AGREEMENT BETWEEN THE STATE OF WEST VIRGINIA AND THE UNITED STATES DEPARTMENT OF JUSTICE:

Report by Subject Matter Expert

March 2024

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

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1. Introduction

DOJ/WV Partnership

In April 2014, the United States Department of Justice (DOJ) launched an investigation into the State of West Virginia's (WV) system for delivering services and supports to children with serious mental health conditions. DOJ found that WV had not complied with Title II of the Americans with Disabilities Act (ADA) and, as a result, many children with serious mental health conditions were needlessly removed from their homes to access treatment. In a May 14, 2019, Memorandum of Agreement (the Agreement), DOJ recognized WV's commitment to providing services, programs, and activities to qualified children in the most integrated, least restrictive environment. The Agreement requires WV to build upon this commitment by offering home- and community-based services (HCBS) to all qualified children and to reduce the number of children in residential mental health treatment facilities.

As part of the Agreement, the State was required to obtain a subject matter expert (SME) in the design and delivery of children's mental health services to provide technical assistance to help the State reach compliance with the Agreement, prepare an assessment of the State's compliance with the Agreement, and provide recommendations to facilitate compliance. Through competitive procurement, the State contracted with The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work to provide this subject matter expertise. In accordance with the Agreement, this contract requires that twice annually the Institute draft and submit to both the State and DOJ a comprehensive report on WV's compliance with the Agreement, including recommendations to facilitate or sustain compliance. Previous reports were delivered in December 2019, June 2020, December 2020, August 2021, April 2022, December 2022 and June 2023.

The SME work has been contracted with the WV Department of Health and Human Resources (DHHR). The passage of WV House Bill 2006, which went into effect on January 1, 2024, separates DHHR into three entities: the Department of Health, the Department of Human Services (DoHS), and the Department of Health Care Facilities. The work of the Agreement is now housed in DoHS, so that is the department that will be referenced throughout this report.

Report Methodology and Structure of Each Review Area

This report is divided into sections according to content areas as outlined in the Agreement. Each requirement of the Agreement is scheduled for compliance review in phases through the summer of 2024, when all Agreement requirements will be rated for compliance. Compliance is rated as follows: substantial (achieved); partial (with needs identified to reach substantial compliance); or non-compliance. Even in cases when a provision is rated as in substantial compliance, DoHS is expected to maintain that compliance and continue its commitment to continuous quality improvement (CQI). See Appendix D for more details on the rating methodology.

Agreement Categories	Spring 2022	Fall 2022	Spring 2023	Spring 2024
Assessment	X	X	X	X
Wraparound	X	X	X	X
Assertive Community Treatment (ACT)	X	X	X	X
Quality Assurance & Performance Improvement System (QAPI)		X	X	X
Screening		X	X	X
Target Population		X	X	X
Children's Mobile Crisis Response System (CMCRS)		X	X	X
Residential Reductions			X	X
Behavioral Support Services			X	X
Therapeutic Foster Care (TFC)*			X	
Outreach & Education				X
Workforce				X
Children with Serious Emotional Disorder (CSED) Waiver				X

*Per a decision with DoHS/DOJ, TFC is not being rated during this SME review period. It will be rated in the next period.

For reference, commonly used abbreviations throughout this report are included in Appendix A. For each area, the report includes the following sections:

1. *Introduction*. This includes the relevant requirements from the Agreement, as well as a basic description of the area itself.
2. *Achievements and Developments*. This section provides an overview of the information the SME received regarding DoHS's progress toward compliance during the reporting period. A full list of these documents is provided in Appendix B. While each of the sections received some information that was specific to that content area, there are several documents that provided relevant information across most or all of the content areas:
    a. *January 2024 WV DoHS Children's Mental Health and Behavioral Health Services: Quality and Outcomes Report (January 2024 SAR)*
    b. *Implementation Plan for the Memorandum of Understanding Between the State of WV and the U.S. Department of Justice, Year 5, January 2024*
    c. *Suite of West Virginia University (WVU) Evaluations*
    d. *November 2023 Quality Committee Review Preliminary Slide Deck* (for internal review only)

e. *SME/DoHS Recommendations Matrix* (last updated January 31, 2024). See Appendix E for this document that began as a compilation of all recommendations from the SME June 2023 report. It became a vehicle for the SME and DoHS to discuss the most recent recommendations and for DoHS to provide publications and resources to document progress and evidence on the recommendations. This communication and information tool helped guide the SME ratings and understanding for each subject area. See Appendix C for a list of all meetings attended during this review period.

3. *Ratings and Recommended Activities to Reach Compliance.* In this section, the SME rates each Agreement area relevant to the specific subject being discussed. The SME provides justification for the rating and, in cases where WV has not yet reached full compliance, the SME outlines the actions needed to achieve that goal. The SME notes that, across all sections, progress will next be evaluated in July 2024. See Appendix D for SME Compliance Rating Criteria.

Overarching Issues

- *Access.* The *WVU Detailed Report* focused on the Community-Based Services Population at 2 Years provides a great deal of insight into the challenges and issues that children, families, and providers face around access. "That said, stakeholders want more—organizations and facilities reported challenges with service coverage and continue to experience difficulties hiring and retaining providers with advanced training and experience, caregivers and youth need more community-based services with higher levels of intensity, and opportunities exist to further engage stakeholders in discharge planning and transitioning youth out of RMHT" (p. 3). In that report, providers felt the top three barriers to maximizing referrals were: lack of qualified providers; lack of resources; lack of information about resources. "Approximately 70% of Year 2 providers who had heard of the mental and behavioral health services of interest indicated that they (the services) need more resources" (p. 51). Waitlists have also increased: "A larger percentage of organizations reported having waitlists for services in Year 2 compared to Baseline. Statewide, 30% of organizations at Baseline and 40% in Year 2 reported having waitlists" (p. 104). In reviewing all of the materials for this review, the SME notes the recurring theme of a need for more services with better access.
- *Foster Care Capacity.* Many of the children remaining in residential mental health treatment facilities (RMHTFs), despite being ready for discharge, are waiting for a home to discharge to, but homes are hard to come by for these youth, who may be older and have greater needs. Further, with the discontinuation of stabilization and treatment (STAT) homes, the tiered system of foster care will be essential to divert children in foster care from admission to an RMHTF, requiring that recruitment also focus on families willing to care for youth with higher SED needs. DoHS acknowledges the shortage of foster homes, particularly for older youth and youth with serious emotional disturbance (SED) and has initiated a marketing campaign to address this concern. Consistent and high-intensity services, as described above, will enable placements in family homes.
- *Data.* WV has demonstrated significant gains in the collection of and use of high-quality data. In turn, DoHS has made great strides in using data to drive decision-making through Quality

Committee meetings, data dashboards, and the developing data store. Challenges continue with data quality, despite documented efforts to refine data systems and reporting. Further, while collaborations with WVU and Marshall University (MU) have yielded evaluation reports, opportunities exist to refine these reports to further measure and understand the impacts of DoHS's work as related to the Agreement.

- *Centering Children, Families, and Providers.* DoHS is actively working to gather and include more perspectives from children, families and providers. Quality Committee meetings and reviews now routinely include information about the child and family journey. In addition, DoHS developed a youth and family survey in partnership with DoHS staff and individuals with lived experience. These surveys will explore youth and family experiences with DoHS services and will be followed up by listening sessions. WV's System of Care (SOC) grant also includes goals to empower youth and families and promote peer support. DoHS also meets with providers regularly. DoHS will want to continue these efforts to engage family, children and providers more actively in decision making processes. Such collaborative processes will yield services that are sustainable and effective and ensure that DoHS's services, marketing and language used is strengths-based and child and family-friendly.
- *Implementation Plan.* Overall, the SME notes that WV and DoHS have done an excellent job of establishing infrastructure and laying the groundwork for building a strong and successful system of HCBS for children and families, as outlined in the *Year 5 Implementation Plan.* By creating systems for designing, implementing, and evaluating intervention services, DoHS is taking important strides towards the ultimate goal of reducing residential placements.

2. Summary of Compliance Ratings

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
24a (Also see Agreement Item 28 and 40a)	Timely access HCBS services	Partial	ACT, CMCRS, PBS/BSS, TFC*, Wraparound	See Agreement Item 28.
24b (Also see Agreement Items 40b)	Meets individual needs. . . services provided in a manner to enable child to remain/ return to family	Partial	ACT, CMCRS, PBS/BSS, TFC*, Wraparound	Survey a representative sample of participants who receive HCBS to determine if individual needs are met through the respective programs. This may be accomplished through the WVU Children's Mental Health Evaluation with adjustments to the population surveyed and questions asked. This could also be addressed with post-treatment surveys that WV is developing to deliver to program participants.
24c (Also see Agreement Items 33 and 39)	Statewide access	Substantial	ACT, CMCRS, PBS/BSS, TFC*, Wraparound	N/A
26	Times/locations mutually agreed upon by provider, child and family	Partial	ACT, CMCRS, CSED, PBS/BSS, TFC*, Wraparound	Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation.
28	Timely provision of mental health services	Partial	ACT, CMCRS, CSED, PBS/BSS, TFC*, Wraparound	ACT Needs: Report data on youth who are offered ACT and do not enroll for various reasons (waitlist or engagement issues). CMCRS Needs: Continued evidence on examining and analyzing data, such as the rates of face-to-face contact with families that request services. Wraparound Needs: More specific definitions and measures to track and evaluate data with regards to which/intensity of services are listed on POCs and if youth are being connected to these services. PBS/Behavioral Support Services Needs: • Continued documentation of the length of the waitlist for services, along with the average wait time.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
				• The modifier to the Medicaid billing code is necessary to demonstrate access to Behavioral Support Services; while this was originally expected in the summer of 2024, these revisions are now expected spring/summer 2024. <u>CSED Waiver Needs:</u> • Report data around interim services received while awaiting eligibility determination. • Report child-level data looking across systems. • Report data on "on-hold" population.
29a	Availability of crisis response to all children to include toll-free crisis hotline and crisis response teams staffed 24/7	Substantial	CMCRS	N/A
29b	Callers connected directly to trained mental health professionals with children's crisis competency	Partial	CMCRS	Evidence that mobile response teams are staffed with professionals trained to respond to the needs of youth/families and that the transfers are made to these child-specific teams.
31a	DHHR shall ensure that all children who are eligible to receive mental and physical health care and services through DHHR are screened to determine if they should be referred for further mental health evaluation or services	Partial	Screening	• Evidence of statewide coverage to ensure that all children who are systems-involved are being reached; for example, for Probation Services, concrete steps to ensure that all 55 counties are conducting screenings. • Efforts to understand the population of children not being screened as data capacity and the data store buildout continue.
31b	DHHR shall adopt a standardized set of screening tools	Substantial	Screening	N/A
31c	A mental health screen will be conducted upon entry into state service systems or if the family requests it	Partial	Screening	See 31a.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
31d	DHHR shall conduct outreach and training to physicians who serve children that are Medicaid-eligible	Substantial	O&E	N/A
31e	52% of Medicaid-eligible children who are not in state service systems shall be screened with a mental health screening tool annually	Partial	Screening	• Continued efforts to reach the 52% benchmark. • Efforts to reach a broader group of Managed Care Organizations (MCOs) under Mountain Health Trust, as well as efforts to reach out to children and families directly Continued evidence from the Wellness Screening PIP. • Additional information about the meetings between the Office of Quality Assurance (OQA) and representatives of Bureau of Medical Service (BMS).
32	Established intake/assessment process	Partial	Assessment	• Increased availability, accessibility, and awareness of effective HCBS to prevent unnecessary RMHTF admissions. • In identifying youth eligible for discharge, DoHS could enhance the timeliness, accuracy, and meaning making of Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) assessments. • Further analysis of discharge barriers, disaggregated by youth characteristics and systemic factors. • Progress needs to continue with Bureau of Juvenile Services (BJS) to continue to enhance data collection associated with submission of CSED Waiver applications. • Documentation of how children and families progress through the Assessment Pathway, including analysis of low levels of Bureau of Behavioral Health (BBH)-associated referrals to CMCRS

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
33	Statewide access to Wraparound Facilitation through Child and Family Teams (CFTs)	Substantial	Wraparound	N/A
34 (Also see Agreement Item 49f)	Adherence to Wraparound/CFT model fidelity	Partial	Wraparound	• Detailed Performance Improvement Plan (PIP) workplan with clear actions, timelines, etc. • Documentation of actions items reported in the *January 2024 SAR* and timelines to address. • Enhanced cross-bureau efforts. • Efforts to create clearer/uniformed messaging of Wraparound Model, i.e. in manual, policies, etc. • Evidence from Aetna, MU, Wraparound providers, and families that 10 Wraproud Principles are known, shared and visible in practice. • List of trainings completed and attendees from last 12 months and future trainings scheduled.
35a	Use of Child and Adolescent Needs and Strengths (CANS) tool to develop individualized service plans (ISP) for youth needing HCBS	Partial	Assessment	• Improvement in needs identified in the CANS being reflected in Plans of Care (POCs). • Training on the importance of documenting and addressing needs identified in the CANS, which should lead to an increase in needs being present in POCs. • Documentation/examples of Aetna's review process to more fully understand the representation of needs identified in the CANS in POCs.
35b	For children in RMHTF, the individualized service plans will include discharge planning	Substantial	Residential Reduction	N/A
36	DHHR provision of child screenings, assessments, and ISPs to multi-disciplinary teams (MDTs)	Partial	Assessment	Documentation of the process of the Bureau of Social Services (BSS) Behavioral Support Services Division of Planning and Quality Improvement (DPQI) for sampling the provision of screenings to MDTs.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
37a	Provision of family support services/training	Partial	CSED	• Evidence that family supports provided are sufficient. • Documentation regarding how Aetna provides quality assurance.
37b	Provision of Behavioral Support Services	Substantial	Behavioral Support Services	N/A
37c	Provision of in-home therapy	Partial	CSED	• Evidence of a policy/approach regarding how evidence-based practices (EBP are ensured. • Evidence that in-home therapy provided is sufficient. • Documentation regarding how Aetna provides quality assurance.
38	Expansion of statewide TFC	Not rated	TFC*	N/A
39	Availability of ACT statewide and provided to youth 18-20 who need the service.	Substantial	ACT	N/A
40a (Also see Agreement Items 24a and 28)	Timely access to home and community based mental health services	Partial	Wraparound, CMCRS, TFC*, ACT, BSS	See Agreement Item 28.
40b (Also see Agreement Item 24b)	Individualized home and community based mental health services	Partial	ACT, CMCRS, PBS/BSS, TFC*, Wraparound	See Agreement Item 24b.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
40c (Also see Agreement Item 24c)	Statewide access to home and community-based services	Substantial	ACT, CMCRS, PBS/BSS, TFC*, Wraparound	N/A
40d	Provide families and children with accurate, timely, and accessible information regarding available HCBS	Substantial	Outreach & Education	N/A
41a	Implementation Plan: ensure statewide access	Substantial	ACT, CMCRS, CSEDW, PBS/BSS, TFC*, Wraparound	N/A
41b (Also see Agreement Item 29a)	Implementation Plan: evaluate adequacy of crisis response	Substantial	CMCRS	N/A
41c (Also see Agreement Item 34)	Implementation Plan: evaluate fidelity of Wraparound	Substantial	Wraparound	N/A
41d	Implementation Plan: address workforce shortages	Substantial	Workforce	N/A
41e	Implementation Plan: evaluate provider capacity	Partial	Workforce	• Continue monthly cross-bureau data review of the *Wraparound Facilitator Capacity and Caseload Analysis*. • A more flushed out Implementation Plan to evaluate provider capacity.
41f (Also see Agreement Item 31d)	Implementation Plan: develop outreach tools for medical professionals	Substantial (see 31d)	Outreach and Education	N/A

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
41g (Also see Agreement Items 48a-c)	Implementation Plan: develop QAPI measures	Substantial	QAPI	N/A
41h (Also see Agreement Item 52c)	Implementation Plan: achieve RMHTF reduction	Partial	Residential Reduction	See 52c
48a	Analysis of the quality of mental health services	Partial	QAPI	• Continue meaningful progress on the use of data to assess child and system level journeys and outcomes. • DoHS must continue demonstrating the value of rich data resources through analyses and review described in the *SARs*, including expansion of child-level, cross-system review. Identify the source of data (specifically if it comes from the data store/dashboard) when discussing the findings. See QAPI section item 48c for suggested language.
48b	Analysis of Agreement across all child-serving agencies	Partial	QAPI	
48c	Analysis of data per paragraph 49	Partial	QAPI	
49	Specification of data to be collected and analyzed	Partial	QAPI	• Substantial compliance will require a fuller data store buildout that includes a sufficiently meaningful set of the measures described in this Agreement item. • More thorough and deeper understanding of the data collected by disaggregating at youth and county/region, and cross-system analysis.
50	Quality sampling reviews of Target Population	Partial	QAPI	• The WVU survey is not providing meaningful actionable data. DoHS should follow through on planned changes to implementation. Refer to the QAPI section Agreement Item 50 for specific recommendations from the SME. • Explain how item 50 plans to be fully met, providing clarity on quality and plans pertaining to the "cross-system" requirement.
51	Remediation Efforts	Substantial	QAPI	N/A

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Specific Evidence/Progress Needed to Achieve Substantial Compliance
52b (Also see Agreement Item 50)	As HCBS expands to new regions, assess strengths/needs of residential placements from regions, identify services children need to return to community, develop a plan to address any barriers	Partial	Residential Reduction	• Improved timeliness and data quality of CANS/CAFAS, especially with out-of-state providers. • Integrate referrals and warm hand-offs to specific HCBS providers in discharge planning.
52c	Reduction of unnecessary use of RMHTFs and meet goal; if goal is not met state will assess reasons and create an action plan. With target date of 12/31/24	Partial	Residential Reduction	• Continue to enhance collaborative relationships with stakeholders • Monitor new marketing effort to recruit resource families
52d	As of 12/31/24 all children must have been assessed by a qualified professional to meet their needs	Partial	Assessment	• Increased effort towards and documentation of Qualified Independent Assessments (QIAs) occurring in a timely fashion. • The SME also needs to see evidence that the children who are in RMHTF are in the most integrated setting appropriate to their needs; i.e. children who can be served in the community do not enter RMHTF and children who are appropriate for discharge to the community are in fact discharged from RMHTF.
54	Develop Outreach & Education Plan for Stakeholders	Substantial	Outreach & Education	N/A

3. SME Compliance Agreement Review Areas

3.1 Assessment

Overview

The Agreement requires that, for children and youth whose screening indicates a need for further evaluation, or who are recommended for or placed in a RMHTF, or who have received mental health crisis intervention, the State must provide timely, face-to-face intake and assessment, delivered at times and locations mutually agreed upon by the provider, child, and family. The Agreement also requires that a qualified individual use the CANS assessment tool (or similar tools) to identify needs and assist the CFT in the development of an individualized service plan. Lastly, the Agreement requires DoHS to provide the child's assessment to the MDT.

Throughout the course of the Agreement, DoHS has made significant strides in building the infrastructure necessary to meet the terms of the Agreement. The first of these is the establishment of the Assessment Pathway, which simplifies and streamlines access to children's mental or behavioral health services. The Assessment Pathway streamlines access to services and offers a "no wrong door" approach, providing children and families the opportunity to apply for the CSED Waiver and to access other HCBS.

The state has also embraced statewide implementation of the CANS tool. Child-level matching data is now available for the CANS score history data set in the data store.

The state has also adopted the CAFAS and PECFAS as one element of the criteria for determining CSED Waiver eligibility. Child-level matching data for residential CAFAS/PECFAS score history is available in the data store with CSED Waiver CAFAS/PECFAS scores planned for addition to the data store in 2024. Both RMHTF and CSED Waiver CAFAS/PECFAS are available at the child-level and are included in multiple analyses as reflected in the semiannual report.

As part of the Agreement, DoHS has developed a QIA process to assess children and youth who are at high-risk for or currently placed in a RMHTF. A CAFAS/PECFAS and CANS Assessment, including the CANS Decision Support Model, are all used in the QIA.

WV continues to work on establishing and operationalizing the process of sharing assessments with children's MDTs. The MDT process received particular focus in 2023, as legislation addressed representation in MDT meetings of individuals who directly support the child, such as the Aetna care manager. The MDT must receive timely QIA information.

Achievements and Developments

The core of the Agreement in this area concerns the required intake and assessment process. There is evidence that the overarching goal of "no wrong door" is being met. The *WVU Detailed Report* focused on the Community-Based Services Population at 2 years found that 86% of community-based caregivers who were aware of Wraparound services reported no barriers related to understanding how to navigate getting mental health services for their child, a statistically significant finding. The

establishment, growth and statewideness of the Assessment Pathway is also addressed in the *January 2024 SAR* which shares the following:

- From January to June 2023, 1,417 unique children were referred to the Assessment Pathway to be assessed and connected to HCBS. This is a 35% increase from the previous six-month period (July-December 2022), during which 1,046 children were referred.
- Pendleton and Tucker Counties were the only two counties that did not submit a referral during the last half of 2022. However, in the first six months of 2023, a referral was received for at least one child in all 55 counties.
- It is important to look specifically at referrals from the BBH Assessment Pathway Support Team. These referrals are not associated with child welfare and therefore may be more representative of children and families with less system involvement. There were 465 children with BBH-associated referrals in January to June 2023. Children 5-to-12-years-old comprised 53% of these referrals, compared to 35% of total CSED Waiver application referrals. This may partially represent DoHS's efforts to intervene with families early, stabilizing them before they become system-involved. Of these BBH-associated referrals, 72% received preliminary or final approval for CSED Waiver services. Additionally, it is noteworthy that only 5.3% of BBH-associated referrals came from CMCRS. This is a lower rate than may be expected and might warrant further investigation. BJS began making referrals to the Assessment Pathway in the fourth quarter of 2022. Because this process is still relatively new, tracking and reporting information is also not as complete as for other systems. Tracking and referrals can now be captured in the BJS Offender Information System, although DoHS notes that data completion by BJS staff is an area for improvement. Facility-specific spreadsheets for completion by facility case managers are being used as an interim solution to maintain accountability for BJS case managers.

