Virginia's Annual Report on the Five Year Child Welfare Plan

2013

Submitted June 2013

Commonwealth of Virginia

Department of Social Services

Division of Family Services

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Frequent Abbreviations

APSR	Annual Progress Services Report
DBHDS	Virginia Department of Behavioral Health and Developmental Services
CAPTA	Child Abuse Prevention and Treatment Act
CFCIP	Chafee Foster Care Independence Program
CFSP	Child and Family Service Plan
CFSR	Child and Family Services Review
CPMT	Community Policy and Management Teams
CPS	Child Protective Services
CRAFFT	Community Resource, Adoptive and Foster Family Training
CSA	Comprehensive Services Act for At Risk Youth and Families
CSB	Community services boards
CQI	Continuous Quality Improvement Unit
DFS	Division of Family Services
DJJ	Virginia Department of Juvenile Justice
DMAS	Virginia Department of Medical Assistance Services
DOE	Virginia Department of Education
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ETV	Education and Training Vouchers
FACES	Virginia's Foster, Adoptive, and Kinship Parent Association
FAPT	Family Assessment and Planning Teams
FFY	Federal fiscal year
ILP	Independent Living Program
LDSS	Local departments of social services
NYTD	National Youth in Transition Database
OBRA	Outcome Based Reporting and Analysis Unit
OCS	Office of Comprehensive Services for At Risk Youth and Families
PCAV	Prevent Child Abuse Virginia
PSSF	Promoting Safe and Stable Families
QSR	Quality Services Review
SEC	State Executive Council
SFY	State fiscal year
SLAT	State and Local Advisory Team
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
VYAC	Virginia's Youth Advisory Council

Format of the Report

I. Description of Continuum of Child and Family Services

This section describes the continuum of child and family services in Virginia. It includes child safety services, permanency services, child well-being services, and DFS' quality assurance and data management systems.

II. Primary Strategies, Goals and Action Steps

Virginia is pursuing six primary strategies to improve safety, permanency and well-being outcomes for children and families. These strategies are fundamental for transforming and strengthening Virginia's service system. They strive to create a more comprehensive, family-focused, integrated and effective service of care for children and families.

This section delineates the six primary strategies, goals and action steps for the five years of this plan. This represents an evolving process that will be enhanced as Virginia continues to learn. For each strategy, the applicable Children's Services System Transformation outcomes, CFSR outcomes and Systemic Factors, and CFSR items that Virginia is striving to achieve are listed. This section contains progress made on Program Improvement Plan (PIP) strategies in addition to other divisional activities.

III. Additional Reporting Information

This section details monthly case worker visits, timely home studies, inter-country adoptions, licensing waivers, juvenile justice transfers, collaborations with tribes, and continuations of operations.

IV. Outcomes, Goals and Measures

Virginia has integrated the outcomes, goals and measures of two important initiatives into Virginia's Five Year State Plan for Children and Family Services:
Virginia's Children's Services System Transformation; and
The Federal Child and Family Services Review *(CFSR).*

V. Attachments

Attachments include the Virginia Child Welfare Staff and Provider Training, the CAPTA plan, Budget and Finance plans, and reports from the Citizen Review Panels.

I. Description of Continuum of Child and Family Services

1. Child Safety Services

VDSS' child safety efforts involve prevention services, prevention collaborations and the Child Protective Services Program. Each area is described below:

1. Child Safety Prevention Services

Prevention services include activities that promote certain behaviors as well as stop actions or behaviors from occurring. Child abuse and neglect prevention activities in Virginia include the following recognized approaches:

- Public awareness activities such as public service announcements, information kits and brochures that promote healthy parenting practices and child safety;
- Skills-based curricula for children that help them learn about and develop safety and protection skills;
- Parent education programs and parent support groups that help caregivers develop positive discipline techniques, learn age appropriate child development skills and gain access to needed services and support;
- Home visitation programs that provide support and parenting skill development;
- Respite crisis care programs that provide a break for caregivers in stressful situations; and
- Family resource centers that provide formal and informal support and information.

Healthy Families: The Virginia General Assembly appropriates funding for the Healthy Families program. These funds are currently awarded to 33 local Healthy Families sites serving 81 communities in Virginia to provide home visiting services to new parents who are at-risk of child maltreatment. Funding for Healthy Families Programs had been reduced since 2010 to the current level of $3,235,501 in SFY 2013; however, the SFY 2014 funding amount has been increased by $550,000 to $3,785,501. Contracts are being re-negotiated for the new state fiscal year. The Healthy Families' goals include: improving pregnancy outcomes and child health; promoting positive parenting practices; promoting child development; and preventing child abuse and neglect. The statewide organization, Prevent Child Abuse Virginia (PCAV), also receives funding through the Healthy Families Initiative to provide technical assistance, quality assurance, training and evaluation for the Healthy Families sites.

Child Abuse and Neglect Prevention Sub-Grants: The child abuse and neglect prevention sub-grants have served a critical need by providing community organizations with an opportunity to develop and expand services for the prevention of child abuse and neglect. Public and private non-profit, incorporated agencies and organizations in Virginia are eligible to apply. A range of primary and secondary child abuse and neglect prevention services and activities, both statewide and locally based, such as parent education and support, public education and awareness, and home visiting are funded. This section addresses three Request for Proposals (RFP) for Child Abuse and Neglect Prevention funds.

For Federal Fiscal Year 2012 **(October 1, 2011 - September 30, 2012)**, the Virginia Department of Social Services issued a RFP #FAM-11-067 on June 30, 2011 to distribute federal Community-Based Child Abuse Prevention (CBCAP) funds. CBCAP funded projects provide a 25% cash match in non-federal funds. A total of 24 proposals requesting over $1 million was received by the August 2, 2011 deadline. Proposals were reviewed by a nine (9) member multidisciplinary committee composed of VDSS staff and collaborative partners such as the Family and Children's Trust Fund, the Virginia Department of Health, and local departments of social services. A total of $815,000.00 in CBCAP funds were awarded to 18 programs. These projects ended September 30, 2012.

For State Fiscal Year 2013 (July 1, 2012 - June 30, 2013), all seventeen (17) of the CBCAP grants awarded in RFP #SVC-10-037 were renewed, for a total of $810,257.00 awarded in federal CBCAP funds. All eleven (11) Virginia Family Violence Prevention Program (VFVPP) Child Abuse Prevention grants were also renewed totaling $500,000 in state funds. This was the third year for these grants which were originally awarded for SFY 2011, renewed for SFY 2012 and again for SFY 2013.

On February 12, 2013, a new RFP was issued for the period of **July 1, 2013 - June 30, 2014**. VDSS received 37 eligible proposals by the April 4, 2013 deadline. The grant review was conducted May 6 and 7th with 11 reviewers. Contracts will be negotiated with the selected applicants. The RFP includes $150,000 in CAPTA funds, $600,000 in federal CBCAP funds, and $500,000 in state funds from the VFVPP Child Abuse Prevention Program.

Child Safety Prevention Collaborations

Family and Children's Trust Fund, Child Protective Services Committee: Effective July 1, 2012, the Governor's Advisory Board on Child Abuse and Neglect merged with the Family and Children's Trust Fund (FACT). FACT also provides grant funding to the state and local programs that provide prevention and family support services in the Commonwealth. FACT's mission focuses on intergenerational violence including child abuse, domestic violence and elder abuse. A standing committee of the FACT Board has been established to serve as a Citizen Review Panel. FACT has been and will continue to be a partner with VDSS and others such as Prevent Child Abuse Virginia (PCAV) on child abuse prevention initiatives.

Child Abuse Prevention Play: VDSS annually contracts with Theatre IV for the production and delivery of performances of the child sexual abuse prevention play "Hugs and Kisses" in elementary schools across Virginia. Theatre IV subcontracts with Prevent Child Abuse Virginia *(PCAV)* for coordination with local social services and schools and continued evaluation. VDSS and PCAV staff provides training on child sexual abuse to each touring cast. Approximately 50,000 K-5 elementary school children see the performances each year.

State Child Fatality Review Team: The State Child Fatality Review Team is an interdisciplinary team that reviews and analyzes sudden, violent or unnatural deaths of children so that strategies can be recommended to reduce the number of preventable child deaths in Virginia. The Team has reviewed 119 cases for SIDS, SUIDS, and unsafe sleep practices from 2009 and will soon move to findings and recommendations. The Child Protective Services Program Manager serves as a permanent member of the Team. The Team also serves as one of the Citizen Review Panels.

Home Visiting Consortium: The Virginia Home Visiting Consortium operates as part of Virginia's Early Childhood Initiative to increase local and state collaborative efforts and to increase the efficiency and effectiveness of home visiting services. Established in 2006, the Consortium is coordinated by the Virginia Department of Health (VDH). Members of the Consortium include representatives of home visiting programs funded through the Departments of Social Services; Health; Medical Assistance Services; Behavioral Health and Developmental Services; Education and non-profit partners. The Consortium sponsors a home visiting website and training through a VDH contract with James Madison University. The Consortium also addresses issues such as data collection, centralized intake, and professional development. VDH administers the federal Maternal, Infant and Early Childhood Home Visiting federal grants and the Home Visiting Consortium provides input and support to MIECHV. VDSS administers funds appropriated by the General Assembly for Healthy Families programs and VDSS administers the Head Start Collaboration Grant.

The Virginia Statewide Parent Education Coalition *(VSPEC)* was convened as part of the Virginia Early Childhood Comprehensive Systems initiative sponsored through the VDH as a result of a Maternal and Child Health Bureau grant. The work of this group is linked to the Virginia Early Childhood Initiative and also links with child abuse prevention initiatives. VSPEC consists of state and community stakeholders and service providers working together to identify gaps in parent education; strengthen existing services; and to improve the availability and quality of parent education programs. VDSS participates on VSPEC and provides sub-grant funding to Prevent Child Abuse Virginia to assist with facilitation of VSPEC.

Children's Justice Act/Court Appointed Special Advocate (CJA/CASA) Advisory Committee: The CJA/CASA Advisory Committee oversees the CJA and CASA programs and makes recommendations to the Criminal Justice Services Board. The Committee is composed of 15 members appointed by the Board and is focused on improving the investigation and prosecution of child abuse and neglect. The CJA/CASA Advisory Committee serves as one of the Citizen Review Panels. The CJA Program collaborated with VDSS, and the Office of the Chief Medical Examiner, VDH in sponsoring the first statewide Regional Child Fatality Review Team conference on April 30 – May 2, 2013. Approximately 100 people participated representing all five teams across the state.

Child Abuse Prevention Month: Dr. Robert Dugger, a founder of ReadyNation and advocate for investing early in the lives of American children, served as the Honorary Chair for Child Abuse Prevention Month. A Child Abuse Prevention Conference was held on April 15, 2013 with the theme "Insure Their Future: Invest in Children." Over 400 people participated in this very successful event. The Child Abuse Prevention Month packet is developed collaboratively with PCAV. Approximately 1,800 packets were printed and distributed for April 2013. The packet is posted on the VDSS public web site at: http://www.dss.virginia.gov/family/prevention.cgi and on the PCAV web site at: http://pcav.org/child-abuse-prevention-month/ for wider distribution.

Virginia Child Protection Newsletter *(VCPN):* An agreement utilizing CAPTA funds is renewed annually with James Madison University for the publication of VCPN. The circulation of the newsletter is approximately 12,000 people. The topics for the three newsletters for SFY 2013 are *Risk of Maltreatment for Children with Autism Spectrum Disorder; Evidence-Based Treatments for Childhood Trauma; and Evidence-Based Prevention.* VCPN is also on the web at: http://www.psychweb.cisat.jmu.edu/graysojh.

2. Child Protective Services *(CPS)* Program

Children Served. The number of CPS complaints has remained relatively stable over the past 10 years with approximately 32,000 to 36,000 reports annually involving approximately 48,000 to 53,000 children. In 2012, there were 35,478 completed reports of suspected child abuse and neglect involving 52,675 children. There were 6,365 children in founded reports and 37,366 children in the Family Assessment Track. In SFY 2011 -2012, 37 children died as a result of abuse and neglect.

Child Protective Services *(CPS)*: CPS is a program operated by VDSS focused on protecting children by preventing abuse and neglect and by intervening in families where abuse or neglect may be occurring. Services are designed to:

- Protect a child and his/her siblings;
- Prevent further abuse or neglect;
- Preserve family life, where possible, by enhancing parental capacity of adequate child care;
- Provide substitute care when the family of origin cannot be preserved.

CPS in Virginia is a specialized service designed to assist those families who are unable to safely provide for the care of their children. CPS, by definition, is child-centered, family-focused, and limited to caretaker situations. The delivery of CPS is based upon the belief that the primary responsibility for the care of children rests with their parents. Parents are presumed to be competent to raise, protect, advocate, and obtain services for their children, until or unless they have demonstrated otherwise.

Activities for child protection take place on the state and local levels. At the state level, the CPS Unit is divided into central and regional offices. Roles of the central office include:

- Developing regulations, policies, procedures and guidelines;
- Implementing statewide public awareness programs;
- Explaining programs and policies to mandated reporters and the general public;
- Coordinating and delivering training;
- Funding special grant programs; and
- Maintaining and disseminating data obtained from an automated information system.

In addition to its administrative responsibilities, the CPS Unit offers two direct services: operating a statewide 24-hour Child Abuse and Neglect Hotline; and maintaining a Central Registry of victims and caretakers involved in child abuse and neglect.

Regional office staff provides technical assistance, case consultation, training, and monitoring to the 120 LDSS. LDSS staff is responsible for responding to reports of suspected child abuse and neglect and for providing services in coordination with community agencies in an effort to provide for the safety of children within their own homes. Services can be provided through either an Investigation or a Family Assessment Response. The Investigation focuses on the situation that led to a valid abuse or neglect complaint involving a serious safety issue for the child. A disposition of founded or unfounded is made, and, if the disposition is founded, the name(s) of the caretaker(s) responsible for the founded abuse or neglect is entered in the state's Central Registry. The Investigation will also identify services that are to be provided to the family.

The Family Assessment Response is for valid CPS reports when there is no immediate concern for child safety and no legal requirement to investigate. LDSS work with the family to conduct an assessment of service needs and offer services to families, when needed, to reduce the risk of abuse or neglect. No disposition is made and no names are entered into the Central Registry.

Under Virginia law, an abused or neglected child is one under the age of 18 whose parents or other person responsible for his care cause or threaten to cause a non-accidental physical or mental injury, create a high risk of death, disfigurement or impairment of bodily or mental functions, fail to provide the care, guidance and protection the child requires for healthy growth and development, abandon the child, or commit or allow to be committed any act of sexual exploitation or any sexual act on a child.

Services include, but are not limited to: individual and/or family counseling; crisis intervention; case management; parenting skills training; homemaker services; respite day care; and/or family supervision provided through home visits by the CPS worker. The nature and extent of services provided to families depends upon the needs of the family and the availability of services within the community.

B. Permanency Services

VDSS' permanency efforts are implemented through the Promoting Safe and Stable Families Program, Permanency Program including Foster Care and Adoptions, Independent Living, Interstate Compact on the Placement of Children, Resource Family Development, and Prevention Services. Each area is described below:

1. Promoting Safe and Stable Families *(PSSF)*

PSSF services reflect the Virginia Children's Services Transformation Practice Model concept that "Children are best served when we provide their families with the supports necessary to safely raise them. Services to preserve the family unit and prevent family disruption are family focused, child centered, and community based."

PSSF services may be provided through local public or private agencies, individuals, or any combination of resources. The funding for the program is used for direct and purchased services to preserve and strengthen families, avoid unnecessary out-of-home or out-of-community placements, reunify children and their families, or to find and achieve new permanent families for those children who cannot return home. The program funding is flexible and a local planning body determines what community services on behalf of the children and families in their respective communities will be funded or reimbursed for services.

The PSSF Program provides services to children who are at risk of out-of-home placement or who are in Foster Care. Services include:

- ***Family preservation*:** These services are designed to help families alleviate crises that might lead to out-of-home placements for children because of abuse, neglect, or parental inability to care for them. They help maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining other services to meet multiple needs.
- ***Family support*:** These services are voluntary, preventive activities to help families nurture their children. They are often provided by community-based organizations. These services are designed to alleviate stress and help parents care for their children's well-being before a crisis occurs. They connect families with available community resources and supportive networks which assist parents with child rearing. Family support activities include respite care for parents and caregivers, early development screening of children to identify their needs, tutoring health education for youth, and a range of center-based activities.
- ***Time-limited family reunification*:** These services and activities are provided to children who have been removed from home and placed in a foster home or a child care institution and to their parents or primary caregivers. The goal is to facilitate reunifications safely and appropriately within a timely fashion, but only during the 15-month period that begins on the date that children entered foster care. Services may include: individual, group, and family counseling; inpatient, residential, or outpatient substance abuse treatment services; behavioral health services; assistance to address domestic violence; temporary child care and therapeutic services for families, including crisis nurseries; and transportation to or from any of the services.
- ***Adoption promotion and support*:** These services and activities are designed to encourage adoptions from the foster care system that promote the best interests of children. Activities may include pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families.

The following services are offered under each of the program service types depending on the needs of the family:

Table 1: Promoting Safe & Stable Families Program

Service Array

Service Code	Service Array	Service Code	Service Array
010	Adoption Promotion/Support Services	160	Juvenile Delinquency/Violence Prevention Services
020	Assessment	170	Leadership and Social Skills Training
030	Case Management	180	Mentoring
040	Community Education and Information	190	Nutrition Related Services
050	Counseling and treatment: Individual	200	Other (identify)
051	Counseling: Therapy Groups	210	Parent-Family Resource Center
060	Day Care Assistance	211	Parenting Education
061	Developmental/Child Enrichment Day Care	212	Programs for Fathers (Fatherhood)
070	Domestic Violence Prevention	213	Parenting Skills Training
080	Early Intervention (Developmental Assessments and/or Interventions)	220	Respite Care
090	Educational/ School Related Services	230	Self Help Groups (Anger Control, SA, DV)
110	Financial Management Services	235	Substance Abuse Services
120	Health Related Education & Awareness	240	Socialization and Recreation
130	Housing or Other Material Assistance	250	Teen Pregnancy Prevention
140	Information and Referral	260	Transportation
150	Intensive In-Home Services		

Children and Families Served. The following table shows the number of children and families that received services by service type in 2013:

Children and Families Served by Service Type SFY 2013 ***98 Agencies reporting***		
Service Type	***Total Children***	***Total Families***

Preservation	*5845*	*3718*
Support	*9553*	*6294*
Reunification	*1073*	*699*
Adoption (1)	*18*	*15*
Other PSSF Services (2)	*54,380*	*52,002*
Total	*70,869*	*62,728*

(1) $2M PSSF funds were allocated for adoption initiatives at the home office level, therefore, localities were not required to spend 20% on adoption promotion. This number includes localities that provided local adoption services.

(2) Some localities provided services that do not lend themselves to identifying data, as they are not targeted toward specific individuals or families (e.g., community fairs, brochures, information and referral, newsletters, library resource centers, websites, etc.)

Many children and families receiving PSSF funds are assessed by the CSA FAPT Teams. These teams provide for family participation, assess the strengths and needs of children and their families, and develop individual family services plans.

Funding process: Title IV-B Subpart 2 funds for this program are allocated to communities for control and expenditure. The CSA CPMTs are designated as the local planning bodies for PSSF funds. This role is consistent with their statutory responsibilities to manage community collaborative efforts for at-risk youth and families, conduct community-wide service planning, and maximize the use of state and community resources.

Local receipt of funding is based on VDSS approval of individual community plans developed from comprehensive community-based needs assessments. Localities are required to spend at a minimum: 20% funding on family preservation; 20% on family support; 20% on family reunification; and 20% on adoption promotion and support. Localities may be eligible for a waiver for these percentages with adequate justification. All localities are given a waiver for adoption promotion and support since the state applies 25% of Title IV-B Subpart 2 to adoption service contracts approved by the state.
Communities are required, under their community assessment and planning process, to establish and document linkages among services, programs, agencies, organizations, parents and advocacy groups in order to identify and prioritize service needs. Of the 120 localities (LDSS) 114 had approved plans for SFY 2013. Some plans cover more than one local jurisdiction. Also, it is not uncommon for the localities to combine their plans and then split based on dictates of local governing bodies during the plan cycle.

Program Monitoring & Outcome Measures: The PSSF state office staff conducts limited training to assure local program staff knowledge in the following key areas: service planning and delivery; outcome measurement; data management; and budget development. Ongoing monitoring through review of quarterly reports and targeted on-site technical assistance as necessary is conducted to ensure the appropriate use of funds.

Regular reports are required of each locality to determine how well the localities meet the objectives. The reports include numbers of:

- Families receiving prevention services, and how many of their children enter foster care;
- Families whose children are in foster care 15 months or less who receive reunification services;
- Children who are placed with relatives other than the natural parents;
- Children for whom a new abuse complaint was made; and
- Families served by ethnicity.

2. Permanency Program – Foster Care Services and Adoptions

Children served. A total of 7,216 children received foster care services throughout FFY 2012. However, this number reflects children who were in care at any point in time during the year and is an aggregate number of children served. On September 30, 2012, there were 4,627 children in foster care.

After several years of declining congregate care populations and reducing the percentage of clients in congregate care by ~50% from FFY 2005 to FFY 2011, Virginia experienced a small increase in the number of clients in congregate care for FFY 2012. From FFY 2011 to FFY 2012 there are now 62 more clients in congregate care, a ~9% increase. Virginia also has a strong commitment to increasing our reliance on foster family homes. For FFY 2012 there was a slight decrease of ~1% in the percent of clients in a foster family home from FFY 2011. The percent of clients discharged to permanency also experienced a slight decrease of ~1% from FFY 2011. Virginia is still a strong supporter of managing by data and has continued to expand its capabilities and use of data across the state through the use of SafeMeasures, dashboards, and other methods.

Permanency Unit - Foster Care Services: The objective of Foster Care Services is to provide the programmatic and fiscal guidance and technical assistance to LDSS to enable them to provide safe, appropriate, 24-hour, substitute care for children who are under their jurisdiction and to increase their ability to find family homes and develop or maintain positive adult connections for all children in care.

Foster care in Virginia is required by state law to provide a "full range of casework, treatment and community based services for a planned period of time to a child who is abused, neglected, or in need of services." All children in foster care are placed through a judicial commitment or a voluntary placement agreement to a LDSS or a licensed child-placing agency. Foster care services are provided to each child and family to either prevent foster care placement or, once placed in foster care, to facilitate a timely return to a permanent home. The LDSS have either legal or physical custody of children in foster care and are responsible for providing direct services to all children and their families.

VDSS continues to implement best practices to support local efforts to improve services to children and families involved in the foster care system. VDSS provides program training and technical support to each of its 120 LDSS through its regional support network of five permanency consultants. These consultants provide LDSS quality reviews, conduct technical assistance on foster care and adoption policy and procedures, and are available for on-site technical assistance as required. The consultants hold "permanency roundtables" to assist the LDSS in staffing cases (particularly those of older youth) where achieving permanency has been a difficult issue. VDSS home office staff also provides program support

for the implementation of Independent Living Services and family support, stabilization and preservation services through regional training efforts and technical assistance to all localities.

Foster Care Collaborations

Foster care services cut across other programs and child-serving agencies, including foster care prevention, Adoption, OCS, BHDS, DJJ, DOE and VDH. Virginia is actively working with other internal Divisions and State agencies to improve service delivery to children and families involved in foster care. Other collaborations include:

FACES: FACES of Virginia Families: Foster, Adoption, and Kinship Association is a multi-year contract with VDSS to "provide a supportive membership association as a partner to the Virginia Department of Social Services' effort to improve the delivery of foster, adoptive, and kinship care services to children living in resource family homes as a result of abuse, neglect, abandonment, or parental limitations in providing a safe and nurturing home." FACES activities are based on contractual goals including maintaining a "Warm Line" for support of current and potential foster, adoptive and kinship care providers. The Warm Line is averaging over 40 calls a quarter. In addition, FACES has developed a Trailblazer's program. Trailblazers is the FACES mentoring program to support foster, adoption, and kinship parents as they become caregivers to children recently placed in their homes. The program is implemented in partnership with local departments of social services. Trailblazers have been developed in three local agencies with the training of 24 individual Trailblazers.

FACES also provides an educational newsletter to a mailing list of 1,100 interested members as well as conducting educational webinars on "Webinar Wednesdays" that cover a broad range of topics to include diverse topics such as dealing with difficult child rearing situations and VDSS policy on enhanced maintenance determination. FACES provided 89 educational scholarships to the NACAC Conference 2012. FACES is currently operating a consignment shop in Ashland, Virginia to develop a means of becoming self-supporting in the future.

Permanency Advisory Committee (PAC) The purpose of the PAC is to advise the permanency programs in DFS on improving permanency and well-being for children and families across the Commonwealth. PAC has had regular meetings since 2009 with a variety of stakeholders from around the Commonwealth. In addition PAC is charged with assisting VDSS to align policies and guidance to promote a seamless "best practice" continuum, improve coordination and integration and provide consistency across the various LDSS' in the Commonwealth. With this goal in mind, the PAC membership was realigned and additional recruitment of members was initiated to utilize local departments of social service representatives reflecting various regions, agency size and job duties. Consultants from private stakeholder groups continue to be kept informed of PAC's work and are engaged as needed.

In FFY 2013, PAC has reviewed studies and provided input into extending foster care to 21; guidance development with the Health Plan Advisory Committee; assisted in defining best practice in guidance development around providing Independent Living services, concurrent planning, family visitation, keeping siblings together, and practices to provide permanency for children under five. PAC members are actively involved in the revisions to various screens in OASIS including but not limited to assessment, service plan, funding, placement and disability.

Office of Comprehensive Services for At Risk Youth and Families *(OCS):*

Areas of collaboration include: clarifying guidance related to what CSA funds can be used for when Title IV-E funds are not allowable. SFY 2013 has seen an increase in work by OCS in the areas of establishing Systems of Care across Virginia that will improve services available to children in foster care.

Department of Education (VDOE):
The Permanency Program staff continued its collaborative partnership with VDOE staff. In October 2012, VDSS and VDOE issued and disseminated revised joint guidance and tools to ensure educational stability and educational outcomes for school-aged children and youth in foster care. This revision addressed changes in federal and state law, issues from the field, and guidance on procedures when children in foster care are special education students. The guidance and tools were developed by a cross systems work group of VDSS, DOE, legal advocacy, and local stakeholders. VDSS and VDOE continue to provide training (separately and together) on the new guidance and tools across the state for local schools, LDSS, and other stakeholders.

Department of Medical Assistance Services (DMAS):
DMAS is actively working with the VDSS to implement managed care for all children in foster care and for all children who receive adoption assistance. Since December 2001, children in foster care and residing in Richmond City have been successfully included in managed care as a pilot project. Effective July 1, 2013, children in foster care or receiving adoption assistance who reside in the Central or Tidewater managed care regions and are receiving Medicaid will be enrolled in a managed care organization (MCO). By October 1, 2013, all Medicaid eligible children who are in foster care or receiving adoption assistance statewide will be enrolled in an MCO. Statewide planning for this transition to managed care continues through monthly meetings with DMAS, MCOs, LDSS from across the state, and other key players. (See also the Health Care Services section)

Health Plan Advisory Committee (HPAC):
HPAC advises and makes recommendations to VDSS and DMAS to provide vision, coordination, and oversight of health care services for children in foster care. HPAC is addressing health screening, assessments, and treatment of children in foster care, including treatment of trauma due to maltreatment and removal from home. Health is broadly defined as developmental, health, dental, mental health, and substance abuse services. HPAC is also working to ensure continuity of health care services, to provide oversight of prescription and psychotropic medications, and to update and appropriately share child health information with caregivers and health care providers. HPAC is co-chaired by VDSS and DMAS. Members include foster families; state and local social service agencies; other child serving agencies; health care providers including pediatricians, child and adolescent psychiatrists, pharmacists, dentist, social workers, nurses, health educators, managed care organizations, trauma experts; and advocacy groups. (See also the Health Services Section)

National Resource Center *(NRC):*
In early 2012, Virginia requested and was approved for technical assistance on assessment in kinship care. The goal of this request was to support the implementation of the foster care permanency option of Placement with Relative/ Transfer of custody to relative with custody assistance as described in the Fostering Connections Act. Dr. Gary Mallon, consultant with the NRC on Permanency came to Virginia on April 23, 2012 to facilitate a site assessment and again on July 23 to facilitate a progress review. Participants in these meetings included state and local staff with experience in working with foster, adoptive and informal and formal (resource) kinship families.

This group developed a work plan which included three main goals which are described below. For each goal a small (sub) work group comprised of some members of the larger group met as often as needed to complete the work required. Below the three goals and progress towards each is addressed.

1) Select or develop a tool or instrument for use in conducting kinship family assessments which will address domestic violence, substance abuse and mental health issues and make it available to child welfare staff conducting kinship home screenings and staff conducting mutual family assessments (for foster home approval).

The small work group met multiple times and developed a draft "VDSS Kinship Assessment Guide" for use with both potential formal and informal kinship providers. The Assessment Guide is based on the work of Dr. Crumbley. It includes suggested questions designed to facilitate exploration of the following issues: motivation; household configuration; potential caregivers (primary and secondary); birth parent interaction with relative caregiver; family legacies; relative resources and ability to provide safety and protection; alternative permanency planning; and the child or siblings readiness for placement. The Guide also provides questions relative to eligibility for becoming an approved resource family, for use by LDSS staff when appropriate.

2) Select or develop a training curriculum for child welfare staff to facilitate their skills for working effectively with kinship families and evaluating the appropriateness of family members to meet the needs of children in foster care as the child's permanent family and develop an implementation plan

The work group reviewed multiple curricula addressing the training of public agency staff. The final recommendation was that elements of a number of different existing curricula be incorporated into a 1 day training which addresses: 1) staff attitudes and potential biases towards relatives as caregivers 2) requirements and benefits of relative/ kinship care-giving 3) engagement strategies for use with relatives and 4) use of the VDSS Kinship Assessment guide to screen potential caregivers "in" and identify areas where support would increase the likelihood of a placement (formal or informal) being successful. An outline addressing the recommendations was provided to the Training Unit. The Training Unit with VDSS has identified the course as one which will be mandated for new staff and placed it on the list of courses to be developed ASAP.

3) Develop a script/strategy to assist child welfare workers in explaining to relatives the various ways that they can be involved in a child in foster care's life including custody transfer, adoption and custody assistance and make it available to child welfare workers.

The small work group ultimately developed two products: a revision to an existing VDSS brochure on Permanency Options and a list of "Frequently Asked Questions" designed for relatives. The update to the brochure was written but not implemented. The FAQs are completed in draft form. They address permanency options, available financial assistance, and resources which may be available to kinship families. The directions which accompany the FAQs instruct the LDSS staff to review the material in person first and then provide the written material for the family's later use.

As noted above, significant progress towards addressing all three goals was made between April and November 2012. However, during that same period, Virginia ultimately decided not to pursue the custody assistance option. As a result, the sense of urgency which had imbued the work in 2012 diminished considerably, and the charge of the Kinship Workgroup became somewhat less clear.

However, although custody assistance is currently on hold, work with kinship families has continued, particularly in the area of "diversion placements" where children are temporarily or permanently placed with relatives through informal kinship care as an alternative to entering foster care. VDSS is increasingly aware of the need to provide practice guidelines and tools to the LDSS in addition to enhancing the

limited practice guidance relative to diversion which was published in the Early Prevention Manual in September 2012.

What is planned at this point is to reconvene the larger Kinship workgroup; there has been some discussion of having Gary Mallon of the NRC come back for one additional meeting. The VDSS Kinship Assessment Guide and the Relative FAQs need a final review by the workgroup. Dr. Mallon has agreed to have the Guide further reviewed by the NRC staff and, perhaps, by Dr. Crumbley. Dr. Mallon has also offered to have the NRC staff review the curriculum developed by the Training Unit for the Kinship course to be developed.

Moving forward, there is a need to pilot the tools developed and to get feedback from LDSS staff regarding helpfulness and procedures for use. Several LDSS staff on the Kinship Workgroup have already volunteered their LDSS to be a "pilot" site. Finally, these tools need to be made more widely available and Guidance needs to be enhanced where appropriate in the Family Engagement, Child Protection, Early Prevention and Permanency chapters.

Independent Living

Virginia is receiving training and technical assistance (T/TA) on an integrated approach to youth permanency and preparation for adulthood from the National Resource Center on Permanency and Family Connections (NRCPFC). Gary Mallon, Executive Director of NRCPFC, initially met with representatives from VDSS and LDSS in May 2012 and collaboratively a work plan was developed and three promising strategies identified to assist in achieving permanency for older youth in and transitioning out of foster care. Over the past year, NRCPFC has been actively working with VDSS by providing information, support and practical applications on the following three strategies: 1) Family Finding, 2) Permanency Roundtables (PRT), and 3) Engagement of youth voice in Family Partnership Meetings and other venues. Currently, two regions in Virginia are conducting their own versions of PRTs which are primarily case staffing and discussion on options for permanence for children/youth who appear to have a poor prognosis for having a forever family. In addition, using an adapted training developed by NRCPFC, Virginia has piloted "Unpacking the NO of Permanency for Older Adolescents" training which addresses the importance of permanency in two of the five regions in the state. In June, NRCPFC will provide TA to VDSS and Project LIFE (public/private partnership with United Methodist Family Services) in planning a teen conference focusing on youth permanency.

Permanency - Adoption Services:

Virginia's Adoption Program is state supervised and locally administered. LDSS provide direct adoption services to children in their custody with the permanency goal of adoption. The VDSS Permanency Unit Adoption Services is responsible for developing adoption policy and managing the Adoption Resource Exchange, developing and managing special initiatives, managing adoptions records, and maintaining access to adoption records. Virginia's special adoption activities are designed and implemented in order to assist LDSS to ensure that children achieve permanency through adoption. The special activities provide adoption services and funding by VDSS to local departments of social services and private adoption agencies to achieve adoptions.

The following chart shows Virginia's adoption activities and the funding for these activities in SFY 2013.

Adoption Activity SFY 2013	Funding Source	Allocation & Services

Adoption Support	SSBG State General Funds	$1,125,000 Post Legal System
One Church, One Child	SSBG State General Funds Adoption Incentive Funds for Grant Year 2011	$201,259 Recruitment (includes $10,000 Adoption Incentive Funds for Grant Year 2011)
Adoption Services	Title IV-B, Subpart 2 Adoption Incentive Funds for Grant Year 2011	$1,878,342 Adoption Services Performance Based Contracts for Finalized Adoptions (includes $10,000 Adoption Incentive Funds for Grant Year 2011) $173,650 Ainsworth Clinic (Pre-Post Adoption Assessments)
Adoption Assistance	Title IV-E and State General Funds	SFY 2013 $67,246,981 - Title IV-E $39,804,545 - State

Virginia was found to not be in substantial conformity with the adoption outcomes in the 2009 CFSR. Two key findings on adoption from the Review are:

- Delays in completing or approving home studies
- Delays due to a general lack of effort to finalize an adoption.

Data showing the decrease in placements of eligible children in adoptive homes and increase in the numbers of children waiting for such placements suggests that, without focused and intensive strategies to find, approve and place children into safe and permanent adoptive homes, Virginia's waiting children will increase.

Consequently, the adoption services contracts beginning July 1, 2011 to June 30, 2012 were redesigned based on data specific to the number of children in the custody of each LDSS with the goal of adoption, with parental rights terminated but not in an adoptive placement. Virginia contracted with Michaeline (Mickey) Groomes, Consultant, Data Driven Performance Based Management to frame and to guide the contract process.

Virginia awarded approximately $1.8 million in funding through Title XX/SSBG (Social Services Block Grant), Title IV-B Subpart 2 (CFDA 93.556) and State General Funds for adoption services contracts. Thirteen contracts were awarded to private non-profit licensed child placing agencies (LCPA) licensed in

Virginia and Virginia local departments of social services (LDSS). Under the title, "Adoption Through Collaborative Partnerships" (ATCP), two types of contracts were awarded as specified:

- LCPAs (Offeror/Lead Agency) in partnership with a minimum of two (2) local Department of Social Services (total team of at least 3); and
- LDSSs (Offeror/Lead Agency) in partnership with other local Department of Social Services, other child serving agencies, or service providers (total team of at least 3)

The primary outcome expected by VDSS from the use of collaborative partnerships to achieve adoptions is to *finalize* adoptions for a minimum of 356 children and youth in foster care. Grant funds awarded are to be used to expedite the adoption of three particular subsets of children in the custody of LDSS.

Target Group

Category 1 (Cat 1): Children and youth with a goal of adoption, with termination of parental rights (TPR), not in a pre-adoptive home, who have the potential to be adopted prior to twenty-four months (i.e., children in foster care less than 16 months). The target number for final adoptions in this group is a minimum of 32.

Category 2 (Cat 2): Children and youth who have a goal of adoption, with termination of parental rights (TPR), not in a pre-adoptive home, and are not likely to be adopted within 24 months of their entry into foster care (i.e., children in foster care 16 months or more). These youth are at high risk of aging out of foster care due to an excessive length of stay in the foster care system. The target number for final adoptions in this group is a minimum of 149; and

Category 3 (Cat 3): Children and youth in foster homes, with the goal of adoption, with termination of parental rights (TPR), and an adoptive placement agreement has been signed, but the adoption is not finalized. The target number for final adoptions in this group is a minimum of 175.

Focus Areas

- Locate and place children/youth in safe, permanent adoptive homes;
- Increase timely adoptions for children/youth who can be adopted within 24 months of entry into care;
- Increase the number of children/youth adopted over age 6; and
- Increase of children whose foster parents have expressed an interest in adopting the child/youth, but have not yet signed adoptive placement agreements, is a particular area of concern to VDSS.

ATCP Contracts Year One (SFY 2012) Outcomes												
	Adoptions Finalized						Percent of Goals Achieved					
Contractor Name	Unk	Cat 1	Cat 2	Cat 3	Total		Unk	Cat 1	Cat 2	Cat 3	Total	Actual cost per adoption
Bethany Christian Services	0	3	5	4	12		0%	300%	25%	400%	55%	$12,223
Children's Home Society	0	8	23	11	42		0%	160%	82%	79%	89%	$ 5,229
Commonwealth Catholic Charities	0	0	0	13	13		0%	0%	0%	35%	35%	$ 7,858
Coordinators2, Inc.	0	10	15	9	34		0%	250%	79%	129%	113%	$ 5,326
Danville DSS/Coalition for Adoption	0	0	0	14	14		0%	0%	0%	156%	52%	$ 9,951

DePaul	**0**	**0**	**14**	**9**	**23**		**0%**	**0%**	**78%**	**56%**	**68%**	**$ 6,161**
Lutheran Family Services	**2**	**5**	**3**	**2**	**12**		**0%**	**71%**	**27%**	**100%**	**60%**	**$14,317**
Montgomery County DSS	**0**	**4**	**17**	**7**	**28**		**0%**	**0%**	**155%**	**64%**	**127%**	**$ 4,279**
Petersburg DSS	**0**	**12**	**6**	**0**	**18**		**0%**	**86%**	**67%**	**0%**	**72%**	**$ 3,880**
Shenandoah Valley Social Services	**0**	**3**	**11**	**15**	**29**		**0%**	**62%**	**74%**	**285%**	**116%**	**$ 4,596**
The Up Center	**0**	**0**	**3**	**6**	**9**		**0%**	**0%**	**27%**	**100%**	**50%**	**$ 8,889**
UMFS Multi-site	**3**	**0**	**4**	**9**	**16**		**0%**	**0%**	**24%**	**100%**	**47%**	**$10,738**
UMFS Tidewater	**0**	**0**	**14**	**4**	**18**		**0%**	**0%**	**50%**	**36%**	**46%**	**$ 4,957**
Total	**5**	**45**	**115**	**103**	**268**		**0%**	**96%**	**57%**	**79%**	**71%**	**$ 6,591**

The thirteen contractors are partnering with sixty-two local departments of social services. Milestone Performance Measures for the ATCP contractors are as follows:

1. *Home Study Completed/Updated and Approved*
2. *AREVA Family Registration Completed*
3. *ATCP Contract Team Agrees to Match*
4. *Adoption Placement Agreement Signed*
5. *Six (6) Month Supervision Completed, if required*

Based on self-report 3rd Quarter Reports from the thirteen contractors the following are the outcomes:

Unduplicated Children Served through 3rd Quarter							
Measures	*Final Order*	*Age 9<*	*Age 10>*	*Matches*	*Agreement Signed*	*Disruptions*	*Dissolutions*
Total	*216*	*124*	*92*	*146*	*201*	*16*	*0*

Unduplicated Families Served through 3rd Quarter				
Measures	*Home Study Completed/Updated*	*AREVA Registration*	*Match Approved by LDSS*	*Matched and Placement Agreement Signed*
Total	*99*	*16*	*84*	*63*

The ATCP contractors provide recruitment through various means such as Wednesday's Child, flyers, the Heart Galleries, churches, parent magazines, match retreats, etc. Preparation of the children for adoption includes creation of life books, family partnership meetings, etc. Preparation of families includes training using the PRIDE curriculum and training on topics such as CPR, Crisis intervention, Communication in Crisis, Love and Logic Parenting and Foster Parent College. One suggestion for improvement was the need for more approved families available for older and special needs children. At one match retreat, the majority of the families present were interested in younger children.

VDSS Research Brief: "Timeliness of Foster Care Adoptions in Virginia"

Many local agencies in Virginia have not met the federal 24 month adoption timeframe. In the fall of 2012, the Virginia Department of Social Services (VDSS), Division of Family Services formed an

Adoption Initiative Workgroup to analyze the issue of more timely adoptions and to examine potential improvements in the adoption process. The workgroup consisted of individuals from public and private child placing agencies as well as staff from the VDSS Division of Family Services, VDSS Outcomes Based Reporting and Analysis (OBRA) and the VDSS Office of Research & Planning (ORP).

The objective of the analysis was to better understand time to adoption: how long it takes, how Virginia compares to other states, how much timeliness varies across localities, and the factors that may influence timeliness.

The key findings include:

- Half of children with a goal of adoption are adopted within 33 months of entering foster care.
- Time to adoption varies substantially across localities.
- Time to adoption can be separated into two components: the time from foster care entry to termination of parental rights (TPR), and the time from TPR to adoption. Of these two components, the time from TPR to adoption is a stronger predictor of the total time to adoption.
- Age, race, and having a diagnosed disability affect how quickly a child is adopted.
- Adoption subsidy payments do not vary substantially across localities.

The Permanency Unit home office and regional staff have taken steps to review our processes that support adoptions to determine what we can improve. Two of these processes are: Adoption Reports and case reviews of the 100 Longest Waiting Children.

- **Adoption Reports Unit** is a key player in the timeliness of adoptions since that is the unit that issues the adoption case number. This work is a cross function of the child placing agencies, the courts and VDSS. The Continuous Quality Improvement (CQI) unit is undertaking a process mapping of the Adoption Reports Unit. This effort will document the unit's workflow and suggest areas where the work can be streamlined.

- **100 Longest Waiting Children** - Permanency Roundtables are being lead by the regional Permanency Consultants to focus on youth with the goal of adoption and adoption has not been achieved. In consultation with the local agencies, the regional consultants will examine what barriers exist for each case and suggest options for achieving permanency.

Virginia Adopts: The Campaign for 1,000 – Virginia Adopts initiated by Governor Bob McDonnell was kicked-off on May 17 as part of Foster Care Month. The purpose of the campaign is to focus on raising the awareness of the foster care adoption process. The goal is to initiate 1000 adoptive family matches with children from the foster care system by December, 2013. The website is www.VirginiaAdopts.Virginia.gov.

Adoption Assistance Guidance: The Adoption Assistance Chapter in the VDSS Child and Family Services Manual has been completely revised to accurately reflect federal and state law, provide clear procedures, and require specific forms to increase consistency and accuracy and improve quality in the provision of adoption assistance across the Commonwealth. The training curriculum has been developed. The guidance will be disseminated in June 2013 for September 2013 implementation to provide LDSS sufficient time to be trained and implement the major changes in requirements.

Adoption Assistance Program: Virginia's adoption assistance program provides a money payment or services to adoptive parents on behalf of a child with special needs who are either eligible for Title IV-E

or state supported assistance. Virginia also provides non-recurring expenses and may provide special service payments for children who meet the state's definition of special needs.

Number of Children Served during SFY 2012 (last complete year data is available):

- A total of 6,762 children per month received Adoption Assistance.
- 5,241 children received Title IV-E Adoption Assistance.
- Total allocation for Title IV-E Adoption Assistance was $64,970,816
- 1,521 children received State Adoption Assistance.
- Total allocation for State Adoption Assistance was $39,829,644
- The local departments of social services provided for a total of 656 adoptions in federal fiscal year 2012.

Adoption Assistance Reviews

In August 2011, Division of Family Services (DFS), in partnership with the Division of Finance (DOF), formed the Adoption Assistance Review Team (AART), as a temporary team consisting of three to five permanent and four temporary employees from the DFS and DOF to review of Local Departments of Social Services (LDSS) financial information in order to identify adoption cases that might contain improperly reported enhance maintenance costs that may qualify to retroactively pull down Title IV-E funds within a seven quarter window. AART then reviewed the selected case files to determine if the identified additional daily supervision (ADS) or difficulty of care special service payments reported in LASER under Cost Code (CC) 81701 (*Purchase of Service*) qualified to shift to CC81203 (*Title IV-E Enhanced Maintenance*) from October 1, 2009 forward.

While the initial case reviews were very focused on costs reported in LASER under CC81701 (*Purchase of Services*) and if the costs qualified for reporting under CC81203 (*Title IV-E Enhanced Maintenance*), it became very apparent to the reviewers and DFS management the need to expand the original purpose of the reviews to include additional aspects such as proper reporting of other costs associated with adoption subsidy, program compliance, and to consider forming a permanent team. Also, the financial focus shifted from a look back to October 2009 to only the current fiscal year. As the case reviews continued, the AART purpose and scope continued to evolve and expand, with the primary purpose of identifying ADS/EM that qualify to shift to CC81203.

In July 2012, AART became a permanent team within the Division of Family Services consisting of one supervisor and four Adoption Assistance Program Specialists. From August 2011 to December 2012, AART conducted one-hundred-eighteen (118) financial and agency case reviews.

Beginning in January 2013, in order to better assist the LDSS in meeting with federal, state and VDSS adoption assistance compliance requirements and guidance, AART began focusing on LASER and OASIS reconciliations and selected adoption subsidy case file documentation. From January 2013 to April 2013, the AART issued 19 on-site initial review and 22 follow up reports.

Adoption Evaluations and Assessments: VDSS contracts with the Mary D. Ainsworth Child- Parent Attachment Clinic (MDA) to provide pre and post-adoption mental health assessments for children and families interested in adopting or who have adopted children. During SFY 2013, MDA provided assessments to 17 families (as of 4/30/13) and is projected to complete at least 3 additional child and family assessments by 6/30/13. MDA also will have provided training for 40 families on managing children with attachment disorders. The training was a new aspect of services from Mary D. Ainsworth last year and involves 12 sessions of training per family. MDA has collected and shared surveys from

families attending training that affirm the training's efficacy and positive impact on reducing post adoption crisis and disruption.

Adoption Family Preservation Services: Virginia utilized Title IV-B, Subpart 2 funding to create an Adoptive Family Preservation Services *(AFP*) system. United Methodist Family Services manages and provides for the statewide services delivery AFP network. The AFP project serves families who have adopted domestically and may also serve families that have adopted internationally. The AFP program design uses a multi-site, multi-level system of services to offer families an array of options that they may need to support and strengthen functioning, and preserve adoptive families.

The post-adoption services model is implemented in Virginia by a network of a total of four private agencies employing adoption professionals, clinicians, and adoptive parents hired and trained to provide services as Adoptive Parent Liaisons (APLs). These agencies are: UMFS Northern VA, UMFS Tidewater, UMFS Charlottesville, UMFS Lynchburg, UMFS South Central, Center for Adoption Support and Education (C.A.S.E.), Coordinators 2, and DePaul Community Resources in Roanoke/Abingdon. Multiple program sites each operate a somewhat different blend of services tailored to the diverse rural and urban communities served.

For FY 2013 **(**July 2012 - March 2013**),** a total of 309 families were served across these sites. There were 1184 hours of counseling offered to 159 families and 968 hours of support groups offered to 100 families. UMFS is reporting 4260 hours of case management activities with 308 families and 236 hours of educational case management was offered to 55 families. There were 340 hours of information and referral activities completed for 407 inquiries. 521 hours of therapeutic counseling was offered to 29 families and 65 hours of crisis intervention was offered to 21 families. AFP held 53 training events attended by 775 people (adoptive parents and adoption professionals). There were 57 families who accessed the client fund.

Adoption Resource Exchange of Virginia *(AREVA)*

VDSS administers AREVA, providing statewide recruitment efforts for children in foster care who are legally free for adoption. AREVA staff maintains several Internet websites featuring photographs and narrative descriptions of waiting children at the following sites: http://www.dss.virginia.gov/family/ap/children_for_adoption.cgi, http://www.adoptuskids.org/states/va/index.aspx and http://photolisting.adoption.com/foster-adoption/search-results/state-virginia.

AREVA staff supports efforts of AdoptUsKids on a national level and works with local agencies to have Heart Galleries in each of the five regions of the Commonwealth on a continuing basis. The initial modality in 2005 was to have the photographs taken of waiting children in a region and then have a gala for the opening of the gallery to the public. The Heart Gallery has become a traveling collection of photographs of children from all regions to encourage visibility across the state. With the assistance of the staff from Virginia One Church, One Child, the photographs are frequently being featured in venues in the Eastern, Central, Northern and Piedmont areas of the state. Efforts are being made to include more children from the Western portion of the state as well as having displays in that area. The Heart Gallery has had over 300 children featured since 2005 and 51% of these children are either in a finalized adoptive placement or some phase of the adoption process. More information about the Heart Gallery is available at: (www.heartgalleryva.org).

In 2012, VDSS collaborated with a faith-based organization known as "Change Who Waits" (Project 1:27) to create awareness of the need for more foster and adoptive homes in Virginia. This project is similar to the One Church, One Child movement which started in the 80's out of Illinois by a priest,

Father George Clements; that advocated the involvement of the church in finding families to either foster or adopt children from the foster care system nation-wide. Whereas the One Church, One Child movement has been soliciting one church at a time, the Change Who Waits movement uses the format of large rallies at one particular church. Prospective families hear from seasoned families (both foster as well as adoptive) about the joys and trials that come from engaging in this quest. The attendees also hear from adults who were former foster children about their experiences and are given words of advice through several short videos including one produced locally by United Methodist Family Services. Faith based adoption agencies are present at these rallies to assist families interested in starting the process. Two such rallies were held in 2012 in the Central and Eastern regions of VA. On May 11, 2013 another rally was held in the Northern Region. This rally also featured 25-30 photographs from the traveling Virginia Heart Gallery. There were 8-10 licensed agencies ready to assist those families in attendance who want to get started with the approval process in becoming either a foster family, a foster to adopt family or an adoption family. Other rallies are being organized for later in the year. The goal continues to be that there will be families waiting for children rather that children waiting for families.

AREVA works collaboratively with all local agencies and child placing agencies that are dedicated to finding permanent placements for the children from the foster care system. Special attention is giving to all families, community stakeholders, and supportive agencies that have worked to find permanent placements for foster children during the month of November. In 2012, there were 22 adoption events about the state; the Governor signed a proclamation for 2012 declaring November as Adoption Awareness month and 11 Adoption Day Celebrations were held across the Commonwealth.

Number of People Served. As of May, 2013, 1,169 children and 171 families are registered with AREVA.

Adoption Incentive Funds: In October 2011, VDSS received an Adoption Incentive Award in the amount of $72,000. VDSS used these funds to support two faith-based adoptive parent recruitment events. Additionally, the current adoption services contractors "Adoption Through Collaborative Partnerships" (13) received a $5,000 bonus for their efforts to help the state achieve finalized adoptions from foster care. The criteria for use were specific to adoption and foster care services. Some of the proposed expenditures were the following: adoption training for staff and families; cost for background checks for home assessments, travel for meetings with prospective families.

In August, 2012 VDSS received an Adoption Incentive award of $828,784. These funds are being used in conjunction with the Governor's VaAdopts initiative for adoption recruitment services focused on the 100 Longest Waiting Youth and adoption post legal services.

Other Services: In addition to adoption services for children in foster care, VDSS is the central records keeper of closed adoption records. The Department maintains over 250,000 closed adoption records dating back to 1942. During FFY 2012, VDSS added 2,174 more adoption records to the archives. Information from closed adoption records may be released to adopted individuals over the age of 18 under specific circumstances and to adopted parents and birth family members for adoptions finalized after July 1, 1994, all governed by law. VDSS also provides adoption services for children who are not in the custody of LDSS, as well as other court ordered services such as custody investigations and visitation.

Adoption Collaborations

AdoptUsKids: Virginia collaborates with the national adoption network to provide national photo listing of waiting children in Virginia.

Adoption Development Outreach Planning Team *(ADOPT).* ADOPT is a voluntary child-advocacy group of individuals from public and private child welfare agencies, adoptive parents, therapists, attorneys and other interested in promoting its purpose. ADOPT is committed to promoting and assuring the rights of children in Virginia to permanent homes through advocacy, education, legislative activities, and examination of practice issues.

Adoption Exchange Association: This national non-profit organization is committed to the adoption of waiting children. It is the lead agency in AdoptUsKids, a Federal grant through the Children's Bureau, to recruit adoptive families for children waiting in foster care across the United States. It is also the membership organization for Adoption Exchanges, of which VDSS is a member.

American Academy of Adoption Attorneys: This organization is a not-for-profit national association of attorneys, judges, and law professors who practice and have otherwise distinguished themselves in the field of adoption law. It has collaborated with the VDSS by participating on various committees regarding adoption and providing input for proposed legislation regarding adoption and custody issues.

Change Who Waits: This is a faith-based movement led by a local pastor in collaboration with Virginia One Church, One Child. The group leads rallies for foster care and adoption recruitment. Change Who Waits is based on a model of recruitment used in Colorado and other states. The pastor works with faith-based adoption agencies and selected churches to raise awareness about the children in foster care waiting for adoptive families. For SFY 2012, two rallies were held with approximately 600 total participants at both rallies. A third rally will be held on May 11 in northern Virginia.

FACES: This non-profit is a membership organization for foster, adoptive and kinship families and others who support the benefit of children, youth and families across Virginia. FACES stands for Family Advocacy, Collaboration, Empowerment and Support.

Virginia One Church, One Child (OCOC): VDSS has a sole source contract with OCOC to recruit families for children in foster care with the goal of adoption. Virginia's OCOC program is the only organization that solely recruits within African-American churches. These churches make a commitment to find adoptive families within their congregations and throughout their communities. VDSS has contracted with OCOC since 1985. However, beginning in 1994 with the Multiethnic Placement Act (MEPA) and the 1997Adoption and Safe Families Act (ASFA), OCOC has more broadly focused its recruitment efforts to include support of the adoption services contractors in the areas of child specific recruitment for any waiting child. Since May, 2012 VA OCOC has served as rapid responders for the AdoptUSKids Virginia inquiries. The organization now coordinates the Virginia Heart Gallery a photographic display of Virginia's waiting children which circulates throughout the state of Virginia. AdoptUSKids and The Virginia Heart Gallery are programs of The Virginia Department of Social Services. Program efforts also include Best Practice in post-placement services to families and children including training and adoptive family support.

For SFY 2013 the following are outputs from OCOC recruitment, family training and support:

Individuals Attending Church and Community Presentations	2300
Families Attending Orientations	42
Families Referred to Contract Agencies for Adoption Services	24
Families Receiving Post Adoption Services (to-date)	17*

AdoptUSKids Responses (Initial and Follow Up)	943
Heart Gallery Set Ups (At least 8 pictures)	12
Mini Heart Gallery Set Ups (1-7 pictures)	8

OCOC Unduplicated Count of Children

Children Served—Child Specific Recruitment	70
Children/Youth Receiving Post Adoption Services (to-date)	31 *
(Youth participating in Adoptive Family Retreats)	

Service Levels will be increased after Adoptive Family Retreat-May 18-19, 2013

National Resource Center for Adoption: This center provides assistance to states and other federally funded child welfare agencies in building their capacity to ensure the safety, well being, and permanency of abused and neglected children through adoption and post legal adoption services program planning, policy development and practice.

Department of Medical Assistance Service *(DMAS):* DMAS provides a system of cost effective health care services to qualified individuals and families. It provides medical services through Medicaid providers for adopted children with adoption assistance agreements that require medical or rehabilitative needs or who qualified for Title IV-E.

Office of Comprehensives Services for At Risk Youth and Families *(OCS):* OCS administers CSA which provides child-centered, family focused, cost effective, and community-based services to high-risk youth and their families. The VDSS collaborates with CSA to coordinate and provide services for children with adoption assistance agreements.

3. Independent Living Program

Children served. According to FFY 2012 data entered in OASIS by the local departments of social services (LDSS), a total of 1,961 youth ages 14 and over, received independent living (IL) services.

