



# CONTINUOUS QUALITY IMPROVEMENT PLAN FOR CHILDREN'S PROGRAMS

WEST VIRGINIA  
Department of



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## 1.0 Introduction

Quality measurement is a key factor in continuing to transform the child welfare system and child mental and behavioral health programs towards increased use of evidence-based practices and high-quality care that achieves good clinical outcomes, improves quality of life, and helps ensure safety, permanency, and well-being for children and their families.

The Continuous Quality Improvement (CQI) Plan describes the goals, objectives, tools, resources, and processes used by the West Virginia Department of Health and Human Resources (DHHR) to assess, manage, and improve the availability, quality, and sustainability of behavioral health and socially necessary services for children.

West Virginia's commitment to continuous quality improvement is evidenced by the addition of the Office of Quality Assurance for Children's Programs (Office of QA) that is 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 and the Office of QA prioritize the alignment of quality improvement efforts across bureaus in tandem with ongoing cross-bureau collaboration to streamline programmatic work to provide a seamless system of care for children and families.

The CQI Plan builds from existing quality assurance and improvement efforts in place across DHHR and is expected to evolve in response to increased data availability, new information, experience, and best practices.

### 1.1 Mission of DHHR Children's Programs and Services

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

### 1.2 Purpose

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 serious emotional disorders. Ongoing quality improvement will help ensure all eligible children, youth, and families are provided timely, effective, high quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

Quality improvement activities will include two complementary approaches, as follows:

- (1) Quality Assurance (QA) helps ensure programs and services comply with minimum regulatory and quality standards. QA activities are typically retrospective and, therefore, are more reactive in approach.
- (2) Continuous Quality Improvement is the ongoing evaluation of systems and processes for the purpose of identifying problem areas and opportunities for improvement. This approach is proactive and data driven. People at all levels across the service system (e.g., staff, youth,

families, providers, etc.) are involved in planning and implementing ongoing proactive improvements. Everyone involved is encouraged to continuously ask, “How are we doing?” and “How can we do it better?”

### 1.3 Guiding Principles

The following principles will guide West Virginia’s quality improvement activities:

- (1) CQI is prominent in DHHR’s culture. DHHR recognizes system change occurs when people at all levels are working together to improve the outcomes for children, youth, and families.
- (2) CQI training, tools, and resources are provided with support from the top to promote involvement of staff at all levels.
- (3) DHHR uses data to make policy and practice decisions and guide our day-to-day work.
- (4) DHHR focuses on systems and processes rather than individuals. The emphasis is on identifying system gaps rather than blaming individuals.
- (5) DHHR seeks input from employees and stakeholders at all levels within the organization and service delivery system.
- (6) DHHR collaborates with stakeholders, including grantees and vendors, to incorporate these guiding principles into their practices as well.
- (7) DHHR establishes key performance indicators with defined targets or benchmarks and measures progress toward performance goals.
- (8) DHHR facilitates cross-bureau, cross-system collaboration to achieve positive outcomes for children, youth, and families.
- (9) Transparency and accountability are essential to our stakeholders and to each other.

### 2.0 Scope

Quality improvement is integrated into the array of child welfare and mental and behavioral health services, including home- and community-based services and group, short-term, and long-term residential services. Home- and community-based services are prioritized to build and maintain success at home and in the community for children and their families/caretakers and minimize out-of-home placements. These services include, but are not limited to:

- Wraparound Facilitation
- Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services
- Mental Health Screening and Assessment
- Traditional and Treatment/Therapeutic Foster Care Homes
- Stabilization and Treatment Homes (STAT Homes)
- Behavioral Support Services
- Children’s Crisis and Referral Line
- Mobile Crisis Response and Stabilization
- Residential Mental Health Treatment Facility (RMHTF) Services
- Assertive Community Treatment
- Other behavioral and mental health supports as agreed to during the continued evolution of the CQI Plan

Areas for evaluation to drive quality improvement and goal setting may include but are not limited to the list displayed in Table 1 below.

**Table 1: Areas for evaluation**

Evaluation of screening and intake processes	Timely access to services
Care management	Provider capacity
Assessment and individualized service planning	Workforce availability
Caseworker caseloads	Workforce training and certification
Availability and stability of placement options	Family and stakeholder engagement
Permanency	Outreach
Fidelity to evidence-based practices	Child/youth outcomes

### 3.0 Goals

The overarching goal across West Virginia’s child welfare and mental and behavioral health services is to help children, youth, and families thrive in their homes, schools, and communities through a seamless system of care. To that end, the quality improvement framework and processes are guided by the following goals:

- Eligible children, youth, and families are screened, assessed, and provided timely access to appropriate services.
- Barriers are minimized for children, youth, and families, decreasing the burden on accessing treatment.
- Children, youth, and families receive services in their homes and communities and continue to be linked to services to maintain success over time.
- When out-of-home residential intervention is required to help ensure a child’s safety, children are placed in or near their community of origin to keep a child connected to their family and support systems.
- Residential intervention is reduced, as is the length of stay per episode of need.
- Residential interventions engage the family, and community providers throughout care, to ensure rapid reintegration into home and community settings.
- Care provided is aligned with the strengths, needs, and goals of children, youth, and families.
- Children, youth, and families experience positive outcomes, including improved clinical and functional outcomes.
- Services are experienced as collaborative, engaging, effective, and of high quality.

