to maintain the child's connections with his or her neighborhood, community, faith, extended family, Tribe, school, and friends will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 77.6%

FFY 2016: 93.1%



DPQI case review data

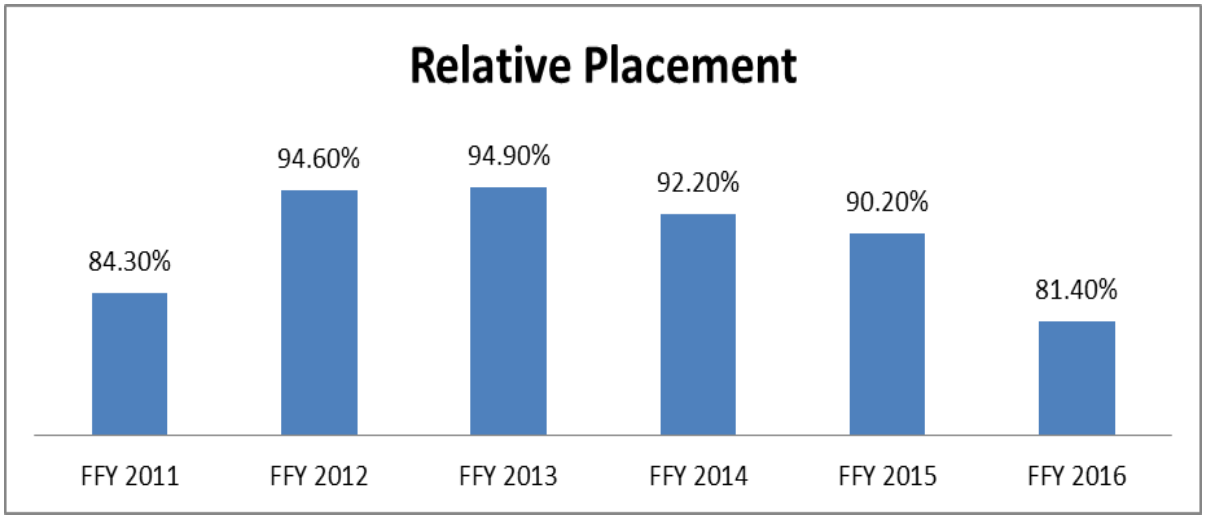
CFSR Item 10: Relative Placement

The percentage of cases in which concerted efforts were made to place the child with relatives when appropriate will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 90.2%

FFY 2016: 81.4%



DPQI case review data

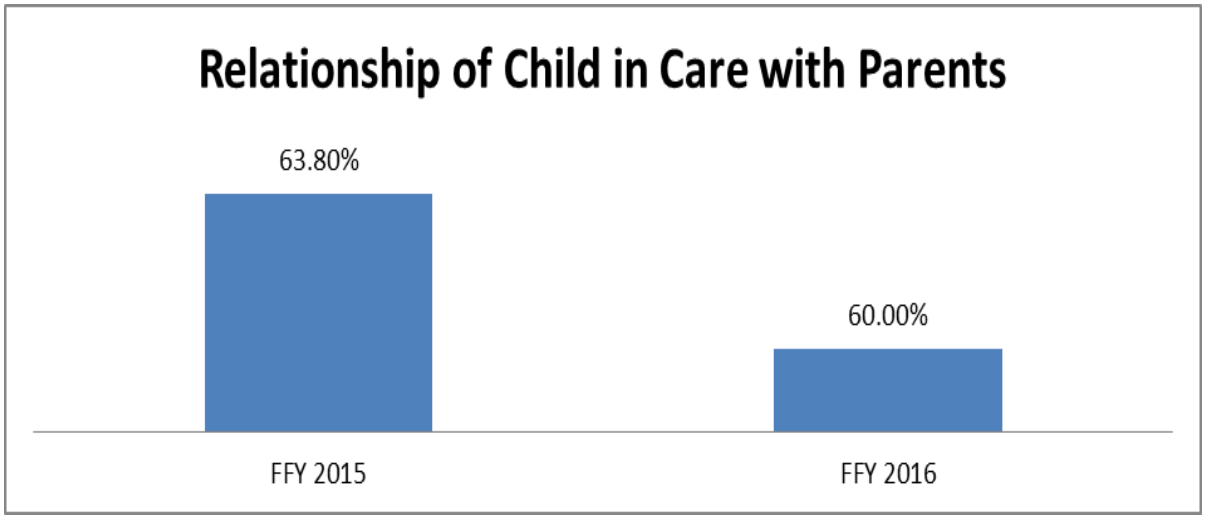
CFSR Item 11: Relationship of Child in Care with Parents

The percentage of cases in which concerted efforts were made to promote, support, and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregivers from whom the child had been removed through activities other than just arranging for visitation will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 63.8%

FFY 2016: 60.0%



DPQI case review data

Assessment of Permanency Outcome 2

Outcome Permanency 2 is measured by performance on Items 7, 8, 9, 10, and 11 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Permanency 2 was substantially achieved in 73.7% of the cases reviewed, and partially achieved in 22.4% of the cases reviewed. The outcome rating for Permanency 2 based on case reviews for federal fiscal year 2016 indicate Permanency 2 was substantially achieved in 76.4% of the cases reviewed, and partially achieved in 22.2% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

The continuity of primary relationships and connections are being preserved for the majority of children served in out of home care. DPQI case review data indicates strength ratings of 80% or more in three of the five items associated with this outcome. Despite these positive findings, DPQI data also indicates there are areas in which improvements can be made. Slight declines in item ratings were observed in all but one of the five CFSR Items associated with Outcome Permanency 2. The number of children entering out of home care in West Virginia has increased. Please refer to information in the APSR (Pg. 98) on the rising numbers of children in West Virginia entering out of home care. Despite the increase in children entering foster care, Department staff and service providers continue to make concerted efforts to meet the ever increasing need for transportation and supervision services associated with parent/family-child visitation.

DPQI case review data indicates the Department is making concerted efforts to ensure that siblings in foster care are placed together unless separation was necessary to meet the needs of one of the siblings. This item rated 90.2% strength during FFY 2016 case reviews. This item and Item 10 (Relative Placement) are often found to be linked during case reviews. The limited number of foster home placement options within most districts ensures that staff diligently seeks out relative placements. This practice often also ensures that sibling groups are able to be placed together.

The measurement for Item 8 (visits with parents and siblings in foster care) changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. Ensuring that the frequency and quality of visits between the parents and/or caregivers with the child, and the child with siblings placed in a different placement setting, are of sufficient quality and frequency to maintain the relationship was determined to be a strength in 76.1% of the cases reviewed by DPQI during FFY 2016. This is a 1.5% decrease from the strength rating found during case reviews during FFY 2015. DPQI reviewers frequently noted delays in initiating visitation with one or more parents/caregivers in cases that did not meet the measure. Addiction issues are often present in cases that do not meet this measure. Children in placement due to abuse and neglect proceedings are often unable to maintain contacts and relationships without approval from the court system. Judges often do not permit contact between the child and the parent/s if the parent/s fails to complete substance abuse treatment or have positive drug screens due to safety concerns for the child.

DPQI case review data indicates workers are exploring and maintaining the primary connections for the child in care and document those efforts in the majority of the cases reviewed. (Please refer APSR Pg. 63 for information on Department policy in relation to the Indian Child Welfare Act.) In 93.1% of the cases reviewed in FFY 2016 reviewers found evidence that workers had made concerted efforts to maintain the child's connections to their community, faith, tribe if applicable, extended family and siblings. This is a 15.5% increase from case review data collected in FFY 2015.

Case reviewers found that the child was placed in a stable relative placement, or that concerted efforts to identify and assess relatives, had been made in 81.4% of the cases reviewed during FFY 2016. In 13 of the 70 applicable cases reviewers did not find documentation or other evidence that the Department had made efforts to locate and assess relatives as possible

placement resources. The searches for paternal relatives were more likely to have insufficient efforts than those for maternal relatives. No case reviewed in FFY 2016 involved a fictive kin placement. Please refer to page 64 of the APSR for additional information on how DPQI case reviewers will address cases involving fictive kin placements.

The measurement for Item 11 (relationship of child in care with parents) changed due to revisions of the OSRI in 2014. Therefore, only FFY 2015 and FFY 2016 data can be compared for this item. DPQI case review data indicates the Department and courts were making concerted efforts to promote, support and maintain positive relationships between the children in foster care and his or her parents or primary caregiver from whom the child had been removed through activities other than visitation in 60% of the cases reviewed. This is a 3.8% decrease from the ratings found on this same item during FFY 2015. Addiction issues are often present in cases that do not meet this measure. Contributing factors to the overall ratings on this item include courts not permitting contact between the child and his/her parent/s due to failure on the part of the parent to complete substance abuse treatment or have negative drug screens, and parents being incarcerated or transient.

C. Well-Being

Well-Being Outcomes 1, 2, and 3

Well-being outcomes include: (A) families have enhanced capacity to provide for their children's needs; (B) children receive appropriate services to meet their educational needs; and (C) children receive adequate services to meet their physical and mental health needs.

- For each of the three well-being outcomes, include the most recent available data demonstrating the state's performance. Data must include relevant available case record review data and relevant data from the state information system (such as information on caseworker visits with parents and children).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Well-Being Outcomes 1, 2, and 3.

State Response:

Insert state response to Well-Being Outcomes 1, 2, and 3

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

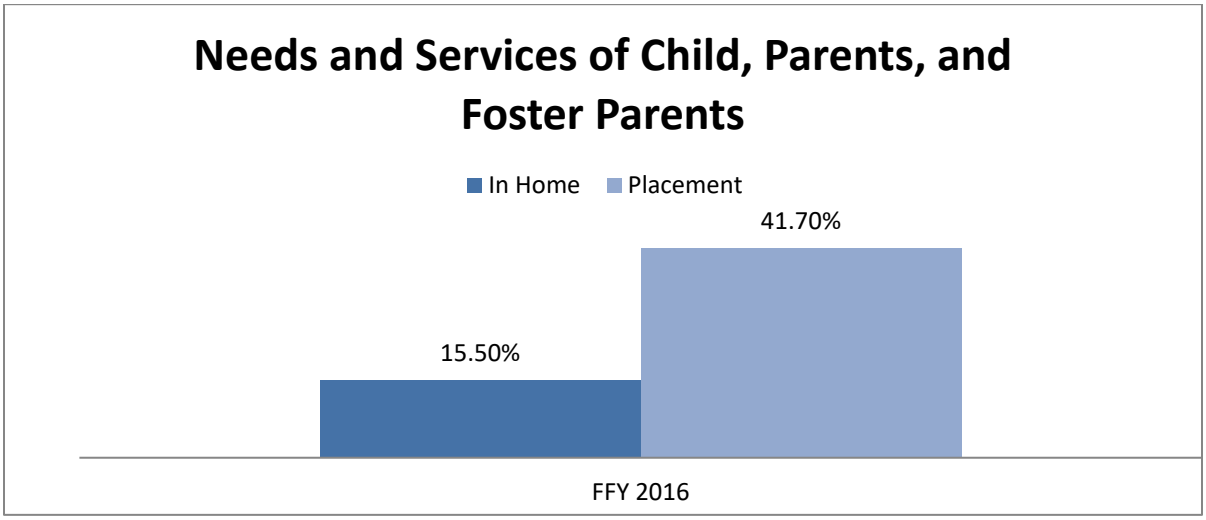
CFSR Item 12: Needs and Services of Child, Parents, and Foster Parents

The percentage of cases in which concerted efforts were made to assess the needs of children, parents, and foster parents throughout the life of the case in order to identify the services necessary to achieve case goals, adequately address the issues relevant to the agency's involvement with the family, and ensure provision of appropriate services will be 95%.

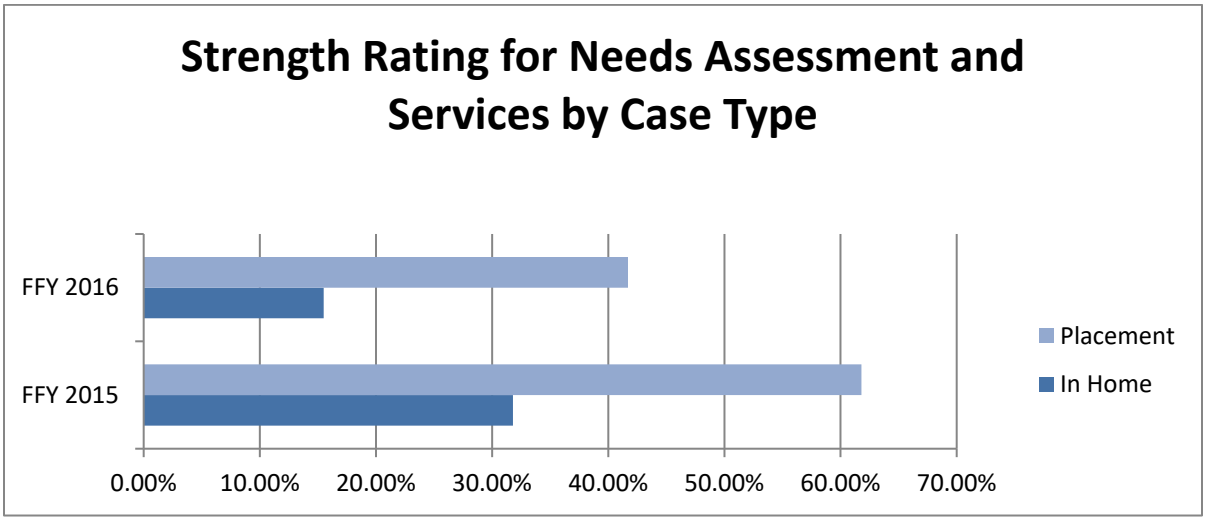
DPQI Quality Assurance Case Review Data

FFY 2015: 47.9%

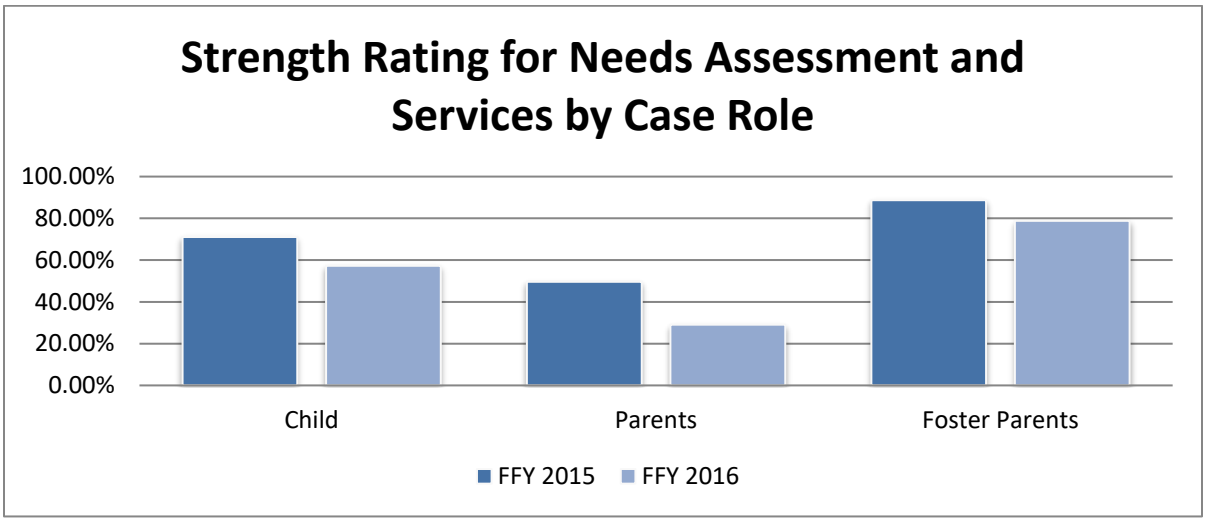
FFY 2016: 28.7%



FFY 2016 DPQI case review data



DPQI case review data



DPQI case review data

CFSR Item 13: Child and Family Involvement in Case Planning

The percentage of cases in which concerted efforts were made to involve the parents and child (if age appropriate) in the case planning process on an ongoing basis will be 95%.

DPQI Quality Assurance Case Review Data

FFY 2015: 52.5%

FFY 2016: 9.3%

Please note: This measurement cannot be compared to prior years due to a change in the way the DPQI case review unit assessed the item. In prior years this item was rated based upon the level of engagement of the family in the case planning process, regardless of the presence of a written case plan. Based on consultation from the Children's Bureau in 2015, during FFY 2016 DPQI case reviews, reviewers only rated this item a strength if a written case plan was found in the case record and was signed by parents, and if age appropriate, the child. The change in rating criteria is the reason for the overall decrease in the percentage of cases that rated as strength for the item. Refer to the APSR Pg. 76 for information on other factors that often impact this item.

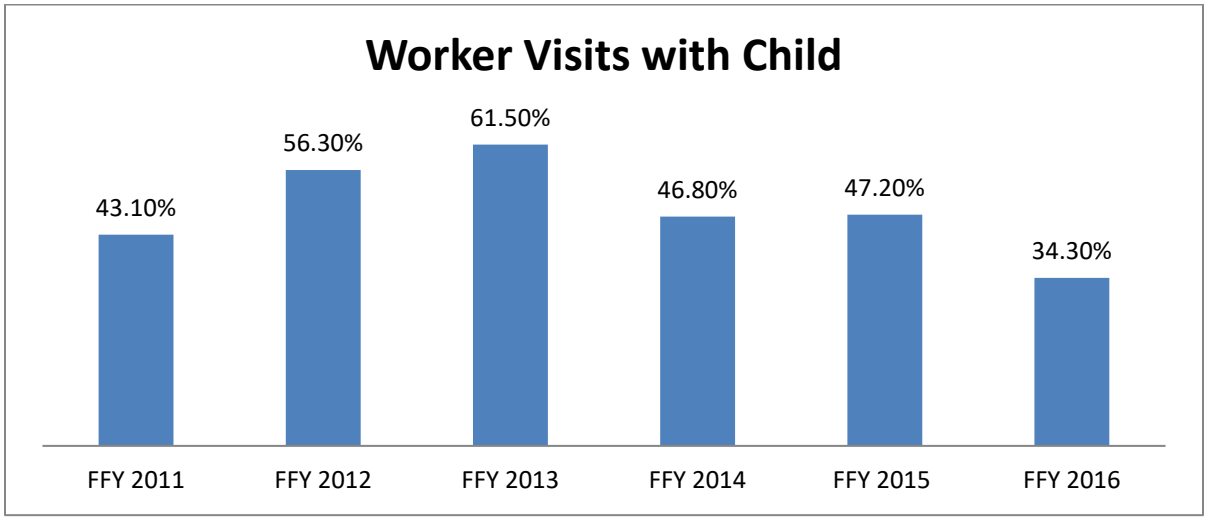
CFSR Item 14: Caseworker Visits with Child

The percentage of cases in which concerted efforts were made to ensure the frequency and quality of the visits between the caseworkers and the child(ren) is sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case will be 95%.

