



CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Reporting Period: January – June 2022

Trend Review Period: January 2021 – June 2022

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1.0 Executive Summary

The West Virginia Department of Health and Human Resources (DHHR) is actively working to reform mental and behavioral health services for children with serious emotional disorders (SED) and their families across West Virginia (WV). Beginning in 2019, DHHR has facilitated in-depth discussions and planning meetings with multiple bureaus, community partners and stakeholders to design and develop new pathways, processes, and services to help ensure home and community-based services (HCBS) are available and accessible statewide to reduce the risk of out-of-home placement in institutional or other settings. DHHR has implemented and built upon the existing frameworks and established new processes and pathways meant to identify children’s mental health needs, provide families with timely and smooth connections to services, and to transition children currently placed in residential settings back to their family homes or other least-restrictive settings. One of the new processes put in place is the Assessment Pathway¹ which creates a “no wrong door” approach, streamlining and facilitating access to assessment and connection to home and community based services for children and families. These new processes continue to be monitored, with family and stakeholder feedback collected as part of DHHR’s continuous quality improvement efforts.

Data collection, reporting, and quality improvement processes are at the forefront of managing and stabilizing these efforts to help facilitate access to HCBS and improve outcomes for youth and families. The purpose of this report is to capture the results of DHHR’s ongoing, collaborative quality reviews and recommended next steps for the period January 2022 – June 2022, including utilization trends for the period January 2021 – June 2022, with some exceptions for newly implemented services.

DHHR is still in the early stages of implementing program and process changes; therefore, much of the data included in this report are initial and emerging. Data for each program is reviewed regularly, using both utilization data and partner evaluation reporting, to allow for data-informed decision-making and improved understanding of the strengths and opportunities in the current system. When necessary, data collection is expanded or adjusted to better assess needs and allow needs to be more easily identified and addressed as noted in the Office of Quality Assurance for Children’s Programs (Office of QA) Continuous Quality Improvement (CQI) Plan (updated January 2023). This plan can be found on the Kids Thrive website at <https://kidsthive.wv.gov/>. Quality improvement processes will be iterative as DHHR builds and assesses its current systems and identifies needs, with special focus at a county and regional level. Department-level reviews are scheduled quarterly to assess data across programs, help prevent silos, and improve opportunities for connectivity across systems.

¹ The Assessment Pathway is the term used to describe the Pathway to Children’s Mental Health Services, which connects youth and families to additional evaluation and referral to home and community-based services.

Summary of Key Findings:

Demographics

- HCBS, such as Wraparound and Behavioral Support Services, served a greater proportion of children in age categories 5 – 8 and 9 – 12, compared to youth in Residential Mental Health Treatment Facilities (RMHTF). The shift toward younger age demographics for community-based programs was identified as a potential early-intervention opportunity for those individuals at risk for placement in an RMHTF.
- Most of the youth in RMHTF settings were in the 13 – 17 age group (82%). In review of the subpopulation of youth in an RMHTF with a most recent Child and Adolescent Functional Assessment Scale (CAFAS) score less than 90, the age distribution shifted older (with 13%, age 18 – 21 in this subpopulation compared to only 5% in the total RMHTF population). This brings to light the importance of further establishment of transitional living services, as well as recruitment and retention of foster homes for older youth.
- Age has been identified as a key factor influencing a child’s likelihood to be served in their home and community. DHHR will place additional focus on analysis around age and early-intervention opportunities in the coming months.

Marketing

- Initial strategies to focus marketing efforts have been informed by county-level data and the West Virginia University Children’s In-Home and Community-Based Services Improvement Evaluation (WVU Evaluation). As stated in previous reports, the baseline WVU Evaluation found low awareness of HCBS among providers, caregivers, and youth.
 - Caregivers and youth also reported concerns navigating the mental health system and confusion around names of services which might have multiple titles or associated jargon (e.g., CCRL, First Choice, Help4WV, and Crisis Hotline).
 - Caregivers want to be engaged and involved in treatment and discharge planning. Better communication and information sharing is desired. Caregivers felt that providers were not always responsive to their or their youth’s needs.
 - Overall, caregivers reported staff in mental and behavioral health services respect and engage youth and families, although demands on their time can make it challenging.
 - Based on these findings, DHHR initiated a recurring outreach approach to address family concerns and questions called the Resource Rundown. This weekly series has been very successful with 18 sessions completed from August 23, 2022 – January 3, 2023, with 81 unique participants, allowing families the opportunity to better understand, in a straightforward manner, the improved pathway to children’s mental health services.

- DHHR will shift to a county-level focus in 2023 to prioritize outreach to counties with lower rates of referrals to services and higher rates of placements in RMHTFs. Along with county-level focused efforts, general outreach will continue with consideration and collaboration with vendors and grantees. Family marketing, such as the Resource Rundown, will be enhanced to include pilot topic areas and expanded opportunities for family engagement.
- DHHR's Bureau for Family Assistance (BFA) has community-based resources available to families to help meet a family's basic needs. A list of these resources is being added to the KidsThrive [website](#). Further collaboration with BFA will help ensure that appropriate entities and personnel also are aware and can help connect families to the Assessment Pathway which can facilitate early-intervention opportunities.

Screening

- Screening and referral processes allow multiple entryways and connections to longer-term services for children and families with different levels of need.
- In 2021, WV had 106,184 Medicaid members aged 0 – 20 with at least 90 days of consecutive eligibility who received HealthCheck (EPSDT) screening during well-child visits. This represents 46% of Medicaid-eligible children aged 0 – 20 with at least 90 days of consecutive eligibility (n= 229,908 total eligible children). This overall screening rate has remained stable since 2020.
- As evidenced during a retrospective analysis of medical records linked to administrative claims for 2021, 83.3% of children's medical records indicated a mental health screening was included during the primary care provider exam, an increase from 79.5% found in the 2020 chart review. Extrapolating from the chart review results, an estimated 38.5% of Medicaid eligible children aged 0 – 20 with at least 90 days of consecutive eligibility received an EPSDT with mental health screening in 2021. This is an increase from 36.5% screened with a mental health component in 2020.
- Child Protective Services (CPS) staff utilize the ongoing assessment to assess ongoing case needs for both children monitored in-home and those placed with CPS (i.e., foster care). In addition to this, it is required that all children placed with CPS receive an EPSDT wellness screening, which includes mental health screening, within 30 days of placement with CPS. EPSDT providers are trained to provide referrals to the Assessment Pathway. On average for the 18-month period from January 2021 – June 2022, 95% of children in CPS custody were screened upon initial placement.
- In total for the period January – October 2022, 662 of the 777 unique children screened through the WV Division of Corrections and Rehabilitation's Bureau of Juvenile Services (BJS) had a positive screen (85.2%), indicating a need for further evaluation of mental health needs. BJS collaborated with DHHR's Bureau for Medical Services (BMS) in late 2022 to establish a process for making referrals to the Assessment Pathway for children in BJS custody who screen positive. The goal is to determine eligibility for services in advance of a youth's release from BJS custody and establish a smooth transition into

services following discharge from BJS. While process logistics are still being worked out, BJS began making limited referrals to the Assessment Pathway in the fourth quarter of 2022.

- From March – October 2022, 281 screenings were conducted through the WV Judiciary’s Division of Probation Services, with an average of 35 screenings per month. Of those children screened for the period, 124 children (44.1%) had a positive screening.
- Data quality improvement efforts and technical assistance initiatives are underway relevant to the needs of each of the primary screening entities (i.e., Youth Services (YS), CPS, HealthCheck, Probation Services, and BJS). Screening activities have been acknowledged as key interaction points to help connect at-risk youth with HCBS, and data reviews occur regularly to allow for identification of strengths and gaps in processes.

Pathway to Children’s Mental Health Services (Assessment Pathway)

- Following the soft launch of the Assessment Pathway in October 2021, a phased rollout with outreach to key stakeholders was executed during the review period from January – June 2022. During this period, 447 youth were referred to the Assessment Pathway.
- Seventeen of WV’s 55 counties had no referrals submitted as of March 2022; however, an additional nine counties submitted referrals between April and June 2022, indicating the success of expanded outreach efforts. Only eight counties had no referrals submitted during the total reporting period. Assessment Pathway referrals will be an important consideration in the analysis planned for early 2023 to assess county-level prioritization.
- On average a family is contacted within two days of referral to the Assessment Pathway. They are given information on how to complete the Children with Serious Emotional Disorder (CSED) Waiver application and information to connect them to interim services including Children’s Mobile Crisis Response and Stabilization (CMCRS), the Children’s Crisis and Referral Line (CCRL), and a regional family coordinator who will help them navigate this process.
- Children referred to DHHR’s Bureau for Behavioral Health (BBH) between January and June 2022 upon initial referral, supported with completing the waiver application and assigned a Wraparound Facilitator (n=61), had an average of 30 days to assignment of a Wraparound Facilitator for interim Wraparound services, with 57% completing the process and being connected to a facilitator in less than 30 days. This average includes individuals who were on a waitlist prior to connection to a facilitator. Expansion of the data store is an ongoing effort which will allow DHHR to better understand the youth and family journey to services and cross systems service utilization.
 - It is important to note that families are connected to other services and supports during the determination process; therefore, this timeline is not representative of the time to connection to *any* service or support. Families are connected to the CCRL in as quickly as 14 seconds with availability of immediate warm transfer to

a mobile response team during the call. As noted above, BBH or one of its contracted family coordinators is typically in contact with the family and connecting them with additional services and support within about two weekdays of referral. The family coordinator can then be there for the family every step of the way.

Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services

- Enrollment in CSED Waiver services increased significantly in the January – June 2022 period. This increase, combined with the well-known workforce shortage crisis in the behavioral healthcare sector, resulted in the need to establish a waitlist for services in a minimal number of cases. As of January 10, 2023, nine youth were on the waitlist due to provider capacity.
 - The waitlist for Wraparound facilitation and associated workforce/staffing is managed through a collaboration between BBH and BMS that includes meeting weekly to triage cases (or same day for urgent circumstances), assigning someone to follow up with the family, staffing cases with contractors and providers, and use of telehealth where appropriate.
- For the January – June 2022 period, 729 applications CSED Waiver applications were received. Over two and a half times more applications were submitted for the period January – June 2022 compared to the July 2021 – December 2021 period. The increase in referrals is evidence of the improvements in screening and referral of children to the Assessment Pathway and increasing awareness of the availability of these services.
- For the period of January – June 2022, the timeline from receipt of the application to CSED Waiver eligibility determination was an average of 42.3 days. Kepro and Psychological Consulting and Associates, LLC (PC&A), the vendor managing the Independent Evaluator network, remain within the required 45-day eligibility determination timeline.
- Ninety-five percent of children referred to Kepro have a CAFAS/Preschool and Early Childhood Functional Assessment Scale (PECFAS) score greater than or equal to 90, which indicates the right children are being screened and referred to the Assessment Pathway.
- Since program inception, at least one application has been submitted from every county across the state, which is a positive sign of the messaging and awareness of CSED services statewide.
- The number of children accessing services has continued to increase significantly over time while the average hours of service per child has remained relatively consistent in the last six months despite increased demand on staffing capacity. As of June 2022, 327 youth were utilizing CSED Waiver services compared to 190 in January 2022.
- The number of providers actively providing CSED Waiver services has increased from 12 to 18, as of January 2023. Four additional providers are in the process of becoming

certified to offer CSED Waiver services. There is at least one CSED Waiver service provider offering services in each county across the state. Forecasting capacity needs and expanding the provider network remains a key focus with collaboration from the Managed Care Organization (MCO).

Wraparound Facilitation

- The period of review for this report, January – June 2022, overlaps the startup period of the Assessment Pathway.
- From January – June 2022, 161 individuals were served through BBH-funded Wraparound services, according to preliminary data, which included services provided on an interim basis while families await final CSED Waiver determination.
- Youth utilizing Wraparound Facilitation services through the CSED Waiver climbed to 298 youth in June 2022 from 163 youth in January 2022.
- Provider status and recruitment efforts to build Wraparound Facilitator capacity are ongoing agenda items which have proven successful in increasing the number of available Wraparound Facilitators throughout the state. Overall, from January 2022 – November 2022, the total number of Wraparound Facilitators has increased by 45, representing a 31.6% increase in number of staff.
- CSED Wraparound Facilitation service utilization increased to an average of six hours per month per child for the second quarter of 2022. Following DHHR’s Quality Committee recommendation to focus on provider education associated with CSED Waiver services billing, BMS, in partnership with the MCO, has made focused effort to educate Waiver providers on billing to help ensure providers are submitting claims for all rendered services.

Behavioral Support Services

- Of the 108 youth engaging in services through the WVU Center for Excellence in Disabilities (CED) Positive Behavior Support (PBS) Program, 53% were less than 13 years old. This service, which offers varying intensity levels based on the needs of the youth and family, can provide an opportunity for early intervention for youth with behavioral health needs, possibly preventing future residential stays.
- Efforts are underway to enhance and standardize the certification process for Behavioral Support Services. Although in early implementation, Concord University provides training and certification for individuals to offer Behavioral Support Services statewide directly from local providers, expanding the resources available in a provider’s tool belt. Concord University certified 29 providers on the new Behavioral Support Services provider certification in 2022. Additional training is planned for 2023.

Assertive Community Treatment (ACT)

- DHHR expects to achieve statewide ACT coverage in 2023, with the number of providers also expanding with the new Certified Community Behavioral Health Clinic

(CCBHC) requirements expected to be implemented in 2024.

- The number of interactions per member indicates this is a high-intensity program providing services to individuals who might otherwise have to live in a residential placement; however, a small number of individuals participated in ACT for the target age range of this report, limiting the ability to interpret the available data with confidence.
- ACT services offer an additional option for intensive services for transition-age youth and their families.

Stabilization and Treatment Homes (STAT Homes)

- Fourteen families have expressed interest in becoming STAT Home providers, and three of those families are in the final stages of STAT Home training. The first children are anticipated to be served in these placement types in early 2023.

Children's Crisis and Referral Line (CCRL)

- Calls to the CCRL in January and February 2022 were similar to the monthly average of 31 calls from July – December 2021; however, there was a large increase in monthly calls during March 2022, up to 108, coinciding with the implementation of the Assessment Pathway and corresponding outreach and education efforts. High call rates were maintained from April – June 2022 for an average of 104.5 calls per month between March – June. Notably, there were more calls in the first half of 2022 (494) than all of 2021 (408).
- At least one individual from 46 of the state's 55 counties called the CCRL during the reporting period. Only 38 counties had an individual call the CCRL during the prior reporting period, indicating that knowledge and usage of the CCRL has expanded in recent months.
- The number of emergency/crisis/urgent calls have increased only slightly over the last 18 months, while total calls have increased significantly since March 2022. DHHR is still working to understand these trends; however, the Quality Committee indicated this may be associated with increased use of the line as a referral source and a decreased rate of crisis use overall. Increased use of the line as a referral source prior to a potential crisis creates the opportunity to divert youth and families from both crisis situations and out-of-home placements by connecting them to services and supports earlier.

Children's Mobile Crisis Response and Stabilization (CMCRS)

- Preliminary reporting indicated over 600 youth were served via CMCRS.
- Statewide CMCRS coverage creates opportunities to offer crisis relief and plans for stability to support families and children in need. In the first several months of 2022, DHHR identified increased awareness, adoption, and utilization of these critical stabilization services, as an additional support to families awaiting longer term services. The implementation of an interconnected network with the CCRL, Wraparound Facilitation services, Assessment Pathway, and warm transfer to mobile crisis and

stabilization teams allows multiple entryways and connections to longer-term services for children and families with different levels of need.

Residential Mental Health Treatment Facility (RMHTF) Services

- Reducing the overall census in RMHTFs continues to be a primary focus for DHHR. DHHR surpassed the initial goal of reducing census to 822 by December 31, 2022, with a preliminary² census of 781 children as of year-end. While an overall decline has been observed, some fluctuation in census throughout the period was noted. DHHR leadership monitors census on a weekly basis. The Quality Review Committee and program teams are continuing to monitor census, admissions, and discharges over time to better understand seasonal trends associated with holidays and school being in and out of session.
- The Qualified Independent Assessment (QIA) is designed to identify a child's needs and provide a recommendation on the appropriate level of intervention and least-restrictive service setting to meet those needs based on the CAFAS/PECFAS and Child and Adolescent Needs and Strengths (CANS) assessments.
 - DHHR began a phased rollout of the QIA process in late 2022, with all counties scheduled to implement this practice as of May 2023 for individuals who are involved with BSS and are not currently placed in an RMHTF.
 - As of December 19, 2022, 20 of WV's 55 counties have implemented this process into their workflows for BSS cases, with 22 referrals received since August 16, 2022, when the process was initially piloted.
 - Plans also include expansion of this process to youth in residential facilities to help ensure youth receive treatment in the least restrictive setting. Throughout the phased implementation, this data will be reviewed and adjustments will be made to the phased approach as relevant. The QIA is expected to reduce the RMHTF census by diverting youth from inappropriate placements and connecting youth and families with HCBS when appropriate.
- DHHR continues actively collaborating with the MCO, Aetna Mountain Health Promise, to address discharge planning barriers for children currently placed in residential settings with a CAFAS/PECFAS score less than 90. To address these barriers, DHHR is prioritizing foster care home recruitment and retention and focusing on data quality improvement. DHHR has also enhanced policies and training to encourage family engagement and has worked with the MCO to improve and help ensure residential facilities have viable discharge plans in place. Preliminary data showed improvements in discharge plans being put in place for these youth going into 2023. As of reporting from

² The year-end census is considered preliminary due to possible lag issues; therefore this number could change slightly once confirmed.

January – October 2022, 17% of youth³ were listed as “The child has no discharge barriers; the discharge plan is in place and actively moving forward” (n=29). The top discharge barriers reported during this period are as follows: “An appropriate and viable discharge plan is not in place” (17.3%, n=29); “Child in need of foster family; none available at this time” (13.7%, n=23); and “Parent/family is not ready to have the child return but is making progress toward that goal” (12.5%, n=21).

- As of July 2022, there were 992 active certified foster homes with a placement, representing 80% of the total active certified foster homes. Foster homes are not required to accept placements and may have preferences for the characteristics of youth they are willing to have placed in their homes. Given these factors and early analysis of youth ready to discharge from an RMHTF, there is great need for additional foster homes willing to accept older youth and youth with mental health disorders.
 - 154 out of 494 (31%) newly certified homes statewide were willing to accept youth aged 13 and older.
 - As of November 2022, 83% of children with a CAFAS/PECFAS less than 90 and with a discharge barrier related to no family to discharge to were ages 13 or older.
 - While foster care capacity is limited, placement of children in kinship homes is a strength in WV’s system of care. WV currently leads the nation in kinship placements—as of December 2022, 57% of in-state placements were in kinship homes.
- Given challenges in finding adequate foster care families to meet the unique needs of some youth and the lack of kinship families, DHHR is also considering what alternative options may be available for youth who do not meet the criteria for a residential setting but have no other options available.
 - DHHR is working collaboratively with residential providers, Chapin Hall, Casey Family Programs and other stakeholders to help ensure children have options to stay closer to home, family, friends, schools, and communities for behavioral and mental health treatment intervention when residential placement is the most appropriate option.
 - DHHR has identified model-of-care changes, such as small, specialized community-based group homes, to expand service offerings and help ensure individualized, high-quality care is available for children with significant needs.
 - As an area of focus for DHHR, sustained decreases have been observed in the number of children in out-of-state placements, with 249 individuals in out-of-state placement as of October 1, 2022, compared to 267 individuals as of October 1,

³ Of percentage of youth with a response for discharge barrier.

2021.

- In 2022, the out-of-state placement request and review process was enhanced to require that any out-of-state placement request first be reviewed with the Program Manager or Child Welfare Consultant and include involvement of the MCO case manager to help ensure all other options have been exhausted before approving and forwarding the request to the BSS Commissioner for final approval. This process, along with enhanced review and data collection of out-of-state placement processes, has increased opportunities to help ensure out-of-state placements were used only as a last resort and kept youth in their communities when possible.

Outcomes

- DHHR began a collaboration in December 2022 with the WV Department of Homeland Security, the court systems, and the WV Department of Education. This collaboration will work to enhance communication and data sharing between agencies, which will ultimately help enhance outreach, family and youth connection to services, data review, and future planning.
- Initial CANS assessment data has been explored to assess indicators of CANS completion and timeliness. For youth who were newly enrolled between January – June 2022, 84% of all youth enrolled in SAH, an RMHTF, CSED, or BBH and reported in the CANS Automated System for at least 30 days had at least one CANS completed. Of all youth enrolled in the CANS System, 58% of individuals enrolled at least 30 days had a CANS completed within 30 days of enrollment. Review of this data will be included as part of the action and planning associated with the Performance Improvement Project (PIP) Team that will lead efforts for WV Wraparound CQI. Collection of timely CANS data is key to informing child and family planning and for assessment of systems and child-level outcomes.
- An initial polypharmacy analysis using pharmacy claims data did not identify significant numbers of children with three or more psychotropic medications. It was identified that 49% of the identified population of at-risk youth⁴ had at least one psychotropic prescription, while 11% had three or more for at least 90 days. This data will be assessed over time to identify any necessary changes to policy.

⁴ At-risk youth were defined as those children (under age 21) with an SED in 2021 (where an SED is defined as ICD10 diagnosis codes in the psychiatric range, or F-range (that is, starting with F) *except* for the F1, or SUD, range and F55 (also a SUD diagnosis) and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021), AND meeting any of the following criteria in the last 3 months of 2021: Medicaid/CHIP member with an ER visit for a psychiatric episode, Medicaid/CHIP member with a psychiatric hospitalization episode; Mobile Response; children who are in state custody because of CPS or YS involvement; OR child with SED as a primary diagnosis on a Medicaid claim in 2021 and a CAFAS \geq 90.

Summary of Key Priorities

DHHR has made meaningful progress in program design and process changes related to serving children with mental and behavioral health needs, as evidenced by the vast increase in screenings, service utilization, and continued decreases in RMHTF census. These positive trends demonstrate increased awareness and embracement by families and other stakeholders of the home and community-based options available to divert children from residential placements and are evidence that DHHR's efforts are having the intended effect. Implementation will continue in the months and years ahead with a continued adherence to data-informed planning. The details of specific service reviews as well as identified strengths, opportunities for improvement, and next steps are included in the full report. The following areas of focus, which DHHR will prioritize in the coming months, were established by Quality Committee review members and are anticipated to have the greatest impact on improved outcomes for youth and families over time:

- CSED Waiver and Wraparound Facilitation services forecasting and provider network expansion in partnership with the MCO and providers.
- Continued efforts around prioritized discharge planning with focus on children with CAFAS/PECFAS less than 90, to include ensuring all children have discharge plans.
- Assessing and building foster and kinship care capacity to meet forecasted needs.
- Full implementation of the QIA process to help ensure children are assessed for appropriate levels of care and intervention.
- Continued development of new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disabilities.
- Coordination across DHHR's Bureau for Public Health (BPH) and MCOs to help ensure EPSDT with mental health screens are conducted annually with Medicaid-eligible children.
- Continued enhancement of quality infrastructure and processes within DHHR to include expansion of the data store to allow synthesis of data across sources and systems, oversight and monitoring of DHHR staff and third-party contracts (e.g., vendors, MCOs), and reporting to provide feedback to providers, ensure accountability to performance outcomes, and assist with focused recruiting and provider network expansion.

2.0 Introduction

DHHR is actively working to reform and enhance programs and services for children⁵ with serious mental health conditions.

The primary goals of this reform are as follows:

- Prevent children with serious mental health conditions from being unnecessarily removed from their family homes for treatment.
- Prevent children with serious mental health conditions from unnecessarily entering RMHTFs.
- Transition children with serious mental health conditions who have been placed in an RMHTF back to their family homes when appropriate.

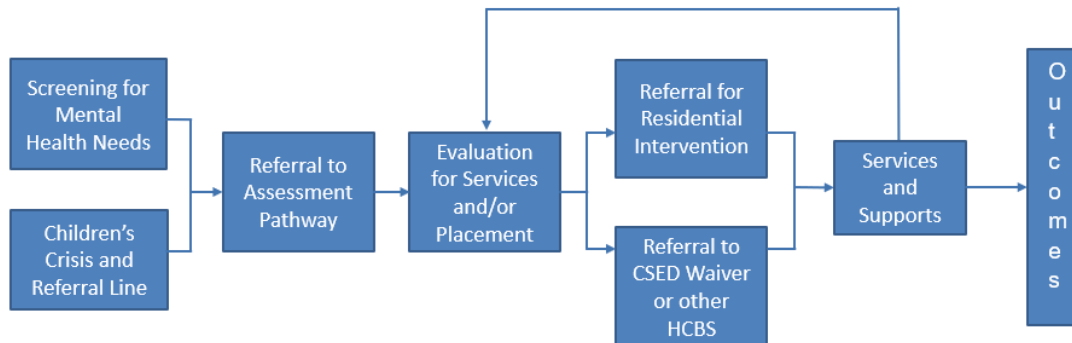
To support these goals, DHHR is committed to providing HCBS to allow children to remain in their homes and communities. HCBS include Wraparound Facilitation, CMCR, STAT Homes as a short-term intervention foster care option, Behavioral Support Services such as PBS, and ACT. In February 2020, DHHR implemented the CSED Waiver to expand the array of HCBS available for children with SED and their families. Over the last two and a half years, DHHR has worked collaboratively with community partners and stakeholders to design and expand services to better meet the needs of children and families statewide. DHHR continues actively implementing these new processes and pathways to improve access to HCBS across the state. Although it will take years to see the full impact of these improvements, positive impacts are already being noted and are captured throughout this report.

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 and continuous approach to improve child welfare services and services for children with mental and behavioral health needs, including SED. Over the last year, DHHR has instituted a data-driven culture to support this effort. These ongoing quality improvements help 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.

Figure 1 provides an overview of the flow of the Assessment Pathway and children’s mental health services process. Data is collected at each step to inform CQI reviews and planning. Quality review reports are published internally on varying frequencies to meet the specific needs of program teams, including monthly, quarterly, and semiannually.

⁵ The terms “child” and “children” will be used throughout this report and are meant to be inclusive of children and youth up to age 21.

Figure 1: Assessment Pathway and Children’s Mental Health Services Process Overview



DHHR completes quarterly cross-functional, cross-bureau Quality Committee review meetings to review and analyze consolidated data from across programs to evaluate the children’s mental and behavioral health services system. The most recent quarterly review meetings were held in October 2022. Individuals participated from across relevant sections of DHHR, including representatives from the Office of the Cabinet Secretary (including but not limited to the Office of Quality Assurance for Children’s Programs), BBH, BMS, and Bureau for Social Services (BSS). Representatives from the BPH were unable to attend the October reviews. However, the BPH team was included in relevant subcommittee reviews and updates. The discussions during these quality review meetings informed the findings—including strengths, opportunities, and next steps—captured in this report.

3.0 Systems and Data Sources

Data and information to evaluate and monitor services and outcomes will be drawn 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. Data sources used to aggregate data for this report include:

- DHHR’s BSS Family and Children Tracking System (FACTS) data for children in DHHR custody.
- DHHR’s Data Warehouse/Decision Support System (DW/DSS) of Medicaid and WV Children’s Health Insurance Program (WVCHIP) data, including data associated with CSED Waiver services.
- DHHR’s BBH grantee reporting via Epi Info system for PBS, CMCRS, BBH Wraparound, and CCRL.
- DHHR’s BBH Assessment Pathway Portal.
- DHHR’s BMS CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, Kepro, including the results of the application process.
- BJS Offender Information System.
- MCO Reporting for Discharge Planning (Aetna Mountain Health Promise is the contracted MCO) and CSED Waiver Status and On Hold reporting from the MCO’s QuickBase system.
- DHHR’s BMS CSED Waiver Enrollment Reporting from the ASO and the contracted assessor, Kepro and Psychological Consultation and Assessment, Inc. (PC&A), respectively.
- DHHR’s BSS YS and CPS Screening Reporting.
- DHHR’s Fostering Healthy Kids Data System including EPSDT screening for CPS (i.e., children placed in foster care).
- Outreach and Education Tracker.
- Probation Services Reporting on Screening.
- CANS Automated System.

DHHR is actively developing 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. The data store will evolve through 2024 in a phased build-out. To date, the data store captures data associated with RMHTF services. Prioritized data elements in the process of being integrated into the data store include indicators associated with CSED Waiver services and RMHTF

discharge planning. Other data elements are being integrated and reviewed per DHHR's data store build-out timeline to allow for data quality improvement prior to full integration into the data store. Over time, additional community-based behavioral health data elements will be included in the data store as child-level and interaction-level data becomes more available and accessible. Full build-out of the data store is anticipated later in 2024 and will allow more in-depth cross-systems analysis of child-level data to support DHHR's continuous quality improvement activities.

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. Following implementation in October 2021 of the BBH Epi Info data collection system—which includes the BBH-funded Behavioral Support Services, Wraparound, and CMCRS programs—additional needs were identified to address questions related to program strengths and opportunities. System updates are expected in 2023 and will help expand data collection, quality, and ability for monitoring and review of expanded information such as timeliness indicators. BSS implemented the West Virginia People's Access to Help (WV PATH) system to replace the FACTS system in January 2023. BMS also plans to implement an Enterprise Data Solution (EDS) to replace the current DW/DSS. Rollout of this new system is projected to begin in March 2023. Both new systems will improve and expand data collection associated with BSS and BMS services and integration of data across bureaus. BSS, BBH, and BMS have also been working with vendors and providers to implement, expand, and refine data collection at the child level, including addition of regular reporting on RMHTF discharge planning, screening of youth interacting with BSS, BJS and Probation Services, CSED Waiver enrollment and services, and the build-out of the Assessment Pathway Portal. Data processes will continue to evolve as DHHR continues to implement more robust CQI activities.

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

- WVU: Contracted to complete an ongoing evaluation of WV's children's home and community-based services. 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 issued in September 2022. Reports will continue to be provided on a routine basis to DHHR as evaluation is conducted on the implementation rollout. Reference Section 5.0 Partner Evaluations for more information.
- Marshall University: Contracted to complete an ongoing evaluation of service fidelity to the National Wraparound Initiative (NWI). Marshall provided the first fidelity report to DHHR in December 2022. The next fidelity review is planned to be completed by summer 2023.

Reports from these contracted vendors serve as data sources in the Quality Committee review cycle as outlined in the CQI plan for analysis and incorporation in quality improvement recommendations and associated action.

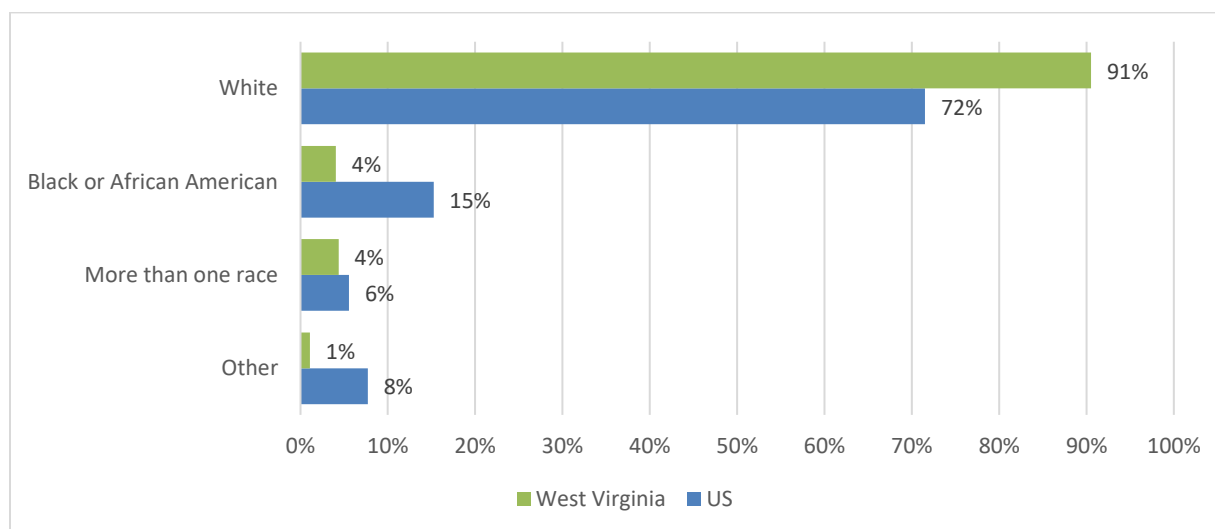
4.0 WV's Child Population and Individuals Utilizing Services

WV Demographics for the General Youth Population

WV has a unique demographic and geographic makeup, which varies significantly from most of the rest of the United States (U.S.). Reference to the state's population is important as DHHR looks at baseline service utilization and for future reports to track whether the populations reached are representative of the state's population.

As shown in Figure 2, the state has a larger proportion of white children compared to the nation (91% in the state compared to 72% nationwide). Black, Indigenous, and People of Color (BIPOC) represent 8% of the WV child population compared to 21% nationally.

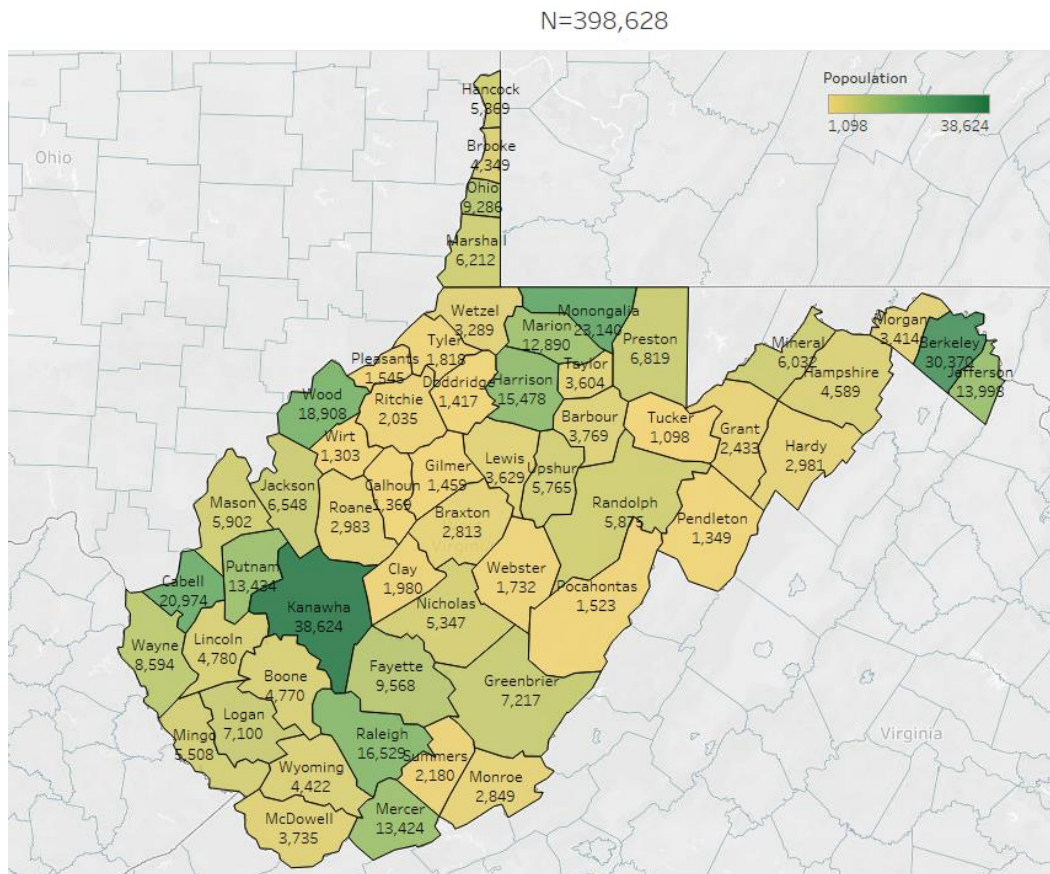
Figure 2: Racial Distribution of West Virginians Less Than Age 21 Compared to the Nation



In addition to consideration of racial distribution, geographic makeup of the state is an important consideration for service utilization and outreach. According to the U.S. Office of Management and Budget, only 21 of WV's 55 counties are considered urban. Children and families who live in rural areas may have additional barriers and considerations to accessing services. Figure 3 represents the population in each county less than 20 years of age for context of service utilization as referenced throughout sections of this report.⁶ Please note these totals are an undercount of the county populations for the report's target age group, children and youth aged less than 21 years. The relevant U.S. Census Bureau data are only available by county in age ranges grouping 20-year-olds with individuals outside the target age group.

⁶ Single-race Population Estimates, United States, 2020. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. <https://wonder.cdc.gov/>. Vintage 2020 estimates released by U.S. Census Bureau on July 27, 2021. Queried < 21 & All Races & All Ethnicities & All Years & All Genders.

Figure 3: WV Child Population Under Age 20



Youth Accessing Services Through the Assessment Pathway and Other Relevant Mental Health Programs

A comparison of demographics of the WV general child population and the children accessing the various children’s mental health programs and services are captured in Figure 4. In summary:

- Consistent with gender proportions identified in the RMHTF, programs typically served more male children; however, data from CMCRS providers (51% female) and CCRL (60% female) services showed more female utilization. There appeared to be a divergence in gender proportion between the pathway to services and determination point. While gender distribution was 50% female and 50% male for referrals to the Assessment Pathway, 60% of youth utilizing CSEDW services were male. The Quality Committee noted that more males utilizing services may be expected as males often have greater intensity of need due to reportedly more dangerous behaviors compared to females. This aligns with findings in reviewed literature, as differences are commonly seen with the manner in which mental health disorder symptoms present among males and females, which would also impact intensity of the services needed based on

presentation of relevant symptoms.⁷

- HCBS such as Wraparound and Behavioral Support Services served a greater proportion of children in age categories 5–8 and 9–12 compared to youth in RMHTF. The shift toward younger age demographics for community-based programs were identified as a potential early-intervention opportunity for those individuals at risk for placement in an RMHTF.
- The vast majority of youth in RMHTF settings were in the 13–17 age group (82%). In review of the subpopulation of youth in an RMHTF with a most recent CAFAS score less than 90, the age distribution shifted older (with 13% of transitional age youth 18–21 in this subpopulation compared to only 5% in the total RMHTF population). At this time, it is unclear if these youth entered an RMHTF with a CAFAS at this threshold or if this was achieved during treatment. Future data collection will aid in establishing this timeline and changes in CAFAS score over the course of treatment. Further assessment of this expanded data set will help to determine commonalities among individuals with a CAFAS score under 90 in the future and help with understanding the variety of needs to be met in order to serve more children in a home and community-based setting.
- Individuals interacting with CMCRS had a slightly older distribution compared to other programs with the exception of RMHTF services (e.g., 54% of CMCRS youth were age 13 – 17 compared to 44% of Assessment Pathway referrals). This was noted as both a strength and an opportunity as this could serve as a critical point of intervention for diverting inappropriate placements from RMHTFs; however, it is important to identify additional opportunities to reach and connect families before a crisis occurs if possible.
- Age has been identified as a key factor influencing a child’s likelihood to be served in their home and community. Correlations in age and intensity of needed services and/or inability to maintain a youth in a home will be demonstrated throughout this report. DHHR will place additional focus on analysis around age and early intervention opportunities in the coming months.
- Based on a comparison of statewide race distribution for youth aged 0 – 20, BBH-funded PBS and Wraparound services tended to serve a slightly higher proportion of BIPOC individuals compared to the general population. It is noted due to low number of BIPOC individuals in WV and thus served in its programs, race distribution is subject to fluctuation, which may not be associated with significant change. Despite these challenges, race will continue to be monitored as an important indicator for assessing youth and family’s access to services. Race data will be expanded as the data store is built out.

⁷ Smith DT, Mouzon DM, Elliott M. Reviewing the Assumptions About Men's Mental Health: An Exploration of the Gender Binary. *Am J Mens Health*. 2018 Jan;12(1):78-89. doi: 10.1177/1557988316630953. Epub 2016 Feb 10. PMID: 26864440; PMCID: PMC5734543.

Figure 4: Summary⁸ Comparison of Demographic Trends Across Service Types

Area of Review	Gender Trends	Age Groups				Race: White	Race: African American	Race: Multiracial	Race: Other
		5-8	9-12	13-17	18-20				
WV – All Youth 0-20	52% Male	23%	19%	25%	15%	91%	4%	4%	1%
CCRL	60% Female	12%	30%	46%	0.4%	--	--	--	--
CMCRS – Preliminary	51% Female	9%	33%	54%	2%	84%	4%	2%	6%
Assessment Pathway Services	50% Male	17%	36%	44%	0.7%	--	--	--	--
CSED Waiver Applications	--	18%	29%	49%	1%	--	--	--	--
CSED Eligibility	--	17%	31%	49%	1%	--	--	--	--
CSED Waiver Utilization	60% Male	16%	31%	47%	3%	--	--	--	--
Interim/BBH Wraparound – Preliminary	55% Male	11%	40%	40%	1%	88%	6%	2%	4%
PBS (BBH)	57% Male	13%	37%	42%	5%	87%	3%	8%	2%
Discharge Planning (CAFAS)	60% Male	2%	8%	78%	13%	--	--	--	--

⁸ This summary comparison only includes relevant percentages (percentages large enough for comparison); however, the denominator for each group is inclusive of all available demographic types including those not listed (e.g., other genders such as transgender, age 0 – 4).

Area of Review	Gender Trends	Age Groups				Race: White	Race: African American	Race: Multiracial	Race: Other
		5-8	9-12	13-17	18-20				
less than 90)									
RMHTF	64% Male	2%	11%	82%	5%	--	--	--	--

5.0 Partner Evaluations

5.1 DHHR Children's In-Home and Community-Based Services Improvement Project Evaluation

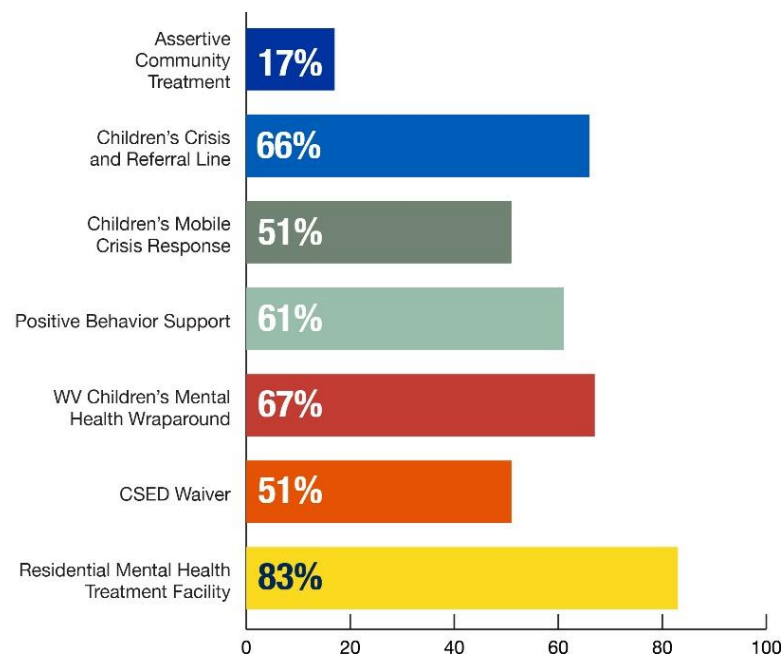
DHHR partners with WVU to capture additional outcome measures as outlined in the DHHR's Children's In-Home and Community-Based Services Improvement Project Evaluation Plan. The evaluation includes performance measures designated by DHHR, child/caregiver level outcomes, community/provider-level outcomes, and system level outcomes. WVU gathered the initial round of caregiver, provider, and child surveys and focus groups in 2021 and 2022. WVU provided a baseline report reflecting responses and perceptions from providers and facilities statewide in July 2022 and a report on feedback from youth, families, and caregivers in September 2022. WVU is currently completing the second round of surveys and focus groups, including surveys and interviews of families of children who are at risk of residential placement. The second report of system, provider, caregiver, and child evaluation is expected in July 2023 with the report of the at-risk evaluation to follow in October 2023.

