Implementation Plan for the Memorandum of Understanding Between the State of West Virginia and the U.S. Department of Justice

WEST VIRGINIA Department of Health & Human Resources

Year Four
January 17, 2023

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1. Introduction

On May 14, 2019, West Virginia (the State; WV) entered an agreement (the Agreement) with the U.S. Department of Justice (DOJ) to address the DOJ's allegations regarding the State's service system for children with serious mental health conditions, as operated by the West Virginia Department of Health and Human Resources (DHHR). The DOJ recognized the current reform efforts underway in the State, and the Agreement reflects DHHR's commitment to improving the State mental health system to ensure children can receive mental health services in their homes and communities. Pursuant to the Agreement requirements, WV must develop an Implementation Plan (Plan) that describes the actions WV will take to ensure programs memorialized in the Agreement are sustainable, statewide, and accessible to children in the target population, as defined in Section 3. The Plan describes WV's efforts to uphold its obligations by outlining the steps to realize each program, including working to ensure statewide access and services, as listed in the Agreement:

- WV Wraparound
- Children's Mobile Crisis Response
- Children with Serious Emotional Disorder (CSED) Waiver Services
- Therapeutic Foster Family Care
- Behavioral Support Services
- Assertive Community Treatment (ACT)
- Mental Health Screening Tools and Processes
- Evaluation, Quality Assurance (QA), and Performance Improvement
- Outreach and Education to Stakeholders
- Workforce Development and Provider Capacity
- Reducing the Reliance on Residential Mental Health Treatment Facilities (RMHTFs)

2. Time Frames and Working Documents

Pursuant to the Agreement, WV may revise the Plan annually and submit the revisions to the DOJ and to the public for comments before finalizing amendments. Prior to finalizing the Plan, DHHR will accept public comments for a minimum of 15 days. All comments will be considered. Although there is no requirement that DHHR provide formal responses to any public comment, DHHR may do so at its sole discretion.

Once the revised Plan is finalized, it will supersede any previous Plan. For the purposes of historical information, all finalized Plans will be stored under the DOJ Partnership tab on the West Virginia Kids Thrive Collaborative (Collaborative) website (https://kidsthrive.wv.gov/DOJ).

In addition to the Plan, WV utilizes detailed work plans that further describe the steps and actions it will take each year to develop the processes and services required by the Agreement. To better explain the intricacy of the tasks outlined in the Plan, WV provides the work plans to the DOJ and the subject matter expert (SME). These documents are subject to change as implementation continues and are not “supplements” or “schedules” to the Plan and shall not be construed as “supplements” or “schedules,” and therefore, are not enforceable provisions of the Agreement. Only documents specifically labeled “supplements” or “schedules” shall become enforceable provisions of the Agreement.

3. Statement of Principle

DHHR's mission is to promote and provide appropriate health and human services for the people of WV to improve their quality of life. DHHR will conduct programs in an effective, efficient, and accountable manner with respect for the rights and dignity of employees and the public served.

DHHR is committed to the following:

- Working to help prevent children with serious mental health conditions from being needlessly removed from their family homes to obtain treatment
- Helping prevent those children from unnecessarily entering RMHTFs
- Transitioning those children who have been placed in these settings back to their family homes and communities
- Providing home and community-based services (HCBS), including Wraparound facilitation, Children's Mobile Crisis Response and Stabilization (CMCRS), Therapeutic Foster Care,[1] and ACT to children in the target population

Through these programs, children receive services in the most integrated setting appropriate for their needs. It is the goal of DHHR to ensure that children covered by the Agreement receive sufficient community-based services to help prevent unnecessary institutionalization.

[1] DHHR's Therapeutic Foster Family Care model is called Stabilization and Treatment Homes (STAT Homes) and will be referred to as such throughout the remainder of the Implementation Plan.

4. Agreement Goals

The overarching goal of the Plan, as outlined in the Agreement, is to reform WV's children's mental health system to ensure that children can receive mental health services in their homes and communities. The Plan will lead WV to successful reform in a timely manner to reduce the number of children unnecessarily placed in RMHTFs and reduce the length of stay for children at these facilities, when appropriate. Specifically, the goal is three-fold:

1. Prevent children with serious mental health conditions from being needlessly removed from their family homes in order to obtain treatment
2. Prevent children with serious mental health conditions from unnecessarily entering RMHTFs
3. Transition children with serious mental health conditions who have been placed in an RMHTF back to their family homes

To support these goals, DHHR is committed to providing HCBS to children in the target population. These programs will be family driven, youth-guided, and culturally and linguistically competent; they will include a broad and diverse array of community-based services that are individualized, as well as strength and evidence based. Through continuous quality improvement efforts, DHHR will ensure statewide access to timely services to help prevent crises and promote stability in the home. Key priorities for the coming year, as identified through quality improvement reviews, are captured in the Open Tasks subsection of each section of the Plan.

The target population of these services, as defined in the Agreement, includes all children under the age of 21 who:

1. Have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (i) who are placed in an RMHTF or (ii) who reasonably may be expected to be placed in an RMHTF in the near future; and
2. Meet the eligibility requirements for mental health services provided or paid for by DHHR

The expected goal by December 31, 2022, is a 25% reduction from the number of children living in RMHTFs as of June 1, 2015.[2] The expected goal by December 31, 2024, is a 35% reduction from the number of children living in RMHTFs as of June 1, 2015. Additionally, any children residing in an RMHTF on December 31, 2024, will have been assessed by a qualified professional and determined to be in the most integrated setting appropriate to their individual needs.

[2] The number of foster children living in RMHTFs as of June 1, 2015, was 1,030 children, as reported by DHHR's Foster Care Placements Report (https://dhhr.wv.gov/bss/reports/Pages/Legislative-Foster-Care-Reports.aspx). This number includes children placed in group residential care, psychiatric facilities (long-term), and psychiatric hospitals (short-term). The number of children placed by their parents in an RMHTF as of June 1, 2015, was 66.

WV is also committed to setting long-term goals regarding the reduction of children living in RMHTFs that will not be recognized during the life of this Agreement. These long-term goals will not create any new requirement to exit the Agreement.

5. Definitions

1. **Assertive Community Treatment (ACT)** is a treatment model in which a multidisciplinary team assumes accountability for a small, defined caseload of individuals. The majority of direct services to those individuals are provided in their community environment and the program operates with high fidelity to an assessment tool, such as the Dartmouth Assertive Community Treatment Scale (DACTS).
2. **Behavioral Support Services** are services that address a child's behaviors that interfere with successful functioning in the home and community. These services include mental health and behavioral assessments; development and implementation of a Positive Behavioral Support (PBS) plan as part of the treatment plan; modeling for the family and other caregivers on how to implement the behavioral support plan; and skill-building services.
3. A **Child and Family Team** is a group of people, chosen with the family and connected to them through natural, community, and formal support relationships, that develops and implements the Individualized Service Plan (ISP), otherwise referred to as the Wraparound plan of care. The Child and Family Team is led by the Wraparound Facilitator (WF).
4. **Children's Mobile Crisis Response and Stabilization (CMCRS)** is a crisis response program for children that includes a hotline and mobile crisis response teams that assess and evaluate the presenting crisis; provide interventions to stabilize the crisis; and provide timely supports and skills necessary to return children and their families to routine functioning and maintain children in their homes whenever possible. These services are delivered in a non-clinical setting. Mobile crisis response teams consist of a clinical supervisor and crisis specialists who will provide direct services to children and families.
5. **Children with a Serious Emotional Disorder (CSED)** is defined by WV as children who, currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) equivalent that results in functional impairment substantially interfering with or limiting the child's role or functioning in family, school, and/or community activities.
6. **DHHR** is the WV Department of Health and Human Resources and includes those bureaus with the responsibility for providing services to the target population.
7. **HCBS** or **Home and Community-Based Mental Health Services** are mental health services provided in the child's family home (or foster or kinship care home, where applicable) and in the community.
8. An **Individualized Service Plan (ISP)** is the detailed plan developed by the Child and Family Team that is person centered and includes the child's treatment goals and

objectives, methods of measurement, the timetables to achieve those goals, a description of the services to be provided, the frequency and intensity of each service, and which service providers will provide each service. This term is synonymous with the Wraparound plan of care.

9. A **Residential Mental Health Treatment Facility** (**RMHTF)** is a structured 24-hour group care treatment and diagnostic setting for children with serious emotional or behavioral disorders or disturbances. These facilities include the following provider types as listed on DHHR's Legislative Foster Care Placement Report: Group Residential Care, Psychiatric Facilities (long-term), and Psychiatric Hospitals (short-term) (https://dhhr.wv.gov/bss/reports/Pages/Legislative-Foster-Care-Reports.aspx). The names and/or functions of these provider types may change as the requirements of the Family First Prevention Services Act are implemented in WV.
10. **Serious Emotional Disorder (SED)** is the presence of a diagnosable mental, behavioral, or emotional disorder that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
11. A **Serious Mental Health Condition** is a serious emotional or behavioral disorder or disturbance.
12. **Stabilization and Treatment (STAT) Homes** are a family alternative to residential placement for children requiring a mental or behavioral health intervention. STAT Homes provide short-term intervention to offer a stable, family-like setting with treatment and behavioral interventions so the child can ultimately return to their home or another family setting.
13. **Therapeutic Foster Family Care (TFC)** is a trauma-informed clinical intervention that is an alternative to residential placement for children and youth who have severe emotional and behavioral needs. This service is provided to children who exhibit mild to significant levels of trauma or behavioral or emotional issues, and this service includes placement of a child in a home with specially trained foster parents. DHHR's TFC includes STAT Homes.
14. **Wraparound facilitation** is a service that facilitates care planning and coordination for children in the target population. The core components of the service are:
    - Meetings of Child and Family Teams that drive the service delivery process
    - Interagency collaboration to develop the supports to help the child succeed in the community
    - Strengths-based planning and facilitation to assist the Child and Family Team to meet the child's needs
15. A **Wraparound Facilitator (WF)** is the leader of the Child and Family Team and is responsible for coordinating the provision of services for children under the Agreement. WFs have knowledge of HCBS and experience serving children with SEDs.