DoHS also shared the *Assessment Pathway Front Door Referrals Form Bureau for Social Services (BSS), Bureau of Juvenile Services (BJS), and Juvenile Probation Standard Operating Procedure (SOP)* which includes a decision tree for children with positive screening assessments. Children and youth with positive screens are referred to the Assessment Pathway with the worker submitting an initial CSED Waiver application to Acentra. For those at high-risk of residential placement, they are referred to Acentra for a QIA. Children without mental health needs identified are referred to HCBS as needed.

The Assessment Pathway and Interim Services Access SOP shares the following process for calls that originate from the Children's Crisis Referral Line(CCRL):

- For children found not at-risk for RMHTF placement or with a screening indicating SED, they are referred to HCBS.
- For children who are at-risk for RMHTF placement or have a screening indicating SED, their referral goes to the Assessment Pathways Intake Box (orders are also received here from the courts and Early Periodic Screening Diagnosis and Treatment (EPSDT).
- BBH assists families with the CSED Waiver application process.

- For children with a CAFAS/PECFAS score over 90, an interim WF is assigned.
- Interim Wraparound services are then provided until eligibility for CSED Waiver is determined.

The *January 2024 SAR* provides insights into **timeliness**, specifically for BBH-associated referrals, as shared in the following flow chart:

1. BBH makes initial contact with family following receipt of referral

    a. 83% of referrals were first contacted within five days.

2. BBH works with the family to complete the CSED Waiver application and submit the application to the Acentra Health (excludes referrals originating with Acentra Health)

    a. Three-quarters (75.9%) of referrals had their application completed and sent to Acentra Health in 10 days or less; this step may be impacted by the families' response time.

3. Acentra Health receives the application, completes the CAFAS/PECFAS, and reports results back to BBH

    a. Initial determination was received from Acentra Health within four weekdays for one-tenth of the referrals (n = 12, 9.2%). The median initial determination was received in 10 weekdays.

4. BBH assigns the Wraparound Facilitator agency or transfers the referral to the CSED Waiver

    a. Across all referral sources, only 1% of children who were approved are assigned a Wraparound Facilitator within five weekdays, the target outlined in policy. Delays are primarily associated with interim Wraparound service capacity limitations.

    b. For children placed on the waitlist for interim Wraparound service (n = 327), 17% (n = 55) were assigned to an interim Wraparound Facilitator, with an average of 23 weekdays to assignment. 80% (n = 262) were transferred to CSED Waiver services prior to assignment, with an average wait of 11.8 weekdays until transfer. The remaining 3% did not have a waitlist end reason.

It is a positive sign that, even though more families are seeking the CSED Waiver, timeliness is improving. The commitment to improving and better understanding the family's journey can be seen in the *November 2023 QC Slide Deck* (for internal review) which shares data on timelines from referral to the Assessment Pathway to determination to approval to service start. The *January 2024 SAR* also addresses the issue of timeliness from the perspective of workforce capacity. (See the Workforce section for more information). DoHS is committed to helping agencies to attract and retain appropriate staff as referrals continue to grow.

The *January 2024 SAR* also addresses **data utilization** on a county level to understand and improve the functioning of the Assessment Pathway. As an example, the *January 2024 SAR* describes the finding that Braxton County had a 79% decrease in referrals from the previous six-month period. However, looking further back, in CY 2022, the Quality Committee saw that that county only had a 26% CSED Waiver application approval rate. DoHS compared technical assistance and approval

ratings and realized that the decline in referrals actually resulted from standardized screening tools being used and referrals being made more appropriately.

Regarding the **use of the CANS** specifically, the *January 2024 SAR* shares that, in Q2 2023, 84% of all children—enrolled in Safe at Home (SAH), RMHTF, CSED, or BBH and recorded in the CANS Automated System for at least 30 days—had at least one CANS completed. The *January 2024 SAR* addresses issues of CANS completion and acknowledges that while CANS **timeliness** is increasing, **the percentage of completed CANS** is decreasing: "The number of newly opened cases significantly increased year-over-year, from 570 in Q1 2022 to 801 in Q2 2023 (41% increase), and from 539 in Q2 2022 to 814 in Q2 2023 (51% increase). The Quality Committee discussed that this influx may have impacted the ability of providers to complete and/or enter CANS data for some children. While the percentage of CANS completed has decreased, CANS completed in a timely manner (within 30 days of enrollment) have increased from 53% to 54% in the first half of 2022 to at least 57% in the subsequent four quarters, with 65% of children with newly opened cases in Q2 2023 having timely CANS completion" (p. 189). Looking at out-of-state placements, CANS assessments were completed for 222 of 333 children (67%) in active out-of-state placement in December 2023. All assessments were expected to be completed by January 31, 2024. The *WVU Detailed Evaluation Report* focused on the Community-Based Services Population at 2 Years finds that the CANS is the most commonly used assessment tool among organizations and providers: 49% of Year 2 organizations report using it and 27% of Year 2 providers.

The August 2023 *West Virginia Wraparound Fidelity Report* from MU also addresses the CANS. They find that 67% of Wraparound Facilitators (WFs) completed the CANS within 30 days. Only 46% of WFs updated the CANS every 90 days. This report addresses the use of the CANS in service plans/plans of care: "In just over half (51%) of the Wraparound Plans of Care, if a need was expressed in the Wraparound plan, it had also been indicated on the initial CANS. There were 34 (18%) that found some of the needs were expressed in the Wraparound Plan and indicated on the initial CANS" (p. 70).

(See the Wraparound section for more information on the CANS.)

The *January 2024 SAR* also shares information about the **QIA process**.

- DoHS is working with Acentra Health and Aetna to expand the QIA process. "DoHS conducts biweekly meetings with Acentra Health and Aetna to help ensure a plan is in place for the fully expanded use of the QIA process for all children in residential settings, ideally prior to admission to address opportunities for diversion" (p. 78).
- As of May 2023, all BSS workers had been trained in the QIA process, with the referral process implemented across the entire state.
- In October 2023, 126 children were referred for a QIA and referrals increased during training and rollout from August 2022 to May 2023.
- From August 2022 to December 2023, 33% of referrals met criteria for expedited assessment (meaning those individuals were at imminent risk of residential placement).

- To maintain focus on the continued adoption of the QIA process, a county-level report depicting total referrals made compared to the number of referrals expected for the month (based on average county-level admissions for the previous year) has been provided to social services managers.
- As the QIA process has expanded, so have wait times: 74% of referrals submitted August 2022 to April 2023 were completed within 30 days, while 64%, (n = 36) of the completed referrals in October took more than 30 days to be completed and communicated back to DoHS. DoHS recognizes these time frames are not acceptable to meet needs and has worked with Acentra Health to improve the process.
- DoHS collaborates with MU and the Praed Foundation to automate the decision support model predicated on the CANS assessment tool.
- Nearly 80% of children with a completed QIA referral in October 2023 received a recommendation to obtain treatment via HCBS.

DoHS also shared the *QIA SOP* which describes the following QIA process.

- For children being considered for or at high-risk for RMHTF placement, the case worker completes the QIA Assessment form and submits to Acentra.
- For children who are already in an RMHTF but have not had a QIA completed, Aetna contacts the residential provider and requests a QIA referral be submitted; the referral is submitted to Acentra.
- In all these cases, the Acentra Qualified Independent (QI) Assessor then completes the QIA
- The QIA Assessor completes the QIA Results and Recommendations Report, and that report is shared with the agency/provider who made the referral.

During this review period, the SME did not receive any new documents regarding **sharing assessments with the MDT**. The January 2024 *Year 5 Implementation Plan* does note that the provision of screening assessments to the MDT will be included in the BSS DPQI team's review through their sampling process/checklist.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 32. For a child whose screening indicates a need for further evaluation or services, for whom placement in a Residential Mental Health Treatment Facility is recommended or has been made, or who has received mental health crisis intervention, DHHR shall timely provide an intake and assessment process which includes a face-to-face meeting with a community provider, the child, and family (or foster or kinship parent, where applicable), to identify the child's need for in-home and community-based services. It is presumed that all children who reside in a Residential Mental Health Treatment Facility on the Effective Date, or who are placed in a Residential Mental Health Treatment Facility after the Effective Date, need in-home and community-based services.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- While DoHS has established an Assessment Pathway process which emphasizes a "no wrong door" approach, and the SME is especially pleased to see the substantial increase in the number of referrals across the state, it is still necessary to increase availability, accessibility, and awareness of effective HCBS to prevent unnecessary RMHTF admissions.
- In identifying youth eligible for discharge, DoHS could enhance the timeliness, accuracy, and meaning-making of CAFAS/PECFAS assessments. The *January 2024 SAR* reports the mean scores on the CAFAS at admissions and follow-up, which shows a decrease over time. However, these scores do not appear to be matched by youth and thus it is difficult to assess the extent to which individual youth experienced an improvement in their score over time. Modifying this analysis to show youth-level progress over time, rather than group averages, should be pursued in future analysis.
- To promote discharge rates, DoHS has made progress in identifying barriers to discharge for youth in RMHTF and should deepen their analysis of discharge barriers and disaggregate these data by youth characteristics and systemic factors.
- Progress needs to continue with BJS to continue to enhance data collection associated with submission of CSED Waiver applications.
- The SME would like to continue to see documentation of how children and families progress through the Assessment Pathway. For example, how many calls from the CCRL are referred to and progress through the Pathway? Additionally, more analysis is needed on the low number of BBH-associated referrals from CMCRS.

Agreement Item 35a. DHHR will use the Child and Adolescent Needs and Strengths (CANS) tool (or similar tool approved by both parties) to assist the Child and Family Team in the development of Individualized Service Plans for each child who has been identified as needing in-home and community-based services, per paragraph 32. A qualified individual, as further determined by the Parties and defined in the implementation plan, shall conduct an assessment of the child's needs with the CANS. The Wraparound Facilitator shall lead the development of the Individualized Service Plan.

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The MU fidelity report makes it clear that needs identified in the CANS are only being reflected in POCs in slightly over half of cases. The SME recommends training on the importance of documenting and addressing needs identified in the CANS, which should lead to an increase in needs being present in POCs.
- The SME would like to review Aetna's review process to more fully understand the representation of needs identified in the CANS in POCs.

Agreement Item 36. For any child who has a Multidisciplinary Treatment Team (MDT), DHHR shall provide the child's screening, assessments, and Individualized Service Plans to the MDT.

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME acknowledges that, according to the *Year 5 Implementation Plan*, the provision of screening assessments to the MDT will be included in the BSS DPQI team's review through their sampling process/checklist. The SME looks forward to seeing documentation of this review process.

Agreement Item 52d. Any children residing in a Residential Mental Health Treatment Facility on December 31, 2024 must have been assessed by a qualified professional and determined to be in the most integrated setting appropriate to their individual needs.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME applauds the establishment of the QIA process and the work with counties to improve QIA rates to ensure that only children who are appropriate for RMHTF settings are in them. However, the SME needs to see more effort towards and documentation of QIAs occurring in a timely fashion.

The SME also needs to see evidence that the children who are in RMHTF are in the most integrated setting appropriate to their needs; i.e. children who can be served in the community do not enter RMHTF and children who are appropriate for discharge to the community are in fact discharged from RMHTF.

3.2 Wraparound

Overview

The Agreement requires that there is statewide availability of and information about Wraparound for children and youth needing in-home and community-based mental health services with times/locations mutually agreed upon by the provider and child and family and provided in a timely manner, and through a teaming approach in which a CFT coordinates and manages the care of each child. Wraparound must function with high fidelity to the National Wraparound Initiative (NWI) model. The CANS assessment (or another tool) is used to inform a POC for each child.

Achievements and Developments

Recommendations were offered by the SME in the June 2023 report to guide DoHS to compliance. The SME continues to evaluate progress in these overarching areas to work towards compliance as Wraparound model implementation progresses. Much of the SME recommendations outlined below (from the June 2023 SME report) are consistent with MU's latest fidelity report and themes (discussed further below):

1. Further assess, build, and monitor program/provider capacity.
2. Continue outreach to counties with low referrals to the Assessment Pathway, with additional focus on areas with limited CSED Waiver referrals and higher rates of residential placements.
3. Expand and operationalize the WV Wraparound Manual and disseminate and train on template Wraparound tools/documents statewide.
4. Train and coach programs/providers in Wraparound curriculum and CANS.
5. Provide cross-bureau training, technical assistance using CQI practices specific to Wraparound.
6. Monitor ongoing fidelity of Wraparound services to NWI model. In response to fidelity monitoring reports, develop and implement needed program changes, provider training or other interventions recommended to attain fidelity.
7. Refine data collection.
8. Promote consistent, centralized data entry for CQI and evaluation and formalize CANS data analysis and outcomes reporting.

Wraparound provider capacity analysis is a key component of ongoing work in WV. The *November 2023 QC Visuals* provided to the SME team contains indicators related to Wraparound service provision and supports many of the improvement areas listed above. Although these data visuals are not yet public for this period, the SME would like to highlight that the *QC Visuals* research questions in this presentation are very valuable. DoHS focused clearly on Wraparound "Approvals and Referrals" and posed these important questions to assess and analyze access:

- What do referrals look like for WV Wraparound as a comprehensive program?

- How have referrals changed over time and geographically?
- How do referrals and the proportion of youth approved for CSED Waiver correlate? Do referral patterns seem appropriate?
- Consider at-risk population in counties and how to use this information to drive outreach as well.

DoHS indicated they are working on a *Full Time Employee (FTE) Wraparound Facilitator (WF) Analysis*. This analysis will help DoHS to better understand workforce hiring needs and caseload capacities in order to respond to demands of Wraparound while maintaining best practice caseload standards. DoHS reported program leads are meeting on a monthly basis to review the WF capacity data. The program leads also work with providers to encourage and ensure consistent data collection. DoHS indicated the need to further vet the data before the analysis is made public.

The *January 2024 SAR* stated that an increased demand for Wraparound facilitation has also led to a waitlist, and Aetna continues to report on this waitlist to BMS leadership on a weekly basis. As such, the DoHS WF Workgroup meets monthly to prioritize provider network needs. The SME is interested in learning more about the relationship between the WF Workgroup and the existing PIP established in early 2023. The *January 2024 SAR* reports that the PIP is focusing on workgroup considerations to include reimbursement rates, addressing competitive neighboring state employment concerns, and changing education and experience requirements to expand the provider pool. DoHS has reported coordination with MU and Aetna to address some of these workforce barriers.

Wraparound infrastructure to develop Wraparound practice and standards in WV is a paramount effort. WV continues to work on strengthening the Wraparound care coordination teaming mechanism for youth enrolled in the CSED Waiver, which is a backbone to WV's HCBS transformation. The SME notes progress in this area. In the last six months, DoHS reviewed policy documents for each of the three funding sources of WV Wraparound and is currently proposing updates to align materials across bureaus to the Document Assessment Review Tool (DART), a measurement of high-fidelity Wraparound service provision. DoHS reported that program leads for each of the Wraparound funding sources reviewed the proposed changes in December 2023, and plans will be made to incorporate agreed upon changes through future updates to programmatic materials. The SME looks forward to reviewing these updated materials when they are available.

Additionally, WV DoHS reported that an Announcement of Funding Availability (AFA) for high-fidelity Wraparound training services was released in September 2023. Responses for the AFA were due by November 2023. BBH received one application that did not meet the required qualifications. In the interim, trainings will continue to be provided by MU through March 2024 while DoHS explores future Wraparound training options.

Funding, tracking and sustainability efforts are addressed in the *January 2024 SAR*. The CSED Waiver continues to be the primary financing modality to fund Wraparound Service. The CSED Waiver five-year renewal was approved by Centers for Medicare and Medicaid Services (CMS) in early

2023 and provides an excellent sustainability plan for Wraparound. The main funding sources for Wraparound are still: BBH Children's Mental Health Wraparound, BMS CSED Waiver, and BSS/SAH. Daily collaboration between these agencies is reported by DoHS to occur if a WF is not immediately available and an alternative service or resource cannot be provided through the Assessment Pathway process. Additional positive developments in this area include:

- The goals for Wraparound laid out across the three funding sources are identical, which is favorable for promoting statewide alignment.
- As intentional alignment of the Wrapround framework continues across the funding sources available statewide. DoHS is also working to streamline the data collection sets across the different funders of Wraparound. These efforts will continue to strengthen the ability to manage and analyze Wraparound in WV.
- The SAH Interim Service designation was added to the CANS automated system in November 2022, so clear tracking is now available to determine when a child goes through the Assessment Pathway and is assigned to a SAH WF. This chart depicts Wraparound service enrollment over time and shows a pattern mostly of growth. There was a dip in BBH enrollment this last period that DoHS has acknowledged and is addressing.

Table 1: Wraparound Service Enrollment Over Time

Funding Source	January – June 2023	July – Dec 2022	January – June 2022
BBH	52	62	160
BMS CSED Waiver	742	573	298
BSS/SAH	538 (106 interim)	Not available	Not available

Additionally, In October 2023, DoHS BMS submitted a 2-tiered approach to CMS to distinguish high and low intensity Wraparound levels. The high-fidelity Wraparound model will remain consistent across WV for both tiers as well as the scope and duration of Wraparound for youth receiving the intervention. Rates for high intensity will be higher and the per member per month rate will be in 15-minute billing increments. DoHS consulted with Myers & Stauffer actuarial team supported by claims analysis and service utilization to develop new rates.

Refining data collection for Wraparound remains an important area of focus. WV DoHS reported that child-level data matching is now in place for the following data sets in the data store: RMHTF, CSED Waiver eligibility, CSED Waiver utilization, RMHTF CAFAS/PECFAS score history, CANS case level completion and timeliness. Early results of cross-systems analysis at the child level are included in the *January 2024 SAR*. DoHS reported addressing additional data collection efforts to include: data enhancements to better understand a child's timeline to access services and CSED Waiver eligibility determination; provider-level data reviews to assess strengths and opportunities across the WF network; and addressing data quality and completion with a particular focus on CANS. However, the SME Team did not receive any specific evidence to support DoHS's self-reporting of this progress and looks forward to seeing more evidence to follow this development going forward.

Fidelity to the model is addressed through the August 2023 *West Virginia Wraparound Fidelity Report*. This was the second fidelity report conducted by MU, released in January 2024 and completed during the period of August – November 2023. The initial report obtained a Baseline fidelity rating using data from August-September 2022 and reviewed 17 providers. During this last year, WV continued to collaborate with the National Wraparound Implementation Center (NWIC) to work towards fidelity. The newly published report expanded its use of evidence-based instruments and includes the following:

- The DART, which examines adherence to Wraparound practice and principles;
- The Wraparound Fidelity Index, Short Form (WFI-EZ), which assesses adherence to Wraparound activities on an individual child and family level; and
- The Wraparound Implementation Standards-Program (WISP), which measures provider agencies implementation of the Wraparound model.

The DART and WFI-EZ administered to youth and family records indicate:

- Wraparound standards were not met or partially met with respect to timely engagement, meeting attendance, strengths and family driven, natural and community supports, needs and outcomes-based care, safety planning, crisis response and transition planning.
- The results of the WFI-EZ survey indicated significant need in Wraparound practice based on WF care coordinator surveys (66% response rate), concluding with a rating of "adequate" overall fidelity.
- The sample size was small and not statistically significant including (47 total) caregiver responses. Hopefully an increased response rate can yield more data to assess accurate satisfaction of Wraparound in the future.

In the area of CQI and implementation, The WISP findings address organizational items with respect to leadership, enrollment, engagement, services and supports, recruitment, staffing, onboarding, wraparound supervision and care coordination and were scored in the pre-implementation stage of high-fidelity**.**

MU's overall analysis indicates that WFs and supervisors have been trained in the basic standards of Wraparound, but execution of these standards remains inconsistent. MU recommends that WV continue to work on building their infrastructure to support Wraparound implementation by further refining policies that support Wraparound standards and communicating provider expectations. The MU recommendations include:

- Hiring a dedicated WV Wraparound director over the entire statewide implementation.
- Enhancing the Wraparound CQI committee.
- Creating a cross-bureau oversight Wraparound group.
- Translating Wraparound philosophy and principles into specific policies, practices and achievements.

- Educating child-serving agency leadership on Wraparound standards that align with the model.
- Establishing a fidelity review team and conducting reviews using reliable and valid assessment tools and methods to identify practice strengths and areas for improvement.
- Requiring consistent and centralized data entry for analysis.
- Ensuring standardized documentation across funding sources.
- Requiring a seamless transition between facilitators.
- Continuing administration of standardized evidenced-based fidelity tools.
- Supporting the effective use of CANS.
- Soliciting appropriate referrals to Wraparound.
- Addressing facilitators' specific training needs.

Additionally, the August 2023 *West Virginia Wraparound Fidelity Report* addresses the current implementation of CANS, which has been used for over 10 years in WV in line with the Transformational Collaborative Outcomes Management (TCOM) tool. (For more information about CANS, see the Assessment section.)