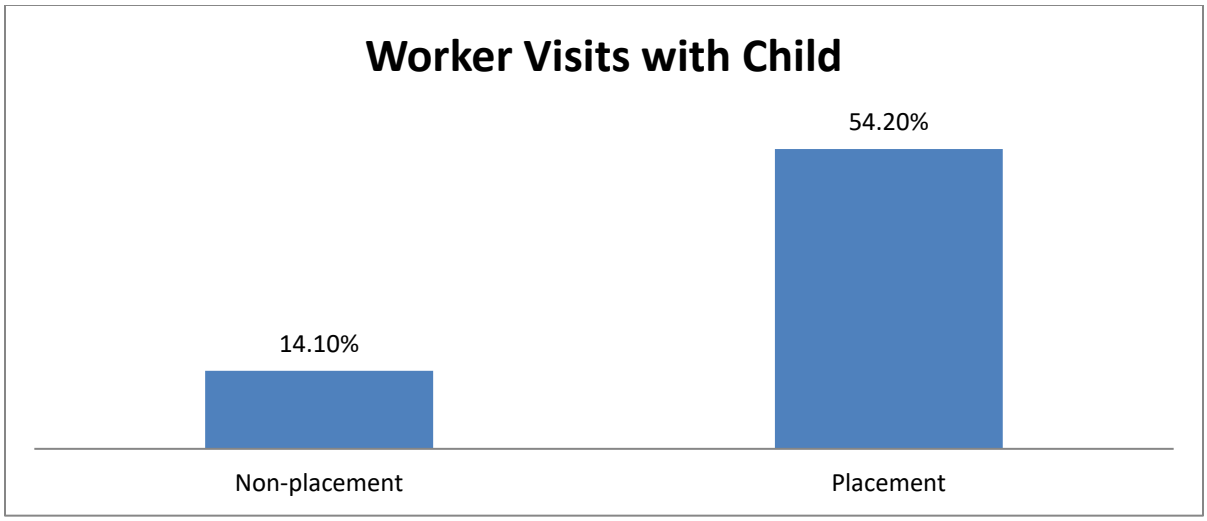
DPQI Quality Assurance Case Review Data

FFY 2015: 47.2%

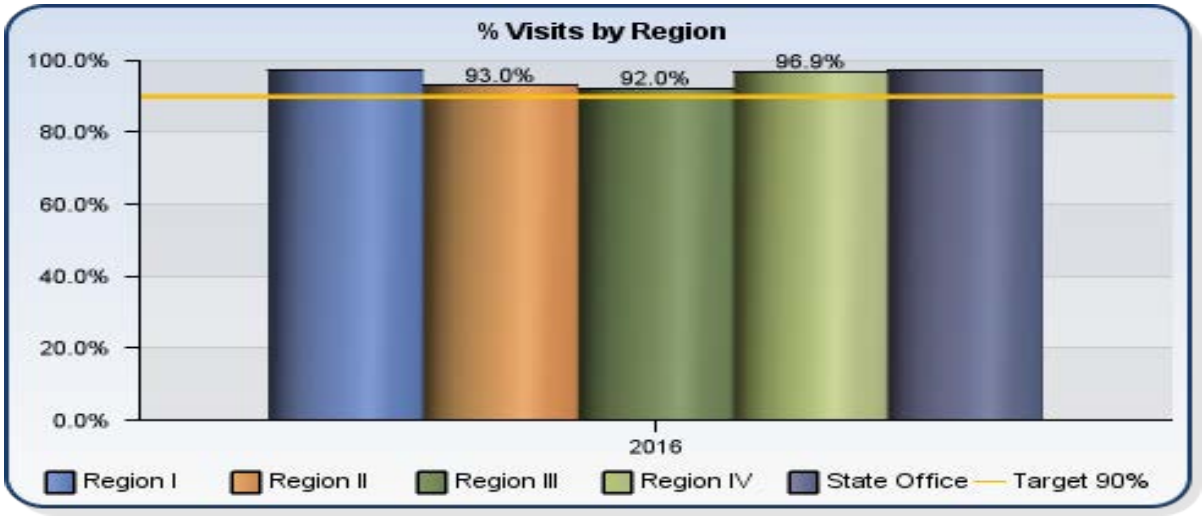
FFY 2016: 34.3%



DPQI case review data



FFY 2016 DPQI case review data



COGNOS Point in Time Report 12/22/16

(COGNOS does not evaluate the quality of the contact and therefore the two data sets cannot be compared.)

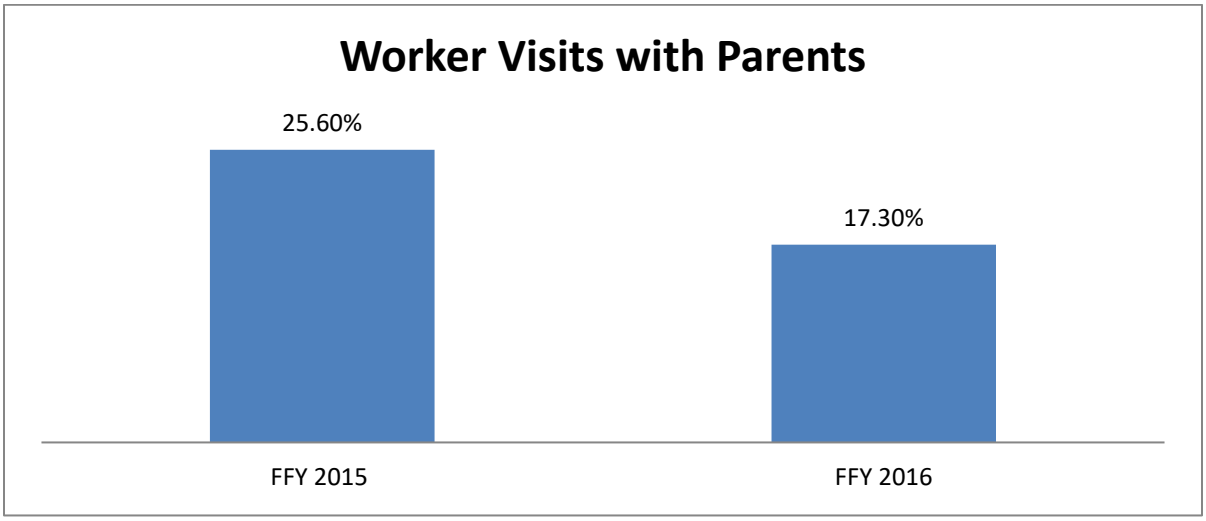
CFSR Item 15: Caseworker Visits with Parents

The percentage of cases in which concerted efforts were made to ensure the frequency and quality of the visits between the caseworkers and the mothers and fathers of the child(ren) is sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case will be 95%.

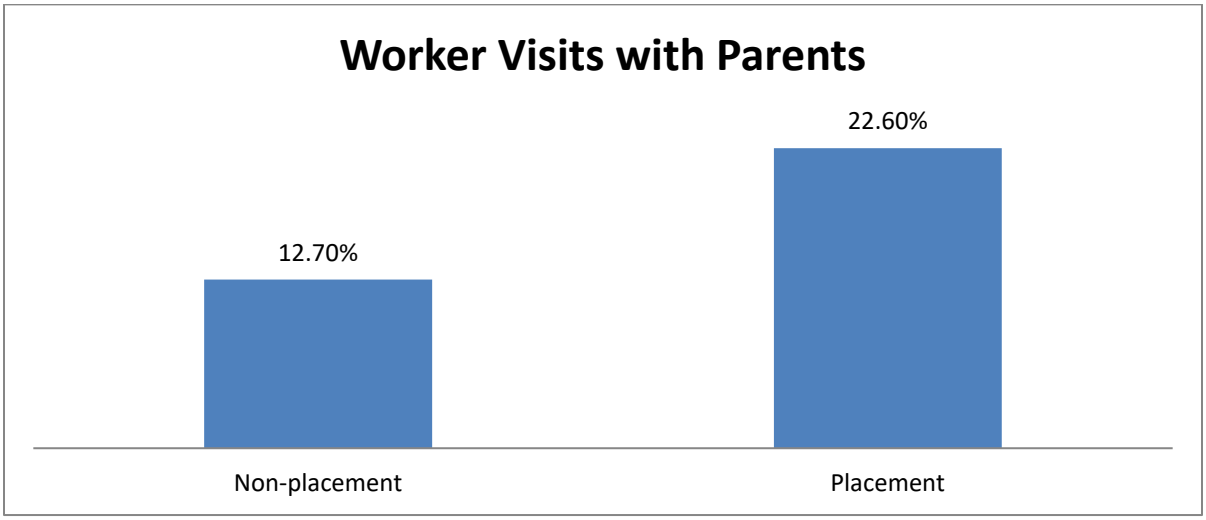
DPQI Quality Assurance Case Review Data

FFY 2015: 25.6%

FFY 2016: 17.3%



DPQI case review data



FFY 2016 DPQI case review data

Focus Groups

Focus groups are conducted with recipients of socially necessary services and children's residential services. The purpose of the focus groups is to provide consumers who are receiving socially necessary services the opportunity to share their experiences and opinions in regard to access, the referral process, and service delivery. These focus groups are conducted by a contracted administrative services organization called KEPRO (previously known as APS Healthcare), as part of their overall contracted utilization management functions. One focus

group consisted of 22 recipients of socially necessary services, with all but two of the participants being adults. The other focus group consisted of 14 youth between the ages of 12 and 18 receiving either medically necessary children's residential services or behavioral health services. Please refer to Item 30 for additional information on focus group participants and questions.

Results of the focus group add to the information available in relation to Permanency Outcome One in regards to DHHR worker contact with families and agency engagement of families in the case planning process. Eleven out of the 14 youth who participated in the focus group comprised only of youth who indicated they see their DHHR worker one time per month. Two of the participants said they see their DHHR worker every three months. In regards to case planning activities, 11 of the 14 youth said they had a service/treatment plan. Four of the participants said they felt they had no input into the development of the plan. Of the 22 participants in the focus group comprised mainly of adults, 15 said they have "regular contact" with their DHHR worker. However when asked what could be done to improve service provision, five of the participants said that seeing the DHHR workers more frequently and two participants stated that meeting with a DHHR worker "period", would assist with improved services. The majority indicated the DHHR worker did not meet jointly with them, their family, or the provider when the service plan was being developed. Fifteen of these participants said that although the DHHR worker completed monthly visits to their home the worker; never visited with the service providers; when services were being provided.

Assessment of Well-Being Outcome 1

Well-Being Outcome 1 is measured by performance on Items 12, 13, 14, and 15 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Well-Being Outcome 1 was substantially achieved in 32.4% of the cases reviewed, and partially achieved in 37.3% of the cases reviewed. Federal fiscal year 2016 case review data indicates Well-Being Outcome 1 was substantially achieved in 15.4% of the cases reviewed, and partially achieved in 30.1% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review.

Rating decreases were observed during FFY 2016 in all four CFSR items related to Well-Being Outcome 1. Overall, placement cases scored higher on the measure than in-home cases. The inability to have frequent and quality contacts with children and parents by caseworkers had a direct impact on Well-Being Outcome 1. Barriers to achieving this measurement include lack of

contacts in the family home, having contact with parents only at MDT meetings and court hearings, and failure to have contact with all children in the home involved in YS cases.

Of the cases that did not meet the measure for assessments and service provision for children, parents, and foster parents, the majority were due to a lack of initial or ongoing assessments and service provision of the parent/s. Non-placement cases rate as an area needing improvement more often than placement cases. Cases rating as an area needing improvement are due to the lack of on-going case work. Ongoing assessments were not frequent enough to continue to assess the family and determine the effectiveness of treatment services. Refer to the 2017 APSR for additional information on the issues that impact the overall rating of Item 12 and sub-items 12A-C.

As indicated earlier, there was a major difference in the way case planning actives were evaluated during case reviews during FFY2016. This lead to the significant decrease observed in the case review findings. Overall, older youth were more likely to be involved in the case planning process than younger children. Older youth in placement were often involved in case planning activities due to the activities being initiated by the placement provider. Older youth were also more likely to attend MDT meetings and court hearings.

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

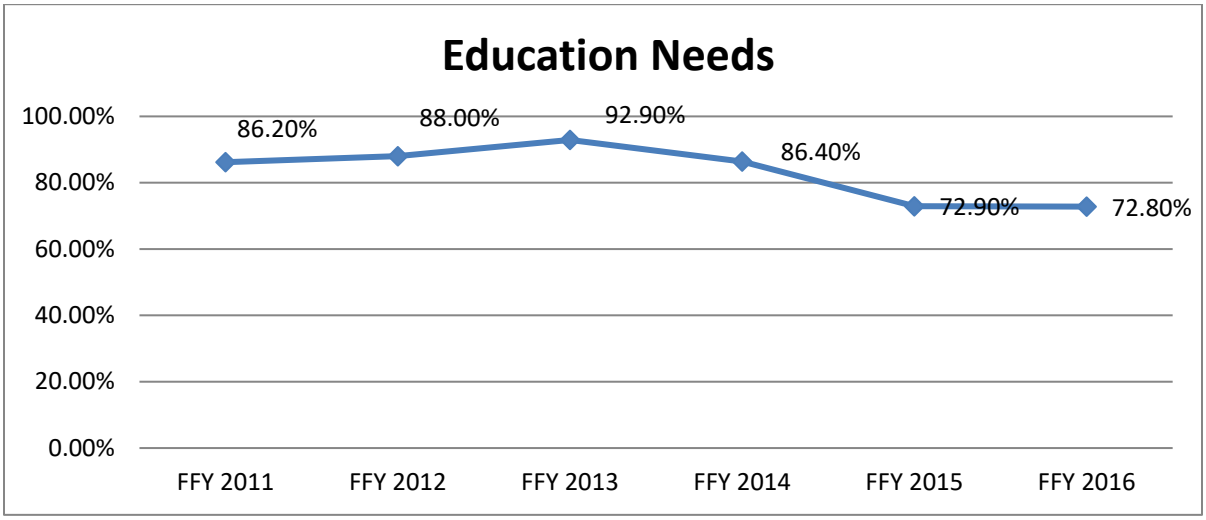
CFSR Item 16: Educational needs of the child.

The percentage of cases in which the educational needs of the child (ren) are assessed and appropriate services provided to address identified needs will be 95% or more.

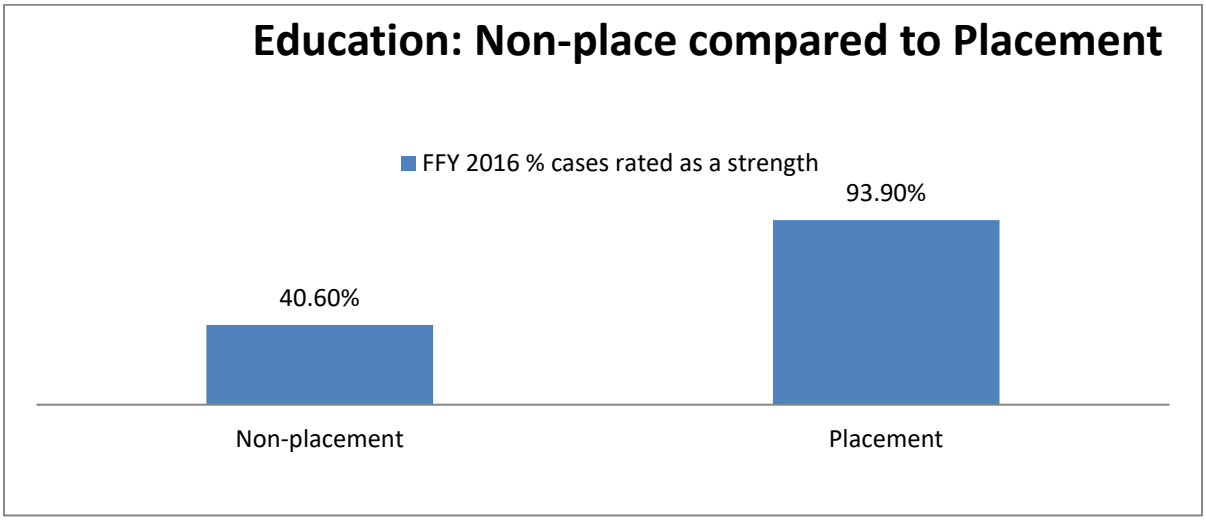
DPQI Quality Assurance Case Review Data

FFY 2015: 72.9%

FFY 2016: 72.8%



DPQI case review data



FFY 2016 DPQI case review data

Assessment of Well-Being Outcome 2

Well-Being Outcome 2 is measured by performance on Item 16 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Well-Being Outcome 2 was substantially achieved in 72.9% of the cases reviewed. The outcome rating for Well-Being Outcome 2 based on case reviews for federal fiscal year 2016 indicates Well-Being Outcome 2 was substantially achieved in 72.8% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12 months prior to the date of the review. Case reviews indicate minimal change in relation to the rating of this item between FFY 2015 and FFY 2016. Factors that contributed to the 2016 ratings include failure to

assess all of the children's educational needs in in-home Youth Services cases. There is often a focus on the child that came to the agency's attention, through formal or informal referrals for services, and other children residing in the home often are not assessed. Additionally, many districts within West Virginia have court systems that open truancy cases for monitoring purposes. The child welfare agency is often tasked with monitoring attendance, and service provision to address the issues contributing to the truancy are often only addressed when ordered by the court, or when the child is removed from the home due to the truancy. Over the past two years, West Virginia has seen an increase in these court-ordered monitoring cases. Please refer to the 2017 West Virginia APSR for details on factors impacting this item as there has been no change noted by reviewers.

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

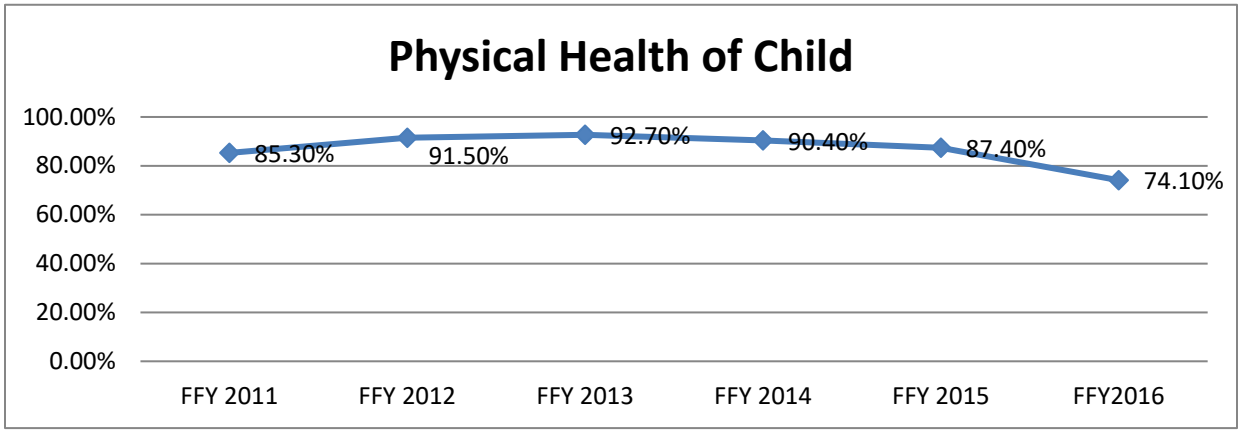
CFSR Item 17: Physical health of the child.

