

CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Reporting Period: January 2023 – June 2023

Trend Review Period: January 2022 – June 2023

When kids and families thrive, West Virginia thrives.



Office of Quality Assurance for
Children's Programs

Laura Hunt, Director
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1.0 Executive Summary

In February 2023, the West Virginia Senate passed House Bill 2006, dividing the West Virginia Department of Health and Human Resources (DHHR) into three agencies. The WV Department of Health, WV Department of Human Services, and WV Department of Health Facilities became effective on January 1, 2024. The Office of Quality Assurance for Children's Programs now operates under the WV Department of Human Services (DoHS).¹ Given the bureaus primarily involved in this work, this report will refer to DoHS for time periods before and after the transition.

DoHS continues diligent efforts to reform mental and behavioral health services for children with serious emotional disorders (SED) and their families across WV. Since 2019, DoHS, in collaboration with various community partners and stakeholders, has built on the existing system frameworks and established new processes and pathways 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, DoHS implemented the Assessment Pathway,² creating a "no wrong door" approach to streamline and facilitate access to assessment and connection to home and community-based services (HCBS) for children and families. As part of this process, children and families are assessed for and given the option of applying for the Children with Serious Emotional Disorder (CSED) Waiver, which offers treatment and supportive services in the home and community-based setting, and includes Wraparound Facilitation services for children with SED. The Assessment Pathway also offers families the opportunity to connect with other HCBS such as Behavioral Support Services, Assertive Community Treatment (ACT), and other locally available services to meet their needs. These significant enhancements over the past several years to the children's mental health system remain in the implementation and monitoring phase as DoHS assesses the efficacy of this system through continuous quality improvement (CQI) efforts.

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

¹ Appendix A contains a glossary of acronyms and abbreviations used throughout the report.

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

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 DoHS’s ongoing, collaborative quality reviews and recommended next steps based primarily on service data for the period January 2023 to June 2023, including utilization trends for the period January 2022 to June 2023, with some exceptions for newly implemented services.

Summary of Key Highlights

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

Data Collection and Reporting

- In the last 12 months, DoHS has spent considerable time enhancing data collection tools to allow data capture at the child-level, reviewing data for opportunities to enhance data quality, and fine-tuning key indicators. DoHS also worked extensively with key partners, such as Aetna³ and Acentra Health⁴, to make enhancements to their data collection systems for improved reporting. Given these efforts, future reporting is expected to be improved to provide more detail and insight into CQI and strategic planning efforts.
 - Significant progress was made on the build-out of the data store throughout 2023. Child-level data matching is currently in place for the following datasets in the data store: RMHTF services, CSED eligibility, CSED utilization, RMHTF CAFAS/PECFAS score⁵ history, and Child and Adolescent Needs and Strengths (CANS) case history (i.e., case service-level completion and timeliness). Based on this progress, additional cross-systems analyses at the child-level are included in this report.
 - Data quality and completion also remain a focus, including several efforts to improve and expand data collection mechanisms.

³ Aetna is one of the Managed Care Organizations under Mountain Health Trust. Aetna is primarily responsible for children in foster care, adopted, and those on the CSED Waiver.

⁴ Acentra Health is the Administrative Services Organization for DoHS helping manage applications to the CSED Waiver, the Qualified Independent Assessment process, among other tasks.

⁵ CAFAS/PECFAS assessment is used as part of the determination of functional impairment that substantially interferes with or limits a child’s role or results in impacted functioning in the family, school, and/or community activities. CAFAS/PECFAS score is one measure of a child’s appropriateness for placement in a residential setting and is currently being used to identify children for prioritized discharge planning.

Marketing and Outreach

- Outreach efforts have continued with a county-level focus to help with public awareness, including accessibility and expansion of education and collaboration with key stakeholders such as the judicial community, West Virginia Department of Education (WVDE), and community providers.
 - CCRL wallet cards have continued to be distributed to grantees and have had positive feedback as evidenced by requests for more cards.
 - DoHS's Bureau for Medical Services (BMS) produced an extensive array of outreach materials and distributed them statewide in December 2023. Resource kits were sent to schools and community organizations (as well as emergency departments and others), including CSED Waiver posters, window clings, magnets, stickers, and wallet cards. Community and school personnel guides were distributed as well. These materials included information about the CCRL. Nearly 1,000 resource kits were sent across the state.
 - Utilization of the CCRL section of the Help4WV website doubled from 14,360 visits from January to June 2023 compared to 7,633 in July to December 2022 (41% of overall website visits).
 - Collaboration between BSS, Mission WV, and child-placing agencies (CPAs) has focused on increasing recruitment of foster homes for older youth with complex needs. The "West Virginia Needs You Now" campaign is currently in production and is expected to go live in early 2024.

WV's Child Population and Individuals Utilizing Services

- In 2022, 11% (n = 43,732) of youth who were members of WV Medicaid/CHIP had a claim that included a SED diagnosis. These youth represent a larger population of children who may need additional mental and behavioral health services, compared to the smaller population of children with additional risk factors that place them at more imminent risk for residential placement.
 - Of the 43,732 youth identified with an SED diagnosis in 2022, 16% (n = 6,811) met the criteria of being at-risk for residential placement. In addition to an SED, these youth were identified as having a CAFAS score greater than or equal to 90 (indicating higher acuity related to functional need) and/or having a crisis-level event⁶ in the past 90 days.
 - An SED diagnosis is only one component of risk and may not be reflective of immediate or unmanaged needs. DoHS aims to prevent out-of-home placement by providing avenues for children to receive services in their homes and communities. Intensity of needs can vary from child to child and can even vary over time for an individual child based on their environment and other factors influencing their mental health needs.

⁶ A crisis-level event is defined as: acute psychiatric care hospital stay, ED visit for psychiatric episode, Mobile Crisis Response incidence, or CPS/YS involvement resulting in the child going into state's custody.

- DoHS is expanding reporting to further evaluate the services and outcomes for children identified as being at risk for residential placement and evaluating the at-risk population in comparison to other populations. Some initial analyses and comparisons are included in this report.
- 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, CSED Waiver services, CMCRS, and Behavioral Support Services, as well as the Assessment Pathway to access these services, reached a greater proportion of children in age categories five to eight and nine to 12 compared to children in RMHTFs, who skewed older.
 - Over 50% of children served through CMCRS and the CSED Waiver were in the age range of 13 to 17, indicating a key demographic overlap and an opportunity for diversion from inappropriate use of RMHTF settings.
 - The shift toward younger-age categorizations for community-based programs was identified as a potential early-intervention opportunity for those individuals who may have current or potential risk for placement in an RMHTF. Although this is a positive finding about early intervention, it may take several years to see the full impact on RMHTF services utilization for children in these age ranges.
 - Most youth in RMHTF settings were in the 13 to 17 age group (82%). In review of this subpopulation of youth in an RMHTF with their most recent CAFAS/PECFAS score being less than 90, the age distribution shifted older (with 6% of transitional age youth 18 to 20 in this subpopulation compared to only 1% in the total RMHTF population), indicating the need for more community-based transitional living options for this age group.

Partner Evaluations

- DoHS has contracted with Marshall University to assess fidelity for WV Wraparound and with West Virginia University (WVU) to provide an overall evaluation of the children's HCBS system.
 - While additional findings and strategies will be provided in an addendum to this report in spring 2024, early review of the CMH Evaluation draft report identified a high level of awareness of Wraparound services (40% of community-based caregivers) and positive associations with utilization of Wraparound services, with 76% of community-based caregivers indicating they believed the services helped avoid or delay the need for residential placement.
 - Attributable to the robust and streamlined pathway built out for families, additional analysis from the CMH Evaluation found 86% of community-based caregivers who were aware of Wraparound services reported no barriers related

to understanding how to navigate getting mental health services for their child, a statistically significant finding.

- According to the CMH Evaluation, families reported greatest awareness of Behavioral Support Services.

Screening

- Wellness screenings through HealthCheck are a key focus of DoHS's work to help ensure children are meeting developmental milestones and are receiving and being connected to important preventative and early-intervention services. The EPSDT/HealthCheck Performance Improvement Project (PIP) team continued to meet throughout this period to review and address low screening rates.
 - In 2022, WV had 113,191 Medicaid members aged 0-20⁷ who received HealthCheck (EPSDT) screening during well-child visits. This represents 47% of Medicaid-eligible children (n=239,987). An estimated 38.9% of Medicaid-eligible children received an EPSDT with mental health screening.
 - Overall EPSDT screenings have increased from 46.4% in 2021 to 47.2% in 2022, while the proportion of these screenings including a mental health component have gone down slightly (83.3% to 82.5%, respectively), similar to the rate in 2019.
 - While screening rates in 2022 did not meet the goal of at least 52% of Medicaid-eligible children receiving an EPSDT with a mental health screening, numerous efforts have been expanded in 2022 and 2023 to help improve the rate, resulting in slight increases in screening rates in 2022 (2023 numbers not yet available). Some examples of expanded initiatives included provider training and technical assistance through the WV HealthCheck program and integrated outreach strategy planning with WVDE and the MCOs.
- Results analyzing the number of screenings versus intakes for BJS (Bureau for Juvenile Services) facilities for August and September 2023 indicate 95% of children entering BJS are screened at intake—excluding a facility noted that has undergone significant staffing shortages. This is a positive sign that screenings are being completed as expected at most BJS facilities.
 - Consistent rates of positive screenings above 80% illustrate the importance of seeking earlier intervention for children involved with BJS and the potential positive impact that connecting this population with services before entering BJS could have on their outcomes.
- In September 2023, DoHS facilitated two full-day workshops between Bureau for Social Services (BSS) staff and Probation Services representatives in an effort to improve understanding of the need for connection to mental health services, increase Probation

⁷ Medicaid members aged 0-20 with at least 90 days of consecutive eligibility

Services screening rates, and raise awareness of the Assessment Pathway and available services for Probation Services teams.

- As of October 2023, 41 of WV's 55 counties have reported screenings at some point since inception of the Probation Services screening processes in March 2022.
- Of the Probation Services mental health screenings that occurred between March 2022 and June 2023, 250 (40.7%) were positive, with consideration to the high positivity rate compared to the general Medicaid population with SED, this finding further suggests the importance of early intervention and screening with Probation-involved youth.
- Of children in foster care from January 2022 to June 2023, 93% were screened via a wellness visit within one year of initial placement. Provider workforce is an important consideration to maintaining and expanding supports and referrals for children in the child welfare system.
 - As of October 2023, more than 6,000 children were in the child welfare system with 84% of child welfare workforce positions filled, which includes CPS and YS workers, supervisors, and coordinators. This is an increase from 80% of positions filled in May 2023.
 - As of November 30, 2023, there were 79 vacant CPS Worker positions out of 458, marking a more than 47% vacancy reduction from the previous year, which saw 150 vacant CPS worker positions, out of 455 on November 30, 2022. Youth Services Worker positions also saw an 80% vacancy reduction with nine vacant positions out of 124, compared to 45 vacant positions out of 127 from the previous year.
 - Improvements in vacancy rates have been largely attributed to recruitment efforts that began in mid-December 2022 that authorized hiring bonuses for several positions in key areas of the state, retention bonuses for years of continued service, and additional positions added to the workforce to support staff. These incentives likely contributed to the increases in positions filled. While workforce recruitment and retention continue to be a challenge, positions filled have increased 9% from the previous year.

Children's Crisis and Referral Line (CCRL)

- There were 771 total calls in January to June 2023, a 25% increase over the previous reporting period (617 calls from July to December 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.
 - At least one individual from 48 of WV's 55 counties called the CCRL January to June 2023, up from 46 during the prior reporting period.

- Of providers who responded to the CMH Evaluation, 85% were aware of the CCRL, compared to 66% at baseline (2022).
- The number of calls from a loved one was far greater than any other source, 43% of calls (n = 333).
- The percentage of calls made by the children themselves increased from 11% during July to December 2022 to 18% (n = 142) in this reporting period.
 - These calls were more likely to be made by chat or text compared to calls from other sources. Over half (n = 66, 52% of calls with non-missing age data) of these calls were received from a child aged 13 to 17.
- From the first half of 2022 to the first half of 2023, calls from community partners/professionals on behalf of families increased from 21% to 36% of all calls. This finding is likely associated with efforts to increase provider and partner awareness of the CCRL and related services.
- Mental health/social service professionals, representing 23% of the source of all referrals, were the second most common referral source, a significant change since the implementation of the Assessment Pathway, when only 11% of calls were the result of referral from mental health/social service professionals. This finding is also likely associated with efforts to increase provider and partner awareness.

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

- CMCRS service utilization increased 64% from the second half of 2022 (357 children receiving services) to the first half of 2023 (587).⁸
 - Upon review of call utilization practices, for children with known call information (n=317), 75% of children utilizing CMCRS services appeared to have their needs met within one call, the same rate observed from July to December 2022. For the remaining children, additional needs were met through multiple interactions.
 - Nearly half of crisis responses with a known response type were completed in-person (45%), excluding follow-ups initiated by the provider and children with missing data. This is a notable shift from the prior reporting period, July to December 2022, with only 26% of responses being reported as in-person.

⁸ A small change in the methodology used to analyze CMCRS data was made from the July 2023 edition of the Quality and Outcomes Report to this January 2024 edition. Previously, due to data quality issues surrounding data submission timelines, a small number of children were identified as "utilizing services" during a time period in which they had actually discharged. The new methodology properly identifies service utilization time frames based on enrollment and discharge dates rather than data submission dates. For consistency, the new methodology was applied to CY 2022 data presented in this report. Thus, data for CY 2022 in this report is not directly comparable to the same time period in prior reports due to this slight change in methodology.

- Given low referral rates to the Assessment Pathway from CMCRS providers (3%), the Quality Committee noted a key next step is ensuring CMCRS providers provide timely referrals to address longer-term needs.

Assessment Pathway, WV Wraparound, and CSED Waiver Services

- The Assessment Pathway offers multiple entry points for families, providers, and advocates to refer children and families to key HCBS, including WV Wraparound. From January to June 2023, 1,417 unique children were referred to be assessed and connected to HCBS. This is a 35% increase from the previous six-month period (July-December 2022), during which 1,046 children were referred.
 - The Quality Committee reviewed county-level referral rates and percent change to assess opportunities for outreach and education (which includes technical assistance and process improvement). In addition to reviewing these maps, DoHS conducted in-depth reviews at the county-level, including reviews of other related maps. Understanding relationships between approval rates, referral rates, RMHTF admission rates, and proportion of the population at-risk is helping the Quality Committee implement a more informed and data-driven approach to marketing and education needs.
 - Education and technical assistance provided to child welfare workers has continued to influence referral rates positively, as counties where technical assistance has been provided often showed increases in referral rates. Many counties with decreases in referral rates were determined to be appropriate as technical assistance had been conducted with many of these counties where “blanket” referrals were being completed without standard screening.
 - Only two counties did not submit a referral during the last half of 2022: Pendleton and Tucker counties; however, in the first six months of 2023, a referral was received for at least one child in all 55 counties. The 35% average increase highlights the extensive work being completed to expand awareness across the state.
- In the first half of 2023, 1,313 CSED Waiver applications were processed compared to the second half of 2022 at 976 applications, an increase of 34.5%. (Note: CSED Waiver applications are a subset of total Assessment Pathway referrals.)
 - Approved applications increased slightly from 62.4% to 64.8%, lending to the immense efforts to reinforce appropriate screening and referrals.
 - DoHS completed further analysis of applications closed from January to June 2023 to better understand the point reached by families before the application was closed. Applications are closed when requested by the applicant, consistent lack of response to follow-up, or if the most recent CAFAS/PECFAS score is less than 90. Findings indicated nearly half (48.5%) of applications closed never reached the point of receiving a CAFAS/PECFAS score, with only one-fifth (22%) of closed referrals being closed for not meeting

CAFAS/PECFAS score-related criteria.

- Children with CAFAS/PECFAS scores⁹ greater than 90 remained consistent between the second half of 2022 and the first half of 2023 at 92%, indicating that children are being referred appropriately.
- Referral to the Assessment Pathway continues to be an opportunity to connect children with other services even if they do not qualify for CSED Waiver services, specifically.
- Despite growth in the number of families seeking CSED Waiver eligibility determination, timeliness from referral to eligibility determination has improved over the past year.
 - Over the last three quarters (Q4 2022 through Q2 2023), the average and median timeline to determination for CSED Waiver services has remained consistent, with the most recent available quarter reflecting an average of 36 days and a median time frame of 32 days to determination.
 - DoHS continues to examine these timelines in summary and stepwise to determine opportunities to improve and maintain timeliness for families. Additional information and a more comprehensive view of this journey, including the timeline to service start, is anticipated for the July 2024 edition of this report.
- The number of children using CSED Waiver services increased 36% in the first half of 2023 with 810 children receiving services during the period compared to 597 children in the second half of 2022. More children are being supported in the community with these critical services.
- A total of 742 children accessed Wraparound Facilitation services through CSED in the first half of 2023, compared to 573 unique children in the second half of 2022, representing a 29% increase in children accessing Wraparound Facilitation services.
- Notably, 42 of West Virginia's 55 counties increased the number of providers offering CSED Waiver services between March and November 2023.

Behavioral Support Services

- 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 (delayed to spring/summer 2024; BMS is continuing efforts to gain CMS approval and complete associated standard processes).
- Concord University has certified 48 providers on the new Behavioral Support Services provider certification since inception, as of their September 2023 report.
 - Training will be conducted three times per year moving forward and will include time for cohorts to receive mentoring post-training.

⁹ Of children with a CAFAS/PECFAS score recorded.

Community-Based Placement Capacity

- As of October 2023, a rate increase took effect for CPAs and socially necessary service providers—a 10% and 30% increase, respectively¹⁰. Additional rate increases are being explored as a potential proposal for state Fiscal Year 2025.
 - Increases to these provider rates are intended to assist with foster family recruitment, provide the additional supports necessary to maintain children within a stable foster family placement, and facilitate reunification with biological families when appropriate.
 - The tiered foster care model allows a child to remain in a placement even if their needs fluctuate by increasing supports to the child and family if needs increase, thus proactively diverting the child from an RMHTF placement when it remains clinically appropriate.
- The ratio of foster homes closed to opened has increased over the past year with 653 homes closing and only 566 homes opening from Q3 2022 to Q3 2023 resulting in an overall decrease in the number of foster homes available.
 - 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.
 - In 2023, a study was conducted by Marshall University at the request of DoHS, 526 WV foster care families, which included relatives and kinship caregivers, were surveyed to provide an opportunity for foster parents and caregivers to celebrate strengths and give voice to areas for improvement that could better support the children in their care. Themes of this survey identified a need for more behavioral health services, improved communication, increased financial support, and additional training or awareness on available resources.
 - In August 2023, a press release was issued reminding WV foster families of available resources that may address these needs.¹¹
- On average, the percentage of licensed families retained over two years has stabilized over the past 12 months. From July to September 2023, the average percentage of families that had been retained for over two years was 48%, despite the number of total licensed foster homes decreasing over this period.
 - This sustained retention is likely largely influenced by nurturing strong relationships, additional focus, and continued strategic planning placed on retention due to feedback from foster parents and the CPAs who work with

¹⁰ <https://dhhr.wv.gov/News/2023/Pages/Gov.-Justice-Approves-dhhr-Rate-Increase-for-Child-Placing-Agencies-and-Socially-Necessary-Services-Providers.aspx>

¹¹ <https://dhhr.wv.gov/News/2023/Pages/dhhr-Reminds-Residents-of-Resources-for-Foster-Care-Families.aspx>

them that began in July 2021.

- Only one-quarter (25%) of certified foster families are willing to accept a teenage child for placement.
 - The state average ratio of placements thirteen and older to homes willing to accept youth in this age group was 0.9, indicating a ratio of one home for every teen placed in foster homes at the state-level. If teens placed in shelters are added to this ratio, the ratio goes up to 1.2 statewide. Teens comprise 24% of children in foster and shelter placements. These ratios are inadequate to meet placement needs, especially given considerations of foster parent autonomy to decline placements.
 - Several counties have more limitations on homes available for teens, with higher relative need compared to other counties in the state, ranging between a ratio of 1.5 to 6 placements per home. This essentially means, setting autonomy aside for review/analytical simplicity only, the number of certified homes available in these counties would require two to six youth aged 13 and older to be placed in each home.
 - The extreme variation in willingness of foster homes families to accept a given placement, compounded by the challenges of multiple placements in one home, highlights the need to focus on increasing the number of foster homes willing to accept teenagers. A list of counties categorized as having higher relative need across key indicators is included in Section 14 (Community-Based Capacity).
 - The conversion to Aetna's Quickbase system for discharge planning (implemented in late 2023) will enable expanded analysis to identify commonalities, such as diagnoses and demographics, for children in shelter or RMHTF settings with a need for a community-based placement to discharge. This level of data is expected to assist with recruiting and developing foster homes to support youth with complex needs.
- WV continues to have one of the greatest rates in the nation of placement with kinship families at 55% of child welfare placements.
- DoHS continues to increase the availability of community-based services, including the recent addition of community-based transitional living for vulnerable youth (TLVY) homes specifically designed to support youth ages 17 – 21. These homes were operationalized in September 2023 and can support a total of up to 22 youth.
- Throughout 2023, DoHS made significant progress on the new RMHTF models of care (expected to go into effect mid 2024) to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs.
 - The new model of care will include an updated rate structure and emphasize use of the least-restrictive setting based on the intensity of the child's needs.
 - The new structure will replace the current residential levels of care with the

following: residential homes, specialized residential intensive treatment facilities (SRIT), and residential intensive treatment facilities (RIT), with emergency shelters and Psychiatric Residential Treatment Facilities (PRTFs) remaining in place as with the previous structure.

Prioritized Discharge Planning

- Significant progress has been made in putting discharge plans in place for youth with a CAFAS <90, including discharge plans continuing to be in place for greater than 95% of children in placement.
- Lack of community-based placement options continues to be a primary barrier to discharging children who are currently in residential placements.
- To understand how long youth with CAFAS/PECFAS scores less than 90¹² remain in placement, the timeline from the score date to the discharge date was calculated for 198 children in RMHTF placement who had a CAFAS/PECFAS score less than 90 at some point between July and December 2022 and whose score remained below 90 until discharge.
 - 40% (n = 79) of these youth were discharged within 90 days of having a CAFAS/PECFAS below 90.
 - 27% (n = 54) remained in placement for at least 180 additional days (approximately six months) before discharge.
 - Furthermore, 14% (n = 27) of youth who had a CAFAS/PECFAS score less than 90 in the period of July – December 2022 had not been discharged as of October 2023.
 - DoHS recognizes that children with CAFAS/PECFAS less than 90 may be lingering in placement. While these results do not align with DoHS' goal of timely discharge, this new baseline data gives DoHS and its partners a starting foundation and further emphasizes the need to capture and understand the barriers that are preventing discharge.
- The primary barriers to discharge reported for children in the prioritized discharge planning population as of December 31, 2022, with CAFAS/PECFAS less than 90 are as follows, differentiated by discharges or active status as of October 2023.
 - The highest proportion of both children active in placement and discharged had a discharge plan in place without any barrier to discharge at the time of analysis (70%).
 - Children that had been able to be discharged were more likely to be indicated

¹² A CAFAS/PECFAS score between 50 and 90 indicates that the child needs additional services beyond outpatient care but may receive the necessary care in their home/community. Once a child has a score less than or equal to 90, there should be plans to discharge to the community.

as “child has no discharge barriers; plan is in place, and actively moving forward”, as would be expected (83%); whereas only 53% of children in active placements had no barriers listed.

- Very few children (4% of all placements) had the barrier “discharge plan not adequate or not in place,” indicative of efforts to ensure discharge plans are in place for all youth.
- Twenty percent (20%, n = 13) of children with active placements did not have a community-based placement available, compared to only 2% of children that have been discharged.

RMHTF Services

- Sharing and reviewing comparison maps of Qualified Independent Assessment (QIA)¹³ referrals to RMHTF admissions have helped increase opportunities for diversion, with QIA referrals for October exceeding November RMHTF admissions (126 referrals compared to 80 admissions). Additional quality improvement efforts to enhance this newly implemented process include weekly data reviews and timely response escalation processes, as outlined in Section 9 (QIA) of this report.
- The overall statewide average change for RMHTF unduplicated headcount per 1,000 youth between January to June 2022 and January to June 2023 was a slight increase of 3.9%. The statewide average placement rate was relatively stable for the two periods, 3.1 for January to June 2022 and 3.2 for January to June 2023.
 - Twelve counties had an increase of greater than or equal to 25% between the two periods, while seven counties had greater than or equal to a -25% decrease. The remaining counties had sustained rates, except for six counties that were excluded due to having a headcount of less than five in January to June 2023. Of note, many counties in West Virginia are rural with smaller child populations; therefore, small changes in headcounts can significantly influence changes in rates.
- There was an increase in the monthly point-in-time RMHTF census from a low of 772 on January 1, 2023, to 889 active placements on May 1, 2023. Point-in-time census numbers remained relatively stable from May to September 2023, then began declining slightly. Point-in-time census was 872 as of December 1, 2023 and 846 as of January 1, 2024. The census from October 2023 to January 2024 is considered preliminary and

¹³ 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. A CAFAS/PECFAS and CANS assessment, including the CANS Decision Support Model, will be utilized for the QIA. A CSWD Waiver application will be submitted concurrently if one has not already been submitted. The QIA will identify the child's needs and recommend the appropriate level of intervention and least-restrictive service setting to meet those needs.

may be subject to change due to data entry lag considerations.

- The increase in census in the first half of 2023 was driven by increases in both in-state and out-of-state census, although out-of-state demand was higher with an increase of 68 children from January 1, 2023 to May 1, 2023, compared to an increase of 49 children in-state. The typical decrease in census over the summer months (which is related to school not being in session) was not observed in summer 2023.
- The increase in census noted in the first half of 2023 is mostly driven by the increase in admissions rather than by a decrease in discharges.
- DoHS recognizes that transitioning to the new residential model of care with expected shorter lengths of stay combined with development of increased community-based placement capacity are needed to materially impact the demand for RMHTF services.
- While some fluctuation is noted for both group RMHTF and PRTF length of stays across the six-month periods, group RMHTF shows an overall decrease in median length of stay with 209 days as the median for the first half of 2023, a decrease of 26 days, compared to the first half of 2022 (235 days). These results are a positive indicator of the focused efforts on discharge planning.
- In-state median RMHTF length of stay has remained relatively stable for the period shown (157 days, median length of stay as of Q3 2023), while out-of-state length of stay shows a consistent decrease throughout the period (183 days, median length of stay as of Q3 2023 compared to 225 days in the same period of the previous year [Q3 2022]).
 - DoHS contracted with Marshall University in April 2023 to focus on discharge planning for children in out-of-state placement. An increase in the number of discharges per quarter is observed following this focused effort to return children to their local communities in West Virginia.
- DoHS identified a cohort of children who were discharged from an RMHTF and aged nine and older at discharge in the period January to June 2022 (n = 531)¹⁴ and completed an analysis of the 12 months following discharge to determine if they were readmitted to an RMHTF. Thirty percent (30%, n=160) of these children were readmitted to a residential placement following discharge to the community. Youth ages 13 to 17, which comprised the largest proportion of youth readmitted, showed a readmission rate of 38% within a one-year period.
- As an initial step to evaluating the appropriateness of admissions to RMHTFs, DoHS completed a preliminary analysis of RMHTF admissions in Q2 2023 with admission CAFAS/PECFAS scores reported (153 children). Twenty-one children (14% of Q2 2023

¹⁴ Children aged less than 9 were excluded from this analysis because fewer than 10 children in this age group were discharged during January to June 2022.

admissions) entered placement with a CAFAS/PECFAS score less than 90 (typically associated with a lower acuity of need).

- Based on a review of this data, the Quality Review Committee discussed some continued challenges and misunderstandings associated with the full adoption of the QIA process as well as opportunities for further education to prevent inappropriate admissions.
- As of January 5, 2024, reporting from Marshall University, CANS assessments were completed for 222 of 333 children (67%) in active out-of-state placement in December 2023. CAFAS assessments were completed for 179 children (54%), and discharge plans were completed for 114 children (34%). Marshall University and BSS continue to partner to address any barriers to completing these critical assessments. CANS and CAFAS assessments are projected to be completed for all children in active out-of-state placement by January 31, 2024. Marshall University is developing a plan and timeline for completing discharge plans for the remaining children in out-of-state placement.

Outcomes

- According to data from the WVDE, while most incidents each school year were classified as “minimally disruptive” behaviors (62% in the 2021-2022 school year and 56% in the 2022-2023 school year), there was an increase in both “disruptive and potentially harmful” and “imminently dangerous, illegal, or aggressive” behaviors in the 2022 to 2023 school year (38% to 44% of total behaviors), implying the proportion of behavior incidents reported has become more intense or more dangerous compared to the previous year. This finding highlights how important it is for schools to have resources and awareness of how to connect children to key prevention and intervention services.
- 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, enabling intervention when necessary.

Emergency Department (ED) and RMHTF Utilization as an Outcome, Comparing Populations

- One in seven (14%) of at-risk youth had an ED visit related to a mental health need in the last quarter of 2022. Since an ED visit can be a reason a youth is flagged as at-risk, it may be expected that these youth have a higher incidence of ED visits.
- Children enrolled in CSED Waiver services and those who ceased participation in the Assessment Pathway application process remained relatively similar over the three quarters (Q4 2022-Q2 2023), with less than 6.5% of children from each group engaging with the ED after application to or utilization of CSED services.

- Youth utilizing CSED Waiver services were the least likely to engage with the ED for mental health reasons from Q4 2022 to Q2 2023 at less than 10% of youth visiting the ED, compared to nearly 19% of at-risk youth and 12.7% of youth ceasing participation with the Assessment Pathway. Although there is slightly higher incidence associated with those ceasing participation, there may be protective factors associated with engaging with the Assessment Pathway and ceasing participation, such as increased awareness of available resources and potentially less intensity of need if no longer pursuing the CSED Waiver.
- Children who began participating in CSED Waiver services during Q4 2022 had fewer RMHTF admissions than at-risk youth and those who ceased participation in the Assessment Pathway application process.
 - Youth ceasing participation in the Assessment Pathway had twice the incidence rate of admission to an RMHTF in the quarter following “engagement in the Assessment Pathway” compared to youth utilizing CSED services (7.1% and 3.4%, respectively). It is a positive finding that incidence is low for both youth ceasing participation and utilizing CSED.

DoHS remains committed to monitoring these new processes continuously for sustainability and identifying 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 established by Quality Committee members, many of which are continued efforts as listed from prior reporting periods, will be prioritized in the coming months. These focus areas, new and continued, are anticipated to have the greatest impact on improved outcomes for children and families over time:

- Coordination between Department of Health’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 analyses of capacity needs and efforts to expand the provider network in partnership with Aetna and providers.
- Monthly data review, responsiveness to Marshall’s Wraparound fidelity review report, and strategic decision-making by the Wraparound Facilitation Fidelity PIP team to ensure the WV Wraparound Facilitation program is implemented with fidelity.
- Onboarding of new CMCRS providers through the addition of mobile response services to West Virginia’s Medicaid State Plan.
- In partnership with Concord University, conduct an initial analysis of statewide and regional needs for Behavioral Support Services, to include provider capacity and identify

barriers and gaps. This information will be used to develop a strategic plan to address identified gaps, while BMS works toward implementation of the Behavioral Support Services modifier code.

- Focused improvements on the prioritized discharge planning process to include:
 - Complete development of flags (beyond CAFAS/PECFAS scores) in Quickbase for identifying children in residential placement to enhance prioritized discharge planning efforts further as well as the associated processes for timely review and follow-up in collaboration with Aetna, CPAs, and other child-serving entities.
 - 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 to 17 with complex mental and behavioral health needs, including strategic planning with CPAs and other stakeholders utilizing county-level information.
- 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 steps to operationalize new RMHTF models of care via smaller homes with higher levels of staffing and use of evidence-based practices to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, autism spectrum disorder (ASD), and sexualized behavior.
- Continued enhancement of quality infrastructure and processes within DoHS to include:
 - Reviews for focused improvement of data collection, quality, and completion across DoHS, vendors, and providers;
 - Ongoing analyses disaggregated by provider, vendor, region, and/or county for key indicators 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, assist with focused recruiting and provider network expansion, and support DoHS's quality improvement efforts.

DoHS 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

DoHS is actively working to reform and enhance programs and services for children¹⁵ with SED.

The primary goals of these reforms are:

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

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

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

- In February 2020, DoHS implemented the CSED Waiver to expand the array of HCBS available to children with SED and their families. In early 2023, the five-year CSED Waiver renewal was approved, extending the waiver through January 2028.
- The CCRL was implemented in October 2020, creating a resource for children and families in crisis to access needed support and an avenue for anyone seeking information on available services and supports, including how to get connected 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, providing children and families with the opportunity to connect to services. The Assessment Pathway was further expanded in late 2022 to include the Qualified Independent Assessment (QIA) process. The QIA process involves a broader assessment of children considered at high risk for placement in an RMHTF, followed by recommendations on whether HCBS are appropriate to meet each child’s needs.
- Community-based TLVY services were operationalized in September 2023. These services, which include housing when needed, are specifically designed to support youth ages 17 to 21, empower youth by equipping them with skills necessary to support independent living while also enabling access to any needed mental and behavioral

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

health treatment from community-based mental health providers.

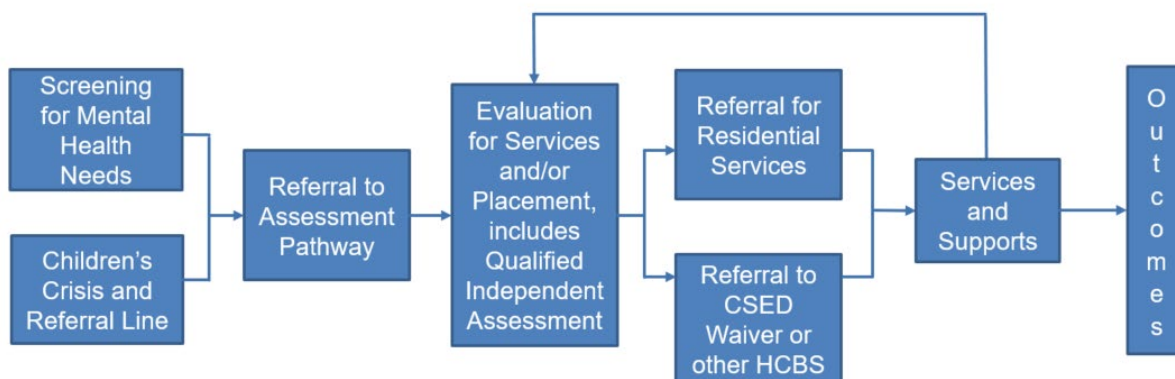
- Throughout 2023, DoHS made significant progress on new models of care to better support the needs of children whose acuity requires residential treatment. These new models of care and the associated payment rate structures were introduced to providers in the second half of 2023, with the goal of operationalizing the model by mid- to late-2024.

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

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

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

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



Recurring monthly bureau-specific program-level quality reviews are in place for all bureaus. Quality review meetings are also held quarterly at a minimum with BPH, BJS, and Probation Services. The program-level reviews facilitate more frequent and timely review of, and response to, data and enable preparation for DoHS’s quarterly cross-systems reviews. Additionally, PIP teams are established to drive rapid improvement when the need for a more focused and

frequent review to address an identified gap or area for improvement arises.

DoHS 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 August and November 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:

- DoHS's BSS Families and Children Tracking System (FACTS) data for children in DoHS custody; this system provides a static history of child placements prior to January 4, 2023.
- DoHS's WV People's Access to Help (WV PATH) system for children in DoHS custody; this new system was implemented in January 2023 to replace FACTS.
- DoHS's Enterprise Data Solution (EDS) system of Medicaid and WVCHIP data, including data associated with CSED Waiver services, Medicaid eligibility, and parental RMHTF placement. This new system was implemented at the end of March 2023 and fully replaced the Medicaid Management Information System (MMIS) Data Warehouse/Decision Support System (DW/DSS) at the end of June 2023. The new EDS system data conversion for CQI reporting was completed in October 2023.
- DoHS's Bureau for Behavioral Health (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.
- DoHS's BBH Assessment Pathway Portal.
- DoHS's BMS CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, Acentra Health¹⁶.
- BJS Offender Information System.
- Aetna Reporting for Discharge Planning, future data will be sourced from Aetna's Quickbase system which was integrated in November 2023.
- Aetna Utilization Management (UM) authorization reporting for children's CAFAS/PECFAS history.
- CSED Waiver Status and On-Hold reporting from Aetna's Quickbase system.
- DoHS's BMS CSED Waiver Enrollment Reporting from Acentra Health and the contracted assessor, Psychological Consultation and Assessment, Inc. (PC&A).
- DoHS's Fostering Healthy Kids Data System (sourced from FACTS/PATH) that includes EPSDT screening for children in foster or certified kinship care including CPS and YS.

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

- DoHS's Outreach and Education Tracker.
- Division of Probation Services Offender Case Management System (OCMS).
- CANS Automated System, which includes CANS assessment data, Safe at Home Wraparound Facilitation services contact data, and data to assist with Wraparound Facilitator capacity and caseload analysis.
- QIA Tracking Spreadsheet, maintained by Acentra Health.
- Marshall University WV Wraparound Facilitator Staff Reporting for capture of Wraparound Facilitator workforce capacity and caseload analysis.
- Marshall University out-of-state placement data report.
- WVU Children's Mental Health Evaluation.

Over the past two-and-a-half years, DoHS has continued to develop a data store to house data from multiple sources across the Department's child welfare and mental and behavioral health services systems, including data from internal systems as well as data from third-party systems (i.e., contractors, vendors, and providers). The goal of this data store is to capture child- and interaction-level data from child-serving entities to enable aggregation, cross-systems analysis, and reporting for use in DoHS's CQI processes. The data store's phased build-out is scheduled to continue through the end of 2024.

Progress on the data store build-out was impacted throughout 2023 by the conversions to new data systems, including from FACTS to WV PATH and from DW/DSS to the EDS system. Significant effort went 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 using multiple datasets. Matching and unifying child-level data has become increasingly challenging as data sources and systems lack a common child identifier. Accordingly, the timelines associated with the build-out of the data store are updated routinely, and priorities are being revisited.

Despite the challenges, significant progress was made on the build-out of the data store throughout 2023. Child-level data matching is currently in place for the following datasets in the data store: RMHTF services, CSED eligibility, CSED utilization, RMHTF CAFAS/PECFAS score history, and CANS case history (i.e., case service-level completion and timeliness). Based on this progress, additional cross-systems analyses at the child level are included in this report.

Datasets in the process of being added to the data store include the following: CANS assessment outcomes, expanded RMHTF discharge planning data, CSED applications, CSED enrollment roster, Probation Services screenings, BJS screenings, and QIAs. Full build-out of the data store is anticipated in late 2024 and will enable expanded cross-systems analysis and prototyping of child-level data to support DoHS's CQI activities and to improve understanding of youth and family experiences within the mental health system.

Other system changes that enabled expanded data collection at the child- and encounter-level were completed in 2023. As noted above, BMS began implementing an EDS to replace the DW/DSS in March 2023, and the full EDS conversion for CQI reporting was completed in

October 2023 after DW/DSS' retirement at the end of June 2023. Enhancements to the Epi Info System, which captures data associated with the BBH-funded Behavioral Support Services, Wraparound Facilitation, and CMCRS programs, went live in October 2023. Improvements to Epi Info will increase data quality and provide the ability to monitor and review expanded information, such as timeliness indicators. BSS, BBH, and BMS spent significant time collaborating with vendors and providers throughout 2023 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, DoHS uses the expertise of community partners for support in quality and evaluation initiatives, including:

- 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. The evaluation spans four years and is currently entering year three. WVU provided a baseline report reflecting responses and perceptions from providers and facilities statewide in July 2022. A report on feedback from youth, families, and caregivers was issued in September 2022. A draft of the Year 2 provider, youth, and caregiver evaluation for children in RMHTFs was completed in summer 2023 and will be finalized in early 2024 following additional analysis to expand the utility of the report to allow a more actionable response. Year two of the evaluation also includes a baseline evaluation of at-risk¹⁷ children and caregivers, which are referred to most commonly in the evaluation as community-based children and caregivers given the comparison to experiences of children and caregivers in a residential treatment setting. This report, Children's In-Home and Community-Based Services Evaluation (CMH Evaluation) is also expected to be finalized in early 2024. Reports will continue to be provided on an annual basis to DoHS as evaluation is conducted on the implementation rollout.
- Marshall University (MU): Contracted to complete an ongoing evaluation of Wraparound service fidelity to the National Wraparound Initiative (NWI). Marshall provided the first fidelity report to DoHS in 2022. The second fidelity report will be finalized in early 2024.

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

¹⁷ At-risk children were defined as those children (under age 21) with an SED diagnosis within 1 year of the review period where an SED is defined as International Classification of Disease-10 (ICD-10) diagnosis codes in the psychiatric range, or F-range (that is, starting with F) except for the following standalone diagnoses: F10-F19, F55 (SUD), F70-F80 range of intellectual and developmental disabilities, G25.6, G25.7 (medication induced movement disorders), Z55-65 (health hazards related to socioeconomic and psychosocial circumstances), Z69-Z76 (persons encountering health services in other circumstances), AND meeting any of the following criteria in the last 3 months of the review period: WV Medicaid/CHIP member with an ER visit for a psychiatric episode, WV Medicaid/CHIP member with a psychiatric hospitalization episode; Mobile Response incidence; children who are in state custody because of CPS or YS involvement; OR child with SED as a primary diagnosis on a Medicaid claim within 1 year of the review period and a CAFAS/PECFAS > 90.

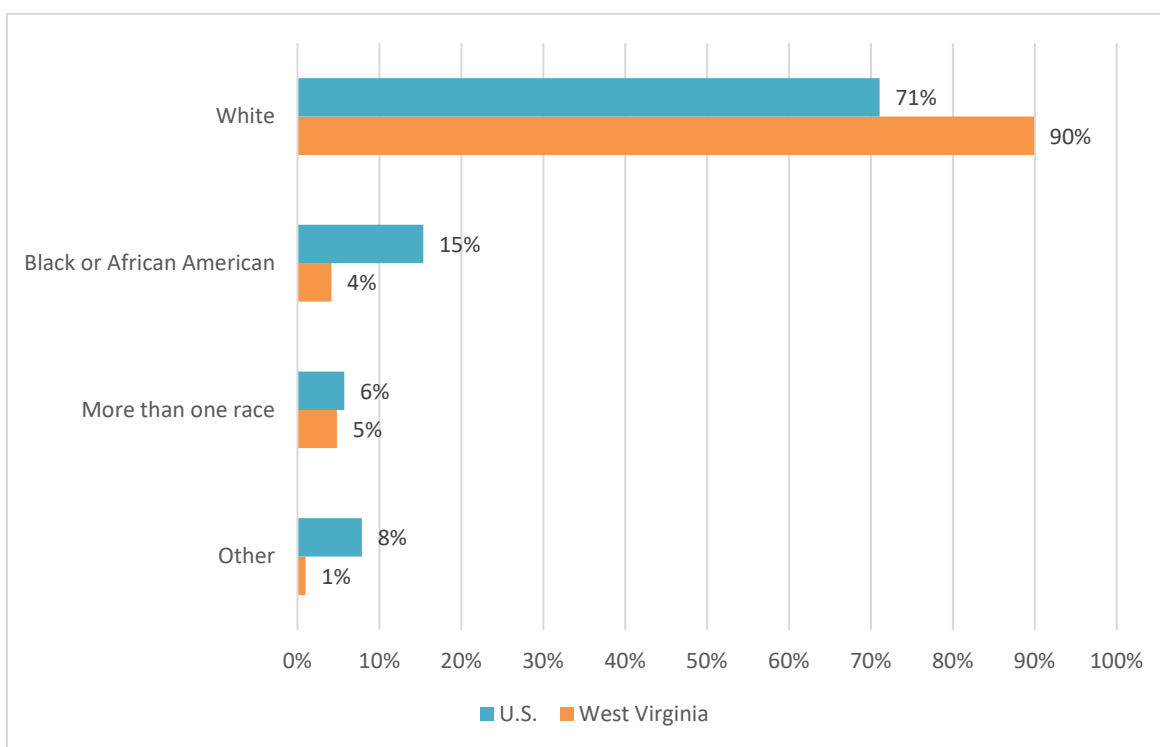
4.0 WV's Child Population and Individuals Utilizing Services

4.1 WV Demographics for General Child Population

WV has a unique demographic and geographic makeup, which varies significantly from most of the rest of the United States. Reference to the state's population is important, as DoHS 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 (90% in the state compared to 71% nationwide). Black, Indigenous, and People of Color (BIPOC) represent only 10% of the WV child population, compared to 29% nationally.

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

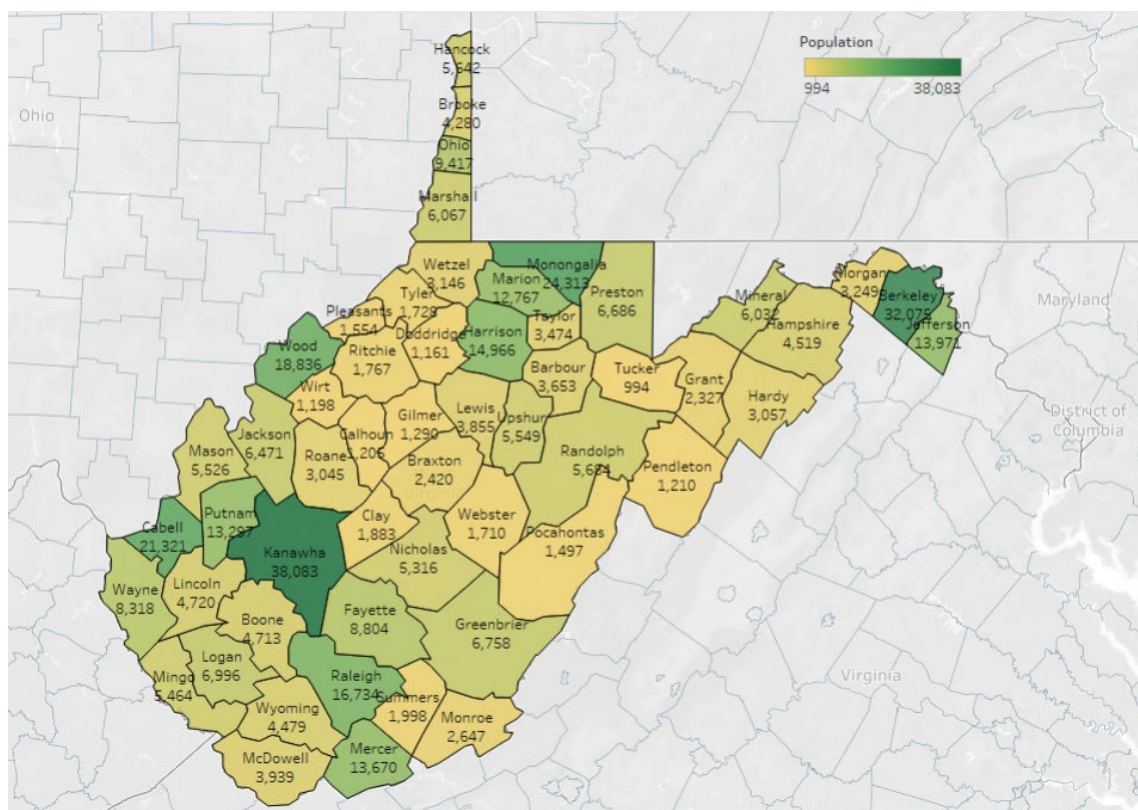


In addition to consideration of racial distribution, the geographic makeup of the state is an important consideration for service utilization and outreach. According to the U.S. Office of Management and Budget, only 21 of WV's 55 counties are considered urban. Children and families who live in rural areas may have additional barriers to accessing services. Figure 3 represents the population in each county less than 20 years of age for context of service utilization as referenced throughout sections of this report.¹⁸ Note that these totals undercount

¹⁸ Single-race Population Estimates, United States, 2020-2022. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. <https://wonder.cdc.gov/>. The 2020-2022 postcensal series of estimates of the July 1 resident population are based on the modified Blended Base produced by the US Census Bureau in lieu of the April 1, 2020, decennial population count, released by the Census Bureau on June 22, 2023. Queried < 21 & All Races & All Ethnicities & All Genders & Year 2022.

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.

Figure 3: WV Child Population Under Age 20

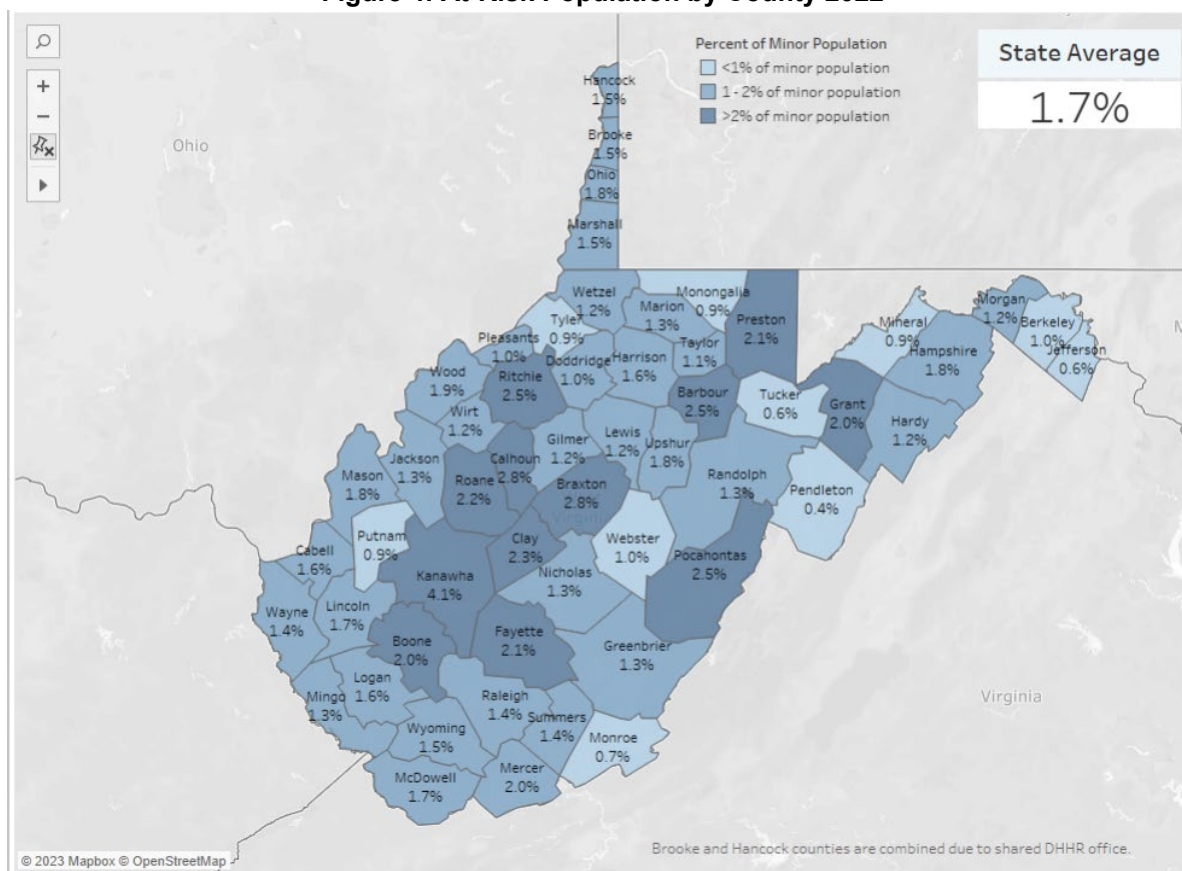


4.2 Children Identified as At-Risk for Residential Placement

DoHS uses the at-risk population as defined in Section 3.0 Systems and Data Sources above as a guide for the target population for HCBS, acknowledging that there are children who may meet these criteria but have yet to be identified due to lack of interaction with the system. The integration of information for at-risk children and families with county-level data has allowed for comparisons to begin to be made between populations and service utilization. These comparisons will enable focused outreach efforts and monitoring. As shown in Figure 4, nearly 2% (approximately 7,000) of WV’s population 0 – 20 were considered at-risk for residential placement in calendar year 2022. While children at risk for residential placement were identified in every WV county, 12 counties had greater than 2% of their population identified as at-risk. Kanawha County identified the greatest percentage of their population as at-risk, 4.1% of the county’s population, and their at-risk rate was notably higher than any other county. The Quality Committee noted the importance of continuing to understand this population and the limitations of the at-risk definition. By default, the at-risk definition includes youth accessing certain services which may have more availability in more populous or urban areas. Kanawha County, home of the state’s capital, Charleston, is more resource-rich than many other WV counties thus

would have more opportunities to “identify” at-risk children. DoHS plans to explore additional cross-analysis of geographic areas to understand, at a systems-level, the interplays between need, awareness, capacity, and utilization.

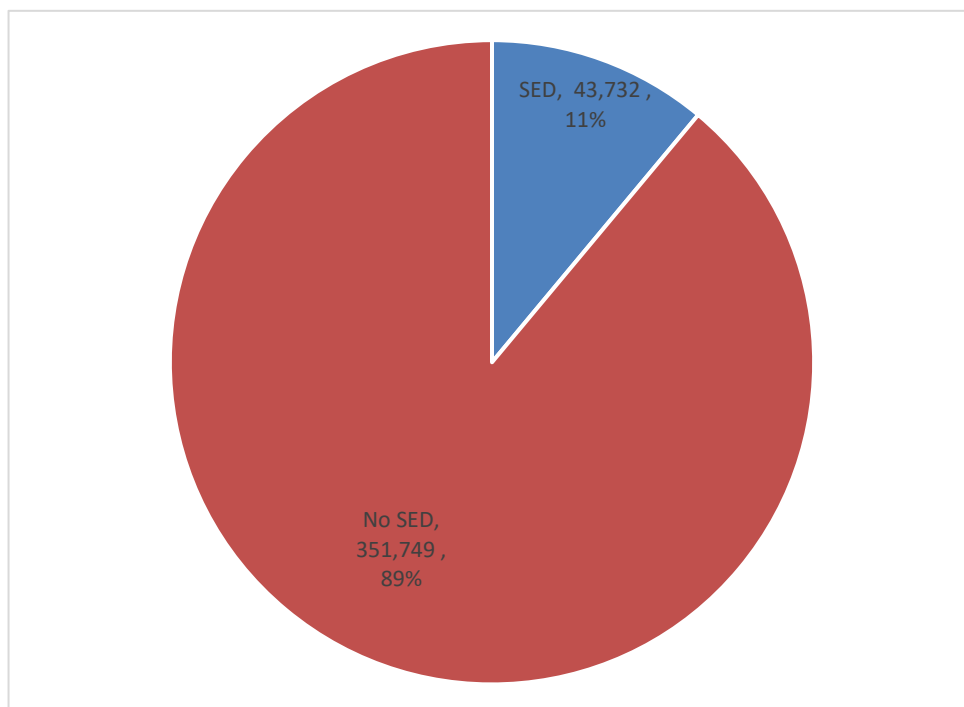
Figure 4: At-Risk Population by County 2022



In 2022, 11% (n= 43,732) of youth who were members of WV Medicaid/CHIP had a claim that included an SED diagnosis, as shown in Figure 5. These youth represent a larger population of children who may need additional mental and behavioral health services, compared to the smaller population of children at risk for residential placement. An SED diagnosis is only one component of risk and may not be reflective of immediate or unmanaged needs. As previously stated, DoHS aims to prevent out-of-home placement by providing avenues for children to receive services in their homes and communities. Intensity of needs can vary from child to child and can even vary over time with individual children based on their environment and other factors influencing their mental health needs. The Quality Committee discussed opportunities to intervene sooner for youth with an SED diagnosis. Early-intervention strategies include considerations around meeting the basic needs of families and helping families become aware and connected with services, ideally before a crisis takes place or systems involvement is necessary (i.e., BJS, Probation, Child Welfare). Furthermore, the Quality Committee recognized the need for a continued, two-prong approach due to the variation in acuity across WV’s population, giving attention to both prevention and intervention needs for children with SED diagnoses. Per the 2022 National Survey of Children’s Mental Health, 26% of responses nationally compared to 33% responses representing WV youth, 3- to 17-years-old, reported one

or more reported mental, emotional, developmental, or behavioral problem and/or qualify on the Children's Special Health Care Needs screening for emotional, behavioral, or developmental criteria¹⁹. The greater proportion of youth with identified mental health needs compared to the national rate further supports the need for available youth mental health services in the state.

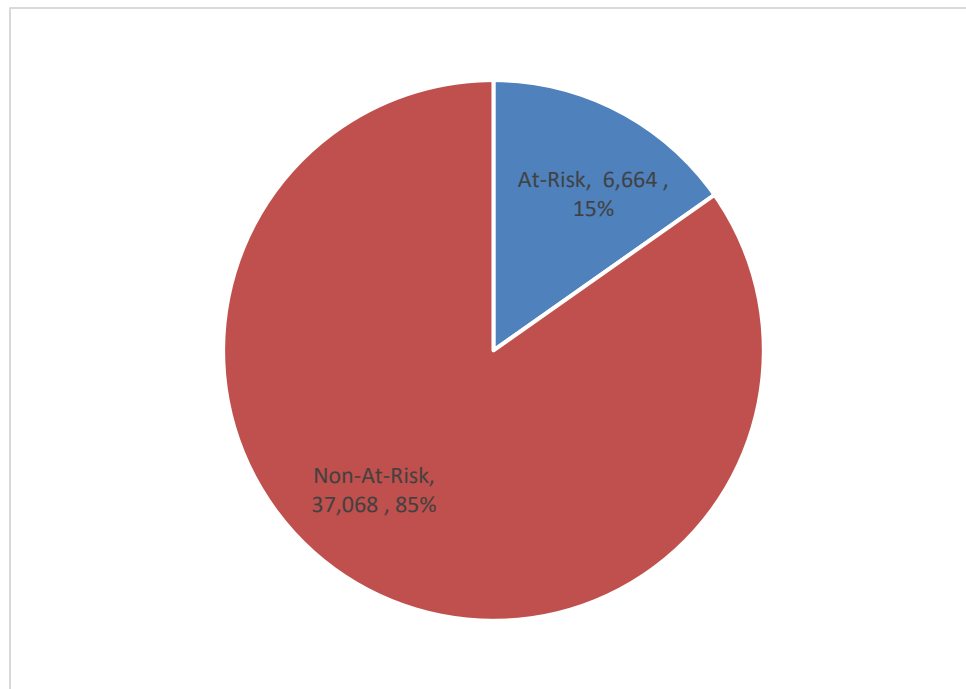
Figure 5: Percent of WV Medicaid Member Children with an SED in 2022



Of the 43,732 youth identified with an SED diagnosis in 2022, 16% (6,811) met the criteria of being at-risk for residential placement (Figure 6). In addition to an SED, these youth have been identified as having a CAFAS score greater than or equal to 90 or having a crisis-level event in the past 90 days. Children identified as at-risk offer a key opportunity for intervention and understanding patterns. Demographics of these youth and their families can help DoHS meet families where they are and provide critical intervention in the least-restrictive setting to benefit that child. Not all children in need of services will have their needs rise to meet the defined at-risk criteria; however, DoHS recognizes the value in serving children meeting clinical necessity criteria as soon as possible. Timely access to appropriate services may prevent a family from enduring a crisis or imminent out-of-home placement risk altogether, thus improving overall outcomes and quality of life via expanded utilization of HCBS.