- Certification status was examined for 115 WFs. Of those, 85% were certified, 10% had expired certifications and 5% had their accounts deactivated. MU recommends that WV's Fidelity coordinator continue to monitor certifications statuses and share with providers on a monthly basis.
- For the CANS, 67% were completed within 30 days, and 46% of youth had their CANS updated every 90 days. In the CANS review, it was found that barriers to improving timeliness of CANS completion should be addressed through improved CQI efforts.
- In 95% of cases, all items on the CANS were rated. If items are rated "2" or "3" it means that these items should be addressed on the care plan with descriptions specific to the child. In 49% of the cases, these justifications were unique with clear descriptions. MU will provide a training video to train on improving unique justifications to support ratings to reinforce the content delivered in the MU TCOM monthly advanced trainings.
- Needs were expressed in 18% of the Wraparound POCs. In 51% of the POCs, if a need was expressed on the Wraparound Plan, it had also been indicated on the CANS. In response to improve this compliance, MU will also develop training to address the importance of the accuracy of CANS and of documenting all needs.

NWI supports using the CANS as an assessment tool and not one for planning, therefore WV will continue to use CANS to inform families and WF's to address and track overall youth outcomes.

Quality assurance and corrective action planning is addressed in the *Year 5 Implementation Plan*, which highlights several areas with respect to needs identified over the last few years:

- The document acknowledges the establishment of a PIP Plan. Additionally, the *January 2024 SAR* reported (Jan to June 2023) that PIP meetings have been held to address data collection, policy updates and programmatic reviews.
- Several action items were highlighted to achieve outcomes in the following areas: clear operation procedures; statewide training; and CQI on capacity and accessibility. The action items formulated to address these items include the following:

    - Revise *Chapter 503 Appendix F* on how RMHTF will offer the child and family information on ACT (vs. Wraparound).
    - Finalize updated Wraparound training plan for practitioners and supervisors and track trainings and participants.
    - Align all DoHS policies with NWI standards.
    - Continue WV capacity data analysis and expand provider network, in collaboration with MCOs and providers.
    - Continue data analysis of all types of assessments, including CANS, CAFAS/PECFAS, and QIA.
    - Continue PIP Team data review and strategic decision-making to implement Wraparound with Fidelity.

The CQI Plan for Children's Programs updated in December 2023 appropriately focuses on building and maintaining HCBS for children in WV with Wraparound as a mechanism to achieve this growth. There continues to be considerable focus on WF assignment and not enough on the actual services that should or do appear on the individualized plans. The SME team looks forward to reviewing progress of those action items assigned to BMS, PIP Team, QA, and Bureaus.

The SME did not receive specific training plans and workforce development updates since the Spring 2023 SME Report. The SME was able to find upcoming Wraparound 2024 trainings on the MU website: https://wvbhtraining.org/wraparound-mobile-response/trainings/. However, the website did not show postings of past trainings in the last 12 months or any information on trainees that attended.

Formal evaluation. According to *WVU's October 2023 Children's In-Home and Community-Based Service Improvement Evaluation* (Summary Report: Baseline Data Collected from Youth and Caregivers):

- 40% of caregivers and 24% of youth report awareness of Wraparound services, which shows relatively good awareness compared to some other services.
- In the last 12 months, 34% caregivers reported utilizing Wraparound, compared to 21% in previous years.

The *WVU's Revised January 2024 Children's In-Home and Community-Based Service Improvement Evaluation* (Summary Report: Year 2 Data Collected from Community Partners, Caregivers, and Youth in RMHT) reported the following findings:

- All six BBH regions have Wraparound services available, although one provider reported difficulties providing adequate coverage which impacts approximately half of the counties in Region 6.
- 31% of caregivers and 23% of youth reported using Wraparound in the last 12 months.
- Providers reported an increase from 62% in Baseline to 67% in Year 2 in their staff having the skills and training to deliver Wraparound.
- Organizations reported splitting staff across programs to overcome recruitment and capacity challenges.
- Overall, 69% of providers are aware of Wraparound (increased from 67% at Baseline), 38% of caregivers are aware at year two (a 14% decrease from baseline), and youth remained steady with 25% awareness.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 24a. DHHR shall ensure timely access to services, Agreement Item 28. DHHR shall ensure the timely provision of mental health services to address any immediate or urgent need for services. Such services will be provided through consultation with the child and family (or foster or kinship parent, where applicable) and include needed in-home and community-based services and linkage to other service providers, and *Agreement Item 40a. DHHR shall provide high quality in-home and community-based mental health services that are timely and individualized to the child's needs.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- DoHS is beginning to capture and analyze timeliness data by looking at waitlists for Wraparound. However, minimal information is provided with regards to which services youth are receiving on their POCs and if they are being connected to these services. More specific plans to track and evaluate this data is recommended.

Agreement Item 24b. DHHR shall provide access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment, in a manner that enables the child to remain with or return to the family whenever possible and *Agreement Item 40b. Individualized home and community based mental health services.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME needs to review additional data from the WVU Children's Mental Health Evaluation that more closely examines services individual children receive and reflects if those services meet individual needs.

Agreement Item 24c. DHHR shall ensure statewide access to these programs, Agreement Item 33. DHHR shall ensure statewide access to Wraparound Facilitation for each child identified as needing in-home and community-based services, per paragraph 32, to allow for meaningful family involvement and timely provision of services. In Wraparound Facilitation, the Child and Family Team shall manage the care of the child, and the Wraparound Facilitator shall lead the Child and Family Team and *Agreement Item 40c. Statewide access to home and community-based services.*
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- All six BBH Regions have Wraparound available. The SME recommends monitoring with respect to workforce needs to ensure ongoing compliance in this area.
- DoHS has clearly established an infrastructure for the provision of Wraparound across the state along with means to evaluate statewide Wraparound practice to this evidence-based model and through quality assurance can continue to move towards fidelity to the model and train providers accordingly. Progress should continue with a strong PIP workplan, WF training/coaching and provider monitoring.

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation

Agreement Item 34. DHHR shall ensure that each Child and Family Team operates with high fidelity to the National Wraparound Initiative's model. and *Agreement Item 49f. The data to be collected and analyzed to assess the impact of this Agreement on children in the target population shall be specified in the implementation plan. At a minimum it shall include data regarding the fidelity of Child and Family teams to the National Wraparound Initiative model.*
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME Team is in overwhelming support of the recommendations outlined in the August 2023 *Wraparound Fidelity Report* to work towards advancing WV to full implementation of the model. The SME would expect that these critical recommendations are reviewed and addressed by the existing DoHS PIP team. Clearly outlining a detailed PIP workplan addressing training, supervision, CQI needs with definitive timelines will assist with progress in this area.
- Focusing on whether a CFT identifies informal and formal supports to address a child's needs should be of key importance. Also determining if youth have been connected to identified

services and supports in the community and are achieving positive outcomes are some of the questions that need to be evaluated for Wraparound implementation. This is an area WFs can focus on to help address fidelity compliance needs.

- Additional statewide efforts recommended last year by the SME team will help build Wraparound infrastructure to continue to move bureaus, providers and WFs in line with Wraparound fidelity principles and standards:

    - Regarding cross-bureau training and technical assistance using CQI practices specific to Wraparound, DoHS reported a monthly meeting will begin with program managers in January, and the first meeting occurred on January 23, 2024. The SME received a copy of the agendas for both January and February 2024 Wraparound PIP Team Meetings, but beyond documentation that these meetings occurred, the content discussed and action items remains unclear. Trainings to bureaus will continue to help with uniformity and clarity in terms of how Wraparound is described across WV.
    - The SME Team would like to see new evidence specifically demonstrating these Wraparound Implementation action items self-reported in the *January 2024 SAR*, such as: data enhancements to better understand a child's timeline to access services and CSED Waiver eligibility determination; provider-level data reviews to assess strengths and opportunities across the WF network; and continued work to address data quality and completion with a particular focus on CANS. The SME is looking for documentation of meetings, agendas, minutes, next steps, and outputs and overall greater clarity demonstrating how the PIP Team functions.
    - Additionally, since Wrapround is a team planning process as opposed to a treatment service, clarifying this difference could be beneficial with marketing campaigns, communication to families and overall DoHS documents. There should also be clarity that WF promotes collaboration with youth and families to connect to needed services through a strength-based lens.
    - In this next period the SME team would also like to see more evidence supporting how WV's Wraparound practice is incorporating Wraparound's 10 principles: family voice and choice, individualized, strengths-based, natural supports, collaboration, unconditional care, community-based, culturally competent, team-based and outcomes based.
    - The SME team would like to see Wraparound training schedules, with documentation of those training sessions that occurred in the last 12 months and those scheduled 6 months forward, as well as information about who will be conducting trainings past March 2024.

3.3 Assertive Community Treatment

Overview

The Agreement requires that the State ensures that ACT is available statewide to young adults in the target population aged 18-20. ACT is a team-based treatment approach for individuals with mental illness. ACT offers 24-hour support and monitoring in the community. This service should be delivered at times convenient to youth and families so that it meets their individualized needs. The Agreement permits ACT teams to substitute for CFTs through Wraparound, provided they have a POC and access to HCBS, as needed. This same service is also available through adulthood, past the target population age range, which makes it a unique service among the children's behavioral health service array.

Achievements and Developments

The SME was looking for updates in these areas since the June 2023 SME Report and found substantial and positive developments:

1. Trainings to providers on *BMS Chapters 503 and 531* revisions
2. Finalization and implementation of ACT retrospective tool.
3. Collaboration with the Eastern Panhandle provider implementation efforts.
4. Growth in ACT data collection, analysis and quality assurance processes reviewing.
5. Completion of provider capacity needs analysis.
6. Increased ACT public awareness.
7. Coordination and communication of freedom of choice ACT v. Wraparound and pathway to either service.

ACT continues to be included in WV's state plan amendment (SPA) and operates out of BMS to provide an array of inclusive community-based mental health services for young adults 18 - 20 with Medicaid and serious and persistent mental illness. The inclusion of ACT in the SPA predates the Agreement. DoHS has been working over the last three years towards statewide implementation. The ACT model eligibility only includes adults, making a fraction of the Agreement target population (18 - 20-year-olds, typically known as the transition aged youth or TAY) eligible for this service.

DoHS recently achieved full operational state wideness. DoHS reported by email to the SME on February 23, 2024, that the ACT vendor, EastRidge has been approved to serve WV's Eastern Panhandle effective February 22, 2024, marking access of ACT in all counties. EastRidge was able to fill the last required position needed to open their services as an ACT provider.

The *January 2024 SAR* offers information about **ACT service utilization, data collection and analysis, outreach, sustainability efforts** as follows:

- With respect to current and historic utilization, ACT remains very low for eligible young adults since inception. Statewide ACT utilization is commonly in the mid-500s, while the under 21 population is in the low single digits.

Table 2: ACT Service Enrollment Over Time

	Jan -June 2022	July – Dec 2022	Jan – June 2023
Youth < 21	4	5	5
Statewide	548	544	546

- In order to better understand the TAY population within the Target Population, DoHS conducted an analysis using claims data to see how many Medicaid youth would be eligible for ACT. Through this analysis covering the 2022 calendar period, it was estimated 26 youth would qualify for ACT. Although not a substantial number, DoHS reports that they will continue to work on communication and engagement strategies related to ACT to reach their TAY population.
- To enhance data collection practices, DoHS reported progress in regard to youth selecting ACT as a service. Effective November 2023, Aetna captures which youth select this service upon discharge from residential setting through their Quickbase system. Additionally, Acentra and Aetna are working to collect data on youth who decline ACT services to track discharge reasons and better understand the reasons for not accepting this service.
- This year the *Resource Rundown* included efforts with respect to ACT services, posting a video online mid-July 2023 to help increase visibility of and enrollment in ACT. As of November 2023, the video has had 109 views. The SME applauds DoHS for developing and delivering this content. The video was clear and very well done with the aim of reaching families. In addition to its succinctness and clarity, the delineation between ACT and the CSED Waiver, in which Wraparound is included, was helpful. The video also shared a map of provider coverage across the various areas of the state which was a useful visual.
- DoHS has plans to require that all Certified Community Behavioral Health Centers (CCBHCs) provide an ACT Team. As such, a SPA for CCBHCs is under draft with an anticipated implementation by early 2025. In line with this change, *Chapter 503* policy updates are planned for spring/summer of 2024. Additionally, DoHS is seeking approval for rural ACT services through an 1115 demonstration grant and is awaiting review by CMS.

Additional documents referenced below provide **information about policy changes, provider networking, visibility, oversight and monitoring, quality assurance, model fidelity and systems evaluation efforts.** The SME notes that training requirements by Aetna can be found in section 3.1.7 of *the SFY24 Aetna Mountain Health Promise Contract* to ensure changes to Medicaid policies are communicated to providers. The last known change was made to ACT *Chapter 531 Psychiatric Residential Treatment Facility Services Provider Manual* related to discharge planning.

On-going provider networking and communication needs continue to be met by DoHS, by conducting provider workshops twice a year. The SME reviewed the agenda, numbers of attendees, and presentation materials. The provider workshop was last held virtually on October 17, 18, 19, 24

and 25, 2023. The *2023 Fall Provider Workshop PowerPoint* shared material specific to ACT on slides 83-99, addressing areas such as service purpose, eligibility, ACT team composition, etc.

Within the context of presenting ACT as an option for young adults who could benefit from the service, **t**he *CSEDW Application Process Flow and Standard Operating Procedures (SOP)* outlines the following:

- Available home and community-based services, including ACT, along with the timing in the Assessment Pathway process when a child could be referred for these services.
- Page 7 of the flow chart shows that if the referred child does not have a CAFAS/PECFAS score of 90 or above, then Acentra will make a referral to BSS or BBH for home and community services, including ACT.

Progress in oversight and monitoring of ACT is reflected in the *Year 5 Implementation Plan***.** These changes and improvements include:

- Increasing review cycle from every 18 months to 12 months;
- Reviewing all youth between 18-20 receiving ACT, not just a sample;
- Requiring technical assistance to all providers falling below the 70% threshold; and
- Adding the annual review results to the monthly BMS and Acentra meetings.

Quality assurance efforts were evident this period through distribution of the *ACT Consultation Summary 2023* document which contains the findings of the latest annual ACT service retrospective review conducted by Acentra. SME also received a copy of the final *Retrospective Tool* approved in 2023 to inform the annual review process and findings for the October 1, 2023-December 31, 2023 period. The review and resulting findings included the following:

- Nine out of ten ACT providers were reviewed; one provider was omitted since they did not have any prior authorizations during the period.
- BMS set a threshold of 70% for passing, and those providers that scored below received follow-up training. Only one of nine ACT providers met the service scoring threshold in full and did not require further training. All eight providers scheduled follow up training. Common areas for improvement include the following:
    - Providers maintain a core ACT team and/or follow BMS requirements when there is a change in staffing.
    - Documentation demonstrates medical service necessity and describes a valid ACT activity.
    - Service Plans include service definition for associated services.
    - The core team and members are present for the Service Plan meeting.
    - Service Plans are signed with clinician's credentials.
    - Service Plans reviews occur within required timelines.

- Members receive at least four contacts per week for a valid ACT activity.
- Daily Log completion with signatures and credentials.
- Team members participate in the weekly intensive review.
- Avoid using template documentation.

DoHS has shown progress in ACT monitoring and CQI practices of this evidence-based model with quality assurance practices in place to reach adherence to model fidelity and train providers accordingly.

Systems evaluation efforts including ACT as a service were included in *WVU's October 2023 Children's In-Home and Community-Based Service Improvement Evaluation* (Summary Report: Baseline Data Collected from Youth and Caregivers). Findings include:

- Awareness of ACT services remains low (18% among caregivers and 8% among youth).
- Caregivers reported utilizing ACT (3% in last 12 months, 0% in years prior, 3% on waitlist, 16% did not know).

WVU's Revised January 2024 Children's In-Home and Community-Based Service Improvement Evaluation (Summary Report: Year 2 Data Collected from Community Partners, Caregivers, and Youth in RMHT) also reported the following data regarding ACT services which shows progress in some areas, but not in others:

- Sixty percent of organizations (close to the Baseline of 64%) reported they have staff with necessary training and skills to service youth who needed services.
- Organizations who did not have capacity did not have nearby providers to whom they could refer youth for ACT.
- Recruitment for specific ACT skills has increased to 72% from 64% at Baseline. Difficulties in recruiting and retaining staff with ACT capabilities, skillsets or credentials have reduced to 80% from 86%.
- ACT providers reported seeking alternative grant funding and splitting staff across programs to address some of these hurdles.
- Waitlists were reported by 20% of organizations.
- No RMHT youth or caregivers reported being on a waitlist for ACT upon discharge.
- Compared to 17% of providers at Baseline, 20% reported awareness of ACT in the Year 2 report.
- Caregiver knowledge of ACT decreased to 11%, down from 16% at Baseline.
- Youth awareness of ACT also decreased to 20%, down from 24% at Baseline.

As DoHS's HCBS outreach and provider networking efforts continue, these results can be used to track change of awareness and accessibility of this service to youth and their families and identify the areas that need improvement and how to address with short- and long-term strategies.

Ratings and Recommended Activities to Reach Compliance

Although the findings of the fall 2023 ACT retrospective tool yielded the need for improvements with most providers, this quality assurance process is exactly what is required to uncover the areas where providers need growth and adherence to model integrity. As a result of the retrospective review, training needs were identified and put in place to course correct and improve fidelity to the ACT model. The SME team is pleased with the mechanism established to continuously oversee, address, support and respond to provider and practice needs to achieve high quality services and in accordance with model fidelity. Enhanced data analysis to reach more youth and communication efforts were also seen this period with respect to ACT. Additionally, considering the remaining region, the Eastern Panhandle, now has an approved provider, this moves ACT to full statewide capacity and into compliance with Agreement Item 39.

Agreement Item 24a. DHHR shall ensure timely access to In-Home and Community-Based Services sufficient to meet the individual's needs, Agreement Item 28. DHHR shall ensure the timely provision of mental health services to address any immediate or urgent need for services and *Agreement Item 40a. DHHR shall provide high quality in-home and community-based mental health services that are timely and individualized to the child's needs.*
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- DoHS is beginning to capture and analyze data by looking at waitlists for ACT. However, given the low ACT enrollment numbers it is difficult to ascertain how many youth may be offered ACT and do not enroll for various reasons (waitlist or engagement issues). The SME acknowledges the presence of indicators in the CQI plan related to this need and will need to see additional data analysis regarding these indicators in order to achieve substantial compliance. It is understood that at the time of this report data was not yet fully available for these indicators due to data system development. The data and analysis is beginning to occur at the point of RMHTF discharge and also through WVU evaluation. More specific evidence is requested to assist the SME in being more definitive on a compliance rating.

Agreement Item 24b: DHHR shall provide access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and ***Assertive Community Treatment,*** *in a manner that enables the child to remain with or return to the family whenever possible and 40b: Individualized home and community based mental health services .*
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME needs to review additional data from the WVU Children's Mental Health Evaluation that more closely examines services individual children receive and reflects if those services meet individual needs.

Agreement 24c. DHHR shall ensure statewide access to these programs and Agreement 40c: Statewide access to home and community based services. **[Substantial Compliance]**

DoHS has demonstrated substantial compliance in the following ways.

- The establishment of a new and operational ACT provider covering the final WV Eastern Panhandle region means that ACT has now achieved statewideness.

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation

Agreement Item 39: DHHR shall ensure ACT, which DHHR began providing in 2003, is available statewide, and that members of the target population between the ages of 18 to - 20 who need ACT receive it timely. ACT teams may substitute for the Child and Family Team under the terms of this Agreement. Where the ACT teams substitute for the Child and Family Teams, the ACT teams shall develop the Individualized Service Plan; and provide or ensure access to needed in-home and community-based services.
[Partial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- The establishment of a new and operational ACT provider covering the final WV Eastern Panhandle region means that ACT has now achieved statewideness and a start to reaching compliance with this agreement
- More evidence is needed to ascertain whether youth that want and need ACT are receiving it and if wanted whether they are receiving in a timely manner with care coordination (adherence to the model). Further building out the quality assurance process beyond retrospective reviews will help answer some of these questions with regards to which youth are receiving ACT.

3.4 Quality Assurance and Performance Improvement System

Overview

The Agreement stipulates that for all children screened, assessed, and receiving services under the Agreement, DOHS is required to collect and analyze data to assess: service delivery (including whether children are unnecessarily institutionalized); measurement of improved positive outcomes and decreased negative outcomes; changes in functional ability; fidelity to the NWI model; and timeliness of crisis/urgent services. The Agreement requires WV to perform quality sampling reviews of a statistically valid sample of youth to identify areas of strength and areas for improvement, with related steps towards improvement reported in the semi-annual report.

QAPI is a cross-bureau system for supporting data-driven decision making and improving timeliness, effectiveness, and efficiency across the state. These activities are intended to support the transition to compliance as well as sustainability through an evolving CQI effort. A centerpiece of this effort is a dashboard which is evolving as DoHS grows in its sophistication of analysis which will eventually be fully supported by a data store that brings together multiple streams of data from each bureau regarding service provision (including timeliness), screenings, outcomes (including functioning, juvenile justice, school, and CPS), fidelity, and RMHTF population characteristics. This data store, and the internal and external reporting, are overseen by the OQA. The main domains of the QAPI work are the data store buildout, use of data in planning and monitoring, and data quality, response to data quality problems, and the results of actions taken to improve data quality.

