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

Subject Matter Expert Compliance Analysis

September 2024

UNIVERSITY *of* MARYLAND
SCHOOL OF SOCIAL WORK

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1. Introduction

As part of the Agreement between the State of West Virginia (WV) and the US Department of Justice (DOJ), the Institute for Innovation and Implementation at the University of Maryland School of Social Work was hired as the subject matter expert (SME). The role of the SME has been to assess compliance with the Agreement, provide recommendations to facilitate compliance, and offer technical assistance. The following compliance analysis is the final SME review for this contract, which is an addendum to the March 2024 SME report. In this report, the SME shares final comments regarding progress since the last SME report and recommendations around future directions. (See Appendices A and B for more information on documents reviewed and meetings attended during this time period.) Importantly, this report also seeks to draw attention to the commendable efforts and progress the WV Department of Human Services (DoHS) has made within the greater context of troubling national trends in child mental and behavioral health. National data shows that children and young adults across the country are experiencing notable increases in behavioral health symptoms and have sought out behavioral health services at high rates. These trends provide important context for West Virginia's work.

Summary: Progress Since the March 2024 SME Report

Since the establishment of the Agreement, DoHS has faced and learned from significant challenges in their transformation process. They are providing new home- and community-based services (HCBS) while also scaling up efforts to use data to inform decision-making. Their efforts towards becoming a data-informed organization have helped DoHS to recognize several challenges and opportunities. In some cases, data have revealed obstacles that require a substantial pivot on implementation strategies. For example, although Stabilization and Treatment (STAT) homes implementation was unsuccessful, residential discharge planning data revealed that not having a home to return to was a substantial impediment to discharge. Based on this finding, DoHS has taken steps to improve foster home recruitment through a robust marketing campaign and decided not to pursue the STAT home design as originally intended. Data reported in the *July 2024 Quality and Outcomes Semiannual Report (SAR)* suggest that the foster care provider marketing campaign is working, as initial recruitment is double the prior rate. It will take time to ascertain whether the increase holds across the entire foster care recruitment and licensing process.

Other major findings resulting from DoHS's data and analysis include:

- More children are using Wraparound than residential mental health treatment facilities (RMHTFs).
- There were more Qualified Independent Assessment (QIA) referrals than RMHTF admissions in March 2024.
- In-depth data analysis revealed that 19% of children identified for discharge from RMHTFs remain institutionalized due to court orders that require them to finish the treatment program or school year, regardless of clinical need.
- Forty-seven percent of Medicaid-eligible children received a mental health screening as part of their annual HealthCheck, a 7% increase from March 2021.
- The Children with Serious Emotional Disorders (CSED) Waiver program continues to increase its enrollment, with the latest data indicating 877 children and families enrolled.

- Probation Services' screening rates have increased in two of four counties selected for "focused improvement."
- By looking longitudinally at youth post-RMHTF, a 43% readmission rate was discovered, which could inform additional in-depth study and practice improvements.

Steady but incremental progress is being made in implementation of newer processes (i.e. QIA) and services (i.e. mobile response), as well. Workflow and service implementation efforts take time (years, often decades), making it challenging to assess the desired effects, some of which will not be apparent for some time (e.g., as programs reach saturation across the state, as children aged five or younger reach adolescence, or as patterns in the data indicate sustained improvement). With few performance measures currently available that are clearly indicative that this transformation effort is working, the SME has focused much of the analyses on processes, and the commitment that DoHS is making to those practices. Where these processes are in place, DoHS can now shift to sustaining and evaluating its child-focused service and program array.

The SME cites the following examples as noteworthy changes to DoHS processes, reflecting continued commitment to improvement. DoHS has:

- Hired a statewide WV Wraparound Coordinator.
- Implemented a new probation officer training as of April 2024.
- Explored a new surveillance data source (The Electronic Surveillance System for the Early Notification of Community-based Epidemics, ESSENCE), which promises more rapid turnaround than Medicaid claims data.
- Conducted outreach based on an analysis of county needs.
- Acknowledged and now addressing quality and timeliness problems with the Child and Adolescent Needs and Strengths (CANS) Assessment data.
- Added three additional modules to the data store.
- Implemented smaller topic-focused data collection to begin to meet the Agreement Item 50 quality sampling review requirement.
- Held consistent office hours between DoHS leadership and residential providers, which reflects a commitment to open communication and improved partnership.

Evaluation Needs

An ongoing challenge for DoHS has been demonstrating that HCBS services meet individual needs (Agreement Items 24b, 37a, 37c, 35a), at times mutually agreed upon by provider, child and family (Agreement Item 26), and in a timely manner (Agreement Item 28). The SME team believes that the best way to collect this data is through a case review of a random selection of participants. This will likely involve drawing on multiple sources of data, but the basic approach could include:

- Selecting a small sample of participants from a respective program (CSED Waiver, Assertive Community Treatment (ACT), Children's Mobile Crisis Response and Stabilization (CMCRS), Positive Behavior Support (PBS)/ Behavioral Support Services, Wraparound).
- Reviewing each participant's experience from referral to the Assessment Pathway to service receipt, through to discharge from services, by looking at the clinical service and support

histories of the participants and if applicable conducting interviews with the youth and/or caregiver.

