



CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Reporting Period: July 2022 – December 2022

Trend Review Period: July 2021 – December 2022

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1.0 Executive Summary

The West Virginia Department of Health and Human Resources (DHHR) is actively working to reform mental and behavioral health services for children with serious emotional disorders (SED) and their families across West Virginia (WV). Since 2019, DHHR, in collaboration with various community partners and stakeholders, has built upon the existing system frameworks and established new processes and pathways meant to identify children’s mental health needs, to provide families with timely and smooth connections to services, and to transition children currently placed in residential settings back to their family homes or other least-restrictive settings. The 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 on available services and supports. The CCRL is available 24 hours per day, 7 days per week. Calls to the CCRL are answered within 14 seconds, on average. In October 2021, DHHR implemented the Assessment Pathway¹, 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 and includes Wraparound Facilitation services for children with SED. In early 2023, the five-year CSED Waiver renewal was approved, extending the waiver through January 2028. These significant enhancements to the children’s mental health system remain in the implementation phase and continue to be monitored by DHHR through continuous quality improvement (CQI) efforts.

DHHR’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 putting intensive focus on mental health services and the children in need of them, DHHR strives to build and sustain a strong system which allows children to remain and thrive in their homes and communities while receiving necessary mental health treatment, as clinically appropriate. DHHR also aims to 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 to the family setting quickly once treatment is completed.

The purpose of this report is to capture the results of DHHR’s ongoing, collaborative quality reviews and recommended next steps based on service data for the period July 2022 – December 2022, including utilization trends for the period July 2021 – December 2022, with some exceptions for newly implemented services.

¹ 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.

Summary of Key Highlights

A summary of key highlights and accomplishments are included below. Further details are included in the body of the report:

- Mental health screenings, and subsequent referrals to the Assessment Pathway for further evaluation and connection to services, conducted as part of early intervention via multiple avenues including Youth Services (YS), Child Protective Services (CPS), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthCheck wellness visits, Division of Corrections and Rehabilitation-Bureau of Juvenile Services (BJS), and Probation Services, have increased.
 - Screening via EPSDT/HealthCheck wellness visits continued to be an area of focus with establishment of an EPSDT/HealthCheck wellness visit Performance Improvement Project (PIP) team to review and address low screening rates.
- There were 617 total calls to the CCRL in July – December 2022, a 25% increase over the previous reporting period (494 calls in January – June 2022). Beginning in early 2022, following the Implementation of the Assessment Pathway, the volume and makeup of calls coming into the CCRL has changed as follows:
 - Calls to the CCRL in July – December 2022 most commonly originated from a child’s loved one (63% of calls).
 - Calls from community partner/professional increased by 50% from the first half of 2022 (105 calls) to the second half of the year (158 calls). These calls represented 25% of all calls to the CCRL during July – December 2022, likely due to efforts to increase provider and stakeholder awareness.
- All children and families connecting with the Assessment Pathway receive timely information on types of services available to meet their needs, including information on how to access the CCRL, inclusive of mobile response and stabilization services.
- To better understand the outcomes for children whose families cease participation in the Assessment Pathway process, a preliminary analysis of children ceasing participation in the Assessment Pathway in 2022 (n=200)² was completed with the following results:
 - Eleven children (5%) entered an RMHTF after ceasing participation in the Assessment Pathway. Of these 11 children, two entered an RMHTF within 30 days of referral, five entered between 31 and 90 days, and the remaining four entered after 90 days.
 - Twenty-one children (11%) accessed the emergency department (ED) for

² This analysis was completed for children who ceased participation in the Assessment Pathway for the period January – December 2022. These children were then matched against Medicaid claims data for RMHTF stays and ED visits through February 2023. The match rate was 81%.

behavioral health reasons. Most of the ED visits occurred within 30 days of referral to the Assessment Pathway (n=13).

- Across the system, a common reason for declining referral to the Assessment Pathway following a positive screen or declining further participation in the Assessment Pathway process was due to the family feeling as if other community-based services already in place were meeting their needs. While these are early analyses, the results may indicate that children and families who disengage are still able to access the services needed to remain in their homes and communities.
- The CSED Waiver program has shown continued growth with 976 applications processed in the second half of 2022 compared to the first half at 730 applications, an increase of 34%.
 - An additional 702 applications have been received for the period January – March 2023, well above what has been seen in previous periods.
- During the July – December 2022 period, 583 children accessed CSED Waiver services compared to 411 children in the prior period, representing an increase of 42%.
- While referrals and service utilization continue to grow, DHHR has worked collaboratively with providers and Aetna to expand capacity to meet needs.
 - As of the May 2023 Quality Committee review, 28 agencies are enrolled as CSED Waiver providers with 19 agencies (68%) actively providing services. Fourteen new providers are in the process of enrollment.
 - As of July 21, 2023, 21 children were on the waitlist for CSED Waiver services due to limitations with Wraparound Facilitator capacity in some areas of the state.
 - Families receive information on other community-based services, including the CCRL, to meet interim needs and provide stabilization options. Due to significant capacity limitations specific to interim Wraparound Facilitation services, there has been very limited ability for interim Wraparound Facilitation services to be offered prior to enrollment in the CSED Waiver program.
- There has been continued progress in the Wraparound Facilitator capacity and caseload analysis, to include the incorporation of full-time equivalent (FTE) status by Wraparound Facilitator which can also be aggregated by provider and funding source.
- A contract with Marshall University was implemented in April 2023 to complete the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS), Child and Adolescent Needs and Strengths (CANS) assessments, and discharge plans for all children in out-of-state residential treatment facilities and psychiatric residential treatment facilities.
- The county-based rollout of the Qualified Independent Assessment (QIA) process across DHHR's Bureau for Social Services (BSS) and the initiation of referral of

children in active RMHTF placement with multiple readmissions to the QIA process was completed. Comprehensive implementation of the QIA process is designed to help ensure children are assessed for appropriate levels of care and can support discharge and diversion from residential placement when clinically appropriate.

- From August 2022-April 2023, 125 children were referred to the QIA process.
- As part of the QIA process, the decision support model—a tool which leverages CANS assessment results of child needs and strengths—assists with making level-of-care recommendations based on treatment need and complexity.
- Nearly 70% of children with a QIA referral received a recommendation to obtain treatment via HCBS (August 2022-April 2023), a positive 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.
- Final QIA recommendations were typically received by the youth’s child welfare worker within the 30-day timeframe set as a goal for this process, with 64% of completed cases meeting this goal. On average, non-expedited referrals were completed in 27.5 days.
- Early data shows, of children with a QIA referral and a court order for residential placement (n=38), 61% were recommended to receive treatment in their home and community as a result of the clinical assessment. This finding further highlights the need for this process, with standardized clinical assessments completed by an independent entity to reduce bias and ensure treatment and services are clinically appropriate to meet each child’s needs.
- The QIA can be used to aide decision making and reframe cultural norms to prevent inappropriate use of residential mental health treatment facilities.
- As of May 2023, 97% of children with CAFAS/PECFAS less than 90 in an in-state RMHTF placement had a discharge plan in place, a remarkable improvement compared to October 2022 at 38%. Efforts have since expanded to ensure discharge plans are also in place for children with CAFAS/PECFAS less than 140; data also indicates that 97% of children in this group had a discharge plan in place.
- For the 166 children included in the prioritized discharge planning population at any point between January and June 2022, 66% (n = 109) have since discharged.
- Need for a community-based placement (family setting) was among the top barriers for children in RMHTF settings with a CAFAS/PECFAS score less than 90. Many characteristics of these children were assessed to help identify and recruit kinship and foster families; one of the noteworthy findings was that 78% of youth in RMHTF settings with a CAFAS/PECFAS score less than 90 were ages 13-17. Additional analysis also found county-level needs for a community-based placement overlapped with counties that had high calculated placement ratios for youth 13+ and families

willing to accept youth 13+. This overlap indicates that there may be limited options available for youth with this discharge barrier, especially after accounting for youth needs and foster family autonomy. To help with this, a collaborative campaign was initiated to focus on recruitment of foster homes to support youth ages 13-17 with complex mental and behavioral health needs.

- Youth aged 18-20 represented 11% of individuals in an RMHTF setting with a CAFAS/PECFAS score under 90, a score that typically indicates a lower acuity of need for youth assessed; this is compared to 1% of the total RMHTF population. Many of these youth had barriers to discharge related to a need for transitional living service options. Based on these findings, DHHR has selected three providers to operationalize transitional living group home services in the community as an alternative to residential placement (projected to be operationalized August 2023).
- DHHR successfully met the goal of reducing the number of children in residential placements below 812 by December 31, 2022, with a census count of 781.
- Data store build-out continued with prototypes of cross-system analyses and integration of RMHTF and CAFAS/PECFAS history data. Data quality and completion also remained a focus, including several efforts to improve and expand data collection mechanisms.

DHHR remains committed to monitoring these new processes continuously for sustainability and to identify any barriers to awareness and access to services in the least restrictive, clinically appropriate setting.

Summary of Key Priorities and Next Steps

The following areas of focus, which DHHR is prioritizing in the coming months, were established by Quality Committee members. These focus areas are anticipated to have the greatest impact on improved outcomes for children and families over time:

- Coordination between DHHR's Bureau for Public Health (BPH) and the managed care organizations (MCOs) under Mountain Health Trust, as a continued PIP team, to help ensure EPSDT with mental health screens are conducted annually on 52% of Medicaid-eligible children, including expanded, recurring data review and focused outreach.
- Continued CSED Waiver and Wraparound Facilitation services analysis of capacity needs and efforts to expand the provider network in partnership with Aetna, an MCO, and providers.
- Monthly data review and strategic decision-making by the Wraparound Facilitation Fidelity PIP team to ensure the WV Wraparound Facilitation program is implemented with fidelity.
- Continued efforts around prioritized discharge planning with focus on children with CAFAS/PECFAS less than 140, to include focus on identifying and addressing discharge barriers.

- Completion of assessment and discharge planning for children in out-of-state placement, with the goal of bringing children home to their families and community supports.
- Focused recruitment and retention of foster care homes to serve youth ages 13-17 with complex mental and behavioral health needs.
- Completion of the QIA process for all children in active RMHTF placement who did not have this assessment prior to admission, and continued implementation of the QIA processes for children at high or imminent risk of residential placement.
- Continued development of new models of care via smaller homes with higher levels of staffing to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, autism spectrum disorder (ASD), and intellectual and developmental disability/borderline intellectual and developmental disability.
- Establishment of transitional living group homes in the community (projected to be operationalized by August 2023).
- Continued enhancement of quality infrastructure and processes within DHHR to include:
 - Reviews for focused improvement of data collection, quality, and completion;
 - Ongoing identification and breakdown by provider, vendor, region, and/or county of indicators of interest to better understand and address areas of need and strength (including data informing marketing strategies);
 - Expansion of the data store to enable synthesis of data across sources and systems, to better understand the child and family journey and outcomes; and
 - Monitoring and reporting to share feedback with vendors and providers, helping ensure accountability to performance outcomes and assist with focused recruiting and provider network expansion.

DHHR has made meaningful progress in program design and process changes related to serving children with mental and behavioral health needs. Implementation will continue in the months and years ahead with a continued adherence to data-informed planning and timely action. The details of specific service reviews as well as identified strengths, opportunities for improvement, and next steps are included in the full report.

2.0 Introduction

DHHR is actively working to reform and enhance programs and services for children³ with serious mental health conditions.

The primary goals of these reforms are:

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

To support these goals, DHHR is committed to providing HCBS to allow children to remain in their homes and communities. HCBS include Wraparound Facilitation, CMCRS, Stabilization and Treatment (STAT) Homes as a short-term intervention foster care option, Behavioral Support Services such as Positive Behavior Support (PBS), family therapy, in-home family supports, and Assertive Community Treatment (ACT). In February 2020, DHHR 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.

DHHR has worked collaboratively with community partners and stakeholders to design and expand services to meet the needs of children and families statewide more effectively. The implementation of the 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 on available services and supports, including how to get connected to them. 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 in providing children and families with the opportunity to connect to services. DHHR 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 see the full impact of these improvements, positive impacts are already being noted and are captured throughout this report.

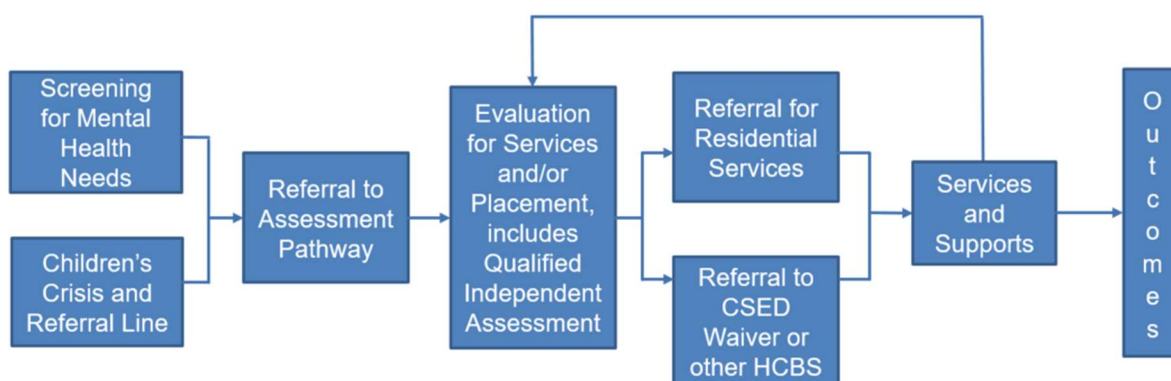
In December 2021, DHHR began implementation of the CQI plan for children’s mental and behavioral health services. The purpose of the CQI plan is to take a proactive and continuous approach to improve child welfare services and services for children with mental and behavioral

³ 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.

health needs, including SED. DHHR 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



As of early 2023, implementation of monthly bureau-specific program-level quality reviews was completed across 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 review of and response to data as well as preparation for DHHR’s quarterly reviews. When there is a need for more focused and frequent review to address an identified gap or area for improvement, PIP teams are established to drive rapid improvement.

DHHR completes quarterly cross-functional, cross-bureau Quality Committee review meetings to review and analyze consolidated data from across programs to evaluate the children’s mental and behavioral health services system. The most recent quarterly review meetings were held in March and May 2023. The discussions during these quality review meetings informed the findings—including strengths, opportunities, and next steps—captured in this report.

3.0 Systems and Data Sources

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

- DHHR’s BSS Family and Children Tracking System (FACTS) data for children in DHHR custody
- DHHR’s WV People’s Access to Help (WV PATH) system for children in DHHR custody; this new system was implemented in January 2023 to replace FACTS
- DHHR’s Data Warehouse/Decision Support System (DW/DSS) of Medicaid and WV Children’s Health Insurance Program (WVCHIP) data, including data associated with CSED Waiver services; this system is in the process of being replaced
- DHHR’s Enterprise Data Solution (EDS) system of Medicaid and WVCHIP data, including data associated with CSED Waiver services; this new system was implemented at the end of March 2023 to replace DW/DSS
- DHHR’s BBH grantee reporting via Epi Info system for PBS, CMCRS, and BBH-funded Wraparound Facilitation services
- HELP4WV – iCarol Call Reporting System for calls made to the CCRL
- DHHR’s BBH Assessment Pathway Portal
- DHHR’s Bureau for Medical Services (BMS) CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, Acentra Health⁴ (formerly Kepro), that includes the results of the application process
- BJS Offender Information System
- Aetna Reporting for Discharge Planning (Aetna Mountain Health Promise is the contracted MCO) and CSED Waiver Status and On Hold reporting from Aetna’s QuickBase system
- DHHR’s BMS CSED Waiver Enrollment Reporting from Acentra Health and the contracted assessor, Psychological Consultation and Assessment, Inc. (PC&A)
- DHHR’s Fostering Healthy Kids Data System that includes EPSDT screening for

⁴ 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. In an effort to ensure clarity between prior semiannual reports and the current report and to support acclimating to the new name, the former name, Kepro, will be referenced throughout this report whenever Acentra Health is mentioned.

children in foster or certified kinship care

- DHHR's Outreach and Education Tracker
- Division of Probation Services Offender Case Management System (OCMS)
- CANS Automated System, which includes CANS assessment data, Wraparound Facilitation services contact data, and data to assist with Wraparound Facilitator capacity and caseload analysis
- QIA Tracking Spreadsheet, maintained by Acentra Health and Marshall University
- Marshall University WV Wraparound Facilitator Staff Reporting for capture of Wraparound Facilitator workforce capacity and caseload analysis

Over the past two years, DHHR 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. The goal of this data store is to capture child-level and interaction-level data from child-serving entities to enable aggregation, cross-systems analysis, and reporting for use in DHHR's CQI processes. The data store's phased build-out is scheduled to continue through the end of 2024. To date, the data store captures child-level data associated with RMHTF services and CSED Waiver services and was expanded in early 2023 to capture RMHTF discharge planning data as well as CAFAS/PECFAS history.

Progress on the data store build-out has been temporarily impacted by the conversions to new data systems, including from FACTS to WV PATH and from DW/DSS to the EDS system. Significant effort has gone into mapping data from the systems into the data store, data quality and validation, and matching at the child level to enable cross-systems analysis across datasets. Matching and unifying child-level data has become increasingly challenging as additional systems and data sources lacking a common child identifier are being integrated into the data store. Accordingly, the timelines associated with the build-out of the data store are routinely being updated and priorities are being revisited. Datasets in the process of being added to the data store include the following: CANS assessments, CSED applications, Probation Services screenings, BJS screenings, and QIAs. Full build-out of the data store is anticipated in late 2024 and will allow more in-depth cross-systems analysis of child-level data to support DHHR's CQI activities.

Some early-stage cross-systems analysis between RMHTF and CSED Waiver Service claims data, CAFAS/PECFAS history, and CSED application datasets began in early 2023. Some preliminary results have been included in relevant sections of this report, such as the Assessment Pathway section, which covers outcomes of individuals who cease participation with the pathway. Since not all components have been able to be incorporated into the data store at this time some of these processes still require more time-consuming, manual techniques. As these cross-systems prototypes are developed and refined in the coming months, further analysis of outcomes information will be available, which will help expand understanding of youth and family experiences with the mental health system.

Other system changes that will enable increased data collection at the child and encounter level

are in process. BMS began implementing an EDS to replace the current DW/DSS in March 2023, with full conversion occurring in July 2023. This conversion is expected to improve data quality and integrity by resolving issues from the legacy data warehouse. Enhancements to the Epi Info system, which captures data associated with the BBH-funded Behavioral Support Services, Wraparound Facilitation, and CMCRS programs, are expected in fall 2023. Improvements to Epi Info will increase data quality and provide the ability to monitor and review expanded information, such as timeliness indicators. BSS, BBH, and BMS continue to work with vendors and providers to address data quality, data completion, and expansion of data elements needed to improve reporting. Details of these improvements are captured in relevant sections throughout the report.

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

- West Virginia University (WVU): Contracted to complete an ongoing evaluation of HCBS for children in WV. This evaluation is commonly referred to as the Children’s Mental Health Evaluation (CMH Evaluation). 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 next report covering results from the Year 2 systems, provider, youth, and caregiver evaluation will be published in late July 2023. The Year 2 evaluation was expanded to include an evaluation of at-risk⁵ children and caregivers. This report is expected in October 2023. Reports will continue to be provided on an annual basis to DHHR as evaluation is conducted on the implementation rollout. More information is presented in Section 5.0 Partner Evaluations.
- Marshall University: Contracted to complete an ongoing evaluation of service fidelity to the National Wraparound Initiative (NWI). Marshall provided the first fidelity report to DHHR in December 2022. The second fidelity report will be completed in December 2023; however, results of a survey conducted with families to gauge families’ perception of whether the program has been implemented with fidelity will be released for initial internal review in late summer 2023.

Reports from these contracted vendors are incorporated into DHHR’s quality review cycles and CQI processes.

⁵ At-risk children were defined as those children (under age 21) with an SED in 2021 (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 F1, or SUD, range and F55 (also a SUD diagnosis) and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021), AND meeting any of the following criteria in the last 3 months of 2021: Medicaid/CHIP member with an ER visit for a psychiatric episode, Medicaid/CHIP member with a psychiatric hospitalization episode; Mobile Response; children who are in state custody because of CPS or YS involvement; OR child with SED as a primary diagnosis on a Medicaid claim in 2021 and a CAFAS/PECFAS > 90.

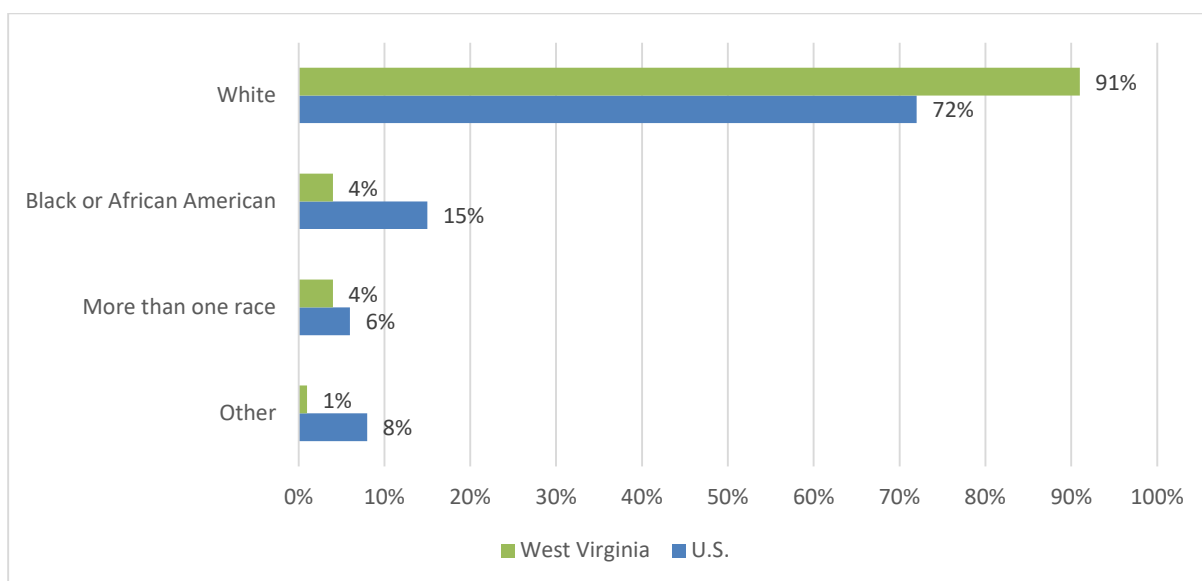
4.0 WV’s Child Population and Individuals Utilizing Services

WV Demographics for the General Child Population

WV has a unique demographic and geographic makeup, which varies significantly from most of the rest of the United States. Reference to the state’s population is important, as DHHR examines service utilization to track whether the populations reached are representative of the state’s population.

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

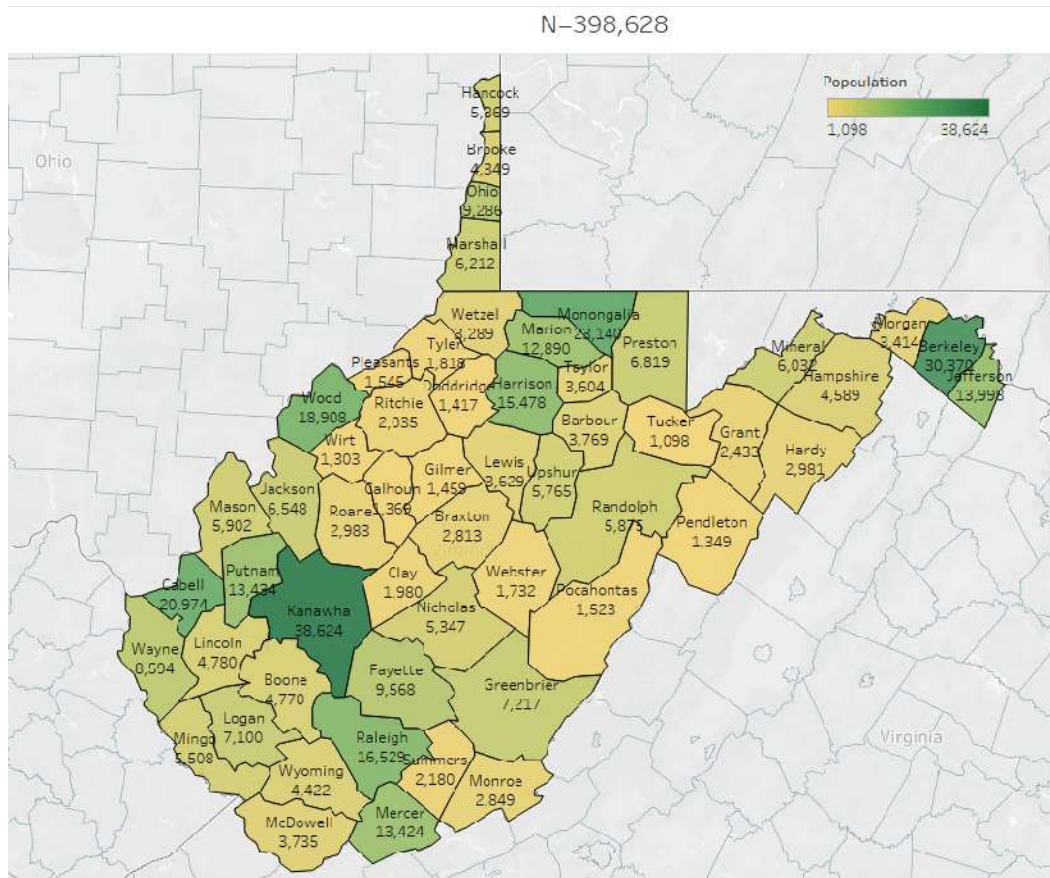
Figure 2: Racial Distribution of West Virginians Less Than Age 21 Compared to the Nation



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

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

Figure 3: WV Child Population Under Age 20



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

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

- Consistent with gender proportions identified in the RMHTF population, programs served more male children. Services (i.e., CMCRS, CCRL) that at baseline reported serving more females have shifted to serving slightly more males than females. The Quality Committee noted that more males utilizing services may be expected, as males often have a greater intensity of need due to presence of sometimes more dangerous behaviors compared to females. This aligns with findings in reviewed literature, as differences are commonly seen with the manner in which mental health disorder symptoms present among males and females, which would also impact intensity of the

services needed based on presentation of relevant symptoms.⁷

- 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 5 – 8 and 9 – 12 compared to children in RMHTFs. The shift toward younger age demographics for community-based programs was identified as a potential early-intervention opportunity for those individuals at risk for placement in an RMHTF. Although this is a positive finding about early intervention, it may take years to see the full impact on RMHTF services for children in these age ranges. Nevertheless, over 50% of youth served through the Assessment Pathway, CMCRS, and CSED were in the age range of 13 – 17 indicating a key demographic overlap and an opportunity for diversion from inappropriate use of RMHTF settings.
- The vast majority of youth in RMHTF settings were in the 13 – 17 age group (81%). In review of the subpopulation of youth in an RMHTF with a most recent CAFAS/PECFAS score less than 90, the age distribution shifted older (with 11% of transitional age youth 18 – 21 in this subpopulation compared to only 1% in the total RMHTF population). At this time, it is unclear if these youth entered an RMHTF with a CAFAS/PECFAS at this threshold or if this was achieved during treatment. Current data collection improvement efforts will aid in establishing this timeline and determining changes in CAFAS/PECFAS score over the course of treatment. Further assessment of this expanded dataset will help to determine commonalities among individuals with a CAFAS/PECFAS score under 90 in the future and help with understanding the variety of needs to address in order to serve more children in a home and community-based setting when possible.
- Based on a comparison of statewide race distribution for children aged 0 – 20, BBH PBS tended to serve a slightly higher proportion of BIPOC individuals compared to the general population. Due to a low number of BIPOC individuals in WV and thus served in its programs, race distribution is subject to fluctuation, which may not be associated with significant change; however, this has been a consistent finding with the PBS program and may be attributable to its focus on minority populations via a section within WVU’s Center for Excellence in Disabilities that provides input and training to staff for program outreach and service delivery for improved cultural competency. Despite challenges with low numbers statewide, race will continue to be monitored as an important indicator for assessing children and families’ access to services. Race data will be expanded as the data store is built out.

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

Figure 4: Summary⁸ Comparison of Demographic Trends Across Service Types

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race: White	Race: Black or African American	Race: Multiracial	Race: Other
			5-8	9-12	13-17	18-20				
WV – All Children 0-20	398,628	52%	23%	19%	25%	15%	91%	4%	4%	1%
CCRL	617	43.9% (40.8% female)	13%	22%	44%	1%	--	--	--	--
CMCRS – Preliminary	481	54%	10%	30%	53%	3%	81%	5%	1%	7%
Assessment Pathway Services	464	56%	14%	31%	51%	1%	--	--	--	--
CSED Waiver Applications	977		14%	22%	58%	5%	--	--	--	--
CSED Waiver Utilization	583	55%	20%	31%	51%	3%	--	--	--	--
Behavioral Support Services – BBH (PBS)	94	55%	14%	39%	39%	4%	87%	3%	9%	1%
RMHTF Discharge Planning (CAFAS/PE CFAS < 90)	241	60%	1%	10%	78%	11%	--	--	--	--

⁸ This summary comparison only includes relevant percentages (percentages large enough for comparison); however, the denominator for each group is inclusive of all available demographic types including those not listed (e.g., other genders such as transgender, age 0 – 4, 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: White	Race: Black or African American	Race: Multiracial	Race: Other
			5-8	9-12	13-17	18-20				
RMHTF Services	1,269	62%	3%	16%	81%	1%	--	--	--	--
QIA (August 2022 – March 2023)	91	67%	4%	15%	79%	1%	--	--	--	--
CPS Screening	1,526	51%	13%	18%	27%	0%	--	--	--	--
Screening: Probation	200	65%	0%	5%	94%	2%	91%	3%	6%	0%
Screening: BJS	516	--	0%	5%	87%	8%	--	--	--	--

5.0 Partner Evaluations

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

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

As stated previously, as part of the CQI process, DHHR’s cross-functional, cross-bureau Quality Review Committee reviewed the baseline report results, identifying common themes and taking action to address areas of need. Given the timing of this report, many opportunities for improvement were already being addressed through the implementation of the Assessment Pathway and several other key changes; however, this information helped solidify development of a system that can meet families’ expressed needs and help ensure key providers and stakeholders are aware of services to enable essential connections. This group still refers to these results to understand some current findings and to address needs. The Quality Review Committee looks forward to upcoming results for future strategic planning. Copies of these reports are located on the [Kids Thrive Collaborative website](#).

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

5.2 Wraparound Facilitation and CANS Fidelity Assessment

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

Marshall University completed the baseline fidelity review using the Document Assessment and Review Tool (DART, an NWI-approved fidelity tool) in December 2022. This baseline fidelity report was finalized in December 2022. The baseline findings indicated needs for additional alignment with NWI standards across programs and changes to written policies. The Wraparound Facilitation PIP team was established in January 2023 as part of the recommendation of the Office of Quality Assurance for Children’s Programs (Office of QA) and the Wraparound Facilitation Fidelity Report. This team meets frequently with the goal of aligning documentation, training, and practice across funding sources, focusing primarily on identified areas of need from the baseline evaluation. As of July 2023, decisions have been made based on recommendations from the PIP team in partnership with program leadership and the Executive Steering Committee, which will help address identified areas of need via updated documentation and training. Results of these changes might not be immediately noted in the next fidelity review planned for fall 2023, as many of these changes will not have time to be fully implemented or take effect. It was noted that the Plan of Care (POC) changes identified as a need in the baseline report were already addressed prior to the report publication; therefore, these changes are expected to make positive impact on the fall 2023 fidelity findings. The Wraparound Facilitation PIP team has also reviewed CANS data to help ensure adequate collection of this information for processes and outcomes. This data review will continue and will be expanded in the coming months.

Marshall University will complete the next round of fidelity reviews by December 2023, which will include findings from the DART and WIFI-EZ review tools. The WIFI-EZ is a survey capturing provider and family experiences related to Wraparound Facilitation service provision. Results and associated reports are expected annually based on recurring reviews using these tools. A preliminary report detailing WIFI-EZ results was shared with DHHR in July 2023 for internal review and consideration. Release of the final report of WIFI-EZ results is expected in late 2023. Preliminary results show that overall fidelity for WV Wraparound Facilitation according to the WIFI-EZ met the “Adequate” benchmark level. Individual category designations included “Adequate” for Effective Teamwork and Strength Family Driven; “Borderline” for Natural Community Support and Needs Based; and “High Fidelity” for Outcomes-Based Metrics. These findings will be reviewed in detail with the Wraparound Facilitation PIP and the QC team to determine next steps to address areas in need of improvement and sustain high-fidelity outcomes results.

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. DHHR's strategy has shifted to a county-level approach involving risk ranking of counties based on a variety of factors, including RMHTF admission rates, CSED utilization rates, and the rate of calls to CCRL, among others. A risk-ranking matrix and associated heat map was introduced in the March 2023 Quality Committee reviews to identify counties for potential focused outreach. Based on feedback from the Quality Committee, ranking factors were updated as relevant to each bureau and services area; meetings were held in the second quarter of 2023 to discuss and identify counties prioritized for outreach. Each bureau is currently in the process of developing specific outreach plans and timelines to address the prioritized counties. An update on progress will be provided in future semiannual reports.

Marketing strategies will also continue to be informed by the annual CMH Evaluation completed by WVU. The next report of systems, provider, youth, and caregiver evaluation is due in July 2023, with a report of survey results of the at-risk youth and caregiver population in October 2023. Both reports will be incorporated into future prioritization and strategies for outreach.

In August 2022, DHHR 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, then shifted biweekly from January-June 2023. From inception through June 2023, 28 sessions have been offered with 95 unduplicated attendees. The initial topics covered SED and the Assessment Pathway process, followed by sessions focused on CSED Waiver services. Since that time, a youth-focused video titled "Did You Know?" was launched in April 2023. ACT services were featured in the June 2023 sessions. Videos remain on the Kid's Thrive website for the topic areas with contact information to allow feedback and questions with timely response.

Resource Rundown Updates

For the period of January to June 2023, the Resource Rundown webpage has had 539 views. The Resource Rundown is recorded and posted on the [Kids Thrive Collaborative website](#) for those unable to attend a live session. The Resource Rundown videos have been viewed 281 times. The "Did You Know?" video has had 55 views.

A survey link is provided to participants following completion of each Resource Rundown session. To date, 30 surveys have been completed with the following results:

- 57% of survey respondents were professionals interested in obtaining information for families with whom they interact, 13% were adoptive parents/guardians, 10% were biological parents/guardians, and 7% were foster parents/guardians.
- 73% of respondents indicated some or all of the information presented in the Resource Rundown was new to them.

- 83% of the respondents indicated the information presented was useful. The information found most useful were details about the CSED Waiver and other services available to families.
- 70% of respondents indicated they are likely or very likely to recommend Resource Rundown to a friend, family member, or colleague.

DHHR-Level Outreach and Education Tracking

The Outreach and Education Tracker was soft launched in April 2022 and shared with relevant DHHR staff in August 2022. In the past six months, data enhancements to the tracker were made, including refinement of the drop-down lists to capture data more concisely and changes to allow reporting of audience size data in greater detail. Low usage of the tracker was noted as an area for improvement.

Recent efforts to expand the tracker have focused on the BSS teams, with the intent to capture increased outreach to the judicial community. The Office of QA initiated a meeting with BSS deputy commissioners in early July 2023 to begin development of a plan and timeline to train BSS social service managers and program managers responsible for outreach and building rapport with judges. During this meeting, BSS gave input on the needed changes to the tracker to be able to capture outreach focused on the judicial community more effectively and completely. These changes will be implemented by August 2023. The group will meet again in August 2023 to continue outlining the plan for training of BSS staff on how to use the tracker, including additional details on expectations for outreach and associated educational materials.

One of the recommended changes to the Outreach and Education Tracker identified in the Quality Committee review meetings was a request to include standardized outreach materials on the DHHR intranet site to make them more easily accessible to DHHR teams. This would include QIA materials for use in increasing awareness of this assessment process to aid in the determination of appropriate clinical supports, which may be particularly useful for the judicial community. Uploading standardized outreach materials to the DHHR intranet site is projected to be complete by the end of August 2023.

Thirty-nine outreach events were tracked from July to December 2022, and September 2022 was the month with the greatest number of events (12). Although multiple purposes for outreach were often noted, the most common purposes for outreach were accessing HCBS; CCRL; Mobile Crisis Response; Wraparound Facilitation; Mental Health Prevention Services; and HCBS as an alternative to residential placement (Figure 5). This information was provided to a wide array of audience types, as indicated in Figure 6. Many outreach events targeted multiple, distinct audiences, so the percentages in Figure 6 exceed 100%. Provider agencies (39%) and the public (33%) were the most common audience types. Compared to the January 2023 Semiannual Report, there was an increase in the percentage of outreach events targeting primary care physicians/healthcare providers (from 7% to 31%) and schools/the WV Department of Education (WVDE) (from 24% to 28%); this shift in audience type data was seen as a positive change, as both schools and physicians/healthcare providers are key groups for helping to ensure children are connected to services. This finding also correlates with findings from the CCRL (section 15), of 50% more “community partners/professionals” calling in on

behalf of youth and families. The July to December data also indicated 87% of outreach events had a statewide focus.

Figure 5: Purpose of Outreach, July to December 2022

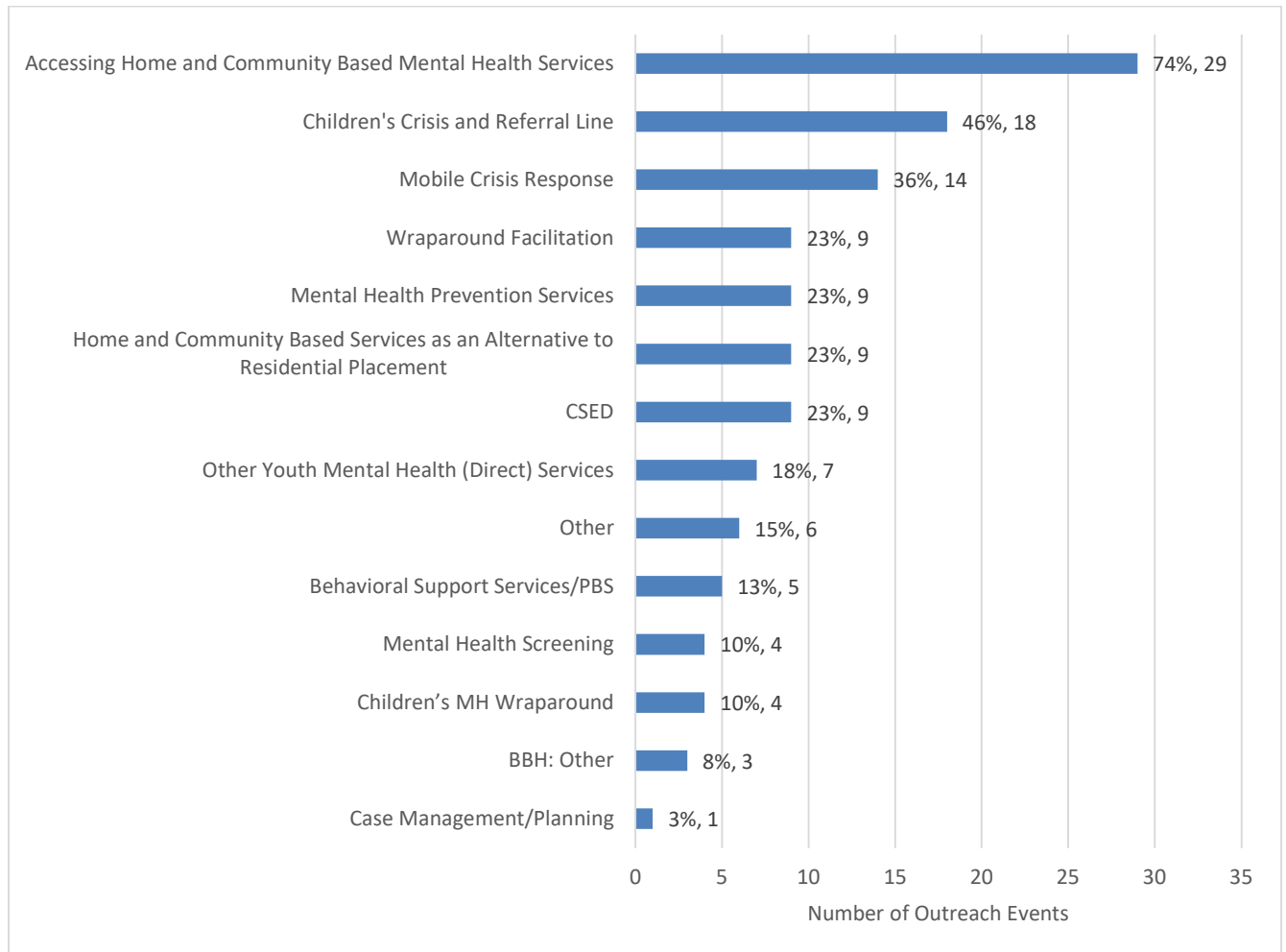
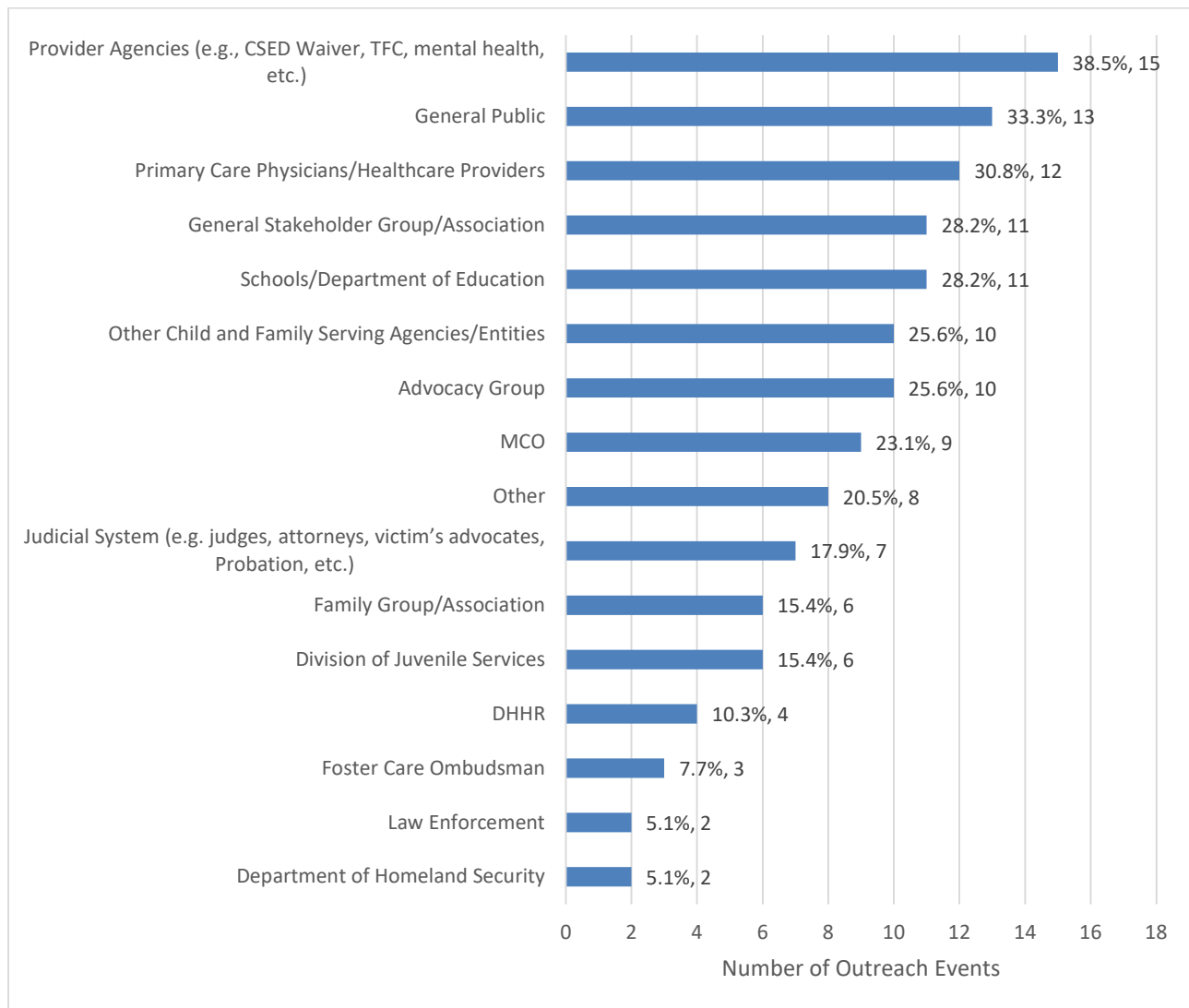


Figure 6: Audience Type, July – December 2022



As use of the Outreach and Education Tracker expands, DHHR 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 for vendor and grantee efforts, understanding these relationships will enable DHHR to know where to focus outreach efforts as well as understand whether current outreach efforts are having the intended impact.

Kids Thrive Collaborative Website

The Kids Thrive Collaborative [website](#), which went live in mid-June 2022 and replaced the Child Welfare Collaborative website, continues to be enhanced based on feedback from families and the identification of additional needs. Changes in the past six months include a link to DHHR’s Bureau for Family Assistance (BFA) updated programs website, which provides information on services and supports in specific counties/regions, and the addition of the “Did You Know?” video specifically for youth. A comprehensive review of the Kids Thrive Collaborative website

with consideration of updates and enhancements is planned for September 2023.

Other Outreach and Education Updates

DHHR continues to work closely with the WV Hospital Association and meets with the children's hospitals on a quarterly basis. The Pediatric Mental Health Summit identified a need for a crisis stabilization unit for children with a mental health crisis, and this need was also discussed internally within DHHR. In fall 2022, DHHR issued a request for architectural services to develop a crisis stabilization unit in Elkins, WV. In early 2023, the contract was awarded. The goal is to have the crisis stabilization unit open in 2024. As policies, procedures, and designs are being developed, the WV Hospital Association will provide input and insight into these documents.

In December 2022, DHHR initiated a collaborative with the WVDE, WV's court system, and the WV Department of Homeland Security (DHS). Meetings are expected to continue quarterly at the leadership level, with meetings in the interim for appropriate personnel to move collaboration and data collection efforts forward. All parties are committed to pushing efforts forward to raise awareness of HCBS, bringing data and information sharing to the forefront of this partnership to enhance interagency planning, and collaborating to identify and break down silos and barriers. A second meeting was held in spring 2023 with a focus on developing a data use agreement with the WVDE. The data use agreement is in negotiations. The next quarterly meeting will be held in summer 2023.

Additional upcoming outreach through the school system will include DHHR providing window clings for use in schools throughout the state. These window clings will include information on CCRL, the Assessment Pathway, and available services. The clings will also provide information and statistics to raise awareness of mental health as a common issue that should not be stigmatized and to normalize getting treatment.

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 are planning a one-day professional development meeting for juvenile probation officers and field staff supervisors in Fall 2023. To accommodate the size of the group, there will be separate meetings for the northern and southern counties. The meeting will focus on the QIA process, changes to RMHTF programming, and the role the Americans with Disabilities Act plays in working with children.

To continue to raise awareness within the judicial community, BSS is initiating statewide, virtual monthly lunch and learn opportunities, including three scheduled for August, September, and October 2023. Initial topics to be covered include the Americans with Disabilities Act and the QIA process. Additional topics and cadence of this outreach is still in discussion.

As identified through DHHR's prioritized discharge planning efforts (further detailed in Section 17.2(a) – RMHTF Services, Prioritized Discharge Planning), additional foster home capacity to serve youth ages 13 – 17 with complex mental and behavioral health needs is necessary to meet the demand of youth ready to be discharged from residential. To meet this need, a partnership has been established between Mission WV, BSS, Aetna, Child Placing Agencies (CPA), and current foster and adoptive parent representatives to drive an initiative to develop

this capacity. As a first step, the group selected 84 Agency, a marketing firm, to develop the overall campaign in conjunction with foster care partners. Proposals include a focus on the need for homes for youth 13+ and include current foster parent’s “voices.” An in-person strategy meeting is scheduled for July 31, 2023, to further outline the campaign and to establish goals, plans, and associated timelines.

BPH has continued outreach to physicians and clinics to improve overall EPSDT screening rates, to raise awareness of the Assessment Pathway as a mechanism for additional assessment and connection to services, and to promote use of the electronic referral process to the Assessment Pathway. As of June 2023, 421 of 694 primary care physicians (PCP) have been reached by HealthCheck specialists. Specific focus was placed on McDowell County, where a BPH program specialist provided in-person presentations to 10 of 13 clinics. For the three clinics that opted not to participate, a link to the presentation was provided. Further focus is planned for Region 2, although vacancy of the assigned program specialist for that region has delayed this training.

The marketing and outreach update from FirstChoice, which operates the HELP4WV call line, including CCLR, reports the following for July to December 2022:

- CCRL received 630 calls, an increase of 24% over the 507 calls in the prior six-month period.
- The HELP4WV program was featured in 53 news stories, with 10 of them specifically mentioning the CCRL.
- In September 2022, an ad campaign was launched that targeted digital ads through Nextstar Digital. The campaign employed various tactics, including search engine optimization, social media, display, pre-roll, YouTube, and CTV (streaming television), resulting in more than 1 million impressions. There were also 186 ads on WOWK TV, a Nexstar station and CBS network affiliate in the Huntington – Charleston, WV market with the second largest market area east of the Mississippi River; as well as 103 spots on WCHS TV, the Huntington – Charleston, WV; and Parkersburg, WV – Marietta, Ohio market areas for the ABC and Fox network affiliates.
- The HELP4WV website received more than 34,000 visits. The subpage dedicated to the CCRL accounted for 7,633 visits (22% of overall website visits). Additionally, the HELP4WV Facebook page had 122 posts, reaching a total of 190,251 people.
- Funds were allocated to print promotional materials, including 15,000 magnets, 8,000 brochures, 1,000 posters, and 40,000 wallet cards. These materials were distributed at community events as well as by local social service and mental health providers. Primary Care Providers, school counselors, school resource officers, and DHS Fusion Center liaison officers have also reach out to request wallet cards to use in their data to day work.

6.1 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 is expanding.

