CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report – Addendum

April 2024 (Supplemental to January 2024 Edition)

When kids and families thrive, West Virginia thrives.

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Assurance for Children's Programs

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Table of Contents

1.0 Introduction

The West Virginia Department of Human Services (DoHS) is actively working to reform and enhance programs and services for children[1] with serious emotional disorders (SED).

The primary goals of these reforms are:

- Prevent children with SED from being unnecessarily removed from their family homes for treatment.
- Prevent children with SED from unnecessarily entering residential mental health treatment facilities (RMHTFs).
- Transition children with SED who have been placed in an RMHTF back to their family homes and communities, when appropriate.

DoHS has worked collaboratively with community partners and stakeholders to design and expand services to meet the needs of children and families statewide more effectively. In January 2024, DoHS produced its most recent version of the semiannual Quality and Outcomes Report semiannual report (SAR); the information provided in this addendum is meant to supplement that version of the report. Since the publication of the January 2024 edition[2] of the SAR, additional information and next steps have become available to demonstrate findings associated with the Wraparound Fidelity Evaluation, the Children's Mental Health Evaluation (CMHE), and timeliness related to receipt of Wraparound services from initial referral. DoHS will continue to collaborate with its array of stakeholders and partners to monitor efforts and use informed strategies to improve outcomes for children and families.

[1] 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.
[2] See January 2024 edition of this report Figure 114 for a glossary of acronyms and abbreviations.

2.0 Partner Evaluations

DoHS previously partnered with Marshall University (MU) for training, coaching, and technical assistance with Wraparound facilitators as well as fidelity evaluation of WV Wraparound. Until March 2024, MU collaborated with the University of Connecticut (UCONN) on this work. As of April 2024, this responsibility has been transitioned fully to UCONN. MU is still responsible for several other roles in collaboration with DoHS, such as the evaluation of Wraparound fidelity. DoHS has also partnered with West Virginia University (WVU) to conduct the Children's In-Home and Community-Based Services Improvement Project Evaluation Plan.

MU Wraparound Facilitation and Child and Adolescent Needs and Strength (CANS) Fidelity Assessment

WV Wraparound strives to adhere to fidelity as defined by the National Wraparound Initiative (NWI). Wraparound providers have been trained on the NWI model since February 2022. Fidelity has been difficult to measure due to differences in policy associated with the multifunding source structure of Wraparound.

The Children with Serious Emotional Disorder (CSED) Waiver provided through Medicaid offers a broad, sustainable funding source to expand these home and community-based services (HCBS) to families, in addition to other funding sources—including via Bureau for Social Services' (BSS) Safe At Home (SAH) Program and Bureau for Behavioral Health's (BBH) Wraparound programming—which provide interim services to individuals waiting for CSED determination and individuals meeting alternative non-CSED program criteria. Funding sources for WV Wraparound within DoHS are designed to work collaboratively so that, when possible, as determination is made for CSED services, the family will be able to start with and maintain the same Wraparound facilitator throughout their Wraparound journey.

Implementation and training for the standardized Plan of Care starting in October 2022 helped further align the three funding sources into one WV Wraparound that allows children and families to have more consistency with a common Wraparound facilitator during the application process for the CSED Waiver. Services are designed to look the same from the family's perspective but are provided via multiple funding sources to allow Wraparound services to be available to children and families who need them.

The fidelity review MU conducted used two methods for measuring Wraparound fidelity and understanding continuous quality improvement needs: the Document Assessment and Review Tool (DART) and Wraparound Fidelity Index, Short Form (WFI-EZ). The DART is the tool DoHS uses to assess fidelity while other tools are used to support CQI efforts to improve or sustain high fidelity to the Wraparound model. Both the DART and WFI-EZ adhere to NWI standards. MU conducted its Wraparound fidelity review from August to November 2023 and provided DoHS with the final report in January 2024.

The DART is comprised of six score areas:

1. Timely engagement
2. Wrapround key elements

3. Safety planning
4. Crisis response
5. Transition planning
6. Outcomes

To be selected for review, provider agencies had to have active cases in the WV CANS system that had also been receiving services for a minimum of four months. Due to these requirements, only 15 out of 22 provider agencies (68%) had cases eligible for participation. Out of the requested 218 records, 171 (78%) met the review criteria. This sample was large enough to allow adequate evaluation. While not equally represented, cases were reviewed from CSED, SAH, and BBH.

The WFI-EZ is a survey given to both Wraparound coordinators as well as caregivers. At minimum, 70% of survey completion is ideal to indicate validity. Coordinators returned 66% of completed forms and caregivers only 24%. Due to low response rates, only the coordinator surveys were provided in the fidelity review.

DART Results

Since the DART is reliant on documentation, issues with data completion and accuracy impacted the findings. Many measures were listed as not met or only partially met. Wraparound Facilitators' understanding of how NWI and the DART defines and measures elements of fidelity, like functional strengths, appears to be inadequate. It was difficult to assess the Child and Family Team due to unclear attendance documentation. Figure 1 below shows the average percentage of cases reviewed that met full compliance for the score area. Safety planning was an area in which WV Wraparound facilitators did well (63% of cases reviewed met full compliance. Still crisis plans need to be more robust with multiple interventions in the event of a crisis in order to meet fidelity, as well as timely documentation after a crisis event (10% of cases met full fidelity requirements).

A smaller sample was assessed when measuring transition planning, due to the lower number of children who were at that stage in the program. The DART found that transition plans did not meet fidelity standards. Moreover, documentation had an inadequate description of the celebration for completing Wraparound. Outcomes-related indicators met fidelity for 51% of cases.

Figure 1: Score Areas and Results of WV DART Assessment 2023

DART Fidelity Score Area	Average Percentage Meeting Full Compliance for Score Area[3]
Timely engagement	44%
Wraparound key elements	• Meeting Attendance: 32% • Driven by Strengths & Families:15% • Natural & Community Supports: 4% • Needs-Based: 39% • Outcomes-Based (outlined measurable goals): 23% Total average for all measures: 26%
Safety planning	63%
Crisis response	10%
Transition planning	16%
Outcomes	51%

WFI-EZ Results

The WFI-EZ is a modified version of the Wraparound Fidelity Index (WFI-4). The WFI-4 is cited as having strong test-retest reliability and internal consistency. The findings of the WFI-EZ, as reported below, are based on responses from the Wraparound Facilitators. Responses and DART findings frequently were not in alignment, suggesting that facilitators may not have understood the questions presented in the WFI-EZ. Disagreement between the two assessments could further support the idea that data quality impacted the evaluation, such as the DART finding low rates of timely engagement while the WFI-EZ responses to timeliness were between 93% and 100%. Additionally, some questions asked the respondent to use a reversed scoring scale, which could have led to the opposite answer being indicated, thereby producing discordant results.