- Important data to look at (depending on the service received) include diagnosis, treatment plan (that is reflective of diagnosis), all services provided, including interim or crisis services (and whether they are reflective of the treatment plan), time between referrals to programs, satisfaction with services, and outcomes (such as any updated assessments, or program discharge).
- Initial efforts could utilize convenience sampling to prioritize feasibility and refine the process; ultimately random sampling strategies would allow greater generalizability of findings.

At the last parties meeting in July 2024, the case review method was discussed and DoHS is considering how best to accomplish this. SME recognizes the challenge of this task. However, once such a method is in place, it will facilitate DoHS to better understand the experience of children and families participating in HCBS services and identify strengths and challenges.

Context: A National Crisis in Child Mental and Behavioral Health

The national landscape of child behavioral health care has changed tremendously over the past several years. DoHS has been undertaking much of their system transformation during what has been described as a severe national child mental and behavioral health crisis. This crisis, which is still unfolding, and shows no sign of abating.

Arguably this crisis is largely due to the COVID-19 pandemic. Other factors include social media, police brutality against Black, Indigenous, and people of color, and a hostile environment for gender and sexual minorities. These factors precede the March 2020 stay-at-home order, and while they are undoubtedly relevant facets of the problem that COVID-19 amplified, the trends clearly show massive changes in child mental health beginning in early 2020.

Worldwide, behavioral health challenges are more prevalent in pediatric populations after COVID-19. A nationwide representative survey shows that rates of persistent sadness or hopelessness in high schoolers increased from 37% in 2019 to 44% in 2021.[1] In fact, global depression rates among children and adolescents have nearly tripled (increasing from 8.5% to 23.8%), and anxiety rates have increased by more than 50% (11.6% to 19%).[2] In the US, emergency department (ED) visits for several mental health disorders including depression, obsessive-compulsive disorder, tic disorders, eating disorders, anxiety, and trauma disorders all increased, with overall ED use for mental health increasing by 24% in 5–11-year-olds and 31% in 12–17-year-olds relative to 2019.[3] National Survey of Drug Use and Health data shows that between 2022 and 2023, nationwide admissions to residential treatment among 12–17-year-olds increased by 100,000 (more than 25%).

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[1] Jones, S. E., Ethier, K. A., Hertz, M. et al. (2022). Mental health, suicidality, and connectedness among high school students during the COVID-19 pandemic – Adolescent Behaviors and Experiences Survey, United States, January-June 2021. *Morbidity and Mortality Weekly Report*, *71*(Suppl-3), 16-21. https://www.cdc.gov/mmwr/volumes/71/su/pdfs/su7103a1-a5-H.pdf

[2] Benton, T. D., Boyd, R. C., & Njoroge, W. F. M. (2021). Addressing the global crisis of child and adolescent mental health. *JAMA Pediatrics*, *175*(11), 1108-1110. https://doi.org/10.1001/jamapediatrics.2021.2479

[3] Radhakrishnan, L., Leeb, R. T., Bitsko, R. H. (2022). Pediatric emergency department visits associated with mental health conditions before and during the COVID-19 pandemic—United States, January 2019-January 2022. *Morbidity and Mortality Weekly Report* , *71*(8), 319-324. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm

Even though COVID-19 is now endemic, it is possible that some of these troubling trends may not subside, given that it is not yet clearly understood how living through the pandemic and its effects on mental health and trauma at a youth age will ultimately impact adolescent development. Notably, WV was ranked third among all states in COVID-19 related mortality rate in 2022,[4] suggesting that the pandemic is still a relevant health factor and may be having an outsized impact on the children in the state.

In the *July 2024 SAR, DoHS examined* ESSENCE data showing that ED visits for mental and behavioral health reasons increased somewhat during 2020 and early 2021. This was followed by a substantial increase in ED visits in the January to June 2023 period, owing in large part to increases in conditions such as anxiety and Attention-Deficit Hyperactivity Disorder (ADHD). In sum, child behavioral health needs have increased nationwide; and it is within the context that WV has been working to create system change.

Concluding Comments

In many of the SME's discussions with DoHS and in the prior SME reports, the SME has suggested policies and practices that may further aid the state in reducing the residential census and improve child mental and behavioral health but go beyond the requirements stipulated in the Agreement. DoHS has prioritized their attention to the Agreement stipulations in order to satisfy the federal oversight requirements. Now, as Agreement items are increasingly being met, the SME encourages DoHS to think broadly about interventions, policies, and programs that research suggests could create a more hospitable environment and improve behavioral health for children and youth.

To continue alignment with national best practices and national trends around community-centered child behavioral health and residential reduction, DoHS should consider the following evidence-based and evidence-informed practices and analyses:

- Increase the availability of primary prevention services and continue working with schools to expand the focus on early intervention.
- Ensure and grow the availability of evidence-informed and based substance use disorder services and interventions for parents/ caregivers and children with need.
- Develop a differential response system, an approach to serving families screened for child maltreatment that de-emphasizes investigation and removal and prioritizes service provision and engagement with families.[5] Differential response has been shown to reduce out-of-home placements. This could potentially relieve some of the pressure on the state's foster care system and could reduce behavioral health problems, given that out-of-home placement can be a risk factor for behavioral health problems.
- Support kin caring for their minor relatives by continuing to promote and expand interventions such as Kinship Navigator Programs and Kinship Therapeutic Foster Care.
- Utilize community based participatory research initiatives to engage children, family and the workforce in supporting WV's mental and behavioral health system transition.