Next steps include DHHR's continued focus on a county-level approach involving risk ranking based on factors such as county-level RMHTF admission rates, CSED utilization rates, and rate of calls to the CCRL. This approach may be further expanded to include other factors, creating a flexible approach that responds to both successes and challenges as they arise. Maps developed from county-level risk ranking will be used by the bureau and program teams to drive county-specific efforts for prioritized service areas. The bureaus are currently in the process of developing specific outreach plans and timelines to address the prioritized counties.

Efforts to improve direct outreach and the Kids Thrive Collaborative website based on feedback will be ongoing.

Based on the lack of available community-based placement capacity to accommodate children ready to discharge from RMHTFs, the prioritized focus for DHHR in the coming months is the foster care collaborative and associated campaign aimed at increasing the number of foster families willing to serve youth ages 13 – 17 with complex needs.

DHHR aims to continue to humanize processes and address common misconceptions, ultimately simplifying system navigation and building trust with the families who need these services. These combined efforts, along with monitoring 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 identifying opportunities for further improvement.

7.0 Screening

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

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

Children with an identified potential mental health need (i.e., positive screen) are then referred to the Pathway to Children’s Mental Health Services (Assessment Pathway) for additional evaluation and referral to 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, while efforts associated with data quality and expanded reporting are 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 who may have lower screening rates and/or underutilization of community-based referrals.

Figure 7: Screening Data Overview

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

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
			– 20 who had a well-child visit during calendar year 2021. The random sample is a subset of the total children screened.	to retrieve information on members in the Medicaid population and members receiving EPSDT screenings.
CPS/YS	N/A – Early data under internal review due to concerns with data reporting consistency, which is being addressed through updated reporting methods and quality checks in place for all counties as of June 2023.	BSS CPS and YS Shared Excel Spreadsheet	Data collection was initiated in April 2022; enhanced collection methodology was put in place statewide as of June 2023, and technical assistance continues to strengthen reporting, screening, and referral practices.	CPS and YS cases including screening and referral information for the case for youth monitored in home or DHHR custody.
CPS and YS	July 2022 to December 2022	Fostering Healthy Kids Data System	The Fostering Healthy Kids data system is a subset of FACTS data and does not include child exit date. This might make it unclear if an individual had time to be screened before exiting placement. Considerations for data lag are still being assessed.	Children with a CPS and/or YS case in DHHR custody including screenings conducted via a wellness visit.
BJS	July 2022 to December 2022	Offender Information System	Some screenings included are representative of youth report centers in addition to screenings that occurred at BJS commitment and detention centers. On occasion, children are screened twice in the	Children in juvenile detention and commitment facilities screened using the MAYSI-2 who have a juvenile delinquency offense; some additional screenings from Youth Report

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
			<p>same day or within a few days of entry if there is reason to believe the first Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) was not valid. This might impact total screens when not unduplicated at the child level.</p> <p>A small number of children who were screened in a given month are not included in existing data pulls if they were not active members of the BJS population when data was pulled early in the following month. This anomaly is expected to be resolved in future data pulls.</p>	Centers have also been included.
Division of Probation Services	July to December 2022	Probation Web-Based Data Collection Form	Screening and data collection was implemented March 1, 2022.	Children adjudicated as a status offender or delinquent as well as children not yet adjudicated who either lack a DHHR worker or are in immediate crisis 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 continue to be a key focus of DHHR’s work to help ensure children are meeting developmental milestones and are receiving and being connected to important preventative and early intervention services. While overall EPSDT screening rates have remained stable from 2020 – 2021 at 46%, the number of children receiving mental health

screenings⁹ increased from 2020 to 2021. The Office of QA has continued to meet with representatives of BMS throughout the first half of 2023 to discuss strategies to further engage the broader group of MCOs under Mountain Health Trust, in the efforts to improve screening rates and move toward the goal of at least 52% of Medicaid-eligible children receiving an EPSDT with mental health screening. As a further step toward meeting this goal, the Wellness Screening PIP team has begun internal and routine review of preliminary claims data to expand understanding of children in need of screening and common characteristics. The team is collaborating with the WVDE and Mountain Health Trust to explore opportunities for additional outreach to children and families directly as well as indirect outreach via school handouts 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, including follow-up with families to remind them of needed visits (by call, text, and mail), calls from the child’s case manager at least quarterly with reminders about wellness screenings and importance of these visits, and gift cards for families completing their annual wellness screening. Although the efforts put in place have been extensive, the MCOs still note challenges contacting families directly. By exploring further outreach via public schools, it might be possible to reach families who might not respond to unknown calls. 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 the MCO that provides care management to the most children, Aetna, on 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 information is provided on the Assessment Pathway and associated children’s mental health services and resources as relevant to each child.

Other efforts in collaboration with the MCOs and HealthCheck specialists will include enhanced and focused training and education with primary care providers to help ensure appropriate mental health screening and use of the electronic referral process when individuals screen positive. Focused training and education were updated based on results from a survey conducted with providers in September 2022, which was designed to collect information on primary care provider perspective and awareness of the electronic referral process (182 surveys submitted). Of those completing the survey, 62% of providers indicated a lack of awareness of the electronic referral process, despite previous outreach. Among responders who were aware of the electronic referral process, 48% responded “agree” or “strongly agree” to “I prefer to refer children/youth to local mental health providers directly,” with an additional 39% neither agreeing nor disagreeing with the statement. Survey responses also noted concerns with inability to know

⁹ Forty-six percent of Medicaid-eligible children aged 0 – 20 with at least 90 days of consecutive eligibility received a HealthCheck screening through their primary care provider in 2021. This data has been compared to the most recently available chart review (children screened in 2021), which found through a retrospective analysis of medical records linked to administrative claims, 83.3% of children’s medical records indicated a mental health screening was included during the primary care provider exam, an increase from 79.5% found in the 2020 chart review. Extrapolating from the chart review results, an estimated 38.5% of Medicaid eligible children aged 0 – 20 with at least 90 days of consecutive eligibility received an EPSDT with mental health screening in 2021. This is an increase from 36.5% screened with a mental health component in 2020. The next medical record review is planned for fall 2023 to review 2022 claims.

the outcome of a referral through the electronic process compared to local/direct referrals. Based on this feedback, DHHR worked with the CCRL vendor to incorporate secure email feedback to primary care providers following submission of a referral. This change allowed providers to know whether the family was able to be connected to the Assessment Pathway. This change, which was incorporated in February 2023, is included in provider trainings and outreach, which are scheduled for completion in July 2023. HealthCheck also provided additional technical assistance to regions indicating higher percentages of training needs or concerns with the electronic referral process. Feedback shared from one of these trainings noted that a staff member from the local ED participated; this participant stated the training was very helpful and could be helpful to share this information with other EDs as an intervention and referral opportunity.

One hundred fifty-four (154) submissions were received through the electronic referral process from January 2022 to March 2023. While the number of electronic referrals has generally increased each month, additional awareness and buy-in is needed among the nearly 700 HealthCheck providers to advocate for the benefits of a centralized process and adequately connect children and families to appropriate services when they are needed. County of submission was added to the referral form in February 2023, and will continue to be helpful for outreach and technical assistance efforts.

Wallet cards continue to be provided to primary care providers to give to families during well-child visits. These wallet cards identify challenges (such as example behaviors) the family might be experiencing with their child and provide multiple avenues to connect to the CCRL. Primary care providers have had a very positive response to the wallet cards and 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 follow up at any time directly based on their own decision-making and schedule. While screening and referrals directly from primary care providers will be a focus area for improvement, the current system allows for multiple opportunities for a family to be connected.

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

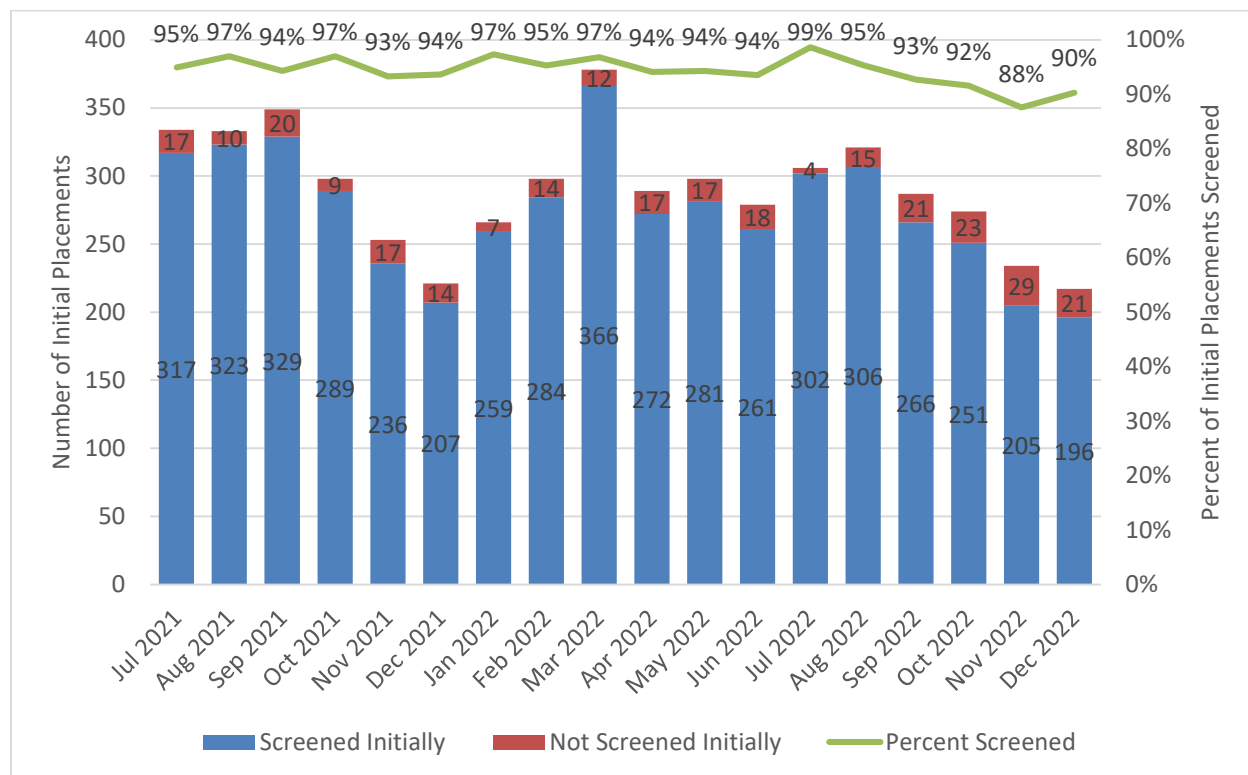
Youth in Foster Care or Certified Kinship Care (includes youth in YS and CPS)

It is required that all children placed in DHHR custody via the child welfare system, including both YS and CPS, receive an EPSDT screening during a well-child visit, which includes 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 8 shows monthly initial screening rates for children placed in DHHR custody. On average for the 18-month period shown, 95% of children were screened upon initial placement. As previously noted, the Fostering Healthy Kids data system is a subset of FACTS data and does not include child exit date; therefore, at this time it is unclear if individuals who were not screened had sufficient time to have an EPSDT screening during a well-child visit before exiting placement. 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 put in place by both CPAs and BSS, help maintain these high screening rates. Ongoing enhancements and validation with the new WV PATH system and the data store build-out will help further DHHR’s understanding of characteristics of unscreened children. Additionally, the slight decreases in placements and children screened have been noted (3,946 placements in 2021 compared to only 3,447 placements in 2022). This decrease will continue to be monitored in the coming months along with considerations for potential data lag, which may impact placement numbers and screening rates in the most recent months; while unclear at this time, these fluctuations may also be associated with the WV PATH system conversion.

Figure 8: Initial Child Welfare Placements and Screenings by Month, July 2021 to December 2022



Initial screenings for children in a child welfare placement (initial placement in 2022) were assessed by age. Figure 9 indicates children ages 0 – 5 had the highest screening rates (96%) compared to children ages 9 – 18 with slightly lower screening rates (93%). In total, 94% of children with an initial placement in 2022 were screened. As noted, the Fostering Healthy Kids data system is a subset of FACTS data and does not include child exit date. This makes it unclear if an individual was in placement long enough for the screening to occur or be required (policy states screenings should be completed within 30 days of placement). Additional analysis following enhanced data availability will allow DHHR to differentiate children whose screenings were missed versus those who were not in placement long enough for screening to be completed. It will also be important to help ensure unscreened children have screening opportunities through other avenues. This can be assessed through future cross-systems utilization analysis.

Figure 9: Initial Screenings for Child Welfare Placements in 2022 by Age Group

Age Group at Beginning of Placement	Screened Initially (n)	Screened Initially (%)	Not Screened Initially (n)	Not Screened Initially (%)	Total
0 – 5	1,470	95.8%	65	4.2%	1,535
6 – 8	411	94.1%	26	5.9%	437
9 – 18	1,364	92.7%	107	7.3%	1,471
Other/Unknown	4	100.0%	0	0.0%	4
Total	3,249	94.3%	198	5.7%	3,447

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 establishment of the case¹⁰. This policy reinforces identification of mental health needs early to allow referrals to be conducted quickly, regardless of whether the child is placed in child welfare custody or receiving home-based services. A phased county-by-county rollout of screening, referral to the Assessment Pathway, and associated data collection was initiated in April 2022.

Analysis of early data showed challenges with data quality and completion. Subsequently, regular data sharing was established with BSS to review county level results, describe data quality and completion issues, and identify areas for technical assistance. Through these reviews, BSS and the Office of QA determined enhanced data collection methodology was needed to help improve data quality and accountability. These changes were implemented via a pilot in December 2022 and subsequent statewide rollout which was completed in June 2023. Monthly data is now available at the county level for field-level feedback and further opportunity to drive accountability and quality improvement in both processes and data collection for these additional screening efforts. Additional training and feedback will also be provided to district leadership via routine monthly meetings and direct outreach as needed. These focused efforts to improve data quality will help DHHR promote consistent use of screening tools for early intervention opportunities, which will influence appropriate referrals to the Assessment Pathway—in addition to those completed via the HealthCheck program.

CPS and YS referrals are identified as the referral source for 65% of CSED Waiver applications submitted to Acentra Health for the period July-December 2022 (see section 10), providing strong evidence that children are being referred to the Assessment Pathway for further evaluation and connection to services. Outreach and direct communication with both BSS field staff and district leadership will continue to ensure appropriate and timely referrals are made

¹⁰ 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.

and documented based on standardized tools and processes, helping ensure children served in the child welfare system can live in the least restrictive setting and be connected to services to meet their needs.

As noted in Section 10 (CSED waiver), referrals meeting initial eligibility requirements for the program decreased slightly over the last six months of 2022. Further investigation identified approximately 89% of referrals that resulted in a CAFAS/PECFAS score less than 90 (which does not meet CSED Waiver eligibility criteria) originated from YS or CPS. While any referral through the Assessment Pathway is processed and referred to other, more appropriate services based on the needs and wants of the family, this finding may be indicative of staff’s eagerness to refer children to the Assessment Pathway rather than relying on the results of the FAST or Ongoing Assessment screening tools. DHHR will continue to monitor these trends as CQI strategies for BSS screening efforts are further implemented.

7.2(c) BJS Screening

Children involved in BJS are screened at intake and at each time they transition between BJS facilities. Figure 10 below captures screening by BJS for the period of January 2022 to March 2023. The total population¹¹ of children in BJS custody varies over time and ranged from 208 (September 2022) to 319 (March 2023) with an average of 257 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 95 for the period shown. Additional data is needed to understand fluctuations in the population and the number of intakes over time.

Unique screenings varied throughout the period with a low of 91 in August 2022 and a high of 162 in March 2023. There was an average of 114 unique screenings per month, an increase from 105 in the data included in the January 2023 Semiannual Report. The number of screenings per month should equal or exceed the number of intakes per month because each child entering BJS custody should be screened at intake. The number of unique screenings per month exceeded the number of intakes for 11 of the 15 months represented with the exceptions occurring in May, September, October, and December 2022. This is a positive sign indicating that screenings are taking place as expected. The Office of QA continues to meet at least quarterly with BJS to improve understanding of the data and work toward quality improvement. Data review has expanded to include review of data disaggregated by BJS facility in order to continue making improvements in screening and provide direct feedback for more targeted improvement efforts. The Office of QA has requested the addition of booking date (i.e., date of intake) in the monthly reporting to facilitate a better understanding of screenings versus intakes, including timelines from intake to screening.

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

The percentage of positive unique screenings remained relatively consistent during the

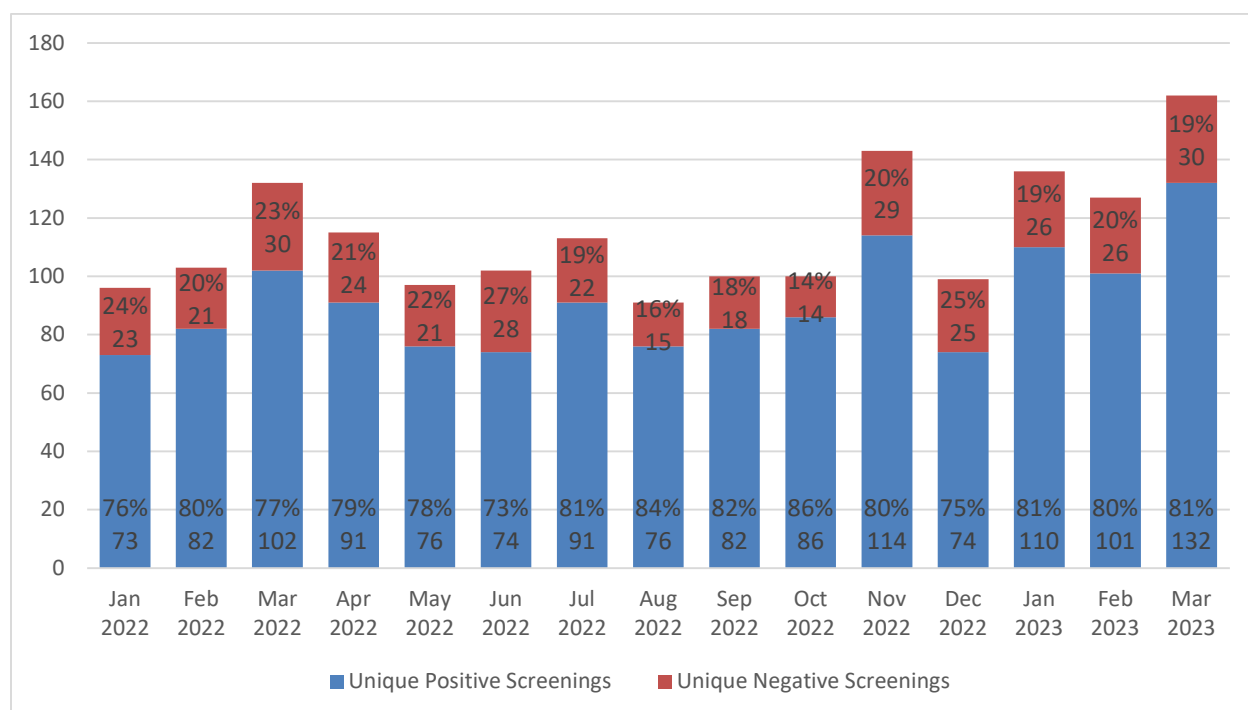
¹¹ BJS population data are a point-in-time measure captured on the last day of each month and do not represent the number of unique children in BJS custody during a given month.

reporting period, ranging from a low of 73% in June to a high of 86.0% in October. In total for January 2022 to March 2023, 1,008 of the 1,166 unique children screened had a positive screen (86.4%), slightly higher than the percentage of positive screenings in the January 2023 Semiannual Report (85.2%).

BJS collaborated with BMS in late 2022 to establish a process for making referrals to the Assessment Pathway for children in BJS custody who screen positive. The goal is to determine eligibility for services in advance of a child’s release from BJS custody and to establish a smooth transition into services following discharge from BJS. To support coordination of care, BJS staff meet with Aetna care managers twice monthly to coordinate services for children approaching discharge. Aetna care managers are also included in the multidisciplinary team (MDT) meetings for children in BJS facilities to assist with coordination of care and services.

BJS began making referrals to the Assessment Pathway in the fourth quarter of 2022. The Office of QA is collaborating with BJS to determine if there is a way to track and report referrals to the Assessment Pathway in the BJS’ Offender Information System. There does not appear to be a direct way to capture this information in the current system, but efforts continue to determine if this can be established. DHHR coordinated with Acentra Health to update data collection to include BJS as a referral source to allow quantification of these referrals for future reporting. This was a recent change; therefore, data on BJS referrals to Acentra Health (i.e., the Assessment Pathway) is not available for this report.

Figure 10: BJS MAYSI-2 Mental Health Screenings, January 2022 to March 2023



7.2(d) Division of Probation Services Screening

Screening of children adjudicated as status offenders or delinquent and the associated data

collection was implemented by the Division of Probation Services effective March 1, 2022. These screenings are conducted at intake by the assigned probation officer. 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 DHHR worker assigned to support early intervention efforts for those children who may pose a higher risk. Screening may also be conducted at other intervals based on the probation officer's discretion. From March 2022 to March 2023, a total of 512 children were screened.

Intakes¹² completed from March 2022 to March 2023 varied from a low of 180 in July 2022 to a high of 978 in March 2022 with an average of 514 intakes per month. For children with an intake date during this period, the number of children adjudicated as status offenders or delinquent ranged from a low of 38 in September 2022 to a high of 102 in March 2023 with an average of 74 children adjudicated per month. The month-end population of children on formal probation (i.e., adjudicated as status offenders or delinquent) for the March 2022 to March 2023 period varied from a low of 974 in December 2022 to a high of 1,138 in May 2022 with an average of 1,066. The Office of QA 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.

The Probation Services screening and referral process is still being adopted across the state and is not considered representative of the total screenings anticipated once the process is more fully adopted. The data in this section is representative of 37 counties in WV, an increase from the 27 counties represented in the January 2023 Semiannual Report.

Based on a recommendation in the prior semiannual report, and to continue to improve awareness and adoption of the screening and referral process, Probation Services began sharing quarterly screening data by county with the chief probation officers. The first quarterly screening report was issued in early March 2023 and has been associated with an increase in screenings. As of July 2023, the screening and referral process has also been incorporated into the training materials for new probation officers. Changes in screening will be monitored quarterly for additional opportunities to address any remaining screening challenges.

Figure 11 shows the number of screenings of children in Probation Services for the 37 counties that submitted data between March 2022 and March 2023. Five hundred twenty-two (522) screenings were conducted during the reporting period,¹³ with an average of 40 screenings per month. Of the 200 individuals screened between July and December 2022, 65% identified as male and 35% as female. Ninety-four percent (94%) of those children were between 13 and 17 years old when they were screened, and 5% were 9 – 12 years old. These demographics are consistent with the prior reporting period. Of the screenings that occurred between March 2022

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

¹³ Ten children were screened twice.

and March 2023, 211 (40.4%) were positive while 311 (59.6%) were negative.

Figure 11: Probation Services MAYSI-2 Screenings, March 2022 to March 2023

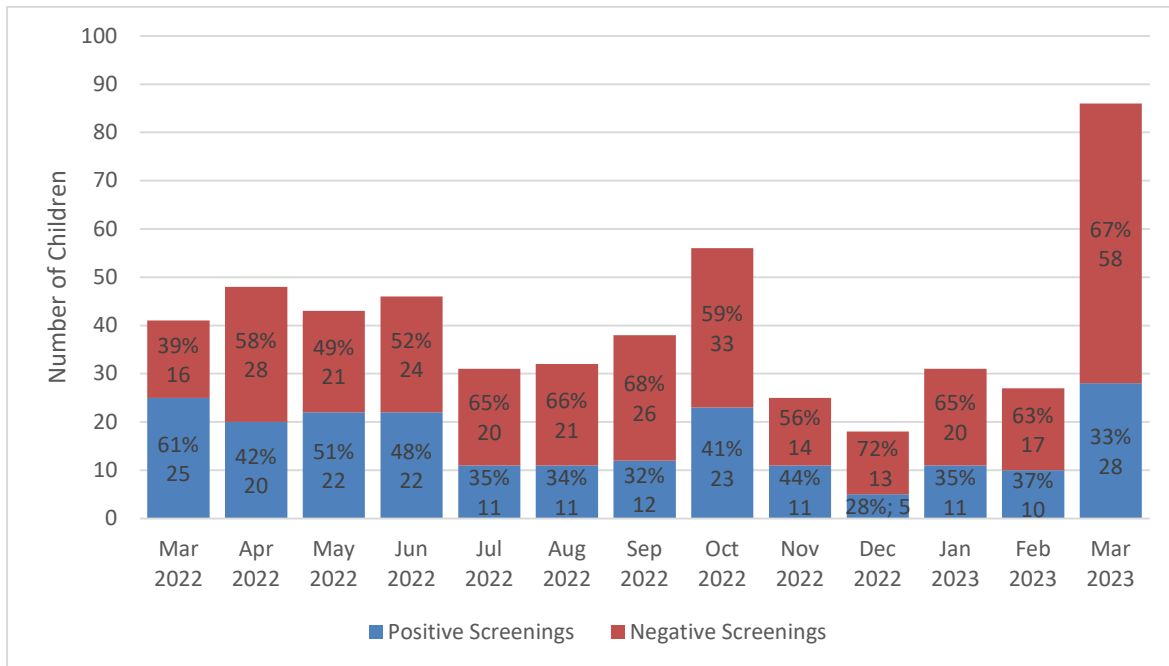
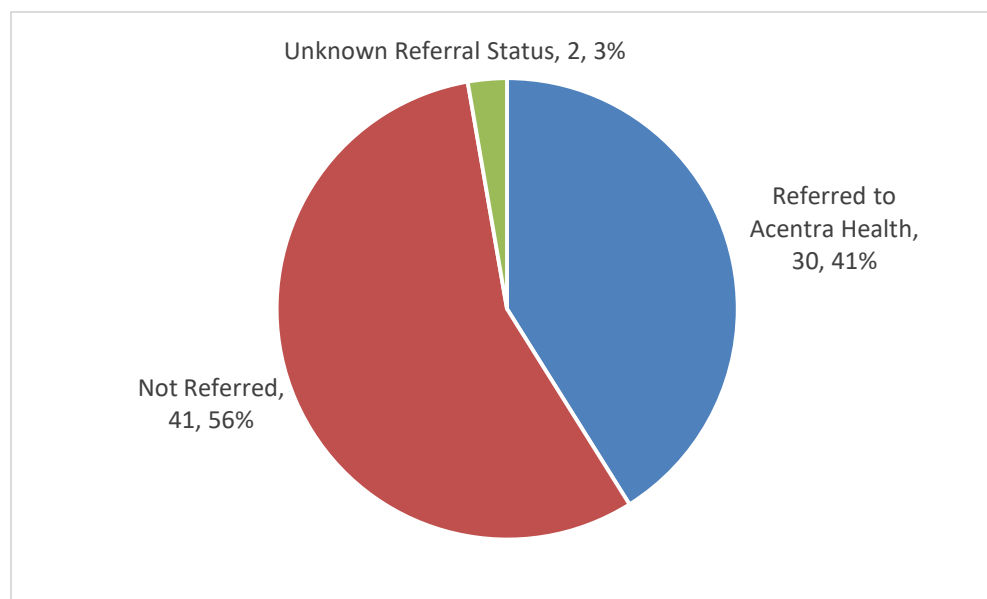


Figure 12 shows the referral status for the 73 children who screened positive from July to December 2022. Thirty children (41%) completed an application and were referred to the Assessment Pathway (Acentra Health, formerly known as Kepro) for further evaluation. On average, these children were referred within five calendar days of their positive screening. Twenty children (66%) were referred within two days of screening, and 77% (n = 23) were referred within 10 days.

Figure 12: Referral to the Assessment Pathway (via Acentra Health) for Children With a Positive MAYSI-2 Screening Through Probation Services, July 2022 to December 2022 (n = 73)



A standardized drop-down was developed in conjunction with the Probation Services team to capture the reason for not completing referrals when a referral was declined. For the 43 children who were not referred or who had an unknown referral status, the most commonly listed reason for declining the referral was that the parent/guardian believed other mental health services that were already in place were sufficient to meet the needs of the child (n = 28, 65%). This is a positive sign that children are already accessing services. Probation officers can voluntarily record service information in the OCMS, and review of that data has been identified as a next step to understand what services children in this population are accessing. Further build-out of the data store will also allow an analysis of services these children are accessing based on claims data (projected availability in 2024). Additional service data will also be available following the build-out of the data store.

7.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing an EPSDT with a mental health screening, outreach to primary care providers about the Assessment Pathway started in November 2021, and all EPDST clinics (approximately 694 clinics) were trained by November 2022 on the CCRL (including CMCRS services) and on the provider electronic referral process. Resources were distributed to all sites. As previously described, enhancement of materials and training for screening and referral efforts is planned for completion in July 2023, and additional training and technical assistance needs will be reassessed in fourth quarter 2023.

Child welfare position vacancies continue to be a concern for effectively implementing screening and maintaining trained staff. As of May 2023, 6,456 children were in the child welfare system. As of May 2023, 80% of child welfare workforce positions were filled, which includes CPS and YS workers, supervisors, and coordinators, compared to 72% of positions filled in December

2022. Figure 13 shows the vacancies by service type. 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, which authorized a \$5,000 hiring bonus for the positions of CPS worker, CPS worker trainee, and social service worker 3 (Youth Services), requiring a one-year employment commitment in Berkeley, Jefferson, and Morgan counties. Twenty-six additional counties were made eligible for a \$2,500 sign-on bonus for the positions listed above, which also requires a one-year employment commitment: Calhoun, Clay, Fayette, Gilmer, Grant, Greenbrier, Hardy, Harrison, Kanawha, Lewis, Logan, Marion, Mercer, Mineral, Mingo, Monongalia, Monroe, Nicholas, Pocahontas, Preston, Roane, Summers, Taylor, Wayne, and Webster. Workforce needs continue to be at the forefront to address both recruitment and retention challenges with this valuable yet challenging work.

Figure 13: Child Welfare Workforce May 2023

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

Service Type	Positions Filled	Positions Vacant	Total Positions	Percent of Positions Filled
CPS	530	124	654	81%
YS	102	37	139	73%
Total	632	161	793	80%

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

7.4 Strengths, Opportunities, Barriers, and Next Steps

Data collection associated with screening has been established across all screening entities and continues to progress based on the needs of the entry point. Processes that touch a broad range of professionals might be expected to take additional time and resources to implement with consistency and integrity. DHHR 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. Given the high percentages of referrals originating with child welfare and other screening sources, DHHR is collaborating with Acentra Health (formerly Kepro) to help ensure they are prepared to handle the continued increase in referrals that is projected.

DHHR will continue to review primary care provider electronic referral submissions to determine effective use of the referral system and implementation of training and technical assistance activities. The addition of county-level information can help drive more direct outreach by the MCOs and HealthCheck specialists. In addition to provider outreach, DHHR will review preliminary claims data and provide feedback to the MCOs regarding provider trainings and outreach to families to encourage wellness visits and screenings. DHHR, with assistance from the MCOs, will also explore outreach on awareness of importance of wellness screenings and availability of the CCRL, which could be provided via school handouts. Efforts continue to

enhance reporting by the MCOs to provide more extensive information related to child screenings.

BJS screening data indicates the screening process has been widely adopted. Work continues between the Office of QA and BJS to provide routine reporting at the facility level. Early analysis of facility-level data identified some discrepancies, which may be a result of current reporting pulling data only for active children. Next steps involve resolving discrepancies in the monthly reporting and enhancing data collection to assist with helping to ensure children who screen positive are referred to the Assessment Pathway. BJS screening data and Acentra Health referral data are expected to be available in the data store by year-end 2023, which will allow improved analysis of whether children are being referred. Given the high rates of positive screens for children in BJS custody, this connection to the CSED Waiver and other services is a critical component for their success in the community.

Probation Services made improvements in the adoption of the screening and referral process with the number of counties reporting screening increasing to 37 counties compared to 27 counties in the prior report. Next steps are to continue providing quarterly screening reports to the chief probation officers, drawing attention to counties with low or no reporting. The reporting will include a new dataset capturing the number of adjudications versus the number of screenings by county. Individual data review meetings are planned with chief probation officers whose counties show significant discrepancies between adjudications and screenings.

WV continues to face workforce shortages in CPS and YS positions; however, recent recruitment efforts have resulted in decreased vacancy rates. Although these improvements are expected to ease strain on the workforce, these impacts have likely not been seen yet due to timelines associated with onboarding new staff. DHHR 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; processes such as screening and referral have been added to new employee training to encourage sustainability.

Data completion, quality, review, feedback, and technical assistance will be key in continuing to enhance screening at multiple entry points. The data store will also help DHHR better understand the child and family journey as well as opportunities and strengths in the current system as it is built out. This component is expected to be built out for early analysis and consideration in early 2024. Screening and referral to the Assessment Pathway and associated efforts to help ensure children with mental health needs are evaluated and connected with services to help them remain in their homes and communities continue to be a strength in DHHR's updated processes.

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 (as outlined previously)
- CSED Waiver services, which include WV Wraparound Facilitation
- 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 appropriate linkages to services while the assessment process is being completed. The Assessment Pathway links 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 will receive community-based services to meet interim needs, and families will receive information on how to connect to crisis services. Unless a QIA is warranted, the child will be referred to HCBS appropriate for their needs, including CSED Waiver services for those who are eligible. Children going through the QIA process will receive further assessment of their treatment needs, including if a residential treatment setting is needed to meet current needs. This process is further outlined in Section 9.0 Qualified Independent Assessment.

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 at immediate risk of RMHTF placement will have 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, allowing many children with lower acuity to be diverted to the community when needs can be met in that setting.

Because children can access the behavioral health service system via multiple avenues, DHHR 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 14 provides an overview of the Assessment Pathway referral data.

Figure 14: Assessment Pathway Data Overview

Description	Data Review Period	Data Source	Details and Limitations	Population Measured
Assessment Pathway – Referrals facilitated through BBH and the CCRL, as well as referrals for connection to interim services originating with Acentra Health (formerly Kepro)	July to December 2022	BBH Assessment Pathway Tracking Portal	The portal is a stand-alone site that allows monitoring of progress but will need to be connected to other data via the data store. Timeliness indicators are calculated using weekdays; this may not account for state and federal holidays, which could provide some additional lag in response.	Referrals to BBH, including referrals for interim services from the CCRL, CMCRS teams, and Acentra Health (formerly Kepro) for children applying directly for the CSED Waiver.
Assessment Pathway – Referrals made directly to Acentra Health (formerly Kepro)	For CSED data, see Section 10.0 CSED Waiver Enrollment and Services, which includes referrals by type (e.g., DHHR, parent). As the data store is built out further, data will be able to be aggregated across provider sources to develop a more complete picture of connection to mental health assessment and related services in WV.			

8.2 Review Summary

BBH implemented the Assessment Pathway Tracking Portal on January 1, 2022, as a means of data collection associated with the early stages of the Assessment Pathway. The results presented in this section correspond to 454 unique children referred from July to December 2022. Some figures include a subset of these children, and the number of children included in those figures has been noted accordingly.

The Quality Committee reviewed county-level coverage to assess opportunities for outreach (Figure 15). The county-level Assessment Pathway referral rates were reviewed per 1,000 children. The counties with the highest referral rates are Ritchie (3.80 per 1,000 children), Mason (3.43 per 1,000 children), and Lincoln (3.02 per 1,000 children), while the counties with the highest number of referrals are Kanawha (n=44, 9.7% of all referrals), Berkeley (n=30, 6.6%), Raleigh (n=29, 6.4%), and Cabell (n=25, 5.5%). The counties with the most referrals from July to December 2022 are similar to those in the previous reporting period; given these counties include many of the state's population centers, this pattern of referrals is to be expected.

Only two counties did not submit a referral during the last half of the year: Pendleton and Pocahontas counties. Pendleton, a small-population county with less than 1,400 children, was the only county to have zero referrals in 2022. Programmatic review processes included discussion regarding the rural nature of these counties, other available mental health services that children may be accessing and sufficiently meeting their needs, and considerations around children with referrals initially processed by Acentra Health (formerly Kepro). These considerations will be further assessed through the data store build-out, which will allow review of referral crossover between BBH and Acentra Health to help ensure consistency, timeliness, and quality in processes. Both counties with zero referrals share borders with Virginia, and it is possible that families in WV may be accessing mental health resources and supports out-of-state. Members of the Quality Committee suggested that additional Medicaid claims data should be explored to better understand services at-risk children are accessing and if this could have an impact on referrals. The team noted availability of additional services as a positive opportunity for children and families and something that should be further explored to help ensure access and awareness are not issues. DHHR will also look to the upcoming Children's Mental Health Evaluation results for insight into regional needs as identified by families, youth, and providers. While robust CQI efforts will continue, referrals to the Assessment Pathway from 96% of the state's counties in 2022 show continued expansion and progress for outreach and awareness-raising efforts, as eight counties had zero referrals during the first half of the year.

Figure 15: County-Level Assessment Pathway Referral Rates, July - December 2022

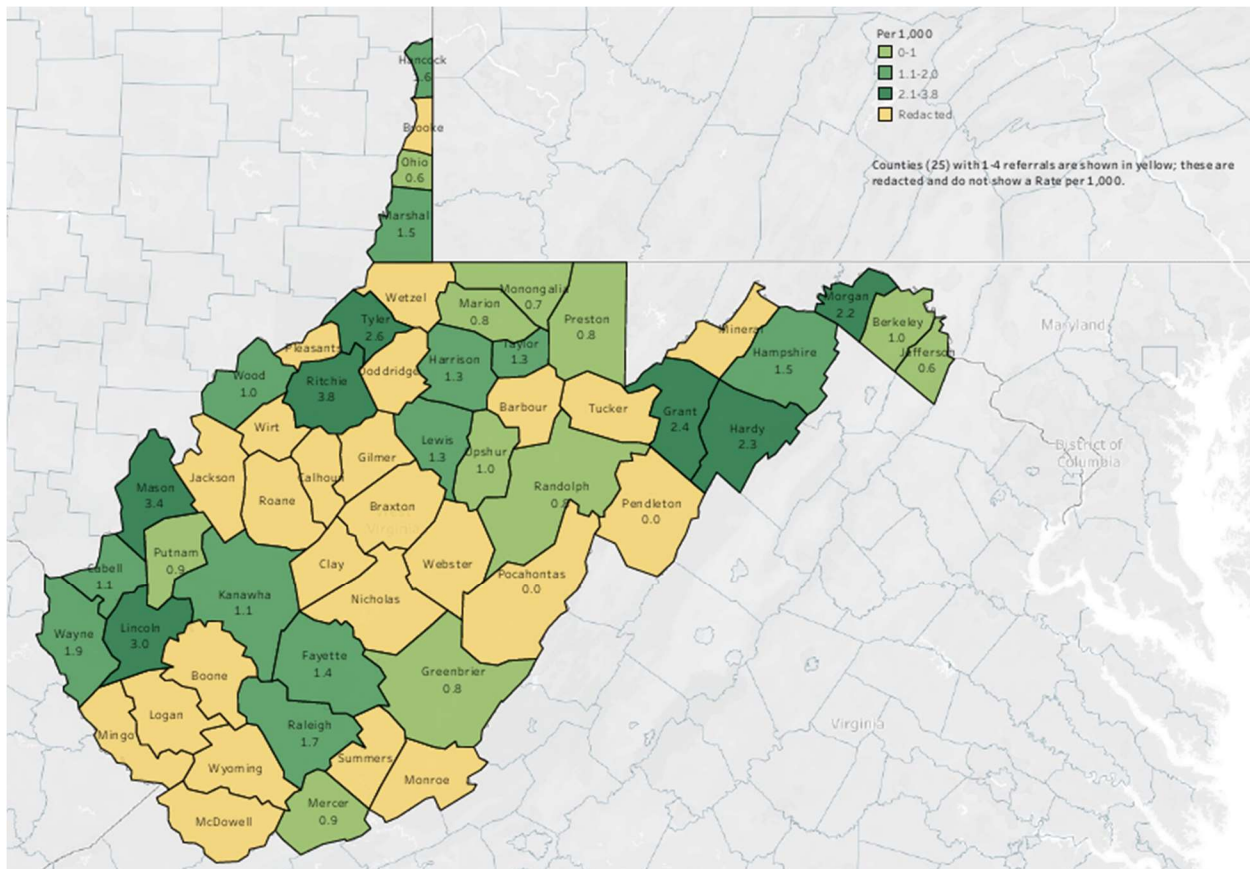


Figure 16 depicts the number of referrals for unique children by month.¹⁴ Referrals have continued to increase since the inception of the Assessment Pathway in late 2021, with an approximate doubling of referrals year-over-year from March 2022 to March 2023. Notably, there were more referrals in the first three months of 2023, 507 unique children referred, than in either six-month period in 2022, which had fewer than 500 referrals in each six-month period. This demonstrates continued growth in awareness as well as the need of connection to services.

¹⁴ Unique children were unduplicated by six-month periods of review. All referral information uses this methodology, including when combining referrals for the year total. This is a slight change in methodology from previous reports, which included all referrals per month. Incidence of multiple, distinct referrals for individual children has been very low but will be continued to be monitored. When multiple, distinct referrals were received in a six-month period for a child, only the most recent referral was included for that child during the six-month periods (January to June and July to December). Referral data for January to March 2023 may be subject to slight change due to this methodology once data for April to June 2023 becomes available and can be unduplicated for the period.

Figure 16: Referrals by Month, January 2022 to March 2023

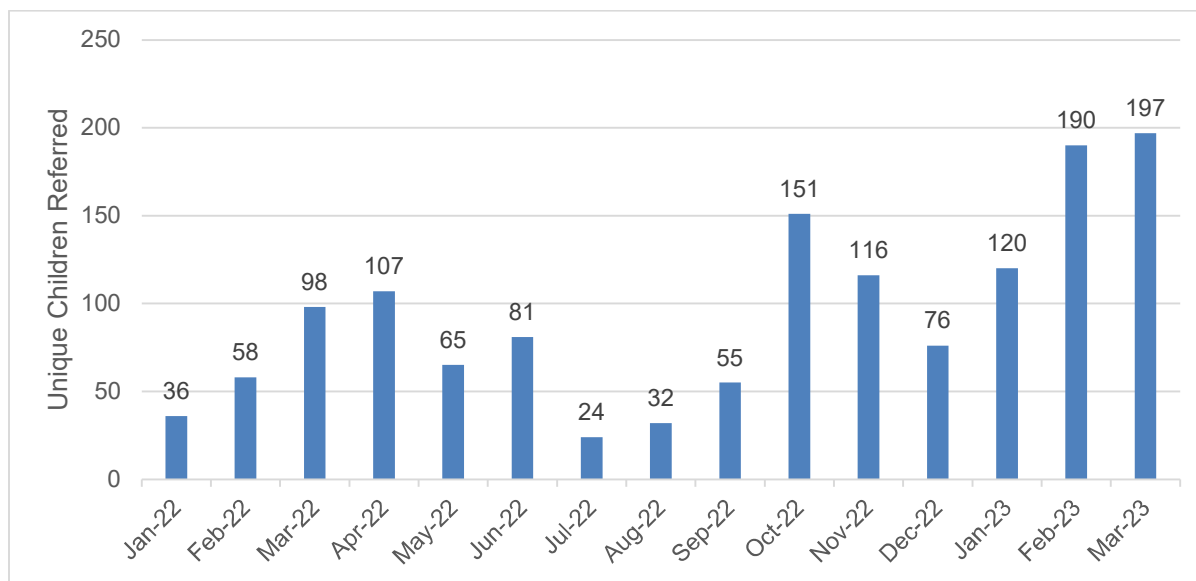
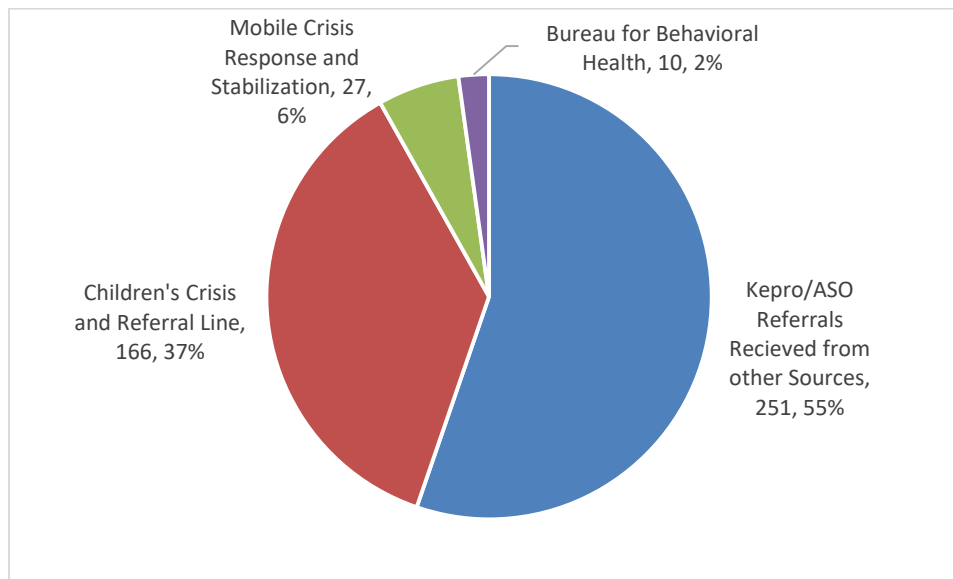


Figure 17 shows the breakdown of referrals by the source of the call/initial referral. As with the previous reporting period, the largest source of referrals to the Assessment Pathway interim services was from Acentra Health (formerly Kepro) (n=251, 55%), followed by the CCRL (n=166, 37%). As the data store is expanded, referral sources originating from Acentra Health will be able to be further integrated into one visual; however, at this time, Acentra Health includes referrals from multiple sources that are connected to the Assessment Pathway via Acentra Health. These sources include, but are not limited to, child welfare, YS, MCO, BJS, and Probation originating referrals. Referrals from BPH screening efforts via HealthCheck/EPSTD electronic referral processes originated via the CCRL (25 referrals for the six-month period), and caregivers also had the option to call the CCRL directly. Referrals from the MCRS comprised only 6% (27 children) of initial referrals. Although not all children engaging in these services may meet CSED eligibility criteria or want additional services, and considering there are some children who engage in MCRS services via a local call line rather than via the CCRL, this may be a lower rate of referrals than would be expected. As noted in Section 16.0 Children’s Mobile Crisis Response and Stabilization, additional focus will be placed on individuals with multiple calls as a starting point to help ensure children are receiving appropriate connection to longer-term services.

Figure 17: Source of Call or Initial Referral, July to December 2022



8.2(a) Timeliness Indicators

DHHR tracks timeliness measures in four key steps from initial contact following referral to assignment of the Wraparound Facilitator for quality improvement purposes related to the Assessment Pathway process for interim services.¹⁵ Once additional components of the data store are built out so critical data elements can be connected across systems, DHHR expects to add the fifth key timeliness step to better understand the family's journey and total time to the child's first meeting with the provider. These timeliness measures are helpful in assessing families' experience in accessing services at individual stages in the process as well as the overall experience.

Of note, out of children continuing to pursue services through the Assessment Pathway (n=333), 297 (89%) were placed on the waitlist for interim Wraparound Facilitation¹⁶ during July to December 2022. Given current data connection limitations, if it is assumed that transfer to CSED Waiver is typically associated with immediate assignment; the typical timeline from receipt of CAFAS/PECFAS information from Acentra Health to assignment or transfer to a facilitator was 20 weekdays. Figure 18 shows the tracked referral outcome for these 333

¹⁵ Note that clients failing to respond to BBH's contact attempts, and clients declining further participation, are not included in analysis past Step 1, while referrals made by Acentra Health (formerly Kepto) bypass Steps 1 – 3 and begin the Assessment Pathway process at Step 4.

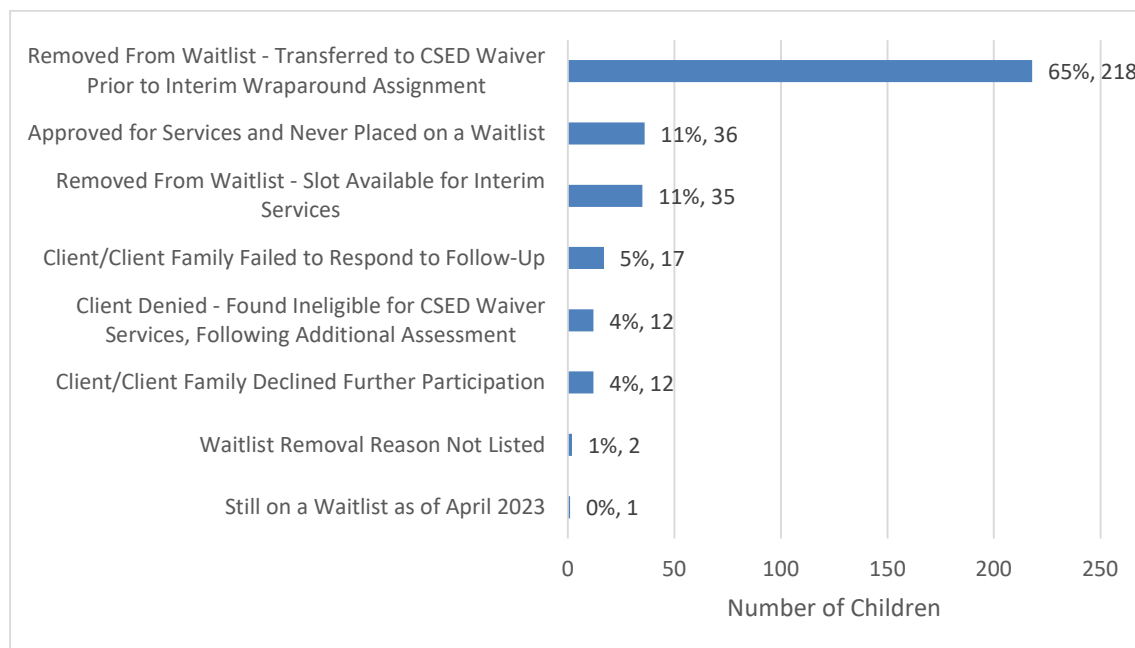
The four key steps include: Step 1: BBH makes initial contact with family following receipt of referral; Step 2: BBH works with the family to complete the CSEDW application and submit the application to Acentra Health; Step 3: Acentra Health receives the application, completes the CAFAS/PECFAS, and reports results back to BBH; Step 4: BBH assigns the Wraparound Facilitator agency. A fifth step will be added once data store build-out is complete: Step 5: The Wraparound Facilitator sets up an initial meeting with the family.