### 4.0 Quality Governance, Leadership, and Infrastructure

The quality infrastructure outlined below provides the framework for carrying out continuous quality improvement activities across the DHHR bureaus and programs providing child welfare and mental and behavioral health services for children, youth, and families.

#### 4.1 Office of Quality Assurance for Children’s Programs

The Office of QA for Children’s Programs has a direct line of reporting to DHHR’s Cabinet Secretary and is responsible for:

- Developing and maintaining the CQI Plan, including an annual review of the plan
- Involving executive leadership to help ensure resources and tools are available to support CQI processes and promote the involvement of staff at all levels in the quality improvement process
- Helping to ensure implementation of CQI-related mentoring, modeling, and support across DHHR, to include, but not limited to:
  - Data-driven decision-making
  - Identification of data and planning needs
  - Integration of quality and compliance staff at the bureau level which includes verification that appropriate program level training and policy is monitored.
  - Day to day multilevel involvement with bureaus and staff at all levels, including integration of data culture into processes at all levels.
- Partnering with DHHR leadership to promote a culture of ongoing quality improvement
- Communicating/supporting awareness of the CQI Plan throughout DHHR children’s services including, but not limited to:
  - Sharing updates at DHHR quarterly meetings, monthly workgroup leads, and bureau level CQI meetings.
  - Continuing involvement of bureau staff in development and updates of KPIs related to their work.
  - Sharing themes and highlights of CQI plans and results/updates with stakeholders.
  - Including CQI tracking as part of collaborative activities to establish clear responsibilities and timelines for prioritized tasks.
- Coordinating an overall data plan to include streamlining of data collection, development and maintenance of the data store and associated dashboards, and reporting to support CQI processes in partnership with respective bureaus and the information technology team
- Defining required data to be tracked, monitored, and reported to the Office of QA
- Providing guidance in defining performance benchmarks and targets
- Helping to ensure aggregation of data across DHHR programs and services for children
- Assisting with data analysis as requested by bureau-level leadership and quality functions
- Collaborating with bureau leadership and bureau-level quality functions to help ensure the formation and implementation of Quality Committees with interdisciplinary, cross-bureau membership who meet on a routine basis to review and analyze data, outline findings to include strengths and opportunities for improvement, and document and follow up on recommended actions
- Prioritizing quality opportunities and chartering performance improvement projects
- Outlining the format, frequency, and expectations for Quality Committee meetings to include associated report format, tracking of action, and planning

#### 4.2 Bureau-Level Quality Functions

Bureau commissioners (or their designees) are responsible for the following:

- Helping to ensure implementation of the CQI Plan and guidance from the Office of QA within their respective bureaus

- Overseeing and monitoring vendor contracts, to include Managed Care Organizations (MCOs) and service providers, to help ensure expectations and accountability for required data reporting, performance measures, quality standards, quality reviews/audits, customer satisfaction, and outreach
- Helping to ensure implementation of quality sampling reviews, fidelity reviews, and other mechanisms for feedback which may include surveys, focus groups, or other methods
- Establishing a regular cadence of meetings with MCOs and/or providers as relevant to address performance and quality issues, systems issues, provider capacity, and workforce challenges
- Overseeing and monitoring bureau staff to help ensure fidelity to policies and processes
- Helping to ensure staff from a variety of levels within each bureau participate in Quality Committees
- Helping to ensure CQI is incorporated in bureau culture and mentorship is supported for new and tenured employees
- Facilitating ongoing partnership, collaboration, and communication with the Office of QA and interdepartmentally to assist with continued enhancements and streamlining of quality improvement data, reporting, and associated activities.
- Ensuring data collection and reporting are in compliance with all applicable laws, regulations, and standards relevant to bureau programs and services.

The Division of Planning and Quality Improvement within the Bureau for Social Services is responsible for oversight and implementation of quality improvement efforts across the child welfare system.

