West Virginia Families Come First

A Five-Year Plan for Title IV-E Prevention Services: 2019-2024

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
CHILDREN & FAMILIES

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Introduction

The Family First Prevention Services Act (FFPSA) has come at a time in West Virginia's history when a solid foundation for prevention is a necessity and, more than ever before, on track for reality. Since West Virginia became a Title IV-E waiver demonstration state in 2014, substantial resources have been directed to diversifying the types of services available to families.

Implementation of the Title IV-E waiver allowed West Virginia to realize reductions in its reliance on residential care for youth aged 12-17. As of April 30, 2019, 3,146 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 97 youth from out-of-state residential placement back to West Virginia, 267 youth have stepped down from in-state residential placement to their communities, and 47 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 2,134 at-risk youth (PCG, 2019). With West Virginia sustaining its wraparound program since the close of the waiver, a little over 1,000 additional youth were enrolled in Safe at Home West Virginia between May 1, 2019 and March 31, 2020.

The work to increase alternatives to out-of-home care has not been an effort undertaken alone by the child welfare agency, the West Virginia Department of Health and Human Resources, (DHHR) Bureau for Children and Families. The collaboration between DHHR's Bureaus for Public Health, Behavioral Health, Medical Services and Children and Families has enabled community-based programming to grow, with plans to further utilize the opportunities under FFPSA to achieve common goals. Leadership provided by Cabinet Secretary Bill J. Crouch has been instrumental in the development of this shared vision.

The Child Welfare Crisis in West Virginia

Despite efforts to build alternatives to out-of-home care over the past five years, West Virginia has seen an unprecedented burgeoning of the foster care numbers. As in many other states, this growth is mostly attributable to the opioid crisis. West Virginia's numbers reflect a growing and severe social crisis:

- 83% of open child abuse/neglect cases involve substance abuse as a factor in the home;
- Since 2014, the number of children in state custody has increased 46%;
- 22% increase in accepted child abuse/neglect referrals between 2014-2017;
- 34% increase in open Child Protective Services (CPS) cases between 2014-2017;
- West Virginia is #1 in child removal, nationally;
- West Virginia is #1 in congregate care usage, nationally;
- 63% of the children entering foster care are age 10 and younger.

There have been positive outcomes occurring simultaneously during this crisis:

- 43% of children in foster care are placed with relative/kin;
- 30% of foster children achieve permanency within 12 months of removal;
- Adoptions in West Virginia have increased 113% since 2005.

DHHR is not the only organization that has been overwhelmed with responding to the human suffering of this crisis. It has impacted every organization whose mission is to serve the public, requiring partnerships to find solutions and bringing child welfare professionals into closer contact.

Setting the Stage: Strengthening Prevention in West Virginia

Prevention is a concept that often requires the child welfare staff to do the nearly impossible in a crisis-driven system and think outside their child protection activities after maltreatment has already occurred. True primary prevention requires focus to be put on families who are not yet engaged with the child welfare agency due to abuse, neglect and/or juvenile justice issues.

In response to the U.S. Department of Health and Human Services' Administration for Children and Families' call to action, DHHR has been refining its prevention vision over the past year. DHHR's Bureau for Public Health and Bureau for Children and Families have been embedded in primary prevention for many years and will be instrumental in enhancing the prevention services opportunities that come with FFPSA.

Within the Bureau for Children and Families (BCF), the Division of Early Care and Education (ECE) has administered the Community-based Child Abuse Prevention grant for the past four years. While operationally part of West Virginia's child welfare organization, the child abuse prevention programs are often not seen as part of the child welfare service delivery system. Furthermore, the predominance of in-home visitation programming is funded through DHHR's Bureau for Public Health - Office of Maternal, Child and Family Health via the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program funding. Any expansion of primary prevention programming will require a new definition of child welfare for West Virginia, one which incorporates the concepts and services that move services "up-stream" to families not yet experiencing crises that require child removal.

In order to strengthen the foundation for primary prevention in preparation for FFPSA prevention opportunities, the ECE recently increased funding to Starting Points Family Resource Centers (SPFRC) through the utilization of Temporary Assistance to Needy Families (TANF) funds. SPFRCs target programs and services to families with children 0-18 years of age or through high school graduation age. SPFRCs serve their identified geographic regions and communities. Services are voluntary and available at no cost to families regardless of status with the child welfare agency. SPFRCs provide primary prevention services based on the protective factors and the family support approach. SPFRCs may offer:

- Parent education classes (which include Parents as Teachers®)
- Child development activities
- Play groups
- Parent-to-parent support groups
- After school and academic enrichment
- High school equivalency diploma (TASC) and literacy instruction
- Health information

- Referrals to programs, activities and services in the community
- Specific services designed in accordance with the needs of the community
- Respite care for caregivers

SPFRCs will support the development and strengthening of the family's protective factors, which are strengths that can be built in all families that expand parental capacity and reduce the risk factors associated with abuse and neglect. This fits very well with the family support approach which embodies concept and practice to include (adapted from Standards for Prevention Programs: Building Success through Family Support/Family Support America):

- Services are responsive and adapt to family needs, involving family members in service planning, delivery, and evaluation.
- Programs are embedded in local communities to provide the best access to services and the development of partnerships within community. Services are integrated as a part of a continuum of services offered by the community and respond to specific community needs.
- Linkages to both formal (agencies and services) and informal (peer) support networks to provide support and reduce isolation are provided.
- Services are available to all families in the community and are voluntary.
- Services are targeted to families and children early to support the development of positive interactions and to intervene at the time of greatest brain development.
- Partnerships with parents as well as other community agencies are a primary focus of services.
- Parents are fully involved in decision making and guiding programs. Resources within the community work collaboratively to maximize and capitalize on available services.
- Program services are developmentally appropriate for the stages and developmental tasks of participants. Programing focuses on building on families' strengths.
- Programs are easily accessible and provide outreach to engage families and build relationships.

Community Stakeholders Embracing Prevention - The Mountain Collaborative to Strengthen and Preserve Families in Mercer County

Jerry Milner, Associate Commissioner for the U.S. Department of Health and Human Services Children's Bureau, has a motivational way of tying primary prevention to traditional child welfare philosophies. His presentation during the Children's Bureau-sponsored State Team Planning Meeting July 17-18, 2018, in Washington, D.C., inspired a West Virginia circuit court judge to make an immediate change in his community.

Upon returning to West Virginia, the Honorable Judge Derek Swope of Mercer County called his local community collaborative together to share his excitement about what he heard in D.C. With his community connections, Judge Swope developed the Mercer County Families First (MCFF) Steering Committee. This committee boasts membership of many important stakeholders of the area: a professor from Bluefield State College, representatives from every branch of local government, the county

commissioner, business leaders, child welfare leaders and many other community partners. From this group, the Empowering Appalachian Families in Mercer County initiative was formed.

West Virginia has the highest combined rate of deaths from drugs, alcohol, and suicide (in 2016, 83.1 deaths per 100,000 population) as well as the largest increase in deaths from these causes since 2005. The rate of drug overdose deaths in West Virginia more than quintupled between 2005 and 2016, while the state's suicide rate increased by 46 percent, and deaths from alcohol abuse rose by 41 percent. Within the state, Mercer County's rates of suicide, drug overdose, and child and family poverty have been significantly higher than the state average over the last five years. These factors combined with increased child abuse and neglect, domestic abuse, decline in family infrastructure, and pervasive hopelessness place Mercer County families at an increased risk for instability and impermanency.

The Mountain Collaborative to Strengthen and Preserve Families (MCSPF) applied for funding from the HHS-2019-ACF-ACYF-CA-1559 Community Collaborations to Strengthen and Preserve Families grant. These funds will enable Bluefield State College and the MCFF Steering Committee and Community Collaborative to promote child permanency, safety, and well-being in families at risk of being referred to Child Protective Services, Youth Services, and the juvenile justice system. This will be accomplished by: (1) establishing in-person outreach and a family mentoring program; (2) transformation of a promising existing wraparound service model to meet families' diverse needs (e.g., mental health, physical well-being, economic, financial, educational, and diversity-related); and (3) providing a Family Coach to facilitate family-centered service coordination promoting families' self-determination and independence.

The MCSPF is centered on a theory of change that a wraparound family support system providing comprehensive, holistic, family-driven responses to needs will increase family stability and permanency and reduce the number of youth entering the child welfare system. This project's primary goals are to reduce the number of referrals to the child welfare system and the number of domestic violence court cases through systematic, family-centered wraparound services and the support of an integrated collaborative of diverse stakeholders.

The measures used to assess the impact that MCSPF has on Mercer County families to enhance ongoing quality improvement will be tracked monthly by each consortium, reported quarterly to the Project Director, and evaluated annually by consortium members and the Project Director to ensure program success (Banks, 2019).

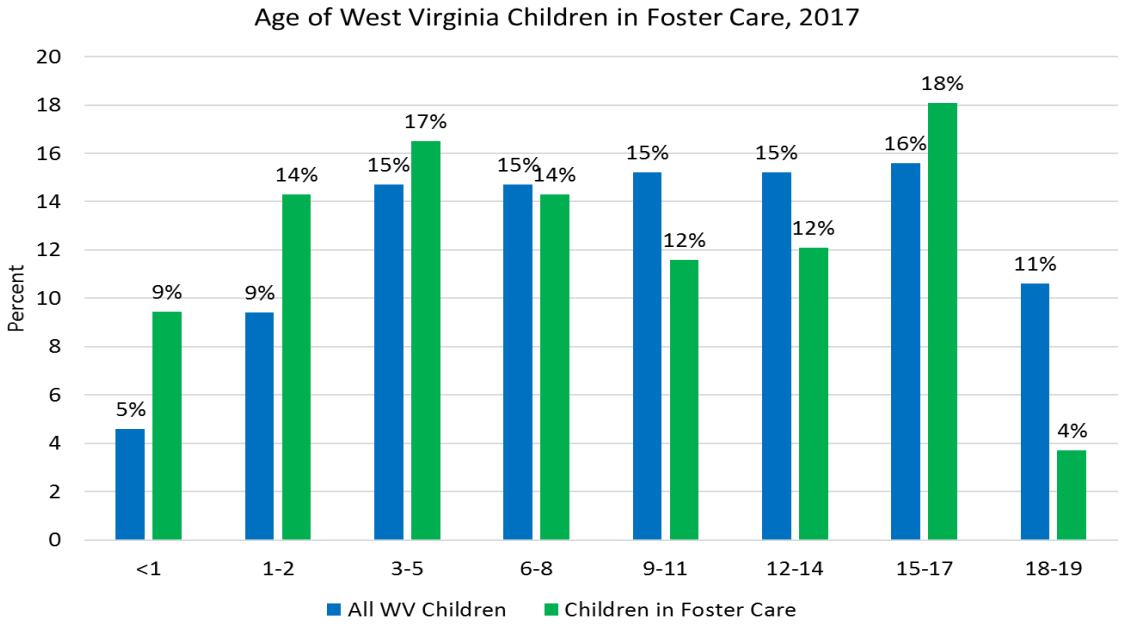
Who is Coming into Foster Care? - West Virginia's Public Health Analysis of Foster Care

During the Summer of 2019, DHHR's Bureaus for Public Health and Behavioral Health joined forces to review public health records for all children who entered foster care in 2017. The purpose of this comprehensive review was to:

- Determine patterns related to age at time of removal;
- Explore services offered to children prior to removal;
- Understand family dynamics for children at-risk of removal;

- Identify family needs to prevent removal; and
- Assist the Bureau for Children and Families in selecting Family First prevention services.

This data review included approximately 12,000 children. The data was obtained through matching records to birth and death certificates, Medicaid claims, public health records, the controlled substance monitoring program and emergency medical services.



