WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia
Strengthening families & children within their home communities

Initial Design and Implementation Report

3rd Quarter

August 2015

West Virginia Department of
Health and Human Resources

Bureau for Children and Families

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I. Demonstration Overview

Focus on Congregate Care

Congregate care, for older youth, often becomes a life style. Some youth experience multiple congregate care placements and never return home until they age out of foster care at age 18 or 21. Congregate care programs are highly structured in order to manage youth behaviors, limiting individual development opportunities.

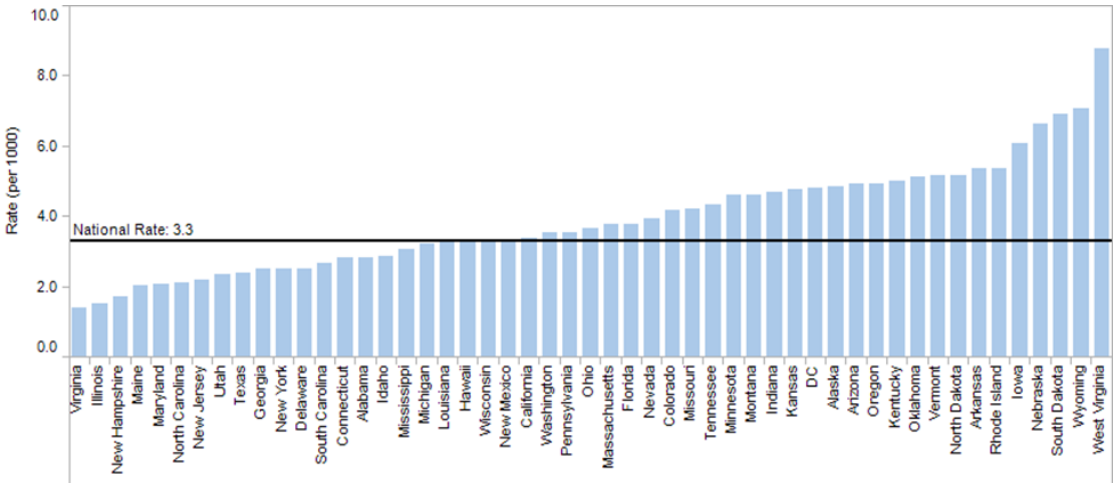
Considerable research and child development experts attest to the negative developmental impact of congregate care facilities on younger children, as well as teens. Adolescents need more than behavior control (provided by congregate facilities); they need support and guidance geared specifically to their individual developmental levels, allowing them to take on more responsibility over time.

Removal from home and separation from primary relationships, even when child safety is a factor, causes trauma and suffering to be compounded for the child or youth. Even youth with special needs thrive when their needs can be safely met in a family setting with people who care about them. Congregate care needs to be understood and utilized only as a short-term intervention; a service that can be used for youth who need extra supervision and structure. These behaviors can usually be de-escalated in three to six months, when the child can be returned to a family setting. (The Annie E. Casey Foundation. ©2010. Rightsizing Congregate Care. Baltimore, MD: Washington, Tanya and Behan, Chris. Retrieved from www.aecf.org.)

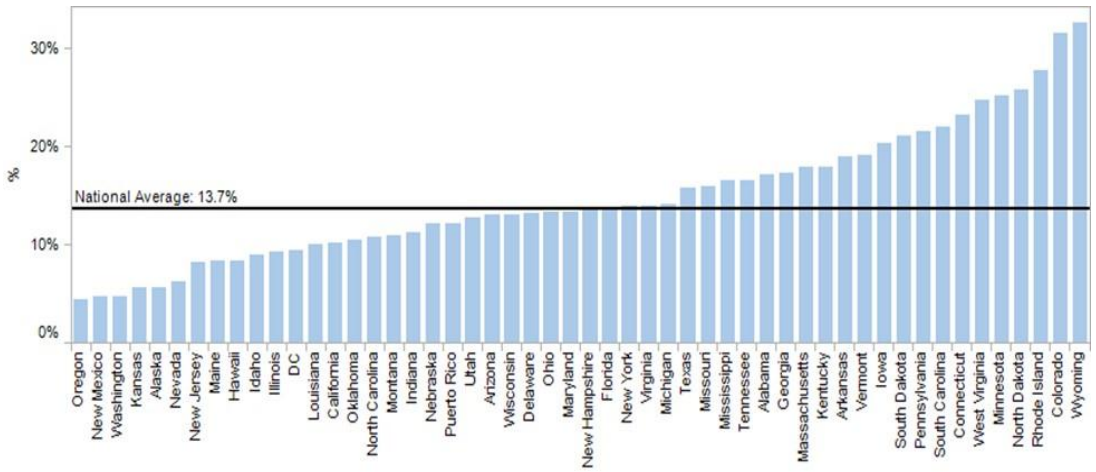
West Virginia Youth and Families

West Virginia continues to struggle with the rate by which children are entering care and the rate by which children are placed in congregate care settings. West Virginia's fiscal year 2013 data shows that we had 3,263 children ages 0 through 17 who entered care. Of the 1,488 children 12-17 years of age, 71 percent of those youth were placed in congregate care.

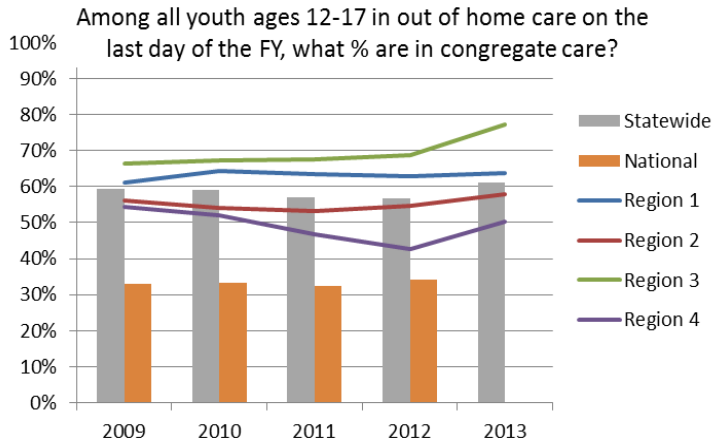
Our state continues to have an increase in the number of children entering care. According to the National Profile, West Virginia's children are more likely to enter out-of-home care during the year than those in other states. During FFY 2013, 3,263 children ages 0 through 17 entered care. In FY12, the entry rate in West Virginia was 8.6 per 1,000 children in the population. This is nearly three times the National entry rate of 3.3.



West Virginia has a long history of reliance on out-of-state care. While the trend of children placed in out-of-state care had shown a steady decrease over several years, the numbers increased in 2013. Based on data from the National profile (FY11), West Virginia has the 6th highest percentage of children placed in congregate care settings. Although West Virginia's children placed out of state may be in a setting other than congregate care, the percentage of those in the target population is extremely small.



West Virginia data indicates that 61 percent of youth ages 12-17 who were in care on September 30, 2013, were in congregate care. This is an increase from the proportion in group care in FY12 and is considerably higher than the national indicator. Among youth in out-of-home care in October 2014 in Phase 1 counties (explained later in this report), 76.5% were in congregate care.



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

- One child and family team across all service environments;
- The family's wraparound plan unifies residential and community treatment;
- Wraparound helps families build long-term connections and supports in their communities;
- Provides concurrent community work while youth is in residential care for a smooth transition;
- Reduces the occurrence and negative impact of traumatic events in a child's life;
- Access to mobile crisis support, 24 hours per day, seven days per week; and
- Crisis stabilization without the need for the youth to enter/re-enter residential care.

The System of Care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access, and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. West Virginia adopted the System of Care values over 20 years ago, and since that time, a great deal of work has been done to embed the core values into our case work practices. Child welfare policies and practice curricula have been revised to be more family-driven and youth guided, community-based, and culturally/linguistically competent. Although *Safe at Home West Virginia* is not a system of care model, it is a true high fidelity wraparound model that incorporates system of care principles.

West Virginia has a history with wraparound. The state previously piloted a wraparound approach titled Next Step Community Based Treatment (CBT) that began in the central, Region II area of the state. CBT was developed through a System of Care grant in the late 1990s. The Region II area experienced positive outcomes in reducing out-of-community placements and increasing services and supports that kept children with their families.

In a report written in December 2003, the wraparound program that operated in the Region II area (which includes some of the same counties we are using for this initiative) had served 165 children over the prior two years. During that time, data was collected through Marshall University and was compiled. The information was collected on families that agreed to participate in the outcome study at the time they entered into the wraparound program and every six months thereafter for the two year period. Not all families agreed to participate in the outcome study.

The results of that study showed: 89% of children were able to remain at home after six months and 83% after one year; 64% of children had a reduction in symptoms of his or her behavioral health condition(s); 52% reported improvement in the day-to-day functioning of the children; 68% of children showed an improvement in emotional strengths, which they reported helped them deal with their problems; 58% of children showed improvement in their grades or maintained their already "A" or "B" average in school; 55% of families reported that the family was functioning better; and 72% of families reported that the caregivers' stress levels improved.

After Region II experienced success, CBT was implemented statewide but faced many challenges. The other three regions of the state did not have the infrastructure and support from the communities that Region II had built over several years. Fidelity of the model could not be maintained and funding challenges saw the end of CBT. Being keenly aware of this, BCF is working with our sister bureaus of Behavioral Health and Medical Services as well as our providers to address shortcomings in other areas of the state.

Many things have changed in West Virginia since the ending of CBT. Probably one of the most important occurrences was the convening of the Commission to Study Residential Placement of Children. The Commission was created by an act of the 2005 West Virginia Legislature to achieve systematic reform for youth at risk of out-of-home residential placement and to establish an integrated system of care for these youth and their families. This focus was broadened with several recommendations made by the Commission in its May 2006 report *Advancing New Outcomes* that include all children and their families in out-of-home placement and those at risk of out-of-home placement. With the release of their 2013 Annual Progress Report and Future Direction paper, the Commission prioritized 10 goals that will make the most significant difference in improving outcomes for children, youth, and families. The Commission supports the continuation of the work to educate stakeholders on

System of Care philosophies. The group has been instrumental in assisting the Department of Health and Human Resources to broaden its ability to collaborate with other stakeholders in the development of a service array to improve outcomes for children, youth, and their families. Because of the 10 years of hard work, a framework of philosophies about the needs of children and youth in out-of-home care, or at-risk of out-of-home care, has already been created that will enhance West Virginia's ability to achieve outcomes. *Safe at Home West Virginia* is a continuation of that work.

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

Standardizing and Sustaining

Many youth are placed into congregate care due to a lack of a comprehensive universal assessment early after initial referral/contact that would guide decision making based on established thresholds. Many times, youth are being placed out of home, perhaps unnecessarily, based on more subjective decisions than those that would be made by an assessment of the needs and strengths of children and families guided by a more objective threshold that would indicate levels of interventions needed. There is also a culture in West Virginia that equates safety and treatment to bricks and mortar. We believe that as we implement *Safe at Home West Virginia*, we will have the ability to implement the Child and Adolescent Needs and Strengths Assessment (CANS) universally across child-serving systems in West Virginia at early points of involvement in the system; develop thresholds to guide decision making about levels of care; and educate our system partners to base decision making on assessed needs and strengths of children using a common assessment language. This action across child-serving systems will lead us to better utilization of our resources, a shift in culture, more accountability, and a clear data-driven understanding of needed community-based program development. At present, our staff and providers have been trained in WV CANS and certifications have been awarded. The CANS Super User Oversight Task Team, a

cross disciplinary workgroup, is also in the process of completing development of CANS 2.0.

West Virginia has completed its expansion of the CANS to CANS 2.0 and it has been approved by all interested parties and Dr. Lyons. It was sent to formatting on the week of July 23rd. One of West Virginia's placement partners volunteered their IT department to do the formatting.

All BCF staff in the Phase 1 counties are being trained in the use and administration of the CANS 2.0 and Wraparound 101 during the months of August and September 2015.

All of the Local Coordinating Agencies contracted with for the phase 1 implementation are being trained in the use and administration of the CANS 2.0 during the month of September 2015.

Safe at Home WV Project Director Lisa McMullen has facilitated meetings with Dr. John Lyons and Dr. Fred Wvulczyn of Chapin Hall and West Virginia's SACWIS representatives to discuss statewide, systems wide automation of the CANS. This is a long term project that will eventually support Safe at Home WV but has much farther reaching implications. It is not something that WV can accomplish quickly but it is a long term goal.

At present, to support automation, West Virginia is working with Hornby Zeller Associates staff. HZA developed a data base website for the automation of the CANS while evaluating a past BCF project. They will be working with WV to update the software to include the expansion of the CANS 2.0 and will make it available for use for Safe at Home WV. This will assist with cross discipline use of the CANS as well as gathering data for outcome evaluation.

In addition to the above, West Virginia does not have a best practice-informed Treatment Foster Care model. As we implement *Safe at Home West Virginia*, we will have the opportunity to use models such as the Foster Family Treatment Association Treatment Foster Care Model to develop, fund, and implement a proven model in the state. Providing this new level of care and developing thresholds based on assessed needs using the CANS will greatly reduce the number of children in congregate care. At present, West Virginia has one licensed Child Placing agency that is developing treatment foster care homes. We believe that it will be beneficial to all of our children entering foster care but that this will work very well with *Safe at Home West Virginia*. Wraparound services could either be provided in these settings to maintain youth in their communities or to return them from congregate care. West Virginia

has requested TA from the National Resource Center to assist with recruitment and retention of quality fostering parents. Included will also be assessing our current training and support services and working with our licensed Child Placing agencies to expand therapeutic or treatment foster care homes.

One of the outcomes of the joint work that BCF has been doing with our Child Placing Partners, outlined on pages 96and 97, is a recommendation by the private foster care agencies to move all of their homes to a therapeutic foster care model and change the name of these private agency homes from "Specialized Foster Care" to "Treatment Foster Care". The group has recommended an evidence based model and performance outcomes for the upcoming agreement renewals. They are currently working with BCF on the rate setting.

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

Theory of Change

We implement CANS and NWI

So That

We have clear understanding of family strengths and needs

And

A framework/process to address those strengths and needs

So that

Families will receive the appropriate array of services and supports

And

Are more engaged and motivated to care for themselves

So that

Families become stabilized and/or have improved functioning

So that

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

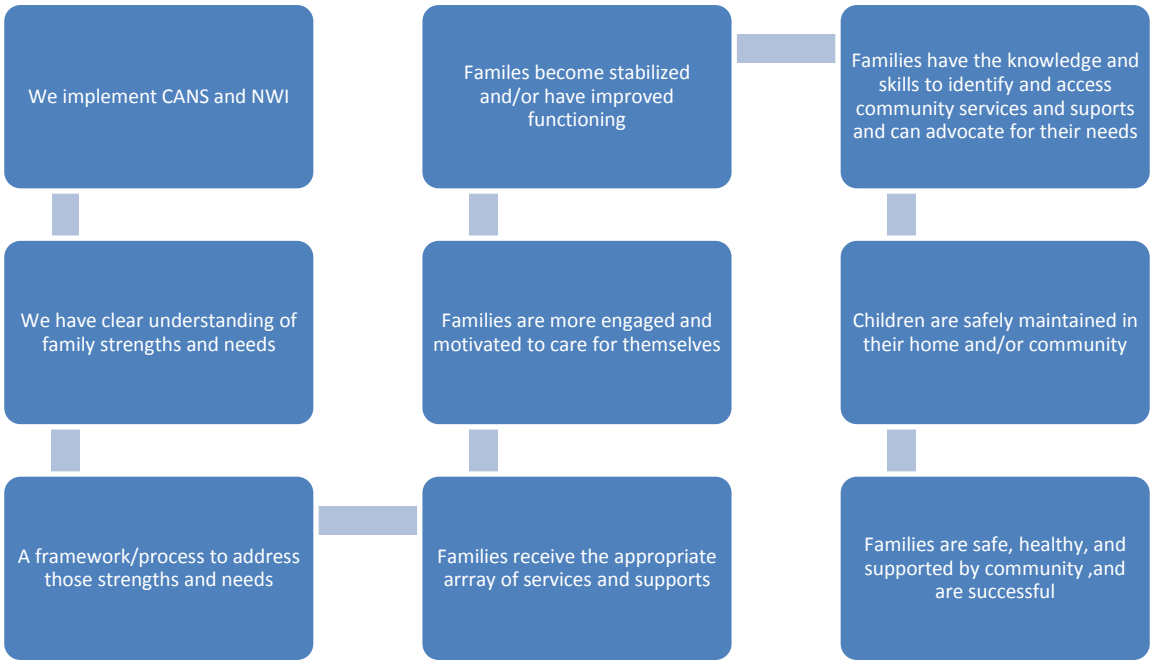
So that

Children are safely maintained in their home and/or community

And

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

Safe at Home West Virginia Theory of Change



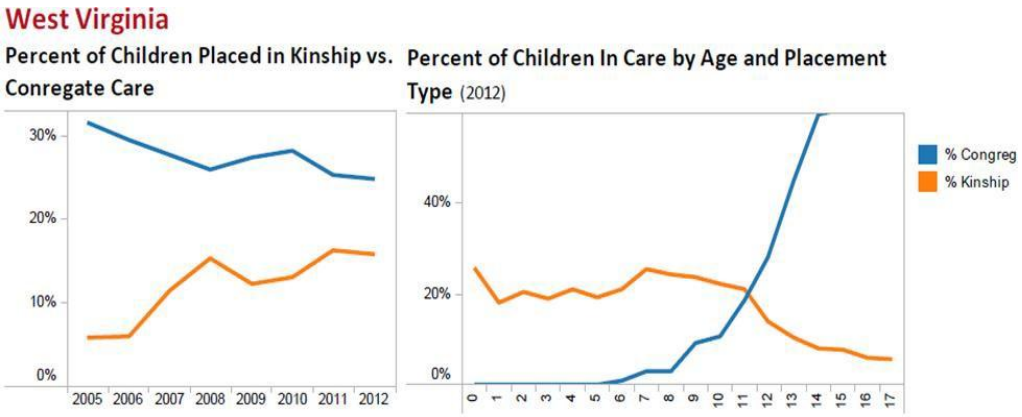
Safe at Home West Virginia Logic Model

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

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

II. Target Population

The chart below demonstrates West Virginia's use of kinship care versus congregate care. As is indicated from the comparison, younger children are more likely to be placed in kinship care while older youth are more likely to enter placement in congregate care. BCF has identified the lack of treatment foster care and in-home services and a weak children's mental health system as contributing factors to the high use of congregate care.



The following are criteria for eligibility for *Safe at Home West Virginia* Wraparound services:

- Youth aged 12-17 with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I) currently in out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by wraparound;

- Youth aged 12-17 with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I) currently in in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by wraparound;

- Youth aged 12-17 with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I) at risk of out-of-state residential placement and utilization of wraparound can safely prevent the placement. The operational definition of at risk for *Safe at Home West Virginia* being any youth 12-17 involved with the child welfare system and that BCF has an open case on; and

- Youth aged 12-17 with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I) at risk of in-state level one, two, or three or PRTF residential placement, and they can be safely served at home by utilizing wraparound.

For clarification purposes, our data only captures youth involved with the child welfare system and that we have an open case on. BCF is currently working with our sister Bureau for Medical Services for the purpose of discussing Medicaid billing. BMS is in the process of updating their state plan.

The CANS Assessment will determine the specific constellation of services provided through the wraparound approach for each youth based upon the level of intensity the youth and family's unique needs. The CANS assessment will also help determine the array and intensity of behavioral health services that will be utilized as part of the wraparound intervention. *Safe at Home West Virginia* will be using a high fidelity wraparound model incorporating the 10 principles of wraparound. One component is the constellation of services.