6. WV Wraparound and Pathway to Children's Mental Health Services

WV has improved access to and the quality of mental health services by implementing a Pathway to Children's Mental Health Services (Assessment Pathway). The Assessment Pathway emphasizes HCBS for children with mental health disorders. Instead of requiring families to navigate these behavioral health services themselves, the Assessment Pathway streamlines access points for assessment for children's mental or behavioral health service needs and provides assistance in linking children and families to services while the assessment process is being completed. This includes linkage to services when children are transitioning back to their home or community settings after an out-of-home or residential placement.

Children who enter the Assessment Pathway will be referred to HCBS appropriate for their needs. The primary mode of delivering intensive care coordination to these children and their families is through WV Wraparound. Once a child is referred to the Assessment Pathway, DHHR's Bureau for Behavioral Health (BBH) works with the family to assign a WF.

WV Wraparound operates with the goal of high fidelity to the National Wraparound Initiative (NWI) model. A key method of funding and delivering WV Wraparound services the CSED Waiver. The CSED Waiver is a Medicaid HCBS waiver program authorized under §1915(c) of the Social Security Act. The CSED Waiver permits DHHR to provide an array of HCBS that enable children who would otherwise require institutionalization to remain in their homes and communities. Service planning and coordination on the CSED Waiver is done through the Wraparound model.

While the CSED Waiver is a primary mode of access to HCBS, some children will not be eligible for waiver services or will choose not to participate. DHHR is committed to ensuring equal access to Wraparound for waiver and non-waiver children; therefore, Wraparound services can be accessed through other funding sources, including BBH and DHHR's Bureau for Social Services (BSS).The goal across DHHR's bureaus is to help children, youth, and families thrive in their homes, schools, and communities through a seamless system of care that includes statewide Wraparound services available through a "no wrong door" approach, with consistently trained WFs and high-fidelity Wraparound services. The intended result is a reduction of children and youth removed from their homes due to an SED or serious mental illness and increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

6.1 Expected Goals

- **Goal 1:** WV Wraparound will be available statewide and accessible to children in the target population who have been identified as needing HCBS, including children for whom placement in an RMHTF is recommended or who have received mental health crisis intervention services.

- **Goal 2:** WV Wraparound will operate with high fidelity to the NWI model.
- **Goal 3:** The Child and Adolescent Needs and Strengths (CANS) assessment will assess the child and assist the Child and Family Team, led by the WF, in the development of Wraparound plans of care for each child within the target population who has been identified as needing HCBS. The CANS assessment will be conducted by a qualified individual, which is defined as a trained professional or licensed clinician who is not a DHHR employee and not directly supporting an RMHTF.
- **Goal 4:** For children in RMHTFs, the Wraparound plan of care will include discharge planning.
- **Goal 5:** For children with a Multidisciplinary Team (MDT), the children's screening, assessments, and Wraparound plans of care will be provided to the MDT.

6.2 Accomplishments

The DHHR Children's Mental Health and Behavioral Health Services Quality and Outcomes Report, published in July 2022 (July 2022 DHHR Quality and Outcomes Report), provides updated data related to the Assessment Pathway process and associated behavioral health services. The full report can be reviewed on the Collaborative website (https://kidsthrive.wv.gov/Documents/WVDHHR_Semi-Annual_Report_July_2022.pdf).

To continue to improve services and increase access, DHHR submitted an amendment to the CSED Waiver, which was approved by the Centers for Medicare & Medicaid Services (CMS) on June 3, 2022, to be effective July 1, 2022. The State was able to make the following changes with the approved amendment:

- Permanently expand Medicaid eligibility for the CSED Waiver
- Permanently expand the list of eligible degree types for providers to include non-licensed clinicians; non-licensed clinicians delivering these services will receive clinical supervision as is required for licensed behavioral health centers, the provider type that delivers CSED Waiver services
- Extend the time frame in which an eligible member must begin HCBS before an unused waiver slot is discharged from 90 days up to 365 days unless the member ages out of eligibility
- Remove the in-home requirement for family therapy to increase service-setting options to align the CSED Waiver with WV's Wraparound initiative
- Add Evidence-Based Therapy requirements to align with CMS and evidence-based practices
- Update the conflict-free case management service radius from 25 miles to 15 miles to increase access to HCBS and allow members more choice in providers to receive their HCBS; the decrease in radius mileage will also be beneficial to families and caregivers by requiring less travel time to receive these services

The WV Wraparound manual was finalized through collaboration with BBH, DHHR's Bureau for Medical Services (BMS), and BSS. The three bureaus have continued to provide Applied Wraparound training to providers since June 2021. Assessment Pathway webinars and technical assistance (TA) for Wraparound providers and facilitators was established in September 2021 and is ongoing.

CSED Waiver enrollment has continued to increase since implementation of the program in 2020. DHHR anticipates that CSED Waiver enrollment and utilization of waiver services will continue to increase as the Assessment Pathway is more fully implemented across the State in partnership with BSS' Youth Services and Child Protective Services (CPS); Department of Homeland Security's Bureau of Juvenile Services (BJS); Supreme Court of Appeals of WV's Division of Probation Services (Probation Services); primary care providers (PCPs); and the school system.

A CANS analysis data plan was established in early 2022. Since that time, DHHR has been meeting with Marshall University and West Virginia University (WVU) at least monthly to better understand uses of CANS data and to further develop a plan to assess outcomes for youth and families receiving mental and behavioral health services. Meetings have included John S. Lyons, PhD, MA, with the University of Kentucky, creator of the CANS assessment and research developer using CANS data. Thus far, accomplishments during these meetings include:

- Understanding how to use CANS results to track a child's functioning over time (i.e., actionable versus non-actionable scores and the initial/ever/most recent paradigm)
- Identifying items/domains relevant for Continuous Quality Improvement (CQI) processes associated with mental health services
- Developing sample visuals and analyses on a small subset of data

Based on preliminary visuals, the group agreed further refinement was needed to better understand children who may have varying levels of need and significant differences in length of service.

Marshall University began training for WV Wraparound providers. Providers can access the training through the Marshall University training website (https://wvbhtraining.org/).

Marshall University is contracted to complete an ongoing evaluation of service fidelity to the NWI. An initial Wraparound fidelity review was completed with the first Wraparound fidelity report finalized in December 2022.

Table 1 represents the completed tasks from the Year 3 Implementation Plan.

Table 1: WV Wraparound Summary of Completed Actions

Outcome	Action	Complete
Clear operating procedures	Demonstrate connection to evidence-based programs such as PBS and include TFC in the Assessment Pathway for diversion and transition from placement.	✓
	Finalize WV Wraparound manual.	✓
	Finalize CSED Waiver enrollment process.	✓
Trained and equipped workforce	Initiate ongoing training on the above policies and process for relevant staff/entities.	✓
	Implement training plan and TA for WF and providers and other stakeholders as necessary.	✓
Youth and families are aware of available services	Coordinate with managed care organizations (MCOs) to continue enhancing outreach for members and enhance communication between members and care managers.	✓
Services are available and accessible to families	Develop and monitor the plan/timeline for Phase 1 implementation of Assessment Pathway and Wraparound services.	✓
	Develop and monitor the plan/timeline for future phases of the Assessment Pathway implementation and Wraparound services.	✓
Evidence-based practices are utilized	Monitor ongoing fidelity of Wraparound services to NWI model.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the Quality Assurance and Performance Improvement (QAPI) team, identify key performance indicators (KPIs), data collection, analysis, and reporting associated with Wraparound facilitation and CSED Waiver services.	✓
Sufficient provider capacity to meet needs	Complete review, as reflected in DHHR's CQI Plan, of Wraparound provider capacity. Recruit for additional providers to meet needs. Reviews are ongoing as demonstrated in Section 6.3 Open Tasks.	✓

6.3 Open Tasks

Continued work is identified in this section, to ensure children receive needed Wraparound services. DHHR has identified key priorities to help improve outcomes for children who access WV Wraparound services, including:

- Identify and work to resolve issues or gaps related to timely access and provision of services
- Continue provider capacity forecasting analysis and projected workforce needs; collaborate with the MCO to continue expansion of the provider network to meet the increase in CSED referrals and subsequent approvals of CSED-eligible children

Table 2 represents the continued project tasks.

Table 2: WV Wraparound Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear Operating Procedures	1	Add detail in the WV Wraparound manual on how individuals will be offered a choice between ACT and Wraparound.	BMS	July 2023
Evidence-based practices are utilized	2	Monitor ongoing fidelity of Wraparound services to NWI model. In response to fidelity monitoring reports, develop and implement needed program changes, provider training, or other interventions recommended to attain fidelity.	DHHR's Office of QA, BMS, and BBH in collaboration with Marshall University	Ongoing
Sufficient provider capacity to meet needs	3	Continue to formalize Wraparound service utilization, waitlist, and provider capacity forecasting analysis and monitoring to assist with ensuring statewide accessibility to Wraparound services as referrals to the Assessment Pathway increase.	BMS, BBH, BSS	Ongoing
Youth, families, and other child-serving stakeholders are aware of available services and supports	4	Complete outreach to counties with low referrals to the Assessment Pathway, with additional focus on areas with limited CSED Waiver referrals and higher rates of residential placement.	BMS, BBH, BSS	Ongoing
Reports are available to DHHR staff to monitor,	5	Establish data collection to allow for aggregation of Wraparound utilization data across funding sources.	QA, BMS, BBH	July 2023

Outcome	No.	Action	Owner	Projected Timeline
analyze, and drive decisions to improve services	6	Formalize CANS data analysis and outcomes reporting.	QA, BMS, BBH, BSS	July 2023
	7	Continue program-level data reviews and follow-up action on published reports for Assessment Pathway and Wraparound data as outlined in the CQI Plan.	QA, BMS, BBH, BSS	Ongoing

7. CMCRS

CMCRS teams help children and youth who are experiencing emotional or behavioral crises by interrupting the immediate crisis and ensuring youth and their families in crisis are safe and supported. Stabilization services are provided to allow an opportunity for children to return to routine functioning and ensure they are maintained in their homes or current living arrangements, schools, and communities whenever possible. CMCRS staff are available 24 hours per day, seven days per week. CMCRS services have been available statewide since May 2021.