The percentage of cases in which the physical health needs of the child-(ren) are assessed and appropriate services provided to address identified needs will be 95% or more.

DPQI Quality Assurance Case Review Data

FFY 2015: 87.4%

FFY 2016: 74.1%



DPQI case review data

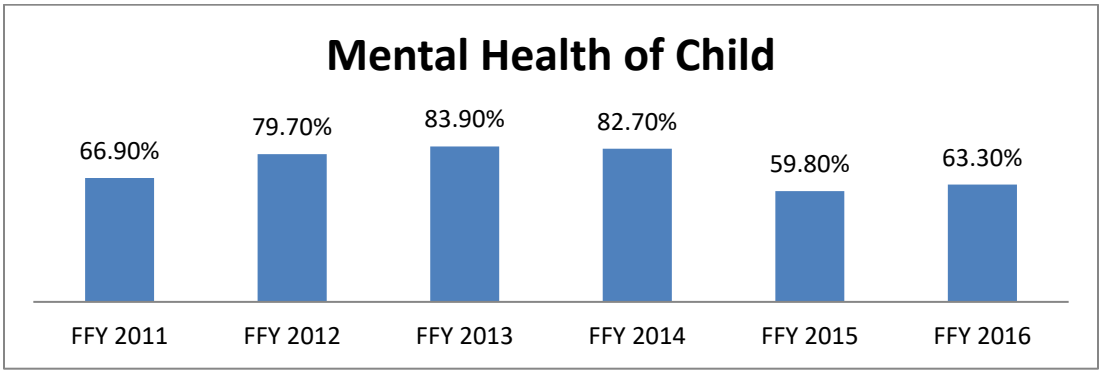
CFSR Item 18: Mental/behavioral health of the child.

The percentage of cases in which the mental health needs of the child-(ren) are assessed and appropriate services provided to address identified needs will be 95% or more.

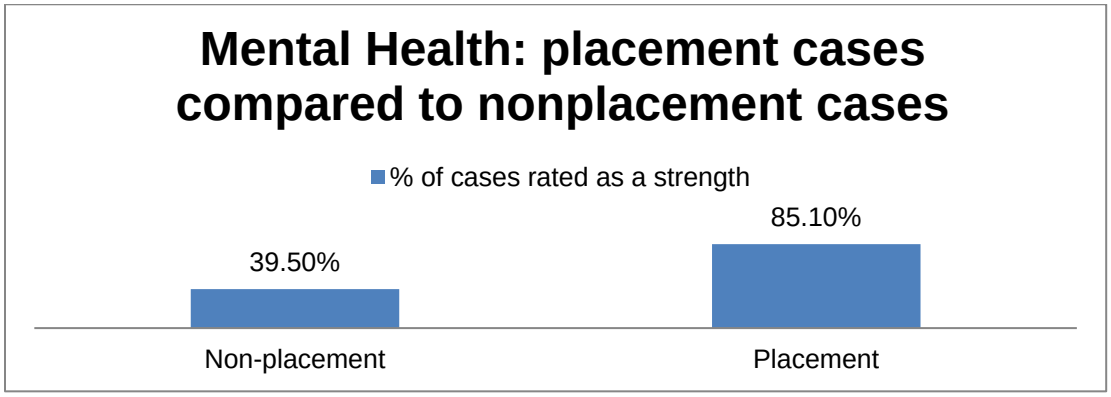
DPQI Quality Assurance Case Review Data

FFY 2015: 59.8%

FFY 2016: 63.3%



DPQI case review data



FFY 2016 DPQI case review data

Assessment of Well-Being Outcome 3

Well-Being Outcome 3 is measured by performance on Items 17 and 18 on the 2016 Federal CFSR Onsite Review Instrument. Federal fiscal year 2015 case review data indicates Well-Being Outcome 3 was substantially achieved in 67.5% of the cases reviewed, and partially achieved in 5.8% of the cases reviewed. The outcome rating for Well-Being Outcome 3 based on case reviews for federal fiscal year 2016 indicates Well-Being Outcome 3 was substantially achieved in 59.0% of the cases reviewed, and partially achieved in 9.8% of the cases reviewed. Case reviews conducted in both federal fiscal years are reflective of practice that occurred 12

months prior to the date of the review. Systemic factors that contributed to the 2016 rating include not gathering and reviewing reports and records from various medical providers, a lack of follow-up for identified medical issues and/or concerns and children not having current medically-related items, such as eyeglasses.

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

Case review data indicates most children in placement have behavioral health assessments and receive services to address their identified needs. In comparison, children in non-placement are much less likely to have behavioral health assessments completed even when displaying overt behaviors that indicate such assessments are warranted. A contributing factor in cases that did not meet the measure was often either assessments and services not being provided or not being initiated in a timely manner. Again, this was particularly found in non-placement cases. Please see the West Virginia 2017 APSR for information on focus groups conducted in 2015 by the Family Support Educator for APS Healthcare Inc.

Summation of Performance

October 1 2015 - September 30 2016 All Cases Outcome or Performance Indicator			
-	Outcome Ratings		
	Substantially Achieved	Partially Achieved	Not Achieved
Outcome S1: Children are, first and foremost, protected from abuse and neglect	67.1%	N/A	32.9%
Outcome S2: Children are safely maintained in their homes whenever possible and appropriate.	22.4%	16.8%	60.8%

Outcome P1: Children have permanency and stability in their living situation	18.3%	64.8%	16.9%
Outcome P2: The continuity of family relationships and connections is preserved for children.	76.4%%	22.2%	1.4%
Outcome WB1: Families have enhanced capacity to provide for their children's needs	15.4%	30.1%	54.5%
Outcome WB2: Children receive appropriate services to meet their educational needs.	72.8%	0%	27.2%
Outcome WB3: Children receive adequate services to meet their physical and mental health needs.	59.0%	9.8%	31.1%

DPQI case review data indicates that West Virginia did not meet the 95% threshold as required by federal guidelines for achieving substantial conformity for the seven performance outcomes. West Virginia did improve ratings on Outcome Permanency 2. The Child and Family Services Review (CFSR 3) Data Profile measuring West Virginia's performance on each of the Round 3 statewide data indicators, as measured against national standards and the results of the data quality checks, indicates that West Virginia met or exceeded the national standard in relation to six of the seven data indicators. West Virginia did not meet the indicator for permanency in 12 months for children entering care. Supreme Court of Appeals of West Virginia Child Abuse and Neglect data also indicates that children remain in placement longer than 12 months before achieving permanency in their living situation. West Virginia continues to work toward shortening the length of time children remain in care without permanency in their living situations. It should be noted that the overall length of time for an abused or neglected child to reach permanency has been reduced over the last eight years.

Multiple factors impact the ability of West Virginia to improve positive outcomes for children and families. One major factor is the ever increasing number of cases in which substance abuse is a factor. West Virginia also struggles to attract and retain qualified staff. As indicated earlier, performance on the Child and Family Services case reviews is directly linked to staffing levels in the district during the period under review. During both federal fiscal years 2015 and 2016, districts continue to list staff turnover as a barrier to achieving better outcomes for children and families. Districts also indicate the limited availability of services including quality ASO providers, mental health services, domestic violence counseling for victims and batterers, and substance abuse treatment for both adults and youth as other barriers in meeting the needs of

children and families. West Virginia continues to work with community partners to increase services to address these barriers.

Section IV: Assessment of Systemic Factors

Instructions

The statewide assessment information for systemic factors is used in determining ratings for substantial conformity. Therefore, it is imperative that the statewide assessment team ensures that information in this section speaks to how well each systemic factor requirement functions across the state. To complete the assessment for each systemic factor, state agencies should:

1. Review the *CFSR Procedures Manual* (available on the Children's Bureau Web site at http://www.acf.hhs.gov/programs/cb), which elaborates on key concepts and provides examples of data that are relevant to the assessment of systemic factor requirements.
2. Respond to each assessment question using the requested data and/or information for each systemic factor item. Relevant data can be qualitative and/or quantitative. Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance for each of the seven systemic factors. Review the information with the statewide assessment team and determine if more recent data is available that can be used to provide an updated assessment of each item. If more recent data are not available, refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each systemic factor item.
3. Emphasize how well the data and/or information characterizes the statewide functioning of the systemic factor requirement. In other words, describe the strengths and limitations in using the data and/or information to characterize how well the systemic factor item functions statewide (e.g., strengths/limitations of data quality and/or methods used to collect/analyze data).
4. Include the sources of data and/or information used to respond to each item-specific assessment question.
5. Indicate appropriate time frames to ground the systemic factor data and/or information. The systemic factor data and/or information should be current or the most recent (e.g., within the last year).

The systemic factor items begin with #19 instead of #1 because items #1 through 18 are outcome-related items covered in the onsite review instrument used during the onsite review. Items related to the systemic factors are items #19 through 36.

A. Statewide Information System

Item 19: Statewide Information System

How well is the statewide information system functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

> Please provide relevant quantitative/qualitative data or information that show the statewide information system requirements are being met statewide.

State Response:

Insert state response to Item 19: Statewide Information System

See pages 111-113 of the most recent APSR submission for historic information on the West Virginia Information System.

See pages 113-114 for most recent information on the West Virginia Information System.

The Kids in Care SOP (Appendix A) was implemented September 1, 2015 to create a uniform system to track vital information for all children in care. It was revised on January 1, 2017 to note that supervisors should review the Kids in Care Report and compare with the Children in Placement Report found in FACTS and also with the monthly payment screens to assure all children have been entered into placement in FACTS. All payments for placement must be verified by the supervisor each month. This report was initially developed as a means of tracking children for Safe at Home; however, it was determined that it would be used to track all children in care and to provide information to ensure all children are being entered into FACTS. The report originated from an August 2015 FREDI report titled “Children in Placement with Level”. This tracking report is kept by each district and is updated monthly concerning new placements and exits from placement.

The Kids in Care report is comprised of the following information:

Youth Demographic information/characteristics
Provider Demographics
Placement date – entry and exit
Permanency plan

As information is updated on the spreadsheet, supervisors will be checking FACTS for matching documentation concerning start and end dates for placements. Workers consult with supervisors when seeking removals or when making changes concerning placements or

reunification. Supervisors use this information when checking and comparing the Kids in Care report.

During monthly conferences with workers, supervisors will review all new removals for the month with the worker and compare with the Kids in Care report to determine that all youth have been listed. Workers and supervisors will also review any changes in placement for current youth in placement in order to ensure all children have been entered or exited into or out of placements. At this time, workers and supervisor will also review face to face visit with child in placement which is also a FREDI report and a COGNOS report.

This spreadsheet is then provided to the Community Service Managers, Regional Program Manager and Director of Social Services. Community Service Managers and Regional Program Manager review the report. This report is also stored electronically and can be printed monthly for easy access in the event of a disaster that would impact electronic records.

Foster care policy indicates that workers must enter the effective date of placement within three days of placement. The exit date should be entered within three days of discharge.

Supervisors and workers address children in placements and any changes in placements such as placements or disruptions during the worker conferences.

By using the Kids in Care spreadsheet and information obtained during worker conferences, the supervisor can compare them with monthly payment approvals for a checks and balances method of ensuring all children have been entered into care or have been discharged as appropriate.

In order to ensure that placements entry changes in placements and exits along with demographic information each supervisor will begin reviewing at least five placement cases per month or 10 percent of total cases. This will provide a check with the case record to ensure payments are being made. Supervisors will also verify the payment screens each month check that each child that has been removed during the month has been entered for payment.

B. Case Review System

Item 20: Written Case Plan

How well is the case review system functioning statewide to ensure that each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions?

> Please provide relevant quantitative/qualitative data or information that shows each child has a written case plan as required that is developed jointly with the child's parent(s) that includes the required provisions.

State Response:

Insert state response to Item 20: Written Case Plan

See pages 117-118 of the most recent WEST VIRGINIA APSR submission for information on foster care policy changes that impact this item.

DPQI case reviews show that of the 72 foster care cases reviewed during FFY 2016, 11.6% contained a written case plan determined to have been developed jointly with the family. A customer focus group completed by KEPRO (pgs. 94-103) consisting of 14 youth found that 11 out of 14 youth said they had a service/treatment plan. All but four of the youth felt they had input into the development of the plan. No information was provided in this focus group of engagement of the parents in the development of the plan.

The "Client 14 and over in Care and in Open Case" FREDI report is generated each month. This report lists each child over the age of 14 years that has a completed Casey Assessment and Learning Plan. In addition, it also indicates any child over 14 that does not have a Learning Plan completed or does not have either a Casey Assessment or Learning Plan completed. This report is reviewed by Regional Program Managers, Community Service Managers and Supervisors. This report identifies any child in custody over 14 that needs a Learning Plan or Casey Assessment completed. Supervisors discuss this report with workers during monthly worker conferences to help ensure the assessments have been completed either by staff or providers. The report for December 2016 indicates a total of 1486 children over the age of 14 years in care of which 749 (50.4%) do not have life skills assessments.

Item 21: Periodic Reviews

How well is the case review system functioning statewide to ensure that a periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

Please provide relevant quantitative/qualitative data or information that show a periodic review occurs as required for each child no less frequently than once every 6 months, either by a court or by administrative review.

State Response:

Insert state response to Item 21: Periodic Reviews

-	2014		2015		2016	
-	Average Days	Percent Compliance	Average Days	Percent Compliance	Average Days	Percent Compliance
Time to Permanency Placement	439.5	None	427.0	None	437.8	None
Time to First Permanency Determination	265.2	None	254.0	None	251.7	None
Judicial Permanent Placement Reviews (Compliance Limit 93 Days)	86.5	76.40%	83.1	78.00%	83.4	76.3%
Disposition to Permanent Placement	144.4	93.80%	142.3	94.00%	150.2	87.30%

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

The Supreme Court of Appeals of West Virginia Child Abuse and Neglect data shows that periodic reviews by the court for the majority of children in foster care occur within the required timeframe. In conjunction with the CIP data and tracking, the Bureau for Children and Families distributes monthly trackers related to IV-E compliance, the Court Order Report and Pending

Cases Report. This report is sent monthly to each Community Services Manager, the Regional Director, and Deputy Commissioners. The use of this report assists districts in tracking judicial and periodic reviews. The report also indicates where there are potential challenges to assuring proper review. The email that accompanies each set of reports gives details of the report and outlines action to be taken. Overall courts are meeting the periodic review timetable requirements and BCF has not had to use the Administrative Review process

Item 22: Permanency Hearings

How well is the case review system functioning statewide to ensure that, for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

> Please provide relevant quantitative/qualitative data or information that show a permanency hearing as required for each child in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.

State Response:

Insert state response to Item 22: Permanency Hearings

The Supreme Court of Appeals of West Virginia Child Abuse and Neglect data shows that, on average, children in foster care in West Virginia have an initial permanency hearing in a qualified court within twelve months of the date of foster care entry. This same data also indicates that on average these children are having regular permanency review hearings. Time to permanent placement is measured by the average (mean) and median time from filing of the original petition to permanent placement. This is calculated using all records, including both original petition filing date and the date of permanent placement.

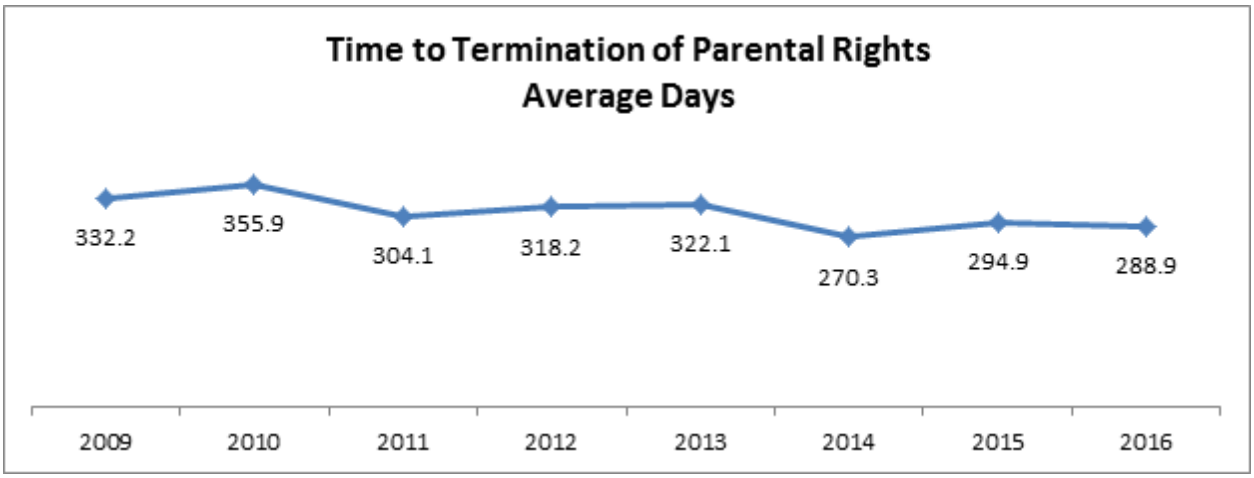
Item 23: Termination of Parental Rights

How well is the case review system functioning statewide to ensure that the filing of termination of parental rights (TPR) proceedings occurs in accordance with required provisions?

> Please provide relevant quantitative/qualitative data or information showing that filing of TPR proceedings occurs in accordance with the law.

State Response:

Insert state response to Item 23: Termination of Parental Rights



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

The Supreme Court of Appeals of West Virginia Child Abuse and Neglect (CAN) data indicates that, on average, the number of days from filling of a child abuse and neglect petition until the termination of parental rights is less than one year.

Item 24: Notice of Hearings and Reviews to Caregivers

How well is the case review system functioning statewide to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to be heard in, any review or hearing held with respect to the child?

> Please provide relevant quantitative/qualitative data or information that show foster parents, pre-adoptive parents, and relative caregivers of children in foster care (1) are receiving notification of any review or hearing held with respect to the child and (2) have a right to be heard in any review or hearing held with respect to the child.

State Response:

Insert state response to Item 24: Notice of Hearings and Reviews to Caregivers

During FFY 2016 DPQI staff reviewed 47 randomly selected foster care cases for Right to Be Heard criteria. Of the 47 cases, 38 cases were applicable for notification of hearings and MDT meetings to foster parents. In 65.78% of the cases reviewed foster parents indicated they had received notification of at least one court hearing, and in 76.31% of the cases reviewed foster parents indicated they had received notification of at least one MDT. Of the 38 applicable cases, 34.21% of foster parents indicated they had never received a notice for court hearings, and 23.68% of foster parents indicated they have never received notification of a MDT.

West Virginia has developed a survey to mail to foster parents to determine if they are receiving hearing notices. The results of the surveys should be available in time to report the information out in the next APSR. (See Appendix B)

C. Quality Assurance System

Item 25: Quality Assurance System

How well is the quality assurance system functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the CFSP are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

> Please provide relevant quantitative/qualitative data or information showing that the specified quality assurance requirements are occurring statewide.