Achievements and Developments

Delays to the data store buildout are an understandable development given the typical challenges involved in linking disparate administrative and primary data sources when no common identifier is utilized across systems. Four additional modules were completed in the data store during the period between this SME report (which uses the December 2023 buildout timeline projection) and the prior one (March 2023 buildout timeline projection): Child CAFAS history; PATH Conversion; EDS conversion; and CANS case history. DoHS has indicated that the two conversion efforts contributed to significantly more delays in the prior year than expected. As a result, the timeline has been revised again, with seven modules currently underway and expected to be completed during the period in which this report is being written. Three modules have been put on hold pending improvements to the data, and 11 have not been started. Strictly on the basis of the number (though not the difficulty, size, or relative importance) of the planned and completed modules, this indicates that the buildout of the data store is approximately one-third complete. According to the *Data Buildout Timeline*, OQA expects numerous data sources to be incorporated into the data store this year, and specifically identifies an ability to report on the pathway from screening to service initiation by the middle of 2024 (*January 2024 SAR*). A realistic assessment of the timeline, based on the build history, suggests that the current projection is ambitious and might be delayed beyond the anticipated schedule.

DoHS has shown, even a partially-built data store provides real additional value to the planning process, as it is now possible to report on the CAFAS/PECFAS and CANS (functioning) histories of youth in RMHTFs, including youth who should be prioritized for discharge (*Data Buildout Timeline*). As additional systems are added to the data store, there will likely be emergent effects on DoHS's ability to understand their child population. As noted in the *January 2024 SAR*, the next stage in the buildout involves incorporating BJS screening data which will, when complete, allow DoHS to get a fuller picture of the experiences of youth coming into the Assessment Pathway from BJS.

The partially-completed data store in addition to existing reports are key tools for **data planning and monitoring**. In the *January 2024 SAR*, DoHS specifically notes the addition of CAFAS/PECFAS histories to the data store as being informative in deeper analyses of the residential population. Based on the December 2023 buildout timeline, child-level cross-system data regarding CSED eligibility and utilization, RMHTF stays and CAFAS/PECFAS score histories, as well as CANS case histories are now available and it should be possible to do cross-system, child-level analysis of these characteristics. The "drill down" analysis of children in residential care who meet the prioritized discharge criteria of having a CAFAS/PECFAS below 90 has led to a deeper understanding of a narrow but critical part of this transformation effort. Combined with the analysis of foster home capacity, there is now significant clarity regarding the challenges involved in discharging these youth from RMHTFs.

As the buildout continues, DoHS continues to utilize program-specific data as well. Although these data do not support whole child-level or cross-system views, they are nevertheless critical to understanding the challenges DoHS faces and providing early insight into the results of changes that have been implemented. Program-specific data have the potential to identify some of the challenges that exist within a specific system (e.g., CCRL call volume, warm hand-off, or presenting need), and utilizing these data, DoHS is working with vendors to improve performance. Further, although DoHS expressed in meetings with the SME that they had some concerns about how to measure certain service capacity characteristics that are complex (e.g., TFC home capacity), the *January 2024 SAR* demonstrates clear improvements in this area. For example, DoHS conducted an analysis comparing foster home availability to placements recognizing that not all available homes will take children at any given time. The resulting analysis depicts an incomplete yet highly informative picture of recruitment challenges overall and geographically.

Program-specific data can be especially useful when disaggregated by youth and counties, and over the last several *SARs*, DoHS has shown an acumen for detailed reporting of state-level indicators in numerous service areas. This strength continues, with DoHS making progress on disaggregation of these indicators across groups of children (by race/ethnicity, age, gender, and diagnosis) as well as county. The *January 2024 SAR* reports regional and county patterns in need, service availability, and service utilization. Maps presented indicate that DoHS is incorporating county data into these program-specific systems to enable the tracking of county and regional variation in needs, efforts, and results. These characteristics reflect efforts to achieve statewide compliance, and require, at a minimum, only county-level aggregation of program-specific data on individual children and

interactions with the system. Given that achieving statewide reach of services is a stated requirement of many Agreement items, there is much to be gained by focusing on these tables, graphs, and maps while the data store build continues.

The standing Quality Committee also contributes to data planning and monitoring. The *CQI Plan* calls for the flow of information up and down the hierarchy of the OQA within this committee, and for shared decision making across all partners on how to address needs and challenges that have been identified. These discussions will ultimately result in recommended actions for DoHS to implement, with OQA, and the committees to monitor. Slide decks from March and November 2023 Quality Committee meetings address ongoing challenges in discharge planning, foster home recruitment, implementation of services, and other areas of the Agreement. PIP teams or other ad hoc committees or workgroups have been formed to address specific critical challenges, including Wraparound fidelity and EPSDT screenings. For discharge planning, BSS is meeting frequently with Aetna to discuss children exhibiting specific placement challenges. Though in many cases, the goals of this work have not yet been realized and results are still pending, the focused nature of this work is helping partners to recognize the challenges and the barriers to meeting stated goals. For example, the Wellness Screening PIP team has proposed and tried several approaches to addressing the shortfalls in the rate of EPSDT mental health screenings (Agreement Item 31) and continues to prioritize this important outcome.

The evidence provided by DoHS (e.g., in the form of slide decks prepared for quarterly Quality Committee meetings and the descriptions, maps, graphs, and tables provided in *SARs*) demonstrates that DoHS is sharing data with partners. The information presented includes static pictures of need, utilization, and system performance, as well as trends across time and county. Following meetings held to discuss the recommendations from the Spring 2023 SME Report, DoHS included new maps in the *January 2024 SAR* showing county-level changes over time in certain conditions (e.g., referral rates) and more sophisticated analyses comparing efforts with outcomes, such as the concordance between change in effort in the form of QIA referrals, and results in RMHTF admissions. Several maps of WV showing county-level metrics were included in the November 2023 Quality Committee Review meeting, including selected maps shared in the *January 2024 SAR* (e.g., change in referral rates.) These are instrumental to understanding critical challenges that DoHS faces in meeting specific Agreement items. This includes any items that suggest statewideness as a criterion for substantial compliance, and (more generally) any system characteristics, such as the lack of homes for youth who have been prioritized for discharge, which might impede progress on this front.

As far as how the Quality Committee and PIP teams engage with the data in their meetings, the SME has received information (i.e., March and November 2023 Quality Committee slide decks) showing the data and discussion points planned by DoHS for Quality Committee review. These present a thorough picture of the data being shared with partners in these meetings, and proposed talking points related to these findings, the SME remains unclear about who is contributing actively to the conversation around these indicators. As one example, the *January 2024 SAR* notes that, "The Quality

Committee discussed county-level changes at length and the varied factors and circumstances influencing changes in RMHTF utilization at the county level," (page 165) but leaves out details about how the conversations unfolded. It is difficult to assess the extent to which the planning and decision-making process is collaborative among a broad spectrum of partners or if this is largely a bureaucratic top-down approach. It is unclear the types of feedback or planning ideas DoHS receives from partners. These meeting agendas remain unclear and unknown to the SME, making it difficult to understand this component of the planning process.

The OQA has demonstrated ongoing concern about **data quality** and has planned or implemented several changes that should improve the quality of data used in the planning process. Further, DoHS has demonstrated a willingness to address data quality issues with vendors and contractors. The *January 2024 SAR* shares efforts being made in response to identified quality problems (e.g., improved service utilization timeframes in the CMCRS data). In some cases, actions are being taken, such as BMS and OQA collaborating with Aetna to improve data on CSED children placed on hold. Historical analysis based on Medicaid claims data may provide a deeper understanding of youths' needs and service histories, but these data are significantly lagged and will not provide timely information Most of the data quality efforts, however, pertain to the use of such timely data. The *January 2024 SAR* reports that the Quality Committee, for example, is examining the value of Medicaid claims data for understanding the service histories of youth with SED or at risk of admission to RMHTFs.

Despite the attention data quality is receiving and the changes that are underway, there are nevertheless still significant quality issues. In particular, the quality sampling reviews (required by Agreement Item 50) are to consist of cross-system analysis, surveys, and interviews with a sample of at-risk children, their caregivers, and providers may not accurately reflect the views of these stakeholders. DoHS has contracted with WVU to conduct these quality sampling reviews. However, the reports issued by WVU on the first wave community sample and second wave residential sample reflect several concerns related to design, sampling, and measurement, which hamper meaning-making from these efforts.

First, the response rates in both reports across several stakeholder groups are poor (e.g., 16.5% of youth with SED; 26% of caregivers). Response rates for community organizations (76%) are much stronger. Low response rates raise questions about whether the data present a trustworthy picture of the views of inadequately represented stakeholder groups. This is a known limitation noted in the WVU report.

Second, the questions asked of respondents across all surveys need to be improved. For example, the data yielded from survey items suggest that: some of the questions were not relevant to some respondents; some questions did not provide sufficient actionable data to DoHS; and some questions were clearly not well-understood by the respondents. For example, the SME questions the relevance of asking a youth in an RMHTF whether they are in need of or using HCBS. Further the SME questions whether sufficient meaning can be obtained from finding that few youth were on a waitlist for Wraparound (which could have multiple divergent meanings: not needing a waitlist, not needing services, or not anticipating a need for services at discharge.) The meaning of questions, particularly

those requiring that youth identify the services they were receiving, were demonstrably problematic. In the Year 2 RMHTF sample, only 76% of caregivers of youth currently in a RMHTF setting reported being aware of RMHT and reported that only 86% of their youth received it in the last 12 months. As noted in the WVU evaluation reports, caregiver and youth respondents were more familiar with the name of the service provider than the service type, which may explain some of this contradictory data. Although this is informative to outreach and marketing efforts, it is not useful to gauging caregiver and child knowledge about where to turn when (for example) a post-discharge crisis may arise. The section on coordination across agencies (based on respondents within provider agencies), which showed low rates of referrals to and from RMHTFs, also raised questions about whether these respondents were sufficiently equipped to answer the questions or if the questions were understood as intended.

Ratings and Recommended Activities to Reach Compliance

Overall, the evidence shared with the SME has made it easier to better understand the progress and challenges that DoHS is experiencing in the implementation of data-driven planning processes. DoHS has demonstrated a great deal of growth in the ability to collect and synthesize data, present these data to partners, make decisions and act on those decisions, and monitor for results. Notably, they are doing so at a significant disadvantage, given that the data store that supports the dashboard for the cross-system child- and interaction-level planning is only approximately one-third complete (based on the inventory of constituent data sources, planned for inclusion, that are complete as of January 2024.)

As part of the ratings of the four CQI/QAPI Agreement items below, the SME has identified two issues that continue to present obstacles to achieving substantial compliance. The first consists of the delays in the data store buildout, which remain an obstacle to understanding child experiences in the system and presents DoHS with a persistently incomplete view of areas requiring attention; second, there are problematic data quality issues particularly as they pertain to the quality sampling review surveys and case reviews.

Agreement Item 48. Within 18 months of the Effective Date, DHHR shall develop a Quality Assurance and Performance Improvement System that facilitates an assessment of service delivery that will provide notification of potential problems warranting further review and response, and enhance DHHR's ability to deploy resources effectively and efficiently. This system will include a data dashboard, which is a compilation of discrete data points that can be used for performance analysis. This system will measure the implementation of this Agreement and whether children are being unnecessarily institutionalized. This system will be used to develop and produce semi-annual reports to the United States. Reports shall include:

a. *Analysis across child serving agencies of the quality of mental health services funded by the state, measured by improved positive outcomes, including: remaining with or returning to the family home; and decreased negative outcomes, including: failure of foster home placement, institutionalization, arrest or involvement with law enforcement and the juvenile or criminal courts;*

b. Analysis of the implementation of the Agreement across and between all child- serving agencies, including the DHHR's Bureau for Children and Families, the Bureau for Medical Services, and the Bureau for Behavioral Health, the Bureau of Juvenile Services of the Division of Corrections and Rehabilitation of the Department of Military Affairs and Public Safety, and the Department of Education, and any barriers to effective coordination between these agencies and the steps taken to remedy these barriers; and

c. Analysis of data described in paragraph 49 below.

[Partial Compliance]

The evidence cited above indicates that DoHS has many of the elements of a functioning QAPI system in place. Further, there is evidence that data are used across the department by the Quality Committee and PIP teams, these data are shared with partners, and decisions are being made that responsible parties must carry out, and then data are reviewed to monitor the results of these actions. The most recent *SARs* indicate that they continue to improve in this regard. Parts of this process are addressed by Agreement Item 51.

However, the dashboard can only partially function as intended given that it is reliant on the incomplete data store, which has experienced lengthy delays. Thus, the data that are being used are, with few exceptions, not cross-system or child-focused data. Rather, they are program-specific data related to individual systems. Although these data have been used effectively to measure implementation and to a lesser extent to track outcomes, they present an incomplete picture. Without a fully-realized data store and dashboard, DoHS may not be aware of implementation challenges that are cross-system in nature until problems emerge in the program-specific data. DoHS has, through its use of the partially complete data store, conducted in-depth analysis of youth who are being prioritized for discharge from RMHTFs, with the results of this analysis so far being highly informative. Finally, although many of the measures described in Agreement Item 49 are collected, analyzed, and disaggregated by youth and county, most of them are not in the data store.

The following activities are recommended to achieve substantial compliance.

- To achieve substantial compliance, further meaningful progress on the data store is, at a minimum, required. This will then allow DoHS to more fully demonstrate capability on the other facets of this Agreement item.
- DoHS must demonstrate the emergent value of the data store by utilizing it for *SAR*s as new modules are added. To help the SME understand the specific sources of data being used when describing a finding, we suggest the following language or something similar to it be included: for single-program-specific data, "using data from program X, we found that..."; for data that combines programs or assessments at the child level, "using data from assessment/program X and program Y, we found that..."; and for data from the data store, "using data on assessment/program X and program Y obtained from the data store..."

Progress on Agreement Item 48 will also heavily influence the compliance rating on Agreement Item 49.

Agreement Item 49: The data to be collected and analyzed to assess the impact of this Agreement on children in the target population shall be specified in the implementation plan. At a minimum it shall include data regarding:

1. *All children receiving services under this Agreement, including the types and amount of services they are receiving;*
2. *All children screened pursuant to paragraph 31, including the dates of screening and the dates of engagement in services;*
3. *All children living in a Residential Mental Health Treatment Facility, including admission dates, length of stay, and number of prior placements in Residential Mental Health Treatment Facilities;*
4. *The outcomes of children in the target population, including: whether they have been arrested or detained without being charged, have been committed to the custody of the Division of Juvenile Services or the Department of Health and Human Resources, have been suspended or expelled from school, and have been prescribed three or more anti-psychotic medications;*
5. *Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment and the quality sampling review process;*
6. *The fidelity of Child and Family Teams to the National Wraparound Initiative model; and*
7. *Data from the Crisis Response Team encounters, including timelines of response and data on connection to services.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Substantial compliance will require a fuller data store buildout that includes a sufficiently meaningful set of the measures described in this Agreement item.
- Additionally, substantial compliance will require a more thorough and deeper understanding of these measures —through disaggregation of state level data by child characteristics, county, or region, and through cross-system analysis.
- It is helpful to identify the data source when discussing findings in the *January 2024 SAR*. Specifically note if the source of the data being discussed is from the data store/dashboard.

Agreement Item 50. At least annually, the State shall conduct quality sampling reviews of a statistically valid sample of children in the target population. The State shall use data from the quality sampling reviews to identify strengths and areas for improvement, and shall include the steps taken to improve services in response to the analysis of quality sampling review data in its semi-annual reports to the United States.

[Partial Compliance]

The following activities related to the quality of the survey data collected by WVU are recommended to achieve substantial compliance.

- WVU and DoHS should continue to collaborate to improve response rates across stakeholder groups. Although response rates (which were also poor in the first year of data collection) are noted as a limitation, it was not clear to the SME what strategies are being considered to improve them.

- Given that so few youth and caregivers know the services available to them by name, WVU should do more thorough question writing, including cognitive pretesting of youth and caregiver questions, to ensure that questions are written to reflect how the children and their caregivers might understand the services that they receive.
- DoHS should work with WVU to revise some of the measures to better meet the requirements of the Agreement. For example, a survey item could be constructed to better capture whether "in-home and community-based services are delivered at times and locations mutually agreed upon by the provider and the child and family."
- To reduce unnecessary respondent burden by asking questions that are not relevant to certain groups of respondents, WVU and DoHS should consider the potential implications of some of the questions and revise the surveys accordingly.
- The SME would like further clarity on how DoHS and their partners will respond to or are currently responding to Agreement Item 50, including clarity on issues related to quality and how the "cross-system" part of the Agreement item will be carried out.

Agreement Item 51. DHHR shall develop and take remedial actions to address problems identified through its analysis of data.

[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- As noted in Agreement Item 48, evidence indicates that data are used across the department by OQA, the Quality Committee, and PIP teams; these data are shared with partners; and planning decisions and actions are carried out and monitored. They have demonstrated a pattern of growth over the last several *SARs*, and the two most recent *SARs* indicate continual improvement in this regard. Although current data comes mostly from program-specific sources, Agreement Item 51 only concerns the process of how DoHS develops plans and acts to carry out these plans, based on analysis of data.
- DoHS shared two (March 2023 and November 2023) Quality Committee meeting slide decks that use data both from the partially complete data store and the program-specific data, often combined with geographical data, in developing talking points for the planning process. DoHS is sharing the data, from the sources currently available and presented in increasingly sophisticated ways, to stakeholders on the Quality Committee.
- The evidence cited above indicates that DoHS is seeing outcomes from these planning decisions. In some cases, the improvements are modest (e.g., improvements in mental health screenings). In other cases, the outcomes suggest that prior actions have not resulted in sufficient progress and that DoHS should pivot to a new strategy. The reports indicate that DoHS has demonstrated the agility to revisit decisions and engage with partners to understand where the challenges are, and how to address them.

3.5 Screening

Overview

The Agreement requires the State to ensure that all children and youth who are eligible to receive mental and physical health care and services through DoHS are screened to determine if they should be referred for mental health evaluation or services and that DoHS adopt a standardized set of mental health screening tools. Additional provisions require screening children entering child welfare and juvenile justice, and screening children as requested by the child or family. Fifty-two percent of Medicaid-eligible children who are not in the YS, child welfare, or juvenile system systems shall be screened with a mental health screening tool annually.

Throughout the course of the Agreement, DoHS has made significant progress in establishing screening protocols across multiple agencies. The following systems complete screenings with the following protocols in place:

- Primary care providers (PCPs): PCPs provide screening for Medicaid- and WV Children's Health Insurance Program (WVCHIP)-eligible children through WV's HealthCheck program (EPSDT) program) within the BPH.
- BSS, Youth Services (YS) and Child Protective Services (CPS): DoHS policy requires that all children placed in DoHS custody via the child welfare system, including YS and CPS, receive an EPSDT screening, which includes mental health screening, within 30 days of placement (as documented in the *Foster Care Policy Manual*, updated June 2023). Screening is provided through the HealthCheck program by the child's PCP. Screening of children by child welfare workers is also conducted using the *Family Advocacy and Support Tool* (*FAST*) for YS involved children and the Ongoing Assessment for CPS involved children within 15 days of establishment of the case.
- BJS and the Division of Probation Services: These departments provide screening for children in juvenile detention and commitment facilities and children on probation using the *Massachusetts Youth Screening Instrument – Second Version* (*MAYSI-2*).

Additionally, the state has undertaken significant efforts to reach the 52% goal for Medicaid-eligible children. This has included concerted efforts with the MCOs and directly with physicians.

Achievements and Developments

As reported in the January 2024 *Year 5 Implementation Plan*, **screening protocols and processes have been established across all appropriate entities**, while data quality and storage are in various stages of development (see QAPI Section). The *January 2024 SAR* shares data on screening rates for systems-involved youth, demonstrating that screenings for children entering service systems are occurring at a high level:

- Of children in foster care or certified kinship care from January 2022 to June 2023, 93% were screened via a wellness visit within one year of initial placement. Follow-up efforts with families by HealthCheck help maintain these high rates. Additionally, ongoing work with the WV PATH system and the data store buildout will help DoHS better understand the population of children who are not being screened.
- As an addition to using the EPSDT for youth in care, screening of children for possible mental health needs using the FAST (YS) and ongoing assessment (CPS) by child welfare workers is required to be completed within 15 days of establishment of the case. There were initial challenges with the quality of this data, but as of fall 2023, maps are shared monthly with BSS to review county-level screening rates.
- 95% of children entering BJS were screened at intake in August and September. This is based on an analysis of screenings versus intakes, broken down by facility. This excludes one facility that, due to staffing shortages, was found in May 2023 to not be completing the appropriate number of screenings. (To address the staffing shortage, there has been an approved increase in starting wages for correctional officers, and a new case manager was being trained at the time of the writing of the *January 2024 SAR*). The Office of QA is also using booking data (date of intake) to examine timeliness of screenings and found that 80% of youth are screened on the day of intake to a BJS facility or the following day, and 92% of youth are screened on the day of transfer between BJS facilities or the following day. Of the children screened from January to June 2023, 82.4% had a positive screen, compared to 85.7% for January 2022 to June 2023. The consistent rate over 80% indicates the importance of early intervention for this population.
- Screenings for children adjudicated as status offenders or as delinquent are conducted by the assigned probation officer at intake to probation. In November 2022, screening expanded to include pre-adjudicatory youth who were in crisis or do not have a DoHS worker assigned. From March 2022 to October 2023, Probation Services conducted 752 screenings. As of October 2023, 41 of WV's 55 counties have reported screenings at some point since inception of the Probation Services screening processes in March 2022. Of the screenings that occurred between March 2022 and June 2023, 250 (40.7%) were positive. The OQA is working with Probation Services to identify possible screening deficits at the county-level.