Caseloads will be set at the caseload standard for Care Coordinators/Wraparound Facilitators of 10.

To aid in collecting and analyzing qualitative data, the quantitative data on the target population in the Phase 1 counties was pulled from a COGNOS report currently in development, "Number of Children Placed in Care," at the end of October 2014. For the eight counties of Region II and the three in the eastern panhandle of the state, a list of 490 youth was created and sent out to the field, along with a case worker survey form to complete for data collection. As the field began to complete the data collection, 10 youth were removed from the list, as their inclusion was in error. Therefore, surveys were completed and submitted on 480 youth ages 12-18 that were in foster care placements in those 11 counties at the conclusion of October 2014. Ten youth are shown as 18 years old because they had birthdays between the time the sample was drawn and the completion of the data collection form.

The data collection form used was initially developed as a tool for assessing the reasons children and youth are being removed from their homes in particular counties where removal rates are the highest per capita. The tool was slightly modified for the purposes of this project to include items on child behavior, diagnoses, and more.

Please remember that this information is caseworker reported on each identified child within the target population.

Profile of All Target Population Youth in Foster Care

Current Placement

Family Foster Care (Includes Kinship Homes)	105	21.9%
Congregate Care (Includes Psychiatric Care Facilities)	367	76.5%
Detention Center	8	1.6%

Numbers for youth in detention are not shown separately due to the small number that was included in the sample drawn. Time had lapsed between the sampling and the data collection, which could account for the inclusion of youth in detention in the sample. Due to their detention, we are unable to engage the youth at that time. Typically, these youth are stepped-down into congregate care placements. At that time, these youth are likely to be eligible for *Safe at Home West Virginia*. Youth in Detention are not always known to BCF until they are ready to exit detention.

These youth would become eligible once they transition from the detention facility into a congregate care setting. At present, we do not have a way to provide wraparound services within the detention setting.

All percentages for Congregate Care and Family Foster Care settings are given as a proportion of their respective totals (367 and 105). Discrepancies in totals can be accounted for by the small number of youth in detention.

Youth Services Cases are cases that come into the child welfare system through Juvenile services either due to a status offense or delinquency. Juvenile and child abuse/neglect are both addressed in the same code in West Virginia.

Case Type

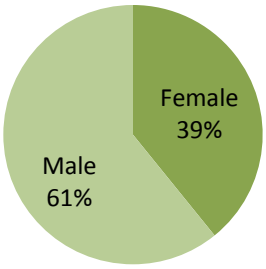
	All		Congregate Care (out of 367 total)		Family Foster Care (out of 105 total)	
Child Abuse and Neglect	168	35%	72	19.6%	95	90.5%
Youth Services	312	65%	295	80.4%	10	9.5%

Age

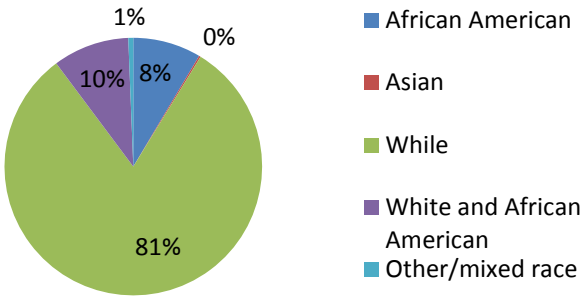
	All		Congregate Care		Family Foster Care	
Age 12	37	7.7%	20	5.5%	17	16.2%
Age 13	47	9.8%	31	8.5%	16	15.2%
Age 14	77	16%	56	15.2%	18	17.1%
Age 15	86	17.9%	68	18.5%	16	15.2%
Age 16	125	26%	104	28.3%	20	19.1%
Age 17	99	20.6%	79	21.5%	17	16.2%
Age 18	10	2%	9	2.5%	1	1%

West Virginia has determined that during the first year of implementation the age for referral eligibility will be 12-17th birthdate. It may be possible that in subsequent years the eligibility age could be changed to 12-17 ½. This timing allows West Virginia to improve our system to assist youth in being successful and focusing the high level of activities necessary due to the high needs of these youth so that they can accomplish what is needed within a year of turning 18 and successfully transition. West Virginia originally wished to include all ages within the demonstration project but was encouraged to focus in on a tighter target population for the demonstration project and for evaluation purposes. Through data review and profiles West Virginia determined to focus on the target population of 12-17 for purposes of the demonstration project and evaluation. It is our goal to expand to all ages outside of the demonstration project. We hope to see community services and availability to all populations increase to a level that would allow this to become the way we serve all of our children that meet wraparound criteria.

Gender



Racial Composition



Petition Type

	All		Congregate Care		Family Foster Care	
Abuse/Neglect	165	34.4%	70	19%	94	89.5%
JD (Juvenile Delinquency)	141	29.4%	131	35.7%	5	4.8%
JS (Juvenile Status Offense)	167	34.8%	161	43.9%	5	4.8%
Missing Data/Other	7	1.4%	5	1.4%	1	0.9%

Did DHHR have involvement with the child and/or family prior to petition?

(Involvement is defined as a current ongoing assessment or open case)

	All		Congregate Care		Family Foster Care	
Yes	218	45.4%	191	52%	66	63%
No	262	54.6%	176	48%	39	37%

Primary Removal Reason (as identified by current case worker)

	All		Congregate Care		Family Foster Care	
DJS Step-down	11	2.3%	11	3%	0	0%
Legal Requirement Only (such as aggravated circumstances as mandated by code or court ordered even with no safety concerns)	206	42.9%	185	50.4%	17	16.2%
Practice (applying safety criteria correctly as per CPS and YS policy)	121	25.2%	67	18.3%	52	49.5%
Lack of Available/Accessible Services to Keep Child Safe in the Home	123	25.6%	91	24.8%	30	28.6%
Missing Data/Other	19	4%	13	3.5%	6	5.7%

Did the Department have the opportunity to give a recommendation to the Court?

	All		Congregate Care		Family Foster Care	
Yes	416	86.7%	311	84.7%	99	94.3%
No	64	13.3%	56	15.3%	6	5.7%

Of those who were able to give a recommendation,

did the Judge follow that recommendation?

	All		Congregate Care		Family Foster Care	
Yes	394	94.7%	291	93.6%	98	99%
No	22	5.3%	20	6.4%	1	1%

Contributing Factors for Removal

Truancy

	All		Congregate Care		Family Foster Care	
Yes	108	22.5%	105	28.6%	3	2.9%
No	372	77.5%	262	71.4%	102	97.1%

Child Behavioral/Mental Health

	All		Congregate Care		Family Foster Care	
Yes	300	62.5%	281	76.6%	12	11.4%
No	180	37.5%	86	23.4%	93	88.6%

Parental Mental Health

	All		Congregate Care		Family Foster Care	
Yes	34	7%	13	3.5%	20	19%
No	446	93%	354	96.5%	85	81%

Substance Abuse

	All		Congregate Care		Family Foster Care	
Yes	207	43%	144	39.2%	61	58.1%
No	273	57%	223	60.8%	44	41.9%

Of those cases in which substance abuse was identified (207),

how many included:

	All		Congregate Care		Family Foster Care	
Parent Only	86	41.6%	38	26.4%	54	88.5%
Child Only	92	44.4%	88	61.1%	3	4.9%
Both Child and Parent	29	14%	18	12.5%	4	6.6%

Domestic Violence

	All		Congregate Care		Family Foster Care	
Yes	76	15.8%	34	9.3%	41	39%
No	404	84.2%	333	90.7%	64	61%

Safety Concerns

If the removal was related to CPS, in what stage did the removal take place?

	All		Congregate Care		Foster Family Care	
Not Applicable	333	--	302	--	24	--
FFA (Family Functioning Assessment)	106	72.1%	47	72.3%	58	71.6%
CSE/PCFA (Continuing Safety Evaluation or Protective Capacity Family Assessment	41	27.9%	18	27.7%	23	28.4%

The following Present Dangers were identified by the current caseworkers on each child in the sample. The chart below shows the number of occurrences of each Present Danger. Each case may have more than one identified Present Danger. Please remember that the majority of the youth in the target population enters the child welfare system through juvenile services not due to abuse/neglect, therefore, there may be no identified present or impending dangers. A review of the presented data shows 65% entering due to Youth Services or Juvenile Petitions with only 35% entering due to Abuse/Neglect. This appears to remain somewhat stable. It should be noted that as you review younger children the reverse would be true.

	All	Congregate Care	Family Foster Care
NONE (number of youth without a PD identified)	396	329	61
Caregiver is Out of Control	29	13	17
Caregiver is Intoxicated (alcohol or drugs)	21	16	6
Child is Fearful or Anxious	21	11	11
Life Threatening Living Arrangements	17	7	11
Child is Unsupervised for Long Periods of Time	12	6	6
Maltreating Now	10	5	5
Child Needs Medical Attention	7	2	5
Face/Head	7	2	5
Caregiver is Described as Dangerous	6	1	5
Caregiver's Viewpoint of Child is Bizarre	6	6	0
Serious Injury	5	2	3
Several Victims	5	3	2
Family Will Flee	5	4	1
Multiple Injuries	3	0	3
Spouse Abuse Present	3	0	3
Unexplained Injuries	1	1	0

The following Impending Dangers were identified by the current caseworkers on child in the sample. The chart below shows the number of occurrences of each Impending Danger. Each case may have more than one identified Impending Danger.

	All	Congregate Care	Family Foster Care
NONE (number of youth without an ID identified)	335	304	26
The caregiver is unwilling or unable to perform parental duties and responsibilities, which could result in harm.	73	33	40
Caregiver's drug and/or alcohol use is pervasive and threatens child safety.	73	33	40
One or both parents/caregivers lack parenting knowledge, skills, or motivation which affects safety.	54	26	28
One or both parents/caregivers cannot control behavior.	52	20	35
One or both caregivers are violent; this includes Domestic Violence and General Violence.	34	6	29
Living arrangements seriously endanger a child's physical health	19	9	10
Family does not have resources to meet basic needs.	18	9	9
Child has exceptional needs which the caregivers cannot or will not meet.	18	9	9
Child is perceived in extremely negative terms by one or both caregivers.	11	4	7
One or both caregivers intended to hurt the child.	10	6	4
One or both caregivers fear they will maltreat their child and/or are requesting placement.	3	2	1

Services

Did the Department identify services to help the family to prevent removal?

	All		Congregate Care		Family Foster Care	
Yes	319	66.5%	251	68.4%	62	59%
No	161	33.5%	116	31.6%	43	41%

Were the identified services not available and/or accessible?

	All		Congregate Care		Family Foster Care	
Yes	57	25%	44	26.5%	12	20.7%
No	170	75%	122	73.5%	46	79.3%
N/A or Missing	253	--	201	--	47	--

Would the family accept services?

	All		Congregate Care		Family Foster Care	
Yes	335	77%	279	82.1%	49	57.6%
No	98	23%	61	17.9%	36	42.4%
N/A or Missing	46	--	27	--	20	--

Diagnoses and Needs

The number of total youth without a diagnosis is smaller than the larger population of 480 children because it represents a sub-group of children that do not have a diagnosis.

Children without a diagnosis indicated by the caseworker	Congregate Care	Home Settings	**Total Youth**
None	125	61	**186**

Occurrence of Child Diagnoses as Indicated by the Current Caseworker

MENTAL RETARDATION	Congregate Care	Family Foster Care	**Total Occurrences**
Mental Retardation (Mild, Moderate, and Severe)	6	4	
Intellectual Disability	1	0	
	7	**4**	**11**

LEARNING DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Learning Disorder	3	0	
Dyslexia	2	0	
Disorder of Written Expression	1	0	
Mathematics Disorder	1	0	
	7	**0**	**7**

COMMUNICATION DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Speech Fluency Problem	1	0	**1**

PERVASIVE DEVELOPMENTAL DISORDERS	Congregate Care	Home Settings	Total Occurrences
Autism/Asperger's	9	4	
Pervasive Developmental Disorder	5	0	
	14	**4**	**18**

DISRUPTIVE BEHAVIOR DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
ADD/ADHD	115	14	
Oppositional Defiant Disorder	110	11	
Conduct Disorder	73	1	
Disruptive Behavior Disorder	61	3	
	359	**29**	**388**

FEEDING AND EATING DISORDERS OF EARLY CHILDHOOD	Congregate Care	Family Foster Care	Total Occurrences
PICA	1	0	**1**

TIC DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Tic Disorder	1	0	**1**

ELIMINATION DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Enuresis	2	0	**2**

OTHER DISORDERS OF INFANCY, CHILDHOOD & ADOLESCENTS	Congregate Care	Family Foster Care	Total Occurrences
Reactive Attachment Disorder	11	0	**11**

SUBSTANCE ABUSE RELATED DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
(Poly)Substance Use/Abuse (alcohol, cannabis, opiods)	102	2	
Nicotine Dependence/Tobacco Use	4	0	
Sedative Hypnotic/Anxiolytic Dependence	2	0	
	108	**2**	**110**

PSYCHOTIC DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Psychotic Disorder	3	1	
Delusional Disorder	0	1	
	3	**2**	**5**

MOOD DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Bipolar Disorder	16	1	
Mood Disorder	47	5	
Depression/Major Depressive Disorder	58	11	
Dysthymic Disorder	3	0	
Unspecified Mental Disorder (Nonpsychotic)	1	0	
	125	**17**	**142**

ANXIETY DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Obsessive Compulsive Disorder	1	0	
Post-Traumatic Stress Disorder	15	1	
Panic Disorder	2	0	
Anxiety Disorder	19	3	
Social Phobia Generalized	1	0	
	38	**4**	**42**

PARAPHILIAS	Congregate Care	Family Foster Care	Total Occurrences
Fetishism	1	0	
Voyeurism	1	0	
Sexual Disorder	1	0	
Juvenile Sexual Perpetrator	4	0	
	7	**0**	**7**

SLEEP DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Insomnia	2	0	
Night Terror Disorder	0	1	
	2	**1**	**3**

IMPULSE CONTROL DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Impulse Control	16	1	
Intermittent Explosive Disorder	4	0	
	20	**1**	**21**

ADJUSTMENT DISORDER	Congregate Care	Family Foster Care	Total Occurrences
Adjustment Disorder	14	6	**14**

PERSONALITY DISORDERS	Congregate Care	Family Foster Care	Total Occurrences
Antisocial Behavior	8	0	
Borderline and/or Narcissistic Traits	3	3	
Personality Disorder	1	0	
	12	**3**	**15**

CONDITIONS THAT WARRANT CLINICAL ATTENTION	Congregate Care	Family Foster Care	Total Occurrences
Academic/Educational Problems	12	0	
Parent-Child Relational Problem	35	0	
Neglect of Child	17	9	
Physical Abuse	23	4	
Relational Problems	3	0	
Sibling Relational Problems	0	1	
Borderline Intellectual Functioning	9	0	
Sexual Abuse (Victim)	28	4	
	127	**18**	**145**

MEDICAL ISSUES	Congregate Care	Family Foster Care	Total Occurrences
Cerebral Palsy	0	2	
Hearing Impaired	1	0	
Mega Colon	1	0	
Spina Bifida	0	1	
	2	**3**	**5**

OTHER INFORMATION PROVIDED	Congregate Care	Family Foster Care	Total Occurrences
Conflict with Adoptive Mother	0	1	
Familial Issues	3	0	
Family and Child Relationship Issues	0	0	
Legal Problems	3	0	
Living Away From Home	1	0	
Problems with Primary Support Group	6	1	
Problems with Social Environment	1	0	
School and Home Stressors	1	0	

OTHER INFORMATION PROVIDED	Congregate Care	Family Foster Care	Total Occurrences
Social Functioning Problem	1	0	
	16	2	**18**

Based on the data collected in this initial capture on the target population, we can see that the youth are most often male, white, and 16-17 years old. More than three-fourths of the youth are in a congregate care placement and 65% are Youth Services clients. We suspect there may be some issues with the quality of this data, specifically with regards to the removal/placement reason, which we hope to address in additional data collection and analysis. Please remember that this is qualitative data generated through caseworker surveys of each identified child in the target population. Discrepancies may occur due to worker tenure or knowledge or interpretation of the requested information.

By and large, case workers report that they are able to give recommendations for placement type to the Court and that most of the time, those recommendations are followed. Although they are allowed to make placement recommendations, the decision to request placement is not made by our workers and, for the most part, has been done by a probation officer. Additionally, our staff is not given a voice in these cases to make a recommendation as to whether or not removal is appropriate. The placement type is also often recommended by the probation officer or MDTT, and the department worker is simply finding a placement that meets the court-ordered criteria. We believe this to be the driving factor regarding the information that the courts are following the worker recommendation for placement. The most frequent reasons for placement are child behavior/mental health (62.5%); substances use/abuse (43%); followed by truancy (22.5%) and domestic violence (15.8%). These rates are higher for the congregate care population (child only substance abuse) except for domestic violence. Out of the 227 cases where the Department identified needed services, only 25% of those cases were identified as not having the service they needed available or accessible; 26.5% in congregate care and 20.7% in foster care. It could be that the Division of Juvenile Services initiated the placement recommendation with the court and that the court did not allow community-based services prior to placement. It may also be that caseworkers consider the services offered within the placement setting as meeting the need and did not delineate between community-based services and congregate-setting based services. Workers in some areas of our state have become so used to accessing services outside of the community and/or placement in residential care, that it is considered the norm. Also, some comments on the data collected from workers indicated that although there may be services available in the

community, that they are frequently ineffective or not available at the frequency or veracity needed. Since this is qualitative data gathered from the caseworkers, it is understandable that answers may be interpreted through their work experience, knowledge, and tenure and will be something that we need to go back and explore. We plan to do parental surveys to assist with exploring service gaps and needs as well as strengths, and this may assist in clarifying this information.

The majority of identified diagnoses are behavior, mood, impulse related. Considering the age/life stage of the youth, the associate behaviors are often relatively normal. Therefore, an area for focus should be in the development or enhancement of supportive services needed to provide relief and support for the parents/caregivers, etc. Exception to this would include substance abuse, ID/DD & PDD, PTSD (any kind of trauma), and sexual abuse (any kind of abuse/neglect). All of these services are limited in many areas, especially substance abuse services for youth in rural areas. We find this important as we look at developing respite services within the wraparound model.

Please remember that this is qualitative data gathered from caseworkers who completed surveys on each youth identified within our target population. Meaning, both youth in congregate care and those at risk of entering congregate care were reviewed. We also have community needs assessments that have been completed in each county that we are reviewing. BCF has conducted meetings with our providers to allow conversations regarding community needs and development as well as open discussions regarding our partners' experiences with Medicaid billing. Our Medicaid partners from the Bureau for Medical Services have also participated.

Kids that are already placed may have an even lesser need than at-risk youth due to having already received intensive services and being ready for step-down. We also acknowledge that many of the youth that are placed in congregate settings may not have needs that require the wraparound approach. The decisions around level of intervention will be assessment guided, not guided merely by the placement location. West Virginia believes that the large number of the youth that are placed in congregate care settings do not have needs justifying the congregate care placement. Many youth are court-ordered into placement settings via recommendations from probation officers that view placement as a punitive option rather than focusing on the needs of the youth and best meeting those needs. This is one of the driving factors in our decision to proceed with a waiver application and focusing on this population. We believe that we can have the biggest impact and positively affect the outcomes for these youth.