¹⁹ Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [01/11/24] from www.childhealthdata.org.

Figure 6: Percent of Youth WV Medicaid Members with SED That Meet At-Risk Criteria in 2022 (n = 43,732)



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

A full comparison of demographics of the WV general child population and children accessing the various children's mental health programs and services is captured in Figure 7. In summary:

- Consistent with gender proportions identified in the RMHTF population, HCBS programs served more male children. This aligns with findings in reviewed literature, as differences are commonly seen 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.²⁰ Services previously reported as serving slightly more females (e.g., CMCRS, CCRL) have shifted to serving slightly more males. With this in mind, DoHS strives to ensure services are available and at the appropriate level of acuity for all youth regardless of gender, and this continues to be a consideration for areas of service enhancement.
- 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.

²⁰ 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.

- HCBS such as Wraparound Facilitation (including CSED), CMCRS, and Behavioral Support Services, as well as the Assessment Pathway to access these services, reached a greater proportion of children in age categories five to eight and nine to 12 compared to children in RMHTFs, who skewed older. The shift toward younger age categorizations for community-based programs was identified as a potential early-intervention opportunity for those individuals who may have current or potential risk for placement in an RMHTF. Although this is a positive finding about early intervention, it may take several years to see the full impact on RMHTF services for children in these age ranges. Nevertheless, more than 50% of youth served through CMCRS and CSED were in the age range of 13 to 17 indicating a key demographic overlap and an opportunity for diversion from inappropriate use of RMHTF settings.
 - The Centers for Disease Control and Prevention (CDC) utilizes the Youth Risk Behavior Surveillance System (YRBSS) to survey youth from grades 9-12 biannually. Data for WV youth collected in 2021 show a significant increase in both feelings of sadness and hopelessness as well as serious consideration of attempting suicide since the previous survey in 2019.²¹ These findings provide insight into the mental health concerns of youth who likely overlap the 13 to 17 age group, the same age group most commonly utilizing HCBS as well as RMHTF placements.
- Most youth in RMHTF settings were in the 13 to 17 age group (82%). In review of this subpopulation of youth in an RMHTF with their most recent CAFAS/PECFAS score being less than 90, the age distribution shifted older (with 6% of transitional age youth 18 to 20 in this subpopulation compared to only 1% in the total RMHTF population). These transitional age youth are elaborated on in Section 17.0, RMHTF Services with considerations given to potential discharge barriers of youth of transitional age that may be influencing this effect.
- Based on a comparison of statewide race distribution for children aged 0 to 20, BBH PBS tended to serve a slightly higher proportion of BIPOC individuals, despite BIPOC representing a small number of the general WV population. This has been a consistent finding with the PBS program. WVU's Center for Excellence in Disabilities (CED) provides input and training to staff for program outreach and service delivery for improved cultural competency, which may be attributable to reaching a higher proportion of BIPOC individuals. Race will continue to be monitored as an important indicator for assessing equitable access to services. Race data will be expanded as the data store is built out.

²¹ [Centers for Disease Control and Prevention. 2021 Youth Risk Behavior Survey Data. Available at: www.cdc.gov/yrbs. Accessed on December 27, 2023.](https://www.cdc.gov/yrbs)

**Figure 7: Summary²² Comparison of Demographic Trends Across Service Types
January to June 2023**

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
WV – All Children 0-20	418,238	51.5%	18%	19%	26%	16%	90%	4%	5%	1%
WV At-Risk 0-20 ²³	6,677	49.5%	13%	19%	48%	17%	--	--	--	--
CCRL	771	46% (47% female)	14%	29%	42%	1%	--	--	--	--
CMCRS – Preliminary	587	47%	14%	26%	51%	2%	82%	5%	2%	7%
Assessment Pathway Services – BBH Support Team	465	54%	20%	33%	41%	2%	--	--	--	--
CSED Waiver Applications	1,313		13%	22%	58%	4%	--	--	--	--
CSED Waiver Utilization	810	54%	20%	32%	50%	4%	--	--	--	--

²² This summary comparison only includes relevant percentages (percentages large enough for comparison); however, the denominator for each group is inclusive of all available demographic types including those not listed (e.g., other genders such as transgender or nonbinary, age 0 – 4, or individuals with missing data). The complete demographic information for children reported for interim Wraparound services was unavailable for this period.

²³ The WV At-Risk population is representative of calendar year 2022; these data do not represent a 6-month period. Youth who were identified as at risk and turned age 21 by 12/31/2022 were included in the 18-20 age category to be inclusive of the whole population during the year.

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
Behavioral Support Services – BBH (PBS)	111	61%	23%	32%	41%	2%	87%	6%	6%	1%
RMHTF Discharge Planning (CAFAS/PECFAS <90) ²⁴	81	65%	6%	11%	77%	6%	--	--	--	--
RMHTF Discharge Planning (CAFAS/PECFAS 90-130) ²⁵	146	59%	1%	10%	86%	3%				
RMHTF Services	1,346	63%	3%	15%	82%	1%	--	--	--	--
QIA ²⁶	126	53%	8%	12%	62%	2%	--	--	--	--
CPS/YS Wellness (EPSDT) Screening ²⁷	1,712	53%	13%	20%	31%	0%	--	--	--	--
Screening: Probation	234	66%	0%	4%	92%	4%	82%	8%	8%	0%

²⁴ Note this is youth active in RMHTF with a CAFAS/PECFAS score <90 as of September 2023; these data do not represent a six-month period.

²⁵ Note this is youth active in RMHTF with a CAFAS/PECFAS score 90-130 as of September 2023; these data do not represent a six-month period.

²⁶ Note this includes only referrals for assessments received in October 2023; 17% of referral records did not include age/date of birth.

²⁷ Youth placed in DoHS custody with an EPSDT screening within one year of placement.

Area of Review	Total Number of Children	Gender Trends (Percent Male)	Age Groups				Race			
			5-8	9-12	13-17	18-20	White	Black or African American	Multiracial	Other
Screening: BJS	518	--	0%	3%	89%	8%	--	--	--	--

5.0 Partner Evaluations

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

DoHS partners with WVU to capture additional outcome measures as outlined in DoHS's Children's In-Home and Community-Based Services Improvement Project Evaluation Plan. The evaluation includes performance measures designated by DoHS, child/caregiver-level outcomes, community/provider-level outcomes, and system-level outcomes. WVU gathered the initial series of caregiver, provider, and child surveys and focus groups in 2021 and 2022. A baseline report was provided to reflect responses and perceptions from providers and facilities statewide in July 2022 and an additional report on feedback from youth, families, and caregivers was published 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 (community-based youth and caregivers). The second report of provider, caregiver, and child surveys was drafted in July 2023, and the draft report of the baseline at-risk evaluation was prepared in October 2023. The finalization of these reports has been delayed to enable detailed analysis and interpretation of findings.

DoHS is collaborating with WVU to plan additional analyses of the surveillance data to better understand the specific needs and barriers of youth and families. More in-depth findings will be reported in the spring addendum to this report, along with strategies DoHS plans to take to address identified needs. Copies of these reports are located and will continue to be published once finalized 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

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

MU completed the baseline fidelity review using the Document Assessment and Review Tool (DART, an NWI-approved fidelity tool) 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 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 met regularly in 2023, with the goal of aligning documentation, training, and practice across funding sources, and focused primarily on identified areas of need from the baseline evaluation. The PIP team has also reviewed CANS data to help ensure adequate collection of this information for processes and outcomes. Policy documents for each of the three funding sources of WV Wraparound were reviewed and

updates proposed to align materials to meet indicators of high-fidelity wraparound service provision. Final review of changes occurred in December 2023, and plans will be made in early 2024 to incorporate agreed upon changes in future updates to programmatic materials.

In addition to policy alignment, the PIP team identified additional needs related to consistent, timely, and sustainable training of the Wraparound Facilitator workforce. An Announcement of Funding Availability (AFA) for high-fidelity Wraparound training services was released in September 2023 with additional planning and decision-making taking place in early 2024. Training will continue to be provided by MU through March 2024. The Wraparound PIP team will continue into 2024 with a shift in focus to data quality and completion, which will influence data review and CQI processes related to service provision and timeliness. This increased focus on data quality in the CANS System will include evaluating and addressing needs at the provider level. The PIP team will strategically address any continued issues with data collection and quality as well as other areas in need of improvement to reach and sustain high-fidelity outcomes.

MU completed a draft report of their fidelity review in December 2023, which includes findings from the DART and WFI-EZ review tools. Release of the final report of WFI-EZ and DART results is expected in early 2024. The Wraparound PIP team will review this in January 2024 and take on any additional considerations. An update is planned for the spring addendum to this report.

6.0 Marketing

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

Marketing strategies are informed by the annual CMH Evaluations completed by WVU. The draft report of year two systems, provider, RMHTF youth, and caregiver evaluation was completed in July 2023, with a draft report of baseline survey results of the at-risk youth and caregiver population completed in October 2023. Both reports will be incorporated into future prioritization and strategies for outreach once finalized in 2024 and shared with the cross-bureau Quality Committee.

6.1 Kids Thrive Collaborative Website

The WV Kids Thrive Collaborative [website](#) went live in mid-June 2022, replacing the Child Welfare Collaborative website, and serves as a hub for providers and families to receive information on resources, services, and initiatives related to meeting children's mental health needs. The Kids Thrive Collaborative continues to be enhanced based on feedback from families and the identification of additional needs. A comprehensive review of the Kids Thrive Collaborative website with consideration to updates and enhancements began in September 2023. During the August 2023 Quality Committee review, several taglines were proposed for the branding of Kids Thrive. In December 2023, "When kids and families thrive, West Virginia thrives," was announced as the official tagline. An updated logo aligning with the tagline will be explored in 2024 in pursuit of cohesive branding. The Statewide Family Advisory Board will be surveyed about the website to provide a stakeholder's view of areas for improvement. The survey will likely be administered in early 2024, with website updates to follow.

6.2 Resource Rundown Updates

In August 2022, DoHS initiated a recurring outreach approach to provide information, raise awareness of the availability of services, and address family and youth questions called the "Resource Rundown." Initially, these 30-minute sessions were offered weekly, but shifted to be biweekly during January to June 2023. In summer 2023, DoHS transitioned away from the live sessions and instead uploaded videos to YouTube to be available on demand. The videos are displayed on the Kids Thrive website and are accompanied by contact information to facilitate feedback and questions with timely responses. DoHS is currently developing a 2024 schedule with quarterly content updates to stakeholders. DoHS will determine which program staff will deliver the message in each of the video recordings, respective to the program content.

As of November 2023, there are three Resource Rundown videos available on the Kids Thrive Collaborative website. Additionally, the DoHS Office of Communications publicizes the

Resource Rundown on its social media platforms.

- WV Kids Thrive Collaborative – Resource Rundown was uploaded to the DoHS YouTube account on September 7, 2022, and has 328 views.
- Resource Rundown ACT was uploaded July 19, 2023, and has 109 views.
- #DYK (Did You Know) video short was uploaded on April 5, 2023, and has 97 views.

6.3 DoHS-Level Outreach and Education Tracking

The Outreach and Education Tracker was soft launched in April 2022 and shared with relevant DoHS staff in August 2022. Data enhancements to the tracker were made based on staff feedback. Usage of the tracker continues to be an area of improvement.

Recent efforts to expand usage of the tracker have focused on the BSS teams, with the intent to capture increased outreach to the judicial community. BSS leadership requested staff to increase contact with circuit court judges to touch base quarterly. BSS social service managers and program managers responsible for outreach and building rapport with judges were trained on use of the Outreach tracker. Feedback was given on elements that could be improved in the tracker to provide more complete information from judicial community outreach. Feedback provided also identified areas to expand and streamline outreach. These changes were implemented in fall 2023.

One of the recommended changes included standardized outreach materials on the DoHS intranet site to make them more easily accessible to DoHS teams. Materials for various programs/services were added to the DoHS intranet in August 2023. As new outreach materials are developed, they will be uploaded to the site. BSS has collaborated with the court system in combination with assessment of available utilization data to identify counties with additional need for outreach.

BBH identified five counties (Barbour, Wayne, Preston, Putnam, and Marion) for targeted outreach related to CCRL and CMCRS. Program staff will work with grantees in these counties to develop outreach plans. Some outreach is reported in the Epi Info System and analyzed for further insight. CCRL wallet cards have continued to be distributed to grantees and have had great reception.

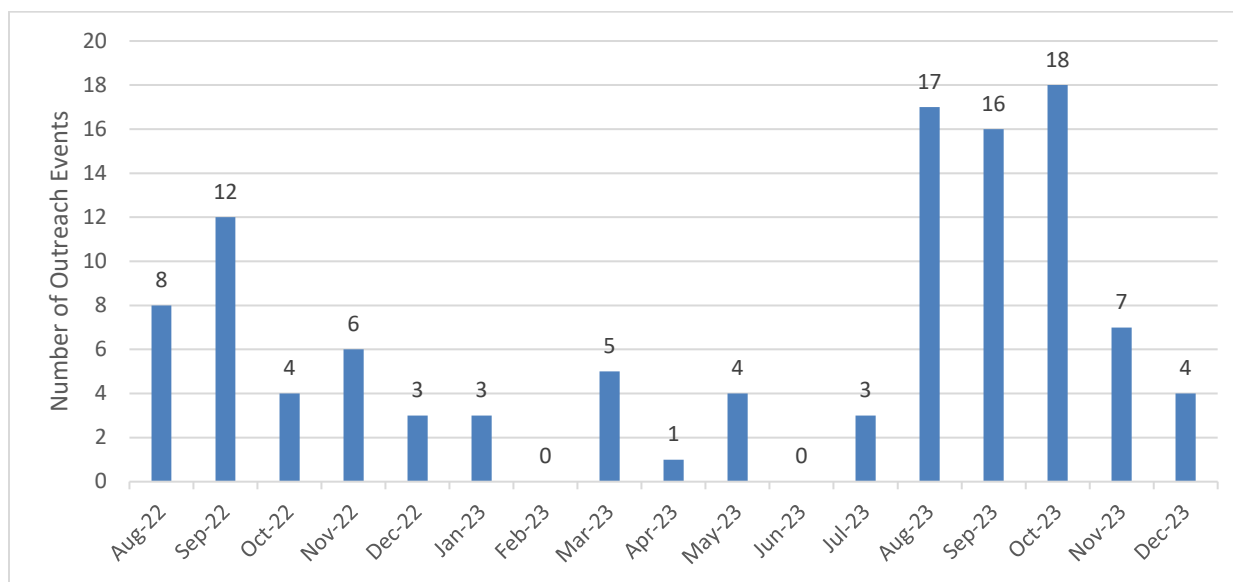
BMS produced an extensive array of outreach materials and distributed them statewide in December 2023. Resource kits were sent to schools and community organizations including CSED Waiver posters, window clings, magnets, stickers, and wallet cards. Community and school personnel guides were distributed as well. These materials included information about the CCRL and 988-Suicide and Crisis Lifeline. Nearly 1,000 resource kits were sent across the state.

Figure 8 below shows the number of outreach events by month from August 2022 to December 2023²⁸. As indicated in the second half of 2023, DoHS put an increased emphasis on tracking

²⁸ Entries as of January 5, 2024, therefore, may be subject to data entry lag.

outreach, expanding specifically to the judicial community given its influence on residential placement diversion opportunities. For purposes of this report, given the timely emphasis on tracking expanded outreach, information entered into the tracker from July to December 2023 was assessed further. Sixty-five outreach events²⁹ were tracked from July to December 2023 with October 2023 having the greatest number of events (18) during the period shown in Figure 8.

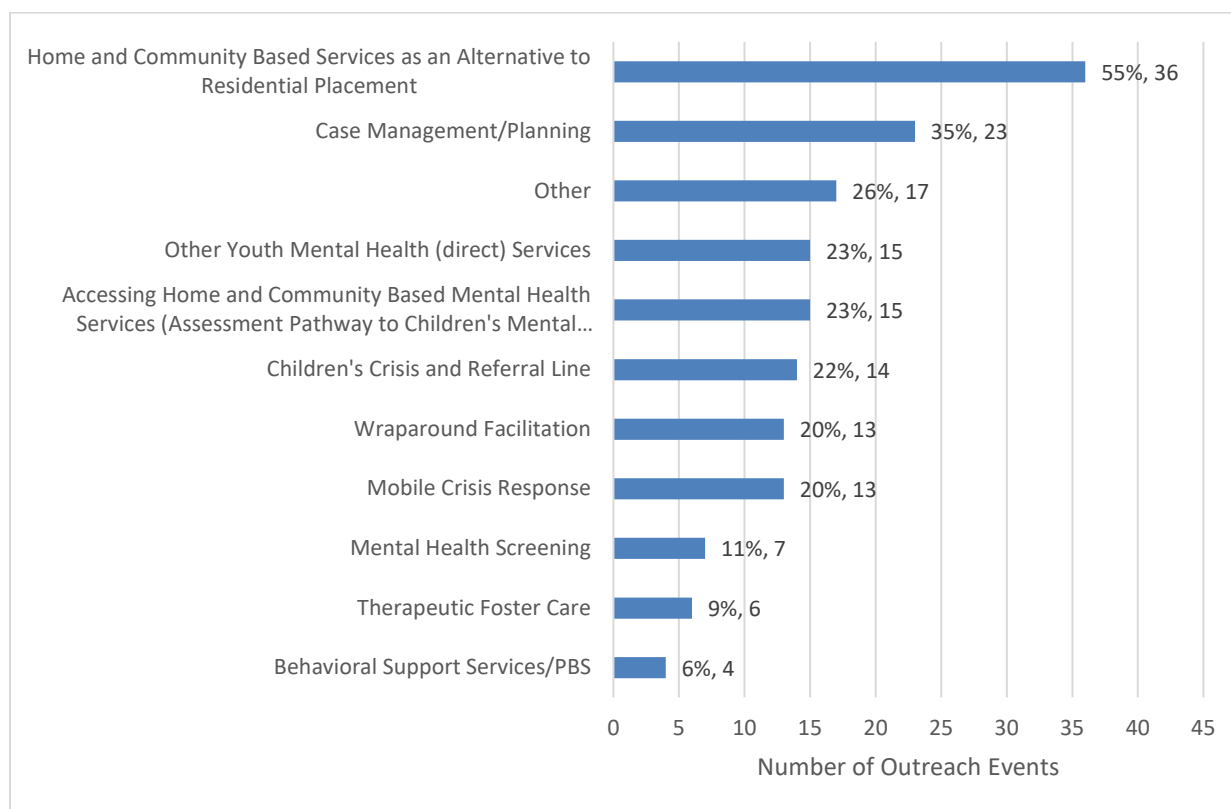
Figure 8: DoHS Outreach Events by Month, August 2022 to December 2023



Although multiple purposes for outreach were often noted for a single outreach event (Figure 9), the most commonly listed purposes for outreach were accessing HCBS as an alternative to residential placement (n = 36, 55%), case management/planning (n = 23, 35%), the Assessment Pathway (n = 15, 23%), the CCRL (n = 14, 22%), Wraparound Facilitation (n = 13, 20%), and Mobile Crisis Response (n = 13, 20%). Staff labeled 17 events (26%) with the “other” category to describe the purpose of their outreach. Along with evaluating the purposes currently being collected, DoHS staff are being educated on how their activities fit into the existing scope of outreach to ensure proper categorization.

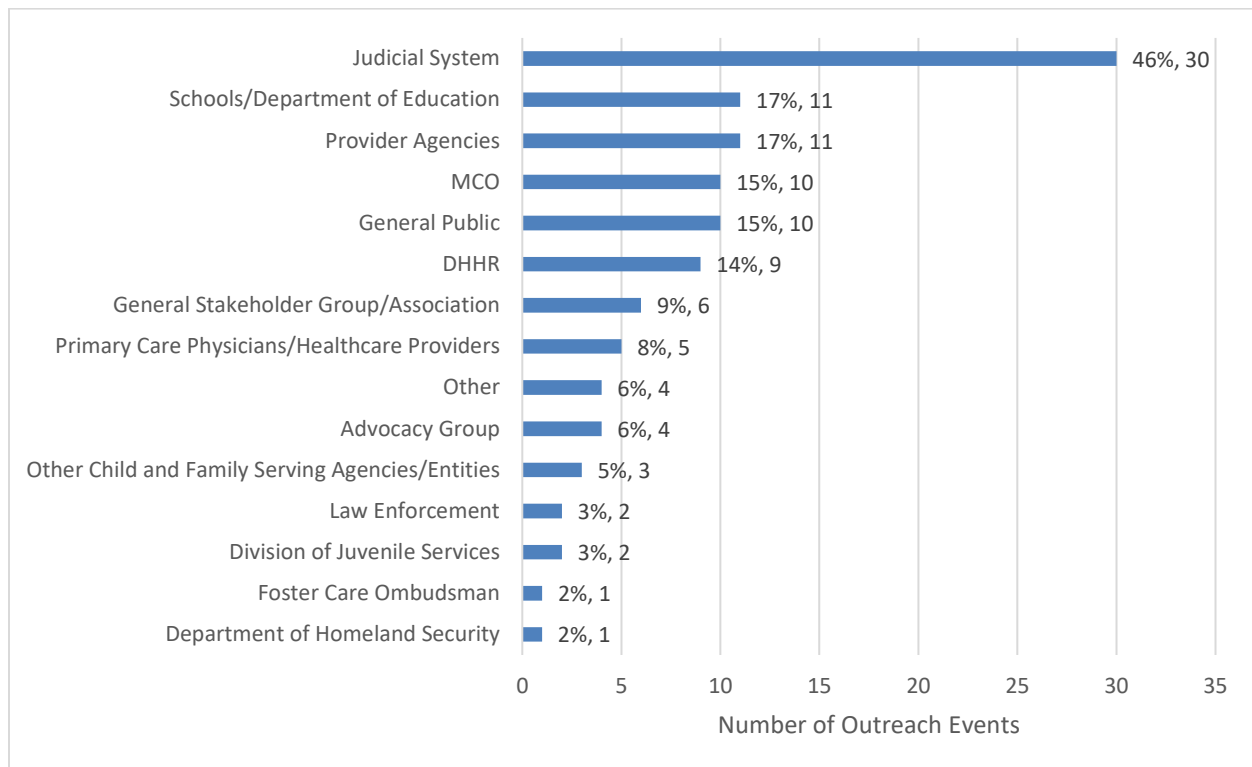
²⁹ As some events are cross-bureau efforts, this number does not account for unique events. Entries for the same event can, and should, be documented by all bureaus who participate as they may be serving different purposes.

Figure 9: Purpose of DoHS Outreach, July to December 2023



This information was provided to a wide array of audience types, as indicated in Figure 10. Many outreach events targeted multiple, distinct audiences, so the percentages in Figure 10 exceed 100%. The judicial system (e.g., judges, attorneys, and victim's advocates) was the most common audience type (n = 30, 46%), followed by schools/the WVDE, and provider agencies (both n = 11, 17%). Compared to the July 2023 Semiannual Report, which included data for the period of July to December 2022, there was a notable increase in the percentage of outreach events targeting the judicial system (from 18% to 46%). The percentage of outreach events targeting the other audience types depicted in Figure 10 either decreased or remained relatively constant. Change in outreach audience is expected as new connections are made and areas in need of improvement are identified. Furthermore, the rise in overall outreach efforts observed during this six-month time frame might have led to a decrease in the percentage targeting specific audiences, even though the absolute number remained relatively constant or increased. The July to December 2023 data also indicated 51% of outreach events had a statewide focus, similar to prior reporting periods.

Figure 10: Audience Type for DoHS Outreach, July – December 2023



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

6.4 Other Outreach and Education Updates

WV Department of Education

DoHS continues to work closely with the WV Hospital Association and meet with the children's hospitals on a quarterly basis. The Pediatric Mental Health Summit identified a need for a crisis stabilization unit for children with a mental health crisis, and this need was also discussed internally within DoHS. In fall 2022, DoHS issued a request for architectural services to develop a crisis stabilization unit in Elkins, WV. In early 2023, the contract was awarded. Plans are moving forward with an anticipated opening date in fall 2024.

WV Department of Education and WV Department of Homeland Security

In December 2022, DoHS began collaboration with the WVDE, WV's court system, and the WV Department of Homeland Security (DHS). Meetings occur multiple times a year at the leadership level, with meetings in the interim for appropriate personnel to advance collaboration

and data collection efforts. All parties are committed to pushing efforts forward to raise awareness of HCBS, bring data and information sharing to the forefront of this partnership to enhance interagency planning, and collaborate to identify and eliminate silos and barriers.

Probation Services

To support relationship building with juvenile probation officers and to continue to raise awareness of the importance of screening and referral to the Assessment Pathway, BSS and the Division of Probation Services held a professional development meeting for juvenile probation officers and field staff supervisors in October 2023. Sessions were held in Beckley and Morgantown (Northern and Southern parts of the state) to accommodate attendees from multiple geographic locations. The meetings focused on residential treatment model changes, CANS and discharge planning, juvenile brain development, and the CCRL. DoHS plans to continue outreach to this group to improve screening and referral rates.

Via collaboration with the court system, BSS is initiating statewide, virtual lunch and learn opportunities to continue to raise awareness within the judicial community, including three that were conducted in June, September, and October 2023. Initial topics covered included the Americans with Disabilities Act and the QIA process. Additional topics and cadence of this outreach is still in discussion.

Foster Home Capacity

As identified through DoHS's prioritized discharge planning efforts (further detailed in Subsection 17.2(a) – RMHTF Services, Prioritized Discharge Planning), additional foster home capacity to serve youth ages 13 to 17 with complex mental and behavioral health needs is necessary to meet the demand of youth ready to be discharged from residential facilities. To meet this need, a partnership was established between Mission WV, BSS, Aetna, Child Placing Agencies (CPAs), and current foster and adoptive parent representatives to drive an initiative to develop this capacity. The group selected 84Agency, a marketing firm, to develop the overall campaign in conjunction with foster care partners. 84Agency is in the process of developing marketing materials based on the chosen theme and plans for campaign rollout in early 2024. The campaign messaging, "West Virginia Needs You Now", is focused on conveying the urgent need for foster parents and families across the state.

HealthCheck

BPH has continued outreach to physicians and clinics to improve overall EPSDT screening rates, raise awareness of the Assessment Pathway as a mechanism for additional assessment and connection to services, and promote use of the electronic referral process to the Assessment Pathway. As of November 2023, 590 of 694 primary care physicians have been reached by HealthCheck specialists. Efforts to reach the remaining 15% of providers will continue in 2024.

FirstChoice Services

The marketing and outreach update from FirstChoice, which operates the HELP4WV call line, including CCRL, reported the following for January to June 2023:

- The HELP4WV program was featured in 74 news stories, with 13 of them specifically mentioning the CCRL.
- In April through June 2023, an ad campaign was launched that targeted digital ads through Nexstar Digital. The campaign employed various tactics, including search engine optimization, social media, display, pre-roll, YouTube, and CTV (local streaming television channel).
- The HELP4WV website received more than 35,000 visits. The subpage dedicated to the CCRL accounted for 14,360 visits compared to 7,633 in the previous six-month period (41% of overall website visits). Additionally, the HELP4WV Facebook page had 130 posts, with 274,395 views.

6.5 Strengths, Opportunities, Barriers, and Next Steps

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

Next steps include DoHS's continued focus on a county-level approach involving risk or need ranking based on factors such as county-level RMHTF admission rates, CSED utilization rates, and rate of calls to the CCRL. This 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/need ranking will continue to be used by the bureau and program teams to drive county-specific efforts for prioritized service areas. The Outreach Workgroup plans to reconvene in early 2024 in order to develop more specific outreach plans for the new year.

Based on the limited community-based placement capacity to accommodate children ready to discharge from RMHTFs, DoHS is committed to sustaining the foster care collaborative and associated campaign aimed at increasing the number of foster families willing to serve youth ages 13 to 17 with complex needs, as well as transitional living opportunities for older youth.

DoHS will remain dedicated to further humanizing processes and addressing common misconceptions, ultimately simplifying system navigation, and building trust with the families who need these services. These combined efforts, along with monitoring and improving the data from the Outreach and Education Tracker, as well as collaborative partner efforts, are expected to help increase awareness, education, and two-way communication among provider groups, stakeholders, and families while 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 Youth Services (YS) or Child Protective Services (CPS) custody.
- BSS, CPS, and YS: provide screening, via primary care providers and reinforced through HealthCheck, for children in DoHS custody for services related to status offenses or juvenile delinquencies or for children in a child abuse and neglect case.
- WV Division of Corrections and Rehabilitation and BJS: provide screening for children in juvenile detention and commitment facilities.
- WV Judiciary and Division of Probation Services: provide screening for children on probation.

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

7.1 Review Period, Data Sources and Limitations, Population Measured

Data collection associated with screening has been established across all screening entities, 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 11: Screening Data Overview

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
Primary Care Providers HealthCheck (EPSDT)	Calendar Year 2022	Chart Reviews DW/DSS CMS-416 Report	Reporting on EPSDT with mental health screens is based on medical record reviews. Department of Health (DH) conducted medical record reviews for	A random sample of children with Medicaid receiving EPSDT with mental health screening during a well-child

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
			a random sample of Medicaid members between ages 0 – 20 who had a well-child visit during calendar year 2022. The random sample is a subset of the total children screened.	visit; the CMS-416 Report was utilized to retrieve information on members in the Medicaid population and members receiving EPSDT screenings.
CPS/YS Direct Screenings by Child Welfare Workers	N/A – Early data are only reviewed internally due to concerns with data reporting and consistency. These concerns are 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 ongoing 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 DoHS custody.
CPS and YS Wellness (EPSDT) Screening	January to June 2023	Fostering Healthy Kids Data System	The Fostering Healthy Kids data system is a subset of (historical) FACTS and PATH data and does not include child exit date. This might make it unclear if an individual had time to be screened before exiting placement. Data may be subject to change given data entry and related claims reporting lag. Further analysis has shown greater stability in these data six months following the period of review.	Children with a CPS and/or YS case in DoHS custody including screenings conducted via a wellness visit, visit completion is reinforced by the HealthCheck program.

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
BJS	January to June 2023	Offender Information System	<p>Some screenings included in previous reports were representative of children screened at Youth Report Centers. However, new methodology applied in this report excluded those screenings since they are not required per the BJS screening policy and instead only reports screenings that occurred at BJS commitment and detention centers.</p> <p>On occasion, children are screened twice in the 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 invalid. This might impact total screens when not unduplicated at the child level.</p> <p>A small number of children who were screened in each month are not included in some monthly data pulls if those children were not active members of the BJS population when data was pulled early in the following month. This anomaly was identified and subsequently resolved in summer 2023. The solution was not applied retroactively.</p>	Children in juvenile detention and commitment facilities screened using the MAYSI-2 who have a juvenile delinquency offense.

Screening Entity	Data Review Period	Data Source	Details and Limitations	Population Measured
Division of Probation Services	January to June 2023	Probation Web-Based Data Collection Form	Screening and data collection was implemented March 1, 2022.	Children adjudicated as a status offender or delinquent along with children not yet adjudicated who lack a DoHS worker or are in immediate crisis are screened using the MAYSI-2.

7.2 Review Summary

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

Wellness screenings through HealthCheck are a key focus of DoHS's work to help ensure children are meeting developmental milestones and are receiving and being connected to important preventative and early-intervention services. In 2022, WV had 113,191 Medicaid members aged 0 to 20³⁰ who received HealthCheck (EPSDT) screening during well-child visits. This represents 47% of Medicaid-eligible children (n=239,987). A retrospective analysis of wellness exam records sampled from provider records and administrative claims for Medicaid utilization in 2022 indicated that 82.5% of children had a mental health screening component included during the visit. Extrapolating from the chart review results, an estimated 38.9% of Medicaid-eligible children received an EPSDT with mental health screening. Overall screenings have increased from 46.4% to 47.2%, while screenings including a mental health component have gone down slightly (83.3% to 82.5%, respectively), similar to the rate in 2019 as shown in Figure 12. To increase the rate of EPSDTs with mental health screening components the HealthCheck program will reach out to providers who are not incorporating this screening in 2024 to provide education and offer technical assistance for integration into their regular practice for wellness visits with emphasis on youth in the key age category: 9- to 18-years-old.

³⁰ Medicaid members aged 0-20 with at least 90 days of consecutive eligibility

Figure 12 – Medical Chart Review³¹ Summary, Percentage of Charts with Mental Health Screens, 2019 to 2022

Age Categories	2019	2020	2021	2022
0 – 5	N/A	70.2%	76.4%	74.9%
6 – 8	79.6%	80.8%	81.4%	84.4%
9 – 18	83.4%	90.3%	91.4%	89.4%
19 – 20	N/A	90.9%	85.7%	80.0%
Total	82.3%	79.5%	83.4%	82.5%

DoHS strategized throughout the first half of 2023 to discuss strategies on further engagement with the broader group of MCOs under Mountain Health Trust, in the effort to improve screening rates and move toward the goal of at least 52% of Medicaid-eligible children receiving an EPSDT with a mental health screening. As a further step toward meeting this goal, the Wellness Screening PIP team began internal and routine review of preliminary claims data to expand the 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 directly to children and families as well as outreach indirectly 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, such as:

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

Although the efforts put in place have been extensive, the MCOs still note challenges contacting families directly. The MCOs will explore their outreach efforts at a more granular level in 2024 to assess further which outreach avenues have been most fruitful. In addition to this, the PIP team, in collaboration with the MCOs, is also exploring structural barriers for families to complete these visits. BMS meets monthly as a touchpoint with MCOs; these meetings include data review and strategic planning.

To encourage and support connection of children and families to the Assessment Pathway, the group has worked with Aetna, the MCO that provides care management to most children, 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 that the information provided on the Assessment Pathway and associated children’s mental health

³¹ Chart review includes a sampling of Medicaid wellness exam records from claims and provider records from 2019 to 2022

services and resources is relevant to each child.

Other efforts in collaboration with the MCOs and HealthCheck specialists will include continued training and education with primary care providers to help ensure appropriate mental health screening and use of the electronic referral process (and/or sharing of CCRL information) when individuals screen positive. The electronic referral process remains an underutilized option for primary care providers, as use of outreach tools such as wallet cards seemed to be the preference of referring providers. Primary care providers have had a very positive response to the wallet cards and continue to request additional cards to share with children and families. This information is noteworthy, as the wallet cards provide an opportunity for the family to follow up at any time directly based on their own need and schedule. Screening and referrals directly from primary care providers are a focus area for improvement although the current system allows for multiple opportunities for a family to be connected. The Quality Committee also discussed exploring expansion of electronic referral to the CCRL from emergency departments and will revisit this concept in spring 2024.

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

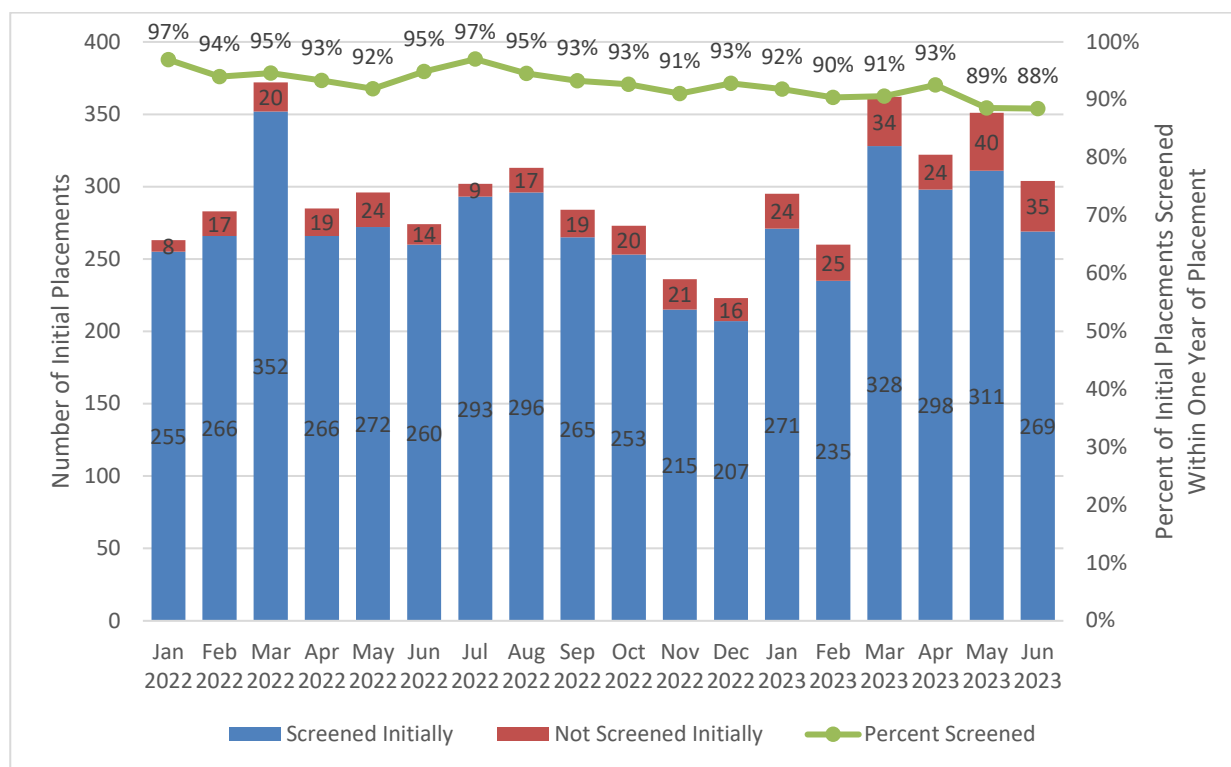
Youth in Foster Care or Certified Kinship Care (Includes Youth in YS and/or CPS)

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

Figure 13 shows the percentage of children with a screening within one year of placement, based on the month the child was placed in DoHS custody. Screenings were reviewed to see if they were completed within a year of placement to align with every child needing to be screened at least once a year. Overall, for the 18-month period shown, 93% of children were screened within one year of initial placement³². 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 DoHS's understanding of the characteristics of unscreened children. Considerations for potential data lag will continue to be assessed.

³² The Fostering Healthy Kids data system is a subset of historical FACTS and current PATH 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 prior to exiting placement.

Figure 13: Initial Child Welfare Placements and Screenings by Month, January 2022 to June 2023



Initial screenings for children in a child welfare placement (initial placement in January to June 2023) were assessed by age at initial placement. Figure 14 indicates children ages zero to five had the highest screening rates (94%) compared to children ages nine to 18 with a lower screening rate (87%). In total, 90% of children with an initial placement in the first half of 2023 were screened.³³

³³ Methodology has been updated from previous reporting periods to account for time sensitivity of screening regarding placement. New methodology only includes screenings occurring within one year of placement, whereas the methodology in prior reports counted *any* screening, regardless of when that screening occurred relative to the initial placement date.

Figure 14: Initial Screenings for Child Welfare Placements in January – June 2023 by Age Group

Age Group at Beginning of Placement	Screened Within One Year of Initial Placement (n)	Screened Within One Year of Initial Placement (%)	Not Screened Within One Year of Initial Placement (n)	Not Screened Within One Year of Initial Placement (%)	Total
0 – 5	693	94.2%	43	5.8%	736
6 – 8	206	90.4%	22	9.6%	228
9 – 18	812	87.4%	117	12.6%	929
Other/Unknown	1	100.0%	0	0.0%	1
Total	1,712	90.4%	182	9.6%	1,894

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 case³⁴. 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 revealed challenges with data quality and completion. Accordingly, 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 statewide rollout which was completed in June 2023. Maps depicting county-level completion rates for data fields in the new collection tool began to be shared monthly beginning in September 2023. BSS leadership in collaboration with the Office of QA will work with district level management in 2024 to focus on data completion by integrating these tools and review efforts into monthly meetings. Continued technical assistance has also focused on appropriate referrals to ensure consistent screening and assessment of needs is completed. These efforts have decreased instances of “across the board” referrals to the Assessment Pathway, as noted in county-level comparisons of the data in Section 8.0 Pathway to Children’s Mental Health Services, thus resulting in the focus on connecting only children who are identified as having a need for services. As noted previously these efforts are in addition to those completed via the HealthCheck program to ensure opportunities are not missed to address needs.

³⁴ 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.

CPS and YS referrals remain as the top source of referrals to the CSED Waiver (61%; see Section 10.0 CSED Waiver Enrollment and Services for additional details), 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 BJS field staff and district leadership will continue to ensure appropriate and timely referrals are made and documented based on standardized tools and processes, helping guarantee children served in the child welfare system can live in the least-restrictive setting and be connected to services to meet their needs.

7.2(c) BJS Screening

Children involved in BJS are screened at intake and each time they transition between BJS facilities. Figure 15 below captures screening by BJS for the period of January 2022 to June 2023. The total population³⁵ of children in BJS custody varies over time and ranged from 208 (September 2022) to 330 (April 2023) with an average of 266 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. An increase in BJS population was observed during the period. BJS leadership attributes this increase in their population to two primary factors: (1) Change in juvenile competency legislation, which resulted in youth under the age of 14 automatically being deemed incompetent and therefore requiring a competency evaluation, and (2) Difficult to place youth being denied placement by out-of-state residential treatment providers or being placed on waitlists. The new models of residential care currently in development by DoHS will be expected to assist with in-state capacity to support youth with complex needs who are currently being placed in BJS custody. Additional time is needed to understand changes in the BJS population and possible correlations with the RMHTF census.

Unique screenings varied throughout the period with a low of 79 in August 2022 and a high of 126 in March 2023.³⁶ BJS conducted an average of 97 unique screenings per month. However, there was a notable upward trend over the reporting period: the average number of unique screenings each month in 2022 was only 93, compared to an average of 107 each month in January to June 2023. The number of screenings per month should equal or exceed the number of intakes per month because each child entering BJS custody should be screened at intake; therefore, the increase in screenings in 2023 is due primarily to the upward trend in BJS population and efforts to screen all children at intake.

Data review and reporting was expanded to include review of data disaggregated by BJS facility to continue making improvements in screening and to provide direct feedback for more targeted improvement efforts. Specifically, effective May 2023, a comparison of screenings versus

³⁵ 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.

³⁶ In past Semiannual Reports, BJS screening numbers included youth screened at Youth Report Centers. Youth receiving services at Youth Report Centers are not in BJS custody and thus are not expected to be screened per BJS policy. To align screening data review more closely with policy, screenings at Youth Report Centers have been excluded from analysis. However, this change means that BJS screening numbers in this Semiannual Report are not directly comparable to screening numbers in prior Semiannual Reports.

intakes at the facility-level was incorporated into monthly reporting. Based on review of this data, it was discovered that one facility had not completed screening as expected; this facility was determined to be short-staffed. Since that time, an increase in starting wages for correctional officers was approved, and a new case manager was hired and is currently in training. Based on a preliminary analysis of screenings versus intakes by facility for August and September 2023, results indicate 95% of children entering BJS are screened at intake—excluding the facility noted that has undergone significant staffing shortages. While this data is representative of a short period, it is a positive sign that screenings are being completed as expected at most BJS facilities.

The Office of QA continues to meet at least quarterly with BJS to improve understanding of the data and work toward quality improvement. Following the last semiannual report, the Office of QA requested the addition of booking date (i.e., date of intake) in the monthly reporting to facilitate a better understanding of screenings and intakes, including timelines from intake to screening. This data became available in August 2023. Based on an initial analysis, 80% of youth are screened on the day of intake to a BJS facility or the following day, and 92% of youth are screened on the day of transfer between BJS facilities or the following day.

Of those screened, the age demographics were consistent with those in residential services, with 89% of individuals screened aged 13 to 17.

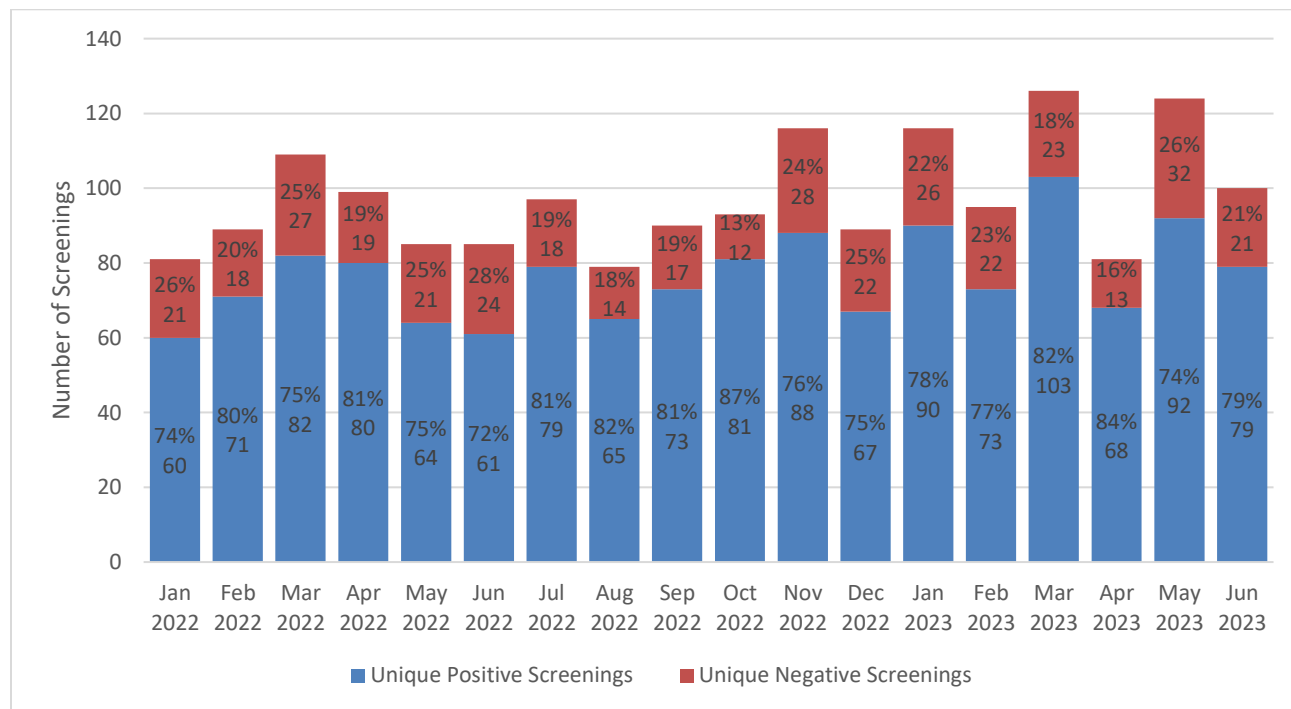
The percentage of positive unique screenings remained relatively consistent during the reporting period, ranging from a low of 72% in June 2022 to a high of 87% in October 2022. In total for January 2022 to June 2023, 960 of the 1,120 unique children screened had a positive screen (85.7%). However, the percentage of positive screenings has decreased over the reporting period, as only 427 of the 518 unique children screened in January to June 2023 had a positive screening (82.4%). Nevertheless, the consistent rate of positive screenings above 80% illustrates the importance of seeking earlier intervention for children involved with BJS and the potential positive impact that connecting this population with services before entering BJS could have on their outcomes.

BJS began making referrals to the Assessment Pathway in the fourth quarter of 2022. The Office of QA is continuing to coordinate with BJS to establish tracking and reporting on referrals to the Assessment Pathway. This information can now be captured in the BJS Offender Information System (OIS), although data completion by BJS staff is an area for improvement. As a temporary solution to support staff accountability, BJS created facility specific spreadsheets for completion by facility case managers, which includes documenting submission of CSED Waiver applications. BJS plans to crosswalk this information with the data in the OIS and use this as a mechanism for feedback to BJS case managers.

DoHS 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 update will be included in Acentra Health's conversion to data collection in Atrezzo which is expected in early 2024; therefore, data on BJS referrals to Acentra Health (i.e., the Assessment Pathway) is not available for this report. BJS screening data and Acentra Health's CSED Waiver application datasets are both in the process of being incorporated into the data store with formal rollout

projected for May 2024. Following that time, cross-systems analyses of children screened via BJS, and subsequently referred to the Assessment Pathway, along with any follow-on utilization of CSED Waiver services will be possible.

Figure 15: BJS MAYSI-2 Mental Health Screenings, January 2022 to June 2023



Children in BJS placement consistently screen positive at high rates (in excess of 80%) indicating this group as a key population of children to target for early intervention and connection to services. 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.

7.2(d) Division of Probation Services Screening

Screening of children adjudicated as status offenders or as delinquent and the associated data collection was implemented by the Division of Probation Services effective March 1, 2022. These screenings are conducted at intake by the assigned probation officer. In November 2022, the Probation Services screening policy was expanded to include screening of pre-adjudicatory children who are in crisis or who do not have a DoHS worker assigned to support early-intervention efforts for those children who may pose a higher risk. Screening may also be conducted at other intervals based on the probation officer's discretion. From March 2022 to October 2023, Probation Services conducted 752 screenings.

Intakes³⁷ completed from March 2022 to June 2023 varied from a low of 180 in July 2022 to a high of 932 in March 2022 with an average of 491 intakes per month. For children with an intake date during this period, the number of children adjudicated as status offenders or delinquents ranged from a low of 40 in September 2022 to a high of 114 in March 2023 with an average of 81 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 June 2023 period varied from a low of 974 in December 2022 to a high of 1,138 in May 2022, with an average of 1,076.

Probation Services continues efforts toward broadening adoption of the screening and referral processes. To support this goal, 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, including on the county-level. As of October 2023, 41 counties have reported screenings at some point since inception of the Probation Services screening processes in March 2022.

Preliminary analyses have allowed for expanded reporting that includes a comparison of adjudications and screenings by county to identify possible deficits in screenings at the county-level. Initial results are being shared with chief probation officers during monthly Chief Probation Officer meetings for the top four counties where adjudications exceeded screenings. Probation Services and the Office of QA remain committed to identifying continued opportunities to screen and refer youth to necessary services. Changes in screening will continue to be monitored for additional opportunities to address any remaining screening challenges.

Additionally, in September 2023, DoHS facilitated two full-day workshops between BSS staff and Probation Services representatives in an effort to improve understanding of the need for connection to mental health services, increase screening rates, and raise awareness of the Assessment Pathway and available services.

Figure 16 shows the number of screenings of children in Probation Services between March 2022 and June 2023. Six hundred fifteen (615) screenings were conducted during this period,³⁸ with an average of 41 screenings per month. Of the 234 unique individuals screened between January and June 2023, 66% identified as male and 33% as female. Ninety-two percent (92%) of those children were between 13- and 17-years-old when they were screened, and 4% were 9- 12-years-old. These demographics are consistent with the prior reporting period. Of the screenings that occurred between March 2022 and June 2023, 250 (40.7%) were positive while 365 (59.3%) were negative. Reflecting on the general population of youth with an SED, 11% of WV youth with Medicaid/WVCHIP had an SED diagnosis in 2022 (reference Figure 5 in Section 4.0 WV's Child Population and Individuals Utilizing Services). While it is not a direct comparison,

³⁷ Intakes during each month do not necessarily equate to children who are adjudicated as status offenders or delinquent because adjudication may occur after intake and may not fall within the same month. Additionally, some children are not adjudicated as status offenders or delinquent (e.g., the child may be found not guilty, or the case may be dismissed).

³⁸ Twelve (12) children were screened twice; 603 unique children were screened.

note 41% of youth with Probation Services were identified with a mental health need, further suggesting the importance of early intervention and screening with these individuals.

Probation-involved youth positive screenings have remained relatively consistent around 37% – 40% since screening was initiated in March 2022. While lower than BJS positive screening rates (an excess of 80% of youth in BJS custody screen positive), Probation-involved youth continue to be a high need population compared to the general youth population³⁹; DoHS remains aware of the need to target these youth for early intervention and connection to services.

Figure 16: Probation Services MAYSI-2 Screenings, March 2022 to June 2023

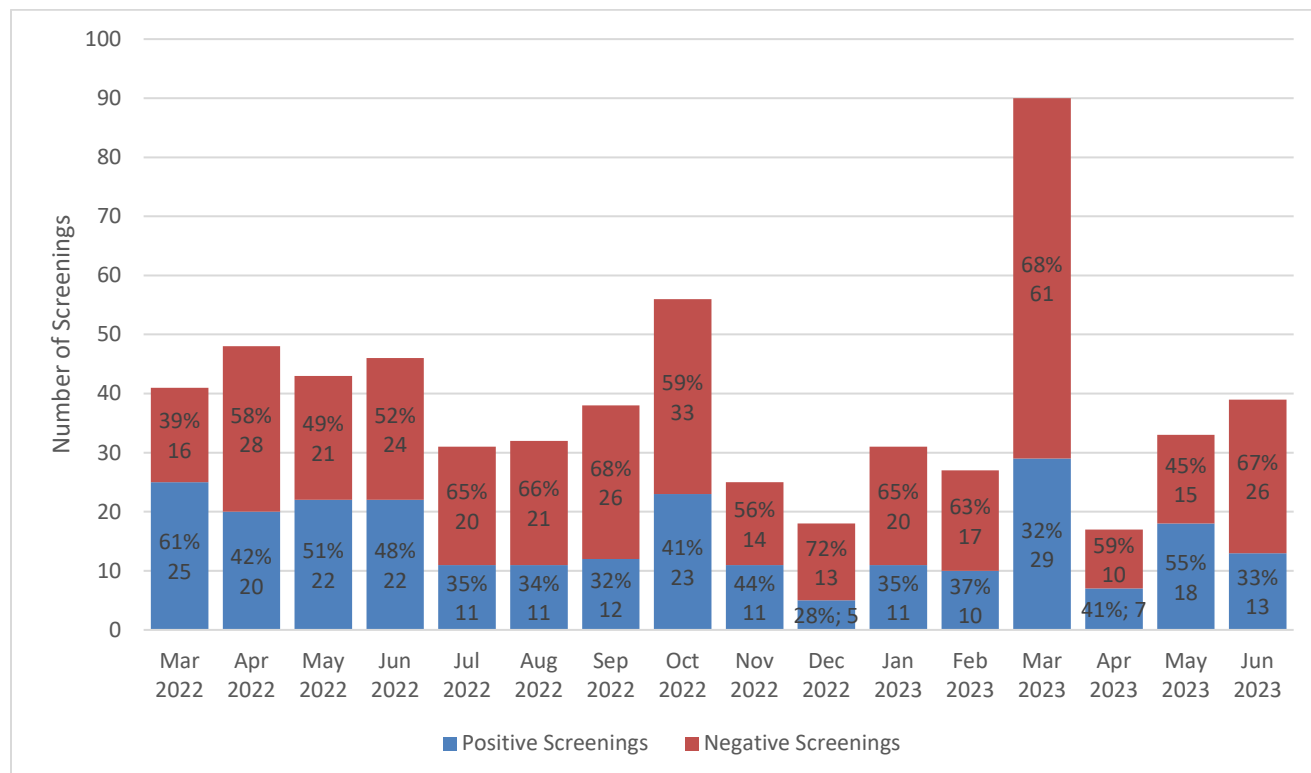
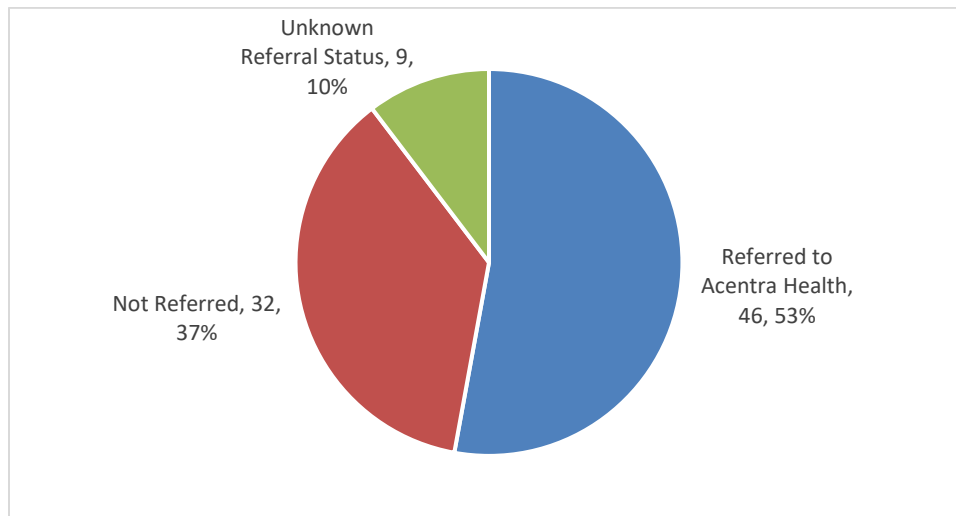


Figure 17 shows the referral status for the 87 unique children who screened positive from January to June 2023. Forty-six children (53%) completed an application and were referred to the Assessment Pathway (Acentra Health) for further evaluation. This represents an improvement from the 41% reported in the July to December 2022 period. On average, these 46 children were referred 2.8 calendar days following their positive screening. Thirty-five children (76%) were referred within two days of screening, 41 children (89%) were referred within five days, and 98% (n = 45) were referred within 10 days.

³⁹ Probation involved youth have positive mental health screens around 37-40%, which is above the rate for WV youth at 33% as noted in the 2022 National Survey of Children's Mental Health: 26% of responses for 3 to 17 years old in the United States reported one or more reported mental, emotional, developmental, or behavioral problem and/or qualify on the Children's Special Health Care Needs screening for emotional, behavioral, or developmental criteria compared to 33% responses representing WV youth.

Figure 17: Referral to the Assessment Pathway (via Acentra Health) for Children With a Positive MAYSI-2 Screening Through Probation Services, January – June 2023 (n = 87)



For the 41 children who were not referred or who had an unknown referral status, the most listed reason for declining the referral was that the parent/guardian believed other mental health services already in place were sufficient to meet the needs of the child (n = 23, 56%). The second most common reason (n = 8, 20%) was that the referral to the Assessment Pathway was already submitted by another entity.