State Response:

Insert state response to Item 25: Quality Assurance System

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

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

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

DPQI completes biennial Child and Family Services Review (CFSR) style social service case reviews for each of the West Virginia Department of Health and Human Resource's districts. One district level review is completed each month by DPQI staff. The review includes the examination of 12 randomly selected cases consisting of six in-home and six placement cases. The largest metropolitan area is reviewed at least once each calendar year. The review cycle is

continued until each district has been reviewed. (See APSR Pgs. 147-148 and CFSR Rd. 3 DPQI Policy Manual Pgs.3-8)

The Bureau for Children and Families is comprised of 29 Community Services Districts that are divided into four regions. During FFY 2016 DPQI completed 143 social services case reviews comprised of 72 foster care and 71 in-home cases. Reviews were completed in each of the four regions. The reviews occurred in 12 different districts representing 40% of the districts in West Virginia. DPQI staff completed approximately 516 interviews during FFY 2016. Of this number, 209 were children, parents, foster parents, or other relatives and/or caregivers of the children involved in the cases being reviewed.

West Virginia has established a centralized intake system. A centralized intake call center is located in the northern and southern part of the state. DPQI is responsible for the sampling and review of intake assessments. The reviews evaluate the quality of intake assessments. The Centralized Intake unit utilizes the results of the reviews to improve the quality of the intakes and adhere to the fidelity of the screening process. (See APSR Pgs. 152-153)

Refer to page 98 of the most recent APSR submission for detailed information on the Centralized Intake Unit initiated in July 2014. During FFY 2016 DPQI staff reduced the number of Centralized Intake reviews from 40% of all accepted and screened out reports received to 20%. DPQI reviewed 2,273 intakes as received by the Centralized Intake Unit during FFY 2016. Intakes as approved by each Centralized Intake supervisor were reviewed. Reviewers agreed with the screening decisions made by Centralized Intake supervisors in over 95% of the intakes reviewed. Centralized Intake staff will be completing peer reviews of intakes during FFY 2017. During FFY 2017 DPQI will not be completing Centralized Intake reviews.

West Virginia has established an internal child fatality review committee to review all child deaths due to child abuse and neglect and child near fatalities. Refer to pages 151-152 of the most recent APSR submission for detailed information on the Critical Incident Review Team. Cases that are deemed by the internal review team to need an intensive level of review are reviewed by a member of DPQI in conjunction with two representatives from field staff. The results are reviewed by an internal review team quarterly. The objective is for the team to learn from these deaths in order to prevent similar deaths in the future. DPQI staff reviewed 62 critical incidents in 2016.

As part of CQI efforts, BCF has created a Data Subcommittee to review data and develop strategies related to the resolution of data quality issues. The committee also identified other data needs for the improvement in case practice. Additionally, the committee has reviewed existing data sources to determine relevance and usefulness. In late November 2016, with assistance from the Capacity Building Center for States, the subcommittee conducted focus groups designed to determine the data needs of field level staff. The goal of the focus groups was to gain a better understanding of how data is used by field staff and what changes in the way data is collected and disseminated would be most useful for the improvement of practice. The group is working toward analyzing the information gained from these groups. (See APSR Pg. 156)

West Virginia has been approved to conduct Round Three of the Child and Family Services Reviews using the State Conducted Case Review process to complete the onsite review. DPQI staff will conduct reviews of 65 social service cases representative of statewide practice in six districts. The six districts selected are representative of the dichotomy of the State from urban to rural practice and will include the largest metropolitan area in West Virginia, Kanawha County. Reviews will be conducted in each of the designated districts with a staggered schedule over the course of the six month review period. Refer to the CFSR Rd. 3 DPQI Policy Manual for further details of how the review will be conducted.

In order to improve outcomes DPQI has recommended to the Commissioner of the Bureau for Children and Families to institute a quality assurance process that incorporates local, regional, and state level Quality Councils. (See Pgs. 153-154 of the APSR) The Quality Councils process in place includes DPQI case review of districts, development of a district corrective action plan (CAP) based upon review results, and submission of the CAPS to agency leadership. Quality councils have been developed and are being refined in order to monitor and update the CAPS.

The DPQI unit also completes targeted reviews. For example, during federal fiscal year 2017, as part of the Juvenile Justice Reform Bill (Senate Bill 393), Aggressive Replacement Therapy will be piloted by Children's Home Society of West Virginia. As part of the implementation of this project the Department must have Model Fidelity Coordinators to conduct fidelity reviews of the program and sessions with the children. DPQI staff will be trained to complete these reviews.

Have standards to evaluate the quality of services

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

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

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

After the cases are rated each case is debriefed. At a minimum, case debriefings are comprised of two review teams and a DPQI program manager. During these debriefings case ratings are discussed in relation to CFSR instrument instructions and clarification guides to ensure accuracy with instrument instructions. A different DPQI Program Manager completes QA activities.

Identifies strengths and needs of the service delivery system

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

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

made in a timely manner and the provider delivered the requested services. Through the review process gaps in service availability and provision are identified. The findings are reviewed at the quarterly critical incident review meeting.

Provides relevant reports

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

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

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

The Critical Incident Review Team develops recommendations for modification of internal procedures, policies or programs of the Bureau for Children and Families; identifies programmatic or operational issues that point to the need for additional internal training or technical assistance; develops recommendations for external stakeholders to assist in the effort to reduce or eliminate future child fatalities through improved services to children and families; and identifies community resources for children and families that are needed but are currently unavailable or inaccessible. The Critical Incident Review Team submits an annual report to the

Commissioner of the Bureau for Children and Families for presentation to the state legislature. The report can be found at: http://www.dhhr.West Virginia.gov/bcf/Reports/Pages/default.aspx

Evaluates implemented program improvement measures

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

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

The Centralized Intake Unit utilizes the results of the DPQI intake assessment reviews, along with feedback from external stakeholders, to improve the quality of the intakes and improve fidelity to the Safety Assessment and Management System. The information is also used to ensure uniformity in screening decisions.

D. Staff and Provider Training

Item 26: Initial Staff Training

How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the CFSP that includes the basic skills and knowledge required for their positions?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- staff receive training pursuant to the established curriculum and time frames for the provision of initial training; and
- how well the initial training addresses basic skills and knowledge needed by staff to carry out their duties.

State Response:

Insert state response to Item 26: Initial Staff Training

Structure of Training System

BCF operates a statewide training system for West Virginia that consists of an administrative office in Charleston and 16 staff trainers who are housed in district offices across the state. The staff trainers provide classroom and online training along with the member schools of the West Virginia Social Work Education Consortium (SWEC), a Title IVE group with representatives from the public accredited social work programs including West Virginia University, Marshall University, Concord University, Shepherd University, West Virginia State University, and West Liberty State University, with the majority of training provided by the staff trainers. Staff trainers work for the state and are required to have at least four years of program experience in the area they train and a social work license. Training is provided in various district offices across the state that house conference and computer training rooms to make training more accessible for field staff. In general training is scheduled in the northern part of the state for BCF regions I and III and in the southern part of the state for Regions II and IV. Training is provided through established curricula that are approved by Policy and/or FACTS so that the training is consistent in all parts of the state. Training completion is tracked through a central database with completion and no-shows reported to the supervisor and manager.

Initial Staff Training: Pre-Service Training

BCF pre-service training is provided to all new workers who are hired into child welfare positions in the agency including Child Protective Services, Youth Services, Adoption, and Home-Finding. This training includes staff who are contracted to provide these services such as contracted Youth Services workers, who are required to complete the same training as agency staff. Pre-service training includes 220 hours of training over an 11 week period followed by a competency test in the twelfth week that must be successfully completed before assuming a caseload. This 12 week period is referred to as a training round, with two training rounds starting per month (generally one north and one south) and start dates for each round established for the next calendar year each fall. Workers are not allowed to assume a primary or secondary caseload until they pass the competency test. After passing the test workers are given a "graduated" caseload, meaning that they are assigned one to two cases per week until a full caseload is reached. The 220 hours of training are required by law through SB559 and will be discussed later in this section.

Preparation for training begins as soon as the paperwork process for hiring is initiated. The Division of Training receives a weekly report from each of BCF's four regions of all the new workers whose paperwork has been submitted for hire. These reports go to the Training On-boarder, who contacts the supervisor and helps him/her to complete network access forms and assign the new worker to a training round prior to the worker's start date. In most cases the new worker is assigned to a round that begins one to three weeks after the first day of employment, unless there are special circumstances such as the worker's inability to travel, so that there is sufficient time to complete an agency/office orientation and required online training. The period between the first day of employment and the first day of classroom training is referred to as Week 0 on the training schedule and specific assignments must be completed during this time, with completion tracked by the lead trainer in the Blackboard system. On the first day of employment the new worker receives an email from the BCF On-boarder with the training schedule and instructions for online training and activities that must be completed prior to the first day of classroom training.

New worker training rounds are provided in 12 consecutive weeks, with each week of classroom training consisting of four-seven hour training days (for a total of six hours of training per day or 24 hours per week). Workers are given an hour of travel time each day and one day in their office each week. The training schedule is set up in two week blocks of time to cover specific material, followed by one week of transfer of learning with structured activities based on the

content from the previous two weeks. The competency test is taken in the twelfth week. The schedule is as follows:

- Classroom training begins with two weeks of training (Weeks 1 – 2) for all job classifications together (CPS, Youth Services, Adoption, and Home-Finding) on interviewing and intake assessments followed by one week of transfer of learning with structured activities at the worker's home office (Week 3). This block includes practice interviews and computer training on FACTS system operation and the intake assessment process.
- Next the workers split out by job classification for two weeks of classroom training (Weeks 4 – 5) on initial assessment based on job function (CPS and Youth Services) and a week of structured transfer of learning (Week 6). This block includes training on the assessment process, protection planning, and safety planning as well as computer training on documentation of emergency custody in FACTS.
- For the next two weeks (Weeks 7 – 8) all job classifications return together for training on children in care and court followed by a week of structured transfer of learning (Week 9). This training includes information on foster care placement and multi-disciplinary team meetings, and provides information on court operations and expectations.
- For the final two weeks of training (Weeks 10 – 11) workers are split out by job classification (CPS, Youth Services, Adoption, and Home-finding) for training on family assessment. This block includes training on any assessment instruments that require a certification, such as the CANS and YLS/CMI so that workers are certified by the end of pre-service training.
- In the final week of pre-service training (Week 12) the worker completes a competency test that includes a knowledge test, two simulated interviews (one with a child and one with an adult), and a critical thinking/decision making assessment. The worker must pass each component of the test with a score of 80% or greater to complete pre-service training. If a worker does not pass any component of the test he/she may retake the test up to three times; if the test is not passed in three attempts the worker must re-take new worker training. The worker may be assigned a graduated caseload after passing the competency test. Competency testing was implemented on January 1, 2016, and every new worker hired in 2016 completed the competency test.
- Workers must complete, or be certified as having completed, 220 hours of training and successful completion of the competency test before they can assume a caseload. This

requirement is written into law through SB559 (discussed in the next section). Completion of the 220 hours of training is tracked in the training database and workers must make up any training hours that were missed due to absence before they can take the competency test. To ensure that no cases are assigned during pre-service training, the lead trainer checks the FACTS system at the end of each two week block of training to validate that workers have not been assigned as primary or secondary worker. If primary or secondary assignments are found in the system the information is reported to the Deputy Commissioner, Regional Director, Manager, and Supervisor so that immediate action is taken.

Students are evaluated on performance in class by the trainer at the end of each two week period of classroom training and the evaluation is sent to the worker, supervisor, and CSM by the third day of the workers' transfer of learning week. This allows supervisors the opportunity to review progress, and take corrective action if necessary, before the next block of training. Workers also complete an evaluation of training at the end of each two week block that assesses the trainer, material, knowledge gained, whether the training met their needs, and areas that still need clarification for the student.

Information to gauge the effectiveness of training is collected from several sources. First, the results of the surveys completed by workers are generated as a report for each class and the information is entered into a database. This database was recently implemented and will be used to evaluate training by class and trainer over a period of time in order to make improvements and to ensure the content meets the workers' needs. Compiled results are not yet available because the information is still in process of being entered into the database, but should be available by the time the next APSR is submitted. Second, BCF recently implemented a survey that will be sent out at least once per year on their experiences in and satisfaction with training. Information is collected for groups according to tenure (less than one year; one to three years; over three years) to see the results of training over a longer period of time and evaluate how training was implemented in practice.

The following statistics demonstrate the functioning BCF Initial staff training in 2016.

- Pre-service training was provided to 211 new workers including 136 CPS, 39 Youth Services, 19 contracted Youth Services, eight Centralized Intake, five Adoption, three Homefinders, and one contracted Homefinder.

- Portions of pre-service training were provided to 38 workers that switched to a restricted license and had to complete training they had not completed before, bringing the number who received all or part of pre-service training to 249.
- 112 workers (53%) out of 211 new workers that were trained had a restricted social work license.
- The average wait time between the first day of employment and the first day of classroom training was 26 days.
- The average number of days between the first day of classroom training and completion of competency testing was 86 days, or 12.29 weeks.
- 100% of new workers completed pre-service training and competency testing within six months of employment.
- 211 or 100% of workers in new worker training took the competency test. Of those, 174 or 82.5% passed on their first attempt. Of the 37 who did not pass, 35 passed on the second attempt, one passed on the third attempt, and one attempted to test twice and left her position prior to testing again.

Initial Staff Training: Year One In-Service Training

New workers are required to complete or be certified as having completed additional training within the first year of employment, referred to as in-service training. Training is provided through established, approved curricula on specific topics that are included in the training plan in both the online and classroom format. The number of hours of training hours required is based on the licensure level of the worker, and completion is tracked in the training database and reported to supervisors and managers on a regular basis. Workers who have a regular social work license (BSW or MSW) must complete 70 hours of classroom and online training, while workers with a provisional license (degree related to social work, as designated by the Board of Social Work) or restricted provisional license (degree unrelated to social work) must complete 100 hours of training in the first year. Generally in-service training is taken after pre-service training is completed, although workers may attend sessions during pre-service training if the round schedule can accommodate it. It is recommended that in-service training be completed as soon as possible after the end of pre-service training while caseload sizes are low to avoid potential conflicts with casework activities and court.

In-service training includes both online and classroom content. Online content is located in the DHHR Blackboard system and workers may self-register and complete the training at any time.

Blackboard tracks completion of the training through a test that is completed at the end of each course. Classroom training is scheduled with one session per month per subject, provided in various locations across the state. New workers are placed on rosters for their required classes prior to the beginning of pre-service training and are given the dates and locations on the back of their new worker pre-service training schedules. They may change their registration in specific workshops as necessary. The in-service training schedule is kept on a calendar with dates and locations and a roster/sign in sheet is placed on the DHHR shared drive for each session so that any trainer can enroll or remove a worker from a class. The rosters are printed off and used as sign in sheets at the sessions to document attendance and no-shows, with no-shows immediately reported to management for action. Attendance at each session is tracked through the training database and workers receive a written report of the training they still need to take each quarter. In-service training is provided by staff trainers and the Social Work Education Consortium schools through their Title IVE training contracts, and domestic violence training provided by the West Virginia Coalition Against Domestic violence through a contract.

The in-service training schedule was developed in response to the passing of West VirginiaSB559 in 2015, which created an option for DHHR to hire staff without a degree related to social work into licensed positions within the agency provided those staff complete a "rigorous" training program provided by the Department. This legislation was passed in response to fewer and fewer applicants for social work positions due to West Virginia's declining population and low numbers of residents with four year college degrees of any type in the rural areas of the state in particular, causing positions to go unfilled for long periods of time. Prior to the passage of SB559 applicants had to either have a degree in social work (regular license) or a degree in a field related to social work (provisional license). Individuals with provisional licenses had to complete 12 hours of college social work classes within the first four years of licensure. The passage of SB559 allowing individuals with unrelated degrees to practice social work was very controversial and created a great deal of conflict in the social work community. In response to this conflict BCF worked with its higher education partners to develop a training plan that would be similar in content to the 12 hours of required coursework for regular provisional licenses over the first four years of restricted licensure, with a large amount of content provided in the first year so that workers would have the basic knowledge they would require up front. The training plan, which includes pre-service and year one in-service training along with additional requirements for years 2 – 4 of licensure that are discussed in the next section, was attached to the SB559 legislative rule and written into law on July 1, 2016.

BCF implemented the year one in-service training requirement so recently that there is little data available to demonstrate its functioning. Workers are still in the process of completing year one requirements so completion data cannot yet be reported but will be available by the time of the next APSR. Questions on the effectiveness of year one in-service training will be included in the surveys that will be sent out to staff twice per year.

Item 27: Ongoing Staff Training

How well is the staff and provider training system functioning statewide to ensure that ongoing training is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Staff, for purposes of assessing this item, also include direct supervisors of all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- that staff receive training pursuant to the established annual/bi-annual hour/continuing education requirement and time frames for the provision of ongoing training; and
- how well the ongoing training addresses skills and knowledge needed by staff to carry out their duties with regard to the services included in the CFSP.

State Response:

Insert state response to Item 27: Ongoing Staff Training

In West Virginia, ongoing training is referred to as professional development training and includes any training provided to tenured staff after the first year of employment that addresses the skill and knowledge needed to carry out their job duties. The baseline requirement for regularly licensed staff is completion of 40 hours of training bi-annually, which is required to maintain social work licensure. The amount of required training is higher for provisional licenses (see information below). If the continuing education requirements are not met, staff will lose their licenses and be removed from their positions in the agency.

Staff are also required to take training on BCF's current initiatives; for example, all staff in the state are required attend nine hours of training on the Safe at Home initiative and six hours of training to certify staff on the CANS assessment, for a total of 15 additional hours of training. Youth Services staff is also required to take training and obtain certification in the YLS/CMI. As of May 2016, 194 Youth Services staff had completed YLS/CMI training and 63 completed and passed certification testing. Both the West Virginia CANS and YLS/CMI requires recertifications which are tracked and reported by the Division of Training to the certifying bodies. Trauma training was also added as a requirement for all staff and foster care providers. For child welfare staff, all tenured workers are now required to attend nine hours of trauma training, and this training has been added to the new worker training plans as part of the in-service training requirements. Foster parents are also required to complete nine hours of trauma training in the first year as a foster parent. There is not, however, an established minimum number of hours of training that must be completed by tenured staff beyond the training required by current initiatives outside of the CEUs required for licensure.

As far as licensure is concerned, agency staff wand contracted staff who provide child welfare services in West Virginia are required to have a bachelor's degree and hold a social work license through the West Virginia Board of Social Work. The same requirements apply to all the agencies that provide child welfare services in West Virginia since those staff are also required to be licensed. There are currently three levels of licensure at the bachelor's degree level:

1) A regular license, which requires a degree in social work. Staff with this license graduate from college with a "temporary permit," which allows them to practice for three months while they take and pass the social work board test. Once the test is passed staff receives a regular license and must complete and report 40 hours of continuing education units every two years to maintain licensure. These hours are tracked by the worker and supervisor for completion. Staff members who do not meet the continuing education requirements required for licensure renewal will lose their licenses and can no longer be employed.
2) A regular provisional license, which requires a degree in a field related to social work. Staff with this license must take 12 hours of college coursework in social work within the four years licensure period, along with 20 hours of CEUs for each two years. These staff must also have a licensing supervisor who has a social work degree and meets with them quarterly, submitting reports to the Board as part of the requirements for renewing the license. At the end of four years, if all the requirements are met, staff must take and pass the social work board test to receive a regular license. Staff members who do not

meet these requirements or who do not pass the test lose their licenses and can no longer be employed. These requirements are tracked by the worker, supervisor, and licensing supervisor for completion.