The Wraparound Evaluation and Research Team used the responses to the WFI-EZ to create benchmark scores. Most items indicated that the Wraparound facilitator felt the measure was being met. Facilitator responses indicated the only category reaching high fidelity was “outcomes-based.” This measure is derived from nine questions on the WFI-EZ pertaining to school, community, and functional outcomes for the children after Wraparound participation. Facilitators felt they were adequate at meeting overall fidelity, effective teamwork, and being strength- and family-driven. Natural community support and being needs-based were the lowest listed as borderline to meeting fidelity.

[3] Additional details can be found in Appendix 2 of the 2024 Fidelity Report.

Outcomes

On the DART, nearly all of the 161 cases of individuals who had completed Wraparound six or more months prior showed positive outcomes related to the need for crisis services, school and interpersonal relationships, and interactions with the legal system. Differences were observed between cases from CSED and SAH.

In response to the four WFI-EZ questions related to functional outcomes, CSED providers indicated that the children and families they served encountered more problems over the previous month when compared to SAH counterparts. In response to the four WFI-EZ questions related to school and community outcomes, children receiving Wraparound services through SAH had more problems with school and law enforcement, while CSED Waiver children had more interactions with the mental health system. These differences likely relate to the acuity of the child and **not** the efficacy of the Wraparound funding source, given that children utilizing SAH can include children who do not have an SED but are in need of Wraparound due to a child welfare-related need. The Quality Committee has noted the characteristics among the SAH population may mean they have less-intense needs than those receiving CSED services.

Family Satisfaction

Although the caregiver responses to the WFI-EZ were low with only 47 surveys returned, the fidelity review still included satisfaction results from 29 SAH caregivers and 18 CSED caregivers. SAH scored slightly higher, with borderline satisfaction, compared to CSED with inadequate satisfaction. Due to the small sample size, these results should not be interpreted as applicable to all families participating in Wraparound. DoHS will, however, keep this finding in mind and monitor satisfaction and opportunities for improvement going forward. DoHS is focusing efforts to achieve high-fidelity Wraparound services, which is anticipated to concurrently drive family satisfaction upwards.

CANS Assessment

DoHS has implemented use of the CANS assessment throughout the continuum of care. The CANS is a Transformational Collaborative Outcomes Management (TCOM) tool that can be used by the Wraparound Facilitator to help identify needs and strengths of the child. Results are used to develop each child's Plan of Care.

Child-level outcomes are tracked through repeated CANS assessments over time. Out of 115 Wraparound facilitators, 85% (n = 98) were certified in CANS assessment. Wraparound facilitators completed 30 CANS assessments (67%) within 30 days and these assessments were updated every 90 days for 46% (n = 26) of children enrolled. Review of CANS data indicated that facilitators need more training on completing all items in the CANS assessment, such as how to make justifications unique.

Recommendations

The fidelity report included 41 recommendations. After reviewing the report, the Wraparound program staff and DoHS leadership selected eight of the recommendations for prioritization and continued integration.

1. Develop position criteria and hire a statewide WV Wraparound Director.
2. Use a continuous quality improvement process and advanced training in engagement to improve timeliness, including provider-level data analysis and monthly monitoring of key metrics.
3. Request that the MU TCOM Team create a training video to discuss the importance of justifications, including examples of how to make them unique.
4. Request that the MU TCOM Team develop training on the importance of accuracy on the CANS assessment and making sure all needs are documented.
5. Continue the use of standardized evidence-based fidelity tools.
    a. Programmatic materials will be updated to better communicate the fidelity elements the DART is assessing.
    b. SAH policy and BBH's statement of work were updated in April 2024 to help ensure that DART fidelity elements are properly and consistently incorporated. The CSED policy is awaiting amendment approval and updates to Chapter 502; however, Frequently Asked Questions clarification documentation has been shared with providers to offer alignment across funding sources.
6. Support the effective use of CANS.
    a. The CANS assessment continues to be a key element of DoHS's continuous quality improvement process. DoHS staff will provide support to Wraparound providers in effective training, documentation, and utilization of CANS assessments in progressing the children and families through the Wraparound process.
7. Improve the WV CANS system for clarity and accuracy of data collection.
    a. DoHS will work with the vendor to update the system to optimize data collection.
    b. Add definitions to required fields.
    c. Develop a required demographics section for all Wraparound funding sources.
8. Improve training for Wraparound facilitators from all funding sources to implement consistent practices.
    a. Analyze provider-level data to identify areas of improvement.

3.0 DoHS Children's In-Home and Community-Based Services Improvement Project Evaluation

The Children's In-Home and Community-Based Services Improvement Project Evaluation Plan includes performance measures designated by DoHS, child-/caregiver-level outcomes, community-/provider-level outcomes, and system-level outcomes. WVU gathered the initial series of caregiver, provider, and child surveys and focus groups in 2021 and 2022. A baseline report was provided to reflect responses and perceptions from providers and facilities statewide in July 2022, and an additional report on feedback from children, families, and caregivers was published in September 2022.

WVU has completed the second round of surveys and focus groups, including the addition of surveys and interviews of families of children who are at risk of residential placement (community-based children and caregivers). The second report[4] of provider, caregiver, and child surveys and the baseline at-risk evaluation was published in January 2024.

Awareness of Mental and Behavioral Health Services

Awareness of services is a critical component of DoHS's efforts to help prevent and divert children from being placed into RMHTFs when clinically appropriate. DoHS intends for early intervention opportunities to be available and accessible to all children and families.

DoHS is focused on children, families, and the family journey. In both the at-risk and RMHTF surveys, caregivers and children indicated they had low awareness of the services available to them. However, there were significant increases in awareness of Positive Behavior Support (PBS) in RMHTF caregivers, with 20% more reporting awareness from the baseline survey (21% at baseline compared to 41% in year 2). Caregivers and children did, however, have awareness of specific interventions (counseling, therapy, residential services, etc.) or the facility where they received those interventions.

To further support this level of understanding between service types and providers, 4% of caregivers of RMHTF children indicated they were unsure if their child had received the RMHTF services in the last 12 months. Several respondents to the survey who did know a service by name did not understand what the service was, such as Wraparound. The terms "Wraparound" and "Safe at Home" were often used interchangeably.

DoHS has made efforts toward aligning the three Wraparound funders (CSED, SAH, and BBH) into one WV Wraparound to streamline understanding. The Assessment Pathway[5], which helps families navigate to a range of HCBS allows a no-wrong-door approach, which does not require families to know the name of services or who provides them but simply that they have a need and can call or text a number or visit a website to get additional information. This approach may help families and simplify navigation but may have a negative impact on recall of specific

[4] https://kidsthrive.wv.gov/DOJ/

[5] The Assessment Pathway is the term used to describe the Pathway to Children's Mental Health Services, which connects children and families to additional evaluation and referral to HCBS.

services, which may be considered acceptable given less-detailed knowledge is needed to attain services.