Further build-out of the data store will enable an analysis of services these children are accessing and will also allow identification of children who screen positive who may not have been referred to the Assessment Pathway. Probation screening data is currently in the process of being incorporated into the data store with a projected release date of May 2024. Additional cross-systems analysis will become available following that time.

7.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing an EPSDT with a mental health screening, outreach to primary care providers about the Assessment Pathway started in November 2021. Out of 694 providers, 85% were reached by HealthCheck specialists in 2023 for training on the CCRL (including CMCRS services) and the provider electronic referral process. Resources were distributed to all sites. HealthCheck is developing an approach to reach the remaining 15% of providers in 2024.

Child welfare position vacancies continue to be a concern for effectively implementing screening and maintaining trained staff. As of November 30, 2023, there were 79 vacant CPS Worker positions out of 458, marking a more than 47% vacancy reduction from the previous year, which saw 150 vacant CPS worker positions, out of 455 on November 30, 2022⁴⁰. Youth Services Worker positions also saw an 80% vacancy reduction with nine vacant positions out of 124, compared to 45 vacant positions out of 127 from the previous year.

⁴⁰ This sentence refers to CPS and YS workers only and does not include coordinator or supervisor positions.

As of October 2023, over 6,000 children were in the child welfare system. As of October 2023, 84% of child welfare workforce positions were filled, which includes CPS and YS workers, supervisors, and coordinators, compared to 80% of positions filled in May 2023. Figure 18 shows the vacancies for these positions 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, that 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. In January 2023, additional incentives were announced. Retention bonuses were put in place for employees who reach two, four, six, and eight years in their positions. Special hiring rates were established for CPS workers in Berkeley, Jefferson, and Morgan counties. Positions were also added for support staff.⁴¹ These incentives likely contributed to the increases in positions filled. While workforce recruitment and retention continue to be a challenge, positions filled have increased 9% from the previous year.

Figure 18: Child Welfare Workforce October 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	559	79	656	85%
YS	123	13	156	78%
Total	682	110	812	84%

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

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. DoHS is committed to continuing efforts to help ensure children can be identified through multiple entry points and are connected to services meeting their needs in settings that are supportive and, in the home and community when clinically appropriate. Given the high percentages of referrals originating from child welfare and other screening sources, DoHS is collaborating with Acentra Health to help ensure they are prepared to handle the continued increase in referrals that is projected.

⁴¹ <https://dhhr.wv.gov/News/2023/Pages/dhhr-Unveils-Major-New-Initiative-to-Strengthen-Protective-Services.aspx>

DoHS will continue to reinforce, in collaboration with WV Department of Health, primary care provider related referrals and screening. As part of this process, the PIP team will determine needs and opportunities with the HealthCheck program focusing on providers in need of education and technical assistance on how to incorporate mental health screening components into the EPSDT visit. In addition to provider outreach, DoHS will review preliminary claims data and provide feedback to the MCOs regarding provider trainings and outreach to families to encourage wellness visits and screenings. Efforts continue to enhance reporting by the MCOs to provide more extensive information related to child screenings. DoHS will also explore the feasibility of expanding electronic referral to the Assessment Pathway from emergency departments in spring 2024.

BJS screening data indicates the screening process is timely and has been widely adopted. BJS screening data and Acentra Health referral data are expected to be available in the data store by May 2024. Following that time, cross-systems analyses of children screened via BJS, and subsequently referred to the Assessment Pathway, along with any follow-up utilization of CSED Waiver services will be possible. 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 the success of these children in the community.

Probation Services continues efforts toward broader adoption of the screening and referral process with initial findings from county-level data comparing adjudications and screenings being reported to the counties with greatest opportunity for improvement via meetings with chief probation officers. Probation services screening data and Acentra Health referral data are expected to be available in the data store by May 2024 with similar cross-systems analysis becoming available as noted above for BJS.

WV continues to face workforce shortages in CPS and YS positions; however, recent recruitment efforts have resulted in decreased vacancy rates—with a total increase in occupancy of 9% in 2023. Although these improvements are expected to ease strain on the workforce, benefits have not yet been realized due to the significant time and effort involved in staff onboarding processes that must be completed before productivity increases can be actualized. DoHS plans to enhance efforts to review screening data and provide feedback over the coming months to solidify processes for new and established employees, while helping to ensure children entering CPS and YS receive timely screening and referral to the Assessment Pathway when a mental health need is identified. Recruitment, training, and technical assistance must be ongoing to meet these needs; as a result, 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 enable DoHS to 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 DoHS'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 in Section 7.0)
- WV Wraparound Facilitation
- CSED Waiver services
- CMCRS
- CCRL
- Connection to HCBS
- BSS programs and services—for children interacting with child welfare (i.e., CPS or YS), including connection to the QIA process for children with high and imminent risk of entering RMHTF settings
- Engagement with the judicial system via the Court Improvement Program
- RMHTF discharge planning

Instead of requiring families to navigate these behavioral health services themselves, the Assessment Pathway streamlines access points for assessment of children’s mental or behavioral health service needs and provides appropriate linkages to services while the assessment process is being completed. The Assessment Pathway also links families to services when children are transitioning back to their home or community settings after an out-of-home or residential placement. The WVU CMH Evaluation report for community-based stakeholders noted that caregivers shared a desire to understand the purpose and goals of each of the services and to receive specific contact information to help them access those services. The Assessment Pathway framework is designed to address these needs and improve a family’s ability to navigate services. Attributable to the robust and streamlined pathway built out for families, additional analysis from the CMH Evaluation found 86% of community-based caregivers who were aware of wraparound services reported no barriers related to understanding how to navigate getting mental health services for their child, a statistically significant finding.

Children who enter the Assessment Pathway will receive HCBS to meet interim needs, and families will receive information regarding how to connect to crisis services. Unless a QIA is warranted, the child will be referred to HCBS that are appropriate for their needs, including WV Wraparound 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 QIA.

The Assessment Pathway is designed to:

- Streamline behavioral and mental health referral and service provision for children and families.
- Connect children and families to WV Wraparound Facilitation and other HCBS.
- Aid families with the CSED Waiver application process.
- Individuals who are involved with child welfare and are at immediate risk of RMHTF placement will 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, enabling 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, DoHS has implemented a “no wrong door” approach (multi-access points) to the Assessment Pathway.

8.1 Review Period, Data Sources and Limitations, Population Measured

Figure 19 provides an overview of the Assessment Pathway referral data.

Figure 19: 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 from Acentra Health	January to June 2023	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 for children applying directly for the CSED Waiver.

Description	Data Review Period	Data Source	Details and Limitations	Population Measured
Matched, unduplicated referrals to WV Wraparound (comprehensive of all entry points in the Assessment Pathway)	January to June 2023	BBH Assessment Pathway Tracking Portal and ASO Reporting Spreadsheet	Matching information from these two sources allows for an expanded scope to understand details for all referrals to the Assessment Pathway, regardless of outcome. However, inconsistencies related to child-level identifiers may impact matching accuracy. Data cleaning was applied to remove as many instances of unintended duplication as possible.	Referrals to the Assessment Pathway/WV Wraparound regardless of referral source/type.
Assessment Pathway – Referrals made directly to Acentra Health	For CSED specific data, see Section 10.0 CSED Waiver Enrollment and Services, which includes referrals by type (e.g., DoHS, parent).			

8.2 Review Summary

The Assessment Pathway represents multiple doorways to access mental health services. The results presented in Subsection 8.3 correspond to an overview of all referrals, regardless of referral source, while a separate update in Subsection 8.4 provides details on the specific activities of the Assessment Pathway that are not associated with children in the child welfare system. In other words, Subsection 8.3 is representative of referrals made directly to Acentra Health that are shared with the BBH Assessment Pathway “Support Team” (i.e., those who are referred through this team from the CCRL, CMCRS, families, and primary care physicians).

8.3 Comprehensive WV Wraparound Referrals

The Assessment Pathway offers multiple entry points for families, providers, and advocates to refer children and families to key HCBS, including WV Wraparound. As shown in Figure 20, From January to June 2023, 1,417 unique children were referred to be assessed for and connected to HCBS. This is a 35% increase from the previous six-month period (July to December 2022), during which 1,046 children were referred, and equates to a referral rate of 3.8 youth referred per 1,000 WV youth in January to June 2023.

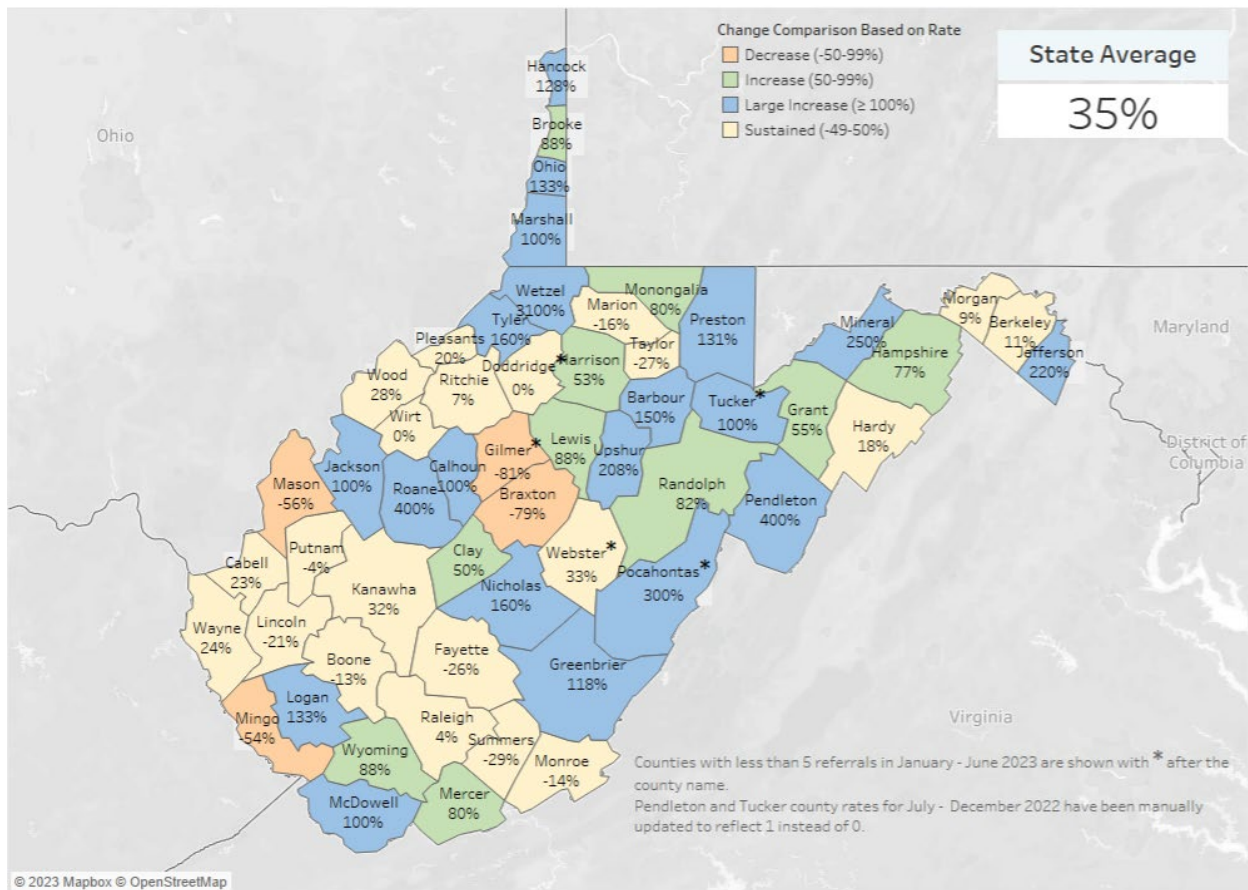
Figure 20: Comprehensive WV Wraparound Referrals- 6-Month Period Comparison

Wraparound Referrals July - December 2022	Referral Rate per 1,000 Youth July - December 2022	Wraparound Referrals January - June 2023	Referral Rate per 1,000 Youth January - June 2023	Percentage Change in Number of Wraparound Referrals
1,046	2.8	1,417	3.8	35%

The Quality Committee reviewed county-level referral rates and percent change to assess opportunities for outreach and education (Figures 21 and 22). In addition to reviewing these maps, DoHS has conducted in-depth reviews at the county-level, including reviews of other related maps. Understanding relationships between approval rates, referral rates, RMHTF admission rates, and proportion of the population at-risk is helping the Quality Committee implement a more informed and data-driven approach to marketing and access education needs. Although additional review and consideration of this information is planned for early 2024, the Quality Committee has already identified some reasons for the changes in some counties. Braxton county, for example, had a 79% decrease from the prior six-month period. DoHS further explored this by comparing information on technical assistance provided and approval rates for Braxton County. It was noted that for CY 2022, Braxton County only had a 26% CSED application approval rate. This low rate of approvals was found to be driven by child welfare related referrals, which had been sent for most youth in care for that county, regardless of screening result. This has since been remedied to reinforce use of standardized tools to inform referral needs. This is just one example of county-level review that will continue to evolve over the coming months to allow DoHS to prioritize counties based on their various needs.

Consideration is also being given to fluctuation in smaller counties that will need to be accounted for in the prioritization process. Education and technical assistance provided to child welfare workers has continued to influence referral rates positively, as counties where technical assistance has been provided often experience increases in referral rates, except for counties where referrals were being completed without standard screening.

Figure 21: County-Level Comprehensive Assessment Pathway Percent Change in Referral Rates per 1,000 Child Population, July – December 2022 to January – June 2023

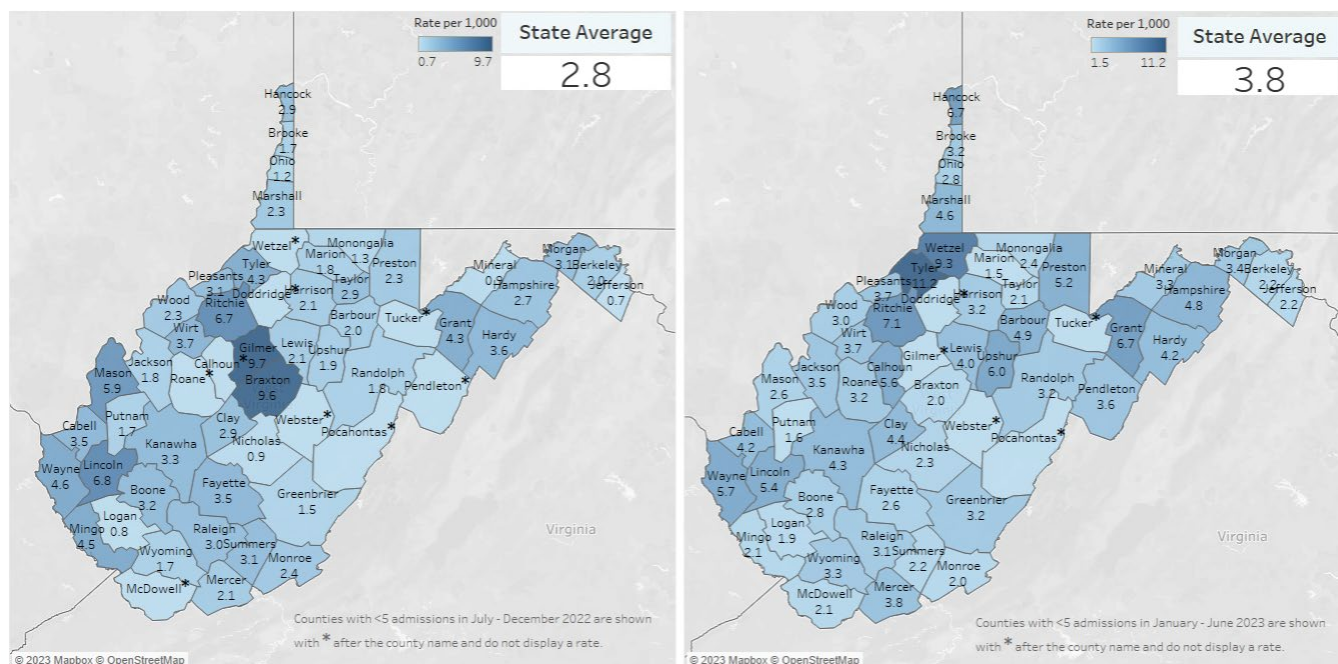


Only two counties did not submit a referral during the last half of 2022: Pendleton and Tucker counties; however, in the first six months of 2023 a referral was received for at least one child in all 55 counties. The 35% average increase shown in Figure 21 highlights the extensive work being completed to expand awareness across the state. As noted previously, DoHS plans to complete further review of geographical data across systems to inform strategy for outreach.

Members of the Quality Committee continued to discuss further investigation into Medicaid claims to improve understanding of services children with SED and/or children at-risk of residential placement 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 an area of further exploration that could help to ensure access and awareness are not issues for areas with lower referral rates. Results of the WVU CMH Evaluation for community-based stakeholders found 34% of caregivers and 60% of youth reported a perception that needed services were not available in their area. DoHS will investigate these results further for any additional insight into regional needs as identified by families, youth, and providers (whether those be education or capacity related). Assessment of cross-systems geographical data will be the next evolution to DoHS's CQI efforts; however, referrals to the Assessment Pathway from all

the state's counties in the first six months of 2023 – an improvement from eight counties with zero referrals during the first half of 2022 – show continued expansion and progress for outreach and awareness-raising efforts.

Figure 22: County-Level Comprehensive Assessment Pathway Referral Rates per 1,000 Child Population, July - December 2022 compared to January-June 2023 (left-to-right)



8.4 BBH-Associated Assessment Pathway Referrals

Since the inception of the Assessment Pathway in late 2021, BBH and associated contractors have helped connect families and advocates (e.g., child welfare workers) with interim services and supports during the CSED Waiver determination process. In spring 2023, MU was added as a resource in this process for children in the child welfare system to enable more timely connection to services in coordination with BSS. Following this process change, referral tracking for youth with social service involvement is now being tracked outside of the Assessment Pathway Portal. Due to the establishment of new data reporting and related limitations, the data on the specific referral processes outside of a CSED applications will be included in future reports.

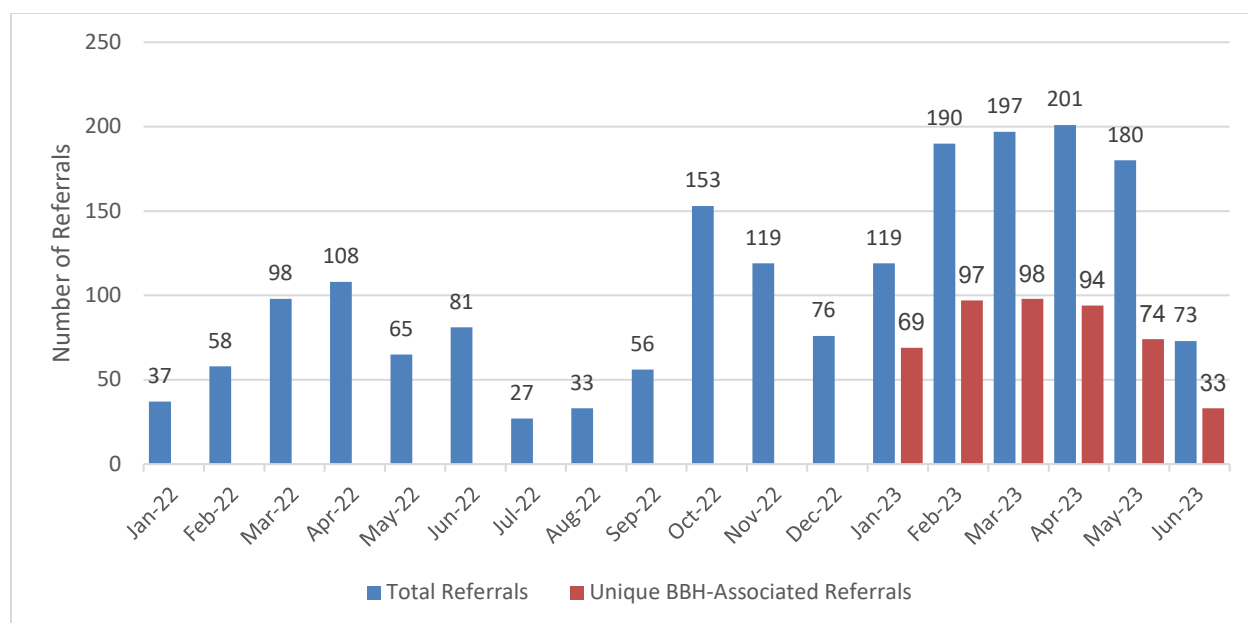
Referrals managed by the BBH Assessment Pathway “Support Team⁴²” – referrals that are not associated with the child welfare system – continue to be monitored and reportable in detail. These referrals can originate from applications made directly to Acentra Health which are shared with the BBH Assessment Pathway “Support Team” or from those who are referred through the BBH team from the CCRL, CMCRS, families, primary care physicians, etc. It is important to take a deeper look at these referrals as they are more representative of families

⁴² The BBH Assessment Pathway “Support Team” includes regional care coordinators (contracted) and BBH staff members.

who may have less system involvement, potentially creating an opportunity to connect children to appropriate services before a systems intervention is needed.

There were 465 children with BBH-associated referrals in January to June 2023. Previous comparisons are not available for BBH-associated referrals to previous periods due to changes in processes. Figure 23 depicts the total number of referrals by month as well as the unique BBH-associated children referred by month, with BBH-associated referrals first captured in January 2023.⁴³ Referrals have continued to increase since the inception of the Assessment Pathway in late 2021, and while there have been noted seasonal decreases, total referrals doubled year-over-year from March 2022 to March 2023. BBH-associated referrals maintained at slightly less than 100 referrals per month from February to April, and then experienced decreases in the summer months, likely associated with the school year ending.

Figure 23: Referrals to the Assessment Pathway by Month, January 2022 – June 2023



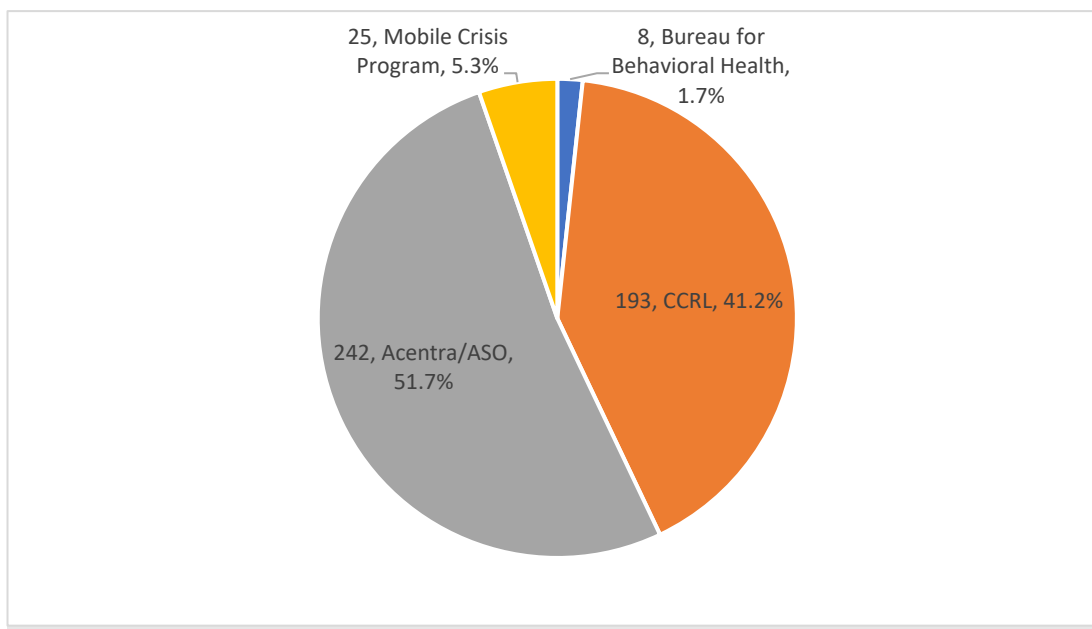
It is noteworthy that children with BBH-associated referrals tended to be younger than other CSED applicants. Children 5-to-12-years-old comprised 53% of BBH-associated referrals compared to 35% of total CSED application referrals. This finding may be associated with DoHS's efforts to outreach to families and provide early intervention, providing opportunities to stabilize youth and families before systems or placement level involvement is needed.

Figure 24 shows the breakdown of referrals by the source of the call/initial referral. As with the previous reporting period, the largest source for BBH-associated referrals is from Acentra

⁴³ 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).

Health (the ASO which accepts applications from a number of sources) (n=242, 51.7%), followed by the CCRL (n=193, 41.2%). 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 BBH-associated referrals from multiple sources that are connected to the Assessment Pathway via Acentra Health. These sources include, but are not limited to, MCO, self/family, and Probation originating referrals. Referrals from BPH screening efforts via HealthCheck/EPSTD electronic referral processes originated via the CCRL (17 referrals for the six-month period), and caregivers also had the option to call the CCRL directly. Referrals from the CMCRS comprised only 5.3% (25 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 CMCRS services via a local call line rather than via the CCRL, this may be a lower rate of referrals than would be expected. Additional analysis was completed to assess referral status of individuals with multiple calls as a starting point to help ensure children are receiving appropriate connection to longer-term services. Preliminary analysis identified additional opportunities to provide referrals to longer-term services, the Quality Committee recommended additional education to providers about referral opportunities and ensuring families were connected to longer-term services with consideration to the family's voice and choice.

Figure 24: Source of Call or Initial BBH-Associated Referral, January – June 2023

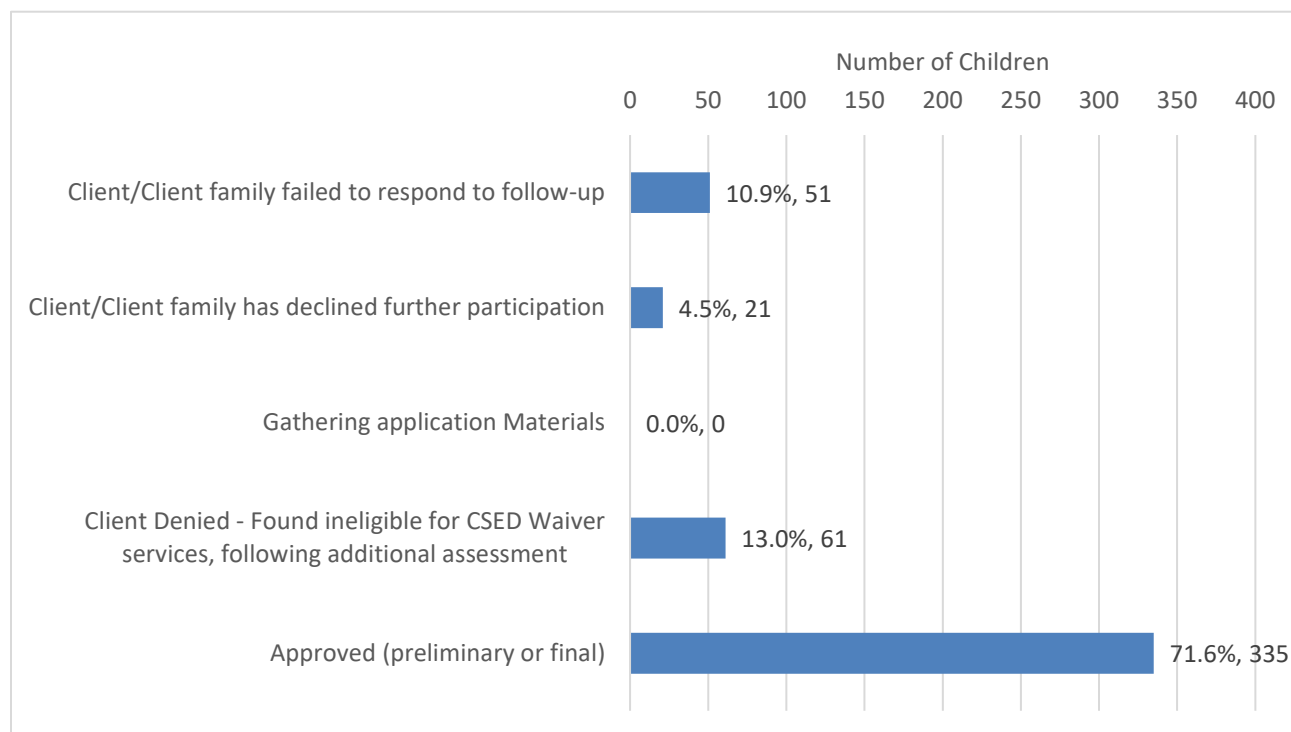


For youth and families engaging in the Assessment Pathway, connection to services is provided based on the wants and needs of the families. DoHS will work in 2024 to increase documentation on interim HCBS (beyond WV Wraparound). As shown in Figure 25, 72% of referrals receive preliminary or final approval for CSED services. A total of 15% cease participation with the Assessment Pathway, with 4.5%, n = 21, directly declining further participation. Thirteen percent (13%) of referrals are determined ineligible. For those determined ineligible, processes are in place to refer families to other services. It is noteworthy that referrals

engaging with the BBH Assessment Pathway “Support Team” come from several entry ways that may influence their likelihood of continued engagement. This may limit the ability to generalize these findings. For example, referrals from Acentra Health, which have already had the CAFAS/PECFAS assessment with a preliminary approval to receive interim Wraparound services, may be more likely to continue engagement as they have already participated in the assessment process. This is compared to families referred via the CCRL who have not yet submitted a CSED Waiver application and could have had a referral made on their behalf (e.g., by a school counselor), but who may or may not be interested in the services.

Of the families directly declining further participation, a third (33.3%, n = 7) reported being referred to, pursuing, or receiving other services. Another 24% (n = 5) of the families directly declining further participation noted that they did not think services were necessary, were not interested, or services were “too intense”. It was noted based on feedback from the BBH “Support Team” that they “regularly” hear feedback from families; once a family hears about additional service options, the family sometimes prefers options in the community, or has reservations about receiving services in their home. Closure reasons will continue to be monitored. However, the small number of closures and reasons for ceasing participation 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 or seeking other services that were meeting or were anticipated to meet their needs, while also maintaining awareness and ability to connect to the Assessment Pathway should additional or more intense needs arise. It should also be noted that some families may cease participation due to not perceiving a need for intensive services; this should also be viewed as a positive outcome that occurred to raise awareness of services should additional needs arise in the future despite the lack of present perceived need. The remaining nine families either gave no reason (n = 6) or reported that the youth was in an RMHTF or no longer in the home (3).

Figure 25 - Progression Through the Assessment Pathway – BBH-Associated Referrals, January-June 2023



Due to statewide workforce capacity shortages through BBH grant-funded Wraparound providers, most youth are approved for the CSED Waiver and transferred to Aetna Case Management before receiving interim Wraparound services (79% of approved referrals, n = 335). This shortage is directly related to the growing system and processes that allow a family to continue with their facilitator once transferred to CSED Waiver funding, a benefit to the family and continued rapport building of the facilitator. As noted above, given limitations on workforce capacity for Wraparound Facilitators by funding source, other HCBS are utilized to connect the family such as Behavioral Support Services, therapy, CMCRS, Functional Family Therapy, Expanded School Mental Health, Respite Care, Regional Youth Service Centers, Nurturing Parenting classes to support the parent, etc. This is also available to families who are determined to be ineligible for CSED Waiver services. Service connection includes access to a regional family coordinator and a local CMCRS team. Calls made to the CCRL that connect to the CMCRS team are on average answered in 13 seconds. The BBH “Support Team” also allows text communication with families in addition to phone or email options to enable flexibility in communicating needs. A triage process has also been implemented to help ensure families in critical need are connected and prioritized appropriately to meet immediate stabilization needs through available and existing services.

DoHS 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 WV Wraparound services.⁴⁴ As additional components of the data store are being built out and data quality initiatives continue, critical data elements will be able to be connected across systems. DoHS expects to add the fifth key timeliness step to improve the understanding of the family's journey and total time to the child's first service with the provider. In the November Quality review, DoHS identified key steps to enhance data quality and completion for these timeliness measures and anticipates increased frequency of review in 2024 to ensure integration of additional CQI processes through the Wraparound Fidelity PIP team. These timeliness measures are helpful in assessing families' experience in accessing services at individual stages in the process as well as the overall experience.

BBH-Associated Referral Timeliness Indicators:

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

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

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

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

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

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

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

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

⁴⁴ 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 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 CSED Waiver 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.

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

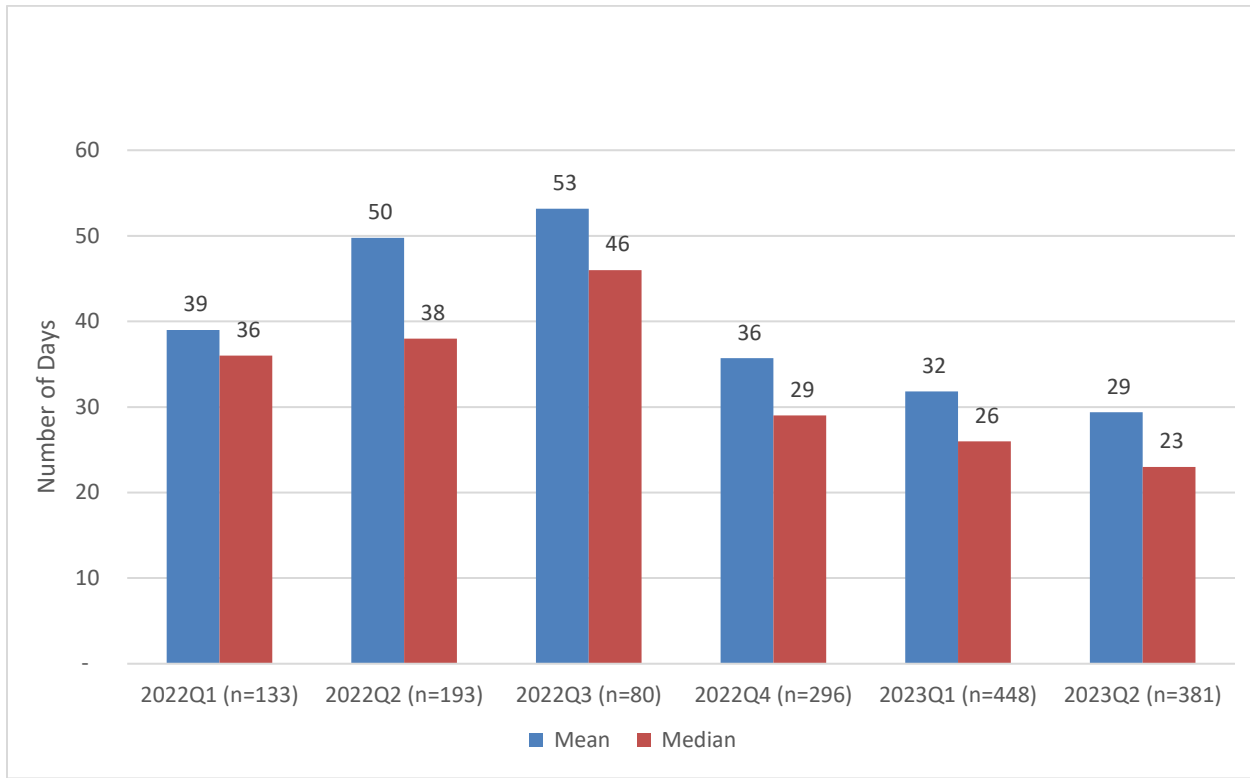
The BBH “Support Team” (Assessment Pathway) process to connect with families and assist them with identifying supports, needs, and with completing the CSED Waiver application, has shown continued success from timeliness data and feedback received from families. As noted above, workforce capacity limits the ability for timely connection to interim wraparound services given workforce availability and transfer of facilitators to CSED funding sources with families already utilizing Wraparound services. Program staff are working with providers to identify opportunities to expand capacity and have expanded provider training to include management of expenses and considerations with additional Medicaid-based income. Acentra Health, Aetna case managers, BSS, and the BBH “Support Team” continue to provide information on other interim HCBS while workforce challenges are resolved.

DoHS is committed to continuing to examine timeliness from the family journey perspective. For this purpose, analysis was completed only for referrals originating with BBH (excluding applications received directly by Acentra Health), which allows insight into timeliness of connection with families including the full CSED Waiver application submission process to final CSED Waiver determination.

As shown in Figure 26, despite growth in the number of families seeking CSED Waiver determination, timeliness from referral to determination has improved over the past year. In April to June 2023, 381 referrals⁴⁵ completed the determination process within an average of 29 days compared to 193 referrals in April to June 2022 at an average of 50 days to determination. The CMS CSED Waiver application lists an intention to complete determination within 45 days of application submission. Therefore, even accounting for additional time that the BBH “Support Team” works with families to prepare for application submission, DoHS remains well within the 45-day goal, thereby allowing families opportunities to be one step closer to the start of services in a timely manner. DoHS continues to look at these timelines in summary and stepwise to determine opportunities to improve and maintain timeliness for families. Additional information and a more comprehensive view of this journey, including service start is anticipated for the July 2024 edition of this report.

⁴⁵ Referrals are only included for youth with non-missing data in relevant date fields. Approximately 18% of records had missing data in at least one field. Efforts will continue to enhance data quality and completion.

Figure 26: Assessment Pathway Referrals Representing the Family Journey to Determination by Quarter – Days from Referral Date to Determination Date



8.5 Provider Capacity/Statewide Coverage

In the past several years, DoHS 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, DoHS 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 to perform and report back CAFAS/PECFAS scores 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. See Section 10.0 CSED Waiver and Enrollment Services for more details on CSED provider capacity. As referrals continue to grow, DoHS 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 continue to monitor as changes were implemented to render processes more seamless for families by allowing them to maintain a facilitator between payor sources. Some intermediate solutions for limited interim Wraparound Facilitator capacity have been to utilize and connect families to other HCBS. Acentra Health, Aetna Case managers, BSS, regional care coordinators, and BBH staff are aware and trained

on how to connect families with local HCBS if immediate wraparound services are not yet available. Acentra Health has 11 total assessors, with six dedicated to CSED Waiver-related assessments and an additional 5 who are dedicated to overlapping assessments occurring with the QIA and CSED Waiver application process. Additional information on provider capacity for services and payor source considerations is included in the Section 11.0 Wraparound Facilitation.

Currently, BBH has four staff via grant funding and one full-time employee processing BBH-associated referrals. BBH is in the process of evaluating staffing needs and determining next steps to meet the volume of referrals. Two 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.

BSS has a dedicated staff member that helps process child welfare related referrals received from Acentra Health. This individual communicates with child welfare workers on determination status and whether the referral can be put into the CANS Automated System. Upon receipt of the entry in the CANS System, two MU staff are dedicated to help facilitate assignment to a facilitator and management of youth placed on the SAH waitlist, which includes but is not limited to providing a list of alternative services that could be put in place in the meantime.

The CMH Evaluation provider survey received responses from 11 organizations offering CSED Waiver Wraparound services in Year 2; eight or 73% of these providers reported difficulties providing service coverage. Among those eight organizations, some difficulty with service coverage was reported for all counties, and the greatest percentage of organizations and facilities that offered CSED Waiver Wraparound in Year 2 had difficulties covering Cabell, Lincoln, Putnam, Wayne, and McDowell counties. These counties are all border counties which can result in workforce challenges due to proximity to neighboring states. Subsequent to the Year 2 survey period (November 2022 to April 2023), the number of CSED Waiver providers in each of these counties increased as of November 2023 (reference Figure 40, Number of Provider Agencies Offering CSED Services by County, in Subsection 10.3 Provider Capacity/Statewide Coverage).

8.6 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 and advocates. The Assessment Pathway aids families in accessing interim or alternative HCBS to meet families' needs while waiting for CSED Waiver determination or deciding to pursue other appropriate mental health services. A 35% increase in statewide referrals and referrals from all the state's 55 counties in the first half of 2023 was found to be an encouraging gauge of expanding awareness and the Assessment Pathway being accessible to families and related advocates (other referral sources).

Another positive step in raising awareness of the Assessment Pathway and connecting families to services and resources included CCRL brochures provided to the Bureau for Family

Assistance (BFA) for dissemination to families served. An array of CCRL information materials (posters, magnets, business cards) were sent to all county DoHS offices. BBH also conducted regional fairs in Raleigh, Kanawha, and Ohio counties 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 through which resources were heavily shared. BBH will provide additional education to MCRS (Mobile Crisis Response Services) providers about referral opportunities and helping to ensure families are connected to longer-term services with consideration to the family’s voice and choice.

A continued next step for DoHS 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 enable collection of interim Wraparound services information to include types of services as well as service start and end dates. This data began to be collected for Safe at Home (SAH) interim cases in December 2022 and has been added to BBH interim cases as of October 31, 2023. These measures will be considered in future reporting once data becomes available. Additionally, DoHS will explore opportunities to capture additional information regarding connections to other HCBS options to demonstrate further the array of supports provided to families.

Assessment Pathway staff (including those covering various entries into the Pathway) continue to focus on both meeting family and support needs as well as on improving data completion and quality. To support this effort, CQI processes are in place for Acentra Health and BBH to provide feedback, enabling additional recurring training opportunities on the process and data entry. As noted previously, these processes will be extended to BSS-referrals going through MU in early 2024. Program staff review Assessment Pathway data reports semiannually 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)

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

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

9.1 Review Period, Data Sources and Limitations, Population Measured

Currently, DoHS is working with Acentra Health and Aetna to expand the QIA process to help ensure all children in RMHTF settings have been assessed for their level of need and appropriate placement setting. Effective August 2022, BSS directed residential providers to begin referring any new children entering residential placement to the QIA process; however, given this process remains in 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 facilitate continuity of the QIA process independent of any staff turnover. DoHS has also

collaborated with Aetna to assist with provider outreach for youth already in residential treatment settings that had not yet had a QIA completed. Youth with multiple historic residential stays as well as children with an in-state length of stay ranging from 90 to 200 days have been prioritized for timely QIA referral; aiming to increase the ability to use the QIA results to facilitate integration back into the community where appropriate.

Figure 27: QIA Process Data Overview

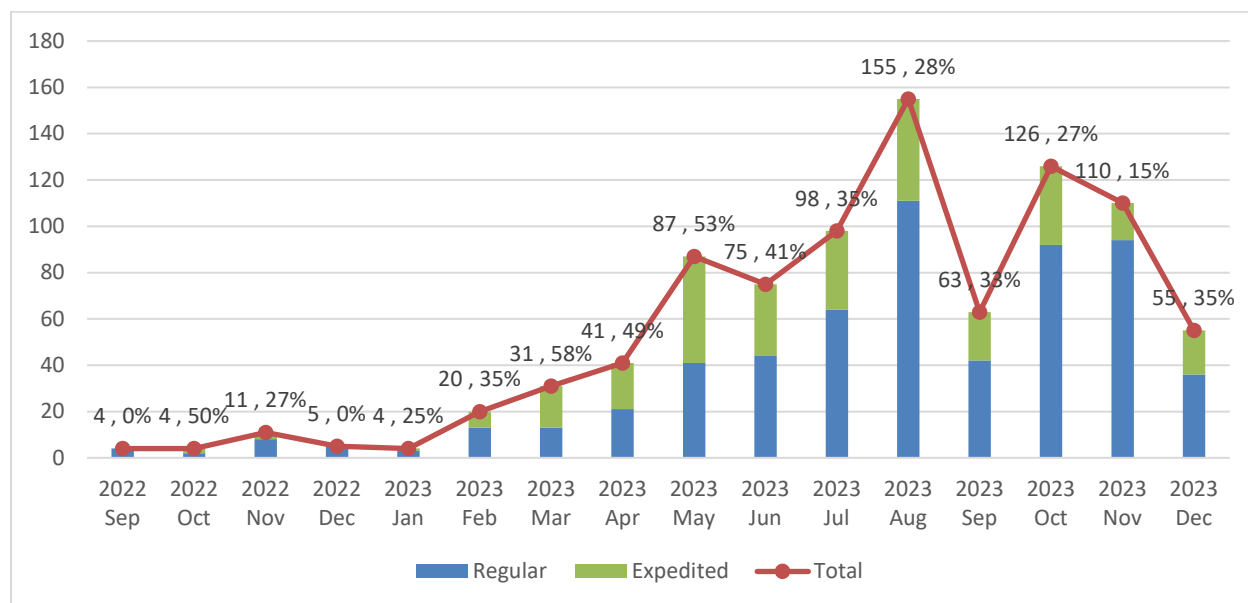
Data Review Period	Data Source	Details and Limitations	Population Measured
October 2023, Referral trends: August 2022 to December 2023	QIA Tracking Spreadsheet	This dataset contains a snapshot of QIA referrals received in October 2023. This month was chosen for review due to data completion and quality limitations for previous referrals. Significant focus has been placed on improvement of data quality and completion for this service since late summer 2023, when tracking was shifted to Acentra Health's tracking spreadsheet. Data continues to be reviewed monthly with vendors, and longer time periods for reporting are expected in the next edition of this report. There are also plans to integrate this tracking into the Atrezzo system.	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.
November 2023	WV PATH	Admissions into residential treatment facilities in November 2023 was used as a proxy at the county-level to determine counties utilizing, or potentially underutilizing QIA processes, based on referrals from October 2023. This data may be subject to change due to data entry lag.	Youth aged 0 – 20 admitted into an RMHTF setting in November 2023 and in DoHS custody.

9.2 Review Summary

In October 2023, 126 children were referred for a QIA. Figure 28 demonstrates referral patterns from August 2022 to December 2023. As shown, referrals increased during the training and rollout period from August 2022 to May 2023. Fluctuations in referral patterns have been noted as additional technical assistance and data quality control processes have been implemented following monthly review of data. Referrals may expect to wane over the holiday season, but DoHS will continue to monitor referrals and data quality on a monthly and weekly basis to help

with implementation efficiency. A process was built out to expedite referrals that had imminent risk of residential placement, shortening timelines for assessment to 14 days rather than 30 days. From August 2022 to December 2023, 33% of referrals met criteria for expedited assessment. Similar trends were observed in October 2023 specifically, when 27% of referrals met criteria to be expedited. Referrals expedited included youth with court orders to residential placement and youth in DoHS custody who were placed in an ED, acute hospital unit, or hotel setting.

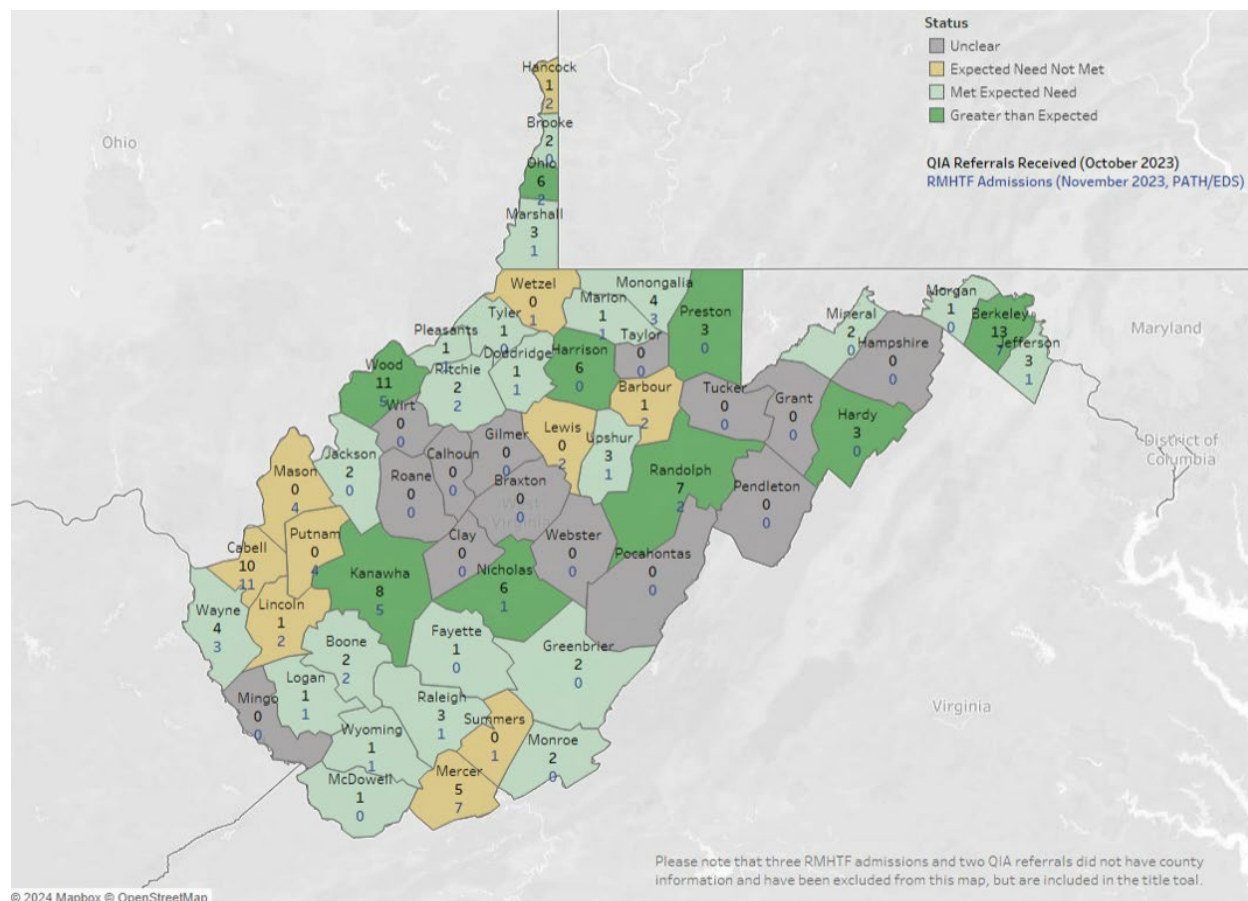
Figure 28: QIA Assessment Referrals by Month, August 2022 to December 2023
Total N = 892 Expedited = 298 (33.4%)



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 depicting total referrals made compared to the number of referrals expected for the month (based on average county-level admissions for the previous year) has been provided to social services managers. Data is now available in WV PATH to review actual RMHTF admissions for the following month after referral. As shown in Figure 29, November admissions to RMHTF placement were compared at the county-level to QIA referrals in October. This map is provided to social services managers monthly and enables managers to reflect on adequate referral processes each month to help ensure the opportunity for diversion from residential treatment has been explored. Visuals like this offer an opportunity for direct and 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, DoHS is expecting referrals greater than or equal to the following month's RMHTF admissions with some flexibility for counties with small populations. Sharing and reviewing these maps has helped increase opportunities for diversion, further displayed by Figure 29, which shows QIA referrals for October exceeding November RMHTF admissions (126 referrals compared to only 80 admissions). Nearly three-fifths (56%) of WV counties met or exceeded expectations for referral practices in October, with only ten counties not meeting expected referral numbers. The

remaining counties listed as “unclear” will continue to be monitored for referral opportunities and appropriate practices, as their small populations make it “unclear” if additional referrals are needed at a systems-level viewpoint.

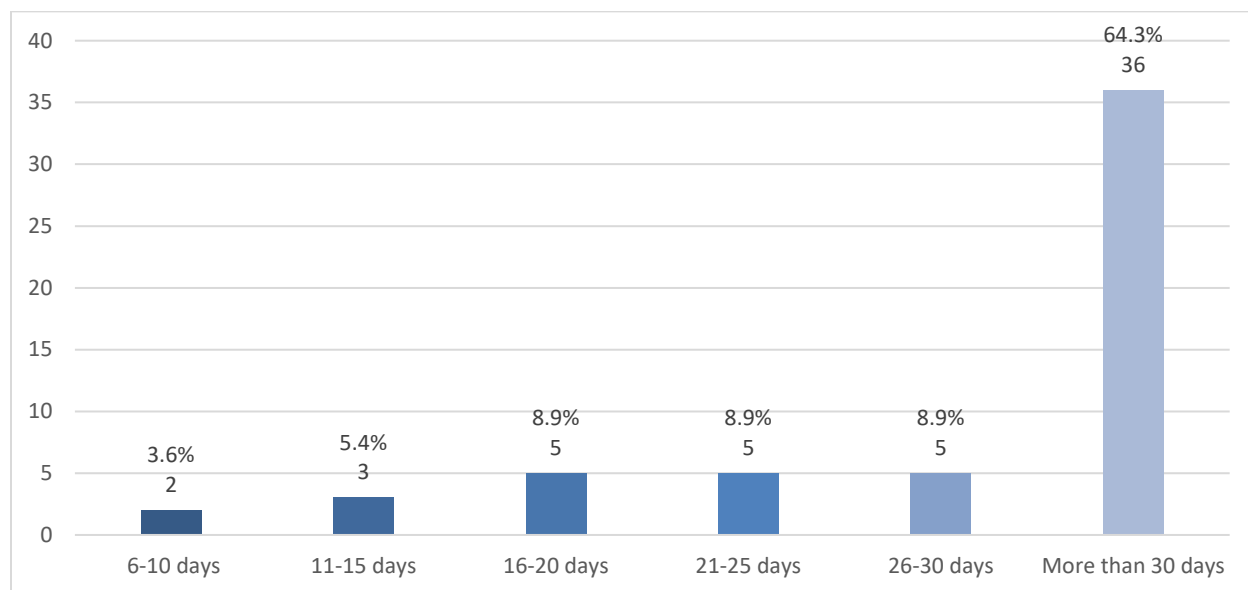
Figure 29: Number of QIA Referrals (October 2023, n = 126) and RMHTF Admissions (November 2023, n = 80)



Acentra Health has worked actively with DoHS to monitor timeliness and address barriers to meeting expected timelines for referrals, 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 documented and completed within 30 days or less has decreased. As reported in the July 2023 edition of this report, 74% of referrals submitted August 2022 to April 2023 were completed within 30 days. Out of total referrals for October 2023 (n = 126), 56 (44%) were completed (not closed). Sixty-four percent (64%, n = 36) of the completed referrals in October took more than 30 days to be completed and communicated back to DoHS, an average of 40 days. DoHS recognizes these time frames are not acceptable to meet needs and has worked with Acentra Health to reinforce and enhance processes to encourage timely and quality assessment reports, reviewing completion data on a weekly basis. It is essential for recommendations to be provided in a timely and accurate manner to help ensure this process is beneficial to the diversion process when clinically appropriate. Referrals “closed out” were

closed due to inadequate response from the referent or closed at the request of the referent; inadequate response is being closely monitored and an escalation process was added to the Standard Operating Procedures to assist leadership in re-enforcing timely response for the required information from BSS workers to the assessors before a QIA is closed.

Figure 30: Distribution of Days from QIA Referral Received to Communication of Results to DoHS, 2023 October (N = 56 / Median = 40.5 / Average = 39.9)



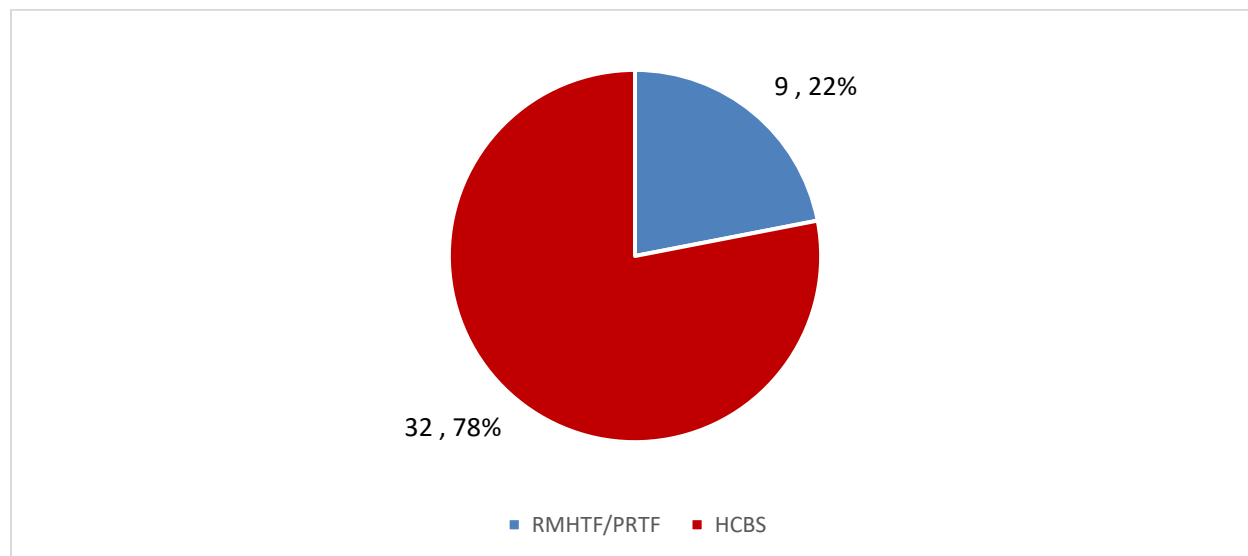
DoHS collaborates with MU and the Praed Foundation to automate the decision support model predicated on the CANS assessment tool. The model consists of five levels of placement need. Level 1 is the lowest level of intervention or need and consists of traditional foster or kinship care, while Level 5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

Nearly 80% of children with a completed QIA referral in October 2023 received a recommendation to obtain treatment via HCBS (Figure 31). 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. The QIA can be used to aid decision-making and reframe cultural norms to help prevent inappropriate use of residential treatment facilities. The MDT process has been a particular area of focus in 2023. Legislation enacted in the 2023 WV legislative session expanded and further encouraged representation in these meetings to include entities directly supporting the child, such as the Aetna care manager. Ensuring that the MDT, and the stakeholders on this team, have timely QIA information to make informed decisions will offer a continued opportunity to shift cultural norms/practices with placements. Timely QIA information will also help to establish norms of assessment and objective determination for treatment needs before referral to an RMHTF. The QIA process has also been a focus of BSS's outreach and education with the judicial community to assist with understanding the benefits of this process while also building

rapport with the court community as implementation moves forward and the process improves.

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 further expanded in the coming months, outcomes following recommendations will also be added as an indicator for review and consideration to influence strategic change.

Figure 31: QIA Recommendations by Setting, October 2023 (N=41⁴⁶)



As noted, review and implementation of referrals by residential providers for referrals not submitted prior to admission has begun with a prioritized list of children who may most benefit from the QIA recommendation. Aetna is directly following up with providers to help ensure referrals are made in a timely manner according to standard operating procedures. DoHS conducts biweekly meetings with Acentra Health and Aetna to help ensure a plan is in place for the fully expanded use of the QIA process for all children in residential settings, ideally prior to admission to address opportunities for diversion.