Services have been designed that align with the following criteria:

1. Criteria for how the crisis line staff will assist with immediate de-escalation and warm transfer to regional CMCRS staff.

   The Children's Crisis and Referral Line (CCRL) acts as a system point of entry for children's crisis and non-crisis referral services. The statewide, 24/7 CCRL connects families in crisis immediately with a regional CMCRS team through a warm transfer. The CCRL vendor has developed a protocol that guides decisions by crisis hotline staff, and the process is outlined in vendor referral guidance and the DHHR CMCRS manual that is on track to be finalized in early 2023.

2. Requirements that hotline staff have access to needed information regarding the child and family when the family provides consent (including any existing crisis plans and ISPs).

   As the state's regional CMCRS teams came on board, they operated their own 24/7, regional crisis lines. To improve access to services (e.g., only one phone number to remember for a multitude of behavioral health services and improved consistency of crisis response across regions), BBH launched the CCRL in late 2020. The *National Guidelines for Child and Youth Behavioral Health Crisis Care* explain on page 16, "Creating a single point of access makes it easier for people to obtain behavioral health-focused crisis services (Manley et al., 2018)" (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf).

   In consultation with the regional CMCRS teams and the CCRL vendor, BBH agreed that families who contacted the CCRL and who were interested in CMCRS would be linked quickly with the nearest regional CMCRS team that would help de-escalate the crisis and provide stabilization services. It is still possible for families to contact the regional CMCRS teams directly, particularly if they have previous experience with the regional agency, but the CCRL is preferred and promoted statewide. It is the regional CMCRS team that responds, de-escalates, provides stabilization services to the child and family that, with family consent, has access to needed information including any existing CANS, Wraparound plans of care, crisis plans and individualized service plans.

3. Guidelines for hotline staff to assess the crisis to determine whether it is appropriate to resolve the crisis through a phone intervention or a face-to-face intervention

   Both CCRL and CMCRS staff are trained that the youth or family determines if they are experiencing a crisis and whether the CMCRS team responds in person. This is consistent with the *National Guidelines*, page 22 (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf). The CMCRS team will speak with the youth or family member and respond in person in the home, school, or community based on the youth's or family's preference. The CMCRS is expected, on average, to provide in-person support within one hour of the request.

4. Each region of the state has sufficient crisis response team(s) to serve the entire region and to respond face-to-face within an average time of one hour.

   CMCRS services are available statewide as of May 2021. Providers have indicated challenges still exist in providing a response within one hour due to the rurality and geography of some areas of the state. In response, BBH has increased grant funding to the regional CMCRS teams to support additional staffing.

5. Data is collected to assess and improve the quality of crisis responses, including the timeliness of the crisis response and subsequent intake process, and effectiveness of engaging families in HCBS following the crisis.

   The DHHR CQI Plan and KPIs include metrics and monitoring related to the response times and CMCRS provider capacity. Data for CCRL and CMCRS is reviewed at least quarterly at the program level and in the DHHR Quality Committee reviews. The July 2022 Quality and Outcomes Report clearly demonstrates DHHR's commitment to collecting and monitoring data to ensure children have access to crisis services and receive the services timely, as required (https://kidsthrive.wv.gov/Documents/WVDHHR_Semi-Annual_Report_July_2022.pdf).

BMS also offers mobile response services through the CSED Waiver, although mobile response is largely provided through BBH funded services.

7.1 Expected Goals

- **Goal 1:** CMCRS services are available to all children, regardless of eligibility. BBH ensures there are sufficient crisis response teams to respond in person to a call within an average time of one hour.
- **Goal 2:** CMCRS services continue to ensure that families will be connected with longer-term services as needed and help them navigate the process to access those services.
- **Goal 3:** As part of the CMCRS services, WV maintains a toll-free hotline called the CCRL that is staffed 24 hours per day, seven days per week. Callers will be directly connected by a warm transfer to a CMCRS team of mental health professionals with

competency-based training and experience working with children in crisis. BBH developed warm transfer protocols with the CCRL and CMCRS teams, which allow the caller to define the crisis and choose whether they prefer in-person or phone intervention. The CCRL worker stays on the line with the caller until they are connected with the CMCRS team. The CMCRS team has access to needed information regarding the child and family when the family provides consent (including any existing plans and/or the ISP).

7.2 Accomplishments

Statewide CMCRS coverage creates opportunities to offer crisis relief and plans for stability to support families and children in need. As noted in data presented in the July 2022 DHHR Quality and Outcomes Report, the number of individuals utilizing these services has increased over time, demonstrating increased awareness and acceptance of these critical services (https://kidsthrive.wv.gov/Documents/WVDHHR_Semi-Annual_Report_July_2022.pdf). The implementation of an interconnected network with the CCRL, Wraparound services, Assessment Pathway, and warm transfer to CMCRS teams allows multiple entryways and connections to longer-term services for children and families with different levels of need.

Data collection, review, and reporting to improve the quality of crisis response has been established. Indicators reviewed and reported for CCRL include the following: calls per month, demographics, referral source, caller relation to individual in need, type of call, presenting need, warm transfer completion, and timeliness of warm transfer. Indicators reviewed and reported for CMCRS include the following: number of children served, demographics, number of CMCRS crisis calls per child, and response type. Timeliness of response data collection and reporting is in the process of being established with the goal of aggregating data from mobile response provided by BBH and the CSED Waiver. Data for CCRL and CMCRS is reviewed at least quarterly at the program level and in the DHHR Quality Committee reviews.

The CCRL QA policy was finalized and implemented in September 2022 and includes the following:

- BBH will gather and review both qualitative information from QA calls and quantitative data submitted by the provider, as well as information obtained from the HCBS Improvement Project Evaluation being conducted by WVU.
- BBH will designate mystery shoppers to act as callers needing to access CCRL services. Mystery shoppers will make monthly calls equal to the number of full-time equivalent CCRL staff to complete a sampling of data on linkage and referral to appropriate service and customer service at the time of the call.
- If information gathered indicates a significant concern for CCRL accessibility or service linkage, BBH will present the information to the CCRL management team as soon as possible to initiate collaboration and provide TA to work on a solution.
- BBH will review monthly provider data to ensure that reported data is complete and accurate. All data concerns will be addressed as needed.

The University of Maryland Institute for Innovation and Implementation is providing TA to Marshall University and DHHR to develop CMCRS training planned for 2023. Training information will be posted online (https://wvbhtraining.org/wraparound-mobile-response).

Table 3 represents the completed tasks from the Year 3 Implementation Plan.

Table 3: CMCRS Summary of Completed Action

Outcome	Action	Complete
Clear operating procedures	Finalize the CMCRS manual.	✓
Youth and families are aware of available crisis response services	Coordinate outreach and education efforts with contracted vendors informed by data collection associated with CMCRS services.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting associated with CMCRS services.	✓
Crisis response teams sufficient to respond within an average time of one hour	Complete review, as reflected in DHHR's CQI Plan, of CMCRS provider capacity compared with average response time data. If applicable, recruit for additional CMCRS providers to ensure sufficient coverage and required response time.	✓

7.3 Open Tasks

Continued work is identified in this section, to ensure mobile crisis services are consistently provided to children. DHHR has identified key priorities to ensure mobile crisis teams and other stakeholders receive the training needed to improve outcomes for children who access children's mobile crisis services, including:

- Increasing awareness of CCRL and CMCRS services
- Improving data quality to support mobile response quality improvement efforts, including timeliness of response

Table 4 represents the continued project tasks.

Table 4: CMCRS Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Trained and equipped workforce	1	Centralize core training for CMCRS providers and other stakeholders or system providers to begin/continue delivery of training.	BBH in collaboration with Marshall University	January 2023
	2	Develop oversight plan for training content delivered by contracted CMCRS providers.	BBH	January 2023
	3	Finalize the CMCRS manual and ensure it is available to stakeholders.	BBH	February 2023
Youth and families are aware of available crisis response services	4	Continue to coordinate outreach and education efforts with contracted vendors informed by data collection associated with CMCRS services.	BBH, BMS	Ongoing
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	5	Establish data collection to allow for aggregation of mobile response data across funding sources.	QA, BMS, BBH	May 2023
	6	Continue program-level data reviews and follow-up action on published reports for CCRL and CMCRS data as outlined in the CQI Plan.	QA, BMS, BBH	Ongoing

8. Behavioral Support Services

Behavioral support services focus on providing prevention and intervention supports for children who are demonstrating significant maladaptive behaviors, are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or psychiatric residential treatment facility or are transitioning to the community from an out-of-home placement. PBS is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life for children who are experiencing significant maladaptive behavioral challenges.

PBS embraces the conceptual approaches of Wraparound or person-centered planning for children who have challenging behavioral needs requiring intensive support to help them demonstrate competencies to participate in community life, develop satisfying relationships, make choices, and gain personal dignity and respect. Services are designed to assist individuals to remain in or return to their homes or communities or to facilitate return from residential treatment programs, psychiatric hospitals, or residential crisis response units. PBS services can be accessed through a variety of methods, such as self-referral, provider referral, community agency referral, or when it is deemed necessary by the MDT, Wraparound plan of care, or other treatment team recommendation.

The current PBS program coordinator is the WVU Center for Excellence in Disabilities (CED), which receives referrals and offers resources online at https://pbs.cedwvu.org/ and by email at pbs@hsc.wvu.edu. The purpose of this center is to build both PBS workforce capacity and systemic capacity and to provide PBS services to individual clients through trainings, PBS brainstorming telehealth sessions, person-centered planning, and intensive services.

Behavior support services are also available via Medicaid state plan services through provider staff who have achieved PBS certification. DHHR contracts with Concord University to oversee PBS credentialing.

8.1 Expected Goal

- **Goal 1:** DHHR will ensure statewide, timely access to PBS services for children in the target population who need those services. Services will be provided to help prevent crises, enable children to remain with or return to the family, where possible, and promote stability in the family home. DHHR will utilize mental health and behavioral assessments; a PBS plan as part of the treatment plan; modeling for the family and other caregivers on how to implement the behavioral support plan; and skill-building services to ensure timely PBS services meet the needs of the children in the target population.