Caregivers for both populations did indicate a desire for more direct information for services, such as what the service entails, what service or services are best for their child, and whom to contact to initiate services. The DoHS (Department of Health and Human Resources [DHHR][6] at time of publication) 2020 – 2024 Outreach and Education Plan names the Children's Crisis and Referral Line (CCRL) as a critical component of the department's outreach to children and families. The department intends to market the CCRL as an "all roads lead to" call-line approach, rather than emphasize any one program.

Figure 2 below shows the awareness of the CCRL by respondents from both the at-risk and RMHTF populations. These ranged from 25% to 35% awareness. Although outreach has continued since these surveys were administered and so awareness may have increased since then, this finding shows the majority of families surveyed were not aware of the CCRL. This may also further explain the request for an explanation of services and more understanding about criteria if families are not aware the CCRL can be used to help with system navigation.

Figure 2: Reported Awareness of the CCRL During Year 2 Surveys

RMHTF Caregivers	At-Risk Caregivers	RMHTF Children	At-Risk Children
25%	35%	35%	27%

Most caregivers indicated they received information on services from a provider in the system. When providers were asked about the CCRL, 85% reported being aware, an increase of 19% from the baseline survey. CCRL wallet cards were distributed to a range of providers across the state starting in October 2022, with positive reception of this marketing tool from providers.

As noted in the January 2024 SAR, the state average CCRL call rate was 1 call per 1,000 children aged 0 to 20. During the first six months of 2023, the CCRL section of the HELP4WV website had a large spike in web traffic. Despite this, 88% of those who utilized the service accessed it by phone call rather than text or chat.

Outreach materials were distributed statewide to schools and community organizations in late 2023 for CSED services and included information on the Assessment Pathway and CCRL. Getting this information into the hands of providers that families trust and receive information from has already yielded an increase in awareness and referrals as demonstrated in preliminary data from 2024 Assessment Pathway referrals.

In addition to the CCRL, stakeholders can gain information from the Kids Thrive website. Stakeholders can also subscribe to the Kids Thrive newsletter, a quarterly publication provided in partnership with Mission WV. DoHS is currently evaluating the Kids Thrive website to understand how best to meet the needs of families, children, and other stakeholders who are looking for information about HCBS.

[6] The Office of Quality Assurance for Children's Programs now operates under the WV DoHS, effective January 1, 2024, given House Bill 2006, which divided the WV DHHR into three agencies.

A goal for DoHS in 2024 is to resume the Resource Rundown, a series of informational videos about the various services available to children and families. This effort is currently on pause to allow refinement: what topics are most in need of coverage and what frequency is most effective? DoHS monitors the web traffic to Kids Thrive and the views on Resource Rundown videos. More details will be provided in the July 2024 SAR.

Other services with increased provider awareness include Children's Mobile Crisis Response and Stabilization (CMCRS; 15% increase) and Behavioral Support Services (i.e., Positive Behavioral Support; 12% increase). Results disaggregated by provider type indicated that social service providers had more awareness of services when compared to healthcare providers. The increase among social service providers is also documented in referral source and caller data from the CCRL directly, indicating not only awareness, but use of this critical entry way. Outreach to providers will remain a crucial step for DoHS to help ensure that children can receive prevention and intervention opportunities through any system-level interaction—a "no-wrong-door" approach.

The CMHE did show a small but positive impact of DoHS's outreach efforts to the law enforcement community, with a 7% increase in knowledge of CMCRS services (18% currently) and a 5% increase in how to access those services (84%). While law enforcement continues to be a group with low awareness of the child mental and behavioral health services system, respondents from this field did express an interest in more information and training on youth crisis intervention.

The judicial system continues to be an area of focus for DoHS. Throughout 2023, BSS made a large effort to connect with members of the judicial system to provide information on HCBS that could serve as an alternative to placement in a residential facility. Surveys with the judicial system were not conducted during year 2 but are being conducted in year 3. The department looks forward to seeing any impacts related to these efforts.

Access to Mental and Behavioral Health Services

Service utilization is a key area of focus for DoHS. When a service is underutilized, evaluating availability and accessibility is an important action to understand utilization trends and systemic needs.

Caregivers and children from the residential population reported low service utilization, which would be expected given the length of stay for the average child utilizing residential mental health treatment services. The services with the largest differences between the two groups of children were PBS and RMHT. At-risk children caregivers reported a 26% utilization rate for PBS and 29% utilization for RMHTF in the previous 12 months for their child; meanwhile RMHT caregivers reported a 46% utilization rate for PBS and 86% utilization rate for RMHTF in the past 12 months for their child.

All services surveyed via the CMHE are currently available statewide, with the final HCBS, Assertive Community Treatment (ACT), going statewide in February 2024. A number of factors at the time the survey was conducted were identified as barriers to accessing HCBS. A recurring theme was the rurality of West Virginia. This barrier was identified by providers, caregivers, and

child respondents. Providers in 19 counties cited rurality as an issue in providing services. About one-quarter of organizations responded that they were aware of nearby organizations they could refer clients to when they were unable to provide services. This creates challenges in the provision of CMCRS, specifically due to needs associated with travel and timeliness of response. Due to the provider coverage areas, some providers may have a large distance between calls, making it difficult to reach those in crises quickly. With the addition of CMCRS to Medicaid services, it is anticipated that provider capacity will increase over time, thus making it easier to reach families in crisis quickly and providing additional back-up when multiple responses are needed in the same region simultaneously. These county- or region-specific barriers will be considered in future cross-county comparisons and analyses to provide additional insight into the obstacles some areas may face.

The department is aware of service utilization obstacles in the eastern panhandle of the state, which was also indicated in the CMHE. Being on the border of Maryland and Virginia, many providers of high-quality services are out-of-state, creating competition for the workforce in this region. Bureau for Medical Services (BMS) provides waivers for Medicaid recipients to utilize out-of-state services within a 30-mile radius of their homes.

Providers identified staffing and lack of resources as frequently occurring issues. A specific need was indicated for more nurses, therapists, social workers, other degreed professionals, and those with experience in the field. Respondents to the survey indicated that they would like to have more training and/or certifications. About two-thirds of providers indicated an interest in additional crisis and stabilization training. The department plans to look further into these needs to determine opportunities for further assistance. Behavior Support Services (PBS) was recognizable to 73% of providers included in the survey. Many facilities indicated a lack of trained PBS staff as a barrier to providing the service. When asked if they felt the training, provided through Concord University, was adequate to prepare them to provide PBS services, providers generally agreed (an average 3.7 on a scale of 1 to 5). Satisfaction was lowest among psychiatrists and psychologists and highest among case workers and managers. DoHs and Concord University will conduct a statewide needs assessment to address gaps and barriers. BMS is also in the process of implementing Behavioral Support Services (PBS) modifier codes which will allow providers to bill for the specific services offered under this program.