III. Demonstration Components and Associated Interventions

Implementation of Safe at Home West Virginia shall begin in the identified 11 demonstration counties on October 1, 2015. West Virginia has determined that we wish to change our focus from only youth in out-of-state congregate care to any youth in congregate care, whether in-state or out-of-state, if their needs would best be met through wraparound during the first federal fiscal year of the implementation. Each youth will be enrolled in the wraparound model that best meets his or her specific needs. All target youth in the Phase 1 counties who enter congregate care after the implementation of *Safe at Home West Virginia* will experience a decreased length of stay under new restrictions and guidelines. BCF is currently in the process of updating all contracts and provider agreements. New agreements (often referred to as contracts) with residential providers will outline a limitation for length of stay and requirements for early discharge planning. This is with regard to our congregate care providers and West Virginia's move to shorten the length of stay of youth when it is safe and in their best interest. Also strengthening this process is Senate Bill 393, Juvenile Justice Reform. This bill requires discharge planning to begin on the day of admission. Prior to discharge, (up to 90 days prior), the youth will be enrolled in wraparound as per his or her specific needs. This timeframe is guided by high fidelity wraparound and will only apply to youth who meet the wraparound criteria and would benefit from wraparound. Enrollment in wraparound will be assessment guided at every level so that the appropriate youth will get the appropriate services to meet their needs. Most of the core services can be viewed as Family Preservation services that always focus on the health of the family and the safety of the youth. The second six-month period will concentrate on exiting target youth who are placed in congregate care facilities in-state. Each will be enrolled in the wraparound model pathway that best meets his or her specific needs. Concurrently, all youth who are at-risk of congregate care will be enrolled in wraparound as per his or her specific needs at any time after the implementation date. All youth enrolled will receive high-fidelity wraparound. Within the framework of the wraparound model, every enrolled youth will receive specific behavioral, therapeutic, and social services that are targeted to their identified needs. The CANS assessment will be updated at each treatment milestone. This will provide information that will guide the decision regarding which wraparound pathway, and supporting natural supports and forma service, would best meet the needs of each child. The operational definition of at risk for *Safe at Home West Virginia* being any youth 12-17 involved with the child welfare system which has an open case with BCF.

As West Virginia has worked on the planning and implementation we have determined

to adjust the phase 1 enrollment population and timeframes. West Virginia will still focus on out-of –state congregate care placements as primary for assessment and referral to wraparound but we believe that we should at the same time allow for assessment and referral of in-state congregate care placements. This will assist in opening space for stepping down some of the out-of-state youth into an in-state placement as well as facilitating the reduction in congregate care settings. Our goal is to be able to move to assessment and referral of the at risk population sooner than the end of the first year. This will be guided by evaluation and successes as the Care Coordinators/Wraparound Facilitators are on boarded and become known.

The Safe at Home Wraparound Interventions are Intensive Care Coordination and Next Steps. Safe at Home Intensive Care Coordination is a wraparound approach which is less intensive for youth and their families to prevent out-of-home care. The eligibility for Intensive Care Coordination are youth ages 12-17 who:

- Have a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis I);
- Are at-risk of a congregate care placement who are currently involved with two or more child-serving agencies (e.g. courts, child welfare, juvenile justice, etc.); or
- A CANS assessment/CAPS assessment determines the child can benefit from an intensive wraparound approach.

Four phases of treatment within the Intensive Care Coordination intervention will consist of:

- Initial Phase-First 90 Days (Engagement and Planning). During the first 90 days, the child and family are often in crisis and formal services are not yet in place. This initial phase requires all of the wraparound team to engage the family. It is time for further assessments, treatment planning, linking and making sure the family is safe. Assessments would be the CANS and any other assessments triggered by the CANS. Meetings would be a minimum of weekly contact with the family with at least one face-to-face meeting per month with the entire child and family team. CANS assessments would be repeated at least every 90 days.
- Implementation Phase 3-6 Months. The child and family are beginning to need less intense care because coordinated services and supports are in place. The family and

child are beginning to develop skills to navigate the system and to manage their own issues through development of natural supports without needing assistance from the Intensive Care Coordinator/Wraparound Facilitator. The Intensive Care Coordinator/Wraparound Facilitator will be determined by a grant process for lead agencies. This phase is independent of the residential agreements or contracts.

- Maintenance Phase 6-9 Months. During this phase, the frequency and intensity of formal services further decreases as the family begins to rely on their community and natural supports that have been developed. The family is working toward being discharged from the Intensive Care Coordination. The frequency and intensity is determined by the needs and strengths of the youth and family. This is the phase in which movement is away from formal services to informal supports. This is the phase in which we are preparing the family to independence.

- Transition Phase 9 Months to 1 Year. This final phase sees in the end of formal intensive care coordination services that were part of the family's treatment plan. The discharge plan is concrete service-based, with plans for the future utilization of natural supports and community involvement. This phase is independent of the residential agreements or contracts.

Next Steps is a wraparound process that will be specifically designed to provide higher levels of intervention for youth who meet the following criteria:

- Has a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM V Axis I);

- CANS Assessment/CAPS Assessment determines the child can benefit from an intensive wraparound approach;

- Is currently placed in highly structured, congregate care outside of West Virginia and may need specific placement resources developed in-state for step-down, as part of initiating wraparound; or

- Is currently placed in congregate care in-state and is at risk of being placed out-of-state. This could occur when there is a lack of appropriate or adequate in-state placement resources to meet the identified needs of the youth.

The Next Steps process will include the four-phases of wraparound mentioned above with an additional phase at the beginning specific to the intense needs to youth who are in

highly structured placements and who have been assessed to have intensive wraparound needs. The phases of *Safe at Home Next Steps* are:

- Pre-Community Integration, which begins 90 days prior to discharge from a residential program. Often, youth in out-of-state programs will need specific resources developed for them in West Virginia – often an out-of-home setting such as a lower level of residential care or a treatment foster care home – to step-down before returning to his or her home for intensive wraparound. There are no special legal issues with moving a youth from out-of-state congregate care placements. Good recommendations to the Multi-Disciplinary Treatment Team and then to the Court will facilitate movement. The Next Steps Coordinator will provide the necessary casework to develop resources and integrate the youth back into the community;

- Intensive Reunification, which begins at discharge from out-of-home placement and provides from six months to one year of intensive care coordination through the five phases of community-based wraparound services, as described above;

- Transition, which lasts 90 days and works intensively with the youth's multidisciplinary team to guide progression to experience minimal setbacks as treatment comes to an end.

The service/model implementation workgroup is currently working on restructuring the model to reflect high fidelity wraparound rather than focusing on phases. This will be included in our next update.

As part of this evolution to move from focusing on different phases to focusing on high fidelity wraparound West Virginia has come to the understanding that wraparound is simply wraparound, no matter the situation that triggers it. The phases and purpose remain the same. Intensity may vary at times due to individual circumstances, but this is true of any phase of wraparound. The different tracks for referral and determining intensity will remain but the focus will be on the phases of high fidelity wraparound as outlined in the National Wraparound Initiative.

There are four phases within wraparound. The timeframes provided are an average of what can be expected but durations can be flexible based on case circumstances. However, when phases go on terribly long, the family may need to be evaluated for movement back to the phase preceding their current phase in order to address any issues that might have been resolved before the family moved to the next phase.

- Phase 1: Engagement and Team Preparation

  During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborated. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations and about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible

  During the first 90 days, the child and family are often in crisis and formal services are not yet in place. This initial phase requires all of the wraparound team to engage the family. It is time for further assessments; treatment planning, linking and making sure the family is safe. Assessments would be the CANS and any other assessments triggered by the CANS. Meetings would be a minimum of weekly contact with the family with at least one face-to-face meeting per month with the entire child and family team. CANS assessments would be repeated at least every 90 days.

- Phase 2: Initial Plan Development

  During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks; a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.

- Phase 3: Implementation

  During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.

  During this phase, the frequency and intensity of formal services further decreases as the family begins to rely on their community and natural supports that have been developed. The family is working toward being discharged from the Intensive Care Coordination. The frequency and intensity is determined by the needs and strengths of the youth and family. This is the phase in which movement is away from formal services to informal supports. This is the phase in which we are preparing the family to independence.

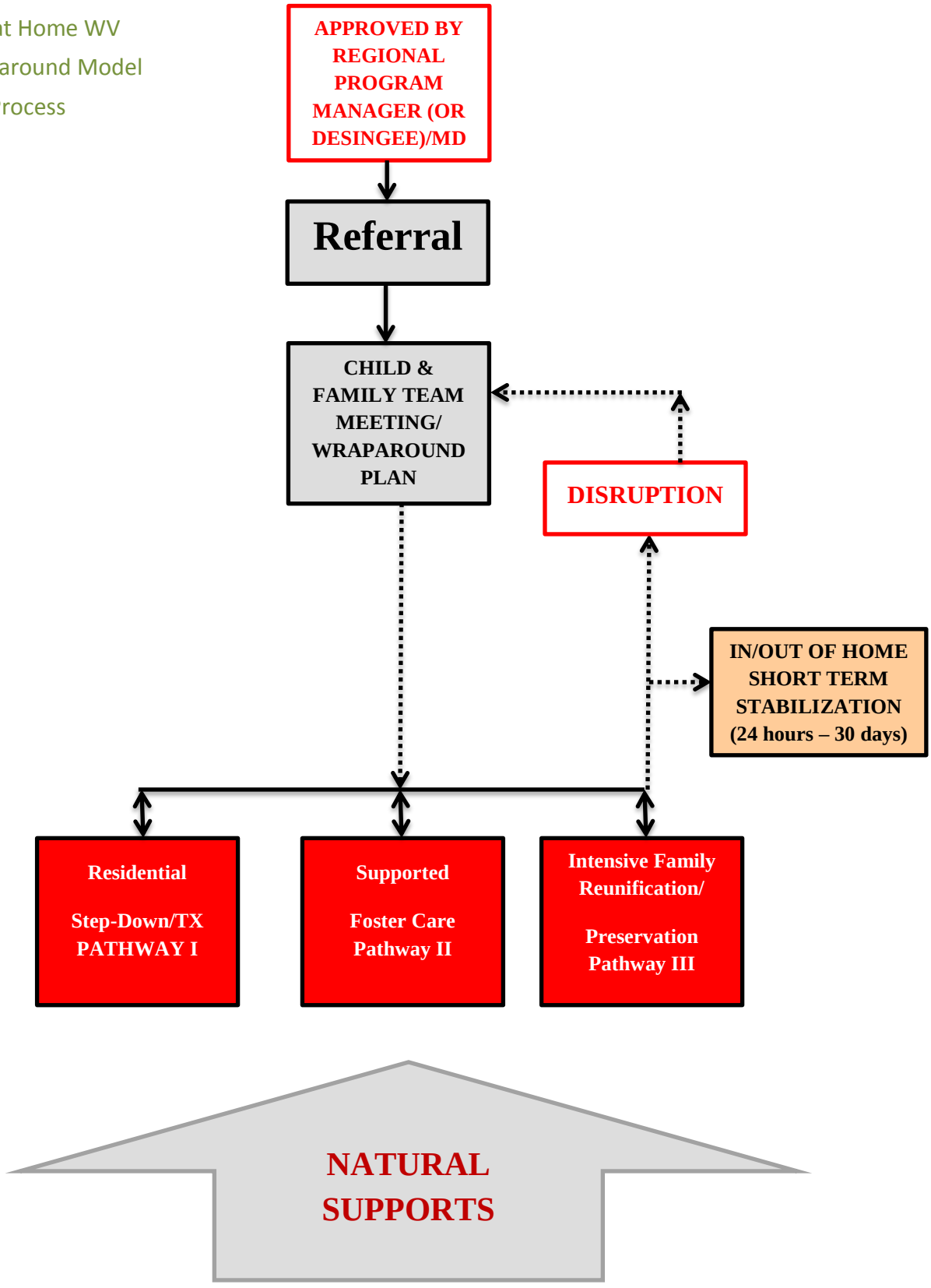
- Phase 4: Transition:

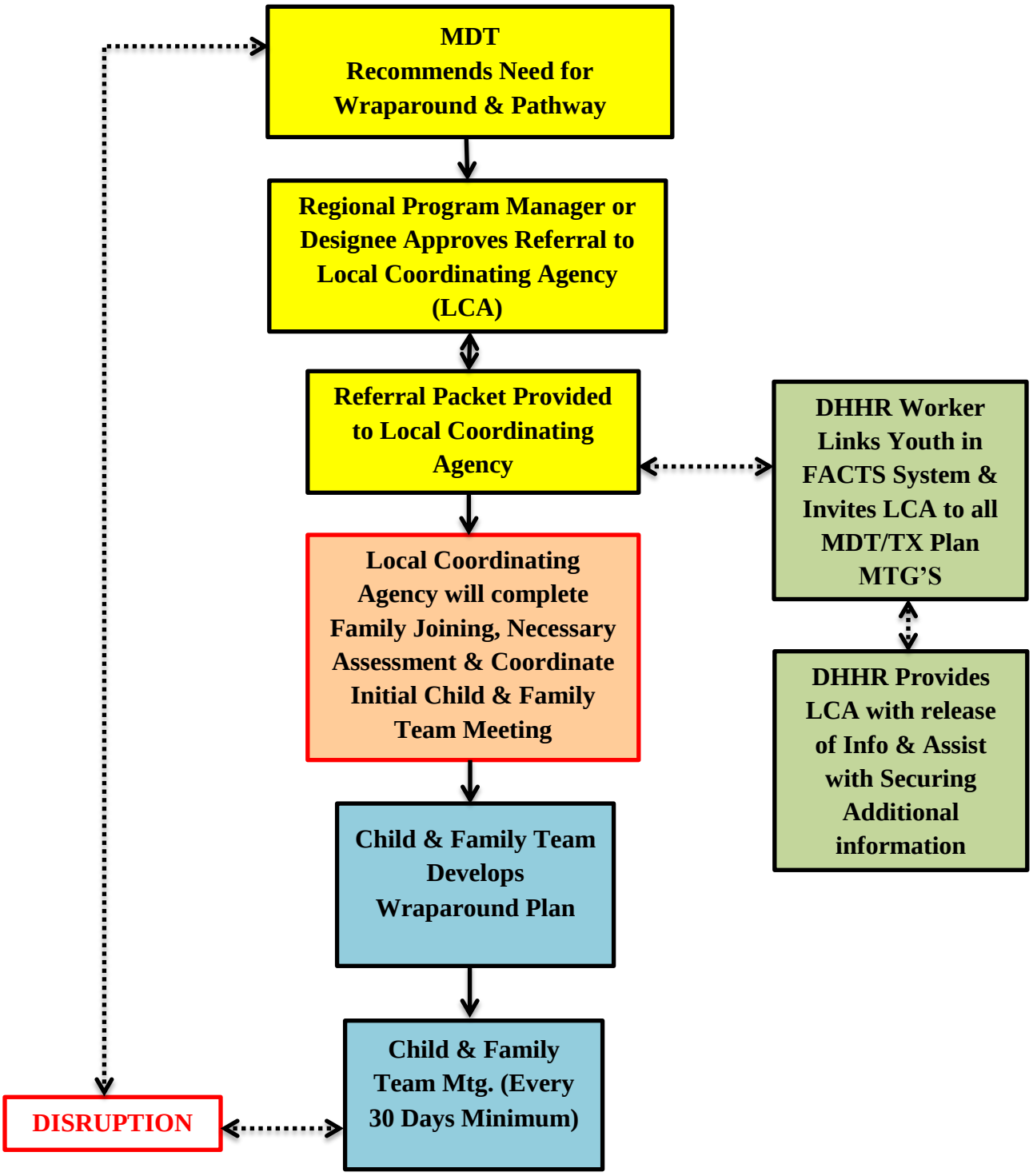
  During this phase, plans are made for purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.

  This final phase sees the end of formal intensive care coordination services that were part of the family's treatment plan. The discharge plan is concrete service-based, with plans for the future utilization of natural supports and community involvement. This phase is independent of the residential agreements or contracts.

On the following 2 pages are revised flow charts that provides an overview of the Safe at Home WV wraparound model as well as a flow chart demonstrating the Safe at Home WV wraparound process.

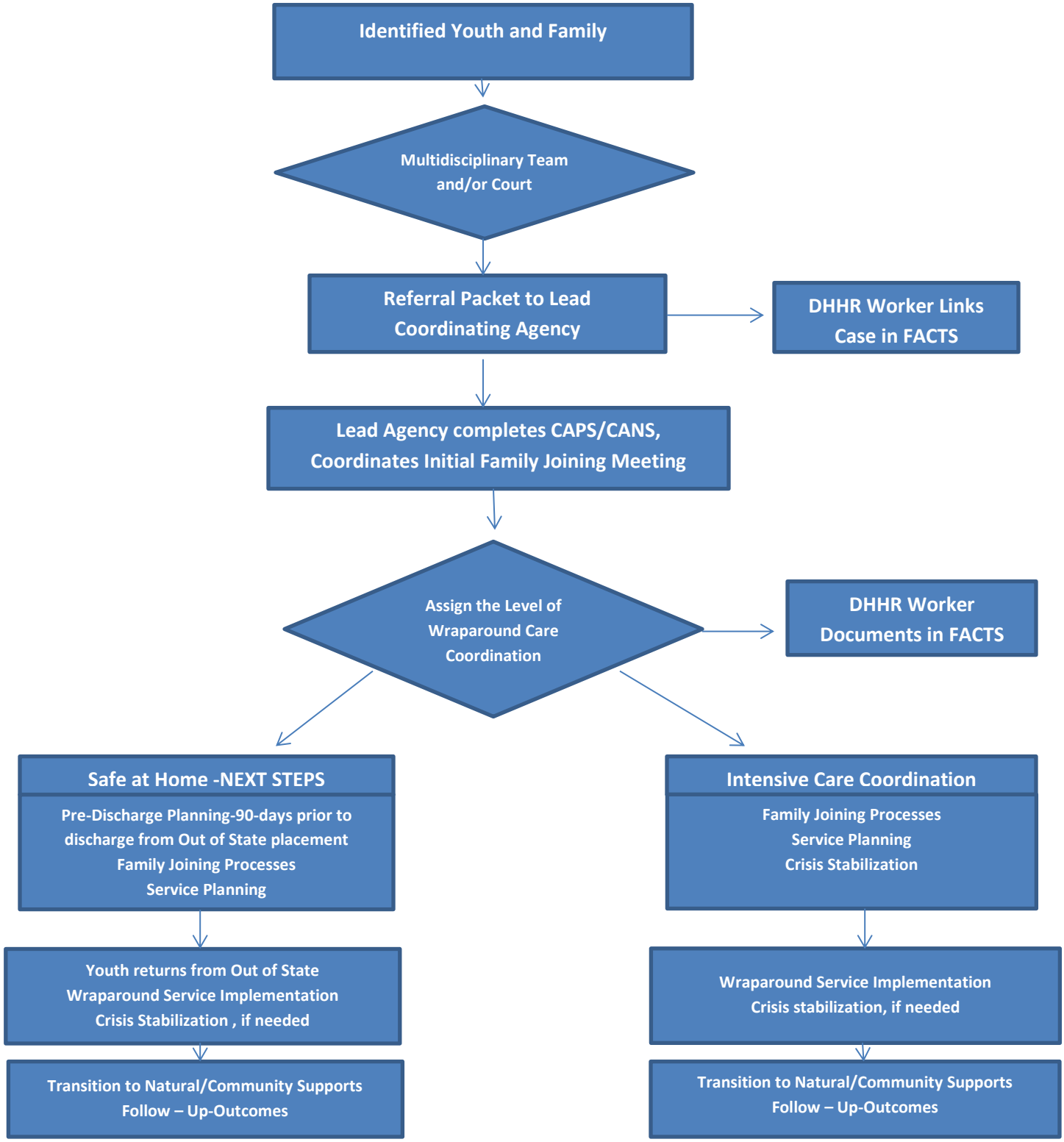
Safe at Home WV
Wraparound Model
And Process





The following 2 charts are from the first Initial Design and Implementation Report and are now replaced by the 2 previous flow charts

Safe at Home West Virginia



Next Steps

Youth in Out-of-State Residential Placement or At-risk of OOS Placement
MDT/Court Recommends Wraparound
90 Days Prior to Discharge, Referral is made to Local Coordinating Agency
CANS/CAP Confirms Eligibility
Initial Family Joining meeting to determine pathway to community intensive reintegration:
Wraparound Plan Developed
Specialized resource development
Youth Returns from out of state/instate placements
Pathway I
Wraparound in Residential Step-down
Development of specialized placement to begin
Pathway II
Wraparound in Treatment Foster Care
Development of child-specific therapeutic foster family to begin
Pathway III
Child can return to Community with Intensive Care Coordination Wraparound
Continuation of Family Joining, Intensive family reunification, or family preservation: Service Provision: Development of Natural Supports
In/Out of Home Short-term Crisis Stabilization, if needed
Transition
Follow-up
Outcomes
Natural Supports

The administration of a trauma-informed assessment, the West Virginia Child and Adolescent Needs (CANS) Assessment, shall be utilized to determine the youth's and family's level of need for either *Safe at Home Next Steps* or *Safe at Home Intensive Care Coordination*. Dr. John S. Lyons, with the University of Chicago's Chapin Hall, shall be retained to assist the Bureau in developing criteria for eligibility for each wraparound approach. The WV CANS was updated in 2012 to incorporate the trauma assessment portion. The WV CANS is the first assessment administered within the Comprehensive Assessment and Planning System (CAPS). The other assessments available within CAPS will be utilized when further assessment is indicated during the CANS assessment to better determine the services needed by a youth and his or her family. West Virginia has been using the CANS since 2003. It has been updated and is currently in the process of another update (CANS 2.0). CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the CANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; GLBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module.

