CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Reporting Period: July 2023 – December 2023

Trend Review Period: July 2022 – December 2023

When kids and families thrive, West Virginia thrives.

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Assurance for Children's Programs

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Acknowledgments

This report, and the progress it summarizes, would not be possible without the hard work of individuals within the West Virginia (WV) Department of Human Services (DoHS), in collaboration with its key partners, who are dedicated to improving the lives of children and families.

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Thank you, "WV team", for all you do and continue to do.

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1.0 Executive Summary

The WV Department of Human Services (DoHS)[1] continues diligent efforts to reform mental and behavioral health services for children with serious emotional disorders (SED) and their families across WV. Since 2019, DoHS, in collaboration with community partners and stakeholders, has built on the existing system frameworks and established new processes, services, and pathways to:

- Identify children's mental health needs
- Provide families with timely and smooth connections to services
- Transition children currently placed in residential settings back to their family homes or other less-restrictive settings

Implementation of the Children's Crisis and Referral Line (CCRL) in October 2020 created a resource for children and families in crisis to access needed support and created an avenue for anyone seeking information regarding available services and supports. The CCRL is available 24 hours per day, seven days per week, with calls answered within 13 seconds, on average.

In October 2021, DoHS implemented the Assessment Pathway,[2] creating a "no wrong door" approach to streamline and facilitate access to assessment and connection to home and community-based services (HCBS) for children and families. As part of this process, children and families are assessed for, and given the option of, applying for the Children with Serious Emotional Disorder (CSED) Waiver, which offers treatment and supportive services in the home and community-based setting, including Wraparound Facilitation services for children with SED. The CSED Waiver is one of three funding sources for the WV Wraparound program which also includes Wraparound Facilitation services covered via the Bureau for Behavioral Health (BBH) and Bureau for Social Services' (BSS') Safe at Home program. The Wraparound Facilitator in partnership with the care team has the primary role of identifying needs and connecting children and families with resources and services, essentially helping to ensure they are "wrapped" in the supports needed to improve their outcomes. Services are considered one WV Wraparound to allow continuity and consistency in care for children and families and to help align processes for providers.

The Assessment Pathway also offers families the opportunity to connect with other HCBS, such as Behavioral Support Services, Assertive Community Treatment (ACT), and other locally available services to meet their needs. These significant enhancements to the children's mental health system over the past several years remain in the implementation and monitoring phase

[1] On January 1, 2024, the West Virginia Department of Health and Human Resources (DHHR) became the WV Department of Health (WVDH), WV Department of Human Services (DoHS), and WV Department of Health Facilities (DHF). Under this new structure, the Office of Quality Assurance for Children's Programs, Bureau for Behavioral Health (BBH), Bureau for Medical Services (BMS), and Bureau for Social Services (BSS) now operate under the WV Department of Human Services (DoHS). The Bureau for Public Health is now part of the WVDH. Given the bureaus primarily involved in this work, this report will refer to DoHS for time periods before and after the transition.

[2] The Assessment Pathway is the term used to describe the Pathway to Children's Mental Health Services, which connects children and families to additional evaluation and referral to home and community-based services.

as DoHS assesses the efficacy of this system through continuous quality improvement (CQI) efforts.

DoHS's CQI strategy incorporates input from service- and child-level data as well as feedback from providers, facilities, youth, and their caregivers to advance and strengthen current systems through collaborative, strategic and timely decision-making, and action. By focusing on mental health services and the children in need of them, DoHS strives to build and sustain a system that enables children to remain and thrive in their homes and communities while receiving necessary mental health treatment, as clinically appropriate.

DoHS also aims to help ensure children with clinical necessity for residential mental health treatment facility (RMHTF) services can access them in a facility in-state, or as close to their community as possible, and that these children have effective discharge plans in place—incorporating family needs and input—to allow the child to reacclimate quickly to the family setting once treatment is completed.

The purpose of this report is to capture the results of DoHS's ongoing, collaborative quality reviews and recommended next steps based primarily on service data for the period July 2023 to December 2023, including utilization trends for the period July 2022 to December 2023, with some exceptions for newly implemented services.

1.1 Summary of Key Results, Accomplishments, and Next Steps

DoHS has identified an increased need for mental health services post-pandemic, while also observing increased awareness and utilization of the state's HCBS. DoHS remains committed to a CQI approach that allows detailed insight into the strengths and needs of the children's mental health system to inform both the department and key partners. The ability of the Department to leverage cross-systems analyses and collaborate across bureaus as well as with external departments and stakeholders has enabled opportunities for collective growth and advancement in missions and goals for improved services and outcomes for children and families.

DoHS's enhanced children's mental health system maintains a trajectory of improvement and growth to continue helping families thrive. Recent highlights include:

- More children are using WV Wraparound services compared to RMHTF
- Children are increasingly connected to services and supports throughout the assessment and service journey
- Enhancement of data quality, collection, and review resulting in an improved understanding of children served and expanded opportunities to identify and address needs of children and families with SED, with a focus on early intervention
- Focused review and strategic planning to mitigate and address discharge barriers and ensure HCBS are in place for children ready for discharge from RMHTF
- Increasing outreach and development of relationships with key partners, such as the court community, Bureau of Juvenile Services (BJS), and Probation Services, who are key influencers in connecting children and families to needed services

- Expansion of services for transitional age youth, a group of individuals identified as needing additional HCBS so they could be served in the community rather than in RMHTF settings
- Amending the CSED Waiver to enhance workforce, provider reimbursement and sustainability, quality, and timely access to services; the number of children accessing these critical services continues to increase
- Launching the "West Virginia Needs You Now" Campaign in March 2024 for focused recruitment of foster homes willing to accept teenagers and youth with complex mental and behavioral health needs; early results show a significant increase in inquiries from potential foster families
- In partnership with Casey Family Programs, Building Bridges Initiative, and residential provider, DoHS continues to make progress on new models of care to better support the needs of children whose acuity requires residential treatment

WV's effective CQI processes allow the Department opportunities to explore and understand its systems in ever-evolving manners with increased levels of sophistication, which allows further opportunities to identify needs and strengths within the layers of this system. A summary of key results, accomplishments, and next steps is included below. Further details and additional topic areas are included in the body of the report.

1.1 (a) Evolving Mental Health Need: In order to improve understanding of the evolving mental health needs for WV children, DoHS, in partnership with WVU Health Affairs Institute (HAI), has begun exploring ESSENCE data[3] for surveillance of mental health needs via emergency department (ED) visits for children 21 years old and younger. The following key changes identified with ED visit trends comparing pre- and post- pandemic periods demonstrates the significant increase in mental health needs of children following the pandemic.

- As the Covid-19 pandemic era was ending, the percentage of mental health visits to the ED increased sharply from the last half of 2022 (8.3%) to the first half of 2023 (11.4%), a percent increase of 37%.
- Conversely, the number of visits between these two periods for *all* ED services, regardless of visit type, *decreased* by 1% (n = 197,642 visits in the last half of 2022 down to n = 195,271 in the first half of 2023), while the number of mental health visits *increased* by 35% (n = 16,431 to 22,232).
- Comparing pre-pandemic to post-pandemic periods, there was a more gradual increase in the percentage of ED visits with an associated mental health diagnosis: 8.6% of ED visits in July to December 2019 had an associated mental health diagnosis, compared to 10.9% of ED visits in July to December 2023, a 27% increase.

[3] ESSENCE is also known as the Electronic Surveillance System for the Early Notification of Community-based Epidemics, part of the National Syndromic Surveillance Program.

- The anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders (International Classification of Diseases (ICD) codes: F40 – F49) category of diagnoses demonstrated an overall trend upward in their proportion of visits from the last half of 2019 to the last half of 2023 (2.6% to 3.7% of total ED visits; approximately 7,400 visits July to December 2023 compared to approximately 4,300 visits July to December 2019). *This category of diagnoses (e.g., anxiety disorders) appeared to be the biggest driver for the increase in the proportion of mental health visits to the ED.*
- Pervasive and specific developmental disorders (ICD codes: F81 – F89) increased by 59% from the last half of 2019 to the last half of 2023 (0.74% to 1.18% of total ED visits; n = 1,227 to 2,337 visits).
- The proportion of ED visits with behavioral syndromes associated with physiological disturbances and physical factors (ICD codes: F50 – F59; e.g., eating disorders) increased by 78% from the last half of 2019 to the last half of 2023. Visits with these diagnoses more than doubled from pre- to post-pandemic time periods (0.06% to 0.13% of total ED visits; n = 101 to 262 visits).
- The RMHTF average monthly point-in-time census[4] also increased sharply from the last half of 2022 to the first half of 2023, with the average census going from 800 to 842, a 5.3% increase.
- Given the large increase in the percentage of mental health visits in the ED during this time, it might be expected that the need for RMHTF services would increase. *However, the substantial efforts associated with broad implementation of the Assessment Pathway and expanded availability of HCBS, including CSED Waiver services, has likely assisted with mitigating similarly sharp increases in RMHTF utilization.*

Conclusions and Next Steps: Based on the results presented above, WV's existing HCBS already appear to be helping divert children from unnecessary RMHTF placement, given the lower increased rate of RMHTF census compared to the steep rise in ED visits. Results will be shared with key stakeholders for strategic planning purposes. DoHS will also begin monitoring ESSENCE data regularly to assess potential changes in mental health needs over time and to inform and educate providers and families on how to access services that are in alignment with increasing needs, based on the symptomatology of emerging disorders.

1.1 (b) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screening:

DoHS's goal is to reach at least 52% of Medicaid-eligible children annually with EPSDT screening including a mental health component to support early identification of mental health needs and connection to services. There has been improvement in the estimated proportion of

[4] This value is calculated as the average monthly point-in-time census as of the first day of the month for each period with the exception of January to June 2019, which includes only the average of the last three months of the period due to data quality concerns for the earlier half of that period.

Medicaid-eligible children who receive an annual EPSDT screening[5] with a mental health component, with 44% screened as of the end of March 2021 compared to 47% at the end of December 2023, a percentage increase of 7%.

Conclusions and Next Steps: DoHS is already making significant efforts to improve screening rates for wellness visits, as shown by the increased rate since 2021. To increase the rate of EPSDT screenings with mental health screening components further, the HealthCheck program will maintain outreach to providers who are not incorporating this screening in 2024 to provide education and offer technical assistance for integration into their regular practice for wellness visits, with an emphasis on youth in the key age category of nine - to 17-years-old. The Bureau for Medical Services (BMS) will also continue to collaborate with Managed Care Organizations (MCOs) to assess impacts of outreach to families and adjust planning and actions accordingly.

1.1 (c) Assessment Pathway: Overall referrals to the Assessment Pathway reached an all-time high (n = 397) in December 2023 following a successful outreach campaign during that time as well as networking efforts with professionals in the education, social work, and counseling community in fall 2023.

- This represents a 99% increase year over year in referrals since December 2022 (n = 199).
- Unique family-driven referrals to the Assessment Pathway—representative of children referred from the MCO, a family, a Primary Care Provider (PCP), the CCRL, or the mobile crisis team—have decreased over the last year from December 2022 (n = 71) to December 2023 (n = 36).

Conclusions and Next Steps: Increased referrals to the Assessment Pathway demonstrate that a growing number of individuals understand how to engage with the system. Higher referral volume also creates additional opportunities for children to access services and families to receive support while navigating the application process. DoHS's CQI plan includes a review of referral sources to identify opportunities for earlier intervention. Increasing and maintaining family-driven referrals helps ensure families are aware of and feel empowered to access services. Early intervention can also help prevent imminent risk of residential placement or other systems-level involvement (e.g., child welfare, probation, Division of Corrections, and Rehabilitation-BJS).

- Focus on increasing family-driven referrals will be largely geared toward marketing efforts completed by the CCRL vendor, First Choice Services.
- BBH will collaborate with First Choice Services to strategize next steps for marketing and increase awareness and ease of access for families.

[5] Note this percentage is calculated based on methodology included in section 7.0 Screening which considers if children meeting eligibility at the end of each quarter have had an annual well-child visit in the past 14-months, giving flexibility for scheduling related needs and requirements related to time between claims.

1.1 (d) County-level Detailed Analysis and Comparisons: DoHS is completing a detailed review of a subset of "high-need" counties to prioritize outreach and intervention efforts. Counties were considered "high need" if they met or exceeded a threshold of 12 or more admissions as well as an average RMHTF utilization (census) rate of four or more per 1,000 youth from January to June 2023. Out of 55 counties, four met both criteria: Harrison, Wayne, Wood, and Kanawha.

Conclusions and Next Steps: The detailed county-level review provides DoHS and stakeholders with a unique opportunity to understand county-level influences across many service types simultaneously, enhancing the Department's understanding of local-level needs and strengths. More specifically, this analysis will also identify cross-systems needs at the county-level, such as needs surrounding awareness of HCBS, concerns around service capacity, or potential impacts of placement-driven decision-making—utilizing the "outdated thinking" that a child *must* be in a facility to be treated for mental health needs. DoHS strives to shift decision-making across key stakeholders to a needs-driven approach—which accounts for the needs of the child and family, and the availability of supports and services to meet those needs—through processes for objective clinical assessment, such as the Qualified Independent Assessment (QIA) and Assessment Pathway.

1.1 (e) Early Connection to HCBS and Related Outcomes: As part of the expansion of accessibility of HCBS, the Assessment Pathway has enabled children and families to be connected to services and supports, while also reducing the burden of navigating the mental health system.

- Of children who went through the Assessment Pathway, applied for CSED, and were approved, 83% received Medicaid claims-based HCBS[6] following eligibility determination, compared to only 60% receiving HCBS documented in Medicaid claims within 90 days *prior to* submitting an application.
- Further demonstrating the association between the Assessment Pathway and connection to HCBS for mental health needs, 93% of these children had a Medicaid claims-based HCBS in place at some point from the time of application to the end of March 2024.
- RMHTF admissions and ED utilization incidence was also reviewed for this cohort. Approximately one in 12 (8%) of the children within this cohort had an ED visit within the period between submission of an application to the CSED Waiver and CSED Service Start Date, CSED Roster Discharge Date, or March 31, 2024 (whichever came first).
- Nearly one in four (23%) children in the approved CSED application cohort were admitted to an RMHTF facility between the time of application submission and the end of March 2024. This time frame equates to the rate of RMHTF entry within approximately

[6] Note services are received based on the family's "voice and choice". Some families may decide not to engage with services until wraparound can be put in place. Another reason for not having services documented could be related to receiving HCBS such as grant covered programs which would not be represented in this analysis.

one year of application[7]. It is expected that some children will require RMHTF placement based on need.

- DoHS compared children in this cohort who went on to receive CSED services with those who did not, and how receipt of services may have influenced outcomes. Of the children approved for CSED but who did not receive CSED services, 26% had an RMHTF placement during the period compared to 18% of children who did receive CSED services.
- The difference between RMHTF placement rate was even more compelling for children with a Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) score 90 – 130, as 12% of the children receiving CSED went on to be placed in a RMHTF compared to 21% of children who did not receive CSED services.
- There were only slight differences for children with CAFAS 140 and above. This may be expected given the higher acuity of need, which for some individuals may necessitate RMHTF placement as the child's least-restrictive setting at the time.
- A relative risk calculation for RMHTF placement was explored and yielded meaningful results[8] for children in this cohort. Children with CAFAS <140 and no CSED service utilization had an 80% higher risk for RMHTF placement compared to children with CSED service utilization.
- For the total cohort of children, regardless of CAFAS score, children who were documented as having no CSED service utilization had a 45% higher risk for RMHTF placement compared to children with CSED service utilization.

Conclusions and Next Steps: These results are positive and demonstrate some of the connections made to services and supports for families that access the Assessment Pathway and opportunities to allow children to remain in an appropriate level of intervention. Future analyses are needed to understand the broader scope of services youth are connected to and volume of services needed to influence positive outcomes.

- It is suspected that children interacting with the Assessment Pathway may have protective factors that would help prevent RMHTF placement when avoidable, such as awareness of the CCRL or Children's Mobile Crisis Response and Stabilization (CMCRS) services, or connection to other available HCBS.
- DoHS plans to explore additional comparison populations for future analyses to understand further risk and protective factors influencing WV children's outcomes.

[7] Note this is for children approved for services, but not all of these children and families decided to continue on to utilization of the CSED Waiver.

[8] See Section 8.0 Pathway to Children's Mental Health Services for additional details on this analysis and caveats of statistical significance.

1.1 (f) WV Wraparound: The number of children enrolled in WV Wraparound[9] services (an intensive HCBS) is now nearly double the number utilizing RMHTF services, 1,649 children in WV Wraparound as of December 2023 compared to 851 in RMHTF as of January 1, 2024.

- The number of children using CSED Waiver services increased 6% in the second half of 2023, with 877 unique children receiving services during the period compared to 826 unique children in the first half of 2023. While the growth rate has slowed compared to prior periods, more children continue to be supported in the community with these critical services.
- Frequent review of data and care coordination among Wraparound program leads, Aetna[10], and providers have continued to help keep waitlist numbers low in comparison to demand. As of the week of June 28, 2024, waitlist numbers were as follows: CSED Waiver (23), BBH Interim Wraparound (56), and Safe at Home (SAH) (3).
- Given family choice of provider and periodic staffing challenges among providers, some level of waitlist might be expected.

Conclusions and Next Steps: The number of youth utilizing WV Wraparound, an intensive HCBS, exceeding the RMHTF census is a remarkable milestone in DoHS's efforts to improve children's access to HCBS. This utilization reduces the reliance on residential placement and empowers children to remain with their families and receive services in their communities when clinically appropriate. Wraparound Facilitation capacity will continue to be an area of focus for DoHS and its partners, given the critical role Wraparound Facilitators play in connecting children with HCBS.

1.1 (g) CSED Hourly Service Utilization: Families accessing family therapy through CSED services increased approximately 5% while maintaining an average of five hours per child per month for this service alone.

- Most children with family therapy provided via CSED services receive therapy on average at least once per week, with some receiving therapy more frequently.
- Children receiving family therapy via the CSED Waiver represented 74% of youth receiving CSED services during the six-month period (children are also able to receive community-based therapy with a non-CSED Waiver provider should they choose to do so). Services provided outside of the CSED Waiver provider network are not included here.
- One out of every four families served from July to December 2023 (25%, n = 219)

[9] WV Wraparound services include services funded through BBH's Children's Mental Health Wraparound, BSS's Safe at Home, and BMS's CSED Waiver. Services are designed to align with National Wraparound Initiative high fidelity standards regardless of source of funding and meant to be seamless to the family when a change in funding source is needed.

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

utilized family support services, with the average family served receiving services at least once a week. A total of 76 families utilized in- or out-of-home respite care, averaging a combined total of 21 hours over the six-month period, or 3.5 hours a month.

Conclusions and Next Steps: Monitoring service utilization allows DoHS to understand needs and utilization patterns for providers and children enrolled in CSED. Reviewing this information helps ensure service volume, type, and intensity meet the expected needs of the children receiving them, including children with SED. BMS and Aetna will continue to collaborate with providers by providing technical assistance regarding implementation of plans of care that are specific to the needs and strengths of the child and family, as well as ensuring claims are documented for the full range of services rendered. In efforts to ease the documentation burden on providers and encourage service delivery BMS was granted an amendment to the CSED Waiver to implement a per-member-per-month rate which will set a threshold for minimum services and allow increases in reimbursement based on this strategy, which is also designed to increase sustainability and capacity of the program over time.

1.1 (h) Behavioral Support Services: West Virginia University Center for Excellence in Disabilities (WVU CED) provided Positive Behavior Support (PBS) services to 146 children from July to December 2023, a 31% increase from the first half of 2023 (n = 111).

- The WVU CED team that provides PBS services meets monthly to discuss best practices and creative solutions to support children whose diagnoses and other characteristics culminate in especially challenging cases.

Conclusions and Next Steps: WVU CED continues to be an important asset to WV's array of HCBS as well as an important resource for support and consultation for identifying creative solutions to help support children with intensive needs. The expanding behavioral support service certified provider network also continues to be an opportunity to increase the number of families able to be served statewide. State Plan Behavioral Support Services data was unavailable at the time of report; process changes to collect data via claims is still underway but expected to be implemented with policy change by early 2025, with consideration for claims data lag and provider training.

- The process change will include a modifier code that will identify Behavioral Support Services provided to Medicaid and WV Children's Health Insurance Program (WVCHIP) members via paid claims.
- Behavioral Support Services training certification has continued throughout 2024. A needs assessment is currently being conducted to further assess areas for focus.

1.1 (i) CCRL: Implementation of children's crisis services and expanding referral and stabilization opportunities have been pivotal in providing a full continuum of supports for families. While overall, there were only 494 total calls to the CCRL in July to December 2023, a 36% decrease from the previous reporting period (771 calls from January to June 2023), some decreases may be expected given growing utilization of the State's 988 mental health call line.

Conclusions and Next Steps: The CCRL's sister call line, 988, which is also operated by First Choice Services, experienced a doubling of calls for people of all ages in 2023. Data for the 988 call line specific to the 0 to 20 age group will be compared with the CCRL in the future to understand impacts on overall call volume and shifts in utilization. This review will also help ensure consistency and training in cross-referral practices among First Choice Services staff. BBH continues to work with First Choice services to ensure processes are in place to allow children and families to be referred and connected to appropriate services regardless of which call line is utilized.

- Implementation of the Medicaid SPA expanding mobile response services may impact needs significantly and influence next steps with training for CMCRS services. Although there is still work to be done to further build-out this piece of the system, enormous opportunity exists to expand access to this critical service given the security of Medicaid claims-based[11] funding for children who are eligible, and continued grant funding for those who are not.
- Epi Info, the system that collects CMCRS data, underwent substantial updates during this period; therefore, data for CMCRS services included in the body of the report is considered preliminary. More frequent data review is planned in the last half of 2024 for BBH-funded CMCRS, including on the provider-level, to understand potential gaps in data completion and areas of improvement following this update.

1.1 (j) QIA Process: QIA referrals for children in imminent risk of RMHTF placement offer a direct opportunity to assess mental health acuity and provide a clinically based recommendation for appropriate level of intervention. QIA referrals for March 2024 exceeded April 2024 RMHTF admissions (127 referrals compared to only 79 admissions), a positive finding reflecting efforts to refer and assess children for appropriate level of care are currently exceeding placement numbers.

- Nearly half of WV counties (47%, n = 26 of 55) met or exceeded expectations for referral practices in March 2024, with 15 counties not meeting expected referral numbers. The remaining counties (14) listed as "unclear" will continue to be monitored for referral opportunities and appropriate practices, as their small populations make it "unclear" if additional referrals are needed from a systems-level perspective.

Conclusions and Next Steps: Implementation and buy-in for the QIA process is a key component to WV's ability to more objectively and appropriately determine and provide recommendations for a child's level of intervention needed. Referral practices show positive trends in uptake of this procedure with BSS workers and additional opportunity to further improve processes and help ensure all children are assessed before being referred to RMHTF placement. DoHS is working diligently with the QIA contractor, Acentra Health, to help ensure QIAs are completed in a timely manner and results provided meet quality standards. BSS

[11] Note this does not mean that all mobile crisis services will be Medicaid reimbursable, as some services may not be deemed medically necessary under CMS rules but still could be considered beneficial to the child (e.g., CMCRS response to EDs).

leadership is also meeting regularly with staff and reviewing data, including newly available RMHTF Automated Placement Referral[12] comparison metrics to message and address needs related to proper QIA referral and completion practices for children with the most imminent risk.

1.1 (k) Discharge Planning: In the first half of 2024, considerable efforts were placed on the establishment of more robust data collection and reporting for the broader residential population. These achieved enhancements allow DoHS and its partners to prioritize discharge planning efforts more effectively by having a wider range of indicators available to identify children who can discharge in the near future and any related needs that should be managed. Accordingly, the focus of prioritized discharge planning efforts has been modified to include children in in-state residential placement with a CAFAS/PECFAS score less than 140 who also have an anticipated discharge date in the next 60 days.

- As of March 31, 2024, 117 children were included in the prioritized in-state population. Seventy-nine percent (n = 93) were ages 13 to 17, 13% (n = 15) were ages nine to 12, and 5% (n = 6) were ages 18 to 20. These age groups are consistent with the broader residential population, with the exception of the 18- to 20-year-old age group, which is only 1% of the broader residential population.
- Data related to primary discharge barriers showed 42% of these children (n = 49) had no reported barriers; the discharge plan is in place and actively moving forward.
- The top three barriers for the prioritized discharge planning population are as follows:
    - Child is court ordered to complete the treatment program or school year (19%, n = 22)
    - Child needs community-based placement (18%, n = 21)
    - Child's behavior is impacting discharge (16%, n = 19)

Conclusions and Next Steps: The goal of prioritized discharge planning is to help ensure all involved stakeholders are focused on identifying and addressing any discharge barriers for these children so they can successfully discharge in the near future as outlined in their discharge plan. These efforts include ensuring that any needed HCBS are in place upon discharge to the community.

- Out-of-state prioritized discharge planning efforts continue to be managed by Marshall University (MU) and have seen increases in discharges since MU's involvement began with out-of-state (OOS) discharge planning and case coordination. These efforts are also helping ensure families feel supported throughout the transition to the community when possible, and that children receive routine assessments to help drive decision-making related to the child's clinical and placement needs.
- One role of Aetna's case managers includes focusing support on the prioritized in-state

[12] Automated Placement Referral (APR) is used by BSS staff members to send automated referrals to in-state RMHTF providers.

discharge planning population and keeping open lines of communication with child welfare workers, families, and providers to help identify needs and coordinate strategies to help address identified needs.

- Transitional Living for Vulnerable Youth (TLVY) home services continue to be expanded to meet the needs of 18- to 20-year-old youth. These homes became operational in September 2023, with an initial capacity to support up to 22 youth. As of July 1, 2024, TLVY home capacity has expanded to serve up to 49 youth.

1.1 (l) RMHTF Readmission: To gain a better understanding of the number of children who readmit following discharge from an RMHTF for purposes of using this information to influence discharge planning efforts and help prevent future readmissions, DoHS identified a cohort of children who were discharged from an RMHTF July to December 2022 (n = 390). This cohort excludes youth 17 years old and up who may not be eligible for readmission for the full 12-month period, past their 18th birthday.

- DoHS found significant differences in the gender of children who readmit to RMHTFs. Females were 30% more likely to readmit within 12 months of discharge compared to males (relative risk of 1.30, p = 0.03). Females comprise only 44% of the overall population, but 49% of children who readmit.

Conclusions and Next Steps: Data from the Youth Risk Behavior Survey (YRBS)[13] show that mental health-related indicators, such as contemplating suicide and persistent feelings of sadness or hopelessness, have seen increases in youth with these needs since 2019 (i.e., pre-pandemic). This trend has primarily been driven by female children and demonstrates a change in mental health-related factors for female children following the pandemic. BSS and Aetna leadership reviewed this information and agreed that discharge planning for female children should focus on helping to ensure services are in place following discharge to meet their unique needs.

- The Quality Committee would like to explore readmission for a larger cohort of children, including expanding the analysis to include CAFAS/PECFAS scores and length of stay in combination with other factors that may be influencing this outcome. DoHS is also planning additional analysis related to the utilization and timeliness of services following discharge to the community. Preliminary data appear to show an association between having intensive CSED services in place within 30 days following discharge date and lower rates of readmission. Based on this information and focus of transition planning in the residential remodel planning, DoHS will continue efforts to influence timely access to services.

1.1 (m) RMHTF Placements and Trends: The statewide average RMHTF utilization placement rate increased from 3.1 children in an RMHTF per 1,000 children July to December 2022 to 3.4

[13] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

in July to December 2023.

- Comparing year over year at a point in time, there were 777 children in RMHTF settings on January 1, 2023, compared to 851 on January 1, 2024.

Conclusions and Next Steps: As noted previously, there was an increase in mental health need during this time period as evidenced by an increase in mental health ED visits; it is believed that the increase in RMHTF census would have been even more dramatic if not for the array of HCBS that youth and their families are accessing. There are many factors and stakeholders that influence the overall RMHTF census as will be noted in detail in the body of the report.

- BSS leadership has directed staff to meet with judges at least quarterly to enhance awareness of available HCBS for mental health needs, and to build relationships that enhance communication and outcomes in the interest of children served.
- Several efforts, such as prioritized discharge planning and intensive HCBS, appear to be influencing the census positively despite challenges faced that have resulted in an overall increase in census.
- Detailed analyses will continue to allow further understanding of the impacts of interventions and strategies used to reduce reliance on residential placement.

1.1 (n) Child and Adolescent Needs and Strengths (CANS) Assessment and Outcomes

Data Quality: DoHS is continuing to work through data quality and validation of data pulled from the CANS automated system, which is used to track, assess, and analyze progress and outcomes at the individual, provider and state level for services, such as RMHTF and WV Wraparound. Current reporting practices in the CANS system, including lag in the reporting of CANS assessments, are not meeting expectations as set in DoHS policy or to Wraparound fidelity.

Conclusions and Next Steps: DoHS is already investing considerable time and resources into improving data quality and enhancing the CANS automated system. These efforts will equip the DoHS team and providers with an expanded ability to monitor services more effectively, manage caseloads, and help ensure Wraparound is implemented to encompass high-fidelity Wraparound standards. Ultimately, these investments should lead to improved outcomes for children and families. In addition to planned system enhancements, monthly review of provider-level data is already helping influence strategic response to providers in need of technical assistance.

1.1 (o) Community-Based Placement Needs

: WV has a critical need for expansion of foster homes across the State. DoHS, Aetna, and Mission WV are collaborating to increase recruitment of foster families. Mission WV reported that from March to June 2024 they received approximately 200 inquiries a month, which is double what they typically receive. Almost half of these are attributed to the campaign. Additional time is needed to determine any changes because of the campaign, as families average about nine months between contacting Mission WV and being certified, and, historically, only about 10% of families who inquire follow through

with the entire certification process.

- Child-Placing Agencies (CPAs) are responsible for the recruitment and retention of certified foster families using the tiered foster care model throughout the State. The ratio of total homes closed to opened has improved slightly from the last six months of 2023 compared to the first six months but remains as a net loss of foster homes over time. From July to December 2023, there was a net decrease of 11 homes; whereas, from January to June 2023, there was a net decrease of 33 homes.
- On average, only one-quarter (26%) of certified foster families were willing to accept a child aged 13 and older for placement for the period July to December 2023. In comparison, 25% of children in foster and shelter placements statewide represented children aged 13 and older, highlighting the need for additional foster parents who are willing to accept teenagers given considerations of foster parent autonomy, compatibility considerations for the child and family, as well as existing foster occupants in the home.
- On average, the percentage of licensed families retained over two years increased slightly from the first half of 2023 (46%) to the second half of 2023 (48%). There was a decrease in the number of total licensed foster homes. However, this decrease was among homes open less than two years (decrease of 49 homes retained less than two years and an increase of 18 homes retained two years or more).
- Placement of children in kinship homes is a strength of WV's System of Care. WV leads the nation in kinship placements. On average from July 2023 to December 2023, 58% of in-state placements were in kinship homes.
- To gain a more detailed understanding of the additional foster and kinship capacity needs, DoHS completed an analysis of children in both in-state and OOS residential placements and emergency shelters who need foster or kinship care placement as of March 31, 2024. The results indicated a total of 158 children in need of community-based placement,[14] indicating a substantial need for additional foster and kinship homes. Nearly three out of every four children in need (73%, n = 113) resided in an RMHTF, while the remainder were in shelter settings.

Conclusions and Next Steps: DoHS, in collaboration with MU, surveys foster parents every two years. Results from the 2023 survey have been used to ensure foster and adoptive families have more opportunities for improved communications and mental health system navigation. This includes the addition of the Kids Thrive Newsletter, which shares resources and information with foster, kinship, and adoptive parents. DoHS has also continued to share resources with families via press releases and updates on social media as described in the

[14] Youth ages 18 to 20 were excluded from this analysis because they do not quality for traditional foster care. Children whose discharge barriers include behavior unchanged or escalating, awaiting transitional living, or court ordered were also excluded. Note a press release from May 2024 reported 250 youth in need of a foster home; the number reported here is not considered a decrease in need, but instead represents a subset of kids who are considered to have limited additional barriers to being discharged, beyond need for a home.

Marketing section of this report.

- A two-year retention rate of nearly 50% is considered a strength of WV's system. Retention is understood to be largely influenced by nurturing strong relationships between CPAs and foster families. DoHS will continue to work with CPAs to understand opportunities to improve retention and ultimately increase availability of experienced foster homes.
- Closure reasons are included as key performance indicators and reviewed with individual CPAs at least quarterly to identify trends and any needs associated with closures.
- County-level foster and kinship need data will be reviewed with CPAs and BSS managers on an ongoing basis to help influence recruitment efforts and consistency and resourcefulness of identifying loving homes for kids who are in need.

1.2 Synopsis: As will continue to be presented throughout this report, DoHS has made considerable progress in its ability to analyze cross-systems data and explore and address the needs and strengths of its children's mental and behavioral health system. Considerable efforts to enhance the children's mental health system in WV have been demonstrated through expanded awareness, accessibility, and availability of HCBS throughout the state. As the data store expands, additional outcomes data will be assessed to determine factors associated with added risk, as well as improved outcomes in WV's system. The robust CQI structure DoHS has implemented provides many opportunities to identify and continue identifying areas of need; with this, DoHS remains dedicated to prioritizing available resources to meet the most critical needs, while also continuing to enhance existing infrastructure.

DoHS recognizes the following as the most pressing needs of its children's mental health system (as of the writing of this report) and will prioritize response and further CQI efforts according to these areas, which are believed to have a large impact on a child's ability to remain in the least-restrictive setting as relates to meeting mental health needs:

- Assessing timeliness to mental health HCBS
- Understanding key interactions and related outcomes for children with SED
- Prioritized discharge planning and expansion of available community-based placement options (i.e., foster homes, kinships homes, non-treatment settings)
- Opportunities for diversion from unnecessary residential placements and potential systems involvement:
    - Increasing family-driven referrals to the Assessment Pathway
    - Enhancing QIA Referral Processes
    - Collaboration with and messaging to key stakeholders about unnecessary RMHTF placement, and available services and processes in place to offer other HCBS options for youth in need.

2.0 Introduction

DoHS is actively working to reform and enhance programs and services for children[15] with SED.

The primary goals of these reforms are:

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

To support these goals, DoHS is committed to providing HCBS, so children can remain in their homes and communities. HCBS includes Wraparound Facilitation, CMCRS, therapeutic foster care, Behavioral Support Services (such as Positive Behavior Support [PBS]), family therapy, in-home family supports, and ACT.

DoHS has collaborated with community partners and stakeholders to design and expand services to meet the needs of children and families statewide more effectively. A summary of these efforts is captured below:

- In February 2020, DoHS implemented the CSED Waiver to expand the array of HCBS available to children with SED and their families. In early 2023, the five-year CSED Waiver renewal was approved, extending the waiver through January 2028. A CSED Waiver amendment was approved with an effective date of July 1, 2024, with changes to enhance workforce, quality, and timely access to services.
- The CCRL was implemented in October 2020, creating a resource for children and families in crisis to access needed support, and an avenue for anyone seeking information on available services and supports, including how to get connected.
- The Assessment Pathway, which was implemented in October 2021, created a “no wrong door” approach to streamline and facilitate access to assessment and connection to HCBS for children and families. Screening and referral to the Assessment Pathway has expanded in phases since late 2021 to include primary care physicians, BJS, Probation Services, CCRL, CMCRS, CPS, and YS, providing children and families with the opportunity to connect to services. The Assessment Pathway was further expanded in late 2022 to include the QIA process. The QIA process involves a broader assessment of children who are considered high risk for placement in an RMHTF, followed by recommendations on whether HCBS are appropriate to meet each child’s needs.
- Community-based TLVY services were operationalized in September 2023 with capacity to serve up to 22 youth. As of July 2024, capacity has been expanded to serve up to 49

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

youth. These services, which include housing when needed, are specifically designed to support youth ages 17 to 21 and empower youth by equipping them with skills necessary to support independent living while also enabling access to any needed mental and behavioral health treatment from community-based mental health providers.

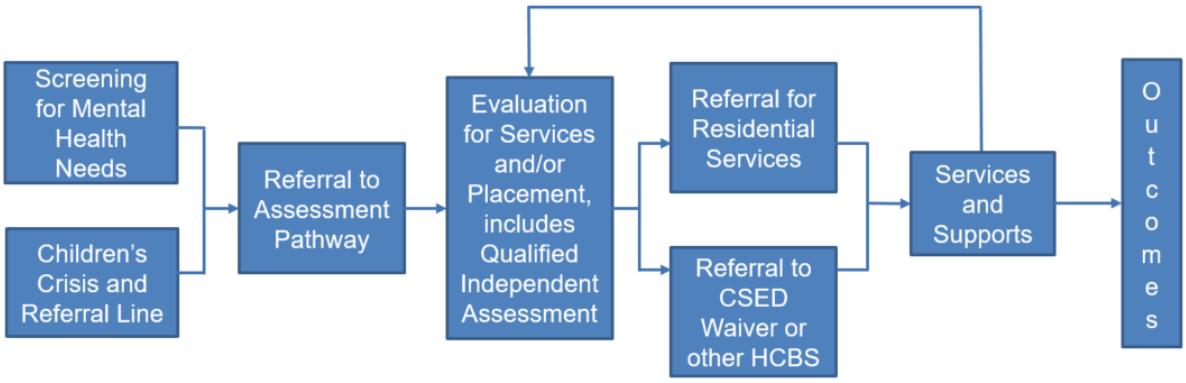
- Throughout 2023 and the first half of 2024, DoHS in partnership with Casey Family Programs, Building Bridges Initiative, and residential providers has continued to make progress on new models of care to better support the needs of children whose acuity requires residential treatment. A small group of providers will begin to pilot the new models of care in the last half of 2024 as more preparations are made for the statewide transition.
- In March 2024, DoHS launched the "West Virginia Needs You Now" campaign in partnership with Mission WV and 84Agency to recruit foster families across the State. The campaign includes radio ads, a web page, and billboards. It is expected that the campaign's potential effectiveness will be seen in mid- to late-2024.
- Many changes to the system are included in BMS Chapter 502, including elements of the Wraparound fidelity Document Assessment and Review Tool (DART), alignment in service time frames and expectations that will be captured across the three Wraparound sources, mobile crisis services being integrated into Medicaid, and a PBS modifier code to enable reimbursement through Medicaid. Chapter 502 is anticipated to go into effect in fall/winter 2024.
- In response to the findings of the Wraparound Fidelity Report from MU, DoHS leadership approved the creation of a WV Wraparound Director position. DoHS began recruiting for this position in June 2024.

DoHS continues to encourage awareness and adoption of these new programs, services, and pathways to improve access to HCBS across the State. Although it will take years to observe the full impact of the improvements and expansions to children's mental and behavioral health services, positive impacts are already being noted and are captured throughout this report.

To further support service enhancements, expansion, and quality, in December 2021, DoHS began to implement the CQI plan for children's mental and behavioral health services. The purpose of the CQI plan is to take a proactive and continuous approach to improve child welfare services and services for children with mental and behavioral health needs, including SED. DoHS has instituted a data-driven approach and culture to support this effort. These ongoing quality improvements help ensure all eligible children and families are provided timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

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

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



Recurring monthly bureau-specific program-level quality reviews are in place for all bureaus. Quality review meetings are also held quarterly at a minimum with BPH, BJS, and Probation Services. The program-level reviews facilitate more frequent and timely review of and response to data and enable preparation for DoHS's quarterly cross-functional, cross-bureau Quality Committee reviews, which analyze consolidated data from across programs to evaluate the children's mental and behavioral health services system. Additionally, PIP teams are established to drive rapid improvement when the need for a more focused and frequent review to address an identified gap or area for improvement arises.

The most recent quarterly Quality Committee review meetings were held in March and May 2024. The discussions during those meetings informed the findings—including strengths, opportunities, and next steps—captured in this report.

3.0 Systems and Data Sources

Data and information to evaluate and monitor services and outcomes will be drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children, families, providers, caregivers, and other stakeholders. Data sources used to aggregate data for this report include:

- DoHS's BSS Families and Children Tracking System (FACTS) data for children in DoHS custody; this system provides a static history of active child placements prior to 2023.
- DoHS's WV People's Access to Help (WV PATH) system for children in DoHS custody; this new system was implemented in January 2023 to replace FACTS.
- DoHS's Enterprise Data Solution (EDS) system of Medicaid and WVCHIP data, including data associated with CSED Waiver services, EPSDT screening, Medicaid eligibility, and parental RMHTF placement. This new system was implemented at the end of March 2023 and fully replaced the Medicaid Management Information System (MMIS) Data Warehouse/Decision Support System (DW/DSS) at the end of June 2023. The new EDS system data conversion for CQI reporting was completed in October 2023.
- DoHS's BBH grantee reporting via Epi Info System for PBS, CMCRS, and BBH-funded Wraparound Facilitation services. The Epi Info System was initially implemented in fall 2021. BBH rolled out a series of system updates to streamline and expand data collection for these services via Epi Info System "Version 2" (V2) in October 2023.
- HELP4WV – iCarol Call Reporting System for calls made to the CCRL.
- DoHS's BBH Assessment Pathway Portal.
- DoHS's BMS CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, Acentra Health[16]. This data set is scheduled for conversion to Acentra's Atrezzo system in August 2024.
- BJS Offender Information System.
- Discharge planning reporting from Aetna's Quickbase system.
- Aetna Utilization Management (UM) authorization reporting for children's CAFAS/PECFAS history.
- CSED Waiver Status and On-Hold reporting from Aetna's Quickbase system.
- DoHS's BMS CSED Waiver Enrollment Reporting from Acentra Health and the contracted assessor, Psychological Consultation and Assessment, Inc. (PC&A).

[16] The ASO Acentra Health was identified as Kepro in prior semiannual reports. A merger between CNSI, a leading provider of innovative healthcare technology solutions, and Kepro was completed in December 2022, and rebranding of the name to Acentra Health was announced in June 2023.

- DoHS's Fostering Healthy Kids Data System (sourced from FACTS/PATH) that includes EPSDT screening for children in foster or certified kinship care including CPS and YS.
- DoHS's Outreach and Education Tracker.
- Division of Probation Services Offender Case Management System (OCMS).
- CANS Automated System, which includes CANS assessment data, SAH Wraparound Facilitation services contact data, and data to assist with Wraparound Facilitator capacity and caseload analysis.
- QIA Tracking Spreadsheet, maintained by Acentra Health. This dataset is scheduled for conversion to Acentra's Atrezzo system in August 2024.
- MU WV Wraparound Facilitator Staff Reporting for capture of Wraparound Facilitator workforce capacity and caseload analysis.
- MU OOS placement data tracking system.
- MU Wraparound Fidelity Evaluation.
- WVU Children's Mental Health Evaluation.
- ESSENCE, Electronic Surveillance System for the Early Notification of Community-based Epidemics, part of the National Syndromic Surveillance Program.
- CPA County-level foster home and key performance indicator reporting.

Over the past three years, DoHS has continued to develop a data store to house data from multiple sources across the Department's child welfare and mental and behavioral health services systems, including data from internal systems as well as data from third-party systems (i.e., contractors, vendors, and providers). The goal of this data store is to capture child- and interaction-level data from child-serving entities to enable aggregation, cross-systems analysis, and reporting for use in DoHS's CQI processes. Build-out of the data store is occurring in phases. Significant time and effort continue to be spent on data quality, validation, and matching at the child-level to enable cross-systems analysis using multiple datasets. The timing to complete these activities can be difficult to forecast, so the timelines associated with the build-out of the data store are updated routinely and priorities are revisited as progress is made and as new information becomes available.

Substantial progress was made on the development of the data store in the first half of 2024. After significant efforts in working with Aetna to operationalize changes with the new Quickbase application, the formal RMHTF discharge planning module is ready to be rolled out for cross-system analyses at the child-level. The Assessment Pathway and discharge planning module is also at the final validation stage. Meanwhile, significant enhancement and refinement have been made to the child unification process. These enhancements accommodate the new additions of CANS assessment, Discharge Planning, and Assessment Pathway systems in which a common child identifier is limited. They will also render incorporation of new systems, such as CSED application, QIA, more scalable and streamlined. Datasets in the process of being added to the

data store include the following: CSED applications, CSED enrollment roster, Probation Services screenings, BJS screenings, and QIAs. As the build-out continues, the data store can be further leveraged to support DoHS's CQI activities and improve understanding of youth and family experiences within the mental health system.

Other system changes that enabled expanded data collection at the child and encounter level were completed in late 2023 and early 2024. Enhancements to the Epi Info System, which captures data associated with the BBH-funded Behavioral Support Services, Wraparound Facilitation, and CMCRS programs, went live in October 2023. Improvements to the Epi Info System will increase data quality and provide the ability to monitor and review expanded information, such as timeliness indicators. While some indicators are included in this report, full review of this data and incorporation of the Epi Info System into the data store is pending further data quality validation, including understanding provider-level use. BSS, BBH, and BMS continue to spend significant time collaborating with vendors and providers to address data quality and completion. Provider-level data reports were initiated in late 2023 and are being produced on a routine basis and shared with providers to improve data completion and quality. Finally, Acentra Health is in the process of converting CSED Waiver application and QIA data sets into an electronic system (Atrezzo) with an expected go-live date in August 2024. These efforts and enhancements are described in greater detail in relevant sections throughout the report.

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

- WVU: Contracted to complete the Children's In-HCBS Improvement Project Evaluation Plan. This evaluation is commonly referred to as the Children's Mental Health Evaluation (CMH Evaluation). The evaluation spans four years and is currently entering year three. WVU provided a baseline report reflecting responses and perceptions from providers and facilities statewide in July 2022. A report on feedback from youth, families, and caregivers was issued in September 2022. The year two provider, youth, and caregiver evaluation for children in RMHTFs was completed in summer 2023 and the report was finalized in January 2024 following additional analysis to expand the utility of the report to allow a more actionable response. Year two of the evaluation also includes a baseline evaluation of at-risk[17] children and caregivers, which are referred to most commonly in the evaluation as community-based children and caregivers given the comparison to experiences of children and caregivers in a residential treatment setting. This report was

[17] At-risk children were defined as those children (under age 21) with an SED diagnosis within one year of the review period where an SED is defined as International Classification of Disease-10 (ICD-10) diagnosis codes in the psychiatric range, or F-range (that is, starting with F) except for the following standalone diagnoses: F10 - F19, F55 (SUD), F70 - F80 range of intellectual and developmental disabilities, G25.6, G25.7 (medication induced movement disorders), Z55 - 65 (health hazards related to socioeconomic and psychosocial circumstances), Z69 - Z76 (persons encountering health services in other circumstances), AND meeting any of the following criteria in the last three months of the review period: WV Medicaid/WVCHIP member with an ER visit for a psychiatric episode, WV Medicaid/WVCHIP member with a psychiatric hospitalization episode; Mobile Response incidence; children who are in state custody because of CPS or YS involvement; OR child with SED as a primary diagnosis on a Medicaid claim within one year of the review period and a CAFAS/PECFAS > 90.

also finalized in January 2024. Both year 2 reports are referred to as the CMH Evaluation throughout this report, with additional clarification provided to identify the specific report being referenced as needed. In year 3, DoHS has proposed a restructure of the reporting cycle to provide more timely, actionable data. This would result in several smaller, topic-focused reports to be published throughout the year as the data becomes available.

- MU: Contracted to complete an ongoing evaluation of Wraparound service fidelity to the National Wraparound Initiative (NWI). Marshall provided the baseline fidelity report to DoHS in October 2022. The second fidelity report was finalized in January 2024.

DoHS incorporated contracted vendor reports into its CQI processes and quality review cycles.

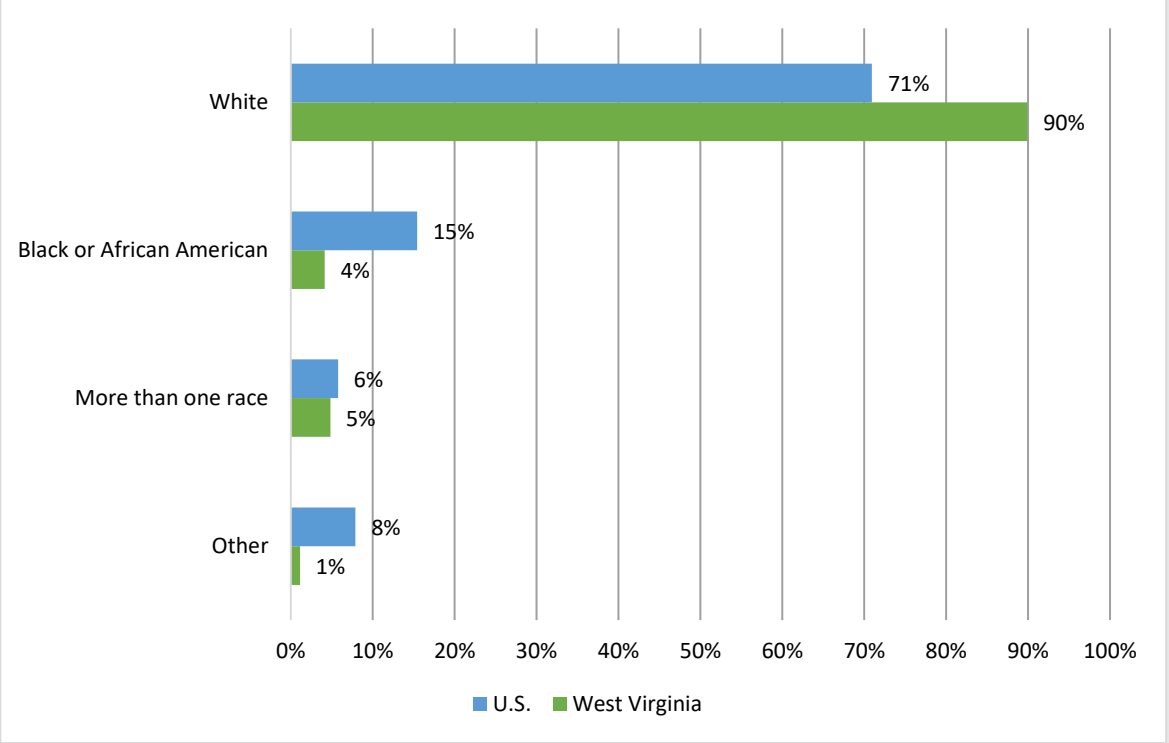
4.0 WV's Child Population and Individuals Utilizing Services

4.1 WV Demographics for General Child Population

WV has a unique demographic and geographic makeup, which varies significantly from most of the United States. As DoHS examines service utilization, reference to the State's population is important to track whether the populations reached are representative of the State's population.

As shown in Figure 2[18], the State has a larger proportion of white children compared to the nation (90% in the State compared to 71% nationwide). Black, Indigenous, and People of Color (BIPOC) represent only 10% of the WV child population, compared to 29% nationally.

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

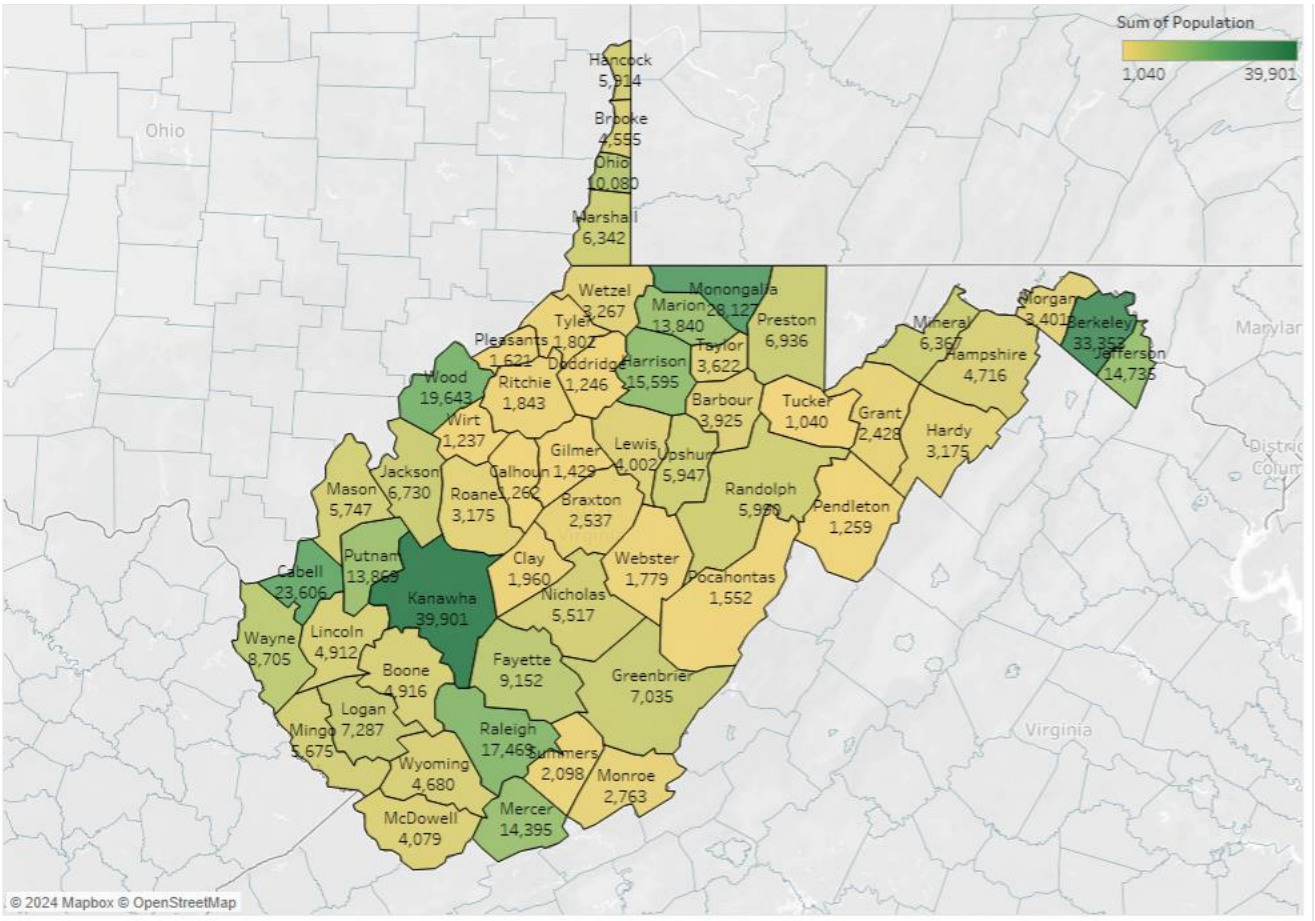


In addition to consideration of racial distribution, the geographic makeup of the State is an important consideration for service utilization and outreach. According to the U.S. Office of Management and Budget, only 21 of WV's 55 counties are considered urban. Children and families who live in rural areas may have additional barriers to accessing services. Figure 3

[18] Single-race Population Estimates, United States, 2020-2022. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. The 2020-2022 postcensal series of estimates of the July 1 resident population are based on the Blended Base produced by the US Census Bureau in lieu of the April 1, 2020, decennial population count, released by the Census Bureau on June 22, 2023. Accessed at http://wonder.cdc.gov/single-race-single-year-v2022.html on May 30, 2024.

represents the population in each county less than 20 years of age for context of service utilization as referenced throughout sections of this report.[19] Note that these totals undercount the county populations for the report's target age group, children, and youth aged less than 21 years. The relevant National Cancer Institute Surveillance, Epidemiology, and End Results Program (SEER) data are only available by county in age ranges grouping 20-year-olds with individuals outside the target age group.

Figure 3: WV Child Population Under Age 20 – 2022 n=418,238 SEER Data Single-Year Age Groups



4.2 Children Identified as At-Risk for Residential Placement

DoHS uses the at-risk population defined in Section 3.0 Systems and Data Sources above as a guide for the target population for HCBS, acknowledging that there are children who may meet these criteria but have yet to be identified due to a lack of interaction with the system. The integration of information for at-risk children and families with county-level data has enabled comparisons to begin to be made between populations of interest and service utilization, permitting focused outreach efforts and monitoring. Updates to information regarding the at-risk

[19] 2010 to 2019 Intercensal Estimates of County Population by Age, Sex, and Bridged Race for Vintage 2022 Postcensal Estimates, Woods & Poole Economics, Inc., Washington D.C. February 2024. https://seer.cancer.gov/popdata/download.html

population were unavailable for this report due to impacts related to Epi Info System updates. DoHS continues to progress toward including this population in its data store for comparison with service utilization, identification of needs, and outcomes. This information is expected to be available for future reviews.

The Quality Committee recognizes the importance of continuing to understand this population and the limitations of the at-risk definition. By default, the at-risk definition includes youth accessing certain services which may have more availability in more populous or urban areas. Furthermore, not all children who are in need of services will have their needs rise to meet the defined at-risk criteria; however, DoHS recognizes the value in serving children who meet clinical necessity criteria as soon as possible. Timely access to appropriate services may help prevent a family from enduring a crisis or reduce imminent out-of-home placement risk, thereby improving overall outcomes and quality of life via expanded utilization of HCBS. With this consideration, DoHS plans to explore other key populations (e.g., children with Medicaid and an SED diagnosis) as the Quality Committee strives to continue to identify opportunities for early intervention and improvement of outcomes, including prevention of "systems-level involvement."[20]

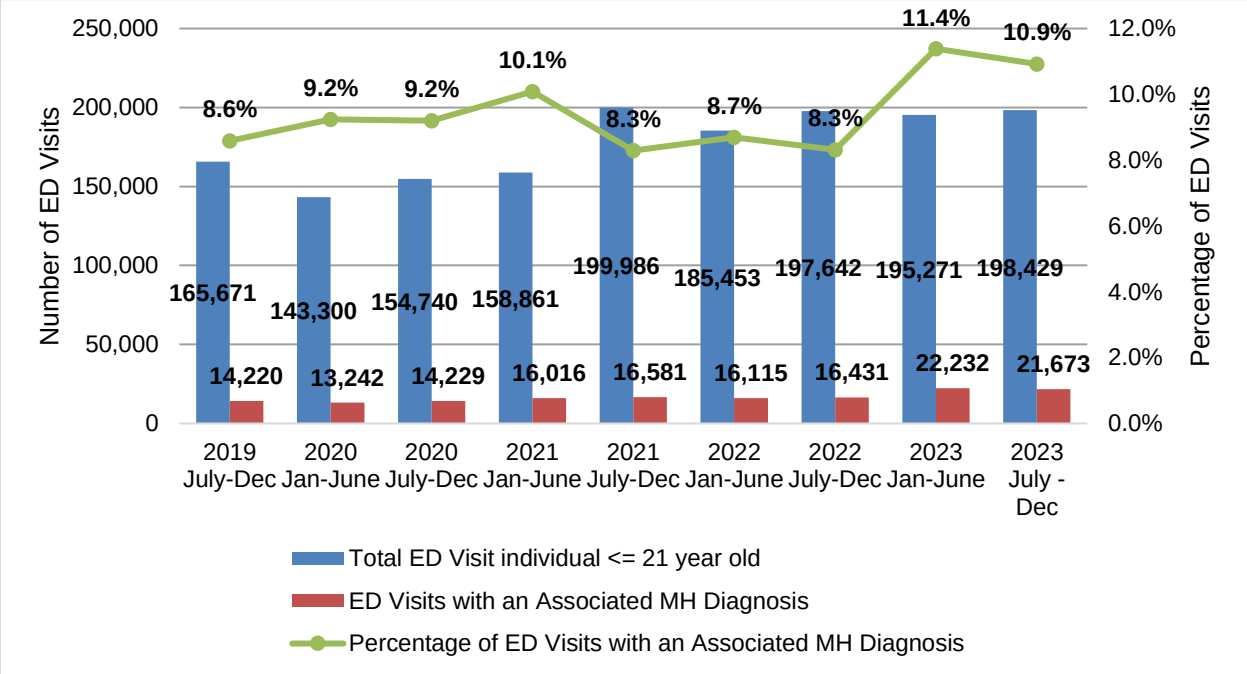
Per the 2022 National Survey of Children's Mental Health, 26% of youth aged three- to 17-years-old nationwide reported having one or more mental, emotional, developmental, or behavioral problems, and/or qualifying for the Children's Special Health Care Needs screening for emotional, behavioral, or developmental criteria. In WV, 33% of youth in this age range reported having one or more of these needs. The greater proportion of youth with identified mental health needs in the State compared to the national rate further supports the need for expanding the array of available youth mental health services throughout WV.

In order to improve understanding of the evolving mental health needs for WV children, DoHS, in partnership with WVU HAI, has begun exploring ESSENCE data for surveillance of mental health needs via ED visits for children less than or equal to 21 years old. These data were reviewed from the second half of 2019 through the end of 2023 by six-month period to provide a comparison of pre-pandemic and post-pandemic mental health visits. As shown in Figures 4(a) and 4(b), as the Covid-19 pandemic era was ending, the percentage of mental health visits to the ED increased sharply from the last half of 2022 (8.3%) to the first half of 2023 (11.4%), a percent increase of 37%. The number of visits between these two periods for all ED services, regardless of visit type, *decreased* by 1% (n = 197,642 visits in the last half of 2022 down to n = 195,271 in the first half of 2023), while the number of mental health visits *increased* by 35% (n = 16,431 to 22,232). Over the full review period, there was a more gradual increase in the percentage of ED visits with an associated mental health diagnosis: 8.6% of ED visits in July to December 2019 had an associated mental health diagnosis, compared to 10.9% of ED visits in July to December 2023 – a 27% increase.

[20] "Systems-level involvement" is defined here as Child Welfare, Youth Services, Probation Services, or Bureau for Juvenile Services involvement.

The RMHTF average monthly point-in-time census[21] also increased sharply from the last half of 2022 to the first half of 2023, with the average census going from 800 to 842, a 5.3% increase. There was an additional 5.4% increase from 842 in the first half of 2023 to 887 children in RMHTF placement on average from July to December 2023 (11% total percent change from the last half of 2022 to the first half of 2023). Comparatively, there were nearly 6,000 additional mental health visits to the ED from the last half of 2022 to the first half of 2023. Given this large increase in the percentage of mental health visits in the ED, it might be expected that the need for RMHTF services would increase. However, given the vast efforts and continued implementation of the Assessment Pathway and expanded HCBS available in WV, it is suspected that this increased demand in ED visits related to mental health needs may instead have resulted in a much larger increase in RMHTF utilization had these expanded services not been available. DoHS plans to analyze additional data at the child-level to understand outcomes and early-intervention opportunities in greater detail.

Figure 4(a): Emergency Department Visits Related to Mental Health Diagnoses Over Time



[21] This value is calculated as the average monthly point-in-time census as of the first day of the month for each period with the exception of January to June 2019, which includes only the average of the last three months of the period due to data quality concerns for the earlier half of that period.

Figure 4(b): Proportion of ED Visits and Percent Change for Related Indicators

Percent Change from Prior Six-Month Period	2019 Jul – Dec	2020 Jan – June	2020 Jul – Dec	2021 Jan – June	2021 Jul – Dec	2022 Jan – June	2022 Jul – Dec	2023 Jan – June	2023 Jul – Dec
Total ED Visits	1.9%	-13.5%	8.0%	2.7%	25.9%	-7.3%	6.6%	**-1.2%**	1.6%
Proportion of ED Visits with Associated Mental Health Diagnosis	-6%	8%	0%	10%	-18%	5%	-4%	**37%**	-4%
Average Point-in-Time RMHTF Census	0.0%	-3.7%	-10.4%	-2.1%	-4.1%	0.8%	-1.6%	**5.3%**	5.4%

***Note:** Sourced from ESSENCE Syndromic Surveillance data

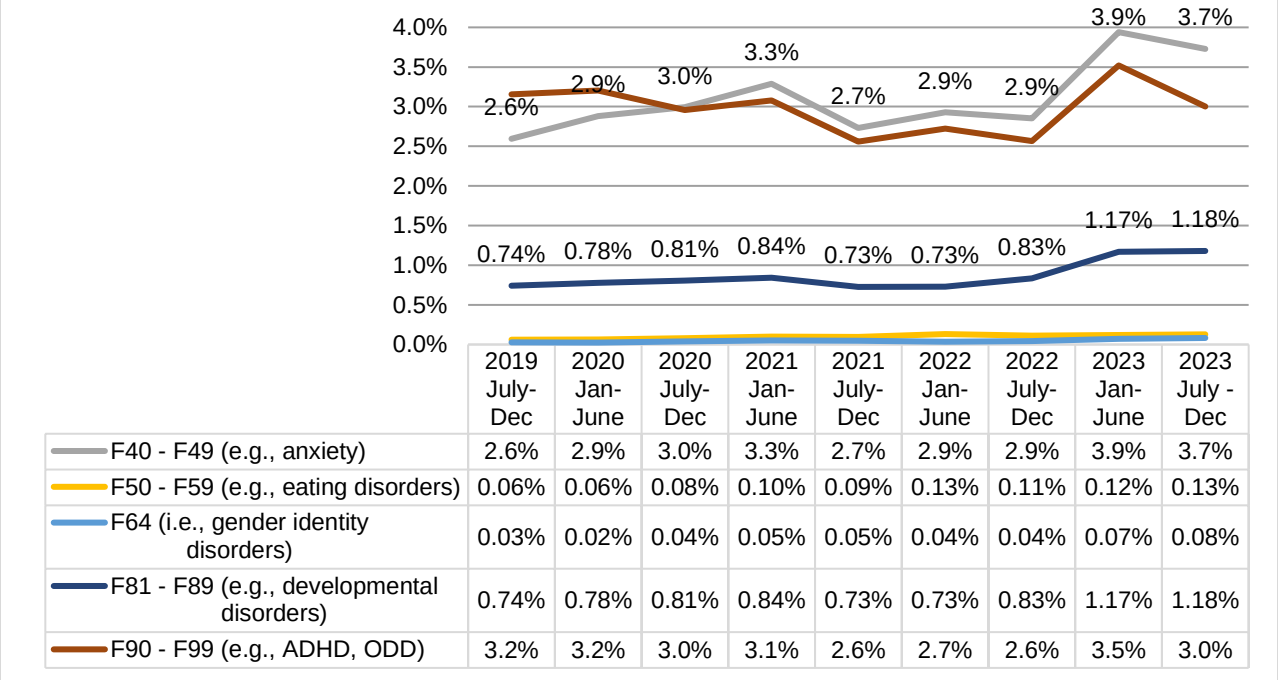
As shown in Figure 5,[22] the changes from pre-pandemic to post-pandemic time periods occurred across an array of diagnoses. However, the largest increases that occurred from the last half of 2022 to the first half of 2023 were largely influenced by visits with associated diagnoses pertaining to behavioral and emotional disorders, with onset typically occurring in childhood and adolescence (ICD codes: F90 - F99; e.g., ADHD, ODD; 2.6% to 3.5% of ED visits) and anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders (ICD codes: F40 - F49; 2.9% to 3.9% of ED visits). A detailed examination demonstrates that changes with behavioral and emotional disorders with onset usually occurring in childhood and adolescence (ICD codes: F90 - F99; e.g., ADHD, ODD) are not as profound a difference when comparing the proportion of visits in the last half of CY 2019 to the last half of 2023, in which the proportion of visits for this diagnosis is approximately 3% in both pre- and post- pandemic periods (approximately 6,700 visits for July to December 2023). This may suggest slight variations in utilization of the ED for children with F90 - F99 range diagnoses during the pandemic period. Conversely, while anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (ICD codes: F40 - F49) also show some variability, these diagnoses have a more pronounced overall trend upward in their proportion of visits from the last half of 2019 to the last half of 2023 (2.6% to 3.7% of total ED visits; approximately 7,400 visits July to December 2023 compared to approximately 4,300 visits July to December 2019).

While not as large a volume or proportion of visits as the F40-and-F90-range diagnoses, other diagnosis categories also had noteworthy changes in proportion of ED visits from 2019 to 2023. Pervasive and specific developmental disorders (ICD codes: F81 - F89) had increased by 59% from the last half of 2019 to the last half of 2023 (0.74% to 1.18% of total ED visits, n = 1,227 to 2,337 visits). The proportion of ED visits with behavioral syndromes associated with

[22] Note while a wide array of F codes was reviewed within the defined SED population, only categories with noteworthy trends have been included in this visual to enable ease of review.

physiological disturbances and physical factors (ICD codes: F50 - F59; e.g., eating disorders) increased by 78% from last half of 2019 to the last half of 2023, and visits with these diagnoses more than double from pre- to post-pandemic (0.06% to 0.13% of total ED visits; n = 101 to 262 visits). Finally, the proportion of ED visits related to gender identity disorders (ICD code: F64; e.g., gender dysphoria, transsexualism) increased by 185% (0.03% to 0.08% of total ED visits, n = 48 to 164 visits). Members of the Quality Committee suspect that this increase might be a result in changes of practice in coding mental health diagnoses as cultural acceptance grows around the LGBTQ+ movement; whereas, in the past these mental health needs might have been underreported and/or coded as other disorders with related symptomatology, such as anxiety or depressive disorders. Most other mental health disorder ICD categories have shown increased representation in proportion of visits but represent either a low number of visits or changes that are not as notable. DoHS will continue to monitor these at a granular level on a more routine basis to identify evolving needs and strategies to help families navigate these challenges in their homes and communities, ideally before needs become urgent or critical in nature.

Figure 5: six-month Trend Comparisons in Proportion of Mental Health Visits to the ED by Diagnosis Category: July 2019 to December 2023



	2019 July-Dec	2020 Jan-June	2020 July-Dec	2021 Jan-June	2021 July-Dec	2022 Jan-June	2022 July-Dec	2023 Jan-June	2023 July - Dec
F40 - F49 (e.g., anxiety)	2.6%	2.9%	3.0%	3.3%	2.7%	2.9%	2.9%	3.9%	3.7%
F50 - F59 (e.g., eating disorders)	0.06%	0.06%	0.08%	0.10%	0.09%	0.13%	0.11%	0.12%	0.13%
F64 (i.e., gender identity disorders)	0.03%	0.02%	0.04%	0.05%	0.05%	0.04%	0.04%	0.07%	0.08%
F81 - F89 (e.g., developmental disorders)	0.74%	0.78%	0.81%	0.84%	0.73%	0.73%	0.83%	1.17%	1.18%
F90 - F99 (e.g., ADHD, ODD)	3.2%	3.2%	3.0%	3.1%	2.6%	2.7%	2.6%	3.5%	3.0%

***Note:** Sourced from ESSENCE Syndromic Surveillance data

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

A full comparison of demographics of the WV general child population and children accessing the various children's mental health programs and services is captured in Figure 6. In summary:

- Consistent with gender proportions identified in the RMHTF population, HCBS programs

served more male children. This aligns with findings in reviewed literature, as differences are commonly seen in the way mental health disorder symptoms present among males and females, which would also impact intensity of the services needed based on presentation of relevant symptoms.[23]

- Age has been identified as a key factor influencing a child's likelihood to be served in their home and community. Correlations between age and intensity of needed services and/or inability to maintain a child in a home will be demonstrated throughout this report.
- HCBS such as Wraparound Facilitation (including CSED), CMCRS, and Behavioral Support Services, as well as the Assessment Pathway to access these services, reached a greater proportion of children in age categories five to eight and nine to 12 compared to children in RMHTFs, who skewed older. The shift toward younger age categorizations for community-based programs was identified as a potential early-intervention opportunity for those individuals who may have current or potential risk for placement in an RMHTF. Although this is a positive finding about early intervention, it may take several years to see the full impact on RMHTF services for children in these age ranges. Nevertheless, more than 50% of youth served through CMCRS and CSED were over the age of 12, indicating a key demographic overlap and an opportunity for diversion from inappropriate use of RMHTF settings.
- The SAH program funds and provides interim Wraparound services for children with mental health needs, but also serves other children with child welfare-related Wraparound needs. Children served through SAH are older in comparison with children served by CSED (84% compared to 49% aged 13 to 17 years, respectively). This difference in characteristics of children served might be associated with higher rates of court involvement for children in the SAH program which could require the SAH program to be mandatory for children ordered to it; while the CSED program has specific policies that require participation to be voluntary.
- QIA demographic data also shows strong overlap with the RMHTF population, which provides another key opportunity to divert children with the most imminent risk from out-of-home placement.
    - The Centers for Disease Control and Prevention (CDC) utilizes the Youth Risk Behavior Surveillance System to survey youth from grades nine – 12 biannually. Data for WV youth collected in 2021 shows a significant increase in both feelings of sadness and hopelessness as well as serious consideration of attempting suicide since the previous survey in 2019.[24] These findings provide insight into the mental health concerns of youth who likely overlap the 13 to 17 age group, the same age group most commonly utilizing HCBS as well as

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

[24] Centers for Disease Control and Prevention. 2021 Youth Risk Behavior Survey Data. Available at: www.cdc.gov/yrbs. Accessed on December 27, 2023.