As part of the CQI process, DHHR's cross-functional, cross-bureau Quality Review Committee reviewed the baseline report results. The Quality Committee identified common themes and action items from these baseline findings, including several takeaways to improve youth and caregiver outreach methods. Copies of these reports are located on the [Kids Thrive website](#).

As previously noted, much of this baseline information was collected during or prior to the implementation of several planned improvements to the system, such as the Assessment Pathway, the CSED Waiver (which began in the early months of the COVID-19 pandemic), and planned awareness training to link individuals discharging from RMHTFs to ACT as an option for continued stabilization and maintenance. The report frequently notes that provider perception differed from current policy or fact, stressing the need for increased awareness and education on available services and how to access them in a manner that is both provider and family friendly. Figure 5 shows the provider and facility survey responses for awareness of each service type.

Efforts are already underway to improve awareness, such as expanding awareness of RMHTF discharge planning options to include ACT. Education with providers who complete screening for the Assessment Pathway is also expected to expand awareness of several of these services. These findings also raised concern regarding jargon and semantics, which may result in a provider not connecting the name of a service on the survey with those provided locally (i.e., a provider may be aware of Wraparound or CSED services, but not that nomenclature; instead, they refer to them as intensive in-home services provided through a local provider). WVU and DHHR are working collaboratively to address any confusion related to identifying and defining services in future surveys.

Figure 5: Provider and Facility Awareness of Services



*Note future surveys will refer to both Behavioral Support Services and PBS for clarity.

Providers and facilities perceived that services were not always accessible in a timely manner. Approximately one-third of organizations and facilities note they had waitlists for new clients to receive services.

In addition to the provider perspectives captured, the youth and caregiver survey for individuals in residential care also identified several key themes. Caregivers and youth reported that services are making a difference and community-based services are valued, although there is a need for more of them. Caregivers wanted more residential services and a variety of home- and community-based specialty services that focus on keeping youth in their homes or helping reintegrate them after placement in residential. Some additional helpful perspectives and responses included:

- Mental health system terminology does not always resonate with caregivers and youth.
- Fifteen percent of caregivers said the services were not available at times they could participate.
- Youth expressed the need for activities that help maintain the progress they had made during residential treatment.
- “Access to services is a challenge”: For the 46% of caregivers who said that they had challenges starting services, this was due to lack of services in their area; caregivers and youth seemed aware of service and staffing shortages.
 - Caregiver engagement is impacted by their experiences navigating the system, which they report as being too complicated.

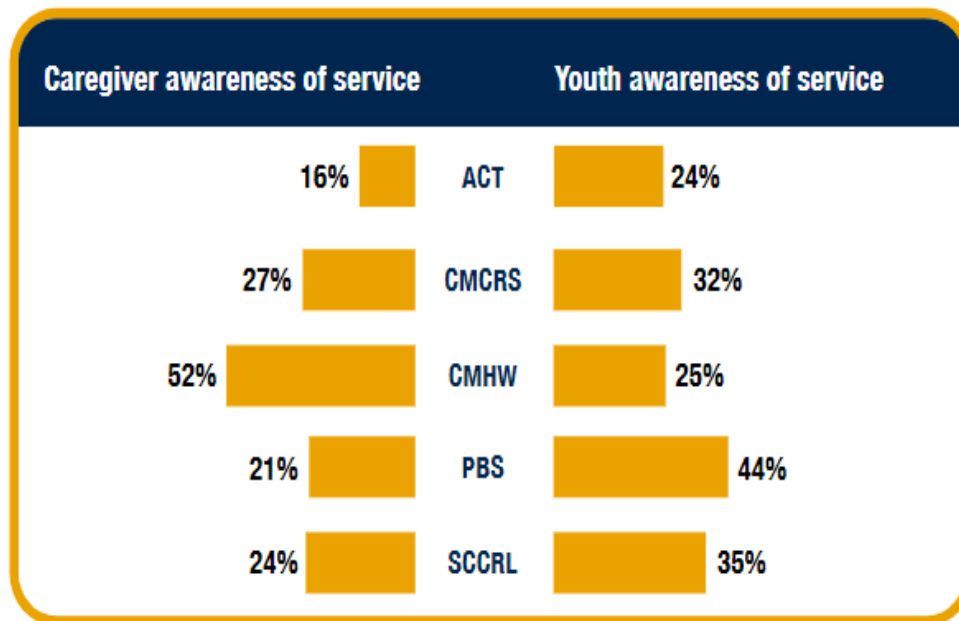
- Thirty-nine percent of caregivers encountering challenges initiating services for their youth reported that they did not understand what they needed to do to start services, and this remained an issue for 19% of caregivers experiencing barriers to continuing services.
- Caregivers want to be engaged and involved in treatment and discharge planning. Better communication and information sharing is desired. Caregivers felt that providers were not always responsive to their or their youth's needs.
- Overall, staff in mental and behavioral health services respect and engage youth and families, although demands on their time make it challenging at times.
- Caregivers reported during interviews that there are significantly longer wait times for in-state residential treatment than for out-of-state placement. Distance from the family home to the service also affected participation in treatment.
- Caregivers report that they see the demands of staff time and capacity. Processes that facilitate caregiver involvement while managing staff time demands may be useful.
- Investments in cultural competence training are reflected in high levels of engagement and respect.
- Caregivers had mixed experiences with communication from providers about care plan changes and feeling supported by their providers.
- Social supports are an important component of caregiver and family wellbeing. Most caregivers reported moderate to high levels of social support, indicating that their families are supported by strong networks.

Case Series Interviews identified positive experiences:

- Caregivers praised mental health workers. One caregiver stated that their Wraparound worker was exceptional, working “above and beyond the call of duty.”
- Another caregiver reported that Wraparound workers “were absolutely fantastic. They really, really helped us; they did everything they could. [...] I think it really opened [Youth's] eyes a little bit to see like, hey there are people that care, there are people that want to help me.”

Caregivers and youth have varying levels of awareness about community-based mental health services with awareness of community-based services being low at the time of the baseline assessment. As shown in Figure 6, caregivers were most aware of Wraparound services, with 52% of caregivers surveyed aware of the service, while Behavioral Support Services and the CCRL were most known among youth in a residential setting. As implementation continues this baseline data provides insight into family awareness of critical services and out-of-home placement diversion opportunities through outreach and education.

Figure 6: Caregiver and Youth Awareness of Services



Additional key findings and next steps have been noted throughout this report in relevant sections.

5.2 Wraparound and CANS Fidelity Assessment

DHHR partners with Marshall University to provide Wraparound training and technical assistance to providers across the state of WV and to complete an ongoing evaluation of Wraparound service fidelity to the NWI standards. To date, Marshall University has established a contract with the University of Connecticut to provide the Wraparound training to providers and to certify Marshall University staff as Wraparound trainers.

Marshall University completed the baseline fidelity review in the latter half of 2022 utilizing NWI approved fidelity tools. The report was issued in November 2022 with Marshall providing an overview of the results and suggested next steps to DHHR staff in mid-December 2022. The primary baseline findings indicated needs for additional alignment with NWI standards across programs and changes to written policies. DHHR will review the results more fully in the next quarterly Quality Committee review to identify and agree on next steps based on the results. During the preliminary review, the team agreed that a PIP team will lead efforts for WV Wraparound CQI. The Wraparound PIP team will be established in early 2023 as part of the recommendation of the Office of QA and the Wraparound Fidelity Report. This committee will kick off in early 2023 with the purpose of addressing findings from the baseline fidelity report.

Marshall University will complete the next round of fidelity reviews by summer 2023. Fidelity reviews and associated reports are expected annually.

6.0 Marketing

Marketing strategies—including outreach and education—continue to be monitored and developed as a key opportunity to raise awareness of available services and influence messaging on the ability of youth to have the option to be served in their homes and communities when clinically appropriate. Strategies have shifted to a data-informed approach throughout 2022, and Department-wide tracking of outreach activities began August 2022 with enhanced training planned for early 2023.

As noted, initial strategies to focus marketing efforts have been informed by county-level data and the WVU Evaluation. As stated in previous reports, the baseline WVU Evaluation found low awareness of HCBS among providers, caregivers, and youth. Caregivers and youth also reported concerns navigating the mental health system and confusion around names of services which might have multiple titles or associated jargon (e.g., CCRL, First Choice, Help4WV, and Crisis Hotline). Based on these findings, DHHR initiated a recurring outreach approach to address family concerns and questions called the “Resource Rundown.” This weekly series has been very successful in allowing families the opportunity to better understand, in a straightforward manner, the improved Pathway to Children’s Mental Health Services. Based off a similar series in New Hampshire, these sessions are designed to be an informal conversation rather than a one-way presentation. Eighteen sessions were completed from August 23, 2022 – January 3, 2023, with 81 unique participants. Information covered in the initial series included walking parents through the Assessment Pathway process, explaining home and community-based service options available, breaking down what an SED is, and providing a step-by-step explanation of what they can expect as they navigate the Assessment Pathway process. A survey is sent to participants at the end of each session, intended to rate their experience and capture additional feedback. Based on feedback, 80% survey respondents (n=25) said either some or all of the information presented was new to them, and the majority (80%) of survey respondents also either agreed or strongly agreed that the information presented was useful. A few examples of responses included, when asked what they found the most useful, they said: “Clarifying the information in a simple manner,” and “the visual was helpful...simple and easy to follow.” The Resource Rundown is recorded and posted on the [Kids Thrive website](#) for those who are unable to attend a live session. In addition to survey feedback, the Resource Rundown platform also gives families an opportunity to send in questions or comments. Specific to completing the Assessment Pathway process, one family took the time to share their appreciation of the information and noted that the process went just as described for their family, allowing for straightforward connection to mental health services and supports their family needed.

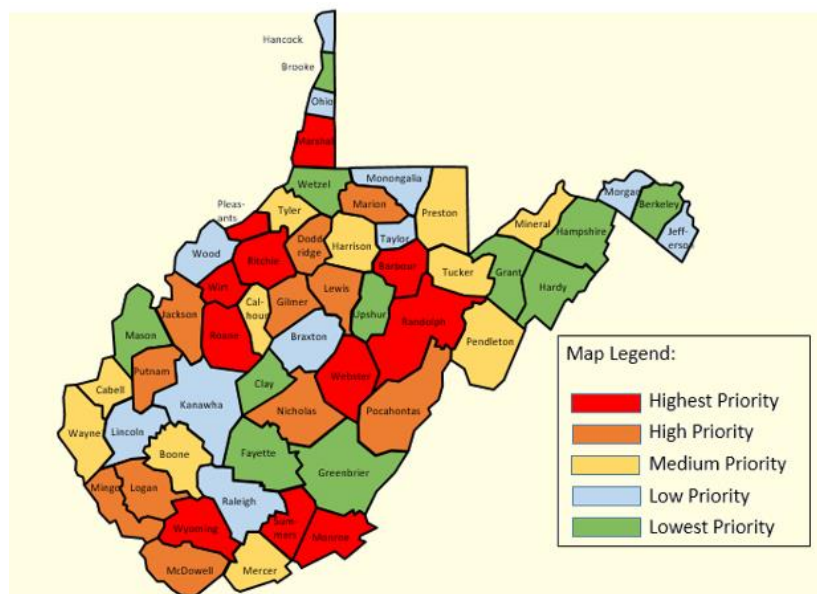
DHHR plans to continue the Resource Rundown activities by expanding to pilot additional information sessions, including a “Did you know?” series specifically for teens focused on connection to services and supports. DHHR is also exploring strategies to engage families with more interactive sessions, and additional topic areas are under consideration. Data will continue to be reviewed from the WVU Evaluation, web-based interactions, surveys, and service utilization to determine any changes needed with this approach.

In addition to insights from the WVU Evaluation, marketing focus was analyzed at a county

level, with stakeholder input and education of map findings at the Commission to Study Out of Home Placement, Court Improvement Program Quarterly Meeting, and the Kids Thrive Collaborative. Although limitations with mapping prioritization were identified, it was determined that mapping combined indicators could provide benefits to identify counties with the greatest rates and number of RMHTF placements compared to their utilization of referral practices to entry points in the mental health system. Figure 7 shows the result of this analysis with red counties having both the highest rates or numbers of RMHTF placement and among the lowest utilization of community-based mental health referrals of specific services studied. Programs and stakeholders shared this information with their teams to determine appropriate use as diverse and complex factors may influence how to prioritize outreach for a given county (e.g., county acceptance/readiness, number of potential youth impacted based on service type and county size, etc.). Similar information will be used in the future and enhanced as additional county-level data becomes available.

In addition to individual program use and reference, Figure 7 was used as a key component of focus for the build-out of the rollout plan for the QIA process. In addition to consideration for geographical proximity and county readiness, the outreach prioritization map was used to identify counties that may have an opportunity to divert children who may be more at risk of placement associated with high rates of RMHTF placement and low HCBS referrals by their county of origin. DHHR used this information to develop the phased rollout plan for the QIA process, which is expected to be fully implemented across the state by May 2023 for individuals who are involved with BSS and are not currently placed in an RMHTF. As of December 2022, RMHTF admission data is reviewed monthly by county to determine opportunities and strengths in this process at a county level.

Figure 7: Children’s Mental Health Services⁹ Referral and Placement Outreach Prioritization Map



DHHR-Level Outreach and Education Tracking

The Outreach and Education tracker was soft launched in April 2022 and shared with relevant DHHR staff in August 2022. Initial data from the tracker was shared and discussed at the October Quality Committee reviews. Forty-one outreach events were tracked from April – August 2022, with the most events (12) occurring in May 2022 shortly after the initial launch. Initial review of the data indicated activities being reported based on intended scope: to raise awareness of HCBS and divert unnecessary placements from RMHTFs. Although multiple purposes for outreach were often noted, the most common purposes for outreach were accessing HCBS; HCBS as an alternative to residential placement; Wraparound Facilitation; Mental Health Prevention Services; and CCRL (Figure 8). This information was provided to a wide array of audience types, as indicated in Figure 9, with the most common being provider agencies (49%) and the general public (44%). This initial data also indicated 83% of outreach had a statewide focus.

⁹ The average was calculated by combining county rankings for both total youth served/placed and population rate per 1,000 youth per county for the following indicators: Priority service referral/interactions (including Children with Serious Emotional Disorder Waiver [CSED] enrollment for 2021), referral to the Assessment Pathway (Jan-May 2022), and calls to the Children’s Crisis and Referral Line (CCRL [July 2021 – March 2022]); RMHTF placement by county of origin (2021).

Figure 8: Purpose of Outreach, April – August 2022

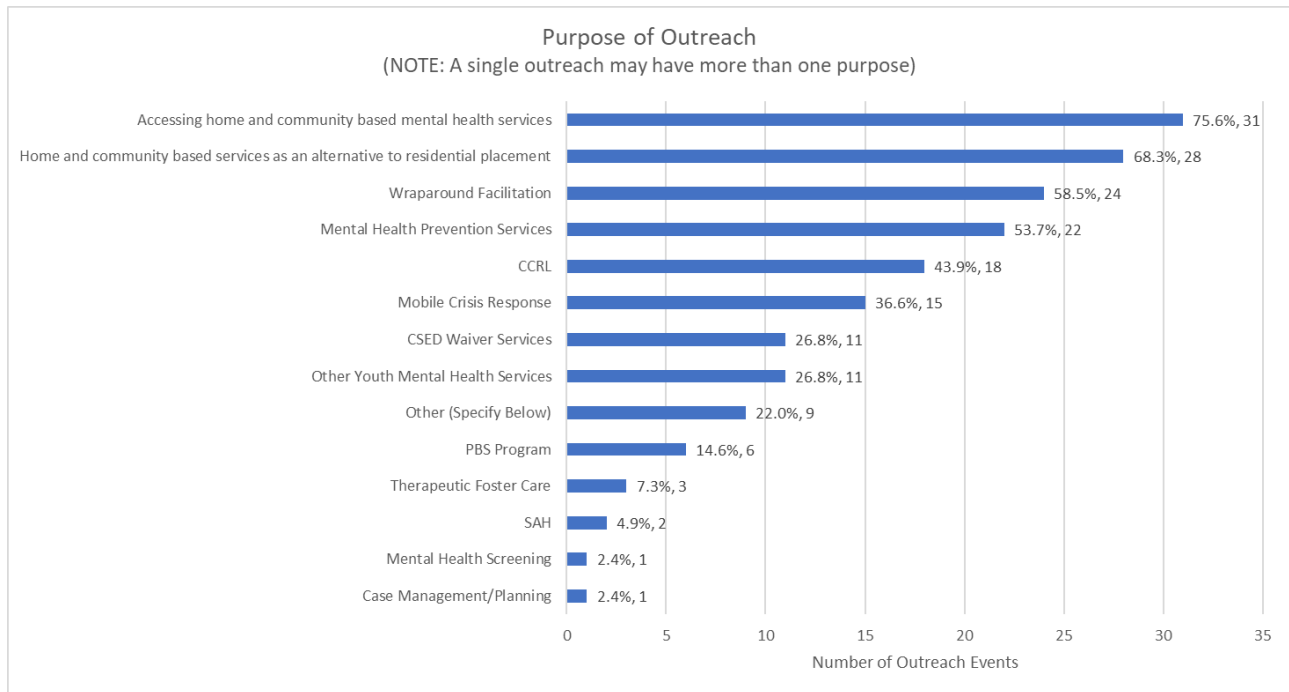
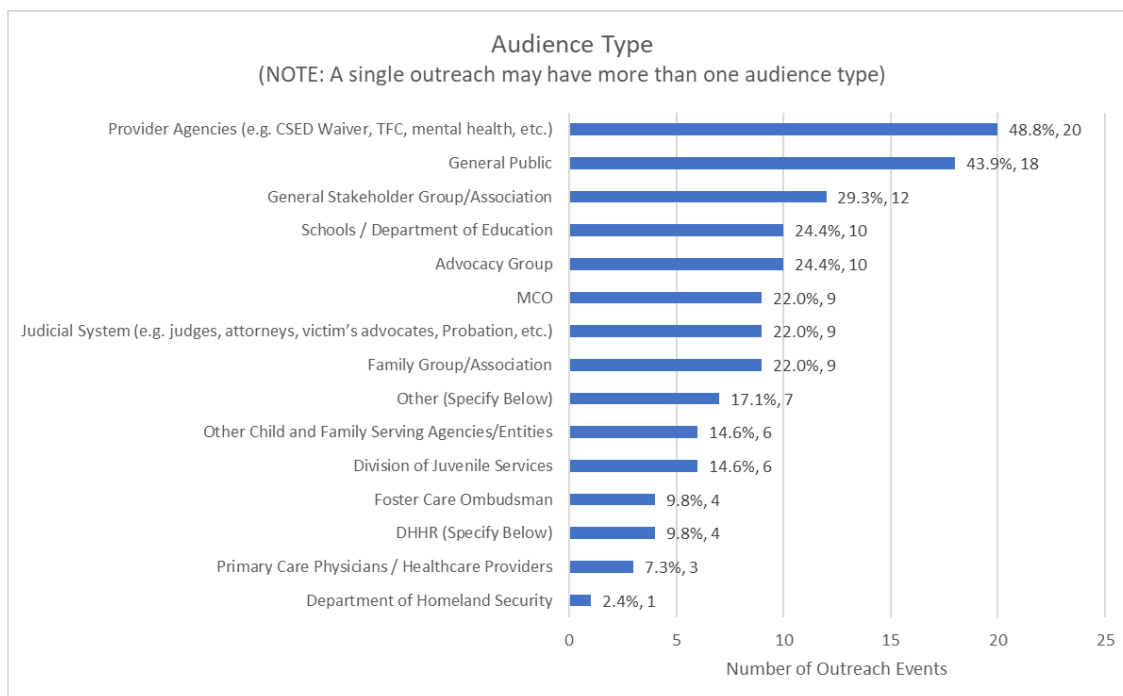


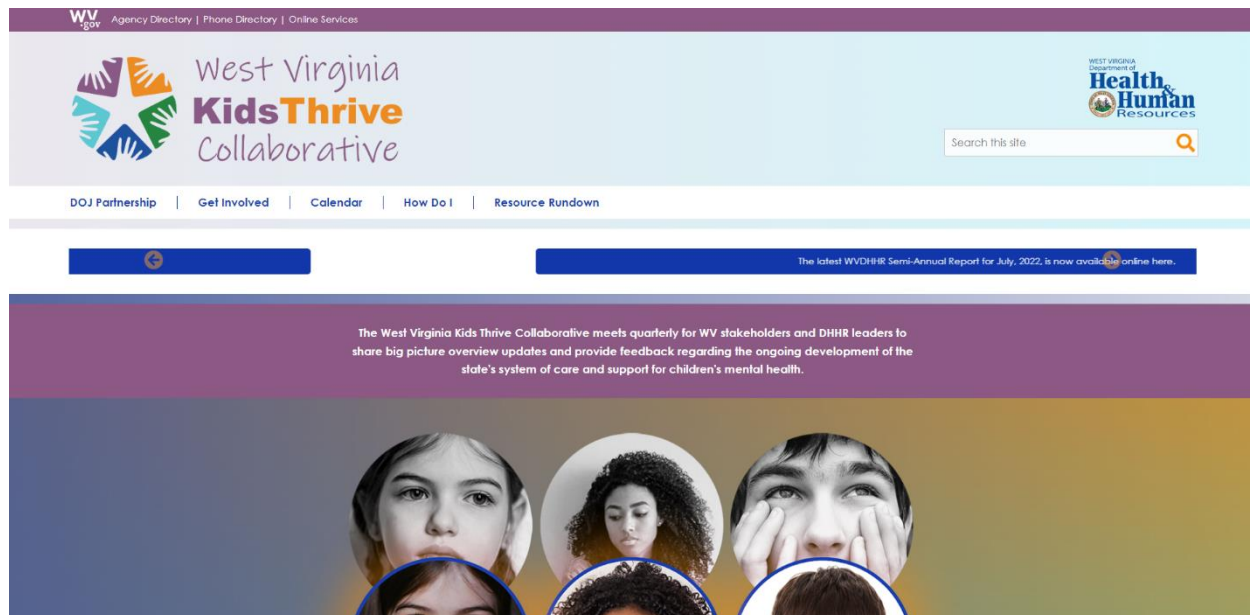
Figure 9: Audience Type, April – August 2022



Given recent large increases in referrals, DHHR will move toward a county-level approach, when appropriate, to focus attention on areas with lower referral rates to HCBS and/or high RMHTF placement rates. Longer term data from the Outreach and Education tracker will be used to correlate outreach efforts at the county level with service utilization trends, residential placement rates, and other county-level data. In addition to consideration for vendor and grantee efforts, understanding these relationships will assist DHHR with knowing where to focus outreach efforts as well as understand whether current outreach efforts are having the intended impact. As a result of these and many combined efforts by DHHR and key partners, service utilization is at an all-time high. Additional plans are underway to enhance training and utilization of the tracker.

The Kids Thrive [website](#) (Figure 10), which went live in mid-June 2022 and replaced the Child Welfare Collaborative website, continues to be enhanced based on feedback from families and identification of additional needs. Recent changes include a separate page for Resource Rundown information and the recorded video sessions. The “How Do I” section is also being expanded to include additional resources to meet the basic needs of families, with careful consideration for simplifying navigation and messaging of how to access services and supports. The website received 1,139 unique user views from January – June 2022.

Figure 10: Kids Thrive Collaborative Website



Two-way communication, including the website-related communication enhancements, will continue to evolve in 2023. The vision for the new year is to offer future Resource Rundown sessions that will include the ability to answer questions live when possible and appropriate to the broader audience, offering an evening session, and considering additional communication segments involving key personnel and partners to help address questions and concerns families may have in a live session.

Another initiative is the BBH Transformation Transfer Initiative (TTI) from the National Association of State Mental Health Program Directors (NASMHPD), which provides technical assistance and support for implementing, expanding, and improving crisis services for children and adolescents with SED or Serious Mental Illness (SMI). This partnership includes an emphasis on engaging youth who are lesbian, gay, bisexual, transgender, questioning, and others (LGBTQ+) and/or BIPOC by collaborating with groups with cultural competence in working with LGBTQ+ and BIPOC youth, developing survey and focus groups to gain feedback on setting up two-way communication strategies, and using feedback to inform training for crisis services providers and improve service delivery systems. BBH has been engaging leaders of various stakeholder groups individually, including contacts from Fairness WV's Safe & Healthy Schools Initiative and the WV Black Voter Impact Initiative. Fairness WV has joined the Expanded School Mental Health Steering Team, and the WV Black Voter Impact Initiative invited BBH staff to Black Policy Day at the Legislature in February 2023. After more individual contacts, a group stakeholder meeting will take place in 2023 to plan further feedback from and ongoing collaboration with the populations of focus. In December 2022, WV was awarded two additional TTI awards, which will help to support continuation of this work, including with adult systems. WV anticipates that this will, in part, address issues of closing the gap for transitional age youth so that individuals will be supported seamlessly whether they interact with an "adult" crisis team or a children's crisis team.

Regional family coordinators continue to be a valuable asset to connect families and youth with key resources. The family coordinators are an essential part of the Assessment Pathway in helping families feel supported as they apply for services and helping them connect with interim services or resources that meet their specific needs. Despite the workforce shortages experienced at both a national and state level, family coordinators are able to help families navigate available services for both interim and longer-term services while also engaging families and gathering feedback to better meet needs.

DHHR continues to partner with the WV Hospital Association to educate its members on the availability of mental health crisis services and community-based services for children. On August 2, 2022, a full-day Pediatric Mental Health Summit brought together WV's leaders in pediatric healthcare. The DHHR Cabinet Secretary kicked off the session and shared goals of the summit, which included increasing awareness of community-based service options for children and enlisting their partnership 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 healthcare workforce, and WV's ideal spectrum of care. Afternoon breakout sessions identified the gaps in the current pediatric spectrum of care and the ideal spectrum of care. The gaps identified were urgent care beds outside of emergency departments, full continuum of adolescent substance use disorder treatment, and knowledge gap. With considerations from these discussions, DHHR is now in the planning stages of a crisis center for youth who may need short-term care to address urgent mental health needs outside of the emergency department. This will allow stabilization of youth so they can return to their families within 14 days rather than entering unnecessarily into a longer term RMHTF setting if clinically inappropriate.

In December 2022, DHHR initiated a collaborative with the WV Department of Education, WV's court system, and the WV Department of Homeland Security. Meetings are expected to continue quarterly at a leadership level, with meetings in the interim for appropriate personnel to continue to move collaboration and data collection efforts forward. All parties committed to push efforts forward to raise awareness of HCBS, bring data and information sharing to the forefront of this collaboration to enhance interagency planning, and work together to identify and breakdown silos and barriers.

6.1 Strengths, Opportunities, Barriers, and Next Steps

Service utilization has significantly increased via the Assessment Pathway based on the increased awareness across the state achieved through outreach and education efforts to a variety of audiences. The Assessment Pathway approach allows youth and families to identify and navigate services more simply through a "no wrong door" strategy, encouraging all stakeholders, including the general public, court systems, and provider networks to maintain an awareness of services. The success of this initial strategy is evident in the Assessment Pathway's early implementation results.

As noted previously, given the success of initial outreach strategies, DHHR will now shift to a county-level focus on counties with lower rates of referrals to services and higher rates of placements in RMHTFs. Along with county-level focused efforts, general outreach will continue.

As noted above, family marketing, such as the Resource Rundown, will be enhanced to include pilot topic areas and expanded opportunities for family engagement. The DHHR Outreach and Education Plan will be updated in early 2023 to include an enhanced training plan and program specific strategies and recommendations informed by county-level data analysis, with special focus on strategies to expand availability of foster homes for youth who are identified as “difficult to place,” counties with low rates of referral to WV Wraparound, and counties that may underutilize the CCRL.

In addition to DHHR’s focused efforts, the Quality Committee recommended further focus on cross-bureau, vendor, and grantee outreach strategies and progress to improve collaboration, avoid duplication of effort, and identify key trends and correlations in marketing successes and opportunities. BFA has community-based resources available to families. A list of these resources is being developed for addition to the Kids Thrive [website](#). Further collaboration with BFA will help ensure that appropriate entities and personnel are aware and can help connect families to the Assessment Pathway, which can facilitate early-intervention opportunities.

DHHR aims to continue to humanize processes and address common misconceptions, ultimately simplifying system navigation and building trust with the families who desperately need these services. These combined efforts, along with monitoring the new tracking log for outreach and education, are expected to help increase awareness, education, and two-way communication among provider groups, stakeholders, and families while identifying opportunities for further improvement.

7.0 Screening

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 help ensure broad reach to children across the state who may benefit from behavioral and mental health services, the following entities complete screenings:

- Primary Care Providers: Provide screening for Medicaid- and WVCHIP-eligible children through WV’s HealthCheck (EPSDT) program within DHHR’s BPH.
- BSS, YS: Provides screening for children referred to DHHR for services related to status offenses or juvenile delinquencies.
- BSS, CPS: Provides screening for children in a child abuse and neglect case.
- WV Division of Corrections and Rehabilitation, BJS: Provides screening for children in juvenile detention and commitment facilities.
- WV Judiciary, Division of Probation Services: Provides screening for children on probation.

Children with an identified potential mental health need (i.e., positive screen) are then referred to the Pathway to Children’s Mental Health Services (Assessment Pathway) for additional evaluation and referral to home- and community-based services. Referrals may also come from calls filtered through the CCRL, although this is not considered a primary screening activity.

7.1 Review Period, Data Sources and Limitations, Population Measured

Data collection associated with screening for possible mental health needs is in the early stages of implementation; therefore, much of the screening data are limited to more recent periods as outlined in Figure 11 below. As data collection continues, the information will be used to forecast provider capacity needs for Wraparound and other HCBS, as well as provide a targeted approach for outreach, education, and training of providers who may have lower screening rates and/or underutilization of community-based referrals.

Figure 11: Screening Data Overview

Screening Entity	Data Review Period	Data Source	Limitations	Population Measured
Primary Care Providers HealthCheck (EPSDT)	Calendar Year 2021	Chart Reviews DW/DSS warehouse CMS-416 Report	Reporting on EPSDT with mental health screens is based on medical record reviews. DHHR conducted medical record reviews for a random sample of Medicaid members between ages 0–20 who	A random sample of children with Medicaid receiving EPSDT with mental health screening during a well-child visit. The CMS-416 Report was utilized

Screening Entity	Data Review Period	Data Source	Limitations	Population Measured
			had a well-child visit during calendar year 2021. The random sample is a subset of the total children screened.	to retrieve information on members in the Medicaid population and members receiving EPSDT screenings.
YS	Early data under review, data quality elements included for comparison purposes	BSS YS Excel spreadsheet	Data collection was initiated on April 1, 2022; enhanced collection and technical assistance is underway.	Number of cases in YS. Information is also included on cases that have received plans, FAST screenings, and referrals to the Assessment Pathway.
CPS	January 2021- June 2022	BSS CPS Excel spreadsheet/ Fostering Healthy Kids Data System	Data collection was initiated on April 1, 2022; enhanced collection and technical assistance is underway. The Fostering Healthy Kids data system is a subset of FACTS data and does not include child exit date. This makes it unclear if an individual had time to be screened before exiting placement. Considerations for data lag are still being assessed.	Number of children with a CPS case screened via a wellness visit.
BJS	January – October 2022	Offender Information System	MAYSI-2 screenings (a type of standardized mental health screening) of children have been conducted in excess of 10 years within BJS. Extracts of MAYSI-2 screening scores from the Offender Information System are being used to calculate positive screens.	Children in juvenile detention and commitment facilities screened using the MAYSI-2 who have a juvenile delinquency offense.

Screening Entity	Data Review Period	Data Source	Limitations	Population Measured
Division of Probation Services	March – October 2022	Probation Web-Based Data Collection Form	Screening and data collection was implemented March 1, 2022 and is still in the early stages of adoption by probation officers.	Children adjudicated as a status offender or delinquent screened using the MAYSI-2.

7.2 Review Summary

7.2(a) HealthCheck Screening Including Mental Health Screening During Well-Child Visits

In 2021, WV had 106,184 Medicaid members aged 0 – 20 with at least 90 days of consecutive eligibility who received HealthCheck (EPSDT) screening during well-child visits. This represents 46% of Medicaid-eligible children aged 0 – 20 with at least 90 days of consecutive eligibility (n= 229,908 total eligible). Medical chart reviews were completed for 813 of these children. The chart review consisted of an examination of medical records for children with Medicaid who had a well-child visit during calendar year 2021. The review consisted of pulling a random sample representative of the Medicaid population including demographics such as gender, age, etc. The sample has adequate estimation power overall but was not tested by these specific age groups.

As evidenced during the retrospective analysis of medical records linked to administrative claims (Figure 12), 83.3% of children’s medical records indicated a mental health screening was included during the primary care provider exam, an increase from 79.5% found in the 2020 chart review. The percent of children with a completed mental health screening increased with age for youth 0 – 18, from 76.1% for 0 – 5 years olds to 91.4% for 9 – 18-year-olds. There was a slightly lower screening rate for youth ages 19 – 20 (85.7%) compared to youth ages 9 – 18 (91.4%). The average age of the children sampled was 7.4. Extrapolating from the chart review results, an estimated 38.5% of Medicaid eligible children aged 0 – 20 with at least 90 days of consecutive eligibility received an EPSDT with mental health screening in 2021. This is an increase from 36.5% screened with a mental health component in 2020. The next medical record review is planned for October and November 2023 to review 2022 claims.

While overall EPSDT screening rates have remained stable since 2020 at 46%, the number of children receiving mental health screenings increased in 2021 compared to 2020. Some lingering effects of the pandemic may have influenced well-child visits during 2021. The Office of QA met with representatives of BMS in mid-December 2022 to discuss strategies to further engage MCOs in the efforts to improve screening rates and move toward the goal of at least 52% of Medicaid-eligible children receiving an EPSDT with mental health screening. The group agreed to further discussions with the MCOs in current monthly meetings—which includes representatives from BMS and the MCOs—to emphasize the importance of EPSDT with mental

health screening and MCO activities to improve these screening rates. Quality related capitation withhold measures¹⁰ are already in place with the MCOs to drive performance improvement. BMS may consider updating quality related capitation withhold measures in the future to incorporate EPSDT with mental health screening rates if these rates do not improve through increased focus with the MCOs over the next year.

To encourage and support connection of children and families to the Assessment Pathway, the group also discussed adding more structure to the MCO care manager call process for MCO members to help ensure questions about mental health needs or changes are asked consistently and information is provided on the Assessment Pathway and associated children’s mental health services and resources.

Other efforts in collaboration with the MCOs will include enhanced and focused training and education with primary care providers to help ensure appropriate mental health screening and use of the electronic referral process when individuals screen positive. Focused training and education will be updated based on results from a survey conducted with providers in September 2022, which was designed to collect information on primary care provider perspective and awareness of the electronic referral process. Eighty-seven submissions were received through the electronic referral process from January-September 2022. While the number of electronic referrals has increased each month, additional awareness is needed among the nearly 700 HealthCheck providers to adequately connect children and families to appropriate services directly when they are needed.

Wallet cards have been provided to primary care providers to give to families during well-child visits. These wallet cards identify challenges the family may be experiencing with their child and provide multiple avenues to connect to the CCRL. Primary care providers have had a very positive response to the wallet cards and have requested additional cards to share with youth and families.

Figure 12: Medical Chart Review Summary (2021)

	Screened		Not Screened		
	Number	%	Number	%	Total
0 – 5 years old	267	76.1%	84	23.9%	351
6 – 8 years old	96	81.4%	22	18.6%	118
9 – 18 years old	308	91.4%	29	8.6%	337
19 – 20 years old	6	85.7%	1	14.3%	7
Total	677	83.3%	136	16.7%	813

¹⁰ Capitation withhold measures are used to incentivize quality improvement. CMS rules allow agencies to withhold a portion of the premiums paid to the MCO plans based on meeting defined quality requirements. Withheld amounts are repaid retrospectively subject to meeting the established quality requirements.

7.2(b) Youth Services (YS) and Child Protective Services Screening (CPS)

Youth Services

Screening of children for possible mental health needs using the FAST is completed when a case is opened in YS. A phased county-by-county rollout of screening, referral to the Assessment Pathway, and associated data collection was initiated in April 2022. Analysis of early data showed some challenges with data quality and completion. Subsequently, regular data sharing was established with BSS to review county level results, describe data quality and completion issues, and identify areas for technical assistance. Based on the results, BSS created a county-by-county schedule for focused technical assistance to work toward improving results. Cabell County was among the first counties where focused technical assistance was initiated. Improvements in data collection for Cabell County from June 2022 to October 2022 are shown in Figure 13. Data completion rates improved significantly over the period following technical assistance.

Figure 13: Cabell County YS Improvements in Data Completion

	June 2022 % Data Completion	October 2022 % Data Completion
Total Cases	225	241
Date FAST completed and uploaded	5%	24%
Mental health issue identified? Y/N	36%	53%
CSED application made? Y/N	36%	50%
CSED application date (for cases with a CSED application)	78%	92%

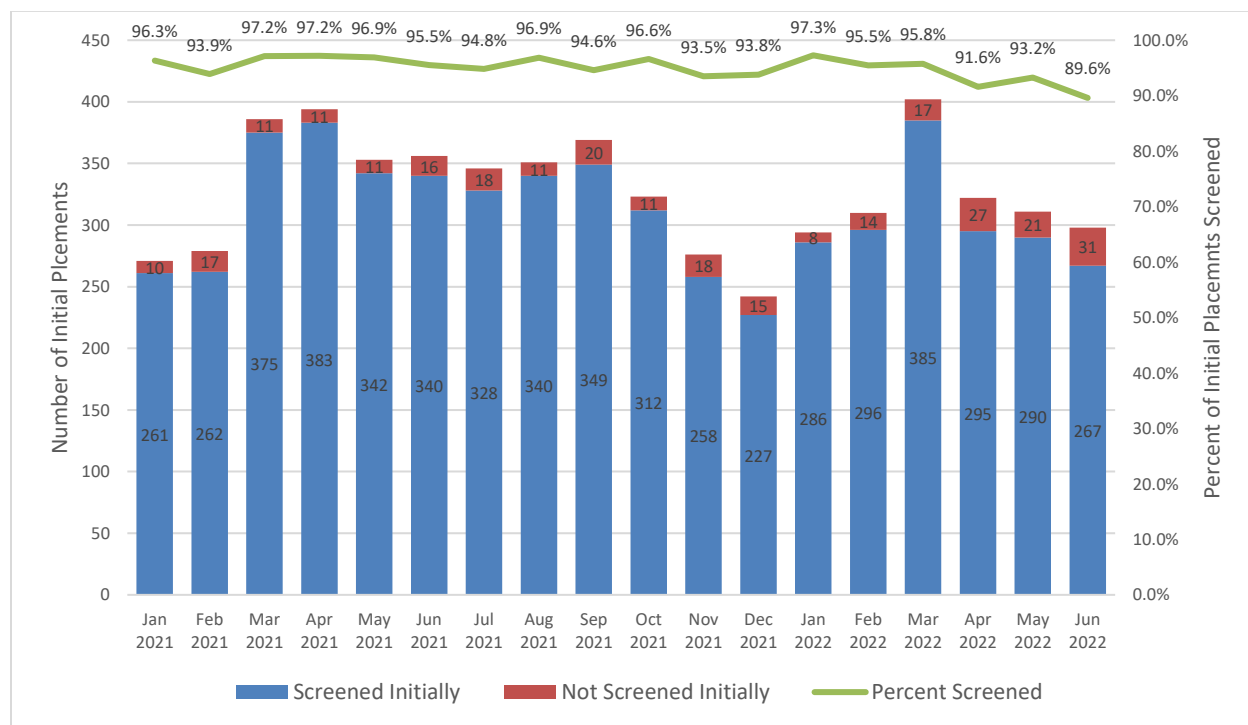
The Office of QA is actively collaborating with the YS teams to identify and make improvements to the data collection tool, including the use of automation to flag missing data and identify required fields. A pilot of the new data collection tool was initiated with Cabell County in mid-December 2022. Contingent on results of the pilot, a broader rollout to additional counties is anticipated for early to mid-2023.

Child Protective Services

CPS staff utilize the ongoing assessment to assess ongoing case needs for both children monitored in-home and those placed with CPS (i.e., foster care). In addition to this, it is required that all children placed with CPS receive an EPSDT screening during a well-child visit, which includes mental health screening, within 30 days of placement with CPS. EPSDT providers are trained to provide referrals to the Assessment Pathway. Figure 14 shows monthly initial screening rates for children placed with CPS. On average for the 18-month period shown, 95% of children were screened upon initial placement. As previously noted, the Fostering Healthy

Kids data system is a subset of FACTS data and does not include child exit date; therefore, at this time it is unclear if individuals who were not screened had sufficient time to have an EPSDT screening during a well-child visit before exiting placement. Enhancements with WV PATH and the data store build-out will help better understand unscreened youth in CPS. Considerations for data lag in reported screenings are still being assessed.

Figure 14: Initial Placements and Screenings by Month, January 2021 – June 2022



Initial screenings for youth in CPS placement (initial placement 2021) were assessed by age. Figure 15 indicated children ages 0 – 5 had the highest screening rates (98%) compared to 9 – 18-year-old children with slightly lower screening rates (96%). As noted, the Fostering Healthy Kids data system is a subset of FACTS data and does not include child exit date. This makes it unclear if an individual was in placement long enough for screening to occur or be required (policy states screenings should be completed within 30 days of placement). Additional analysis following enhanced data availability will allow DHHR to determine additional screening needs versus consideration for CPS placement exit date before screening was completed. It will also be important to help ensure unscreened youth have screening opportunities through other avenues. This can be assessed through future cross-systems utilization analysis.