### 4.3 Quality Committee Functions

Quality Committees may be implemented at a variety of levels including program/service level, bureau level, and Department level. Quality Committees may be appointed by the director of the Office of QA and bureau commissioners (or designees). DHHR will have two main types of quality committees with multiple levels of reviews. The first are standard quality committees which occur on a regular basis, more specifically, monthly at the program, service, and workgroup lead levels, and quarterly at the department level. The second type of quality committee is considered a Performance Improvement Project Team (PIP). The PIP team is formed based on identified opportunities and needs from established data review processes, when routine review, discussion, and action items are not sufficient to understand and/or work through addressing identified needs. The PIP team members will work collaboratively to establish plans and expectations for when the PIP need can be resolved and the team adjourned.

Quality Committee membership is expected to be cross-functional with involvement of people at multiple levels. Membership may include staff, providers, contracted vendors, other child-serving entities, and children, youth, and families with familiarity with the subject matter (as appropriate). Additional requirements will be considered when building membership teams based on relevant subject matter expertise.

Quality Committees are expected to meet on a formal, scheduled basis and have a responsibility to:

- Complete a documented review and analysis of data and information, both quantitative and qualitative, to evaluate performance
- Help ensure baselines are established and performance targets or benchmarks are defined as relevant
- Identify strengths, problem areas, and opportunities for improvements based on data review

- Set goals for improvement, where appropriate, capturing them in the CQI Actions and Recommendation Tracker with owners and timelines—see Appendix B
- Monitor progress toward meeting goals, incorporating problem solving and making course corrections based on new information or lack of progress
- Communicate quality plans and progress updates to leadership to help ensure accountability
- Assist with identifying the relevant key performance indicators as the CQI process continues to evolve to help ensure that meaningful measures are in place to track progress toward the goals for children’s services
- Make recommendations for improvement to data collection and reporting as needed to facilitate quality improvement efforts

## 5.0 Feedback, Data Systems, and Monitoring

Data and information to evaluate and monitor services and outcomes are drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children/youth, families, providers, caregivers, and other stakeholders. The process for defining key performance indicators and the associated reports and dashboards utilized for monitoring are outlined below.

### 5.1 Data Collection/Key Performance Indicators (KPIs)

The KPIs to monitor the progress toward DHHR’s overall goals for child welfare and behavioral and mental health services, are outlined in the tables in Appendix A. Individual bureaus and programs within each bureau may identify and adopt additional KPIs as relevant for their programs and services. At all levels, indicators are anticipated to require revision as more data becomes available. These indicators will be reviewed at least annually to help ensure the metrics are meaningful and capture the information needed to help ensure DHHR is making progress toward the goals for children’s programs and services.

### 5.2 Data Reporting/Dashboards

A data store is under development to house data from multiple sources across DHHR’s child welfare and mental and behavioral health services systems with the goal of aggregating data from all child-serving bureaus. Data is collected from a variety of sources, including DHHR’s internal systems, MCOs, providers, other contracted vendors, and other stakeholders. Data and information are also gathered through a variety of methods such as quality sampling reviews, chart reviews, adverse event reporting, quality audits, surveys, and focus groups.

Each bureau is responsible for ensuring data collection and reporting requirements, including frequency and format, associated with quality assurance/improvement efforts and agreed-upon KPIs are specified in vendor contracts and other agreements. Data is requested to be captured at the child and encounter level using unique child identifiers in order to allow data tracking and comparison across systems and programs. Bureau-level quality functions are responsible for oversight and monitoring of each contract to help ensure accountability. With guidance from the Office of QA, the bureaus are responsible for developing policies and procedures outlining formalized oversight and monitoring processes, to include documenting and reporting of results. This process will be reflective of bureau-level timeframes, but additional needs will be assessed at least annually.

A Quality Assessment and Performance Improvement (QAPI) dashboard was launched to assist Quality Committees and DHHR staff in assessing and monitoring children’s services, systems, and outcomes. The



QAPI dashboard utilizes data from the data store to facilitate the creation of charts and graphs to assist with data analysis and identification of patterns or trends over time. The initial dashboards capture metrics associated with children placed in residential mental health treatment facilities. Over the next several years, the QAPI dashboard system will continue to expand as more data and information is captured in the data store. A standardized suite of reports is published on a recurring basis by analytical staff with close consideration with identified Quality Committee needs and requests. This process will continue while the data store and the dashboard system are being further developed and expanded for future automated processes and reporting.

DHHR utilizes the expertise of community partners for support in quality initiatives, evaluation, and training.

- West Virginia University (WVU) is contracted to complete an ongoing evaluation of children’s in-home and community-based services. Routine reports of the evaluation will be provided to DHHR.
- Marshall University is contracted to complete an ongoing evaluation of service fidelity processes, including utilization of the Child and Adolescent Needs and Strengths (CANS) Assessment, to the National Wraparound Initiative standards. Marshall University will provide routine reports to DHHR.