3) A restricted provisional license, created by the passage of SB559 in 2015, allows individuals with a degree not related to social work to be licensed provided that they meet certain conditions discussed the previous section. Staff with a restricted license may not work anywhere outside of DHHR. Staff with this level of license must complete the requirements of a four year training plan that is spelled out in the SB559 legislative rule. The training plan requires 60 hours of training per year in the second, third, and fourth years of employment. DHHR must report annually to the Social Work Board whether restricted license staff completed the required training in the specified time period, and staff who do not complete the required training will lose their licenses and can no longer be employed. The first report will be submitted to the Board of Social Work on July 1, 2017 so completion data is not yet available. Along with completion of the training plan, restricted license staff must also complete 20 hours of CEUs for each two years of the four year licensing period and have a licensing supervisor who has a social work degree and meets with them quarterly, submitting reports to the Board as part of the requirements for renewing the license. At the end of four years these staff will have to take and pass the social work board test to maintain employment. CEUs and supervisory meetings are tracked by the worker, supervisor, and licensing supervisor, and the Division of Training tracks training plan completion through its training database and submits completion reports to the board annually.

While the Division of Training effectively tracks pre-service training, centralized statewide tracking methods for professional development training must be improved to ensure accuracy of those numbers. This will become even more important in upcoming years as West Virginia continues to implement SB559 requirements because of the large amount of data that will have to be tracked. West Virginia's SACWIS system keeps individual training records based on training enrollment and attendance, and district supervisors and managers track their staff's attendance. However, databases must be developed to track the total number of hours of training each staff person completed to ensure he/she met the training requirement at the statewide level. This data can be tracked and reported to demonstrate the effectiveness of the training program to the Legislature and in the APSR. The Division of Training has developed

and implemented a comprehensive database to track pre-service and restricted license training but it will need to be expanded if BCF is to track all staff's training completion at the state level.

For private providers and residential facilities, BCF requires a minimum number of hours of required training for those providers in order to maintain their licenses to provide services. Training completion is tracked by the licensing division through an agency and facility review process. However, there is currently no method to collect and report collective data on compliance for the state and methods will have to be put in place to accomplish this.

The BCF Division of Training provides training for child welfare supervisors, along with training required by DHHR's Office of Employee Development and the West Virginia Division of Personnel Office of Organization and Human Resource Development (DOP). The Division of Training focuses on program specific training for child welfare supervisors. The Division of Training offers new supervisors nine days of new supervisor training within their first year as a supervisor. The curriculum used for this training is "Putting the Pieces Together," based on curriculum developed by the National Resource Center for Organizational Improvement that has been adapted to West Virginia. This training covers Administrative Supervision (management and organizational theories; power; transitioning from worker to supervisor; supervisor as advocate, change agent, data analyst, recruiter, and performance monitor); Educational Supervision (adult learning; staff ability vs. performance; stages of worker development; balancing compliance with best practice; constructive feedback; coaching); and Supportive Supervision (supervisor as motivator, counselor, team leader, conflict manager). Managers and the Division of Training track attendance at this training; although the training is mandatory, attendance has been sporadic. In FY2015/16, 50 supervisors attended and completed this training; however, 84 supervisors were enrolled. Policies must be put into place to make this training mandatory for new supervisors and the Division of Training must add this training to its database for tracking and reporting.

Along with program specific training, DHHR's Office of Employee Development requires supervisors to attend a week-long "management bootcamp" that covers a variety of management and supervision topics. Their office tracks employees for compliance with the policy. The DOP requires supervisors to take 36 hours of training in their first 12 months on topics such as performance appraisal and supervising for success, then an additional 24 hours of training in the next 24 months including topics such as discipline and documentation and conflict management. After the first three years supervisors are required to take 12 hours of

additional training per year. The DOP tracks compliance and attendance with this policy; however, statewide compliance information is not available to BCF.

To evaluate the effectiveness of training and ensure that training addresses the skills and knowledge needed to carry out their duties, several measures are in place. Staff completes an evaluation for each training they attend that assesses how well the training met their needs and identifies any additional training needs. The information for each session will be compiled into a report and entered into a database so that the information can be reviewed by workshop title, trainer, and job function. This database was recently implemented and will be used to evaluate training by class and trainer over a period of time in order to make improvements and to ensure the content meets the workers' needs. Compiled results are not yet available because the information is still in process of being entered into the database, but should be available by the time the next APSR is submitted. Second, BCF recently implemented a survey that will be sent out at least once per year on employees' experiences in and satisfaction with training. Information is collected for groups according to tenure (less than one year; one to three years; over three years) to see the results of training over a longer period of time and evaluate how training was implemented in practice.

Item 28: Foster and Adoptive Parent Training

How well is the staff and provider training system functioning to ensure that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children?

> Please provide relevant quantitative/qualitative data or information with respect to the above-referenced current and prospective caregivers and staff of state licensed or approved facilities, that care for children receiving foster care or adoption assistance under title IV-E, that show:
>
> - that they receive training pursuant to the established annual/bi-annual hourly/continuing education requirement and time frames for the provision of initial and ongoing training.
> - how well the initial and ongoing training addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.

State Response:

Insert state response to Item 28: Foster and Adoptive Parent Training

In West Virginia foster and adoptive parent pre-service training is primarily provided by the West Virginia Social Work Education Consortium member schools through their Title IVE training contracts, who work with agency home-finders to identify locations for training and enroll participants. Member schools include West Virginia University, Marshall University, Concord University, West Virginia State University, Shepherd University, and West Liberty State University. Each school is required to provide an established number of pre-service training rounds through their contractual requirements; typically each school provides eight to 12 pre-service rounds per year, depending on their available grant funding. Requirements for the number of training rounds, scheduling, and reporting are included in the grant agreements with each university and are monitored through quarterly reports from the universities. The schools are located in various locations across the state, and each school provides foster parent training in their geographic area so that the training is available and accessible statewide for foster and adoptive parents. Concord University maintains a statewide PRIDE training calendar that lists the training round dates and locations for each of the schools for easy reference. Pre-service training may also be provided by private foster care agencies, which must use the same curriculum that is specified in agency policy and provide the same number of hours in order to license their foster homes. Individual agencies may submit their own curriculum to be approved for use; however, it must provide the same number of hours and equivalent information to the agency curriculum. Training information for private providers is monitored through the BCF licensing division.

West Virginia currently uses the PRIDE curriculum developed by the Child Welfare League of America for foster and adoptive parent pre-service training. The PRIDE model is specifically named in BCF policy as the required curriculum. All prospective and new foster parents must attend 24 hours of pre-service training and a three hour agency orientation per policy in order to be certified, although kinship families may be granted a waiver from the training. Training attendance is tracked through sign in sheets that are sent to regional home-finders, who are responsible for licensing foster and adoptive homes for the state. Prospective foster parents must be reported as having completed the entire 27 hours of training in order to be licensed, and may not be licensed until training is completed. The schools and private agencies also track training and report the number of individuals who attended training and completed training for each round through their contract reports including evaluation information that is completed by participants, to gauge how well the training met their needs. Participants who complete the

training are also awarded certificates to document completion that is kept in their home study records.

After a foster home is certified all foster parents must attend 12 hours of in-service training each year in order to maintain certification as a foster home. Foster homes that do not submit verification that they have completed the training will not be re-certified as a foster home. This requirement is the same for agency and private provider foster homes. Training records for BCF homes must be submitted to the regional home-finders who are responsible for recertifying the homes, and documentation is entered into the FACTS system. Training records for private provider homes must be maintained in their files and are periodically reviewed by the agency. The number of agency foster homes that complete this requirement each year is not currently available in the FACTS system; however, a system build is underway that will allow this information to be compiled and reported. Private agency information is reported to the state but is not currently compiled into a single report that would demonstrate completion data; however, plans are in place to modify provider contracts so that they will have to report this information.

In-service training for foster parents is provided through several venues. BCF contracts with Concord University to provide in-service foster parent training statewide. To ensure statewide availability Concord subcontracts with the SWEC member schools to provide the training in their areas. Provider agencies and foster parent associations sponsor and provide foster parent training across the state. In addition, in-service training can be found online from various sources. BCF is in the process of purchasing access to the Foster Parent College, which has many training topics available on child-specific issues such as autism and behavior disorders. In addition, trauma training has been added as a requirement for all foster parents and is currently being scheduled and offered by Concord University. The curriculum is based on the National Child Traumatic Stress Network trauma informed practice curriculum. Tracking of in-service training is done by the regional home-finders who are responsible for recertification of the homes.

Data to demonstrate the functioning and effectiveness of foster parent training is currently collected through quarterly reports from each of the SWEC schools that detail the number of training rounds provided; number of participants in each round; the number of starters per round; number of finishers per round; regional location of participants per round; training evaluation results per round; and post-test scores for each participant.

The following statistics demonstrate the functioning of foster parent training for FY2016:

- There were 62 rounds of PRIDE training provided to 915 new and prospective foster parents.
- There were 131 in-service training sessions provided to 1,313 foster parents.
- Of those who started PRIDE training, an average of 86% completed training.

West Virginia is in the process of working with SWEC to develop a data process that compiles the information that is collected into one report for all the schools and will be available by the time of the next APSR. Contractual requirements for private provider reporting will be included in their contract agreements next year.

E. Service Array and Resource Development

Item 29: Array of Services

How well is the service array and resource development system functioning to ensure that the following array of services is accessible in all political jurisdictions covered by the CFSP?

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

Please provide relevant quantitative/qualitative data or information that show:

- The state has all the above-referenced services in each political jurisdiction covered by the CFSP;
- Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdictions covered by the CFSP.

State Response:

Insert state response to Item 29: Array of Services

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

In 2006, West Virginia worked with Steve Preister, of the National Child Welfare Resource Center for Organizational Improvement (NRCOI) to conduct a statewide assessment of the array of services. However, by 2011 the statewide assessment process was redesigned from its original model for the following reasons: the original design that involved an assessment of services did not always include the right individuals (experts in prevention trying to assess out-of-home care); the original assessment of services was too broad and difficult to manage (too many services to review); and the gap most identified was a lack of service resources for which there was no funding available, and those that we did have (prevention resources), were cut due to economic restraints. The service array redesign plan for improving the array of services in West Virginia includes both the processes that were a part of the original design, and processes that were added as resources became available.

West Virginia has several service mechanisms that assess the strengths and needs of children and families and determine other service needs. These are: Safe at Home West Virginia (IV-E

Waiver) Wraparound Services; West Virginia Child and Adolescent Needs and Strength (CANS); Family Resource Networks; Community Collaborative Groups; Regional Children's Summits; KEPRO, Administrative Services Organization (ASO) services, Socially Necessary Services; and West Virginia System of Care, Regional Clinical Reviews and Out-of-State Reviews.

Safe at Home WEST VIRGINIA (IV-E Waiver)

In October 2014, West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF) was granted a federal Title IV-E Waiver by the U.S. Department of Health and Human Services Administration for Children and Families to conduct a child welfare demonstration project.

West Virginia's Title IV-E Waiver demonstration project (referred to as Safe at Home West Virginia) was rolled out on October 1, 2015, in the phase one counties of Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam and Wayne.

Phase 2 rolled out on August 1, 2016 in the counties of Barbour, Brooke, Grant, Greenbrier, Hancock, Hardy, Hampshire, Harrison, Lewis, Marion, Mercer, Mineral, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Preston, Pocahontas, Randolph, Summers, Taylor, Tucker, and Upshur.

Phase 3 is the final roll out phase and is scheduled for April 1, 2017. Phase 3 will roll in the final 20 counties of Braxton, Calhoun, Clay, Doddridge, Fayette, Gilmer, Jackson, McDowell, Marshall, Mingo, Pleasants, Raleigh, Ritchie, Roane, Tyler, Webster, Wetzel, Wirt, Wood, and Wyoming.

DHHR's BCF provides grants for licensed behavioral health agencies with direct children's service experience to act as local coordinating agencies in the implementation of the high fidelity Wraparound Model, with supporting services, for Safe at Home West Virginia wraparound. The target population for wraparound behavioral health and social services is 12-17 year olds. The West Virginia Child and Adolescent Needs and Strength (CANS) tool is utilized in the Safe at Home West Virginia wraparound process. The CANS tool is designed to support individual case planning and the planning and evaluation of service systems.

As of December 9, 2016, 510 youth have been referred to Safe at Home West Virginia for wraparound services. Of those 510:

- A total of 33 youth have returned to West Virginia.
- 74 youth have returned to their communities from in-state residential placements.
- 210 youth have been or are being prevented from entering residential placement.
- 4 youth have returned to their community from Shelter placements.

WEST VIRGINIA Child and Adolescent Needs and Strength (CANS)

The West Virginia CANS was cross walked with the National Child Traumatic Stress Network Trauma CANS version and CANS sub-modules and was approved by the Praed Foundation in May 2015. Hornby Zeller Associates, Safe at Home West Virginia evaluators, has developed the Automation of the WEST VIRGINIACANS 2.0 that is currently being used for Safe at Home West Virginia wraparound recipients. This automated entry system provides the framework needed to guide decision applications to include the development of specific algorithms for the appropriate intensity of services including intensive community services, treatment foster care, residential treatment, and other traditional outpatient care. West Virginia continues to move toward utilizing the Total Clinical Outcome Management (TCOM) framework to measure, report, and build system capacity, especially in community-based service delivery and supports.

Family Resource Networks (FRNs), Community Collaborative Groups, and Regional Children's Summits

The Family Resource Networks (FRNs), Community Collaborative Groups and Regional Children's Summits play a key role in the Safe at Home West Virginia.

The forty-seven 47 FRNs are organizations that understand and are responsive to the needs and opportunities in West Virginia communities. The FRNs are in all of West Virginia's 55 counties. However, four FRNs Directors manage multi-counties. Partnering with citizens and local organizations, the FRNs develop, coordinate, and administer innovative projects and provide needed resources. FRNs provide indirect services, including managing, supervising, and coordinating a variety of programs and initiatives in their respective community. The FRNs have a Resource Directory for each county in West Virginia. Currently, a website is being developed, as part of a Benedum grant, which will include a link to each of the FRNs that will include their Resource Directories, programs, and current events. They also provide services to

those dealing directly with children and families, specifically organizations and groups. The FRNs Service Agreement include attending and/or participating in the (multi-county) Community Collaborative Groups and Regional Children's Summits to identify existing services and service gaps in the community.

The Community Collaborative Groups that represent 13 districts and four Regional Children's Summits represent the entire state. The Community Collaborative Groups and Regional Children's Summits (along with representation of the FRNs) identify community based services and, if needed, developing services based on the needs of the children and families in their community.

Currently, West Virginiadoes not have a consistent process for pulling all identified service needs and gaps together across systems. However, West Virginiaplans to utilize a continuous Quality Improvement (CQI) process described below:

- The Community Collaborative Groups receive information regarding service gaps from multiple sources: DHHR DPQI review data, Critical Incident Review data, NYTD data, Regional and Out-of-State Clinical Reviews, and other sources. When issues cannot be addressed by the Community Collaborative Group, the Community Collaborative group communicates a service gap to the Regional Children's Summit. Likewise, if the gap cannot be filled at the Regional level, the Regional Children's Summit will be expected to provide these issues to the Child Welfare Oversight (CWO) team.
- The Continuous Quality Improvement (CQI) process begins with the Child and Family Services Review (CFSR) completed by the Division of Planning and Quality Improvement (DPQI) of a district and the development of a correction plan when a district is not in substantial conformity. Within 30 days of the date of the final review report, the district must develop a corrective plan to address the issues for which they are not in substantial conformity. Substantial conformity is the standard at which the Children's Bureau places on an item in order to reach the outcome desired.
- Once the review is completed by DPQI, the district is provided an exit interview to discuss what the review found and to discuss why the district is not meeting the outcomes to the level required. This gives the district

an opportunity to brainstorm reasons for the results of the review and to begin discussing things they can implement to improve their outcomes. This information is then captured in the final review report and submitted back to the district to develop a corrective action plan. The district then has 30 days to develop their corrective action plan and submit to DPQI.

- To improve outcomes, the Bureau for Children and Families has instituted a quality assurance process that incorporates regional Quality Councils. Each district has a corrective action plan, which will be sent to the regional Quality Council for review and monitoring. The regional Quality Councils should meet on a quarterly bases and should have staff that represent each district and each level of management including; child protective workers, supervisors, coordinators, youth service workers, community services managers, and child welfare consultants.

- The Quality Councils activities should include:
    - A review of each districts corrective plan
    - A review of the current data for each district and for the region
    - A discussion on trends within the region
    - A plan on items that need to be addressed as a regional issue
    - Monitoring of each districts plan
    - Update of regional or district plans as needed based on the data
    - A list of items that need to be forwarded to the Child Welfare Oversight (CWO) team for the development of a statewide plan
    - A review of the feedback from the CWO
    - A report to the CWO team after each QC meeting on achievement of outcomes on their regional and district plans
- The chair of the regional Quality Councils should do the following activities:
    - Prepare the agenda
    - Provide copies of each districts corrective plan
    - Provide copies of the data for each team member at each meeting
    - Ensure the team has all required members
    - Assist the team with the development of the regional plan
    - Provide quarterly updates to the CWO

  - Provide feedback from the CWO back to the regional QC Child Welfare Oversight Team
- As a part of the continuous quality improvement process, the Child Welfare Oversight Team activities will include:
  - Reviewing the Regional Quality Council Plans
  - Monitor child welfare data by state, region and district
  - Provide resources to the regions as needed
  - Provide feedback for the regional plans and the outcomes
- The Child Welfare Oversight team is comprised of individuals on the state level that have the ability to impact child welfare in a way that the district and regions may not be able. The list below is an example of some ways the CWO can have an impact but is not all-inclusive:
  - Court system
  - Policy changes
  - Changes to the training
  - Ability to pull statewide resources
  - Impact other bureaus' services
  - Development of services
- The CWO team will also review and provide feedback on stakeholder surveys. The team will review the surveys for statewide trends and provide the feedback to the regions and/or divisions. This data will be given to the regional Quality Councils to process and incorporate into their regional plans as needed.

KEPRO, Administrative Services Organization (ASO), Socially Necessary Services

The Socially Necessary Services (state funded services) are being utilized throughout the state. These services are being monitored by KEPRO, an Administrative Services Organization (ASO). Socially Necessary Services (SNS) are subject to retrospective reviews by KEPRO. The retrospective review is done through a review of case records based upon what the Department has determined to be outcome measures. The outcome measures however, are more compliance based than quality based in that they do not measure the improvements or progress of the client as much as they measure whether the case documents are completed correctly. KEPRO also conducts Socially Necessary Focus Group Summaries. This process is conducted with recipients of each Socially Necessary Service. There are multiple changes being considered to our ASO system as a result of prior audits and our IV-E waiver application. West

Virginia is planning to move forward with changes to the ASO process by developing a monitoring process for all services that will look at the quality of provider services. At this time, there is no resource capacity to complete this monitoring.