[4] National Center for Health Statistics. (2023). *COVID-19 mortality by state*. https://www.cdc.gov/nchs/pressroom/sosmap/covid19_mortality_final/COVID19.htm

[5] Johnson-Motoyama, M., Ginther, D. K., Phillips, R., Beer, O. W. J., Merkel-Holguin, L., & Fluke, J. (2022). Differential response and the reduction of child maltreatment and foster care services utilization in the U.S. from 2004 to 2017. *Child Maltreatment*, *28*(1), 152–162. https://doi.org/10.1177/10775595211065761

- Conduct analyses that describe year to year change in performance indicators such as RMHTF admissions (to eliminate seasonality variation) and pair that change with the national data/trends to inform how WV is performing in comparison to nationwide trends[6].

Finally, the SME expresses appreciation to DoHS for the opportunity to learn about their vision and progress towards achieving a child behavioral health system that meets the needs of WV youth and families. The SME especially commends the growth in data-driven decision-making and data capacity that increased significantly during this era. The SME wishes DoHS every success in their ongoing efforts to serve their children and families well.

[6] For example National Survey of Drug Use and Health data shows that between 2022 and 2023, nationwide admissions to residential treatment among 12–17-year-olds increased by 100,000 (more than 25%). (See footnote 4). Using data reported by DoHS in the *July 2024 SAR* and the two previous *SARs* , over the period of July 2023 to April 2024, admissions to RMHTFs among WV children averaged 93 each month in 2022 and 103 each month in 2023, which suggests that during the same time period, WV saw an increase in admissions of just over 10%.

2. Compliance Ratings

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
24a (Also see Agreement Item 28 and 40a)	Timely access to HCBS services	Partial	ACT, CMCRS, PBS/Behavioral Support Services, TFC*, Wraparound	See Agreement Item 28.	See Agreement Item 28.
24b (Also see Agreement Items 40b)	Meets individual needs. . . services provided in a manner to enable child to remain/ return to family	Partial	ACT, CMCRS, PBS/Behavioral Support Services, TFC*, Wraparound	DoHS is collaborating with West Virginia University (WVU) and recently revised the format and focus of the Children's Mental Health Evaluation released in September 2024. It has clearer reports in six topic areas capturing perspectives and experiences of family, children and providers.[7] CMCRS The Ohio Family Satisfaction Survey (adapted for WV) is being implemented fall 2024 to capture the family	Conduct a case review of a sample of participants in respective service areas. See description of the case review methodology on pages 4-5 of this Compliance Analysis. CMCRS Provide data on the Ohio Family Satisfaction Survey results.

[7] Six reports include data on: 1) Use of Mental and Behavioral Health Services; 2) Services Awareness; 3) Case Series; 4) Workforce, Capacity, and Resources; 5) Collaboration and Referrals; and 6) Barriers and Engagement.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				perspective on the impact of crisis services. <u>PBS/Behavioral Support Services</u> Concord University conducts Behavioral Support Services provider certification training three times per year, and it will include time for cohorts to receive mentoring post-training.	
24c (Also see Agreement Items 33 and 39)	Statewide access	Substantial	ACT, CMCRS, PBS/Behavioral Support Services, TFC*, Wraparound	N/A	N/A
26	Times/locations mutually agreed upon by provider, child and family	Partial	ACT, CMCRS, CSED Waiver, PBS/Behavioral Support Services, TFC*, Wraparound	No new progress noted.	Conduct a case review of a sample of participants in respective service areas. See description of the case review methodology on above pages 4-5 of this Compliance Analysis.
28	Timely provision of mental health services	Partial	ACT, CMCRS, CSED Waiver, PBS/Behavioral Support Services, TFC*, Wraparound	<u>ACT</u> DoHS reported collaborating with Aetna to capture information from youth being offered ACT in the CSED Waiver roster and discharge planning data sets and in data in progress.	Conduct a case review of a sample of participants in respective service areas. See description of the case review methodology on page 2 of this Compliance Analysis. <u>CMCRS</u> Provide additional information on the adapted Ohio Data Management Survey being implemented in WV.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				CMCRS • The Bureau of Behavioral Health (BBH) participates in the national Mobile Response and Stabilization Services (MRSS) Quality Learning Collaborative. Through this collaborative, WV is exploring tools used in other states to capture data. WV met with the State of Ohio and is mirroring their data management survey and adapting this for WV.[8] • In response to regional needs, in February 2024, the Bureau of Medical Services (BMS) began recruiting mobile crisis providers. Maps as of July 2024 were provided to show the expansion of the BMS mobile crisis provider network.	Wraparound Provide future/ongoing documentation of Quality Committee reviews to assess for timely connection of service and service gaps. PBS/Behavioral Support Services Implement the modifier to the Medicaid billing code that is necessary to demonstrate access to Behavioral Support Services (now expected in fall 2024). This will not only provide more documentation of timely access to services but is also expected to reduce wait times as services become billable. CSED Waiver A case review will facilitate an ability to look at other HCBS services received while awaiting CSED Waiver services or interim Wraparound services (e.g., PBS, therapy, regional youth service center participation).