¹⁶ This waitlist number is not inclusive of children on the waitlist for CSED Waiver Wraparound Facilitation services. Reference section 11.2(b) Wraparound Services through CSED Waiver.

children. Eleven percent (11%, n = 36) of children were assigned to an interim Wraparound Facilitator without being placed on the waitlist, while 65% (n = 218) were transferred to CSED Waiver prior to assignment of an interim facilitator.

Of referrals placed on the waitlist (n=297), 10% ceased participation in the pathway¹⁷. As depicted in Figure 18—that is, 9% of children approved or preliminarily approved ceased participation (combined n=29). It is unclear at this time if being placed on the waitlist and/or long waiting times for interim Wraparound Facilitation services influenced families’ decision to cease participation in the Assessment Pathway. Concerns about being added to a waitlist or time to receive Wraparound Facilitation services as a reason for ceasing participation has since been added to the list of options for this indicator, effective June 2023.

Figure 18: Connection to Wraparound Facilitator Outcome Status – Children Approved for Services or Ever Placed on the Waitlist Following Preliminary Approval (n=333), July to December 2022



DHHR continues to monitor timeliness to assignment to a Wraparound Facilitator closely. This timeline to connection to a facilitator has increased due to additional referral and service demands as well as some provider capacity limitations. During the application process, and for any child who is placed on the waitlist for Wraparound facilitation or who is denied CSED Waiver services due to being ineligible, the child and their family are connected to other community services and supports to help the family while they are waiting, or as an alternative to Wraparound Facilitation services. Service connection includes access to a regional family coordinator and a local MCRS team. A triage process has also been implemented to help

¹⁷ Ceasing participation is defined as failing to respond or declining further participation.

ensure families in critical need are connected and prioritized appropriately to meet immediate stabilization needs through available and existing services.

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

Children referred to BBH between July and December 2022 upon initial referral¹⁸ were supported with completing the waiver application and assigned a Wraparound Facilitator or transferred to the CSED Waiver prior to receiving interim Wraparound Facilitation services (n=102). Available data is not yet connected in a way that would allow overlap of timeline data for CSED Facilitator assignment; however, if it is assumed that most children will be assigned a facilitator immediately following CSED transfer/approval determination, then the average time to assignment from initial referral for both children served via interim services and children transferred to the CSED Waiver was 51 days. This average includes individuals who were on a waitlist prior to connection to a facilitator.

This summary in calendar days is expected to be a more realistic representation of the family journey. As part of that journey, there may be some additional time needed in the beginning of the pathway process during the application material collection phase, including potential delays due to family responsiveness. Although this adds to total time to assignment of a facilitator from referral, this is not necessarily something that can be controlled apart from improved follow-up practices, which have been part of the CQI process since spring of 2022.

While the family goes through the determination process, they are connected to other services and supports; therefore, this timeline is likely not representative of the time to connection to *any* mental health service or support. This is further demonstrated through the quick response of the BBH team to referrals received through the Assessment Pathway. Referrals are typically responded to within two weekdays. During this process, the staff member talks to the family about their needs and the child’s behavioral concerns and offers to connect them to community-based services while they wait for determination if not already established for the child. This can include information on what is available locally to the family such as, but not limited to, Regional Youth Service Centers, therapy, mobile response via the CCRL, or Nurturing Parenting classes to support the parent. Families can be connected to the CCRL in as quickly as 14 seconds with availability of immediate warm transfer to a mobile response team during the call. The family coordinator continues to be a resource for the family throughout the process should they have immediate questions or if needs arise.

DHHR is committed to continuing to look at timeliness from the family journey perspective and

¹⁸ Note the family journey in calendar days was not captured for individuals whose applications went directly to Acentra Health (formerly Kepro) due to differences in processes and data collection. This process needs to be better understood from multiple entry points at both the material gathering and Acentra Health assessment phases to identify opportunities for further improvement. Future connection of data within the data store build-out is also expected to bridge gaps in understanding opportunities to improve timeliness to connection to services at all entryways.

stepwise process to continue to understand and improve the efficacy of Assessment Pathway processes.

8.2(c) Summary of Progression Through the Assessment Pathway

Figure 19 summarizes the number of children who have progressed through each step of the Assessment Pathway. Notably, there was little difference in the number or percentage of families ceasing participation between each half of 2022, as 120 children’s families (26.9%) ceased participation in January to June 2022 compared to the latter half of the year where 114 children (25.1%) did not continue participation because their families either failed to respond after multiple contact attempts (n = 82, 18.1%) or declined further participation (n = 32, 7.0%). Although families ceasing participation did not change much overall, there was a shift from families directly declining further participation to families failing to respond. The number of referrals declining further participation dropping from 53 in the first half of 2022 to 32 in the second half, a 40% decrease. Additional analyses detailed below have expanded understanding of family disengagement.

Seventeen children were listed as still gathering materials at the time of review; enhanced follow-up and referral closure policy has been integrated to help prevent this in the future by encouraging families to complete applications in a timely manner and establishing appropriate time frames for returning materials or closing out the application until the family is ready to proceed. Although these allowances can result in skewing the average time to assignment longer due to family responsiveness, these built-in processes help ensure every opportunity is utilized to connect the family with services and supports, including using local providers to help with additional outreach when needed.

As of July 1, 2022, the CSED Waiver program was updated to add a “217- Medicaid eligibility group”¹⁹ which helps to remove financial barriers related to Medicaid eligibility, allowing children to be found eligible based on their income rather than their parents. Following this change, BBH began a retrospective review—beginning in August 2022—of previously closed referrals due to income restrictions, allowing opportunity for these cases to continue along the Assessment Pathway without needing to reapply or restart the process. All families have been contacted for children meeting BBH-funded clinical-need criteria to offer the family the opportunity to apply for CSED Waiver services.

Forty children (8.8%) were denied due to ineligibility for the CSED Waiver, while 282 children (62.1%) were approved for the CSED Waiver (either preliminarily or final approval) of children referred from July to December 2022, indicating an increase in the percentage of children with a referral outcome of “approved” compared to the prior six-month period with 57% of children approved. Consequently, denials have also had marked change with a decrease from 13% of referrals denied in January to June 2022 to 8.8% in the second half of the year, likely a result of

¹⁹ The “217 Medicaid eligibility group” provides coverage to individuals who need HCBS to avert institutional placement. The 217-Medicaid eligibility group helps remove financial barriers to access HCBS if the applicant meets medical eligibility for the CSED Waiver. Expansion of financial eligibility allows children who would not typically be eligible for Medicaid services to receive services and supports to help them remain successful in their home and community.

changes to financial eligibility requirements.

Figure 19: Progression Through the Assessment Pathway, July to December 2022

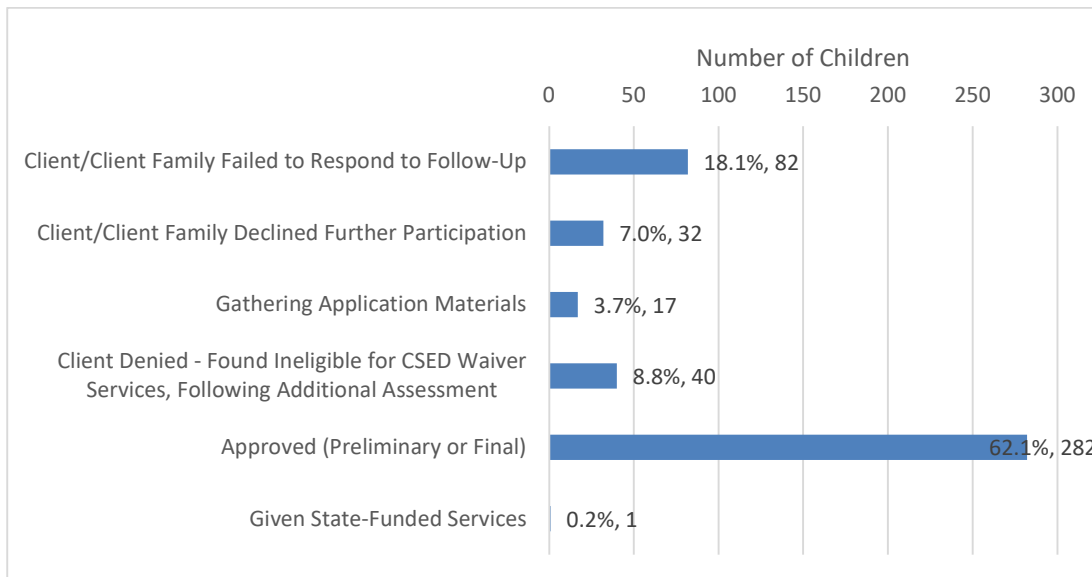
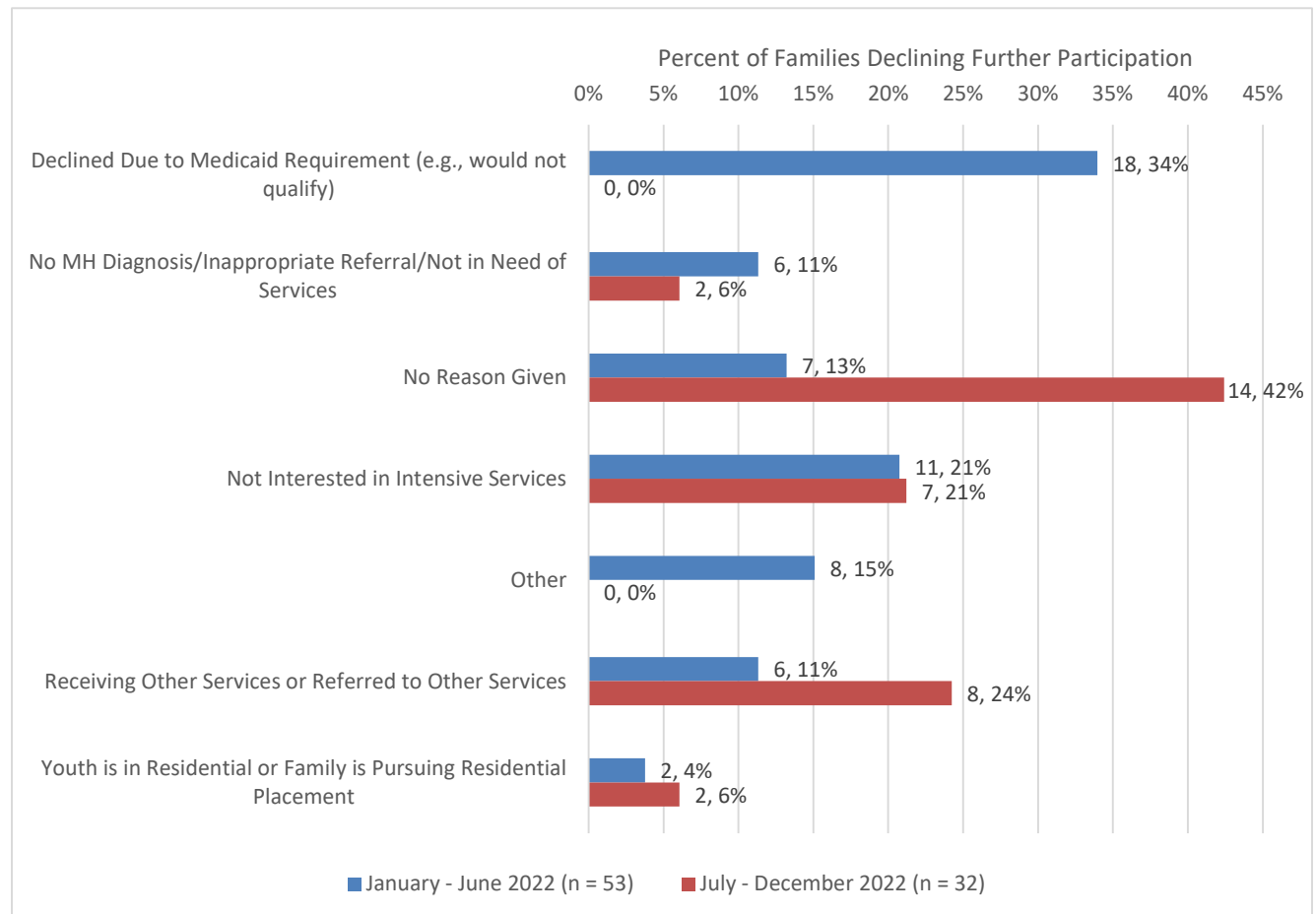


Figure 20 depicts the reasons provided by the families declining further participation, comparing the first half of 2022 to the second half of 2022. Percentages may not add to 100% because some families listed multiple reasons when they declined to participate further. Referrals declining participation decreased, while, as noted above, families failing to respond after multiple attempts increased. For July to December 2022, only 32 children (7%) directly declined further participation, compared to 53 children in the previous period. Given the low number of children in this category, these results should be perceived with caution.

The main reason families declined participation from January to June 2022 was related to the Medicaid requirement (e.g., [perceived] ineligibility to receive services due to the income requirement [n=18, 34%]). As noted above, policy has been adjusted to account for this identified need, allowing children who qualify to apply for Medicaid based on the child's income, which would allow them to become income eligible. As a result, no family listed Medicaid as a reason for declining further participation from July to December 2022. Seven children (13%) did not provide a reason in the first half of the year, while 14 children (43%) did not provide a reason in the second half of the year. The percentage of referrals declining further participation with limited information as to why was noted in quality reviews, and BBH will continue to expand attempts to collect this information when individuals decline referral by expanding options for this indicator to include waitlist concerns and retraining staff on importance of this metric. The percentage of denials who were not interested in intensive services was the same in both halves of the year (21%), whereas a higher percentage of families declined participation in the second half of the year because they felt existing services in place were meeting their needs (11% from January to June vs. 18% from July to December). This will continue to be monitored but may be viewed as a positive outcome indicating that although children did not continue participation to be connected to Wraparound Facilitation services, they were receiving other services that were meeting their needs, while also maintaining awareness and ability to connect

to the Assessment Pathway should additional or more intense needs arise. It should be also noted that some families may cease participation due to not perceiving a need for intensive services; this should also be viewed as a positive connection that occurred to raise awareness of services should additional needs arise in the future despite lack of present perceived need.

Figure 20: Reasons for Declining Further Participation, January to June vs. July to December 2022



Additional analyses were completed to understand at which stage children might cease participation with the Assessment Pathway and some immediate outcomes these children may experience. Over half (53%) of children ceasing participation made it to the initial application submission before ceasing participation, compared to only 15% in the first half of the year. Comparing the first half (n=120) of 2022 to the second half (n=119), children were more likely to have had a CAFAS/PECFAS before ceasing participation in the last half of the year (29% vs. 13% of children with a score). Over the past year of initial implementation, DHHR has focused on improving processes for families through robust CQI efforts. These efforts, in combination with the dedication of Assessment Pathway staff, are likely largely attributable to families making it further along in the process before ceasing participation. In summary, half of the families who ceased participation responded to BBH contact attempts and were able to submit an application to Acentra Health. At this stage, according to both policy and demonstration of this practice via secret shopper checks, children or caregivers would have received information for the CCRL including information about CMCRS teams and additional resources based on

immediate needs identified. This is a positive finding that identifies a key opportunity to connect families with resources that could be used in the future. The proportion of children ceasing participation that had with a CAFAS/PECFAS assessment completed was 29% in the last half of 2022. More information is needed to understand why children and their caregivers might cease participation following referral to Acentra Health. Data store connectivity will allow a better understanding of contact successes, ability to complete the CAFAS/PECFAS, or processes influenced by the workflow of the application process that are impacting this in other manners.

Of children ceasing participation in the pathway with an indication of preliminary eligibility, 88% were placed on a waitlist for interim Wraparound Facilitation services, which was similar to the overall approval waitlist rate of 89%. Therefore, it does not appear at this time that children ceasing participation were any more likely to have been placed on the waitlist than other approvals (July to December 2022). While there was no difference in the proportion placed on a waitlist, most children were put on the waitlist for some period (89%). This information will continue to be monitored for future changes and considerations as to why a family may not continue with the Assessment Pathway process. Additional considerations were also given to factors that could not immediately be measured, such as referrals made without a caregiver's permission, or parents who were not interested or not ready to accept a service, or who cease contact without stating a reason.

Of 200 children ceasing participation in the Assessment Pathway in 2022 who were able to be matched with available Medicaid data, 11 children (or 5% of those ceasing participation) entered an RMHTF by February 2023 (Figure 21). Of these 11 children, two entered an RMHTF within 30 days from Assessment Pathway referral, while five entered in 30 – 90 days, and the remaining four had over 90 days since their referral before entering RMHTF services. This data provides an insightful view into the future state of data store capabilities and outcomes related to the child's journey. This could include identifying key points of intervention or opportunities for follow-up with families that may be at risk. Currently, the number of children entering RMHTFs was very low in comparison to the total number ceasing participation; therefore, the Quality Committee agreed to monitor this without immediate action. Figure 22 indicates referrals from 2022 who ceased participation in the Assessment Pathway and entered the ED for behavioral health reasons by February 2023. While this outcome was double those entering RMHTFs, it represented only 10% of these referrals; most of these ED visits occurred within 30 days of referral. Staff engaging in the Assessment Pathway process will continue to share resources with families (i.e., CCRL) when a family declines other Assessment Pathway services to help ensure the family has a timely resource should their needs change.

Figure 21: Children Who Cease Participation With the Pathway Calendar Year 2022 – Do They Enter Residential? (Claims Paid as of February 2023 and FACTS Data as of December 2022)

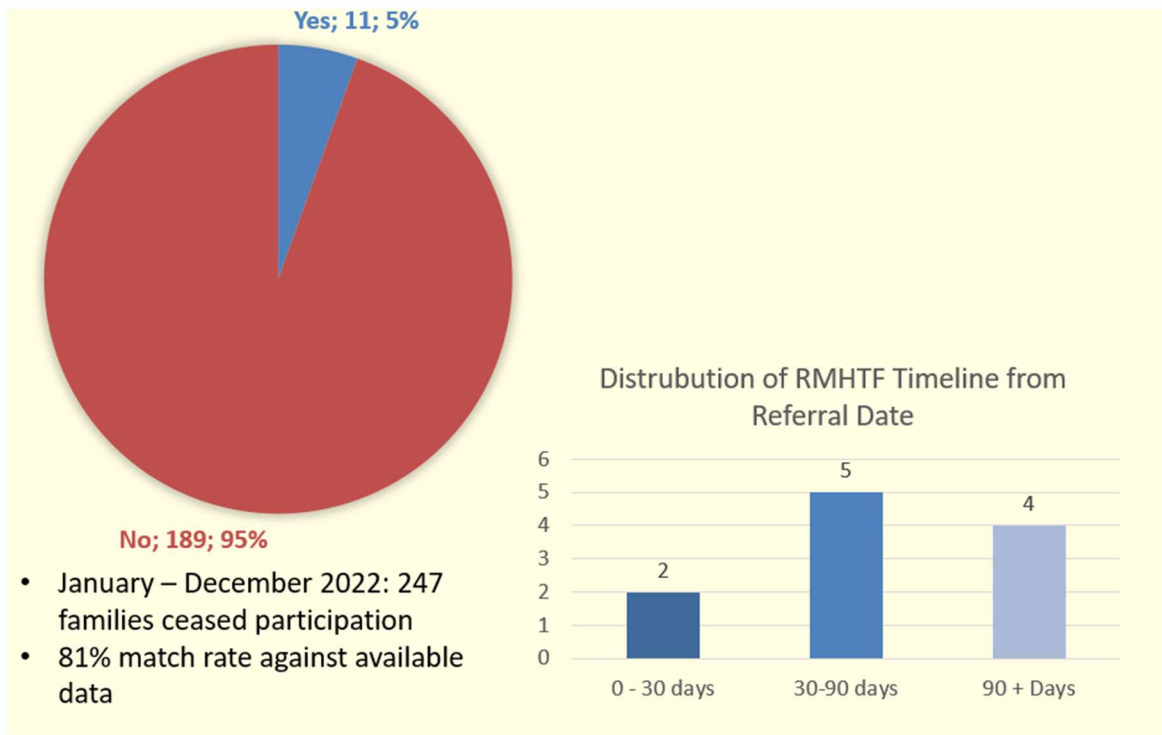
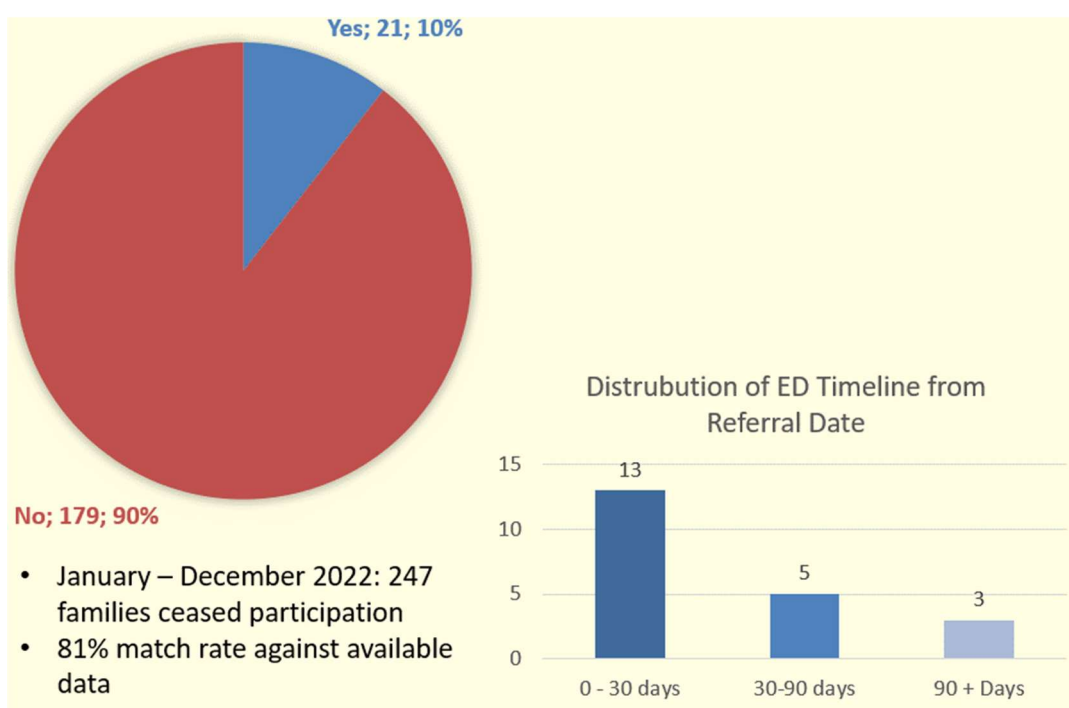


Figure 22: Children Who Cease Participation With the Pathway Calendar Year 2022 – Do They Have Behavioral Health-Related ED Visits? (Claims Paid as of February 2023)



8.3 Provider Capacity/Statewide Coverage

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

For the Assessment Pathway to be effective, statewide coverage of referring entities is needed in conjunction with sufficient personnel at the provider level who accept and process referrals for Wraparound facilitation. In addition, the capacity of assessors at Acentra Health (formerly Kepro) to perform and report back CAFAS/PECFAS in a timely manner is also critical to connecting families to timely services. In general, the initial phase of implementation focused on recruiting provider agencies to offer services. As referrals continue to grow, DHHR will continue to enhance activities that support providers and agencies in attracting and retaining adequate staffing. Considerations for funding source limitations for interim services, and transfer of services following CSED determination, are important to monitor as changes were implemented to make processes more seamless for families by allowing them to maintain a facilitator between payor sources. Additional information on provider capacity for services and payor source considerations will be included in the respective Wraparound Facilitation service section.

Currently, BBH has four staff via grant funding and two temporary full-time employees processing referrals. Three supervisory staff act as reserve staff when there are large influxes of referrals. These staff are dedicated to family assistance, with a focus on follow-up and quality assurance related to the Assessment Pathway, which has significantly improved data collection quality and reduced missing data, enhancing BBH's ability to help ensure children are served in a timely manner.

8.4 Strengths, Opportunities, Barriers, and Next Steps

The Assessment Pathway has continued to accept an expanded number of referrals and maintain continued responsiveness to families and CQI opportunities, centralizing and streamlining entry to services for families. The Assessment Pathway aids families in accessing interim Wraparound Facilitation services and other HCBS to meet families' needs while waiting for CSED Waiver determination or deciding to pursue other appropriate mental health services. Increases in monthly referrals and referrals from all but one of the state's 55 counties in 2022 were found to be an encouraging gauge of expanding awareness and the Assessment Pathway being accessible to families.

Another positive step in raising awareness of the Assessment Pathway and connecting families to services and resources included CCRL brochures provided to the BFA for dissemination to families served. BBH also conducted regional fairs as part of outreach efforts in April 2023 called "Making Connections with Families." Press and social media releases in May for Children's Mental Health Acceptance Month were an additional mechanism by which resources were heavily shared.

A continued next step for DHHR related to the Assessment Pathway is to enhance the tracking

of interim Wraparound Facilitation services while children and families are awaiting eligibility determination for the CSED Waiver. Steps are in process to allow for collection of interim services information to include types of services as well as service start and end dates. This data started being collected for Safe at Home (SAH) interim cases in December 2022 and will be added to BBH interim cases in the fall of 2023. These measures will be considered in future reporting once data becomes available. SAH interim cases have moved to being managed by BSS staff; upon completion of CAFAS/PECFAS determination, data collection will be further built out to meet this modification to processes.

Assessment Pathway staff continue to focus on both meeting family and support needs, as well as on improving data completion and quality. To support this effort, BBH provides recurring training to entities utilizing the portal and includes requirements in Statements of Work. Program staff review Assessment Pathway data reports quarterly at minimum, with referrals reviewed monthly and waitlist information reviewed at least weekly. This data is used to increase agility in CQI approaches to process enhancement and identify data collection, training, and technical assistance needs.

9.0 Qualified Independent Assessment (QIA)

As of May 2023, 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 they could be served 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 referral made to residential treatment facilities.
- The child is not cooperative with the court’s requests.
- The child has disrupted other arranged placement, such as a kinship/relative home or foster home, and no other options are available.
- The child’s family requests removal from the home, or the home is unsafe, and no alternative family settings are available.
- The child has no stable family home or other living arrangement.
- The child requests placement in a residential mental health facility.
- The child has been adjudicated as a status offender or delinquent.
- The child has been referred to a STAT Home within the past 90 days.
- 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 concurrently, if one has not already been submitted. The assessment will identify the child’s needs and provide a recommendation on the appropriate level of intervention and least-restrictive service setting to meet those needs.

9.1 Review Period, Data Sources and Limitations, Population Measured

Currently, DHHR is working with Acentra Health (formerly Kepro) 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. Effective August 2022, BSS directed residential providers to begin referring any new children entering residential placement to the QIA process; however, given this process is in an early adoption phase, the primary focus was placed on BSS worker training, with a goal of children receiving assessments prior to placement to help ensure the setting was appropriate for the child’s needs. A phased, county-by-county training and implementation rollout was completed over a period of months. As of May 2023, all BSS workers statewide had been trained, and the referral process was implemented across all

counties. QIA process training has also been incorporated into the BSS worker new hire training to help ensure continuity of the QIA process independent of any staff turnover. Referrals from counties rolling out prior to May 2023 have been included in this review period. Consideration should be given to counties in which the QIA process was newly implemented as they become acclimated to this new process, and data will continue to be monitored closely.

Figure 23: QIA Process Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
August 2022 to April 2023	QIA Tracking Spreadsheet	This dataset contains a subset of WV county participation due to the planned rollout schedule and represents early implementation efforts for this county-by-county rollout, which began in mid-August 2022. Rollout across all counties was completed in May 2023. Due to these constraints, referrals in future periods are expected to grow significantly compared to information represented in this period.	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.

9.2 Review Summary

From August 2022 to April 2023, 125 children were referred for a QIA. Figure 24 shows the number of counties trained compared to the referrals received by month. As of the end of March, 46 counties had been trained, with an additional five counties trained in mid to late April. To provide timely feedback to the social services managers who work directly with the counties and to maintain focus on the continued adoption of the QIA process, a county-level report on total referrals made compared to the number of referrals expected for the month (based on average county-level admissions for the previous year) is provided to social services managers each month. Once data quality validations are completed for WV PATH, a county-level report of QIA referrals compared to actual RMHTF admissions will be provided to social services managers monthly.

Figure 24: Number of Counties Trained Compared to QIA Assessment Referrals by Month (n=125)

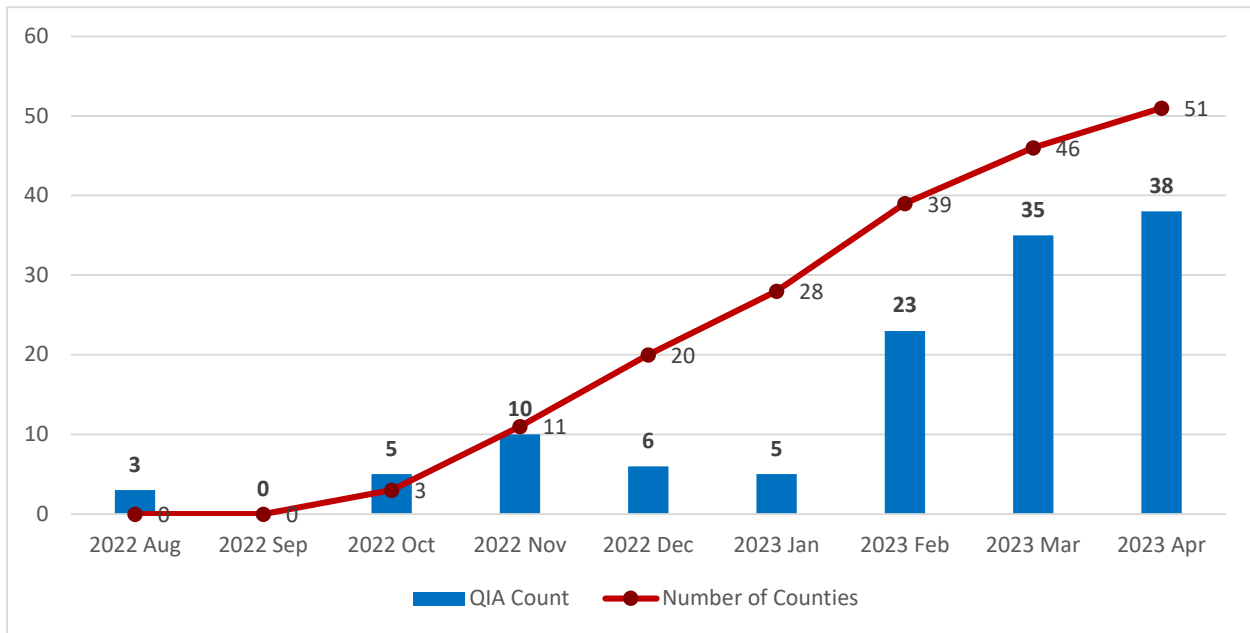
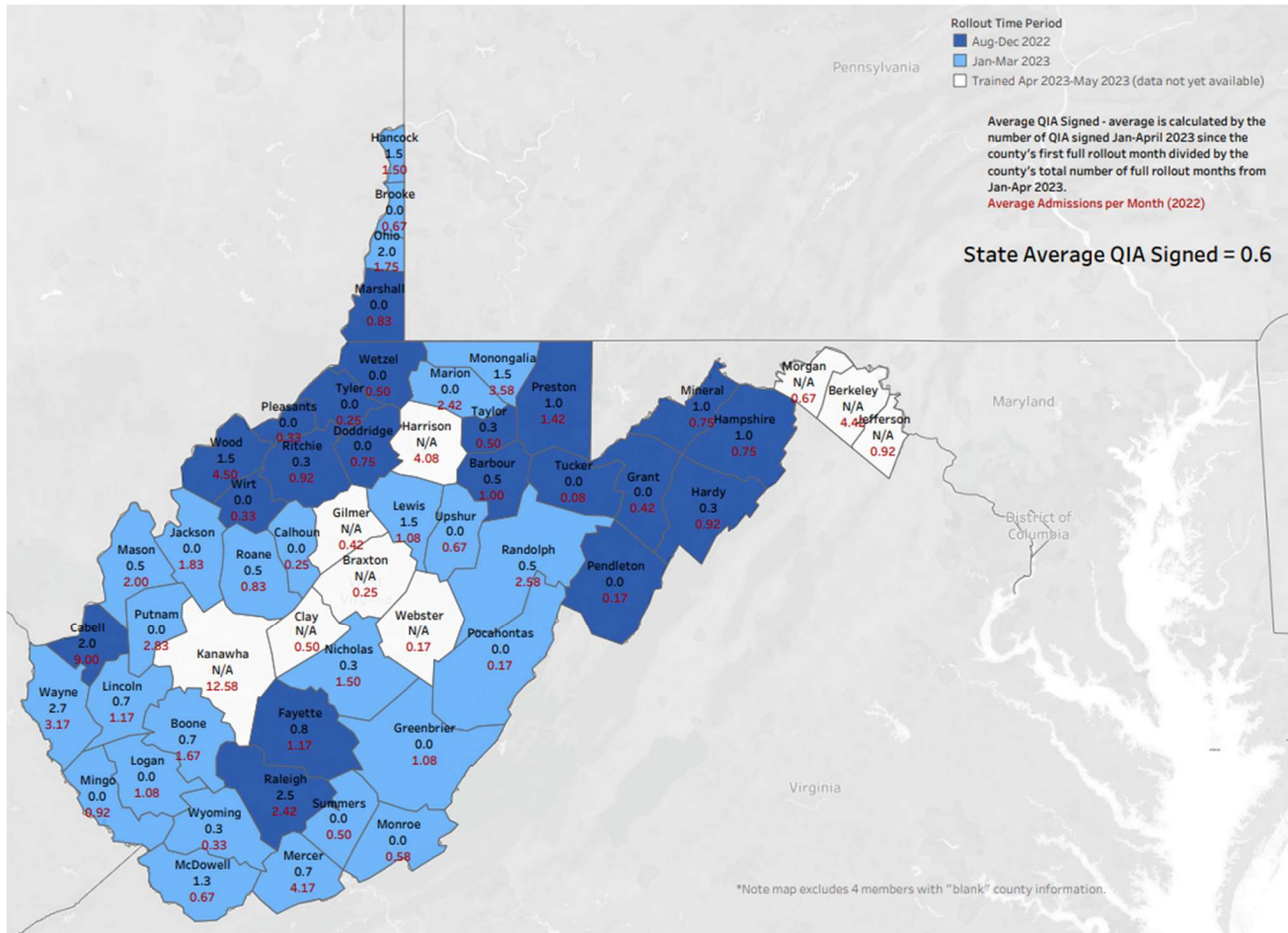


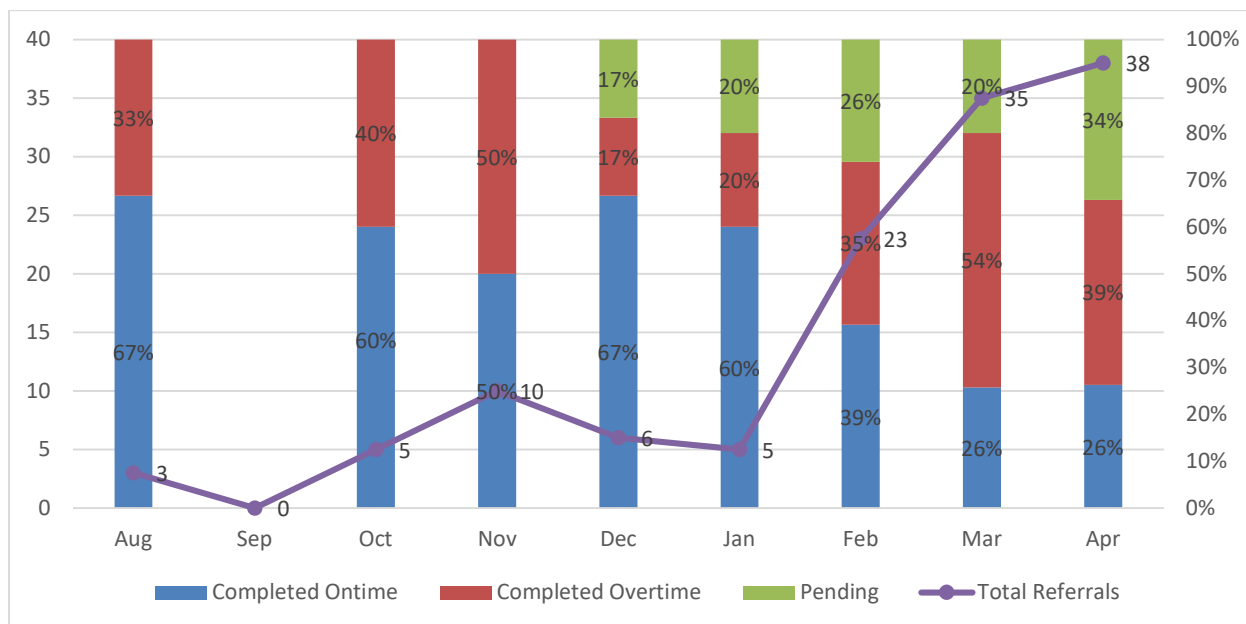
Figure 25 displays the average monthly QIA referrals (QIA signed) January to April 2023 and average RMHTF admissions per month (2022) by rollout period and county as of June 12, 2023. Visuals like this offer an opportunity for direct and timely feedback as workers become more familiar with this process and highlight whether they are identifying at-risk children in a timely manner. When reviewing this information, DHHR is expecting referrals greater than or equal to previous average admissions with some flexibility for counties with small populations. These maps have been shared with BSS social service managers which have resulted in an improvement in referrals in the month of May (not shown) with 55% of counties meeting or exceeding their monthly average. Fifteen counties with small populations and less than one RMHTF admissions per month on average has 0 referrals in May but it is unclear at this time if the small population/need influenced that. This will be monitored over time.

Figure 25: Average Monthly QIA Referrals (QIA Signed) January to April 2023 and Average Admissions Per Month (2022) by Rollout Period and County as of June 12, 2023



The QIA process is designed to provide information to inform decision-making regarding the intensity of care that a child needs. QIAs are expected to be completed with a recommendation provided to the worker within 30 days of submission. If a child has been placed in a hotel, is in the emergency room, or has a court order for residential placement, the referral is expedited with a goal of providing a recommendation within 14 days of the initial referral. Acentra Health (formerly Kepro) has actively worked with DHHR to monitor timeliness and address barriers to meeting these expected timelines, including efforts to hire additional assessors and development of an escalation process to help ensure timely contacts and BSS worker responses to requests for information. As the QIA process has expanded, the percentage of referrals completed within expected time frames has decreased to less than 30% of referrals as of April 2023 (Figure 26). Due to this decrease, as well as the presence of data indicating possible pending referrals dating back several months, DHHR plans to implement more frequent and focused reviews to work toward improvements in timeliness and data completion as discussions have signaled some differences in reported progress compared to data documented in the tracking system. These are essential for recommendations to be provided in a timely and accurate manner to help ensure this process is beneficial.

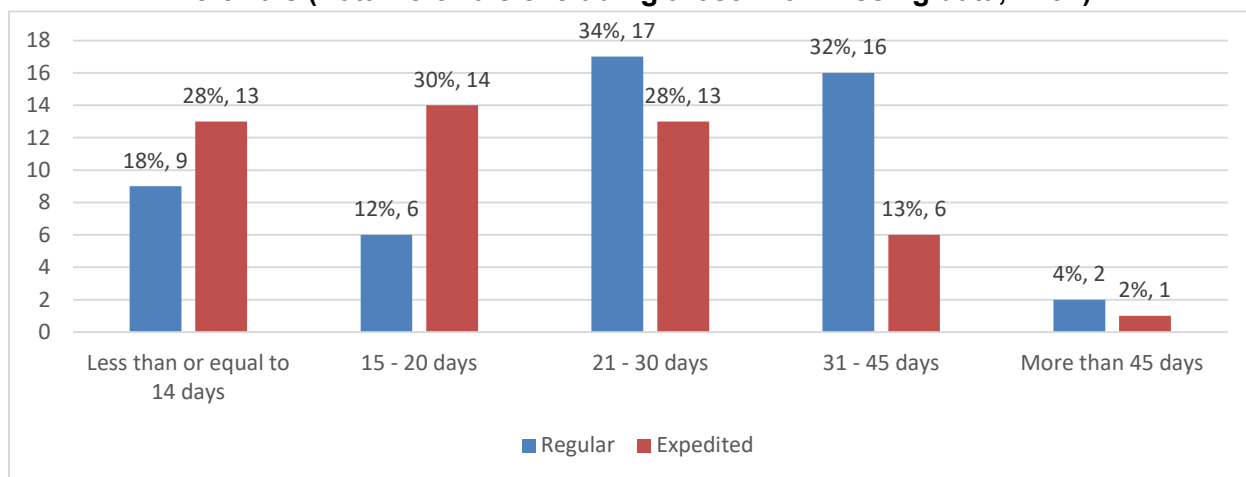
Figure 26: Total Referrals for QIA With Consideration for Timeliness to Recommendation



Of the total QIA referrals submitted during the period reviewed, 47% (n = 59 referrals) indicated a need for expedited review. Most expedited referrals were expedited due to court order for residential placement.

Regular QIA referrals were completed within an average of 28 days, while expedited referrals were completed in an average of 20 days, excluding referrals with missing data (n=28), which will be further addressed through the CQI process. As shown in Figure 27, 64% of regular referrals met the 30-day timeline, while only 28% of expedited referrals were completed in 14 days. Although most of the expedited referrals were not completed within 14 days, 85% were completed within 30 days.

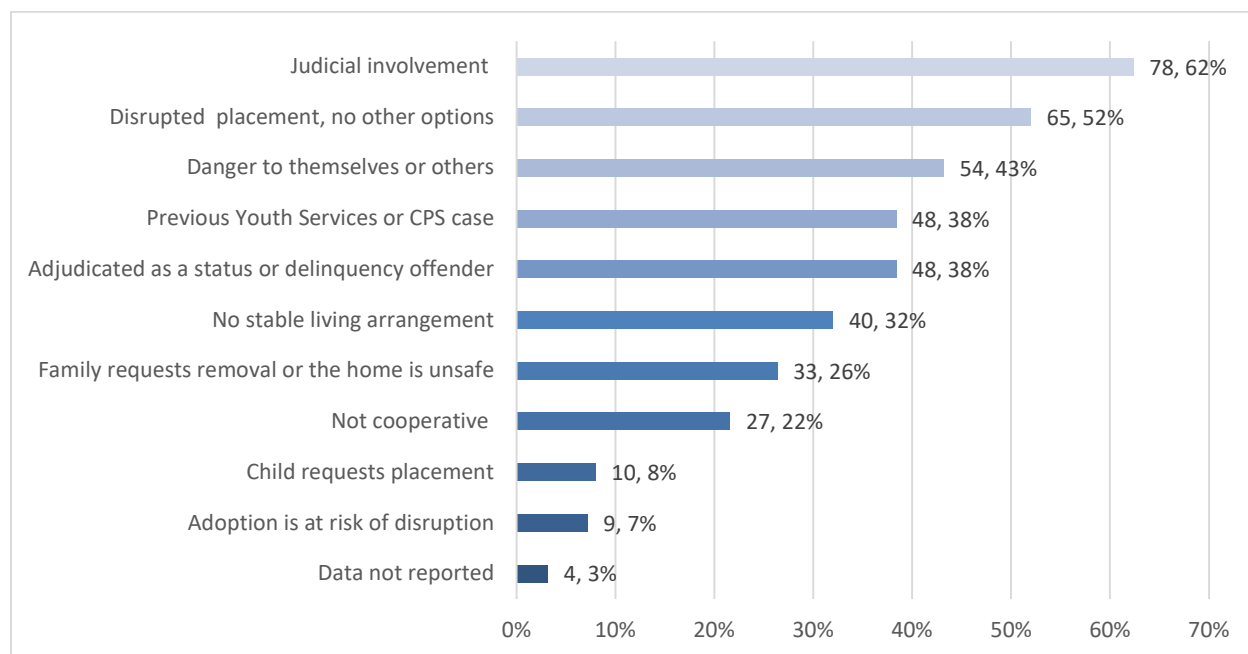
Figure 27: Distribution of Timeliness to QIA Recommendation for Expedited and Regular Referrals (Total referrals excluding those with missing data, n=97)



Judicial involvement was the most common indicator listed as the reason the child was high risk

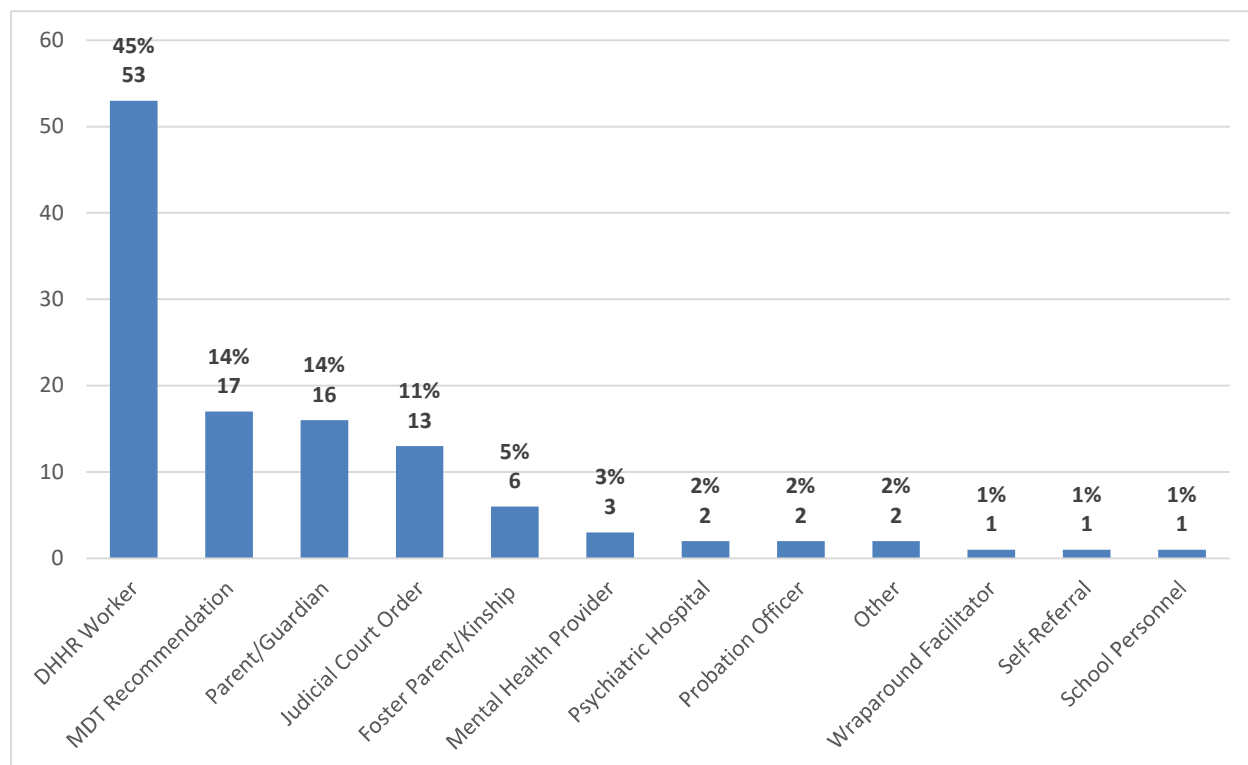
for residential placement, with 62% of referrals indicating this reason (Figure 28). Other commonly listed reasons include disrupted placement, no other options, and danger to themselves or others. Children could have more than one risk factor reported, thus the percentages in Figure 28 add to over 100%.

Figure 28: Reason High Risk for Residential Placement (n=125)



As shown in Figure 29, 45% of referrals where RMHTF placement has been requested were prompted by a DHHR worker. The second most common entity recommending placement in an RMHTF was the MDT, followed by the parent/guardian. The MDT process has been a particular area of focus in the last six months. 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. This information will continue to be monitored as an opportunity to shift cultural norms/practices with placements and to establish norms of assessment and objective determination for treatment needs before referral to an RMHTF. Seven children did not have information to indicate an RMHTF referral had been requested. This could be an indication of early identification for referral before a RMHTF is considered, which would be considered a positive finding for these youth.

Figure 29: Number and Percentage of Assessments by Entity Who Prompted the Referral to an RMHTF Setting, if Applicable (n=118)



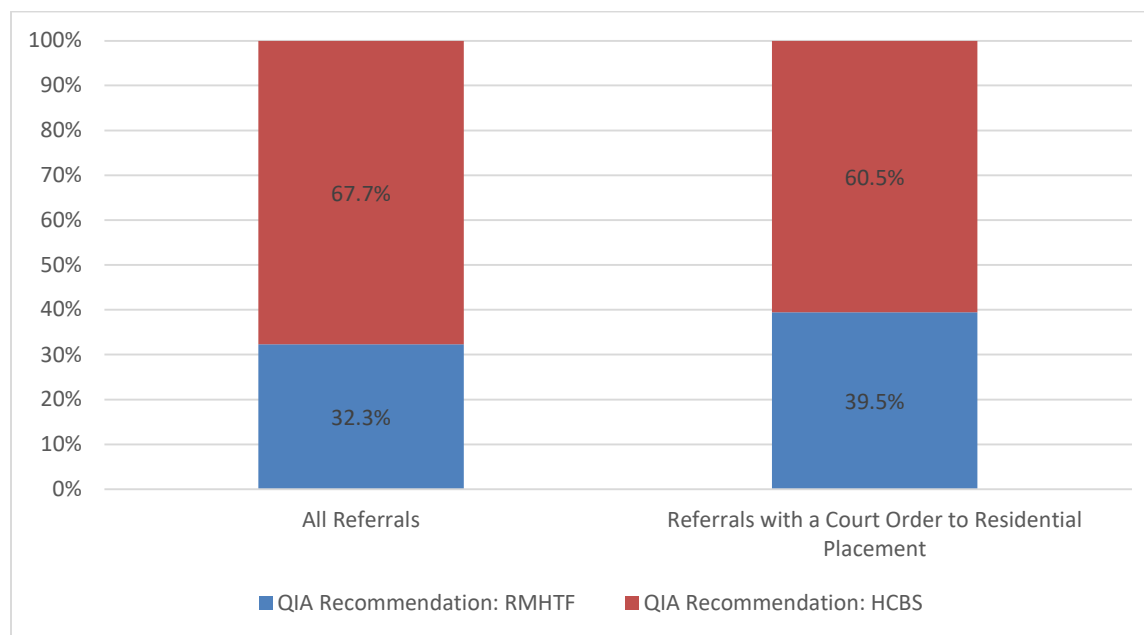
DHHR has continued collaboration with Marshall University and the Praed Foundation to automate the decision support model predicated on the CANS assessment tool. The model consists of five levels of placement need. Level 1 is the lowest level of intervention or need and consists of traditional foster or kinship care, while Level 5 is the highest level of residential placement, a Psychiatric Residential Treatment Facility (PRTF). The decision support model assists with making level-of-care recommendations that are 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.