WEST VIRGINIA System of Care, Regional Clinical Reviews and Out-of-State Reviews

The West Virginia System of Care worked through two processes to identify gaps in services, barriers to serving youth in the state, and returning youth to the state. These processes have also prevented youth from being placed in out-of-state placement, identified services appropriate for the youth, and assisted in the planning for youth returning to the state. These two processes are the Regional Clinical Review Team and the Out-of-State Review Team.

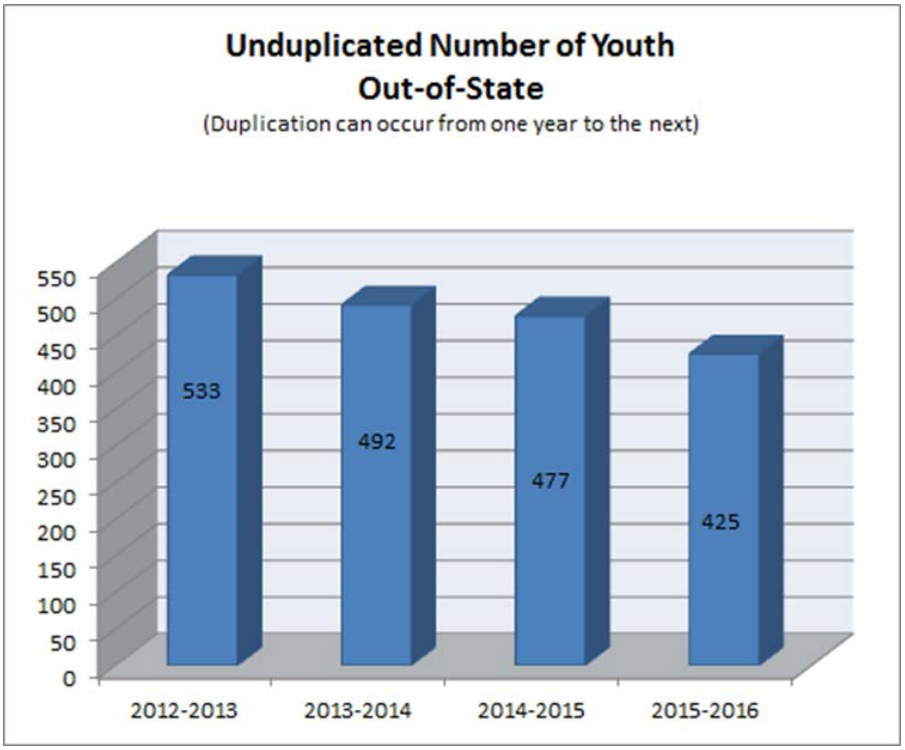
The Regional Clinical Review process is a coordinated effort designed to provide a comprehensive, objective, clinical review of designated youth. The process has several steps to assure that the review is objective and thorough and includes the CANS in all reviews. The participants in this process include the youth/family/legal guardian, a regional clinical coordinator, an individual reviewer and a regional clinical review team. Information provided during the Clinical Review process is confidential and protected by federal and state statute. The targeted populations for these reviews are youth currently in out-of-state residential facilities or youth who are at risk of out -of-state placement. The role of this review process is to identify what the youth's current treatment and permanency needs are and serve as a resource to the youth's individual Multidisciplinary Team (MDT) in guiding decision making. Full reviews as described above can occur or an update review may take place after the youth has had a full review. A total of 401 youth have been through a Regional Clinical Review in the last 4 years (duplication may occur from year to year).

1. Youth who are at risk of being placed out-of-state - If a youth is reviewed before placement then the team can help suggest possible community services or other in-state service to keep the youth in West Virginia. Some youth are never placed out-of-state. Between July 2012 and June 2016, 295 youth were reviewed who were at risk of going out of state.
2. Youth who are already placed out-of-state - In these cases the team may need to assist with discharge planning and recommend services to successfully return the youth to West Virginia. Between July 2012 and June 2016, 100 youth were reviewed who were at risk of going out of state.

3. In the last four years there has been a steady decrease in the number of youth placed out-of-state for services. This is a 20% reduction over the last four years.

   The reduction in youth placed out-of-state can be contributed to one or more of the following:

   - Continuation of the Regional Clinical Review Process
   - Implementation of the Out-of-State Review Process
   - Implementation of the Safe at Home Program



From July 2014-June 2016, 492 youth have been reviewed through an Out-of-State Review Team.

Gaps in services and barriers were identified through the Out-of-State and Regional Clinical Review Teams.

Gaps in services identified included:

- No psychiatric residential treatment facilities (PRTF's) for youth age 14 or younger that address severe mental health issues.

- No psychiatric residential treatment facilities (PRTF's) services for youth who are already age 18 or older are available in state.
- Limited group residential services for youth who are age 18 or older.
- There are no in state level 3 facilities that are able to handle youth who are aggressive and have an intellectual and developmental disabilities (IDD) diagnosis.
- No in-state programs for Intellectual and Developmental Disability /Sex Offenders.
- Services for older youth who have experienced trauma at a young age but are older now are limited. There are no trauma programs in the state for youth over the age of 12.
- There are no in-state residential programs that address trauma with youth who have a diagnosis of intellectual and developmental disabilities (IDD).
- Lack of treatment foster care
- Youth in parental custody may end up in state's custody because they cannot obtain the needed services for youth (they can only obtain psychiatric residential treatment facilities (PRTF) level services).

West Virginia has remedied some of these gaps by implementing the Safe at Home West Virginia wraparound and is in the process of implementing the Children's Mental Health Wraparound Model; and tiered treatment Foster Care.

West Virginia has also opened several new programs and expanded capacity for others. These include: Highland Hospital expanded their services to include PRTF level; Lily's Place, a facility for infants recovering from addition; Campolina Way, a program for co-existing (low functioning/mental health); Old Fields, a level III program for young children; several emergency shelters added capacity to include a few more youth; Florence Crittenden, a level II program for pregnant youth added a level 1 to provide additional support to parenting youth as they transition; and two residential facilities are group homes and are expanding their program to include foster homes.

In 2016, the West Virginia Department of Education and the Out-of-Home Care Education Advisory Committee studied the educational growth of children in out-of-home care. Although preliminary, they found students in out-of-home care were not included in the data and there was some student growth data discrepancy. In 2017, the Out-of-Home Care Education Advisory Committee will further examine these issues and study those students in out-of-home care that are proficient students and see why these students are doing better; obtain change of

placement data and correlate with assessment data; and examine disciplinary infractions to see if the infractions made are accurate and consistent across the state.

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

As mentioned above, the Administrative Services Organization (ASO) KEPRO is conducting retrospective reviews that monitor provider outcomes on Socially Necessary Services (SNS). Among those services is Safety Services.

The Safety Bundle includes: supervision; parenting assistance; family crisis response; social and emotional support; and crisis home management services.
The mix of these services and other services provided is based upon the in-home safety plan completed by DHHR. Safety Services are offered statewide.

KEPRO and the SNS Review Committee review non-compliance issues identified during the retrospective reviews. The “80% Rule”, effective November 4, 2015, requires that socially necessary services providers score at least 80% during their retrospective review.

The retrospective review is conducted by the managed care organization at least every 18 months. If the provider scores less than 80% on any service the provider receives written notice that a six month probationary period is in effect. Training and technical assistance will be offered. After six months, the managed care organization will conduct another review on the services scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider’s record and they will no longer be able to receive referrals to provide that service. If, during the retrospective review process, a provider scores zero on any safety-related service, that service will be automatically closed from the provider’s record. There will not be a six month probationary period when a safety service scores zero. KEPRO provides training and technical assistance to all providers failing to meet the 80% requirement on any service.

Recently, the Retrospective Reviews have shown an increase in SNS providers failing to meet the safety definition for Parenting Assistance and are providing Individualized Parenting instead. KEPRO and the SNS Review Committee are looking at ways to gather better data and provide

additional assistance to these agencies that are failing to meet the 80% on their Retrospective Reviews.

In 2015, a survey was completed to identify the service gaps for the 17 identified services/supports that were determined to be highly effective services in wraparound. The survey responses were categorized by adequate amount of available services, inadequate amount of services and services not available at all. This survey was sent to the Community Collaborative groups (including service providers, Family Resource Network members, and others) with input from the Regional Children's Summits. Fifty-two of the 55 counties completed the survey. Below are the results for that survey:

NAME OF SERVICE	% of Services in Community	% of Services Needed
1. Assessment and Evaluation	63%	37%
2. Outpatient Therapy - Individual	52%	48%
3. Outpatient Therapy - Family	33%	67%
4. Medication Management	15%	85%
5. Behavior Management Skills Training	16%	84%
6. Intensive Home-Based Therapy	10%	90%
7. School-Based Behavioral Health Services	19%	81%
8. Substance Abuse Intensive Outpatient	15%	85%
9. Crisis Services – In Home	8%	92%
10. Mobile Crisis Response	6%	94%
11. Youth Transition Coach (Youth Advocacy)	4%	96%

12. Peer Support (Youth)	2%	98%
13. Peer Support (Family)	6%	94%
14. Respite	2%	98%
15. Peer Support (Recovery Support)	6%	94%
16. Therapeutic Mentoring	0.0%	100.0%
17. Therapeutic Foster Care (Medically Necessary)	2%	98%

The information from these surveys was used as a benchmark in each Community Collaborative group to develop strategic plans to assist with the development of needed services. These plans were to then be provided to the state semi-annually. This information would then be used to further identify community and out-of-home service gaps, what actions are being taken, and the challenges that hinder addressing these service gaps.

Currently, these reports are not submitted consistently by all the Community Collaborative groups. However, the following is an example of what is reported:

- The Family Central Collaborative, in their first semi-annual report (July 2015-December 2015), identified Substance Abuse Programs as one of their service gaps. To address this issue, a Prestera adult male recovery unit is now accepting referrals in Mason County; Wayne County has a new women's recovery home through Prestera; Putnam County has an Adolescent Drug Court; and a Women's facility is planned for Charleston.
- The Little Kanawha Community (LKC) Collaborative, in their second annual report (January 2016-June 2016), identified school-based behavioral health as one of the service gaps. To address this issue, several counties within the LKC district have applied for school-based behavioral health grants.

A comprehensive and searchable Provider Directory was added to the Bureau of Medical Services website to allow members, parents or legal guardians of members, and field office staff to have access to a directory of a variety of behavioral health providers that are available throughout West Virginia. This is checked on a regular basis to ensure that accurate information is available on this site: http://www.West Virginiacca.org/directory.html .

The Centralized Intake (CI) is a call center that was created to accept all reports of alleged abuse or neglect involving West Virginia children or West Virginia's vulnerable adult population. By having a 24/7 "hotline" all reports are documented consistently and the decision of who will be served is made by a small group of supervisors who are experienced in field work and trained in evaluating reports and making screening decisions. The Call Center uses an internet based Verizon Call Center platform that allows workers at both sites to answer calls from any location and serve clients statewide. CI began operating on July 1, 2014 and was fully implemented, serving all counties, by January 31, 2015. CI operates 24 hours a day, 7 days a week, 365 days a year. The unit began with 10 Child Protective Services (CPS) Supervisors and 35 social workers housed in two locations. In 2016, an additional CPS Supervisor and recently, 20 new social worker positions were allocated to the unit. The first full year of operation was 2016, and CI handled over 105,000 calls.

Furthermore, CI worked with stakeholders and addressed their concerns about the wait times when calling. A process was developed to allow Judges, Magistrates, and Prosecuting Attorneys a more convenient avenue to initiate a report. Additionally, the Verizon Call Center platform that CI utilizes is designed to decrease the wait time for Law Enforcement calls and medical emergencies.

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

West Virginia has an array of prevention services that enable children to remain safely with their parents when reasonable. These services focus on building resiliency skills and education.

The prevention services include the following:

Family Resource Centers (FRCs) – There are currently 26 FRCs that provide voluntary family support services to children, prenatal through age eighteen, and their families. All FRCs offer core services such as: parenting skills and training, outreach and referral services, linkages to health services, linkage to respite/crisis care, and linkages to transportation. The FRCs can also offer optional services based on the needs of their community. These optional services include early childhood playgroups, afterschool services, food pantries, clothing closets, and more.

Family Leadership First – A parent led initiative that works to promote and build Protective Factors in all families. In addition to a yearly conference for families, Family Leadership also hosts the West Virginia Family Links network and community meetings to develop interest in mutual parent support groups.

In Home Family Education – The Bureau for Children and Families Bureau for Public Health, Office of Child and Maternal health worked together to add services in three counties and expanded programs in two counties for a total of 18 In Home Family Education programs. The services are voluntary home visiting services to pregnant women and families with children up to age five. The In Home Family Education programs utilized evidence-based models.

Partners in Prevention Teams – These 40 community based teams provide public education and awareness activities in communities across West Virginia. The teams of at least three community partners come together and develop a plan for their community. Some teams provide direct services but the majority of the activities are aimed at raising awareness and educating the public on the Protective Factors framework.

The Bureau for Behavioral Health and Health Facilities has the following prevention services that enable children to remain safely with their parents when reasonable:

Statewide Behavioral Health Youth Services Network is a cross-system/cross-continuum approach to programming for youths with substance use and co-occurring disorders. There are six regional locations emphasizing close-to-home services for children and families that offer a single point of access 24/7, referral line engagement, diagnostic and out-patient services, non-traditional service locations, telemedicine expansion, and collaborative services.

System of Care is a public-private-consumer partnership dedicated to building and maintaining effective integrated and coordinated community based services for children and youth with or at-risk for behavioral health related challenges and their families. The System of Care is essential to staff training and workforce development. The System of Care also coordinates the Regional Clinical Reviews and Reviews of Children Placed Out of State.

Prevent Suicide WEST VIRGINIA – Provides prevention and “post-prevention” services across the life span, including mobile response to support communities in the aftermath, building local capacity to provide evidence-based prevention programming, and offering individual follow up support for attempt survivors. Also funds the Suicide Lifeline.

Statewide Family Advocacy, Support and Training (FAST) Program uses peers and professionals to advocate on behalf of children's educational rights, and empowers families to have a voice in decisions about their child

West Virginia Youth Leadership and Mentoring Development follows the principles of the nationally recognized Students Against Destructive Decisions (SADD) leadership initiative. SADD's philosophy is that young people, empowered to help each other, are the most effective force in prevention.

Children's Homeless Outreach provides for case management, life skills education, brief counseling referrals and linkage to community based services for children and their families who are experiencing homelessness and are residing in a homeless shelter at risk for social/emotional problems. The Children's Homeless Outreach new Pilot Partnership with Home Visitation Program is designed to strengthen families with young children who are homeless.

Children's Clinical Outreach Services Liaisons is provided by each of the 13 Comprehensive Behavioral Health Centers. The liaisons are Masters level clinicians with expertise in children's behavioral health who work with systems to improve the overall capacity to serve children with behavioral health needs and their families. The Children's Clinical Outreach Services Liaisons develop and maintain collaborative cross-system relationships.

Expanded School Mental Health (ESMH) services recognize the critical link between social and emotional well-being and academic success. ESMH services augment the standard services provided in schools by emphasizing shared responsibility among families, students, the school, and community mental health agencies and being committed to the full continuum of mental health services, including assessment, education and promotion of well-being, prevention, early intervention, and treatment. ESMH services include three "tiers" of programming that engage both the academic and behavioral health system. In FY2017 – West Virginia increased from 12 sites to 40 sites.

The Children's Mental Health Wraparound model involves individualized, strengths-based, trauma-focused planning and intensive intervention delivered in a community-based setting that safely preserves family relationships and empowers children and families to meet their own needs. This is an evidence-based model based on the National Wraparound Initiative and West

Virginia's Safe at Home program. This program serves children with SED/complex support needs who are in their parents' custody and who are at risk of placement in an intensive psychiatric treatment setting. Referrals and intakes come from the Regional Clinical Coordinators

In 2011 and 2012, West Virginia was among five states selected by the Three Branch Institute partners to work together on strategies to enhance permanency for older adolescents in foster care. In 2013-2014, West Virginia was selected among six states to focus on the social and emotional well-being of children in foster care, including behavioral and mental health, physical health, psychotropic medications, substance abuse, child well-being finance, and cross agency collaborations. Recently, West Virginia was again selected along with six states to participate on the Three Branch Institute on Improving Child Safety and Preventing Child Fatalities.

This recent Three Branch Institute will assist West Virginia to develop an integrated and comprehensive approach for improving the safety of children known to the child welfare system or at risk of child welfare involvement by aligning the work of the executive, legislative and judicial branches of state government.

Currently, West Virginia has the following challenges:

- The entry rate for foster care is 8.6 percent, the highest rate in the U.S.
- In West Virginia, 12.8 percent of the child maltreatment victims are under one year of age.
- In 2013, 54.3 percent of the maltreatment of children was neglect, 33.9 percent was physical abuse, 27.3 percent was emotional abuse, 5.2 percent was sexual abuse, and 1.2 percent was medical neglect.
- In 2013, the median length of stay in foster care was 9.7 months.
- West Virginia is one of four states where less than 40 percent of the children legally available were adopted in less than 12 months.
- In 2013, child fatalities were at their highest in four years at 17, a rate of 4.5 per 100,000. To address this issue, the DHHR, Bureau for Children and Families provided 46 critical Incident training sessions from October 2015 to November 2016 with a total of 916 participants in attendance.

- In 2014, the DHHR Bureau for Children and Families (BCF) established an internal child fatality review team to review incidents involving families who have a prior history with the Bureau.
- In 2015, the team began reviewing incidents of not only fatalities, but near fatalities and became the Critical Incident Review Team.
- In the FFY2015 Report on Child Fatalities and Near Fatalities Due to Abuse or Neglect in West Virginia, the fatality rate was seven, a decrease from the prior year of 17.

Beginning in 2017, West Virginia's outcomes as a result of partnering with the Three Branch Institute are:

- All children and families at risk have access to evidence-based prevention and early intervention services.
- All children and families are identified at earliest signs of risk. Children under one year old are given high priority.
- The State has a comprehensive, multi-agency plan to prevent child maltreatment deaths.

Services that help children in foster and adoptive placements achieve permanency.

West Virginia included in the Safe at Home West Virginia Terms and Conditions two program improvement policies that will be implemented by February 25, 2017 (three years from the application date).

One of the selected program improvement policies is that West Virginia will claim IVE reimbursement for subsidized kinship legal guardianship. West Virginia's IVE plan included this and was approved by the Federal Children's Bureau in 2015. BCF believes West Virginia has good outcomes for placing children with kinship/relatives but has been unable to show it through data because our SACWIS system (Family and Child Tracking System – FACTS) does not differentiate between a non-relative provider and a relative provider. West Virginia amended its Adoption and Legal Guardianship Policies as well as its IV-E State Plan to accommodate claiming for Guardianship Assistance. This included kinship guardianship assistance.

Although West Virginia foster parents are formally evaluated initially for their needs and strengths prior to certification, there is not an ongoing assessment process for identifying foster parent's needs.