8.2 Accomplishments

BBH issued a grant to Concord University to develop and implement a training and curriculum plan to increase capacity in the PBS workforce for training behavior support service professionals. This curriculum and training will include certification and recertification. The initial cohort of training began in October 2022.

BMS is currently revising Chapter 503 to add a modifier to existing behavior management codes to distinguish PBS services. The draft changes to Chapter 503 are expected to be out for public comment in the spring of 2023. In 2023, BMS will implement the new modifier to allow for tracking of PBS services provided via the state plan.

Table 5 represents the completed tasks from the previous Year 3 Implementation Plan.

Table 5: PBS Summary of Completed Actions

Outcome	Action	Complete
Monitoring to ensure behavioral support services are available and accessible	Implement PBS modifier code to allow for additional monitoring of service utilization. Build into relevant documents, including the provider billing guide.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting associated with PBS services.	✓
Sufficient provider capacity to meet needs	Complete review, as reflected in DHHR's CQI Plan, of provider capacity to meet needs. If applicable, recruit for additional providers to meet needs.	✓

8.3 Open Tasks

Continued work is identified in this section, to ensure PBS services are consistently provided to children. DHHR has identified key priorities to ensure PBS providers and other stakeholders receive the training needed to improve outcomes for children who access PBS services, including:

- Finalize the PBS certification, which is a type of behavioral support services
- Implement the Medicaid billing modifier code
- Expand the certified provider network

Table 6 represents the continued project tasks.

Table 6: PBS Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Trained and equipped behavioral support services workforce	1	Finalize PBS training plan. Implement online training platform.	BBH	October 2022
	2	Finalize PBS credentialing plan.	BBH	April 2023

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	3	Finalize Chapter 503 revisions.	BMS	April 2023
Monitoring to ensure behavioral support services are available and accessible	4	Complete implementation and training on use of PBS modifier code to allow for additional monitoring of service utilization.	BMS	June 2023
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	5	Continue program-level data reviews and follow-up action on published reports for PBS services.	QA, BBH, BMS	Ongoing
Sufficient provider capacity to meet needs	6	Complete review, as reflected in DHHR's CQI Plan, of provider capacity to meet needs. If applicable, recruit for additional providers to meet needs, as more information becomes available through credentialing.	QA, BBH, BMS	Ongoing

9. STAT Homes

The STAT Home[3] model is designed to complement the current WV tiered therapeutic foster care model to provide stabilization services for children in foster care or kinship care who are currently receiving CSED services and are at risk of residential placement. The STAT Home program is a family alternative to residential placement for children requiring a behavioral or mental health intervention. Child placing agencies (CPAs) will be responsible for providing these services statewide. In partnership with CSED Waiver services, STAT Homes provide short-term intervention to create a stable, family-like setting with treatment and behavioral interventions so the child can ultimately return to their home or another family setting, proactively diverting from an RMHTF placement. STAT Home parents will be specifically recruited and trained to provide intensive support for these children, so they can remain in and actively participate in their home, school, and local community. WV has been building the STAT Home program through development of model standards that clearly define services and activities that support the STAT Home parents, the child, and the family of origin and clarify the role of the CPAs' case managers.

9.1 Expected Goal

- **Goal 1:** The WV STAT Home model will be accessible and sustainable statewide for all eligible children in the child welfare population who are in need of out-of-home placement and can be safely served in a foster family care setting.[4] The goal of STAT Home services is to ensure that children are timely placed in a home in their own community with specially trained treatment foster parents. STAT home foster parents act as resource parents to the child's family of origin and provide children with high-quality treatment services in a foster family home setting in conjunction with WV Wraparound.

9.2 Accomplishments

DHHR continues to move forward with STAT Home implementation. As the model has developed, DHHR has identified KPIs for the STAT Home services that CPAs have reviewed and approved. Data will be collected and monitored routinely, with CPAs contractually required to provide monthly reports that adhere to DHHR data requirements. As performance data is collected, the information can be used for ongoing refinement of the STAT Home model and will help DHHR understand provider capacity needs. Once available, the data will be included in future semiannual reports.

The support and collaboration of CPAs and other stakeholders has been critical as the STAT Home model has developed. DHHR expects to continue recurring meetings with stakeholders to

[3] In the January 2022 DHHR Quality and Outcomes Report, the term used for this type of foster care home was "Therapeutic Foster Care." This home model has been renamed to "Stabilization and Treatment."
[4] The parties acknowledge there is a disagreement as to whether therapeutic foster family homes must be available to children outside of the child welfare population. Nevertheless, WV's goal is to expand this service to be accessible statewide for the child welfare populations. When the parties reach an agreement, this goal will be modified, if needed.

closely manage implementation. Recurring meetings or roundtables with CPAs and other stakeholders to provide information and receive feedback will continue to achieve this flow of communication. DHHR will maintain collaboration and transparency with CPAs as they recruit families to serve as STAT Home parents in this new model. This model serves a specific population with a higher level of need that will require additional skills.

Table 7 represents the completed tasks from the Year 3 Implementation Plan.

Table 7: STAT Home Summary of Completed Action

Outcome	Action	Complete
Clear operating procedures	Complete draft Treatment Home workflow and policy based on new model and input from providers. Treatment Home workflow will accommodate the following scenarios: • New children to foster care • Children currently in traditional foster care • Children transitioning from RMHTF • Children cared for under the prior TFC model	✓
Trained and equipped workforce	Complete curriculum on the training for new workflow and policy, to include roles and responsibilities.	✓
	Schedule and complete training on the new workflow and policy, to include roles and responsibilities, with relevant staff/entities.	✓
TFC services are available and accessible	Amend Treatment Home provider contracts to align with the new model, roles, and responsibilities.	✓
Children are appropriately placed	Develop a plan for phase-in of the new model with input from provider agencies.	✓
	Begin phase-in of new model as outlined in Treatment Home Standard Operating Procedure (SOP).	✓
Trained and equipped foster parents	Develop requirements and an oversight plan for the CPA specialized training for Treatment Home parents.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting associated with TFC services.	✓

9.3 Open Tasks

Continued work is identified in this section, to ensure STAT Homes are available to children in early 2023. DHHR's key priority in the upcoming year is the recruitment and training of STAT Home providers across the State.

Table 8 represents the continued project tasks.

Table 8: STAT Home Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Services are available and accessible statewide	1	Implement the phase-in plan to initiate STAT Home services.	BSS	January 2023 and ongoing as new homes are certified
Sufficient provider capacity to meet needs	2	Coordinate with CPAs to recruit and establish STAT Homes.	BSS	Ongoing
	3	Develop foster care and STAT Home forecasted needs based on profiles of children identified through the prioritized discharge planning process and profiles of children with placement disruptions. Complete review, as reflected in DHHR's CQI Plan, of foster home provider capacity compared to forecasted needs.	QA, BMS, BBH, BSS,	June 2023 and ongoing
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	4	Implement program-level data collection, review, and reporting of STAT Home KPIs as outlined in the CQI Plan and Key Performance Indicators (working document).	QA, BSS	July 2023 and ongoing
Open communication and feedback from stakeholders	5	Collaborate with youth and families receiving STAT Home services to evaluate performance and seek input. Implement annual family survey.	BSS	December 2023

10. ACT

ACT is an inclusive array of community-based rehabilitative mental health services for WV Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and integrated package of services provided over an extended duration to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions, including mental health and substance use disorder or mental health and mild intellectual disability. ACT is a specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals.

ACT combines clinical, rehabilitative, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

ACT is a recovery-oriented program. Because ACT is a community-focused treatment modality, a minimum of 75% of services must be delivered outside program offices. The team must develop an initial service plan for the ACT member within seven days of admission into the program that authorizes the services for the member until the comprehensive plan for the member is complete. BMS offers ACT services to Medicaid members 18 years and older, with no limitation on length of services. Individuals receiving ACT services are currently required to have an ISP, and BMS uses DACTS to ensure that fidelity is met for this evidenced-based practice.

10.1 Expected Goal

- **Goal 1:** DHHR will increase capacity and address any related ACT provider workforce capacity issues to ensure that ACT is available statewide and that services are delivered in a timely manner.

10.2 Accomplishments

DHHR has established ACT services in the eastern panhandle through a contract with Mountaineer Behavioral Health (MBH). DHHR has regular meetings with MBH as MBH begins to recruit and hire a qualified ACT team. Services in the eastern panhandle are anticipated to begin in early 2023, which will make ACT services available statewide.

To improve oversight and monitoring of ACT services— currently coordinated by Kepro with regular reporting to DHHR—DHHR is in the process of making the following updates to the review process, with the changes expected to go into effect in January 2023:

- Modify review cycle to occur every 12 months instead of every 18 months
- Review every youth receiving ACT services rather than a sample of youth

- Update the retrospective review process to include required TA for any ACT team that falls below a 70% threshold during its retrospective review
- Add retrospective review results to the standing monthly meeting with Kepro

Table 9 represents the completed tasks from the Year 3 Implementation Plan.

Table 9: ACT Summary of Completed Action

Outcome	Action	Complete
ACT services are available statewide	Initiate ACT vendor contract in the eastern panhandle.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting associated with ACT services.	✓

10.3 Open Tasks

Continued work is identified in this section, to ensure ACT is available to youth statewide in early 2023. DHHR's key focus areas for the coming year include:

- Collaborating with the eastern panhandle provider to ensure an ACT team is approved in early 2023
- Ensuring eligible youth are offered the choice of ACT versus Wraparound.

Table 10 represents the continued project tasks.