Independent Living Program *(Services to Older Youth)*

Services to older youth (also known as the Independent Living Program) are a component of the state's foster care program. While the goals and services of the program apply to older youth in care, these services are integrated throughout the Foster Care Manual to reinforce the need for all children and youth to learn independent living skills as their age and capability permits. These services are provided to each youth, age 14 or over, in foster care regardless of the youth's permanency goal or living arrangement. While the provision of such services is mandated by law, assisting youth in developing the permanent connections and skills necessary for long-term success is the most important consideration in utilizing the Chafee Foster Care Independence (CFCIP) funding.

State staff is responsible for developing policies, procedures and develop new programs as necessary to increase understanding of, and statewide services to older youth in accordance with the CFCIP and the Education and Training Vouchers (ETV) Program. VDSS has developed a chapter in the Foster Care

Manual, entitled, *Serving Older Youth* which provides guidance to the local workers in working with youth in and transitioning out of care.

LDSS are primarily responsible for providing IL services to eligible youth ages 14-21. They continue to work closely with the local CSA teams which are responsible for overseeing the planning of, and approving state funds for, additional services for youth not covered by the CFCIP funds. Together, LDSS and CSA teams share the primary responsibility for ensuring that youth in foster care are provided with the services needed to enhance their transition into adulthood. Virginia Code indicates that youth are no longer in foster care when they reach the age of majority; however youth over the age of 18 who have been in foster care can voluntarily agree to receive IL services until age 21. This population continues to receive all services available to youth in foster care and continue to have Medicaid coverage as long as they meet eligibility requirements. In addition, funding and services are available for youth between ages 18 and 21 who discontinued receiving IL services and then requested the resumption of IL services within 60 days. In accordance with options in the Fostering Connections to Success and Increasing Adoptions Act (FCA) of 2008, Virginia continues to develop or refine guidance addressing youth engagement, educational stability and attendance, health, transitioning planning for young adults aging out and how VDSS and LDSS will support youth who are adopted after attaining 16 years of age.

The FCA also promotes increased permanency and improved outcomes for children in the foster care system. During FY 2013, the Virginia Senate Committee on Rehabilitation and Social Services requested that VDSS conduct a fiscal analysis to assess the impact of extending Title IV-E assistance to youth ages 18 to 21 in the Commonwealth. VDSS contracted with The Finance Project to produce a report on the the costs.

In addition, the 2013 General Assembly session passed legislation (Senate Joint Resolution No. 282) requesting VDSS to develop and present options for implementing the extension of foster care maintenance and adoption assistance payments for individuals up to 21 years of age. VDSS has to submit a report of its findings and recommendation to the Governor and General Assembly by November 30, 2013.

Due to a change in state law, LDSS can no longer assign the goal of IL to youth. This law allows youth ages 16 and over with the goal prior to July 1, 2011 to retain this goal with no changes required; however LDSS must provide a program of care and services. In FY 2013, state staff developed and is in the process of implementing, in collaboration with key stakeholders including youth, a work plan that will provide technical support, resources, tools, policy and practice guidance on achieving permanency with a sense of urgency for all youth. Eliminating the goal of IL was a major change for the state, and training and technical assistance (T/TA) are needed in assisting workers in achieving permanency and lifelong connections for youth. Currently, Virginia is receiving T/TA on developing an integrated approach to youth permanency and preparation for adulthood from the National Resource Center on Permanency and Family Connections (NRCPFC).

Gary Mallon, Executive Director of NRCPFC, initially met with representatives from VDSS and LDSS in May 2012 and collaboratively a work plan was developed and three promising strategies identified to assist in achieving permanency for older youth in and transitioning out of foster care. Over the past year, NRCPFC has been actively working with VDSS by providing information, support and practical applications on the following three strategies: 1) Family Finding, 2) Permanency Roundtables (PRT), and 3) Engagement of youth voice in Family Partnership Meetings (FPM) and other venues. Two regions in Virginia are conducting their own versions of PRTs which are primarily case staffing and discussion on options for permanence for youth who appear to have a poor prognosis for having a forever family. In addition, using an adapted training developed by NRCPFC, Virginia piloted "Unpacking the NO of

Permanency for Older Adolescents" training which addresses the importance of permanency in two regions with plans to extend the training to the other three regions.

IL funds

For FY 2013, VDSS allocated its CFCIP funds into two primary spending categories: basic allocations and private contractor. VDSS does not have a trust fund for foster care youth. Approximately 90% of Virginia's Chafee grant is spent on the following services to prepare youth for self-sufficiency: education; vocational training; daily living skills/aid; counseling; outreach services; and, other services and assistance related to building competencies that strengthen individual skills, promote leadership skills and foster successful independent living. The majority of the LDSS collaborate with community-based organizations and agencies to provide support and services to youth (i.e., local health departments, workforce investment boards [WIB] including one-stop centers and VA Cooperative Extension offices, etc.).

VDSS determines basic allocations to each LDSS based on their percentage of the statewide population of foster care youth, 13 years old and over, for the previous 12 month period. Currently, 111 of Virginia's 120 LDSS actively participate in providing services to older youth. The 9 LDSS not participating do not have age appropriate youth or they opt to use other funding sources to provide services to youth. Project LIFE, a private/public partnership between VDSS and United Methodist Family Services (UMFS), has been instrumental in getting youth in, and transitioning out, of foster care involved in trainings, activities, and events that promote permanency and self-sufficiency. The goal of Project LIFE is to support permanency and lifelong connections for youth ages 14-21, while coordinating and enhancing their life skills instruction and development by collaborating with LDSS, private providers and community stakeholders. Seven Project LIFE regional Independent Living (IL) Consultants assist VDSS in carrying out the vision, mission and goals of the Chafee Foster Care Independence Act, the principles of the Virginia Children's Services Practice Model and family engagement in collaboration with LDSS and private providers by offering:

- Hands-on training
- Structured, uniform program of services
- Technical assistance
- Best practice development

During FY 2013, Project LIFE offered the following training, technical assistance (T/A), and services to LDSS:

- Casey Life Skills Assessment (CLSA) (replaced Ansell Casey Life Skills Assessment effective 9-1-12)
- National Youth Transition in Database (NYTD)
- Independent Living Program (ILP); Education and Training Vouchers Program (ETV); Transition Living Plan (TLP); Permanency for Youth
- Permanency Pact (a formalized, facilitated process to connect youth in foster care with a supportive adult)
- Regional youth events
- Statewide teen conferences

Project LIFE provided the following activities/services with youth:

Topic/Activities	# of Activity	# of youth participants
Transition Living Plan	2	25
IL Life Skills	1	13
Post -Secondary Education Workshops	1	20
Generosity activities-(i.e., giving back, service learning projects, community services)	2	27
Permanency workshop	1	14

During this fiscal year, the Project LIFE team achieved the following:

- Coordinated two teen weekend conferences with at least 65 youth participants at each. Older youth co-facilitated some of the workshops and activities;
- Participated in state work groups and committees representing the needs of older youth (i.e., National Youth and Transition Database (NYTD), Permanent Roundtables, Extending Foster Care to age 21, Permanency Workgroup);
- Developed a "Guide for Older Youth in and Aging Out Foster Care in Virginia" in collaboration with youth;
- Collaborated with VDSS to develop new templates with instructions for the transitional living plan (youth ages 14 to 17) and the 90-day transition plan (ages 18 and over); and
- Coordinated five regional trainings on "Trauma Informed Foster Care" for workers, foster and adoption parents, group home providers and other stakeholders.

In order to increase the LDSS' capacity to meet the goals of establishing permanent connections for older youth and developing adult living skills, Project LIFE and VDSS are committed to assisting LDSS in providing necessary services to eligible youth on a statewide, regional and local basis. During FY 2013, Virginia moved to Performance-based Contracting with UMFS with the main focus on providing T/TA to LDSS on IL assessments and transitional living plans on youth. VDSS provided the leadership necessary for Project LIFE to begin working on the following goals:

- Strengthen the capacity of LDSS to more effectively support youth in conducting life skills assessments and transition plans in preparing youth to make successful transitions to adulthood,
- Promote youth's meaningful engagement in case planning and in advocating for themselves; and
- Increase the capacity of public and private service providers to engage in IL best practices with older youth in foster care.

Virginia is committed to having youth's voice and involvement in their service planning, foster care policy, NYTD workgroup and other state committees. In June, NRCPFP will provide technical assistance to VDSS in planning a teen conference focusing on youth permanency.

Also, VDSS provided T/TA to LDSS on the SFY 2012 ILP/ETV Funding package including using up to 30% of their basic allocation for room and board for young people who left foster care at age 18 but have not turned 21, or who have moved directly from foster care to IL programs. In Virginia, room and board includes security deposits, apartment application fees, utilities and telephone connection fees, emergency shelter, and rent payments if youth are at risk of being evicted. Approximately 20% of Virginia's Chafee grant was spent on room and board for eligible youth. In Virginia, youth who are receiving IL services can continue to receive Medicaid coverage until the age of 21 as long as they continue to meet eligibility requirements.

During FY 2013, NTYD IL services were required to be part of a planned program of service to youth that meets their assessed needs for permanency and development of life skills. Formal service planning and review of the service plan by the juvenile and domestic relations court occurs at least annually. Service planning involved multiple parties (i.e. mentors, foster parents, birth parents, relatives, and other individuals) as identified by the youth and as appropriate in the development of the service plan. During this fiscal year, VDSS experienced an increased number of youth receiving IL and post-secondary educational services and increased its ability to reach more youth through partnering with Project LIFE. For FY 2014, VDSS and Project LIFE will continue to collaborate to ensure older youth and LDSS staffs are receiving the support, training and technical assistance needed for an integrated approach to youth permanency and preparation for adulthood.

The 2012 Virginia General Assembly required the VDSS to establish policy and procedures and furnish a report by December 1, 2012 on its activities to implement provisions of § 63.2-905.2 of the Code of Virginia that requires annual credit checks on children ages 16 and over in foster care. This Code mirrors the federal Child and Family Services Improvement and Innovation Act (CFSIIA) of 2011 which also requires that annual credit checks be conducted on all youth age 16 and older in foster care. VDSS collaborated with stakeholders in an attempt to implement the provisions of these laws. However, Virginia, a state supervised and locally administered child welfare system, continued to face barriers in developing a systematic approach with the three national credit reporting agencies (CRA) for conducting the credit checks on each youth, paying for the fees (initial and monthly) to set up an account with each CRA, and procedures for correcting situations where identity theft and misuse of personal information is identified.

For FY 2014, VDSS will continue to enhance and increase linkages, coordination and collaborations among the different local and state agencies, organizations, and private providers. Such linkages would clarify funding sources available for service provision and allow for effective and efficient planning around use of such funds; develop shared policies across child-serving agencies; and increase knowledge across systems regarding available services. Additional goals include:

- Increase youth involvement in service planning and developing transition living plan to promote permanency and self-sufficiency;
- Increase the full array of independent living services and resources through implementing strategies for successful transition to self-sufficiency;
- Explore ways to utilize the federal ASSET (Assets, Saving, Support, Education and Training) Initiative in order to connect youth to asset building opportunities and to establish a foundation for economic success in adulthood; and

- Continue to work collaboratively with stakeholders in developing an effective and efficient approach in conducting credit checks on foster care youth ages 16 and over.

Education and Training Program

During FY 2013, VDSS continued to use the allotted ETV funds to service eligible youth across the state. The ETV Program provides federal and state funding to help youth receive post-secondary education, training, and services necessary to obtain employment by covering the expenses associated with college or vocational training programs. Vouchers are available of up to $5,000 (based on availability of funds) per year per eligible youth for post-secondary education and training. Virginia administers its own ETV Program through Services to Older Youth staff. Although the ETV Program is integrated into the overall purpose and framework of the Chafee Foster Care Independence Program (CFCIP)/ILP, the program has a separate budget authorization and appropriation from the general program.

During FY2013, VDSS allocated ETV funds to the LDSS that are primarily responsible for serving the youth. All localities are eligible to participate in the ETV Program. However, some localities do not participate due to not having eligible foster care youth. Youth must have a high school diploma or GED. Youth are made aware of program services and eligibility guidelines through social workers, IL coordinators, life skills training and educational workshops, Project LIFE, and marketing efforts of the VDSS Permanency Program staff. For SFY 2012, Virginia was allotted approximately $580,599 in ETV funds. From the FFY 2012 grant, over 573 students took advantage of ETV services and of that number 225 were new students. For FFY 2013, ETV grant is reduced to $541,193 due to the sequestration. Currently, over 578 students have utilized ETV funds and of that number approximately 250 are new students.

LDSS applying for ETV funds must agree to the following special requirements:

1. Reimbursements for expenses will not exceed the cost of the annual education or training program tuition and related expenses or $5,000 (whichever is less) per eligible youth per fiscal year;
2. Will track and report on use of ETV funds separately from the Basic ILP allocation.
3. Will use ETV funds to supplement and not supplant any other state or local funds previously expended for the same general purposes; and
4. Will administer these funds in any amount on the behalf of any eligible youth as long as it does not exceed $5,000 per youth per fiscal year, or the amount awarded to any student does not exceed the "cost of attendance" (whichever is less).

Each year, the LDSS must complete an ETV Application and submit the number of eligible youth on the application to VDSS. Eligible youth are those who will be/are attending post-secondary education institutions or vocational training programs for the fiscal year. The number of eligible youth in Virginia is totaled and then divided into the available allocation, giving a basic amount per youth. The funding is then allocated to the LDSS in accordance with the number of eligible youth they serve. Youth in foster care with the guidance of their IL coordinators create a transition plan which is a program requirement. Youth are then able to access ETV funds based on the ETV student application, educational needs and availability of funding. Youth who were adopted from foster care after the age of 16 are also eligible for ETV funds. Due to the state's significant outreach efforts in partnership with LDSS, Project LIFE and public and private partners, there has been an increase in the number of eligible youth participating in the program each year.

In addition to coordinating the state's ETV program, the VDSS Education Specialist is involved in several educational initiatives such as supporting the Community College Tuition Grant for foster care

youth, the Great Expectations Program, and the Fostering Connections to Success Education workgroup. Educational initiatives are collaborative, strategic, multi-tiered, and above all youth oriented. These core initiatives help to strengthen the state's postsecondary education assistance program and promote academic achievement and educational stability. A collaborative strategy which includes VDSS, LDSS, Project LIFE, the Department of Education, and local school divisions, families and children can help improve youth educational outcomes. The education specialist serves on various education committees which help to educate other professionals about the ETV program and eligibility requirements for foster youth that are served at community colleges and disable youth attending college. As a result, professionals, foster parents and other stakeholders can assist youth in preparing for higher education earlier so they can succeed throughout their educational journey.

A strength of Virginia's ETV program stems from the strong relationships that state staff has with local workers. ETV regional trainings were conducted with VDSS's key partner, Project LIFE, which helped serve youth who are in foster care or transitioning out of foster care. The ETV program was strengthened by FCA. The FCA helped VDSS to facilitate discussions with LDSS agencies about educational decisions that can potentially impact youth attending post-secondary institutions.

Independent Living Collaborations

Project LIFE: Project LIFE is a partnership with the VDSS. The goal of Project LIFE is to support permanency for older youth in care through the coordination and enhancement of independent living services by collaborating with local departments of social service, private providers and community stakeholders. (www.vaprojectlife.org) Project LIFE has taken over the responsibility of managing the Virginia's Youth Advisory Council *(VYAC)* which is composed of youth ages 15-21 statewide.

Community College Tuition Grant: Tuition Grant pays for tuition and fees at the Virginia Community Colleges for foster care youth or special needs adoptees that have graduated from high school or obtained their GED and meet eligibility requirements.

Great Expectations: Great Expectations helps Virginia's foster youth complete high school, gain access to a community college education and transition successfully from the foster care system to living independently. The program helps ensure that young people have the personal connections and community support they need to live productive and fulfilling lives. (Website: http://greatexpectations.vccs.edu/) This initiative of the Virginia Foundation for Community College Education is in partnership with:

- VDSS and LDSS;
- Workforce Investment Boards; and
- One-stop centers, community colleges, alternative education providers, other public agencies, school to career partnerships, and employers.

The intent of Great Expectations includes:

- Help foster care youth ages 13 – 17 complete high school and move into higher education;
- Encourage youth transitioning from foster care to continue in an ILP;
- Offer a comprehensive program for foster care youth and alumni ages 18 -24 to help them gain access to a community college education; and
- Create an endowment that will provide long-term, consistent funding for the program when traditional sources are not available.

National Resource Center for Youth Development (NRCYD)*:* VDSS continues to collaborate with the NRCYD for training and TA *(e.g. Ansell Casey Life Skills Assessment Training, Adult and Youth Partnership).*

National Resource Center for Permanency and Family Connections (NRCPFC): Virginia requested and received approval for training and technical assistance from NRCPFC on youth permanency. NRCPFC will assist the state in developing and implementing an integrated approach to permanency and preparation for adulthood.

Virginia Workforce Investment Act Youth Services Programs: Local programs and career centers provide "transitional services to employment" for Virginia's neediest youth.

Virginia's Intercommunity Transition Council (*VITC):* VITC is an interagency initiative that ensures effective coordination of transition services for youth and young adults with disabilities in an effort to increase the accessibility, availability and quality of transition for these young people. Among other activities, VITC encourages a seamless movement from school to post-secondary services for all youth regardless of the nature of the disability**.** VITC members include: DOE, Virginia Department of Rehabilitative Services, Virginia Department of Behavioral Health and Development, Virginia Community College System, Virginia Department of Correctional Education, State Council of Higher Education for Virginia, VDSS, Virginia Department for Blind and Vision Impaired, Virginia Department of Juvenile Justice, Centers for Independent Living, Social Security Administration, Virginia Board for People with Disabilities, Virginia Department of Health, Woodrow Wilson Rehabilitation Center, and Workforce Development Centers.

Foster Care Alumni of America (FCAA): The mission of FCAA is to connect the alumni community of youth who are in foster care and to transform policy and practice, ensuring opportunity for people in and from foster care. Virginia's chapter had a successful "family reunion" for alumni, families and friends. The Chapter is involved in outreach and recruitment efforts.

4. Virginia's Interstate Compact on the Placement of Children *(ICPC)*

Children placed out of the state need to be assured of the same protections and services that would be provided if they had remained in their home state. They must also be assured of a return to their original jurisdictions should placements prove not to be in their best interests or should the need for out-of-state services cease.

The great variety of circumstances which makes interstate placement of children necessary and the types of protections needed offer compelling reasons for a mechanism which regulates those placements. An interstate compact – contract among the states that enact it – is one such mechanism. Under a compact, the jurisdictional, administrative, and human rights obligations of all the parties involved in an interstate placement can be protected.

Children Served. As of May 1, 2013, Virginia has 2,415 open ICPC cases and 2,422 open Interstate Compact on Adoption and Medical Assistance (ICAMA) cases.

Types of Placements Covered. The ICPC Compact applies to four types of situations in which children may be sent to other states:

- Adoptions: Placement preliminary to an adoption (independent, private or public adoptions);
- Licensed or approved foster care (placement with related or unrelated caregivers);
- Placement with parents and relatives when a parent or relative is not making the placement as defined in Article VIII (a)n "Limitations"; and

- Group homes/residential placement of all children, adjudicated delinquents in institutions in other states as defined in Article VI and Regulation No. 4.

Types of Placements Not Covered. Not all placements of children in other states are subject to the Compact, nor are all person who place children out of state. The Compact does not include placements made:

- In medical and mental facilities;
- In boarding schools;
- In "any institution primarily educational in character" (see Article II(d)

Or by any of the following making a placement with any of the following:

- Parent
- Step-parent
- Grandparent
- Adult brother or sister
- Adult uncle or aunt
- The child's guardian

Safeguards Offered by the Compact. In order to safeguard both the child and the parties involved in the child's placement, the Interstate Compact:

- Provides the sending agency the opportunity to obtain home studies, licensing verification, or an evaluation of the proposed placement;
- Allows the prospective receiving state to ensure that the placement is not "contrary to the interests of the child" and that its applicable laws and policies have been followed before it approves the placement;
- Guarantees the child legal and financial protection by fixing these responsibilities with the sending agency or individual;
- Ensures that the sending agency does not lose jurisdiction over the child once the child moves to the receiving state.
- Provides the sending agency the opportunity to obtain supervision, services and regular reports on the child's adjustment and progress in placement.

These basic safeguards are routinely available when the child, the person, or responsible agency and the placement are in a single state or jurisdiction. When the placement involves two states or jurisdictions, however, these safeguards are available only through the Compact.

The Sending Agency's Responsibilities: While the child remains in the out-of-state placement, the sending agency retains legal and financial responsibility for the child. This means that the sending agency has both the authority and the responsibility to determine all matters in relation to the "custody, supervision, care, treatment, and disposition of the child", just as the sending agency would have "if the child had remained in the agency state." (See Article V (a))

The sending agency's responsibilities for the child must continue until it legally terminates the interstate placement:

- By returning the child to the home state
- When the child is legally adopted
- When the child reaches the age of majority or becomes self-supporting, or
- When the child is discharged with appropriate concurrency of the receiving state.

The sending agency, via the sending state's ICPC office, must notify the receiving state's Compact Administrator of any change in the child's status, again using form ICPC-100B. Changes of status may include a termination of the interstate placement or such things as a new placement type of the child in the receiving state or a transfer of legal custody.

Virginia/Tennessee Border Agreement – Non-custodial Children
The Virginia/Tennessee workgroup continues to meet on a quarterly basis to assess the program, make identified process changes as needed and discuss challenges that may have developed related to individual cases. This process and meeting has been extremely useful and has expedited the placement of non-custodial children across state lines with their relatives. There have been approximately 40 border agreement cases as of April 2013.

Virginia/Tennessee Border Agreement –Custodial Children
Due to staff changes in Tennessee as well as a reorganization and political election, the discussion related to a border agreement for custodial children has been put on hold. A decision has not been made to resume this discussion at this time.

5. Resource Family Development

In 2008, VDSS created the Resource Family Unit *(RFU)* that is responsible for recruitment, development and support activities for foster, adoptive and kinship caregivers, referred to as "resource families" in the Commonwealth. One program manager and five regional consultants comprise this unit. The overarching goal is to increase the quantity and quality of resource parents to be viable placement options for children in the system of care. In late 2009, regulations were implemented mandating pre- and in-service training as well as implementing dual approval for family assessments (home studies). To ensure that agencies have the tools, knowledge and technical assistance needed to fully realize a system of recruitment and retention for resource families, the RFU implemented a series of structured meetings and information based on Annie E. Casey's Breakthrough Collaborative methodology, called "Regional Peer Collaboratives" (RPC) which were offered through December 2011.

Since the conclusion of the RPC initiative, the Resource Family Consultants have continued to provide technical assistance to local agencies regarding their home approval process and recruitment strategies. In several of the regions there are quarterly meetings held to focus specifically on resource family practice. Through these meetings, the Resource Family Consultants provide technical assistance and training in the areas of targeted and child specific recruitment, the development of strategic recruitment plans and development of recruitment presentations. In other regions, this work is done at the Quarterly Supervisors' meetings, along with updates and technical assistance related to Permanency and CPS practices. In some cases, the Resource Family consultant has met one-on-one with new local agency staff in order to assure that the agency continues to comply with policy guidelines.

During Foster Care Month, the Resource Family Consultants have made presentations, supported local agency public awareness campaign efforts through technical assistance, and provided grocery totes and Resource Family appreciation certificates to local agencies to be distributed to their resource parents. The Resource Consultants continue to review monthly data reports that provide agency information regarding family-based placements and kinship placements during agency visits and when assistance is requested. The Consultants develop targeted strategies to assist the agencies that are below the national practice standards.

Within recruitment, there are two key themes: using a data-driven approach to target what kinds of families are needed based on the needs of the children in foster care, and using accurate messaging about

foster care as a family support service for birth families. Regarding adoption, recruitment efforts include a sharp focus on older youth, children with special needs, and sibling sets. In all cases, the emphasis is on maintaining children's family and community connections in order to:

- Increase the likelihood that children are kept within their communities, without having to change schools or leave their faith community;
- Make better matches between children and their caregivers, so as to preserve their significant relationships, cultural and racial heritage, and family traditions;
- Decrease separation and loss issues inherent in foster care by focusing on those individuals already known to the child/family rather than defaulting to "stranger" foster care;
- Strengthen the communities from which our children are most often removed by investing in building strong resource families there; and
- Promote longer-term stability and safety for children by ensuring that their supports, services, care providers, and other important adults can be maintained both during placement and after reunification.

In three regions, Permanency Roundtables are being used to focus on the barriers to achieving permanency for a select group of older children in care at one agency at a time. All three regional consultants: CPS, Permanency and Resource Family; participate in the roundtable and brain storm with the local agency staff around ways to move cases forward. This activity is often an opportunity for the Resource Family consultants to provide technical assistance around child-specific recruitment and/or revisiting potential relative placements. Over the next year, Permanency Roundtables are expected to be implemented in all five regions.

Through consultation from the Annie E. Casey Foundation, the Resource Family Consultants received training in this area of family search and engagement. In an effort to increase the number of kinship providers, the Resource Family Consultants continue to offer two levels of training around Diligent Search and Family Engagement on as needed basis. In addition, the Consultants provide technical assistance to local agencies regarding the use of Accurint, the internet search system used to locate relatives and permanent connections for youth.

The Resource Family unit is continuing to work closely with the CRAFFT Coordinators to ensure the resource family training needs within the region are met. This year, they began team-training the CWS 3103 Mutual Family Assessment course with the regional CRAFFT coordinators. The revised training covers both policy considerations and best practices regarding the mutual family assessment process.

Resource Family Collaborations

Community Resource, Adoptive and Foster Family Training *(CRAFFT).* CRAFFT has been addressing development and support issues for resource families for nearly seven years. It is a collaborative venture between VDSS and Norfolk State University, Virginia Commonwealth University and Radford University. Two Coordinators are housed by each university. CRAFFT Coordinators provide direct pre-service training to families *(conducted in coordination with LDSS),* as well as provide some support to agencies to build their own training and support capacity. Similarly, CRAFFT Coordinators provide a wide range of in-service training to families on topics responsive to local needs and issues.

6. Prevention Unit

The Division of Family services established the Prevention Unit in 2009 to accomplish the following:

a. Give clarity to the definition of prevention that provides the framework for a common language to use across the continuum of child welfare services;
b. Promote prevention services as a "core" program within the VDSS system;
c. Develop the capacity of our local departments to recognize, promote, and support prevention services;
d. Build a repertoire of prevention strategies and best practice guidelines that can be used by localities in their delivery of prevention services;
e. Create a presence for prevention in the DSS database so that services can be recorded and outcomes measured;
f. Coordinate and collaborate with our community partners to maximize our prevention efforts.

In order to obtain a picture of Prevention Services in Virginia, the Prevention Unit conducted a survey of local departments during the summer of 2011. Ninety six percent of local departments responded to the survey, providing a wealth of information related to what prevention services are being provided, how the services are funded, who provides the services, and how collaboration with community partners is occurring.

The focus of the Prevention Unit's efforts is on Early Prevention, defined as those prevention services provided prior to, or in the absence of, a current valid child protective services (CPS) referral. Results of the 2011 Prevention Survey indicated that 94% of responding Virginia localities offer prevention services to families prior to CPS involvement.

A statewide Prevention Committee was formed with the task of developing a program that would reflect what localities are already doing, to develop guidance based on current best practice models and to make changes in OASIS to capture prevention data. Over time the committee expanded to 44 local, regional and state staff and community partners. Two series of regional meetings with local supervisors and community partners were held across the state to solicit input for guidance and other Early Prevention initiatives. Staff also made presentations at regional local director's meetings.

In addition to the meetings held statewide, a literature review of best practice models was conducted and other states who have initiated Early Prevention services using evidence informed models were contacted. Based on the information gathered, the committee developed a strength based trauma informed family engagement approach that uses the protective factors as a framework. This approach combines the following evidence informed models:

- **Trauma Informed Practice**: Neuroscience has significantly enhanced our understanding of trauma, its impact on children and their parents for a lifetime and how abuse, chronic neglect, poverty, homelessness, maltreatment, family violence and system induced trauma (CPS investigation, removal, and multiple moves both before and after removal) interfere with brain development, the ability to manage emotions and behavior, to form trusting relationships and healthy parent child attachments, to think and plan. Trauma also contributes to a negative, hopeless and fearful response of parents and children to the world around them and challenges caregivers' ability to protect and nurture their children.

- **Strength Based Family Engagement**: Research and practice confirm that, given the impact of trauma on both children and their parents (who often experienced trauma as children), the most effective approach to helping parents protect their children and meet their needs is to focus on parents' strengths, rather than their deficits, and to engage them at every step in the child welfare process-from intake through assessment, planning, decision making and service delivery. Our

primary job as practitioners is to create a space where parents and children can hear what we have to say and, in order to do that, we have to work at helping them feel psychological as well as physical safety and establishing trust.

- **Protective and Risk Factors**: Protective and Risk Factors were developed as a result of research that found that five factors most influence abuse and neglect: 1. parental resilience, 2. social connections, 3. knowledge of parenting and child development, 4. concrete support in times of need, and 5. social emotional competence of children. If these factors are addressed in assessment, planning and service delivery, we are more likely to facilitate changes in families that enhance child well-being, keep children safe and stabilize families; and

- **Shift from Problem Focus to Solution Focus in Child Welfare**: A solution focused approach to working with parents shifts the focus from what's wrong to what's happened, from the view of the parent as "bad" to struggling with a challenge, from an interrogation approach to gathering information to consensus building, from worker driven to family driven assessment, planning and decision making and from compliance as the goal and worker driven outcomes to the family gaining new knowledge and skills and owning the change goal and outcome.

Accomplishments of the Early Prevention Staff and Committee

- Supervisor training was conducted in each region in preparation for guidance training to workers;
- The first 2 sections of guidance were published in September 2012, presenting an overview of early prevention and why it's important, introducing the best practice models for administration, supervision and practice, describing how those models are applied from intake to closure with families, introducing a protocol for foster care diversion and providing a full range of resources for information and training;
- Statewide training to approximately 200 local staff was conducted;
    - Numerous presentations were made to groups whose support and resources impact outcomes in Early Prevention, such as Family and Children's Trust Fund Board, Commission on Youth, Child Welfare Advisory Committee and Prevent Child Abuse Virginia affiliates
- Early Prevention Program was launched on SPARK and the VDSS Website in December 2012
    - Training on the best practice models were conducted at the following conferences: Child Abuse and Neglect Conference, Family Engagement Conference, Statewide CASA, North American Council on Adoptable Children National Conference and Virginia Association of Social Workers
- Early Prevention Screens in OASIS were developed and implemented and training was conducted in the use of these screens in February and March 2013;
- Technical assistance to LDSS on Early Prevention has been provided to more than 50 staff

Future Plans

- The final section in guidance, which presents a process for building the capacity of LDSS to provide Early Prevention through organizational development and collaboration, has been finalized and will soon be available on SPARK
- Funding needs are being explored including how to realign current funding sources and identify additional funding sources
- Additional training needs are being identified

- A new Early Prevention Advisory Committee is being formed. It is anticipated that this group will meet on a quarterly basis to continue to nurture and push this work forward.

Prevention Collaborations

The Early Prevention Advisory Committee

The Prevention Committee was formed to address the goals identified above. With the publication of Early Prevention Guidance, the charge for this group has been completed. Therefore, the Prevention Committee had its last meeting in April 2013. However, a newly formed Early Prevention Advisory Committee co-chaired by Em Parente of VDSS and Kiva Rogers of Chesterfield DSS will begin meeting in July 2013. It is anticipated that the advisory Committee will be comprised of many of the same members as the Prevention (implementation) Committee including state staff, community partners, and representatives from local departments. The community partners invited to participate will include: Virginia Sexual and Domestic Violence Action Alliance, Quinn Rivers Agency for Community Action, Healthy Families, Prevent Child Abuse Virginia, Virginia Cooperative Extension, and Child Care Aware of Virginia. The Advisory Committee will meet quarterly to provide input to VDSS around Guidance and practice issues which arise.

Trauma Informed Community Network

Trauma Informed Community Network (TICN) is a diverse group of professionals in the Greater Richmond area who are dedicated to supporting and advocating for continuous trauma informed care for all children and families within the Child Welfare system in the City of Richmond and surrounding counties. The TICN initiated in the fall of 2012 and is comprised of trauma informed experts from different non-profit, for-profit and government agencies.

Founding member organizations in the Greater Richmond TICN include:

- Children's Mental Health Resource Center
- Virginia Department of Social Services
- Coordinators2inc
- VCU School of Social Work
- Greater Richmond SCAN
- Family and Children's Trust Fund of Virginia
- VCU School of Education
- ChildSavers
- Family Preservation Services, Inc. a division of Providence Service Corporation

TICN professionals have utilized online materials provided by the National Child Traumatic Stress Network on enhancing a Trauma Informed Child Welfare System. The TICN has provided resources, education, and consultation to a variety of child welfare, juvenile justice, and mental health stakeholders to promote the utilization of strengths based trauma informed best practices in their work with children and families. Membership has now expanded beyond the founders to include representatives from the Department of Medical Assistance, Comprehensive Services Act, Comprehensive Services Board, Department of Behavioral Health, Systems of Care Initiative, Commonwealth attorney's office, Lutheran Family Services, private consultants and other community partners.

The TICN has also been authorized by Dr. Lisa Conradi of the Chadwick Rady Center to use their Trauma System Readiness Survey and supporting documents to aid in an organizational assessment for trauma informed care. In February 2013, the TICN initiated Trauma Informed Child Welfare (TICW)

project proposals with two Departments of Social Services of major counties in the Greater Richmond area and have already begun an organizational assessment for one agency.

The TICN will provide the following through the TICW Projects with local DSS agencies:

- Facilitate the TICN and incorporation of new DSS members
- Organizational assessment: assist with implementation of the Trauma System Readiness Tool, facilitate Focus Groups, and analyze TSRT and Focus Group data then format in narrative report following guidelines from Chadwick Rady Center)
- Training series that follows the NCTSN Child Welfare Trauma Toolkit
- Facilitation of subcommittees to review TICW Project goals (e.g., development of trauma screening tool, trauma certification of mental health providers, referral directory for trauma informed practitioners, trauma informed family assessment and home study protocol, and outcome measurement tool)
- Monthly case consultation
- Develop a model to be used by other Departments of Social Services in Virginia to become a Trauma Informed Organization
- Provide information and training to community partners on trauma informed care

C. Quality Assurance

1. Continuous Quality Improvement *(CQI)* Unit – Quality Service Review

The Continuous Quality Improvement *(CQI)* Unit in DFS is based in a philosophy and practice of quality and process improvement and is accountable to the principles of the Virginia Children's Services Practice Model. It conducts quality reviews of LDSS and will measure child status and system performance indicators to improve outcomes for children and families.

I. Foundational Administrative Structure

The CQI Unit consists of five Quality Analysts and a Quality Manager. In July 2010 with the support and funding from Casey Family Programs, the CQI Unit began development of a Quality Service Review (QSR) Process. The QSR is a quality standard based on the Virginia Practice Model. The QSR is an action-oriented learning process that provides a way of recognizing what is working or not working, at the point of practice, for children and families receiving services. Practice is assessed in two domains using the QSR, the child and family status including safety and well being and practice performance relating to agency and community partners and their work with families. The QSR process supports the focus on the quality of practice rather than the quality of compliance

A QSR is planned by the CQI Unit staff and the reviews are conducted by Virginia social service professionals working in pairs to interview all of the significant parties in the case. We recruit for reviewers with direct experience with child welfare practice. These local professionals complete a two day new reviewer training class and then are coached and mentored during a review with approved trained mentors. Reviewers are evaluated after each review and our experience indicates that usually after 3 to 4 cases a review will progress to become an independent reviewer. This peer review process is seen as a professional development opportunity by local case workers and supervisors. An additional benefit of using locals LDSS professionals creates the opportunity to build internal capacity for quality in local departments of social services.

II. Data Quality Collection

The QSR Protocol has 22 indicators with detailed definitions and scoring instructions. All QSR reviewers have classroom training and then coaching/mentoring in the field to address consistency in ratings and results. A state CQI staff completes a second level review of the quantitative scores and the qualitative work book for reliability and consistency. The QSR is primarily a qualitative review however we have created cross walks with the Virginia Child Services Practice Model and the QSR indicators. In addition there is a crosswalk with the VDSS Critical Outcomes Report and the QSR indicators. Both of these documents link the case review of a sample of cases with the overall data and status performance for each agency reviewed.

III. Case Record Data and Process

The QSR tool was piloted in November 2010 and in 2011 there were six reviews conducted covering ten local agencies. In 2012 there were seven reviews covering 17 local departments. In 2013 we have conducted four reviews covering nine local departments. Sites are selected from each of the five regions of the state, and often are recommended by of regional staff. QSR reviews include various sizes of agencies and in rural areas multiple agencies may be included for a QSR. Shared courts and service providers along with geographic boundaries provide for natural merging of smaller agencies into one review.

There is an established standard process of 14 to 16 weeks of advance work with an agency to conduct a review. We have an assigned CQI Lead staff and a local site coordinator for each review. The stages of pre work, review week and post work are all documented in an electronic policy/process manual. This includes all tools, templates, correspondence and support materials developed over the past two years. We have surveyed the local departments after a QSR to assess the process and have evolved and improved steps and tools based on this feedback from our customer group.

There is an established methodology for a stratified sample of CPS Ongoing cases and Permanency cases including foster care and adoption. For foster care we sort cases by 4 age categories from 0 to 21 years and randomly select cases and then sort by caseworker. One case is selected for each caseworker representing various permanency goals. CPS ongoing cases are sorted by case worker and randomly selected identifying the target child in each case.

IV. Analysis and Dissemination of Quality Data

The CQI Unit utilizes several software packages to manage and analyze data from a QSR. Each case is scored on a 1 to 6 metric and qualitative data is gathered on each indicator identifying strengths in practice and opportunities for improved practice. We utilize File Maker Pro, Delta Graphics and Excel software to develop reports, data analysis and illustrative graphs. The CQI Unit web page on SPARK has all reports completed for access to local agencies statewide.

The results of a case review are shared first with the caseworker and supervisor as to strengths of the case, challenges and opportunities for improvement. A community meeting is held Friday morning of review week with agency personnel and community partners to hear the preliminary results of a review. A follow up comprehensive report is provided to the LDSS and then work with the Regional Consultants and analyzed from two perspectives: 1. Strengths and good performance are identified, as well as systems and processes in place to ensure good practices continue. This is also an opportunity to identify best practices in the agency to be shared across regions. 2. Opportunities for improvement are identified through an examination of root causes and strategies for addressing the issues. Gaps in performance are

also identified, as well as what factors need to change to add in order to address the gaps and improve performance.

V. Feedback to Stakeholders and Decision-Makers and Adjustments of Programs and Processes

Feedback of results and practice reform after a QSR occurs at two levels the local agency through the development of System Improvement Plans and then on a state level through training and practice initiatives.

System Improvement Plan Process
A System Improvement Plan (SIP) is comprised of a series of action plans to improve practice and outcomes for children and families. There is a dual purpose of the local department SIP: 1) to outline how the LDSS will adjust their services/practice in response to the QSR results in order to improve their outcomes as reported in Critical Outcomes Report and Safe Measures, and 2) to serve as a mechanism for VDSS to report on progress made on both local and state levels to improve outcomes for children and families as outlined in Virginia's federal Program Improvement Plan in response to VA's 2009 CFSR.

Initial results are shared with the caseworker and supervisor of each case reviewed and then overall results are shared with the locality at the end of the QSR week. After the receipt of the final written report, a next steps meeting with the LDSS and Regional Consultants is facilitated by CQI state staff. The SIP process has been defined and templates for action plans and linkages to outcome measures are provided to the local department. The purpose of the meeting is to discuss the results of the QSR, the analysis by the local department, and to identify priorities for practice change and improvement that will impact outcomes for children and families. Outcome of the meeting is two-fold. First, the prioritization and identification of one to three issues that the LDSS can commit to work on that will improve processes and outcome measures. Second, the identification of steps towards solutions and the development of specific action plans for the identified solutions. SIP results are reported on quarterly to the CQI Unit and Regional Consultants

State Level Initiatives – Training
Issues from various QSR are brought to the state level through the CQI Unit, SIP plans by local agencies or individual requests. Current emphasis is on building on family partnership meeting practice to encourage ongoing child and family teams. Special topic training has been developed on "Implementing and Sustaining Child and Family Teams." This workshop includes discussion of engagement concepts and strategies to implement and conduct Child and Family Teaming (CFT). Case examples are used to illustrate key points, while small and large group activities provide opportunities to practice skills and assess individual strengths. Strategies are discussed regarding best practices for managing CFTs, including running meetings, maintaining communication between meetings and ensuring all needed parties are engaged. In addition, supervisors have specific opportunities to assess resources and plan how to evaluate application of strategies in their agencies. Both Child Welfare Workers and Supervisors are encouraged to attend.

Future Issues
The QSR process as currently designed will take four years to reach all 120 LDSS in the Commonwealth. Responses over the last two years have been strong and favorable to the information obtained in the assessment of casework practice. The QSR protocol operationalizes the Virginia Practice model and sets a standard of quality practice. The question arises as to how we can increase the use of the QSR protocol to assess more cases and provide local supervisors the tools to asses' casework practice for this quality standard. Our outcome would be statewide systemic review of the quality of child welfare practice in Virginia.

In the summer of 2013 we will develop a work group to explore the development of a supervisory tool based on the VA QSR protocol to be utilized by local supervisors on a regular and continual basis to assess the quality of practice and assist in the supervision process all to improve outcomes for children and families. Based on models from Indiana and Utah we will we will facilitate a work group/committee of representative state and local LDSS professionals from various regions. Our tasks will be to produce a model supervisor tool, and then develop the method, timeline and approach for implement of this tool in local departments to include training for supervisors, pilot testing of instrument, data collection of results and implementation. Our goals will be to increase the number of cases reviewed utilizing the QSR protocol and develop local ownership for assessing quality in case practice

3. Outcome Based Reporting and Analysis (OBRA) Unit

In 2008, DFS created the Outcome Based Reporting and Analysis Unit which oversees all reporting, research and information technology for DFS. In 2012, OBRA was encapsulated by the Quality Assurance and Accountability Team within DFS, which also included the Title IV-E Review Team, the Adoption Assistance Review Team and the Continuous Quality Improvement Team. The scope of management and oversight responsibilities of OBRA expanded between 2008 and 2012 to include:

- Performance based contracting
- FFATA requirements
- Sub-recipient monitoring
- Enhancements to OASIS and coordination of business requirements specifications and development with the OASIS Liaison.
- Business ownership for all other DFS information management systems, including prioritization of all system edits and enhancements for release
- DFS information management system training
- Liaising with Managing By Data (VDSS and LDSS collaborative stakeholder advisory board to OBRA) and additional workgroups
- Liaising with Continuous Quality Improvement Team to cross-walk quantitative and qualitative data
- DFS data and research analysis.

OBRA successfully released consecutive versions of OASIS; a new iteration of OASIS was released in February 2013; and iteration to update and perfect changes required to map AFCARS elements is planned for release in fall 2013.

VDSS administratively reorganized on April 1, 2013, affecting the structure and roles of the OBRA Unit, which previously had oversight of business requirements and development of OASIS, amongst other functions. Effective April 1, 2013, OBRA was transitioned out of the DFS to the Office of Research and Planning, and restructured primarily as a data and research analysis unit. The OBRA Program Manager, one data analyst and one policy analyst transitioned within OBRA to the Office of Research and Planning. The policy analyst within OBRA previously tasked with convening workgroups for the business requirements development of OASIS updates was administratively reorganized out of OBRA to the Division of Workforce Development. Both the OBRA Contracts & Grants Manager and the Sub-Recipient Monitoring Coordinator remained part of the DFS organizational structure, under separate managers. The Title IV-E Foster Care Review Team and the Adoption Assistance Review Team remained in the DFS, under the Assistant Director. Oversight of OASIS and all DFS information management systems remains within DFS. Business requirements development remains a function of the Division of Family Services.

D. Child and Family Well Being Services

Services to address children's educational needs
The Permanency Program staff continued its collaborative partnership with VDOE staff. In October 2012, VDSS and VDOE issued and disseminated revised joint guidance and tools to ensure educational stability and educational outcomes for school-aged children and youth in foster care. This revision addressed changes in federal and state law, issues from the field, and guidance on procedures when children in foster care are special education students. The guidance and tools were developed by a cross systems work group of VDSS, DOE, legal advocacy, and local stakeholders. VDSS and VDOE continue to provide training (separately and together) on the new guidance and tools across the state for local schools, LDSS, and other stakeholders.

VDSS and VDOE met several times on improving educational performance and outcomes of children in foster care through improved decision-making based on data. The components of a Memorandum of Understanding on appropriate data sharing have been identified. Specific data elements have been identified and VDOE has implemented an initial data run test using mock data. Specific steps for sharing data have been identified: VDSS will provide the Student Testing Identifier for foster care children to VDOE; VDOE will provide specific educational data to VDSS; VDSS with assistance from VDOE will analyze the data; VDSS and VDOE will disseminate management reports to LDSS and school divisions reporting aggregate data.-Aggregated data for LDSS or schools with less than ten children will not be reported to prevent any potential identification of individual children. VDOE is awaiting federal guidance on the Uninterrupted Scholars Act authorizing the sharing of VDOE student educational data on children in foster care, including outcomes and predictors of success, with VDSS prior to implementation. This initiative was included as part of the *Commonwealth of Virginia's Proposal for the Three Branch Institute on Ensuring Well-being for Children and Youth in Foster Care* to the National Governors Association Center for Best Practices in April 2013. Virginia was notified in May that they were selected to participate.

Health Care Services

The Virginia Health Plan Advisory Committee (HPAC) advises and makes recommendations to the VDSS and the Virginia Department of Medical Assistance Services (DMAS) on improving health outcomes for children in foster care across the Commonwealth. The committee ensures that children receive appropriate services to meet their health needs, defined as developmental, medical, dental, and mental health, and substance abuse needs. The committee provides ongoing oversight and coordination of health care services. It helps articulate the vision, determine effective strategies, make decisions, and follow through to ensure the health needs of children in the foster care system are met.

This section on health care services provides information on progress in and modifications to Virginia's Health Care Oversight and Coordination Plan, including those resulting from the "Because Minds Matter Summit." It also provides information on trainings provided to LDSS, community services boards (CSBs), CSA teams, judges, and providers on trauma, systems of care, mental health services, and psychotropic medications. Specific updates to Virginia's Health Care Oversight and Coordination Plan are attached to this document.

A. Overview of Transition to Managed Care
DMAS is transitioning children who are in foster care or receiving adoption assistance and who are eligible for Medicaid to managed care. This report focuses solely on children in foster care. Managed care aims to improve the short and long-term well-being of children in foster care by facilitating continuity of

care that is patient-centered and well coordinated. It is the major health care delivery model for Virginia's children in Medicaid as evidenced by 89% of children enrolled in Virginia Medicaid are in managed care as of May 2013. As of July 1, 2012, managed care is available statewide through six Medicaid Managed Care Organizations (MCOs), although not all six MCOs are available in every area.

In the DMAS contracts with the MCOs, children in foster care are included in the definition of Children with Special Health Care Needs (CSHCN). CSHCN are defined as children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age.

The benefits for children in foster care being enrolled in an MCO and having medical management services and member services include:

- A primary care provider (PCP) who is a doctor or other health provider will manage each child's health care and refer the child to other providers when necessary.
- Assistance with choosing or changing PCP. Families can have children in foster care in one MCO and with one primary care physician. However, multiple children in foster care living in the same household do not need to be enrolled in the same MCO or PCP.
- Case management for children who need assistance with medical issues and do not have access through another program.
- Care coordination among the multiple providers, agencies, advocates, and funding sources serving CSHCN
- Increased access to credentialed physicians and other providers.
- Disease management services (e.g., asthma, COPD, child weight management).
- Services for children with special health care needs.
- Transportation for children to a physician or a health care facility when foster, adoptive, and resource parents do not have any other means of transportation. Trips must be for a Medicaid covered service, medically necessary, and pre-approved (e.g., doctor appointments, counseling, dialysis, dental appointments, pharmacy pick up for prescriptions).
- 24-hour nurse advice line.
- Member orientation to MCO
- Explanation of benefits
- Member outreach and health education materials.
- Health education programs (e.g., exercise, smoking cessation, women's health, nutrition and weight management classes, prenatal classes).
- Home health and durable medical equipment to address needs.
- MCO member ID card, handbook, and provider directory.
- Toll-free member helplines.
- Access to free translation services /language telephone line.
- Assistance with hearing loss, impaired vision and limited reading ability to obtain materials in Braille, large print or TDD/TTY

Some groups of children are excluded from the transition to managed care, including:

- Children who are hospitalized at the time of enrollment.
- Children placed in psychiatric residential care (Level C).
- Children in Medicaid waivers. If the waiver ends, the child will be enrolled in managed care – even if the waiver is reinstated later. At that point, services are split between DMAS and the MCO (waiver services through DMAS and acute care services through the MCO).

Preparing for the transition to managed care. The MCOs were required to submit a letter of intent to DMAS requesting to expand coverage to children in foster care at least 6 months prior to the expansion date. The letter included the localities where the expansion was proposed, a proposed effective date, copies of approval from the Bureau of Insurance and the Virginia Department of Health (if already obtained), a network development plan and a marketing plan. Specific requirements must have been satisfied by the MCO prior to DMAS approval of expansion. The MCO must demonstrate its ability to retain accreditation by the National Committee for Quality Assurance (NCQA).

The MCO's were responsible for assessing the quality of care of CSHCN in the following areas:

- Program Development – Involving stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.
- Enrollment Procedures – Identifying and collecting data on children with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs.
- Provider Networks – Assuring the availability of providers who are experienced in serving children with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.
- Care Coordination – Providing care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN.
- Access to Specialists – Providing a mechanism in place for members determined to have ongoing special conditions that require a course of treatment or regular care monitoring and that allows the member direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member's conditions.

Enrolling children in managed care. The schedule for transitioning children in foster care to the managed care system is being set at this time. It is anticipated the process will begin in September 2013 for the Central and Tidewater regions. The rest of the state will be phased in with the goal of completion by the end of the state fiscal year 2014.

The most critical next step is completing the reformatting of the address fields in MMIS to ensure correct preassignments occur, that parents and service workers are able to communicate directly with the managed care plans and HelpLine staff and that the MCO mail is sent directly to the Resource Parents. DMAS is sending LDSS Eligibility Workers in the Central and Tidewater managed care regions a weekly file to help track the address clean up status.

DMAS and VDSS have provided the following trainings/webinars on the transition to managed care:

- LDSS: 8 webinars (5 general for eligibility & permanency staff; 3 specific for eligibility staff).
- Resource Parents: 6 in person.
- Licensed Child Placing Agencies: 1 webinar.
- Providers/Advocates: 3 in person.

The two agencies will be providing additional trainings and communication to LDSS and Resource Parents between now and September 2013. Trainings will be held via conference calls and webinars as well as in-person.

The Foster Care Chapter of the VDSS Child and Family Services Manual will be revised to incorporate the role of LDSS in managed care with children in foster care (key factors have been identified).

B. Bringing Systems of Care to Scale

This year Virginia celebrates the 20th anniversary of the landmark CSA legislation that significantly restructured services and funding for troubled and at risk youth across the Commonwealth. The statutory purpose of the CSA is to create a collaborative system of services and funding that is child-centered, family-focused, and community-based. The purposes of the law are: to preserve and strengthen families; to design and provide services that are responsive to the unique and diverse strengths and needs of youth and families; and to provide appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining public safety.

In 1993, the CSA combined eight funding streams across four child-serving agencies (Department of Education (VDOE), Department of Social Services (VDSS), Department of Juvenile Justice (DJJ), and Department of Behavioral Health and Developmental Services (DBHDS)) into one state pool of funds (the "State Pool"). The State Executive Council (SEC), comprised of the agency heads of the state's child serving agencies, local government officials, private providers, and parent representatives, is responsible for establishing interagency programmatic and fiscal policies to ensure implementation of the Act. The Office of Comprehensive Services (OCS) is responsible for providing oversight to implementation of the Act and policies of the SEC.

State Pool funds are allocated to and managed by Community Policy and Management Teams (CPMTs) that develop interagency policies to govern implementation of CSA within their communities. Local governments provide a required local match for services purchased with State Pool funds. Family Assessment and Planning Teams (FAPTs) provide for family participation, assess strengths and needs of children and their families, develop individual family services plans, and make recommendations for funding to CPMTs. These local teams are also responsible for appropriately accessing and maximizing resources across all sectors, including family, private insurance, Medicaid, Title IV-E, and agency, private, and community resources.

Virginia remains committed to assuring that a unified system of care is available to all at-risk youth across the state. Through cross-agency collaboration, with leadership from the Secretary of Health and Human Resources Office, efforts are underway to expand understanding of systems of care philosophy to ensure that every community provides equal access to services and funding for its at risk youth and their families, including children in foster care. This past year Virginia has been developing a statewide strategic plan as a deliverable through a one year SOC Expansion Planning Grant through the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMSHA).

As a result of the strategic planning process Virginia determined there is a continued need for infrastructure development of the children's behavioral health service system to infuse and sustain SOC in every community statewide. The DBHDS was awarded a four year grant through SAMSHA. The population receiving services through this grant is children and adolescents with serious emotional disturbance birth through age 21 with an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-IV or subsequent revisions. Further, the population is targeted towards those youth that are in out of home placements or at risk for out of home placements. The population includes youth with complex behavioral health needs that are served by one or more of the following child serving systems: child welfare, juvenile justice, mental health and/or special education.

As the focus of this SOC Expansion Implementation Grant project, Virginia is using a two pronged approach: 1) to strengthen care coordination at the individual child and family level through wraparound philosophy; and 2) to support mini-grant projects through public-private partnerships in each region of the state for SOC services and family support development. Specifically, this grant funding supports SOC expansion and implementation statewide through the following major initiatives:

1) Establishment of a Center of Excellence dedicated to supporting evidenced-based care coordination with youth in, or at-risk of, out of home placements for statewide implementation. The Wraparound Center of Excellence and Coordinator is housed at OCS. The Coordinator, DBHDS staff, and OCS staff are establishing:
    - A statewide provider network of Intensive Care Coordination Services. CSB and/or private providers will respond to a Request for Applications to participate in training which will enable them to offer the Intensive Care Coordination as a service for purchase from local communities via CSA funds.
    - Each Provider will identify staff to become trained as Intensive Care Coordinators. Intensive Care Coordinators will receive Institute training:
        - Introduction to Wraparound
        - Engagement in the Wraparound Process
        - Intermediate Wraparound Practice
    - Each provider will identify Coach(es) to supervise Intensive Care Coordinators. Coaches will receive all of the above training plus:
        - Advancing Wraparound Practice – Supervision and Managing to Quality
    - The Wraparound Center of Excellence Coordinator will work with the Institute to develop local capacity for wraparound and to increase referrals to the Intensive Care Coordination service. She coordinates trainings, technical assistance, and support to CPMTs, FAPTs, Providers, Coaches, and trainings in communities.
2) Awarding five mini-grants in years 1-2 and five mini-grants in years 3-4 of the SAMSHA grant (approximately $150,000 per year for each grant) on a competitive basis to communities that can demonstrate readiness to implement innovative strategies to fill service gaps in the statewide service array, and particularly those identified by the CSA Service Gap Analysis. The grants will require development of care coordination that supports the Wraparound philosophy at the individual service planning level and implementation consistent with Systems of Care values and principles at the larger community level system.
3) Family engagement and use of family members in coordination with case management and care coordination services to assure family perspective in the wraparound process.

C. Three Branch Policy Institute. Virginia submitted a proposal for and was awarded participation in the Three Branch Policy Institute by the National Governors Association Center for Best Practices on May 16, 2013. The work includes monitoring psychotropic medications and managing by data.

- Team Leadership and Core Team Membership who will lead this cross-branch initiative to improve quality outcomes for children in foster care include:
    - **Executive Branch** members
        - Governor McDonnell designated ***Margaret Ross Schultze***, VDSS Commissioner, to serve as Virginia's Team Leader.
        - ***Julia Ciarlo Hammond***, Director of Legislative Affairs and Policy Advisor, Governor Robert F. McDonnell.
        - ***Sandra Brown***, Manager, Office of Behavioral Health Services, Virginia Department of Medical Assistance Services.
    - **Legislative Branch** members:
        - ***The Honorable Barbara A. Favola***, Virginia Senate (Primary) is a member of the Commission On Youth (COY) and has introduced several pieces of legislation related to foster care.
        - ***The Honorable Bryce Reeves***, Virginia Senate (Secondary) is a member of the Courts of Justice and the Rehabilitation and Social Services committees.
        - ***The Honorable Peter Farrell***, Virginia House of Delegates (Primary) is a member of COY and the Courts of Justice Committee.