[8] The adapted Ohio Data Management survey will be implemented by CCRL and CMCRS when interacting with families who contact the CCRL or are referred to mobile crisis services. BBH anticipates training and technical assistance will be needed to support providers to address data quality or completion issues.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				<u>Wraparound</u> DoHS reported reviewing services children are receiving at various points of the Assessment Pathway and initiated evaluation of services received at the county level. DoHS reported that this was reviewed in both the May and August 2024 Quarterly Quality Committee reviews. <u>PBS/Behavioral Support Services</u> • The WVU Center for Excellence in Disabilities provided PBS services to 146 children from July to December 2023, a 31% increase from the first half of 2023 (n = 111). • The average waitlist time for PBS services was reported as 1.5 months and the triage system ensures that all families are contacted within one week of their referral being received.	

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				CSED Waiver DoHS completed a more robust analysis of waitlist data in their April Addendum, which demonstrated how the distribution of days from application received to determination date, and from application received to service date varies widely.[9]	
29a	Availability of crisis response to all children to include toll-free crisis hotline and crisis response teams staffed 24/7	Substantial	CMCRS	N/A	N/A
29b	Callers connected directly to trained mental health professionals with children's crisis competency	Partial	CMCRS	• DoHS reports that WV requires qualifications for licensure and BBH compliance reviews and BBH ensures that the staff working at CCRL and within CMCRS meet the requirements of the statement of work. The University of Connecticut is contracted to train crisis providers.	Provide evidence that: • Providers are fully staffed with trained mental health professionals; and • Transfers are effectively being made to child-specific teams when such a referral is requested by the family/child.

[9] A suggestion is to complete an analysis of reasons for delay in CSED Waiver determination date and service day in only those who took 45+ days.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				• Documentation was provided showing basic information on staff trained, and trainings received between Jan-July 2024. • Updated CCRL desk guide (March 2024) was provided.	
31a	DHHR (now DoHS) shall ensure that all children who are eligible to receive mental and physical health care and services through DHHR are screened to determine if they should be referred for further mental health evaluation or services	Partial	Screening	• The Office of Quality Assurance (OQA) continues to coordinate with Probation Services. • DoHS continues to work with Probation Services to identify trends regarding children involved with Probation Services, the number of screenings expected, and any relationships between the number of monthly intakes and the number of children formally adjudicated as delinquent or status offenders, including analyses on the county-level. Forty-one counties are conducting screenings, which is unchanged	• Continue efforts to understand the population of children not being screened as data capacity and the data store buildout continue. • Continue the continuous quality improvement (CQI) work with individual counties to increase Probation Services screening rates.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				since screening started in March 2022. • A new probation officer training was offered effective April 2024.	
31b	DHHR shall adopt a standardized set of screening tools	Substantial	Screening	N/A	N/A
31c	A mental health screen will be conducted upon entry into state service systems or if the family requests it	Partial	Screening	See Agreement Item 31a.	See Agreement Item 31a.
31d	DHHR shall conduct outreach and training to physicians who serve children that are Medicaid-eligible	Substantial	Outreach & Education	• The percentage of primary care physicians reached by HealthCheck remains at 85% (no change since previous *SAR*). • Additional HealthCheck staff have been hired and a mid-year report will be completed to identify remaining primary care physicians who require outreach.	N/A
31e	52% of Medicaid-eligible children who are not in state service systems shall be screened with a mental health screening tool annually	Partial	Screening	• The current screening rate is 47%. • Increases in screening rates have been noted by the Well-Child Screening Performance	Continue the efforts currently being employed to reach the 52% benchmark.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				Improvement Project (PIP) team in all age groups. • Efforts to improve screening rates for managed care organizations (MCOs) have included outreach to the MCOs and additional work by the BerryDunn Healthy Analytics Practice Group. • The Early Periodic Screening Diagnosis and Treatment (EPSDT) Workgroup is looking at retrospective analyses, case studies, etc., to improve rates. • BBH hosts a monthly meeting for statewide stakeholders regarding EPSDT. • HealthCheck is working with additional staff to ensure all providers receive outreach on screening by the end of 2024.	
32	Established intake/assessment process	Partial	Assessment	• The Assessment Pathway reached 397 referrals in December 2023.	• Continue to enhance the Assessment Pathway processes (backed by CQI) to provide connection to HCBS including interim and CSED Waiver Wraparound Facilitation services

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				• Overall, the total referral rate has declined, as have family-driven referrals. • 83% of children that went through the Assessment Pathway and were approved for CSED Waiver services had a claims-based HCBS following CSED Waiver eligibility determination. • The Assessment Pathway process fully transitioned to Acentra as of July 1, 2024. • Work continues with the OQA to analyze Child and Adolescent Functional Assessment Scale (CAFAS) scores.	and other short- and long-term mental health services, as needed and available. • Continue work to increase family-driven referrals.
33	Statewide access to Wraparound Facilitation through Child and Family Teams (CFTs)	Substantial	Wraparound	• There has been increased utilization of WV Wraparound services since July 2023. As of March 2024, 245 more children were served (1,649 total children enrolled). • As of January 1, 2024, findings indicate more	N/A