When caregivers were asked about barriers, 47% of community-based caregivers and 54% of RMHT caregivers responded “yes” to experiencing some type of barrier to their child starting a needed service. Over half of those individuals (56% and 58%, respectively) stated difficulty contacting the right person to get their child established in care as a barrier they encountered.

Another common response from caregivers about accessing services was a lack of appropriate intensity of services. DoHS has discussed this finding with WVU and has asked that changes be made to the year 3 evaluation to look closer at what type of intensity people feel they are missing. In both at-risk and RMHTF caregivers, 26% said that services were “not a good fit” for their child and/or family.

Difficulty gaining teen buy-in and participation in services has been a topic of discussion within DoHS’s Quality Committee. DoHS would like to consider this further and explore any possible

solutions to encourage increased engagement and response of teenagers and young adults to participation in services.

Reducing Unnecessary Placement in RMHTF

Providers responding to the survey generally agreed with DoHS's efforts to keep children in their homes and communities when clinically appropriate. This was further supported by an average ranking of 3.6 on a Likert scale of 1 – 5, indicating providers "somewhat agreed" their policy and procedures were in alignment with these efforts. However, providers reported some roadblocks to this goal, including lack of community-based capacity, lack of necessary supports, and instability of home environments. Almost three-quarters of service providers (70%) that were aware of services reported a lack of resources; however, the evaluation did not ask what those resources were.

DoHS is aware of these important barriers and is constantly looking for ways to overcome them. The department has been offering weekly Office Hours to residential providers as a forum to address questions and concerns about the upcoming changes to the model of care for residential services. By establishing and continuing this open dialogue, the department is able to help residential providers work through barriers they may have in regard to inappropriate admissions, timely discharge, and changes to how a child's treatment and transition to the community is planned.

Some caregivers and children who had utilized services expressed that Wraparound and PBS services were effective at delaying a placement in an RMHTF. Caregivers' responses via interview indicated they felt some services could have prevented placement, but they were made aware of them too late. Multiple caregivers felt more intense services were needed to meet their child's needs in order to stay in the home.

In addition to the intensity of services, the ability to engage children was also a concern. Varying levels of intensity and activities children are willing to participate in are essential to the success of community-based services. Consideration should again be given to children's average time in RMHTF related to the time the survey was conducted. The implementation of HCBS expansions may not have been relevant to families whose children were already in an RMHTF; however, these results may point toward additional opportunities for ensuring awareness of available services and connection prior to transition home.

Evaluation in the coming year is anticipated to show more impacts related to the implementation of the Assessment Pathway and impacts on delay or prevention of residential placement. DoHS remains dedicated to the family journey and will continue to make appropriate services available statewide.

Caregiver and Child Experiences

Caregivers and children generally had positive feelings toward the services they had received, whether they were in the at-risk or RMHTF population. Caregivers expressed frustration with turnover as a barrier to progress, reporting a lack of consistent communication when providers, such as social workers, would change. In 2023, DoHS focused on recruitment and retention for Child Protective Service and Youth Service workers. Higher satisfaction with the services

received was linked to caregivers feeling they had a support system and a choice in their child's care. Out-of-state placements made caregivers feel like they did not have the ability to be as involved with their child's treatment.

The department has prioritized returning children from out-of-state facilities to their community or to an in-state facility, when clinically appropriate, through collaboration with MU, as described in the January 2024 report. DoHS also offers travel assistance to families who would otherwise not be able to visit their child out of state.

Several caregivers and children in the RMHTF survey reported a regression in behavior after being discharged back to their community. Families feel that a lack of continued services and disruption of structure or routine causes their children to revert to their pre-treatment behaviors. Children are cognizant of the possibility of readmission. Some children reported this possibility motivates them not to regress, while others say that, despite not wanting to return to placement, they struggle to manage their behaviors.

DoHS has planned analyses to assess the services most successful in preventing readmissions as data collection becomes more robust through the data store. Extensive work has gone into discharge planning, and DoHS continues to work with Aetna[7] on identifying the needs of children to make their return to the community sustainable.

DoHS's new Residential Intensive Treatment (RIT) model of care will emphasize the discharge planning process beginning with the engagement of a Wraparound facilitator, secure and established support systems, and linkage to services as part of the discharge criteria. Some discharge planning requirements include addressing the fears of the family, providing opportunities to the child and family to rehearse and practice strategies, and establishing a strong safety and crisis plan. To discharge a child, the provider must hold a meeting with the child and family to review the HCBS they have established, important contacts, and the safety and crisis plan.

DoHS Next Steps in Response to the 2024 CMHE Reports

- Consider marketing of services and how families perceive them
- Continue outreach and education to equip providers with knowledge of the array of services available to child and families; utilize county-level data review for strategic planning
- Explore reasons and timing of when families have barriers related to consistent contact with providers to better understand needs
- Work with law enforcement to provide youth crisis intervention training
- Explore new ways to approach at-risk children with information about accessing and engaging with mental and behavioral health services
- Monitor the efficacy of recent CCRL outreach and identify areas that may need more targeted focus

[7] Aetna is one of the Managed Care Organizations under Mountain Health Trust. Aetna is primarily responsible for children in foster care, adopted, and those on the CSED Waiver.

- Evaluate and expand service availability, including workforce capacity across the state to bolster provider capacity
- Work with Aetna and providers to help ensure discharge barriers are properly identified and sustainable solutions are in place to make sure children have a smooth transition back to their community, with added infrastructure through the residential remodel planned for October 2024
- Work with WVU to evolve the evaluations to more effectively meet DoHS's needs and answer critical questions with more detail

4.0 Timeliness to Wraparound Services

The Assessment Pathway is designed to streamline access points for children and families in need of support and services for children with SED or children up to age 21 with serious mental illness (SMI). To meet needs of these families, DoHS and its partners acknowledge the importance of the family's journey to services, including critical timelines that can influence a child's ability to be maintained in their home and community. Children who enter the Assessment Pathway are connected to HCBS to meet immediate needs, and families receive information regarding how to connect to crisis services for urgent and immediate needs and stabilization.

One of the primary services children are connected to in the Assessment Pathway are Wraparound services. WV Wraparound offers services as stated in previous reports that are meant to "wrap around" a family to help support, stabilize, and manage SED and SMI through services offered in the home or community, based on the family's needs and choices.