Figure 15: Initial Screenings for Placements in 2021 by Age Group

Age Group at Initial Screening	Screened Initially (n)	Screened Initially (%)	Not Screened Initially (n)	Not Screened Initially (%)	Total
0 to 5	1812	97.8%	41	2.2%	1853
6 to 8	481	96.2%	19	3.8%	500
9 to 18	1,483	95.8%	65	4.2%	1548
Other/Unknown	1	2.2%	44	97.8%	45
Total	3,777	95.7%	169	4.3%	3946

DHHR, which includes CPS and YS referrals, is identified as the referral source for over 50% of CSED Waiver applications submitted to Kepro for the period January – June 2022 which shows strong evidence that children are being referred to the Assessment Pathway for further evaluation and connection to services. As data collection improves through the efforts identified above, additional details such as the number of children screened, those who screen positive, and those referred to the Assessment Pathway are anticipated for inclusion in future semiannual reports.

7.2(c) BJS Screening

BJS involved children are screened at intake and each time they transition within BJS facilities. Figure 16 below captures screening for children in the custody of the BJS for the period January – October 2022. The total population¹¹ of children in BJS custody varies over time, and ranged from 221 to 265 with an average of 235 for the period shown. The number of intakes per month varied over time with a range from 69 – 110 and an average of 91 for the period shown. More data is needed to understand fluctuations in the population and number of intakes over time.

Unique screenings varied throughout the period with a low of 91 in August and a high in March of 132. There was an average of 105 unique screenings per month. The number of screenings per month should equal or exceed the number of intakes per month because each child entering BJS custody should be screened at intake. The number of unique screenings per month exceeded the number of intakes for seven of the 10 months represented with the exceptions occurring in May, September, and October. This is a positive sign indicating that screenings are taking place as expected. The Office of QA continues to meet routinely with BJS to better understand the data and work toward quality improvement. A follow-up meeting is scheduled for early 2023 to establish a process for recurring review of the screening data by BJS facility supervisors in order to continue making improvements in screening. BJS and the Office of QA have identified breaking down the number of intakes and screenings by facility as a next step in the data analysis and reporting.

Of those screened, the age demographics were consistent with those in residential services,

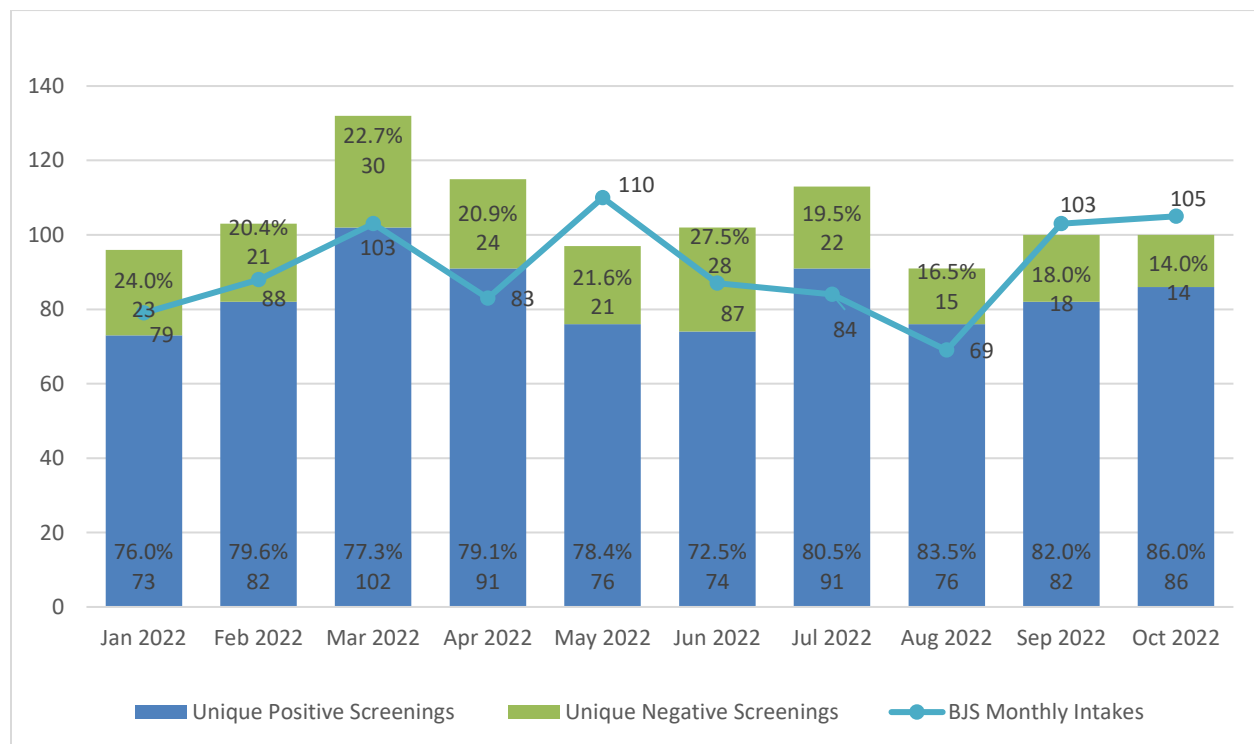
¹¹ BJS population data are a point-in-time measure captured on the last day of each month and does not represent the number of unique children in BJS custody during a given month.

with 88% of individuals screened ages 13 – 17.

The percentage of positive unique screenings remained relatively consistent during the reporting period, ranging from a low of 72.5% in June and a high of 86.0% in October. In total for January – October 2022, 662 of the 777 unique children screened had a positive screen (85.2%).

BJS collaborated with BMS in late 2022 to establish a process for making referrals to the Assessment Pathway for children in BJS custody who screen positive. The goal is to determine eligibility for services in advance of a youth’s release from BJS custody and establish a smooth transition into services following discharge from BJS. While process logistics are still in progress, BJS began making limited referrals to the Assessment Pathway in the fourth quarter of 2022. DHHR will coordinate with Kepro on updating data collection to include BJS as a referral source to allow quantification of these referrals for future reporting.

Figure 16: BJS MAYSI-2 Mental Health Screenings, January – October 2022



7.2(d) Division of Probation Services Screening

Screening of children adjudicated as status offenders or delinquent and the associated data collection was implemented by the Division of Probation Services effective March 1, 2022. These screenings are conducted at intake by the assigned probation officer. Screening may also be conducted at other intervals based on the probation officer’s discretion. From March –

October 2022, a total of 277 children were screened. Intakes¹² completed from March – October 2022 varied from a low of 179 in July to a high of 977 in March with an average of 431 intakes per month. For this same period, the number of children adjudicated ranged from a low of 88 in September to a high of 200 in March with an average of 139 children adjudicated per month. The month-end population of children on formal probation (i.e., adjudicated as status offenders or delinquent) for the March – October 2022 period varied from a low of 1,062 to a high of 1,138 with an average of 1,087. DHHR will continue to work with Probation Services to identify trends in the youth interacting with Probation Services and number of screenings expected.

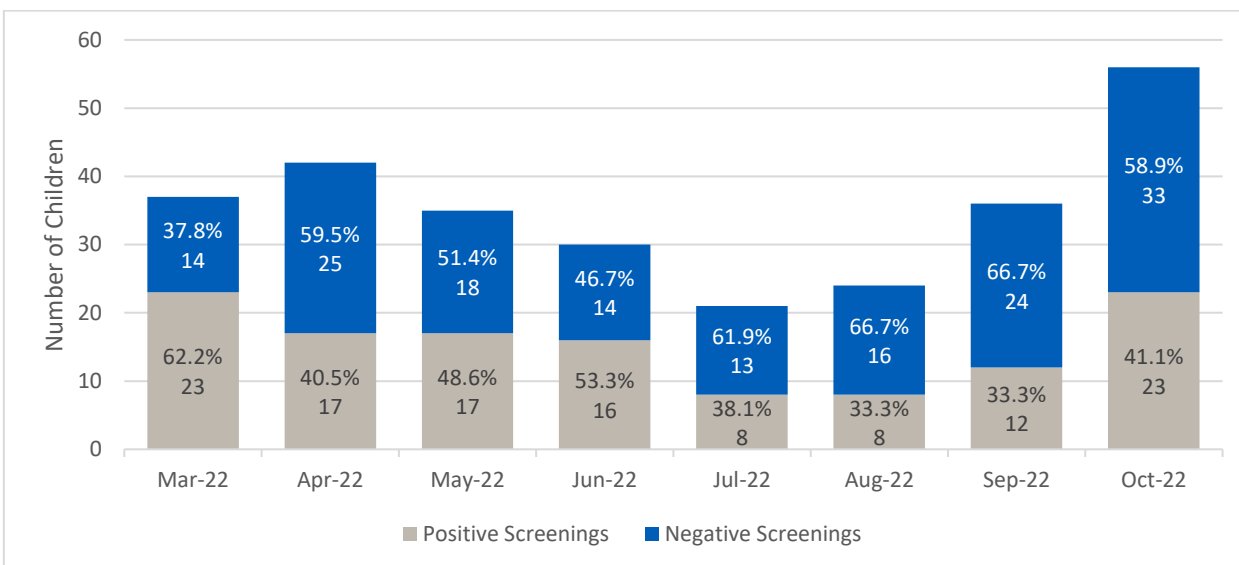
Given this early implementation stage, the screening and referral process is still being adopted across the state and is not considered representative of the total screenings anticipated once the process is fully adopted. The data in this section is representative of 27 counties in WV. This represents a significant increase over the 11 counties represented in the prior reporting period.

To improve screening rates, additional education was provided to probation officers at their October 2022 conference, including describing the importance of and process for screening and referral and sharing specific county-level data. Additionally, the monthly probation screening report with data through November 2022 was forwarded to the respective chief probation officers for counties with no or limited screening and referral rates with a request to share the data with their teams.

Figure 17 shows the number of screenings of children in Probation Services for the 27 counties that submitted data for March through October 2022. Two hundred eighty-one (281) screenings were conducted during the reporting period with an average of 35 screenings per month. Of those screened, 63% identified as male and 37% as female. Of the individuals screened, 93.5% were 13 – 17 years old and 6% were 9 – 12 years old. These demographics are consistent with the prior reporting period and somewhat aligned with those of children in RMHTFs. Of those children screened for the period, 124 children (44.1%) had a positive screening while 157 children (55.9%) had a negative screening.

¹² Intakes during each month do not necessarily equate to children who are adjudicated as status offenders or delinquent because adjudication may occur subsequent to intake and may not fall within the same month.

Figure 17: Probation Services MAYSI-2 Screenings, March – October 2022



Of the 124 children who screened positive, 74 (60%) completed an application and were referred to the Assessment Pathway for further evaluation. Referrals to the Assessment Pathway are down from the prior reporting period (March – April 2022), which indicated 85% of children screening positive were referred to the Assessment Pathway for further evaluation. The reason for not completing a referral to the Assessment Pathway was incomplete for a significant number of cases. Following discussion with the probation team, a standardized drop down will be created to capture the reason a child is not referred to the Assessment Pathway and incorporated into future data collection. In those cases where data was provided, some caregivers believed their child was already accessing adequate services, others wanted to take the application home for consideration, and some indicated another entity had already made the referral (e.g., Youth Services).

To support early intervention for children who may pose a higher risk, following a discussion between Probation Services and BSS leadership, the decision was made to update the Probation Services policy to incorporate screening of pre-adjudicatory youth in those cases where a youth does not currently have a BSS worker assigned and in cases where the probation officer believes the youth may be a danger to themselves or others. This policy change became effective November 1, 2022.

Effective February 2023, recurring quarterly reviews have been scheduled to review and evaluate Probation Services screening and referral data at the county level. Quarterly reports will be shared with the chief probation officers to assist with making continued improvements at the county level.

7.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing an EPSDT with a mental health screening, outreach to primary care providers about the Assessment Pathway started in November 2021, and all EPDST clinics (approximately 659 clinics) were trained by November

2022 on the CCRL (including CMCRS services), and the provider electronic referral process. Resources were distributed to all sites. As previously described, enhancement of material and training for screening and referral efforts are planned for early 2023.

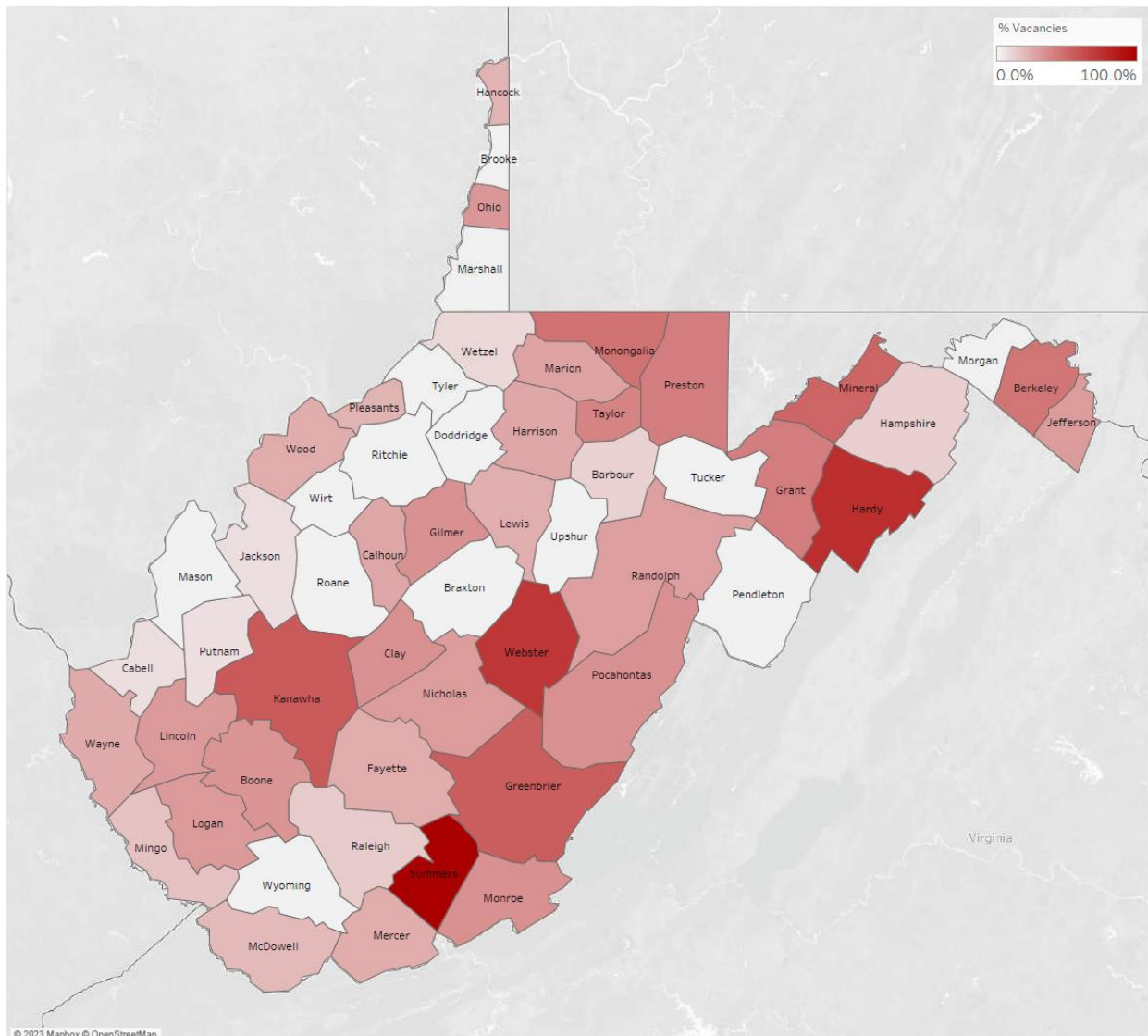
Child welfare position vacancies continue to be a concern for effectively implementing screening and maintaining trained staff. As of January 2023, 6,154 children were in the Child Welfare System, with 635 youth indicated as a YS case and 5,519 youth listed as a CPS case. As of December 2022, 72% of child welfare workforce positions were filled which includes CPS and YS workers, supervisors, and coordinators. Figure 18 shows the vacancies by service type, and Figure 19 provides data on vacancy by judicial district. Vacancies are reviewed at the district level to better understand the impact on screening and referral of children to the Assessment Pathway. Additional discussion involved identifying areas of focus for recruitment efforts and to discuss what is working well for counties able to retain staff. Several strategies have been implemented to improve vacancy rates, capacity needs, and staff retention. DHHR has added 48 CPS positions since 2018 and increased workers' salaries, with an additional 20% increase effective July 2022.

Figure 18: Child Welfare Workforce January 2022

Workforce in this context includes CPS and YS workers, supervisors, and coordinators.

Service Type	Positions Filled	Positions Vacant	Total Positions	Percent of Positions Filled
CPS	484	169	653	74%
YS	91	48	139	65%
Total	575	217	792	73%

Figure 19: Social Service Position¹³ Vacancies by Judicial District – January 2022



DHHR will continue to monitor screening rates over time and assess any additional needs related to training or staffing capacity with each entity as needed.

7.4 Strengths, Opportunities, Barriers, and Next Steps

Data collection associated with screening has been established across all screening entities and continues to progress toward full implementation and adoption across the state. Given the high percentages of positive screens across well-child visits, BJS, and probation-involved children, DHHR is collaborating with the ASO to help ensure it is prepared to handle the continued increase in referrals that is projected.

¹³ Social Service Positions in this context includes CPS and YS workers, supervisors, and coordinators.

As noted in the July 2022 report, the Preventative Health Screening form was enhanced to collect additional measures related to identification of SED in the fourth quarter of 2021. The updated form continues to be included in outreach to providers and regular site visits. A plan to expand training and prioritize technical assistance with EPSDT providers, regarding the Assessment Pathway to Children’s Mental Health services, will be implemented in early 2023, making training available to all providers. Prioritized providers and regions will be based on a survey conducted in the fall of 2022, which assessed provider perspectives and preferences on mental health referral processes. EPSDT screening and referrals are also part of the process to screen foster children placed with CPS. DHHR will continue to review primary care provider JotForm submissions to determine effective use of the referral system and implementation of training and technical assistance activities. The MCOs will continue provider trainings and outreach to families to encourage wellness visits and screenings. DHHR will begin quality related capitation withhold measures regarding screenings for calendar year 2023 to encourage the MCOs to focus on and improve screening rates. Effective July 2023, the MCOs will begin new reporting to provide more extensive information related to child screenings. BMS determined it is not feasible at this time to implement a procedure code modifier to be utilized for EPSDT screening claims to indicate whether the screening is positive or negative; however, additional indicators will be explored through cross-systems utilization analysis and the data store build-out to more adequately assess screening related strengths and opportunities.

BJS screening data indicates the screening process has been effectively implemented on an aggregate basis across the state with referrals to the Assessment Pathway initiated in the fourth quarter of 2022. Next steps include continued monitoring to help ensure referrals are occurring for children who screen positive, analysis and reporting of data at the facility level, and to work out the logistics to help ensure a smooth transition for eligible children into CSED Waiver services upon discharge from BJS. Given the high rates of positive screens for children in BJS custody, this connection to CSED Waiver services is a critical component for their success in the community.

Probation Services made positive strides in the adoption of the screening and referral process with the number of counties reporting screening more than doubling (i.e., 27 counties compared to 11 counties in the prior period). Additionally, the probation policy was updated to include screening of pre-adjudicatory youth. Key next steps include routine review of screening results with chief probation officers and technical assistance as needed to support continued implementation of the screening and referral process across more counties. Additionally, the chief probation officers requested that future reporting include the number of children screened and referred who subsequently access CSED Waiver services. DHHR will work to make this reporting available following further build-out of the data store so probation officers supporting these youth see the outcome of their efforts to connect youth to services.

Workforce shortages in WV’s CPS and YS are similar to child welfare workforce shortages nationally, which creates an ongoing barrier in helping to ensure children entering CPS and YS receive timely screening and referral to the Assessment Pathway. Recruitment, training, and technical assistance must be ongoing to meet these needs. DHHR is also implementing additional workforce recruitment and retention incentives in 2023.

Data completion, quality, review, and technical assistance will be key in continuing to enhance screening at multiple entry points. The data store will also help DHHR better understand the child and family journey and opportunities and strengths in the current system as it is built out. Screening and referral to the Assessment Pathway continues to be a strength in DHHR's updated processes and efforts to help ensure children with mental health needs are evaluated and connected with services to help them remain in their homes and communities.

8.0 Pathway to Children's Mental Health Services

WV continues to improve access to and quality of mental health services through the implementation of the Pathway to Children's Mental Health Services (Assessment Pathway). The Assessment Pathway emphasizes in-home and community-based services for children with SED or youth up to age 21 with SMI. The Assessment Pathway comprises multiple initiatives, including the following:

- Screening (as outlined previously)
- WV Wraparound, which includes and extends to CSED Waiver
- CMCRS
- CCRL
- Connection to HCBS
- BSS programs and services (for youth interacting with CPS or YS)
- Engagement with the judicial system via the Court Improvement Program
- RMHTF Discharge Planning

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 appropriate linkages to services while the assessment process is being completed, as well as 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 home- and community-based services appropriate for their needs, including CSED Waiver services for those who are eligible.

The Assessment Pathway is designed to:

- Streamline behavioral and mental health referral and service provision for children and families.
- Connect children and families to WV Wraparound and other in-home or community-based services.
- Aid families with the CSED Waiver application process.
- Through a county-by-county rollout schedule, which will be completed by May 2023 for individuals who are involved with BSS and are not currently placed in an RMHTF, individuals at immediate risk of RMHTF placement will have a QIA to determine if the youth needs a higher level of behavioral healthcare than can be provided in the home or community.

Because children can access the behavioral health service system via multiple avenues, DHHR has implemented a “no wrong door” approach to the pathway.

8.1 Review Period, Data Sources and Limitations, Population Measured

Figure 20 provides an overview of the Assessment Pathway referral data.

Figure 20: Assessment Pathway Data Overview

	Data Review Period	Data Source	Limitations	Population Measured
Assessment Pathway – Referrals facilitated through BBH and the CCRL, as well as referrals for connection to interim services originating with the ASO	January 1, 2022 – June 30, 2022	BBH Assessment Pathway Tracking Portal	<p>The portal is a standalone site that allows monitoring of progress but will need to be connected to other data via the data store.</p> <p>Timeliness indicators are calculated using weekdays.</p> <p>Data collection procedures are still being refined and, consequently, some indicators may have a large percentage of missing values but have shown improvement over the recent implementation period.</p> <p>Content and format of future reports, including specific indicators and/or indicator definitions, may change, potentially creating difficulties when comparing reports over time.</p>	<p>Number of referrals to BBH and the CCRL.</p> <p>Referrals to BBH include referrals for interim services from the CCRL, CMCRS teams, and the ASO for children applying directly for the CSED Waiver who are not involved with BSS.</p>
Assessment Pathway – Referrals made directly to the ASO	For CSED data, see the CSED Waiver Enrollment and Services Section which includes referrals by type (e.g., DHHR, parent). As the data store is built out further, data will be able to be aggregated across provider sources to develop a larger picture of connection to mental health assessment and related services in WV.			

8.2 Review Summary

BBH implemented the Assessment Pathway Tracking Portal on January 1, 2022, as a means of data collection associated with the early stages of the Assessment Pathway. The results presented in this section correspond to 447 children referred in January – June 2022. Some figures include a subset of these children, and the number of children included in those figures has been noted accordingly.

The Quality Committee reviewed county-level coverage to assess opportunities for outreach (Figure 21). The county-level Assessment Pathway referral rates were reviewed per 1,000 children; counties with the highest rates are Hardy (2.9 per 1,000 children) and Fayette (2.6 per 1,000 children)—the same two counties with the highest rates in January – March 2022. The counties with the highest number of referrals are Kanawha (n=45, 10.1% of all referrals), Cabell (n=37, 8.3%), Berkeley (n=28, 6.3%), and Fayette (n=26, 5.8%) The counties with the most referrals during January – June 2022 are similar to those in the previous reporting period, given these counties include many of the state’s population centers this number of referrals is to be expected. Seventeen counties had no referrals submitted as of March 2022; however, an additional nine counties submitted referrals between April – June 2022, indicating the success of expanded outreach efforts. Only eight counties had no referrals submitted during the reporting period. Assessment Pathway referrals will be an important consideration in the analysis planned for early 2023 to assess county-level prioritization.

Figure 21: County-Level Assessment Pathway Referrals, January – June 2022

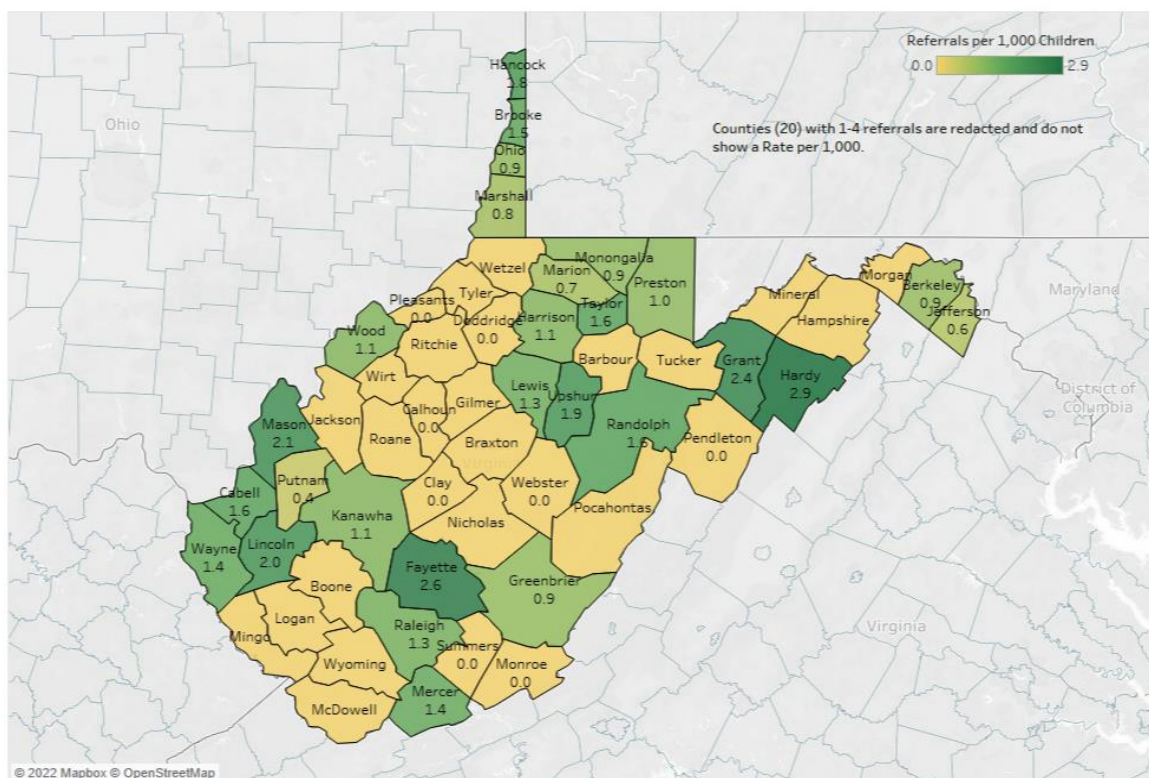


Figure 22 depicts the number of referrals by month. Referrals increased month-over-month from January to April 2022, from a low of 37 (8% of all referrals) in January, to a high of 108 (24%) in April. Referrals dropped to 65 in May but then increased again to 81 in June. In recent internal data reviews, DHHR continues to note increases in referrals in alignment with the school year starting. These trends are encouraging and suggest expanding awareness among professionals and in communities of the Assessment Pathway.

Figure 22: Referrals by Month, January – June 2022

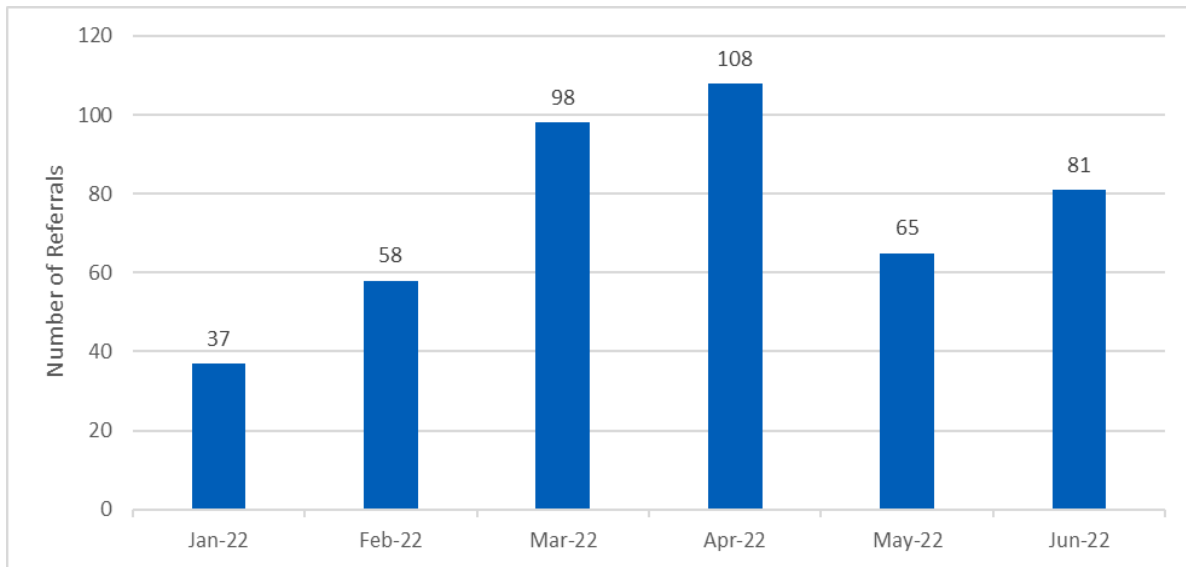
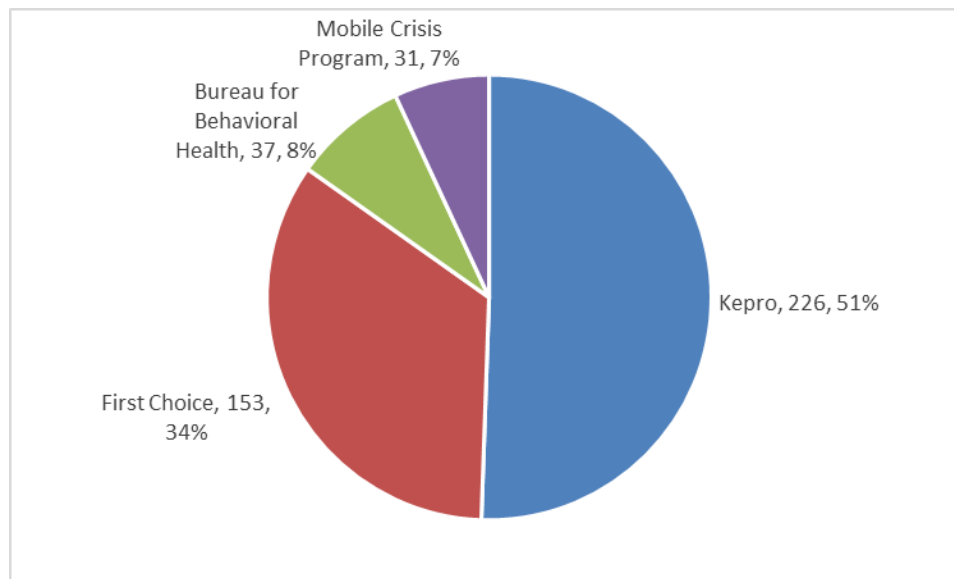


Figure 23 shows the breakdown of referrals by the source of the call/initial referral. The largest source of referrals to the Assessment Pathway-interim services was from Kepro, the ASO (n=226, 51%), followed by First Choice, the CCRL (n=153, 34%).

Figure 23: Source of Call or Initial Referral, January – June 2022



8.2(a) Timeliness Indicators

DHHR tracks timeliness measures in four key steps for quality improvement purposes related to the Assessment Pathway process for interim services.¹⁴ This section presents the timeliness values for each of these steps and compares the actual values to the target timelines as outlined in policy. These timeliness measures are helpful in assessing families' experience in accessing services. DHHR will continue to monitor these indicators closely as this work is still in the early implementation stage, and it is unclear if timeliness has normalized for the following steps:

1. BBH makes initial contact with family following receipt of referral from CCRL, CMCR, or other sources.
 - a. Target: Within five weekdays¹⁵
 - b. Actual Average: 2.1 weekdays
 - c. Eighty-four percent of referrals were contacted within 5 weekdays.
2. If the child has not applied for the CSED Waiver, BBH works with the family to complete the CSED Waiver application and submit the application to the ASO (excluding children declining, failing to respond, or who have already had an application submitted to the ASO and are being referred only for connection to interim services).
 - a. A target is not established but instead is driven by the needs of the family.
 - b. Actual Average: 8.6 weekdays (excluding children with missing data or still gathering materials, which represents 20% of children's records) with 58% of children's applications submitted in 10 days or less.
3. The ASO receives a CSED Waiver application (from BBH, BSS, or directly from families), completes the CAFAS/PECFAS, and reports results to BBH.
 - a. Target: Within four weekdays
 - b. Actual Average: 6.7 weekdays; note: this average is based on 74% of referrals, as this data was not collected until May 2022 and could not always be retrospectively added. Greater data availability is expected in future reports. Although this average exceeds the target for completing and returning CAFAS/PECFAS results, the turnaround time was found to be encouraging given

¹⁴ Note that clients failing to respond to BBH's contact attempts, and clients declining further participation, are not included in analysis past Step 1, while referrals made by the ASO bypass Steps 1 – 3 and begin the Assessment Pathway process at Step 4.

¹⁵ Weekdays include nonweekend days, Monday through Friday. Some delays may occur due to state holidays when staff are unavailable; however, these are not expected to have a high impact on time to contact.

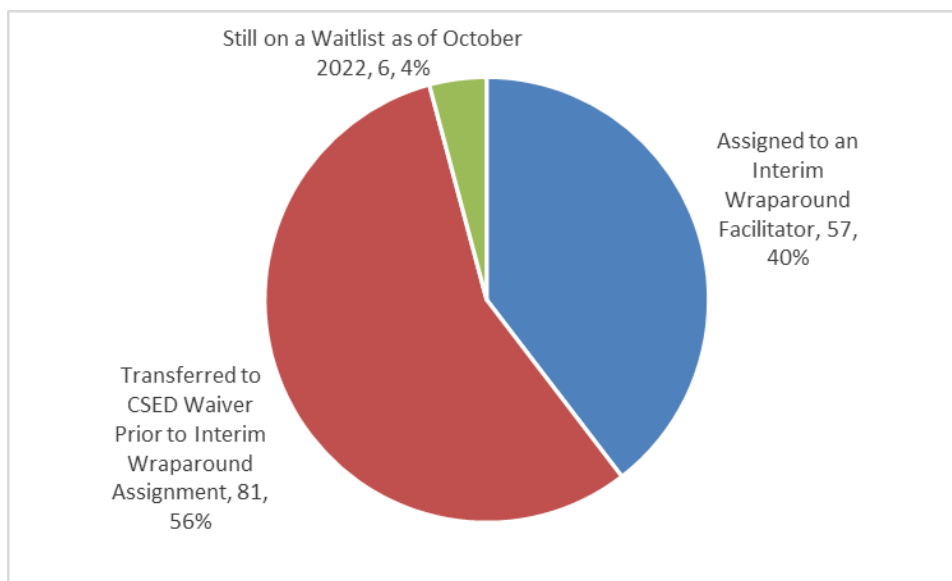
the increasing referral rate. This measure will continue to be monitored in coordination with monthly referrals to help ensure the ASO has adequate staffing to meet current demands.

4. BBH assigns the Wraparound Facilitator agency for interim WV Wraparound services if the child is not already receiving Wraparound services.¹⁶
 - a. Target: Within five weekdays
 - b. Actual Average: 9.2 weekdays; 35% occurred within five weekdays
 - i. For children not placed on a waitlist (n=114¹⁷), the average time to assignment was 2.4 weekdays.
 - ii. On average, children put on the waitlist were assigned to a facilitator in 30 weekdays.
 - iii. For children placed on the waitlist (n=144), as shown in Figure 24 below, 40% were assigned to an interim Wraparound Facilitator with an average of 20 weekdays to assignment, while 56% were transferred to CSED Waiver prior to assignment with an average wait of 35 weekdays until transfer. As of October 2022, 4% of children (n=6) remained on the waitlist.

¹⁶ Due to the nature of the Assessment Pathway allowing a “no wrong door” approach, this indicator had to be calculated using different date fields that captured the same intended timeline. For children referred by the ASO (n=174), this indicator is the number of weekdays between “Date of Referral” and “Date Assigned to Agency (Wraparound tracking),” as children referred by the ASO bypass Steps 1 – 3 for data collection in the portal, allowing BBH to begin the assignment of the Wraparound Facilitator immediately upon receiving the referral. For children referred by other entities (n=82), this indicator is the number of weekdays between “Date Initial Determination Received from ASO” and “Date Assigned to Agency (Wraparound tracking).” The ASO has up to four weekdays to process applications they receive from BBH before sending CAFAS/PECFAS scores back to BBH to begin the assignment process. Previously, this timeline had to be approximated, as BBH was not collecting the date they received this information from the ASO; however, more accurate timelines are now available due to the addition of the “Date Initial Determination Received from ASO” field in the Portal.

¹⁷ Note: Though 114 children were not placed on a waitlist, data needed to calculate time to assignment was only available for 91 children.

Figure 24: Connection to Wraparound Facilitator Waitlist Status, January – June 2022



DHHR continues to monitor timeliness to assignment to a Wraparound Facilitator closely. The increased timeline to connection to a facilitator is due to increased service demands and some provider capacity limitations. Children on the waitlist are included in this average. During the application process, and for any child placed on the waitlist, the youth and their family are connected to other interim services and supports, including a regional family coordinator and their local Mobile Crisis Response and Stabilization team. A triage process has also been implemented to help ensure families in critical need are connected and prioritized appropriately.

8.2(b) Overall: From Referral to Assignment to a Wraparound Facilitator – A Family’s Perspective (Calendar Days)

Children referred to BBH between January – June 2022 upon initial referral, supported with completing the waiver application, and assigned a Wraparound Facilitator (n=61), took an average of 30 days to assignment of a Wraparound Facilitator, with 57% completing the process and being connected to a facilitator in less than 30 days. This average includes individuals who were on a waitlist prior to connection to a facilitator.

The family is connected to other services and supports during this process; therefore, this timeline is not representative of the time to connection to *any* service or support. Families are connected to the CCRL in as quickly as 14 seconds with availability of immediate warm transfer to a mobile response team during the call. As noted above, BBH is typically in contact with the family and connecting them with additional services and support within about two weekdays of referral. The family coordinator can then be there for the family throughout the process.

This summary may be a more realistic representation of the process for families; there may be some additional time needed in the beginning, during the application material collection phase, including potential delays due to family responsiveness. This step in the process was not captured in the steps above for individuals whose applications went directly to the ASO due to

differences in processes and data collection. This process needs to be better understood from multiple entry points at both the material gathering and ASO assessment phases to identify opportunities for improvement. Future connection of data within the data store build-out is also expected to bridge gaps in understanding opportunities to improve timeliness to connection to services.

8.2(c) Summary of Progression Through the Assessment Pathway

Figure 25 summarizes the number of children who have progressed through each step of the Assessment Pathway. 120 children (26.9% in all) did not participate because their families either failed to respond after multiple attempts (15.0%) or declined further participation (11.9%), 59 children (13.2%) were denied due to ineligibility for the CSED Waiver, nine children were still gathering application materials, and 256 children (57.3%) were approved (either preliminary or final approval) for the CSED Waiver.

Additionally, as of July 1, 2022, the CSED Waiver program was updated to remove income limitations, and BBH has begun a retrospective review of cases previously closed due to income. All families have been contacted for youth meeting BBH-funded clinical-need criteria to offer the family the opportunity to apply for CSED Waiver services. Nine children were listed as still gathering materials at the time of review; policy has been implemented to help prevent this in the future by encouraging families to complete applications in a timely manner and establishing appropriate time frames for returning materials or closing out the application until the family is ready to proceed.