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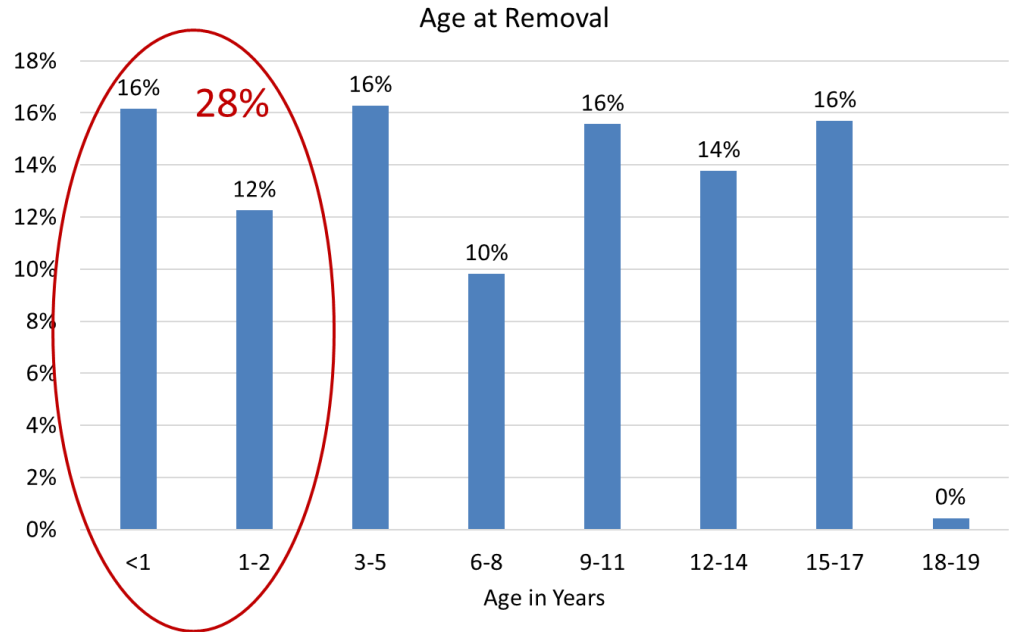
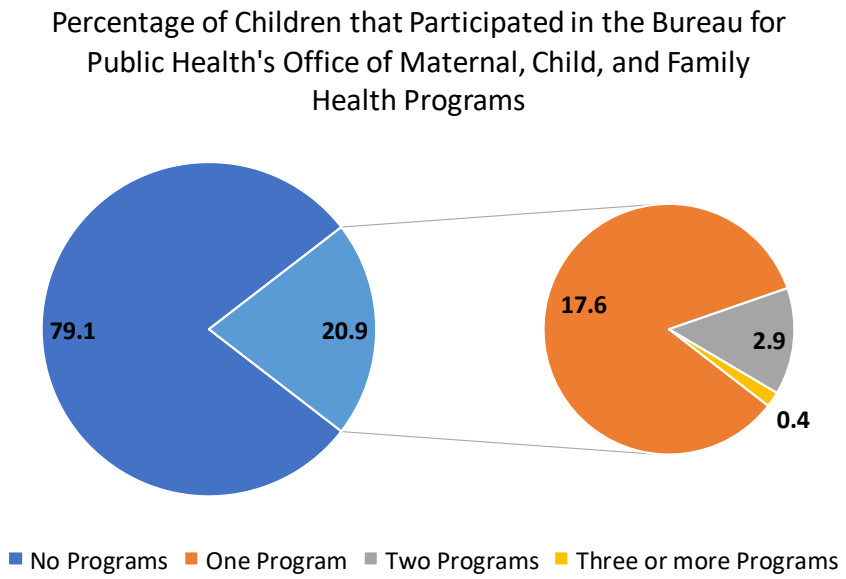
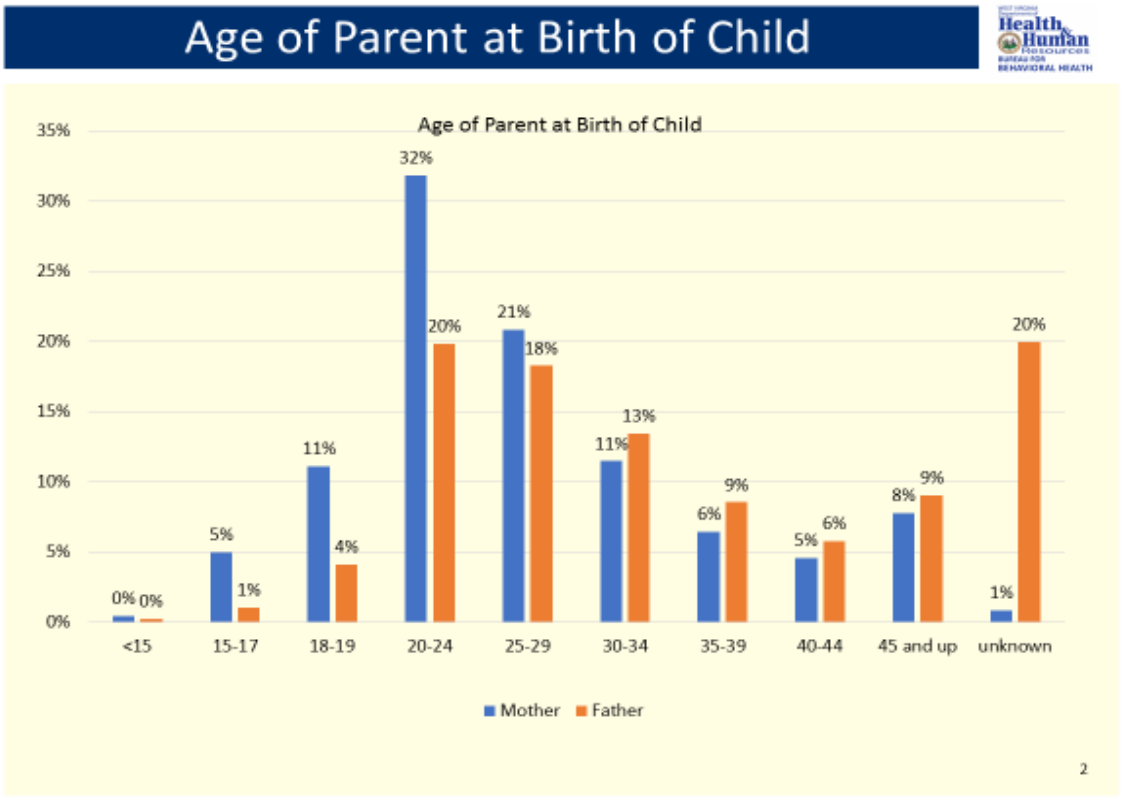


The data collected show that 44%, nearly half, of children entering foster care are under the age of five, with 28% being age two or younger. Following behind at a close second for highest entry rate are youth aged 12-17, representing 30% of the total. Frequently, youth in this age group enter due to juvenile justice issues.



Most children in foster care placement (79.1%) had no history of services from DHHR's Bureau for Public Health's Office of Maternal, Child and Family Health's (OMCFH) prevention programs. For the purpose of this analysis, prevention programs included Birth to Three, Home Visitation (including Parents as Teachers®, Healthy Families America® and Right from The Start), and Children with Special Health Care Needs. Of the children enrolled in OMCFH programs, the majority utilized only one service. The most commonly utilized service is the Birth to Three Program. This is likely due to the Bureau for Children and Families' requirement that all children with an open Child Protective Services case ages 0-3 years are referred to the Birth to Three Program as part of the compliance with the Child Abuse Prevention and Treatment Act requirements for drug-affected infants.

Utilization of OMCFH programs suggest that children are more likely to receive services when there is an identified developmental delay or medical condition that requires intervention. The data also suggests that policy requiring referral may positively impact utilization of services. While this population is less likely to receive prevention services from Home Visitation programs, this finding is expected since these programs have been demonstrated to reduce child abuse and neglect (Mullins and Sanders, 2019).



In order to offer some description of the parent at the time of the child's birth, birth certificate data was analyzed. Mothers of children in foster care tended to be younger than expected with 48% of mothers less than 25 years of age, compared to 39% of the overall number of 2015 West Virginia births (Mullins and Sanders, 2019).

Foster Care Candidate: West Virginia's Definition

For the provision of FFPSA prevention services, a **foster care candidate** is identified as follows: A foster care candidate is a child, under the age of 21, who is at imminent risk of foster care entry or re-entry, and who:

- Has not been removed from their home and placed in foster care; or
- Is not under the placement and care of the Title IV-E agency and is residing with a relative or an individual with whom the child has an emotionally significant relationship characteristic of a family relationship (fictive kin); or
- Has returned home on a trial home visit; or
- Has returned from a foster care placement and is residing with their parent or a non-paid kinship relative caregiver; or
- Has been adopted or is in a legal guardianship arrangement.

The child is considered at imminent risk of foster care entry, or re-entry, if at least one of the following conditions exist:

- Has been abused or neglected or has been identified as unsafe and, without intervention, is likely to be removed;
- Suffers a serious emotional, behavioral or mental disturbance and without intervention will be unable to reside in their home;
- Has committed a prosecutable offense in which the state has filed, or is considering filing, a juvenile petition and the planned out-of-home living arrangement is a foster care setting;
- Is a runaway or homeless youth;
- Is, or will be born to, a youth residing in foster care;
- Is an adopted child or in a legal guardianship arrangement at risk of disruption.

DHHR's Bureau for Children and Families will identify pregnant and parenting youth through enhancements that have been made to the state Administered Child Welfare Information System (SACWIS). Plans are also underway to incorporate documentation strategies into the state's Centralized Child Welfare Information System (CCWIS), WV PATH (People's Access to Help), to assist with identification of pregnant and/or parenting youth.

Service Selection: Developing West Virginia's FFPSA Five-Year Prevention Plan

While the public health analysis of foster care provided compelling data to guide decisions on the needs of our most vulnerable populations, West Virginia's prevention strategies could not have been developed without the assistance of community stakeholders. Their engagement began in July 2018, when a statewide survey was circulated to query the types of evidence-based services that were being provided. Thirty-one unique providers responded. Thirty-three responses were received, with two agencies sending two surveys due to the diversity of their programming. Of the 31 respondents, nine children's residential and foster care agencies responded to the survey. Of those, three agencies

responded that they are currently providing a significant number of evidence-based, in-home prevention services.

A formal workgroup was developed following the release of the *Title IV-E Prevention Services Clearinghouse.* Members of the workgroup were chosen from the providers of the services on the clearinghouse. Initial meetings have been related to information-gathering and determining how to phase the implementation strategies. Future workgroup meetings will be held to develop expansion strategies and examine fiscal implications. Budget projections are critical in determining the speed at which West Virginia will be able to expand existing services, as well as invite new services into the array. As services are added to the clearinghouse, this workgroup will be instrumental in assisting each other, and other stakeholders, in the education and assessment to determine which services work best for West Virginia families.

Prevention Workgroup/Sub-group Meeting	Meeting Description/Accomplishments
Sub-group Learning Collaborative In-Home Visitation Providers April 15, 2019	• Education of Bureau for Children and Families' staff about the in-home visitation programs available in WV
Workgroup Meeting #1 In-home Visitation Providers, Functional Family Therapy® (FFT), and Other Stakeholders June 19, 2019	• Provider learning opportunity about FFPSA • Overview of preliminary public health analysis of foster care results • Discussion of services to meet the needs of the target population
Workgroup Meeting #2 July 10, 2019	• Review of Title IV-E Clearinghouse • Discussion of services unique to WV that research could support for inclusion in Clearinghouse
Sub-group Meeting In-Home Visitation July 11, 2019	• Budget overview • Preliminary review of expansion
Sub-group Meeting FFT® August 2, 2019	• Budget overview • Preliminary review of expansion
Sub-group Meeting Parents as Teachers®(PAT) August 8, 2019	• Discussion of pilot to complement the Family Treatment Courts • Budget overview for different phases of implementation
Sub-group Meeting Healthy Families America® (HFA) October 10, 2019	• Program overview • Review of current WV catchment • Discussion of payment structure and outcomes measures

Several of the services included in the *Title IV-E Prevention Services Clearinghouse* are currently available in West Virginia. However, many are not available statewide or have waiting lists. For the first two years of the five-year planning period, West Virginia will place highest priority on the sustainability and expansion of services that have been shown to be meaningful for West Virginia families.