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				youth are using Wraparound services compared to residential treatment (nearly double).	
34 (Also see Agreement Item 49f)	Adherence to Wraparound/CFT model fidelity	Partial	Wraparound	• DART fidelity tool elements are included and aligned with procedure and policy across all funding sources. • DoHS is prioritizing and implementing the recommendations found in the *Marshall University Wraparound Fidelity Report*.[10] • The Statewide WV Wraparound Coordinator position was posted/filled during this period. • Training and coaching of Wraparound Facilitators transitioned from Marshall University to the University of	• Ensure progress and implementation of new Performance Improvement Plan Action Log. • Continue uniform messaging of Wraparound Model and principles, i.e., in manuals, policies, etc. and with all partners and providers. • Share ongoing postings/documentation of upcoming and completed Wraparound trainings and attendees.

[10] DoHS has prioritized nine of the recommendations from the *August 2023 Wraparound Fidelity Report* detailed in an action log, including: 1) hiring a WV Statewide Wraparound Program Director; 2) continuing to use standardized evidence-based fidelity tools; 3) supporting effective use of CANS; 4) in the WV CANS system, clarifying date of enrollment definition and importance of demographic information; 5) training Wraparound Facilitators to complete signature sheets; 6) monitoring CANS certifications and notify providers on statuses; 7) addressing CANS timeliness completion with engagement training; 8) Marshall University creating a training video on CANS rating justifications; and 9) Marshall University creating a training video on importance of accuracy in documentation in CANS. Updates on the status of these recommendations is provided to the Wraparound Fidelity and CANS PIP team monthly.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				Connecticut (as of April 2024); recent documentation of trainings was provided (for April – June 2024). • The Safe at Home Policy and Program Manual addresses/outlines Wraparound principles.	
35a	Use of CANS tool to develop individualized service plans (ISP) for youth needing HCBS	Partial	Assessment	To address timeliness and completion of CANS data, DoHS reported provider level reports are being generated monthly and shared with the Wraparound PIP team to share with Wraparound providers.	• Share provider level report findings. • Conduct a case review of a sample of children's CANS and ISPs. See description of the case review methodology on page 2 of this Compliance Analysis.
35b	For children in RMHTF, the individualized service plans will include discharge planning	Substantial	Residential Reduction	94% of youth in RMHTF (including both in-state and out-of-state youth) have discharge plans in place.	N/A
36	DHHR provision of child screenings, assessments, and ISPs to multi-disciplinary teams (MDTs)	Partial	Assessment	New processes were not implemented until July 2023; therefore, data from these reviews would not have allowed time for full implementation or analyses.	Provide documentation and analyses of new processes implemented in July 2023.
37a	Provision of family support services/training	Partial	CSED Waiver	• CSED Waiver service utilization by service type averages from	Conduct a case review of a sample of CSED Waiver participants to review the quality of POCs and whether services provided are then reflective of the

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				July-December 2023 were similar to the previous reporting period (January-June 2023), with a quarter of CSED Waiver families using family support services on average once-per-week. • DoHS provided Aetna training material and review documents used to ensure the quality of CSED Waiver plans of care (POCs). • DoHS demonstrates continued commitment to getting qualitative feedback regarding the child and family's experience with CSED Waiver services by sharing a case example in the *July 2024 SAR*.[11]	POC. See description of the case review methodology on pages 4-5 of this Compliance Analysis. DoHS may be able to conduct this through the existing Aetna process that reviews POCs.
37b	Provision of Behavioral Support Services	Substantial	Behavioral Support Services	N/A	N/A
37c	Provision of in-home therapy	Partial	CSED Waiver	• DoHS reported that 74 % of CSED Waiver participants received	• Conduct a case review of a sample of CSED Waiver participants to review the quality of POCs and whether services provided are then

[11] For the case example provided on page 97 of the *July 2024 SAR*, SME suggests further exploration into how services impact change by asking questions such as, "What aspects of the CSED Waiver program were most helpful/ least helpful? . . . In what way were they helpful/unhelpful?" In this way, DoHS can strategize around program strengths and challenges to better serve families and children.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				family therapy between July-December 2023 (an increase of 5% from January-June 2023), and the average hours of family therapy per month remain at 5 (about once per week). Of note, CSED Waiver participants may receive community-based therapy with a non-CSED Waiver provider if they prefer to do so. • DoHS noted that Chapter 503 states the requirement of using evidence-based practices.[12]	reflective of the POC. See description of the case review methodology on page 2 of this Compliance Analysis. • Report data around the number of CSED Waiver clients receiving community-based therapy by a non-CSED Waiver provider. Include at least one of these clients in the above suggested case review to determine how services/ processes may differ or not. • Provide ongoing data that reflects that intensive services are being delivered to high-need children and families (as completed in the *July 2023 SAR* with figures 40 and 41 looking at the utilization of CSED Waiver services by acuity. With this analysis, SME recommends specifying the number of therapy hours received).
38	Expansion of statewide TFC	Not rated	TFC*	N/A	N/A
39	Availability of ACT statewide and provided to youth 18-20 who need the service.	Substantial	ACT	• DoHS reported the retrospective review process and program level data reviews will continue to be used to indicate and review quality of ACT services.	N/A