        - ***The Honorable Richard P. Bell***, Virginia House of Delegates (Secondary) is a member of the State Executive Council and the Education and the Health, Welfare, and Institutions Committees.
    - **Judicial Branch** members:
        - ***Lelia Hopper***, Director of the Court Improvement Program, Office of the Executive Secretary, Supreme Court of Virginia.
        - ***The Honorable Elizabeth Kellas***, Judge, Frederick/Winchester Juvenile & Domestic Relations District Court. Since 2004, she served as Lead Judge for the Best Practice Court Team for Winchester/Frederick and chairs the Northern Shenandoah Alliance for Children & Youth that is developing systems of care for its communities.
- The **Home Team Steering Committee** will meet periodically with the Core Team and help coordinate implementation of the work plan across groups and agencies. It will include:
    - **The leaders of existing groups** that are currently working on these activities and have primary responsibility for implementing the work plan:
        - Office of Comprehensive Services (OCS) - Susie Claire, Executive Director.
        - Health Plan Advisory Committee (HPAC) - Kim McGaughey, Co-Chair, Permanency Policy, VDSS; and Ashley Harrell, Co-Chair, DMAS.
        - Foster Care and Education Committee (FCEC) - Renee Garnett, VDSS; and Dr. Vivian Stith-Williams, DOE.
        - Center for Excellence - Deborah Pegram, OCS.
    - **Leaders from additional state agencies or organizations:**
        - VDSS - Paul McWhinney, Deputy Commissioner of Programs and Director of Family Services; and Alex Kamberis, Assistant Director, Division of Family Services.
        - Virginia League of Social Services Executives.
        - COY – Amy Atkinson, Executive Director.
        - Office of the Executive Secretary, Supreme Court of Virginia – Lori A. Battin, Senior Research Analyst, Court Improvement Program.
        - DBHDS - Pam Fisher, DBHDS.
    - Additional groups the Home Team will be engaged for input and/or assistance on implementation, consistent with the role of the organization include: Virginia Center for Health Innovation; Joint Commission on Health Care; Virginia Commission on Youth; VDSS Child Welfare Advisory Committee; Court Improvement Program Advisory Committee; VDSS Permanency Advisory Committee; Virginia League of Social Services Executives; Virginia Alliance of Social Work Practitioners; State and Local Advisory Team; and Voices for Virginia's Children.

Two outcomes listed below were identified for the work of the Policy Institute (an additional outcome is to improve educational outcomes for school-aged children/youth in foster care).

I. Improve Health Outcomes for Children and Youth in Foster Care	
Goal	**Measure**
1) Increase children receiving primary health care services through health homes.	a. 100% of children have physical health exams within thirty days of entering foster care.
	b. 100% of children over age 3 have at least annual physical health exams and under age 3 have exams consistent with the EPSDT Periodicity Table, based on American Academy of Pediatrics and Bright Futures guidelines.

	c. 100% of children in foster care have electronic health records.
2) Increase children receiving dental health care services.	a. Increased percentage of children have dental exams within sixty days of entering foster care.
	b. Increased percentage have dental exams at age 3 years and 6 years.
	c. Increased percentage have dental exams every 6 months.

II. Improve Mental Health Outcomes for Children and Youth in Foster Care	
Goal	**Measure**
1) Increase children screened and assessed for mental health needs.	a. 100% of children screened for mental health needs and referred to qualified mental health providers for full assessments when indicated on screen, within 72 hours of entry into foster care.
	b. 100% of children referred from screening receive comprehensive mental health evaluation, within 30 days by qualified mental health provider.
	c. 100% of children assessed with CANS and referred to qualified mental health provider for full assessment when indicated, within 30 days entry into foster care
	d. 100% of children referred to qualified mental health provider after CANS administration received comprehensive mental health evaluation within 60 days entry into foster care.
	e. 100% of children have CANS reassessment based on needs of child and family and on intensity of services provided, and have comprehensive CANS assessment annually.
	f. 100% of children have comprehensive CANS assessment within 90 days prior to exiting foster care.
2) Increase access to appropriate mental health care services.	a. Increased percentage of children who have moderate or severe behavioral health/emotional needs indicated on CANS receive community mental health services.
	b. Increased percentage of Medicaid providers in communities with identified service gaps.
3) Improve appropriate use of psychotropic medication.	a. Increased percentage of children who receive pediatric medical exams within 30 days prior to starting psychotropic medications.
	b. Increased percentage of children who receive psychiatric diagnostic evaluations within 14 days prior to starting new psychotropic medications.
	c. Increased percentage of children with medication plans implemented.
	d. Decreased percentage of children under age 6 receiving atypical antipsychotic medications.
	e. Decreased percentage of children receiving multiple psychotropic medications.

To help assess changes following implementation of actions in the proposal, OCS provided baseline data on the behavioral and emotional needs of children, age five and older, who have open cases to foster care services and who had a CANS assessment in state FY 2012. These behavioral and emotional needs either: (i) are causing severe or dangerous problems, and require immediate and intensive action; (ii) are causing problems consistent with diagnosable disorder, and require action or intervention to address need; or (iii) represent significant history or possible need which is not interfering with functioning, and requires monitoring, watchful waiting, or preventive activities. This data will be tracked over time to assess results

from actions taken to improve behavioral health outcomes, including improving the appropriate and effective use of psychotropic medications..

2012 baseline data for these 4,597 children ratings from the first CANS assessments shows the following needs:

- 70% had impulsivity/hyperactivity;
- 69% anxiety;
- 66% depression;
- 60% anger control;
- 59% oppositional;
- 48% adjustment to trauma;
- 46% conduct; and
- 12% psychosis.

Virginia's work plan to achieve these outcomes focuses on two strategies to improve the well-being of children in foster care (a third strategy addresses improving educational outcomes for these children).

Strategy I: Improve Health and Behavioral Health Outcomes.		
Goal 1: Manage by data.		
Actions	**Products**	**Responsibility**
1. Improve health and behavioral health outcomes of children in foster care through improved decision-making based on data.	a. Cost estimates on analyzing health, behavioral health, and psychotropic medications data from SAS, External Quality Review Organization, and other appropriate entities.	VDSS, OCS, DMAS
	b. Decisions on scope, organization, and funding to conduct analysis.	DMAS, VDSS, Core Team
	c. Final data elements.	HPAC, Home Team
	d. Baseline data analysis using VDSS, CSA, and Medicaid data.	Contracted organization
	e. Core outcome measures to be tracked.	Home Team
	f. Management reports to LDSS, CSA teams, CSBs.	VDSS, OCS, DBHDS
	g. Data elements in VDSS IT systems not captured.	VDSS
	h. Reports in VDSS Safe Measures.	VDSS
Goal 2: Coordinate health and behavioral health care for children in foster care.		
Actions	**Products**	**Responsibility**

1. Coordinate & integrate health & behavioral health care services.	a. Health homes for children in foster care.	VDSS, DMAS, MCOs, VCHI
	b. Electronic health records for children.	DMAS, VDSS

Strategy II: Improve Behavioral Health Outcomes for Children & Youth in Foster Care.		
Goal 1: Increase percentage of children screened and assessed for mental health needs.		
Actions	**Products**	**Responsibility**
1. Implement behavioral health screening tool for LDSS workers to use within 72 hours of child's entry into care to identify urgent needs and referral for evaluation, when indicated.	a. Tool.	HPAC
	b. Guidance disseminated.	VDSS
	c. Training provided.	VDSS, CIP
2. Implement CANS as mandatory assessment for all children in foster care.	a. Trauma domain revised	HPAC, OCS
	b. Guidance revised.	VDSS, OCS
	c. Training provided.	VDSS, OCS
Goal 2: Increase behavioral health services available for children in foster care.		
Actions	**Products**	**Responsibility**
1. Disseminate guidance and provide training on mental health screening and trauma-informed practice and interventions.	a. Guidance disseminated.	VDSS, HPAC, DBHDS
	b. Training.	DBHDS, CIP
2. Increase availability of behavioral health services and treatments, trauma informed and evidence-based, for children with behavioral health needs.		Core Team, CSA, DBHDS
Goal 3: Increase appropriate and effective use of psychotropic medications.		
Actions	**Products**	**Responsibility**
1. Monitor psychotropic medications by prescribers.	a. Comparison of policies/practices for fee for service & 6 MCOS to national best practices	DMAS, VDSS
	b. Strategies identified for monitoring psychotropic medications.	Core & Home Teams, HPAC
2. Increase availability of child and adolescent psychiatrists.	a. Current psychiatrists identified across systems.	DBHDS, CSBs DMAS

	b. Strategy developed and implemented to increase number in all geographic locations.	Core & Home Teams, DBHDS, HPAC
3. Increase knowledge of appropriate and effective use of psychotropic medications.	a. Training provided for prescribers, mental health clinicians, health care providers, child welfare staff, family members, caregivers, judges.	Core Team, OCS, DBHDS, CIP

D. Schedule for initial and follow-up health screenings that meet reasonable standards medical practice.

Virginia continues to utilize multiple health screenings as described last year, including: Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings, developmental screenings, dental screenings, behavioral health assessments and substance abuse assessments; safety and family assessments; and functional assessments (CANS) including a trauma module.

A major difference in Virginia's health plan is that the MCO's will be responsible for ensuring screenings and assessments (including, EPSDT, developmental, and dental screenings) for children in foster care beginning September 1, 2013 for the Managed Care Central and Tidewater regions and effective statewide by June 30, 2014. (Please see attached update on Virginia's health care plan.)

The VDSS Permanency Regulation was approved and in effect in 2012, requiring that children in foster care receive:

- A medical evaluation within 72 hours of initial placement if conditions indicate necessary.
- Medical examination no later than 30 days after initial placement (was 60 days).

These requirements are specified in the Foster Care Chapter of the VDSS Child and Family Services Manual (Section 4.9).

Health Screening Tool: HPAC is evaluating alternative health screening tools for LDSS service workers to use within 72 hours of child's entry into foster care to identify urgent health needs of child and to refer child for immediate and appropriate medical or behavioral health evaluation. HPAC is to recommend screening tool by June 15, 2013. Preliminary criteria include that the tool:

- Addresses urgent mental health, health, domestic violence, and trauma needs.
- Is appropriate for child welfare.
- Applies to wide age range of children.
- Helps in decision-making for making referrals to health providers and communicating the urgency of referrals.
- Is quick and easy to use.
- Can be administered by LDSS service workers.
- Uses information service workers already collect to extent possible.
- Valid and reliable.
- Free.

Some tools being considered:

- Mental Health Screening Tools from California Institute for Mental Health (Age 5 to adult; Age 0 to 5).
- Child Welfare Trauma Referral Tool from National Child Traumatic Stress Network (NCTSN)
- Michigan Screening Checklists developed with NCTSN (Identifying Children at Risk Ages 6-18; Identifying Children at Risk Ages 0-5).

- Child Exposure to Domestic Violence Scale (CEDV).

Functional Assessment: As reported last year, Virginia's CANS assessment is the mandatory uniform assessment instrument for all children age 0-18 and their families who receive services funded by the CSA (§ 2.2-5209 Code of Virginia). The local CSA teams use the CANS to help plan, make decisions, and manage services at both an individual and system of care level. It helps:

- Identify the strengths and needs of the child, youth, and family.
- Enhance communication among participants working with the child, youth, and family.
- Identify children and youth who require and are referred for in-depth assessments, including assessments for health and behavioral health needs. It also has a domain for assessing trauma.
- Guide and inform service planning with the child, youth, and family.
- Capture data to track progress on child and family outcomes.
- Identify service gaps and promote resource development.

Children receiving CSA services shall initially receive comprehensive CANS assessment, with reassessments determined based on the needs of the child and family and the intensity of services. A comprehensive assessment is required annually and when the child is discharged from CSA.

The mandated CANS assessment requirement includes Title IV-E children and non-Title IV-E children that receive CSA services. However, for Title IV-E children who do not receive funding for maintenance or services from CSA, the CANS has not been required. The 2012 VDSS Permanency Regulation was revised to require that children in foster care receive an initial foster care assessment within time frames developed by VDSS but shall not exceed 30 calendar days after acceptance of the child in a foster care placement, utilizing assessment tools designated by VDSS. This requirement is specified in the Foster Care Chapter of the VDSS Child and Family Services Manual (Section 5.5). This requirement also allows the CANS to be mandated for all children in foster care. The VDSS Permanency Advisory Committee recommended at two meetings in the past that CANS be mandated for all children in foster care. VDSS is making decisions on incorporating the most appropriate assessment and service plan information into OASIS.

There is the infrastructure in place for expanding the CANS mandate to these remaining children and their families. LDSS staff who provide case management services for children and youth served by CSA are responsible for administration of the CANS. In FY 2012:

- Approximately 1,165 LDSS staff were certified to administer the CANS, providing coverage for all 122 LDSS. Training and certification is provided on-line (www.CANSTraining.com) by the Praed Foundation, which holds the copyright to the CANS assessment and is managed by John Lyons, Ph.D., the creator of the CANS. Certification must be renewed annually.
- Seventy-five (75) LDSS staff were selected by their communities to serve as Super Users. Super Users receive specialized training and were certified by Dr. Lyons. They serve as a resource and provide technical assistance on rating the CANS to local staff who administer the CANS. About half of all current Super Users statewide are LDSS staff. Other child-serving agencies that serve as Super Users include Community Services Boards, Court Services Units, and schools.

The HPAC Tools and Guidance (TAG) Work Group is also revising the trauma module of CANS. The Center for Child Trauma Assessment and Service Planning (CCTASP) at Northwestern University Medical School revised the trauma module of CANS with Dr. Lyons and NCTSN for Illinois. They also developed guidelines for using CANS from clinician, supervisor, team, and worker perspectives to do trauma informed assessment, treatment planning and treatment, to make CANS relevant for the family and worker, to engage children and families, and guide services and treatments. TAG will use these tools

and the *Use of the CANS in Relation to Complex Trauma: Adaptation and Application of the CANS within the National Child Traumatic Stress Network*. The Foster Care Chapter of the VDSS Child and Family Services Manual will be revised to incorporate the mandated CANS and to make it more relevant once this work is complete.

E. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home.

A major difference in Virginia's health plan is that the MCO's will be responsible for ensuring the monitoring and treatment of medical needs for children in foster care beginning July 1, 2013 for the Managed Care Central and Tidewater regions and effective statewide on October 1, 2013. (Please see attached update on Virginia's health care plan.)

Virginia continues to utilize family engagement, Family Partnership Meetings, the foster care service plan, FAPT, the Individualized Family Services Plan, and utilization management to inform decision-making, service planning, implementation, and monitoring of services identified during screenings and assessments. The LDSS service worker continues to play a central and essential role in managing services for the child or youth in foster care.

Information on a wraparound approach and intensive care coordination was added to Virginia's health plan and is included in the Foster Care Chapter of the VDSS Child and Family Services Manual. DBHDS, DMAS, and/or OCS provided trainings on these two approaches and implementing systems of care. Funding for Wraparound training, coaching, certification, and capacity building was provided through the PRTF Waiver at DMAS by the University of Maryland Institute for Innovation and Implementation. Staff from Community Services Boards, LDSS, local CSA teams, and juvenile justice attended these trainings.

Event and Location	**Dates**
Orientation to Wraparound-Fairfax	March 11, 2013
Orientation to Wraparound-Richmond	March 12, 2013
Orientation to Wraparound-Hampton	March 13, 2013
Orientation to Wraparound-Bristol	April 18, 2013
Orientation to Wraparound-Roanoke	April 19, 2013
Together We Can…Creating A Caring Community for Our Children: A Behavioral Health Symposium- Williamsburg	April 18, 2013
Second Annual CSA Conference – System of Care	April 29-May 1, 2013
High Fidelity Wraparound- Coaches Orientation-Richmond	May 20, 2013
Intensive Care Coordinators-Cohort I- Introduction-Richmond	May 21-23, 2013
Intensive Care Coordinators-Cohort I- Engagement-Richmond	June 24, 2013
High Fidelity Wraparound Coaches- Coach Training-Richmond	June 28, 2013
Intensive Care Coordinators-Cohort II Introduction-Richmond	June 25-27, 2013
Intensive Care Coordinators-Cohort II- Engagement-Richmond	July 23, 2013
Intensive Care Coordinators-Cohort III- Introduction-Roanoke	July 24-26, 2013

Intensive Care Coordinators-Cohort III-Engagement-Roanoke	August 27, 2013
Intensive Care Coordinators-Cohort I-Intermediate-Richmond	November, 2013
Intensive Care Coordinators-Cohort II-Intermediate- Richmond	December, 2013
Intensive Care Coordinators-Cohort III-Intermediate-Roanoke	January, 2014

Trauma Informed Care and Treatment. HPAC developed a draft tool kit, including:

- Understanding traumatic stress of children in foster care.
- Diagnoses and treatments for trauma and mental health issues.

In addition, key information from the National Child Traumatic Stress Network has been identified in the *Child Welfare Trauma Training Toolkit*, including the *Essential Elements of Trauma-Informed Child Welfare Practice* and *Empirically Supported Treatments and Promising Practices*. The Foster Care Chapter of the VDSS Child and Family Services Manual is currently being revised to incorporate this information for the LDSS.

The DBHDS, in collaboration with DMAS and OCS, held or provided access to the training events listed below on trauma, impact on children, approaches to care, and trauma informed treatment. CSB clinicians, LDSS service workers, CSA staff, court services staff, and private providers attended.

Event and Location	**Dates**
Treating Addictive Behaviors in Traumatized Adolescents, Lisa Ferentz	May 7-8, 2012
Trauma and Recovery with Tonier Cain, Consumer Advocate	September 5, 2012
Understanding and Treating Self Destructive Behaviors in Traumatized Adolescents - Richmond	October 17-18, 2012
Trauma-Focused Cognitive Behavioral Therapy for Traumatized Children and Their Families – Georgetown University National Technical Center for Children's Mental Health	February 14-15, 2013
Understanding and Treating Self Destructive Behaviors in Traumatized Adolescents - Alexandria	February 28, 2013
Understanding and Treating Self Destructive Behaviors in Traumatized Adolescents - Norfolk	March 2, 2013
Child Trauma and Juvenile Offenders - DBHDS and DCJS Joint Sponsorship - Charlottesville	April 23-24, 2013
Trauma Focused Cognitive Behavioral Therapy - Richmond	July 15-17, 2013
Trauma Focused Cognitive Behavioral Therapy - Fairfax	July 18-19, 2013
Trauma Focused-Cognitive Behavioral Therapy - Roanoke	August 2013

DMAS' Office of Behavioral Health (OBH) also has multiple efforts underway to conduct trainings on Community Mental Health Rehabilitative Services throughout 2013. The planned trainings are specifically for Intensive In-Home, Therapeutic Day Treatment, Mental Health Support Services (skills based) and Crisis Intervention/Crisis Stabilization. These trainings are geared towards all Medicaid youth with Severe Emotional Disturbances, including children in foster care.

The Court Improvement Program (CIP) in the Office of the Executive Secretary, Supreme Court of Virginia, is responsible for court activities related to children and families and for qualification of lawyers as guardians ad litem for children. Major activities include: (i) developing, conducting, and supporting

special projects that address issues of concern to children and families involved with the court system; and (ii) implementing standards promulgated by the Judicial Council of Virginia governing lawyers who serve as guardians ad litem.

CIP has sponsored numerous local and state trainings in recent years on trauma and children. Audiences have included juvenile and domestic relations (J&DR) district court judges; lawyers for children (GALs), clerks, parents, LDSS, CASA employees, and other community service providers serving children and families before the courts.

F. How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

DMAS focused on MCO network development and expansion to assure access is better than what is currently available in the area the MCO sought to expand into. DMAS determines network adequacy based on specific utilization for the expansion area not later than 90 days prior to the planned implementation date.(Please see attached update on Virginia's health plan for requirements on specialty care network, credentialing/re-credentialing policies and procedures, practice guidelines).

The MCO shall be solely responsible for arranging for and administering covered services to enrolled members and must ensure that its delivery system provides available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services. In establishing and maintaining the network, the MCO shall consider all of the following:

- The anticipated Medicaid/FAMIS Plus enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid/FAMIS Plus population to be served;
- The numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;
- The numbers of network providers not accepting new Medicaid/FAMIS Plus members;
- The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by Medicaid/FAMIS Plus members; and
- Whether the location provides physical access for members with disabilities.

G. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.

A major difference in Virginia's health plan is that the MCO's will be responsible for ensuring continuity of health care services. (Please see attached update on Virginia's health care plan for requirements on MCO primary care provider network, care coordination, and case management.)

The MCO contract with DMAS requires that the MCO shall have a primary care network that includes contracting with all area health departments, major hospitals, CSBs, Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.

The MCO's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The MCO shall submit to DMAS prior to signing the initial contract, upon revision or on request referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

H. How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record.

HPAC continues to defer to larger efforts in Virginia to implement electronic medical records (EMRs) as described below, rather than create a separate electronic health record for children in foster care.

In the interim until the EMR for children in Medicaid is established, HPAC developed the Child Health Information Form for LDSS service workers to gather known health information on the child and the child's birth family from health care providers, caregivers, MCOs, and other entities in one place. The worker will then appropriately share this information with caregivers and health care providers.

- Child's General Information (i.e., demographics; physical description, birth information, developmental information, and critical events in the child's life including trauma).
- List of screenings, assessments, and evaluations by qualified professional (e.g., attachment, developmental, hearing, vision, or behavioral health screens; early intervention program or child find assessments; CANS; mental health evaluations; Ansell-Casey Life Skills assessments).
- Child's Health Information, including:
    - Child Current Health Status (i.e., conditions, description including diagnosis, services/treatment
    - Prior Illness/Disease/Condition that no longer exists (i.e., condition; date or age)
    - Prior Hospitalizations (i.e., purpose, date or age, place)
- Health History of Child's Family for family members related by blood to the child, including condition and relative and explanation:
    - If disease, specify age of onset.
    - If early death, specify cause and age.
    - If mental health issue, specify age, treatment.
    - If substance abuse, specify age started using, treatment, outcomes.
- Current and previous provider names, addresses and phone numbers for the child's routine care and special services, including medical, dental, behavioral health, clinic, urgent care, emergency room, hospitals.
- Current and previous psychotropic medications for child, including name of medication, class if psychotropic, purpose, dose and frequency, and side effects/how managed. Date of refill if needed, or dates used and reason stopped.
- Immunization record attached and other documents.

This form is being included in the Foster Care Chapter of the VDSS Child and Family Services Manual.

For the first time, Virginia will now be able to identify children in foster care or children receiving adoption assistance in the Medicaid Management Information System (MMIS). This will allow the aggregate reporting of data by MCO region on children in foster care. All LDSS have been involved in completing data clean up of the MMIS and the VDSS Application Benefit Delivery Automation Project (ADAPT) computer systems. Solely two Aid Categories will now be used to identify youth in foster care (072) and youth receiving adoption assistance. For children in foster care, the member screen has the child's physical address and city/county code and the case screen has the LDSS address and the city/county code.

Virginia has made significant progress on electronic medical records (EMRs) and exchanging information with providers.

- ConnectVirginia (www.connectvirginia.org), Virginia's health information exchange (HIE), is in place and the first node (Inova) will be live shortly for exchanging clinical records. It is

expected by the end of this year that central and tidewater hospitals and provider systems will be online. Virginia will also have the capability to exchange records with states on the national network as well as with federal agencies: DoD, VA, CMS and SSA.

- Virginia will also be connected as a node on the HIE. Virginia Department of Health, DBHDS, and Department of Corrections will be able to interoperate, as well as provide access to health department and state labs from the HIE. These three state agencies are in the process of getting EMRs. They will be able to share clinical records with the provider community (or other state agency) as allowable under law (behavioral health has restrictions on what they can share). Only the providers via their EMRs will have access to the systems. However, providers are required to provide electronic copies to patients (and parents/guardians of children). Some providers do have patient portals. Providers will have access as long as the parent/guardian ops in. The patient goes to a doctor and the doctor (via the technology) accesses any records available for the patient (assuming the patient opted in for the statewide exchange). The selected record is imported into the new doctor's system and they can add to the record. That updated record is made available on the exchange (assuming they opted in). Medical records are patient centric. Overtime, many types of medical records will be available (xray etc). The only medical record being exchanged at the moment is called a continuity of care document (CCD); it is a container for a number of different things.
- The number of nodes on the federal network are expected to double by the end of this year (to 100+); one of them will be ConnectVirginia.

- The provider incentive program became operational in August 2012 to incent eligible professionals and hospitals to adopt, implement, and upgrade to certified electronic medical record systems. As of the end of January, Medicaid has paid out about $47 million in incentives. There is a very good turnout of providers seeking incentives.
- VDSS and DMAS are in the process of replacing the legacy eligibility and enrollment systems, working towards a goal of self-directed services for Medicaid/CHIP programs. CommonHelp is a key part of the enterprise strategy (https://commonhelp.virginia.gov/access/).

A working group in the Commonwealth consisting of VDH, Division of Consolidated Laboratory Services, the eHHR Program Management Office, and Virginia Information Technologies Agency (VITA) are exploring the new requirements and impacts of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the AHRQ partnership with CMS to deliver an EHR format to meet the needs of healthcare providers for children. New EHR format aligns with best practice clinical standards, federal health IT standards, and clinical expertise from healthcare providers. HPAC is inviting Dr. Joseph Grubbs, Enterprise Information Architect, Commonwealth Data Governance to share the requirements and how this will impact children in foster care.

I. The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.

Virginia continues to use the service authorization requirement for any atypical antipsychotic prescribed for a child under the age of six in the fee-for-service population, including children in foster care, implemented by DMAS' Drug Utilization Review Board.

Activities and progress on psychotropic medications include:

- **HPAC's Psychotropic Medications Work Group** continues to meet. It is comprised of: child pediatricians; child and adolescent psychiatrists from a Community Service Board and the Virginia Commonwealth University (VCU); DMAS and VCU pharmacists; psychiatric nurses; mental health professionals; and other DMAS, DBHDS, VDSS, and LDSS staff.

- **HPAC identified national and other state best practices and standards** for monitoring appropriate and effective use of psychotropic medications at both child and systems levels. Examples of resources used:
    - **Federal resources** (GAO Reports; ACYF information memos; Joint letter from HHS, CMS, and SAMHSA).
    - **Three multi-state studies** (Multi-State Study on Psychotropic Medication Oversight in Foster Care; Interstate Variation in Trends of Psychotropic Medication Use Among Medicaid-Enrolled Children in Foster Care; Report and resource guide from 16 State Study with Medicaid Directors Learning Network).
    - **National organizations** (e.g., American Academy of Child and Adolescent Psychiatry practice guides; American Bar Association Center on Children and the Law practice policy brief; National Technical Assistance Center for Children's Mental Health; Center for Health Care Strategies' Sharepoint on Psychotropic Medications Virtual Learning Community (PMVLC); National Child Traumatic Stress Network; Center for Child Trauma Assessment and Service Planning; California Evidence-Based Clearinghouse for Child Welfare; and Child Welfare Information Gateway.)
    - **States:** Texas, Tennessee, Oregon, Connecticut, New York, Georgia, Arizona, Wisconsin, University of South Florida, Michigan. DMAS identified Texas and Arizona as having Medicaid systems more closely aligned with Virginia.
- **Some of the most effective practices and strategies** nationally were identified, including:
    - Psychotropic Medication Advisory Committee
    - Practice parameters as resource for physicians and clinicians
    - Approved/preferred medications
    - Prescribing guidelines (e.g., initial and maximum dosing, schedule, monitoring)
    - Tracking use of medications through key measures using Medicaid claims data
    - Prior authorization process
    - Utilization review process
    - Annual reporting of outcomes using Medicaid claims data
    - Educational materials
- **HPAC defined psychotropic medications** based on Texas parameters. The medications are the same as the ones identified in the GAO report, however subcategories have been identified consistent with the pharmaceutical literature. The VCU clinical pharmacist updated the charts used in Texas to reflect 2013 information. Classes include:
    - Stimulants (for treatment of ADHD)
    - Non-Stimulants (for ADHD treatments)
    - Antidepressants, SSRIs
    - Antidepressants, SNRIs
    - Antipsychotics: Second Generation (Atypical)
    - Antipsychotics: First Generation (Typical)
    - Mood Stabilizers
    - Benzodiazepines for anxiety (Virginia added this class to Texas list; it was used in the GAO report)
- **HPAC identified target audiences:**
    - Front line workers (VDSS service worker, FAPT & CSB case managers, clinicians, managed care managers)
    - Caregivers/providers where child lives (foster care parents, treatment foster care and residential treatment providers, etc.)
    - Prescribers of psychotropic medications (child & adolescent psychiatrists, nurse practitioners, primary care providers in public and private sectors)
    - Youth and birth parents

- **HPAC developed draft tool kit**, including:
  - Protocol for effective prescribing of psychotropic medications for children and youth in foster care (adapted from information from the American Academy of Child & Adolescent Psychiatry, the ACYF-CB-IM-12-03 dated April 11, 2012; and the American Bar Association Center on Children and the Law).
  - Checklist for effective use of psychotropic medications.
  - Information on monitoring psychotropic medications at systems level.
  - Psychotropic medication management plan form.
- **VDSS is incorporating information from the protocol and materials** in the Foster Care Chapter of the VDSS Child and Family Services Manual consistent with the role of LDSS service worker.
- **HPAC made progress on using data to identify baseline, trends and issues in Virginia:**
  - Identified health utilization measures, HEDIS measures, and data elements.
  - Identified pros and cons of using three alternatives vehicles for analyzing VDSS child data and Medicaid claims data
  - Requested cost estimates for analyzing data from:
    - SAS project through the Office of Comprehensive Services for At Risk Youth and Families.
    - External Quality Review Organization (EQRO) through DMAS.

  Proposed health outcome/utilization measures given to SAS for cost estimate on all children in foster care to analyze and identify baseline, trends and issues in Virginia.

  1) % of children had psychotropic drugs within one year of entry of foster care
    - **Age of children**
      - % were age 16-20
      - % age 10-15
      - % age 6-9
      - % age 3-5
      - % age 0-2
    - **Assessment conducted** (will get psychiatrists' input on specifics)
      - % children had pediatric medical exam prior to (within x days?) psychiatric diagnostic evaluation
      - % had psychiatric diagnostic evaluation prior to (within x days?) initiation of new psychotropic medication
      - % of children with follow up visit(s) with either prescriber or primary care provider after medication prescribed within time frame recommended by prescriber
      - % of children with follow up visit(s) with either prescriber or primary care provider after medication discontinued
    - **Number of psychotropic drugs per child**
      - % had only one drug
      - % had two drugs
      - % had three drugs
      - % had four drugs
      - % had five drugs
      - % had six or more drugs
      - % had multiple drugs before single drug used
      - % of children had more than x number of drugs over x period of time
    - **Use of select medications compared to AACAP practice parameters** (difficult to get data; not high priority first analyses)
      - % had maximum dosage longer than recommended
      - % had maximum duration longer than recommended

- % were under age approval for drug prescribed
- **Class of psychotropic drugs**
  - % had Stimulants (for treatment of ADHD)
  - % had Non-Stimulants (for ADHD treatments)
  - % had Antidepressants, SSRIs
  - % had Antidepressants, SNRIs
  - % had Antipsychotics: Second Generation (Atypical)
  - % had Antipsychotics: First Generation (Typical)
  - % had Mood Stabilizers
  - % of children had two or more medications within same class
- **Providers prescribing psychotropic medications**
  - % by child and adolescent psychiatrists
  - % by neurologists
  - % by family practice physicians
  - % by nurse practitioners
  - % by developmental/behavioral pediatrician
  - % had one prescriber
  - % had two prescribers
  - % had three prescribers
  - % had four prescribers

2) Providers prescribing psychotropic medications for children in foster care

- Number of providers
- Type of providers
- Specialty of providers
- Geographic location (FIPS code)

Proposed data elements given to SAS for cost estimate - to analyze, report baseline/trends

- **Descriptive child data** from VDSS information system (OASIS)
  - Age
  - Gender
  - Race
  - Ethnicity
  - Diagnosis
  - Permanency goal
  - Placement type
  - Date of entry in foster care
- **Assessment data from DMAS medical claims**
  - Date of service - medical well child visits
  - Dates of psychiatric diagnostic evaluation visits
  - DSM-IV diagnoses submitted on claims
  - Dates of consultation with psychiatrist
- **Data on each psychotropic prescription medication prescribed from DMAS**
  - Date filled
  - Diagnosis
  - Name of psychotropic medication
  - Class of psychotropic medication
  - Dosage provided
  - Name of provider who gave prescription
  - Type of provider
  - Specialty of provider
  - Geographic area of provider
  - Dates medications were purchased/paid for

- **HEDIS follow-up visit** from DMAS within one month of diagnoses or within one month of psychotropic medication (or how long after?)
    - Date of visit
    - Name of servicing provider
    - Provider type
    - Provider specialty
    - Geographic area of provider (FIPS location of servicing address)
- **Behavioral health services received** from DMAS
    - Dates
    - Type of service (e.g., case management; in-home services; community treatment; waiver services; hospitalization)

Possible types of analysis by:

- Age of child
- Prescriber type
- Psychotropic medication class?
- Top ten diagnoses by age
- Top ten medications by age
- Diagnoses by age of child and by medication

Exploring possibility of calculating statewide measures using HEDIS-like measures that do not include medical record extraction – possible request of cost estimate through EQRO

- Anti-depressant medication management (currently for over 18 yrs, can be tweaked for age)
    - % newly diagnosed and remained on meds for at least 84 days
    - % newly diagnosed and treated and remained on meds for at least 180 days
- Follow up care for children prescribed ADHD med (ages 6 – 12)
    - % newly prescribed ADHD meds with at least three follow visits within 10 month period with
    - one being within 30 days of prescribing visit
- Follow up after hospitalization for mental illness (discharged from an acute inpatient setting)
    - At least one visit after discharge with behavioral health provider within 7 days of discharge
    - At least one visit after discharge with behavioral health provider within 30 days of discharge
- Access to primary care practitioners (have they gone to the doctor)
    - One or more visits with a PCP during the year
- % of adolescents with a new episode of alcohol or other drug dependence that have initiated an engagement
    - % who initiate inpatient/intensive outpatient within 14 days of diagnosis
    - % who initiate treatment and have two or more treatments within 30 days
- Mental Health Utilization
    - Number and % receiving mental health services:
        - Any service
        - Inpatient
        - Intensive outpatient or partial hospitalization
        - Outpatient or Emergency department
    - % had at least one dental visit during the year

- **The Court Improvement Program (CIP) sponsored trainings** in recent years on psychotropic medications. Audiences have included J&DR district court judges; GALs, parents, LDSS, and other community service providers.

- **OCS issued its sixth annual report on the top twenty critical service gaps** and barriers by CPMTs for 2012. Nine (9) of the 20 service gaps directly relate to behavioral health services and psychotropic medications. The number in parenthesis indicates its ranking, with 1 signifying the highest statewide service need reported.
    - **Assessment**: Psychiatric assessment (6); Psychological Assessment (9); Short-term diagnostic assessment (17).
    - **Crisis services**: Crisis intervention and stabilization (3); Emergency Shelter Care (8).
    - **Behavioral health services**: Intensive substance abuse services (1); Substance abuse prevention and early identification (10); Medication follow-up/psychiatric review (12); Wrap-around services (16).
- **DBHDS established priority services.** The 2010 General Assembly directed DBHDS to establish a comprehensive plan to "identify concrete steps to provide children's mental health services, both inpatient and community-based, as close to children's homes as possible." In the final report to the General Assembly, *A Plan for Community-Based Children's Behavioral Health Services in Virginia* (2011), DBHDS identified the following base services as immediate priorities for community services capacity investment:
    - Crisis Response Services, including crisis stabilization, emergency respite, in-home crisis stabilization, and mobile child crisis response;
    - Case Management and Intensive Care Coordination; and
    - Psychiatric Services.

DBHDS' *Comprehensive State Plan 2012-2018* includes the goal to enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community. Objectives and implementation action steps include: (i) Increase the statewide availability of a consistent array of base child and adolescent mental health services; (ii) Implement a children's behavioral health workforce development initiative; and (iii) Establish quality management and quality assurance mechanisms to improve access and quality to behavioral health services for children and families.

Virginia has worked to obtain top government ownership, commitment, and knowledge to improve appropriate use of psychotropic medications for children in foster care.

- **Virginia sent team to participate in the "**Because Minds Matter Summit."
- **Virginia was selected as one of six states as a case study in national study** conducted by Tufts Medical Center on implementing improvements in use of psychotropic medications.
- **Virginia submitted a proposal for and was awarded participation in the Three Branch Policy Institute** by the National Governors Association Center for Best Practices that includes monitoring psychotropic medications and managing by data.
- **DMAS and VDSS top management met** in April 2013, including all appropriate deputies and program managers, to clarify the roles of VDSS, DMAS, LDSS, and the MCOs:
    - The MCOs are responsible for monitoring the appropriate and effective use of psychotropic medications for children in foster care.
    - DMAS requested the MCOs to describe their plan's protocol(s) for monitoring psychotropic medications, as defined by the GAO, for children under the age of 18. DMAS also requested any forms that are used in monitoring or if they have educational tools that are used to alert providers of effective and appropriate use of psychotropic medications for children and youth under the age of 18, as appropriate.
    - The VDSS service worker is responsible for ensuring the child in foster care receives appropriate health screens, assessments, doctor visits, service planning, treatment, etc.
    - DMAS ran preliminary data on children in foster care, in Medicaid, and who live in Richmond City (because of managed care pilot, DMAS could identify children in foster

care.) DMAS has submitted a request for the same statewide data now that Virginia can identify all children in foster care (see below).
    - DMAS will share aggregate data with VDSS based on the MCO regions to identify and address concerns.
    - DMAS said MCO contract can be modified to specify additional requirements as we move forward, whether amendment to contract, next contact, and/or future contracts.

DMAS is collecting baseline data to track improvements in use of psychotropic medications. In January 2012, DMAS replicated the data analysis in the December 2011 General Accounting Office (GAO) report, "Foster Children HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions."[1] At that point in time, DMAS could only identify children in foster care in Richmond City in the Medicaid Management Information System (MMIS), due to the Richmond City pilot transitioning these children into managed care. Therefore, it was not possible to accurately compare the data to children in Medicaid who are not in foster care.

DMAS used the same criteria that were used in the GAO report:

- Definition for psychotropic medications
    - ADHD Drugs (i.e. Strattera, methyphenidate)
    - Anti-Anxiety Drugs (i.e. clonazepam, lorazepam)
    - Antidepressants (i.e. fluoxetine, citalopram, buproprion)
    - Antipsychotics (i.e. Haldol, Zyprexa, Risperdal)
    - Hypnotics (i.e. Lunesta, Ambien)
    - Mood stabilizer (i.e. lithium, Depakote, Tegretol)
- Age cohorts: 0-5, 6-12, 13-17
- Usage categories:
    - Use of 5 or more psychotropic drugs for all ages by age cohort.
    - Use of any of these classes of drugs for children under age 1.
    - Use by age cohort for dosages that exceed FDA recommended dosage levels.

In addition, DMAS added:

- The specific therapeutic class, the GCN, the NDC, and the dosage for each medication.
- For patients:
    - The total number of enrolled patients and compare the percentage of patients by age cohort who meet the conditions compared to the total population for the time period.
    - The age.
    - City/county code
    - Any principle diagnoses for any patient who falls under the usage categories above.

Results are shown below based on the percentage of children in foster care in Richmond City who were prescribed a psychotropic medication compared to the five GAO selected states. While there are significant shortcomings comparing one urban locality in 2012 to entire states in 2008, it provides useful anecdotal data to see what is possible. The following percentage of children in Richmond City were prescribed a psychotropic medication:

- Half (48.97%) of all 194 children age 0-17 years old.
- More than half (58.25%) of children age 13-17 years old.

[1] DMAS' fiscal agent contractor, Xerox State Healthcare, LLC, created the report that replicated the 2011 GAO report referenced above. The data provided by Xerox has not been independently validated by DMAS at the time of this report.

- Half (48.78%) of children age 6-12 years old.
- 4% of children age 1-5 years old.

Age Group	Percent of Children in Foster Care Prescribed Psychotropic Medications Comparing Richmond City Virginia (2012) to GAO States (2008)					
	Richmond City (N=194)	**Texas**	**Massachusetts**	**Florida**	**Michigan**	**Oregon**
0-17 years old	**49.0%**	32.2%	39.1%	22.0%	21.0%	19.7%
13-17 years old	**58.2%**	58.2%	53.4%	36.8%	35.0%	43.3%
6-12 years old	**48.8%**	45.8%	44.8%	31.2%	26.7%	23.4%
0-5 years old	**4.0%**	9.1%	4.9%	5.3%	4.4%	2.5%

The results also documented the percentage of children prescribed psychotropic medications that were identified with the GAO defined indicators for increased potential health risk:

- 1.33% of children aged 0-17 in Richmond City were prescribed 5 or more medications concomitantly. GAO reported: "Our experts also said that no evidence supports the use of five or more psychotropic drugs in adults or children, and only limited evidence supports the use of even two drugs concomitantly in children. Increasing the number of drugs used concurrently increases the likelihood of adverse reactions and long-term side effects, such as high cholesterol or diabetes, and limits the ability to assess which of multiple drugs are related to a particular treatment goal."
- 6.64% of children aged 0-17 in Richmond City had a dose exceeding the maximum guidelines based on FDA-approved labels. GAO reported: "According to our experts, taking drugs at dosages exceeding levels recommended by the FDA and medical literature increases the potential for adverse side effects. Although there may be cases in which such doses are clinically justified, in general, there is a lack of research demonstrating that high dosages are more effective. In addition, our experts said that for some drugs, a higher dose may be less effective than the more moderate recommended dose."
- 0.44% of children under 1 year in Richmond City were prescribed a psychotropic drug. GAO reported: "Our experts said that there are no established mental health indications for the use of psychotropic drugs in infants, and providing them these drugs could result in serious adverse effects."

Percent of Children Identified with GAO Defined Indicators of Potential Health Risk Comparing Richmond City Virginia (2012) to GAO States (2008)						
Psychotropic Drug Risk	**Richmond Virginia**	**Texas**	**Massachusetts**	**Florida**	**Michigan**	**Oregon**

Children age 0-17 prescribed 5 or more medications concomitantly	**1.33%**	1.05%	1.33%	0.11%	0.29%	0.13%
Children age 0-17 with a dose exceeding the maximum guidelines based on FDA-approved labels	**6.64%**	3.27%	2.21%	1.50%	1.67%	1.12%
Children under 1 year prescribed a psychotropic medication	**0.44%**	1.2%	0.7%	2.1%	1.5%	0.3%

These above results reflect psychotropic medication utilization in foster children in the Richmond City "pilot" while the children were covered under the fee-for-service program. Effective December 2011, these children were transitioned into Virginia Medicaid's managed care network.

Virginia Medicaid will be collecting baseline information related to psychotropic medication utilization for all foster children enrolled in Medicaid. This will allow DMAS to evaluate the impact of managed care and policies on the appropriate and effective use of psychotropic medications.

C**oncurrent analysis under the Comprehensive Services Act (CSA)**: Virginia, through a separate database, examined children in the child welfare system served through CSA during state fiscal year 2012. Of the 15,305 children served through CSA:

- More than two-thirds (69%) were served through mandated foster care services (11,203 children).
- Over half (57%) received services primarily for abuse and/or neglect (8,656 children).
- 43% were in foster care (6,655 children).
- 26% received services to prevent foster care (3,892 children).

Of the 6,655 children in foster care who received CSA services:

- Over one-third (37%) had a DSM IV mental health diagnosis.
- 27% were prescribed medications by a physician for mental health problems. The types of medications are not defined for this data element.

This CSA data was the sole information historically available on psychotropic medications for children in foster care. The new DMAS analysis now provides more specific and useful data for evaluating the impact of managed care and policies on the appropriate use of psychotropic medications.

II. Primary Strategies, Goals and Action Steps

This section delineates the six primary strategies, goals and action steps for the five years of this plan. This plan represents an evolving process that will be enhanced as Virginia continues to learn. For each

strategy, the applicable Children's Services System Transformation outcomes, CFSR outcomes and Systemic Factors, and CFSR items that Virginia is striving to achieve are listed.

Virginia completed the second round of the Child and Family Services Review in July 2009. As a result of the review, a Program Improvement Plan (PIP) was developed. There are four Primary Strategies in the PIP that are incorporated into the 5 year plan strategies. Those strategies are:

1. Engage Families across the Continuum of Child Welfare
Goal: Ensure children, youth and parental input is heard and considered in the decision-making processes regarding safety, permanency, well-being, and service planning and placement decisions

2. Improve Assessment and Service Delivery
Goal: Appropriately assess safety, risk, and the needs of children and families in order to provide high quality, timely, efficient, and effective services.

3. Reengineer Competency Based Training System
Goal: Improve training and supervision in order to serve children and families through high quality, timely, efficient, and effective services

4. Managing by Data and Quality Assurance
Goal: Create a performance management system that utilizes data to inform management, improve practice, measure effectiveness and guide policy decisions

Both PIP strategies and non-PIP strategies will be reported in this section. If a PIP strategy was the same as what was indicated in the CFSP, the PIP strategy will take the place of the original strategy. PS in the follow sections stands for Primary Strategy.

I. Safe children and stable families

These strategies strives to assure the safety of children within their homes, protect children in at risk situations, and ensure they are protected from abuse and neglect in a permanent setting responsive to their well being. It preserves and strengthens intact families who ensure the safety and well-being of their children. It strives to prevent child maltreatment among families at risk through the provision of supportive family services.

- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 1; Safety Outcome 2; Permanency Outcome 1; Wellbeing Outcome 1; Wellbeing Outcome 3; Systemic Factor: Service Array and Resource Development
-
- **Applicable CFSR Items:** Item 1, Item 3, Item 4, Item 17, Item 23, Item 32, Item 33, Item 35, Item 36,

Goal: Protect children at risk of abuse and neglect

1. **Implement the Structured Decision Making *(SDM)* Model statewide**

a) Gain top level administrative commitment and provide organizational structure to support SDM.

b) Develop and implement a plan to gain support for SDM from local agency directors, supervisors, and direct child welfare staff.
c) Incorporate SDM philosophy, processes and practices into child welfare policy and guidance manuals.
d) Incorporate SDM tools into OASIS.
e) Develop and/or contract for the implementation of a comprehensive training program to support SDM practice.

Completed

PS 2 Obj. 1. Improve local department staffs' abilities to assess initial safety and risk

Strategy 1.1 Develop and/or revise and implement tools to improve local staffs' ability to improve response times to CPS reports

a) review SDM intake tools to ensure consistency with VA regulations and guidance
b) develop policy on timeframes for face to face contact with victims
c) obtain input from CPS policy advisory committee
d) incorporate intake tools in guidance manual
e) disseminate manual

Completed

Strategy 1.2 Revise CPS guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse.

a) review SDM safety and risk assessment tools to ensure consistency with VA regulations and guidance
b) obtain input from the CPS policy advisory committee
c) incorporate safety and risk assessment tools into guidance
d) disseminate guidance

Completed

Strategy 1.3 Develop and implement statewide training for CPS supervisors and workers on the use of new initial safety and risk tools.

a) develop training curriculum
b) select and train Trainers, to include CPS regional consultants and supervisors
c) develop statewide training schedule
d) train all CPS supervisors and workers on use of new tools

Completed

Strategy 1.4 Develop OASIS screens to reflect new CPS safety and risk assessments.

a) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and determine if current screens can be modified or if new screens must be created
b) meet with Family Services Managing by Data workgroup to determine requirements
c) implement new screens

Completed

Strategy 1.5 Quality Service Review will evaluate the extent to which initial safety and risk assessments are being completed correctly and within the required timeframes

2013 update

Twenty CPS ongoing cases were selected to review for this analysis. The cases listed were selected for this review because there was some SDM information (safety assessments, risk assessments, and risk reassessments) in OASIS. The localities that conducted risk reassessments are the localities that were using SDM before it was incorporated into guidance and required statewide. It appears that the reassessments are tied into the updating of the service plans. With each new referral, even if the ongoing case was already open, there was a new initial safety and risk assessment completed. SafeMeasures data was used to determine if first meaningful response was reached in a timely manner. Seventeen of the cases had first meaningful response times that fell within the response priority assigned to the case. Because of the limited timeframe of the QSR (30 days) and a different focus there cannot be a direct comparison to the initial safety and risk assessments. The SDM Risk Assessment tool looks at the likelihood of any occurrence or recurrence of abuse or neglect. The QSR's risk indicators are directed at the target child and his/her behaviors towards self and others, not the risk of recurrence of abuse or neglect by the family.

While there cannot be a one to one comparison between the QSR and the results of the SDM tools, several inferences can be made about these cases using both the QSR scores and reassessments that occurred close to the time of the QSR in the locality. Of the cases reviewed, sixteen had a safety or risk (and in some cases both) reassessment completed within two months, before or after the QSR. In eleven of those cases, having reviewed the QSR scores and narratives from the workbook, it seems that the QSR scores and reassessments are reflecting the same overall conclusions. Those children were deemed safe by the QSR and SDM tool. The remaining cases either did not have an SDM assessment or reassessment conducted within two months of a QSR or the SDM tools and QSR ratings did not match.

The information from this reviewed was shared with CPS program staff at the state level.

Strategy 1.6 Identify and implement tools for local staff to use in assessing safety, domestic violence, substance abuse, and mental health issues present in relative and other caregiver families.

2013 update

VDSS and the Resource Family Consultants identified that the LDSS particularly need assistance with assessing kinship families. VDSS requested T/TA from the NRC. A course titled "Mutual Family Assessment" was extensively revised as a collaborative effort between CRAFFT and the Resource Family Consultants and addresses the mutual family assessment process. It is designed to cover both policy/guidance adherence issues and assessment issues around safety and resource family capacity to provide quality care for children in foster care. A total of 41 local staff completed the course at its initial offering. The CRAFFT coordinators and Resource Family consultants are now offering this course regionally on an occasional, ongoing basis until such time as it is formally incorporated into the VDSS training system and/or an alternative training method is developed.

VDSS has purchased a statewide license for CWLA's Tradition of Caring curricula and mutual family assessment guide for kinship care providers. While CRAFFT coordinators have been providing Tradition of Caring pre-service training for some time, LDSS who provide their own training have not had access to the pre-service curriculum. Additionally, the Tradition of Caring assessment guide for kinship families includes elements of particular concern for kinship care giving families, including family legacies (child

abuse, substance abuse, domestic violence and mental health issues, etc). CRAFFT has begun training LDSS staff to train to Tradition of Caring pre-service curriculum.

The Kinship Project which Virginia is engaged with through a T/TA request to the NRC identified several goals related to kinship which have relevance to the goal of providing tools to local staff to use in assessing kinship care families. The first is a "script" to be made available to all child welfare staff to use to explain to relatives their options in terms of involvement with their child relative who has come in contact with the child welfare system. The options will include taking custody, becoming a foster parent, adoption and/or maintaining a life-long connection. The goal is to empower LDSS staff to have straightforward, meaningful conversations with relatives about their motivation and their capacity to provide care prior to children coming into foster care whenever possible- and as quickly as possible after entry into foster care if having the discussion prior was not possible. These conversations would then serve as the initial "assessment" of a relative family and help determine whether the family should be assessed further to become a resource family.

The Kinship Project workgroup has developed a draft VDSS Assessment Guide based on the work of Dr. Crumbley (an expert on kinship care) to be used with relative families interested in providing placement for their child relative. This guide is intended for use both prior to the child entering foster care and after a child is in foster care; it was designed for use in assessing informal kinship care or diversion arrangements as well as exploring relatives to provide placement as a foster family and potentially long term caregiver for a child in foster care. The guide needs further review by stakeholders and grammatical refinement. Once a draft is finalized, the NRC has offered to arrange to have Dr. Crumbly review it and then to work with the workgroup on developing a plan for implementation. This work is planned for the summer of 2013.

The final product of the work group is the development of a training for child welfare workers on working with kinship families. The group developed an outline of elements which should be included in the training which included full disclosure skills and how to use the Assessment Guide. Although this training is not intended to address this goal of the PIP, it is anticipated that as workers feel more comfortable and confident in their ability to work collaboratively with relatives their ability to assess issues in relative caregivers will improve. This training has been added to the list of required training for new staff in both Permanency and CPS and development of the formal curriculum is planned for the summer of 2013.

VDSS conducted a web-based survey of public and private (licensed child-placing agency) resource parents between March 21 and April 30, 2013. Email invitations for resource parents were sent through the Broadcast system to LDSS staff for distribution. The VDSS Licensing Division used their email distribution lists to similarly provide the email invitations for resource parents to Virginia LCPAs for distribution. Additionally, two LCPA organizations, VALCPA and FFTA-VA, were provided with the information to send to their member agencies. Finally, FACES (Foster, Adoption and Kinship families Association) sent the invitation via email to their resource family members.

The survey included questions about training, meeting the needs of the children within the home, participation in case decision making, relationship with biological parents, placement disruptions and general satisfaction. No identifying information was collected, and information about specific agencies was not requested. Participants' responses will be shared with LDSS and LCPAs as state-wide and regional aggregate data if regional differences are found to be significant. Two hundred sixty three individual resource parents completed the survey. Seventy-eight percent of respondents were LDSS resource parents. Fourteen percent were LCPA resource parents and the remainder reported they were approved both by LDSS and a private agency. All five regions were represented.

Initial data analysis found that 74% of respondents reported they were satisfied with the pre-service training they received, while 84% percent reported they were satisfied with the in-service training they received. Ninety-one percent of respondents indicated that they enjoyed being resource parents and 86% said that they would encourage others to become resource parents. Only 35% of respondents indicated that they had experienced a placement disruption in their home. For these, the leading cause was identified as inability to meet the child's behavioral needs (77.5% of disruptions).

Eighty percent of respondents indicated that they were satisfied with their relationship with the public agency with whom they worked. Additionally, there was a positive correlation among all respondents between being notified about, attending and feeling that their opinion is taken into account during Family Partnership Meetings, service planning/treatment meetings, and court hearings, and satisfaction. Satisfaction with communication with LDSS staff was also found to be correlated to overall satisfaction.

PS 4 Obj. 1. Increase use of data driven decision making in Virginia's child welfare system

Strategy 1.4 Develop a new report by locality on face to face contact with victims to be disseminated on a monthly basis

a) train regional consultants on face to face contact report
b) introduce the report as a data management tools for state CPS staff and local departments of social services

Completed

PS 2 Obj. 2. Improve local department staffs' abilities to conduct service needs assessments and develop relevant service plans.

Strategy 2.1 Revise CPS guidance manual to provide tools to support on-going assessment, risk reassessment and service planning for children and families' service needs

~~a) review SDM family strengths and needs assessment tools to ensure consistency with VA regulation and policy.~~
~~b) obtain input from the Child Protective Services Advisory Committee~~
~~c) revise on-going services section of CPS guidance to enhance and strengthen workers ability to assess and provide services to families~~

a) Obtain input from the Child Protective Services Advisory Committee on enhancing the current services section of the CPS manual
b) Work with NRC in home services to develop review tool for regional specialist
c) review 50 in home cases to assess quality and level of service provision statewide (10 per region) in order to determine strengths and weaknesses in policy/guidance/ practice

2013 update

The CPS Advisory Committee created a sub-committee to focus on the services section of the manual. The group provided input for a survey about the utility and compiled a list of problems with the existing service plan. The sub-committee was also used to field responses to the minor changes in guidance. They were sent the sections of policy, including the services section, for review and input. The committee also provided input for development of a field guide to use for safety and risk assessments. This field guide can be used by CPS staff in the field as a quick reference for key considerations in assessing safety and risk. It is not intended to replace the existing tools or procedures currently used by CPS but can enhance their use.

The National Resource Center for In-Home Services (NRC) has assisted VDSS in the design of a survey tool that was used for a case review of 53 CPS On-going cases conducted by the 5 regional policy consultants. VDSS provided input as to existing policy requirements and best practice framework to NRC and then worked in collaboration with NRC via email and phone conversations to develop a comprehensive tool that was easy to access and user friendly. The review tool was accessible through the internet and also available in PDF format so it could be used for future reviews. Ten cases were selected randomly from open cases during the month of November 2011 from each of the 5 regions. Each regional consultant was responsible for reviewing the records in the automated data system (OASIS) and completing the tool. Extra cases were reviewed and a total of 53 cases were analyzed by NRC.

Strategy 2.2 Revise Foster Care Guidance to provide specific tools to guide service workers in conducting child and family needs assessment and risk assessment prior to reunification.

a) Create workgroup to review tools and recommend tools to be used.
b) Obtain input from the Permanency Advisory Committee on recommended tools
c) Incorporate tools into Foster Care Manual
d) Disseminate guidance

2013 update

The Foster Care Manual, posted in April 2013, includes chapter 5 "Conducting Child and Family Assessments". This chapter goes into detail about the importance of assessments throughout the life of the case, beginning with the first contact in CPS and continuing through to the end of the case. The chapter details several types of assessments that are to be completed with the child and family. http://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/section_5_conducting_child_and_family_assessment.pdf

Strategy 2.3 Create requirements for OASIS screens to reflect new CPS and Foster Care service needs assessment and service plans

a) Utilize workgroup to review OASIS screens and make recommendations for screen changes
b) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and the workgroup recommendations and determine if current screens can be modified or if new screens must be created
OBRA and Family Services meet to develop requisition to present to the Managing by Data workgroup (MBD) to approve screen changes.
OBRA and Family Services meets with MBD prioritize timing for screen changes in OASIS

2013 update

Two Service Requests were submitted to the Division of Information Services (DIS) for this effort in updating OASIS. The Service Requests were accepted and approved for the commencement of work. Workgroups for business requirements specification and development were targeted for summer 2013 with a new production release targeted for early 2014. Subsequent to that timeline development, the VDSS administratively reorganized on April 1, 2013, affecting the structure and roles of the OBRA Unit, which previously had oversight of business requirements and development of OASIS, amongst other functions. Effective April 1, 2013, OBRA was transitioned out of the DFS to the Office of Research and Planning, and restructured as a data and research analysis unit. Oversight of OASIS and all DFS information management systems remains within DFS. The policy analyst within OBRA previously tasked with convening workgroups for the business requirements development of OASIS updates was also administratively reorganized out of OBRA to the Division of Workforce Development. Business requirements development remains a function of the Division of Family Services. Progression by DIS is

pending DFS identification of a resource for oversight of both the information management systems and business requirements development.