Data from DHHR's public health analysis of foster care supports prioritizing expansion of the in-home visitation programs, Parents as Teachers® and Healthy Families America®. Since nearly 70% of West Virginia's foster care population is eligible for Medicaid or the Children's Health Insurance Program (CHIP) prior to entering care, the services chosen for initial consideration should be those with insecure and/or inadequate funding streams. The predominance of mental health and substance abuse services on the *Title IV-E Prevention Services Clearinghouse* currently available in West Virginia are funded by Medicaid, CHIP, and private insurance. This justified the selection of Functional Family Therapy and Motivational Interviewing, neither of which have sufficient funding but result in positive outcomes for the families who have received these services.

In-Home Visitation Programs – Parents as Teachers® and Healthy Families America®

The in-home parenting education programs, Parents as Teachers® (PAT) and Healthy Families America® (HFA), are well-supported, evidence-based programs that have demonstrated positive outcomes in preventing abuse and neglect for a population of families that West Virginia currently serves through its Bureaus for Public Health and Children and Families. These services were chosen for inclusion in this plan after the public health analysis revealed the lack of prevention services provided to West Virginia children prior to entering foster care. The analysis also showed that many mothers of West Virginia children in foster care are young and likely unprepared. In-home visitations programs' research and outcomes measures provide compelling evidence of their efficacy and since West Virginia's families meet the same demographics as those involved in established outcomes, DHHR believes that in-home visitation can help West Virginia in realizing a reduction in the rate of out-of-home placements, among other outcomes, as discussed below.

PAT® is currently available in 49 of West Virginia's 55 counties. Most of the counties have wait lists. HFA® is located in six counties along the south-eastern portion of the state. Both programs have the infrastructure to expand services with additional home visitation staff to meet increased needs. DHHR's Office of Maternal, Child and Family Health, housed within the Bureau for Public Health, has worked strategically over the past five years to develop leadership and resource/referral partners in counties to more readily add staff as needed (based upon funding availability). In addition, West Virginia now has a state-level PAT® training team, which has reduced staff training costs. Both programs have demonstrated positive outcomes for West Virginia's families and children.

Attachment C includes infographics related to the outcomes for PAT®. These in-home visitation programs can offer life-changing opportunities for the young mothers of West Virginia's foster care population. Program staff help schedule regular doctor's visits, improve diets, reduce stress levels, and provide supports to quit smoking or substance use (University of Texas at Austin 2015). These benefits could be the path to reducing poverty and increasing economic stability over the mother's lifetime.

Currently, the Maternal, Infant and Early Childhood Home Visitation funds (MIECHV) and a small amount of Community-Based Child Abuse Prevention (CBCAP) funding, and the required state match, are

the only funding streams for in-home visitation programs. This causes limited availability despite positive outcomes.

Target Population of In-Home Visitation Programs

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will implement Mountain State Healthy Families/HFA® to families with increased risk of child maltreatment or those who have already experienced abuse/neglect within the home, and

- have an active Child Protective Services case; and
- at least one parent is pregnant or has a newborn.

The service will be initiated during pre-natal or at birth, continuing for a minimum of three years. This service will also be available to pregnant foster children or a foster child who has a newborn, as their children will be eligible as foster care candidates.

Parents as Teachers® will be implemented for families expecting a new infant, have increased risk of child maltreatment or have already experienced abuse/neglect in the home with a child kindergarten age or younger and have an active child protective services case, and meet the criteria to be defined as a foster care candidate. This service will also be available to pregnant and/or parenting foster youth.

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment K.

Phased-in Implementation

A two-phased approach is planned for the utilization of IV-E funding for these in-home visitation programs.

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to DHHR's Office of Maternal, Child and Family Health (OMCFH) for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include CPS families and pregnant and/or parenting youth in foster care. The utilization process would include tailored guidelines that have the same look and feel that all other social necessary services possess.

The second phase includes efforts to expand services beyond their current localities of coverage as well as increase service capacity in areas where services are located but have waiting lists. Service expansion will require budgetary appropriation from the West Virginia Legislature and proposals will be drafted for the 2021 legislative session.

Caseloads

For newly hired home visitors, the recommended caseload is no more than 10 families with higher risks. After the first year, the home visitor can carry an average of around 20 cases. Cases are assigned to the home visitors by their supervisors, and reports are frequently generated to track the number of families per home visitor. If a home visitor is at capacity, families can still participate in other parenting programs. Many families are referred to Help Me Grow West Virginia. Help Me Grow is a free referral service that connects families with critical developmental resources for their children, from birth through five years. The goal of Help Me Grow is to successfully identify children at-risk and link them to the supports they need.

OMCFH also works with community in-home parenting education providers to evaluate if additional home visitors are needed. Additional home visitors are hired as funding is available. Since the training is already embedded into the formal structure required for the MIECHV grants, bringing on new home visitors can be expedited. In the interim, when staffing may be a factor in controlling caseload sizes, the home visitor supervisor can carry four-six cases each. The supervisors must also be certified in-home educators and receive regular training in order for them to be able to carry out this role, when needed.

Monitoring Child Safety

All in-home visitation program staff are considered mandated reporters, as per West Virginia Code §49-2-803. The mandated reporter training curricula used was developed by TEAM for West Virginia Children, the West Virginia Chapter of Prevent Child Abuse America. This organization is a grant recipient of DHHR's Bureau for Children and Families, whose statement of work requires conducting statewide stakeholder trainings and events related to child abuse recognition and reporting, as well as maintaining a website for mandated reporter resources. TEAM for West Virginia Children provides mandated reporter training to all in-home visitation program staff statewide to enable them to recognize and respond properly to signs of child abuse and neglect that they may encounter in their work with families. During every home visit, the provider is informally assessing the environment for indictors of child well-being or threats to safety. Formal screenings include:

- Developmental screenings (ASQ-3 and ASQ:SE2)
- Depression screenings (PHQ-9)
- Intimate Partner Violence screenings (Relationship Assessment Tool or HITS)
- Parent-Child Interaction screenings, such as CHEERS Check-In which was developed by HFA® National

Additional components of the TEAM for West Virginia Children training curriculum focus on safety, stress, anger management, and other topics that are related to abuse/neglect potential.

All DHHR case workers, which include CPS and Youth Services workers, represent the child welfare agency's ultimate responsibility in ensuring the safety for children who remain with their families through the provision of prevention services (See Ensuring Child Safety below).

Fidelity and Outcome Measures-Evaluation Waiver Justification

West Virginia is submitting evaluation waiver requests for Parents as Teachers® and Healthy Families America® as part of this plan submission (see attachments A-F). The model fidelity outcomes used in West Virginia were developed by PAT® and HFA®.

The PAT® model currently available in West Virginia, which is being utilized for expansion through this Title IV-E opportunity, is the evidence-based model developed and owned by Parents as Teachers®. Each of West Virginia's PAT® providers is an affiliate of PAT® and must be accredited by the proprietor. Examples of accreditation documents are provided as part of Attachment B.

When a provider agency becomes an affiliate, they must develop an Affiliate Plan that outlines their specific roadmap to implementation. Once certified as an affiliate, home visitors are sent for five days of initial training in Foundational and Model Implementation and then an additional two days in Foundational Two training before they can become a model certified home visitor. Home visitors also have mandatory online modules (approximately 32 hours provided by PAT® national). An additional three-day training is required on-site by OMCFH's State PAT® on MIECHV required outcomes and activities. Approximately four weeks of shadowing with an experienced home visitor are also required. West Virginia has a certified in-state PAT® trainer and is in the process of having a second trainer certified through PAT®. In addition, the in-state trainer is in the process of being certified in the newly approved virtual PAT® trainings.

All PAT® sites are required to maintain accreditation and have a site visit for renewal every five years. Each of West Virginia's PAT® sites are in various years of their accreditation. National peer reviews are completed electronically with occasional on-site peer reviews. In addition, peer reviewers conduct interviews with families who have received PAT® services, community partners and the State PAT® office. They must meet at least 85% of the practice standards to be accredited. Essential requirements are attached along with the accreditation process.

The most comprehensive and thorough feedback from PAT® national occurs following a site visit. However, PAT® requires their affiliates to provide yearly fidelity monitoring reports called Affiliate Performance Reports (APR) in order to continue affiliation. During the fourth and fifth years of affiliation, each provider agency is expected to participate in the affiliate quality endorsement and improvement process. The State PAT® office completes site visits to all PAT® programs annually to monitor progress and ensure standards are met. If an essential requirement is not met, the site must complete a Success Plan. Also, the Director of OMCFH and a PAT® national technical assistance specialist check in monthly via telephone at all sites, and as needed.

If an affiliate's performance is below standards, the corrective action will depend on the deficiency. If it is below standards based on internal quality assurance activities, the program manager or direct supervisor will work with the staff person in question (if a specific person) or use problem solving/Continuous Quality Improvement (CQI)-type methods to improve, if an overarching problem. If performance on the standards is below 85% based on a site visit, the affiliate must submit a Performance Improvement Plan and be re-reviewed again within 3-6 months, at which time improvement must be demonstrated or risk of loss of accreditation. Any site receiving federal funding must maintain fidelity to the model, or they could lose funding. West Virginia employs two contracted CQI specialists who work

with each site on CQI as needed based upon their data reports and identified needs. Each site must submit a monthly CQI report showing progress related to the CQI project. Attachment A outlines the measures used by PAT® national to monitor fidelity and model compliance.

The HFA® model currently available in West Virginia, known as Mountain State Healthy Families, which is being utilized for expansion through this Title IV-E opportunity, is the evidence-based Signature HFA® model developed and owned by Healthy Families America®. West Virginia's Mountain State Healthy Families provider is an affiliate of HFA® and must be accredited by the proprietor. The accreditation document for Mountain State Healthy Families is provided as part of Attachment E.

When a provider agency becomes an affiliate, they have access to in-person training from an HFA® certified trainer for all positions, including supervisors. HFA® also provides affiliates with technical assistance, which is offered in multiple communication venues, including webinar. There is also technical assistance that can be provided to affiliates who may be new to working with families involved with the child welfare system. West Virginia requires providers utilizing the HFA® program be accredited by HFA® and utilize the best practices standards and participate in fidelity monitoring activities. Staff are sent for two separate weeks of core training by an HFA® certified trainer. Staff also have mandatory online modules (approximately 24 hours provided by HFA® national), additional training on-site by program coordinator and/or their direct supervisor, and approximately six weeks of mentoring with a veteran home visitor. They also are required to complete one week of Growing Great Kids® (GGK) curriculum training by a GGK certified trainer. With the current COVID-19 situation, both HFA® national and GGK® national are piloting virtual trainings. Therefore, in the future, staff will not have to attend mandatory training out of state, but they will still be delivered by a nationally certified trainer. An additional three-day training is required on-site by OMCFH's state team on MIECHV required outcomes and activities.