Reports from these contracted vendors will be included in the Quality Committee review cycle for analysis and incorporation in quality improvement recommendations and associated action.

## 6.0 Systematic Analysis and Action

Consistent and collaborative review and analysis of data with associated action based on findings must take place across multiple levels of the system in order to continuously improve quality. This section outlines the expectations for a regular cadence of Quality Committee reviews and action based on the data and reports described above.

### 6.1 Data Analysis/Identification of Strengths and Opportunities for Improvement

Quality Committees are expected to meet quarterly, per the agreed-upon schedule established by the Office of QA in collaboration with the bureau commissioners (or designees). Activities will be documented and monitored via the CQI Actions and Recommendation Tracker, with check-ins occurring via Quality Committee meetings and formal updates published in each semi-annual report. While performance metrics may be reviewed on varying frequencies (i.e., weekly, monthly, quarterly, annually, etc.) as relevant to each metric and factoring in any lag time associated with the data, Quality Committees will meet a minimum of quarterly, per the schedule displayed in Table 2 below.

**Table 2: Quality Committee quarterly review schedule**

Review Period	Report/Dashboard Publication	Quality Committee Review Meeting
January – March	April	May
April – June	July	August
July – September	October	November
October – December	January	February

During each Quality Committee meeting, the following will be completed:

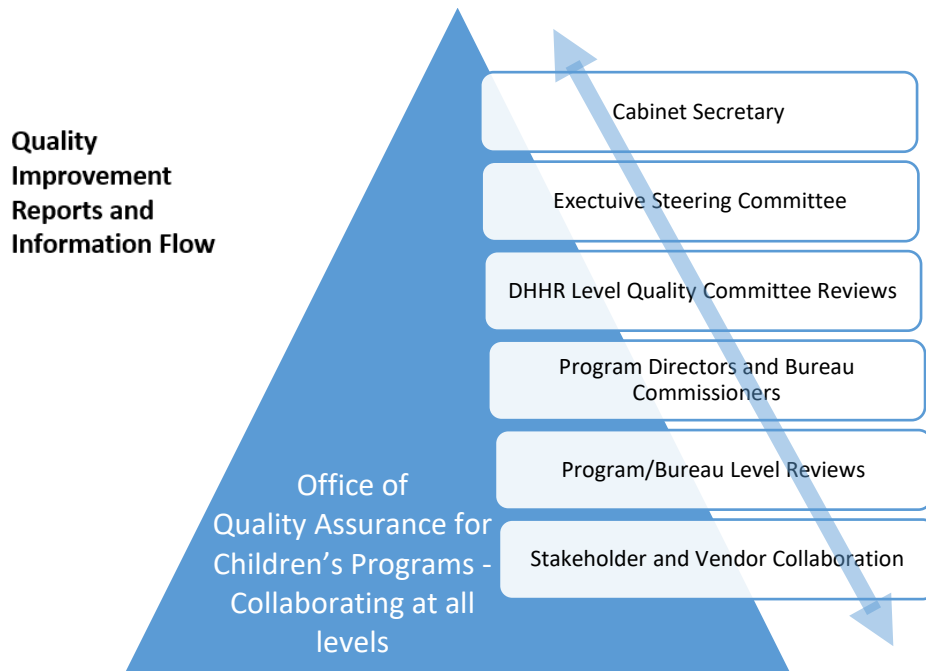
- Documented review and analysis of performance data against targets/benchmarks and recommendation of new targets, as relevant
- Review of progress on quality improvement activities in follow-up to action identified in prior review meeting
- Identification of strengths and opportunities for improvement
- Prioritization of opportunities for improvement
- Identification of any new action(s) based on findings
- Identification of any issues, resources needed, recommendations for policy and/or practice changes that should be communicated to leadership, up to and including the Executive Steering Committee, which is made up of Deputy Secretaries, Commissioners, and the Chief Information Officer.
- Documentation and assignment of responsibility and next steps utilizing the CQI Actions and Recommendation Tracker shown in Appendix B

During review processes, consideration should be given to differences, patterns, and/or trends associated with diagnoses, age, gender identification, race/ethnicity, region/county, sexual orientation, service utilization profiles, etc.

Within each bureau and at the program/service level, more frequent reviews may be warranted and may include regular review meetings with MCOs, Administrative Service Organizations (ASOs), provider groups, other contracted vendors, other child-serving agencies, and/or children, youth, and families. More frequent reviews may be determined as needed during early implementation periods, process changes, or when monitoring for Rapid Cycle Improvement. These reviews may be based on identified opportunities related or in addition to criteria captured in the guidance for review information in the related KPI tables. Documentation of the review meetings will be maintained and provided to the Office of QA upon request.