Goal: Keep children and families together through providing families with the necessary supports to safely raise their children.

1. **Prevent families from disrupting and children entering foster care** through providing prevention, support and family preservation services.
   a) Assess desired outcomes and service delivery in the Promoting Safe and Stable Families Program *(PSSF)*.
   b) Identify and promote best practice service models for prevention, family preservation and support to localities annually and as requested.
   c) Design and present training annually for localities on the use of the PSSF funding incorporating the principles of the Children Services Transformation and the CFSR outcome measures.
   d) Disseminate the Child Welfare Funding Package in sufficient time annually for localities to complete a community needs assessment and develop a comprehensive proposal.
   e) Collect, analyze, report and monitor the use of PSSF funds annually in accordance with federal requirements.

2013 update

Item 1a.
To meet the deadline for submission of the APSR the PSSF Year-End Report uses three quarterly reports (within the period June, 2012- February, 2013) and a summary report that includes total number of children and families served, data on ethnicity, priority services and services delivered using recognized best practice models. At the time of preparation for this APSR report, 98 localities had submitted complete Year-End Reports. This is 86 percent of the 114 localities with SFY 2013 approved plans. This is an increase in total year-end reports that were received in 2012 for the APSR (total received in 2012 was 92 compared to 77 in 2011). Approval for continued SFY 2014 PSSF funds to localities is contingent upon submission of the year-end report and this requirement seems to encourage compliance with reporting.

Item 1b.
Family Partnership Meetings (also known as Family Engagement Meetings) continues as an important practice model and tool used in the delivery of services to families.

Scott County DSS: "The progress this agency has had in working with families through this program has continued to be positive. There are limited resources in this area, so it is an immediate response to aid CPS in providing services to families without going through a lengthy referral process. Introductions and information sharing are easier since it is in-house. The Family Partnership Meetings have been instituted into the CPS process and this had been beneficial to all involved."

Henrico County: The Family Engagement Model/Family Partnership Meetings has provided consistent opportunities for parents, relatives, community partners and identified service providers to have input into the child and family service plan. Over 125 family partnership meetings have occurred through DSS and this service has been utilized by other local agencies such as, Mental Health and Court Services."

There also appeared to be more reporting on parent skills training focused on different levels of child development and needs. In the table that follows, some of the curricula used by the localities are highlighted:

Table 1: Curricula Used By Localities and by Service Types

Curriculum	Description
Parents as Teachers (PAT) for Home Visitors Petersburg Health Department CHIP (Family Support) – Donna Rohde 804.861.4720 Brad Burdette, Appomattox County 434.352.7125	Identified as an evidence-based practice that focuses on three domains: Parent-Child Interactions, Development-Centered Parenting, and Family Well-Being. PAT is accomplished through four interrelated service delivery components: home visits, group connections (parent groups), screenings (ASQ), and connections to resources/services.
Are We There Yet? – birth to 11 **Parenting Today's Teens** Spotsylvania DSS (Family Preservation) Mary Holloway 540.507.7845	Uses multifaceted presentations to reach different learning styles. The key concepts covered include: child development, safety, effective communication, stressors, self-esteem, conflict resolution, problem solving, single and step-parenting, effective discipline techniques, parenting styles and community resources. These classes have a positive and strength based approach and is based on the belief that parents care about their children and need current information and effective tools to face the challenges of parenting in today's world.
Active Parenting Today **Active Parenting of Teens** **1,2,3,4 Parents** **I Am Your Child Series** Stafford DSS (All service types) Kimberly Strader 540.658.4284	Some of the topics covered are: how parenting is our most important job, instilling courage and self-esteem in our children, understanding our children, teaching our children responsibility and cooperation, and how to be an effective, active parent in today's society.
Nurturing Program (Family Support and Family Preservation) Fairfax DSS Rhonda Richardson 703.324.7734	The Nurturing Parenting Program is an internationally recognized, group-based approach for working simultaneously with parents and their children in reducing dysfunction and building healthy, positive interactions. The program uses curriculum for the following classes: Ages 0-4 (English and Spanish), Ages 5-11 (English and Spanish), Adolescent (English), Ages 0-4 and 5-11 African American Cultural Focus (English) and Teen Parents (English).
Systematic Training for Effective Parenting – STEP & Active Parenting/Padres Activos Arlington DSS	STEP is for young children through teens. Parents in the program report they have learned helpful parenting skills, to help them to better understand their children. Individual parents are assessed using the STEP surveys. These are administered as both pre and post tests. Additionally, a Parent Feedback Form is completed by the facilitator for each parent that completes the program. This is similar to a report card and provides a snapshot of the

Table 1: Curricula Used By Localities and by Service Types	
Curriculum	**Description**
Cheryl Fuentes 703.228.1551	parent's participation, engagement and application of material learned.
Comenzando Bien (Family Support and Family Preservation) – Loudoun County Beth Rosenberg 703.771.5881	Comenzando Bien is a prenatal education program for Hispanic women. It takes into account the unique needs of the Hispanic pregnant women and their families. It is culturally and linguistically relevant and appropriate for implementation in a variety of settings. Other Resources: 1. Nurturing Parenting; Teaching Empathy, Self-Worth and Discipline to School Age Children – by Stephen Bavolek, PhD 2. Nurturing Program for Parents and Their infants, Toddlers and Preschoolers – by Stephen Bavolek, PhD 3. Crianza Con Carino, Programa Para Padres E Hijos - Stephen Bavolek, PhD 4. Parenting Your Out of Control Teen – by Scott Sells, PhD Lessons were designed to help parents acquire best practice techniques that would improve their overall parenting skills and positive ways of interacting with their children.
	Early Head Start uses the following curricula: • Family Preservation Assessment, Ages & Stages/Denver II • Early Intervention (Developmental Assessments and/or Interventions) • Parents as Teachers
Strengthening Families Program (SFP) (Prevention Services through the CSB) City of Norton Glenda Collins 276.523.5064 Radford-Leslie Sharp 540.961.8355 & other localities	SFP (Kumpfer & DeMarsh, 1989; Kumper, DeMarsh, & Child, 1989) is an evidence-based 14 week family skills training program that involves the whole family in three classes run on the same night once a week. The parents or caretakers of high-risk youth attend the SFP Parent Training Program in the first hour. At the same time their children attend the SFP ages 6-11 Skills training Program. In the second hour, the families participate together in a SFP Family Skills Training Program.
Master Financial Volunteer Education through Virginia Polytechnic Institute and State University (VT) Corinne Brace, Shenandoah Valley 540.245.5914	Topics covered are Financial Management Services/Budgeting; Self-Sufficiency and Life Management Skills; Positive Solutions for Families.

Additional Programs and Initiatives

It is also worth noting the frequent identification by localities of the **Virginia Cooperative Extension Service** to conduct parent skills training and to train families around meal planning and nutrition. 4-H

Leadership Training is provided to youth. The Extension Service was also identified as a resource for after school and summer activities for older children, and for incarcerated fathers.

PSSF is one of several funding streams that help fund services delivered under the Healthy Families Program in localities. Localities report that **Healthy Families** consistently produces excellent child abuse prevention outcomes at the local, state and national level. The program is evaluated annually by the College of William and Mary in conjunction with Lee Huntington and Associates. The Petersburg PSSF report provided the following Healthy Families outcome: "*98% of children were covered by insurance as compared to 73% at the time of program enrollment; 98% of children were connected to a medical home as opposed to 67% at enrollment; 95% of children were fully immunized, a 33% increase from time of enrollment; 94% of children were connected to a dental home; 90% of children were regularly screened for developmental delays.*"

An increasing number of localities are enhancing services provided to families by focusing on the needs of fathers through support groups, parenting skills and employment training services. Additionally, a fatherhood initiative grant is available for community-based organizations that partner with faith-based and local governments. Some examples are below:

Fathers In New Directions (FINDS), Chesapeake DSS [Non-grant specific funding] -
The FIND Program provides support, employment resources, financial assistance and groups for fathers in Chesapeake area. The program is ongoing and now has 52 active participants. The FINDS program currently has 48 out of 52 participants employed full-time, whereas none of the fathers were employed when they came into the program.

Other Fatherhood Programs/services under the non-grant specific funding included: King William County, Loudoun County, Portsmouth, Norfolk, Roanoke City, Shenandoah County and Virginia Beach.

GRANTS: Family Strengthening & Fatherhood Initiative
VDSS awarded $449,614 during December 1, 2011 – November 30, 2012 to support 8 community-based programs addressing the areas of responsible fatherhood, healthy marriage and relationships, effective parenting, and youth development. The target populations include families with children ages 0-12, families with youth ages 13-19, non custodial parents and custodial parents. Key focus areas of this funding include strengthening the non‐custodial father's everyday emotional and financial role in the family and in the lives of his children; and supporting evidenced-based fatherhood, family preservation and family strengthening projects and programs. Contractors undergo a rigorous sub-recipient monitoring evaluation during the grant year. Grantees were the following:

1. Capital Youth Empowerment Program (CYEP), Alexandria, VA – "Fathers in Touch" (FIT) program for non-custodial fathers ages 16 and older involved in child abuse and neglect, domestic violence, foster care and child support cases.

2. Center for Child & Family Services (CCFS), Hampton, VA – "Not in the Home but in the Heart" program for fathers, 15 and older, unmarried, married, separated, or divorced with at least one child from newborn to 19 years of age.

3. Chesterfield Community Services Board (CCSB), Chesterfield, VA – *"Within Our Reach,"* is an empirically based program designed to strengthen low-income couple relationships in committed relationships and parenting children under the age of 18.

4. Child Development Resources (CDR), Norge, VA – "*Building Secure Families"* (BSF) program targeting expectant families and those with newborns and families with incarcerated fathers and with children under age 12. *Linkages: Building Strong Connections* that provides one-on-one coaching,

parenting education and family support services for incarcerated fathers and their child's birth mother or caregiver.

5. For the Children Partners in Prevention (FTC), Martinsville, VA – Partners in Prevention program involves a network of 40 health and human services groups, with a focus on youth development, responsible fatherhood, marriage and relationship education and marriage mentoring.

6. Highlands Community Services Board (HCSB), Abingdon, VA – Developed a project identified as "Project Dads." The project targets noncustodial/nonresident fathers and is implemented through the 24/7 Dad curriculum, by offering a 12-session educational program focusing on key fathering characteristics such as, masculinity, discipline and work-family balance.

7. New Jubilee Education & Family Life Center (NJEFLC), Richmond, VA - The project includes **"**Connections: Relationships and Marriage curriculum" delivered to 100 selected males at Armstrong High School which has a predominately African American student population. It includes 25 weeks of one-hour in class sessions, five weeks each on the topics: Personality, Relationships, Communication, Marriage, and Money & Budgeting.

8. Rubicon, Inc**.** (RI), Richmond, VA – Developed a program focusing on single and married fathers in its residential and/or outpatient substance use disorder treatment community. The program promotes participation in various kinds of relationship-enhancing activities through increased exposure to healthy lifestyle options, character building, and broadening of cultural and artistic exposure.

Table 2:
Family Strengthening & Fatherhood Grantees
Children and Families Served

	SFY 2012	***SFY 2013***
Total Children	628	1009
Total Families	614	1020

Table 3: **Curricula Used By Family Strengthening & Fatherhood Grantees**

Curriculum	Description
24/7 Dad , InsideOut Dad, Boyz2Dads , DoctorDad, Mom As Gateway, and Why Knot Capital Youth Empowerment, Center for Child and Family Services Highlands Community Services Board	The National Fatherhood Initiative (NFI) has developed a large series of curricula to meet the needs of fathers that are researched, evaluated, and/or evidence-based. NFI has conducted a number of evaluations on the effectiveness of its products and programs. The evaluations show positive, statistically-significant increases occurred in parenting skills and knowledge among the fathers who participated in the program. 24/7 Dad™ is a comprehensive fatherhood program available with innovative tools, strategies, and exercises for fathers of all races, religions, cultures, and backgrounds. Developed by fathering and parenting experts, it focuses on the characteristics men need to be good fathers 24 hours a day, 7 days a week. Independent, third-party research shows that 24/7 Dad™, improves attitudes towards fathering, fathering knowledge, and fathering Skills**.** InsideOut Dad™ is the only **evidence-based** reentry program in the country designed specifically for incarcerated fathers. It develops pro-fathering attitudes, knowledge, and skills, and provides fathers with strategies to connect them with their families and prepare them for release. Standardized programming for 24 states and Washington, D.C., and the City of New York's corrections system, InsideOut Dad™ helps reduce

Table 3: Curricula Used By Family Strengthening & Fatherhood Grantees	
Curriculum	**Description**
	recidivism rates by reconnecting incarcerated fathers to their families. Boyz 2 Dads™ helps teen boys connect their choices to consequences and guides their attitudes around important decisions and risky behaviors. Dads, moms, educators, mentors, social workers, or any concerned adult can use this program to help prepare boys to make healthy choices on topics like relationships, sex, and peer pressure. Research shows that Boyz 2 Dads™ has positive effect on teen boys' attitudes and knowledge of how their choices affect their lives. DoctorDad™ is a workshop designed to reach new and expectant Dads to help increase fathers' health literacy by providing men with the knowledge and skills they need to successfully care for their young children right from the start. Mom As Gateway™ is a workshop that helps to break down barriers between mothers and fathers by addressing what is known as Maternal Gatekeeping - when a mother's belief about a father, as well as her behaviors, hinder a father's involvement - and facilitate helpful discussions and efforts towards co-parenting. Why Knot? ™ is a Marriage-Readiness curriculum for men that prepares them for healthy relationships and equips them in making decision around marriage. This training helps men breakdown common misconceptions about relationships and marriage, equips them with important relationship skills, and helps assess their readiness for marriage. Created for men ages 18-30, to compliment programs that provide relationship skills critical to sustaining healthy marriages.
Within Our Reach and Within My Reach Chesterfield Community Services Board	*Within Our Reach,"* is an empirically based program designed to strengthen low-income couple relationships in committed relationships and parenting children under the age of 18. The curriculum is designed to build on the existing strengths of couples and add critical life and relationship skills that will help them create safer, more stable couple relationships, and by extension, better environments for children. This program is a product of the Center of Marital and Family Studies at the University of Denver. It is an adaptation of the PREP curriculum (Prevention and Relationship Enhancement) curriculum, which has been taught by Chesterfield Prevention Services for 15 years. Both *Within Our Reach* and PREP are founded on best practices, including strategies that are empirically informed, both are currently being empirically tested in outcome studies, and both are regularly refined based on new scientific knowledge in the field of research on relationships. *Within My Reach* (WMR) is an adaptation of the PREP curriculum a relationship skills and decision making program for helping individuals achieve their goals in relationships, family, and marriage. The curriculum is especially tailored for those who have struggled with economic disadvantage. WMR is a 15 hour program developed by PREP that is a non-couples based curriculum designed to help economically disadvantaged adults (most typically who are already parents, but not necessarily) who are at risk for poorer quality relationships and relationship instability.
Rookie Dads and Linkages: Building Strong Connections Child Development Resources	Rookie Dads' trains expectant dads to be involved in the care of their new baby. The two-hour class gives men a chance to gather with other men to talk about what to expect from their new role; discuss concerns; and learn about feeding, diapering, bathing, and sleeping techniques in a safe, supportive arena. Rookie Dads PLUS is a special program for Rookie Dads graduates. It offers dad/child playgroups; developmental screening; home visits; resources and information on behavior, potty training, and development; dad discussion groups; and

Table 3: Curricula Used By Family Strengthening & Fatherhood Grantees	
Curriculum	**Description**
	dinner out gift cards for couples. Linkages: Building Strong Connections provides weekly parenting education sessions, one-on-one coaching, and family support services for incarcerated fathers and their families. The sessions address parenting topics such as child growth and development, positive discipline, communication, and co-parenting. The program is operated in collaboration with Virginia Cooperative Extension's Family Focus program and the Virginia Peninsula Regional Jail.
PREARE/ENRICH For the Children	PREPARE/ENRICH is a customized couple assessment completed online that identifies a couple's strength and growth areas. It is one of the most widely used programs for premarital counseling and premarital education. It is also used for marriage counseling, marriage enrichment, and dating couples considering engagement. Based on a couple's assessment results, a trained facilitator provides 4-8 feedback sessions in which the facilitator helps the couple discuss and understand their results as they are taught proven relationship skills.
Connections: Relationships and Marriage New Jubilee Education & Family Life Center	Developed by the Dibble Institute for Marriage Education, a nonprofit organization, that helps young people learn how to create healthy romantic relationships now and in the future. It offers tools for teaching the practical skills essential for enhancing friendships, dating and love. Connections is based on decades of research developed and refined through the Prevention and Relationship Enhancement Program (PREP). PREP is the core of Connections, being empirically informed and tested. The Connections curriculum has been evaluated to be successful at improving healthy relationship knowledge and behaviors when implemented in high school settings. It is designed to teach students to develop healthy relationships and marriages It also is effective at improving parent-child relationships, and reducing the risk factors associated with teen pregnancies. It has been effective for diverse groups of participants and widely used across the country in classrooms, social agencies, after school programs and other youth settings. One study evaluated the effectiveness of this curriculum with 375 students from rural Midwest high schools who were in either the Connections group or in another Family and Consumer Sciences course. Findings suggest that students taking the Connections curriculum improved in their conflict resolution skills, became less likely to see divorce as a good option for troubled marriages, and were more likely to take advantage of pre-marital and post-marital programs to build better marriages.
Prevention and Relationship Enhancement Program (PREP) Chesterfield Community Services Board New Jubilee Education & Family Life Center	Based on over twenty years of research, PREP teaches marital/premarital couples essential skills: how to communicate effectively, work as a team, solve problems, manage conflict, and preserve and enhance love, commitment and friendship. PREP has extensive experience in training mental health professionals and clergy in civilian and military settings to conduct PREP Workshops and/or use the concepts in their practice. The goal of PREP is to modify or enhance those dimensions of couples' relationships that research and theory have linked to effective marital functioning. Using techniques of cognitive-behavioral marital therapy and communication-oriented marital enhancement programs, PREP aims to help couples maintain high levels of functioning and prevent marital problems from developing.

Item 1c

Due to a need to prudently manage resources of program staff and available funds statewide training for PSSF was not provided. However, one-on-one technical assistance was provided to localities regarding how to complete the reporting forms and how to apply for funding.

Item 1d

This report is year four of the five year funding cycle. The comprehensive Community Needs Assessment was completed leading up to year one (SFY 2009-2010). Only when a locality is making major changes to its services is a new Community Needs Assessment required. This approach reflects efforts by PSSF home office staff to streamline the annual application process. At this time, May, 2013, 114 of the 120 localities have approved plans for SFY 2013. Localities renewing their application for funding in a timely manner reflect outcomes of staff sub-recipient monitoring through desk-top assistance and telephone feedback.

Item 1e

Information is reported by localities on a fillable report form that is then entered into an Excel database by PSSF state staff. The tables below show the children and families served by service type and the ranking of most frequently provided services.

Table 4: Children and Families Served by Service Type

98 Agencies Reporting

Service Type	*Total Children*	*Total Families*
Preservation	*5615*	*3828*
Support	*7401*	*5892*
Reunification	*1149*	*741*
Adoption (1)	*26*	*22*
Other PSSF Services (2)	*61,343*	*58,322*
Total	*75,534*	*68,805*

(1) $2M PSSF funds were allocated for adoption initiatives at the home office level, therefore, localities were not required to spend 20% on adoption promotion. This number includes localities that provided local adoption services.

(2) Some localities provided services that do not lend themselves to identifying data, as they are not targeted toward specific individuals or families (e.g., community fairs, brochures, information and referral, newsletters, library resource centers, websites, etc.)

Table 5: SFY 2010-2013

Top Five Services Most Often Provided to Families

(rankings based on a total of 31 possible service codes)

Service Type	***1st***	***2nd***	***3rd***	***4th***	***5th***
Family Preservation	*Housing or Other Material Assistance*	*Parenting Education*	*Intensive In-Home Services*	*Substance Abuse Services*	*Assessment*
Family Support	*Housing or Other Material Assistance*	*Transportation*	*Case Management, Mentoring and Socialization and Recreation*	*Information and Referral*	*Education/School Related Services*
Reunification	*Transportation*	*Housing or Other Material Assistance*	*Assessment and Counseling Treatment: Individual*	*Parenting Skills Training*	*Parenting Education*

Examples of program challenges cited in the 2013 year end reports:

"Pregnant teens who are carried under their parents' health insurance do not have coverage for prenatal care. Teen parents lack childcare which interferes with their ability to return to school. Fathers are unaware of their rights as parents." (Appomattox)

"We continue to have an overwhelming amount of referrals from people who have cut off notices in hand and want the bill paid that day. Many of those individuals have balances that have not been paid on in

several months and many of these clients decline budgeting assistance. We have been able to point families to other resources." (Augusta)

"Psychiatric services were requested for a youth after suicidal ideation was known...with plan and due to limited psychiatric hours, (the youth) is on a wait list."

Family stress remains high as a result of the unemployment rate...almost double the Virginia average. (Brunswick)

Lack of resources for homeless families and families living in hotels to move forward and maintain stability continues to be a challenge.

This agency continues to have heavy demand for purchase of service, with the majority of funds exhausted. Families present with complex issues, particularly substance abuse, domestic violence, and mental illness. Intensive preservation services address lifestyle issues that compromise the ability of children to remain in their homes. The agency has received an inordinate number of service referrals from the court upon a custodian's petition for relief of custody. These cases involve birth parents, adoptive parents, and other family/surrogate family members who are custodians. The ongoing CPS staff is working to better address childhood trauma, techniques for foster care diversion and in response to substance abuse recidivism. (Campbell County)

Newly enrolled refugee families take much longer to assess and provide education. (Charlottesville/Albemarle County)

Parents trying to work and arrange child care... particularly for those in school (Charlottesville/Albemarle County)

Families working two jobs make it hard to both connect with them and because they work two jobs they are frequently really stressed when they are home. (Charlottesville/Albemarle County)

Families with increased financial stressors alone present more challenges for staff who try to help move them in a more positive direction while also helping them focus on their children's needs. Additionally increased drug usage, diagnosed but untreated mental illness, and/or undiagnosed mental health issues present greater challenges for staff when working with families on goal plans and parenting skills. Mental health service providers have raised criteria for what meets individual needs and increased group counseling sessions. Many parents in needs of counseling are not comfortable in group setting and are therefore not receiving needed services (Montgomery)

Our locality continues to have limited opportunity to provide services in the evening when it would be most convenient for working families with children. During this fiscal year, the agency has begun extending hours one night per week to allow families to receive counseling services after normal business hours. (Matthews)

With the growing drug problem, screening of individuals is a necessity in order to insure a child's safety in the home. This also means that the cases can become extremely long-term due to the length of time required for clients to receive treatment and become drug-free. Also, the amount of placements diversions has increased in order to decrease the number of children in foster care. This requires much more work and often results in a change of custody to another family member in the end. (Scott)

Table 6: Children and Families Referred to the PSSF Program							
Measures: Outputs and Outcomes		*SFY 2009* *74 localities reporting*	*SFY 2010* *90 localities reporting*	*SFY 2011* *77 localities reporting*	*SFY 2012* *92 localities reporting*	*SFY 2013* *98 localities reporting*	*SFY 2014*
Number of families receiving PSSF services		*9,790 families 13,316 children*	*8,572 families* *11,417 children*	*7,807 families* *9419 children*	*10,726 families* *18,867 children*	*10,474* *Families* *14,185* *children*	
	Of this number, children who enter foster care will not exceed 5%	*331=2%*	*181 = 1%*	*228 = 2%*	*191=1%*	*188=1%*	
Number of families whose children are in foster care 15 mos. or less who receive reunification services		*1,409 children in* *889 families*	*1,104 children in* *692 families*	*985* *children in 731 families*	*1,048 children in 699 families*	*1,141* *children in* *738 families*	
	Number of children targeted for Reunification at the end of the year	*1268*	*488*	*436*	*512*	*515*	
	Number of children reunited with their birth family during the year	*376*	*289*	*218*	*184*	*227*	
Number of children placed w/relatives other than the natural parent who was the last custodian		*195(1.5%)*	*142 (1%)*	*154 (1.6%)*	*180(1%)*	*145(1.2%)*	
Number of children for whom a new abuse complaint was		*79* *(less than*	*45* *(less than 1%)*	*56* *(less than*	*118* *(less than*	*103* *(less than*	

Table 6: Children and Families Referred to the PSSF Program						
Measures: Outputs and Outcomes	*SFY 2009* *74 localities reporting*	*SFY 2010* *90 localities* *reporting*	*SFY 2011* *77 localities reporting*	*SFY 2012* *92 localities reporting*	*SFY 2013* *98 localities* *reporting*	*SFY 2014*
made/baseline = 6.1%	*1%)*		*1%)*	*1%)*	*1%)*	
Number of families by ethnicity *(*based on the ethnicity report)*	*42%* *African American* *44% Caucasian* *10% Hispanic* *3%* *Asian or other race*	*50% African American* *54% Caucasian* *13% Hispanic* *3%* *Asian or other race*	*39%* *African American* *41% Caucasian* *13% Hispanic* *7%* *Asian or other race*	*34%* *African American* *49%* *Caucasian* *13% Hispanic* *4%* *Asian or other race*	*32%* *African American* *44%* *Caucasian* *13%* *Hispanic* *11%* *Asian or other race*	

*Localities are asked to discuss how staff communicates effectively with families where English is their second language. Below are some of the responses:

"The Family Support and Preservation service agencies employ bi-lingual staff (Spanish/English). DSS does not have bi-lingual staff; we hire translators as needed. In addition, the City of Petersburg has recently employed a Hispanic liaison who will be available to help with interpreting and translating." (Petersburg)

"Bi-lingual social worker is employed by the agency." (Page County)

"Spanish is the primary second language in Prince William County. All programs have bi-lingual staff, materials translated into Spanish, and use interpreters were warranted. Materials include flyers, correspondence, curriculum, and assessments. In addition, the programs must address low literacy in both populations. As a note Prince William County is officially a minority community. ...Staff utilize specialized curriculum that includes visual aids and graphics to make the home visiting a more culturally sensitive and comprehensive experience. While we continue to have a large percentage of Spanish speaking families we are seeing an increase in families from the continent of Africa; where a variety of languages are spoken. Most of these families have some level of English proficiency and staff has attended a penal discussion and training on working with families from Africa to enrich their cultural competencies. We have found and used a provider who speaks Armenian and Russian. Virginia

Cooperative Extension provides all of their parenting classes in both English and Spanish. All Spanish instructors are native speakers with an understanding of the issues facing immigrants." (Prince William)

Summary of Service Array Findings

Based on locality reports, (Tables 7 – 9) that follows are a composite of the most frequently used services during Fiscal Years 2010, 2011, 2012 and 2013. The rankings are based on the frequency by which each service was applied to assist a family. Based on the PSSF Service Array 31 allowable services; Assessments, Parenting Education, Housing and Other Material Assistance, and Transportation were most often applied to prevent family crisis and/or to achieve the goal of return home. These findings are consistent with those reported in the statewide assessment for the 2009 CFSP. At that time, VDSS requested ldss and their local partners (localities) to complete two surveys. The findings are in Virginia's Five Year Plan for Children and Family Services 2010 – 2014 available at: http://www.dss.virginia.gov/family/cfs_plan.pdf

Based on the 2009 survey findings, Assessments and Parenting Education are widely used in local agencies; 95% of the respondents indicated they conduct client needs assessments; and that parent education services are available in their locality. The majority of respondents *(80%)* felt that parenting education programs were community-based and family-centered.

Localities indicated substantial gaps in the availability of primary services such as Transportation, Housing and Substance Abuse Counseling; that would allow parents to more fully participate in parenting and other family strengthening services. Transportation was a 'Gap' and/or 'Need' for all VDSS regions.

Table 7: Family Preservation Summary
Most Frequently Provided Services

Year	Ranking							
2013	**#5**	**n/a**	**n/a**	**#1**	**#3**	**#2**	**#4**	**n/a**
2012	**n/a**	**#3**	**#4**	**#1**	**#2**	**#2**	**n/a**	**#5**
2011	**#4**	**#5**	**n/a**	**#1**	**#3**	**#2**	**n/a**	**n/a**
2010	**n/a**	**#5**	**#4**	**#1**	**#3**	**#2**	**n/a**	**#4**
Service Code	020	030	050	**130**	150	211	235	260

Table 8: Family Support Summary
Most Frequently Provided Services

Year	Ranking									
2013	**n/a**	**n/a**	**#5**	**#1**	**#4**	**n/a**	**#3**	**n/a**	**n/a**	**#2**
2012	**n/a**	**#3**	**n/a**	**#2**	**n/a**	**n/a**	**n/a**	**#1**	**#4**	**#5**
2011	**#4**	**#3**	**n/a**	**#2**	**n/a**	**#5**	**n/a**	**#1**	**#5**	**n/a**
2010	**#5**	**#4**	**#5**	**#2**	**n/a**	**#4**	**#3**	**#1**	**n/a**	**n/a**
Service Code	020	030	090	130	140	150	180	**211**	213	260

Table 9: Time-limited Family Reunification Summary
Most Frequently Provided Services

Year	Ranking								
2013	**#3**	**n/a**	**#3**	**#2**	**n/a**	**#5**	**#4**	**n/a**	**#1**

2012	**#5**	**n/a**	**#1**	**#3**	**n/a**	**#4**	**n/a**	**n/a**	**#2**
2011	**#1**	**n/a**	**#3**	**#2**	**n/a**	**#5**	**n/a**	**#3**	**#4**
2010	**#1**	**n/a**	**#2**	**#2**	**#5**	**#2**	**n/a**	**n/a**	**#1**
Service Code	**020**	030	**050**	130	150	211	213	235	**260**

Most Frequently Provided Services

Service Array Code Legend:

020	Assessment	030	Case Management
050	Counseling and Treatment-Individual	090	Educational/School Related Services
130	Housing or Other Material Assistance	140	Information and Referral
150	Intensive In-Home Services	180	Mentoring
211	Parenting Education	213	Parenting Skills Training
235	Substance Abuse Services	260	Transportation

II. Family, child and youth-driven practice

This strategy fulfills the mission of transforming how services are delivered by giving a stronger voice to children and families in decision-making. The state practice model enables families to actively engage with child welfare staff and other important stakeholders in facilitated meetings to collaborate on the key decisions *(such as placement or moves)* that affect a child's life. Through collaboration, the practice model is achieved according to individual circumstances while empowering families to participate in the process.

- **Applicable Children's Services System Transformation Outcomes:** Permanency Outcomes: Increase Permanency Discharges, Decrease Time to Permanency Discharge; Family Based Care: Increase Family Based Care, Increase Kinship care; Congregate Care Reduction: Decrease number of youth in congregate care, Decrease time spent in congregate care

- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 2; Permanency Outcome 1; Permanency Outcome 2; Wellbeing Outcome 1; Systemic Factors: Staff and Provider Training, Service Array and Resource Development, Foster and Adoptive Parent Licensing, Recruitment, and Retention

- **Applicable CFSR Items:** Item 3, Item 4, Item 6, Item 7, Item 8, Item 9, Item 10, Item 11, Item 12, Item 14, Item 15, Item 16, Item 18, Item 32, Item 33, Item 34, Item 35, Item 44 & Item 45

Goal: Engage families in decision making using a strength-based, child-centered, family-focused and culturally competent approach

1. Implement a state-endorsed Family Engagement Model

a) Develop and implement a plan for providing a consistent statewide approach to family engagement.

- Enhance and increase the involvement of parents, children, youth, and other significant social network members in service delivery, policy and program development and evaluation.

- Assess LDSS' needs, training, intersection with CSA, documentation in OASIS, and evaluation of practice.
- Develop resources and tools for service providers to more fully engage parents, youth and other significant individuals in planning, implementation and evaluation processes.

b) Train selected service providers and state/regional staff on strategies for engagement on a regional basis.
c) Establish a plan for regional staff to provide training and technical assistance to localities on family engagement strategies.
d) Survey selected programs to determine the level of change in involvement and recommendations for improvements.
e) Develop and implement recommendations to improve parent, youth and other significant individual's involvement.

2013 update

Continued efforts have been made by VDSS to support the practice of family engagement. A family engagement newsletter featuring promising local agency practice, tips and training information is published quarterly.

In collaboration with the QA Unit, a presentation for child welfare supervisors on the use of Child and Family Team meetings, a meeting model which promotes continuous family engagement and teaming, was provided in 4 of the 5 regions. The presentation will be made in the 5th region during FY 14. The written description and supporting written materials regarding family engagement, voice and choice and teaming have been made widely available to supervisors and staff across the state. This Spring, the Training Unit provided a Subject Matter Expert (SME) training series on teaming in child welfare practice and incorporated the materials developed by the Family Engagement and QA Program managers. This training was attended by workers and supervisors in all five regions and additional training sessions have been added due to its popularity.

An additional effort to support local agencies included the availability of funding. In FY 2013 local agencies were eligible to receive FPM Incentive Funds for valid documented meetings in OASIS. Incentive funds were distributed quarterly to local agencies in state FY 13 and were used to fund facilitators or facilitator coaches, transport family members to Family Partnership Meetings, purchase equipment for FPM, fund staff training, or create resources to support families. FPM Incentive funds will not be available again in FY 14. Although included in the Department's budget request, the General Assembly allocated these funds elsewhere.

In FY 14, VDSS staff will focus on supporting regional Family Engagement Roundtables. In some regions, these quarterly meetings where local agency staff share concerns and suggestions with each other and receive technical assistance from the regional consultants have continued to be held on a quarterly basis. In other regions, they have been held less often, and geographical constraints have hindered regular local agency staff participation. VDSS staff will work with regional consultants to insure that Family engagement Roundtables are being held in each region on a quarterly basis, and where advisable, the local of the meeting may vary in order to make it more accessible to staff across the region. Presentations regarding FPM model fidelity, workers' understanding of and comfort with family engagement, training of community partner staff, and the importance of teaming as an agency practice will be included.

PS 1 Obj. 1. Utilize Family Partnership meetings as a way to involve families, youth, and significant others

Strategy 1.1 Develop Family Partnership resources and tool kit for service providers, relevant family service contractors, and LDSS to share with families
a) Post local and national sample documents such as brochures, forms, contact information
b) Post family engagement guidance

Completed

Strategy 1.2 Train LDSS workers and members of the bar on Virginia's Family Engagement Model including Family Partnership meetings, Diligent Family Search and Engagement.
a) develop curricula, in conjunction with VISSTA, based on FEM guidance
b) develop training phases for LDSS and determine which localities will be trained in which phase
c) schedule training for members of the bar
d) evaluate trainings

Completed

Strategy 1.3. Revise CPS and Foster Care guidance manuals to support family engagement philosophy and partnership meetings.
a) review Family Engagement guidance
b) review current program guidance to identify key decision points
c) obtain input from the Permanency Advisory Committee and the Child Protective Services Advisory Committee
d) coordinate language across CPS and foster care programs and incorporate consistent language in the respective guidance manuals
e) disseminate guidance in CPS and foster care manuals

Completed

Strategy 1.4. Increase the number of family partnership meetings
a) Set the expectation that each locality within the state will implement Family Partnership Meetings at at least one decision point by the end of the calendar year 2010
b) Review the Family Partnership report to inform technical assistance needs
c) Provide technical assistance through Regional Consultants

2013 update
As of the end of September 2012, 119 of 120 Local Department of Social Services were meeting VDSS' requirement that they have Family Partnership Meetings (FPMs) at critical decision points in child welfare cases. There is still work to do in regards to full implementation. Many small localities continue to struggle to hold FPMs at all 5 decision points. This is primarily due to two issues. First, in smaller agencies where staff "wears multiple hats" there is a very real challenge to identify a neutral facilitator, that is, a staff person who doesn't already have a relationship to the family. Additionally, it is not feasible to have a dedicated FPM facilitator, and therefore, when a meeting needs to be scheduled urgently, a trained facilitator or a neutral facilitator may simply not be available. The second issue if that in these smaller agencies, critical decision points arise very infrequently, which has the effect of limiting the experience and also confidence of staff and FPM facilitators in the process.

Many LDSS staff report that the FPM process both works and permits them to do more meaningful work with their clients. The FPM practice appears to be fully integrated in many LDSS; and staff experience of

success with the model insures that it will continue to be how business is done there. However, this experience has not been as common in very small LDSS, where FPMs are required only infrequently. To date, Family Partnership Meetings are required by VDSS, but not by law or regulation. In this state supervised, locally administered state, implementation has been driven by setting expectations, encouragement and support, rather than legislation.

Across the state, support for FPM implementation has taken the form of focused T/TA provided by regional implementation teams initially and continued by Regional Consultants and Directors. VDSS has provided training for LDSS staff and for FPM facilitators and incentives were used to encourage early implementation and the growth of the practice. In the last year, the Regional Consultants have increasingly focused on those LDSS who were slow to conduct their first FPM and/or are not routinely scheduling them for all 5 decision points. Additional support for struggling LDSS has included the development of opportunities for facilitator peer support through Regional FPM Roundtables and FPM Project group meetings will include targeted outreach to smaller agency facilitators.

Strategy 1.5 CIP to fund facilitation of 20 of family partnership meetings at LDSS
a) RFA developed in conjunction with CIP and Family Engagement Manager and sent to all local departments
b) Selected localities will be notified and included in a pilot project for Family Partnership training
c) Judges from the pilot site localities will be trained on Family Partnership meetings
d) Develop a process for formally notifying the Court about the outcome of the family partnership meeting.

Completed

2. **Enhance the current CPS Differential Response System *(DRS)* Practice Model to ensure a more family-focused and family-driven approach**

a) Incorporate the Children's Services Practice Model into the CPS DRS Family Assessment Track.
b) Revise and align the CPS policy and guidance manual consistent with strengthened family engagement philosophy, procedures and practices.
c) Develop and/or contract for the development of training for local CPS workers in implementing the Family Engagement Model when conducting Family Assessments.

Completed

3. Collaborate with the Office of Comprehensive Services to support engaging families in service delivery:

a) Provide opportunities for LDSS and local CSA staff to receive training about family engagement policy approved by the State Executive Council.
b) Develop a cross-systems family satisfaction survey.

Goal: Engage youth at the service, program and policy levels.

1. **Increase youth involvement in service planning and developing transitional planning to promote permanency and self-sufficiency.**

a) Develop strategies to increase the level of youth involvement in program planning, implementation and evaluation.
b) Involve the Virginia Youth Advisory Council *(VYAC)* and regional councils in the development and improvement of state and local child-serving policies and practices by

creating and/or supporting initiatives and partnerships that promote permanency, self-sufficiency, and networking.

c) Involve youth in providing input into foster care policy development, conducting life skills and self-advocacy training, and increasing youth's understanding of the concept of achieving permanency.

d) Provide training and technical assistance to LDSS in developing appropriate youth-driven service plans that focus on transitional living plans for older youth.

2013 Update

Project LIFE, a private/public partnership between VDSS and United Methodist Family Services (UMFS), has been instrumental in getting youth in and transitioning out of foster care involved in trainings, activities, and events that promote permanency and self-sufficiency. The goal of Project LIFE is to support permanency and lifelong connections for youth ages 14-21, while coordinating and enhancing their life skills instruction and development by collaborating with local departments of social services (LDSS), private providers and community stakeholders. Seven Project LIFE regional Independent Living (IL) Consultants assist VDSS in carrying out the vision, mission and goals of the Chafee Foster Care Independence Act, the principles of the Virginia Children's Services Practice Model and family engagement by collaborating with LDSS and private providers by offering:

- Hands-on training
- Structured, uniform program of services
- Technical assistance and
- Best practice development

Project LIFE offered the following training, technical assistance (T/A), and services:

- Casey Life Skills Assessment (CLSA) (replaced Ansell Casey Life Skills Assessment effective 9-1-12)
- National Youth Transition in Database (NYTD)
- Independent Living Program (ILP); Education and training Vouchers Program (ETV); Transition Living Plan (TLP); Permanency for Youth
- Permanency Pact (a formalized, facilitated process to connect youth in foster care with a supportive adult)
- Regional youth events
- Statewide teen conferences

Project LIFE provided the following activities/services with youth:

Topic/Activities	**# of Activity**	**# of youth participants**
Transition Living Plan	2	25
IL Life Skills	1	13
Post Secondary Education Workshops	1	20
Permanency, Generosity activities-(i.e., giving back, service learning projects, community services)	2	27
Permanency workshop	1	14

During this fiscal year, the Project LIFE team achieved the following:

- Coordinated two teen weekend conferences with at least 65 youth participants at each. Older youth co-facilitated some of the workshops and activities;
- Participated in state work groups and committees representing the needs of older youth (i.e., National Youth and Transition Database (NYTD), Permanent Roundtables, Extending Foster Care to age 21, Permanency workgroup);
- Developed a "Guide for Older Youth in and Aging Out Foster Care in Virginia" in collaboration with youth;
- Collaborated with VDSS to develop new templates with instructions for the transitional living plan (youth ages 14 to 17) and the 90-day transition plan (ages 18 and over);and
- Coordinated five regional trainings on "Trauma Informed Foster Care" for workers, foster and adoption parents, group home providers and other stakeholders.

In order to increase the LDSS' capacity to meet the goals of establishing permanent connections for older youth and developing adult living skills, Project LIFE and VDSS are committed to assisting LDSS in providing necessary services to eligible youth on a statewide, regional and local basis. During FY 2013, Virginia moved to Performance-based Contracting (PBC) with UMFS with the main focus on providing training and technical assistance (T/TA) to LDSS on IL assessments and transitional living plans for youth. VDSS provided the leadership necessary for Project LIFE to begin working on the following goals:

- Strengthen the capacity of LDSS to more effectively support youth in conducting life skills assessments and transition plans in preparing youth to make successful transitions to adulthood,
- Promote youth's meaningful engagement in case planning and in advocating for themselves; and
- Increase the capacity of public and private service providers to engage in IL best practices with older youth in foster care.

Virginia is committed to having youth's voice and involvement in their own service planning, foster care policy, NYTD workgroup and other state committees. In June, National Resource Center for Permanency and Family Connection (NRCPFP) will provide technical assistance to VDSS in planning a teen conference focusing on youth permanency.

III. Achieving Permanency

This strategy ties directly to the Children's Services Practice Model. We believe that all children and youth need and deserve a permanent family. It is VDSS' responsibility to promote and preserve kinship, sibling and community connections for each child. Permanency is best achieved through a legal relationship such as parental custody, adoption, kinship care or subsidized custody.

- **Applicable Children's Services System Transformation Outcomes:** Permanency Outcomes: Increase Permanency Discharges, Decrease Time to Permanency Discharge; Family Based Care: Increase Family Based Care, Increase Kinship care

- **Applicable CFSR Outcomes or Systemic Factors:** Permanency Outcome 1; Permanency Outcome 2; Wellbeing Outcome 1; Systemic Factors: Staff and Provider Training; Service Array Resource Development; Foster and Adoptive Parent Licensing, Recruitment, and Retention

- **Applicable CFSR Items:** Item 7, Item 8, Item 9, Item 10, Item 12, Item 14, Item 15, Item 17, Item 32, Item 33, Item 34, Item 35, Item 44, Item 45

Goal: Find and support permanent families and/or life-long connections with a responsible, caring adult for every youth in foster care.

1. Evaluate and recommend changes in the processes and procedures to achieve legal permanency for children in foster care that are consistent with research and best practices related to stability and permanent families.

a) Assess OASIS data on achieving permanency for children under the current permanency goals allowed under Virginia law.

b) Review, as indicated, other states' permanency goals and data to assess how Virginia could improve its legal permanency options for children in foster care.

c) Using the Process Improvement Team model, make recommendations to the Division Director for improving the processes, procedures and how the legal permanency options available for children in care are used.

2013 Update

Due to changes in state law, the LDSS can no longer assign the goal of IL to youth. This law allows youth ages 16 and over with the goal prior to July 1, 2011 to retain this goal with no changes required; however LDSS must provide a program of care and services. IL services are not affected. In FY 2012, state staff developed and is in the process of implementing, in collaboration with key stakeholders including youth, a work plan that will provide technical support, resources, tools, policy and practice guidance on achieving permanency with a sense of urgency for all youth. Virginia requested and received approval for training and technical assistance (T/A) from the National Resource Center on Permanency and Family Connections (NRCPFC). Eliminating the goal of IL is a major change for Virginia and training and T/A are needed in assisting local workers in achieving youth permanency and lifelong connections. NRCPFC will assist the VDSS in developing and implementing an integrated approach to permanency and preparation for adulthood. Gary Mallon, consultant with NRCPFC, met with representatives from VDSS and LDSS on May 9, 2012 and collaboratively a work plan was developed to address permanency for older youth. For FY 2013, NRCPFC will provide detailed information and T/A to inform three action groups focusing on; Family Finding; integration of youth voice in Family Partnership meetings, and Permanency Roundtables.

2. Increase kinship care services for families involved with the child welfare system.

a) Explore multiple options for supporting kinship care relationships *(including subsidized custody)* for children at risk of entering or in the foster care system.

b) Explore the use of Subsidized Custody as another permanency option for children who are in foster care and placed with a relative foster parent in accordance with the Title IV-E requirements of The Fostering Connections to Success and Increasing Adoptions Act, 2008.

c) Establish the decision process, plan and timeline regarding the option of a Subsidized Custody *(guardianship)* goal in foster care by July 2009.

d) Support state collaborations that focus on increasing awareness and training of kin *(relatives)* as valuable resources in creating permanency options for children who cannot live with their birth parents.

e) Provide ongoing support and involvement of staff in local and regional initiatives to train and support kinship care providers.

PS 1 Obj. 4. Implement Subsidized Custody as a permanency option for children in foster care

Strategy 4.1. Develop guidance in foster care manual for subsidized custody as one of two options for the foster care permanency goal of placement with relatives

a) workgroup formed
b) determine what sections of foster care manual will be amended
c) determine definition of relative
d) clarify the process of ruling out reunification and adoption as not appropriate for the child
e) clarify how the VEMAT will apply to relative subsidy payments
f) develop tools for assessing families and children as appropriate for subsidized custody
g) create guidance regarding all siblings qualifying for a subsidy
h) develop post-custody review procedures
i) Provide process for continued Medicaid eligibility when a family with custody moves to another state
j) Collaborate with Office of Comprehensive Services to amend CSA guidance to include requirements for subsidized custody consistent with guidance in the foster care manual.
k) PAC to review guidance

2013 update

The status of Custody Assistance is on hold. All the pieces recorded in the CFSR PIP were completed; however, the decision was made to not implement this program at the time. Training was created. Foster care guidance was created. A communication plan was created in conjunction with FACES of Virginia's Families. See below for details:

1. Including an overview of custody assistance in regional trainings for caregivers. This training may be coordinated and delivered with CRAFFT (the statewide foster family training group).
2. VDSS staff will attend the FACES Board meeting to present information on CA.
    a. Therese Wolf attended the FACES Annual meeting on July 26, 2012 at the NACAC Conference in Washington D.C. and provided an overview of CA to 80 members of FACES, including Board Members. Follow up with the Board members only will occur once CA is implemented.
    b. Board Members will promote relative custody of foster children as a permanency option for kin caregivers and will be available in their regions to provide information about CA when necessary.
3. Developing and posting Department approved information about CA on the FACES web site once CA has been implemented. This will include:
    a. link to the guidance for CA.
    b. creating a discussion stream about CA facts on the FACES blog.
    c. an update to the Relative Caregiver Brochure from FACES

The PAC reviewed the guidance on June 14, 2012 where they reviewed the training plan, the guidance, and associated forms. There was also a discussion about how OCS will play a role with children who are non-IVE eligible.

Strategy 4.2. Identify OASIS updates

a) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and determine if current screens can be modified or if new screens must be created
b) meet with Managing by Data workgroup to determine requirements

Completed

Strategy 4.3 Examine and amend CPS guidance to determine revisions required to support subsidized custody.

a) With CPS policy person, draft guidance around identification and notification of relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child
b) review guidance with CPS policy advisory team
c) disseminate guidance

Completed

Strategy 4.4 Develop training for workers on the appropriate use of Subsidized Custody as an option under the goal of Placement with Relatives
a) Provide Subsidized Custody policy and procedures to VISSTA to incorporate into new worker policy training for both CPS and Foster Care workers
b) Provide Foster Care Guidance Transmittal Training including Subsidized Custody procedures to local social worker coordinators and staff
c) Work with NRC to plan and conduct skills training on assessment and preparation of relatives for taking custody of kin for local staff
d) Provide Child Welfare Training committee a training curriculum, consistent with the NRC skill training on assessment and preparation of relatives, to incorporate into the array of competency based courses

2013 update
Because of the delay in implementation of Custody Assistance, training has not occurred. A training plan has been created for when approval is given. Training will begin starting 60 days following approval to implement Custody Assistance. Once Custody Assistance is approved, policy will be posted on the SPARK page and the VDSS web page 45 days prior to the beginning of training. A broadcast will go out for the public and private child placing agencies and CSA. Training will be conducted by the 5 Regional Family Resource Specialists and the 5 Permanency Consultants. Training will be face-to-face and on-site in each of the 5 regional offices and will be one day (6 hours). Permanency Consultants will provide additional training on-site at the local departments of social services offices as requested. Follow-up to the training will include the development of an FAQ page based on the questions and discussion that occurs in the training sessions. Development of the FAQ page is the joint responsibility of the Permanency Consultants and the Permanency Policy Specialist at VDSS and will be posted on SPARK within 45 days of the final training session.

Strategy 4.5 Educate judges and attorneys on subsidized custody in collaboration with Court Improvement Office.
a) provide Foster Care guidance on Subsidized Custody to support development by CIP of curriculum to train judges
b) meet with CIP staff to discuss CIP training schedule and determine options for training judges
c) provide training in conjunction with CIP

2013 Update
Permanency Unit staff worked with the Court Improvement Program staff to develop training for both juvenile court judges and local attorneys on custody assistance. The training was delivered in fall of 2011 at two separate conferences of judges and attorneys and reported on in the CFSR PIP quarterly report. Additionally, a Custody Assistance Tip sheet was created and shared with the juvenile court judges through the Court Improvement Program.

Strategy 4.6 Develop evaluation plan in conjunction with VDSS research department
a) Identify variables to be tracked
b) Determine methods of evaluation (i.e. surveys, interviews, etc)

c) set baselines

2013 Update

DFS partnered with the Office of Research and Planning to create an implementation plan for evaluating Custody Assistance. Again, because of the delayed implementation, this plan has not yet been put into action and baselines have not been set. Evaluation will begin with interviews of directors and social worker supervisors at ten to twelve local departments. Agencies will be identified by Office of Research and Planning staff after reviewing relative placement data and diversion information for each local agency. Agencies selected will have either high or low proportions of children in foster family relative homes. A second round of follow-up interviews will be conducted approximately one year later to determine if agencies are using the program and what (if any) barriers they have encountered when deciding to use the program. In addition, a short web-based survey may be administered to all 120 local agencies in order to ascertain how many agencies are using the program as a permanency option. Area of focus for the interviews include, for those agencies electing this option for permanency, what are the barriers/solutions in going forward, and for agencies not electing this option, why is the program not being utilized. Areas that the interviews will cover include are children and their relatives being identified for program eligibility? What barriers are relatives encountering prior to achieving guardianship (and solutions to barriers):

- Inability to become licensed foster parents
- Difficulty in sustaining stable placement for 6 months
- Inability to achieve guardianship from courts
- Other issues;

The interviews will also address what is the satisfaction of agency staff, relatives, and foster youth with the Custody Assistance program.

3. Evaluate and implement best-practice models that are consistent with the Family Engagement Model.

a) Increase local capacity for locating absent parents, siblings, other relatives and significant others to engage them in service delivery and establishing permanent, life-long connections.
b) Research the benefits and challenges of statewide implementation of: concurrent planning and using the Child and Adolescent Needs and Strengths Assessment *(CANS)* tool for every child in foster care.
c) Obtain National Resource Center technical assistance to access lessons learned by other states and to assess the benefits of, and processes for, implementing multiple best practices.
d) Convene ad hoc workgroups involving key stakeholders to assist in the analysis *(including evaluating current needs and the status of these practice models in Virginia and other states)* and to provide input on formal recommendations for implementation.
e) Develop plans and implement additional best-practice models as indicated.

4. Develop a wider array of options for local department use of respite funding to support connections with relatives and siblings for children in foster care with a community-based focus.

a) Establish and convene a respite advisory team in each region, to include local departments, respite care providers, and key members of local communities;
b) Utilize regional respite advisory teams to determine the needs for, current uses of, and barriers to use of respite care program funding;
c) Explore respite programming options beyond those that current exist (utilizing resources from the Collaboration to AdoptUsKids), particularly those that would encourage collaborations among local departments and the faith community, business community, civic groups, and/or other key stakeholders;

d) Include expanded respite options in the FY2012 applications for respite care program funding

2013 Update

Virginia's regulations for resource family approval now include specific approval processes for those families wishing to provide respite care only so as to increase the likelihood for approval of relatives to provide respite care. Guidance provides information and resources for locating and approving relatives (for full or respite only approval). Applications for respite care program funding encouraged use of funds to promote visits among siblings and connections with relatives. Regional consultants continue to work with local agencies to implement opportunities for resource families who do not have current placements to serve as respite providers for youth in congregate care settings to promote lifelong relationships.

After local agencies completed their applications for respite funding last year, it was determined by VDSS that the budget allocation language actually restricted respite funding to the provision of "respite for foster parents." Therefore it was not permissible to utilize this funding for prevention respite. One hundred thousand dollars was made available in PSSF funding to rectify this error, but most local agencies were unable to take advantage of this funding source due to the required local match. It was anticipated that the budget language would be corrected for FY 14, however, now a concern about the authority of DSS to facilitate prevention respite has arisen. The Attorney General's office is currently studying the legal issues. If the issues can be resolved, a request will be made to modify the budget allocation language to facilitate greater flexibility in the use of Respite funds.

Goal: Recruit, develop and support resource families

The continuum of work with resource families includes recruitment, development, and support such families, which include foster, adoptive, and kinship parents. Research has shown that children experience better outcomes, with fewer disruptions and greater family retention, when agencies actively pursue resource family development.

1. Increase the availability of viable resource families through diligent recruitment (including kin), thorough development, and targeted training and support.

a) Develop a framework for and engage service providers in best practice across the recruitment, development and support continuum.
b) Implement dual approval for resource families and increase options for formal and informal kinship care.
c) Increase local skills and capacity for locating extended family and non-relative significant relationships for children and youth in system of care.
d) Provide direct pre-service training to families, utilizing the PRIDE Model, and increase local utilization of this model or comparable pre-service that is competency-based.
e) Provide direct in-service training to families, using PRIDE and other in-service curricula, with a focus on topics related to engaging families.
f) Increase provider *(family)* approval regulations to reach greater consistency in the provision of pre-service and in-service *(e.g., mandate the number of hours required)*.

2013 update

The Resource Family Consultants have continued to provide technical assistance to local agencies regarding their home approval process and recruitment strategies. In several of the regions there are quarterly meetings held to focus specifically on resource family practice. Through these meetings, the Resource Family Consultants provide technical assistance and training in the areas of targeted and child specific recruitment, the development of strategic recruitment plans and development of recruitment presentations. In other regions, this work is done at the Quarterly Supervisors' meetings, along with

updates and technical assistance related to Permanency and CPS practices. In some cases, the Resource Family consultant has met one-on-one with new local agency staff in order to assure that the agency continues to comply with policy guidelines.
During Foster Care Month, the Resource Family Consultants have made presentations, supported local agency public awareness campaign efforts through technical assistance, and provided grocery totes and Resource Family appreciation certificates to local agencies to be distributed to their resource parents. The Resource Consultants continue to review monthly data reports that provide agency information regarding family-based placements and kinship placements during agency visits and when assistance is requested. The Consultants develop targeted strategies to assist the agencies that are below the national practice standards.

In three regions, Permanency Roundtables are being used to focus on the barriers to achieving permanency for a select group of older children in care at one agency at a time. All three regional consultants, CPS, Permanency and Resource Family, participate in the roundtable and brain storm with the local agency staff around ways to move cases forward. This activity is often an opportunity for the Resource Family consultants to provide technical assistance around child-specific recruitment and/or revisiting potential relative placements. Over the next year, Permanency Roundtables are expected to be implemented in all five regions.

Through consultation from the Annie E. Casey Foundation, the Resource Family Consultants received training in this area of family search and engagement. In an effort to increase the number of kinship providers, the Resource Family Consultants continue to offer two levels of training around Diligent Search and Family Engagement on as needed basis. In addition, the Consultants provide technical assistance to local agencies regarding the use of Accurint, the internet search system used to locate relatives and permanent connections for youth.

The Resource Family unit is continuing to work closely with the CRAFFT Coordinators to ensure the resource family training needs within the region are met. This year, they began team-training the CWS 3103 Mutual Family Assessment course with the regional CRAFFT coordinators. The revised training covers both policy considerations and best practices regarding the mutual family assessment process.