RMHTF placements.

- Most youth in RMHTF settings were in the 13 to 17 age group (81%). In review of the prioritized discharge population, the age distribution shifted older (with 6% of transitional age youth 18 to 20 in this subpopulation compared to only 1% in the total RMHTF population). These transitional age youth are elaborated on in Section 17.0, RMHTF Services with considerations given to potential discharge barriers of youth of transitional age that may be influencing this effect.
- Based on a comparison of statewide race distribution for children aged 0 to 20, BBH PBS (13%) and SAH (11% of active and 13% of new cases), showed programs serving a slightly higher proportion of BIPOC individuals, despite BIPOC representing a small number of the general WV population (9% reported as multiracial or black/African American). This has been a consistent finding with the PBS program. WVU's CED provides input and training to staff for program outreach and service delivery for improved cultural competency, which may be attributable to reaching a higher proportion of BIPOC individuals. Race will continue to be monitored as an important indicator for assessing equitable access to services. Race data will be expanded as the data store is built out and data quality improvements are achieved.

Figure 6: Summary[25] Comparison of Demographic Trends Across Service Types July to December 2023

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
WV – All Children 0-20	418,238	51.5%	18%	19%	26%	16%	90%	4%	5%	1%
Medicaid/ WVCHIP Eligible 0-20	266, 475	51%	19.2 %	19.6 %	24.7 %	12.3 %	68.%5	4.5%	- -	26.9%
Medicaid/ WVCHIP	64, 698	51%	17.8 %	23.9 %	35.6 %	15.4 %	76.5%	4.2%	- -	19.3%

[25] This summary comparison only includes relevant percentages (percentages large enough for comparison); however, the denominator for each group is inclusive of all available demographic types including those not listed (e.g., other genders such as transgender or nonbinary, age 0 to 4, or individuals with missing data). The complete demographic information for children reported for interim Wraparound services was unavailable for this period.

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
Eligible 0-20 with SED[26]										
WV At-Risk 0-20[27]	6,677	49.5%	13%	19%	48%	17%	--	--	--	--
CCRL	494	49%[28]	13%	28%	42%	1%	38%	3%	4%	--
CMCRS – Preliminary	334	49%	16%	25%	50%	3%	77%	7%	2%	6%
BBH Wraparound	43	58%	23%	23%	35%	7%	86%	7%	2%	2%
Assessment Pathway – Family-Driven Referrals	201	61%	22%	28%	37%	5%	55%	3%	7%	1%
Assessment Pathway-Aggregate Referrals	1,347	59%[29]	13%	21%	59%	4%	--	--	----	
CSED Waiver Applications	1,167		12%	19%	58%	9%	--	--	--	--

[26] The Medicaid/WVCHIP Eligible with SED population is representative of calendar year 2023; these data do not represent a six-month period.

[27] The WV At-Risk population is representative of calendar year 2022; these data do not represent a six-month period. Youth who were identified as at risk and turned age 21 by December 31, 2022 were included in the 18 to 20 age category to be inclusive of the whole population during the year.

[28] Approximately 12% of gender data was missing from calls for the CCRL, 39% of calls were recorded as being for female children.

[29] Gender data is only available for referrals logged in BBH's Assessment Pathway Portal, as Acentra does not track gender data for CSED applications. Therefore, this percentage is based on a subset of only 320 referrals with available gender data.

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
CSED Waiver Utilization	877	55%	21%	32%	49%	4%	--	--	--	--
Safe at Home Wraparound -New Cases	540	59%	1%	13%	85%	0%	83%	8%	5%	1%
Safe at Home Wraparound -Active Cases	1,100	58%	1%	14%	84%	0%	85%	7%	4%	1%
Behavioral Support Services – BBH (PBS)	146	62%	27%	30%	36%	3%	85%	5%	8%	2%
RMHTF Prioritized Discharge Planning[30]	81	65%	6%	11%	77%	6%	--	--	--	--
RMHTF Services	1,409	62%	3%	15%	81%	1%	--	--	--	--
QIA[31]	601	57%	5%	14%	76%	3%	--	--	--	--
CPS/YS Wellness (EPSDT) Screening[32]	1,589	54%	12%	19%	28%	0%	--	--	--	--

[30] The prioritized discharge planning population includes youth in an active in-state RMHTF placement with CAFAS <140 and anticipated discharge in 60 days or less.

[31] Note this includes only referrals for assessments received in October 2023; 17% of referral records did not include age/date of birth.

[32] Youth placed in DoHS custody with an EPSDT screening within one year of placement.

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
Screening: Probation	179	64%	0%	3%	92%	4%	83%	8%	3%	1%
Screening: BJS	465	--	0%	5%	88%	8%	--	--	--	--

5.0 Partner Evaluations

DoHS partners with WVU HAI to conduct DoHS's Children's In-Home and Community-Based Services Improvement Project Evaluation, MU for Wraproud Fidelity, and University of Connecticut (UCONN) for Wraparound Facilitation Training. DoHS will report relevant updates to these partner evaluations and findings on an annual basis. The most recent partner evaluation findings and next steps can be found in the April 2024 Quality and Outcomes Report Addendum.

6.0 Marketing

Marketing strategies that include outreach and education continue to be monitored and developed. These strategies are a key opportunity to raise awareness of available services and to influence messaging regarding the ability of children to have the option to be served in their homes and communities when clinically appropriate. DoHS continues to utilize a data-driven, county-level outreach approach involving risk ranking of counties based on a variety of factors, including RMHTF admission rates, CSED utilization rates, and CCRL call rates, among other factors.

Marketing strategies are informed by the annual CMH Evaluations completed by WVU. The draft report of year two systems, provider, RMHTF youth, and caregiver evaluation was completed in July 2023, with a draft report of baseline survey results of the at-risk youth and caregiver population completed in October 2023. Both reports were finalized in January 2024 and shared with the cross-bureau Quality Committee. Further information on these reports can be found in the April 2024 Quality and Outcomes Report Addendum.

6.1(a) Kids Thrive Collaborative Website

The WV Kids Thrive Collaborative website went live in mid-June 2022, replacing the Child Welfare Collaborative website, and serves as a hub for providers and families to receive information on resources, services, and initiatives related to meeting children's mental health needs. The Kids Thrive Collaborative continues to be enhanced based on feedback from families and on the identification of additional needs. A comprehensive review of the Kids Thrive Collaborative website with consideration to updates and enhancements began in September 2023. During the August 2023 Quality Committee review, several taglines were proposed for the branding of Kids Thrive. In December 2023, "When kids and families thrive, West Virginia thrives," was announced as the official tagline. An updated logo aligning with the tagline will be explored in 2024 in pursuit of cohesive branding. The Office of Quality Assurance is conducting surveys about the website with the Family Advisory board to provide insight into perspectives and needs from a family stakeholder viewpoint. The survey will likely be completed in fall 2024, with website updates to follow.

From July to December 2023, the Kids Thrive website had 1,890 views from 969 users. Of those, 886 (91%) were new users. DoHS made 10 social media posts via Facebook and Twitter promoting the Resource Rundown and Kids Thrive newsletter. As of July 2024, there are 155 subscribers to the Kids Thrive Collaborate newsletter.

6.1(b) Resource Rundown Updates

In August 2022, DoHS initiated a recurring outreach approach to provide information, raise awareness of the availability of services, and address family and youth questions called the "Resource Rundown." Initially, these 30-minute sessions were offered weekly and then shifted to biweekly from January to June 2023. In summer 2023, DoHS transitioned away from the live sessions and instead uploaded videos to YouTube that are available on demand. The videos are displayed on the Kids Thrive website and are accompanied by contact information to

facilitate feedback and questions with timely responses. Production was paused in late 2023 to allow the Department time to explore the best direction for the initiative. It was decided that the Resource Rundown would be released quarterly and cover a variety of topics presented by relevant program staff. Current topics are still in development.

6.2 DoHS-Level Outreach and Education Tracking

The Outreach and Education Tracker was soft launched in April 2022 and shared with relevant DoHS staff in August 2022. This tracker documents efforts made by Department offices only. Grantees, vendors, and other contractors who provide outreach on DoHS's behalf are captured via other means. Usage of the tracker was re-emphasized in fall 2023 and continues to be an area of focus.

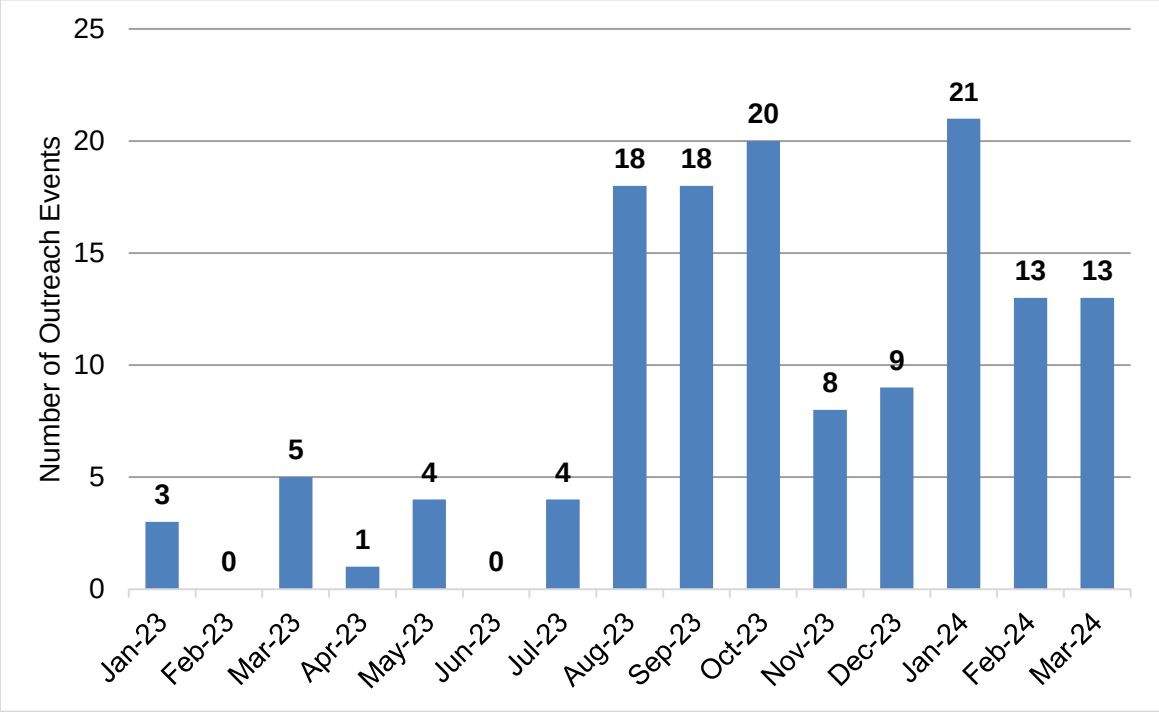
To help ensure the best possible utilization of the outreach tracker, each bureau and relevant staff were asked to select someone to represent them as an outreach delegate. This individual is responsible for ensuring that outreach was documented in a timely manner, either by direct data entry or delegation. Since the implementation of the outreach delegates, documentation has improved in timeliness and quality.

The Outreach Workgroup reconvened with program representatives from each DoHS bureau in February 2024 to develop more specific outreach plans for the year, including the "Resource Rundown" cadence in 2024 and Outreach Tracker utilization.

BBH identified five counties (Barbour, Wayne, Preston, Putnam, and Marion) in 2023 for targeted outreach related to CCRL and CMCRS. Program staff worked with grantees in these counties to develop outreach plans. Nineteen events were conducted between July and December 2023, and 15 events took place during the first quarter of 2024. First Choice Services, the CCRL vendor, has conducted 13 outreach events in these target counties from January to May 2024. BMS produced an extensive array of outreach materials and distributed them statewide in December 2023. Resource kits were sent to schools and community organizations including CSED Waiver posters, window clings, magnets, stickers, and wallet cards. Community and school personnel guides were also distributed. These materials included information about the CCRL and 988-Suicide and Crisis Lifeline. Nearly 1,000 resource kits were sent across the State. Referrals to the Assessment Pathway increased throughout the first half of 2024, a likely result of this broad marketing of information to communities.

Figure 7 below shows the number of outreach events by month from January 2023 to March 2024. In the second half of 2023, DoHS emphasized tracking outreach, expanding specifically to the judicial community given its influence on residential placement diversion opportunities. This resulted in 77 outreach events from July to December 2023, compared to only 13 in the previous six-month period (January to June 2023).

Figure 7: DoHS Outreach Events by Month, January 2023 to March 2024

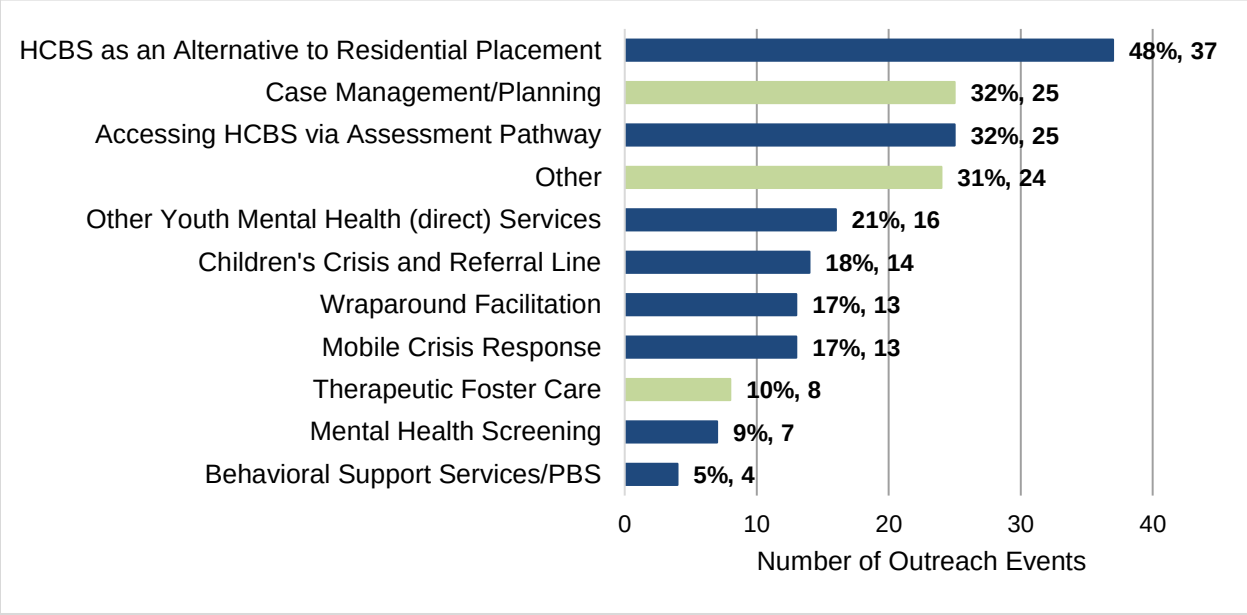


Although multiple purposes for outreach were often noted for a single outreach event (Figure 8), the most commonly listed purposes for outreach were:

- Accessing HCBS as an alternative to residential placement (n = 37, 48%)
- The Assessment Pathway (n = 25, 32%)
- Case management/planning (n = 25, 32%)
- Other youth mental health (direct) services (n = 16, 21%)
- The CCRL (n = 14, 18%)
- Wraparound Facilitation (n = 13, 17%)
- Mobile Crisis Response (n = 13, 17%)

Staff labeled 24 events (31%) with the “other” category to describe the purpose of their outreach. Along with evaluating the purposes currently being collected, DoHS staff are being educated on how their activities fit into the existing scope of outreach to help ensure proper categorization.

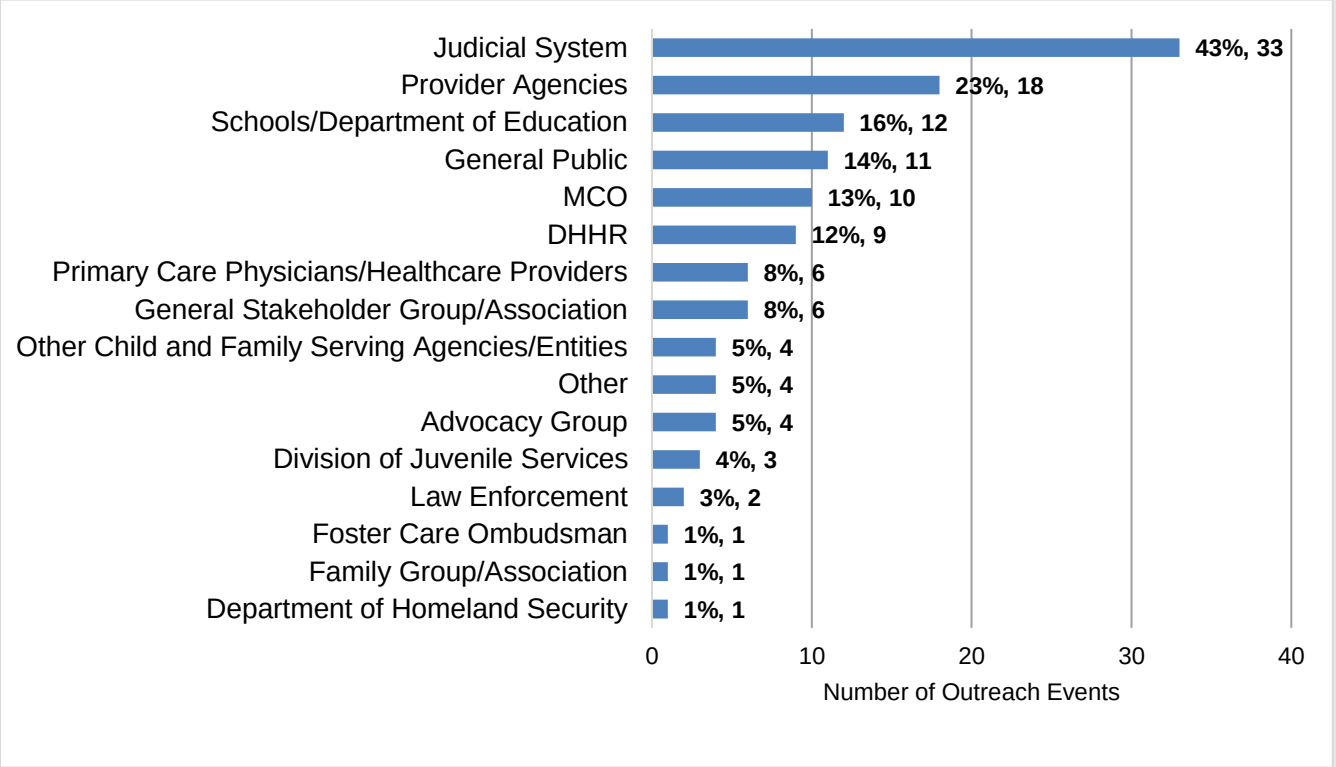
Figure 8: Purpose of DoHS Outreach, July to December 2023



*__Note:__ Blue bars indicated a mental-health related topic

This information was provided to a wide array of audience types, as indicated in Figure 9. Many outreach events targeted multiple, distinct audiences, so the percentages in Figure 9 exceed 100%. The judicial system (e.g., judges, attorneys, and victim's advocates) was the most common audience type (n = 33, 43%), followed by provider agencies (n = 18, 23%), and schools/Department of Education (n = 12, 16%). Change in outreach audience is expected as new connections are made and areas in need of improvement are identified. The Outreach Workgroup is striving to further understand the impact of outreach and how to determine where efforts are best focused.

Figure 9: Audience Type for DoHS Outreach, July to December 2023



DoHS intends to use longer-term data from the tracker to correlate outreach efforts at the county-level with service utilization trends, residential placement rates, and other county-level data. In addition to consideration of vendor and grantee efforts, understanding these relationships will enable DoHS to know where to focus outreach efforts geographically as well as systematically to make the most impact where it is needed.

6.3 BSS Judicial Outreach

In spring 2023, BSS started a large outreach effort with the judicial system. Social service managers were asked to meet with judges on a quarterly basis to provide information and answer questions about available services and needs. A total of 40 meetings were documented by SSMs from July 2023 to March 2024. This goal was met (on average) in nine of the 31 districts. BSS leadership and the Office of QA will collaborate with the SSMs to better understand the relationships with the court community and strategize how to meet and maintain quarterly contact in all districts. As noted in Section 6.0 Marketing, outreach efforts to the judicial community are included as an indicator for assessing needs and strengths in a given county. This will be evaluated further in the coming months and addressed according to identified and prioritized needs.

6.4 DoHS County-Level Analysis

DoHS conducted a county-level analysis to identify and prioritize counties for targeted outreach and education. The primary criteria for this analysis were focused on admissions and utilization

of RMHTFs. Counties were considered “high need” if they met or exceeded a threshold of 12 or more admissions as well as an average RMHTF utilization (census) rate of four or more per thousand youth over the six-month period of January to June 2023. Out of 55 counties, four met both criteria: Harrison, Wayne, Wood, and Kanawha. Figure 10 below shows the number of RMHTF admissions, as well as RMHTF utilization and admissions rate per 1,000 youth for the four counties, and the state averages. Total admissions for these counties ranged from 27 (Wayne) to 124 (Kanawha) for the six-month period compared to an average of 12 admissions per county statewide. RMHTF utilization rates for the four high-need counties ranged from 4.2 (Harrison) to 5.1 (Kanawha) children in placement per 1,000 youth in the county, compared to a rate of 3.3 children in placement per 1,000 youth statewide.

Figure 10: RMHTF Admissions and Utilization Census, January to June 2023

County	RMHTF Utilization per 1,000 Youth Jan-June 2023	RMHTF Admissions Jan-June 2023	RMHTF Admissions Rate per 1,000 Youth Jan-June 2023
Wayne	4.6	27	3.2
Harrison	4.2	32	2.1
Wood	4.2	36	1.9
Kanawha	5.1	124	3.3
State Average	**3.3**	**12**	**1.6**

The four identified counties were examined further for HCBS utilization and community-based capacity to identify specific areas for targeted intervention. These indicators were:

- CMCRS Utilization
- CCRL Utilization
- Assessment Pathway referrals
- CSED Applications
- CSED Utilization
- QIA Referrals
- Ratio of available foster homes by age group
- Kinship placement rates

These county-level profiles have been shared with representatives from each bureau for prioritization. DoHS leadership will facilitate development and execution of a strategic work plan with the larger DoHS team for outreach and intervention strategies based on identified needs and suggested prioritization over the coming months.

6.5 Other Outreach and Education Updates

WV Hospital Association

DoHS continues to work closely with the WV Hospital Association and meet with the children's hospitals on a quarterly basis. The Pediatric Mental Health Summit identified a need for a crisis stabilization unit for children experiencing a mental health crisis. DoHS secured approval and funding. Plans are progressing with an anticipated opening date in fall 2025.

WV Department of Education and WV Department of Homeland Security

In December 2022, DoHS began collaboration with the WVDE, WV's court system, and the WV Department of Homeland Security (DHS). Meetings between members of leadership occur multiple times annually with additional meetings in the interim for appropriate personnel to advance collaboration and data collection efforts. All parties are committed to advancing efforts to raise awareness of HCBS, bring data and information sharing to the forefront of this partnership to enhance interagency planning, and collaborate to identify and eliminate silos and barriers. Recent meetings have included discussion on concerns related to court-ordered placements and the need for use of clinically based assessment such as the QIA process to help with objective decision-making by MDTs. The group has also discussed discipline in schools in consideration of mental health needs and opportunities for connection to related services. In addition to sharing key information about available services and strategizing opportunities for impact, WVDE and DoHS have data use agreements in place that will allow outcomes reporting once data is able to be matched and transferred securely between systems.

In spring 2024, the WV Department of Education announced a new resource for parents and families of school-aged children. ParentGuidance.org provides access to mental health resources such as parenting coaching and the "Ask a Therapist" forum. WVDE secured a three-year grant through The Cook Center for Human Connection and the Substance Abuse and Mental Health Services Administration and hopes this connection will bridge the gap for families who might not be accessing services elsewhere, especially in more rural communities.

Probation Services

To support relationship building with juvenile probation officers and to continue to raise awareness of the importance of screening and referral to the Assessment Pathway, BSS and the Division of Probation Services held a professional development meeting for juvenile probation officers and field staff supervisors in October 2023. To accommodate attendees from multiple geographic locations, sessions were held in both Beckley and Morgantown in the southern and northern parts of the State, respectively. The meetings focused on residential treatment model changes, CANS and discharge planning, juvenile brain development, and the CCRL. DoHS plans to continue outreach to juvenile probation officers to improve screening and referral rates and to understand barriers or concerns with the referral and screening process.

Foster Home Capacity

As identified through DoHS's prioritized discharge planning efforts (further detailed in Section 14.0 Community-Based Placement and Section 17.0– RMHTF Services), additional foster home

capacity to serve youth ages 13 to 17 with complex mental and behavioral health needs is necessary to meet the demand of youth ready to be discharged from residential facilities. To meet this need, a partnership was established between Mission WV, BSS, Aetna, CPAs, and current foster and adoptive parent representatives to drive an initiative to develop this capacity. The group selected 84Agency, a marketing firm, to develop the overall campaign in conjunction with foster care partners. The campaign messaging, "West Virginia Needs You Now",[33] which began in March 2024, is focused on conveying the urgent need for foster parents and families across the State. The campaign's messaging addresses the misconceptions about who can become a foster parent as well as the unique experience that comes from fostering teens. The campaign also focuses on the goal of foster care: reunification when in the best interest of the child.

Mission WV reported that from March to June 2024 they received approximately 200 inquiries a month, which is double what they typically receive. Almost half of these are attributed to the campaign. Mission WV states that around 10% of those who inquire eventually go on to become certified foster parents, and the timeline between inquiry and certification is typically nine months. Therefore, the Department would expect to see the greatest impact from the campaign later in 2024.

HealthCheck

BPH has continued outreach to physicians and clinics to improve overall EPSDT screening rates, raise awareness of the Assessment Pathway as a mechanism for additional assessment and connection to services, and promote use of the electronic referral process to the Assessment Pathway. As of November 2023, 590 of 694 primary care physicians (85%) have been reached by HealthCheck specialists. Efforts to reach the remaining providers will continue throughout 2024.The HealthCheck team is running a mid-year report to determine the number of providers remaining, and additional HealthCheck staff have been hired to meet needs. This outreach effort remains a priority for the HealthCheck program.

First Choice Services

The marketing and outreach update from First Choice Services, which operates the HELP4WV call line, including CCRL, reported the following for July to December 2023:

- The HELP4WV program was featured in 75 news stories, with 12 of them specifically mentioning the CCRL.
- In September 2023, six digital outdoor billboard placements were purchased.
- The HELP4WV website received more than 18,000 visits. The subpage dedicated to the CCRL accounted for 2,567 visits (14% of overall website visits). Additionally, the HELP4WV Facebook page had 137 posts, with 25,300 views.
- There were 284 instances of outreach for HELP4WV. This includes exhibits at health fairs, resource fairs, festivals, and social service access points, as well as community

[33] https://www.wefosterwv.org/

presentations and literature distribution.

Traffic reported from First Choice Services is significantly lower than reported in the past. During July to December 2023, First Choice Services did not employ any ads, which may have contributed to the high levels of web traffic seen previously. The last ad campaign went live in April 2023. First Choice Services and BBH are discussing advertising strategies and hope to see improvements later in 2024.

6.6 Strengths, Opportunities, Barriers, and Next Steps

Screening, referrals to the Assessment Pathway, and service utilization continue to increase as will be noted throughout the remainder of this report. This trend is a positive sign that awareness of programs and services among youth, families, and the providers that serve them continues to expand.

Next steps include DoHS's continued focus on a county-level approach and the work plans developed for the target counties. Maps developed from county-level risk/need ranking will continue to be used by the bureau and program teams to drive county-specific efforts for prioritized service areas.

The next quarterly Outreach Workgroup meeting is set for August 2024 to review the Kids Thrive website for streamlining messaging and updating information, as well to discuss the future of the five-year Outreach and Education Plan ending this year. Additionally, DoHS will host the next Kids Thrive Collaborative combined with the Commission to Study Residential Placements of Children meeting in early September 2024.

Based on the limited community-based placement capacity to accommodate children ready to discharge from RMHTFs, DoHS is committed to sustaining the foster care collaborative and associated campaign aimed at increasing the number of foster families willing to serve youth ages 13 to 17 with complex needs, as well as transitional living opportunities for older youth. The Department is optimistic that the "WV Needs You Now" campaign will show impactful recruitment later this year.

DoHS will remain dedicated to further humanizing processes and addressing common misconceptions, ultimately simplifying system navigation, and building trust with the families who need these services. These combined efforts, along with monitoring and improving the data from the Outreach and Education Tracker, as well as collaborative partner efforts, are expected to help increase awareness, education, and two-way communication among provider groups, stakeholders, and families while also identifying opportunities for further improvement.

7.0 Screening

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

- Primary Care Providers: provide screenings for Medicaid- and WVCHIP-eligible children through WV's HealthCheck (EPSDT) program within BPH, including youth who are in Youth Services (YS) or Child Protective Services (CPS) custody.
- BSS, CPS, and YS: provide screenings, via primary care providers and reinforced through HealthCheck, for children who are in DoHS custody for services related to status offenses or juvenile delinquencies, or for children who are in a child abuse and neglect case.
- WV Division of Corrections and Rehabilitation and BJS: provide screenings for children who are in juvenile detention and commitment facilities.
- WV Judiciary and Division of Probation Services: provide screenings for children who are on probation.

DoHS also plans to bring Certified Community Behavioral Health Clinics to WV later this year, which must provide services to anyone seeking help for a mental health or substance use condition. Screening, diagnosis, and risk assessment is one of nine core services for these clinics.

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

7.1 Review Period, Data Sources and Limitations, Population Measured

Data collection associated with screening has been established across all screening entities, and efforts associated with data quality and expanded reporting continue in varying stages. As data quality and reporting efforts continue, the information will be used to forecast provider capacity needs for Wraparound Facilitation and other HCBS, as well as provide a targeted approach for outreach, education, and training of providers and stakeholders who may have lower screening rates and/or underutilization of community-based referrals.

Figure 11: Screening Data Overview

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
Primary Care Providers	CY 2022 January 2021-	Chart Reviews DW/DSS	Chart review reporting on EPSDT with mental health	Children in WVCHIP or Medicaid with an

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
HealthCheck (EPSDT)	December 2023		screens is based on medical record reviews. WVDH conducted medical record reviews for a random sample of Medicaid members between ages 0 and 20 who had a well-child visit during the review period. The random sample is a subset of the total children screened. DW/DSS data from claims represents the children with WV Medicaid or WVCHIP who had at least 90 days of consecutive eligibility in the last year and were eligible on the last day of the period. Reviewing these children to identify number screened annually through EPSDT, on a rolling 12-month basis.	annual EPSDT well-child visit.
CPS and YS Wellness (EPSDT) Screening	July 2023 to December 2023	Fostering Healthy Kids Data System	The Fostering Healthy Kids data system is a subset of (historical) FACTS, and PATH data and does not include child exit date. This might make it unclear if an individual had time to be screened before exiting placement. Data may be subject to change given data entry and related claims reporting lag. Further analysis has shown greater stability in these data six months following the period of review.	Children with a CPS and/or YS case in DoHS custody including screenings conducted via a wellness visit, visit completion is reinforced by the HealthCheck program.

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
BJS	July 2023 to December 2023	Offender Information System	Reporting was implemented January 2022.	Children in juvenile detention and commitment facilities screened using the MAYSI-2 who have a juvenile delinquency offense.
Division of Probation Services	July 2023 to December 2023	Probation Web-Based Data Collection Form	Screening and data collection was implemented in March 2022.	Children adjudicated as a status offender or delinquent, as well as children who have not yet been adjudicated who lack a DoHS worker or who are in immediate crisis are screened using the MAYSI-2.

7.2 Review Summary

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

Wellness screenings through HealthCheck are a key focus of DoHS's work to help ensure children are meeting developmental milestones and are receiving and being connected to important preventative and early-intervention services. During the first half of 2024, DoHS has continued to pursue quarterly review and data availability of annual EPSDT screenings from claims for eligible children with Medicaid or WVCHIP to enable additional discussion and strategic planning with stakeholders. Based on these efforts, the Wellness Screening PIP team has implemented some adjustments to methodology for reviewing screening rates related to EPSDT visits to enable more timely and frequent review, and to help ensure the definition for eligibility allows full opportunity for children to receive an annual wellness visit during the period of review.[34]

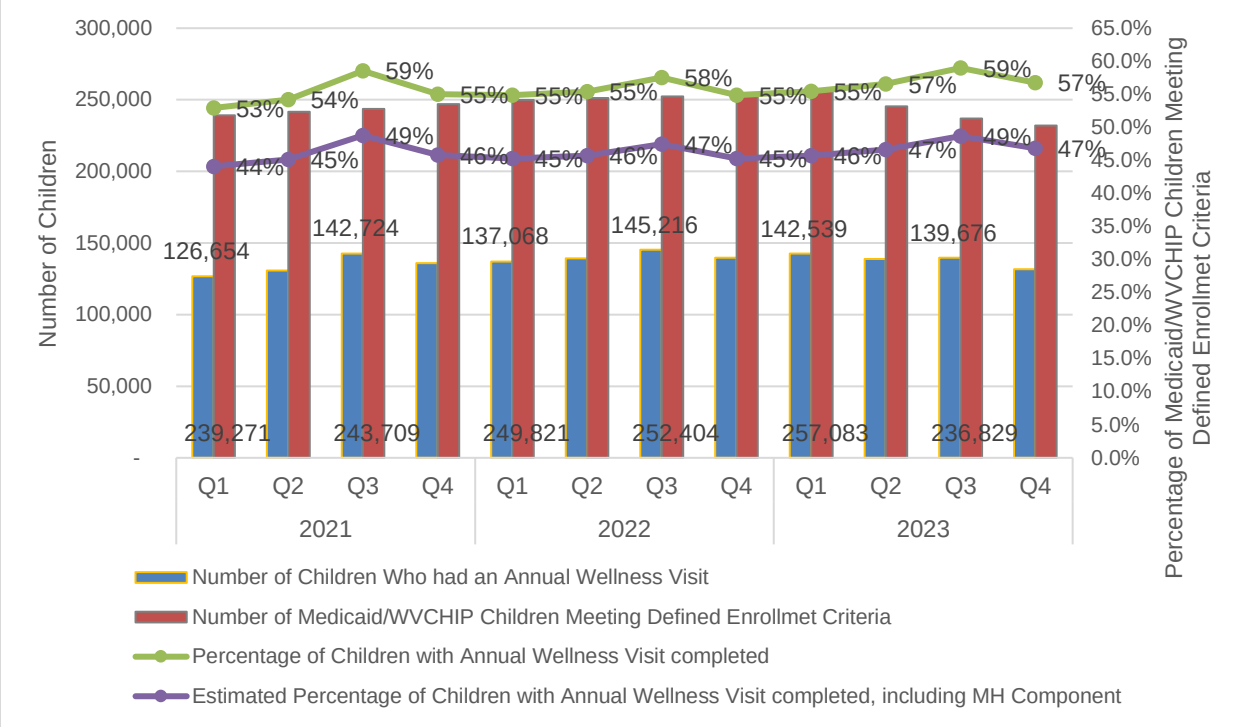
[34] Children included as primary insurance, Medicaid or WVCHIP eligible for the period were eligible as of the end of the respective reporting period and had at least 90 days of consecutive eligibility during the 14-month rolling period; children meeting this definition may vary from quarter to quarter based on this criteria. Note this is a change in methodology from previous reports as eligibility as of the end of each period was also viewed as important to ensure the child had ample opportunity to receive the annual well-child visit. DoHS also completed analyses to understand impacts of primary insurance designations and patterns and ability for families to get their annual looking back only 12 months, which also resulted in listed changes to methodology. BMS requires annual well-child visits to be at least 365 days apart, so in order to factor in potential scheduling needs of the family or provider, DOHS has added an additional two months to the rolling annual review. The federal reporting instructions for CMS-416 reporting were referenced to maintain consistency in methodology for defined procedure codes and related diagnosis combinations to identify applicable EPSDT screenings recorded during well-child visits.

As of September 30, 2023, (end of Quarter 3), WV had 139,676 Medicaid members aged 0 to 20 who received an annual HealthCheck (EPSDT) screening during well-child visits in the previous 14 months (Figure 12), representing 59% of the defined Medicaid-eligible population of children (n = 236,829). A retrospective analysis of wellness exam records sampled from provider records and administrative claims for Medicaid utilization in 2022 indicated that 82.5% of children had a mental health screening component included during the visit. Extrapolating from the most recently conducted chart review in CY2022, an estimated 49% of children received an annual EPSDT with mental health screening. Quarter 3 is noted to be most inclusive of annual visits due to seasonal association with going back to school and sports physicals in the fall.

Overall annual screenings[35] have increased from 53% as of the end of March 2021 to 57% as of the end of December 2023, while retrospective review of screenings including a mental health component have decreased slightly (83.3% to 82.5%, from CY2021 to CY2022 chart reviews, respectively). The HealthCheck epidemiologist and Program Director will work with the HealthCheck specialists to help ensure outreach and education is offered to providers, with a targeted focus on the nine –17-year-olds. HealthCheck will review the data by regions to identify potential technical assistance needs of providers for screening this particular age group. DoHS's goal is to reach at least 52% of Medicaid-eligible children annually with EPSDT screening including a mental health component. As shown in Figure 12, there has been improvement in the proportion of Medicaid-eligible children screened annually, with 44% screened as of the end of March 2021 compared to 47% at the end of December 2023, a percentage increase of 7% between the two time periods with the most sustained improvements in screening rates reflected beginning at the end of June 2023, reflecting annual screenings for eligible children occurring in the 14 months prior (May 1, 2022 to June 30, 2023). Improvements in screening rates as of quarter 2 2023, looking back 14-months, reflect extensive efforts of BMS and MCOs to increase awareness with families and identify structural barriers, as is described in more detail later in this section.

[35] This rate is without consideration for the mental health component.

Figure 12: Quarterly View of Rolling 14 Month Annual Wellness Screening Rates for Medicaid-Eligible[36] Children 0 to 20



Increases in screening rates have been noted by the Well-Child Screening PIP team in all age groups. However, children in younger age categories are more likely to receive at least one EPSDT screening annually. This may be expected due to the frequency related to development and vaccination schedules for younger children. However, to advance opportunities for early identification of needs and connection to services, it is important to target the older population of youth, primarily nine- to 17-year-olds. As shown in Figure 13, 52% of children 13- to 17-year-olds and 57% of children nine- to 12-years-old received EPSDT screening from August 2022 to September 2023 compared to 80% of children aged 0 to four years. It is noteworthy that children in the age category 13 to 17 years represent the largest number of youth eligible for screening, so improving their screening rates will further influence achieving the overall goal of 52%.

[36] Children included as Medicaid or WVCHIP eligible for the period were eligible as of the end of the respective reporting period and had at least 90 days of consecutive eligibility during the 14-month rolling period; children meeting this definition may vary from quarter to quarter based on this criteria. Note this is a slight change in methodology from previous reports as eligibility as of the end of each period was also viewed as important to ensure the child had ample opportunity to receive the annual well-child visit. The federal reporting instructions for CMS-416 reporting were referenced to maintain consistency in methodology for defined procedure codes and related diagnosis combinations to identify applicable EPSDT screenings recorded during well-child visits. This definition is used throughout this section.

Figure 13: EPSDT Annual Screening Rates for Eligible Children by Age Category, Quarter 3 – 2023 (Screenings occurring August 2022 to September 2023)

Age Category	Percent of Children with Annual Screening	Number of Children Eligible
Age 0 - 4	80%	53,420
Age 5 -8	63%	47,187
Age 9 -12	57%	48,165
Age 13 -17	52%	60,286
Age 18 -20	30%	27,771

In early 2023, the Well-Child Screening PIP team began engagement with the broader group of MCOs under Mountain Health Trust and partnered with the WVDE to attempt to improve screening rates and progress toward the goal of at least 52% of Medicaid-eligible children receiving an EPSDT with a mental health screening component. Through these collaborations, the team began to explore opportunities for additional outreach directly to children and families, as well as outreach indirectly via school-related messaging as avenues to expand awareness of the importance of wellness visits. MCOs under Mountain Health Trust already have several strategies to attempt to improve wellness screening efforts, such as:

- Follow-up with families to remind them of needed visits (via call, text, and mail).
- Calls from the child's case manager with reminders about wellness screenings and the importance of these visits.
- Consistent messaging on materials, including reference to the CCRL for immediate needs.
- Gift cards for families completing their annual wellness screening.

Although the efforts implemented have been extensive, the MCOs still note challenges reaching families directly due to noted and often frequent changes in contact information (e.g., phone number, home address) for many families. Families may also face structural barriers, including childcare-related needs while taking another child to an appointment, concerns with employment schedules and needing to take leave from work, and inconsistent availability of transportation. BMS has worked with the MCOs to expand their outreach reporting to enable the review of outreach efforts and barriers for families at a more granular level to further assess which outreach avenues have been most fruitful. BMS meets monthly as a touchpoint with MCOs; these meetings include data review and strategic planning.

To encourage and support connection of children and families to the Assessment Pathway, the group has worked with Aetna, the MCO that provides care management to most children, to

improve the care manager call process. The goal of these call process enhancements is to help ensure questions about mental health needs or changes are asked consistently, and that the information provided on the Assessment Pathway and associated children's mental health services and resources is relevant to each child.

Other efforts in collaboration with the MCOs and HealthCheck specialists will include continued training and education with primary care providers to help ensure appropriate mental health screening and use of the electronic referral process (and/or sharing of CCRL information) when individuals screen positive. The electronic referral process remains an underutilized option for primary care providers, as use of outreach tools such as wallet cards seemed to be the preference of referring providers. Primary care providers have had a very positive response to the wallet cards and continue to request additional cards to share with children and families. This information is noteworthy, as the wallet cards provide an opportunity for the family to directly follow up at any time based on their own needs and schedule. Screening and referrals directly from primary care providers are a focus area for improvement although the current system enables multiple opportunities for a family to be connected. The Quality Committee also discussed exploring expansion of electronic referral to the CCRL from emergency departments. BBH expects that the updated platform for the CCRL will be able to meet the need for this critical connection and plans to have this realized in 2025.

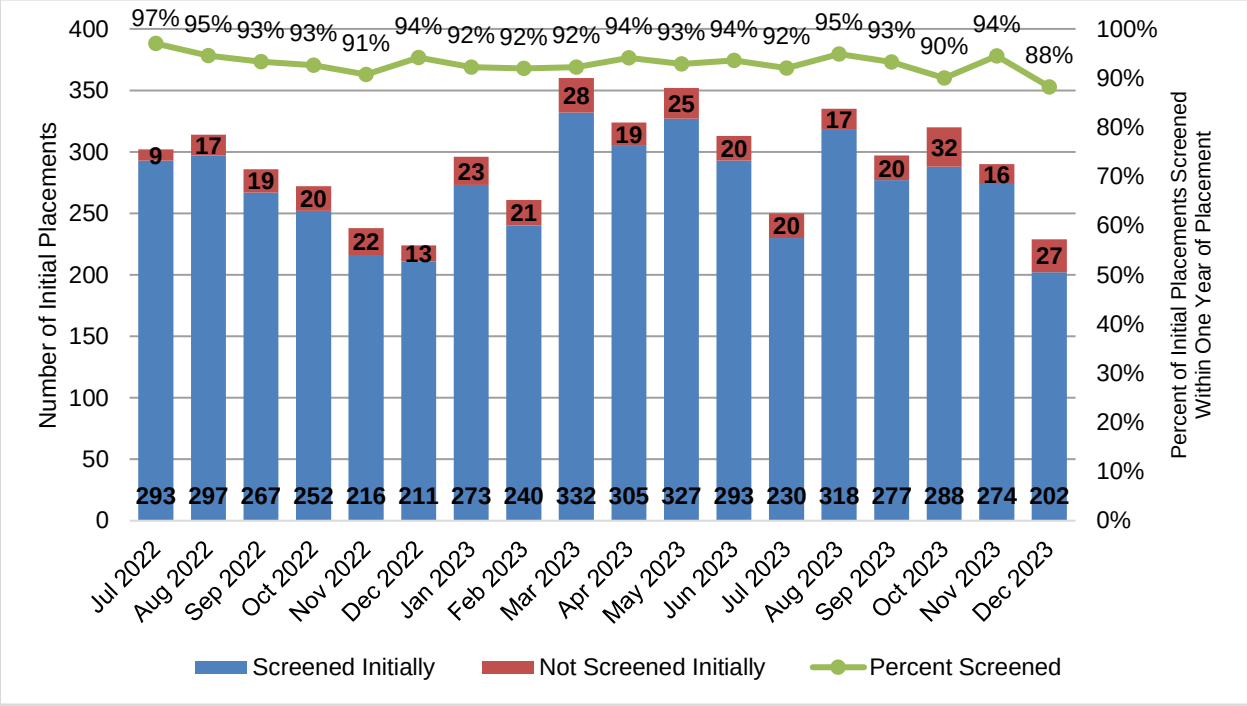
7.2(b) Youth Services (YS) and Child Protective Services (CPS) Screening

Youth in Foster Care or Certified Kinship Care (Includes Youth in YS and/or CPS)

All children placed in DoHS custody via the child welfare system (including both YS and CPS) are required to receive an EPSDT screening during a well-child visit, which includes a mental health screening within 30 days of placement. EPSDT providers are trained to provide referrals to the Assessment Pathway via both electronic referral processes and informational materials connecting families to the CCRL.

Figure 14 shows the percentage of children with a screening within one year of placement, based on the month the child was placed in DoHS custody. Screenings were reviewed to determine whether they were completed within one year of placement to align with every child needing to be screened at least once per year. Overall, for the 18-month period shown, 93% of children were screened within one year of initial placement. HealthCheck continues to follow up with families regarding these important screenings for children in the child welfare population. These follow-up efforts, in addition to policies implemented by both CPAs and BSS, help maintain these high screening rates. Data lag is expected for more recent months because one year has not yet passed since placement, meaning some kids may not yet be eligible for their annual wellness visit if they already received this visit within the 365-day period prior to placement.

Figure 14: Initial Child Welfare Placements and Screenings by Month, July 2022 to December 2023



Initial screenings for children in a child welfare placement (initial placement in July to December 2023) were assessed by age at initial placement. Figure 15 indicates children ages zero to five had the highest screening rates (94%). However, compared to the first half of 2023, there was an improvement in the percentage of children screens ages nine to 18 with a lower screening rate (87%) in the first half of 2023 and a higher rate (92%) in the last half of 2023. In total, 92% of children with an initial placement in the last half of 2023 were screened.

Figure 15: Initial Screenings for Child Welfare Placements by Age Group, July to December 2023

Age Group at Beginning of Placement	Screened Within One Year of Initial Placement (n)	Screened Within One Year of Initial Placement (%)	Not Screened Within One Year of Initial Placement (n)	Not Screened Within One Year of Initial Placement (%)	Total
0 – 5	701	**93.6%**	48	**6.4%**	749
6 – 8	185	**91.6%**	17	**8.4%**	202
9 – 18	703	**91.5%**	65	**8.5%**	768
Other/Unknown	0	**0.0%**	2	**100.0%**	2
Total	1589	**92.3%**	132	**7.7%**	1721

Early Screening Opportunities

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 the

case establishment.[37] This policy reinforces early identification of mental health needs to enable referrals to be conducted, regardless of whether the child is placed in child welfare custody or receiving home-based services. As previously stated, these efforts are in addition to those completed via the HealthCheck program to help ensure opportunities are not missed to address needs.

CPS and YS referrals continue to reflect the top source of referrals to the Assessment Pathway (66% of referrals), providing strong evidence that children are being referred to the Assessment Pathway for further evaluation and connection to services. As DoHS begins to have access to additional information on outcomes and timeliness, additional insight can be gathered regarding how to help guarantee children are referred and connected, ideally before a crisis or imminent need for residential placement occurs. The Quality Committee considered impacts on outcomes for youth not referred to, or not identified with, a need for the Assessment Pathway in a timely manner, even when a referral was eventually made. These processes increase consistency and help guarantee children served in the child welfare system can be connected to timely services to meet their needs and, when possible, avoid incidents of imminent risk for more restrictive placement.

7.2(c) BJS Screening

Children involved in BJS are screened at intake and each time they transition between BJS facilities. Figure 16 below captures screening conducted by BJS between July 2022 and December 2023. The total population[38] of children in BJS custody varies over time and ranged from 208 (September 2022) to 330 (April 2023), with an average of 274 youth for the period shown. The number of intakes per month varied over time with a range from 69 (August 2022) to 111 (February 2023) and an average of 92 for the period shown.

The BJS population increased from July 2022 to July 2023, followed by a decrease in the second half of 2023, then an increase in early 2024. BJS leadership attributes the increase in their population to two primary factors: (1) Change in juvenile competency legislation,[39] which resulted in youth under the age of 14 automatically being deemed incompetent and therefore requiring a competency evaluation, and (2) Difficult to place youth being denied placement by in-state and OOS residential treatment providers or being placed on waitlists. BJS leadership also anecdotally shared that the complexity of mental health needs of children in BJS placement has been increasing. The new models of residential care currently in development by DoHS will be expected to assist with in-state capacity to support youth with complex needs who are currently being placed in BJS custody. Based on a review of trends in BJS and RMHTF census

[37] CPS policy states that the Ongoing Assessment will be completed within the first 15 days of transfer of the case to ongoing services. YS policy states that the FAST will be completed within the first 15 days of initial contact with the family. If a child goes immediately into a shelter or RMHTF before the Ongoing Assessment or FAST are completed, the child welfare worker will complete referrals within 24 hours of placement.

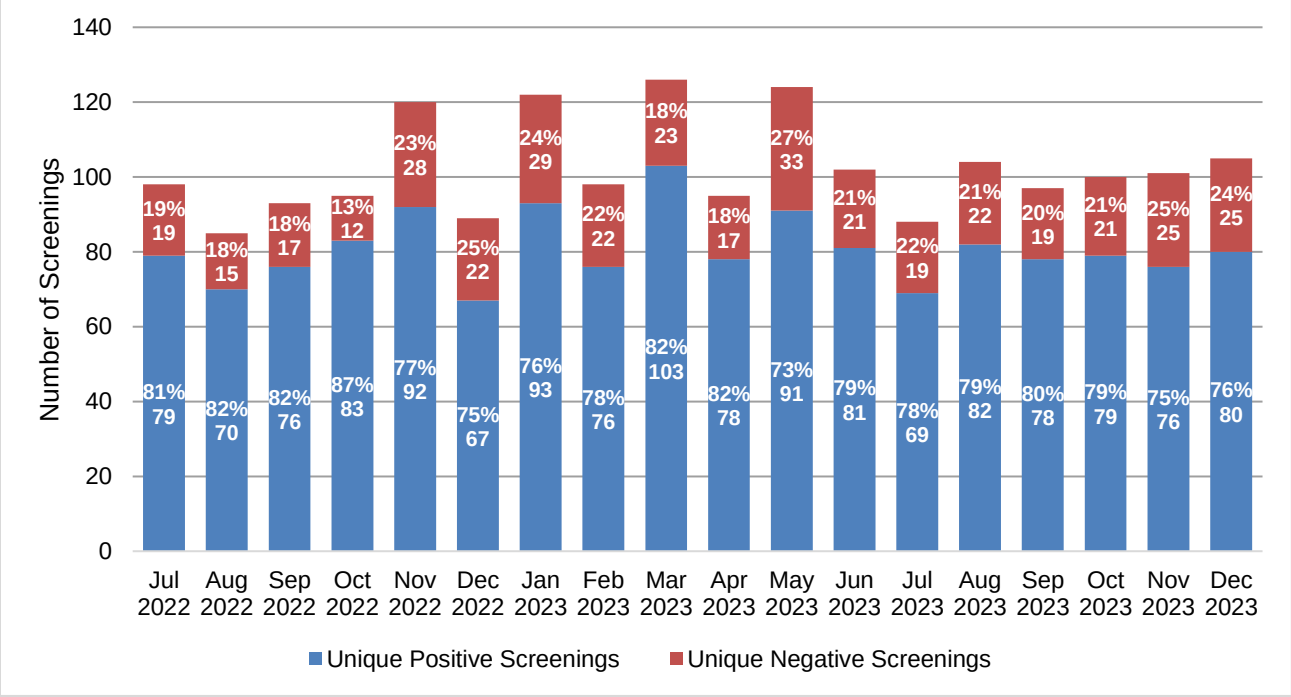
[38] BJS population data are a point-in-time measure captured on the last day of each month and do not represent the number of unique children in BJS custody during a given month.

[39] These increases in children in BJS custody are opposite of the legislation's intent. Key stakeholders are exploring the data to understand these findings and possible steps to lessen this occurrence.

data, DoHS and BJS would like to further explore children who may be interacting with both systems, including an evaluation of readmissions to BJS and RMHTF and associated child outcomes as part of expanded cross-systems analysis planned for 2025.

Unique screenings varied throughout the period with a low of 79 in August 2022 and a high of 126 in March 2023.[40] BJS conducted an average of 102 unique screenings per month from July 2022 to December 2023. However, there was variation in screening numbers across the reporting period: the first half of 2023 averaged 111 screenings per month compared to only 99 per month in July to December 2023. The number of screenings per month should equal or exceed the number of intakes per month because each child entering BJS custody should be screened at intake. Therefore, the greater number of screenings in the first half of 2023 is primarily attributable to BJS population trends and efforts to screen all children at intake.

Figure 16: BJS MAYSI-2 Mental Health Screenings, July 2022 to December 2023



Data review and reporting was expanded in May 2023 to include BJS facility-level screenings versus intakes to support targeted improvement efforts. Based on initial review of this data, it was discovered that one facility was not completing screenings as expected. Through focused effort and hiring a new case manager, recent data shows this facility now completes more screenings than intakes. An updated analysis of screenings versus intakes across BJS facilities showed 91% of intakes were screened for the period January to May 2024 compared to only

[40] In DoHS Quality and Outcomes Reports prior to January 2024, BJS screening numbers included youth screened at Youth Report Centers. Youth receiving services at Youth Report Centers are not in BJS custody and thus are not expected to be screened per BJS policy. To align screening data review more closely with policy, screenings at Youth Report Centers have been excluded from analysis for the January 2024 DoHS Quality and Outcomes Report and all subsequent reports. This change means that BJS screening numbers in this report are not directly comparable to screening numbers in reports prior to January 2024.

83% of intakes that were screened for the period August to December 2023, evidence that screenings are being completed as expected at most BJS facilities.

DoHS continues to meet at least quarterly with BJS to improve understanding of the data and work toward quality improvement. Following the July 2023 Quality and Outcomes Report, DoHS requested the addition of the booking date (i.e., date of intake) in the monthly reporting to improve understanding of screenings and intakes, including timelines from intake to screening. This data became available in August 2023. Based on available data for the reporting period, 82% of youth are screened on the day of intake to a BJS facility or on the following day, and 93% of youth are screened on the day of transfer between BJS facilities or on the following day.

Of those screened, the age demographics were consistent with those in residential services, with 88% of individuals screened aged 13 to 17.

The percentage of positive unique screenings remained relatively consistent during the reporting period, ranging from a low of 73% in May 2023 to a high of 87% in October 2022. During the primary reporting period of July to December 2023, 374 of the 465 unique children screened had a positive screen (80.4%), consistent with rates of positive screenings reported in prior periods. The steady rate of positive screenings at or above 80% illustrates the importance of seeking earlier intervention for children who are involved with BJS and the potential positive impact that connecting this population with services before entering BJS could have on their outcomes.

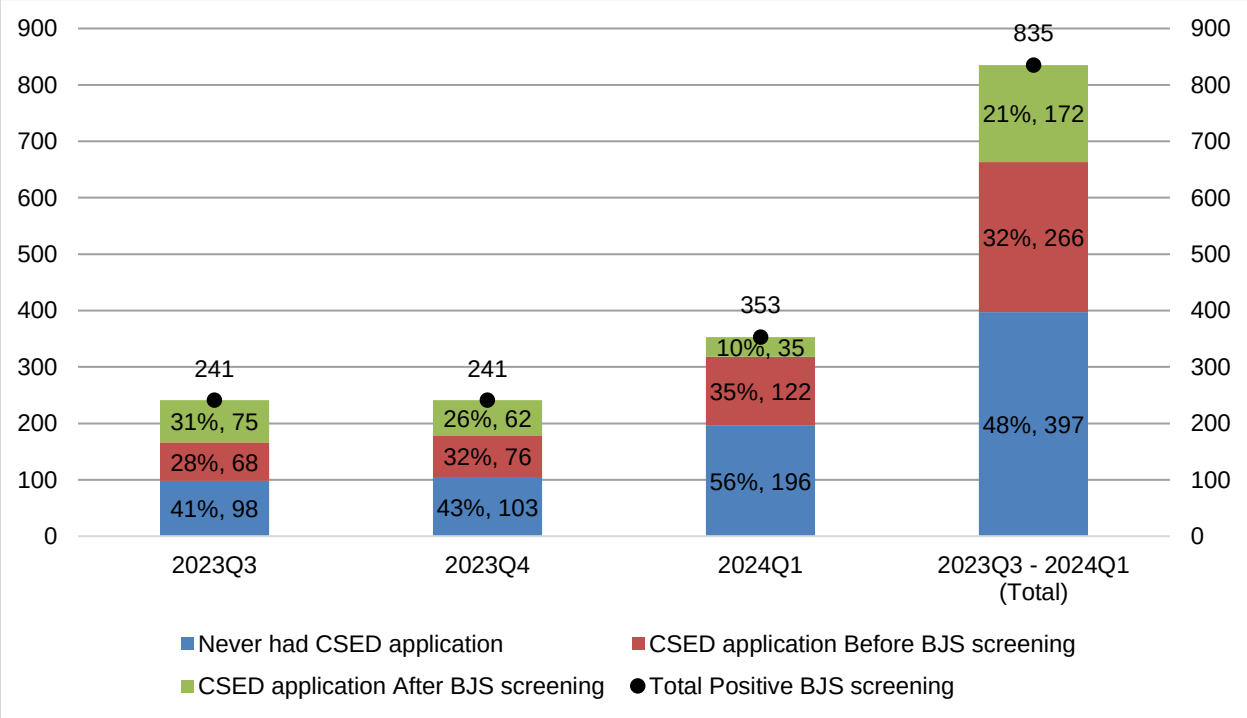
BJS began making referrals to the Assessment Pathway in the fourth quarter of 2022. DoHS is continuing to coordinate with BJS to enhance tracking and reporting on referrals to the Assessment Pathway (i.e., submission of CSED Waiver applications). This information can now be captured in the BJS Offender Information System (OIS), although data completion by BJS staff continues to be an area for improvement. As a temporary solution to support staff accountability, BJS created facility-specific spreadsheets for completion by facility case managers, which includes documenting submission of CSED Waiver applications. BJS continues to crosswalk this information with the data in the OIS and uses this as a mechanism for feedback to BJS case managers. Challenges remain with accuracy of documentation in both the spreadsheet and the OIS.

As a next step, DoHS was able to leverage progress in data store development to complete a cross-systems analyses of children in BJS with positive mental health screens and CSED Waiver application data from Acentra Health for the first time. The results were shared in DoHS's May 2024 Quality Committee review and with BJS leadership. Figure 17 captures CSED application status by quarter for children in BJS with positive mental health screens for the period Q3 2023 to Q12024 (n = 835). Note that Q1 2024 results may be impacted by data reporting lag. In aggregate for the full nine-month period, 48% (n = 397) of children in BJS who screened positive never had a CSED Waiver application submitted. Based on this initial result, there is more work to do to help ensure children who screen positive are referred for CSED Waiver eligibility determination. To that end, BJS plans to implement monthly unit manager meetings, which will include review of screening and application data to continue to improve screening and referral results. Office of QA representatives will be invited to some of these

meetings to share data and support improvement efforts.

Further analysis of referral sources of the CSED Waiver applications submitted for children in BJS with positive screens indicated DoHS workers are the primary referral source (DoHS comprised 65% of referrals for children before BJS screening occurred and 53% of referrals made after BJS screening occurred). These results are evidence of the close partnership between BJS and DoHS workers in coordinating care of children in BJS. Of the children in BJS for whom a CSED Waiver application was submitted, 59% were approved for CSED Waiver services, 22% were closed, 5% were denied, and 14% were still pending as of April 2024. The 59% approval rate for children in BJS is higher than the 42% approval rate for the full population of children with CSED Waiver applications submitted for the period July to December 2023. This finding is an encouraging sign that these children could potentially be served in the community following discharge from BJS. Closed applications for BJS (22%) were much lower than the closures for the full population (42%). Denials were consistent with the full population. This data will continue to be explored in the future, including future cross-systems analysis of CSED Waiver and other HCBS following utilization following discharge from BJS and other associated outcomes.

Figure 17: CSED Application Status by Quarter for Children in BJS with Positive Mental Health Screens, Quarter 3 2023 to Quarter 1 2024



Screening is an important safety net for children involved with BJS. This group of children engages with multiple entities including BJS, Probation, BSS workers, and Aetna care managers, providing multiple opportunities for screening and referral to services. In the future, DoHS would like to further explore the relationships between these entities, given their role in influencing the outcomes for children involved with BJS.

7.2(d) Division of Probation Services Screening

Screening of children who are adjudicated as status offenders or as delinquent and the associated data collection was implemented by the Division of Probation Services effective March 1, 2022. These screenings are conducted at intake by the assigned probation officer. In November 2022, the Probation Services screening policy was expanded to include screening of pre-adjudicatory children who are in crisis or who do not have a DoHS worker assigned to support early-intervention efforts for those children who may have a higher risk. Screening may also be conducted at other intervals based on the probation officer's discretion. From July 2022 to December 2023, Probation Services screened 609 unique children.

Intakes[41] completed from July 2022 to December 2023 varied from a low of 152 in July 2023 to a high of 747 in February 2023, with an average of 423 intakes per month. The number of children adjudicated as status offenders or delinquents ranged from a low of 47 in October 2023 to a high of 119 in March 2023 with an average of 84 children adjudicated per month. The month-end population of children on formal probation (i.e., adjudicated as status offenders or delinquent) for the July 2022 to December 2023 period ranged from a low of 974 in December 2022 to a high of 1,149 in October 2023, with an average of 1,071.

Probation Services continues efforts toward broadening adoption of the screening and referral processes. To support this goal, DoHS continues to work with Probation Services to identify trends in the children interacting with Probation Services, the number of screenings expected, and any relationships between the number of monthly intakes and the number of children formally adjudicated as delinquent or status offenders, including analyses on the county-level. As of May 2024, 41 counties have reported screenings at some point since inception of the Probation Services screening processes in March 2022. This number remains unchanged since the January 2024 DoHS Quality and Outcomes Report. Based on a more detailed review of these counties, with the exception of Boone County, the remaining 13 counties who have not reported screenings have very few children who are on formal probation, leading to few screenings expected. Further follow-up on Boone County revealed that the person responsible for populating screening data in the Probation data collection system was not uploading the information correctly. This issue has been addressed and will be monitored for improvement going forward.

As noted in the January 2024 Quality and Outcomes Report, based on an analysis of adjudications and screenings by county, four counties were selected for focused improvement of screenings: Mason, Mercer, Monongalia, and Putnam. Since then, a monthly update on the progress in these counties has been shared with the chief probation officers. Based on screening data through May 2024, improvements were noted in Mason and Putnam counties. Mercer county continues to have lower rates of screening than would be expected based on adjudications, while Monongalia reports zero screenings. Both counties report that their cases

[41] Intakes during each month do not necessarily equate to children who are adjudicated as status offenders or delinquent because adjudication may occur after intake and may not fall within the same month. Additionally, some children are not adjudicated as status offenders or delinquent (e.g., the child may be found not guilty, or the case may be dismissed).

are assigned a DoHS worker through YS, where screening would be expected to be completed. Chief probation officers from these counties also report that many children are already receiving CSED Waiver services.

Early findings from the Children's Mental Health Evaluation for 2024 show: "When youth were involved with juvenile justice, caregivers reported that probation officers were particularly helpful with system navigation and often filled the role of care coordinator. Families also valued the structure, supervision, and authority afforded by probation and other court services and supports, which helped promote youth well-being and response to treatment in and outside of their homes." DoHS commemorates the positive nature of these interactions and acknowledges opportunities to leverage these relationships by providing further education and messaging to probation officers to improve understanding of their essential role in identifying youth needs through screening, connecting youth to mental health services and supporting utilization of those services.

Additional steps to improve Probation screening results include the enhancement of new probation officer training effective April 2024, which includes a review of the probation screening policy. Chief probation officers also requested a monthly report of children screened that would enable them to cross-reference the children adjudicated in their respective counties to identify any gaps in their screening efforts. Child-level reports of children screened by county are being provided to chief probation officers monthly effective June 2024.

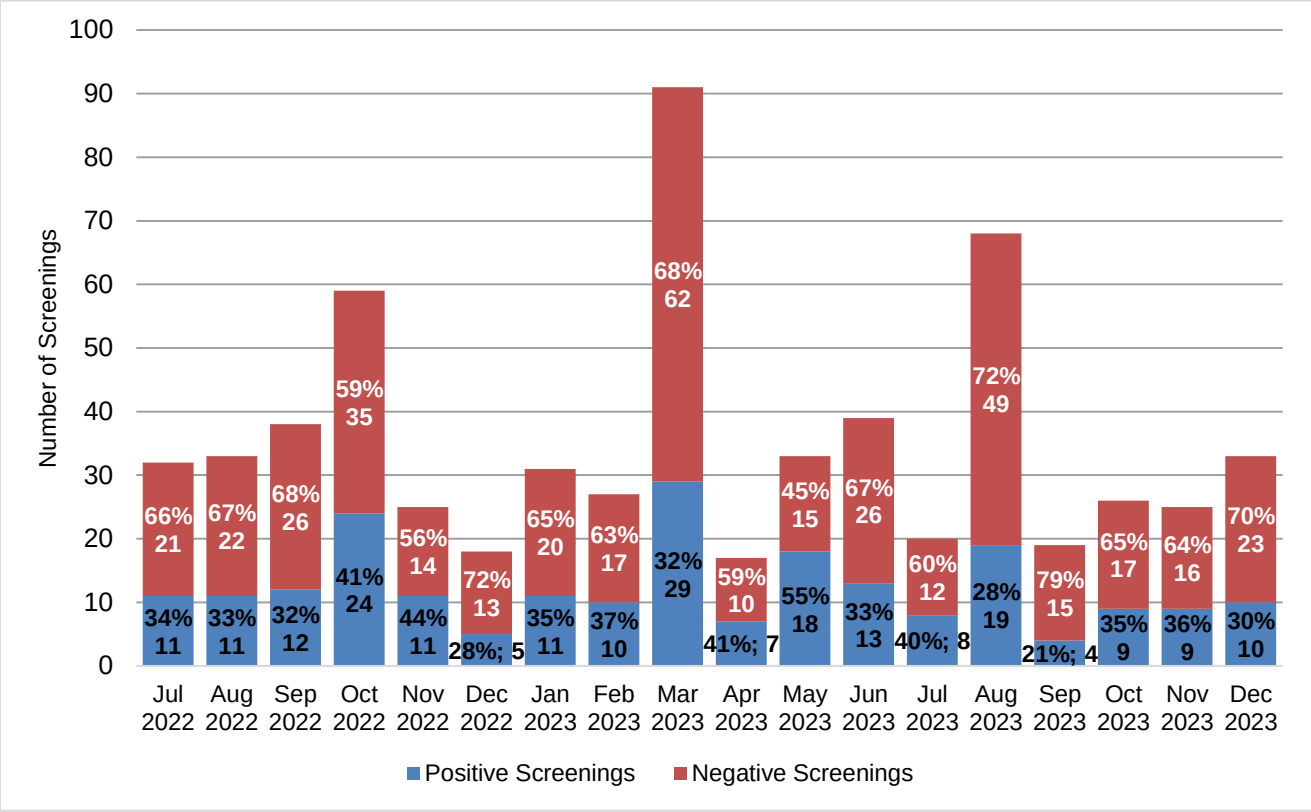
Figure 18 shows the number of screenings of children in Probation Services between July 2022 and December 2023. Six hundred thirty-four (634) screenings were conducted during this period,[42] with an average of 35 total screenings per month. One hundred seventy-nine (179) unique individuals were screened between July and December 2023, a decrease from 234 unique children screened in the first half of 2023. Monthly screenings have increased in the first five months of 2024 because of focused improvement efforts mentioned previously. Of those screened, 64% identified as male and 36% as female. Ninety-two percent (92%) of those children were between 13- and 17-years-old. These demographics are consistent with the prior reporting period. Of the screenings that occurred between July 2022 and December 2023, 221 (34.9%) were positive while 365 (65.1%) were negative. Reflecting on the general population of youth with an SED, 11% of WV youth with Medicaid/WVCHIP had an SED diagnosis in 2022 (as noted in the January 2024 DoHS Quality and Outcomes Report, Section 4.0 WV's Child Population and Individuals Utilizing Services). While it is not a direct comparison, 35% of youth with Probation Services were identified with a mental health need, further suggesting the importance of early intervention and screening with these individuals.

Probation-involved youth positive screenings have remained relatively consistent between approximately 30% to 40% since screening was initiated in March 2022. While lower than BJS positive screening rates (an excess of 80% of youth in BJS custody screen positive), Probation-involved youth continue to be a high-need population compared to the general youth

[42] Twenty-five (25) children were screened twice; 609 unique children were screened.

population;[43] DoHS remains aware of the need to target these youth for early intervention and connection to services.

Figure 18: Probation Services MAYSI-2 Screenings, July 2022 to December 2023



From July to December 2023, 54 unique children screened positive for a mental health need. Only 12 children (22%) were referred to the Assessment Pathway (Acentra Health) for further evaluation. This represents a decrease from 53% reported in the January to June 2023 period. On average, these 12 children were referred 2.7 calendar days following their positive screening. Eight children (67%) were referred within two days of screening, with the remaining children having been referred within 10 days of screening.

For the 42 children who were not referred or who had an unknown referral status, the most frequently listed reason for declining the referral was that the parent/guardian believed other mental health services already in place were sufficient to meet the needs of the child (n = 20, 48%). The second most listed reason (n = 8, 19%) was that the referral to the Assessment Pathway was already submitted by another entity. Given the strong association with concurrent involvement with Probation Services and YS, and the high proportion of referrals that originate

[43] Probation involved youth have positive mental health screens around 30 to 40%, which is above the rate for WV youth at 33% as noted in the 2022 National Survey of Children's Mental Health: *26% of responses for three- to 17-year-olds in the United States reported one or more reported mental, emotional, developmental, or behavioral problem and/or qualify on the Children's Special Health Care Needs screening for emotional, behavioral, or developmental criteria compared to 33% responses representing WV youth.*

from a CPS/YS worker, it is expected that some children may be screened at multiple touch points with referrals already taking place by other entities.

Implementation of increased and consistent screening practices for identification of mental health needs is being prioritized in outreach and education provided to chief probation officers. DoHS continues to highlight the importance of mental health screening regardless of the child's YS involvement because screening and referrals completed by probation officers can provide an additional opportunity and safety net for children who are in need of critical mental health services to help prevent further negative outcomes.

7.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing an EPSDT with a mental health screening, outreach to primary care providers about the Assessment Pathway started in November 2021. Out of 694 providers, 85% were reached by HealthCheck specialists in 2023 for training on the CCRL (including CMCRS services) and the provider electronic referral process. Resources were distributed to all sites. HealthCheck has hired additional staff and is conducting a mid-year review to determine the remaining providers in need of outreach. Conducting outreach to all providers by the end of 2024 is a priority for the HealthCheck team.

Child welfare position vacancies remain a barrier for effectively implementing screening and maintaining trained staff. As of June 30, 2024, there were 101 vacant CPS Worker positions out of 524 (19% vacant).[44] Youth Services Worker positions also experienced vacancies, with 14 vacant positions out of 126 (11% vacant)[45].