HFA® requires applicants for affiliation to provide, along with an implementation plan, a detailed description of how HFA® will be implemented within the communities the organization wishes to serve. Accreditation happens after a two-year process that includes core training, application for accreditation and a site visit by HFA®. Site visits for accreditation renewal occur every four years. The current sole provider of this model is accredited through June 2021. National peer reviewers come on-site to review files as well as interview staff, families, and community partners. The affiliate must meet at least 85% of the 400+ best practice standards to be accredited (including certain "safety standards" and "sentinel standards" that must be met to be accredited regardless of the 85%). Site visits are completed by peer reviewers who have completed HFA® Implementation and Peer Reviewer training by an HFA® certified trainer. Program Managers are also required to complete this training, meaning they are certified to be Peer Reviewers whether they actually conduct site visits for other programs or not. There are quarterly Peer Reviewer Community of Practice calls to stay informed. Fidelity to the HFA® Signature model is done through reporting. An annual site report is submitted to HFA® virtually.

The most comprehensive and thorough feedback from HFA® national occurs following a site visit. However, since HFA® Program Managers are required to complete Implementation/Peer Reviewer training, there is an expectation that each HFA® affiliate also self-monitor. HFA® provides formulated spreadsheets for all of the best practice standards that are related to daily activity, so at any given time, it can be monitored by the affiliate's program managers to check trends in meeting those standards. Each

affiliate must also develop and implement an annual Quality Assurance Plan that includes file reviews, supervision observation, home visit observation, monitoring of those spreadsheets and other activities. Each affiliate has an assigned HFA® national technical assistance representative that checks in periodically, or as needed.

If an affiliate's performance is below standards, the corrective action will depend on the deficiency. If it is below standards based on internal quality assurance activities, the program manager or direct supervisor will work with the staff person in question (if a specific person) or use problem solving/CQI-type methods to improve, if an overarching problem. If performance on the standards is below 85% based on a site visit, the affiliate must submit a Performance Improvement Plan and be re-reviewed again within 3-6 months, at which time improvement must be demonstrated or risk of loss of accreditation. Any site receiving federal funding must maintain fidelity to the model or they could lose funding. West Virginia employs two contracted CQI specialists who work with each site on CQI as needed based upon their data reports and identified needs. Each site must submit a monthly CQI report showing progress related to the CQI project. Attachment D outlines the measures used to monitor fidelity and model compliance by HFA® national.

In addition to the fidelity monitoring through PAT® national, each affiliate of these in-home visitation services must also be scored on MIEHCV program outcomes, which are monitored through OMCFH annual site visits using the *West Virginia Maternal, Infant & Early Childhood Home Visiting Quality Assurance/Improvement Annual Site Visit Review* tools, which are included in Attachment G.

Attachment G, pages 1-3, outlines the outcomes, or benchmarks, that will be used to monitor PAT® in West Virginia. Specifically, the six outcomes are:

- Improved maternal and newborn health
- Child Injuries, child abuse/neglect/maltreatment and reduction in emergency room visits
- Improvements in School Readiness and achievement
- Crime and domestic Violence
- Family economic stability
- Coordination and referrals for other community resources and support

The PAT® program was implemented in West Virginia using the established federal MIEHCV review tool criteria as a guide for ensuring West Virginia implemented the programs with measurable outcomes and evidence to show efficacy.

In addition to the fidelity monitoring through HFA® national, each affiliate of these in-home visitation services must also be scored on MIEHCV program outcomes, which are monitored through OMCFH annual site visits using the *West Virginia Maternal, Infant & Early Childhood Home Visiting Quality Assurance/Improvement Annual Site Visit Review* tools, which are included in Attachment G.

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- Improved maternal and newborn health
- Child Injuries, child abuse/neglect/maltreatment and reduction in emergency room visits

- Improvements in School Readiness and achievement
- Crime and domestic Violence
- Family economic stability
- Coordination and referrals for other community resources and support

The HFA® program was implemented in West Virginia using the established federal MIEHCV review tool criteria as a guide for ensuring West Virginia implemented the programs with measurable outcomes and evidence to show efficacy.

While the population of recipients under IV-E will not be funded using MIECHV dollars, the programs will still be part of the established structure of oversight for these evidence-based programs. New providers of PAT® and HFA® will be required to become affiliates of the proprietors and become accredited. The IV-E funded recipients will be tracked independently from the recipients utilizing MIECHV funds in order to allow reporting of outcomes to ACF.

Literature Review

The evidence detailing the use of Parents as Teachers® as a tool to help reduce the number of children under five from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

- The evidence shows that the service is effective in lowering the occurrences of child abuse and neglect;
- The evidence indicates that PAT® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

An example in the literature has shown Parents as Teachers® to be more effective than usual parenting education services at reducing the occurrence of abuse and neglect. There was a significantly lower occurrence of any substantiated child maltreatment in the home-visiting group than in the comparison group (7.8% vs. 9.9%). Home visiting was also associated with lower rates of substantiated neglect (7.5% vs. 9.7%). Results showed that substantiated reports of maltreatment among families receiving home-visiting services occurred later in the child's life than families in the comparison group (Chaiyachati, B.H 2018). West Virginia has seen an increase of children under age five coming into foster care due to abuse and neglect, with nearly half, or 44%, of all children in foster care aged five or younger.

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with PAT®.

The evidence detailing the use of Healthy Families America® as a tool to help reduce the number of children under five from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

- The service has shown to be effective in ensuring child safety;
- The evidence shows HFA® to increase positive parenting practices;

- The evidence indicates that HFA® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

An example in the literature has shown HFA® to be more effective than usual parenting education services at increasing child safety. Mothers in New York who received the service were found to use serious physical abuse less frequently (.03 versus .15 p<01) than mothers in the control group and used non-violent strategies more often (49.27 versus 45.27 p<05) (Dumont 2010). West Virginia, during FY19, reported that half of child fatalities and near fatalities were children aged four or younger with slightly fewer than half of the perpetrators being the child's mother.

As stated previously, West Virginia found young motherhood to be a significant risk factor for children entering foster care, revealing the potential lack of positive parenting practices. One study shows that HFA® increases positive parenting practices. In Arkansas, the mothers who participated in this program had greater parenting self-efficacy (35.1 vs. 34.6 based on the Teti Self-Efficacy Scale, p<.05).

Services that can help mitigate the risk of removal due to substance use disorders are key to decreasing the rate West Virginia removes children. With over 80% of families encountering the child welfare system due to substance use issues, it is vital that services be available to help struggling parents. A study involving mothers in Hawaii showed a significant reduction in one measure of poor mental health … a significant reduction in maternal problem alcohol use and repeated incidents of physical partner violence (Duggan, 2004).

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with HFA®.

Furthermore, West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and Families' *Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia*, the socially necessary services program will be transferred to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for PAT® and HFA® will be incorporated into the retrospective review process. These reviews are described in more detail below in the section *Quality Matters - Continuous Quality Improvement*.

Functional Family Therapy® as a Mental Health Service in West Virginia

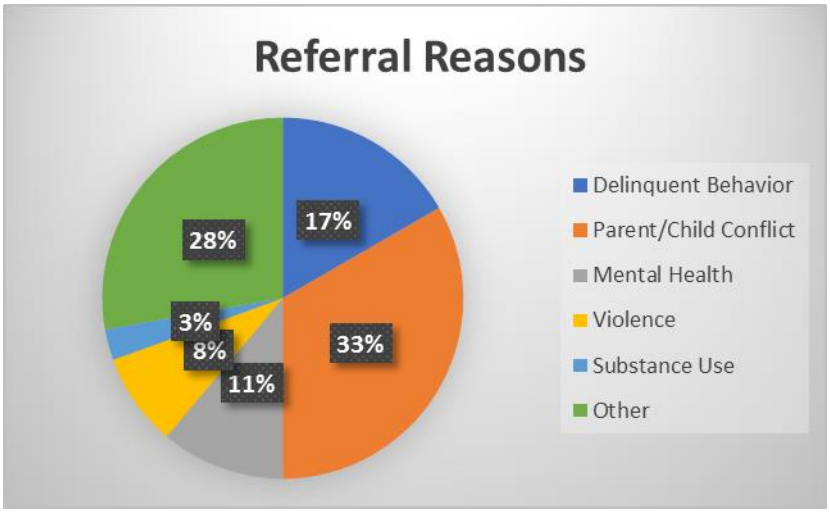
The Functional Family Therapy® (FFT) program was implemented in West Virginia following a 2015 legislative bill that required development of community-based mental health services for youth engaged with the juvenile justice system. Funding has been the primary issue for FFT® not being available statewide. When adopted by the Juvenile Justice Commission to meet the requirements of West Virginia Code §49-4-712, a legislative appropriation was provided in the amount of $1,000,000 yearly. With

training and administrative costs, this amount was not enough to fund expansion to more than a few providers.

FFT® is a well-established, well-supported, evidence-based intervention model utilized in 12 countries, including the United States. FFT® was chosen for inclusion within West Virginia's array of services because it has been shown, among other outcomes, to reduce recidivism as much as 50%. Research and outcomes measures provide compelling evidence of its efficacy. Since West Virginia's families meet the same demographics as those involved in established outcomes, DHHR believes FFT® can help West Virginia in realizing its outcomes for reducing the rate of children entering congregate care settings, improving youth and community safety factors, reducing recidivism rates and reducing out-of-home placements, among other outcomes, as discussed below.

FFT® has the added benefit of cost savings allowing West Virginia to reinvest dollars saved to fund additional preventative community-based programs. West Virginia currently has one FFT® team, consisting of three master's level therapists, with the ability to add five more therapists to their team. FFT® is available in six counties in the northern half of the state. FFT® is primarily utilized to prevent removal of children from the home but may also be utilized to help reunify families when youth have been living in a foster care setting.

Functional Family Therapy®, LLC, the proprietors of the FFT® model, provides internal fidelity controls for the one existing FFT® team in West Virginia. This is primarily accomplished through the required use of the Client Services System (CSS), which monitors therapist contacts with families, diagnosis, demographic information, and referral reasons. The CSS identifies primary and secondary reasons for referrals to the program. These range from youth delinquency behaviors to mental health and substance use problems. The chart below represents referral reasons for active cases in FFY18. The most common referral reason is parent/youth conflict in the home.



Families are more likely to voluntarily accept FFT® services than be required to participate through a court order. Those who are mandated to participate in FFT® do not typically see positive outcomes; the 12% of cases which were court ordered during FFY18 all experienced treatment failure.

FFT® is most often successful when utilized as a voluntary prevention strategy to keep children and families from being separated due to abuse and neglect or juvenile justice involvement. Fifty percent of families who voluntarily participated in services completed the program, and of those, none of the youth were placed outside of the home. This makes FFT® ideal for youth who are at-risk of removal but can be diverted through the utilization of a well-supported service.

The FFT® model currently available in West Virginia, which is being utilized for expansion through this Title IV-E opportunity, was built from the framework of the evidence-based model. The manual and resources supporting West Virginia's FFT® program is: *Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy® for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association.*

Target Population for Functional Family Therapy®

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will be implementing FFT® for 11 to 18-year-old youth who experience behavioral or emotional problems that bring them into contact with the juvenile justice system and meet the criteria to be defined as a foster care candidate. These children will be assessed for eligibility through the completion of the FAST (Family Advocacy and Support Tool).

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment K.

Phased-in Implementation for Functional Family Therapy®

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to current providers for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include children who interface with the juvenile justice system and pregnant and/or parenting youth in foster care.

Expansion of FFT® will require appropriation from the West Virginia Legislature and budget proposals will be drafted for the 2021 legislative session. Future phases will include onboarding new FFT® providers and extending geographic coverage.

Caseloads

The full-time FFT® practitioner carries a caseload of 10-12 cases, depending on the acuity of the family. A part-time practitioner carries a caseload of 5-7 cases. All team supervisors should carry a caseload of up to five cases. The team supervisor monitors caseloads to ensure adherence to caseload standards. Functional Family Therapy®, LLC also monitors caseloads as part of the fidelity monitoring process. Teams can be decertified by Functional Family Therapy®, LLC at any time for failing to maintain the appropriate caseloads. If patterns and trends emerge for providers, Functional Family Therapy®, LLC, contacts the contract oversight staff within DHHR's Bureau for Children and Families.