Figure 1 below depicts the expected flow of communication and reporting between the levels of the quality improvement infrastructure to help ensure recommended action, policy and practice changes, resource needs, etc., are considered and acted on.

**Figure 1: Communication flow within the quality improvement infrastructure**



## 6.2 Performance Improvement Plan Quality Committees

A key purpose of the quality review process is to identify areas needing improvement and make recommendations for action to achieve those improvements. In some cases, a formal Performance Improvement Project team may need to be commissioned and action steps should be documented in the internal CQI Actions and Recommendation Tracker.

Based on reports and recommendations from Quality Committees, the bureau commissioners (or designees) in partnership with the Office of QA will prioritize any opportunities for improvement that warrant a formal PIP.

The PIP team is expected to have a leader identified along with interdisciplinary team members (i.e., representing each of the areas of expertise affected by the project) and may include other stakeholders such as youth, families, vendors, providers, etc.

At present PIP teams meet on a frequency agreed upon by the team, based on the activities and timeline to be completed. If key stakeholders or staff are unavailable, meetings are rescheduled to ensure appropriate representation is available for discussions.

As part of the CQI process, additional data collection and analysis needs will be identified by the quality committee and/or PIP team and create a plan in conjunction with the Office of QA. Analytical staff (i.e., embedded analysts, epidemiologists) will help support mentoring and discussion of best analytical practices to better understand data and needs. Larger system and processes changes may be identified for items with a high likely impact on outcomes or ability to access appropriate services. DHHR tracks findings, discussion, and action plans via program, department, and workgroup lead level meetings. This or similar approaches may also be tracked or expanded to a PIP team. All tracking is completed via the

CQI Actions and Recommendation Tracker to ensure accountability to identified actions and activities. Discussion, additional analysis, and programmatic next steps should typically be driven by identifying vulnerabilities, determining action plans, sorting data for common themes, discussing results with leadership/stakeholders, and using results or themes to shape priorities for future action.

### 6.3 Measuring Success/Impact

A key function of the quality infrastructure is to collaboratively set and attain meaningful performance goals at all levels of the system. Quality Committees are responsible for making recommendations for performance benchmarks or targets for relevant KPIs with support from the Office of QA. Performance targets will be agreed upon by the Office of QA and relevant program staff. Targets should include consideration for baseline findings and a goal to improve or sustain indicator levels. In cases where a benchmark is not available or where a target is not appropriate—due to measures new to collection or not having an expected threshold yet due to pandemic or implementation impacts—Quality Committees will monitor for changes in patterns or trends. The Office of QA will provide guidance to Quality Committees and bureau/program leadership in performance measurement, including assisting with establishing targets and benchmarks. Guidance and recommendations will be provided based on existing program or state policy, recent literature or statistics, and provide support as needed to staff by discussing needs to help with identifying benchmarks including program level reviews. The Office of QA is embedded in this work by participating in program level reviews and relevant meetings. The Quality Committees and Executive Steering Committee will have additional influence on guidance and support provided and stakeholders also have opportunities to provide feedback in commission/collaborative meetings.

Required performance measures may be included in vendor contracts and may also include incentives or penalties related to performance outcomes. Additionally, where more formal intervention is needed, Performance Improvement Project Teams may be required in collaboration with vendors. As with the process described above, the quality committee and/or relevant program leads will determine when a PIP is needed related to a vendor activity and needs to be further addressed.

## 7.0 Communication of Results

DHHR aims to ensure transparency and accountability through interdepartmental collaboration and enhanced communication with our stakeholders, including children, youth, and families. To that end, the Office of QA in partnership with bureau leadership, bureau-level quality functions, and DHHR's Office of Communications collaborate to enhance CQI processes and associated reporting. Data sharing and feedback occur via routine meetings with stakeholders, evaluation activities, direct feedback to and from staff, and via family and youth outreach—such as the Resource Rundown information sessions and the Kid's Thrive website contact opportunities. Communication of results includes meetings and data sharing with the following groups:

- DHHR Executive Steering Committee
- Internal DHHR staff at all levels
- External stakeholders such as other child-serving entities, MCOs, providers, children, youth, and families
- Partners at the West Virginia Department of Education, West Virginia Department of Homeland Security, and Supreme Court of Appeals of West Virginia
- Others as recommended by the Office of QA and Quality Committees

DHHR publishes a comprehensive report semiannually on the quality and outcomes for children’s mental and behavior health services. Additionally, monthly data indicators are published on the Kids Thrive Collaborative website.

## 8.0 Plan Review

The director for the Office of QA is responsible for ensuring the CQI Plan is reviewed annually with updates considered when relevant. Any significant changes will be shared for feedback with the Executive Steering Committee. The plan will continue to evolve in response to increased data availability, new information, experience, and best practices as DHHR seeks to impact the success of children, youth, and families across West Virginia.