Nearly 70% of children with a QIA referral received a recommendation to obtain treatment via HCBS (Figure 30). This was viewed as a positive 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. Early data shows that of children with a QIA referral and a court order for residential placement (n=38), 60.5% were recommended to receive treatment in their home and community as a result of the clinical assessment. This finding further highlights the need for this process, with standardized clinical assessments completed by an independent entity to reduce bias. The QIA can be used to aide decision-making and reframe cultural norms to help prevent inappropriate use of residential treatment facilities.

The QIA recommendations and related support tools are still in the early adoption phase; therefore, data is monitored closely along with additional mental health records/documentation,

when available, to help ensure the recommendations are based on the needs and resources available to the child and their family. As the data store is built out in the coming months, outcomes following recommendations will also be added as an indicator for review and consideration to influence strategic change.

Figure 30: QIA Recommendations by Setting, Including Children Court Ordered to Residential Placement Prior to Referral (“All referrals”, n=99; “Referrals with...”, n=38)



Review and implementation of referrals by residential providers for referrals not submitted prior to admission has begun, starting with children who have a prior history of RMHTF placements. This effort is being driven by Aetna following up directly with providers to help ensure referrals are made in a timely manner according to standard operating procedures. DHHR conducts biweekly meetings with the Acentra Health (formerly Kepro) and Aetna to help ensure a plan is in place to fully expand use of the QIA process for all children in residential settings, ideally prior to admission to address opportunities for diversion. The QIA workgroup discussed the following criteria to consider when identifying the next group of children in residential placement for referral in the continued phased rollout of the QIA process: children experiencing longer than average lengths of stay, children by facility, or children by residential tier. In addition to these planned rollouts, more focused and frequent data review will be reestablished given availability of validated WV PATH data to help ensure new admissions from the previous month have been referred to the QIA. In addition to this CQI approach, this process will be sustained within the BSS workforce through the inclusion of the details of this process in new worker training.

9.3 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 will assist with diverting children from unnecessary residential placement. The QIA process has many opportunities for improvement as statewide rollout was just completed in May

2023. Social service managers, Acentra Health (formerly Kepro), and Aetna have been active in this process since training initiated through data review and discussion. Future plans include analysis of outcomes data with the WV PATH system integration into the data store as well as with QIA data to understand where the child was placed and to explore reasons for any contradictions to the recommendations. In addition to planned outcomes analyses, DHHR will continue to monitor timeliness to completion of the QIA closely in the coming months to help ensure the information can be beneficial in these time-sensitive situations. Expanded outreach and education around the importance of the QIA process will also be an important piece to increased utilization and trust in the process. This will include active engagement with the court community as well as further integration into MDT decision-making.

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

DHHR implemented the CSED Waiver effective March 1, 2020. Recently, the five-year waiver renewal was approved, extending waiver services through January 2028. The CSED Waiver provides additional services to Medicaid State Plan coverage for members ages 3 up to their 21st birthday who meet eligibility criteria. The CSED Waiver permits DHHR to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated this waiver will reduce the number of children placed in residential and other out-of-home placements. This waiver prioritizes children with SED who are:

- In PRTFs or other residential facilities either in-state or out-of-state
- 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 | • Community Transition |
| • Mobile Response | • Family Therapy |
| • Independent Living/Skills Building | • In-Home and Out-of-Home Respite Care |
| • Family Support | • Peer Parent Support |
| • Job Development | • Non-Medical Transportation |
| • Individual Supportive Employment | • Specialized Therapy |
| • Assistive Equipment | |

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

10.1 Review Period, Data Sources and Limitations, Population Measured

Figure 31: CSED Waiver Enrollment and Services Data Overview

CSED Waiver Dataset	Data Review Period	Data Source	Details and Limitations	Population Measured
CSED Waiver Enrollment Data	July to December 2022; in some datasets, more recent data is reflected	ASO Reporting Spreadsheet	DHHR is still actively working with Acentra to enhance data collection and reporting.	Children who may be eligible for the CSED Waiver who are going through the application process
CSED Waiver Service Data	July to December 2022	DW/DSS	CSED service use is sourced from DW/DSS paid claims for services rendered July 2021 through December 2022 and paid through April 2023. 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 three years and is still expanding. The number of applications for the CSED Waiver continues to increase, resulting in more children and families accessing services. While significant growth of the program has continued, the data available cannot yet be assumed to reflect the routine and ongoing operation of the program.

While data driven, DHHR is also 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 involves a 16-year-old individual. This individual did not immediately engage in services; however, since engaging, he has realized several positive accomplishments and milestones including the ability to navigate and cope with different situations, particularly in school. Overall, he reports feeling more independent. He has participated in CSED services for approximately one year and continues working toward graduation from services. He offered to share his story with other children to help them see how support can improve a child’s worst days and positively change the long-term outlook.

10.2(a) CSED Waiver Applications and Enrollment

Figure 32 below compares application status for the first and second half of 2022 as reported by Acentra Health (formerly Kepro) as of May 2023 reporting. Nine hundred seventy-six (976) applications were processed in the second half of 2022 compared to the first half at 730 applications, an increase of 34%. A modest drop of 6% was observed in the number of applications approved from July to December 2022 compared to January to June 2022. The number of applications denied also dropped by 2.4%. The number of applications being closed increased 8.4% in the second half of the year with nearly one third of applications being closed during the period.

Given the increase in the number of closed applications, DHHR completed a further review of closures and determined that approximately two thirds of the closures were due to children with CAFAS/PECFAS scores less than 90. An increased number of children with CAFAS/PECFAS less than 90 submitted CSED Waiver applications during this period. Reasons for this increase are described later in this section. Preliminary review of the balance of applications closed indicates families' failure to respond and repeated missed appointments. DHHR continues to work with Acentra Health on data collection and quality, including tracking of contact attempts and reasons for closures. DHHR would also like to improve understanding of children and families who do not follow through with the CSED Waiver eligibility process, including demographics, other services being received, and the outcomes for these children. Once the Acentra Health CSED Waiver application dataset is added to the data store (targeted for spring 2024), additional analysis is planned to investigate the services and outcomes for children who do not complete the CSED eligibility process.

Figure 32: CSED Waiver Application Status Comparison Across Six-Month Periods

Status	January to June 2022		July to December 2022	
	n	%	n	%
Approved	501	68.6%	609	62.4%
Closed ²⁰	170	23.3%	309	31.7%
Denied ²¹	59	8.1%	56	5.7%
Pending ²²	0	0.0%	2	0.2%
TOTAL	730	100.0%	976	100.0%

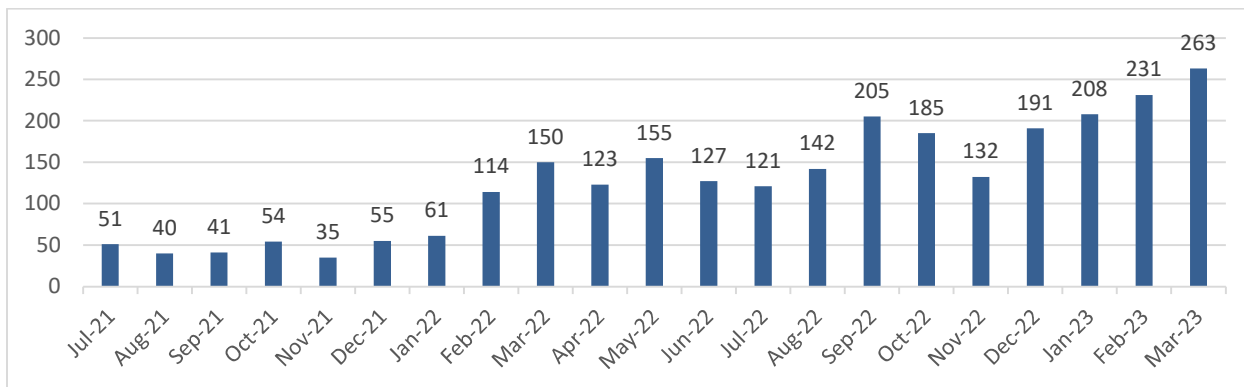
CSED Waiver application trends for the period of July 2021 to March 2023 are shown in Figure 33 below. The increase in referrals is evidence of the improvements to screening and referral of children to the Assessment Pathway and of the increasing awareness of the availability of these services. Probation Services and BJS implemented screening in March 2022 and began supporting families to complete the application process later in 2022. Additionally, the rollout of the screening and referral process for YS and CPS-involved children was completed in May 2022. As noted in the more recent period of January to March 2023, applications for the CSED Waiver continue to rise, with 702 applications received. This significant increase in a three-month period compared to the prior periods is a continued positive outcome from DHHR’s efforts to help ensure families and child-serving entities are aware of the Assessment Pathway and of the availability of CSED Waiver services.

²⁰ Applications are closed when families are non-responsive and, in limited cases, when families move out-of-state. Multiple contact attempts are made through a variety of mechanisms before cases are closed. Note: During the review period, analysis identified that children with CAFAS/PECFAS scores below 90 are having their cases documented as closed rather than denied. BMS is planning to work with Acentra Health to address this discrepancy.

²¹ Denials are based on one or more of the following: no eligible diagnosis or Basic Assessment System for Children (BASC) or CAFAS/PECFAS score did not meet eligibility criteria.

²² 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 33: CSED Waiver Applications by Month, July 2021 to March 2023



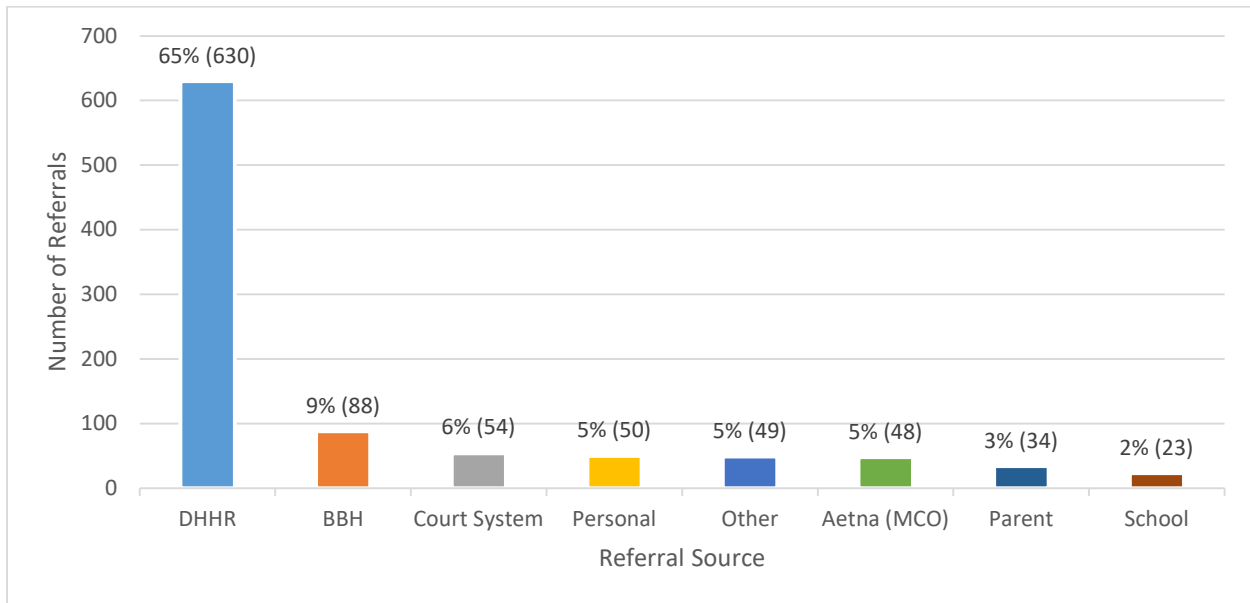
CAFAS/PECFAS scores for children going through the CSED Waiver eligibility process are shown in Figure 34 below. Children with scores less than 90 increased slightly to 7.9% in the current period, compared to approximately 5% in the prior period. To better understand this slight change, DHHR completed further review and found that 89% of the 66 children with scores less than 90 were referred by DHHR. This aligns with the rollout of the screening and referral process to child welfare staff, which was completed in May 2022. Given the newness of this process, and child welfare staff's eagerness to help ensure children gain access to needed services, this increase was viewed as positive and as an opportunity to connect children with other services even if they do not qualify for CSED Waiver services specifically.

Figure 34: CAFAS/PECFAS Scores for CSED Waiver Applicants, July to December 2022

CAFAS/PECFAS Score Range	Children	Percent
0 – 40	31	3.7%
50 – 80	35	4.2%
90 – 120	336	40.4%
130 – 160	299	35.9%
170+	131	15.7%
No score reported	144	--
Total	976	100% (*excludes individuals with no scores reported)

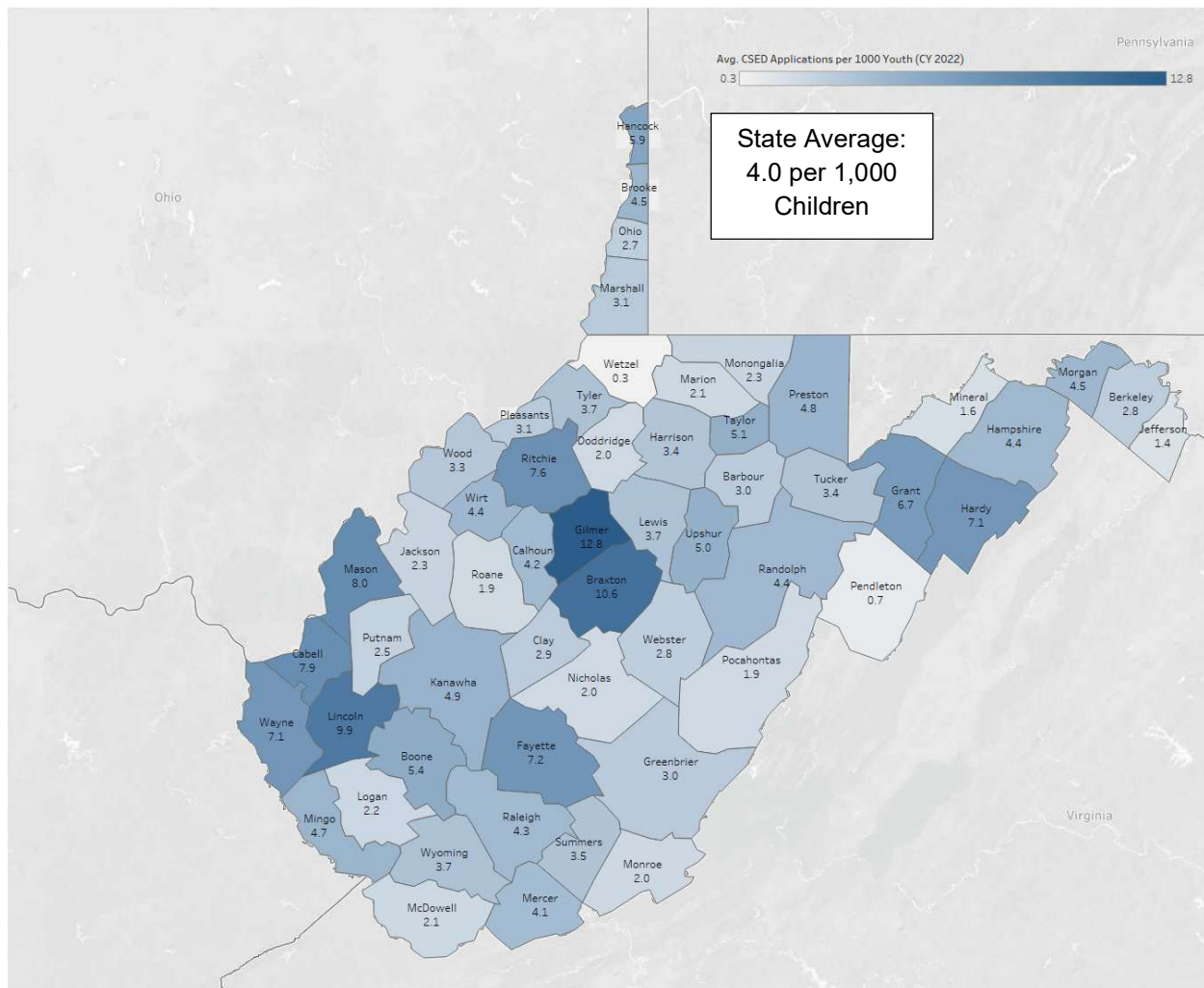
Figure 35 below captures the referral source for CSED Waiver applications submitted to Acentra Health for the period of July to December 2022. These referrals represent the varied points of entry through screening by entities engaging with children. The majority of referrals (65%) originate from DHHR (CPS, YS, and other DHHR involvement), while remaining referrals are split across varied sources. DHHR continues to work with Acentra Health to enhance data collection associated with referral sources to better understand the origin of referrals.

Figure 35: CSED Waiver Referral Sources, June to December 2022 (n = 976)



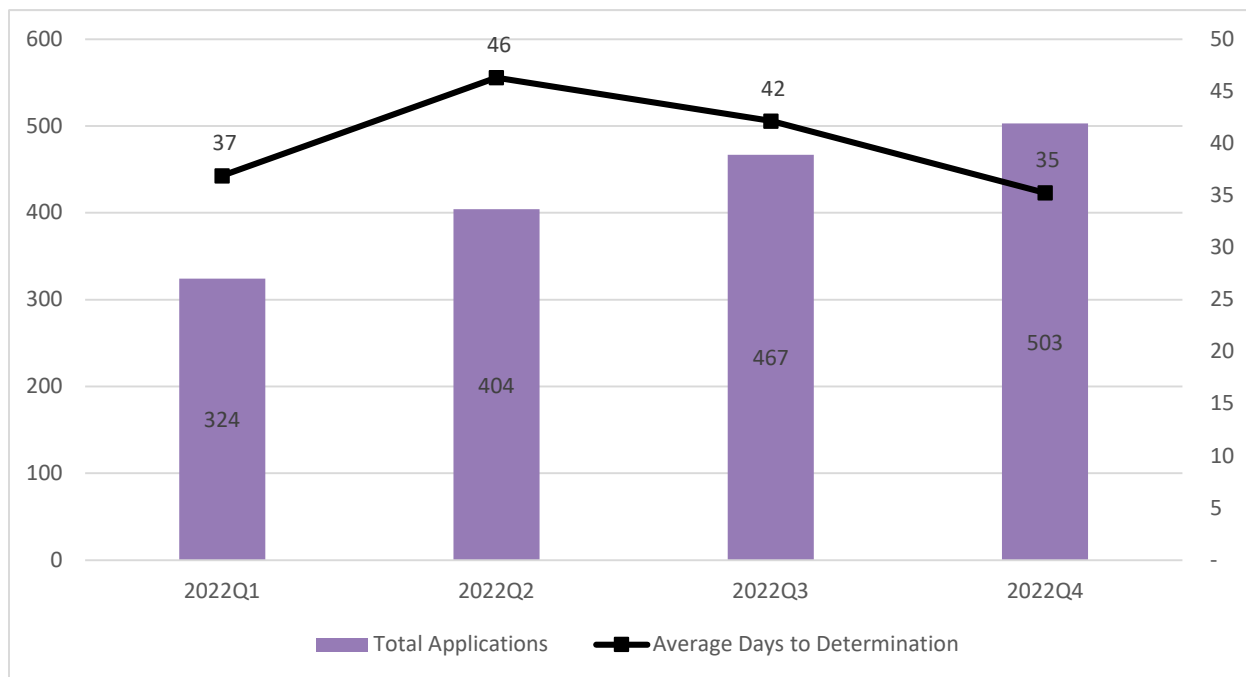
For the period of January to December 2022, applications have been submitted from every county across the state, with a statewide average of four applications submitted per 1,000 children, a positive sign of the messaging and awareness of CSED services statewide (Figure 36).

Figure 36: CSED Waiver Applications per 1,000 Children by County, January to December 2022



One of DHHR’s goals is timely access to services. After the data store is expanded to enable alignment of child-level data across systems (anticipated in 2024), DHHR intends to measure and report the timeline from screening to the start of services. Within the overall timeline to services, DHHR continues to monitor the timeline from receipt of the waiver application to eligibility determination. In response to the ongoing increase in applications, Acentra Health hired additional assessors with resultant improvement in the timelines from receipt of application to eligibility determination, specifically this process was one week faster in Quarter 4 2022 compared to Quarter 3, as shown in Figure 37 below. The timeline to eligibility determination is influenced by the responsiveness of the family in making themselves available to complete the assessment process, as well as by completing the Freedom of Choice process to select an independent evaluator. Effective January 26, 2023, BSS provided a directive allowing foster parents to complete and sign Freedom of Choice forms for CSED Waiver assessments and selection of service providers in an effort to decrease barriers to timely connection to services and supports. The directive also allows the foster parents to attend all Child and Family Treatment Team meetings in place of caseworkers.

Figure 37: Timeline From CSED Waiver Application to Eligibility Determination, Quarterly View, January 2021 to December 2022



10.2(b) CSED Waiver Service Utilization

CSED Waiver Diagnoses

In prior reporting, primary diagnosis information associated with paid claims for CSED Waiver services was included. While DHHR continues to analyze diagnosis data internally as part of the Quality Committee and program-level review processes, diagnosis information is not included in this report. While all children found eligible for the CSED Waiver have at least one SED, in the future, DHHR would like to understand in greater detail the prevalence and types of diagnoses among children accessing CSED services as well as any comorbidities and the impact on functional impairment and outcomes. Program teams have also requested evaluating diagnosis information stratified by age since some mental health disorders may not be diagnosed until a child reaches their teen years.

CSED Waiver Service Utilization

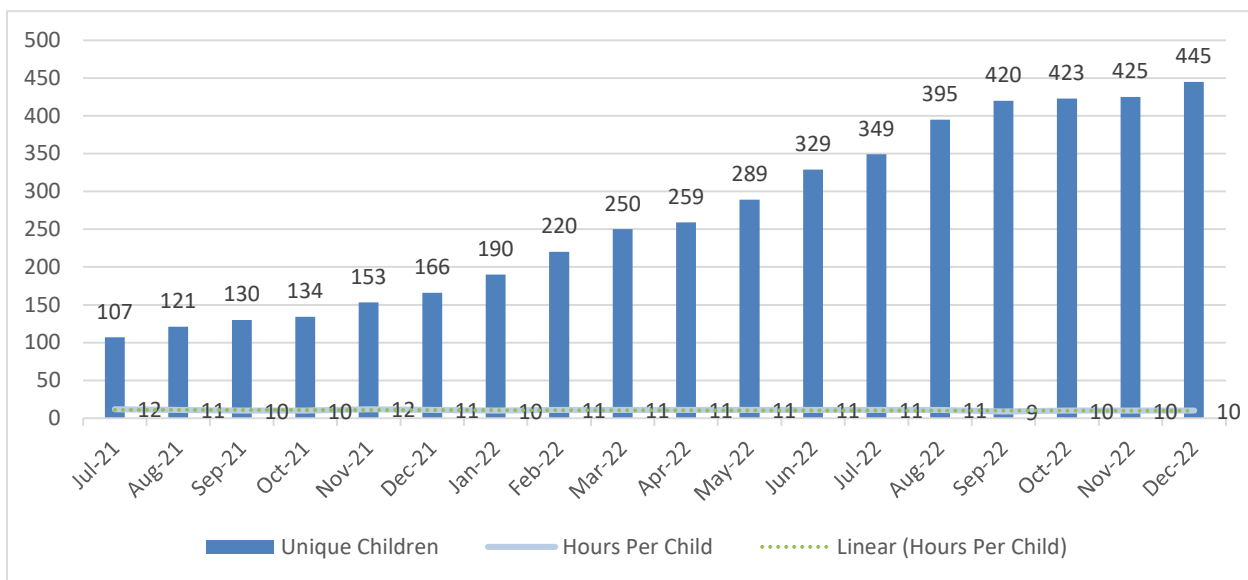
The number of children accessing services each month continues to increase while the average hours of service per child has remained relatively consistent, as shown in Figure 38. The CSED Waiver requires Aetna to manage prior authorizations, service utilizations, and care coordination and to help ensure that the development and execution of each member’s POC aligns with state and federal person-centered planning and HCBS requirements. Concurrent reviews of all enrolled members are carried out by Aetna to help ensure the member’s POC 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 POC 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 POC. 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 POC is comprehensive and includes access to non-wavier services, including, but not limited to, natural supports and healthcare. This review is completed monthly.

In response to utilization monitoring and questions about what can and cannot be billed, BMS and Aetna continue to educate providers on CSED Waiver billing. In early 2023, to continue workforce support efforts, BMS began program trainings, learning sessions, and monthly policy and billing spotlights with providers. BMS leadership also instituted monthly meetings with individual providers to address questions and respond to any concerns.

Identified next steps from Quality Committee reviews include completing an analysis of service utilization by provider and at the county level.

Figure 38: CSEDW Service Utilization for Hourly Services, July 2021 to December 2022 (Excluding Independent Evaluations)



Hourly CSED Waiver services used during the January to June 2022 period compared to the July to December 2022 period are captured in Figure 39 below. While CSED Waiver services are always person-centered with hours and types of services tailored to each child and family’s needs, data is reviewed by looking at average utilization to better understand the entire population receiving services. The number of children using CSED Waiver services increased 42% in the second half of 2022 with 583 children receiving services during the period compared to 411 children in the first half of 2022.

Given the continued increased demand for services, BMS and Aetna are focused on provider network expansion to help ensure adequacy of services to meet the needs of children statewide. Reference Section 10.3 for additional details.

BMS is working with WVU to enhance Wraparound Facilitator knowledge of the waiver services. This collaboration will include education on HCBS definitions, the population who may benefit from specific services, the duration the services are intended to be provided, which services may complement each other, and potential interventions or therapies.

BMS and the Office of QA are also working with Aetna to enhance data collection for children who begin accessing services and then are placed “on hold” due to temporary placement in a non-community-based setting such as juvenile detention, shelters, or residential facilities. An initial report of this data was provided to DHHR, and steps to address data quality and matching across datasets at the child level are currently underway. DHHR would like to better understand the impact that placing a child on hold has on service utilization. This is a new and developing dataset, and DHHR looks forward to having more time and data to better understand patterns, reasons, and timelines for children being on hold as well as any associated impacts on access to services for children and families.

Figure 39: CSEDW Service Utilization by Service Type, Comparison of January to June 2022 Period to July to December 2022 Period²³

Service Description	January-June 2022			July-December 2022		
	Hours Provided	Unique Youth	Hours per Child per Service Month	Hours Provided	Unique Youth	Hours per Child per Service Month
Crisis Service: Mobile Response	12	9	0.9	19	7	1.6
Family Therapy	4,437	275	4.7	7,771	417	5.0
Family Support	2,504	169	5.2	2,936	235	3.8
Independent Living/Skills Building	333	6	15.1	144	8	6.2
Job Development	1	1	1.0	3	1	1.4
Peer Parent Support	65	16	1.3	61	15	1.2
Respite Care, In-Home	770	27	10.3	1,257	23	19.0
Respite Care, Out-Of-Home	865	25	11.5	1,148	38	10.7
Wraparound Facilitation	7,655	396	5.5	11,003	556	5.0
All 15-Minute CSEDW Services	16,641	411	10.8	24,341	583	9.9

Consistent with prior periods, the services with highest utilization include Wraparound Facilitation, Family Therapy, and Family Support. BMS program teams and the DHHR Quality Committee continue to monitor utilization trends closely given the importance of CSED Waiver services in supporting children to remain in community-based services. As mentioned previously, identified next steps from Quality Committee reviews include completing an analysis of service utilization by provider and by county.

Previously, the Quality Committee had recommended an analysis be completed to enhance understanding of utilization through a child’s life cycle of accessing CSED Waiver services. In follow-up to this recommendation, an analysis of children who started services between October 2021 and March 2022 and accessed at least 90 days of services was completed. Results of

²³ Note: “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.

this analysis, which used claims data paid through April 2023, are included in Figures 40 and 41. This period was chosen to allow adequate time for the sample population to complete the expected duration of services per the waiver's design. In general, the highest utilization occurs during the first three months of services. Utilization then declines in each subsequent three-month period, corresponding with the phases of Wraparound Facilitation. Children with higher levels of acuity based on CAFAS/PECFAS scores of 140 and higher access slightly more services on average compared to children with CAFAS/PECFAS scores of 90 – 130. Utilization over the life cycle of services analyzed by acuity is a new analysis. Additional time and data should enable an enhanced understanding of how children with varying levels of needs are using services and the associated impact of these services on outcomes.

Figure 40: CSED Waiver Wraparound Facilitation Services: Life Cycle Utilization by Acuity for Children Starting Services Between October 2021 and March 2022

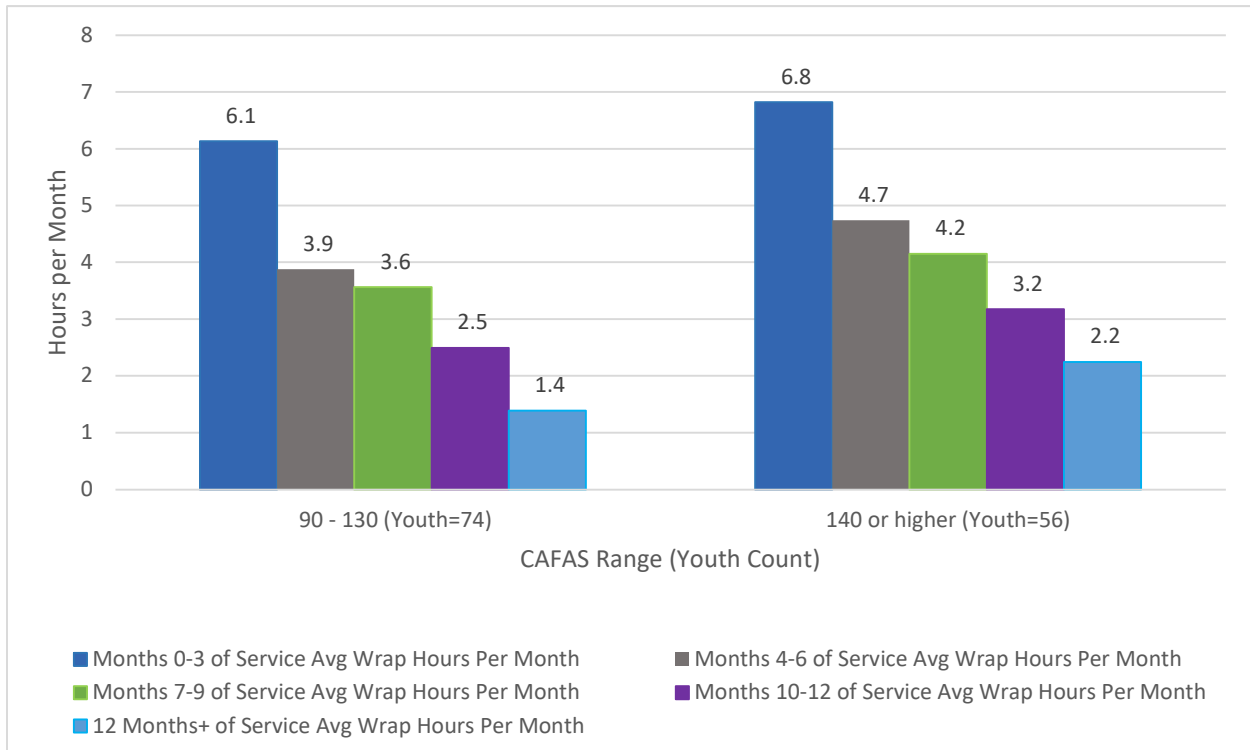
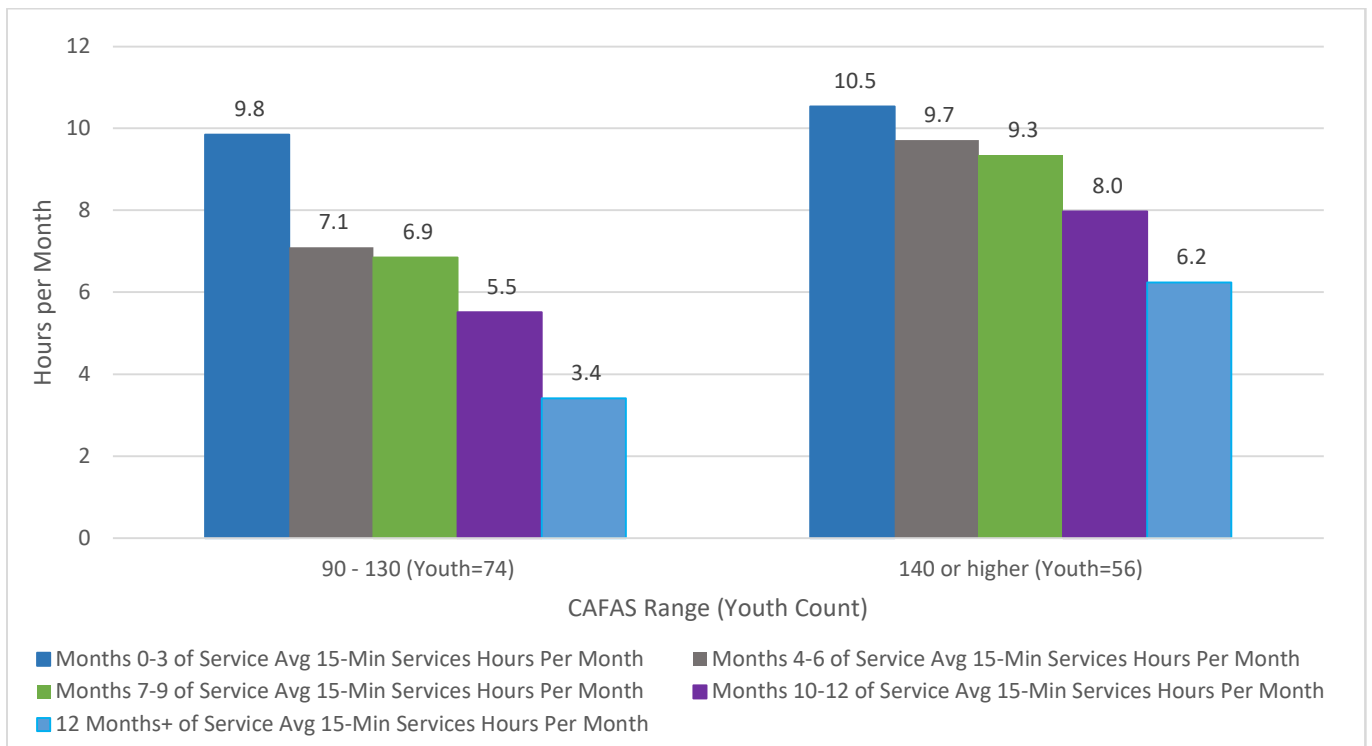


Figure 41: CSED Waiver Hourly Services: Life Cycle Utilization by Acuity for Children Starting Services Between October 2021 and March 2022

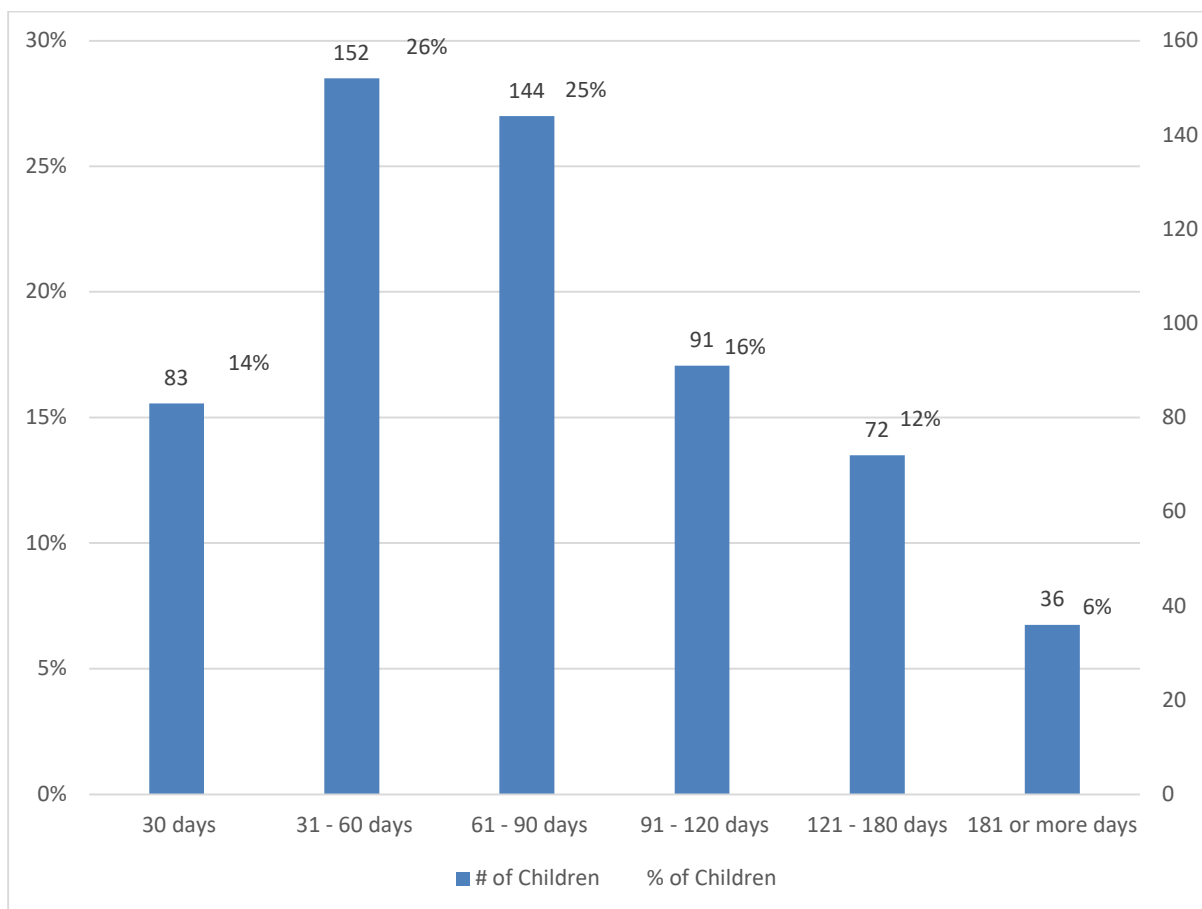


Timeliness of Access to CSED Services

As noted previously, DHHR is committed to timely access to services to meet the needs of children and families. After the data store is expanded to allow alignment of child-level data across systems (anticipated in 2024), DHHR intends to measure and report the timeline from screening to the start of services. Within the overall timeline to services, an important timeline that DHHR continues to monitor is the timeline from eligibility determination to the date of first CSED Waiver service.

To work toward better understanding of this timeline, DHHR completed a preliminary analysis of children whose CSED Waiver applications were received during the period of July 2021 to December 2022 and went on to start Wraparound Facilitation services (n=578). The average (mean) from eligibility determination to date of first billed CSED service was 83 days, with a median of 70 days. The distribution timeline is shown in Figure 42 below. This may include children in residential facilities prior to starting CSED services (which would not exclude time to discharge) or whose families chose not to start services immediately, this may account for longer than expected start to services although additional analysis and information via the data store is needed to better understand these caveats.

Figure 42: Timeline From Eligibility Determination to Date of First Billed CSED Service (n=578)



This timeline does not currently capture the timeline to *any* interim services the child and family may be receiving while they are going through the process of eligibility determination and establishing CSED services. As data collection associated with interim services is enhanced and the data store build-out continues, interim services will be included in the analysis to create a more complete picture of a child's timeline to access services. The ability to complete this analysis is expected in 2024.

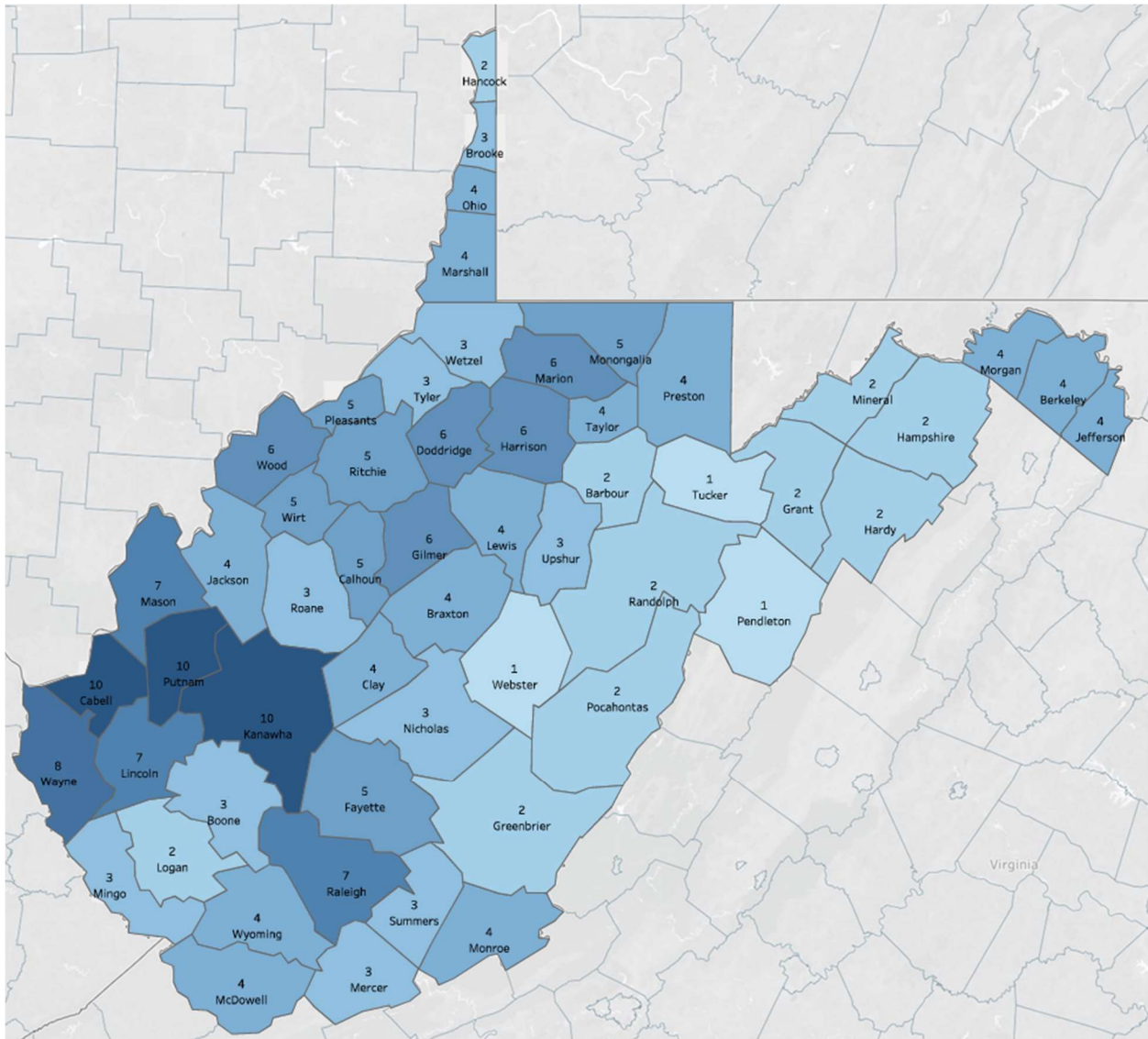
As mentioned above, BMS and the Office of QA are working with Aetna to enhance data collection associated with children who are eligible for enrollment in CSED Waiver services. In addition to on-hold data, Aetna has also added data components to track children who are enrolled in the CSED Waiver who are on service-specific waitlists. Aetna provides waitlist data to BMS leadership weekly. While this is a new and emerging dataset, DHHR plans to use this data to assist with any barriers associated with timely access to services.

BMS program teams and the DHHR 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

DHHR and Aetna remain focused on building the CSED Waiver provider network. In the May 2023 Quality Committee review, maps of CSED services by county by service type were reviewed. These new views provided additional insight into services by county and areas of focus for network expansion. As of the May Quality Committee review, 28 agencies are enrolled as CSED Waiver providers with 19 agencies actively providing services. Fourteen new providers are in process of enrollment. For those agencies enrolled but not actively providing services, staffing is the primary barrier. Aetna reaches out to these providers monthly. 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. BMS continues to work with Aetna to help ensure services are available statewide. Notably, as shown in Figure 43, there is at least one CSED Waiver service provider offering services in each county across the state.

Figure 43: Number of Provider Agencies Offering CSED Services by County as of March 31, 2023



DHHR is in the early stages of forecasting demand for CSED Waiver services. Preliminary forecasting was discussed in the October 2022 quarterly Quality Committee reviews. Wraparound Facilitation, family therapy, in-home family supports, and respite were identified as priorities for forecasting. Forecasting is based on referral and application trends, current and expected utilization, and additional factors.

Forecasting Wraparound Facilitation remains the primary focus. In early 2023, DHHR began collecting FTE status by Wraparound Facilitator to enhance the Wraparound Facilitator capacity and caseload analysis. DHHR will continue defining and testing the forecasting algorithms and assumptions. Plans include collaborating with Aetna and providers to understand their experience of service provision, including staffing patterns and other workforce constraints. Forecasting results will be used to assist Aetna and providers with focused recruiting and building network capacity to meet expected demand for services. Collaborating with Aetna and

providers continues to be a priority area of focus for DHHR to help ensure children are receiving services in the appropriate amount, duration, and intensity to meet their needs.

10.4 Strengths, Opportunities, Barriers, and Next Steps

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

- The CSED Waiver was approved for an additional five years, through January 2028.
- Nine hundred seventy-six (976) applications were processed in the second half of 2022 compared to the first half at 730 applications, an increase of 34%, with an additional 702 applications received for the period of January to March 2023. This represents an increased opportunity to connect children and families to services irrespective of whether they qualify for the CSED Waiver.
- During the July to December 2022 period, 583 children accessed CSED Waiver services compared to 411 children in the prior period, representing an increase of 42%.
- Data collection and quality improvements are actively in process with Acentra Health and Aetna. Additionally, CSED Waiver utilization data is now available in the data store and can be used in cross-systems analysis with residential services data.
- Twenty-eight agencies are enrolled as CSED Waiver providers with nineteen agencies actively providing services. Fourteen new providers are in the process of enrollment.
- Initiated mapping of county-level services offerings to assist with evaluation of service availability in each county.
- Implemented monthly billing and policy spotlight with CSED Waiver providers.
- BMS initiated monthly one-on-one meetings with each CSED Waiver provider to seek feedback, understand their needs, and address any barriers to expansion and sustainability of services.
- Began collection of Wraparound Facility FTE status for improved capacity and caseload analysis.
- Effective March 1, 2023, all CSED Waiver providers began entering CANS assessment data into the CANS automated system, enabling DHHR to move forward with outcomes reporting.
- Effective January 26, 2023, BSS provided a directive allowing foster parents to complete and sign Freedom of Choice forms for CSED Waiver assessments and selection of service providers in an effort to decrease barriers to timely connection to services and supports. The directive also enables the foster parent to attend all Child and Family Treatment Team meetings in place of the caseworker.

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

- Analysis of CSED service utilization at the provider level and county level to better understand areas of strength and need
- Further analysis related to children and families who do not follow through with the CSED Waiver eligibility process including demographics, other services being received, and the outcomes for these children
- Continue with data enhancements in process to improve the capture of information related to interim services while awaiting CSED eligibility determination, children on hold, waitlists for services, and timelines to access services as well as factors influencing those timelines
- Continue 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
- Continue efforts actively in process to forecast provider capacity needs and continue provider network expansion in partnership with Aetna

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. 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 services
 - Children who are ineligible for the CSED Waiver but who 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 services
 - Children who are ineligible for the CSED Waiver but who meet criteria for non-CSED Waiver Wraparound Facilitation through the same facilitator when possible

The goals across the agencies funding Wraparound 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.
- Provide increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

11.1 Review Period, Data Sources and Limitations, Population Measured

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

and fall 2022 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 (e.g., staffing) were listed as one of the most pervasive concerns impacting the ability to access services timely.

The implementation of the BBH System of Care Epi Info Interface enables capture of more service-level data and child-level data that will result in enhanced reporting for subsequent reports. An update to enhance this system further and refine key indicators is being built out with anticipated go-live in fall 2023. Updates will include revisions to timeliness indicators, mechanisms to differentiate interim Wraparound Facilitation services, and other refinements to improve data collection and quality. Updates were made in early 2023 to Aetna’s eligibility collection system to enhance tracking of individuals on hold for CSED Waiver services, including Wraparound Facilitation. Data validation is currently underway for this new dataset. Figure 44 below provides an overview of the Wraparound Facilitation data currently available.

Figure 44: Wraparound Facilitation Data Overview

WV Wraparound DHHR Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
Wraparound services provided by BBH CMHW providers	July to December 2022	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. Some concerns have been identified related to the new Epi Info System’s architecture. The system is currently undergoing further testing to identify any adjustments that may need to be made. Due	Interim Wraparound Facilitation while applying for the CSED Waiver and non-CSED Waiver Wraparound Facilitation with criteria agreed upon with BSS and BMS: <ol style="list-style-type: none"> 1. As of July 1, 2022, financial ineligibility will no longer be a barrier for the CSED Waiver, due to an approved waiver amendment. 2. Clinical ineligibility for CSED Waiver; DHHR’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:

WV Wraparound DHHR Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			to this, data in Section 11.2(a) is considered preliminary.	<ul style="list-style-type: none"> • Significant mental health needs • At risk of out-of-home placement • CAFAS/PECFAS score of 80, or 70 or below with current involvement by DHHR's BSS • Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver, such as Intellectual/ Developmental Disabilities Waiver or Traumatic Brain Injury Waiver
Wraparound Facilitation services provided by SAH WV providers	July to December 2022 (all SAH) and December 2022 to March 2023 (interim SAH)	CANS Automated System	Differentiation of SAH and interim services began in December 2022. Services through the agreement between bureaus to allow SAH facilitators to serve WV Wraparound clients went into effect June 10, 2022. 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 was as of April 30, 2023, which should account for data lag, although some may	*See description above

WV Wraparound DHHR Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			still exist due to the previous lack of submission timeline.	
CSED Waiver Wraparound Facilitation	July to December 2022	DW/DSS	Data are based on claims through April 2023, so there may be some claim lag in the data presented.	Children enrolled in the CSED Waiver

11.2 Review Summary

Wraparound Facilitation services have been divided by payor source for this report due to current data consolidation limitations. Work is underway to allow aggregation of this data to look at overall utilization and outcomes for children in WV Wraparound Facilitation throughout their journey through the Assessment Pathway. Although data in this section are reported separately by payor, as of October 2021, the system allows 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 increase in referrals, Wraparound Facilitation service trends across payor sources will be monitored to understand impacts of continued system changes and need.