2. Engage youth in child-specific recruitment efforts to achieve permanency, as appropriate.

a) Develop resources and provide training to service providers regarding child-specific recruitment.
b) Provide training and technical assistance to service providers to better engage youth in understanding the options and planning for permanency.
c) Develop tools, strategies and guidelines for preparing youth for child-specific recruitment.

Goal: Increase timely and sustained adoptions

1. Increase timeliness of adoptions of children discharged from foster care.

a) Implement case practice strategies *(~~Concurrent Planning and~~ Family Team Meetings)* statewide that support decision making and action related to achieving the goal of adoption.
b) Support other case management strategies that increase the number of and timeliness of adoptions (e.g., concurrent planning; permanency roundtables).
~~c) Promote and support interjurisdictional adoptions among local agencies and between local departments and child placing agencies through request for proposals and/or memorandum of agreement.~~

~~**2. Increase the number of youth, aged nine and older, who achieve the goal of adoption.**~~

~~a) Provide training and other supports for youth in foster care to explore the option of adoption as a lifelong event.~~

~~b) Establish a youth adoption project that will identify youth with TPR and promote adoption and/or other permanent options for these youth.~~

3. Increase the number of youth adopted with the goal of adoption but not placed in pre-adoptive homes.

a) Contract with public and private child placing agencies to focus on achieving finalized adoptions of a specified group of eligible children and youth.
b) Work with the contractors to set specific milestones to achieve and a set number of adoptions to finalize each year.
c) Work with the faith-based community to explore holding additional rally's for children waiting for adoption.

2013 update:

The Department continued contracting with licensed and public private adoption agencies (13 agencies) to assist local agencies with adoption services. In SFY 2012, these contracts were changed to focus on specific outcomes related to finalizing adoptions of children who had a goal of adoption, Termination of Parental Rights and were not placed in an adoptive home. Recipients of awards were asked to develop working relationships with LDSS who had specific children whose adoptions were lagging due to lack of placements. More emphasis was placed on the contractual agency assuming responsibility for achieving clear finalized adoption –related milestones (e.g., completed home study; matching the child with a family). The Adoption Through Collaborative Partnerships (ATCP) contacts were based on the data that showed the real need for adoption services was to children of all ages who were clear for adoption but not in adoptive homes. As a result, the goal to increase the number of youth aged nine and older has been deleted and a new goal reflecting the ATCP has been included. The ATCP is reported on in the **Permanency - Adoption Services** section of this report.

Interjursidictional adoptions remained a problematic area for Virginia although some gains were made through ATCP. With the better defined goals of these contracts, contractors were more assertive in identifying families for children and working across jurisdictions. In addition, the new requirements that social workers are required to register waiting children in AREVA before accessing and printing the court-required adoption progress report has helped get more children on the AREVA list. Working with the adoption contractors to continue developing relationships with the LDSS who need help achieving adoptions is seen as a much better approach to increasing these interjurisdictional adoptions.

In 2012 the faith-based community under the leadership of Pastor Christopher Barras held two adoption rallies called "Change Who Waits". These rallies were the culmination of several months of planning and activities in local churches to bring the need for adoptive families to the attention of the faith-based community. A minimum of 500 people attended the rallies (one held in Richmond the other in the eastern region). The adoption contractors were present at the rallies and able to begin work with families that were interested in adoption or fostering. Seven LDSS were also present. Rev. Barras has been asked to do similar rallies in northern Virginia and the Piedmont region.

4. Sustain adoptions through the provision of post adoption services for children adopted from foster care and for children adopted from other countries.

a) Maintain the Adoption Preservation System with added components to provide services for children adopted through inter-country adoptions.

2013 update:

Virginia utilized Title IV-B, Subpart 2 funding to create an Adoptive Family Preservation Services *(AFP)* system. AFP began serving adoptive families in June 2000. Through United Methodist Family Services, the AFP serves families who have adopted domestically and may also serve families that have adopted internationally. The AFP provides post legal adoption services to address presenting issues and concerns of the adoptive family.

Of the total 264 adoptive families served during the third quarter (SFY 2013), 57 have adopted internationally. These 57 families represent 21.59 % of total families served in this fiscal year. In the 57 families, there are 62 children adopted internationally. Shown in the table below are the numbers of children and families served by AFP fiscal year 2012-13, compared with the 2011-12 program year. Included in the table are countries of origin for children and the percentage of families served who adopted internationally:

Families Served in 2011-12		**Families Served in 2012-13**					
July 1, 2011 – June 30, 2012		**July to Sept 2012**		**Oct to Dec 2012**		**Jan to Mar 2013**	
Country	**# Children**	**Country**	**# Children**	**Country**	**# Children**	**Country**	**# Children**
Russia	24	Russia	17	Russia	16	Russia	17
Guatemala	7	China	8	China	9	China	10
China	7	Kazakhstan	6	Kazakhstan	6	Kazakhstan	7
Kazakhstan	6	Guatemala	5	Guatemala	5	Guatemala	4
Ukraine	4	Ukraine	4	Ukraine	4	Ukraine	4
Bulgaria	3	Bulgaria	3	Ethiopia	4	Ethiopia	4
Ethiopia	3	Ethiopia	3	Bulgaria	2	Bulgaria	2
Romania	2	Romania	2	Romania	2	Romania	2
Columbia	2	Korea	2	India	2	India	2
Latvia	2	India	2	Korea	2	Korea	2
Korea	2	Latvia	2	Latvia	2	Latvia	1

Families Served in 2011-12		Families Served in 2012-13					
July 1, 2011 – June 30, 2012		July to Sept 2012		Oct to Dec 2012		Jan to Mar 2013	
Country	**# Children**	**Country**	**# Children**	**Country**	**# Children**	**Country**	**# Children**
Ecuador	1	Ecuador	1	Ecuador	1	Ecuador	1
Hungary	1	Hungary	1	Hungary	1	Hungary	1
India	1	Venezuela	1	West Africa	1	West Africa	1
Venezuela	1	Malawi	1	Malawi	1	Malawi	1
Malawi	1	Paraguay	1	Philippines	1	Philippines	1
Mexico	1	Philippines	1	Venezuela	1	Venezuela	1
Paraguay	1	Not specified	1	Not specified	1		
Peru	1						
Philippines	1						
Totals							
Children	**73**		**61**		**61**		**62**
# Families w/ international adoptions	**63**		**53**		**53**		**57**
	19.33% of 326 families served		**19.49% of 272 families served**		**19.92% of 266 families served**		**21.59% Of 264 families served**

The Department also contracts with the Mary D. Ainsworth Clinic to provide unique services to adoptive children and families. The Ainsworth Clinic provides Attachment training to localities and therapy to children and families throughout the state. The contract is limited in funding and therefore, the areas to which it can provide services are also limited. Through competency building work conducted by the Ainsworth Clinic, additional therapists are available in some areas around the state to provide parenting classes that focus on interventions with attachment disordered children. These services are available on a post-adoptive basis.

PS 1 Obj. 2. Increase timeliness and discharges to permanency

Strategy 2.1. Target children who have the goal of adoption, with TPR who are not in adoptive placements to achieve permanence.
a) Generate list of children with TPR who are not in a pre-adoptive placement
b) Send the list of children to LDSS to find out if there is any progress towards adoption
c) Revise the list of children and share with contractors
d) Meet with contractors to inform them about changes to the renewal process
e) Revise current adoption contracts so that contractors will be required to increase the number of children and families served by 25% over previous year
f) revise current adoption contracts so that contractors use child specific targeted recruitment
g) Hold regional meetings to inform local departments about contract changes & negotiate agreements with contractors

Completed

Strategy 2.2 Revise current contractor reports
a) process measures incorporated into reports
b) reformat reports to include all contacts with child and family
c) create roles and responsibilities agreement form for LDSS and contractors

Completed

Strategy 2.3 Provide training on child specific, targeted recruitment
a) gather input from LDSS and contractors on training needs
b) review quarterly reports to determine training needs
c) contract for training

Completed

Strategy 2.4 Analyze information gathered during contract year
a) compile and review data from contractor reports
b) solicit and discuss feedback from contractors about what is working, barriers, etc
c) solicit and discuss feedback from participating LDSS

Completed

Strategy 2.5 Using data gathered from quarterly reports, revise upcoming RFP for new adoption contracts
a) highlight positive approaches from contractors and share with others
b) working with advisory committee make decisions about how to achieve desired outcomes for children awaiting adoption and design RFP accordingly

Completed

PS 1 Obj. 3. Collaborate with CIP to promote child welfare outcomes

Strategy 3.1 Reevaluate the Adoption Progress Report in collaboration with CIP for LDSS to better utilize the report
a) Create a collaborative work group to review the report and make any necessary changes
b) incorporate revised report into guidance

c) Train staff on use of the report
d) Train court personnel on use of the report

Completed

IV. Comprehensive child welfare training program

This strategy strives to develop a consistent training program, built with state and local partners, as an engine for supporting all of the Transformation building blocks and for spreading the practice model among all of the system's stakeholders.

- **Applicable CFSR Outcomes or Systemic Factors:** Systemic Factors: Staff and Provider Training; Foster and Adoptive Parent Licensing, Recruitment, and Retention

- **Applicable CFSR Items:** Item 32, Item 33, Item 34, Item 44, Item 45

Goal: Develop and maintain trained and skilled professionals and resource families who work in alignment with the state practice model.

PS 3 Obj. 1. Establish training requirements for front-line and supervisory staff that align with child welfare competencies

Strategy 1.1 Establish sets of core competencies for child welfare supervisors
a) Identify a point person(s) to lead establishment of core competencies for child welfare supervisors
b) Develop a process for establishment of competencies
c) Identify a group of LDSS supervisors and managers to participate in process
d) Collect and summarize feedback
e) Present core competencies to Steering Committee for approval

Strategy 1.2. Establish sets of core competencies for child welfare staff
a) Identify a point person(s) to lead establishment of core competencies for child welfare staff
b) Develop a process for establishment of competencies
c) Identify a group of LDSS supervisors managers to participate in process
d) Collect and summarize feedback
e) Present core competencies to Steering Committee for approval

2013 update 1.1 and 1.2
Due to the VDSS internal changes around training, the family services steering committee was disbanded and the Virginia League of Social Service Executives (VLSSE) Professional Development Subcommittee (PDC) agreed to take on some of the responsibilities the family services steering committee. The majority of the work around the creation of the competencies for both supervisors and child welfare staff occurred before the steering committee was disbanded. LDSS workers provided input and with the guidance of IHS, the core competencies were completed in December 2011. The PDC gave the final blessing of the competencies in April 2012.

Strategy 1.3 Guide the revision of existing curricula to reflect core competencies.

~~a) Modify VCU-VISSTA contract language to include the development of curricula that will reflect core competencies~~
~~b) Collaborate with VCU-VISSTA around the integration of core competencies into curricula through the Steering Committee~~

a) VDSS curriculum developers will develop curriculum that reflects the core competencies

2013 update

To analyze the degree to which existing Virginia courses covered the core competencies for child welfare caseworkers and supervisors, a cross walk was conducted of the competencies and courses currently existing in Virginia. The core competencies for caseworkers are covered in nine courses that constitute 24 days of training and only two courses are primarily policy courses. The cross walk of Core Competencies for Child Welfare Supervisors showed that the existing curriculum in Virginia was lacking and two new courses have been developed to make the coverage complete. The OCWTP and the Institute for Human Services were willing to give permission for Virginia to adopt the two new courses which will be known in Virginia as CWS5702 *Issues in Supervision: Communication, Conflict and Change,* and CWS5703 *Issues in Supervision: Collaboration and Teamwork.* Adding these two courses will bring the total number of training days to seven and assure complete coverage of Virginia's Core Competencies for Child Welfare Supervisors.

Strategy 1.4 Establish training requirements for child welfare workers and supervisors to reflect core curriculum

a) Develop a process to reevaluate training requirements through the Steering Committee once core curriculum is finalized
b) Develop recommendations for new training requirements
c) Present recommendations to Steering Committee for approval

Strategy 1.5 Establish standards for completion time frames for required initial in-service training

a) Develop a process to reevaluate standards for timeliness of completion for initial in-service training through the Steering Committee once core competencies are finalized
b) Develop recommendations for timeframes
c) Present recommendations for timeframes to Steering Committee for approval

2013 update 1.4 and 1.5

CORE COMPETENCIES: VDSS along with several advisory groups have established Core (fundamental and essential) Competencies for child welfare caseworkers and supervisors. These competencies are contained in 9 existing courses (24 days) for caseworkers and 3 courses (7 days) for supervisors.

PROGRAM MANDATES: Since the mid 1990s, VDSS has established "mandated training" specific to child welfare staff dependent upon whether they specialize in Child Protection (CPS) or Foster Care/Adoptions (Permanency). Further specialization is a separate requirement for CPS staff who conduct Investigations in *Out of Family* settings such as schools, and residential facilities. These "mandates" evolved to include both policy based and skill based courses over time.

FUTURE REQUIREMENTS: As the training team for Family Services curriculum identified the courses required to cover the Core Competencies for Caseworkers, the totals were 9 courses that constitute 24 days of training. Within the mandates are courses that are also a part of the Core series. As the two sets of requirements at combined they total 37 days of training for new CPS as well as new Permanency caseworkers. Based on the immediacy of the requirements for program mandated training

(much of it in the first six months and the rest within the first year) the recommendation was for both the Core and Program mandated training to be completed within the first 24 months of a new worker's employment.

VDSS convened a committee of training management staff, the Program Managers for CPS and Permanency, as well as a trainer, a curriculum developer and a regional program consultant to look at ways the courses can be collapsed to reduce the number of days of required training and maintain fidelity to the Core Competencies. This group and the PDC made the decision to deliver the core courses over 24 days instead of the 37 that was proposed.

Strategy 1.6. Establish annual in-service training requirements for child welfare supervisors and front-line workers

a) Develop a process to establish annual in-service training requirement for child welfare supervisors and front-line workers through the Steering Committee once core competencies are finalized

b) Develop recommendations for annual in-service training requirements

c) Present recommendations for annual in-service training requirements to Steering Committee for approval

2013 update

Virginia is recommending that the annual training requirement for both child welfare supervisors and caseworkers be set at 24 hours. This number was determined as a reasonable compromise to begin with compared to two other "county administered systems", Ohio (36 for caseworkers and 30 for supervisors) and Pennsylvania (20 for both supervisors and caseworkers) The 24 hour requirement was presented to the VA League of Social Services Executives Professional Development Committee (PDC) at their May 11, 2012 meeting. The PDC agreed that the requirement was reasonable and recommended the Department proceed.

PS 3 Obj. 2. Ensure ongoing training opportunities for experienced staff

Strategy 2.1. Develop VCU-VISSTA and ATC capacity to engage, develop, and evaluate subject matter experts as both trainers and workshop curriculum developers through training and consultation with IHS

a) Conduct assessments of each Area Training Center to evaluate strengths, knowledge and understanding of a competency based system, relationship with LDSS, and relationship with host agency

b) Assess VCU-VISSTA capacity through consultation with IHS and ongoing collaboration with VDSS

c) Modify VCU-VISSTA and ATC contract language to reflect expanded roles with LDSS and expectations regarding workshop development

Completed

Strategy 2.2 Establish process to provide ongoing training that is based on staff and supervisors' assessed needs

a) Develop process through the Steering Committee for ATCs and VCU-VISSTA to work together to develop and deliver trainer-developed workshops

b) Pilot process through the development and delivery of one trainer-developed workshop in each ATC region

c) Evaluate pilot findings and refine process through Steering Committee if necessary

2013 update

The pilot for the SME workshops was a successful endeavor with positive feedback from participants. In the new Virginia Department of Social Services (VDSS) training unit, going forward we want to keep the same quality of the SME workshop with a more streamlined approach to save resources: time and money. In doing so, the following process has been previously approved and vetted in its longer version and now approved by the Professional Development Committee on June 7, 2012 in its shorter version. The VDSS will use these four steps to offer continuing education to Child Welfare Services (CWS) employees:

- Needs Assessment
- Identification of SMEs
- Selection of SMEs and Workshop Development
- Evaluation

Learning Needs Assessment

The purpose of needs assessment is to gather information to determine individual and regional training needs. This information will be used to plan and deliver targeted continuing education to enhance the competencies and job performance of LDSS CWS employees.

The Family Services Training Manager (FSTM) and the Regional Training Managers (RTMs) will actively seek input and respond to requests for training of LDSS CWS employees. Assessing training needs is a continuous process. Learning needs will be assessed annually and ongoing through formal and informal needs assessment mechanisms listed below. The FSTM will gather, track and review needs assessment data on an ongoing basis and plan additional continuing education offerings accordingly. The FSTM and the RTMs will create a continuing education training schedule of courses that is released to all CWS Workers each year. At a minimum, VDSS will deliver six SME Seminars in a two-year period and at least 1 hot topic seminar per regional need.

Formal

Statewide Survey: Once every two years, The FSTM will coordinate and the RTMs will send a formal survey via email to all CWS employees and supervisors. The survey will include specialized competencies (adapted from the Ohio Child Welfare Training Program) for LDSS CWS employees. First one to be distributed in June 2012, tabulated in July 2012. Sample attached.

Regional Survey: Once a year, each RTM will send an email survey to gather hot topics for which workers would like to be trained. This is region specific. The RTM will gather data and offer a minimum of one class per year specific to their region. The process will include identifying competencies and developing curriculum with the chosen subject matter expert (SME). The first survey will be distributed in January 2013.

Class Evaluations: At the end of each class, participants will complete an electronic survey which includes an open ended question regarding what other training topics they need. Responses will be sent to the FSTM and RTMs for ongoing review.

Request from VDSS or LDSS Leadership: Leadership may submit a request at any time for a class to be offered to CWS workers. Leadership may include the VDSS Executive Team, the VDSS Leadership team, LDSS Directors or the Virginia League of Social Services Executives (VLSSE) Committees such as the Professional Development Committee.

Regional Offices Input: The FSTM and RTMs will seek input from regional office staff as to training needs in the field.

Quality Service Review Results: Any findings that result in a need for training will be included.

Legislation: New legislation that impacts CWS workers will be monitored and considered a potential immediate need for curriculum updates and training.

Informal
Informally, training needs are discussed via meetings, emails and phone calls from supervisors or employees, etc. Ongoing information gathered from these sources will be documented in the following folder on the shared drive: W/organizational development/training/needs assessment/CWS.

New policies that impact LDSS CWS workers are the responsibility of the program consultants in the five regional offices.

Identification of SMEs*

Subject Matter Experts (SMEs) may be found through:
- referrals from Regional Specialists/Consultants or other local and state
- staff who have observed previous SME presentation(s)
- websites and membership lists of professional organizations
- speakers at conferences
- speaker bureaus
- literature searches to include professional literature and the Internet

SMEs will be asked to submit a resume and list of references.

Regional Training Managers (RTM) will select potential SMEs based on:
- appropriate educational credentials and/or practice experience in the proposed topic area
- history of presentations on the topic
- references from those who have seen the SME presentation(s)

Regional Training Managers will determine whether educational credentials are a requirement for a particular topic and will seek consultation from VDSS Curriculum Developers (CDs) as necessary.

Selection of SMEs and Workshop Development*

SMEs will submit an outline(s) of their proposed workshop(s). RTMs may offer guidance or provide a Workshop Outline Guide to assist them in making the following decisions:
- length of training
- minimum and maximum number of participants
- learning activities
- identified competencies
- learning objectives
- methodologies
- transfer of learning strategies
- reference list

1. RTMs will review outlines provided by SMEs using an outline review guide to determine suitability. RTMs may request assistance from VDSS curriculum developers to review outlines and reference lists.

2. RTMs will issue contracts to SMEs for training the workshop(s).

3. At any point in the process, RTMs may recommend that an SME attend a course on Training for Trainers offered by the VDSS training program to enhance the SME's presentation skills.

4. RTMs will work with the SMEs to ensure that the course meets identified learning needs and reflects competencies and learning objectives.

5. RTMs will develop marketing that accurately reflects the content of the course.

6. SMEs are responsible to obtain copyright permissions when necessary as the SME retains ownership of his/her workshop materials.

7. RTMs will assist SMEs with the logistical needs of the training to include the recommended font size on handouts, requirements for audiovisual equipment and internet access, necessary materials, room set up, and duplication of handouts.

Evaluation

The VDSS is currently using the tool, Survey Monkey, to evaluate training sessions. The process will match all trainings which are:
The survey is sent to learners via email the following day after class
The surveys are collected for analysis three weeks after the training and shared with

- FSTM
- RTMs
- Trainers
- The PDC reviews the evaluation results quarterly
- Results from evaluations serve as feedback and impacts future courses

**Condensed from A Process for Trainer-Developed Workshops by Subject Matter Experts for the VA Dept. of Social Services, Part II: Procedures – Trainer-developed Workshops by SMEs December, 2011,sec.II, pg 3-6;Casey Family Programs Service Agreement Contract ID# FY11-0317 with VCU School of Social Work, Office of Continuing Education*

PS 3 Obj. 3. Assess and evaluate training system

<u>Strategy 3.1</u> Explore better utilization of existing participant evaluation tool through the current Learning Management System
a) Assess current functionality around participant evaluation through the Knowledge Center
b) Develop a process to better utilize participant evaluation
c) Submit recommendations for improvement of the function to the Steering Committee

<u>2013 update</u>
Formalized evaluation process
The Virginia Department of Social Services (VDSS) is committed to managing the relationship between learners and the Child Welfare Program training content. To the extent possible, the Department will use the existing technological (Knowledge Center) infrastructure to achieve the successful creation and transfer of information and knowledge to enhance the Virginia Child Welfare system.

The current VDSS Knowledge Center (KC) Learning Management System (LMS) has course survey functionality. In addition, course content owners also have the ability to create surveys using both Likert scale and free-text/comment responses. These surveys can be attached to both Instructor led classes and Interactive self paced courses. Independent surveys can also be stand alone tools (not attached to courses). All three options may be utilized in evaluating successful acquisition of skills needed to achieve program objectives and the intentional linkage/integration of training curriculum to successful outcomes.

Students who successfully complete these classes will be presented with the survey as a prerequisite to being able to print the course certificate. In addition, administrators will analyze the data collected, redesign instructional courses as needed, track and evaluate local learning experiences to validate the effectiveness of the training and the quality and positive outcomes of the services delivered.

Report on the degree of functionality of current participant evaluation through LMS or Knowledge Center
The VDSS KC information system infrastructure is the product of the Commonwealth of Virginia Department of Human Resources Management. The system is used by all State agencies and it uses Meridian Knowledge solutions software. The KC Website presents a visual metaphor of a Campus Map that uses a centralized database, and online content and employee training records. This system has not been upgraded since its inception in 2008. In 2012, the system will undergo major changes that will enhance the overall learning management system.

The current functionality of the KC evaluation survey, when attached to a course, is limited because it aggregates the collected data to that course. The data can be extracted for periods of time using upper and lower date limits. The vendor, however, (in this version of the LMS) did not make provisions to extract the course data at the course section level. So, while we can look at overall performance by course, we cannot look at data for standalone classes. VDSS anticipates the functionality will be greatly improved with the system upgrade. However, in the interim, the Department is utilizing the Survey Monkey Tool, to gather participant/learner information.

This issue should be resolved in the new KC version to be delivered in June 2012

Process to better utilized participant evaluation
There are several efforts that can better utilize participant evaluation.

- Surveys attached to the courses (classroom or self paced) are invoked when a user tries to print their certificate(s). The survey is a prerequisite to be completed prior to being given access to printing the survey. This insures survey data from each participant.
- Extract tools allow for data to be pulled by Course and also then by date(s).
- The new system (June 2012) will present expanded features of session level reporting
- Extracted data is then able to be exported to third party data tools such as Microsoft Excel Spread Sheets and Microsoft Access data base.

Committee Input on evaluations and any other recommendations.
The Professional Development Committee (PDC) of the Virginia League of Social Services Executives (VLSSE) will review participant evaluation data and provide change recommendations to the Department based on the data presented. The VLSSE PDC meets monthly and will be provided the data at regularly scheduled meetings.

Interim Use of Survey Software.
In December 2011, VDSS purchased the use of SurveyMonkey to facilitate a course specific evaluation of both the curriculum and trainer being developed and put into operation. The initial evaluation was piloted

in both the Western (Abingdon) and Piedmont (Roanoke) Regions. Several changes were made to the instrument and the process was initiated state wide on April 1, 2012.

Currently, the evaluations are emailed to participants the first business morning after the training and "collected" for analysis after 2 weeks. The collated results of the individual class evaluations are shared with the trainer and members of training management and curriculum developers. In addition, the instrument inquires of each participant about what other training they see as needed for their professional development. The answers to that question are being captured to further inform our training needs assessment.

Based on the findings from these evaluations, improvements will be made to curriculums that improve effectiveness. On-going coaching of training facilitators will be informed from these evaluations as well.

Strategy 3.2 Establish evaluation process for trainers

a) Assess existing processes for evaluating trainers
b) Develop strategies to improve evaluation process for trainers as needed
c) Submit recommendations for trainer evaluation process to Steering Committee

2013 update

PROCESS FOR EVALUATING TRAINERS

HOW TRAINERS HAVE BEEN EVALUATED

This assessment will cover the way Trainers have been evaluated dating back to the early days of the Virginia Commonwealth University School of Social Work VISSTA Project in 1992. This was the beginning of a formalized staff development system. Trainees and Training Management have observed and evaluated the Trainers throughout this period. This process pertains to the Full-time and Part-time Trainers who have been employed by the VISSTA Project through September 30, 2011 and the Part-time Trainers employed by Virginia Department of Social Services (VDSS) since October 1, 2011.
Trainers are selected based on their areas of expertise. They go through an interview process, Trainer skills assessment, and course knowledge review prior to training any classes. These assessments are conducted by Family Services Training Management.

Once the above processes have been completed, the Trainer is scheduled to train classes. Trainers have been observed by Family Services Training Management and at times the Regional Training Managers (formerly Area Training Managers). Curriculum Developers also observe the training although their main emphasis is on the curriculum content and not the Trainer's performance. Tools which have been used are attached. The tool "Trainer Observation Form" is used by the Trainer Development Specialist to observe Trainers at least annually.

An opportunity for Trainees to evaluate the training (environment, curriculum, and Trainer) has been a long-time practice of the VDSS Training System. Trainee evaluation started out with in class administered paper tool. Trainees completed an evaluation and the Training System compiled the results which were then provided to the Trainer and Training Management. Eventually, the evaluation process results were compiled in the Pathlore Learning Management System. The process progressed into an on-line evaluation which is currently voluntary. Course results not Trainer results were captured in the Knowledge Center Learning Management System and the format is contained on the model attachment, "Course Name: VDSS – CWS1041." Beginning in early 2012, VDSS purchased Survey Monkey, an evaluation program software, and this tool is providing the system class evaluations on both curriculum and the Trainer. The tool "VDSS Current Eval Template" is currently being used to evaluate the Trainers. The statewide use of this tool began on April 1, 2012. The evaluation summary is being emailed to the Trainer, Curriculum Developer, Family Services Trainer Development Specialist, Family Services Training Manager, and Local Programs Training Director.

EVALUATION OF THE EVALUATION PROCESS

The current VDSS Training Team is comprised of members of the Division of Workforce Planning and Development (DWPD) was consulted on this evaluation. The primary evaluators also had an opportunity to view other states' processes. This evaluation focused on the methods used by the Trainees and Training Management to evaluate Trainers.

The Trainee evaluation procedure is a good process. However, there are areas that will make it stronger and more effective. The current survey tool, Survey Monkey, is anticipated to be a temporary fix until at which time the Meridian Global Learning Management System (an upgrade to current Knowledge Center LMS) can be studied to determine if it can meet our needs. Whatever system is selected will contain the following features:

- It will be mandatory and not optional.
- It will be anonymous.
- It will be completed within two –three weeks of the class end date.
- The system will send the evaluations directly to the Trainer manager/supervisor, the Trainer, the curriculum developer, and Local Programs Training Director.
- The class summary will contain both aggregate scores and comments.
- The system will store the evaluations for a specific period of time.
- The Training Manager and the Trainer Development Specialist will use these reports as tools in assessing Trainer performance, both their strengths and areas in need of strengthening.

RECOMMENDATIONS FOR IMPROVING THE TRAINER EVALUATION PROCESS

The Family Services PIP Training Committee and the VSSLE Professional Development Committee have the following recommendations:

- We will continue to have the Trainees complete an on-line survey.
- The survey will be available on-line for 2 weeks and then the system (Meridian Global LMS or Survey Monkey) (SM) will compile the scores and create a report that contains aggregate compilations of numeric scores (no linkage back to the Trainee) and perhaps groupings of similar responses by topic.
- This report will then be emailed to the Trainer, his/her Supervisor, and to Local Programs Training Director.
- This report will be used by the Trainer manager as a resource when meeting with the Trainer especially around performance evaluations. When there are areas that the Trainer needs to improve upon, the Trainer manager (TM) and the Trainer will develop a plan to address the needs. TM will follow up as indicated in the improvement plan.
- In July 2012, the new Meridian Global should be operational and Training Information Technology staff will determine the best alternative (LMS or SM). Of note, Virginia is also anticipating adding a product currently used by the Virginia Department of Health, TrainVA with Meridian Global.
- whether TrainVA or Knowledge Center meets our needs for evaluating classes or whether we will continue to use SM.
- In addition to evaluation by the Trainees, training management will continue to observe Trainers using a pre-approved observation form. At least some of the observations will be unannounced.
- The Training Team will decide the parameters of the observation (length of observation time, what intervals, etc.) but will occur at least annually.
- The Training Team will determine competencies for all Trainers. We are currently reviewing Ohio's Institute for Human Services' adopted competencies and anticipate the adoption of these in Virginia.
- The Training Team will periodically evaluate the tools that are used to evaluate Trainer performance, will develop additional core training for all Trainers, and will establish on-going professional development opportunities for Trainers.

Strategy 3.3. Establish a training needs assessment process to inform training delivery and system development and management

a) develop ATC capacity to support needs assessment process and analysis
b) develop learning management system functionality to support needs assessment information management
c) develop needs assessment protocol

2013 update

In order to serve local departments of social service as effectively as possible in the area of child welfare training, VDSS' Local Programs Training Unit developed and administered a survey to local department child welfare supervisors and staff statewide in June 2012. The purpose of the four-question survey was to determine how well VDSS is supporting local departments in child welfare trainings and to identify future training needs and topics. This survey was used to provide more information for the Needs Assessment that follows.

Needs Assessment Plan for Continuing Education Child Welfare Services (CWS)

Purpose

The purpose of this plan is to gather information to determine individual and regional training needs. This information will be used to plan and deliver targeted continuing education to enhance the competencies and job performance of LDSS CWS employees.

Method

The Family Services Training Manager (FSTM) and the Regional Training Managers (RTM) will actively seek input and respond to requests for training of LDSS CWS employees. Assessing training needs is a continuous process. Needs will be assessed annually and ongoing through formal and informal needs assessment mechanisms listed below.

Formal

Statewide Survey**:** Once every two years, The FSTM will coordinate and the RTMs will send a formal survey via email to all CWS employees and supervisors. The survey will include specialized competencies (adapted from the Ohio Child Welfare Training Program) for LDSS CWS employees. First one to be distributed in June 2012, tabulated in July 2012. Sample attached.

Regional Survey: Once a year, each RTM will send an email survey to gather hot topics for which workers would like to be trained. This is region specific. The RTM will gather data and offer a minimum of one class per year specific to their region. The process will include identifying competencies and developing curriculum with the chosen subject matter expert (SME). The first survey will be distributed in January 2013.

Class Evaluations: At the end of each class, participants will complete an electronic survey which includes an open ended question regarding what other training topics they need. Responses will be sent to the FSTM and RTMs for ongoing review.

Request from VDSS or LDSS Leadership: Leadership may submit a request at any time for a class to be offered to CWS workers. Leadership may include the VDSS Executive Team, the VDSS Leadership team, LDSS Directors or the Virginia League of Social Services Executives (VLSSE) Committees such as the Professional Development Committee.

Regional Offices Input: The FSTM and RTMs will seek input from regional office staff as to training needs in the field.

Quality Service Review Results**:** Any findings that result in a need for training will be included.

Legislation**:** New legislation that impacts CWS workers will be monitored and considered a potential immediate need for curriculum updates and training.

Informal
Informally, training needs are discussed via meetings, emails and phone calls from supervisors or employees, etc. Ongoing information gathered from these sources will be documented in the following folder on the shared drive: W/organizational development/training/needs assessment/CWS.

New policies that impact LDSS CWS workers are the responsibility of the program consultants in the five regional offices.

Results
In general, the Local Programs Training Unit will create program plans based on need, target audience, learning style/preferences, adult learning theory, affected learning domains (cognitive, affective, and psychomotor), and content. Content is based on knowledge from the SMEs, research, requirements of regulatory standards, feedback from participants, and input from department managers and staff. Programs include a variety of delivery methods (classroom, computer-based training, videos, eLearning, etc.), vary in length, and utilize an array of instructional techniques including interactive learning (case studies, simulations, problem-solving activities, discussion cards, role playing, etc.).

Specifically, the FSTM will gather, track and review needs assessment data on an ongoing basis and plan additional continuing education offerings accordingly. The FSTM and the RTMs will create a continuing education training schedule of courses that is released to all CWS Workers each year.

At a minimum, the plan is to deliver six SME Seminars in a two-year period and at least 1 hot topic seminar per regional need.

Facilitators will be utilized from VDSS, LDSS, or contracted with from the community if expertise is needed in a specific subject matter.

Strategy 3.4. Establish a process to promote transfer of learning for training participants
a) Modify FY2011 contract language with VCU-VISSTA
b) Develop a process for integration of existing curricula through the Steering Committee

2013 update
The Virginia Department of Social Services does not believe that training is a standalone event. We view training as a collaborative effort to meet the emerging needs of our valued workforce. Research shows that activities completed before, during, and after training can help a participant better understand the content of the training and apply it on the job much more effectively.

3.4 Course specific tool for supervisors:
VDSS has included the attached supervisory tool as a way to facilitate discussion on the content of each course including specific topics covered, a description of transfer of learning from the classroom back to the agency, and suggestions for continuing the learning process in the local agency to increase the knowledge, skills and abilities of caseworkers - see attached tool.

3.4b Develop process for integration of transfer of learning tools
A committee of Regional Consultants and local child welfare supervisors was formed to develop a process and course specific supervisory tools to integrate transfer of learning activities and enhance worksheets developed by VISSTA. As a way to collaborate more effectively with LDSS supervisors, we have developed a process to promote transfer of learning for workers to provide direct feedback and support from the classroom to the agency supervisor to further enhance the skill-building and learning achieved through child welfare training. The three types of transfer of learning activities were implemented into all child welfare training:

a) Individual Action or Learning Plans - at end of each child welfare training session each participant is ask to complete their Individual Action/Learning Plans. These course specific plans are a tool to document the learner's self-assessed strengths in mastering new materials and identify possible issues to follow-up on in the field, along with identified support and resources to enhance their learning.
b) Field Practice Activities in New Worker Policy Training – following the end of the second day of training, participants are given letters to their supervisors with suggested field practice activities to be implemented during the two weeks between the next part of the training session. The supervisor must guide the worker and sign off on the trainees completed activities and they are processed with the group during the return to the classroom.
c) Transfer of Learning Supervisory Tool – Supervisor Training Follow-up Guides are emailed to the trainee's supervisor following each training session to provide specific information on the content of the training and to provide field activities to enhance the learning and skill development of the worker.

PS 3 Obj. 4. Ensure delivery of state-approved pre-service and in-service training for resource, foster, and adoptive parents

~~**Strategy 4.1. Conduct annual needs assessment of current pre-service and in-service training needs**~~
~~a) Create work group made up of LDSS, CRAFFT, and VDSS to develop needs assessment~~
~~b) CRAFFT to administer needs assessments with LDSS~~

~~**Strategy 4.2. Create regional pre-service and in-service training plans for resource families based on needs assessment data**~~

~~**Strategy 4.3. Establish a Steering Committee subcommittee to address resource family training**~~
~~a) review models of resource parent competencies~~
~~b) develop Virginia universe of competencies~~
~~c) make recommendations to Steering Committee~~

Strategy 4.1. Revise format and structure for the needs assessment of current pre-service and in-service training needs

Completed

Strategy 4.2. Conduct annual needs assessment of current pre-service and in-service training needs

Completed

Strategy 4.3. Identify outcomes for resource parents to measure skills and knowledge gained and impact of training on behaviors
a) review and refine resource parent training evaluation
b) compile results of training evaluation regionally and statewide and distribute to resource and regional consultants

4.4 Create regional pre-service and in-service training plans for resource families based on needs assessment data

2013 update 4.3 and 4.4
CRAFFT is contracted to provide pre-service and in-service training to resource families especially for those LDSS which do not have their own training staff. In addition, CRAFFT provides training and technical assistance around training to LDSS staff that provide training for their own families. CRAFFT training events are typically "hosted" by one or more LDSS and depending on anticipated participation can be "opened up" to the neighboring LDSS resource families or the region (including families of those LDSS who generally do their own training events.) Because neither VDSS nor the CRAFFT coordinators have contact information for all the prospective resource families or all the currently approved resource families, all training events are coordinated through LDSS. LDSS staff are responsible for communicating directly with the prospective or approved resource families and encouraging their participation in the training events.

CRAFFT coordinators are expected to develop and maintain collegial relationships with the supervisor(s) at the LDSS who are responsible for resource family activities; agency visits are one of the deliverables upon which CRAFFT coordinators report. Additionally, the CRAFFT coordinators work closely with their Regional Resource Family Consultant counter-parts. Where to offer which training is determined primarily through LDSS request. An annual "needs assessment" is conducted by CRAFFT with the LDSS to solicit their input as to in-service topics which should be offered and anticipated need for pre-service training. The CRAFFT coordinators develop an annual training plan based on this input. This plan will be modified over the course of the year to insure that if LDSS needs change, CRAFFT can be responsive.

Although the CRAFFT needs assessment does not directly collect information from resource families as to their perceived needs, it is intended to collect information from the LDSS staff who work most closely with the families and who are in a position to report both what type of training families have requested and also what type of training the agency staff assess is needed. In particular, the LDSS staff is in a position to know is there are particular changes in practice or "themes" with which their resource families have been struggling. This information is used by CRAFFT to provide targeted in-service training to meet those assessed needs.

In addition, the standardized CRAFFT training evaluation form used by all CRAFFT coordinators at the conclusion of any training event asks participants what other training they would like to receive. This information is reviewed by the coordinator and utilized in discussion with LDSS to plan future training activities. However, this information is not currently being systemically captured. CRAFFT and VDSS are working on developing strategies to better collect data in a manner that can be used more meaningfully to guide decision making in the future.

Finally, VDSS is currently exploring the logistical issues involved in conducting a state-wide foster parent survey. Our Division Assistant Director, Alex Kamberis, has indicated that VDSS will conduct a survey in the next year. Although not intended solely to inquire about training needs, questions about

training will most certainly be included. The information from that survey will be included in Virginia's APSR.

V. Strengthening community services and supports

All of these strategies contribute to developing an accessible array of community-based services across the Commonwealth. This strategy addresses the nature, scope, and adequacy of existing child and family and related services. This approach, which includes wraparound services when indicated, reduces the need for more intensive levels of service such as residential care – and shortens length of stay when placement is required. It contributes to the well-being of children and families.

- **Applicable Children's Services System Transformation Outcomes:**
- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 2; Permanency Outcome 1; Wellbeing Outcome 1; Well Being Outcome 2; Well Being Outcome 3; Systemic Factors: Staff and Provider Training, Service Array and Resource Development
- **Applicable CFSR Items:** Item 3, Item 4, Item 10, Item 17, Item 21, Item 22, Item 23, Item 32, Item 33, Item 35, Item 36,

Goal: Expand community services and supports that are child-centered, family-focused and culturally relevant.

1. **Expand services to prevent and treat child abuse and neglect** through supporting and advocating for interdisciplinary resources.

a) Utilize child abuse and neglect prevention funds to support evidenced-informed and evidenced-based programs and practices.
b) Utilize child abuse and neglect treatment funds for support services to child victims.

Completed

2. Expand services that allow children to remain safely in their own homes

a) Evaluate the recent survey on service array from local departments of social services where 52% responded that services to allow children to remain safely at home were available in their communities.
b) Convene a group of LDSS staff to further examine the problem and identify areas of the State where these services are not available.
c) Request assistance from the National Resource Center on In-Home Services.
d) Develop and implement a plan to improve services that allow children to remain safely in their own homes in underserved areas of the State.

Completed

3. Help meet the educational and health needs for all children in, or at risk of foster care through developing and implementing a comprehensive plan for improving LDSS staff understanding and skills related to advocacy and effective practice.

a) Implement the health-related advisory group's ongoing recommendations to ensure the health *(physical, emotional and mental health)* needs of children in foster care are being addressed in a timely manner.

b) Increase LDSS workers ability to enhance the educational success of children in, and at risk of, foster care through training for LDSS workers on educational advocacy through Virginia resources.

2013 update

For SFY 2012 VDSS, the education workgroup and other key stakeholders continued to meet in order to promote promising strategies to improve educational outcomes that support the enhancement of educational continuity and school stability for Virginia children in out of home and adoptive care. Additional guidance that addresses the responsibility of the Comprehensive Services Act (CSA) vs. the local school district in funding transportation when a child has an IEP was clarified and the workgroup completed a joint guidance update (VDSS and DOE) that will be published in June 2012. In addition, the Educational Specialist completed 8 regional training events (226 people) on Fostering Connections and ETV. Educational training continues to be a priority given the need to remind localities of the importance of this requirement for all children attending school and in foster care.

4. Increase the full array of independent living services and resources through implementing strategies to prepare youth in, and aging out of, foster care for successful transition to self-sufficiency.

a) Implement the Ansell Casey Life Skills Assessment statewide to assess youth's independent living *(IL)* skill needs.
b) Select a contractor to accomplish the deliverables of the Best Value Acquisition *(BVA)*, including, but not limited to:
c) Establishing 5 regional IL specialists and regional youth councils;
d) Training on the Ansell Casey Life Skills Assessment; and
e) Training youth to develop or enhance their life, leadership, and advocacy skills.
f) Establish an effective statewide educational program through local, regional and state partnerships and linkages to assist youth in completing secondary education and enrollment assistance and support for post-secondary education.

2013 Update

During this fiscal year, VDSS began transitioning Project LIFE to a Performance-based Contract with the main focus on providing training and technical assistance to LDSS on conducting IL assessments and transitional living plans for youth. Seven Project Life regional Independent Living (IL) Consultants are assisting VDSS in carrying out the goal to have an IL assessment and transitional living plan on all youth ages 14 and over which will be conducted annually. Effective September 31, 2012, Casey Life Skills Assessment (CLSA) replaced the Ansell Casey Life Skills Assessment (ACLSA). Although, CLSA offers a tutorial to use the assessment, many LDSS requested Project LIFE to provide hand-on instructions with the new assessment. In addition, VDSS and Project LIFE collaboratively developed new templates with instructions for the transitional living plan (youth ages 14 to 17) and the 90-day transition plan (ages 18 and over) to be used statewide.

Project LIFE has been instrumental in getting youth in and transitioning out of foster care involved in trainings, activities, and events that promote permanency and self-sufficiency. However, due to focus of the PBC, some contract deliverables were "taken off the table" (i.e., developing five regional youth councils, Speaker's Bureau, facilitation of Family Partnership Meetings) at this time. VDSS continues to work with Project LIFE, LDSS, Great Expectations and other stakeholders to increase the number of youth completing school and enrolling in post-secondary education or vocational programs by providing technical support and guidance.

Goal: Partner with stakeholders to strengthen and expand the continuum of community based services.

1.Collaborate with CSA's Community Service Development Steering Committee and its workgroups on:

a) Managing the array of community services through designing and using existing resources and tools to help localities:
   - Assess trends in how services are changing over time, compare services utilization with peer communities with similar demographics, and prioritize service gaps *(using CSA management team reports, Critical Services Gap Survey, vendor reports, and Comprehensive Community Based Service Array Guide).*
   - Gather family input on improving services and measuring program progress though family satisfaction surveys.
   - Create services through a new tool for estimating program costs, workload volumes, and alternative revenue models and guidance on how to quantify gaps in local service arrays, being developed by the Casey Strategic Consulting Group.

b) Engaging providers through developing:
   - Toolkit on how to recruit and sustain non-traditional providers;
   - Public/private partnerships, including a Model Memorandum of Understanding *(MOU)* to facilitate multi-locality or regional procurement of services;
   - Model contract that includes family engagement and outcomes;
   - Model process for expedited provider authorization for licensing new programs; and
   - Vendor evaluation tool.

c) Using tools for utilization management and review:
   - Using the CSA Model Utilization Management Plan;
   - Developing a model utilization review process, using data from CANS, the CSA data set, OASIS, SafeMeasures, and other relevant systems; and
   - Incorporating the family and youth voice into these processes.

2. Collaborate with state and local stakeholders on developing and strengthening services that preserve families, achieve permanency, and promote child health, safety and well being.

a) Participate on state level inter- and intra-agency workgroups tasked with coordinating service and program initiatives.
b) Develop and provide education materials to inform key stakeholders on effective strategies *(e.g., mandated reporters and the general public on child abuse and neglect; kinship care providers; judges)*.

Goal: Provide culturally relevant and diverse services in collaboration with families and children to meet their needs.

1. Address the disproportional representation of youth of color and the system's responsiveness to cultural diversity.

a) Establish a workgroup to identify issues and make recommendations.
b) Develop and implement a plan to provide culturally relevant and diverse services.
c) Track and disseminate information on best practices, resources and approaches to delivering culturally relevant and diverse services to LDSS.

VI. Continuous quality improvement

Using the right data to manage performance is a key driver of the Transformation. Virginia is developing and implementing a consistent process statewide for capturing and using data to support decision-making, improve practice quality, and promote accountability. Virginia is defining outcomes based on the Transformation goal of developing lifelong family connections for children within their own community, and then creating measures to track progress.

- **Applicable CFSR Outcomes or Systemic Factors:** Systemic Factors: Statewide Information System; Quality Assurance System, Staff and Provider Training

- **Applicable CFSR Items:** Item 24, Item 30, Item 31, Item 32, Item 33

Goal: Promote a seamless continuum of policy and guidance across the child welfare programs.

1. **Align policies and guidance in child protective, foster care and adoption services** to provide consistency and improve coordination and integration across programs on a regular basis.

a) Examine other states' approaches.
b) Solicit input from committees comprised of key stakeholders.
c) Develop consensus on definitions, structure and format for policies, guidance and procedures.
d) Revise the manuals to provide consistency, integration and linkages across programs and to incorporate the state practice model.
e) Routinely update and revise materials as needed.

COMPLETED

Goal: Use data to inform management, guide policy decisions, improve practice, measure effectiveness and promote accountability.

1. Create a robust reporting system for the Division of Family Services

a) Continue to produce and disseminate reports created by OBRA that provide outcome and process data to LDSS. Increase the use of longitudinal data in Virginia's child welfare system:
- Continue membership to Chapin Hall's Multi-state Foster Care Data Archive; and
- Routinely share analyses completed by the Outcome Based Reporting and Analysis Unit with state and local stakeholders.

b) Implement SafeMeasures in all 120 LDSS, regional offices and the VDSS home office. Seek funding to extend subscription annually starting 2010.
c) Create an automated data system for ad hoc requests by 2012.

PS 4 Obj. 1. Increase use of data driven decision making in Virginia's child welfare system

<u>Strategy 1.1</u> Conduct Translating Outcomes to Practice (TOP) meetings quarterly.
a) Routinely examine data to determine both best practices and opportunities for improvement across program areas.
b) Provide data to program staff/process improvement teams as they develop and implement process improvement plans.
c) Monitor outcomes to determine if process improvement plans are moving the outcomes.

2013 update

DFS held a TOP meeting in June and September 2012. Both meetings focused on exploring kinship care. Data shows that Virginia has one of the lowest rates of kinship placements for children in foster care. The group discussed reasons this could be possible including; ldss foster care prevention activities are occurring but aren't being captured in OASIS, barrier crimes inhibit family approvals, and social worker attitude toward family. The group determined two questions that could be addressed: 1) How well are we doing before the children that enter care? We need data for this to see if we are doing a good job., and 2) why aren't the children that are coming into care not going to relatives? There has not been a follow up meeting of this group to address these issues.

Strategy 1.2 Utilize available reporting tools in all 120 LDSS, regional offices, and the VDSS home office.

a) Train and monitor the use of SafeMeasures

b) Expand the use and awareness of the Virginia Child Welfare Outcomes Reporting Utility (VCWOR)

2013 update

This strategy is ongoing. SafeMeasures usage continues to remain at around 400 active users in any given month. Local department and state staff continue to utilize SafeMeasures as a supervisory tool and for reporting. There have not been new SafeMeasures trainings, however, there are plans for training in the fall of 2013.

Strategy 1.3 Improve programmatic performance by monitoring process and outcome data.

a) Develop a method of tracking children at risk of aging out of foster care that will focus on children with long term permanency goals, TPR without placement in pre-adoptive homes, and children in congregate settings for more than 180 days.

b) Develop a report that monitors participation in Family Partnership Meeting

c) Develop and disseminate to regional staff reports on case worker visits with children, parents, foster parents, sibling visits, and child and family visits

2013 update

This strategy has been completed. The reports have all been created and the worker visit reports have been incorporated into SafeMeasures.

Strategy 1.5 Develop a method to track recurrence in Family Assessment cases.

2013 update

The Department revised guidance in the area of making a track assignment. More detailed examples are being provided. The revised policy/guidance was made available by January 2013. Policy stated the investigation track, or the more traditional approach, must be used if a family has had three family assessments in the past twelve months. This has been changed to suggest investigating if there has been two family assessments in past twelve months, the next one should be investigated. History of prior reports is one of the criteria in determining track, the more prior incidents the more serious because it is easily interpreted as the family has not made the necessary changes to keep the child safe. It may also suggest that the prior interventions were not done in a comprehensive manner and failed to engage the family and help them recognize their needs. It also could mean someone has a vendetta against them and the numerous reports could in fact be malicious. If so, an investigation would at least allow for legal recourse on the part of the alleged abuser because they can petition the court to find out who made the report and pursue civil action against them. A report was created to help track the recurrence of Family Assessment cases.

2. **Develop and implement the National Youth in Transition Database *(NYTD)* to collect and report required data on independent living services for youth in and transitioning out of foster care.**

a) Work collaboratively with OASIS staff to ensure that required data elements are in the system.
b) Provide training to LDSS on the database.
c) Develop initiatives to help youth in foster care and those aging out to understand and participate in the NYTD.

2013 Update

Virginia implemented the National Youth in Transition Database (NYTD) on October1, 2010 as required by the federal government. During federal fiscal year (FFY) 2012, a total of 1,961 youth were eligible to receive independent living services, and 99% percent received at least one service. Local workers documented IL services provided to youth age 14 and older in the Online Automated Services Information System (OASIS) during FFY 2012. A total of 14 types of services were reported in the areas of: employment, education, independence preparation, interpersonal development/health, and financial assistance. Youth may have received more than one type of service. Information is provided on youth by age group: 14 to 15 years, 16 to 17 years, and 18 years and older as well as VDSS region.

Key Findings:

Nearly all (99%) of eligible youth received at least one IL service in FFY 2012. A majority (69%) of youth received some type of independence preparation service, and over half (56%) received services in the area of interpersonal development and health. In terms of specific areas of services, youth were most likely to receive academic support and budget/financial management training and least likely to receive room and board financial assistance and post-secondary academic support. Between FFY 2011 and 2012, provision of services improved substantially for Western region youth. Ninety-four percent (94%) of eligible Western youth received at least one IL service in FFY 2012 – up from 53 percent in FFY 2011.

Youth age 18 and over comprise over half (58%) of the IL-eligible population – up from 44 percent in the previous year. Possible reasons for this shift include statewide efforts to provide continued services for youth after age 18, improvements in developing more permanent placements for older youth, and limited job opportunities for workers with low levels of education. The changing demographics of foster youth in Virginia require a thorough examination of currently provided services to improve the provision of post-secondary education and employment services.

Service intensity varied by age, region, and agency size. Youth in the youngest age group were least likely to receive intensive help (6 or more services) than youth age 16 or older. About half of the youngest group (49%) received only one or two IL services over the course of the year. In contrast, approximately 60 percent of youth ages 16 and older received three or more IL services during the year. Two-thirds (67%) of youth in the Central region received moderate (3 to 5) or intensive services as compared to just over half (57%) in the other regions. Youth from mid-sized agencies (Level 2) had the highest service intensity. About two-thirds (65%) of youth from Level 2 agencies received at least three IL services and one-third (34%) of those youth received six or more services.

For agencies with at least 30 eligible youth, 70 percent of those agencies provided three or more services to the majority of eligible youth.

The type of IL services received differed by age and region. Younger youth (age 14 to 15 years) were least likely to receive budget/financial management services, education services, and financial assistance.

Older youth (age 18 and older) were most likely to receive those same categories of services. Compared to all VDSS regions, youth in the Eastern region were least likely to receive education and employment services whereas Central region youth were most likely to receive these types of services. Over two-fifths (42%) of youth from the Western region received financial assistance as compared to approximately one quarter of youth from other regions.

For FY 2013, VDSS completed the following objectives:

- Provided five regional training for LDSS workers on NYTD;
- Further strengthened VDSS Foster Care Guidance Manual to include information on NYTD and collecting data on youth;
- Presented NYTD information at teen conferences; and
- Produced meaningful reports for stakeholders based on the NYTD and other IL data collected from LDSS.

For FY 2014, VDSS and Project LIFE will continue to provide T/ TA to LDSS to support young people and comply with federal NYTD requirements. In addition, Virginia has a scheduled site visit June 26 – 27, 2013 with the Administration for Children and Families (ACF) Children's Bureau. The purpose of the Children's Bureau site visits is to begin documenting how states are collecting and managing NYTD data in order to assess multiple states capacity for reporting accurate data consistent with the requirements specified in the NYTD regulation. The Children's Bureau also uses site visits as a method to test strategies that might later prove effective in evaluating data collection and reporting through a formal NYTD Assessment Review.

3. Develop a comprehensive quality assurance system that measures child status and system performance indicators.

a) Establish a mechanism and process with accountability and feedback loop to review each LDSS agency
b) Establish protocol and process for Quality Improvement Unit to work with regional consultants to establish system improvement plans by July 2009.
c) Develop a report template to be used by regional consultants and LDSS to track system improvement goals by July 2009.
d) Develop a process to gather and report on child status and system performance indicators by July 2010.

Completed

PS 4 Obj. 2. Develop a comprehensive quality assurance system that measures child status and system performance indicators.

<u>Strategy 2.1</u> Develop and implement QSR as Virginia's quality assurance system.

a) Finalize work plan for 2010
b) Communicate & educate stakeholders on the plan
c) Develop and pilot instrument Fall of 2010
d) Make modifications and finalize the instrument
e) Train reviewers in January 2011 and June 2011
f) Conduct 5 reviews in 2011 beginning in February

Completed

<u>Strategy 2.2</u> Implement a System Improvement Plan (SIP) to be used after the Child Welfare Quality Review (CWQR) by regional consultants and LDSS to track continuous progress towards performance outcomes.

a) Regional consultants conduct feedback meeting with LDSS after a CWQR focused on outcomes.
b) SIP developed by LDSS, distributed and monitored by regional consultants based on outcome measures.
c) VDSS compiles semi annually SIPs and status and distributes to LDSS and stakeholders.
d) Develop link with System Improvement Plan process in order to help inform training priorities

2013 update

Since beginning QSR 18 local departments have submitted SIPs. And 16 of these are posted on SPARK, the VDSS website. In response to the trends identified in the practice performance indicators in the QSRs, the majority of the SIPs are addressing teaming and engagement. These plans contain action steps around policy, training, and the creation of tools. Assessment and Understanding is also an area being addressed in some SIPs, specifically surrounding comprehensive family assessments and the tracking and monitoring of services stemming from those assessments.

Many of the SIPs have identified certain Critical Outcome measures to monitor for impact as a result of the plans. Some of these measures include: increase% of discharge to permanency, decrease % of children in foster care for 24+ months, increase % of kinship placements, decrease % of youth in congregate care placements, and decrease % of youth entering foster care. Each locality is to submit quarterly progress reports in order to monitor improvement in practice and outcomes. A summary of issues identified and proposed action steps are as in the table below.

System Improvement Plan Contents

Identified Issue	Identified Action Steps
Enhance Family Engagement	• Educate community (private providers, schools, etc.) on family engagement • Train staff & community on engaging fathers • Develop fatherhood engagement initiative • Create workgroup for fatherhood engagement workgroup • Identify and utilize Genogram software • Utilize ACCURINT/Family finding tools • Create/distribute parent involvement handbook when child enters foster care • Create/refine internal policy & procedures on engagement
Increase Team Formation & Function through increased understanding & effectiveness of team meetings	• Refine/update treatment team meeting policy & procedures • Create Family Team Meeting unit – conduct Family Partnership Meetings, Family Group Conferences & Family Finding • Hold team meetings every 90 days • Create system for documenting assessments & meetings • Create team meeting and member tracking tool • Educate community (private providers, schools, courts, etc.) on family engagement and in particular Family Partnership Meetings and best practice • Training for staff on conducting effective team meetings • Implement Family Partnership Meetings • Utilize Family Partnership Meeting debrief sessions • Hold monthly case staffing between CPS/FC staff

Assessment & Understanding	• Develop/implement protocol on assessment & ongoing monitoring • Create family assessment tool • Conduct comprehensive family assessment (train staff to do so)

Strategy 2.3 Develop a report on child status and system performance indicators from the QSR.