CANS 2.0 has been submitted to all interested parties with a requested approval date of May 22, 2015, at which time it will be submitted to Dr. Lyons for review and approval. The final approvals have been given and the CANS 2.0 has been sent for formatting.

West Virginia is providing data to Dr. Lyons for him to assist in creating the thresholds to guide *Safe at Home West Virginia* eligibility decisions. We anticipate the eligibility criteria to be completed by August 1, 2015. Eligibility criteria have been established.

A wide range of new services will be needed for *Safe at Home West Virginia*, in addition to the enhancement of traditional services that are specific to the strengths and needs of the youth and family. The in-home and community-based service array shall include, at a minimum, the following services which have been nationally recognized for supporting wraparound initiatives. (The italicized entries indicate new service development needs for West Virginia that have been preliminarily identified to support our wraparound approach. However, the need for enhancement of all existing services will be assessed.)

- Assessment and evaluation (CANS/CAPS and supporting assessments);
- Outpatient therapy-individual, family and group;
- Medication management;

- Behavior management skills training;
- Intensive home-based mental health services;
- School-based behavioral health services;
- Substance abuse intensive outpatient services;
- Crisis services;
- Mobile crisis response;
- Youth advocacy;
- Peer youth support;
- Peer family support;
- Respite services;
- Mentoring;
- Transition coaching;
- Recovery support;
- Aftercare services (post wraparound); and
- Therapeutic foster care.

Every Youth/Family referred for wraparound will be referred to a Local Coordinating Agency who will assign a Care Coordinator/Wraparound Facilitator who will assure the following:

- Contact with Family within 72 hours;
- Family joining meeting; the first meeting is called the Family Orientation meeting and will happen within 5 days of a wraparound case being open. The plan development meeting occurs within 30 days. Within the first month or two, these family meetings will likely occur every two to three weeks, then go to monthly once the plan is implemented and services are in place. These meetings will occur based on the need of the youth and family.
- Initial CANS – repeated every 90 days, or as needed;
- Contact with the family and team members weekly;

- Wraparound team meetings every 30 days and more often as needed – additional meetings are triggered by significant events or crisis and must occur within 24 hours, if needed;

- Initial Wraparound Plan Developed at the first 30-day meeting along with Proactive and Reactive Crisis Plans;

- Strengths Discovery- Ongoing;

- Informal and Natural Support Identification – Ongoing; and

- No meetings occur without the family present.

West Virginia has selected to use high fidelity wraparound as our intervention due to evidence demonstrating success in terms of our selected outcomes and target population.

The National Wraparound Initiative lists the following Evidence based/informed information:

- In Los Angeles County, initial analysis found that 58% of youth discharged from wraparound had their case closed to child welfare with 12 months. Youth in the wraparound group also had significantly fewer total days in out-of-home placement. During the 12-month follow-up, 77% of the wraparound graduates were placed in less restrictive environments.

- Los Angeles County reduced its out-of-home care population by 25.3%. Savings from this reduction were redirected to programs focused on strengthening families.

- In Nevada, after 18 months, 27 of the 33 youth (approximately 82% who received wraparound services) moved to less restrictive environments. More positive outcomes were also found on school attendance, school disciplinary actions, and grade point averages.

- Based on the National Wraparound Initiative, the values associated with wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family-driven, culturally competent, and community-based. The wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available.

Wraparound has been a challenging concept on which to gather quantitative verification of its impact. There are many reasons for this, such as variations in implementation styles across states, communities and populations; the non-research setting in which many wraparound initiatives have been implemented, such as families and providers of social services; the focus on broad populations with overlapping and complex needs; and the fact that each participant may have varying needs and outcomes when compared to others accessing wraparound (Bruns, E. 2008).

Given the challenges that researchers have found, there are at least 10 peer reviewed studies providing evidence in support of wraparound. These articles also support West Virginia's *Safe at Home* use of a wraparound approach for serving youth aged 12-17, as well as the eventual expansion to all at-risk children with behavioral and mental health issues and histories of congregate care placements.

- Clark, H. B., Lee, B., Prange, M. E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? Journal of Child and Family Studies, 5(1), 39-54. A randomized controlled trial of 132 youth at least seven years of age who were children living in foster care or an emergency shelter placement. The summary of this study: Children determined by caseworkers to be at-risk, due to behavioral indicators such as harm to self or substance use, or to situational indicators such as failed placement or more restrictive placement in the past six months, were randomly assigned to receive Wraparound services or to standard practice conditions. The study measured placement settings and changes, runaway status, and incarceration. The rate of placement changes per year was assessed for both groups prior to entering the study and after the Wraparound intervention. The Wraparound group had significantly fewer changes after the beginning of the intervention than did those receiving standard services. Groups did not differ on number of runaway incidents per year: both groups decreased in incidents after receiving services. However, wraparound children with runaway incidents showed a decrease in the number of days away, while the comparison group showed an increase. Both groups increased in the number of days spent incarcerated for the subset of children with any incarceration, but the increase was significantly greater for the standard services group. Finally, the Wraparound group children were significantly more likely to have received a permanent placement than were the comparison children.

- Evans, M. E., Armstrong, M. I., & Kuppinger, A. D. (1996). Family-centered intensive case management: A step toward understanding individualized care. Journal of Child and Family Studies, 5(1), 55-65. A randomized controlled trial of 42 children

and families. The children were between the ages of five and 12. The participants were children referred to services for serious emotional disorders in New York State. The summary of the study: Families were randomly assigned to Family Based Treatment (FBT) or to Wraparound services, here called Family-Centered Intensive Case Management (FCICM). Assessments were conducted at baseline and every six months up through six months after discharge. The measures included the Client Description Report (CDR), the Child Behavior Checklist (CBCL), the Child and Adolescent Functional Assessment Scales (CAFAS), and the Family Adaption and Cohesion Scales (FACES III). Children in FCICM showed a significant decrease in symptoms and problem behaviors based on the CDR after receiving one year of services. CBCL scores, which were assessed by parents, did not change for either group. The children in FCICM also improved significantly on behavior, moods, emotions and role performance as measured by the CAFAS. Family outcomes did not differ across groups on the FACES III, although caseworkers did note greater improvement for FCICM families on ability to understand children's problems; willingness to access services; provide structure; making children feel loved and wanted; identifying appropriate discipline; and knowing when to call the treatment team. The authors note that at the one year time-point, data was only available on 17 families, and the differences between the groups were no longer statically significant. Limitations include the small sample size, differences between the two groups at baseline, and the large amounts of missing data. Length of post-intervention follow-up: six months after discharge from the programs.

- Hyde, K. L., Burchard, J. D., & Woodworth, K. (1996). Wrapping services in an urban setting. Journal of Child and Family Studies, 5(1), 67-82. Type of Study: Non-equivalent comparison groups with 121 youth. The age range was WD: Mean Age=15.6 years; WR: Mean Age=17.5 years; NW: Mean Age=16.9 years; PW: Mean Age=20.1 years, living in Baltimore, Maryland. The Participants were youth at risk for out-of-home placements and youth diverted from out-of-state residential treatment centers. The summary of the study: Four groups of youth were compared. Two groups received wraparound services. Both groups were diverted from out-of-state residential treatment centers. The Wraparound Return (WR) group included youth returning from residential treatment. The Wraparound Diversion (WD) group included those who were at-risk of residential treatment. Two other groups received traditional services. The Pre-Wraparound (PW) group had been returned from out-of-state residential programs in the year before the implementation of Wraparound services. The Non-Wraparound (NW) group returned from residential treatment at the same time as the WR group, but did not receive Wraparound services. The authors developed the Community Adjustment Rating Scale, which includes measures of restrictiveness of living; school attendance; job training attendance; and harmful behaviors rated by the youth, parent, and case manager. Based on scores, adjustment could be categorized as Good, Fair, or Poor.

Involvement in community activities and evaluation of services provided were also measured. A higher percentage of youth in both Wraparound groups were rated as good or fair in adjustment than in the other two groups. Those in the NR group had the poorest ratings, with none achieving a rating of Good and 60% being rated as Poor. The levels of statistical significance for these differences were not reported. The same patterns held for ratings of the number of youth with more than 10 days of community involvement. Limitations noted were the small sample sizes and the lack of normative data for the measures used.

- Bickman, L., Smith, C., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. Journal of Child and Family Studies, 12(2), 135-156. The type of study was a non-randomized comparison group with 71 youth in the wraparound and 40 in the comparison group. The age range was 4 to 16 years and the population was 72% Caucasian. The participants were dependents of members of the military referred for services. The summary of the study compared a sample of families who had been referred to a Department of Defense mandated wraparound demonstration implementation and agreed to participate to a sample who were referred to the demonstration and refused or were ineligible on some criteria. Criteria for ineligibility for wraparound services included long-term residential treatment; persistent substance abuse, persistent, untreatable antisocial behavior; and conviction of sexual perpetration or predatory behavior. This article provides a list of the 17 measures used to assess youth and family outcomes, but does not provide specific data, which is available from the authors. The assessments cover mental health status; behavior problems; treatment and medication; school performance; family socioeconomic data; and contact with services. They report that both groups showed some improvement, but there were no differences between groups on functioning, symptoms, life satisfaction, or serious events. Wraparound costs were greater due to the use of expensive traditional services and addition of nontraditional services. Limitations of this study include the short time span (six months) and whether the demonstration project truly followed the wraparound process. Authors stated the “wrap” condition had access to informal services and flexible funding, but authors did not assess “wrapness” and stated that, “there is no evidence that the content or the quality of the services were different for the Wraparound children.”

- Carney, M. M., & Butell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. Research on Social Work Practice, 13(5), 551-568. The study was a randomized controlled trial with 73 participants in wrap-around and 68 controls enrolled in conventional services. The mean age of the participants was 15 years. The ethnicity was 45.2% Caucasian, 53.4% African American, and 1.4% biracial for the wrap-around group, and 55.9% Caucasian, 42.6% African American,

and 1.5% biracial for the control receiving conventional services. This study took place in Columbus, Ohio. The summary of the study: Youth were randomly assigned to the Wraparound services or conventional services conditions. Effects of conditions were assessed using interviews with parents or guardians and juvenile courts re-arrest data. Parent/Guardian interviews included questions about school attendance; unruly or delinquent behavior; team functioning (Wraparound only); and service receipt. Analyses indicated that youth in the wraparound group had fewer absences and suspensions from school and fewer incidents of running away from home. They were also less assaultive and less likely to be picked up by police. No significant differences were found in arrests or incarceration during the course of the evaluation at 6, 12, and 18 months.

- Bruns, E. J., Rast, J., Peterson, C., Walker, J., & Bosworth, J. (2006). Spreadsheets, service providers, and the statehouse: Using data and the wraparound process to reform systems for children and families. American Journal of Community Psychology, 38, 201-212. The type of study was a matched comparison group with 97 participants. The participants were children with severe emotional disorders who were involved with child welfare services in Nevada. The summary of the study: Children who were placed into a wraparound process were matched with a comparison group receiving traditional casework on age, sex, race, current residential placement, and severity of mental health problems. Researchers found that youth receiving wraparound services moved to less restrictive placements more often than those in the comparison groups after 18 months (82% versus 38%), and more comparison group youth moved to more restrictive placements than Wraparound group youth (22% versus 6%). Using the Child and Adolescent Functional Assessment Scale (CAFAS), researchers found that scores indicating the seriousness and impact of mental illness were lower for the Wraparound group after six months.

- Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. Crime and Delinquency, 52(3), 375-397. The type of study was an historical comparison group with 106 wraparound youth and 98 youth in the comparison group. The youth were 15 years of age at the start of the intervention. The ethnicity of the wraparound group was 88% Caucasian. The comparison group was 89% Caucasian. The participants were youth involved with the juvenile justice system and mental health system in Clark County, Washington. The summary of the study: Youth receiving wraparound services were compared to youth who had been in the same system prior to implementation of wraparound. The researchers measured recidivism for both groups as number of days between the time they entered services and any substantiated probation violations, misdemeanors and

felonies. They also measured number and length of detentions. Youth in the comparison group were significantly more likely to commit an offense and to commit an offense sooner after entering services than the wraparound group. This pattern was repeated when the analysis looked at felony offenses alone. All of the comparison group youth served detention at some point in the follow-up time compared to 72% of youth receiving Wraparound services.

- Stambaugh, L. F., Mustillo, S. A., Burns, B. J., Stephens, R. L., Baxter, B., Edwards, D., & Dekraai, M. (2007). Outcomes from Wraparound and Multisystemic Therapy in a center for mental health services system-of-care demonstration site. Journal of Emotional and Behavioral Disorders, 15(3), 143–155. The type of study was non-equivalent comparison groups with 320 children and youth between the ages of four and 17.5 years. The ethnicity was 90% White, 4% American Indian, and 6% other. The participants were families enrolled in a Center for Mental Health Services System of Care site after being referred by child-serving agencies in the State of Nebraska. The summary of the study: The study compared families receiving wraparound services (Wrap), families receiving Multisystemic Therapy (MST), and those receiving both treatments (Wrap + MST). This report documents outcomes from enrollment through 18 months of follow-up. Children's outcomes were assessed with the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS) completed by caregivers. Type and frequency of service access were measured with the Multisector Service Contact Questionnaire (MSCQ). Several differences were found across groups at baseline: Youth in the Wrap + MST group had more severe problems, as measured by the CBCL and the CAFAS. They also experienced more placements. The Wrap-only group was younger, more likely to be referred from school rather than court, and had higher internalizing scores. The study found that the percentage of children moving from severe to minimal/moderate impairment by the end of the study was 36% for the Wrap-only group, 66% for the MST group, and 26% for the Wrap+ MST group. On the CBCL, the MST groups' scores improved significantly more than the Wrap-only group. The Wrap-only and Wrap+MST groups' scores did not differ significantly. On the CAFAS, wrap-only and MST did not differ, but the Wrap+MST groups' scores were significantly worse than the Wrap-only group. Limitations include a high level of attrition, although this did not differ across groups and differences across groups at baseline.

- Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. Research on Social Work Practice, 19, 678-685. The type of study was a pre-test, post-test control group design with nonequivalent groups. There were 126 participants between the ages of five and 18 years of age. The youths' ethnicity was 61% Caucasian, 17% African American, 13%

Hispanic, 6% American Indian/Alaska Native, 2% Asian, and 1% Native Hawaiian/Pacific Islander. The gender break-down was63% Male and 37% Female. The participants were youth in foster care with severe emotional disturbance (SED) referred by clinical resource coordinators in Nevada. The summary of the study: The study evaluated the implementation of wraparound services for youth in foster care with severe emotional disturbance (SED). Two intervention groups (state custody foster care and parental custody) receiving wraparound services were compared to traditional foster care case management. Participants were assessed for SED using the Child and Adolescent Functional Assessment Scale (CAFAS) at intake and six months into treatment. Measures used included the Child Behavior Checklist (CBCL) for Ages 6-18 (CBCL/6-18) and the Restrictiveness of Living Environment Scale (ROLES). Results indicated that youth receiving the Wraparound approach showed significant improvement on the CAFAS when compared with youth receiving traditional child welfare services. Results also showed that youth receiving traditional child welfare services experienced significantly fewer placements. However, neither group showed significant differences on other clinical or functional outcomes. Major study limitations include lack of randomization, lack of a post-intervention follow-up, and missing data on the CBCL measure.

- Painter, K. (2012). Outcomes for youth with severe emotional disturbance: A repeated measures longitudinal study of a Wraparound approach of service delivery in systems of care. Child & Youth Care Forum, 41(4), 407-425. The type of study was a group longitudinal study with repeated measures with 160 participants. The youth were between five and 18 years of age. The ethnicity of the participants was 41% White (non-Hispanic), 33% African American, 24% Hispanic/Latino, and 3% American Indian, with 67% Male and 24% Female. The youth in foster care with severe emotional disturbance (SED) referred by clinical resource coordinators in Nevada. The summary of the study: The purpose of this study was to evaluate outcomes for children experiencing serious emotional disturbances who received wraparound in a system of care community funded through a six-year federal grant from the Substance Abuse and Mental Health Services Administration, Grant # SM54497-06. Measures utilized include the Behavioral and Emotional Rating Scale (BERS-2); Child Behavior Checklist 6–18 (CBCL 6–18); the Reynolds Adolescent Depression Scale (RADS-2); the Revised Children's Manifest Anxiety Scale (RCMAS-2); the Columbia Impairment Scale (CIS); and the Caregiver Strain Questionnaire (CGSQ). Results indicate all of the caregiver-completed measurement instruments showed statistical and clinical levels of improvement in youth behavioral and emotional strengths, mental health symptoms, and caregiver stress. Youths rated themselves as having fewer problems than the ratings given by caregivers at intake. Changes across the youth-rated instruments did not show significant improvement until the 12- or 18-month data points. Limitations include non-randomization of

subjects, lack of a comparison group, and lack of examination of possible nesting factors due to the multiple sites and therapists. In addition, some of the youths in this study (35 of 160) were not followed the full 24 months due to the grant ending and were excluded from analysis and nearly half (47%) of the youths who participated in Wraparound were not included in this study due to timing issues with the national evaluation protocol.