Table 10: ACT Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Complete updates to Chapter 531 and Psychiatric Residential Treatment Facility (PRTF) Provider Agreements to require the choice of ACT versus Wraparound for eligible youth discharging from PRTFs.	BMS	January 2023
Quality monitoring and oversight	2	Finalize and implement changes to the retrospective review tool and process.	BMS	January 2023
ACT services are available statewide	3	Collaborate with the eastern panhandle provider to begin ACT service provision.	BBH	Early 2023 (contingent on staff recruiting)

Outcome	No.	Action	Owner	Projected Timeline
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	4	Implement program-level data collection, review, and reporting of ACT services KPIs, as outlined in the CQI Plan and Key Performance Indicators (working document).	BMS and QA	February 2023
Clear operating procedures	5	Complete updates to Chapter 503 Appendix F for group residential to require the choice of ACT versus Wraparound for eligible youth discharging from group residential.	BMS	April 2023
	6	Complete provider and stakeholder training related to the changes in Chapters 503 and 531.	BMS	May 2023
Sufficient provider capacity to meet needs	7	Complete review, as reflected in DHHR's CQI Plan, of provider capacity. If applicable, recruit for additional providers to meet needs.	BMS and QA	July 2023 and ongoing

11. Mental Health Screening Tools and Processes

Screening for possible mental health needs is a critical first step in identifying children for further evaluation to determine treatment needs, with subsequent referrals to appropriate HCBS. To ensure a broad reach to children across the State who might benefit from behavioral and mental health services, the following entities complete screenings:

- **PCPs:** Provide screening for Medicaid and WV Children's Health Insurance Program-eligible children through the HealthCheck program within DHHR's Bureau for Public Health (BPH)
- **BSS, Youth Services:** Provides screening utilizing the Family Advocacy and Support Tool (FAST) for children referred to DHHR for services related to status offenses or juvenile delinquencies
- **BSS, CPS:** Provides screening for children in State custody that is conducted by the child's PCP within 30 days of foster care placement through the HealthCheck program; for children who remain in their home and are receiving CPS services or are parentally placed into residential care, BSS will utilize the CPS Ongoing Assessment as the primary screening tool
- **WV Division of Corrections and Rehabilitation, BJS:** Provides screening utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) for children in juvenile detention and commitment facilities
- **WV Judiciary, Division of Probation Services:** Provides screening utilizing the MAYSI-2 for children on probation

Children with an identified potential mental health need (i.e., positive screen) are then referred to the Assessment Pathway for additional evaluation and referral to HCBS.

11.1 Expected Goals

- **Goal 1:** WV will ensure that a mental health screening using an approved screening tool is completed for any child not already known to be receiving mental health services when the child enters BSS Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted.
- **Goal 2:** WV will ensure that HealthCheck forms are available for healthcare providers who serve these children and that these providers are trained on and have access to HealthCheck age-appropriate screening forms. This is to ensure WV Medicaid-eligible children are screened to determine if they should be referred for further mental health evaluation or services. No less than 52% of WV Medicaid-eligible children who are not in the BSS Youth Services, child welfare, or juvenile justice system will receive annual trauma-informed psychosocial screening.

11.2 Accomplishments

DHHR approved standardized children's mental health screening tools across the various bureaus completing screenings as outlined above. In conjunction with initiating screening, policies were developed, and training was completed to establish the process for referring children who screen positive to the Assessment Pathway.

Data collection for screenings completed by Probation Services and BJS was implemented in March 2022. Data collection for screenings completed by BSS Youth Services and CPS was implemented in April 2022. Mental health screenings conducted by PCPs as part of HealthCheck are measured annually via medical chart reviews for a sample of children. The medical record review was expanded in 2021 (for review of calendar year 2020 records) to include children ages 0 – 5, in addition to those 6 – 20 years old, effectively establishing a baseline for all children ages 0 – 20. Review of screening data is included in DHHR's Office of QA's quarterly Quality Committee reviews.

BPH and BBH have partnered to provide PCPs with details on how to make referrals to CCRL. In fall 2021, the bureaus began distributing flyers to PCPs with a QR code and URL to make referrals online via JotForm (an electronic referral form): https://hipaa.jotform.com/PGHN/help4wv-PCP-referral. The flyers state that electronic referrals can be made anytime (24 hours a day, seven days a week), and the family will be contacted within 24 hours of receipt of the referral. All electronic referrals will receive an automatic reply confirming receipt of referral. Refresher training for PCPs began in late fall 2022.

Table 11 represents the completed tasks from the Year 3 Implementation Plan.

Table 11: Mental Health Screening Summary of Completed Action

Outcome	Action	Complete
Clear operating procedures	Finalize screening tools and HealthCheck guidance for physicians with additional detail on how different referrals are handled.	✓
	Draft BSS Youth Services and CPS screening procedure.	✓
	Draft Probation Services screening and referral procedure.	✓
	Draft BJS screening and referral procedure.	✓
Trained and equipped workforce	Complete training and job aids as appropriate for relevant entities on the screening and referral procedures.	✓
Individuals are consistently identified	Implement Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mental health screening modifier code to differentiate when a mental health screen is conducted.	✓

Outcome	Action	Complete
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting for screening.	✓

11.3 Open Tasks

Continued work is identified in this section, to ensure mental health screening is consistently conducted and monitored. DHHR has identified key priorities that include:

- Ongoing TA with Youth Services and CPS staff to ensure screening and referral to the Assessment Pathway and associated data collection are completed
- Continued collaboration with MCOs and the HealthCheck program to educate primary care physicians and increase awareness among families to increase the rates of EPSDT mental health screening and referral to the Assessment Pathway when appropriate

Table 12 represents the continued project tasks.

Table 12: Mental Health Screening Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Develop and implement process for BJS referral of children who screen positive to the Assessment Pathway.	BJS, BMS	March 2023
Trained and equipped workforce	2	Implement the TA plan for Youth Services and CPS staff for completing screening, making referrals to the Assessment Pathway, and completing associated data collection.	BSS	July 2023
Trained and equipped workforce	3	Complete PCP training and implement survey of PCPs to evaluate their understanding of referring to the Assessment Pathway and the availability of HCBS.	QA, BPH, BBH	August 2023
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	4	Continue implementation of program-level data collection, review, and reporting for screening KPIs as outlined in the CQI Plan and Key Performance Indicators (working document).	QA, BJS, Probation Services, BSS, BPH	October 2023

12. QAPI System

DHHR's Office of Management Information Services (OMIS) reports directly to the DHHR cabinet secretary and is charged with providing the leadership, innovation, and services needed to achieve efficient and effective technology solutions to meet DHHR's goals, which are key to DHHR's QAPI efforts.

DHHR draws data and information to evaluate and monitor mental and behavioral health services and outcomes from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children, families, providers, caregivers, and other stakeholders.

DHHR continues the phased build-out and implementation of a data store to house data from multiple sources across the department's child welfare and mental and behavioral health services systems with the goal of aggregating data from child-serving bureaus to review and improve outcomes over time. To date, the data store captures data associated with RMHTF services. Efforts to expand the data store to include prioritized data elements associated with CSED Waiver services and RMHTF discharge planning are currently underway. Over time, additional community-based behavioral health data elements will be included in the data store as child-level and interaction-level data become more available and accessible.

As the mental health system and programs in the State continue to grow and evolve, so do the data systems that support these activities. DHHR is working toward system changes that will allow increased data collection at the child and encounter level.

In addition to internal data systems, DHHR uses the expertise of community partners for support in quality and evaluation initiatives, including:

- **WVU:** WVU is contracted to complete an ongoing evaluation of WV's children's HCBS. WVU provided a baseline report reflecting responses and perceptions from providers and facilities statewide in July 2022. A report on feedback from youth, families, and caregivers was provided in September 2022. Reports will continue to be provided to DHHR on a routine basis as the implementation rollout is evaluated.
- **Marshall University:** Marshall University is contracted to complete an ongoing evaluation of service fidelity to the NWI and will provide routine reports to DHHR, with the baseline report provided in December 2022.

WV's commitment to CQI is evidenced by the addition of the Office of Quality Assurance for Children's Programs (Office of QA), responsible for driving the strategic vision, mission, and scope for quality improvement and data-driven practice. The director for this office reports to DHHR's cabinet secretary. DHHR leadership prioritized the alignment of quality improvement efforts across bureaus in tandem with the cross-bureau collaboration currently underway to streamline programmatic work and provide a seamless system of care for children and families.

12.1 Expected Goals

- **Goal 1:** DHHR will develop a QAPI system, including a data dashboard, which provides data and analytic capability necessary to assist with the assessment of service delivery and support the development of semiannual reports in alignment with the goals and objectives of the Agreement. To support QAPI of the Agreement goals, WV will focus on the collection, synthesis, and analysis of various known DHHR data sources in the following areas:
    - Examination of the quality of mental health services funded by the State, measured by improved positive outcomes, including remaining with (or returning to) the family home; and decreased negative outcomes, including disrupted foster home placement, institutionalization, arrest, or involvement with law enforcement and the juvenile or criminal courts, suspension or expulsion from school, commitment to the custody of BJS or DHHR, or being prescribed three or more psychotropic medications
    - All children receiving services under the Agreement, including the types and number of services they are receiving
    - All children screened pursuant to the Agreement, including the dates of screening and the dates of engagement in services
    - All children living in an RMHTF, including admission dates, length of stay, and number of prior placements in RMHTFs
    - Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment and the quality sampling review process
    - The fidelity of Child and Family Teams to the NWI model
    - Data from the crisis response team encounters, including timelines of response and data on connection to services
- **Goal 2:** DHHR will conduct annual quality sampling reviews of a statistically valid sample of children in the target population.

12.2 Accomplishments

In December 2021, DHHR began implementation of the CQI Plan for children's mental and behavioral health services. The purpose of the CQI Plan is to take a proactive approach to continually improve child welfare services and services for children with mental and behavioral health needs, including SED. Ongoing quality improvement will ensure all eligible children and families are provided timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

In May 2022, DHHR hired a director of the Office of QA. An embedded analyst was also assigned to the Office of QA to support analysis and publication of routine reports to program

teams. Since that time, the director and analyst have been actively involved in leading the CQI implementation efforts across DHHR.

As part of the CQI process, DHHR continues to hold quarterly cross-functional, cross-bureau Quality Committee review meetings to review and analyze data associated with children's mental and behavioral health services. Representatives from across DHHR participate in the quality reviews. The discussions during these quality review meetings inform the strengths, opportunities, and recommendations captured in DHHR's Semiannual Children's Mental and Behavioral Health Services Quality and Outcomes Reports.

Since the CQI Plan implementation began, quarterly Quality Committee reviews were held in November/December 2021, May 2022, and August 2022. The next review is scheduled for late October 2022. Semiannual reports were published in January and July 2022. These reports can be found on the Collaborative website (https://kidsthrive.wv.gov/).