2013 update

With the development of the new QSR protocol and process and the revised SIP we began an annual report process beginning in August 2012, and will continue each August. This report will link critical outcome measures with aggregate measures from the QSR and the work of system improvement plans. This report will address the feedback loop at the state and local level to inform practice and outcome improvements in child welfare . Here are some highlights from the August 2012 Report

Methodology & Approach for a QSR

Each review involves the selection of a random sample of cases from Child Protective Services ongoing and Permanency cases in a local department of social services. These cases are reviewed through detailed interviews by trained reviewers with input from key case contributors. The interviewees for each case may include the case worker, foster parent, focus child and his/her family members, attorneys, therapeutic supports, school personnel, service providers and other persons associated with helping the family.

Specifically, each case review is conducted by two person review teams of Virginia professionals who have a working knowledge of Virginia's Children Services Practice Model and the QSR protocol. Reviewers have two days of classroom training on the protocol and then training continues through mentoring and coaching during an actual QSR. In this sample of 164 cases there were a total of 1,207 interviews conducted. The average number of interviews per case was 7.5 interviews and a range of 3 to 13 interviews per case across the sample.

Characteristics of Children in this Report

Sample cases for a QSR are selected randomly from CPS ongoing and Permanency cases using five categories for age. Additional sampling methodology includes a variance of permanency goals and insuring that a caseworker has only one case in the sample. This report covers a random sample of 164 cases. Characteristics of this sample include:

- 46 cases (28%) CPS ongoing cases and 119 cases (72%) were children in foster care or adoptive placements.
- 52% were male and 48% were female
- 39% White/Caucasian and 52% were Black/ African American, 7% Biracial, 2% Asian and 1% American Indian/Alaskan Native

A. Overview of Results

The twenty indicators assessed using the QSR protocol are organized here as to the areas in which there is strong practice and areas in which there are opportunities to improve practice statewide.

Definitions and details on each of the QSR protocol indicators listed below can be found in the Detailed Results section of this report beginning on page 14 of this report

Areas of Strength – Child and Family Status Indicators

- Safety – Exposure to Threats of Harm
- Safety – Risk to Self/Other
- Living Arrangement
- Physical Health
- Learning/Academic Status.

Areas of Strength – Practice Performance Indicators

- Cultural Awareness and Responsiveness
- Resource Availability

Opportunities for Growth – Child and Family Status Indicators

- Stability
- Permanency
- Emotional Well-Being
- Pathway to Independence
- Parent and Caretaker Functioning

Opportunities for Growth – Practice Performance Indicators

- Engagement
- Voice and Choice.
- Teaming – Formation and Functioning
- Assessment and Understanding
- Long Term View
- Planning For Safe Case Closure
- Transitions and Life Adjustments
- Intervention Adequacy
- Maintaining Quality Connections
- Tracking and Adjustment

B. QSR Results – Implications for Practice

This report identifies strengths in practice and three identified themes as opportunities for improved practice, Engagement, teaming, and assessment and understanding indicators were found to be recurrent across the state and these issues offer significant implications for practice.

- **Engagement**

The Virginia Children's Services Practice Model is the foundation of the work we do and the QSR operationalizes this model. The Practice Model states Virginia shall be family focused with the belief in family, child, and youth driven practice. The QSR indicators for engagement and voice and choice measure the level of trust based relationships being built by the local department with families, and the families' engagement in service and case planning, as well as whether or not they have a voice and choice in decisions. These elements of engagement epitomize the family focus of the Practice Model. Results indicate casework practice is strong for engaging children and substitute caretakers but there is an opportunity to improve practice on engagement for mothers and fathers. The lack of engagement with parents can negatively impact client progress and successes. When families are engaged for planning and service delivery, child and family status outcomes can be improved and cases can move closer to permanency.

- **Teaming**

Teaming, both formation and functioning, is about the identified child, family, family supports, and service providers meeting on a regular basis and sharing common goals of permanency and working

towards accomplishing those goals. With quality teamwork and good communication among the team members occurring, a clear, long term view for the child is formed and thus the planning for safe case closure and permanency is better, faster, and more successful.

Results indicate that while some cases had Family Partnership Meetings, there is an overall lack of ongoing teaming in case practice. Results showed service providers in some cases holding different information and working toward conflicting goals. When teaming with the appropriate team members occurs on a regular basis, this can be avoided. With the practice of strong engagement of all parties, teaming is successful.

- **Assessment & Understanding**

The QSR evaluates whether or not there is adequate assessment of the child and family needs and whether everyone on the team understands what needs to occur to respond to the assessments. Results indicate that while resources appear to be available, children and families are not being linked with the appropriate services due to lack of or inadequate assessment of needs. When comprehensive quality assessments occur, the appropriate services can be identified and the ongoing work of the team can monitor, track and adjust services to fit the needs of the child and family.

- **Strengthening Families- Mothers and Fathers**

With opportunities present in relation to performance indicators for parents, a linkage is made to the strengthening families initiative of VDSS. Results indicate that in some cases parents have not consistently been engaged and included in case planning and they report feeling as though they do not have a voice in decisions made for their children and families. It is of interest to note that fathers are noticeably absent or on the periphery of the cases reviewed and are not fully engaged. Mothers and fathers are often not fully assessed for their issues and needs and thus limited or inadequate services are provided to support them for improved outcomes for children and permanency. The results of these reviews also revealed that maintaining connections for children in foster care with their parents, siblings and extended families is also an opportunity for improvement.

These results reveal the significant opportunity for identification, engagement, and inclusion of mothers and fathers in case practice. Doing so will align with the efforts of VDSS to strengthen families and improve outcomes for children.

- **Summary**

These three indicators and additional focus on mothers and fathers will impact outcomes for children and families. By enhancing core practices in areas of engagement, teaming, and assessment and understanding overall, other areas such as permanency, long-term view, and planning for safe case closure can be impacted. These issues above are the significant opportunities identified through the QSR in this review period. The next step in the QSR is the System Improvement Plan and many local agencies are addressing these issues in that next step.

Feedback Loop – VDSS Action

- **Feedback Protocol for System Improvement Plans**

The response to Quality Service Review for improved practice occurs on multiple levels: the individual caseworker, the local department through the development of System Improvement Plans and then on a state level through the Division of Family Services (DFS) and VDSS Local Programs Training Unit. This model is provided to standardize the feedback and analysis in the support of the SIP after a QSR. The basic model of process improvement includes five steps, Define, Measure, Analyze, Improve and Control. This model will be used to identify implications for policy, training and practice improvement in the child welfare system in Virginia to improve outcomes for children and families.

Key players in this process include the Quality Manager and Quality Analysts of the Continuous Quality Improvement (CQI) Unit who manage the QSR and the SIP developed by a local department of social services. These positions identify emerging issues on a local level.

The Quality Manager will on a six month basis develop a report of identified emerging issues related to policy, practice and training to be presented and discussed with the following stakeholders as appropriate.

- Division of Family Services Leadership Team
- Division of Family Services Training Manager in Local Programs Training
- Program Managers for Permanency, Child Protective Services, Prevention and Family Engagement

Program areas as appropriate will initiate training for practice change. The CQI Unit will report annually on the issues identified and any practice changes that various program areas have initiated to improve outcomes for children and families. Two examples of steps taken by VDSS include first, a revised curriculum on improved practice on family engagement for new local department of social services workers. Secondly a model is being created for the development of child and family team meetings creating a linkage between the current initiative of family partnership meetings and ongoing teaming as defined in the QSR teaming indicator.

- **Training Initiative on Engagement of Families**

Division of Family Services, in collaboration with Local Programs Family Services Training Unit, is addressing the opportunities for improvement identified in engagement and the implications for practice. In order to support this opportunity for improved practice, DFS offered a three day pilot training "Engaging Families and Building Trust-Based Relationships" for child welfare supervisors and senior workers on December 6, 7 and 8, 2011 at two training sites. Participation was targeted at supervisors, senior workers and curriculum developers and forty professionals attended the training. This training was offered through the support of Casey Family Programs and conducted by the nationally recognized Child Welfare Policy and Practice Group of Alabama. The Division of Family Services has used the content of the curriculum to make major revisions to CWS4020, *Introduction to Virginia's Family Partnership Meeting*, now called **Engaging Families and Building Trust-Based Relationships** which will be piloted in October of 2012 and available for state wide dissemination after that with the course included on the list of mandated courses for new staff. Some training topics include:

- Explore characteristics of family culture and information in policies and practices that support the engagement process with families.
- Practice specific engagement and trust building skills of exploring, focusing, and guiding
- Learn and practice solution-focused questions to surface family member's strengths, needs, culture, and solution patterns.
- Identify ways to formulate, evaluate and refine options with families.
- Learn to define and identify essential underlying needs that are often a description of the underlying conditions.
- Learn how to develop a working agreement with families and to utilize this agreement, core conditions and core helping skills to build a trusting relationship with families.

- **Teaming Initiative – A Continuum of Practice**

Program Managers in the Division of Family Services have collaborated to address the opportunities for teaming, building on the strengths already in place through the establishment of the Family Partnership Meetings (FPM). FPMs are one practice strategy for ensuring that family engagement, voice and choice and teaming are part of the agency's day to day case work practice in support of the Practice Model. However, FPMs are only one strategy and generally occur infrequently over the course of a case and,

therefore, are not sufficient in and of themselves to ensure systems change. Teaming for the QSR indicators is about ongoing communication and meeting of family and service providers sharing a commonality of purpose in the delivery of services and planning for the child and family.

VDSS is proposing the use of regular Child and Family Team meetings as a continuation of the work of FPMs. This meeting would include the youth, parents, extended family and all service providers. It would provide a mechanism by which regular review of services and progress would be shared among all the individuals involved in the case and where the family's needs and preferences could routinely inform decision making. Tools are being created to assist supervisors in local agencies in order to clarify the purpose of both types of team meetings as well as when each is appropriate and how to implement and facilitate all meetings. This information is to be distributed in the fall of 2012 with a tool kit to support this model of child and family team meetings. Resources and tool kit will be developed and available on the agency SPARK page to support this practice improvement.

Special topic training has been developed for June 2013 on "Implementing and Sustaining Child and Family Teams." This workshop includes discussion of engagement concepts and strategies to implement and conduct Child and Family Teaming (CFT). Case examples are used to illustrate key points, while small and large group activities provide opportunities to practice skills and assess individual strengths. Strategies are discussed regarding best practices for managing CFTs, including running meetings, maintaining communication between meetings and ensuring all needed parties are engaged. In addition, supervisors have specific opportunities to assess resources and plan how to evaluate application of strategies in their agencies. Both Child Welfare Workers and Supervisors are encouraged to attend.

III. Additional Reporting Information

A. Monthly caseworker visits

LDSS have improved their percentage of monthly worker visits in part, as an artifact of reducing the number of children in foster care and improving placements in the child's local community. Instituting Family Partnership Meetings as a statewide initiative has also contributed to children's placement in their home community and increased availability to workers by keeping children in their community. Workers have been able to increase visitation despite receiving very few additional resources.

Federal Title IV-B funds to support worker visits have been used to pay for additional staff, purchase laptops computers as a time-saving measure, allowing for quicker documentation and downloading of the visit information in to OASIS; transcribers; and travel costs for increased visitation. Because federal allocation of these funds are limited to five years, the finance division of the VDSS has retained their commitment to identify and allocate equivalent funds to each locality as part of their base administrative cost base once federal funding ends.

Aggregate data for the year indicates Virginia did not reach the goal for monthly visits during FFY 2012. Virginia continues to look for strategies to reach federal measures. The quality of these visits has been an on-going emphasis as well and the Quality Services review team reviews worker contacts in their scheduled agency visits.

The state continues to publish a monthly visit report as part of the "Critical Outcomes Report" available to all LDSS staff through SafeMeasures. The report provides monthly updates on worker visits and allows users to "drill down" to the worker level to identify where improvements in visits need to be made to reach and surpass federal goals. Statewide SafeMeasures training will be offered in the late summer to help workers utilize this took including prioritizing monthly worker visits to ensure the safety of foster

children in their care. VDSS staff are exploring options to build a new measure in the tool to enhance workers understanding of monthly federal reporting.

B. National Youth in Transition Database

Virginia implemented the National Youth in Transition Database (NYTD) on October1, 2010 as required by the federal government. During federal fiscal year (FFY) 2012, a total of 1,961 youth were eligible to receive independent living services, and 99% percent received at least one service. Local workers documented IL services provided to youth age 14 and older in OASIS during FFY 2012. A total of 14 types of services were reported in the areas of: employment, education, independence preparation, interpersonal development/health, and financial assistance. Youth may have received more than one type of service. Information is provided on youth by age group: 14 to 15 years, 16 to 17 years, and 18 years and older as well as VDSS region.

Key Findings:

Nearly all (99%) of eligible youth received at least one IL service in FFY 2012. A majority (69%) of youth received some type of independence preparation service, and over half (56%) received services in the area of interpersonal development and health. In terms of specific areas of services, youth were most likely to receive academic support and budget/financial management training and least likely to receive room and board financial assistance and post-secondary academic support. Between FFY 2011 and 2012, provision of services improved substantially for Western region youth. Ninety-four percent (94%) of eligible Western youth received at least one IL service in FFY 2012 – up from 53 percent in FFY 2011.

Youth age 18 and over comprise over half (58%) of the IL-eligible population – up from 44 percent in the previous year. Possible reasons for this shift include statewide efforts to provide continued services for youth after age 18, improvements in developing more permanent placements for older youth, and limited job opportunities for workers with low levels of education. The changing demographics of foster youth in Virginia require a thorough examination of currently provided services to improve the provision of post-secondary education and employment services.

Service intensity varied by age, region, and agency size: Youth in the youngest age group were least likely to receive intensive help (6 or more services) than youth age 16 or older. About half of the youngest group (49%) received only one or two IL services over the course of the year. In contrast, approximately 60 percent of youth ages 16 and older received three or more IL services during the year. Two-thirds (67%) of youth in the Central region received moderate (3 to 5) or intensive services as compared to just over half (57%) in the other regions. Youth from mid-sized agencies (Level 2) had the highest service intensity. About two-thirds (65%) of youth from Level 2 agencies received at least three IL services and one-third (34%) of those youth received six or more services.

For agencies with at least 30 eligible youth, 70 percent of those agencies provided three or more services to the majority of eligible youth.

The type of IL services received differed by age and region: Younger youth (age 14 to 15 years) were least likely to receive budget/financial management services, education services, and financial assistance. Older youth (age 18 and older) were most likely to receive those same categories of services. Compared to all VDSS regions, youth in the Eastern region were least likely to receive education and employment services whereas Central region youth were most likely to receive these types of services. Over two-fifths (42%) of youth from the Western region received financial assistance as compared to approximately one quarter of youth from other regions.

For FY 2013, VDSS completed the following objectives:

- Provided five regional training for LDSS workers on NYTD;
- Further strengthened VDSS Foster Care Guidance Manual to include information on NYTD and collecting data on youth;
- Presented NYTD information at teen conferences; and
- Produced meaningful reports for stakeholders based on the NYTD and other IL data collected from LDSS.

For FY 2014, VDSS and Project LIFE will continue to provide T/ TA to LDSS to support young people and comply with federal NYTD requirements. In addition, Virginia has a scheduled site visit June 26 – 27, 2013 with the Administration for Children and Families (ACF) Children's Bureau. The purpose of the Children's Bureau site visits is to begin documenting how states are collecting and managing NYTD data in order to assess multiple states capacity for reporting accurate data consistent with the requirements specified in the NYTD regulation. The Children's Bureau also uses site visits as a method to test strategies that might later prove effective in evaluating data collection and reporting through a formal NYTD Assessment Review.

C. Timely home studies

The effort continues to reduce the home study time for requests coming into Virginia and for those going out of Virginia. Nationally the experience has been the same – while there has been a decrease in time for relative and parental placement studies, for those states like Virginia, who require foster care certification for all relatives except parents, the length of time has not decreased significantly.

Placement Requests Into Virginia
May 1, 2012 to May 31, 2013

Type o f Placement	Public Agency	Private Agency	Court	Individual	None
Parent(s)	186	1			
Relative	8				
Foster Home	564	5			
Adoptive	219	52		11	1
Group Home				1	
Residential	273	1	3	50	
Institutional Care (Article VI)					
Child Care Institution					
Other					
Total	**1,250**	**59**	**3**	**62**	**1**

Sex of Children	**Male**		**Female**		**Unknown**	
	696		535		2	
Ages of Children	**Under 1**	**1-5**	**6-10**	**11-15**	**16-18**	**19-21**
	219	261	248	318	177	
Ethnic Group	**White**	**African American**	**Asian**	**American Indian**	**Hawaiian/ Pacific Islander**	**Unable to determine**
	619	375	20	13	7	199

Hispanic	Yes	No	Unable to determine	Declined		
	106	886	240	1		

# of Calendar Days Between Sending ICPC-100A and Receipt Back with Decision	0-30	31-60	61-90	Over 90
	371	147	128	271

Adoption Assistance Subsidy: 47

Total Number of Agreements Into Virginia Terminated

Adoption Finalized	266	**Total: 1372**
Age of Majority/Emancipation	86	
Legal custody returned to parents (concurrence)	47	
Legal custody to relative (concurrence)	52	
Treatment complete	85	
Sending state jurisdiction terminated (concurrence)	1	
Unilateral termination	6	
Child returned to sending state	189	
Child moved to another state	11	
Proposed placement request withdrawn	72	
Approved resource will not be used for placement	67	
Other	490	

Number of children returned to Virginia: 182

Placement Requests Out of Virginia

May 1, 2010 to May 31, 2011

Type o f Placement	Public Agency	Private Agency	Court	Individual	None
Parent(s)	196		2		1
Relative	10		2		
Foster Home	451	1			3
Adoptive	46	71		7	2
Group Home	1				
Residential	49		2	73	1
Institutional Care (Article VI)					
Child Care Institution					
Other					
Total	**753**	**72**	**6**	**80**	**7**

Sex of Children	Male	Female	Unknown
	392	365	1

Ages of Children	Under 1	1-5	6-10	11-15	16-18	19-21
	132	177	148	192	102	
Ethnic Group	**White**	**African American**	**Asian**	**American Indian**	**Hawaiian/ Pacific Islander**	**Unable to determine**
	401	222	9	2	1	122
Hispanic	**Yes**	**No**	**Unable to determine**			
	61	590	106			

# of Calendar Days Between Sending ICPC-100A and Receipt Back with Decision	0-30	31-60	61-90	Over 90
	164	84	117	337

Adoption Assistance Subsidy: 11

Total Number of Agreements Out of Virginia Terminated

Adoption Finalized	134	**Total: 868**
Age of Majority/Emancipation	38	
Legal custody returned to parents (concurrence)	25	
Legal custody to relative (concurrence)	40	
Treatment complete	31	
Sending state jurisdiction terminated (concurrence)		
Unilateral termination	12	
Child returned to sending state	55	
Child moved to another state	2	
Proposed placement request withdrawn	67	
Approved resource will not be used for placement	55	
Other	409	

Number of children returned to Sending state: 83

2. ICPC elements will be evaluated and recommendations made.

The report writing program continues to have problems. As previously stated, the ARRIS system is outdated and as such is not at the top of the priority list for enhancements. The Program Manager has identified and discussed the issues with the Information Technology Department and some issues that were identified have been resolved.

3. National information system.

The national data information system was discussed at the May 2012 meeting of the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC). There are a number of challenges related to the development of a national data system because not all states use the same federal reporting system. Those states that use SACWIS have a built in ICPC reporting mechanism. However, those of us who use other systems continue to have unreliable reports.

In the Spring of 2013, the AAICPC received a $1,250,000 grant to pilot the implementation of real-time, on-line data exchange for States to share records and other information to support permanent placements of foster care children in homes across state lines.

The pilot's evaluation will measure communication, expeditious exchange of case documentation and similar immediate outcomes as well as utilization and adherence to streamlined ICPC processes.

As of this submission, at least five (5) pilot sites will be selected but the sites have not been determined.

D. Inter-country adoptions

The data and service information is from United Methodist Family Services, the private contractor that manages the statewide Adoptive Family Preservation Program for Virginia's adopted families. This program is funded through the Title IV-B, Subpart II funds. Below is the report from the contractor according to the data and analysis by their subcontractor evaluator Policy Works Inc.

AFP Data Excerpt on Disruption/Dissolution of Families Served with International Adoptions – May 2013

Families with International Adoptions:

- No disruptions/dissolutions

Four-year profile		**One-year profile**	
Families with international adoptions served since 4/1/09		Families with international adoptions served since 4/1/12	
Total served: 91 (unduplicated count)		Total served: 63 (unduplicated count)	
Breakout of all cases closed:		Breakout of all cases closed	
Reason for Case Closure	**Count**	**Reason for Case Closure**	**Count**
Disruption/Dissolution	0	Disruption/Dissolution	0
Child out of home (no dissolution)	5	Child out of home (no dissolution)	3
Family moved	2	Family moved	0
No longer need services	20	No longer need services	11
No contact for 60 days	16	No contact for 60 days	5
	43		19

All Families Served:

- In past 4 years (since 4/09), 10 disruptions/dissolutions
- In past 1 year (since 4/12), 3 disruptions.

Four-year profile	**One-year profile**
All families served since 4/1/09	All families served since 4/1/12
Total served: 524 (unduplicated count)	Total served: 320 (unduplicated count)
▪ Total 10 families whose cases were closed due to dissolution/disruption	▪ Total 3 families whose cases were closed due to dissolution/disruption
▪ Adoption types for families with dissolution/disruption:	▪ Adoption types for families with dissolution/disruption:
- 7 Foster Parent Adoptions	- 2 Foster Parent Adoptions

Four-year profile		One-year profile	
- 3 Matched		- 1 Matched	
Breakout of all cases closed:		Breakout of all cases closed	
Reason for Case Closure	**Count**	**Reason for Case Closure**	**Count**
Disruption/Dissolution	10	Disruption/Dissolution	3
Child out of home (no dissolution)	38	Child out of home (no dissolution)	11
Family moved	15	Family moved	3
No longer need services	127	No longer need services	48
No contact for 60 days	83	No contact for 60 days	28
	273		93

Virginia utilized Title IV-B, Subpart 2 funding to create an Adoptive Family Preservation Services *(AFP*) system. AFP began serving adoptive families in June 2000. Through United Methodist Family Services, the AFP serves families who have adopted domestically and may also serve families that have adopted internationally. The AFP provides post legal adoption services to address presenting issues and concerns of the adoptive family.

Of the total 264 adoptive families served during the third quarter (SFY 2013), 57 have adopted internationally. These 57 families represent 21.59 % of total families served in this fiscal year. In the 57 families, there are 62 children adopted internationally. Shown in the table below are the numbers of children and families served by AFP fiscal year 2012-13, compared with the 2011-12 program year. Included in the table are countries of origin for children and the percentage of families served who adopted internationally:

Families Served in 2011-12		**Families Served in 2012-13**					
July 1, 2011 – June 30, 2012		**July to Sept 2012**		**Oct to Dec 2012**		**Jan to Mar 2013**	
Country	**# Children**	**Country**	**# Children**	**Country**	**# Children**	**Country**	**# Children**
Russia	24	Russia	17	Russia	16	Russia	17
Guatemala	7	China	8	China	9	China	10
China	7	Kazakhstan	6	Kazakhstan	6	Kazakhstan	7
Kazakhstan	6	Guatemala	5	Guatemala	5	Guatemala	4
Ukraine	4	Ukraine	4	Ukraine	4	Ukraine	4
Bulgaria	3	Bulgaria	3	Ethiopia	4	Ethiopia	4
Ethiopia	3	Ethiopia	3	Bulgaria	2	Bulgaria	2
Romania	2	Romania	2	Romania	2	Romania	2

Families Served in 2011-12		Families Served in 2012-13					
July 1, 2011 – June 30, 2012		**July to Sept 2012**		**Oct to Dec 2012**		**Jan to Mar 2013**	
Country	**# Children**	**Country**	**# Children**	**Country**	**# Children**	**Country**	**# Children**
Columbia	2	Korea	2	India	2	India	2
Latvia	2	India	2	Korea	2	Korea	2
Korea	2	Latvia	2	Latvia	2	Latvia	1
Ecuador	1	Ecuador	1	Ecuador	1	Ecuador	1
Hungary	1	Hungary	1	Hungary	1	Hungary	1
India	1	Venezuela	1	West Africa	1	West Africa	1
Venezuela	1	Malawi	1	Malawi	1	Malawi	1
Malawi	1	Paraguay	1	Philippines	1	Philippines	1
Mexico	1	Philippines	1	Venezuela	1	Venezuela	1
Paraguay	1	Not specified	1	Not specified	1		
Peru	1						
Philippines	1						
Totals							
Children	**73**		**61**		**61**		**62**
# Families w/ international adoptions	**63**		**53**		**53**		**57**
	19.33% of 326 families served		**19.49% of 272 families served**		**19.92% of 266 families served**		**21.59% Of 264 families served**

E. Licensing waivers

The Resource, Foster, and Adoptive Family Home Approval Standards became effective September 2, 2009. The guidance to support the implementation of these regulations was disseminated to the field in

June 2010. The regulations allow variances from a standard on a case by case basis and the variance must not jeopardize the safety and proper care of the child or violate federal or state laws or local ordinances. A local department of social services is required to submit the request for a variance to the regional Resource Family Consultant for review and approval. Any variances granted must be reviewed on an annual basis by the Department. Virginia state code as well as federal law limits variances to relative foster families.

F. Juvenile Justice Transfers

Through the OASIS data system, Virginia tracks reasons why children exit foster care. For SFY 2012, 29 children left foster care due to a commitment to corrections.

Defining when a child should be considered to have left foster care to the custody of DJJ was clarified in Foster Care Guidance. When the child's commitment to corrections terminates, Virginia Code specifies that for youth under 18 who were previously in foster care, they are to be returned to foster care unless another arrangement has been made (e.g., return to the parent).

G. Collaboration with tribes

Virginia has no federally recognized tribes and children belonging to a Virginia tribe are not subject to the Indian Child Welfare Act (ICWA). However, children who have American Indian, Eskimo or Aleut heritage may also be subject to the Indian Child Welfare Act. Foster Care policy was strengthened in 2011 and 2012 to provide additional information, to be consistent with CPS guidance and to provide updated tribal contact information. It directs that if the LDSS suspects or knows that a child in foster care, or one about to be placed in foster care, is of American Indian or Alaskan Eskimo or Aleut heritage, and the child belongs to a tribe located outside Virginia, the LDSS must contact the designated tribal agent about the child. The guidance also stresses that LDSS should consider any tribal culture and connections – including Virginia tribes - in the placement and care of the child. Current guidance is being reviewed and will be revised to enable amendment of the State IV-E Plan as relates to procedures for the transfer of responsibility for the placement and care of a child to Tribal IV-E agency or an Indian Tribe with a title IV-E agreement. Posting of revised guidance will be in July 2013.

The guidance links to more comprehensive information available in the Appendix A of section 1 of the CPS Manual. This guidance provides:

- Information on the Federal Act, including background, purpose and overview of applicable children.
- Responsibilities of local service workers.
- Requirements that apply to four types of custody proceedings, including foster care placements, termination of certain parental rights, pre-adoption placements, and adoption placements.
- Information on how Virginia tribes are organized and the federal funding they receive for education and community development.
- Specific Virginia Tribes that are recognized by the Commonwealth of Virginia, including the Cheroenhaka (Nottoway), Chickahominy, Eastern Chickahominy, Mattaponi, Monacan, Nansemond, Nottoway of Virginia, Pamunkey, Patawomek, Rappahannock, and Upper Mattaponi.

Past efforts to consult with Virginia's tribes to review and revise procedures related to their role in child welfare services were minimal.

H. Child Maltreatment Deaths

Sources of Information

The Virginia Department of Social Services currently uses data from child deaths investigated by local departments of social services and determined to be founded when reporting the number of child maltreatment-related deaths to NCANDS. This data comes from information reported and documented into OASIS (Online Automated Services Information System) by local CPS workers in local departments of social services. The reported death must first meet the criteria to be determined valid. The validity criteria are specified in regulation 22 VAC 40-705-50 B:

1. The alleged victim child or children are under the age of 18 at the time of the complaint and/or report
2. The alleged abuser is the alleged victim child's parent or other caretaker
3. The local department receiving the complaint or report is a local department of jurisdiction; and
4. The circumstances described allege suspected child abuse and/or neglect as defined in §63.2-100 of the *Code of Virginia.*

In determining if the report is founded or unfounded, the evidence must meet the standard of preponderance of the evidence.

Use of information from the State's vital statistics department, child death review teams, law enforcement agencies and medical examiner's offices

The main reason that the State does not use information from the State's vital statistics department, child death review teams, law enforcement agencies and medical examiner's offices when reporting child maltreatment fatality data to NCANDS, is because the persons who investigate these cases have very different roles, laws and policies governing these investigations. While the various investigators work together and clearly overlap, they do not duplicate each other's roles and tasks. The numbers will likely be different because the reporting entities have different tasks and responsibilities. The Department of Social Services is the only entity in Virginia charged by statute with determining whether or not a child was abused or neglect by a caretaker. The roles and tasks of the various entities are described below.

Virginia Department of Health, Office of the Chief Medical Examiner

- Reports all deaths that occurred in a Virginia jurisdiction, regardless of residence of the decedent. Does not typically investigate or report on deaths to Virginia residents occurring outside of Virginia.
- Investigates infant and child deaths that are sudden, unexpected, violent, traumatic, suspicious for sudden infant death syndrome, suddenly while in apparent good health, etc.
- Medico-legal death investigation to determine cause and manner of death, not whether or not child abuse or neglect occurred:
    - Cause of death: a medical diagnosis about the disease, abnormality, injury, or poison that set the lethal chain of events in motion.
    - Manner of death: depending on circumstances, could be homicide, suicide, natural, accident, or undetermined.
    - Homicide occurs when the injury reveals intent on the part of person who injured the decedent.
- Some injury patterns clearly linked to child abuse and neglect: in infants and toddlers, abusive or inflicted head trauma, blunt force trauma to abdomen, or failure to thrive directly related to caretaker neglect.
- Others injuries are accidental because the injury was not inflicted on the child in an intentional way; e.g., a child drowning in a bathtub or dying in a fire; a child unintentionally forgotten in an

automobile. In these cases, the caretaker may be deemed neglectful by a department of social services, but it does not mean they intentionally inflicted the injuries on the dead child.

- **Task:** To determine how a person died and the intention behind the fatal injury if manner of death was unnatural.

Virginia Department of Health, Division of Health Statistics

- Part of Vital Records system.
- Reports deaths occurring in Virginia and including Virginia residents and non-residents. Also reports on death events, which includes all deaths to Virginia residents where Virginia was notified of the death, regardless of where they died.
- Uses ICD-10 coding system, which is established and maintained by the World Health Organization. ICD-10 means *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision.* Although mostly overlapping with how the Office of the Chief Medical Examiner signs a case out, this coding system is not exactly the same as the schema used by the Office of the Chief Medical Examiner.
- **Task:** To report deaths, but uses a national reporting and coding schema that differs from the other reporting entities.

Virginia Department of Social Service, Child Protective Services

- Cases are identified only when reported to the state hotline or a local department of social services as suspicious for child abuse or neglect.
- Complaint must be valid. (See above for validity criteria)
- Investigates the death to determine if abuse and/or neglect occurred and who abused and/or neglected the child;
- Makes a finding of either founded or unfounded using preponderance of the evidence as the standard of evidence;
- The only entity in Virginia legally charged with determining whether or not a child was abused or neglect by a caretaker.
- **Task:** To determine whether a child was abused or neglected.

Law Enforcement/Commonwealth's Attorney

- Law enforcement uses *Code of Virginia* framework to investigate whether or not a crime was committed: murder, manslaughter, felony child abuse, felony child neglect, etc. Works with our state prosecutors, called Commonwealth's Attorneys, to investigate, develop evidence, etc.
- Differences in how they might determine whether or not a crime occurred. E.g., a gunshot wound death where a person who killed another person when "playing" with a gun, pointing it at the decedent in play, pulling the trigger because they didn't think it was loaded, etc. would typically be called a homicide by the Office of the Chief Medical Examiner (because they person playing with the gun knew it was a lethal weapon and pointed it at another anyway) while a criminal investigation would result in an accidental death outcome; and the department of social services would likely consider it a founded case of neglect due to a lack of supervision. Likewise, if a child drowned in a swimming pool, social services might decide the child was neglected by

inadequate supervision, but law enforcement could decide no crime was committed because there was no criminal intent.

- **Task:** To determine whether a crime was committed.

Expansion of sources of information

The Department of Social Services will begin by first exploring in detail the extent to which the numbers of child deaths reported and investigated by other sources are in agreement taking into account our various roles and tasks. The *Code of Virginia*, §63.2-1503 D requires that departments of social services upon receipt of a complaint regarding the death of a child to report immediately to the attorney for the Commonwealth and the local law enforcement agency and make available to them all records. The *Code of Virginia*, §63.2-1503 E requires that when abuse or neglect is suspected in any case involving the death of a child, the local department of social services report the case immediately to the regional medical examiner and to the local law enforcement agency. All cases that are investigated by the Office of the Chief Medical Examiner are made available to the Office of Vital Records.

Assuming that there will likely be some discrepancies in cases of reported deaths, the Department of Social Services will work with the Office of the Chief Medical Examiner to determine the extent of agreement or overlap in reported cases of child fatalities for SFY 2013 involving children ages 0 to four. This group of children is being targeted because these are the children who are at the greatest risk of child death due to their vulnerability. If the Department finds that cases are being missed, we will ascertain how, where, and why the numbers differ and develop a plan to gain greater consistency. We suspect that the areas of discrepancy will be in cases determined to be homicides, accidents and in cases involving non-caretakers. Furthermore, we suspect that the types of deaths will involve abandoned infants and family annihilation.

In addition, the State Child Fatality Review Team and Virginia's regional child fatality review teams review child death cases by a multidisciplinary group including social services, law enforcement, and the medical examiner. These teams are also in a position to identify cases that may have been screened out by CPS or never reported.

I. Populations at Risk for Maltreatment

The Commonwealth has identified the population of children zero to four as the population at the greatest risk of maltreatment due to the vulnerability of this population. This population is also the most likely to die as a result of maltreatment. In SFY 2011, 60% of the founded cases of child maltreatment related to fatalities were less than one year of age and all but four of the 30 children who died as a result of maltreatment were under the age of four. In SFY 2012, 78% of the children who died were under the age of four. This is consistent with national data that finds young children to be the most vulnerable. In addition, when the unfounded reports are filtered in, 46 (88.5%) of the 52 unfounded reports involved a child under the age of one in SFY 2011 and 54 or 77% of the 70 unfounded reports involved a child under the age of one in SFY 2012. In both years, approximately 70% of those cases were related to sleep environments. This means the actual surface the child slept on, with whom the child was sleeping with, or how the child was sleeping.

The State Child Fatality Team has just completed its review of 119 cases from 2009 related to unsafe sleep environments. These findings are consistent with the cases that were investigated by local departments of social services. Risk factors have been identified, findings are being reviewed, and recommendations will be made in the coming year. Some of the recommendations that seem likely are providing more awareness and training to child welfare workers in assessing the sleep environments for

young children when responding to reports of suspected maltreatment. VDSS will also likely partner with the Virginia Department of Health in implementing a campaign about safe sleep environments.

Services that are being provided are home visiting services. VDSS administers $3,785,501 in funding for the Healthy Families Program. Healthy Families targets first time parents and works with families until the child reaches the age of four. It is a program grounded in research and evidence-based practice with families and children designed to improve pregnancy outcomes and children health, promote positive parenting practices, promote child development, and prevent child abuse and neglect. Healthy Families Programs help parents provide a safe, supportive home environment, gain a better understanding of their child's development, access health care and other support services, use positive forms of discipline, and nurture the bond with their child, thereby reducing the risk factors linked to child maltreatment.

Another initiative targeted to this population, is in the area of Abusive Head Trauma (AHT). Nationally, it is estimated that each year approximately 1,200 to 1,400 babies die or suffer injury from Abusive Head Trauma. Of the 16 child fatalities due to shaking injuries, five were caretakers in regulated child care settings, three were babysitters in non-regulated settings, and one was a foster parent. As a result, VDSS made information about AHT, its effects, and resources to assist in prevention available on the Department's website. In addition, this information was provided to every child welfare program that is licensed by VDSS at the time of initial licensure and upon request. Training provided to operators and staff of licensed child day programs now includes printed and audiovisual information regarding AHT, its effects, and resources for help and support for caretakers. Prospective foster or adoptive parents are now informed that information about AHT, its effects, and resources for help and support for caretakers is available on the VDSS website. The Department's AHT website (http://www.dss.virginia.gov/family/cps/shaken_baby.cgi) includes the following: a printable brochure, audiovisual clips, links to national and state resources and supports, advice on coping with frustration and triggers, tips to soothe a crying child, and where to get help in Virginia.

J. Services for Children under the Age of Five

Virginia estimates approximately 563 children ages 5 and under who may not be with a permanent family in FY 2013. This estimate does not include those children who are in a pre-adoptive placement waiting termination of parental rights or on trial home visits. Forty seven percent of these children are female and fifty three percent are male. The majority of the children, fifty percent, are white. Thirty six percent are black and thirteen percent are mixed race.

Services for these youth include the following:

- For those with the goal of adoption and where TPR has been ordered, these children are identified as available for adoption through the ATCP adoption project
- Family engagement and family partnership meetings are used to involve relatives in the caretaking of thee children. When possible, these children are placed with relatives.
- For those children with the goal of reunification, visits with parents are to be scheduled weekly if not more often.
- Concurrent planning practices and placement with a resource family (i.e., a family that will take the child and support both reunification and adoption).
- Placement with siblings.

All of these services respond to the need to keep the family together as much as possible; to build on the attachment needs of the young child to their parent (when reunification is likely); and to identify and place the child in an adoptive home (or make the home an adoptive home) as quickly as possible once reunification has been ruled out.

VDSS offers several trainings that that deal with children's issues from a developmental perspective and discuss this age group specifically. Those classes are: CWS1021 Effects of Abuse & Neglect on Child & Adolescent Development; CWS1031 Separation and Loss Issues in Human Services Practice; CWS3041 Working with Children in Placement; DVS1031 Domestic Violence and Its Impact on Children; CWS5692 Recognizing and Reporting Child Abuse and Neglect – Mandatory Reporter Training – eLearning. There are two courses offered to foster parents, Nurturing Parents and PRIDE, which provide training specific to this age group.

DFS has created a child specific list, broken out by locality, of all children in foster care age 5 and under. This list will be shared with the regional permanency consultants and will be shared with localities to bring attention to this population. Localities will be encouraged to consider ways to shorten the length of time these children remain in foster care.

K. Program Improvement Plan updates

Virginia successfully completed its CFSR PIP in April 2013. Virginia's second round CFSR took place in 2009 and the state was not in substantial conformity with seven out of seven outcome areas and six out of seven systemic factors. Themes of the key areas for concern included inadequate assessment of safety and risk for youth as well as a lack of service provision for those youth and their families based on their assessed needs. Virginia also needed significant improvement in efforts to include parents and family members in every step of a case from case planning to visitation to a viable option for discharges to permanency. Finally, Virginia struggled significantly with moving children in foster care to permanency and even more so in finding that permanency for youth in a timely manner. Virginia's PIP was accepted in September 2010 and work on all Strategies, action steps, and all but one item specific measurement were accepted by September 30, 2012. The remaining item specific measure was accepted in April 2013, successfully wrapping up the PIP without a penalty. The PIP has been incorporated into the five year plan and has been reported on yearly.

Virginia is currently working on two other PIPs. The AFCARS PIP was initially submitted in August 2012 after having the AFCARS review in June 2010. Virginia is still waiting on official approval of that PIP but has already been working on the recommended changes that came from the review. There were many technical and mapping fixes that were immediately addressed to bring the AFCARS submission into compliance. A workgroup was created with representatives from state and local dss as well as representatives from the VDSS Division of Information Systems to address other areas that continue to need attention. The workgroup has given its blessing to several OASIS changes; like adding new values to pick lists; as well as helping to design a "diagnosed disabilities" screen and redesigning the foster care funding screen. The workgroup is currently working on creating a new adoption subsidy screen. Until official recognition of the PIP has occurred there will be no timeframe for completion however, Virginia continues to be proactive in making changes that will provide better data.

April 26, 2013, Virginia received notice that our IV-E plan had been approved and that the PIP received in December, 2012 was also approved. The PIP includes: updates to Virginia's automated service plan; revisions in State Code and DSS policy in timeframes and purposes of case reviews and permanency hearings; changes in Code to allow for fair hearings for covered individuals; revisions to licensing regulations to include regular reviews of the amounts paid for foster care maintenance and adoption assistance; and modifications to State police to comply with requests for child abuse and neglect registry checks received from another state. The first quarterly report on the PIP is due July 15, 2013.

L. Continuation of operations planning

Division of Family Services Continuity of Operations Plan

As of 5/30/13

The Virginia Department of Social Services' Division of Family Services is responsible for developing policies, programs and procedures to guide local social service agencies in providing direct services to Virginia's citizens in need of social services assistance. The Division provides administrative direction through comprehensive planning, policy oversight, program monitoring and technical assistance to regional offices, local agencies, and private vendors.

The Division of Family Services participates in the DSS overall emergency/disaster plan development. This process is ongoing and our plan is changing as each division within the agency develops, evaluates and refines its plans to be incorporated into the overall Department and Commonwealth plans. In the Commonwealth's plan, VDSS has responsibility for sheltering individuals displaced during a disaster when the local capacity is exceeded and state level shelters are needed. Division of Family Services staff will participate in the establishment and manning of shelters as necessary in the immediate aftermath of a disaster. In addition to its role in sheltering victims, the Division of Family Services must plan for recovery of its normal functions in the event of an emergency or disaster and the continuity of services during that process where possible.

The division submitted its formal COOP plan in December 2012 and it was incorporated into VDSS's larger agency COOP plan.

I. Primary Functions of the Division of Family Services to be Recovered

1. Establishment of off-site capacity for the Child Protective Services and Adult Protective Services *(CPS/APS)* 24-Hour Hotline. During normal time there is a rotation of 4 workers per shift. This is a state hotline that is used to report abuse and neglect. Information from the report is immediately sent to the local departments of social services for investigation.

2. Establishment of a system for gathering and providing information on children in foster care. A provision in the placement agreement provides the hotline phone number and requires foster parents to call and report their location and contact information if they are required to evacuate during an emergency. In addition, there are social services workers at shelter locations identifying foster care and other clients and forwarding that information to DSS.

3. Maintaining communication with local agencies and ensuring the continuation of services. The OASIS child welfare information system is a "Priority 1" for recovery during an emergency. If this system goes down the Virginia Information Technology Agency *(VITA)* is to have it up and running within 24-hours.

4. Through DSS regional consultants, Family Services maintains a line of communication with local department of social services. In the state structure, regional offices are in direct contact with local departments. VDSS will contact regional consultants and regional directors to assist with communication.

5. Ensuring the safety of the Commonwealth's adoption records. Currently, records are stored in a secured room within the home office. In addition, copies of records are maintained off-site.

II. Secondary Functions to be Recovered

Once the primary functions have been addressed the Division of Family Services must ensure its capacity to meet its state and federal requirements including reporting and grants management. DSS' disaster recovery plans include maintaining or recovering the numerous information systems that support the agency's programs. Such systems that need to be operational for the central, regional and local social service agencies are OASIS, VACIS, and ARRIS. Plans for the protection and recovery of information systems and finance systems are developed by those divisions and are part of the overall agency plan.

III. Notification of Key Personnel
In the event of an emergency, the Commissioner of Social Services or his designee will contact the Division of Family Services' primary or secondary contact who will be responsible for notifying program mangers and staff.

Primary Contact: Division Director

Paul McWhinney: Work: 804-726-7590
Home: (434) 989-1275
E-mail: paul.mcwhinney@dss.virginia.gov

Secondary Contact: Assistant Division Director

Alex Kamberis: Work: 804-726-7084
Home: 804-594-7276
E-mail: alex.kamberis@dss.virginia.gov

Family Services COOP coordinator:

Phyl Parrish Work: 804-726-7926
Home: 804-320-5121
E-mail: phyl.parrish@dss.virginia.gov

Family Services back up COOP coordinator:

Deborah Eves Work: 804-726-7506
Home: 804-270-2365
Email: deborah.eves@dss.virginia.gov

Each program manager, division director, assistant director, and COOP coordinators will maintain off-site lists of contacts and descriptions of their unit's job functions. Staff will be notified if the emergency requires the relocation or closure of the DSS home office. DFS conducted its annual tabletop exercise in 2012 by testing the phone tree calling system. The exercise was successfully completed in less than an hour. In late 2012 the VDSS COOP coordinator assisted the division in updating the Business Impact Analysis for each unit within the Division.

DFS staff with appropriate skills may be called upon to assist in areas outside of their normal job duties and geographic locations. Regional Offices will maintain lists of contact information for the local departments of social services and will stay apprised of the local department's plans including alternate emergency locations and will relay that information to the Director of Family Services and program managers.

All management staff, regional consultants and some program specialists must have laptop computers or home computers that enable them to communicate and access necessary systems through dial-up or internet connections. Workers are advised upon hiring that they are required to report for work in the event of any disaster or emergency.

IV. Implementation of Plans for Relocation

In the event of the destruction of DSS' physical plant, some child welfare functions could be operated from nearby locations including local departments of social services or regional offices. Relocation of the entire DSS would fall under the Commonwealth's plan and the Division of Family Services staff would cooperate and help ensure a smooth transition. In the DSS Continuity of Operations Plan (COOP) each central office facility has one alternate location selected where operations can be relocated depending on the nature of the emergency.

In the event of destruction of a local department of social services physical structure, many localities have formed agreements with neighboring localities to make temporary facilities available for staff for essential activities. They also use other facilities within their own jurisdictions when needed such as the sheriff's departments and the health departments. They use the Red Cross and the schools for shelters. Local departments of social services are part of local government and follow the COOP guidelines for localities per the Virginia Department of Emergency Management.

Continued Communication with Local Staff

Virginia's child welfare services are carried out in a state supervised and locally administered system, with regional offices serving in the capacity of liaison between the state and local departments. Additionally, local departments, as part of local government, must develop individual emergency procedures as they are aware of emergency resources and supports within their area as well as the unique disasters to which each region of the state is particularly exposed. It is recommended that all local agencies have at least one laptop computer configured for dial-up access. Regional staff is the primary connection between the local departments of social services and the Home Office and both state and regional staff works to keep the flow of communication ongoing. In order to maintain communication with caseworkers and staff on the local level, the regional staff will be the primary point of contact between state and local staff in an emergency situation. The regional staff has an established relationship with the local departments and will be knowledgeable of their emergency plans. It is essential that local agencies maintain close communication with their Regional Specialists during system outages. This will enable the regional offices to contact other regional and state staff to enlist support from available staff statewide. Regional staff will be in touch with local agency staff in their regions and will be responsible for forwarding home office broadcasts and communications to key local agency personnel when those agencies are unable to access the VDSS system.

Primary responsibility for the recovery of key automated systems is with the Division of Information Systems (DIS). The Email servers as well as the OASIS system are Priority 1 and are to be recovered within 24 hours. In Virginia, applications such as OASIS are within the responsibility of DSS. Information system infrastructure is the responsibility of the Virginia Information Technology Agency (VITA) through a contract with Northrop Grumman. The VITA Customer Care Center (VCCC) provides 24/7 support. The Director of Family Services will work with DIS and ensure the division provides programmatic or other support as requested, to recover these functions.

Contact with clients

The Active Foster Care Report will be maintained in an Excel file on external hardware ("jump drive") which will be in the possession of both the Foster Care Program Manager and the Title IV-E specialists. Placement agreements contain a provision requiring foster parents to contact the Hotline in the event they must evacuate an area due to an emergency situation. The Hotline will collect contact information for these families and this information will be entered into the OASIS system as well as forwarded to Regional Consultants who will alert the agency with custody as well as the agency in the location in which the family is currently residing. Families will be given contact information for the local department of social services. Social Services staff will be at the state run shelters and will collect similar information from individuals who are being sheltered. This will be added to the list of families forced to new locations by the crisis.

The regional offices serve as operation centers for service referrals and information throughout the state. VDSS staff will be available by a centralized toll- free number for the community to contact for child welfare related service needs referral information for services, and to notify the state office of displaced clients. The toll-free number will be given to the media and disseminated to local departments of social services. Virginia also operates "211" Information and Referral hotline that is available for locating services and assistance.

Hotline Contingency Plan
The CPS/APS telephone system is operated by the CISCO Automatic Call Distribution system. This system may be inoperative during inclement weather conditions and/or disasters; therefore a plan has been devised to continue services to the public and mandated reporters. Several tests of moving the hotline have been completed successfully. Twenty-four hour technical assistance for the hotline is provided through VITA/NG VCCC. The contact number for DSS to use is: 1-866-637-8482. Specific instructions for the family services' hotline have been updated in the online application for the VCCC, to assist in their technical issue response.

Response to the need to respond to new allegations of abuse/neglect during a disaster
Virginia's child welfare services are carried out in a state supervised and locally administered system. Local departments, as part of local government, must develop individual emergency procedures as they are aware of emergency resources and supports within their area as well as the unique disasters to which each region of the state is particularly exposed. As mentioned above, there are procedures in place around the relocation of foster children due to a disaster. If during the emergency/disaster situation child abuse or neglect is reported, it will be handled by the locality where the alleged abuse/neglect occurred.

V. Continued Review and Revision of Plan
In addition to the above-mentioned procedures, the Division of Family Services is continuing to work with the Disaster Coordinator for the Department to develop more specific procedural guidance for child welfare programs. As a result, the plan will be modified to ensure compliance with state emergency procedures and the needs of other divisions within the Department and with the Continuity of Operations Plans of the Commonwealth of Virginia. Updates to the COOP plan as related to child welfare programs and services will be made available to regional and state staff as necessary. State and local staff will continue to work together to find ways to ensure continuation of services.

VI. Outcomes, Goals and Measures

Virginia has integrated the outcomes, goals and measures of two important initiatives into Virginia's Five Year State Plan for Children and Family Services:

- Virginia's Children's Services System Transformation; and
- The Federal Child and Family Services Review *(CFSR).*

The charts below list the goals Virginia is tracking for the Virginia Children's Services System Transformation and some of the CFSR outcomes. For each goal, the quantitative measure, national comparative, and Virginia's goal, baseline and trend data will be provided, as available. The last column highlights whether this goal is an area of strength or needs improvement based on Virginia's performance.

A. Safety of Children							
Children are, first and foremost, protected from abuse and neglect							
CFSR Indicator/ Transformation Outcome	**Safety Goal**	**Measure**	**National**	**Virginia**			
				Goal	**Baseline**	**Trend**	**Strength/ Need**
SafeMeasures Critical Outcome	**1) Increase the number of children remaining safely in their own homes.**	Reduce rate of child abuse and neglect per 100,000 children		Below 3.0 in June 2009		2.86 (SFY 2012)	strength
CFSR Safety Indicator 1: More children do not experience repeat	**2) Increase the percentage of children who do not have repeat incidents of abuse and neglect.**	Increase percent of all children who were victims of substantiated or indicated abuse or neglect	94.6% or higher	94.6% or higher	97.98%	97.98% (2011) 97.70% (SFY 12)	strength

abuse and neglect		allegation during the first 6 months of the fiscal year who <u>were not</u> victims of another substantiated or indicated abuse or neglect allegation within 6 months following that incident					
<u>CFSR Safety Indicator 2</u>: More children in foster care do not experience repeat abuse and neglect	**3) Increase the percentage of children who are not abused or neglected in foster care.**	Increase percent of all children served in foster care during the fiscal year who were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff member during fiscal year	99.67% or higher	99.67% or higher	99.84%	99.84% (2011) 99.92% (SFY 12)	strength
<u>CFSR Item 1</u> – Timeliness of initiating investigations of reports of child maltreatment	**4) Children are seen in a timely manner.**	How effective is the agency in responding to incoming reports of child maltreatment in a timely manner?	90%	90%		87.4% contact made on time (SFY 2012) (P:\Oasis_Adhoc\RecurringReports\Timeliness\Older Reports; Summary Reports)	ANI
<u>CFSR Item 3 –</u> Services to family to protect child(ren) in the home and prevent	**5) Services are in place to prevent removal from the home or reentry into foster care**	How effective is the agency in providing services, when appropriate to prevent removal of children from their homes?		82.0%	73.2%	95.3% (from case reviews conducted for PIP)	strength

removal or reentry into foster care							
CFSR Item 4 – **Risk assessment and safety management**	**6) Risk and safety assessments are in place**	How effective is the agency in reducing the risk of harm to children, including those in foster care and those who receive services in their own homes.		76.4%	70.1%	92.8% (from case reviews conducted for PIP)	strength

B. Children Achieving Permanency							
Children have permanency and stability in their living situations							
CFSR Indicator/ Transformation Outcome	**Permanency Goal**	**Measure**	**National**	**Virginia**			
				Goal	**Baseline**	**Trend**	**Strength/ Need**
SafeMeasures Critical Outcome	**1) Decrease the number of children in out of home care**	Reduce rate of children in foster care per 1,000 children	Declined from 7.5 in 2000 to 7.0 in 2006		3.05 (2011)	3.6 (SFY 2012)	strength
Transformation Outcome: More children in foster care achieve	**2) Increase percentage of all children in foster care who achieve permanency.**	Increase percentage of all children in foster care who are discharged to reunification, adoption, or		81.00% or higher	73.77% (2011)	72.92% (SFY 2012) (VCWOR)	ANI

permanency *(SafeMeasures Critical Outcome)*		custody transfer to relatives					
<u>Transformation Outcome:</u> Children achieve permanency with shorter length of stays. *(SafeMeasures Critical Outcome)*	**3) Decrease the amount of time it takes for a child to achieve permanency**	Decrease the time to permanency for all children who are reunified, transferred to a relative, or adopted.			25.02 months (2011)	26.05 months (SFY 2012)	ANI
<u>Transformation Outcome:</u> More children are placed in relative foster homes *(SafeMeasures Critical Outcome)*	**4) Increase placements of children in kinship care *(relative foster family)***	Increase percentage of all children currently placed in relative foster family			6.16% (2011)	6.47% (SFY 2012)	ANI
		Increase percentage of all children whose first placement was in relative foster family			4.0% (2011)	4.03% (SFY 2012)	ANI
<u>Transformation Outcome:</u> More children are placed in family based care *(SafeMeasures Critical Outcome)*	**5) Increase placements of children in family based care**	Increase percentage of all children currently placed in relative or non relative foster care *(therapeutic foster care included)*, non-finalized adoptive homes, or trial home visits.		85.00% or higher	82.64% (2011)	80.69% (SFY 2012)	ANI

		Increase percentage of all children whose first placement was in relative or non relative foster care *(therapeutic foster care included)*, non-finalized adoptive homes, or trial home visits		85.00% or higher	80.7% (2011)	82.95% (SFY 2012)	ANI
CFSR Permanency Composite 1: Timeliness and Permanency of Reunification	**6) Children have permanency and stability in their living situations.**	From State Data Profile: Component A: Timeliness of Reunification and Component B: Permanency of Reunification	122.6	121.3	117.9 (2008b09a)	110.2 (2009ab) 120.2 (2010ab) 123.0 (2011ab)	Strength
CFSR Permanency Composite 2: Timeliness of Adoptions	**7) Children are adopted in a timely manner.**	From State Data Profile Component A: Timeliness of Adoptions of Children Discharged From Foster Care Component B: Progress Toward Adoption for Children in Foster Care for 17 Months or Longer. Component C: Progress Toward Adoption of Children Who Are Legally Free for Adoption.	106.4	78.2	75.1(2007 B08a)	73.5 (2009ab) 83.7 (2010ab) 93.5 (2011ab)	ANI

<u>CFSR</u> **Permanency Composite 3: Permanency for Children and Youth in Foster Care for Long Periods of Time**	**8) Children exit care to a permanent situation**	From State Data Profile; Component A: Achieving permanency for Children in Foster Care for Long Periods of Time. Component B: Growing up in foster care	121.7	105.4	102.5 (2007b08a)	107.9 (2009ab) 108.4 (2010ab) 111.0 (2011ab)	ANI
<u>CFSR Item 7:</u> Permanency goal for child	**9) The child's permanency goal is appropriate and established in a timely manner.**	How effective is the agency in determining the appropriate permanency goal for children on a timely basis when they enter foster care?		65%	76.7%	80% (2013) (case reviews for PIP)	strength
<u>CFSR Item 10:</u> Other planned permanent living arrangement	**10) Alternative goals are appropriate for the child and services are provided**	How effective is the agency in establishing planned permanent living arrangements for children in foster care, who do not have the goal of reunification, adoption, guardianship, or permanent placement with relative, and providing services consistent with the goal		63.2%	46.7%	76.4% (2011) (case review for PIP)	strength
<u>Transformation Outcome:</u> Fewer children are placed	**11) Reduce placements of children in congregate care**	Decrease percentage of all children currently placed in congregate care		15% or fewer	15.10% (2011)	13.48% (SFY 2012)	strength

in congregate care *(SafeMeasures Critical Outcome)*		Decrease percentage of all children whose first placement was in congregate care		15% or fewer	18.5% (2011)	16.62% (SFY 2012)	ANI
		Decrease average number of months children spent in congregate care		TBD	33.42 months (2011)	30.74 months (SFY 2012)	

C. Child and Family Well Being							
Families have enhanced capacity to provide for their children's needs							
CFSR Indicator/ Transformation Outcome	**Well Being Goal**	**Measure**	**National**	**Virginia**			
				Goal	**Baseline**	**Trend**	**Strength/ Need**
<u>CFSR Item 17:</u> Needs and services of child, parents, and foster parents	**1) Services are provided to children, parents, and foster parents**	How effective is the agency in assessing the needs of children, parents, and foster parents, and in providing needed services to children in foster care, to their parents and foster parents, and to children and families receiving in-home services?		67.6%	60.9%	72.4% (2011) (case reviews for PIP)	strength

CFSR Item 18: **Child and family involvement in case planning**	**2) Children and family are involved in case planning**	How effective is the agency in involving parents and children in the case planning process?		77.2%	70.7%	74.7% (2011) (case reviews for PIP)	strength
CFSR Item 19: **Caseworker visits with child**	**3) Caseworkers visit children monthly face to face with the majority of the visits in the child's residence and those visits are quality visits**	How effective are agency workers in conducting face-to-face visits as often as needed with children in foster care and those who receive services in their own homes?		75%	68.6%	81.7% (2011) (case reviews for PIP)	strength
CFSR Item 20: **Caseworker visits with parents**	**4) Caseworkers visit parents monthly face to face and those visits are quality visits**	How effective are agency workers in conducting face-to-face visits as often as needed with parents of children in foster care and parents of children receiving in-home services?		59.4%	51.5%	61.4% (2011) (case reviews for PIP)	strength

Virginia State Plan for the Child Abuse Prevention and Treatment Act (CAPTA)

Commonwealth of Virginia
Department of Social Services
Division of Family Services

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CAPTA Update for 2013

1. Describe substantive changes, if any, to State law or regulations, including laws and regulations relating to the prevention of child abuse and neglect, that could affect the State's eligibility for the CAPTA State grant (section 106(b)(1)(C)(i)). The State must also include an explanation from the State Attorney General as to why the change would, or would not, affect eligibility. Note: States do not have to notify ACF of statutory changes or submit them for review if they are not substantive and would not affect eligibility.