## Appendix A: Key Performance Indicators (KPIs)

The bullets below outline the KPIs associated with systems, processes, and outcomes for children’s mental and behavioral health services. As DHHR has continued implementing CQI processes and learning from these processes, updates have been made to the indicators. The indicators can be expected to change and evolve for a variety of reasons including, but not limited to, additional data and information becoming available, recognition that indicators are not providing meaningful and relevant information needed to measure progress toward goals as determined through regular quality committee reviews and feedback, and/or new learning that indicates the need for additional or modified indicators. DHHR is partnering with WVU to capture additional outcome measures as outlined in the DHHR Children’s In-Home and Community-Based Services Improvement Project Evaluation Plan. Annual evaluation reports are provided by WVU and incorporated into DHHR’s quality review processes.

Regular discussions between the Office of Quality Assurance and program teams clarify data needed, data sources, as well as format and process for submitting the data on a routine basis. Efforts continue to ensure data is captured at the child and encounter level with unique child identifiers, so data can be tracked and compared across programs and systems. Frequency of review, who is responsible for review, and guidance for review associated with the indicators are subject to change based on recommendations from the director of the Office of Quality Assurance for Children’s Programs, program level quality committees, and DHHR’s cross-functional, cross-bureau quality committees.

Indicators may be disaggregated by demographics and other characteristics such as age, gender, diagnosis, LGBTQ+, race, ethnicity, county, child serving entity. Any indicators associated with “timeliness” will be evaluated against the timelines defined by policy or contract where applicable. Measures of timeliness of service engagement may include comparisons to screening dates, dates of mobile response encounters, referral dates, eligibility determination dates, etc.

Program teams in partnership with the Office of Quality Assurance continue to evaluate which comparison populations may be most relevant for each data set. Comparison populations in discussion include WV general child population, Medicaid eligible children, children in DHHR custody, children in Bureau of Juvenile Services (BJS) custody, children formally adjudicated, among others.

### Mental Health Screening Indicators

- Number/proportion of screenings by screening entity (Youth Services, CPS, primary care physician, Probation Services, Bureau of Juvenile Services, Children’s Crisis and Referral Line, Mobile Crisis Response)
- Number/proportion of positive screens
- Number/proportion of negative screens
- Number/proportion of referrals to Assessment Pathway
- Timeliness of referral to the Assessment Pathway
- Number/proportion of decline of referral to Assessment Pathway and reason for decline

### Assessment Pathway (Interim Wraparound Services) Indicators

- Number of referrals received by DHHR’s Bureau for Behavioral Health (BBH) by source
- BBH referrals to other services by service type

- Timeliness of first family contact by BBH for referrals from the children’s crisis and referral line, mobile response teams, or Kepro
- Timeliness of assignment of Wraparound Facilitator or other interim services
- Number/Proportion on waitlist for assignment of interim Wraparound Facilitator
- Average time on interim Wraparound waitlist
- Number/proportion of families declining to complete Children with Serious Emotional Disorder (CSED) Waiver application and reason for decline
- Number/proportion of families failing to respond
- Timeliness of referral to Kepro for completion of Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS)
- Timeliness of initial family engagement meeting by Wraparound Facilitator
- Timeliness of completion of the CAFAS/PECFAS
- CAFAS/PECFAS assessor capacity (by geography)
- Timeliness of completion of CANS
- Service Plans are individualized and aligned with CANS results (per Marshall review)
- Timeliness of engagement in behavioral health services by service type (from screening to date of service)

### **Residential Mental Health Treatment Facility (RMHTF) Referral Indicators (Qualified Independent Assessment Process)**

- Number of referrals to Qualified Independent Assessment process for RMHTF placement (in state versus out of state), by referral source
- Count/proportion of referrals by system the individual is entering from (i.e., Youth Services, CPS)
- Reason why the referral source believes the individual cannot be served in the community (per drop down list)
- Reason for request of out-of-state placement (per drop down list)
- Number/proportion of Qualified Independent Assessment placement recommendations by placement type
- Number/proportion of Qualified Independent Assessment recommendations that are followed
- Number/proportion of Qualified Independent Assessment recommendations that are not followed and the corresponding reason why (per drop down list)
- Number/proportion of approvals for out-of-state placement
- Number/proportion of diversions of out-of-state placement and associated alternative service/placement
- Number/proportion of diversions from in-state RMHTF placement and services child is receiving in place of residential treatment
- Number/proportion of admissions by RMHTF placement/facility type