As of May 2024, approximately 6,000 children were in the child welfare system. Figure 19 displays both filled and vacant positions for the child welfare workforce. Despite worker position vacancies, staffing continues to grow across both CPS and YS since May 2023. Vacancies are reviewed at the district level to focus recruitment efforts. Improvements in position vacancy rates have been largely attributed to recruitment efforts that began in mid-December 2022 and continued into 2024 that authorized hiring and retention bonuses. Positions were also added for support staff.[46] These actions likely contributed to the increases in positions filled. While workforce recruitment and retention continue to be a challenge, overall child welfare workforce positions filled have increased 3% from the previous year. DoHS will continue to monitor screening rates over time and assess any additional needs related to training or staffing capacity with each entity as needed.

[44] This sentence refers to CPS and YS workers only and does not include coordinator or supervisor positions. Worker is inclusive of all levels under the worker classification.

[45] https://dhhr.wv.gov/News/2024/Pages/DoHS-Reduces-Number-of-Children-in-State-Custody,-Continues-CPS-Workforce-Vacancy-Improvements.aspx

[46] https://dhhr.wv.gov/News/2023/Pages/dhhr-Unveils-Major-New-Initiative-to-Strengthen-Protective-Services.aspx

Figure 19: Child Welfare Workforce, May 2024

Service Type	Positions Filled	Positions Vacant	Total Positions	Percent of Positions Filled May 2024	Percentage of Positions Filled May 2023
CPS	551	114	665	83%	81%
YS	121	19	140	86%	73%
Total	672	133	805	83%	80%

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

7.4 Strengths, Opportunities, Barriers, and Next Steps

Data collection associated with screening has been established across all screening entities and continues to progress based on the relative needs of the entity providing screening. Processes that touch a broad range of professionals might be expected to require additional time and resources to implement with consistency and integrity. DoHS is committed to continuing efforts to help ensure children can be identified through multiple entry points and are connected to services meeting their needs in settings that are supportive and, in the home and community when clinically appropriate.

DoHS will continue to reinforce, in collaboration with WV DH, PCP-related referrals and screening. As part of this process, the PIP team will determine needs and opportunities with the HealthCheck program, focusing on providers in need of education and technical assistance regarding how to incorporate mental health screening components into the EPSDT visit. In addition to provider outreach, DoHS will review quarterly claims data and provide feedback to the MCOs regarding provider trainings and outreach to families to encourage well-child visits and screenings. Efforts continue to enhance reporting by the MCOs to provide more extensive information related to child screenings and barriers.

BJS screening data indicates the screening process is timely and has been widely adopted. Probation Services continues efforts toward broader adoption of the screening and referral process through training and monthly reporting enhancements. Preliminary data for early 2024 shows signs of improved screening rates, so the continued focus on screening is having the intended effect.

WV continues to face workforce shortages in CPS and YS positions; however, recent recruitment efforts have resulted in decreased vacancy rates—with a percentage increase in occupancy of nearly 4% in 2024. Although these improvements are expected to reduce strain on the workforce, benefits have not yet been fully realized due to the significant time and effort involved in staff onboarding processes that must be completed before productivity increases can be actualized. DoHS plans to enhance efforts to review screening data and provide feedback over the coming months to solidify processes for new and established employees while helping to ensure children entering CPS and YS receive timely screening and referral to the Assessment Pathway when a mental health need is identified. Recruitment, training, and

technical assistance must be ongoing to meet these needs, and accordingly processes such as screening and referral have been added to new employee training to encourage sustainability.

Routine data review, feedback, and technical assistance efforts continue with the screening entities to maintain and enhance screening and referrals across multiple entry points. Continued leverage of the data store will also enable DoHS to better understand the child and family journey and related outcomes, as well as opportunities and strengths in the current system as it is built out, with more sophisticated analysis planned for calendar year 2025. Screening and referral to the Assessment Pathway and associated efforts to help affirm children with mental health needs are evaluated and connected with services continue to be a strength in DoHS's updated processes, which help children remain in their homes and communities.

8.0 Pathway to Children's Mental Health Services

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

- Screening
- WV Wraparound Facilitation
- CSED Waiver services
- CMCRS
- CCRL
- Connection to HCBS
- BSS programs and services—for children interacting with child welfare (i.e., CPS or YS), including connection to the QIA process for children with high and imminent risk of entering RMHTF settings
- Engagement with the judicial system via the Court Improvement Program
- RMHTF discharge planning

Instead of requiring families to navigate these behavioral health services themselves, the Assessment Pathway streamlines access points for assessment of children's mental or behavioral health service needs and provides appropriate linkages to services while the assessment process is being completed. The Assessment Pathway also connects families to services when children are transitioning back to their home or community settings after an out-of-home or residential placement.

Children who enter the Assessment Pathway receive HCBS to meet interim needs, and families also receive information regarding how to connect to crisis services. Unless a QIA is warranted, children are referred to HCBS that are appropriate for their needs, including WV Wraparound services for those who are eligible. Children completing the QIA process will receive further assessment of their treatment needs, including if a residential treatment setting is appropriate to meet current needs. This process is further outlined in Section 9.0 QIA.

The Assessment Pathway is designed to:

- Streamline behavioral and mental health referral and service provision for children and families.
- Connect children and families to WV Wraparound Facilitation and other HCBS.
- Aid families with the CSED Waiver application process.

- Individuals who are involved with child welfare and are at immediate risk of RMHTF placement will be referred for a QIA to determine if they need a higher level of behavioral healthcare than can be provided in the home or community. This provides an objective opportunity to determine a child's intensity of need, enabling many children with lower acuity to be diverted to the community when their needs can be met in that setting.

Because children can access the behavioral health service system via multiple avenues, DoHS has implemented a "no wrong door" approach (multi-access points) to the Assessment Pathway.

8.1 Review Period, Data Sources and Limitations, Population Measured

Figure 20 provides an overview of the Assessment Pathway referral data. Based on progress in the data store build-out, additional Assessment Pathway referral data is reported in aggregate, inclusive of referrals through BBH and direct to Acentra through the CSED Waiver application process.

Figure 20: Assessment Pathway Data Overview

Description	Data Review Period	Data Source	Details and Limitations	Population Measured
Matched, unduplicated referrals to WV Wraparound (comprehensive of all entry points in the Assessment Pathway)	July to December 2023	BBH Assessment Pathway Tracking Portal and ASO Reporting Spreadsheet	Matching information from these two sources enables an expanded scope to understand details for all referrals to the Assessment Pathway, regardless of outcome. However, inconsistencies related to child-level identifiers may impact matching accuracy. Data cleaning removed as many instances of unintended duplication as possible.	Referrals to the Assessment Pathway/WV Wraparound regardless of referral source/type.
Assessment Pathway – Family-Driven Referrals	July to December 2023	BBH Assessment Pathway Tracking Portal	The portal is a stand-alone site that allows monitoring of progress but must be connected to other data via the data store.	Family-Driven referrals, including referrals for interim services from the CCRL, CMCRS teams, and Acentra Health for children applying directly for the

Description	Data Review Period	Data Source	Details and Limitations	Population Measured
				CSED Waiver that come from sources such as MCOs and families directly.
Assessment Pathway – Referrals made directly to Acentra Health	July to December 2023	ASO reporting spreadsheet	The ASO reporting spreadsheet data was received in May 2024 and captures data through April 2024. Acentra Health is currently working toward incorporating CSED application data into one of their existing data systems (Atrezzo) to enhance data collection and reporting. This enhanced system is expected to go-live in August 2024.	Children who may be eligible for the CSED Waiver who are going through the application process.

8.2 Comprehensive WV Wraparound Referrals

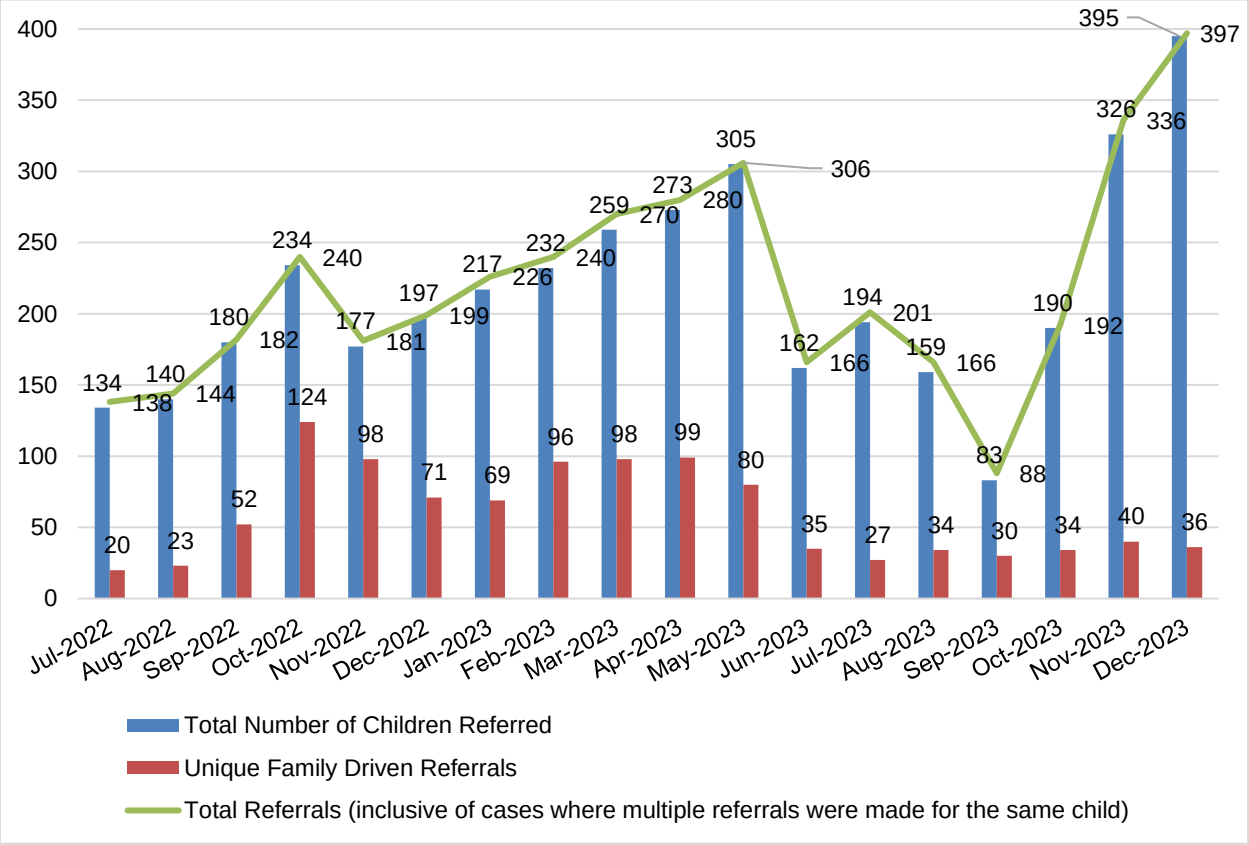
The Assessment Pathway offers multiple entry points for families, providers, and advocates to refer children and families to key HCBS, including WV Wraparound. For the period of July to December 2023, 1,347 unique children were referred for assessment and connection to HCBS, a rate of 3.2 youth per 1000 WV youth, compared to 1,449 unique children referred in January to June 2023, a rate of 3.5 youth per 1000 WV youth (Figure 21). Though the overall referral rate has decreased by 9%, this is a relatively small fluctuation that may be expected with seasonal variation and whether the system has reached a stable, consistent rate of referrals. However, DoHS acknowledges that referrals from some sources are not at the desired proportion to enable adequate early-intervention opportunities. Referral sources will be discussed in more detail later in this section; however, it is unclear at this time if increases in referrals from sources outside of the child welfare system would result in an increase in the total volume of referrals. Assuming other referral sources increase their screening and referral practices and also that families are potentially able to avoid child welfare involvement through added supports and early intervention, it is possible, over time, a maintained or slightly increased volume of referrals could be seen with a decrease in the proportion of child welfare-driven referrals.

Figure 21: Comprehensive Assessment Pathway (WV Wraparound Referrals): Six-month Period Comparison

Wraparound Referrals January – June 2023	Referral Rate per 1,000 Youth January – June 2023	Wraparound Referrals – July - December 2023	Referral Rate per 1,000 Youth –July - December 2023	Percentage Change in Referral Rate per 1,000 Youth
1,449	3.5	1,347	3.2	-9%

Referrals have grown significantly since the implementation of the Assessment Pathway with considerations for seasonal fluctuations; referrals historically have increased throughout the school year and waned during the summer months. As shown in Figure 22, total referrals to the pathway (in green) reached an all-time high (397) in December 2023 following a successful outreach campaign during that time as well as networking efforts with professionals in the education and counseling community in fall 2023. This was a 99% increase in referrals since December 2022 (199). The blue bar represents unique children referred to the pathway, given it is possible for multiple referrals to be sent for the same child within the time period, especially if the child has interactions with multiple referral sources or intervention points. Unique BBH-associated referrals (red bar) are also included in Figure 22 and are representative of children referred from the MCO, a family, a PCP, the CCRL, or the mobile crisis team. While these may not be exhaustive of all referrals from families, they are used as a proxy to indicate the number and proportion of referrals that appear to be “family-driven”. Members of the Quality Committee noted the number of family-driven referrals have decreased over the last year, decreasing 49% from December 2022 (71) to December 2023 (36). While overall referrals have increased, DoHS has noted the importance of early intervention and enabling families to have access and be aware of how to access services without need for “systems-level” intervention such as being involved with the child welfare or juvenile justice system. As noted in Section 6.0 Marketing, BBH is working with First Choice Services, the vendor for the CCRL, to explore expansion of outreach and education opportunities since these have decreased over the last year.

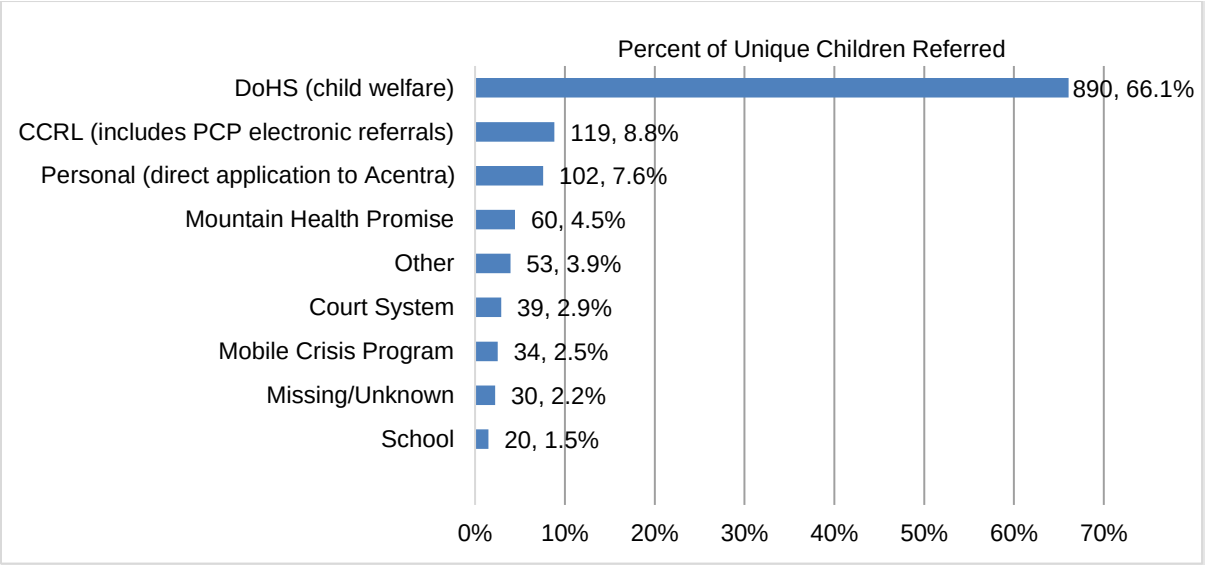
Figure 22: Aggregate Referrals to the Assessment Pathway by Month, July 2022 to December 2023



As previously noted, the majority of referrals from the Assessment Pathway originate from child welfare workers (66%, n = 890), shown in Figure 23. The CCRL is the next most common referral source with 9% (n = 119) of referrals originating from the call line or a PCP electronic-based referral (JotForm), orchestrated through the CCRL. Families applying directly to Acentra Health represented 8% of referrals (n = 102), with the remaining referrals originating from a small mix of sources including Mountain Health Promise, the court system, MCRS, schools, and other sources. Although school referrals are listed as having the least number of referrals (n = 20), this is expected as messaging to schools has been focused on empowering families and youth to utilize the CCRL when a need arises. Although direct data points for school referrals are unavailable, the influence school professionals have, and can have, on referral rates should not be understated. Increases in referrals are often associated with outreach and marketing activities with school personnel and seasonal increases associated with the school calendar. It is also understood that a large volume of referrals may not be expected from the court and BJS systems, as many professionals in these settings will coordinate with the child welfare worker and will not make a referral if the worker has already done so. Notably, however, the importance of screening and verification of referral for professionals working in these areas to help ensure children are identified and connected to services in a timely manner.

The Quality Committee recognizes the importance of early intervention and empowering families to access services and supports without systems-level involvement,[47] and is continuing to explore strategies to increase awareness and mental health services accessibility for families in collaboration with First Choice Services and Aetna. The intention behind increasing family-driven referrals is to shift the overall culture and perceptions in WV to allow more children to receive services in their homes and communities, while also supporting parents through the challenges associated with SED diagnoses, which could ultimately help prevent potentially avoidable undesirable outcomes (e.g., child welfare involvement, probation, RMHTF placement).

Figure 23: Aggregate Assessment Pathway Referral Sources, July to December 2023



The Quality Committee reviewed county-level referral rates and percentage change to assess improvement opportunities (Figures 24 and 25). Referrals continue to be made in all 55 counties, evidence that referral practices have continued statewide. The Quality Committee concluded it is difficult to evaluate county-level referral rates without consideration for other factors and influences. Decreases in referrals in particular counties may be expected for a variety of reasons. Based on a similar recommendation from the Quality Committee in fall 2023, DoHS shifted to a more sophisticated county-level analysis that incorporates Assessment Pathway referrals, along with other key indicators such as RMHTF utilization, to identify high-risk counties for further analysis and action (see Section 6.0 Marketing). The goal is to begin to understand influences between these indicators and to use the information to drive focused efforts in specific counties. This analysis will assist in determining if there are specific counties where referral opportunities are being missed and potential impacts to out-of-home placement rates.

[47] Defined here as Child welfare, Youth Services, Probation Services, or Bureau for Juvenile Services involvement.

Figure 24: County-Level Comprehensive Assessment Pathway Percent Change in Referral Rates per 1,000 Child Population, January to June 2023 to July to December 2023

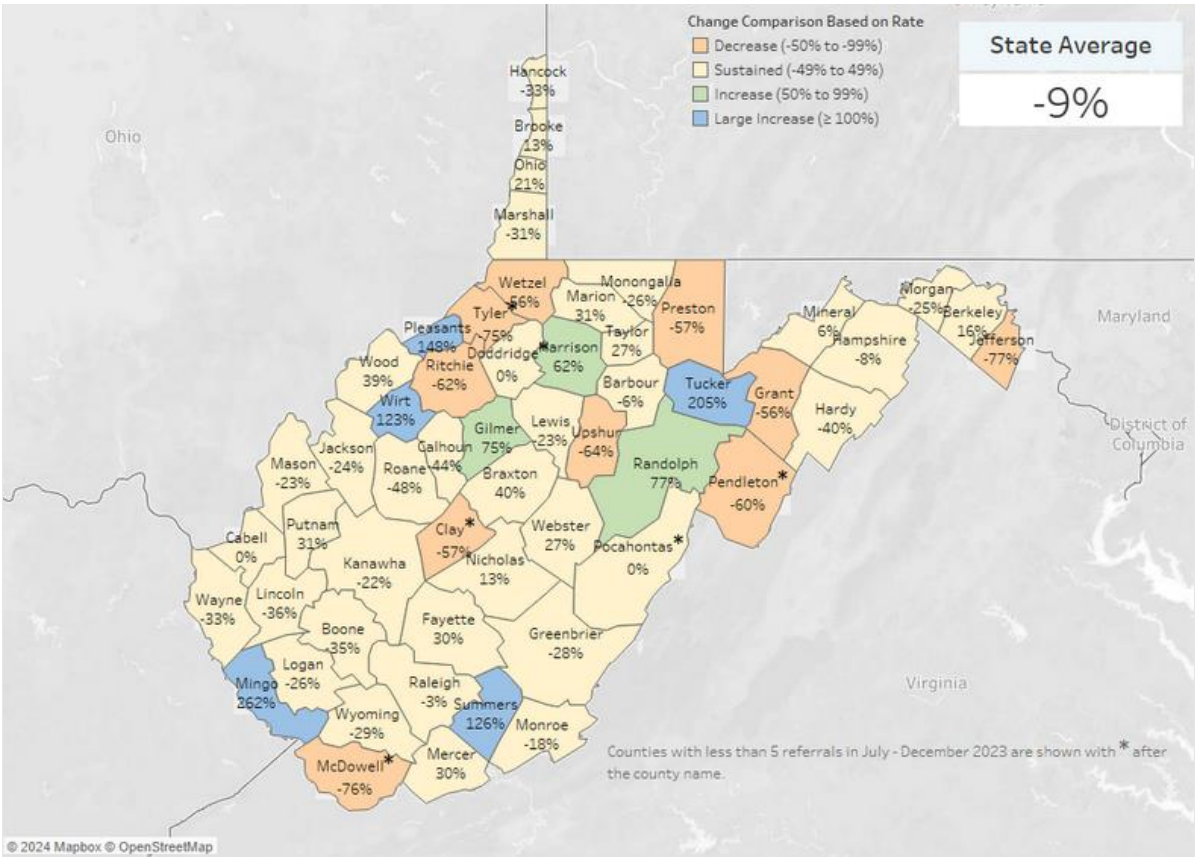
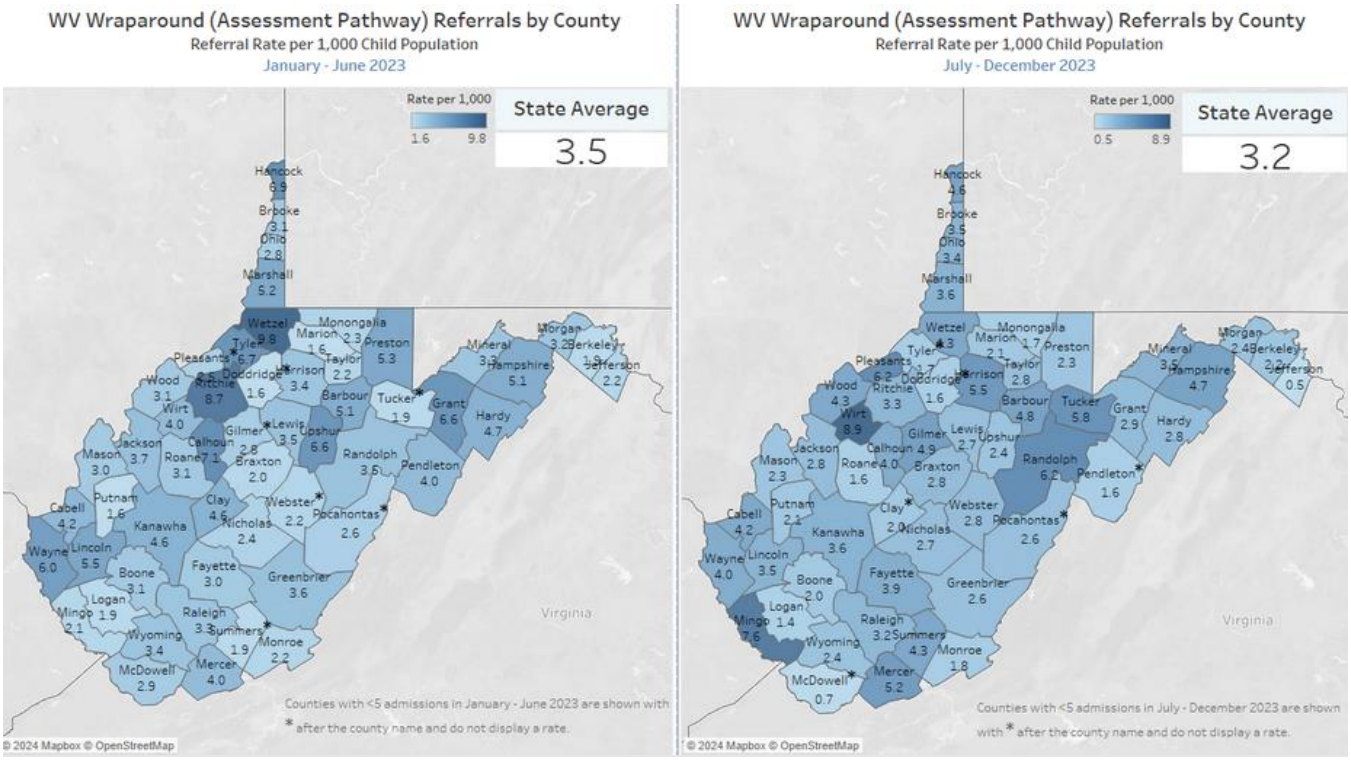


Figure 25: County-Level Comprehensive Assessment Pathway Referral Rates per 1,000 Child Population, January to June 2023 compared to July to December 2023 (left-to-right)



8.3 Family-Driven Referrals

All referrals to the Assessment Pathway are an important opportunity for a child and family to get connected to key services and supports based on the family's needs. As previously discussed, family-driven referrals to the pathway are critical to empower families and help prevent adverse outcomes, such as need for systems-level intervention. From July to December 2023, 201 family-driven referrals were managed by the BBH Assessment Pathway "Support Team[48]," encompassing 15% of total aggregate referrals to the Pathway (Figure 26). These referrals can originate from applications made directly to Acentra Health, which are shared with the BBH Assessment Pathway "Support Team," or from those who are initially referred through the BBH team from the CCRL, CMCRS, families, primary care physicians, etc. Family-driven referrals have decreased 57% since the prior six-month period in which 468 referrals were made, 32% of aggregate referrals. This large decrease in family-driven referrals highlights the importance of marketing efforts to help ensure families are aware of and can easily navigate service entry when they need it.

[48] The BBH Assessment Pathway "Support Team" includes regional care coordinators (contracted) and BBH staff members.

Figure 26: Family-Driven Referrals to the Assessment Pathway (WV Wraparound Referrals): Six-month Period Comparison

Family-Driven Wraparound Referrals - January – June 2023	Percentage of Total Wraparound Referrals that were Family-Driven January – June 2023	Family-Driven Wraparound Referrals - July - December 2023	Percentage of Total Wraparound Referrals that were Family-Driven –July - December 2023	Percentage Change in Number of Family-Driven Referrals
468	32%	201	15%	-57%

Notably, children with family-driven referrals tended to be younger than other CSED applicants. Children five- to-12-years-old comprised 50% of family-driven referrals compared to 34% of total CSED application referrals. This finding may be associated with DoHS's efforts to increase awareness and access to services though early intervention, providing opportunities to stabilize youth and families before systems-level involvement or out-of-home placement is needed. DoHS acknowledges that expansion of family-driven referrals is necessary to make larger impacts over time; however, the Quality Committee has noted in previous reviews of demographic data that existing referrals for younger children who meet criteria may lead to improved outcomes several years from now due to the average age of children being referred for services compared to the age of children involved with the child welfare system, probation, BJS, or in RMHTF placements.

From July to December 2023, over one-quarter (26%, n = 53) of family-driven referrals failed to respond to follow up, an increase from 11% (n = 51) in the prior six-month period. Members of the Quality Committee noted concerns with families potentially not fully understanding what they are being referred for (which has been described as reasons for directly declining further participation) or changing their minds after initial referral and not returning contact attempts. A script with information on screening and the Assessment Pathway is referenced by First Choice Services– CCRL call line operators who help families understand services available to them and what to expect when a referral is made. It is noteworthy that family-driven referrals engaging with the BBH Assessment Pathway "Support Team" come from several entry ways that may influence their likelihood of continued engagement. This may limit the ability to generalize these findings. For example, referrals from Acentra Health that have already had the CAFAS/PECFAS assessment with a preliminary approval to receive interim Wraparound services may be more likely to continue engagement as they have already participated in the assessment process. This is compared to families referred via the CCRL who have not yet submitted a CSED Waiver application and could have had a referral made on their behalf (e.g., by a school counselor), but who may or may not be interested in the services. DoHS will continue to monitor trends and feedback to identify opportunities to increase referral retention.

Of the 201 family-driven referrals, 53% (n = 106) were determined eligible or preliminarily eligible for interim Wraparound services. Significant improvements in the proportion of children who were able to be connected to an interim Wraparound Facilitator were noted in the last half

of 2023 (53%, n = 56), compared to the first half of 2023 when only 16% of referrals were able to be assigned to an interim Wraparound Facilitator (n = 52). Notably, however, approximately the same number of children were able to be assigned a facilitator for interim Wraparound services, showing consistency across periods in the capacity of facilitators available via BBH grant funding for interim Wraparound services. Nearly one-third of youth are approved for the CSED Waiver and transferred to an Aetna Case Management before receiving interim Wraparound services (30% of approved referrals, n = 32). This shortage in facilitators is directly related to the growing system and processes that enable a family to continue with their facilitator once transferred to CSED Waiver funding, a benefit to the family and continued rapport building of the facilitator.

As noted above, given limitations on workforce capacity for Wraparound Facilitators by funding source, other HCBS are utilized to connect the family, such as Behavioral Support Services, therapy, CMCRS, Functional Family Therapy, Expanded School Mental Health, Respite Care, Regional Youth Service Centers, Nurturing Parenting classes to support the parent, etc. See Section 8.0 Pathway to Children's Mental Health Services, for additional details. Other HCBS, and BBH-funded Wraparound are also available to families who are determined ineligible for CSED Waiver services. Service connection includes access to a regional family coordinator and a local CMCRS team. Calls made to the CCRL that connect to the CMCRS team are on average answered in 13 seconds. The BBH "Support Team" also allows text communication with families in addition to phone or email options to enable flexibility in communicating needs. A triage process has also been implemented to help ensure families in critical need are connected and prioritized appropriately to meet immediate stabilization needs through available and existing services. BBH program staff are working with providers to identify opportunities to expand capacity and have expanded provider training to include management of expenses and considerations with additional Medicaid-based income. Acentra Health, Aetna case managers, BSS, and the BBH "Support Team" continue to provide information on other interim HCBS while workforce challenges are resolved.

8.4 Timeliness and Eligibility

DoHS remains focused on understanding the timeline for children and families to access services. Results of DoHS's initial analysis of timeline to services were included in the DoHS Quality and Outcomes Report addendum that was published in April 2024. In follow-up to this analysis, significant efforts continue to address data quality with DoHS's partners and providers, so the data store can be further leveraged to address timeliness data. Within the overall timeline to services, DoHS continues to monitor the timeline from receipt of the waiver application to eligibility determination for children who complete the eligibility determination process (Figure 27). The quarterly average and median timeline to determination have remained consistent and within required contract timelines over the last 18 months despite fluctuating levels of CSED Waiver applications. The timeline to eligibility determination is dependent on the responsiveness of the family and on their availability to participate in the assessment process, including the completion of required program documents.

Figure 27: Timeline from CSED Waiver Application to Eligibility Determination by Quarter, July 2022 to December 2023

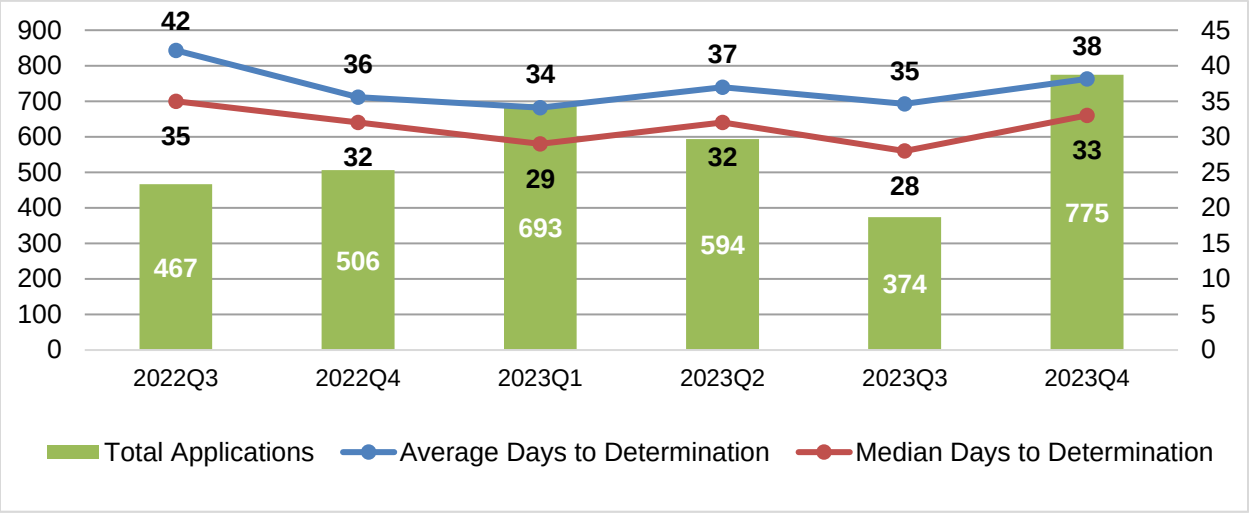


Figure 28 below compares application status for the first half of 2023 and second half of 2023 as reported by Acentra Health, for application data completed through the end of April 2024. In the second half of 2023, 1,284 CSED applications were processed compared to 1,313 applications in the first half of 2023, a slight decrease of 2.2%. Approved applications decreased significantly from 65.0% to 42.1%, primarily driven by an increase in the number of closed applications which increased from 29.9% in the first half of 2023 to 41.5% in the second half. Per discussions with BMS CSED Waiver program team, Acentra was completing some cleanup of applications in the latter part of 2023 which may have impacted the increase in closed applications. DoHS will continue to monitor application closures to determine if this increase was related to cleanup of applications or whether there may be other factors impacting closures. Denied applications increased from 4.8 to 7.8% and there was also a sharp rise in the number of pending applications. Until the second half of 2023, approval and denial rates had remained somewhat consistent.

Figure 28: CSED Waiver Application[49] Status Across Six-Month Periods

Status	January to June 2023		July to December 2023	
	n	%	n	%
Approved	853	65.0%	541	42.1%
Closed[50]	379	28.9%	533	41.5%
Denied[51]	63	4.8%	100	7.8%
Pending[52]	18	1.4%	110	8.6%
Total	**1313**	**100.0%**	**1284**	**100.0%**

CAFAS/PECFAS scores for children navigating the CSED Waiver eligibility process are shown in Figure 29 below. For children with scores reported, the distribution across the score ranges remains somewhat consistent between the two periods and compared to prior periods. Children with scores greater than 90 remained consistent between the first and second halves of 2023 at 90% to 92%, an indicator that most children who complete the CAFAS/PECFAS assessment are appropriately referred. Referral to the Assessment Pathway continues to be an opportunity to connect children with other services, even if they do not qualify for CSED Waiver services specifically.

[49] Note this figure is only inclusive of applications to the CSED Waiver, some families referred to the comprehensive Assessment Pathway do not go on to apply to CSED Waiver.

[50] Applications are closed when CAFAS/PECFAS scores are below 90, when families are non-responsive to the ASO (Acentra Health), when families request to discontinue the application process, and, in limited cases, when families move out-of-state. Multiple contact attempts are made through a variety of mechanisms before cases are closed.

[51] Denials are based on one or more of the following: no eligible diagnosis or Basic Assessment System for Children (BASC) and/or CAFAS/PECFAS score not meeting eligibility criteria, primary diagnosis was intellectual disability or autism spectrum disorder, or the evaluation process was not completed by the family. Note: PC&A makes denial decisions and communicates them to Acentra Health.

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

Figure 29: CAFAS/PECFAS Scores for CSED Waiver Applicants[53], January to June 2023 Compared to July to December 2023

CAFAS/PECFAS Score Range[54]	January to June 2023		July to December 2023	
	Children	Percent	Children	Percent
0 – 40	42	3.7%	30	3.6%
50 – 80	49	4.3%	52	6.2%
90 – 120	431	38.1%	329	39.4%
130 – 160	454	40.2%	310	37.1%
170+	154	13.6%	114	13.7%
No score reported[55]	183	--	449	--
Total	**1,313**	**100% (*excludes individuals with no scores reported)**	**1,284**	**100% (*excludes individuals with no scores reported)**

Given the increase in the percentage of applications closed in the second half of 2023 (Figure 28, CSED Waiver Application Status Across Six-Month Periods) and the increase in the number of children with no CAFAS/PECFAS score reported (Figure 29, CAFAS/PECFAS Scores for CSED Waiver Applicants, Six-Month Period Comparison), DoHS completed further analysis of applications closed to better understand how far into the process families have progressed before the application was closed.

Figure 30, below, shows increases in the number of closed applications that did not have a CAFAS/PECFAS assessment completed, indicating the application was closed early in the process, likely due to lack of response from the family. In the fourth quarter 2023, 71% (n=300) of closed applications did not have a CAFAS/PECFAS score recorded. This represents a sharp increase compared to prior quarters. In follow-up, DoHS determined this increase might likely be the result of changes associated with the early integration of CSED Waiver application and QIA referral processes. DoHS will continue to monitor closure trends as these processes are more

[53] Note this figure is only inclusive of applications to the CSED Waiver, some families referred to the comprehensive Assessment Pathway do not go on to apply to CSED Waiver.

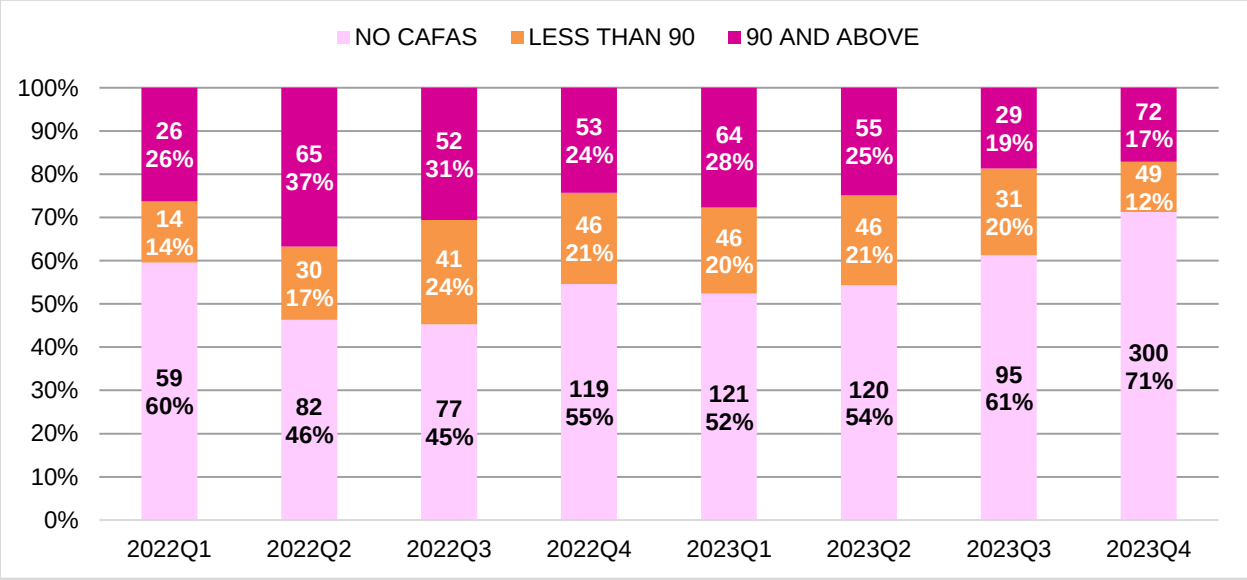
[54] Levels of Overall Dysfunction Based on Youth's Total Score:

- Score of 0-10: *Youth exhibits no noteworthy impairment.*
- Score of 20-40: *Youth likely can be treated on an outpatient basis, provided that risk behaviors are not present.*
- Score of 50-90: *Youth may need additional services beyond outpatient care.*
- Score of 100-130: *Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care.*
- Score of 140 and higher: *Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community.*

[55] DoHS is collaborating with Acentra Health to review reporting processes for data collection to help ensure program assessments are conducted and documented according to program timeframes. Scores may also not be reported for families ceasing participation in the application and assessment process.

fully integrated. Closure reasons will be included in updates made to CSED application data collection when integrated into the Atrezzo data system projected for August 2024. Collection and analysis of closures reasons will assist DoHS with further understanding closures and associated influences. The percentage of children with a closed application and a score less than 90 represented only 12% of closed applications compared to an average of 21% over the previous four quarters. A closed application with a score less than 90 is evidence of the child not meeting the criteria for acuity of need as defined by the WV CSED Waiver program. Given the low percentage of applications closed with a score less than 90, it appears that most children who are referred and are later assessed meet programmatic criteria and are likely appropriate referrals to CSED Waiver services although continued monitoring is needed to better understand the increase in application closures before a CAFAS/PECFAS is completed.

Figure 30: CAFAS/PECFAS Scores for Closed Applications (Aggregate Assessment Pathway Referrals) by Quarter, January 2022 to December 2023

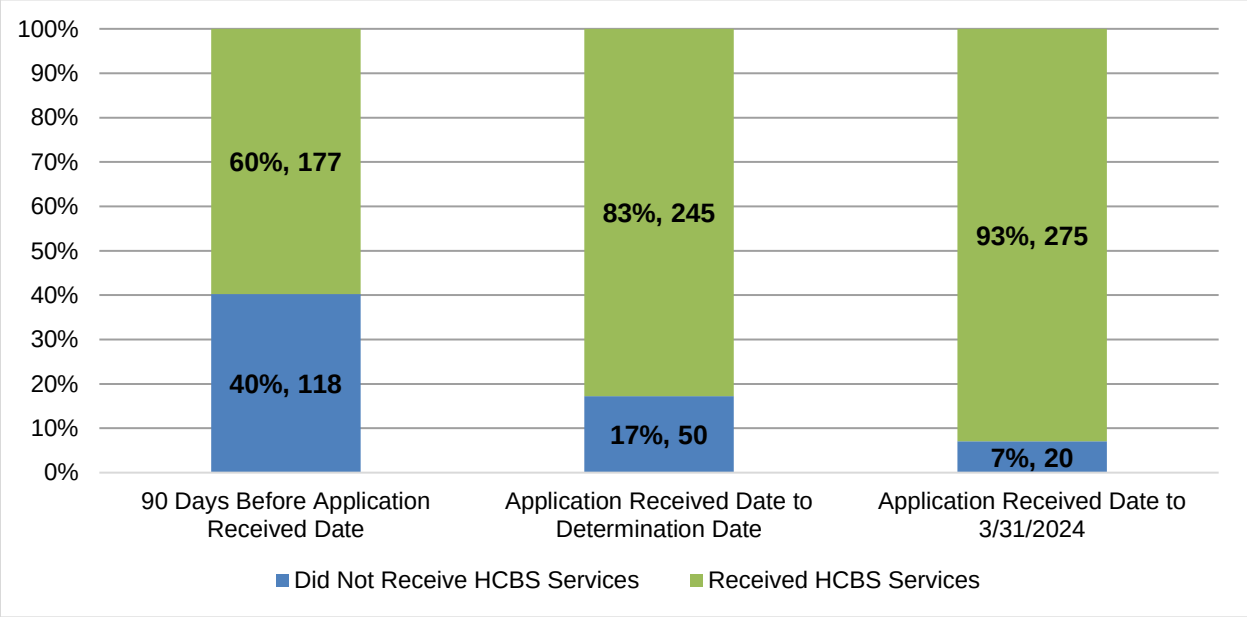


8.5 Home and Community-Based Service Utilization Across Time and Events

The Assessment Pathway is designed to provide a straightforward and supportive avenue for families to identify the intensity of their child's needs and appropriate services for them. For families who are in need of mental health services, especially those with a high acuity of need, timing is critical. To further assess timeliness of connection to HCBS, DoHS began by looking at a cohort of children who had been determined eligible (approved) for CSED services with referrals to the Pathway from April to June 2023 (Q2, n = 295). Children in BJS or RMHTF facilities at the time of application were excluded from this analysis. This population was selected to help prevent data lag impacting the analysis results. An expanded population and the quantity of services received are expected to be reviewed in the future for timeliness and utilization practices associated with HCBS as reported in Medicaid claims—programs provided via grant funding were not referenced for this analysis but might have been part of the array of services offered to families. As shown in Figure 31, 60% of children who went on to have an

approved CSED application had a HCBS[56] documented in Medicaid claims within 90 days prior to application referral. From the time the CSED Waiver application was received until eligibility determination was completed, the percentage receiving HCBS increased from 60% to 83%. Further demonstrating the association between the Assessment Pathway and connection to HCBS for mental health needs, 93% of children had a Medicaid-based HCBS in place at some point from the time of application to the end of March 2024. These results are a positive finding demonstrating only a partial view of the connections made to services and supports for families that access the Assessment Pathway.

Figure 31: HCBS Utilization Across Time and Events for Children with Approved CSED Applications (n=295)

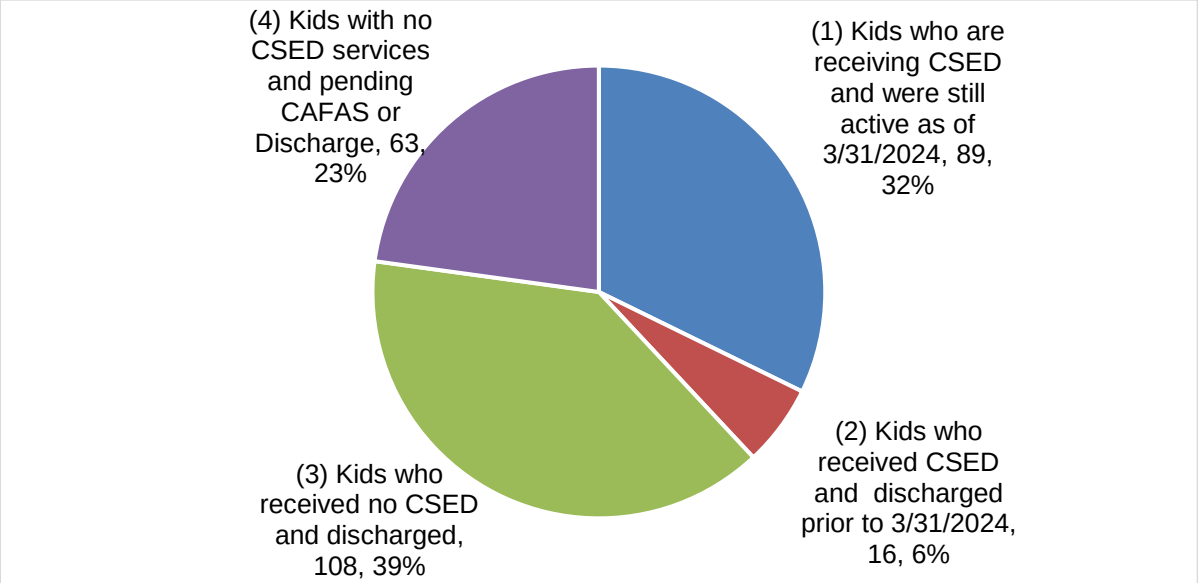


Nearly 40% of approved children for the period were recorded as receiving CSED Waiver services (sum of #1 and #2 in Figure 32), while an additional 39% (#3) discharged from the program prior to receiving CSED Waiver services. The remaining 23% (#4) had not yet received services but were pending CAFAS reassessment or discharge from the program. The Quality Committee noted utilization rates for CSED services for approved children were lower than expected. Additional analyses to understand impacts on continuation to service utilization and associated timelines will be completed in the future following efforts to improve CANS data collection and quality going into CY 2025. There were three primary discharge reasons: “no longer meeting CAFAS eligibility requirements” (12%), “family voluntarily declined CSED Waiver” (25%), and “family unable to be reached or unable to obtain the Freedom of Choice agreement” (62%). The high rate of discharges being related to “family unable to be reached or unable to obtain the Freedom of Choice agreement” may be indicative or a family’s willingness

[56] Over 160 service codes associated with a SED diagnosis (as previously defined) and a mental health service were included for review of HCBS utilization. Emergency department visits were excluded from results related to HCBS, screenings and assessments outside

to participate in services but could also be indicative of a family's willingness to participate in services but could also be an unvoiced barrier. DoHS will continue to explore CSED service utilization and reasons for discontinuation in future analyses.

Figure 32: Approved CSED Applications Received in Q2 2023, Review Time Period: Application Received Date to CSED Service Start Date or Roster Discharge Date or 3/31/2024 (n=276 of 295[57])



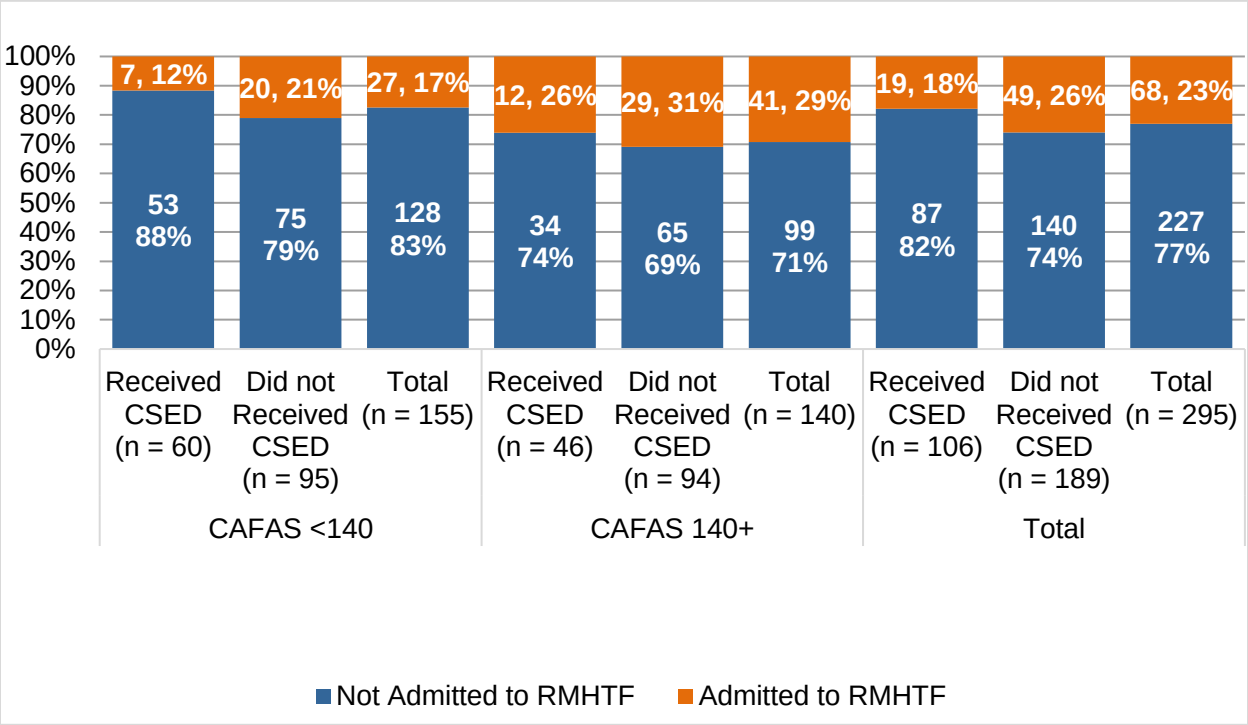
RMHTF admissions and ED utilization incidence was also reviewed for this cohort. Approximately one in 12 (8%), a total of 25 of the children within the cohort, were admitted to the ED within the period between submission of an application to the CSED Waiver and Application Received Date to CSED Service Start Date OR Roster Discharge Date OR March 31, 2024 (whichever came first). All children with ED utilization had a documented connection to HCBS following application to the Assessment Pathway. The majority of these children, 84%, had received HCBS on or before interaction with the ED, while the remaining four children (16%) received services after the ED event. All but one of the 25 children spent one to two days in the ED during the defined period, as identified via claims data. The low number of children and days interacting with the ED during the period and seemingly low reliance on the ED as a sole mental health service is a positive finding that may suggest protective factors associated with the supports provided via the Assessment Pathway. However, additional analysis is needed to assess and develop proper comparison populations to better understand the risk factors and influences outside of the Assessment Pathway.

As shown in Figure 33, 68 individuals (23% of total approved applicants) were later admitted to an RMHTF facility between the time of application submission and end of March 2024, which equates to within approximately one year of application. DoHS compared children who went on to receive CSED services with those who did not, and how receipt of services may have

[57] Status unknown for 19 cases due to data matching and documentation anomalies, reflecting children with approved applications, but were not found in the roster data match.

influenced outcomes. CSED Waiver services allow children who might otherwise be in an institution or hospital to receive intensive services, similar to an in-patient level of care, in their home, when it is safe to do so. For this cohort of children with intensive needs, 227 were able to be diverted from unnecessary placement. More specifically, of the kids approved but did not receive CSED services, 26% had an RMHTF placement during the period compared to 18% of kids who did receive CSED services. The difference between RMHTF placement rate was even more compelling for children with a CAFAS/PECFAS score <140, as 12% of the children receiving CSED went on to be placed in a RMHTF compared to 21% of children who did not receive CSED services. There were only slight differences for children with CAFAS 140 and above, this may be expected given the higher acuity of need, which for some individuals may necessitate RMHTF placement as the child's least-restrictive setting at the time.

Figure 33: RMHTF Admission by CAFAS Score and CSED Receipt for Approved CSED Applications Received in Q2 2023 (n = 295*) Review Time Period: Application Received Date to 3/31/2024



The relative risk was calculated for each group to understand if not receiving CSED services was associated with an increased risk of RMHTF placement (Figure 34). While none of the groups met the standard criteria for statistical significance (p = 0.05), the p-values for the total group and the group with CAFAS <140 fell within a p-value of 0.15 or less, meaning there is a 15% chance of these differences being attributable to chance alone, but in contrast, an 85% chance of a true difference observed. The higher p-value observed here is likely influenced by the small n when dividing groups, and larger cohorts will be considered related to this need in the future. Given these considerations, the results are considered a meaningful initial examination of the potential impacts of effective HCBS intervention for children at risk of residential placement. These results, which should be interpreted with caution given the caveats

listed about statistical significance, reflect children in this cohort with a CAFAS <140 and no CSED service utilization having an 80% higher risk for RMHTF placement compared to children with CSED service utilization. For the total cohort of children, regardless of CAFAS score, children who were documented as having no CSED service utilization had a 45% higher risk for RMHTF placement compared to children with CSED service utilization. Furthermore, it is suspected that children interacting with the Assessment Pathway may have protective factors that would help prevent RMHTF placement when avoidable, such as awareness of the CCRL or CMCRS services, or connection to other available HCBS. DoHS plans to explore additional comparison populations for future analyses to better understand risk and protective factors influencing WV children's outcomes.

Figure 34: Relative Risk for RMHTF Admission for Individuals without Record of CSED Utilization by CAFAS Score for Approved CSED Applications Received in Q2 2023 (n = 295)
Review Time Period: Application Received Date to 3/31/2024

	CAFAS <140	CAFAS 140+	Total Cohort
Relative Risk	1.80	1.18	1.45
p-value	0.15	0.57	0.13
95% Confidence Interval	0.81-4.01	0.67-2.10	0.90-2.32

8.6 Provider Capacity/Statewide Coverage

Effectiveness of the Assessment Pathway process is contingent on the adequacy of BBH and Acentra Health staffing to meet demand in referrals to the pathway. As noted previously, the average timeline to determination has remained consistent (34 to 38 days) throughout each quarter of 2023 and within the contracted timelines, evidence that Acentra's staffing capacity remains adequate to meet the continued demand in referrals. A decrease was noted in BBH support teams' ability to contact families in response to referrals. Currently, BBH has four staff via grant funding and one full-time employee processing BBH-associated referrals. Two supervisory staff act as reserve staff when there are large influxes of referrals. Some staffing shortages were noted resulting in the increase in the number of days from referral to family contact (eight days in the second half of 2023 compared to three days in the first half of 2023). To meet the growing volume of referrals, BBH expanded their partnership with Acentra Health and began transitioning operation of the Assessment Pathway to them at the beginning of July 2024.

8.7 Strengths, Opportunities, Barriers, and Next Steps

All counties continue to make referrals to the Assessment Pathway to support children and families to be assessed and connected to services when needed. While some leveling in the number of referrals was noted when comparing the second half of 2023 to the first half of 2023, this can be expected due to seasonal fluctuations and the potential that the Assessment Pathway process may be moving toward steady state. The need to focus on family-driven referrals was noted to ensure early intervention, prior to systems involvement, to get children and families connected to HCBS and support diversion efforts.

The first analysis of children and families being connected to services following referral to the Assessment Pathway showed positive results, with the percentage of children accessing HCBS increasing from 60% to 83% between CSED Waiver application receipt and waiver eligibility determination, then further increasing to 93% as HCBS service utilization was tracked through March 2024. These results are evidence that children and families are being connected to services throughout the Assessment Pathway process. Additionally, preliminary results showed some evidence of reduced reliance on ED visits and RMHTF following access to HCBS, further evidence that the Assessment Pathway processes are supporting diversion efforts.

Priorities and next steps include the following:

- Collaboration with First Choice Services and Aetna to develop strategies to increase families' awareness of and access to mental health services to support early-intervention efforts and avoid system involvement. This includes coordination with FirstChoice to explore additional outreach to promote use of CCRL as a key mechanism for connecting children and families to the Assessment Pathway.
- Transitioning the full Assessment Pathway process to Acentra Health.
- Follow-up on the county-level analysis that incorporates additional key indicators by county such as Assessment Pathway referrals, QIA referrals, CCRL utilization, CMCR utilization, CSED Waiver approvals and service utilization, foster capacity, provider capacity and judicial outreach to assist with understanding influences between these indicators and how they are impacting RMHTF utilization at the county level. Then use this information to prioritize and drive focused efforts in specific counties.
- Further analysis of connection to HCBS through the Assessment Pathway and associated impacts on ED and RMHTF utilization, including considerations for acuity and levels of HCBS utilization.

9.0 Qualified Independent Assessment (QIA)

Any child involved with child welfare who is at high risk of residential placement should be referred for a QIA as part of the Assessment Pathway process. Children will be referred for further assessment to evaluate their level of acuity objectively and whether their needs could be met in a home and community-based setting. “High risk” is defined as meeting at least one of the following categories:

- Judicial involvement that indicates the child may need residential care, or requests residential placement options, and/or requests that a referral be made to residential treatment facilities.
- The child is uncooperative with the court’s requests.
- The child has disrupted other arranged placement, such as a kinship/relative home or foster home, and no other options are available.
- The child’s family requests removal from the home, or the home is unsafe, and no alternative family settings are available.
- The child has no stable family home or other living arrangement.
- The child requests placement in an RMHTF.
- The child has been adjudicated as a status offender or delinquent.
- The child has been previously adopted, and the adoption is at risk of disruption.
- The child is a danger to themselves or others.

A CAFAS/PECFAS and CANS assessment, including the CANS Decision Support Model, will be utilized for the QIA. A CSED Waiver application will be submitted by the BSS caseworker concurrently if one has not already been submitted. The QIA will identify the child’s needs and recommend the appropriate level of intervention and least-restrictive service setting to meet those needs.

9.1 Review Period, Data Sources and Limitations, Population Measured

DoHS is working with Acentra Health and Aetna to expand the QIA process to help ensure all children in RMHTF settings have been assessed for their level of need and appropriate placement setting, ideally prior to placement to inform decision-making. The QIA process was implemented in phases starting in August 2022 and has continued to evolve and improve since that time. As of May 2023, all BSS workers statewide had been trained with the referral process implemented across all counties. The QIA process is included in the new worker training for BSS staff as well. To help ensure safety net processes are in place, data sharing has been enhanced with Aetna to enable follow-up with residential providers and with other key stakeholders for children who are at imminent risk of residential placement. Aetna works as a central entity that can confirm a QIA has been completed for the child and guarantee the appropriate parties have the information needed to make decisions related to the least-

restrictive/most appropriate setting.

Figure 35: QIA Process Data Overview

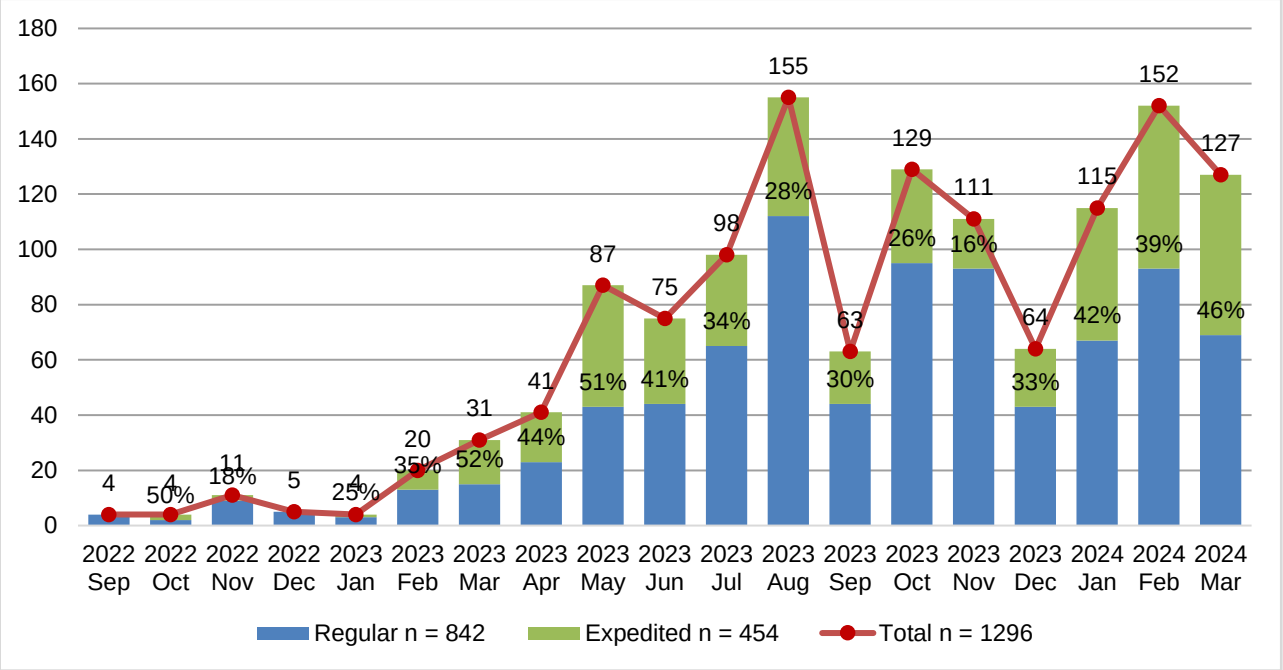
Data Review Period	Data Source	Details and Limitations	Population Measured
January 2024 to March 2024 unless otherwise noted.	QIA Tracking Spreadsheet and Marshall OOS Discharge Planning Tracking Spreadsheet	This dataset contains indicators QIA referrals. This quarter was chosen for review due to data completion and quality limitations for previous referrals. Significant focus has been placed on improvement of data quality and completion for this service since late summer 2023 and continues with many improvements going into summer 2024. Data is shared weekly and reviewed biweekly with vendors. Longer time periods for reporting are expected in the next edition of this report. There are also plans to integrate this tracking into the Atrezzo system with a goal of going live August 1, 2024. Data is refreshed as of May 23, 2024.	Children at high risk for residential placement (see definition above) being referred for a QIA. These results include characteristics of the child and related recommendations statistics based on the assessment findings.
April 2024	WV PATH	Admissions into residential treatment facilities in April 2024 were used as a proxy at the county-level to determine counties utilizing, or potentially underutilizing QIA processes, based on referrals from March 2024. This data may be subject to change due to data entry lag. Data was also included to show referrals for in-state RMHTF which is orchestrated through the Automated Placement Referral process in PATH.	Youth aged 0 – 20 admitted into an RMHTF setting in March 2024 and in DoHS custody.

9.2 Review Summary

On average, in quarter 1 2024, 131 children were referred for a QIA monthly. Figure 36 demonstrates referral patterns from September 2022 to March 2024. As shown, referrals increased during the training and rollout period from August 2022 to May 2023. Fluctuations in referral patterns have been noted as additional technical assistance and data quality control processes have been implemented following monthly review of data. Referrals may be expected

to wane over the holiday season, but DoHS will continue to monitor referrals and data quality on a monthly and weekly basis to help facilitate complete and efficient implementation of the QIA. A process was developed to expedite referrals that had imminent risk of residential placement, decreasing timelines for assessment to 14 days from 30 days. From August 2022 to December 2023, 33% of referrals met criteria for expedited assessment. Expedited referrals have increased in demand January through March 2024 at 42% of referrals on average being flagged for expedited completion. Much lower rates were observed in November 2023 specifically, when 16% of referrals met the criteria to be expedited. Referrals expedited included youth with court orders to residential placement and youth in DoHS custody who were placed in an ED, acute hospital unit, or hotel setting.

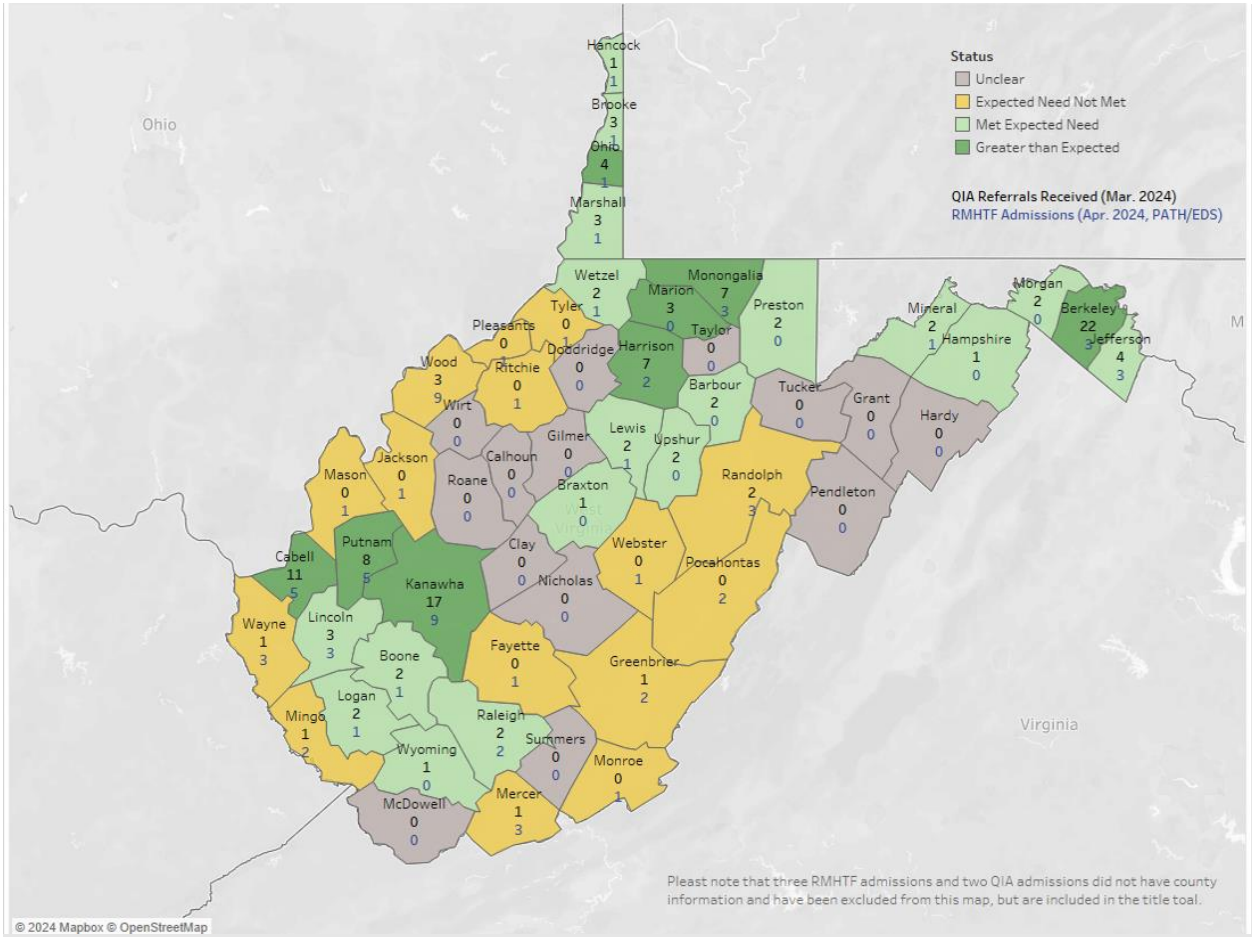
Figure 36: QIA Referrals by Month, September 2022 to March 2024
Total N = 1296 Expedited = 454 (35.0%)



To provide timely feedback to the social services managers (SSMs) who work directly with the counties, and to maintain focus on the continued adoption of the QIA process, a county-level report depicting total referrals made compared to the minimum number of referrals expected for the month (based on county-level admissions for the following month) is provided to social services managers monthly. This visualization enables managers to reflect on adequate referral processes each month to help ensure the opportunity for diversion from residential treatment has been explored. Visuals like this offer an opportunity for direct and prompt feedback as workers become more familiar with this process and highlight whether they are identifying at-risk children in a timely manner. When reviewing this information, DoHS expects referrals greater than or equal to the following month's RMHTF admissions, with some flexibility for counties with small populations. Sharing and reviewing these maps has helped increase opportunities for diversion, and those diversion results are further displayed by Figure 37, which shows QIA referrals for March 2024 exceeding April 2024 RMHTF admissions (127 referrals compared to

only 79 admissions). Nearly half (47%, n = 26) of WV counties met or exceeded expectations for referral practices in March 2024, with 15 counties not meeting expected referral numbers. The remaining counties (14) listed as “unclear” will continue to be monitored for referral opportunities and appropriate practices, as their small populations make it “unclear” if additional referrals are needed from a systems-level perspective. It is noted that since the last comparison period, October 2023 referrals compared with November 2023 admissions, there has been a decrease in the number of counties meeting or exceeding expected need (n=31 counties in October 2023), despite the total number of referrals staying relatively stable. BSS leadership will share this information with social service managers and have noted the Automated Placement Referral (APR) process to also be key in helping counties identify if they are meeting needs. APR data has been included later in this section.