[12] A suggestion is to create a resource list of evidence-based practices for the DoHS behavioral health workforce to provide direction around what is considered an evidence-based practice.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				• ACT is a required service in forthcoming CCBHCs.	
40a (Also see Agreement Items 24a and 28)	Timely access to home and community based mental health services	Partial	Wraparound, CMCRS, TFC*, ACT, PBS/Behavioral Support Services	See Agreement Item 28.	See Agreement Item 28.
40b (Also see Agreement Item 24b)	Individualized home and community based mental health services	Partial	ACT, CMCRS, PBS/Behavioral Support Services, TFC*, Wraparound	See Agreement Item 24b.	See Agreement Item 24b.
40c (Also see Agreement Item 24c)	Statewide access to home and community-based services	Substantial	ACT, CMCRS, PBS/Behavioral Support Services, TFC*, Wraparound	N/A	N/A
40d	Provide families and children with accurate, timely, and accessible information regarding available HCBS	Substantial	Outreach & Education	• DoHS released a new Resource Rundown regarding Regional Youth Service Centers in August 2024. • General and targeted outreach events increased in the period of July to December 2023 (as compared	N/A

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				with January to June 2023).[13]	
41a	Implementation Plan: ensure statewide access	Substantial	ACT, CMCRS, CSED Waiver, PBS/Behavioral Support Services, TFC*, Wraparound	N/A	N/A
41b (Also see Agreement Item 29a)	Implementation Plan: evaluate adequacy of crisis response	Substantial	CMCRS	N/A	N/A
41c (Also see Agreement Item 34)	Implementation Plan: evaluate fidelity of Wraparound	Substantial	Wraparound	N/A	N/A
41d	Implementation Plan: address workforce shortages	Substantial	Workforce	DoHS continues to monitor workforce shortages in all relevant professional domains, as reported in each chapter in the *July 2024 SAR*. Some highlights include: • DoHS reported that 23 agencies now provide CSED Waiver services, up from 21 providers reported in	N/A

[13] Note: In subsequent *SARs*, it would be helpful to delineate the outreach events by county to observe trends.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				the previous *SAR*, with over 80 % of WV counties increasing the number of CSED Waiver providers between March 2023-March 2024. • CMCRS staffing has improved to being 93 % fully staffed, up from 80 % reported in the last *SAR*. This increase was attributed to a marketing campaign and updated salary scale.	
41e	Implementation Plan: evaluate provider capacity	Partial	Workforce	• Marshall University is in the final stages of piloting a Wraparound Facilitator caseload and capacity tracking tool, which uses Wraparound Facilitator FTE status and clients' CANS data. This will replace previous efforts to track capacity and is expected to be more accurate and useful. • Regarding the evaluation of provider capacity in other domains: DoHS	• Provide results of Marshall University Wraparound Facilitator caseload and capacity tracking tool. • Continue to report on provider capacity and statewide coverage in each respective profession related to the Agreement.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				reports workforce capacity is discussed on a recurring basis as part of DoHS's CQI processes and are an ongoing part of DoHS's collaboration with providers.	
41f (Also see Agreement Item 31d)	Implementation Plan: develop outreach tools for medical professionals	Substantial (see 31d)	Outreach and Education	N/A	N/A
41g (Also see Agreement Items 48a-c)	Implementation Plan: develop QAPI measures	Substantial	QAPI	N/A	N/A
41h (Also see Agreement Item 52c)	Implementation Plan: achieve RMHTF reduction	Partial	Residential Reduction	The census of youth in RMHTF as of March 2024 was 870.	See Agreement Item 52c.
48a	Analysis of the quality of mental health services	Partial	QAPI	Data analysis has led to a county-level approach for screening and outreach efforts.	• Continue meaningful progress on the use of data to assess child and system level journeys and outcomes. • Continue building and using the data store for deeper child-level, cross-system analysis.
48b	Analysis of Agreement across all child-serving agencies	Partial	QAPI	DoHS has demonstrated greater use of the data store, such as increased use of disaggregation by county and youth characteristics.	
48c	Analysis of data per paragraph 49	Partial	QAPI	DoHS has begun using ESSENCE surveillance data of EDs, which appears to have a shorter	

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				lag time to readiness than Medicaid claims data.	
49	Specification of data to be collected and analyzed	Partial	QAPI	Three more modules have been added to the data store.	• Continue the data store buildout and use it for cross-system, youth-level analysis. • Continue analyzing data by disaggregating at youth and county/region.
50	Quality sampling reviews of Target Population	Partial	QAPI	Evaluation will be directed towards topic-focused data collection with current plans focused on six topic areas as noted elsewhere.	Topic-focused data collection should adhere to quality data collection standards; questions should be appropriate for the populations sampled from; and resulting data should be actionable.
51	Remediation Efforts	Substantial	QAPI	N/A	N/A
52b (Also see Agreement Item 50)	As HCBS expands to new regions, assess strengths/needs of residential placements from regions, identify services children need to return to community, develop a plan to address any barriers	Partial	Residential Reduction	Although the *July 2024 SAR* recognizes that the long-term impacts of the investment in HCBS have not yet been realized in residential reductions, there are several efforts underway to decrease RMHTF placement, including: the WV Intensive Clinical Care Coordination Team's focus on reducing out-of-state placements; Marshall University's efforts to improve the timeliness and completion of standardized assessments that can demonstrate readiness for discharge; and the data-driven work of the Quality Committee to monitor	• Now that CANS/CAFAS completion and timeliness have improved, this data should be used to guide discharge and referrals to HCBS post-discharge. • Given the high rate of re-admission (43% within 12 months), having HCBS in place at the time of discharge that aligns to the intensity and frequency needed at discharge is essential for stabilizing young people in their home and community setting will be important to ameliorate the need for readmission.