IV. Readiness to Implement the Demonstration

In order to implement the Safe at Home Wraparound, we must develop a network of providers including Local Coordinating Agencies. There already exists a good network of these providers who are highly interested and invested in the wraparound model. Many are represented on our workgroups. These agencies must be a licensed behavioral health agency; have the capacity to build and nurture their own "provider network" relationships for services that cannot be provided in-house; assure caseload sizes of 8-10 families for Care Coordinator/Wraparound Facilitators and after-care coordinators; and ensure caseload sizes of less than eight for intensive care coordination Care Coordinator/Wraparound Facilitators. We will develop flexible performance-based contracts between the Bureau and Local Coordinating Agencies that include an allowance for funding of flexible staff that can provide immediate and creative responses to families; detailed staffing patterns for each type of wraparound; allowance for Medicaid billing for services outside the wraparound definition; responsibility to recruit employee; and train the Care Coordinators/Wraparound Facilitators, After-care Coordinators, and the Intensive Care Coordination Care Coordinator/ Wraparound Facilitators. To further assist us with moving forward with Results Based Accountability the outcomes included within the statements of work are connected to the outcomes for Safe at Home West Virginia. All of our community partners are aware of this movement to outcome based performance measures and have been a part of the development of those outcomes. They are also aware that West Virginia will begin posting all of our outcomes and data on our website for public viewing. The contracts will require the use of evidence-informed, promising practices and trauma-focused curricula in the provision of wraparound interventions such as described on the National Wraparound Initiative and National Child Traumatic Stress Network. Provisions for training other wraparound team members with specialized roles, such as Peer Support Specialist, Parent or Youth Advocates, Mentors, and all wraparound team members outside of the Local Coordinating Agencies, and adherence to clear performance measures for families utilizing Safe at Home Wraparound. The performance measures shall be implemented within

the contracts of the Local Coordinating Agencies that will identify their success with Safe at Home wraparound in areas such as:

- Youth are able to be at home and in their home school without getting into trouble;
- Children are able to be at home without being re-abused or neglected;
- Parents, youth, and children have increased skills and strengths and their needs are reduced; and
- Parents voice and demonstrate, through actions, a higher level of well-being and satisfaction in their role as a parent.

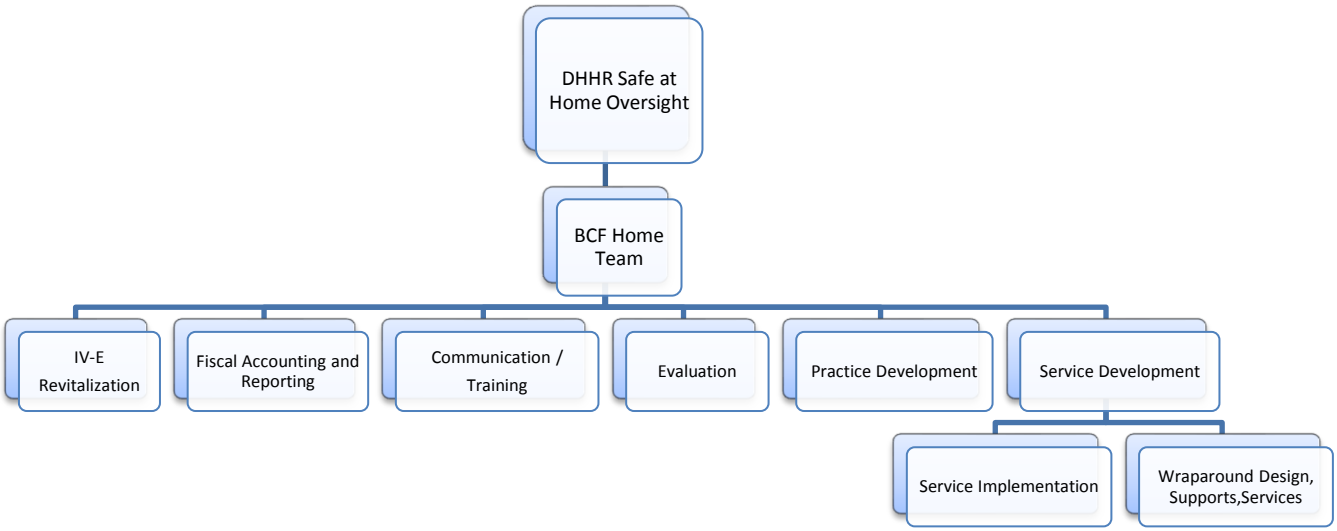
These performance measure outcomes will be linked to continuation of yearly contractual relationships between the Bureau and each Coordinating Local Agency. Responsibility of executing the duties of the contractual relationship with the Bureau shall rest with the Local Coordinating Agency, as well as development of an inclusive network of community providers in order to ensure youth and families receive services that are needed, when they are needed, and where they are needed. We hope to award 10, but we will work with our Local Coordinating Agencies to assure that their workforce development meets the needs.

Clear referral criteria will be developed to ensure our caseworkers, families, and other stakeholders have a clear pathway to enter wraparound in a timely fashion. This will include enrollment and assignment protocols to ensure that families are matched to Local Coordinating Agencies that are best able to meet the needs of the family and youth.

Strategic Implementation Plan and Work Groups:

The details of the implementation of the demonstration are being accomplished by six work groups that include persons with the expertise in specific issues or practice areas. As the demonstration project proceeds, additional work groups may be formed as additional need for expertise is identified. For the initial implementation of the demonstration, the following groups have been established to accomplish the tasks necessary to implement the demonstration.

Based on the work of these work groups and the oversight team, the following implementation plan and work plan show the major tasks and deliverables to be accomplished. This will be reviewed and updated as the demonstration progresses to ensure that implementation of the demonstration proceeds in accordance with the Terms and Conditions.



Overview

DHHR *Safe at Home West Virginia* Oversight Team

In order to manage the implementation of the demonstration, a senior implementation team has been established. This oversight group is composed of senior managers from BCF and DHHR along with Juvenile Services and the Supreme Court of Appeals.

Contributing team members

- **Nancy Exline, Co-Chair, BCF Commissioner**
- **Lisa McMullen, Co-Chair, Safe at Home Project Manager**
- **Karen Bowling, Secretary Department of Health and Human Resources**
- **Nancy Sullivan, Assistant to the Secretary**
- **Harold Clifton, DHHR Deputy Secretary of Human Services**
- **Sue Hage, BCF Deputy Commissioner Programs**
- **Linda Adkins, BCF Duty Commissioner Office of Operations**
- **Tina Mitchell, BCF Deputy Commissioner Field Operations South**
- **Tanny O'Connell, BCF Deputy Commissioner Field Operations North**
- **Jane McCallister, BCF Director of Social Services**
- **Michael Johnson, Program Manager of Office of Information Technology**
- **Cindy Bean- Commissioner Bureau for Medical Services**
- **Cynthia Parsons – Bureau for Medical Services**
- **Stephanie Bond, Division of Juvenile Services**
- **Cindy Largent-Hill – Supreme Court of Appeals**
- **Nikki Tennis – Supreme Court of Appeals**

Overview

BCF Home Team

This team manages the day-to-day activities of the development and implementation of *Safe at Home West Virginia*.

Contributing team members

- **Lisa McMullen, Co-Chair, Safe at Home Project Director**
- **Sue Hage, Co-Chair, BCF Deputy Commissioner Programs**
- **Nancy Exline, BCF Commissioner**
- **Jim Weekley, BCF Chief Financial Officer**
- **Laura Barno, BCF Program Manager**
- **Kevin Henson, BCF Director Research and Analysis**
- **Linda Adkins, BCF Duty Commissioner Office of Operations**
- **Tina Mitchell, BCF Deputy Commissioner Field Operations South**
- **Tanny O'Connell, Deputy Commissioner Field Operations North**
- **Jane McCallister, BCF Director of Social Services**
- **Michael Johnson, Program Manager of Office of Information Technology**
- **Jennifer Beckett, BCF Program Manager**
- **Angie Sloan, BCF Social Services Program Manager**
- **Cheryl Salamacha, BCF Regional Director Region II**
- **Kathryn Bradley, BCF Community Services Manager Region III**
- **Joe Bullington, BCF Regional Director Region IV**
- **Cree Lemasters, BCF Interim Regional Director Region I**
- **Beverly Heldreth, BCF Program Manager Region I**
- **Patricia Vincent, BCF Office Director of Social Service for Field Operations**
- **Heather Grogg, BCF Interim Regional Director Region III**
- **Melanie Urquhart, BCF Social Services Program Manager**
- **Renea Brown, BCF Program Manager IV-E Unit**
- **Peter Layne, Program Manager IV-E Unit**
- **Carla Harper, BCF Program Manager**
- **Rebecah Carson, BCF Child Welfare Consultant**
- **Susan Richards, BCF Director Division of Training**
- **Susan Fry, Executive Director Stepping Stones**

Overview

Service Development Work Group – Co-Chairs/ Laura Barno- BCF and Susan Fry-Stepping Stones

This work group is a multi-agency group that includes members from BCF and community partners. This group is responsible for determining the appropriate service intervention model, structure, and service design. This group will also provide guidance and/or technical assistance on program practice in order to best use the flexibility of the demonstration to improve child welfare practice. This group will consider how the improved array of community-based service provisions of the demonstration can be used to accomplish the well-being and safety outcomes for children and families contemplated in the demonstration and to improve the permanency of children.

Sub Group- Service Implementation – Chair, Laura Barno
Contributing team members

Licensed Behavioral Health, Residential and Specialized Foster Care Partners

- **Frank Fazzolari, Counseling Connection**
- **Susan Fry, Stepping Stones, Chair Service Development Delivery Work Group**
- **Lata Menon, Home Base**
- **Michael Fidgeon, Family Preservation**
- **Michele Vaughn or Steve Tuck, Children's Home Society**
- **Peter Callahan, Counseling Services**
- **Mindy Thornton, Prestera**
- **Jennifer Graham, NECCO**
- **Taunja Hutchinson, Children First**
- **Shanna Wideman, Youth Advocate Program**
- **Mia VanSant, Burlington UM Family Services**
- **Jackie Columbia, Board of Child Care**
- **Melinda Eaton, Counseling and Advocacy**

Other Partners

- **Tammy Pearson, Marshall University**
- **Linda Watts, System of Care Grant Program Manager**

BCF Field and Central Office Staff

- **Laura Barno, Chair, BCF Program Manager**
- **Cheryl Salamacha, BCF Regional Director**
- **Lance Whaley, BCF Community Services Manager**

- **Stephanie Drake, BCF Foster Care Program Specialist**
- **Alicia McIntire, BCF Youth Services Program Specialist**
- **Carla Harper, BCF Program Manager, Child and Adult Services Policy**
- **Kathy Bradley, BCF Regional Director**
- **Shelly Nicewarner, BCF Community Services Manager**
- **Linda Dalyai, Office of the Deputy Commissioner, Programs and Resource Development**
- **Misty Prillaman, BCF CPS Program Specialist**
- **Lance Whaley, BCF Community Services Manager**
- **Elva Strickland, BCF Program Manager, Division of Training**
- **Angela Seay, BCF Social Services Coordinator**
- **Rebecca Farmer, BCF Child Welfare Consultant**
- **Ivy Legg, BCF CPS Supervisor**
- **Elizabeth Leonard, BCF Youth Services Supervisor**
- **Rebecah Carson, BCF Child Welfare Consultant**

Sub Group- Wraparound Design, Supports, and Services – Co-Chairs, Susan Fry and Beverly Heldreth

Contributing team members

- **Susan Fry, Co-Chair, Stepping Stones**
- **Beverly Heldreth, Co- Chair, WVDHHR, BCF Region 1 Child Welfare Consultant**
- **Raymona Preston – Stepping Stones**
- **Linda Watts- WV System of Care**
- **Rhonda McCormick – WV Family Advocacy and Support Team (FAST)**
- **Beverly Petrelli – Wellspring – Crittenton Services**
- **Renee Ellenberger/Patty Lewis – National Youth Advocate Program**
- **Laura Barno – WVDHHR, BCF Program Manager**
- **Debi Gillespie – Division of Juvenile Services**
- **Jason Deusenberry – WVDHHR, Bureau for Behavioral Health and Health Facilities**
- **Mindy Thornton – Prestera**
- **Linda Daylia – WVDHHR, BCF**
- **Elva Strickland – WVDHHR, BCF Training Division**
- **Jennifer Graham – Necco**
- **Lorie Bragg – WVDHHR, BCF Region IV Child Welfare Consultant**
- **Lisa Vinson – Region II BCF Supervisor**
- **Tammy Pearson – West Virginia System of Care**
- **Leslie Welton See – Family Preservation**
- **Rebecah Carson – WVDHHR, BCF Region III Child Welfare Consultant**
- **Mia VanSant – Burlington United Methodist Family Services**

Goals

Goal: Service Development

Goal: Wraparound Model Support-Development of Provider Network – to be coordinated with Local Coordinating Agencies (and Fiscal Accounting Workgroup)

Overview

Practice Development Work Group

This workgroup will look at the internal program revisions that will take place related to embedding the wraparound and system of care values. This workgroup will address the philosophies, outline practice changes and FACTS/policy revisions for staff, which will occur as a result of the implementation of *Safe at Home West Virginia*.

Contributing team members

- **Rebecah Carson, Chair, BCF Child Welfare Consultant**
- **Linda Watts, System of Care Grant Program Manager**
- **Carla Harper, BCF Program Manager, Child and Adult Services Policy**
- **Stephanie Drake, BCF Foster Care Program Specialist**
- **Misty Prillaman, BCF CPS Program Specialist**
- **Susan Richards, BCF, Director Division of Training**
- **Michelle Dean, BCF, Youth Services Program Specialist**
- **Crystal Kendall, BCF CPS Supervisor/MSW Intern**

Overview

Communications and Training Work Group

This work group is responsible for development and deployment of training and training material related to the demonstration project as well as developing effective mechanisms and plans to share information about the demonstration with Department staff, stakeholders and interested parties.

Contributing team members

- **Jessica Holstein, Co-Chair, Secretary's Office of Communications**
- **Susan Richards, Co-Chair, BCF Director of Training**
- **Brandon Lewis, BCF Policy**
- **Alicia McIntire, BCF Policy**
- **Gary Keen, BCF CAPS coordinator**
- **Kathy Bradley, BCF Regional Director**
- **Shelly Nicewarner, Community Services Manager**
- **Lori Bragg , Child Welfare Consultant**
- **Crista Janes-Ash, Child Welfare Consultant**
- **Lance Whaley, Community Services Manager**
- **Amy Booth, Community Services Manager**
- **Becky Farmer, Child Welfare Consultant**

Audiences

Internal audience: Any person, office, or division within the Department of Health and Human Resources, for example:

- BCF Field staff
- Supervisors
- Managers
- Executive leadership
- DHHR Commissioners

External audience: Entities outside DHHR, specifically:

- Service providers
- Judicial (law enforcement, prosecutors, judges, GALs (Guardian ad Litem), state police unit, probation, family law judges)
- Legislature
- Board of Education
- Community and Technical College System of West Virginia

- Medical personnel (health professionals/hospitals)
- Community members
- Families
- Youth organizations
- Division of Juvenile Services
- Local health departments
- Family Resource Networks
- Community Collaboratives
- Regional Summits
- Emergency Shelter Provider Network
- Out of state service providers
- Media
- Other stakeholders

Goals

- **Goal: Consistency and clarity in the message**

- **Goal: Develop and put in place, mechanisms/systems for two way communication and feedback**

- **Goal: Convey message to all stakeholder groups**

- **Goal: Stakeholder participation**

Messages

Topic	Message	Audience
Safe Children	WV will adapt strategies to keep children safe within their own families and communities. Our children will be safe and have permanent, strong connections with their family and community.	Internal and External
Strong Families	WV can better adapt community-based strategies to help at-risk families raise happier and healthier children. Our children and families will be successful in their lives, mentally and physically healthy, and have enhanced well-being.	Internal and External
Supportive Communities	WV children and families will be supported, first and foremost, in their homes and communities by receiving the appropriate services to meet their needs.	Internal and External
Smart Investment	As the use of congregate care safely declines, DHHR will have the flexibility to reinvest resources into more cost efficient approaches that achieve better outcomes.	Internal and External
Innovation	Our child-serving systems will be transformed to meet the needs of children and families.	Internal and External
Results	Congregate care will be used as a way of protecting life not as a way of life. Our children will be safe and have permanent, strong connections with their family and community.	Internal and External

Overview

Evaluation Work Group

This workgroup will assure that an independent evaluation is conducted that meets the requirements of the waiver terms and conditions. This will include procurement of the evaluator, assuring that an evaluation design document is submitted for review and approval to the Children's Bureau and ongoing coordination with the evaluator throughout the course of the demonstration.

Contributing team members

- **Kevin Henson, Co-Chair, BCF Director of Research and Analysis**
- **Lisa McMullen, Co-Chair, Project Manager *Safe at Home West Virginia***
- **Jim Weekley, BCF Chief Financial Officer, Chair Fiscal Accounting**
- **Linda Adkins, BCF Deputy Commissioner of Operations**
- **Patricia Vincent, Office Director of SS of Field Operations, Chair Data**
- **Michael Johnson, DHHR, Program Manager Office Of Information Technology**
- **Brenda McPhail, BCF Director of DPQI**
- **Laura Scarberry, Research and Analysis**
- **Helaine Hornby, Principal Evaluator, Hornby Zeller Associates**
- **Dennis Zeller, Principal Evaluator, Hornby Zeller Associates**
- **Susan Richards, Director Division of Training, Co-Chair Training/Communication**
- **Sue Hage, BCF Deputy Commissioner of Programs**

Overview

Fiscal Accounting and Reporting Work Group

This work group will address issues related to cost allocation, financial accountability, and reporting related to the demonstration. The group will develop procedure to assure that financial information related to the demonstration is reported on Form ACF-IV-E -1, and relevant attachments are completed in sufficient detail to assure that information needed for effective management of the demonstration is provided. This work group will also provide information necessary for preparation of the fixed schedule of payments for the five-year demonstration period as required by the Terms and Conditions and recommend any subsequent modification to this schedule. This work group will also assure the cost neutrality provisions section of the Terms and Conditions are met.

Contributing team members

- **Jim Weekley, Chair, BCF Chief Financial Officer**
- **Tara Buckner, DHHR Chief Financial Officer**
- **Linda Adkins, BCF Deputy Commissioner Office of Operations**
- **Larry Easter, DHHR Grants and Contracts**
- **Michael Johnson, DHHR, Program Manager Office Of Information Technology**

Overview

IV-E Revitalization Work Group

This workgroup will develop procedures to ensure that IV-E eligibility determinations can be made for all children who are involved in the demonstration project to ensure eligible children retain their eligibility after the demonstration ends and to ensure that IV-E eligibility can be properly determined for the purpose of Adoption Assistance payments.

Contributing team members

- **Renea Brown, Chair, BCF Program Manager IV-E Unit**
- **Tara Buckner, DHHR Chief Financial Officer**
- **Linda Adkins, BCF Deputy Commissioner Office of Operations**
- **Jim Weekley, BCF Chief Financial Officer**
- **Michael Johnson, DHHR, Program Manager Office Of Information Technology**
- **Peter Layne, BCF, Program Manager IV-E Unit**
- **Lynda Ahmad, BCF OA**
- **Jennifer Beckett, BCF Region 2 Program Manager**
- **Christina Bertelli-Coleman, BCF Program Manager**
- **Stephanie Drake, BCF Policy Unit**
- **Sue Hage, BCF, Deputy Commissioner**
- **Kevin Henson, BCF, Director Research and Analysis**
- **Tina Mitchell, BCF, Deputy Commissioner**
- **Susan Richards, BCF, Director Division of Training**
- **Angie Sloan, BCF, Region 3 Program Manager**
- **Melanie Urquhart, BCF, Region 4 Program Manager**

Overview

Data Workgroup

This workgroup will assist in identifying data needs, gathering identified data, and analyzing identified data to support the successful implementation of West Virginia's IV-E Demonstration Project; Safe at Home WV.