The Agreement specifically states that **52% of Medicaid-eligible children who are not in the YS, child welfare, or juvenile system systems shall be screened with a mental health screening tool annually**. The *January 2024 SAR* finds that an estimated 38.9% of Medicaid-eligible children received an EPSDT with mental health screening. This percentage was 38.5% in the previous semi-annual report. The EPSDT/HealthCheck PIP has continued to meet over this reporting period to address low screening rates. The January 2024 *Year 5 Implementation Plan* reports that the Wellness Screening PIP is reviewing preliminary claims data in order to better understand the common characteristics of children in need of screening. Additionally, the Office of QA has continued to meet with representatives of BMS in 2023 to discuss strategies to further engage the broader group of MCOs under Mountain Health Trust. The *January 2024 SAR* shares the following strategies that MCOs under Mountain Health Trust are already using to increase screening rates:

- Follow-up with families to remind them of needed visits (by call, text, and mail).
- Calls from the child's case manager at least quarterly with reminders about wellness screenings and importance of these visits.
- Gift cards for families completing their annual wellness screening.

See the Outreach and Education Section for more information on outreach work with PCPs.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 31a. DHHR shall ensure that all children who are eligible to receive mental and physical health care and services through DHHR are screened to determine if they should be referred for further mental health evaluation or services. and *Agreement Item 31c. A mental health screen will be conducted upon entry into state service systems or if the family requests it.*
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME applauds the establishment of clear protocols across multiple agencies. However, particularly in the case of Probation Services, the SME needs to ensure that screening is occurring across all counties, statewide. The SME looks forward to seeing continued and increasing evidence of statewide coverage to ensure that all children who are systems-involved are being reached. For example, for Probation Services, the SME needs to see concrete steps to ensure that all 55 counties are conducting screenings.
- The SME also looks forward to seeing efforts to understand the population of children not being screened as data capacity and the data store buildout continue.

Agreement Item 31b. DHHR shall adopt a standardized set of screening tools.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS has clearly delineated specific tools to be used by each agency.

Agreement Item 31e. 52% of Medicaid-eligible children who are not in state service systems shall be screened with a mental health screening tool annually.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- DoHS acknowledges that the 52% benchmark has not been reached. Work must continue to reach a broader group of MCOs under Mountain Health Trust, as well as efforts to reach out to children and families directly. The SME would like to see continued evidence from the Wellness Screening PIP as well as more information about the meetings between the OQA

and representatives of BMS. For additional strategies to increase screening rates, see the Outreach and Education section.

3.6 Children's Mobile Crisis Response and Stabilization

Overview

The Agreement requires the State to develop a CMCRS statewide for all children, regardless of eligibility, to prevent avoidable higher levels of care and connect with community services. The CMCRS must operate 24/7, via a toll-free number and must have plans to respond to crises by telephone or in-person and to collect and report data to track timeliness of response and family engagement in HCBS following a crisis.

Achievements and Developments

Significant and continued effort has been demonstrated with respect to CMCRS, a critical service and implementation. The SME noted improvements in these following areas as well as other sustainability and policy efforts since the following overarching recommendations were presented in the June 2023 SME Report:

1. Increase community knowledge of WV crisis response system for children and families.
2. Adhere to national best practice, such as timely access to the crisis lines, increased mobile response dispatches and delineation between initial mobile response and stabilization service components, and warm hand-off practices.
3. Further develop and train the CCRL workforce to ensure call center customization and principles specific to children and families are understood and in practice.
4. Strengthen CCRL and CMCRS data collection and CQI processes.
5. Increase collaboration between CCRL and CMCRS providers.

CMCRS services are well established statewide with both a consistent CCRL provider answering calls statewide and seven regional CMCRS providers that respond when needed in person. WV continues to strengthen its three core components to a full crisis system that includes: 1. a single access crisis line; 2. mobile response; and 3. stabilization (follow-up) component. The last two components (mobile response and then stabilization) are provided by the same provider in each region.

Refined policies and procedures, increased youth and family awareness and connection to the Assessment Pathway, continued workforce training and enhanced data processes are all areas identified and prioritized in the Year 5 *Implementation Plan* and are reflective of WV's progress in this large statewide effort.

Growth and sustainability efforts are demonstrated through recent and major policy and funding mechanism changes that occurred during this period. Most notably, on September 5, 2023, CMS approved a SPA to allow BMS to provide statewide community-based mobile response to all Medicaid recipients. BMS policies were drafted in fall 2023 and became effective February 1, 2024. Up to this point children's mobile response services were only provided through BBH and/or CSED Waiver

funding. As a result of the amended SPA, changes are scheduled to be made to the CSED Waiver, as crisis services will be removed from this time-limited and enrollment-limited waiver. Creating a SPA that makes crisis services available to all Medicaid youth demonstrates DoHS's commitment to this service and its resounding effort to create a long term and broader sustainability mechanism for WV's crisis system. Children that are not Medicaid-eligible will continue to receive mobile response services through BBH funding. Many documents were provided to the SME team in support of this enormous undertaking by BMS and DoHS that involved drafting the SPA, seeking public comments, obtaining approval and adjusting the *Chapter 503 Provider Manual* to reflect these changes. The next steps will involve recruiting new crisis Medicaid providers to deliver this service as reflected in the provider application posted. The documents the SME reviewed included the following:

- *SPA Approval letter* (September 5, 2023)
- *Chapter 503 Appendix H Mobile Crisis Public Comment Log* (effective February 1, 2024)
- *Chapter 503 Appendix H Community-Based Mobile Crisis Intervention Services* Chapter 503 Licensed Behavioral Health Centers (wv.gov) (effective February 1, 2024)
- *Chapter 503 Appendix Mobile H Mobile Crisis Application* (effective February 1, 2024)

The revisions to *Chapter 503, Appendix H for Community-Based Mobile Crisis Intervention Services* addressed many areas to prepare for this service to be delivered by Medicaid providers. The specific areas addressed include the following: Medical Necessity Criteria, Admission Criteria, Discharge Criteria, Community-Based Intervention Services, Screening and Assessment, Crisis Planning and Brief Counseling, Crisis Resolution and Debriefing, Crisis Coordination, Provider Qualifications, Staff Qualifications, Supervisory Staff, Clinical Staff, Direct Care Staff, Documentation and Billing Procedures.

The *Mobile Crisis Provider Application* opened effective February 1, 2024, and is available to a broad array of organization types, including CCBHCs, Federally Qualified Health Center (FQHCs), Licensed Behavioral Health Centers (LBHC), and Comprehensive Behavioral Health Center (CBHCs). The SME looks forward to tracking future growth as WV is committed to transforming and growing its crisis response system.

The *SOC Grant Goals and Objectives* were shared with the SME this period. The new goals established demonstrate the use of this substantial federal SAMHSA grant originally intended to build out WV's crisis system but now has a broader reach. The new goals demonstrate a connection between the crisis system and WV's larger HCBS array along with addressing the importance of youth and family support and engagement. The SME looks forward to tracking this grant's evolving progress and reaching its benchmarks. This grant can have an impactful and intentional connection to the Agreement requirements and WV's sustainability efforts.

In the area of **increasing community knowledge**, as the CCRL provider, First Choice is responsible for CCRL outreach related to CMCRS services. As shown in the *Education Conference Presentation November 29-30, 2023* and the *CCRL Marketing Plan 2023-2024*, great efforts have been made to create

visibility and understanding of WV's crisis system. DoHS staff presented at the Department of Education (DOE) Student Support and Well-Being Conference, which was attended by 140 people, including school counselors, psychologists, principals, and educators from across the state. BBH also hosted an information session and answered questions regarding crisis services. BBH facilitated sessions focused on their service array and expanded school mental health services. BBH continues to meet regularly with school districts statewide to provide service updates and discuss local education agency updates and trends. DoHS also reported that more outreach and education sessions are planned for spring 2024, specifically with hospital emergency departments.

Additionally, the SME reviewed the *School and Resource Kits* (infographic and wallet card) intended for school personnel and community support organizations. They list CCRL's purpose and 988 information. (See the Outreach & Education section for more information about communication efforts.)

The *Year 5 Implementation Plan* also identified and outlined goals with respect to CMCRS awareness, including:

- Adding specific CMCRS information and education to the *Resource Rundown*. DoHS is developing a family-centered outreach calendar of planned topics including crisis.
- Raising awareness of CMCRS and providing outreach to diverse communities that include families that include people of color, indigenous individuals, individuals that identify as Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+), and families formed through adoption.
- Expanding data to include referrals from schools and other sources to better understand connections made to the CCRL.

WV is making progress with regards to **adherence to national best practice standards**. The first edition of the *CMCRS Manual* was finalized in January 2023 and is currently undergoing revisions to align with *BMS Chapter 503H*. Areas that may require updates include staffing requirements and screening processes between BBH and BMS due to the SPA changes discussed at the beginning of this section.

National best practice standards, such as timely access to the crisis lines, increased mobile response dispatches, delineation between initial mobile response and stabilization service components, and warm hand-off protocol remain critical crisis system practices to develop. DoHS continues to work with University of Connecticut (UCONN) to address these crisis service components and practices. Currently, when someone calls CCRL more than three times, a youth is considered for stabilization services. This is criteria defined by BBH. Starting this fall, BBH will follow SAMHSA National Guidelines to begin to build the stabilization side of the mobile crisis service.

DoHS reported analyzing warm transfer failures through retrospective reviews. A tiered approach has been implemented that is outlined in the *CMCRS Desk Guide* and *CMCRS Manual* and reflects what

staff should do and who to contact when a warm transfer is unsuccessful. A process is in place for responses that are not reflective of the WV's warm transfer standard which are then reviewed with providers and monitored for trends and improvements. Helpline specialists have been trained and received protocols that contain the contact information for CMCRS and instructions for the steps to take when a hand-off fails. DoHS reported in-person shift leads have been added and are available, along with a program coordinator and program director who are on call to provide support to the helpline specialist if supervision is needed when a warm transfer was attempted but did not occur.

In the areas of contract monitoring and workforce/training, DoHS reported monthly reviews occur with providers to examine trends and areas of improvement. The *CMCRS Meeting Agenda Template* was shared to show an example of a grant monitoring meeting agenda with a CMCRS provider lead by BBH. This agenda addressed the following topics: budgets and finances; service gaps and challenges; positing/hiring updates; outreach efforts, CMCRS staff training updates with a final question to providers asking what is needed from BBH. Such a convening shows active grant-managing processes are in place.

WV continues to work diligently to address the evolving crisis system workforce training needs and address policy changes. The *CCRL Desk Guide* was updated in September 2023 and again in early 2024 to align with updated BMS policy to reflect the inclusion of crisis services in the SPA. Additionally, due to *BMS Chapter 503H* policy changes, BBH is updating areas in the *CMCRS Manual*. In the manual, BBH has outlined the requirements that providers need to fulfill for key roles in this service. There are similar roles outlined in the scope of the vendor *First Choice's Grant Agreement*. Exhibit A in the Agreement outlines the scope of work to deliver the CCRL and warm peer line, statewide. This Agreement expired 9/29/2023 and the SME is looking forward to seeing any changes in the renewed 2024 Agreement currently being negotiated. The SME was provided internal data shown in the CCRL July-December Slides PowerPoint from January 22, 2024. This data is what is collected and reported by First Choice as required in the Expected Outcomes/Performance Measures portion of the Agreement. This data shows the call volume and basic demographic information which begins to capture the reach and volume trends of WV's children's crisis system.

Continued oversight of CMCRS providers and the workforce delivering CMCRS remains important. DoHS reported that monthly meetings continue to occur with providers to discuss trends and needs, and to provide requested training focused on key areas. DoHS maintains their ongoing relationship with UCONN to receive mobile response training education and technical assistance to align with national standards for children and families. SME was provided the *CMCRS Meeting Notes from April 2023 through January 2024* documenting a sampling of monthly meetings including attendees and agenda items covered. DoHS indicated trainings are planned as requested by providers to include most recently the following content: mobile response and stabilization services (MRSS) system readiness tools and Medicaid billing codes related to the new SPA. DoHS reported other trainings have been provided by UCONN under DoHS's training grant. The providers are still asking for more in-depth training on the SPA changes and this information be delivered by BBH once the content is prepared and scheduled. WV CMCRS providers are also receiving training through the UCONN MRSS trainers

through a two-year Quality Learning Collaborative. This collaborative meets monthly and DoHS also receives coaching from UCONN MRSS faculty.

The area of **strengthening CMCRS and CCRL data collection and analysis** will continue to evolve, and WV has identified many priorities, strategies, and enhancements to continue to increase and improve these processes.

DoHS reports that, as the stabilization service component is designed and rolled out, additional data will be collected through a uniformed call line tracking system BBH is creating. This new system will be built with funding from the recent SOC grant that focuses primarily on crisis response. Considerable effort will be required to streamline this process as new CQI measures and processes are introduced. The system is scheduled for completion by fall 2024. This upgrade will help aid the crisis line staff to assess the volume of calls resolved with telephonic support only, along with repeat calls to ensure that calls are receiving the appropriate level of intervention needed.

In response to the need to improve data completion rates, DoHS reported that beginning in November 2023, BBH CMCRS providers began to enter CCRL and CMCRS data into Epi Info. The collected data is now available to evaluate how the process of warm hand-offs occurs and will be reviewed at Quality Committee meetings. DoHS reported they are hopeful that providers will see the value in this increased data collection and reported efforts to identify ways BBH and providers can work together using data to improve their crisis system. DoHS indicated planning and design meetings are scheduled for early 2024 to determine which CMCRS provider is best positioned to partner on this enhanced data collection process to improve the effectiveness and efficiency of collecting referral data and closing feedback loops. The SME notes this increased collaboration between CCRL, CMCRS providers and BBH will be very beneficial to further develop WV's crisis system.

Previously the SME had recommended collecting and monitoring regional and county variation in CCRL and CMCRS through CQI processes, to identify and address any disparities. DoHS reported BBH and providers are looking at the trends in utilization of services across all WV counties. During quarterly data reviews, the BBH team discusses why they think specific regions are more active than others. The *November 2023 QC Visual* document (data not public at this time) describes research questions to help understand if children with mobile response crisis calls are being referred to the Assessment Pathway as well as identifies those who are repeat callers. This data analysis is exactly the progress the SME is looking for: to collect, analyze and react to incoming data in real time, with weekly, monthly, quarterly and annual basis intervals.

DoHS also reported that data collected is being analyzed and used to inform outreach and education efforts with respect to regional and county variations. BBH and providers continue to partner in their efforts to educate the community about the services available to them. BBH relies on providers to use their regional knowledge and implement the most effective methods to reach their communities. BBH continues to build relationships with school districts and emergency departments (EDs) to provide education around what services are available and how to reach those in need.

The previous four *SARs* capture what types of referrals a youth receives from a coded "emergency, crisis or urgent" call across several periods. This data is valuable to further understand the large portion of calls without recorded referrals or warm transfers.

Table 3: Warm Transfer, Attempted or Completed, of Calls Reported as "Emergency/Crisis/Urgent" and had a Response Listed for Referral (across four time periods)

	July-Dec 2021	Jan-June 2022	July-Dec 2022	Jan–June 2023
Referral Type	**Percentage (N=63)**	**Percentage (N=99)**	**Percentage (N=62)**	**Percentage (N=80)**
Short- or Long-Term Treatment	Not reported	1% (1)	No reported	1% (1)
Crisis Stabilization Unit	2% (1)	2% (2)	1% (1)	3% (2)
Comprehensive Behavioral Health Facility	Not reported	4% (4)	5% (3)	4% (3)
Children's Mobile Response Team	41% (26)	25% (25)	32% (20)	29% (23)
No Referral Listed/No Warm Transfer Attempted	55% (35)	68% (67)	60% (37)	62% (50)
Other	Not Reported	Not reported	2% (1)	1% (1)
911	2% (1)	0%	0%	0%

The connection to mobile response remains very low, and in fact dipped in this last period. This is a referral that has not seen an improvement or substantial growth as one would expect. Recommendations to address this concern are addressed further in the section and reflected in the compliance rating.

The past *SARs* share these important data points below which continue to demonstrate that more counties are accessing CCRL and shows growth in reach and access.

Table 4: County Reach Across Five Reporting Periods

Reporting Period	Volume	County Reach	Missing Data
Jan – June 2023	At least one caller	48/55 counties	44%
July – Dec 2022	At least one caller	46/55 counties	52%
January – June 2022	At least one caller	46/55 counties	41%
July – Dec 2021	At least one caller	38/55 counties	unknown
July 2020 – June 2021	At least one caller	43/55 counties	unknown

The CCRL call volume also continues to grow across the state. From January to June 2023 there was a 25% increase from the last reporting period, which was the same percentage increase as the prior six-month period.

Table 5: Six Month CCRL Call Volume Across Three Reporting Periods

Reporting Period	CCRL calls
January – June 2023	771
July – December 2022	617

January – June 2022	494

These benchmarks are a few examples across time to compare and track growth in WV's crisis system. The SME will look for continued growth with their CCRL/CMCRS system.

The *January 2024 SAR* report stated there were limitations with data indicators regarding timely provision of services and referral to additional services were unavailable. Since the report, indicators were added with the update to the Epi Info System (V2) and went live October 31, 2023. Timeliness data will be reviewed in the future. The *January 2024 SAR* indicated CMCRS utilization trends will continue to be monitored and validated by BBH as more data becomes available at the child level to continue establishing normal trends versus changes in service utilization. The Epi Info System and new updates (V2) are currently undergoing further testing to determine if the fall 2023 changes are sufficient.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 24a. DHHR shall ensure timely access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment, Agreement Item 28. DHHR shall ensure the timely provision of mental health services to address any immediate or urgent need for services. Such services will be provided through consultation with the child and family (or foster or kinship parent, where applicable) and include needed in-home and community-based services and linkage to other service providers and *Agreement Item 40a. DHHR shall provide high quality in-home and community-based mental health services that are timely and individualized to the child's needs.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Continued evidence on examining and analyzing data, such as the rates *of face-to-face contact with families that request services.*
- The SME recommends looking at a well-developed quality and outcome measurement system like Connecticut (see link above) to identify metrics to capture crisis response timeliness. Examining data such as the *rates of face-to-face contact with families that request* services could aid in moving this crisis response Agreement into compliance. There are several ways to capture data that may lead to this evidence and the SME welcomes the opportunity to discuss options. For now, the SME does not have enough evidence to rate this item.
- The SME looks forward to reviewing the impact of some of BBH's next steps outlined in the *January 2024 SAR* to help ensure families are aware of CCRL/CMCRS and can access in a timely way when the need arises. These next steps include:
    - Raising awareness to diverse communities and stakeholders
    - Collect and use data on timeliness of response and identify and address regional needs
    - Provide additional training and technical assistance (TA) to improve data quality and completion

- Analysis of provider level data to determine invention opportunities related to referral practices, response type, frequency of return callers
- Regarding CCRL, provide additional outreach to stakeholders to include ED, medical offices, and schools

Agreement Item 24b. DHHR shall provide access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment, in a manner that enables the child to remain with or return to the family whenever possible and *Agreement Item 40b. Individualized home and community based mental health services.*
[Partial Compliance]

The following activities are recommended to achieve substantial compliance:

- Survey a representative sample of participants who receive HCBS to determine if individual needs are met through CMCRS. This may be accomplished through the WVU Children's Mental Health Evaluation with adjustments to the population surveyed and questions asked. This could also be addressed with post-treatment surveys that WV is developing to deliver to program participants.

Agreement Item 24c. DHHR shall ensure statewide access to these programs, Agreement Item 29a. Children's Mobile Crisis Response shall be available to all children, regardless of eligibility, to prevent unnecessary institutionalization of children with serious mental health crises. Children's Mobile Crisis Response shall provide toll-free crisis hotline services and Crisis Response Teams that are available throughout the state and staffed 24-hours per day, seven days per week, Agreement Item 33. DHHR shall ensure statewide access to Wraparound Facilitation for each child identified as needing in-home and community-based services, per paragraph, Agreement Item 40c. Statewide access to home and community-based services and *Agreement Item 41a. Implementation Plan, ensure statewide access.*
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways along with implementation growth and monitoring recommendations below.

- Crisis providers are available across the state, in each region, and the SME did not review any evidence indicating that those families that want mobile response are not being served.
- Further data collection as described in **Agreement Items 26 and 28 is** recommended to track more details on who is benefiting from crisis response and through what mechanisms in order to address growing pains and increase in-person response. More marketing and awareness will yield more demand. Tracking data around deployment of crisis response to homes, schools and community locations to provide in-person crisis stabilization and linkage to other needed services should continue to evolve over time. The SME recommends collecting and analyzing more specific data to create a clearer tie to demonstrate WV's robust children's crisis system

is in fact reducing unnecessary institutionalizations, behavioral health related hospitalizations and visits to the ED.

- Continued and strong oversight of CCRL and CMCRS providers will also continue to strengthen this Agreement item moving forward to ensure WV's providers' support DoHS's data collection vision and enormous roll-out of statewide crisis services now funded by Medicaid.
- Since a crisis system is often a first point of contact for families in crisis and seeking help, the SME had recommended in the prior SME report to collect data on the presenting concerns and the outcomes of the calls and the *January 2024 SAR* highlighted such next steps to use data to understand presenting concerns and outcomes of calls by:
    - Addressing needs to encourage CMCRS providers to make direct referrals to the Assessment Pathway upon resolution of a crisis and agreement with family.
    - Through data store, engage in additional analysis and explore outcomes following CMCRS interaction and associated characteristics.
- This would assist and ensure staff are aware of and trained in youth-specific concerns. This practice will promote and develop staff to be able to make appropriate referrals and resources when mobile response is needed or when a 911 intervention may be required. DoHS reported these enhanced clinical measures have not yet been established to collect this specificity of data. In the interim, BBH monitors repeat calls and when referrals to other services have been made. The SME will expect further development in this area as WV's continues to strengthen its crisis system. The SME looks forward to reviewing the impact of some of BBH's next steps outlined in the SAR:
    - Raising awareness to diverse communities and stakeholders
    - Collect and use data on timeliness of response and identify and address regional needs
    - Provide additional training and TA to improve data quality and completion
    - Analysis of provider level data to determine invention opportunities related to referral practices, response type, frequency of return callers
    - Regarding CCRL, provide additional outreach to stakeholders to include ED, medical offices, schools
    - Address needs to encourage CMCRS providers to make direct referrals to the Assessment Pathway upon resolution of a crisis and agreement with family.
    - Through data store, engage in additional analysis and explore outcomes following CMCRS interaction and associated characteristics.