The CSED Waiver provided through Medicaid offers a more robust and sustainable funding source to expand these HCBS to families, in addition to other funding sources—including via BSS's SAH Program and BBH's Wraparound programming—which provide interim services to individuals waiting for CSED determination or individuals meeting alternative non-CSED program criteria. Funding sources for WV Wraparound within DoHS are designed to work collaboratively so that, when possible, as determination is made for CSED services, the family will be able to maintain the same Wraparound facilitator throughout their Wraparound journey, even if they transition from an interim service to CSED. This enables families to start services during the CSED determination process, which can take up to 45 days according to West Virginia Bureau for Medical Services policy. Continued efforts are needed to expand capacity to levels needed to implement interim Wraparound services more comprehensively.

The Assessment Pathway was introduced in October 2021 with significant growth in referrals coming into the Assessment Pathway by early spring of 2022. By the end of March 2022, a waitlist due to Wraparound facilitator capacity had to be established for this service, and DoHS began offering other HCBS options to families while they waited. The waitlist has continued to be managed collaboratively by the three funding sources; however, limitations on available workforce still exist, particularly with BBH-funded interim services.

Figure 3 shows the waitlist by funding source as of March 29, 2024. BBH provides services to children and families, who are not child welfare involved, through grant funding while waiting on the CSED Waiver. The ability for children to "carry" their Wraparound facilitator with them as they are deemed eligible for CSED services has had both negative and positive impacts. The positive, of course, allows consistency and rapport to be built by allowing the same individual to work with the child and family throughout their Wraparound journey. However, when children move over to CSED funding, they typically receive services for 9 to 12 months, thus limiting the ability of facilitators covered by grant funding to take on new interim cases.

DoHS continues to explore opportunities to expand the availability of interim services and, following the Quality Committee's review of this information, has developed a team to look

closer at strategies for improving the availability and timeliness of interim Wraparound Facilitation services.

Figure 3: West Virginia Wraparound – Children on Waitlist for Wraparound Facilitation by Funding Source as of March 29, 2024

Wraparound Funding Source	Number of Children on Waitlist for Wraparound Facilitation
CSED	29
BBH Interim Services	98
SAH Interim Services	9

Data quality continues to be at the forefront of DoHS's CQI efforts and plays a key role in analysis of timeliness data. Timeliness data related to Wraparound services is expected to evolve, given the intensive efforts put into improving data systems, quality, and completion; however, DoHS acknowledges the importance of reviewing the child's journey to services regularly to help ensure child and family needs are met. To understand timeliness to Wraparound services, DoHS utilized and matched across several data sets (Figure 4) for all approved CSED Applications from April 2023 to June (Q2) 2023.

Figure 4: Cross-Systems Wraparound Timeliness Analysis Data Sources

Data Source	Date Information Pulled	Analysis Utilizing Data
EDS data (Claims)	12/31/2023	Timeline from determination to service Overall timeline from application to first service
CANS service start related data	1/10/2024	Timeline from determination to service Overall timeline from application to first service
CSED applications	1/5/2024	Timeline from application submission to determination Timeline from determination to service Overall timeline from application to first service
Aetna CSED Roster[8] (preliminary)	03/10/2024	Comparisons of children listed in the CSED roster and service utilization

[8] Data from the Aetna CSED Roster is considered preliminary as some indicators in that (newer) system are still being validated and understood. The Office of Quality Assurance team will work with BMS and Aetna to work through this as part of next steps. The roster represents children enrolled and eligible for the CSED Waiver.

Children with approved applications during Q2 2023 would have had, at minimum, approximately six months to begin services and have them recorded in the CANS and/or claims systems. Given the typical four to six month lag for Medicaid claims, it might be expected that the CANS system will be the timelier source of this data, especially for children who may have taken longer to receive services. Additional work is needed to break down steps in the overall child journey and understand additional influences on timeliness.

A summary of the average and median timeline to first Wraparound service and determination for CSED approvals from Q2 2023 is included in Figure 5 below. Average timeline from application submission to CSED determination was 39 days, while the median time was 35 days. As noted previously, BMS policy states determination will be made within 45 days; therefore, the timeline for this process is often exceeding expectations, despite the growing number of applications received.

Total time from application to first Wraparound service (which includes CSED and interim BBH and SAH services, whichever came first) averaged 82 days, or a median of 75 days, with the longest step in the process being between determination and the first Wraparound service. The Quality Committee discussed potential implications of these results and how additional stepwise data analysis could help identify areas that cause delays in the timeline to determination and subsequent start of Wraparound Facilitation services.

Figure 5: Average and Median Time to Determination and First Wraparound Service – Q2 2023

Indicator	Application to CSED Determination	CSED Determination to First Wraparound Service (calculated difference[9])	Overall Application to First Wraparound Service
Average Time (days)	39	43[9]	82
Median Time (days)	35	40[9]	75

Figure 6 displays the distribution in time from application to CSED Waiver determination. Nearly three quarters (74%) of approved applications received a determination within 45 days. This information was shared with Acentra Health to allow further awareness of the success of the process and opportunities to address applications taking longer than 45 days to reach determination.

[9] Note this is an estimated time. Number of children with available data varied, which may result in fluctuation in future reporting. This is representative of the calculated average difference between time to service start and time to determination of CSED Waiver application. A proportion of children would have received services before determination was made, meaning the total time from referral to services would be more representative when considering these children. The specific indicator for time from determination to services was not included due to the Freedom of Choice calculation limitations by service type but will be added in the future to consider stepwise information for interim and CSED Wraparound services.

Members of the Quality Committee noted that some delays in determination have happened due to the family missing appointments or not responding to outreach. To limit this and help ensure adequate support and opportunities for the family were available, a protocol is in place to follow up with families and to close cases within a set amount of time and attempts if no response is received.