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 has and will continue to assist in diverting children from unnecessary residential placement. The QIA process has many opportunities for improvement as statewide rollout was completed in May 2023 and monthly and weekly indicators are assessed to address needs in near real-time. In pursuit of WV's goal of bringing more children "back home" to receive mental health treatment, future reports will include out-of-state placement results and outcomes.

⁴⁶ Due to data quality and completion related issues, some of the recommendations for completed QIAs were not included in the tracker. Efforts persist to improve reporting.

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

- Continued improvement of data collection and quality improvement to inform process needs further.
- Analysis of outcomes data with the WV PATH system integration into the data store connected with relevant QIA data to understand where the child was placed and to explore reasons for any contradictions to the recommendations.
- MU completing QIAs for youth in out-of-state placements.
- Use of the formal tracking system for out-of-state discharge planning (development began January 1, 2024). Historical information will be added for children actively in placement prior to rollout.
- Monitoring timeliness of QIA completion closely to ensure information can be beneficial in time-sensitive situations.
- Expanded outreach and education around the importance of the QIA process to increase utilization and trust in the process, including ongoing 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

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

The CSED Waiver permits DoHS to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated 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 ⁴⁷ | ● 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 | |

⁴⁷ DoHS is moving mobile response services to the state plan, and it will be removed from the waiver service list. A transition plan for mobile response services is included in the CSED Waiver amendment. With this change, mobile response will now be available to all Medicaid youth, including those enrolled in the CSED Waiver.

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

10.1 Review Period, Data Sources and Limitations, Population Measured

Figure 32: CSED Waiver Enrollment and Services Data Overview

CSED Waiver Dataset	Data Review Period	Data Source	Details and Limitations	Population Measured
CSED Waiver Enrollment Data	January to June 2023; in some datasets, more recent data is reflected and noted	ASO Reporting Spreadsheet	DoHS is still actively working with Acentra Health to enhance data collection and reporting. Acentra Health is also planning to incorporate CSED application data collection into one of their existing data systems.	Children who may be eligible for the CSED Waiver who are going through the application process.
CSED Waiver Service Data	January 2022 to June 2023	EDS	CSED service use is sourced from DW/DSS and EDS paid claims for services rendered January 2022 through July 2023 and paid through October 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 almost four years and is still expanding. The number of applications for the CSED Waiver continues to increase, resulting in more children and families accessing services as will be noted in greater detail throughout this section. 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 being data driven, DoHS is very focused on each child and family's journey. As DoHS partners with Acentra Health, Aetna, CSED Waiver providers, and other stakeholders to make improvements to the CSED Waiver, the question asked at each decision point is "How does this

impact the child and family journey?” DoHS is 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 young adult who was in the process of transitioning to a PRTF when the family learned about CSED Waiver services. The young adult was provided specialized therapy which included piano lessons and access to a piano. The young adult rapidly progressed in piano acumen, school attendance, and family relationships. The individual has since graduated high school and intends to pursue undergraduate studies in music.

10.2(a) CSED Waiver Applications and Enrollment

Figure 33 below compares application status for the second half of 2022 and first half of 2023 as reported by Acentra Health as of November 2023 reporting. In the first half of 2023, 1,313 applications were processed compared to the second half of 2022 at 976 applications, an increase of 34.5%. Approved applications increased slightly from 62.4% to 64.8%. Denied applications decreased from 5.7% to 4.8% and the number of applications being closed dropped from 31.8% to 28.6%. While there were slight fluctuations in percentages, the status of applications remains consistent across prior periods and may be indicative of what DoHS could expect in the future.

Figure 33: CSED Waiver Application Status Comparison Across Six-Month Periods

Status	July to December 2022		January to June 2023	
	n	%	n	%
Approved	609	62.4%	851	64.8%
Closed ⁴⁸	310	31.8%	375	28.6%
Denied ⁴⁹	56	5.7%	63	4.8%
Pending ⁵⁰	1	0.1%	24	1.8%
Total	976	100.0%	1313	100.0%

⁴⁸ Applications are closed when CAFAS/PECFAS scores are below 90, when families are non-responsive to the ASO (Acentra Health), when families request to discontinue the application process, and, in limited cases, when families move out-of-state. Multiple contact attempts are made through a variety of mechanisms before cases are closed.

⁴⁹ Denials are based on one or more of the following: no eligible diagnosis or Basic Assessment System for Children (BASC) and/or CAFAS/PECFAS score not meeting eligibility criteria, primary diagnosis was intellectual disability or autism spectrum disorder, or the evaluation process was not completed by the family. Note: PC&A makes denial decisions and communicates them to Acentra Health.

⁵⁰ 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.

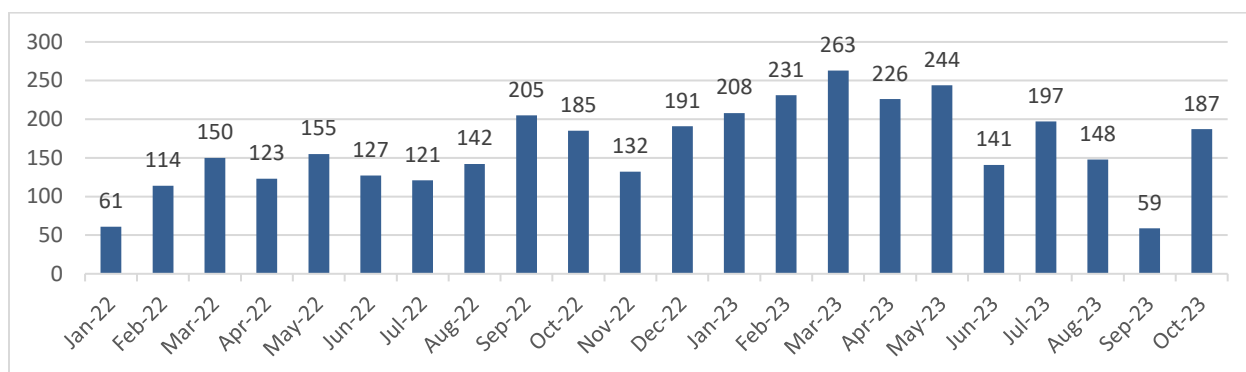
DoHS completed further analysis of applications closed for the period January to June 2023 to better understand how far into the process families had gotten before the application was closed:

- 182 applications (48.5% of closed applications, 14% of all applications) were closed with no CAFAS/PECFAS score recorded.
- 82 applications (21.9% of closed applications, 6.2% of all applications) were closed due to a CAFAS/PECFAS score less than 90.
- 111 applications (29.6% of closed applications, about 8.5% of total applications) were closed with a CAFAS/PECFAS score greater than or equal to 90.

This information bulleted above indicated nearly half of applications closed never reached the point of receiving a CAFAS/PECFAS score, with only one-fifth (22%) of closed referrals being closed for not meeting CAFAS/PECFAS score-related criteria. DoHS continues to work with Acentra Health on data collection and quality. Significant time was spent in the second half of 2023 outlining the data specifications associated with CSED Waiver applications as Acentra Health is planning to add this data collection to the Atrezzo data system to support improved data quality and reporting. Given DoHS's desire to improve understanding of children and families who do not follow through with the CSED Waiver eligibility process, additional detail and drop-down options were developed and will be included in Acentra Health's system, which is expected to come online in early to mid-2024. Acentra Health's CSED Waiver application dataset is scheduled for addition to the data store following their data system conversion. Once in the data store (projected for summer 2024), additional analysis is planned to investigate the services and outcomes for children who do not complete the CSED eligibility process.

CSED Waiver application trends for the period of January 2022 to October 2023 are shown in Figure 34 below. As noted previously, there were 1,313 applications from January to June 2023, a 34.5% increase compared to July to December 2022, which had 976 applications. This increase is in line with the 34.0% increase from the prior six-month period January to June 2022 demonstrating a consistent and continued rise in applications for CSED Waiver services and a reflection of DoHS's efforts to help ensure families and child-serving entities are aware of the Assessment Pathway and availability of CSED Waiver services. Following applications in excess of 200 each month from January to May 2023, applications dropped somewhat in June through October 2023, with September 2023 being a particularly low month. The BBH Assessment Pathway showed similar trends. Some seasonality is expected with school being in and out of session. When children are in school, there is more focus and attention on each child and therefore greater opportunity for referral. Additional time is needed to determine if recent trends are reflective of CSED Waiver applications having reached a steady state given that screening and referral processes are largely in place across the state or are a result of other factors.

Figure 34: CSED Waiver Applications by Month, January 2022 to October 2023



CAFAS/PECFAS scores for children going through the CSED Waiver eligibility process are shown in Figure 35 below. Children with scores greater than 90 remained consistent between the second half of 2022 and the first half of 2023 at 92%, indicating that appropriate children are being referred. Referral to the Assessment Pathway continues to be an opportunity to connect children with other services even if they do not qualify for CSED Waiver services specifically.

Figure 35: CAFAS/PECFAS Scores for CSED Waiver Applicants, Six-Month Period Comparison

CAFAS/PECFAS Score Range ⁵¹	July to December 2022		January to June 2023	
	Children	Percent	Children	Percent
0 – 40	31	3.7%	36	3.2%
50 – 80	35	4.2%	49	4.4%
90 – 120	336	40.4%	430	38.3%
130 – 160	299	35.9%	455	40.5%
170+	131	15.8%	153	13.6%
No score reported⁵²	144	--	190	--
Total	976	100% (*excludes individuals with no scores reported)	1,313	100% (*excludes individuals with no scores reported)

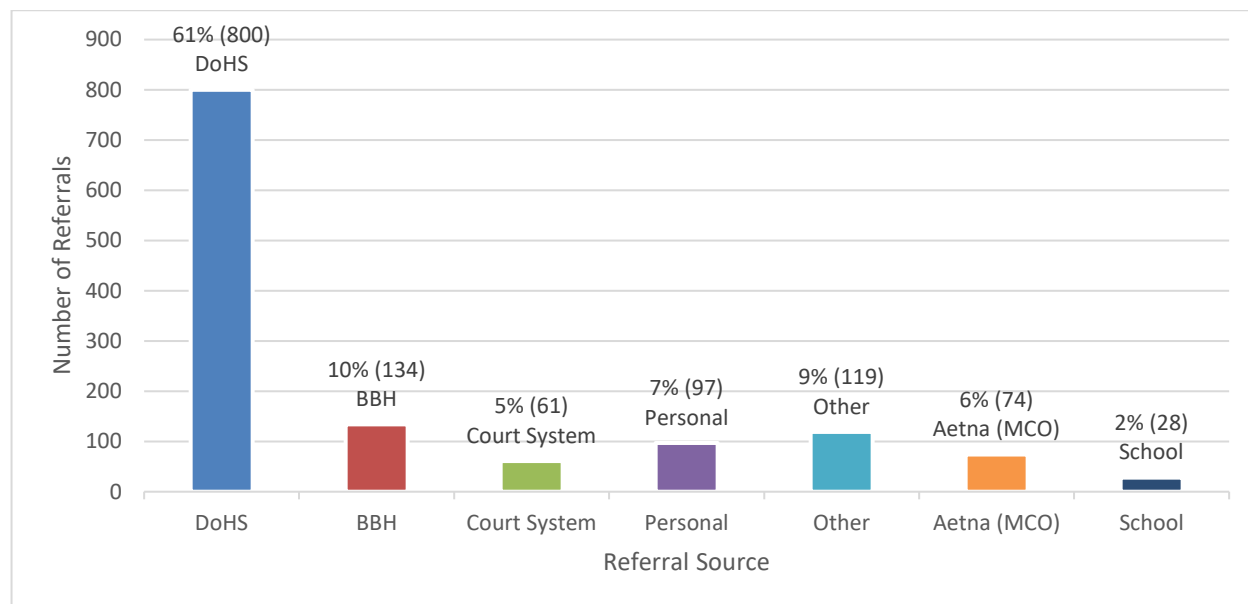
⁵¹ Levels of Overall Dysfunction Based on Youth's Total Score:

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

⁵² DoHS is collaborating with Acentra Health to review reporting processes for data collection to help ensure program assessments are conducted and documented according to program timeframes. Scores may also not be reported for families ceasing participation in the application and assessment process.

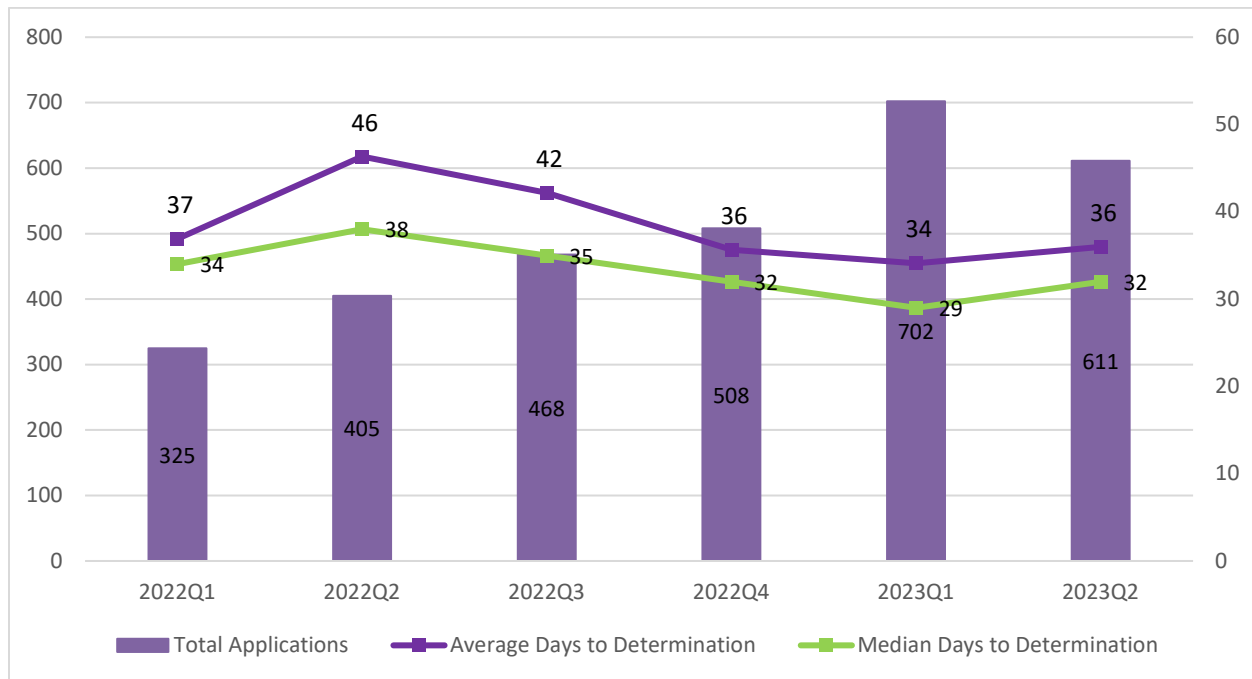
Figure 36 below captures the referral source for CSED Waiver applications submitted to Acentra Health for the period of January to June 2023. These referrals represent the varied points of entry through screening by entities engaging with children. The majority of referrals (61%) originate from DoHS (CPS, YS, and other DoHS involvement), while the remaining referrals are split across varied sources. Referral sources remain consistent with prior periods reported. As noted previously, DoHS and Acentra Health spent considerable time in the last six months updating CSED application data specifications, which included expanding the drop-down list for referral sources for future reporting.

Figure 36: CSED Waiver Referral Sources, January to June 2023 (n = 1313)



DoHS remains focused on understanding the timeline for children and families to access services. After the data store is expanded to enable alignment of child-level data across additional systems (projected by mid-2024), DoHS intends to measure and report the timeline from screening to the start of services. Within the overall timeline to services, DoHS continues to monitor the timeline from receipt of the waiver application to eligibility determination. Over the last three quarters, the average and median timeline to determination has remained consistent, with the most recent available quarter (Q2) reflecting an average of 36 days and a median time frame of 32 days to determination (Figure 37). Acentra Health remains responsive to ensuring adequate assessors are in place to process applications within required timelines including 11 assessors capable of completing assessments for applications with six dedicated only to CSED Waiver assessments. The timeline to eligibility determination is dependent on the responsiveness of the family and their availability to participate in the assessment process, including the completion of required program documents.

Figure 37: Timeline From CSED Waiver Application to Eligibility Determination, Quarterly View, January 2022 to June 2023



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 DoHS continues to analyze and understand 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, DoHS would like to understand in greater detail the prevalence and types of diagnoses among children accessing CSED services as well as any comorbidities and their 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. DoHS plans to further analyze diagnoses to better understand children served in the CSED Waiver program, those engaging in other HCBS services, and those accessing RMHTF for comparison purposes; however, this work is currently on hold as DoHS continues to focus on data quality and on build-out of the data store.

CSED Waiver Service Utilization

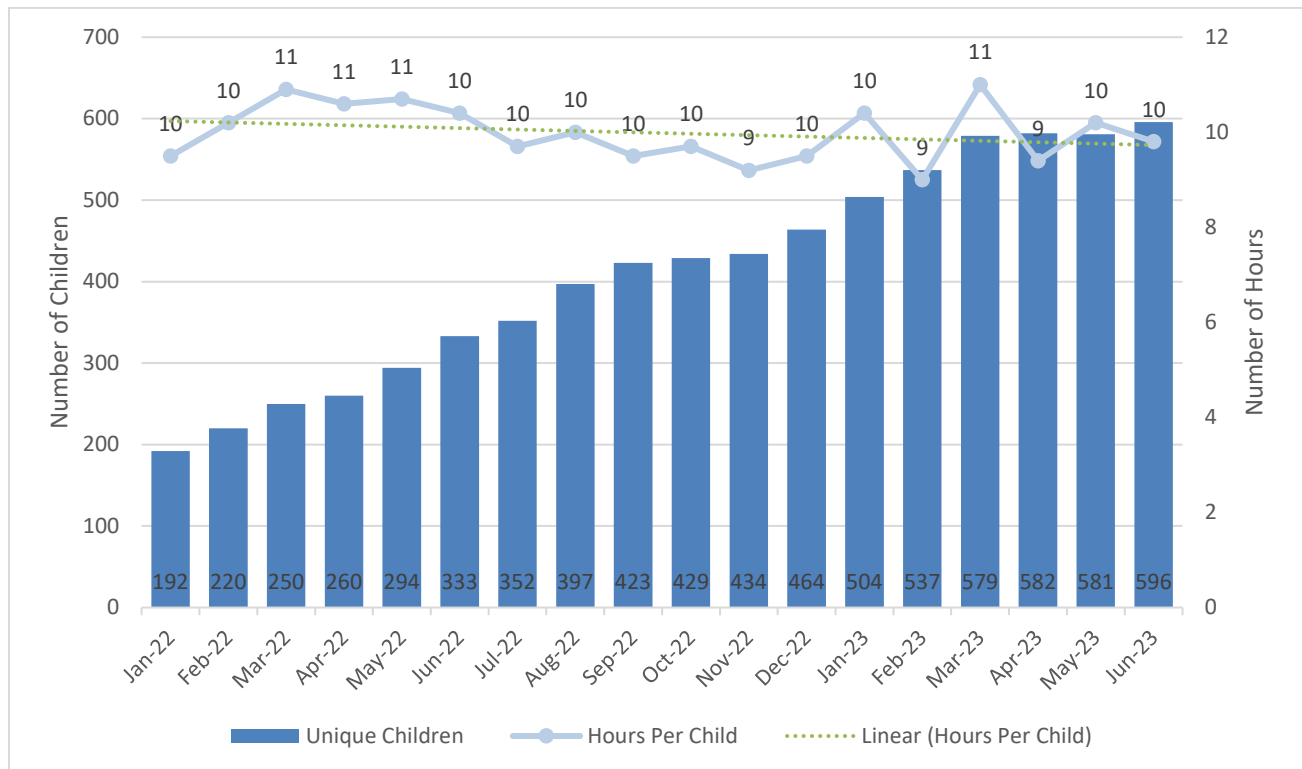
The number of children accessing services monthly continues to increase, while the average hours of service per child have remained relatively consistent, as shown in Figure 38. Aetna manages prior authorizations, service utilization, and care coordination. In addition to these services, Aetna oversees the development and implementation of each member's plan of care in the CSED Waiver to help ensure each member's plan of care aligns with State and federal

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

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. Facilitation of the monthly spotlight meetings has now transitioned to Acentra Health and Aetna. BMS leadership continues to meet one-on-one with individual CSED Waiver providers (one provider per month) to complete a needs assessment with the agency and help address any barriers or needs.

Identified next steps from Quality Committee reviews include completing an analysis of service utilization by provider and at the county-level. While much focus in 2023 was spent on data specifications and quality, DoHS plans to include analysis by provider and county in 2024.

**Figure 38: CSED Waiver Service Utilization for Hourly Services, January 2022 to June 2023
(Excluding Independent Evaluations)**



Hourly CSED Waiver services used during the July to December 2022 period compared to the January to June 2023 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 these services. The number of children using CSED Waiver services increased 36% in the first half of 2023 with 810 unique children receiving services during the period compared to 597 unique children in the second half of 2022. More children are being supported in the community with these critical services.

Given the continued increased demand for services, BMS and Aetna remain highly focused on provider network expansion to help ensure adequacy of services to meet the needs of children statewide. Reference Subsection 10.3 Provider Capacity/Statewide Coverage for additional details.

BMS and the Office of QA are continuing to collaborate with Aetna to enhance data collection for children enrolled in CSED Waiver services who are subsequently placed “on hold.” Services can be placed “on hold” if requested by the member or their family/legal guardian or if the member is receiving care in an inpatient hospital setting such as PRTF or RMHTF, if the member is in the care of BJS, or if the member resides in an emergency children’s shelter. Aetna is now capturing this data in their Quickbase system with updates provided at least monthly. DoHS is continuing to work with Aetna to address data quality issues in this critical data set, which is expected to assist with better understanding the impact that placing a child on

hold has on service utilization and the timeline to accessing services. This is a new and developing dataset, additional time and data will help DoHS 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: CSED Waiver Service Utilization by Service Type, Comparison of July to December 2022 Period to January to June 2023 Period⁵³

Service Description	July-December 2022			January-June 2023		
	Hours Provided	Unique Youth	Hours per Child per Service Month	Hours Provided	Unique Youth	Hours per Child per Service Month
Crisis Service: Mobile Response	19	7	1.6	29	9	2.4
Family Therapy	7,681	421	4.8	11,916	609	5.2
Independent Living/Skills Building	145	8	6.3	624	18	10.2
In-Home Family Support	2,874	234	3.6	3,601	266	4.2
Job Development	4	1	1.3			
Peer Parent Support	57	15	1.1	43	17	0.9
Respite Care, In-Home	1,166	22	18.2	769	39	7.6
Respite Care, Out-Of-Home	1,092	39	10.0	1,696	67	9.1
Wraparound Facilitation	10,889	573	4.8	15,065	742	5.0
All 15-Minute CSEDW Services	23,927	597	9.6	33,742	810	10.0

Consistent with prior periods, the services with highest utilization include Wraparound Facilitation, Family Therapy, and Family Support. BMS program teams and the Quality Committee continue to monitor utilization trends closely given the importance of CSED Waiver services in supporting children to remain at home or in community-based settings. As mentioned previously, future planned steps for 2024 include completing an analysis of service utilization by provider and by county.

In the July 2023 edition of this report, an analysis of utilization throughout a child's time of accessing CSED Waiver services was completed. DoHS anticipates revisiting this analysis annually rather than semiannually to allow adequate time for completion of the typical life cycle of utilization of CSED services which averages more than six months; therefore, this analysis will be revisited in a future reporting period and is not included in this report.

Timeliness of Access to CSED Services

As noted previously, DoHS is committed to timely access to services to meet the needs of children and families. Timeline to service access data was reviewed in DoHS's quarterly Quality Committee reviews in November 2023. At that time, concerns with data quality, including some missing data, were identified as issues impacting the accuracy of the analysis. As a next step, program leaders are meeting with relevant providers to work through the data quality issues and further clarify expectations around data entry and associated definitions. As mentioned previously, work is also in progress with Aetna to address data quality issues identified in the

⁵³ "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.

on-hold reporting, which impacts the timeline to services analyses. Given these considerations, timeline to services analyses are not included in this report and will be revisited in DoHS's quarterly Quality Committee reviews in 2024.

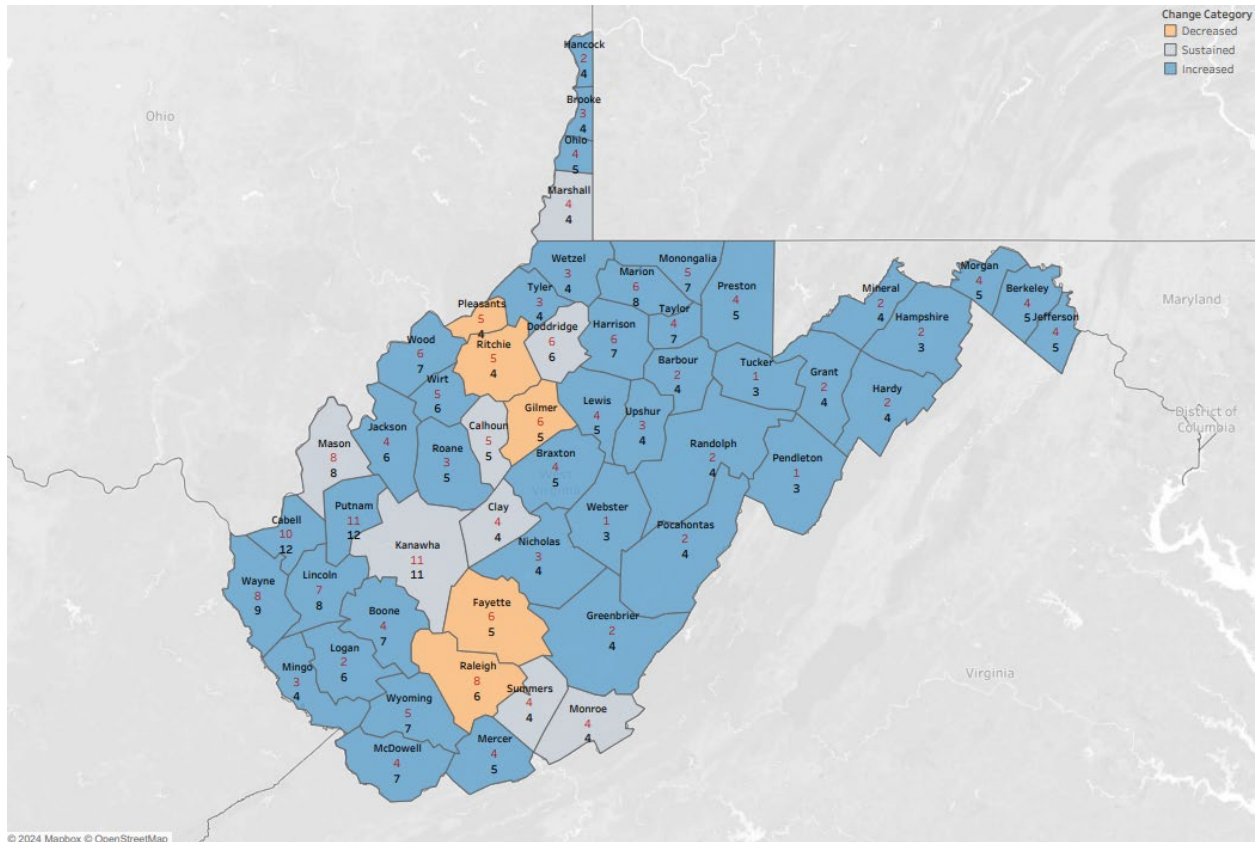
BMS and the Office of QA are working with Aetna to enhance data collection associated with children who are eligible for enrollment in CSED Waiver services. In addition to on-hold data, Aetna is tracking and reporting children who are enrolled in the CSED Waiver who are on service-specific capacity waitlists. Aetna and BMS leadership meet weekly to review and discuss children on the waitlist, care manager linkage and referrals to other HCBS, and other follow-up that needs to occur to help ensure timely access to services.

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

10.3 Provider Capacity/Statewide Coverage

DoHS and Aetna remain focused on building the CSED Waiver provider network given the continued increased demand for these services. In Quality Committee reviews, county-level data for CSED applications, approvals, and utilization is reviewed with reference to other factors deemed to have an impact on service demand. DoHS is still in the early stages of beginning to understand the relationships between these datasets and how they can be used to assist with identifying demand for services and possible gaps in the provider network. As of November 2023, the CSED Waiver provider network comprises 21 agencies actively providing CSED Waiver service while additional providers are in the process of onboarding. Aetna monitors its provider network based on the needs of the CSED Waiver population and meets regularly with BMS to communicate barriers and strategize solutions. BMS continues to work with Aetna to help ensure services are available statewide. Figure 40 below shows the change in CSED Waiver provider agencies offering services by county comparing March 2023 provider counts (red font) to November 2023 provider counts (black font). Notably, 42 of West Virginia's 55 counties increased the number of providers offering CSED Waiver services between March and November 2023. Eight counties sustained the same number of providers, while five counties experienced a decrease in providers, specifically Pleasants, Ritchie, Gilmer, Fayette, and Raleigh.

**Figure 40: Number of Provider Agencies Offering CSED Services by County as of March 2023
(gray font) November 2023 (red font)**



DoHS is continuing to focus on tracking and monitoring Wraparound Facilitator provider capacity. As of March 2023, all CSED Waiver providers were required to enter information into the CANS Automated System, which is used to determine caseloads and capacity in addition to reporting FTE status by Wraparound Facilitation which was initiated in May 2023. DoHS leadership is continuing to work with providers to improve data completion and quality which will facilitate improved tracking and monitoring of Wraparound Facilitator capacity by region and by provider. Once the Wraparound Facilitator capacity logic is further refined, DoHS intends to move toward analyzing capacity associated with family therapy and in-home family supports, which continue to be the most utilized services in the CSED service array along with Wraparound Facilitation.

Collaboration with Aetna and providers is planned to understand their experience of service provision, including staffing patterns and other workforce constraints. Collaborating with Aetna and providers continues to be a priority area of focus for DoHS to help ensure children are receiving the services at the frequency, scope, and duration outlined in their plan of care.

10.4 Strengths, Opportunities, Barriers, and Next Steps

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

- DoHS is highly focused on the child and family journey. As DoHS partners with Acentra Health, Aetna, CSED Waiver providers, and other stakeholders to make improvements to the CSED Waiver, the question asked at each decision point is “How does this impact the child and family journey?”
- Applications increased 34.5% from July to December 2022, to January to June 2023 with 976 and 1,313 applications received during the respective periods. This increase is in line with increases from the previous period demonstrating a consistent and continued rise in applications for CSED Waiver services, and a reflection of DoHS’s efforts to help ensure families and child-serving entities are aware of the Assessment Pathway and of the availability of CSED Waiver services.
- The number of children using CSED Waiver services increased 36% in the first half of 2023 with 810 unique children receiving services during the period compared to 597 unique children in the second half of 2022. More children are being supported in the community with these critical services.
- Data collection and quality improvements are actively in process with Acentra Health and Aetna.
- Forty-two of West Virginia’s 55 counties increased the number of providers offering CSED Waiver services between March and November 2023.
- BMS is in the process of creating an amendment to CSED Waiver services. The most notable change in the amendment involves defining Wraparound Facilitation as a service with moderate and high intensity levels along with meaningful contact guidance to help providers understand and measure the type and quality of service a child/young adult must be provided to meet waiver expectations. The mobile response service has been removed from the waiver service list. A transition plan to the state plan amendment (SPA) service is referenced in the waiver.

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

- Analysis of CSED service utilization at the provider- 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, reasons for declining services, other services being received, and the outcomes for these children.
- Continuation of 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.

- Continuation of the scheduled build-out of the data store to capture the full view of a child's service access following referral to the Assessment Pathway, including timelines and outcomes.
- Continuation of efforts 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 Pathway to Children's Mental Health Services. WV Wraparound Facilitation is designed for uniform service delivery regardless of funding source. The main funding sources for WV Wraparound Facilitation include:

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

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

- Help children and families thrive in their homes, schools, and communities.
- Implement a seamless system of care that includes statewide Wraparound Facilitation services available through a "no wrong door" approach.
- Provide consistently trained Wraparound Facilitators and high-fidelity Wraparound Facilitation services.
- Reduce the number of children removed from their homes due to SED or SMI.
- 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 DoHS 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 DoHS for record-level data through the data store. This will enable DoHS to assess WV Wraparound Facilitation as one consistent and unified service as well as by funding source. DoHS has also contracted with MU to assess fidelity and contracted with WVU to provide an overall evaluation of the children's HCBS system. Early review of the CMH Evaluation draft report identified a high level of awareness of Wraparound services (40% of community-based caregivers) and positive associations with utilization of wraparound services, with 76% of

community-based caregivers indicating they believed the services helped avoid or delay the need for residential placement. Baseline findings also indicated positive perspectives around Wraparound service delivery and rapport with facilitators. Wraparound Facilitation services were one of the most well-known services among providers and caregivers; however, concerns about workforce limitations (i.e., staffing) were listed as one of the most pervasive concerns impacting the ability to access services timely.

The 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 was put in place October 31, 2023. Updates included revisions to timeliness indicators, mechanisms to differentiate interim Wraparound Facilitation services, and other refinements to improve data collection and quality. Updates were also 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 41 below provides an overview of the Wraparound Facilitation data currently available.

Figure 41: Wraparound Facilitation Data Overview

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

WV Wraparound DoHS Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			adjustments that may need to be made. Due 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 DoHS's BSS • Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver, such as Intellectual/ Developmental Disabilities Waiver or Traumatic Brain Injury Waiver
Wraparound Facilitation services provided by SAH WV providers	January to June 2023	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 includes entries into the CANS System through September	<i>*See description above.</i>

WV Wraparound DoHS Provider	Data Review Period	Data Source	Details and Limitations	Population Measured
			2023, which should account for data lag, although some may still exist due to the fairly new implementation of this submission timeline.	
CSED Waiver Wraparound Facilitation	January 2022 to June 2023	EDS	Data are based on claims through October 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 examine 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 Assessment Pathway 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 the 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

Information on the demographics of children enrolled in Wraparound Facilitation services through BBH is included in Section 4.0 WV's Child Population and Individuals Utilizing Services. From January to June 2023, 52 individuals were served by BBH. This is a slight decrease from 60 individuals served in the previous six months, but significantly fewer than January to June 2022, when 160 individuals were served. This decrease is largely attributable to the nature of interim wraparound 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 for interim Wraparound services. Although capacity barriers exist for new referrals, it is likely also associated with smoother processes from the family's

perspective for existing enrollees, as they can 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. DoHS is currently assessing avenues to improve and sustain Wraparound Facilitator capacity across all payor sources to enable more timely connection to Wraparound Facilitation services and supports; however, as noted in Section 8.0 Pathway to Children's Mental Health Services, children were typically transferred to CSED Waiver enrollment prior to receiving interim Wraparound services during the period January to June 2023.

Data collection and review processes aim to continue to establish baseline numbers of children receiving services and the number of services being utilized as implementation is underway, as well as baseline characteristics of 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 Subsection 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 additional outcomes data, including CANS assessments.

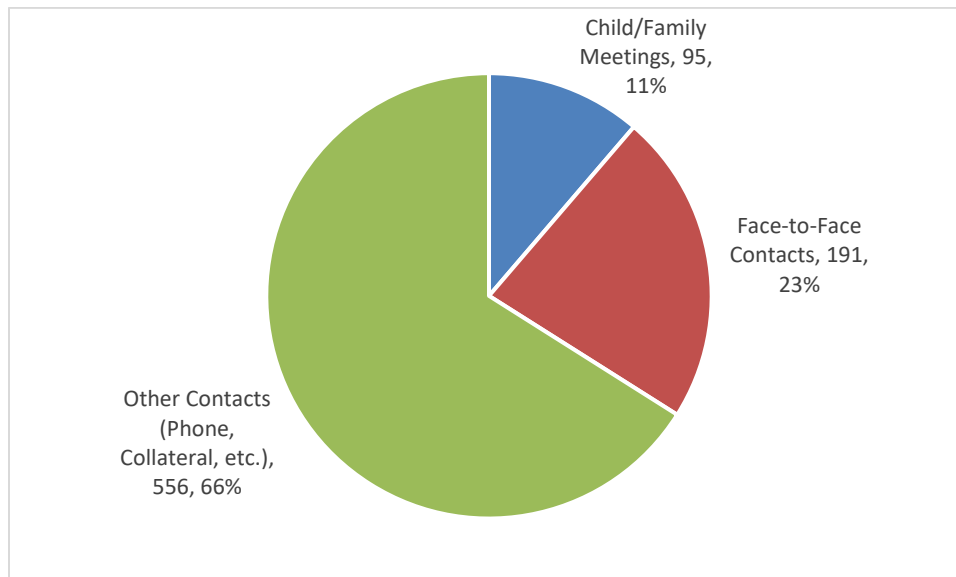
Since the beginning of the pandemic, service delivery has shifted to meet needs and safety concerns. Represented in the "Other Contacts" category in Figure 42, telehealth services have been viewed as one of the more positive outcomes of the pandemic, allowing for more frequent and timely connection to families as needed or requested by the family without replacing key face-to-face interactions.

Two-thirds (66%) of the contacts for services in the first half of 2023 were via virtual means, a decrease from 75% of contacts in the second half of 2022. Providers are trained to use virtual services based on the needs and requests of the family; however, in-person service engagement is encouraged. Notable shifts have been seen in this contact type during the period, including face-to-face contacts increasing from 18% to 23% since the prior six-month period.

For the 52 individuals served, 842 total contacts/interactions were made, less than three reported contacts on average per month per child. This is a notable decrease from 1,480 contacts, an average of four per child in the prior period. These changes will be further explored and addressed in 2024 through provider specific analysis.

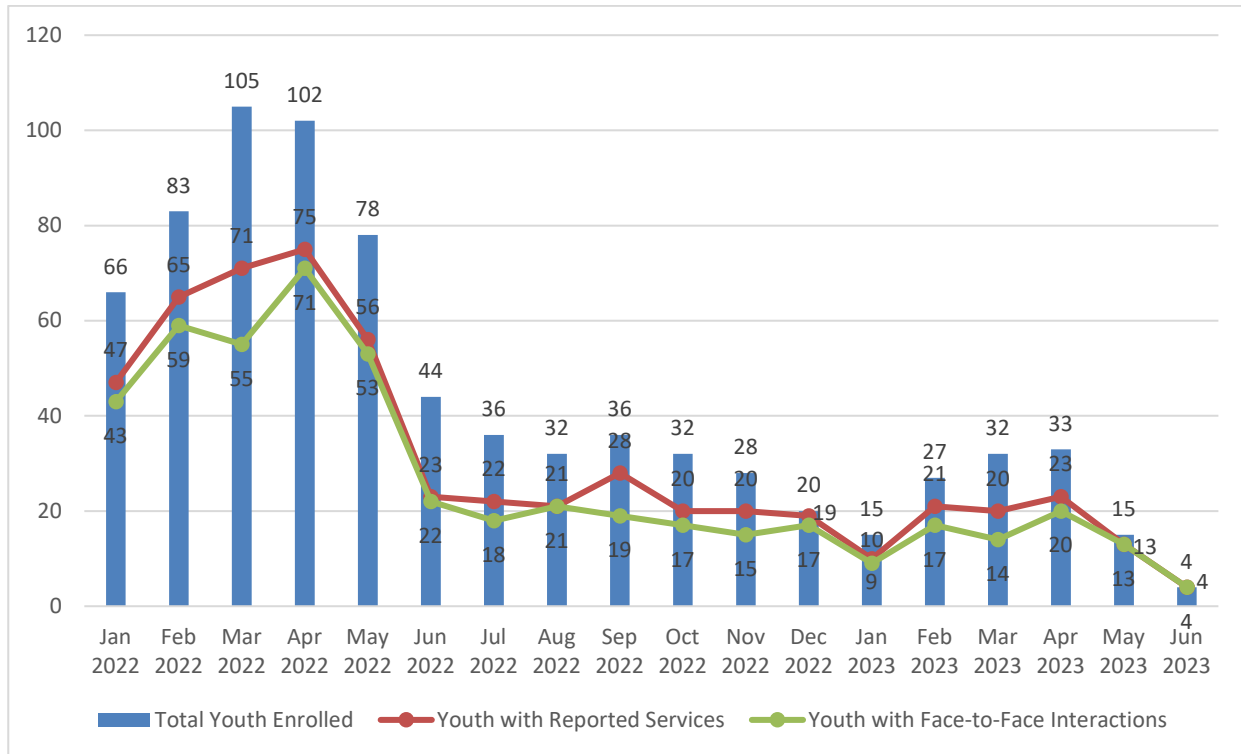
At the time of this report, data interactions with individuals were captured differently for Wraparound Facilitation funded by BBH and SAH versus CSED. For BBH and SAH, "interaction" referred to a contact with the individual regardless of time spent, while CSED "interaction" referred to hours spent with the individual. 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 went live October 31, 2023.

Figure 42: BBH Wraparound Facilitation Services by Contact/Interaction Type, January to June 2023, (n = 842 Contacts) – Preliminary



Monthly enrollment and service utilization (Figure 43) have declined significantly since the waitlist for interim Wraparound Facilitation services increased in spring of 2022. Enrollment peaked in March 2022, when 105 children were enrolled, followed by a steady decline to 15 children enrolled in January 2023. Enrollment increased slightly from February to April 2023, but dropped again in May and June, with the lowest number of enrollments in June 2023 (4 youth). These decreases will be explored at the provider-level, but at this time are assumed to be associated with limitations on capacity for BBH-funded Wraparound Facilitators. The drop in monthly service utilization and face-to-face interactions was also substantial: 75 children received any services and 71 children received face-to-face services in April 2022, compared to 10 children receiving any services and nine children receiving face-to-face services in January 2023. All four youth enrolled in June 2023 received face-to-face services. Overall, the decrease in enrollment totals and service utilization since early 2022 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 who are able to be reimbursed by BBH or SAH payor sources for interim Wraparound Facilitation services. DoHS is exploring options for expanding the 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 43: BBH Wraparound Facilitation Monthly Enrollment Totals and Service Utilization, January 2022 to June 2023 – Preliminary

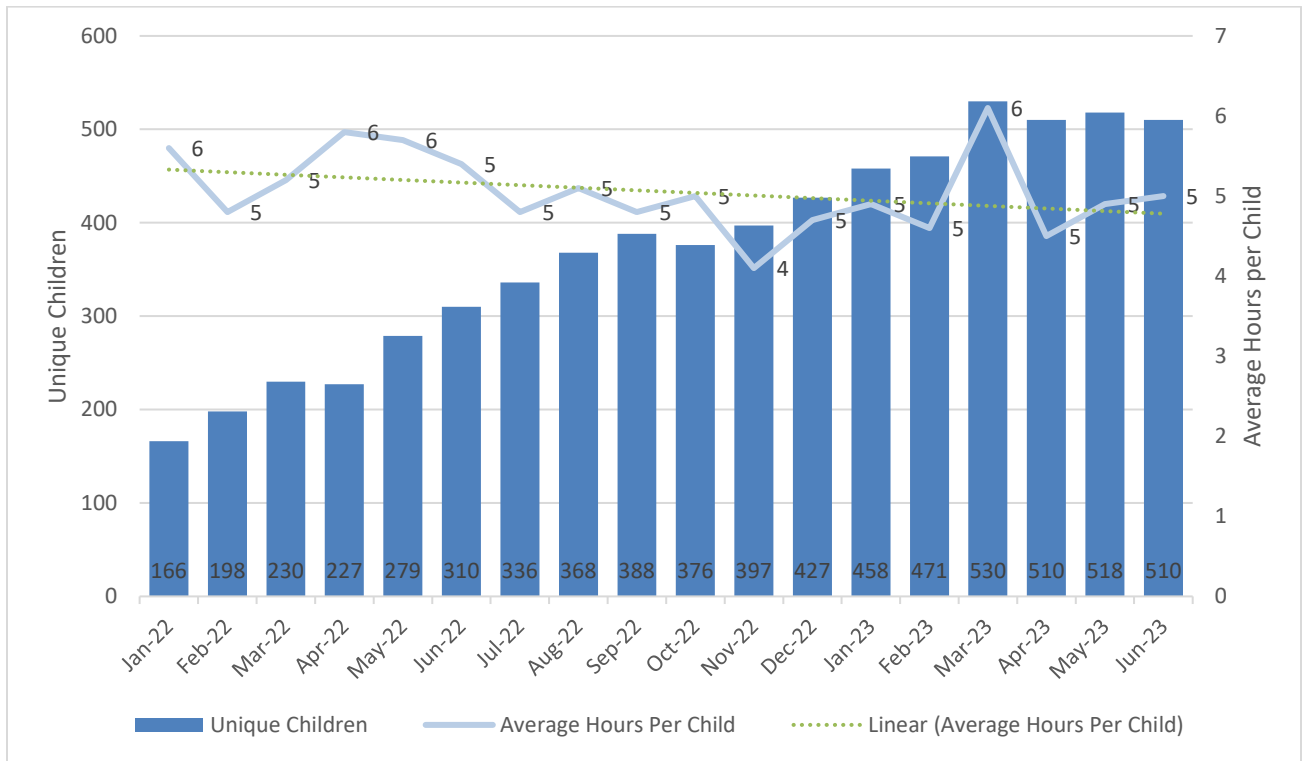


11.2(b) Wraparound Facilitation Services Through CSED Waiver

Seven hundred forty-two (742) unique children accessed Wraparound Facilitation services in the first half of 2023 compared to 573 unique children in the second half of 2022, representing a 29% increase in children accessing Wraparound Facilitation services (Reference Figure 39: CSED Waiver Service Utilization by Service Type, Comparison of July to December 2022 Period to July to December 2022 Period in Subsection 10.2(b) CSED Waiver Service Utilization).

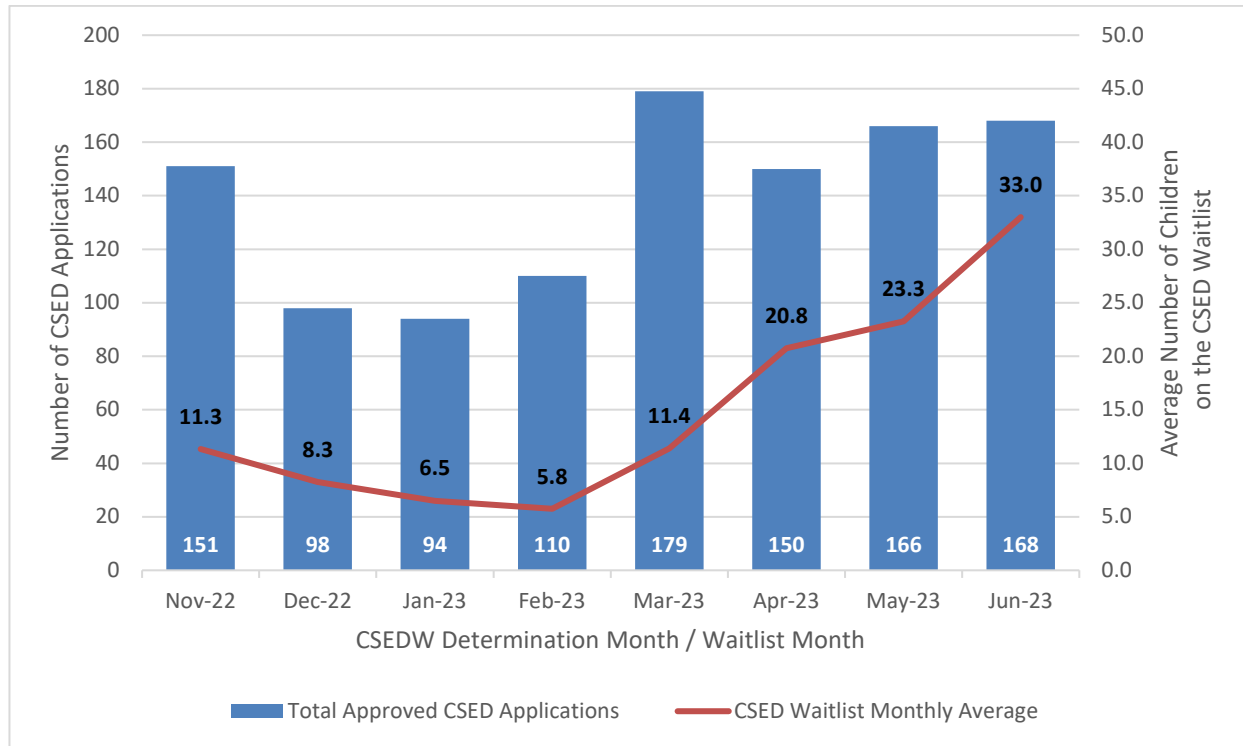
The CSED Waiver Wraparound Facilitation utilization 18-month trend from January 2022 to July 2023 is shown in Figure 44. While the number of children accessing CSED Wraparound Facilitation services has increased, the average number of hours being provided per child each month has remained stable. BMS continues to work with providers about the CSED Waiver, including policy and billing support, technical assistance opportunities, and targeted assistance and support to help providers resolve billing barriers.

Figure 44: CSED Waiver Wraparound Facilitation Utilization, January 2022 to July 2023



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 45 below, the increase in the average number of children on the waitlist corresponds to the increase in approved CSED Waiver applications. However, the proportion of new approved applicants, which are expected to begin services, far exceeds the number of children on the waitlist. To support children and families on the waitlist, Aetna care managers complete weekly check-ins and coordinate care and connection to services while the child and family are awaiting Wraparound Facilitator assignment. Frequent review of data and care coordination among wraparound program leads, Aetna, and providers has helped keep waitlist numbers low in comparison to demand and helped support families during any necessary waiting periods. More recent waitlist trends show signs of leveling off July through September 2023, with a relatively consistent waitlist of 20 to 25 individuals at any given time.

Figure 45: CSED Waiver Wraparound Facilitator Waitlist Trended With Approved CSED Waiver Applications, November 2022 to June 2023



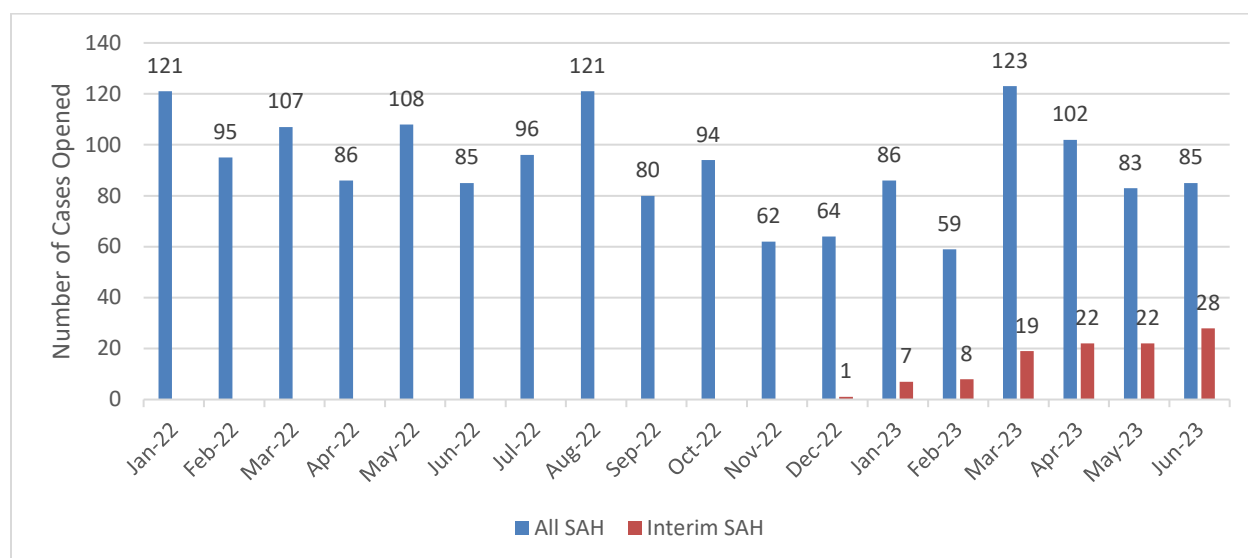
Expansion of the Wraparound Facilitation provider network remains a primary focus. DoHS's Wraparound Facilitator workforce workgroup meets monthly. Details of the progress made and planned next steps are captured in Subsection 11.3 Provider Capacity/Statewide Coverage.

Through the Wraparound Fidelity Performance Improvement Plan team, capacity will be a component of review in 2024. The PIP team will continue to review provider expansion initiatives as well as current data on caseloads and needs. Factors impacting the sustainability of services, such as reimbursement rate considerations, state-border employment competition, challenges, and successes in expansion will be evaluated. 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. Materials were reviewed in 2023 to align policy and procedures across funding sources, and relevant changes will be incorporated in 2024.

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

New monthly enrollments in SAH Wraparound Facilitation for January 2022 to June 2023 are shown in Figure 46. Enrollments for any SAH Wraparound Facilitation case are relatively constant throughout the period; although there is some month-to-month variability (from a minimum of 62 new enrollments in November 2022 to a maximum of 123 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 46 beginning in December 2022 with growth in the number of cases flagged as interim through June 2023.⁵⁴ Given fairly new implementation for reporting and flagging some SAH Wraparound Facilitation cases as interim, these cases may be underreported and will continue to be assessed as continued provider education takes place.

Figure 46: SAH Wraparound Facilitation New Monthly Enrollments, January 2022 to June 2023



From January to June 2023, 538 total children were enrolled in SAH Wraparound Facilitation, with 106 children enrolled in an interim SAH Wraparound Facilitation case; timeliness and contact data for these children are displayed in Figure 47. Overall, the majority of SAH cases had at least one contact reported, 87% ($n = 469$) for all SAH and 84% ($n = 89$) for interim SAH. Nearly two-thirds of both all SAH cases (64%, $n = 346$) and interim SAH cases (64%, $n = 68$) 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 (4.5 days) than for interim SAH cases (3.5 days). Seventy-eight percent (78%) of all SAH cases and 74% 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 slightly longer for all SAH cases (13.0 days) than for interim SAH cases (11.8 days). Preliminary benchmarks have

⁵⁴ Prior to this change, interim SAH cases were included with regular SAH cases in the CANS Automated System.

been established based on feedback from the DART fidelity evaluation tool. 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 facilitate timely documentation of data and positively impact data completion and quality. BSS, in collaboration with the Office of QA, plans to enhance SAH provider meetings to review data and to 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.

Figure 47: SAH Wraparound Facilitation Contact and Timeliness Data

Metric	All SAH (n = 538)	Interim SAH (n = 106)
Presence of Contact Data	87% (n = 469)	84% (n = 89)
Timeliness to First Contact (Preliminary goal: within three days of assignment)	<ul style="list-style-type: none"> 64% (n = 346) met goal Average of 4.5 days from assignment to first contact 	<ul style="list-style-type: none"> 64% (n = 68) met goal Average of 3.5 days from assignment to first contact
Face-to-Face Contact (Preliminary goal: within 10 days of assignment)	<ul style="list-style-type: none"> 78% (n = 417) had a face-to-face contact Average of 13.0 days from assignment to first face-to-face contact 	<ul style="list-style-type: none"> 74% (n = 78) had a face-to-face contact Average of 11.8 days from assignment to first face-to-face contact

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 reported across the state. DoHS has expanded collection and analysis of Wraparound Facilitator capacity data by leveraging Wraparound Facilitation coaching connections to collect updates on facilitator capacity and full-time equivalency (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 MU. Baseline data was reviewed in the November Quality Committee; however, data quality and completion concerns have resulted in putting further assessment on hold until quality is addressed and reassessed in early 2024. Following these improvements, capacity data will be analyzed and reviewed by the workgroup leads, the Wraparound Facilitation PIP team, and program leads with DoHS leadership, on an ongoing basis to inform areas of need and improve understanding of acuity levels, geographic considerations, and available workforce based on caseload ratios. This new reporting will increase available information for Wraparound

Facilitation PIP Team and Aetna to expand outreach and recruitment efforts to areas where providers are needed most (areas with the most limited capacity), with additional considerations by payor source for FTE-related needs.

In addition to understanding current caseloads and capacity based on FTE for facilitators, DoHS 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 DoHS 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 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, DoHS plans to confirm outcomes are not impacted by virtual service delivery, following data store expansion. DoHS continues to encourage in-person engagement in alignment with NWI philosophy.

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

- Robust Assessment Pathway processes to include (but not limited to) referral and utilization of interim Wraparound Facilitation services when available, 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.
- Seven hundred forty-two (n = 742) unique children accessed Wraparound Facilitation services in the first half of 2023 compared to 573 unique children in the second half of 2022, representing a 29% increase in children accessing Wraparound Facilitation services.
- Progress toward aligning procedure and policy across funding sources to ensure quality and continuity of care for children and families regardless of wraparound funding source.

DoHS recognizes the need to expand the Wraparound Facilitator workforce to connect children with Wraparound Facilitators more expediently. 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 MU 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.
- Reviewing provider-level data to assess strengths and opportunities across the Wraparound Facilitator network.
- 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. Data review will focus 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 for children who are experiencing significant maladaptive behavioral challenges. Behavioral Support Services are used widely, including within BBH, BSS, BMS, and WVDE programs and providers, and according to the CMH Evaluation 44% of community-based caregivers reported awareness Behavioral Support Services, which was slightly greater than awareness for wraparound services. Figure 48 below provides an overview of the data currently available for Behavioral Support Services.

12.1 Review Period, Data Sources and Limitations, Population Measured

Figure 48: 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	January to June 2023	BBH Children's PBS Grant Reporting	Data includes only children served directly through the BBH grant through WVU CED PBS program and is not representative of all children with Medicaid receiving Behavioral Support Services.	Children served directly through the BBH grant through WVU CED PBS program; services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs.

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

In addition to the BBH-funded Children's PBS program provided by WVU CED, services are also conducted through trained providers of BBH, BSS, BMS, and WVDE programs. Data 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 (delayed to spring/summer 2024; BMS is continuing efforts to gain CMS approval and associated standard processes). In addition to the review of information for individuals directly served, training is also conducted for providers via the WVU CED. Additional training was conducted in June 2023 following a needs assessment conducted by Concord University to improve training quality and satisfaction, with the next training completed in August 2023. Concord University certified 48 providers on the new Behavioral Support Services provider certification since inception, as of their September 2023 report. Training will be conducted 3 times a year moving forward and will include time for cohorts to receive mentoring post-training. Routine availability and awareness of these online trainings will eventually enable Behavioral Support Services training and certification to be more widely utilized, with information on certified professionals' capacity to be included in future reports. Concord University plans to work closely with DoHS to conduct an initial analysis of statewide and regional needs for Behavioral Support Services, provider capacity, identify barriers and gaps; this information will be used to develop a strategic plan to address identified gaps.