Contributing team members

- **Patricia Vincent, BCF Office Director of Social Services for Field Operations**
- **Kevin Henson, BCF Director of Research and Analysis**
- **Tanny O'Connel, BCF Region 1 Regional Director**
- **Cheryl Salamacha, BCF Region 2 Regional Director**
- **Kathryn Bradley, BCF Region 3 Interim Regional Director**
- **Joe Bullington, BCF Region 4 Regional Director**
- **Beverly Heldreth, BCF Region 1 Program Manager**
- **Jennifer Beckett, BCF Region 2 Program Manager**
- **Angie Sloan, BCF Region 3 Program Manager**
- **Melanie Urquhart, BCF Region 4 Program Manager**
- **Paula Taylor, BCF Region 1Community Services Manager**
- **Shelly Nicewarner, BCF Region 3 Interim Community Services Manager**
- **Sandra Wilkerson, BCF Region 2 Child Welfare Consultant**
- **Rebecah Carson, BCF Region 3 Child Welfare Consultant**

Service/Model Implementation Workgroup was created to (1) develop a model for the delivery of a wraparound approach to service provision; (2) build upon existing initiatives in West Virginia to prepare communities and community providers, including congregate care providers, for the implementation of *Safe at Home West Virginia* by assisting in the development of an infrastructure to support wraparound; and (3) assist community stakeholders in the development of services and supports to reduce their reliance on congregate care.

The workgroup is comprised of members from the Bureau for Children and Families ("Bureau") and the provider community, which includes congregate care providers. The Service Implementation Workgroup is co-chaired by the Bureau for Children and Families and a Provider Representative. These workgroups will work cooperatively with the existing Service Delivery and Development Workgroup that was formed through the West Virginia Commission to Study the Residential Placements of Children and sub-groups in order to include the widest range of providers, families, and community stakeholders and to build upon the work that has been done to date to reduce the reliance on out-of-home care.

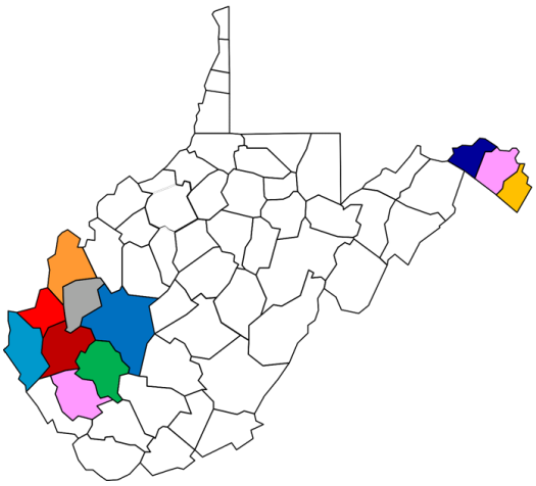
The Service Implementation Workgroup, on behalf of all the groups and sub-groups working on the development of *Safe at Home West Virginia*, will make developmental recommendations to the governing Home Team. The work of this group and its subgroups will focus on the implementation themes outlined in the National Wraparound Initiative's (NWI) Wraparound Implementation Guide: *A Handbook for Administrators and Managers*. The work of the sub-groups will focus primarily on Community Partnerships, Collaborative Action, and Access to Needed Supports and Services.

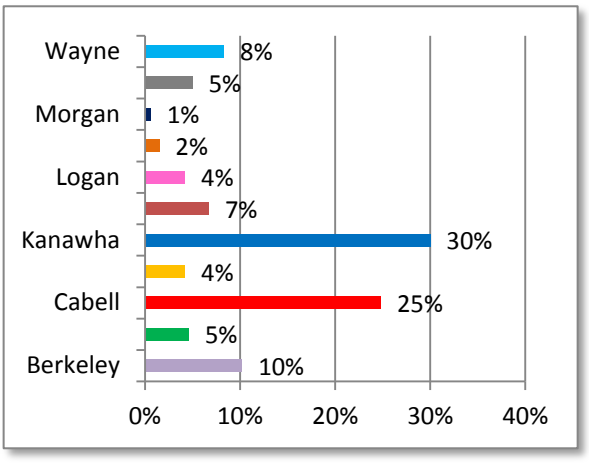
Deputy Secretary Harold Clifton has been leading a focused workgroup with Deputy Secretary Jeremiah Samples, BCF Commissioner Nancy Exline, BHHF Commissioner Victoria Jones, BMS Commissioner Cynthia Bean, BCF Deputy Commissioner Sue Hage, and Program Manager Laura Barno to assure that BCF and BHHF are using the same terminology and definitions of services and service populations and to coordinate with BMS to determine available Medicaid billing for core wraparound services.

V. Work Plan

Developmental Activities:

Approximately 400-500 youth could receive Safe at Home Wraparound Services during the first year of the Demonstration Project. Phase 1 of *Safe at Home West Virginia* will start in the eight counties of BCF Region II (southwestern area of the state, includes Mason, Putnam, Kanawha, Cabell, Lincoln, Boone, Wayne, and Logan counties); as well as Berkeley, Jefferson, and Morgan counties in BCF Region III (eastern panhandle). These two areas were selected due to their need and readiness. Region II has been identified as an area that has extensive partnerships and services with the ability to provide the necessary supports. Berkeley, Jefferson, and Morgan counties have a large number of children in congregate care and a lack of services. Service development will be necessary in those counties. At present, BCF has strong relationships with several licensed behavioral health providers in the Berkley, Jefferson, Morgan County area that are partnering with us in expanding the necessary services. There are several that keep contact with us regarding our grant process for our Lead Agencies. BHHF and BMS are also working with the Comprehensive Community Mental Health providers in all areas of the state. By developing the necessary services and demonstrating success in the counties of Berkeley, Jefferson, and Morgan, we will be able to systemically replicate *Safe at Home West Virginia* successfully throughout the state. Below you will see the selected counties for Phase 1 and the approximate percentages of eligible youth for *Safe at Home West Virginia* by county as of October 31, 2014. Further expansion and implementation plan development will begin after initial implementation and will be determined by our evaluator, our Home Team, and Regional Management teams.





Development of Wraparound staffing plans, caseload characteristics, and job descriptions for the models shall include:

- Safe at Home Next Steps Care Coordinator/Wraparound Facilitator
- Intensive Care Coordination Care Coordinator/Wraparound Facilitator

The Home Team and the Safe at Home Advisory Committee shall assist the Summits and Community Collaboratives with the development of services and natural supports to include services beyond behavioral health and socially necessary services. The Safe at Home Advisory Team members shall assist in educating communities regarding how to develop natural and social support networks for families and youth. West Virginia has had Community Collaboratives in place for over 27 years. These Collaboratives often include more than one county and are comprised of DHHR staff and community partners in education, behavioral health, juvenile services, in-home service providers, residential placement providers, families and even out-of-state residential providers that border West Virginia. At present, there are 14 Community Collaboratives in West Virginia. Their role has always been to develop needed services within their communities. They review service gaps and attempt to fill those gaps. The Collaboratives feed into four Regional Children's Summits. They are comprised of the membership of all of the Collaboratives within their respective regions. This allows for further service refinement or development on a larger scale. In April, the local Collaboratives and Regional Summits completed a checklist of services survey to assess whether core wraparound services exit within each county in the Phase 1 counties. They are then reviewing them within their respective Collaboratives and Summits and using them to guide their work on service development. During the month of May, they are completing the "Community Self-Assessment" from the National Wraparound Initiative's Implementation Guide for Managers.

Although this tool is meant for coordinating agencies, it also allows a community view of readiness to implement. The Collaboratives and Summits will again use this information to guide their future work in their areas. The above information will also be compiled to give a statewide view of service gaps and readiness.

As these have been completed, West Virginia's Phase 1 Collaboratives and Summits have been provided with guidance and a format for developing a strategic plan for development of identified needed services. This plan is incorporated into their reporting form and is to be submitted to BCF by September 30, 2015 and thereafter updated and submitted semi- annually. All other Collaboratives are required to proceed with the needs assessments and submit their plan and report within 90 days of completion of the assessments and then semi-annually.

Existing behavioral health providers will be required to enhance their services in order to continue their existing contracts. The Commissioner for Behavioral Health and Health Facilities is already working with the licensed Community Comprehensive Mental Health Agencies as well as licensed behavioral health providers to address needed service expansion and cooperation in working with their communities. Gaps in behavioral health and socially necessary services that have been recommended by the Safe at Home Advisory Team and approved by the Home Team shall be developed by the Local Coordinating Agencies as per their contracts using the following outline:

- Evidence-based, evidence-informed or promising practices;
- Trauma-informed and compatible with the use of the philosophies of the ACES study;
- Creative interventions can be developed on a one-youth/family-at-a-time basis as long as it helps maintain a child safely at home;
- Purposeful and designed to assist the family get through the processes of the child welfare, juvenile justice and/or mental systems in which they are involved;
- Includes after-hours coverage and non-traditional business hours;
- Includes up-front stabilization to help families feel supported and comfortable; and
- Can be implemented with current workforce availability within the specific community.

Extra focus shall be given to Crisis Planning by creating the capacity for immediate crisis response services and supports. Families enrolled in wraparound cannot safely manage a crisis on their own. Each family shall receive an individualized plan with effective crisis programming

and services.

- Natural supports shall be developed and nurtured for each individual family, based upon need. Natural supports include individuals or organizations in the family's own community: family members, faith-based networks, friends and neighbors; and

- Service definitions and utilization management procedures shall be developed by the Safe at Home Service Development Workgroup to support *Safe at Home West Virginia*'s two wraparound processes.

    - Utilization management criteria and definitions for services will be changed from the current compliance-based requirements to performance measures;

    - Service types will be defined and outlined instead of individual service definitions; and

    - Performance measures will be assigned to coordinating local agencies and not individual services.

Formal services that are not currently being provided in the demonstration communities shall be reviewed for a statewide "Request for Applications" publication for the identification of agencies wishing to develop said service, upon approval by the Home Team**.** These will be newly procured in order to fill existing gaps. A protocol for waiving the criteria for formally creating and establishing a crisis or non-crisis service shall be developed to support the construction of "just in time" services. Just in time services are for critical instances when urgency is a factor. A protocol for formally exiting services that families, Local Coordinating Agencies and other stakeholders don't find helpful shall be developed.

At present, the DHHR Office of Administration and BCF Finance are working on the development of a rate structure for payment of care coordination and services within the wraparound model that are not payable by other sources. They have requested data from the Utilization Management organization for Medicaid and our SACWIS system in order to review several years of data on service utilization and payment. The startup funding for Care Coordinator/Wraparound Facilitators for Local Coordinating Agencies and daily rate for Wraparound services has been developed and included within a Request for Applications.

The Service/Model Development Workgroup has developed the entire process and criteria for identification of eligible youth, referral process, assessments, treatment planning, to transition. Everything is based on the National Wraparound Initiative and high fidelity wraparound. West Virginia does not plan to veer from the high fidelity wraparound. All necessary forms and flow charts are in draft format and awaiting approval. All necessary forms and flow charts are approved and complete. The flow charts have been inserted into previous sections of this update. All forms for use by the Local Coordinating Agencies and Care Coordinators/Wraparound Facilitators are being included in a Manual for their use. They will also be provided to BCF staff for informational purposes. The manual is complete and ready for release. They have also written a Safe at Home WV Family Handbook.

The Practice Development Workgroup has reviewed existing Youth Service and Child Protective Service Policy and made the appropriate insertions of *Safe at Home West Virginia*. The policy is in draft and in the review phase. The policy is now complete and approved and the group has developed guidance for BCF staff regarding location and filing of documents. They are also working with the group on automation of the CANS to assist with thinking through logistical case work issues.

Family Centered Practice training is being scheduled for all Phase 1 areas to assure that newer staff has participated.

Family Centered Practice and Family and Youth Engagement Strategies trainings have been conducted in all Phase 1 areas as well as other areas in the state during the months of June and July.

BCF Community Services Managers and Supervisors have held staff meetings to focus on discussing the 10 Principles of Wraparound. This was done as a first step to begin the philosophical shift that our staff would need to make. Meeting agenda's and sign in sheets were required.

BCF has drafted the RFA for the contracting of Local Coordinating Agencies. The retired director of the BCF Contracts Division has agreed to come back to work on a temporary basis to assist with this particular RFA. Once the contracts are awarded, BCF will work with the Local Coordinating Agencies to develop the statements of work and finalize rate fees. At present, we have several Licensed Behavioral Health Providers expressing their desire to partner with us.

The Request for Applications for Local Coordinating agencies and Care Coordination/Facilitation was released on July 14, 2015. The Request for Applications closes on August 14, 2015. The outlined expectation is that the awards will be by August 21, 2015. A

statement of work for the contracts is in draft format and will be completed with the Local Coordinating Agencies. The rate setting was completed prior to release of the RFA so that it could be included for applicants consideration. Preliminary staffing is to be done by September 1, 2015 to allow for necessary training during the month of September.

The Secretary's Office of Communication has approved a *Safe at Home West Virginia* Power Point Presentation as well as Speaking Points. These have been used numerous times to communicate with BCF staff and stakeholders throughout the state. At every presentation the audience has been asked to go back to their offices and review the 10 Principles of wraparound and to challenge themselves and their staff as to whether they agree with them or have room for change.

Commissioner Nancy Exline, Deputy Commissioner Sue Hage, and Project Director Lisa McMullen have met with the Judiciary in the Eastern Panhandle and are scheduling to meet with the Judiciary in Region II of the state; these are the Phase 1 areas.

During the last legislative session, the West Virginia Legislature passed Senate Bill 393; this bill makes changes to the juvenile services section of child welfare code to address specific issues. Many of these changes will work supportively with *Safe at Home West Virginia* but will need to be considered upon evaluation of the demonstration. The changes listed below will have an effect on the congregate care population but we must remember that approximately 65% of our 12-17 year olds in congregate care enter through a Juvenile proceeding. The other 35% enter through an abuse/neglect proceeding. Also, of the 65% Juveniles, the ability to transition them out of placement in this brief timeframe will be dependent upon access to necessary community based services. Many of these youth will be part of our target population. Also, BCF is changing the outcome measures for our residential or congregate care providers to assure a shortened length of stay that mirrors this timeframe. This has been one of the focuses on our advancements and changes in our child placing system. Below is an overview list of the changes made by Senate Bill 303:

- Limited time a juvenile may be committed to custody and placement in some instances.

- Requirement that DHHR develop a transition plan designed to bring juveniles back home immediately upon placement in a residential facility.

- Juveniles are expected to transition home between 30 and 90 days of placement.

  This is a guideline with requirements. If it does not occur or is not in the best interest of the child the MDT must make the recommendation to the court for the stay to continue and the court must rule on the record.

- Pre-petition diversionary treatment for first time status offenders.

- Restricts placement of first time adjudicated status offenders.

- Requires the development and use of a standardized risk and needs assessment by the BCF and DJS; specifically the CANS. The courts have selected the YLS/CMI- Youth Level of Service/Case Management Inventory for use in Juvenile Cases. At this time DJS and Probation staff will be responsible for completing this assessment and BCF and community partners will continue to use the CANS in conjunction and will use the YLS/CMI to inform the CANS. BCF staff that work with the juvenile population will need to be trained to conduct the YLS/CMI.

- Allows for adjudicated status offenders and non-violent misdemeanor offenders be referred to restorative justice programs, where available.

- BCF is changing our provider agreements and licensing regulations in order to limit length of stay of youth.

- The Department of Education has been awarded a grant for "Project Aware, Now is the Time." It is a SAMSHA grant to focus on mental health needs of children, families, and communities through the public school system. The service population differs from that of *Safe at Home West Virginia* but compliments and works in conjunction.

Teaming and Building an Accountable, Collaborative Governance Structure:

Determination of the level of community and work-force readiness and "ownership" for wraparound, using the Self-Assessment of Strengths and Needs from the National Wraparound Initiative's Wraparound Implementation Guide, *Community Groundwork for Wraparound Implementation,* which includes an assessment of the workforce development needs, will need to be addressed. The county assessments are being completed by the Local Collaboratives and Regional Children's Summits and are to be turned in by the end of April. Once the initial development phases of wraparound are completed, community action work shall be administered through the existing Regional Summits and Community Collaboratives. A panel of key stakeholders from the Regional Summits and the Community Collaboratives, including family representatives, shall be formed and called the Wraparound Advisory Team. The decision as to the formation of this team has been made that the Advisory or Oversight team will be developed by November 30, 2015. This team shall act as the liaison with the Safe at Home Wraparound Home Team which shall help create vertical ownership from administrative to supervisory to community levels. This is the team that will transition us from implementation to ongoing practice. Their full activities will begin after full implementation. Duties of the Wraparound Advisory Team shall include:

- Define and assign key leadership roles within each wraparound community;
- Written protocols for how decision-making occurs;
- Detailed descriptions of each member's role and responsibility to the team;
- Evaluate recommendations made by the Summit and Community Collaboratives for formal service development for appropriateness before sending to the Home Team;
- Ensure the health and productivity of the community partnerships by monitoring membership and facilitating communication between community stakeholders when attrition occurs;
- Develop policies and procedures at the local level that are consistent across member agencies to support sustainability of the wraparound work;

- Develop satisfaction surveys for providers, Bureau staff, families, and youth to help measure well-being factors and fidelity of wraparound; this will be done by the evaluator

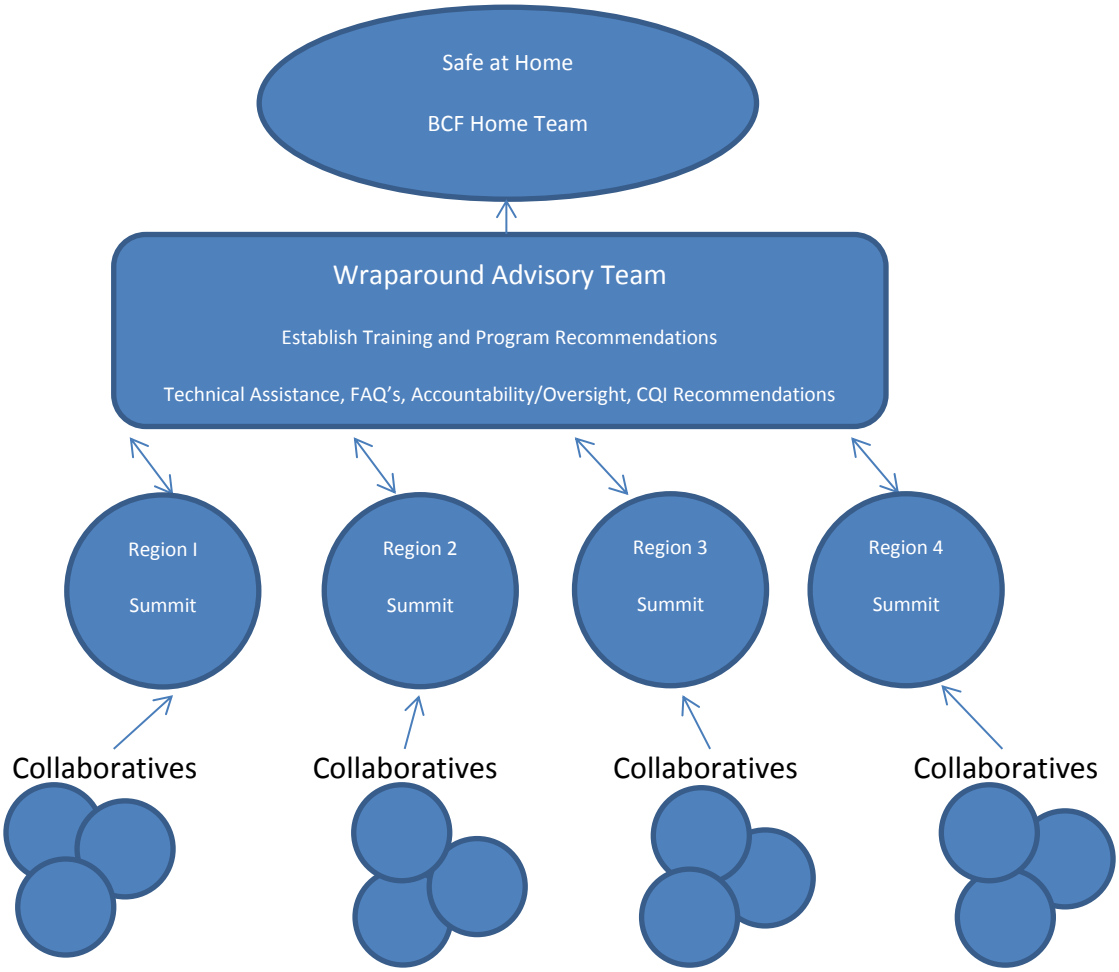
- Assist the Summits and Community Collaboratives with developing alliances outside the typical “child welfare” or “behavioral health” milieu that allow the widest range of services possible to meet the needs of the youth and family;

- Establish workforce development and training recommendations;

- Review and assist in the development and oversight of work plans detailing how gaps in services will be addressed by local Summits and Community Collaboratives;

- Provide technical and “troubleshooting” assistance to Summits and Community Collaboratives; and

- Make recommendations to the Home Team for quality improvement actions that would provide program enhancements.