Figure 6 - Distribution of Days from Application Received Date to Determination Date, Q2 2023 Total Approved CSED Applications (N = 370)

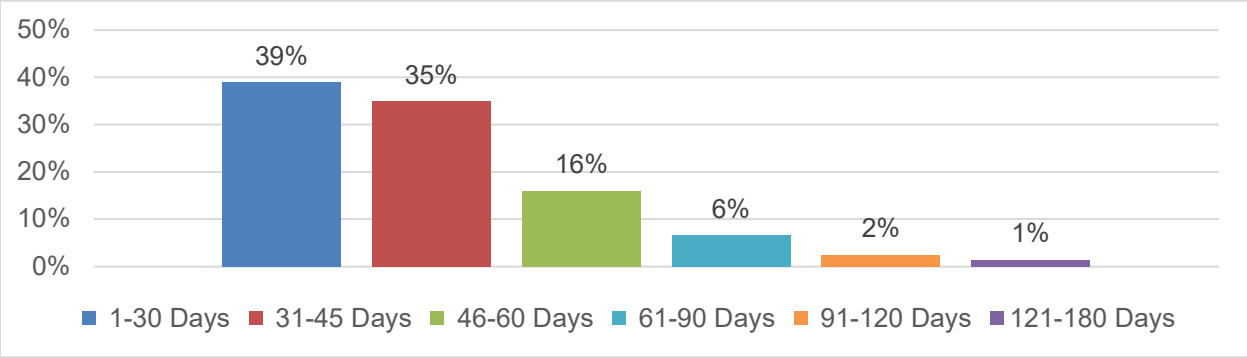
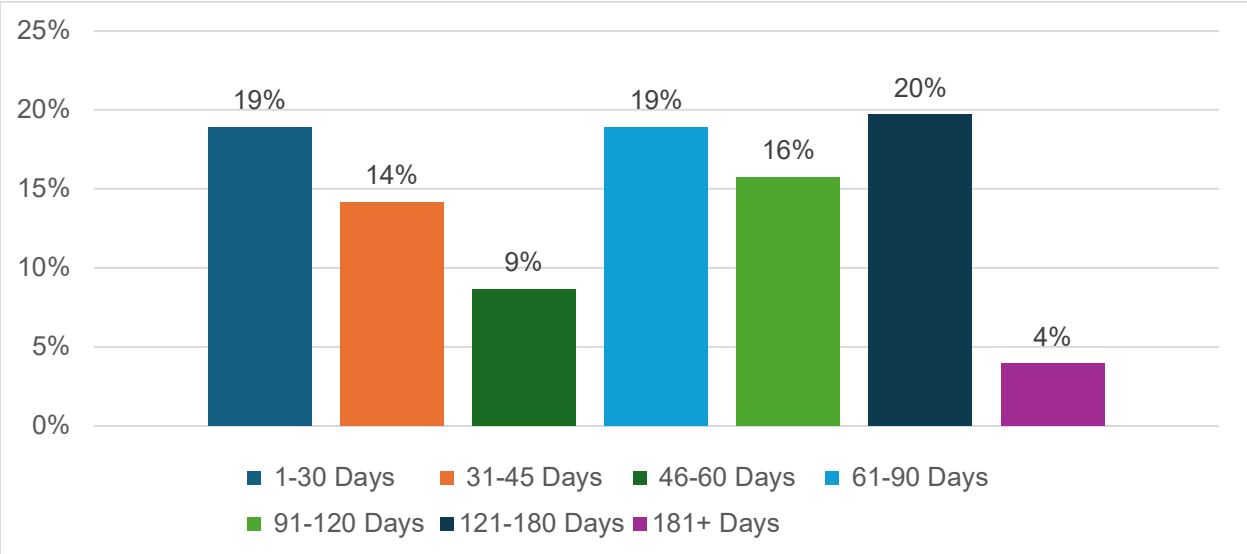


Figure 7 displays the distribution in time from application to any Wraparound facilitation service. Approximately one out of five children (19%) received services within a month of application, 23% within one to two months, and another one out of five (19%) began services within two to three months. The remaining children (two out of every five, 41%) who started services did not start until over three months after the submission of an application to Wraparound services via the Assessment Pathway.

Figure 7 - Distribution of Days from Application Received Date to Service Date, Q2 2023 Total Approved CSED Applications with Wraparound Service Date (N = 127)

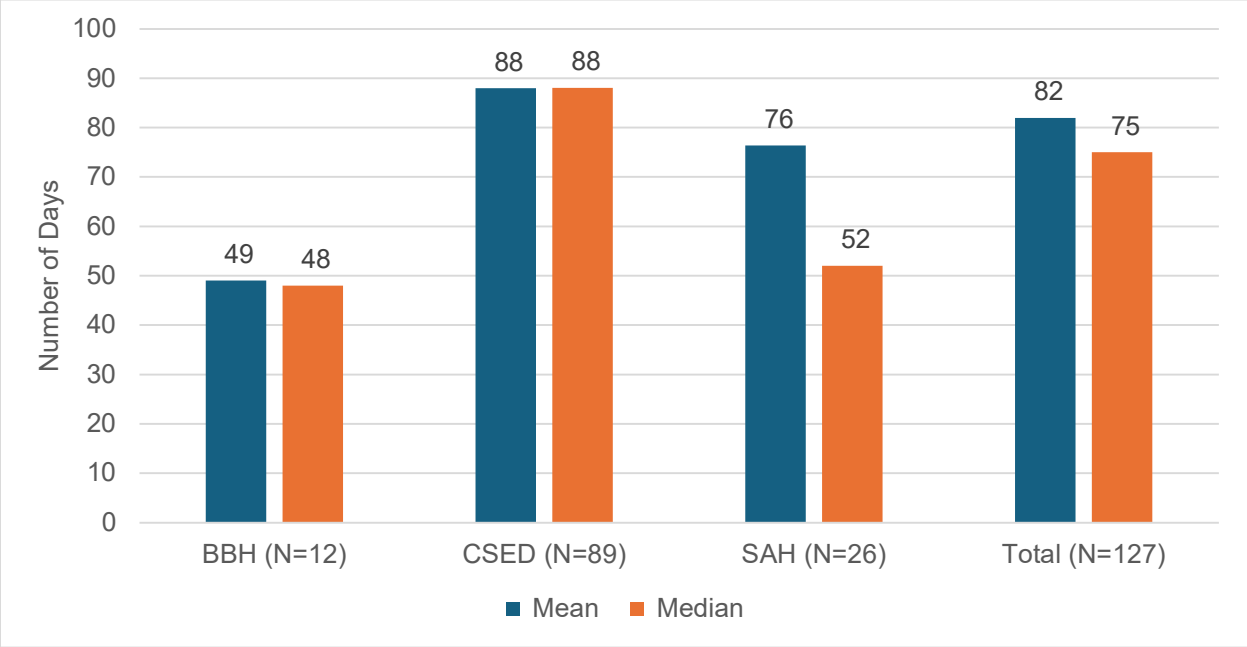


As shown in Figure 8, for children connected to a Wraparound facilitator through interim services, wait times were nearly a month shorter compared to those who were not able to

access services until funded by CSED, with a median time to services of 48 days for BBH (n = 12) and 52 days for SAH (n = 26) Wraparound Facilitation funded services compared to 88 days for CSED (n = 89) as first Wraparound service.

Although other HCBS (e.g., PBS, therapy, regional youth service centers) are always offered to families through the Assessment Pathway process, only one third (30%) of children who received services were recorded as receiving an interim Wrapround Facilitation service for applications approved in Q2 2023 (38 out of 127 children). As stated above, the members of the Quality Committee have expressed continued need to explore additional strategies to improve the available Wraparound Facilitator capacity for interim services. Additional strategic planning to help address this area of concern will take place in spring of 2024.