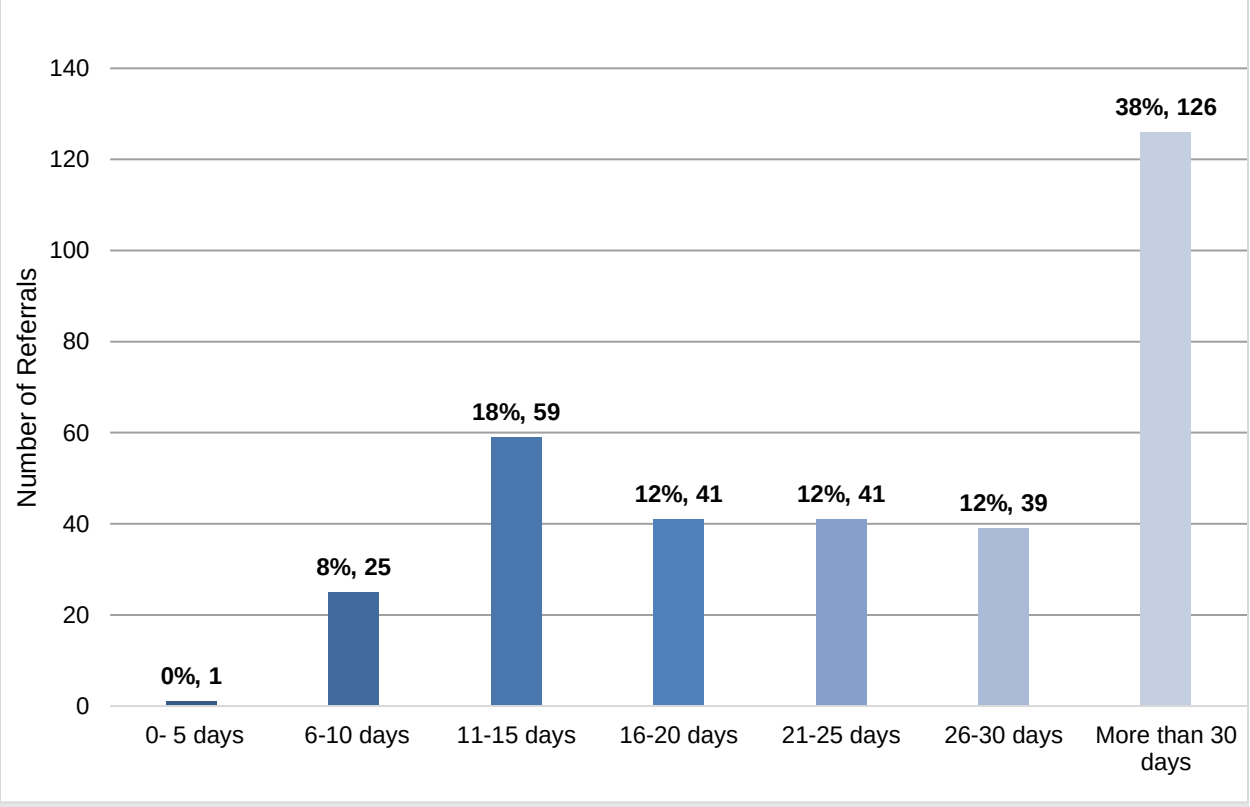
Figure 37: Number of QIA Referrals (March 2024, n = 127) and RMHTF Admissions (April 2024, n = 79)



DoHS has worked diligently with Acentra Health to monitor timeliness and address barriers to meeting expected timelines for referrals. Some components of these efforts have included Acentra hiring additional assessors, implementing an escalation process to help ensure timely contacts and BSS worker responses to requests for information, and increasing the frequency of data review, which is shared and reviewed in recurring QIA meetings. As the QIA process has expanded, the percentage of referrals documented and completed within 30 days or less has

increased. As reported in the January 2024 edition of this report, out of 56 completed referrals originating from October 2023, 64% (n = 36) took more than 30 days to be completed and communicated back to DoHS, an average of 40 days. In comparison, completed referrals originating from January to March 2024 (n = 332) were communicated back to DoHS 28 days following referral on average, with only 38% (n = 126) taking longer than 30 days to be returned (displayed in Figure 38 below). This reflects improvements since October 2023 for both completion rates and timeliness. However, DoHS recognizes that, although improvements have been noted, these shorter time frames are still insufficient to meet needs, and DoHS continues to work closely with Acentra Health to reinforce and enhance processes to encourage punctual and quality assessment reports, including reviewing completion data on a weekly basis. It is essential for recommendations to be provided in a timely and accurate manner to help ensure this process is beneficial to the diversion process when clinically appropriate. Closures due to inadequate response are also being closely monitored to help ensure escalation processes are followed to assist leadership in reinforcing expedient response for the required information from BSS workers to the assessors before a QIA referral is closed.

Figure 38: Distribution of Days from QIA Referral Received to Communication of Results to DoHS, January to March 2024 (n = 332* / Median = 25 / Average = 27.6)

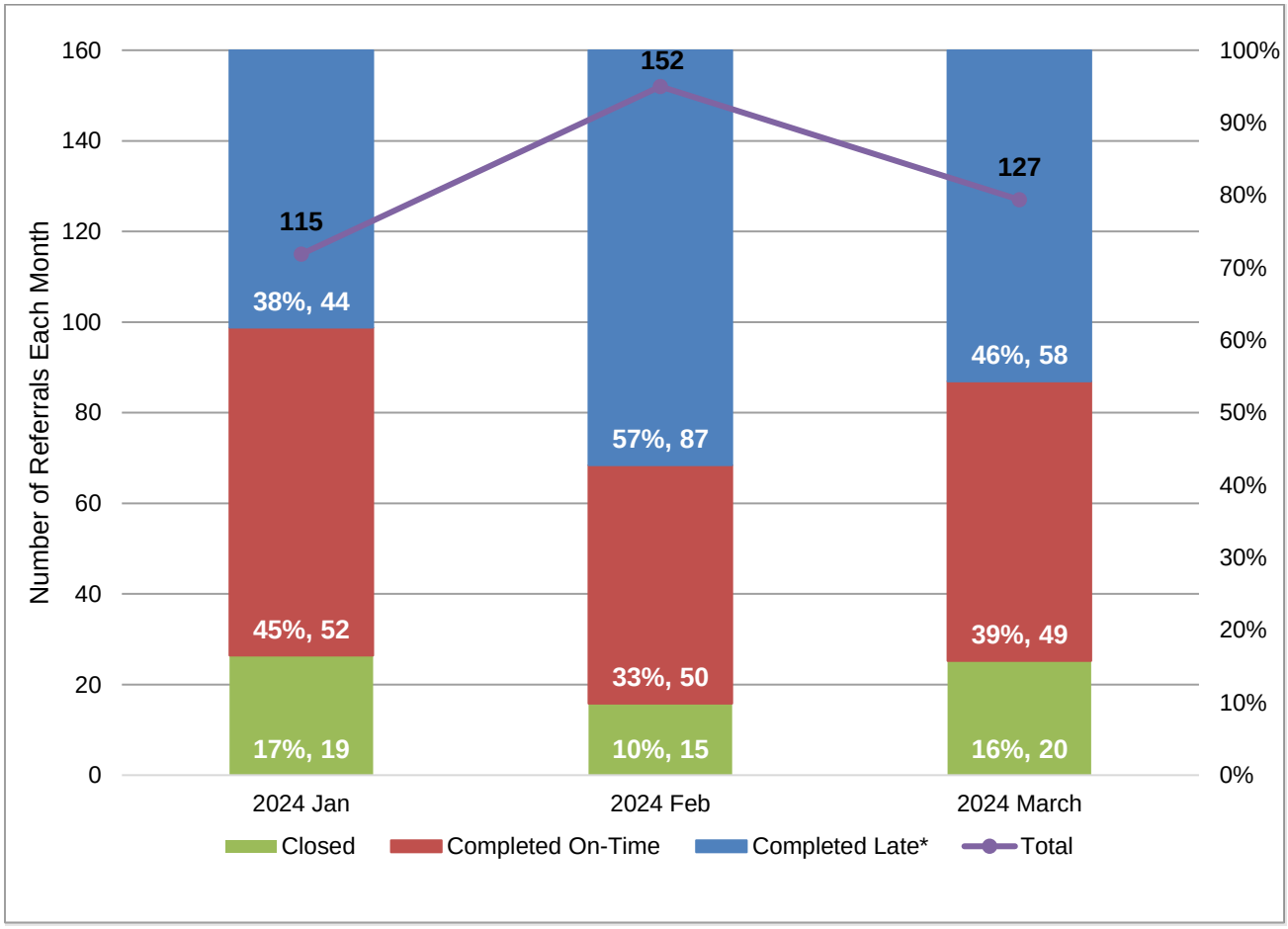


***Note:** Only includes completed cases with completion date documented.

While the previous analysis investigates whether QIA completion met or exceeded an overall timeline of 30 days, Figure 39 considers Standard Operating Procedures that follow a 14-day turnaround for expedited cases and 30 days for regular cases. For quarter 1 2024, 15 to 20

referrals monthly (one in seven referrals on average, 14%) were closed without recommendation, compared to 56% of referrals in October 2023. This improvement is attributed to CQI efforts which have equipped the QIA PIP team with timely insight to address needs related to the QIA completion process. On average out of the total referred, 39% were completed on time, while 47% did not meet standards for timeliness. DoHS and Acentra Health will continue to monitor and address timeliness needs to meet expectations set in policy.

Figure 39: Completion and Timeliness of QIA Referrals, January to March 2024 (n = 394)



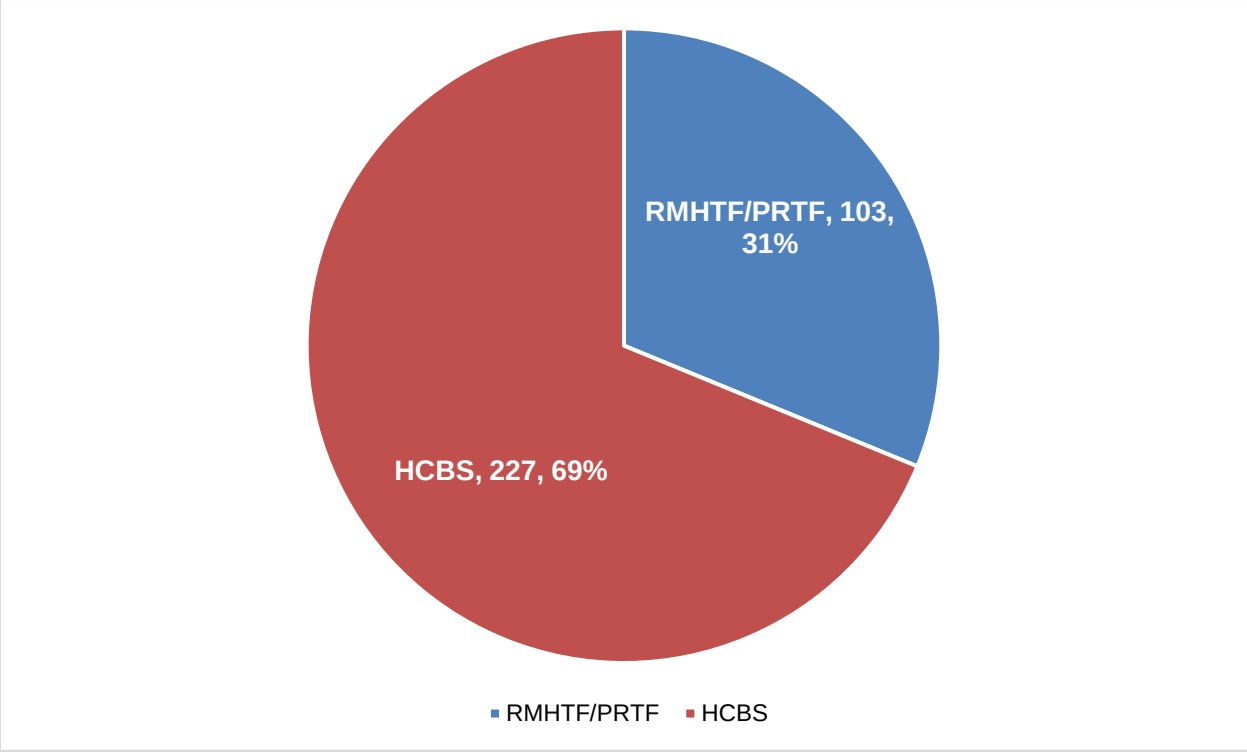
***Note:** Referrals "completed late" include eight completed cases with missing completion date. Closed applications include referrals closed prior to completion.

DoHS collaborates with MU and the Praed Foundation to automate the Decision Support Model predicated on the CANS assessment tool. The model consists of five levels of intervention. Level 1 is the lowest level of intervention or need and consists of treatment and services offered through traditional foster or kinship care, while Level 5 is the highest level of intervention, treatment provided by a PRTF. The Decision Support Model assists with making intensity of intervention recommendations based on treatment need and complexity. For simplicity of data review, categories were aggregated to represent decisions for community-based placement versus a residential setting.

For children with a completed QIA referral in January to March 2024 (n = 330 total referrals), nearly 70% (n = 227) received a recommendation to obtain treatment via HCBS (Figure 40). This was viewed as an encouraging finding that reflects the balance between the ability to meet needs through intensive services provided in the HCBS setting versus some children having a clinical need for residential care.

Recommendations from the QIA can be used to aid decision-making and reframe cultural norms to help prevent inappropriate use of residential treatment facilities. For example, the MDT process was a particular area of focus in 2023. Legislation enacted in the 2023 WV legislative session expanded and further encouraged representation in these meetings to include entities directly supporting the child, such as the Aetna care manager. Key stakeholders such as Aetna and MU have been added as additional advocates to MDTs since this legislation went into effect. Access to timely QIA information to make informed decisions will offer a continued opportunity to shift cultural norms/practices with placements. Prompt QIA information will also help establish norms of assessment and objective determination for treatment needs before referral to an RMHTF. The QIA process has also been a focus of BSS's outreach and education with the judicial community to assist with understanding the benefits of this process while also building rapport with the court community as implementation moves forward and the process improves. Enhanced processes and protocol to help ensure quality and validity of each QIA recommendation will be expanded within the next six to nine months, through the end of 2024 and into the beginning of 2025.

Figure 40: QIA Recommendations by Setting, January to March 2024 (n=330*)



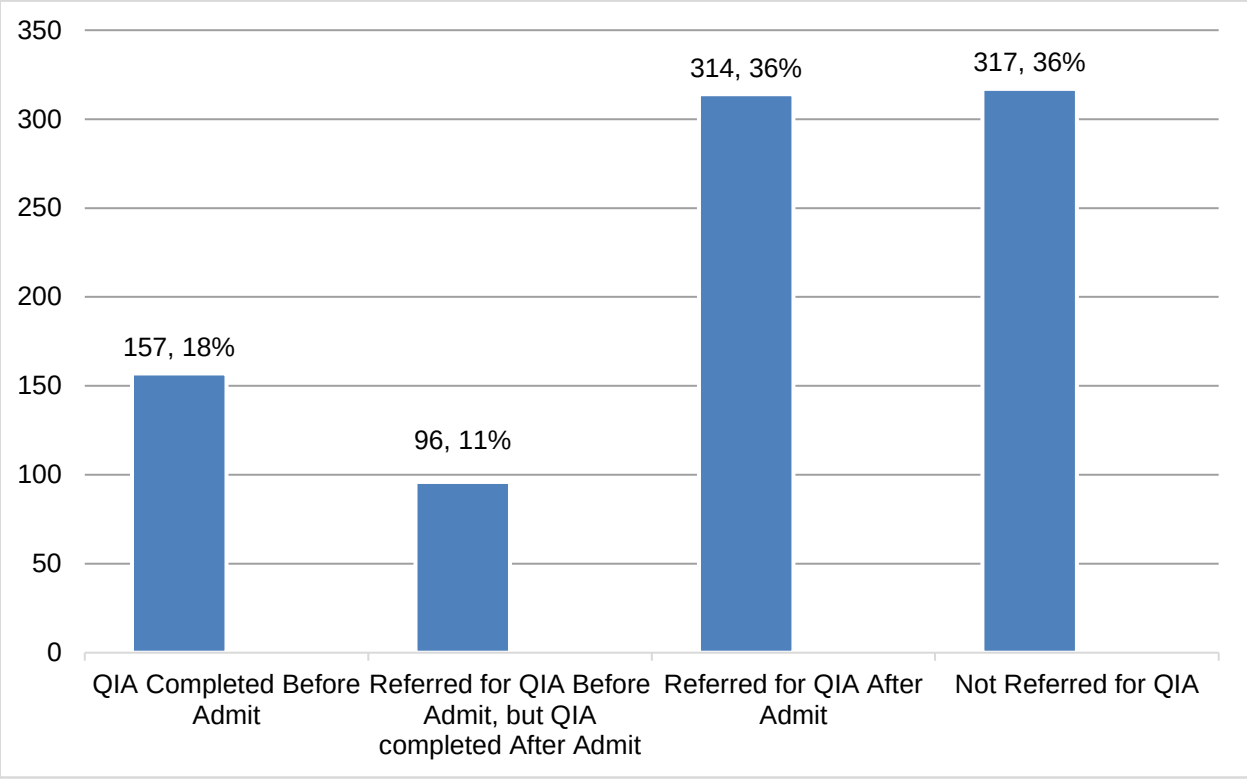
***Note:** 64 Referrals without documented recommendations have been excluded.

9.3 QIA Completion Prior to RMHTF Admission and Related Outcomes

As part of the implementation of the QIA process, DoHS aims to have a QIA completed for every child who is admitted to a RMHTF. Given the volume of children in residential facilities and the recurring demand for QIAs for children at imminent risk of residential placement, it would not be possible to complete all referrals at the same time and in a timely manner. Therefore, DoHS has prioritized referrals for children with imminent risk of residential placement, as this strategy is expected to offer opportunities for diversion from inappropriate placement and allow youth who newly admit to a residential placement to have a recommendation in place, ideally, prior to admission. As previously noted, safety net procedures have been developed with Aetna to identify children without QIAs entering RMHTFs and to follow-up with providers to have a referral sent in. Enhanced availability of QIA status information with Aetna began in May 2024. It is expected that over time, as children are discharged and new children are admitted utilizing the QIA referral process, all children in residential facilities will have had a QIA.

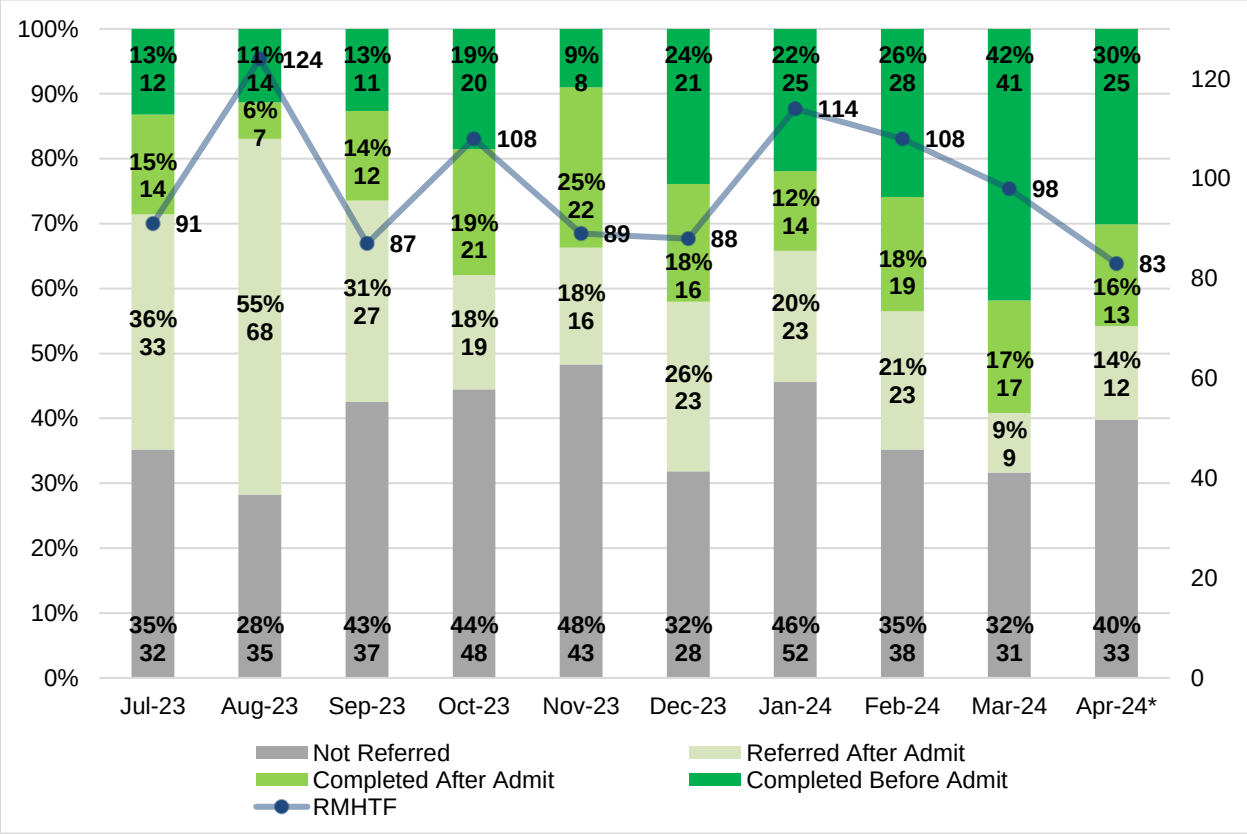
Figure 41 shows children in an RMHTF placement as of April 1, 2024, along with information regarding QIA referral status. As shown on the right side of this figure, 36% of children had not been referred for a QIA, while an additional 36% had been referred after admission. Nearly one-fifth of children (18%) had a QIA completed before admission, and the remaining 11% had a referral made before admission, but a recommendation was not available until after admission. DoHS has begun exploring these indicators further to understand if these results reflect that additional time is needed for processes to “catch up” to the full RMHTF population, or if more specific strategies are needed to improve the proportion of children with a QIA recommendation prior to entering RMHTF. Analyses of the timeline from QIA referral to residential admission for children recommended for HCBS have been explored, but given the limited currently available data, this information is not yet available for public release due to small sample sizes and concerns related to the child’s privacy. This will be explored in future updates when longer time frames and a larger sample size becomes available.

Figure 41: Children in Active RMHTF Placement as of April 1, 2024, Compared to Information on QIA Referrals as of May 23, 2024 (n=884)



DoHS is also reviewing monthly QIA status for new admissions to RMHTF to measure implementation progress of the QIA process. As noted in the county-level information above, it is known that there are many counties meeting QIA referral needs. However, there are still several counties not meeting expectations for QIA referrals, thus impacting timely assessment. This concept is also demonstrated in Figure 42 at the state level for monthly admissions. For example, in March 2024, 32% of children with a new admission to a RMHTF had not been referred for a QIA. In contrast, 42% of these children had been referred and had a recommendation made before admission. The remaining subset of children were referred or completed after admission. The Quality Committee noted the increase in QIAs completed before admission, with only 24% completed in December 2023 compared to 42% of March 2024 residential admissions. This is an encouraging finding likely associated with the focused efforts for timely referral and recommendation, which is expected to increase insight into child clinical needs and to offer opportunities for diversion from inappropriate placement.

Figure 42: Monthly RMHTF Admissions* by QIA Status, July 2023 to April 2024 (n = 990)

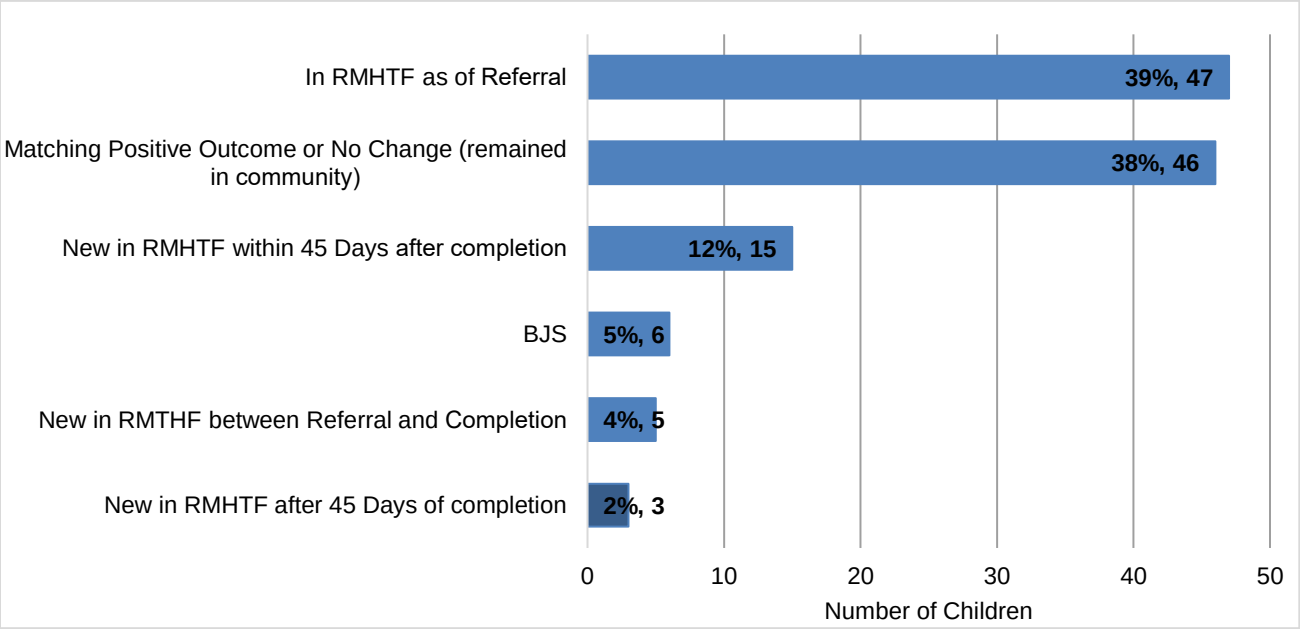


***Note:** If individual children had multiple stays per month, the most recent stay was utilized for the analysis. Data pulled as of May 23, 2024; April data should be considered preliminary.

The QIA recommendations are intended to offer opportunities to divert children from inappropriate settings based on their clinical needs. Of children with QIA referrals in January and February 2024, with a recommendation of HCBS (n = 122), 38% were noted as remaining in their community within 45 days after QIA completion. This is considered a positive outcome. Conversely, 12% were placed in an RMHTF placement within 45 days of completion, which might be considered a missed opportunity for diversion. Driving factors for missed opportunities are not yet concretely understood, but understanding those barriers will be a consideration as additional data becomes available for outcomes analysis. Other considerations for outcomes related to QIA recommendations included only 4% of children being placed while waiting for the QIA to be completed, and a large proportion of children who were already placed in RMHTF as of referral and remaining in that placement within 45 days of completion (39%, n = 47).

The findings in Figure 43 highlight the importance of early identification of imminent risk, given the proportion of kids in RMHTF at the time of referral. The QIA process is still in implementation; therefore, additional time and efforts are needed to enhance processes and critical use of QIA recommendations.

Figure 43: Outcomes for Children with a QIA Recommendation for HCBS, January to February 2024 (n = 122)



Another opportunity to monitor implementation and timely referrals for QIAs is via comparison of the APR process in PATH. This process tracks referrals for in-state RMHTF placement. BSS policy and training have dictated the importance of referring children at imminent risk for a QIA and, when possible, waiting for the completed recommendation prior to making referrals to RMHTFs. BSS leadership recommended monitoring APR referrals instead of only RMHTF placements to allow for a more “real-time” response to imminent needs. Comparing referral data from the QIA and APR from March 2024, 43% of APR referrals had never received a QIA referral, while 22% competed a referral to the QIA process after the APR referrals had already been submitted. Encouragingly, 28% of referrals for the APR in March 2024 had a QIA referral made over 30 days in advance of submitting an APR referral, with the remaining 7% having a QIA submitted within 30 days of APR referral. As shown in Figure 44, the bars to the right indicate inadequate time for QIA recommendation feedback, and decreased opportunities for diversion, whereas the bars to the left include increased opportunities for diversion given consideration for time needed to obtain a recommendation from the QIA process.

Figure 44: Timeliness of QIA Referral Compared to In-State RMHTF Referral Processes (Automated Placement Referral, APR) (n=164), March 2024

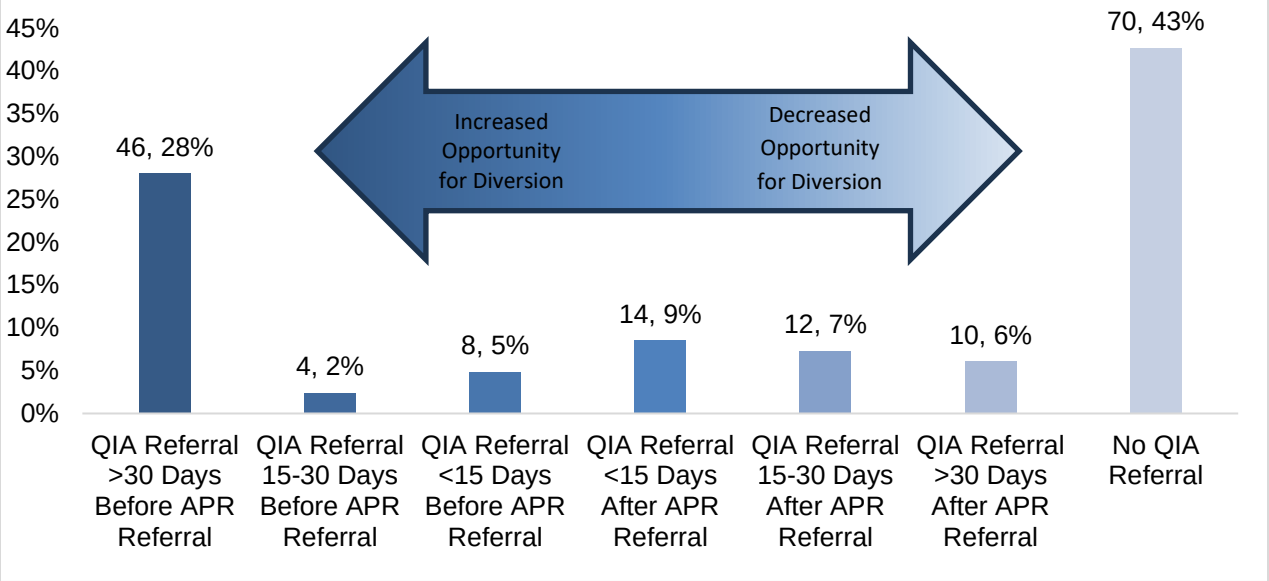
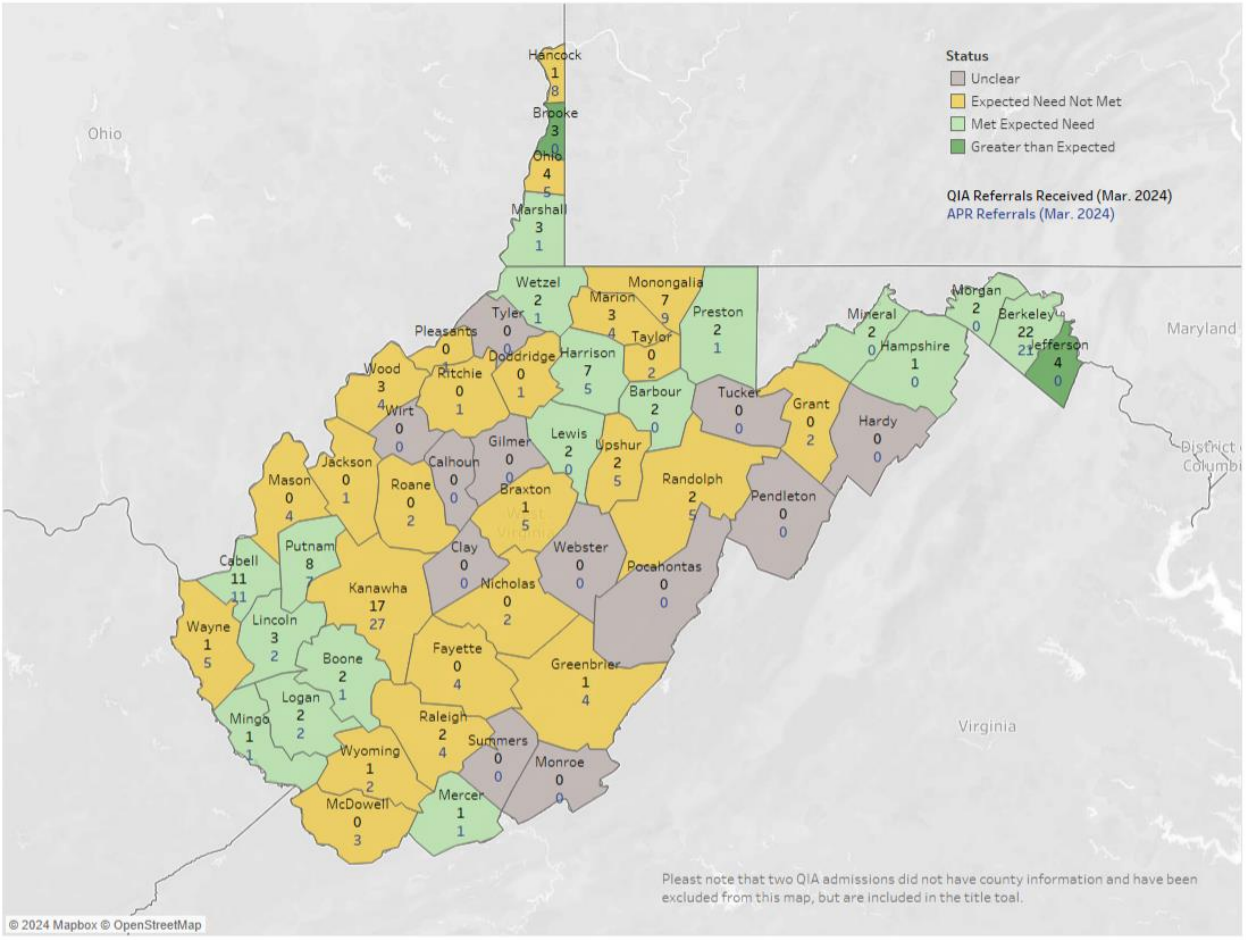


Figure 45 shows a comparison of counties meeting QIA referral needs compared to use of the APR referral process. Similar to the map comparing RMHTF utilization to QIA referrals, this map is a gauge of the adequacy of QIA referral volume. Counties are expected to meet or exceed the number of referrals to the APR for the referenced month or time period. Some counties with no APR referrals during the period (typically smaller population counties) will be labeled unclear as it is unknown if they are meeting expected referral quotas for the time period. In March 2024, 21 counties met or exceeded referral expectations to the QIA process (green shading), 22 counties did not meet expectations (yellow shading), while 12 counties were deemed as unclear if expected need was met (grey shading). BSS will plan to share updates to APR related indicators monthly with social service managers for review and technical assistance opportunities. BSS leadership believes this metric can be highly influential to impact timely strategic response to inadequate referrals.

Figure 45: Number of QIA Referrals and APR Referrals Received in March 2024 by Status (QIA, n=127; APR, n=164)



9.4 Strengths, Opportunities, Barriers, and Next Steps

The QIA process is a key component of helping to ensure children are assessed for appropriate treatment intervention and placed in the least-restrictive setting to meet their needs. This process has and will continue to assist in diverting children from unnecessary residential placement. The QIA process has many opportunities for enhancement as CQI processes continue on a weekly basis.

Social service managers, Acentra Health, and Aetna have been active in this process since the onset of training through data review and discussion. Future plans include:

- Continued improvement of data collection and quality improvement to inform process needs further.
    - Development of more robust processes and protocols to help ensure quality QIAs and validity of recommendations.
    - Monitoring timeliness of QIA completion closely to help ensure information can be beneficial in time-sensitive situations.

- Further analysis of outcomes data with the WV PATH system integration into the data store in conjunction with relevant QIA data to understand where the child was placed and to explore reasons for any contradictions to the recommendations.
- Expanded outreach and education around the importance of the QIA process to increase utilization and trust in the process statewide, including ongoing review and feedback to social service managers at a county-level, engagement with the court community, and persistent integration into MDT decision-making.

10.0 Children with Serious Emotional Disorder (CSED) Waiver Services

DoHS implemented the CSED Waiver effective March 1, 2020. The five-year waiver renewal was approved in early 2023, extending waiver services through January 2028. The CSED Waiver provides additional services to Medicaid State Plan coverage for members ages three to 20 who meet eligibility criteria. West Virginia is the only state in the nation to include the 217-Medicaid eligibility group in the CSED Waiver, which helps remove financial barriers to access HCBS if the applicant meets medical eligibility for the waiver. Expansion of financial eligibility allows children who would not typically be eligible for Medicaid services to receive services and supports to help them remain successful in their home and community.

To continue making improvements to quality and access to CSED Waiver services, a CSED Waiver amendment was approved with an effective date of July 1, 2024, with the following changes:

- Addition of two Wraparound Facilitation services: The current Wraparound Facilitation service (T016 HA) will be replaced by two Wraparound Facilitation services. The two services include T1015 HA-TF for members with moderate needs and T1016 HA-TG for members with high needs. Both services have a per-member-per-month (PMPM) unit instead of the previous Wraparound Facilitation service 15-minute unit. These services aim to provide comprehensive support and coordination to better address the complex needs of each member. T016 HA ended on June 30, 2024, and the two new codes, T016 HA-TF and T016 HA-TG went into effect July 1, 2024.
- Streamlined geographical exception process: Due to the current limited number of CSED Waiver provider agencies, it was necessary to grant geographic exceptions for Conflict-Free Case Management. The process for requesting geographic exceptions has been streamlined for providers. This change is intended to allow for more timely access to services, ensuring that members receive care without undue delays.
- Strengthened coordination and responsibilities: The language around coordination and responsibilities of members and their families has been further developed. This enhancement emphasizes the importance of active participation and clear communication in the planning and care process.
- Removal of mobile crisis services: The amendment includes removal of mobile crisis services because it will be available as a State Plan service. Members will not experience interruptions or loss of mobile response services. If there are questions or concerns, members can reach out to their Wraparound Facilitator, Aetna care manager, or BMS for assistance.
- Revised experience requirements: Pre- and post-graduate relative experience requirements have been revised. The revisions aim to increase the potential workforce by recognizing a broader range of relevant experience, thereby facilitating the recruitment and retention of qualified professionals.

- Reduction of administrative burden: Efforts have been made to reduce administrative burdens on providers. These reductions are intended streamline processes that allow providers to focus more on direct care activities.

The CSED Waiver permits DoHS to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated that this waiver will reduce the number of children placed in residential and other out-of-home placements. This waiver prioritizes children with SED who are:

- In PRTFs or other residential facilities either in-state or OOS
- Other Medicaid-eligible children with SED who are at risk of institutionalization

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

The following services are available under the CSED Waiver:

- Wraparound Facilitation
- Mobile Response[58]
- Independent Living/Skills Building
- Family Support
- Job Development
- Individual Supportive Employment
- Assistive Equipment
- Community Transition
- Family Therapy
- In-Home and Out-of-Home Respite Care
- Peer Parent Support
- Non-Medical Transportation
- Specialized Therapy

DoHS contracts with Acentra Health, the ASO responsible for program eligibility and enrollment. DoHS also contracts with Aetna Mountain Health Promise, an MCO responsible for CSED service authorization and utilization.

[58] DoHS's state plan amendment to add mobile response services was approved in September 2023 and became effective in February 2024. DoHS allowed a transition period for mobile response providers between February and June 2024. Mobile response services are no longer available via the CSED Waiver and instead are offered through West Viginia's state plan. With this change, mobile response is now available to all Medicaid youth, including those enrolled in the CSED Waiver.

10.1 Review Period, Data Sources and Limitations, Population Measured

Figure 46: CSED Waiver Enrollment and Services Data Overview

CSED Waiver Dataset	Data Review Period	Data Source	Details and Limitations	Population Measured
CSED Waiver Service Data	July to December 2023	EDS	CSED service use is sourced from DW/DSS and EDS paid claims for services rendered July 2022 through December 2023 and paid through April 2024. WV Medicaid providers have up to 12 months from the date of service to submit claims; therefore, results for the more recent months in the analysis period may change over time as providers submit or adjust claims.	Children deemed eligible for the CSED Waiver and accessed services.

10.2 Review Summary

The CSED Waiver has been in effect for over four years and is still expanding. The number of applications was relatively stable, decreasing only slightly (-2.2%) in the second half of 2023 compared to the first half of 2023. Despite this, the number of children and families accessing services continued to increase as will be noted in greater detail throughout this section. While growth of the program has continued, the data available cannot yet be assumed to reflect the routine and ongoing operation of the program.

While being data driven, DoHS is also very focused on each child and family's journey. As DoHS partners with Acentra Health, Aetna, CSED Waiver providers, and other stakeholders to make improvements to the CSED Waiver, the question asked at each decision point is "How does this impact the child and family journey?" DoHS is similarly focused on the individual stories of lives impacted by the CSED Waiver program. As part of ongoing collaboration with providers, Wraparound Facilitators share success stories of children accessing CSED Waiver services. A recent story involved a young girl who was very physically aggressive at home and at school. She was being sent home from school multiple times a week. "Mom" was accessing the mobile crisis line routinely for support. This child was connected to CSED Waiver services, and the WVU PBS team also got involved to support behavioral intervention strategies. Since that time, the child and family have made significant progress, and the child is now able to identify and express her emotions. She has since graduated from CSED Waiver services. "Mom" reported that she was "blown away that the day the team had been working toward was finally here."

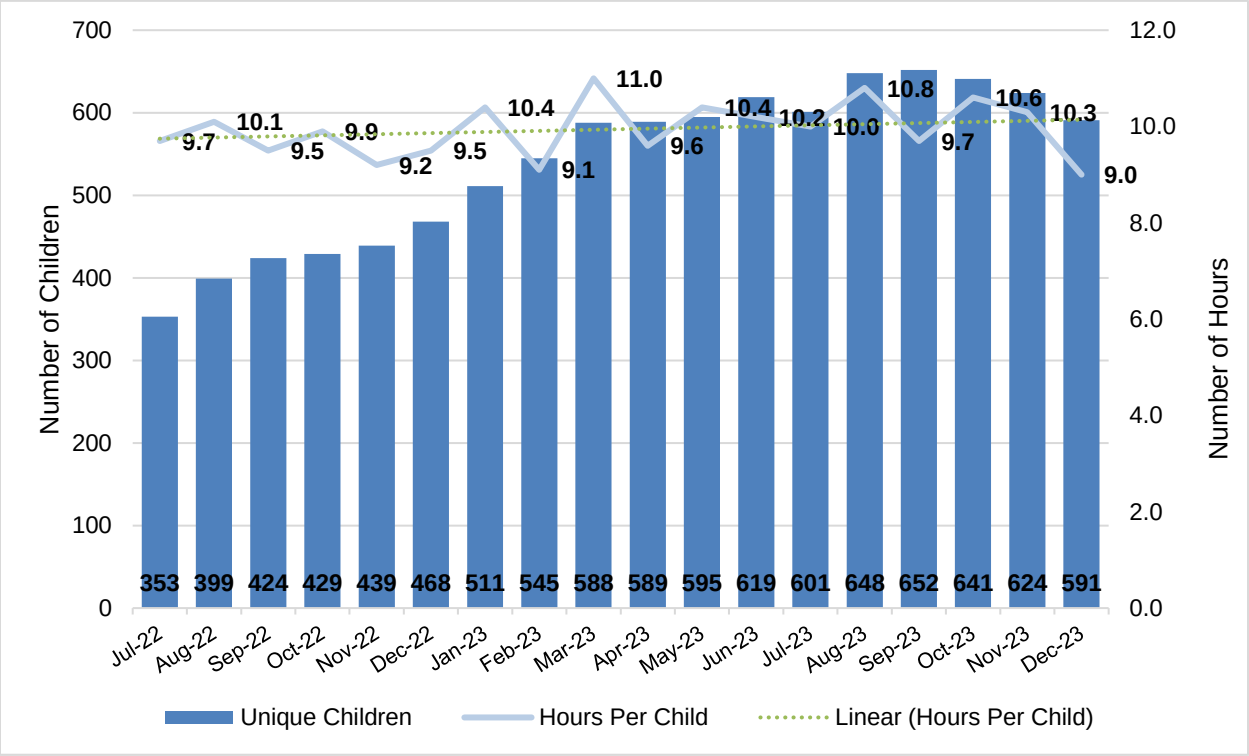
CSED Waiver Service Utilization

The number of children accessing services continued to increase monthly from inception through September 2023. Since that time, the number of children accessing services has leveled off and subsequently decreased in November and December 2023 (Figure 47). As noted in Section 8.0, Pathway to Children's Mental Health Services, there was a decrease in the number of referrals to the Assessment Pathway in the second half of 2023 as well as a decrease in the number of approved CSED Waiver applications; both trends are likely impacting the number of children accessing services. Referrals began increasing again in late 2023 and early 2024, and DoHS will monitor service utilization following this increase in referrals. The average hours of service per child have remained relatively consistent throughout the period.

Aetna manages prior authorizations, service utilization, and care coordination. In addition to these services, Aetna oversees the development and implementation of each member's plan of care in the CSED Waiver to help ensure each member's plan of care aligns with State and federal requirements regarding person-centered planning and coordination and Medicaid service standards. Concurrent reviews of all enrolled members are conducted by Aetna to help ensure the member's plan of care addresses all identified goals and needs. Periodic reviews of the member's claim history are conducted to help ensure all services outlined in the member's plan of care are being delivered and monitored as well as to provide an opportunity to address any barriers in receiving those services. The Aetna care managers are required to connect with the Wraparound Facilitator at least quarterly to discuss the CSED Waiver member's progress with the goals outlined in the plan of care. If there are issues noted, additional communication between Aetna and the Wraparound Facilitator is required. Aetna meets, at a minimum, monthly with BMS to provide updates and address any concerns. The CSED Waiver requires Aetna to report on the number of CSED Waiver members whose plan of care is comprehensive and includes access to non-waiver services, including, but not limited to, natural supports and healthcare. This review is completed monthly.

Other utilization monitoring efforts include the ongoing program trainings, learning sessions, and monthly policy and billing spotlight meetings with providers which were initiated in early 2023 and have continued. Meetings with individual providers to review utilization and billing trends were also initiated in 2023. During follow-up meetings with individual providers, any changes in utilization and billing trends are reviewed and discussed.

Figure 47: CSED Waiver Service Utilization for Hourly Services (Excluding Independent Evaluations, July 2022 to December 2023)



Hourly CSED Waiver services used during the January to June 2023 period compared to the July to December 2023 period are captured in Figure 48 on the following page. While CSED Waiver services are always person-centered, with hours and types of services tailored to each child and family's needs, data are reviewed by examining average utilization to better understand the entire population receiving these services. The number of children using CSED Waiver services increased 6% in the second half of 2023 with 877 unique children receiving services during the period compared to 826 unique children in the first half of 2023. While the growth rate has slowed compared to prior periods, more children continue to be supported in the community with these critical services.

Upon further examination of individual services, the number of families accessing family therapy increased approximately 5%, while maintaining an average of five hours per child per month for this service alone. This highlights that most children with family therapy provided via CSED services had therapy on average at least once per week, with some having therapy more frequently. Children receiving family therapy via the CSED Waiver represented 74% of youth receiving CSED services during the six-month period (children are also able to receive community-based therapy with a non-CSED Waiver provider should they choose to do so). Services provided outside of the CSED Waiver provider network are excluded in this analysis. One out of every four families served from July to December 2023 (25% n = 219) utilized family support services, with the average family served receiving services at least once a week. A total of 76 families utilized in- or out-of-home respite care, averaging a combined total of 21 hours

over the six-month period, or 3.5 hours a month.

DoHS is continuing to collaborate with Aetna to enhance reporting for children enrolled in CSED Waiver services who are subsequently placed "on hold." Services can be placed "on hold" if requested by the member or by their family/legal guardian, if the member is receiving care in an inpatient hospital setting such as PRTF or RMHTF, if the member is in the care of BJS, or if the member resides in an emergency children's shelter. Aetna is capturing this data in their Quickbase system. DoHS is continuing to work with Aetna to capture on-hold reporting history as well as additional details around waitlists. This is a new and developing dataset; additional time and data will help DoHS better understand patterns, reasons, and timelines for children who are on hold, as well as any associated impacts on access to services for children and families.

Figure 48: CSED Waiver Service Utilization by Service Type, Comparison of January to June 2023 Period to July to December 2023 Period[59]

	January-June 2023			July-December 2023		
Service Description	Hours Provided	Unique Children	Hours Per Child Per Service Month	Hours Provided	Unique Children	Hours Per Child Per Service Month
Crisis Service: Mobile Response	29	9	2.4	12	7	0.9
Family Therapy	12,163	616	5.2	12,972	648	4.9
Independent Living/Skills Building	699	19	10.9	729	17	12.6
In-Home Family Support	3,641	268	4.2	3,602	219	4.5
Peer Parent Support	43	17	0.9	81	21	1.2
Respite Care, In-Home	853	42	8.0	686	29	8.9
Respite Care, Out-Of-Home	1,738	68	9.2	928	47	7.0
Wraparound Facilitation	15,779	770	5.0	18,877	823	5.5
All 15-Minute CSEDW Services	**34,946**	**826**	**10.1**	**37,886**	**877**	**10.1**

Consistent with prior periods, the services with highest utilization include Wraparound Facilitation, Family Therapy, and Family Support. BMS program teams and the Quality Committee continue to monitor utilization trends closely given the importance of CSED Waiver services in supporting children to remain at home or in community-based settings. To improve understanding of CSED Waiver services utilization, the Quality Committee requested an analysis of service utilization by county, which is captured below. In the future, DoHS would also like to evaluate service utilization by provider.

County-Level Analysis of CSED Waiver Services Utilization

Based on a recommendation from the Quality Committee, a county-level analysis of hourly CSED Waiver services utilization (i.e., unique youth accessing services and average hours of service utilization) was completed. The following figures capture the county-level comparison of

[59] "Hours per Child per Service Month" is calculated by averaging the number of hours of services received by each child over the number of months in the period in which the child received services, and then calculating the mean of that result across children. Therefore, it is the average hours of service per child per month, conditional on the child having at least one service in that month.

the first and second half of 2023. Only counties with data in both time periods will appear on the maps.

Figure 49 captures the percentage change in the number of unique children accessing CSED Waiver services by county between the two six-month periods of January to June 2023 and July to December 2023. Note that counties serving a small number of children may show larger percentage increases or decreases. Seven counties (highlighted in orange) had an increase of greater than or equal to 25% between the two periods. Twenty-six counties (highlighted in green) had greater than or equal to a -25% decrease. Sixteen counties had sustained rates. Figure 50 shows the number of unique children accessing services by county for each six-month period. Note small county population may result in large increases for a smaller number of children served.

Figure 49: Percentage Change in Number of Unique Youth Accessing CSED Waiver Services by County, January to June 2023 vs. July to December 2023

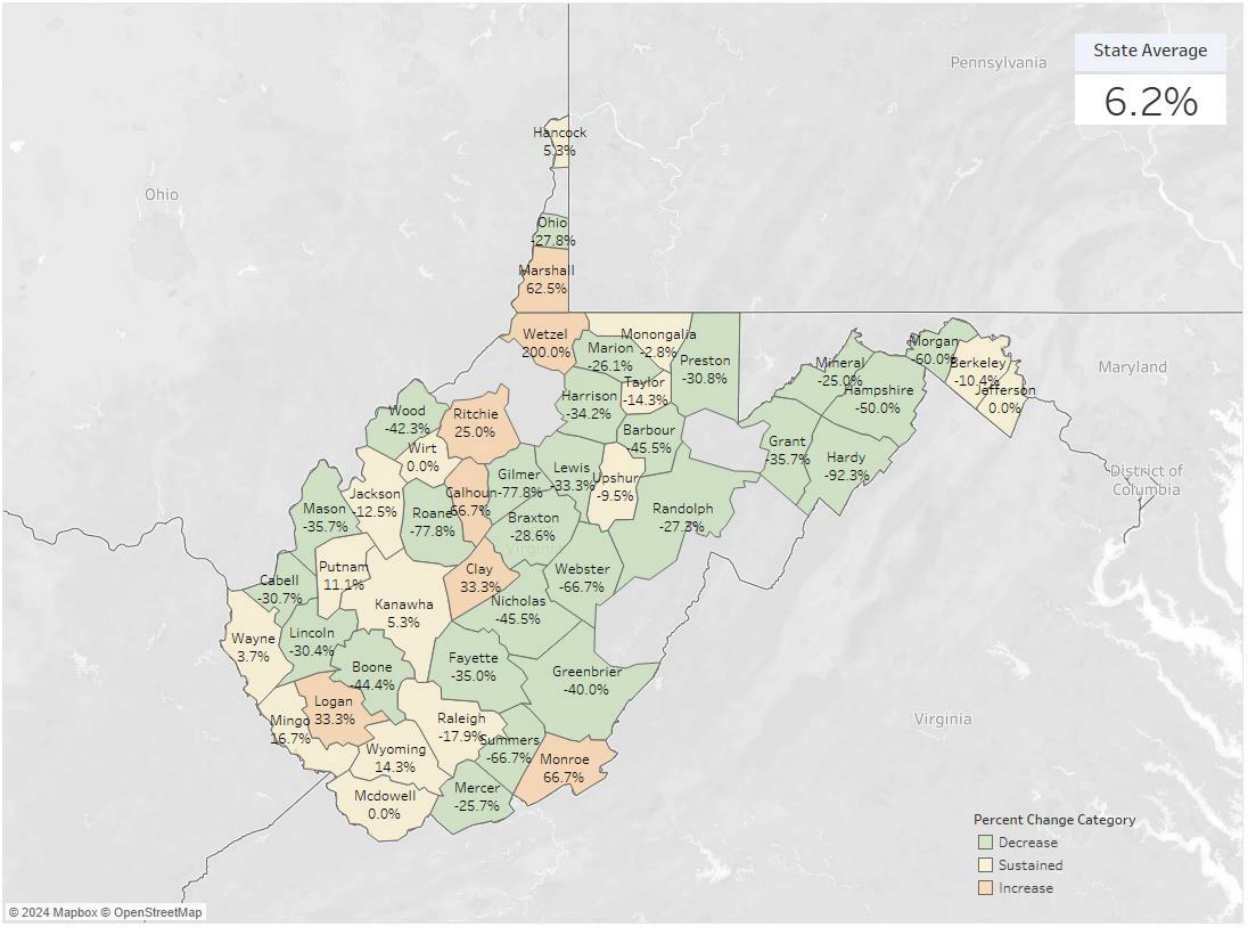


Figure 50: Number of Unique Youth Accessing CSED Waiver Services by County, January to June 2023 vs. July to December 2023 (Left-to-Right)

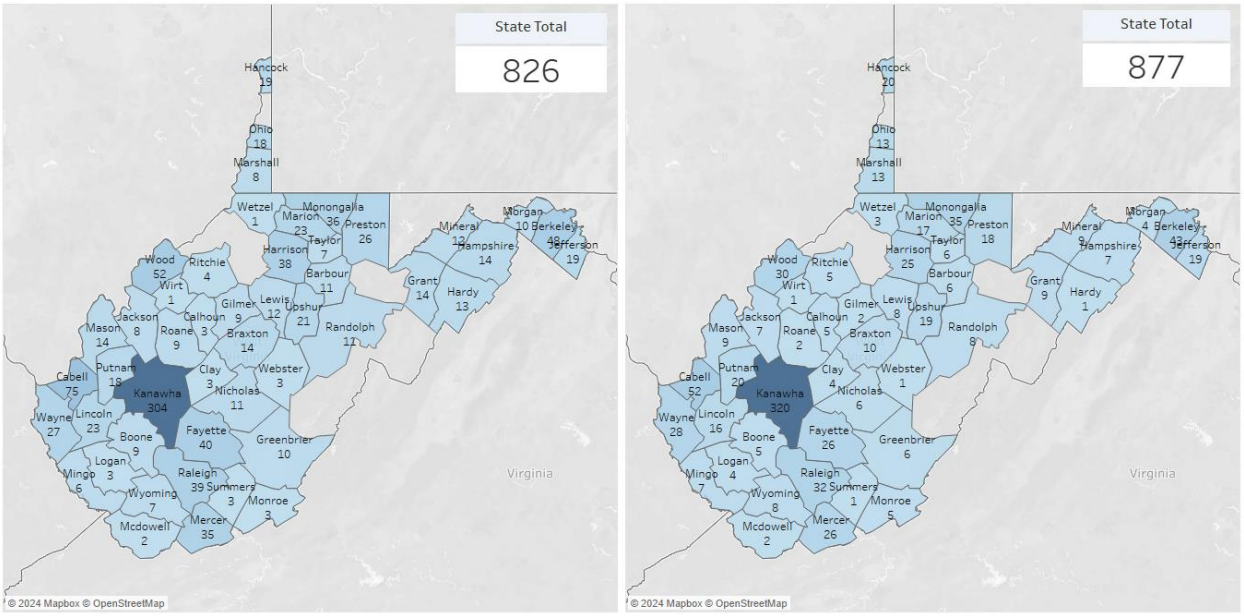


Figure 51 captures the percentage change in average hours of CSED Waiver services per child per month by county between the two six-month periods January to June 2023 and July to December 2023. The statewide average hours of services per child per month was consistent between the two periods. Eight counties (highlighted in orange) had an increase in average hours per child per month of greater than or equal to 25% between the two periods. Four counties (highlighted in green) had greater than or equal to a -25% decrease in hours per child per month. Thirty-seven counties had sustained hours. Figure 52 shows the number of average hours of CSED Waiver services per child per month by county for six-month periods. Positively, the majority of counties are offering sustained levels of services for children accessing CSED Waiver services.

Figure 51: Percentage Change in Average Hours Per Child Per Month by County, January to June 2023 vs. July to December 2023

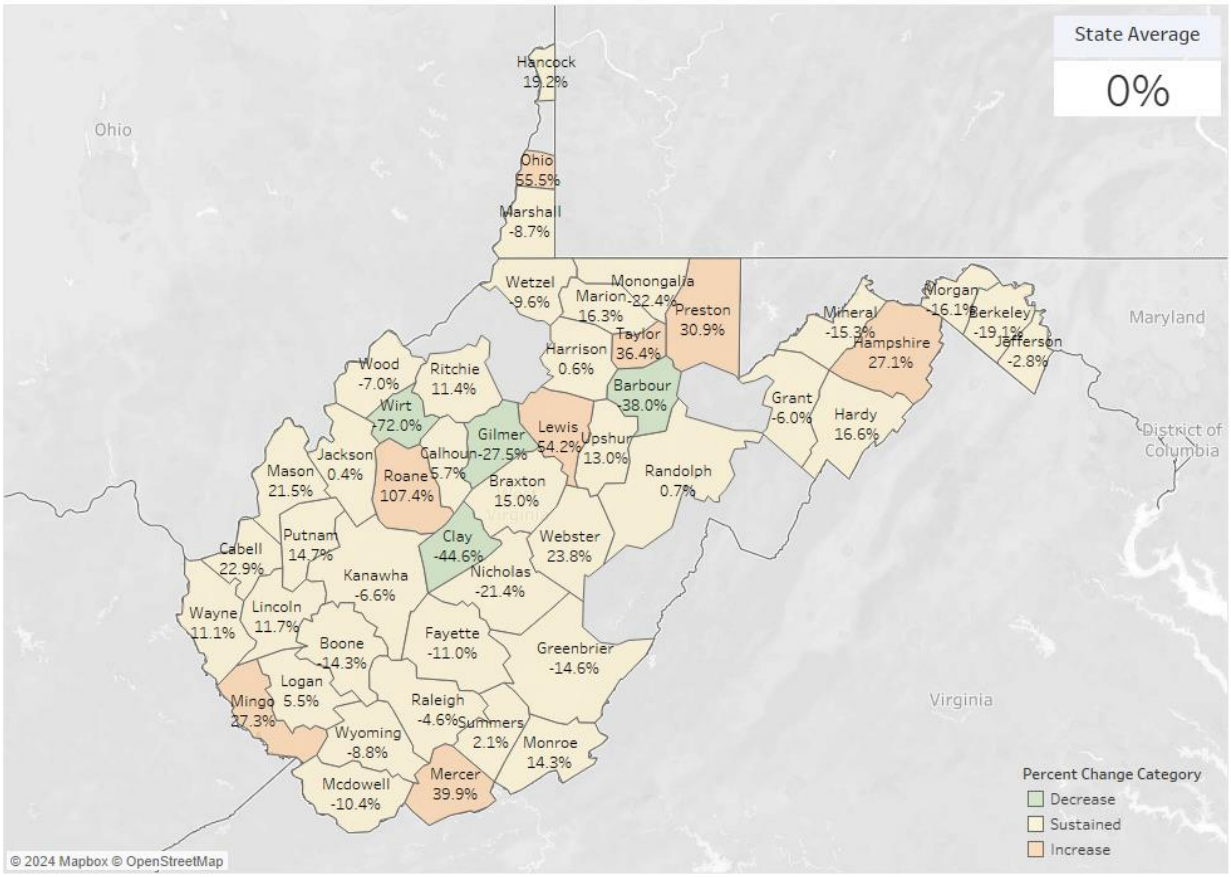
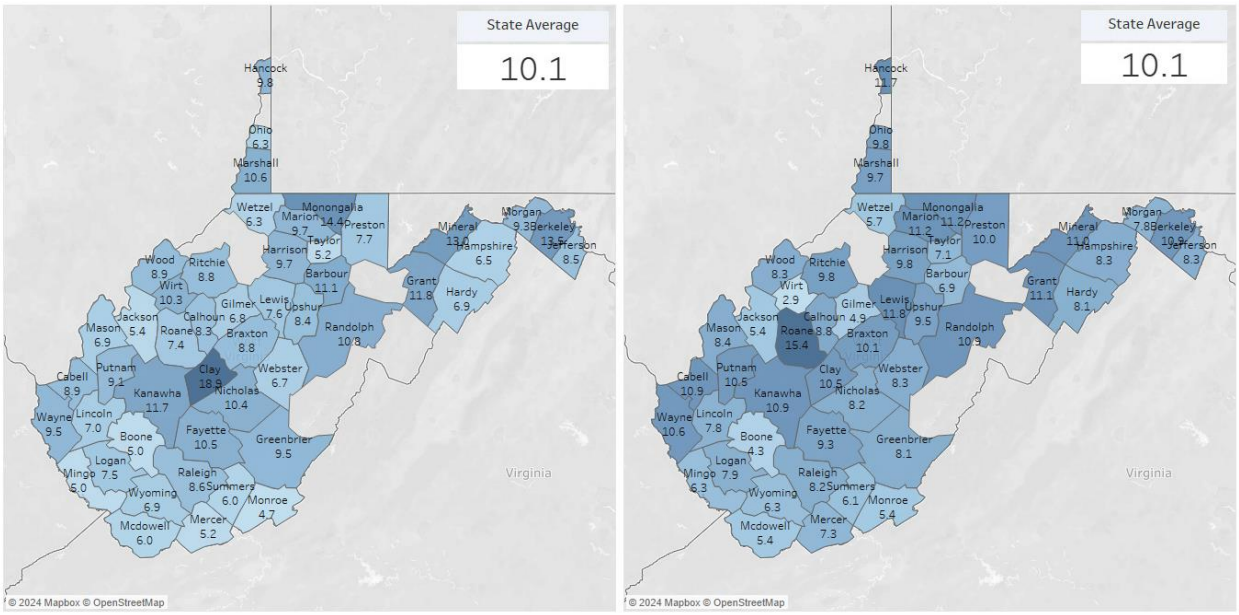


Figure 52: Percentage Change in Average Hours Per Child Per Month, January to June 2023 vs. July to December 2023 (left-to-right)



As noted elsewhere, in response to a request from the Quality Committee, DoHS initiated a more sophisticated county-level analysis that incorporates additional key indicators by county such as Assessment Pathway referrals, QIA referrals, CCRL utilization, CMCR utilization, CSED Waiver approvals and service utilization, foster capacity, provider capacity and judicial outreach. The goal is to begin to understand influences across these indicators and how they are impacting RMHTF utilization at the county-level. This information will be used to prioritize and drive focused efforts in specific counties, which may include addressing any gaps in CSED Waiver services. Please reference Section 6.0 Marketing for further detail.

Timeliness of Access to CSED Services

DoHS is committed to timely access of services to meet the needs of children and families. Timeline to service access data was updated and reviewed in early 2024 with results provided in the April 2024 DoHS Quality and Outcomes Report. This analysis will be revisited in late 2024 to allow time for program teams to continue to work with service providers on data quality and completion in the CANS automated system.

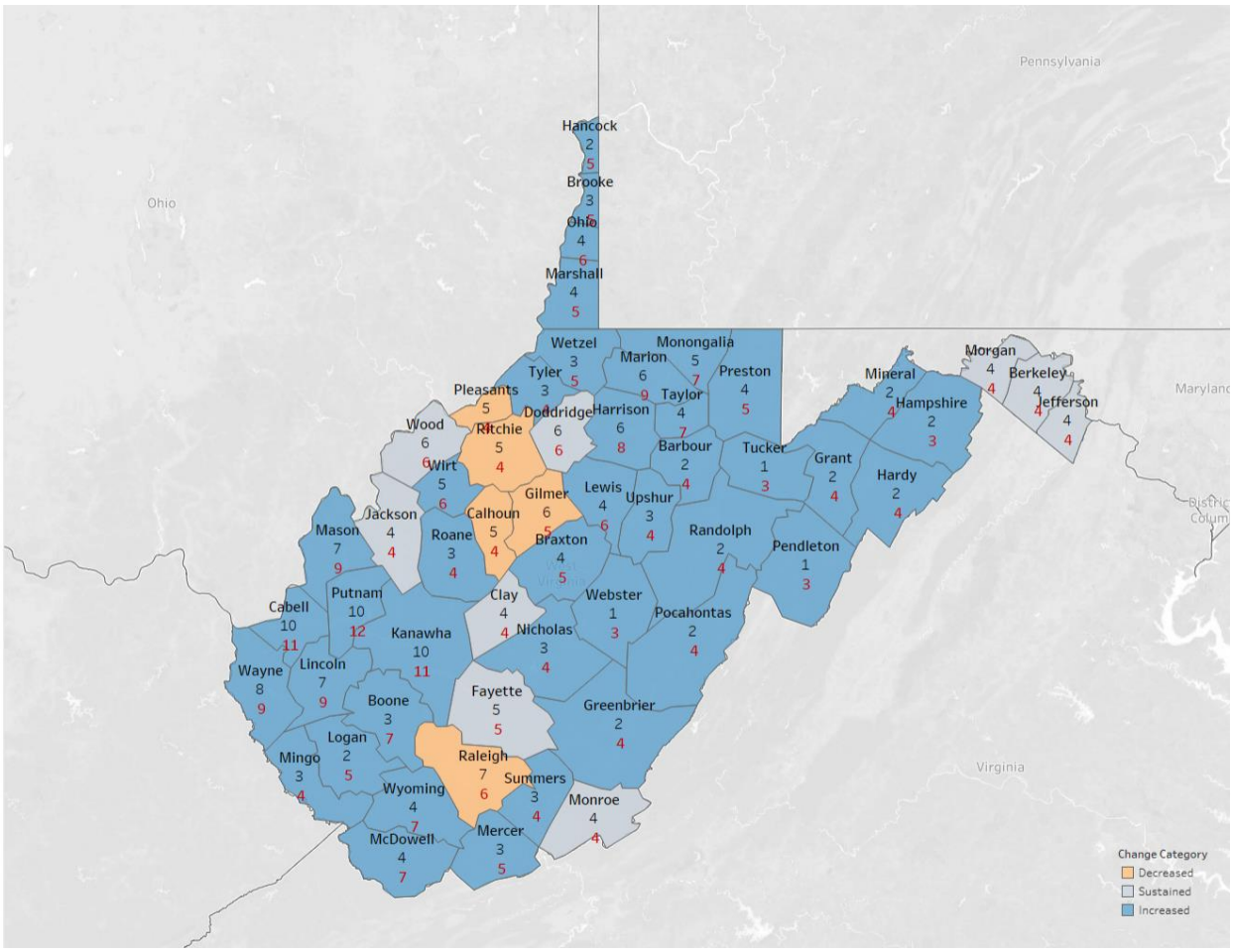
BMS program teams and the Quality Committee continue to prioritize timely access to services and will continue working to understand system, provider, workforce, and/or family-related factors that may be impacting this timeline.

10.3 Provider Capacity/Statewide Coverage

DoHS and Aetna remain focused on building the CSED Waiver provider network given the continued increased demand for these services. In Quality Committee reviews, county-level data for CSED applications, approvals, and utilization is reviewed in conjunction with other factors deemed to have an impact on service demand. DoHS is still in the early stages of beginning to understand the relationships across these datasets and how they can be used to

assist with identifying demand for services and possible gaps in the provider network. As of March 2024, the CSED Waiver provider network comprises 23 agencies actively providing CSED Waiver service while additional providers are in the process of onboarding. Aetna monitors its provider network based on the needs of the CSED Waiver population and meets regularly with BMS to communicate barriers and strategize solutions. As a result, the number of provider agencies offering CSED services has continued to increase. Figure 53 below shows the change in CSED Waiver provider agencies offering services by county comparing March 2023 provider counts (red font) to March 2024 provider counts (black font). Notably, over 80% (45) of West Virginia's 55 counties increased the number of providers offering CSED Waiver services between March 2023 and March 2024. Six counties sustained the same number of providers, while four counties—Pleasants, Ritchie, Gilmer, and Raleigh—experienced a decrease in providers. These four counties only lost one provider each while also maintaining multiple other CSED providers.

Figure 53: Number of Provider Agencies Offering CSED Services by County, March 2023 (black font) and March 2024 (red font)



10.4 Strengths, Opportunities, Barriers, and Next Steps

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

- DoHS is highly focused on the child and family journey. Considerations for impacts to the child and family journey are revisited frequently as DoHS partners with Acentra Health, Aetna, CSED Waiver providers, and other stakeholders to make improvements to the CSED Waiver.
- The number of children using CSED Waiver services increased 6% in the second half of 2023, with 877 unique children receiving services during the period compared to 826 unique children in the first half of 2023. While the growth rate has slowed compared to prior periods, more children continue to be supported in the community with these critical services.
- County-level analysis of CSED Waiver service utilization and unique children accessing CSED Waiver services was completed for the first time and incorporated into a more sophisticated county-level analysis involving multiple indicators as described in Section 6.0 Marketing. This analysis is supporting DoHS in focused efforts in specific counties.
- Data collection and quality improvements are actively in process with Acentra Health and Aetna.
- Forty-five (45) of West Virginia's 55 counties increased the number of providers offering CSED Waiver services between March 2023 and March 2024.
- Effective July 1, 2024, the CSED Waiver amendment includes key improvements. Wraparound Facilitation services have been enhanced by two new services tailored to members with moderate and intensive needs. The geographic exception process is streamlined for quicker access, and mobile crisis services are now available as a State Plan service. Lastly, revised experience requirements aim to expand the workforce. These changes enhance support for children with emotional disorders and their families.

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

- Provider education and support of implementation of the CSED Waiver amendment changes.
- Continuation of data enhancements in progress with Acentra and Aetna to improve the capture of information related to history of children on hold and additional detail on waitlists for CSED services.
- Continuation of the scheduled build-out of the data store to capture the full view of a child's service access following referral to the Assessment Pathway, including timelines and outcomes.

11.0 Wraparound Facilitation

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

- BBH Children's Mental Health Wraparound (CMHW) grants for:
    - Interim Wraparound services
    - Children who are ineligible for the CSED Waiver but meet criteria for non-CSED Waiver Wraparound Facilitation.
- BMS CSED Waiver
- BSS interim services for children involved with child welfare, provided by BSS Wraparound Facilitators:
    - Interim Wraparound services
    - Children who are ineligible for the CSED Waiver but meet criteria for non-CSED Waiver Wraparound Facilitation through the same facilitator when possible

The goals across the agencies funding Wraparound Facilitation services are to:

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

11.1 Review Period, Data Sources and Limitations, Population Measured

As DoHS aligns services to meet the NWI model across all providers, data collection and systems have been and continue to be enhanced to allow interconnectivity of datasets across DoHS for record-level data through the data store. This has enabled DoHS to begin to assess WV Wraparound Facilitation as one consistent and unified service as well as by funding source. DoHS has also contracted with MU to assess fidelity and contracted with WVU to provide an overall evaluation of the children's HCBS system. The CMH Evaluation identified a high level of awareness of Wraparound services (40% of community-based caregivers) and positive associations with utilization of Wraparound services, with 76% of community-based caregivers indicating they believed the services helped avoid or delay the need for residential placement.

Baseline findings also indicated positive perspectives around Wraparound service delivery and rapport with facilitators. Wraparound Facilitation services were one of the most well-known services among providers and caregivers; however, concerns about workforce limitations (i.e., staffing) were listed as one of the most pervasive concerns impacting the ability to access services timely.

The continued implementation of the BBH System of Care Epi Info System enables capture of additional service-level data and child-level data. An update to enhance this system further and refine key indicators was implemented on October 31, 2023. Updates included revisions to timeliness indicators, mechanisms to differentiate interim Wraparound Facilitation services, and other modifications to improve data collection and quality. Data reporting and tracking for the BBH System of Care Epi Info System V2 is still in validation stages. Thus, data included is considered preliminary, and data for some indicators is unavailable at the time of this report. Figure 54 below provides an overview of the Wraparound Facilitation data currently available.