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- DoHS/BBH is continuing to grow and refine its data collected and methods with respect to their crisis response line. Through these efforts, the SME would like to review the more specific measures adopted to ensure the times/location and mobility rates (by phone or in-person) are better documented. Collecting more data that documents evidence supporting "timely" or "sufficient to meet the individual's needs will be critical going forward to advance the compliance rating.
- Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation.
- Connecticut Department of Children and Families provides and an excellent example of monthly, quarterly and annual data reports conducted to capture their state's data around appropriate access to crisis services: https://www.chdi.org/our-work/evidence-based-practices/emps/. Such state examples could aid WV in further developing their data collection to sow evidence to this Agreement item.

Agreement Item 29b. Callers connected directly to trained MH professionals with children's crisis competency.

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Evidence that mobile response teams are staffed with professionals trained to respond to the needs of youth/families and that the transfers are made to these child-specific teams.

3.7 Residential Reductions

Overview

WV must achieve a reduction in the number of children living in RMHTFs (based on the census of June 1, 2015 of 1,096) to 822 (a 25% reduction) by December 31, 2022, and a further reduction to 712 youth (35% reduction) by December 31, 2024. DoHS is taking steps to ensure that residential programs serve only youth who require that level of supervision and care for safety or flight reasons, and that all youth who enter an RMHTF have a discharge plan that stipulates the conditions under which the child should be discharged to a foster placement or permanency setting.

In addition to the development and expansion of HCBS to support youth with behavioral health needs, several efforts have focused more specifically on reducing the number of youth receiving RMHTF level of care. DoHS has identified proximal steps in the process of effecting change in the ultimate outcome of residential reduction. These areas of focus include:

- Reducing the number of admissions;
- Assessing appropriate placement so RMHTF is reserved only for the youth who need it;
- Increasing the number of discharges through focused effort on discharge planning;
- Reducing the average length of stay; and
- Reducing out-of-state placement.

Each of these efforts and the resulting progress are presented in greater detail below.

Achievements and Developments

According to data from the *January 2024 SAR*, the total number of youth in RMHTF since February 2023 has exceeded 800 (range: 805 in February to 889 in May 2023). At any given month, out-of-state placements constitute about 40% of the total RMHTF population. The *January 2024 SAR* noted that in reviewing admission versus discharge trends over the past 17 months, the Quality Committee concluded that the census increase in the first half of 2023 was driven by an increase in the rate of admissions rather than a decrease in the rate of discharges. The Quality Committee is looking at census trends across time and between geographic areas. Mental health challenges post-pandemic, the return to in-person school, and the lag time to seeing an impact from developing community-based placement capacity are hypothesized to explain the increase in the RMHTF census.

Reducing the RMHTF census and admissions is a primary focus that DoHS leadership report monitoring each week. According to the *January 2024 SAR, o*n January 1, 2024, 846 youth were in RMHTF (compared to 772 on January 1, 2023). County-level analysis in the *January 2024 SAR* suggests county-level differences in the growth and reduction of RMHTF placement across the state. The Quality Committee has discussed county-level variation and has plans for more exploration and

analysis to drive future efforts. Youth who ceased participation in the Assessment Pathway are at elevated risk for RMHTF admission; according to the *January 2024 SAR*, these youth have twice the incidence of admission relative to youth who receive CSED services.

In seeking to reduce admissions, re-admissions into RMHTF should be a significant concern. Although the *January 2024 SAR* reports that the overall risk of readmission averages 30%, it is 48% for youth age 9-to-12-years old. Readmissions happen on average within less than 6 months of discharge (ranging from 89 to 142 days by age group).

Ensuring that youth who enter RMHTF need this level of service is one of the Assessment Pathway's intended goals. Given that the courts are a key decision-maker related to placement, DoHS has worked with the Court Improvement Project (CIP) to promote adherence to the Assessment Pathway. The Assessment Pathway was introduced at the June 2023 WV CIP Board Meeting (per the provided slides), and was the focal topic featured in great detail at the September 2023 WV CIP Board Meeting. Attendance records suggest that a number of judges, attorneys, CASA representatives, as well as Aetna and DoHS staff were present. According to the *December 2023 CQI Plan*, DoHS has plans to monitor several key performance indicators (KPIs) related to adherence to the Assessment Pathway and RMHTF referrals by source and system. BSS has completed training of current caseworkers to improve adherence to the Assessment Pathway and should ensure that new hires are also trained. (See the Assessment section for more information.)

Completing assessments in a timely way is another effort to promote appropriate placement and identify when a change is needed. CAFAS/PECFAS assessments should be completed within 30 days of admission to a RMHTF; however, according to the *January 2024 SAR* in Q2 2023, 22% of youth did not have a completed assessment within 45 days. The QIA process is also intended to increase opportunities for diversion from RMHTF. By end of 2024, all children in active residential placement are expected to have completed the QIA process. (See the Assessment section for more information.)

In addition to completing timely assessments, all children in RMHTF must be "determined to be in the most integrated setting appropriate to their individual needs" As one dimension of assessing appropriateness of RMHTF placement, special attention has been paid to youth with CAFAS scores below 90 being served in RMHTFs. In the *January 2024 SAR*, DoHS recognized that more than 80% of these youth were 13 years old or above. Further, although youth over 17 comprised only 1% of the overall residential population, 6% of youth below 90 on CAFAS were 17 or older. Consequently, DoHS accepted proposals from providers to create settings that offer Transitional Living for Vulnerable Youth (TLVY). In September 2023, there was capacity to serve 22 youth ages 17 to 21 in these settings and DoHS plans further expansion given the continued demand. Despite these efforts, DoHS recognizes that children with CAFAS/PECFAS less than 90 continue to linger in RMHTF, with more than half of youth with CAFAS/PECFAS<90 being retained in RMHTF more than 90 days after scoring below the threshold for this level of care.

Based on data provided in the *January 2024 SAR*, significant progress has been seen as a result of the **increased focus on discharge planning**. Since April 2023, over 95% of youth in in-state RMHTF placements have a discharge plan, and this rate appears to be consistently tracked each month. The expectation that discharge planning should begin at entry into a residential facility is codified in the *Residential Treatment Provider Agreement*.

The discharge plan is intended to record any discharge barriers. According to the *January 2024 SAR* incomplete discharge barrier data was initially a prevalent issue, as seen in about one-third of youth in RMHTF. After Aetna implemented a quality review process, missing data rates are only about 2%; however, accuracy of data related to discharge barriers remains a focal area.

In analyzing barriers to discharge, the *January 2024 SAR* reports a lack of available community-based placement options as a common barrier for discharge (20% of youth in the prioritized discharge planning population who were still in active placement as of August 2023). DoHS's difficulty in recruiting foster providers willing to support older youth, and the uneven distribution across the state in the availability of such providers, has likely impacted the ability of DoHS to discharge youth who are ready.

According to several documents provided by DoHS, DoHS is revising their residential levels system and instead creating new residential placement options (e.g., residential homes, residential intensive treatment settings, and specialized residential intensive treatment settings) as well as increasing foster family recruitment efforts. These new residential models were developed with consultation from Casey Family Programs; a rate structure has also been created by Myers and Stauffer. According to a December 2023 memo from the West Virginia Childcare Association, current residential providers in the state have raised some concerns about re-tooling to serve youth in these new models.

In addition to new residential settings, DoHS is enhancing **foster family recruitment** for youth ages 13 to 17. A marketing firm has been chosen to launch a statewide initiative "West Virginia Needs You Now" to convey the urgent need for foster families across the state. DoHS is also in initial conversations with Aetna and child placement agencies (CPAs) about building capacity and streamlining the process of referring and finding community-based placements for youth.

According to the *January 2024 SAR*, to assist with quality improvement, all youth placed in-state and in out-of-state residential settings have been entered into the Quickbase system as of December 2023. The Quickbase system allows easier tracking and reporting of youth experiences including flagging or prioritizing youth whose data (around length of stay and placement level) falls outside expected values. This system is also expected to include all discharge planning data for youth in in state and out-of-state residential placements.

With the goal in mind of **reducing the average length of stay**, the *January 2024 SAR* depicts length of stay comparisons in several different ways, including looking only at discharged youth median length of stay, to focusing only on in-state or out-of-state placements, to stratifying by age group and at monthly, quarterly, and semi-annually intervals. In-state median RMHTF/PRTF length of stay has

remained relatively stable for the period shown in the *January 2024 SAR* (157 days, median LOS as of Q3 2023), while out-of-state LOS shows a consistent decrease throughout the period (183 days, median LOS as of Q3 2023 compared to 225 days in the same period of the previous year [Q3 2022]).

*The WV Youth in Group Residential and Psychiatric Residential Treatment Facilities - 2023 Repor*t is anticipated to include cluster analysis of youth in these types of placements (produced by Marshall University). The SME received summary slides in March 2024 of a presentation of this report, but not the full narrative. From the slides, it appears that two latent classes include special populations, which supports DoHS's plans to develop the capacity for specialized placement settings for youth with these needs. In the 2023 analysis, the largest latent class of youth (35%) in RMHTF have legal problems but low levels of other needs, suggesting that there is still work to do to promote discharge or identify placement alternatives for youth with legal involvement. Although there is much to be learned from this analysis, see the QAPI section for a discussion of issues related to the comparability with the 2021 cluster analysis.

DoHS has partnered with MU to **build knowledge about the youth placed out-of-state in RMHTFs**. MU is contracted to complete CAFAS/PECFAS, CANS, QIA, and discharge plans for all children in out-of-state placement. According to a one-page memo from DoHS on information received from MU as of January 3, 2024, 54% of all youth and 67% of active youth in out-of-state RMHTF placement have a completed CANS. The initial CAFAS is available for 43% of all youth and 54% of active youth. MU reports that all initial CANS and CAFAS/PECFAS for active cases are to be completed by January 31, 2024.

Ratings and Recommended Activities Needed to Reach Compliance

Agreement Item 35b. For children in RMHTF, the individualized service plans will include discharge planning.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS has made significant progress toward ensuring that 100% of currently admitted youth have discharge plans, with rates over 95% for the past several months. The Quality Committee regularly review this data. Further, the focus on discharge planning was demonstrated by training to service providers and codifying discharge planning expectations in the service provider contract.

Agreement Item 52b. As in-home and community-based services developed pursuant to this Agreement expand to new regions of the state, DHHR will assess the strengths and needs of children in residential placement from those regions, identify services children need to return to those communities, and develop a plan to address any barriers to accessing those in-home and community-based services, including gaps in services.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The Quality Committee should continue to monitor the timeliness and data quality of all assessments of the needs and strengths of youth in residential placement.
- Discharge planning efforts should include identifying the HCBS youth will need after RMHTF placement and facilitating a warm hand-off or similar transition.
- Out-of-state RMHTF providers should have increased accountability in completing required assessments in a timely and complete way. The SME has not received a copy of the contracts with MU relating to the scope of work for evaluating out-of-state placement, which may demonstrate the oversight mechanisms in place.

Agreement Requirement 52c. If the state has not met its interim or final goals for a reduction in the use of Residential Mental Health Treatment Facilities, the state will assess the reasons why it has not met these goals and create an action plan to meet these goals.

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Stakeholders buy-in (including residential and community-based providers as well as family and youth advocacy organizations that represent youth and family voice) will be essential for the successful implementation of new residential models. Opportunities to engage stakeholders in this process should be included.
- DoHS needs to continue to assess the reasons why youth enter or remain in these settings when they are not needed and develop new interventions and action plans to meet the reduction goals.
- Out-of-state placements continue to be a sizable portion of the RMHTF census. Developing specialized expertise to reduce out-of-state placements and keep youth in WV can support continuity in family and community connections to promote discharge.
- DoHS must monitor and evaluate the current marketing effort to promote foster family recruitment and revise as needed to engage potential resource families for youth who need family-based care.

See also Agreement Item 52d. in the Assessment section.

3.8 Behavioral Support Services

Overview

The Agreement requires the State to implement statewide Behavioral Support Services, which include mental and behavioral health assessments, the development and implementation of a positive behavioral support plan as part of the individualized treatment plan, modeling for the family and other caregivers on how to implement the behavioral support plan, and skill-building services.

Behavioral Support Services is an approach that is used widely by BBH, BSS, BMS, and WV DOE programs and providers. Behavioral Support Services are intended to provide both prevention and intervention support to children and families in the community in addressing maladaptive behaviors. Positive Behavior Support (PBS) is a type of Behavioral Support Services 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.

Throughout the course of the Agreement, DoHS has made significant strides in setting up an infrastructure for Behavioral Support Services. Most significantly, there is now a PBS Program at WVU CED, and DoHS has contracted with CU to provide PBS training, with the former responsible for direct service and the latter addressing workforce capacity building.

Achievements and Developments

In the area of **statewide implementation**, the *January 2024 SAR* shares information about the services being provided. WVU CED provided PBS services to 111 children from January to June 2023. This compares to 108 youth from January to June 2022, as reported in the *January 2023 SAR*. The number of children served has remained relatively stable over the past 18 months, with an average of 53 children served each month in January to June 2023, compared to 49 in the first half of 2022 and 52 in the second half of 2022. However, a shift in the required intensity of services may be occurring; total child interactions have increased over the reporting period, with 1,085 contacts during the first half of 2022, compared to 1,330 in the second half of 2022 and 1,399 in the first half of 2023. The most common PBS services received breakdown as follows:

- PBS Plan Writing, 82%
- Brainstorming (a service typically completed with initial or lower-need cases to provide ideas and support for families), 19%
- Person-Centered Planning, 16%

As previously addressed, and as discussed further in the Workforce Section, capacity remains an issue in WV. As of December 2023, there was a waitlist of 22 children for PBS services (the SME notes that this number was 14 in December 2022). This may be partially due to staffing issues: as of the writing of the *January 2024 SAR*, one of the 10 FTE slots for the BBH PBS program through WVU CED was open and interviews were being scheduled. Additionally, the *WVU Detailed Report* focused

on the Community-Based Services Population at 2 Years reported that 35% of organizations that offered Behavioral Support Services (including PBS) in Year 2 reported difficulties providing service coverage, with the biggest challenges in Regions 5 and 6. However, the capacity challenge may also partly be a result of increased referrals, which is a positive development. In response to the waitlists, WVU has implemented a triage process for families involving sharing lists of resources, and weekly calls to these families. Examples of resources that families on the waitlist received include a Facebook page (https://pbs.cedwvu.org/pbs-trainings/) and online trainings and courses (https://pbs.cedwvu.org/pbs-trainings/). WV reports that correspondence with individuals while they are on the waitlist is documented in a secure CODA database. Average time on the waitlist was two months.

Recent reports demonstrate that community awareness about Behavioral Support Services and PBS is increasing. The *WVU Detailed Report* focused on the Community-Based Services Population at 2 Years found a 12% increase in the awareness of Behavioral Support Services, including PBS, among providers (73% at Year 2, compared to 61% at Baseline). Additionally, at least as perceived by caregivers and youth, BSS is doing the important work of keeping youth in the community and out of residential placements: "The greatest percentage of caregivers and their youth in RMHT in Year 2 reported that Wraparound and Behavioral Support Services (including PBS) helped delay RMHT" (p. 58). These percentages were 33% for caregivers and 38% for youth. Perhaps contributing to this success, a new website has been developed for PBS (https://www.wvapbs.org/), which includes resources such as example behavior plans, staff communication plans, and assessments.

An ongoing challenge is tracking individuals receiving Behavioral Support Services through Medicaid, which limits the understanding of utilization. The modifier code for PBS within BMS claims remains incomplete. This makes it difficult to track individuals receiving BSS services through Medicaid. The addition of the code will allow for a more thorough and accurate picture of who is receiving these services in WV.

WV, through work with Concord University (CU) and the WVU CED (Center for Excellence in Disabilities), has made great strides in **establishing and providing PBS/Behavioral Support Services training** since the beginning of the Agreement (as evidenced by training and credentialing materials provided to SME). The *January 2024 SAR* notes that, in addition to existing PBS training, the state is currently working to enhance and standardize the certification process for Behavioral Support Services. CU has begun training and certifying providers in Behavioral Support Services on a statewide basis, so that more providers have more tools for working with children. Additionally, CU holds monthly WV Association for PBS (WVAPBS) Network Meetings with relevant stakeholders in order to address regional needs, capacity and gaps (*CU Collaborative Center PBS September 2023 report*).

According to the *January 2024 SAR*, an average of 292 individuals were trained by the WVU CED in PBS each month from January to June 2023, compared to 295 trained each month from July to December 2022, and 333 individuals from January to June 2022. The highest single month was March 2022, when 472 individuals were trained. One note of caution comes from the *WVU Detailed Report* focused on the Community-Based Services Population at 2 years. As part of this evaluation,

researchers asked providers for feedback on the PBS training. Overall, results were relatively negative, with providers not offering strong endorsements of how prepared they felt to provide the services, how clear the certification requirements were, and how useful the certification requirements were to service delivery. Overall, "Findings suggest that opportunities exist to improve the certification process for PBS" (p. 69). In response, changes are being made, such as instituting mentoring post-training.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 24a. DHHR shall ensure timely access to services, Agreement Item 28. DHHR shall ensure the timely provision of mental health services to address any immediate or urgent need for services. Such services will be provided through consultation with the child and family (or foster or kinship parent, where applicable) and include needed in-home and community-based services and linkage to other service providers, and *Agreement Item 40a. DHHR shall provide high quality in-home and community-based mental health services that are timely and individualized to the child's needs.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- The SME remains concerned about the waitlist for services. However, DoHS provided information about how children are being connected to HCBS while on the waitlist, as well as the triage system that is activated. The SME would like to see continued documentation of the length of the waitlist, along with the average wait time.
- The modifier to the Medicaid billing code is necessary to demonstrate access to Behavioral Support Services. While this was originally expected in the summer of 2024, these revisions are now expected spring/summer 2024.

Agreement Item 24b. DHHR shall provide access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment, in a manner that enables the child to remain with or return to the family whenever possible. and *Agreement Item 40b: Individualized home and community based mental health services.*

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Survey a representative sample of participants who receive HCBS to determine if individual needs are met through the respective programs. This may be accomplished through the WVU Children's Mental Health Evaluation with adjustments to the population surveyed and questions asked. This could also be addressed with~~; or~~ post-treatment surveys that WV is developing to deliver to program participants.

Agreement Item 24c. DHHR shall ensure statewide access to these programs and *Agreement Item 40c. Statewide access to home and community-based services.*
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- Through their work with CU and the WVU CED, DoHS has clearly established an infrastructure for the provision of Behavioral Support Services across the state.

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.
[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation.

Agreement Item 37b. DHHR shall provide Behavioral Support Services.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- In WV, there is now a clear system of Behavioral Support Services including PBS, as well as a focus on the provision of training to providers of those services. New programs such as the inclusion of mentoring as part of training will continue to strengthen DoHS's ability to provide quality services. The partnerships with CU and the WVU CED have helped establish solid infrastructure and will be crucial in continuing to build capacity. The SME looks forward to receiving information about the growth of CU's training program introduced in the *January 2024 SAR*.
- In order to continue to grow and strengthen the PBS program in WV, the SME encourages the WVAPBS Network to continue meeting monthly and to produce strategic quality improvement plans accordingly. The SME also remains interested in any developing data trends focused on race that may emerge as the data store buildout continues. The January 2024 SAR notes an overrepresentation of Black, Indigenous, and People of Color (BIPOC) children among those receiving services, and the SME would like to learn more about these trends.

3.9 Therapeutic Foster Care

Overview

The Agreement stipulates that DOHS "shall develop Therapeutic Foster Family Homes and provider capacity in all regions and shall ensure that all children who need this service are timely placed in a Therapeutic Foster Family Home with specially trained therapeutic foster parents, in their home community whenever possible."

Achievements and Developments

In response to these Agreement items, **DoHS developed a new intensive family-based residential setting for higher needs youth at high risk for admission to an RMHTF**, referred to as a Stabilization and Treatment (STAT) Home. These homes were not intended to take the place of the legacy tiered foster care system, but to supplement it as a short-term or temporary placement strictly for stabilization of the youth after which the youth would be sent back to the prior placement setting (or another suitable tiered setting.) Although STAT had the support of legislation authorizing higher payments to caregivers, at the time of the *June 2023 SME Report*, only one STAT home had been recruited and fully trained, 3 had neared completion of training, and only 14 families had expressed interest in taking part in this new service. As a result, the STAT home model was discontinued during the time between the *July 2023* and *January 2024 SARs,* and there is now a renewed focus on providing services youth with higher levels of need within the existing tiered system.

The existing system has included the following three tiers:

1. Tier 1 – traditional foster care;
2. Tier 2 – treatment foster care for youth with mild to moderate trauma, behavioral problems, or emotional dysregulation; and
3. Tier 3 – intensive treatment for youth with moderate to significant trauma, behavioral problems, or emotional dysregulation.

