

Program Improvement Plan for West Virginia

The West Virginia Department of Health and Human Resources Bureau for Children and Families has been working to improve the quality of services to the children and families we serve. In the late nineties, the Department began a system of reviewing cases based on the Child and Family Service Review (CFSR) format used by the federal government. The purpose of the reviews was to prepare the staff for the review that was completed in May 2002. As a result of these reviews, the Bureau determined that we were not providing quality services to the children and families in West Virginia and an effort began to move us in this direction. The Bureau adopted a new mission and vision that shows our commitment to this goal. The new mission is: **“The Bureau for Children and Families provides an accessible, integrated, comprehensive quality service system for West Virginia’s children, families and adults to help them achieve maximum potential and improve their quality of life.”** The new vision is: **“West Virginia’s children, families, and adults have achieved well being, safety, and independence.”** The Federal Review in May of 2002 confirmed what we had found in our local reviews, that children and families in West Virginia needed safety, permanency and well being. As part of our state reviews, two initiatives started in 2002: The Comprehensive Planning and Assessment System (CAPS); and defining social necessity services through the Administrative Services Organization (ASO). These initiatives will assist West Virginia in working to achieve our goals and the outcomes of the CFSR.

The first initiative, the Comprehensive Planning and Assessment System (CAPS) goal was to provide a standardized system of assessing children and families to identify services needed. The Bureau was aware that our staff turnover rate and staffing numbers were directly impacting the quality of assessments being completed and the effectiveness of service planning. The lack of good assessment and treatment planning resulted in the agency providing services that were not needed and did not move families toward independence. West Virginia is not a state of vast resources, so it became imperative to move toward a more efficient system. In the past, the Bureau has tried to increase staff numbers in order to provide better services, but the realization is that we need to be more efficient with the resources that we have and look to expanding our resource base by involving our provider community. There were concerns with this initiative since providers had not always provided the services that we requested. To address some of these issues, the providers were involved in the development of the initial framework of CAPS by determining with state staff assistance the role that the providers will assume. The format is structured to be outcome based in order to do performance-based contracting. The role of the Bureau staff will be to monitor the providers to ensure they are meeting the requirements of the contract and, therefore, the needs of our children and families. As roles change, our staff will be able to focus on the quality of the services and ensure that contractual obligations are being met.

A collaborative group of DHHR staff and providers through the development of a framework for CAPS, determined what assessments would be completed, specifying assessments for children and families and the credentials required to perform the assessment. The assessments are leveled based on the needs of the child or the family. The chart below identifies the assessments completed on the child and family and the levels:

Child/Youth – Initial Battery			
Assessment	Tool	Time	By
Psychosocial	WVIACY	Within 5 days of referral	CAPS staff Masters Degree
Physical	Health Check	Within 5 days of referral	Medical Doctor
Care Giver	WV CAPS Care Giver Assessment	Weekly	Care Giver
Personal Safety *	WVCPSS	Prior to referral	WVDHHR SW
Adaptive Functioning	Vineland	Within 10 days of referral	CAPS staff Bachelor degree
	CAFAS	Within 10 days of referral	CAPS staff Bachelor degree
	Daniel Memorial	Within 10 days of referral	CAPS staff Bachelor degree
	Independent Living	Within 10 days of referral	CAPS staff Bachelor degree
	ABS	Within 10 days of referral	CAPS staff Bachelor degree
Child/Youth – Second Battery			
Assessment	Tool	Time	By
Psychological	See Outline/Contract	Within 20 days of referral	CAPS staff Masters Degree
Sex Offender	Juvenile Sexual Offender Decision Criteria	Within 20 days of referral	CAPS staff Bachelor degree
Domestic Violence	(Linda’s tool)	Within 20 days of referral	CAPS staff Bachelor degree
Substance Use	SASSI	Within 20 days of referral	CAPS staff Bachelor degree
Juvenile Service Battery	Jessness Inventory	Within 20 days of referral	CAPS staff Bachelor degree
	Pride in Delinquency Scale	Within 20 days of referral	CAPS staff Bachelor degree
	Youthful Level of Service/Case Management Inventory	Within 20 days of referral	CAPS staff Bachelor degree