Figure 54: Wraparound Facilitation Data Overview

WV Wraparound DoHS Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
Wraparound services provided by BBH CMHW providers	July to December 2023	BBH System of Care Epi Info Interface	As of October 31, 2021, BBH Wraparound Facilitation became considered WV Wraparound Facilitation and primarily contributes to interim services. Data will need to be reported separately for each payor source until the data store is built out further for connection across data systems. Ongoing concerns have been noted related to Epi Info System's architecture and are still being validated for version 2 of this system. The system is currently undergoing further testing to identify any adjustments that may	Interim Wraparound Facilitation while applying for the CSED Waiver and non-CSED Waiver Wraparound Facilitation with criteria agreed upon with BSS and BMS: 1. As of July 1, 2022, financial ineligibility will no longer be a barrier for the CSED Waiver, due to an approved waiver amendment. 2. Clinical ineligibility for CSED Waiver; DoHS's bureaus recognize that some children may be appropriate for high-fidelity Wraparound Facilitation even if they do not meet clinical eligibility for the CSED Waiver in the following circumstances: ● Significant mental health needs ● At risk of out-of-

WV Wraparound DoHS Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			need to be made to reporting. Due to this, data in subsection 11.2(a) is considered preliminary.	home placement ● CAFAS/PECFAS score of 80, or 70 or below with current involvement by DoHS's BSS ● Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver, such as Intellectual/ Developmental Disabilities Waiver or Traumatic Brain Injury Waiver
Wraparound Facilitation services provided by SAH WV providers	July to December 2023	CANS Automated System	Differentiation of SAH and interim services began in December 2022. Services through the agreement between bureaus to enable SAH facilitators to serve WV Wraparound clients went into effect June 10, 2022. As of July 1, 2023, providers are required to report data for the previous month within five business days following the reporting month's end. Data included in this report includes entries into the CANS system through April 2024, which should account for data lag, although some may still exist due to the fairly new	**See description above.*

WV Wraparound DoHS Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			implementation of this submission timeline.	
CSED Waiver Wraparound Facilitation	July 2022 to June 2023	EDS	Data are based on claims through April 2024, so there may be some claim lag in the data presented.	Children enrolled in the CSED Waiver

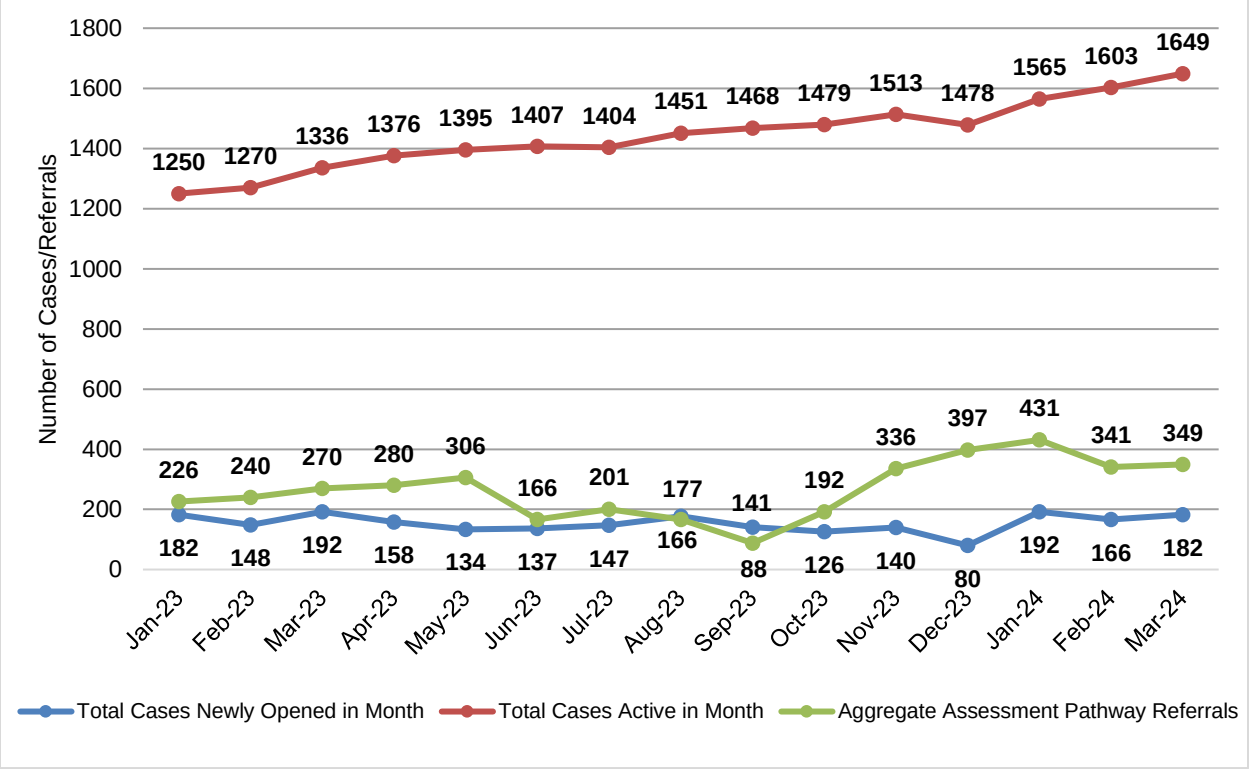
Wraparound Facilitation services will be reported in aggregate across funding sources and by payor source. The Assessment Pathway enables families to access Wraparound Facilitation seamlessly and maintain their current Wraparound Facilitator, even when changing payors, to help ensure consistency in service provision and maintenance of already established relationships.

Data periods reviewed are noted throughout. The implementation of the Assessment Pathway resulted in a large influx of children referred and served via Wraparound Facilitation services. Given these changes and the increase in referrals over time, Wraparound Facilitation service trends across payor sources will be monitored to understand impacts of continued system changes and need.

Aggregated Wraparound Facilitation cases are shown in Figure 55 compared to aggregate referrals. Overall, utilization of WV Wraparound services has increased rapidly since July 2023, with 245 additional children being served as of March 2024. These increases appear to be driven by outreach efforts occurring in the last quarter of 2023, which lead to sharp increases in both referrals to the Assessment Pathway as well as utilization in subsequent months. In addition to mass marketing and materials which were shared in December 2023 throughout key interaction points across the State, members of the DoHS team also networked with professionals and presented at major WV conferences[60] in fall 2023, reaching educators, counselors, and social workers—all of whom have regular opportunities to engage with children and families to share critical resources such as mental health service access information.

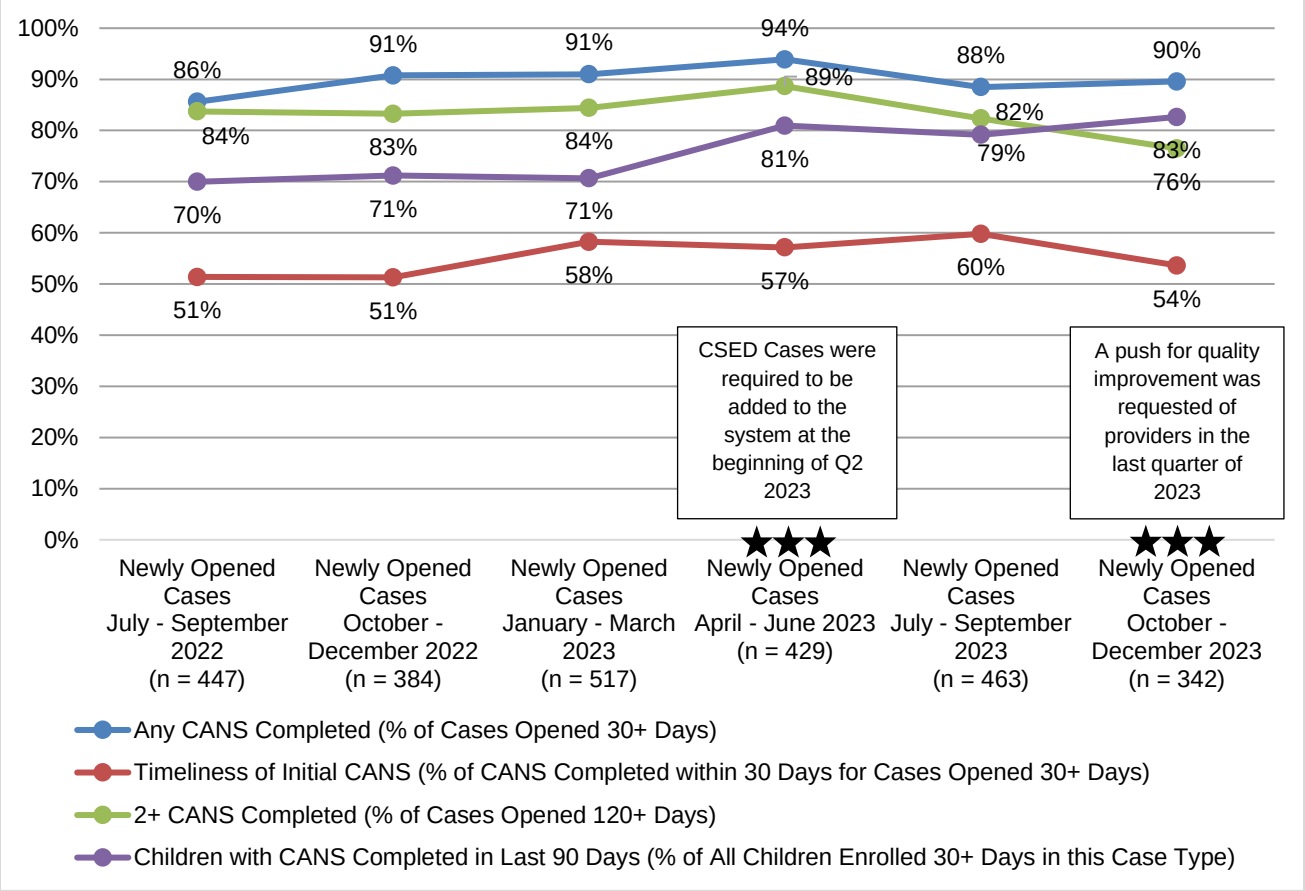
[60] Some larger conferences and marketing opportunities reported included the Handle with Care Conference (September 13-15, 2023) and the WV Counseling Association Fall Conference which was advertised via DoHS's Expanded School Mental Health website and network (November 2-5, 2023).

Figure 55: Aggregate Wraparound Facilitation Active Point in Time Cases as documented in the CANS Automated System, January 2023 to March 2024



DoHS is continuing to work through data quality and validation of data pulled from the CANS automated system. Figure 56 below captures aggregate Wraparound CANS completion and timeliness by quarter for 2023. Current reporting practices in the CANS system, including lag in reporting of CANS assessments, are not meeting expectations as set in DoHS policy or described by Wraparound fidelity. The Quality Committee has discussed the possibility that these activities might be happening with families but might not have been documented. Regardless, the group noted the importance of documentation of these activities to help ensure families are receiving high-fidelity Wraparound services that promote the success of providers and families. As a next step to improving timeliness and completion of CANS data, provider-level reports are being published monthly and shared with the Wraparound PIP team for program leaders to share with Wraparound providers. Based on review of this data, and with input from Wraparound providers, a list of requested enhancements to the CANS automated system has been outlined, with each enhancement prioritized based on the ease and expected value of the update. This list includes automated CANS provider-level reporting and quality assurance related queries, which will begin to be developed in early fall 2024. These changes are expected to have a significant impact on the ability to influence timelier CQI practices and influence improvements to provider accountability to Wraparound fidelity indicators.

Figure 56: Aggregate Wraparound CANS Completion and Timeliness by Quarter, July 2022 to December 2023



11.2(a) Wraparound Facilitation Services Through BBH

Information on the demographics of children enrolled in Wraparound Facilitation services through BBH is included in Section 4.0 WV's Child Population and Individuals Utilizing Services. From July to December 2023, 43 individuals were documented in the Epi Info System as having received services through BBH. This is a slight decrease from 52 individuals served in the previous six months. Data collection and review processes aim to continue to establish baseline numbers of children receiving services and the number of services being utilized as implementation is underway, as well as baseline characteristics of children who are receiving services and where services are occurring. At this time, given the decrease in family-driven referrals, the transition from Epi Info System Version 1 (V1) to Version 2 (V2), and associated limitations with implementing the new system, the cause of this decrease is currently unclear, but trends will be monitored in the coming months at the provider-level to provide insight into the cause of this decrease. Data in this subsection are considered preliminary.

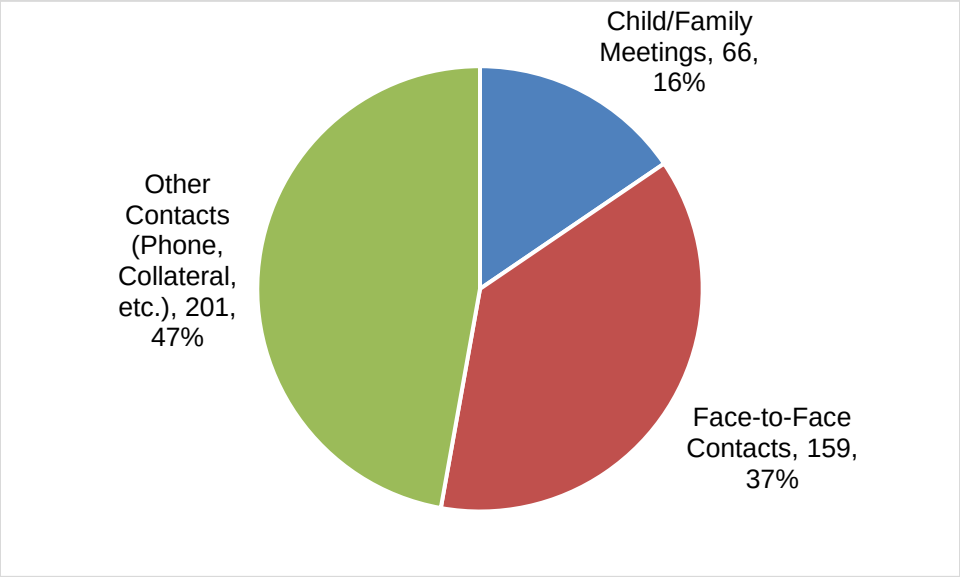
Since the beginning of the pandemic, service delivery has shifted to meet needs and safety concerns. Represented in the "Other Contacts" category in Figure 57, telehealth services have been viewed as one of the more positive outcomes of the pandemic, enabling more frequent and timely connection to families as needed or requested by the family without replacing key

face-to-face interactions. However, the percentage of contacts that occurred virtually dropped significantly from the first half of 2023 (66%) to the second half of 2023 (47%). Providers are trained to use virtual services based on the needs and requests of the family; however, in-person service engagement is strongly encouraged. Some of these shifts from virtual to in-person services may be expected based on this guidance, and due to a “return to normalcy” post-pandemic. Remarkably, family-driven referrals and children utilizing these services tend to be younger than children referred from other sources. Younger children, who might be more easily distracted, may have better engagement via in-person communication, which could also drive increased in-person contacts post-pandemic.

For the 43 individuals served, 426 total contacts/interactions were made, about 10 contacts per child during the six-month reporting period, a decrease from 15 to 20 contacts per child observed in past reporting periods. This drop is driven exclusively by the reduced number of “other” contacts. The number of child and family team meetings per child (1.5) and face-to-face interactions per child (3.7) are within the range of values observed in prior reports, while the other contacts per child have dropped from 10 to 15 in past periods to less than 5 in July to December 2023. These changes will be further explored and addressed in 2024 through provider-specific analyses and via additional Epi Info System V2 validation to understand if there was a notable shift in how providers were interacting with families, or if this drop is an artifact of the updated data system and provider documentation changes. DoHS also plans to investigate length of service for youth receiving interim Wraparound to understand and explore the possibility that lower utilization was driven by shorter lengths of service, which would imply that youth had less time to receive interim Wraparound before being transferred to CSED as the Wraparound funding source.

At the time of this report, data interactions with individuals were captured differently for Wraparound Facilitation funded by BBH and SAH versus CSED. For BBH and SAH, “interaction” referred to a contact with the individual regardless of time spent, while CSED “interaction” referred to hours spent with the individual.

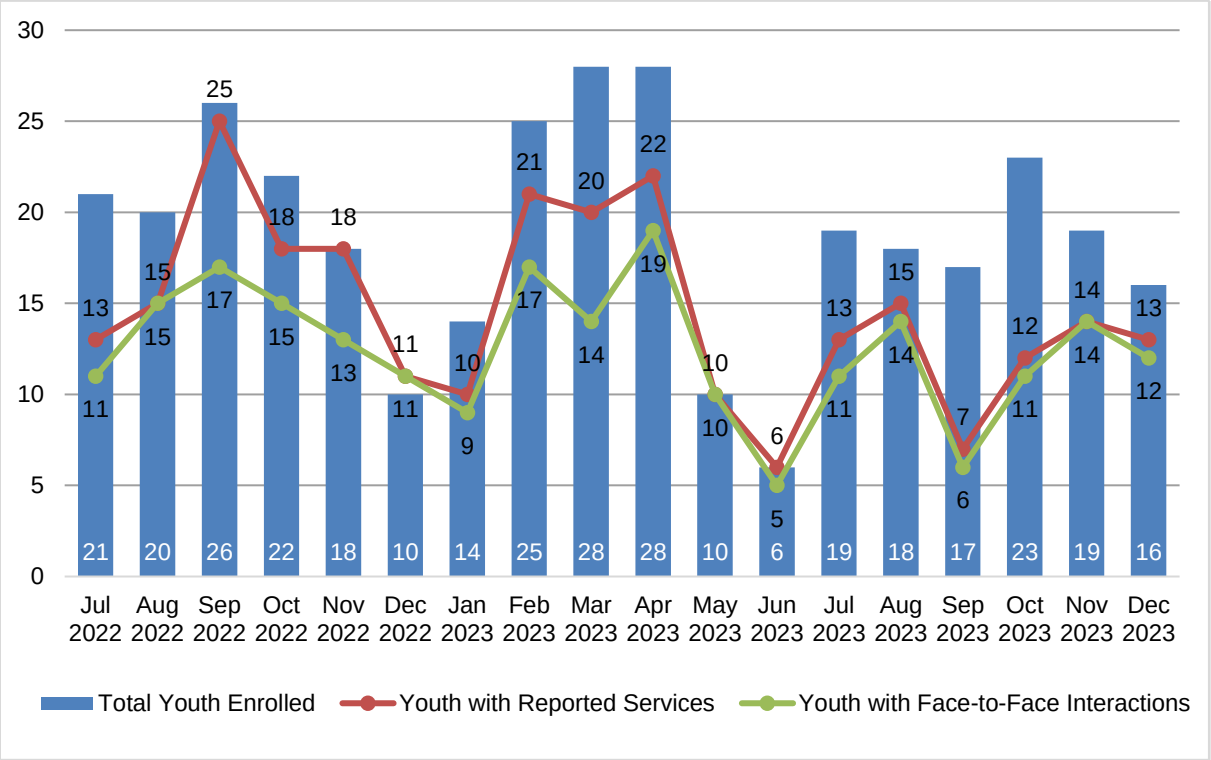
Figure 57: BBH Wraparound Facilitation Services by Contact/Interaction Type, July to December 2023, (n = 426 Contacts) – Preliminary



Monthly enrollment and service utilization (Figure 58) have been fairly consistent since July 2022. Enrollment peaked in March and April 2023, when 28 children were enrolled, followed by a steady decline to 15 children enrolled in January 2023. Enrollment decreased sharply in May and June 2023, but then rebounded for the remainder of the year, though enrollment numbers were lower overall in the second half of 2023 compared to the first half of 2023. Lower enrollment of children through BBH-funded Wraparound services is largely influenced by limitations in grant-enrolled provider capacity, which had a waitlist of 20 children for interim services as of January 5, 2024. Increased referrals to the Assessment Pathway and thus demand for Wraparound Facilitators from November 2023 through early 2024 has resulted in an increased waitlist of 56 children as of June 21, 2024. WV Wraparound policy allows children to keep the same facilitator as they transfer funding sources to enable continuity of care. Although this practice is very positive for families and provides stability while a child receives services, the policy also impacts the number of facilitators available for new interim cases as children transfer to CSED funded services. BBH has been working with providers on strategies to expand availability of interim Wraparound.

The trends of monthly service utilization and face-to-face interactions mirrored the enrollment trend (Figure 58). Notably, a higher percentage of youth received face-to-face services in July – December 2023. This may be expected if providers and families are shifting away from virtual contacts to in-person interaction, as identified in Figure 57 above.

Figure 58: BBH Wraparound Facilitation Monthly Enrollment Totals and Service Utilization, July 2022 to December 2023 – Preliminary



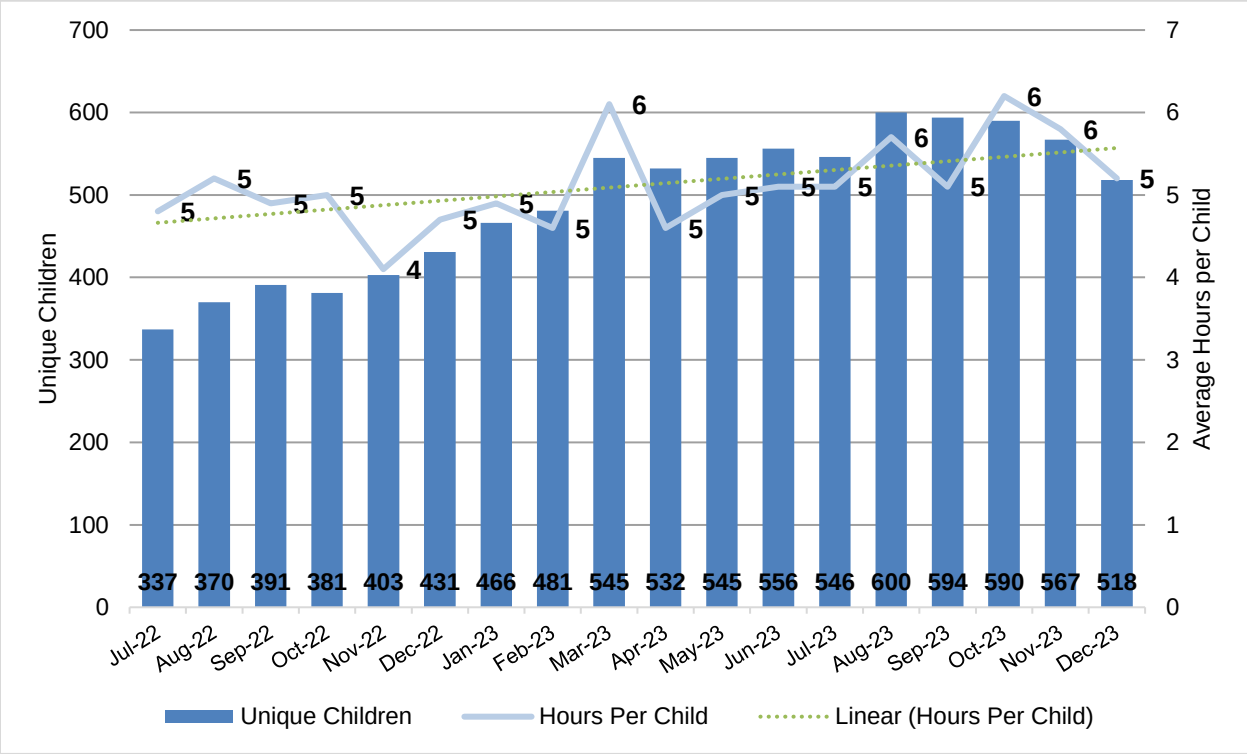
11.2(b) Wraparound Facilitation Services Through CSED Waiver

Eight hundred twenty-three (823) unique children accessed CSED Waiver Wraparound Facilitation services in the second half of 2023 compared to 770 unique children in the first half of 2023, representing a 7% increase in children accessing Wraparound Facilitation services (reference Figure 48: CSED Waiver Service Utilization by Service Type, Comparison of January to June 2023 Period to July to December 2023 Period in Section 10.0 CSED Waiver Services).

The CSED Waiver Wraparound Facilitation utilization 18-month trend from July 2022 to December 2023 is shown in Figure 59. The number of children accessing CSED Wraparound Facilitation services continued to increase through August 2023, then remained stable through September and then decreased in November and December 2023. As noted in Section 8.0, Pathway to Children's Mental Health Services, there was a slight decrease in the number of referrals to the Assessment Pathway in the second half of 2023 that may be impacting the number of children accessing services. Considerations may also be noted for potential seasonal trends due to families' availability typically decreasing during the holidays. Referrals began increasing again in early 2024; CQI processes will continue to allow monitoring of Wraparound service utilization following this increase. The average number of hours being provided per child each month has remained stable throughout the 18-month period. BMS continues to support CSED Waiver providers through ongoing program trainings, learning sessions, and monthly policy and billing spotlight meetings. Meetings with individual providers to review utilization and billing trends were also initiated in 2023. During follow-up meetings with individual providers,

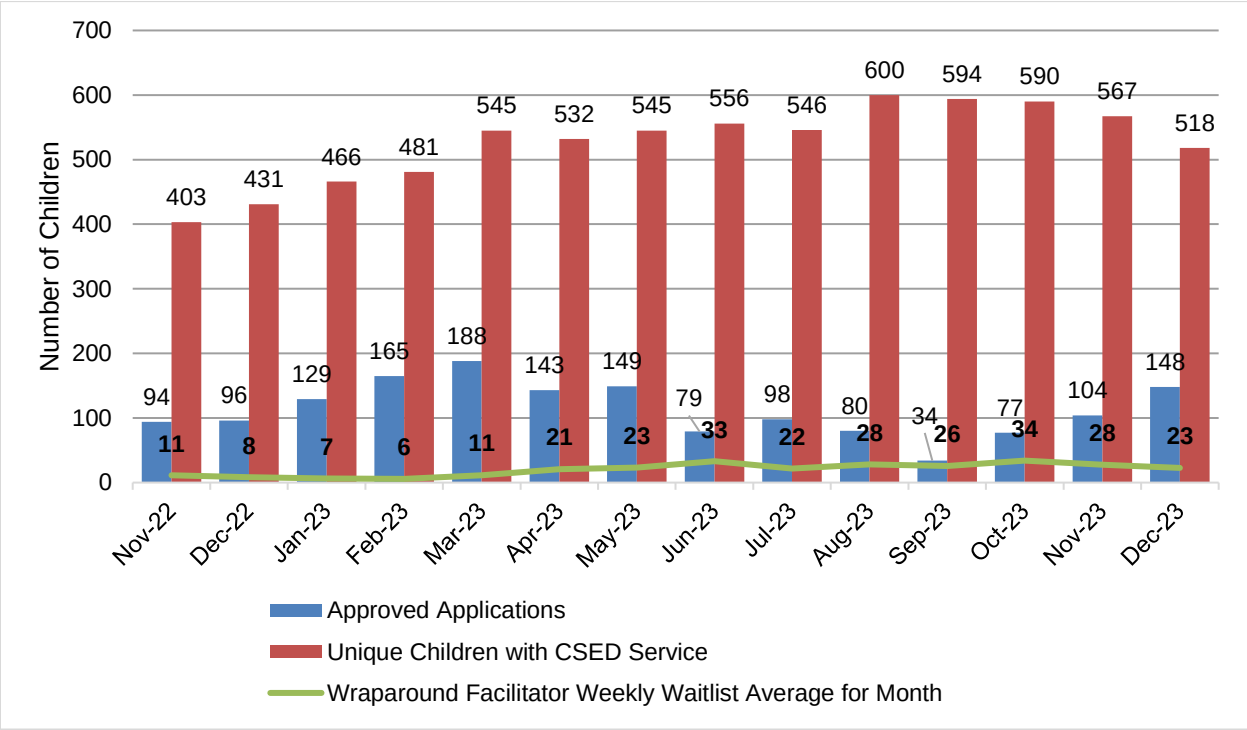
any changes in utilization and billing trends are reviewed and discussed.

Figure 59: CSED Waiver Wraparound Facilitation Utilization, July 2022 to December 2023



DoHS monitors Wraparound Facilitator waitlists on a weekly basis to assist with helping ensure services are available to meet the continued demand. Waitlist compared to CSED Waiver-approved applications and unique children accessing CSED Waiver services by month is shown in Figure 60. Despite the average waitlist increasing in early 2023, the number of children on the CSED Waiver waitlist has remained stable from April through December 2023. Aetna care managers complete weekly check-ins and coordinate care and connection to services while the child and family are awaiting Wraparound Facilitator assignment. Frequent data review and care coordination among Wraparound program leads, Aetna, and providers has continued to help keep waitlist numbers low in comparison to demand. Given family choice of provider and periodic staffing challenges among providers, a waitlist might be expected. Expansion of the CSED provider network and Wraparound Facilitator capacity continues to be a focus to help meet growing demand, additional details are noted in the provider capacity subsection below.

Figure 60: CSED Waiver Wraparound Facilitator Waitlist Trended with Approved CSED Waiver Applications and Unique Children Accessing CSED Waiver Services, November 2022 to December 2023



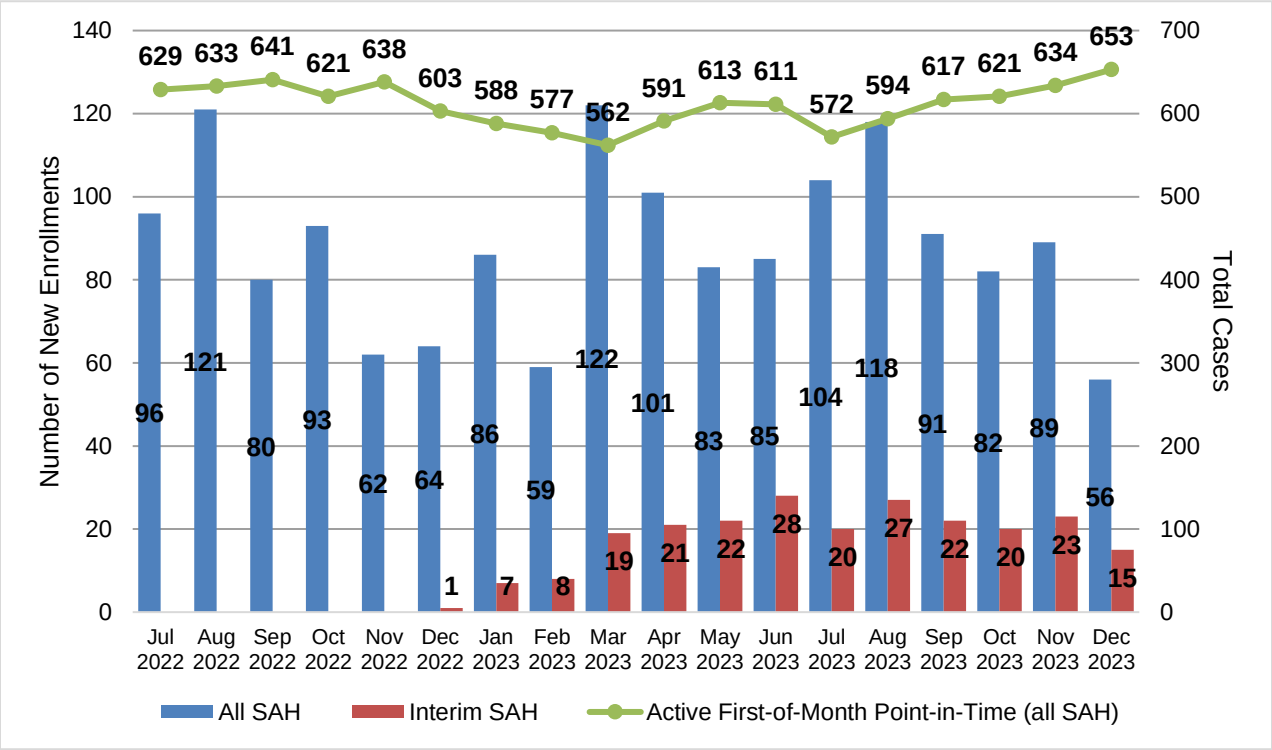
11.2(c) Wraparound Facilitation Services Through Safe at Home (SAH)

New monthly enrollments in SAH Wraparound Facilitation for July 2022 to December 2023 are shown in Figure 61. Enrollments for any SAH Wraparound Facilitation case are relatively constant throughout the period, although there was some month-to-month variability with a minimum of 62 new enrollments in November 2022 and a maximum of 122 in March 2023. Increases in enrollments occurred in both August of 2022 (n=121) and August 2023 (n=118), which may be associated with the beginning of the school year and related referrals given increased child-level interaction with some key stakeholders. Children considered active as of the first of the month for SAH services increased to 653 children enrolled as of December 2023, compared to 603 cases in December 2022. The interim service designation was added to the CANS Automated System in November 2022, with reporting implemented the following month. The interim services distinction is intended to indicate children who are going through the Assessment Pathway and are assigned a Wraparound Facilitator providing services via the SAH program funding. New interim enrollments are provided in Figure 61, beginning in December 2022 with growth in the number of cases flagged as interim through June 2023.[61] Given recent implementation of reporting and flagging some SAH Wraparound Facilitation cases as interim, these cases may be underreported. This is suspected to occur more

[61] Prior to this change, interim SAH cases were included with regular SAH cases in the CANS Automated System.

frequently with cases who are directly referred to SAH and apply for CSED Waiver services after enrollment. Ongoing review of these cases will continue as provider understanding regarding when and how to flag cases as interim improves.

Figure 61: SAH Wraparound Facilitation New Monthly Enrollment and Active Point-In-Time Cases, July 2022 to December 2023



From July to December 2023, 540 total children were newly enrolled in SAH Wraparound Facilitation, with 127 children reported as an interim SAH Wraparound Facilitation case. Timeliness and contact data for these children are displayed in Figure 62. There were minimal changes in timeliness and contact rates for children enrolled in SAH Wraparound Facilitation from the prior reporting period. Overall, the majority of SAH cases had at least one contact reported, 84% (n = 454). Nearly two-thirds of all SAH cases (63%, n = 340) met the preliminary goal of having the first contact with the child within three days of the assignment of the Wraparound Facilitator. Average timelines to first contact were slightly longer for all SAH cases (5.6 days) than for interim SAH cases (4.0 days). Seventy-five percent (75%) of all SAH cases had at least one face-to-face contact. As with initial contacts, average timelines from assignment to the first face-to-face contact were slightly longer for all SAH cases (13.1 days), compared to interim SAH cases (11.5 days).

Preliminary benchmarks have been established based on feedback from the DART fidelity evaluation tool. Review of timeliness and contact data for SAH Wraparound Facilitation cases has evolved to include reviewing information disaggregated at the provider-level. This process has resulted in the Wraparound PIP team determining a need to update the CANS system to make reporting contact data clearer and more concise. These changes are under development and are not expected to be in production until late 2024. Automated reports available for all

Wraparound providers will also be expanded in fall 2024 to enable more timely feedback and increase accountability for both provision and documentation of quality and timely services. Further alignment of data reporting for additional fidelity related indicators will also be included as part of the prioritized updates to the CANS system.

Figure 62: SAH Wraparound Facilitation Contact and Timeliness Data

Metric	All SAH (n = 540)	Interim SAH (n = 127)
Presence of Contact Data	84% (n = 454)	82% (n = 104)
Timeliness to First Contact *(Preliminary goal: within three days of assignment)*	• 63% (n = 340) met goal • Average of 5.6 days from assignment to first contact	• 65% (n = 82) met goal • Average of 4.0 days from assignment to first contact
Face-to-Face Contact *(Preliminary goal: within 10 days of assignment)*	• 75% (n = 407) had a face-to-face contact • 47% (n = 256) met goal • Average of 13.1 days from assignment to first face-to-face contact	• 74% (n = 94) had a face-to-face contact • 48% (n = 61) met goal • Average of 11.5 days from assignment to first face-to-face contact

11.3 Provider Capacity/Statewide Coverage

Wraparound Facilitation capacity continues to be an area of focus for DoHS, and its partners given the critical role Wraparound Facilitators play in connecting children with HCBS. As noted previously, frequent review of data and care coordination among Wraparound program leads, Aetna, and providers has continued to help keep waitlist numbers low in comparison to demand. As of the week of June 28, 2024, waitlists were as follows: CSED Waiver (23), BBH Interim Wraparound (56), and SAH (3). Through collaboration with MU and focus on creative solutions and case management technical assistance with providers, SAH has been able to decrease their waitlist to only three children. BBH is currently working with providers to assess Wraparound Facilitator staffing and associated funding to work toward capacity expansion to address the BBH interim Wraparound waitlist which has remained consistently high. CSED Waiver Wraparound waitlist remains in the range of 22 to 32 children each week. Given family choice of provider and periodic staffing challenges among providers, a waitlist might be expected, and ability of a family to maintain the rapport and connection of a single Wraparound Facilitator across their Wraparound journey, regardless of source of funding for the service, is viewed as a significant benefit of the approach WV Wraparound is taking.

Effective April 2024, training and coaching of Wraparound Facilitators was transitioned from MU to the UCONN. MU will continue to support efforts associated with data collection in the CANS automated system and the collection of information to support capacity and caseload monitoring activities.

Since March 2023, all Wraparound Facilitation providers are required to enter information into the CANS Automated System. Review of provider-level data completion in the CANS automated

system compared to Wraparound Facilitation services data from other sources (e.g., claims, etc.) indicated issues with data quality and completion. In the first six months of 2024, DoHS's program leaders have focused efforts on improvements to data quality and completion with individual providers. Additionally, through this analysis and based on feedback from providers, enhancements to the CANS automated system have been recommended to better support accuracy of data collection. DoHS is collaborating with MU and its vendor Public Consulting Group to prioritize these recommended enhancements and establish a timeline for implementing these system changes.

MU is also supporting the continued pilot of Wraparound Facilitator caseload and capacity tracking, which factors in Wraparound Facilitator full-time equivalency (FTE) status[62] as well as child case intensity through a tool incorporating child-level CANS results. The pilot of this tool has expanded to two additional providers as of July 2024. This tool will continue to be revised based on feedback from providers related to their experience of service provision, including staffing patterns and other workforce considerations.

Capacity data will continue be analyzed and reviewed by the workgroup leads, the Wraparound Facilitation PIP team, and program leads with DoHS leadership, on an ongoing basis to inform areas of need and improve understanding of acuity levels, geographic considerations, and available workforce based on caseload ratios. Based on input from providers, as well as a recommendation from the Wraparound Facilitation PIP team, changes to the reimbursement rate structure for CSED Waiver Wraparound Facilitators were included in the CSED Waiver amendment to support capacity expansion. These changes in rate structure are effective July 1, 2024. Reference Section 10.0 CSED Waiver Enrollment and Services for details. Impacts on capacity associated with these changes may not be observed till 2025.

Capacity and caseload analyses will continue to inform potential policy development, outreach, and funding for Wraparound Facilitator recruitment and retention to areas of highest need. Adequate workforce capacity will help ensure more timely services can be offered, assist with alignment to NWI fidelity guidance for facilitator caseloads, and allow time for provision of high-fidelity Wraparound Facilitation programming, increasing the likelihood of positive outcomes for the child and their family.

11.4 Strengths, Opportunities, Barriers, and Next Steps

Wraparound Facilitators have continued to provide services to help children stay in their homes and communities. The ability to conduct many of these services via phone or virtual communications expands the ability to meet families' needs as well as to meet demand during extenuating circumstances. Although virtual services can extend the ability to deliver services, DoHS plans to confirm outcomes are not impacted by virtual service delivery as part of future planned efforts to better understand outcomes and related impacts. DoHS continues to encourage in-person engagement in alignment with NWI philosophy.

[62] FTE was added to data collection as it became clear that facilitators may have multiple roles in their agency or may serve children covered under multiple payor sources.

DoHS continues to see increases in the number of children utilizing WV Wraparound services, a positive step toward increasing the overall number of children and families who can be supported and sustained in their homes and communities. Daily collaboration across BMS, BSS, and BBH occurs to help ensure children are connected to Wraparound Facilitators or other services and resources in cases in which a Wraparound Facilitator is not immediately available. Additional strengths include:

- Robust Assessment Pathway processes to provide connection to HCBS which include (but are not limited to) referral and utilization of interim and CSED Waiver Wraparound Facilitation services, when available, and connection to other mental health services based on the immediate and longer-term needs of the family.
- Overall, utilization of WV Wraparound services has increased rapidly since July 2023, with 245 additional children being served as of March 2024, a total of 1,649 children enrolled.
- Progress toward incorporation of elements of the DART fidelity tool and alignment of procedure and policy across funding sources to help ensure quality and continuity of care for children and families regardless of Wraparound funding source.
- Prioritization and implementation of the recommendations found in MU Wraparound fidelity report. A WV wraparound director position has been developed and was posted in June 2024.

As WV explores utilization and related outcomes further, data quality and completion are key to understanding and influencing factors for needs and strengths. DoHS is investing considerable time and resources to improving data quality and enhancing the CANS automated system. This will allow the DoHS team and providers expanded opportunities to monitor services more effectively, manage caseloads, and help ensure Wraparound is implemented to encompass high-fidelity standards which ultimately should lead to improve outcomes for children and families. In addition to planned system enhancements, monthly review of provider-level data is already helping influence strategic response to providers in need of technical assistance.

DoHS recognizes the need to expand the Wraparound Facilitator workforce to connect children with Wraparound Facilitators more expediently, while also celebrating advances in ability to connect children to services quickly and maintain low waitlists in comparison to demand. Opportunities and prioritized next steps per recommendation of the Quality Committee include:

- BBH has updated its provider statements of work to include a fee-for-service model for Wraparound services covered under BBH grant funding, which is expected to encourage expansion of the workforce available for interim Wraparound services.
- A Wraparound Facilitator capacity tool is being piloted to incorporate level of acuity with provider and facilitator caseloads and FTE capacity considerations to help bureaus respond to capacity and assignment needs as they arise. In coordination with MU and Aetna, this information and tool will be used for case management, caseload validation, and provider network expansion effort exploration based on findings.

- Data enhancements via current individual reporting systems, as well as expansion of the data store to capture and understand interim Wraparound Facilitation services, and how these fit into the overall view of a child's timeline to access services, including bridging any potential gaps while a child is going through the CSED Waiver eligibility determination process.
- Continued work to improve data quality and completion through provider training, technical assistance, and data system revisions. Review will focus on timely reporting of CANS data, which will expand to outcomes reporting over time through the Wraparound Fidelity PIP team. Enhance availability of data via the data store is expected to advance understanding of service utilization across a child's timeline to services, including identifying strengths and needs of existing processes.

12.0 Behavioral Support Services

Behavioral Support Services focus on providing prevention and intervention supports for children who are demonstrating significant maladaptive behaviors, who are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or PRTF, or who are transitioning to the community from an out-of-home placement. PBS is a type of behavioral support service and is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life for children who are experiencing significant maladaptive behavioral challenges. Behavioral Support Services are used widely, including within BBH, BSS, BMS, and WVDE programs and providers According to the CMH Evaluation, 44% of community-based caregivers reported awareness of Behavioral Support Services, which was slightly greater than awareness for Wraparound services. Figure 63 below provides an overview of the data currently available for Behavioral Support Services.

12.1 Review Period, Data Sources and Limitations, Population Measured

Figure 63: Behavioral Support Services Data Overview

Behavioral Support Services Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
WVU Center for Excellence in Disabilities (CED) PBS Program	July to December 2023	BBH Children's PBS Grant Reporting	Data includes only children served directly through the BBH grant through WVU CED PBS program and is not representative of all children with Medicaid receiving Behavioral Support Services.	Children served directly through the BBH grant through WVU CED PBS program; services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs.

Behavioral Support Services Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
Medicaid Providers with a Behavioral Support Services Certification	Not applicable at this time	DW/DSS	State Plan Behavioral Support Services data are unavailable at the time of report; process changes to collect data via claims is still underway but expected to be implemented with policy change by early 2025, with consideration for claims data lag and provider training. The process change will include a modifier code that will identify Behavioral Support Services provided to Medicaid and WVCHIP members via paid claims.	Services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs who are ages 0 – 21 and members of Medicaid or WVCHIP.

In addition to the BBH-funded Children's PBS program provided by WVU CED, services are also conducted through trained providers of BBH, BSS, BMS, and WVDE programs. Data is currently only available for direct services provided by WVU CED under the BBH PBS grant; however, BMS is working to implement a Behavioral Support Services modifier code that will allow Behavioral Support Services-related claims data to be captured for children receiving these services through Medicaid. The modifier code is included in an update to BMS policy anticipated for fall/winter 2024. Updates to this policy have been delayed due to the establishment of certified community-based health clinics across the State. Once operationalized, these will be an integral part of the system to help ensure access to services. In addition to the review of information for individuals directly served, training is also conducted for providers via the WVU CED. Additional training was conducted in June 2023 following a needs assessment conducted by Concord University to improve training quality and satisfaction, with the next training completed in August 2023. Concord University certified 48 providers on the new Behavioral Support Services provider certification since inception, as of their September 2023 report. Training is conducted three times per year and will include time for cohorts to receive mentoring post-training. Routine availability and awareness of these online trainings will eventually enable Behavioral Support Services training and certification to be more widely utilized, with information on certified professionals' capacity to be included in future reports. Concord University and WVU CED are collaborating on an additional needs assessment to provide an initial analysis of statewide and regional needs for Behavioral Support Services, provider capacity, identify barriers and gaps; this information will be used to develop a strategic plan to address identified gaps.

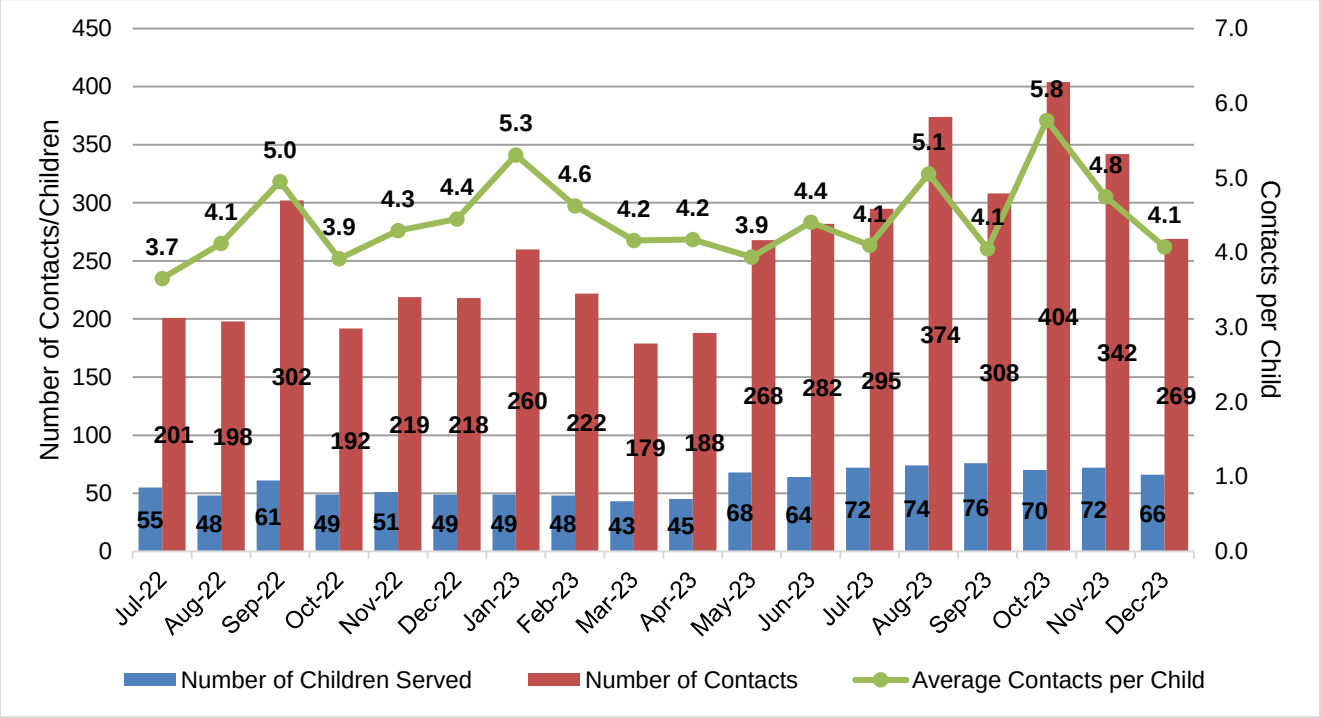
12.2 Review Summary

WVU CED provided PBS services to 146 children from July to December 2023, a 31% increase from the first half of 2023 (n = 111). This program has limited capacity but focuses on working directly with families and children with intensive needs and provides training for parents and providers on related strategies. WVU CED services, while only one piece of the behavioral support puzzle, offer grant-funded direct services for children typically indicated as having more intense needs; these direct services can vary from brainstorming PBS strategies with the family to intensive services and PBS plan writing.

Information on the demographics of these children is included in Section 4.0 WV's Child Population and Individuals Utilizing Services of this report. Interactions and caseload needs have increased for PBS direct services, making increased provider capacity and certification even more important for delivery of quality and timely services. Further assessment of all Behavioral Support Services data via the BMS claims, once available, will be helpful to assess the full scope of children reached through these strategies and understand how needs vary geographically.

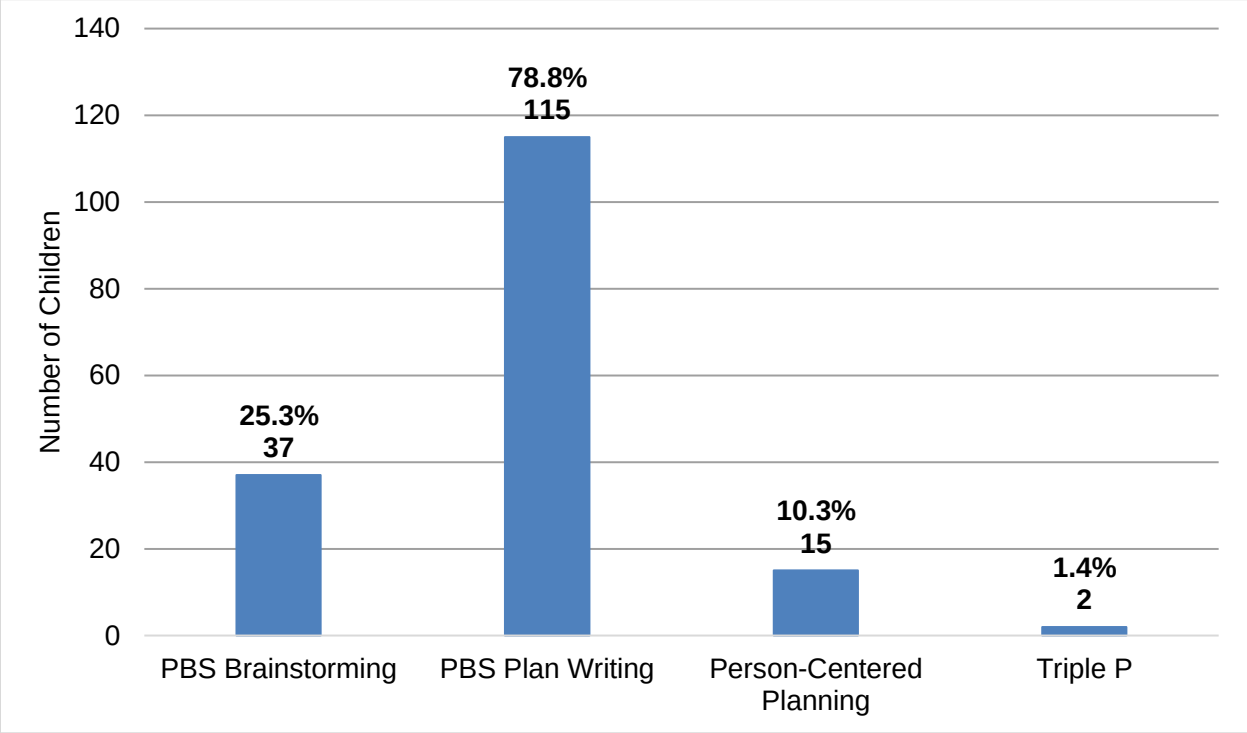
As shown in Figure 64, the number of children served by PBS remained relatively constant from July 2022 to April 2023. However, the number of children served began to increase in May 2023. There was an average of 52 children served monthly in July to December 2022, and 53 children served monthly in January to June 2023, compared to an average of 72 children in the last half of 2023. Total child interactions have also increased over the reporting period, from 1,330 in July to December 2022 to 1,399 in the first half of 2023 and 1,992 in the second half of 2023; however, the average number of contacts per child has remained fairly constant. This trend will continue to be monitored, as a shift in the contacts per child may correspond to a shift in intensity of children served.

Figure 64: Children and Interactions, Monthly, July 2022 to December 2023



The most common services provided to individuals as highlighted in Figure 65 were PBS Plan Writing (79%); Brainstorming, a service typically completed with initial or lower-need cases to provide ideas and support for families (25%); and Person-Centered Planning (10%). Some shifts in service type were observed. In January to June 2023, 82% of individuals received PBS Plan Writing, and 16% received Person-Centered Planning, while only 19% received Brainstorming. These changes would be expected based on the individual youth being served and what best meets their needs. WVU CED is shifting to provide more intensive services and training more individuals to expand behavioral support certified provider availability.

Figure 65: PBS Services Provided*, July to December 2023



***Note:** Individuals may have received more than one service, resulting in totals greater than 100%.

12.3 Provider Capacity/Statewide Coverage

The BBH PBS program through WVU CED has 10 full-time equivalent staff budgeted. At time of writing, only one behavioral specialist position was open, but the program reported already having a candidate for the position, pending hiring process (Figure 66). As of December 2023, there was a waitlist of 19 children for PBS services, as WVU CED continues to report increased referrals. Given this waitlist, WVU CED has implemented a triage process of replying to families with an initial email sent with a list of general resources to inform them their application was received. Staff use a triage process to call these families weekly to continue to assess risk and to provide direct opportunities to connect with families. The average time on the waitlist was one and a half months, or less, dependent on the services needed. WVU CED staff report that this process has been helpful in further identifying risk levels and connecting families to other services, resources, and ideas that improve behavioral needs. BBH will continue to monitor PBS related needs as training is expanded to determine if further process or structure change is necessary to meet demand.

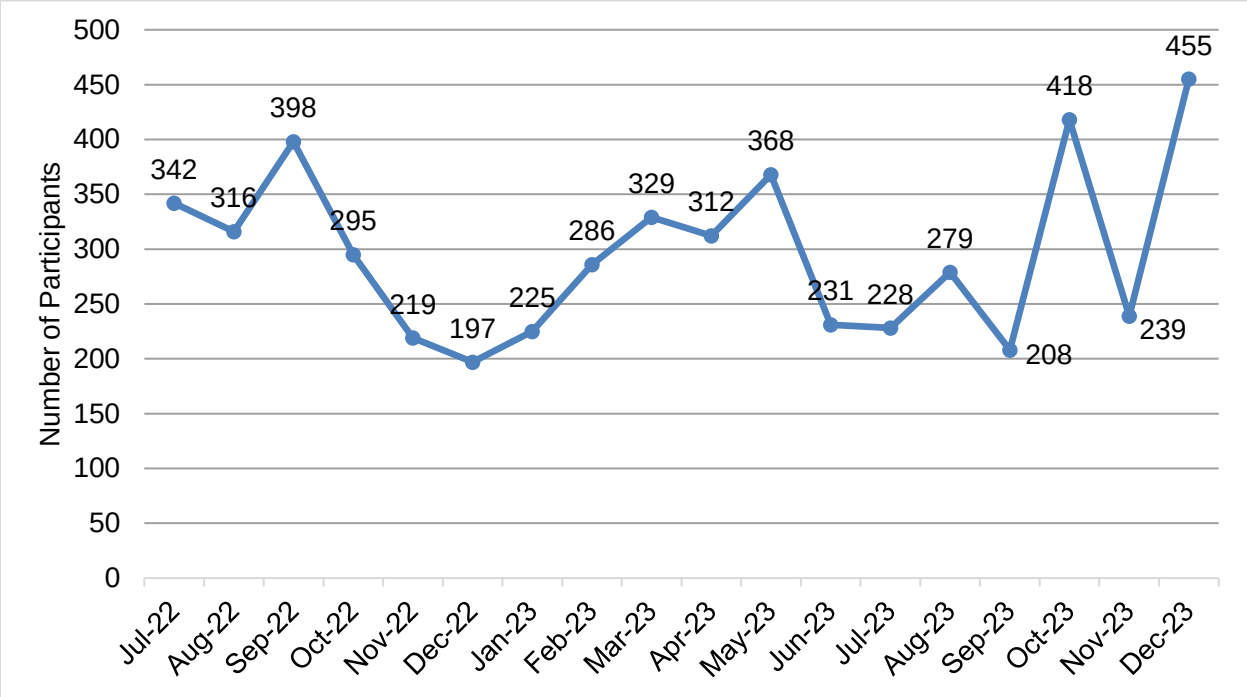
Figure 66: PBS Staffing at WVU CED

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Behavior Specialists	6	7	86%

	Current Personnel	Budgeted Personnel	Occupancy Rate
Curriculum Developer/ Behavior Specialist	1	1	100%
Program Assistant	1	1	100%

Efforts are underway to enhance and standardize the certification process for Behavioral Support Services. As previously noted, Concord University has begun providing training and certification for individuals to offer Behavioral Support Services statewide directly from local providers, thus expanding available resources. Concord University's initial analysis of statewide and regional needs should be considered to conduct awareness of training and to expand the breadth of certified providers available to provide these services. Historically, PBS training has been provided by WVU CED, and WVU CED continues to provide some provider-based trainings while Concord University's process is developed and expanded for Behavioral Support Services. PBS training efforts will now largely shift to a family focus with likely one training annually geared toward certification of providers serving individuals with intellectual or developmental disabilities. Figure 67 shows that there has not been much change in the number of individuals trained monthly since July 2022; an average of 305 individuals were trained monthly from July to December 2023, while an average of 292 individuals and 295 individuals were trained in January to June 2023 and July to December 2022, respectively. The greatest number of participants were trained in December 2023 (455).

Figure 67: Participants* Attending WVU CED PBS Training, July 2022 to December 2023



*__Note__: Participants can include parents and professionals.

The WVU CED PBS program previously provided case consultations prior to May 2023. Case consultations have primarily been restructured to be conducted by Aetna's clinical review team, resulting in less participation needed from the PBS team, although still considered a valuable resource for additional input to support families. This restructuring enables WVU CED to focus more on direct services and training for families.

12.4 Strengths, Opportunities, Barriers, and Next Steps

Behavioral Support Services enable children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program works directly with families as a result of referrals from other organizations. The WVU CED team that provides PBS services meets monthly to discuss best practices and creative solutions to handle children whose diagnoses and other characteristics culminate in especially challenging cases.

Approximately half (56%) of individuals served are five- to 12-years-old, providing an opportunity to serve younger children and potentially divert them from more intensive out-of-home services. As noted in Section 4.0 WV's Child Population and Individuals Utilizing Services, 15% of the children served the BBH PBS are non-white individuals. Although race distribution is subject to fluctuation due to the low number of children represented in both the State population and programs, BIPOC individuals have continued to show a greater representation among children receiving PBS services compared to the general WV child population. This may be attributable to the focus on minority populations via a team within WVU CED, which provides input and training to staff for program outreach and service delivery for improved cultural competency.

In addition to current data review, the implementation of a modifier code to expand capacity for data collection for Medicaid Behavioral Support Services will help influence future planning and quality improvement from review of additional services available through an expanded and certified provider network. Continued provision of training orchestrated through Concord University, which is provided at low cost to individuals, will continue to help expand the provider network across the State and establish integrity within the array of Behavioral Support Services. As of January 2024, training cohorts through Concord University will also have mentoring opportunities available to them to support them as they implement their new skills, at no additional cost. Fees paid for training will be reinvested into future trainings, providing a sustainable certification model that will yield continued expansion and enhancement of the workforce.

Next steps include:

- Continue monitoring WVU CED PBS program data to assess ongoing needs with an emphasis on capacity and waitlist considerations.
- After data becomes available in BMS claims with the modifier code, further assess training provided to organizations in low-utilization areas as well as rural areas to identify whether needs are being met through direct or indirect services (training).

- Collaborate with Concord University to understand the geographic locations of certified providers and use this information to expand awareness in areas with fewer available HCBS.
- Work with Concord University as training and certification is expanded to establish formal data collection and recurring reporting on trainings and certifications.
- Despite challenges with low numbers statewide, race will continue to be monitored as an important indicator for assessing children's and families' access to services. Race data will be expanded as the data store is built out.

13.0 Assertive Community Treatment (ACT)

ACT is an inclusive array of community-based rehabilitative mental health services for WV Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and integrated package of services provided over an extended duration to live successfully in the community of their choice. ACT is an evidence-based model of treatment/service delivery in which an MDT assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which an ACT team provides the majority of direct services in the member's community environment. ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management and facilitating a supportive environment to meet basic needs and to improve social, family, and environmental functioning.

ACT is an option for youth ages 18 to 20 to help prevent unnecessary institutionalization. As part of the Assessment Pathway, eligible youth 18 or older are expected to be offered the choice of ACT or Wraparound Facilitation services. BMS policy manuals are in the process of being updated and approved for CSED, RMHTFs, licensed behavioral health centers, and other providers to include the Freedom of Choice form for Medicaid members eligible for ACT services. Updates for PRTF providers went into effect January 1, 2023. The children's residential provider manual (Chapter 503 Appendix F) and the general 503 manual for Licensed Behavioral Health Center services, ACT, PBS, and outpatient services are in the process of being updated with an expected rollout in late 2024.

13.1 Review Period, Data Sources and Limitations, Population Measured

Figure 68: ACT Enrollment and Utilization Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2023	EDS and WVCHIP Claims	The population served includes Medicaid members 18 years of age and older with no limitation on length of service; however, for purposes of this report, review was conducted for members 18 – 20 years of age to reflect transition-age youth potentially at risk for RMHTF placement.	Eligible members must have a primary mental health diagnosis and may have co-occurring conditions, such as mental health and substance use disorder (SUD) or mental health and mild intellectual disability. Members must also have a history of high use of psychiatric hospitalization and/or crisis stabilization.

13.2 Review Summary

Youth aged 18 to 20 who are progressing through the Assessment Pathway and are eligible for ACT are offered Freedom of Choice freedom of choice between CSED Waiver (available until the child's 21st birthday) and ACT services. This choice is documented on the Freedom of Choice form. A key difference in this service is the length of time the service is designed to be offered. CSED services are designed to be shorter-term (i.e., typically up to one year), while ACT is intended to be a long-term service for individuals with ongoing high intensity needs.

Although the number of youth accessing ACT services remains low, given the reluctance of youth to participate in services, during the July to December 2023 period, the number of youth accessing ACT services increased to seven, up two from the prior periods (Figure 69). This is a positive sign given the work underway to help ensure eligible youth are offered the choice of ACT.

Figure 69: ACT Youth Utilization Comparison Across Six-Month Periods, July 2022 to December 2023

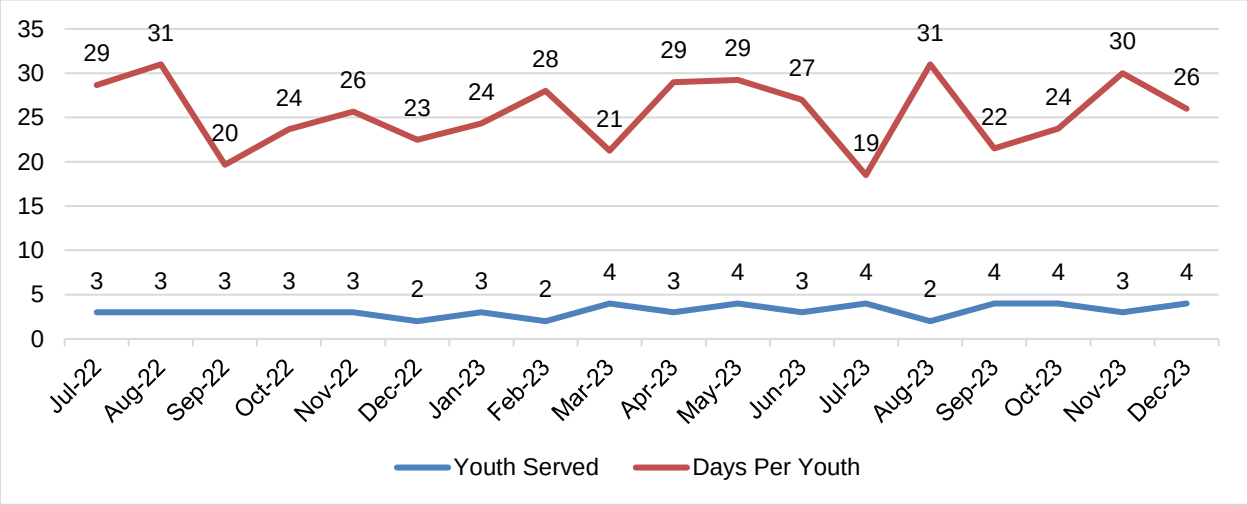
	July – December 2022	January – June 2023	July – December 2023
Youth < 21	5	5	7

To understand further how many youth across the State might qualify for ACT, DoHS completed an analysis of youth ages 18 to 20 who were Medicaid eligible as of December 31, 2023, and evaluated their claims against the qualifying criteria for ACT for the 12-month period from January to December 2023. Note that there are some differences in available claims data compared to ACT program eligibility criteria; therefore, this analysis provides only an estimate. There were 31 youth who met the claims criteria used in the analysis, so it is estimated that at least 31 youth may qualify for ACT.

While numbers remain low, any type of engagement in ACT services provides an introduction for youth to these services, creating an awareness of the availability of these services, which individuals may choose to access later in life. The average age of ACT utilization for all members remains consistent at 46 years old.

Figure 70 below displays enrollment and the days of service per youth for January 2022 to July 2023. For the purposes of comparison, ACT utilization for all members, regardless of age, is shown in Figure 56. Discharge and decline reason information is unavailable, but it is commonly understood that many youth are transient and perceive ACT to be intrusive. As awareness of ACT services increases, individuals in RMHTFs have appropriate discharge plans developed, and eligible youth are offered ACT services at discharge, DoHS will monitor to assess whether the number of youth accessing ACT services increases.

Figure 70: ACT Youth and Days Per Youth by Month, July 2022 to December 2023



Note: Reflects claims paid through April 2024.

13.3 Provider Capacity/Statewide Coverage

ACT services are available statewide as of February 2024. The State's Eastern Panhandle has faced challenges procuring an ACT provider; however, EastRidge Health Systems was approved and became operational in February 2024.

To expand the availability of ACT services further, DoHS will require an ACT team for all certified community behavioral health centers. A SPA was submitted for certified community behavioral health centers for federal approval in July 2024 with a tentative timeline for rollout in late 2024 to early 2025.

ACT team capacity is monitored during retrospective reviews. Currently, there is no waitlist for ACT services.

13.4 Strengths, Opportunities, Barriers, and Next Steps

DoHS achieved statewide coverage of ACT services in February 2024. The number of ACT providers will expand further when the new certified community behavioral health center requirements to provide ACT go into effect. These requirements are expected to be implemented by early 2025. DoHS is also pursuing rural ACT services through an 1115 demonstration grant. DoHS's application for the grant has been submitted. The Centers for Medicare & Medicaid Services (CMS) delayed the review and extended the current 1115 grant to October 2024.

As noted previously, additional efforts to increase enrollment include revision of the BMS policy manuals.

DoHS has made progress with data collection associated with youth choosing ACT services. As of November 2023, data collection for youth who chose ACT upon discharge from residential settings was implemented as part of Aetna's enhanced data collection associated with

conversion to the Quickbase system. Data quality and validation is in process. Once data quality issues are addressed and validation is complete, these data will be included in future DoHS Quality and Outcomes Reports.

DoHS is still working toward collection of discharge reason data to improve understanding of and seek opportunities for youth who are resistant to continuing ACT services. The requirement to collect and report discharge reason data is planned for contract updates with Aetna and Acentra Health in July 2024.

DoHS will continue to improve education and promotion of the availability of community-based services, such as ACT, when appropriate for the needs of the youth.

14.0 Community-Based Placement Capacity

Community-based placement capacity is a key component of maintaining and discharging kids back into the community, especially for children in the child welfare system. In March 2024,[63] DoHS launched a recruitment campaign to address the foster parent shortage and released an additional update in May 2024[64] highlighting the need for certified foster families, including noting at the time about 250 children were in need[65] of a foster home.

Community-based settings must be able to provide a supportive and stable environment for children with SED, although these families and community-based settings can vary widely based on the needs of an individual child. As will be described further in Section 17.0 RMHTF Services, having an appropriate setting to receive treatment and/or to discharge to has been identified as a primary barrier for many children. To begin to address some of the needs associated with this barrier, DoHS is focused on strengthening the existing tiered foster care model and community-based supports and services available to youth and families. All foster parents are trained in caring for children in this tiered model, and additional training and support is provided based on the needs of the children in the home. A rate increase took effect in October 2023 for CPAs and socially necessary service providers—a 10% and 30% increase, respectively.[66] Additional rate increases will continue to be explored; however, legislative budget restrictions prevented further increases during the 2024 legislative session. Increases to these provider's rates are intended to assist with foster family recruitment, provide the additional supports necessary to maintain youth within a stable foster family placement, and facilitate reunification with biological families when appropriate. The tiered foster care model allows a child to remain in a placement even if their needs fluctuate by increasing supports to the child and family if needs increase, thus proactively diverting the child from an RMHTF placement when it remains clinically appropriate.

14.1 Review Period, Data Sources and Limitations, Population Measured

Data on community-based placements and available foster homes were gathered from available WV PATH data and information submitted by the CPAs. Time periods may vary by data source and information availability, which is noted accordingly.

[63] https://dhhr.wv.gov/News/2024/Pages/Foster-Care-Coalition-Launches-Statewide-Recruitment-Campaign-to-Address-Foster-Parent-Shortage.aspx

[64] https://dhhr.wv.gov/News/2024/Pages/West-Virginia-Department-of-Human-Services-Celebrates-National-Foster-Care-Month.aspx

[65] "In need" is inclusive of children in emergency shelters or RMHTFs with a documented need for a foster home, regardless of other factors which have been prioritized in other areas of this report.

[66] https://dhhr.wv.gov/News/2023/Pages/Gov.-Justice-Approves-dhhr-Rate-Increase-for-Child-Placing-Agencies-and-Socially-Necessary-Services-Providers.aspx

Figure 71: Community-Based Placement Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
Comparison periods defined with accompanying figures and statistical information	CPA Reporting	Data is collected in aggregate from each agency; therefore, analysis limitations exist and potential for manual entry error is increased. DoHS is considering mechanisms to improve data collection and review.	Foster homes certified through and reported by CPAs.
July 2023 to December 2023	WV PATH Reporting	The WV PATH system went live in January 2023. Given adjustment to the new system, unexpected errors from the transition may exist. Data quality and completion are expected to improve over time as staff acclimate to these changes.	Children in the child welfare system by placement type.

14.2 Review Summary

DoHS strives to provide every WV child with the opportunity to grow and thrive in their community when it is safe and clinically appropriate for them to do so. Unfortunately, finding a good fit for a community-based placement can be a significant barrier for children who are in residential care, children who are older, and/or children who are in the child welfare system with SED diagnoses who are unable to return to their biological family. In order for these children to be able to remain in the community and have success utilizing HCBS options, it is critical that they are able to build a life with loving and committed families. Given the needs of this population, DoHS, in collaboration with CPAs, is identifying ways to increase supports to foster parents and kinship parents. DoHS and its partners also continue to provide supports to biological families to increase the likelihood of reunification success, as well as to youth of transitional age who want to pursue independent living options. As HCBS are expanded and gain rapport in communities, DoHS anticipated that the level of support available will help change the culture around need for RMHTF placement and empower families—whether they are foster, kinship, or biological—to be able to stay together.