Figure 8 - Days from CSED Application Date to Earliest Wraparound Service Date
Q2 2023 Total Approved CSED Applications[10] (N = 127)



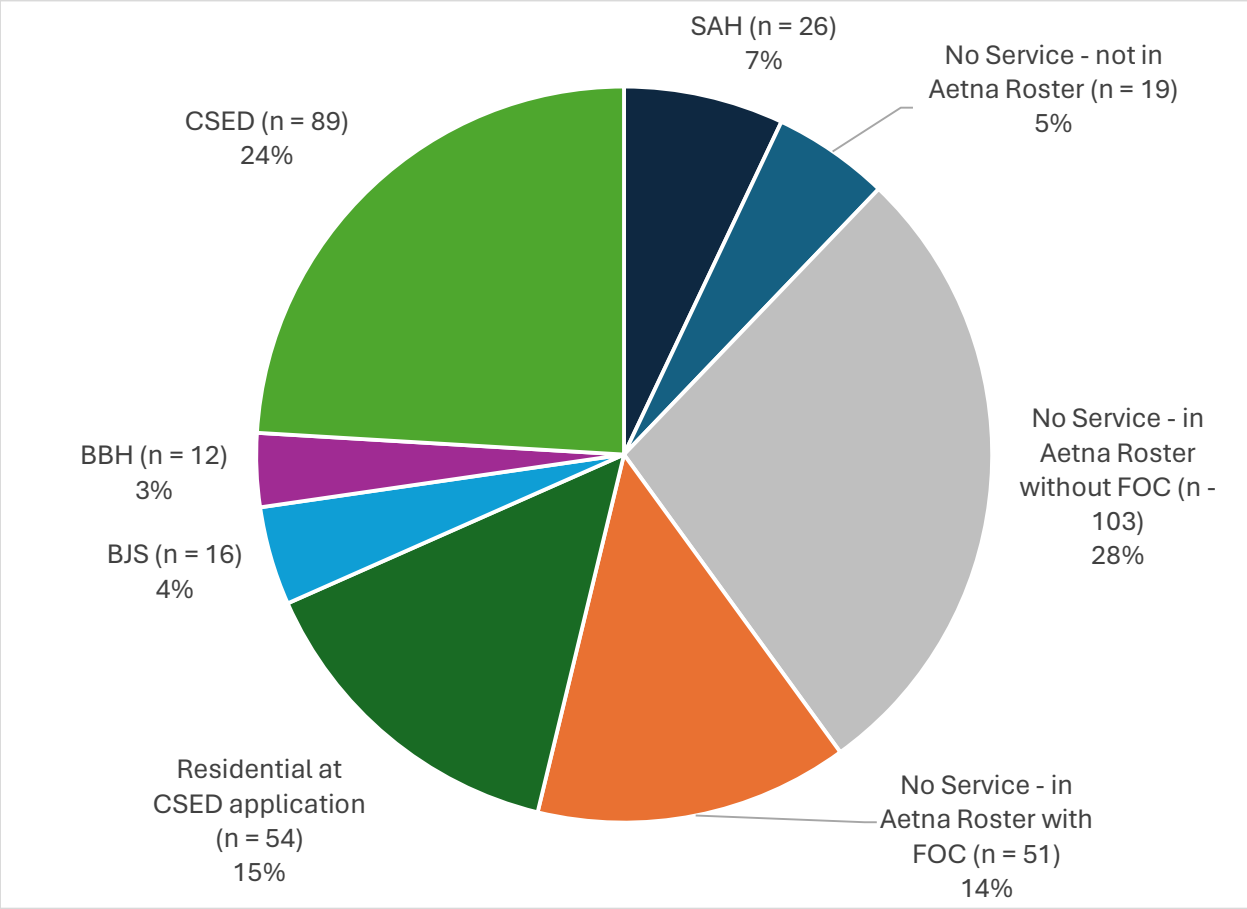
The information above included children who received Wraparound Facilitation services per documentation in the CANS system. Figure 9 shows service status for all children approved for the CSED Waiver in Q2 2023. Services in this context included Wraparound separated by payor source of first Wraparound service, Bureau for Juvenile Services (BJS) or residential interaction, and lack of these services types being indicated in the CANS system. Lack of service was further distinguished by whether the child was listed in the Aetna CSED Roster and if a Freedom of Choice form was on file for the child, which would indicate some level of participation and agreement to continue pursuit of services from the family.

SAH services following application were included regardless of interim status to represent any Wraparound services received. Nearly half (47%) of children did not have Wraparound services documented in claims or CANS data systems. More than half (60%) of children without services

[10] Includes only applications with a service start date for children not indicated as being in residential or BJS custody.

did not have a Freedom of Choice form documented. More information is needed, but this data may indicate, in some instances, lack of response or interest from families. However, nearly one third of children with no services had a Freedom of Choice in place but no services documented.

Figure 9 – Service Status
Q2 2023 Total Approved CSED Applications (N = 370)



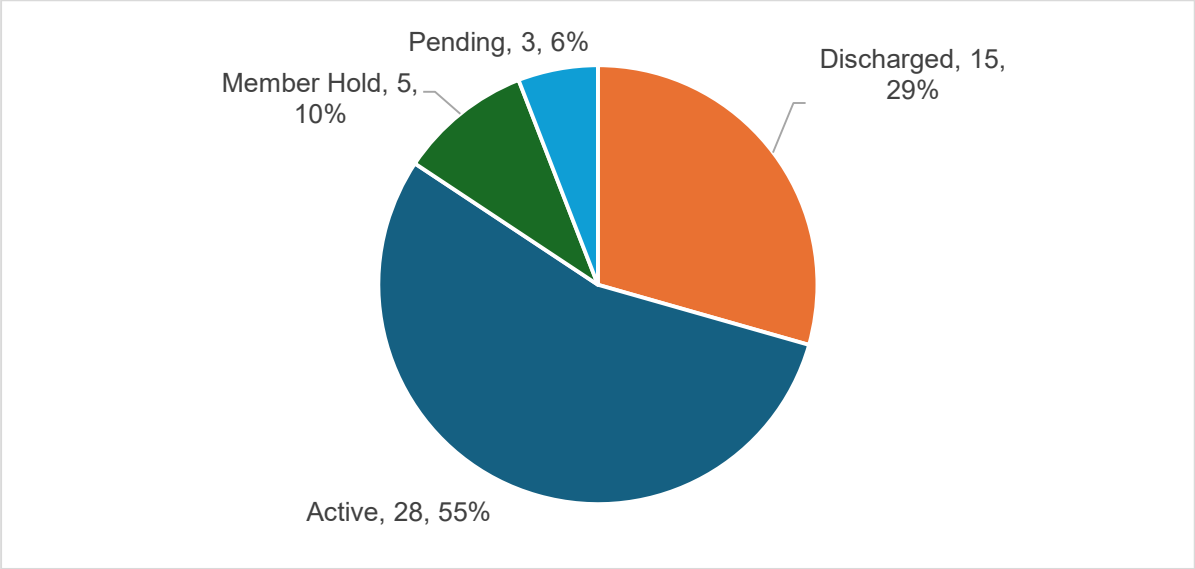
Children with no Freedom of Choice documented tended to be on hold due to placement in a residential facility such as shelter, BJS, or RMHTF, but the most common reason for this group was that the family could not be reached. Figure 10 displays enrollment status of children listed in the Aetna CSED Roster with a Freedom of Choice form in place (indicating the family had agreed to start services) but did not have a service listed in claims or CANS. Of these children with no services, 29% had discharged, 55% were listed as active, and the remaining had a "hold" or "CAFAS[11] needed" listed, which would help prevent them from receiving services until a repeat CAFAS is completed (due to the initial CAFAS being expired, greater than 90 days since initial CAFAS) or the hold status is lifted.