Monitoring Child Safety

Functional Family Therapy® program staff are considered mandated reporters, as per West Virginia Code §49-2-803. All FFT® staff are trained on child abuse and neglect recognition and how to make a referral to the child abuse/neglect hotline. They are also trained on indicators of self-harm and risks a youth may pose to family or community members. The therapists screen for child and community safety as part of the initial assessment process. If there are any concerns, more specialized assessments, such as those to determine suicide, homicide and/or self-harm, are conducted. An FFT® therapist will implement a crisis plan for a family, if needed. FFT® is contraindicated if the safety issues in the home involve someone who is actively psychotic or whose acuity rate is too high. FFT® would not be put in place, and a referral to another service would be made to stabilize the family before FFT® could be placed in the home.

All DHHR case workers, which include CPS and Youth Services workers, represent the child welfare agency's ultimate responsibility in ensuring the safety for children who remain with their families through the provision of prevention services (See *Ensuring Child Safety* below).

Fidelity and Outcome Measures – Well-Supported Services Evaluation Waiver

West Virginia is submitting an evaluation waiver request for FFT® since it is rated as a well-supported service on the *Title IV-E Prevention Services Clearinghouse*. Participation in FFT® requires that program fidelity be paramount to the process. Functional Family Therapy®, LLC, has embedded quality into its services.

Functional Family Therapy®, LLC's web-based Client Services System (CSS) is the primary tool used to monitor program fidelity. Clinicians are required to document cases using the CSS, which is designed to ensure that goals and interventions at each session are consistent with the family's phase of treatment and the FFT® model. Supervisors and consultants review documentation in the CSS as one way to monitor therapists' adherence to the FFT® model. Therapist alliance with family members, which is emphasized from the start of treatment and is critical to the model, is monitored by the Family Self Report (FSR) and Therapist Self Report (TSR), rating scales completed by the therapist and every family member after the first and second sessions. FSR and TSR scores help therapists identify when an alliance is not developing as it should. FSR and TSR data are gathered during the first 2 sessions of each phase of treatment (Engagement/Motivation, Behavior Change and Generalization).

In addition, specific adherence measures are collected in the CSS and monitored by the site supervisor and Functional Family Therapy®, LLC, the consultant assigned to West Virginia. The supervisor or consultant rates each therapist weekly on several factors based on cases he/she discussed during supervision. At least three times per year, these ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model. The Global Therapist Rating includes two scales: 1) Dissemination Adherence, which is the degree to which the therapist adheres to FFT® protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, responsiveness to community partners, etc.; and 2) Fidelity, which considers both therapist competence (e.g., sophistication of interventions, tailoring treatment to the family) and adherence (e.g., applying the model as intended and doing the "right thing at the right time").

The provider also manages outcomes through use of the following assessment tools administered at pre- and post-treatment, as well as following booster sessions:

- Outcome Questionnaire (OQ) - for all caregivers and adults over 18 to score on themselves;
- Youth Outcome Questionnaire (YOQ) - for all caregivers to score on the identified youth;
- Youth Outcome Questionnaire - Self-Report (YOQ-SR) - for the identified youth to score on him or herself.

At the culmination of treatment, the FFT® therapist administers the following:

- Client Outcome Measure (COM-A) - completed with the identified youth;
- Client Outcome Measure (COM-P) - completed on the caregivers;
- Therapist Outcome Measure (TOM) - completed by the therapist. This tool explores the changes the therapist and family report over the treatment process.

Therapists also document presence of and/or change in risk and protective factors over the course of treatment.

Outcomes are further monitored through data gathered including the following: length of time between referral and first contact (no more than 48 hours), length of time between referral and first session (no more than 7 days), and number of sessions required in each phase of treatment (goal is first three sessions in 10 days).

Longitudinal data is gathered at six months post-discharge, measuring youth who still have continued involvement in the juvenile justice system.

Functional Family Therapy®, LLC, also has their own internal measures for determining program fidelity, which is the Tri-Yearly Performance Evaluation (TYPE Report). The TYPE report is pulled by FFT® three times per year. They send it to the provider and review with them. The provider than has to provide a corrective action plan on how they will fix the areas that are below threshold. This helps ensure fidelity to the model the timeframes and expectations of the program. See Attachment H for a sample report.

Weekly Supervision Checklist: Following every clinical staffing, the clinical supervisor completes a fidelity rating for the case that was reviewed for each therapist. This fidelity rating reflects the degree of adherence and competence for that therapist's work in that case in a specific session. Thus, the weekly supervision ratings are not global, but specific to a single case presentation. Over the course of the year, a therapist may receive up to 50 ratings, which provide the supervisor with critical information about the therapist's progress in implementing FFT®.

Global Therapist Rating (GTR) is another tool to measure therapist componence and adherence to the model. Three times a year the clinical supervisor rates each therapist's overall adherence and competence in FFT®. The GTR allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each phase and general FFT® counseling skills. The GTR specifically targets time period measures with the hope of displaying therapist growth. With respect to the GTR, DHHR

encourages supervisors to utilize the comments box under each phase to target specific strengths and specific phase areas of growth.

Cut-off scores indicate whether the therapist demonstrates satisfactory dissemination adherence and model fidelity, and each therapist has a Learning and Growth Plan to facilitate adherence and competence (Alexander, et. al., 2013).

Functional Family Therapy®, LLC, requires the use of its Client Services System (CSS) by licensed FFT® providers to document the application of treatment and clients' subsequent progress. Functional Family Therapy®, LLC, monitors its licensed providers through this system ensuring compliance with key service delivery factors. Providers who struggle with fidelity are contacted by Functional Family Therapy®, LLC, and provided technical assistance to remedy the identified issues. Providers who are unable to maintain fidelity to the model, after technical assistance is provided, may lose their license.

Unique to West Virginia, the partnership with Functional Family Therapy®, LLC, began as a state funded initiative, therefore, West Virginia also maintains monitoring access through the CSS system and is notified by Functional Family Therapy®, LLC, when providers are struggling to come into compliance with fidelity standards. Upon notification that a provider is struggling with fidelity, the state immediately reaches out to the provider to discuss key issues affecting service delivery and possible solutions.

If the state recognizes poor outcomes through its quarterly reporting requirements, it will initiate contact with the provider prior to Functional Family Therapy®, LLC, involvement. This system has proven effective. It has also helped to identify external factors affecting fidelity, such as referrals for service. These issues are quickly addressed on a systems level with ongoing outreach and education to potential referents.

The FFT® outcome data process is provided with this plan with Attachment H.

West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and Families' *Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia*, the socially necessary services program will be transferred to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for FFT® will be incorporated into the retrospective review process. These reviews are described in more detail below in *Quality Matters: Continuous Quality Improvement*.

Literature Review

The evidence detailing the use of FFT® as a tool to help reduce the number of children aged 11-18 from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

- The evidence shows that the service is effective in reducing problem behaviors;
- The evidence indicates that FFT® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

There are multiple examples in the literature that verify FFT® to be effective at reducing juvenile delinquency, improving behavioral and emotional functioning. A study in Washington State showed that when FFT® was delivered with fidelity by competent therapists, it reduced felony and violent felony recidivism in a cost-effective manner (Baronski, 2004).

When FFT® was delivered to an at-risk group of adolescents in New Jersey as a preventive service, "FFT participants, relative to those in the comparison group, improved more on the Life Domain Scale ($F = 5.571$, $p < 0.05$), the Child Behavioral/Emotional Needs Scale ($F = 8.137$, $p < 0.01$), and the Child Risk Behaviors Scale ($F = 12.459$, $p < 0.001$)" (Celinsa, 2013). Researchers in the United Kingdom found significant reductions in all measures of reoffending and anti-social behaviors at six-month and 18-month follow-up for youth receiving FFT® (Hunayun, 2017).

The reductions in behaviors outlined is compelling for West Virginia since approximately 40% of foster children between the ages of 11 and 18 are coming into contact with the juvenile justice and child welfare systems due to their unsafe behaviors and mal-adaptive functioning issues that manifest in delinquency.

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with FFT®.

Motivational Interviewing – A Complement to West Virginia's Substance Use Disorder Strategies

As outlined, an extraordinarily high number of children are removed due to substance use disorders of their parents or guardians. State Opioid Response grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Ryan Brown Act (passed by the West Virginia Legislature in 2017) and DHHR's Bureau for Medicaid Services have provided West Virginia with significant funding opportunities related to substance use prevention and treatment. The Ryan Brown Act allowed DHHR to provide more than $20.8 million in funding to nine substance use disorder programs to expand residential treatment services across West Virginia. This funding is supported by the Ryan Brown Addiction Prevention and Recovery Fund as part of a comprehensive statewide plan to combat the opioid epidemic.

Motivational Interviewing will be an important complementary service due to its ability to enhance client motivation for behavior change. Motivational Interviewing will be utilized by the providers who deliver prevention services, as well as BCF staff. A more detailed plan for West Virginia's intentions for using Motivational Interviewing will be provided in a prevention plan modification, once West Virginia develops the required infrastructure to meet the requirements of FFPSA.

Trauma-Informed Delivery of Prevention Services

The organizations providing Title IV-E evidence-based services will be required to contractually attest to their adherence to a trauma-informed organizational structure. The MCO will incorporate measures into the retrospective review process to determine the organizations' understanding and ability to recognize and respond to the effects of all types of trauma. The evidence that the MCO will require is as follows:

- Sufficient workforce development in understanding trauma and staff support in sustaining trauma-informed treatment;
- Residents and their families are part of care planning and decision-making;
- Use of data as a driving force with quality improvement; and
- Systemic reviews conducted within the organization.

Title IV-E Claiming-Prevention Services

In order to provide direction to the BCF's IV-E specialists, the IV-E unit program managers developed a new policy specific to Title IV-E claiming. This policy was submitted to the U.S. Department of Health and Human Services Administration for Children and Families as part of the Title IV-E state plan amendment. Attachment I provides further details related to Title IV-E claiming. Section 6.3 of Attachment I provides a detailed guide of components that are required for Title IV-E claiming for foster care candidates.

Child Welfare Workforce Training and Support: Worker Readiness Initiatives for FFPSA and Prevention Planning

One of the most important components of West Virginia's Prevention Plan will be to ensure that the public and private child welfare workforce is well-trained and prepared to implement the provisions of the FFPSA. The child welfare workforce must be proficient in conducting strengths-based, trauma-informed assessments; connecting families to appropriate and timely services; and overseeing and evaluating the continuing appropriateness of services for the families. They must be able to recognize, understand, and respond to the effects of trauma using the principles of a trauma-informed approach to address the consequences of past trauma, and must understand why and how evidence-based practices will be used to prevent children from being removed from their families and to improve outcomes for children and families.

To ensure that the child welfare workforce is ready to implement the provisions of FFPSA, initial training and technical assistance will be focused on conducting high quality, strengths-based assessments; identifying goals and objectives for the family; and monitoring and evaluating the families' progress toward meeting their goals with an emphasis on working with foster care candidates and in-home cases. In September 2018, an existing workgroup was repurposed to develop a plan to integrate the new prevention planning/foster care candidacy requirements into policy, training and case work practice. The workgroup members represented multiple programs within DHHR's Bureau for Children and Families. Part of the scope of work included defining foster care candidacy for West Virginia, streamlining some of the

safety planning requirements and policies, developing a total family assessment process for youth services and incorporating a prevention planning process for both Child Protective Services (CPS) and Youth Services. The new tools that were developed were piloted from February through May 2019, with Youth Services workers from four districts across the state. The response to the new policies and tools was favorable, with several staff requesting to continue using the tools post-pilot. A great deal of emphasis has been placed, both in training and in policy, on the importance of case planning for foster care candidates.