11.2(a) Wraparound Facilitation Services Through BBH

A goal of the semiannual reports is to continue to establish baseline numbers of children receiving services and the amount of services being utilized as implementation is underway, as well as baseline characteristics of who is receiving services and where services are occurring. Another consideration is validation around the new Epi Info System. Some concerns have been identified related to the system's architecture, and the system is currently undergoing further testing to identify any adjustments that may be needed. Due to this, data in Section 11.2(a) is considered preliminary. Following this validation, and as reporting becomes more robust and the data store grows, it is anticipated that indicators will also evolve to include more outcome data, including CANS assessments, over time.

From July to December 2022, 60 individuals were served. This is a decrease from 160 individuals served in the previous six months. Information on the demographics of children enrolled in Wraparound Facilitation services through BBH is included in Section 4.0. This decrease is largely attributable to the nature of interim services and increased entry of children approved for services. Most children with preliminary approval for interim Wraparound Facilitation services were never assigned an interim facilitator due to limited availability of Wraparound Facilitators available through the payor source assigned. Children on average were transferred to CSED Waiver services within 20 weekdays of assignment, following receipt of initial determination. Although these capacity barriers currently exist for new referrals, it is likely attributable to smoother processes from the family's perspective for existing enrollees as they are able to transfer a facilitator with them to CSED services from interim Wraparound Facilitation. This ability can contribute to continued building of rapport with the family and potentially better outcomes due to that trust and connection that has already been established. Even though the number of responses to the survey was small and caution in interpretation should be taken, baseline results on the WIFI-EZ fidelity evaluation survey found responses from families indicating WV was meeting high fidelity to the NWI Wraparound model for outcome-related measures. DHHR is currently assessing avenues to improve and sustain Wraparound Facilitator capacity within all payor sources to allow for more timely connection to

Wraparound Facilitation services and supports.

Since the beginning of the pandemic, service delivery has shifted to meet needs and safety concerns. Represented in the “Other Contacts” category in Figure 45, telehealth services have been viewed as one of the more positive outcomes of the pandemic, allowing for more frequent and/or timely connection to families as needed or requested by the family without replacing key face-to-face interactions.

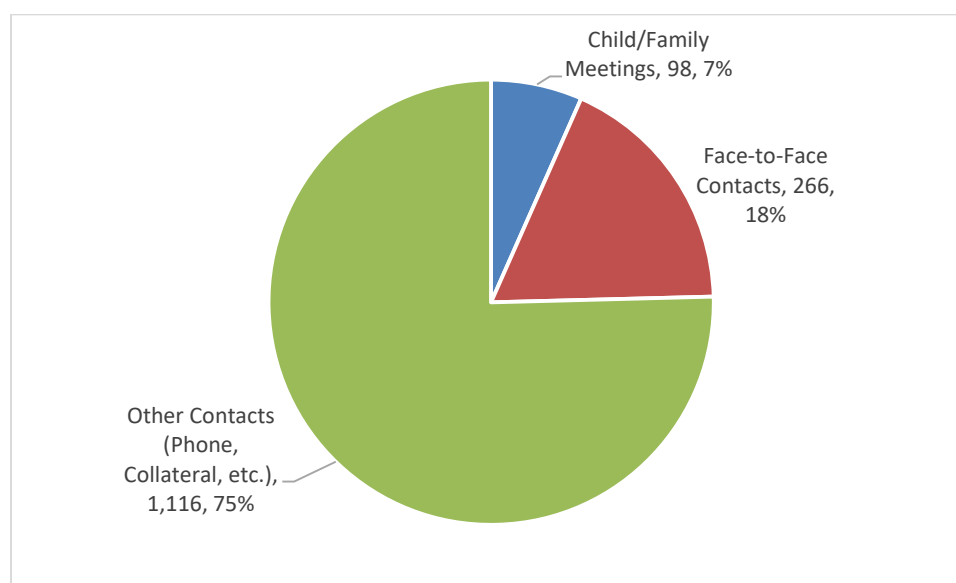
Three fourths (75%) of the contacts for services in the second half of 2022 were via virtual means, an increase from 62% of contacts in the first half of the year. Providers are trained to use virtual services based on the needs and requests of the family; however, there were several instances (e.g., multiple staff on maternity leave at the same time, multiple facilitators putting in resignation at one time) during the period that resulted in extreme capacity challenges related to children already assigned a facilitator. In order to continue services despite the shortage, virtual services were provided when capacity would not allow for all active children to be served otherwise.

Nearly 1,500 total contacts/interactions were made for the 60 individuals served, or four reported contacts on average per month per child. While individuals served has decreased, contacts per child have increased. When discussing this change, the Quality Committee discussed improvements and consistency in training offered, which may have resulted in increased focus on needs-based interventions as described in the child’s individual service plan or POC. It is also possible the acuity of children served has increased. As additional data is built into the data store, descriptive factors such as child acuity and its impact on service engagement and outcomes will be analyzed for further insight.

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 refers to hours spent with the individuals. Work is underway to capture time spent with children and families in the Epi Info System for future Wraparound Facilitation data collection updates, allowing service utilization to be reviewed and compared by average hours of service. Updates to Epi Info are tentatively planned to go live in September 2023.

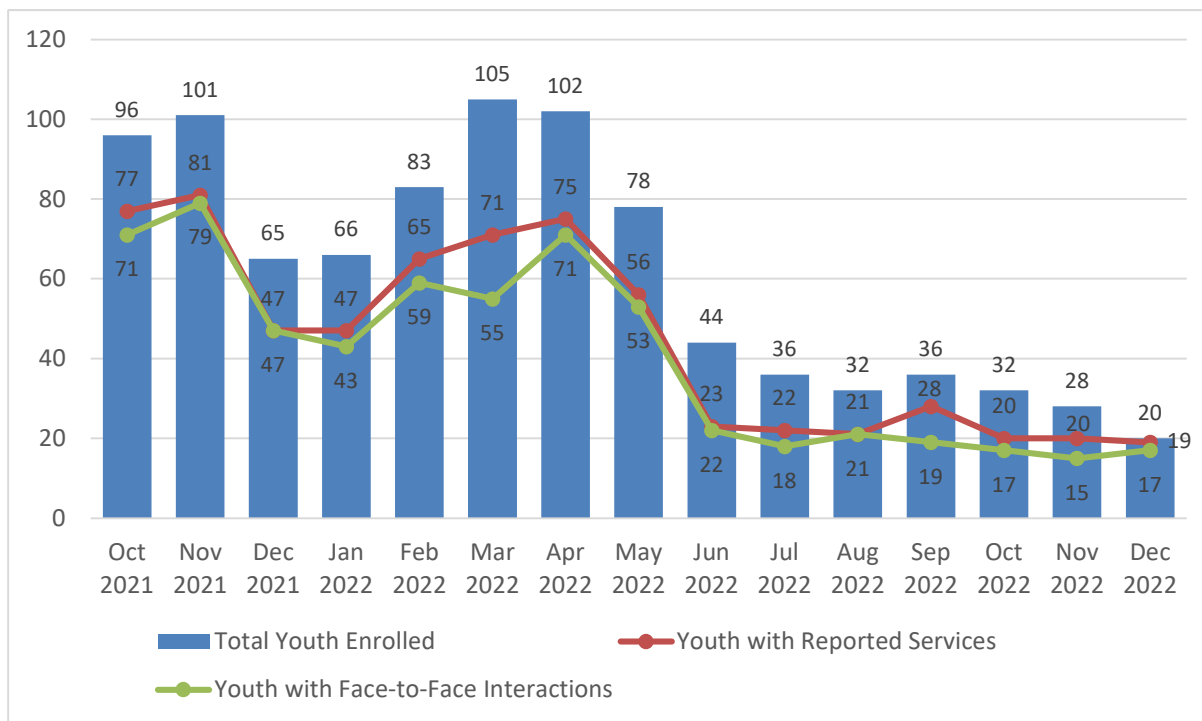
Interaction and service types are expected to vary based on the child and family’s level of need and amount of time served through the programs, with a higher number of interactions for children who have enrolled in the program recently. More in-depth assessment of intensity and length of services will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

**Figure 45: BBH Wraparound Facilitation Services by Contact/Interaction Type, July to December 2022
(n=1,480 Contacts) – Preliminary**



Monthly enrollment and service utilization (Figure 46) have declined significantly since the waitlist for interim Wraparound Facilitation services increased in spring of 2023. Enrollment peaked in March 2022, when 105 children were enrolled, followed by a steady decline to a low of 20 children enrolled in December 2022. The drop in monthly service utilization and face-to-face interactions was also large but not as dramatic: 75 children received any services and 71 children received face-to-face services in April 2022, compared to 19 children receiving any services and 17 children receiving face-to-face services in December 2022. This decrease is largely due to transfer of children from interim Wraparound Facilitation services to CSED Waiver services upon final approval for determination. While the ability to maintain connection with a Wraparound Facilitator may help support longer and more effective use of Wraparound Facilitation services, this has left a gap in availability of Wraparound Facilitators able to be reimbursed by BBH or SAH payor sources for interim Wraparound Facilitation services. DHHR is exploring options for expanding workforce and navigating these needs. As data collection is enhanced, CMHW data will continue to be monitored to assess impacts of interim and BBH-funded Wraparound Facilitation services.

Figure 46: BBH Wraparound Facilitation Monthly Enrollment Totals and Service Utilization, October 2021 to December 2022 – Preliminary

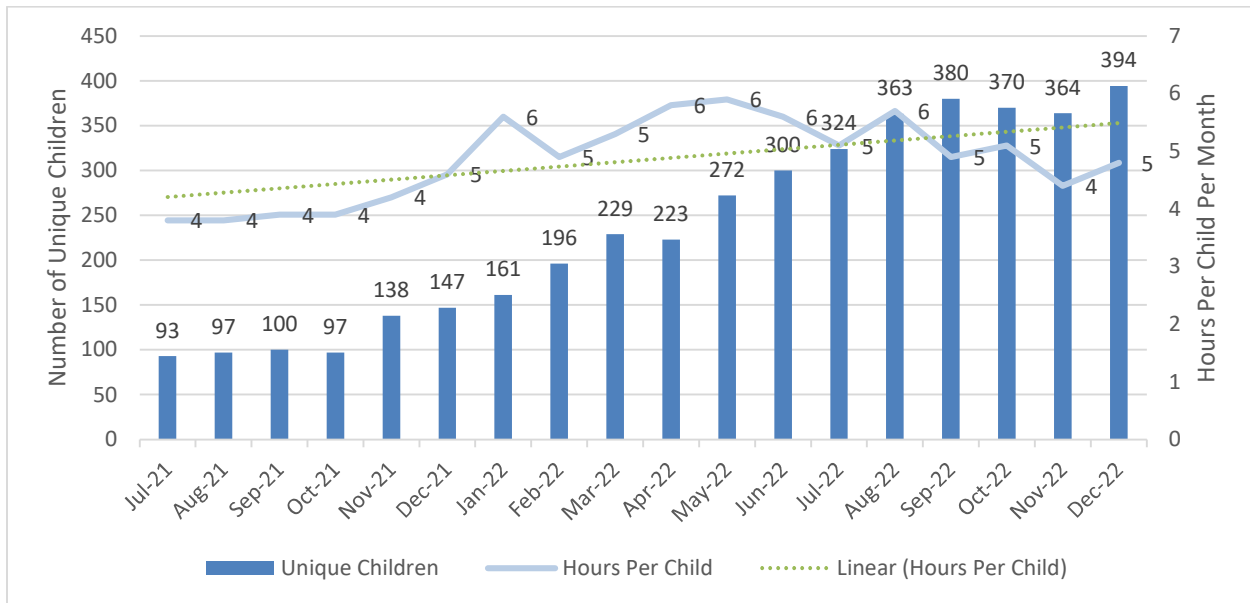


11.2(b) Wraparound Facilitation Services Through CSED Waiver

Five hundred fifty-six (556) unique children accessed Wraparound Facilitation services in the second half of 2022 compared to 396 unique children in the first half of 2022, representing a 40% increase in children accessing Wraparound Facilitation services (Reference Figure 39: CSEDW Service Utilization by Service Type, Comparison of January to June 2022 Period to July to December 2022 Period in Section 10.2(b) CSED Waiver Service Utilization).

The CSED Waiver Wraparound Facilitation utilization 18-month trend from July 2021 to December 2022 is shown in Figure 47.

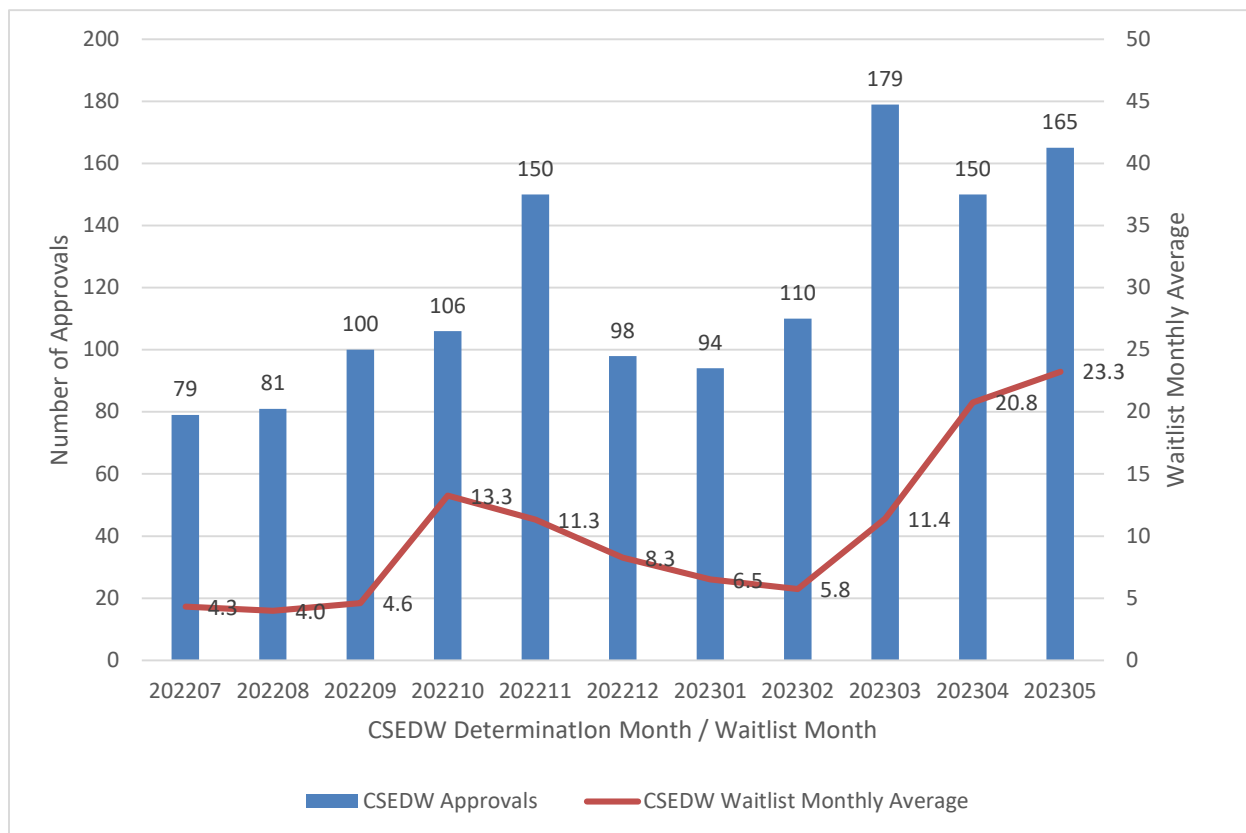
Figure 47: CSED Waiver Wraparound Facilitation Utilization, July 2021 to December 2022



While the continued increase in children and families accessing Wraparound Facilitation services is very positive, the increased demand has led to a waitlist for Wraparound Facilitation services. Waitlist tracking was initiated in mid-2021 with Aetna reporting the number of children on the waitlist to BMS leadership weekly. As shown in Figure 48 below, the increase in average number of children on the waitlist corresponds to the increase in approved CSED Waiver applications.

Given the increase in children on the waitlist, BMS implemented a new process in which an Aetna care manager is assigned to the family to provide weekly check-ins and coordinate care and connection to services while the child and family are awaiting Wraparound Facilitator assignment.

Figure 48: CSED Waiver Wraparound Facilitator Waitlist Trended With Approved CSED Waiver Applications, July 2022 to May 2023



As shared in Section 10.3 Provider Capacity/Statewide Coverage, expansion of the Wraparound Facilitation provider network remains a primary focus. In March 2023, DHHR began collecting FTE status by Wraparound Facilitator to enhance the Wraparound Facilitator capacity and caseload analysis. DHHR is working to align FTE status reporting with CANS service-level data from the CANS automated system. Additionally, DHHR is addressing data quality issues in Wraparound Facilitator data collection with Marshall University and PCG. While this analysis is still in the early stages, this is a positive step toward more effectively using available capacity to best meet the needs of children across the state while simultaneously taking steps to impact the workforce shortage.

Through the Wraparound Fidelity Performance Improvement Plan team, capacity issues are discussed while seeking to understand workforce limitations versus other factors impacting the sustainability of services, such as reimbursement rate considerations. The team has proposed, and BMS is pursuing, a possible change in Wraparound Facilitator education and experience requirements to expand the pool of providers while maintaining the quality of services.

Length of Service

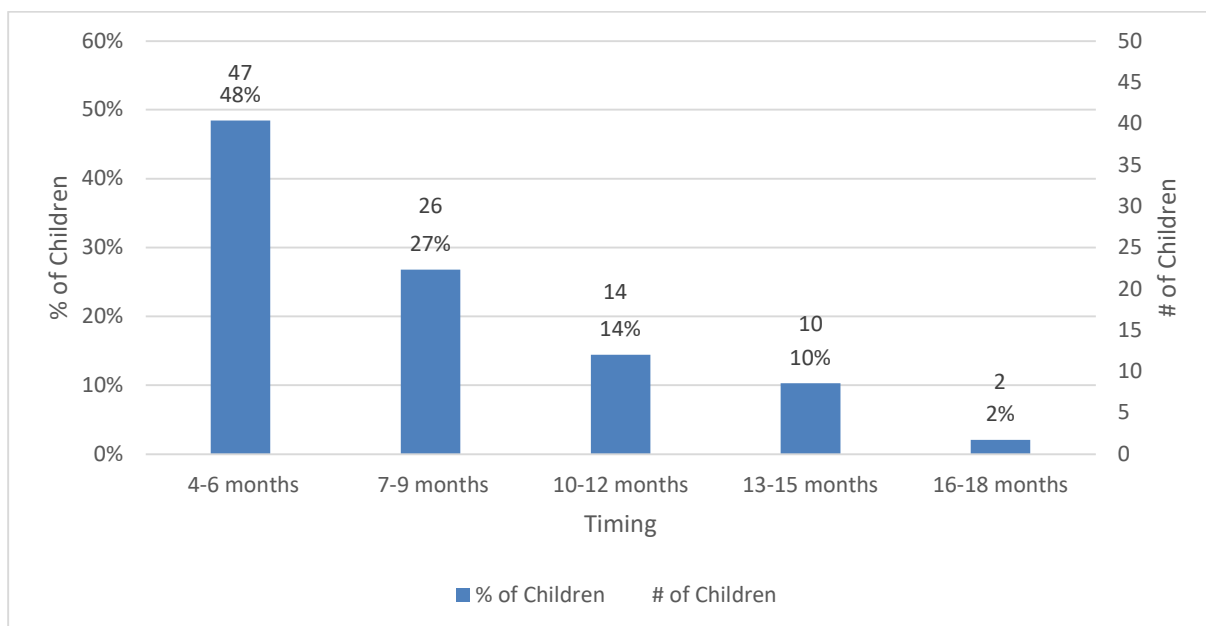
An analysis of length of service for CSED Waiver Wraparound Facilitation was completed for children with waiver approval dates in the period of January to December 2021, who met the following criteria:

- Accessed at least 90 days of Wraparound Facilitation services
- Did not have a gap greater than 60 days between services²⁴

For the 97 children who met the above criteria, the average (mean) length of service was 7.3 months with a median of seven months. This is similar to the prior period data in the January 2023 Semiannual Report with an average of 9.3 months and median of eight months. This length of service is limited to CSED Waiver Wraparound Facilitation and does not include interim Wraparound Facilitation length of service that children and families may access once referred to the Assessment Pathway and while going through the CSED Waiver eligibility process. While more detailed analysis is needed over time to include children who may go on hold for limited periods, as well as an analysis of a larger population of children as the waiver continues to grow and achieve a steady state, this early data is positive and demonstrates that children and families are utilizing Wraparound Facilitation services in alignment with the design of the waiver program (i.e., intensive services for an average of six to nine months).

Figure 49 below captures CSED Waiver Wraparound Facilitator length of service distribution. Based on this early analysis, the majority (approximately 89%) of children received services for up to one year, with only 12 children receiving services for up to 18 months.

Figure 49: CSED Waiver Wraparound Facilitation Length of Service



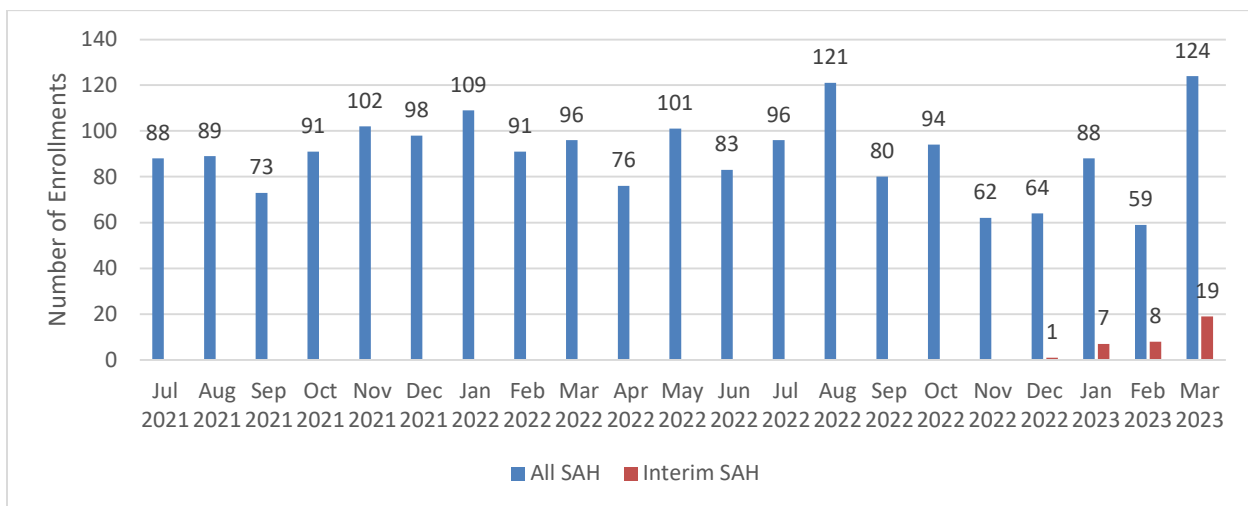
11.2(c) Wraparound Facilitation Services Through Safe at Home (SAH)

New monthly enrollments in SAH Wraparound Facilitation for July 2021 to March 2023 are shown in Figure 50. Enrollments for any SAH Wraparound Facilitation case are relatively

²⁴ A gap no greater than 60 days was included in the analysis as a consideration for children who may temporarily suspend services due to placements in BJS or a residential facility, as these circumstances would impact length of service calculations.

constant throughout the period; though there is month-to-month variability (from a minimum of 61 new enrollments in November 2022 to a maximum of 124 in March 2023), there is no clear seasonal trend. 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 meant to indicate children going through the Assessment Pathway and assigned a Wraparound Facilitator serving the SAH program; new interim enrollments are provided in Figure 50 beginning in December 2022.²⁵ Initially, new monthly enrollment reporting for interim SAH Wraparound Facilitation cases was low, and additional months of data are needed to understand the population of children served via interim services.

Figure 50: SAH Wraparound Facilitation New Monthly Enrollments, July 2021 to March 2023



Between July and December 2022, 517 children enrolled in SAH Wraparound Facilitation, while 35 children enrolled in an interim SAH Wraparound Facilitation case between December 2022 and March 2023; timeliness and contact data for these children are displayed in Figure 51. Overall, the majority of SAH cases had at least one contact reported – 88% (n = 455) for all SAH and 83% (n = 29) for interim SAH. Three fifths (60%) of all SAH cases and 71% of interim SAH cases met the preliminary goal of having the first contact with the child within three days of the assignment of the Wraparound Facilitator. Average timelines were longer for all SAH cases (7.1 days) than for interim SAH cases (1.5 days). Eighty-one percent (81%) of all SAH cases and seventy-one percent (71%) of interim 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 longer for all SAH cases (14.4 days) than for interim SAH cases (8.7 days). Preliminary goals have been established based on feedback from the DART fidelity evaluation tool. DHHR plans to maintain provider meetings and discuss ideal goals and benchmarks for relevant SAH metrics. Timeliness will continue to be assessed as more interim data becomes available for comparison and additional consideration.

²⁵ Prior to this change, interim SAH cases were included with regular SAH cases in the CANS Automated System.

Figure 51: SAH Wraparound Facilitation Contact and Timeliness Data

Metric	All SAH (n = 517, July to December 2022)	Interim SAH (n = 35; December 2022 to March 2023)
Presence of Contact Data	88% (n = 455)	83% (n = 29)
Timeliness to First Contact <i>(Preliminary goal: within three days of assignment)</i>	<ul style="list-style-type: none"> 60% (n = 310) met goal Average of 7.1 days from assignment to first contact 	<ul style="list-style-type: none"> 71% (n = 25) met goal Average of 1.5 days from assignment to first contact
Face-to-Face Contact <i>(Preliminary goal: within 10 days of assignment)</i>	<ul style="list-style-type: none"> 81% (n = 420) had a face-to-face contact Average of 14.4 days from assignment to first face-to-face contact 	<ul style="list-style-type: none"> 71% (n = 25) had a face-to-face contact Average of 8.7 days from assignment to first face-to-face contact

Review of timeliness and contact data for SAH Wraparound Facilitation cases is in the early stages. Beginning in July 2023, SAH providers are expected to enter data for the prior month by the fifth business day of the month. Adherence to this new policy will help ensure timely documentation of data and positively impact data completion and quality. BSS also plans to share data with SAH providers to drive improvement on fidelity, quality of service provision, data collection, and consistent reporting. The initial focus will be to refine reporting with respect to weekly face-to-face meetings, child and family team meetings, documentation of crisis plans, and discharging cases that have exited services, are ready, or are due to complete/exit services.

11.3 Provider Capacity/Statewide Coverage

Wraparound Facilitation capacity has a very large impact on the HCBS highlighted in this report, thus information on this workforce need has been noted throughout this document. As of July 2023, there are 175 Wraparound Facilitators and 53 Wraparound Facilitator supervisors across the state. DHHR has expanded collection and analysis of Wraparound Facilitator capacity data by leveraging Wraparound Facilitation coaching connections to collect updates on facilitator capacity and FTE at the agency by payor source. 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. This FTE-level data is then compared with the Wraparound Facilitation cases in the CANS Automated System to assess caseloads both statewide and disaggregated by agency, facilitator, and payor source. Data collection for this process began in March 2023, and efforts have continued to validate data quality and address needed improvements with related agencies with assistance from Marshall University. Once the baseline data validation and improvement process for this workforce capacity assessment is completed, anticipated for fall 2023, capacity data will be analyzed and reviewed by the workgroup leads, Wraparound Facilitation PIP team, and ESC. This new reporting will increase information available for use by Wraparound Facilitation leads and Aetna to expand outreach

and recruitment efforts to areas where providers are needed most (those with the most limited capacity), with additional considerations by payor source for FTE-related needs. Aetna and Wraparound Facilitation leads maintain biweekly meetings to review waitlist and agency expansion progress.

In addition to understanding current caseloads and capacity based on FTE for facilitators, DHHR will continue to build-out forecasts for projected number of facilitators needed using CSED trend data to predict incoming referral, approval, and utilization trends. As this model is developed it can be applied to smaller areas of the state to assess approximate capacity needs at an FTE level and at a county, regional, or agency level.

Understanding and being able to make strategic decisions around capacity will help DHHR identify critical need areas to explore. This information will help focus 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 will 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 enables the continuation of these critical services to extend after the pandemic to meet families' needs as well as to meet demand during extenuating circumstances. Although virtual services can extend the ability to deliver services, DHHR will plan to confirm outcomes are not impacted, following data store expansion.

Daily collaboration between BMS, BSS, and BBH occurs to help ensure children are connected to Wraparound Facilitators or other services and resources in cases where a Wraparound Facilitator is not immediately available. Additional strengths include:

- Utilization of interim Wraparound Facilitation services while awaiting CSED Waiver determination when available, and awareness and connection to other mental health services while waiting for interim Wraparound Facilitation services or transfer to the CSED Waiver
- Forty percent increase in children accessing Wraparound Facilitation services; specifically, 556 unique children accessed CSED Wraparound Facilitation services in the second half of 2022 compared to 396 unique children in the first half of 2022
- Increase in contacts per child per month for children accessing Wraparound Facilitation via CMHW
- Provider education and training on WV Wraparound Facilitation and CMCRS through Marshall University in partnership with University of Connecticut to better equip the workforce and consistently train them; the Wraparound Facilitation Fidelity PIP team has conducted additional reviews of training and recommends adding information to help

ensure providers know what is required to meet high-fidelity Wraparound Facilitation programming requirements

DHHR recognizes the need to expand the Wraparound Facilitator workforce in order to connect children with Wraparound Facilitators in a timelier fashion. Opportunities and prioritized next steps per recommendation of the Quality Committee include:

- Per a recommendation from the Wraparound Facilitation Fidelity PIP team, BMS is pursuing a possible change in Wraparound Facilitator education and experience requirements to expand the pool of providers while maintaining the quality of services
- Wraparound Facilitator forecasting analysis, current caseload validation, and provider network expansion effort exploration based on findings, in coordination with Marshall University and Aetna, which could help address workforce barriers
- 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, including CSED Waiver providers beginning to input CANS data into the CANS Automated System, which went into effect March 2023; initial review has focused on timely reporting of CANS data, which will expand to outcomes reporting over time through the Wraparound Fidelity PIP team

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 of children who are experiencing significant maladaptive behavioral challenges. Behavioral Support Services are used widely, including within BBH, BSS, BMS, and WVDE programs and providers. Figure 52 below provides an overview of the data currently available for Behavioral Support Services.

12.1 Review Period, Data Sources and Limitations, Population Measured

Figure 52: 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 2022	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 program; services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs.
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 fall 2023, 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 are currently only available for direct services provided by WVU CED under the BBH PBS grant; however, BMS is working to implement a Behavioral Support Services modifier code that will allow Behavioral Support Services-related claims data to be captured for children receiving these services through Medicaid (expected fall 2023). In addition to the review of information for individuals directly served, training is also conducted for providers via the WVU CED. Concord University certified 29 providers on the new Behavioral Support Services provider certification in 2022. Additional training was conducted in June 2023 following a needs assessment conducted by Concord to improve training quality and satisfaction, with the next training planned for August 2023. Concord, in conjunction with DHHR, will continue to assess and address training demand accordingly until a regular cadence can be established. Routine availability and awareness of these online trainings will eventually allow Behavioral Support Services training and certification to be more widely utilized, with information on certified professionals' capacity to be included in future reports.

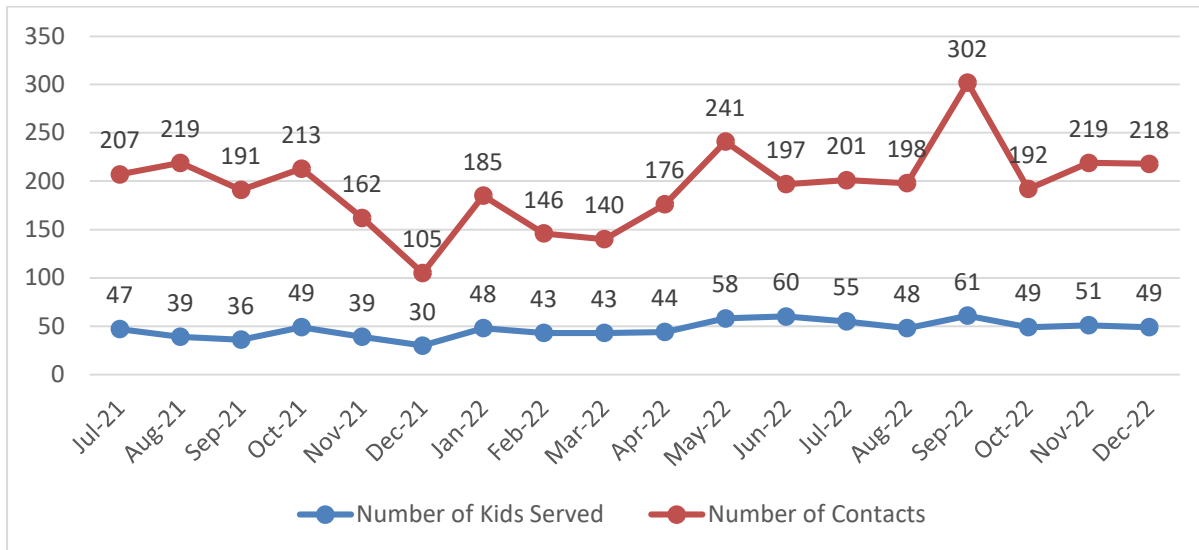
12.2 Review Summary

WVU CED provided PBS services to 94 children from July to December 2022. This program is not expected to have a broad reach for direct services but is instead meant to provide training to expand provider-level services throughout the state as well as assist with consultation for children and families with more intense needs. Children who are provided with direct services are typically indicated as having more intense needs; these direct services can vary from brainstorming positive behavior support strategies with the family to intensive services and plan writing.

Information on the demographics of these children is included in Section 4.0 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 to understand how needs vary geographically.

PBS referrals have continued to increase over the past year, as shown in Figure 53, with an average of 52 children served per month from July to December 2022, compared to an average of 40 children in the last six months of 2021 and 49 children in the first six months of 2022. Similarly, total child interactions have also increased. In the six-month review period, 1,330 total services were conducted, compared to 1,085 total contacts during the first half of 2022.

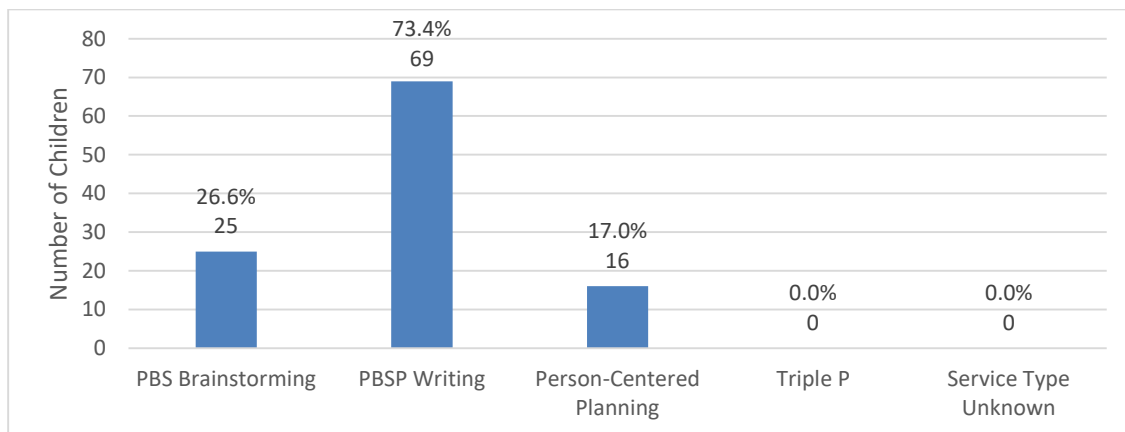
Figure 53: Children and Interactions, Monthly, June 2021 to December 2022



WVU CED has experienced some workforce shortages. As of July 2023, there was a waitlist of 27 children for PBS services, as WVU CED reported increased referrals during the past several months. Families are prioritized based on need and wait times were reported to be short. As of the writing of this report, the WVU CED PBS program is fully staffed and as onboarding occurs, this is expected to decrease the waitlist and associated wait times.

The most common services provided to individuals as highlighted in Figure 54 were PBS Plan Writing (73%); Brainstorming, a service typically done with lower-need cases to provide ideas and support for families (27%); and Person-Centered Planning (17%). Data quality has improved to eliminate missing service types in this period.

Figure 54: PBS Services Provided,²⁶ July 2022 to December 2022



²⁶ Note that individuals may have received more than one service, resulting in totals greater than 100%.

12.3 Provider Capacity/Statewide Coverage

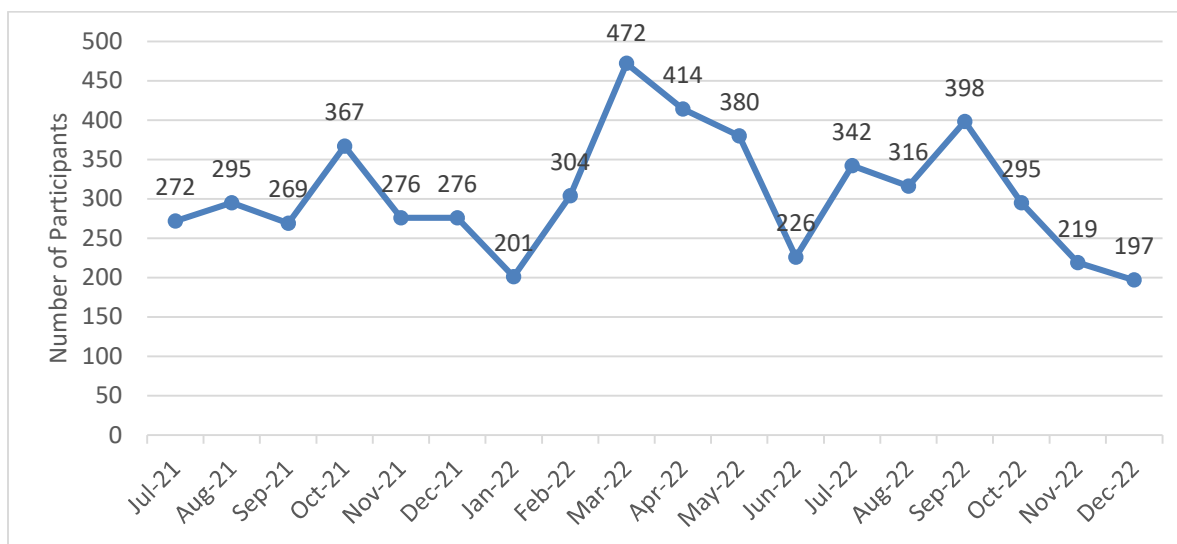
The BBH PBS program through WVU CED has nine full-time equivalent staff budgeted and is fully staffed as of July 2023 (Figure 55). The last position was filled in July and as this staff member is onboarded, a positive impact is expected on ability to serve children in a timely manner without the need for a waitlist.

Figure 55: PBS Staffing at WVU CED

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Behavior Specialists	8	8	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, expanding the resources available in each provider’s tool belt. 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 per year geared toward certification of providers serving individuals with intellectual or developmental disabilities. Figure 56 shows that an average of 295 individuals have been trained each month from July to December 2022, compared to 333 individuals from January to June 2022. The greatest number of participants were trained in March 2022 (472).

Figure 56: Participants Attending PBS Training, July 2021 to December 2022

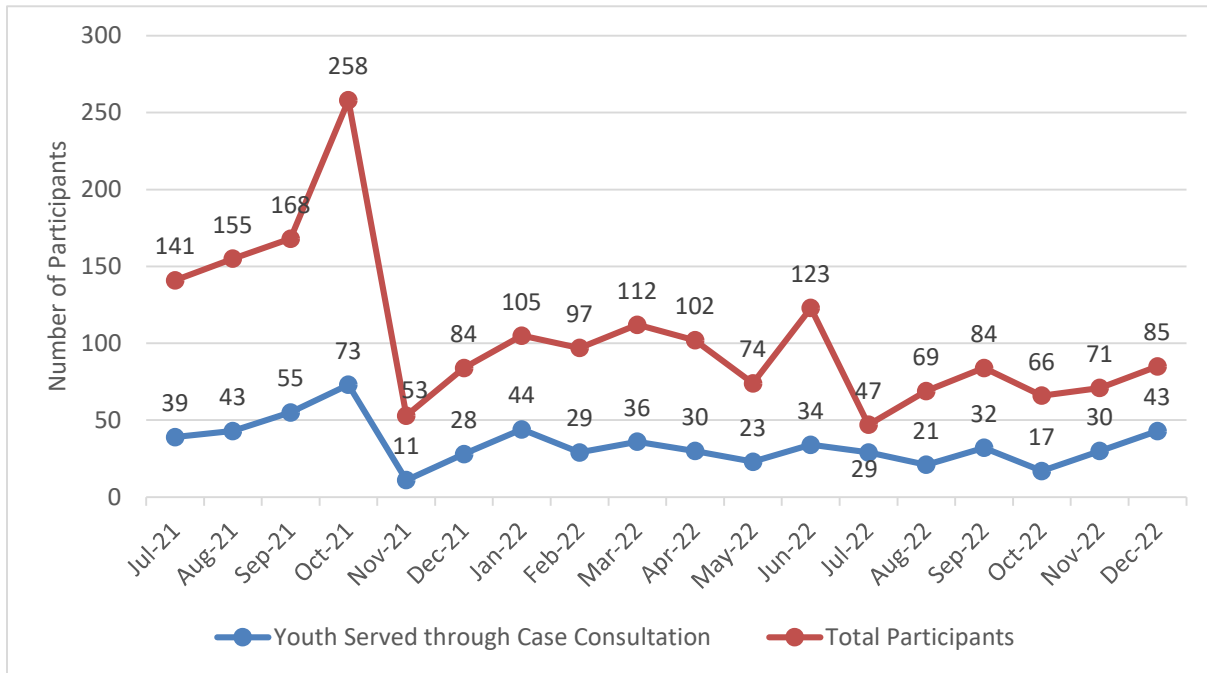


*Participants can include parents and professionals

The WVU CED PBS program provided consultations for an average of 29 children per month from July to December 2022 compared to the previous six-month period of 33 children per

month as shown in Figure 57. This decrease in consultations is likely due to out-of-state clinical review restructuring with Aetna, which resulted in less participation needed from the PBS team. Consultation allows a trained provider or providers to continue to support children while getting technical assistance and consultation from the WVU CED team.

Figure 57: Number of Children Served Through Case Consultation, July 2021 to December 2022



12.4 Strengths, Opportunities, Barriers, and Next Steps

Behavioral Support Services allow children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program allows direct services and case consultations as a result of referrals from other organizations. Approximately half (53%) of individuals served are 5 – 12 years old, which provides an opportunity to serve younger children and potentially divert them from more intensive out-of-home services. As noted in Section 4.0 WV’s Child Population and Individuals Utilizing Services, although race distribution is subject to fluctuation due to low number of children represented in both the state population and programs, BIPOC have shown 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 section within WVU’s Center for Excellence in Disabilities, 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 consultation services provided via WVU CED will provide support and build integrity within the array of Behavioral Support Services.

Next steps include:

- Continue monitoring WVU CED PBS program data to assess ongoing needs and consult program staff to identify trends and potential reasons for changes in service utilization.
- After data are available in BMS claims with the modifier code, further assess training provided to organizations in low-utilization areas as well as rural areas to identify whether needs are being met through direct or indirect services (training).
- Continue to work with Concord University as training and certification is expanded to establish formal data collection and recurring reporting on trainings conducted and individuals certified.
- 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 a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the ACT team provides the majority of direct services in the member's community environment. ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management and facilitating a supportive environment to meet basic needs and improve social, family, and environmental functioning.

ACT is an option for youth ages 18 – 20 to help prevent unnecessary institutionalization. As part of the Assessment Pathway, youth 18 or older who are eligible are 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) is scheduled for update in fall 2023. The general 503 manual for Licensed Behavioral Health Center services, ACT, PBS, and outpatient services is scheduled for update by year-end 2023. These manual updates will include the requirement for ACT providers to collaborate with residential providers to help youth transition to community settings.

13.1 Review Period, Data Sources and Limitations, Population Measured

Figure 58: ACT Enrollment and Utilization Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2022	DW/DSS 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 – 20 moving through the Assessment Pathway and eligible for ACT are offered freedom of choice between CSED Waiver (available until the child’s 21st birthday) and ACT services. This choice is documented on the Freedom of Choice form. A key difference in this service is the length of time the service is designed to be offered. CSED services are designed to be shorter-term (i.e., up to one year), while ACT is intended to be a long-term service for individuals with ongoing high intensity needs.

The number of youth accessing ACT services remains low, as has been the historical pattern. When reviewing data for all individuals accessing ACT regardless of age, the numbers are significantly higher (reference Figure 59).

Figure 59: ACT Member Utilization Comparison

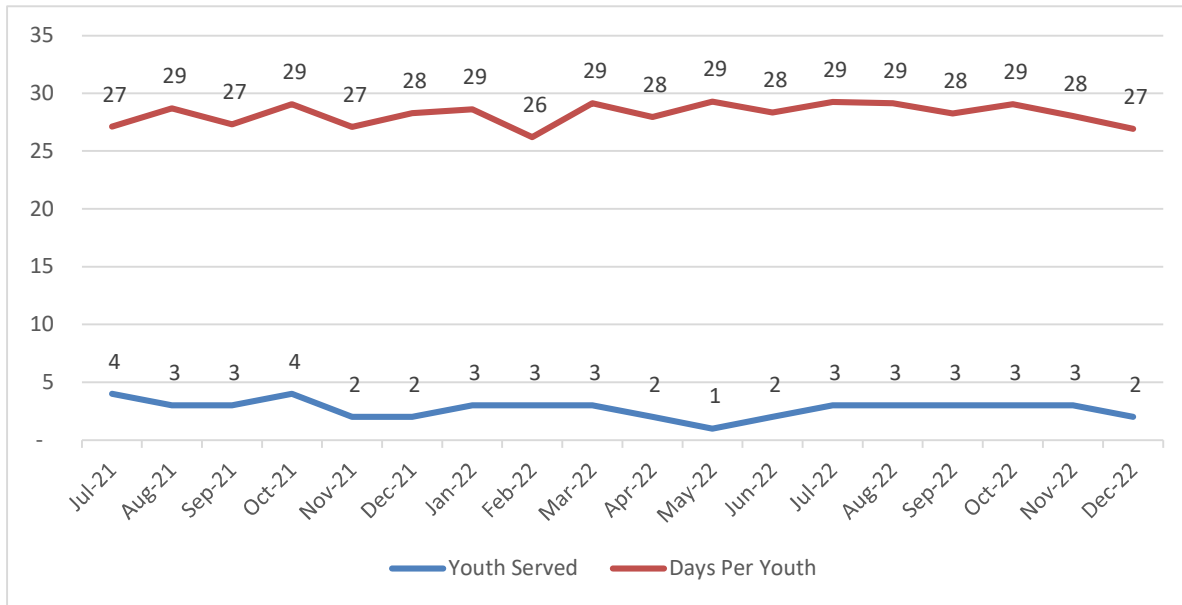
	July - December 2021	January - June 2022	July - December 2022
Youth < 21	5	4	5
All Members	552	544	540

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 they may choose to take advantage of later in life. The average age of ACT utilization for all members remains consistent over time at 46 years old.

Figure 60 below displays enrollment and the days of service per youth for July 2021 to December 2022. For purposes of comparison, ACT utilization for all members regardless of age is shown in Figure 61. Discharge and decline reason information is not available, but it is

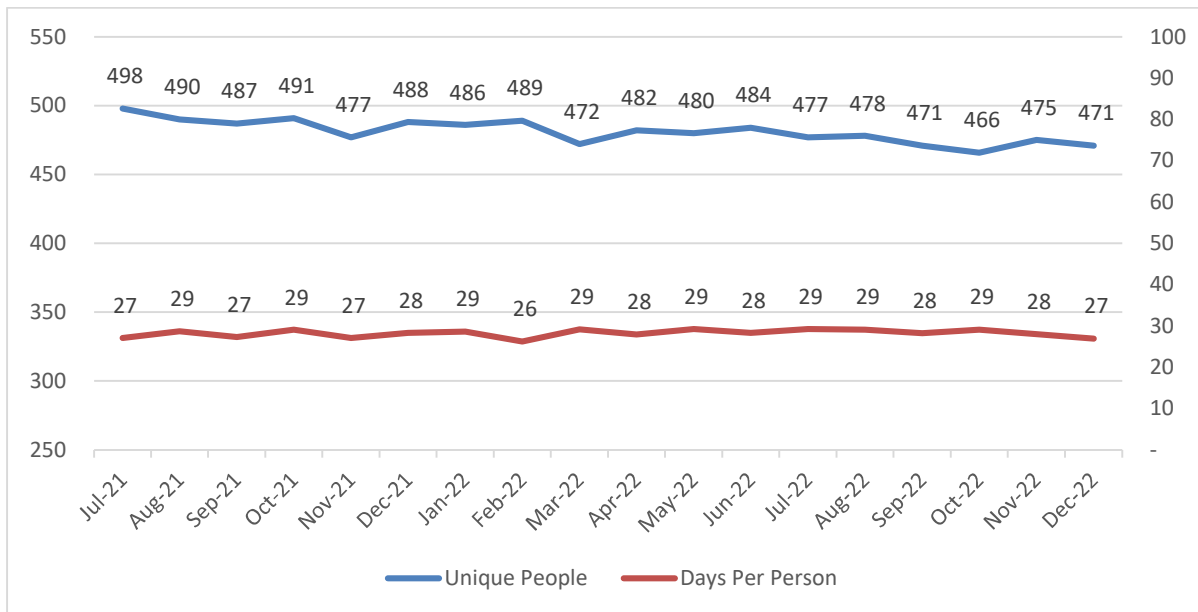
commonly understood that many youth are transient and perceive ACT as an intrusion in their lives. As awareness of ACT services increases, individuals in RMHTFs have appropriate discharge plans developed, and eligible youth are offered ACT services at discharge, DHHR anticipates the number of youth accessing ACT services might increase.