Unlike STAT, these are foster home placements that are intended to serve youth until they can return to their permanency setting. Despite the loss of the STAT home model, utilizing the tiered system to treat youth with an elevated level of need will directly reduce the number of placement changes (a risk factor for behavioral health problems).

The challenges with the reversion to the legacy system for addressing the needs of these youth fall into two mutually reinforcing categories: recruiting foster homes willing to take youth with high needs; and ensuring that these homes have the specialized knowledge, training, and supports that these children require—including many of the supports that were intended to be provided through the STAT homes—to effectively divert them from admission to RMHTFs.

In general, and like many other states, WV is currently experiencing **challenges with foster family recruitment**. Slack capacity, i.e., the percentage of homes without an active placement, has been largely stable over the 18 months prior to the *January 2024 SAR*, at around 20% (rising to 30% in the first quarter of 2023). Further, over the reporting period, the number of homes closed exceeded the number of homes opened.

Findings reported in the *January 2024 SAR* show that these challenges are particularly acute for ensuring that older youth 13-17 years old, who constitute an overwhelming proportion of youth with SEDs living in residential facilities who have been prioritized for discharge planning, have families to care for them. The lack of families willing to take on older youth with higher levels of need is impacting the ability of DoHS to discharge youth who do not need residential care. (See the Residential Reductions section for additional information.)

In the *January 2024 SAR*, DoHS has incorporated a simplified metric for reporting the ratio of need to TFC home capacity. This shows that the availability of such homes is not distributed evenly across the state and in many cases, does not match with the level of need, particularly not for older youth. This analysis indicates that the current capacity would require, at a minimum, that two to six youth in this age group be placed in each home, which is inconsistent with evidence-based practice regarding care for high-needs youth.

The *January 2024 SAR* notes that a survey distributed to 526 foster families suggested that improved communication and support could encourage more families to agree to become foster parents or take children. A campaign scheduled to begin in early 2024, in partnership with Mission WV and Aetna, is aimed at expanding recruitment to families willing to take these youth with higher levels of needs and older youth.

Ensuring that homes that take youth diverted from RMHTFs have specialized knowledge, training, and support is critical as well. Although support for crisis intervention can be provided through CCRL and CMCRS, families agreeing to take children may prefer having a dedicated connection to the CPA or a sub-unit of the CPA or the state, to receive these services.

Recommendations

TFC will not be rated for compliance at this time.

Agreement Item 24. For every child in the target population for whom community-based services are appropriate and whose family or guardian does not oppose community-based services or in the case of children aged 18 or over, the individual does not oppose community-based services, DHHR shall ensure timely access to In-Home and Community-Based Services sufficient to meet the individual's needs including Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment. These services will be provided in a manner that enable the child to remain with or return to the family (or foster or kinship care family or an independent living setting, where applicable) whenever possible. DHHR shall ensure

statewide access to these programs to prevent crises and promote stability in the family home (or foster or kinship care home, where applicable).

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.

The following activities are recommended to move DoHS towards compliance on Agreement Items 24 and 26 for TFC.

- DoHS has already recognized and begun planning for and acting on current recruitment challenges and should continue prioritizing recruitment and training of foster homes at all tier levels and in all areas of the state, particularly homes for older youth and youth with higher levels of need.
- In addition to recruiting new providers, DoHS should also continue efforts to place these children in existing homes that may be, as needed, trained to take older youth and youth with higher levels of need.
- Future *SARs* should report statewide trends, sharing both static maps of current conditions and changes that are occurring across WV's counties. They should also describe the steps being taken in the marketing campaign to recruit new families or license existing homes for TFC placement.
- Given that it is speculated on, if the necessary data is available, DoHS should complete an analysis on historical recruitment, licensure, and placement data to ascertain whether there is in fact a seasonal pattern to recruitment, entries, and exits.
- DoHS should ensure that parents or caregivers have access to information about TFC in the tiered system, including specialized care for children with specific high levels of SED needs. This includes making sure that caregivers who seek out care from local and general medical providers have access to information about TFC placement.

Agreement Item 28. DHHR shall ensure the timely provision of mental health services to address any immediate or urgent need for services. Such services will be provided through consultation with the child and family (or foster or kinship parent, where applicable) and include needed in-home and community-based services and linkage to other service providers.

The following activities are recommended to move DoHS towards compliance on Agreement Item 28 for TFC.

- DoHS should ensure that children who are placed in tiered homes, either as a step-up in service need or as a placement after discharge from an RMHTF, have access to the HCBS services available to the other children in the state. However, see the recommendations for Agreement Items 38 and 40, as they pertain to youth with high levels of SED needs who are placed in TFC homes to divert them from RMHTF admission.

- DoHS should clarify what additional changes or complements to the existing tiered system of care will be made. As noted by the SME in the December 2020 report, "TFC parents who serve children with SED must acquire and retain skills that are different in kind than those required to support the other Tier III populations (p. 17)." (We offer clear recommendations in response to Agreement Item 38.)

Agreement Item 38. DHHR shall expand Therapeutic Foster Family Care statewide. DHHR shall develop Therapeutic Foster Family Homes and provider capacity in all regions and shall ensure that all children who need this service are timely placed in a Therapeutic Foster Family Home with specially trained therapeutic foster parents, in their own community whenever possible.

In addition to the preceding recommendations, the following activities are recommended to move DoHS towards receiving a rating on Agreement Item 38.

- DoHS must improve the efficacy of the care provided to youth with higher levels of need through the tiered system to improve diversion from RMHTF placement. Evidence suggests that higher acuity TFC for youth with SED requires that caregivers can give more attention and time to the youth in their care, implying that: caregivers take on no more than 1-2 children at any given time; caregivers are offered periodic respite from caregiving responsibilities; caregivers receive support, including regular contact and feedback (including face to face meetings), from professionals working in a specialized unit, each of whom manages a small caseload; there is ongoing contact with the youth's family of permanency; and caregivers receive larger payments to compensate for the care and complex treatment of youth with higher levels of need. At least some of these characteristics are currently true of the highest tier of care.
- The *Standard Operating Procedure* or other relevant documentation describing the tiered foster system should be updated to address this renewed focus of treating youth with higher levels of need within the tiered system, including clarifying youth eligibility, placement transition rules and eligibility, roles and responsibilities of the agency and CPAs including care and support provided through direct "intensive TFC" services, care and support provided through standard HCBS, training curricula, and monitoring expectations.
- DoHS should incorporate the plans regarding specialized training for TFC homes, such as the training curricula on crisis prevention and de-escalation, parenting strategies, and children with special needs, as well as similar programs and skills, in planned enhancements to the tiered TFC levels.
- For youth with very high levels of need who may be at particular risk for admission to an RMHTF, more intensive TFC in the form of specialized providers who care only for one youth at a time, specialized training or experience in caregiving for youth with particular needs, and 24-hour crisis support, may be required. DoHS should be specific, through a Standard Operating Procedure, about how they plan to recognize, train, assign, and provide this kind of specialized care to youth.

3.10 Outreach & Education

Overview

The Agreement requires the State to: 1. conduct outreach to, and training for, physicians who treat Medicaid-eligible children on the use of the chosen standardized mental health screening tools; 2. develop outreach tools for medical professionals who treat Medicaid-eligible children; 3. develop an outreach and education plan for interested/affected groups in the State of WV on the importance of the stated reforms prescribed in the Agreement; 4. provide timely, accurate information to families and children regarding the in-home and community-based services that are available in their communities; and 5. collaborate with relevant WV agencies and stakeholders around care for the target population.

Throughout the course of the Agreement, DoHS has made significant strides in Outreach and Education. DoHS created guiding documents for their overall Outreach and Education strategy through both their *Standard Operating Procedures: Outreach to External Audiences Regarding the Pathway to Children's Mental Health Services* and their *2020-2024 Outreach and Education Plan*.

One of the major achievements includes the creation of (and continued updating of), the Kids Thrive Collaborative Website, which provides information for families and community members regarding DoHS services for children's mental health. *Resource Rundowns*, recorded webinars to inform community members regarding DoHS services, are posted on the Kids Thrive Collaborate website. Community members can find opportunities for involvement with DoHS on the Kids Thrive Collaborative website, as through the statewide Family Advisory Board. Another significant achievement includes DoHS's facilitation of quarterly Kids Thrive Collaborate virtual meetings to provide updates and continued information to interested community members around DoHS services.

Achievements and Developments

DoHS has made significant progress in **reaching more physician offices** through the provision of materials related to mental health screening and information regarding accessing services for children with behavioral health needs.

The *January 2024 SAR* shares the following data:

- Between November 2021-December 2023, 590 of 694 (85%) PCP offices were visited by HealthCheck specialists to provide the *Children's Crisis and Referral Line (CCRL) PCP Desk Guide*, and a link to the *HealthCheck Primary Care Provider Mental/ Behavioral Health Screening and CCRL Presentation*. This webinar is targeted towards office staff and PCPs. It provides information on WV rates of mental health screening within EPSDT exams, additions made to preventative health forms to increase mental and behavioral health screening rates, and shares

information about the CCRL. As an update to this information provided in the *January 2024 SAR*, DoHS reported that as of February 21, 2024, HealthCheck specialists have visited nearly 100% of PCP offices to provide the *CCRL PCP Desk Guide*, and a link to the *HealthCheck Primary Care Provider Mental/ Behavioral Health Screening and CCRL Presentation*. There is a delay in visiting providers in Cabell County due to staffing shortages. In the interim, HealthCheck is mailing a packet to those providers and following up with an email to the office's point of contact.

- One of the EPSDT/ HealthCheck Performance Improvement Project (PIP) team's priorities is to review HealthCheck program needs and opportunities, including how to incorporate mental health screening components into the EPSDT visit.

The *WV DoHS Outreach Update 20240105/ Meeting notes from 12.8.24 meeting with Health Check* shares the following data:

- HealthCheck specialists sent 257 emails to PCP offices regarding the *CCRL PCP Desk Guide*, since beginning PCP outreach in November 2021.
- The HealthCheck director has communicated with HealthCheck specialists regarding the need to visit all PCP offices in-person on a regular basis.
- The HealthCheck program has a standard procedure to collect data around PCP outreach, which includes HealthCheck specialists submitting monthly reports to the HealthCheck director who compiles data and provides data summaries to staff.
- PCP offices fill out a provider contact form for HealthCheck. This form is in the process of being updated to include questions on screening awareness (such as for signs of mental health issues) and information regarding the provider type (pediatrician, nurse midwife, physician's assistant, other). This updated form will support HealthCheck specialists to ensure that they are contacting each provider within each clinic and will provide more data around behavioral health screening awareness.

DoHS has **enhanced and maintained their methods to provide accurate, timely, and accessible information to families and children**. These methods include *Resource Rundowns*, the Kids Thrive Collaborative website and meetings, and the statewide Family Advisory Board.

The *January 2024 SAR* shares the following data:

- *Resource Rundowns* are maintained on the Kids Thrive Collaborative website and are publicized on social media platforms. These include: 1. *WV Kids Thrive Collaborative regarding HCBS* (328 views on YouTube since uploaded on September 7, 2022; 2. *ACT* (109 views on YouTube since uploaded on July 19, 2023); and 3. *Did You Know* video short for youth (97 views on YouTube since uploaded on April 5, 2023).
- DoHS is developing a content schedule for quarterly *Resource Rundown* updates in 2024.
- The Kids Thrive Collaborative website provides information regarding upcoming Kids Thrive Collaborative meetings. The listserv notifies subscribers regarding upcoming meetings. The

"Get Involved" tab provides several ways to get involved and provide input, as through involvement in the statewide Family Advisory Board.

- DoHS plans to survey the statewide Family Advisory Board in 2024 about the Kids Thrive Collaborative website to identify areas for improvement.

The *WV DoHS Outreach Update 20240105/ Meeting notes from 12.8.24 meeting with Health Check* noted that DoHS promotes two-way communication between families and DoHS through the statewide Family Advisory Board that meets quarterly (October 2023 and scheduled for January 2024). The DoHS's OQA and as many as 15 Board members attend these meetings.

The *CFSP Planning Committee Notes 20231110* document describes another DoHS effort to get community input. BSS formed a Children and Family Services Planning committee that first met in November 2023. The charge of this committee is to create a survey and organize listening sessions with family and youth to solicit feedback about experiences with DoHS services, specifically youth awareness of their case plan and reasons for placement, services received, general experiences with service and staff, and awareness of community services. The family survey will cover similar themes, geared towards the family perspective. The surveys were developed in partnership with relevant staff and people with lived experiences. Aetna has sent out both of the surveys. Once the data is received and completed, the results will guide listening sessions with youth and families. Either people with lived experiences (DoHS's preference) or Aetna care managers will guide the listening sessions, as opposed to a DoHS employee to create a space where feedback can be shared freely.

The *Outreach Tracker Training* lists the outreach materials that are available for DoHS staff to provide to community members regarding services offered by DoHS. This ensures that DoHS staff are providing consistent materials to the community.

The *EPSDT Standard Postcard 09.12.2022* (reminder postcard mailed from MCO to patients) now reminds patients about screening for mental and behavioral health at the HealthCheck exam, providing another avenue to encourage behavioral health screenings.

Mountain Health Promise (MHP) November 2023 Outreach data summarizes outreach completed by MHP for children in foster care, kinship care and adoptive care (inclusive of children who are enrolled in the CSED Waiver). In 2023 Q3, outreach included 523 flyers/letters sent to members, 31,147 outreach phone calls to members, and 403 community meetings attended (these numbers are inclusive of outreach regarding mental health screens, but also encompass other information). This is in addition to the case management that members receive, which may include face-to-face visits, weekly contacts, and an annual health risk assessment. The frequency of case management contacts is based on the severity of the child's mental and physical health needs.

The WVU Detailed Report Focused on Youth in Group Residential and Psychiatric Residential Treatment Facilities at 2-Years case series found that youth and caregivers were more familiar with available services upon discharge in year two of the evaluation in comparison to year one. Awareness of community services was low to moderate among caregivers and youth surveyed in RMHTF. However, it may be that

caregivers and youth are not familiar with services by name, particularly if they are focused on their RMHTF treatment at the time of being surveyed. The WVU *Detailed Report Focused on* Youth in Community *Based Services at Baseline* found that while youth and caregivers largely weren't aware of home and community based services by name (e.g. Assertive Community Treatment), they were generally aware of available mental and behavioral health interventions (e.g. counseling) and service locations.

DoHS has also **increased their outreach to other relevant WV agencies** and tracked these events in the *Outreach and Education Tracker*. The *January 2024 SAR* shares the following data:

- DoHS created, and now utilizes the O*utreach and Education Tracker,* to keep track of Outreach and Education events and meetings across staff. DoHS created a staff training on utilizing the tracker *(Outreach Tracker Training)* and continues to modify the tracker based on staff feedback. DoHS's intention is to use the tracker to examine correlations between outreach efforts and service utilization, residential placement rates and other county-level data.
- DoHS has begun targeted outreach to counties based on low utilization of services within different counties. For example, BBH identified five counties (Barbour, Wayne, Preston, Putnam and Marion) for increased outreach regarding CCRL and CMCRS. That outreach plan is being developed with collaboration between BBH program staff and relevant county grantees.
- Outreach materials are a key avenue for publicizing DoHS services. DoHS widely distributed wallet cards that highlight relevant numbers to call, such as the CCRL, and 988-Suicide and Crisis Lifeline. In December 2023, BMS sent nearly 1000 resource kits across the state to schools and community organizations. These resource kits include CSED Waiver posters, window clings, magnets, stickers and wallet cards. The *CSEDWED Asset Distribution List* details their plan to distribute materials across education providers, healthcare entities, psychiatric hospitals, mental health providers, the legal system and other community groups.
- DoHS has intensified efforts to work with the judicial community (recognizing judicial influence on diverting children from residential placement to HCBS). Thirty outreach events to the judicial system were tracked between July to December 2023 (46% of all outreach events). The second most frequently reached out to organizations were schools and WV's Department of Education (WV DOE) with 11 outreach events (17% of all outreach events).
- Beginning in December 2022, leadership from DoHS, WV DOE, WV's court system and the WV DHS committed to meeting multiple times annually to promote HCBS, advance data and information sharing, enhance interagency planning, and address any barriers to interagency work. Other cross-bureau efforts include:

    - BSS initiated virtual lunch and learn sessions with the judicial community through the WV CIP. As stated on the CIP website, the mission of the CIP is to "advance practices, policies, and laws that improve the safety, timely permanency, and well-being of children and due process for families in child abuse/neglect and juvenile cases." At the June 2023 lunch and learn, DoHS presented information about the QIA, the

M*ultidisciplinary Team Meeting Desk Guide*, the F*amily Connections Contact Sheet,* and *Prudent Parenting in West Virginia Child Welfare* training. In September 2023, DoHS presented an in-depth look at the QIA process including referral to the Assessment Pathway. In October 2023, a visiting lawyer discussed working with families with disabilities.

- In September 2023, DoHS ran two day-long workshops with BSS and Probation Services to build awareness around the importance of connection to mental health services, and to foster increased screening rates and awareness of the Assessment Pathway among probation officers.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 31d. DHHR shall conduct outreach and training on the use of screening tools to physicians who serve children who are Medicaid-eligible.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS created the *Children's Crisis and Referral Line (CCRL) PCP Desk Guide,* and the *HealthCheck Primary Care Provider Mental/ Behavioral Health Screening and CCRL Presentation.* These resources provide information around the screening tools and information regarding how to access HCBS services.
- DoHS has disseminated the above two resources to nearly all the PCP offices by HealthCheck specialists as reported in the *January 2024 SAR,* the *WV DoHS Outreach Update 20240105/ Meeting notes from 12.8.24 meeting with Health Check,* and email updates to SME.

Agreement Item 40d. DHHR shall provide families and children with accurate, timely, and accessible information regarding the available in-home and community-based services in their communities.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS created and continues to update the Kids Thrive Collaborative website and meetings.
- DoHS created and has plans to update the *Resource Rundowns.*
- DoHS facilitates the Statewide Family Advisory Board.
- DoHS has prioritized efforts to educate children and families about mental health screenings (for example, through collaboration with MCOs to send reminder cards, and related outreach).
- The CCRL also demonstrates an avenue to provide information to families. For the purposes of the SME Report, the CCRL is not included as an Outreach and Education strategy, because it is considered a treatment service.

Agreement Item 54. As part of its implementation plan described in paragraph 41 above, the State shall develop a plan for outreach and education of stakeholders in the state of West Virginia on the importance of the stated reforms prescribed in this Agreement.

[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS created the *2020-2024 Outreach and Education Plan*.
- DoHS developed and uses the O*utreach and Education Tracker*.
- DoHS has built collaborations across bureaus including with the court system, WV DOE and WV DHS. Evidence of this collaboration includes regular leadership meetings, CIP lunch and learns, and the outreach events documented in the O*utreach and Education Tracker*.

Note: To better represent the impacts of outreach on children and caregivers, the *WVU Evaluation* can focus more on understanding if youth and caregivers are aware of home and community based services specifically in relation to their discharge plan. Further, DoHS can consider interviewing caregivers and children who are familiar with services to determine the most efficacious outreach efforts.

3.11 Workforce

Overview

The Agreement requires the State to create an implementation plan that includes steps to 1. address workforce shortages related to the services under the Agreement, and 2. evaluate the provider capacity needed to address the requirements of the Agreement. Inherent in fulfilling the Agreement is the need to understand current capacity; and to recruit, retain, train, and coach a behavioral health workforce to support WV's vision for reforming its system and delivering services to children and families as outlined in the Agreement.

Throughout the course of the Agreement, DoHS has made significant strides in building workforce capacity. DoHS has invested in the infrastructure to train, coach and assess skills, as with CANS delivery, WF, CMCRS, and BSS. DoHS has partnered with Casey Family Programs to promote practice change among residential providers. Additionally, American Rescue Plan Act (ARPA)-funded initiatives have focused on children's behavioral health (as with trauma-informed trainings for Medicaid HCBS front-line workers). In terms of analyzing the workforce, DoHS created the *Wraparound Capacity Spreadsheet* that tracks individual WFs by bureau, number of children served by each facilitator, and child's county of residence. Finally, DoHS has incentivized and grown the workforce through creating and collaborating on efforts such as 1. The State Loan Repayment Program, 2. Aetna's reinvestment program providing monetary incentives to enhance the provider network, and 3. a master's-level mental health counseling program at West Virginia Wesleyan College.

Achievements and Developments

Regarding **evaluating provider capacity**, DoHS continues to prioritize assessment of the WF workforce. DoHS has plans to address CSED Waiver family therapy and in-home therapy capacity after completing their WF assessment. The *Workforce Plan Updates for SME Compliance-January 2024* details:

- The previous Workforce guiding document, *Plan to Assess Service Capacity & Workforce* was retired, with The *Workforce Plan Updates for SME Compliance-January 2024* replacing that former document as the guiding DoHS Workforce plan.
- DoHS anticipates that a *Wraparound Facilitator Capacity and Caseload Analysis* prototype (that will include FTE status for each WF) will be completed in the first half of 2024. A key step towards DoHS's ability to do this analysis was the initiation of WFs entering data into the CANS data system in March 2023. Currently, DoHS is collaborating with MU and Wraparound providers to address data quality issues. When complete, it is anticipated that the *Wraparound Facilitator Capacity and Caseload Analysis* will allow DoHS to assess WF caseload ratios statewide, by provider and by funding source. This can then be checked against NWI suggestions to ensure fidelity. DoHS will also be able to develop and test algorithms to forecast expected WF capacity needs.