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				changes in census by county. In addition, DoHS has proposed new residential models for providers, and the SPA has been drafted (submission to CMS is currently on hold).	
52c	Reduction of unnecessary use of RMHTFs and meet goal; if goal is not met state will assess reasons and create an action plan. With target date of 12/31/24	Partial	Residential Reduction	As noted above, there are several efforts underway with the state and their contracted research partners to improve assessment and discharge planning in RMHTF and increase access and availability to HCBS.	• Continue to use mechanisms like Office Hours to allow providers to offer feedback and collaborate with DoHS on the new residential program models. • Assess foster parent recruitment and marketing efforts in relation to the number of new placement opportunities for youth exiting RMHTF settings. •
52d	As of 12/31/24 all children must have been assessed by a qualified professional to meet their needs	Partial	Assessment	• The QIA process has been centralized at Aetna. • QIA referrals for March 2024 exceeded April 2024 RMHTF admissions (127 referrals compared to only 79 admissions), a positive finding, reflecting efforts to refer and assess children for appropriate levels of care. • For referral cases that are expedited, the	• As the new models of care for residential placements are operationalized, provide documentation that they are serving youth in settings appropriate to their needs. • Continue efforts to ensure that children are not admitted to RMHTFs unless they are assessed to have a clinical need for such a setting (i.e. through the QIA) Continue efforts to use the Automated Placement Referral (APR) metric to gauge how much opportunity counties have for diversion from RMHTF. • Continue to assess youth in RMHTF settings for readiness for discharge in a timely manner,

Agreement Item	Agreement Item Intent	Compliance Rating	Compliance Rating supported by Progress in Subject Areas	Progress Since Previous Report	Evidence/Progress Needed to Achieve Substantial Compliance
				timeline from referral to assessment is 14 days, compared to 30 days for regular cases. • Social service managers in each county receive monthly reports to help with CQI. • 47% of WV counties met or exceeded expectations for referral practices in March 2024, with 15 counties not meeting expected referral numbers; this is a decrease since the last comparison period. • Acentra is working to monitor timeliness and address barriers.	
54	Develop Outreach & Education Plan for Stakeholders	Substantial	Outreach & Education	N/A	N/A

* Per a decision with DoHS/DOJ, TFC is not currently being rated for compliance.

3. Appendices

APPENDIX A

New Documents/Evidence Received through September 2024

Document Name	Subject-Compliance Area
No specific documents sent	*ACT*
Aetna Agency Plan of Care (POC) Training	Assessment
BBH – CMH – Children's Wraparound – Final rev	Assessment
Final FY25 LCA Contract and Appendix	Assessment
Final Initial POC Review Guide	Assessment
Final POC Review Checklist for Providers Updated 4.01.2024	Assessment
Safe at Home Updated Manual (March 2024)	Assessment
Safe at Home Updated Policy (May 24, 2024)	Assessment
Adult Child Mobile Crisis Map 07.09.2024	CMCRS
WV MRSS Training Participants Jan 2024 – July 2024	CMCRS
Youth Only Mobile Crisis Map 07.09.2024	CMCRS
Final CMCRS Manual 20240312	CMCRS
CCRL Referral Desk Guide FINAL rev20240326	CMCRS
Aetna Agency Plan of Care (POC) Training	CSED Waiver
Kids Thrive Collaborative (KTC) – 9.5.24 Quarterly Meeting Agenda & PowerPoint	General
KTC – 9.5.24 Aetna Mountain Health Promise PowerPoint	General
KTC – 9.5.24 WVU Medicine PowerPoint (Partial Hospitalization)	General
KTC – 9.5.24 WVU Health Affairs- Children's In-Home & Community Based Services Improvement Project Evaluation PowerPoint	General
DoHS Response to SME Recommendations FINAL 20240731	General
5.2.2024 WV Thrive Collaborative Linkshttps://www.wefosterwv.org/	General
20231207 Notes Kids Thrive Collaborative	General
20240502_Agenda Kids Thrive Collaborative	General
No specific documents sent	*Outreach &Education*
Concord University Training	PBS/Behavioral Support Services
Addendum to January 2024 Quality and Outcomes Report_4_30_2024	QAPI

Document Name	Subject-Compliance Area
July 2024 DoHS Semi-Annual Report_FINAL	QAPI
QAPI-CQI Data Store Buildout Timeline Projection Jul 2024 Update	QAPI
System Engagement Dashboard Screenshots 07262024	QAPI
August 2024 Quality Committee Final & Review Reference Document	QAPI
KTC (9.5.24) – July 2024 Semi-Annual Report Summary	QAPI
Latent Class Analysis Supplemental Class Data-Final-03-29-2024	R3
Office Hours Notes Jan-June 2024	R3
Detailed Discharge Plan – Final – 06-21-2023	R3
OSA Grant Agreement – G231014	R3
West Virginia Intensive Clinical Care Coordination Team SOW 2024-2025	R3
WVICCC Quarterly Report – 04-29-2024	R3
No specific documents sent	*Target Population*
No specific documents sent	*Therapeutic Foster Care*
MCO Screening Outreach	Screening
EPSDT Workgroup Meeting 7.24.24 Notes	Screening
No specific documents sent	*Workforce*
Wraparound Fidelity PIP Team Prioritized Recommendations Action Log	Wraparound
WV Engagement in the Wrap Process May 30 2024	Wraparound
WV Introduction to Wrap April-23-25 2024	Wraparound
WV Engagement in the Wrap Process May 30 2024	Wraparound
WV Introduction to Wrap April-23-25 2024	Wraparound
Safe at Home Updated Manual (March 2024)	Wraparound
Safe at Home Updated Policy (May 24, 2024)	Wraparound

APPENDIX B

Virtual Contacts with West Virginia DoHS Team and the Department of Justice
Review Meeting Period May - September 2024

Meetings With:	**Dates**
DOJ	5/25/24, 6/28/24, 9/18/24
Semi-Annual Parties Meeting	7/10/24
Kids Thrive Collaborative & Commission to Study Residential Placement	5/2/24, 9/5/24

APPENDIX C

SME Compliance Rating Criteria

COMPLIANCE CRITERIA	
CATEGORY	**CRITERIA**
Substantial Compliance	1. Has undertaken and completed the requirements of the paragraph; no further activity needed OR 2. Has undertaken and completed the requirements of the paragraph--met with updates continuing to occur.
Partial Compliance	1. Compliance has been achieved on some of the components of the assessed paragraph or section of the agreement, but significant work remains; 2. Has developed deliverables that indicate the state is actively addressing the requirements of the paragraph; 3. Has provided data that indicates the State is actively addressing the requirements of the paragraph; 4. Has implemented activity and has yet to validate effectiveness; 5. Has implemented activity but has not developed procedures to assess the effectiveness of the service or has not taken adequate measures to ensure its sustainability after the agreement terminates; 6. Has begun activities but not completed implementation activities.
Non-Compliance	1. Non-compliance indicates that most or all of the components of the assessed paragraph or section of the Agreement have not been met; 2. Has made little or no progress to meet the targets set forth in the Agreement, Implementation Plan or other plans; 3. Has done no work to meet the date as set forth in the paragraph of the Agreement. 4. Has not provided data or access to staff so that the Subject Matter Expert may properly assess compliance.
Not Rated	Not Rated indicates a paragraph or section of the agreement where the parties have agreed that the Subject Matter Expert shall not rate the State's compliance during the assessment period.
NOTE: All criteria are applied specific to the time period reviewed. For example, a rating of partial compliance in one report period would not necessarily continue to be rated as partially compliant if there is no continued evidence of progress. A rating of substantial compliance in one report period would not continue to be rated as substantially compliant if achievements were not maintained.	

SUPPORTING DOCUMENTATION

The SME will rely on written information, and data from the Quality Assurance and Performance Improvement (QAPI) System and the quality sample reviews of children, provided by the State in order to arrive at its evaluation. Deriving compliance from written document has limitations as even the best-intentioned policies do not succeed or fail on their own merits; their progress is dependent upon the processes of implementation. Noting this limitation, the SME's determination of substantial compliance will rely on data from the QAPI and the quality sample reviews of children, and implementation of the State's continuous quality improvement plan in which the State implements changes to policies, procedures, practices, regulations and other relevant State guidance and activities based on trends in QAPI data.

Information reviewed will include, but is not limited to:
1. Standard Operating Procedures and Contracts – contract requirements, policies and related documents such as service descriptions; admissions, continuing stay, medical necessity, and discharge criteria; provider bulletins, communications with providers, manuals, and transmittals; billing and reporting requirements and manuals; staffing requirements; and documentation requirements, meetings with providers and interested/affected groups.

2. Training - initial and continuing training requirements for services, supports, and staffing; training curricula, including seat-time and competency-based requirements; training specificity (i.e., is the training sufficient to deliver to the service in a manner that is likely accomplish Agreement goals); and training evaluation practices.

3. Oversight and Monitoring - identification of measures and operational objectives; selection and validation of performance measures, benchmarks, and targets for improvement over time; use of measurement and analysis to identify relative areas of success and weakness; measurement of community partners and family engagement (e.g., survey instruments, focus groups, independent observation, etc.); case reviews with attached methodology (e.g., random sampling, statistical sampling, etc.); performance improvement plans; audits and auditing procedures.

4. Data-driven Quality Improvement - Planning, implementation, and regular use of well documented, structured, iterative processes for reviewing data from #3, above, to drive continuous quality improvement; goal setting, looking at the actual data for performance measures, and acting on results.