In August 2019, new policies, tools and training were released that focus more on prevention planning and in-home service provision for Youth Services. The first round of changes for youth services included a new assessment tool, the Family Advocacy and Support Tool (FAST), which replaces the Child and Adolescent Needs and Strengths (CANS) as the initial assessment and ongoing assessment for all Youth Services cases. The training and tools also provide skill-building opportunities for Youth Services workers on identifying casework goals and objectives. Marshall University will provide ongoing technical assistance for Youth Services workers and supervisors in their local offices with a monthly regional training for skills development in each region that will include evaluating the continuing appropriateness of services. In the Summer and Fall of 2020, the focus will shift to CPS, concentrating on completion of the revised family assessment tool along with identifying casework goals and objectives emphasizing the provision of in-home prevention services and keeping children from entering the system.

FFPSA training will also focus on recognizing and responding to the effects of trauma using the principles of a trauma-informed approach. The principles of a trauma-informed approach are already infused into new worker and foster parent pre-service training, and both new CPS and Youth Services workers and foster parents must take nine additional hours of trauma training in the first year of employment or first year as a foster parent. Trauma training will be provided to tenured staff through a variety of methods including providing trauma content in all scheduled regional and statewide training sessions and meetings for CPS and Youth Services workers, supervisors, and managers; releasing short video clips and online trainings on trauma; providing training outlines for supervisors to use at unit meetings with their staff; and implementing an online library of readily available content that can be accessed and used whenever a caseworker needs additional information on trauma or other FFPSA provisions. The Bureau for Children and Families is exploring ways to ensure that providers and staff have the same opportunities for ongoing training on trauma-informed care through joint training opportunities and yearly requirements for both public and private providers. The Bureau for Children and Families is also working with colleges and universities in West Virginia to ensure that their degree programs are geared towards a trauma-informed approach and other FFPSA principles, and that information on trauma and other FFPSA provisions is included in foster parent training so that foster parents are knowledgeable and informed.

As the provisions of FFPSA are implemented, training will also be provided so that staff and providers have the knowledge and skills necessary to access and deliver evidence-based services to children and families. Staff will be trained to ensure they understand the components of evidence-based services and the specific requirements of those services as they are used in West Virginia so that they can make appropriate referrals and understand how to monitor and evaluate the services that families receive. Targeted training/technical assistance teams will be deployed to local DHHR offices identified as

struggling through data and quality assurance reviews completed by the Division of Planning and Quality Improvement. Ongoing training will be provided to DHHR staff through web-based and face-to-face trainings designed to educate staff on the evidence-based services along with the referral process to each service to ensure families have access. Providers will be required to be trained on specific evidence-based models selected for use by the state, and their contracts will require they are appropriately certified in the models they administer. Compliance with these requirements will be addressed through contract monitoring activities and other technical assistance and support.

Training that will support the new CPS policy, the new case planning/prevention planning process for foster care candidates and education about Title IV-E prevention services will be provided to DHHR caseworkers in Fall 2020. This training had been planned for roll-out in June 2020; however, the COVID-19 pandemic has diverted valuable human resources to emergency activities. Providers of evidence-based services will be contractually required to provide additional educational opportunities to DHHR caseworkers to prevent "cookie-cutter" approaches to case planning and service selection. This training will also provide DHHR caseworkers with the skills to enhance case planning skills as required for West Virginia's Child and Family Services Review (CFSR) Program Improvement Plan (PIP), as detailed in *Coordination with Child and Family Services Review*.

Consultation and Coordination: Family First Isn't Being Implemented in a Bubble

"Committing to a broader continuum of prevention services that emphasizes primary prevention is contingent on a change of mindset and reorientation of what child welfare is intended to accomplish."

- Jerry Milner, Associate Commissioner, Office of the Administration for Children and Families (ACF), U.S. Department of Health and Human Services

ACF Associate Commissioner Jerry Milner honored West Virginia by addressing some of the state's most influential leaders on December 11, 2018, during a meeting hosted by Casey Family Programs. During his presentation, Mr. Milner urged West Virginia to remember that FFPSA will be a helpful first step in re-visioning child welfare but must be viewed as only one of many tools that states will need. Funding allowances under FFPSA are revolutionary, but additional supports and funding streams will be necessary to affect real change.

The timing of the FFPSA came when West Virginia was already deeply engaged in several initiatives to reform its child welfare system and sustain the advancements brought about by the Title IV-E waiver, Safe at Home West Virginia. FFPSA is a much-needed bridge for families who may not qualify for other support sources. The following provides an overview of West Virginia's commitment to providing a more robust continuum of care to families involved with the child welfare system.

Coordination with Child and Family Services Review

Round three of the Child and Family Services review began in January 2017 with submission of the statewide assessment. West Virginia did not meet substantial conformity with seven CFSR outcomes and four CFSR systemic factor outcomes (Larew, December 2019). An item-by-item review was conducted to determine the factors that impacted scores, the end result being a program improvement plan developed to identify those core influences and develop strategies to improve West Virginia's performance.

One of the contributing factors for low performance for Well Being Outcome 1, Item 13 was the discrepancy between the DHHR caseworker involvement with in-home versus foster care cases. Foster care cases experienced a significantly higher level of DHHR caseworker interaction than cases where children remained in the home. Part of the reason for this was attributed to the insufficient array of services available to families whose children could safely remain in the home. Evidence also suggested that part of the problem was that workers were also unaware of all services within the community.

BCF streamlined the work needed to meet CFSR PIP requirements for in-home cases with the planning for the new provisions of FFPSA for foster care candidates. The work entailed the development of a more effective assessment and case planning process, as well as providing additional guidance related to meaningful contact with families. By enriching the communication and contact, DHHR caseworkers will have an enhanced ability to identify the unmet needs of families, increasing the understanding of needs versus services. DHHR caseworkers will be provided with training on the role of services in the treatment process, and a new section of CPS and Youth Services policy will provide a guide on how to choose services for specific familial issues. DHHR caseworkers will also understand the limitations of services and service providers. The most important component will be that DHHR caseworkers will understand how to stagger services to meet the immediate needs of a family member. Instead of throwing all foreseeable services a family may need onto a prevention plan at once, DHHR caseworkers will be taught that the prevention plan is an evolving document, reassessed at intervals and revised when factors improve or change. A prevention plan should move the family forward throughout the life of the case. Planning for service unavailability will also be addressed.

The evidence-based services available through FFPSA will increase the state's prevention service array for families involved with the child welfare agency. In combination, these converging opportunities for system improvements should reduce the likelihood of children coming into foster care and improve West Virginia's service to families whose children remain in the home.

Coordination with Title IV-B Services

Prevention services that are currently funded through Title IV-B will be coordinated with the Title IV-E prevention services, increasing the array of services available to our families. The DHHR caseworkers will not be required to concern themselves with funding streams or which families can receive FFPSA prevention services. The FFPSA services will be embedded into the service manual and workers will simply choose the best service to meet the needs of the family. Financial coding has been embedded into the SACWIS system to ensure proper claiming for foster care candidates and their families, as well as pregnant/parenting foster youth. The IV-E program staff at BCF will then be able to provide manual oversight, with the enhancements made to the SACWIS, to reduce claiming errors.

The Children with Serious Emotional Disorders Medicaid Waiver

The sustainability planning for West Virginia's Title IV-E waiver project, Safe at Home West Virginia, has been an on-going project and efforts are underway to fund expansion of the project. While the FFPSA funding will help support important service provision, immediate federal funding for Safe at Home West Virginia cannot be anticipated due to the selection of initial services to be reviewed for the clearinghouse.

In April 2019, DHHR's Bureau for Medical Services, the agency that manages the state's Medicaid program, applied for a 1915 (c) waiver. The Children with Serious Emotional Disorders Waiver (CSEDW) is part of DHHR's child welfare reform effort and will provide an array of services that enable children who would otherwise require institutionalization to remain in their homes and communities. The services to be offered under the waiver were chosen due to their compatibility with a wraparound approach:

- Case Management
- In-Home Family Therapy
- Independent Living/Skill Building
- Job Development
- Respite Care, In-Home
- Supported Employment
- Assistive Equipment
- Community Transition
- In-Home Family Support
- Mobile Response
- Non-Medical Transportation
- Peer Parent Support
- Respite Care, Out-of-Home
- Specialized Therapy

In order to truly embed and sustain the Safe at Home West Virginia wraparound into West Virginia's service lexicon in a meaningful way, DHHR is developing a longer-term funding solution. In order to accomplish this, the wraparound service model, upon which Safe at Home West Virginia was designed, needs to be placed on the *Title IV-E Prevention Services Clearinghouse*. Conversations are occurring between consultants from Casey Family Programs, Marshall University, BerryDunn (a national accounting and management consulting firm), and the BCF leadership team related to engaging the provisions allowable under the *Transitional Payments for the Title IV-E Prevention and Family Services and Programs* program instructions memorandum, released on July 18, 2019.

Managed Care for Foster and Post-Adoptive Children

West Virginia Code §9-5-27, passed during West Virginia's 2019 legislative session, requires that medical, pharmacy, dental and behavioral health services for foster children and children adopted through the state's child welfare agency be transferred to an MCO. Traditionally, medical and social needs of foster and adopted children have been managed by the case worker, in conjunction with the Multidisciplinary Team (MDT). This process has proven ineffective in ensuring the child receives wholistic care or preventing adoption dissolution. Often, the worker is unaware of medical histories, having to rely on family members to provide necessary information. The goal with an MCO is to engage the family and the case worker in service planning and provision, creating more efficiency and preventing delays in children receiving medical care. The role of the MCO will be to track down medical history and coordinate care to prevent duplication, creating greater opportunities for CPS and Youth Services workers and the MDT to receive complete information for planning purposes. The MCO will also be instrumental in developing services to assist in keeping families in the home when possible, as it will be financially beneficial to create a continuum of in-home, community-based care.

Additionally, DHHR is including socially necessary services under the MCO contractual umbrella. The MCO will, however, sub-contract socially necessary services to the current administrative services organization, which is Kepro, for day-to-day operations of the program. The reason for the transfer of socially necessary services to the MCO was one of continuity. Because socially necessary services, under which Title IV-E Prevention Services will fall, are provided to both in-home families and families whose children are in custody, it would have caused logistical issues, and potential interruptions in services, for families to be transferred back and forth between an MCO and an ASO when custody changes occur. The MCO will not have a hand in the day-to-day operation of socially necessary services but will be able to provide resources to develop new services or innovations that support keeping children with their families.

The MCO procurement process began in July 2019, with implementation beginning on March 1, 2020. The MCO will be instrumental in partnering with the providers and DHHR in transforming the behavioral health and socially necessary systems and identifying service gaps to enhance West Virginia's service array. This organization will also be required to serve recipients of socially necessary services who are not in foster care. More information can be found in *Quality Matters-Continuous Quality Improvement.*

Ensuring Child Safety - Children and Families are Served Safely in the Home

Over the past two years, a team of Bureau for Children and Families' subject matter experts have been working on a process to streamline and enhance efficiency of decision making and safety planning for Child Protective Services and Youth Services.

Youth Services

The primary goal for youth services was to implement a decision-making model that assessed the family and not just the child. Traditionally, this population of youth have been served in somewhat of a vacuum. Services offered were often only directed toward the youth, isolating him/her from the family unit.

West Virginia's Family Advocacy and Support Tool (FAST) is a product developed in collaboration with Chapin Hall and the Praed Foundation. This tool will allow a Youth Services worker to better understand family dynamics that are impacting not only the youth's behaviors but also factors that influence the safety of the youth and community.