Communication Plan and Strategies:

Please refer to the Training/Communication Workgroup as well as the associated sections of the *Safe at Home West Virginia* Work Plan. 2 of the key initiatives to increase knowledge through communication are West Virginia's weekly email blasts. The Secretary's Office of Communications assists with sending out a weekly email blast to all DHHR employees as well as external partners. Each of the email blasts is a short 1 page "did you know" informational blurb about Safe at Home WV. The Secretary's Office of Communications is also assisting with the quarterly newsletter in which Secretary Bowling always has an editorial. The newsletters are also posted on the Safe at Home WV website.
http://www.wvdhhr.org/bcf/safe/

Quality Assurance:

West Virginia will be working with our evaluator to determine the most appropriate plan for assuring quality. Our director and program managers for the Division of Planning and Quality Improvement (DPQI) are a part of the evaluation team and will guide this process with our evaluator. DPQI has representation on the Evaluation Team to assure that we assess quality.

West Virginia will be working with our evaluator to determine the most appropriate plan for assuring quality. The Assistant Commissioner for the Office of Planning Research and Evaluation, under which the Division of Planning and Quality Improvement falls is the co-chair of evaluation team and the Director of Planning and Quality Improvement is a member. Both will assist in the guidance of this process along with our evaluator.

The Safe at Home Team and the Safe at Home Oversight Team will be establishing a tool and process for use for ongoing fidelity monitoring as an integral part of the Demonstration Project. This process will lead to a continuous quality improvement process focusing on refinements and recommendations with the intended benefit of assisting West Virginia in meeting the stated outcomes in our application. The DPQI staff will review cases using the fidelity tool and present the findings to the independent evaluators.

West Virginia has an operational Division of Planning and Quality Improvement (DPQI) which continues its efforts to further enhance the State's performance in the areas of safety, permanency, and well-being by utilizing the Federal Child and Family Services Review (CFSR) process as a model to measure and evaluate the State's performance for the above mentioned areas. In addition to the evaluation component required as part of the Title IV-E waiver, the Bureau for Children and Families Division of Quality Improvement will continue to conduct CFSR quality service reviews. The CFSR case review tool will be used to conduct case reviews focusing on qualitative measures of case success. The CFSR data for counties will be provided to the Evaluators as part of the evaluation process.

The Division of Planning and Quality Improvement, Social Services Review Unit, completes biennial Child and Family Services Reviews (CFSR) style reviews for each of the West Virginia Department of Health and Human Resource's districts.

The CFSR review instrument (OSRI) is and will continue to be the unit's primary internal tool for evaluating the quality of service delivery to children and families. Each reviewed case must follow the guidelines established by the Federal Bureau for Children and Families.

The CFSR style review provides meaningful data to the districts to assist them in improving services to children and families. All cases reviewed are completed by pairs of reviewers, per

federal guidelines. In addition to completing a review of the paper record and FACTS, client and stakeholder interviews are conducted for each case reviewed.

Currently WV's CQI system is operational. WV has continued to utilize the Quality Councils as part of its Continuous Quality Improvement (CQI) process. CQI is a management concept built upon employee empowerment which promotes increased efficiency, higher levels of professionalism, and enhanced job satisfaction. CQI is different from traditional quality assurance in that the focus is self-directed, self-determined change rather than change imposed by an external entity. To implement this process and provide a continuous information flow, the Bureau for Children and Families has established a statewide Quality Improvement Council system. This system consists of three council levels: Local, Regional and State.

The Local Level Quality Improvement Council (QIC) is used to improve processes and systems within the districts and to make recommendations for improvements to the Regional and Statewide Quality Improvement Councils. The Local (District) Level councils are comprised of representatives from Economic Services, WV Works, Adult Services, Children Services, Operations staff, and Administration. The program groups will be facilitated by the Regional Program Managers or a designated Community Service Manager. The Local Level QIC's utilize relevant data to make informed decisions regarding case practice. The Local Level QIC also reviews their District's Program Improvement Plans (PIP) that was developed based on the finding of the District's Social Services review. Progress is reported to the council as well as barriers to achieving the goals of the plan. Improvements are measured based on relevant data such as COGNOS, Fredi, dashboards, and case review data. With the implementation of the Safe at Home Project, all data will be presented at each level and reviewed by the Quality Councils. The results are documented on the program improvement plan quarterly summary and forwarded to DPQI and the Regional QIC.

The local councils also provide a means for the district to self-monitor the Quality Council Activity Summary and report on progress or adjust the plans to improve services to families and children. This allows the districts to focus on issues relevant to them while remaining focused on key national standards and measurements that impact the State as a whole. The Safe at Home Project will be an integral part of the Quality Improvement Process.

Evaluation Schedule:

The Request for Proposals for an independent evaluator has been approved by the West Virginia Department of Administration and has been released. The close date for Proposals is May 27th. Hornby Zeller Associates received the award on July 1, 2015. West Virginia held the first meeting with HZA Principals on July 8th in order to provide an orientation to West Virginia's Demonstration Project. Safe at Home WV Project Director Lisa McMullen facilitated a face to face meeting with HZA staff and SACWIS staff to discuss data needs and CANS automation. The Safe at Home Evaluation Work Group held its first meeting on Monday July 27th and was

presented with the first draft of our evaluation plan. The team reviewed and commented on the plan. HZA completed all updates and the first draft was submitted to the Children's Bureau on August 3, 2015.

Phase Down Plan:

A plan for phasing down the demonstration project has not yet been developed. BCF is planning on making system changes as we implement *Safe at Home West Virginia* so that it is eventually embedded into our structure. The phasing down will have to focus on how we pay for the interventions once the demonstration project has ended. At present, we have been closely working with the Bureau for Medical Services to assure that all interventions that can will be billed to Medicaid. We have been working with the Bureau for Behavioral Health and Health Facilities as well as the Bureau for Public Health to review any grants that will assist with paying for interventions. As we move through the implementation process and the stages of our evaluation, we will use that information to determine steps necessary to assure a smooth transition out of the waiver demonstration.

West Virginia recognizes that the Title IV-E waiver allows us the flexibility to fund and support interventions that are intended to support and encourage families to make substantial changes to their lives to improve child safety, permanency, and well-being. Safe at Home WV provides a unique opportunity for West Virginia to lean how this flexibility of funding and the interventions meet our goals as a state and result in a reduction of our total children in congregate care. West Virginia's Evaluator will help inform the process and ongoing strategies to improve practice.

The West Virginia Department of Health and Human Resources and Bureau for Children and Families will track intervention spending to assess what changes would be necessary when the Title IV-E waiver ends. West Virginia's goal is to divert funding that would have been spent on excessive use of out-of-state and in-state congregate care to community based services. The Bureau for Children and Families Finance Division is currently developing the schedule of quarterly payments with this issue in mind; knowing that there needs to be a savings attached to the last quarter for transition back to traditional claiming.

Overall Work Plan:

On the following pages is the current *Safe at Home West Virginia* Implementation/Work Plan:

Safe at Home West Virginia Implementation/Work Plan

IDIR Attachment Revised May 4, 2015

Task	Lead				
Service Development	**Laura Barno/ Susan Frye**	**Start**	**End**	**Frequency**	**Status**
Develop and Revise work plan		4/23/15		Ongoing	In Process
Determine service needs based on population / in collaboration with Collaboratives		3/14/15		Ongoing	Completed
Evaluate existing service availability	With Regional Summits, Community Collaboratives and Local Coordinating Agencies	3/14/15 Reg. 1 Reg. 2 Reg. 3 Reg. 4		Ongoing	In Process Completed Completed In Process
Develop and implement provider recruitment strategies for services that are lacking in specific geographical locations	With Local Coordinating Agencies via the development of Provider Networks	9/1/15		Ongoing	In Process
Define each new service that will be developed for Safe at Home wraparound	With BMS and BHHF via Deputy Secretary Clifton	5/1/15	10/1/15		In Process, finalizing last one

Service Development	Laura Barno/ Susan Frye	Start	End	Frequency	Status
Determine eligibility for each new service	With BMS and BHHF via Deputy Secretary Clifton	5/1/15	10/1/15		In Process
Redesign socially necessary services current structures. Rename (Community Support Services)		3/13/15		Ongoing Overall plan approved-detail work in process	Preliminary redesign for *Safe at Home West Virginia* and then statewide
Provide work plan for revisions, UM Guidelines	With Utilization Management Organization	?	Ongoing	Ongoing	Related to finalization of the UM Contract rebidding, which is not yet completed
Examine grant funded vs. fee for service		10/1/14	Ongoing		A dual process will be required due to the nature of some services, such as Homestudies
Support and development of wraparound provider networks-to be coordinated with Local Coordinating Agencies and Fiscal Accountability workgroup	With Local Coordinating Agencies and Fiscal Accounting Workgroup	9/1/15	Ongoing	Ongoing	Will require the on-boarding of Local Coordinating Agencies
Develop and release grant announcement for Local Coordinating Agencies	With Fiscal Accounting Workgroup and BCF's Grants	5/15/15	First release 7/20/15	As needed for expansion and each	Completed for Phase 1 areas

Service Development	Laura Barno/ Susan Frye	Start	End	Frequency	Status
	and Contracts staff			phase	
Select Local Coordinating Agencies and develop statements of work that detail the wraparound model components	With Fiscal Accounting Workgroup and BCF's Grants and Contracts staff	8/17/15	8/24/15 first release	As needed for expansion and each phase	In Process
Begin technical assistance with current child residential and child placing providers to examine changes in business model, to encourage development of community-based services		5/11/15	11/1/15	Ongoing 6/5/15 6/26/15 7/10/15 7/30/15 8/18/15	In Process
Identify structure of finance model and make recommendations to leadership regarding case rate, fee for service, fixed funding, etc.		10/1/14	10/30/14		Possible TA request
Work with Collaboratives and Regional Summits to conduct core service needs assessments	Lisa McMullen and Regional Directors	4/1/15	4/30/15		Completed in Phase 1 areas then repeat as phases occur
Work with Collaboratives and Regional Summits to conduct Community Self- Assessment of Strengths and Needs	Lisa McMullen and Regional Directors	4/23/15	5/31/15		Completed in Phase 1 areas then repeat as phases occur
Determine structure of Wraparound oversight	Lisa McMullen and Regional	4/23/15	5/31/15		Completed Flow chart in

Service Development	Laura Barno/ Susan Frye	Start	End	Frequency	Status
teams and develop	Directors with co-chairs				IDIR
Refine and edit Wraparound 101 training	With training workgroup	4/1/15	7/31/15		Completed
Identify Train the Trainers and train wraparound 101	With training workgroup	4/1/15	7/31/15		Completed
Identify and support Wraparound champions		3/1/15		Ongoing	In Process
Standardize wraparound plan		3/1/15	7/1/15		Completed
Develop a wraparound facilitator matrix		3/1/15	7/1/15		Completed
Develop wraparound referral form		3/1/15	7/1/15		Completed
Develop wraparound Family Handbook		3/1/15	8/10/15		Completed
Develop memo of understanding and service agreement templates		3/1/15	7/1/15		Completed
Develop confidentiality and consent for treatment templates		3/1/15	7/1/15		Completed
Develop wraparound manual		3/1/15	8/10/15		In draft
Research and recommend Coordinating Agency		7/1/15	10/30/15		In process

Service Development	Laura Barno/ Susan Frye	Start	End	Frequency	Status
and Wraparound Facilitator Certification Training and Curriculum/Process					
Revise the CBT Youth Advocate Model		3/1/15	8/10/15		Completed
Revise guidelines for flexible funds		3/1/15			In process
Develop trauma informed family engagement model, training, support, resources and guides		3/1/15			In process
Provide ongoing technical assistance and support		9/1/15		ongoing	
Expansion of CANS to CANS 2.0					Completed
Finalize CANS 2.0			7/1/15		Completed
Approvals of CANS 2.0			7/21/15		Completed
Formatting of CANS 2.0		7/21/15			In Process
Submit data to Dr. Lyons for his assistance in creating the eligibility criteria	Susan Fry, Linda Watts, Tammy Pearson	4/1/15	6/1/15		Completed
Final eligibility criteria developed	Dr. Lyons – workgroup		8/1/15		Completed

Task Lead

Communication	Susan Richards/ Jessica Holstein	Start	End	Frequency	Status
Develop and revise communication plan	Jessica Holstein	11/1/14		Ongoing	In Process
Identify audiences	Team	11/1/14		Ongoing	In Process
Develop Safe at Home WV logo	Team	11/1/14	11/17/14	--	Completed
Draft Media release in coordination with Governor's office	Jessica Holstein	11/1/14	10/15/14	--	Completed
Develop and launch external website	Jessica Holstein	11/1/14	12/10/14	--	Completed
Add feedback portal to external website	Jessica Holstein	11/1/14	1/26/15	--	Completed
Coordinate interviews with local media and Cabinet Secretary	Jessica Holstein	11/1/14	2/29/15	Ongoing	In Process
Develop approved PowerPoint presentation	Jessica Holstein	11/1/14	2/19/15	As needed	Completed and ongoing as updates needed
Develop and distribute approved talking points	Team	11/1/14	2/20/15	--	Completed
Develop and distribute newsletters to DHHR staff and stakeholders	Jessica Holstein	11/1/14		Quarterly	In Process Quarterly
Develop and send email blasts to BCF staff	Jessica Holstein	4/30/15		Weekly	In Process
Feature *Safe at Home West Virginia* on DHHR television	Jessica Holstein Lisa McMullen interview by	3/30/15	4/30/15	Ongoing	Completed, continual availability

Communication	Susan Richards/ Jessica Holstein	Start	End	Frequency	Status
show, "The State of Health"	Secretary Bowling				
Gather lists of scheduled DHHR and stakeholder conference/events and request to go on agenda	Team	11/1/14	4/30/15 Initial areas	Ongoing	In Process
Identify community champions and reach out for support	Team	11/1/14	4/30/15 Initial areas	Ongoing	In Process
Add *Safe at Home West Virginia* on agenda's for State and Regional Management meetings	Regional Management	11/1/14		Ongoing	In Process
Add *Safe at Home West Virginia* to agenda for all regularly scheduled district and unit meetings	Community Service Managers and Supervisors	2/1/15		Ongoing	In Process
Send wraparound principles to managers and supervisors to use during staff unit meetings	Lisa McMullen/Susan Richards	3/31/15	3/31/15		Completed
Meet with Judges to discuss *Safe at Home West Virginia*	BCF Leadership and Local Management	2/1/15	10/1/15 Initial areas	Ongoing	In Process
Meet with Prosecuting Attorney's and Guardian Ad Litem to discuss *Safe at Home West Virginia*	At conferences and then Local Management teams at local level	2/1/15	10/1/15 Initial areas	Ongoing	In Process

Communication	Susan Richards/ Jessica Holstein	Start	End	Frequency	Status
Meet with Division of Juvenile Services to discuss *Safe at Home West Virginia*	BCF Leadership	2/1/15		Ongoing	In Process
Meet with Education staff	Local Management Teams	2/1/15	10/1/15 Initial areas	Ongoing	In Process
Identify BCF staff to serve as Safe at Home subject matter experts and send email blasts announcing individuals and contact information	Susan Richards/ Jessica Holstein	5/1/15	5/28/15	Update as needed	Completed
Identify staff to respond to Safe at Home feedback	Jessica Holstein/Lisa McMullen and team	7/15/15		As needed	At present Project Director – add others to assist

Task Lead

Training	Susan Richards/ Jessica Holstein	Start	End	Frequency	Status
Develop and Revise work plan		11/1/15	Ongoing	Ongoing	In Process
Develop wraparound 101 training	Revise as needed with Wraparound workgroup	2/1/15	3/31/15	Ongoing	Completed
Deliver wraparound 101 training to all workgroup members		2/1/15	3/31/15		Completed
Deliver wraparound 101 training to BCF Experts		7/29/15		As needed	Completed
Develop a schedule for delivery of wraparound 101 training to		4/1/15	8/15/15		Completed

Training	Susan Richards/ Jessica Holstein	Start	End	Frequency	Status
identified audiences					
Delivery of Wraparound 101 training to identified audiences	Training workgroup and model development group	8/1/15 phase 1	9/30/15	As needed	In process
Develop training curriculum for processes		5/1/15	6/30/15		Documents Complete
Develop training schedule for processes		6/1/15	6/30/15 Initial areas	Ongoing	In bedded in Wraparound 101 Completed
Deliver of training for processes		8/1/15 phase 1		In conjunction with Wrap 101	In process
Delivery of CANS training to field staff		7/1/15	10/1/15 Initial areas	Ongoing	Kanawha8/14,27 Cabell 8/18,26 Berkley 8/19,20 Putnam9/1
Coordinate training of lead agencies with service development and delivery workgroup		7/1/15	9/30/15 Initial areas	Ongoing	In Process

Task Lead

IV-E Revitalization	Renee Brown / IV-E Unit Program Managers	Start	End	Frequency	Status
Develop and revise work plan		1/15/13		Ongoing	In Process
Review policy and procedures for opportunities to improve eligibility and reimbursement Reduce the number of Pending and Undetermined IV-E determinations		1/15/13		Ongoing	In Process
Identify areas where we are not claiming and could be claiming		1/15/13		Ongoing	In Process
Certify a greater number of Kinship/Relative providers		1/15/13		Ongoing	In Process
Utilize our ACF partners as resources		1/15/13		Ongoing	In Process
Continue to educate field staff and stakeholders (Judges, PA's) on the importance of IV-E and the role they play in determinations		1/15/13		Ongoing	In Process
Ensure eligibility determinations for *Safe at Home West Virginia* target youth				10/1/19	In Process

Task Lead

Practice Development	Rebecca Carson	Start	End	Frequency	Status
Develop and Revise work plan		4/1/15		As needed	In Process
Identify and make appropriate program revisions		5/1/15		As needed	In Process
Identify and make necessary policy revisions		5/1/15		As needed	Completed for implementation
Identify documentation requirements and develop documentation guides for field staff		7/1/15		As needed	Completed for implementation
Identify practice requirements as related to embedding the wraparound core values		5/1/15		As needed	Completed and included in training workgroup planning