### **RMHTF Service Indicators**

- Basic characteristics (e.g., age, gender, race/ethnicity, region/county, diagnosis)
- Census by RMHTF placement/facility type
- Length of stay by RMHTF placement/facility type
- Number of prior RMHTF stays
- Proportion of individuals with discharge plans

- Quality and appropriateness of discharge plans
- Proportion of monthly CANS completed
- Changes in CANS Domain Scores (child functional ability)
- Proportion of monthly evaluations and reauthorizations completed
- Number/proportion of individuals recommended for transition to lower level of residential care
- Number/proportion of individuals recommended for discharge to community-based setting
- Discharge barriers (per drop down list)

#### **RMHTF Transition/Discharge Indicators**

- Number/proportion of individuals transitioned to lower level of residential care, by level of care
- Number/proportion of individuals discharged to family/kinship setting
- Number/proportion of individuals discharged to adoptive setting
- Number/proportion of individuals discharged to foster care by type/level of foster care
- Number/proportion of individuals where a community-based setting is not available and reason community-based setting is not available (per drop down list)

#### **Children's Crisis and Referral Line Indicators**

- Number of crisis line calls received by the children's crisis and referral line
  - Repeat calls by child
- Referral source for call
- Caller relation to individual in need
- Presenting need for crisis call
- Number/proportion of calls connected via warm transfer to mobile response team
- Timeliness of warm transfer to mobile response team
- Number/proportion of referrals to other services and supports by service type
- Number/proportion of occupied crisis line staff positions

#### **Children's Mobile Crisis Response Indicators**

- Basic characteristics (e.g., age, gender, race/ethnicity, region/county, diagnosis)
- Number of referrals to mobile response from crisis hotline
- Number of mobile crisis response encounters
- Response type (in person versus telehealth)
- Timeliness of mobile crisis response
- Duration of mobile response encounter
- Number/proportion of occupied mobile response staff positions
- Number/proportion of referrals to other services by service type
- Number/proportion of repeat mobile response encounters
- Number/proportion of initial crisis plans completed

#### **Children's Serious Emotional Disorder (CSED) Waiver Enrollment Indicators**

- Number of CSED waiver applications (initial versus resubmissions)



- Proportion by source of applications submitted (e.g., CMCR, PCP, BSS, etc.)
- Number of referrals to Assessment Pathway for interim Wraparound Facilitator assignment
- Timeliness of Kepro notification to the BBH Assessment Pathway following completion of the CAFAS/PECFAS
- Timeliness of CAFAS/PECFAS screening following receipt of the CSED Waiver application
- Number/proportion of CAFAS/PECFAS scores greater than or equal to 90
- Number/proportion of CAFAS/PECFAS scores below 90
- Number/proportion of youth over age 18 offered the choice of ACT or Wraparound
- Number/proportion of youth over age 18 who chose ACT versus Wraparound
- Timeliness of Independent Evaluation
- Timeliness of eligibility determination
- Number/proportion of applications approved
- Number/proportion of applications denied
- Reason for denied applications
- Timeliness of notice of decision to families
- Timeliness of completion of Freedom of Choice forms
- If denied for CSED Waiver, number/proportion of referrals to other services by service type
- Number/proportion of families choosing not to participate in the enrollment process and associated reason
- Number/proportion of appeals following denial of eligibility
- Timeliness of appeal process
- Outcome of eligibility appeals

#### **Children's Serious Emotional Disorder (CSED) Waiver Services Indicators**

- 
- Basic characteristics (e.g., age, gender, race/ethnicity, region/county, diagnosis)
- Number of children actively enrolled in CSED services
- Number/proportion of children on hold for CSED services and reason for being on hold
- Number of children on waitlist for CSED services, time on waitlist, and reason on waitlist
- CSED service utilization overall and by service type (average hours per child)
- Average utilization through life cycle of CSED services (by quarter)
- CSED length of service
- Timeliness of CSED service engagement (from date of eligibility determination)
- CSED services provider capacity by service type

#### **Foster Care Home Indicators**

- Number of foster homes available
- Number of new foster homes
- Number of foster home closures and associated reason
- Foster care waitlist and average time on waitlist

#### **Stabilization and Treatment (STAT) Home Indicators**

- Number of referrals to STAT homes and the placement settings they are coming from
- Number/proportion of admissions to STAT homes

- STAT home census
- STAT home length of stay
- Number/proportion of discharges from STAT homes by discharge setting
- Number of children that moved between STAT homes and reason for move
- Total number of certified STAT homes
- Number/proportion of certified STAT homes with a placement
- Number/proportion of certified STAT homes without a placement
- Number of newly certified STAT homes in last month
- Number of STAT home closures and associated reason