The data store and associated automated dashboards capturing KPIs associated with residential services went live in the fourth quarter of 2021. At that time, DHHR staff were trained in use of the dashboard. In January 2022, data associated with children parentally placed were added to the dashboards. In August 2022, a plan and timeline for continued phased implementation of the data store and automated dashboards were developed, outlining a plan for continued build-out and automation of existing reports over the next two years.

Over the last year, significant effort has gone into establishing data collection across programs and services. Based on the established data collection, the Office of QA began publishing recurring monthly reports for program-level teams to review and analyze their respective programs and services.

DHHR collects and analyzes data according to its CQI Plan and corresponding KPIs, which are inclusive of data points listed under the Agreement. In addition to this, DHHR collaborates with its partners, WVU and Marshall University, to evaluate its children's mental health system, assess fidelity to the NWI model, and complete quality sampling reviews. The Office of QA will provide the infrastructure to lead the implementation and continued evolution of the CQI Plan and associated processes.

The minimum data DHHR collects and analyzes through internal systems, reporting from vendors and contractors, and efforts with its partners, WVU and Marshall University, includes the following metrics and measures:

- All children receiving services under this Agreement, including the types and amounts of services they are receiving
- All children screened pursuant to Paragraph 31 of the Agreement, including dates of screening and the dates of engagement in services
- All children living in an RMHTF, including admission dates, length of stay, and number of prior placements in RMHTFs

- The outcomes of children in the target population, including whether they have juvenile petitions filed, have been committed to the custody of BJS or DHHR, have been suspended or expelled from school, and have been prescribed three or more antipsychotic medications
- Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment and the quality sampling review process
- The fidelity of Child and Family Teams to the NWI model
- Data from crisis response team encounters, including timelines of response and data on connection to services

Additional data may be collected and analyzed as CQI efforts evolve based on learning and experience and/or increased data availability. The Office of QA will provide the infrastructure to lead the implementation and continued evolution of the CQI Plan and associated processes.

Under contract with DHHR, WVU submitted an evaluation plan for children's in-home and community-based mental and behavioral health services in April 2021. The evaluation includes measures aligning with the Agreement, youth/caregiver-level outcomes, community/provider-level outcomes, and system-level outcomes. WVU completed interviews, focus groups, and surveys in late 2021 and early 2022 as part of the evaluation of the system-, community/provider-, and child/caregiver-level mental and behavioral health services and outcomes. The first report, which included a baseline evaluation of provider and facility service awareness, ability to provide services, and identification of needs and strengths of the mental health system from May 2021 to April 2022, was finalized in July 2022. A second report reflecting family, child, and caregiver feedback was finalized in September 2022. DHHR's cross-functional, cross-bureau Quality Review Committees will review these results as part of the CQI process.

Wraparound and CANS fidelity reviewer training and certification for DHHR's partner Marshall University was completed in July 2022. The fidelity review sample cases were pulled in August 2022 and the initial fidelity review has been completed with the full report currently being drafted. The first report of results was provided in December 2022.

Public-facing data was added to the Collaborative website in June 2022. Highlights are posted to the site monthly and cover both residential and community-based service utilization data. Expansion of the website's public-facing data points is planned for 2023.

Table 13 represents the completed tasks from the Year 3 Implementation Plan.

Table 13: QAPI Summary of Completed Action

Outcome	Action	Complete
Data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	Complete Phase 1 Dashboard indicators pilot group user testing.	✓
	Roll out DHHR training on the Phase 1 Dashboard indicators.	✓
Children are consistently identified and engaged in services	Develop and implement testing plan for the target population to ensure the definition is sufficient in scope to identify the children within the intended population.	✓
Performance measurement of children's services related to the Agreement	Develop and submit semiannual reports to DOJ to evaluate the quality of services and outcomes for children and families.	✓
Statewide access to services	Develop plan for routine provider capacity review to meet forecasted needs and to ensure statewide access to services.	✓
CQI and sustainability	Continue development and implementation of annual quality sampling review plan/process.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	Continue development of KPIs, data collection, analysis, and reporting of performance measures and outcomes associated with services.	✓
Consolidated, cross-bureau data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	Based on the prioritized data/indicators, continue build-out of the data store and associated dashboards.	✓
CQI and sustainability	Complete review of data/indicators on an ongoing basis to drive policy and practice decisions.	✓

12.3 Open Tasks

Continued work related to DHHR's ongoing quality improvement efforts is identified in this section. Key priorities for DHHR for the coming year include:

- Supporting the prioritized discharge planning process to include targeted expansion of foster care home capacity to meet the needs of children ready for discharge from residential settings
- Supporting the implementation of the Qualified Independent Assessment process and the associated data collection and reporting
- Improving data quality, county-level data analysis and reporting, and support of workforce forecasting efforts in collaboration with program-level teams and vendors/contractors to ensure availability and timely access to services across the State

Table 14 represents the continued project tasks.

Table 14: QAPI Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	1	Continue implementing the CANS data analysis plan.	QA	July 2023
	2	Establish data collection process for additional child outcomes, including involvement with law enforcement and school performance.	QA	July 2023
	3	Continue annual quality sampling reviews through the WVU evaluation.	QA and external partners	Ongoing (Reporting timelines to be detailed in the updated WVU evaluation plan, which is anticipated in early 2023)
	4	Continue CANS and Wraparound fidelity monitoring.	QA and external partners	Ongoing (First report in November 2022)
	5	Continue formalizing program-level report publication and review processes per the Suite of Report Publication and Program-Level Quality Review.	QA, BMS, BBH, and BSS	Ongoing per Suite of Report Publication and Program-Level Quality Review

Outcome	No.	Action	Owner	Projected Timeline
	6	Continue publication of semiannual reports on the quality and outcomes of children's programs and services.	QA, BMS, BBH, and BSS	Annually in January and July
	7	Implement formalized tracking for follow-up on findings and recommendations from semiannual reports and Quality Committee reviews.	QA	May 2023
Quality infrastructure for children's services	8	Complete annual update of CQI Plan.	QA	December 2022
	9	Further define roles, responsibilities, relationships, and reporting between the Office of QA and QA/compliance functions within each bureau.	QA, BMS, BBH, and BSS	April 2023
CQI and sustainability	10	In collaboration with relevant bureaus, guide the development of plans for oversight, monitoring, and accountability for DHHR staff to follow workflows, policies, and procedures.	QA, BMS, BBH, and BSS	December 2023
	11	In collaboration with relevant bureaus, guide the development of plans for oversight, monitoring, and accountability for vendor contracts.	QA, BMS, BBH, and BSS	December 2023
Consolidated, cross-bureau data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	12	Based on the projected QAPI-CQI data store roadmap, continue build-out of the data store and associated dashboards.	QA, OMIS	Ongoing
Ongoing stakeholder education and involvement	13	Establish ongoing collaboration with the West Virginia Department of Education (WVDE), West Virginia Department of Homeland Security (DHS), and court systems.	QA	December 2022
	14	Expand public-facing indicators on the Collaborative website.	QA	April 2023
	15	Continue ongoing collaboration with the WV Commission to Study Residential Placement of Children.	QA	Ongoing

Outcome	No.	Action	Owner	Projected Timeline
	16	Continue ongoing collaboration with the Court Improvement Program.	QA	Ongoing

13. Outreach and Education for Stakeholders

DHHR has instituted a more unified, department-wide approach to engaging stakeholders in its services and programming for children.

DHHR hosts an open stakeholder association, the Collaborative—which is a broad group of independent stakeholders with participation from the DOJ and the SME—to share information, ideas, and feedback regarding major child welfare initiatives throughout the State. Meetings are facilitated by DHHR and open to the public. Regular attendees include representatives of the legislature, judicial, and executive branches of state government, foster and adoptive families, residential care providers, socially necessary service providers, educational institutions, social work organizations, advocacy organizations, law enforcement, and concerned community members. Representatives of press organizations have also attended meetings.

DHHR continues to focus on children and families as important stakeholders. DHHR and its vendors and grantees also continue to look for opportunities to solicit feedback from children and families in the implementation and monitoring of services, programs, and activities under the Agreement. Additional opportunities for feedback include, Information obtained through the WVU evaluation and survey process and enhancements to the Collaborative website.

DHHR also continues to encourage a streamlined approach to outreach and education so other helping professionals in roles outside mental health service provision—including caseworkers, teachers, or judges—will streamline their outreach and education materials to emphasize screening and assessment; encourage use of the crisis line and mobile response teams to assist with stabilization and de-escalation of potential crisis situations while children and families are getting connected to services; and work to ensure families are aware of available HCBS to meet their child's mental health needs.

13.1 Expected Goals

- **Goal 1:** Maintain the information contained in the Collaborative website as the primary source for DOJ-related communications about program- and service-specific materials regarding home and community-based mental health services.

13.2 Accomplishments

The State continues to utilize the Collaborative website as a primary hub for stakeholder communication as it moves forward with its broader child welfare reform efforts and implementation of the Agreement. Based on stakeholder feedback on the Collaborative website, DHHR engaged with WV Interactive on a website modernization project. Key goals for these updates were to improve access for families by including:

- Brighter colors with more photos and videos
- Streamlined access to information related to children's mental and behavioral health services
- Easier navigation, including direct links to the CCRL and Assessment Pathway

- Increased opportunity for two-way communication

The updated Collaborative website went live in mid-June 2022, replacing the prior Collaborative website. The site will continue to evolve in the months ahead as more families and stakeholders access the site and provide feedback.

A DHHR Outreach to External Audiences Regarding the Assessment Pathway SOP has been finalized that provides guidance for three objectives:

1) To coordinate communication regarding programs and concepts to improve access to home and community-based mental health and social services and reduce unnecessary institutional settings of children and youth

2) To provide ongoing oversight and maintenance of information on the Collaborative website

3) To support the goals of DHHR's 2020 – 2024 Outreach and Education Plan

To establish data collection to capture DHHR outreach and education efforts, a web-based tracker was developed and soft launched in April 2022. This tracker allows DHHR staff to input public-facing and community-based outreach activities with external stakeholders. Examples of data elements tracked include the date outreach was completed, purpose/message of outreach, method, audience, county, and number of participants. The goal is to be able to correlate outreach efforts at the county level with service utilization trends, residential placement rates, and other data at the county level. Understanding these relationships will assist DHHR with knowing where to target outreach efforts as well as understand whether current outreach efforts are having the intended impact.