12.2 Review Summary

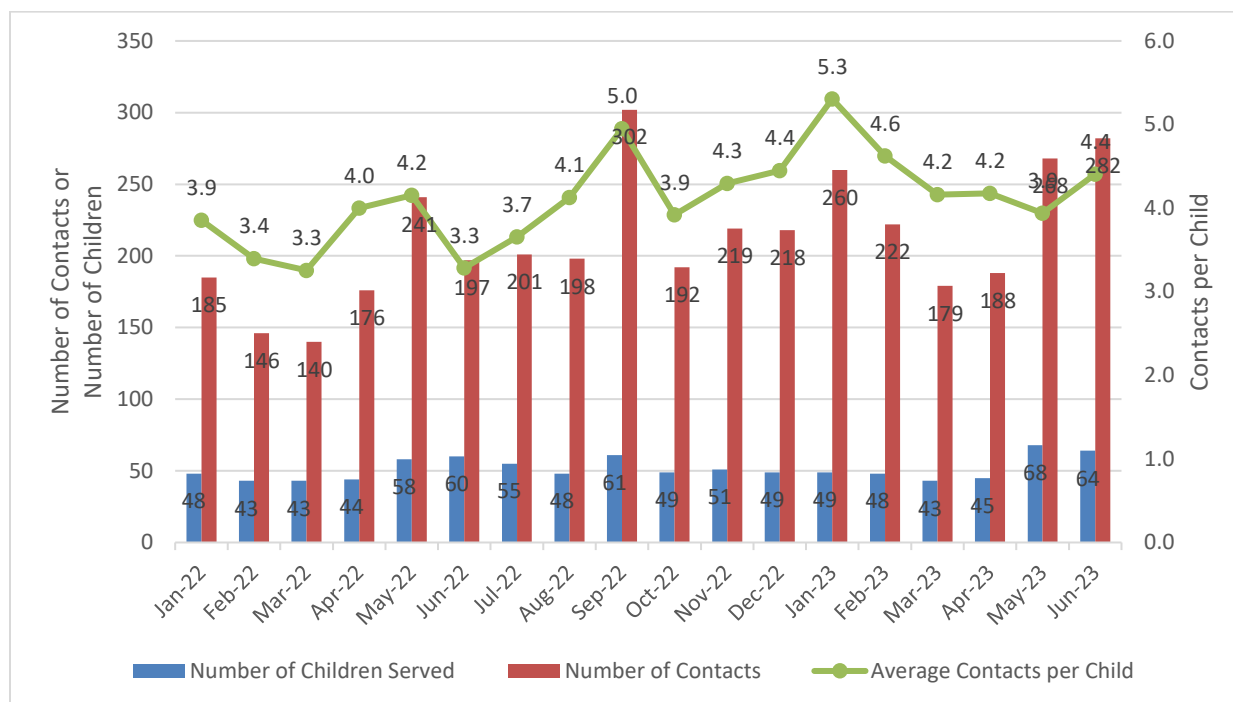
WVU CED provided PBS services to 111 children from January to June 2023. This program has limited capacity but focuses on working directly with families and children with intensive needs

and provides training for parents and providers on related strategies. WVU CED services, while only one piece of the behavioral support puzzle, offer grant-funded direct services for children typically indicated as having more intense needs; these direct services can vary from brainstorming PBS strategies with the family to intensive services and PBS plan writing.

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

The number of children served by PBS has remained relatively constant over the last 18 months, as shown in Figure 49. There was an average of 53 children served each month in January to June 2023 compared to an average of 49 children in the first half of 2022, and 52 children served per month in the second half of 2022. Conversely, total child interactions have increased over the reporting period. Only 1,085 contacts occurred during the first half of 2022, compared to 1,330 in July to December 2022 and 1,399 in the first half of 2023. This trend will continue to be monitored, but it may be related to a shift in intensity of children served if more contacts are needed per child.

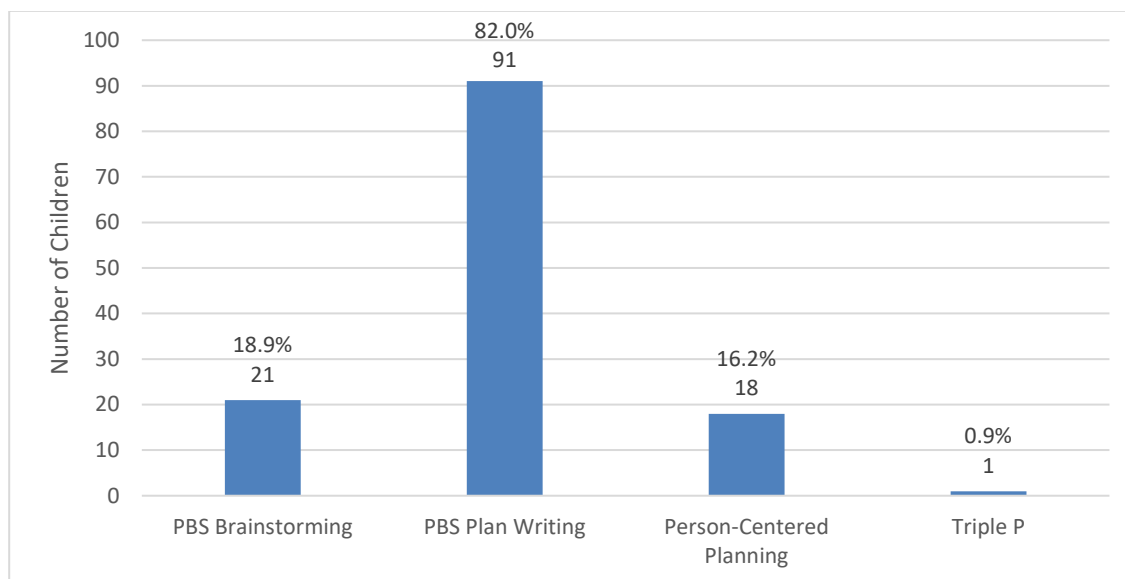
Figure 49: Children and Interactions, Monthly, January 2022 to June 2023



The most common services provided to individuals as highlighted in Figure 50 were PBS Plan Writing (82%); Brainstorming, a service typically completed with initial or lower-need cases to provide ideas and support for families (19%); and Person-Centered Planning (16%). A slight

shift in service type was observed for the two most commonly provided services; in July to December 2022, only 73% of individuals received PBS Plan Writing, while 27% received Brainstorming. These changes would be expected as WVU CED shifts to providing more intensive services and behavioral support certified provider availability expands as more individuals are trained.

Figure 50: PBS Services Provided,⁵⁵ January to June 2023



12.3 Provider Capacity/Statewide Coverage

The BBH PBS program through WVU CED has 10 full-time equivalent staff budgeted. At time of writing, only one of these 10 positions, a behavioral specialist position, is open, and interviews for this position are being scheduled in January 2024 (Figure 51). As of December 2023, there was a waitlist of 22 children for PBS services, as WVU CED continues to report increased referrals. Given this waitlist, WVU CED has implemented a triage process of replying to families with an initial email sent with a list of general resources to inform them their application was received. Staff use a triage process to call these families weekly to continue to assess risk and to provide direct opportunities to connect with families. The average time on the waitlist was two months. WVU CED staff report that this process has been helpful in further identifying risk levels and connecting families to other services, resources, and ideas that improve behavioral needs. BBH will continue to monitor PBS related needs as training is expanded to determine if further process or structure change is necessary to meet demand.

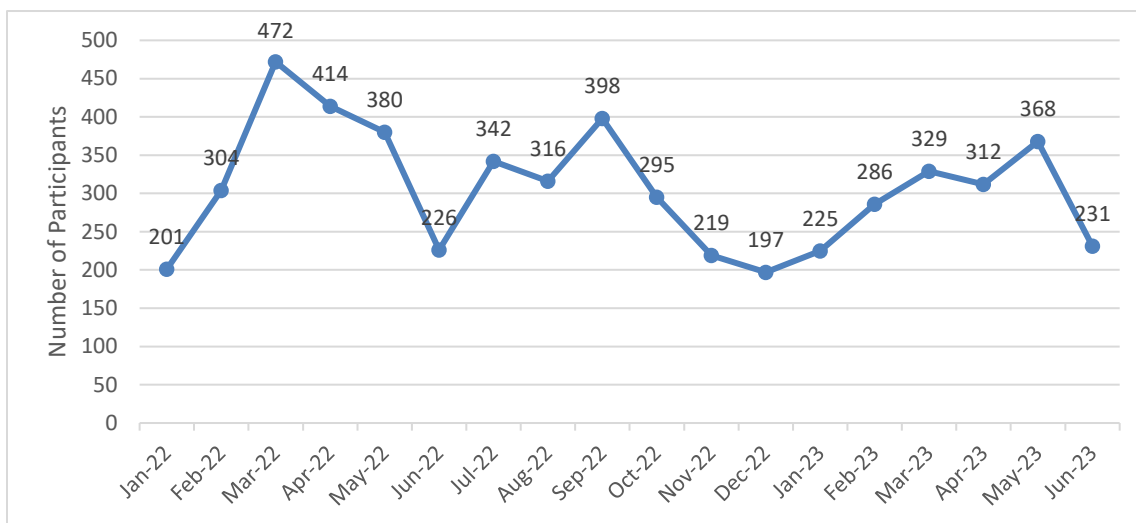
⁵⁵ Note that individuals may have received more than one service, resulting in totals greater than 100%.

Figure 51: PBS Staffing at WVU CED

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Behavior Specialists	6	7	86%
Curriculum Developer/ Behavior Specialist	1	1	100%
Program Assistant	1	1	100%

Efforts are underway to enhance and standardize the certification process for Behavioral Support Services. As previously noted, Concord University has begun providing training and certification for individuals to offer Behavioral Support Services statewide, directly from local providers, thus expanding the resources available in each provider's tool belt. Concord University's initial analysis of statewide and regional needs should be considered to conduct awareness of training and expand the breadth of certified providers available to provide these services. Historically, PBS training has been provided by WVU CED, and WVU CED continues to provide some provider-based trainings while Concord University's process is developed and expanded for Behavioral Support Services. PBS training efforts will now largely shift to a family focus with likely one training per year geared toward certification of providers serving individuals with intellectual or developmental disabilities. Figure 52 shows that there has been a slight decrease in the number of individuals trained each month since January 2022, particularly over the last 12 months; an average of 295 were trained each month from July to December 2022, while an average of 292 individuals were trained in January to June 2023; compared to 333 individuals from January to June 2022. The greatest number of participants were trained in March 2022 (472).

Figure 52: Participants* Attending WVU CED PBS Training, January 2022 to June 2023



*Participants can include parents and professionals.

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

12.4 Strengths, Opportunities, Barriers, and Next Steps

Behavioral Support Services enable children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program works directly with families as a result of referrals from other organizations. Approximately half (55%) of individuals served are 5- to 12-years-old, providing an opportunity to serve younger children and potentially divert them from more intensive out-of-home services. As noted in Section 4.0 WV's Child Population and Individuals Utilizing Services, 14% of the children served the BBH PBS are non-white individuals. Although race distribution is subject to fluctuation due to the low number of children represented in both the state population and programs, BIPOC individuals have continued to show a greater representation among children receiving PBS services compared to the general WV child population. This may be attributable to the focus on minority populations via a team within WVU CED, which provides input and training to staff for program outreach and service delivery for improved cultural competency.

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

Next steps include:

- Continue monitoring WVU CED PBS program data to assess ongoing needs with emphasis on capacity and waitlist considerations.
- 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).
- Collaborate with Concord University to understand the geographic locations of certified providers and use this information to expand awareness in areas with fewer available HCBS.

- Work with Concord University as training and certification is expanded to establish formal data collection and recurring reporting on trainings and certifications.
- Despite challenges with low numbers statewide, race will continue to be monitored as an important indicator for assessing children's and families' access to services. Race data will be expanded as the data store is built out.

13.0 Assertive Community Treatment (ACT)

ACT is an inclusive array of community-based rehabilitative mental health services for WV Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and integrated package of services provided over an extended duration to live successfully in the community of their choice.

ACT is an evidence-based model of treatment/service delivery in which an MDT assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which a ACT team provides the majority of direct services in the member's community environment. ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management and facilitating a supportive environment to meet basic needs and to improve social, family, and environmental functioning.

ACT is an option for youth ages 18 to 20 to help prevent unnecessary institutionalization. As part of the Assessment Pathway, 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) and the general 503 manual for Licensed Behavioral Health Center services, ACT, PBS, and outpatient services are in the process of being updated with expected rollout by summer 2024.

13.1 Review Period, Data Sources and Limitations, Population Measured

Figure 53: ACT Enrollment and Utilization Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
January to June 2023 with trend data for January 2022 to July 2023	EDS and WVCHIP Claims	The population served includes Medicaid members 18 years of age and older with no limitation on length of service; however, for purposes of this report, review was conducted for members 18 to 20 years of age to reflect transition-age youth potentially at risk for RMHTF placement.	Eligible members must have a primary mental health diagnosis and may have co-occurring conditions, such as mental health and substance use disorder (SUD) or mental health and mild intellectual disability. Members must also have a history of high use of psychiatric hospitalization and/or crisis stabilization.

13.2 Review Summary

Youth aged 18 to 20 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., typically 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, given the reluctance of youth to participate in services. When reviewing data for all individuals accessing ACT regardless of age, the numbers are significantly higher (Figure 54).

Figure 54: ACT Member Utilization Comparison

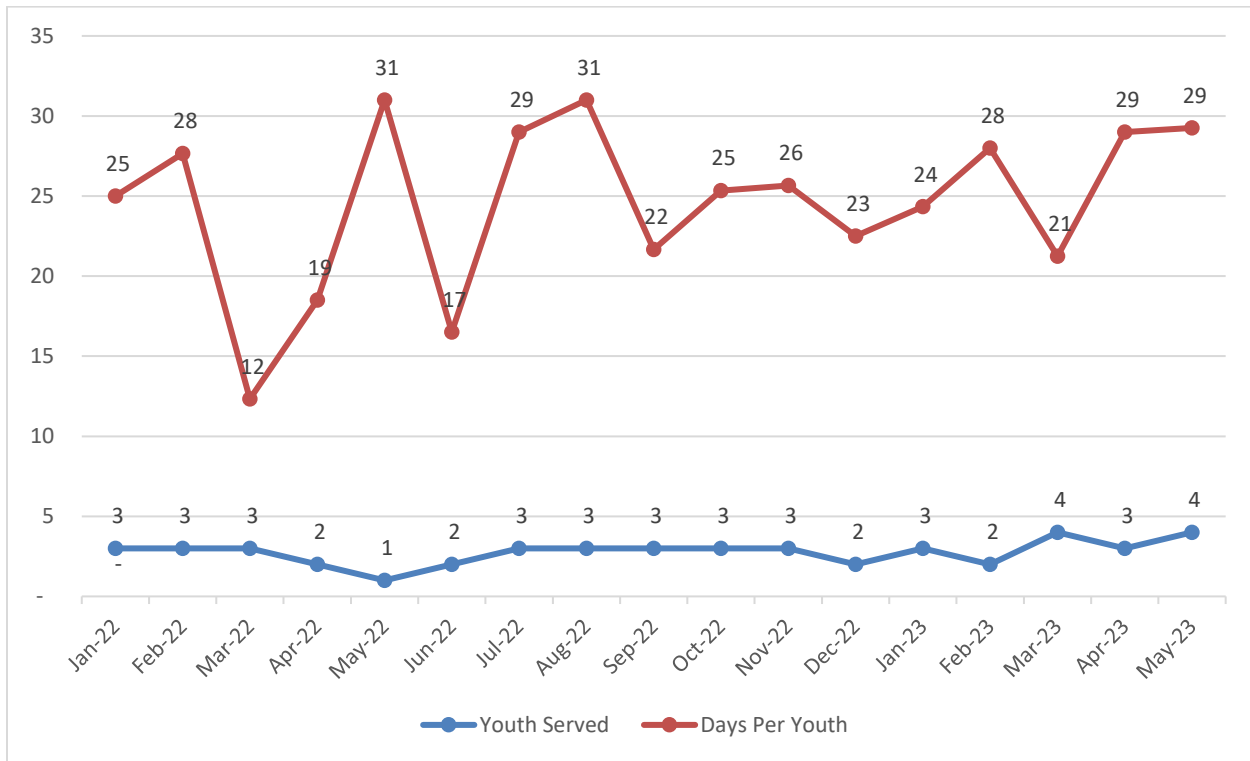
	January - June 2022	July - December 2022	January - June 2023
Youth < 21	4	5	5
All Members	548	544	546

To understand further how many youth across the state might qualify for ACT, DoHS completed an analysis of youth ages 18 to 20 who were Medicaid eligible as of December 31, 2022, and evaluated their claims for the 12-month period January to December 2022 against the qualifying criteria for ACT. Note that there are some differences in available claims data compared to ACT program eligibility criteria, therefore this analysis serves as an estimate. There were 26 youth who met the claims criteria used in the analysis, so it is estimated that at least 26 youth may qualify for ACT.

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

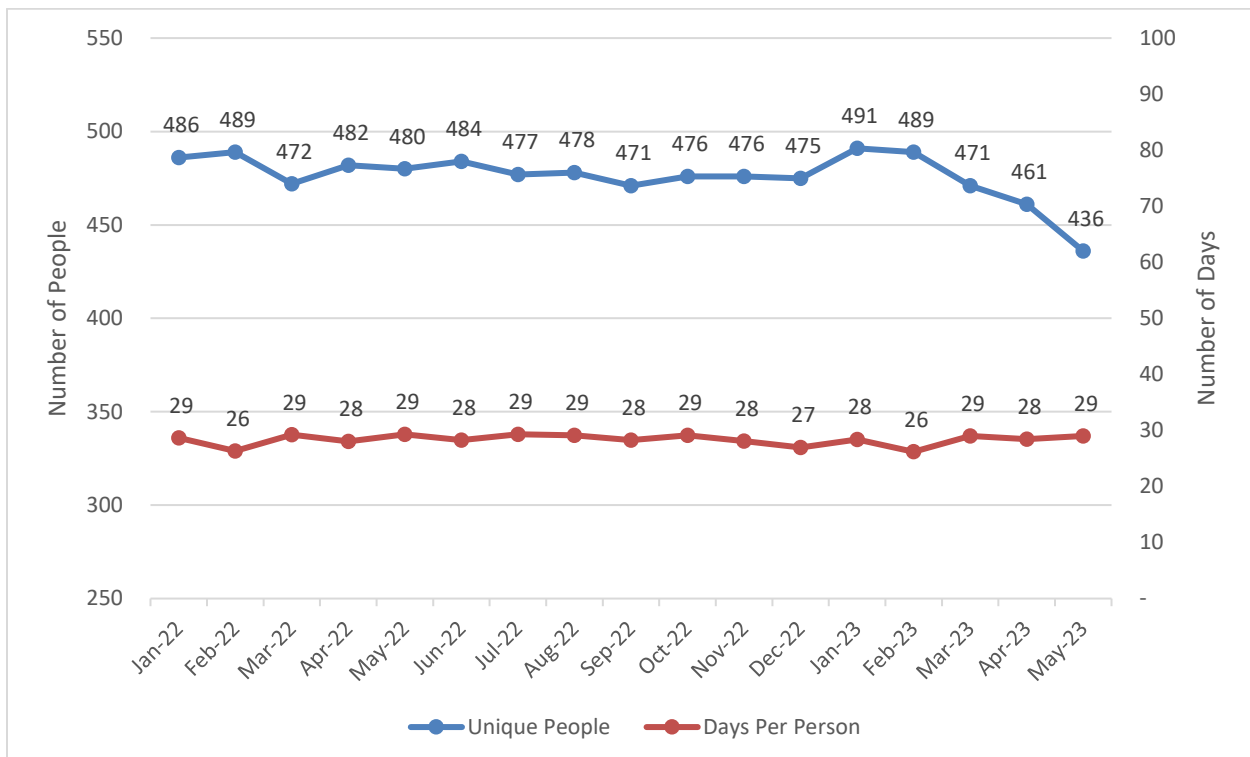
Figure 55 below displays enrollment and the days of service per youth for January 2022 to July 2023. For the purposes of comparison, ACT utilization for all members regardless of age is shown in Figure 56. Discharge and decline reason information is unavailable, but it is commonly understood that many youth are transient and perceive ACT to be intrusive. As awareness of ACT services increases, individuals in RMHTFs have appropriate discharge plans developed, and eligible youth are offered ACT services at discharge, DoHS will monitor to determine if the number of youth accessing ACT services increases.

Figure 55: ACT Youth and Days Per Youth by Month, January 2022 to July 2023



Note: Reflects claims paid through October 2023.

Figure 56: Total ACT Utilization by Month, ACT Members of All Ages January 2022 to July 2023



13.3 Provider Capacity/Statewide Coverage

DoHS 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 that part of the state. EastRidge still has one staff vacancy that must be filled before services can be operationalized.

To expand the availability of ACT services further, DoHS plans to require an ACT team for all certified community behavioral health centers (CCBHC). A draft state plan amendment (SPA) is in development for CCHBCs with a tentative timeline for rollout in early 2025.

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 workforce issues arise.

13.4 Strengths, Opportunities, Barriers, and Next Steps

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

As noted previously, additional efforts to increase enrollment include revision of the BMS policy manuals. ACT services were also the topic area of a Resource Rundown video published online in mid-July 2023. As of November 2023, the video had 109 views.

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

DoHS is still working toward collection of discharge reason data to improve understanding of 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.

DoHS 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. In May 2023, DoHS issued a press release highlighting the need for certified foster families for older youth. At that time, it was reported that there were an average of 1,427 certified foster homes in the first quarter of the year, with only one-quarter (25%) willing to accept youth 13 and older.⁵⁶

Community-based 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 and/or to discharge to has been identified as a primary barrier for many children. To address this barrier, DoHS has explored multiple options using existing data to guide decision-making. Initially, DoHS had planned to incorporate the stabilization and treatment (STAT) home model, a mechanism that aims to prevent disruption to placements; however, there were significant challenges in finding foster homes willing to participate in this model that did not already have existing placements in their homes. Therefore, this plan has shifted to continue strengthening the existing tiered foster care model and community-based supports and services available to youth and families. All foster parents are trained in caring for children in this tiered model, and additional training and support is provided based on the needs of the children in the home. As of October 2023, a rate increase took effect for CPAs and socially necessary service providers—a 10% and 30% increase, respectively⁵⁷. Additional rate increases are being explored for potential proposals for state Fiscal Year 2025. Increases to these provider's rates are meant to assist with foster family recruitment, provide the additional supports necessary to maintain youth within a stable foster family placement, and facilitate reunification with biological families when appropriate. The tiered foster care model allows a child to remain in a placement even if their needs fluctuate by increasing supports to the child and family if needs increase, thus proactively diverting the child from an RMHTF placement when it remains clinically appropriate.

14.1 Review Period, Data Sources and Limitations, Population Measured

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

⁵⁶ <https://dhhr.wv.gov/News/2023/Pages/dhhr-Highlights-Need-for-Foster-Parents-for-Older-Youth.aspx>

⁵⁷ <https://dhhr.wv.gov/News/2023/Pages/Gov.-Justice-Approves-dhhr-Rate-Increase-for-Child-Placing-Agencies-and-Socially-Necessary-Services-Providers.aspx>

Figure 57: Community-Based Placement Data Overview

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

14.2 Review Summary

DoHS strives to enable every WV child to have 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, children who are older, and/or children in the child welfare system with SED diagnoses who are unable to return to their biological family. In order for these children to be able to remain in the community and have success utilizing HCBS options, it is critical that they are able to build a life with loving and committed families. Given the needs of this population, DoHS, in collaboration with CPAs, is identifying ways to increase supports to foster parents and kinship parents. DoHS and its partners also continue to provide supports to biological families to increase the likelihood of reunification success, as well as to youth of transitional age who want to pursue independent living options. As HCBS are built out and gain rapport in communities DoHS aspires 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.

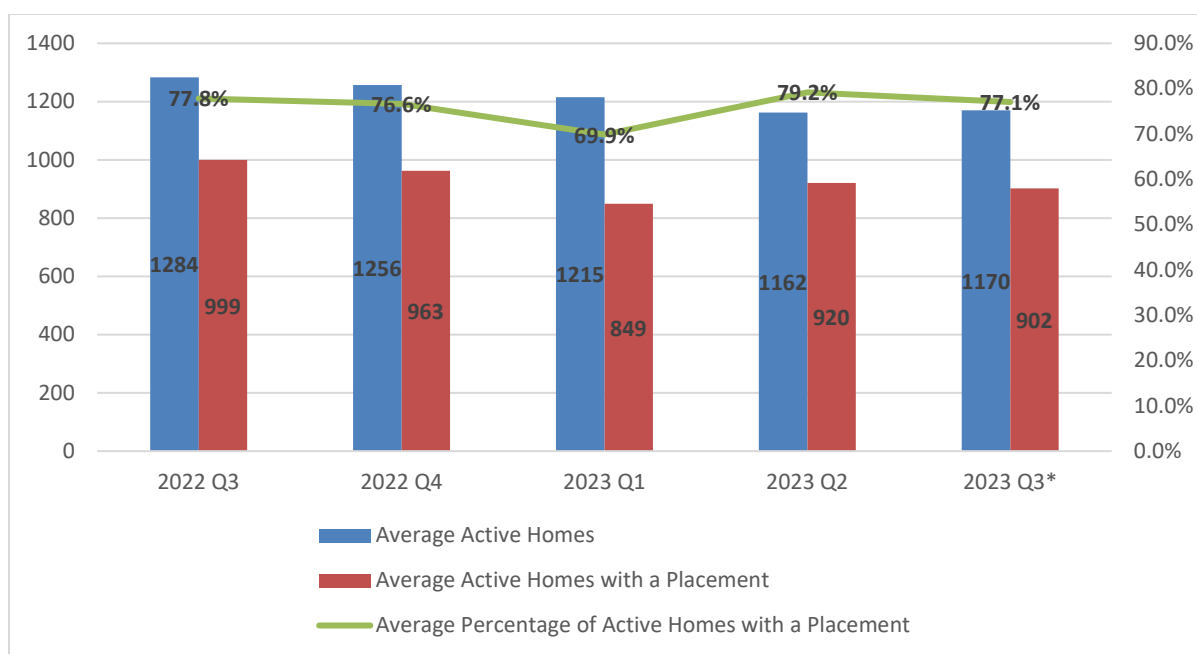
14.2(a) Foster Care Homes

Foster placements in WV—including children in certified foster homes or certified kinship placements—are orchestrated through CPAs. As noted above, DoHS is no longer focusing on the STAT Home Model due to challenges with recruitment. Instead, DoHS has shifted focus to strengthening the existing tiered foster care model, which allows youth to remain in a single foster placement without the need to move if their needs increase or decrease. In this model, if a child's needs change, then the supports provided to the child and family are also modified to align with their new needs. DoHS continues to meet regularly with CPAs to help ensure open communication and feedback on successes and barriers related to the recruitment and retention

process, including regular data reviews on key indicators. Recent conversations have centered on retaining and recruiting seasoned foster families or families with experience with children with significant mental health needs. CPAs continue to express that additional support will be needed for these families to be successful and feel cared for. The rate increase that went into effect in October was applied to funds directly received by CPAs and is intended to help address this need. Additional opportunities to address financial needs will be evaluated in the upcoming legislative session.

CPAs are responsible for recruitment and retention of certified foster families using the tiered foster care model throughout the state. As shown in Figure 58, the average number of active homes by quarter has decreased from 2022 to 2023; however, the percentage with placements has been maintained going into quarter 3 2023, with 77% of those homes having a placement during that time.

Figure 58: Average Foster Care Home Capacity by Quarter (Calendar Year), July 2022 to September 2023



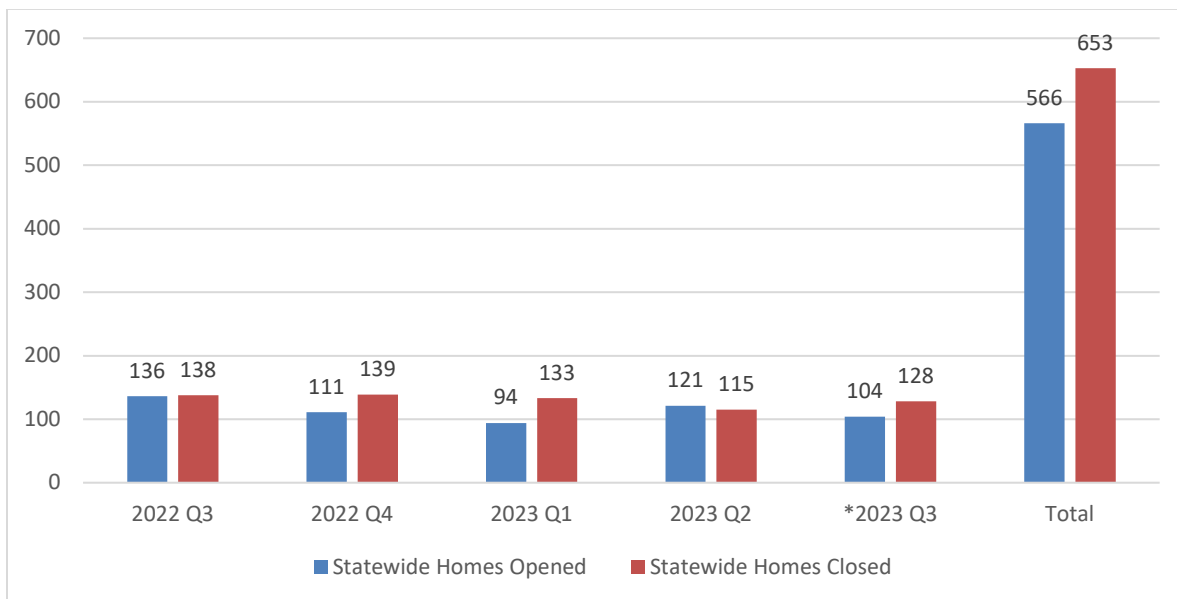
Note: Q3 2023 (July to September 2023) data is preliminary.

The ratio of homes closed to opened has increased over the past year (Figure 59) with 653 homes closing compared to only 566 homes opening from Q3 2022 to Q3 2023. 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. In 2023, a survey of 526 foster care families, which included relatives and kinship caregivers, was conducted to provide an opportunity for foster parents and caregivers to celebrate strengths and identify areas for improvement that could better support the children in their care. Themes of this survey identified a need for more behavioral health services, improved communication, increased financial support, and additional training or awareness on available resources. In August 2023, a press release was issued reminding WV

foster families of available resources that may address these needs.⁵⁸

Families also desired increased communication among all members of the system, which could strengthen their ability to advocate for kids in their care, and specifically noted little to no contact from Guardians ad Litem who are attorneys appointed to advocate for the child. Since receiving the results of this survey, DoHS continues to explore options to enhance relationships and processes with everyone involved in a child's case. This has included work completed through the Reducing the Reliance on Residential Workgroup, which has enhanced processes and training related to MDTs, prudent parenting, and expanded the ability of foster children to maintain friend and family connections while in care (improved contact documentation and protocol). These system enhancements, along with working closely with the court systems to provide collaboration and training, are anticipated to continue to impact placement stability and foster care family recruitment and retention. In addition to these updates, CPA reporting has also been expanded as of July 2023 to provide greater detail regarding voluntary home closures. Preliminary results show the majority of closures are related to adoption and legal guardianships taking place; however, these results will continue to be monitored as additional data become available to understand where changes can be made to help retain families.

Figure 59: Foster Care Homes Opened/Closed by Quarter⁵⁹, Q3 2022 to Q3 2023



Note: Q3 2023 (July to September 2023) data is preliminary.

⁵⁸ <https://dhhr.wv.gov/News/2023/Pages/dhhr-Reminds-Residents-of-Resources-for-Foster-Care-Families.aspx>

⁵⁹ Quarter is based on calendar year.

DoHS and CPAs also review retention data at least quarterly. Figure 60 shows the number of licensed foster families compared to the percentage who have been licensed for at least two years. Note that the number of licensed families is higher than the number of active families, as some families will become inactive temporarily for various reasons, including to take a break from fostering or to manage health or family needs that are short-term in nature (e.g., surgery or pregnancy). On average, the percentage of licensed families retained over two years has stabilized over the past 12 months. Comparing July to September 2023, to April to June 2023, the average percentage of families retained were 45.7% and 47.6%, respectively, despite the number of total licensed foster homes decreasing over this period. This sustained retention is likely largely influenced by nurturing strong relationships, 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.

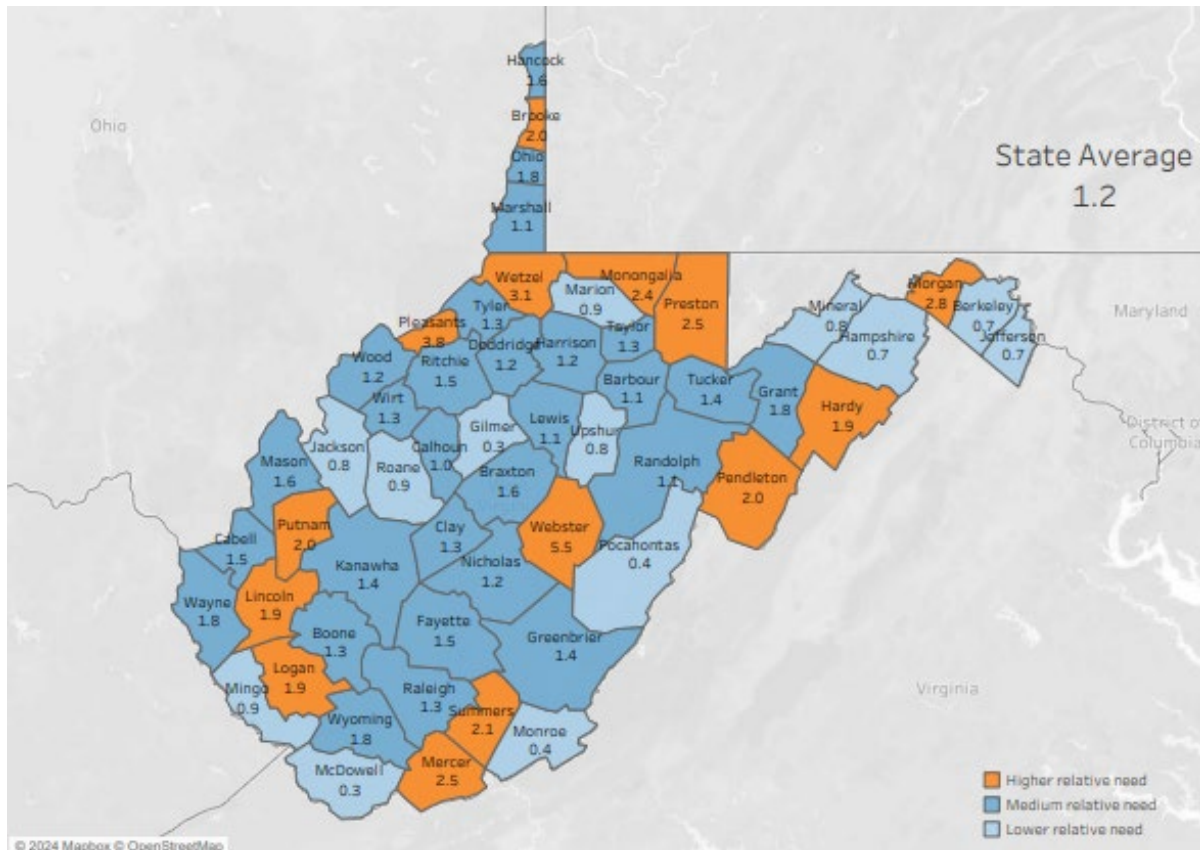
Figure 60: Number of Licensed Foster Families and Percentage Retained for Two or More Years

Average Across Period for Retention	Apr to Jun 2023	Jul to Sept 2023
Number of licensed foster families	1,389	1,374
Percentage of families licensed for at least two years	45.7%	47.6%

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 provide an approximate view of levels of need for a given area. A higher ratio indicates a greater need for additional foster homes, given that in realistic circumstances an open and active home does not always indicate a placement would be accepted. Therefore, it is ideal to expand the pool of available homes to increase the likelihood of an appropriate match.

The state average ratio of certified homes to placements was 1.3, meaning, on average, there was one home for every one child placed. Many counties had higher ratios, indicating higher relative need for foster home recruitment in these areas. Counties highlighted in orange below had ratios from 1.9 to 5.5 children per home (Figure 61). For counties with small populations, neighboring counties may be relied on for adequate placement capacity, especially if safety related to proximity, is a concern; however, it is ideal for counties to have more families than needed to support the range of children in care to accommodate foster family autonomy. In relation to these needs, DoHS has partnered with Mission WV and Aetna to develop a statewide foster care campaign that will put focus on expanding recruitment for families willing to accept teenagers and children with more intense needs. Some themes of this campaign are to emphasize reunification and supportive co-parenting, choices and support available to foster families, positive messaging, and to utilize foster parent's own experiences to recruit additional families. This campaign is expected to roll out in early 2024.

Figure 61: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, All Ages, July to September 2023: Average PATH Placement Data Extracts and Average Certified Homes

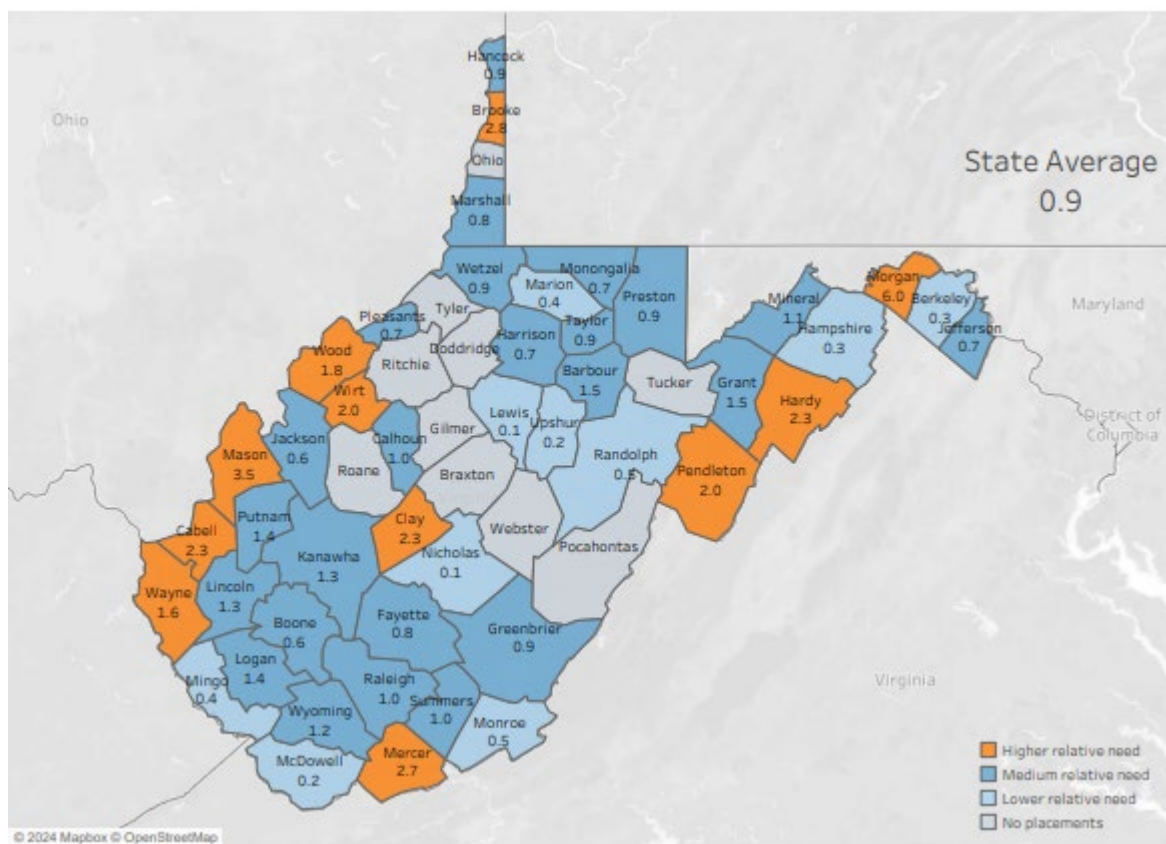


As has been a pattern identified in past prioritized discharge plan reporting, youth with lower CAFAS/PECFAS scores in RMHTF settings tend to be older compared to all youth in these placements regardless of CAFAS/PECFAS score. Youth aged 13 to 17 with CAFAS/PECFAS scores from 90 to 130 represented 86% of youth within this score category, compared to only 82% of youth in the overall RMHTF census. Although this is different for youth with a CAFAS/PECFAS score less than 90, it was evident there was a difference in the population of 18- to 20-year-olds, with 6% of placements with a CAFAS/PECFAS score less than 90 falling in this age range compared to only 1% of all RMHTF placements. Youth with lower CAFAS/PECFAS scores (<140) commonly have barriers pertaining to not having a home setting available for discharge. These findings have led to expanded analysis focusing on youth aged 13 and older compared to homes that indicated they would be willing to consider accepting placements for youth in this age range. Figure 62 displays the ratio of placements 13 and older to homes willing to accept youth in this age group by county. The state average ratio was 0.9, indicating a ratio of at least one home for every teen placed at the state-level. Only one-quarter (25%) of certified foster families were willing to accept a teenage child for placement on average for the period July to September 2023.

As with the previous figure for all ages, several counties have more limitations on homes available as shown in orange with higher relative need, ranging between 1.5 to 6 placements

per home. This essentially means, setting autonomy aside for review/analytical simplicity only, the number of certified homes available in these counties would require two to six youth aged 13 and older 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 strategic planning of recruitment efforts in addition to current efforts to expand recruitment via the statewide campaign.

Figure 62: Ratio of Average Therapeutic Foster Care Placements Per Foster Home, Age 13+, July - September 2023: Average PATH Placement Data Extracts and Average Certified Homes Willing to Accept Placements 13+



In addition to the previous figures which displayed foster home ratios to placements, the next two figures are also being reviewed by the Quality Committee to expand understanding of placement needs. Figures 63 and 64 reflect placement ratios with the addition of children who have been placed in an emergency shelter. Shelters are not considered a community-based placement but do indicate a need for community-based placement, as stays at shelters are meant to be acute and temporary. Children are often placed in shelters due to the lack of available foster care placement; therefore, it is important to consider these placements when assessing foster home capacity. As with the two preceding maps, counties in Figures 63 and 64 have been categorized based on relative need compared to other counties, with counties in orange indicating the greatest need for additional foster homes for children originating from

those counties. As previously stated, this ratio is determined simply by considering the number of active homes compared to the number of placements originating from that county, which in this case have or need a foster home. This ratio does not consider foster family autonomy or bed counts and is meant only as a tool to better understand geographic needs and opportunities for prioritization. Figure 63 shows a state average of 1.3 children per home including youth in shelters, only slightly higher than the rate excluding shelter placements, which was 1.2 children per home.

Figure 63: Ratio of Average Therapeutic Foster Care Placements and Emergency Shelter Placements Per Foster Home, July to September 2023: Average PATH Placement Data Extracts and Average Certified Homes

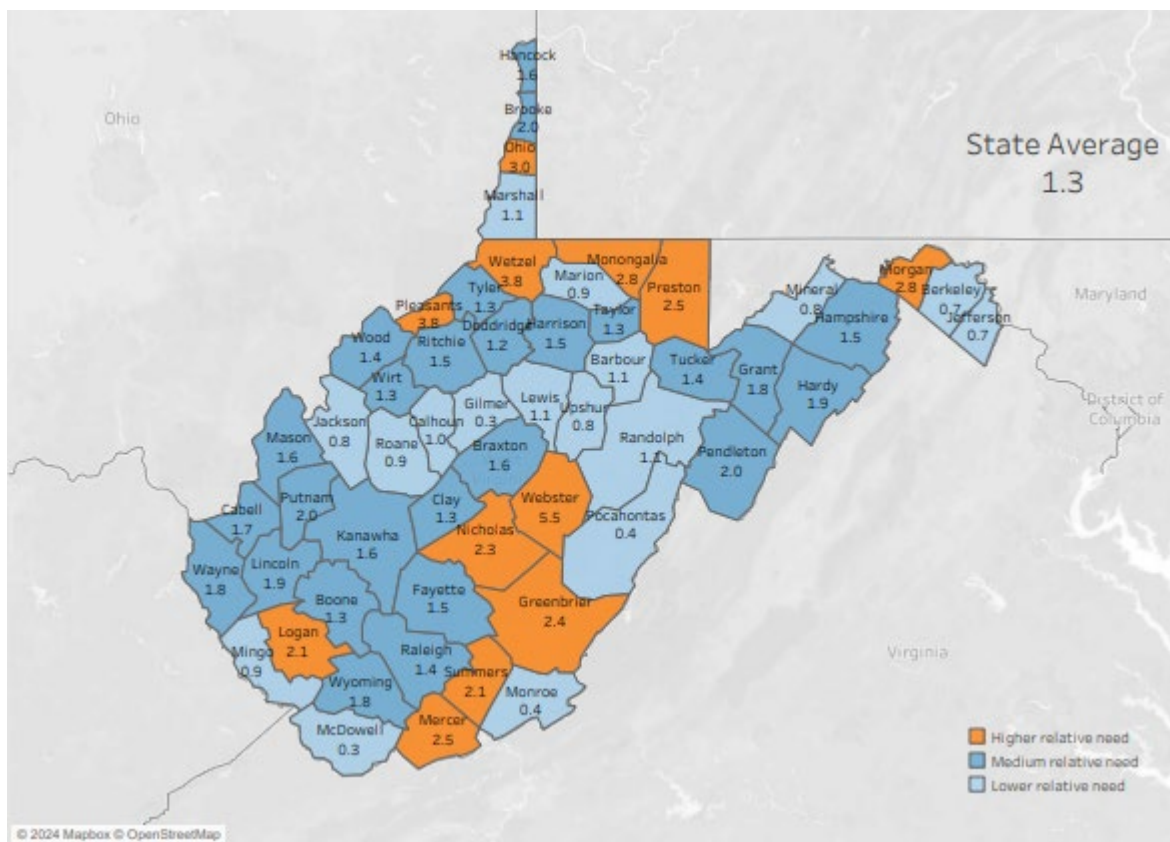
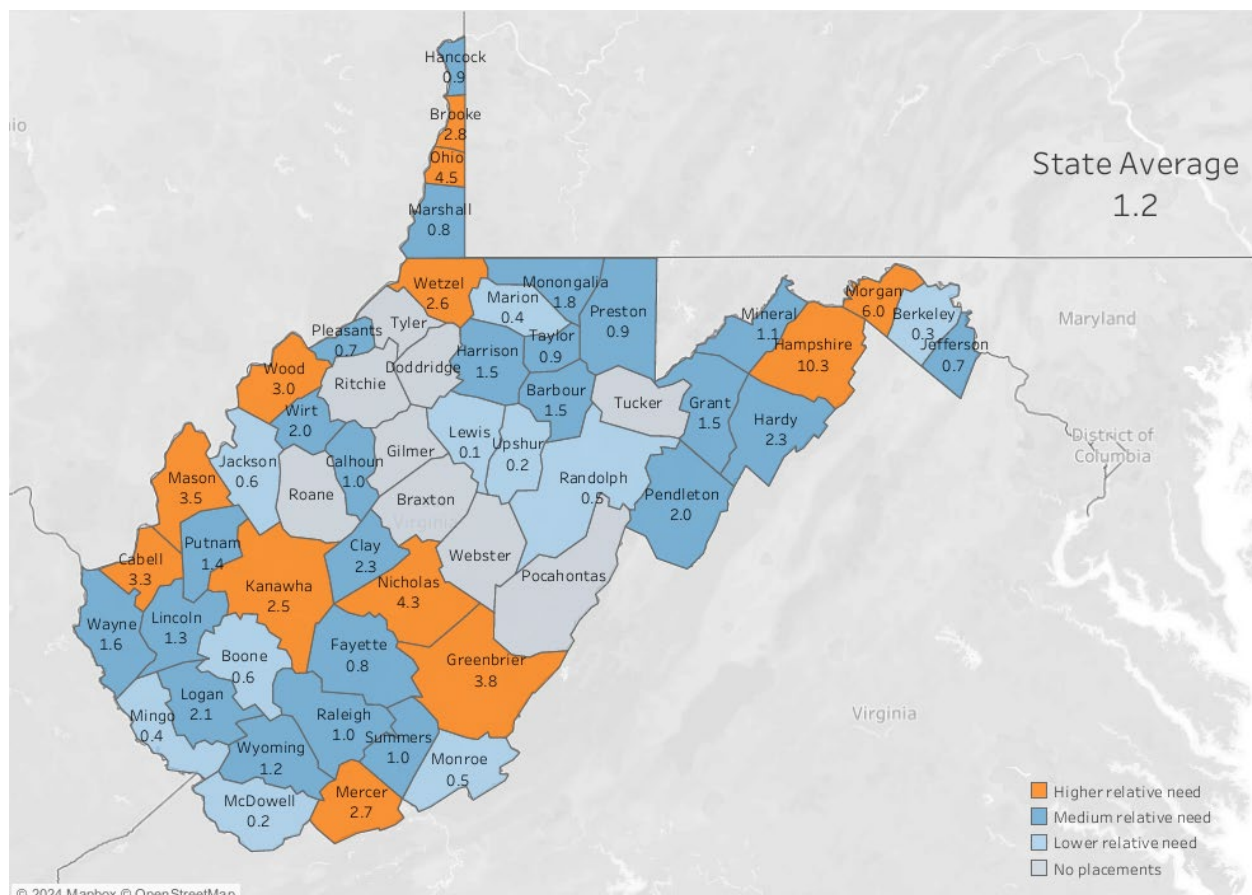


Figure 64 focuses on needs for youth 13 and older, with a statewide ratio including children placed in shelters of 1.2 compared to 0.9 excluding shelter placements. Teens comprise 24% of children in foster and shelter placements yet only 25% of certified foster homes reported being willing to accept a teen on average from July to September 2023. These ratios are inadequate to meet placement needs, especially given considerations of foster parent autonomy to decline placements. There were 12 counties with higher relative needs.

Figure 64: Ratio of Average Therapeutic Foster Care Placements and Emergency Shelter Placements Per Foster Home, Age 13+, July to September 2023: Average PATH Placement Data Extracts and Average Certified Homes Willing to Accept Placements 13+



Summary of Need Across Figures 61 through 64

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

- Morgan, Brooke, Mercer, and Wetzel counties were indicated in multiple foster placement ratio maps as having higher relative need for expanded foster care capacity compared to other counties in the state, regardless of placement age considerations.
- Hardy and Pendleton counties showed higher relative need for both homes of all ages and those willing to accept teens.
- Mason, Cabell, Wood, and Kanawha counties indicated higher relative need for foster homes willing to accept teen placements, across maps, including consideration for shelter placements.
- Ohio, Nicholas, and Greenbrier counties showed higher relative need when additional consideration was given for shelter placements with all age categories showing a ratio of two to three children per home and the ratio of placements to teen homes was approximately 4:1.

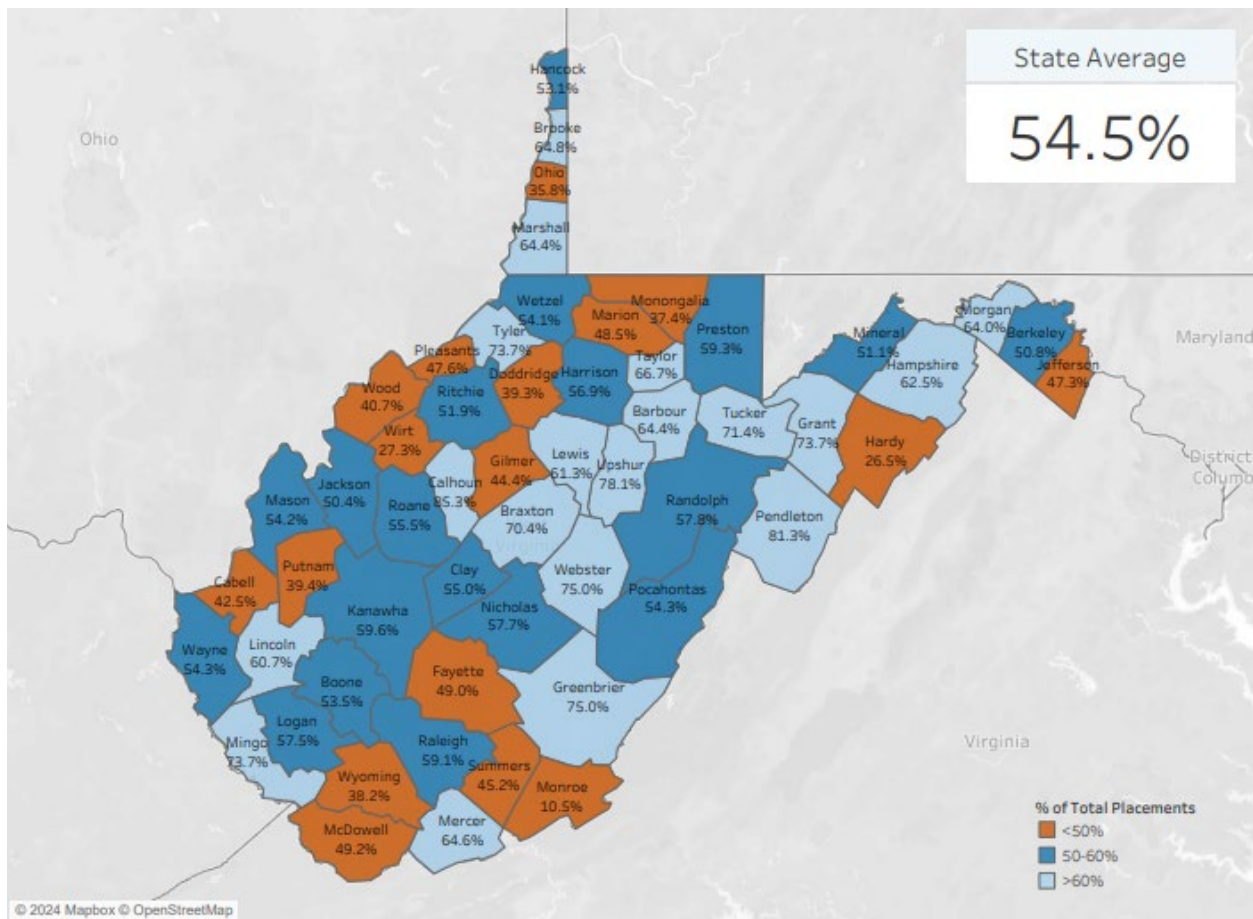
- Logan, Monongalia, Summers, Preston, Pleasants, and Webster counties showed higher relative need in the “all age categories” and medium relative need for teen foster families.

14.2(c) Kinship Homes

While foster care capacity is limited, placement of children in kinship homes is a strength of WV’s system of care. WV currently leads the nation in kinship placements with more than 55% of children in the child welfare population being placed in kinship homes each year. As of May 2023, 55% of in-state placements were in kinship homes. This has been maintained in the past several months with a continued rate of 55% as of October 2023. The Quality Committee noted some counties have a higher rate of kinship placement than others. Several counties with higher foster placement ratios—such as Grant, Mason, and Wayne—seemed to make up for this with higher rates of kinship placement. Furthermore, the Quality Committee compared counties with low kinship placement rates to counties with high placement-to-foster-homes ratios, identifying counties that have the greatest overall need for community-based placement availability. Wirt (27%), Monroe (11%) and Hardy (27%) counties were among the lowest in the state for percentage of placements located in kinship-type homes. Including consideration for youth in shelter placements, placement ratios for these counties were as follows: Wirt (1.3), Monroe (0.4) and Hardy (1.9) counties. Only Hardy County was above the state average, meaning these other counties fell into medium or lower relative need for foster homes. Greater needs were seen with youth 13 and older, including shelter placements, with the ratio of youth to homes as follows: Wirt (2), Monroe (0.5), Hardy (2.3) County.⁶⁰ Wirt and Hardy fell into medium relative need categories for foster placements. Considering the low rate of kinship placements in these counties, additional focus should be considered for family finding activities and expanding available foster homes. These findings will be shared with CPAs and workers in these areas to address and troubleshoot barriers to establishing and retaining homes and placements in these communities.

⁶⁰ Placement ratios are based on mathematical assumptions as to whether homes were limited to county of origin for review and planning purposes only.

Figure 65: Percentage of Kinship Foster Placements by County – October 2023



14.3 Strengths, Opportunities, Barriers, and Next Steps

DoHS continues to move forward with strengthening community-based placement availability despite identified challenges. Meetings and feedback from CPAs and other stakeholders have been a great strength of CQI efforts and will continue in the coming year. WV foster home capacity has decreased over time, with more homes closing than opening over the last several quarters. Although data are preliminary, adoption or establishment of legal guardianship is the most common reason homes close. Recruiting and retaining foster home families has remained an ongoing challenge noted by CPAs, especially for homes willing to accept older children and/or children with SED. However, increases have been seen in families retained for two years or longer, with increased focus on CQI helping retention efforts over the past year. Retention efforts will continue, along with strategic planning and marketing for recruitment of foster parents interested in accepting an older child with mental health needs into their home. Strategies will continue to be developed in collaboration with CPAs with a focus on county-level findings and needs for certified homes. The Office of QA will complete further analysis of children in need of community-based placement utilizing the new QuickBase system for discharge planning which will help identify commonalities, such as diagnoses and demographics for these children. DoHS is also collaborating with CPAs to explore enhancement of processes for identifying foster placement needs and prioritizing youth who have been identified as being “difficult to place.”

Additional information will be provided in future reports on these strategies as they become available; however, these discussions have prompted more robust conversations during special reviews, including added processes to update CPAs when a child finds a home so that agencies can continue looking for homes efficiently. In addition to these efforts, as of September 2023, group homes for transitioning youth are now 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, DoHS continues efforts to expand awareness and use of the CCRL and to address evolving data needs, including regular review meetings to inform planning and quality assurance. Figure 66 provides an overview of the CCRL data currently available.