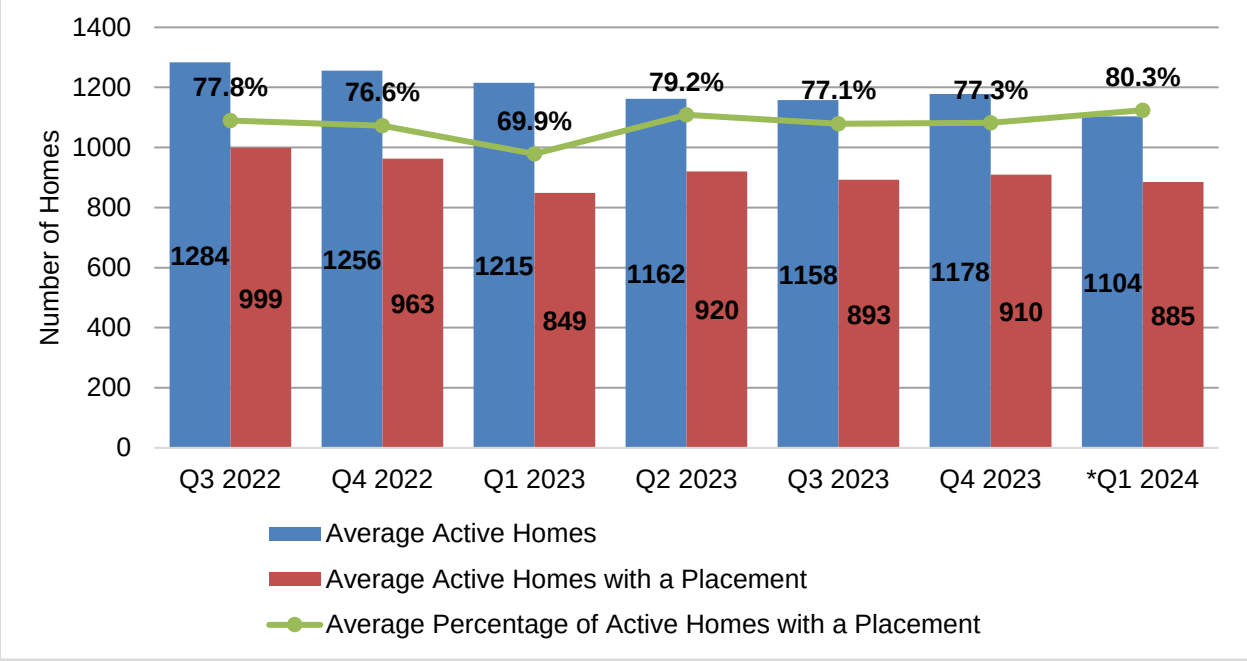
14.2(a) Foster Care Homes

Foster placements in WV—including children in certified foster homes or certified kinship placements—are orchestrated through CPAs and BSS. As noted, DoHS is focused on strengthening the existing tiered foster care model, which enables youth to remain in a single foster placement without requiring a move if their needs increase or decrease. In this model, if a child's needs change, then the supports provided to the child and family are also modified to align with their new needs. DoHS continues to meet at least quarterly with CPAs to help ensure open communication and feedback on successes and barriers related to the recruitment and retention process, including regular data reviews on key performance indicators. The primary

focus of discussion continues to be on recruiting and retaining seasoned foster families or families with experience with children who have significant mental health needs. CPAs continue to express that additional support will be required for these families to feel cared for and to be successful. The rate increase that went into effect in October 2023 was applied to funds directly received by CPAs and is intended to help address this need. Additional time is needed to determine whether any changes to outcomes resulted from this rate increase.

CPAs are responsible for recruitment and retention of certified foster families using the tiered foster care model throughout the State. As shown in Figure 72, the average number of active homes by quarter has decreased from Q3 2022 to Q1 2024. The percentage of active homes with placements has increased to 80.3% as of Q1 2024, further emphasizing the critical need for certified foster homes given the range of factors to consider related to matching a child with a family that is willing and meets their needs.

Figure 72: Average Foster Care Home Capacity by Quarter (Calendar Year), July 2022 to March 2024



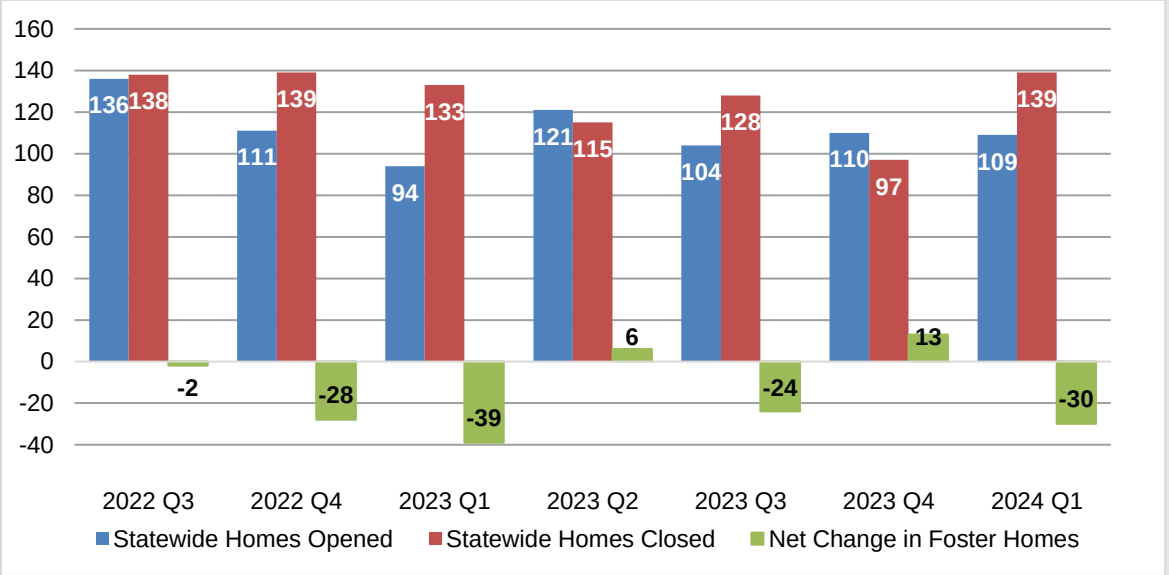
***Note:** Q1 2024 data is considered preliminary.

The ratio of homes closed to opened has improved slightly from the last six months of 2023 compared to the first six months but remains as a net loss of foster homes over time. From July to December there was a net decrease of 11 homes, whereas, from January to June 2023 there was a net decrease of 33 homes (Figure 73). This change was influenced by an atypical net gain in foster homes in Q4 2023. As discussed with the Quality Committee, Q4 is typically a quarter associated with net loss of homes due to adoptions occurring around the winter holidays. DoHS, in collaboration with MU, surveys foster parents every two years. Results from the 2023 survey have been used to ensure foster and adoptive families have more opportunities for improved communications and mental health system navigation. This includes the addition of the Kids Thrive Newsletter which shares resources and information with foster, kinship, and

adoptive parents. DoHS has also continued to share resources with families via press releases and updates on social media as described in the Outreach section of this report (Section 6.0 Marketing).

DoHS continues to explore options to enhance relationships and processes with everyone involved in a child's case. This has included work completed through the Reducing the Reliance on Residential Workgroup, which has enhanced processes and training related to MDTs, prudent parenting, and expanded the ability of foster children to maintain friend and family connections while in care (improved contact documentation and protocol). These system enhancements, along with working closely with the court systems to provide collaboration and training, are anticipated to continue to impact placement stability and foster care family recruitment and retention. Child Stat meetings, a child welfare focused CQI initiative, has included review of meaningful contact and related indicators. BSS leadership has noted that these reviews have been very helpful in influencing strategic planning including helping drive updates to the meaningful contact guide which was updated July 2024. In addition to these updates, CPA reporting has also been expanded as of July 2023 to provide greater detail regarding voluntary home closures. Indicators for voluntary foster home closure reasons from July 2023 to April 2024 showed that one-third of reported closure reasons are related to adoption and legal guardianships (33%, n = 132) or a change in family circumstances (e.g., medical, lost job, divorce; 28%, n = 111). Approximately 13% of homes had an involuntary closure reason, such as failing to respond to agency referrals or completing required training. Families could report multiple reasons for closure. Closure reasons are included as key performance indicators and reviewed with individual CPAs at least quarterly.

Figure 73: Foster Care Homes Opened/Closed by Quarter (Calendar Year), July 2022 to March 2024



DoHS and CPAs also review retention data at least quarterly. Figure 74 shows the number of licensed foster families compared to the percentage who have been licensed for at least two years. Note that the number of licensed families is higher than the number of active families, as some families will become inactive temporarily for various reasons, including to take a break from fostering or to manage health or family needs that are short term in nature (e.g., surgery or pregnancy). On average, the percentage of licensed families retained over two years increased slightly from the first half of 2023 (46%) to the second half of 2023 (48%). There was a decrease in the number of total licensed foster homes; however, this decrease was among homes open less than two years (decrease of 49 homes retained less than two years and an increase of 18 homes retained two years or more). Retention is understood to be largely influenced by nurturing strong relationships between CPAs and foster families. A retention rate of nearly 50% is considered a strength of WV's system. DoHS will continue to work with CPAs to understand opportunities to improve retention and ultimately to increase availability of experienced foster homes.

Figure 74: Number of Licensed Foster Families and Percentage Retained for Two or More Years

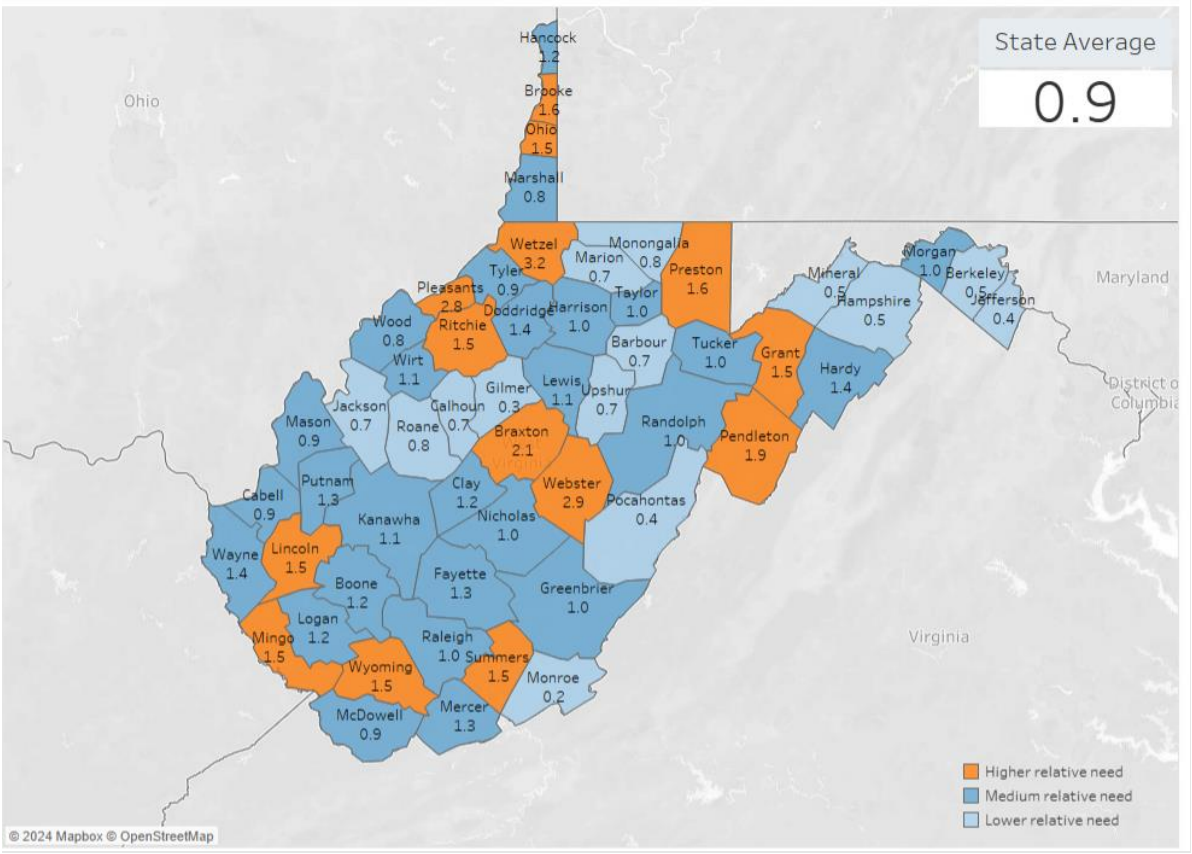
Average Across Period for Retention	Jan to June 2023	Jul to Dec 2023
Number of licensed foster families	1,399	1,366
Percentage of families licensed for at least two years	45.5%	47.8%

In past reviews, the Quality Committee requested that county-level information be assessed for regional needs and the ability to plan more strategically. Given the autonomy afforded to each foster family, it is not possible to predict the exact number of homes available for children of various characteristics at any one time; however, it was agreed that a ratio of the average number of certified homes compared to therapeutic foster care placements within a given county could provide an approximate view of levels of need for a given area. A higher ratio indicates a greater need for additional foster homes, given that in realistic circumstances an open and active home does not necessarily indicate a placement would be accepted. Therefore, it is ideal to expand the pool of available homes to increase the likelihood of an appropriate match.

The State average ratio of certified homes to placements was 0.9, meaning, on average, there was one home for every one child placed. Many counties had higher ratios, indicating higher relative need for foster home recruitment in these areas. Counties highlighted in orange below had ratios from 1.5 to 3.2 children per home (Figure 75). For counties with small populations, neighboring counties may be relied on for adequate placement capacity, especially if safety related to proximity is a concern. However, it is ideal for counties to have more families available than needed to support the range of children in care to accommodate foster family autonomy. In relation to these needs, as noted in the previously mentioned press release, DoHS has partnered with Mission WV and Aetna to implement statewide foster care campaign that focuses on expanding recruitment for families who are willing to accept teenagers and children with more intense needs. Some themes of this campaign are emphasizing reunification and supportive co-parenting, choices and support available to foster families, positive messaging,

and utilizing foster parent's own experiences to recruit additional families. This campaign launched in March of 2024, with 350 inquiries received as of June 3, 2024. Mission WV reported seven families selecting an agency to begin the certification process. Additional time is needed to determine any changes because of the campaign as families average about nine months between contacting Mission WV and being certified, and historically, only about 10% of families who inquire follow through with the entire certification process.

Figure 75: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, All Ages, July to December 2023



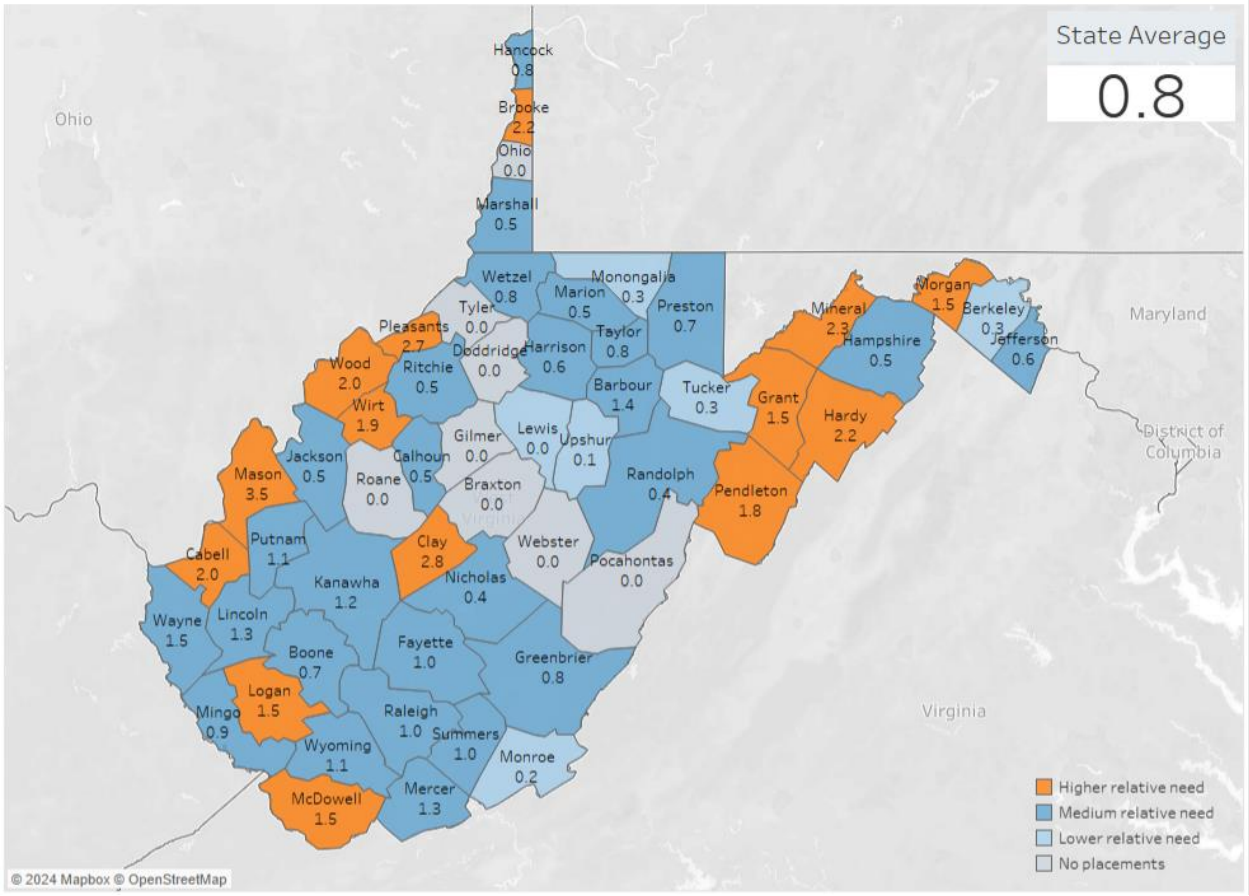
Average PATH Placement Data Extracts and Average Certified Homes

Children aged 18 – 20 continue to be overrepresented among the prioritized discharge planning population compared to the general RMHTF population. These children in DoHS's prioritized discharge planning focus population include individuals with a CAFAS <140 who are anticipated to discharge in the next 60 days. As of March 31, 2024, 5% of these children were 18 – 20 years old, compared to only 1% of the overall RMHTF population. This pattern continues to emphasize the importance of expanding options such as foster homes, kinship connection, transitional or independent living programs, and residential homes for older youth so that once their treatment has been completed, they can avoid barriers to returning to their community and be able to return as quickly as possible. Additionally, nearly one in five (18%, n = 21) of these prioritized children with CAFAS/PECFAS scores <140 and anticipated discharge in 60 days had a barrier to discharge pertaining to not having a home setting available for discharge, the third

most commonly listed barrier for this group after no barriers (42%, n = 49) and court ordered to complete program or school year (n = 22, 19%). These findings have led to an expanded analysis focusing on youth aged 13 and older compared to homes that indicated they would be willing to consider accepting placements for youth in this age range. Figure 76 displays the ratio of placements 13 and older to homes willing to accept youth in this age group by county. The State average ratio was 0.8, indicating a ratio of at least one home for every teen placed at the state level.

As with the previous figure for all ages, several counties have more limitations on homes available as shown in orange with higher relative need, ranging between 1.5 to 3.5 placements per home. This essentially means, setting autonomy aside for review/analytical simplicity only, the number of certified homes available in these counties would require two to four youth aged 13 and older to be placed in each home. The wide variation in willingness of foster home families to accept a given placement, combined with the challenges of multiple placements in one home, highlights the need to focus on increasing the number of foster homes willing to accept teenagers. This updated information will be shared with CPAs at a future quarterly review to focus strategic planning of recruitment efforts and current efforts to expand recruitment via the statewide campaign.

Figure 76: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, Age 13 and older, July to December 2023

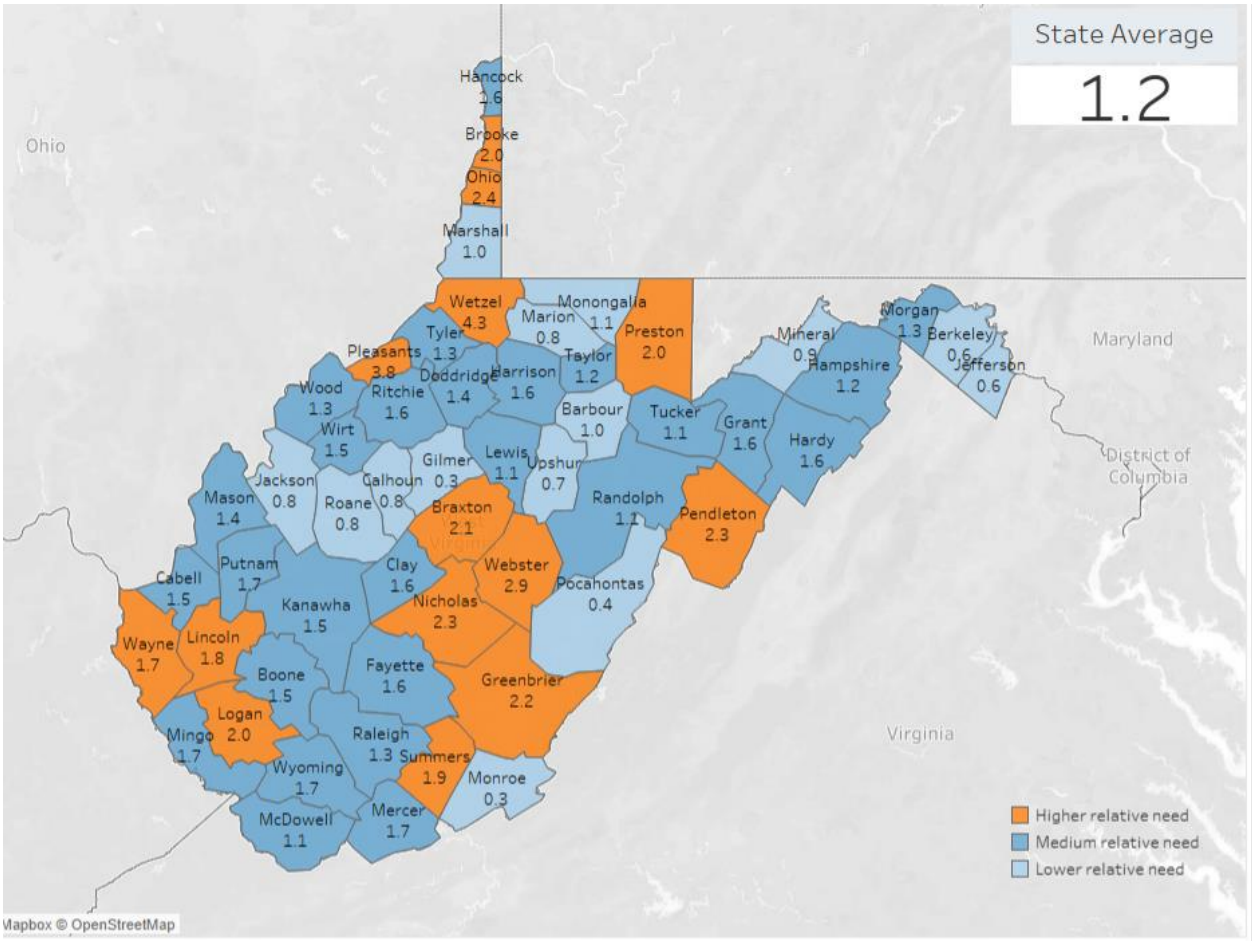


Average PATH Placement Data Extracts and Average Certified Homes Willing to Accept Placements 13 and older

In addition to the previous figures which display foster home ratios to placements, the following two figures are also being reviewed by the Quality Committee to expand the understanding of placement needs. Figures 77 and 78 reflect placement ratios with the addition of children who have been placed in an emergency shelter. Shelters are not considered a community-based placement but are indicative of a need for community-based placement, as stays at shelters are meant to be acute and temporary. Children are often placed in shelters due to the lack of available foster care placement; therefore, it is important to consider these placements when assessing foster home capacity. As with the two preceding maps, counties in Figures 77 and 78 have been categorized based on relative need compared to other counties, with counties in orange indicating the greatest need for additional foster homes for children originating from those counties. As previously stated, this ratio is determined by considering the number of active homes compared to the number of placements originating from that county, which in this case have or need a foster home. This ratio does not consider foster family autonomy or bed counts, and instead is meant to serve only as a tool to better understand geographic needs and opportunities for prioritization. Figure 77 shows a State average of 1.2 children per home including youth in shelters, only slightly higher than the rate excluding shelter placements, which

was 0.9 children per home. The ratio for counties with higher relative need ranged from 1.7 (Wayne) to 4.3 (Wetzel) children per home.

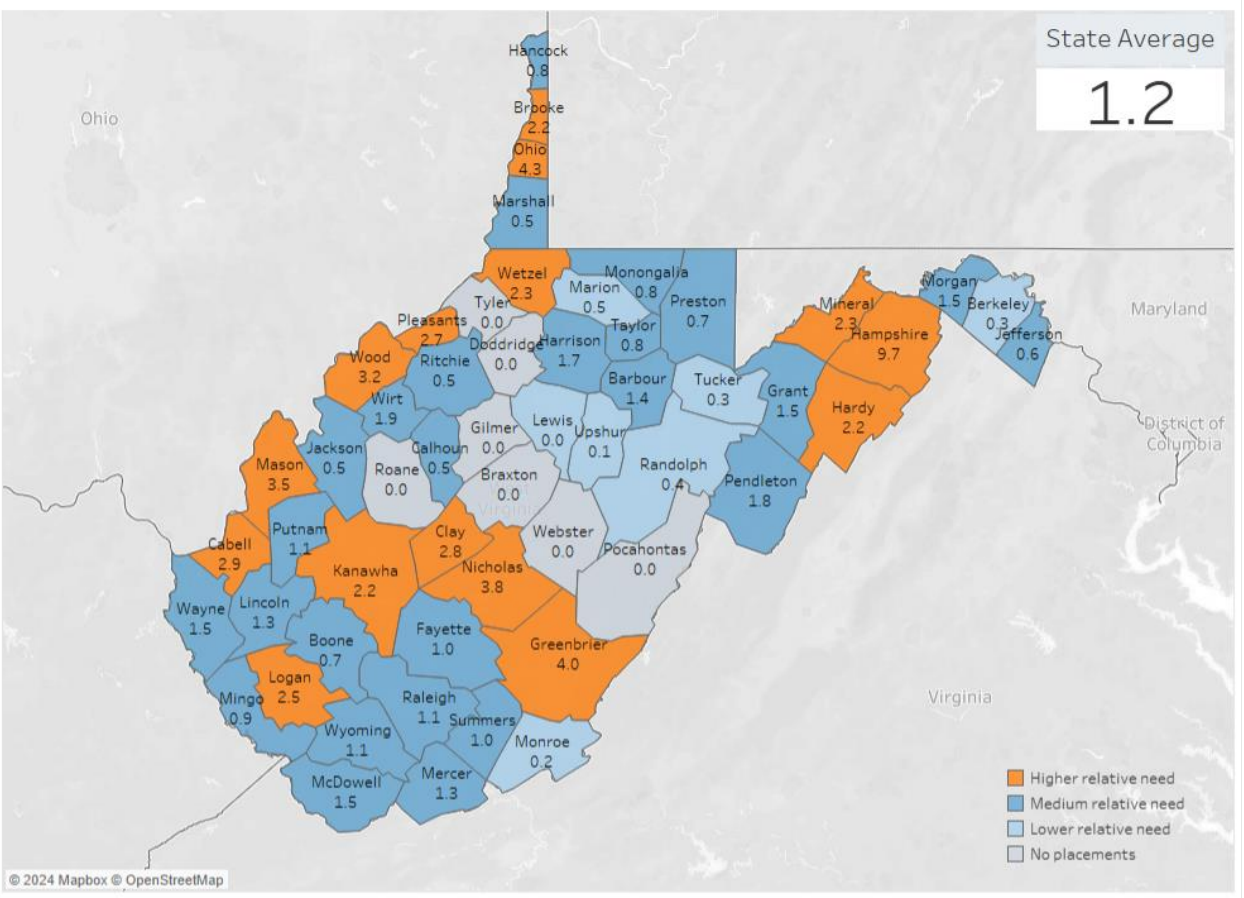
Figure 77: Ratio of Average Therapeutic Foster Care Placements and Emergency Shelter Placements Per Foster Home, July to December 2023



Average PATH Placement Data Extracts and Average Certified Homes

Figure 78 focuses on the needs for youth 13 and older, with a statewide ratio including children placed in shelters of 1.2 compared to 0.8 excluding shelter placements. Only one-quarter (26%) of certified foster families were willing to accept a child aged 13 and older for placement on average for the period July to December 2023. In comparison, 25% of children in foster and shelter placements statewide represented children aged 13 and older. This comparison highlights the need for additional foster parents who are willing to accept teenagers given considerations of foster parent autonomy, compatibility considerations for the child and family, as well as existing foster occupants in the home. There were 15 counties with higher relative needs with ratios ranging from 2.2 (Kanawha) to 9.7 (Hampshire).

Figure 78: Ratio of Average Therapeutic Foster Care Placements and Emergency Shelter Placements Per Foster Home, Age 13 and older, July to December 2023



Average PATH Placement Data Extracts and Average Certified Homes Willing to Accept Placements 13 and older

Summary of Need Across Figures 75 Through 78

The following counties warranted increased priority for consideration of expanded foster parent recruitment and retention activities based on combined considerations across figures:

- Two counties were identified as having higher relative need on all four maps representing needs regardless of age and use of emergency shelters influencing higher relative need: Brooke and Pleasants counties.[67]
- Six counties (Grant, Morgan[68], Wirt, Mingo, Ritchie, and Wyoming) were noted as having a higher relative need for increased foster homes regardless of age. This need was not influenced by shelter placements.

[67] Note less than five placements for children 13 and older for these counties.

[68] Note less than five placements of all ages for this county.

- Seven counties (Cabell, Clay, Hardy[69], Mason, Mineral, Wood, and McDowell[70]) were reported as higher relative need for only youth 13 and older. These county-level needs were also influenced by shelter placements for children 13 and older, except for McDowell County.
- Seven other counties indicated a strong influence on shelter placements related to a higher relative foster home need designation. Over utilization or longer-term use of shelter placements are an important gauge of foster home capacity and adequacy to help ensure normalcy and stability in a child's life.
    - Ohio and Wetzel counties indicated high relative need regardless of shelter placement inclusion for children ages 0 to 20, but an additional need for foster homes for teens 13 and older was identified when shelter placements were included in the ratio.
    - Hampshire and Kanawha counties were reported as having higher relative need for foster placements for youth 13 and older only when shelter placements were considered.
    - Greenbrier, Logan, and Nicholas were noted as having higher relative need for foster placements for all ages and youth 13 and older only when shelter placements were considered.
- Two counties identified as in high need for foster homes (Wood and Kanawha), as previously listed, also were flagged as having a high proportion of RMHTF placements (see Section 6.0 Marketing).

14.2(c) Kinship Homes

The placement of children in kinship homes is a strength of WV's system of care. WV leads the nation in kinship placements. On average from July 2023 to December 2023, 58% of in-state placements were in kinship homes[71], as seen in Figure 79. The Quality Committee noted some counties have a higher rate of kinship placement than others. Several counties with higher foster placement ratios—such as Kanawha, Mason, Hampshire, Morgan, Grant, Wetzel, Ritchie, Greenbrier, Logan, and Mingo—seemed to compensate for this with higher rates of kinship placement (greater than 60% of foster placements in kinship care). Furthermore, members of the Quality Committee compared counties with low kinship placement rates to counties with high placement-to-foster-homes ratios, identifying counties that have the greatest overall need for community-based placement availability. Wirt (18%), Wood (46%), Ohio (47%), Cabell (47%), and Wyoming (49%) counties were among the lowest in the State for percentage of placements located in kinship-type homes and were also identified as high need for foster homes. Because of the low rate of kinship placements in these counties, additional focus should

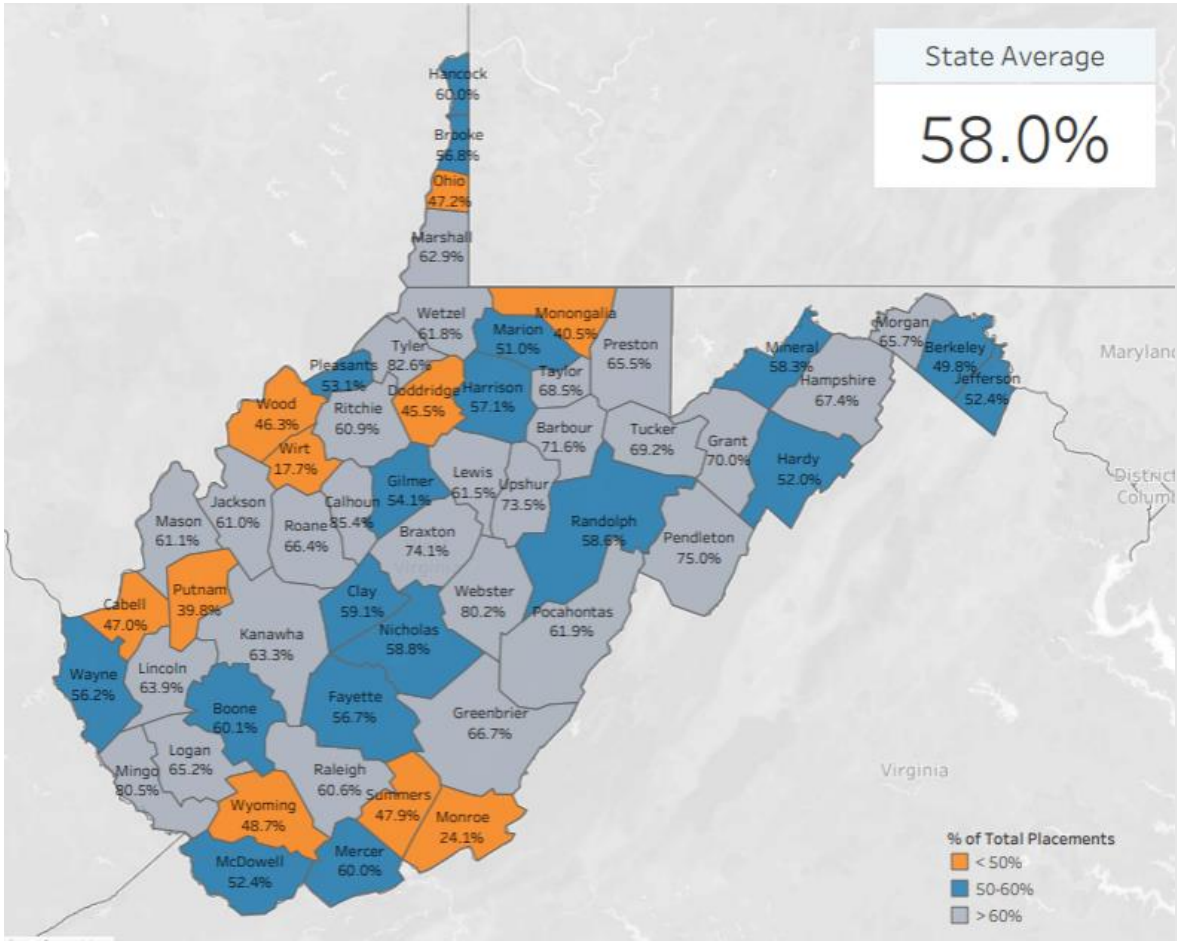
[69] Note less than five placements for children 13 and older for this county.

[70] Note less than five placements for children 13 and older for this county.

[71] This includes both certified and non-certified kinship homes.

be considered for family finding activities and expanding available foster homes. Furthermore, Wood County was flagged among multiple risk/need data indicators, including being noted as in high need of foster homes (especially for youth aged 13 and older), a low proportion of kinship placements compared to other counties, and one of the greatest rates of residential placement in the State. These findings will be shared with CPAs and workers in these noted areas to address and troubleshoot barriers to establishing and retaining homes and placements in these communities.

Figure 79: Percentage of Kinship Foster Placements* by County (Average), July to December 2023



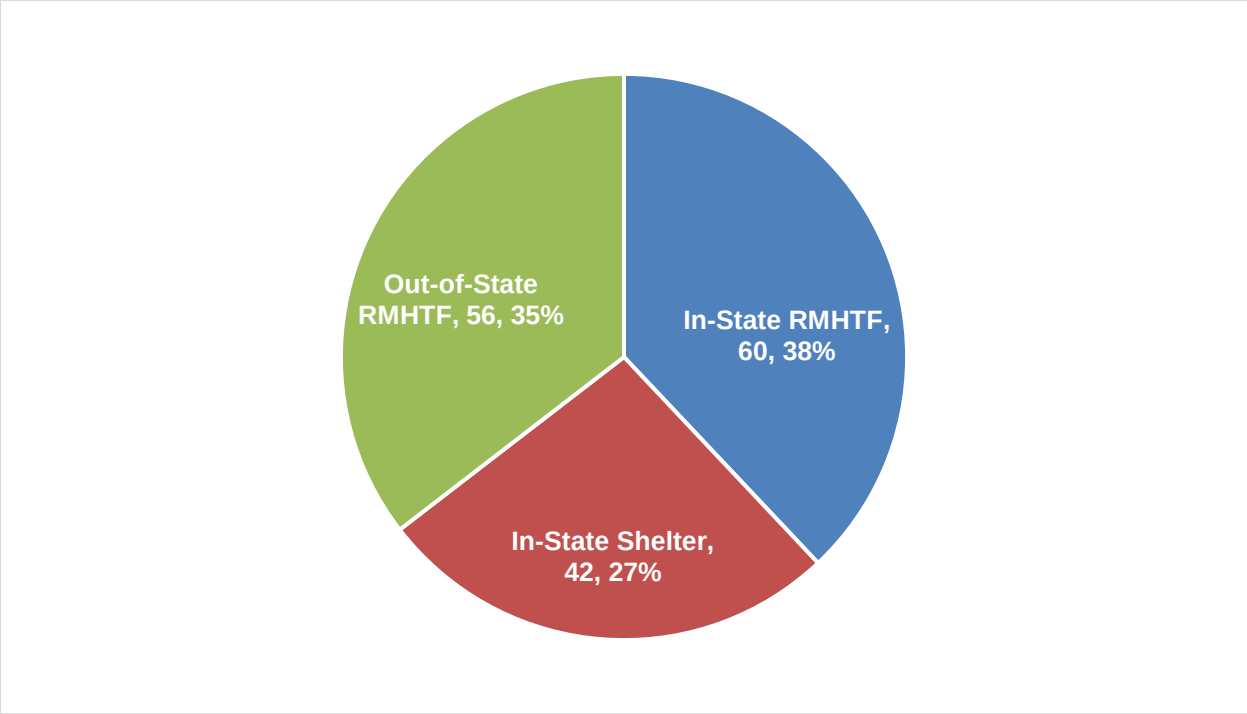
***Note:** This map is inclusive of certified and non-certified kinship homes.

14.2(d) Characteristics of Children in Need of Foster or Kinship Care

To gain a better understanding of the additional foster and kinship capacity needs, DoHS completed an analysis of children in both in-state and OOS residential placements and emergency shelters who need foster or kinship care placement as of March 31, 2024. Youth ages 18 to 20 were excluded from this analysis because they do not qualify for traditional foster care. Youth whose discharge barrier data included behavior unchanged or escalating, awaiting transitional living, and/or court ordered were also excluded. After applying all criteria, a total of

158 children were identified as needing community-based placement,[72] indicating a substantial need for additional foster and kinship homes. The current placement setting for these children is shown in Figure 80, with nearly three out of every four children in need (73%, n = 113) residing in an RMHTF, while the remainder (n = 42, 27%) were in shelter settings. Children in need of a community-based placement were nearly evenly split between in-state and OOS placements with 56 children in OOS RMHTF compared to 60 children in in-state RMHTF settings.

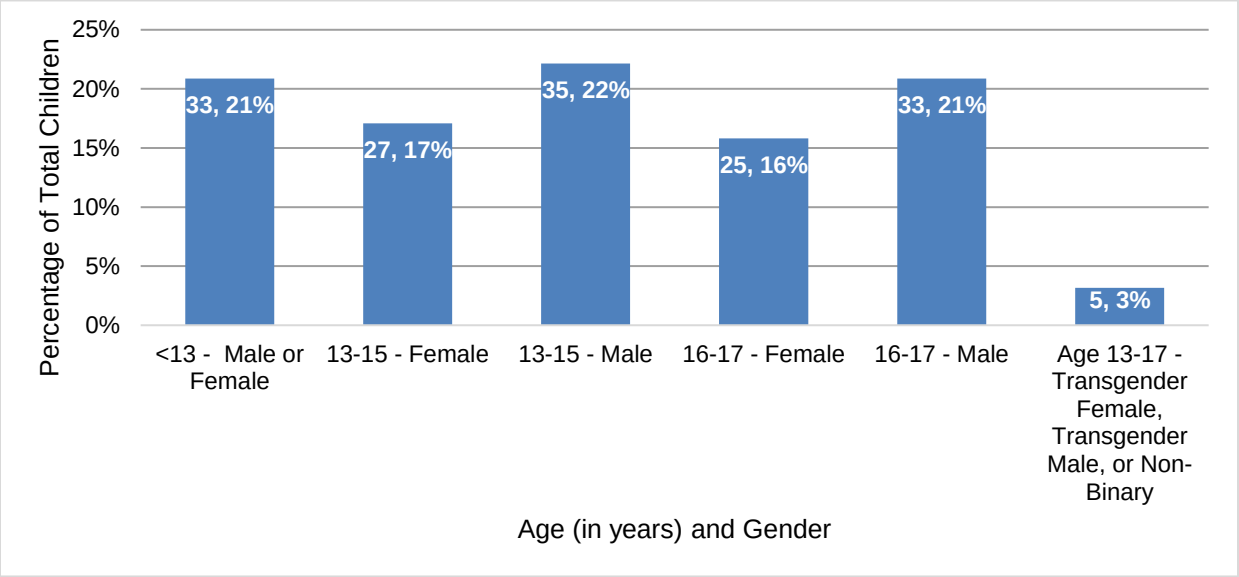
Figure 80: Placement Setting for Children in Need of Community-Based Placement as of March 31, 2024 (n = 158)



Age and gender distribution were also examined to provide additional insight into family recruitment. Five major categories stood out, but it is also notable that five children in need of a home in the age range of 13 to 17 years identified as transgender or non-binary (Figure 81). One in five children (21% n = 33) were younger than 13 years old; gender was not reported for this group due to the low number of youth. Male children (age 13-17) represented two out of every five children with a need (43%), with a fairly even distribution between age ranges 13 to 15 (n = 35, 22%) and 16 to 17 (n = 33, 21%). Only one in three children (33%) were aged 13 to 17 and female, with 27 children aged 13 to 15 and 25 children aged 16 to 17.

[72] Note a press release from May 2024 reported 250 youth in need of a foster home; the number reported here is not considered a decrease in need, but instead represents a subset of kids that are considered to have limited additional barriers to being discharged, beyond need for a home.

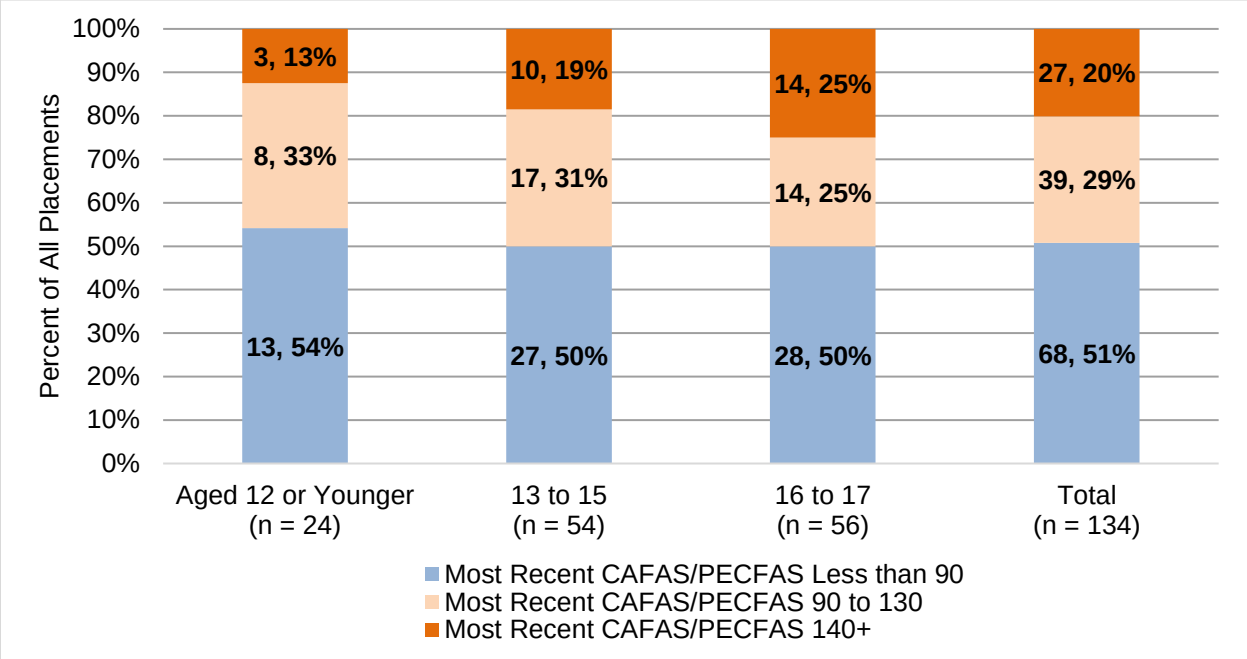
Figure 81: Age and Gender Distributions for Children in Need of Community-Based Placement as of March 31, 2024 (n = 158)



In addition to age and gender, DoHS explored the acuity of mental health needs by reviewing CAFAS/PECFAS scores for children in this cohort. As previously described, a CAFAS score <90 would typically indicate a child with lower acuity of need, while children with a CAFAS greater than 130 (i.e., 140+) would typically be among the highest acuity of need. Note CAFAS alone does not predict a child's need to be placed out of the home; the CSED Waiver and ACT programs, for example, are both designed to meet the needs of many children with CAFAS 90 or higher. The QIA process uses a combination of information from interviews, CAFAS score, CANS assessment findings to provide a recommendation for the least-restrictive setting to meet a child's need. However, a CAFAS score alone may nevertheless be used to help guide the general level of acuity of the child, and potential approximation of the level of additional supports needed should the child be discharged. CAFAS score distribution was very similar across all age groups, with over half of children (51%) having a most recent[73] CAFAS score below 90, indicating a likely lower acuity of need. Only one in five children (20%) of children in need of a home had a CAFAS score ranging higher than 130.

[73] CAFAS scores are reported through utilization management, which are sourced from RMHTF and shelter providers. Results may vary from those completed by the CSED Waiver process via Acentra Health.

Figure 82: Most Recent CAFAS/PECFAS - By Age Group as of March 31, 2024, (n = 134)



***Note:** Youth with no CAFAS score listed were excluded

As of March 31, 2024, 55 (47%) of the children who were in an RMHTF placement had been in residential placement for longer than six months; whereas children in shelter placements had been in placement a shorter period, with 52% (n = 22) having been in the placement for less than or equal to two months. It is critical to a child's well-being to be able to live in the least-restrictive setting possible based on their mental health and physical needs, especially when considering longer-term stability and permanency needs.

Most of the children who need a community-based placement (67%, n = 106) were reported to have no other discharge barrier beyond needing a home or placement to return to (Figure 83). One in five children had another reported barrier to discharge (22%, n = 34) with the most common additional[74] barriers being:

- "Discharge plan needs updated" (n = 12)
- "Parent/family has ongoing personal circumstances that are preventing/delaying discharge, and the discharge plan should be revisited" (n = 6)
- "Child is not meeting treatment goals" (n = 6)
- "Parent/family has temporary personal circumstances that are preventing/delaying

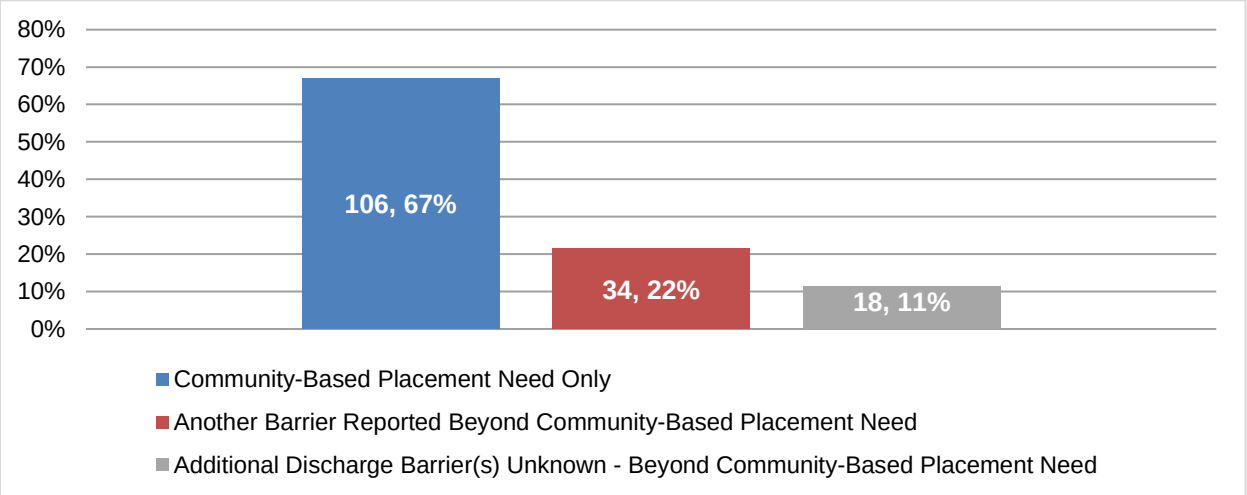
[74] Children could have multiple barriers selected. The remaining barriers not reported above were reported for only one child each: "Disagreement of MDT team member (e.g. child, parent, GAL, judge, attorney, facility, BSS) on child's plan is preventing/delaying discharge," "Parent/family has significant concerns with child's behaviors that are preventing/delaying discharge to their home," "Pending (kinship/relative) ICPC," and "Pending court approval."

discharge” (n = 4)

- “Child is pending move to independent living” (n = 5)

Over one-third of children with an additional discharge barrier beyond community-based placement listed the need to update the discharge plan (n = 12). The Quality Committee and stakeholders from Aetna noted the importance of quality and up to date discharge plans, even when child welfare and/or family situations can be fluid. Aetna plans to revisit this need with their case and UM teams to emphasize the importance of having accurate and valid plans in place and to enhance protocol to follow up with providers when reported plans are deemed inadequate. Case managers are also trained and will continue to be coached in strategies to help children overcome or navigate barriers to discharge. Given the additional common barriers listed for this subgroup, such as the family having personal circumstances delaying discharge, more frequent discharge plan updates may be needed for the child and the situation may be more fluid in nature. However, RMHTF settings should not be used as homes for children while family circumstances are managed. Therefore, it is important that the child has a kinship or foster home as an alternative while family circumstances and needs are being managed. Furthermore, there may be additional considerations for children with a barrier related to “not meeting treatment goals,” especially if the child has been in placement for longer than necessary. The child may be “not meeting treatment goals” due to impacts of the placement environment and congregate (non-family based) setting. DoHS plans to complete additional analyses in the future to better understand impacts of discharge barriers among priority groups.

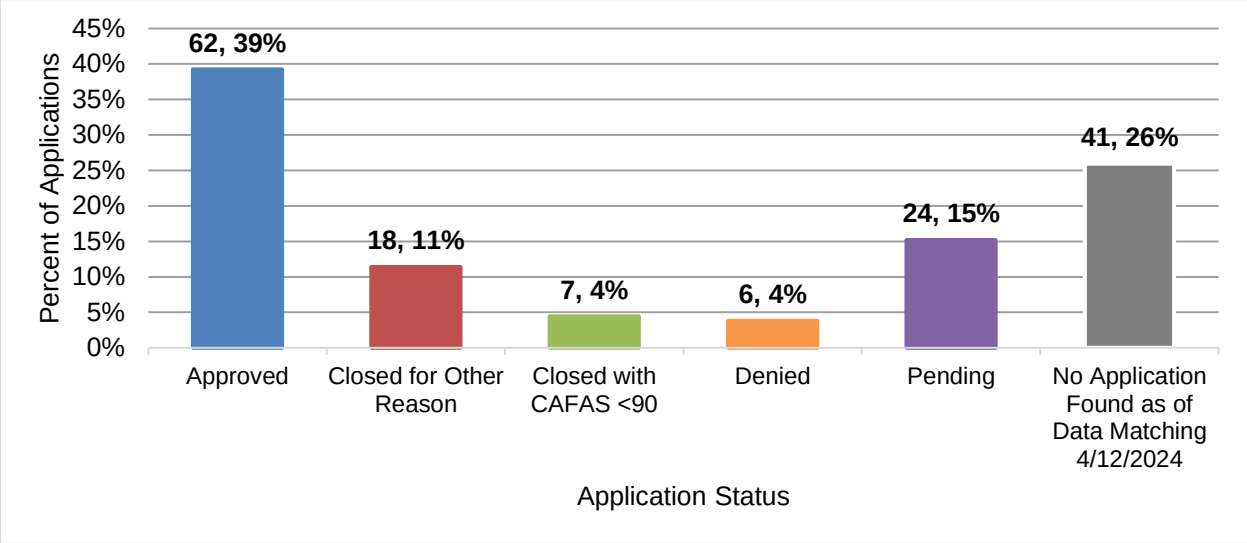
Figure 83: Discharge Barriers for Children in Need of Community-Based Placement as of March 31, 2024 (n = 158)



As will be discussed in more detail in Section 17.0 RMHTF Services, having supports and services in place prior to discharge is critical to help prevent readmission to a residential facility. Providers and child welfare workers are encouraged to refer children to the Assessment Pathway to be assessed for HCBS, such as the CSED Waiver, prior to discharge. Of the

children in need, 74% had an application submitted to the CSED Waiver.[75] A total of 54% had an approved or pending application, while only 8% were denied or closed due to having a CAFAS score less than 90. In cases in which children do not meet program requirements, the application is closed, and the family, worker, or provider is given information on other available HCBS to help meet the needs of the child as they transition back into the community. As part of the planned remodel of RMHTF services, transition plans and connections to services and supports will be emphasized as part of the key infrastructure needed to improve child and family outcomes.

Figure 84: CSED Waiver Application Status for Children in Need of Community-Based Placement as of March 31, 2024 (n = 158)



Information on the characteristics of children in shelter and RMHTF placements in need of a community-based placement will be shared with CPAs and other stakeholders to help inform recruitment strategies and to strategize supports needed for children ready to discharge to the community. Updates for these indicators will be provided routinely to help ensure recruitment strategies remain in alignment with the characteristics of children in need.

14.3 Strengths, Opportunities, Barriers, and Next Steps

With focus on a campaign to expand foster family capacity and strengthen the tiered foster care model, DoHS is taking steps to strengthen community-based placement availability despite identified challenges. As of June 3, 2024, Mission WV had received 350 inquiries, with seven families selecting an agency to begin the certification process. Additional time is needed to determine any changes as a result of the campaign as families average about nine months between contacting Mission WV and being certified, and historically, only about 10% of families who inquire follow through with the entire certification process.

[75] Data is matched across systems, data matched for 74% of children in need, some children may not have matched due to factors other than not submitting an application such as errors or slight differences in name, date of birth, or other identifier on record.

Meetings and feedback from CPAs and other stakeholders have been a great strength of CQI efforts and will continue in the coming year. WV foster home capacity has decreased over time, with more homes closing than opening over the last several quarters. Although data is preliminary, adoption or establishment of legal guardianship is the most common reason homes close. Recruiting and retaining foster home families has remained an ongoing challenge noted by CPAs, especially for homes willing to accept older children and/or children with SED. However, increases have been seen in families retained for two years or longer, with increased focus on CQI helping retention efforts over the past year. Retention efforts will continue, along with strategic planning and marketing for recruitment of foster parents interested in accepting an older child with mental health needs into their home. Strategies will continue to be developed in collaboration with CPAs with a focus on county-level findings and characteristics of children in need of a certified home, results will be shared with CPAs and used to further focus recruitment efforts.

DoHS is also collaborating with CPAs to explore enhancement of processes for identifying foster placement needs and prioritizing youth who have been identified as being “difficult to place.” One strategy for this has been to implement an electronic referral system for foster placement needs. Testing of this system is anticipated for fall 2024 and is expected to provide more timely data, including report and dashboard visualization to CPAs and BSS staff. This will enable continued awareness of foster home recruitment needs and children who have continued placement needs, regardless of timespan since the initial referral (in cases in which an immediate placement could not be found). These strategies, including the campaign to increase foster home capacity, provide an opportunity for growth and improvement, which will be monitored in future reports to identify impacts of these efforts.

15.0 Children's Crisis and Referral Line (CCRL)

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

Using CQI processes, DoHS continues efforts to expand awareness and use of the CCRL and to address evolving data needs, including regular review meetings to inform planning and quality assurance. Figure 85 provides an overview of the CCRL data currently available.

15.1 Review Period, Data Sources and Limitations, Population Measured

Figure 85: CCRL Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2023	Help4WV – iCarol Call Reporting System	CCRL was implemented in conjunction with an active HELP4WV line in October 2020. Higher rates of incomplete data are expected for the call line, especially for demographic information. When a family/person calls in crisis, it might not be prudent to collect all the desired data fields due to the urgent nature of the call or the need to establish a rapport quickly. "Calls" include texts and chats unless otherwise noted.	Children served directly through the CCRL; services are provided to individuals and families with children ages 0 – 21 who are having a behavioral health crisis or who have a diagnosis of an SED or SMI, and their families who are in crisis or who are seeking referrals to related services. For purposes of this report, callers reporting an age over 20 were excluded from the dataset.

As noted above, the CCRL officially launched services in October 2020. While the HELP4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated CCRL offers the added benefit of referral, support, and information services for children and their families. CCRL data is reviewed at least semiannually to assess call and referral quality and to determine the need for adjustment or improved outreach efforts. Additionally, the number of calls by acuity is included in the monthly internal Kids Thrive update, which is highlighted for review of key fluctuations in data as part of monthly workgroup leads meetings.

15.2 Review Summary

At least one individual from 45 of WV's 55 counties called the CCRL in July to December 2023, down from 48 during the prior reporting period. When reviewing all calls from 2023, 51 out of the 55 counties are represented. Only 38 counties had an individual call the CCRL in the last half of 2021, indicating that knowledge and usage of the CCRL has expanded, but traction across the State may be waning. Consideration has been given to changes or shifts in utilization to the CCRL's sister call line, 988. Data for the 988-call line will be compared with CCRL in the future to understand impacts on overall call volume, and to help ensure consistency and training in cross referral practices among First Choice Services staff. The Quality Committee continues to review county-level maps and data for several services to assess opportunities for outreach. BBH selected several counties in mid-2023 for focused outreach related to the CCRL and access to the Assessment Pathway as described in Section 6.0 Marketing. Working with its vendors and providers, BBH has placed increased emphasis on marketing efforts in the previously identified counties and plans to broaden advertisement across the State in 2024. Caution should be taken when reviewing county-specific CCRL caller data, as 29% of calls indicated the county of origin as missing. However, this is a significant improvement from 44% of calls in the prior period, and improving data collection continues to be a focus area with the vendor.

Figure 86 shows available data for calls per 1,000 youth in each county during 2023, with a comparison provided for each six-month period. The counties with the greatest rate of calls per 1,000 youth during July to December 2023 (right half of Figure 86) were Pendleton, Hampshire, Grant, Wirt, and Braxton. The counties with the greatest number of calls regardless of population during this period largely followed population centers: Kanawha (n = 47), Berkeley (n = 31), Monongalia (n = 26), Harrison (n = 21), and Marion (n = 17). When comparing calls at the county-level from January to June 2023 to July to December 2023, a net decrease was identified: the State average for calls per 1,000 children dropped from 1.0 to 0.8. Only 12 of WV's 55 counties had a net increase in calls from the first half to the second half of 2023, down from 32 counties that had a net increase from July to December 2022 to January to June 2023. Thirty-three (33) counties had a net decrease in calls from prior to the current reporting period. In January to June 2023, 23 counties (19 identified in dark blue in Figure 67 along with four counties with redacted data) had at least one call per 1,000 youth, while in the last six months of 2023, only thirteen (13) counties were noted as having at least one call per 1,000 children. DoHS will continue to monitor county-level trends and work with the CCRL vendor to understand potential explanations for changes in county- and regional-level utilization.

Figure 86: CCRL Calls per 1,000 Children Aged 0-20 County Population, January to June 2023 compared to July to December 2023 (Left-to-Right)

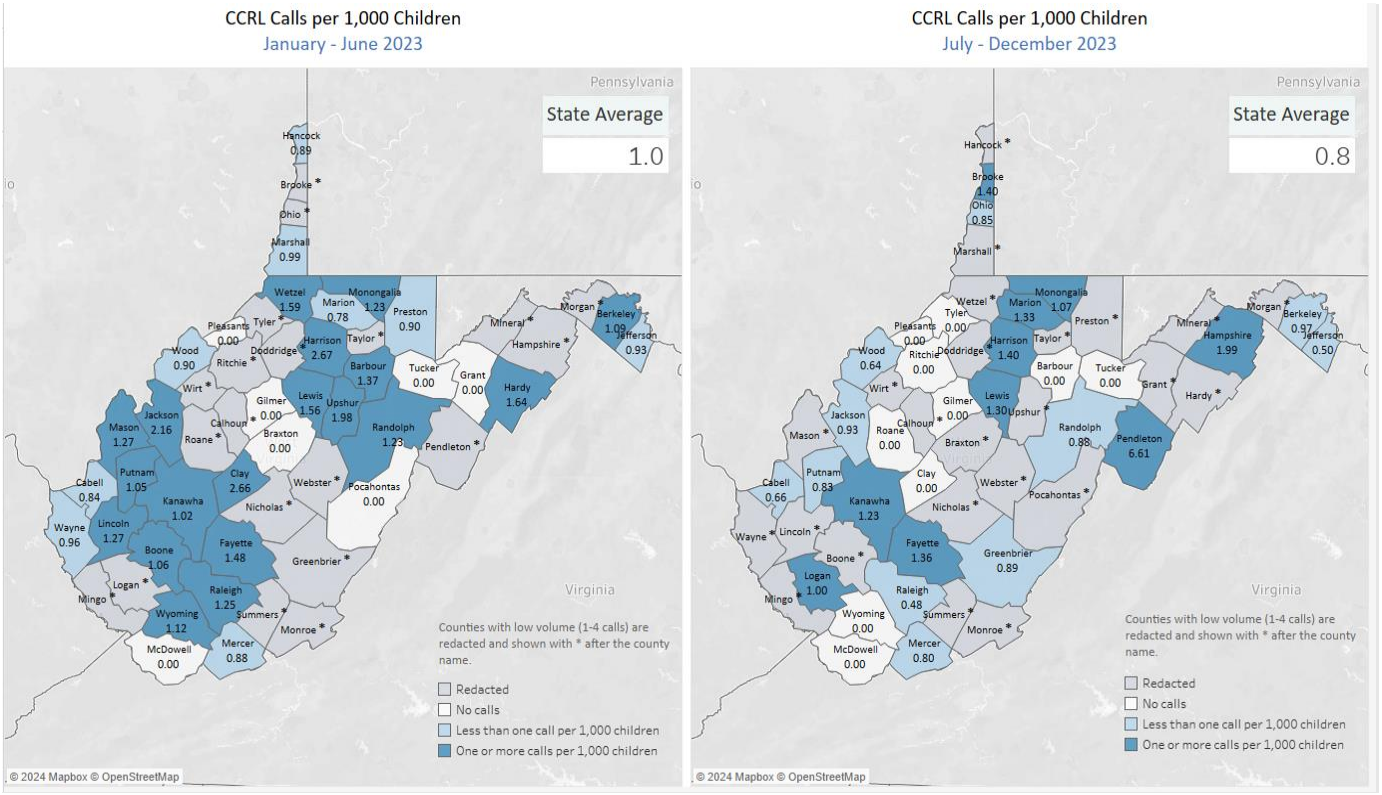
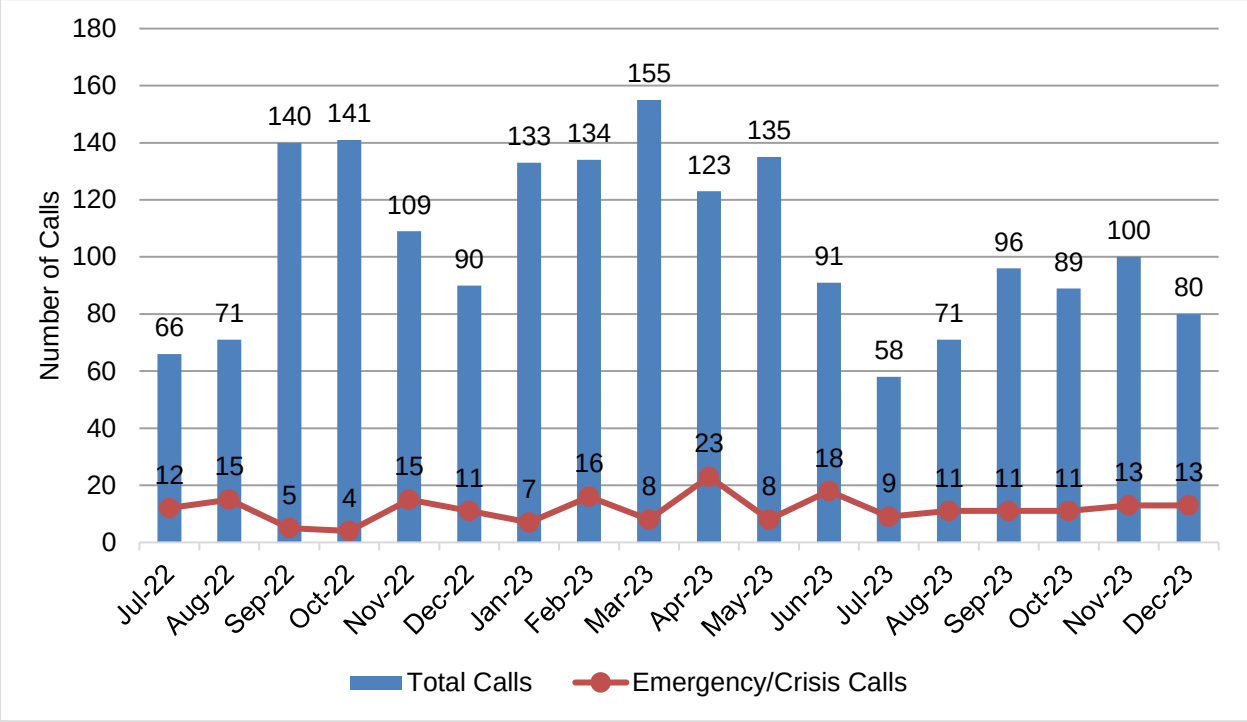


Figure 87 shows the number of calls by month and acuity type from July 2022 to December 2023. From July 2022 to June 2023, call numbers were generally high, ranging from 123 (April 2023) to 155 (March 2023), excluding expected seasonal dips related to school closings and associated holidays in the summer (July and August 2022 and June 2023) and winter (November and December 2022). The average number of monthly calls during that full 12-month period was 116 calls. However, call volume was notably lower in the latter half of 2023. Though call numbers in July (66 calls in 2022 vs. 58 in 2023) and August (71 calls in both 2022 and 2023) were consistent with numbers from the prior year, the observed increase in September 2023 (up to n = 96 calls) was far lower than the increase in the prior year (n = 140 calls in September 2022). The CCRL averaged 82 calls per month in July to December 2023, and no month had more than 100 calls (November 2023). Overall, there were only 494 total calls in July to December 2023, a 36% decrease from the previous reporting period (771 calls from January to June 2023). The CCRL vendor did not run any advertisements during this reporting period, a likely reason for a decrease in calls. BBH will be discussing the marketing needs of the CCRL with the vendor to try and create a more consistent stream of messaging moving forward. Of providers who responded to the CMH Evaluation, 85% were aware of the CCRL compared to 66% at baseline.

Figure 87: CCRL Calls by Type of Acuity by Month, July 2022 to December 2023



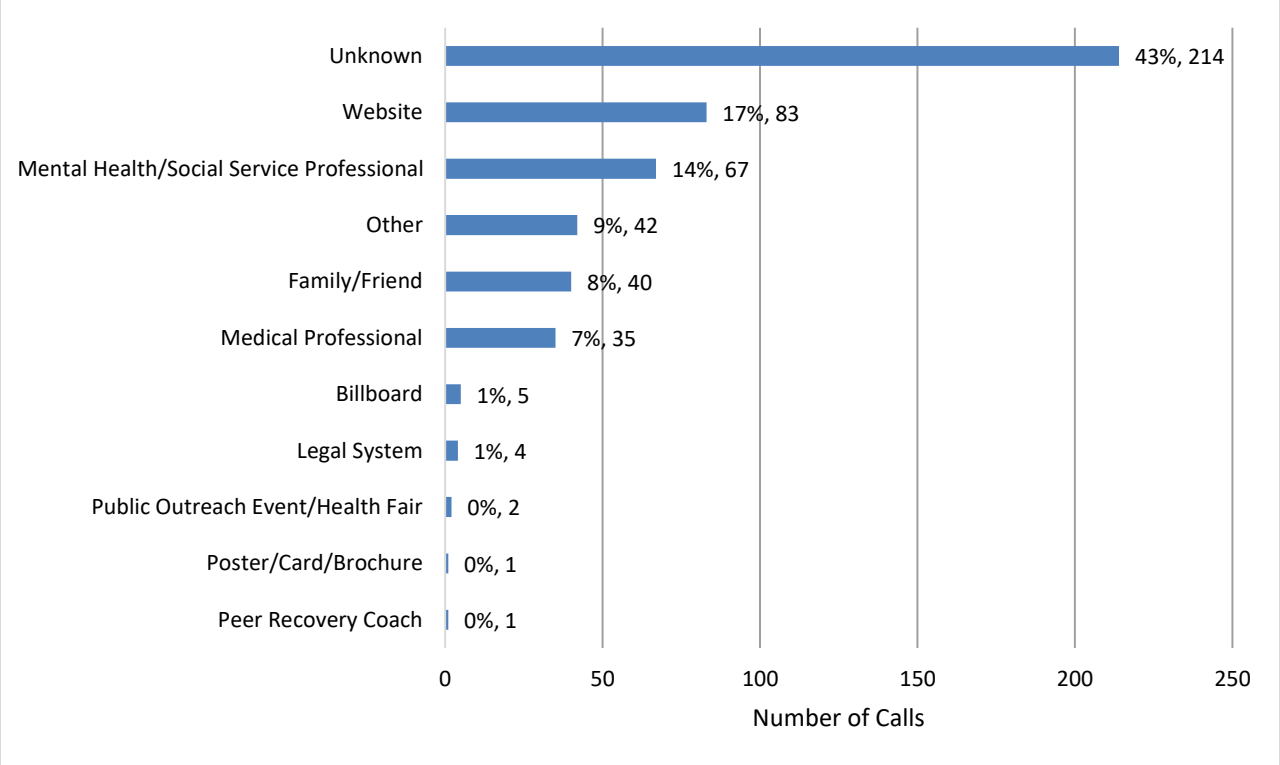
Although total calls decreased in the last half of 2023, the percentage of calls that are emergency/urgent/crisis increased slightly, from 10% in prior reporting periods to 14% in July to December 2023 (Figure 88). DoHS is still working to understand these trends; however, the Quality Committee indicated this may be associated with increased use of the line as a referral source and, therefore, a decreased rate of crisis usage overall. It is noted that the use of local lines for CMCRS continues to be prevalent despite marketing efforts for use of the CCRL with warm transfer as needed. This will continue to be monitored; however, both entryways offer connection to the Assessment Pathway, and continued outreach efforts to market the line as not only a resource for families in crisis, but also as a key entry point to mental health services, has laid the groundwork for increased accessibility and ease of navigation for families. Increased use of the line in this manner prior to a potential crisis creates the opportunity to divert children and families from both crisis situations and out-of-home placements by connecting them to services and supports early. To help ensure accuracy of reporting, BBH has collaborated with the call-line vendor to update the call center's desk guide and data reporting. Further updates are expected during summer 2024.