Figure 60: ACT Youth and Days Per Youth by Month, July 2021 to December 2022



Note: Reflects claims paid through April 2023.

Figure 61: Total ACT Utilization by Month, ACT Members of All Ages July 2021 to December 2022



13.3 Provider Capacity/Statewide Coverage

DHHR continues to recruit ACT teams to increase ACT availability statewide. The state’s

Eastern Panhandle has faced challenges procuring an ACT provider; however, EastRidge Health Systems has been contracted to cover ACT services in the Eastern Panhandle. Services are expected to begin in 2023 barring any issues with hiring required staff, which has been a challenge. Twenty (20) individuals have been identified who qualify and are interested in receiving services through ACT.

To further expand the availability of ACT services, DHHR plans to require all CCBHCs to have an ACT team. DHHR leadership will be reviewing the final requirements in July 2023. These updates are anticipated to go into effect in 2024. In addition, DHHR will continue to seek alternative providers to build ACT teams to offer these services.

ACT team capacity is monitored during retrospective reviews; however, workforce capacity is rarely listed as a concern. ACT teams remain in contact with the state if issues arise to troubleshoot scenarios, such as temporary lack of nursing staff. At the time this report was written, there were no vacancies reported on ACT teams statewide.

13.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR expects to achieve statewide ACT coverage in 2023, with the number of providers also expanding with the new CCBHC requirements expected to be implemented in 2024. DHHR is also pursuing rural ACT services through an 1115 demonstration grant. DHHR's application for the grant has been submitted. The Centers for Medicare and Medicaid Services (CMS) has delayed the review and extended the current 1115 grant to March 2024.

As noted previously, additional efforts to increase enrollment include revision of the BMS policy manuals. Provider workshops reinforcing messaging around offering the choice of ACT are planned for spring 2024. Additionally, as noted in Section 6.0 Marketing, ACT services are the topic area for the next phase of Resource Rundown beginning in June 2023.

DHHR has made progress around data collection associated with youth choosing ACT services, including Aetna tracking youth who chose ACT upon discharge from residential in the discharge planning data collection in the QuickBase system (planned implementation by fall 2023) and capturing the Freedom of Choice result (including choice of ACT) in the CSED QuickBase Roster. The Aetna QuickBase Roster data is being reported monthly and is in the process of being validated. Once data for youth who choose ACT is available, DHHR plans to compare choice data against ACT claims data.

DHHR is still working toward collection of discharge reason data to help further understand and seek opportunities for transient youth resistant to remaining with ACT services. The requirement to collect and report discharge reason data is planned for contract updates with Aetna and Acentra Health in July 2024.

DHHR will continue to work on educating and promoting 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. These settings must be equipped to be supportive and stable 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 Subsection 17.2(a) Prioritized Discharge Planning, having an appropriate setting to receive treatment or to discharge to has been identified as a primary barrier for many children.

One planned mechanism for helping to prevent disruption to placements is the STAT Home model, which is designed to complement the current WV Tiered Foster Care model (also expected to remain in place). STAT Homes will provide stabilization services for children in foster care or kinship care who are at risk of residential placement. The STAT Home program is a family alternative to residential placement for children requiring behavioral or mental health interventions. CPAs are responsible for providing these services statewide. In partnership with CSED Waiver services, STAT Homes will provide short-term intervention to provide a stable, family-like setting with treatment and behavioral interventions so the child can ultimately return to their home or another family setting, proactively diverting them from an RMHTF placement. Efforts will be made to help ensure the child placed in a STAT Home can maintain visitation with the family they will be reconnecting with following the stabilization period. STAT Home parents are specifically recruited and trained to provide intensive support for these children so they can remain in and actively participate in their home, school, and local community. Over the last two years, WV has been building the STAT Home program through development of model standards that clearly define services and activities that support the STAT Home parents, the child, and the family of origin and clarify the role of CPA case managers. Despite significant recruitment efforts by CPAs, only a limited number of families have been identified as potential STAT Home candidates and none are available for placement currently due to various reasons, the most common reason being the fact that the family has current placements. DHHR and the CPAs remain committed on improving recruitment not only for STAT Homes but for the complete WV tiered model of care.

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. No data is currently available for STAT Homes, as recruitment is still ongoing to establish the first STAT Homes. Time periods may vary by data source and information availability, which is noted respectively.

Figure 62: 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. DHHR is considering mechanisms to improve data collection and review.	Foster homes certified through and reported by CPAs
May 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 once staff and experts acclimate to these changes.	Children in the child welfare system by placement type

14.2 Review Summary

DHHR strives to allow every WV child the opportunity to grow up 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 in residential care or children who are older and/or have SED diagnoses in the child welfare system who are not able to return to their biological parents. In order for these children to be able to be maintained in the community and have success in HCBS options, it is critical that they have loving and committed families to build a life with. Given the needs of this population, DHHR, in collaboration with CPAs, is identifying ways to increase supports to foster parents and kinship parents. DHHR also continues 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 built out and gain rapport in communities, it is hoped 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

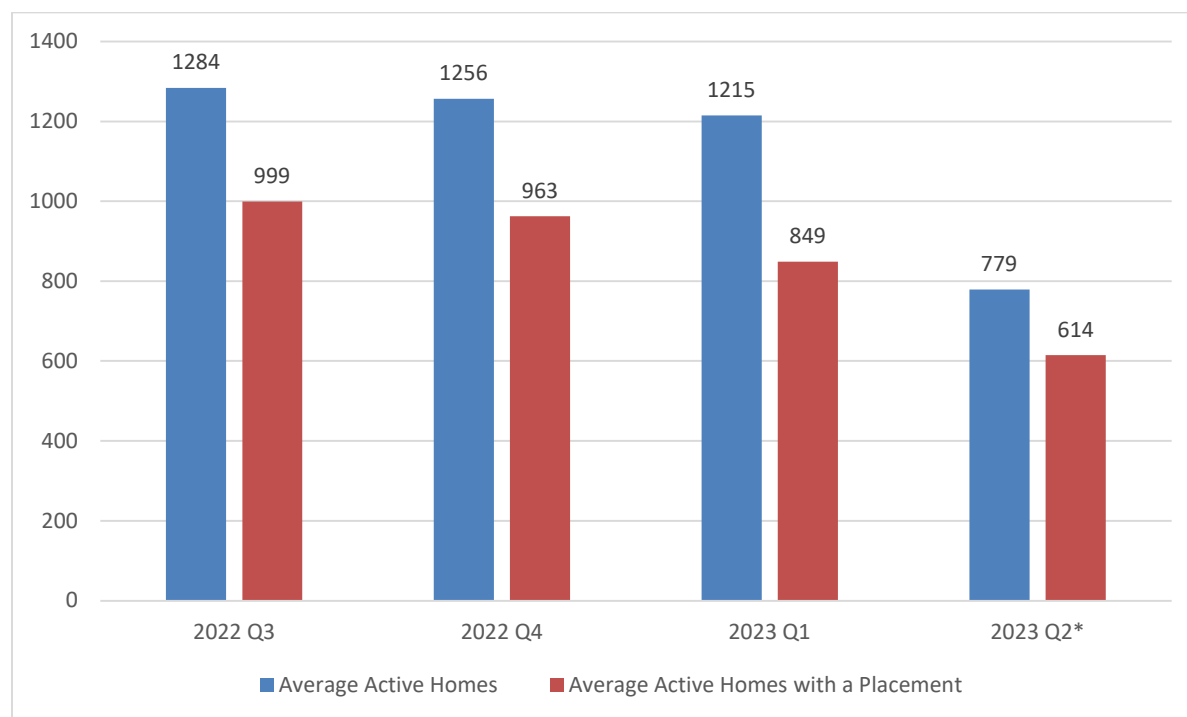
Foster placements in WV—including children in certified foster homes or certified kinship placements—are orchestrated through CPAs. CPAs are responsible for recruitment and retention of certified foster families throughout the state. As shown in Figure 63, on average from January to March 2023, 1,215 foster homes were considered active²⁷ with 70% of these

²⁷ Active homes are certified and willing to accept calls for potential placements; all foster homes have the autonomy to accept or decline placement referrals at any time.

homes placed with at least one placement. Both the number of active homes and percentage with placements have decreased compared to the previous quarters, as there were 1,284 active homes on average during July to September 2022, and 77% of those homes had a placement during that time.

Figure 63: Average Capacity by Quarter July 2022 to June 2023

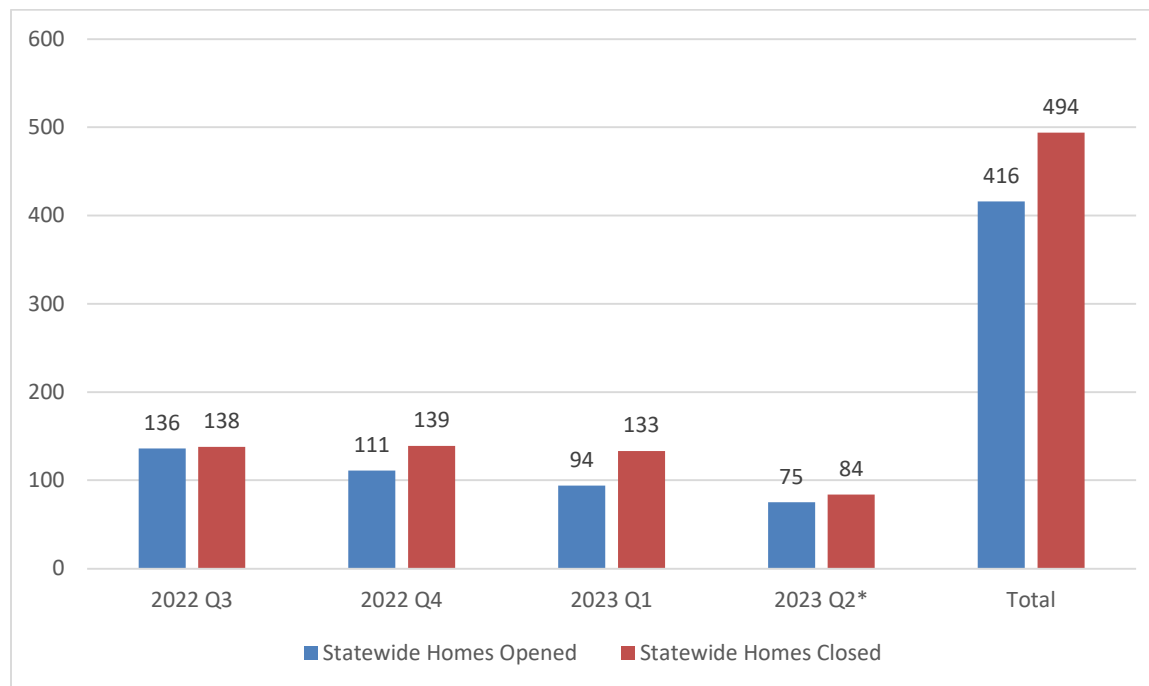
*Note: Q2 2023 (April to June 2023) data is preliminary.



It was also noted that the ratio of homes closed to opened has increased in Quarter 4 2022 and Quarter 1 2023 compared to Quarter 3 2022 (Figure 64). The Quality Committee discussed potential seasonal implications, including recognition that adoptions are often completed near the holiday season (Q4) and that adoption has been found as a common reason for certified home closure. Upon publication of foster parent survey results, DHHR plans to review this information to identify additional next steps to improve recruitment and retention based on direct family feedback.

Figure 64: Homes Opened/Closed by Quarter

*Note: Q2 2023 (April to June 2023) data is preliminary.



DHHR and CPAs also review retention data at least quarterly. Figure 65 shows the number of licensed foster families compared to the percentage who have been licensed for at least two years. Note the number of licensed families is higher than active families, as some families will go 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, pregnancy). On average, the percentage of licensed families retained over two years has increased over the past 12 months. Comparing January to May 2023 to January to May 2022, the average percentage of families retained were 45% and 38%, respectively. This improvement is likely largely influenced by additional focus and continued strategic planning placed on retention as a result of feedback from foster parents and the CPAs who work with them that began in July 2021.

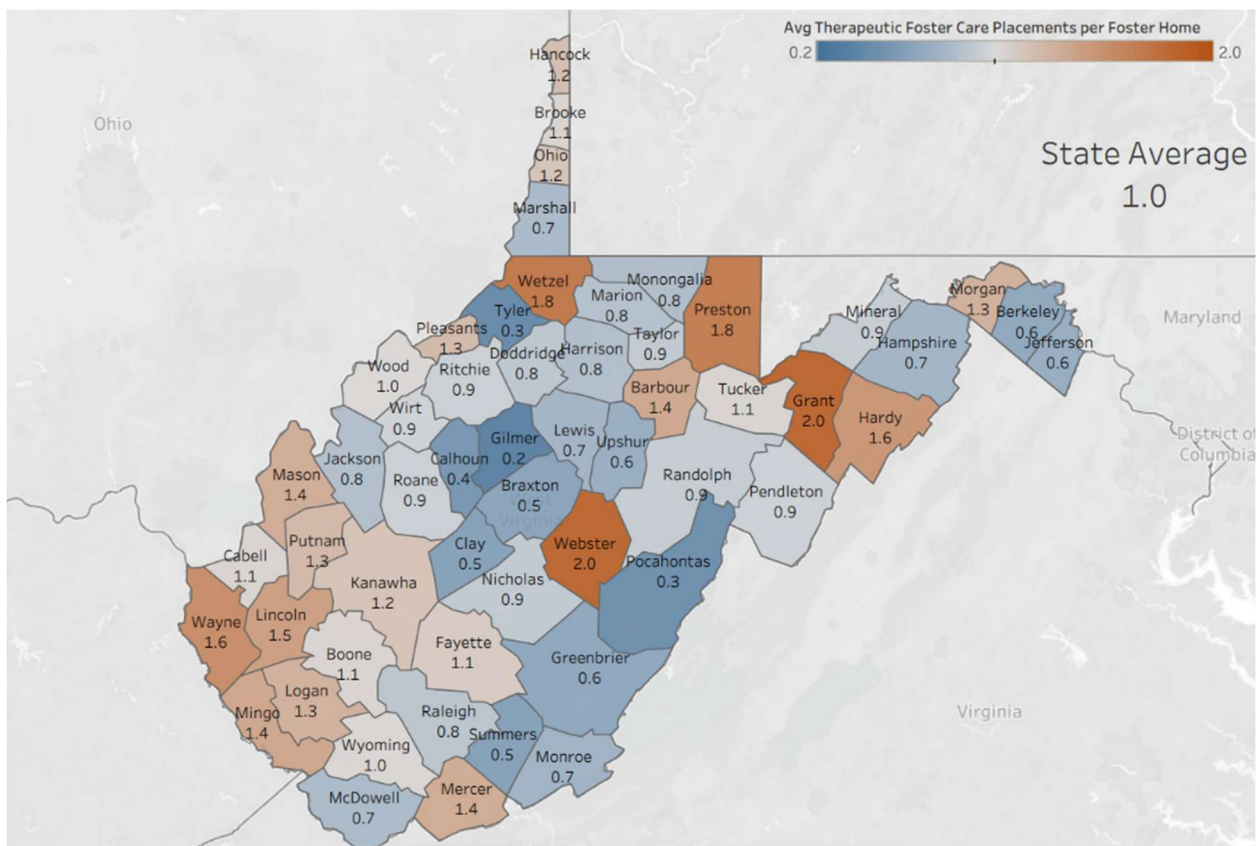
Figure 65: Number of Licensed Foster Families and Percentage Retained for Two or More Years

Average Across Period for Retention	Jan to May 2022	Jan to May 2023
Number of licensed foster families	1,507	1,402
Percentage of families licensed for at least two years	37.8%	45.4%

The Quality Committee requested in past reviews 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 impossible 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 give an approximate look at levels of need for a given area. The higher the ratio, the more need for additional foster homes, given that in realistic circumstances an open and active home does not always mean a placement would be accepted. Therefore, it is ideal to widen the pool of available homes to increase the likelihood of a good match. The state average ratio of certified homes to placements was 1.0, meaning, on average, there was one home for every one child placed. Many counties had higher ratios, thus highlighting additional need. For example, this ratio implies that there was only one home available for every two children needing foster care in counties such as Wetzel, Preston, Grant, Hardy, Webster, Wayne, and Lincoln (Figure 66).

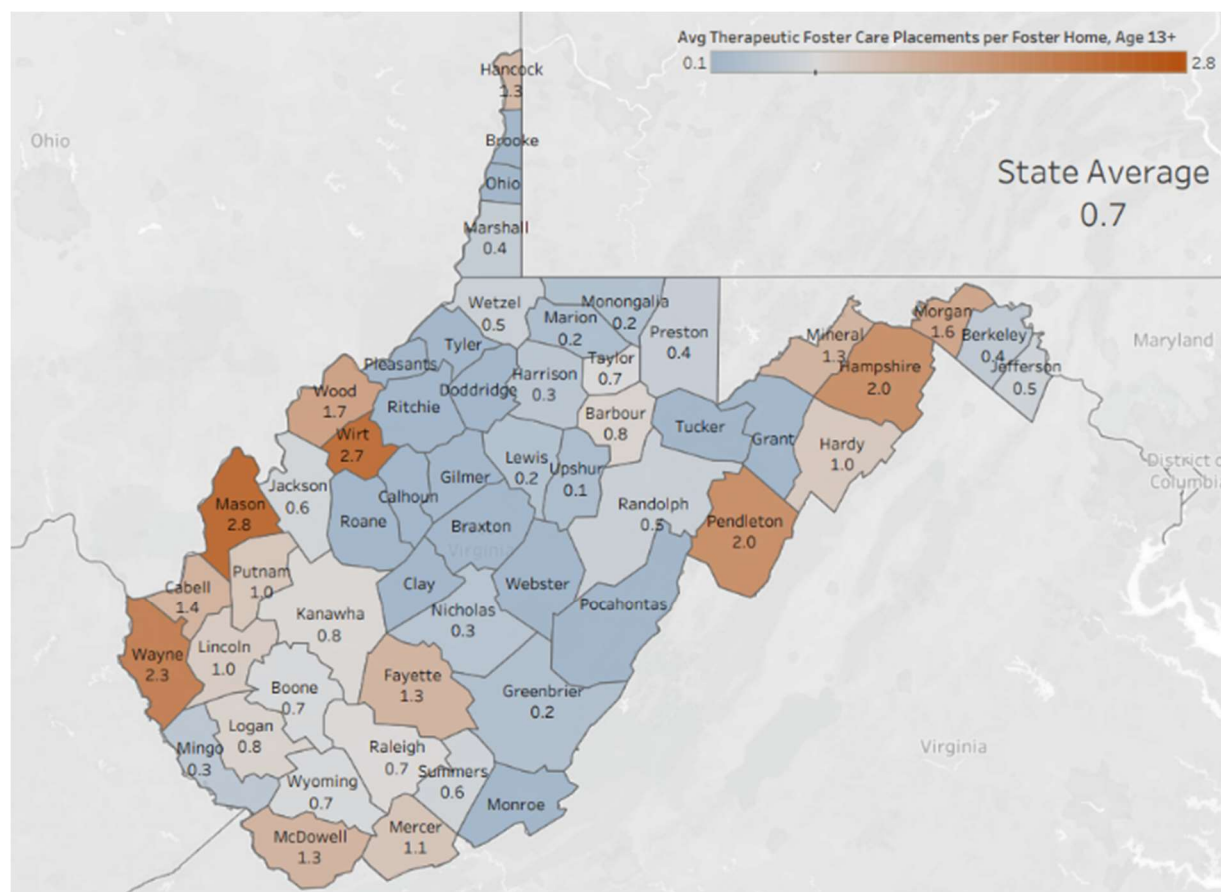
Figure 66: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, All Ages, Placement Data May 2023, Average Certified Homes January to April 2023



Diving further into characteristics of children with a barrier to discharge being lack of community placement, age was a common determining factor with 86% of individuals with CAFAS/PECFAS scores less than 90 falling into the 13 – 17 age category as of February 2023. Given this finding, analysis of foster homes and placements was expanded to focus on youth aged 13+ compared to homes that indicated they would be willing to consider accepting placements for youth in this age range. Figure 67 displays the state average ratio of placements 13 and older to homes willing to accept youth of this age group. The average was 0.7, indicating at least one home for every teen placed. As with the previous figure, several counties have more limitations on homes available. Mason and Wirt counties had the highest ratios of 2.8 and 2.7 youth per home,

respectively. This essentially means, setting autonomy aside for review/analytical simplicity only, the number of certified homes available in these counties would require three youth aged 13+ to be placed in each home. The extreme variation in willingness of foster homes families to accept a given placement, paired 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 information will be shared with CPAs at a future quarterly review to focus recruitment efforts in addition to current efforts to expand recruitment via a marketing effort in coordination with Mission WV and Aetna.

Figure 67: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, Age 13+, Placement Data for Youth 13+ May 2023, Average Certified Homes Willing to Accept Youth 13+ January to April 2023



14.2(b) STAT Homes

DHHR’s STAT Home workgroup has continued collaborating with all stakeholders to identify barriers to STAT Home implementation. CPAs initiated active recruitment strategies in late 2022 to identify potential STAT Homes and provide additional training. Several families were interested in and completed training in early 2023; however, certification to become a STAT Home was not completed by any home due to the family having current placements or personal conflicts that prevented them from moving forward. DHHR continues regular meetings with CPAs to help ensure open communication and feedback on successes and barriers related to

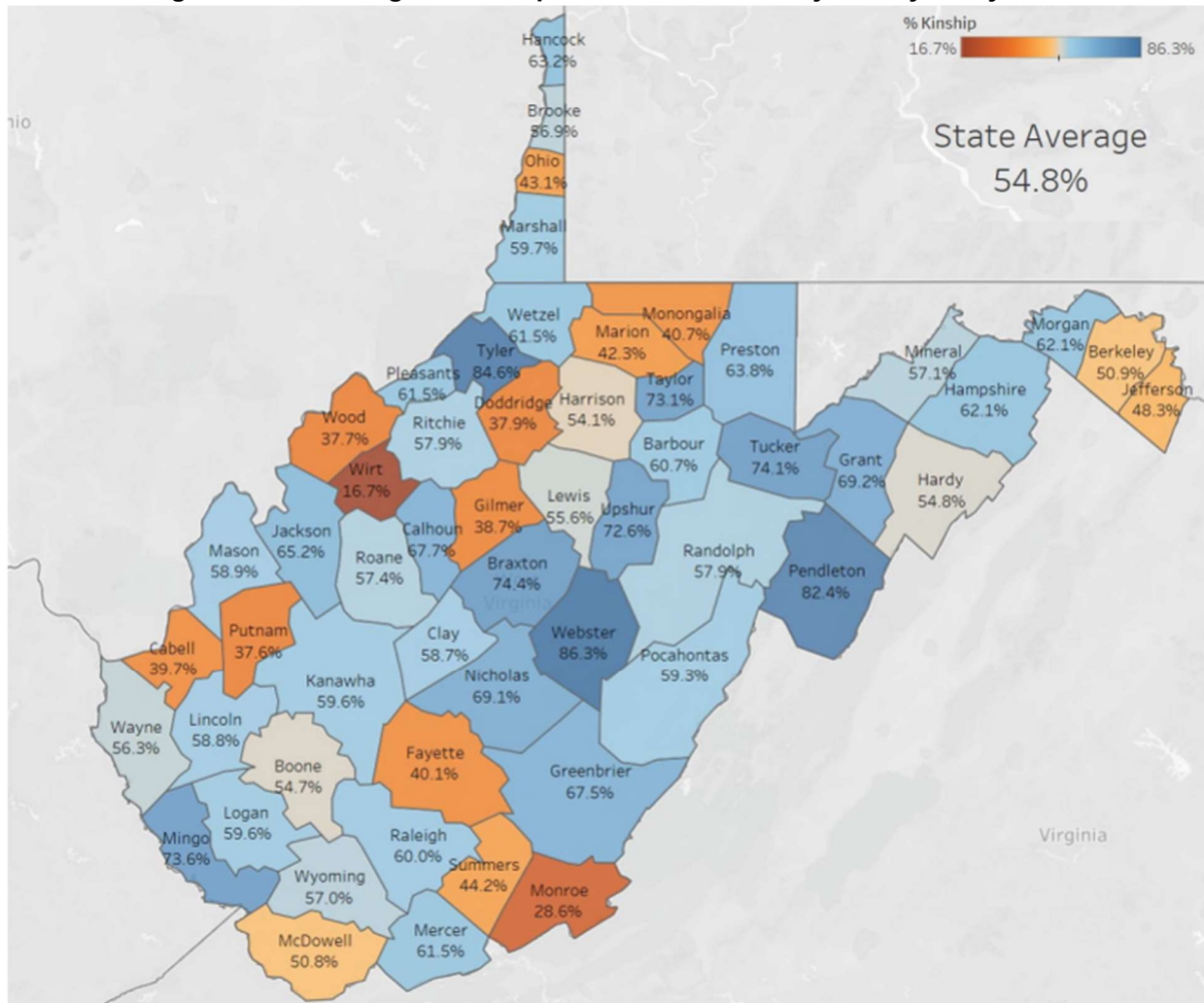
the recruitment process. Recent conversations have centered on retaining and recruiting seasoned foster families or families with experience with children with significant mental health needs. CPAs indicated additional support will be needed for these families to be successful and feel cared for, and DHHR is exploring additional options to meet these needs in collaboration with the CPAs. Once STAT Homes are operational for a period allowing adequate data collection for analysis, this information will be incorporated into DHHR's quarterly Quality Committee and BSS program-level review processes and included in future reports.

14.2(c) Kinship Homes

While foster care capacity is limited, placement of children in kinship homes is a strength in WV's system of care. WV currently leads the nation in kinship placements, with over 50% of children in the child welfare population being placed in kinship homes each year. As of December 2022, 57% of in-state placements were in kinship homes. This has decreased slightly as of May 2023, at 55%. The Quality Committee noted some counties have a greater rate of kinship placement than others. Several counties with high foster placement ratios—such as Grant, Mason, and Wayne—seemed to make up for this with higher rates of kinship placement. Furthermore, the group compared counties with low kinship placement rates to counties with high placement-to-foster-homes ratios, identifying counties that have the most need overall for community-based placement availability. Wirt and Wood counties were among the lowest in the state for percentage of placements located in kinship-type homes. While Wirt and Wood's placement ratios for children of all ages was comparable to the state average of one child per certified home, greater needs were seen with youth 13+, with the ratio of youth to homes as high as 2.7 for Wirt County and 1.7 for Wood County.²⁸ Remarkably, when reviewing discharge planning data for children with community-based placement need as a barrier to discharge from an RMHTF, Wood County was the most common county of origin for children with this need. These findings will be shared with CPAs and workers in these areas to work to address and troubleshoot barriers to establishing and retaining homes and placements in these communities.

²⁸ Placement ratios are based on mathematical assumptions as to whether homes were limited to county of origin for review and planning purposes only.

Figure 68: Percentage of Kinship Foster Placements by County – May 2023



14.3 Strengths, Opportunities, Barriers, and Next Steps

DHHR continues to move forward with strengthening community-based placement availability, despite identified challenges. Meetings with CPAs and other stakeholders to evaluate progress and continue shaping data collection, forecasting efforts, and recruiting and training processes, including addressing barriers, 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 seasonality may impact these comparisons, 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. Increased focus on CQI has helped retention efforts increase 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. These strategies will be developed in collaboration with CPAs and focus on county-level findings and needs for certified homes with consideration also given to associated results and information collected in the WV Foster Caregiver survey that will be published in summer 2023. In addition to these efforts, as of

August 2023, group homes for transitioning youth will be available, offering transitional living services and supports outside the RMHTF setting. These services are further detailed in Section 17.2(a) Prioritized Discharge Planning.

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/ccl>. Primary care providers have the option to make referrals through the CCRL by JotForm (electronic secure form referral process) to connect children and families with appropriate services. The CCRL contacts families with referrals made from their primary care providers within 24 hours.

Using CQI processes, DHHR continues efforts to expand awareness and use of the CCRL and address evolving data needs, including regular review meetings to inform planning and quality assurance. Figure 69 provides an overview of the CCRL data currently available.

15.1 Review Period, Data Sources and Limitations, Population Measured

Figure 69: CCRL Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2022	Help4WV – iCarol Call Reporting System	<p>CCRL was implemented in conjunction with an active HELP4WV line in October 2020.</p> <p>Higher rates of incomplete data are expected for demographic information for this call line. 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.</p> <p>“Calls” include texts and chats unless otherwise noted.</p>	<p>Children served directly through the CCRL; services are provided to individuals and families with children ages 0 – 25 who are in emotional distress, 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 21 were excluded from the dataset.</p>

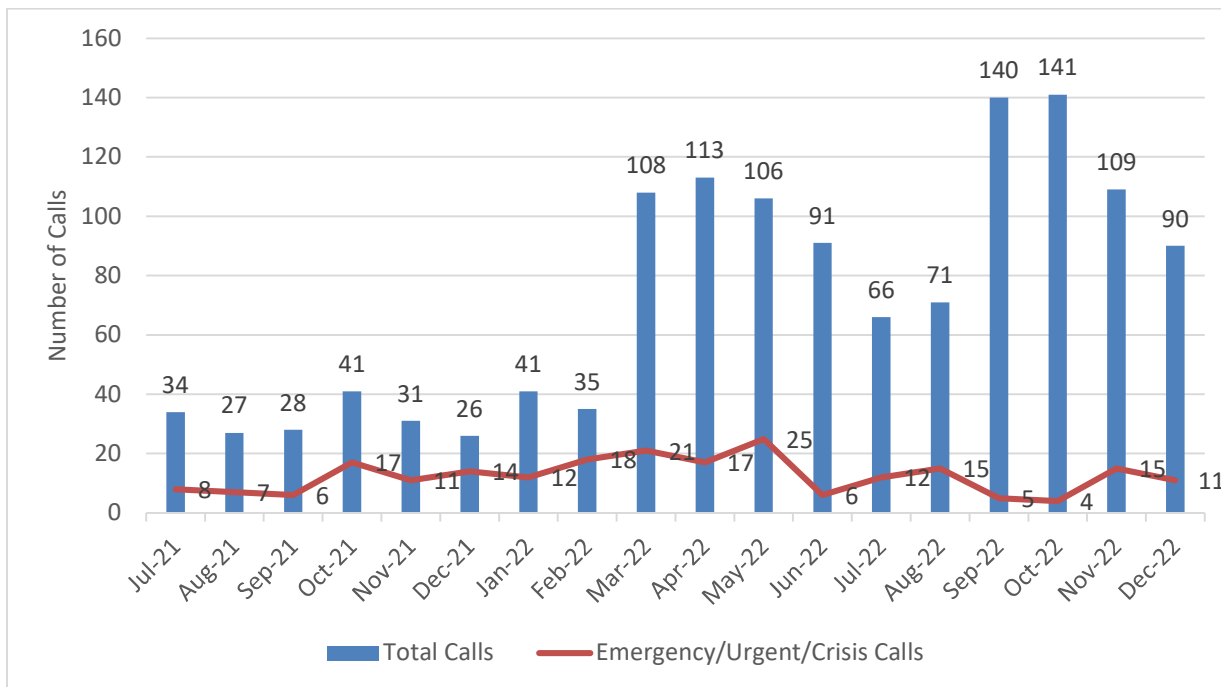
As noted above, the CCRL officially launched services in October 2020. While the HELP4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated CCRL offers the added benefit of referral, support, and information services for children and their families. CCRL data is reviewed at least quarterly, with the number of calls by acuity reviewed monthly, to assess call and referral quality and to determine the need for adjustment or improved outreach efforts.

15.2 Review Summary

At least one individual from 46 of WV's 55 counties called the CCRL during the reporting period, with 51 out of the 55 counties represented when reviewing all calls in 2022. Comparing July to December 2022 to July to December 2021, 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. The Quality Committee reviewed county-level coverage to assess opportunities for outreach. In addition, the Office of QA provided program teams with information and cross-comparisons of several data sources at the county level (e.g., counties with high utilization of RMHTF placements, low CMCRS rates, and low use of the CCRL). Based on this review, BBH has selected the counties to focus outreach on related to the CCRL and access to the Assessment Pathway. The specific CCRL caller map was excluded from this report due to the low rate of calls when viewing the information at the county level and considering 52% of calls indicated the county of origin as missing. This will be a focus for data quality improvement in the coming months.

Figure 70 shows the number of calls by month and acuity type. Monthly values from July 2021 to June 2022 have also been included to compare with monthly values from the current reporting period. Following the period of high call rates during March to June 2022, calls were lower in July (66) and August (71) 2022; however, these call numbers are still higher than any month prior to March 2022 and represent an approximate year-over-year doubling. Call values increased sharply in September and peaked in October (141) before dropping in November (109) and December (90). It is suspected this fluctuation is largely influenced by school openings and closings. Overall, there were 617 total calls from July to December 2022, a 25% increase over the previous reporting period (494 calls from January to June 2022). Despite seasonal fluctuation in call volumes, implementation of the Assessment Pathway has drastically changed the volume and makeup of calls coming into the CCRL beginning in early 2022.

Figure 70: CCRL Calls by Type of Acuity by Month, July 2021 to December 2022



While the percentage of emergency/crisis/urgent calls have decreased over the last 18 months, total calls have increased significantly since March 2022 (Figure 71). DHHR is still working to understand these trends; however, the Quality Committee indicated this may be associated with increased use of the line as a referral source and, therefore, a decreased rate of crisis use overall. 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 entry ways 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.

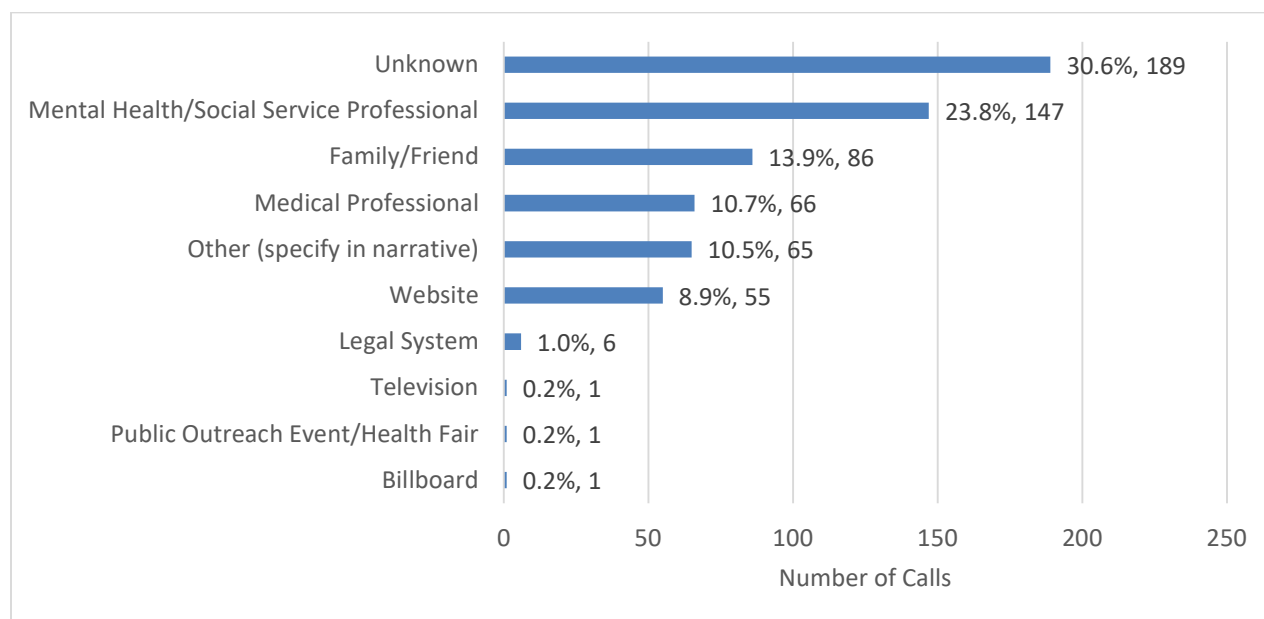
Figure 71: Comparison of Six-Month Period Calls to the CCRL by Type or Nature of the Call

Type/Nature of Call	July to December 2021	January to June 2022	July to December 2022
Emergency/Urgent/Crisis Calls [n (%)]	63 (34%)	99 (20%)	62 (10%)
Total Calls	187	494	617

The referral source for calls is depicted in Figure 72. Less than a third of calls, 30.6%, had an unknown referral source—the highest rate of any referral source, which is a slight decrease

since the previous reporting period when 33.4% of calls had an unknown referral source. Mental health/social service professionals, representing 23.8% of all referrals, were the second most common referral source. This represents a significant change from previous reporting periods, as only 11.2% and 14.8% of calls were the result of referral from mental health/social service professionals in July to December 2021 and January to June 2022, respectively. The percentage of referrals made by families/friends decreased from 18.2% during the previous reporting period to 13.9% in July to December 2022. These shifts in referral sources continue to be monitored to understand the impact on expanded outreach efforts to entities including mental health/social service professionals who, according to the CMH Evaluation, showed limited awareness of these services at baseline. 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.

Figure 72: Referral Source for Call, July to December 2022

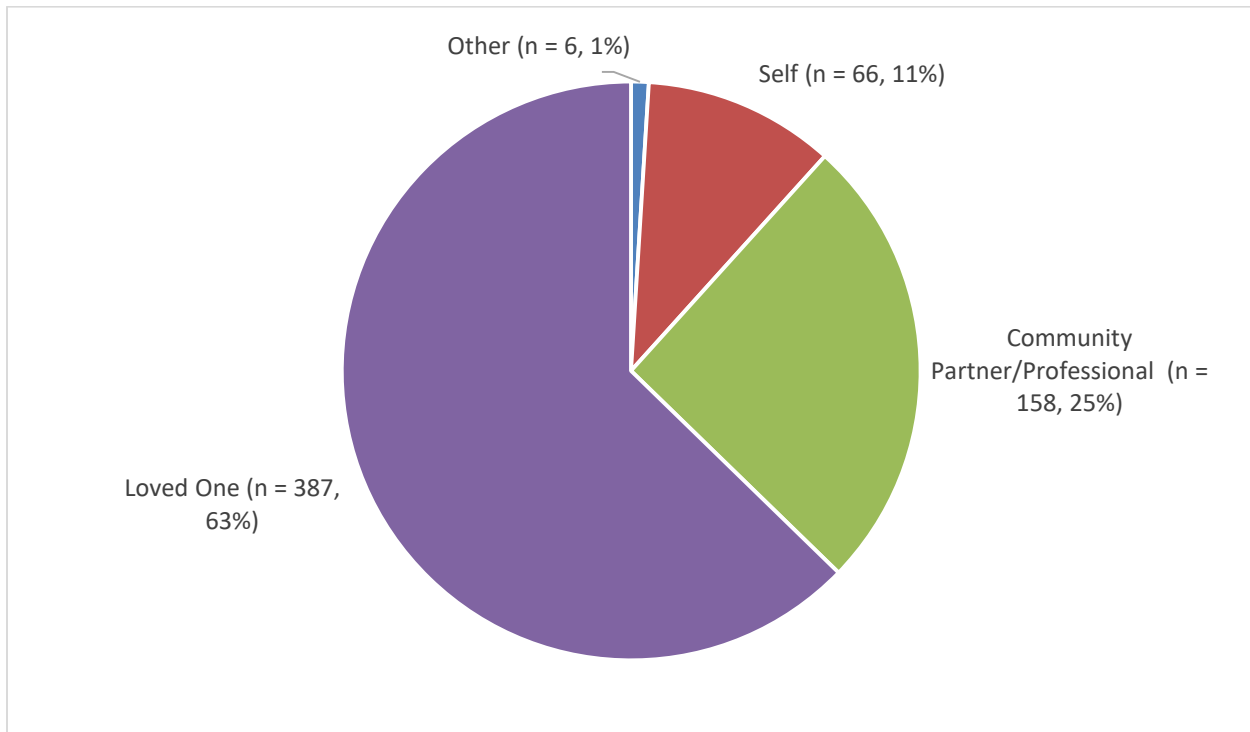


The caller’s relation to the individual in need is displayed in Figure 73. It is noteworthy that:

- Out of all calls for the CCRL, 63% came from a loved one,²⁹ while only 11% were the child themselves making the call.
- The number of calls from a loved one was far greater than any other source.
- Community partner/professional calling increased by 50% from the first half of 2022 (105 calls) to the second half of the year (158 calls), a finding likely associated with efforts to increase provider awareness.

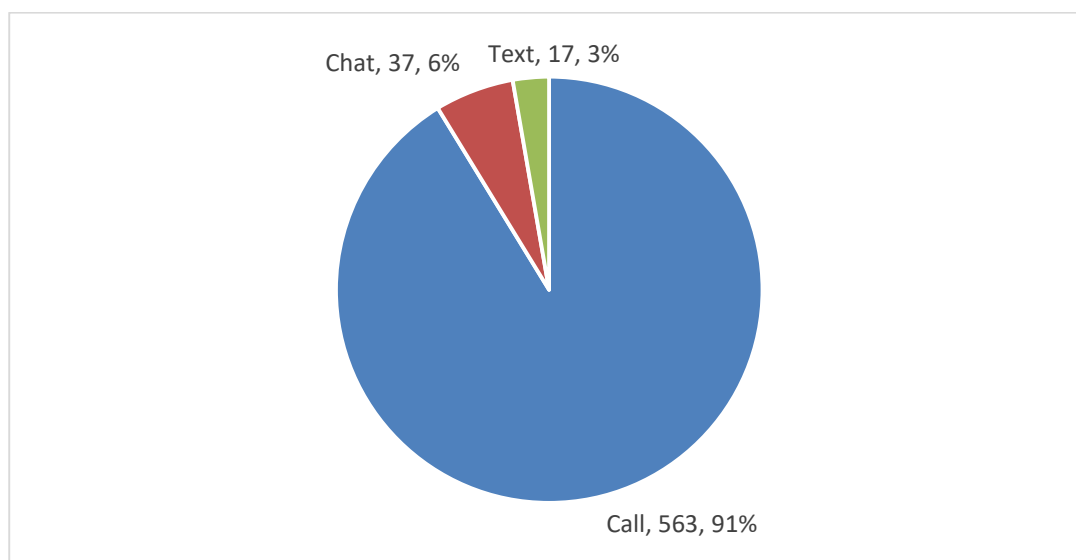
²⁹ Note that “loved one” includes parent, grandparent, other family, guardian, friend, significant other, and/or spouse.

Figure 73: Caller Relation to Individual in Need, July to December 2022



As displayed in Figure 74, 91% of contacts in July to December 2022 came via a traditional call compared to 9% of contacts that came from text and chat features; text and chat decreased from 14% of total contacts in the previous period. The utilization of chat or text highlights the importance of this alternative feature for children and families in need who may not feel comfortable reaching out verbally. This feature presents a great opportunity for families in need; however, it also presents challenges for capturing call-related data due to limitations of the chat/text format. As discussed in Section 6.0 Marketing, additional marketing to teens in 2023 has highlighted these features. DHHR will monitor impacts of this outreach in the coming months, along with shifts in use of the line given the rollout in July 2022 of the 988 suicide prevention line, which 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 have the ability to cross-refer via a warm handoff between lines for more technical needs.

Figure 74: Type of Contact, July to December 2022³⁰

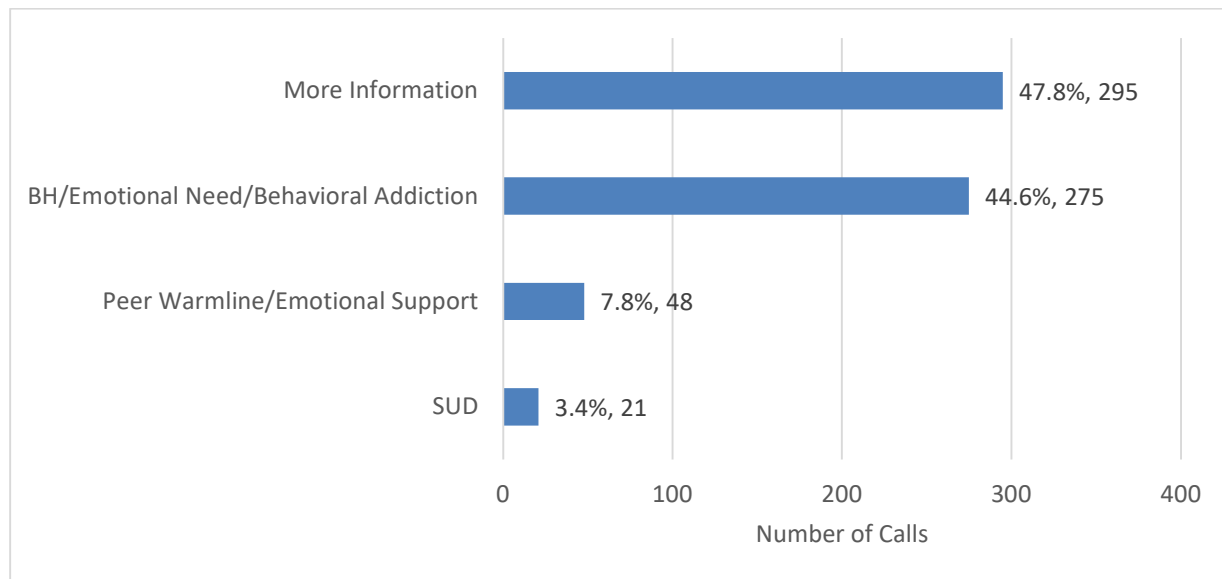


Individuals reached out to the CCRL for various reasons (i.e., presenting needs). As seen in Figure 75, in order of descending frequency, the needs of these individuals were the following: acquiring more information (48%), behavioral health or emotional need (45%), seeking connection with Peer Warmline³¹/Emotional Support (8%), and SUD (3%). The number of individuals requesting more information (n = 295) increased by 23% from the previous period (n = 224), which aligns with both the rollout of the Assessment Pathway and with relevant outreach and education efforts related to the CCRL. As of January 2022, staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs.

³⁰ Note that individuals may have reported more than one need, making the total add up to greater than 100%, and all needs are self-reported and not necessarily representative of a clinical diagnosis.

³¹ 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 75: Presenting Need, July to December 2022

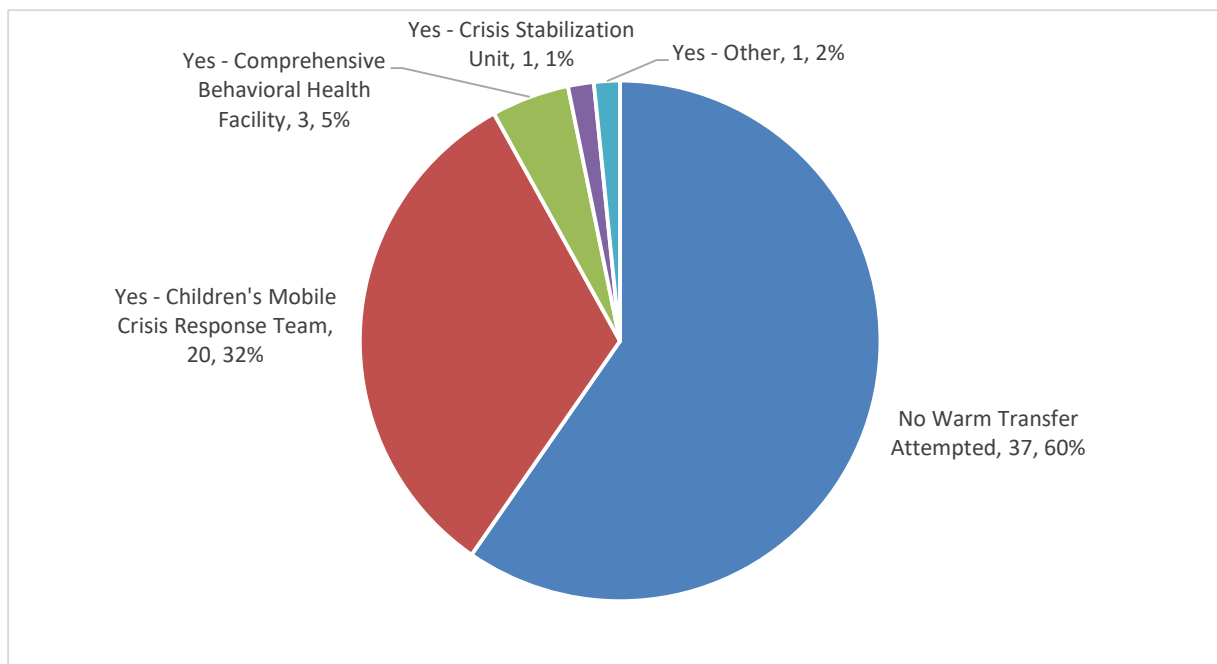


Of individuals for whom the call was reported as "emergency, crisis, or urgent" and had a response listed for referral,³² Figure 76 highlights 32% (up from 25% of these calls during January to June 2022) were reported as being directly transferred to a mobile crisis response team via "warm transfer."³³ 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 better understand call outcomes.

³² Note: Twenty emergency/urgent/crisis calls were transferred to mobile crisis. However, an additional 27 routine calls (5% of routine calls) were also transferred. Thus, 47 total calls were transferred to CMCRS. Emergency/urgent/crisis calls have been a focus of review to narrow down to calls with the greatest need and to help ensure appropriate referrals take place; however, given this finding, all calls will continue to be monitored, and this will be reaffirmed with the vendor to help ensure call acuity is labeled appropriately.