15.1 Review Period, Data Sources and Limitations, Population Measured

Figure 66: CCRL Data Overview

Data Review Period	Data Source	Details and Limitations	Population Measured
January to June 2023	Help4WV – iCarol Call Reporting System	CCRL was implemented in conjunction with an active HELP4WV line in October 2020. Higher rates of incomplete data are expected for 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. “Calls” include texts and chats unless otherwise noted.	Children served directly through the CCRL; services are provided to individuals and families with children ages 0 – 21 who are having a behavioral health crisis or who have a diagnosis of an SED or SMI, and their families who are in crisis or who are seeking referrals to related services. For purposes of this report, callers reporting an age over 20 were excluded from the dataset.

As noted above, the CCRL officially launched services in October 2020. While the HELP4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated CCRL offers the added benefit of referral, support, and information services for children and their families. CCRL data is reviewed at least quarterly to assess call and referral quality and to determine the need for adjustment or improved outreach efforts. Additionally, the number of calls by acuity is included in the monthly internal Kids Thrive update, a comprehensive report that was temporarily paused while integrating new data systems. This

monthly review process will restart in January 2024 following successful deployment of those systems.

15.2 Review Summary

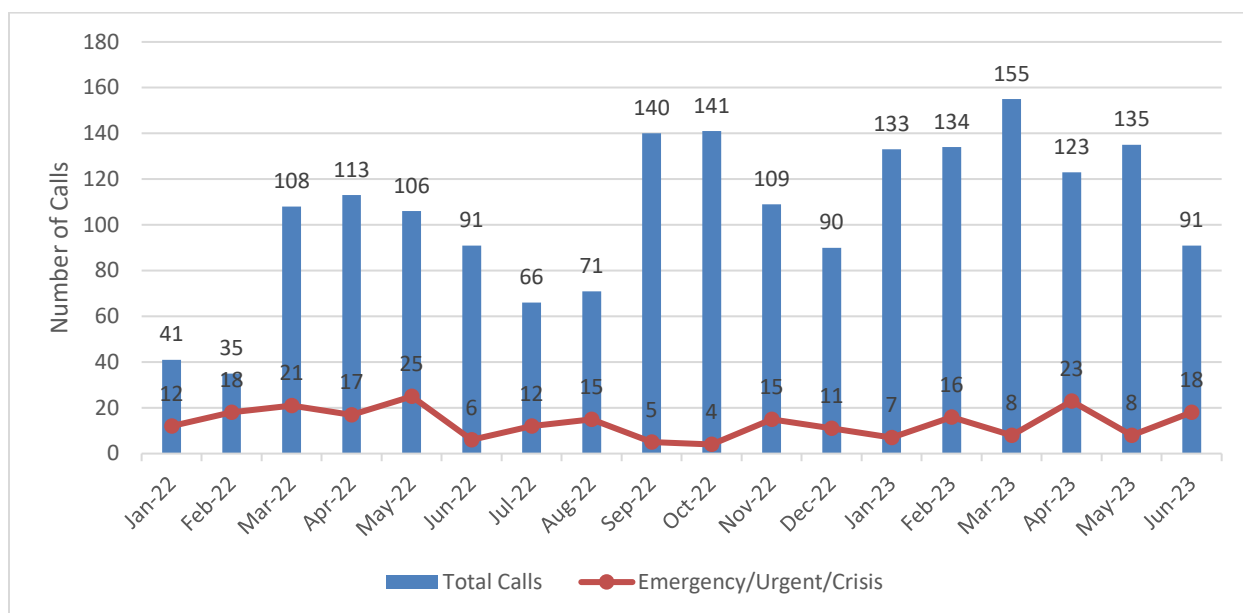
At least one individual from 48 of WV's 55 counties called the CCRL January to June 2023, up from 46 during the prior reporting period. When reviewing all calls from July 2022 to June 2023, 51 out of the 55 counties are represented. Only 38 counties had an individual call the CCRL in the last half of 2021, indicating that knowledge and usage of the CCRL has expanded. The Quality Committee continues to review county-level maps and data for several services to assess opportunities for outreach. BBH selected several counties in mid-2023 to focus outreach on related to the CCRL and access to the Assessment Pathway. BBH is working with vendors and providers to further develop a plan for outreach to the identified counties and continue outreach more generally in early 2024. Caution should be taken when reviewing county-specific CCRL caller data as 44% of calls indicated the county of origin as missing. However, this is an improvement from 52% of calls in the prior period and continues to be a focus area for improving data completion with the vendor.

Figure 67 shows available data for calls per 1,000 youth in each county during January to June 2023. Counties with the greatest rate of calls per 1,000 youth were Harrison, Clay, Webster, Jackson, and Upshur. The counties with the greatest number of calls regardless of population largely followed population centers except for Harrison County, which had the highest number of calls (40 calls) and was comparable to Kanawha County (39 calls), which has more than double the population size of Harrison County. This county was noted to include WVU hospital locations as well as an active CMCRS provider with strong rapport built and utilization with local schools which could potentially be associated with this finding. When comparing calls at the county-level from July to December 2022 to January to June 2023, a net increase was identified. Thirty-two (32) of WV's 55 counties had a net increase in calls in the first six months of 2023 compared to the previous period. While nine counties maintained the same number of calls for each period, 13 counties had a net decrease in calls of one or greater. The largest decrease in number of calls occurred in Raleigh County, which has noted general staffing challenges among the behavioral health workforce; however, given the overall volume of calls received, this only impacted the rate slightly, going from 1.9 to 1.3 calls per 1,000 youth in the mentioned 6 months periods respectively. From July to December 2022, 9 counties (identified in dark blue in Figure 67) had at least 1 call per 1,000 youth in each county, while in the first six months of 2023, twenty-three (23) counties were noted as having at least 1 call per 1,000 children.

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Figure 68: CCRL Calls by Type of Acuity by Month, January 2022 to June 2023



While the percentage of emergency/crisis/urgent calls have decreased over the last 18 months, total calls have increased significantly since March 2022 (Figure 69). DoHS is still working to understand these trends; however, the Quality Committee indicated this may be associated with increased use of the line as a referral source and, therefore, a decreased rate of crisis usage overall. It is noted that the use of local lines for CMCRS continues to be prevalent despite marketing efforts for use of the CCRL with warm transfer as needed. This will continue to be monitored; however, both entryways offer connection to the Assessment Pathway, and continued outreach efforts to market the line as not only a resource for families in crisis, but also as a key entry point to mental health services, has laid the groundwork for increased accessibility and ease of navigation for families. Increased use of the line in this manner prior to a potential crisis creates the opportunity to divert children and families from both crisis situations and out-of-home placements by connecting them to services and supports early. To ensure accuracy of reporting, BBH will collaborate with the call-line vendor to update the call center's desk guide and data reporting which will include reinforcing alignment and consistency in reporting such as with acuity of call designation, these changes are expected by summer 2024.

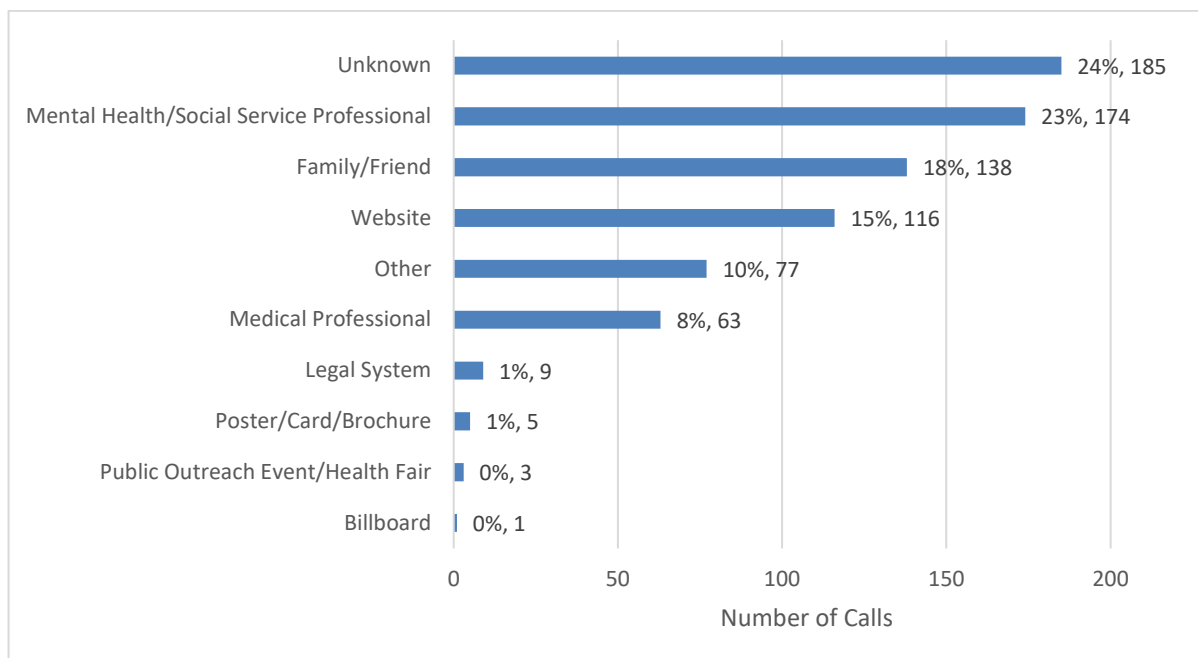
Figure 69: Comparison of Six-Month Period Calls to the CCRL by Type or Nature of the Call

Type/Nature of Call	July to December 2021	January to June 2022	July to December 2022	January to June 2023
Emergency/Urgent/Crisis Calls [n (%)]	63 (34%)	99 (20%)	62 (10%)	80 (10%)
Total Calls	187	494	617	771

The referral source for calls is depicted in Figure 70. Nearly one-quarter of calls, 24%, had an unknown referral source—the highest rate of any referral source. However, this is a decrease

from the previous reporting period when 31% of calls had an unknown referral source. Mental health/social service professionals, representing 23% of all referrals, were the second most common referral source. This is consistent with referral source data from July to December 2022 (24%), but both periods represent 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. 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 by summer 2024.

Figure 70: Referral Source for Call, January to June 2023



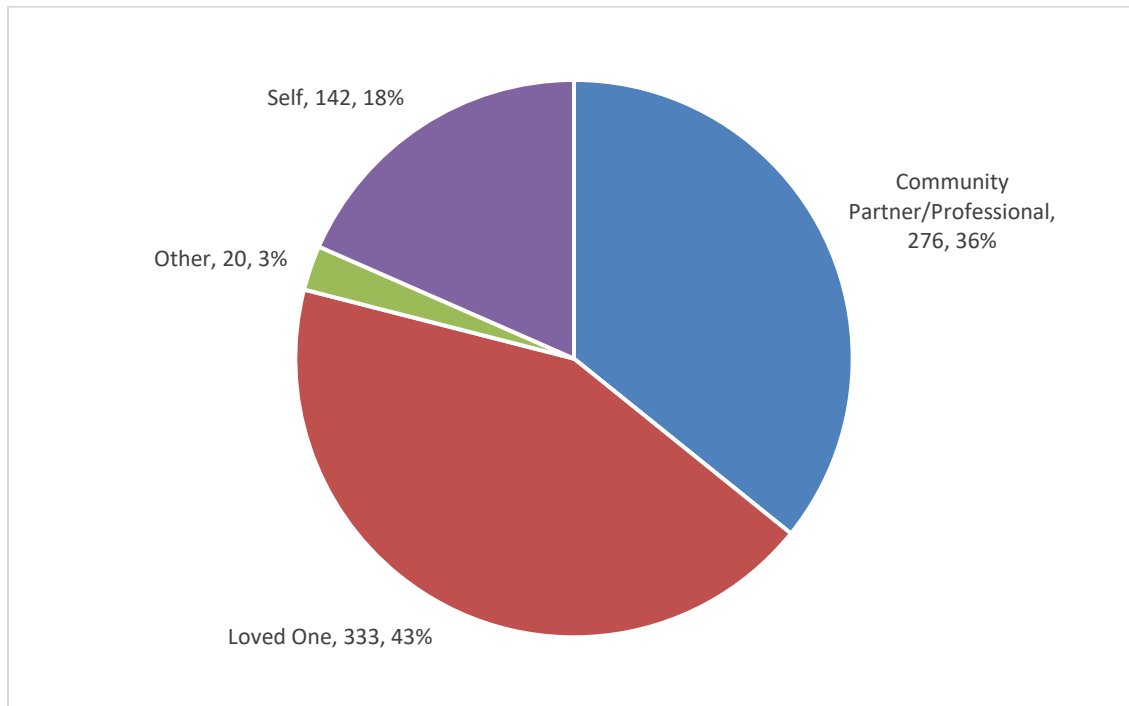
The caller's relation to the individual in need is displayed in Figure 71. It is noteworthy that:

- Out of all calls for the CCRL, 43% (n = 333) came from a loved one,⁶¹ a notable decrease from the prior reporting period, when 63% of all calls came from a loved one.
- The percentage of calls made by the children themselves increased from 11% during July to December 2022 to 18% (n = 142) in this reporting period. These calls were more likely to be made by chat or text compared to calls from other sources. Over half (n = 66, 52% of calls with non-missing age data) of these calls were received from a child aged 13 to 17. The #DYK series and Resource Rundown about availability of the CCRL for use by teens in need was released in this time period which may have had some influence on this increase.

⁶¹ Note that “loved one” includes parent, grandparent, other family, guardian, friend, significant other, and/or spouse.

- 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 2022 (158 calls) and then increased by an additional 75% in the first half of 2023 (376 calls). Over those three reporting periods, calls from community partners/professionals increased from 21% to 36% of all calls. This finding is likely associated with efforts to increase provider and partner awareness of the CCRL and related services.

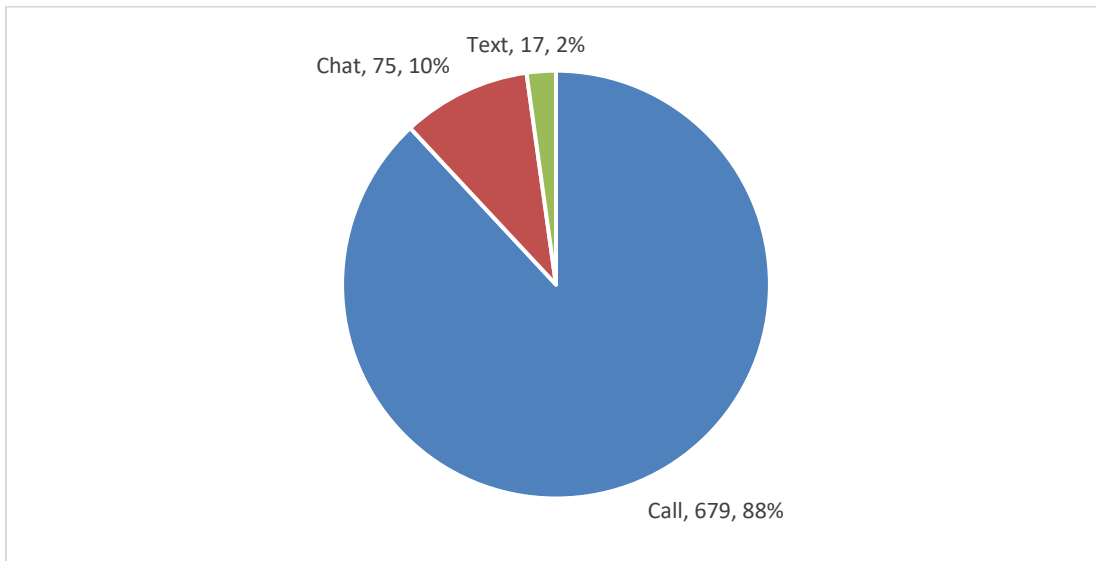
Figure 71: Caller Relation to Individual in Need, January to June 2023



As displayed in Figure 72, 88% of contacts in January to June 2023 came via a traditional call compared to 12% of contacts that came from text and chat features; text and chat increased from 9% 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 was conducted starting in April 2023 highlighting these features. During this period, teens who used the CCRL for themselves tended to use the chat/text feature more, compared to only 12% of all calls.

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

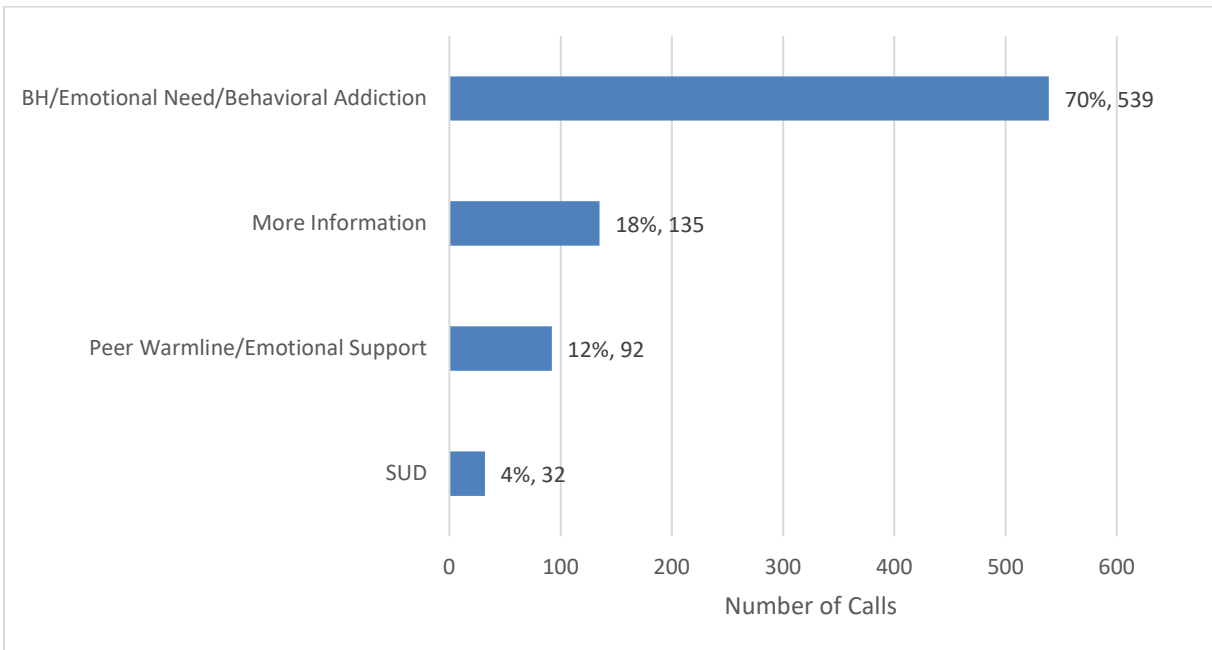
Figure 72: Type of Contact, January to June 2023



Individuals reached out to the CCRL for various reasons (i.e., presenting needs). As seen in Figure 73, in order of descending frequency, the needs of these individuals were the following: behavioral health or emotional need (70%), acquiring more information (18%), seeking connection with Peer Warmline⁶²/Emotional Support (12%), and SUD (4%). As of January 2022, staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs. Updates to the CCRL desk guide are also anticipated to address consistency related to presenting needs and detail of the types of information or services to which the caller is referred.

⁶² 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 73: Presenting Need, January – June 2023⁶³



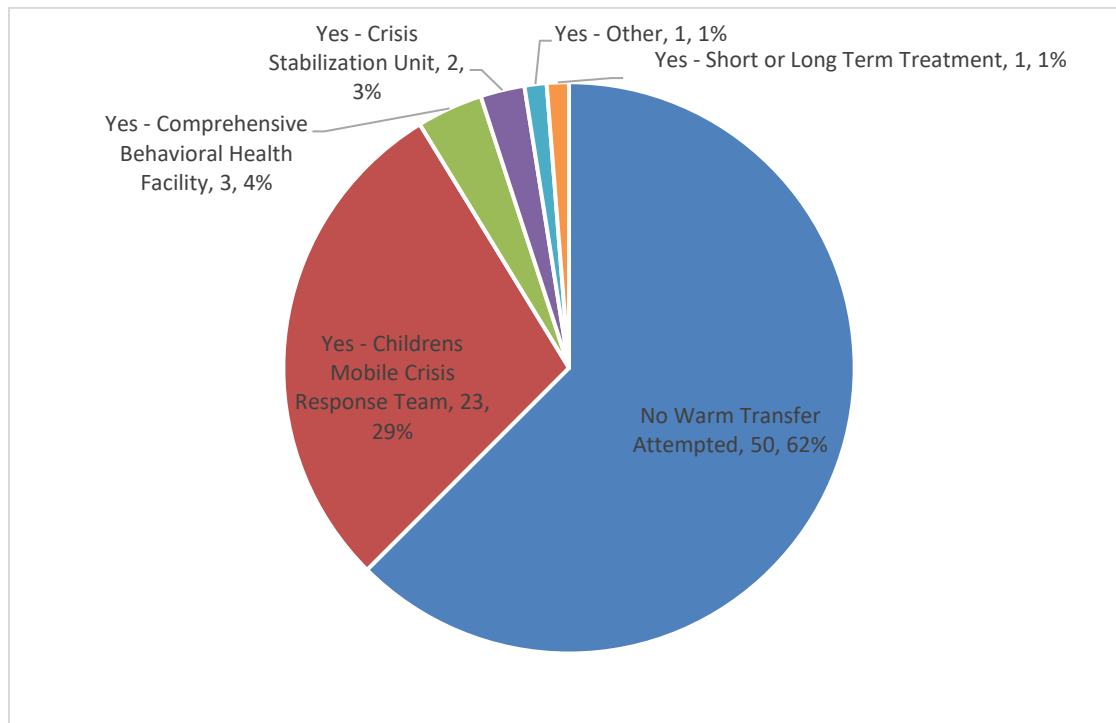
Of individuals for whom the call was reported as "emergency, crisis, or urgent" and had a response listed for referral, Figure 74 highlights 29% (down from 32% of these calls during July to December 2022) were reported as being directly transferred to a mobile crisis response team via "warm transfer."⁶⁴ Figure 74 notes 52% of calls had no warm transfer attempted; the call line noted that mobile response is offered when requested or is needed, but based on family preference and willingness, families may choose to be referred or receive information on other services, or simply to have someone be a support and listen in their time of need.

BBH continues monthly meetings with the vendor and has established more consistency with data definitions and collection focus. This effort will continue over the next six months with a broader system focus to eliminate duplicative fields and focus on key metrics to better understand call outcomes including for those calls with no warm transfer. To assist with this endeavor, the vendor will review a sample of routine calls and emergency/urgent calls to determine if these should have been labeled with a different acuity, received appropriate response/referral, or if additional considerations are needed. Education will be provided to call-line specialists based on findings and feedback from BBH.

⁶³ Individuals may have reported more than one need, making the total add up to greater than 100%. All needs are self-reported and not necessarily representative of a clinical diagnosis.

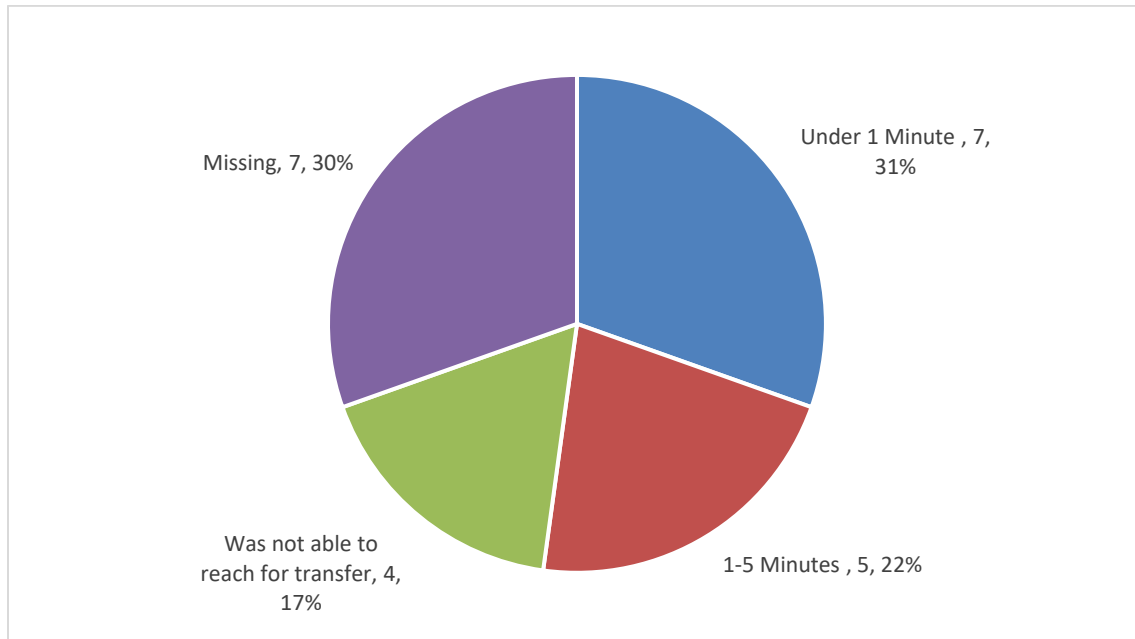
⁶⁴ "Warm transfer" is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed. The decision to attempt a warm transfer is made in conjunction with the family and their needs and willingness to accept assistance at the time of the call.

Figure 74: Referral Types for Calls Reported as “Emergency/Crisis/Urgent,” January to June 2023 (n=80)



Timeliness measures for warm transfer from the CCRL to a mobile crisis response team were added in May 2021 as seen in Figure 75. Of emergency/urgent/crisis calls with a reported warm transfer attempt to mobile crisis services, 53% were connected in five minutes or less, with 31% connected in under one minute. Note there were only 23 calls meeting this definition during the period, with 30% having missing timeliness information; therefore, continued focus and improvement in data collection is needed to identify patterns with call transfers. Four call records listed that the helpline specialist was unable to reach the mobile crisis agency for transfer, compared to three calls in the previous reporting period. When a CMCRS team is unable to be reached, the call-line specialists reach out to regional supervisors or BBH staff directly through a defined escalation process. DoHS will work with the vendor, as noted above, to continue to improve these metrics. In addition to these CQI processes in place, BBH also routinely reviews calls that are recorded as not being connected to a CMCRS team to help ensure that these calls were escalated at the time and as an opportunity to reenforce best practices and protocols with both CCRL and CMCRS teams.

Figure 75: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team, of Calls Reported as "Emergency/Crisis/Urgent" With Transfer Attempt, January – June 2023 (n=23)



15.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway, as well as media campaigns and other outreach campaigns, is anticipated to increase the number of services and awareness of the CCRL. CQI processes have permitted timely changes to training strategies and data indicators. First Choice Services, the provider that runs the CCRL, monitors call loads and weekly or seasonal trends to help ensure adequate coverage to meet family and child needs. Figure 76 provides data on CCRL current and budgeted personnel.

Figure 76: CCRL Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Help Line Specialists	16	16 ⁶⁵	100%
Program Coordinator	1	1	100%
Shift Leads (shared with other call lines)	3	3	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. Although only a small number of youth responding to the

⁶⁵ Only 15 of these staff are via the BBH budget for the CCRL according to First Choice reporting.

community-based CMH Evaluation indicated utilizing the CCRL, these youth also reported that the call line helped them avoid or delay residential placement. Given the nature of a line that helps families in times of critical need, data collection is not always the top priority, as the urgency of the child and family's needs should always come first. These efforts have been demonstrated through sustained increases in calls and by individuals seeking information for children in need, including expansion of calls received 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. BBH and the call-line vendor have identified, and will continue to find, opportunities to improve data collection to be able to tell the story of call outcomes more completely, regardless of caller acuity, when possible. This will be addressed by summer 2024.

In addition to helping families in crises, it is noteworthy that only 10% of calls for the period were reported as emergency/urgent/crisis. Although a sample review will be completed to validate this finding, the Quality Committee viewed this as a likely positive finding, 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' needs are met. Outreach in late 2023 for the CSED Waiver included information on the CCRL as a resource for families. This outreach included providing materials to emergency departments, a noted area of need from the most recent edition of this report.

Next steps include:

- Continue to work with the CCRL vendor to help ensure that processes are in place to capture complete data when feasible and to capture missing data on follow-up calls.
 - Focus on data fields monitored frequently for improved completion rates, such as county of origin information and call transfer-related outcomes.
 - By summer 2024, expand data collection to include referrals from school personnel and "other" sources to improve understanding of connections made to the CCRL and outreach opportunities. In addition to this, expand collection of call outcome data related to referrals made and 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.
 - The call-line vendor will complete a review of calls for different acuity and outcomes to assess appropriate documentation practices. Call-line specialists will be educated according to findings and any decided next steps.

- Continue to review call-line data routinely to identify opportunities for further outreach to families across the state and provide technical assistance to the call-line staff and the teams they refer to, as needed, to improve call and referral quality, including review of calls unable to be transferred in a timely manner.
- Continue outreach to medical offices and schools as part of expanded screening efforts.

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 if needed, to help them receive treatment in their home and community and prevent out-of-home placement. In addition to calling the CCRL, which has been available since October 1, 2020, children and families may call the regional CMCRS teams directly; however, DoHS’s crisis line promotional campaigns have shifted to calling the centralized CCRL first since its implementation.

In addition to services provided by CMCRS, BMS also offers mobile response services through the CSED Waiver. However, these services were reviewed and noted in Quality Committee reviews that utilization had primarily shifted to calls to the CCRL regional CMCRS; therefore, only CMCRS data was included for review purposes in this report. BMS mobile response will be monitored routinely for any changes in utilization, especially given the recent expansion of the SPA to include mobile response for all Medicaid members, not just those enrolled in the CSED Waiver (January 2024). This will provide the opportunity for expanded CMCRS networks, including the potential for expanded funding availability and mobile response teams continuing into adult services as well. Figure 77 provides an overview of the CMCRS data currently available.

16.1 Review Period, Data Sources and Limitations, Population Measured

Figure 77: CMCRS Data Overview

Data Review Period	Data Source	Limitations	Population Measured
January to June 2023	BBH System of Care Epi Info Interface	At the time of this report, indicators regarding timely provision of services and referral to additional services were unavailable. Indicators were added with the update to the Epi Info System (V2), which went live October 31, 2023. Timeliness data will be	Children served directly through grantees of the BBH program; this includes BMS-funded mobile response by these overlapping providers.

Data Review Period	Data Source	Limitations	Population Measured
		reviewed in the future once available. 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 to this, data in Section 16.2 is considered preliminary.	Services are provided to individuals and families with children ages 0 – 21 experiencing an emotional or behavioral crisis initially through BBH's CCRL or connected through a local CMCRS line.

16.2 Review Summary

CMCRS utilization trends will continue to be monitored as more data becomes available at the child level to continue establishing normal trends versus changes in service utilization. The Epi Info System and new updates (V2) are currently undergoing further testing to determine if updates made in fall 2023 were sufficient. Due to this, data in this section is considered preliminary. The BBH team will continue to review and validate data and understand any considerations related to these changes over the next six months.

For the review period (January to June 2023), 587 children received CMCRS services across 40 of the state's 55 counties (Figures 78 and 79), with over half of counties experiencing a sustained or increased number of calls from the second half of 2022 to the first half of 2023 (inclusive of counties with zero calls in July to December 2022 and non-zero calls in January to June 2023). The counties with the greatest number of children enrolled in January to June 2023 were Berkeley (91), Raleigh (60), Cabell (50), and Harrison and Kanawha (both n = 40). Harrison and Marion counties had remarkable increases, as both counties increased from 0 calls in the last six months of 2022 to 40 and 36 calls, respectively, during the first six months of 2023. As shown in Figure 79, Raleigh (3.59 enrollees per 1,000 children), Summers (3.50), Hancock (3.37), Morgan (3.08), and Fayette (2.95) had the highest enrollees per capita in the first six months of 2023. 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. The provider in these counties also has a dedicated staff member to handle data collection requirements, which could impact other counties' reporting given system changes and requirements.

Figure 78: Children Enrolled in CMCRS by County, Percent Change from July to December 2022 to January to June 2023 – Preliminary

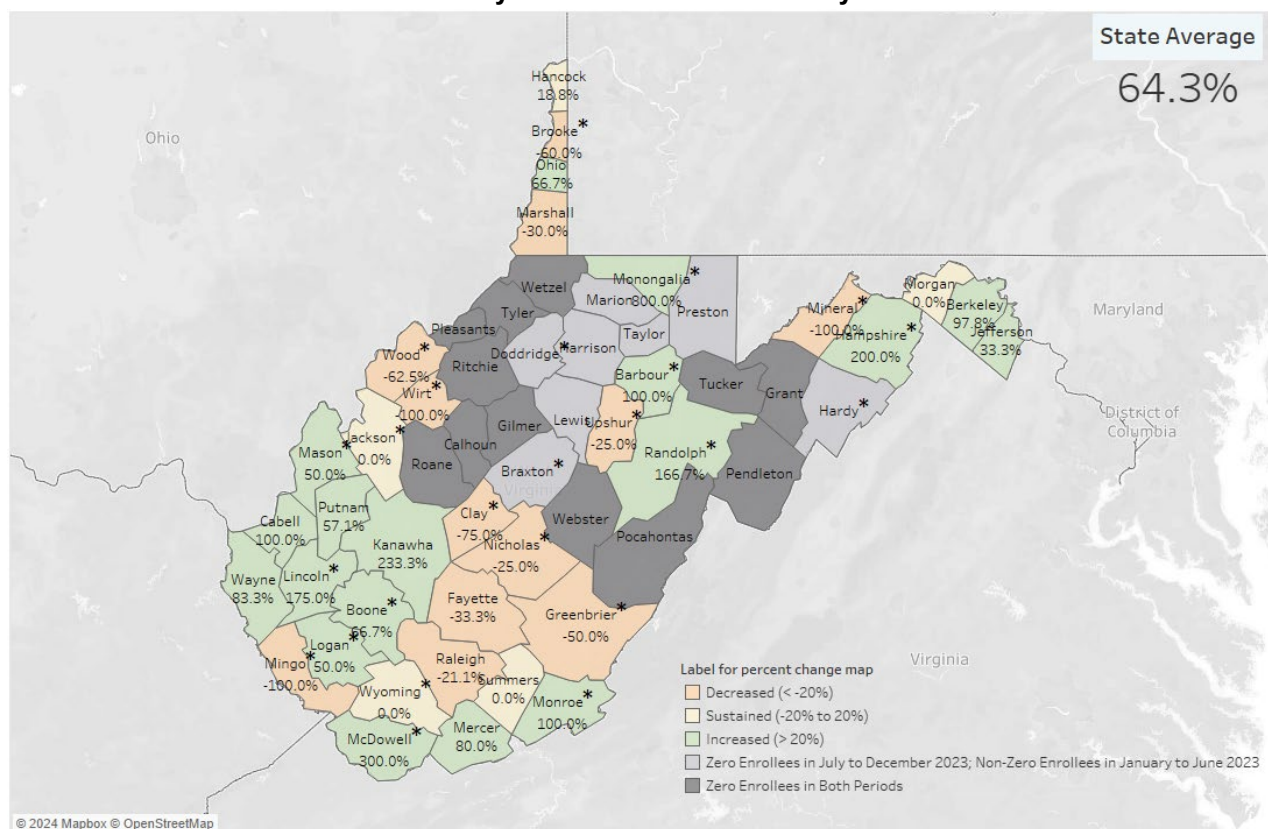


Figure 79: Rate Per Capita of Children Enrolled in CMCRS by County, July to December 2022 (left) to January to June 2023 (right)– Preliminary

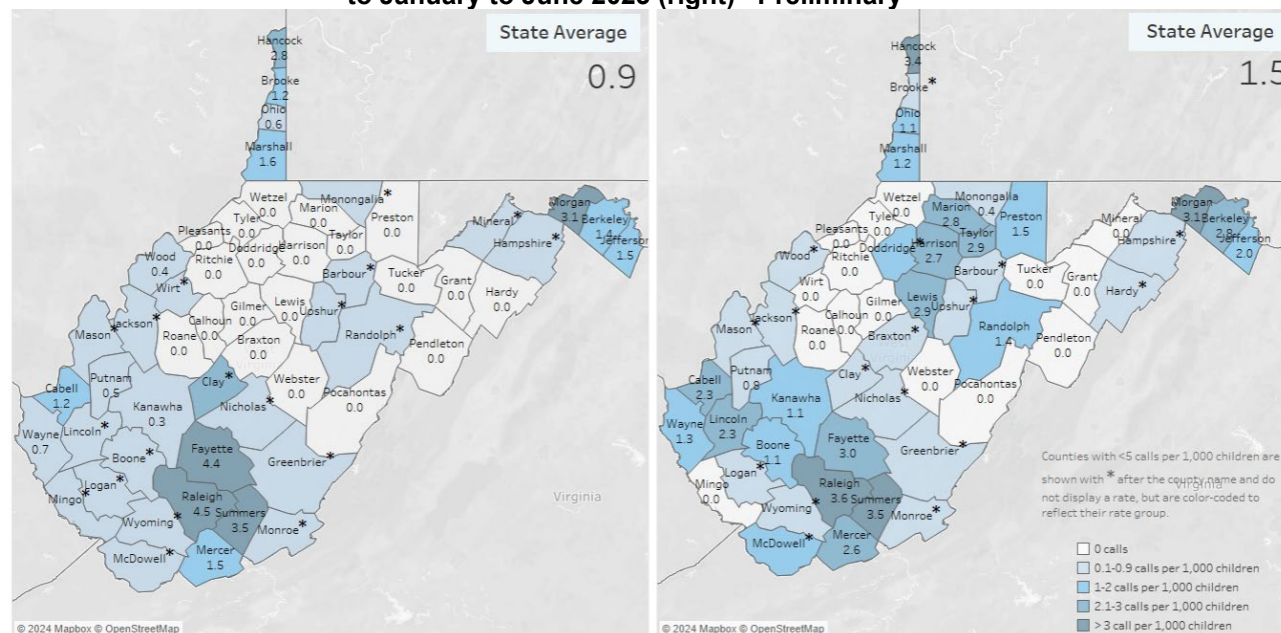
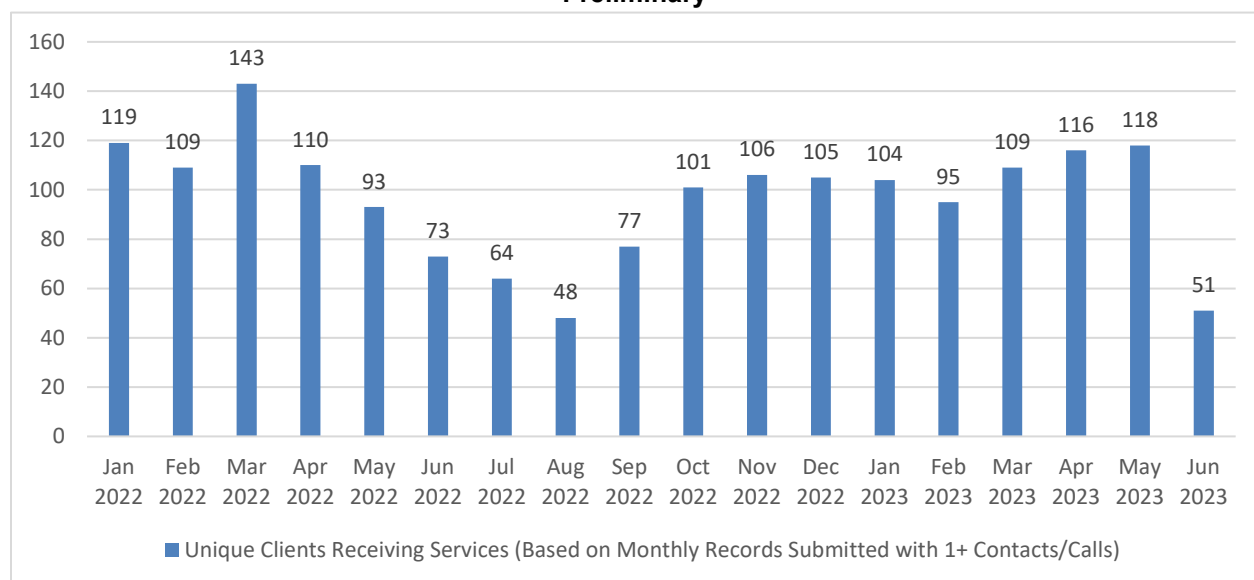


Figure 80 below demonstrates current CMCRS demand and enrollment from January 2022 to June 2023. March 2022 showed peak enrollment and utilization, coinciding with Assessment

Pathway referrals and HCBS utilization expansion. Enrollment decreased from April to August 2022, but this trend reversed in September 2022, and a general upward trend was observed until May 2023. Service utilization dipped sharply in June 2023, which may be expected given seasonal fluctuations. Overall, service utilization increased 64% from the second half of 2022 (357 children receiving services) to the first half of 2023 (587).⁶⁶ Children may continue to be enrolled in the service for up to eight weeks and only utilize additional services as needed. Additional quality checks were conducted over the past six months to assess for gaps in data collection and any technical assistance that providers might need. Assistance was provided upon request and as needs arose, given the updates to the Epi Info System (V2), more frequent data review is planned in early 2024, including on the provider-level, to understand potential areas of improvement.

Figure 80: CMCRS Monthly Enrollment Totals and Service Utilization, January 2022 to June 2023 – Preliminary



Information on the demographics of children enrolled in CMCRS services is included in Section 4.0 WV's Child Population and Individuals Utilizing Services.

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 similar percentage of missing information for race and children identifying as LGBTQ+ compared to previous data collection, and addressing rates of missing data continues to be an opportunity for improvement of data capture to assess family and children

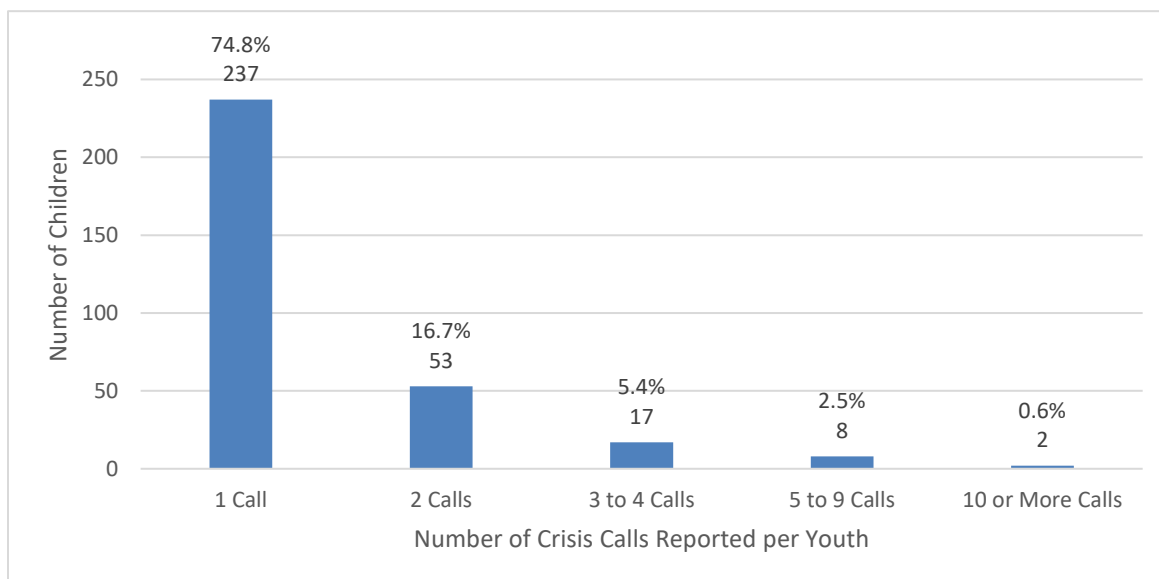
⁶⁶ A small change in the methodology used to analyze CMCRS data was made from the July 2023 edition of the Quality and Outcomes Report to this January 2024 edition. Previously, due to data quality issues surrounding data submission timelines, a small number of children were identified as "utilizing services" during a time period in which they had actually discharged. The new methodology properly identifies service utilization time frames based on enrollment and discharge dates rather than data submission dates. For consistency, the new methodology was applied to CY 2022 data presented in this report. Thus, data for CY 2022 in this report is not directly comparable to the same time period in prior reports due to this slight change in methodology.

needs and utilization more thoroughly. 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, 14% of children served were represented as non-white compared to 10% statewide representation of non-white child population. In addition to this, although approximately one-quarter of adoption status data and nearly one-half of LGBTQ+ identification data was missing, representation for these groups was also above average proportions for the typical WV population, including 17% of youth identifying as LGBTQ+ and 11% 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.

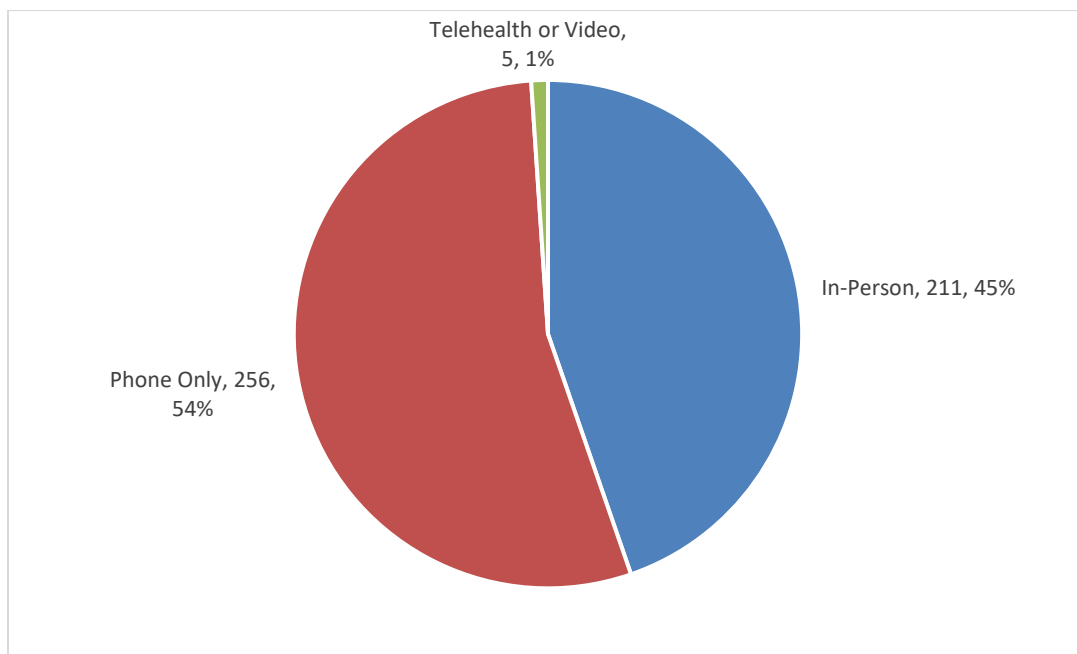
Repeat calls were assessed for individuals enrolled during the six-month period. Follow-up calls initiated by the provider were excluded. Data completion for enrolled children was somewhat low, with 26% of children having missing call information; however, this is a notable improvement over the prior reporting period, when 53% of children had missing data. DoHS is working with providers to improve data collection and completion efforts via provider-specific feedback. Figure 81 shows the frequency of repeat call utilization for children with known call information, with 75% of these children appearing to have their needs met and/or stabilized with one call, the same rate observed in July to December 2022. 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 67% of children with more than two calls received an in-person response, up from 32% in the prior reporting period. These calls for children with more than two crisis calls included 27 children with a total of 129 crisis calls during the period, 54 of which were in-person responses.

Figure 81: Number of CMCRS Crisis Calls Reported Per Children Served January – June 2023 – Preliminary (n=472 Calls for 317 Children; Excludes Follow-Ups Initiated by the Provider and Children with Missing Call Data)



Nearly half of crisis responses with a known response type were completed in-person (45%; Figure 82), excluding follow-ups initiated by the provider and children with missing data. This is a notable shift from prior reporting periods; in January to June 2022, and July to December 2022, only 21% and 26% of responses, respectively, were in-person. This may be a result of increased encouragement of in-person response, or feedback to providers regarding virtual responses practices. It is also possible this finding could indicate greater needs for some children, requiring an in-person response. The Quality Committee noted this information would be helpful at the provider-level to understand practices as well as to expand discussion and intervention with providers.

Figure 82: Response Type for CMCRS Crisis Calls January – June 2023 (Excluding Follow-Ups Initiated by the Provider and Children with Missing Data; n = 472 Calls for 317 Children) – Preliminary



Follow-up calls represented 1,225 additional calls directly from providers to follow up post crisis (22% of calls) or to work through prevention strategies with the family (78% of calls). These services provided after the initial crisis, which include further follow-up on needs such as referrals, are very important to helping ensure the child is stabilized while being connected to additional longer-term services, if not already established.

Additional updates to data collection for timeliness and detail of services rolled out on October 31, 2023. These updates 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 MU 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.

MU is contracted in conjunction with University of Connecticut in the development of CMCRS training. This training follows the national standard curriculum for mobile response and incorporates 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 SPA

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.

Providers have indicated challenges still exist in responding within one hour due to the rurality and geography of the state. Providers have also indicated difficulty due to increasing turnover of staff and concerns of how to handle multiple crises if they occur at the same time; however, build-out of stabilization and preventative intervention services has helped alleviate this issue. Data regarding timely response is not yet available but are being refined to help ensure national standards are being met and to support CQI reviews in the future.

As reflected in Figure 83, CMCRS capacity and FTEs have increased in every region of the state except for region 4, which is currently at 50% capacity. Providers in this region have indicated that they are actively pursuing new hires for these positions, and most positions have only been open a few months. Efforts to increase capacity include a marketing campaign to recruit behavioral therapeutic specialists as well as updating the salary scale to offer more competitive compensation. At this point, providers in region 4 have not encountered issues with coverage adequacy. Other regions with vacancies noted active plans for hiring as well. Eighty percent (80%) of positions throughout the state are filled. DoHS will continue to work with providers to offer technical assistance to improve workforce capacity, especially with the transition to and availability of Medicaid State Plan funded services.

Figure 83: BBH CMCRS Provider Capacity by Region⁶⁷

Region	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	9	10	90%
Region 2	6	6	100%
Region 3	7	7	100%
Region 4	3	6	50%
Region 5	4	7.5	53%
Region 6	5	6	83%
Total	34	42.5	80%

16.4 Strengths, Opportunities, Barriers, and Next Steps

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

⁶⁷ BBH Region Map can be found in Appendix B.

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, which will be expanded to include timeliness information in the coming months. This includes the shift toward the CCRL as the centralized call line to help ensure families are responded to in a timely manner, and an escalation process is initiated if any issues arise. Social service managers have also been made aware of the escalation process for children in kinship or in-home care who may need CMCRS services to help prevent disruption.⁶⁸ Analyses disaggregated at the provider-level will be presented in early 2024 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. This will be a focus area for BBH and the Office of QA in the coming months, with provider-level data review to determine intervention opportunities in relation to referral practices, response type, frequency of return callers⁶⁹, and data quality.
- As with CCRL, provide additional stakeholder outreach and education for access points such as EDs, medical offices, schools, etc., focusing on counties identified for outreach.
- Encourage CMCRS providers to make direct referrals to the Assessment Pathway immediately upon resolution of the crisis when agreed upon with the family. Providers noted difficulty getting families to participate in follow-up. BBH will continue to navigate and provide technical assistance to address these challenges and encourage referral to longer-term services.
- Through additional analysis opportunities made possible via the data store, explore outcomes following CMCRS interaction and associated characteristics.

⁶⁸ 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.

⁶⁹ Frequency of calls by child is not necessarily positive or negative result, but it should be considered in combination with the needs of the family to understand if their needs are being addressed sufficiently at each call.

17.0 Residential Mental Health Treatment Facility (RMHTF) Services

The overarching goal to improve outcomes for children is to reduce the State's reliance on RMHTFs and to increase HCBS available to children with SED. DoHS continues to increase the availability of community-based services, including the recent addition of community-based TLVY homes specifically designed to support youth ages 17 to 21. In these homes, youth can continue to gain skills to support independent living and access any needed mental and behavioral health treatment from community-based mental health providers. These homes became operational in September 2023 and can support a total of up to 22 youth.

Throughout 2023, DoHS also made significant progress on the new RMHTF models of care to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs. DoHS has partnered with Casey Family Programs over the last two years to develop these proposed new RMHTF models of care. DoHS contracted with Myers and Stauffer in March 2023 to develop the rate methodology and associated rates for the new models of care.

The new model of care will emphasize use of the least-restrictive setting based on the intensity of the child's needs. The new structure will replace the current residential levels of care with the following: residential homes, specialized residential intensive treatment facilities (SRIT), and residential intensive treatment facilities (RIT), with emergency shelters and PRTFs remaining in place as with the previous structure. Figure 84 below provides an overview of these new types of settings.

Figure 84: Proposed program structure: Settings

Residential Homes	<ul style="list-style-type: none"> • Focus on achieving a permanent family placement • This type of setting would have community-based treatment services and children would attend public school
Specialized Residential Intensive Treatment Facility	<ul style="list-style-type: none"> • Focus on particular groups depending on specific treatment needs who have historically been sent out of state for care (e.g., sex offenders, individuals on the autism spectrum who have major behavior challenges) • This type of setting would have a specific treatment requirement
Residential Intensive Treatment Facility	<ul style="list-style-type: none"> • Offer the highest level of treatment services • This type of setting would have a treatment requirement

The residential homes setting is a new community-based placement type which will afford children the opportunity to focus on achieving a permanent family placement without the restrictions of a RMHTF; all treatment services needed will be provided through HCBS treatment options. This setting was included due to overutilization of RMHTF placements for

youth that, simply put, did not have a less-restrictive setting for discharge available. Residential homes enable the child to gain family living skills while also experiencing a less-restrictive environment, enabling them to attend public school and be part of the community.

SRIT and RIT facilities will increase focus on intensive treatment needs, including restructuring facilities to meet specific treatment needs for many individuals who were historically sent out of state due to a lack of available options in West Virginia. The SRIT will offer services for special populations, including those with severe aggression and/or violent behaviors, problematic sexual behaviors, neurodevelopmental and comorbid conditions, and ASD. Facilities will receive an increased rate based on the intensity of the individual's need. The rate will be flexible so that if a child's needs change, then payment can be increased to meet those needs. DoHS has set a goal of beginning to operationalize these new models of care by July 2024, pending federal approval. Following approval, there will be a period in which facilities will continue to transition to the new model, including implementing new model requirements. Key components to help ensure quality of care for children and improved child-level outcomes include small group cottages where each child has their own bedroom with specific requirements around family engagement, discharge planning, trauma-informed treatment models, and use of evidenced based programming. Changes in methodology and culture are expected to impact length of stay and therefore the census, with a goal of reducing the average stay of an individual in a group residential setting to 90 to 120 days. The WV Youth in Group Residential and Psychiatric Residential Treatment Facilities - 2023 Report, which includes a cluster analysis of youth in these types of placements (produced by MU), is expected to be finalized in January 2024 and will also help DoHS and providers gain additional insight into WV's specific needs for residential facility types. DoHS continues to collaborate with providers, meeting frequently, to gather feedback and discuss considerations as this model is developed and implemented.

Reducing the overall census in RMHTFs continues to be a primary focus for DoHS. DoHS leadership monitors the census on a weekly basis. The Quality Review Committee and program teams routinely monitor census, admissions, and discharges, along with other residential treatment indicators and are aware of changes required to the residential treatment model to achieve DoHS's census reduction. Additionally, the model of care changes are currently in process as noted above.

The point-in-time RMHTF census on January 1, 2023, was 772 children compared to a preliminary census of 846 as of January 1, 2024. An increase in the census was observed between January 1 and May 1, 2023. Census remained relatively stable from May through September 2023, followed by a slight decline October 1 to December 1, 2023. The point-in-time RMHTF census on December 1, 2023, was 872. The census from October 2023 to January 2024 is considered preliminary and may be subject to change due to data entry lag considerations. Increased demand for out-of-state placements and resultant census increases were observed. Given the increased demand for out-of-state placement coupled with DoHS's goal of reducing the number of children placed out-of-state, significant effort has been directed toward developing an out-of-state electronic referral system over the last six months of 2023. Additional details of that referral system will be described throughout this section.

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, DoHS 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 continued throughout 2023. Completing the QIA process for children currently in residential placement is occurring in phases. The first phase included children with multiple placements in in-state residential settings. The next phase includes children whose length of stays are greater than 90 days and less than the average length of stay. By the end of 2024, all children in active residential placement are expected to have completed the QIA process.

DoHS contracted with MU in April 2023 to complete CAFAS/PECFAS, CANS assessments, QIA, and discharge plans for all children in out-of-state residential placement. In the last six months, the Office of QA collaborated with Marshall to establish specifications for data collection associated with children in out-of-state placement. Once fully implemented, this data will be shared with Aetna for incorporation into their Quickbase system, which launched in November 2023 and further enhance monitoring and reporting of children in residential placements. Additional details about this dataset will be included later in this section.

DoHS, in partnership with Aetna and residential providers, has a focus on prioritized discharge planning. Significant progress has been made, including discharge plans continuing to be in place for greater than 95% of children in placement. Lack of community-based placement options continues to be a primary barrier for discharging children who are currently in residential placements. As noted above, DoHS 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. Additionally, a collaborative focused on recruiting foster families for youth ages 13 to 17 is underway to address this critical need. These efforts 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
<p>January to June 2023</p> <p>Trend data January 2022 through June 2023 (in some cases, more recent and/or older data dating back to 2019 is included for evaluating trends)</p>	<p>BSS FACTS/WV PATH Data System</p> <p>EDS</p>	<p>EDS claims are the data source for parental placements to PRTFs. Due to claim payment lag and data warehouse update cycles, parental placement data for the later part of the study period may be incomplete. Claims data account for less than 2% of RMHTF data. Claims data reported here include payments through October 2023.</p> <p>FACTS data includes a static history of child placements prior to the go-live of the new PATH system on January 4, 2023.</p> <p>PATH data may show a brief lag, as field workers may not be able to update the system immediately, particularly around the exit status and timeline of child placements. DoHS is still monitoring the pattern of this lag and impact of the retroactive updating, but the initial analysis shows PATH data are stable after one to two months.</p>	<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 EDS.</p>
<p>Active Placements as of September 30, 2023</p>	<p>MCO RMHTF Monthly Report Spreadsheet</p>	<p>Discharge date data for children in this population are not yet universally available. Therefore, it was not possible to determine definitively the number of active placements during a period; therefore, the data provided is point-in-time as of the end of September 2023.</p> <p>Some results in this subsection use data through the end of August 2023 instead of September 2023 and are noted accordingly.</p>	<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).</p>

17.2 Review Summary

17.2(a) Prioritized Discharge Planning

DoHS continues to collaborate actively with Aetna to prioritize discharge planning for children currently placed in residential settings with a CAFAS/PECFAS score less than 90.⁷⁰ 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. Data collection was expanded to include children with a CAFAS/PECFAS score less than 140 effective April 2023. In spring and summer 2023, DoHS and Aetna spent considerable time detailing data specifications, enhancing drop-down options based on lessons learned from prior data collection, identifying system configuration to address data quality issues, and outlining workflows associated with discharge planning. Based on this work, Aetna converted data collection for children in the discharge planning population to the Quickbase system in November 2023. Moreover, all children in both in-state and out-of-state residential settings – independent of CAFAS/PECFAS score – have been entered into the Quickbase system as of December 2023. Aetna care managers are still in the process of ensuring all required fields are populated. This conversion to Quickbase will increase the ability to track and report on all children in residential placement, including the capability to create notifications to flag children for review and prioritized focus whose data falls outside of expected thresholds. Early discussion of possible indicators to flag include length of stay values, CAFAS/PECFAS scores, and court orders to maintain placement that do not align with treatment recommendations. Incorporation of this enhanced and expanded discharge planning dataset into the data store is anticipated in early 2024 once validation of reporting from Aetna’s new Quickbase system is complete.