In August 2022, DHHR initiated the Kids Thrive Resource Rundown to provide families and youth with a weekly virtual informational session designed to walk them through the Assessment Pathway process, explaining available service options, defining an SED, and providing a step-by-step explanation of what to expect when an individual accesses the CCRL (https://kidsthrive.wv.gov/rundown). Participants are invited to submit questions and will receive a written response following the session. Participants may also request a phone call to discuss their questions. There is a recorded option available on the website for parents who are unable to attend a live session. A survey is sent to participants at the end of each session to rate their experience and capture additional feedback. Based on feedback, the presentations will be updated as needed.

DHHR partnered with the WV Hospital Association and held a full-day Pediatric Mental Health Summit to bring together WV's leaders in pediatric healthcare on August 2, 2022. Former DHHR Cabinet Secretary Bill J. Crouch opened the summit by sharing goals, which included increasing awareness of community-based service options for children and enlisting pediatric healthcare leaders as partners in identifying and addressing gaps in the current system of care. Topics included national mental health challenges, awareness of community-based resources, efforts to expand the healthcare workforce, and WV's ideal spectrum of care. Afternoon breakout sessions were held to identify the gaps between the current pediatric spectrum of care and the ideal spectrum of care, pinpoint barriers to addressing the gaps, and agree on actions and next

steps. An outcome of the summit was the establishment of a Communication Team made up of public relations representatives from the hospitals. This group will focus on communication to assist with awareness of available home and community-based resources and services. In follow-up, DHHR representatives also met with the Children's Hospital Collaborative.

DHHR has continued to partner with the West Virginia Commission to Study Residential Placement of Children and the WV Court Improvement Program. The director of the Office of QA presented data and information from the July 2022 DHHR Quality and Outcomes Report, providing an opportunity for expanded outreach collaboration and to address potential misconceptions.

Judicial outreach has continued with DHHR presentations during the spring judicial conference and quarterly Court Improvement Program meeting, as well as one-to-one discussions with district judicial partners during BSS Assessment Pathway implementation. A meeting was held with leadership from the WV Department of Education, WV Department of Homeland Security, and the WV Court System in early December 2022 to provide an update on the work in progress, which is aimed to improve and expand community-based services and improve outcomes for children and families. Additionally, the group discussed the support needed from each respective group, including judges, and outlined future data-sharing needs and frequency of collaboration. Continued meetings with these key leaders are anticipated quarterly. Judicial outreach and education remain a top priority.

Table 15 represents the completed tasks from the Year 3 Implementation Plan.

Table 15: Outreach and Education Summary of Completed Action

Outcome	Action	Complete
Robust and engaging Collaborative website	Develop the Collaborative website SOP to include the process to communicate stakeholder meetings and engaging providers/families/youth/stakeholders to provide feedback.	✓
Families and stakeholders have information regarding available services	Finalize internal communication SOP to include ongoing development and approval of written materials as program needs change.	✓
Open communication and feedback from stakeholders	Publish guidance for bureaus on methods for enhancing two-way communication with stakeholders and periodic review of stakeholder feedback.	✓

13.3 Open Tasks

Continued work is identified in this section, to ensure outreach and education efforts are prioritized. DHHR has identified key priorities that include:

- Monitoring and tracking of MCO outreach efforts related to contract requirements

- Continued focus on outreach to the judicial community
- Continued outreach to families and youth through the Kids Thrive Resource Rundown webinars

Table 16 represents the continued project tasks. There is overlap in many of the workgroup tasks related to outreach and education. As such, some of the work related to outreach with external stakeholders is captured in the QAPI section.

Table 16: Outreach and Education Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	1	Complete broader DHHR rollout of the Outreach Tracker.	QA, Marketing Leadership	November 2022
Improved communication and collaboration among child-serving agencies (DHHR, WVDE, and DHS)	2	Meet with key leadership from DHHR, WVDE, and DHS to establish formal processes, communication, and buy-in from key partners for routine data collection and review.	QA, Marketing Leadership	December 2022
Families and stakeholders have information regarding available services	3	Update DHHR's Outreach and Education Plan.	QA, Marketing Leadership	March 2023
	4	In collaboration with bureau quality and compliance teams, develop guidance for bureaus related to monitoring outreach and education efforts of contracted vendors with specific focus on MCO contract requirements.	QA, Marketing Leadership	July 2023
Data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	5	Collaborate with bureau quality, compliance, and program operation staff to enhance MCO outreach and education reporting to allow for a more unified marketing approach to outreach and review of data in collaboration with DHHR's direct efforts.	QA, Marketing Leadership, BMS, BSS	July 2023
Families and stakeholders have information	6	Continue the Kids Thrive Resource Rundown and revise as relevant based on feedback from participant surveys.	Marketing Leadership	Ongoing

Outcome	No.	Action	Owner	Projected Timeline
regarding available services and have a means to provide feedback	7	Continue enhancements to the Collaborative website.	QA, Marketing Leadership	Ongoing
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	8	Continue implementation of program-level data collection, review, and reporting for outreach KPIs as outlined in the CQI Plan and Key Performance Indicators (working document).	QA, Marketing Leadership, BBH, BMS, BSS	June 2023 and ongoing

14. Reducing Reliance on RMHTFs

The overarching goal to improve outcomes for children in WV is to reduce the reliance on RMHTFs and to increase HCBS available to children with SED. In addition to increasing availability of HCBS, DHHR is focused on RMHTF models of care to ensure children placed in care are served in the least restrictive setting and for a length of time that meets their needs.

14.1 Expected Goals

- **Goal 1:** Assess the strengths and needs of children in and entering residential placement, identify services those children need to return to their communities, and develop a plan to address barriers to accessing those services
- **Goal 2:** Ensure that children have access to the mental health services they need in their communities to avoid placement in RMHTFs
- **Goal 3:** Reduce the number of children living in RMHTFs to 822 or fewer children by December 31, 2022[5]
- **Goal 4:** Reduce the number of children living in RMHTFs to 712 or fewer children by December 31, 2024[6]
- **Goal 5:** Use data to enhance strategic planning for reduction of children living in RMHTFs in years beyond the Agreement[7]
- **Goal 6:** Ensure that any child residing in an RMHTF on December 31, 2024, is in the least restrictive setting appropriate to meet their individual needs, as determined through an assessment by a qualified professional

14.2 Accomplishments

DHHR is actively collaborating with the MCO Aetna Mountain Health Promise to prioritize discharge planning for children currently placed in residential settings with a Child and Adolescent Functional Assessment Scale (CAFAS) or Pediatric and Early Childhood Functional Assessment Scale (PECFAS) score less than 90. To assist with this effort, collection of data elements associated with discharge planning was initiated in January 2022. A discharge planning report is published monthly for use by the BSS field staff, supervisors, and managers as well as the Aetna Mountain Health Promise care managers, to create prioritized focus on finding community placements and services for these individuals.

Effective May 1, 2022, DHHR expanded its contract with Kepro, an Administrative Services Organization (ASO), to perform a Qualified Independent Assessment of children who are at high

[5] This number is calculated by reducing by 25% the number of children who were living in an RMHTF as of June 1, 2015.
[6] This number is calculated by reducing by 35% the number of children who were living in an RMHTF as of June 1, 2015.
[7] The goals established for years beyond December 31, 2024, do not create additional requirements to the Agreement and are not binding on WV to exit the Agreement.

risk of residential placement or referred to residential placement or shelter care, as a part of the Assessment Pathway process. A CAFAS/PECFAS and CANS assessment is utilized in the development of the Qualified Independent Assessment. The assessment identifies the child's needs and provides a recommendation on the appropriate level of intervention and least restrictive service setting to meet those needs. DHHR began a pilot of the Qualified Independent Assessment process in mid-August 2022 and continues to work with the ASO and MCO to further detail the process, data collection, communication, and monitoring. Following the pilot, a phased implementation is being planned and will continue into the first half of 2023.

Additionally, DHHR collaborated with Marshall University and the Praed Foundation to finalize a decision support model predicated on the CANS assessment tool. The model consists of five levels of placement need, with Level 1 being the lowest level of intervention or need and consisting of traditional foster care or outpatient services, and Level 5 being the highest level of residential placement, a PRTF. The decision support model will assist with making level-of-care recommendations that are based on treatment need and complexity. The Qualified Independent Assessment process is a key component to ensure children are placed in the least restrictive setting while best addressing their needs and will assist with diverting children from unnecessary residential placement.

DHHR continues to meet monthly with an external stakeholder workgroup. The workgroup designed a new model of care with input from several internal and external stakeholders. DHHR has solicited feedback through one-on-one residential provider meetings and a planned stakeholder meeting in October 2022 to discuss the model of care continuum that includes transitional living opportunities and a high-intensity residential treatment model.

DHHR fully implemented the pathway for entry, diversion, and transition from RMHTFs, drafting criteria for the types of future programming necessary to meet the identified needs of children. This is referred to informally as the Reducing Reliance on Residential Pathway (R3 Pathway).

DHHR continues to work aggressively on the following processes:

- The prioritized discharge planning process DHHR and the MCO implemented in early 2022, which is expected to result in continued census reductions, as is the broader implementation of the specialized review process for children experiencing a placement disruption. DHHR continues to partner with the MCO to improve data collection to better understand the profiles of children ready for discharge from residential settings and to share these profiles with CPAs to inform focused foster home recruitment in counties where the need exists.
- Implementation of the monthly clinical review and reauthorization process in October 2022 for children in in-state residential placement, which is expected to result in reduced lengths of stay and faster transition to lower levels of care and discharge to community placements.
- Broader implementation of the Qualified Independent Assessment process, which is expected to increase the number of diversions from residential placement, resulting in decreased placements, and to ensure that if residential intervention is needed, it is in the

least restrictive, most appropriate setting.