Task Lead

Evaluation	Kevin Henson/ Lisa McMullen	Start	End	Frequency	Status
Develop RFP	Lisa McMullen and BCF Finance				Completed
Determine selection committee					Completed
Selection Committee complete required training	Selection Committee				Completed
Select independent evaluator	Selection Committee		6/30/15		Completed
Develop evaluation plan	Evaluator and Evaluation Team	7/1/15			In process
Submit evaluation plan to Children's Bureau	Evaluator		8/3/15	Within 90 days of award	Draft submitted 8/3/15
Development of APD for develop funds	Michael Johnson/Heather Abbott	8/15			In Process
APD Approval		8/15	10/1/15		Pending
RFQ Development for servers, software, and staff	Michael Johnson/Heather Abbott	10/1/15	10/31/15		Pending
RFQ approval		11/1/15	11/30/15		Pending
RFQ award	Michael Johnson/Heather Abbot and team	12/1/15	12/31/15		Pending
Work with RBA committee to include *Safe at Home West Virginia* outcomes on scorecard		11/1/15	1/31/16		travel to Nebraska to review how they incorporated into RBA

Task Lead

Fiscal Accounting and Reporting	Jim Weekley	Start	End	Frequency	Status
Develop and revise work plan				Ongoing	
Develop and submit developmental cost plan	BCF and DHHR Finance and Administration	11/14/14	8/21/15		In Process
Submit updated Development Cost plan to CB	BCF Finance and DHHR Administration	8/24/15			
Assure financial information related to the demonstration is reported to Children's Bureau	BCF Finance and DHHR Administration	10/1/15		Ongoing	
Develop schedule of quarterly payments	BCF Finance and DHHR Administration	4/1/15	9/16/15		In process
Submit schedule of quarterly payments to CB	BCF Finance and DHHR Administration	9/8/15	9/16/15		
Continually address cost allocation and financial accountability and reporting related to the demonstration	BCF Finance and DHHR Administration	10/1/15	1/1/20	Ongoing	Ongoing

Task Lead

Reporting Requirements		Start	End	Frequency	Status
Draft RFP			12/14/14		Completed
Evaluation Plan (Due within 90 days after evaluation contract is awarded)		7/1/15	9/1/15		In Process
Initial design and implementation report (1st quarterly progress report)			1/13/15	One Time	Completed 1/21/15
Second quarterly progress report (IDIR)			5/14/15	One Time	Completed
Third quarterly progress report			8/14/15	One Time	Completed

Task Lead

Data Workgroup		Start	End	Frequency	Status
Organize workgroup	Patty Vincent	6/12/15	Ongoing	As needed	Completed
Develop a universal spreadsheet to track FC entries and exits by county	Patty Vincent/Kevin Henson	6/12/15	8/15/15	As needed	In Process
Determine information to be tracked	Patty Vincent/Workgroup	6/12/15	7/30/15	As needed	Completed
Develop/clarify definitions/codes for spreadsheet	Kevin Henson/Paula Taylor	6/12/15	7/30/15	As needed	In Process
Develop SOP for process to track children entering and exiting care on spreadsheet	Patty Vincent/Melanie Urquhart	6/16/15	8/15/15	One Time	In Process
Distribute SOP and Spreadsheet to Districts/counties	Patty Vincent/RPM's	8/15/15		Monthly	In Process
Develop spreadsheet to track foster care re-entry and cross track with safe at home	Renea Brown	8/4/15	9/1/15	One time	In Process
IV-E unit submit monthly spreadsheet to RPM's	Renea Brown	9/1/15		Ongoing	In Process
Develop Spreadsheet to track wraparound referrals/services	Patty Vincent	7/21/15	7/27/15		Completed
Release wraparound spreadsheet	Patty Vincent/RPM's	9/15/15 Phase 1		Ongoing	In Process
Provide updated spreadsheet when requested	Patty Vincent/RPM's	10/1/015		When requested	

Task **Lead**

Other Implementation Tasks	Project Manager	Start	End	Frequency	Status
Develop and revise implementation plan	Home Team				As needed
Conduct *Safe at Home West Virginia* Home Team Meetings	Project Director	11/1/14		Weekly	In Process
Request TA from Children's Bureau when necessary	Home Team				As needed
Request TA from Casey Family Foundations when necessary	Home Team				As needed
Meet with work group chairs to review work plans and progress	Project Director			Weekly	In Process
Work with independent evaluator to develop thorough plan for implementation	Evaluation Team			Monthly team meeting and contact as needed	In Process
Identify cases appropriate for referral wraparound services	Local BCF child welfare staff	7/1/15 Phase 1		Ongoing	In Process
Staff identified cases with program staff and local Collaboratives to begin service gap identification and planning	Local BCF child welfare staff and managers	7/1/15 Phase 1		Ongoing	In Process
Refer cases to Regional Program Manager for approval to refer to	Local BCF child welfare staff and managers	9/1/15 Phase 1		Ongoing	In Process

Local Coordinating Agency/s					
Referral of cases to Local Coordinating Agency/s	Local BCF child welfare staff and managers	10/1/15 Phase 1		Ongoing	
Notify Project Director of referral and complete tracking log	Local BCF child welfare staff and managers	10/1/15 Phase 1		Ongoing	
Determine timing of implementation phases and next phase areas	Home Team with input from Evaluation Workgroup	8/31/15		Ongoing as adjustments are determined to be needed	In process
Monitor implementation plan	Project Director and Home Team				In Process

Task Lead

Accounting of Investments					
Federal fiscal year 2012 and 2013 accounting of investments				12/31/14	In Process
Subsequent FFY updates (annually by December 31st)					

Task	Lead				
Progress Reports: Due semi-annually after implementation (30 days after reporting period)					
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	
Semi-annual progress report				TBD	

Task			Lead		
Documentation of Plans for Implementation of Program Improvement Policies				**2/25/17**	
Interim Evaluation Report (60 days after conclusion after the 10th quarter following the implementation date)				**TBD**	
Final Evaluation Report (Due 6 months after project ends)				**TBD**	
Public use data (6 months after project ends)				**TBD**	
Public use data (6 months after project ends)				**TBD**	

VI. Training and Technical Assistance Assessment

At this time, we look forward to receiving guidance and feedback from the Children's Bureau as we continue to analyze the characteristics and needs of the target population as well as further development of our plans to educate and train our community service providers to prepare to implement a new business model and philosophy of service provision. We will also be accessing technical assistance from James Bell Associates in developing evaluation plans once we have procured an independent evaluator for the project. Additionally, we plan to access technical assistance from Casey Family Programs as needs are identified.

West Virginia hosted a full day meeting with our residential, shelter care, and specialized foster care providers. This meeting is was facilitated by Casey Family Programs and also attended by the Cabinet Secretary Karen Bowling, Deputy Secretary of Human Services Harold Clifton, Commissioner for the Bureau for Medical Services Cindy Bean, the Commissioner for the Bureau for Behavioral Health and Health Facilities Vickie Jones and the Commissioner for the Bureau for Children and Families Nancy Exline. The morning focused on the paradigm shift in the way we will be providing care of West Virginia children. Secretary Bowling opened the meeting with a very encouraging discussion regarding our youth and the role that we all play in their success. Part of the discussion centered on the vision of Safe at Home West Virginia, the change that DHHR will be making to our licensing contracts/agreements that will begin to focus limiting the length of stay in any residential facility, the requirement for meaningful discharge planning that begins on the day of admission and performance based contracts. Our desire was to encourage our partners to begin thinking outside of their walls and to consider that they are an integral part of the community for the youth they serve and to encourage a changed business model and growth of community-based services.

Erwin McEwin did a presentation on Cook County Illinois' change to performance based contracts. Nadia Sexton did a presentation on New Jersey's experience with reform of their child placing system. Four West Virginia provider agencies served on a panel to discuss their agencies and some very innovative changes they have been involved in. During the afternoon our provider partners were allowed the opportunity to meet in like groups and discuss their agencies alignment with the vision of Safe at Home West Virginia and the direction we are moving with placement changes, their desires, and any barriers they see. At the end of the day Commissioner Exline requested their assistance with our initiative and to be an active part of change and formed task teams to address the necessary changes. Our partners readily volunteered to serve on those groups. A series of 3 meetings is already scheduled to allow the task teams to focus on their charges. The group make-up and charge for each is being developed prior to the first meeting on June 5th.

On July 5th BCF's Child Placing partners submitted proposals for structural changes, outcome measures, and rate setting. They are now meeting to combine the proposals and for further work with BCF on the rate setting. They have purposed elimination of the levels of care system that currently exists and moving to a child placing system that is flexible to meet the individual needs of the identified child as well as moving to more community based services. Using RBA, they developed proposed outcomes measures that are also consistent with Safe at Home WV goals and outcomes. This process has demonstrated the engagement of our partners in wanting to improve West Virginia's child welfare systems.

BCF submitted a formal TA request to the National Resource Center for Diligent Recruitment for a comprehensive assessment and work plan to address multiple issues affecting recruitment and retention efforts with regard to foster homes. There have already been a couple of meetings and the assessment process has begun to assist in determining where to focus.

There is a 1 ½ day TA scheduled with DHHR Office of Administration and BCF Finance to work on rate setting for the wraparound model as well as residential rates. That meeting is scheduled for May 27 -28, 2015.

West Virginia will be requesting TA as needed as we move forward with implementation.

West Virginia and HZA look forward to working with James Bell Associates in the finalizing of our evaluation plan.

West Virginia has met with our leads from the Capacity Building Center for States and completed our assessment and our work plan is being drafted. Technical Assistance regarding our waiver activities are primary. They will be continuing to assist with focus on recruitment and retention of quality foster homes as well as assistance to our community partners in reaching out and developing informal community supports.

VII. Barriers and Risk Management

At this time, we have identified four main areas that may present barriers to implementing *Safe at Home West Virginia*.

As discussed in previous conversations with the Children's Bureau and James Bell Associates, the procurement process for the independent evaluator is expected to be lengthy and include delays as the approval process has many steps. In an effort to mitigate these issues, DHHR Cabinet Secretary Bowling will be supervising the process to make sure delays are minimized and we are able to implement on the scheduled date of October 1, 2015. Fortunately this barrier was overcome and we have our independent evaluator on board.

We expect there to be issues in implementation related to having an adequate workforce in the state to provide services to youth and families at the level of their needs. A high level of qualifications and specialized skills will need to be developed among our current workforce in order to meet these needs. Please see the current work plan regarding training and communication plans. There have been numerous opportunities for discussions with our community partners, especially our behavioral health partners. It has been very encouraging to hear their support regarding the demonstration project.

Many of West Virginia's community service providers will need assistance in transitioning to a new model of providing services and in order to expand into areas that lack services that will enable Safe at Home Wraparound to operate. We are currently still working on a plan to address these issues. This issue has been an ongoing part of the working meetings BCF has had with our child placing agency partners. West Virginia's child placing agencies have submitted proposals that outline their business model changes.

In addition, in order to make Safe at Home Wraparound a success, we will need to develop stronger partnerships with the Judiciary. At this time, we plan to address this barrier by including key stakeholders in the DHHR Safe at Home Oversight Team and through well-planned and frequent communication with our friends in the Judiciary. Our discussions with the Judiciary are centered on allowing the department to make recommendations for referral for wraparound for appropriate youth and not just ordering youth into wraparound. We always must keep in mind that most of our target population enters care through a juvenile status or delinquency petition and not abuse/neglect. In juvenile petitions, the Department is not the petitioner and is only a party to the action without representation. Focusing on stronger relationships with our Judiciary and Juvenile Services only allows for better planning and serving

of our youth. In the caseworker's report, they are able to give recommendations for placement to the court, but we must remember those are recommendations for a placement facility not whether or not the youth should be placed out of home. Our work with both the Judiciary and the Division of Juvenile Services will need to focus on appropriate removal and placement of youth. The West Virginia Legislature just passed Senate Bill 393 that addresses new requirements for DHHR, Juvenile Probation, the Board of Education, and the Division of Juvenile Services. It addresses when removal from the home is appropriate, length of stay, and discharge planning. Our hope is that this bill will further facilitate the paradigm shift in thinking from placement out of home being punishment to it being used when it is truly the best service for a youth.

West Virginia does have a need for more treatment or therapeutic foster care providers as well as traditional foster care homes. BCF submitted a formal TA request to the National Resource Center for Diligent Recruitment for a comprehensive assessment and work plan to address multiple issues affecting recruitment and retention efforts. Part of our TA is to assess whether the preparation of families is sufficient for the high needs of children entering care. West Virginia does contracts with private agencies that offer specialized foster care in foster home settings. Those specialized foster care agencies are a part of the TA and will have representation at every juncture. The barrier exists in relation to timing. West Virginia's child placing agency partners have submitted a proposal for all private agency foster care homes to move to "treatment" foster care homes. They have proposed specific evidence based model of therapeutic foster care and are currently working with BCF on the rate setting and outlining this transition.

We recognize that the necessary paradigm shift in the philosophy of how we serve families in West Virginia is probably our largest barrier. We say this knowing that it encompasses our own staff as well as our partners. Our communication plan with our staff started at the most basic level of discussions regarding the 10 Principles of Wraparound. Every time we do a presentation, with our own staff or partners, we discuss those 10 Principles and encourage further personal reflection and staff discussions. Our training workgroup has developed a very specific approach to training due to the identified need for a philosophical change. In the place of traditional classroom training, West Virginia has identified Subject Experts that are embedded in the field and central office. Those experts are driving the transfer of learning through conversations and educational meetings and will be present for any questions or assistance as needed.

Major Barrier	Associated Interventions	Planned Strategies
Failure to safely reduce the number of children in out-of state or in-state congregated care or other goals/outcomes identified in our Demonstration Project	Identify interventions to begin with year 2 of the waiver Engagement and assessment strategies leading to appropriate intervention resources	Leverage strategies such as Clinical Review/Out-of State Review Teams to concentrate on identifying service gaps that continue. Work with Local Coordinating Agency/s and community partners to improve service provision. The quality assurance plan and evaluation plan will monitor the number of children in congregate care and out-of-home care and assist with providing needed information.
Lack of communication or insufficient communication with staff or critical partners (Probation, Judges, partner agencies, etc.)	Ensure all appropriate partners are involved in the planning and work groups.	Expand membership of the workgroups to include critical partners. Expand communication distribution networks to critical partners.
Engagement of staff in the Demonstration Project.	Ensure staff are engaged in all stages of planning.	Agency communication strategies including meetings, newsletters, and email blasts.
Staff training insufficient to fully implement all of the interventions identified throughout the course of the Demonstration Project.	Staff training is critical to the implementation of family of the CANS and wraparound engagement strategies.	Train the Subject Experts and transfer of learning with sufficient ongoing training to optimally operate the Demonstration Project.
Adding additional tasks to the expectations and schedules of current staff.	Staff engagement.	Review of data a discussions to ensure that additional tasks are realistic and that staffing levels remain appropriate.

VIII. Program Improvement Policies

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

West Virginia amended its Adoption and Legal Guardianship Policies as well as its IV-E State Plan to accommodate claiming for Guardianship Assistance. This included kinship guardianship assistance. DHHR Office of Administration as well and the Office of Information Technology are currently working on the requirements for this expanded claiming.

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

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

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

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

West Virginia is currently drafting all necessary policies.

IX. Quarterly Updates

2nd Quarterly Report

Additional activities undertaken in the current reporting period:

- The RFP for the Independent Evaluator was approved by the West Virginia Department of Administration and released. It has a close date for proposals of May 27th.
- The Service/Model Development Workgroup has all paperwork required under the wraparound model in draft form.
- Wraparound 101 training has been delivered to all workgroup members and is being updated for delivery to all BCF staff and providers.
- The CANS 2.0 has been submitted to all interested parties for approval.
- Safe at Home has been imbedded into all current Youth Service and Child Protective Service Policy and is in draft.
- West Virginia developed a *Safe at Home West Virginia* Website, newsletter, and email address for questions and comments.
- *Safe at Home West Virginia* presentations have been given to CIP, NASW Conference, Children's Summits, and Community Collaboratives.
- *Safe at Home West Virginia* has been featured on Secretary Bowling's TV Show.
- Secretary Bowling has created a "Quick Fix Team" to coordinate services and payment between BDF, BHHF, and BMS.
- Service needs assessments have been completed by the Phase 1 counties.

3rd Quarterly Report

Additional activities undertaken in the current reporting period:

- CANS training/certification for all BCF field staff in Phase 1 counties
- Evaluator selected and on board
- Draft Evaluation Plan submitted to Children's Bureau
- All Safe at Home WV wraparound paperwork, guides and manuals finalized
- Safe at Home WV Wraparound model and process flow charts finalized
- Safe at Home WV BCF policy finalized
- Safe at Home paperwork guide for BCF child welfare staff completed
- Service flow charts for BCF staff to accompany policy
- Completed the update Wraparound 101 Overview training
- Completed the develop in Depth Wraparound 101 training
- Selection of BCF Subject Experts to assist with transfer of learning
- Training and equipping of Subject Experts
- Continued meetings with Judges in Phase 1 jurisdictions
- Assessments and planning with Capacity Building Center for States
- Safe at Home presentations at the National Association of Social Workers Conference, Court Improvement Project Conference, and other local meetings

- Briefing meetings held with all child welfare supervisors, coordinators, program staff, and managers to review and discuss Safe at Home WV and all other child welfare initiatives
- Utilization Manual descriptions written for new services
- Approval and formatting of CANS 2.0
- CANS automation discussions and decisions
- Family Centered Practice Basics training conducted in all Phase 1 counties
- Family/Youth Engagement Strategies training conducted in all Phase 1 counties
- Institution of weekly email blasts to DHHR staff and our partners
- Development of a daily case rate for Safe at Home WV wraparound services
- Request to Receive Applications for Local Coordinating Agencies was created and released
- Questions regarding the RFA were received and answered
- Collaboratives completed Community Needs Assessments and Readiness to Implement Assessments
- Direction has been given to the Community Collaboratives with a format for development of strategic plans to develop services that were identified as needs or gaps
- Education of BCF child welfare supervisors and managers on the use of the YLS/CMI and how it fits with the CANS
- Updates to the Developmental Cost Plan

Planned activities for the upcoming reporting period:

- The Service/Model Development Workgroup is currently working on changes to the flow of wraparound; instead of getting too focused on the different flows or tracks, it will focus on the actual wraparound process.
- Selection of the Independent Evaluator and development of the evaluation plan.
- The finalization of an APD and purchase of software and hiring of staff to assist with data collection.
- Continued activity with regard to the Communication Plan.
- Finalization of RFA for Local Coordinating Agencies, Grant Awards, Rate Setting, and Scope of Work.
- Child Placing partners task force to address changes in licensing agreements, performance measures, and rate setting
- Finalization of the CANS 2.0.
- Finalization of all necessary documents for use within *Safe at Home West Virginia*.
- Staff and Provider training as outlined in training plan.
- Submission of Schedule of Quarterly Payments
- All other activities outlined in Work Plan.
- Award of Grants to Local Coordinating Agencies for Wraparound Facilitators
- Continued meetings with Judges
- Local management teams meeting with community partners
- Training of Wraparound Facilitators and Train the Trainers in phase 1

- Wraparound 101 training for BCF Child Welfare staff in phase 1
- Release of policy and documents to BCF child welfare staff
- Identification of youth meeting wraparound criteria
- Staffing of youth cases for possible referral to wraparound
- Approvals for referral of youth to wraparound
- Continue meeting with Judges
- Finalization of the Evaluation Plan
- Submission of Schedule of Quarterly Payments to Children's Bureau
- Release referrals for wraparound to Local Coordinating agencies
- Continue with briefings with child welfare supervisors and managers
- Updates to SACWI/FACTS software
- Automation of the CANS 2.0
- Further development of Wraparound Advisory Team
- Identification and selection of Fidelity Review process
- Identification of next Phase counties
- Determination timing of next Phase roll outs
- Begin activities with Phase 2 counties