Child/Youth - Third Battery			
Assessment	Tool	Time	By
Psychiatric	As indicated	Within 20 days of referral	Medical Doctor

Family – Initial Battery			
Assessment	Tool	Time	By
Psychosocial	WVFFS	Within 5 days of referral	CAPS staff Masters Degree
Personal Safety *	WVCPSS	Prior to referral	WVDHHR SW

Family – Second Battery			
Assessment	Tool	Time	By
Psychological	See Outline/Contract	Within 20 days of referral	CAPS staff Masters Degree
Sex Offender	As indicated	Within 20 days of referral	CAPS staff Bachelor degree
Domestic Violence	As indicated	Within 20 days of referral	CAPS staff Bachelor degree
Substance Use	As indicated	Within 20 days of referral	CAPS staff Bachelor degree
Medical	As indicated	Within 20 days of referral	Medical Doctor

Family - Third Battery			
Assessment	Tool	Time	By
Psychiatric	As indicated	Within 20 days of referral	Medical Doctor

The CAPS will also identify absent fathers and other possible relatives for involvement by doing a genogram in the psychosocial assessment. This information will be given to the DHHR worker who will pursue the relatives as possible placements or involvement in the treatment planning process. With CAPS doing the assessments, the responsibilities of DHHR staff will be to focus on locating and identifying relatives who would be interested in involvement or possible placement. As relatives are identified, they will be included in the treatment planning process.

Another item we had identified that the review confirmed was the involvement of children and families in the treatment planning process. The framework of CAPS will require that the family and child, if of the age and ability to participate, will be involved in the treatment planning process. The treatment planning process in West Virginia is referred to as the Multidisciplinary Team or MDT. To strengthen the involvement of families and the recommendations made by the MDT, the Bureau got a change made in our state law in the 2003 legislative session making families a part of the MDT process and strengthening the decisions made by the MDT with the court. As a result, judges who do not agree with the recommendation of the MDT must hold a hearing to consider evidence from the team as to its rationale for the proposed service plan. If the court does not adopt the team's recommended service plan, it shall make a specific written finding as to why the team's recommended service plan was not adopted. As part of the CAPS framework, the CAPS coordinator and DHHR worker will have a family meeting to discuss the assessment process/findings and the MDT. The purpose is to explain the MDT process and the need for their participation in the meeting.

The CAPS provider will complete all required assessments and develop an assessment report for the MDT meeting. The CAPS provider will schedule the MDT within 30 days of the date of custody and ensure that all family members are present. The treatment plan will be developed in the MDT meeting and the services recommended will be submitted by CAPS to the ASO for approval. If the child is being moved to a new placement as a result of the assessment process, the new provider will be matched to the needs of the child and will be provided information based on the assessment. The CAPS will remain involved with the child for a specified time frame to ensure that services and placement recommendations are appropriate. Providers will be held accountable for their recommendations.

CAPS will be implemented in phases. The first phase of CAPS will begin July 1, 2003 and will include children placed in shelters, either for the first time or due to a disrupted placement. Phase II will be for children removed from their homes due to child protective service issues and youth service children involved with the Department but remaining at home. The third and final phase will include all children involved with the Department either through child protective services or youth services. This will include children removed from their homes or children remaining at home. The purpose of the phased-in approach is twofold, one to give providers the time to build the capacity needed and to allow DHHR time to redevelop the child protective services policy with CAPS.

The second initiative of the Bureau is the development of a system to assure appropriateness of social necessity services. Treatment services are provided through the Medicaid system, but there have been few resources in the past to invest in social necessity services. All services identified in the CAPS process will then go through the Administrative Services Organization (ASO) for approval. The purpose of the ASO is to regulate social necessity services to ensure that services provided are based on the needs of the child or family and are at the intensity needed. The ASO will review the services approved every ninety days to ensure the service is still needed and the appropriate intensity. This system will ensure that the services are appropriate based on the assessed needs and will limit services that are not being effective. This system will allow us to collect data on service gaps and help us to identify the areas of the state in which we need to concentrate to develop providers. This system will also allow us to use non traditional providers as long as they meet the credentialing for the services provided, which will increase service availability.