Figure 88: Comparison of Six-Month Period Calls to the CCRL by Type or Nature of the Call

Type/Nature of Call	January to June 2022	July to December 2022	January to June 2023	July to December 2023
Emergency/Urgent/Crisis Calls [n (%)]	99 (20%)	62 (10%)	80 (10%)	68 (14%)
Total Calls	494	617	771	494

The referral source for calls is depicted in Figure 89. Nearly half of all calls, 43%, had an unknown referral source—the highest rate of any referral source, and an increase from the prior reporting period, when only 24% of calls had an unknown referral source. DoHS is working with the vendor to make referral source a mandatory data field to address this shortcoming in data collection. Despite a large decrease in web traffic, the CCRL website was the second most common referral source, representing 17% of all referrals, similar to 15% from the prior period. There was a decrease in referrals from mental health/social service professionals, from 23% in the first half of 2023 to only 14% in the second half In addition to continuing to monitor this indicator, BBH will work with the call-line vendor to expand referral source categories to include school-related referrals and add a separate field for the "other" category so additional referral sources can be explored to identify outreach strategies that may support increased utilization of the CCRL. These changes are in progress and are expected to be finished in summer 2024.

Figure 89: Referral Source for Call, July to December 2023



The caller's relation to the individual in need is displayed in Figure 90. It is noteworthy that:

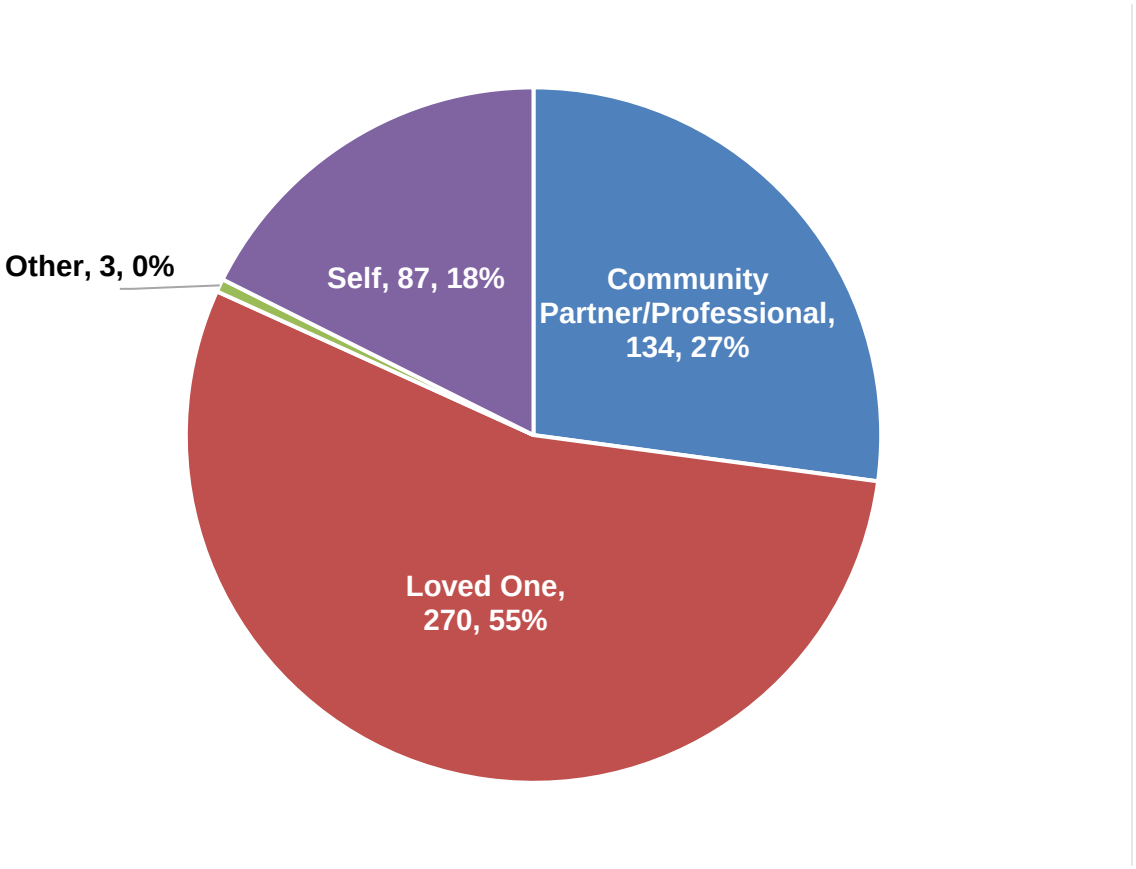
- The number of calls from a loved one was far greater than any other source. Out of all calls for the CCRL, 55% (n = 270) came from a loved one,[76] a notable decrease from the prior reporting period in which only 43% of all calls came from a loved one.
- The percentage of calls made by the children themselves was 18% (n = 87), the same percentage as observed in the first half of the year. These calls were more likely to be

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

made via chat or text compared to calls from other sources. Over half (n = 66, 52% of calls with non-missing age data) of these calls were received from a child aged 13 – 17.

- Community partner/professional calling decreased from the first half of 2023 (36% of all calls) to the second half of 2023 (27%). However, 27% is within the expected range from the past four reporting periods (values have ranged from 21% to 36% of all calls). This finding is likely associated with efforts to increase provider and partner awareness of the CCRL and related services.

Figure 90: Caller Relation to Individual in Need, July to December 2023

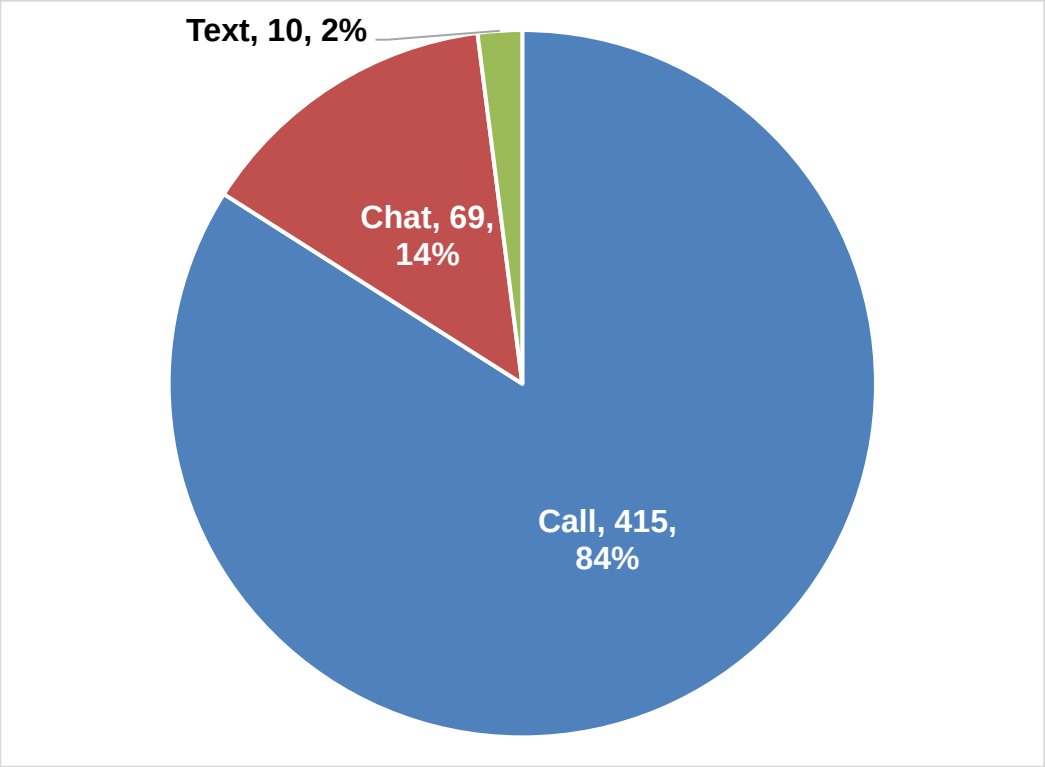


As displayed in Figure 91, 84% of contacts in January to June 2023 came via a traditional call compared to 16% of contacts that came from text and chat features; text and chat increased from 12% of total contacts in the previous period. The utilization of chat or text highlights the importance of this alternative feature for people who may not feel comfortable reaching out verbally, especially since this feeling is likely to be higher among children. This feature presents a great opportunity for families in need; however, it also presents challenges for capturing call-related data and for responding in a timely manner, due to limitations of the chat/text format.

Considerations remain for the implementation of the 988-Suicide and Crisis Lifeline, which went live in July 2022, offers similar features to the CCRL, and is operated by the same vendor. Call-line staff are cross-trained to help identify and meet callers' immediate needs, and staff can cross-refer via a warm handoff between lines for more technical needs. Additional efforts are

increasing to help ensure continuity with helpline staff between call lines.

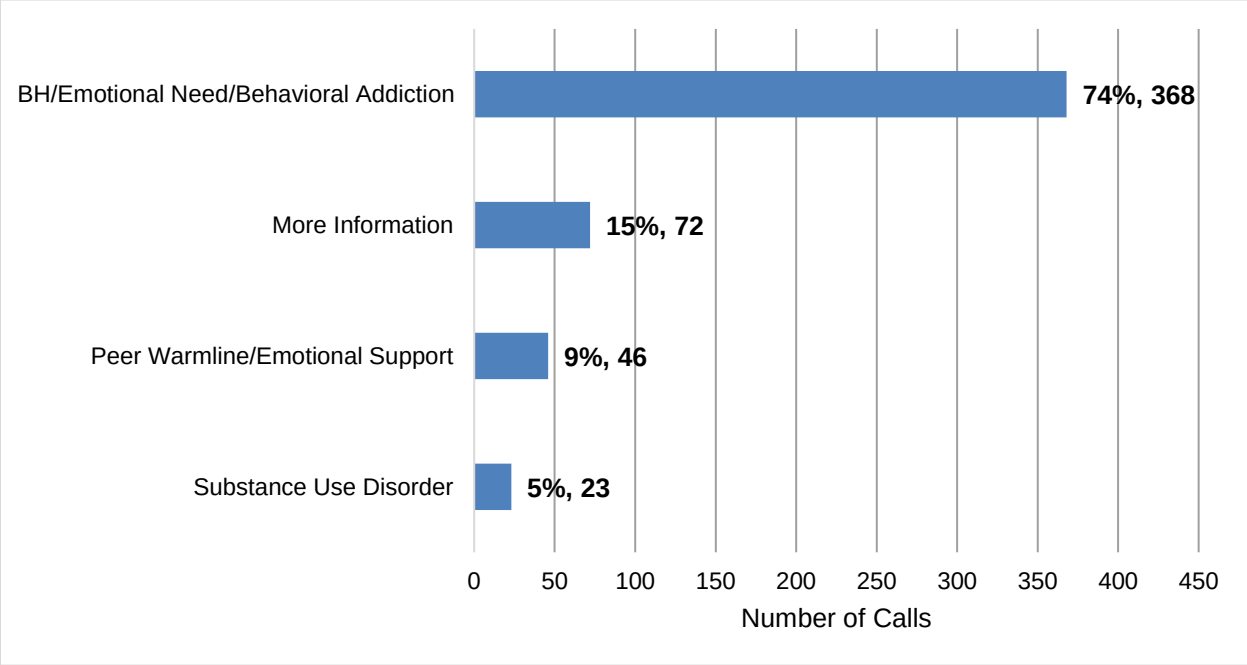
Figure 91: Type of Contact, July to December 2023



Individuals reached out to the CCRL for various reasons (i.e., presenting needs). As seen in Figure 92, in order of descending frequency, the needs of these individuals were the following: behavioral health or emotional need (74%), acquiring more information (15%), seeking connection with Peer Warmline[77]/Emotional Support (9%), and SUD (5%). As of January 2022, staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs. Updates to the CCRL desk guide are also anticipated to address consistency related to presenting needs and detail of the types of information or services to which the caller is referred.

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

Figure 92: Presenting Need, July to December 2023[78]



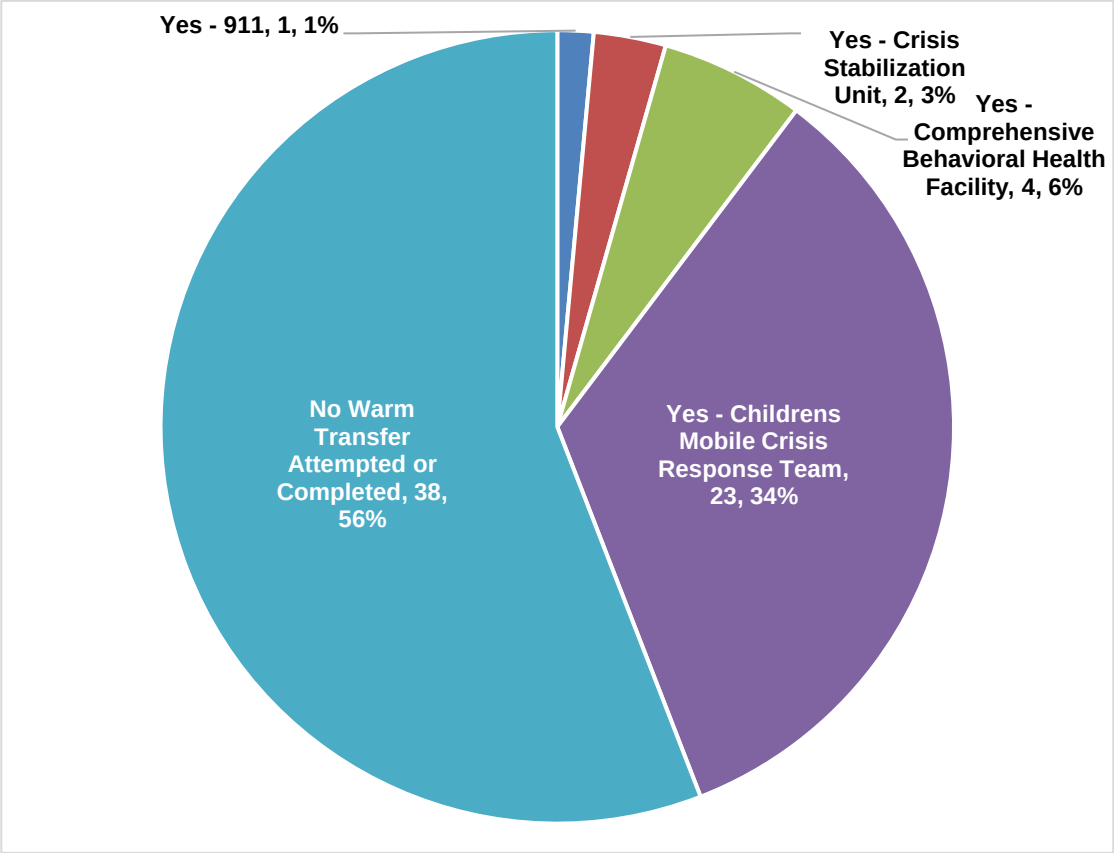
Of individuals for whom the call was reported as "emergency, crisis, or urgent" and had a response listed for referral, Figure 93 highlights 34% (up from 29% of these calls during January to June 2023) were reported as being directly transferred to a mobile crisis response team via "warm transfer."[79] Figure 93 notes 56% of calls had no warm transfer attempted; the call line noted that mobile response is offered when requested or is needed, but based on family preference and willingness, families may choose to be referred or receive information on other services, or simply to have someone be a support and listen in their time of need.

BBH continues monthly meetings with the vendor and has established more consistency with data definitions and collection focus. This effort will continue over the next six months with a broader system focus to eliminate duplicative fields and focus on key metrics to understand call outcomes in greater detail, including for those calls with no warm transfer. To assist with this effort, the vendor reviewed a sample of routine calls and emergency/urgent calls to determine if these calls were labeled properly and if they received an appropriate response/referral. During this review process, only one call was identified as being handled improperly, and DoHS met with the call-line vendor to develop an improved workflow that addressed this outlier.

[78] Individuals may have reported more than one need, making the total add up to greater than 100%. All needs are self-reported and not necessarily representative of a clinical diagnosis.

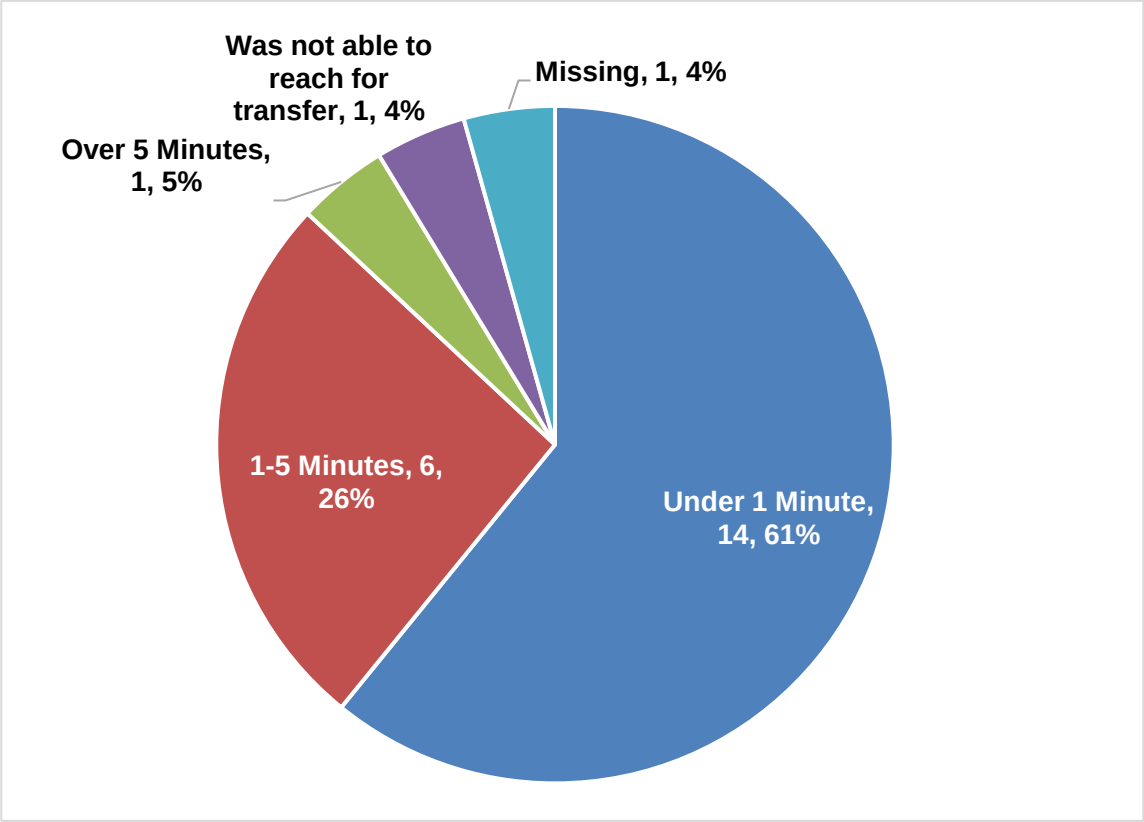
[79] "Warm transfer" is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed. The decision to attempt a warm transfer is made in conjunction with the family and their needs and willingness to accept assistance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

Figure 93: Referral Types for Calls Reported as "Emergency/Crisis/Urgent," July to December 2023 (n=68)



Timeliness measures for warm transfer from the CCRL to a mobile crisis response team were added in May 2021 as seen in Figure 94. Of the 23 emergency/urgent/crisis calls with a reported warm transfer attempt to mobile crisis services, 87% (n = 20) were connected in five minutes or less, with 61% (n = 14) connected in under one minute. Both rates are significant improvements over the prior reporting period (53% in five minutes or less and 31% in under one minute). Furthermore, July to December 2023 timeliness data was only missing for one caller (4%), significantly lower than 30% of missing data in the first half of 2023, representing notable improvement in data collection. Only one call record showed that the helpline specialist was unable to reach the mobile crisis agency for transfer, compared to four calls in the previous reporting period. When a CMCRS team is unable to be reached, the call-line specialists reach out to regional supervisors or BBH staff directly through a defined escalation process. DoHS will work with the vendor, as noted above, to continue to improve these metrics. In addition to these CQI processes in place, BBH also routinely reviews calls that are recorded as not being connected to a CMCRS team to help ensure that these calls were escalated at the time, and as an opportunity to reenforce best practices and protocols with both CCRL and CMCRS teams.

Figure 94: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team, of Calls Reported as "Emergency/Crisis/Urgent" With Transfer Attempt, July to December 2023 (n=23)



15.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway, as well as media campaigns and other outreach campaigns, is anticipated to increase the number of services and awareness of the CCRL. CQI processes have permitted timely changes to training strategies and data indicators. First Choice Services, the provider that runs the CCRL, monitors call loads and weekly or seasonal trends to help ensure adequate coverage to meet family and child needs. Figure 95 provides data on CCRL current and budgeted personnel.

Figure 95: CCRL Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Help Line Specialists	16	16[80]	100%
Program Coordinator	1	1	100%
Shift Leads (shared with other call lines)	3	3	100%

[80] Only 15 of these staff are via the BBH budget for the CCRL according to First Choice Services reporting.

BBH allocated funds for the CCRL in their System of Care grant which renewed in fall 2023. First Choice Services will be upgrading the platform utilized for CCRL to provide help line specialists with the ability to refer callers directly to a mental health provider for appointment availability, scheduling, or immediate medication management needs. This change is expected to allow for a reduction in the utilization of emergency departments for routine mental health needs. BBH is hoping to have processes outlined with additional details by 2025.

15.4 Strengths, Opportunities, Barriers, and Next Steps

The CCRL continues to be an integral entry point for the Assessment Pathway as well as a mechanism to access crisis services. Although only a small number of youth responding to the community-based CMH Evaluation indicated utilizing the CCRL, these youth also reported that the call line helped them avoid or delay residential placement. Given the nature of a line that helps families in times of critical need, data collection is not always the top priority, as the urgency of the child and family's needs should always come first. The centralized call-line staff help individuals quickly connect with behavioral health services and can divert inappropriate use of emergency rooms and 911 calls. BBH and the call-line vendor have identified and will continue to find opportunities to improve data collection to be able to tell the story of call outcomes more completely, regardless of caller acuity when possible. Some steps have been taken and should be fully implemented by summer 2024. Changing the platform that is used for the CCRL is anticipated to have a robust impact on the vendor's ability to make real-time connection between callers and the services they need; however, this type of change can take time for the benefits to be fully realized.

In addition to helping families in crises, it is noteworthy that only 14% of calls for the period were reported as emergency/urgent/crisis. As described above, a sample review was completed and validated this finding. The Quality Committee viewed this as a likely positive result, as it was hypothesized families were able to access information and be connected to the Assessment Pathway before a crisis occurred, thereby enabling a potentially critical prevention opportunity. While most crisis services are addressed directly through local CMCRS calls, outreach continues to emphasize use of the centralized CCRL due to its ability to navigate needs quickly via its broad resource inventory, as well as its established quality control mechanisms to help ensure callers' needs are met. Outreach in late 2023 for the CSED Waiver included information on the CCRL as a resource for families. This outreach included providing materials to emergency departments, a noted area of need from the most recent edition of this report.

Next steps include:

- Continue to work with the CCRL vendor to help ensure that processes are in place to capture complete data when feasible and to capture missing data on follow-up calls.
    - Focus on data fields monitored frequently for improved completion rates, such as referral source, county of origin information and call transfer-related outcomes.

    - By the end of summer 2024, expand data collection to include referrals from school personnel and “other” sources to improve understanding of connections made to the CCRL and outreach opportunities. In addition to this, expand collection of call outcome data related to referrals made, and caller needs to help ensure needs are being met, and warm transfer is offered and occurs when appropriate and agreed on by the family.

- Continue to review call-line data routinely to identify opportunities for further outreach to families across the State and provide technical assistance to the call-line staff and the teams they refer to, as needed, to improve call and referral quality, including review of calls unable to be transferred in a timely manner.
- Continue outreach to medical offices and schools as part of expanded screening efforts.
- The call-line vendor will upgrade the platform for the CCRL to create more functionality for real-time connection between callers and providers as well as improve transfer processes between the CCRL and 988 line.
- First Choice Services and BBH will develop an outreach plan for the target counties, as well as a more general statewide outreach plan.

16.0 Children's Mobile Crisis Response and Stabilization (CMCRS)

The CCRL can connect children who are experiencing a behavioral health crisis and their families to regional CMCRS services through a warm transfer to the closest regional CMCRS team. CMCRS services have been available statewide since May 2021. The family determines whether a situation is a crisis from their perspective. The CMCRS team will speak with the child or family member and respond via virtual means or in person in the home, school, or community-based on the child's or family's preference. The crisis specialist is expected, on average, to provide on-site support within one hour of the request.

After de-escalating the crisis, the CMCRS team completes a crisis plan and links the child or family to appropriate community-based services, including the Assessment Pathway if needed, to help them receive treatment in their home and community and help prevent out-of-home placement. In addition to calling the CCRL, which has been available since October 1, 2020, children and families may call the regional CMCRS teams directly. However, DoHS's crisis line promotional campaigns have shifted to calling the centralized CCRL first since its implementation.

In addition to services provided by CMCRS, BMS also offers mobile response services through the CSED Waiver. However, these services were reviewed and noted in Quality Committee reviews that utilization had primarily shifted to calls to the CCRL regional CMCRS. Therefore, only CMCRS data was included for review purposes in this report. BMS mobile response will be monitored routinely for any changes in utilization, especially given the recent expansion of the SPA to include mobile response for all Medicaid members, not just those enrolled in the CSED Waiver (January 2024). This will provide the opportunity for expanded CMCRS networks, including the potential for expanded funding availability and mobile response teams continuing into adult services. Figure 96 provides an overview of the CMCRS data currently available.

16.1 Review Period, Data Sources and Limitations, Population Measured

Figure 96: CMCRS Data Overview

Data Review Period	Data Source	Limitations	Population Measured
July to December 2023	BBH System of Care Epi Info Interface	At the time of this report, indicators regarding timely provision of services and referral to additional services were unavailable. Data fields to capture this information were added with the update to the Epi Info System (V2), which went live October 31, 2023; however, components of V2 are still being validated to identify any adjustments needed. Timeliness data	Children served directly through grantees of the BBH program; this includes BMS-funded mobile response by these overlapping providers. Services are provided to individuals and families with children ages 0 – 21 experiencing an emotional or behavioral crisis initially

Data Review Period	Data Source	Limitations	Population Measured
		will be reviewed in the future once available. Due to the implementation of Epi Info System V2 in October 2023, results in this section use a combination of V1 and V2 data. Although data was able to be merged at the child-level across both versions, there is likely some discontinuity in data collection when providers converted from the old to new data system. Due to ongoing testing and validation of the V2 system, results in this section are considered preliminary.	through BBH's CCRL or connected through a local CMCRS line.

16.2 Review Summary

CMCRS utilization trends will continue to be monitored as more data becomes available at the child-level to continue establishing normal trends versus changes in service utilization. Issues relating to the structure of the Epi Info System and new updates (V2) have posed challenges for many CMCRS providers, resulting in incomplete documentation. Due to this, data in this section is considered preliminary. DoHS will continue to review and validate data to understand any considerations related to these changes while implementing short-term solutions until Epi Info System V2 is fully functional for all providers.

For the review period (July to December 2023), 376 children received CMCRS, a 69% decrease from the prior reporting period (n = 600). Providers indicated this finding did not match perceptions of the number of calls received or families calling for services. CMCRS data will undergo further assessment to validate and understand trends in utilization overtime and impacts on data system change and reporting practices. Information on the demographics of children enrolled in CMCRS services is included in Section 4.0 WV's Child Population and Individuals Utilizing Services. Youth received services in 38 of the State's 55 counties (Figures 97 and 98), but 29 counties experienced a decrease in the number of youth receiving services from the first half to the second half of 2023. Several of these counties with decreases contain the largest populations of youth in the State, which could have a large impact on the total volume of calls. Nine counties sustained their service rate, while only four counties (Grant, Mason, Pendleton, and Wyoming) experienced an increase (inclusive of counties with zero calls in January to June 2023 and non-zero calls in July to December 2023). Thirteen counties did not have any calls reported in 2023, with nearly half of the counties with no calls located in BBH region 3 (see Appendix B: BBH Region Map), with six of the eight counties in that region having no calls in 2023. A provider in region 3 has reported difficulties with obtaining consent to collect information. This direct consent is not required per the public health privacy rule but could be part of the reason for this lack of data. BBH is working with providers to overcome existing

concerns. Region 3 has a strong network of Expanded School Mental Health (ESMH), which could be meeting the needs of some youth in that area. Further investigation is needed to determine if the decreases in calls were related to reporting issues, as some providers stated they were unable to use the Epi Info System for a period of time.

The counties with the greatest number of children enrolled in July to December 2023 were Berkeley (71), Raleigh (55), Cabell (42), Kanawha (29), and Mercer (24). As shown in Figure 79, Raleigh (3.15 enrollees per 1,000 children), Fayette (2.40), Berkeley (2.13), Cabell (1.78), and Morgan (1.76) had the highest enrollees per capita in the last six months of 2023. Six children enrolled during the period had no county listed. As in the prior reporting period, some of the counties with the greatest rate of CMCRS utilization were counties where CMCRS was first rolled out and best practices have been established. Distinct from other providers across the State, the provider in these counties has a dedicated staff member to handle data collection requirements, which could impact other counties' reporting given system changes and requirements.

Figure 97: Children Enrolled in CMCRS by County, Percent Change from January to June 2023 to July to December 2023 – Preliminary

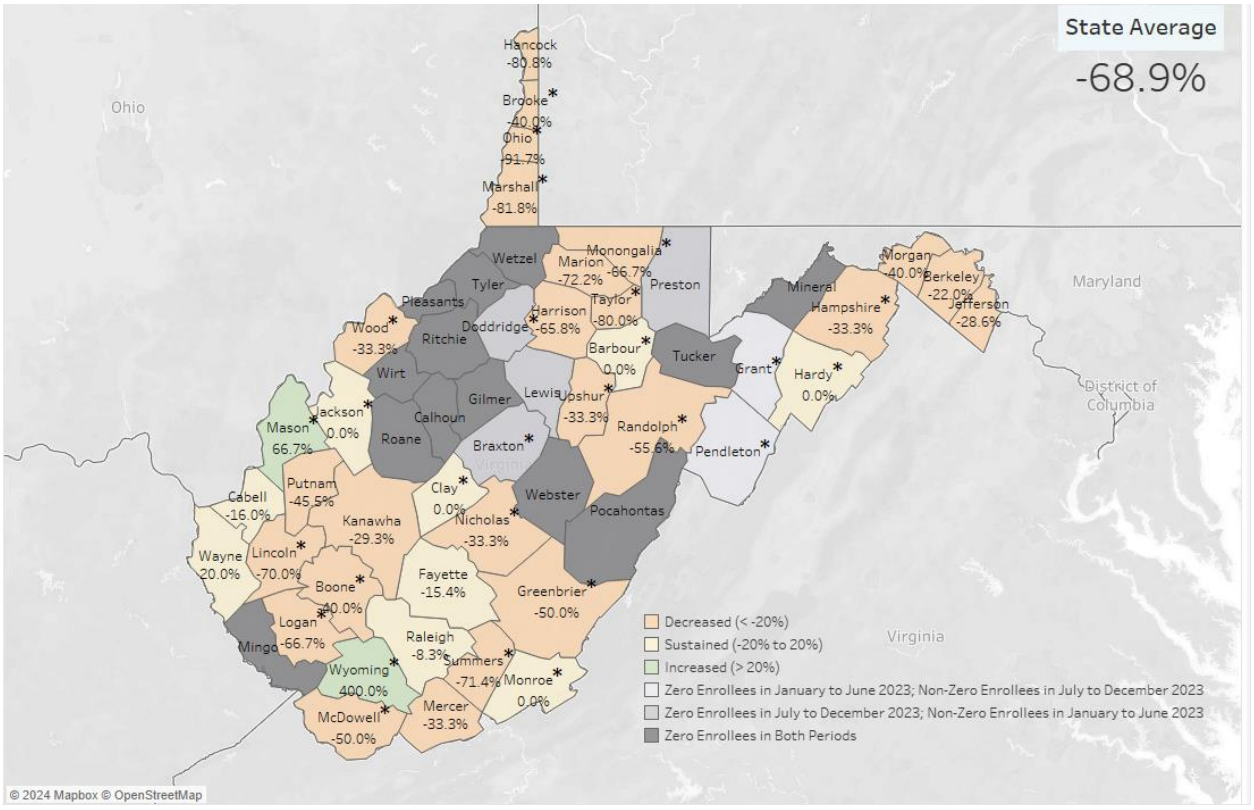


Figure 98: Rate Per Capita of Children Enrolled in CMCRS by County, January to June 2023 (left) to July to December 2023 (right)– Preliminary

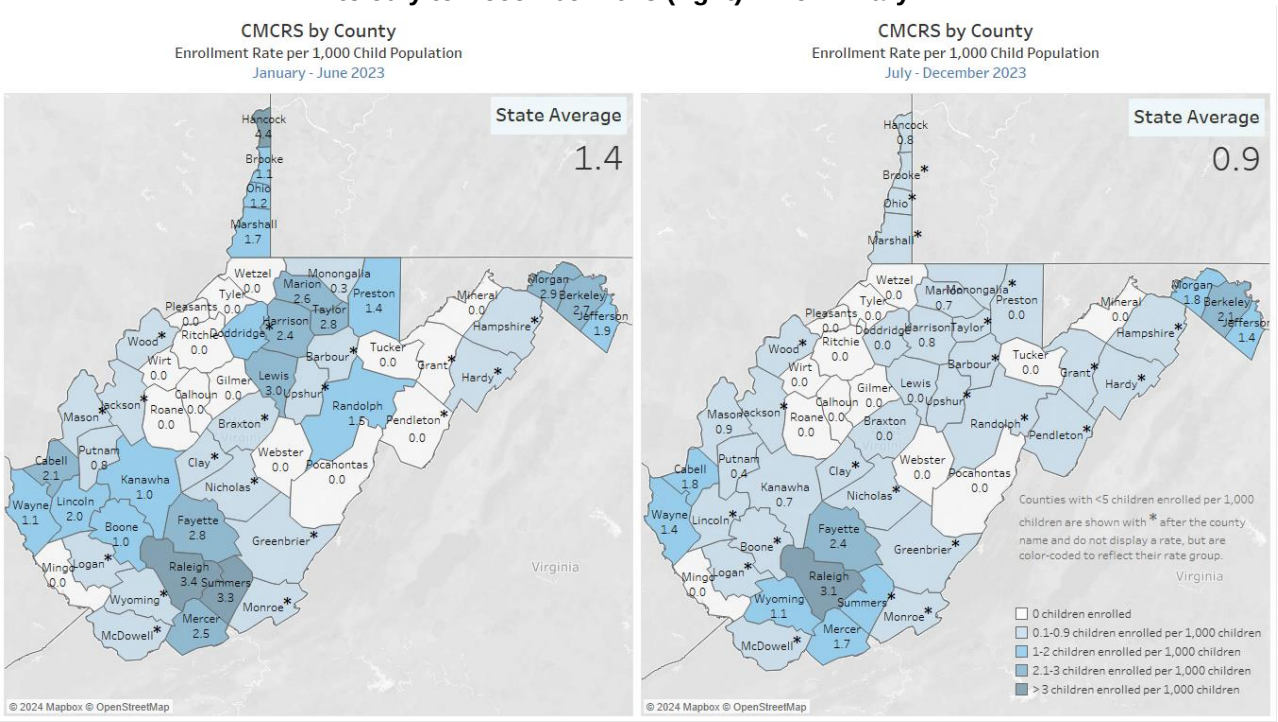
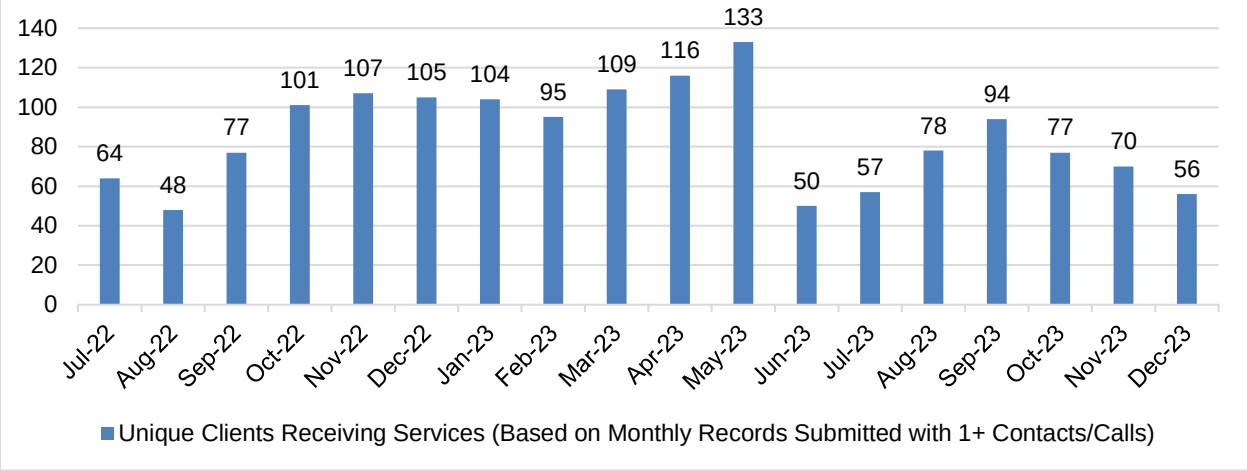


Figure 99 below demonstrates current CMCRS demand and enrollment from July 2022 to December 2023. Enrollment increased from summer 2022 through May 2023, but then dropped sharply in June 2023. This drop may be expected given seasonal fluctuations, and enrollment numbers rebounded in August and September 2023. However, the rebound in 2023 was not as significant as in 2022, and numbers decreased in October through December 2023. One provider indicated that they have struggled to connect with the school system, an important source of their referrals; this barrier likely contributed to the lower utilization numbers in fall 2023 compared to fall 2022. Overall, service utilization decreased 69% from the first half of 2023 (600 children receiving services) to the second half of 2023 (376).[81] Children may continue to be enrolled in the service for up to eight weeks and may only utilize additional CMCRS services as needed. Given the updates to the Epi Info System V2, more frequent data review is planned in the last half of 2024, including on the provider-level, to understand potential areas of improvement.

Figure 99: CMCRS Monthly Enrollment Totals and Service Utilization, July 2022 to December 2023 – Preliminary



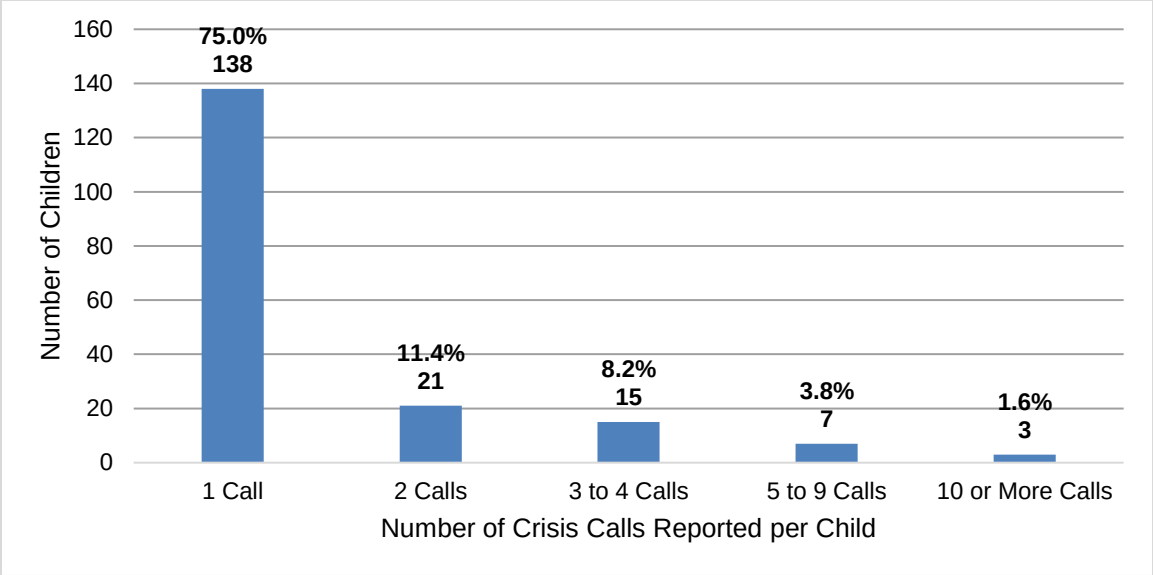
CMCRS teams strive to reach vulnerable and marginalized populations, such as children who are adopted from foster care, children who identify as BIPOC, or children who identify as lesbian, gay, bisexual, transgender, questioning, or another identity (LGBTQ+). Data for the current review period had a similar percentage of missing information for race and children identifying as LGBTQ+ compared to previous data collection. Addressing rates of missing data continues to be an opportunity for improvement of data capture to assess child needs and utilization more thoroughly, though this has been a lower priority effort due to the need to focus on implementation and validation of the V2 system. Moreover, this information may always have limitations due to the nature of crisis work, therefore some information may need to be obtained from other sources where available as the data store is built out. Nevertheless, currently available data suggests that CMCRS serves higher rates of children in these vulnerable populations, relative to the statewide averages. For example, 14% of children served were represented as non-white compared to 10% statewide representation of non-white child population. In addition to this, although nearly half of LGBTQ+ identification data was missing, representation for this group was also above average proportions for the typical WV population, with 15% of youth served identifying as LGBTQ+.

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

Repeat calls were assessed for individuals enrolled during the six-month period. Follow-up calls initiated by the provider were excluded. Data completion for enrolled children was somewhat low, with 51% of children having missing call information. This was a slight increase in missing data over the prior reporting period, in which 46% of children had missing call information. DoHS is working with providers to improve data collection and completion efforts via provider-specific feedback. Figure 100 shows the frequency of repeat call utilization for children with known call information, with 75% of these children appearing to have their needs met and/or stabilized with one call, the same rate observed in the last two reporting periods. For the

remaining children, additional needs were met through multiple interactions. Additional analysis explored children with call-type data and more than two (>2) crisis calls and found that 72% of children with more than two calls received an in-person response, up from 67% in the prior reporting period. These calls for children with more than two crisis calls included 25 children with a total of 142 crisis calls during the period, 88 of which were in-person responses (62% of total calls for children flagged as having >2 calls).

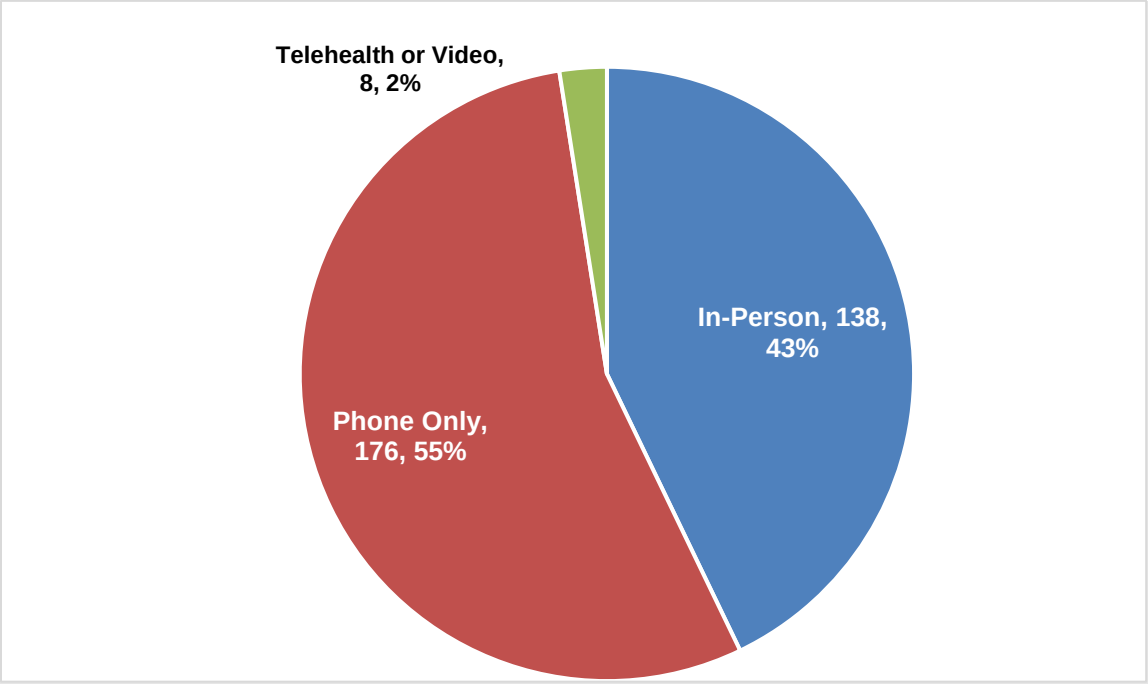
Figure 100: Number of CMCRS Crisis Calls Reported Per Children Served, January to June 2023 – Preliminary (n=322 Calls for 184 Children*)



***Note:** Excludes follow-ups initiated by the provider and children with missing call data.

Nearly half of crisis responses with a known response type were completed in-person (43%; Figure 101), excluding follow-ups initiated by the provider and children with missing data. This is similar to the prior reporting period, during which 45% of responses were in-person. However, a much higher percentage of responses were in-person in 2023 compared to 2022; in January to June 2022 and July to December 2022, only 21% and 26% of responses, respectively, were in-person. This may be a result of increased encouragement of in-person response, or feedback to providers regarding virtual response practices. It is also possible this finding could indicate greater needs for some children, requiring an in-person response. The Quality Committee noted this information would be helpful at the provider-level to understand practices as well as to expand discussion and intervention with providers.

Figure 101: Response Type for CMCRS Crisis Calls, July to December 2023 --Preliminary (n = 322 Calls for 184 Children*)



***Note**: Excludes follow-ups initiated by the provider and children with missing call data.

Follow-up calls represented 909 additional calls directly from providers to follow up post crisis (22% of calls) or to work through prevention strategies with the family (78% of calls). These services provided after the initial crisis, which include further follow-up on needs such as referrals, are very important to helping ensure the child is stabilized while being connected to additional longer-term services, if not already established.

Additional updates to data collection for timeliness and detail of services rolled out on October 31, 2023, in the Epi Info System V2 update. However, technical challenges related to querying the new system and associated fields prevented review of comprehensive indicators at this time. The updates to Epi Info System, once new data can be reviewed, will enable quality monitoring of timely response to needs, as well as improved understanding of capacity and intensity of service needs.

16.3 Provider Capacity/Statewide Coverage

CMCRS services were made available statewide as of May 2021, and have been expanding their network of providers through the build-out of CMCRS as a general Medicaid-covered service. In addition, the CCRL is transitioning to being the primary source to route individuals in crisis to the appropriate mobile crisis team. Individuals may also be connected to mobile crisis services through the Assessment Pathway or via cross referral through the 988-call line.

Initially, MU was contracted in conjunction with UCONN in the development of CMCRS training, but UCONN is now the sole facilitator who provides consistent training and curricula across payor sources for CMCRS. This training follows the national standard curriculum for mobile

response and incorporates frequent feedback from providers regarding training needs. CMCRS teams are passionate about making connections for children and families and have been actively participating in training and feedback opportunities. Implementation of the Medicaid SPA expanding mobile response services may impact needs significantly and influence next steps with training. Although there is still work needed to build out this piece of the system further, enormous opportunity exists to expand access to this critical service.

Providers have indicated challenges still exist in responding within one hour due to the rurality and geography of the State. Providers have also indicated difficulty due to increasing turnover of staff and concerns of how to handle multiple crises if they occur at the same time. Providers have also noted, however, that expansion of stabilization and preventative intervention services have helped alleviate this issue, helping to prevent need for repeat calls. Expanded provider network given changes to Medicaid and available network should help with concerns regarding availability due to ability to share region coverage and response. Data regarding timely response is not yet available for review. Data for this indicator will be part of the validation and review steps taken as V2 is further implemented.

As reflected in Figure 102, CMCRS capacity and FTEs have been maintained in every region of the state except for region 4 and 5, which have increased from 50% and 53% of positions filled to 100% and 85% of CMCRS positions occupied, respectively. Their efforts to increase capacity included a marketing campaign to recruit behavioral therapeutic specialists as well as updating the salary scale to offer more competitive compensation. Other regions with vacancies noted active plans for hiring. DoHS will continue to work with providers to offer technical assistance to improve workforce capacity, especially with the transition to and availability of Medicaid State Plan-funded services.

Figure 102: BBH CMCRS Provider Capacity by Region[82]

Region	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	9	10	90%
Region 2	6	6	100%
Region 3	7	7	100%
Region 4	9	9	100%
Region 5	6	7	85%
Region 6	5	6	83%
Total	**42**	**45**	**93%**

16.4 Strengths, Opportunities, Barriers, and Next Steps

Statewide CMCRS coverage creates the opportunity to offer crisis relief and plans for stability to support families and children in need, helping to prevent unnecessary placements for mental

[82] BBH Region Map can be found in Appendix B.

health treatment. Most children enrolled through the CMCRS can be stabilized in one call, with follow-up and referrals to longer-term services also provided. This key intervention is valued by children and families, which is further evidenced by the rapport built and maintained in communities as shared via feedback from children and families. While most feedback from CMCRS is positive, processes are in place for CQI purposes to address needs quickly, which will be expanded to include review of timeliness information in the coming months. This includes the shift toward the CCRL as the centralized call line to help ensure families are responded to in a timely manner, and an escalation process is initiated if any issues arise. Social service managers have also been made aware of the escalation process for children in kinship or in-home care who may need CMCRS services to help prevent disruption.[83] Analyses disaggregated at the provider-level have been delayed due to the conversion to Epi Info System V2 but will be presented later in 2024 to inform CQI strategies and technical assistance efforts.

Next steps:

- Calls to CMCRS will be monitored monthly to validate Epi Info System V2 data and to understand further the drivers for the decrease in overall calls for the period, with county-level data shared with providers for additional input and discussion.
- Implement and validate Epi Info System V2 through more regular review of data, including analysis at the provider-level. Additional training and technical assistance should be provided to improve data quality and completion as specific issues are identified. This will be a focus area for BBH and the Office of QA in the coming months, with provider-level data review to determine intervention opportunities in relation to referral practices, response type, frequency of return callers,[84] and data quality. BBH and the Office of QA are in the process of developing a reporting cadence and prioritizing the indicators for review. Initial plans are expected to be finalized in Q3 2024. As data becomes available on timeliness of response, additional assessment will also focus on regional needs and technical assistance.
- As with CCRL, conduct additional stakeholder outreach and education for access points such as the ED, PCPs, schools, etc., focusing on counties identified for outreach.
- Encourage CMCRS providers to make direct referrals to the Assessment Pathway immediately upon resolution of the crisis when agreed upon with the family. Providers noted difficulty in getting families to participate in follow-up. BBH will continue to navigate and provide technical assistance to address challenges and to encourage referral to longer-term services.
- Continue raising awareness of these services to diverse communities, including BIPOC, children identifying as LGBTQ+, and adoptees. This includes continuing meetings with stakeholders to brainstorm ideas and plan outreach. Partnerships for Success

[83] Children in certified foster homes receive crisis response from CPAs that undergo similar training to CMCRS staff. CPAs may use CMCRS as a resource as needed but act as first-line responders for foster children in crisis.

[84] Frequency of calls by child is not necessarily a positive or negative result, but it should be considered in combination with the needs of the family to understand if their needs are being addressed sufficiently at each call.

administered a mini grant to work with agencies serving these diverse groups, as well as other grants to create a more diverse workforce. The grant awards will be issued to recipients in late July 2024. BBH also focuses on children who may encounter or be impacted by human trafficking, homelessness, or SUD. BBH helps ensure specific training is available for providers and BBH staff for strategies recognizing these needs and supporting these individuals, despite challenges that often accompany groups experiencing these issues.

17.0 Residential Mental Health Treatment Facility (RMHTF) Services

The overarching goal to improve outcomes for children is to reduce the State's reliance on RMHTFs and to increase HCBS available to children with SED. DoHS continues to increase the availability of community-based services, including the recent addition of community-based TLVY homes specifically designed to support youth aged 17 to 21. In these homes, youth can continue to gain skills to support independent living and access necessary mental and behavioral health treatment from community-based mental health providers. These homes became operational in September 2023, with an initial capacity to support up to 22 youth. Given increased demand for these homes, DoHS worked with existing providers to expand capacity to serve an additional 10 youth in late 2023 and early 2024. As of May 2024, TLVY homes had a total capacity to serve up to 32 youth. Two new TLVY providers became operational effective July 1, 2024, with capacity to serve 17 youth, bringing total TLVY capacity to serve up to 49 youth.

DoHS continues to make progress on the new RMHTF models of care to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs.

The new model of care emphasizes use of the least-restrictive setting based on the intensity of the child's needs. The new structure will enhance the current residential treatment with the following: residential homes, specialized residential intensive treatment facilities (SRIT), and residential intensive treatment facilities (RIT), with emergency shelters and PRTFs remaining in place as with the previous structure. Figure 103 below provides an overview of these new types of settings.

Figure 103: Proposed program structure: Settings

Residential Homes	• Focus on achieving a permanent family placement • This type of setting would have community-based treatment services and children would attend public school
Specialized Residential Intensive Treatment Facility	• Focus on particular groups depending on specific treatment needs who have historically been sent out of state for care (e.g., sex offenders, individuals on the autism spectrum who have major behavior challenges) • This type of setting would have a specific treatment requirement
Residential Intensive Treatment Facility	• Offer the highest level of treatment services • This type of setting would have a treatment requirement

The residential homes setting is a new community-based placement type which will offer children the opportunity to focus on achieving a permanent family placement without the restrictions of a RMHTF; all treatment services needed will be provided through HCBS

treatment options. This setting was included due to overutilization of RMHTF placements for youth that, simply put, did not need the intensity of RMHTF services and did not have a less-restrictive setting for discharge available. Residential homes enable the child to gain family living skills while also experiencing a less-restrictive environment, enabling them to attend public school and be part of their community.

SRIT and RIT facilities will increase focus on intensive treatment needs, including restructuring facilities to meet specific treatment needs for many individuals who were historically sent out of state due to a lack of available options in West Virginia. The SRIT will offer services for special populations, including those with severe aggression and/or violent behaviors, problematic sexual behaviors, neurodevelopmental and comorbid conditions, and ASD. Facilities will receive a payment rate based on the intensity of the program. When an individual needs more intensive services, a provider may access “add on” payments to support the youth and their needs.

In partnership and ongoing discussions with Casey Family Programs, Building Bridges Initiative, and residential providers, DoHS has explored a variety of ways to transition to the new models of care. In July 2024, DoHS made the decision to accomplish the transition by amending and strengthening policy requirements for supervision and treatment in the residential provider manual. Draft contracts are in development for the new models of care. One provider started an RIT facility in July 2024. Another provider has started the remodel of a home for SRIT services for children with autism. DoHS anticipates the transition of current facilities to the new models of care will occur over a period of time, allowing time for the new models to be piloted. A more detailed plan and timeline for update of the residential provider manual and the associated transition is expected by the end of August 2024. Key components to help ensure quality of care for children and improved child-level outcomes include small group cottages where each child has their own bedroom with specific requirements around family engagement, discharge planning, trauma-informed treatment models, and use of evidence-based programming. Changes in methodology and culture are expected to impact the length of stay and therefore the census, with a goal of reducing the average stay of an individual in a group residential setting to 90 to 120 days. This represents a significant decrease when compared to recent length of stay results: median in-state length of stay for children who were discharged in quarter 4, 2023, was 157 days and 198 days for children in OOS placements. In January 2024, MU finalized the WV Youth in Group Residential and Psychiatric Residential Treatment Facilities – 2023 Report. DoHS and providers are using this report, which includes a cluster analysis of youth in these types of placements, to gain additional insight into WV’s specific needs for residential facility types.

DoHS continues to hold weekly office hours with providers to present information, answer questions and gather feedback, and discuss considerations as this model is developed and implemented. Implementation of the new models of care are critical for supporting the following priorities:

- Helping to ensure children currently placed in RMHTFs are appropriately placed.
- Reducing the average length of stay for children after residential placement occurs.
- Reducing the number of children placed OOS to allow children to receive treatment

closer to their homes and communities.

- Ensuring adequate discharge and transition planning are in place to allow children to be successful in the community once discharged.

17.1 Review Period, Data Sources and Limitations, Population Measured

Figure 104: Overview of RMHTF Data

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2023 Trend data July 2022 through December 2023	FACTS/WV PATH Data System EDS	EDS claims are the data source for parental placements to PRTFs. Claims data account for less than 2% of RMHTF data. Claims data reported here include payments through April 2024. Due to claim billing/reporting lag and data warehouse update cycles, parental placement data for the later part of the study period may be incomplete. Based on the general pattern we have observed, more than 96% of claims with services dates through the end of January 2024 should have been included in the current EDS data. FACTS data includes a static history of active child placements prior to 2023. The new PATH system replacing FACTS went live on January 4, 2023. PATH data may show a brief lag, as field workers may not be able to update the system immediately, particularly around the exit status and timeline of child placements. DoHS is still monitoring the pattern of this lag and impact of the retroactive updating, but the initial analysis shows PATH data are stable after one to two months.	RMHTF enrollment and utilization data for children in state custody are sourced from FACTS/WV PATH. Parental placements of children in PRTFs are sourced from the EDS.
Active Placements as of March 31, 2024	MCO Quickbase system	In prior semiannual reports, this data came from the MCO RMHTF Monthly Report Spreadsheet. Beginning in November 2023, this data was transitioned to Aetna's	Children included in this report related to prioritized discharge planning are in an in-state RMHTF and have a CAFAS/PECFAS

Data Review Period	Data Source	Details and Limitations	Population Measured
		Quickbase system. Due to the relatively recent implementation of this new system, this data set is still being evaluated for quality and completion.	score less than or equal to 130 (i.e., less than 140) and an anticipated discharge date within 60 days after March 31, 2024.
July to December 2023	Aetna's UM Report	CAFAS/PECFAS data for children in residential placement with MCO case management is sourced from Aetna's UM report.	
January to March 2024	Quarter 1 2024 West Virginia Clinical Care Coordination Report	MU publishes a quarterly report with status updates related to assessment and discharge planning for children in OOS placement.	Children in out-of-state residential placement prioritized for discharge planning care coordination.

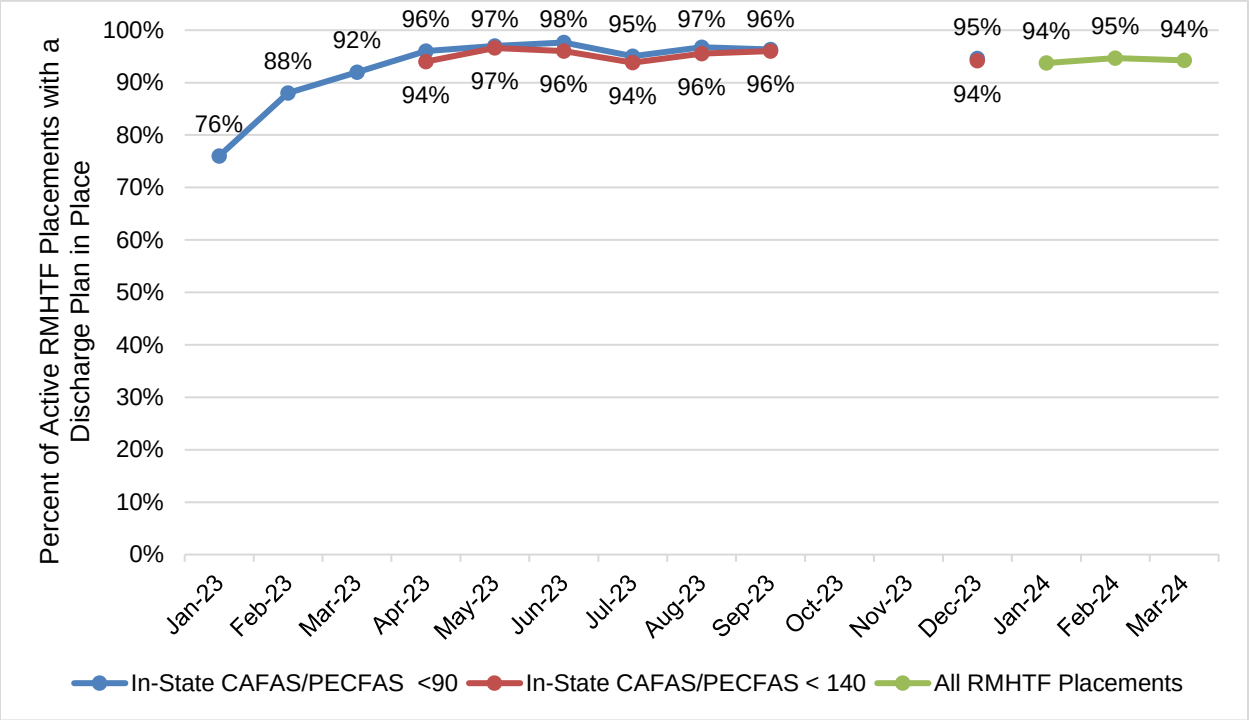
17.2 Review Summary

17.2(a) Prioritized Discharge Planning

DoHS continues to collaborate actively with Aetna and MU to prioritize discharge planning for children currently placed in residential settings. A key part of this effort is ensuring discharge plans are in place for all children in active placement. Through expanded data collection and reporting, discharge plan status can now be monitored for all children who are in in-state and OOS placement as of January 2024. As shown in Figure 105, discharge plans are in place for 94% to 95% of children, which meets the expected threshold.[85] Data for the period prior to January 2024 is for children in in-state placements only and is broken out by CAFAS/PECFAS scores, while data shown for January through March 2024 includes children who are in both in-state and OOS placements regardless of CAFAS/PECFAS score once data for this broader population became available via Aetna's Quickbase system. However, the data might not be reflective of all children in placement, as a comparison of children documented in the PATH system versus those documented in Aetna's Quickbase system identified discrepancies between the systems. Such inconsistencies are to be expected due to the relatively recent implementation and expansion of Aetna's Quickbase system; DoHS is continuing to work with Aetna and MU to address any discrepancies in reporting across Aetna, MU, and the PATH system.

[85] Some allowance is made for lag time associated with time needed to develop discharge plans and submit them through Aetna's authorization process.

Figure 105: Discharge Plan Status for Children in In-State and OOS Residential Placement, January 2023 to March 2024[86]



DoHS continues to monitor CAFAS/PECFAS scores[87] for children who are in residential placement to assist with understanding needs and functional abilities and how they align with available HCBS across the State to work toward addressing any gaps in services. Figure 106 captures the CAFAS/PECFAS score distribution for children in in-state placements[88] with a CAFAS/PECFAS score within the last six months. Thirty percent of children have a CAFAS/PECFAS score less than 90, so they would not qualify for CSED Waiver services and would instead need other services and supports. The balance of children (70%) would potentially be eligible for CSED Waiver services upon discharge. Approximately 6% of the youth with CAFAS/PECFAS less than 90 are aged 18 to 20 and would likely qualify for community-

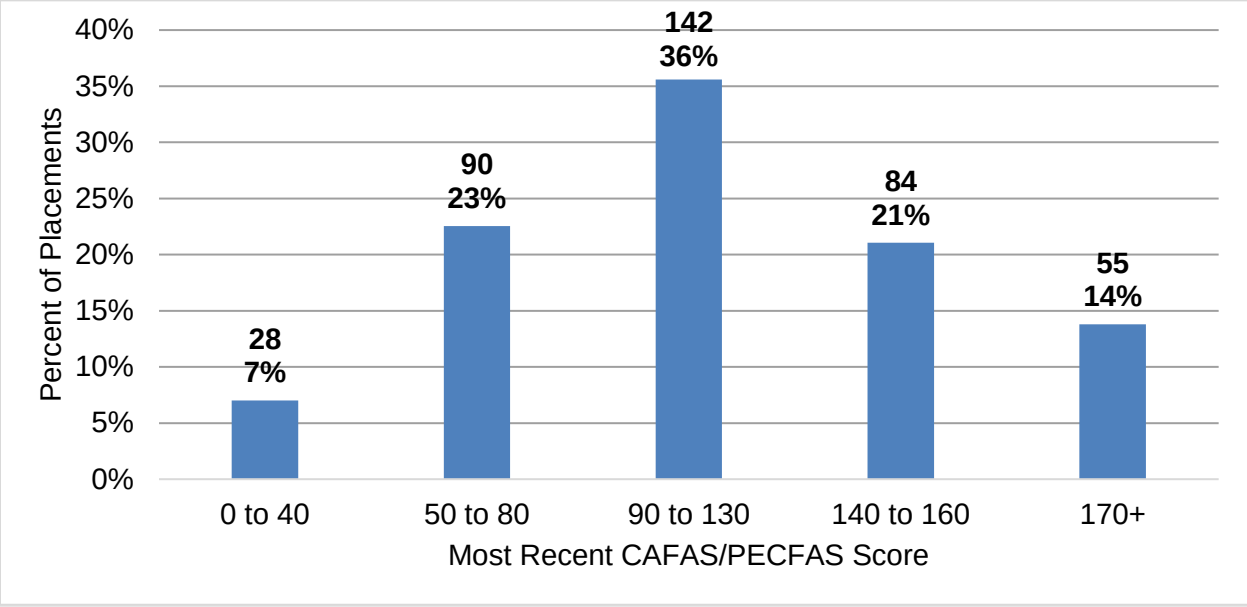
[86] Data are unavailable for October and November 2023 due to a pause in reporting because of Aetna's transition to data collection in the Quickbase system. Discharge plan status for in-state and out-of-state placements in this figure are pulled from Aetna's Quickbase system as input by Aetna's care managers.

[87] CAFAS/PECFAS assessment is used as part of the determination of functional impairment that substantially interferes with or limits a child's role or results in impacted functioning in the family, school, and/or community activities. A CAFAS/PECFAS is expected to be completed every 90 days for children in residential placement. CAFAS/PECFAS score is one measure of a child's appropriateness for placement in a residential setting and is currently being used as a measure of a child's acuity and to identify children for prioritized discharge planning.

[88] CAFAS/PECFAS scores are currently only being reported for children in in-state residential placement. DoHS is currently collaborating with MU to work through data quality and validation of CAFAS/PECFAS scores for children in out-of-state residential placement for future reporting. Prior to MU's contract for clinical care coordination for children in out-of-state placement, CAFAS/PECFAS scores were not required or reported for children in out-of-state residential placements.

based TLVY homes, members of the Quality Committee agreed to follow up on this list of children to ensure referral and connection to TLVY services if deemed appropriate. As noted previously, TLVY home services continue to be expanded to meet the needs of older youth who are ready to live in the community.

Figure 106: CAFAS/PECFAS Score Distribution for Children in In-State Placement as of March 31, 2024 (n = 399[89])



In the first half of 2024, considerable effort went into the establishment of more robust data collection and reporting for the broader residential population to gain a better understanding of the characteristics and needs of children in in-state and OOS placement. As noted in prior DoHS Quality and Outcomes Reports, initial prioritized discharge planning efforts were primarily focused on children in placement with a CAFAS/PECFAS score less than 90. Now that expanded reporting is available and given that children with a CAFAS/PECFAS score less than 140 may be able to be served in the community with supports to meet their needs, DoHS and its partners modified the focus of prioritized discharge planning efforts to include children who are in in-state residential placement with a CAFAS/PECFAS score less than 140 who also have an anticipated discharge date in the next 60 days. The goal is to help ensure all involved stakeholders are focused on addressing any discharge barriers for these children, so they can successfully discharge in the near future as outlined in their discharge plan. These efforts include ensuring that any needed HCBS are in place upon discharge to the community. The information that follows is specific to this newly identified prioritized discharge planning population in active in-state residential placement as of March 31, 2024. Prioritized discharge planning efforts for children in OOS placement will continue to be managed by MU given the intensive care coordination effort and resources needed for this population. MU's prioritized

[89] This figure is not representative of all active in-state placements as of March 31, 2024, due to (1) discrepancies between Aetna's Quickbase system and PATH and (2) some youth in placement having CAFAS scores older than six months. DoHS is working with Aetna and MU to resolve these issues.

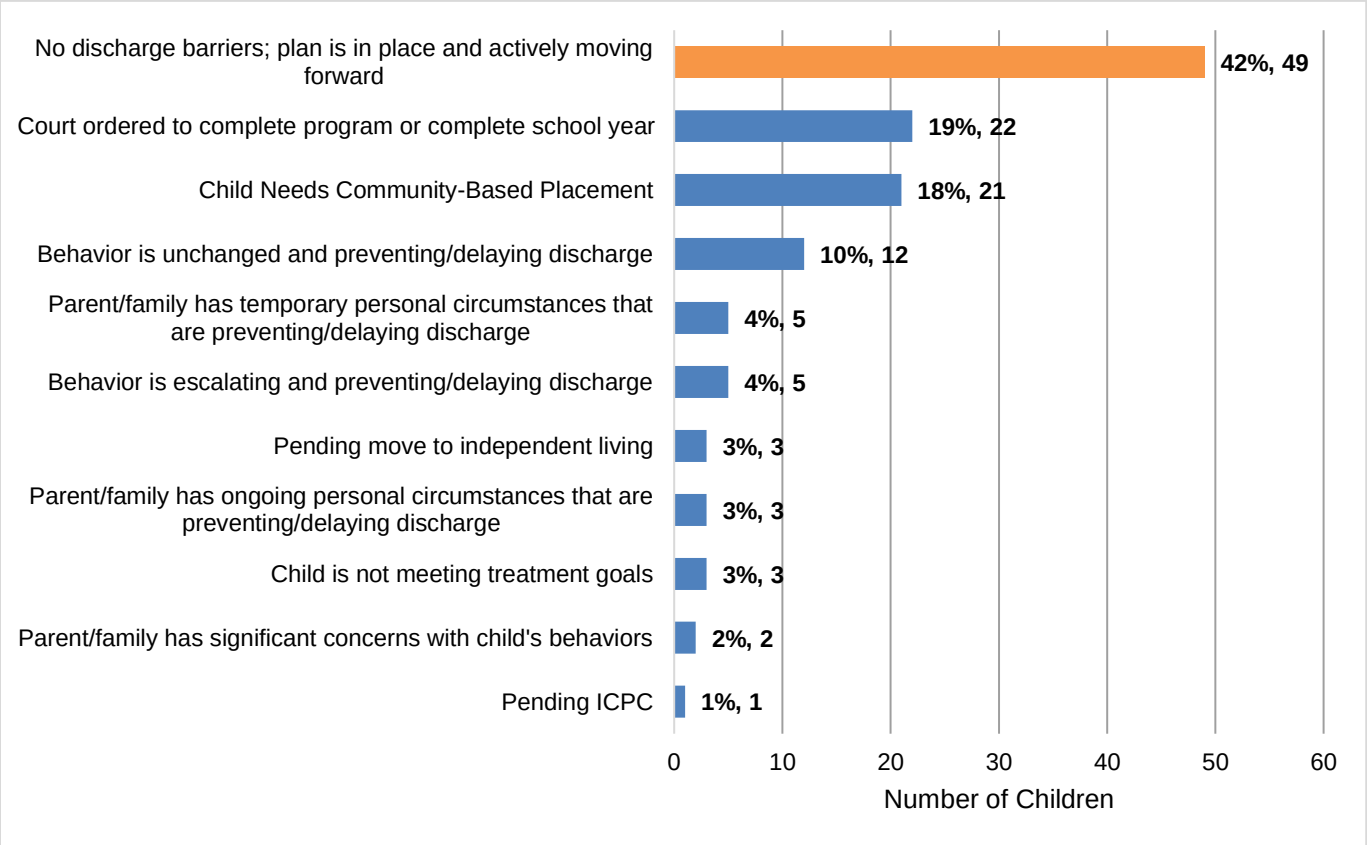
discharge planning efforts are focused on all children in OOS placement irrespective of CAFAS/PECFAS scores. Further details on this effort will be included later in this section.

Sixty-four percent (64%) of the in-state prioritized discharge planning population (n = 117) were male and 35% were female, consistent with 62% male and 38% female in the broader residential population. Seventy-nine percent (n = 93) were ages 13 to 17, 13% (n = 15) were ages nine to 12, and 5% (n = 6) were ages 18 to 20. These age groups are consistent with the broader residential population except for the 18- to 20-year-old age group, which is only 1% of the broader residential population. As mentioned previously, TLVY home services continue to be expanded to meet the needs of 18- to 20-year-old youth.