- Following the development of the *Wraparound Facilitator Capacity and Caseload Analysis*, DoHS will complete a provider analysis for CSED Waiver family therapy and in-home family support (anticipated last half of 2024), followed by other services relevant to the Agreement.
- The general steps to DoHS's workforce capacity analysis include: 1. determine data reporting source; 2. complete data quality analysis and validation of data; 3. analyze and review current capacity; 4. develop a forecasting model; 5. estimate workforce demand compared to available workforce, with consideration of geographical needs; 6. determine an action plan to meet workforce needs; and 7. develop report prototypes, including frequency of reporting, for ongoing review and analysis of the efficacy of workforce and provider capacity efforts.
- In terms of ongoing processes, workforce is discussed on a recurring basis as part of DoHS's CQI processes and is an ongoing part of DoHS's collaboration with MCOs, CPAs, and providers. The SME team noted on their site visit to several WV providers in December 2023 that one community provider shared that they feel like there are several avenues to share their concerns with DoHS, through regular meetings. DoHS reports that they have begun evaluating capacity at the county-level to facilitate targeted efforts to address workforce shortages. An example of this is looking at vacancies at the district level and then creating targeted recruitment strategies.

From the provider perspective, there were some conflicting findings regarding workforce capacity. The *WVU Summary Report* focused on Workforce at 2 Years reports that over half (57%) of organizations in the mental and behavioral health system at Baseline and 35% in Year 2 felt they had the capacity to serve the youth for which they received referrals to obtain mental and behavioral health services. At the same time, at Year 2 more organizations (69%) believed that they had adequate staff to meet demand as opposed to at Baseline (41%).

Regarding **addressing workforce shortages** related to the services under the Agreement, DoHS and partners have implemented a range of strategies, such as increasing wages, providing sign-on bonuses, providing increased funding to identified providers and establishing a statewide loan repayment plan.

The January 2024 *Year 5 Implementation Plan* details that Statewide Therapist Loan Repayments were established to incentivize mental health providers to work in WV. By the end of fiscal year 2023, BBH will have granted awards to approximately 60 providers. The incentives provide $35,000 to master-level therapists and $100,000 to psychiatrists and psychiatric nurse practitioners. The third round of awards prioritized applicants whose clinical interests include children's mental health.

The *January 2024 SAR* shares the following data regarding service-specific areas vacancies and retention/hiring strategies:

- Child welfare. Position vacancies have decreased among the workforce, which is integral for completing screenings. There has been a 47% reduction in CPS workers vacancies, from 150 vacancies out of 466 on November 30, 2022, to 79 vacancies out of 458 on November 30, 2023. There has been an 80% reduction in YS vacancies, from 45 vacancies out of 127 on November 30, 2022, to nine vacancies out of 124 on November 30, 2023. Vacancies are

reviewed at the district level to create relevant and targeted recruitment. Some of the recruitment efforts (since December 2022) that have led to the decrease in position vacancies include hiring bonuses, retention bonuses and special hiring rates in select counties.

- CSED Waiver. Twenty-one agencies now provide CSED Waiver services (up from 18 noted in the last SME report), with additional providers currently being on-boarded. DoHS reported that the *WVU Provider Evaluation* found that eight (73%) of CSED Waiver providers reported difficulty with service coverage. DoHS provided additional context that the counties who reported the most difficulties were Cabell, Lincoln, Putnam, Wayne, and McDowell (these are all border counties, which can have workforce challenges due to proximity to neighboring states). DoHS noted that after the completion of the survey, the number of providers in these counties increased, which may alleviate these reported service coverage difficulties. In terms of continually considering CSED Workforce needs, DoHS reports that Quality Committee reviews look at county level data around CSED applications, approvals and utilization. DoHS is in the early stages of understanding the relationships between data sets to inform service demand and provider network gaps.
- Behavioral Support Services. There is one of 10 positions vacant (hiring scheduled for January 2024). As of December 2023, there was a waitlist of 22 children (average waitlist duration is two months). They have developed a triage process that includes 1. sending an initial email with general resources when a BSS application is received, and 2. calling families on the waitlist weekly to assess risk and provide opportunities to connect families.
- CCRL has no position vacancies.
- CMCRS positions are 80% filled. DoHS has looked at vacancies across regions and found that regions 4 and 5 have the most vacancies (50 and 53%, respectively). Activities to address vacancies include a marketing campaign to recruit behavioral health specialists and offering a more competitive salary. DoHS will also provide TA to providers around improving workforce capacity, particularly with the transition to Medicaid State Plan funded services.

AETNA MHP Phase II/III documents share the ways in which Aetna has reinvested money saved into multiple provider and community partner projects, in three phases. Phase II included a reinvestment of $8.5 million, with 19 residential, foster care and shelter providers contractually agreeing to expand their services. Phase III included a reinvestment of $46.6 million. Provider and community partner projects included but are not limited to: 1. expansion of small cottage residential care for youth currently out-of-state, with an emphasis on youth on the spectrum, high acuity trauma, and borderline intellectual functioning; 2. CSED Waiver expansion throughout the state; 3. expansion of TFC, and a foster care recruitment campaign; and 4. expansion of community based-care and aftercare.

The *Application for 1915(c) HCBS Waiver Draft* details how DoHS has expanded the educational qualifications of WFs to allow for people having at least a BA or BS in a human services field, two years post-college work experience in the field, and certification in the on-line case management training. This update will open up a larger potential workforce pool.

Several of the documents submitted to the SME team demonstrate a high level of care and thought within the WV workforce. The *CSED Public Comment Log* raised provider and community concerns related to the CSED Amendment submitted (*Application for 1915(c) HCBS Waiver Draft).* The level of detail put into these comments demonstrates how thoughtful and dedicated the WV workforce is to build the most effective workforce possible. Of note, there were several concerns raised around reimbursement and provider pay, including concerns around: 1. the average costs per unit being low; 2. CSED Waiver therapists inability to bill for attending POC meetings; and 3. confusion around whether rates have decreased or not. Salary was also raised as an important factor in impacting staff recruitment in the *WVU Summary Report* focused on the Workforce at 2 Years. Relatedly (as mentioned in the Residential Reductions chapter), RMHTF providers gave feedback about the new residential models in several memos with concerns around the impact that plans to remove residential levels of care would have in terms of needing to re-tool their services through these new models. These examples highlight not only the dedicated WV workforce, but also the importance of engaging the workforce in shared decision making.

Regarding **staff training**, there are a few general updates around Person-Centered Trauma Informed Care, and WVU evaluation findings. Service specific training updates are highlighted in relevant chapters.

The *Year 5 Implementation Plan* details how WVU supported the integration of a Person-Centered Trauma-Informed Care (PCTIC) approach for Medicaid HCBS frontline health staff as part of the ARPA funded initiatives. These initiatives are an important investment to support home and community-based workers. WVU reported in September 2023 the PCTIC program trained 45 HCBS personnel as trainers in person-centered trauma-informed care practices. WVU will continue this work through September 2024 with a focus on training up to 500 direct care workers and up to 35 new PCTIC certified trainers.

The *WVU Summary Report* focused on the Workforce at 2 Years reflected that most providers agree with the statement that they have the necessary training to function in their current role, and this sentiment increased from the Baseline sample.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 41d. DHHR shall create an implementation plan that describes the actions it will take to. . . Address workforce shortages relating to services under this Agreement.
[Substantial Compliance]

DoHS has demonstrated substantial compliance in the following ways.

- DoHS established the State Loan Repayment Program initiative.
- DoHS is in the process of amending the CSED 1915(c) waiver to include a four-year degree (BA or BS) in a human service field with one (1) years' post graduate experience in a related field and certification in the on-line case management training developed by BMS OR may

be an individual with a two-year degree (Associates) in a human service field with two (2) years post graduate work experience to enter the WF workforce.

- Aetna has made reinvestments in relevant programs and initiatives, including contributing to the establishment of the Masters in Mental Health Program at West Virginia Wesleyan College, along with Community Care of WV.
- DoHS has built in regular CQI processes to discuss regional vacancies and determine recruitment strategies (such as raising salaries and offering bonuses).

Agreement Item 41e. DHHR shall create an implementation plan that describes the actions it will take to. . . Evaluate the provider capacity needed to address the Agreement.
[Partial Compliance]

DoHS has made significant gains in this area. The creation of the *Wraparound Capacity Spreadsheet* demonstrates an in-depth look at providers by bureaus, counties, and caseload. The SME recognizes that DoHS is taking this a step further now by evaluating FTE to give a more accurate picture of capacity. WV is also prioritizing workforce service areas. After addressing Wraparound, DoHS plans to address CSED Waiver family therapy and in-home family therapy. Because these are two of the most popular CSED Waiver services, , the SME agrees that this is a good area to prioritize. (For additional information see the CSED Waiver section.)

The following activities are recommended to achieve substantial compliance.

- DoHS can complete the *Wraparound Facilitator Capacity and Caseload Analysis.* In completing this analysis, DoHS will demonstrate their ability to use the capacity analysis to evaluate provider capacity and then this can be a prototype for studying other workforce areas.
- The SME agrees with DoHS's decision to retire their former *Plan to Assess Service Capacity & Workforce.* However, in its stead DoHS must demonstrate that they have a comprehensive implementation plan to evaluate provider capacity. The seven steps that were included in the *Workforce Plan Updates for SME Compliance-January 2024* are a good outline. DoHS can now add to this to show a more fleshed out implementation plan. This can be informed by the completion of the *Wraparound Facilitator Capacity and Caseload Analysis.* Specific suggestions around fleshing this out include:
    1. Step 3 (analyze and review current capacity) could be a place to insert how WV is including/will include provider voice to inform the capacity analysis.
    2. For step 5 (estimate workforce demand compared to available workforce, with consideration of geographical needs), it will be important to include ways in which WV can accurately determine demand based on best practices. For example, while the average CSED Waiver monthly family therapy provision is currently five hours in practice, DoHS needs to develop a strategy for anticipating the CSED Waiver workforce based on best practice.

3.12 CSED Waiver

Overview

The CSED Waiver is a Medicaid-funded program. It provides HCBS (using the Wraparound care coordination model developed by NWI) to children and youth aged 3 to 21 with a SED. The CSED Waiver prioritizes children with SED who are in residential treatment facilities, or Medicaid-eligible and at risk of institutionalization. As related to the Agreement, the CSED Waiver addresses provisions related to: 1. in-home and community-based services being delivered at times and locations mutually agreed upon by the provider and the child and family; 2. timely service provision; 3. family support and training services; and 4. in-home therapy.

Throughout the course of the Agreement, DoHS has made significant strides in establishing the CSED Waiver program. Since CSED Waiver inception in 2020, each subsequent *Semi-Annual Report* has demonstrated a rise in the number of CSED waiver enrollees. The five-year renewal for CSED Waiver was secured in 2023, extending the service through January 2028.

Achievements and Developments

The *January 2024 SAR* demonstrates that **DoHS has successfully established the CSED Waiver program**, as applications processed, approved applications and utilization continues to grow.

Table 6: CSED Waiver Applications and Enrollees Comparisons: Second Half of 2022 and First Half of 2023

	July-December 2022	January-June 2023
Applications processed	976	1,313
Approved applications	609 (62.4 %)	851 (64.8 %)
Number of children enrolled	597	810

The *January 2024 SAR* also includes analysis looking at the outcomes of CSED Waiver participants. DoHS reported that youth utilizing CSED Waiver services were the least likely to visit the ED for mental health reasons (between Q4 2022-Q2 2023) at 10 % of that population, compared with 19% of at-risk youth and 12.7% of youth who had ceased participation with the Assessment Pathway. DoHS also reported that children who began participating in CSED Waiver services during Q4 2022 had fewer RMHTF admissions than at-risk youth and those who ceased participation in the Assessment Pathway application process; with youth ceasing participation in the Assessment Pathway having twice the incidence of rate of admission to an RMHTF in the quarter following engagement in the Assessment Pathway compared to youth utilizing CSED Waiver services (7.1 % and 3.4 %, respectively).

DoHS continues to make improvements to the CSED Waiver program, as with their latest 1915(c) waiver amendment that includes a rate structure update for WF to a per member per month reimbursement, removal of geographic exclusion language to increase access to care and strengthening

existing language regarding the coordination and responsibilities of the child and family treatment team (*Application for 1915(c) HCBS Waiver Draft).*

In terms of the four areas of the Agreement specific to the CSED Waiver program, DoHS progress is detailed below.

Regarding in-home and community-based services being delivered at times and locations mutually agreed upon by the provider and the child and family, data was included from the Childrens Mental Health Evaluation, with questions related to satisfaction with, and barriers to meeting times and locations, such as "The locations of behavioral or mental health services were easy to get to for me." However, there is no question that specifies that times and locations were *mutually agreed upon*, and responses to questions are not delineated by particular service areas (e.g. CSED Waiver), limiting the ability to determine mutually agreed upon meetings by service area.

DoHS continues to demonstrate efforts to improve **timeliness** of CSED Waiver services. The main challenge is awaiting the data store expansion to enable alignment of child-level data across systems and services. The *January 2024 SAR* shares the following information and data:

- The average number of days from CSED Waiver application to eligibility determination in quarter one of 2023 was 34, and 36 in quarter two of 2023 (quarter three of 2022 was 42 and quarter four of 2022 was 36). The *CSEDW Application Process Flow and SOP Draft* provides a process flow for enrollment into the CSED Waiver program and demonstrates how, after the CAFAS/PECFAS score is determined to be over 90, a request is made for an interim WF assignment. This is an important process to ensure that applicants are receiving services while waiting for application determination (data is not yet available on these interim services). In the *January 2024 SAR,* DoHS noted that since early 2022 the transfer of children from interim Wraparound services to CSED Waiver services led to a significant decrease in BBH-funded Wraparound facilitation. DoHS will continue to monitor the data around interim Wraparound services and whether action is needed.
- BMS and the OQA are collaborating with Aetna to enhance data of CSED Waiver participants placed "on hold" (for reasons including a family/legal guardian request or participant is in a BJS facility, emergency children's shelter or an inpatient hospital setting). Aetna provides DoHS with monthly updates regarding this data, but they are still ironing out data quality issues.
- DoHS anticipates the *July 2024 SAR* will provide more detailed data about the timeline to CSED Waiver service start. The DoHS's Quality Committee reviewed the timeline to service access in the *November 2023 QC Slide Deck* and identified concerns with data quality (such as missing data) and a fleshed-out analysis of the "on hold" population. To address these issues, program leaders are meeting with relevant providers to clarify data entry expectations, and Aetna is working on the "on-hold" data. Timeliness data will be revisited in DoHS's 2024 quarterly committee reviews.

DoHS continues to monitor the **average hours of service provision per child**, which has remained relatively consistent as previous reports. WF, **family support and family therapy** were the services with highest utilization within CSED Waiver. The *January 2024 SAR* shares the following data:

- Aetna is responsible for ensuring that an individual's POC is reflected in the services received. Aetna does so by: 1. reviewing all POCs to ensure that they address an individual's goals and needs; 2. periodic reviews of individuals' claim histories to ensure that they are consistent with POCs and address any barriers to receipt of care that are identified; 3. meeting with WFs quarterly to discuss CSED Waiver participants' progress; 4. meeting monthly with BMS to provide updates; and 5. providing a monthly report regarding the number of CSED Waiver enrollees whose plans of care are comprehensive.
- Relatedly, at the SME site visit to WV community providers on December 4-5, 2023, one provider reported that it was a hindrance to work with Aetna care managers due to waiting to get the POC approved prior to delivering services and in general feeling like the addition of Aetna care managers adds an extra layer of unneeded oversight. This was also brought up in the *CSEDW Public Comment Log* on page 27: "Plan of Care continues to be a barrier with Aetna approval time and the amount of time the facilitator is putting on revisions." The *January 2024 SAR* noted that BMS leadership meets one-on-one with CSED Waiver providers to complete a needs assessment with the agency and address any barriers or needs. This may be an avenue for providers to express concerns such as the above one regarding Aetna care managers.
- The average number of hours of monthly services for CSED Waiver participants was ten in January-June 2023. Highest utilization included WF (average of 5.0 hours per month per child), family therapy (average of 5.2 hours per month per child), and family support (average of 4.2 hours per month per child). The *July 2023 SAR* provides an analysis of utilization of CSED waiver services by CAFAS score (90-130 vs 140+) and months in the CSED waiver program (0-3, 4-6, 7-9, 10-12, 12+). CSED Waiver participants received more hours of service per month if they had a 140+ CAFAS score at all the different time points. Both the 140+ group and 90-130 group had the highest service utilization in months 0-3, with declines in each subsequent 3-month group. These analyses may reflect that children with higher levels of need get more services. They may also reflect that services decrease over time, as children are more stabilized.
- The *CSEDW Public Comment Log* raises an important point on page three: while WV requires an evidence-based therapeutic approach, "no approach is named nor is a policy for approval of the approach outlined."
- The *CSEDW Public Comment Log* also raises an important point about the $1,000 cap per year for assistive equipment plus specialized therapy. This is insufficient over the course of a year, even if no assistive equipment is needed.

Ratings and Recommended Activities to Reach Compliance

Agreement Item 26. In-home and community-based services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family, where applicable), to assist the child in practicing skill development in the context of daily living.

[Partial Compliance]

The following activities are recommended to achieve substantial compliance.

- Continue to monitor feedback and next steps from the results of relevant questions in the WVU Children's Mental Health Evaluation.

Agreement Item 28. DoHS shall ensure the timely provision of mental health services to address any immediate or urgent need for services. Such services will be provided through consultation with the child and family (or foster or kinship parent, where applicable) and include needed in-home and community-based services and linkage to other service providers.

[**Partial Compliance]**

The following activities are recommended to achieve substantial compliance.

- DoHS can provide data around interim services that youth receive while awaiting CSED Waiver services, thereby demonstrating that applicants receive services while awaiting eligibility determination.
- DoHS can provide enhanced data looking at child-level data across systems
- Report updated information regarding CSED Waiver participants "on hold" and reasons for hold. DoHS mentioned they will be looking at this data at quarterly QC meetings.

Agreement Item 37a. Family support and training services that provide education and training for the child's family (or foster or kinship care, where applicable) about the child's condition and how the family can best support the child in the home and community.

[Partial Compliance]

DoHS has demonstrated partial compliance by consistently providing utilization data in each *SAR* that demonstrates that family support training is utilized by CSED Waiver participants. In addition, their analysis of CSED Waiver hours by acuity and time demonstrates that they are looking at how CSED service provision might differ based on the severity of child's needs and how long they have been in treatment. However, it remains difficult for the SME to determine whether the family support provides the necessary education and training, and whether children and families with the identified need for these services receive it. As such, the following activities are recommended to achieve substantial compliance.

- DoHS can provide documentation that reflects the role of Aetna in providing quality assurance regarding CSED Waiver POCs. This could include the monthly reports that Aetna provides regarding the number of CSED Waiver participants whose POCs are complete/incomplete and a summary of the points of discussion/challenges from monthly Aetna and BMS meetings.

- This Agreement item can be assessed through the *WVU evaluation* by asking additional and specific questions to directly capture compliance with it.
- One way to address whether children and families with need receive the services is to conduct a case review of a random selection of CSED waiver participants to review whether services provided are reflective of plans of care.

Agreement Item 37c. In-home therapy that provides a structured, consistent, strengths-based therapeutic relationship between a licensed clinician, the child, and family (and foster or kinship care family, where applicable) for the purpose of effectively addressing the child's mental and behavioral health needs.
[Partial Compliance]

DoHS has demonstrated partial compliance by consistently providing utilization data in each *SAR* that demonstrates that family therapy is utilized by CSED Waiver participants. However, it remains difficult for SME to determine whether the therapy is "structured, consistent and strengths based. . . for the purposes of effectively addressing the child's mental and behavioral health needs," and whether children and families with the identified need for these services receive it.

The following activities are recommended to achieve substantial compliance.

- DoHS can enunciate their policy/approach as to how they are supporting providers to deliver EBPs (to reinforce their stated requirement that therapists should use an evidence-based approach). By creating a policy/approach around supporting providers to deliver EBPs, they will demonstrate investment in building the infrastructure to support therapists to provide effective therapy. For example, potential approaches are 1. using the Aetna monthly meetings or the monthly one-on-one meetings between BMS and CSED Waiver providers to discuss and train on EBPs, or 2. accessing the evidence-based therapeutic approaches offered through the Family First plan, as through Functional Family Therapy (FFT).
- DoHS can provide documentation that reflects the role of Aetna in providing quality assurance regarding CSED Waiver POCs. This could include the monthly reports that Aetna provides regarding the number of CSED Waiver participants whose POCs are complete/incomplete and a summary of the points of discussion/challenges from monthly Aetna and BMS meetings.
- This Agreement item can be assessed through the *WVU evaluation* by asking additional and specific questions to directly capture compliance with it.
- One way to address whether children and families with need receive the services is to conduct a case review of a random selection of CSED waiver participants to review whether services provided are reflective of plans of care.

4. Conclusion

DoHS continues to progress on meeting the Agreement requirements, including expanding and enhancing the availability of HCBS mental health services to work toward the ultimate goal of reducing reliance on residential placement. The SME noted several strengths in this report, including statewide availability of ACT, crisis system and sustainability developments, enhancements to the data store as well as the capacity to continually use data to drive decisions about the service array, an increased focus on the child and family experience, and improvements in the assessment process, highlighting a "no wrong door" approach. The recruitment of foster homes, particularly those for older youth and youth with high SED needs, for both diversion and discharge from RMHTFs, is critical to achieving the census reduction aim. To sustain its achievements and reach substantial compliance on the remaining Agreement items, WV can continue to work on the overarching issues of increasing timely access to services, ensuring quality of services and fidelity to models, and continuing to grow and refine the collection and use of high-quality data.