Figure 25: Progression Through the Assessment Pathway, January – June 2022 (n=447)

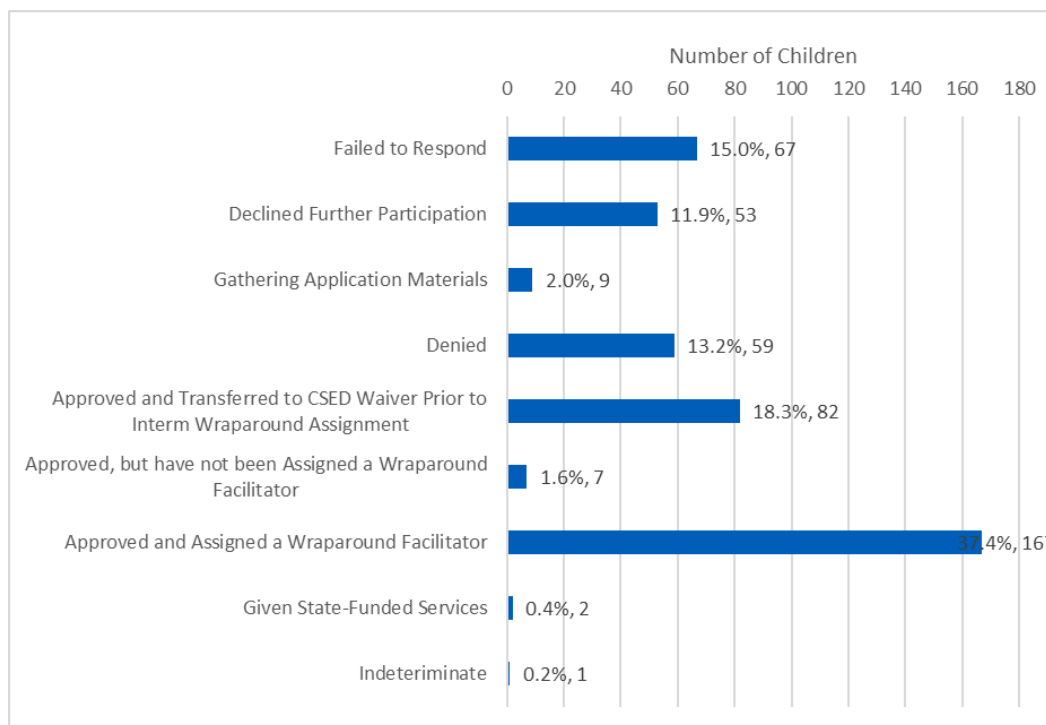
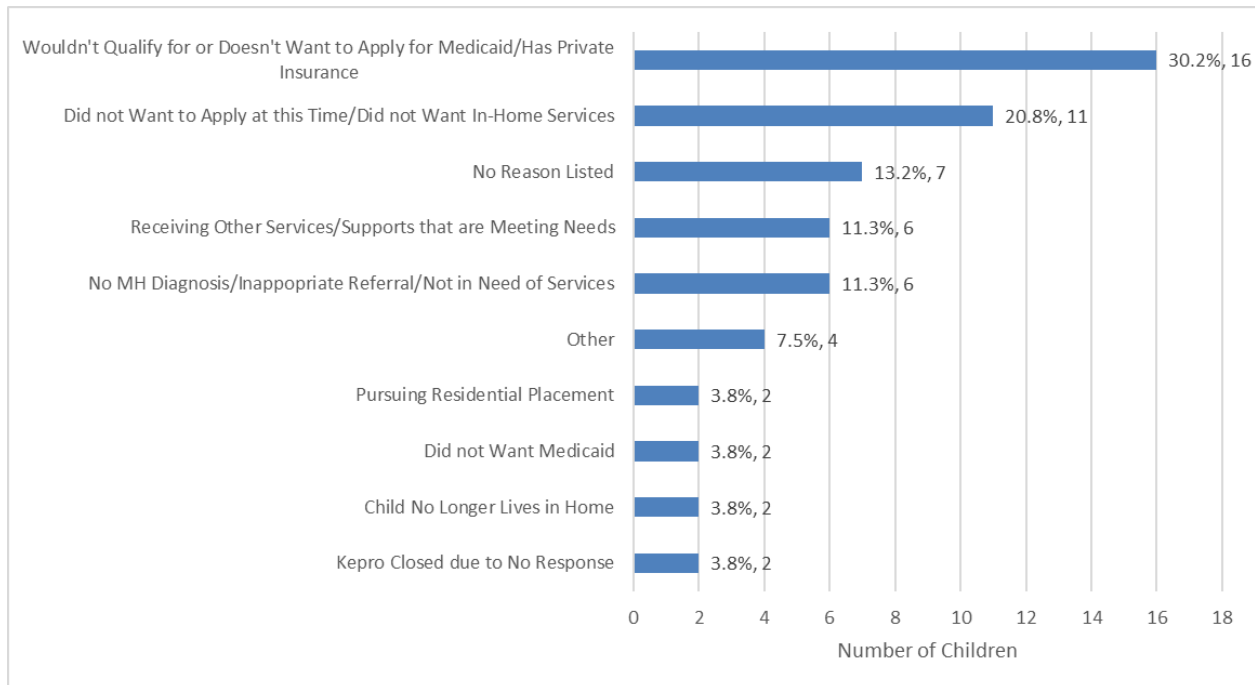


Figure 26 depicts the reasons provided by the 53 families declining further participation. Percentages do not add to 100% because some families listed multiple reasons when they declined to participate further. The main reason to decline participation relates to (perceived) Medicaid/income eligibility (n=16, 30.2%). As of July 1, 2022, BMS expanded its policy to account for this identified need, allowing children who qualify to apply for Medicaid based on the child’s income, which would allow them to become income eligible. Seven children did not provide a reason. This was noted in quality reviews, and BBH will continue to expand attempts to collect this information when individuals decline referral.

Figure 26: Reasons for Declining Further Participation (n=53)



8.3 Provider Capacity/Statewide Coverage

Over the past two years, DHHR has emphasized building and expanding the capacity to provide statewide services. This is demonstrated by the enhancements in the number of providers and counties the programs serve. Training has been completed with the CCRL staff members, DHHR staff, and external partners to formalize processes, work toward implementation of the Assessment Pathway, and help ensure accuracy in data collection.

For the Assessment Pathway to be effective, statewide coverage of referring entities is needed as well as sufficient personnel at the provider level who accept and process referrals for Wraparound facilitation. In addition, the capacity of assessors (the ASO) to perform CAFAS/PECFAS in a timely manner is also critical to connecting families to timely services. In general, the initial phase of implementation focused on recruiting provider agencies to offer services. As referrals continue to grow, DHHR will continue to enhance activities that support providers and agencies in attracting and retaining adequate staffing. Additional information on provider capacity for services will be included in the respective service section.

Currently, BBH has five staff processing referrals and supervisory staff who act as reserve staff when large influxes of referrals come in. The new position added in early 2022 includes a focus on follow-up and quality assurance related to the Assessment Pathway, which has significantly improved data collection quality and reduced missing data, enhancing BBH's ability to help ensure youth are served in a timely manner. Of the staff processing referrals, two are family coordinators at agencies that work on behalf of BBH.

Provider capacity continues to be monitored closely, as referenced throughout this report. Additional review and analysis are being conducted to better understand workforce needs, including workforce shortages, high-intensity clients impacting expected ratios, and potential regional concerns.

8.4 Strengths, Opportunities, Barriers, and Next Steps

The Assessment Pathway is working as designed and has centralized and streamlined entry to services for families. The Assessment Pathway aids families in accessing interim services and other home- and community-based services to meet their needs while waiting for CSED Waiver determination. Increases in monthly referrals and referrals from most of the state's 55 counties were found to be an encouraging gauge of expanding awareness and the Assessment Pathway being an open door to families.

Another positive step in raising awareness of the Assessment Pathway and connecting families to services and resources in the latter part of 2022 was the creation and distribution of wallet cards. DHHR created these cards as an easy reference for families and providers who are referring families to get connected to the Assessment Pathway via the CCRL. Thousands of these cards have been distributed to primary care physicians and other stakeholders, including members of the Court Improvement Program. These cards have been well received with more requested.

Through the implementation of the Assessment Pathway portal, data collection and reporting on the Assessment Pathway has improved significantly over the last year. Focus remains on improving data completion and quality. To support this effort, BBH provides recurring training to entities utilizing the portal. Program staff review Assessment Pathway data reports quarterly at minimum, with referrals reviewed monthly and waitlist information reviewed at least weekly. This data is used to identify data collection enhancements and training and technical assistance needs.

A key next step for DHHR related to the Assessment Pathway is to enhance the tracking of interim services while children and families are awaiting eligibility determination for the CSED Waiver. Steps are in process to allow for collection of interim services information to include types of services and start and end dates. This data will be included in future reporting.

9.0 Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services

DHHR implemented the CSED Waiver effective March 1, 2020. The CSED Waiver provides additional services to Medicaid State Plan coverage for members ages 3 up to their 21st birthday who meet eligibility criteria. The CSED Waiver permits DHHR to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated this waiver will reduce the number of children placed in residential and other out-of-home placements. This waiver prioritizes children with SED who are:

- In Psychiatric Residential Treatment Facilities (PRTFs) or other residential facilities either in-state or out-of-state; and
- Other Medicaid-eligible children with SED who are at risk of institutionalization.

The CSED Waiver provides services to children with SED based on the NWI model. This model is strengths-based, meaning it uses the strengths of families and individuals as a starting point for growth and change, with a goal of helping waiver members and their families develop skills to cope with challenges and maintain stability in their homes. The model is centered on the needs of the child and their family. The child experiencing challenging behaviors is central to the process and engaged in a plan to help develop the skills necessary to achieve stability and improve coping strategies, ideally enabling the child to achieve their personal goals.

The following services are available under the CSED Waiver:

- | | |
|--------------------------------------|--|
| • Wraparound Facilitation | • Community Transition |
| • Mobile Response | • Family Therapy |
| • Independent Living/Skills Building | • In-Home and Out-of-Home Respite Care |
| • In-Home Family Support | • Peer Parent Support |
| • Job Development | • Non-Medical Transportation |
| • Individual Supportive Employment | • Specialized Therapy |
| • Assistive Equipment | |

DHHR contracts with Kepro, the ASO, to address program eligibility and enrollment. DHHR contracts with Aetna Mountain Health Promise, an MCO responsible for CSED service authorization and utilization.

9.1 Review Period, Data Sources and Limitations, Population Measured

The period reviewed is January – June 2022 with trends reviewed looking back to January 2021. CSED Waiver enrollment data is sourced from the ASO’s data systems. CSED service use is sourced from DW/DSS paid claims for services rendered January 2021 through June 2022 and paid through October 2022. WV Medicaid providers have up to 12 months from the date of service to submit claims; therefore, results for the more recent months in the analysis period may change over time as providers submit or adjust claims. The population measured includes children who may be eligible for the waiver and are going through the application process as well as children accessing CSED Waiver services during the review period.

9.2 Review Summary

The CSED Waiver is in its first two and a half years of operation, and BMS implemented significant policy changes to improve access beginning July 1, 2021; therefore, the data available cannot yet be assumed to reflect the routine and ongoing operation of the program. The COVID-19 pandemic also impacted service use during these early stages of the CSED Waiver implementation and continues to have some effect on services. Services are traditionally rendered in-person. Many families have continued to opt for services via telehealth when available or have put services on hold.

Enrollment in CSED Waiver services has increased significantly in the last 6-month period. This increase, combined with the well-known crisis of workforce in the behavioral healthcare sector, has resulted in the need to establish a waitlist for services in a minimal number of cases. DHHR is working with the MCO to formalize waitlist data collection and monitoring. The waitlist for Wraparound Facilitation and associated workforce/staffing is being managed through a joint collaboration between BBH and BMS that includes the following:

- Meeting weekly, or same day for urgent circumstances, to triage cases
- Assigning someone to follow up with the family
- Staffing cases with contractors and providers
- Use of telehealth where appropriate

The use of telehealth services will continue to be monitored and is being considered for permanent policy change. As of January 10, 2023, 9 youth were on the waitlist due to provider capacity.

9.2(a) CSED Waiver Applications and Enrollment

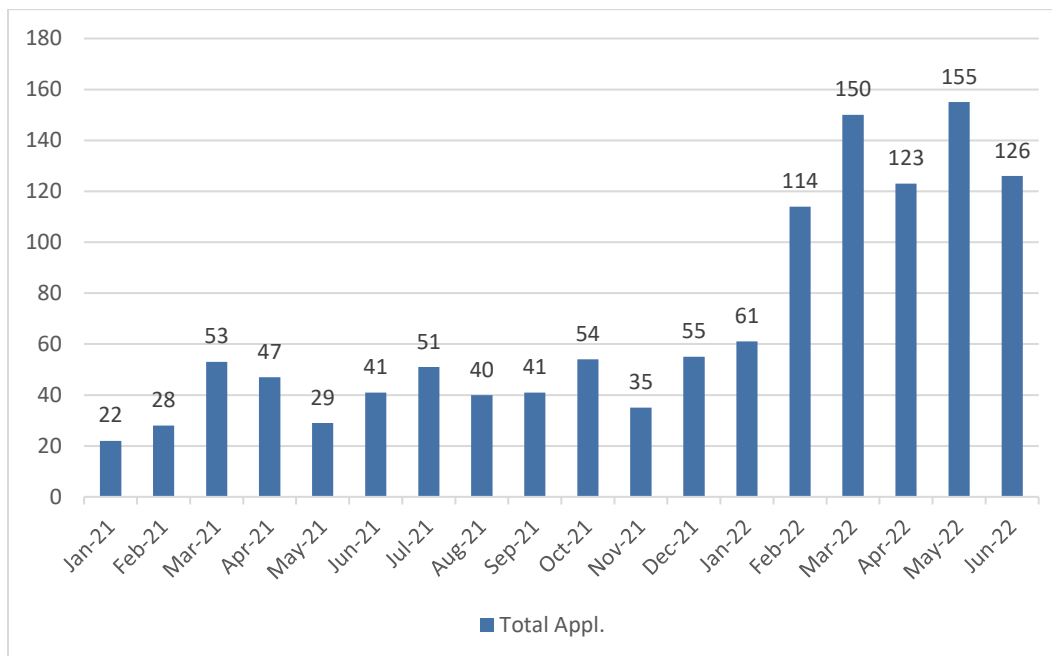
For the January – June 2022 period, Kepro, the ASO, reports the following for the CSED Waiver as of September 2022 reporting:

- 729 applications received
- 496 (68%) applications approved

- 59 (8%) applications denied¹⁸
- 160 (22%) applications closed¹⁹
- 14 (2%) applications pending²⁰

CSED Waiver application trends over the 18-month period, January 2021 – June 2022, are shown in Figure 27 below. Over two and a half times more applications were submitted for the period January – June 2022 compared to the July 2021 – December 2021 period. The increase in referrals is evidence of the improvements to screening and referral of children to the Assessment Pathway and the increasing awareness of the availability of these services.

Figure 27: CSED Waiver Applications by Month, January 2021 – June 2022



CAFAS/PECFAS scores for children going through the CSED Waiver eligibility process are shown in Figure 28 below. Ninety-five percent of children referred to Kepro have a CAFAS/PECFAS score greater than or equal to 90, which indicates the right children are being screened and referred to the Assessment Pathway.

¹⁸ Denials are based on one or more of the following: no eligible diagnosis or Basic Assessment System for Children (BASC) or CAFAS/PECFAS score did not meet eligibility criteria.

¹⁹ Applications are closed when families are non-responsive and in limited cases where families move out of state. Multiple contact attempts are made through a variety of mechanisms before cases are closed.

²⁰ At any point in time, there are a minimal number of pending applications, which represent applications that are actively in process while gathering documentation and scheduling appointments with families.

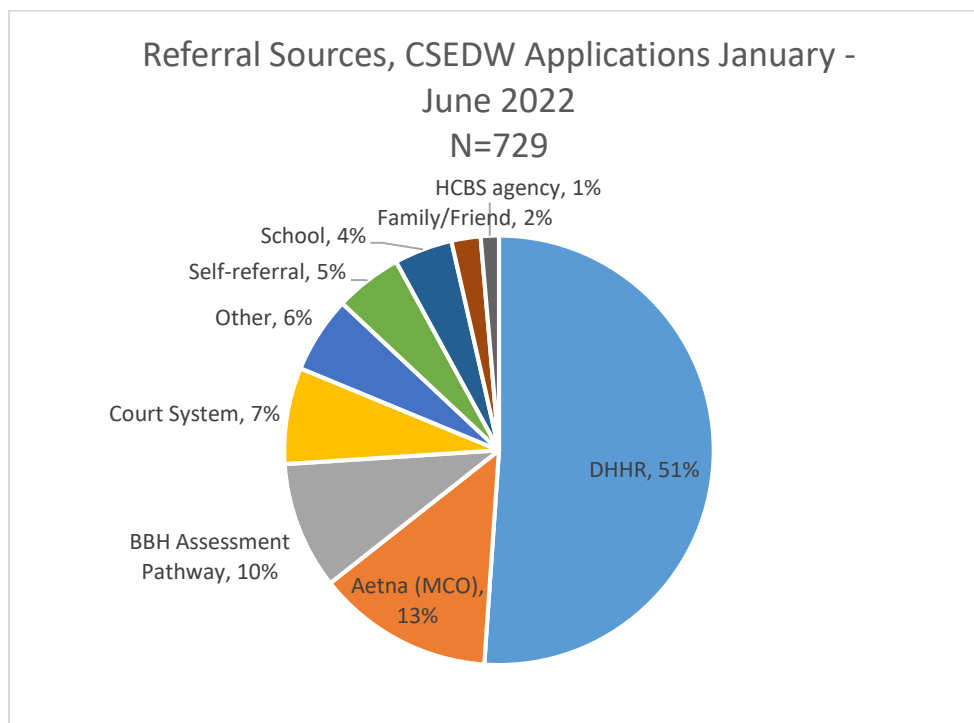
Figure 28: CSED Waiver Applications

CAFAS Score Range	Children	Percent
0-40	24	2.5%
50-80	23	2.4%
90-120	428	44.5%
130-160	384	39.9%
170+	103	10.7%
Total	962	100%

Figure 29 below depicts a new data set capturing the referral source for CSED Waiver applications submitted to Kepro. These referrals represent the varied points of entry through screening by entities engaging with children. Most referrals (51%) are coming through DHHR (CPS and YS) and others through Aetna (children ready for discharge from residential settings), the BBH Assessment Pathway, and court systems. This review process also identified that some of the referrals coming through the Assessment Pathway via BBH may be labeled as DHHR (general). Steps are being taken to improve data quality for this measure by modifying referral category options in the application data system to create more specificity.

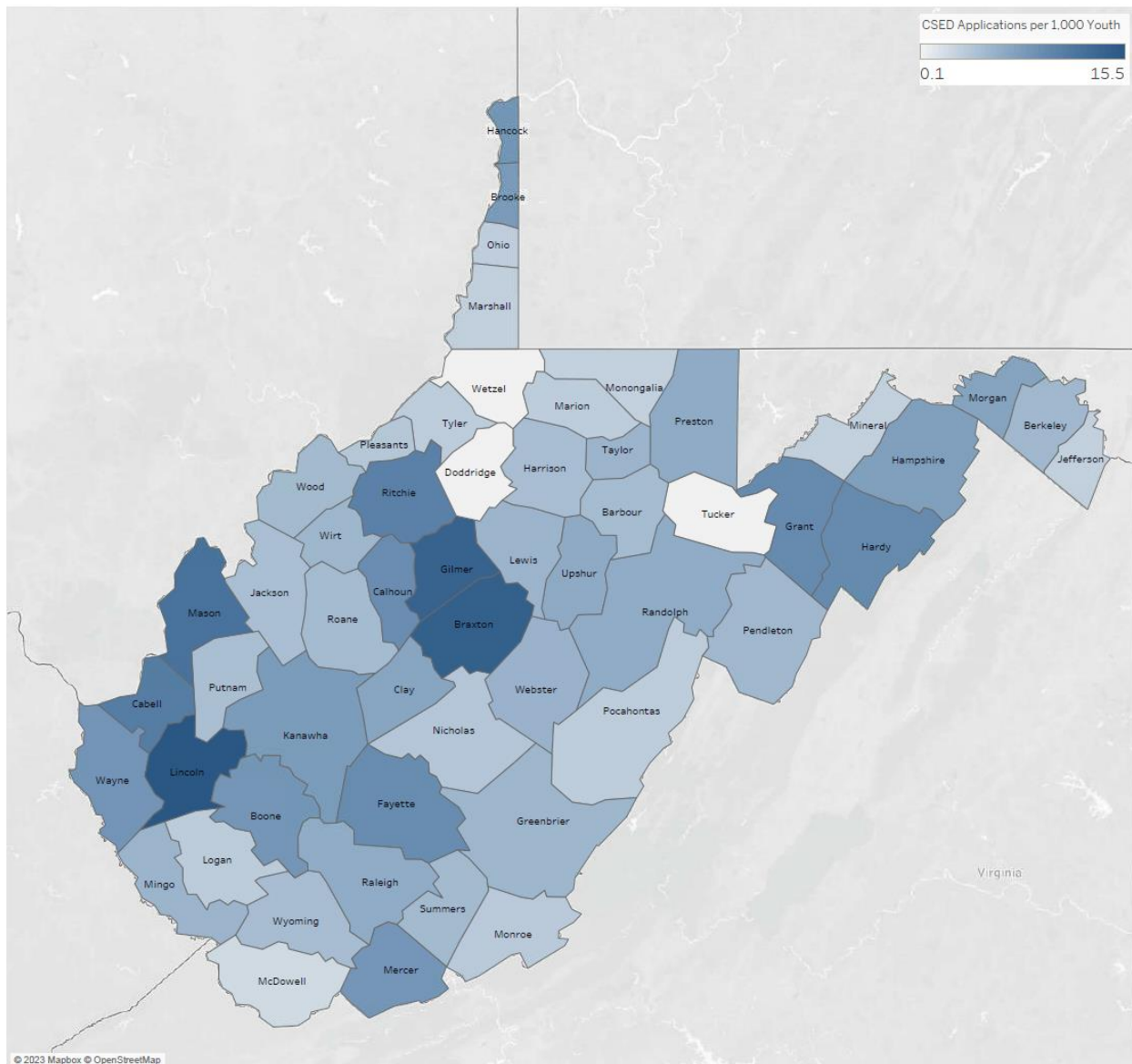
In the latter part of 2022, BJS began sending referrals to Kepro; this additional referral source is expected to appear in future reporting periods. Given recent collaboration with the WV Department of Education to increase awareness of the availability of these and other services through the CCRL and the Assessment Pathway, increased referrals from the school system are also expected. Schools will typically not make referrals directly but through the CCRL; therefore, additional enhancements to collection of referral source to the CCRL will be required to track such referrals.

Figure 29: CSED Waiver Referral Sources, January – June 2022



Since program inception, at least one application has been submitted from every county across the state, a positive sign of the messaging and awareness of CSED services statewide. Figure 30 captures the number of applications by county per 1,000 youth.

Figure 30: CSED Waiver Applications by County, Program Inception to December 2022



One of DHHR’s goals is timely access to services. After the data store is expanded to allow alignment of child-level data across systems, DHHR intends to measure and report the timeline from screening to eligibility determination. DHHR continues to monitor the timeline from receipt of the waiver application to eligibility determination. For the period January – June 2022, the timeline from receipt of the application to eligibility determination was an average of 42.3 days. As applications increased over two and a half times for this period compared to the July – December 2021 period, this represents an increase of 7 days compared to the prior period average of 35 days. Kepro and PC&A, the vendor managing the Independent Evaluator network, remain within the required 45-day eligibility determination timeline. To align with program growth and meet the increased demand within the required time frame, Kepro has hired multiple staff members to conduct CAFAS/PECFAS assessments. PC&A is also working to expand the network of Independent Evaluators, including seeking to add evaluators who can

offer in-person and telehealth appointments, to provide families more options to meet their needs.

9.2 (b) CSED Waiver Service Utilization

During the January – June 2022 period, 410 children accessed CSED Waiver services, excluding children with an independent evaluation only. An additional 315 children had paid claims for independent evaluations for the CSED Waiver but did not access any other waiver services.²¹ Children are commonly referred for eligibility determination for CSED Waiver services while they are in out-of-home placements, such as juvenile detention, shelters, RMHTFs, PRTFs, and the hospital, so they can transition more readily into HCBS services upon discharge from these settings. Eligibility determinations are valid for one year. Completing eligibility determination in advance assists with a timelier transition into CSED Waiver services upon discharge. Children completing the eligibility process and approved while in placements where they cannot access CSED Waiver services are then placed “on hold” for services. Since the last semiannual report, based on a recommendation from the Quality Committee, DHHR collaborated with the MCO to begin collecting data for children on hold. More details on children placed on hold are found later in this section.

As indicated in Figure 30, 46% of children utilizing the CSED Waiver had a CSED Waiver service claim associated with attention deficit hyperactivity disorder (ADHD) during the first half of 2022 out of 410 children utilizing services during the period (note that youth diagnosed with ADHD must have a comorbid or other primary SED diagnosis to be eligible for the CSED Waiver). Other common diagnoses associated with CSED Waiver claims were conduct disorder (41%), cyclothymia (22%), and post-traumatic stress disorder (PTSD, 17%).²² Please note that many children have multiple CSED Waiver claims reporting varying primary diagnosis; therefore, in Figure 30, the same child may be counted in multiple diagnosis columns (e.g., ADHD and conduct disorder). However, a given child is counted only once in each diagnosis column.

Seventy-nine percent of children with CSED Waiver services claims with a principal diagnosis of cyclothymia also have CSED Waiver claims with a different principal diagnosis, most commonly ADHD (51%) and Conduct Disorder (27%).

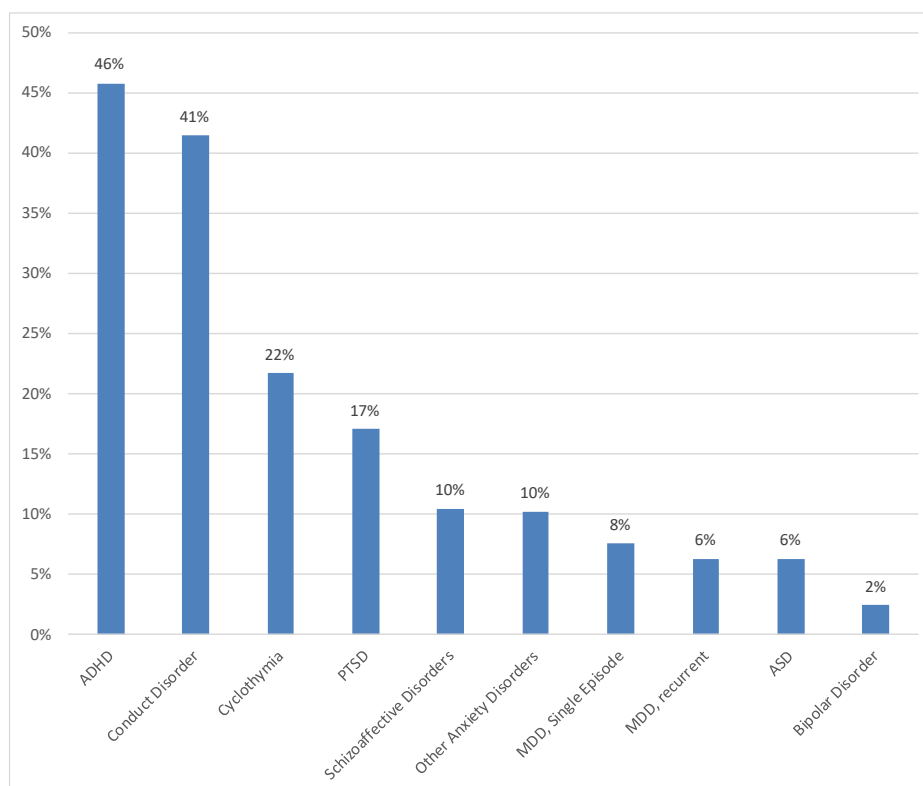
As ADHD is commonly found with co-occurring mental health diagnoses, studies have found that children with both ADHD and oppositional defiant disorder or conduct disorder have an earlier onset of symptoms, have more school dysfunction, and are often more aggressive than

²¹ These counts are not expected to match the application total of 729 above, as they reflect utilization for CSED program members approved for eligibility prior to January 2022, and not all independent evaluations appear in the claims data.

²² Diagnosis is defined here as the diagnostic category defined by the first three digits of the primary International Classification of Disease (ICD)-10 diagnosis code reported on the paid claim.

other children with only one identified mental health disorder.²³ Additional information is needed to be able to understand the prevalence of related disorders among this group of children and common co-occurrences, which may lead to increased functional impairment. The Quality Review Committee also recommended further research of waiver utilization by children with autism spectrum disorder (ASD) in combination with an SED, which was reported on associated claims for 9% of children. These children are also served by a separate Medicaid Waiver program in WV, and ASD is not a qualifying standalone diagnosis for the CSED Waiver. Diagnosis information will continue to be monitored to better understand the needs of children utilizing CSED Waiver services. Note the diagnoses reported in Figure 31 are primary diagnoses given as justification for CSED Waiver claims occurring during the six-month period and may not be inclusive of all behavioral diagnoses for an individual.

Figure 31: Percentage of Children Accessing CSED Waiver Services with a CSED Waiver Claim Reporting a Primary Diagnosis in the Top 10 Diagnoses Associated With CSED Waiver Claims, January – June 2022 (Excluding Independent Evaluations)

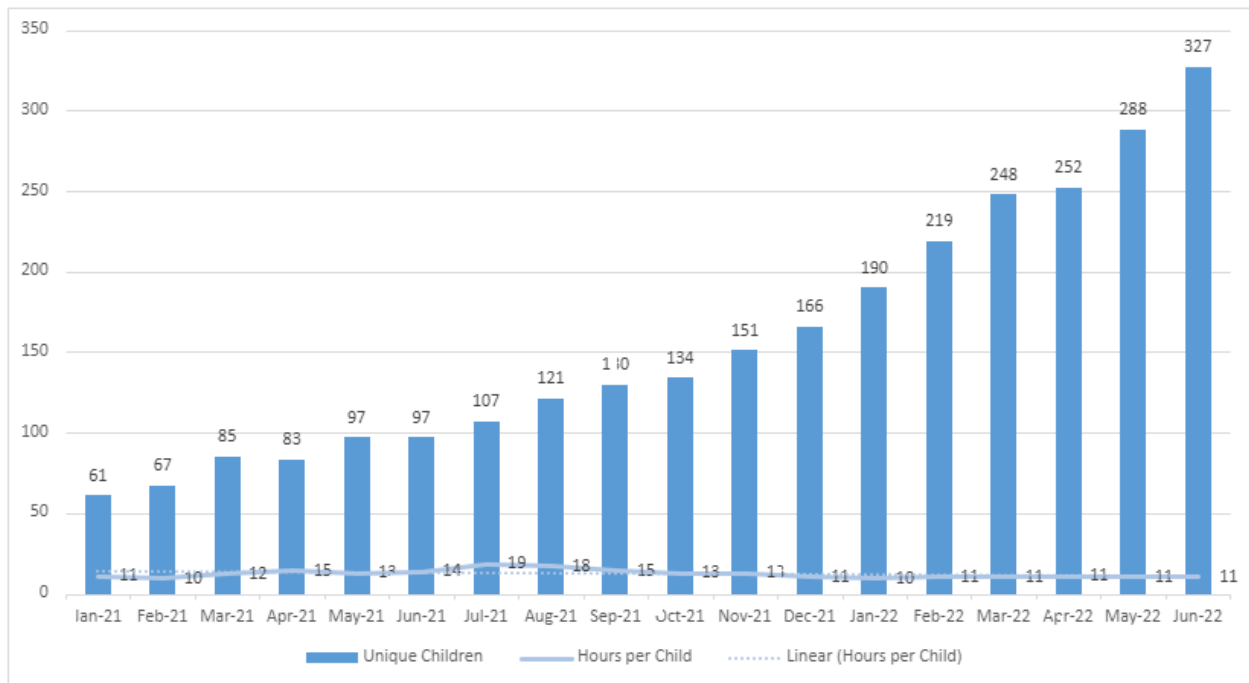


The number of children accessing services has continued to increase significantly over time while the average hours of service per child has remained relatively consistent in the last six months, as shown in Figure 32. Given the current reported utilization and questions from providers about what is appropriate for billing, BMS and Aetna continue to educate providers on

²³ Spencer, T. (2006). *ADHD and Comorbidity in Childhood*. *Journal of Clinical Psychiatry*, 67 [suppl 8], 27-31. Retrieved from <https://www.psychiatrist.com/read-pdf/435/>.

CSED Waiver billing. This education was initiated in the spring of 2022; therefore, the potential impact is not reflected in the data for this period. Additionally, based on the Quality Committee’s recommendation, some preliminary analysis of service utilization over the life cycle of a child’s enrollment has been initiated to begin to understand how services are utilized throughout a child’s access to CSED Waiver services, including possible differences based on geography and CSED provider. Additional time is needed to help ensure a large enough data set to provide a valid and quality analysis, so life cycle utilization data is not included in this report.

Figure 32: CSEDW Service Utilization for Hourly Services, January 2021 – June 2022 (Excluding Independent Evaluations)



A comparison of hourly CSED services used during the July – December 2021 period compared to the January – June 2022 period is captured in Figure 33 below. While CSED Waiver services are always person-centered with hours and types of services tailored to each child and family needs, data is reviewed by looking at average utilization to better understand the population receiving services as a whole. The number of children using CSED Waiver services nearly doubled in January – June 2022 compared to the prior six-month period. The average number of hours per child for each hourly service decreased for the current period compared to the prior period, with the exception of Wraparound Facilitation. DHHR and the MCO have focused on Wraparound Facilitator capacity, so the increase in Wraparound Facilitator hours is a positive outcome of this effort. The decrease in average hours used per child for other services may be a product of a variety of factors that will take time to understand. The substantial growth in the number of children accessing services throughout the period may have resulted in skewing the average hours per child given the influx of children with limited time in the program. Additionally, a broader array of acuity levels may exist among the larger group of children accessing services which could also influence service hours. Provider capacity may likely be a factor as well, and DHHR continues to work across bureaus to have greater program insight and coordination.

More time and data are needed to understand stabilized utilization trends once the Waiver reaches steady state. Given the anticipated increased demand for these services, the Quality Committee recommends continued focus be placed on helping to ensure adequacy of the CSED Waiver provider network. More details related to provider capacity for Wraparound Facilitation and other services is captured in Section 9.3.

Figure 33: CSEDW Service Utilization by Service Type, Comparison of July – December 2021 Period to January – June 2022 Period

Service Description	June-December 2021			January-June 2022		
	Hours Provided	Unique Youth	Hours per Child per Service Month	Hours Provided	Unique Youth	Hours per Child per Service Month
Crisis Service: Mobile Response	53	7	2	12	9	1
In-Home Family Support	2,827	117	6	2,522	167	4
In-Home Family Therapy	3,309	160	5	4,279	275	4
Independent Living/Skills Building	252	<5	15	333	6	12
Peer Parent Support	138	10	3	69	16	1
Respite Care, In-Home	1,162	20	16	778	27	8
Respite Care, Out-Of-Home	988	20	13	861	25	9
Wraparound Facilitation	2,850	206	4	7,444	392	5
All 15-Minute CSEDW Services	11,578	218	12	16,298	410	9

Note: “Hours per Child per Service Month” is calculated by averaging the number of hours of service received by each child over the number of months in the period in which the child received services and then calculating the mean of that result across children. That is, it is the average hours of service per child per month, conditional on the child having service in that month.

Consistent with prior periods, the services with highest utilization include Wraparound Facilitation, Family Therapy, and In-Home Family Support. BMS program teams and the DHHR Quality Committee continue to monitor utilization trends closely given the importance of CSED Waiver services in supporting children to remain in community-based services.

Monitoring the timeline from the date of eligibility determination to the date of provision of CSED services remains a priority for DHHR to better understand the child and family journey. Children may be found eligible for CSED Waiver services while in out-of-home settings but are not formally enrolled until they are discharged from the relevant facility or placement. During this period between eligibility determination and formal enrollment, children may be designated as “on hold,” which impacts timeline to service engagement. To work toward better understanding this timeline, DHHR continues collaboration with the MCO to improve the data collection associated with children on hold,²⁴ reasons for being on hold, and timelines on hold. This

²⁴ An on-hold child is a child who has gone through the CSED Waiver eligibility process, including completion of the Independent Evaluator assessment, and been determined eligible for CSED Waiver services but is not currently accessing services. Examples of on hold reasons include the following: detention, hospital admission, legal guardian request, placement in a group residential setting or PRTF, shelter, provider capacity.

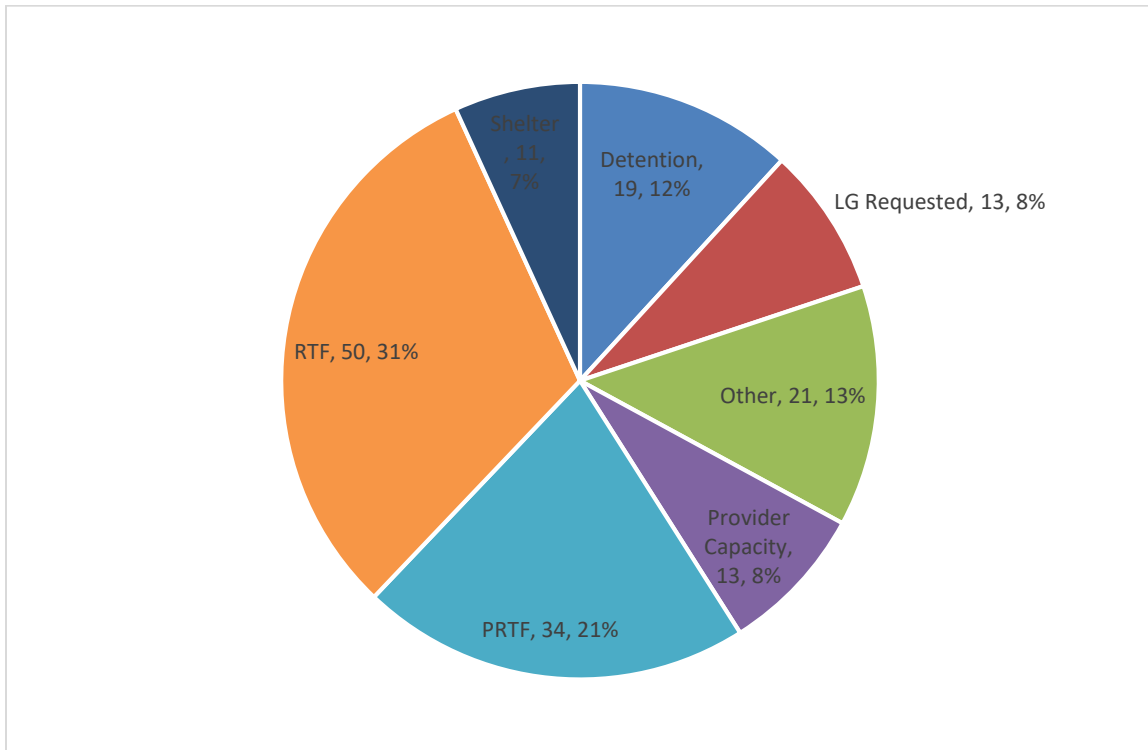
information is essential to better understanding the factors impacting the timelines to access services.

A preliminary analysis of children on hold as of December 5, 2022, was completed for this report. As of that date, there were 161 children whose eligibility status was indicated as “Member Hold.” Figure 34 below captures the hold reasons. At least 73% of the children are on hold due to their current treatment settings (e.g., PRTF, group residential treatment, hospital, etc.). An additional 7% were designated as “other,” and a review of the notes associated with these children indicate the hold reason is related to placement setting. Only 8% (n=13) of the holds were related to provider capacity.

This is a new and developing data set, and DHHR looks forward to more time and data to better understand patterns, reasons, and timelines for children being on hold and any associated impacts on access to services for children and families.

Figure 34: CSED Waiver Hold Reasons for Children on Hold as of December 5, 2022

N=161²⁵



An analysis of timeline from eligibility determination to date of the first provision of any CSED

²⁵ Note: The “Other” category includes the hold reasons “Runaway,” “Hospital Admission,” “<null>,” and “Other.” These categories were aggregated to provide adequate cell sizes for presentation.

service, excluding Wraparound Facilitation,²⁶ was completed for children with Waiver approval dates in the period January 1, 2022 – March 31, 2022, who met the following criteria:

- Has an “active” eligibility status per the on-hold roster.
- Does not indicate a “hold” start date in the on-hold roster.

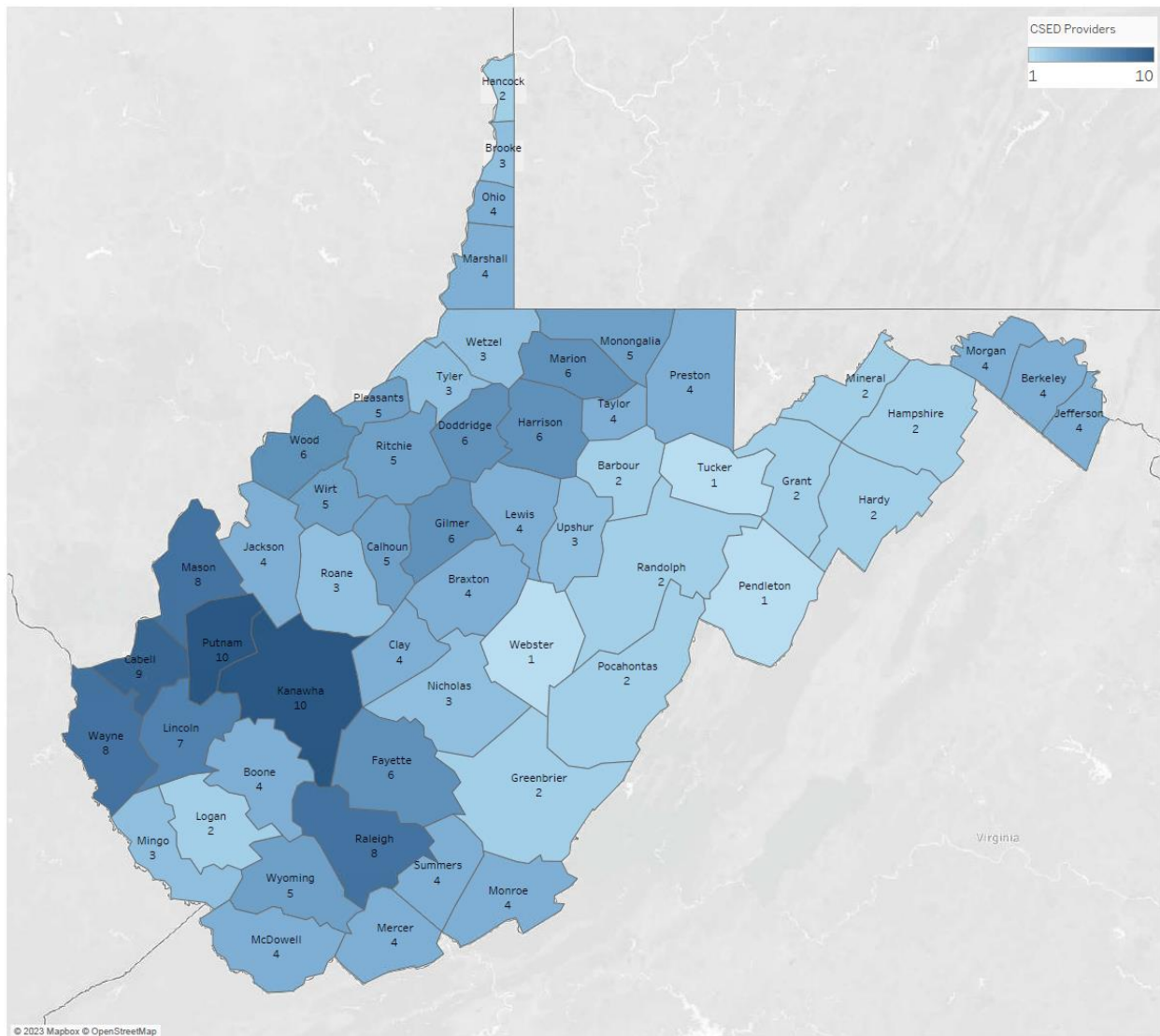
An analysis of the 55 children who met the above criteria showed that 52 (95%) had engaged in CSED services by October, with an average time of 62 days from the date of eligibility determination to the date of first CSED service provision and a median of 50 days. Plans are already in place to expand data collection for on-hold youth to enhance tracking over time. Note this timeline does not currently capture the timeline to any interim services the child and family may be receiving while they are going through the process of eligibility determination and establishing CSED services. As data collection associated with interim services is enhanced and the data store build-out continues, interim services can be included in the analysis to create a more complete picture of a child’s timeline to access services. BMS program teams and the DHHR Quality Committee continue to prioritize timely access to services and recommend further work be done to better understand system, provider, workforce, and/or family related factors that may be impacting this timeline. Additionally, DHHR is actively collaborating with the MCO to enhance on-hold related data collection as mentioned above, which will assist with future analyses of timeliness of service engagement.

9.3 Provider Capacity/Statewide Coverage

As of January 2023, the number of providers actively providing CSED Waiver services has increased from 12 to 18. Four additional providers are in the process of becoming certified to offer CSED Waiver services. There is at least one CSED Waiver service provider offering services in each county across the state as shown in Figure 35.

²⁶ Timeline from eligibility determination from date of first CSED Wraparound Facilitation service is captured in Section 10.2 CSED Wraparound Facilitation.