[11] The Child And Adolescent Functional Assessment Scale must be completed or repeated no more than 90 days prior to the start of CSED Waiver services per eligibility criteria.

A child can go on “hold” for a range of reasons, including placement in BJS or residential placement or by request of the family. The Quality Committee noted that continued data quality and completion efforts were needed to verify whether low utilization rates were a result of incomplete documentation or discontinuation with the Assessment Pathway. The group identified the next steps, including working with providers to offer technical assistance and CQI strategies to improve data completion and quality.

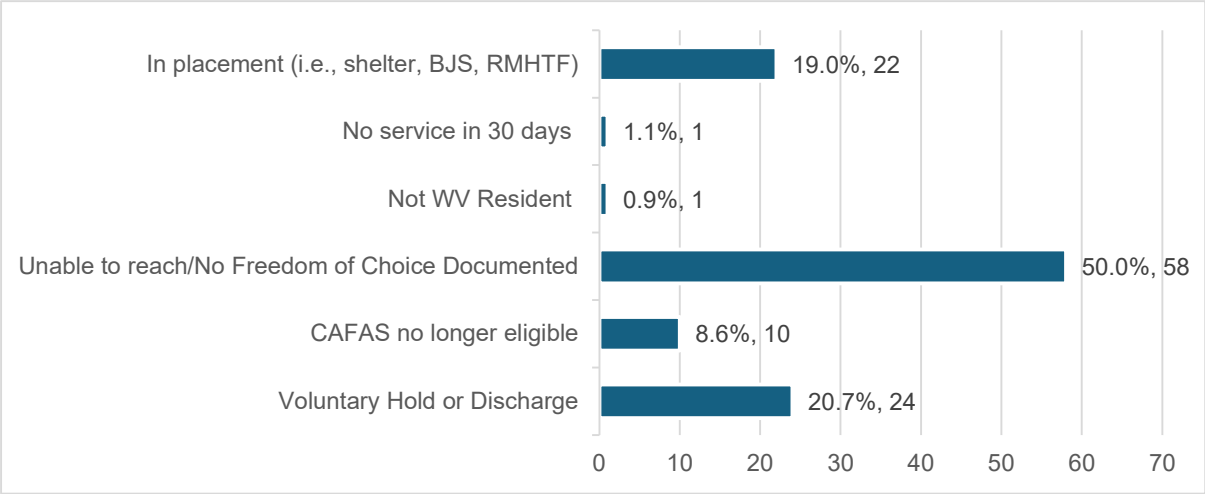
Additional analyses will be completed to understand stepwise, where children are potentially ceasing participation, not being connected to services timely, or disengaging, and—if possible, with existing data sources—understanding why this might be happening. Updates to the Aetna CSED Roster system and related reporting have resulted in delays to these analyses and review, but they are anticipated to be completed before fall 2024.

Figure 10 - Q2 2023 Approved CSED Applications
No Service with Freedom of Choice in Place and in Aetna CSED Roster, by Status (N = 51)



Initial analyses (Figure 11) showed that among children who were not listed as active and had no services, 50% were unable to be reached while 21% had a voluntary hold or discharge, and 19% were placed on hold due to being in a placement (e.g., shelter, BJS, RMHTF, PRTF). Ten children (9%) had been indicated as no longer meeting CSED criteria before starting services by scoring <90 on a follow-up CAFAS when a previous one expired. Updates to the data system are expected to include an expansion of reason for closure so more CQI opportunities can be explored.

Figure 11 - Q2 2023 Approved CSED Applications
No Service, in Aetna CSED Roster, and Discharged or On-Hold Reason (N = 116)



In summary, additional analysis and review is needed to understand if all children with Wraparound services had representative documentation in the CANS and claims systems. This will be further explored in future Wraparound Performance Improvement Plan and Quality Committee meetings.

In the coming months, DoHS will focus particularly on strategic planning to expand capacity for interim Wraparound services and a stepwise analysis of the timeline and journey to Wraparound services for children approved for the CSED Waiver. This information will be used to guide DoHS and its partners in ways to decrease the timeline to services for children with SED.

5.0 Conclusion

DoHS remains focused on the experience of the child's and family's journey to services, recognizing that timely connection to services is a critical component of supporting children to be successful in their homes and local communities. With that focus in mind, DoHS is prioritizing the following:

- Continuing efforts to align policy, practice, and training across West Virginia Wraparound funding sources to move toward Wraparound service fidelity to NWI standards
- Continuing county- and stakeholder-specific outreach to raise awareness of available services and supports to address mental and behavioral health needs, including exploring new ways to approach at-risk children with information about accessing and engaging with mental health services
- Increasing the availability of CMCRS services by offering these critical services through West Virginia's Medicaid State Plan
- Continuing to work with Aetna and providers to identify and address discharge barriers for children in residential placement and help ensure sustainable solutions are in place to facilitate a smooth transition back to their community
- Implementing the new residential models of care (projected October 2024) to help ensure children clinically assessed as needing more intensive support can receive effective and time-limited treatment close to home with involvement from family
- Identifying and implementing strategies for improving the availability and timeliness of interim Wraparound Facilitation services
- Continuing efforts to expand Wraparound Facilitator capacity across funding sources
- Continuing to focus on data quality and completion with vendors and providers to better understand the timeline and journey to Wraparound Facilitation services, with a specific focus on identifying any barriers or process improvements needed to help ensure children and families are connected to services timely and avoid unnecessary residential placement