Safety and case planning for Youth Services will take on a much broader perspective, not focusing solely on the isolated behaviors that led the youth to the juvenile justice system. Having a full picture of the needs and strengths of the entire family will allow the worker to develop case plans that address behaviors and influences. Youth Services families will receive wholistic services geared to build upon each member's strengths and provide services to mitigate conditions that make children and communities unsafe.

FAST will also be instrumental is assisting Youth Services workers with monitoring outcomes, quickly identifying where a family may be losing ground. FAST and its plans will be revisited with the family every 90 days, at a minimum, to track a family's success. However, re-visitation of a safety plan will be done at any time there is an indication of crisis. Youth Services workers began the process for utilizing FAST on September 13, 2019.

There is a formal safety plan for families accessing the Youth Services system. This plan's purpose is to neutralize identified safety threats using safety resources such as service providers and extended family. This concept will allow Youth Services workers and other stakeholders to reframe how they have historically served youth. It is important for Youth Services workers to understand that many youth who commit status offenses, and other low-risk crimes, achieve better outcomes if served at home. The Youth Services worker will evaluate for safety during each home visit. At any time the youth is unsafe, the Youth Services worker will understand the next course of action to take.

A new case plan was developed to support the information that would be gathered with FAST. Prior Youth Services assessment models focused only on the functioning of the young person who committed the status or criminal offense; there was minimal insight into the family dynamic that may be contributing to the unsafe behaviors of the youth. FAST allows the worker to assess each family member individually and as part of the family until to determine service needs to reduce risk of harm to the youth and/or his community. The Youth Services policy has also been updated to create more guidance to staff about the importance of family engagement.

The process for Youth Services begins with an Immediate Safety Threat Assessment. This assessment is conducted upon initial contact with the family and is continued, informally, at every subsequent visit. During this process, the Youth Services worker verifies that children in the home are safe from Immediate Safety Threats. If Immediate Safety Threats are identified in the home, the Youth Services worker contacts their supervisor to request a Child Protective Services worker respond. The CPS worker is required to review the Youth Services worker's assessment, verify its accuracy, and implement

an immediate safety plan. This plan is revisited frequently, and the CPS worker will initiate a full CPS investigation which is required to be completed in seven days. If the Immediate Safety Threats cannot be resolved, and there is no support network to provide for the safety of the child, the CPS worker will pursue custody of the child through the initiation of an abuse and neglect petition. The Youth Services worker will then proceed to complete the FAST assessment. This assessment serves as the initial, ongoing, and Impending Safety Threat assessment throughout the life of the case.

FAST, along with the Progress Evaluation Tool, provide valuable insight into the continued risk of a child to enter foster care. FAST scores items on a scale: 0 – No Need; 1 – Watchful/Waiting; 2 – Action Needed; 3 – Immediate Action Needed. This ranking is based on interviews, observations, child/family specific behaviors, provider reports, medical or clinical assessments, and other relevant documentation. These scores are designed to be modified anytime there is a change in circumstance and indicate the need to conduct a formal case review process. Children and their caregivers can either move up in score indicating a heightened risk of placement or move down in score indicating a lowered risk of placement. Certain FAST items are designed to also determine a safety threat to the child or to the family.

A youth's running behavior, high risk behaviors, or peer influences are just a few of the factors which may indicate the child's safety is in jeopardy. When assessing safety utilizing FAST, the worker has a clear indication when a safety plan must be implemented in conjunction with a prevention case plan. The child's worker is required to obtain information relevant to the child's and caregiver's safety and functioning monthly through provider reports, contacts with the family, or other collaterals.

The Progress Review Tool is designed to evaluate the progress toward an individual's goal achievement. Together, these two measures clearly indicate to a Youth Services worker and the family whether the indicated intervention or Title IV-E prevention service is working, reducing the risk of out-of-home placement, or whether the intervention is not working, increasing the risk of out-of-home placement. FAST categorizes needs in three distinct ways: Considerations, Target Needs, and Anticipated Outcomes.

Considerations

These needs are items scored 2 or 3 that should inform or guide service delivery. These needs can often be thought of as things that cannot change, such as a developmental disability or being a witness to school, family or community violence. Considerations, also known as background needs, should guide the intervention strategy.

Target Needs

Target Needs are items scored 2 or 3 which should be the focus of treatment. Effective intervention in these areas create change. Items such as mental health and substance use, if treated, will likely result in improvements in other areas.

Anticipated Outcome

These are needs that likely do not need treatment because they will change once a Target Need has been met. Organizing needs into these three categories will help focus treatment in the most appropriate areas and help families understand where the priority of treatment lies. If a Title IV E

prevention service targets the appropriate treatment need, one of the anticipated outcomes will be a reduction in safety threats.

Likewise, when a youth's scores increase in need across several areas, it is a clear indication the intervention must change. When scores begin to decrease, the Youth Services worker must begin to determine if the youth's and family's continued needs can be met through community services outside of the department involvement and whether the family maintains motivation to continue towards goal achievement.

If the Youth Services worker determines that the youth's or family's needs are increasing and the goals are not being achieved, the worker must explore with the family and provider the changes necessary to meet the youth's needs. Exploration of this topic must include a review of the individual service, the motivation of the youth or family, and the possibility that temporary placement outside of the home may be required. If placement outside of the home is the only feasible resolution, the worker will take the necessary steps to initiate a Multidisciplinary Treatment Team to discuss placement options.

The FAST, safety planning, on-going safety evaluation, prevention and case planning are all responsibilities of DHHR's Youth Services worker. All DHHR case workers, which include Youth Services workers, represent the child welfare agency's ultimate responsibility in engaging families whose children are at-risk of removal. Active cases are maintained by Youth Services workers until services are no longer needed and there is low risk of harm and/or removal. The Youth Services policy has been provided with this plan as Attachment J.

Child Protective Services

Child Protective Services (CPS) is undergoing changes to terminology and documentation requirements intended to more closely align and simplify the Youth Services and CPS programs, realigning focus on child safety and family needs. CPS workers have identified several barriers to timely completion of assessments, family visits and planning. These barriers mostly center around burdensome documentation requirements, redundant processes and the use of the outdated SACWIS system. As West Virginia continues in its new CCWIS design sessions with implementation still more than a year away, the need to remove these barriers remained imminent. As such, the state underwent months of planning to enable CPS workers to complete their mandates while reducing documentation burdens. These changes will be implemented through a phased-in approach. The phased-in approach will allow the state to ensure adequate oversight of the implementation and provide intensive technical assistance to workers and staff as needed. The first group of counties was targeted for implementation in June, however, due to the global pandemic, the implementation has been delayed until fall, currently targeted for September 2020.

The process for CPS begins with an Immediate Safety Threat assessment. If a Child Protective Services worker identifies an Immediate Safety Threat, the worker implements a safety plan to protect the child. The plan must be a concrete strategy to protect the child prior to leaving the family and situation. Once the worker and family believe they have a plan, the worker will contact their supervisor and ensure the planned actions are sufficient to control child safety. The worker will then immediately begin the Initial Assessment process to determine whether abuse and neglect have occurred and the presence of any Impending Safety Threats. When an Immediate Safety Threat has been identified, the worker will only have seven days to complete the Initial Assessment process and must maintain frequent

contact with the family to assure the continued efficacy of the Safety Plan. If the Initial Assessment identifies the need for a case to be open, the case will be transferred to an ongoing caseworker. The ongoing caseworker will immediately revisit the safety plan with the family, make necessary changes, and begin the Ongoing Assessment process. The Ongoing Assessment is informed by interviews with the family, collaterals, medical and clinical assessments, and other records as appropriate. Once the worker has identified the needs and strengths of the family, they will proceed to prevention case planning. The Ongoing Assessment process will require the documentation of the Impending Safety Threats identified, the strengths (Protective Factors) and needs of the caregivers, and the strengths and needs of the children. The presence of an Immediate Safety Threat is directly correlative to the needs and diminished strengths, or diminished Protective Factors, of the caregivers.

When developing the prevention case plan with the family, the worker will indicate the Impending Safety Threats found and pair with the associated needs. These are the treatment targets. The worker will help the family identify goals necessary to enhance their Protective Factors and meet their needs. Protective Factors, when appropriate, are used to develop goals for the prevention plan. This process helps a family understand how to continually utilize their own strengths to meet their needs long after DHHR involvement has ended. Once this is accomplished, the appropriate service will be identified and added to the prevention plan. The Ongoing Assessment is intended to be revisited every 90 days or sooner, as circumstances change. The child's CPS worker is required to obtain information relevant to the child's and caregiver's safety and functioning monthly through provider reports, contacts with the family, or other collaterals. Through this process, the worker will be able to identify any changes needed to ensure safety and treatment progress. Formally, the case worker reviews the case plan, safety plan, and assessment minimally every 90 days. The worker will utilize the Progress Evaluation Tool to determine the family's progress toward meeting their individualized goals.

If the worker determines that a caregiver's needs are increasing, additional safety threats are identified, or the goals are not being achieved, the worker must explore with the family and provider the changes necessary to meet their needs. Exploration of this topic must include a review of the individual services on the prevention plan, the motivation of the caregivers, and the possibility that temporary placement outside of the home may be required if safety cannot be maintained. If placement outside of the home is the only feasible resolution, the worker will take the necessary steps to adjust the safety plan to identify a placement resource and commence the filing of a petition with the court.

The assessments, safety planning, on-going safety evaluation, prevention and case planning activities are all responsibilities of DHHR's CPS workers. All DHHR case workers, which include CPS workers, represent the child welfare agency's ultimate responsibility in engaging families whose children are at-risk of removal. Active cases are maintained by CPS workers until services are no longer needed and there is low risk of harm and/or removal.

The draft CPS policy, originally set for release on May 1, 2020, has been postponed to September 2020 due to the COVID-19 pandemic, which has diverted valuable human resources to emergency activities.

The draft Child Protective Services policy has been provided with this plan as Attachment L.

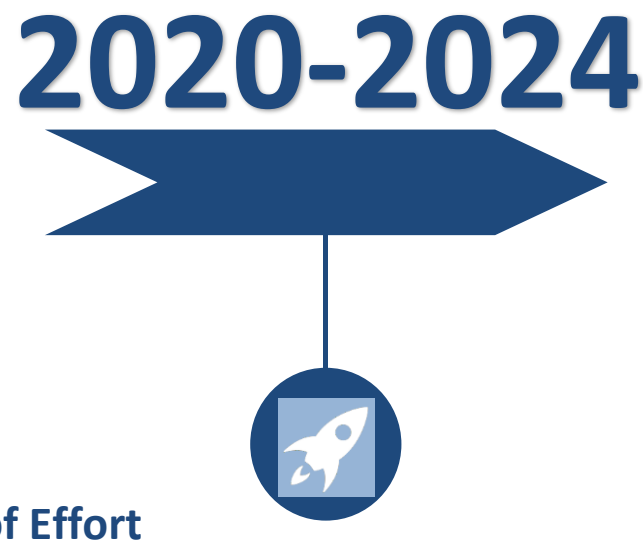
Prevention Caseloads

Youth Services workers carry a mixed caseload of both prevention and court-involved families. The prevention cases are comprised of youth (and their families) who are working with the child welfare agency to remediate the issues that resulted in the youth committing a status or juvenile delinquency offense. These youth may have court oversight and receive Title IV-E prevention services to divert the need for placement or have been in a court-ordered placement and are returning home. The targeted mixed caseload for Youth Services workers is 1:12.

The Bureau for Children and Families uses a caseload ratio calculation when allocating Youth Services worker positions to the district offices. When one district's caseloads tip over the caseload standard, they become eligible for position allocations when vacancies arise in counties that do not have critical caseload overages.