Figure 35: Number of Provider Agencies Offering CSED Services by County



Providers have expressed that they continue to struggle with staffing challenges due to the pandemic and national labor shortages. Providers are continuing recruiting efforts in a difficult labor market and report a lack of applicants. The MCO has offered monetary incentives to providers in an effort to enhance the provider network, given the anticipated continued increase in demand for waiver services as Assessment Pathway referrals grow. Additional provider locations were added to increase the network capacity as a result.

DHHR is in the early stages of forecasting demand for CSED Waiver services. Preliminary forecasting was discussed in the October 2022 quarterly Quality Committee reviews. Wraparound Facilitation, family therapy, in-home family supports, and respite were identified as priorities for forecasting. Forecasting is based on referral and application trends, current and expected utilization, and additional factors. In 2023, DHHR will continue defining and testing the forecasting algorithms and assumptions. Plans include collaborating with the MCO and providers to understand their experience of service provision, including staffing patterns and

other workforce constraints. Forecasting results will be used to assist the MCO and providers with focused recruiting and building network capacity to meet expected demand for services. Collaborating with the MCO and providers continues to be a priority area of focus for DHHR to help ensure children are receiving services in the appropriate amount, duration, and intensity to meet their needs.

9.4 Strengths, Opportunities, Barriers, and Next Steps

Strengths of the continued implementation of CSED Waiver services across the state include the following:

- A 250% increase in the number of applications submitted compared to the previous reporting period, including at least one application received from every county.
- The number of children accessing CSED Waiver services nearly doubled compared to the prior period.
- The right children are being referred for services, as evidenced by 95% of children having a CAFAS/PECFAS score greater than or equal to 90.
- An increase in the number of Waiver providers from 12 to 18, with more in process.

To further enhance access, choice, and availability of CSED Waiver services, DHHR submitted an amendment to the Waiver, which was approved in June 2022 and included the following:

- Implementation of a 217-Medicaid eligibility group helps remove financial barriers to access HCBS if the applicant meets medical eligibility for the CSED Waiver. Expansion of financial eligibility allows children who would not typically be eligible for Medicaid services to receive services and supports to help remain successful in their home and community.
- Removing service authorizations for Wraparound Facilitation, Mobile Response, Family Therapy, In-Home Family Support, Peer Parent Support, and Non-Medical Transportation.
- Updating program assessment requirements to help support coordination across programs, reduce frequent assessments between care programs, and help better inform member care and coordination.
- Effective March 1, 2023, BMS will require providers to start utilizing the CANS Automated System.

Opportunities and follow-up recommendations from Quality Committee reviews include:

- Continued education of providers to help ensure they are billing for all services rendered.
- Analysis of county-level service offerings to evaluate service availability in each county.
- Continued analysis of utilization throughout the life cycle of CSED Waiver services and length of service analysis to understand patterns of service utilization more fully.

- Data enhancements to improve the capture of information related to interim services while awaiting CSED eligibility determination, children on hold, waitlists for services, and timelines to access services as well as factors influencing those timelines.
- Continued build-out of the data store to capture the full view of a child's service access following referral to the Assessment Pathway and the associated timelines.

DHHR's prioritized next steps involve completing forecasting analysis for CSED services and working in partnership with the MCO to expand the CSED Waiver provider network to help ensure children receive the amount, duration, and intensity of services to meet their needs most effectively.

10.0 Wraparound Facilitation

WV offers Wraparound services to children with SED or SMI through the Assessment Pathway described in Section 8.0. WV Wraparound Facilitation is designed for uniform service delivery regardless of funding source. The main funding sources for WV Wraparound include:

- BBH Children’s Mental Health Wraparound grants for:
 - Interim services; or
 - Children not eligible for the CSED Waiver but who meet criteria for non-CSED Waiver Wraparound Facilitation.
- BMS CSED Waiver
- BSS Interim services for children involved with BSS, provided by BSS Wraparound Facilitators:
 - Interim services; or
 - Children not eligible for the CSED Waiver but who meet criteria for non-CSED Waiver Wraparound Facilitation through the same facilitator when possible.

The goals across the agencies funding Wraparound services are to:

- Help children and families thrive in their homes, schools, and communities.
- Implement a seamless system of care that includes statewide Wraparound services available through a “no wrong door” approach.
- Provide consistently trained Wraparound Facilitators and high-fidelity Wraparound services.
- Reduce the number of children removed from their homes due to SED or SMI.
- Provide increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

10.1 Review Period, Data Sources and Limitations, Population Measured

As DHHR aligns services to meet the NWI model across all providers, efforts are underway to enhance data collection and upgrade systems to allow interconnectivity of data sets across DHHR for record-level data through the data store. This will allow DHHR to assess WV Wraparound as one consistent and unified service as well as by funding source. DHHR has also contracted with Marshall University to assess fidelity and WVU to provide an overall evaluation of the children’s HCBS system. DHHR looks forward to the WVU Evaluation reports WVU, which are expected in summer and fall of 2023, to continue to assess and react to feedback from providers, youth, and families regarding Wraparound services following the initial baseline findings. Baseline findings from summer and fall 2022 indicated positive perspectives around

Wraparound service delivery and rapport with facilitators. Wraparound services were one of the most well-known services among providers and caregivers; however, concerns about workforce limitations were listed as one of the most pervasive concerns impacting the ability to access services timely. The implementation of the BBH System of Care Epi Info Interface enables capture of more service-level data and child-level data that will result in enhanced reporting for subsequent reports. An update to enhance this system further and refine key indicators is being built out in 2023. Updates will include revisions to timeliness indicators, mechanisms to differentiate interim Wraparound Facilitation services, and other refinements to improve data collection and quality. Updates will also be made in 2023 to the MCO's eligibility collection system to enhance tracking of individuals on hold for CSED Waiver services, including Wraparound Facilitation. Figure 36 below provides an overview of the Wraparound Facilitation data currently available.

Figure 36: Wraparound Facilitation Data Overview

WV Wraparound DHHR Provider	Data Review Period	Data Source	Limitations	Population Measured
Wraparound services provided by BBH Children's Mental Health Wraparound (CMHW) providers	January – June 2022	BBH System of Care Epi Info Interface	<p>As of October 31, 2021, BBH Wraparound became considered WV Wraparound and primarily contributes to interim services. Data will need to be reported separately for each payor source until the data store is built out further for connection across data systems.</p> <p>Some concerns have been identified related to the new Epi Info System's architecture. The system is currently undergoing further testing to identify any adjustments that may need to be made. Due to this, data in Section 10.2(a) is considered preliminary.</p>	<p>Interim Wraparound Facilitation while applying for the CSED Waiver and Non-CSED Waiver Wraparound Facilitation with criteria agreed upon with BSS and BMS:</p> <ol style="list-style-type: none"> 1. As of July 1, 2022, financial ineligibility will no longer be a barrier for the CSED Waiver, due to an approved Waiver amendment; or 2. Clinical ineligibility for CSED Waiver. DHHR's bureaus recognize that some children may be appropriate for high-fidelity Wraparound even if they do not meet clinical eligibility for CSED Waiver in the following circumstances: <ul style="list-style-type: none"> • Significant mental health needs.

WV Wraparound DHHR Provider	Data Review Period	Data Source	Limitations	Population Measured
				<ul style="list-style-type: none"> • At risk of out-of-home placement. • CAFAS score of 1) 80, or 2) 70 or below with current involvement by DHHR's BSS. • Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver, such as Intellectual/ Developmental Disabilities Waiver or Traumatic Brain Injury Waiver.
Wraparound services (provided by SAH WV providers)	Unavailable at time of report	CANS Automated System	This data was unavailable at the time of report but will be included in future reports as a source of interim Wraparound service. Differentiation of SAH and interim services began in December 2022. Services through the agreement between bureaus to allow SAH facilitators to serve WV Wraparound clients went into effect June 10, 2022.	*See description above.
CSED Waiver Wraparound	Utilization trends for January 2021 – June 2022	DW/DSS	Data are based on claims through October 2022, so there may be some claim lag in the data presented.	Children enrolled in the CSED Waiver.

10.2 Review Summary

Wraparound Facilitation services have been divided by payor source for this report due to current data consolidation limitations. Work is underway to allow aggregation of this data to look at overall utilization and outcomes for youth in WV Wraparound throughout their journey through the Assessment Pathway. Although data are separated by payor, as of October 2021, the system allows families to access Wraparound Facilitation seamlessly and maintain their current provider in instances where they are already accessing Wraparound services to help ensure consistency in service provision and maintenance of already established relationships.

Data periods reviewed are noted throughout. As the Assessment Pathway early implementation was still occurring during this review period and will be assessed moving forward to understand if there is a shift in children served, changes may be expected. Establishment of new data collection strategies are in early implementation and will continue to be assessed for training or revision needs.

10.2(a) Wraparound Services Through BBH

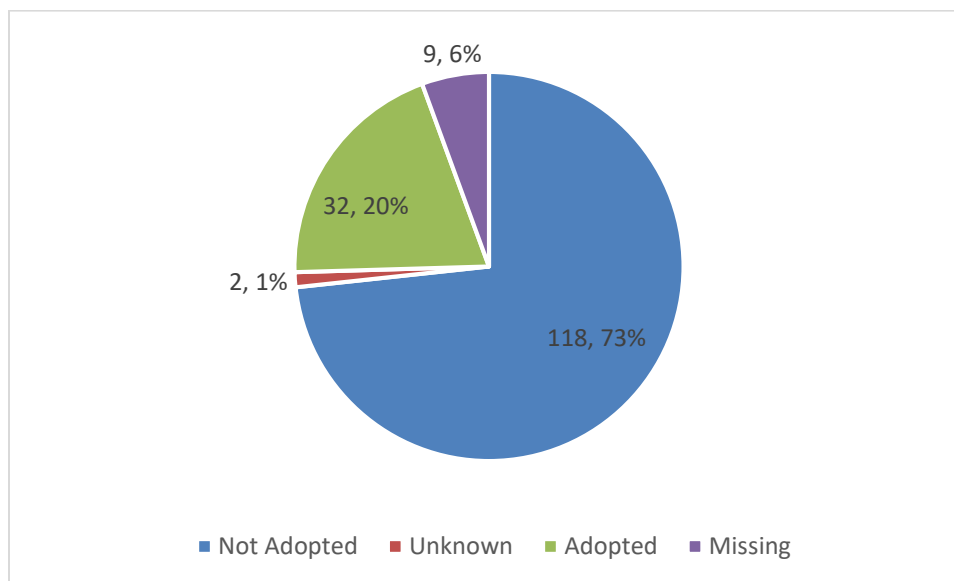
A goal of these early semiannual reports is to continue to establish baseline numbers of children and services as implementation is underway, and baseline characteristics of who is receiving services and where services are occurring. Another consideration is validation around the new Epi Info System. Some concerns have been identified related to the system's architecture, and the system is currently undergoing further testing to identify any adjustments that may need to be made. Due to this, data in Section 10.2(a) is considered preliminary. Following this validation, and as reporting becomes more robust and the data store grows, it is anticipated that indicators will also evolve to include more outcome data, including CANS Assessments, over time.

From January – June 2022, 161 individuals were served. Information on the demographics of children enrolled in Wraparound Facilitation services through BBH are included in Section 4.0.

Figure 37 summarizes adoption status, which was added with the System of Care Epi Info Interface upgrade in October 2021. Although the comparison is not exact, as more than one child could be served with Wraparound per family, it should be noted that only 3% of WV households in 2019 identified as adoptive families according to the American Community Survey. The larger percentage of adopted children served by Children's Mental Health Wraparound (CMHW) providers (20%) during the reporting period is indicative of both a continued need to be met for adoptive families and demonstrative of program reach to an identified at-risk group.

LGBTQ+ service utilization is also reviewed internally to help ensure continued inclusivity in connection to these services but was not included in this report due to the low number of children (ages 13+) reporting LGBTQ+ identities.

Figure 37: Adoption Status of CMHW Youth Served January – June 2022 (n=161) – Preliminary

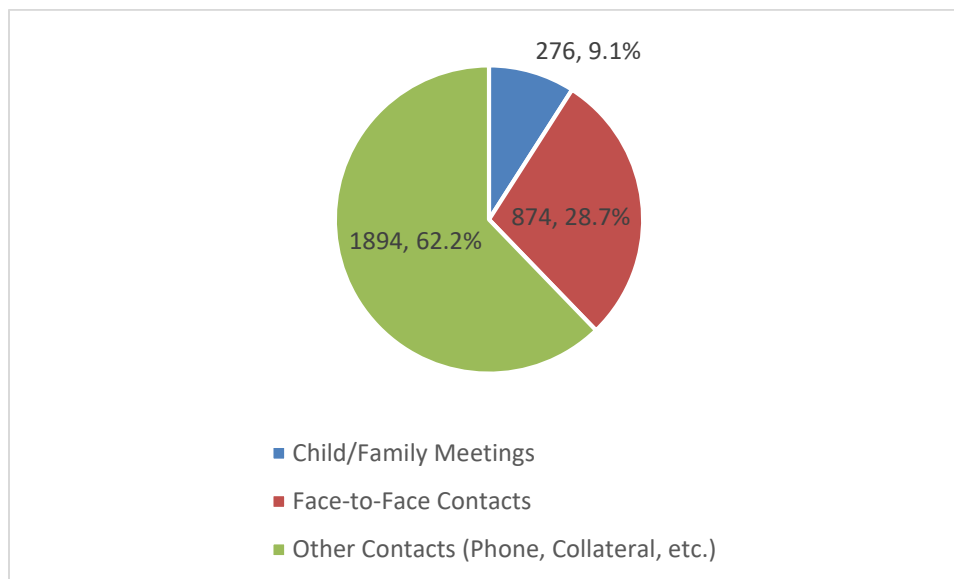


Since the beginning of the pandemic, service delivery has shifted to meet needs and safety concerns. Represented in the “Other Contacts” category in Figure 38, telehealth services have been viewed as one of the more positive outcomes of the pandemic, allowing for more frequent and/or timely connection to families as needed or requested by the family without replacing key face-to-face interactions.

Over 60% of contacts for services in the first half of 2022 were via virtual means based on the needs and requests of the family. Over 3,000 total contacts/interactions were made for the 161 individuals served, or three reported contacts on average per month per youth. At the time of this report, data interactions with individuals were captured differently for Wraparound Facilitation funded by BBH vs. CSED. For BBH, “interaction” referred to a contact with the individual regardless of time spent, while CSED refers to hours spent with the individuals. Work is underway to capture time spent with children and families in Epi Info for future Wraparound data collection updates, allowing service utilization to be reviewed and compared by average hours of service.

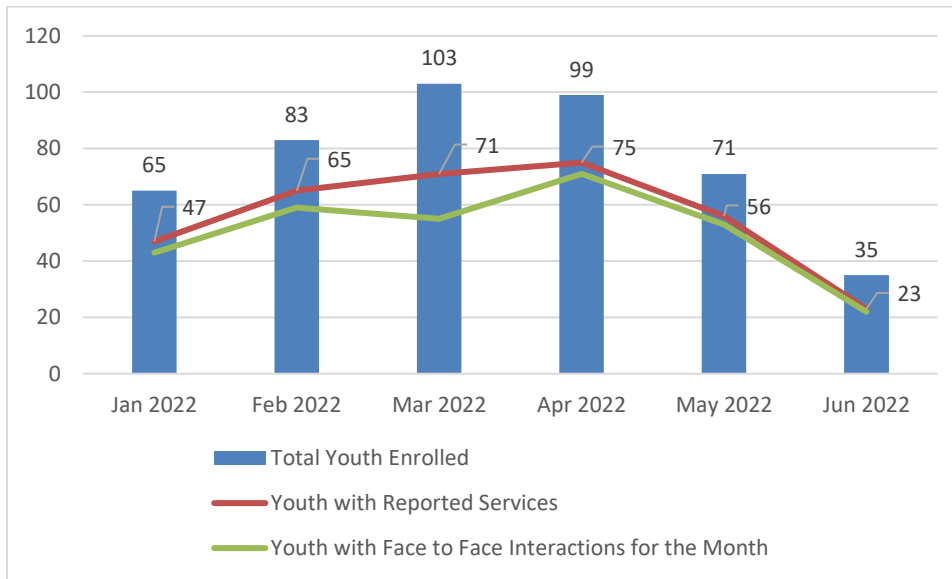
Interaction and service types are expected to vary based on the child and family’s level of need and amount of time served through the programs, with a higher number of interactions for newer children. More in-depth assessment of intensity and length of services will be determined as cross systems utilization data is enhanced and analysis can be expanded.

**Figure 38: BBH Wraparound Services by Contact/Interaction Type, January – June 2022
(n=3,044 contacts) – Preliminary**



Monthly enrollment and service utilization (Figure 39) closely matched growth seen with the Assessment Pathway and implementation of interim Wraparound services prior to a family’s final CSED Waiver determination. Youth enrollment peaked in March 2022 and decreased during the summer months, which follows trends commonly seen when school is out of session. The Quality Committee also noted the possibility of transfer or immediate utilization of CSED Waiver funded Wraparound Facilitation services due to workforce limitations. Since these data and processes are still in early implementation, additional time will need to elapse to understand routine enrollment and service utilization more fully, including what seasonal changes might be expected. Gaps between enrollment and service utilization are also being assessed further to determine whether quality improvements are needed with data collection or service utilization. As data collection is enhanced, CMHW data will continue to be monitored to assess impacts of interim and BBH-funded Wraparound Facilitation services.

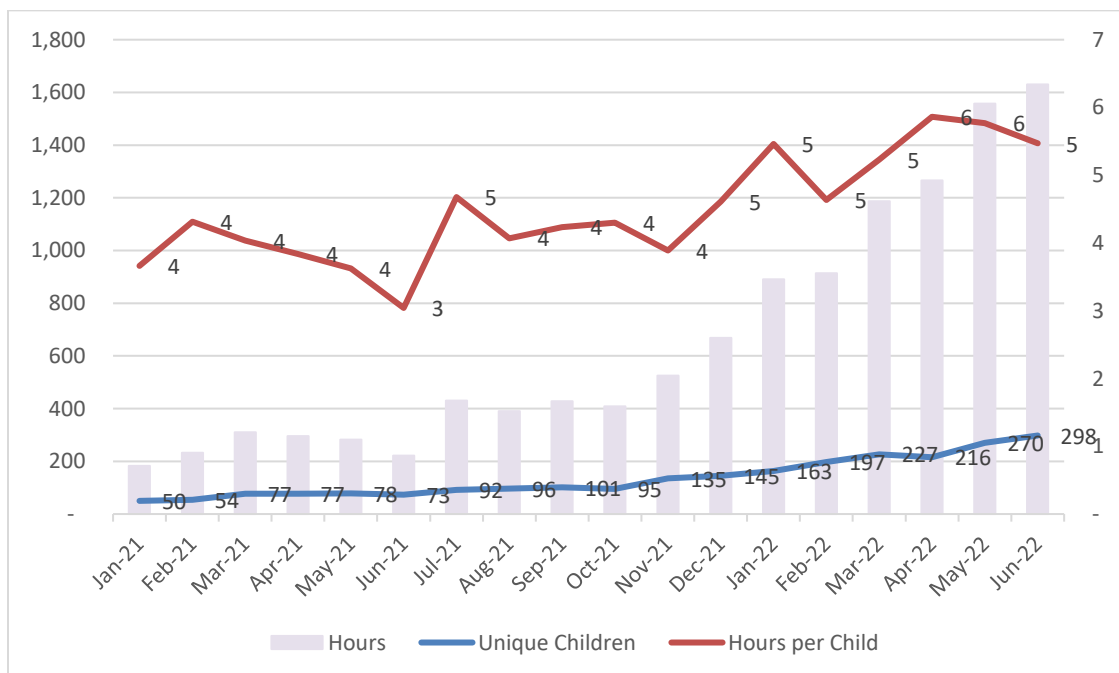
Figure 39: Monthly Enrollment Totals and Service Utilization – Preliminary



10.2(b) Wraparound Services Through CSED Waiver

CSED Waiver Wraparound utilization from January 2021 – June 2022 is shown in Figure 40. The number of children accessing CSED Waiver Wraparound Facilitation services continues to increase significantly.

Figure 40: CSED Waiver Wraparound Utilization (Average Hours Per Child, Unique Number of Youth, and Total Service Hours Rendered), January 2021 – June 2022



Monitoring of the timeline from eligibility determination to the date of first CSED Wraparound services is a priority for DHHR to understand the child and family journey more fully. To work

toward improved understanding of this timeline, DHHR continues collaboration with the MCO to improve the data collection associated with children on hold,²⁷ reasons for being on hold, and timelines on hold. This data is essential to better understanding the factors impacting the timelines to access services.

An analysis of timeline from eligibility determination to date of first CSED Wraparound service was completed for children with Waiver approval dates in the period January 1, 2022 – March 31, 2022, who started CSED Wraparound Facilitation services²⁸ had an “active” eligibility status per Aetna’s eligibility roster and had not been placed “on hold” for services. Based on an analysis of the 49 children who met these criteria (i.e., were not placed on hold), the average timeline from the date of eligibility determination to the date of first CSED Wraparound service is 60 days with a median of 48 days. These statistics do not capture the timeline to the child and family receiving interim Wraparound Facilitation services or other HCBS outside of the Waiver. As data collection associated with interim Wraparound Facilitation services is enhanced and the data store build-out continues, interim Wraparound Facilitation services can be included in the analysis to create a more complete picture of a child’s timeline to access services. BMS program teams and the DHHR Quality Committee continue to prioritize timely access to services and recommend further work be done to better understand system, provider, workforce, and/or family related factors that may be impacting this timeline. Additionally, DHHR is actively collaborating with the MCO to enhance data collection related to children on hold, as mentioned above. This will assist with future analyses of timeliness of service engagement.

An initial analysis of length of service for CSED Waiver Wraparound Facilitation was completed for children with Waiver approval dates in the period July 1, 2020 – June 30, 2021, who met the following criteria:

- Accessed at least 90 days of Wraparound Facilitation services.
- Did not have a gap greater than 60 days between services.

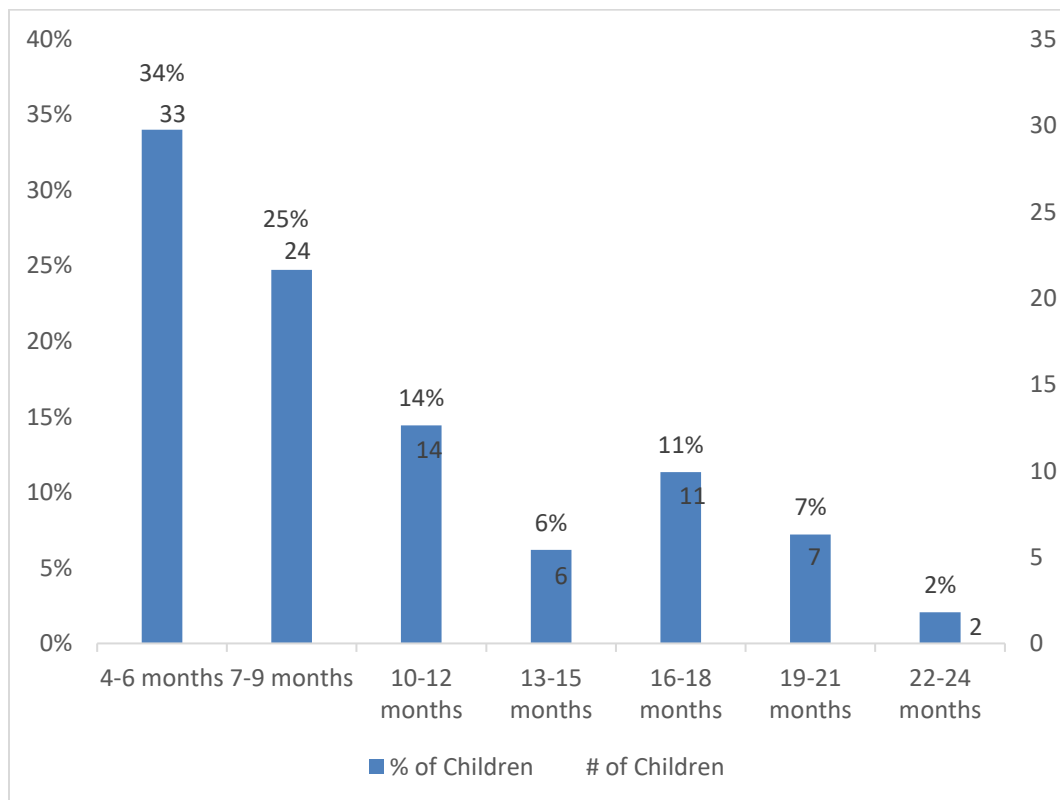
For the 88 children who met the above criteria, the average length of service was 9.3 months with a median of 8 months. This length of service is limited to CSED Waiver Wraparound Facilitation and does not include interim Wraparound length of service that children and families may access once referred to the Assessment Pathway and while going through the CSED Waiver eligibility process. While more detailed analysis is needed over time to include children who may go on hold for limited periods as well as an analysis of a larger population of children as the Waiver continues to grow and achieve steady state, this early data is positive and demonstrates children and families are utilizing Wraparound Facilitation services in alignment with the design of the Waiver program (i.e., intensive services for an average of 6-9 months).

²⁷ “On hold” is defined as a child who has gone through the CSED Waiver eligibility process, including completion of the Independent Evaluator assessment, and has been determined to be eligible for CSED Waiver services but is not currently accessing services. Examples of on hold reasons include the following: detention, hospital admission, legal guardian request, placement in a group residential setting or PRTF, shelter, and provider capacity.

²⁸ Based on Medicaid claims paid through October 2022.

Figure 41 below captures CSED Waiver Wraparound Facilitator length of service distribution. Based on this early analysis, the majority (approximately 73%) of children received services for up to one year, while some children have continued in services for as many as two years. Following review of the data, BMS program staff identified a need to improve the understanding of the characteristics and circumstances of children who are continuing to access the services beyond the timeline expected based on Wraparound national practices.

Figure 41: CSED Waiver Wraparound Length of Service



10.3 Provider Capacity/Statewide Coverage

DHHR continues to monitor Wraparound Facilitator capacity by agency, county, and service type through biweekly cross-bureau meetings with the MCO. Provider status and recruitment efforts to build capacity are ongoing agenda items which have proven successful in increasing the number of available Wraparound Facilitators throughout the state. During the review period January 2022 - June 2022, the number of Wraparound Facilitators increased 16.9% from 142 to 166. As of November 2022, Wraparound Facilitators increased to 187, representing an additional 12.6% increase. Overall, from January 2022 – November 2022, the total number of Wraparound Facilitators increased by 45, representing a 31.6% increase.

Additional data is needed to effectively measure caseload capacity for each Wraparound Facilitator. As some Wraparound Facilitators have other responsibilities or may work part-time in their roles, DHHR recognizes the need to capture the percentage of time Wraparound Facilitators are allocated to Wraparound services in order to capture caseload and capacity measures more effectively. DHHR will be working to gather data related to time allocations for

facilitators to enhance caseload measurement and monitoring to help ensure alignment with NWI guidance for facilitator caseloads.

DHHR is in the early stages of forecasting demand for Wraparound Facilitator services. Preliminary forecasting was discussed in the October 2022 quarterly Quality Committee reviews. The committee reviewed a 12-month forecast for Wraparound Facilitation services and the projected increase in the number of facilitators to meet the demand. The Wraparound forecast was based on referral and application growth trends, application approval rates, average length of service, demand per current and expected utilization, and a series of caseload ratios. In 2023, DHHR will continue refining and testing the forecasting algorithms and assumptions. Next steps include updating the forecast based on more recent trends and collaborating with the MCO and providers to understand their experience of service provision, including staffing patterns and other workforce constraints, while considering national workforce shortages. Forecasting results will be used to assist the MCO and providers with focused recruiting and building network capacity to meet expected demand for Wraparound Facilitation services. Collaborating with the MCO and providers continues to be a priority area of focus for DHHR to help ensure children and families are promptly connected with a Wraparound Facilitator.

Based on provider feedback regarding the viability of CSED Wraparound Facilitator services and ongoing challenges in workforce recruiting due the current reimbursement rate structure, BMS is considering modifying the CSED Wraparound Facilitator rate structure to help ensure viability of the services and allow for successful recruitment and retention of facilitator workforce.

10.4 Strengths, Opportunities, Barriers, and Next Steps

Despite unprecedented conditions brought forth by the pandemic, Wraparound providers have continued to provide services to help children stay in their homes and communities. The ability to conduct many of these services via phone or virtual communications has been a strength to the continuation of these important services. Cross-bureau efforts in partnership with the MCO and providers have resulted in a 32% increase in Wraparound Facilitator capacity between January – November 2022. Daily collaboration between BMS and BBH occurs to help ensure children are quickly connected to Wraparound Facilitators or other services and resources in cases where a Wraparound Facilitator is not immediately available. Additional strengths include:

- Utilization of interim Wraparound Facilitation services while awaiting CSED Waiver determination.
- Significant increase in the number of children applying for and accessing CSED Waiver Wraparound Facilitation services.
- Slight increase in the average hours of Wraparound Facilitation services being used per child, which is a positive outcome of the focus DHHR and the MCO have placed on Wraparound Facilitator network capacity and appropriate documentation of services.
- Continued provider education and training on WV Wraparound and CMCRS through

Marshall University in partnership with University of Connecticut to better equip the workforce.

Opportunities and prioritized next steps per recommendation of the Quality Committee include:

- Wraparound Facilitator forecasting analysis and provider network expansion efforts in coordination with the MCO, which can help address workforce barriers.
- Continue efforts to recruit staff within BBH, including but not limited to helping with overseeing and managing programs sufficiently, helping with CQI implementation efforts, and data analysis such as filling epidemiological vacancies.
- Data enhancements to capture and understand interim Wraparound Facilitation services and how these fit into the overall view of a child's timeline to access services, including bridging any potential gaps while a child is going through the CSED Waiver eligibility determination process.
- Continued work to improve data quality and completion through provider training, technical assistance, and data system revisions, including CSED Waiver providers beginning to input CANS data into the CANS Automated System effective March 2023.
- Understanding the child and family's journey throughout the Pathway to Mental Health Services, including identifying strengths and barriers.
- As noted in Section 5.0, a Wraparound PIP team will be initiated in early 2023 as part of the recommendation of the Office of QA and the Wraparound Fidelity Report. The PIP team will work to address quality improvement for CANS completion and timeliness as well as implementing and helping to ensure processes and documentation are in place to address fidelity needs.
- Continued build-out of the data store to allow aggregation and alignment of Wraparound Facilitation services irrespective of payor source.
- Considerations with the current Wraparound Facilitator rate structure.

11.0 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 PRTF or are transitioning to the community from an out-of-home placement. Positive Behavioral Support (PBS) is a type of Behavioral Support Service and is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life of children who are experiencing significant maladaptive behavioral challenges. Behavioral Support Services is an approach that is used widely including within BBH, BSS, BMS, and WV Department of Education programs and providers. Figure 42 below provides an overview of the data currently available for Behavioral Support Services.

11.1 Review Period, Data Sources and Limitations, Population Measured

Figure 42: Behavioral Support Services Data Overview

Data Review Period	Data Source	Limitations	Population Measured
July 1, 2021 – December 30, 2021	BBH Children's PBS Grant Reporting	Data includes only youth served directly through the BBH grant through WVU CED – PBS program and is not representative of all children with Medicaid receiving Behavioral Support Services.	Children served directly through the BBH grant through WVU CED program. Services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs.
Not applicable at this time	DW/DSS Warehouse	State Plan Behavioral Support Services data are unavailable at the time of report; process change to collect data via claims is still underway but expected to be implemented with policy change, which is expected to be implemented by fall 2023 to be available in future reports, with consideration for claims data lag and provider training. The process change will include a modifier code that will identify Behavioral Support Services provided to Medicaid and WVCHIP members via paid claims.	Services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs who are ages 0 – 21 and members of Medicaid or WVCHIP.

In addition to the BBH-funded Children's PBS program provided by WVU CED, services are also conducted through trained providers of BBH, BSS, BMS, and WV Department of Education

programs. Data are currently only available for direct services provided by WVU CED under the BBH PBS grant; however, BMS is working to implement a Behavioral Support Services modifier code that will allow Behavioral Support Services-related claims data to be captured for children receiving services through Medicaid (expected fall 2023). In addition to the review of information for individuals directly served, training is also being conducted for providers via the WVU CED. Concord University certified 29 providers on the new Behavioral Support Services provider certification in 2022. Additional training is planned in 2023 following a needs assessment. This will eventually allow Behavioral Support Services training and certification to be available statewide, with information on certified professionals' capacity to be included in future reports.

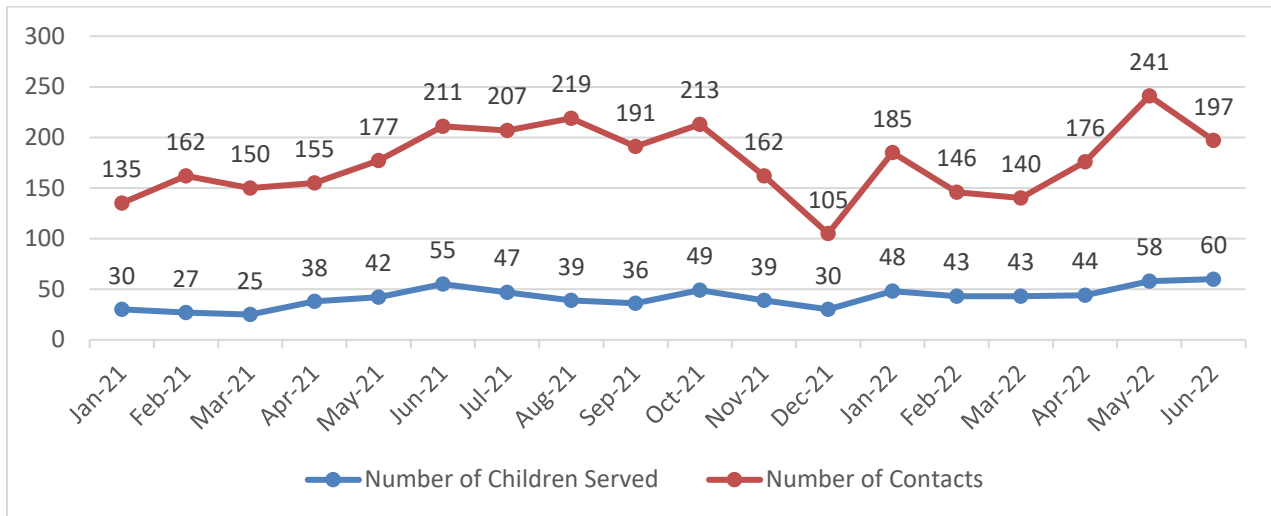
11.2 Review Summary

WVU CED provided PBS services to 108 youth from January – June 2022. This program is not expected to have a broad reach for direct services, but is instead meant to provide training to expand provider-level services throughout the state and assist with consultation for youth and families with more intense needs. Youth provided direct services are typically indicated as having more intense needs, and services can vary from brainstorming with the family to intensive services.

Information on the demographics of these youth is included in Section 4.0 of this report. Interactions and caseload needs have increased for PBS direct services, making increasing provider capacity and certification even more important for delivery of quality and timely services. To better understand geographic need, further assessment of all Behavioral Support Services data via the BMS claims, once available, will be helpful to assess the full scope of children reached through these strategies.

PBS referrals have continued to increase over the last year, as referenced in Figure 43, with an average of 49 children served per month from January to June 2022, compared to an average of 36 children in first 6 months of 2021. Similarly, total child interactions have also increased. In the six-month review period, 1,085 total services were conducted.

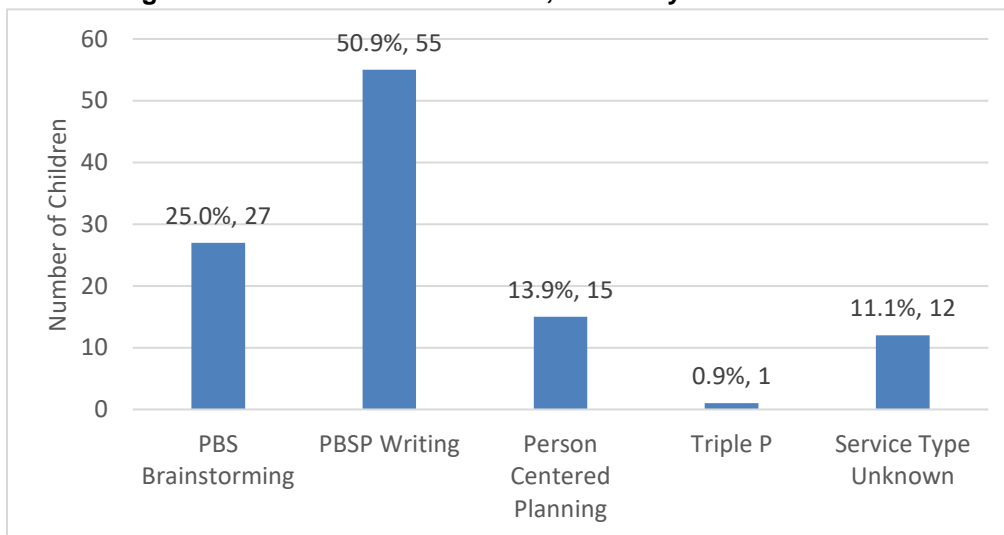
Figure 43: Children and Interactions, Monthly, January 2021 – June 2022



WVU CED continues to experience workforce shortages. As of December 2022, there was a waitlist of 14 children for PBS services, but families were prioritized based on need, and BBH continued to meet regularly with the provider to troubleshoot workforce shortages and hiring barriers. As of January 2023, offers had been accepted to fill two behavior specialist positions.

The most common services provided to individuals as highlighted in Figure 44, were PBS Plan Writing (51%); Brainstorming, a service typically done with lower-need cases to provide ideas and support for families (25%); and Person-Centered Planning (14%). Intensive services are also a service provided but were unknown for this period as 11% of service type were listed as unknown.

Figure 44: PBS Services Provided,²⁹ January 2022 – June 2022



²⁹ Note that individuals may have received more than one service, resulting in totals greater than 100%.

11.3 Provider Capacity/Statewide Coverage

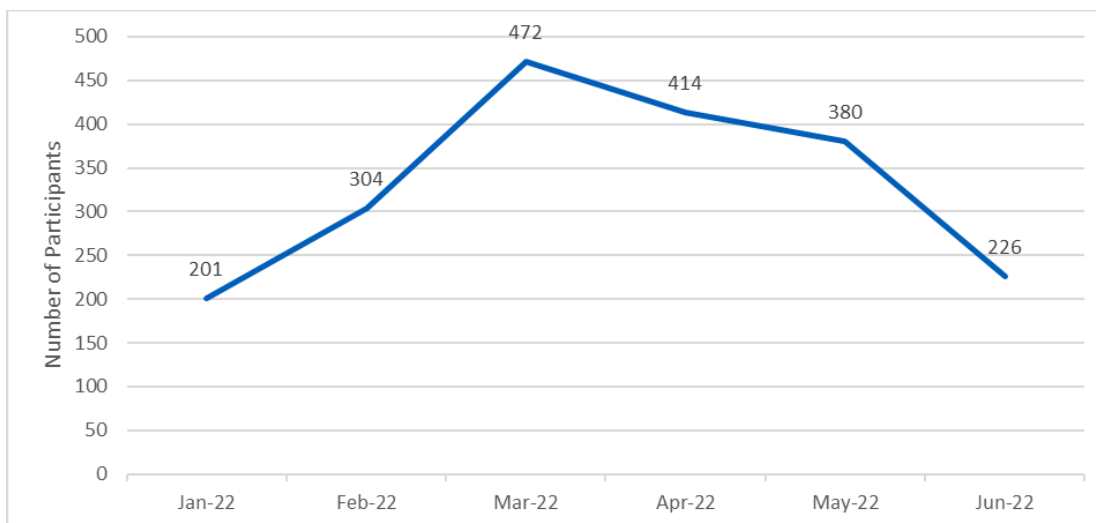
The BBH PBS program through WVU CED has nine full-time equivalent staff and four vacancies, Figure 45, which will be reduced to two vacancies following onboarding of individuals recently accepting offers for the openings for behavior specialists. WVU CED continues to be actively focused on recruiting to fill current vacancies.

Figure 45: PBS Staffing at WVU CED

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Behavior Specialists	4 (2 additional onboarding soon)	8	75% (After onboarding new staff)

Efforts are underway to enhance and standardize the certification process for Behavioral Support Services. Although in early implementation, Concord University provides training and certification for individuals to offer Behavioral Support Services statewide, directly from local providers, expanding the resources available in a given provider’s tool belt. Historically, PBS training has been provided by WVU CED and continues to be provided while Concord University’s process is developed and implemented for Behavioral Support Services. Figure 46 shows an average of 333 individuals have been trained each month from January – June 2022, with the greatest number of trainings conducted in March (472).

Figure 46: Participants Attending PBS Training January 2022 – June 2022

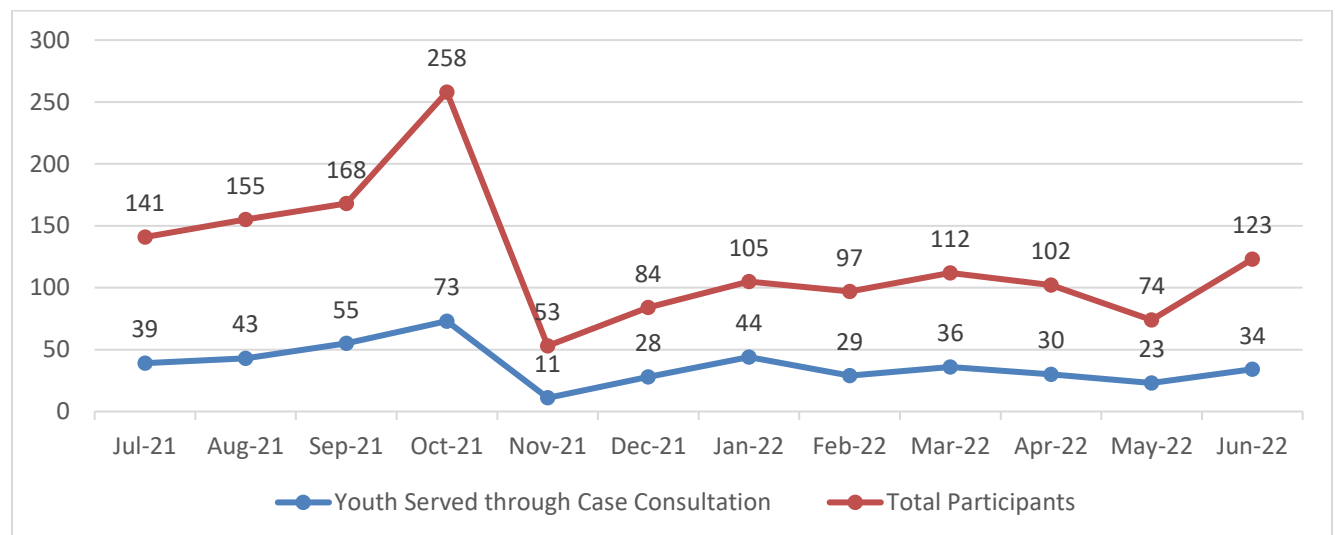


*Participants can include parents and professionals

The WVU CED PBS program provided consultation for an average of 33 youth per month compared to the previous 6-month period of 42 youth per month as shown in Figure 47. This decrease in consultations may have been due to staffing shortages during the period.