Table 17 represents the completed tasks from the Year 3 Implementation Plan.

Table 17: Reducing the Reliance on RMHTF Summary of Completed Action

Outcome	Action	Complete
Clear operating procedures	Finalize RMHTF referral policy.	✓
	Finalize policy on monthly assessments for children placed in an RMHTF.	✓
	Finalize policy on transitioning children from an RMHTF.	✓
Children are appropriately placed	Develop and implement the plan/timeline for phased implementation of R3 Pathway and processes.	✓
	Develop and implement a plan for ongoing outreach and education with judges, with a focus on decreasing placements in RMHTFs.	✓
	Monitor phased implementation of R3 Pathway.	✓
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	In collaboration with the QAPI team, identify KPIs, data collection, analysis, and reporting associated with services.	✓

14.3 Open Tasks

Continued work is identified in this section, to ensure children are appropriately placed in residential care. DHHR's key priorities for the coming year include:

- Discharge planning will continue, with specific focus on children currently placed in RMHTFs with a CAFAS/PECFAS under 90. This will include focused recruitment of foster homes in specific counties to meet the needs of children ready for discharge.
- Implementing the Qualified Independent Assessment process statewide to ensure children are appropriately placed and receive services in the least restrictive setting to meet their needs.
- Finalizing the residential continuum of care model that best supports the needs of children.

Table 18 represents the continued project tasks.

Table 18: Reducing the Reliance on RMHTF Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Children are evaluated and appropriately placed	1	Collaborate with the facility, caseworker, and other stakeholders to continue the prioritized discharge planning process for children with a CAFAS/PECFAS score under 90 in an RMHTF. If children in this population remain in RMHTFs after May 2023, develop and implement a revised approach.	BSS	May 2023
	2	Complete full implementation of the monthly clinical review and reauthorization process for children in in-state residential placement.	BSS	March 2023
	3	Collaborate with the MCOs on a strategy to ensure all children in in-state residential and out-of-state PRTFs with a CAFAS/PECFAS under 90 have discharge plans.	BSS, BMS	February 2023
	4	Finalize the model for residential continuum of care that supports the needs of the children.	BSS	April 2023
	5	Develop and/or amend residential provider contracts that support the residential continuum of care model once established.	BSS	July 2023
	6	Complete statewide implementation of the Qualified Independent Assessment process for referrals for out-of-home placement and high risk of out-of-home placement.	BSS	July 2023
	7	Collaborate with the MCO to develop and implement a quality oversight plan to ensure discharge plans are maintained and individualized to meet needs.	BSS	October 2023
	8	Develop process and policy requiring children in out-of-state placements to have routine CAFAS/PECFAS assessments, CANS reviews, and discharge plans.	BSS, BMS	December 2023
	9	Engage the court system through coordinated awareness of new processes and provide opportunity to respond to identified concerns or needs through collaboration at shared meetings, as tracked in the Outreach Tracker.	BSS, QA	March 2023
Reports are available to DHHR staff to	10	Align foster care capacity tracking and foster care home recruiting efforts with data for	QA, BSS	April 2023

Outcome	No.	Action	Owner	Projected Timeline
monitor, analyze, and drive decisions to improve services		children ready for discharge from residential settings.		
Data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	11	Establish tracking and reporting of CAFAS/PECFAS and CANS scores for all children in in-state residential facilities.	QA, BSS, BMS	July 2023
	12	Expand data collection to include out-of-state group residential providers, to include completion of CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state placements.	QA, BSS, BMS	December 2023
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	13	Continue implementation of program-level data collection, review, and reporting for residential services KPIs as outlined in the CQI Plan and Key Performance Indicators (working document).	QA, BSS	Ongoing

15. Workforce Development and Provider Capacity

The State has a workforce workgroup to identify and address healthcare resource and provider needs to fulfill the Agreement. The State has identified multiple issues impacting workforce, the array of services WV is implementing, and department staff's limited bandwidth.

The State has begun work to focus on workforce-related requirements, which includes preparedness of providers to deliver services.

The following list identifies the ongoing work to improve provider capacity for services under the Agreement:

- The State has initiated training and coaching contracts for CMCRS, Wraparound, and behavioral support services.
- The State has continued to focus on requirements for training for existing services incorporated under the Agreement such as ACT, screening, and CANS assessment.
- The State has developed an agreement with Marshall University to implement a workforce training center named the WV Behavioral Health Workforce and Health Equity Training Center. The initial contract with Marshall University focuses on Wraparound and CMCRS. Trauma-sensitive workplace training is in development with staff training to be completed in December 2023.
- The State continues to contract with the WVU Centers for Excellence in Disabilities PBS Program. Concord University has finalized its PBS training and certification program. The initial cohort of PBS training began in October 2022. Additionally, the State reviews comparison data of WF capacity and availability of Wraparound services by provider, WF, county, and region.

15.1 Expected Goals

- **Goal 1:** Assess the provider capacity needed to comply with the Agreement
- **Goal 2:** Develop programs to increase provider capacity throughout the State for the programs outlined in the Agreement to ensure statewide access to children in the target population
- **Goal 3:** Evaluate the outcomes of WV's efforts to increase provider capacity and the mental health workforce and make changes where necessary

15.2 Accomplishments

The workgroup developed a comprehensive project plan to complete analysis for behavioral health service providers. The high-level tasks include:

- Forecasting service demands
- Confirming statewide access of home and community-based behavioral health services

- Evaluating provider network adequacy and workforce availability

Additional strategies have been implemented to attract and train a qualified workforce that include:

- Statewide Therapist Loan Repayment (STLR) – In this DHHR project, STLR awardees are provided $20,000 toward their eligible student loan expenses in exchange for a two-year service obligation with a qualified employer in the State. Prioritized clinical professions include counseling, psychology, and/or social work master's-level therapists or counselors. As of 2022, child psychiatrists and psychiatric nurse practitioners will also be prioritized to meet the needs of West Virginians.
- The State has contracted with WVU to focus on educational and training partnerships that will create a pipeline for a well-prepared workforce. The initiatives are an important investment to support home and community-based workers. The training initiatives below are provided to a broad group of community stakeholders and have varying relevancy to child and family services:
    - Medicaid HCBS Waiver Programs Education and Outreach
    - Integration of a Person-Centered Trauma-Informed Approach for Medicaid HCBS Frontline Health Workers
    - Safe Interactions for Law Enforcement and Persons with Intellectual or Developmental Disabilities
    - Mindfulness-Based Resilience Training for WV Frontline Health Workers and Law Enforcement Personnel
    - Evaluation of HCBS Training and Public Education Efforts

Table 19 represents the completed tasks from the Year 3 Implementation Plan.

Table 19: Workforce Summary of Completed Action

Outcome	Action	Complete
Sufficient provider capacity to meet needs	In collaboration with TFC, ACT, PBS, Wraparound, and CMCRS workgroups, as well as the MCO and other vendors, develop a written plan for completing a routine analysis of provider capacity and workforce data.	✓
Sufficient provider capacity to meet needs	Complete provider capacity reviews, as reflected in DHHR's CQI Plan. If applicable, recruit for additional providers to meet needs.	✓
Trained workforce	Finalize contract with Marshall University to establish Trauma-Informed Care Center for Excellence.	✓
	Establish Workforce Development and Training contract with WVU.	✓

Outcome	Action	Complete
Sufficient provider capacity to meet needs	Track outreach and mental health and behavioral provider enrollment related to the STLR program through BBH.	✓

15.3 Open Tasks

Continued work is identified in this section, to ensure workforce capacity is consistently monitored. DHHR's key priority for this area is to ensure provider capacity forecasting analysis is prioritized and completed. Capacity forecasting will be shared with relevant vendors/contractors such as MCOs to better inform provider network capacity and focused recruiting efforts.

Table 20: Workforce Action Items and Related Outcomes

Outcome	No.	Action	Owner	Projected Timeline
Sufficient provider capacity to meet needs	1	Continue implementation of provider capacity analysis per the Workforce Capacity Work Plan.	QA, BMS, BBH, BSS	Ongoing
Sufficient provider capacity to meet needs	2	Continue provider capacity reviews, as reflected in DHHR's CQI Plan. If applicable, recruit for additional providers to meet needs.	QA, BMS, BBH, BSS	Ongoing
Trained workforce	3	Establish data collection and implement recurring reporting of workforce training indicators as outlined in the DHHR CQI Plan and Key Performance Indicator Tables (working document).	QA, BMS, BBH, BSS	March 2023

Appendix A: Glossary of Acronyms and Abbreviations

Table 21: Glossary of Acronyms and Abbreviations

Acronym	Description
ACT	Assertive Community Treatment
ASO	Administrative Service Organization
BBH	Bureau for Behavioral Health
BJS	Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CED	WVU Center for Excellence in Disabilities
CMCRS	Children's Mobile Crisis Response and Stabilization
CMS	Centers for Medicare & Medicaid Services
Collaborative	Kids Thrive Collaborative
CQI	Continuous Quality Improvement
CSED	Children with Serious Emotional Disorders
DACTS	Dartmouth Assertive Community Treatment Scale
DHHR	West Virginia Department of Health and Human Resources
DHS	West Virginia Department of Homeland Security
DOJ	U.S. Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FAST	Family Advocacy and Support Tool
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
ISP	Individualized Service Plan
KPI	Key Performance Indicator
MAYSI-2	Massachusetts Youth Screening Instrument – Second Version
MBH	Mountaineer Behavioral Health
MCO	Managed Care Organization

Acronym	Description
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
Office of QA	Office of Quality Assurance for Children's Programs
OMIS	Office of Management Information Services
PBS	Positive Behavioral Support
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assurance and Performance Improvement
R3	Reducing the Reliance on Residential
RMHTF	Residential Mental Health Treatment Facility
SED	Serious Emotional or Behavioral Disorder or Disturbance
SME	Subject Matter Expert
SOP	Standard Operating Procedure
STAT	Stabilization and Treatment
State	State of West Virginia
STLR	Statewide Therapist Loan Repayment
TA	Technical Assistance
TFC	Therapeutic Foster Care
WF	Wraparound Facilitator
WV	West Virginia
WVDE	West Virginia Department of Education
WVU	West Virginia University