### **Assertive Community Treatment (ACT) Indicators**

- Number of ACT referrals by referral source
- ACT length of service
- Number/proportion of eligible youth offered choice of ACT versus Wraparound
- Number of youth enrolled in ACT services
- ACT service utilization
- Timeliness of ACT enrollment after initial referral
- ACT provider capacity

### **Indicators Associated with Services and Child/Youth Outcomes**

- Concurrent service utilization
- Cross-system involvement
- Changes in functioning levels as measured by CANS Domain Scores over time (may include measures associated with reductions in level of need)
- Commitments to custody of DHHR
- Commitments to custody of Bureau of Juvenile Services
- Number/proportion of children prescribed 3 or ore psychotropic medications
- Emergency department visits for psychiatric episodes
- Acute psychiatric stays
- Involvement with law enforcement
- Performance at school (i.e., Absenteeism, suspension, expulsion)
- Number of youth placed in an emergency shelter
- Length of emergency shelter stay
- Number of youth placed in a hotel when no other placement option available

### **Workforce and Training Indicators**

- Approved providers by region for each service (e.g., CSED Waiver, Foster Care Homes, STAT Homes, ACT, PBS, etc.)
- Number of wraparound facilitators and associated caseloads
- Wraparound Facilitator training
- Mobile crisis response training
- Number of CANS-certified staff

- Number of credentialed PBS providers
- Trauma-informed care training

### **Outreach Measures**

- Number/proportion of outreach events by month and purpose
- Number/proportion of outreach events by method
- Number/proportion of outreach events by audience type
- Number/proportion of outreach events by audience size
- Number/proportion of outreach events by location

### **Other Quality/Fidelity Evaluation and Oversight Processes**

*Note: This section captures quality and fidelity information that may not be data related but is important for DHHR's evaluation of quality processes and outcomes.*

- WVU Evaluation – System and Community Level
- WVU Evaluation – Child and Caregiver Level
- National Wraparound Initiative Fidelity Reviews
- CANS Fidelity Reviews
- Quality sampling reviews (per WVU Evaluation Plan)
- MCO/vendor compliance with contract requirements
- DHHR staff fidelity to policies and procedures

### **Wraparound Facilitation Indicators**

- Basic characteristics (e.g., age, gender, race/ethnicity, region/county, diagnosis)
- Number of children receiving Wraparound Facilitation services (interim and by funding source)
- Wraparound utilization (average number of hours/units per month per child)
- Number/proportion of Wraparound Facilitation services by type (in person versus telehealth)
- Timeliness of service engagement (timeline to first meeting with Wraparound Facilitator)
- Wraparound Facilitation length of service
- Wraparound provider capacity and caseload analysis
- Wraparound Facilitator waitlist, reason for being on waitlist, and average time on waitlist

### **Behavioral Support Services Indicators**

- Basic characteristics (e.g., age, gender, race/ethnicity, region/county, diagnosis)
- Number of children engaged in behavioral support services
- Behavioral support services utilization
- Behavioral support services length of stay
- Behavioral support services provider capacity (number of credentialed providers)

## Child Welfare Measures

The Child and Family Services Review performance indicators associated with outcomes for children's safety, permanency, and well-being are outlined in the [CQI Processes and Procedures Manual](#) maintained by the Division of Planning and Quality Improvement within the Bureau for Social Services.

## Appendix B: CQI Actions and Recommendations Tracker

Finding/ Recommendation	Action Plan	Priority	Owner	Target Completion/ Implementation Timeline	Status Updates

## Appendix C: Glossary of Acronyms and Abbreviations

**Table 14: Glossary of Acronyms and Abbreviations**

Acronym	Description
ACT	Assertive Community Treatment
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 (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CMCR	Children’s Mobile Crisis Response
CMS	Centers for Medicare & Medicaid Services
CSED	Children with Serious Emotional Disorder
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DACTS	Dartmouth Assertive Community Treatment Scale
DHHR	Department of Health and Human Resources
DHS	Department of Homeland Security
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
ESC	Executive Steering Committee
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
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-II	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OMCFH	Office of Maternal, Child and Family Health
OMIS	Office of Management Information Services
PBS	Positive Behavioral Support
PCP	Primary Care Provider
PECFAS	Preschool and Early Childhood Functional Assessment Scale
QA	Quality Assurance
QAPI	Quality Assurance and Performance Improvement

Acronym	Description
RMHTF	Residential Mental Health Treatment Facility
R3	Reducing the Reliance on Residential
SED	Serious Emotional or Behavioral Disorder or Disturbance
SME	Subject Matter Expert
SMI	Serious Mental Illness
SOP	Standard Operating Procedure
STAT Home	Stabilization and Treatment Home
TFC	Therapeutic Foster Care
WV	West Virginia
WVU	West Virginia University
WVDE	West Virginia Department of Education
YS	Youth Services