Consultation allows a trained provider or providers to continue to support youth while getting technical assistance and consultation from the WVU CED team.

Figure 47: Number of Youth Served Through Case Consultation, July 2021 – June 2022



11.4 Strengths, Opportunities, Barriers, and Next Steps

Behavioral Support Services allow children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program allows direct services and case consultation as a result of referrals from other organizations. Half of individuals served are 5 – 12 years old, which provides an opportunity to serve younger children and potentially divert them from more intensive out-of-home services. In addition to current data review, the implementation of a modifier code to expand capacity for data collection for Medicaid Behavioral Support Services will help influence future planning and quality improvement from review of additional services provided.

Next Steps:

- Continue monitoring WVU CED PBS program data to assess continued needs and consult program staff to identify trends and potential reasons for changes in service utilization.
- Assess missing service indicators and provide technical assistance to provider for improved future collection.
- Continue outreach to BIPOC to meet needs and help prevent barriers to accessing mental health services through current infrastructure and initiatives such as the TTI grant.
- After data are available in BMS claims with the modifier code, further assess training provided to organizations in low-utilization areas as well as rural areas to identify whether needs are being met through direct or indirect services (training).

- Continue to work with Concord University as training and certification is expanded to establish formal data collection and recurring reporting on trainings conducted and individuals certified.

12.0 Assertive Community Treatment (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.

ACT is an option for youth ages 18 – 20 to help prevent unnecessary institutionalization. As part of the Assessment Pathway, youth 18 or older who are eligible are to be offered the choice of ACT or Wraparound services. BMS policy manuals are currently being updated and approved for CSED, RMHTFs, licensed behavioral health centers, and other providers to include the freedom of choice form for Medicaid members eligible for ACT services. Updates for PRTF providers went into effect January 1, 2023. Providers will be trained on the form, expanding knowledge of this freedom of choice, and this offering will be widely implemented in the next year as additional training occurs. The final updates are expected by summer of 2023, with continued training on the update and awareness of the program. The policy manuals will clarify that eligible youth exiting residential placement must be offered the choice of ACT to help them remain in their home and community upon discharge.

ACT is an evidence-based model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the ACT team provides the majority of direct services in the member's community environment.

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

12.1 Review Period, Data Sources and Limitations, Population Measured

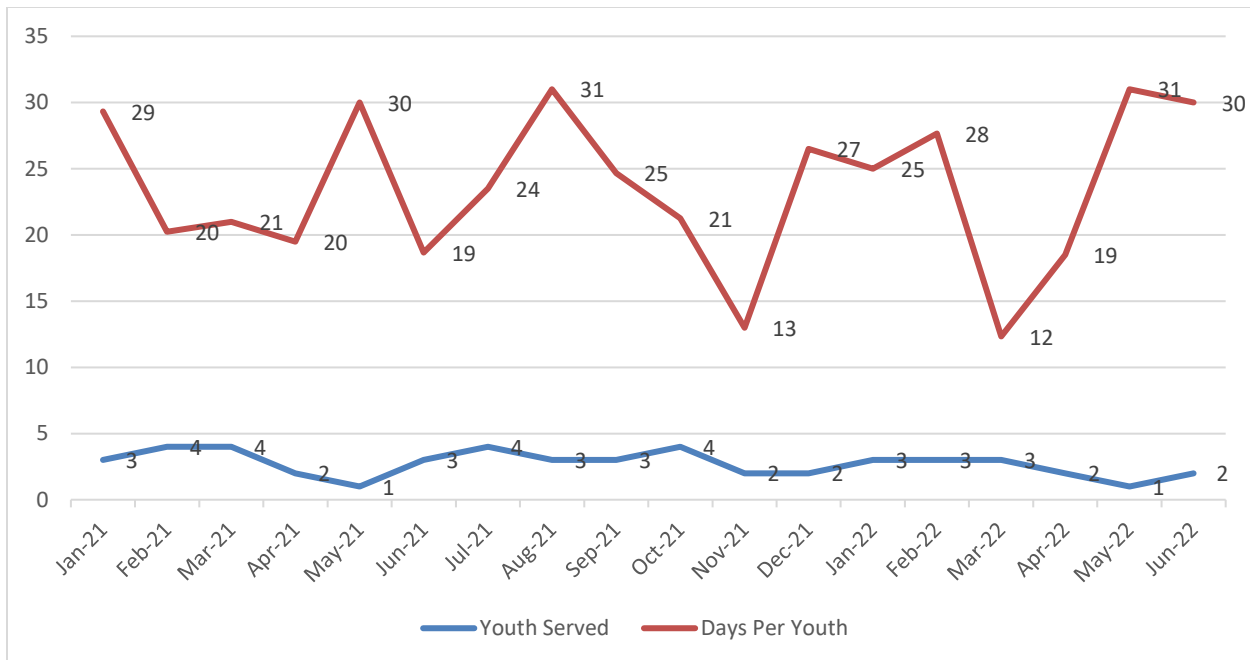
The period reviewed for this report is January – June 2022. ACT enrollment and utilization data are sourced from the DW/DSS of Medicaid and WVCHIP claims. Eligible members must have a primary mental health diagnosis and may have co-occurring conditions, including mental health and substance use disorder or mental health and mild intellectual disability. Members must also have a history of high use of psychiatric hospitalization and/or crisis stabilization. The population served includes Medicaid members 18 years of age and older with no limitation on length of service; however, for purposes of this report, review was conducted for members 18 – 20 years of age to reflect transition-age youth potentially at risk for RMHTF placement.

12.2 Review Summary

For the review period, ACT enrollment remained low throughout the state for this age group. Three individuals were served during the period of review (January – June 2022) compared to the previous 6-month period, which included five youth served who met clinical criteria, were 18 –20 and chose ACT services. Youth 18 – 20 moving through the Assessment Pathway and

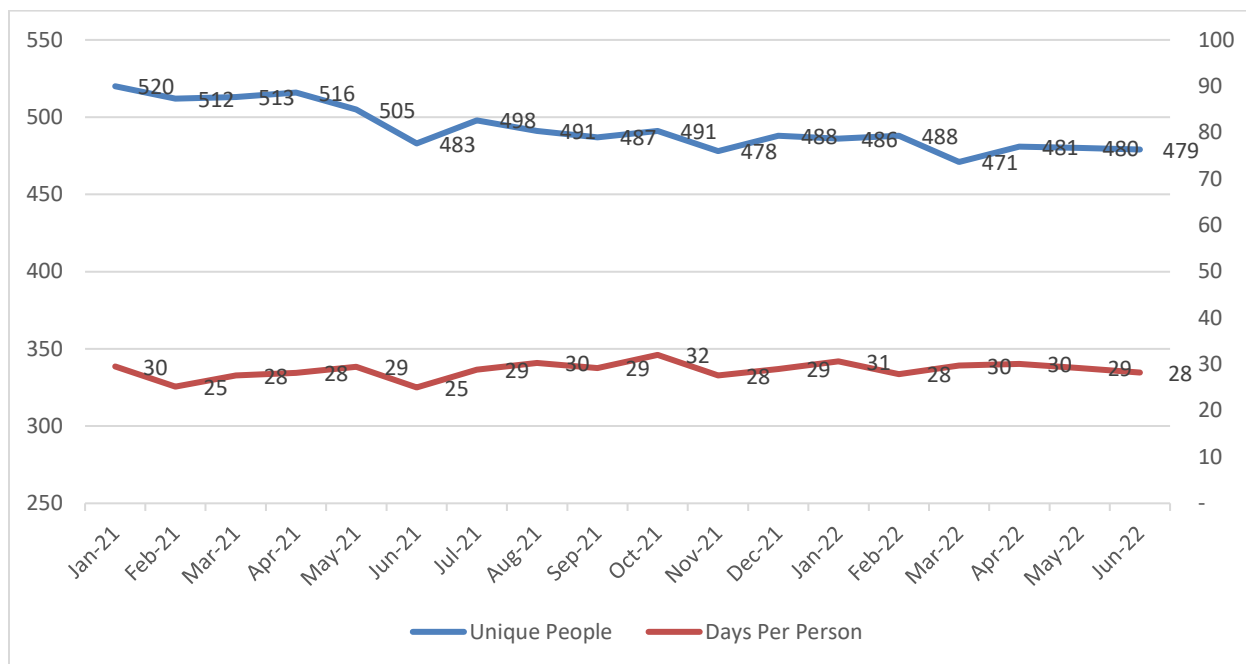
eligible for ACT are offered freedom of choice between CSED Waiver (available until the child's 21st birthday) and ACT services. This choice is documented on the Freedom of Choice form. A key difference in this service is the length of time the service is designed to be offered. CSED services are designed to be shorter term (i.e., up to one year) to give the child and family the tools they need, while ACT is intended to be a long-term service for individuals with ongoing high-intensity needs. Figure 48 below displays enrollment and the days of service per youth. Number of youth served remains low, as has been the historical pattern. The average age of ACT utilization for all members is 46 years old. For purposes of comparison, ACT utilization for all members regardless of age for the last 6 months of 2022 was on average 27 days per month per person with an average of 443 members enrolled during the period as shown in Figure 49. Discharge or decline reason information are not available, but it is commonly understood that many youth are transient and do not want someone intruding in their lives. As awareness of ACT services increase and individuals in RMHTF have appropriate discharge plans developed, DHHR expects utilization of ACT to increase.

Figure 48: ACT Youth and Days Per Youth by Month, January 2021 – June 2022



Note: Reflects claims paid through October 2022.

Figure 49: Total ACT Utilization by Month, ACT Members of all Ages January 2021 – June 2022



12.3 Provider Capacity/Statewide Coverage

DHHR continues to recruit ACT teams to increase ACT availability statewide. The state’s Eastern Panhandle has faced challenges procuring an ACT provider; however, EastRidge Health Systems has been contracted to cover ACT services in the Eastern Panhandle. Services will begin in 2023.

To further expand the availability of ACT services, DHHR intends to require all CCBHCs to have an ACT team. This requirement is anticipated to go into effect in 2024. In addition, DHHR will continue to seek alternative providers to build ACT teams and offer these services.

ACT team capacity is monitored during retrospective reviews; however, workforce capacity is rarely listed as a concern. ACT teams remain in contact with the state if issues arise to troubleshoot scenarios such as temporary lack of nursing staff. At the time this report was written, five vacancies were known on ACT teams statewide. Staffing needs will continue to be reviewed for additional needs and action.

12.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR expects to achieve statewide ACT coverage in 2023, with the number of providers also expanding with the new CCBHC requirements expected to be implemented in 2024. The number of interactions per member indicates this is a high-intensity program providing services to individuals who might otherwise have to live in a residential placement; however, very small numbers of individuals participate in ACT for the target age range of this report, limiting the ability to interpret the available data with confidence. The Quality Review Committee maintained the recommendation that a comparison be explored, if available, for utilizing ACT in other states and/or national averages. The full population of ACT users was included as a comparison to

verify intensity of services for members and that utilization was happening among older individuals. Collection of discharge-reason data was further discussed to help further understand and seek opportunities for transient youth resistant to remaining with ACT services. It was determined that opportunities to better understand these reasons could be explored through the retrospective review processes for these members within the target age range. This will be added to vendor contracts in July 2024.

As noted above, additional efforts to increase enrollment include revision of the BMS policy manuals for RMHTFs to include language that will require an ACT service staff meeting with eligible youth and their families prior to discharge, including a freedom of choice form to decide between ACT and Wraparound services. Continued reviews of utilization data will help to drive this effort as well.

DHHR will have ongoing communication with residential providers about policy requirements to help ensure ACT is included as an offered service for eligible participants as part of discharge planning. DHHR will work with its vendors to further document and review training activities.

DHHR will continue to work on educating and promoting availability of community-based services, such as ACT, when appropriate for the needs of the youth.

13.0 Stabilization and Treatment Homes (STAT Homes)

The STAT Home³⁰ model is designed to complement the current WV Tiered Foster Care model and to provide stabilization services for children in foster care or kinship care who are at risk of residential placement. The STAT Home program is a family alternative to residential placement for children requiring behavioral or mental health interventions. Child placing agencies (CPAs) are responsible for providing these services statewide. In partnership with CSED Waiver services, STAT Homes provide short-term intervention to provide 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 are 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. Over the last 18 months, 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 CPA case managers. Current efforts are focused on recruiting and training STAT Homes. Family training and certification requirements were finalized and are in use by the CPAs. DHHR also launched STAT Home training for BSS staff on December 9, 2022, with the expectation that assigned staff complete the training by February 2023. The first STAT Homes are anticipated to be available to accept children in early 2023.

13.1 Review Period, Data Sources and Limitations, Population Measured

No treatment home data were available during the period of review as STAT Home providers are currently being recruited and trained. STAT Home indicators and the associated data collection and reporting have been outlined in collaboration with CPAs.

13.2 Review Summary

DHHR's STAT Home workgroup has continued collaborating with all stakeholders to define both the initial monthly and long-term measures necessary to monitor program efficacy and RMHTF diversion rates. Over time, data and information to capture potential needed supports and training for CPAs and STAT Home families will also be considered. To date, agreed upon indicators include, but are not limited to:

- Trends of RMHTF placement over time by county of origin
- STAT Home admissions and discharges
- STAT Home discharge analysis to understand where children reside after leaving a

³⁰ In the January 2022 semiannual 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 Homes.

STAT Home (e.g., higher level of care, home of origin, etc.)

- STAT Home length of stay
- STAT Home recruitment and certification, including information on age ranges the home is willing to serve
- STAT Home capacity to include homes opened, closed, and reasons for closures

Once STAT Homes are operational for a period allowing adequate data collection for analysis, this information will be incorporated into DHHR's quarterly Quality Committee and BSS program level review processes and included in future reports.

13.3 Provider Capacity/Statewide Coverage

As of early December 2022, 10 CPAs have agreed to be STAT Home providers and associated contracts are in place. Currently, CPAs are focused on recruiting families who are experienced with providing foster care. This approach will allow experienced families to pilot the STAT Home design while CPAs recruit families who may have no prior experience but are interested in providing short-term supports for children with intense needs. Fourteen families have expressed interest in becoming STAT Home providers, and three of those families are in the final stages of STAT Home training. The first children are anticipated to be served in early 2023.

Consideration is being given to what available data and information on children currently being served in foster care might best help inform future demand for STAT Homes to assist with focused recruiting of STAT Home providers in specific geographies. DHHR recently requested feedback from CPAs on what data and information may be helpful in developing STAT Home forecasting along with recruitment strategies they have found most successful to date. This information will be shared across CPAs and used to inform next steps.

13.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR continues to move forward with STAT Home implementation. Meetings with CPAs and other stakeholders to evaluate progress and continue shaping the data collection, forecasting efforts, and recruiting and training processes, including addressing barriers, will continue in the coming year. WV foster home capacity has remained flat over the last year with a similar number of homes opening and closing. Recruiting and retaining foster home families remains an ongoing challenge. Similar barriers are anticipated with STAT Home recruitment.

Next steps include establishing regular internal DHHR reviews of foster and STAT Home indicators, establishing regular review of indicators with CPAs to inform capacity needs, and evaluating recruitment and retention strategies.

14.0 Children’s Crisis and Referral Line (CCRL)

BBH launched the CCRL in October 2020. This line is a centralized access point to connect youth and families with CMCRS teams and other community-based services, including the Assessment Pathway and WV Wraparound services. Youth and families can also connect with someone who can act as a “listening ear” and provide ideas for coping skills. Youth, families, and those who work with them can call, text, or chat with the CCRL 24 hours a day, 7 days a week, at 844-HELP4WV (844-435-7498) or <https://www.help4wv.com/ccl>. Primary care providers have the option to make referrals through the CCRL by JotForm (electronic secure form referral process) to connect children and families with appropriate services. The CCRL contacts families with referrals made from their primary care providers within 24 hours.

Using CQI processes, DHHR continued efforts throughout the reporting period to expand awareness and use of the CCRL and address evolving data needs, including regular review meetings to inform planning and quality assurance. Figure 50 provides an overview of the CCRL data currently available.

Since the activation of the CCRL, DHHR has conducted outreach activities, including press releases and media campaigns, presentations, informational booths at events, and information sharing by stakeholders (e.g., WV Department of Education) and other partners. BBH also conducts monthly meetings with the CCRL provider to identify areas of needed refinement and technical assistance. Examples of outcomes of these touchpoints include reporting changes in May 2021 and additional routine trainings for CCRL staff, conducted at least twice annually and more often if a need arises, to help ensure consistency in call quality and data collection.

14.1 Review Period, Data Sources and Limitations, Population Measured

Figure 50: CCRL Data Overview

Data Review Period	Data Source	Limitations	Population Measured
January 1, 2022 – June 30, 2021	Help4WV – iCarol Call Reporting System	CCRL was implemented in conjunction with an active Help4WV line October 2020. Higher rates of incomplete data are expected for demographic information for this call line. When a family/person calls in crisis, it may not be prudent to collect all the desired data fields due to the urgent nature of the call or the need to establish a rapport quickly. “Calls” include texts and chats unless otherwise noted.	Children served directly through the CCRL. Services are provided to individuals and families with children 0 – 25 who are in emotional distress or with a diagnosis of an SED or SMI and their families who are in crisis or seeking referrals to related services. For purposes of this report, callers reporting an age over 21 were excluded from the data set.

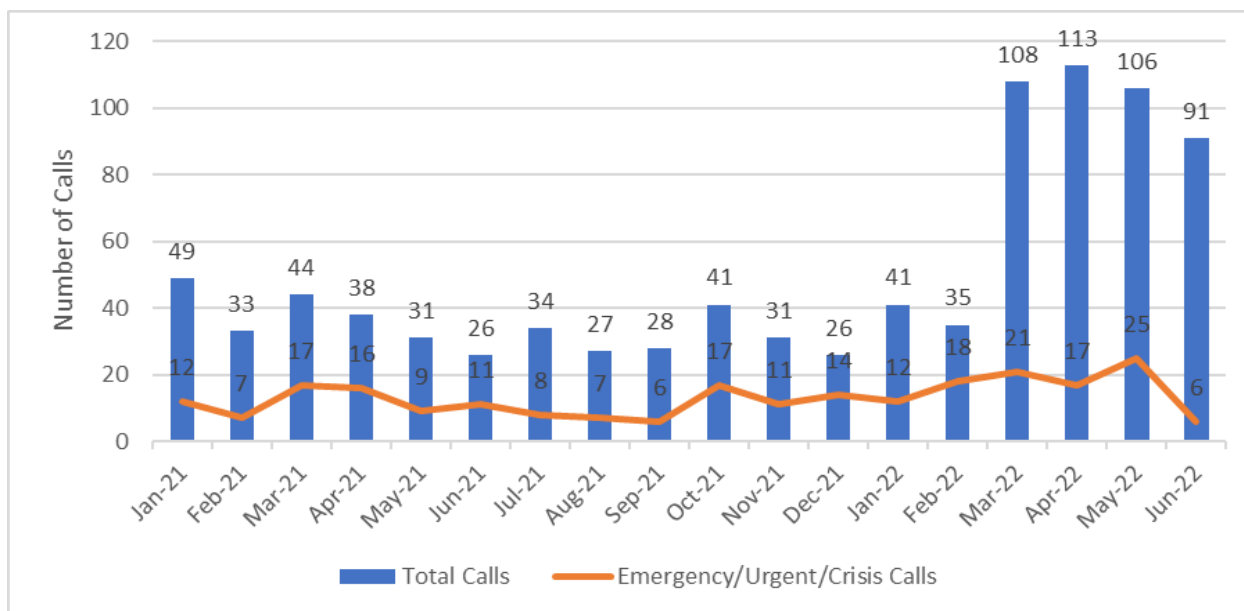
As noted above, the CCRL officially launched services in October 2020. While the Help4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated CCRL offers the added benefit of referral, support, and information services for children and their families. CCRL data is reviewed at least quarterly, with number of calls by acuity reviewed monthly, to assess call and referral quality and determine need for adjustment or improved outreach efforts.

14.2 Review Summary

At least one individual from 46 of the 55 state counties called the CCRL during the reporting period. Only 38 counties had an individual call the CCRL during the prior reporting period, indicating that knowledge and usage of the CCRL has expanded in recent months. Given the CCRL is still in its beginning stages as a resource for families, changes are expected as further outreach and knowledge of the line are expanded. The Quality Committee reviewed county-level coverage to assess opportunities for outreach; however, the map was excluded from this report due to the low rate of calls when viewing the information at the county level and considering 41% of calls indicated the county of origin as missing. The Office of QA will provide additional information and guidance in early 2023 based on cross comparison of several data sources at the county level (e.g., counties with high utilization of RMHTF placements and low use of the CCRL).

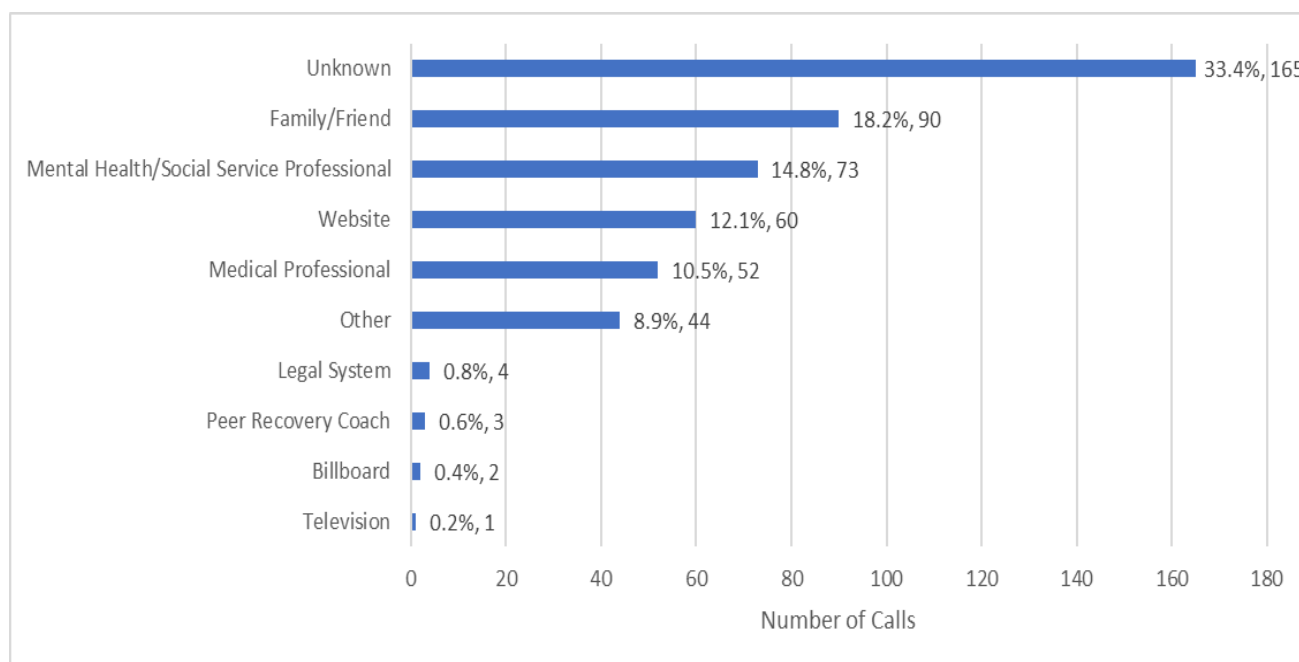
Figure 51 shows the number of calls by month and acuity type. Monthly values from January – December 2021 have also been included to compare with monthly values from the current reporting period. Calls in January and February 2022 were similar to the monthly average of 31 calls from July – December 2021; however, there was a large increase in monthly calls during March 2022, up to 108. The Quality Committee identified that this was similar to other increases in service utilization and referral, coinciding with the implementation of the Assessment Pathway and corresponding outreach and education efforts. High call rates were maintained from April – June 2022, ranging between 91 (June) and 113 (April) for an average of 104.5 calls per month between March and June. Notably, there were more calls in the first half of 2022 (494) than all of 2021 (408). While emergency/crisis/urgent calls have increased only slightly over the last 18 months, total calls have increased significantly since March 2022. DHHR is still working to understand these trends; however, the Quality Committee indicated this may be associated with increased use of the line as a referral source and, therefore, a decreased rate of crisis use overall. Increased use of the line as a referral source prior to a potential crisis creates the opportunity to divert youth and families from both crisis situations and out-of-home placements by connecting them to services and supports early.

Figure 51: CCRL Calls by Type of Acuity by Month, January 2021 – June 2022



The referral source for call is depicted in Figure 52. 33.4% of calls had an unknown referral source—the highest rate of any referral source, and a slight increase over the previous reporting period, when 29.4% of calls had an unknown referral source. Family/Friend was the second most common way individuals found out about the call line (18.2% of all calls). Up from 11.2% in the previous reporting period, 14.8% of all calls were the result of referral from mental health/social service professionals. BBH will work with the call-line vendor to expand referral source categories to include school related referrals and add a separate field for the “other” category so additional referral sources can be explored to identify outreach strategies that may support increased utilization of the CCRL.

Figure 52: Referral Source for Call, January – June 2022



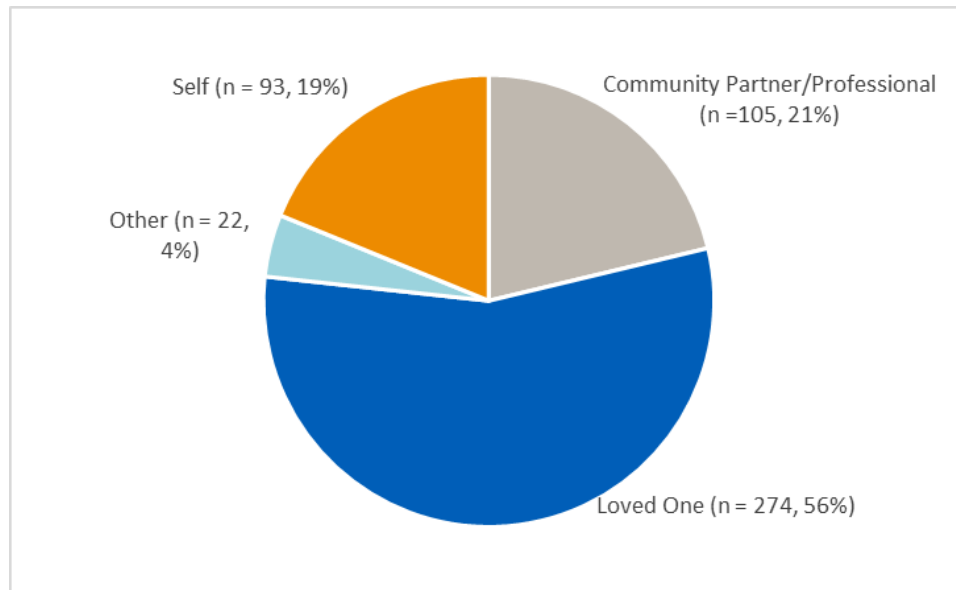
The increase in number of calls to the CCRL is largely a result of focused efforts to raise awareness given this is one of the primary entry points to the Assessment Pathway. Several press releases and meetings with partners occurred during this period, with over 100 additional outreach events and two dozen billboards placed by the CCRL vendor, as well as frequent social media posts and ads describing how to access CCRL services conveyed by both the vendor, DHHR, and involved partners. BBH also presented at the Healthcare Leadership Summit, Children with Emergency Health Needs group in 2022. Use of wallet cards with CCRL information and common behaviors on them have been popular, especially among primary care providers. Training and education with primary care providers about the line also occurred statewide during this period.

The caller's relation to the individual in need is displayed in Figure 53. It is noteworthy that:

- Out of all calls for the CCRL, 56% came from a loved one,³¹ while 19% were the child themselves making the call.
- The number of calls from a loved one was far greater than any other source (over 3 times the calls in the previous period).
- Community partner/professional calling had over twice as many calls (105) in the first six months of 2022 compared to the last six months of 2021 (45).

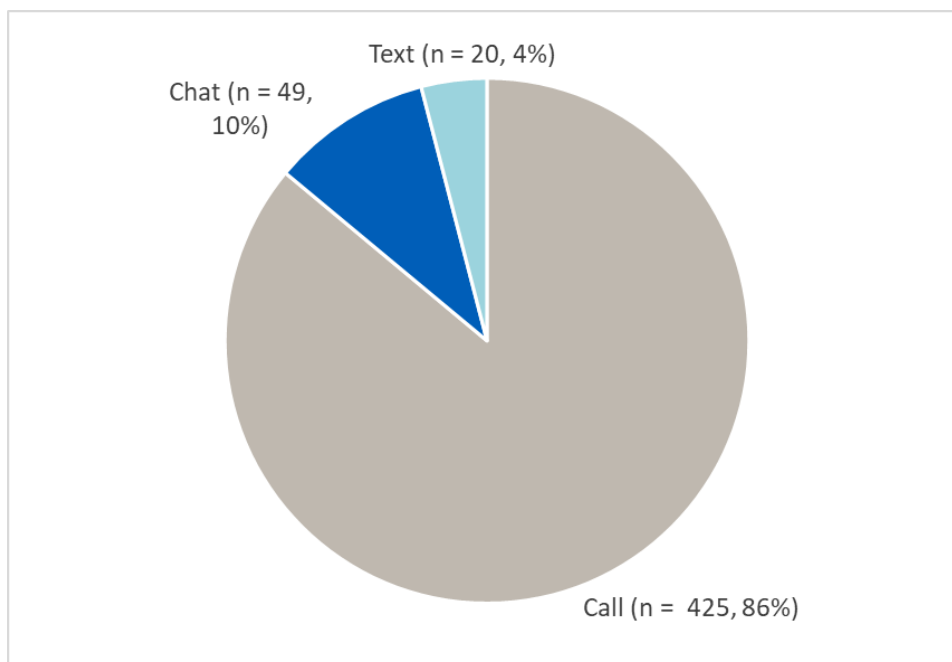
³¹ Note that "loved one" includes parent, grandparent, other family, guardian, friend, significant other, and/or spouse.

Figure 53: Caller Relation to Individual in Need, January – June 2022



As displayed in Figure 54, 86% of contacts in January – June 2022 came via traditional call compared to 14% of contacts that came from text and chat features; text and chat decreased from 18% of total contacts in the previous period. The utilization of chat or text highlights the importance of this alternative feature for children and families in need who may not feel comfortable reaching out verbally. As discussed in Section 6.0 Marketing, additional marketing to teens in 2023 will highlight these features. This feature presents a great opportunity for families in need; however, it is important to note it also presents challenges for capturing call-related data due to limitations of the chat/text format.

Figure 54: Type of Contact, July – December 2021³²

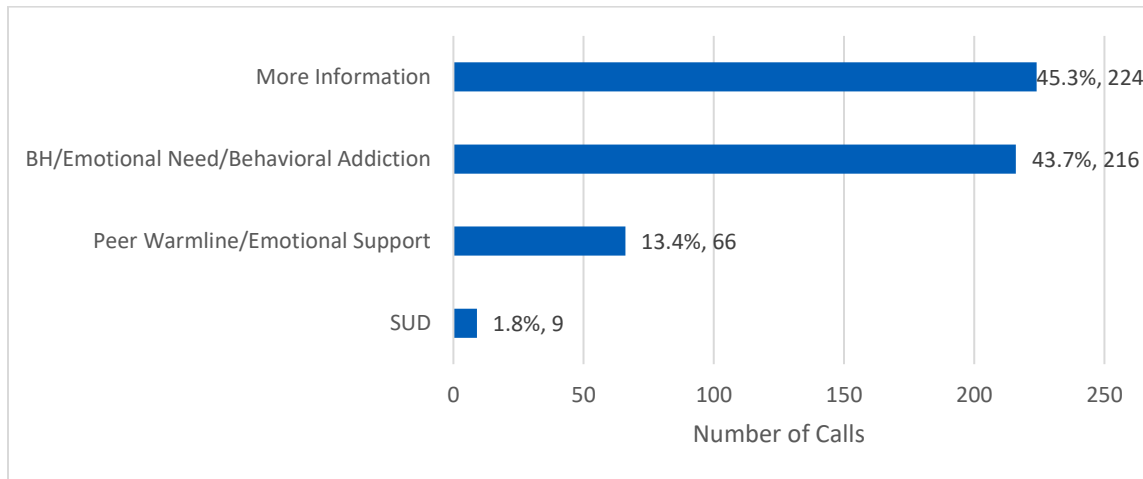


Individuals reached out to the CCRL for various reasons. As seen in Figure 55, in order of descending frequency, the needs of these individuals were the following: acquire more information (45%), behavioral health or emotional need (44%), seeking connection with Peer Warmline³³/Emotional Support (13%), and substance use disorder (2%). The number of individuals requesting more information (224) more than tripled since the previous period (65), which aligns with the rollout of the Assessment Pathway and relevant outreach and education efforts related to the CCRL. As of January 2022, staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs.

³² Note that individuals may have reported more than one need, making the total add up to greater than 100%, and all needs are self-reported and not necessarily representative of a clinical diagnosis.

³³ Warmline is a line that offers a personal connection; it can be to offer emotional support, help problem solve, or just listen; it can also help connect people to services.

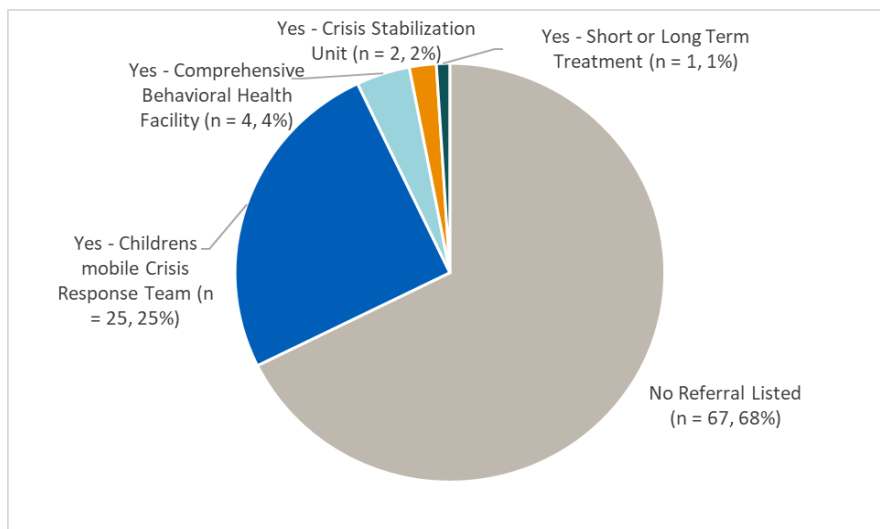
Figure 55: Presenting Need, January – June 2022



Of individuals for whom the call was reported as "emergency, crisis, or urgent" and had a response listed for referral, Figure 56 highlights 25% (down from 41% of these calls during July – December 2021) were reported as being directly transferred to a mobile crisis response team via "warm transfer."³⁴ BBH is in the process of working with the vendor to update the CCRL Desk Guide (revisions to be finalized February 2023) and to establish monthly data review meetings with the vendor to further identify opportunities for improvement and current strengths and improve understanding of the vendor's CQI processes. More information will be gathered to determine if these results reflect appropriate action by the CCRL and if additional training should be provided to call specialists.

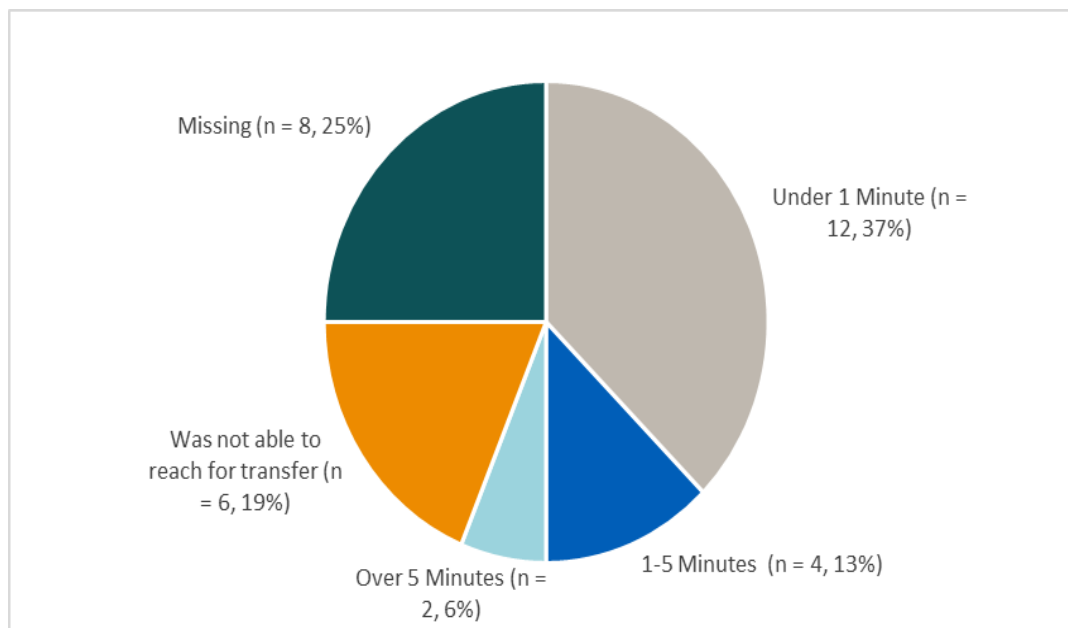
³⁴ "Warm transfer" is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed. The decision to attempt a warm transfer is made in conjunction with the family and their needs and willingness to accept assistance at the time of the call.

Figure 56: Referral Types for Calls Reported as “Emergency/Crisis/Urgent,” January – June 2022 (n=99)



Timeliness measures for warm transfer from the CCRL to a mobile crisis response team were added in May 2021 as seen in Figure 57. Of calls with a reported warm transfer attempt to mobile crisis services, 50% were connected in five minutes or less, with 37% connected in under a minute. Twenty-five percent of timeliness data was missing/unknown, identifying an opportunity for training for Help Line staff. Six call records listed that the Help Line specialist was unable to reach the mobile crisis agency for transfer. In cases where a CMCRS team is unable to be reached, the call-line specialists reach out to regional supervisors or BBH staff directly. DHHR will work with the vendor through established monthly meetings to help ensure data collection indicators are well defined, utilized, and all staff are aware of the process to transfer a call to a supervisor if a need arises.

Figure 57: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team, of Calls Reported as "Emergency/Crisis/Urgent" With Transfer Attempt, January – June 2022 (n=32)



14.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway, as well as media campaigns and other outreach campaigns, are anticipated to increase the number of services and awareness of the CCRL. CQI processes have permitted timely changes to training strategies and data indicators. First Choice Services, the provider that runs the CCRL, monitors call loads and weekly or seasonal trends to help ensure adequate coverage to meet family and child needs. Figure 58 provides data on the CCRL current and budgeted personnel.

Figure 58: CCRL Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Help Line Specialists	15	16.5	91%
Crisis Counselors	1	2	50%
Shift Leads (shared with other call lines)	4	4	100%

14.4 Strengths, Opportunities, Barriers, and Next Steps

Successful crisis response procedures require a focus on quick rapport-building and needs assessment, which can result in barriers to complete data collection. BBH and the call-line

vendor have worked consistently over the past year to improve data collection and to be able to tell the story of call outcomes more completely regardless of whether the caller needs a listening ear, additional information, or immediate services with a warm transfer. This has been demonstrated through sustained increases in calls and individuals seeking information for children in need. The centralized call-line staff help individuals quickly connect with behavioral health services and can divert inappropriate use of emergency rooms and 911 calls.

In addition to helping families in crises, 45% of calls requested information from the referral line, indicating individuals are using the CCRL as a valuable resource for information and connection to/awareness of services. It is also noteworthy that only 20% of calls for the period were reported as emergency/urgent/crisis. This was viewed as a likely positive indicator in the quality review meetings, as it was hypothesized families were able to access information and be connected to the Assessment Pathway before a crisis occurred, allowing for a potentially critical prevention opportunity. It is critical for the CCRL to maintain continuous awareness of various services statewide with access to efficient connections. Continued communication and training are essential in pursuit of this important function.

Next steps:

- Continue to work with the call center provider to help ensure that processes are in place to capture complete data when feasible and to capture missing data on follow-up calls.
 - The Quality Review Committee recommended working with the vendor to further explore data needs and quality through monthly reviews, making changes to data collection or providing additional training to staff when needed.
- Expand outreach and continue to encourage calls to the central line rather than local provider lines when possible, with focused outreach to counties identified via the additional analysis completed by the Office of QA.
- Continue to routinely review call-line data to identify opportunities for further outreach to families across the state and provide technical assistance for the call-line staff and the teams they refer to as needed to improve call and referral quality, including review of calls unable to be transferred in a timely manner.
- Continue outreach to medical offices and schools as part of expanded screening efforts.
- Work with providers and partners, including the WV Department of Education, to identify opportunities to collect information on direct referrals from schools to assess reach and need for outreach via schools more effectively.

15.0 Children’s Mobile Crisis Response and Stabilization (CMCRS)

The CCRL can connect youth experiencing a behavioral health crisis and their families to regional CMCRS services through a warm transfer to the closest regional CMCRS team. CMCRS services have been available statewide since May 2021. The family determines whether a situation is a “crisis” from their perspective. 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 crisis specialist is expected, on average, to provide on-site support within one hour of the request.

After de-escalating the crisis, the CMCRS team completes a crisis plan and links the youth or family to appropriate community-based services, including the Assessment Pathway, to help them stay in their homes and communities. In addition to calling the CCRL, which has been available since October 1, 2020, youth and families may call the regional CMCRS teams directly; however, DHHR’s crisis line promotional campaigns have shifted to calling the CCRL since its implementation.

In addition to services provided by CMCR, BMS also offers mobile response services through the CSED Waiver; however, these services were reviewed and noted in Quality Committee reviews that utilization had primarily shifted to calls to the CCRL regional CMCRs; therefore, only CMCRS data was included for review purposes in this report. BMS CSED Waiver mobile response will continue to be monitored routinely for any changes in utilization. Figure 59 provides an overview of the CMCRS data currently available.