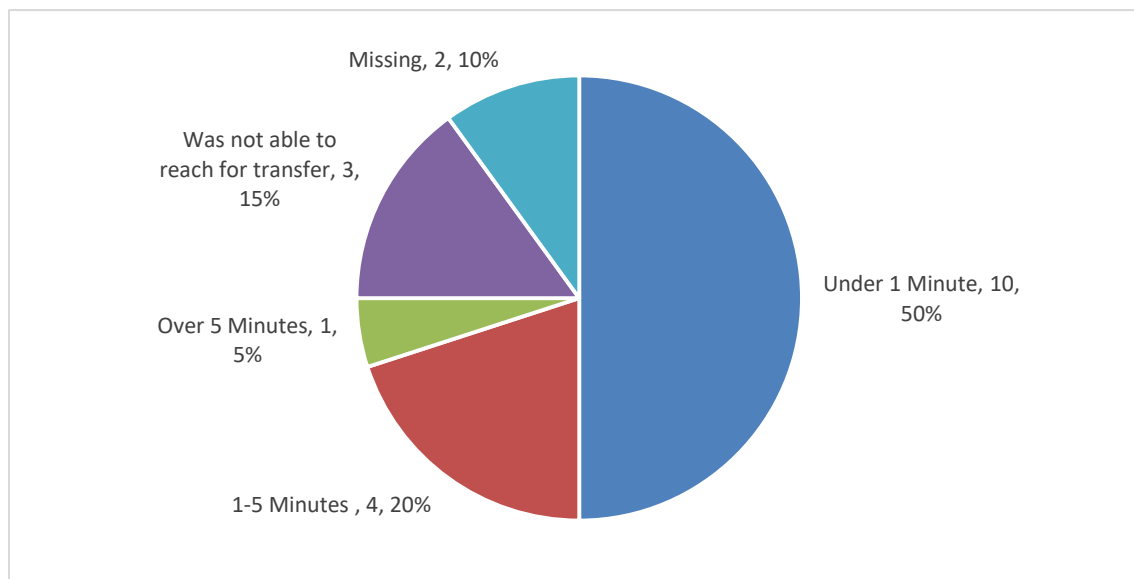
³³ "Warm transfer" is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed. The decision to attempt a warm transfer is made in conjunction with the family and their needs and willingness to accept assistance at the time of the call.

Figure 76: Referral Types for Calls Reported as “Emergency/Crisis/Urgent,” July to December 2022 (n=62)



Timeliness measures for warm transfer from the CCRL to a mobile crisis response team were added in May 2021 as seen in Figure 77. Of calls with a reported warm transfer attempt to mobile crisis services, 70% were connected in five minutes or less, with 50% connected in under one minute. Ten percent (10%) of timeliness data was missing/unknown, an improvement from the previous reporting period, when 25% of timeliness data was missing/unknown, likely attributable to continued focus and efforts on training and feedback to CCRL staff. Three call records listed that the help line specialist was unable to reach the mobile crisis agency for transfer, a reduction from six 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. DHHR 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 77: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team, of Calls Reported as "Emergency/Crisis/Urgent" With Transfer Attempt, July to December 2022 (n=20)



15.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway, as well as media campaigns and other outreach campaigns, are anticipated to increase the number of services and awareness of the CCRL. CQI processes have permitted timely changes to training strategies and data indicators. First Choice Services, the provider that runs the CCRL, monitors call loads and weekly or seasonal trends to help ensure adequate coverage to meet family and child needs. Figure 78 provides data on CCRL current and budgeted personnel.

Figure 78: CCRL Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Help Line Specialists	15	16.5	91%
Crisis Counselors	1	2	50%
Shift Leads (Shared With Other Call Lines)	4	4	100%

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. Given the nature of a line that helps families in times of critical need, data collection is not always at the forefront, as the urgency of the child and family's needs should always come first. However, 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, where possible. These efforts have been demonstrated through sustained increases in calls and by individuals seeking information for

children in need, including expansion of calls coming in or being referred by providers and advocates interacting with children and their families. The centralized call line staff help individuals quickly connect with behavioral health services and can divert inappropriate use of emergency rooms and 911 calls.

In addition to helping families in crises, 48% of calls requested information from the referral line, indicating individuals are using the CCRL as a valuable resource for information and connection to/awareness of services. It is also noteworthy that only 10% of calls for the period were reported as emergency/urgent/crisis. This was viewed as a likely positive indicator in the quality review meetings, as it was hypothesized families were able to access information and be connected to the Assessment Pathway before a crisis occurred, thereby allowing for 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 can get their needs met.

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 county of origin information and call transfer-related outcomes.
 - Establish a plan to expand data collection to include referrals from school personnel and “other” sources to better understand connections made to the CCRL and outreach opportunities. In addition to this, expand collection of call outcome data related to referrals made and needs of the caller to help ensure caller needs are being met and warm transfer is offered and occurs when appropriate and agreed on by the family.
- Continue to routinely review call line data 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.
- Consider mechanisms for additional outreach to EDs, given noted interest during HealthCheck training.

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

The CCRL can connect children 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, to help them stay in their homes and communities. 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, DHHR’s crisis line promotional campaigns have shifted to calling the 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 State Plan Amendment to include mobile response for all Medicaid members, not just those enrolled in the CSED Waiver (July 2023). This will provide the opportunity for expanded CMCRS networks, including the potential for expanded funding availability and mobile response team response continuing into adult services as well. Figure 79 provides an overview of the CMCRS data currently available.

16.1 Review Period, Data Sources and Limitations, Population Measured

Figure 79: CMCRS Data Overview

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

Data Review Period	Data Source	Limitations	Population Measured
		any adjustments that may need to be made. Due to this, data in Section 15.2 is considered preliminary.	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 further establish normal trends versus changes in service utilization. Some concerns have been identified related to the new Epi Info System’s architecture, and the system is currently undergoing further testing to identify any adjustments that may need to be made, with scheduled updates set to be implemented in fall 2023. Due to this, data in this section is considered preliminary. The BBH team is meeting weekly with its data system vendor to better understand any limitations or needed enhancements to the Epi Info System.

For the review period (July to December 2022), 481 children received CMCRS services across 43 of the state’s 55 counties (Figure 80). The counties with the greatest number of children enrolled were Raleigh (76), Berkely (71), Fayette (40), Jefferson (29), and Cabell (27). Raleigh and Fayette also had the highest enrollees per capita (4.41 and 4.01 enrollees per 1,000 children, respectively); Summers (3.09 enrollees per 1,000 children), Morgan (2.79), and Hancock (2.61) rounded out the top five county-level rates. Two children enrolled during the period had no county listed. It was noted that 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. This provider also has a dedicated staff member to handle data collection requirements, which could be impacting other counties’ reporting given system changes and requirements.

Figure 80: Children Enrolled in CMCRS by County, July to December 2022

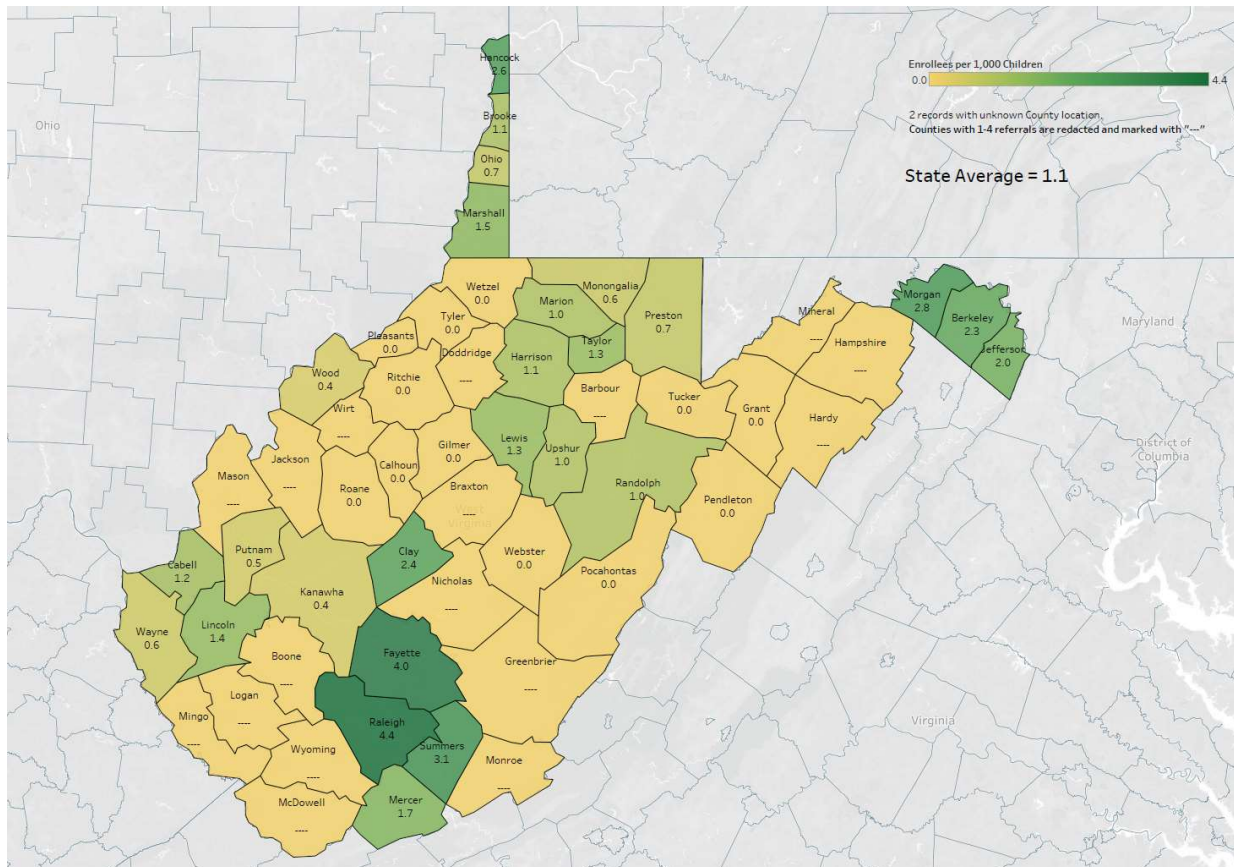
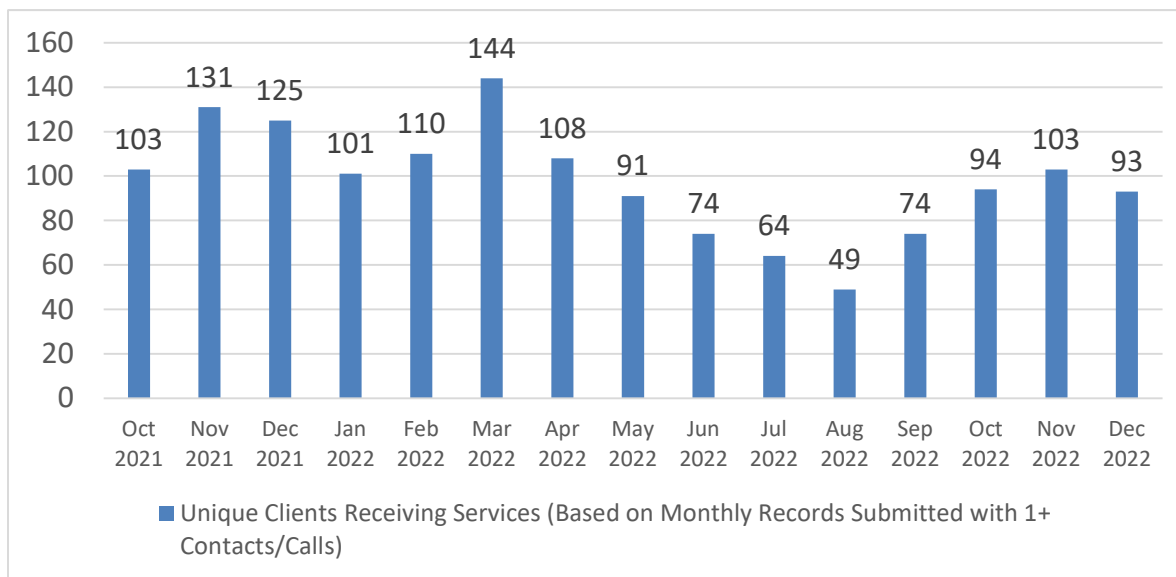


Figure 81 below demonstrates current CMCRS demand and enrollment from October 2021 (the inception of Epi Info) to December 2022. March 2022 shows peak enrollment and utilization, coinciding with Assessment Pathway referrals and HCBS utilization. Enrollment decreased from April to August 2022, but this trend reversed in September 2022, culminating in 103 unique clients utilizing services in November 2022, the highest during the review period. Overall, service utilization decreased by 20% from the first half of the year (605 children receiving services) to the second half (481). Children may continue to be enrolled in the service for up to eight weeks and only utilize additional services as needed. Due to the data collection system being in the early implementation phase, additional quality checks are being conducted to assess for gaps in data collection and any technical assistance that providers might need.

Figure 81: CMCRS Monthly Enrollment Totals and Service Utilization, October 2021 to December 2022 – Preliminary



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

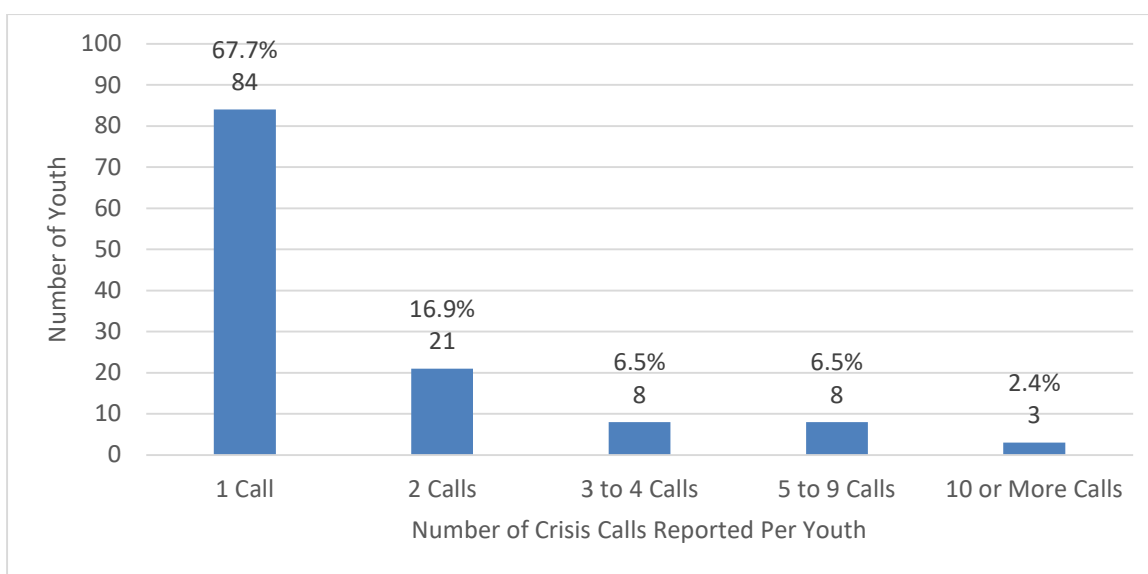
CMCRS teams strive to reach vulnerable and marginalized populations, such as children who are adopted from foster care, children who identify as BIPOC, or youth who identify as lesbian, gay, bisexual, transgender, questioning, or another identity (LGBTQ+). Data for the current review period had a lower percentage of missing information for race and children identifying as LGBTQ+ compared to previous data collection, though addressing rates of missing data continues to be an opportunity for improvement of data capture to assess family and children needs and utilization more thoroughly. It should be noted that this information may always have limitations due to the nature of crisis work; however, some information may also be available from other sources as the data store is built out. Nevertheless, currently available data suggests that the CMCRS serves higher rates of children in these vulnerable populations, relative to the statewide averages. For example, 12% of children served were represented as non-white compared to 9% statewide representation of non-white child population. In addition to this, although a third of data for indicators related to adoption status and identification as LGBTQ+ was missing, representation for these groups was also above average proportions for the typical WV population, including 14% of youth identifying as LGBTQ+ and 8% of children reported as being adopted.

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 low, with 74% of children having missing call information. DHHR will continue working with providers to

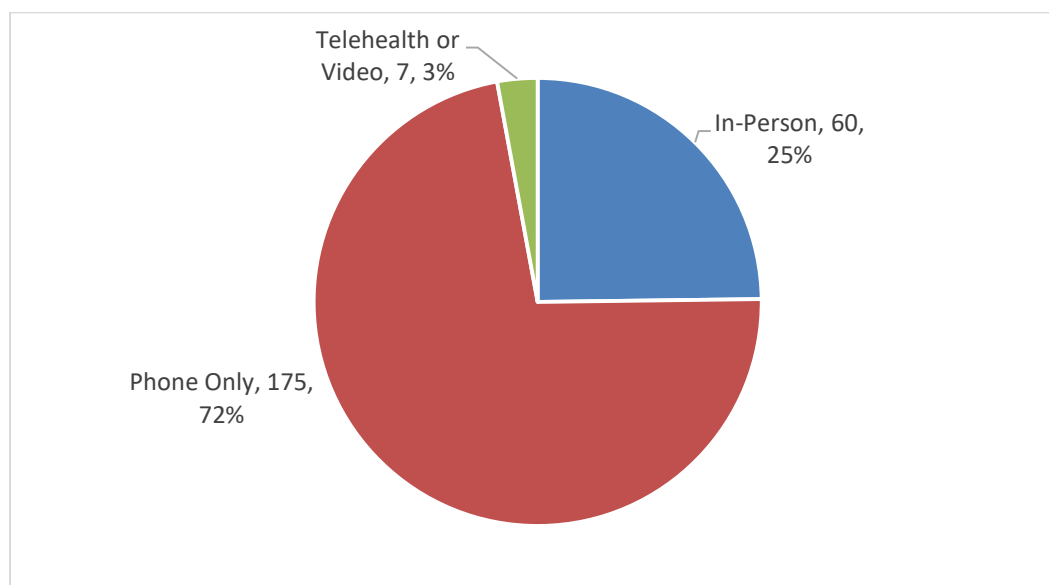
improve data collection and completion efforts via provider-specific feedback. Figure 82 shows the frequency of repeat call utilization for children with known call information, with 68% of these children appearing to have their needs met and/or stabilized with one call. For the remaining children, additional needs were met through multiple interactions. Additional analysis explored children with call-type data and more than two (>2) crisis calls and found that 32% of children with more than two calls received an in-person response. These calls for children with more than two crisis calls included 19 children with a total of 116 crisis calls during the period, 18 of which were in-person responses. Utilizing the results of this analysis, BBH will provide feedback and technical assistance to providers serving children with multiple crisis calls and no in-person response to identify opportunities for future improved response and stabilization strategies.

Figure 82: Number of CMCRS Crisis Calls Reported Per Children Served January to June 2022 – Preliminary (n=124; Excludes Follow-Ups Initiated by the Provider and Children with Missing Data)



As previously found, the majority of crisis calls with a known call type (75%, Figure 83), excluding follow-ups initiated by the provider and children with missing data, were indicated as completed and stabilized over the phone or via telehealth, while 25% required or preferred in-person intervention and stabilization services. January to June 2022 call data indicated that 81% of calls were completed over the phone or via telehealth with 19% requiring or preferring in-person intervention and stabilization, indicating a slight shift in the method of service provision.

Figure 83: Response Type for CMCRS Crisis Calls January to June 2022 (Excluding Follow-Ups Initiated by the Provider and Children with Missing Data; n=242 Calls for 124 Children) – Preliminary



Follow-up calls represented 1,058 additional calls directly from providers to follow up post crisis (15% of calls) or to work through prevention strategies with the family (85% 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 will occur in fall 2023. This will allow quality monitoring of timely response to needs, as well as improved understanding of capacity and intensity of service needs. Training is developed through Marshall University in conjunction with the University of Connecticut for both Wraparound Facilitation and mobile response/crisis services to provide consistent training and curricula across payor sources.

16.3 Provider Capacity/Statewide Coverage

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

Providers have indicated challenges still exist in 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 if multiple crises occur at the same time; however, build-out of stabilization and preventive intervention services has helped alleviate this issue. Data regarding timely response are not yet available but are being refined to help ensure national standards are being met and to support CQI reviews in the future.

Marshall University is contracted in conjunction with University of Connecticut in the development of CMCRS training. This training follows the national curriculum for mobile response. The next training is planned for August 2023, and continued cadence of trainings is still being evaluated, with close and frequent feedback coming from providers about training needs. CMCRS teams, in general, are passionate about making connections for children and families and have been actively participating in training and feedback opportunities. Implementation of the State Plan Amendment expanding mobile response services may impact needs significantly and influence next steps with training. 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.

As indicated in Figure 84, some BBH CMCRS providers are currently undergoing staffing shortages, with only 73% of positions throughout the state filled. Regions 3 and 6 indicated all positions were filled; in contrast, Region 5 added personnel, but vacancies remain high, with only 50% of positions occupied. DHHR will continue to work with providers to offer technical assistance to improve workforce capacity.

Figure 84: BBH CMCRS Provider Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	4	7	57%
Region 2	4	5	80%
Region 3	5	5	100%
Region 4	5	7	71%
Region 5	4	8	50%
Region 6	5	5	100%
Total	27	37	73%

16.4 Strengths, Opportunities, Barriers, and Next Steps

Statewide CMCRS coverage creates opportunity to offer crisis relief and plans for stability to support families and children in need, helping to prevent unnecessary placements for mental 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 immediately. 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.³⁴ Analyses disaggregated at the provider level will continue in order to inform CQI strategies and technical assistance efforts.

Next Steps:

- 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 is considering administering a mini grant to work with agencies serving these diverse groups, as well as other grants to create a more diverse workforce. BBH also focuses in general 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.
- As data become available on timeliness of response, additional assessment should focus on regional needs and technical assistance.
- Additional training and technical assistance should be provided to improve data quality and completion. BBH has already begun to develop detailed reports highlighting missing data, which can be addressed with providers.
- As with CCRL, provide additional outreach and education to stakeholders for identified access points such as EDs, medical offices, schools, etc.
- 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 getting families to participate in follow-up. BBH will continue to navigate and provide technical assistance to address these challenges.
- Through additional analysis opportunities provided through the data store, explore outcomes following CMCRS interaction and associated characteristics.
- Follow up with providers utilizing virtual response only in cases with multiple crisis calls in the same six-month period.

³⁴ 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.

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. In addition to increasing availability of community-based services, DHHR is focused on RMHTF models of care to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs.

Reducing the overall census in RMHTFs continues to be a primary focus for DHHR. DHHR surpassed the initial goal of reducing the census to 822 by December 31, 2022, with a census of 781 children as of year-end. DHHR has a further goal to decrease census to 712 by December 31, 2024. DHHR leadership monitors the census on a weekly basis. The Quality Review Committee and program teams are continuing to monitor census, admissions, and discharges over time to better understand seasonal trends associated with holidays and school being in and out of session.

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

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

As noted in Section 9.0 QIA, DHHR completed the statewide rollout of the QIA process for children involved in the child welfare system in May 2023. Continued implementation and adoption of this important assessment process is anticipated to assist with diverting children from residential placement. Between now and the end of 2024, all children in residential placement will complete the QIA process. As a first step, DHHR and Aetna are prioritizing children in an in-state residential placement with multiple stays for referral to the QIA process.

DHHR contracted with Marshall University in April 2023 to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placement. CAFAS/PECFAS and CANS are underway for children in out-of-state placement. Development of discharge plans began in June 2023.

DHHR, in partnership with Aetna and residential providers, has continued to focus on prioritized discharge planning. Significant progress has been made, and details will be shared within this section. Lack of community-based placement options continues to be a barrier to discharging children currently in residential placements. DHHR is making progress toward creating additional community-based placement options, including transitional living and development of a new model of care to support children with complex mental and behavioral health needs, which will be described later in this section.

17.1 Review Period, Data Sources and Limitations, Population Measured

Figure 85: Overview of RMHTF Data

Data Review Period	Data Source	Details and Limitations	Population Measured
July to December 2022	BSS FACTS/WV PATH Data System BMS DW/DSS	<p>DW/DSS claims are the data source for parental placements to PRTFs. Owing to claim payment lag and data warehouse update cycles, parental placement data for the later part of the study period may be incomplete. As noted, claims data account for less than 2% of RMHTF data. Claims data reported here include payments through April 2023.</p> <p>FACTS data may show a brief lag, as field workers may not be able to update the system immediately, but analysis shows FACTS data are stable after one to two months.</p> <p>WV PATH data was still being validated at the time this report was published; preliminary data may be subject to change as DHHR and associated entities acclimate to the new system, which was incorporated in January 2023.</p>	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 DW/DSS.
January 2022 to May 2023	MCO RMHTF Monthly Report Spreadsheet	<p>Data for the primary reporting period (July to December 2022) are representative of data through the end of March 2023. Age calculations for active placements in this population use December 31, 2022, as a reference date for the period, while the discharge date is used for children who have been discharged.</p> <p>Some results in this subsection use more recent data and are noted accordingly.</p>	Children included in this report related to discharge planning are in an in-state RMHTF and have a CAFAS/PECFAS score less than or equal to 130 (i.e., less than 140).

17.2 Review Summary

17.2(a) Prioritized Discharge Planning

DHHR continues actively collaborating with Aetna to prioritize discharge planning for children currently placed in residential settings with a CAFAS/PECFAS score less than 90.³⁵ To assist with this effort, collection of data elements associated with discharge planning was initiated in January 2022. Since that time, efforts to improve data quality have continued, and data collection was expanded to include children with a CAFAS/PECFAS less than 140 effective April 2023. In recent months, DHHR and Aetna have spent considerable time detailing the data specifications and workflows associated with discharge planning. In the third quarter of 2023, Aetna will convert data collection to a QuickBase system. This dataset is prioritized for incorporation into DHHR's data store to allow analysis at the child level and comparison to other datasets, such as those associated with the CSED Waiver. Incorporation of the discharge planning dataset into the data store is anticipated by end of year 2023.

A discharge planning report is published monthly for use by BSS field staff, supervisors, and managers as well as by Aetna care managers. As of May 2023, 140 children were in in-state residential settings with a recent CAFAS/PECFAS score less than 90.³⁶ To better understand improvements in CAFAS/PECFAS scores over time and allow differentiation between children who enter with scores less than 90 and those who make improvements through intervention, DHHR has prioritized CAFAS/PECFAS score reporting for addition to the data store. This dataset is currently integrated into the data store with data validation and data matching at the child level currently in process. Once complete, additional analysis will be possible. Timing is contingent on DHHR's WV PATH conversion.

DHHR continues review and analysis to understand the characteristics and discharge barriers of children placed in residential settings with a CAFAS/PECFAS score less than 90. There are some challenges to effectively completing this analysis due to data quality issues that DHHR is working through with Aetna, though these challenges are anticipated to be resolved through the implementation of the QuickBase system in the third quarter of 2023. As data quality continues to improve, DHHR will use information from the analysis of child characteristics and discharge barriers to understand if there any gaps in community-based care as well as areas where additional outreach and education is needed.

Based on available data for the period of July to December 2022 (n=241), characteristics of the children in in-state residential settings with a CAFAS/PECFAS score less than 90 are as follows:

Gender: 60% were male, showing a similar proportion to all individuals in RMHTF settings.

Age: Similarly, 78% of individuals with CAFAS/PECFAS scores less than 90 fell into the 13 – 17 age category (Figure 86) compared to 81% of all individuals in RMHTFs. This points to similarities in populations for the broader RMHTF population and those with scores below 90;

³⁵ A CAFAS/PECFAS is completed every 90 days for children in residential placement. A child's most recent CAFAS/PECFAS score is being utilized for the purposes of this report and may not be reflective of the child's initial needs or score at entry to the RMHTF.

³⁶ DHHR and Aetna are working through validation of CAFAS/PECFAS scores and addressing some data quality issues; therefore, in some cases, a CAFAS/PECFAS greater than 90 may be reflected for some of the children prioritized for discharge planning.

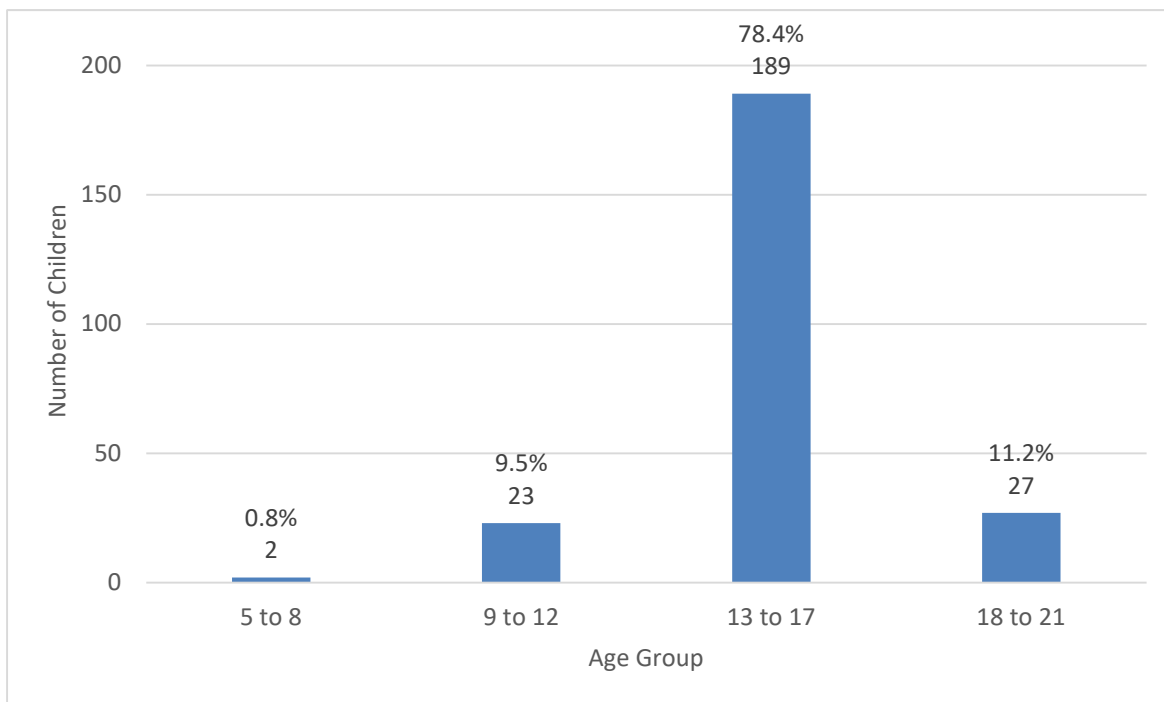
however, there were some identified differences in the 9 – 12 age category and a larger difference in individuals 18 – 21. For example, approximately 11% of individuals with a CAFAS/PECFAS less than 90 were ages 18 – 21 compared to 1% in the broader residential population. CAFAS/PECFAS scores at admission were not available for some individuals; therefore, functional improvement during residential treatment could not be accurately assessed for the purposes of this report. As noted previously, CAFAS/PECFAS score history is prioritized for addition to the data store to allow a more complete analysis of changes in child-level functioning while in residential treatment.

In June 2023, DHHR shared preliminary analysis of CAFAS/PECFAS completion and timeliness data with Aetna. In follow-up, Aetna identified a small number of providers who were not completing the CAFAS/PECFAS within required timelines. Aetna is completing training with these providers. Going forward, CAFAS/PECFAS timeliness and completion data will be reviewed monthly, and BSS licensing and Aetna will follow up with providers as needed to work toward meeting required timelines. Additionally, BSS is planning to add the completion of CAFAS/PECFAS every 90 days as a requirement in residential provider agreements. The timeline for the updated provider agreements has not been identified as of the writing of this report.

The 18 – 21 age group representing a greater proportion for those with an identified CAFAS/PECFAS less than 90 could be an artifact of longer time in care—time to stabilize the individual—or could be indicative of a need for alternative community-based placement options to meet the unique needs of transitioning youth. The transition of discharge planning data collection to the QuickBase system and subsequent integration into the data store will allow for more detailed analysis and improved understanding of the factors impacting these individuals.

Based on the number of 18 – 21-year-old youth who need transitional living supports and services, DHHR is seeking to implement a transitional living model. DHHR released a Request for Proposals for Transitional Living for Vulnerable Youth in Residential Programs in early 2023. Following review of respondents, DHHR accepted proposals from three providers on May 31, 2023. These residential service providers will convert existing residential capacity to serve youth between the ages of 17 – 21 who are in the custody of BSS, have demonstrated an inability to function in a foster home, kinship/relative home, or other less-restrictive community-based placement setting, and who are engaged or ready to develop or improve their independent living skills (e.g., ready to connect to employment, educational programs, community resources, permanent connections, and community medical and mental health resources). The goal of these services is to prepare and facilitate youth transitioning into independent or semi-independent community-based settings and to develop permanent connections to support their success. These new community-based transitioning youth group home services are anticipated to begin by fall 2023.

Figure 86: Age of Children With CAFAS/PECFAS Less Than 90 in an In-State RMHTF Setting, July to December 2022 (n=241)



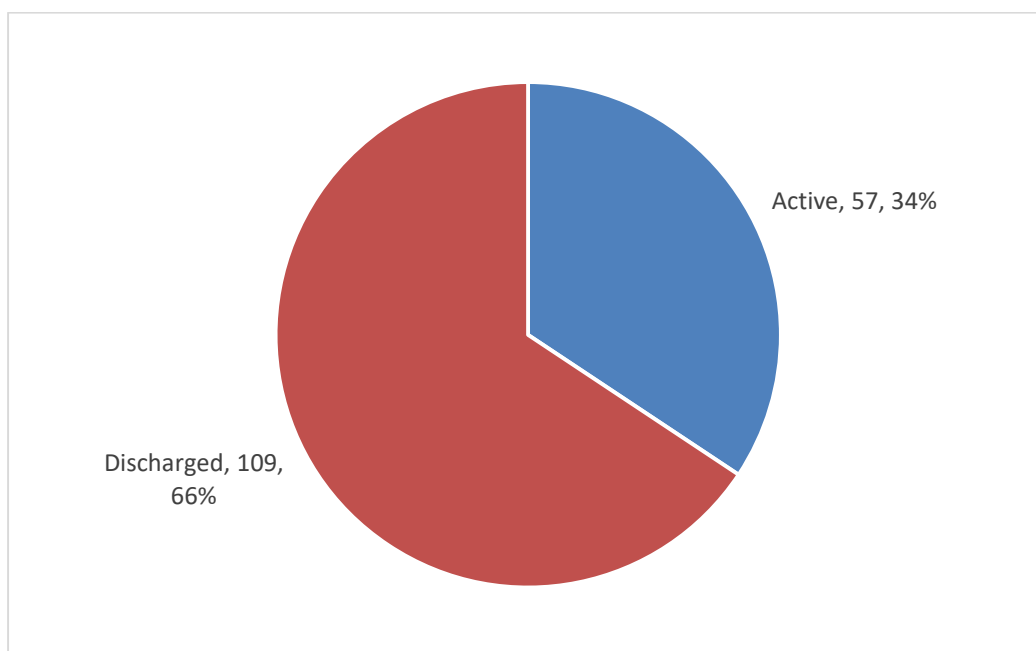
Diagnosis: Primary diagnosis related to authorization for residential services for children with CAFAS/PECFAS less than 90 was also considered in this review. The most common primary diagnosis for authorization is conduct disorder or oppositional defiance disorder (32%) followed by anxiety disorders (23%) and mood disorders (21%). These percentages are consistent with the prior reporting period. Note while children may have had co-occurring or coexisting diagnoses, only the primary diagnosis related to authorization is reported here. BSS program staff note that based on historical experience, foster families are less willing to accept a child diagnosed with oppositional or conduct disorders. Given the potential challenges of serving children with complex needs, either due to willingness of the foster family or requests of the child, DHHR is actively working toward new models of care to support these individuals in the community. Additional time and data are needed to better understand the considerations associated with diagnosis and barriers with community placements.

Next steps based on discussions in the Quality Committee review meetings will involve further exploration of diagnosis and CAFAS/PECFAS score impacts on length of service in residential settings.

Discharge Planning and Review Processes

Since June 2022, BSS and Aetna meet twice monthly to review the status of children prioritized for discharge and to address any identified discharge barriers. For the 166 children included in the prioritized discharge planning population at any point between January and June 2022, 66% (n = 109) had been discharged by March 31, 2023 (Figure 87).

Figure 87: Placement Status as of March 2023 for Children With CAFAS/PECFAS Less Than 90 in the Period January to June 2022 (n = 166)



For the January to June 2022 period, discharge barrier data was reported for 107 of 166 children (64%). Given that discharge data was incomplete for 34% of children, DHHR requested Aetna implement a quality review process before each monthly data submission to help ensure data completion. Following the implementation of Aetna’s quality review process, incomplete data was reported for only 3% of children based on the May 2023 submission. Given some expected lag associated with data entry, this result is within the expected threshold.

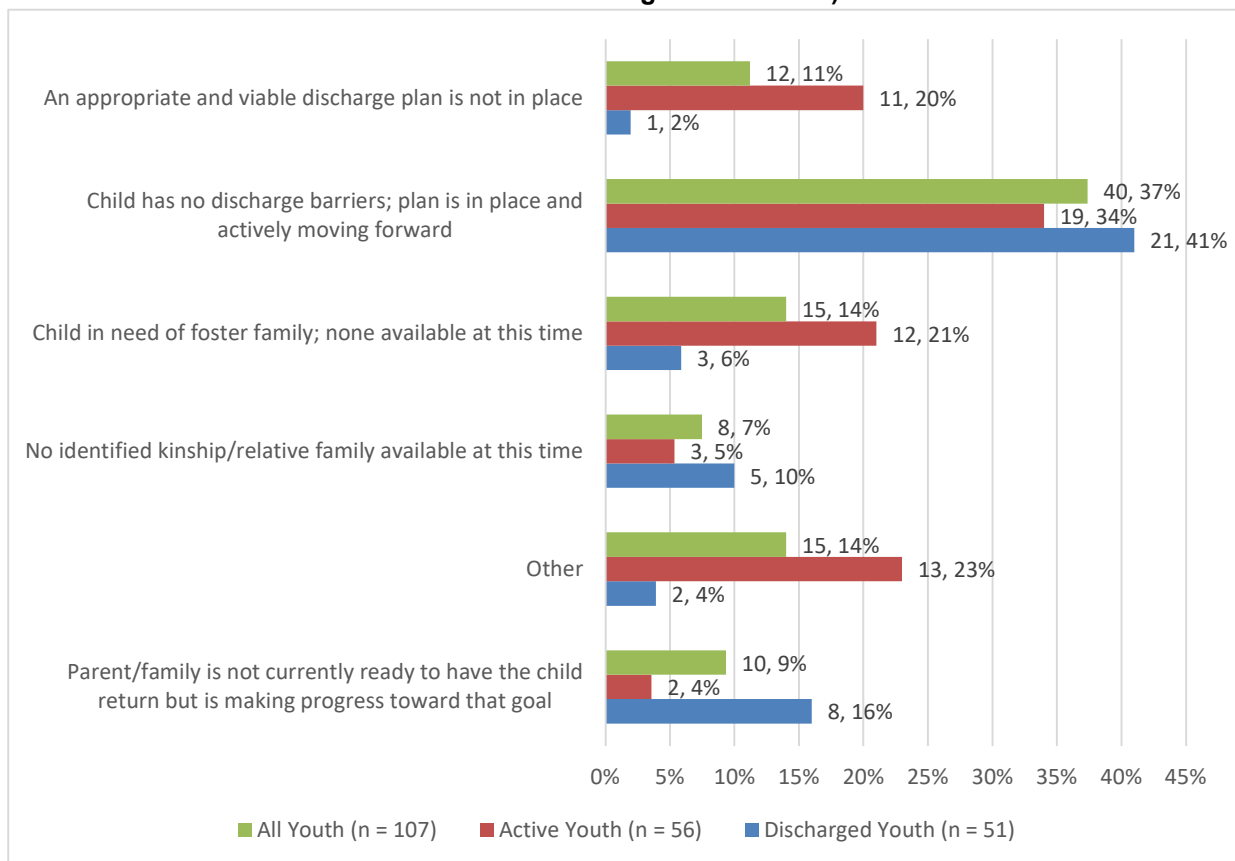
The top six barriers to discharge reported for children in placement during that time period with CAFAS/PECFAS less than 90 are displayed in Figure 88, broken out by whether the child had been discharged to the community or was still in active placement as of March 2023. As noted in the prior semiannual report, enhancements to barrier data collection were made, including the addition of “Child has no discharge barriers; plan is in place and actively moving forward.” While this is not considered a barrier, DHHR is tracking this information to better understand what is occurring with children who are ready for discharge. As such, this option from the discharge barrier list is included in the discussion below.

Overall, the highest proportion of both active and discharged placements had a discharge plan in place without any barrier to discharge at the time of analysis (37%). Placements that had been able to be discharged were more likely to be indicated as having no barriers, with their

plan moving forward, as would be expected (41%). Only 34% of active placement had no barriers listed. Alternatively, 20% of active placements lacked an appropriate and viable discharge plan, compared to only 2% of placements that have been discharged. Together, this data emphasizes the importance of a viable discharge plan being in place to further the discharge process.

Twenty-one percent (21%) of active placements indicated the lack of a foster family as a barrier to discharge, compared to only 6% of discharged placements. On the other hand, there was minimal difference among placement types for the percentage without any identified kinship/relative family available: 5% (n = 3) of active placements have this barrier, compared to 10% (n = 5) of discharged placements. This may imply that it is more difficult to place children in a foster home than in a kinship home. Finally, nearly one quarter of active placements (23%) have some type of “other” discharge barrier that did not fall into existing categories, compared to only 4% of children who have been discharged; this may indicate children still in placement have more complex needs that contribute to their longer length of stay, although more time and data is needed to reach a definitive conclusion. Additional data and more detailed analyses (e.g., disaggregation of discharge barriers by child characteristics such as age) will increase understanding of the ways in which discharge barriers influence a child’s ability to be discharged, as well as their length of stay.

Figure 88: Top Discharge Barrier Comparison of Discharged Versus Active Placements as of March 2023 for Children With CAFAS/PECFAS Less Than 90 in the Period January to June 2022 (n = 107 With Discharge Barrier Data)

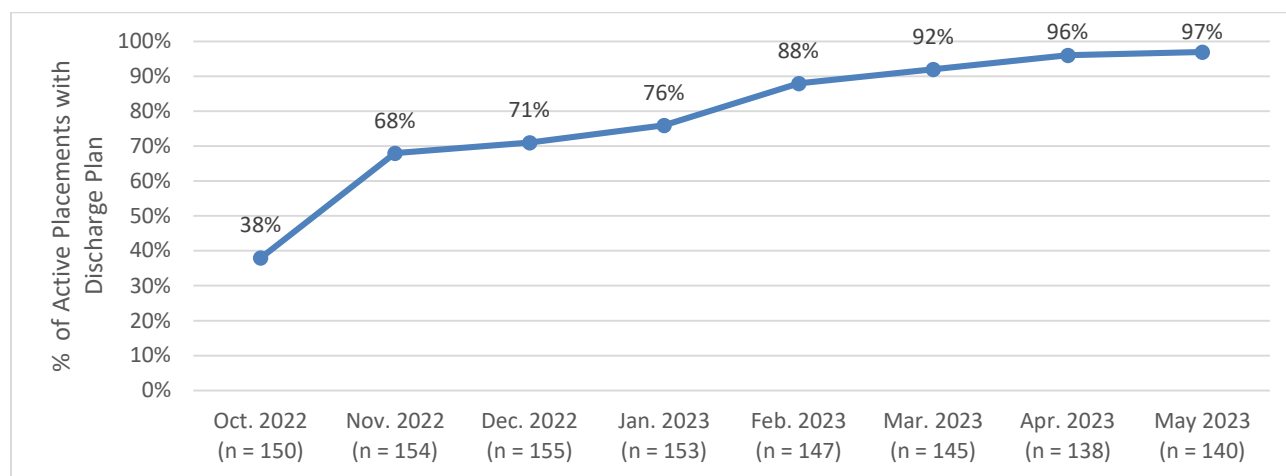


Based on data review, it was noted that “other” was often selected as the discharge barrier with details captured in a separate field, making analysis of this data challenging. To enhance data collection and provide more specific information on barriers encountered, a thorough review of the existing drop-down options as well as common themes in the “other” category were reviewed to refine and update the list of discharge barriers further, including the removal of “other” to promote the collection of actionable data. This new list of discharge barriers will go into effect when the MCO transitions its data collection tool from a spreadsheet to the QuickBase system and will enable a more thorough analysis and understanding of discharge barriers.

As noted in the January 2023 Semiannual Report, lack of having a discharge plan in place was identified as a primary barrier to discharging children to community-based settings. In the third quarter of 2022, BSS licensing and Aetna partnered with residential providers to focus on discharge plans. As a result of increased accountability, including the monthly reauthorization process, additional training, and licensing visits with increased focus on discharge plans, discharge plans are in place for 97% of children in active placement as of the end of May 2023 (reference Figure 89 below). Given data lag associated with submission of discharge plans with the first monthly reauthorization, this result meets the expected threshold. Data analysis of discharge plans in place for children with CAFAS/PECFAS <140 produces a similar result (96.6%).

Other positive changes noted through the focus on discharge planning and the implementation of the monthly reauthorization process include increased attention on timely discharge to the community, consideration of alternative placements before moving to residential placement, and additional discussion around level of care appropriate to meet the child’s needs.

Figure 89: Discharge Plan Status for Active In-State RMHTF Placements With Recent CAFAS/PECFAS Less Than 90, October 2022 to May 2023



As follow-up to the Quality Committee recommendation to establish discharge planning as a requirement for out-of-state providers, effective April 1, 2023, BSS contracted with Marshall University to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placements. Per Marshall’s plan, CAFAS/PECFAS and CANS

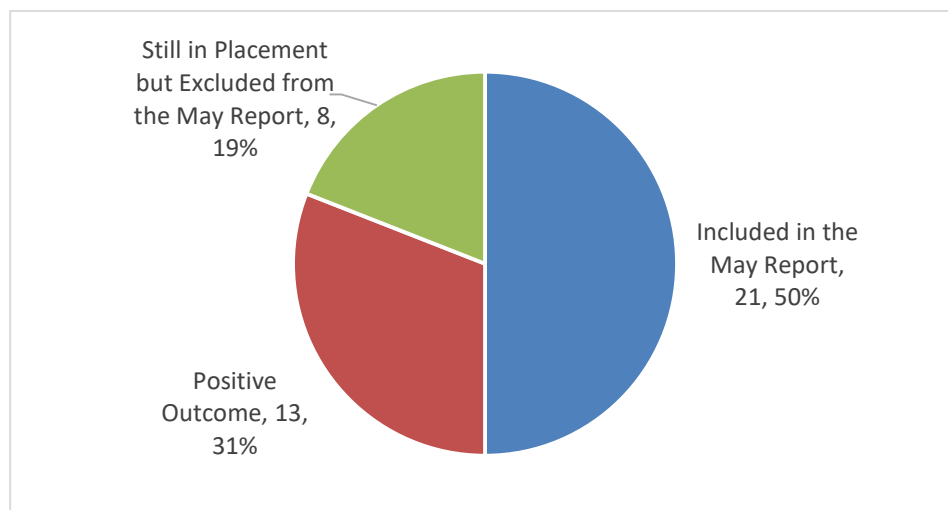
assessments will be completed by late summer/early fall 2023. Discharge planning will begin in late June 2023. Timing for completion of discharge plans for out-of-state placements has not been established as of the writing of this report. Biweekly meetings between DHHR, Aetna, and Marshall are occurring as these processes are implemented. As part of this process, data collection is being established to help ensure results can be incorporated into future semiannual reports.

Aetna continues to hold specialized reviews for children experiencing a crisis or placement disruption and monthly Faces to Cases meetings with CPAs. BSS and Aetna continue to work toward alignment of these processes with the data available to help ensure everyone remains focused on children prioritized for discharge to community settings and to continue to look for opportunities to improve these processes to support timely transitions to the community.

Children in Need of Foster/Kinship Care

In response to a primary discharge barrier being lack of available foster and kinship homes, beginning in February 2023, BSS initiated a process to review children in both RMHTFs and emergency shelters with recent CAFAS/PECFAS scores less than 90 whose barrier to discharge was related to a need for foster or kinship care and collaborate with CPAs to develop foster homes for these children. Demographic information, authorized diagnosis data, CAFAS/PECFAS scores, and length of stay values are reviewed each quarter to understand the characteristics of this population, and individual-level data is assessed to try to connect specific children with community-based placements. The initial report, published in February 2023, included 42 children. As shown in Figure 90, 21 of those children (50%) were also included in the subsequent report in May 2023 (based on data through the end of April 2023), and an additional eight (19%) were still in placement but were excluded from the May 2023 report due to changes in placement type (i.e., sent out of state or to a BJS facility), discharge barriers, or CAFAS/PECFAS scores. However, 13 (31%) had a positive outcome as a result of this new process: nine were discharged while the other four are actively moving toward discharge.

Figure 90: May 2023 Status Update for Children Needing Foster or Kinship Care in February 2023 (n = 42)



The May 2023 update of this report included 33 children, representing an overall decrease in the number of children for whom foster or kinship home placement is a barrier. The next step is for DHHR and Aetna to seek input from CPAs on how to best facilitate communicating information about these children and finding homes to meet their complex needs. Initial input from CPAs and analysis of data for homes opening/closing as well as homes willing to accept youth ages 13 and older highlight the challenges of finding homes for these youth ages 13 and older with complex needs. Next steps to address these challenges are further outlined in Section 14.0 Community-Based Placement Capacity.

17.2(b) Residential Services

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

For purposes of quality improvement and identifying where to focus efforts, DHHR has begun tracking residential placement rates by child's county of origin. Figure 91 shows placements throughout calendar year 2022. The greatest rates of RMHTF utilization were represented by some of the most rural counties in the state, with Randolph County having the highest rate at 7.6 per 1,000 children with a population of less than 6,000 children under age 20. In contrast, Jefferson County, an urban county, had the lowest rate at 1.3 per 1,000 children, with nearly 15,000 children living in the county. Highly populated counties with a high number of admissions, including Kanawha, Cabell, Wood, Berkeley, and Mercer counties, have been identified for the increased ability to impact decreasing RMHTF census. These counties can also be used to bring a regional focus to outreach, education, and service provision, which could make some of the largest impacts to WV's overall number of placements.

In follow-up to the January 2023 Semiannual Report, the Office of QA completed a ranking analysis comparing the following by county per 10,000 children for 2022: residential admission rates, CSED application rates, and CSED service utilization rates. This county-level ranking analysis was shared in the March 2023 Quality Committee review. As a result of this analysis, BSS chose seven counties for focused outreach. This focused outreach is part of a continued effort to develop rapport with the judicial community and raise awareness among the judicial community about the mental health system and expanded ability to serve youth in the home and community-based setting. WV is currently undergoing significant turnover at the judicial level and redistricting is underway. The timing aligns well with the BSS proposed outreach plan, which involves statewide lunch and learns offered via video conference, as well as a focus on building relationships and routine communication between BSS social service managers and local judges. The lunch and learns in the planned series are scheduled in August, September, and October 2023.