Effective July 1, 2013, the *Code of Virginia* will reflect two Code changes that will not impact the Commonwealth's compliance with CAPTA as reauthorized on December 20, 2010. The *Code of Virginia*, § 63.2-1505 will be revised to reflect if a report of child abuse and neglect is founded, and the subject of the report is a full-time, part-time, permanent, or temporary teacher or employee of a local school division, CPS will be required to notify the relevant school board of the founded complaint. .

Effective July 1, 2013, the *Code of Virginia* will reflect changes to § 63.2-1505 addressing changes in time frames to complete CPS investigations. In cases involving the death of a child or alleged sexual abuse of a child who is the subject of the report, the time during which records necessary for the investigation of the complaint but not created by the local department, including autopsy or medical or forensic records or reports, are not available to the local department due to circumstances beyond the local department's control shall not be computed as part of the 45-day or 60-day period.

2. Describe any significant changes from the State's previously approved CAPTA plan in how the State proposes to use funds to support the 14 program areas (section 106(b)(1)(C)(ii)).

The majority of the previously approved CAPTA plan remains in effect. Several new or enhanced areas of work include the periodic review of CPS regulations, full implementation of regional child fatality review teams, new and enhanced child welfare policy and guidance for screening and assessing for domestic violence, a review of screened out reports, and an exploration of the feasibility of electronic reporting of child abuse and neglect. New initiatives will be incorporated into the attached plan in *italic.*

- Describe how CAPTA state grant funds were used, alone or in combination with other Federal funds, to meet the purposes of the program since the submission of the CAPTA State Plan (section 108(e) of CAPTA).

In Virginia, CAPTA funds align and support the overall goals for the delivery and improvement of child welfare services, Title IV-B, and the Community-Based Child Abuse Prevention (CBCAP) program. CAPTA state grant funds were used, alone or in combination with Title IV-B, CBCAP, and other child welfare programs in three major areas: Safe Children and Stable Families; Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. The plan will identify areas of work that have been completed, items being currently worked on, as well as ongoing activities.

CAPTA Virginia State Plan

2013 submission

The Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized in 2010, Public Law 111-321. States are required to prepare and submit a State plan that will remain in effect for the duration of the state's participation in the grant program. The Plan must be prepared and submitted annually describing how the funds provided under CAPTA were used to address the purpose and achieve the objectives of the grant program (section 108(e)). In Virginia, CAPTA funds align and support the overall goals for the delivery and improvement of child welfare services, Title IV-B, and the goals and strategies outlined in Virginia's Program Improvement Plan (PIP).

Using the format from Virginia's CFSP, the CAPTA Plan will incorporate PIP strategies as well as other strategies that will address the purpose and objectives of the CAPTA program areas.

The PIP strategies are:

1. Engage Families across the Continuum of Child Welfare
Goal: Ensure children, youth and parental input is heard and considered in the decision-making processes regarding safety, permanency, well-being, and service planning and placement decisions

2. Improve Assessment and Service Delivery
Goal: Appropriately assess safety, risk, and the needs of children and families in order to provide high quality, timely, efficient, and effective services.

3. Reengineer Competency Based Training System
Goal: Improve training and supervision in order to serve children and families through high quality, timely, efficient, and effective services

4. Managing by Data and Quality Assurance
Goal: Create a performance management system that utilizes data to inform management, improve practice, measure effectiveness and guide policy decisions

To mirror the five year plan, this plan will highlight activities in three areas: Safe Children and Stable Families, Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. Strategies will be updated yearly or as activity occurs.

VII. Safe Children and Stable Families

These strategies strive to assure the safety of children within their homes, protect children in at risk situations, and ensure they are protected from abuse and neglect in a permanent setting responsive to their well being. It preserves and strengthens intact families who ensure the safety and well-being of their children. It strives to prevent child maltreatment among families at risk through the provision of supportive family services.

- **Applicable CAPTA program areas described in section 106(a**): 1. The intake, assessment, screening and investigation of reports of child abuse and neglect; 2. Improving legal preparation and representation, including procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; 3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families; 4. Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response; 5. Develop and update systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange; 7. Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protections system, including improvements in the recruitment and retention of caseworkers; *8. Developing and facilitating training protocols for individuals mandated to report child abuse or neglect;* 14. Developing and implementing procedures for collaboration among child protective services, domestic violence services and other agencies.

Goal: Protect Children At Risk of Abuse and Neglect

1. Improve local department staffs' abilities to assess initial safety and risk

a) Assess and review how local CPS workers have implemented the new intake tools that became effective July 2011 **Completed**
b) Hold focus groups with local supervisors and workers to assess and identify any areas of concern or need for clarification **Completed**
c) Clarify and disseminate revised policy/guidance manual, as needed **Completed**
d) Work with the Quality Service Review Unit to evaluate the extent to which initial safety and risk assessments are being completed correctly and within the required timeframes
e) Develop new intake measures into Safe Measures to determine how well ldss are implementing the new intake tools. **Ongoing**
f) Provide refresher training, as needed **Ongoing**
g) Review and evaluate statewide and by locality the number and percentage of cases being screened out.
h) Develop and implement a method to review a sample of these cases to determine level of agreement.
i) Develop and implement a plan to make any needed changes to policy regarding intake and definitions of abuse and neglect.
j) *Provide training for local staff on any changes made*

2013 Update

State staff is continuing to work with localities to support and sustain the practice change around intake, safety and risk assessments and the use of structured decision making tools. Support groups for supervisors were held bi-monthly for supervisors to review the case monitoring tools and discuss outstanding issues. New reports have been generated by locality from Safe Measures to assist the State in evaluating the current use of the intake, safety and risk assessment tools as well as to evaluate local agency response times to reports of suspected child abuse and neglect. A new report was developed in Safe Measures to assess how well local CPS workers are adhering to the new policy on timeframes for face to face contact with victims. Regional CPS consultants are working with individual localities to help them improve in all of these identified areas and providing additional training as needed.

2. Revise CPS guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse.

a) Obtain input from the CPS Policy Advisory Committee, the Office of Family Violence, and the Department of Behavioral Health and Developmental Services to ensure that the tools are assessing issues of domestic violence, mental health and substance abuse **Completed**
b) Revise, if needed and incorporate these factors in the current safety and risk assessment tools and into the CPS policy/guidance manual **Completed**
c) Disseminate guidance and make necessary changes to OASIS **Completed**
d) Collaborate with VDSS' Office on Family Violence to develop a guidance manual section on domestic violence to include a definition of domestic violence, revised screening and assessment tools, interviewing the non-offending parent, the child and the alleged perpetrator, safety planning ,and service provision.
e) Train child welfare workers on the domestic violence protocol

2013 Update

The tools that were revised in 2012 do not seem sufficient to meet the needs of CPS workers in managing cases dealing with the co-occurrence of domestic violence and child abuse. Therefore, the above outlined initiatives are being planned for 2014.

3. Evaluate local staffs' ability to improve response times to CPS reports

a) Develop and review reports in Safe Measures to assess how well staff are responding to reports of suspected child abuse and neglect as a result of the new policy/guidance that was implemented in July 2011. **Completed**
b) Develop a report in Safe Measures to assess how well staff are adhering to the new policy on timeframes for face to face contact with victims **Completed**
c) Review the reports generated through Safe Measures with CPS regional consultants and develop a plan to work with those individual localities having problems in responding to reports in a timely manner **Completed**
d) Clarify and disseminate policy/guidance manual, as needed **Completed**
e) Provide consultation to ldss, as needed. **Ongoing**

2013 Update

Reviewing and evaluating local agency response times to CPS reports is an ongoing concern. CPS regional consultants monitor local agency response time reports closely and work with local agency to improve responses as needed.

4. Develop strategies to support and sustain the practice change for CPS supervisors and workers on the use of the new intake, safety and risk assessment model.

a) Hold focus groups and/or survey local CPS supervisors to assess their continued needs **Completed**
b) Develop tools for supervisors to use with workers to support the use of the structured decision making tools in casework practice. **Completed**
c) Hold peer support groups for supervisors to practice using this tool and conduct peer reviews of cases. **Ongoing**
d) Schedule and conduct refresher training as needed. **Ongoing**

2013 Update

CPS regional consultants continue to hold refresher training for local CPS workers who continue to struggle with assessing safety and risk. This work is ongoing especially when there are new supervisors and/or workers.

5. Improve local department staffs' abilities to conduct service needs assessments and develop relevant service plans.

a) Review SDM family strengths and needs assessment tools to ensure consistency with VA regulation and policy. **Completed**

b) Obtain input from the CPS Policy Advisory Committee **Current work**

c) Request assistance from the In-Home NRC to review current policy/guidance manual and recommend changes. **Completed**

d) Revise on-going services section of CPS guidance to enhance and strengthen workers ability to assess and provide services to families by providing tools to support on-going assessment, risk reassessment and service planning for children and families' service needs **Current work**

e) Disseminate the revised policy/guidance manual.

2013 Update

In terms of improving local department staffs' abilities to conduct service needs, risk re- assessments and develop relevant service plans, State CPS staff have reviewed the SDM family strengths and needs assessment tools to ensure consistency with Virginia policies and regulation, and have completed a case review of approximately 50 cases to assess the quantity and quality of services being provided. This work was done in conjunction with the National Resource Center for In-Home Services. The report completed by the National Resource Center will inform current revisions to policy/guidance and training needs in this area. This work will continue in the coming year. The CPS Policy Advisory Committee assisted with a survey regarding the current service plan's usefulness and made suggestions for improvement.

6. Develop and implement statewide training for CPS supervisors and workers on the use of new assessment of family strengths and needs, service plans and risk re-assessment tools

a) Develop training curriculum

b) Select and train Trainers, to include CPS regional consultants and supervisors

c) Develop statewide training schedule

d) Train all CPS supervisors and workers on use of new policy/guidance

7. Create requirements for OASIS screens to reflect new CPS service needs assessment and service plans

a) Utilize workgroup to review OASIS screens and make recommendations for screen changes **Current work**

b) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and the workgroup recommendations and determine if current screens can be modified or if new screens must be created

c) OBRA and Family Services will meet to develop requisition to present to the Managing by Data workgroup (MBD) to approve screen changes.

d) OBRA and Family Services will meet with MBD prioritize timing for screen changes in OASIS

8. Revise policy/guidance on conducting investigations in Out of Family Setting

a) Establish a committee composed of local CPS workers and supervisors to review the current policy/guidance and identify areas needing revision or clarification**. Completed**

b) Request assistance from the NRC on CPS to review materials and make recommendations for changes

c) Solicit input from the Out of Family Advisory Committee to the State Board of Social Services **Completed**

d) Revise policy/guidance manual and disseminate **Completed**

2013 Update

Another area of CPS policy/guidance that has needed attention is the investigation of CPS reports in out-of-family settings. A committee composed of local CPS workers and supervisors was established to review the current policy/guidance manual and identify areas needing revision and/or clarification. Many of the CPS cases that are amended or overturned on appeal involve out of family caretakers. CPS policy/guidance was revised with input from the Out of Family Advisory Committee to the State Board of Social Services and other interested parties and was released in July 2012. The regulation governing the investigation of Out of Family cases was reviewed this year and minor changes were made focusing on ensuring consistency in definitions of abuse and neglect. The final approval of the regulation is awaiting the Governor's signature.

9. Develop and implement statewide training for CPS supervisors and workers on the revised policy on investigating CPS reports in Out-of-Family Settings

a) Develop training curriculum **Completed**

b) Select and train trainers, to include CPS regional consultants and supervisors **Completed**

c) Develop statewide training schedule **Completed**

d) Train all CPS supervisors and workers on use of new policy/guidance **Completed**

2013 Update

When the revised policy/guidance was released, each of the CPS regional consultants reviewed the changes with CPS supervisors within their regions. Since the overall revisions were minor, this training was completed during regularly scheduled meetings.

10. Review/enhance current policies and protocols on the handling of child deaths

a) Work with the subcommittee of the State Board of Social Services to study the increase of child deaths to gain a better understanding of the factors surrounding those deaths **Ongoing**

b) Review cases of children who have been known to the child welfare system over the past several years to determine what lessons may be learned to prevent child deaths **Completed**

c) Request assistance from the In-Home NRC to assist in this review and make recommendations **Completed**

d) Explore the regional child fatality team operating in the Eastern Region and develop a plan to replicate it in the other four regions of the State. **Completed**

d) Review recommendations with subcommittee of the State Board of Social Services and the State Child Fatality Team and develop a plan to implement new practices, as appropriate **Completed**

e) Work with the Office of the Chief Medical Examiner to implement five regional child fatality review teams **Completed**

f) Provide technical assistance and consultation to teams in reviewing cases, making recommendations, and data collection **Ongoing**

g) Prepare an annual report compiling findings and recommendations from the teams **Ongoing**

h) Work with the Office of the Chief Medical Examiner to plan and co-sponsor a conference for regional child fatality team members **Completed**

2013 Update

The State Board of Social Services established a Child Fatality Committee to study the increase of child deaths to gain a better understanding of the factors surrounding these deaths. One of the recommendations of the Committee and the Board was the development and implementation of five regional child fatality review teams. In collaboration with the Virginia Department of Health (VDH), Office of the Chief Medical Examiner (OCME) and VDSS, each of the five regions within the VDSS system now has an operating Regional Child Fatality Review Team in place. During the past year, these five teams have reviewed all child deaths that were investigated by local departments of social services from July 1, 2010 throughout June 30, 2011. A total of 81 cases were reviewed. Each team was asked to collect data on each case to be reported to the National Center for the Review and Prevention of Child Death utilizing the National Maternal Child Health Center for Child Death Review Case Report tool. Regional team reports have been drafted and the State is now reviewing the findings and recommendations. A final report will be developed by September 2013.

In addition, a statewide conference for all regional team members took place on April 30 through May 2, 2013. This was a collaborative effort between the VDH- OCME, VDSS, and the Department of Criminal Justice Services, Children's Justice Program (CJA). Approximately 75 team members participated in the conference as well as child fatality review coordinators from the states of Delaware, Colorado, Wisconsin, and the National Center for Review and Prevention of Child Deaths. CAPTA funds were used to support this effort along with CJA funds and state funds.

With the implementation of the Regional Child Fatality Review Teams, revisions were also made to the CPS policy/guidance manual for local departments of social services regarding the investigation of child fatalities. Local agencies were provided additional resources to aide in their investigations including a field guide/check list of critical steps to be taken in the investigation of these cases. Additional appendices were added to the manual that provided detailed information about the child death review process, roles and responsibilities of team members and how to present a case at the review. A special informative and detailed appendix provided child death interview and documentation guidelines and included a comparison chart to show the characteristics of Sudden Infant Death Syndrome and the red flags which may indicate child abuse and neglect.

VDSS will continue to work closely with the OCME to provide technical assistance and support to the regional teams as they struggle to continue to recruit critical team members and to identify risk factors, trends and make recommendations for prevention.

11. Examine the current trends in CPS appeals to determine if ldss' are clearly interpreting CPS policies and procedures, providing consistent information to appellants, and adequately documenting their case decisions.

a) Establish a committee of representatives from the League of Social Services Executives, State Board members, and other Department staff to identify and review the trends to determine the number of decisions that are being sustained, amended or overturned by type of abuse and neglect, in-home or out-of-family setting, and locality. **Completed**

b) Review and evaluate findings from the committee and revise/clarify policy/guidance manual, as appropriate **Quarterly updates**

c) Review and revise Appeal Handbooks, if needed

d) Develop training materials and/or provide consultation to ldss to support their practice in this area **Completed**

e) *Identify and review all state CPS appeals to document trends and determine the number of decisions that are being sustained, amended or overturned by type of abuse and neglect, in home or out of family setting and locality*

f) Develop a CPS appeals manual for local social services workers

g) Review and revise Appeal Handbooks, as needed

2013 Update

State CPS staff is continuing to review all state level CPS appeal cases each month as submitted by the Division of Appeals and Fair Hearings. The purpose of this review is to identify strengths in the child protective service investigative findings being sustained, identify areas needs improvement in cases which were overturned, and to identify any trends that would lead to a policy/guidance change and/ or training opportunity. This review also helps to identify how local departments of social services are interpreting CPS policies and procedures and providing consistent information to appellants, and adequately documenting their cases. During the first quarter of calendar year 2013, the Division of Family Services reviewed 41 cases that were heard by the state hearings officers. Of the cases reviewed, there were 25 sustained allegations, 13 cases overturned, and five cases where the level of the findings was reduced or amended. Some of these cases included multiple allegations and this accounts for the discrepancy between the total case count and the number of cases sustained, overturned or amended. A Broadcast to all local directors, CPS supervisors and workers was sent out identifying the strengths in cases that were sustained and identifying the areas needing improvement in the cases that were amended or overturned. Two training sessions were presented for local staff responsible for hearing local appeals. CPS regional consultants are working with local CPS supervisors and workers in improving case documentation, case presentation, and understanding legal requirements. Feedback will be given to localities on a quarterly basis.

12. Enhance the effectiveness and efficiency of the State Child Abuse and Neglect Hotline

a) Review the current schedule and revise to accommodate the incoming calls to ensure that the most adequate coverage is available **Completed**
b) Train the Hotline staff on the new intake, safety and risk assessment tools to ensure a family-focused, and strength–based approach to responding to calls of suspected child abuse and neglect **Completed**
c) Ensure that the Hotline phone number is published in all directories across the Commonwealth. **Completed**
d) *Establish emergency procedures and protocols for the State Hotline*
e) Develop and provide training to Hotline staff pertaining to family focused, strength based approach and proper use of safety and risk assessment tools for intake purposes
f) Review and revise the Hotline policy and procedures manual
g) Explore the feasibility of developing an electronic on-line reporting tool for mandated reporters.

2013 Update

A number of actions have been taken to enhance the effectiveness and efficiency of the State Child Abuse and Neglect Hotline. The Hotline schedule has been revised to more adequately accommodate the volume of incoming calls and reduce wait times for callers and additional classified staff positions have been request. Quarterly reviews of all Hotline staff have been implemented to ensure consistency in report writing, documentation and procedures as well as regular feedback. All Hotline workers have completed the CPS new worker training. A new training guide has been developed for all Hotline workers. A number of measures were also taken to enhance procedures and better ensure child safety. Any report involving a foster child is reported to the locality of jurisdiction immediately. All CPS referrals entered into OASIS are distributed to the local department's OASIS inbox upon receipt and the development of a generic after-hours on-call calendar for use by all local departments of social services.

13. Develop a method to track recurrence in Family Assessment cases

a) Develop a method of tracking recurrence in Family Assessment cases.
b) Develop a report that monitors repeat reports of cases that received a Family Assessment response.

c) Disseminate reports to ldss, CPS regional consultants to review and make recommendations for program changes, if needed.
d) Provide consultation to ldss, revise policy/guidance manual, if needed.

2013 Update

The Department revised guidance in the area of making a track assignment. More detailed examples are being provided. The revised policy/guidance was made available by January 2013. Policy stated the investigation track, or the more traditional approach, must be used if a family has had three family assessments in the past twelve months. This has been changed to suggest investigating if there has been two family assessments in past twelve months, the next one should be investigated. History of prior reports is one of the criteria in determining track, the more prior incidents the more serious because it is easily interpreted as the family has not made the necessary changes to keep the child safe. It may also suggest that the prior interventions were not done in a comprehensive manner and failed to engage the family and help them recognize their needs. It also could mean someone has a vendetta against them and the numerous reports could in fact be malicious. If so, an investigation would at least allow for legal recourse on the part of the alleged abuser because they can petition the court to find out who made the report and pursue civil action against them. A report was created to help track the recurrence of Family Assessment cases.

14. Develop, facilitate, and conduct training for mandated reporters

a) Update the online training curriculum for mandated reporters incorporating the changes made by the 2012 Virginia General Assembly including additional people as mandated reporters, increased penalties for failure to report especially in cases of rape, sodomy, and object penetration, and other pertinent requirements **Completed**
b) Review and revise all printed materials including brochures and the Mandated Reporter Booklet to reflect the Code changes **Completed**
c) Develop and implement a plan to inform persons required to report suspected cases of child abuse and neglect of these responsibilities **Completed**

2013 Update

The Code of Virginia, § 63.2-1509 relating to mandated reporter requirements was amended to include additional persons required to report suspicions of child abuse and neglect; shorten the timeframe for reporting concerns; and provides for stricter penalties for failure to report sexual abuse. As a result of these changes in the Code of Virginia it was necessary to revise the on-line training course for mandated reporters. Three on-line courses were revised to include one for the general public, one for educators and one specifically for eligibility workers. Review and revision of all printed materials regarding mandated reporting was also necessary. All informing brochures for mandated reporters were revised and included the revision of a 36 page guide for mandated reporters in recognizing and reporting child abuse and neglect. A massive project was undertaken by VDSS to inform major stakeholders and community partners who would be affected by these changes to mandated reporting. Bulletins and broadcasts were distributed to state and local agencies and to professional organizations. State, regional and local staff has conducted numerous presentations and workshops for mandated reporters as a result of adding new persons to the list of mandated reporters. In addition, the CPS policy/guidance manual was revised to also reflect these changes as well as the CPS regulation, 22 VAC 40-705-40.

15. Revise CPS regulations and policy/guidance manual to reflect changes related to the reporting of substance exposed infants

a) Review and revise CPS regulation 22 VAC40-705 to reflect changes related to the reporting by health care providers of infants born with Fetal Alcohol Spectrum Disorder and the revised time frames **Completed**

b) Review and revise CPS policy/guidance manual to reflect changes related to the reporting by health care providers of infants born with Fetal Alcohol Spectrum Disorder and the revised time frames **Completed**

c) Provide training to local CPS supervisors and workers on the changes **Completed**

d) Work with health care providers and substance abuse treatment providers to inform them of the changes **Completed**

e) Revise brochure for health care providers on the reporting of substance exposed newborns **Completed**

2013 Update

The *Code of Virginia*, § 63.2-1509 relating to the reporting of substance exposed newborns was amended to include Fetal Alcohol Spectrum Disorder replacing Fetal Alcohol Syndrome. It also required health care providers to report suspected cases of substance exposed newborns instead of attending physicians and it extended the timeframes to make these reports based on toxicology studies. These changes have brought the Commonwealth in stronger compliance with CAPTA as reauthorized on December 20, 2010. CPS regulation, 22VAC40-705-40, was also changed to reflect the legislative changes. CPS policy/ guidance manual was updated to reflect the reporting requirements of substance exposed newborns and included specific information on Fetal Alcohol Spectrum Disorder. Training on policy/guidance changes was provided to CPS workers and supervisors throughout the Commonwealth by the five regional CPS policy consultants. The brochure entitled "Perinatal Substance Use: Promoting Healthy Outcomes" was updated to reflect changes regarding substance exposed newborns. This brochure is a guide for hospital and healthcare providers for Virginia legal requirements for reporting substance exposed infants and practice implications for health care providers. Healthcare providers were notified of these changes by issuance of the revised brochure and collaborative efforts with the Virginia Department of Health. Revisions to the on-line courses for mandated reporters was also revised to reflect this change.

16. Conduct periodic reviews of CPS regulations

a) Conduct a comprehensive review of the CPS regulations to include the incorporation of 22 VAC 40-700 and 22 VAC 40-720 into 22 VAC 40-705.

b) Solicit input from the CPS Policy Advisory Committee, League of Social Services Executives, and the Citizen Review Panels.

c) Develop proposed regulations incorporating relevant statutory and needed practice changes to be presented and approved by the State Board of Social Services

d) Implement changes in the CPS policy/guidance manual

e) Train local staff on the changes

17. Provide guidance to CPS workers on how and when to use diversion practices

a) Seek consultation from the Office of the Attorney General on the authority of local departments of social services to use diversion as a prevention of foster care service

b) Develop clear guidelines for inclusion in the CPS policy/guidance manual

c) Train staff on the role of the local department and the policies and procedures governing this practice.

II. Family, Child and Youth-Driven Practice

This strategy fulfills the mission of transforming how services are delivered by giving a stronger voice to children and families in decision-making. The state practice model enables families to actively engage with child welfare staff and other important stakeholders in facilitated meetings to collaborate on the key decisions *(such as placement or moves)* that affect a child's life. Through collaboration, the practice

model is achieved according to individual circumstances while empowering families to participate in the process.

> **Applicable CAPTA program areas as described in section 106(a):**
> 6. Developing, strengthening, and facilitating training including – training regarding research-based strategies, including the use of differential response, to promote collaboration with families; 11. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

Goal: Engage Families in Decision Making Using a Strength-Based, Child-Centered, Family-Focused and Culturally Competent Approach

1. Develop and implement a plan for sustaining and supporting a consistent statewide approach to family engagement and kinship care

a) Train selected service providers and state/regional staff on strategies for engagement on a regional basis. **Completed**

b) Implement a plan for regional staff to provide training and technical assistance to ldss on family engagement strategies **Completed**

c) Survey selected programs to determine the level of change in involvement and recommendations for improvements. **Completed**

d) Explore the use of CAPTA funds to ldss to support Family Partnership meetings **Completed**

2013 Update

VDSS has trained selected service providers and state regional staff on strategies for family engagement and kinship care. Family Partnership Meetings (FPM) are being held in all decision points including cases that have been determined to be at very high or high risk with services are being provided and at the point of an emergency removal. CAPTA funds have been used to support FPM. Statewide, there were 3,247 High/Very High Risk FPMs and 950 Emergency Removal FPMs from held from January 2012 through March 2013.

2. Examine and amend CPS guidance to determine revisions required to support subsidized custody and connections to relatives

a) Review guidance around identification and notification of relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child **Completed**

b) Support state collaborations that focus on increasing awareness and training of kin *(relatives)* as valuable resources in creating permanency options for children who cannot live with their birth parents. **Completed**

c) Increase local capacity for locating absent parents, siblings, other relatives and significant others to engage them in service delivery and establishing permanent, life-long connections by providing the use of Accurint, a web-based search engine that will be available statewide. **Completed**

d) Implement in OASIS the ability to document this notification to relatives in order to collect data

2013 Update

The CPS policy/guidance manual was amended to better support connections to relatives. Revisions included the requirement to identify and notify relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child. This requirement is also being included in the proposed changes to the CPS regulations. In an effort to increase local capacity for locating absent parents, siblings, other relatives and significant others, the use of Accurint, a web-based search engine was made available to staff statewide. CAPTA funds assist in the support of Accurint.

3. Enhance the current CPS Differential Response System *(DRS)* Practice Model to ensure a more family-focused and family-driven approach

a) Incorporate the Children's Services Practice Model into the CPS DRS Family Assessment Track. **Completed**
b) Revise and align the CPS policy and guidance manual consistent withfamily engagement philosophy, procedures, and practice. **Completed**
c) Develop and/or contract for the development of training for local CPS workers in implementing the Family Engagement Model when conducting Family Assessments. **Completed**
d) *Revise the Family Assessment Track brochure to reflect changes in policy/guidance and practice.*

2013 Update

Last year, the Department of Social Services (VDSS) concentrated efforts on the improvement of the differential response system within CPS. Differential response was implemented statewide in 2002; however, few changes had been made to the policy/guidance manual since its implementation. This year the CPS policy/guidance manual was revised with regards to making the initial track decision and the criteria used to designate a report as an investigation or a family assessment. One significant change was to require an investigation after two family assessments had been completed within the past year. Further revision to the family assessment policy/guidance included a recommendation, not a requirement for local departments of social services to use announced visits and family interviews when possible in alternative response cases. Definitions were provided for protective capacities that should be assessed during the CPS response regardless of the assigned track. State staff developed and implemented training for CPS supervisors and workers throughout the state which provided policy and skills instruction for these revisions with a strong emphasis on using family engagement skills and practices in all CPS responses. Twenty-five one-day sessions were held between Mary and May 2013 throughout the state.

4. **Work collaboratively with the Prevention Unit to promote the early prevention guidance for local departments of social services around kinship care diversion and early prevention strategies**

a) Serve on Prevention Committee to develop guidance manual on kinship care diversion and early prevention strategies **Ongoing**
b) Collaborate on the development of a common service plan for use by local agency staff **Ongoing**
c) Develop and conduct training for local dss staff as needed

2013 Update

The DFS Prevention Unit worked in partnership with the statewide Prevention Committee, comprised of local departments of social services representatives and state staff as well as a number of statewide and local community partners. One of the Committee's objectives was to create guidance for local departments of social services that reflected how local departments and their community partners are providing prevention services in Virginia; incorporated best practice models gained from a variety of

sources across the state and the country; and made changes to OASIS that will allow Early Prevention data entry so local departments can record and track their prevention efforts.

The focus of the Prevention Committee was to address early prevention services, i.e., those prevention services provided prior to, or in the absence of a current, valid Child Protective Services referral. The first two sections of guidance (Overview of Prevention and Early Prevention Services to At-Risk Families) were published in October 2012. During November and December of 2012, the DFS Prevention Unit staff trained approximately 200 local social services staff across the state on the practice model and standards presented in these first two sections of guidance. The Prevention Unit staff completed the third and final section of guidance in April 2013 and submitted for approval. In addition, changes were made for prevention to OASIS to include updating prevention case types, developing and implementing early prevention screens for assessment, case planning and services using the protective factors as a guide. Statewide training was conducted on the OASIS changes during March – April 2013. Two sessions were held in each region as well as several sessions for specific large agencies. The training covered the new Prevention screens added in OASIS and how they support guidance. Local Programs Training Team staff trained 302 people.

III. Strengthening Community Services and Supports

These strategies contribute to developing an accessible array of community-based services across the Commonwealth. This strategy addresses the nature, scope, and adequacy of existing child and family and related services. This approach, which includes wraparound services when indicated, reduces the need for more intensive levels of service such as residential care – and shortens length of stay when placement is required. It contributes to the well-being of children and families.

- **Applicable CAPTA program areas as described in section 106(a):**

3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families; developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect; 10. Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response; 13. Supporting and enhancing interagency collaboration among public health agencies in the child protective service system, and agencies carrying out private community-based programs – to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports

Goal: Expand Community Services and Supports that are Child-Centered, Family-Focused and Culturally Relevant.

1. Expand services to prevent and treat child abuse and neglect through supporting and advocating for interdisciplinary resources.

a) Utilize child abuse and neglect prevention funds to support evidenced-informed and evidenced-based programs and practices. **Ongoing**
b) Utilize child abuse and neglect treatment funds for support services to child victims. **Ongoing**

c) Develop Request for Proposals, select and negotiate contracts, monitor grantees and evaluate performance for programs such as Healthy Families, parent support groups, parent education programs, Child Advocacy Centers, Court Appointed Special Advocates (CASA), etc. **Ongoing**
d) Work with the Outcome Based Reporting and Analysis Unit to develop stronger performance-based contracts.

2013 Update

Expanding community services and supports that are child-centered, family-focused and culturally relevant is another area where CAPTA funds have been used as well as CBCAP, Promoting Safe and Stable Families (PSSF), and Victims of Crime Act (VOCA). A total of 45 programs supporting child abuse and neglect prevention have been funded with CBCAP funds and State funds to support evidenced-informed and evidenced –based programs and practices. These services include Healthy Families, parent support groups, and parent education programs.

A total of 40 programs utilizing VOCA funds support child abuse and neglect treatment services for child victims. A number of Court Appointed Special Advocate (CASA) programs are also funded through VOCA. There are currently 15 Child Advocacy Centers (CAC) across the state receiving State funds to support child abuse treatment services as well. CAPTA funds support a part-time staff person to administer the funding for the CACs as well as provide technical assistance and consultation to grantees.

2. Collaborate with state and local stakeholders on developing and strengthening services that preserve families, achieve permanency, and promote child health, safety and well being.

a) Participate on state level inter- and intra-agency workgroups tasked with coordinating service and program initiatives such as the Governor's Advisory Board on Child Abuse and Neglect; the Children's Justice Act/CASA Advisory Committee; and the State Child Fatality Team. **Ongoing**
b) Develop and provide educational materials to inform key stakeholders on effective strategies *(e.g., mandated reporters and the general public on child abuse and neglect; kinship care providers; judges)*. **Ongoing**
c) Participate in the Statewide Home Visiting Consortium that operates as part of Virginia's Early Childhood Initiative to increase local and state collaborative efforts around home visiting programs. **Ongoing**
d) Evaluate and renew contracts for performances of sexual abuse prevention play to be presented to school-aged children statewide **Ongoing**
e) Evaluate and renew contract with James Madison University for the publication of the Virginia Child Protection Newsletter **Ongoing**
f) Review and revise the Interagency Agreement with the VA Department of Education and disseminate to all ldss' and public school divisions
g) Participate on the Virginia Interagency Coordinating Council to collaborate on the implementation of Part C of IDEA including public awareness efforts, child find, data collection and training. **Ongoing**
h) Participate on the Partnership for People with Disabilities, Child Abuse and Neglect Collaborative to evaluate the current training and develop and implement training sessions for the coming year. **Ongoing**
i) Continue to collaborate with the Department of Criminal Justice Services in the Child First forensic training program by providing scholarships for local CPS workers and supervisors to participate in the training. **Ongoing**
j) Review and revise the Memorandum of Understanding with the Department of Education regarding the reporting and investigation of child abuse and neglect complaints involving school personnel.

2013 Update

CAPTA funds were used to support other contracts and training opportunities. For SFY 2012 approximately 52,184 children participated in one of the 159 performances of the child sexual abuse prevention play "Hugs & Kisses". In the fall of 2012, 58 performances were held in 43 schools reaching approximately 18,343 children. VDSS works with Theatre IV, a Division of The Virginia Repertory Theatre, and Prevent Child Abuse Virginia for the implementation of this program.

Over 400 people attended the 2013 Virginia Child Abuse Prevention Conference "Insure Their Future: Invest in Children" held on Monday, April 15, 2013. The conference was sponsored by the VDSS, and Prevent Child Abuse Virginia and co-sponsored by The Family and Children's Trust Fund (FACT), the Virginia Statewide Parent Education Coalition and the Virginia Coalition for Child Abuse Prevention. Acting Commissioner Margaret Ross Schultze delivered the welcome and introduced keynote speaker Dr. Terry Morris. Dr. Robert Dugger also spoke during the opening session. The FACT Child Welfare Awards presented to seven individuals who have made outstanding contributions to the field of child abuse and neglect from across Virginia. The Reverend Dr. Clifford Barnett, Sr., delivered a rousing and motivational luncheon address. Twenty-one workshops and twenty exhibitors were featured. Feedback has been very positive, particularly for the three keynote speakers. Registration fees, CBCAP, CAPTA, and a grant from The Family and Children's Trust Fund helped to support this conference.

VDSS has collaborated with the VA Department of Criminal Justice Services (DCJS) in the ChildFirst forensic training program supported by the use of CAPTA and Children's Justice Act funds. CAPTA funds are used to provide scholarships for local CPS workers and supervisors to participate in this five-day intensive forensic interviewing training program. Three sessions involving approximately 60 workers will be funded this grant year. One session was held in September 2012, and March and June of 2013.

CAPTA funds were also used to support the training on child abuse and neglect for children with disabilities sponsored by the Partnership for People with Disabilities, Child Abuse and Neglect Collaborative involving VDSS, DCJS, Virginia Department of Education, and Virginia Commonwealth University. A video teleconference is held four times a year in four sites with a facilitator available in each site to field questions and facilitate small group discussions. Between 2011-2012 there were 204 participants representing social services, education, Community Services Boards, mental health advocates, court personnel, CASA, foster parents, and parents of children with disabilities. The current plan to continue this training involves the development, piloting and implementation of a web-based training delivery system by January 2014.

VDSS has a contract with James Madison University for the publication of the *Virginia Child Protection Newsletter* which provides the latest research and resources on selected topics. CAPTA funds are used to support this contract. The circulation of the newsletter is approximately 12,000 people. In SFY 2012, the following publications were released - *Developing Resilience and Strengthening Families*; and *Partnering for Prevention* which also featured a section on *Worker Safety*. The topics for the three newsletters for SFY 2013 are *Risk of Maltreatment for Children with Autism Spectrum Disorder; Evidence-Based Treatments for Childhood Trauma; and Evidence-Based Prevention* VCPN is also on the web at: http://psychweb.cisat.jmu.edu/graysojh.

CAPTA Annual State Data Report

Juvenile Justice Transfers

Through the OASIS data system, Virginia tracks reasons why children exit foster care. For SFY 2012, 29 children left foster care due to a commitment to corrections.

Defining when a child should be considered to have left foster care to the custody of DJJ was clarified in Foster Care Guidance. When the child's commitment to corrections terminates, Virginia Code specifies that for youth under 18 who were previously in foster care, they are to be returned to foster care unless another arrangement has been made (e.g., return to the parent).

Information on Child Protective Workforce

Education, qualifications, and training requirements established by the State: VDSS does not current collect demographic information, education, qualifications, or training requirements on local department workers. Virginia is a state supervised, locally administered system for social services. Because localities are responsible for hiring CPS workers, there are no education, qualification, and training requirements established by the State. The state's human resources department has occupational title descriptions for social work professionals that can be modified by local departments including Social Worker Program Manager, Social Work Supervisor, and Social Worker I-IV. Each title description include the level of supervision suggested for each level and upon completion of a training program or other requirements the person may be redefined to a higher level social worker. There is an educational and experience section of the title description that states: "Minimum of a Bachelor's degree in a Human Services field or minimum of a Bachelor's degree in any field with a minimum of two years of appropriate and related experience in a Human Services area as mandated in Section 22VAC40-670-20 of the Administrative Code of Virginia and implemented by the Virginia Board of Social Services. Possession of a BSW or MSW degree and a Commonwealth of Virginia Social Worker license are desirable."

CPS case loads: Using 2011 NCANDS data, there were 862 CPS workers in Virginia. There were 34,041 completed reports which average out to 40 reports per worker. Virginia is comprised of 120 local departments that range in size. The Division of Family Services has created a report to record active caseloads of all local department child welfare workers and another report that records referrals. The attachment Active Caseload SFY 2013.xlsx (CPS referrals and cases tab) lists the number of cases, the number of workers, and the caseload for both ongoing cases and referrals. This report counts any worker that was assigned to a child at any given so the count may be inflated.

CPS required training: All CPS workers in the state are mandated to complete skills and policy training within the first year of employment. Since 1996 Virginia has had regulations addressing CPS training.

22 VAC 40-705-180 mandates uniform training requirements for CPS workers and supervisors:

"*The department shall implement a uniform training plan for child protective services workers. The plan shall establish minimum standards for all child protective services workers in the Commonwealth of Virginia*."

22 VAC 40-705-180 (B) requires CPS workers to complete training within their first year.

"*Workers shall complete skills and policy training specific to child abuse and neglect investigations within the first year of their employment*."

Changes were made to the training requirements for CPS workers, managers, and supervisors. All Child Protective Services staff hired after March 1, 2013 who are designated to respond to reports of child abuse and neglect; manage or supervise CPS, shall complete the following on-line courses as soon as possible after their hire date, but no longer than the first three weeks of employment.

- CWS1002: Exploring Child Welfare
- CWS1500: Navigating the Child Welfare Automated Information System: OASIS

- CWS5692: Recognizing and Reporting Child Abuse and Neglect – Mandated Reporter Training.

The following instructor led course is required within the first three month of employment.

- CWS2000: Child Protective Services New Worker Policy/Guidance Training with OASIS

The following instructor led courses are required to be completed no later than within the first 12 months of employment.

- CWS1021: The Effects of Abuse and Neglect on Child and Adolescent Development
- CWS1041: Legal Principles in Child Welfare Practice
- CWS1061: Family Centered Assessment
- CWS1071: Family Centered Case Planning
- CWS1305: The Helping Interview
- CWS2011: Intake Assessment and Investigation
- CWS2021: Sexual Abuse
- CWS2031: Sexual Abuse Investigation
- CWS4020: Engaging Families and Building Trust-Based Relationships

The following instructor led courses are required to be completed no later than within the first 24 months of employment.

- CWS1031: Separation and Loss Issues in Human Services Practice
- DVS1001: Understanding Domestic Violence
- DVS1031: Domestic Violence and Its Impact on Children
- CWS2141: Out of Family Investigation (if conducting designated out of family investigations pursuant to 22 VAC 40-730-130.
- CWS5305: ADVANCED Interviewing : Motivating Families for Change

In addition to the courses listed above, all Child Protective Services supervisors hired after March 1, 2013 are required to attend the Family Services CORE Supervisor Training Series – SUP5702, SOP5703, and SUP5704. These courses must be completed within the first two years of employment as a supervisor.

Effective March 1, 2013, all CPS service workers and supervisors are required to attend a minimum of 24 contact hours of continuing education/training annually. Continuing education/training activities to be credited toward the 24 hours should be pre-approved by the LDSS supervisor or person managing the CPS program. Continuing education/training activities may include, but are not limited to, organized learning activities from accredited university or college academic courses, continuing education programs, workshops, seminars and conferences. Documentation of continuing education/training activities is the responsibility of the LDSS.

Updates to Virginia's Health Care Oversight and Coordination Plan for Children in Foster Care

Anticipated to be effective September 1, 2013, children in foster care and who reside in the Central or Tidewater managed care regions and are receiving Medicaid will be enrolled in a managed care organization (MCO). Virginia's goal is by June 30, 2014, all Medicaid eligible children who are in foster care statewide will be enrolled in an MCO, including children who are Title IV-E from another state and have been placed in Virginia. The Statewide list of DMAS approved MCO participation by locality is attached. The MCOs include:

- Anthem HealthKeepers Plus.
- Amerigroup.
- CoventryCares of Virginia (previously CareNet – Southern Health).
- Optima Family Care.
- Virginia Premier Health Plan.
- MajestaCare.

In the DMAS contracts with the MCOs, children in foster care are included in the definition of Children with Special Health Care Needs (CSHCN). CSHCN are defined as children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age.

The following services are carved out of managed care and will continue to be paid through Medicaid fee-for-service for children in foster care:

- Community Mental Health Rehabilitative Services
    - Crisis Intervention
    - Crisis Stabilization Services
    - Mental Health Support Services
    - Intensive In-Home Services for Children and Adolescents
    - Therapeutic Day Treatment for Children and Adolescents
    - Targeted Case Management.
    - Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, and Intensive Community Treatment are CMHRS programs for older youth on a case by case basis.
- Mental Retardation Community Services
    - Targeted Case Management Services provided by the Community Services Boards (CSBs).
- Private Duty Nursing for HCBS waiver enrollees
- Substance Abuse Treatment Services
    - Substance Abuse Crisis Intervention
    - Substance Abuse Intensive Outpatient
    - Substance Abuse Day Treatment
    - Opioid Treatment
    - Substance Abuse Targeted Case Management.
- Dental (Smiles For Children)
- School Health Services
- Specialized Infant Formula for Children Under Age 21
- Health Department Lead Investigations
- Early Intervention Services
- Personal Care services

J. Schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

MCO initial and biannual assessment: The MCO shall make a best effort to conduct an assessment of all CSHCN, as identified and reported by DMAS, within 60 calendar days of enrollment and every two (2) years thereafter. A successful assessment is considered a contact by the MCO that results in a fully completed health assessment questionnaire which assesses health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs with completion of an approved assessment tool. The assessment should include:

- Application of screening procedures/instruments for all new members.
- Review of physician, hospital, and pharmacy utilization.
- Providing referral policies and procedures for providers or, where applicable, authorized persons, to make referrals for a needs assessment.
- Identifying any ongoing special conditions of the child that require a course of treatment or regular care monitoring.
- Utilization of appropriate health care professionals.

The MCO shall provide a monthly report to DMAS detailing and confirming by identification number the number of completed assessments. The MCO shall provide copies of completed assessments upon request. The MCO shall provide, prior to signing the initial contract, upon revision, or on request, to DMAS a copy of the detailed policies and procedures of the MCO's assessment mechanism.

Screenings and assessments: The MCO shall provide comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals specified in DMAS' EPSDT medical periodicity schedule and as required and indicated. EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics (AAP). The MCO shall inform members about EPSDT services.

Medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screens rendered by providers other than the primary care provider.
- A comprehensive unclothed physical examination, including:
    - Vision and hearing screening;
    - Dental inspection;
    - Nutritional assessment; and
    - The MCO shall encourage pediatric primary care providers to incorporate the use of a standardized developmental screening tool for children consistent with the AAP policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings should be documented in the medical record using a standardized screening tool. The MCO shall not require any prior authorization associated with the appropriate billing of these developmental screening services in accordance with AAP recommendations.
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.

- Appropriate laboratory tests: The following recommended sequence of screening laboratory examinations shall be provided by the MCO; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
    - hemoglobin/hematocrit;
    - urinalysis;
    - tuberculin test (for high-risk groups); and
    - blood lead testing including venous and/or capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using bloodlevel determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater that 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to The Virginia Department of Health, Office of Epidemiology. The MCO shall work with DMAS' EPSDT program and send lead notices to primary care providers whose patients who have been identified by DMAS or the MCO as needing a blood lead screen.
- Health education/anticipatory guidance.
- Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

Vision services: Periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DMAS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist. Periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DMAS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

Dental Screenings: An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist. Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her three-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral must be made for needed dental services. Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines shall be covered. The pediatric dental services for eligible children up to age 21 continue to be covered through the Smiles for Children Program described last year.

K. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home.

MCO Monitoring

- The MCO shall assure that a participating child is periodically screened and treated in conformity with the EPDST periodicity schedule. To comply with this requirement, the MCO shall design and employ policies and methods to assure that children receive prescreening and treatment when due. If the family requests assistance with transportation and scheduling to receive services, the MCO is to provide this assistance.
- EPSDT services shall be subject to all the MCO's documentation requirements for its network provider services. EPSDT services shall also be subject to the following additional documentation requirements:
    - The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider.
    - Documentation of a comprehensive screening shall, at a minimum, contain a description of the required components.
- The MCO shall incorporate EPSDT requirements such as lead testing and developmental screenings in its quality assurance activities. The MCO must implement interventions/strategies identified below and meet specific requirements:
    - Childhood Immunization rates.
    - Well-child rates in all age groups.
    - Lead testing rates (i.e., increase percentage of lead testing of 1-5 year olds for prior contract year).
    - Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).
    - MCOs without a baseline rate must use the Medallion II average rate among all plans in the areas listed above as their EPSDT benchmarks. Baseline detail will be provided directly to the MCO. Each MCO will follow a long-term improvement plan not to exceed five (5) years to increase EPSDT levels using CY 2004 levels as baseline.
    - When a developmental delay has been identified by the provider, the MCO shall ensure appropriate referrals are made and documented in the member's records.

Medically Necessary Services: EPSDT requires that all medically necessary health care, diagnostic services, treatment, and other services for children shall be covered by the MCO as needed to correct or treat defects and physical and mental illnesses and conditions discovered, or determined as necessary to maintain the child's current level of functioning or to prevent the child's medical condition from getting worse including, but not limited to, private duty nursing.

Assurance of Trauma Expertise: The DMAS contract states that the MCO shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical and psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse and neglect and domestic violence. The MCO shall include such providers in its network. The MCO shall utilize human services agencies or appropriate providers in their community.

The MCO shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The MCO assures that providers with appropriate expertise

and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

Routine Childhood Immunizations: The MCO shall ensure that providers render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening and that members are not inappropriately referred to other providers for immunizations. The MCO shall work with its network providers to adhere to the ACIP recommendations. The MCO is responsible for educating providers about reimbursement of immunizations, educating members about immunization services, and coordinating information regarding member immunization. The MCO shall encourage all primary care providers (PCPs) who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health and shall include enrollment instructions in the provider network enrollment and re-enrollment paper-work. The capitation rate paid to the MCO does include the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The MCO shall not allow primary care providers to routinely refer Medicaid members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, the MCO and its network of providers shall participate in the statewide immunization registry database, when it becomes fully operational. Further, the MCO is required to submit its immunization data to the Virginia Immunization Registry on a monthly basis, beginning with January 1, 2013.

Other Covered Services Include**:**

- Clinic Services
- Colorectal Cancer Screening
- Court-Ordered Services
- Emergency Services
- Family Planning Services and Supplies
- General Obstetrical Hospital Services
- Home health services, including nursing services and home health aide services
- Hospitalization and Anesthesia Related Services
- Inpatient hospital stays in general acute care and rehabilitation hospitals for all members
- Inpatient and Outpatient Behavioral Health Services
    - Inpatient Psychiatric Hospitalization
    - Outpatient Individual Therapy
    - Outpatient Family Therapy Outpatient Group Therapy
    - Electroconvulsive Therapy
    - Pharmacological Management Services
    - Transportation (for traditional and CMHRS)
    - Smoking Cessation Counseling and
    - Medications For Pregnant Women
    - Care Coordination Services
- Inpatient Rehabilitation Hospitals
- Laboratory and X-Ray Services.
- Medical Supplies and Equipment.
- Medical Nutritional Supplements and Supplies
- Obstetric and Gynecologic Services
- Organ Transplants
- Outpatient Hospital Services
- Physical Therapy, Occupational Therapy, Speech-Language, Pathology Audiology Services
- Physician Services and Screenings

- Podiatric Services
- Prenatal and Infant Programs
- Prescription Drugs
- Private Duty Nursing (PDN)
- Prosthetic/Orthotic Services
- Second Opinions
- Telemedicine Services
- Temporary Detention Order (TDO)
- Tobacco Cessation Services.
- Women's Health Care Services

In addition to the MCOs, the local department of social services (LDSS) service worker is responsible for tailoring services to meet the strengths and needs for children in foster care, including using a wraparound approach and intensive care coordination services.

- **Wraparound Approach.** Section 16.6 of the Foster Care Chapter of the VDSS Child and Family Services Manual describes the use of a wraparound approach to help achieve the child's permanency goal and address the child and family's needs. The process involves an intensive, individualized process for planning, implementing, and managing care to achieve positive outcomes with the child and family. The information was adapted from the National Wraparound Initiative website

A team of people, relevant to the child's life, collaboratively develops and implements a creative wraparound plan. This holistic plan is designed based on an assessment of the needs of the child, caregivers, and siblings. A wraparound set of services and supports is individually designed with the child and family to meet their identified needs. The services creatively build upon and enhance the unique strengths, resources, and natural supports of the child and family.

The planning process, as well as the services and supports provided, are individualized, family-driven, culturally-competent, youth-guided, and community-based. The process and plan are strengths-based, including activities that purposefully help the child and family recognize, use, and build their talents, assets, and positive capacities.

The process strives to develop the coping skills, problem-solving skills, and self-efficacy of the child and family members. It increases the "natural support" available to the family by strengthening their interpersonal relationships and using other available resources in the family's network of social and community relationships. It emphasizes integrating the child into the community and building the family's social support network.

Additional information and practical tools on the wraparound process are provided:

- The CSA website has training slides developed by expert consultants in wraparound strategies that were used in Virginia. It also provides links to national resources.
- The National Wraparound Initiative (NWI) convened national experts to define the wraparound practice model, develop standards, compile resources, strategies and tools, and disseminate guidance and information on high quality wraparound implementation to achieve positive outcomes for youth and families.
- The NWI "Resource Guide to Wraparound" provides information on the basics, principles, theory and research, wraparound practice, and supports for implementation.

- **Intensive Care Coordination (ICC) Services:** Section 16.6 of the Foster Care Chapter of the VDSS Child and Family Services Manual describes the use of intensive care coordination services for children who are at risk of entering, or who are placed in, a residential program. The purpose of intensive care coordination services is to safely and effectively maintain, transition, or return the child home or to a relative's home, family-like setting, or community at the earliest appropriate time that addresses the child's needs.

The service worker shall coordinate efforts with the provider of intensive care coordination services through the Community Services Board. Such services must be distinguished as above and beyond the regular case management services provided within the normal scope of responsibilities for the public child serving systems. Case load size is small to allow for the intensity required and is between 7 to 12 children per intensive care coordinator.

Services and activities include:

- Identifying the strengths and needs of the child and his family through conducting or reviewing comprehensive assessments including, but not limited to, information gathered through the CANS.
- Identifying specific services and supports necessary to meet the identified needs of the child and his family, building upon the identified strengths.
- Implementing a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care.
- Implementing a plan for regular monitoring and utilization review of the services and residential placement for the child to determine whether the services and placement continue to provide the most appropriate and effective services for the child and his family.

The Community Policy and Management Team (CPMT) establishes policy for the provision of ICC and the FAPT makes referrals for the ICC service. LDSS service workers shall work collaboratively with the FAPT and the provider of intensive care coordination services to develop and implement a plan for transitioning the child. This collaborative planning should involve the child, family, service worker, and Intensive Care Coordinator and other members from the Family Partnership Meeting.

DBHDS has an ICC service toolkit on its website (http://www.dbhds.virginia.gov/CFS-ICC_AB.htm) based on Wraparound Principles and the work of the National Wraparound Initiative (http://www.nwi.pdx.edu/). According to the National Wraparound Initiative, wraparound is a process that achieves positive outcomes through intensive, creative, individualized, family/youth focused, team-based service planning. It is different from traditional service planning in that it identifies needs of the youth and family in a range of life areas, emphasizes helping youth/families to identify and recognize their strengths, and utilizes resources that are available in the family's network of social and community relationships. It is consistent with Systems of Care values and principles in that it is individualized, family driven, culturally competent and community based.

L. How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

The MCO shall maintain adequate provider network coverage to serve the entire eligible populations in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week. The MCO shall make arrangements to refer members seeking care after regular business hours to a

covering physician or shall direct the member to go to the emergency room when a covering physician is not available. Such referrals may be made via a recorded message.

In accordance with Virginia law, the MCO shall maintain after-hours telephone service, staffed by appropriate medical personnel, which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying member enrollment with the MCO.

Primary Care Network: The MCO shall have a primary care network that includes contracting with all area health departments, major hospitals, community services boards (CSBs), Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.

The following types of specialty providers may perform as primary care providers (PCPs):

- Pediatricians;
- Family and General Practitioners;
- Internists;
- Obstetrician/Gynecologists; Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or
- Other providers approved by DMAS.

Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The MCO shall make a good faith effort to ensure that children for whom the PCP is a specialist receives EPSDT services, including immunizations and dental services. The MCO shall have in place procedures for ensuring access to needed services for these members or shall grant these PCP requests, as is reasonably feasible and in accordance with MCO's credentialing policies and procedures.

Specialty Care Network: The MCO specialty care network shall provide for therapy, laboratory, vision, pharmacy, psychiatric, and transportation service providers. The following specialties shall be included:

Allergy and Immunology	Pediatric Critical Care
Audiologist	Pediatric Development
Audiology	Pediatric Endocrinology
Endocrinology	Pediatric Gastroenterology
Family Medicine	Pediatric General Surgery
Gastroenterology	Pediatric Genetics
Geriatric	Pediatric Hemotology/Oncology
Gynocologic Oncology	Pediatric Nephrology
Health Department	Pediatric Orthopedics

Home Health

Hospice

Hospitalist

Infectious Disease

Licensed Clinical Social Worker

Maternal and Fetal Medicine

Midwifery

Nephrology

Nurse Practitioner

Occupational Medicine

Oncology, Hematology

Orthopedics

Otolaryngology

Pathology

Pediatric Allergy & Immunology

Pediatric Pulmonology

Pediatric Specialist

Physical Medicine

Physical Therapy

Prosthetics and Orthotics

PT, OT, ST

Pulmonary Medicine

Radiation Oncology

Rehabilitation

Surgery (various)

Transplant Surgery

Urgent Care

The MCO shall include in its network or otherwise arrange care by providers specializing in early childhood and youth services. The MCO is encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions, and facilities that are needed to assure that the members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed.