Primary discharge barriers for the prioritized discharge planning population are shown in Figure 107. Data for 42% of these children (n = 49) indicate there are no barriers; the discharge plan is in place and actively moving forward. As noted in the January 2024 DoHS Quality and Outcomes Report, enhancements were made to the discharge barriers drop-down list as part of Aetna's conversion to data collection in the Quickbase system that went into effect in November 2023 to enable more detailed insight into the barriers preventing or delaying discharge to the community. Based on this enhanced list, the top three barriers for the prioritized discharge planning population are as follows:

- Child is court ordered to complete the treatment program or school year (19%, n = 22)
- Child needs community-based placement (18%, n = 21)
- Child's behavior is impacting discharge (16%, n = 19), stratified as:
    - Behavior unchanged (10%, n = 12)
    - Behavior escalating (4%, n = 5)
    - Parent/family has concerns with the child's behavior (2%, n = 2)

Figure 107: Discharge Barriers for the Prioritized Discharge Planning Population as of March 31, 2024



Court orders to complete the treatment program or school year continue to be an issue impacting residential placements. BSS program managers and supervisors are continuing outreach efforts to the court systems to support changes in this culture. As part of this effort, DoHS is focusing on quality improvements to QIA reporting to capture key information needed to inform court recommendations more effectively. Additionally, Aetna has a weekly to biweekly meeting with residential providers which includes discussions to facilitate moving the culture away from the idea of children needing to complete a program and instead focusing on a child's readiness to discharge based on clinical factors. DoHS will share relevant data in future collaborations with court system representatives as it is expected to take a multi-faceted approach to impact change.

Efforts to address community-based placement capacity are further detailed in Section 14.0 Community-Based Placement Capacity. This continues to be a key area of focus for DoHS and its partners. Additional details on the need for community-based capacity for the broader residential population will be shared later in this section.

Behavior-related barriers are expected to be more effectively addressed through the residential model of care changes, including treatment for specific populations as well as the required use of evidence-based practices and outcomes-based interventions.

Based on discussions in the May 2024 Quality Committee review, there may still be some degree of underreporting of discharge barriers. Essentially, there may be times where children with barriers do not have those barriers documented due to an issue of awareness, barriers not being documented accurately, or the documentation may reflect only some and not all barriers for children with multiple barriers to discharge. To address this potential issue, Aetna created definitions for each of the discharge barriers in the drop-down list and continues to revisit and educate on the importance of accurately capturing the barriers with their care managers.

Effective June 2024, the list of children who are in the in-state prioritized discharge planning population is being updated monthly and shared between the BSS and Aetna teams. BSS workers and Aetna care managers work together to identify barriers and transition plans with oversight from BSS program managers. BSS and Aetna leadership meet biweekly to review progress and develop strategies to address specific discharge barriers and are collaborating to help ensure a team approach across the child, family, BSS staff, Aetna, and other stakeholders to address identified barriers to help support timely transitions to the community. This list will be updated and shared monthly. Future reporting is expected to capture the impact of these efforts.

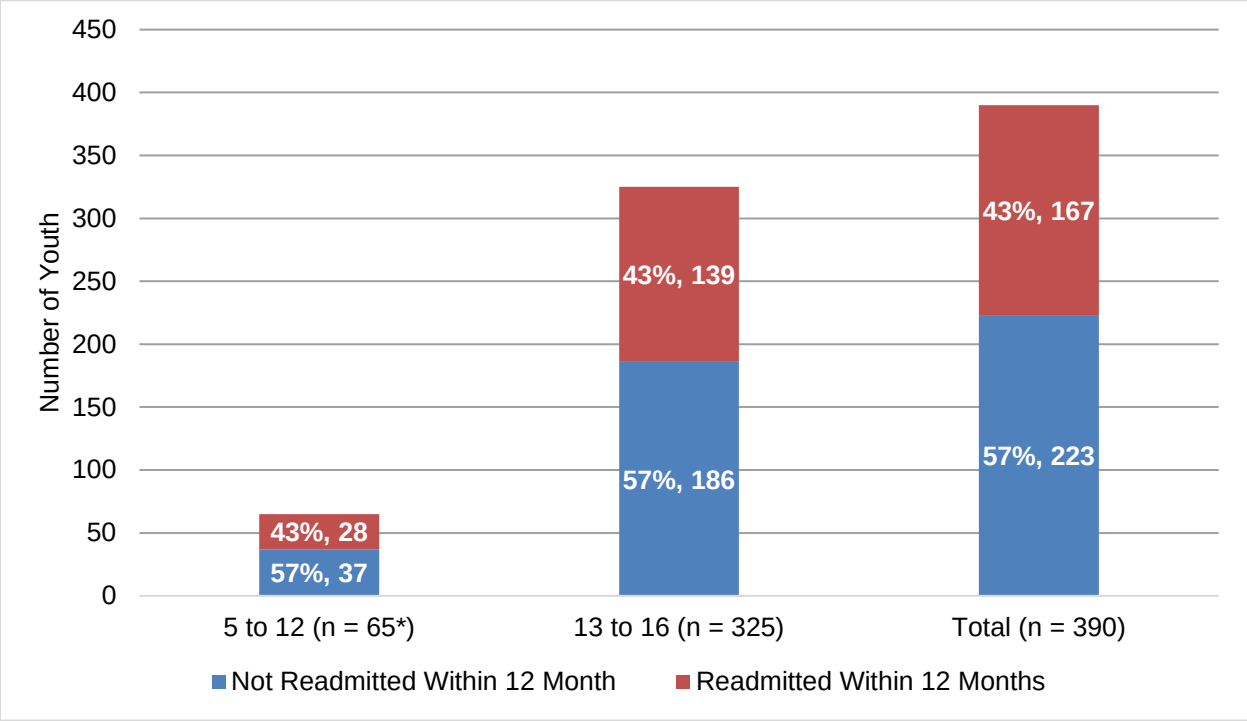
DoHS and CPAs completed an evaluation of the possible implementation of an electronic referral process for making referrals to CPAs for children in need of foster care. A pilot of the findhelp system is currently being planned. The timeline for this pilot has not yet been determined. DoHS is continuing to collaborate with Aetna and CPAs to streamline these processes and expand community-based placement capacity to meet the needs of difficult to place children. Following review of the data in the November 2023 Quality Committee review, the committee recommended reviewing and considering more specifically defining the roles and responsibilities of Aetna and CPAs associated with this process. DoHS has initiated conversations around this need beginning in December 2023 and continues to monitor progress on Aetna and CPAs collaboration regarding Faces to Cases Presentations which allow further opportunity to place a spotlight on children in need of a caring foster home and highlight information about the child and positive information to help with identifying or recruiting a family for the child. This will be revisited further following the implementation of the electronic foster placement referral system.

17.2(b) Residential Readmission

Some children may not be successful in the home and community and therefore may experience multiple placements in RMHTFs (i.e., readmissions) during their life cycle of care and support. DoHS is focused on efforts with the Assessment Pathway to offer children and families home and community-based interventions to decrease the number of readmissions children experience. To gain a better understanding of the number of children who readmit following discharge from an RMHTF for purposes of using this information to influence discharge planning efforts, DoHS identified a cohort of children who were discharged from an RMHTF in July to December 2022 (n = 390). A cohort during this period was chosen to allow sufficient lag time to assess for readmission. This cohort excludes youth 17 years old and up who would not be eligible for in-state readmission for the full 12-month period, past their 18th birthday.

DoHS completed an analysis of readmission by age (Figure 108) and found that there is little to no impact on readmission related to age: both younger kids (aged less than or equal to 12) and older kids (aged 13 to 16) readmit at the same rate: 43%.

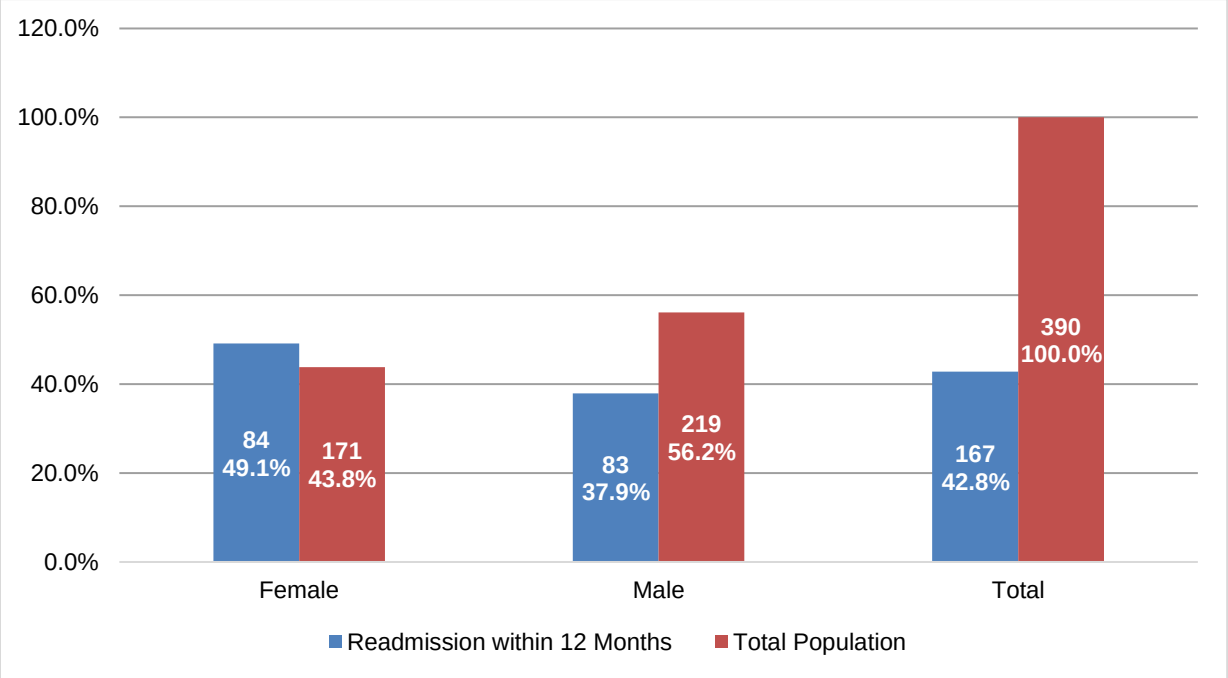
Figure 108: Readmission by Age Group for Discharges July to December 2022 (n = 390)



***Note:** Children ages five to eight were included with the nine to 12 age group due to a very low n for children in the five to eight age range.

DoHS evaluated the gender of children readmitting (Figure 109) and found that females are 30% more likely to readmit within 12 months of discharge compared to males (relative risk of 1.30, p = 0.03) – even though females comprise a smaller proportion of the overall RMHTF population. In other words, females comprise only 44% of the overall population, but 49% of children readmitting.

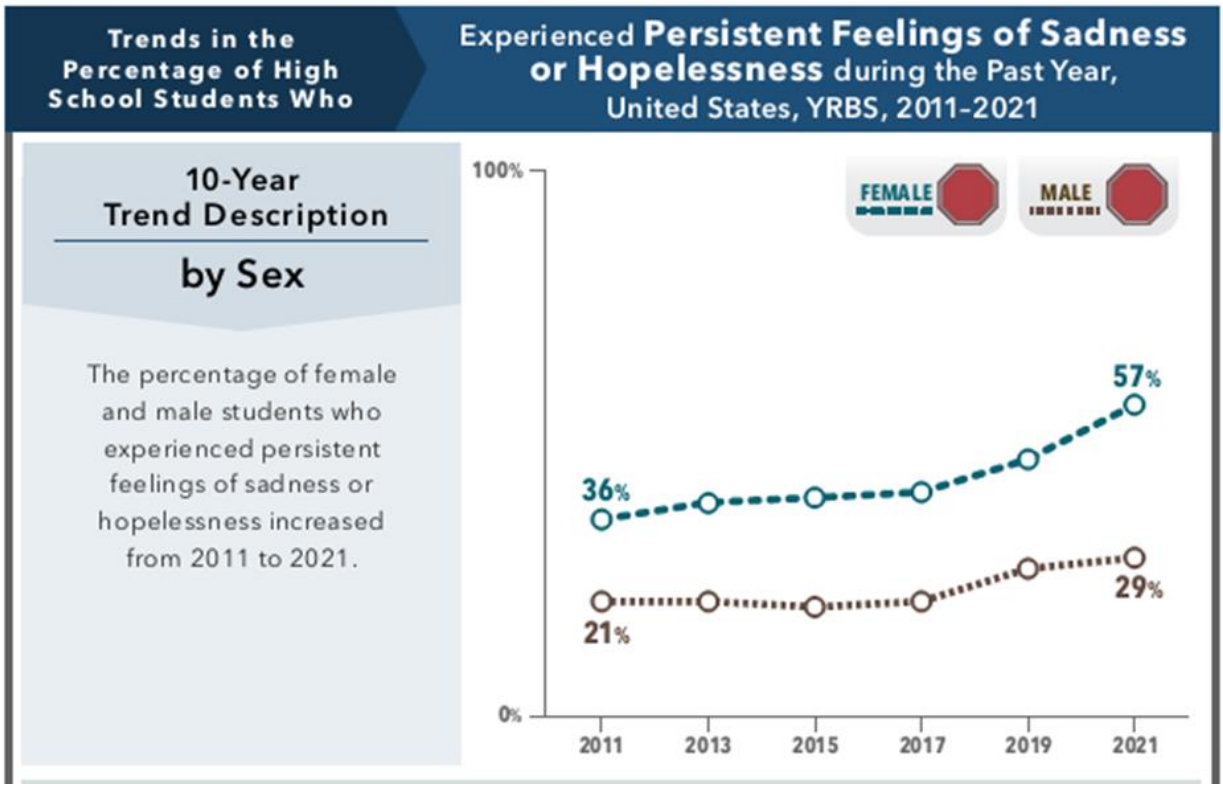
Figure 109: Readmission by Gender for Discharges July to December 2022 (n = 390)



In follow-up to the higher rate of readmission of females compared to those in the broader RMHTF population, DoHS reviewed the YRBS.[90] Trends for mental health indicators have been increasing since 2011, which is expected given factors related to SUD and child welfare increases. However, for the indicators such as contemplating suicide and persistent feelings of sadness or hopelessness, most of the increase since 2019 (i.e., pre-pandemic) documented in the YRBS is driven by females (Figure 110). It is difficult to know how to interpret this information in the context of readmissions, but these trends demonstrate a change in mental health-related factors for female children following the pandemic. BSS and Aetna leadership reviewed this information and agreed that discharge planning for female children should focus on ensuring services are in place immediately following discharge to meet their unique needs.

[90] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Figure 110: Trends in Percentage of High School Students Who Experienced Feelings of Sadness or Hopelessness, 2011 to 2021



DoHS also completed an analysis of readmission rates compared to the timeliness of HCBS following discharge from residential treatment. While additional analysis is needed, preliminary data appears to show an association between having HCBS within 30 days following discharge date and lower rates of readmission. Based on this information, DoHS will continue efforts to influence timely access to services. The Quality Committee discussed the need to incorporate CAFAS/PECFAS scores into the analysis as a measure of acuity to help with a more in-depth understanding of the results related to services accessed and the timeliness of those services post-discharge. CAFAS/PECFAS score data for this cohort was unavailable for analysis. CAFAS/PECFAS scores have been collected since March 2023 and are expected to be included in future analyses.

As a next step, the Quality Committee would like to explore readmission for a larger cohort of children, including expanding the analysis to include CAFAS/PECFAS scores and length of stay in conjunction with the other factors discussed throughout this section. DoHS is also planning additional analysis related to the utilization and timeliness of services following discharge to the community and associated impacts on readmission.

17.2(c) Residential Services

The following figures depict information for children in state custody who are placed in residential settings and parentally placed children in PRTFs. Demographic information for children in residential settings is reported in Section 4.0 WV's Child Population and Individuals

Utilizing Services.

For purposes of quality improvement, understanding county-level changes, and identifying where to focus efforts, DoHS continues to track residential placement rates by child's county of origin. To normalize this analysis, unduplicated headcount (i.e., the number of unique children who were in RMHTF placement at any time during the identified review period) per 1,000 children under age 20 by county was used. Figure 111 shows the percent change in RMHTF unduplicated headcount by county comparing two six-month periods, July to December 2022 and July to December 2023.[91] Specific rates by county for these two six-month periods are shown in Figure 112. The overall statewide average increased 8.7% from July to December 2022 to July to December 2023. The statewide average placement rate increased from 3.1 children in an RMHTF per 1,000 children July to December 2022 to 3.4 in July to December 2023.

Fourteen counties (highlighted in orange in Figure 111) had an increase of greater than or equal to 25% between the two periods, while four counties (highlighted in green) had greater than or equal to a -25% decrease. The remaining 32 counties had sustained rates, except for six counties that were excluded due to having a headcount of less than five in July to December 2023. Of note, many counties in West Virginia are rural with smaller child populations, so small changes in headcounts can cause great influence for changes in rates.

[91] Due to historical patterns of seasonality associated with RMHTF service utilization, the six-month periods for comparison include the half of the year being reviewed compared to the same period in the prior year.

Figure 111: Percentage Change in RMHTF Unduplicated Headcount Per 1,000 Children Under 20 by County of Origin, July to December 2022 vs. July to December 2023

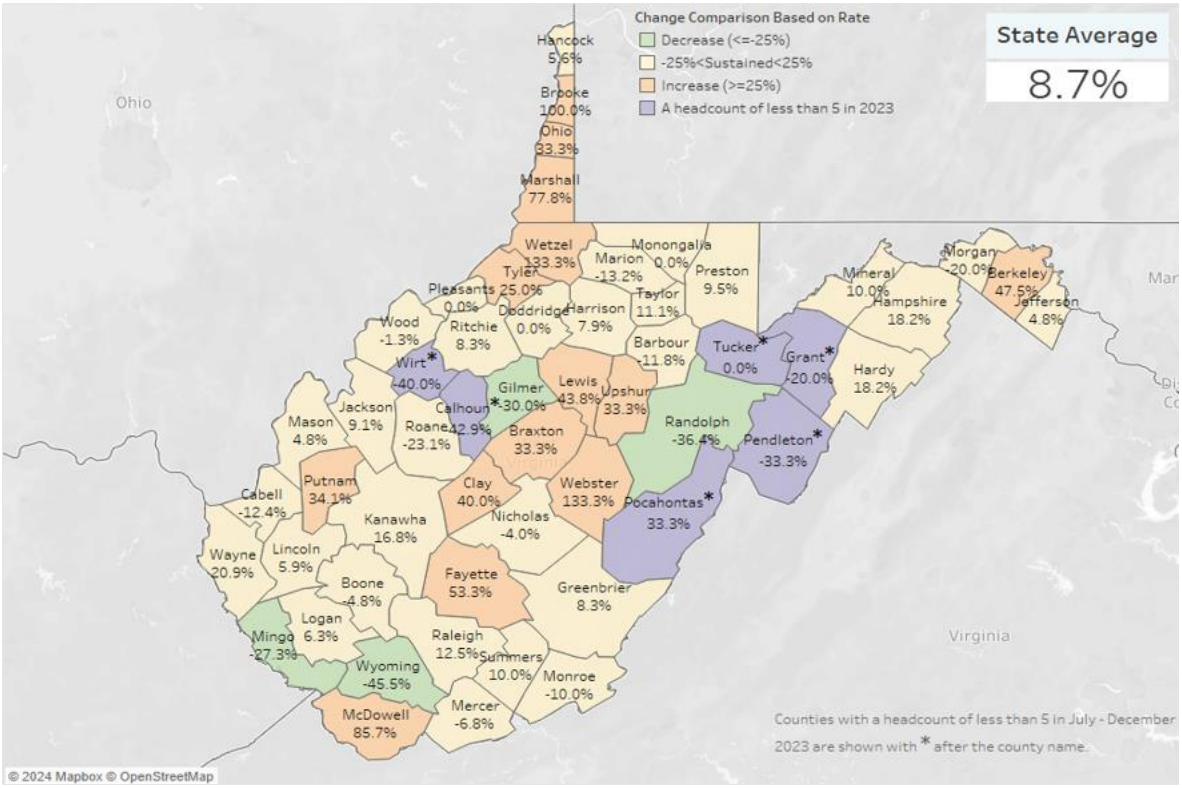
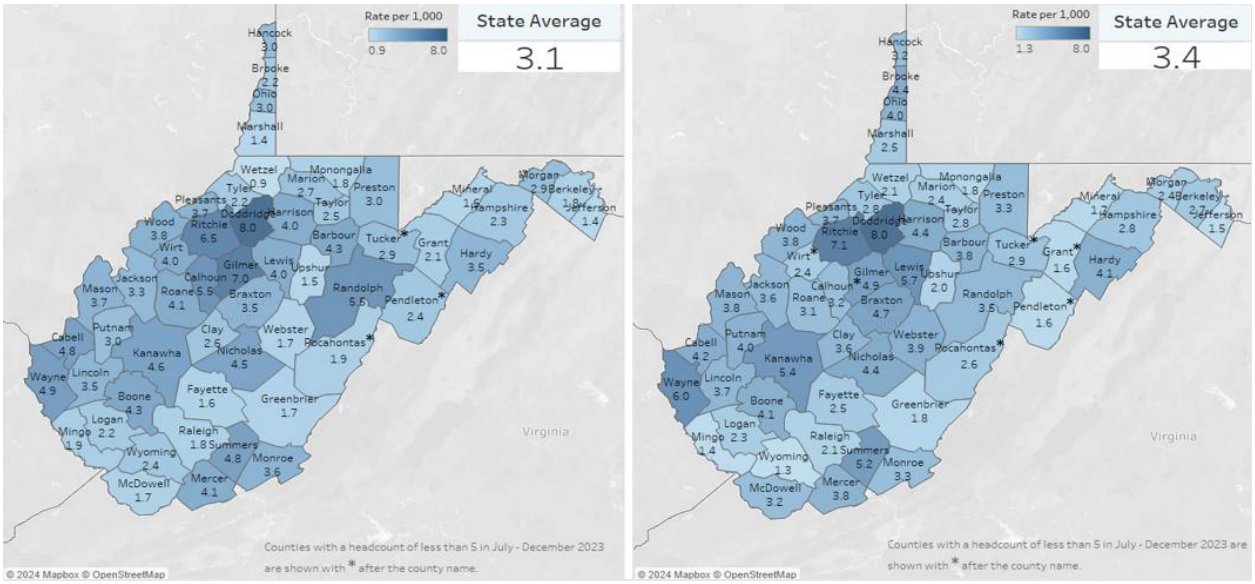


Figure 112: Placement Rate Comparison for Six-Month Period, July to December 2022 vs. July to December 2023 (left-to-right)



The Quality Committee discussed county-level changes at length and the varied factors and circumstances influencing changes in RMHTF utilization at the county-level. One common theme was children being court ordered to receive treatment. The group discussed differences

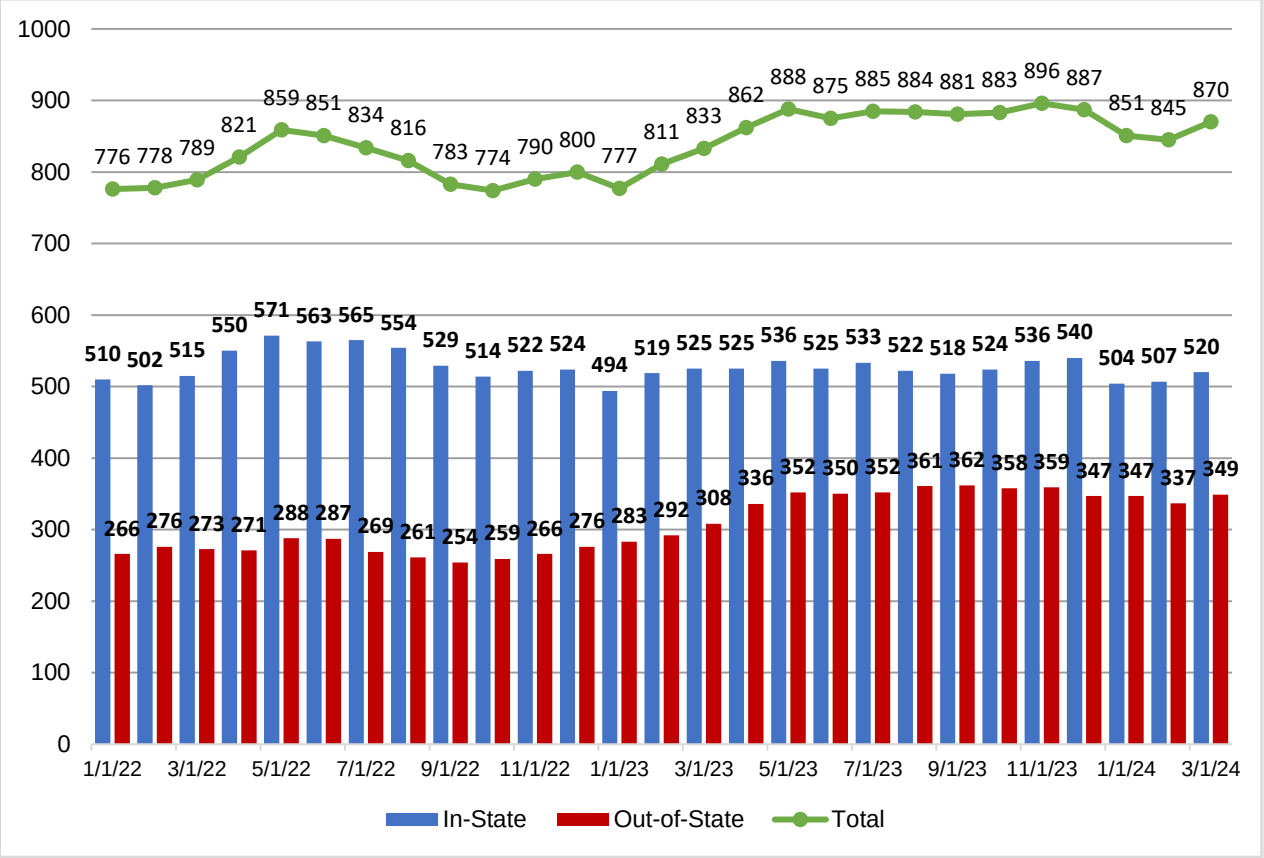
in the court system cultures and dynamics in various counties and the associated impacts on communication and collaboration with BSS workers. The group also discussed the return to in-person schooling following the pandemic impacting increased RMHTF utilization. The West Virginia Department of Education is observing an increase in the severity of behavioral issues following return to in-person schooling, specifically when looking at the reasons for disciplinary action, increases in the severity of behavior has been noted (reference Section 18.0 Outcomes). The group requested further analysis of county-level utilization compared to other factors such as QIA referrals. In response, DoHS initiated a more sophisticated county-level analysis that incorporates additional key indicators by county such as Assessment Pathway referrals, QIA referrals, CCRL utilization, CMCR utilization, CSED Waiver approvals and service utilization, foster capacity, provider capacity and judicial outreach. The goal is to begin to understand influences between these indicators and how they are impacting RMHTF utilization at the county level. This information will be used to prioritize and drive focused efforts in specific counties. Please reference Section 6.0 Marketing for further detail.

Point-in-Time Census

Figure 113 captures the monthly point-in-time census for January 2022 to March 2024. The census began increasing in early 2023 then remained relatively stable from May through December 2023. The census from January to March 2024 is considered preliminary and may be subject to change due to data entry lag considerations. The increase in census in the first half of 2023 was driven by increases in both in-state and OOS census, although OOS demand was higher. Throughout 2022, the ratio of in-state compared to OOS placements was approximately 65% in-state and 35% OOS. From January to May 2023, the ratio began shifting with an increase in the percentage of OOS placements each month. From May 2023 through March 2024, the ratio of in-state to OOS placements remained steady at 60% in-state and 40% OOS. The historical decrease in census over the summer months (which is related to school not being in session) was not observed in summer 2023; therefore, the census was sustained over the summer and through the end of 2023. Census trends have seen increased numbers of parental placements since quarter 2 2022. These placements make up only a small portion of overall census (n=40 as of December 2023) but have increased by 54% since January 2022 (n=26). As noted previously, the YRBS confirmed an increase in mental health-related indicators in children following the pandemic, which may also be a contributing factor. To understand the significant and sustained increase in census in greater detail, the Office of QA also reviewed ESSENCE data. When comparing the percentage of mental health visits to the ED from the last half of 2022 (8.3%) to the first half of 2023 (11.4%), a percent increase of 37% was seen. These data, which are reviewed in greater detail in Section 4.0 WV's Child Population and Individuals Utilizing Services, show emerging needs, and align with observed changes in RMHTF census.

Based on a prior request from the BSS program team to incorporate comparisons to child removal rates and juvenile petitions filed into future analyses of census, a preliminary analysis has been completed and is planned for an upcoming internal review to be validated for more broad and consistent use. Juvenile petitions are the primary entry point to RMHTF settings in YS cases. Monitoring and evaluation of county-level trends in petition filings may be indicative of placement rate changes observed in RMHTF and PRTF settings.

Figure 113: Monthly RMHTF Point-in-Time Census*, January 2022 to March 2024



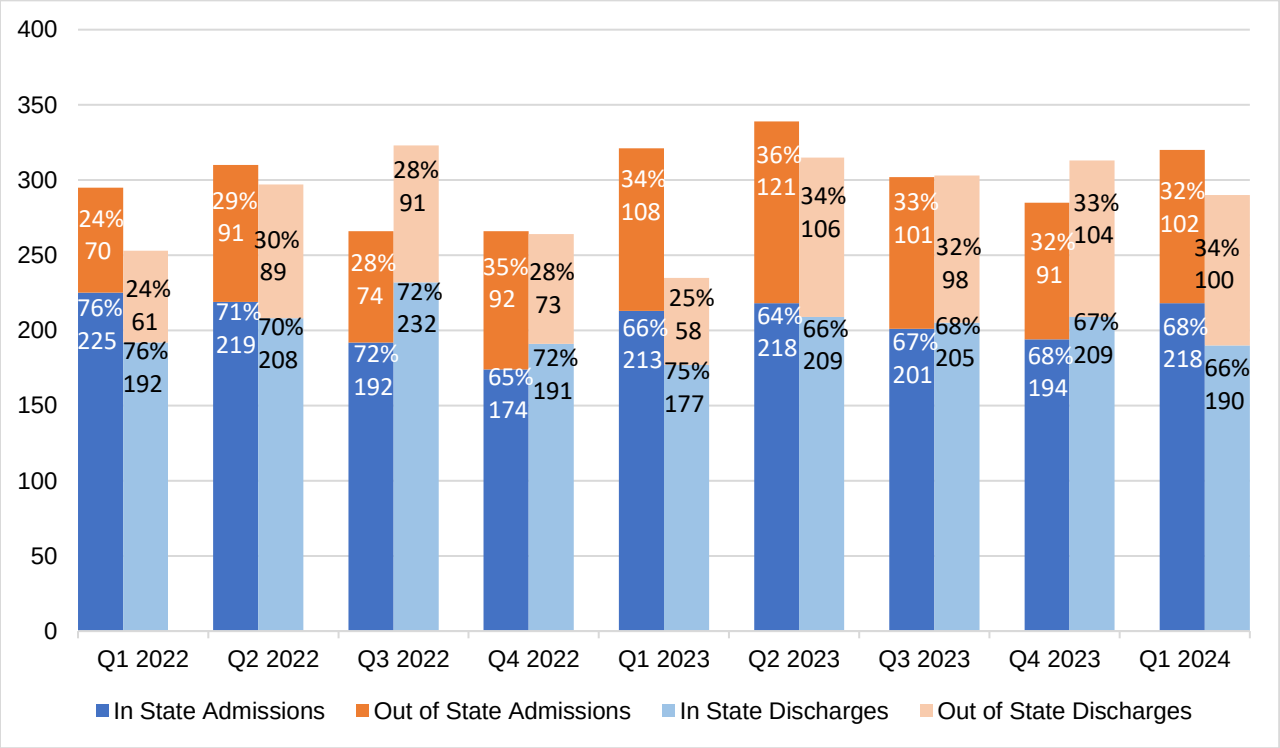
***Note:** In some months, the sum of in-state and OOS census may be slightly less than the total headcount due to a small number of placements with incomplete data related to in-state status.

Admission and Discharge Trends

To understand trends, and seasonality in census trends, year over year in greater detail, DoHS completed an analysis of in-state and OOS admissions versus discharges by quarter for January 2022 to March 2024 (Figure 114). As noted above, the census increase in the first half of 2023 was driven by admissions, largely OOS admissions, as can be seen in quarters 1 and 2 2023 compared to quarters 1 and 2 2022. Some increases in admissions in Q1 are expected due to children returning to care following the holidays, although the increase between Q1 2023 and Q1 2022 is particularly striking. Q3 2022 follows the typical pattern of discharges exceeding admissions associated with summer break from school. This pattern was not observed in Q3 2023 and, therefore, higher census levels were sustained. Positively, there is a 65% increase in OOS discharges in Q1 2024 (100 discharges) compared to Q1 2022 and Q1 2023 (61 and 58 discharges respectively). This increase highlights the work of the MU clinical team supporting prioritized discharge planning for children in OOS placements. This significant increase in OOS discharges is largely offset by OOS admissions remaining at typical levels, therefore, OOS census has remained steady.

DoHS recognizes that transitioning to the new residential model of care with expected shorter lengths of stay combined with development of increased community-based placement capacity are needed to materially impact the demand for RMHTF services. As noted elsewhere in this report, this work is in progress, and it will take time for the effects to be realized.

Figure 114: In-State and OOS Admissions Versus Discharges by Quarter, January 2022 to March 2024



OOS Placements Update

DoHS continues to make process enhancements to impact OOS placements. DoHS's goal is to bring children back to WV to assist with building connections and networks of support in their local communities, including engagement with their schools and families, to improve the possibility of reunification. To support this goal, effective April 1, 2023, BSS contracted with MU to complete CAFAS/PECFAS, CANS assessments, QIA, and discharge plans for all children in OOS residential treatment facilities and psychiatric treatment facilities. The MU clinical care coordination team reviews each case and makes recommendations and assists with the development of the discharge plan and implementation of that plan. When a residential treatment option is the most appropriate level of care, the team determines if an alternative in-state residential treatment provider within proximity to the child's community is available and, in the child's, best interest. In the last six months of 2023, DoHS collaborated with Marshall to establish specifications for data collection associated with children in OOS placement. MU's data collection was operationalized in January 2024. DoHS is collaborating with MU to address data quality and reporting and will eventually incorporate this dataset into the data store in alignment with those being captured in Aetna's Quickbase system for children in in-state placement. Once completed, the expanded data will enable more robust analyses of children in

in-state and OOS placement. DoHS is seeking to understand any differences between children placed in-state versus OOS to determine what, if any, unmet needs or gaps in services exist within the current in-state service array and use this information to further refine and influence the new models of care.

Per the quarter 1 2024 report from MU, CAFAS/PECFAS and CANS assessments were completed for 87% of children in active OOS placement in March 2024. More information on care coordination and discharge planning for children MU is working with OOS is available on the Kids Thrive website via MU's West Virginia Intensive Clinical Care Coordination Report (March 2024). DoHS is working with MU and Aetna to further align and validate reporting efforts to allow aggregation of results.

To support diversion efforts for OOS placements, DoHS developed an electronic referral process to capture, track, and report on children who are recommended for OOS placements. This new system was rolled out in December 2023 and is accessible by BSS workers, supervisors, program managers, and child welfare consultants. The system creates process efficiencies, including the elimination of paper documents, the addition of automated notifications, and tracking of information in a dashboard format for ease of monitoring the status of each child in the process. Additionally, the system captures the reason(s) for the OOS placement request which will assist with identifying any gaps in in-state services. DoHS is still working through some system reporting implementation obstacles, therefore the data has not been validated and is not included in this report but is expected for inclusion in future reports.

DoHS recognizes that the long-term impacts of service system changes over the last three and a half years, including implementation of CSED Waiver services, the QIA process, and MU's clinical team involvement with OOS placements have not yet been fully realized. As such, the opportunity to demonstrate full impact on residential treatment may not yet be evident. Continued focus on screening and referral, evaluation and connection to services, and development of additional community-based capacity (e.g., CSED Waiver, Behavioral Support Services, foster and kinship homes, and TLVY homes) are the appropriate next steps and will take additional time to produce intended results. Additionally, the new models of care for residential services will focus on intensive, evidence-based, short-term treatment (i.e., three to four months), reducing the number of children lingering in placement. In the coming year, DoHS's ongoing prioritized focus will be on rollout and operationalizing the new models of residential treatment and the development of additional community-based capacity alternatives.

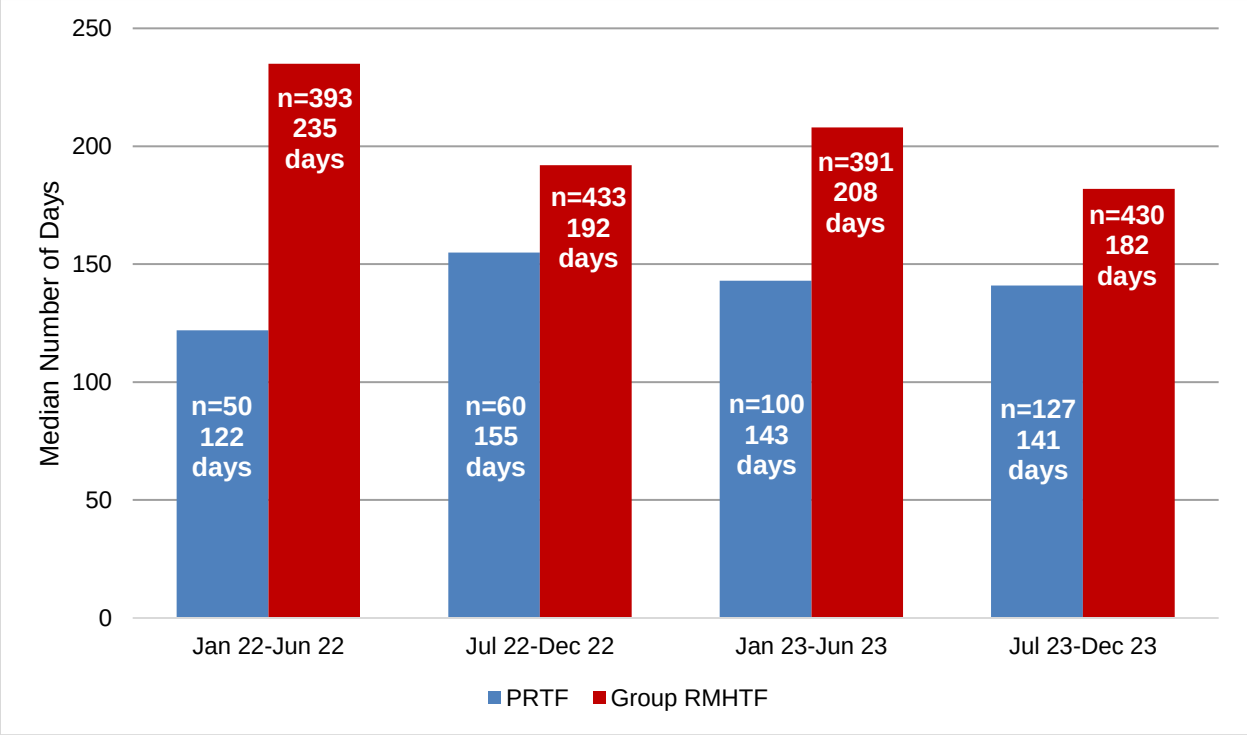
Length of Stay

DoHS continues to explore ways to analyze length of stay more effectively for children in residential settings. The figures throughout this section represent a variety of periods, as DoHS is in the early stages of seeking to understand factors impacting length of stay. Median length of stay is represented to capture trends more accurately, since children with long lengths of stay can skew the mean. Length of stay results shown in Figures 116, 117, and 118 are calculated based on children who discharge during each period and therefore do not include ongoing stays.

Figure 115 provides a comparison of median length of stay by facility type across six-month

periods from January 2022 to December 2023. This analysis includes children who are in in-state and OOS facilities. While some fluctuation is noted for both group RMHTF and PRTF length of stays across the six-month periods, group RMHTF shows an overall decrease. These results are a positive indicator of the focused efforts on discharge planning described in Section 17.2(a).

Figure 115: Comparison of Median Length of Stay by Facility Type, Comparison of Six-Month Periods, January 2022 to December 2023



***Note**: Excludes short-term acute psychiatric hospitalization due to small n.

Figure 116 captures median length of stay trends by quarter for the Q1 2022 through the Q4 2023 for children in in-state RMHTF placement, while Figure 117 captures median length of stay trends for children in OOS placement for the same period. The total number of discharges by quarter is also represented in each figure. Comparing in-state median length of stay for the first three quarters of 2023 to the same period in 2022 shows that median length of stay was largely unchanged. Q4 2023 compared to Q4 2022 shows a large drop in median length of stay from 198 days to 157 days, representing a 21% decrease. While DoHS will continue to monitor length of stay trends, these results are promising. OOS median lengths of stay decreased significantly throughout 2022 and have remained unchanged throughout 2024. As noted previously, DoHS contracted with MU in April 2023 to focus on discharge planning for children in OOS placement. Year over year comparison of total discharges shows a 22% increase in the number of discharges per quarter following this focused effort to return children to their local communities in West Virginia, with total discharges per quarter remaining relatively stable since MU's initial involvement. DoHS will continue to monitor length of stay trends in combination with

admission, discharge, and readmission trends to expand future understanding. Additionally, DoHS expects implementation of the new residential models of care may also impact lengths of stay and monitoring will continue as this transition occurs.

Figure 116: RMHTF In-State Median Length of Stay

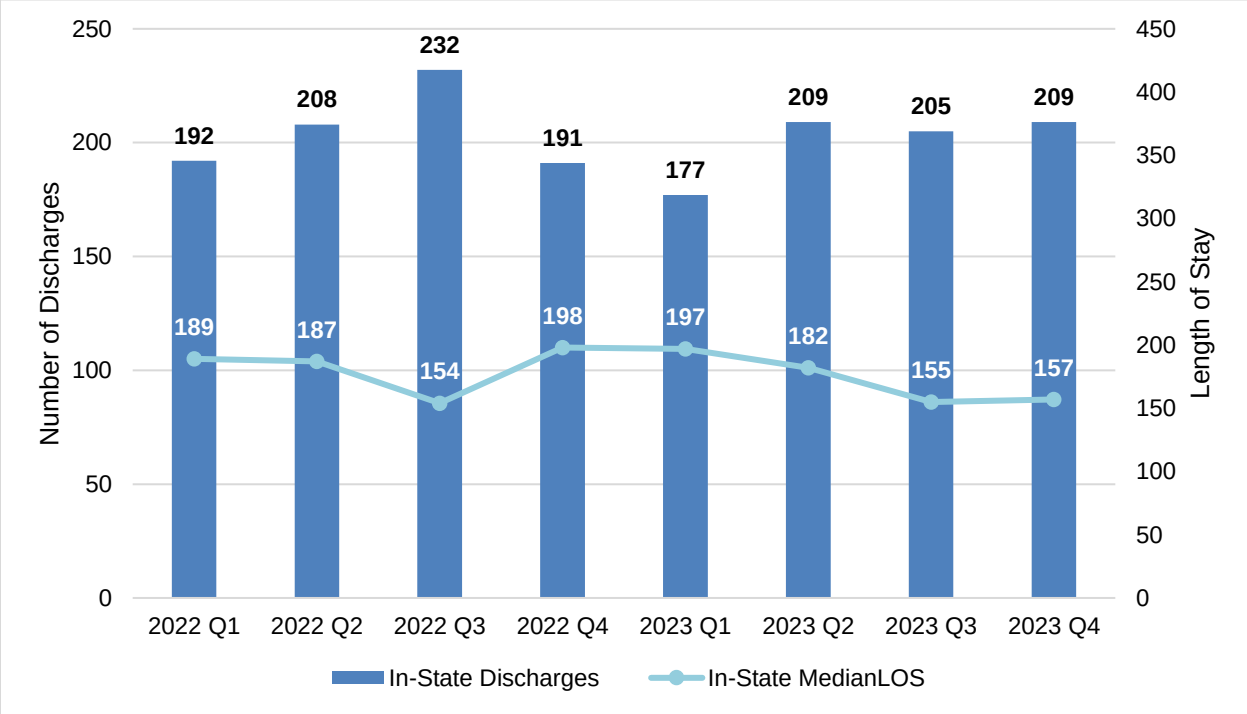
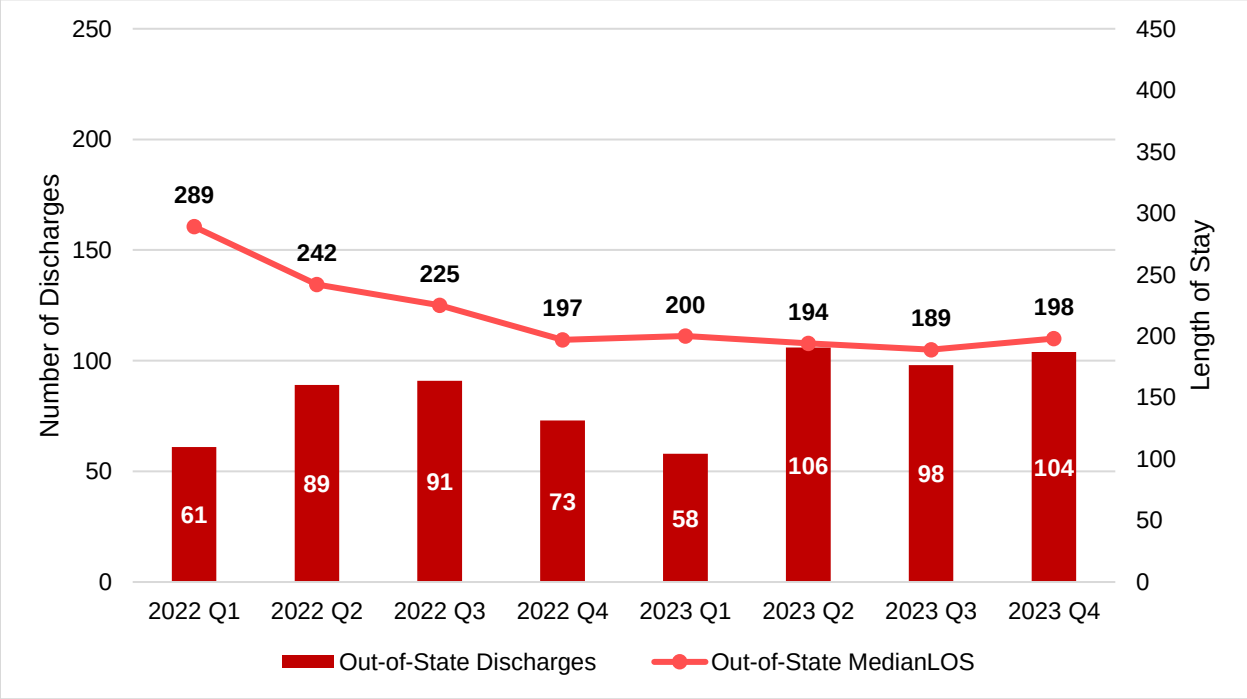
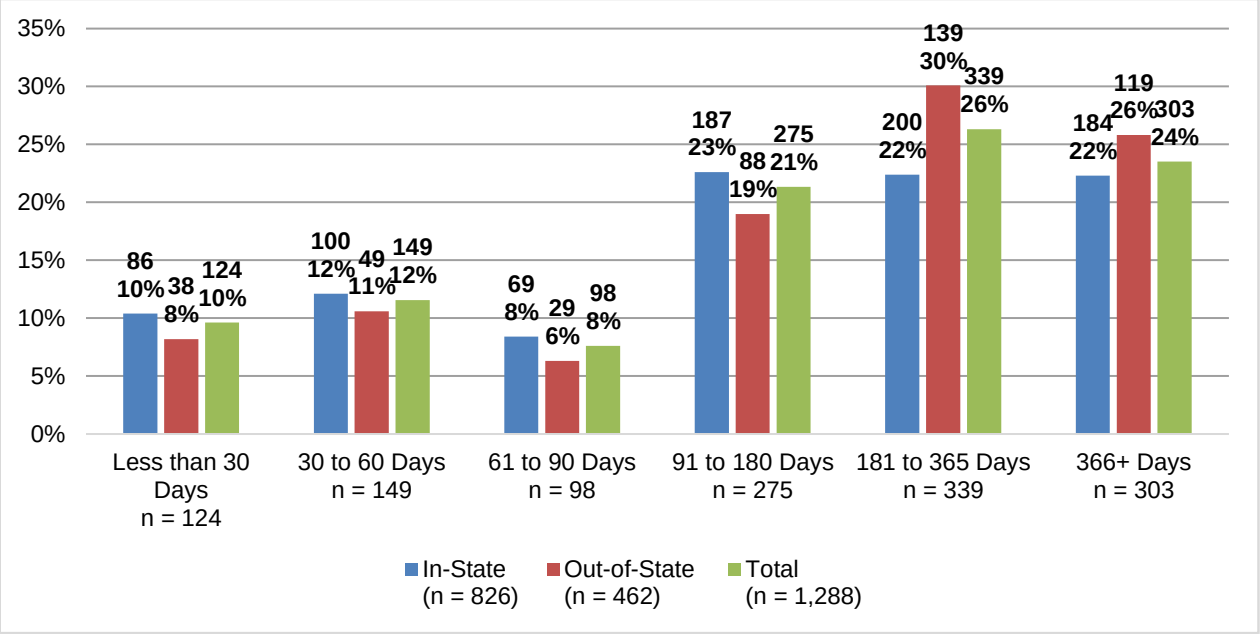


Figure 117: RMHTF OOS Median Length of Stay



Historically, DoHS has analyzed length of stay based on children who were discharged during the relevant period of review (i.e., completed stays). To understand how length of stay is impacted by "long stayers," DoHS completed an analysis of a cohort of children that includes active placements (i.e., ongoing stays) as well as those who were discharged. Figure 118 below shows in-state and OOS median length of stay distribution for children who discharged during the period as well as children who were in active placement. For those children still in active placement as of March 31, 2024, this date was used to calculate their length of stay. In-state median length of stay including active placements is 166 days. OOS median length of stay including active placements is 207.5 days. During the Quality Committee review, it was noted that 70% of children in active placement during this time had a length of stay greater than 90 days and 24% have a length of stay greater than one year. When comparing in-state and OOS placements, children in OOS facilities made up the greatest percentage of extended lengths of stay. DoHS anticipates using this analysis as a baseline to understand how lengths of stay are impacted once the new model of care is fully implemented.

Figure 118: In-State and OOS Median Length of Stay Inclusive of Active Placements, December 1, 2023, to March 31, 2024 (n = 1,288)



DoHS recognizes that further development of community-based placement capacity, as well as operationalizing the new residential models of care, will influence lengths of stay. DoHS will continue to monitor these trends as the new model of care is implemented later in 2024 and into 2025. DoHS anticipates future analyses of length of stay may be stratified by other factors such as CAFAS/PECFAS scores, discharge barriers, diagnoses, etc. DoHS will continue efforts to improve understanding of the characteristics and circumstances of children who discharge quickly versus those who remain in residential placements for an extended time.

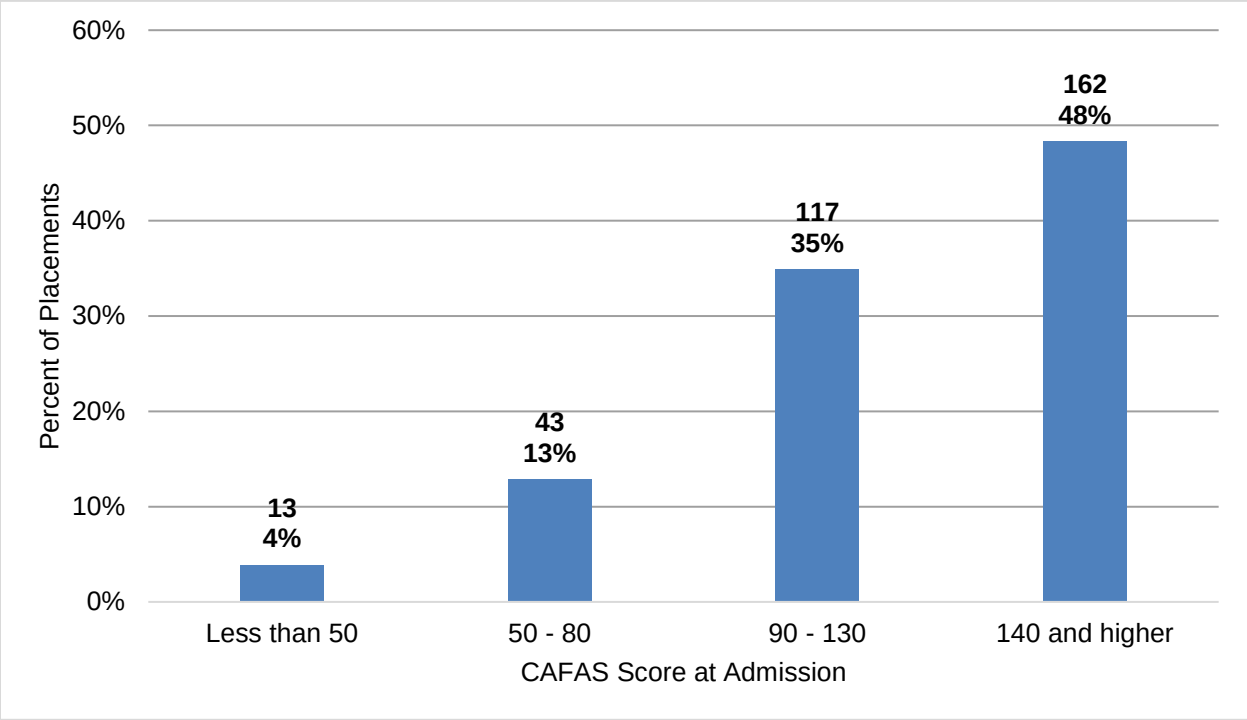
CAFAS/PECFAS Score Analysis and Trends

Due to improvements in data collection and child-level matching in late 2023, DoHS can evaluate CAFAS/PEFAS scores at admission and over time for in-state RMHTF placements. The CAFAS/PECFAS is required to be completed upon admission and every 90 days thereafter as part of Aetna's UM. As noted previously, MU has established data collection, including CAFAS/PECFAS scores, for children in OOS placement. This dataset is currently in the process of review for data quality and validation and will be included in future reporting once validation is completed.

The distribution of CAFAS/PECFAS scores for children admitted to in-state RMHTF placement July to December 2023 with a CAFAS/PECFAS completed within 45 days of admission (n = 335) is shown in Figure 119.[92] Median CAFAS/PECFAS score at admission is 130. Seventeen percent (17%, n = 56) entered placement with a CAFAS/PECFAS score less than 90. The Quality Committee reviewed the range of CAFAS/PECFAS scores for children entering placement and discussed how this data might be used to develop future opportunities for diversion and assist with understanding potential gaps in HCBS. The group also discussed continued challenges associated with the QIA process, which helps assess the clinical needs of children before admission to an RMHTF. Ongoing implementation of the QIA process and improvements to the quality and timeliness of QIA recommendations are anticipated to assist with decreasing admission of children who may not be clinically appropriate for residential treatment (Reference Section 9.0 QIA for further details). Based on a prior Quality Committee recommendation to evaluate possible differences in the administration of CAFAS/PECFAS, an analysis of CAFAS/PECFAS score by provider was completed and is planned for inclusion in an upcoming internal review. The Quality Committee also discussed possible next steps, including a comparison of QIA-related CAFAS/PECFAS scores to those of residential providers in future analyses, as well as considering possible technical assistance related to CAFAS/PECFAS administration depending on the results of these analyses.

[92] Children in out-of-state residential placement and short-term, acute PRTF as well as children who discharged within 45 days following admission were excluded from the analysis. CAFAS/PECFAS assessment is not expected for children in short-term PRTF due to the short-term nature of this treatment. CAFAS/PECFAS scores for children in out-of-state placement are currently unavailable for reporting but can be expected in future reports.

Figure 119: CAFAS/PECFAS Score Distribution for Children Admitted to RMHTF, July to December 2023



Following full implementation of the new model of care, DoHS may consider further analysis of changes in CAFAS/PECFAS scores during treatment as a first step toward using these scores as one possible measure for monitoring the effectiveness of residential treatment. The new models of residential care include a requirement for use of evidence-based practices with expected shorter, high intensity intervention, followed by timely return to the community.

17.3 Provider Capacity/Statewide Coverage

TLVY homes became operational in September 2023 with an initial capacity to support up to 22 youth. Given increased demand for these homes, DoHS worked with existing providers to expand their capacity to serve an additional 10 youth in late 2023 and early 2024. As of May 2024, TLVY homes had total capacity to serve up to 32 youth. Two new TLVY providers became operational effective July 1, 2024, with capacity to serve 17 youth, bringing total TLVY capacity to serve up to 49 youth. An existing provider also has plans to add capacity to serve another eight youth, although the timeline has not been specified. DoHS will continue to monitor TLVY capacity needs and may consider expanding capacity further in the future if needed.

DoHS continues ongoing collaboration with residential providers regarding current residential treatment capacity and the transition to the new models of care. As noted previously, the transition will occur over a period of time. One provider has already operationalized an RIT facility in July 2024. DoHS is also in communication with providers from other states who may have interest in providing services in West Virginia under the new models of care.

17.4 Strengths, Opportunities, Barriers, and Next Steps

Key accomplishments include the following:

- Progress continues toward implementing the new models of care. In partnership and ongoing discussions with Casey Family Programs, Building Bridges Initiative, and residential providers, DoHS has explored a variety of ways to transition to the new models of care. Draft contracts are in development for the new models of care. One provider started an RIT facility in July 2024. Another provider has started the remodel of a home for SRIT services for children with autism. DoHS anticipates the transition of current facilities to the new models of care will occur over a period of time, allowing time for the new models to be piloted. A more detailed plan and timeline for update of the residential provider manual and the associated transition is expected by the end of August 2024.
- As of July 1, 2024, TLVY homes have been expanded, with the total capacity to serve up to 49 youth. Capacity to serve an additional eight youth is planned, although the timeline is unknown.
- Per the quarter 1 2024 report from MU, CAFAS/PECFAS and CANS assessments were completed for 87% of children in active OOS placement in March 2024. Discharge plans were completed for 74% of children. Positively, there was a 65% increase in OOS discharges in Q1 2024 (100 discharges) compared to Q1 2022 and Q1 2023 (61 and 58 discharges, respectively). This increase highlights the work of the MU clinical team supporting prioritized discharge planning for children in OOS placements.

To reach further census reductions, and to help ensure children are provided the services and supports to address the amount, duration, and intensity of their assessed needs, DoHS is prioritizing the following actions:

- Operationalize the new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and sexualized behavior.
- Continue MU's efforts to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in OOS residential placement to facilitate return to their local communities in West Virginia.
- Continue efforts with Aetna to support prioritized discharge planning for children who are in in-state placement with a CAFAS/PECFAS score less than 140 and anticipated discharge in the next 60 days.
- Explore readmission for a larger cohort of discharged children, including expanding the analysis to include CAFAS/PECFAS scores, once available, and length of stay in combination with the other factors discussed throughout this section. DoHS is also planning additional analysis pertaining to the utilization and timeliness of services following discharge to the community and associated impacts on readmission.

18.0 Outcomes

DoHS continues to establish data sources, systems, and processes to collect outcomes data for children who are receiving mental and behavioral health services. Enhancing data quality and collection continues to be a key step to assess outcomes following early process implementation, and the continued build-out of the data store. A sufficient number of children have been able to go through the expected service period to enable preliminary cross-systems analyses to begin to be conducted. DoHS plans to emphasize developing these cross-system views in the coming months.

Service use and cross-systems utilization will be used to improve understanding of the patterns in utilization and the ability of youth to remain in their home and community. These analyses will also contribute to continued build-out of prototypes for routine and automated review of cross-systems utilization. Child severity of need will also be considered, as different service intensity may be needed depending on the child's functional ability and environment. DoHS will explore commonalities for service utilization for at-risk children not interacting with an RMHTF to understand best prevention practices. Plans for this cross-systems analysis will expand and be refined as the data store is built out and systems utilization is better understood.

Below is an update on the data sources and associated results for each outcome.

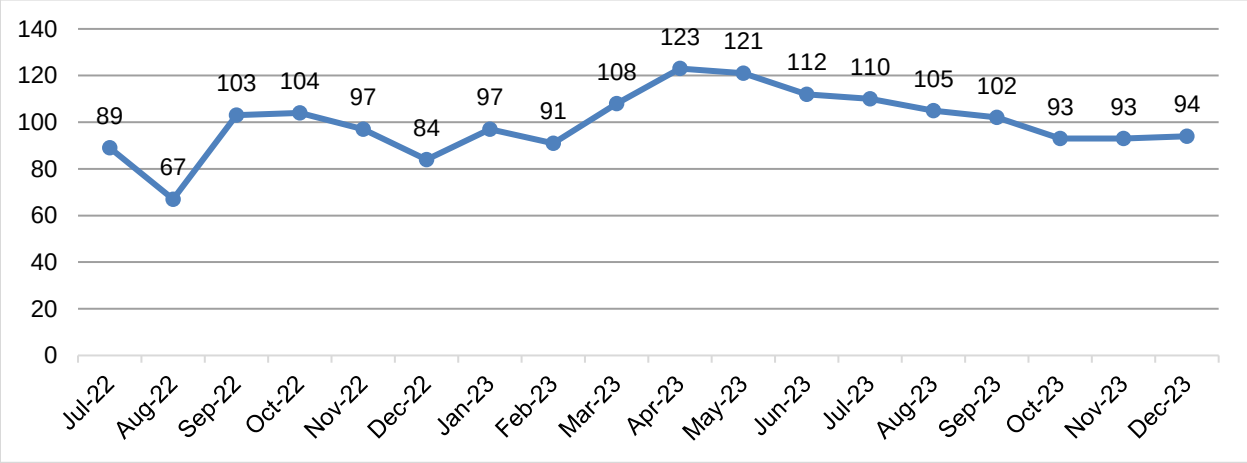
18.1 Encounters with Law Enforcement

The CMH Evaluation asks youth and caregivers about their experiences with law enforcement to provide a sample of these key populations. Data on law enforcement encounters will be updated annually. For the most recent reporting of this data, please refer to the January 2024 Quality and Outcomes Report.

18.2 Commitment to the Custody of BJS or DoHS

The data source for commitments to BJS has been identified as the OIS. Commitments to DoHS will be reported from the WV PATH system. These data sources will be further assessed and integrated into the data store to analyze commitment to custody for the at-risk population in the future. Figure 120 shows the number of children in BJS custody at the end of each month from July 2022 to December 2023. During review with BJS staff, it was noted that changes in criteria led to the appearance of an upward trend in commitments in early 2023, while previous trends were influenced by the COVID-19 pandemic. The census had begun to decrease in the latter part of 2023, although preliminary data from early 2024 shows some increases in commitments. It will also be important to integrate child-level commitment data into the data store to better understand a child's journey and, over time, to identify influences on children who are or are not committed to BJS custody.

Figure 120: BJS End-of-Month Committed Children, July 2022 to December 2023



18.3 School Performance

DoHS is collaborating with the WVDE, as part of the greater collaborative, started in December 2022. A data use agreement (DUA) is in place that will enable sharing and review of data for the at-risk population. These data will be used to reduce disciplinary action for students residing in foster care and form trauma-informed approaches. A second DUA for matching data from the West Virginia Education Information System (WVEIS) to improve understanding of child outcomes over time is also in place. Data collected from WVEIS will allow for tracking of student progress and need indicators such as attendance, school performance, disciplinary actions, and educational accommodations (i.e., 504, IEP), which will become part of the data store for review of cross-systems-related outcomes. DoHS is currently coordinating with WVDE to establish the formal and routine data transfer processes.

Due to limitations of data reporting frequencies from WVDE's ZOOMWV information website, aggregate, statewide school performance metrics will be reported on an annual basis. For the most recent update, please refer to the January 2024 Quality and Outcomes Report. Data matched through the DUA process should be able to be reported more frequently once fully established.

18.4 Polypharmacy Utilization

Polypharmacy utilization will be reported annually. For the most recent available data, please refer to the January 2024 Quality and Outcomes Report.

18.5 CANS Assessment

DoHS continues actively working toward capturing changes in functional ability (as measured by the CANS assessment), both statewide and by region, including data from the CANS assessment and the quality sampling review process. Details of this work are captured in previous sections of this report including Section 9.0 QIA (as part of the Decision Support Model) and Section 8.0 Pathway to Children's Mental Health Services.

As noted in previous reports, further outcome methodology for the CANS assessment has been developed and tested to assess functional improvements over time. This methodology has not yet been applied on a broader dataset due to data quality and completion concerns. To improve data completion, during the May quarterly review, the Quality Committee reviewed data that compared documentation across systems to help ensure all children expected to be utilizing WV Wraparound services were documented in the CANS Automated System. Documentation in the CANS system allows the Wraparound team to track evolving needs and strengths for children served and allows DoHS and key stakeholders the ability to review outcomes and verify alignment with high-fidelity Wraparound practices. A list of children[93] who were expected to be receiving services were reviewed from the CSED roster, BBH Assessment Pathway, and SAH interim services referral list. While most children were found to have documentation for WV Wraparound services nearly a third (31%) of children did not have services documented despite assignment to a Wraparound Facilitator. This information has been shared with bureau leadership and Aetna to address deficits in documentation. Aetna and members of the DoHS team are conducting detailed review at the child-level to identify why children expected to have services would not have documentation in the CANS system. Early findings from this review have shown many families did not return the Freedom of Choice form, despite multiple contact, which is required per CMS to begin services. Strategies are also being put in place to try to ensure CANS documentation is completed, including efforts to enhance automated reporting and quality-based queries in the CANS system. There are also plans to give technical assistance to providers not meeting reporting standards. As data collection becomes more robust and quality is enhanced, DoHS anticipates additional outcomes data will become available for consideration and reporting via the data store.

18.6 Outcomes Across Populations

As data collection and quality improves, DoHS is developing cross-systems views to better evaluate outcomes for WV youth. Recent cross-systems analyses have focused on outcomes for children approved for CSED services, and on comparing outcomes for those who do and do not utilize certain HCBS. See Section 8.0 Pathway to Children's Mental Health Services, for additional details. DoHS anticipates exploring additional comparison populations in 2025 to better understand protective factors and risk factors for WV youth at risk of residential placement.

[93] Accounting for and excluding children who had an on-hold status, were on a waitlist, or had not had sufficient time to be entered in the system.

19.0 Conclusion

DoHS continues to make significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of WV, including raising awareness of the availability of these services. Mental health needs of children in WV have increased following the pandemic, yet DoHS's continued focus on and expansion of available services and supports is assisting with offsetting further increases in residential treatment services utilization. Key accomplishments in the first half of 2024 include the following:

- DoHS has spent considerable time enhancing data quality and completion with key partners including providers, Aetna, Acentra Health, and MU. Continued progress was made on child-level reporting through the data store, which is now being leveraged for more sophisticated cross-systems analyses and reporting. Provider and county-level reports are now published on a recurring basis to support CQI efforts. Following a detailed county-level analysis involving multiple key indicators related to HCBS and RMHTF utilization, four high-need counties have been identified for focused intervention.
- The CSED Waiver amendment was approved with an effective date of July 1, 2024, with changes to enhance workforce, reimbursement rates, quality, and timely access to services. The number of children and families accessing these critical services continues to increase.
- Launch of the "West Virginia Needs You Now" Campaign in March 2024 for focused recruitment of foster homes willing to accept youth with complex mental and behavioral health needs. From March to June 2024 Mission WV received approximately 200 inquiries a month, which is double what they typically receive. Almost half of these are attributed to the campaign.
- The number of community-based TLVY homes was expanded with capacity to serve up to 49 transition-age youth as of July 2024, up from a capacity of 22 in September 2023.
- Outreach to the judicial community by BSS leadership has increased, which is critical given the court community's significant influence over RMHTF service utilization. Stronger relationships are being formed between BSS, Probation Services, BJS, and Aetna as key influencers in connecting children and families to needed services.
- DoHS in partnership with Casey Family Programs, Building Bridges Initiative, and residential providers has continued to make progress on new models of care to better support the needs of children whose acuity requires residential treatment. A small group of providers will begin to pilot the new models of care in the second half of 2024 as more preparations are made for the statewide transition.

DoHS's CQI processes continue to expand and evolve with more sophisticated levels of cross-systems analysis and reporting. The Office of QA collaborates daily with program leadership and staff, as well as with vendors and providers, to continue to align efforts, improve data quality

and reporting, and facilitate responsive, nimble action for improved outcomes. Expanded data sharing with a variety of partners and stakeholders, including the WVDE, DHS, court systems, and vendors and providers, is recurring. These efforts are building momentum to help ensure sustainable, available, and accessible programs and services for children and families across WV.

DoHS recognizes the following as the most pressing needs of its children's mental health system, as of the writing of this report, and will prioritize action and further CQI efforts according to these areas, which are believed to have a large impact on a child's ability to remain in the least-restrictive setting as relates to meeting mental health needs:

- Assessing timeliness and related needs for mental health HCBS
- Understanding key interactions and related outcomes for children with SED to assist with future service and system changes to continue to improve outcomes
- Prioritized discharge planning and expanding available community-based placement options (i.e., foster homes, kinships homes, non-treatment settings)
- Enhancing opportunities for diversion from unnecessary residential placements and potential systems involvement:
    - Increasing family-driven referrals to the Assessment Pathway
    - Enhancing QIA referral processes with a focus on improved timeliness and quality
    - Collaboration with and messaging to key stakeholders about unnecessary RMHTF placement, and available services and processes in place to offer other HCBS options for children in need.

DoHS will also continue to prioritize the transition to the new residential models of care to help ensure children whose acuity and clinical needs rise to the level of residential treatment receive those services that best meet their needs.

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

Appendix A: Glossary of Acronyms and Abbreviations

Figure 121: Glossary of Acronyms and Abbreviations

Acronym/ Abbreviation	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
APR	Automated Placement Referral
ASD	Autism Spectrum Disorder
ASO	Administrative Service Organization
BASC	Basic Assessment System for Children
BBH	Bureau for Behavioral Health
BFA	Bureau for Family Assistance (formerly Bureau for Children and Families)
BIPOC	Black, Indigenous, and People of Color
BJS	Division of Corrections and Rehabilitation-Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CMCRS	Children's Mobile Crisis Response and Stabilization
CCRL	Children's Crisis and Referral Line
CMH Evaluation	Children's Mental Health Evaluation being completed by West Virginia University
CMHW	BBH Children's Mental Health Wraparound
CMS	Centers for Medicare and Medicaid Services
CSED	Children with Serious Emotional Disorder
SED	Serious Emotional Disorder
CPA	Child-Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DART	Document Assessment and Review Tool
DH	West Virginia Department of Health

Acronym/ Abbreviation	Description
DUA	Data Use Agreement
DHHR	WV Department of Health & Human Resources
DHS	WV Department of Homeland Security
DoHS	WV Department of Human Services
DW/DSS	Data Warehouse/Decision Support System
ED	Emergency Department
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics, part of the National Syndromic Surveillance Program
ESMH	Expanded School Mental Health
FACTS	Family and Children Tracking System
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, and Others
MU	Marshall University
MAYSI	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OCMS	Offender Case Management System
Office of QA	Office of Quality Assurance for Children's Programs
PBS	Positive Behavior Support
PCP	Primary Care Provider
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PIP	Performance Improvement Project
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
QIA	Qualified Independent Assessment

Acronym/ Abbreviation	Description
RIT	Residential Intensive Treatment Facility
RMHTF	Residential Mental Health Treatment Facility
SAH	Safe at Home
SEER	National Institute of Health Cancer Institute Surveillance, Epidemiology, and End Results (SEER)
SMI	Serious Mental Illness
SPA	State Plan Amendment
SRIT	Specialized Residential Intensive Treatment Facility
STAT	Stabilization and Treatment
SUD	Substance Use Disorder
WV	West Virginia
WVCHIP	WV Children's Health Insurance Program
WVDE	WV Department of Education
WVDH	WV Department of Health
WV PATH	West Virginia People's Access to Help
WVU	West Virginia University
WVU CED	West Virginia University Center for Excellence in Disabilities
WVU HAI	West Virginia University Health Affairs Institute
YRBS	Youth Risk Behavior Survey
YS	Youth Services

Appendix B: BBH Region Map

Figure 122: Map of the Six BBH Statewide Regions