There are three items listed on the CFSR in which West Virginia was rated in compliance that need to be addressed here. The three items are: recurrence of maltreatment, foster care re-entries and administrative reviews. The data from our SACWIS (FACTS) shows that we are in compliance, but there is concern that our data is not accurate. As we move toward correcting the data it is expected that we will see an increase in the percentages on these items which will make us out of compliance. Though it was not a requirement to address these issues since they we were in compliance, West Virginia will be looking at each of these items to not only correct the data but to work toward meeting compliance once the data is corrected.

We feel the impact of these major program and technological initiatives will provide relief from an unmanageable workload to DHHR staff and improve retention. We are also undertaking major initiatives to retrain the staff we currently have and develop new worker training that is more comprehensive and consistent with the Council on Accreditation standards.

The Bureau for Children and Families is currently implementing a continuous quality improvement process according to the Council on Accreditation standards and guidelines. In order to measure improvement and quantify progress towards achieving Bureau goals and outcomes, the Bureau will implement a case review process consisting of peer case record review, case record review process completed by the Office of Planning Improvement staff, which mimics the Child and Family Services Review process. In addition, the Office of Planning and Quality Improvement will develop Local, Regional, and State Quality Improvement Councils as the mechanism for feedback and corrective action. The completed implementation of the continuous quality improvement process will not only allow us to measure the effectiveness of the strategies identified for program improvement around the outcomes of safety, permanency, and well being for children and families, it allows us to utilize information collected and modify strategies based upon empirical data.

This information will be disseminated through management reports on a quarterly basis. The management reports will be used as the basis for decision making, corrective action, and localized resource planning in the Quality Improvement Councils. This process encourages all staff to participate and facilitates an awareness of expectations in meeting outcomes for children and families.

The Bureau for Children and Families is requesting technical assistance from various National Resource Centers in order to successfully implement this Program Improvement Plan. A list of technical assistance is attached.

All of the aforementioned efforts are directed at improving the quality of services and outcomes to children and families. It is recognized that the Department cannot achieve all of these initiatives alone. We are heavily dependent on our collaborative relationships with stakeholders, such as private providers, court and judicial systems, as well as education and mental health systems. We look forward to strengthening existing relationships and forging new ones in order to achieve the outcomes of safety, permanency and well-being for the children and families in West Virginia.

Technical Assistance Requested			
National Resource Center	Reason	PIP Reference	Date
Family Centered Practice	1. Expand community collaboration and partnerships. 2. Implement a competency based and performance based contracts and outcomes. 3. Implement a competency based family centered practice training.	1. Item 3 Action Step 3 2. Item 17 Action Step 1 3. Item 17 Action Step 1	9-04
Child Maltreatment	1. Improve implementation of risk assessment and decision making model.	1. Item 4 Action Step 4	5-03
Legal & Judicial	1. Increase stakeholder knowledge and awareness of adoption, permanency, and concurrent planning.	1. Item 9 Action Step 2	1-04
Organizational Improvement	1. Implement a case review system.	1. Item 31 Action Step 1	6-03

Definition of Terms and Acronyms

ASO – the Administrative Services organization

BCF - Bureau for Children and Families

CAPS – the Comprehensive Assessment and Planning System

CFSR - Child and Family Service Review

CPS - Child Protective Services

CSM – Community Services Manager. The Community Services Managers are responsible for child welfare services in one or more counties.

DHHR - Department of Health and Human Resources

FACTS – the Family and Children Tracking System which is the acronym for the state's SACWIS system.

MDT – Multidisciplinary Treatment Team – the team established pursuant to 49-5D-3 of the Code of West Virginia. The purpose of the MDT is to develop and oversee the case planning process for children who enter the custody of the Department through Child Protective Services and Youth Services. The MDT remains involved in a case until permanency is achieved.

RD – Regional Director. The Department is divided into four administrative Regions and each Regional Director is responsible for child welfare services provided within their region.

SACWIS - Statewide automated child welfare information system

Social Necessity Services – services necessary to improve relationships and social functioning. These services include interventions designed to maintain or establish safety, permanency and well being for families and children receiving Child Protective Services and Youth Services.

WVCPSS – the West Virginia Child Protective Services System which is the name used to designate the structured decision making model used in Child Protective Services. This model includes components to address both risk and safety.

YS - Youth Services - Which includes children who have juvenile delinquency issues or status offence issues.