Credentialing/Recredentialing Policies and Procedures. The MCO's QIP shall contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the MCO or its subMCO(s) are qualified to perform their medical or clinical services. The MCO shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170. The MCO's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys. The MCO shall perform an annual review on all subMCOs to assure that the health care professionals under contract with the subMCO are qualified to perform the services covered under this contract. The MCO must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The MCO shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application, this includes integrity-related and adverse actions (See Attachment XXI).

Practice Guidelines. The MCO shall establish practice guidelines that are congruent with current NCQA Standards for establishing guidelines. In accordance with 42 C.F.R. § 438.236, the MCO shall adopt practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of the members;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically, as appropriate.

The MCO must establish a system to monitor its provider network to ensure that the access standards below are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to DMAS that these access standards have been met.

- **Travel Time Standard.** The MCO shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any member in urban areas unless the MCO has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The MCO shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than sixty (60) minutes travel time from any member in rural areas unless the MCO has a DMAS-approved alternative time standard.
- **Travel Distance Standard.** The MCO shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the MCO has a DMAS-approved alternative distance standard. The MCO must ensure that a member is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, or other necessary providers, unless the member so chooses. An exception to this standard may be granted when the MCO has established, through utilization data provided to DMAS, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the MCO, and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area such as treatment of cancer, burns, or cardiac diseases.
- **Appointment Standards.** The MCO must arrange to provide care as expeditiously as the member's health condition requires and according to each of the following appointment standards:
    - Appointments for emergency services shall be made available immediately upon the member's request.
    - Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the member's request.
    - Appointments for routine, primary care services shall be made within thirty (30) calendar days of the member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.
- **Emergency Services Coverage.** The MCO shall ensure that all emergency Medallion II covered services are available twenty-four (24) hours a day, seven (7) days a week, either in the MCO's own facilities or through arrangements with other subMCOs. The MCO must designate emergency sites that are as conveniently located as possible for after-hours emergency care. The MCO must provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist members.

HEDIS Measures: The MCO is encouraged to calculate all Medicaid HEDIS measures for the Medicaid product. In addition, the MCO shall, at a minimum, consider the following Medicaid HEDIS performance measures as a priority. The MCO will assure annual improvement in these Medicaid HEDIS measures until such time that the MCO is performing at least at the 50th percentile as reported by Quality Compass. Thereafter, the MCO is to at least sustain performance at the Medicaid 50th percentile.

1. Childhood Immunization Status (Combo 2) and each vaccine must be reported separately as well
2. Childhood Immunization Status (Combo 3) and each vaccine must be reported separately as well.
3. Lead Screening in Children
4. Breast Cancer Screening
5. Timeliness of Prenatal Care
6. Postpartum Care
7. Well-Child Visits in the First 15 Months of Life each number of visits listed separately
8. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
9. Adolescent Well-Care Visit
10. Comprehensive Diabetes Care all age categories set forth by the HEDIS technical specifications for these diabetes measures only:
    - HbA1c Testing
    - HbA1c Control
    - Eye Exams
    - LDL Screen
    - LDL Control
    - BP Control <140/90
11. Asthma – Appropriate Use of Medication (all age categories set forth by the HEDIS technical specifications)
12. Cholesterol Management for Patients with Cardiovascular
13. Conditions (Control only)
14. Control of High Blood Pressure (<140/90) among members diagnosed with hypertension
15. Antidepressant Medical Management (Acute and Continuation) 15. Follow Up After Hospitalization for Mental Illness 7 day and 30 day

M. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.

The Primary Care Provider (PCP), care coordination, case management, and improved communication between LDSS and MCOs will improve continuity of health care and improve health outcomes for children in foster care.

Primary Care Provider: The PCP is responsible for providing preventive and primary medical care for children in foster care and for certifying prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Outreach and Case Management: The MCO shall provide local outreach and case management to its membership. Case management is the process of identifying patient needs and developing and implementing a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner. The MCO is responsible for establishing policy and procedures which facilitate

provider contact with medical management staff to explore resources and services for members with special health care needs. Case management shall be provided through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise. The MCO shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Medicaid/FAMIS Plus members' case management needs at all times. The MCO, on a quarterly basis, shall notify the Department of all full time case managers by region, and report any staff changes.

Case managers shall assist members in scheduling appointments, providing referrals to appropriate medical providers, offering assistance in identifying resources, other appropriate treatment options, referrals to resources, and shall make contact with the member or his family on a regular basis. The MCO shall assess, and provide if necessary, members' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services.

Coordination and Continuity of Care: In accordance with 42 C.F.R. § 438.208, the MCO shall have systems in place that ensure coordinated patient care for all members and that provide particular attention to the needs of members with complex, serious and/or disabling conditions. The systems, policies and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers. The MCO's coordination and continuity of care systems shall include provisions for all of the following processes:

- Members must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.
- The MCO's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.
- The MCO shall ensure that the process utilized to coordinate the member's care complies with member privacy protections described in HIPAA regulations and in Title 45 C.F.R. parts 160 and 164, subparts A and E, to the extent applicable.
- The MCO's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The MCO shall submit to DMAS prior to signing the initial contract, upon revision or on request referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.
- The MCO shall require their contracted providers to ensure that members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.
- The MCO shall have in place a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, MCOs shall provide discharge planning and/or coordination with long-term care service providers for members who are being enrolled in home and community based care waivers or nursing facilities to assure continuity of care.

Patient Centered Medical Home (PCMH): The MCO shall make best effort to develop and implement a patient-centered medical home initiative or pilot individually or in collaboration with other MCOs. If successful, this initiative shall be effective April 1, 2013 in the region defined by the Department as Far

Southwest Virginia and includes the localities of Bland, Tazewell, Buchanan, Dickenson, Wise, Norton, Lee, Scott, Russell, Washington, Smyth, Bristol, Grayson, Galax, and Carroll.

The initiative or pilot shall encompass a core set of Medical Home principles that include the following:

- Demonstrated Leadership;
- Team-based approach to care;
- Population risk stratification and management;
- Practice-integrated care management;
- Enhanced access to care;
- Behavioral-physical health integration;
- Connection to community resources;
- Commitment to reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services;
- Integration of health information technology;
- Inclusion of patients and families in implementation of the PCMH model; and
- Provider recognition for improved outcomes.

The MCOs may pilot with a physician practice(s) already Medical Home NCQA certified.

The ultimate goal of this initiative or pilot is to sustain and revitalize primary care to both improve customer outcomes for all members and to reduce overall health care costs. The MCO shall submit its plan to the Department for the initiative by December 31, 2012. Nothing in this section shall preclude the MCO from developing medical home initiatives in other regions.

N. The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.

Prescription Drugs: The MCO shall be responsible for covering all prescription drugs for its members, as set forth in 12 VAC 30-50-210, and in compliance with § 38.2-4312.1 of the Code of Virginia. The MCO shall cover all Medicaid/FAMIS Plus covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The MCO shall cover therapeutic drugs even when they are prescribed as a result of non-covered services or carved-out services (e.g., narcotic analgesics after cosmetic surgery).

The MCO may establish a formulary. However, the MCO shall have in place, and/or shall similarly require its pharmacy benefit manager to have in place, mechanisms to ensure the effective transition of care for members with established pharmacological treatment regimens, including for medications that are not on the MCO's formulary, and especially in relation to the ADHD class of medications. The MCO shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary. If the MCO establishes a formulary, the formulary and preauthorization requirements must be reported and updated to DMAS. This is due prior to signing the original contract, upon revision, and upon request. Any updates to the formulary must be sent to DMAS prior to their effective date. If a formulary is in place, in accordance with NCQA, the MCO is required to notify those members who are affected by any product withdrawal, as well as notify the practitioner who prescribed the product. The MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO may not impose co-payments on prescription drugs for any medications provided to children.

The MCO shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the patient. The MCO shall monitor and report atypical utilization to DMAS upon

request, providing the number of requests and denials. The MCO shall follow its authorization procedures within its prescribed timeframe and promptly notify both the physician and the pharmacy providers of its decision. Pharmacy services which are denied for children must be afforded a secondary review in accordance with the EPSDT requirements. The MCO shall respond to the authorization request within 24 hours. The MCO's response may be a request for additional information from the provider if this is needed to make the decision. If coverage is denied, the MCO shall inform the member of his or her rights and the procedures for filing an appeal. If the drug is prescribed for an "emergency medical condition," the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision.

Virginia Child Welfare Staff and Provider Training

Child welfare training for local agency staff that originates from the Virginia Department of Social Services (VDSS) is developed either within the Division of Family Services (DFS) or the Division of Training and Development (DTD) or is initiated at the local department of social services (LDSS).

Training that comes out of DFS is largely guidance/policy/regulations driven and is conducted for the most part by VDSS staff from the Home or Regional Office. Training for local agency approved providers is primarily provided by a contract with several universities and is based on the Pride curriculum.

A. VDSS Division of Training & Development

The training developed by the DTD Family Services Programs is the legacy training system that started some years ago as the "comprehensive, competency-based child welfare in-service training program" based on a model use in Ohio. Established Supervisor and Caseworker Core Competencies have guided the development of several documents to inform agency directors, supervisors, and caseworkers on how to best integrate training and maximize learning in order to improve child welfare services. The DTD Family Services Programs training is tasked with providing initial in-service training, based on these core competencies, for newer staff as well as training for supervisors and experienced workers.

Recent guidance (policy) in both Child Protection and Permanency has established new mandates for an initial in-service training program for CPS, Foster Care and Adoption workers and for all new supervisors and those with less than two years of experience. DTD also provides subject matter expert (SME) trainings based on assessed needs of local staff. The assessments are an ongoing process that is run in conjunction with the evaluation system as well a being a bi-annual assessment survey topic.

DTD Family Services Programs
Process to Promote Transfer of Learning

The VDSS DTD does not believe that training is a standalone event. Trainings are viewed as a collaborative effort to meet the emerging needs of our valued workforce. Research shows that activities completed before, during, and after training can help a participant better understand the content of the training and apply it on the job much more effectively.

DTD Family Services Programs has included a supervisory tool as a way to facilitate discussion on the content of each course including specific topics covered, a description of transfer of learning from the classroom back to the agency, and suggestions for continuing the learning process in the local agency to increase the knowledge, skills and abilities of caseworkers.

A committee of Regional Consultants and local child welfare supervisors was formed to develop a process and course specific supervisory tools to integrate transfer of learning activities. As a way to collaborate more effectively with LDSS supervisors, we have developed a process to promote transfer of learning for workers to provide direct feedback and support from the classroom to the agency supervisor to further enhance the skill-building and learning achieved through child welfare training. The following three types of transfer of learning activities were implemented into all child welfare training:

a) Individual Action or Learning Plans - at end of each child welfare training session each participant is ask to complete their Individual Action/Learning Plans. These course specific plans are a tool to document the learner's self-assessed strengths in mastering new materials and identify possible issues to follow-up on in the field, along with identified support and resources to enhance their learning
b) Field Practice Activities in New Worker Policy Training – following the end of the second day of training, participants are given letters to their supervisors with suggested field practice activities to be implemented during the two weeks between the sessions of the training. The supervisor must guide the worker and sign off on the trainees completed activities and they are processed with the group during the return to the classroom
c) Transfer of Learning Supervisory Tool – Supervisor Training Follow-up Guides are emailed to the trainee's supervisor following each training session to provide specific information on the content of the training and to provide field activities to enhance the learning and skill development of the worker

The DTD Family Services Programs provided 282 classes for July, 2012 – May, 2013 with a total attendance of 3167.

Attachment A addresses course listings. The Title IV-E reimbursement rates that have been established are also listed. Virginia's Child Welfare CORE and Mandated training course descriptions are provided for more content specific information on the training available to caseworkers and supervisors in Virginia.

B. DFS Training

The following are courses provided mostly by the Division of Family Services Home Office and Regional Staff. Included are statewide numbers of attendees. These represent classes that have been held since July 1, 2012. *Training initiated by the Division of Family Services is produced and conducted by state agency staff and not cost allocated to Title IV-E funds.* Numbers in attendance are for July 2012 – May 2013.

FAMSC0007 Family Assessments in CPS, Revisited
Description: This training combines new CPS guidance and practice skills which will enhance assessment practices in responding to all CPS reports with an emphasis on family assessments. Learning objectives include an opportunity to learn • the purpose, philosophy, and defining characteristics of Virginia's differential response system, and how it supports principles of strengths-based, family-centered, and collaborative child welfare practice; • the criteria to use when screening referrals to determine the appropriate track response; • the importance in family assessments and investigations establishing rapport with family members from the first telephone or face to face contact; • strategies for engaging and empowering families to collaborate in family assessments; and • how to engage parents to jointly assess factors that increase risk to their children and to develop and strengthen their protective capacities and parenting skills. Statewide attendance 396

VDSS – FAM1020: Introduction to Quality Service Review
Introduction to the Quality Service Review (QSR) Protocol and process to review child welfare cases with indicators in two domains, child and family status and practice performance. Training participants will be able to: (1) Learn an overview of the Quality Service Review (QSR) Process (2) Utilize the QSR Protocol and apply it to a child welfare case study and (3) Apply concepts to simulations provided during training. Statewide Attendance 25

VDSS – FAMWorkshop12-004:QSR New Reviewer Training
This training is intended for those interested in becoming QSR Reviewers for the state. Learning

Objectives 1. Learn an overview of the Quality Service Review (QSR) Process 2. To be able to utilize the QSR Protocol and apply it to a case study 3. Apply concepts to simulations provided during training. This training is for those who express an interest in becoming a QSR Reviewer.

Statewide Attendance 25

VDSS – FAM1050: VEMAT Changes for October 2012

This course is required to be completed in person for local agency or CSA staff who are designated as Virginia Enhanced Maintenance Assessment Tool (VEMAT) Raters. Other Permanency staff may attend as space is available. The course will cover changes to the VEMAT, changes to the rates and several changes to guidance. The course will also include discussion of strategies to develop a high degree of objectivity and consistency in the administration of the Tool. Statewide Attendance 419

VDSS – FAM1017: VEMAT Rater Training

This course is required for local agency or CSA staff who have been designated as Virginia Enhanced Maintenance Assessment Tool (VEMAT) Raters. The course will cover the use and characteristics of the tool. The course will also include discussion of eliminating bias in the completion of the tool and strategies to bring consistency to its use. Statewide Attendance 19

VDSS FAMSC0008-Unpacking the NO of Permanency for Older Adolescents

Family and life-long connections are crucial in achieving successful outcomes for youth in foster care. Unpacking the "NO" of Permanency for Older Adolescents Training addresses the importance of permanency using an adapted training developed by the National Resource Center for Permanency and Family Connections. This training will provide an overview of National and Virginia data on older youth in foster care, major policy changes in foster care, definition of permanency, the concept of permanency for youth, and strategies on how to change an initial "no" to permanency to "yes." At the end of the training the participant will understand what permanency and permanent connections are and why they are important, understand how adolescent development relates to permanency, know how to talk to youth about permanency, and understand the importance of having youth involvement in permanency planning.

Statewide Attendance 32

VDSS- FAMSC0007- Family Assessment Revisited

This course was trained statewide for child protective services staff and supervisors. This one day training combined new CPS guidance and practice skills and enhanced assessment practices in responding to all CPS reports with an emphasis on family assessments. Learning objectives included an opportunity to learn the purpose, philosophy, and defining characteristics of Virginia's differential response system, and how it supports principles of strengths-based, family-centered, and collaborative child welfare practice; the criteria to use when screening referrals to determine the appropriate track response; the importance in family assessments and investigations establishing rapport with family members from the first telephone or face to face contact; strategies for engaging and empowering families to collaborate in family assessments; and how to engage parents to jointly assess factors that increase risk to their children and to develop and strengthen their protective capacities and parenting skills. Statewide attendance: 268

VDSS: FAMC1000-Introduction to Early Prevention Guidance

Course description This course presents best practice guidelines for the provision of Early Prevention Services, i.e., those prevention services provided prior to, or in the absence of a valid CPS referral. The training emphasizes the strength-based approach to engaging families and service planning as well as introducing protective factors in family assessments, trauma-informed case management, and guidelines for working with foster care diversion cases Statewide Attendance 191

VDSS-FAMWkshp 12-007 Independent Living Services

Independent Living Program Requirements and Services, National Youth in Transition Database (NYTD), to include: -History, purpose, and requirements of NYTD, -Results from the Department's

research on the served and survey populations for federal fiscal year 2011; -Virginia NYTD implementation for the follow-up survey; and –Using NYTD data for program planning and evaluation. Education and Training Voucher Requirements, and Fostering Connections to Success & Increasing Adoptions Act of 2008 – Educational Provision. OASIS NYTD Training – Navigating the OASIS screens to ensure NYTD data are collected uniformly. Statewide Attendance 124

In addition to the courses above VDSS contractor United Methodist Family Services (UMFS) coordinated five regional trainings on "Trauma Informed Foster Care" for workers, foster and adoption parents, group home providers and other stakeholders. Participants learned about the devastating impact traumatic experiences can have on children, altering their physical, emotional, cognitive, and social development. Also, the training suggested ways adults can help children in foster care better understand the traumatic events affecting their lives and to identify and build on their strengths.

The Independent Living Educational Specialist completed eight regional training events (192 people) on the educational requirements of children in foster care. Some of these trainings were done with the workgroup co-lead from Department of Education and some were done independently.

C. LDSS Training Initiatives (IV-E "Pass Through")

Sixty LDSSs submitted plans to provide child welfare training under this category for SFY2013. These plans described the type of training to be provided (i.e., new worker or on-going training for staff/ resource parents) as well as the topic area to be covered and the over-all plan for training.

Approval of LDSS training plans is contingent upon the plan's compliance with federal guidelines regarding allowable expenses. Total funding approved for SFY 2013 for this category of training was $2,074,916. This amount includes funding for purchase of services such as travel, hotel accommodations, conference fees, training supplies and/or curriculum, training equipment, contractual services for the purpose of administering training, etc. It does not include the salary and related costs incurred by LDSS staff providing training. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate of 75 percent subject to the application of the penetration rate. Approved training at the enhanced rate was $1,984,201 and approved training at the administrative rate was $90,715.

Fifty-eight LDSSs have submitted plans to provide local agency initiated training for SFY2014. Approved training at the enhanced rate or 75 percent, subject to the penetration rate is projected (subject to final approval) to be $1,824,730. Approved training at the 50 percent rate, subject to the penetration rate is projected to be $81,560. Courses will be submitted to the federal Administration for Children and Families for approval on a quarterly basis.

Administrative costs such as the salary of a LDSS employed training staff are part of VDSS' Random Moment Sampling (RMS) process. (Administrative functions, excluding salaries and related expenses, relating to trainings that are eligible for Title IV-E will be charged at the federal financial participation (FFP) rate of 50 percent with the application of the penetration rate. LDSS provide the appropriate match.)

D. Resource Family Training

The purpose of this training is to enhance the knowledge, skills, and abilities of current and prospective resource, foster, and adoptive families in order for them to meet the needs of Title IV-E children. Training is comprised of two major components: pre-service training and in-service training.

Pre-service training provides resource, foster, and adoptive families with knowledge, skills, and abilities that prepare them to meet the needs of the child. In FY 2010, Agency-Approved Provider Regulations (22VAC40-211) were approved that require specific core competencies consistent with the Parent Resource for Information, Development and Education (PRIDE) pre-service curriculum. PRIDE is made available to LDSS who wish to use this as their training curriculum. LDSS that do not use PRIDE are able to purchase or develop an alternative curriculum and submit a copy to VDSS for approval.

In-service training is for current resource, foster and pre-adoptive parents to refresh and enhance their knowledge and skills related to working with the LDSS and children in foster care. Families are surveyed no less than annually to determine training needs and the determination is practiced uniformly and fairly across families and involves the family in the determination of training needs.

Total program costs approved for SFY 2013 for resource, foster and adoptive family training is $1,417,959. Of that amount $1,355,243 is approved at the enhanced rate and $62.715 is approved at the administrative training rate. This amount includes only funding for purchase of services such as travel, hotel accommodations, conference fees, training supplies and/or curriculum, training equipment, contractual services for the purpose of administering training, etc. It does not include salaries and related expenses of LDSS staff that provide training. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate of 75 percent subject to the application of the penetration rate.

Administrative costs such as the salary of a LDSS employed training staff are part of the RMS process. Administrative functions relating to training that are eligible for Title IV-E will be charged at the FFP 50 percent rate with the application of the penetration rate. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate subject to the application of the penetration rate. Other resource, foster, and adoptive parent training will be charged at the regular rate with the application of the penetration rate. LDSS will provide appropriate matching funds. Expenses related to this program not allowable under Title IV-E will be borne by the LDSS.

The Resource Family Consultants continue to provide formal training to agency staff around diligent search, family engagement, working with relatives, adoption matching, support of resource families, and other topics on an as needed basis. For example, VA Beach LDSS requested that their entire child welfare staff be trained on Diligent Search and Family Engagement. This is a training that is no longer being routinely offered, but can be provided by the Resource Family Consultants upon request. It was also offered twice in the Western Region this year. A more advanced version of this course called, "Family Engagement… next steps" has also been delivered upon request. "Support is everyone's job" is a training for all LDSS staff addressing the ways that resource parents can be supported through routine contact with the agency. This course has been offered multiple times in several regions this year.

Two of the five Resource Family consultants have received specialized training in fatherhood programs and father engagement. They have offered several trainings to LDSS staff who are planning to implement fatherhood programs this year.

Additionally, the Resource Family Consultants routinely train LDSS staff around Guidance revisions. This year they team-taught with the Permanency Consultants around new Permanency Guidance and changes to VEMAT as well training on minor changes to Resource Family Guidance.

The majority of the Resource Family Consultants' work with the LDSS staff is done 1:1 in the form of technical assistance, particularly in regards to new resource family staff and issues/ questions regarding

Guidance and regulations regarding resource family approval. Additionally, the Resource Family Consultants provide individualized assistance to LDSS around developing their own resource parent recruitment plans.

CRAFFT (Community Resource, Adoption and Foster Family Training program) promotes the safety, permanency and well-being of children through the training of LDSS foster, adoptive, and resource parents (collectively referred to as resource parents) to meet the needs of children in Virginia's child welfare system. CRAFFT's goal is to increase the knowledge and skills of resource parents through the development and delivery of standardized, competency- based, pre-and in-service training, as required by VDSS. The standardized curriculum used are the PRIDE training curriculum and A Tradition of Caring (Kinship PRIDE). CRAFFT delivers statewide pre-service and in-service training in each region, based on the completion of an annual needs assessment completed with each local department of social services. For larger agencies, CRAFFT collaborates with LDSS training staff to prepare the LDSS staff to deliver both PRIDE and/or A Tradition of Caring training. CRAFFT staff can serve as the PRIDE co-trainer with a local foster parent trainer when the LDSS has no professional trainer available. CRAFFT Coordinators also conduct the following activities:

- Develop and deliver additional in-service training for resource families, based on input from families as well as the local agencies and VDSS;
- Develop and maintain a regional training plan, updated as needed, based on the results of the needs assessment demonstrated in LDSS' local training plans;
- Work closely with the Regional Resource Family consultants and training, meetings, conference calls, and activities related to the implementation of a family engagement model, permanency roundtable process and LDSS recruitment needs as available;
- Collaborate with the Regional Resource Family Consultants around the delivery of the newly revised Mutual Family Assessment course (CWS 3103) which covers both assessment skills and a review of resource family approval policy and is team-taught;
- Collaborate with LDSS and Virginia Foster, Adoptive and Kinship Parents Association (FACES) to promote membership, participate in the annual FACES conference/training, and develop relationships with regional FACES board members and FACES staff; and,
- Conduct regularly scheduled regional roundtable meetings with LDSS staff and other key stakeholders to provide training and resources regarding resource parent development and support; inform agencies of current state or program initiatives related to resource parent training; and allow agencies to collaborate, exchange resources and share challenges and solutions.

During the 2013 fiscal year, the CRAFFT program was successful in providing eight (8) pre-services series, using the PRIDE curriculum. Each PRIDE pre-service series is comprised of 9 weeks and a total of 27 hours of resource parent applicant training. In addition to the pre-service series, the CRAFFT coordinators facilitated twenty-four (24) PRIDE-pre-service sessions. These sessions were held for family members that were unable to attend a session in a series or for agencies that needed assistance with facilitating a particular session but not the entire series. Approximately, two hundred and fifteen (215) resource family individuals attended the PRIDE pre-service training provided by the CRAFFT Coordinators. An additional four (4) pre-service series and twelve (12) pre-service sessions are scheduled between May and June 2013. During the 2013 fiscal year, the CRAFFT Coordinators also began preparing to use an additional pre-service curriculum "A Tradition of Caring". The new curriculum is designed exclusively for kinship families.

The CRAFFT Coordinators also facilitated a total of thirty-five (35) in-service sessions for four hundred and sixteen (416) resource family members between July 1, 2012 and April 30, 2013. The topics for the in-service sessions varied from Lifebooks to Parenting with Love and Logic, each session ranged from

two to six hours. An additional twenty-five (25) in-service sessions are scheduled between May and June 2013.

In addition to the pre-service and in-service sessions facilitated by the CRAFFT coordinators, they also provided assistance to local department of social services to help them increase their capacity for offering training more frequently. The CRAFFT Coordinators provided six (6) of the 2-day Introduction to PRIDE course for LDSS. They revised the 2-day Mutual Family Assessment course and provided it three (3) times. Additionally, the Coordinators developed a 1-day course to introduce and prepare LDSS kinship trainers/assessors to facilitate "A Tradition of Caring" pre-service curriculum for kinship families and it was offered once. The CRAFFT Coordinators also facilitated seven (7) roundtable meetings for LDSS workers to network and exchange ideas for training resource families. Between May and June 2013, the Mutual Family Assessment course is scheduled three (3) times, Introduction to PRIDE is scheduled once, and the roundtable meetings are scheduled four (4) times.

The CRAFFT Program employs six staff (five regional CRAFFT Coordinators throughout the state, and a Program Manager who oversees the program) based at three universities in Virginia (Norfolk State University, Radford University and Virginia Commonwealth University) with whom VDSS has a Memoranda of Agreement (MOA) for the provision of statewide competency-based training. The total of the CRAFFT contract budgets is $563,119. All CRAFFT coordinator activities are directly related to the development and delivery of federally approved training.

Attachment A

DTD Family Services Programs
On-line Courses

Prerequisites for all mandated Child Welfare (CW) training will be a series of eLearning (on-line) courses that range from a broad overview to fairly specific information about casework documentation and mandated reporter status. These include:

CWS1002: Exploring Child Welfare – On-line
(Pre-requisite for CWS2000, CWS3000, CWS3010)

Target Audience: Child Welfare workers with less than twelve months experience working in a local DSS agency; experienced workers who have not had formal training in Child Welfare. This self-paced online course will introduce you to the basic concepts and skills necessary to ensure the safety, permanency, and well-being of children.
Topics Include: Historical evolution of Child Welfare; Examination of key Child Welfare Federal legislation; Basic assumptions and guiding principles of Virginia practice; Ethics and values clarification; Cultural awareness; Roles, rights, and responsibilities of the worker, child, parents, and the community.
Fund: IV-E IV-E rate: 75%

CWS1500 Navigating the Child Welfare Automated System: OASIS – On-line
(Pre-requisite for CWS2000, CWS3000, CWS3010)

Local staff will be able to explore the OASIS tutorial through an eLearning experience that will guide them through actual practice with the major uses of the OASIS system. Practical information on the Help section will provide valuable resources for the new worker unfamiliar with the child welfare automated system.
Fund: IV-E IV-E rate: 75%

CWS5692 Recognizing & Reporting Child Abuse and Neglect – On-line Mandatory Reporter Training
(Pre-requisite for CWS2000, CWS3000, CWS3010)

Fund: IV-E IV-E rate: 75%

DTD Family Services Programs
Instructor Led Courses

CWS1021 Effects of Abuse and Neglect on Child and Adolescent Development - 2 days

After exploring the parameters of normal child development, learn to identify abnormal development and practice assessing whether it appears to be situational, congenital, or the consequence of maltreatment.
Topics include: Child development across the cognitive, emotional, moral, physical, and social domains; Development across the age-stages that comprise childhood and adolescence; Current theories related to attachment and resiliency; Ethnically-sensitive child welfare practice.
Fund: IV-E IV-E rate: 75%

CWS1031 Separation and Loss in Human Service Practice - 2 days

Understand the dynamics of separation and loss in children and families. Examine the stages of grief and the effects of stress and trauma on children, birth parents, and foster parents.
Topics Include: Parent/child attachment and foundations of a healthy relationship; Feelings commonly associated with separation; Stages of grief - how it manifests in children and impacts birth parents'

actions; Impact of loss on children and families in placements; Post-traumatic stress disorder and its impact; Crisis intervention theory; Strategies to minimize impact of trauma on children and families.
Fund: IV-E IV-E rate: 75%

CWS1041 Legal Principles in Child Welfare Practice - 2 days
An overview of the court structure in Virginia is provided to enhance trainees' understanding of the goals, outcomes, requirements, and burdens of proof at each stage of the civil and criminal court process.
Topics include: Explore the meaning of "reasonable efforts"; roles and responsibilities of key players in the court process; how to document a case for court; how a case record may be used for court and the legal requirements for case documentation; types and purposes of frequently used court orders; analyze and organize information to support the elements of relevant statutes.
Fund: IV-E IV-E rate: 50%

CWS1051: Crisis Intervention – 2 days
Target Audience: Human services workers and supervisors. CPS Required if Assessed Need. Learn about the dynamics of crisis and the principles, goals, and steps of intervention for working with various populations in crisis.
Topics Include: Crisis assessment; Effective strategies for defusing crisis; Restoring or improving coping strategies; Worker safety in crisis; The crisis of suicide.
Fund: IV-E IV-E rate: 50%

CWS1061: Family Centered Assessment in Child Welfare - 2 days
Provides an overview of the fundamental assessments skills used in all phases of the child welfare practice continuum (CPS, Foster Care, Adoption and Home Studies) and provides trainees a solid foundation for using critical thinking skills and avoiding bias in their assessments. The course focuses on using family centered assessment skills to build effective helping relationships and gain relevant accurate information as the basis for making correct and timely decisions.

Topics include: Seven stage critical thinking process; Common assessment factors in child welfare cases related to safety, permanency, and well being; Interviewing strategies that engage families and reveal pertinent information; Assessment and reassessment of safety and risk; Making sense of extensive information and focusing on what is relevant; Understanding the influence of the family's culture; Avoiding bias the assessment process; Helpful interview and assessment tools.
Fund: IV-E IV-E rate: 75%

CWS1071: Family Centered Case Planning - 2 days
Case planning is a collaborative effort between families, caseworkers, and other providers. It helps identify, organize, and monitor activities and services to families needed to achieve and document case outcomes. This foundational course discusses how these formal "action plans" are based on family assessments that identify high need areas and help determine service objectives. Learn how the planning process is dynamic and occurs throughout the life of a case.
Topics Include: Define case planning and list in order the steps in effective case planning; Strategies to engage families in the case planning process; Issues of culture, motivation, and change impact the development of the case plan; Interview strategies to engage families; Engage and involve fathers in the case planning process; Identify the goals of case planning; Correctly formulate objectives and activities to address the case plan goal; Fundamental concepts regarding concurrent planning; Regular case reviews to monitor progress and modify case assessment, goals, objectives, and activities as needed; Interview strategies to help clients stay invested in the change process; Home visits to provide casework services; Factors to consider for appropriate case closures.
Fund: IV-E IV-E rate: 75%

CWS1305: The Helping Interview – 2 days
Target Audience: Local staff with less than two years experience in child welfare or child welfare workers who will be enrolling in CWS5305: This course provides a condensed introduction to basic communication and particular helping skills that facilitate interviewing for assessment and problem-solving with adult clients.
Topics Include: Understanding the helping relationship and how it develops through interviews with clients; Improve understanding of the interview process and its phases; Strategies to facilitate communication; increase competence in basic interviewing skills that improve the quality of interviews, assessment, and problem-solving. Specific techniques to facilitate interviewing adults are attending and joining skills for building rapport; developing and demonstrating empathy; active listening; selective use of verbal and non-verbal communication skills; managing conflict and resistance; acknowledging culture and its influence on the interview encounter; identifying and capitalizing upon client strengths in assessment and problem-solving.
Fund: IV-E IV-E rate: 75%

CWS2000: CPS New Worker Policy Training With OASIS – 4 days
Target Audience: Local staff new to Child Protective Services program in Virginia. Learn the policy requirements of the CPS program in Virginia. Become knowledgeable about the laws, regulations, and policy that guide CPS practice at the local level. Practice documenting the policy requirements in OASIS.
Topics Include: Purpose and basic assumptions of CPS; Definitions of child abuse and neglect in Virginia; How to receive and respond to a report of child abuse or neglect; How to conduct a family assessment or investigation; Requirements for informing all parties while maintaining confidentiality; Best practice and policy requirements for provision of ongoing services in an open CPS case; How to assist the alleged abuser through the appeals process; How to document all policy requirements in OASIS.
Fund: State IV-E rate: N/A

CWS2011: Intake Assessment and Investigation in Child Protective Services - 3 days
Learn practical skills and techniques for interviewing children and their families in child abuse and neglect assessments and investigations. Learn the best practices to be used throughout the process of Child Protective Services including intake, assessment, and investigation.
Topics Include: Interpersonal, family, and environmental factors that increase the risk of abuse and/or neglect; How to gather pertinent information to assess risk, safety, and service needs; How to interview children, non-offending caretakers, and the alleged offending caretaker in assessments and investigations; How to assess information gathered to make safety plans; How to assess information gathered to make informed case decisions and identify service needs.
Fund: State IV-E rate: N/A

CWS2021: Sexual Abuse – 2 days
Target Audience: Child Welfare workers who require an overview of child sexual abuse. CPS Mandatory. Understand the dynamics and scope of child sexual abuse. Examine attitudes toward sexual abuse and the implications for best practice interventions.
Topics Include: Virginia's definitions of child sexual abuse and the extent of the problem; Consequences of sexual abuse from a developmental perspective; Profiles, characteristics, and treatment needs of the abuser and the non-offending caregiver; Circumstances that make children vulnerable to sexual abuse and inhibit disclosure; Dynamics of sexual abuse and intervention strategies to promote safety and well-being in children and families.
Fund: State IV-E rate: N/A

CWS2031: Sexual Abuse Investigation – 3 days

Target Audience: Child Welfare workers and supervisors responsible for investigating child sexual abuse complaints. CPS Mandatory. Explore the critical issues that impact the investigation of child sexual abuse. Practice the essential skills necessary when interviewing the victim, non-offending caretaker, and alleged offender.
Topics Include: Forensic investigation – goals, roles, and preparation; Developmental issues to consider for the child interview; The child interview process; Interviewing teens, credibility, and evidence collection; Interviewing and engaging the non-offending caretaker; Interviewing the offender; Focusing on safety; and Legal issues.
Fund: State IV-E rate: N/A

CWS2141: Out-of-Family Investigations – 2 days
Target Audience: Child Protective Services workers and supervisors who conduct out-of-family investigations. Mandatory for CPS Staff designated to perform Out of Family Investigations. Gain an understanding of the policy requirements and special challenges and dynamics of out of family investigations. Increase skill level in interviewing strategies to assess and intervene effectively in out of family situations. Learn how to inform and collaborate with all appropriate parties.
Topics Include: Risk factors related to the out-of-family caregiver; Collaborating with regulatory agencies, facility administrators, and family members; Working with legal representatives; Strategies for supporting the family; Policy unique to out-of-family investigations.
Fund: State IV-E rate: N/A

CWS3000: Foster Care New Worker Policy Training with OASIS – 4 days
Target Audience: Local staff new to the Foster Care program in Virginia. Learn the requirements of the Foster Care program in Virginia. Become knowledgeable about the laws, regulations, and policy that guide Foster Care practice at the local level. Practice documenting the policy requirements in OASIS.
Topics Include: Purpose and guiding principles of Foster Care services; Legal requirements for Foster Care, Foster Care prevention, and family preservation; How children enter care, safeguards, and placement authorities and options; Requirements for opening a case and completing all required referrals; Assessment and service planning, and choosing the Permanency Goal; Reassessments, reviews, and redeterminations; Policy and practice related to closing the case; Funding maintenance and service provision; How to document all policy requirements in OASIS.
Fund: IV-E IV-E rate: 75%

CWS3010: Adoption New Worker Policy Training with OASIS – 3 days
Target Audience: Local staff new to the Adoption program in Virginia. Learn the policy requirements of the agency placement Adoption program in Virginia. Become knowledgeable about the laws, regulations, and policy that guide Adoption practice at the local level. Practice documenting the policy requirements in OASIS.
Topics include: Purpose and guiding principles of providing agency placement Adoptions in Virginia; Provisions of pre and post-placement, and post-Adoption services; How to register and update information in the Adoption Resource Exchange of Virginia (AREVA) Policies and funding sources related to provision of Adoption subsidies; Best practice, as well as policy requirements, for conducting adoptive home studies; How to respond to appeals regarding the adoptive home approval process; and how to document all policy requirements in OASIS.
Fund: IV-E IV-E rate: 75%

CWS3021: Promoting Birth and Foster Parent Partnerships – 2 days
The relationship between foster parents and birth families can have a significant impact in the overall course of placement. When the relationship is respectful, non-judgmental, and supportive, all parents are able to do a better job in meeting the children's needs. Creating a team approach with planned contact

between birth and foster parents have shown that children return home sooner, have more stable placements, experience better emotional development and are more successful in school. This course will specifically deal with one of the core principles of family engagement - promoting meaningful partnerships between foster and birth families as partners in promoting safety, well being and permanency for children.
Topics include: Benefits and challenges of working with the child's family; Roles and responsibilities of birth parents, foster parents, and social workers in promoting partnerships; Ways to work with the child's family and/or support on-going communication between the birth family and foster family; Minimize the challenges of working with the child's family; Conduct an Ice-breaker Meeting with all interested stakeholders; Engage fathers in the permanency planning process; Visit Coaching techniques and strategies; Importance of Shared Parenting in assisting the family; Supervisory Issues to support the partnerships.
Fund: IV-E IV-E rate: 75%

CWS3041: Working With Children in Placement – 2 days
Target Audience: Child Welfare workers and supervisors. Learn practical skills and techniques for working with children in placement. Experience an interactive and resource-filled curriculum that includes videos, children's books, storytelling, and life books.
Topics Include: Assessing children's needs; Preparing children for placement; Talking about the past; Coping with emotions and grief; Managing behavior and preventing disruptions; Developing a planned and purposeful visitation plan; Conducting placement family meetings.
Fund: IV-E IV-E rate: 75%

CWS3042: Orientation to the ICPC - 1 day
Target Audience: Local agency child welfare supervisors, workers and other local agency staff who are likely to prepare ICPC documents and materials for placing children in out of state placement or those child welfare workers who may be requested to facilitate and supervise the placement of a child from out of state. This course provides the basic knowledge of the Interstate Compact on the Placement of Children (ICPC), including requirements and practices. The ICPC procedures are to assure that children placed across state lines receive the same protections and support services as children placed within the state. Training on the Compact will help to assure that the requirements established by law do not become barriers for children whose needs can best be served through interstate placement.
Topics Include: History of the ICPC; Philosophy, legal base, and placement authority; Placing a child out of state: Responsibilities and expectations; Receiving a child from another state: Responsibilities and expectations; unusual circumstances in the ICPC process.
Fund: IV-E IV-E rate: 75%

CWS3061: Permanency Planning for Teens-Creating Life Long Connections – 2 days
Target Audience: Foster Care and Adoption workers and those individuals involved in the permanency planning process. Learn how to help teens identify and establish emotional connections and build the family support necessary for navigating the difficult transition into adulthood.
Topics Include: Developmental issues and the need for permanency for teens; Impact of the Child Welfare system and barriers to permanency; The concept of resiliency and resiliency led practice to assist youth in care; The key elements of loyalty, loss, self-esteem, behavior management, and self-determination as the foundation of permanency; Ways to involve teens in identifying their own permanency resources; The role of youth-specific recruitment in making permanent connections; Strategies for preparing teens for family living and supporting permanency.
Fund: IV-E IV-E rate: 75%

CWS3071: Concurrent Permanency Planning – 2 days

Target Audience: All Child Welfare caseworkers, supervisors, and administrators who provide direct services to families and/or develop policy that guides casework practice. Concurrent planning is an approach that seeks to eliminate delays in attaining permanent family placements for children in foster care. Concurrent Planning is a process of working towards reunification with parents while at the same time establishing an alternative plan for permanent placement. Concurrent rather than sequential planning efforts are made to more quickly move children from the uncertainty of foster care to the security of a safe and stable permanent family. CWS3071 teaches practical skills and techniques for implementing concurrent planning.
Topics Include: Impact of ASFA and Fostering Connections Act on permanency for children in foster care; Components of effective concurrent planning – six essential processes; Three-Stage Case planning process for early and targeted family change; Finding, engaging and supporting relatives and kinship care providers; Use of Family Partnership Meetings to enhance collaboration among parents, resource/foster parents, service providers and those within the child welfare and legal systems; Use of the Permanency Planning Indicator in the assessment process; Engaging parents in the decision-making process and practicing full disclosure interviewing; Identifying and addressing parental ambivalence; Frequent and constructive use of parent-child visitation; Involvement of resource and kinship parents in working directly with the biological parents; Documenting the concurrent plan in the case record.
Fund: IV-E IV-E rate: 75%

CWS3081: Promoting Family Reunification – 1 day
Target Audience: Foster Care workers, Child Welfare workers, and others involved in the permanency planning process. For children in foster care, reunification with birth parents or prior custodians is often the primary permanency goal and the most likely reason a child will leave placement. This course will examine the planned process of reconnecting children in out-of-home care with their families or prior custodians by means of a variety of services and supports to the children, their families, their foster families, and other service providers.
Topics Include: Family-focused practice; Principles of reunification; Impact of separation and loss; Maintaining connectedness; Planned visitation; Partnership and collaboration; Role of foster parents, birth parents, or prior custodians in the casework process, service delivery, case planning; Safety assessment.
Fund: IV-E IV-E rate: 75%

CWS4020: Engaging Families and Building Trust-based Relationships – 2 days
Target Audience: All child welfare workers and their supervisors currently working with children and families, especially those involved in Family Partnership Meetings should attend this course. Family engagement is the foundation of good child welfare casework practice that promotes the safety, permanency, and well-being of children and families. It is a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes.
Topics Include: Explore characteristics of family culture and information in policies and practices that support the engagement process with families; Develop a working agreement with families; Connect personal experiences with change and the experiences families have in order to better engage with family members and assess in a non-judgmental manner; Identify and address primary and secondary losses resulting from change and help families transition from their discomfort zone to practicing the desired behavior; Understand the various types of resistance often encountered in working with families and learn specific techniques to work with resistance; Practice specific engagement and trust building skills of exploring, focusing, and guiding to help the worker and the child and family gain insight into their current situation; Learn and practice solution-focused questions to surface family member's strengths, needs, culture, and solution patterns; Define and practice the use of self-disclosure, normalization, and universalization to help to normalize feelings and experiences; Identify ways to formulate, evaluate and refine options with families; Define and identify essential underlying needs that are often a description of the underlying conditions and source of the behavioral expressions of problems that a family may be encountering; Evaluate the use of Core Conditions and Engagement Skills used by workers with family

members; Define and practice the steps of the working agreement and how these steps are used to build a partnership relationship with the family; Develop a plan to practice the strategic use of the working agreement, core conditions and core helping skills to build a trusting relationship with families.
Fund: IV-E IV-E rate: 75%

CWS4030: Family Partnership Meeting Facilitator Training – 3 days
Target Audience: Locally identified department of social services staff, child welfare supervisors and administrators as well as intensive care coordinators. This course will prepare experienced child welfare professionals to serve as family partnership meeting facilitators using the principles and process of the Virginia Practice Model. This course will be presented as four-day classroom training. Participants will attend three consecutive days of training, practice facilitation skills and/or develop implementation plans in their localities for approximately one month, and return on the final training day to discuss progress, receive feedback and complete the training content. Successful completion of CWS4020: Engaging Families and Building Trust-based Relationships is a prerequisite.
Topics Include: Review of Virginia's Practice Model and FPM values; Role of the family partnership facilitator and skills to promote effective meetings; Family engagement techniques; Meeting preparation; Stages of the solution-focused Family Partnership Meeting; Security issues and accommodation of special needs; Responsibilities of the facilitator following the meeting; Local implementation considerations to include training of family partnership meeting participants; continued professional development.
Fund: IV-E IV-E rate: 75%

CWS5011: Case Documentation – 2 days
Target Audience: Child Welfare workers and supervisors. In day one, trainees learn writing skills that support case documentation in all social services areas. In day two, trainees build upon skills learned in day one to enhance their ability to document casework activity, Assessment, decision-making, and planning in Child Welfare cases.
Topics Include: Purpose, goal, and strategy: Focusing on your reader's needs; How to review your work from your reader's perspective; How to recognize bias, passive voice, and the difference between fact and opinion; An overview of the writing manual, The Elements of Style; Child Welfare case narrative: How much is too much?; The elements of a Child Welfare assessment; Service planning in Child Welfare the SMART way; Tips for correspondence and intake.
Fund: IV-E IV-E rate: 75%

CWS5305: Advanced Interviewing: Motivating Families for Change – 2 days
Target Audience: Child Welfare workers and supervisors across all program areas. Strongly recommended that supervisors attend prior to social work staff. This course will assist workers to engage families in a mutually beneficial partnership and assess a family's readiness for change. Workers will learn two client engagement models and the recommended strategies for sustaining motivation and commitment to change.
Topics Include: Engagement and the Strengths Perspective; The Stages of Change; Motivational Interviewing Techniques; Solution-Focused Interviewing Techniques.
Fund: IV-E IV-E rate: 75%

CWS5307: Assessing Safety, Risk, and Protective Capacities in Child Welfare – 2 days
Target Audience: Child Welfare workers and supervisors in Child Protective Services and/or permanency programs. Learn practical techniques for conducting fair and accurate assessment of safety and risk, utilizing protective capacities to promote child safety and reduce risk in child protection and permanency plans.
Topics Include: Definitions of safety, risk, assessment, and protective capacity and how to distinguish between risk and safety; Assess and monitor safety at decision points across the service continuum throughout life of case; Interventions based on level of risk and identified protective capacities; Identify

the minimum sufficient level of care for children and explore the least drastic/restrictive alternatives to address concerns of safety and risk; Solution-based model to increase family and caregiver involvement in the creation of assessments, safety plans, and service plans.
Fund: IV-E IV-E rate: 75%

DVS1001: Understanding Domestic Violence – 2 days
Target Audience: Caseworkers and supervisors in all service programs. This course provides a basic knowledge of domestic violence and establishes the most effective means through which intervention may be initiated in instances of domestic abuse.
Topics Include: Impact of domestic violence on the family structure and the community at large; Causation theories and dynamics of domestic violence; Safety issues for the worker and assessing safety of the victim and the victim's children; How to assess the lethality of the domestic violence situation; Resources available in the community, including legal resources.
Fund: IV-E IV-E rate: 75%

DVS1031: Domestic Violence and its Impact on Children – 1 day
Target Audience: Workers and supervisors in all service programs, particularly those in Child Welfare. CPS Required if Assessed Need. Learn core principles of domestic violence intervention techniques and discuss assessment skills necessary to determine risk for all family members. Review community resources that collaboratively address family violence and protect family members.
Topics Include: The impact of domestic violence on children's healthy development; Essential procedures and techniques for interviewing children in violent homes; Development of effective intervention and safety plans; Appropriate community referrals and proper monitoring techniques; Virginia law and legal options.
Fund: IV-E IV-E rate: 75%

DTD Family Services Programs
Mandated CORE Supervisor Series

The CORE Supervisor Series is intended for new supervisors with less than two years of supervisory experience or supervisors needing refresher training. This new supervisor series expands the original CWS5701 three-day course and the only training that was available for supervisors. It is two consecutive days per month for a period of four months and includes transfer of learning field practice activities assigned in between sessions that will further enhance learning. In order to fully maximize the training experience, supervisor's need to enroll in the entire series and commit to these training dates. With that said, supervisors who have to miss a session due to an emergency can pick it up in another region or at another time. The intent is for the supervisors to be able to network regionally and gain valuable support from each other as they attend this training series together!

SUP5701: Fundamentals of Supervising Family Services Staff – 2 Days
This course emphasizes the crucial role played by family service supervisors. Supervisors will increase their understanding of the demands of their role, and be introduced to basic tools and strategies to help them supervise direct practice caseworkers. The fundamental principles for casework supervision of Parallel Process, Strengths-Based, Mission-Focused, Culturally Competent and Evidence-Based practices are introduced. Attention is also given to the unique attributes of adult learners, how to promote a learning environment that will enhance caseworkers training experiences, how to identify staff's learning needs, stages in the coaching process as well as identify common pressures and stresses that supervisors often face.
Fund: IV-E IV-E rate: 50%

SUP5702: Management of Communication, Conflict & Change – 2 Days
This course introduces three concepts that directly impact the work of supervisors and the functioning of their unit: Communication, Conflict, and Change by examining the importance of good communication in family service practice. Strategies for improving communication and ensuring that intended messages are received, the conflict cycle and management of resolving conflict that is frequently caused by poor communication or lack of communication are addressed. Change is a force that is both necessary and unavoidable in the social services field. The types of change that impact organizations and ways to assist staff implement change will be discussed with a review of strategies for change management by emphasizing the interrelated relationship between these three concepts.
Fund: IV-E IV-E rate: 50%

SUP5703: Supporting and Enhancing Staff Performance – 2 Days
This course is intended to help new supervisors develop competent, confident, and committed staff that can perform the tasks assigned to them and support the agency mission/goal. Supervisors are introduced to the concepts of managing by data, performance assessment, performance evaluation, and performance improvement of the individual staff in their unit. In addition, the characteristics of effective leaders and managers will be examined as well as how the two are distinguished. Supervisors will learn about four styles of leadership: Participatory, Transformational, Transactional, and Strengths-Based and several leadership tools that can be used in their units or assessing their own leadership qualities and potential.
Fund: IV-E IV-E rate: 50%

SUP5704: Collaboration and Teamwork – 2 Days
This course applies many of the concepts learned throughout the previous supervisor modules with an emphasis on collaboration with others and the successful functioning of the unit. Benefits and strategies for collaboration are highlighted through consideration of the unit as a single system within the larger agency, department, and community. Characteristics of units that function effectively are also presented. Supervisors are given tools to assess the level of performance of their unit and are presented with an opportunity to develop a plan to improve their unit's functioning. Finally, strategies are introduced to help the supervisor build a unit that is successful in achieving the agency mission and vision through successful collaboration and teamwork.
Fund: IV-E IV-E rate: 50%

DTD Family Services Programs
Subject Matter Expert (SME) Workshops

New guidance was issued requiring all child welfare workers with more than two years experience to attend a minimum of 24 hours of training per year after completing initial in-service training mandates. Training for experienced workers will be developed and delivered by practice experienced subject matter experts (SME) engaged and supervised by the training system in response to regionally assessed needs of staff. Continuing education activities may also include organized learning activities from accredited university or college academic courses, continuing education programs, workshops, seminars and conferences. Documentation of continuing education activities is the responsibility of the local department of social services and should be pre-approved by the child welfare supervisor or person managing the caseworkers program.

The Bi-Annual VDSS Child Welfare Training Needs Assessment Survey conducted by DTD in June 2012 culminated in three one day continuing education workshops and one "HOT TOPIC" being developed and offered for experienced workers and supervisors. The survey asked LDSS child welfare staff to rank order 10 caseworker specialized competencies according to highest priority for their desired

learning needs. The following were the highest ranked competencies and identified hot topics statewide and were used to develop the four SME workshop topics to be offered in each of the five regions in FY13:

SME001: Building Litigation Proof Cases: Protecting Parental Rights Through Diligent Casework
Statewide Attendance: 239
This workshop is designed to ensure that experienced child welfare professionals understand the legal rights of parents, children, non-custodial parents, incarcerated parents, grandparents, and substitute caregivers in child welfare cases. Learners will discover how deficiencies in casework processes, improper caseworker conduct, and lack of adherence to policies and standards can increase the risk of liability for the caseworker and the agency. This course will also demonstrate how inappropriate language used in verbal communication and written documents can increase risk of liability for the agency. Attendees will learn how to present and explain case information to family members, defense attorneys, and community agencies in a manner that preserves the rights of family members and protects caseworker and agency from liability.
About the trainer: Rachel Allen's experience in family law dates back to her earliest work with the Woehrle & Franklin law firm where she handled custody and child support cases, and represented children as guardian ad litem in abuse/neglect proceedings. Ms. Allen has previously served as the Deputy City Attorney for the City of Hampton and is currently the Associate City Attorney for the City of Virginia Beach. In each position, she has been responsible for representing and advising the Department of Human Services, including child protective services, foster care and adult protective services units. Additionally, Ms. Allen is an adjunct professor in the law program at Regent University.
*This SME Workshop was so popular we will be offering it again in all five regions in FY14.
Fund: IV-E IV-E rate: 75%

SME002: Kids Deserve a Permanent Home
Statewide Attendance: 148
This workshop is designed to ensure experienced child welfare professionals are competent in their ability and knowledge to reunite children in placement with their families and to provide services to prevent placement disruption and re-entry of children into out-of-home care. Learners will discover how best practice in casework, combined with community resources, result in permanency.
About the trainer: Betty McCrary's experience in social work dates back to her earliest work with McVitty House, Inc. Dr. McCrary currently serves the community as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, and Certified Family Mediator for the Supreme Court of Virginia. She previously served as a social worker, a Social Work Supervisor and Director of Roanoke County Department of Social Services. In each position, she has been responsible for representing and advising families in setting and obtaining goals for their children. Additionally, she serves in the following capacities: Military and Family Life Consultant for MHN, American Association for Counseling and Development, Virginia Counselors Association, Board of Directors, Conflict Resolution Center, Blue Ridge Behavioral Health Child and Family Services Advisory Committee, Board of Directors, Roanoke County Police Foundation, and on the Roanoke County Dept of Social Services Advisory Board.
Fund: IV-E IV-E rate: 75%

SME003: Helping Children Find the Words
Statewide Attendance: 164
This workshop is designed to provide experienced social workers with advanced knowledge regarding investigative interviews of alleged victims and siblings in CPS cases. Social Workers will gain an understanding of child development and the impact of the interview, memory, suggestibility, and testifying in court. Techniques to help children feel safe, comfortable, and supported during investigative interviews will be discussed; as well as steps to reduce trauma. We will also explore the benefits and liabilities of using interview aids such as drawings and anatomical dolls.

About the trainer: Wendy Holland, MSCJ is trained in Forensic Interviewing by APRI and Corner House. She has 13 years of experience interviewing alleged victim children and their siblings in child maltreatment investigations. Furthermore, she is an Expert Witness on Physical and Sexual Abuse in Virginia Beach and Chesapeake.
Fund: State IV-E rate: N/A%

SME004: Implementing and Sustaining child and Family Teaming
Statewide Attendance: 198
This workshop includes discussion of engagement concepts and strategies to implement and conduct Child and Family Teaming (CFT). Case examples are used to illustrate key points, while small and large group activities provide opportunities to practice skills and assess individual strengths. Strategies are discussed regarding best practices for managing CFTs, including running meetings, maintaining communication between meetings and ensuring all needed parties are engaged. In addition, supervisors have specific opportunities to assess resources and plan how to evaluate application of strategies in their agencies. **Both Child Welfare Workers and Supervisors are encouraged to attend.**

Child Welfare Workers Learning Outcomes:

- Recognize and articulate the benefits of engaging the family and the whole service provision team;
- Know and explain the differences and similarities between a family partnership meeting and child and family teaming;
- Describe effective methods of practice that promote engagement and teaming to achieve commonly held goals;
- Determine an initial plan to address issues identified as personal or systemic barriers to effective teaming.

Supervisors Learning Outcomes:

- Set clear expectations for engagement and maintenance of a family focused service delivery team (CFTs).
- Explain how the formation and functioning of these teams will be evaluated through supervision practices and providing formative oral and written feedback to team participants.

About the trainer: Ms Betty Jo Zarris holds a Masters of Social Work degree from Virginia Commonwealth University and has more than forty years experience in a variety of local and state level positions including social worker, Social Work Supervisor, and Regional consultant in the Central Region. As the VDSS Assistant Director of the Family Services Division, Ms Zarris played a lead role in the implementation of the Children's Services Transformation. Since her retirement, in January 2012, she has worked with Children's Research Center (CRC) and several local departments. She participated as a volunteer mentor in numerous Quality Service Reviews (QSRs) and her interest in Teaming has grown out of those reviews.
Fund: IV-E IV-E rate: 75%