Child Protective Services caseloads are separated into initial assessments/investigations and on-going services. The on-going caseload is a mix between prevention and court-involved families. The prevention cases will be comprised of children who have come to the attention of the child welfare agency through an abuse/neglect referral and who have been identified as unsafe and at imminent risk of removal; children who are returning home from a court-ordered placement; and children who were adopted through the child welfare system and are experiencing risk to the stability of the adoptive relationship. The targeted in-home caseload for CPS workers is 1:10.

The Bureau for Children and Families uses a caseload ratio calculation when allocating Child Protective Services worker positions to the district offices. When one district's caseloads tip over the caseload standard, they become eligible for position allocations when vacancies arise in counties that do not have critical caseload overages.



Maintenance of Effort

In August 2019, Casey Family Programs sponsored a two-day collaborative session with Dennis Blazey, an independent contractor who provides financial consultation to state child welfare agencies as part of the technical assistance services offered by Casey Family Programs. Mr. Blazey provided consultation on key policy and finance projects related to FFPSA and other social services initiatives. The consultation services helped West Virginia determine the maintenance of effort calculation, which is zero.

The calculations are detailed in Attachment V.

Quality Matters – Continuous Quality Improvement

West Virginia has partnered with an administrative services organization since 2004 to provide continuous quality monitoring and improvement strategies for West Virginia's socially necessary services program. Effective January 1, 2020, West Virginia's new MCO became contractually required to perform administration services organization management services not only for all medical and dental services but also for all socially necessary services for foster children, post-adoptive children and foster care candidates. The Title IV-E prevention services that West Virginia will be providing will be embedded into the current utilization management structure as all other socially necessary services. Contracts outlining performance requirements for providers of socially necessary services were implemented in July 2018, which require providers to achieve a score of 80% or higher during retrospective quality assurance reviews.

The "80% Rule," which has been in effect since 2015, requires that socially necessary services providers score at least 80% during their retrospective on-site review. The retrospective review is conducted by the ASO, as part of their contractual relationship with the MCO, at least every 12 months. If the provider scores less than 80% on any service they provide, the provider receives written notice that a six-month probationary period is in effect. Training and technical assistance is offered during the probationary period. After the six-month probationary period ends, the administrative services organization conducts another on-site review on the service(s) scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider's service offerings, 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 array of services. There will not be a six-month probationary period when a safety service scores zero.

The retrospective review tool that is used by the ASO, as part of their contractual relationship with the MCO, will be revised to meet the needs of capturing outcomes and fidelity measures to the models for the Title IV-E prevention services through a public-private partnership that will include providers of each prevention service.

The Bureau for Children and Families currently determines qualitative data and customer satisfaction for socially necessary services through client focus groups. These focus groups are conducted with recipients of all services offered through the socially necessary services program. The results from the focus groups are shared with Bureau for Children and Families managers, the service array workgroup and the socially necessary services providers for improvements to be made to programs. These focus groups will continue with the new MCO, as part of their continuous quality improvement processes.

The Division of Program and Quality Improvement, housed within BCF, will utilize its CFSR-style reviews to collect data for CQI monitoring of outcomes, unmet needs and service availability. This will ensure that West Virginia is capturing specific service-related patterns as they develop. There will be reference to unmet needs within each CQI review that will be compiled for the CFSR service array workgroup, the entity responsible for ensuring availability of adequate services for families who are served by West Virginia's child welfare agency. The program manager for the service array is the key player in using the focus group results and DPQI unmet needs data to inform the community collaboratives about service development work and system improvements.

Additional Outcomes Monitoring

An important provision of the MCO contract will be the enhanced outcomes monitoring of socially necessary services for all foster care candidates. DHHR will use the established outcome measures that have been demonstrated by research and have been embedded into each evidence-based service. The outcomes developed for West Virginia with Functional Family Therapy®, LLC, will continue to be used as outlined in Attachment H.

DHHR's Bureau for Children and Families will partner with DHHR's OMCFH to utilize the established state and federal outcome measures for the two in-home visitation programs through MIECHV, as mentioned above and outlined in Attachment G.

Prevention Program Reporting

The Bureau for Children and Families has developed a new statement of work with Optum, the organization under contract for development of WV PATH, a comprehensive child welfare information system (CCWIS) to add the FFPSA minimum data/reporting requirements into FACTS, West Virginia's SACWIS. The first round of data is due to the U.S. Department of Health and Human Services Administration for Children and Families in 2021. The release date for this provision was October 1, 2019. These data sets are also being imbedded into WV PATH which will replace DHHR's FACTS in 2021. The minimum data requirements are:

- The specific prevention services provided to the child and family;
- The total expenditures for each of the services provided to the child and/or family;
- The duration of the services provided;
- If the child was identified in the prevention plan as a child who is a candidate for foster care:
    - The child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a child who is a candidate for foster care in a prevention plan; and
    - Whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period; and
    - Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity).

See Attachment I: *State Title IV-E Prevention Program Reporting Assurance*

Workforce Support: Now and Into the Future

Technical Assistance: Casey Family Programs Supports CFSR PIP

During West Virginia's planning for the reforms to its child welfare system, it became evident that the impact on Child Protective Services and Youth Services staff could be devastating if the supervisors were not prepared for the implementation of these initiatives. Casey Family Programs has been instrumental in responding to the technical assistance needs that have created barriers in West Virginia for many years. For that reason, BCF's Commissioner Linda Watts reached out to Casey Family Programs to help determine the best approaches to prevent chaos in the field during the roll-out of changes.

One of the first initiatives was supervisory skill-building workshops to front-line supervisors to strengthen their understanding of the importance of case planning and meaningful supervisor/worker interactions. Reflective supervision skills were taught to all front-line supervisors over several multi-day workshops beginning in late 2018 and lasting through summer 2019. Casey Family Programs brought Sue Badeau, a national child welfare speaker and author, to West Virginia for each workshop. Ms. Badeau has targeted specific counties that experience crisis-level turnover rates for additional supports for their supervisory staff that will continue over the next year.

Meaningful program-related supervisory training has not been historically available to new supervisors. As part of CFSR PIP, BCF will provide more training and resources to front-line supervisors. Over the next five years, the Reflective Supervision model will be prioritized to continue the work in strengthening the relationship between worker and supervisor begun in 2018. The model's benefits include teaching managers how to provide productive space for case reviews to occur between supervisor and worker. Reflective Supervision will be complemented with other skills-based training for supervisors, including how to work with non-custody prevention cases and recognizing the unique case requirement for in-home safety planning. Since West Virginia's child welfare agency does not have the true ability to limit the number of cases a worker can carry, the Reflective Supervision initiative for supervisors will assist in managing prevention caseloads by giving them the proper skills to engage in meaningful case reviews, identifying issues within families and selecting interventions that create change and not placing services in the home just to have a service documented.

Operationalizing the Reflective Supervision initiative will be the development of a Standard Operating Procedure to assist DHHR caseworkers and their supervisors on how to make meaningful contacts and interactions with families. This guide will provide an overview of the goals of a meaningful visit with the family to help them achieve better treatment outcomes. By placing focus on prevention caseloads, West Virginia could stop the increase of children entering foster care.

Regional management meetings held twice per year, including line supervisors up to the Commissioner level, will help reinforce the professional development initiatives described above. These meetings will provide skills building workshops related to FFPSA and other child welfare initiatives, self-

care opportunities and ways to deal with secondary trauma of caseworkers. For more information about these activities, please review West Virginia's CFSR PIP.

Casey Family Programs also sponsored two day-long workshops to assist the financial planning efforts as West Virginia plans for evidence-based practice spending, exits the Title IV-E waiver and transitions back to traditional IV-E claiming. These workshops helped key leaders within the Bureau for Children and Families develop tools and theories to assist with budget planning.

Casey Family Programs will continue to provide access to national experts on topics such as front-line worker support, evidence-based programming, IV-E claiming, asset allocation and other topics as they are identified.

Court and Stakeholder Education: Child Welfare Partners with the Court Improvement Project

As part of DHHR's partnership with the Supreme Court of Appeals, which holds West Virginia's court improvement program (CIP) grants, there have been multiple, targeted engagement activities related to FFPSA in place since summer 2018. These activities included community engagement forums and trainings across the state for a broad child welfare audience, as well as targeted judicial training on the provisions of FFPSA for the state's circuit court judges. The training collaboration included a more intense workshop in September 2019 for recently elected as well as tenured judges that utilized case scenarios. Participants were led step-by-step through the prevention services and explored how the new non-family placement options could be used as a complement to community-based treatment.

One of the paradigm shifts West Virginia will need to make is only utilizing congregate care to meet specific treatment needs or short-term homelessness. CIP cross-training sessions for spring 2020 are currently being planned, and there will be presentations on FFPSA and the CSED Waiver. These presentations will be delivered in conjunction with the new MCO to help participants learn how the MCO will be utilized to support the expansion of community-based services in West Virginia.

The intent over the next five years is to provide opportunities for circuit court judge engagement at their bi-annual conferences and statewide child welfare trainings about FFPSA prevention services and how they support the ongoing child welfare reforms. CIP and DHHR were to hold a judicial workshop in June 2020, with support from Casey Family Programs, that would utilize national judicial experts to further engage the judicial community. However, the COVID-19 epidemic prevented the workshop from occurring. It will be rescheduled for a later date. The hope is that utilizing external credible sources, especially those viewed as peers, will go a long way in assisting West Virginia meet its goals.

Looking Ahead - Increasing Evidence-Based Programming in WV

In realizing the vision to develop a proactive system which preserves safe and healthy families, West Virginia is committed to showing meaningful and measurable improvement in increasing its reliance on in-home community-based services and reducing its usage of out-of-home care, especially congregate care. The expected goal is to meet national standards for congregate care usage by mid-2024.

The five-year prevention plan will be a dynamic, ever-evolving document. West Virginia anticipates making regular amendments which will occur as future waves of evidence-based programs are added to the *Title IV-E Prevention Services Clearinghouse*. West Virginia will embrace services that meet target population needs as they become available instead of waiting for annual progress and services report to make changes. High-quality, in-home programming will enable West Virginia to experience sustained improvement in its child welfare system to benefit the state's families and children.

Citations

1. Vulnerable Families: A Public Health Analysis of West Virginia Children in Foster Care. Christina Mullins and Sarah Sanders, September 2019.
2. Mercer County Families First. U.S. Department of Health and Human Services – Administration for Children and Families HHS-2019-ACF-ACYF-CA-1559 Grant Application Abstract. Amanda Banks, Ph.D., 2019.
3. West Virginia Safe at Home Semi-Annual Progress Report. Public Consulting Group (PCG). May 2019.
4. Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A Functional family therapy for adolescent behavior problems. Washington, DC, US: American Psychological Association. 2013.
5. Child and Family Research Partnership. University of Texas at Austin. The Top 5 Benefits of Home Visiting Programs. June 2015.
6. Larew, Rhonda. West Virginia's Child and Family Services Review Program Improvement Plan. December 2019.
7. Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. Child Abuse & Neglect, 79, 476-484.
8. DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., ... & Greene, R. (2010) . A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment? Rensselaer, NY: New York State Office of Children & Family Services and Albany, NY: University of Albany, State University of New York.
9. Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. Child Abuse & Neglect, 31(8), 829-852.
10. Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. Child Abuse & Neglect, 28(6), 623-643.
11. Barnoski, R. (2004). Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders. Olympia, WA: Washington State Institute for Public Policy.

12. Celinska, K., Furrer, S., & Cheng, C.-C. (2013). An outcome-based evaluation of Functional Family Therapy for youth with behavioral problems. OJJDP Journal of Juvenile Justice, 2(2), 23-36.
13. Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. Journal of Child Psychology and Psychiatry, 58(9), 1023-1032. doi:10.1111/jcpp.12743.