Residential CAFAS/PECFAS score history from Aetna’s UM system was added to the data store in summer 2023, enabling additional analysis related to CAFAS/PECFAS scores for children in residential placement. Through the process of more detailed analysis of discharge planning data over the last year, DoHS is aware that there are many factors outside of CAFAS/PECFAS scores that can impact a child’s continued placement in an RMHTF. Until enhanced data collection through Quickbase is fully operational and validated, DoHS and Aetna will continue to use CAFAS/PECFAS score as a primary indicator to identify children for prioritized discharge planning.

As part of the quality improvement process, DoHS continues to review and analyze the characteristics and discharge barriers of children in RMHTF settings with a CAFAS/PECFAS score less than 90 to make changes to address the needs of these children. Effectively

⁷⁰ CAFAS/PECFAS assessment is used as part of the determination of functional impairment that substantially interferes with or limits a child’s role or results in impacted functioning in the family, school, and/or community activities. A CAFAS/PECFAS is expected to be completed every 90 days for children in residential placement. 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. CAFAS/PECFAS score is one measure of a child’s appropriateness for placement in a residential setting and is currently being used to identify children for prioritized discharge planning.

completing this analysis is somewhat challenging due to data quality issues related to discharge barriers that DoHS is actively addressing with Aetna. These challenges are anticipated to be resolved through the implementation of the Quickbase system conversion described above and through the ongoing education of Aetna care managers on data entry into this new system. Discharge barriers can change as circumstances change and as new information is gathered, making an accurate assessment of current discharge barriers a challenge. As data quality continues to improve, DoHS will use information from the analysis of child characteristics and discharge barriers to understand if there are any gaps in community-based care, areas where additional outreach and education is needed, or other factors that DoHS and stakeholders can impact to help ensure that children are served in their homes and communities when possible and clinically appropriate.

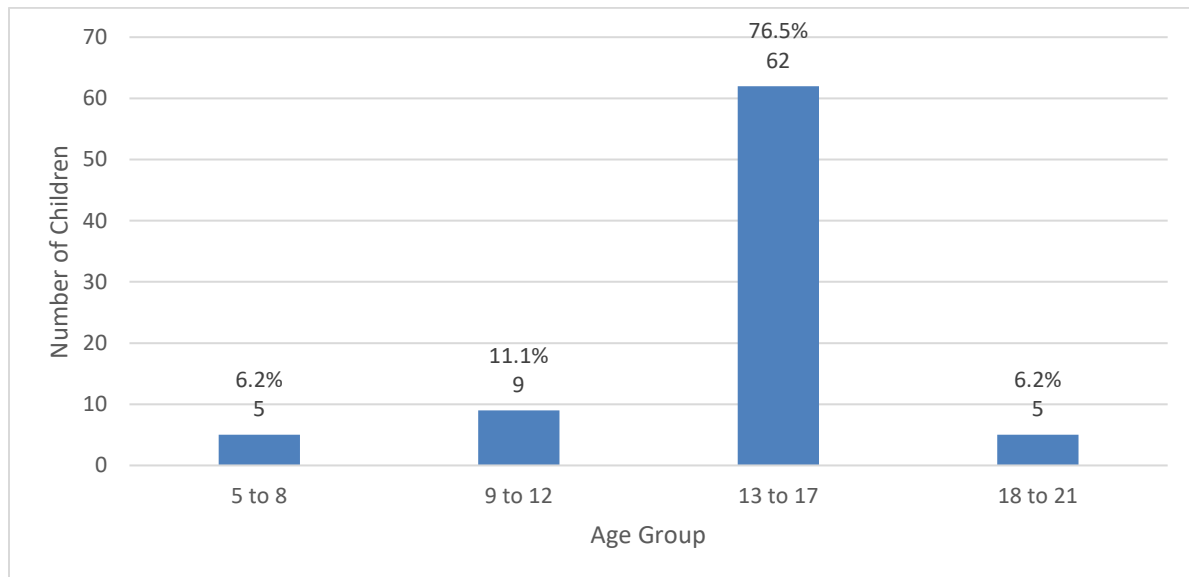
As of September 30, 2023⁷¹, 81 children whose most recent CAFAS/PECFAS⁷² score was less than 90 were in in-state residential settings. Characteristics of these children are as follows:

- *Gender*: 65% were male, showing a similar proportion to all individuals in RMHTF settings.
- *Age*: Similarly, 77% of individuals with CAFAS/PECFAS scores less than 90 fell into the 13 to 17 age category (Figure 86) compared to 82% of all individuals in RMHTFs. This reflects similarities in populations for the broader RMHTF population and for those with scores below 90. However, there were some identified differences in the 9 to 12 age category and a larger difference in individuals 18 to 21; approximately 6% of individuals with a CAFAS/PECFAS less than 90 were ages 18 to 21 compared to 1% in the broader residential population.

⁷¹ The July 2023 Semiannual Report identified 140 children in an in-state RMHTF whose most recent CAFAS/PECFAS score was less than 90 as of May 30, 2023. The large decrease from that report to this report (81 children) is due primarily to improvements in data quality and not necessarily to a true shift in the number of youth in residential settings with a CAFAS/PECFAS score less than 90. Due to differences in primary data sources for CAFAS/PECFAS scores and residential placements, some youth were improperly identified as having their most recent CAFAS/PECFAS score under 90 in past reports. (Those youth had a CAFAS/PECFAS score less than 90 within the prior six months, but their *most recent score* did not necessarily meet that criterion). Once CAFAS/PECFAS score data was linked to residential placement data in the data store, the methodology was updated to include only youth whose most recent score was less than 90 in this analysis. This updated methodology was established during summer 2023.

⁷² The CAFAS/PECFAS scores for the population of children captured in the discharge planning analysis are not necessarily reflective of their scores at admission. Additional detail regarding CAFAS/PECFAS scores at admission will be captured in the Subsection 17.2(b) Residential Services.

Figure 86: Age of Children With CAFAS/PECFAS Less Than 90 in an In-State RMHTF Setting as of September 30, 2023 (n=81)



Based on the number of 18- to 21-year-old youth with CAFAS scores less than 90 identified as needing transitional living supports and services, DoHS released a Request for Proposals for TLVY in early 2023. Following review of respondents, DoHS accepted proposals from three providers on May 31, 2023. These providers began operating services in September 2023 and have the capacity to serve a total of 22 youth aged 17 to 21. Youth receiving these services 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 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 other independent or semi-independent community-based settings and to develop permanent connections to support their success. To date, these services have been well received, and the TLVY program remains at or near capacity. Given the continued demand for these services, DoHS is planning additional expansion of TLVY services in 2024.

- 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 categories of primary diagnoses for authorization are anxiety disorders (32%), conduct disorder or oppositional defiance disorder (22%), and attention deficit/hyperactivity disorder (ADHD, 21%). These percentages shifted slightly compared to the prior reporting period, with ADHD replacing mood disorders as the third most authorized diagnosis category. Note that while children may have had co-occurring or coexisting diagnoses, only the primary diagnosis related to authorization is reported here. BSS continues to report challenges in finding foster families willing to support youth ages 13 to 20 with complex needs. Given the potential challenges of serving these youth, either due to lack of willingness of the foster family or requests of the youth,

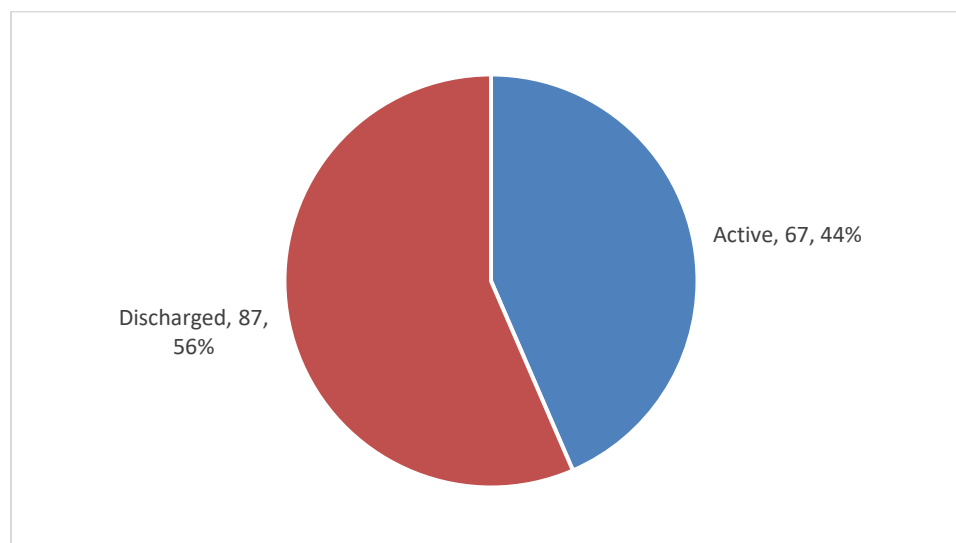
DoHS has made progress toward establishing new models of care to support these individuals in residential settings and in the community, as noted in the introductory paragraphs of Section 17.0. Additional time and data are needed to better understand the considerations associated with diagnosis and barriers with community placements. As noted in prior reports, DoHS would also like to explore in greater detail how diagnosis, CAFAS/PECFAS scores, and other factors impact length of stay 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. In the second half of 2023, this process was expanded to include the review of children who are disruptive in their current placements, children who will be presented to CPAs for foster care placement, and other children seeking additional resources/supports to remain successful in their current placements. This review process has shifted to be more proactive; children are reviewed before their CAFAS/PECFAS score drops below 90. Aetna care managers are proactively identifying children approaching readiness for discharge and discussing options for these children in the recurring meetings with BSS.

For the 154⁷³ children included in the prioritized discharge planning population as of December 31, 2022, 56% (n = 87) had been discharged by August 31, 2023 (Figure 87).

Figure 87: Placement Status as of August 2023 for Children Included in the Prioritized Discharge Planning Population on December 31, 2022 (n = 154)

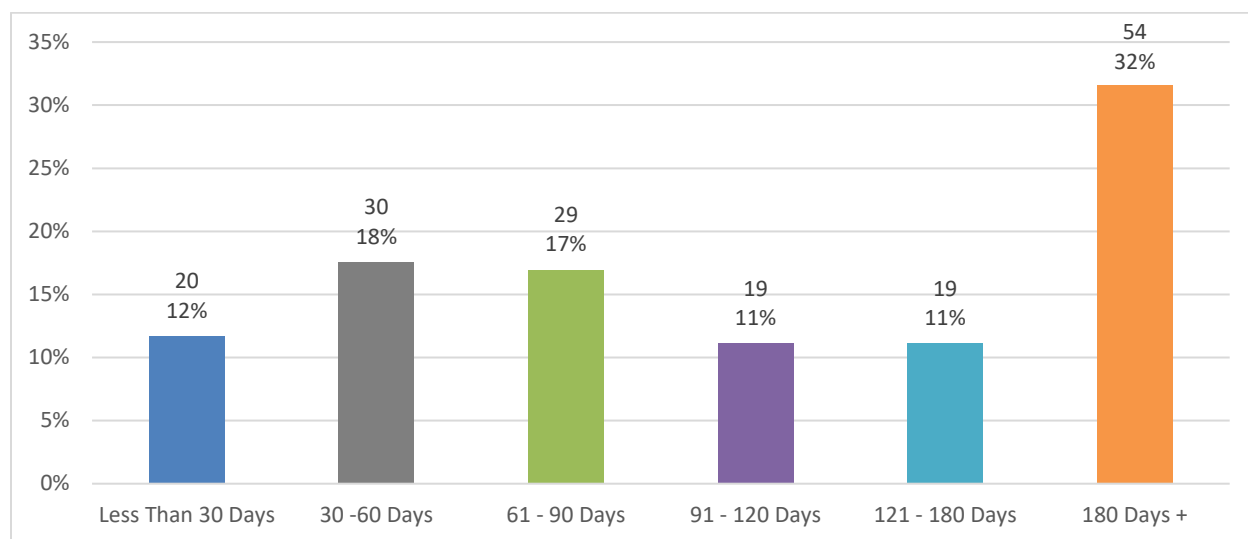


To understand how long youth with CAFAS/PECFAS scores less than 90 remain in placement, the timeline from the score date to the discharge date was calculated for 171 children in RMHTF placement who had a CAFAS/PECFAS score less than 90 at some point between July and

⁷³ As mentioned in a prior footnote, data improvements associated with CAFAS/PECFAS score reporting were made in summer 2023. Therefore, this analysis of children identified as part of the prioritized discharge planning population on December 31, 2022, may include children whose CAFAS/PECFAS score later increased above 90.

December 2022 and whose score remained below 90 until discharge. The results of this analysis are depicted in Figure 88. Although 47% (n = 79) of these youth were discharged within 90 days of having a CAFAS/PECFAS below 90, 32% (n = 54) remained in placement for at least 180 additional days (approximately six months) before discharge. Furthermore, there were an additional 27 youth who had a CAFAS/PECFAS score less than 90 in the period of July to December 2022 who had not been discharged as of October 2023 (not included in figure 88 below). DoHS recognizes that children with CAFAS/PECFAS less than 90 are lingering in placement. While these results do not align with DoHS's goal of timely discharge, this new baseline data gives DoHS and its partners a starting foundation and further emphasizes the need to capture and understand the barriers that are preventing discharge.

Figure 88: Timeline from CAFAS/PECFAS Score less than 90 to Discharge (n = 171 with CAFAS/PECFAS Score less than 90 in July – December 2022, includes only children discharged by October 2023)



To assess discharge barriers in further detail, an analysis of discharge barrier data was completed for children included in the prioritized discharge planning population as of December 31, 2022. Discharge barrier data was reported for 146 of these 154 children (95%). Progress continues to be made in the capture of discharge barrier data. Prior data reviews indicated that approximately one-third of children had incomplete discharge barrier data. DoHS 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 less than 2% of children based on data through September 2023. Given some expected lag associated with data entry, this result is within the expected threshold. While data completion has improved, the accuracy of data, particularly discharge barriers, remains an area of focus.

The primary barriers to discharge reported for children in the prioritized discharge planning population as of December 31, 2022, with CAFAS/PECFAS less than 90 are displayed in Figure 89, broken out by whether the child had been discharged to the community or was still in active placement as of August 2023. Figure 89 depicts only the top three barriers for each group of

placements (active, discharged, and overall); some youth may have other discharge barriers, though less than 10% of any group of youth included in Figure 89 have a discharge barrier that is not listed. 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, DoHS is tracking this information to help 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. Additional analysis of children identified as having no discharge barriers was completed in recent months, and results suggest that Aetna care managers are not consistently using this option accurately. In follow-up, Aetna continues to educate care managers on accurate use of this option. Furthermore, the discharge barrier drop-down list implemented in the new Quickbase system has been expanded to include additional barriers not previously captured.

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 (70%). Placements that had been able to be discharged were more likely to be indicated as “child has no discharge barriers; plan is in place and actively moving forward”, as would be expected (83%), whereas only 53% of active placement had no barriers listed. Very few placements (4% of all placements) had the barrier “discharge plan not adequate or not in place,” indicative of work that has been done to ensure discharge plans are in place for all youth.

Twenty percent (20%, n = 13) of active placements did not have a community-based placement available, compared to only 2% of placements that have been discharged. Most active placements with this barrier noted a need for foster care (n = 11) and not a need for kinship care (n = 2). This may imply that it is more difficult to place children in a foster home than in a kinship home. Eleven percent (11%) of active placements have some type of “other” discharge barrier that did not fall into existing categories, compared to only 6% 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.

Figure 89: Top Discharge Barrier Comparison of Discharged Versus Active Placements as of August 2023 for Children in the Prioritized Discharge Planning Population on December 31, 2022 (n = 146 with Discharge Barrier Data)

	Discharged (n = 82)	Active (n = 64)	Total (n = 146)
Barrier #1	Child has no discharge barriers; plan is in place and actively moving forward: 83% (n = 68)	Child has no discharge barriers; plan is in place and actively moving forward: 53% (n = 34)	Child has no discharge barriers; plan is in place and actively moving forward: 70% (n = 102)
Barrier #2	Expected placement is with family/kinship but placement is not ready at this time: 6% (n = 5)	Community-based placement not available: 20% (n = 13)	Community-based placement not available: 10% (n = 15)

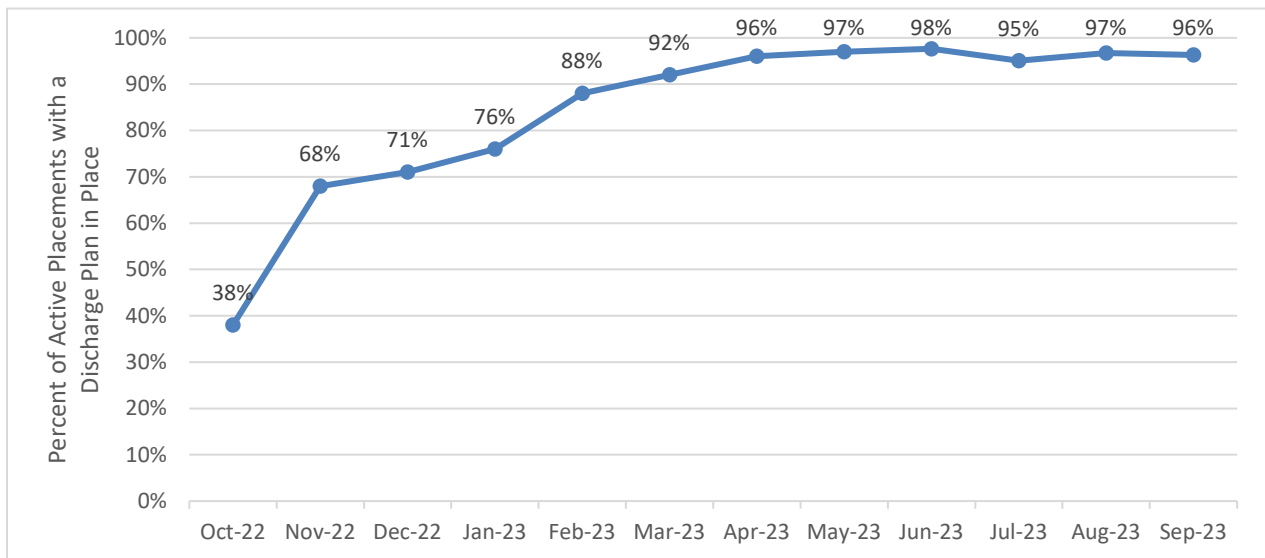
	Discharged (n = 82)	Active (n = 64)	Total (n = 146)
Barrier #3	Other: 6% (n = 5)	Other: 11% (n = 7)	Other: 8% (n = 12)

Based on data review, it was noted that “other” was often selected as the discharge barrier with details captured in a separate free-text field, making analysis of this data challenging and limiting the use of this data in prioritized discharge planning. To enhance data collection and provide more specific and actionable 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 went into effect with Aetna’s transition to the Quickbase system in November 2023. Updated data was not available for review in time for inclusion in this report, but future analyses aim to provide a more thorough understanding of how discharge barriers influence a child’s ability to be discharged, as well as their length of stay.

The BSS Residential Licensing Unit and Aetna have continued to hold residential providers accountable for ensuring discharge plans are in place. As a result of increased accountability, including the monthly reauthorization process, additional training, and licensing visits with increased focus on discharge plans, discharge plans have remained in excess of the expected 95% threshold since April 2023 (Figure 90). Data analysis of discharge plans in place for children with CAFAS/PECFAS <140 produces a similar result (96% as of September 2023). With the November 2023 conversion of discharge planning data collection to Quickbase, discharge plan status for all children in both in-state and out-of-state⁷⁴ residential placement is expected to be included in the next semiannual report.

⁷⁴ As noted in the previous semiannual report, BSS contracted with Marshall University in April 2023 to complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placements. This data is expected to be imported into Aetna’s QuickBase system in early 2024.

Figure 90: Discharge Plan Status for Active In-State RMHTF Placements with Recent CAFAS/PECFAS Less Than 90, October 2022 through September 2023



Aetna continues to hold specialized reviews for children experiencing a crisis or placement disruption and monthly Faces to Cases meetings with CPAs to provide information on children in need of foster homes. 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 identify opportunities to improve these processes to support timely transitions to the community.

Children in Need of Foster/Kinship Care

Beginning in February 2023, in response to a primary discharge barrier being lack of available foster and kinship homes, 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 were reviewed quarterly to understand the characteristics of this population, and individual-level data were assessed to try to connect specific children with community-based placements. This detailed review process identified some data quality issues with the discharge barrier data including possible misidentification and underreporting of some barriers. As a result, an updated version of this analysis is not included in this report. Instead, DoHS is working with Aetna to address these data quality concerns with the implementation of Quickbase, and continued Aetna staff education is anticipated to mitigate future issues.

DoHS is in the early stages of evaluating the possible implementation of an electronic referral process for making referrals to CPAs for children in need of foster care. Some early work has been completed on defining data specifications and reviewing possible systems. Planned next steps include demonstrations of systems capabilities and discussions with CPAs on system needs to streamline the process for referring children and following up until homes are found.

DoHS is continuing to collaborate with Aetna and CPAs to work toward streamlining these processes and expanding community-based placement capacity to meet the needs of difficult to place children. Following review of the data in the November 2023 Quality Committee review, the committee recommended reviewing and considering more specifically defining the roles and responsibilities of Aetna and CPAs associated with this process, then updating contracts and providers agreements accordingly. An initial meeting was held with DoHS and Aetna representatives in December 2023 to start the discussion on current responsibilities and future needs.

The collaboration between BSS, Mission WV, and CPAs to increase recruitment of foster homes specifically focused on homes for older youth with complex needs has continued to progress. A marketing firm, 84Agency, was chosen to lead West Virginia's foster care campaign focused on finding homes for youth with complex needs. The "West Virginia Needs You Now" campaign is currently in production and is expected to go live in early 2024. Mission WV will host the website and provide associated analytics.

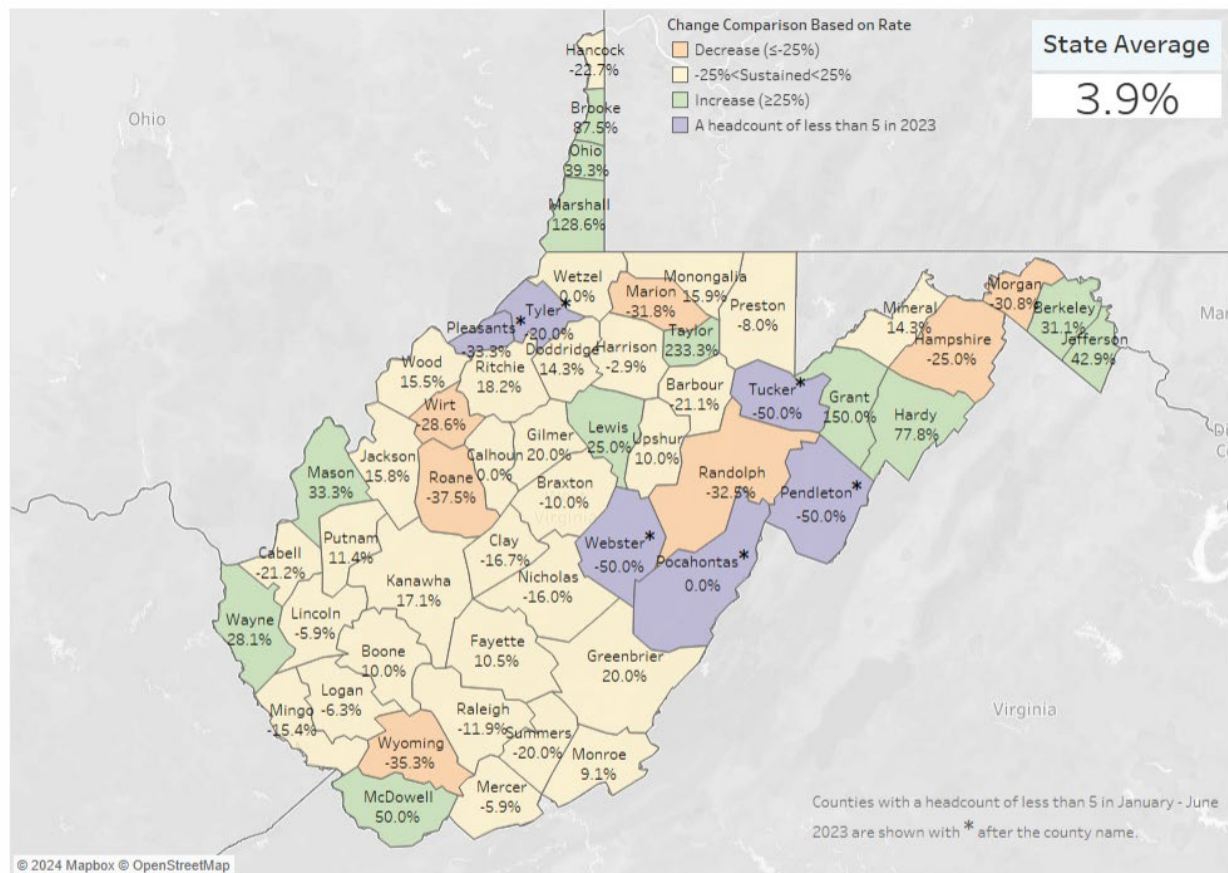
17.2(b) Residential Services

Information reflected in the following figures represents children in state custody who are placed in residential settings and parentally placed children in PRTFs. Demographic information for children in residential settings is reported in Section 4.0 WV's Child Population and Individuals Utilizing Services.

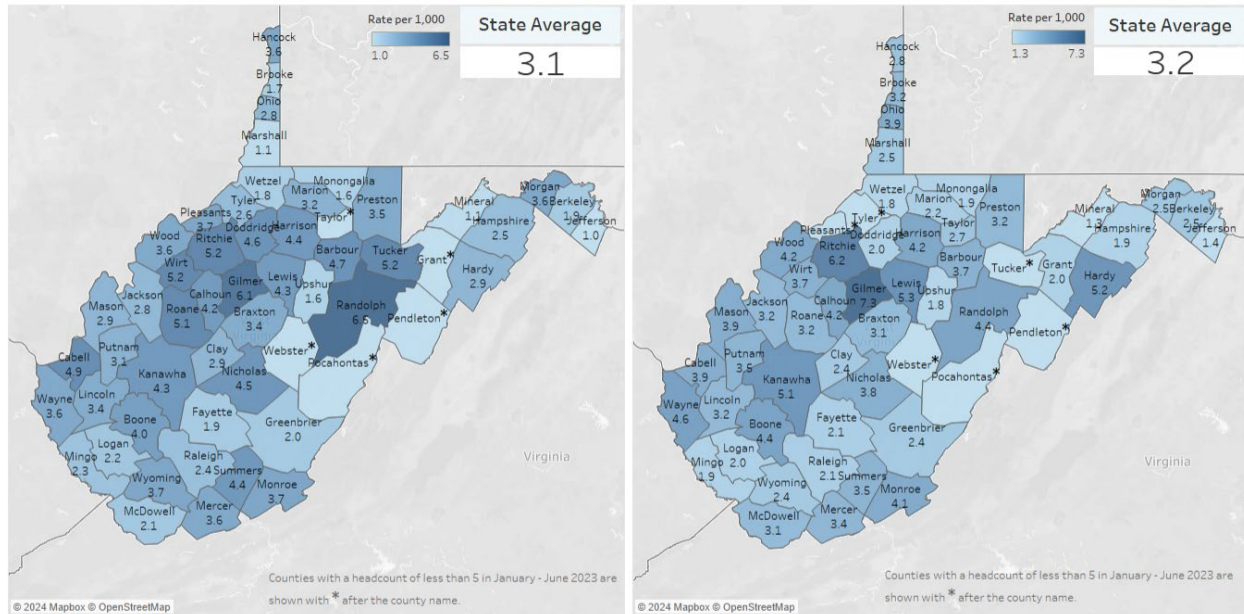
For purposes of quality improvement, understanding county-level changes, and identifying where to focus efforts, DoHS has begun tracking residential placement rates by child's county of origin. To normalize this analysis, unduplicated headcount (i.e., the number of unique children who were in RMHTF placement at any time during the identified review period) per 1,000 children under age 20 by county was used. Figure 91 shows the percent change in RMHTF unduplicated headcount by county comparing two six-month periods, January to June 2022 and January to June 2023. Specific rates by county for these two six-month periods are shown in Figure 92. The overall statewide average change between January to June 2022 and January to June 2023 was a slight increase of 3.9%. The statewide average placement rate was relatively stable for the two periods, 3.1 for January to June 2022, and 3.2 for January to June 2023.

Twelve counties (highlighted in green in Figure 91) had an increase of greater than or equal to 25% between the two periods, while seven counties (highlighted in orange) had greater than or equal to a -25% decrease. The remaining counties had sustained rates, except for six counties that were excluded due to having a headcount of less than five in January to June 2023. Of note, many counties in West Virginia are rural with smaller child populations, therefore, small changes in headcounts can significantly influence changes in rates.

Figure 91: Percentage Change in RMHTF Unduplicated Headcount Per 1,000 Children Under 20 by County of Origin, January – June 2022 vs. January – June 2023



**Figure 92: Placement Rate Comparison for Six-Month Period,
January – June 2022 vs. January – June 2023 (left to right)**



Highlights of counties with increases are as follows:

- Marshall County (128.6% increase): Rate increase from 1.1 to 2.5 but remains well below the state average of 3.2.
- Brooke County (87.5% increase): Rate of 1.7 January to June 2022 was below the state average and equaled the state average at 3.2 for January to June 2023.
- Hardy County (77.8% increase): Rate of 2.9 January to June 2022 was below the state average. Rate increased significantly to 5.2 January to June 2023, well above the state average of 3.2.
- Ohio County (39.3% increase): Rate of 2.8 January to June 2022 was below the state average and increased above the state average to 3.9 January to June 2023.
- Mason County (33.3% increase): Rate of 2.9 January to June 2022 was below the state average and increased above the state average to 3.9 January to June 2023.
- Wayne County and Lewis County (28.1% and 25% increases, respectively) with rates above the state average for both January to June 2022 and January to June 2023.

Highlights of counties with decreases:

- Roane County: Experienced the largest decrease of 37.5%. The rate of 5.1 January to June 2022 was well above the state average and dropped to 3.2 for January to June 2023, in line with the state average.

- Wyoming County: Second largest decrease of 35.3%. The rate of 3.7 January to June 2022 was above the state average and dropped below the state average to 2.4 January to June 2023.
- Randolph County: Third largest decrease at 32.5%, although the rate remains well above the state average at 4.4 for January to June 2023, Randolph County had the highest rate of all counties in January to June 2022 at 6.5.
- Marion County: Decrease of 31.8%. Rate of 3.2 matched the state average for January to June 2022 and dropped below the state average to 2.2 for January to June 2023.
- Morgan County: Decrease of 30.8%. The rate of 3.6 was above the state average for January to June 2022 and dropped below the state average to 2.5 for January to June 2023.

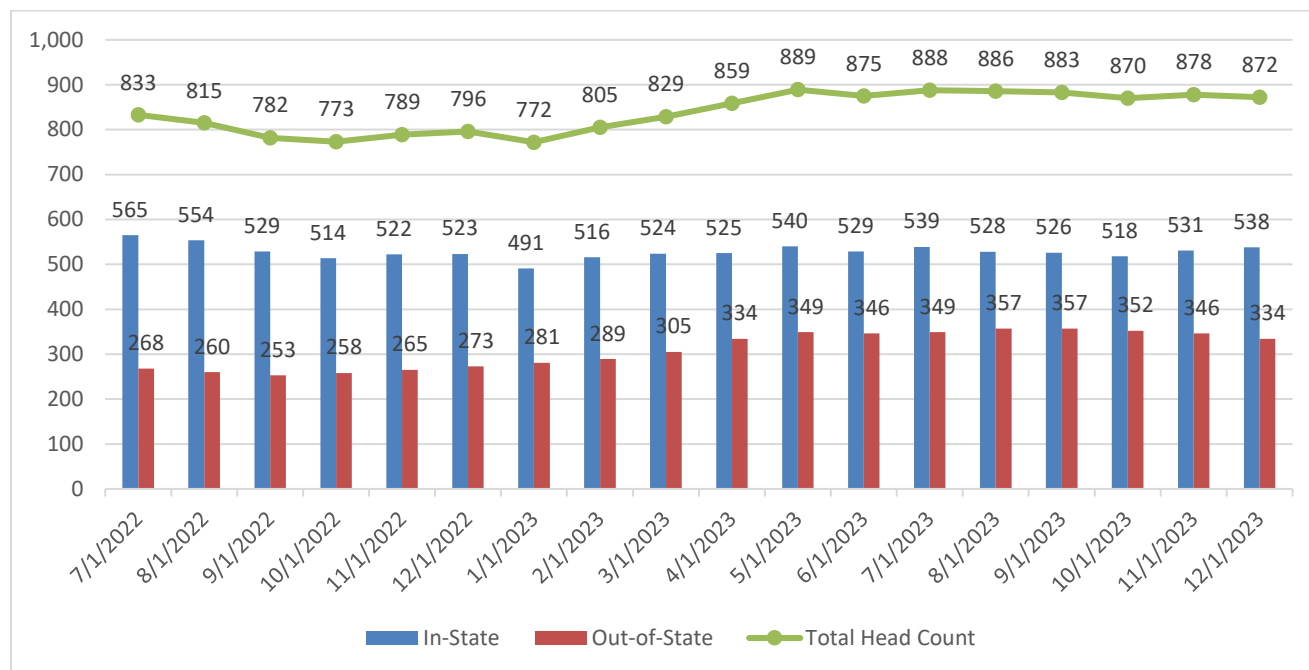
The Quality Committee discussed county-level changes at length and the varied factors and circumstances influencing changes in RMHTF utilization at the county level. Factors discussed included cultural perceptions by families on what services are needed to meet their child's needs with some families believing their child is too challenging for HCBS and is better served in residential treatment. Rural families may be more influenced by word of mouth. In those same counties, given small populations of children, there may not be many children accessing services; therefore, any associated word of mouth about those services would be limited. Other considerations include judicial changes, judicial outreach by BSS teams, provider capacity and any associated waitlist implications, as well as impact of technical assistance provided to BSS workers. DoHS teams are in the early stages of evaluating county and regional impacts and influences. Following finalization of the CMH Evaluation, the program teams look forward to factoring in provider, family, and youth perceptions about services into understanding county-level changes in RMHTF utilization. More time, data both qualitative and quantitative, and additional cross-systems analysis at the county level is needed to assist with pulling all this information together in a cohesive way to allow improved understanding of the unique factors specific to each county and how best to use the information to impact future utilization trends.

Point-in-Time Census

Figure 93 captures the monthly point-in-time census for July 2022 to December 2023. Notably, there was an increase in the census from a low of 772 on January 1, 2023, to 889 active placements on May 1, 2023. Point-in-time census numbers remained relatively stable from May to September 2023, then began declining slightly. Point-in-time census was 872 as of December 1, 2023. The census from October to December 2023 is considered preliminary and may be subject to change due to data entry lag considerations. The increase in census in the first half of 2023 was driven by increases in both in-state and out-of-state census, although out-of-state demand was higher with an increase of 68 children from January 1, 2023 to May 1, 2023, compared to an increase of 49 children in-state. The typical decrease in census over the summer months (which is related to school not being in session) was not observed in summer 2023. DoHS is continuing to explore the reasons for these changes. Based on review of this data, the BSS program team has requested that future analyses include comparisons to child removal rates and juvenile petitions filed. Juvenile petitions are the primary entry point to

RMHTF settings in YS cases. Monitoring and evaluation of county-level trends in petition filings may be indicative of placement rate changes observed in RMHTF and PRTF settings.

Figure 93: Monthly RMHTF Point-in-Time Census, July 2022 to November 2023⁷⁵

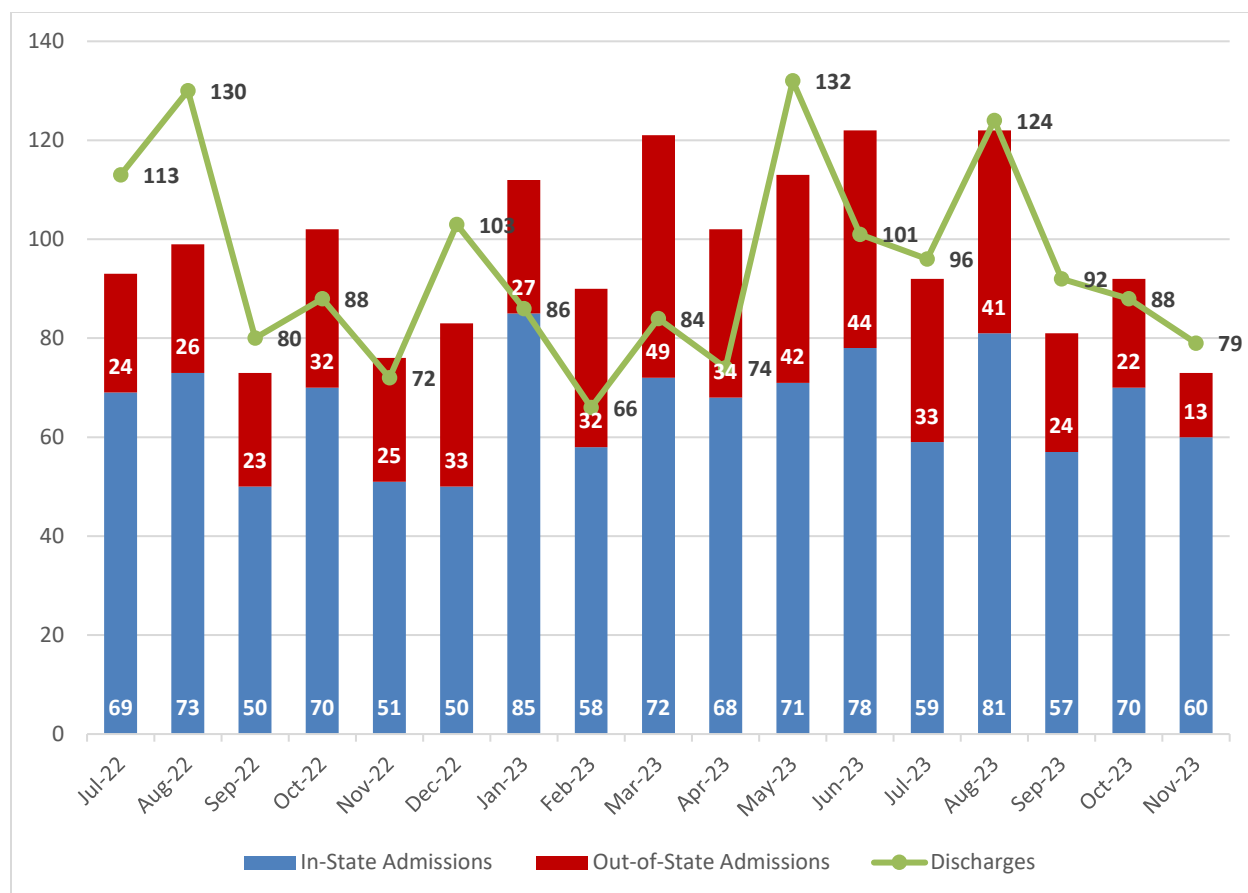


Admission and Discharge Trends

Figure 94 below reflects admissions versus discharges for July 2022 to November 2023. Overall, a step change in admissions was noted, whereas the pattern of discharges is somewhat consistent with historical trends. Specifically, admissions increased significantly in the first half of 2023 with an average of 110 admissions per month compared to the second half of 2022, which averaged 88 admissions per month. Discharges decreased slightly between the two periods with an average of 98 discharges per month in the second half of 2022 and 91 per month in the first half of 2023. The increase in census noted in the first half of 2023 is mostly driven by the increase in admissions rather than by a decrease in discharges. The Quality Committee hypothesized that the increase may be driven by children returning to in-person school following the end of the pandemic, where there is more focus and attention on youth. BJS also saw a similar increase in the end-of-month census during the January to April 2023 period, coinciding with the increase in the RMHTF census. Increases in both RMHTF and BJS may be indicative of an increase in mental health needs following the pandemic. DoHS recognizes that transitioning to the new residential model of care with expected shorter lengths of stay combined with development of increased community-based placement capacity are needed to materially impact the demand for RMHTF services. As noted elsewhere in this report, this work is in progress, and it will take time for the effects to be realized.

⁷⁵ In some months, the sum of in-state and out-of-state census may be slightly less than the total headcount due to a small number of placements with an unknown in-state status.

Figure 94: Total Admissions Versus Discharges (Exits) by Month for In-State and Out-of-State Placements, July 2022 to November 2023



Out-of-State Placements Update

DoHS continues to make process enhancements to impact out-of-state placements. DoHS's goal is to bring children back to WV to assist with building connections and networks of support in their local communities, including engagement with their schools and families, to improve the possibility of reunification. To support this goal, effective April 1, 2023, BSS contracted with MU to complete CAFAS/PECFAS, CANS assessments, QIA, and discharge plans for all children in out-of-state residential treatment facilities and psychiatric treatment facilities. In the last six months of 2023, the Office of QA collaborated with Marshall to establish specifications for data collection associated with children in out-of-state placement. Once fully implemented, this data will be shared with Aetna for incorporation into the Quickbase system.

As of January 5, 2024, reporting from MU, CANS assessments were completed for 222 of 333 children (67%) in active out-of-state placement in December 2023. CAFAS assessments were completed for 179 children (54%), and discharge plans were completed for 114 children (34%). MU and BSS continue to partner to address any barriers to completing these critical assessments. CANS and CAFAS assessments are projected to be completed for all children in active out-of-state placement by January 31, 2024. MU is developing a plan and timeline for

completing discharge plans for the remaining children in out-of-state placement.

Marshall will play a key role in partnership with DoHS 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.

To support these efforts further, DoHS developed an electronic referral process to capture, track, and report on requests for out-of-state placements and processes to increase opportunities for diversion. This new system was rolled out in December 2023 and is accessible by BSS workers, supervisors, program managers, and child welfare consultants. To date, feedback regarding the new system has been very positive, as it creates process efficiencies, including the elimination of paper documents, the addition of automated notifications, and tracking of information in a dashboard format for ease of monitoring the status of each child in the process. Since this system was recently implemented, data on out-of-state referrals is not included in this report but is expected for inclusion in future semiannual reports.

As Marshall completes CANS assessments on out-of-state placements and the other data collection on out-of-state placements is further established, DoHS is seeking to profile any differences between 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 and use this information to further refine and influence the new models of care.

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

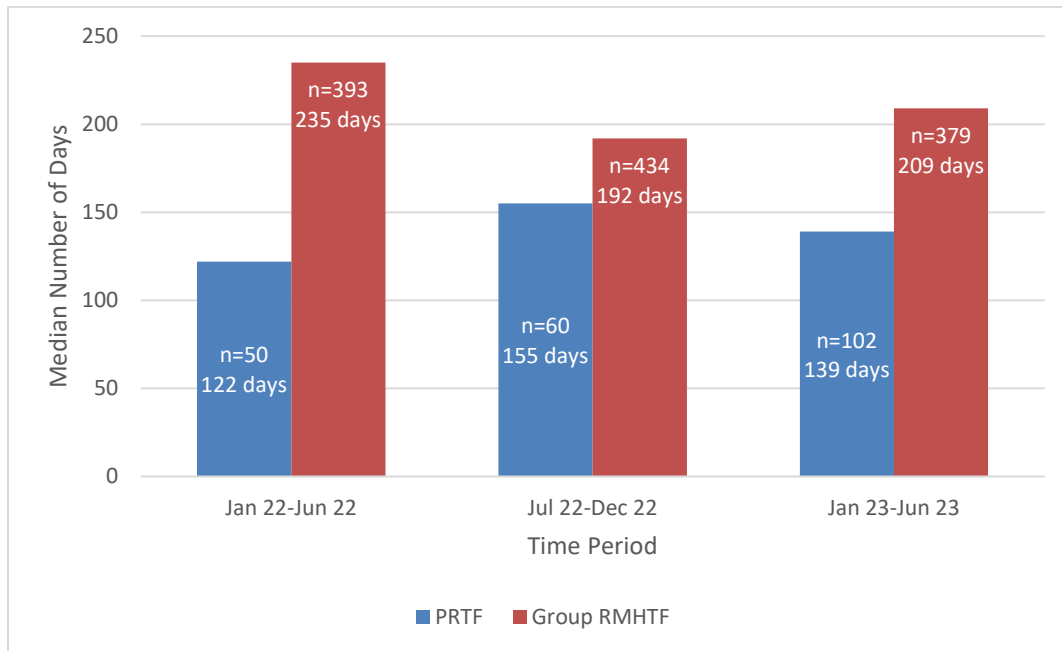
Length of Stay

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

Figure 95 provides a comparison of median length of stay by facility type across six-month periods from January 2022 to June 2023. This analysis includes children in in-state and out-of-state facilities. While some fluctuation is noted for both group RMHTF and PRTF length of stays across the six-month periods, group RMHTF shows an overall decrease. These results are a

positive indicator of the focused efforts on discharge planning described in Subsection 17.2(a).

Figure 95: Comparison of Median Length of Stay by Facility Type, Comparison of Six-Month Periods, January 2022 to June 2023



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

Figure 96 captures median length of stay trends by quarter for the first quarter 2022 through the third quarter 2023 for children in in-state RMHTF placement, while Figure 97 captures median length of stay trends for children in out-of-state placement for the same period. The total number of discharges by quarter is also represented in each figure. In-state median length of stay has remained relatively stable for the period shown, while out-of-state length of stay shows a consistent decrease throughout the period. As noted previously, DoHS contracted with MU in April 2023 to focus on discharge planning for children in out-of-state placement. An increase in the number of discharges per quarter is observed following this focused effort to return children to their local communities in West Virginia.

Figure 96: RMHTF In-State Median Length of Stay

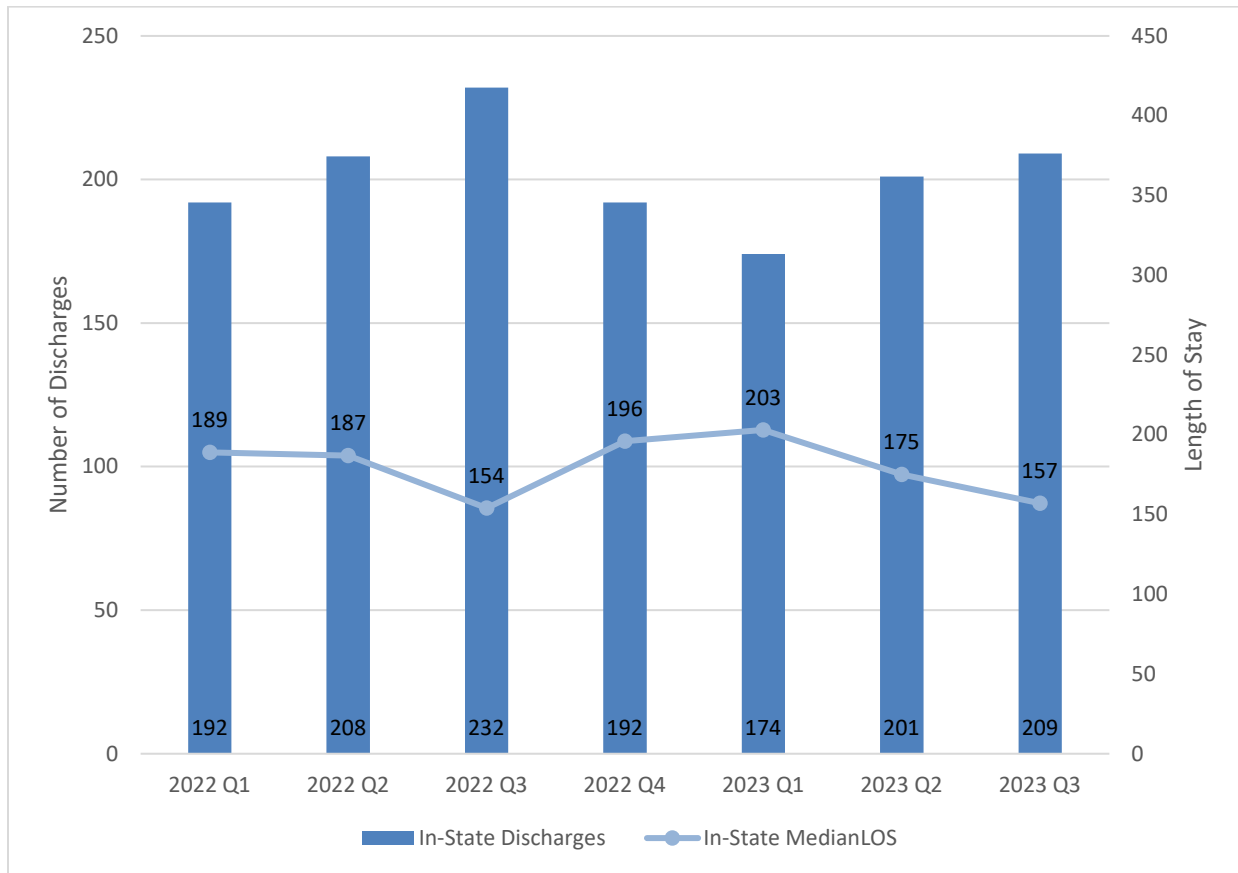


Figure 97: RMHTF Out-of-State Median Length of Stay

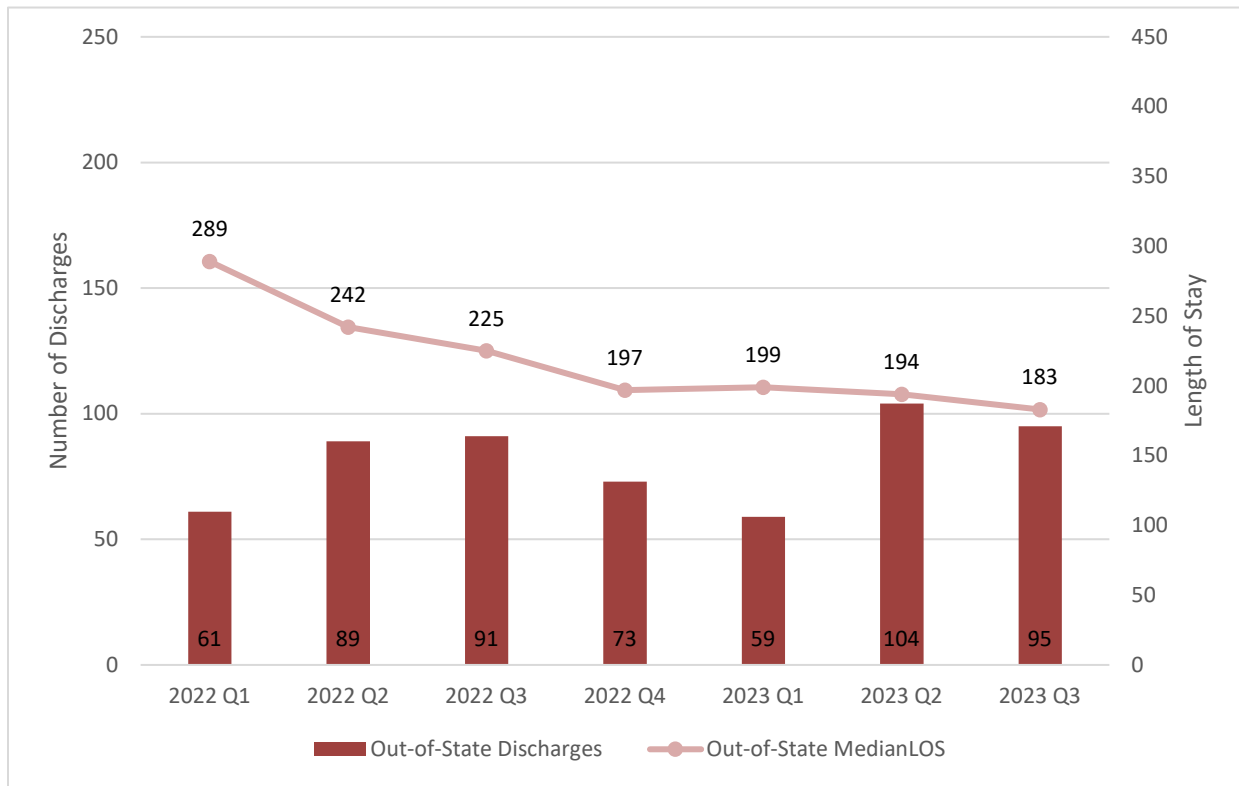


Figure 98 shows the rolling six-month average length of stay trends by age group for the period October 2019 through October 2023. The child's age at discharge was used for the analysis. Additionally, DoHS analyzed each age group as a percentage of point-in-time RMHTF census comparing July 2019 (pre-pandemic) and July 2023 (post pandemic); these results are shown in the table in Figure 99. Rolling six-month average length of stay for 9- to 12-year-old children fluctuated throughout the period while trending down throughout 2023, while the population of 9- to 12-year-old children as a percentage of the point-in-time census also decreased from 13.9% in July 2019 to 10.5% in July 2023. This decrease in both length of stay and population may be a result of increased utilization of HCBS by the 9- to 12-year-old age group. Average length of stay for 13- to 17-year-old youth remained relatively stable throughout the period with the population increasing slightly from 78.0% of the point-in-time census in July 2019 to 81.5% in July 2023. Average length of stay for 18- to 20-year-old youth trended up throughout the period with the population remaining relatively consistent between July 2019 and July 2023, which may indicate the need for additional community-based capacity for transition-age youth. DoHS intends to further expand community-based TLVY homes in 2024 to create additional capacity for these youth to be supported in the community.

Figure 98: Rolling Six-Month Average Length of Stay by Age Group at Discharge⁷⁶

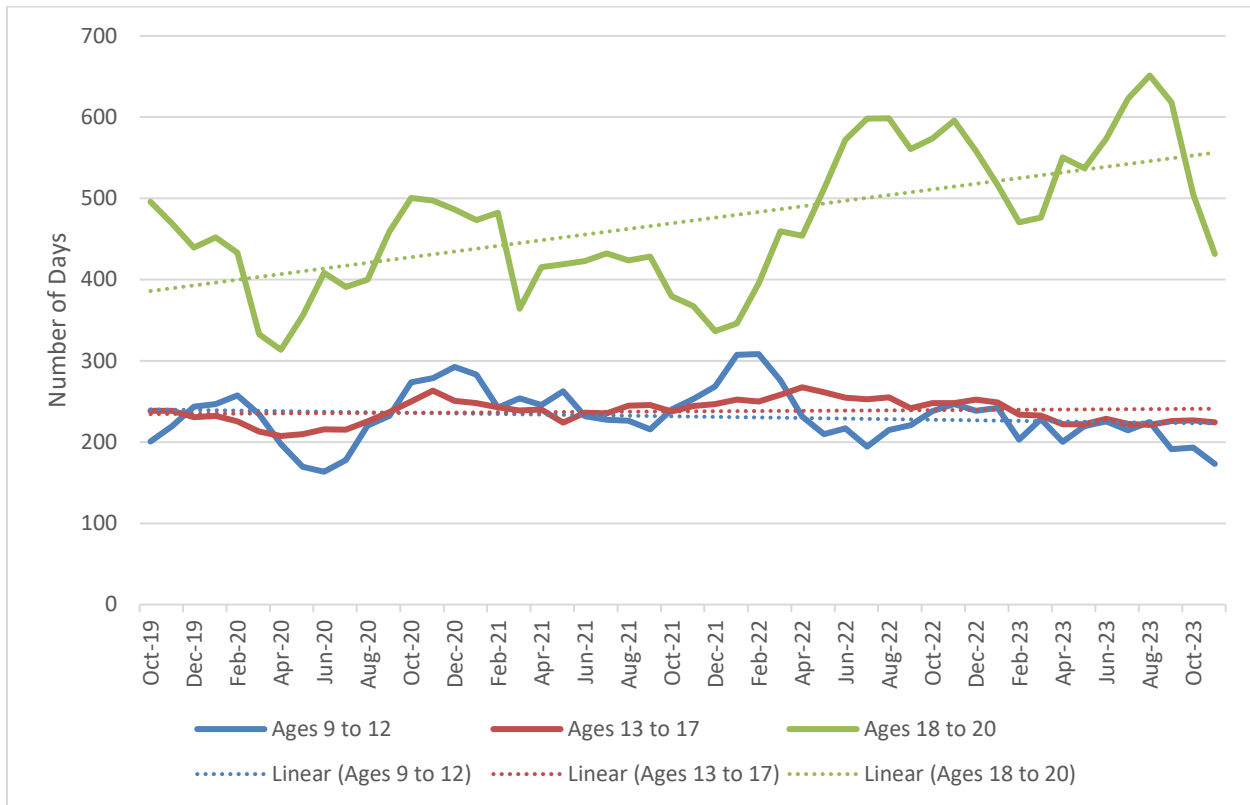


Figure 99: Age Groups as a Percentage of Point-in-Time Census, July 2019 vs. July 2023

Age Group	July 1 st , 2019 (n = 1,022)	July 1 st , 2023 (n = 888)
0-8*	2.9% (n = 30)	2.3% (n = 20)
9-12	13.9% (n = 142)	10.5% (n = 93)
13-17	78.0% (n = 797)	81.5% (n = 724)
18-20	5.2% (n = 53)	5.8% (n = 51)

*Note: Children under the age of four were included with children aged five to eight due to the small number of children in the former age group.