- ***The state has all the above-referenced services in each political jurisdiction covered by the CFSP;***

  Covered above

- ***Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdiction covered by the CFSP.***

  Covered above

Item 30: Individualizing Services

How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be individualized to meet the unique needs of children and families served by the agency?

Please provide relevant quantitative/qualitative data or information that show whether the services in item 29 are individualized to meet the unique needs of children and families served by the agency.

- Services that are developmentally and/or culturally appropriate (including linguistically competent), responsive to disability and special needs, or accessed through flexible funding are examples of how the unique needs of children and families are met by the agency.

State Response:

Insert state response to Item 30: Individualizing Services

West Virginia has two Transitional Living grants that fund provider's Stepping Stones, *It's My Move* program, and Burlington, *Pathways* program for youth ages 18 to 21, with priority given to youths with serious emotional disturbance or complex support needs currently placed in out-of-state facilities and those who have been in long-term out-of-home placements. These programs provide support services for up to 16 hours per day in their own housing as determined by individual needs.

The Tuel Center program at McCrary Center, Wheeling, West Virginia is designed to fill the gap between supervised placement and independent living, by teaching independent living skills with a "hands-on" approach. The Tuel Center, an 11 unit supported apartment complex, is for 18 to 20 year old males or females in DHHR custody under a voluntary FC 18 agreement. The Tuel Center program also recently secured scattered community apartment sites.

Functional Family Therapy (FFT) is an evidence-based therapy and is Medicaid billable. The FFT requires very intense therapy that requires a full knowledge of the FFT national model and is being implemented through the Licensed Behavioral Health Centers. The FFT Involves 12-14 short term sessions. West Virginia sent out an RBA, received proposals and has recently selected the provider. The provider is in the process of recruiting therapists for this program.

The Bureau for Children and Families has put a process in place that broadens the family foster care program statewide. This three-tiered foster care program in West Virginia will serve children through traditional foster care, treatment foster care and intensive treatment foster care. The foster family care model provides a milieu of treatment services and supports to ensure the safety, well-being and permanency goals are met in a family-like setting either through reunification and/or adoption. The three tiers of the Foster Family Care program are:

1. Traditional Foster Care is the system that West Virginia has historically provided. This level of care is ideal for children who have no significant indicators of trauma, behavioral, emotional and/or developmental issues and difficulty in school, home, and community. These children do not exhibit any high risk behaviors; have any significant medical issues, and no assessed needs for mental or behavioral health treatment;

2. Treatment Foster Care is the level of care to be used for children who exhibit a mild to moderate level of trauma, behavioral, emotional and/or developmental issues as identified through the CANS assessment. These children may present with moderate risk behaviors and have moderate difficulty in school, home and community. This level would include pregnant/teen mothers and other children who have medical needs that exceed preventative measures. This level will be used for all children entering care on an emergency basis; and

3. Intensive Treatment Foster Care will be the level of care used for children who exhibit significant indicators of trauma, behavioral, emotional and/or developmental issues. These children present with high risk behaviors and have significant difficulty in school, home and community. This level will be used for children who are stepping down from a higher level of care, are at risk for out-of-state placement, can be supported in the community as an alternative to residential care, are drug-exposed infants with additional medical needs, and children who are considered to be medically fragile as diagnosed by a physician.

The three-tiered foster family model has been implemented by several of our licensed child placing providers who received grant funds for the development of this model. Each provider was required to recruit and train eight Tier 2 (treatment) and three Tier 3 (intensive treatment) foster homes. These homes may be existing foster care homes or new homes.

The Bureau for Children and Families currently determines customer satisfaction with two categories of services through client focus groups. These focus groups are conducted with recipients of socially necessary services and children's residential services. These focus groups are conducted by a contracted administrative services organization called KEPRO (previously known as APS Healthcare), as part of their overall contracted utilization management functions. A summary of the most recent focus group results follows below.

As you will see from the questions asked in the focus groups, there has been nothing that explores a client's receipt of services to address cultural differences, specific disabilities or special needs. In order to correct this, the focus group questions will be revised during the first quarter of 2017, to be implemented immediately followed development. Specific questions will be added to engage clients on their experiences of being served in ways to meet their unique needs.

Socially Necessary Services Focus Group Results September-December 2016

Twenty-two recipients of socially necessary services were interviewed between September 2016 and December 2016. All but two participants were adults. Two were youth that receive socially necessary services.

The purpose of this focus group is to provide consumers who are receiving Socially Necessary Services in West Virginia the opportunity to candidly share their experiences and opinions. These focus groups are conducted on a regular basis to gain insight regarding the utilization and impact of these services in the state. Each focus group may consist of youth, biological parents, or foster families. Information is gathered throughout the year through a minimum of six focus groups that reflect consumers' voices with regard to access, service delivery, referral process, reimbursement etc.

1. Do you have regular contact with your DHHR Worker? Is s/he available when you need him/ her or have a question?

Fifteen participants stated, “Yes, they had regular contact with DHHR workers.”

Three participants agreed that they had regular visits and meeting with the provider, but not the DHHR worker.

Two participants stated that their workers changed frequently and it was a challenge getting visits scheduled and questions answered.

Two youth participants had no response.

2. Did DHHR meet jointly with you, your family, and provider when the service plan was being developed?

Seven participants stated that the provider and therapists, not the DHHR workers, met with the families to develop plans.

Seven participants responded “no”.

Fifteen participants agreed that the providers (case managers) assisted in the development of the individualized plans, then sending them to the DHHR workers for sign-off and referrals for SNS services.

3. Is DHHR meeting jointly with your family and provider as the services are being carried out?

Four participants agreed that the DHHR worker made home visits and observed some activities that were on individualized plans.

Three participants said there had been no DHHR worker that observed anything.

Fifteen participants agreed that DHHR did monthly home visits but never attended with providers.

4. Do you feel actively involved in your service plan? Why or why not?

Seven participants agreed that they were actively involved in the children’s plans; they assisted youth in activities listed.

Seven participants agreed that they were actively involved in the children’s plans, though parts of the plans (therapy, anger management sessions) were private. They were, however, instructed on how to work on these issues with each specific child.

Seven participants agreed that because of instruction on dealing with the children, they were an integral part of each plan.

Six participants agreed that they helped implement plans for the children and were actively involved with each child by taking youth to appointments, visitation and school activities.

Two youth participants agree that they were involved in their service plans. Both youth agreed that going to therapy, spending time with school tutors and working with anger management people kept them very involved in their individualized plans.

5a. Do you see your service plan as being helpful and focused on the issues? Why or why not?

Seven stated, “Yes, the plans are helpful because they address the needs of each child individually and guide the foster parent or caregiver to get the children what they need to succeed.”

Eight participants stated, “Yes, the plans are helpful because they address the needs of each individual and guide the foster parent or caregiver to get the children what they need to succeed”.

Seven participants agreed that the plans were helpful and ensured that the specific needs of each child would be addressed.

5b. What have the services helped?

Seven participants agreed that therapy, anger management and travel reimbursement for visits were the most helpful.

Fifteen participants agreed that therapy, anger management and travel reimbursement for visits were the most helpful.

Five participants were pleased with the respite services that SNS provided.

Two participants had not utilized respite to date.

5c. What would improve your services?

Five agreed that seeing the DHHR workers more frequently would be beneficial in keeping up with correct court dates and necessary changes in visitations.

Two participants stated that meeting with a DHHR worker, period would assist with improved services.

Eight participants agreed that an increase in clothing voucher dollars would really help as kids grow fast and many times hand-me-downs aren’t available.

Seven participants agreed that getting medical cards in a timely manner and with an MCO that matched doctors in the area would greatly improve services.

Two participants agreed that having additional support when a child was in crisis would be beneficial. (Child in ER for six hours, husband at work…unplanned and no time to arrange for respite care for other kids.)

Five participants had no reply.

6. Have you ever felt like you've had to cope with your situation alone? What has made you feel this way?

Seven participants said, "No, our provider is very helpful in getting services and needs met for our families."

Two youth responded that before foster care they felt they had to deal with difficult situations beyond their control. They reported a lack of nutritional meals, no supervision, no one caring.

Six adult respondents agreed that over the course of providing foster care there had been an occasional "worker or two" that wasn't available for supports or service referrals.

Two participants agreed that during a weekend crisis situation they felt somewhat isolated.

Five adult respondents agreed that they had the supports they needed to cope with various situations.

7. Do you know what is expected of you and your family to finish services and have the case closed? How do you know this?

Seven participants agreed that they know how to finish services and how cases get closed. All agreed that previous experiences provided the knowledge.

Two youth participants stated that plans might change over time as they reach their therapy and treatment goals; not sure about the cases being closed because their parents weren't doing well with court orders. They stated that, "a social worker told them."

Six adult participants agreed that none of the youth they were providing care for were ready for reunification or adoption; per the service provider and DHHR workers.

Seven participants agreed that they were aware of closing cases because of previous experience with foster children.

8. Do you know of a service you would like to receive that you are not currently receiving? Do you know how to get these services?

Twelve participants agreed that they just informed the provider of what occurs and they make referrals and appointments for the youth. The youth are receiving everything they need right now.

Seven participants agreed that they are receiving what is needed for each child.

Seven participants stated that they would ask the providers to contact DHHR workers for any needed

Two youth participants stated that, "Things are okay right now, but the DHHR worker or provider always gets the services they need."

9. What would prevent you from seeking services in the future?

Nineteen adult participants stated that there was nothing to prevent them from getting what the children need.

One participant gave no response.

Two youth participants said, “we wouldn’t need services if we get to return home.”

10. Do you see any problems in the system that prevent you and your family from achieving your service plan goals? How do they cause problems? How do you deal with this?

Five participants said there wasn’t anything to prevent achieving plans and goals because of the support from the provider.

Two participants stated some concern about the lack of DHHR workers and appropriate court dates and visitation schedules. They always check with provider for correct information.

Four participants stated that delays in court hearings hindered the youth from achieving service plan goals.

Our participants agreed that reunification was often delayed, leaving the youth in limbo. They provide continued support to youth.

Three participants saw no problems at this time.

Eight participants agreed that there were no immediate problems with the system; but getting natural families to seek treatment and follow court orders was another story.

Six adult participants agreed that they support the children through time of disappointment and continue implementing the service plans.

Two youth agreed that anger management help sort out feelings.

Children’s Residential Services Focus Groups

Focus Group Participant Demographics:

Eleven youth ages 12-18 receiving medically necessary children’s residential services; three male youth participants in foster care ages 17-18 currently receiving behavioral health services, focusing on community integration and independent living.

The Focus:

The purpose of this focus group is to provide consumers who are receiving Medically Necessary Services for behavioral health in West Virginia the opportunity to candidly share their experiences and opinions. These groups are conducted on a regular basis to gain insight regarding the utilization and impact of these services in the state. Each group may consist of youth receiving individualized and group treatment in a residential facility and or in the

community. Information is gathered throughout the year through a minimum of six focus groups that reflect consumers' voices with regard to access, service delivery, treatment plan goals and outcomes.

1a. **How often do you see your DHHR case worker?**

Eleven participants stated that they saw their DHHR worker once a month.

Two participants stated that they see their DHHR worker every three months.

One participant said, "Every three to four months."

1b. Does this person know what you are working on in therapy?

Eleven participants agreed that their DHHR case workers knew what they were working on in therapy.

Three participants agreed, "Yes," it was discussed during their visits.

2a. Do you have a treatment or a service plan?

Eleven participants stated they all had treatment/service plans.

Three participants stated, "Yes," and knew what their treatment plan consisted of.

2b. Was your input considered in this plan?

Seven participants agreed that their input was considered in the development of their plans.

Three participants stated, "Yes," in addressing anger issues and goals for school.

Four participants said, "No," their input wasn't considered."

3a. Has your outlook about yourself or your situation changed since you came into the program?

Thirteen participants stated, "Yes."

One participant stated transitioning to public school has improved their grades.

3b. If so, what has helped change your outlook?

Five participants agreed that therapy services, treatment for substance abuse issues and the desire to succeed has changed their outlook.

Three participants agreed that feeling more confident helped change their outlook.

One participant stated transitioning to public school has improved their grades.

Two participants stated, "Getting to live on our own,"

Five participants stated that having positive role models and staff that really cared helped to change their outlook.

One participant had no response.

3c. If not, do you have an interest in changing your outlook regarding anything in particular?

None of the participants responded to the question.

4a. If you had an issue that was bothering you, do you trust your therapist and/or provider to freely talk to about those concerns?

Five participants agreed that they trusted the therapists and could speak freely about issues and co

Three participants stated,"Yes." The therapists were the ones that had helped them reach their goals and deal with life issues and concerns.

Six participants said "yes,"they trusted the therapists and staff.

4b. Why or why not?

Five participants stated that the therapists were members of their teams and wanted to see them succeed.

Three participants responded, "Because they are here to help us."

Three participants all stated, "Yes," and confided in their therapist and staff.

Six participants agreed that the staff had their best interest at heart; they support them in good and bad times.

5a. Is your therapy dealing with matters and goals that are of concern to you?

Fourteen participants stated, "Yes."

5b. What goals do you think you should be working on?

Five participants agreed on the following issues: anger management, sobriety, coping skills and completing GED of high school.

One participant stated, "anger management."

One participant stated, "family conflicts and closure."

Six participants agreed on the following issues that needed to be addressed with goal setting: communication skills, withdrawing from group, depression, drugginess (drug use), peer pressure, thinking before acting, anger, being defiant, coping strategies, huddle expectations,

One participant stated, "boundaries."

5c. Do you feel other parties involved support these goals, do they do they match your treatment plan?

Nine participants agreed that these goals were supported and matched with their individual treatment plans.

Three participants agreed, “Yes.”

Two participants stated, “maybe” or “don’t know.”

5d. Do you feel you are learning the proper tools to obtain these goals?

Eight participants stated, “Yes.”

Four participants stated, “Yes,” “We learn a lot of coping skills for different situations.”

Two participants stated, “No, they hadn’t learned of any tools to use in obtaining their goals.”

6a. Do you feel your therapy is frequent enough?

Eight participants stated, “Yes.”

Six participants agreed that they were getting plenty of therapy. Some received therapy for substance use issues as well as problem solving.

6b. Are there any issues surrounding family participation?

Nine participants stated, “No.”

Three participants agreed, “Yes.”

Two participants stated that they had no real family to attend, via termination of parental rights.

7a. Do you feel confident about exiting the program?

Ten participants agreed that they felt confident in leaving the programs, with four stating they were looking to the future with going to college and getting their own place to live while still being in the state’s custody.

Two participants were unsure of their ability to succeed at this point in time.

Two participants had no response.

7b. Has anyone talked with you about concerns you have for when you leave the program?

All participants stated, “Yes.” They stated that all staff are focused on helping them leave the program and succeed.

7c. Do you feel confident that you will have the tools you need and a plan in place for when you leave?

Twelve participants said, “Yes.” Six participants stated, “Yes, because they couldn’t leave the program until they recognized how to use specific tools to cope and succeed.”

Two participants weren’t sure.

7d. Do you know how to access activities and services within your community?

Ten participants said, “Yes.” Three participants agreed ‘Yes,” and stated that they had been integrated into the community to learn of employment opportunities, college and fun activities. Four participants agreed that they were familiar with activities and services in the communities they were going to be living in.

Two participants were going to be in new areas of the state and were unsure of activities and services at this time.

Two participants weren’t sure.

8a. What has been the biggest help in this program? Why, what did it improve?

Five agreed that substance abuse treatment and coping skills were the biggest help they had received and it improved the overall quality of their lives.

Three participants stated, “Daily living skills, learning and doing things for ourselves, like laundry. Going to the store to learn about shopping and household budgets.”

Three participants agreed that learning teamwork was a great help.

Five participants agreed that the structure and rules had been the biggest help. They agreed it helped them focus and work hard to meet their goals.

9a. What changes to this program would you recommend? Why, what would this improve?

Five participants had no response.

Three participants stated that there was nothing they would change; the program worked very well for them.

Six participants agreed that there was no need to improve, they had all been in placement at other facilities and agreed that this was the best.

10. If you could make up a service or activity to have in your community what would it be? What would it help?

Five participants agreed that AA for young adults and fun, quality activities would improve the success for many youth.

Three participants agreed that having safe, fun activities on a daily basis would help youth to stay out of trouble; also they could learn to interact with others in their community.

Four participants stated that a substance abuse support group for young people is needed. Young people have different issues and need continued guidance in their communities. It would help young people to stay clean and sober and learn new tools to cope.

11a. Have you or your family ever received Socially Necessary Services?

Four participants stated, “Yes.”

Four participants stated, “No.”

Six had no response.

11b. What did you like most about those services?

Two participants stated that it afforded their parents visitation.

One participant liked the respite services.

One participant stated that he was glad her mom could afford to travel for the therapy sessions.

Ten participants had no response.

11c. What would improve those services?

Thirteen had no response.

One participant said nothing would improve them.

12a. Have you encountered any problems in the system that prevent you from achieving your goals?

Seven participants had no response.

Three participants agreed that they had been lucky enough to succeed in reaching their goals.

Two participants stated that they had been held back a grade because the other facility didn’t forward their records.

Two participants agreed that changing court dates and social workers were a problem.

12b. How do they cause problems?

Twelve had no response.

Two participants said it kept them from graduating on time.

F. Agency Responsiveness to the Community

Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

How well is the agency responsiveness to the community system functioning statewide to ensure that in implementing the provisions of the CFSP and developing related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

> Please provide relevant quantitative/qualitative data or information that show that in implementing the provisions of the CFSP and related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP.

State Response:

Insert state response to Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

When the West Virginia Department of Health and Human Resources is working on rulemaking and revisions, all relevant providers are made aware of impending changes. The providers are notified of rulemaking or revision meetings and are invited to attend. It is the provider's choice if they wish to participate in any meetings or workgroups. The providers are encouraged to provide feedback and to offer suggestions/solutions. After any revisions are completed, there is a comment period. Providers may share any/all thoughts during this period.

When a Correction Action Plan (CAP) is indicated as a result of an Institutional Investigative Unit investigation, a licensing investigation or a licensing review, providers are to develop CAPs for their agency to address any issues identified. The licensing specialist reviews the CAP and makes suggestions or asks for revisions depending on the need. The CAP is monitored by the licensing specialist.

If there is a need for a licensing investigation, the licensing specialist informs the provider of the allegation/complaint. The documentation and findings of the provider's internal investigation are requested. Interviews are coordinated with the providers as needed. The providers are provided a summary of findings when the investigation is completed. The findings include any

violations or issues that were identified during the process. Additional meetings may be arranged, as needed, to discuss findings/outcomes or CAP needs.

The Residential Licensing Specialist works with the West Virginia Child Care Association (WEST VIRGINIACCA) when issues arise and to develop protocols and curriculum. Licensing Specialist, Ed Waugh, is a member of the Emergency Shelter Provider Network (ESPN) and attends meetings with them. In the past we have worked with Foster Family Treatment Association (FFTA) and attended meetings and will resume that process if deemed appropriate by FFTA.

Stakeholders have access to reports related to the CFSP and APSR on the BCF website located at http://www.dhhr.West Virginia.gov/bcf/Reports/Pages/default.aspx

Item 32: Coordination of CFSP Services With Other Federal Programs

How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population?

> Please provide relevant quantitative/qualitative data or information that show the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population.