15.1 Review Period, Data Sources and Limitations, Population Measured

Figure 59: CMCRS Data Overview

Data Review Period	Data Source	Limitations	Population Measured
January – June 2022	BBH System of Care Epi Info Interface	<p>At the time of this report, indicators regarding timely provision of services and referral to additional services were unavailable. Indicators will be added to the updated reporting system set to be revised in 2023 and will be reviewed in the future.</p> <p>Some concerns have been identified related to the new Epi Info System’s architecture. The system is currently undergoing further testing to identify any adjustments that may need to be</p>	<p>Children served directly through grantees of the BBH program. This includes BMS funded mobile response by these overlapping providers.</p> <p>Services are provided to individuals and families with children ages 0 – 21 experiencing an emotional or behavioral crisis initially through BBH’s CCRL or connected through a local CMCRS line.</p>

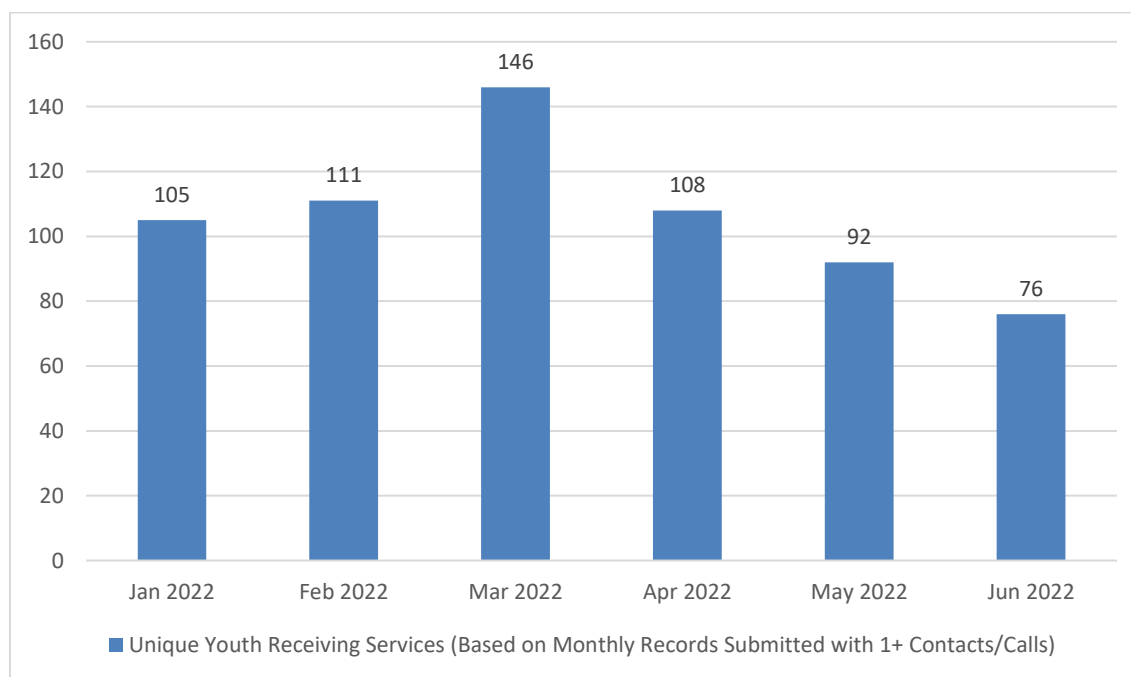
Data Review Period	Data Source	Limitations	Population Measured
		made. Due to this, data in Section 15.2 is considered preliminary.	

It is expected that the number of children and families served over time will increase as these new providers grow in rapport and awareness within their communities.

15.2 Review Summary

For the review period (January – June 2022), 604 children received CMCRS services across six regions. Utilization trends will continue to be monitored as more data becomes available at the child-level to further establish normal trends versus changes in service utilization. Some concerns have been identified related to the new Epi Info System’s architecture, and the system is currently undergoing further testing to identify any adjustments that may need to be made. Due to this, data in this section is considered preliminary. The BBH team is meeting weekly with its data system vendor to better understand any limitations or needed enhancements to the Epi Info System. Figure 60 below demonstrates current CMCRS demand and enrollment across the first 6 months of 2022, with March showing peak enrollment and utilization, coinciding with Assessment Pathway referrals and HCBS utilization. Youth may continue to be enrolled in the service for up to eight weeks and only utilize additional services as needed. Due to the data collection system being in the early implementation phase, additional quality checks are being conducted to assess for gaps in data collection and any technical assistance needed providers.

Figure 60: CMCRS Monthly Enrollment Totals and Service Utilization – Preliminary



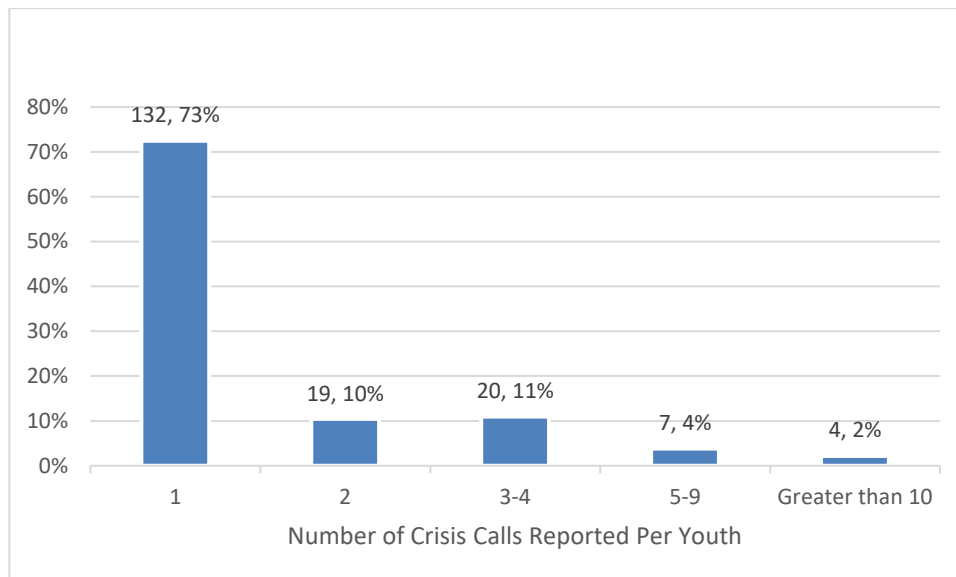
Information on the demographics of children enrolled in CMCRS services are included in Section 4.0.

CMCRS teams strive to reach vulnerable and marginalized populations, such as children who are adopted from foster care or children who identify as BIPOC or LGBTQ+. Data from the new interface had a larger percentage of missing information for adoptive status and identifying as LGBTQ+ compared to previous data collection, indicating an opportunity for improvement of data capture to assess family and youth needs and utilization more comprehensively. It should be noted, however, that this information may always have limitations due to the nature of crisis work. On the other hand, some information may also be available from other sources as the data store is built out.

CMCRS services provide a key opportunity for individuals who need to be connected to preventative and supportive services, such as Wraparound services. While CMCRS services are designed to provide short-term support, the connections and planning developed are meant to provide the family longer-term stability when possible.

Repeat callers were assessed for individuals enrolled during the 6-month period. Follow-up calls initiated by the provider were excluded. Data completion for enrolled youth was low, with 70% of youth having missing call information. DHHR will work with providers to improve data collection and completion efforts. Figure 61 shows frequency of repeat call utilization for youth with known call information, with 73% of those youth documented as having their needs met and/or stabilized within one call. For the remaining children, additional needs were met through multiple interactions. During review of the data, BBH program staff indicated they would like to look at outliers in the future to understand the characteristics and circumstances of individuals accessing crisis response repeatedly (e.g., greater than 10 calls in a period). The program team agreed that this information could help identify possible unmet needs or gaps in available services which can help stabilize families and keep youth in their homes and communities when possible. The proportion of missing data identified will be a key item to improve upon following identification and resolution for any areas of concern with system architecture.

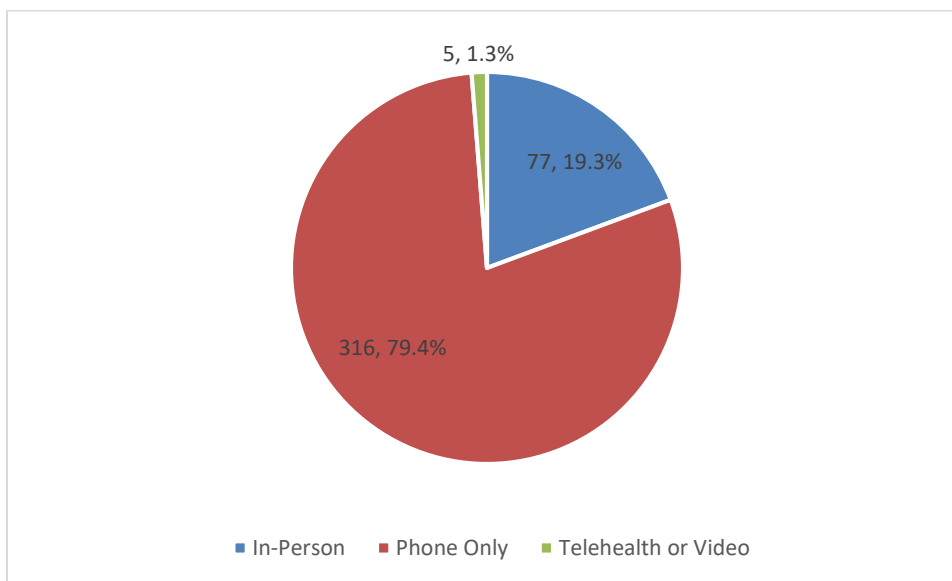
**Figure 61: Number of CMCRS Crisis Calls Reported Per Youth Served January – June 2022
(Excluding Follow-Ups Initiated by the Provider and Youth With Missing Data n=182) – Preliminary**



The majority of crisis calls with a known call type (81%, Figure 62), excluding follow-ups initiated by the provider and youth with missing data, were indicated as completed and stabilized over the phone or via telehealth while 19% required or preferred in-person intervention and stabilization services. Additional analysis explored children with call-type data and more than two (>2) crisis calls and found that 52% of children with more than two calls received an in-person response. These calls for children with more than two crisis calls included 31 children with a total of 228 crisis calls during the period, and 37 of which were in-person responses. Additional assessment is needed to help determine if needs are being met and if in-person services are offered when appropriate and agreed upon by the family.

Figure 62: Response Type for CMCRS Crisis Calls January – June 2022

(Excluding Follow-Ups Initiated by the Provider and Youth With Missing Data n=398 Calls, for 182 Youth) – Preliminary



Follow-up calls represented 1,438 additional calls directly from providers to follow-up post-crisis (16% of calls) or to work through prevention strategies with the family (84% of calls).

Additional updates to data collection for timeliness and detail of services will occur in 2023. This will allow quality monitoring of timely response to needs, as well as to improve understanding of capacity and intensity of service needs. Training is developed through Marshall University in conjunction with the University of Connecticut for both Wraparound and Mobile Response/Crisis services to provide consistent training and curriculums across payor sources.

15.3 Provider Capacity/Statewide Coverage

CMCRS services were available statewide as of May 2021. In addition, the CCRL is transitioning to being the primary source to route individuals in crisis to the appropriate mobile crisis team. Individuals may also be connected to mobile crisis services through the Assessment Pathway.

Providers have indicated challenges still exist in providing response within one hour due to the rurality and geography of the state. Data regarding timely response are not yet available but are being refined to help ensure national standards are being met and to support CQI reviews in the future. Since BMS only accounts for a small number of response services, that information was not included here. It should also be noted that children enrolled in CSED are referred to the CCRL and thus CMCRS services as a primary mobile response service option.

Marshall University is contracted in conjunction with University of Connecticut to assist with development of training and curriculum programs for both CMCRS and WV Wraparound. Currently BBH, BMS, and BSS staff meet with Marshall University weekly as part of the continuing planning efforts.

As indicated in Figure 63, some BBH CMCRS providers are currently undergoing staffing shortages, with only 62% of positions throughout the state filled. Region 3 indicated all positions were filled; in contrast, Region 5 added budgeted personnel, but vacancies have increased since the previous period, with only 25% of positions occupied. DHHR will continue to work with providers to offer technical assistance for improving workforce capacity.

Figure 63: BBH CMCRS Provider Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	4	7	57%
Region 2	4	5	80%
Region 3	5	5	100%
Region 4	5	7	71%
Region 5	2	8	25%
Region 6	3	5	60%
Total	23	37	62%

15.4 Strengths, Opportunities, Barriers, and Next Steps

Statewide CMCRS coverage creates opportunities to offer crisis relief and plans for stability to support families and children in need. In the first several months of 2022, DHHR identified increased awareness and adoption of these critical stabilization services, as well as utilization as an additional support to families awaiting longer term services. The implementation of an interconnected network with the CCRL, Wraparound services, Assessment Pathway, and warm transfer to mobile crisis and stabilization teams allows multiple entryways and connections to longer-term services for children and families with different levels of need.

Next Steps:

- Continue raising awareness of these services to diverse communities, including BIPOC, children identifying as LGBTQ+, and adoptees.
- As data become available on timeliness of response, additional assessment should focus on regional needs and technical assistance.
- Additional training and technical assistance should be provided to improve data quality and completion. BBH has already begun to develop detailed reports highlighting missing data, which can be addressed with providers.
- Continue to conduct outreach for crisis services based on findings across the state and in key access points, as with CCRL services, with identification and outreach for areas of focus with low utilization of crisis services and/or high RMHTF placements. With support

from the Office of QA, identify counties for prioritization.

- Increase two-way communication about service accessibility to all families through marketing efforts.
- DHHR will work with CMCRS providers to offer technical assistance to improve workforce occupancy.
- As with CCRL, provide additional outreach and education to stakeholders for identified access points such as emergency departments, medical offices, schools, etc.

16.0 Residential Mental Health Treatment Facility (RMHTF) Services

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

Reducing the overall census in RMHTFs continues to be a primary focus for DHHR. DHHR surpassed the initial goal of reducing census to 822 by December 31, 2022, with a preliminary³⁵ census of 781 children as of year-end. DHHR has a further goal to decrease census to 712 by December 31, 2024. While an overall decline has been observed, some fluctuation in census throughout the period was noted. Following the lifting of pandemic restrictions in February 2022, an increase in overall RMHTF census was observed, followed by a decline when schools released for the summer. An increase was noted with school going back into session followed by a decrease around the holidays. DHHR leadership monitors the census on a weekly basis. The Quality Review Committee and program teams are continuing to monitor census, admissions, and discharges over time to better understand seasonal trends associated with holidays and school being in and out of session. Figure 64 provides an overview of the RMHTF data sources and limitations.

In addition to overall census reductions, other areas of focus include:

- Helping to ensure children currently placed in RMHTFs are appropriately placed.
- Reducing the average length of stay for children after residential placement occurs.
- Reducing the number of children placed out of state to allow children to receive treatment closer to their homes and communities.

DHHR's prioritized activities in the last six months include implementation of the QIA process and continuing prioritized discharge planning, both of which will be described in more detail later in this section.

³⁵ The year-end census is considered preliminary due to possible lag issues; therefore, this number could change slightly once confirmed.

16.1 Review Period, Data Sources and Limitations, Population Measured

Figure 64: Overview of RMHTF Data

Data Review Period	Data Source	Limitations	Population Measured
January – June 2022	BSS FACTS Data System BMS DW/DSS	DW/DSS claims are the data source for parental placements to PRTFs. Owing to claim payment lag and data warehouse update cycles, parental placement data for the later part of the study period may be incomplete. As noted, claims data accounts for less than 2% of RMHTF data. Claims data reported here include payments through October 2022. FACTS data may show a brief lag, as field workers may not be able to update the system immediately, but analysis shows FACTS data are stable after one to two months. Therefore, FACTS data for the study period, based on analyses completed in December 2022, including FACTS data updated through November 2022, can be considered complete.	RMHTF enrollment and utilization data for children in state custody are sourced from FACTS. Parental placements of children in PRTFs are sourced from the DW/DSS.
January – October 2022	MCO RMHTF Monthly Report spreadsheet	The data was updated on November 17, 2022, and is representative of data through the end of October. All date calculations (e.g., age and length of stay) for children in placement are done using October 31, 2022, as a reference date for the period, while the discharge date was used for children who have been discharged.	Children included in this report related to discharge planning are in an in-state RMHTF and have a CAFAS/PECFAS score less than or equal to 80 (i.e., less than 90).
July 2021 – June 2022	Child Placing Agency (CPA) Reporting	Data is collected in aggregate from each agency therefore analysis limitations exist and potential for manual entry error is increased. DHHR is considering mechanisms to improve data collection and review.	Foster homes certified through and reported by CPAs.

16.2 Review Summary

16.2(a) Qualified Independent Assessment (QIA)

Effective May 1, 2022, DHHR expanded its contract with Kepro, the ASO, to perform a QIA of children who are at high risk of residential placement or referred to residential placement or shelter care, as a part of the Assessment Pathway process. “High risk” is defined as meeting at least one of any of the following categories:

- Judicial involvement that indicates the child may need residential care or requests residential placement options and/or requests referral made to residential treatment facilities.
- The child is not cooperative with the court’s requests.
- The child has disrupted other arranged placement such as a kinship/relative home or foster home and no other options are available.
- The child’s family requests removal from the home, or the home is unsafe, and no alternative family settings are available.
- The child has no stable family home or other living arrangement.
- The child requests placement in a residential mental health facility.
- The child has been adjudicated as a status or delinquency offender.
- The child has a previous YS or open CPS case with history of removal within the last 24 months.
- The child has been previously adopted and the adoption is at risk of disruption.
- The child is a danger to themselves or others.

A CAFAS/PECFAS and CANS assessment, including the CANS Decision Support Model, will be utilized for the QIA. The assessment will identify the child’s needs and provide a recommendation on the appropriate level of intervention and least-restrictive service setting to meet those needs.

Currently, DHHR is working with the ASO and MCO to implement the QIA process, data collection, communication, and monitoring through a phased rollout approach, with all counties active as of May 2023 for individuals who are involved with BSS and are not currently placed in an RMHTF. As of December 19, 2022, 20 of WV’s 55 counties have implemented this process into their workflows for BSS cases, with 22 referrals received since the process was initially piloted on August 16, 2022. Additional data to be monitored will include timeliness of processes, county comparison to residential admission, key assessment decisions, outcomes, and reasons for deviations from assessment recommendations. Throughout the phased implementation, this data will be reviewed, and adjustments made to the phased approach as relevant.

Effective August 2022, BSS directed residential providers to begin referring any new children

entering residential placement to the QIA process. This new process is still in the early stages of adoption among residential providers. Following increased referrals from residential providers, the ASO experienced staffing challenges and is working to increase assessor capacity to meet the demand. Due to staffing limitations, referrals from residential facilities are currently only receiving CSED application determination. A plan for review and full implementation of referrals by residential providers through the QIA process will be established in early 2023, with biweekly meetings continuing with the ASO to help ensure a plan is in place to fully expand use of the QIA process.

Additionally, DHHR is collaborating with Marshall University and the Praed Foundation to continue to validate and refine the 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 or kinship care, and Level 5 being the highest level of residential placement, a PRTF. The decision support model assists with making level-of-care recommendations that are based on treatment need and complexity.

The QIA process is a key component of helping to ensure children are assessed for appropriate treatment intervention and placed in the least-restrictive setting to meet their needs and will assist with diverting children from unnecessary residential placement.

16.2(b) Prioritized Discharge Planning

DHHR continues actively collaborating with the MCO, Aetna Mountain Health Promise, to prioritize discharge planning for children currently placed in residential settings with a CAFAS/PECFAS score less than 90.³⁶ To assist with this effort, collection of data elements associated with discharge planning was initiated in January 2022. Since that time, efforts to improve data quality have continued, and Aetna has indicated plans to convert data collection to a QuickBase system sometime in the first half of 2023. This data set is prioritized for incorporation into DHHR's data store to allow analysis at the child level and comparison to other data sets such as those associated with the CSED Waiver. Incorporation of the discharge planning data set into the data store is anticipated by mid-year 2023.

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. As of October 2022, 150 children were in residential settings with a CAFAS/PECFAS score less than 90. These are primarily children who have made improvements through residential intervention (i.e., their scores have dropped below 90 during treatment), with the balance representing children who were admitted with a score less than 90. To better understand improvements in CAFAS/PECFAS scores over time and allow differentiation in children who enter with scores less than 90 from those who make improvement through intervention, DHHR has prioritized CAFAS/PECFAS score reporting for addition to the data store. This data set is expected to be

³⁶ A CAFAS/PECFAS is completed every 90 days for children in residential placement. A child's most recent CAFAS/PECFAS score is being utilized for purposes of this report and may not be reflective of the child's initial needs or score at entry to the RMHTF.

operational within the data store in early 2023 at which time additional analysis will be possible.

As described in the previous subsection, once the qualified independent assessment process is fully implemented, all children, including those with a score less than 90, will be assessed for appropriate treatment intervention and services to meet their needs in the least restrictive environment. DHHR is taking steps to understand the characteristics and discharge barriers of children placed in residential settings with a CAFAS/PECFAS score less than 90. There are some challenges to effectively completing this analysis due to data quality issues that DHHR is working through with the MCO, though these challenges are anticipated to be resolved through the implementation of the QuickBase system in the first half of 2023. As data quality improves, DHHR plans to use information from the analysis of child characteristics and discharge barriers to better inform any gaps in community-based care or areas where additional outreach and education is needed.

DHHR is working to enhance data collection to understand the characteristics of the population of children in residential with CAFAS/PECFAS score under 90 in residential settings more comprehensively. Available data for the period January – October 2022 are as follows:

Gender: 61% were male showing a similar proportion to all individuals in RMHTF settings.

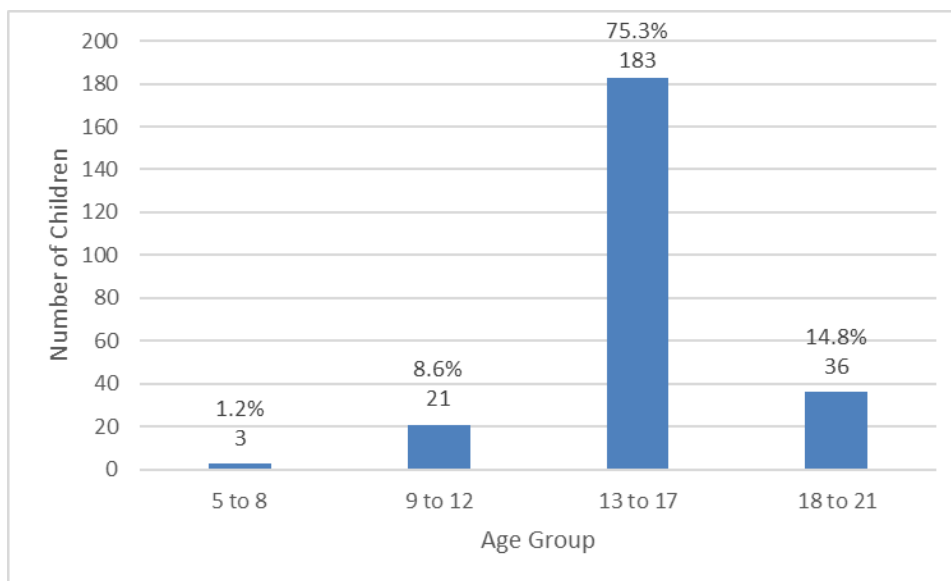
Age: Similarly, 75% of individuals with CAFAS less than 90 fell into the 13 – 17 age category (Figure 65) compared to 80% of all individuals in RMHTFs. This points toward similarities in populations for the broader RMHTF population and those with scores below 90; however, this will need to be considered further as more data become available, as there were some identified differences in the 9 – 12 age category and a larger difference in individuals 18 – 21.

Approximately 15% of individuals with a CAFAS/PECFAS less than 90 were ages 18 – 21 compared to 5% in the broader residential population. CAFAS/PECFAS scores at admission were not available for some individuals; therefore, functional improvement during residential treatment could not be accurately assessed for purposes of this report. As noted previously, CAFAS/PECFAS score history is prioritized for addition to the data store to allow a more complete analysis. Based on preliminary review, many of these individuals have made progress during residential intervention as evidenced by transitioning to lower levels of care, including transitional and independent living settings with some participating in college or vocational programs. Some of these individuals have requested to remain in a residential setting where they receive housing and educational supports, as they do not have family available and do not want to be placed in a foster home. The 18 – 21 age group representing a greater proportion for those with an identified CAFAS/PECFAS less than 90 could be an artifact of longer time in care—time to stabilize the individual—or could be indicative of a need for alternative community-based placement options to meet the unique needs of transitioning youth.

Based on the number of 18–21-year-old youth who need transitional living supports and services, DHHR is seeking to implement a transitional living model of care. As a first step toward establishing this new model, DHHR is planning to release an Announcement of Funding Availability for Transitional Living for Vulnerable Youth in Residential Programs in early 2023. DHHR is seeking current residential service providers to convert existing residential capacity to serve youth between the ages 17 – 21 who are in the custody of BSS, have demonstrated an

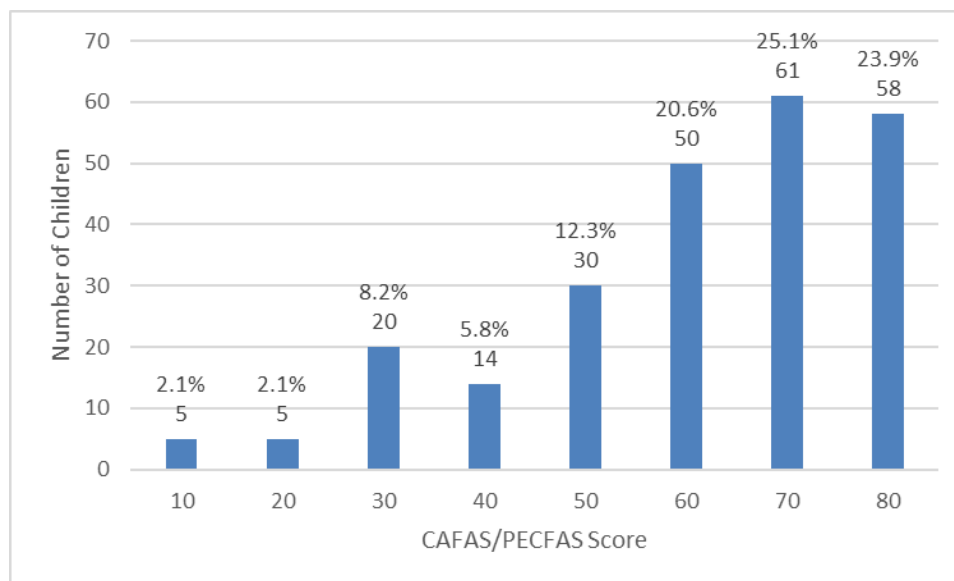
inability to function in a foster home, kinship/relative home or other less-restrictive community-based placement setting, and are engaged or ready to develop or improve their independent living skills (e.g., ready to connect to employment, educational programs, community resources, permanent connections, community medical and mental health resources). Based on forecasted need, DHHR is seeking capacity for a total of 70 youth with approximately 35 in the northern region of the state and 35 in the southern region. The goal of these services is to prepare and facilitate youth transitioning into independent or semi-independent community-based settings and the development of permanent connections to support their success.

Figure 65: Age of Children With CAFAS/PECFAS Less Than 90 in an RMHTF Setting



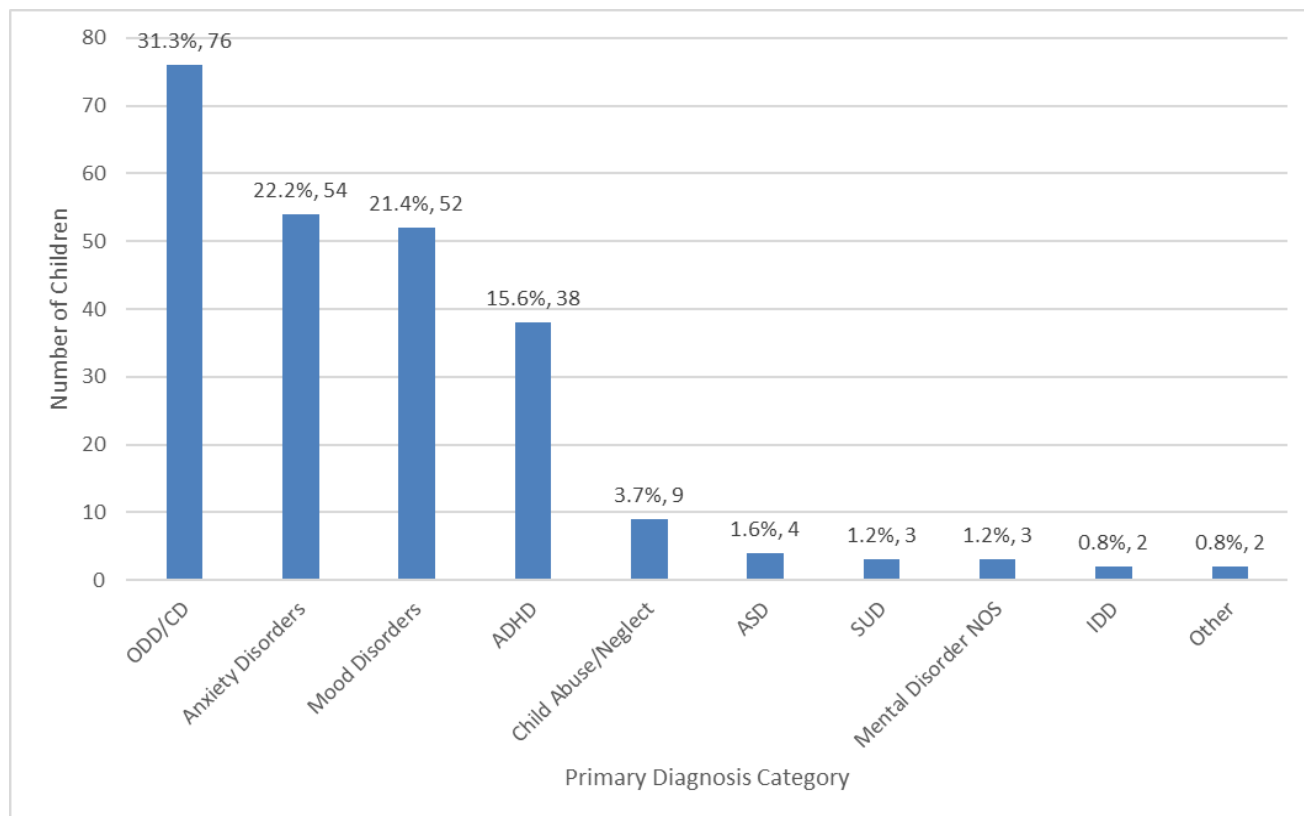
Functional Ability: CAFAS/PECFAS scores for children in in-state residential placement prioritized for discharge are shown in Figure 66. Approximately 70% of these individuals have scores in the 60 – 80 range with a very small percentage of children scoring in the 10-20 range. The decrease in scores may be an element of time in residential intervention resultant in improvement in functional ability, although more time is needed to better understand the characteristics and unique circumstances of these children, particularly those with very low scores. Currently, out-of-state residential providers are not required to complete CAFAS/PECFAS. Previously, the Quality Review Committee asked consideration to be given to requiring out-of-state providers to implement, track, and report CAFAS/PECFAS scores for children in out-of-state residential placements. As a next step, the Office of QA will be contacting the Casey Family Programs for technical assistance on how this is handled in other states to assist with evaluating feasibility of requiring CAFAS/PECFAS assessments for children in out of state placements.

Figure 66: CAFAS/PECFAS Scores Less Than 90 for Children in Residential Placement, January – October 2022



Diagnosis: Primary diagnosis related to authorization for residential services was also considered in this review (Figure 67). The most common primary diagnosis for authorization is conduct disorder or oppositional defiance disorder (31%) followed by anxiety disorders (22%) and mood disorders (21%). Note while children may have had co-occurring or coexisting diagnoses, only the primary diagnosis related to authorization was reported here. BSS program staff note that based on historical experience, foster families are less willing to accept a child diagnosed with oppositional or conduct disorders. Additional time and data are needed to better understand the considerations associated with diagnosis and barriers with community placements. As characteristics of children ready for discharge to the community is shared with CPAs in early 2023, DHHR will seek input from CPAs and foster care families on the concerns and barriers with supporting children with these disorders in an effort to determine any additional training and supports needed to encourage families to serve these children.

Figure 67: Primary Diagnosis for Authorization for Children With CAFAS/PECFAS Less Than 90 in In-State Residential Placement, January – October 2022



Discharge Planning and Review Processes:

Since June 2022, BSS and the MCO, Aetna Mountain Health Promise, meet twice each month to review the status of children prioritized for discharge and address any identified discharge barriers. Outcomes related to this process are still being assessed, as data quality improvement efforts continue to be strengthened.

For the January – October 2022 period, discharge barrier data was reported for 168 of 243 children (70%). Through monthly data reviews, DHHR and the MCO have continued to refine the discharge barrier options, including adding an option “child has no discharge barriers, plan is in place and actively moving forward,” so that data can be captured in this field even if a child has no barriers to discharge. Additionally, to help ensure improved data completion, the MCO recently implemented a quality review process prior to each monthly data submission.

Based on available data, 29 records (17.3% of youth with discharge barrier data reported) indicate the child has no discharge barriers; the discharge plan is in place and actively moving forward. The top discharge barriers remain the same as the prior reporting period as follows:

- An appropriate and viable discharge plan is not in place (17.3%, n=29)
- Child in need of foster family; none available at this time (13.7%, n=23)
- Parent/family is not ready to have the child return but is making progress toward that

goal (12.5%, n=21)

Lack of an appropriate and viable discharge plan has continued to be a barrier. To address this barrier, DHHR and Aetna are partnering on the following steps:

- Discharge plans are expected to be in place for all children in in-state residential settings with a CAFAS/PECFAS score less than 90 by December 31, 2022.
- An initial meeting was held with the in-state residential provider stakeholder group on November 30, 2022, to receive feedback from providers on any barriers to discharge planning. There was some confusion among providers on what constitutes an appropriate and viable discharge plan. As a result, additional training on discharge plans will be conducted in 2023. The December 31, 2022, target date was communicated to providers.
- Effective October 31, 2022, monthly reauthorization is required for all children in in-state residential placement. The monthly reauthorization process requires a review of the discharge plan. While this process is in the early stages of being adopted across residential providers, once fully implemented, the process will assist with helping to ensure discharge plans are in place for all children in residential settings.
- The BSS team recently increased licensing visits to two visits per year and one unannounced visit. A review for discharge plans is included in the licensing reviews.
- The MCO, Aetna Mountain Health Promise, continues to provide discharge planning training for Aetna Mountain Health Promise care managers, BSS staff, and residential providers. This training is based on standards for discharge planning defined by the Council on Accreditation. For the period January – November 2022, training was completed with 747 participants. In January 2023, the MCO is retraining all staff. Retraining of residential providers and BSS staff is planned for the second quarter of 2023.
- The Quality Committee also recommended coordinating with the MCO to begin completing formal, periodic quality reviews of discharge plans. This possibility will be explored with the MCO in 2023.
- The Quality Committee continues to recommend that discharge planning be established as a requirement for out-of-state providers. BMS updated the PRTF policy manual effective January 1, 2023, to require out-of-state PRTFs to complete discharge plans. In 2023, BSS will take steps to address discharge planning for out-of-state group residential providers.

Since March 2021, the MCO has continued to hold specialized reviews for children experiencing a crisis or placement disruption. Any member of the child's multidisciplinary treatment team can request the review. Once requested, the review is typically held within 24 hours, and all multidisciplinary treatment team members are invited. From March – December 2021, 116 reviews were completed. From January – November 2022, 210 reviews were completed. Judges are invited to participate in specialized reviews with some judges being more active than

others. The MCO plans to place emphasis on involving judges in 2023. To support enhanced data collection associated with specialized reviews, including capturing data at the child level, the MCO recently converted to the QuickBase system. Preliminary review of the data indicates that recommendations from the review team are not necessarily followed due to a variety of factors. The MCO and the Office of QA have agreed to explore data enhancements in the QuickBase system related to recommendations versus actual outcomes of specialized reviews. DHHR would like to be able to include this information in the data store at some point in the future.

To help facilitate transitions to lower levels of care and community placements, the MCO implemented monthly Faces to Cases meetings with providers in February 2022 to provide more individualized information for children needing placement. Each level of care has a set monthly review meeting in which information on children is presented. Through this process, individualized information on three to four children is shared with specific providers based on possible fit. For the period February – November 2022, 26 Faces to Cases meetings have been held and 64 children reviewed. While this process is still new, the initial outcomes represent an improvement over what DHHR has observed historically, as there is better coordination among providers working together to find community placements. To improve data tracking associated with these reviews, the MCO recently converted data collection to the QuickBase system. The MCO and the Office of QA have agreed to review data needed to improve understanding of the outcomes for children following Faces to Cases reviews and help ensure data is available to assess the strengths and barriers of this process. BSS and the MCO will continue to partner to find ways to improve sharing the characteristics of children ready for discharge with CPAs and other community-based providers to support more timely transitions from residential care into the community.

Expanding Foster Care and Kinship Home Capacity:

To help address the lack of available foster families, DHHR is in the early stages of establishing data collection and monitoring of foster home capacity. In the October 2022 reviews, the DHHR Quality Committee reviewed several indicators related to foster care capacity gathered from CPAs in July 2022, including active foster homes, newly certified foster homes that accept youth aged 13 and older, and preliminary data on the ratio of child placements per certified home by child welfare district. Initial review indicated approximately one-fifth (20%) of active foster homes did not have a current placement (Figure 68). There were over 1,200 active homes across WV with an average of two placements in each home. CPAs reporting showed 494 homes opened from July 2021 – June 2022 and 490 homes closed during that period out of the total homes certified, yielding a net gain of four homes. As such, overall statewide foster home capacity remained essentially flat.

Given the high demand for children ages 13 and over, the Quality Committee noted that 154 out of 494 (31%) newly certified homes statewide were willing to accept youth aged 13 and older. As of November 2022, 83% of children with a CAFAS/PECFAS less than 90 and with a barrier of no family to discharge to were age 13 or older. The Quality Committee identified the need for additional homes accepting youth in this age group, which will be an important consideration as additional analysis, reviews with vendors/CPAs, and planning takes place in the coming months.

Additional analysis is planned to determine specific information for youth in an RMHTF with a CAFAS/PECFAS score less than 90 in need of a community-based placement to assist with focused foster care recruiting. DHHR will work with CPAs to identify what is working and not working for recruitment and retention efforts, as well as gain a more detailed understanding of home closures. Discussions with the CPAs will also include additional analysis and review of data to determine districts where there is greatest need and the characteristics to look for in a foster family that will meet those needs, as recommended by the Quality Committee. These efforts, in collaboration with the CPAs, will be a prioritized area of focus for DHHR in 2023.

Figure 68: Summary of Child Placing Agency Certified Foster Homes in WV as of July 2022

	Total	Percentage of Active Homes
Certified homes	1,490	--
Active homes	1,235	100%
Active homes with placement	992	80%
Active homes without placement	243	20%

While foster care capacity is limited, placement of children in kinship homes is a strength in WV’s system of care. WV currently leads the nation in kinship placements with over 50% of children being placed in kinship homes each year. As of December 2022, 57% of in-state placements were in kinship homes.

DHHR contracted with Marshall University to develop a survey for foster, adoptive, and kinship care families for purposes of gaining an understanding of the needs of foster, kinship, and adoptive parents and the needs of the children in their care. This annual survey, which is currently in development, will cover training, support, services, other resources, barriers and opportunities experienced in the WV Child Welfare System. Information gained from the survey will assist with identifying ways to bolster support for families so they can better support the children in their care.

Developing Alternative Options to Support Individuals When No Family Setting is Available

Given challenges in finding adequate foster care families to meet the unique needs of some youth and the lack of kinship families, DHHR is also considering what alternative options may be available for youth who do not meet the criteria for a residential setting but have no other options available. A residential stakeholder meeting was held in July 2022 to share with providers and other stakeholders the upcoming Call for Information with an August 2022 scheduled release date. The Call for Information was a request for innovative ideas and feedback from providers, youth, families, and advocates on how to serve children who do not meet the criteria for continued placement in a residential facility and do not have a family setting available at discharge. The Call for Information was posted on August 8 – September 30, 2022, on the Kids Thrive Collaborative [website](#) and participants on the listserv were notified via email.

There were 19 responses from providers, youth, families, and advocates. Feedback from the responses was shared at the Kids Thrive Collaborative meeting on December 1, 2022, and will be used to inform future models of care.

In addition, DHHR is collaborating with Chapin Hall and Casey Family Programs as the model-of-care continuum evolves in WV.

16.2(c) Residential Services

Information reflected in the following figures represent children in state custody placed in residential settings and parentally placed children in PRTFs. Demographic information for children in residential settings are reported in Section 4.0.

The first day of the month, point in time census trend data are provided for an expanded period outside the typical review period for this report. The January 2021 – October 2022 data show census has declined from 817 on January 1, 2021, to 757 as of October 1, 2022. Given the importance of this metric, census is monitored weekly by the Executive Steering Committee and other DHHR leadership.

For purposes of quality improvement and identifying where to focus efforts, DHHR has begun tracking residential placement rates by child's county of origin. Figure 69 shows placements throughout calendar year 2021. The greatest rates of RMHTF utilization were represented by some of the most rural counties in the state, with Randolph County having the highest rate at 9.2 per 1,000 children with a population of less than 6,000 children under age 20. In contrast, Jefferson County, an urban county, had the lowest rate at 1.1 per 1,000 children, with nearly 14,000 children living in the county. Counties with a high number of admissions are also being identified, as they will have a greater impact on decreasing RMHTF census. These counties can also be used to bring a regional focus to outreach, education, and service provision, which could make some of the largest impacts to WV's overall number of placements. Counties such as Kanawha and Cabell, among the most populous areas in the state, were expected to have higher numbers of admissions, with an average admission, respectively, of 12 and 9 children monthly in 2021. Wood and Mercer counties, each with populations less than 20,000, had approximately the same average monthly admissions (four) as Berkeley County with a population of over 30,000 children. To consider reductions in overall census it is important to continue to look at the number of placements by removal county to identify state needs—just because a county is more populous does not mean the number of placements will necessarily be higher.

The Office of QA will conduct additional analysis in early 2023 to enhance prioritization for outreach across service types and relevant agencies. In 2022, DHHR focused on counties with low referrals to HCBS and high rates of placement to RMHTFs, as noted in Section 6, Marketing. Priority counties were considered for early implementation when planning county-level rollout of the QIA. Additional information was also noted and considered as important for comparison in establishing future geographic areas of prioritization among the Quality Committee members. The Office of QA will work with the relevant program teams to refine this analysis and provide additional recommendations for the remainder of 2023, utilizing complete 2022 data once available.