DoHS recognizes that further development of community-based placement capacity as well as operationalizing the new residential models of care are key steps to achieving reduced lengths of stay. The Quality Committee and program teams require additional time to understand further the varied factors impacting length of stay. As more data becomes available in the data store

⁷⁶ The ns for the July 2019 to October 2023 average length of stay by age group analysis were as follows:

- 9–12 year-old youth: 536 total discharges for the period, averaging 9.8 discharges per month
- 13–17 year-old youth: 4291 total discharges for the period, averaging 78 discharges per month
- 18–20 year-old youth: 600 total discharges for the period, averaging 11 discharges per month

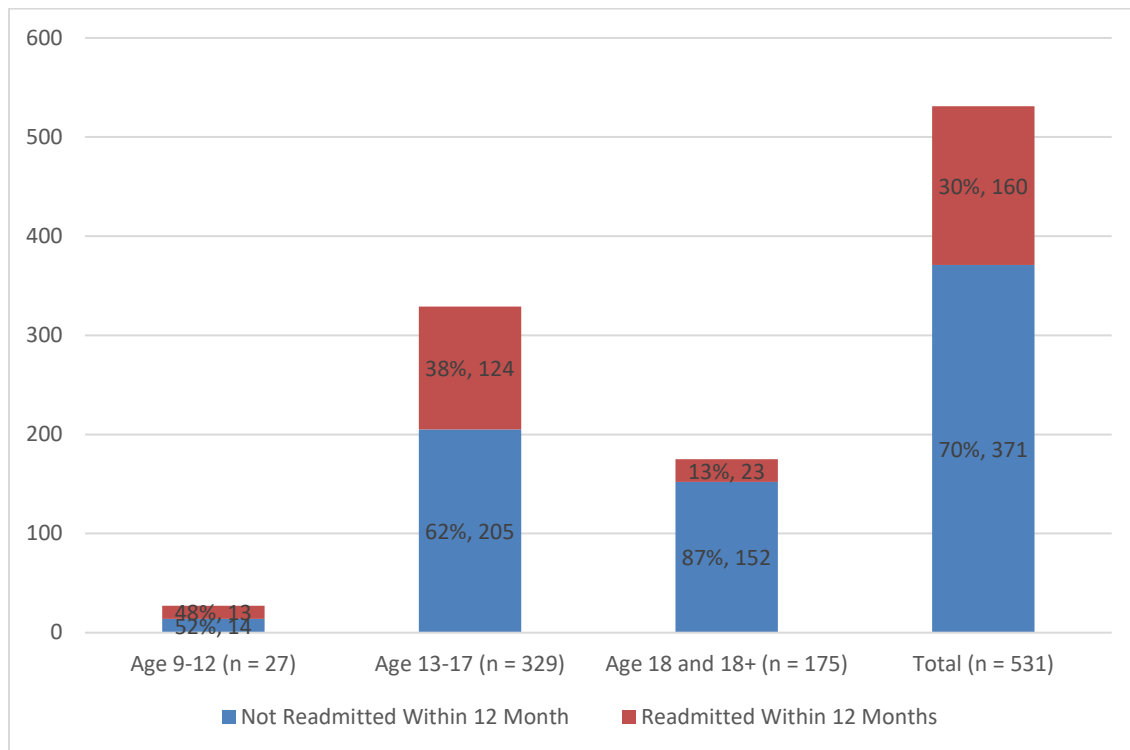
associated with the enhanced data collection from both Aetna and MU, DoHS anticipates additional analyses of length of stay, stratified by other factors as they become available (e.g., CAFAS/PECFAS scores, discharge barriers, diagnoses, etc.). DoHS will continue efforts to improve understanding of the characteristics and circumstances of children who discharge quickly versus those who remain in residential placements for an extended time. Length of stay 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. DoHS is focused on efforts with the Assessment Pathway to offer children and families home and community-based interventions to decrease the number of readmissions children experience. To gain a better understanding of the number of children who readmit following discharge from an RMHTF, DoHS identified a cohort of children who were discharged from an RMHTF and aged nine and older at discharge in the period January to June 2022 (n = 531)⁷⁷ and completed an analysis of the 12 months following discharge to determine if they were readmitted to an RMHTF. As shown in Figure 100, 30% (n=160) of these children were readmitted to a residential placement following discharge to the community. The 9- to 12-year-old age group showed the highest rate of readmission with 48% readmitting, although this data should be interpreted with caution given the small sample size (n=27). The Quality Committee speculated this may be reflective of the intensive needs of this age group of children who are in residential placement. Youth ages 13 to 17 also showed a high readmission rate of 38% while youth ages 18 and over showed the lowest rate of readmission at 13%, potentially because youth over 18 often do not go back into children's residential placement but instead may be directed to adult services.

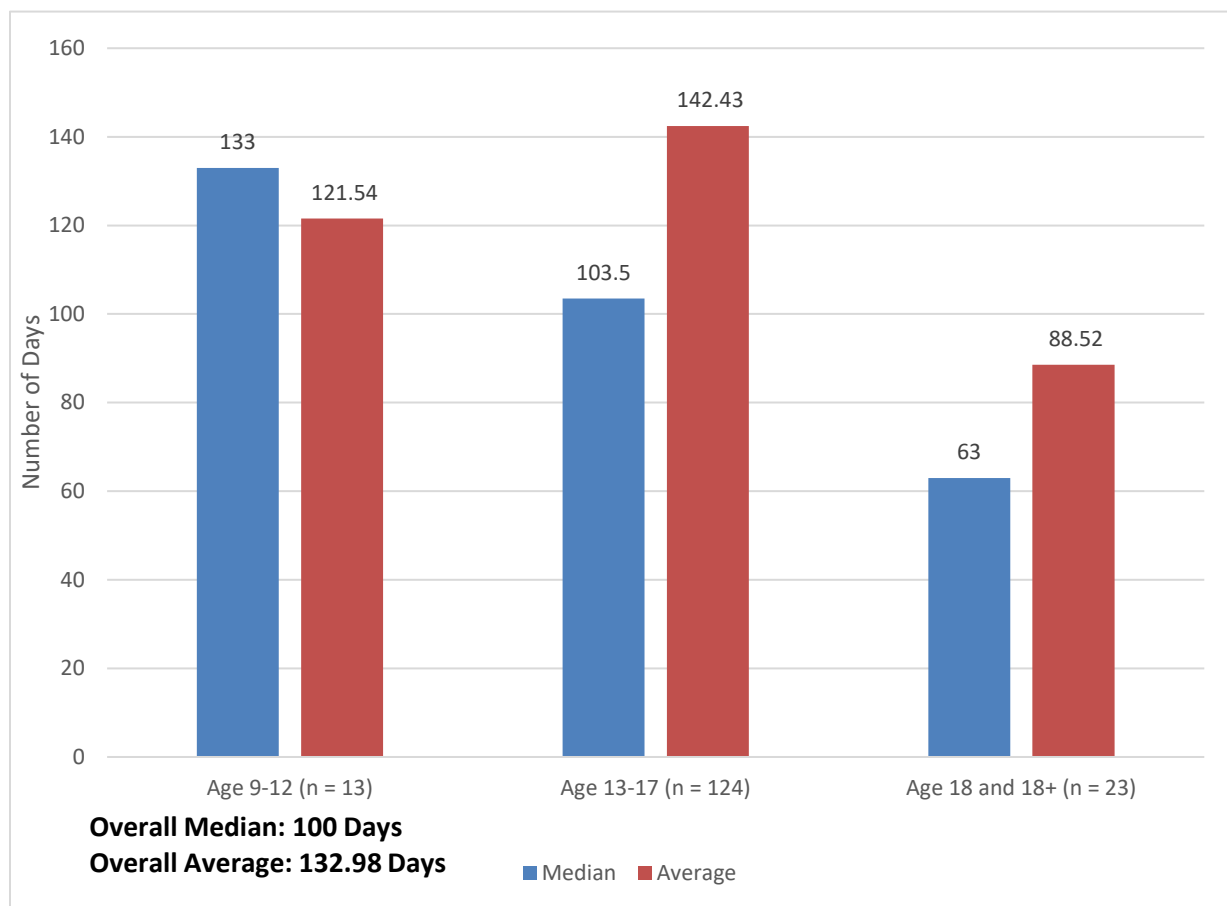
⁷⁷ Children aged less than 9 were excluded from this analysis because fewer than 10 children in this age group were discharged during January to June 2022.

Figure 100: RMHTF Readmission Analysis for Children Discharged January to June 2022 (n = 531)



Further analysis of the timeline between discharge to the community and readmission to RMHTF was completed, including a breakdown by age at discharge (Figure 101). The overall average timeline to readmission was 133 days with a median of 100 days. Seventy-eight percent (n = 124) of children readmitted were ages 13 to 17, and an additional 14% (n = 23) were ages 18-20. Only 8% of readmitted youth were aged 12 or under. The 13 to 17 age group had notably longer timelines to readmission (median of 104 days, average of 142 days) compared to the 18 to 20 age group (median of 63 days, average of 89 days). The Quality Committee indicated longer times to readmission for children ages nine to 12 and youth ages 13 to 17 is potentially reflective of those children being reunified with families or placed in foster care. Youth aged 18 and older, represented only 23 youth and shorter readmission times may be associated with limitations or considerations related to the youth being a legal adult or in need of transitional living services.

Figure 101: Average and Median Timeline to Readmission by Age for Children Discharged January to June 2022 and Readmitted Within 12 Months (n = 160)



CAFAS/PECFAS Score Analysis and Trends

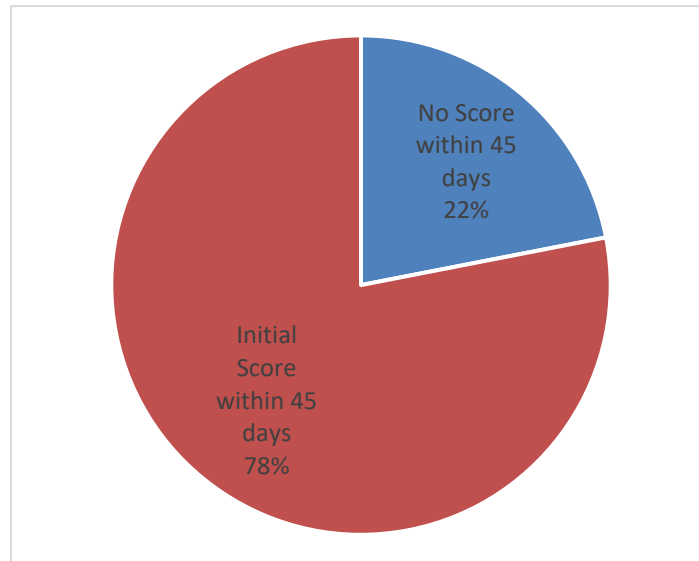
Improvements in data collection and matching were made in late 2023 allowing DoHS the ability to complete additional analyses associated with CAFAS/PECFAS scores. DoHS is continuing to explore a variety of ways to use analyses of these scores to inform future efforts and drive change. Accordingly, CAFAS/PECFAS analyses included in this report may differ from analyses included in the prior semiannual report. CAFAS/PECFAS scores in this section are sourced from Aetna's UM CAFAS/PECFAS history report.

Due to improvements in data collection and child-level matching, DoHS can now evaluate CAFAS/PECFAS scores at admission and over time for in-state RMHTF placements. The CAFAS/PECFAS is required to be completed upon admission and every 90 days thereafter as part of Aetna's UM, and DoHS and Aetna are in the early stages of tracking and monitoring CAFAS/PECFAS timeliness and completion.

DOHS completed an analysis of children admitted to in-state RMHTFs in the second quarter of 2022 (Figure 102). Of these children (n=196), 153 children (78%) received a CAFAS/PECFAS

within 45 days of admission.⁷⁸ BSS licensing and Aetna are collaborating to hold providers accountable to completing CAFAS/PECFAS within required timelines. Additional analysis of the children with no CAFAS/PECFAS score within 45 days of admission is planned to understand the reason for the lack of scores.

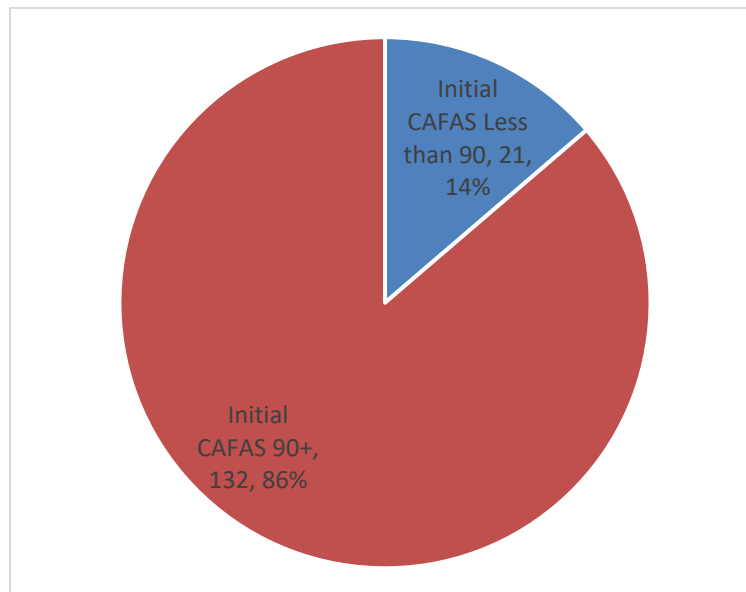
Figure 102: CAFAS/PECFAS Completion at Admission (n = 192 Admissions Q2 2023)



As an initial step to evaluating the appropriateness of admissions to RMHTFs, DoHS completed a preliminary analysis of RMHTF admissions in Q2 2023 with admission CAFAS/PECFAS scores reported (153 children). Twenty-one children (14% of Q2 2023 admissions) entered placement with a CAFAS/PECFAS score less than 90 (Figure 103). Based on a review of this data with the Quality Review Committee, the committee discussed some continued challenges and misunderstandings associated with the full adoption of the QIA process which helps assess the clinical need of the child as well as QIA data quality issues which have impacted the recurring monthly reporting of QIA referrals compared to RMHTF admissions by county. This reporting was implemented monthly and supported the significant increase in adoption of the QIA process observed in the early stages of the implementation. Identified next steps include continued efforts to improve QIA data quality, continued technical assistance to BSS workers in identified counties where QIA submissions do not align with RMHTF admissions, and reinstituting recurring monthly reporting once data quality issues have been addressed.

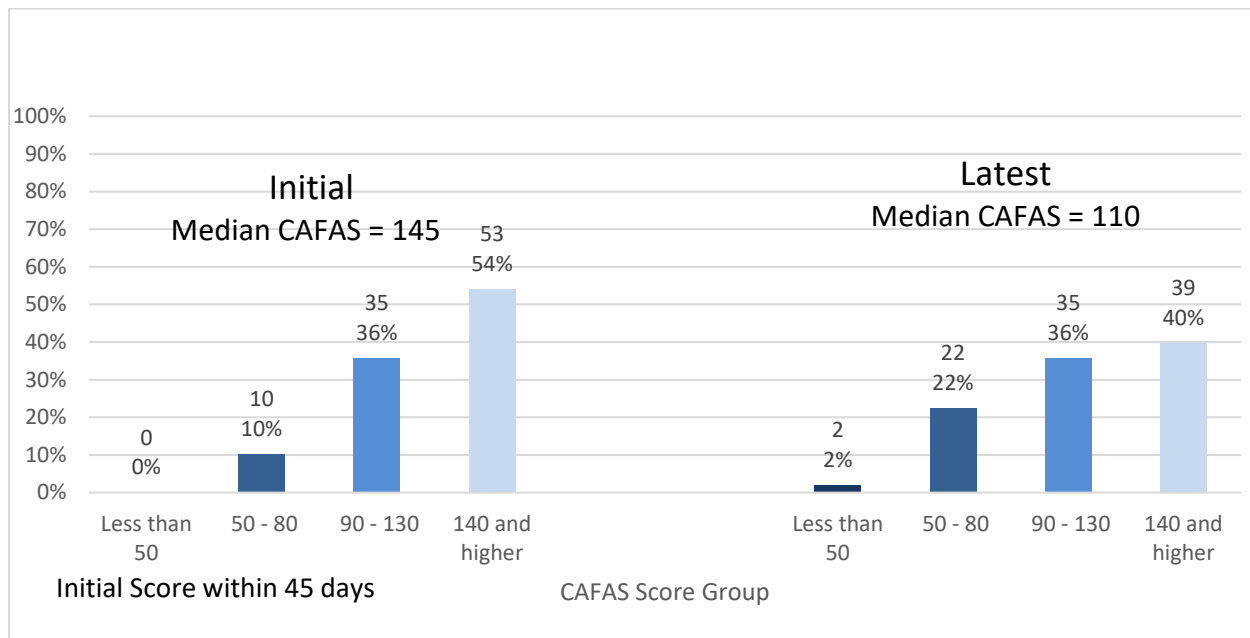
⁷⁸ Children in out-of-state residential placement and short-term, acute PRTF were excluded from the analysis. CAFAS/PECFAS assessment is not expected for children in short-term PRTF due to the short-term nature of this treatment. CAFAS/PECFAS scores for children in out-of-state placement are currently unavailable for reporting but can be expected in future reports.

Figure 103: Percentage of CAFAS/PECFAS Scores Less than 90 at Admission (N = 153 admissions in Q2 2023 with CAFAS/PECFAS conducted within 45 days of admission)



DoHS also completed an analysis of changes in CAFAS/PECFAS scores during treatment as a first step toward using CAFAS/PECFAS scores as a measure for monitoring the effectiveness of residential treatment. For those children admitted to RMHTF placement during Q2 2023, who had both an initial CAFAS/PECFAS score, and a follow-up score reported during treatment (n=98), the shift from initial to latest score is shown in Figure 104. Results showed an overall decrease from an initial median CAFAS of 145 to a follow-up CAFAS median of 110. These early results reflecting an overall decrease in CAFAS/PECFAS score (i.e., increase in functional ability) are promising, although more time and data are needed to better understand the effectiveness of RMHTF treatment. The Quality Committee members expressed interest in completing this analysis by residential provider to measure the quality and effectiveness of treatment by each residential provider, particularly as the transition to the new models of residential care occurs with a requirement for use of evidence-based practices with expected shorter, high intensity intervention, followed by timely return to the community.

Figure 104: Change in CAFAS/PECFAS Scores During Treatment (N = 98, Q2 2023)



17.3 Provider Capacity/Statewide Coverage

DoHS continues to work with in-state residential providers to improve provider capacity tracking. The current expectation is for providers to update capacity information daily, including any current holds.

Given the number of children being placed in out-of-state facilities, concerns remain regarding the adequacy of in-state residential programs to meet the needs of children with more complex needs. DoHS partnered with Casey Family Programs over the last two years to develop proposed new residential treatment models of care. DoHS contracted with Myers and Stauffer in March 2023 to develop the associated rate model and rates for these new models of care. In August 2023, DoHS representatives participated in an on-site visit of Iowa's intensive residential treatment programs. Throughout the process of researching and developing these new models of care, DoHS has continued to communicate openly and involve the residential provider community and stakeholders. The new models and associated rates were presented to current residential providers and stakeholders in November 2023. The new models of care include community-based residential homes, RIT homes, and SRIT homes as detailed in the introductory paragraphs of Section 17.0. DoHS's goal is to begin transition to these new models of care by July 2024.

As noted previously, DoHS partnered with existing residential providers to operationalize community-based TLVY homes (22 beds total) in September 2023. Given the success of these homes to date and the demand for additional capacity, DoHS intends to expand these services further in 2024 in tandem with implementing the new models of care for residential treatment.

17.4 Strengths, Opportunities, Barriers, and Next Steps

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

- Aetna converted discharge planning data collection to the Quickbase system in November 2023 with all children in both in-state and out-of-state residential placement being tracked in this enhanced system as of December 2023. Implementation of this system is expected to address many of the data quality issues as well as produce more specific and actionable reporting on discharge barriers.
- Expanded data analysis associated with CAFAS/PECFAS scores due to incorporation of historical CAFAS/PECFAS reporting in the data store and establishment of child-level data matching. DoHS can now evaluate child-level CAFAS/PECFAS scores at admission and follow changes in scores through residential treatment.
- As of January 5, 2024, reporting from MU, CANS assessments were completed for 222 of 333 children (67%) in active out-of-state placement in December 2023. CAFAS assessments were completed for 179 children (54%), and discharge plans were completed for 114 children (34%). MU and BSS continue to partner to address any barriers to completing these critical assessments. CANS and CAFAS assessments are projected to be completed for all children in active out-of-state placement by January 31, 2024. MU is developing a plan and timeline for completing discharge plans for the remaining children in out-of-state placement.
- The QIA process has been implemented statewide, and children in current residential placement are being reviewed in phases. Phase 1 involved children with multiple stays and has been completed. Phase 2 is in process and involves completing the QIA for children with a length of stay greater than 90 days and less than the average residential length of stay. QIA referral is also being added to Aetna's UM authorization process. Aetna is currently developing the plan and timeline for educating residential providers on these process changes. BSS licensing continues to emphasize the requirement to complete the QIA process with residential providers through periodic written communications.
- 84Agency was chosen to lead West Virginia's foster care campaign focused on finding homes for youth with complex needs. The "West Virginia Needs You Now" campaign is currently in production and is expected to go live in early 2024.
- Based on the continued focus and reporting on discharge plans over the last year, Aetna care managers are being more proactive in planning ahead for children nearing readiness for discharge to the community and discussing these cases in their recurring meetings with BSS. Additionally, discharge plans continue to be in place for greater than 95% of children.

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

- Further explore and define roles and responsibilities associated with discharge planning, quality review of treatment plans, including discharge plans, expansion of community-based placement options (e.g., foster homes) to meet the demand of children ready for discharge from RMHTF, and follow-on care management following discharge to ensure a child's ongoing success in the community (i.e., mitigate readmission to RMHTF placement). Update contracts and provider agreements to clearly capture expected roles, responsibilities, and associated reporting to DoHS.
- Operationalize the new models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and sexualized behavior.
- Further expand community-based TLVY homes to meet the demand for services for transition-age youth.
- Complete CAFAS/PECFAS, CANS assessments, and discharge plans for all children in out-of-state residential placement to facilitate return to their local communities in West Virginia.
- Complete development of flags in Quickbase for identifying children in residential placement to further enhance prioritized discharge planning efforts and the associated processes for timely review and follow-up in collaboration with Aetna, CPAs, and other child-serving entities.

18.0 Outcomes

DoHS 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 continues to be a key step to assess outcomes following early process implementation, and the continued build-out of the data store. A sufficient number of children have been able to go through the expected service period to allow for preliminary cross-systems analyses to begin. The Office of QA plans to emphasize developing these cross-system views in the coming months.

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

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

18.1 Encounters with Law Enforcement

The CMH Evaluation asks youth and caregivers about their experiences with law enforcement to provide a sample of these key populations. Figure 105 details the responses of caregivers when asked, "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. Caregivers of youth in RMHTF reported much higher rates of police encounters than caregivers of at-risk youth (community-based caregivers), with 42% and 16% reporting an encounter respectively. When asked if the youth were arrested, 45% of caregivers of youth in RMHTF settings who had had a police encounter reported it resulted in an arrest, with 70% of those arrested reporting going to court over the incident. Of those community-based caregivers reporting police encounters for youth, 30% noted an encounter resulting in arrest, with only 33% of arrests resulting in need to go into court.

It is difficult to draw conclusions at this time for these populations given these responses are at baseline for the community-based survey and year two for residential caregivers being surveyed. However, some considerations may include the limited ability for youth in residential sites, given their average lengths of stays to have interacted with the growing availability of HCBS, which could prevent law enforcement interactions. This will continue to be explored over time as implementation and exposure to these changes can be reflected in the system. For community-based caregivers, the difference between interactions is noteworthy, and it is possible that youth in residential settings have more severe behaviors than youth surveyed in the community setting, which may have resulted in a lower incidence of police interactions. However, it is also possible that appropriate community-based services have decreased the likelihood of or need for police engagement for most of these at-risk youth. Comparison data will

be needed to draw additional conclusions, and it would also be insightful to understand more about the similarities between the two populations sampled related to police engagement. This will be taken into consideration for additional assessment with the CMH Evaluation to see if youth engaging in services were less likely to report police encounters.

Figure 105: Encounters With Law Enforcement according to Caregiver Responses, Surveyed November 2022 to March 2023

Interaction	RMHTF Caregivers ⁷⁹ (n=180)	Community-Based Caregivers ⁸⁰ (n= 174)
Police Encounter	42% (n= 76)	16% (n=27)
Arrest After Police Encounter	45% (34 out of 76)	30% (8 out of 27)
Went to Court After Police Encounter	70% (53 out of 76)	33% (9 out of 27)

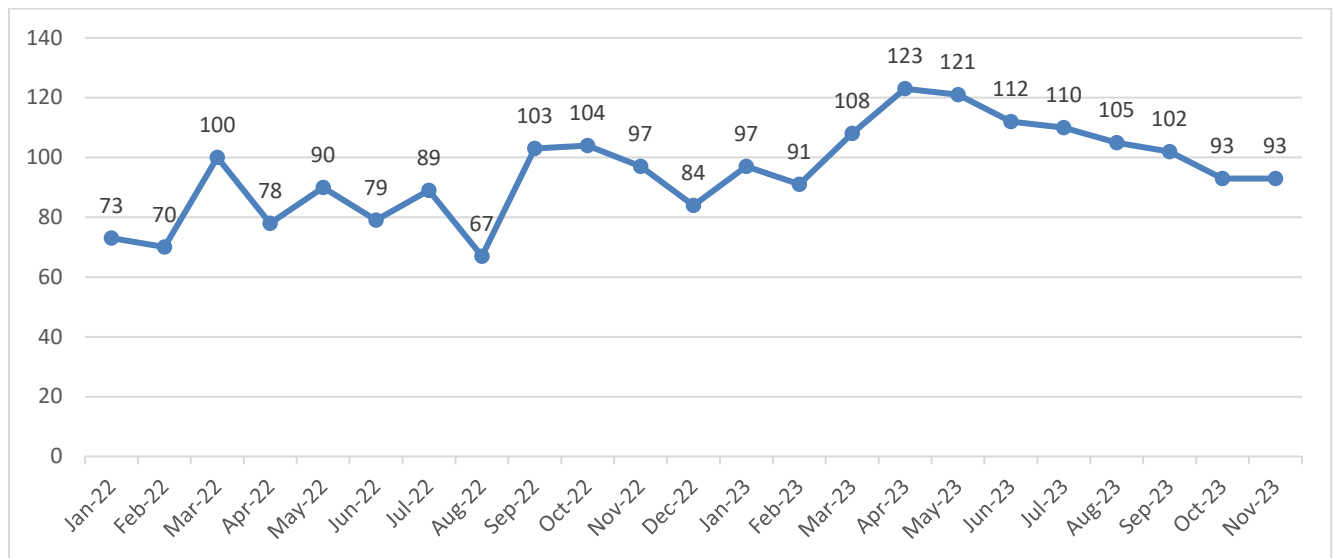
18.2 Commitment to the Custody of BJS or DoHS

The data source for commitments to BJS has been identified as the OIS. Commitments to DoHS will be reported from the WV PATH system. These data sources will be further assessed and integrated into the data store to analyze commitment to custody for the at-risk population in the future. Figure 106 shows the number of children in BJS custody at the end of each month from January 2022 to November 2023. During review with BJS staff, it was noted that changes in criteria led to the appearance of an upward trend in commitments in early 2023, while previous trends were influenced by the COVID-19 pandemic. The census has begun to decrease in the latter part of 2023, although additional time will be needed to better understand if this decrease will continue to levels seen in previous periods. It will also be important to integrate child-level commitment data into the data store to better understand a child's journey and, over time, to identify influences on children who are or are not committed to BJS custody.

⁷⁹ Participants in the Year 2 CMHE Survey for Youth in Residential Mental Health Treatment

⁸⁰ Participants in the Baseline CMHE Survey for Community-Based Stakeholders

Figure 106: BJS End-of-Month Committed Children, January 2022 to November 2023

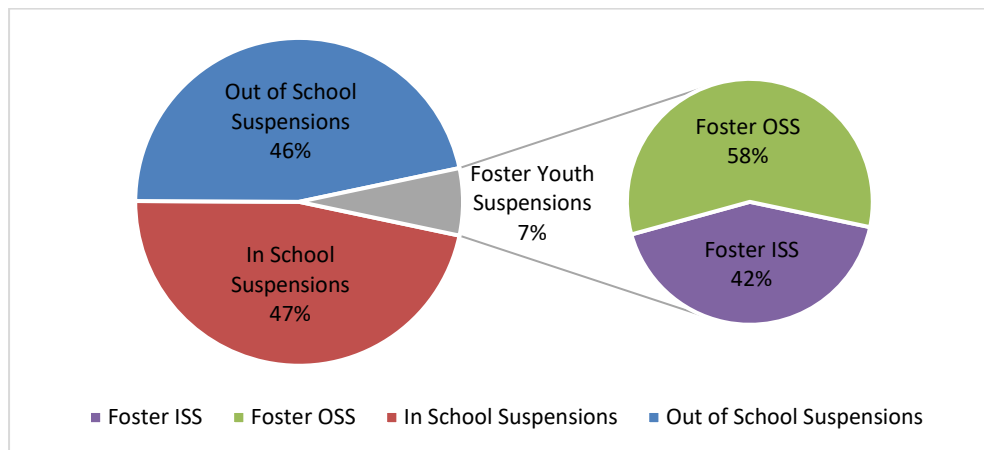


18.3 School Performance

DoHS is collaborating with the WVDE, as part of the greater collaborative, started in December 2022. A data use agreement (DUA) that will enable sharing and review of data for the at-risk population is in the final draft stage, awaiting final feedback and signatures. These data will be used to reduce disciplinary action for students residing in foster care and form trauma-informed approaches. A second DUA for matching data from the West Virginia Education Information System (WVEIS) to improve understanding of child outcomes over time is in the review stage. Data collected from WVEIS will allow for tracking of student progress and need indicators such as attendance, school performance, disciplinary actions, and educational accommodations (i.e., 504, IEP), which will become part of the data store for review of cross-systems-related outcomes.

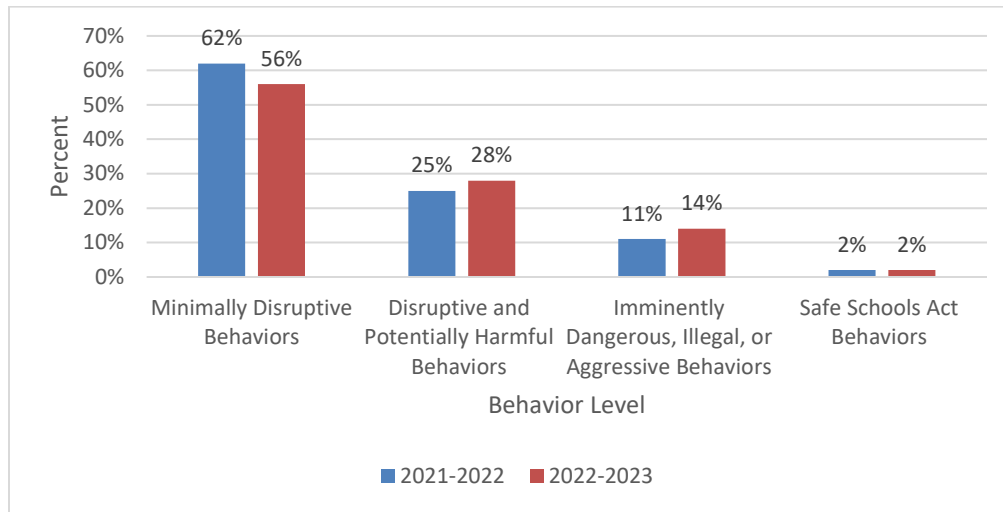
- **Suspensions and expulsions:** While record-level data is not available for analysis at the time of this report, WVDE publishes data via ZoomWV. Disciplinary data from the 2022 to 2023 school year is shown in Figures 107 and 108 below. Foster youth accounted for 7% of all suspensions during the school year, and they were more likely to receive an out-of-school suspension compared to their peers. DoHS continues to emphasize monitoring and reducing disciplinary actions for students in foster care through trauma-informed approaches and interventions. DoHS's collaboration has been expanded in recent months with WVDE to help improve outcomes specifically for youth with child welfare involvement. DoHS has participated in past conferences and plans to participate in future conferences for WVDE school administrators and counselors. This opportunity allows the departments to identify needs and provide expertise on addressing concerns and overcoming misunderstandings, especially regarding addressing and understanding needs related to trauma, mental health needs, and connection to services and supports.

Figure 107: 2022-2023 School Year Suspensions by Type (n= 67,749 Suspensions)



- Disciplinary action is determined by the level of behavior displayed by the student during the incident. Behaviors classified as “Safe Schools Act Behaviors” include: battery on a school employee, felony crime, illegal substance related behaviors, and possession or use of dangerous weapons. By law, these incidents are required to result in an out-of-school suspension. While most incidents each school year were classified as “minimally disruptive” behaviors (62% in the 2021 to 2022 school year and 56% in the 2022 to 2023 school year), there was a slight increase in both “disruptive and potentially harmful” and “imminently dangerous, illegal, or aggressive” behaviors in the 2022 to 2023 school year, implying the proportion of behavior incidents reported have gotten more intense or more dangerous compared to the previous year, highlighting the importance that schools have resources and awareness of how to connect children to key prevention and intervention services. A total of 507 students were expelled during the 2022 to 2023 school year. Considerations related to WVEIS 2.0, an update to WVDE data system, may have accounted for changes in data reporting patterns across school years. WVEIS 2.0 was implemented in the beginning of the 2022 to 2023 school year. This information will continue to be monitored in subsequent periods to identify trends in school behavior related indicators.

Figure 108: Level of Incident Behavior by School Year



18.4 Polypharmacy Utilization

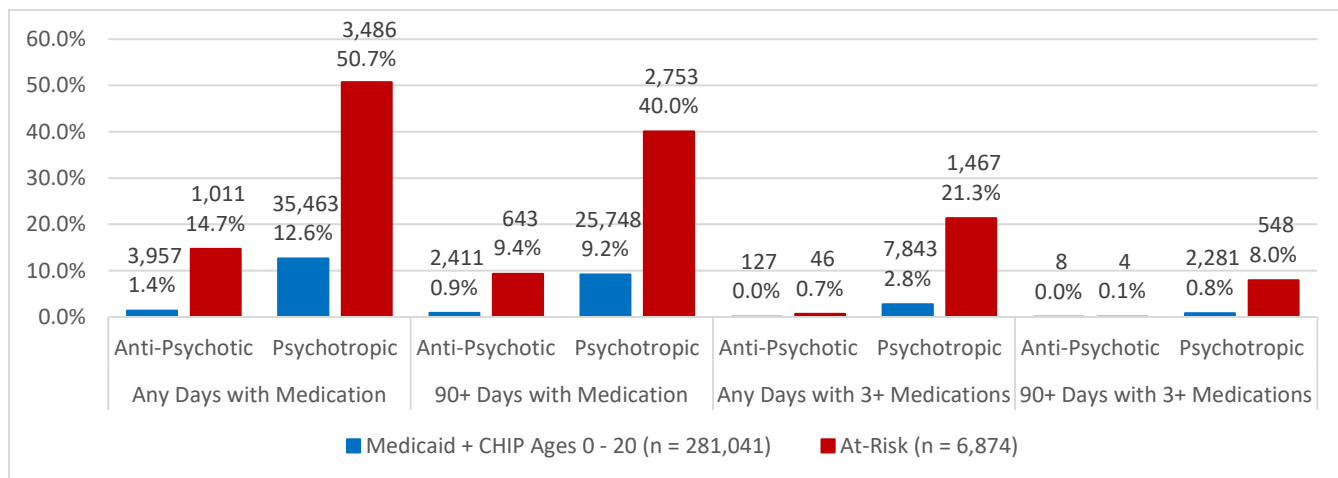
Polypharmacy analyses using pharmacy claims data did not identify significant numbers of children with three or more psychotropic medications, which included use of antipsychotic medications. BMS has policies and processes in place to flag any child for whom polypharmacy may be an issue, enabling intervention when necessary.

A comparison for children in the general population and those at risk of residential placement was completed, as shown in Figure 109, using preliminary data for 2023. It was identified that 40.0% (n = 2,753) of the identified population of at-risk children⁸¹ had at least one psychotropic prescription for at least 90 days, while 8.0% (n = 548) had three or more for at least 90 days. Among the general Medicaid population of children aged 0 to 20, 9.2% (n = 25,743) had at least one psychotropic prescription for at least 90 days, while less than 1% (n = 2,281) 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. Less than 1% (n = 2,411) of Medicaid children utilized an antipsychotic for more than 90 days, while approximately 10% (n = 643) of at-risk children did. Less than five⁸² at-risk children used three or more antipsychotics for 90 days or more.

⁸¹ At-risk children were defined as those children (under age 21) with an SED in 2022 (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 ≥ 90 .

⁸² Data is redacted from Figure 109 to reflect low number of children.

Figure 109: Psychotropic and Antipsychotic Utilization Among Children with WV Medicaid and Children at Risk for Residential Placement January to June 2023

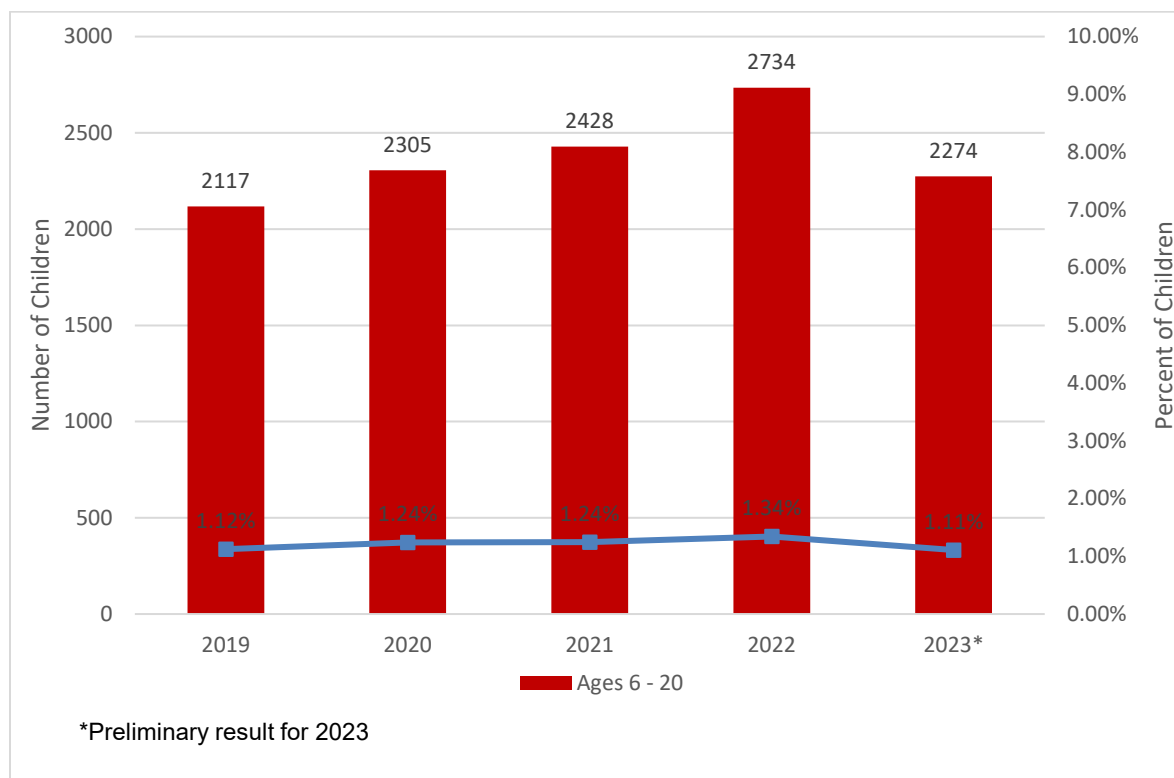


The COVID-19 pandemic impacted healthcare significantly. WV Medicaid's extended eligibility for individuals enrolled in Medicaid ended in March 2023. Increased allowances for telehealth services have improved access for some populations who have reliable access to phone and internet capabilities. Figure 110 shows the number and percentage of Medicaid children aged six to 20 with three or more psychotropic medications for 90+ days from 2019 to June 2023⁸³. Preliminary 2023 data showed 2,274 children utilized three or more psychotropic medications for 90+ days⁸⁴, representing 1.1% of children aged six to 20. This was very similar utilization compared to 2019, prior to the pandemic. DoHS will continue to monitor this to help ensure prescriptions, including polypharmacy utilization, remain appropriate.

⁸³ Data included claims incurred through June 2023 and paid through October 2023.

⁸⁴ It was noted in quality reviews that titration of medications during a medication change could result in the appearance of usage of multiple medications used while in actuality it was changing medications and needing to wean off of a previous drug according to set protocol.

Figure 110: Utilization of Three or More Psychotropic Medications for 90+ Days for Medicaid and CHIP Children Aged 6 – 20, Calendar Years 2019 – 2023*



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 reviewed for appropriate age, dose, therapeutic duplication, and potential drug-drug and drug-disease interactions. When claims are denied, prescribers are required to complete a prior authorization and provide justification for the prescription. These requests are reviewed by a child psychiatrist available through a contract with MU. 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.

18.5 CANS Assessment

DoHS continues actively working toward capturing changes in functional ability, statewide and by region, including data from the CANS assessment and the quality sampling review process. Details of this work are captured in this subsection.

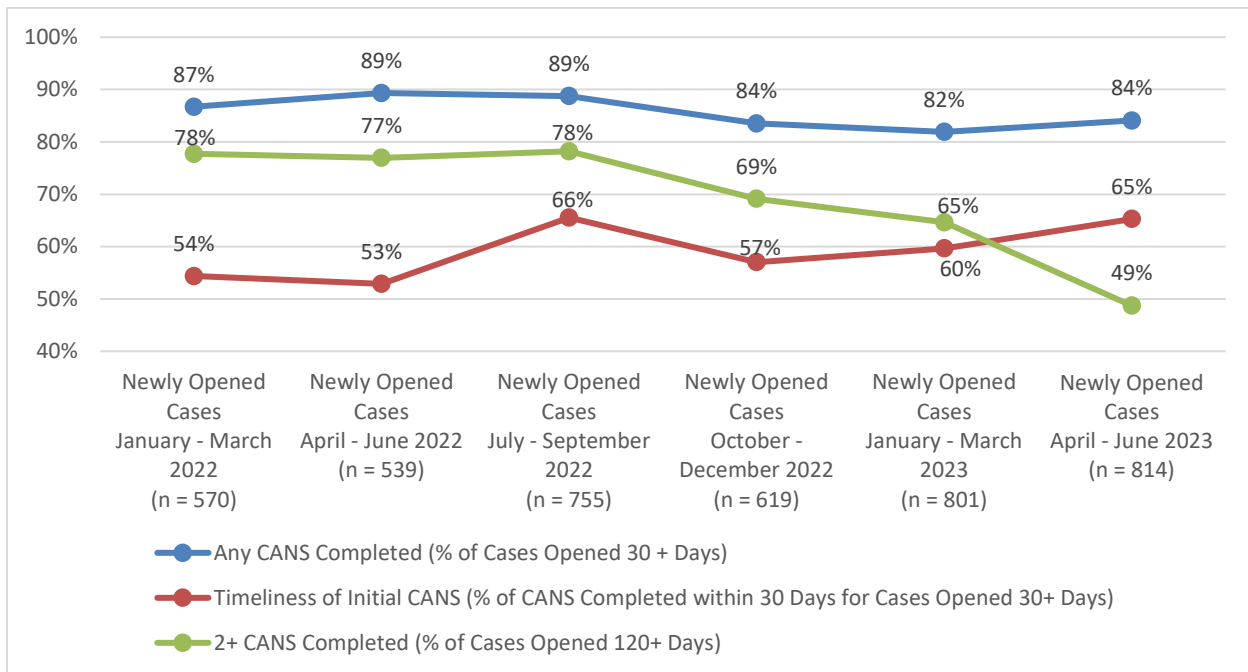
DoHS is partnering with WVU to complete quality sampling reviews, which will include cross-systems analysis, surveys, and interviews with a sample of at-risk children and their caregivers. Initial cross-system analyses have been completed and included in other areas of this report regarding the at-risk population. In addition to this, the community-based quality sampling review findings will be included in the CMH Evaluation report to be finalized in early 2024. DoHS will provide an update on next steps in an addendum to this report in spring 2024.

Initial CANS assessment data has continued to be monitored 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 in Q2 2023, 84% of all children—enrolled in SAH, RMHTF, CSED, or BBH and reported in the CANS Automated System for at least 30 days—had at least one CANS completed (Figure 111). This was similar to rates in Q4 2022 and Q1 2023 but slightly lower than the first three quarters of 2022. Similarly, the percentage of children who were enrolled at least 120 days who had two or more CANS was highest in the first three quarters of 2022 before dropping in Q4 2022 and the first half of 2023.

The number of newly opened cases (Figure 111) significantly increased year-over-year, from 570 in Q1 2022 to 801 in Q2 2023 (41% increase), and from 539 in Q2 2022 to 814 in Q2 2023 (51% increase). The Quality Committee discussed that this influx may have impacted the ability of providers to complete and/or enter CANS data for some children. While the percentage of CANS completed has decreased, CANS completed in a timely manner (within 30 days of enrollment) have increased from 53 to 54% in the first half of 2022 to at least 57% in the subsequent four quarters, with 65% of children with newly opened cases in Q2 2023 having timely CANS completion.

Decreases in recent quarters may be influenced by data entry lag, considerations related to transfer of interim wraparound cases (case closeout), and integration of changes and new providers in the system who may take time to improve utility. Considerations related to data quality and completion were discussed in depth during the November Quality Committee review, the group decided to reach out to providers to remind them of the importance of data completion to address these issues. The Quality Committee identified a deadline of January 10, 2024 to have all data through the end of November brought up to date. Data will be reevaluated in early January 2024 to see if this intervention had an effect. Data will also be pulled at the provider-level to address specific issues related to data quality and completion.

Figure 111: CANS Completion and Timeliness – Newly Enrolled Children by Quarter, Q1 2022 – Q2 2023



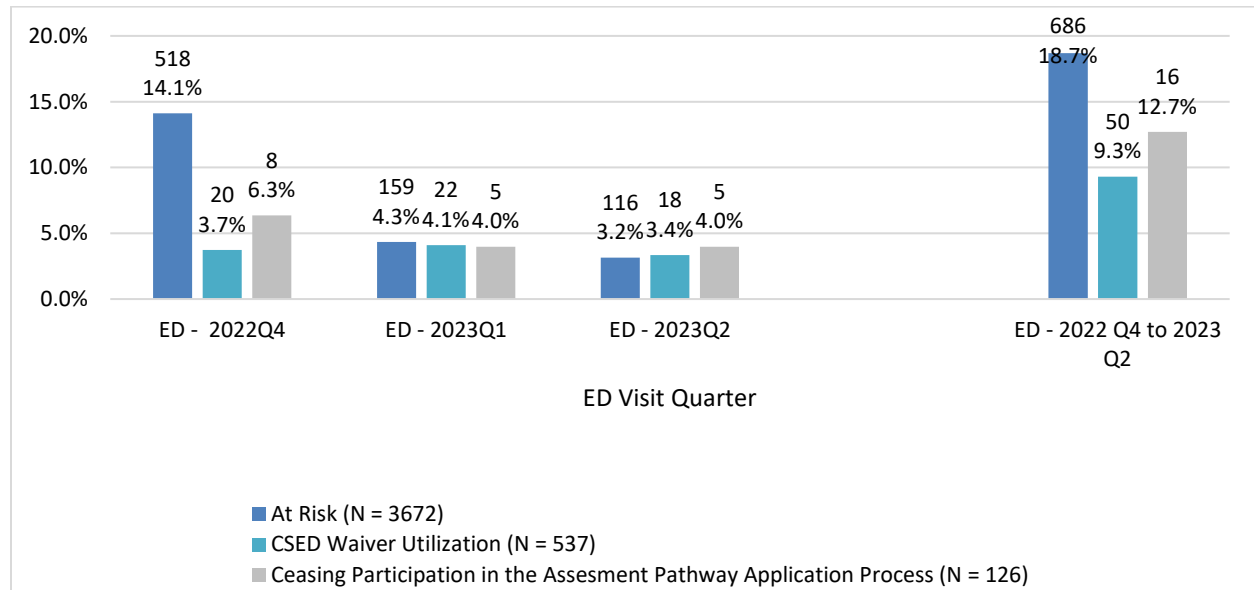
As noted in previous reports, further outcome methodology for the CANS assessment has been developed and tested to assess functional improvements over time. This method has not yet been applied on a broader dataset due to data quality and completion concerns. As data collection becomes more robust and the data store continues to grow, DoHS anticipates additional outcomes data will become available for consideration and reporting.

18.6 Outcomes Across Populations

Some youth and families utilize the ED for behavioral health needs and crisis stabilization. Visiting the ED is one element of the criteria for a youth to be identified as at-risk. Connecting youth and families to HCBS should reduce inappropriate or unnecessary use of the ED. Figure 112 displays ED visits for at-risk youth, youth utilizing CSED Waiver services, and youth who ceased participation in the Assessment Pathway application process during the fourth quarter of 2022. One in seven (14%) of at-risk youth had an ED visit related to a mental health need in the last quarter of 2022. Since an ED visit can be a reason a youth is flagged as at-risk, it may be expected that these youth have a higher incidence of ED visits. Once identified as at-risk, there was a decrease in the incidence of youth with visits in the following two quarters. Children enrolled in CSED Waiver services and those who ceased participation in the Assessment Pathway application process remained relatively similar over the three quarters, with less than 6.5% of respective children engaging with the ED after application to or utilization of CSED services. Youth utilizing CSED Waiver services were the least likely to engage with the ED for mental health reasons from Q4 2022 to Q2 2023 at less than 10% of youth visiting the ED, compared to nearly 19% of at-risk flagged youth and 12.7% of youth ceasing participation with the Assessment Pathway. Although there is slightly higher incidence associated with those

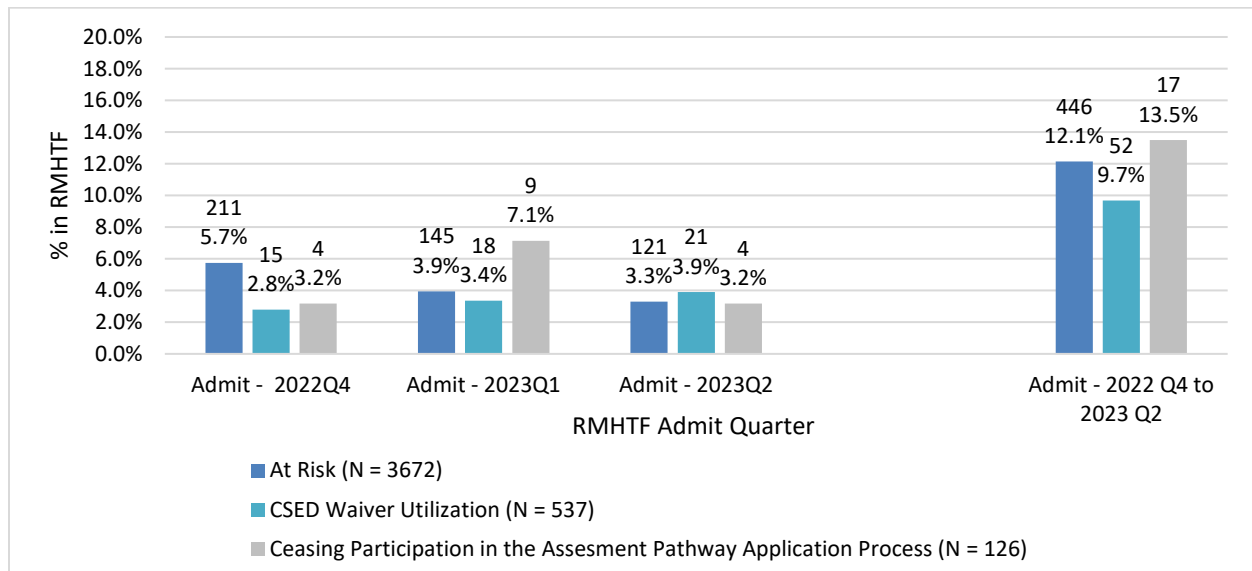
ceasing participation, there may be protective factors associated with engaging with the Assessment Pathway and ceasing participation such as increased awareness of available resources and potentially less intensity of need if no longer pursuing the CSED Waiver.

Figure 112: Emergency Department Visits After Identified At-Risk/CSED Waiver Utilization/Ceasing Participation in the Assessment Pathway Application Process by Quarter



The CSED Waiver permits DoHS to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. As shown in Figure 113 below, children who began participating in CSED during Q4 2022 had fewer RMHTF admissions than at-risk youth and those who ceased participation in the Assessment Pathway application process. Youth ceasing participation in the Assessment Pathway had twice the incidence rate of admission to an RMHTF in the quarter following “engagement” compared to youth utilizing CSED services (7.1% and 3.4%, respectively). It is a positive finding that incidence is low for both youth ceasing participation and utilizing CSED, likely due to protective factors mentioned previously; however increased incidence in the months following ceasing participation for relevant youth will be an area continued to be monitored for additional opportunities for diversion.

Figure 113: RMHTF Admission After Identified At-Risk/CSED Waiver Utilization/Ceasing Participation in the Assessment Pathway Application Process by Quarter



19.0 Conclusion

DoHS continues to make significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of WV, including raising awareness of the availability of these services. Key accomplishments in the second half of 2023 include the following:

- DoHS has spent considerable time enhancing data collection tools to allow data capture at the child-level, reviewing data for opportunities to enhance data quality, and fine-tuning key indicators. DoHS also worked extensively with key partners, such as Aetna and Acentra Health, to make enhancements to their data collection systems for improved reporting.
- Significant progress was made on the build-out of the data store. Child-level data matching is currently in place for the following datasets in the data store: RMHTF services, CSED eligibility, CSED utilization, RMHTF CAFAS/PECFAS score history, and CANS case history (i.e., case service-level completion and timeliness).
- BMS produced an extensive array of outreach materials and distributed them statewide in December 2023. Resource kits were sent to schools and community organizations (as well as emergency departments), including CSED Waiver posters, window clings, magnets, stickers, and wallet cards. Community and school personnel guides were distributed as well. These materials included information about the CCRL and 988-Suicide and Crisis Lifeline. Nearly 1,000 resource kits were sent across the state.
- Development of the “West Virginia Needs You Now” Campaign for focused recruitment of foster homes willing to accept youth with complex mental and behavioral health needs. This campaign will formally launch in early 2024.
- Community-based TLVY homes were operationalized in September 2023 with the capacity to serve a total of 22 transition-age youth.
- DoHS continued to make progress in developing the new RMHTF models of care. The new models and associated rates were presented to current residential providers and stakeholders in November 2023. The new models of care include community-based residential homes, RIT homes, and SRIT homes. DoHS’s goal is to begin transition to these new models of care by July 2024.

Implementation and adoption, as well as efforts to raise awareness, are ongoing, 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 demonstrate that DoHS’s efforts are having the intended effect.

DoHS's CQI processes continue to expand and evolve. The Office of QA collaborates daily with program leadership and staff, as well as with vendors and providers, to continue to align efforts, improve data quality and reporting, and facilitate responsive, nimble action for improved outcomes. Expanded data sharing with a variety of partners and stakeholders, including the WVDE, DHS, court systems, and vendors and providers, is recurring. These efforts are building momentum to help ensure sustainable, available, and accessible programs and services for children and families across WV.

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

- Further expansion of community-based services capacity to include:
 - Continued CSED Waiver and Wraparound Facilitation services forecasting and provider network expansion in partnership with Aetna and providers.
 - Focused recruitment of foster care homes to serve youth ages 13 to 17 with complex mental and behavioral health needs.
 - Further expand TLVY homes to meet the needs of transition-age youth.
- Focused improvements on the prioritized discharge planning process to include:
 - 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.
 - Further explore and define roles and responsibilities associated with discharge planning, quality review of treatment plans, including discharge plans, expansion of community-based placement options (e.g., foster homes) to meet the demand of children ready for discharge from RMHTF, and follow-on care management following discharge to ensure a child's ongoing success in the community (i.e., mitigate readmission to RMHTF placement).
 - Update contracts and provider agreements to clearly capture expected roles, responsibilities, and associated reporting to DoHS.
 - Complete development of flags in Quickbase to identify children in residential placement to enhance prioritized discharge planning efforts further as well as the associated processes for timely review and follow-up in collaboration with Aetna, CPAs, and other child-serving entities.
- 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.
- Operationalize the new RMHTF models of care to support children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and sexualized behavior.
- Coordination between BPH and the MCOs to help ensure EPSDT with mental health

screens are conducted annually on 52% of Medicaid-eligible children.

- Onboarding of new CMCRS providers through the addition of mobile response services to West Virginia's Medicaid State Plan.
- Continued enhancement of quality infrastructure and processes within DoHS to include:
 - Reviews for focused improvement of data collection, quality, and completion across DoHS, vendors, and providers;
 - Ongoing analyses disaggregated by provider, vendor, region, and/or county for key indicators 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, assist with focused recruiting and provider network expansion, and support DoHS's quality improvement efforts.

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

Appendix A: Glossary of Acronyms and Abbreviations

Figure 114: 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
CMHW	BBH Children's Mental Health Wraparound
CMS	Centers for Medicare and Medicaid Services
CSED	Children with Serious Emotional Disorder
SED	Serious Emotional Disorder
CPA	Child Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DART	Document Assessment and Review Tool
DUA	Data Use Agreement
DHHR	WV Department of Health & Human Resources

Acronym/ Abbreviation	Description
DHS	WV Department of Homeland Security
DoHS	WV Department of Human Services
DW/DSS	Data Warehouse/Decision Support System
ED	Emergency Department
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, and Others
MU	Marshall University
MAYSI	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OCMS	Offender Case Management System
Office of QA	Office of Quality Assurance for Children's Programs
PBS	Positive Behavior Support
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
RIT	Residential Intensive Treatment Facility
RMHTF	Residential Mental Health Treatment Facility
SAH	Safe at Home
SMI	Serious Mental Illness
SPA	State Plan Amendment
SRIT	Specialized Residential Intensive Treatment Facility

Acronym/ Abbreviation	Description
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
WVU CED	West Virginia University Center for Excellence in Disabilities
YS	Youth Services

Appendix B: BBH Region Map

Figure 115: Map of the Six BBH Statewide Regions