State Response:

Insert state response to Item 32: Coordination of CFSP Services With Other Federal Programs

The Bureau for Children and Families (BCF) currently collaborates on many groups with the Bureau for Behavioral Health and Health Facilities (BBHHF) and Bureau for Public Health (BPH). These three bureaus have been working collaboratively on a combined effort to reduce the number of pregnant women using drugs and a coordinated effort to address the needs of infants and their families when the children are born drug exposed. Currently, we are collectively developing resource manuals and flow charts to determine available initiatives in the five points of intervention; pre-pregnancy or prevention, prenatal, birth, post-partum and infancy. These three bureaus will also be working jointly to establish training for all community providers on available resources for families experiencing substance abuse.

BCF and BPH have worked collaboratively for the last five years on the Fostering Healthy Kids initiative. This program allows BCF to share daily children coming into foster care in order for BPH's Office of Maternal, Child and Family Health (OMCFH) to establish medical homes for all of West Virginia's foster children. All children entering foster care have a Sanders Liaison from OMCFH assigned to insure they have a Health Check within 30 days of entering foster care and staff from OMCFH assigned to any child considered to be a child with special health care needs.

BCF also works with TANF and WEST VIRGINIA Works to determine programs for children aging out of foster care. Foster youth aging out of care who do not intend to pursue a post-secondary education are referred to Family Assistance and WV Works to determine their eligibility for those programs. West Virginia currently maintains a contract with WVU-CED to a staff of 10 to address the needs of this population as well as complete the NYTD survey's and follow youth exiting care through their 21st birthday.

Children and Adult Services staff within the Bureau for Children and Families meets periodically with staff from the Bureau for Child Support Enforcement to address issues in practice. Staff from both bureaus have addressed practice issues and developed protocols in handling cases that have extended the time frames of foster care. Standard Operating Procedures have been developed for both bureaus in addressing those cases.

G. Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: Standards Applied Equally

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

> Please provide relevant quantitative/qualitative data or information that show the state's standards are applied equally to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds.

State Response:

Insert state response to Item 33: Standards Applied Equally

Refer to pages 216-220, and page 301, of the most recent WEST VIRGINIA APSR submission for additional information on foster and adoptive parent licensing, recruitment, and retention.

Licensing Reviews are at a minimum of once every two years. As part of the review process, the Renewal Licensing Application is provided and renewed. The licensing specialist will review the agencies, policies and procedure and agency forms. The agency handbooks for children, foster and adoptive parents and the training curriculum for foster/adoptive parents and employees are reviewed. The licensing specialist will review 10% of the foster parent records, the children and youth records and the employee records. The agency grievance procedures are reviewed as well as grievances filed. Other documents are also reviewed including: continuous quality improvement activities, incident reports and corrective action plans, board minutes, board member orientation, etc., financial audits and job descriptions.

During the review process the licensing specialist conducts interviews with children/ youth currently in placement, foster parents, homefinders and administrators.

On an ongoing basis the licensing specialist provides technical assistance as needed to ensure compliance and quality services. They conduct licensing investigations regarding complaints which generally include; review of documentation and interviews with employees and children. They request corrective action when licensing violations have been identified through the licensing or IIU investigation process.

Licensing ensures timely certification by reviewing 10% of foster/adoption records during the licensing review process. If/when an agency is found to be out of compliance with this requirement a corrective action plan is required.

Agencies ensure foster homes receive timely certification by maintaining a checklist in the front of charts noting when required items are requested, received and/or completed. Agencies typically audit records routinely to ensure timelines are being met. They generally also track due dates on electronic databases.

If the licensing rules are developed or revised, the provider agencies work with the policy staff to ensure that both the policy for the West Virginia Department of Health and Resources foster homes and the rules for private agency homes meet the same standards.

Although the licensing review does contain positive items at the end of the report, the current review process and tool is deficit based; providers are cited for non-compliance issues. The Residential Licensing Unit could begin looking at other tools or processes that are not deficit based.

Item 34: Requirements for Criminal Background Checks

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

> Please provide relevant quantitative/qualitative data or information that show the state is complying with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children.

State Response:

Insert state response to Item 34: Requirements for Criminal Background Checks

West Virginia requires all individuals who apply to be foster parents, whether with a Specialized Foster Care Agency or with the DHHR, to have a complete background check that indicates they are eligible to be foster parents, prior to being approved as a foster parent. The

background check consists of a State Criminal Information Bureau (CIB) check, a National Crimes Information Center (NCIC) check and a Child Protective Service and Adult Protective Service (CPS/APS) check. Determinations as to whether an individual is eligible to be a foster parent are made by the State Office CIB Unit, the Residential Child Care and Child Placing Agency Licensing Unit or by the local county Homefinding Unit. The background check results are maintained at the State Office CIB Unit. Child Placing Agencies are notified via letter, as to whether an individual is eligible to be a foster parent, when a determination is made on the background check results.

During a Licensing Review of a Child Placing Agency, a sample of 10% of the agencies foster homes is pulled to be reviewed. The background checks of each adult in the home are reviewed to determine if those individuals met the standards for background checks. Background checks are required every five years on individuals who are providing foster care, as well as other adults living in their home. The subsequent checks are also reviewed during the licensing review process of an agency.

A safety check form is used to maintain documentation of those homes reviewed and the dates of the background check submissions, background check results, date of certification for the home, and waiver information if it was needed. The safety check form is maintained in the agency paper record.

If an agency is found to be non-compliant with the background standards, they must immediately develop a corrective action plan to address any deficits. The state maintains individual files on providers with the safety check information. Information on how many reviews were completed and how many agencies had 10% of their homes reviewed for background checks is maintained. West Virginia does not currently have a system set up to track the number of the homes that met or did not meet the standard for all agencies combined. The Licensing Unit reviewed four child placing agencies between July 1, 2016 and January 2017. A 10% sample of the foster parent records under each agency was reviewed for meeting the standard. There were a total of 25 foster home records reviewed. Out of the 25 foster home records reviewed, 23 records met the standard for background checks and 2 records did not meet the standard for background checks. West Virginia does not currently have a way to determine how well the providers (combined) are doing in relation to the background check standard. The state is exploring a way to log the homes checked during a review for each

agency and track if they met or did not meet the standard and then compare reviews once two reviews have been completed.

For DHHR foster homes, a Statement of Criminal Record, CPS/APS, and CIB checks are required before a home is approved. For Foster Care records the status screen cannot be complete until the CIC/NCIC both contains a result. If anything other than "Clear No Conviction" or "No Findings" is checked, then a CIB waiver is required on the waiver tab before the status screen can be unlocked. These are mandatory screens within the FACTS system so a home is not approved unless these have been completed.

A recertification is completed every year on the DHHR foster homes. The Statement of Criminal Record is due by policy every two years and a new CIB is required every five years. Homefinders obtain the Statement of Criminal Record every year at the annual recertification to avoid missing the two year deadline. The Homefinder documents in the yearly evaluation when the CIB/NCIC is due and supervisor reviews to prevent lapsed background checks.
The process for the CIB begins at the four year mark in order to have completed by the 5th year during the recertification. Homefinders are prompted to do this by printing out the provider re-evaluation-they look through and check print results and when last received. A new CIB is completed during the fourth year review in order to ensure the five year deadline is met.

The Homefinding supervisor conducts provider record reviews to determine that the Statement of Criminal Record is current and is in the provider record file cabinet. The supervisor will also review to determine that CIBs and background checks have been completed and have not lapsed. These reviews are completed when the provider is due for recertification which can be found in a FREDI report and also in COGNOS. The supervisor will review 10% of the provider due for recertification.

Item 35: Diligent Recruitment of Foster and Adoptive Homes

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

> Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the diligent recruitment of potential foster and adoptive families who

reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide.

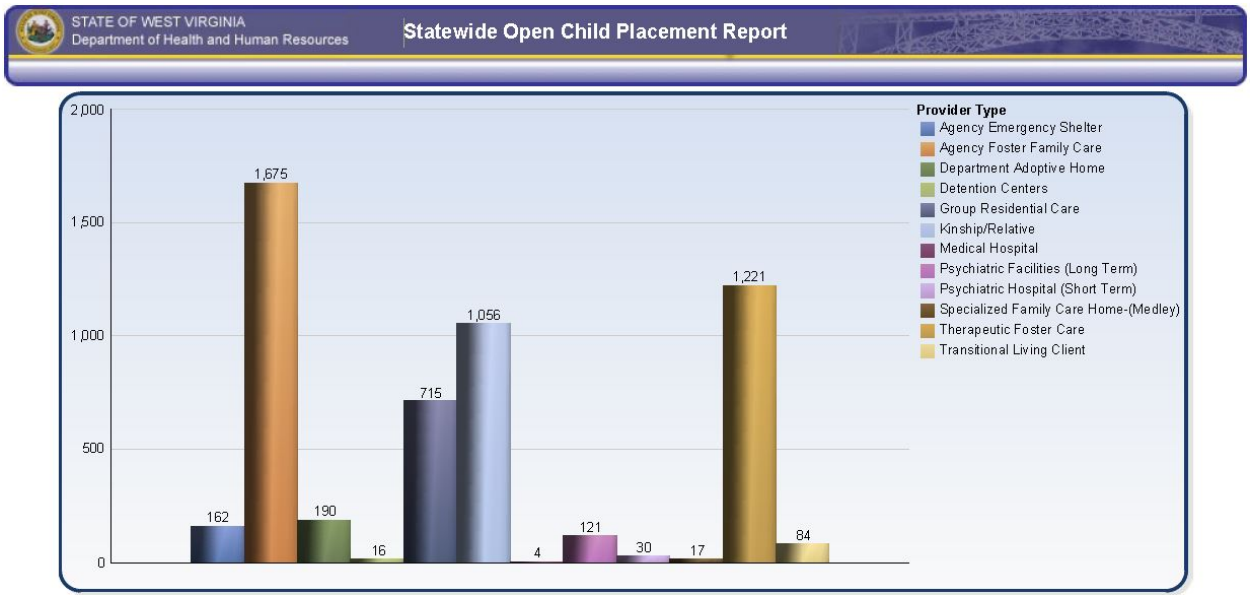
State Response:

Insert state response to Item 35: Diligent Recruitment of Foster and Adoptive Homes

With a focus on reducing the number of youth in residential care, BCF has partnered with our private agencies to provide a tiered treatment foster care system as well as increase recruitment of traditional foster homes. As reported in last year's APSR, West Virginia has contracted with Mission West Virginia to provide a more diligent response to inquiries from the community to provide foster care. Mission West Virginia has been contracted for years to provide many recruitment activities for West Virginia. Recruitment conducted by Mission West Virginia has always focused on special needs children which include racial/ethnic minorities and their child-specific recruitment efforts include the preference of child regarding race/ethnicity when a preference is expressed by the child.

West Virginia's overall population, according to Census records from 2015, reports that the general population is 93% white, 3% African American, 1% two or more races and all other races are less than 1% each and make up the remaining 3% or the population.

The following is a current breakdown of foster care placements for the state.



1,056 of the 5,291 total numbers (20%) of children in foster care are placed in relative or kinship homes. 1,675 (31.6%) children in foster care are placed in homes managed by the Bureau for

Children and Families. Although we do not have a breakdown of the race or ethnicity of these homes, the majority of them originated as kinship or relative homes. The assumption is that the home would be more culturally sensitive or similar to the child. Another 902 (17%) are placed in group type settings. 84 (1.6%) are placed in a transitional living setting.

In the fall of 2015 the Bureau for Children and Families entered into a cooperative agreement with Specialized Foster Care agencies to handle traditional foster care homes. 1,221 (23%) of the children in foster care in West Virginia are placed with our private agency homes. The private agencies report that 22 of their homes have at least one parent that is African American. Our latest AFCARS data indicates that West Virginia has 1,609 currently in placement in foster family home (non-relative). Of those, 42 have indicated African American for their race and 99 have two or more races chosen.

Although West Virginia does not currently track the number of homes by race, our priority has been a push to place children with kin or relatives in their home schools and communities. This push has been successful and allows our children to remain with family and friends who care for them and in a community that shares their values and beliefs. BCF will pursue adding a performance measure to specialized agency contracts requesting they track this information in the future. We will also request a report from our SACWIS system for this information.

Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

> Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide.
>
> Please include quantitative data that specify what percentage of all home studies received from another state to facilitate a permanent foster or adoptive care placement is completed within 60 days.

State Response:

Insert state response to Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

West Virginia has a process for tracking some data in relation to Cross-Jurisdictional Placements and Requests for Placements, but we do not have a “monitoring” system to track the progress of home study requests from other states. There were 188 incoming requests from November 1, 2015 to November 1, 2016. Out of the 188 requests, West Virginia completed 62 or 33% of the home studies within the 60 day timeframe. The most documented reason for the home studies not being completed within the 60 day timeframe is due to the fingerprint results not being back in that 60 days, but staff has been very inconsistent in their reporting reasons for delays.

The ICPC Office will start looking at a way to revise our tracking system, so reminders can be sent to the local staff, prior to the due date. The office will also work with the central office CIB Unit to determine if the CIB checks are being held up and why they are not being processed timely. Currently our CIB Unit reports that most CIB results are processed within two weeks to four weeks, so this should not delay the home study process.

The ICPC Office will be reviewing current options of using other methods of transferring home study packets to the local office to ensure timeliness.

Appendix A

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Jim Justice
Governor

Bureau for Children and Families
Deputy Commissioner of Field Operations
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Bill J. Crouch
Cabinet Secretary

STANDARD OPERATING PROCEDURE
Monthly Reporting on Kids in Care

EFFECTIVE DATE: September 1, 2015
Revised: January 1, 2017

1.0 PURPOSE: To create a uniform system statewide for tracking vital information on all kids in care. This report can be compared to the Children in Placement Report in FACTS to compare and determine accuracy.

2.0 SCOPE: This protocol was developed in response to the need to collect information for children age 12 through their 17th birthday for the purpose of collecting and reporting data for Safe at Home West Virginia. However, the collection of data for all children in care serves additional purposes including, but not limited to, a valuable management tool and having readily available information to locate children in the event of an emergency.

3.0 DEFINITIONS:

Kids in Care Report – The spreadsheet to be kept by every district and updated monthly that collects information pertaining to every child in BCF care, custody, and control.
Spreadsheet Columns and Definitions –

- **Worker Region**
- **Worker County**
- **Worker Name**
- **Client ID**
- **Client Name**
- **Birth Date**
- **Gender** – This is a drop down box and the correct gender should be selected.
- **Race** – This is a drop down box and the correct race should be selected.

- **Removal Date**
- **Removal Reason** – This is a drop down box where the primary removal reason must be selected. There are five removal reasons to choose from including:
  AN – Abuse and Neglect
  JD – Juvenile Delinquent
  JS – Juvenile Status (Not Truancy)
  JST – Juvenile Status Truancy
  VOL – Voluntary
- **Provider Type** – Specify if this is a Temporary Foster Care Home (DHHR), Specialized Foster Care Home (Private Agency), Treatment Foster Care Home (Pressley Ridge pilot), Group Residential, PRTF, etc.
- **Provider Name**
- **Provider State**
- **Placement Entry Month** – Enter the full date
- **Placement Exit Date**
- **Number of Previous Placements**
- **Permanency Plan** – This is a drop down box with selections including reunification, adoption, legal guardianship, and APPLA (Another Planned Permanent Living Arrangement – only to be used for youth 16 and older).
- **Multiple Agency Involvement** – This is a drop down where all agencies involved must be selected.
  BOE – Board of Education
  DJS – Division of Juvenile Services
  DV – Domestic Violence
  MH – Mental Health
  Prob - Probation
- **Diagnosis** – This is a drop down box where you must select:
  MH – Mental Health
  Med – Medical
  Both – Medical and Mental Health
  NA – No Diagnosis
- **Intelligence Quotient (IQ) Score**
- **Psychological Evaluation Date**
- **Date of Last Assessment –** This applies to the assessment types in the next field.
- **Type of Assessment** – This is a drop down box where you must select the type of assessment that was last completed:
  CANS – Child and Adolescent Needs and Strengths Assessment
  CAPS - Comprehensive Assessment Planning System
  YLS/CMS – Youth Level of Service Case Management Inventory
- **Last MDT Date**
- **Unmet Needs –** This is a drop down to select yes or no to reflect if needed services are available to meet the needs of the children and family (examples: treatment for substance abuse, DV, etc.).

- **Referred to Wraparound (Y/N) –** This is a drop down to select yes or no as to whether or not the case has been referred for wraparound.
- **Date of Clinical Review Team –** Enter the date of the Regional Clinical Review Team if applicable.

4.0 PROCEDURE:

- Beginning August 2015, the Program Manager or Designee will provide to each district their Kids in Care Report that will be based off the July PLC0700 report in FREDI titled, “Children in Placement with Level”.
- Supervisors must enter the documentation for blank fields and provide any updates to the Kids in Care Report. The final report must be provided to the Program Manager or Designee by the last working day of every month.
- A person within the district must be designated to compile the information for the entire district prior to submission to the Program Manager or Designee.
- Needed updates include, but are not limited to, the following:
    1. Removal of children from the report who exited care during the month. <u>When a district is no longer responsible for a child due to transfer to adoption, the district will remove that child from their report the same as they would for a child who exits care. The adoption supervisor will be responsible for adding the child to the adoption tab at the time of transfer.</u>
    2. Adding children to the report who entered care during the month.
    3. Changes in worker.
    4. Placement changes.
    5. Completed assessments.
    6. Changes in diagnoses.
- Supervisors will review with workers to ensure all children have been identified and have been entered or exited into or from placement.
- Supervisors will review the Kids in Care report and compare with the Children in Placement report in FACTS and also with the monthly payment screens to assure all children have been entered into placement in FACTS.
- The Kids in Care Report should be stored electronically but also should be printed monthly for easy access in the event of a disaster that impacts our electronic records.
- As information is updated on the spreadsheet, supervisors should be checking FACTS for matching documentation. This is especially important for removal start and end dates and placement changes.

Appendix B

The WEST VIRGINIA DHHR requests your assistance in determining your participation, as a foster parent, in multidisciplinary team meetings (MDT) and court hearings. Please return the completed questionnaire to your homefinder at your earliest convenience. Thank you for taking the time to complete this questionnaire. The WEST VIRGINIA DHHR appreciates all that you do for our foster children.

1.) How often do you receive notice of scheduled multidisciplinary team meetings (MDT)?

1	2	3	4	5
Never	Sometimes	Often	Almost Always	Always

2.) How often do you receive notice of scheduled court hearings?

1	2	3	4	5
Never	Sometimes	Often	Almost Always	Always

3.) Does anyone ask you for your opinion to assistance with the completion of the case plan for the foster child(ren)?

1	2	3	4	5
Never	Sometimes	Often	Almost Always	Always

4.) Do you feel that your opinion is heard/considered?

1	2	3	4	5
Never	Sometimes	Often	Almost Always	Always

5.) Are you requested by anyone to bring the foster child(ren) to MDTs? If yes, please specify.

YES [ ] NO

6.) Are you requested by anyone to bring the foster child(ren) to the court hearings? If yes, please specify.

YES NO

7.) Additional comments or concerns: