

West Virginia Service Array Process

Resource and Capacity Development Plan



**Seven Capacity
Preliminary Report**

KIT (Kids In Transition) Collaborative
Berkeley, Morgan, Jefferson Counties

May 26, 2010

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Capacities Assessed

Safety Outcome 1

Children are first and foremost protected from abuse and neglect

Safety Outcome 2

Children are safely maintained in their homes when possible

Permanency Outcome 1

Children have permanency and stability in their living situation

Permanency Outcome 2

The continuity of family relationships and connections are preserved

Well-being Outcome 1

Families have enhanced capacity to provide for children's needs

Well-being Outcome 2

Children receive services to meet their educational needs

Well-being Outcome 3

Children receive services to meet their physical and mental health needs

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KIT Collaborative RCDP Preliminary Report

KIT Collaborative members attended training on the RCDP process on March 3, 2010. Following the training, the Steering Committee met to determine how they would proceed. It was decided that they would plan one day long session to complete the worksheets for the RCDP, rather than attending a series of short meetings. The date chosen was May 5, 2010. After that decision, the Behavioral Health Work Group asked to be a part of the process at a separate meeting on May 10. They worked solely on the Well Being 3 Capacity, *Children receive services to meet their physical and mental health needs*. Between the two groups, 18 participants met for a total of 9.5 hours.

Safety Outcome 1

Children are first and foremost protected from abuse and neglect

The following data elements from the Kids in Transition Child and Family Snapshot were utilized during the assessment of Safety Outcome 1.

a) *Timeliness of Initial Assessments of Reports of Child Maltreatment Data Chart*

- Determines whether responses to all accepted child maltreatment reports were initiated and face to face contact with the children was made within the required timeframes.
- Determines if any child in the family experienced repeat maltreatment within a six-month period.

b) *Allegations by Maltreatment Data Chart*

- Counts of maltreatment by type.

c) *CPS Referrals by Disposition Type Data Chart*

- Disposition assigned that summarizes each type of maltreatment.

The data related to “*Timeliness of Initial Assessment of Reports of Maltreatment*” indicates that timeline indicators were met over the 2003 through 2006 period only 28% of the time, and not met 72% of the time. This indicates a performance weakness for the tri-county area.

The data related to “*Repeat Maltreatment*” indicates that over the course of time from 2003 through 2004 there was a significant 18% increase of repeat maltreatment. However from 2004 through 2005 there was a modest decrease of 4% of repeat maltreatment. For the three year data indicators, repeat maltreatment occurred each year. This indicates a performance weakness for the tri-county area.

The data related to “*Allegations of Maltreatment*” indicate that from 2004 through 2005 allegation type remained proportionately consistent. The most significant change was an increase of 57.7% in the category of referrals relating to psychological or emotional maltreatment. This would be followed by the second highest increase of 31.1% in the referral category of physical abuse. The data shows for this time period there was a notable decrease of 38.7% in medical neglect referrals. There is a large portion of the cases which fell in “other” category.

Goals: Strengthen Need Based Service Planning Practice – This was also chosen as a goal for Safety 2, and strategies are listed under that capacity.

Operationalize Family Centered Practice across the Collaborative to enhance families’ capacity to provide for their children’s needs. – also chosen by Safety 2, Permanency 1 and Permanency 2 and listed there.

Bring in needed new services: School Based Family Resource Workers, Wrap Around Services, listed in Safety 2.

**Strategy #1: (Identify Strategy Here)
Strengthen Need Based Service Planning Practice**

Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed strategy Completion Date Quarterly Status
1. Implement the use of CANS assessment	<i>Provide CANS training to all DHHR workers, appropriate schools workers, service providers.</i>	Jan. 2011	Use of the CANS will allow families to come up with attainable goals, will allow workers to address family goals and make appropriate referrals and increase awareness of available services	Check with service providers about rates of referrals to assess whether or not this has resulted in an increase in appropriate referrals.		
	<i>Consult with administrators about CANS training and use of CANS to provide appropriate referrals for families.</i>	August 2010				
	<i>Encourage schools, DHHR and service providers to share information about CANS. evaluation</i>	Feb. 2011				

Strategy #2: (Identify strategy Here)						
Bring in needed new service: School Based Family Resource Workers						
Action Steps of the strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchm arks and Propose d Timefra mes for Action Steps	Intended Effects of Action Steps	Continu ous Quality Improve ment Process Utilizing Data for Action Steps	Person/Gro ups Responsibl e for Action Steps	Proposed Strategy Completion Date Quarterly Status
1. Research other jurisdictions that have School based Family Resource Workers to find out what the job description is and what qualifications are required.	Talk to Grant County and other jurisdictions that have school based family resource workers.	August 30, 2010	Schools have the opportunity to serve the broader needs of families and communities by connecting families with needed resources, supports and services. In creating partnerships between our schools, DHHR and community supports and services, schools can serve as a safe place for families to access supports and services. A "coordinated service delivery" approach such as School Based Family Resource Workers would allow for an increase in communication, coordination and collaboration between DHHR, schools and community services and support so that Children are, first and foremost, protected from abuse and neglect.			
	Identify qualifications and services that would be provided, include direct service in job description.	Sept. 30, 2010				

	<i>Define relationship with other school personnel such as guidance counselors, truancy workers.</i>	Oct. 31, 2010				
<i>2. Research funding possibilities – grants, cost sharing, etc.</i>	<i>Explore funding sources for providing therapy, call Diane Ansari from Head Start.</i>	Jan. 1, 2011				
<i>3. Create partnerships between service providers and schools for this.</i>	<i>Talk to schools about partnering on this.</i>	Feb. 1, 2011				

Safety Outcome 2

Children are safely maintained in their homes when possible

The following data elements from the Kids in Transition Child and Family Snapshot were utilized during the assessment of Safety Outcome 2

1. Services to Family to Protect Children in Home and Prevent Removal

- This indicator determines whether the agency made concerted efforts to the family to prevent children's entry into foster care.
- In year 2005-2006, 57 % of the cases reviewed indicated that services were provided to families to protect children in home and prevent removal.

2. Risk of Harm to Children

- This indicator determines the risk and safety considerations for children in their own homes or while in foster care.
- The data chart indicated this as strength.

3. Emergency Removals by condition type

- This chart provides information on the conditions that were presents at the time of emergency removals.
- During fiscal year 2006, the percentage of cases pulled for the case review indicated that two (2) emergency removals by condition type were neglect, incarceration of parent and abandonment.

Data indicators reflect that a small percentage of cases reviewed during fiscal year 2006 were emergency removals and more often than not services were provided to families to protect children in the home and prevent removal.

Goals: Strengthen Need Based Service Planning Practice, also listed by Safety 1, additional strategies listed here.
Operationalize Family Centered Practice across the Collaborative to enhance families' capacity to provide for their children's needs— also chosen by Safety 1, Permanency 1 and Permanency 2 and listed there.
Bring in Wrap Around Services to the jurisdiction, also listed by Safety 1

Strategy #1: (Identify strategy Here)

Strengthen Need Based Service Planning Practice

<p>Action Steps of the strategy <i>Community/Collaborative</i></p>	<p>Tasks to Complete Action Steps</p>	<p>Benchmarks and Proposed Timeframes for Action Steps</p>	<p>Intended Effects of Action Steps</p>	<p>Continuous Quality Improvement Process Utilizing Data for Action Steps</p>	<p>Person/Groups Responsible for Action Steps</p>	<p>Proposed strategy Completion Date Quarterly Status</p>
<p>1. Strengthen input into MDT's or wider attendance at MDT's.</p>	<p>At unit meeting, discuss MDT's, who is contacted and how their information is used. Suggest alternate individuals who's information may be helpful for resolution of issues at MDT's.</p>	<p>Dec. 2010</p>	<p>Expanding the input for MDT's to include foster parents, mental health providers, schools personnel will improve the understanding of what issues each child is dealing with and help to identify specialized needs for which to provide service, increasing the likelihood that children will be safely maintained in their homes.</p>	<p>Using blog, assess whether or not foster parents, mental health providers and schools staff are being contacted for MDT's.</p>	<p>Unit managers, KIT Collaborative</p>	<p>April 2011</p>
	<p>Educate and train workers about benefits of seeking wider input for MDT's.</p>	<p>Jan. 2011</p>				
	<p>Educate and train workers on continuity of care and sharing of information with clinicians providing direct services to children.</p>					
	<p>Education clinicians regarding current strains and limitations on DHHR workers.</p>	<p>Jan. 2011</p>				

	<i>Encourage school personnel and service providers and foster parents to be more proactive in engaging with workers assisting with children in care.</i>	Jan. 2011				
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Strategy #1: (Identify strategy Here)						
Bring in Wrap Around Services to the jurisdiction						
Action Steps of the strategy	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Processes Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed strategy Completion Date
<i>Community/Collaborative</i>						Quarterly Status
<i>1. Investigate jurisdictions where this service is provided to find out what it would take to bring it here.</i>	<i>Call Susan Frye at Stepping Stones.</i>	August 1, 2010	The provision of this service would allow for individualization of services to prevent removal. It would enable families to use professional services to be utilized and would teach a family how to replace professional services with natural supports.			
<i>2. Contact local agencies to find out who might have the capacity to provide this service.</i>	<i>Contact local agencies that provide services to families and children.</i>	Oct. 1, 2010				
<i>3. Talk with workers to find out how</i>	<i>Utilize unit or district DHHR</i>	Oct. 1, 2010				

<i>many families might benefit from this service.</i>	<i>meeting to discuss wrap around, create survey for workers to determine how many families might benefit from the service.</i>					
<i>4. Determine if the number of families and the costs would make this service cost effective.</i>	<i>Research reimbursement rates, etc. to determine cost effectiveness of this service.</i>	Nov. 1, 2010				

Permanency Outcome 1

Children have permanency and stability in their living situation

In regards to “Foster Care Re-Entries,” data shows that of the 100% of children, who were returned back to the home during 2003/04, 50% re-entered foster care during the 2004/05 period. Of the 50% that still remained in their home during 2004/05, 0% re-entered during the 2005/06 period.

Regarding Permanency Goal for Child the data shows that between 2005-2006, increased from 67% to 100%.

Reunification, Guardianship or Permanent Placement with Relatives data shows that that the reunification rate decreased statistically in 2004-2006 from 83% to 60%.

In regards to “Preserving Connections,” data shows that of the 100% of children sampled in 2003/04, concerted efforts were made to maintain connections with a child’s community 75% of the time in 2004/05. That rate declined 2005/06 to 33% of the time.

In the area of Adoption the data shows that efforts to achieve finalized adoptions increased from 67% in 2003 to 100% in 2005.

Proximity of Foster Care Placement data indicates a continued strength with a performance of 100% in facilitating placement.

In regards to Placement with Siblings has continued to increase from 67% 2003 to 100% in 2005.

Visiting with Parents and Siblings in Foster Care data indicates that is a strength increasing from 67% to 100% during 2003-2005.

The data related to Child and Family Involvement in Case Planning has increased from 2003, 29% to 2006, 75%.

Related to Relationship of Child in Care with Parents, the data indicates that this is a challenge for our area with statistics indicating in 2003 67% and in 2005 0%.

In regards to “Number of Placements,” 2004 data shows that 426 children were in care. Of those 54% only had one placement and the remaining 46% had more than one placement. In 2005 there were 534 children in care. Of those children 57% only had one placement with the remaining 43% having more than one placement. In 2006 there were 433 children in care. Of those children 52% only had one placement with the remaining 48% having more than one placement. The data indicates over the course of time, the percentage of children experiencing more than one placement has increased.

Goals:

Strengthen Life Skills Training/Household Services across the jurisdiction

Operationalize Family Centered Practice across the Collaborative to enhance families’ capacity to provide for their children’s needs— also chosen by Safety 1 and 2, and Permanency 2 and listed there.

Strengthen Transportation assistance including transportation for parents and children to court dates, support groups, MDT’s, IEP’s, therapy, parenting classes and other trainings.

Strategy #1: (Identify Strategy Here) Strengthen Life Skills Training/Household Services across the jurisdiction						
Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
1. Identify agencies and organizations providing this service	Make inquiries among providers utilizing KIT, HHSC and NASW distribution lists concerning who provides these services.	August 1, 2010	This will tell us who is providing services.		Monica, FRN	
2. Invite providers to attend Sept. KIT meeting to make presentations, including which services are provided, how to make referrals, costs associated with the services, etc.	Structure Sept. KIT meeting to focus on this service and how it is being provided. Create flyers, publicize the meeting to beyond regular attendees to include DHHR, other agencies who provide services to families.	Sept. 1, 2010	Providing information about the services and providers will increase the possibility that families will receive services and maintain permanency and stability in their homes.		Monica, FRN	
3. Create resource list for families, DHHR workers, schools personnel and other agencies	Solicit information from providers and create listing, posted to website and available electronically.	Sept. 1, 2010	Providing information about the services and providers will increase the possibility that families will receive services and maintain permanency and stability in	FRN will annually update list and recommend that new providers present to KIT.	Dawn, FRN & Justin	

			their homes.		
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Strategy #2: (Identify Strategy Here) Strengthen Transportation assistance including transportation for parents and children to court dates, support groups, MDT's, IEP's, therapy, parenting classes and other trainings.						
Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
1. Research who is providing transportation in the Eastern Panhandle, including Patient Transportation, Shenandoah, Berkeley Senior Center, Pan Tran, VIP and what is required to get free or reduced cost transportation.	Call existing transportation services to find out rates, routes, hours of operation, reservation requirements, payment options, etc.	Sept. 1, 2010	Gaining information about existing services will enable us to better inform families of the options and identify gaps in transportation, allowing children to have more stability and permanency in their homes.			
2. Research through DHHR whether or not transportation costs may be covered for an open case.	Contact DHHR to inquire about transportation reimbursement, check out codes for socially necessary services.	Sept. 1, 2010	Gaining information about possible reimbursements will enable us to better provide			

			transportation to families allowing children to have more stability and permanency in their homes.			
<i>3. Educate workers and parents on transportation reimbursement, provide hands on training if necessary on process of accessing transportation and reimbursement.</i>	<i>Set up training opportunities for parents, contact RAPP, foster parent groups and other groups of parents who may be eligible for transportation assistance, provide information through newsletters, flyers, email distribution lists, etc.</i>	Oct. 1, 2010	Providing more transportation assistance for children and parents to court dates, MDT's, support groups, IEP's, therapy, parenting classes and other trainings will contribute towards children's permanency and stability.			
<i>4. Provide annual refresher for new parents, workers.</i>	<i>Through KIT and other networks, provide annual opportunity to be updated on transportation assistance.</i>	Oct. 2011	Providing more transportation assistance for children and parents to court dates, MDT's, support groups, IEP's, therapy, parenting classes and other trainings will contribute towards	On-going attention to this need will meet the needs of new families and those families who have not previously accessed services.		

			children's permanency and stability.			
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Strategy #2: (Identify Strategy Here)						
Action Steps of the Strategy	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
State						
1. Obtain funding for transportation assistance for court ordered services, therapy, MDT's, IEP's, etc.	Research possible funding streams, determine eligibility guidelines, provide funding to jurisdiction.	July 2011	With greater support to get to necessary meetings and services, parents will be able to provide more stability and keep children in the home more effectively.	Maintain funding.	State	

Permanency Outcome 2

The continuity of family relationships and connections are preserved

The following data elements from the Kids in Transition Child and Family Snapshot were utilized during the assessment of Permanency Outcome 2.

1. Proximity of foster care placement
This data indicator determines whether concerted efforts were made to ensure the child's foster care placement was close enough to the parents to facilitate face-to-face contact between child and parents. Data charts for KIT indicated this was considered a strength.
2. Placement with siblings
This data shows the percentage of siblings in foster care who were placed together. This was considered a strength for KIT. This was a strength for KIT.
3. Preserving Connections
This data indicator determines that the agency made concerted efforts to maintain the child's connections to his or her neighborhood, community, faith, extended family, tribe, school and friends.
4. Relative Placement
This data indicator determines whether maternal and paternal relatives were considered for placement at removal and if not was the reason appropriate. This was considered a strength
5. Relationships of child in care with parents.
This data indicator determines whether there is a strong relationship and in what percent of cases DHHR made efforts to promote or maintain relationships between the child and parent. This was a weakness for DHHR.

Data charts that offered information on Permanency goals were also reviewed. The data indicated that for the most recent year of data FFY06, 433 children's permanency goal was Reunification.

Goals: Operationalize Family Centered Practice across the Collaborative to enhance families' capacity to provide for their children's needs— also chosen by Safety 2, Permanency 1.
Bring in Sexual Abuse Treatment to the jurisdiction.

Strategy#1: (Identify Strategy Here)
Operationalize Family Centered Practice across the Collaborative to enhance families' capacity to provide for their children's needs.

Action Steps of the strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed strategy Completion Date Quarterly Status
1. Establish recognition/rewards for agencies and individuals who model good family-centered practice.	Research Awards programs in other jurisdictions- Starfish award. Institute annual recognition/reward nomination process. Get funds for reward incentive.	Sept. 30, 2010 - Complete research by Nov. 30, 2010 - design nomination process, set deadlines, ceremony target dates, get funding for rewards. Jan. 30, 2011- Promote recognition/award process, accept nominations. Feb. 28, 2011- Distribute first awards.	Raise awareness of family centered practice. Strengthen desire for individuals & agencies to implement family centered practice. Recognize individuals, agencies that are models of family centered practice.	Create subcommittee for Family Centered practice within KIT Collaborative to institutionalize process.	KIT Collaborative	
2. Develop training for operationalizing family centered practice for supervisors.	Find speaker, coordinate date/location with DHHR.	Sept. 30, 2010 – find speaker,	Supervisors will have greater ability	Include family centered		

		select date. Nov. 30, 2010 – hold training.	to assist workers in family centered practice. Workers will receive greater direction in implementing family centered practice.	practice criteria as part of worker/supervisor evaluation.	
3. Survey workers who have participated in training to discover barriers to implementation of family centered practice.	Create electronic survey to assess worker ability to implement family centered practice. Distribute surveys. Follow up with those who do not return surveys.	August 31, 2010 – create survey. Sept. 15 – distribute survey. Oct. 1 – begin contacting non-participants. Oct. 15 – close survey.	Workers will be able to articulate reasons for lack of implementation of family centered practice. KIT will gain knowledge of implementation barriers.	Do survey every 2-3 years to maintain awareness of the need to implement training.	Kit Collaborative
4. Using survey results, begin to explore strategies for overcoming barriers to full implementation of family centered practice.	Using survey responses, discover primary and secondary barriers to implementation of family centered practice. Pull together ad hoc committee to create strategies.	Oct. 31 – summarize survey results. Nov. 15 – create 2-3 strategies for overcoming barriers. Jan. 1, 2011 – begin to address barriers.	Over come barriers for implementation of family centered practice.	Do survey every 2-3 years to maintain awareness of the need to implement training.	KIT Collaborative
4. Offer CEU's for an advanced family centered practice training.	Find speaker, coordinate date/location with DHHR.	December 30, 2010 – find speaker, select date. February 28,	Workers will have deeper understanding of family centered	Hold training bi-annually.	Monica Cogle, KIT Collaborative

		2011 – hold training.	practice and opportunity to get CEU's. Ultimately, this strategy will build continuity of family relationships and connections for children.			
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Strategy #2: (Identify Strategy Here) Bring in Sexual Abuse Treatment to the jurisdiction.						
Action Steps of the Strategy	Tasks to Complete Action Steps	Bench marks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
<i>Community/Collaborative</i>						
1. Research what kind of treatment is being provided to sexual abuse victims, both children and adults. Find out who is providing treatment, what specific treatment models are being used.	Contact service providers to inquire about sexual abuse treatment options.		Currently, specialized treatment for sexually abused individuals is not available in this community. Sexual abuse victims are currently referred to mental health providers without specialized training. An emphasis on developing this service should be made to current community health providers to			

			encourage them to recruit provider with expertise. Additionally, specialized training could be made available to current providers. Ultimately, this would provide continuity of family relationships and preserve connections for children.			
<i>2. Identify training sources for sexual abuse treatment.</i>	<i>Contact schools, trainers to inquire about options.</i>		Without specialized training, providers are unable to provide this service.			
<i>3. Identify providers who are willing to provide services.</i>	<i>Dialog with providers about providing sexual abuse treatment.</i>		Providers would have to have the capacity to provide this service.			
<i>4. Seek funding sources to pay providers.</i>	<i>Research grants, other funding streams.</i>		Without funding, few patients will be able to afford specialized therapy.			

Well-being Outcome 1

Families have enhanced capacity to provide for children's needs

The following data was obtained where DHHR adequately assessed the needs of child, parents and foster parents to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family and provided the appropriate services. This was the data obtained:

	2003-2004	2004-2005	2005-2006
Weakness	71%	75%	38%
Strength	29%	25%	63%

The data shows that over the course of time making these adequate assessments has been strengthened. Therefore, families are having necessary services identified to achieve case goals with the ultimate goal being discharged from DHHR involvement and increased family sustainability.

The following data was obtained relating to Child and Family involvement in case planning shows. The data will be a percentage of parents and age-appropriate children's who have been involved in case planning. This also includes pre-adoptive parents and permanent relative caretakers.

	2003-2004	2004-2005	2005-2006
Weakness	71%	50%	25%
Strength	29%	50%	75%

The data shows that over the course of time, family involvement in case planning has increased. The ability for a family to be involved in its own treatment gives a greater sense of empowerment, which can lead to a greater chance for change.

The following data was obtained related to a worker's visit with the child where there was regular face-to-face contact per policy, which is typically once every 30 days.

	2003-2004	2004-2005	2005-2006
Weakness	86%	88%	88%
Strength	14%	13%	13%

Over the course of time, the ability for a worker to meet the once every 30 day contact for a child and/or family has remained about the same and is not being met. This is likely due to high caseloads and lack of staff. We do not know if this data is for children in care, since children not removed from the home are an open CPS case still has the same standard.

The following data was obtained related to a worker's visit with the parent where there was regular face-to-face contact per policy, which is typically once every 30 days.

	2003-2004	2004-2005	2005-2006
Weakness	80%	83%	86%
Strength	20%	17%	14%

Over the course of time, the ability for a worker to meet the once every 30 day contact for a child and/or family has gotten worse and is not being met. This could be due to families who have left the area or can not be located. This is likely due to high caseloads and

lack of staff. We do not know if this data is for parents who have children in care, since children not removed from the home are an open CPS case still has the same standard.

According to KIT Snapshot the following information was obtained in regards to children enrolled in pre-K (4 year olds):

	2006	2007
Berkeley served	30.5%	27.9%,
Jefferson served	21.4%	19.1%
Morgan served	38.8%	46.7%

Number of eligible children served in Head Start:

	2006
Berkeley County served	41.6%,
Jefferson served	51 %,
Morgan served	130%

Key Findings from the Data:

Overall, families are able to receive services needed to enhance their capacity to provide for their children’s needs. Follow up by caseworkers with children and families is a weakness, likely due to high caseloads and lack of staff. Half to less than half of all eligible children in the Collaborative are enrolled in Pre-Kindergarten or Head Start, with the exception of Head Start in Morgan County, where more than 100% of eligible children are enrolled in Head Start.

Well-being Outcome 1: Families have enhanced capacity to provide for children’s needs

Goals: Strengthen the empowerment of front-line service workers and middle-management supervision by leadership to do “whatever it takes” to achieve outcomes for children and families in regards to enhancing family capacity, and strengthen the empowerment of private providers to do “whatever it takes” to achieve outcomes for children and families in regard to enhancing family capacity – strategies also developed by Well-Being 3 and listed there as well.

Strengthen current accountability structures in which the community holds agencies and agency leaders accountable for performance outcomes in regard to enhancing family capacity.

Strengthen Need Based Service Planning Practice, also listed by Safety 1.

Strengthen School Based Personal Safety Curriculum, including sexual, physical, emotional and psychological abuse and neglect, also chosen by Well-Being 1 and 2 and listed there.

Bring in needed new services: School Based Family Resource Workers, listed in Safety 1, Wrap Around Services, listed in Safety 2.

Strategy #1: (Identify strategy Here)

Strengthen the empowerment of front-line service workers and middle-management supervision by leadership to do “whatever it takes” to achieve outcomes for children and families in regards to enhancing family capacity, and strengthen the empowerment of private providers to do “whatever it takes” to achieve outcomes for children and families in regard to enhancing family capacity.

Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed strategy Completion Date Quarterly Status
<p>1. Provide opportunities for DHHR workers to learn about services provided by local service providers at quarterly district meetings.</p>	<p>Contact Shelly Nicewarner about inviting maximum of 4 service providers to speak at district meetings once a quarter.</p>	<p>Get permission to start by Sept. 16 district meeting.</p>	<p>Expand worker knowledge of local service providers, allow time for problem solving between service providers and DHHR staff, giving families enhanced capacity to provide for their children’s needs.</p>	<p>Check back by Sept. 2011 district meeting to assess worker knowledge of service providers.</p>	<p>KIT members, Shelly Nicewarner, Dawn Heatwole.</p>	<p>Sept. 2011</p>
	<p>Schedule 4 service providers per quarter to present at quarterly district meetings.</p>	<p>Contact agencies to get 4 to the Sept. 16 district meeting.</p>	<p>Allow agencies to explain their services DHHR workers, allow time</p>	<p>Check back with service providers at Sept. 2011 KIT meeting to</p>	<p>KIT members, Dawn Heatwole.</p>	

			for problem solving between service providers and DHHR staff.	assess the success of the quarterly district meetings.		
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Strategy #1: (Identify Strategy Here)						
Action Steps of the Strategy	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
State						
1.Revise service provider funding structure.	Create a case rate for services similar to Chafee.	May 2011	Would allow for greater individualization of services and for more service providers to afford to provide greater services.	Survey workers and service providers to see if more services are being provided as needed for the enhancement of family capacity.	State	

Strategy #2: (Identify strategy Here)

Strengthen current accountability structures in which the community holds agencies and agency leaders accountable for performance outcomes in regard to enhancing family capacity.

Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
<p>1. At quarterly KIT meetings, schedule accountability issue sessions.</p>	<p>Inform KIT members and DHHR workers about accountability issues sessions, invite them to submit issues for discussion.</p>	<p>Begin incorporating accountability issues discussions at Sept. 2010 KIT meeting.</p>	<p>Provide a vehicle by which shortcomings are recognized and addressed by KIT members.</p>	<p>Survey service providers, KIT members, DHHR workers annually to assess success of system.</p>		<p>Sept. 2011</p>
<p>2. Create KIT Blog to allow KIT members, service providers, DHHR workers to address issues of service provision, empowerment.</p>	<p>Create website for KIT, install Blog, addressing security issues, membership issues.</p>	<p>August 2010.</p>	<p>The blog will permit members to address issues as they arise, and for other members to comment or respond actively, giving families enhanced capacity to provide for their children's needs..</p>	<p>Through blog, survey service providers, KIT members, DHHR workers annually to assess success of system.</p>	<p>Tom Kimm</p>	
	<p>Train all service providers, KIT members and DHHR workers on blog, how it will be used and maintained.</p>	<p>Sept. 2010</p>			<p>Tom Kimm</p>	
	<p>Oversee blog use, report regularly at KIT collaborative meeting.</p>				<p>Tom Kimm</p>	
<p>3. Provide client advocacy training</p>	<p>Create advocacy training,</p>	<p>April 2011.</p>	<p>Increase</p>	<p>At least once</p>	<p>KIT</p>	

for frontline workers within DHHR and agencies.	schedule, identify location and recruit attendees to training.		advocacy for clients within DHHR and agencies that provide services, giving families enhanced capacity to provide for their children's needs..	a year, assign KIT members to call agency, DHHR to assess ease of service provision.	Collaborative	
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Strategy #2: (Identify strategy Here)						
Action Steps of the Strategy	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date
State						Quarterly Status
1. Create accountability structures for DHHR & service providers.	Incorporate some kind of accountability process for DHHR and providers	Oct. 1, 2010 - preliminary action steps created by state.	Provide reasons for supervisors and providers to implement family centered practice.	Create incentives for implementation, corrective measures for lack of implementation.	State	

Well-being Outcome 2

Children receive services to meet their educational needs

The data related to educational needs of children indicates during the 2003-2004 year strengths and weaknesses were equal at 50%. In 2004-2005 the weakness decreased to 29% and the strength increased to 71%. However, in the 2005-2006 year there was an increase in the weakness back to 50% and a decrease in the strength to 50%.

The data related to the Temporary Removals by Disability Type shows that in the fiscal year of 2006, the state received into custody 214 children that needed special educational assessments and services. Of the 214, 205 of the children were recognized under the mental retardation category.

According to KIT Community Snapshot, Berkeley County serves 41%, Jefferson service 51 %, Morgan serves 130% of the eligible children for Head Start.

In regards to children enrolled in pre-K (4year old): In 2007 Berkeley served 27%, Jefferson served 19% and Morgan served 47% of the children eligible.

According to the KIT Community Snapshot, the number of children enrolled in Pre- K(4 year old) decreased in by 2% in Jefferson County and 3% in Berkeley County. However, there was increase of 8% in Morgan County

According to the KIT Community Snapshot, School Attendance and the Drop Out Rate in 2004/2005 school year Jefferson County had a drop out rate of 3.2%, Berkeley County at 3.1%, and Morgan County at 1.4%. In the 2005/2006 year there was a decrease of .4% in Berkeley County and .3% in Jefferson County. Morgan County remained the same.

According to the KIT Community Snapshot, the number of students with English as a Second Language has increased in Berkeley County from 283 in 2004/2005 to 363 in 2006/2007. Jefferson County was 224 in 2004/2005 and increased to 319 in 2006/2007. Morgan County had 12 students in 2004/2005 and 11 students in 2006/2007.

According to the KIT Community Snapshot, the number of students receiving free and reduced lunches is: 42% in Berkeley, 35% in Jefferson, and 46% in Morgan 46%.

Key Findings from the Data:

Overall, it appears that children struggle to have their educational needs met, with strengths and weaknesses each at 50%. The Collaborate disputes the data on Temporary Removals by Disability Type because the chart for temporary removal shows 205 of 214 children removed had an MR diagnosis. Although the drop out rate dropped incrementally, it remains higher than the national average. This issue merits action. The low level of enrollment in Pre-K and Head Start (except for Morgan County Head Start) is an issue that should be addressed, since these programs positively impact children's educational success.

Goals: Increase the current accountability structures in which the community holds agencies and agency leaders accountable for performance outcomes in regard to the child's educational needs.

Strengthen School Based Personal Safety Curriculum, including sexual, physical, emotional and psychological abuse and neglect, also chosen by Well-Being 1 and 3.

Strengthen educational services to children

Bring in needed new services: School Based Family Resource Workers, listed in Safety 2.

Strategy #1: (Identify Strategy Here)

Increase the current accountability structures in which the community holds agencies and agency leaders accountable for performance outcomes in regard to the child’s educational needs.

<p>Action Steps of the Strategy</p> <p><i>Community/Collaborative</i></p>	<p>Tasks to Complete Action Steps</p>	<p>Benchmarks and Proposed Timeframes for Action Steps</p>	<p>Intended Effects of Action Steps</p>	<p>Continuous Quality Improvement Process Utilizing Data for Action Steps</p>	<p>Person/Groups Responsible for Action Steps</p>	<p>Proposed Strategy Completion Date</p> <p>Quarterly Status</p>
<p>1 .Create a community education program regarding educational abuse.</p>	<p>Create flyers, posters, take home materials for parents about educational abuse.</p>	<p>July 31, 2010</p>	<p>Increase awareness among parents and community members regarding children’s educational needs. Build a sense of accountability among parents, agencies serving children and the community so that children receive appropriate services to meet their educational needs.</p>		<p>Heather Hoelscher-Garcia, KIT Collaborative members, schools staff</p>	
	<p>Distribute flyers and posters to sites such as libraries, DHHR, churches, schools, service providers, etc.</p>	<p>October 1, 2010</p>	<p>Increase awareness among parents and community members regarding children’s educational needs. Build a sense of accountability among parents, agencies serving</p>	<p>Begin to track numbers of children not attending school or getting their educatio</p>	<p>Heather Hoelscher-Garcia, KIT Collaborative members, schools staff</p>	

			children and the community.	nal needs met.		
	<i>Create and air public service announcements, put in newspapers, radio stations</i>	Oct. 1, 2010	Increase awareness among parents and community members regarding children's educational needs. Build a sense of accountability among parents, agencies serving children and the community.	Through survey or other means determine community engagement in the sense of accountability for getting children's educational needs met.	Heather Hoelscher-Garcia, KIT Collaborative members, schools staff	
	<i>Assess effectiveness of awareness campaign with survey, focus group, one to one.</i>					
<i>2. Work with judges and the legal system to find ways to intervene with families earlier.</i>	<i>Research laws regarding getting children's educational needs met.</i>	August 1, 2010	Knowledge of existing laws will help in discussing enforcement.			
	<i>Talk directly to judges to ascertain how they decide who gets a court hearing in truancy cases.</i>	Sept. 1, 2010	If we know how they determine who gets a court hearing, we can find ways to get judges to intervene with younger children.			
	<i>Present information to judges to see if they will work with parents of elementary and middle school children more effectively, encourage them to give more attention to intervention with parents of elementary school age</i>	Oct. 1, 2010	Having judges to work more effectively with parents of elementary age children and assign probation officers			

	<i>children than high school age children. Suggest that judges use alternative sentences with parents, such as community service. Ask that a probation officer be assigned to truancy cases, to hold parents accountable.</i>		would raise accountability of parents, so that children receive appropriate services to meet their educational needs.			
<i>3. Strengthen Watchdogs program in area schools.</i>	<i>Research existing school Watchdog programs, history and effectiveness of programs.</i>	June 30, 2010	Learn about existing program to increase accountability, so that children receive appropriate services to meet their educational needs.			
	<i>Work with principals to extend Watchdog program to more schools.</i>	Oct. 1, 2010	Engage current, former and new principals in the program.			
	<i>Recruit new volunteers for program</i>	Nov. 1, 2010	Widen community awareness about Watchdogs and the need in the community.			
	<i>Provide training and supervision for volunteers</i>	Jan. 30, 2011	Educate volunteers and community about the program.			
	<i>Find funding to sustain program</i>	Oct. 1, 2011	Funding for supervision and training will ensure that the program can be sustained.			

Strategy #2: (Identify strategy Here)

Strengthen School Based Personal Safety Curriculum, including sexual, physical, emotional and psychological abuse and neglect.

<p>Action Steps of the Strategy</p> <p><i>Community/Collaborative</i></p>	<p>Tasks to Complete Action Steps</p>	<p>Benchmarks and Proposed Timeframes for Action Steps</p>	<p>Intended Effects of Action Steps</p>	<p>Continuous Quality Improvement Process Utilizing Data for Action Steps</p>	<p>Person/Groups Responsible for Action Steps</p>	<p>Proposed Strategy Completion Date</p> <p>Quarterly Status</p>
<p>1. Identify 1-2 research based curricula to recommend to all 3 Eastern Panhandle school districts</p>	<p>Find and review curricula, contact other school districts to get recommendations, make formal recommendation to the school superintendents.</p>	<p>August 1, 2010</p>	<p>Researching curricula before making the recommendation will help to illustrate results oriented approach to the school superintendents</p>		<p>Deb Barthlow, Michelle Ransom, Monica Cogle, Heather Hoelscher-Garcia</p>	
<p>2. Begin training, orientation of program</p>	<p>Get approval for 1 curriculum.</p>	<p>May 2011</p>				
	<p>Identify key staff and provide training</p>		<p>Providing training, information to a wide variety of community members will strengthen the program.</p>			
	<p>Make presentation to parents other staff, open to the public, engage Boys and Girls Clubs, Big Brothers/Big Sisters</p>			<p>Do surveys at trainings to assess participant response, possibility of implementing program.</p>	<p>Deb Barthlow, Michelle Ransom, Monica Cogle, Heather Hoelscher-Garcia, other KIT members</p>	
<p>3. Implement full program</p>	<p>Provide literature to all agencies, parents, fully implement school</p>	<p>Sept. 2011</p>	<p>Strengthen children's</p>			

	<i>based curriculum</i>		parents capacity for safe response to potential abuse and neglect, so that children receive appropriate services to meet their educational needs.			
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Strategy #3: (Identify Strategy Here) Strengthen educational services to children						
Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
1. Restrict Homebound schooling	<i>Require that children who are referred to homebound services because of behavioral issues be seen by a psychotherapist and that home bound forms be signed by a therapist.</i>	April 2011	Requiring that children be seen by a psychotherapist will ensure that there is an authentic need for the child to receive educational services at home and that the psychological need leading to the homebound services is being addressed.		Pertinent school staff and service providers.	
	<i>Require parents to attend school with their children before permitting the child to receive</i>		Requiring parents to attend school may help the		Pertinent school staff.	

	<i>homebound educational services for behavioral issues.</i>		parent to understand the full scope of the child's behavioral issues and lead to more success at addressing them.			
	<i>Require therapists to notify the school after 2 unexcused appointment cancellations -as appropriate.</i>		Missing therapy may be an indicator that the parents are not attending to the needs of the children and is a cause for concern.			
	<i>Require therapists to notify the school of non-compliance with therapy plan.</i>		Lack of follow through with therapy planning may be an indicator that the parents are not attending to the needs of the children and is a cause for concern.			

Well Being 3

Children receive services to meet their physical and mental health needs.

The data related to children's mental health needs being assessed and services to meet those needs indicates strength of 50% and a weakness of 50% for the years 2003-2004, 2004-2005 and 2005-2006. This included both custody and non-custody cases.

The data related to children's physical health needs being assessed and services to meet those needs reveals that 2003-2004 it was a weakness 67% and a strength of 33% . However in 2004-2005, the weakness was reduced to 38% and strength increased to 63%. In 2005-2006, the weakness increased to 40% and the strength decreased to 60%. Data indicates that DHHR is improving its ability to ensure that children receive an assessment of their physical health and that they are seeking services to meet those needs. This included both custody and non custody cases.

The data related to the number of children in custody that have a Disability Type was:

- 72 in 2006 (42 emotionally disturbed, 24 other medical condition, 5 physically disabled, 1 mental retardation)
- 80 in 2005 (70 emotionally disturbed, 9 other medical condition, 1 physically disabled)
- 98 in 2004 (91 emotionally disturbed, 5 other medical condition, 2 physically disabled)

The temporary removals by Disability Type were:

- 214 in 2006 (205 mentally retarded, 9 visually or hearing impaired)
- 222 in 2005 (216 mentally retarded, 6 visually or hearing impaired)
- 226 in 2004 (200 mentally retarded, 26 visually or hearing impaired)

Based on a review of the data for Temporary Removal by Disability Type, the work group disputes how the data was collected. It is difficult to imagine that 205 of 214 children removed had a diagnosis of mental retardation.

We are correcting the service rating for substance abuse treatment. It is available to some youth in the jurisdiction at the Board of Child Care and was rated as not meeting enough need.

Goals: Strengthen the empowerment of front-line service workers and middle-management supervision by leadership to do "whatever it takes" to achieve outcomes for children and families in regards to enhancing family capacity, and strengthen the empowerment of private providers to do "whatever it takes" to achieve outcomes for children and families in regard to enhancing family capacity. – Strategies also developed by Well-Being 1 and listed there.

Strengthen outpatient mental health services for children and adults.

Strengthen School Based Personal Safety Curriculum, including sexual, physical, emotional and psychological abuse and neglect, also chosen by Well-Being 1 and 2, listed there.

Strategy #1: (Identify Strategy Here)

Strengthen the empowerment of front-line service workers and middle-management supervision by leadership to do “whatever it takes” to achieve outcomes for children and families in regards to enhancing family capacity, and strengthen the empowerment of private providers to do “whatever it takes” to achieve outcomes for children and families in regard to enhancing family capacity.

<p>Action Steps of the Strategy</p> <p><i>Community/Collaborative</i></p>	<p>Tasks to Complete Action Steps</p>	<p>Benchmarks and Proposed Timeframes for Action Steps</p>	<p>Intended Effects of Action Steps</p>	<p>Continuous Quality Improvement Process Utilizing Data for Action Steps</p>	<p>Person/Groups Responsible for Action Steps</p>	<p>Proposed Strategy Completion Date</p> <p>Quarterly Status</p>
<p>1. Create liaisons within each service providing agency to assist with getting needed service, improve intake procedures, improve referral processes, or identify key staff at each agency who can streamline service provision and respond quickly and effectively.</p>	<p>Create point of contact within each agency which has the capacity to respond quickly and accurately to requests for services and the authority to facilitate service provision.</p>	<p>Jan. 2011 have POC's in place in each agency</p>	<p>Increase the ability of workers and families to get needed physical and mental health services for children.</p>	<p>At an annual KIT meeting, invite POC's, workers and families to discuss their ability to get needed physical and mental health services for their children.</p>	<p>KIT collaborative, agencies that provide services.</p>	<p>April 2011</p>
	<p>Distribute POC information to DHHR workers, schools, families.</p>	<p>Feb. 2011</p>				
<p>2. Post referral/intake packets on line for needed services, provide training for workers on new procedures.</p>	<p>Make sure that all intake/referral packets are available electronically via agency website or KIT website, email packets to workers with information about new electronic processing procedures. Ensure that intake forms can be faxed in to agencies.</p>	<p>March 2011.</p>	<p>Increase the ability of workers and families to get needed physical and mental</p>	<p>At an annual KIT meeting, invite POC's, workers and families to discuss their ability to get needed physical and mental health services for</p>	<p>All agencies that provide services.</p>	

			health services for children.	their children.		
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Strategy #2: (Identify Strategy Here)
Strengthen outpatient mental health services for children and adults.

Action Steps of the Strategy <i>Community/Collaborative</i>	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
1. Strengthen collaboration between behavioral health providers, other service providers, school personnel, DHHR staff and community members.	Structure monthly KIT meetings to include focus on one particular issue, such as: Behavioral Health, Housing, Transportation, Health,	Nov. 1, 2010	Strengthening the KIT Collaborative will provide greater opportunities for service providers and workers who serve children to collaborate, improving understanding of service provision and making it easier for services to be provided to children.	Schedule an annual joint meeting to discuss service provision, barriers to obtaining service, and how to overcome any perceived barriers.		
	Set schedule up at least one quarter in advance and send out notices to service providers, community members, etc. inviting their participation.	Nov. 1, 2010				
	Survey KIT members to identify ways that KIT could better meet their needs.	Nov. 1, 2010				
	Research which organizations	Nov. 1,				

	would be beneficial to have attending KIT and contact representatives about attending regularly.	2010				
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Strategy #2: (Identify Strategy Here) Strengthen outpatient mental health services for children and adults.						
Action Steps of the Strategy	Tasks to Complete Action Steps	Benchmarks and Proposed Timeframes for Action Steps	Intended Effects of Action Steps	Continuous Quality Improvement Process Utilizing Data for Action Steps	Person/Groups Responsible for Action Steps	Proposed Strategy Completion Date Quarterly Status
State						
1. Open up reimbursement avenue for LPC's through Medicaid.	Meet with LPC Board members to research options.	April 2011	Increase the number of clinicians who will be paid to provide behavioral health services to children.	Monitor who is being reimbursed.	Sybill Schaffner, Board of Psychologists.	
	Actively support work of LPC Board					