Figure 69: 2021 RMHTF Unduplicated Head Count Per 1,000 Children Under 20 by County of Origin

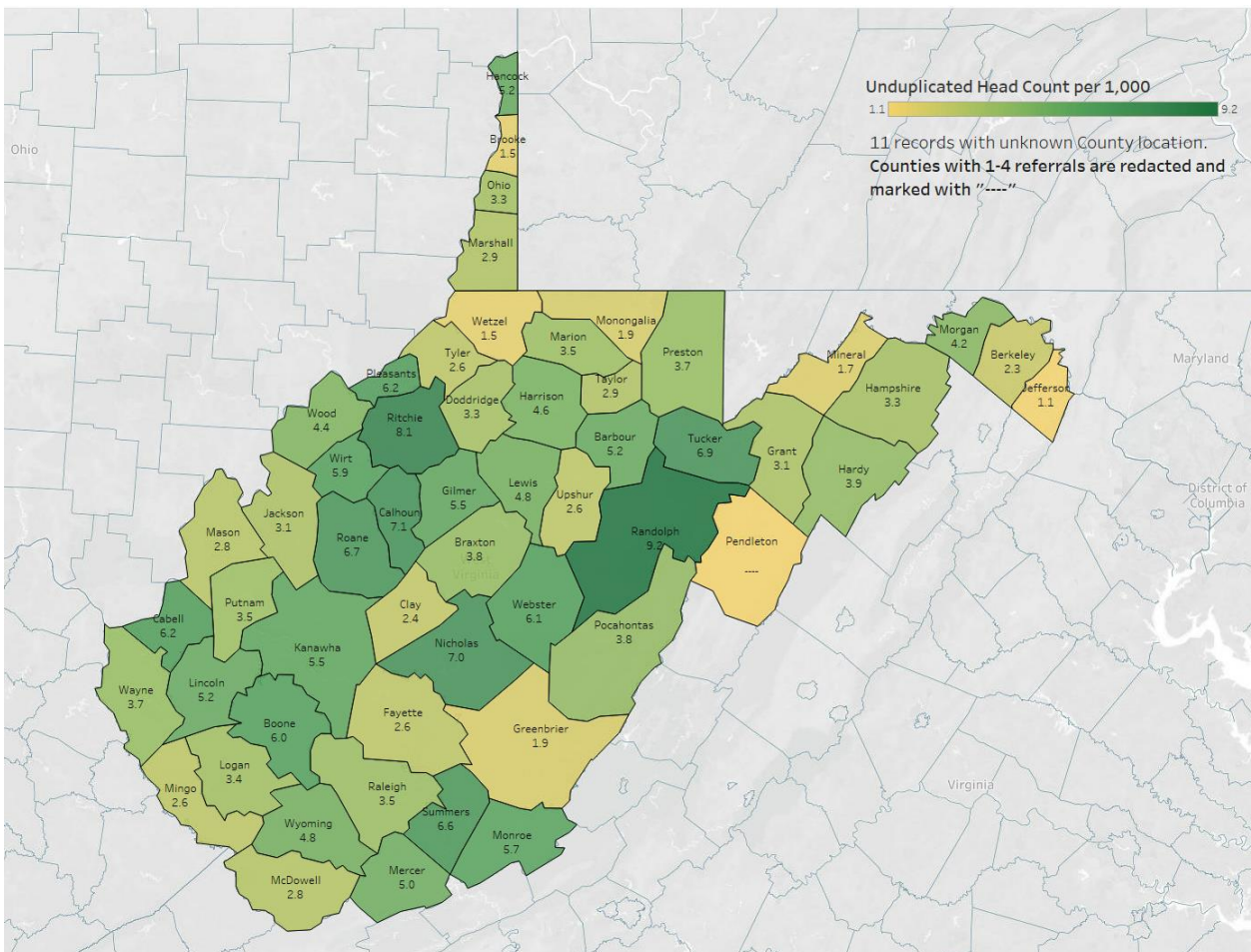


Figure 70 captures the point in time census for the period January 2021 – October 2022. Notably, there is an overall decline in census over the 18-month period. Although the census shows some fluctuation, these changes may be expected due to seasonal effects and changes in bed utilization due to easing of restrictions associated with the pandemic. DHHR recognizes that the long-term impacts of service system changes over the last two years, including implementation of CSED Waiver services, have not yet been recognized. Continued focus on screening and referral, evaluation and connection to services, and development of additional community-based capacity (e.g., foster and kinship homes) are the right steps and will take additional time to produce intended results. Additionally, the QIA process was not yet implemented during this period. Continued implementation of the QIA process which began late in the period (i.e., August 2022), with a phased rollout scheduled through May 2023 (for individuals who are involved with BSS and are not currently placed in an RMHTF), is expected to impact census further.

Of the overall decrease in census, the larger decrease was observed in the number of children in out-of-state placements; this has been an area of focus for DHHR. DHHR continues to make process enhancements to impact out-of-state placements. Effective March 2022, the out-of-state placement request and review process was enhanced to require that any out-of-state

placement request first be reviewed with the Program Manager or Child Welfare Consultant and include involvement of the MCO case manager. The Program Manager is required to help ensure all other options have been exhausted before approving and forwarding the request to the BSS Commissioner for final approval. In recent months, BSS created a process outline for use in training and technical assistance for staff involved in staffing cases being referred for out-of-state placements. Additionally, in December 2022, BSS updated and standardized the out-of-state face sheet to support enhanced review and data collection of out-of-state placement processes, increasing opportunities to help ensure out-of-state placements were used only as a last resort, keeping youth in their communities when possible. Based on a recommendation from the Quality Committee, BSS recently established a data collection process for referrals and placements in out-of-state facilities. Data collected includes:

- Primary reason for requesting out-of-state placement (per standardized list)
- Diagnosis
- Adjudication status
- Dates of staffing and who was involved
- Staffing recommendations
- Staffing disposition

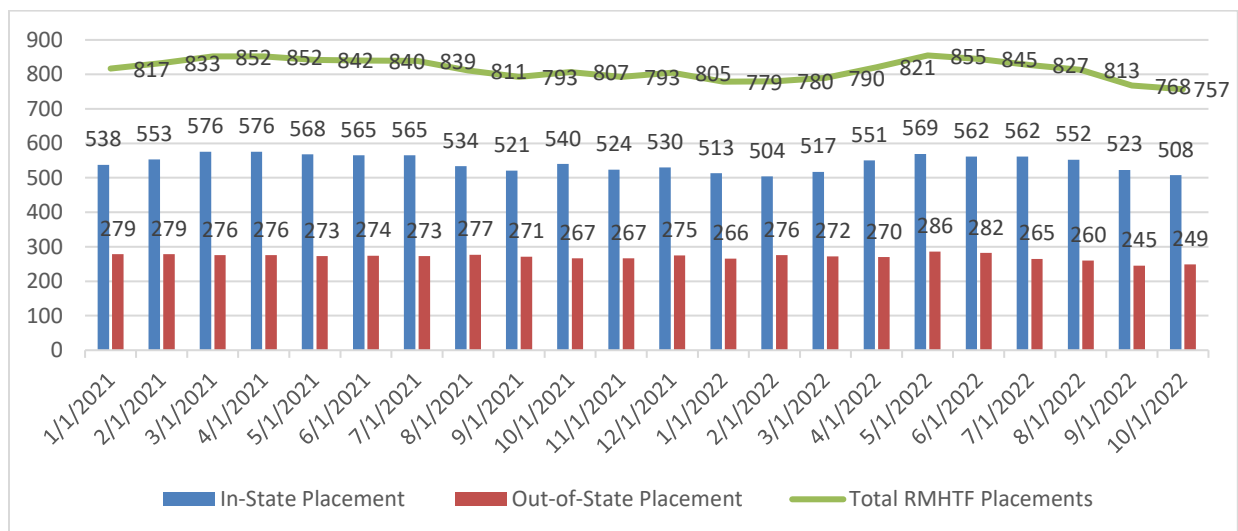
To better capture the characteristics of children being referred for out-of-state placement and to enhance data collection, BSS is exploring conversion to an electronic referral form. The Office of QA is currently collaborating with the BSS team to identify additional data needs and work toward streamlining the data collection.

In December 2022, DHHR contracted with Marshall University to complete CANS assessments on all children in out-of-state residential placements to include updating the CANS every 60 days. A phased implementation plan is currently being developed. This represents a significant step forward in better understanding children in out-of-state placements and ensuring a standardized assessment of functional ability is completed on a recurring basis to help ensure children are receiving appropriate services to meet their needs and when possible, returning to in-state services.

As CANS information becomes available and as data collection on out-of-state placements is further established, DHHR is seeking to profile any differences in children placed in-state versus out-of-state to determine what, if any, unmet needs or gaps in services exist within the current in-state service array.

DHHR expects to see additional declines in census as the Assessment Pathway—including the QIA, prioritized discharge planning, and focused foster care home recruiting—are more fully established.

Figure 70: Monthly RMHTF Point in Time Census, January 2021 – June 2022



Figures 71, 72, and 73 capture length of stay by facility type comparing in-state versus out-of-state placements.³⁷ This is a new data set; the Quality Review Committee and program teams will require additional time to begin to understand the implications. Previously DHHR reviewed overall average length of service but has moved towards analysis of the length of stay distribution by categories of time (e.g., 0-30 days, 1-3 months as relevant to the facility type). While there are currently other prioritized activities, anticipated future steps for this data set include the possibility of stratification by age and other factors to improve understanding of the characteristics and circumstances of children who discharge quickly versus those who remain in residential placements for an extended time. Length of service is currently used to identify children selected for focus in the prioritized discharge planning process.

³⁷ The data represented in these figures are based on children who discharged between January 2021 and June 2022. Children currently in residential placement are excluded from the analysis.

Figure 71: Group Residential Placement by Length of Service (In-State vs. Out-of-State)

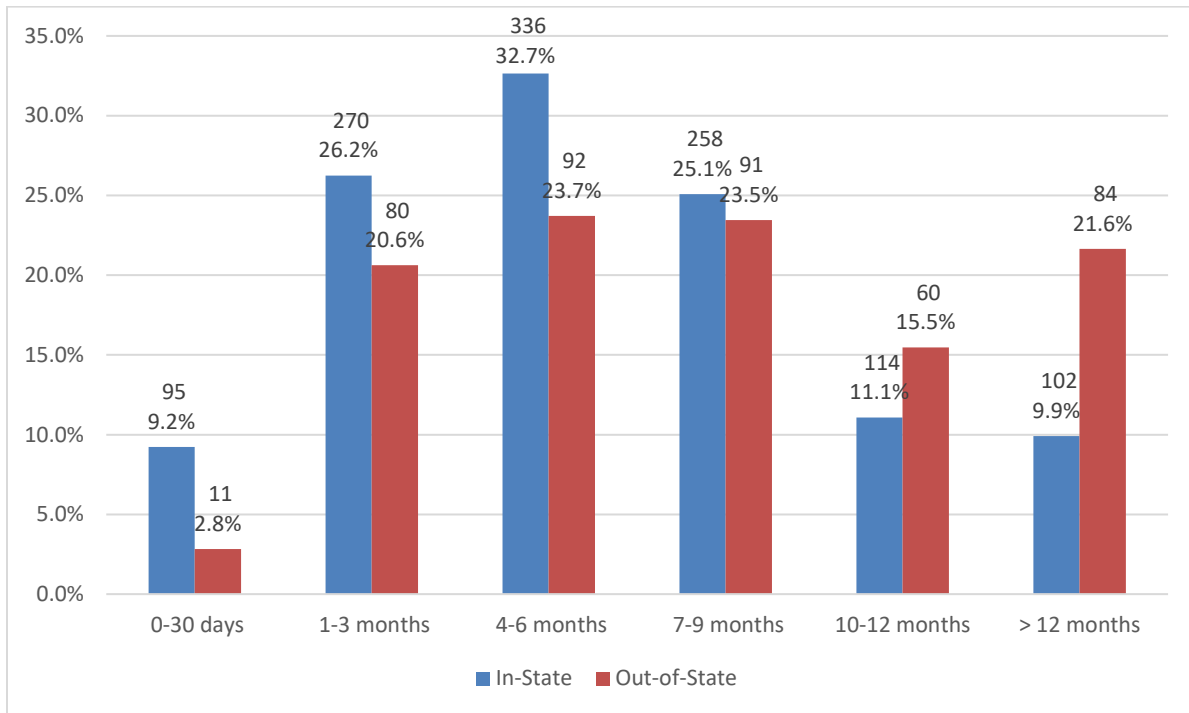
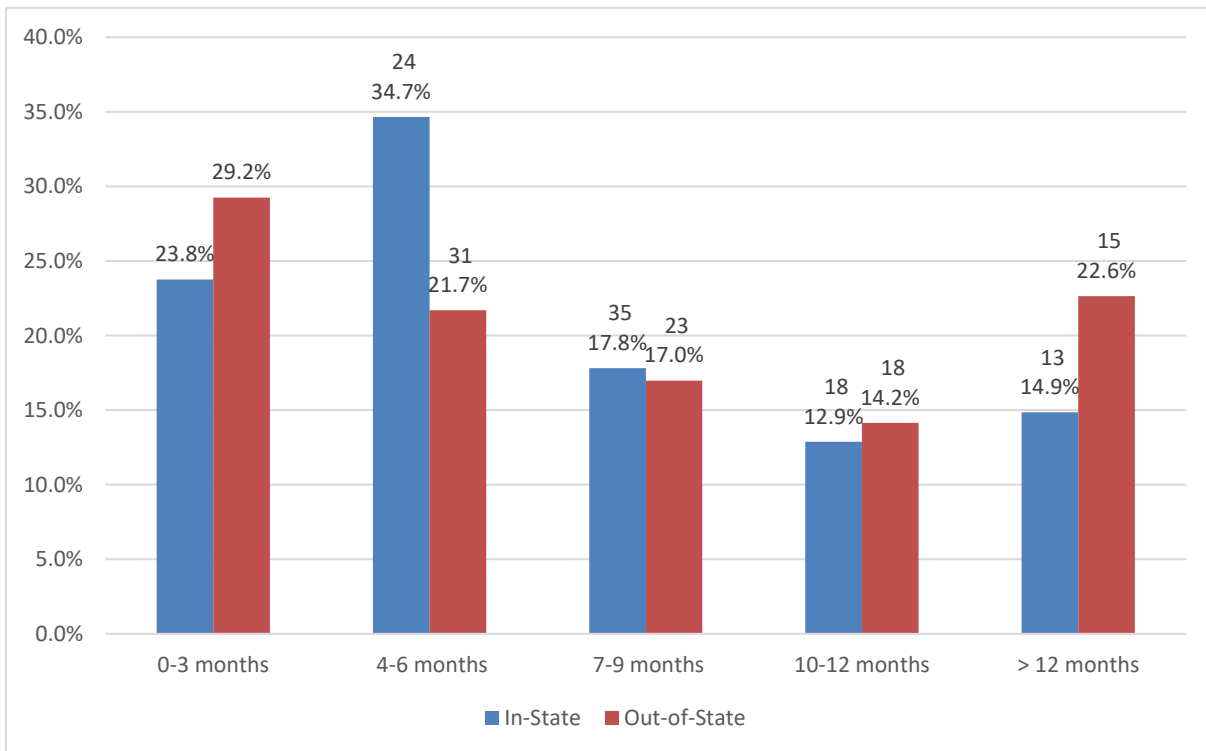
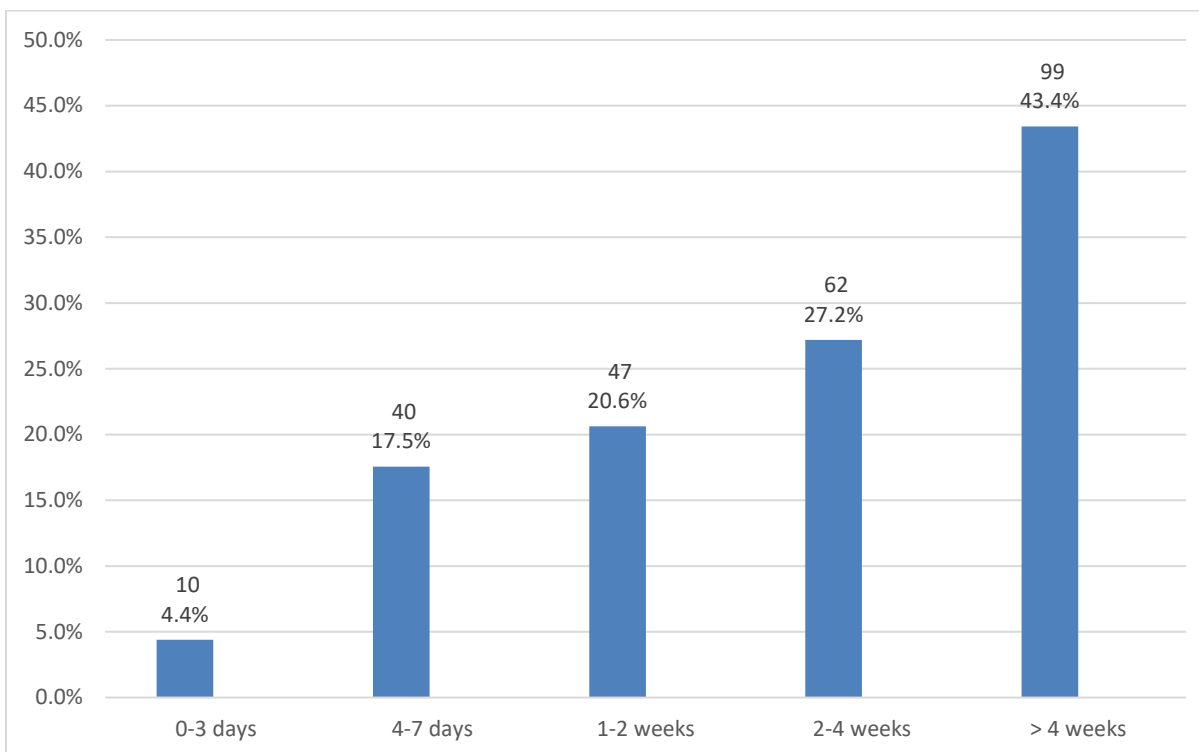


Figure 72: PRTF Placement by Length of Service (In-State vs. Out-of-State)



Note: The 0 – 30 days and 1 – 3 months are combined in Figure 74 to create adequate cell sizes for presentation.

Figure 73: Psychiatric Hospital (Short-Term) Placement by Length of Service



Note: In- and out-of-state placements are combined in Figure 73 to create adequate cell sizes for presentation.

DHHR is working collaboratively with residential providers, Chapin Hall, Casey Family Programs, and other stakeholders to help ensure children have options to stay closer to home, family, friends, schools, and communities for behavioral and mental health treatment intervention when residential placement is the most appropriate option. DHHR has identified model-of-care changes, such as small, specialized community-based group homes, to expand service offerings and help ensure individualized, high-quality care is available for children with significant needs.

Some children may not be successful in the home and community and therefore may experience multiple placements (i.e., readmissions) in RMHTF during their life cycle of care and support. DHHR is focused on efforts with the Assessment Pathway to offer children and families home and community-based interventions to decrease the number of readmissions children experience.

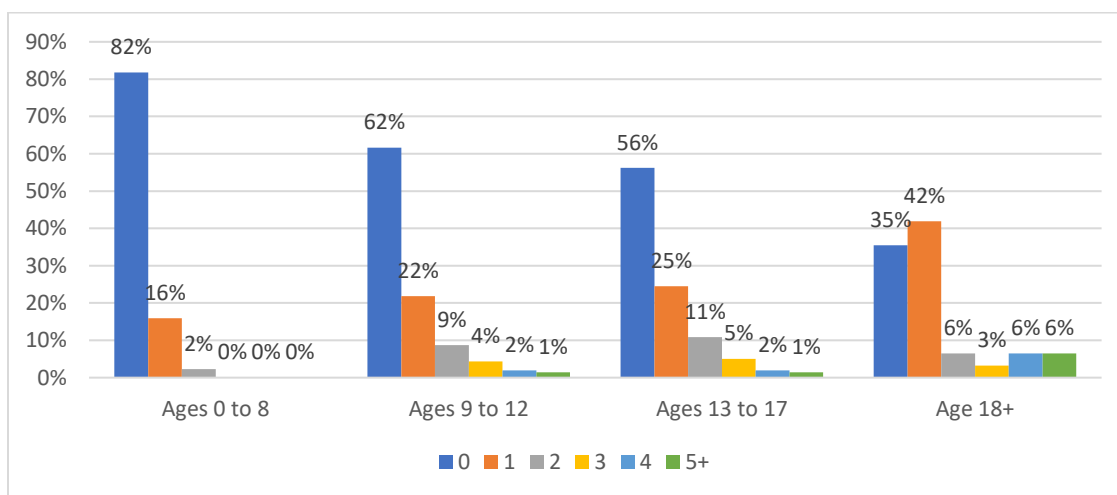
Figure 74 summarizes the number of prior RMHTF stays experienced per child by age group for children with admissions to RMHTF care during the January 2021 – June 2022 period. Please note these figures do not tally to the number of changes in placement (e.g., change in facility of

residence) a child might experience during a continuous stay³⁸ in the RMHTF care system but the number of prior continuous RMHTF stays each child experienced. For example, a child who resided in three different RMHTF facilities over the course of their first continuous RMHTF stay would be recorded in the “0” category.

Admissions displayed in the light blue “0” color were the first reported state custody RMHTF admission for the child. Most admissions for children in all age groups except the 18+ age group are the first admission.

The increase in percentage of readmissions as a child ages may be attributed to many factors, including a longer period of interaction with the Child Welfare System, unique service needs, housing issues, or other considerations. There is no national data available for comparison with the number of readmissions for WV’s children in residential placement. While current efforts are focused on prioritized discharge planning and implementation of the QIA process, per a recommendation of the Quality Review Committee, BSS in partnership with the Office of QA would like to complete a more detailed analysis of children with multiple readmissions to work toward understanding the unique characteristics and circumstances for these children that may be driving repeat placements. This analysis is anticipated to occur in late in 2023.

Figure 74: Admissions During the Period January 2021 – June 2022 in Each Displayed Age Group With 0, 1, 2, 3, 4, and 5 or More Prior RMHTF Stays

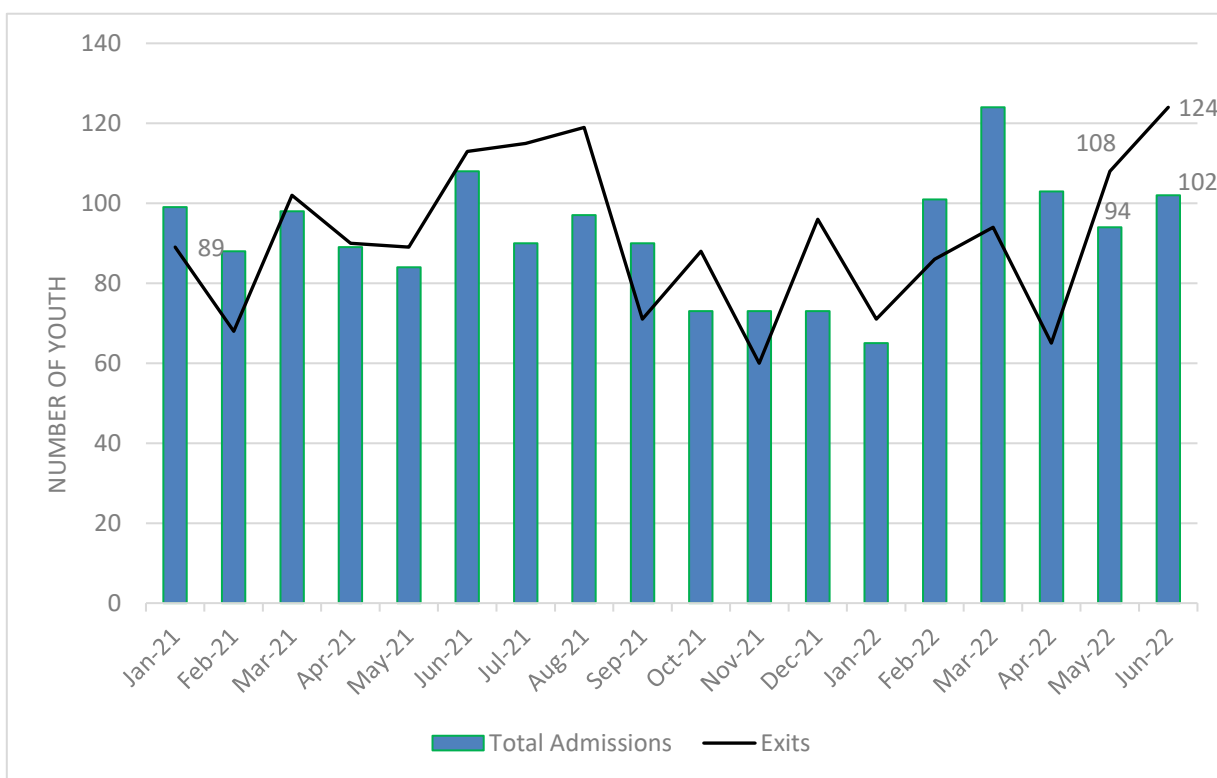


DHHR is actively focused on reducing admissions through implementation of the Assessment Pathway, including the QIA process for determining the appropriate level of intervention and least-restrictive service setting, and prioritized discharge planning and specialized reviews to help ensure children who are currently in an RMHTF are transitioned, where appropriate, to a less restrictive level of care or discharge to community settings.

³⁸ A continuous RMHTF stay is defined as a period during which a child is placed in group residential care or PRTF with no gaps of 14 days or more between reported exit and entry dates, or in short-term acute psychiatric hospitalization with no gaps of 2 or more days between reported exit and entry dates, or the exit reason from the stay is a permanent reason such as reunification.

Figure 75 below reflects admissions versus discharges for the 18-month period of January 2021 – June 2022. The Quality Review Committee discussed possible trends related to the holiday season (November and December) as well as late spring/early summer months (May – July). Specific patterns or trends in this data are still being established with review necessary over a longer period post pandemic to better understand seasonal fluctuations associated with school, holidays, etc. The Quality Committee continues to hypothesize that increased discharges associated with the timing of school breaks may indicate an opportunity to address cultural norms around requiring a child to remain in a residential setting to finish out a term or related session before transitioning to the community. In May and June of 2022, exits exceeded admissions by 36 youth, resulting in a net decrease of individuals in an RMHTF setting. The QIA process will be integral to continue to progress in appropriate census counts. The QIA process will aid in ensuring admissions are appropriate based on a youth’s needs, and youth who are in RMHTFs can be further assessed to more quickly discharge individuals who are able to be served in HCBS.

Figure 75: Total Admissions Versus Discharges (Exits) by Month for In-State and Out-of-State Placements, January 2021 – June 2022



16.3 Provider Capacity/Statewide Coverage

The RMHTF provider capacity statewide is adequate to meet the needs for the number of children placed compared to the number of licensed bed capacity. However, the level and type of care offered by each in-state provider varies and, in some cases, may not meet the individual needs of the children needing residential intervention, as evidenced by children continuing to be

sent out-of-state. The focus over the coming years will be to increase in-state provider capacity and training to serve children with high level-of-care needs who are now being served in out-of-state facilities.

DHHR is working collaboratively with providers, Chapin Hall and Casey Family Programs, to develop a service model for small community-based group homes that will serve children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability. Children with these needs appear more likely to be declined by in-state residential providers due to severity of behaviors or need. A subgroup of residential stakeholders will focus on development of a high acuity residential treatment model. DHHR presented a high acuity draft model the subgroup will work from as they meet with other states for peer-to-peer discussions to learn what processes other states have used to develop this model of care.

Additionally, DHHR will coordinate with CPAs to do focused foster home recruiting as the lack of available foster homes is contributing to increased demand for residential facilities.

As described in Prioritized Discharge Planning Section 16.2(b), DHHR is taking steps to expand transitional living options and services for older youth. DHHR is seeking in-state providers willing to transform their current residential offerings to provide transitional living services for these youth. An Announcement of Funding Availability is expected to be released in early 2023 as a step toward establishing these services. Additionally, DHHR began holding in-person stakeholder meetings to gather feedback regarding the residential model continuum of care including the types of services and supports needed to expand community-based transitional living services for older youth. If these older youth can be successfully served in lower levels of care, this might allow current in-state residential providers to accept and support children with higher-acuity needs.

16.4 Strengths, Opportunities, Barriers, and Next Steps

Overall residential census continues to trend down with some seasonal fluctuation throughout each year. DHHR exceeded the goal of reducing census to 822 by December 2022, with a preliminary³⁹ census of 781 children as of that date. To reach further census reductions and help ensure children are provided the services and supports to address the amount, duration, and intensity to address their assessed needs, DHHR is prioritizing the following actions:

- Helping to ensure discharge plans are in place for all children in residential placements.
- Assessing and building foster care capacity to meet forecasted needs to include exploring concerns from foster care families and CPAs related to supporting children with complex needs (e.g., physical aggression, sexual issues, etc.).
- Full implementation of the monthly reauthorization process for children in in-state

³⁹ The year-end census is considered preliminary due to possible lag issues; therefore, this number could change slightly once confirmed.

residential placement to support reduced lengths of stay and more timely transition to lower levels of care and discharge to community placements.

- Full implementation of the QIA process to increase the number of diversions from residential placement, resulting in decreased placements. Target date is May 2023 for phased county-by-county rollout to be complete for individuals who are involved with BSS and are not currently placed in an RMHTF.
- Continue to develop new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability.
- Continue to develop new models of care for transitional living to support youth ages 17 – 21.
- Completing CANS assessments for all children in out-of-state residential placements per the December 2022 contract established with Marshall University.

DHHR will continue to monitor trends in the quarterly Quality Review Committee reviews as these processes are implemented to determine if expected results are achieved and make recommendations for adjustments as relevant. County-level data will now be included as part of ongoing monitoring to be used to identify prioritized areas for focus to further impact increased utilization of HCBS and reduce reliance on residential interventions.

Other recommendations and activities in process include:

- Assessing the feasibility of requiring CAFAS/PECFAS assessments and discharge planning for children in out-of-state group residential placements.
- Further understanding of the profile of children with a high number of failed placements.
- Understanding patterns of residential placements and CSED service utilization once this data is available in the data store, which is anticipated in early to mid-2023.
- A longer-term goal will be to improve understanding of the characteristics of children who discharge from residential services timely versus those who remain in residential services over longer periods.

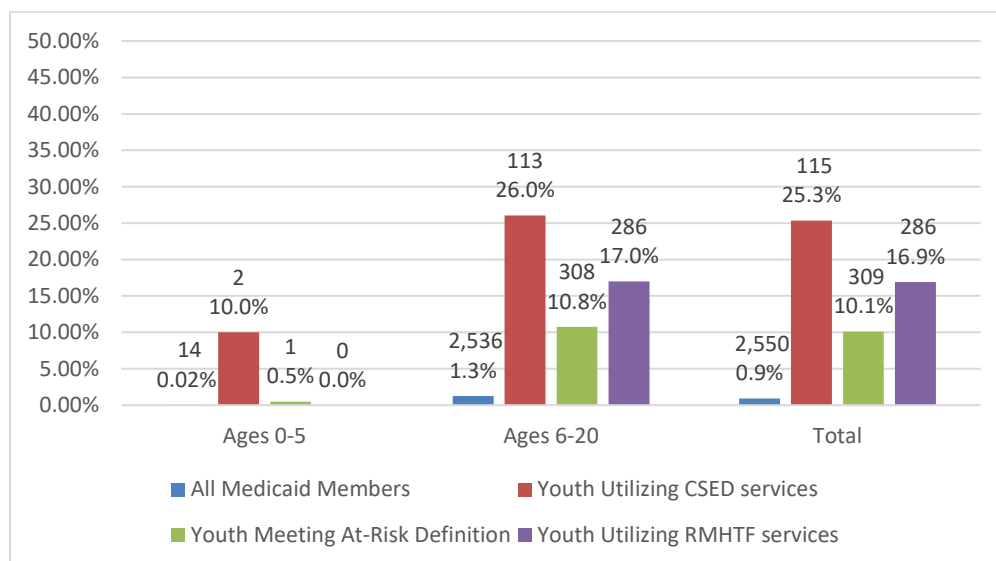
17.0 Outcomes

DHHR continues to establish data sources and systems for collecting outcomes data for children receiving services. Enhancing data quality and collection has been identified as a key step to assessing outcomes following early process implementation and the continued build-out of the data store. Time is needed to allow youth to go through the full expected service period, to assess more long-term impacts of service and cross-systems utilization. An analysis of cross-systems utilization—which will be recurring and built on over time with increased access to data—is planned for fall 2023 and will focus on youth at risk for residential placement. Service utilization and cross-systems utilization will be used to better understand patterns in utilization and ability to remain in the home and community. Child severity of need will also be considered, as different service intensity may be needed depending on the child’s functional ability and environment. Analysis will first focus on children utilizing residential services and contingent on available data, what HCBS they may have used before residential placement, and what services they may have been connected to after services. DHHR will also explore commonalities for service utilization for at-risk youth not interacting with a RMHTF. Plans for this cross-systems analysis will grow and be refined as the data store is built out and systems utilization is better understood. Below is an update on the potential data sources for each outcome:

- Arrests or detainments: DHHR began a collaborative in December 2022 with the WV Department of Homeland Security, the court systems, and the WV Department of Education. This collaboration will work to enhance communication and data sharing between agencies. Although the source for this data is still being determined, additional resources were discussed and will be explored further in the first half of 2023.
- Commitment to the custody of BJS or DHHR: The data source for commitments to BJS has been identified as the Offender Information System. The data source for commitments to DHHR will now be WV PATH. These data sources will be further assessed and integrated into the data store to analyze commitment to custody for the at-risk population.
- Suspension or expulsion from school: DHHR is collaborating with the WV Department of Education as part of the greater collaborative started December 2022. A data sharing agreement will be established in 2023 to begin sharing and review of data for the at-risk population.
- Prescribed three or more psychotropic medications: An initial polypharmacy analysis using pharmacy claims data did not identify significant numbers of children with three or more psychotropic medications, which included use of antipsychotic medications. BMS has policies and processes in place to flag any child for whom polypharmacy may be an issue and can intervene when needed. Additional analysis was conducted for youth in various populations of interest, as shown in Figure 76. It was identified that 49% of the

identified population of at-risk youth⁴⁰ had at least one psychotropic prescription, while 11% had three or more, for at least 90 days. When looking at children under 6 with any psychotropic for at least 90 days, it was found only two youth under 6 in the at-risk population had at least one psychotropic prescription. Notably, youth utilizing CSED services had the greatest rate of psychotropic medication use with 26% of youth using three or more medications for at least 90 days. This data will be assessed over time to identify any necessary changes to policy.

Figure 76: Youth With 90+ Days Using Three or More Psychotropic Medications, July 2021 – June 2022⁴¹



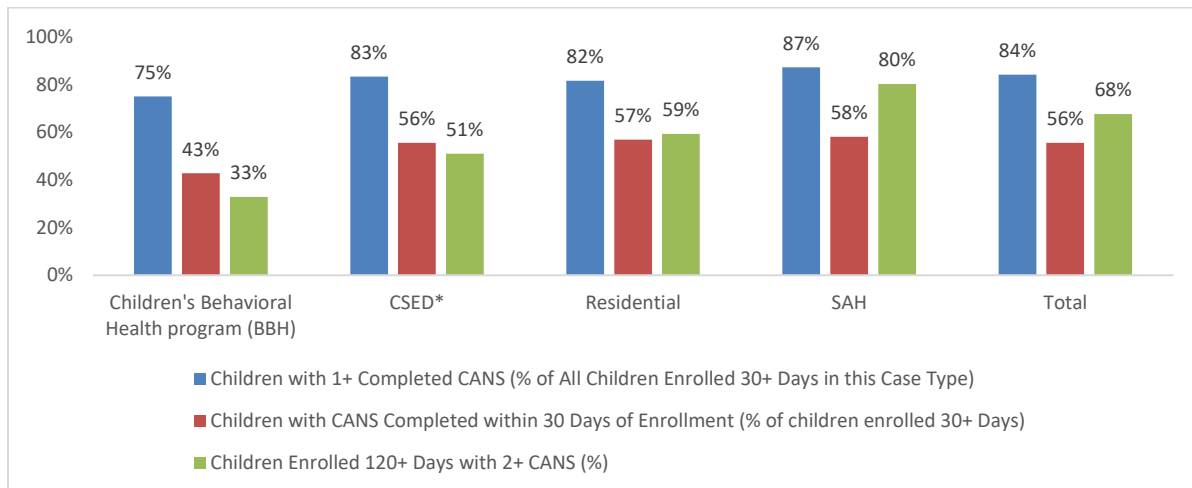
- Changes in functional ability, statewide and by region, including data from the CANS assessment and the quality sampling review process:
 - DHHR is partnering with WVU to complete quality sampling reviews which will include cross systems analysis, surveys, and interviews with a sample of at-risk youth and their caregivers. A report on these initial findings is expected in fall 2023.
 - Initial CANS assessment data have been explored to assess indicators of CANS completion and timeliness. Data quality and CANS completion is essential to tracking outcomes over time. For youth who were newly enrolled between

⁴⁰ At-risk youth were defined as those children (under age 21) with an SED in 2021 (where an SED is defined as ICD10 diagnosis codes in the psychiatric range, or F-range (that is, starting with F) *except* for: -The F1, or SUD, range and F55 (also a SUD diagnosis), and The F70-F80 range of intellectual and developmental disabilities during calendar year 2021): AND meeting any of the following criteria in the last 3 months of 2021: Medicaid/CHIP member with an ER visit for a psychiatric episode, Medicaid/CHIP member with a psychiatric hospitalization episode; Mobile Response; Children who are in state custody because of CPS or YS involvement; OR Child with SED as a primary diagnosis on a Medicaid claim in 2021 and a CAFAS \geq 90.

⁴¹ Pharmacy Claims paid through October 2022.

January – June 2022, 84% of all youth—enrolled in SAH, an RMHTF, CSED, or BBH and reported in the CANS Automated System for at least 30 days—had at least one CANS completed. Figure 77 below displays these results by program of enrollment and total. Figure 77 below also shows CANS completion within the first 30 days of service for youth enrolled at least 30 days. The figure also shows indications for multiple CANS for youth enrolled 4 months or more. In addition to the findings listed in the Marshall University Fidelity Evaluation, noted in Section 5.0, this information can be used as baseline findings to address quality improvement for CANS completion and timeliness. Review of this data will be included as part of the action of continued review and planning with the PIP team that will lead efforts for WV Wraparound CQI. The Wraparound PIP team will be stood up in early 2023 as part of the recommendation of the Office of QA and the Wraparound Fidelity Report. As of the period of this review, CSED providers were not required to enter information into the CANS Automated System but were encouraged to. BMS will begin requiring CSED providers to use the CANS Automated System, effective spring 2023. Further outcome methodology for the CANS assessment has been developed and tested to assess functional improvements over time. This could not yet be assessed across individual programs as natural service length and time lapse needs to occur, post Assessment Pathway implementation, to allow for adequate data to determine change over time.

Figure 77: CANS Completion and Timeliness – Newly Enrolled Youth, January – June 2022



As data collection becomes more robust and the data store continues to grow, DHHR anticipates more outcome data will become available for consideration and reporting.

18.0 Conclusion

DHHR has made significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of WV, including raising awareness of the availability of these services. Throughout 2022, DHHR has continued implementation and adoption of new processes and pathways associated with services and establishing data collection and reporting to allow continuous evaluation and improvement of services. Though implementation is still in process and services have not reached expected routine and ongoing operations, the increase in mental health screenings conducted as part of early intervention, increased referrals to the Assessment Pathway for further evaluation and connection to services, and increased use of CCRL, mobile response, and CSED Waiver services are all positive signs. These positive trends demonstrate increased awareness and uptake by families and other stakeholders of the home and community-based options available to divert children from residential placements and are evidence that DHHR's efforts are having the intended effect. DHHR successfully met the goal of reducing the number of children in residential placements below 812 by December 31, 2022, with a preliminary census count of 781.

DHHR's CQI processes continue to evolve, and a data-driven culture is being established throughout the department. The Office of QA and program leadership and staff collaborate day-to-day to continue to align efforts and improve data quality. Additionally, more data sharing is occurring or being planned with a variety of partners and stakeholders, including the WV Department of Education, WV Department of Homeland Security, court systems, and vendors and providers, among others. These efforts are building momentum to help ensure sustainable, available, and accessible programs and services for children and families across WV.

Key priorities for DHHR in the coming year include the following:

- CSED Waiver and Wraparound Facilitation services forecasting and provider network expansion in partnership with the MCO and providers.
- Continued efforts around prioritized discharge planning with focus on children with CAFAS/PECFAS less than 90, to include helping to ensure all children have discharge plans.
- Assessing and building foster and kinship care capacity to meet forecasted needs.
- Full implementation of the QIA process to help ensure children are assessed for appropriate levels of care and intervention to support diversion from residential placement and help ensure services are provided in the least restrictive setting.
- Continued development of new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability.
- Coordination across BPH and the MCOs to help ensure EPSDT with mental health

screens are conducted annually on 52% of Medicaid-eligible children.

- Continued enhancement of quality infrastructure and processes within DHHR to include expansion of the data store to allow synthesis of data across sources and systems, oversight and monitoring of DHHR staff and third-party contracts (e.g., vendors, MCOs), and reporting to provide feedback to providers, help ensure accountability to performance outcomes, and assist with focused recruiting and provider network expansion.

DHHR is committed to continuing to transform children’s mental and behavioral health programs toward increased use of evidence-based practices and high-quality care that facilitates positive clinical outcomes, improved quality of life, and safety, permanency, and wellbeing for children and their families.

Appendix A: Glossary of Acronyms and Abbreviations

Figure 78: Glossary of Acronyms and Abbreviations

Acronym/ Abbreviation	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ASO	Administrative Service Organization
BASC	Basic Assessment System for Children
BBH	Bureau for Behavioral Health
BFA	Bureau for Family Assistance (formerly Bureau for Children and Families)
BIPOC	Black, Indigenous, and People of Color
BJS	Division of Corrections and Rehabilitation-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
CIP	Court Improvement Partnership
CMCR	Children’s Mobile Crisis Response
CCRL	Children’s Crisis and Referral Line
CSED	Children with Serious Emotional Disorder
SED	Serious Emotional Disorder
CPA	Child Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement

Acronym/ Abbreviation	Description
DHHR	West Virginia Department of Health and Human Resources
DW/DSS	Data Warehouse/Decision Support System
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, and Others
MAYSI	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
NWI	National Wraparound Initiative
Office of QA	Office of Quality Assurance for Children's Programs
PBS	Positive Behavior Support
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PRTF	Psychiatric Residential Treatment Facility
QIA	Qualified Independent Assessment
RMHTF	Residential Mental Health Treatment Facility
SMI	Serious Mental Illness
STAT	Stabilization and Treatment
TTI	Transformation Transfer Initiative
WV	West Virginia
WVCHIP	WV Children's Health Insurance Program
WV PATH	West Virginia People's Access to Health
WVU	West Virginia University
YS	Youth Services