Figure 91: 2022 RMHTF Unduplicated Head Count Per 1,000 Children Under 20 by County of Origin

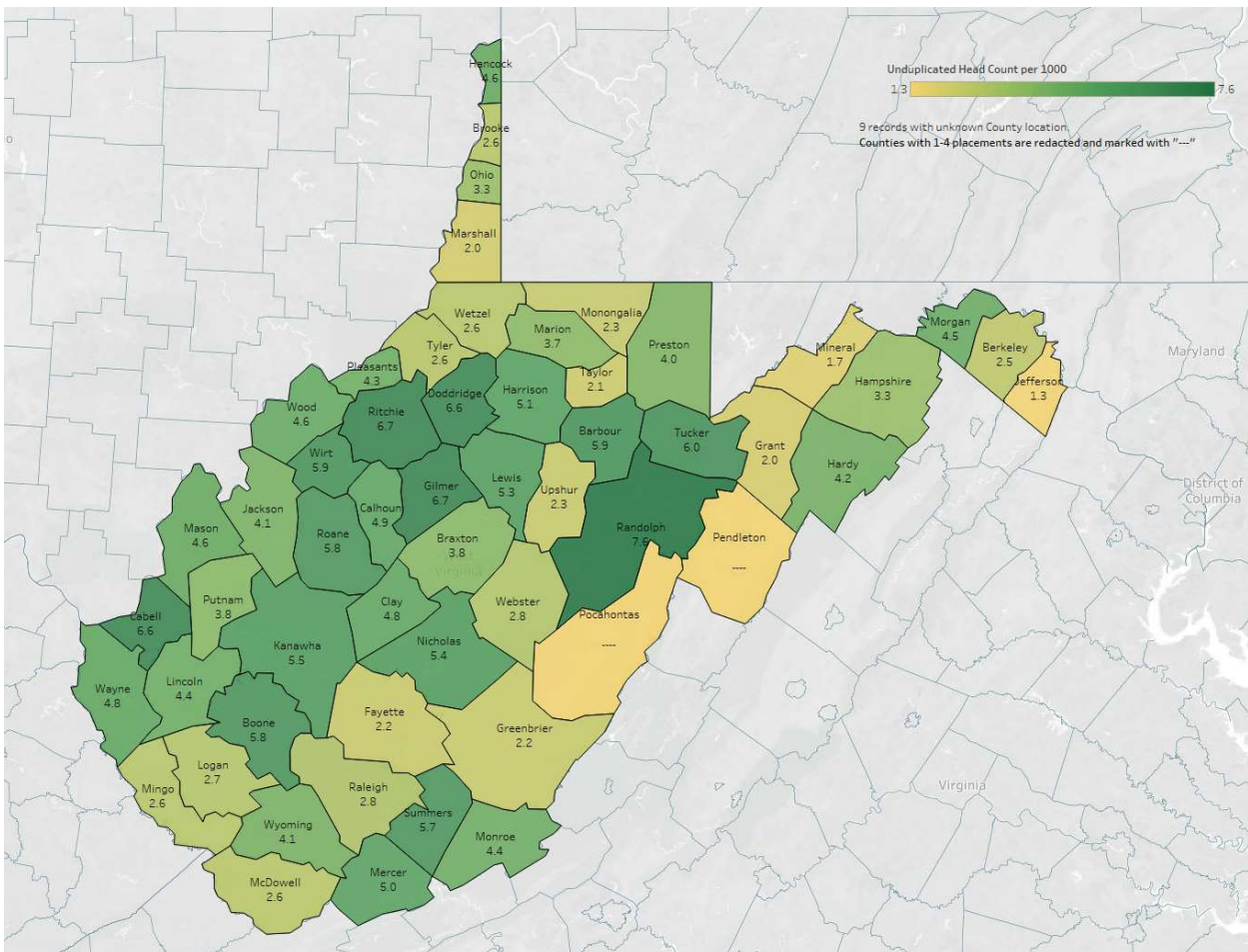


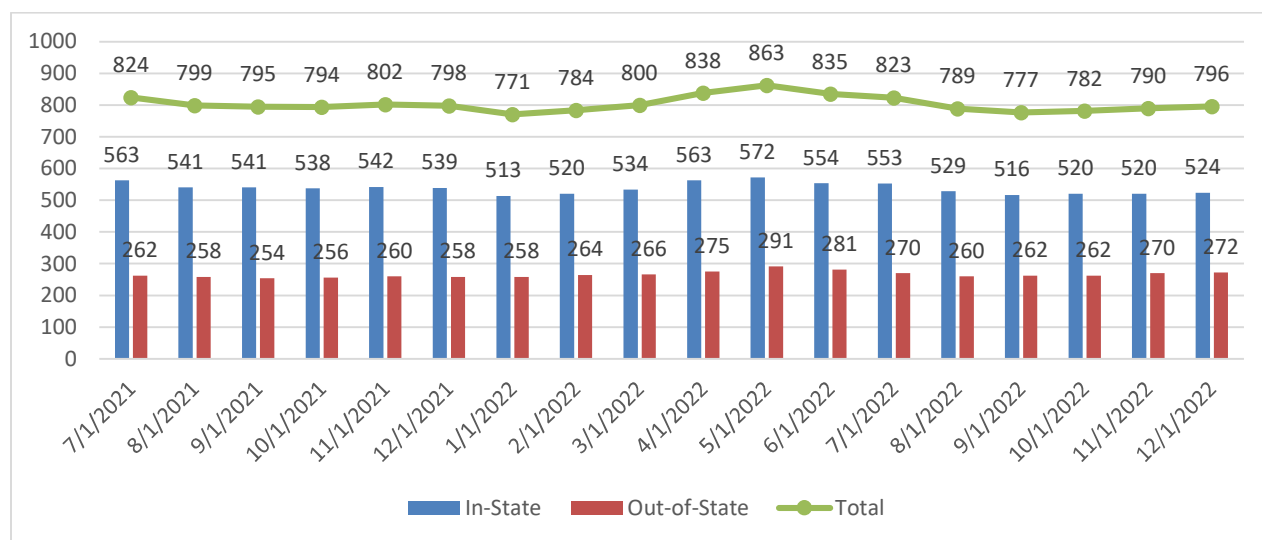
Figure 92 captures the monthly point in time census for the period of July 2021 to December 2022. Notably, there is an overall decline in the census over the 18-month period. Although the census shows some fluctuation, these changes may be expected due to seasonal effects and changes in bed utilization due to easing of restrictions associated with the pandemic. DHHR recognizes that the long-term impacts of service system changes over the last two years, including implementation of CSED Waiver services and the QIA process, have not yet been recognized. Continued focus on screening and referral, evaluation and connection to services, and development of additional community-based capacity (e.g., foster and kinship homes) are the appropriate steps and will take additional time to produce intended results. In the upcoming months, DHHR’s prioritized focus will be on the development of additional community-based capacity alternatives.

DHHR continues to make process enhancements to impact out-of-state placements. DHHR’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 Marshall University to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential treatment facilities and psychiatric treatment facilities.

Marshall will play a key role in partnership with DHHR and Aetna to reduce the number of children in out-of-state placements. Aetna will also play a key role in supporting early diversion efforts to help prevent children from going out-of-state. DHHR is in the process of developing an electronic referral form and building a system to capture out-of-state placement information. Implementation of this system is expected in the fourth quarter of 2023.

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

Figure 92: Monthly RMHTF Point in Time Census, July 2021 to December 2022



Length of Service

Over the last several reporting periods, DHHR has explored a variety of ways to evaluate length of service for children in residential settings. The Office of QA is currently exploring the future approach, methodology, and time periods for analysis of length of stay to begin assessing the impact of new processes such as monthly reauthorization, prioritized discharge planning, and QIA. For this reason, while a more detailed analysis of length of service data is analyzed and reviewed as part of the program-level and quarterly Quality Committee reviews (e.g., distribution of length of service for in-state and out-of-state, stratified by type of setting and age), a simplified analysis is presented in Figure 93 below.

Figure 93: Comparison of Average Length of Service by Facility Type, 2021 and 2022

Facility Type	2018	2019	2020	2021	2022
Group Residential	204	223	223	218	221
PRTF	276	257	275	267	258
Short-Term Acute Psychiatric Hospitalization	35	40	34	37	49

*Includes only state-custody individuals; ongoing stays were excluded from this analysis.

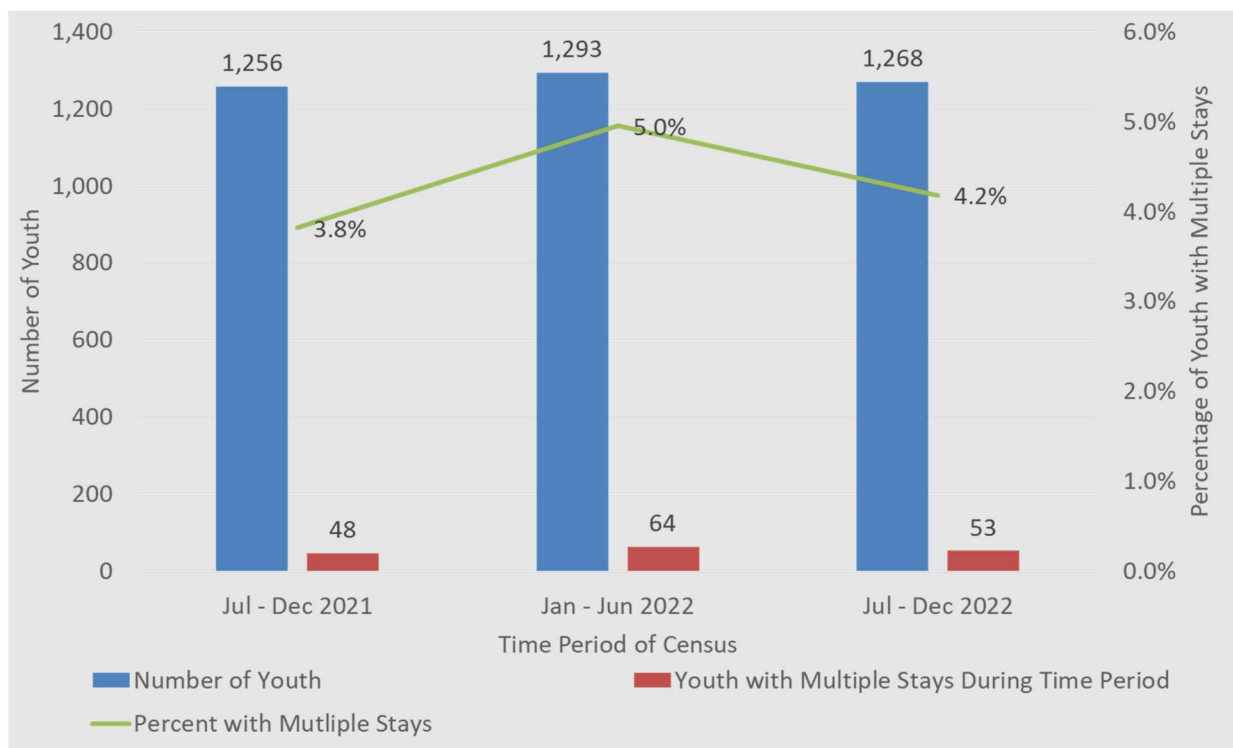
DHHR recognizes that further development of community-based placement capacity is a key step in achieving reduced lengths of stay. The Quality Committee and program teams will require additional time to begin to understand the varied factors impacting length of stay. While there are currently other prioritized activities, DHHR anticipates future steps for this dataset include the possibility of stratification by other factors (i.e., CAFAS/PECFAS scores) to improve understanding of the characteristics and circumstances of children who discharge quickly versus those who remain in residential placements for an extended time. Length of service is currently one of the elements used to identify children selected for focus in the prioritized discharge planning process.

Readmission Analysis

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

Figure 94 summarizes children with multiple readmissions to residential facilities over the three six-month periods spanning July 2021 to December 2022. The number of children experiencing repeat admissions to residential facilities is consistent across the three periods at 4% – 5% of the total children in care for each period. The children identified through this analysis have been prioritized for referral to the QIA process to better understand their care needs. In June 2023, a list of children in active placement with multiple readmissions was provided to Aetna to initiate the QIA process. Completion of the QIA process for these children will provide additional information on their unique characteristics and circumstances and may assist with identifying possible ways to help prevent future readmissions.

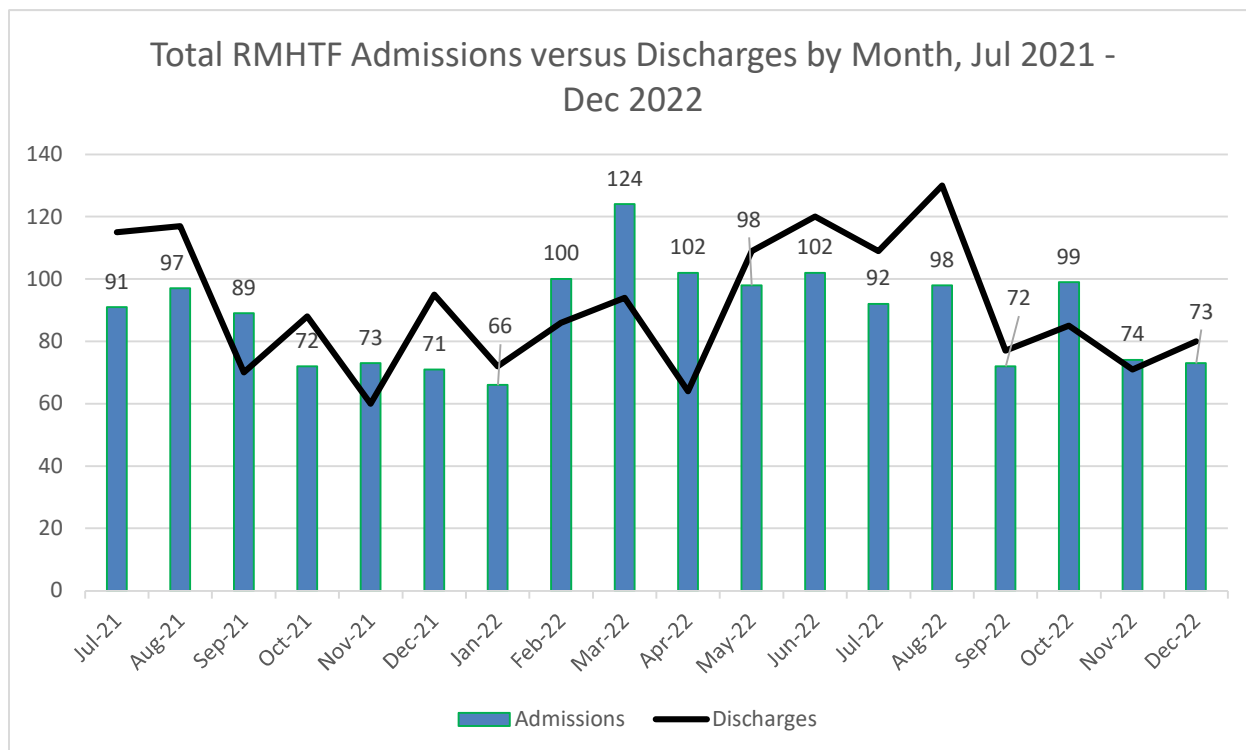
Figure 94: Six-Month Census and Readmission Analysis, July 2021 to December 2022



DHHR is actively focused on reducing admissions through the implementation of the Assessment Pathway, including the QIA process for determining the appropriate level of intervention and least-restrictive service setting, and prioritized discharge planning.

Figure 95 below reflects admissions versus discharges for the 18-month period of July 2021 to December 2022. The Quality Committee discussed possible trends related to the holiday season (November and December) as well as late spring/early summer months (May to July). Specific patterns or trends in this data are still being established with review necessary over a longer period post pandemic to better understand seasonal fluctuations associated with school, holidays, etc. The Quality Committee continues to hypothesize that increased discharges associated with the timing of school breaks indicate an opportunity to address cultural norms around requiring a child to remain in a residential setting to finish out a term or related session before transitioning to the community. Admissions are somewhat consistent when comparing each month to the same month one year prior. Increased implementation of the QIA process, as well as development of alternative community-based settings, will be integral to reducing overall admissions and are prioritized next steps for DHHR.

Figure 95: Total Admissions Versus Discharges (Exits) by Month for In-State and Out-of-State Placements, July 2021 to December 2022

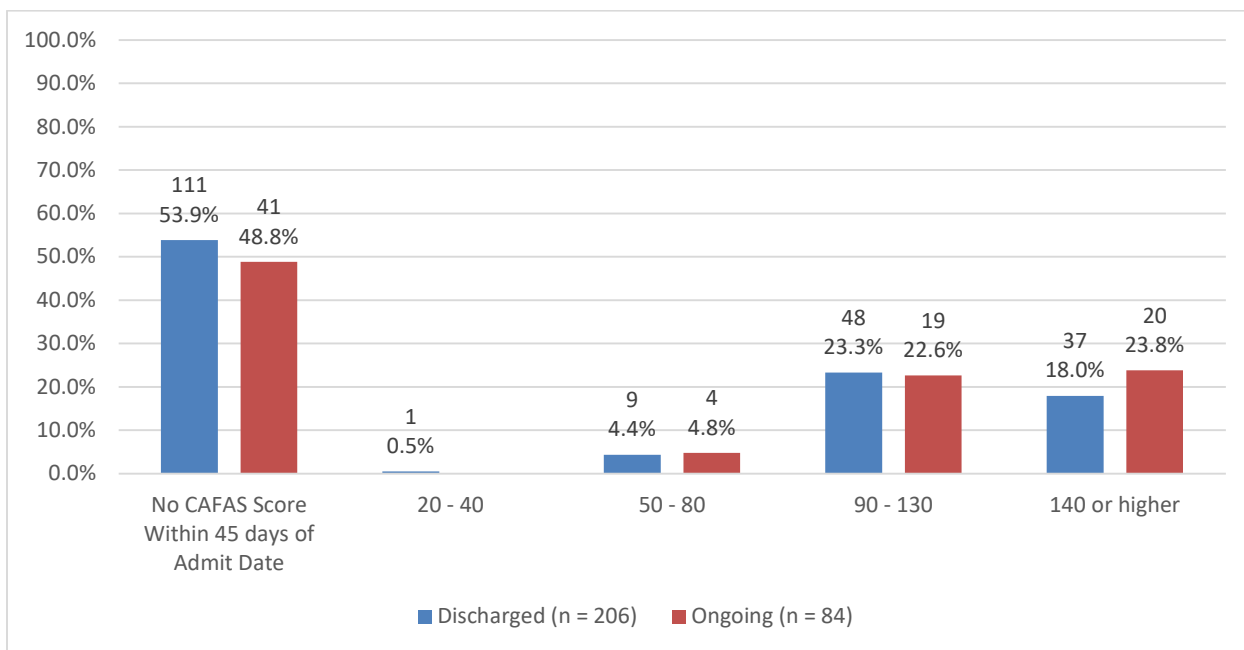


As a next step toward understanding differences in children who discharge from care versus those with ongoing stays, DHHR completed two new analyses for review in the May 2023 Quality Committee review. Both analyses were completed for children with a residential admission date from January to March 2022. The first analysis in Figure 96 shows children discharged versus children with ongoing stays stratified by CAFAS/PECFAS score near admission.³⁷ CAFAS/PECFAS scores near admission were not available for approximately half of the children included in the analysis. As noted previously, in June 2023, BSS began collaborating with Aetna to address timeliness and completion of CAFAS/PECFAS assessments for children in residential placements. As data completion improves, additional analysis will be conducted.

While the data is limited, initial impressions are that children with higher CAFAS/PECFAS scores near admission (>140) are somewhat more likely to have a longer length of stay, but overall, scores near admission alone may not be a strong predictor of whether a child discharges quickly or remains in placement.

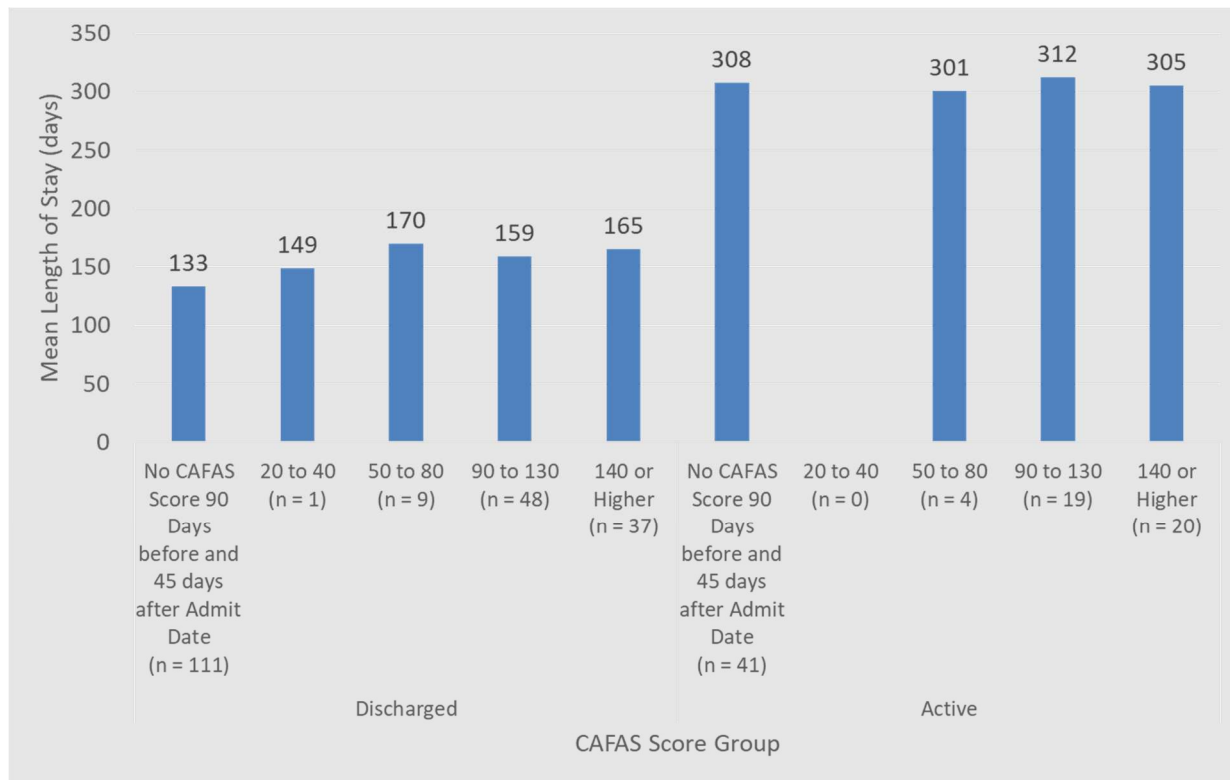
³⁷ “Near admission” means a score within 45 days following admission or 90 days prior to admission. CAFAS/PECFAS is expected to be completed within 30 days of admission unless a score is available within the last 90 days. CAFAS/PECFAS scores following admission are submitted as part of the first monthly reauthorization, which is why the 45 days after admission criteria was selected for the analysis.

Figure 96: Discharged Versus Ongoing Stays Stratified by CAFAS/PECFAS Score Near Admission



The second analysis shown in Figure 97 compares length of stay for children discharged versus children with ongoing stays (i.e., active placements) stratified by CAFAS/PECFAS score. While the sample size is low for CAFAS/PECFAS <90, initial impressions are that CAFAS/PECFAS scores alone do not appear to have a direct correlation to length of stay. Individuals with CAFAS/PECFAS scores <90 have similar lengths of stay to those with scores >90 and those with scores >140 (i.e., 150 to 170 days, so less than three weeks' differentiation). Following review of the data, Aetna and DHHR discussed a variety of factors impacting length of stay, such as time needed to prepare a family, time associated with finding a home, or court orders to complete the school year or finish a residential treatment program.

Figure 97: Length of Stay of Children Discharged Versus Children with Ongoing Stays Stratified by CAFAS/PECFAS Score



More time is needed to better understand differences between children who discharge quickly and those with longer lengths of stay. These datasets represent early steps in the process of understanding these differences.

17.3 Provider Capacity/Statewide Coverage

DHHR continues to work with in-state residential providers to improve provider capacity tracking. The current expectation is for providers to update capacity information, including any current holds, on a daily basis. DHHR reiterated this expectation at the last residential stakeholder meeting.

Given the number of children being placed in out-of-state facilities, concerns remain over the adequacy of in-state residential programs to meet the needs of children with more complex needs. In response, DHHR has partnered with providers Chapin Hall and Casey Family Programs over the last 18 months to work toward new models of care. In the latter part of 2022, DHHR met individually with each residential provider to share the goals of developing a residential intensive treatment model and to seek provider input and ideas. A subcommittee of the residential stakeholder group has continued to work on the model. Additionally, DHHR has reviewed programs from other states, such as Iowa. The proposed residential intensive treatment model involves serving children in smaller home settings with higher staffing ratios, using a defined treatment model, and including the use of evidence-based practices.

To address the population of children whose needs do not rise to the level of the residential

intensive treatment model and who do not have a family, kinship, or foster home, an alternative model is being considered. This model would serve as a step down from residential for individuals to live in the community. This model would rely on HCBS and would not be considered a residential treatment setting.

DHHR is currently working with a consultant to complete a rate analysis for both models. Next steps include sharing the proposed models and associated rates with residential providers in summer 2023 and allowing them an opportunity to work through how these new models may align with their current array of services. DHHR's goal is to implement both models by July 2024.

17.4 Strengths, Opportunities, Barriers, and Next Steps

Key accomplishments and follow-through on recommendations from the prior semiannual report include the following:

- Discharge plans are in place for 97% of children in active placement as of the end of May 2023.
- Completed further enhancements in discharge planning data collection and improved data quality (i.e., 97% completion of discharge barriers).
- DHHR contracted with Marshall University in April 2023 to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placement.
- The monthly reauthorization process for children in residential placements is fully implemented with the following positive outcomes being noted: increased attention to timely discharge to the community, consideration of alternative placements before moving to residential placement, and increased discussion around level of care appropriate to meet the child's needs.
- The QIA process has been implemented statewide and has now expanded to include children currently in placement. The first list of approximately 50 children in active placement prioritized for referral to the QIA process was provided to Aetna in June 2023.
- Implemented regular analysis of county-level data to drive future action and strategy.
- Completed early-stage analysis to assist with understanding of the characteristics of children who discharge from residential services timely versus those who remain in residential services over longer periods.

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, DHHR is prioritizing the following actions:

- Continue efforts to improve communication with CPAs and modify recruitment strategies to develop more foster homes willing to accept children with complex needs per the partnership recently established between Mission WV, BSS, Aetna, CPAs, and current

foster and adoptive parent representatives to drive an initiative to develop this capacity.

- Continue the work in progress to develop new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability.
- Operationalize the new community-based transitioning youth group home services by fall 2023 to support youth ages 17 – 21.
- Complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placement. CAFAS/PECFAS and CANS are underway for children in out-of-state placement. Development of discharge plans began in June 2023.
- A continued recommendation from the prior semiannual report is to work with Aetna to begin completing formal, periodic quality reviews of discharge plans. This possibility will be explored with Aetna in late summer/early fall 2023.

18.0 Outcomes

DHHR continues to establish data sources, systems, and processes to collect outcomes data for children receiving mental and behavioral health services. Enhancing data quality and collection has been identified as a key step to assess outcomes following early process implementation and the continued build-out of the data store. Time is needed to allow children to go through the full expected service period in order to evaluate longer-term impacts of service and cross-systems utilization.

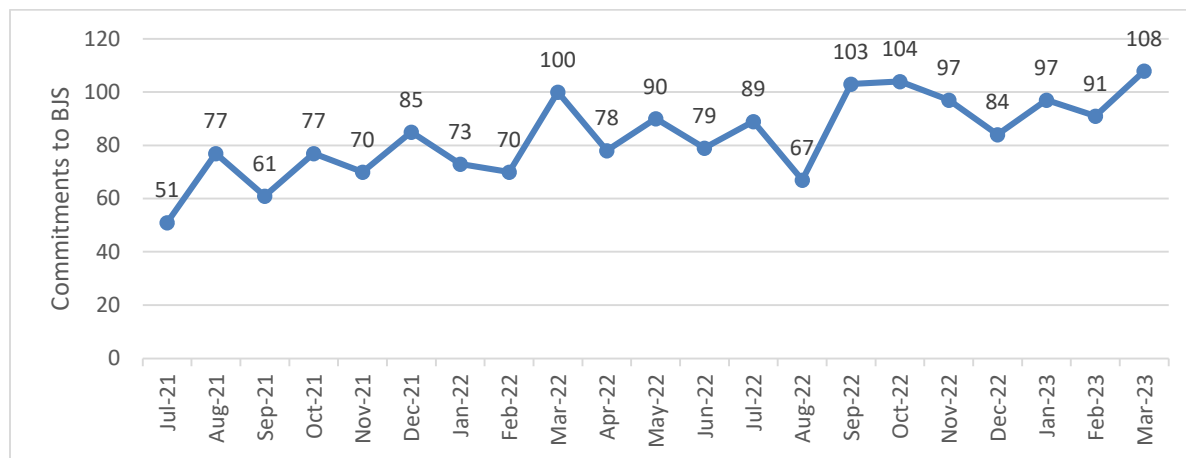
An analysis of cross-systems utilization—which will be recurring and built on over time with increased access to data—is planned to begin in fall 2023 and will focus on children at risk for residential placement. Service utilization and cross-systems utilization will be used to improve understanding of patterns in utilization and ability to remain in the 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. Initial analysis will focus on children utilizing residential services and, contingent on available data, what HCBS they may have used before residential placement as well as what services they may have been connected to after RMHTF services. DHHR will also explore commonalities for service utilization for at-risk children not interacting with an RMHTF. Plans for this cross-systems analysis will grow and be refined as the data store is built out and systems utilization is better understood.

Below is an update on the data sources for each outcome:

- **Arrests or detainments without being charged:** The CMH Evaluation asks youth and caregivers about their experiences with law enforcement to capture this information for children in residential treatment and children at-risk of residential placement to provide a sample of this key population.
 - The baseline CMH evaluation survey asked caregivers, “Has your child had an encounter with the police in the past 12 months? Encounters with police include being arrested, hassled by police, or taken by the police to a shelter or crisis program.” Out of 108 caregivers for children in an RMHTF as of October 1, 2021, 39% (n=42) reported a police encounter in the previous 12 months. Of those encountering law enforcement, 43% (n=18) indicated the child had been arrested.
 - Additional information will be reviewed following the release of the CMHE reports in summer and fall 2023, which will provide further data for both at-risk children and children in RMHTF placements.
- **Commitment to the custody of BJS or DHHR:** The data source for commitments to BJS has been identified as the Offender Information System. The data source for commitments to DHHR will now be WV PATH. These data sources will be further assessed and integrated into the data store to analyze commitment to custody for the at-risk population. Figure 98 shows children in BJS custody by month. In review with BJS

staff, it was noted that some change in criteria at a facility led to the appearance of an upward trend in commitments in recent months, while previous trends were influenced by the COVID-19 pandemic. However, additional time and trend data will be needed to better understand these trends and any influences HCBS may make on these numbers over time. It will also be important to integrate this information into the data store to better understand a child’s journey and, over time, identify influences on children who are or are not committed to BJS custody.

Figure 98: BJS-Committed Children by Month, July 2021 to March 2023

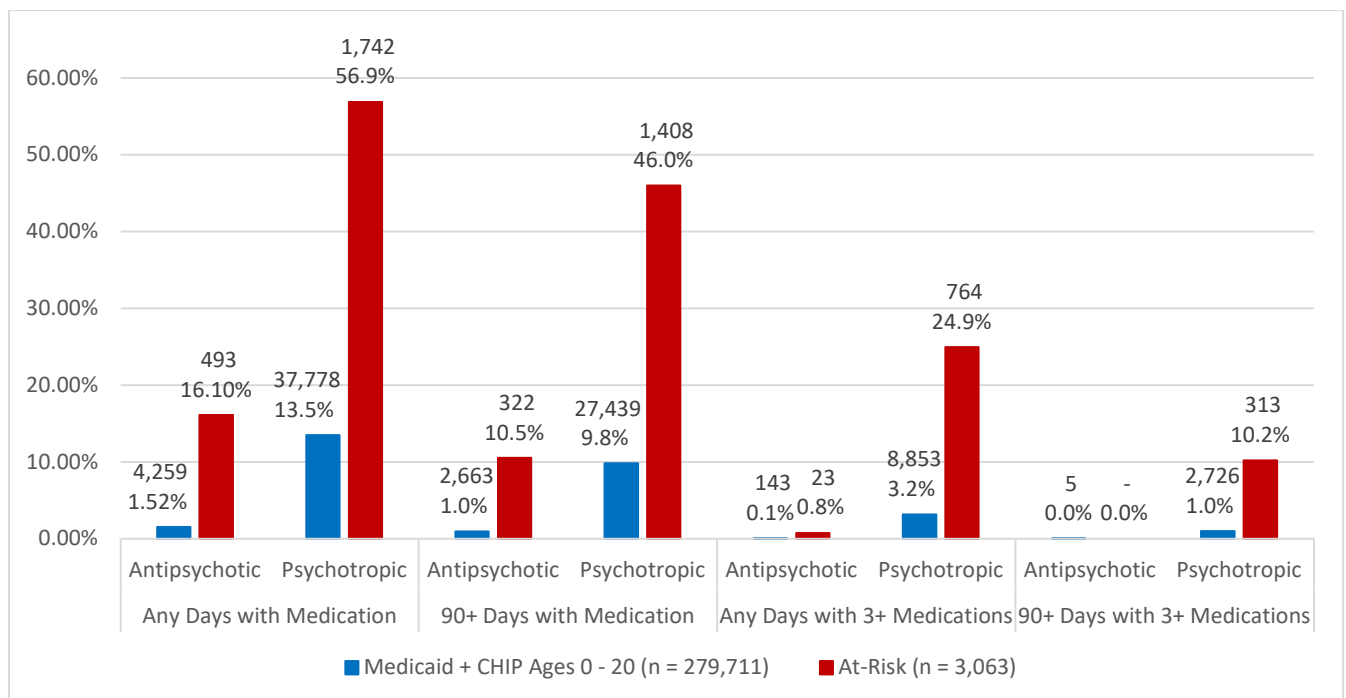


- **Suspension or expulsion from school:** DHHR is collaborating with the WVDE as part of the greater collaborative started in December 2022. A data-sharing agreement, which is currently being drafted, will be established in fall 2023 and will allow sharing and review of data for the at-risk population. Data on the at-risk population will be matched with data from the West Virginia Education Information System (WVEIS) to better understand child outcomes over time.
- **Prescribed three or more psychotropic medications:** Initial polypharmacy analyses using pharmacy claims data did not identify significant numbers of children with three or more psychotropic medications, which included use of antipsychotic medications. BMS has policies and processes in place to flag any child for whom polypharmacy may be an issue and can intervene when needed.
 - A comparison for children in the general population and those at risk of residential placement was completed, as shown in Figure 99, for calendar year 2022. It was identified that 46% of the identified population of at-risk children³⁸ had at least one psychotropic prescription for at least 90 days, while 10% had

³⁸ At-risk children were defined as those children (under age 21) with an SED in 2021 (where an SED is defined as ICD-10 diagnosis codes in the psychiatric range, or F-range [that is, starting with F] *except* for: the F1, or SUD, range and F55 [also a SUD diagnosis], and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021) AND meeting any of the following criteria in the last three months of 2021: Medicaid/CHIP member with an ER visit for a psychiatric episode, Medicaid/CHIP member with a psychiatric hospitalization episode, Mobile Response, children who are in state custody because of CPS or YS involvement, OR children with SED as a primary diagnosis on a Medicaid claim in 2021 and a CAFAS/PECFAS \geq 90.

three or more for at least 90 days. Among the general Medicaid population of children aged 0 – 20, 3% had at least one psychotropic prescription for at least 90 days, while 1% had three or more for at least 90 days. It was noted that some children considered to be on “maintenance medications” for continued mental health treatment may not be included in the at-risk population despite polypharmacy use, as the child did not flag for at-risk indicators such as child welfare involvement or recent identification of functional impairment or mental health crisis service engagement. Only 1% of Medicaid children utilized an antipsychotic for more than 90 days, while approximately 10% of at-risk children did. No at-risk children used three or more antipsychotics for 90 days or more.

Figure 99: Psychotropic and Antipsychotic Utilization Among Children with WV Medicaid and Children At Risk for Residential Placement January to December 2022



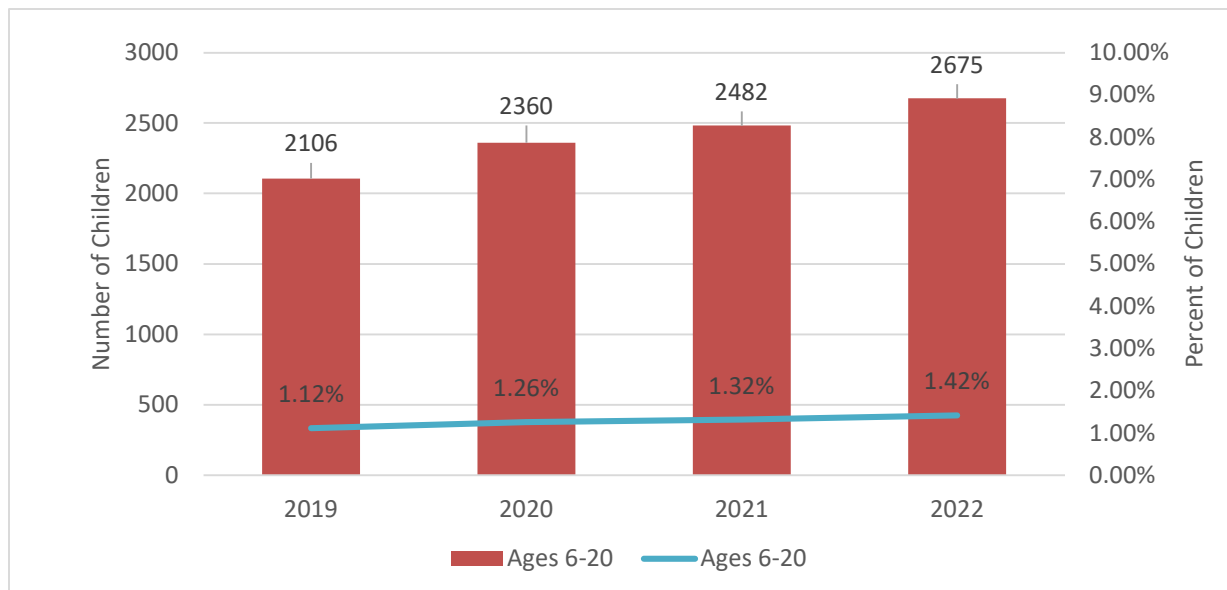
- The COVID-19 pandemic impacted healthcare significantly, including shifting healthcare utilization due to stay-at-home orders in 2020 and continued concerns with spread of the virus going into 2021. WV Medicaid extended eligibility for individuals enrolled in Medicaid to March 2023. This change diminished concerns related to service gap but also significantly increased the number of members enrolled compared to a typical year. The constraints and circumstances of the pandemic have increased mental health treatment utilization for children during and post pandemic. Increased allowances for telehealth services have also improved access for some populations who also have reliable access to phone and internet capabilities. Figure 100 shows the number and percentage of Medicaid children aged 6 – 20 with three or more psychotropic medications for 90+ days from 2019 – 2022. Children 0 – 5 were reviewed internally and represented less than 21

individuals meeting these criteria each year. Significant restrictions are in place for children aged 0 – 5, helping to ensure prescriptions are appropriate for children based on age and other clinical factors. In 2022, 2,675 children utilized three or more psychotropic medications for 90+ days,³⁹ representing 1.4% of children aged 6 – 20. This is a very slight increase compared to 2019, when 1.1% of children aged 6 – 20 utilized three or more psychotropic medications for 90+ days. DHHR will continue to monitor this to help ensure prescriptions, including polypharmacy utilization, remain appropriate.

- The WV Medicaid Pharmacy Program has several procedures and policies in place to prevent inappropriate utilization of psychotropic medications, including prospective drug utilization review edits. Claims are edited for appropriate age, dose, therapeutic duplication, and potential drug-drug and drug-disease interactions. When claims are denied, prescribers are required to request a prior authorization and provide justification for the prescription. The requests are reviewed by a child psychiatrist available through a contract with Marshall University. Metabolic laboratory tests and an involuntary movement scale are required for continued prior authorizations.
- The Quality Review Committee noted considerations for additional analysis such as new diagnoses, prescriber types, and associated prescriptions which could help the team understand utilization practices in greater detail; however, at this time, no major concerns were identified with current practices given the established checks and balances infrastructure. WV will continue to monitor this and expand these analyses as data becomes more readily available in the data store to understand influences of the child journey and mental health system engagement.

³⁹ It was noted in quality reviews that titration of medications during a medication change could result in children to appear like there may be multiple medications used when they are merely changing medications and needing to wean off of a previous drug according to set protocol.

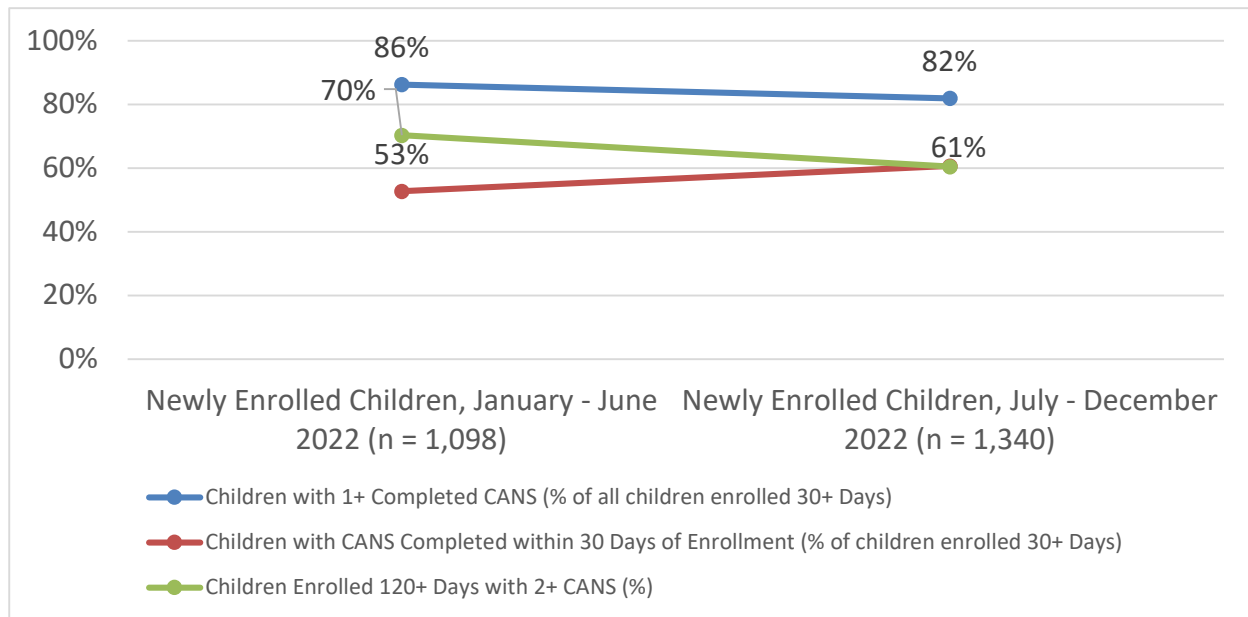
Figure 100: Utilization of Three or More Psychotropic Medications for 90+ Days for Medicaid and CHIP Children Aged 0 – 20, Calendar Years 2019 – 2022



- **Changes in functional ability, statewide and by region, including data from the CANS assessment and the quality sampling review process:**
 - DHHR is partnering with WVU to complete quality sampling reviews, which will include cross-systems analysis, surveys, and interviews with a sample of at-risk children and their caregivers. A report on these initial findings is expected in fall 2023.
 - Initial CANS assessment data have been explored to assess indicators of CANS completion and timeliness. Data quality and CANS completion is essential to tracking outcomes over time. For children who were newly enrolled between January and June 2022, 86% of all children—enrolled in SAH, an RMHTF, CSED, or BBH and reported in the CANS Automated System for at least 30 days—had at least one CANS completed (Figure 101). This dropped to 82% in the last six months of 2022. The percentage of children with two or more CANS, who were enrolled at least 120 days, also decreased from 70% to 61%. However, there were 22% more newly enrolled children in July to December 2023 (1,340) than in January to June 2022 (1,098), and the Quality Committee discussed that this influx may have impacted the ability of providers to complete and/or enter the CANS data for some children. While percentage of CANS completed has decreased, CANS completed in a timely manner (within 30 days of enrollment) have increased from 53% to 61% for children with at least 30 days of service enrollment. In 2022, significant efforts occurred to train facilitators in Wraparound Facilitation fidelity; this likely attributed to improved timeliness. There were additional changes to the system during these periods that also could have impacted data collection. For example, implementation of the Assessment Pathway impacted the funding sources utilized to cover Wraparound Facilitation

services. This change led to changes in documentation in the CANS system, which could have impacted data collection efforts. This will continue to be addressed with providers, and this data will be part of the focus of the Wraparound Facilitation PIP team for rapid cycle improvement. Data will also be reviewed internally by payor source and at the provider level to focus data collection and procedural efforts as well as to improve overall fidelity. As of March 2023, all CSED providers were required to utilize the CANS Automated System. Although most CSED providers utilized the CANS Automated System prior to this date, reporting was not required and may not have been consistent or complete; therefore, this change will be monitored and validated moving forward.

Figure 101: CANS Completion and Timeliness – Newly Enrolled Children, January to June 2022 vs. July to December 2022



- As noted in previous reports, further outcome methodology for the CANS assessment has been developed and tested to assess functional improvements over time. This could not yet be assessed across individual programs, as natural service length and time lapse need to occur post Assessment Pathway implementation to allow for adequate data to determine change over time.

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

19.0 Conclusion

DHHR 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. Key accomplishments in the first half of 2023 include the following:

- Completion of rollout of the QIA process across BSS and the initiation of referral of children in active RMHTF placement with multiple readmissions to the QIA process
- 97% of children with CAFAS/PECFAS less than 140 in in-state RMHTF placements have discharge plans in place
- Expansion of data collection and further build-out of the data store to include RMHTF discharge planning data as well as CAFAS/PECFAS history, allowing early-stage cross-systems analysis
- Expansion of data analysis to review expanded data sets at the county level for focus on service area-based needs and strengths
- Increased referrals to the Assessment Pathway for further evaluation and connection to services, and the increased use of CCRL, mobile response, and CSED Waiver services
- Five-year renewal of the CSED Waiver through January 2028
- As of March 2023, all CSED Waiver providers are inputting CANS results into the CANS Automated System to support improved outcomes reporting
- Continued progress in Wraparound Facilitator capacity and caseload analysis, to include the incorporation of FTE status by Wraparound Facilitator
- Contract with Marshall University implemented in April 2023 to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential treatment facilities and PRTFs
- Three providers were chosen to operationalize transitional living group home services in the community as an alternative to residential placement (projected start of August 2023)
- Initiation of the collaborative campaign focused on recruitment of foster homes to support youth ages 13 – 17 with complex needs

Implementation and adoption, as well as efforts to raise awareness, are continually in process, and services have not yet reached expected routine and ongoing operations. Nevertheless, the increase in mental health screenings conducted as part of early intervention, the increased referrals to the Assessment Pathway for further evaluation and connection to services, and the increased use of CCRL, mobile response, and CSED Waiver services are all positive indicators that demonstrate increased awareness and uptake by families and other stakeholders of the HCBS options available to divert children from residential placements. Together, these trends

provide evidence that DHHR's efforts are having the intended effect. DHHR successfully met the goal of reducing the number of children in residential placements below 812 by December 31, 2022, with a preliminary census count of 781.

DHHR's CQI processes continue to expand and evolve. The Office of QA collaborates daily with program leadership and staff to continue to align efforts and improve data quality. Additionally, more data sharing is occurring, and is in some cases still in development, with a variety of partners and stakeholders, including the WVDE, DHS, court systems, and vendors and providers, among others. These efforts are building momentum to help ensure sustainable, available, and accessible programs and services for children and families across WV.

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

- Continued CSED Waiver and Wraparound Facilitation services forecasting and provider network expansion in partnership with Aetna and providers
- Completion of CAFAS/PECFAS, CANS assessments, and discharge plans for children in out-of-state placement, with the goal of bringing more children home to their families and local community support networks
- Focused recruitment of foster care homes to serve youth ages 13 – 17 with complex mental and behavioral health needs
- Establishment of transitional living group homes in the community
- Completion of the QIA process for all children in active RMHTF placement, to help ensure:
 - Children are assessed for appropriate levels of care and intervention to support discharge and diversion from residential placement when clinically appropriate
 - Services are provided in the least restrictive setting
- Continued development of new models of care via smaller homes with higher levels of staffing to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability
- Coordination between BPH and the MCOs to help ensure EPSDT with mental health screens are conducted annually on 52% of Medicaid-eligible children
- Continued enhancement of quality infrastructure and processes within DHHR to include:
 - Expansion of the data store to enable synthesis of data across sources and systems
 - Oversight and monitoring of DHHR staff and third-party contracts (e.g., vendors)
 - Reporting to provide feedback to providers, to help ensure accountability to performance outcomes, and assist with focused recruiting and network expansion

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

Appendix A: Glossary of Acronyms and Abbreviations

Figure 102: Glossary of Acronyms and Abbreviations

Acronym/ Abbreviation	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ASO	Administrative Service Organization
BASC	Basic Assessment System for Children
BBH	Bureau for Behavioral Health
BFA	Bureau for Family Assistance (formerly Bureau for Children and Families)
BIPOC	Black, Indigenous, and People of Color
BJS	Division of Corrections and Rehabilitation-Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
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
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
DHHR	WV Department of Health & Human Resources
DHS	WV Department of Homeland Security
DW/DSS	Data Warehouse/Decision Support System

Acronym/ Abbreviation	Description
ED	Emergency Department
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
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
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
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
RMHTF	Residential Mental Health Treatment Facility
SAH	Safe at Home
SMI	Serious Mental Illness
STAT	Stabilization and Treatment
SUD	Substance Use Disorder
WV	West Virginia
WVCHIP	WV Children's Health Insurance Program
WVDE	WV Department of Education
WV PATH	West Virginia People's Access to Help
WVU	West Virginia University
YS	Youth Services